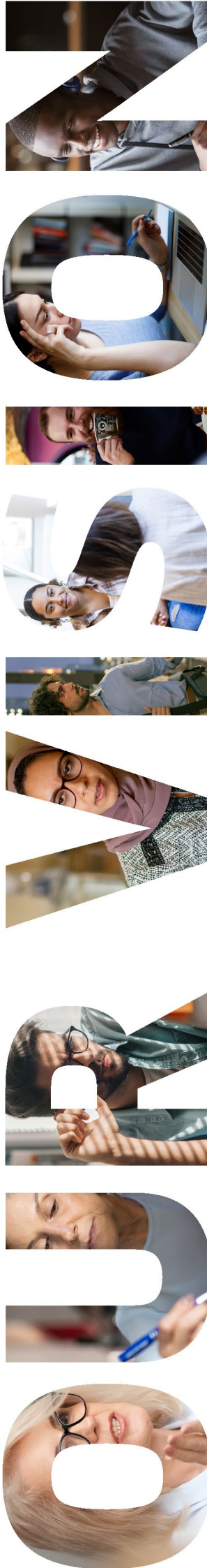
THE PLACE OF USEFUL LEARNING

STRATHCLYDE

suicide prevention STRATEGY



University of Strathclyde Glasgow

STRATHSafe360

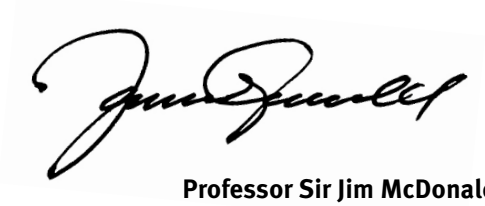
Principal's Introduction

At the University of Strathclyde, we strive to innovate and build upon our founding mission as 'a place of useful learning'. As part of this, we must strengthen our collective efforts to make this a 'safe place of useful learning' too, one that places the wellbeing of everyone in our University at its heart.

Our community has been impacted by suicide. That's why we've developed a strategy aimed at both staff and students to address this public health concern. Our first step toward achieving this goal has been to appoint a full-time Suicide Prevention Project Coordinator - the first post of its kind within Higher Education in Scotland. We will be bold in our approach to mental health and suicide prevention and nurture a mentally healthy and flourishing community. This vital work sits within our wider safe 360 safeguarding framework[1] and it further demonstrates our strategic commitment to being a 'people first' institution.

Suicide impacts all of us at some point in our lives, whether on a personal level or at a distance. That's why we consider suicide prevention to be a shared responsibility. It is 'everyone's business'. To achieve our strategic aims we have established strong and sustainable links with Scottish Government, the National Health Service (NHS), Public Health Scotland (PHS), Universities, Colleges, and a range of external organisations. A core component of our strategy development has been to establish an External Advisory Group with these partners. The expertise of this group has ensured that our strategy is both open to scrutiny and closely aligned to Scotland's National Suicide Prevention Strategy 'Creating Hope Together 2022-2032', fulfilling our commitment as a socially progressive institution.

Our long-term commitment will address organisational challenges and bridge the 'implementation gap' that often exists in strategy delivery. By placing the theme of 'Time, Space, Compassion' at the centre of our efforts, we can move forward together to become a safer and more connected community. My final message is to encourage you to seek support if you are currently experiencing suicidal thoughts or a suicidal crisis. Please ask for support, and please know that there is help available. There is a range of support resources listed in Appendix 1.



Professor Sir Jim McDonald
GBE FREng FRSE
Principal & Vice-Chancellor

1. https://www.strath.ac.uk/whystrathclyde/safe360/

Spotlight: Lived and living experience

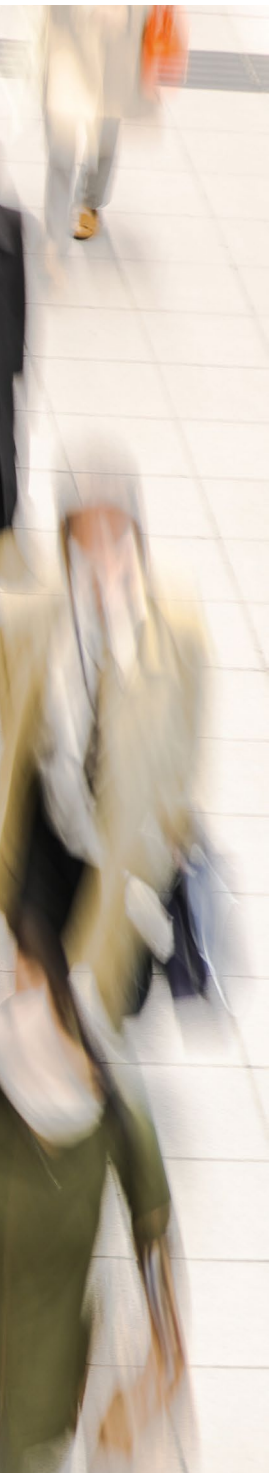
My name is Scott, and I attempted suicide on 8th February 2018. Suicide. I know how difficult that word can be for people to say and how it makes them uncomfortable. Too often, people avoid it entirely. But avoiding the word does not take away its reality–if anything, it gives it more power. This is something I am passionate about changing.

Since my own suicide attempt, I have worked to recover, rebuild, and ultimately, to find purpose—not just for myself, but to help others who may be struggling. In 2020, after sharing my story in a tutorial, Dr. Susan Rasmussen, the chair of the Suicide Safer at Strathclyde group, reached out to thank me for sharing my experience and invited me to join the group. As soon as Susan outlined its purpose, I knew I wanted to be a part of it—not just to share my own experiences, but to help ensure that the voices of those who have struggled are heard, respected, and included in shaping meaningful change.

Lived experience is not just a story to be heard, it is a perspective that can drive real change. And 'living' experience matters just as much. It highlights that people are still here, still fighting, and still navigating their own journeys. Recognising both lived and living experience helps us understand what truly makes a difference, what barriers stop people from seeking help, and how we can create a culture and environment where no one feels alone in their darkest moments.

Through my own lived and living experience, I have contributed significantly to this project and, by extension, this strategy. I have shared my story to shape conversations, ensuring that the university's approach to suicide prevention is not just policy-driven but deeply human and focused on the people it is designed to support. I have presented to different groups both within and outside the university, encouraging meaningful discussions that have led to real progress. My involvement expanded when I was invited to join the project board of the Suicide Safer group, where I had a voice in the decision-making process. I have also completed a research internship, co-hosted lived experience focus groups, led suicide awareness training, and attended external advisory group meetings, working alongside a team of individuals with vast knowledge and experience in suicide prevention.

Being part of this project has given me purpose, but more importantly, it has given me hope—hope that we are moving towards a culture where people feel able to ask for help without fear or shame. Hope that suicide will no longer be something whispered about, but something we can openly talk about with care and compassion. Suicide is preventable, and with this strategy, Strathclyde is taking a vital step toward becoming a suicide-safer place.



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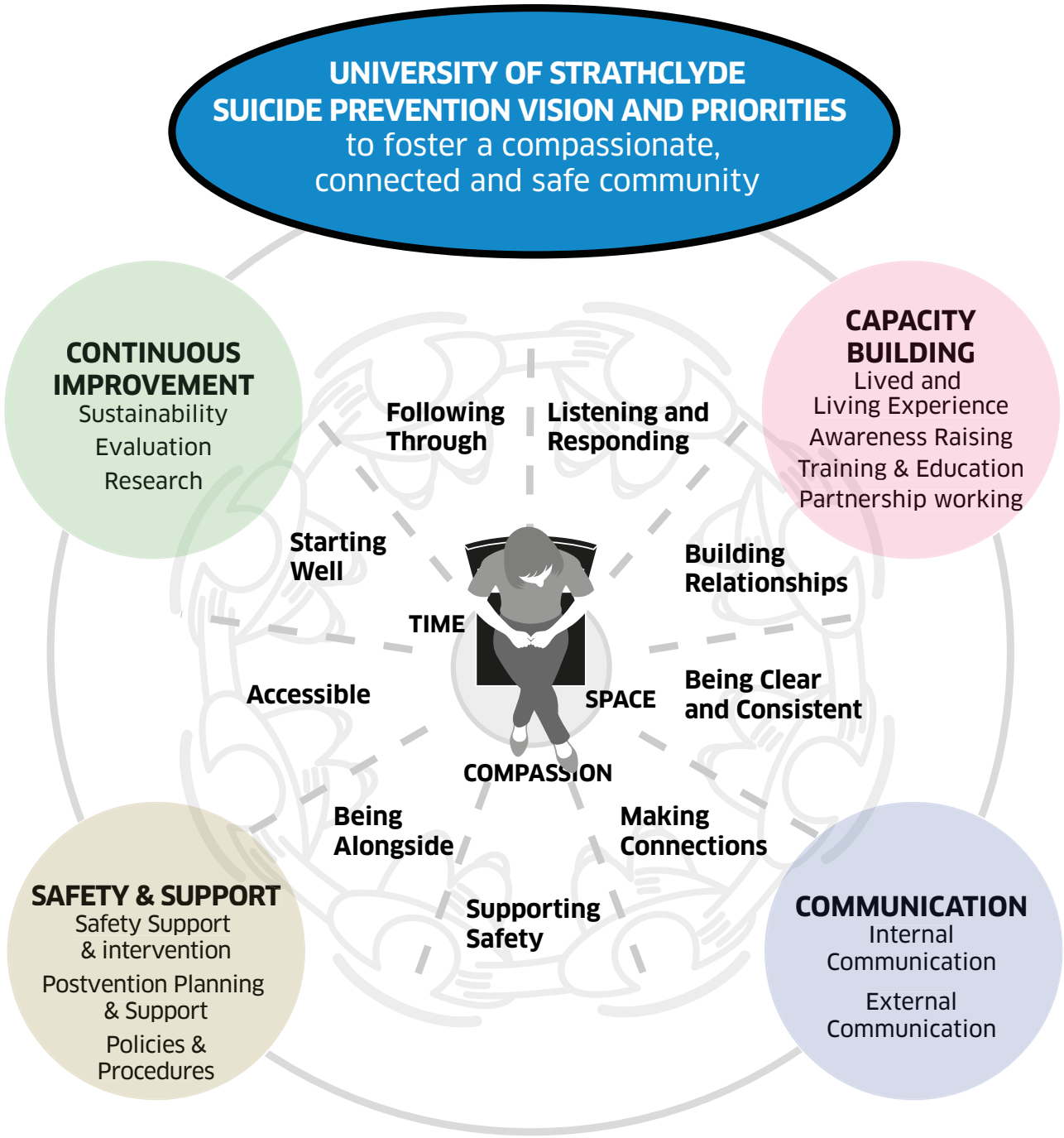
1. Statement of purpose

Suicide prevention is about people. Our suicide prevention strategy was written by members of the Strathclyde community, for our community. The voices of those with lived and living experience are at its core. This strategy is about staff and students coming together to think about how we can prevent suicide and support those with lived and living experience.

