

Protocol regarding students' suicide

Ivonne Zwanet Heideman

2502122

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Bureau studentenartsen

University of Amsterdam | Amsterdam

University of Applied Sciences



Protocol regarding students' suicide

UvA / HvA

Recognizing, help providence and aftercare

I.Z. Heideman Bsc - 2502122

E-mail: ivonneheideman_2@hotmail.com

Tel.: +31 (0)6 15213060

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VU University Amsterdam

Master Management, Policy Analysis and Entrepreneurship in the Health and Life Sciences

First year internship - Management track

VU supervisor:

Dr. S.C. van Veen

Tel.: +31 (0)20 5982562

On-site supervisors:

Drs. C.M. van der Heijde

Drs. P. Vonk

Prof. dr. F.J. Meijman

Bureau Studentenartsen, University of Amsterdam | Amsterdam University of Applied Sciences

Oude Turfmarkt 151

1012 GC Amsterdam

Tel.: +31 (0)20 5255306

Summary

Suicide remains a considerable problem among students. In their age group, death by suicide is the second main cause of death and the data on suicide attempts and suicidal ideation among students is concerning. Besides, students are considered at elevated risk for suicide, due to the difficult phase of life they are confronted with and due to several other suicide risk factors related to studying, such as facing academic difficulties and suffering from study stress. Furthermore, students show limited help-seeking behaviors when suffering from psychological problems. Considering this latter, it is important that those students will be timely identified by educational key players, and consequently, do receive the required help. Additionally, a suicide or suicide attempt often has a major impact on the people involved, such as the student's parents and peer students.

However, at the University of Amsterdam (UvA) and the Amsterdam University of applied sciences (HvA), despite these concerning facts, to date, both information on suicide prevention and on proper aftercare for people involved, is lacking. Therefore, a protocol is needed containing the required information for educational key players on the recognition of students at suicide risk, the subsequent help providence and the aftercare for people involved. The current study aimed to provide recommendations regarding the content of this protocol through answering the following research question: *What are the stakeholders' perceptions regarding the content of the students' suicide protocol which will be for the purpose of UvA and HVA educational key players to increase the probability of timely recognizing students at suicide risk, including the adequate procedures they need to follow after this recognition, to prevent suicides or attempts to occur, and information on appropriate help providence for several groups involved, in case of attempted and committed suicides?*

In order to answer this question, the qualitative research method of semi-structured in-depth interviews was used in this exploratory study. These interviews were conducted with six educational key players, employed at Dutch universities or universities of applied sciences, and six experts in the field of youth and/or student's suicide and suicide prevention. The discussed topics were based on the developed conceptual model and concerned the content of the suicide protocol. Several efforts were made enhancing the validity and reliability and minimizing bias. The data was analyzed using axial and, subsequently, selective coding.

With regard to the recognition of students at risk for suicide, the results showed that the presence of a gut-feeling is the most important warning sign. Other important signs involved the

student becoming quiet, withdrawing into oneself, looking down, and showing decreased performances or absenteeism. Other recommendations for the content of this section were: enhancing the students' knowledge regarding the available services at the educational institutes; raising the awareness among students regarding suicide and mental health problems; offering and promoting trainings covering several (study) difficulties; setting-up a mental health team responsible for the suicide prevention and for the promotion of mental health; and offering gatekeeper trainings to the educational key players.

The results have shown the following recommendations for the protocol content regarding the stepwise approach to perform after recognizing a risk student: The educational key player should: 1) talk to the student; 2) make an inventory of the severity of the situation; 3) recommend/call the appropriate service; 4) monitor the students and provide follow-up care; and 5) discuss the event with colleagues.

This study has recommended to incorporate in the protocol section regarding appropriate aftercare that: in case of a severe student's suicide attempt, the educational key player should perform first aid and call an ambulance, the parents and the police; the risk students should be monitored and should receive follow-up care; and an informal conversation should be organized for near peers and witnesses. Further, with regard to this section in case a student committed suicide, it was recommended to include: calling the parents; organizing an informal conversation; being clear and transparent about the situation; and organizing a moment for the personnel for coming together.

The last important finding involved taking into consideration the prevalence of the lonely type of suicide among students and the increased risk in immigrants and foreign students. It was recommended that educational key players should take particular care of these students and verify the strength of the social network of lonely students during the second step of the stepwise approach.

Taken together, aforementioned recommendations can be used to develop a protocol regarding students' suicide for the UvA and HvA. This protocol may lead to an increased familiarity among educational key players of what to do in particular circumstances, better mental-well beings of the students, help providence for those risk students who do not seek help themselves and to lessen the impact of the event on people related to the student who attempted or committed suicide. However first further research should be carried out, investigating the correct implementation of this protocol at these institutes.

