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1 **Abstract**

2 *Background*

3 There are longstanding concerns over the mental health and suicide risk of university students in the
4 UK and internationally.

5 *Aims*

6 Identify risk factors for suicide amongst students attending universities in a UK city.

7 *Method*

8 Suicide deaths between January 2010 and July 2018 were identified from university records. An
9 audit tool was used to collate data from university records and coroners' inquest files.

10 *Results*

11 37 student deaths were identified. Only 10.8% of the students had disclosed a mental health issue at
12 university entry. There was strong statistical evidence that students that died by suicide were more
13 likely to have been male, experiencing academic difficulties (repeated years, changing course and
14 suspension of studies were all associated with 5-10 fold increased risk) and in need of financial
15 support than other students.

16 *Limitations*

17 The coroners' records were only available for around half of the deaths. Healthcare records were not
18 available.

19 *Conclusion*

20 Markers of academic and financial difficulty should be considered as flags to identify students at
21 heightened risk. Improved disclosure of mental health issues at university registration could
22 facilitate targeted support for vulnerable students.

23 **Keywords**

24 Suicide, university, college, student, risk factors

25

26 **Introduction**

27 There has been longstanding concern over the mental health and suicide risk of university students
28 in the UK and internationally (Schwartz, 2006; Keith Hawton, 2012; Carpenter, 1959; Uchida &
29 Uchida, 2017). Data from the Office for National Statistics (ONS) in the UK indicate that the rate of
30 suicide for university students in England and Wales has increased in recent years (Gunnell, Caul,
31 Appleby, John, & Hawton, 2019). Nevertheless the ONS data (Office for National Statistics, 2018),
32 and international studies (Schwartz, 2006) indicate that the rate of suicide is lower amongst
33 students than in the general population of similar ages. These lower rates may reflect the well-
34 recognised reduced risk of suicide amongst people from affluent backgrounds, those with higher
35 levels of educational attainment and those without serious mental illness (Batty, et al., 2018) as such
36 groups are likely to be over-represented in university populations.

37 Few studies have reported on the academic and university-specific factors associated with suicide in
38 university students and published case series often include small numbers of cases and lack
39 comparison risk factor data from the wider student population; a psychological autopsy study of UK
40 university student suicides in 2000-2005 suggested that the experience of transition for these
41 students had been a significant factor and academic difficulties were reported for half the deaths
42 (n=10) (Stanley, Mallon, Bell, & Manthorpe).

43 We undertook a detailed case review of 37 deaths by suicide of students studying at the two
44 universities in a UK city between 2010-2018 to identify possible risk factors for suicide amongst
45 students and to inform suicide prevention in university settings. Both universities are large, high-
46 ranking, UK institutions (ranked top 50 in the UK in 2020 (UKuni, 2020)), with around 20,000
47 undergraduate and postgraduate students enrolled from around the UK, and with a high proportion
48 (10-15%) of overseas students.

49 **Methods**

50 *Deaths by suicide*

51 University student information databases including deaths (by any cause) together with information
52 from wellbeing service/vulnerable students' service teams concerning the cause of death were used
53 to identify student suicides between January 2010 to July 2018. Neither university kept a formal
54 register of suicide deaths.

55 Following accepted research practice in England, supported by findings from previous studies of
56 coroner-records (Gunnell, et al., 2013) we included in the case review deaths certified by the
57 coroner as suicide or given open conclusions(formerly known as verdicts), as well as some receiving
58 narrative and accident conclusions, where staff indicated suicide as the likely cause of death. Due to
59 resource limitations coroner data were not collected for deaths outside the study area (n=20).

60 *Audit tool*

61 A 74-item audit tool (see e-supplement) was developed to collate sociodemographic, clinical and
62 university study-related information about each case. The tool was initially developed by DG, based
63 on proformas used in previous studies of coroner records (see e.g. (Gunnell, et al., 2013)) and
64 findings from the recent literature on student suicide (Schwartz, 2006; Uchida & Uchida, 2017;

65 Stanley, Mallon, Bell, & Manthorpe) and further refined with input from UK experts on student
66 suicide and Public Health England.

67 Data to complete the form came from a number of sources (Fig 1). Academic and sociodemographic
68 data for all deaths was provided directly by the university central IT system teams (including but not
69 limited to the student administration, residences, schools, secretary's office and finance office
70 systems). Further information was available for a subset of students (n=35 deaths) from the
71 university student wellbeing and support service teams. Inquest records held by the PLACEHOLDER3
72 Coroner (n=17 deaths) were made available to JM and used to complete any further fields on the
73 form. JM and DG discussed approaches to coding variables and reviewed the first 3 completed forms
74 together.