Our vision is to ensure a compassionate community where everyone can contribute to achieving our suicide prevention mission and where suicide prevention is embedded into our daily activities. To realise this vision, we will take a whole university approach to create a compassionate, connected and safe environment for staff, students, and visitors. We have identified four areas of priority to achieve this *(see Figure 1)*. The aims set out in our four priority areas are what we see as achievable and realistic within a 5-year delivery plan. They take the key themes from our statement of purpose and translate them into a set of actions that will move us towards our goals.

The delivery of these actions will be guided by an Implementation Action Plan, which will be developed using our principles of Time Space Compassion. We will rely on a whole University approach, delegating areas of responsibility to staff and students through the analysis of our implementation plan by our project board. We will identify annual KPI's and areas for key improvement and develop checklists for all directorates so action can be owned at a local level. We have created a sustainable structure, and the actions of our plan will have clear lines of reporting.

FIGURE 1


UNIVERSITY OF STRATHCLYDE
SUICIDE PREVENTION VISION AND PRIORITIES
to foster a compassionate, connected and safe community
CONTINUOUS IMPROVEMENT
Sustainability
Evaluation
Research
CAPACITY BUILDING
Lived and Living Experience
Awareness Raising
Training & Education
Partnership working
Following Through
Listening and Responding
Starting Well
Building Relationships
TIME
Accessible
SPACE
Being Clear and Consistent
COMPASSION
Being Alongside
Making Connections
Supporting Safety
SAFETY & SUPPORT
Safety Support & intervention
Postvention Planning & Support
Policies & Procedures
COMMUNICATION
Internal Communication
External Communication

2. Background

The University of Strathclyde was founded in 1796 as 'a place of useful learning'. We received our royal charter as the UK's first technological university in 1964. As a socially progressive and people-oriented employer, the University recognises the importance of a strong health and wellbeing culture within the workplace, as evident in our People Strategy. We recognise that suicide prevention is complex. However, the University of Strathclyde is able to bring together a wide range of resources (existing systems, procedures, skills, knowledge, expertise, and experience), as well as the support of the wider community (e.g., the NHS, third sector organisations, alumni) to develop coherent prevention, intervention and postvention policies and practices.

The University's suicide prevention work takes its place within over 20 years of initiatives focused on supporting the mental health and wellbeing of the Strathclyde community. Most recently, a Safety, Wellbeing and Resilience directorate has been established, and a new Culture of Care strategy has been launched.

The University of Strathclyde acknowledges that universities can play an important role in helping both to prevent suicide and support those who feel suicidal or who have been affected by suicide. Aligned with the University of Strathclyde Values[2] , and the strategic plan 2030[3] , our Suicide Safer Strathclyde Working Group has prioritised a whole university approach to suicide prevention since 2018. Our suicide prevention work acknowledges the unique perspectives of our university environment, as well as the wider national and international context. Our work presented within this document therefore draws on our knowledge of our local community, the existing research evidence base, as well as broader suicide prevention policy work.

There are six main sources we have used to inform the development of our strategy:

1. Scotland's National Suicide Prevention Strategy 'Creating Hope Together 2022-2032'[4]
2. Universities UK and Papyrus guidance on developing suicide safer Universities[5]
3. Our understanding of the unique strengths and needs of our own community at Strathclyde[6]
4. The Scottish Government's principles of Time Space Compassion[7]
5. The Integrated Motivational-Volitional Model of Suicide[8]
6. The Scottish Government's Student Mental Health Action Plan[9]

2. https://www.strath.ac.uk/whystrathclyde/values/
3. https://www.strath.ac.uk/whystrathclyde/strathclyde2030/
4. https://www.gov.scot/publications/creating-hope-together-scotlands-suicide-prevention-strategy-2022-2032/
5. https://www.universitiesuk.ac.uk/what-we-do/policy-and-research/publications/features/suicide-safer-universities
6. https://www.strath.ac.uk/professionalservices/accessequalityinclusionservice/equalitydiversity/reports/
7. https://www.gov.scot/publications/time-space-compassion-supporting-people-experiencing-suicidal-crisis-introductory-guide/pages/3/
8. https://suicideresearch.info/the-imv/
9. https://www.gov.scot/publications/student-mental-health-action-plan/

3. Understanding suicide and self-harm

Suicide and self-harm thoughts and behaviours are globally recognised as significant public health concerns. Every death by suicide represents a life lost with devastating consequences for families, friends, and communities.

Suicide is defined as a "death resulting from an intentional self-inflicted act"[10] while self-harm is an "an intentional act of self-poisoning or self-injury, irrespective of the motivation or apparent purpose of the act and is an expression of emotional distress"[11]. Importantly, suicide is preventable with the right support, and suicidal thoughts can be interrupted.

The National Records of Scotland (NRS) provides detailed information about the suicide statistics for Scotland on an annual basis. NRS data[12] has highlighted that:

- There were 792 deaths by suicide in Scotland in 2023
- Scotland has the highest suicide rate in the United Kingdom
- Males are 3 times more likely to die by suicide in Scotland than females
- The rate of suicide mortality Scotland's most deprived areas was 2.5 times higher than in the least deprived areas
- Suicide is the biggest cause of death in young adults in Scotland
- Only 31% of people who died by suicide in Scotland in 2022 were in contact with mental health services in the 12 months prior to their death
- Between 2011-2019, 77.3% of those who died by suicide in Scotland had contact with at least one of nine healthcare services

Suicide can rarely be reduced to a single factor. Research13 has highlighted that it is the combination of social, biological, and psychological variables which act to increase or decrease the risk of suicide. A review of the past 50 years of research14 on risk for suicidal thoughts and behaviours summarised these into 16 broad categories.

Some examples from these broad categories include:

- Prior suicidal thoughts or behaviours
- Lower socioeconomic status
- Stressful life events like debt or financial worries, relationship or family breakdown, bullying
- Hopelessness, anxiety, and depression
- Feelings of being defeated and trapped

10. https://www.gov.scot/publications/scotlands-suicide-prevention-action-plan-life-matters/pages/5/
11. National Institute for Health and Care Excellence (NICE). Self-harm in over 8s: long-term management. Clinical Guideline [CG133]. NICE, 2011. (https://www. nice.org.uk/guidance/cg133).
12. https://www.nrscotland.gov.uk/publications/probable-suicides-2023/
13. Turecki, G., Brent, D. A., Gunnell, D., O'Connor, R. C., Oquendo, M. A., Pirkis, J., & Stanley, B. H. (2019). Suicide and suicide risk. Nature reviews Disease primers, 5(1), 74.
14. Franklin, J. C., Ribeiro, J. D., Fox, K. R., Bentley, K. H., Kleiman, E. M., Huang, X., ... & Nock, M. K. (2017). Risk factors for suicidal thoughts and behaviors: A meta-analysis of 50 years of research. Psychological bulletin, 143(2), 187.

Researchers have also developed theories of suicide that provide us with a promising way to advance our knowledge. Therefore, it is important that any suicide prevention efforts also consider what these theories can add in terms of managing risk and understanding protective factors around suicide.

One of these theories, the Integrated Motivational Volitional (IMV) Model of Suicide[15] is recognised within the Scottish Government's Suicide Prevention Work and will also form one of the building blocks of suicide prevention at the University of Strathclyde. It is one of the most widely accepted theories of suicidal behaviour and has a strong evidence base[16].

The IMV model conceptualises suicide as a behaviour. This is important because it moves the focus away from viewing suicide as a symptom of a psychiatric condition. This move in focus allows us to integrate existing biological, sociological and psychological knowledge at each stage of this pathway, illuminating potential targets for intervention, and helping us to understand the pathway from suicidal thoughts to behaviours. As shown in *Figure 2*, it is a phased model which divides this pathway into three stages.

The IMV recognises that suicide can affect anyone but that it is socially patterned (the pre-motivational phase). It further argues that the experience of defeat or humiliation from which there is no escape, i.e., entrapment, is the key driver of suicidal thinking (the motivational phase). Finally, it provides information about the factors which might impact on whether a person will act on these thoughts (the volitional phase). See *Figure 3* for information about the key factors that impact this transition from ideation to behaviour.

Theories such as the IMV are important because they allow researchers and practitioners to better understand the complex series of events which precede a person considering ending their own life, as well as the reasons why some individuals act on those thoughts and others do not. It therefore helps us to not only advance our understanding of suicide risk but also provide us with opportunities to develop prevention and intervention efforts. As practitioners within Higher Education, working with these theories means we can consider suicide prevention action beyond the moment in which it is being considered. Our strategy for suicide prevention can also target those earlier phases by understanding why someone might begin to feel suicidal in the first place.

The IMV model will be used to guide action. Throughout this strategy document, there will be specific references to key factors highlighted within this model. In particular, we feel it is important to understand why our staff and students might experience feelings of defeat and entrapment, and to develop strategies to reduce these feelings. Our strategic work will therefore draw on theory, research, lived and living experiences of suicidal thinking, behaviours, and loss, as well as our Strathclyde specific knowledge, expertise, and practice.