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1. Introduction

Suicide and suicide attempts remain a considerable problem: worldwide, every forty seconds someone commits suicide and every three seconds someone attempts this (World Health Organization, 2014). Kerkhof *et al.* (2004) stated that in the Netherlands, death by suicide is the second leading cause of death among the general young and young adult population. The exact number of students' suicides is unknown, however, data is present regarding suicide attempts and suicide considerations among students: Mazurel (2014) revealed that 1.8 percent of the Dutch students attempted suicide at least once and 8.6 percent of the students ever seriously considered an attempt. Additionally, it is important to underline that the numbers of suicides are increasing (Centraal Bureau voor de Statistiek, 2015; World Health Organization, 2014).

Various explanations are suggested why students may be at increased risk for suicide and suicide attempts (Tompkins & Witt, 2009). In essence, this involves the shift from youth to college which is described as a major life transition, leading to substantial changes in students' psychological, academic and social selves (Westefeld *et al.*, 2006). One of these changes is the often first experience of separation from close family and friends which may cause distress (Westefeld *et al.*, 2006).

Another important concern involves the limited help-seeking behavior of students: several studies indicated that the majority of the students suffering from health problems do not seek help themselves (Eisenberg *et al.*, 2007; Vaez, 2004; Verouden *et al.*, 2010); only a fraction of depressed students ever visit counseling services (Furr *et al.*, 2001); and a minority of the students who attempted or committed suicide had sought these services (Gallagher *et al.*, 2004). Furthermore, previous research showed an increase in the number of students suffering from severe psychological problems (Benton *et al.*, 2003; Kitzrow, 2003).

Abovementioned matters concerning students and suicide illustrate the importance to tackle this problem. However, to date, at the University of Amsterdam (UvA) and the Amsterdam University of Applied Sciences (HvA) no active efforts have been made regarding suicide prevention among their students. Considering the mentioned limited help-seeking behavior among students, students at risk for suicide should be timely identified by educational key players in order that these students, subsequently, do receive the required help. Furthermore, the UvA and HvA lack information on the appropriate aftercare for peers, family of the student and other people involved, while studies reveal that a suicide or suicide attempt may have a major impact on those people concerned (Kerkhof *et al.*, 2004; Magne-Ingvar & Öjehagen,

1999). Therefore, a protocol is needed for educational key players containing the required information on the recognition of students at suicide risk, the subsequent help providence and on appropriate aftercare for people involved.

The aim of this study is to contribute to the prevention of students' suicides and suicide attempts at the UvA and HvA and to the defining of proper aftercare in these situations, by providing recommendations for the content of a protocol regarding students' suicide, based upon the perceptions of relevant stakeholders. This protocol will be for the purpose of UvA and HvA educational key players to increase the probability of timely recognizing students at suicide risk and will include the procedures they need to follow after this recognition. In addition, the protocol will contain information on what actions should be taken when a suicide or suicide attempt has occurred, including the appropriate help providence for several groups involved. The accompanying research question is then:

What are the stakeholders' perceptions regarding the content of the students' suicide protocol, which will be for the purpose of UvA and HVA educational key players, to increase the probability of timely recognizing students at suicide risk, including the adequate procedures they need to follow after this recognition, to prevent suicides or attempts to occur, and information on appropriate help providence for several groups involved, in case of attempted and committed suicides?

2. Content background

In this chapter, relevant background information concerning the research subject will be provided. First, information will be given on suicide risk factors and other reasons for students being at elevated risk for suicide. Subsequently, this section will provide information on suicide prevention measures and their importance for universities. Finally, an actor map will be presented and elaborated upon.

2.1 Students at risk for suicide

Hawton *et al.* (1998) indicated that a former suicide attempt is the best predictor for a future suicide. In her review of studies of suicide in youth, Beautrais (2000) stated that a history of psychopathology and mental disorders are the strongest risk factors for suicide in youth and young adults. These mental disorders involve in particular depression, anxiety disorders, antisocial behaviors and substance use disorders (Beautrais, 2000). Other common risk factors for suicide in young people are having a low socio-economic status, exposure to problematical family circumstances and personality factors like neuroticism and novelty-seeking behavior (Beautrais, 2000; Fergusson *et al.*, 2000).

Regarding students specifically, abovementioned risk factors in the young adults in general, overlap with those in students: Mazurel (2014) demonstrated, that depression, psychological problems and anxiety were correlated with suicide risk among students. Other aspects identified as suicide risk factors in students, involve academic difficulties, helplessness and hopelessness, relationship problems and financial difficulties (Furr *et al.*, 2001; Strang & Orlofsky, 1990). In addition, Heisel *et al.* (2003) found an association between stress and increased suicidal ideation among college students. Further, an important phenomenon elevating the risk in students is that of suicide contagion: the increased suicide ideation among peers in the event a student's suicide has occurred (Debski *et al.*, 2007; Poland & McCormick, 1999).

As mentioned in the introduction, it is suggested that students may have a heightened risk for suicide. In addition to aforementioned student specific risk factors, an explanation was the transition in young adults' lives when entering college (Tompkins & Witt, 2009; Westefeld *et al.*, 2005). An example was the experience of distress due to separation from their beloved (Westefeld *et al.*, 2006). This elevated risk is further exemplified by the following two examples: firstly, during the shift from school to the university, many students will be exposed to alcohol/substance use which are significant risk factors for suicidal behaviors (Beautrais, 2000;

Tompkins & Witt, 2009; Weitzman, 2004); and secondly, although applying for non-studying peers too, psychological conditions frequently associated with suicide attempts and ideation, typically have an age of onset between eighteen and 24 years (Tompkins & Witt, 2009).