75 The students' healthcare and counselling service records were not made available, except where
76 they formed part of the coroner's records, due to confidentiality concerns.

77 POLAR 3 (Participation of Local Areas) was used as a proxy area measure of socioeconomic
78 deprivation for students whose parents lived in the UK (Office for Students, 2019). POLAR quantifies
79 relative levels of youth participation in higher education, based on parents' address.

80 Comparative data for each university's wider student population was drawn from the following
81 sources:

- 82 • Proportion of all students enrolled in 2014/15 who were male, overseas students, full-time
83 students, post-graduate students, and in their first year of study (Higher Education Statistics
84 Agency, 2019).
- 85 • Proportion of all placed applicants in 2014 who were in each POLAR quintile (Universities
86 and Colleges Admissions Service, 2018).
- 87 • Proportion of all students enrolled in 2018 who were aged 30+ (University published data
88 PLACEHOLDER1&2).
- 89 • Bespoke enquiries raised with the universities' administration teams concerning academic
90 difficulty and receipt of bursaries (available for 2017/18).

91 As data were not available for the whole study period, we used data from the year closest to the
92 midpoint of the study period (2014) wherever possible.

93 *Analyses*

94 Descriptive statistics were used to summarise the characteristics of the student suicide deaths.
95 Incidence rate ratios (IRR) for potential risk factors were estimated using the 'iri' command and
96 Poisson regression in Stata version 13. For the IRR calculation the mean proportion of each variable
97 (see sources described above) was applied to the background population of 113815 students
98 admitted to the universities over the timeframe of the study (2010-2017), multiplied by 8.5 (the time
99 period of the study) to give number of person years at risk.

100 For the free-text qualitative data fields, data were summarised and thematic trends were
101 documented. In acknowledgement of the incomplete access to records and therefore the likely
102 underestimates for many variables, estimates were described in terms of "at least x%".

103 *Ethics approval / data sharing agreement*

104 This work was undertaken as part of best practice endeavours within the actions of the existing
105 institution-led suicide prevention response groups; therefore prospective ethics approval was not
106 required. The PLACEHOLDER1 Faculty of Health Science Research Ethics Committee (FREC) met and
107 reviewed the documentation provided outlining the suicide case review and the ethical guidelines
108 followed and confirmed that good ethical principles were adhered to and have issued a
109 recommendation letter for publication.

110 **Results**

111 *Sociodemographic characteristics*

112 Thirty-seven suicide deaths were identified. Coroners' records were available for 17 (45.9%) of the
113 deaths and student support team records for 35 (94.6%), all had data from one or other of these two
114 sources (Fig 1). Nineteen (51.4%) of the deaths occurred away from the city, generally in or near to
115 the student's own/family home.

116 Table 1 presents the sociodemographic and university registration characteristics of the deaths and
117 comparison data for all students. Twenty-four (64.9%) were male and one was transgender.
118 Compared to the general student population at the two universities males were at increased risk
119 (IRR 2.40 (95% confidence interval (CI) 1.15, 5.26) $p=0.012$) compared to females.

120 The median age at the time of death was 21 years (range 18 - 54, interquartile range 20 – 25). There
121 was no strong statistical evidence of an increased risk amongst older students, those from more
122 deprived backgrounds (as indexed by POLAR quintile), or amongst ethnic minority or overseas
123 students (Table 1).

124 Over one third (37.8%) of the students suicides held a bursary and this was associated with
125 increased risk (IRR 5.48 (2.61, 11.11) $p<0.001$). A further four (10.8%) had other evidence of financial
126 difficulty.

127 Only four students (10.8%) declared that they had a mental health condition on entry to the
128 university or on their UCAS application.

129 *Academic characteristics*

130 There was no evidence that risk of suicide differed according to year of study, undergraduate vs.
131 postgraduate or full-time vs. part-time (Table 1). There was no evidence of disproportionate
132 numbers of deaths by course or Faculty (data not shown).

133 There was strong statistical evidence that the proportion of students who needed to resit exams,
134 repeat years, changed course or suspended study was higher in students that died by suicide
135 compared to other students (IRRs ranged from 2.47 (CI 1.13 to 5.11) for exam resits to 31.52 (CI
136 14.43 to 65.10) for suspension of studies; Table 2). Almost half ($n=18$ (48.6%)) of the students that
137 died experienced one or more of the three indicators of academic difficulty with a prevalence of <5%
138 in the general student population (i.e. repeated a year, changed course, suspended studies).