15. O'Connor, R. C., & Kirtley, O. J. (2018). The integrated motivational–volitional model of suicidal behaviour. Philosophical Transactions of the Royal Society B: Biological Sciences, 373(1754), 20170268.
16. Souza, K., Sosu, E. M., Thomson, S., & Rasmussen, S. (2024). A systematic review of the studies testing the integrated motivational-volitional model of suicidal behaviour. Health psychology review, 1-25.

FIGURE 2. The Integrated Motivational Volitional Model of Suicide (O'Connor & Kirtley, 2018)

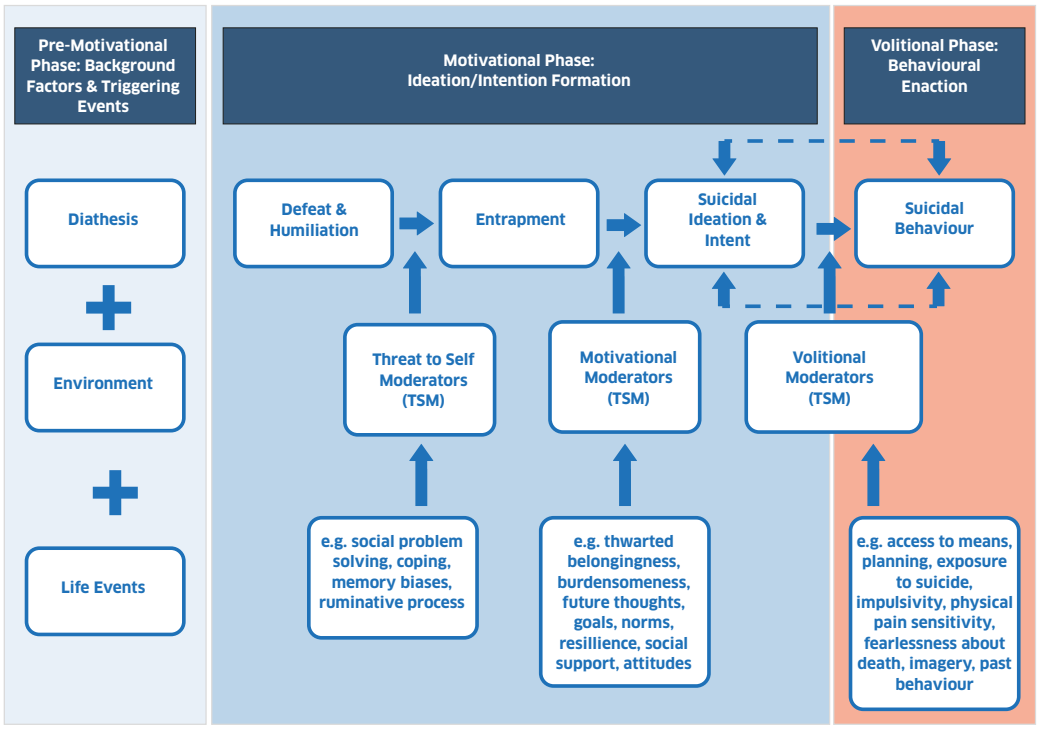


FIGURE 3. The 8 Volitional Factors: the transition from suicidal ideation to suicidal behaviour

For more detailed information on this model please access the following **link.**

https://suicideresearch.info/the-imv/

Spotlight: The Integrated Motivational-Volitional (IMV) Model of Suicidal Behaviour

Our Knowledge and Skills Framework (KSF) is described in more detail in the 'Capacity Building' section of the document. Staff in specific intervention roles will develop their knowledge through theoretically informed training developed by the Suicidal Behaviour Research Lab, led by Professor Rory O'Connor, who is part of our External Advisory Group. We will also train all staff in the Disability and Wellbeing Service in the Collaborative Assessment and Management of Suicidality (CAMS Framework). This builds on traditional safety planning by also focusing on the 'drivers' associated with suicidal thoughts and behaviour, and it is closely aligned with the IMV model.

4. The Higher Education context

In Scotland there are no accurate statistics for the number of university students who die by suicide each year. More broadly speaking there is evidence in the UK that the rates of suicide are lower for students than the general population. The Office for National Statistics published an analysis of probable deaths by suicide of students between 2017 and 2020 in England and Wales. This showed the suicide rate for students was 3.9 deaths per 100,000, which is significantly lower than the 12.5 deaths by suicide per 100,000 for the general population[17]. That said, it is of note that research suggests the rates of student suicide have risen by 52% since 2000/2001, prompting a need for action[18].

Furthermore, in the 'Thriving Learners' survey (2021), 74% of the Scotland-based university students surveyed reported having low wellbeing and 19.6% reported that they either had suicidal ideation or had attempted suicide in the 6 months prior to the survey.

Everyone's wellbeing matters. Staff wellbeing is key to supporting students and to creating a place of belonging for them to feel safe at work.

There are no accurate statistics for staff suicide rates in Higher Education in Scotland. In addition, while research on suicidal thinking and behaviours in students has received attention in the research literature, there is far less information about these in university staff. Existing work does however suggest that the prevalence of mental health problems for academic staff is similar to what is found in students[20]. In addition, there is also emerging evidence to suggest that there are comparable levels of suicidal thinking in university staff[21] to what is found in students. We also know that 68% of people who died by suicide in Scotland in 2022 were in employment. This means it is a priority to ensure our strategy is for both students and staff.

The suicide of any member of a university community is felt by both staff and students. This makes it vital that we consider the impact of a suicide on our community as a whole[22], being mindful that some members of our community may be both staff and student, and that people's roles and responsibilities may both overlap and conflict.

17. Estimating suicide among higher education students, England and Wales: Experimental Statistics - Office for National Statistics
18. Prevalence of mental health issues within the student-aged population - Education Policy Institute (epi.org.uk)
19. Thriving Learners | Mental Health Foundation
20. Meeks, K., Peak, A. S., & Dreihaus, A. (2023). Depression, anxiety, and stress among students, faculty, and staff. Journal of American college health, 71(2), 348-354.
21. Dres, M., Copin, M. C., Cariou, A., Mathonnet, M., Gaillard, R., Shanafelt, T., ... & Azoulay, E. (2023). Job strain, burnout, and suicidal ideation in tenured university hospital faculty staff in France in 2021. JAMA Network Open, 6(3), e233652-e233652.

Spotlight: University KPI

Statistics for 2023 show there were 2.4 times more deaths by suicide in the most deprived areas than the least deprived areas in Scotland. This has been a consistent trend over the years, and it highlights the wider social determinants and health inequalities that contribute to increased suicide risk[23]. The University understands that work across all sectors and partners is essential to tackling health inequalities and widening access to higher education is one of our key priorities. KPI 1 of Strathclyde 2030 has a target of 1300 student entrants from the Scottish Index of Multiple Deprivation (SIMD 0-40) with an even distribution across the deciles[24]. This means we need to prioritise our support for at risk groups and also to recognise that extra vigilance is required to ensure safeguarding of all students.

5. University of Strathclyde Context

The University has four faculties which covers engineering, business, science and humanities and social sciences. Our student community includes over 30,000 students. These students are supported by nearly 5000 staff, 66% of which are based within the faculties, with the remaining staff within professional services.

Students: 30,024

- 61% Undergraduate
- 51% Female/49% Male
- 24% Black, Asian and Minority Ethnicity (BAME)
- 11% Disabled
- 50% 21 years or younger

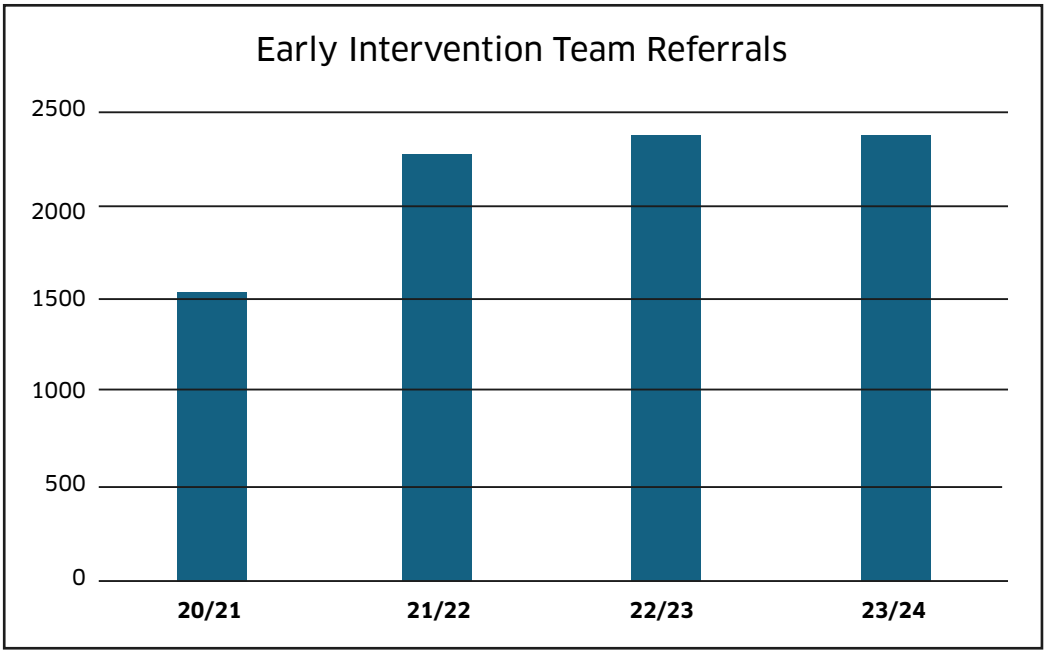
Staff: 4,547

- 80% hold full-time posts
- 51% Female/49% Male
- 10% Black, Asian and Minority Ethnic (BAME)
- 5% Disabled
- Highest proportion of staff are aged 30-39 years (27%)

Student referrals to our Early Intervention (EI) team for counselling and wellbeing support are rising. The graph (Figure 4) below shows that since 2020 there has been a considerable increase in referrals to this service. This demonstrates the need for robust strategies around mental health and wellbeing.