2.2 Prevention measures in universities

Considering the concerning data regarding suicide rates and suicide attempts and considerations among students, the various risk factors related with going to the university and the increasing number of students with severe psychological problems (American College Health Association, 2008; Tompkins & Witt, 2009), it is of great importance to take preventative measures in universities. Several prevention plans exist, Haas *et al.* (2008), for instance, examined an interactive web-based screening method at two American universities, for identifying students who are at risk for suicide. Their aim showed similarities with the aim of the current study, since this involved encouraging those students who appeared to be at suicide risk, to seek help. They revealed some promising results, however, no firm conclusions could be made on the effectiveness, since no control groups were included in their study (Haas *et al.*, 2008).

Another prevention plan involves gatekeeper training programs for improving detection and referral of students at risk for suicide, available in several countries including the Netherlands (113online, 2015; Isaac *et al.*, 2009; Tompkins & Witt, 2009). These trainings showed positive effects on the skills and knowledge of the trainees, however, evidence-based studies are lacking (Isaac *et al.*, 2009; Mann *et al.*, 2005; Tompkins & Witt, 2009). Furthermore, despite the existing prevention measures, the issue of suicide and suicide prevention continues to be problematical on college campuses (Westefeld *et al.*, 2005). Besides, as for the programs discussed above, little research has been done to the effectiveness of those prevention programs developed for universities (Gaynes *et al.*, 2004; Tompkins & Witt, 2009). Moreover, to the knowledge of this research, to date, no studies have investigated the effectiveness of such programs for Dutch universities, nor of a suicide protocol.

2.3 Actor map

In this section, the relevant stakeholders of this research will be introduced. These stakeholders concern the groups of people contributing to the content of the suicide prevention protocol and several other relevant involved groups.

The protocol will be for the purpose of UvA and HvA educational key players and the protocol is mainly intended for the risk students. Therefore, these two groups are considered this study's main stakeholders. First, the risk students involve those students who are at any risk for suicide,

for example due to suffering from suicide risk factors or having attempted suicide before. However, although significant stakeholders, this group will not be included as participants in this research, due to the highly sensitive topic dealt with in the current study and the vulnerability of this stakeholder group. Second, the group of educational key players consists of all employees of the UvA and HvA involved in the education, safety and/or well-being of the students. Examples of these persons include tutors/study coaches, teachers, coordinators and counseling services employees, such as student deans and study counselors. The latter service is not present at the HvA, where the student deans cover their tasks. This stakeholder group will be the target user of the final protocol and will be involved in the protocol development process. Chapter four will further elaborate on this stakeholder group.

Another stakeholder group involved in the development process of the protocol, concern the professionals in the field of this research topic. These professionals could be psychologists, researchers specialized in youth/students' suicide or employees of the foundation for suicide prevention 113online.nl. Due to their knowledge and expertise, this group was considered to make a valuable contribution to the content of the protocol. This stakeholder group too, will be further discussed in chapter four.

Other important involved groups are the peer students, family of the student and the possible bystanders of the suicide. These individuals are considered important because of the major impact a suicide or suicide attempt may have on those concerned (Kerkhof *et al.*, 2004; Magne-Ingvar & Öjehagen, 1999). They may for instance feel physically unwell, suffer from vocational difficulties or experience mood, appetite and/or sleeping problems (Magne-Ingvar & Öjehagen, 1999). Therefore, it is considered important to incorporate information on the appropriate aftercare for these stakeholders in the protocol.

The last group of stakeholders involves the Student Doctors' Office. This office is part of the UvA and HvA and the current research is originated from this stakeholder group. A schematic representation of the stakeholders and the relatedness between them is shown in the actor chart as presented in figure 2.1. The relatedness of the stakeholders will be discussed below.