139 Data on submission of extenuating circumstances forms (ECFs, forms submitted by students who felt
140 their performance in a university assessment had been affected by health or social concerns) was
141 unavailable for students that died at one of the institutions; data from the other institution indicated
142 that students that died were at least 3-4 times more likely to have submitted ECFs than other
143 students.

144 *Mental health and help seeking*

145 The extensiveness of the available data on mental health and social circumstances was greater for
146 some cases than others, so percentages presented in this section are likely under-estimates (see Fig
147 1). At least eleven (29.7%) of the students who died had a history of self-harm. At least nineteen

148 (51.4%) had evidence that they were known to the NHS regarding any mental health difficulties, at
149 least fifteen (40.5%) were known to secondary mental health services at some point in their lives.

150 Thirteen (35.1%) made initial contact with student support services and then either failed to
151 complete registration, respond to initial contact or to attend one or more appointments. In some
152 cases, these contacts were many months before death. At least eleven (29.7%) of the students that
153 died by suicide had sought help from academic or administrative staff in their university school or
154 department.

155 There was some evidence of higher than expected levels of illegal drug misuse within the last year
156 (at least eleven (29.7%) compared to 20% of 16-24yr-olds nationally (Home Office, 2018)) and
157 alcohol misuse (at least ten (27.0%), by contrast only 14% of 16-24yr-olds in England drink more than
158 21 units of alcohol a week) (NHS Digital, 2016).

159 Significant concerns about the students that died by suicide had been identified by their peers in at
160 least five (13.5%) of the cases, but these peers had felt uncertain about how to help.

161 Five students who died had no evident social, academic or previous mental health risk factors.

162 *Other risk factors*

163 Most of the students who died had no current partner (n=32, 86.5%); at least nine (24.3%) had
164 recent relationship difficulties or breakups and at least ten (27.0%) had some evidence of social
165 isolation (living alone or noted to have few friendships). Difficulties in family circumstances e.g.
166 interpersonal discord or immediate family bereavements were common (in at least 16 (43.2%) of
167 cases), but levels of these factors in the wider student population are not known so comparison was
168 not possible.

169 *Methods of suicide*

170 The most commonly used method was by hanging (n=21, 56.8%). The other main methods were
171 jumping from a height (n=6, 16.2%) and self-poisoning (n=5, 13.5%). No students obtained their
172 means for suicide from university premises.

173

174

175 **Discussion**

176 Students that died by suicide were more likely than other students at their institutions to: be male,
177 be in receipt of a bursary or other financial assistance or have experienced academic difficulties.
178 Three factors were particularly strongly related to risk: suspension of studies, repeating a year and
179 changing course; 18 students (48.6%) that died by suicide had at least one of these factors recorded,
180 compared to a prevalence in the wider student population of <5%.

181 Other factors that appeared to be related to risk, but for which there were no robust comparison
182 data, were drug or alcohol misuse, personal life difficulties including relationship break-up or
183 bereavement, prior self-harm or suicide attempts and previous or current contacts with secondary
184 care mental health services. These are all well-recognised risk factors for suicide in the general
185 population (Turecki & Brent, 2016).

186 Very few (10.8% (n=4)) of the students had disclosed a mental health issue when they registered
187 with the university and up to half (48.6% (n=18)) had no record of contact with health services for
188 mental health issues.

189 *Comparison with existing literature*

190 Few studies have reported on associations between academic difficulty and suicide risk in university
191 students. Data from Japan indicate that students within later years of study who need to repeat
192 years or who took academic leave of absence were at heightened risk of suicide (Uchida & Uchida,
193 2017). In a recent study of suicides amongst young people in England (National Confidential Inquiry
194 into Suicide and Homicide (NCISH): Annual Report 2017), common antecedents of suicide included
195 alcohol misuse (23%), illicit drug misuse (23%), social isolation (27%) and a diagnosis of mental illness
196 (47%) (Healthcare Quality Improvement Partnership (HQIP), 2017), all factors that were pronounced
197 in this case review.