22. Pitman, A., Khrisna Putri, A., De Souza, T., Stevenson, F., King, M., Osborn, D., & Morant, N. (2018). The impact of suicide bereavement on educational and occupational functioning: A qualitative study of 460 bereaved adults. International Journal of Environmental Research and Public Health, 15(4), 643.
23. Scottish Index of Multiple Deprivation 2020 - gov.scot (www.gov.scot)
24. https://www.strath.ac.uk/whystrathclyde/strathclyde2030/

FIGURE 4. Total referrals to the early intervention team per academic year



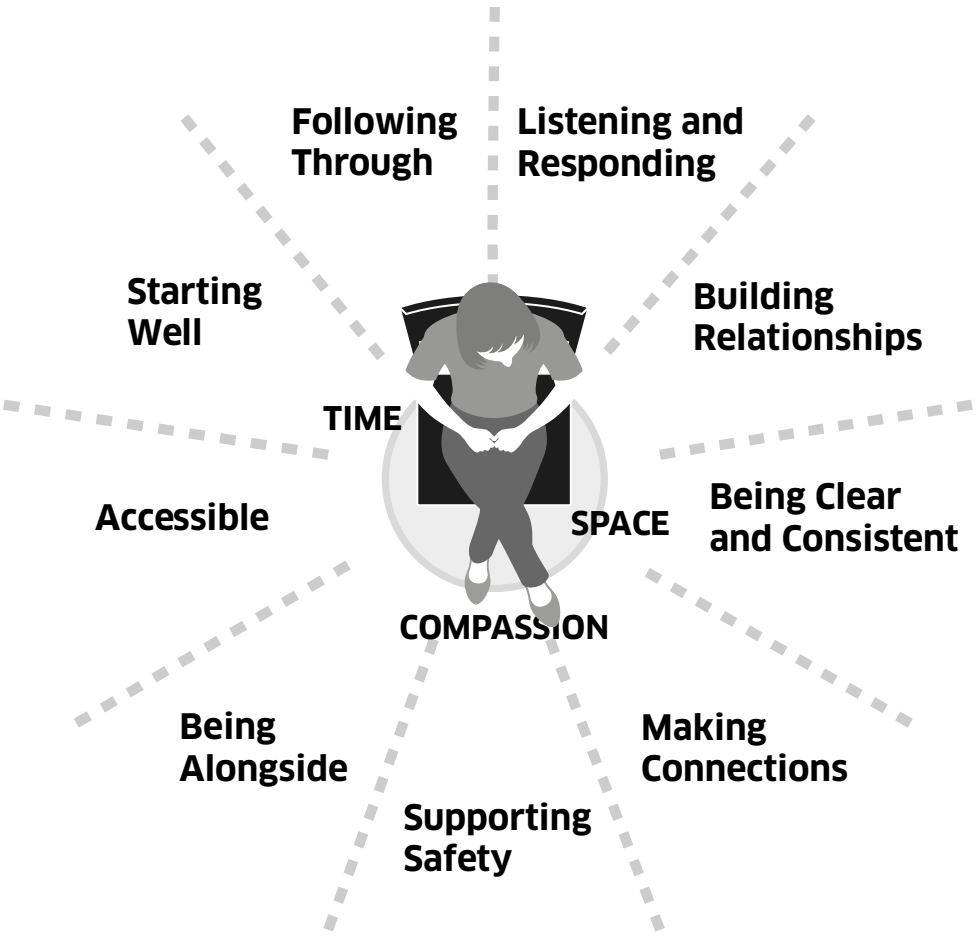
6. Underpinning our work at Strathclyde – Time Space Compassion

The University of Strathclyde initially set out to map our existing activities, gaps in provision and knowledge, as well as to identify what our priorities should be in our own context. Our framework was developed to recognise the importance of ensuring the active participation of the people for whom the strategy was developed, including in the decision-making processes surrounding these activities. We wanted the work to be guided by the voices of those with lived and living experience of suicidal thoughts and/or behaviours, as well as lived or living experience of suicide bereavement. The Implementation Action Plan will be developed to ensure that active engagement with the community both within and outside the University is considered beyond the development phase, across the strategy's implementation, and its future. Health care systems embed mechanisms for continuous quality improvements, and in a similar way, this suicide prevention strategy has been developed to ensure we consider the impact of our proposed activities. We will evaluate what worked and what did not and consider how we can use this feedback to inform future work taking place as part of the University's commitment to suicide prevention.

We have aligned our work with the outcomes of the National 'Creating Hope Together' Suicide Prevention Strategy for Scotland, while also mirroring the suicide prevention guidance provided by Universities UK. Time Space Compassion[25] is foundational to our suicide prevention work. This approach recognises the importance of time, space, and compassion for those who are struggling with suicidal thoughts and behaviours, those who have been bereaved by suicide, and those who support people affected by suicide and suicidal crisis.

Time Space Compassion started as part of Every Life Matters, Scotland's previous strategy for suicide prevention, but is now integrating into the current suicide prevention strategy as well as the Scottish Government's core mental health quality standards[26]. It recognises that we do not yet have sufficient evidence to recommend one single effective model of suicidal crisis service model, but that a good starting point for an approach to suicide prevention is one that emphasises responding to a suicidal crisis as a human reaction first and foremost. In that context, people's lived and living experience of suicidality have highlighted the importance of embedding the principles of Time Space and Compassion into all practices. The Time Space Compassion guide from Scottish Government provides detailed guidance on supporting practices to allow people, groups and organisations to offer Time Space Compassion as part of everyday actions. These are also summarised in Figure 5 below.

FIGURE 5. Time Space Compassion supporting practices[27]



25. https://www.gov.scot/publications/time-space-compassion-supporting-people-experiencing-suicidal-crisis-introductory-guide/pages/1/
26. https://www.gov.scot/publications/core-mental-health-standards/
27. https://www.nationalarchives.gov.uk/doc/open-government-licence/version/3/

7. Priority one: Capacity Building

Our suicide prevention work puts a strong emphasis on the importance of training and building capacity across the university to promote compassionate conversations and to ensure our staff and students are equipped and confident to support positive mental health and suicide prevention. Importantly, it focusses on partnership working both within and outside of the university to ensure suicide prevention can continue to be a core focus within the university.

Lived and Living Experience

Scotland's National Strategy sets a clear aim that work in suicide prevention should be based on research, subject matter expertise and lived/living experience. Embedding a lived and living experience approach into this work in a higher education setting is a challenging but necessary process.

1.1. Staff and students with lived and living experience are members of our project board and suicide safer working groups. This will remain.

1.2. Our internal training delivery will include: 'Ask, Tell, Respond' (adult) resource, 'Wave after Wave Suicide Bereavement training' and 'What's the Harm - Self-harm skills and awareness training'. All of which involved lived and living experience input in their development.

1.3. Suicide awareness training is being delivered by students with lived and living experience to their peers. We will explore possible opportunities for peer led training and this will be included as an objective within the Student Mental Health Agreement[28].

1.4. The voices of lived and living experience will be considered in all aspects of strategy development and impact evaluation. Those with lived and living experience will also be involved in any reviews and updates of the strategy.

1.5. We will continue to create external partnerships that give a voice to those with lived and living experience.

Spotlight: Lived and living experience

My name is Scott, and I attempted suicide on 8th February 2018. Suicide. I know how difficult that word can be for people to say and how it makes them uncomfortable. Too often, people avoid it entirely. But avoiding the word does not take away its reality—if anything, it gives it more power. This is something I am passionate about changing.

Since my own suicide attempt, I have worked to recover, rebuild, and ultimately, to find purpose—not just for myself, but to help others who may be struggling. In 2020, after sharing my story in a tutorial, Dr. Susan Rasmussen, the chair of the Suicide Safer at Strathclyde group, reached out to thank me for sharing my experience and invited me to join the group. As soon as Susan outlined its purpose, I knew I wanted to be a part of it—not just to share my own experiences, but to help ensure that the voices of those who have struggled are heard, respected, and included in shaping meaningful change.

28. https://www.strathunion.com/pageassets/union/governance/policy/Mental-Health-Agreement-23-24.pdf

Lived experience is not just a story to be heard, it is a perspective that can drive real change. And 'living' experience matters just as much. It highlights that people are still here, still fighting, and still navigating their own journeys. Recognising both lived and living experience helps us understand what truly makes a difference, what barriers stop people from seeking help, and how we can create a culture and environment where no one feels alone in their darkest moments.

Through my own lived and living experience, I have contributed significantly to this project and, by extension, this strategy. I have shared my story to shape conversations, ensuring that the university's approach to suicide prevention is not just policy-driven but deeply human and focused on the people it is designed to support. I have presented to different groups both within and outside the university, encouraging meaningful discussions that have led to real progress. My involvement expanded when I was invited to join the project board of the Suicide Safer group, where I had a voice in the decision-making process. I have also completed a research internship, co-hosted lived experience focus groups, led suicide awareness training, and attended external advisory group meetings, working alongside a team of individuals with vast knowledge and experience in suicide prevention.

Being part of this project has given me purpose, but more importantly, it has given me hope—hope that we are moving towards a culture where people feel able to ask for help without fear or shame. Hope that suicide will no longer be something whispered about, but something we can openly talk about with care and compassion. Suicide is preventable, and with this strategy, Strathclyde is taking a vital step toward becoming a suicide-safer place

Awareness Raising

We have collated information about all existing suicide awareness raising activities in the University. This has helped us to identify gaps and build on current good practice, working towards achieving the following objectives:

1.6. Raise awareness about suicide prevention to help tackle the stigma associated with suicide.

1.7. Encourage help-seeking behaviour and find new and innovative ways to bring awareness of support to staff and students. In particular, we will focus on help-seeking awareness raising activities for specific at-risk groups (e.g., members of the LGBTQ+ community, those who are neurodivergent, international students) and those who are 'hardly reached' (e.g., those who have jobs that are not computer based).