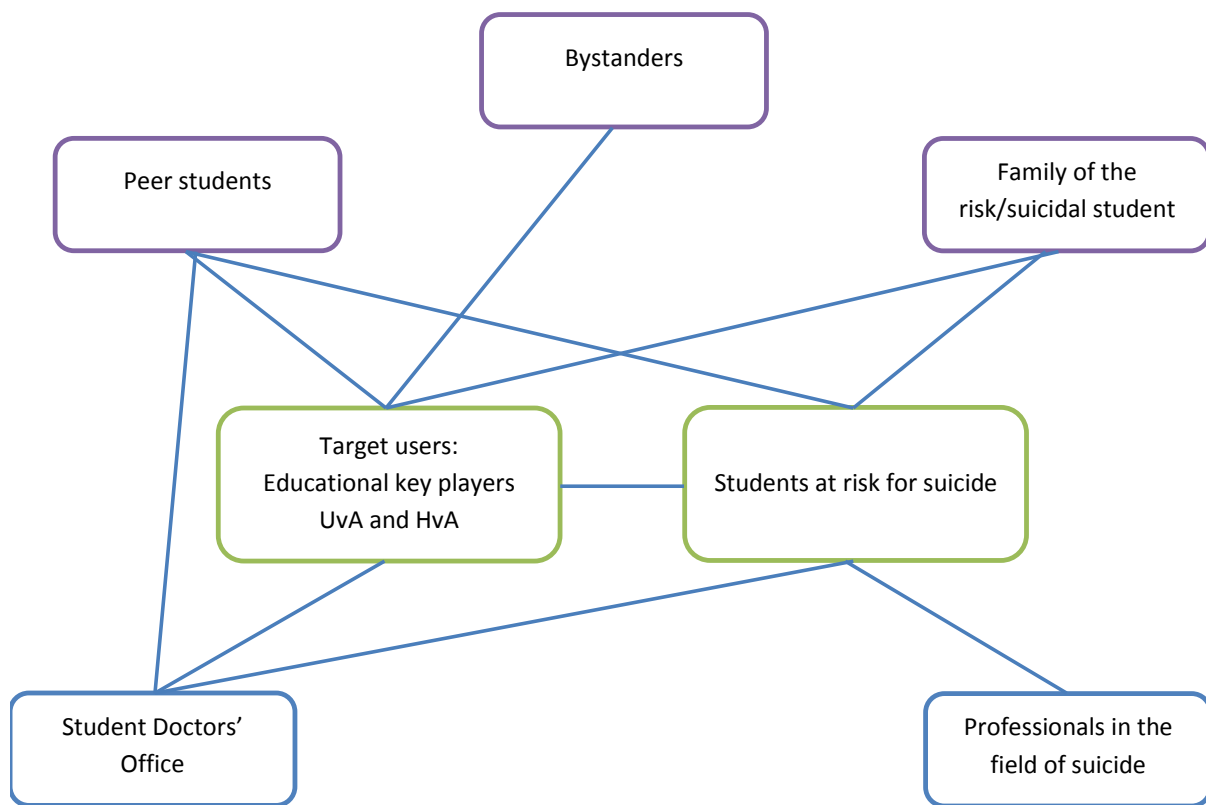


Figure 2.1 Actor chart.

The target users are related with the risk students, because of their task to signal these students and to take appropriate actions afterwards. Further, these educational key players are linked with the families, peer students and bystanders for the reason they are committed to provide the needed aftercare when suicide is attempted or succeeded. Finally, the educational key players are connected with the Student Doctors' Office, since the protocol will be for the purpose of the educational key players and originated from this office.

Additionally, the Student Doctors' Office is linked to the risk students due to the fact the protocol is intended for this group. Further, the office is connected with the peer students, since students in general comprise the area of concern of the Student Doctors' Office. The peer students, together with the target users, bystanders and families are related to the risk students, for the reason that the suicide or suicide attempt of this latter impacts these other groups. Finally, professionals in the field of suicide are linked to the students at risk for suicide, due to their knowledge of and expertise with these individuals.

3. Theoretical background

In this chapter, the theoretical background will be provided, needed for the development of the conceptual model of this study. The chapter begins with defining the concept of suicide and elaborating on several subtypes. Subsequently, the framework for protocol development for the purpose of universities will be examined and its concepts will be defined. Thereafter, the conceptual model will be presented and explained. The chapter ends with a set of sub questions derived from this model.

3.1 Suicide defined

Suicide was one of the sociological topics that devoted extensive attention during the nineteenth century, since many thinkers were attempting to link the increasing suicide rates with the suffered social transformation (Bradatan, 2007). The majority of these nineteenth century suicide theories are currently forgotten, however, with the remarkable exception of Emile Durkheim's work: *Le Suicide* (1897)(Bradatan, 2007). Hollinger *et al.* (1994) stated that the roots of the suicidology began with the work of Durkheim and Bradatan (2007) suggested that Durkheim's study of suicide is one of the main contributions to the history of the sociology. This is for the reason that Durkheim was the first who discussed suicide from a moral and social point of view (Bradatan, 2007). He assumed that suicide resulted from society's strength or inadequacy of control over people (Shneidman, 1981). The present study adopted Durkheim's (1951 [1897]) definition for suicide, including: "*The term suicide is applied to all cases of death resulting directly or indirectly from a positive or negative action of the victim himself which he knows will produce this result*".