198 A recent analysis of student suicides in England and Wales (Gunnell, Caul, Appleby, John, & Hawton,
199 2019) suggested that around 17% occurred in those who had been in current or recent contact with
200 NHS psychiatric services. This figure is in line with Japanese data indicating 16% of students had a
201 psychiatric diagnosis (Uchida & Uchida, 2017) and data from the USA indicating that only around a
202 quarter of student suicides were counselling service clients (Schwartz, 2006). The higher figure in our
203 study (41%) may reflect the fact that we were only able to estimate life time rather than recent
204 contacts. Of note, only 12% of suicide deaths in the NCISH study had evidence of contact with
205 college / university support services, although over a third (38%) had evidence of some mental
206 health service contact (Healthcare Quality Improvement Partnership (HQIP), 2017); in our case
207 review, mental health contacts with health and care services were even higher (51.4%) and this is
208 likely to be an underestimate as we did not have full access to health records.

209 Five (13.5%) students had no evident flags of concern or contributory factors for their suicide. This
210 type of occurrence is also reflected in a recent national study of suicide in young people where 29%
211 (n=84) deaths were deemed 'out of the blue' (University of Manchester, 2017).

212 16.2% of the suicides reported in our study were aged >30 years – a finding in keeping with studies
213 from the USA (Silverman, Meyer, Sloane, Raffel, & Pratt, 1997) and Sweden (Lageborn, Ljung, Vaez,
214 & Dahlin) but lower than a recent study of all student suicides in England (Gunnell, Caul, Appleby,

215 John, & Hawton, 2019). In keeping with findings from Japan (Uchida & Uchida, 2017) and in recent
216 ONS analysis (Gunnell, Caul, Appleby, John, & Hawton, 2019) we found no evidence of a heightened
217 risk of suicide during the first year of study.

218

219 *Strengths and limitations*

220 To our knowledge this is the largest study of student suicide deaths in the UK to draw on evidence
221 from students' individual academic records and compare these with the wider student population.
222 This approach elicited information on academic and university setting specific risk factors and points
223 of concern that have not been widely reported previously.

224 Nevertheless, our findings should be interpreted in the light of a number of limitations. First,
225 healthcare and counselling service records were not included due to data sharing limitations and
226 may have offered further insights. We did, however, obtain relevant healthcare information from
227 the coroner inquest records (available for almost half the cases). Both coroner and wellbeing
228 records data varied in length and detail, but one or the other of these sources was available for all
229 students. These factors have likely resulted in underestimates of the prevalence of some factors, in
230 particular personal/social factors and mental health and substance misuse. Second, we did not have
231 coroners' conclusions for all deaths outside the study area and so we may have been over- or under-
232 inclusive of relevant deaths. Third, the case series study design cannot determine whether the
233 factors detected such as academic and personal difficulties preceded or were partly a result of
234 mental distress. This does not change the importance of noting these strong associations and
235 therefore the consideration of these factors as important risk markers. Fourth, POLAR is an
236 imperfect measure of socioeconomic position, as it is related to area-of-residence rather than
237 individual characteristics and it only measures an area's university participation rate rather than
238 other, more direct socioeconomic measures such as income and employment levels. Fifth, coroner
239 data were extracted by a single researcher, without inter-rater reliability testing other data were
240 provided from multiple sources. Sixth, some of our data on risk factor levels in the wider student
241 population was drawn from a single year – this may lead to an over- or under-estimation of levels.
242 Last, the denominators for our risk ratio estimates were estimated relatively crudely based on the
243 best available data, but it is unlikely that this approach will have biased the risk estimates.

244 *Conclusions*

245 A number of UK universities are piloting risk screening tools, based on routinely available data (e.g.
246 attendance, academic and student registration data). We identified a number of university-specific
247 risk markers for student suicide which could be considered in risk identification tools and the design
248 of university processes for struggling students:

- 249 • Demographics: male, in receipt of a bursary or other financial assistance
- 250 • Markers of academic difficulty, particularly repeating a year, changing course and
251 suspension of studies.

252

253 Due to the low incidence of suicide, the specificity of prediction tools based on these factors is likely
254 to be relatively low, and whilst such approaches may help institutions identify high risk students, it is
255 important they also focus on whole-institution population-based approaches aimed at, for example,

256 enhancing student wellbeing, preventing alcohol and drug misuse and encouraging help-seeking
257 (Universities UK, 2018) .

258

259 The low number of students disclosing mental health difficulties on university entry represents a
260 further priority area for action as improved disclosure rates at registration could facilitate targeted
261 support of vulnerable students.

262 Research is now urgently required into how best to intervene to reduce risk associated with these
263 factors and evaluate ongoing initiatives to address these problems.

264

265 Our audit tool is available (e-supplement) for use by institutions seeking to identify risk factors in
266 their student populations.

267

268 **Electronic Supplementary Material**

269 ESM 1. Audit tool (Electronic Supplementary Material 1 - audit tool.pdf)

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