1.8. Target isolation through greater promotion of the clubs, peer support networks and societies within **StrathUnion**.

1.9. Embed opportunities for volunteering in suicide prevention within the Student Mental Health Agreement by continuing to strengthen partnerships with external organisations such as Papyrus.

Training and Education

As part of a whole University training group, we have developed a knowledge and skills framework (KSF)[29] for wellbeing, mental health and suicide prevention that aligns closely with the KSF from NHS Education for Scotland (NES) and Public Health Scotland (PHS).[30] This has been worked on in collaboration with NHS Greater Glasgow & Clyde (NHSGGC), PHS, NES, and Glasgow City HSCP (Appendix 2). This framework will help the University move toward our training and education objectives for the next 5 years. These objectives are listed below.

1.10. Provide training opportunities that enable all staff and students to take actions to help themselves and others to feel physically and emotionally safe.

1.11. Promote our knowledge and skills framework for mental health and suicide prevention effectively throughout the University.

1.12. Ensure all counselling staff working in the disability and wellbeing service will be trained in Collaborative Assessment and Management of Suicidality (CAMS).

1.13. Ensure all our students, assignment workers and staff in private Purpose-Built Student Accommodation (PBSA) have access to an 'informed level' of suicide awareness training.

1.14. Explore partnerships with other colleges and universities in Glasgow to maximise our training provision and resources.

1.15. Embed sustainable training delivery and increase the training capacity through a 'train the trainer' approach.

1.16. A major objective within the Disability and Wellbeing Service is that every student and staff member within the University knows someone who is trained to ask them RUOK[31]. Our hope is that this objective will be part of the DNA of everyone at Strathclyde.

1.17. Staff and students who deliver training or who contribute through lived and living experience will have access to support and supervision.

Partnership Working

1.18. Have continued membership from Strathclyde representatives on The National Suicide Prevention Academic Advisory Group, and Glasgow City Suicide Prevention Partnership Group.

1.19. Establish a National Suicide Prevention Network for all Scottish universities and colleges in partnership with Suicide Prevention Scotland and COSLA.

29. This is the Suicide Prevention part of the Strathclyde KSF. The full KSF with all the Wellbeing and Mental Health Training can be accessed here
30. Suicide Contagion training is placed on a different level than the NES/PHS KSF due to delivery consideration in our setting
31. A conversation could change a life | R U OK?

Spotlight: Effective partnership working

NES and PHS have assisted our Education Enhancement team to host a learning resource module for wellbeing, mental health, and suicide awareness on our internal 'MyPlace' system. This module includes the 'Ask, tell respond' resource (adult) that was developed by PHS and NES in partnership with those with lived and living experience of suicide and mental illness. The resource is available for all staff and students. This internal availability has removed barriers to access and means we can build extra safeguarding and evaluation questions specific to our setting. The data gathered from this feedback will help in the evaluation phase of the project where we will measure the individual and organisational impact of this work. Feedback and data will also be shared with NES and PHS to help assess the 'Ask, tell, respond' resources suitability for further and higher education settings.

8. Priority two: Communication

At both an organisational and individual level, effective communication is essential for creating a suicide safer environment. Our student members with lived and living experience of suicide identified it as the single most important issue. It is also key to ensuring people receive the support they need, when it matters most. We have set out our key strategic communication objectives below.

Internal Communication

2.1 Promote both online and in person crisis intervention services and ensure routes to support are clear and accessible.

2.2 Explore how our communications strategy can be informed by the IMV model to highlight opportunities to reduce feelings of being defeated and trapped.

2.3. Develop inclusive and accessible information about how to manage wellbeing and mental health and use our digital team to convey appropriate messaging and measure its effectiveness through data analysis.

2.4. Encourage innovative ways to improve messaging around suicide prevention through accessible and creative approaches (film, art, writing, etc.) and to share personal stories of hope from people across different backgrounds with the aim of reducing stigma.

2.5. Increase active membership and participation of staff and students with lived and living experience in our suicide safer working groups (See Appendix 6).

2.6. We will use the 10 principles of Time Space Compassion as noted in Figure 3 to build effective interpersonal communication around suicide.

2.7. Ensure existing systems and processes are used effectively to provide accurate, meaningful, and regular reports.

External Communication

2.8. Facilitate learning by sharing findings from impact evaluations within the sector and to wider stakeholders.

2.9. Work closely with external partners to understand their needs and develop relationships, networks and feedback loops that allow us to share the impact of our work.

9. Priority three: Safety and Support

The wellbeing and safety of our community is paramount. Therefore, our plan prioritises work to ensure those who are affected by suicidal thoughts and/or behaviours or are affected by the loss of someone to suicide, have compassionate support available to them when they need it. In addition, we will develop opportunities to restrict access to means and ensure safe spaces for anyone who is in crisis.

Safety

3.1. Improve our community's understanding of suicide risk and ability to respond confidently, appropriately, and with compassion to people who may be suicidal or affected by suicide.

3.2. Develop physical safe spaces that staff and students can access if they are in crisis.

3.3. Restricting access to means will be routinely considered as part of building design, procurement processes, refurbishments and estate planning.

3.4. Routine safety, security, building and estate reviews will continue to take place to ensure our campus is as safe as possible.

3.5. Online safety – real time monitoring of social media will take place where possible in circumstances where there has been a suicide, to address issues around clusters and suicide contagion.

3.6. Responsible communication and reporting will be in line with the Samaritans' media guidelines on how to respond to a suicide[36].

3.7. Monitoring of CCTV and increasing staffing and foot patrols will take place around any high-risk locations. Report any locations of concern to Glasgow City Suicide Prevention partnership group.

3.8. Signage and information around support will be carefully placed and will signpost to sources of help.

3.9 Delivery of suicide contagion training as appropriate to those who are most likely to be involved in a postvention response.

3.10 Suicide prevention will be considered in full campus risk assessment processes (this includes off-field locations, students' union, sports facilities etc.) and the storing and access to chemicals and equipment.

32. https://www.samaritans.org/scotland/about-samaritans/media-guidelines/

Spotlight: Restricting access to means

Restricting access to means is one of the most successful approaches to reducing suicide rates and attempts[33]. Ease of access to lethal means can influence the outcome of a suicide attempt, which means that managing both physical and cognitive access to suicide is a priority. Through our suicide safer project board, we have established a specific 'restricting access to means' working group which involves senior members of Estates, Corporate Communications and Safety, Wellbeing and Resilience. Members of this group will work on the objectives set out in the safety section and will involve the project board and wider University as required.

Support and Intervention

3.11. All staff and students who present with suicidal thoughts or behaviours will receive timely and compassionate support.

3.12. Our 'Helping Students in Distress Guide' will be updated on an annual basis (this guide focuses on appropriate signposting and referral pathways). Additionally, 'Helping Students in Distress' training will be available to all student facing staff.

3.13. A 'Helping Staff in Distress Guide' will be developed in partnership with Human Resources and the Workplace Wellbeing Manager. This will be available to every staff member in the University.

3.14. Ensure that referral pathways to external organisations are communicated effectively to staff and students. Particularly, ensure staff in supporting roles are aware of the help that can be accessed via NHS 24's mental health hub, compassionate distress response service and across mental health services, primary care and the third sector.

3.15. Strengthen partnerships with GP practices, local mental health services and the third sector.

3.16. Follow up with students, staff and services after incidents to make sure the right support is in place for individuals.

3.17. Ensure all staff and students in University or private PBSA have information on available student support in a range of formats.

3.18. The EI Counsellors within Disability and Wellbeing will aim to meet with students within 24 hours of the student referring to the service and refer them to the most appropriate support.

3.19. The EI Team will provide emergency slots which assess students who are at greatest risk of self-harm and offer intervention to those students.

3.20. Improve our communities' understanding of the dangers of harmful behaviours, such as Gender Based Violence and how this can lead to impulsive actions and feelings of entrapment.

33. Chen, Y. Y., Wu, K. C. C., Wang, Y., & Yip, P. S. (2016). Suicide prevention through restricting access to suicide means and hotspots. The International Handbook of Suicide Prevention, 609-636.

Spotlight: Lived and living experience and peer support

Responding appropriately to suicide is a vital element of suicide prevention. We know that those bereaved by suicide are at a higher risk of future suicide[34] and have put measures in place to support any members of our community who have been impacted by suicide.

My name is John Gibson and I am the CEO of The Canmore Trust (SC051511). The charity was founded in 2022, after our son, Cameron, died by suicide in 2019. He was 24 years old and a young veterinary surgeon, just a few months out of university. Cameron had no obvious psychological distress and left no note. He had always wanted to be a vet and was doing his "dream job". He had a great circle of friends and loved the great outdoors of Scotland – hillwalking, kayaking, running and cycling. Cameron's death is a mystery. However, what is not a mystery is the carnage which we, as a family, have experienced and, indeed, live with every day since. I wish I could show you the reality of the pain left behind by a suicide death – the utter desolation created by two police officers coming to our door to tell us that our beloved son was dead and that he had taken his own life. As a charity, we would do anything to stop any further deaths by suicide. We CAN do more and we MUST do more.

That is why I am very excited to be part of the External Advisory Group which has helped the University of Strathclyde to create and hone its Suicide Prevention Strategy, and to be at the forefront of suicide prevention in Higher Education in Scotland and the wider UK. I congratulate Strathclyde for its boldness, innovation, compassion and great care of its students and staff.

Strathclyde kindly invited me and the team from Canmore to facilitate monthly postvention Safe Space meetings on campus, supporting students and staff who have been impacted by suicide. Good quality suicide postvention today is tomorrow's prevention. Such a privilege to be part of all of this.