In his work, Durkheim mentioned four types of social conditions which predispose an individual to suicide: egoism, altruism, fatalism and anomie (Dohrenwend, 1959; Durkheim, 1951 [1897]). First, egoistic suicide arises when the ties between the individual and his/her community are inadequate (Shneidman, 1981). This type is characteristic, for instance, of Protestants and intellectuals (Dohrenwend, 1959). Second, it is called altruism, when suicide is demanded by the rules or customs of a group (Gust-Brey & Cross, 1999). Here, an individual sacrifices one's life for the goals of the group, which is for instance the case with suicide terrorism (Riemer, 1998). Third, fatalism is a condition in which "excessive regulation" exist, for instance in the circumstances of slavery (Dohrenwend, 1959). This type is considered extremely rare in the modern society and was not widely elaborated upon in Durkheim's (1951 [1897]) work (Davies & Neal 2000). Fourth, when suicide occurs due to sudden damage or destruction of the relationship between the individual and society, it is called anomic suicide (Gust-Brey & Cross,

1999). Examples are the loss of significant others, loss of employment or loss of finances (Gust-Brey & Cross, 1999).

In the context of the current study, it was considered important to be familiar with the distribution of these types of suicide among students: as a result, the protocol content will be suited to the students, leading to a more adequate and efficient recognition of students at risk for suicide, and a more appropriate help providence afterwards. Therefore, the four types of social conditions will be taken into account in the protocol development and will be studied in this research.

3.2 Framework protocol development

In addition to Durkheim who considered suicide as being a societal phenomenon (Bradatan, 2007), more recent studies acknowledged this and stated that suicide is recognized as a public health concern (Knox *et al.*, 2004; Leenaars, 2005; The Jed Foundation, 2006; World Health Organization, 2010). Therefore, suicide prevention necessitates a public health approach, implying for this study a college-wide strategy through the implementation of a protocol regarding students' suicide for the UvA and HvA.

The term *protocol* is defined by the Merriam Webster Dictionary (2015) as a “*system of rules that explain the correct conduct and procedures to be followed in formal situations*”. In the present study, this refers to the proper conduct and procedures regarding the students' suicide prevention and the adequate aftercare. When examining the literature on protocols regarding suicide, several were found, including protocols for prisons, for hospitals, and for nursing homes (Ballard *et al.*, 2008; Correia, 2000; Hogarty & Rodaitis, 1987; Kurlowicz & Faculty, 1997). However, no protocol regarding students' suicide could be found and the listed protocols emerged to remain inadequate for universities and universities of applied sciences, and therefore, for the current study.

There was found, however, a framework for the development of protocols for the suicidal or actually distressed college student, generated by The Jed Foundation (2006). This framework is listed in the Best Practice Registry of the Suicide Prevention Resource Centre (SPRC) (2015). The section of this registry in which the framework is listed, summarizes the best knowledge in the field of suicide prevention, including consensus statements, protocols and guidelines (SPRC, 2015). Moreover, Barr (2014) suggested the Jed Foundations' Framework to be “*an excellent research-based resource for assisting colleges and universities in the development of mental health policies*”. Therefore, the framework was adopted in the current research and will be further discussed below.

The framework resulted from an expert roundtable discussion including senior college administrators, mental health practitioners, attorneys specialized in college issues and college counselors. This discussion was organized in response to the absence of consensus in universities and colleges about the content of a comprehensive, college-wide approach for managing the suicidal or actually distressed student. The product was the “*framework for developing institutional protocols for the acutely distressed or suicidal college student*” (The Jed Foundation, 2006). The purpose of this framework was to help colleges and universities with the development of a protocol which is suitable to its particular environment. According to the discussion group of experts, an all-encompassing effort to tackle the suicide problem among students, should contain the following three components: *Prevention*, *Intervention* and *Postvention* (The Jed Foundation, 2006). The concepts are represented in figure 3.1.

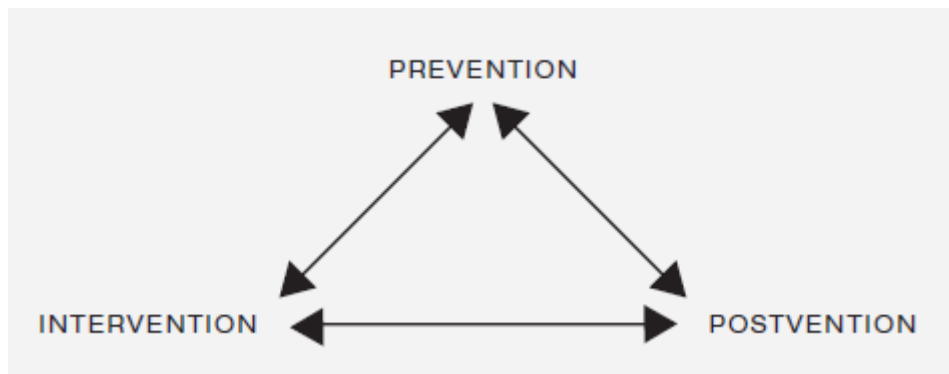


Figure 3.1 The three components needed for confronting the suicide problem among students (The Jed Foundation, 2006).

The aim of the participants of the roundtable discussion broadly corresponds with the aim of the current study. Both intend to contribute to the prevention of suicides among students and to performing the appropriate post-crisis actions, by the development of a protocol for educational institutions. Therefore, above presented model will be incorporated in the development of this study’s conceptual model. However, the framework developed by the expert group provided limited information and lacked definitions of the three components, disallowing the incorporation of the model as such. Therefore, in this chapter, it is attempted to scientifically underpin this model to the feasible extent, based upon scientific literature and theories on these concepts. In the following sections, the concepts *prevention*, *intervention* and *postvention* will be explained and defined. With this, the concepts will be placed in the right context for this study and the model will be scientifically underpinned.