The Canmore Trust currently provide a peer support safe space session at Strathclyde for staff and students who have been impacted by suicide. Appropriate peer support wherever possible will also continue. Through our newly established Higher and Further Education National Network we will extend an invitation to all universities and colleges in Glasgow to make this peer support session available to them

34. McDonnell, S., Flynn, S., Shaw, J., Smith, S., McGale, B., & Hunt, I. M. (2022). Suicide bereavement in the UK: Descriptive findings from a national survey. Suicide and Life- Threatening Behavior, 52(5), 887-897.

Postvention planning

3.21. The University Postvention Plan (PVT), which details the response provided if there is a death by suicide of any student or staff member, will be updated on an annual basis.

3.22. Working with a range of external partners, including the Samaritans Step by Step service, and those with lived experience within our community, we will continue to develop and adapt our postvention support procedures.

Spotlight: Postvention

Those bereaved by suicide are at an increased risk of suicide attempts and death by suicide across the lifespan, and postvention support is therefore a fundamental part of our suicide prevention efforts[35]. The suicide safer project board and working groups have developed a detailed PVT to be used if there is a death by suicide of a student or staff member. The objective detailed in this plan is to provide a 'timely, appropriate, compassionate and flexible response' following a death by suicide. This has been approved by the University Incident Management team.

Our supporting document to the PVT is a postvention plan designed for use at a department level. In our scoping work and when reviewing previous incidents this was highlighted as a major gap. Our suicide safer group developed this plan during a series of conversation cafes, workshops, and meetings. We were supported to do this by members of the Samaritans Step by Step [36] service and this partnership has been invaluable in our critical incident planning.

Policies and procedures

3.23. Review and refresh our policies and practices on early alert and following up on students who may be experiencing difficulties.

3.24. All students will continue to be asked during registration each year to provide additional details of a trusted individual to be their 'wellbeing contact.' Find out about our consent to contact process here.

3.25. Review and refresh our policies on disclosure of risk and consent to share information.

3.26. Develop our protocols, handbooks and the support offered to students on placements and international exchange.

3.27. Ensure that staff and students are aware of the mechanisms within the University for escalating concerns for welfare and that key services including Security, Report and Support, and Disability and Wellbeing are promoted.

3.28. Through the National Suicide Prevention Network of Colleges and Universities we will share resources and examples of good practice wherever possible.

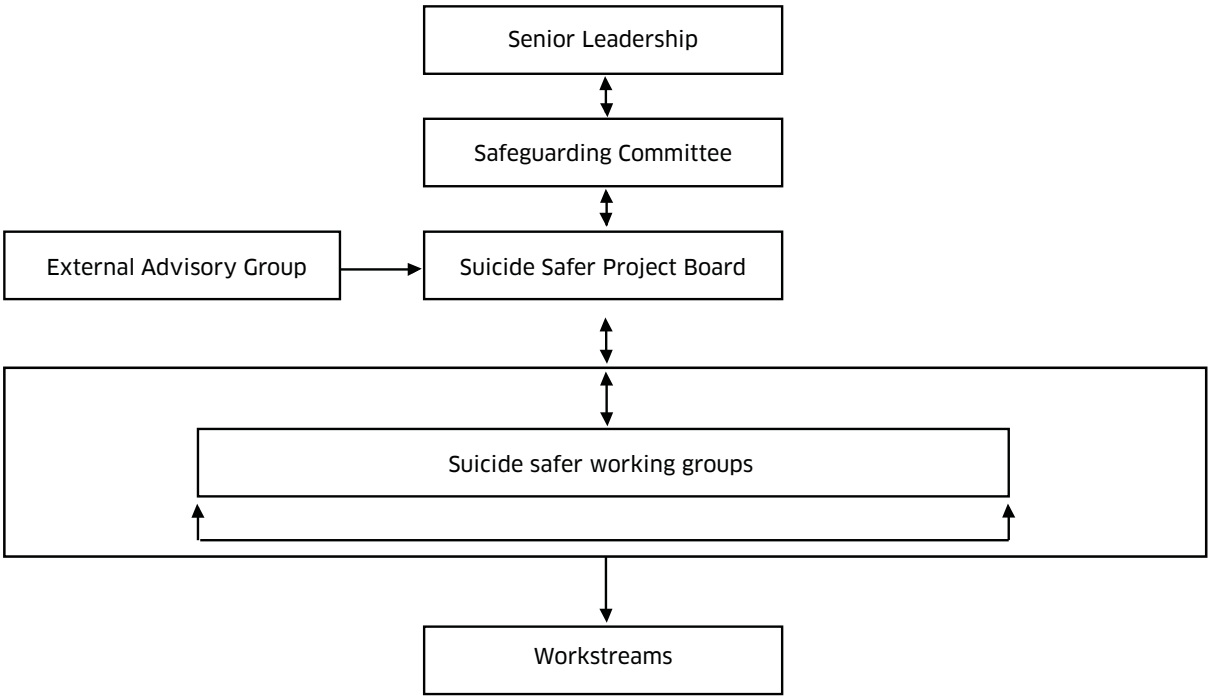
35. Pirkis, J., Bantjes, J., Dandona, R., Knipe, D., Pitman, A., Robinson, J., ... & Hawton, K. (2024). Addressing key risk factors for suicide at a societal level. The Lancet Public Health, 9(10), e816-e824.

36. https://www.samaritans.org/scotland/how-we-can-help/schools/step-step/

10. Priority four: Continuous Improvement

We will monitor and evaluate the impact of our strategy at an organisational and individual level. It is crucial that our strategy is long-term and sustainable. Our project structure (Figure 6) is designed to create and promote a whole University approach to suicide prevention, and it is in line with Universities UK guidance on making it an institutional priority. Of note is the clear line of communication between our External Advisory Group and our Project Board, which ensures our strategy is continually informed by 'critical' subject expertise.

FIGURE 6. Suicide Project Structure



Sustainability

4.1. The suicide project structure (Figure 6), which demonstrates clear and visible support from senior leadership, will remain and it will ensure our efforts are sustainable and flexible.

4.2. Our Suicide Prevention Implementation and Evaluation phase will align with the objectives of the newly formed Student Mental Health Strategy Group, which adheres to the guidelines in the Stepchange Mentally Healthy Universities Framework[37].

4.3. Encourage active participation of staff in the suicide safer working groups and training through the University's Annual Development Review process.

4.4. A co-production approach to strategy documents and supporting projects will remain a focus.

4.5. Create a specific self-harm policy for staff and students linked to the Scottish Government Self Harm Strategy and Action Plan 2023-2027.[38]

4.6. An Equality Impact Assessment will be a standing item throughout our implementation and evaluation phases of the project.

4.7. The strategy will interact with wider University policies and strategies recognising that there are many shared objectives.

Spotlight: External Advisory Group

Our External Advisory Group (EAG) have a key role in providing oversight and accountability to our strategy (See Appendix 7). Their specialised knowledge in suicide prevention, lived and living experience and public health ensures we can make our strategy inclusive, addressing the needs of different populations whilst working towards our priority areas. The EAG Chair Tony McLaren, National Coordinator of Breathing Space, (NHS 24) commented,

'It is our commitment to continue the work of the EAG throughout the implementation, operational delivery and evaluation of the suicide safer work at the University of Strathclyde ensuring we adapt creatively and with good judgement where necessary'.

Evaluation

4.8. Use systems effectively to collect feedback and data from all our internal Mental Health and Wellbeing training included on our KSF.

4.9. Develop a process for internal recording of all deaths by suicide. This will be the foundation of our suicide review process.

4.10. Create a robust process for reviewing suicides at the University, considering the national context and guidance provided by Universities UK .

4.11. Remove barriers to accessing training wherever possible and explore further opportunities to bring external training onto our systems for monitoring and evaluation purposes.

4.12. Carry out a full impact evaluation report over the next five years to measure the effectiveness of the training/KSF at both at an individual and organisational level. A particular focus will be on at-risk groups.

4.13. Use data from referrals and support platforms such as Nightline and Spectrum. Life to inform the provision of support services, making them specific to the needs of our community.

37. https://www.universitiesuk.ac.uk/what-we-do/policy-and-research/publications/stepchange-mentally-healthy-universities
38. Our Understanding of Self-Harm - Self harm strategy and action plan 2023 to 2027 - gov.scot (www.gov.scot)
39. https://www.universitiesuk.ac.uk/what-we-do/policy-and-research/publications/features/suicide-safer-universities/responding-suicide-advice-universities

4.14. Promote a compassionate culture that enables a proactive and early response to a person's situation through early recognition, communication, action planning, recording and information sharing.

4.15. Build on our model of co-production, where students and staff actively contribute to the design and evaluation of suicide safer projects.

4.16. Further develop our capacity to deliver and monitor the 'What's the Harm' self-harm training, whilst making it more specific to our setting.

Spotlight: Self Harm

We know that the relationship between self-harm and suicide is complex but research highlights that those who self-harm are at a far greater risk of suicide than the general population . The report prepared by NHSGGC Mental Health Improvement team details how we developed and began to monitor self-harm local training delivery within the University.

Research

Community-based suicide prevention activities primarily focus on identifying and supporting people who are at increased risk of suicidal thoughts and behaviours, promoting long-term recovery for those who are experiencing suicidal thinking or have engaged in suicidal behaviours, and supporting those who have experienced a suicide loss. To ensure our suicide prevention plan has mental health equity embedded in all our activities, we must include research within the scope of our plan. We will use the IMV model (Figure 2) as a tool to inform our research. This theoretically informed work will allow us to continue to build our understanding of the factors which make a person more likely to have thoughts of suicide, and to examine what factors impact on whether these thoughts are acted upon. This work, alongside the broader research evidence base, will be used to inform our service delivery and suicide prevention efforts, including communication and training. As a result, research updates will be provided to the Project Board on a regular basis. Our research will:

4.17. Focus on understanding which identities, characteristics and situations will increase the risk of feeling defeated and entrapped for our university population.

4.18. Examine how we best tailor our services to meet the needs of our diverse staff and student community, with a specific focus on reducing feelings of defeat and entrapment.

4.19. Investigate how we can increase help-seeking for those who are least likely to ask for help.

4.20. Determine what we can do at Strathclyde to stop people from acting on any thoughts of suicide they might experience.

4.21. Explore the effectiveness of our training through building evaluation into all training where feasible.

40. Chan, M. K., Bhatti, H., Meader, N., Stockton, S., Evans, J., O'Connor, R. C., ... & Kendall, T. (2016). Predicting suicide following self-harm: systematic review of risk factors and risk scales. The British Journal of Psychiatry, 209(4), 277-283.

41. https://www.stor.scot.nhs.uk/handle/11289/580402

11. Key messages

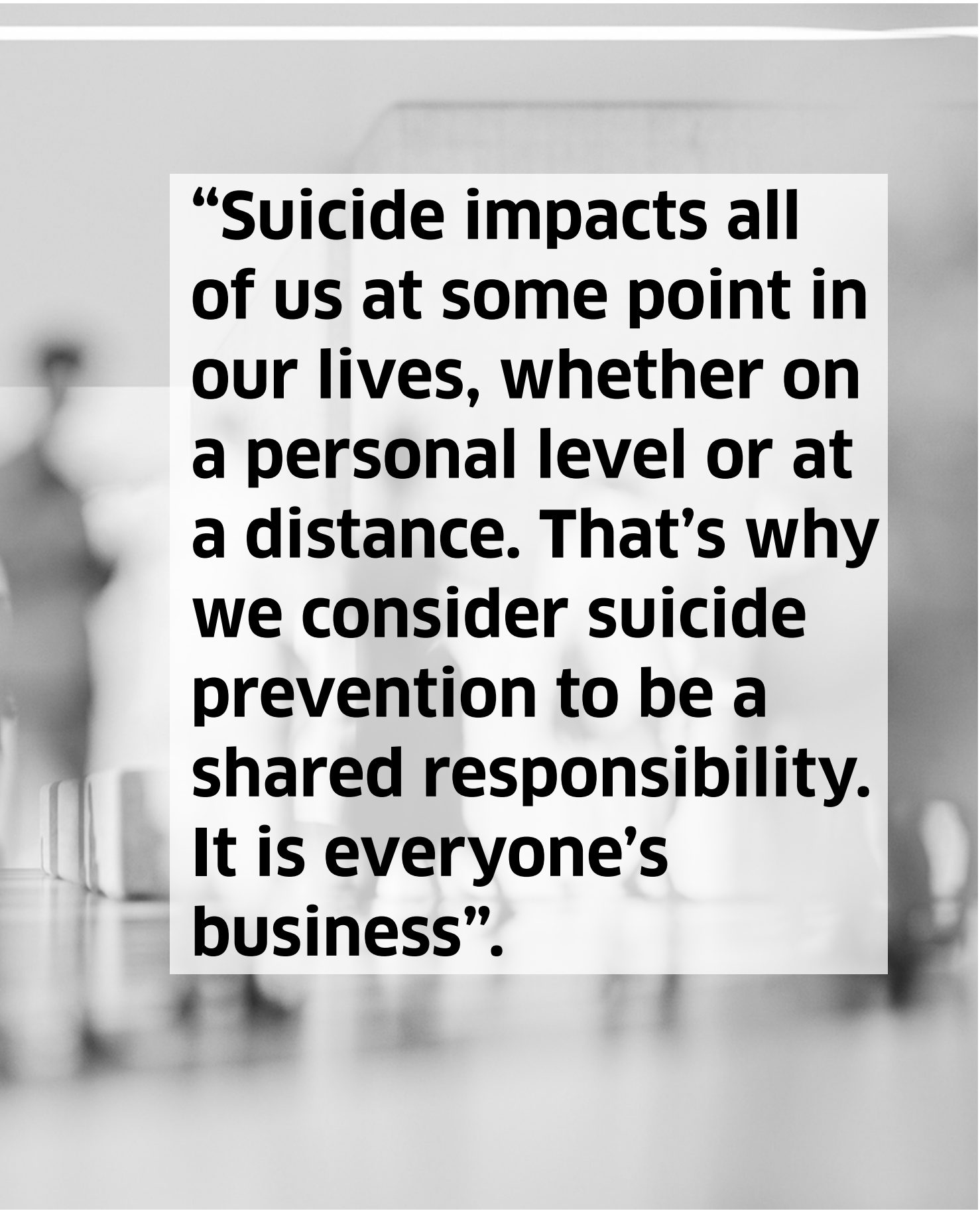
Deaths by suicide are **preventable**.

Adopting a Time, Space, Compassion approach to suicide prevention allows us to take a **person-centred** approach to supporting people in distress, looking after people who have been bereaved by suicide, and ensure that everyone has the opportunity to be trained to feel better equipped to contribute to suicide prevention.

The voices of people with **lived and living experience** of suicidal thoughts, behaviours, and bereavement, are essential to our suicide prevention efforts.

Our work will take a **whole-community** approach to focus on our four key priorities:

- **Capacity building:** We will equip our community with the knowledge, confidence, and skills to support individuals in distress by creating a suicide-safer culture.
- **Communication:** Communication is at the heart of suicide prevention because open, compassionate conversations can reduce stigma and save lives.
- **Safety and support:** Safety and support are fundamental in suicide prevention because they create a protective environment where people in distress feel valued, connected, and guided toward help.
- **Continuous improvement:** Suicide prevention is not a one-time effort. Continuous improvement is essential because it ensures that our work continues to be evidence-based and responsive to the needs and voices of the Strathclyde University community.



“Suicide impacts all of us at some point in our lives, whether on a personal level or at a distance. That’s why we consider suicide prevention to be a shared responsibility. It is everyone’s business”.

Appendix 1: Useful resources and support

There are a number of different resources and support options available to staff and students, both internally within the university, as well as outside of the university. Below are some of the core resources and support options.

Internal resources and support mechanisms

Student Specific Support: For a comprehensive list of internal support please access this link to see our university wellbeing map. You can also access the map through the QR code below:

Staff Specific Support: For a comprehensive list of internal support please access the following link which takes you to the university's wellbeing hub. You can also access the wellbeing hub through this QR code:

Resources available to everyone:

Report and Support

As part of Strathclyde Safe360°, we are committed to a safe campus for all and believe everyone who is a part of the University community: staff, students, and visitors, have a responsibility in ensuring this is the case. Report & Support is a facility where anyone can disclose behaviours or issues they believe puts the safety of the Strathclyde community at risk. Report and support can be accessed through this link.

PAM Assist Wellbeing App

The University provides an employee assistance programme through PAM Assist. PAM Assist allows staff and students to download an app which supports all aspects of wellbeing. You can access information about PAM Assist and get information about the app through this link.

External Support

Samaritans	We're waiting for your call. Whatever you're going through, a Samaritan will face it with you.	Website: https://www.samaritans.org/ Phone: **116 123** (24 hours a day, 365 days a year) Email: jo@samaritans.org (It may take several days to get a response by email)
PAPYRUS HOPE LINE247	Lines are open 24 hours every day of the year (Weekends and Bank Holidays included). Our suicide prevention advisers are ready to support you	Website: https://www.papyrus-uk.org/papyrus-HOPELINE247/ Phone: **0800 068 4141** Text: **07860 039967** Email: pat@papyrus-uk.org
Breathing Space (NHS 24 Mental Health Hub)	Breathing space is a free confidential phone service for anyone in Scotland feeling low, anxious, or depressed	Website: https://www.breathingspace.scot/ Phone: **0800 83 85 87** (Monday - Friday 6PM -2AM and 24 hours at weekends)
Chris's House	A safe environment where people in or approaching a suicidal crisis can have a safe place to go to and get professional support.	Website: https://chrisshouse.org/ Phone: **01236 766 755** Email: info@chrisshouse.org
The Canmore Trust	Creating safe spaces for lives impacted by suicide.	Website: https://thecanmoretrust.co.uk/ Text: Text **'Canmore' to 85258** for support
SHOUT	Shout is a free, confidential and 24/7 text messaging service for anyone in the UK who needs support. If you are struggling to cope and need to talk, our trained Shout Volunteers are here for you	Website: https://giveusashout.org/get-help/ Text: To start a conversation, text the word **'Shout' to 85258**
CALM	Campaign against living miserably (CALM) offers a suicide prevention, helpful for anyone affected by suicide or suicide thoughts	Website: https://www.thecalmzone.net/suicide-prevention-helpline (The website has links to a live chat and WhatsApp contact details) Phone: **0800 58 58 58** (The helpline is open 5PM - midnight)
SOBS	Survivors of bereavement by suicide (SOBS) is an organisation that offers peer-led support to adults impacted by suicide loss.	Website: https://uksobs.com/ Phone: **0300 111 50 65** (The support line is open every day 9AM - 7PM)
Suicide Prevention Scotland	Find suicide prevention support around you	Website: Home - Suicide Prevention Scotland.
Think Positive	The Think Positive Hub works to create a more joined up student mental health support section and to improve student well-being. The hub provides links to a number of resources to support students and staff dealing with their own or someone else's suicidal thoughts or behaviours	Website: https://thinkpositive.scot/mental-health-area/suicide/ (This hub does not provide direct support but instead lists a number of different organisations)
NHS 24 - Mental Health Hub	The NHS 24 Mental Health Hub can be accessed by calling 111 and choosing the mental health option. This service is available 24 hours a day, 7 days a week.	**Phone: 111** Mental health services at NHS 24 | NHS inform

Appendix 2: University of Strathclyde Knowledge and Skills Framework for Suicide Prevention