3.3 Prevention

Prevention is defined as “*The action of stopping something from happening or arising*” (Oxford Dictionaries, 2015). The American Association of Suicidology (1998) defined *suicide prevention*

as plans to advocate a professional, appropriate response to students being potentially suicidal. In addition, Leenaars (2005) states that *suicide prevention* relates to a good mental health in general and consists strategies ameliorating suicide predisposing conditions: doing something prior to the occurrence of the event. The outcome of suicide prevention can be measured by factors like knowledge and awareness, rather than the actual reductions of suicide rates (Leenaars, 2005).

3.3.1 Prevention levels

Suicide prevention can be organized into three levels: the primary, secondary and tertiary level of prevention (Taylor *et al.* 1997; Uppane 1995) or the universal, selective and indicated prevention levels (US Department of Health and Human Services, 2001; World Health Organization, 2010). The terminology might be different, their meanings are similar as shown in table 3.1. Hereafter, the terms primary, secondary and tertiary are used to refer to these three levels. Leenaars (2005) suggested these levels to form the layers of a comprehensive response to suicide. Furthermore, the World Health Organization (2010) stated that worldwide, many of the works regarding suicide prevention have adopted these three levels. Similarly, in the current study these levels are adopted and will be returned to throughout this chapter.

	Primary or Universal level	Secondary or Selective level	Tertiary or Indicated level
Meaning	Targets everybody in a particular population, disregarding the suicide risk	Affects subgroups with particular risk (e.g. suffering from mental illness, (study) stress, substance abuse, etcetera)	Targets individuals with specific conditions or risk factors putting them at serious risk (e.g. attempted suicide before)

Table 3.1 Overview of the three prevention levels (Taylor *et al.* 1997; Uppane 1995; US Department of Health and Human Services, 2001; World Health Organization, 2010).

Primary level

Several suicide prevention efforts for universities were advised in literature (e.g. Furr *et al.*, 2001; Goldney & Fisher, 2008). These efforts are important for every student, whether at risk for suicide or not, affecting therefore the primary level. Therefore, in the present study, *suicide prevention at primary level* is understood to concern the efforts that can be made for the suicide prevention amongst UvA and HvA students. An example of the advised suicide prevention efforts at universities involved setting up a mental health team which is responsible for the development and implementation of the plans for suicide prevention and for the promotion of mental health (The Jed Foundation, 2006). Other examples were the awareness-raising among the students, staff and faculty about mental illness symptoms and suicide risk factors (Goldney

and Fisher, 2008; The Jed Foundation, 2006) and elevating the help-seeking behavior in students (Furr *et al.*, 2001). The request to and importance of abovementioned prevention efforts for the UvA and HvA will be examined in this study.

Secondary and tertiary level

As mentioned, the secondary and tertiary level of prevention relate to students at, respectively, particular and high risk for suicide. Gould *et al.* (2003) indicated that recognizing the risk students contributes to the prevention of actual suicides. Therefore, in the current study, *suicide prevention at secondary level* is understood to be the timely identification of students at particular risk for suicide, and *suicide prevention at tertiary level* includes the timely identification of students at high risk for suicide. How these risk students can be identified adequately, is attempted to determine based upon the results of this research.

3.4 Intervention

The Oxford dictionary (2015) defined *intervention* as “*The action or process of intervening*”. Additionally, this dictionary defined *intervening* as “*Take part in something so as to prevent or alter a result or course of events*” (The Oxford dictionary, 2015). In the context of the present study, the “*result or course of events*” includes the suicide or suicide attempts. Hence, in the present context, the term *intervention* involves the processes or actions altering or preventing suicide and suicide attempts. A sharpened definition of the concept *suicide intervention* more satisfying this research, is attempted to establish based upon the theories described below. In contrast to the outcome measure of suicide prevention, the outcome of *suicide intervention* can be measured by reductions in suicidal behavior and/or suicide rates (Leenaars, 2005; World Health Organization, 2010).

3.4.1 Intervention criteria

The World Health Organization (2010) proposed four criteria for achieving an effective intervention for tackling the suicide problem (see table 3.2). First, a conceptual framework should be empirically established. This framework will be developed on the basis of the results of the present study involving the theories of the interviewed stakeholders regarding suicide, causes, signs, intervention steps and aftercare. The conceptual framework regarding these results will be presented in the last chapter of this report.

The second criterion will be fulfilled when the target users are clearly identified (World Health Organization, 2010). In the former chapter, the relevant stakeholders of this study were elaborated upon, including the target users of the prevention protocol. Therefore, this second criterion seems to be fulfilled. However, it remains uncertain whether this stakeholder group

was defined completely and whether the currently mentioned target users were assigned correctly. Therefore, this will be tested through this study.