Suicide Prevention Knowledge & Skills Framework				
Enhanced Level	**Course**	**Target Group**	**Method**	**Duration**
	CAMS Collaborative Assessment and management of Suicidality)	Disability and Wellbeing - Early Intervention Staff	Online	TBC
	ASIST Applied Suicide intervention training	All Staff & Students	In Person	2 Full days
	Understanding and Preventing Suicide: Module 3-4 Core psychological interventions for suicide prevention | Turas | Learn (NHS Scotland)	Available to every-one with a focus on those who are CAMS trained.	Online	30 mins per module
Skilled level	**safeTALK**	All Staff & Students	In Person	3.5 Hours
	Suicide Contagion Training (Developed by NHSGGC)	Staff on a selected basis	In Person	1.5 Hours
	Understanding and Preventing Suicide: Module 2 Core psychological interventions for suicide prevention | Turas | Learn (NHS Scotland)	All Staff & Students	In Person	30 mins
Informed level	**Mental Health and Suicide awareness Myplace module for staff and students** (This includes 'Ask Tell Respond', adult resource.	All Staff & Students	Online	40 mins
	Understanding and Preventing Suicide: Module 1 Core psychological interventions for suicide prevention | Turas | Learn (NHS Scotland)	All Staff & Students	Online	30 mins
	Wave after Wave (Suicide Bereavement Training)	All Staff & Students	In Person	3 hours
	SuicideTALK	All Staff & Students	In Person	90 mins

My Place links:
Staff Wellbeing Training: Mental health and suicide awareness
Student Wellbeing Training: Mental health and suicide awareness

Sign up link to set up a Turas account:
https://learn.nes.nhs.scot

42. https://learn.nes.nhs.scot/17099/mental-health-improvement-and-prevention-of-self-harm-and-suicide

Note: There are variations in our KSF against the National one from PHS and NES. We have matched some training at slightly different levels based on our setting. Below is our interpretation of the training levels.

Informed Level – Available to our whole student, assignment worker and staff population as a basic level of awareness that can contribute to the improvement of mental wellbeing and the prevention of suicide.

Skilled Level – Available to all 'non specialist' staff, assignment workers and students who may have contact with people at risk of mental ill-health, self-harm or suicide.

Enhanced Level – Available to all but recommended for those who may have more intense contact with those experiencing distress or suicidal crisis and who may be required to carry out role specific interventions.

For more information on the National KSF[42] please access this link.

Appendix 3: Myths and facts about suicide

MYTH	FACT
Talking about suicide encourages it.	Talking about suicide can save a life by encouraging someone to seek help. It validates to the person that it is something they can share with others.
People who talk about or threaten suicide are attention seeking.	People who die by suicide have often told someone that they do not feel life is worth living. Someone may talk about suicide to get the attention they need while in distress. It's important to take anyone who talks about feeling suicidal seriously.
Suicide is a choice and it's not preventable.	Suicide is preventable and often people feel suicidal during times of extreme stress or isolation. Suicidal thoughts can be interrupted and can pass with the correct support in place.
Only people with mental disorders are suicidal.	Suicidal thoughts are common. One recent study highlighted up to 25% of students have felt suicidal. Only 1 in 3 people who die by suicide have reached out to mental health services for support, so it's crucial that training is rolled out across communities and not just services.
If a person is serious about killing themselves, there's nothing you can do.	Often feeling suicidal is temporary and with the correct support, people can and do recover. Being able to listen and have a conversation about suicide is lifesaving. Please refer to Appendix 2 for a range of training that can equip someone with the skills and confidence to have a conversation with someone about suicide.
Most suicides happen without warning.	There are often warning signs before a suicide attempt. Please follow the link to learn more about warning signs of suicide.

Appendix 4: Compassionate language around suicide

The information below is to be used as a guide. Some people bereaved by suicide may choose to use language in the 'less helpful' section because they relate to it or find it familiar. We should respect the way those bereaved by suicide choose to talk about it. The main aim is encouraging people to talk. Please access the link below for top tips on talking safely about suicide
How to talk about suicide safely online | Online Safety Resources| Samaritans

LESS HELPFUL	MORE HELPFUL	WHY?
Avoid sensationalising or normalising suicide	Remain sensitive and factual in all conversations	Sensationalising or normalising suicide may put others at risk
Never reference the method of suicide in any conversations	Do not be afraid to use the term 'suspected suicide' and avoid euphemisms	Excessive information or imagery may put vulnerable people at risk if they over identify with the person who has died
Speculating about reasons for or circumstances surrounding the suicide	Be respectful to the family and don't speculate	The family have the right to privacy and speculation may also impede ongoing investigations
Commit/committed suicide	Died by suicide	Suicide is a cause of death and should be treated as such. Commit is stigmatising and outdated language with connotations of illegality, shamefulness, and sin
'Self-harmer'	Person who self-harms	'People first language' recognises and values the person first and foremost. Self-harm may be a way in which someone copes, but it is not who they are
Unsuccessful	Attempted suicide	Any attempt should be taken seriously. We need to recognise distress and provide appropriate, timely and compassionate support. Any notions of 'failure' don't contribute to that
Any language that recognises the possibility of change and recovery is beneficial. Hope is vital. It keeps people alive		

ACTION

If you are a Strathclyde member of staff you can access our STEP CPD module on: Compassionate Language Around Suicide on the following **link**.

Other useful resources for developing a compassionate approach to suicide are included in the links below:

Scottish Government's Time Space Compassion Framework

Finding The Words – Support After Suicide

Mental Health UK has several resources relevant to workplace mental health

Appendix 5: Glossary

Suicide	Death resulting from an intentional, self-inflicted act.
Safety Plan	A tool for helping someone develop coping strategies to manage suicidal thoughts or plans. It can include what and who may help someone who is experiencing a suicidal crisis. Please access the Samaritans' Safety Plan Template here.
Lived and Living Experience	The knowledge and understanding of having lived or to be currently living through something. In relation to suicide, lived or living experience includes those bereaved by suicide, those who may be experiencing a suicidal crisis or those who have been previously impacted by suicide, suicidal thoughts, plans, or actions.
Prevention	Prevention aims to catch people before they start planning a suicide or attempt it. It requires a clear approach aiming to change the culture using a whole university approach.
Intervention	The action of providing support or services to produce a different outcome. In the case of suicide prevention, it is to work with a person experiencing suicidal thoughts to help them identify reasons why they may want to keep safe, to agree a plan for doing so and to engage further support as required.
Postvention	The timely, appropriate, and compassionate support given following a death by suicide.
Capacity Building	The United Nations define capacity building as 'the process of developing and strengthening the skills, instincts, abilities, processes and resources that organizations and communities need to survive, adapt, and thrive'.
Contagion	Death by suicide may trigger suicidal thoughts and feelings in some other individuals and may increase their risk. This is also known as suicide contagion.
Cluster	A cluster is usually 3 or more deaths that occur unexpectedly closely in terms of time, place or both. In a University setting, two suicides occurring close to each other may indicate a cluster and should be taken seriously. Public Health Scotland have issued guidance around suicide clusters and contagion which can be accessed **here**

Appendix 6: Suicide Safer working groups

The groups are chaired by Dr Susan Rasmussen who oversees the project management of the suicide safer workstreams and strategy. Meetings are every 2nd month, and the aim is to build suicide prevention into the operational running of the University. To express interest in becoming part of the groups, please email us on **suicide-safer@strath.ac.uk**

- Student Union
- Disability and Wellbeing 'Early Intervention Team'
  (Click **here** to view the evidence-based model of managing suicidal risk by our EI Team)
- Faculties of Science, Engineering, Business & Humanities and Social Sciences
- University Security Team
- University Accommodation Team
- Human Resources
- University Library
- Strathclyde Sport
- Students and Staff with lived/living experience of suicide
- Internal Communications
- Safety Health and Wellbeing
- Equality Diversity and Inclusion
- Chaplaincy
- Estates
- Careers

Appendix 7: External Advisory Group

We would like to extend our warmest thanks to our External Advisory Group (EAG) who have supported us throughout the development of this strategy. The group will continue over the next 2 years to advise on the implementation, operational delivery, and evaluation of our work. Measuring the impact of this work was one of the key elements of our strategy that the EAG felt strongly about.

- **Tony McLaren** (Chair) National Coordinator, Breathing Space (NHS 24)
- **Rory O'Connor** Professor of Health Psychology and Suicidal Behavioural Research Laboratory Lead, University of Glasgow
- **Katie Endacott** CEO, Nightline
- **Trevor Lakey** Health Improvement & Inequalities Manager – Mental Health, Alcohol and Drugs, NHS Greater Glasgow & Clyde
- **Christine Towers** Community Link Worker, Townhead Health Centre
- **Fiona Drouet** CEO, Emily Test
- **John Gibson** CEO, The Canmore Trust
- **Lee Knifton** Director, Mental Health Foundation Scotland & Northern Ireland, Co-Director Centre for Health Policy, University of Strathclyde Glasgow
- **Dr Ian Marsh** Reader, School of Allied and Public Health Professions & Suicide Safer Project Lead - Canterbury Christ Church University
- **Geoff Rickson** Postvention Advisor, Samaritans (Step by Step service)
- **Rosie Allister** Postvention Advisor, Samaritans (Step by Step service)
- **Elizabeth Boyle** Postvention Advisor, Samaritans (Step by Step service)
- **Nicola Reed** Director of Client Services, Cruse Scotland
- **Ciara Queen** Community Development Officer, PAPYRUS
- **Kimberly McNicol** Mental Health, Public Health & Suicide Prevention, Police Scotland
- **Jenny Ferguson** Children and Young People Delivery Lead, Suicide Prevention Scotland

“we must strengthen our collective efforts to make this a ‘safe place of useful learning’ too, one that places the wellbeing of everyone in our University at its heart.”

This strategy has been developed by the University of Strathclyde Suicide Prevention Project management team.

Dr Susan Rasmussen
Reader in Psychology

Tony Kane
Mental Health Strategy, Training and Partnerships Manager

Colin Flynn
Acting Head of Disability and Wellbeing

Ann Duncan
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