Third, the interventions need to be planned carefully (World Health Organization, 2010). In the context of the present study, this intervention planning includes the stepwise approach concerning the procedures to follow after a risk student has been identified. The appropriate content of this planning will be determined by means of the current research and will further elaborated on below.

The fourth criterion for achieving an effective intervention includes conducting systemic evaluations (World Health Organization, 2010). In the context of this study, this includes the systemic evaluations of the complete protocol including *prevention*, *intervention* and *postvention*. The evaluations need to be structurally organized after the protocol implementation and additionally, after the occurrence of a situation necessitating applying the complete protocol. It will be studied in this report which persons should be responsible for these evaluations. Table 3.2 represents an overview of these four criteria for an effective intervention regarding confronting the suicide problem.

Criterion 1	Criterion 2	Criterion 3	Criterion 4
Conceptual framework establishment	Target users identification	Stepwise approach after risk student recognition	Conducting systemic evaluations

Table 3.2 Overview of the four criteria for achieving an effective intervention for tackling the suicide problem (The World Health Organization, 2010).

3.4.2 Interventions per level

Returning to the former subchapter, it is illustrated that every level relates to different situations accompanying different risk levels. It is stated that each level of suicide prevention necessitates different intervention steps, appropriate for that particular risk group (World Health Organization, 2010). Considering the first, second and fourth intervention criteria, these are not related with the risk levels. This is in contrast to the third criterion involving the stepwise approach, since, as mentioned, this approach concerns the steps to follow after the identification of a student at risk for suicide. Thus, these intervention steps follow on from the *suicide prevention at secondary and tertiary level*. Therefore, this intervention does not apply to the students at primary level. Based on abovementioned, in the present study, the first, second and fourth criteria are rather considered additional, whereas the third criterion is part of the essence of this research. The latter will be further elaborated upon below.

As mentioned the secondary level concerns students at particular suicide risk, and the tertiary level concerns students at high risk for suicide. Accompanying intervention measures include follow-up care providence and the close monitoring of these students (World Health Organization, 2010). The Jed Foundation (2006) add the providence of *effective* and *accessible* services for mental health as an example of suicide intervention efforts in universities. The exact content of the necessary intervention steps after recognizing a student corresponding to the tertiary as well as to the secondary level, remains unclear. As mentioned, this content is attempted to determine by means of this research. Concluding, in the present study, *suicide intervention at secondary level* is understood to be the stepwise approach of the required procedures to follow after identifying a student at particular risk for suicide, and *suicide intervention at tertiary level* includes this stepwise approach regarding students at high risk for suicide.

3.5 Postvention

The concept *postvention* does not appear in the Oxford Dictionary (2015). Shneidman (1973) introduced the term referring to everything done after the occurrence of the event. A more extensive definition of *postvention* is included in the Psychology Dictionary (2015): “*The emotional release necessary for helpers and other people who work with those who have endured a traumatic occurrence or who have directly encountered a private trauma or natural disaster*”. This involves a general definition of postvention and is therefore inadequate for this study’s purpose. The definition of *suicide postvention* adequate for the current research will be further defined below.

Suicide postvention is defined by the American Association of Suicidology (1998) as plans for the promotion of a professional and appropriate response after completed suicides. This appropriate response in the suicide aftermath of a student may reduce the probability of suicide contagion (Debski *et al.*, 2007; Poland & McCormick, 1999). For schools, postvention protocols have been outlined, however, information on the impact of such protocols is scarce (Debski *et al.*, 2007). Postvention handles the traumatic effects in the suicide survivor and in those who are close to him or her (Leenaars, 2005). Suicide postvention efforts could contain the providence of mental health resources and outreach programs for those students, staff, faculty and others who are affected by a suicide or an attempt (The Jed Foundation, 2006).

The American Association of Suicidology restricted the definition singularly to completed suicides. This is in contrast to the other mentioned studies where postvention includes both attempts and completed suicides. In the current study this latter is adopted. Therefore, here, *suicide postvention* includes the emotional release and appropriate response after attempted or

completed suicide by a student, necessary for the fellow students, educational key players, family, bystanders and in case of survival, the student itself.

With regard to the three levels of suicide prevention, the following can be stated: in case a student attempted suicide, this student falls within the tertiary level. In this situation, aftercare is needed for this particular individual. However, other people involved may require help too and those people concerned may correspond to each of the levels. This holds true for the situation where a student was successful in committing suicide.

3.6 Conceptual model

Based upon the model shown in figure 3.1 and abovementioned descriptions of the concepts used in this study, a conceptual model is established as represented in figure 3.2. The concepts are extended with subheadings and several blocks are added. As a result, the concepts are placed in the intended context, making the model suitable for the purpose of the present study. An explanation of the model will be provided below.

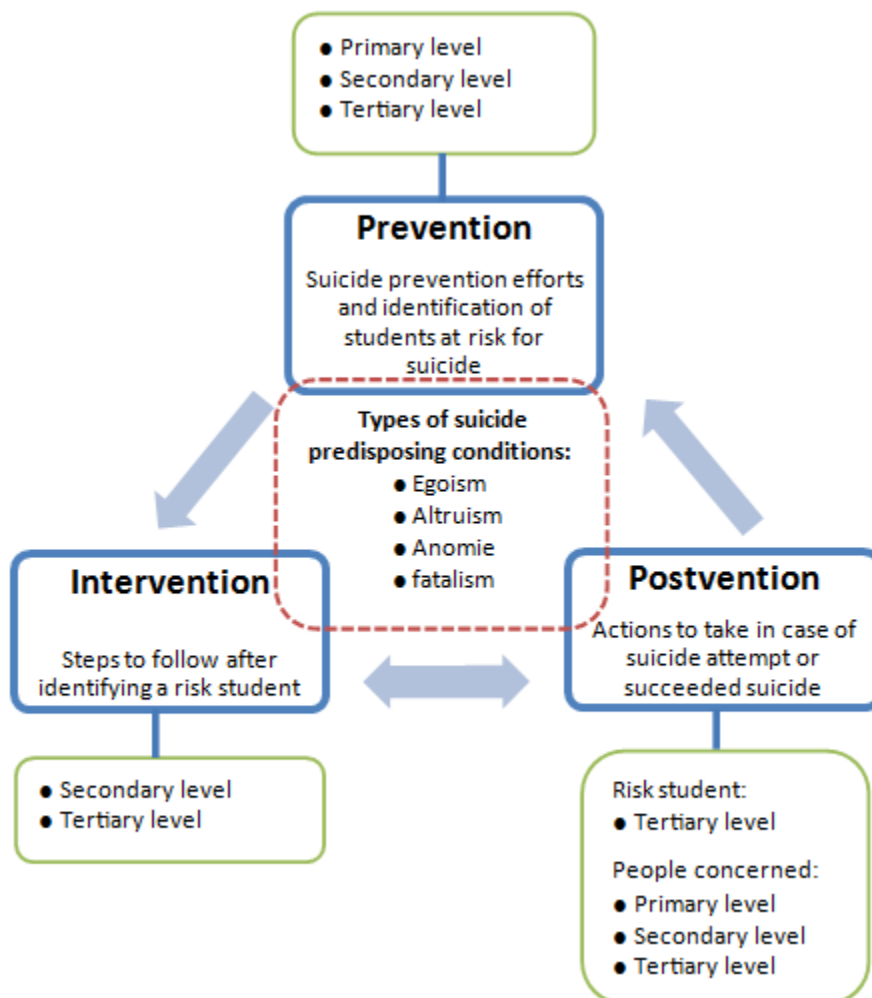


Figure 3.2 Conceptual model for the content of the protocol regarding students' suicide.

In this conceptual model, each blue block represents a section of the suicide prevention protocol. Hence, the protocol will be subdivided into three parts: the prevention section, the intervention section and the postvention section. Each of these sections will contain the particular information suitable for that concept including the accompanying levels (green blocks). The concepts and levels have been discussed previously. As mentioned before, the appropriate content of each of the sections is attempted to determine by means of the current research.

In the middle dotted red block, the four types of social conditions which predispose an individual to suicide are represented (Dohrenwend, 1959; Durkheim, 1951 [1897]). These different predisposing conditions may be present in students at particular and high risk for suicide. These risk levels relate to each section of the protocol and therefore, the types are concerned with all three sections. The distribution of these types among students will be researched in this study, leading to an adequate protocol adjusted to these students.

The relatedness and, therefore, the used arrows can be explained as follows. A single arrow connects the concept of prevention with the concept of intervention, since the use of the prevention section (recognition) leads to the subsequent use of the intervention section (taking action). In case this intervention failed and a student attempted or committed suicide, the postvention section (aftercare) will subsequently be needed. Then, after using the postvention section, the remaining sections, as mentioned, need to be evaluated, declaring the arrows towards these sections. Considering the obviousness of this relatedness, the relations will not be further examined in this study.

3.7 Sub questions

In order to answer the main research question, a set of sub questions have been formulated, whose answers together will give insight into the appropriate content of the suicide protocol. The sub questions derived from above explained model and are listed below. The methods used for answering these questions are discussed in the next chapter.

Main research question:

What are the stakeholders' perceptions regarding the content of the students' suicide protocol which will be for the purpose of UvA and HVA educational key players to increase the probability of timely recognizing students at suicide risk, including the appropriate procedures they need to follow after this recognition, to prevent suicides or attempts to occur, and information on appropriate help providence for several groups involved, in case of attempted and committed suicides?

Sub questions:

1. *What is the appropriate content of the Prevention section of the protocol according to the interviewed stakeholders?*
 - a. *What is the appropriate content of the Prevention section at primary level?*
 - b. *What is the appropriate content of the Prevention section at secondary level?*
 - c. *What is the appropriate content of the Prevention section at tertiary level?*

2. *What is the appropriate content of the Intervention section of the protocol according to the interviewed stakeholders?*
 - a. *What is the appropriate content of the Intervention section at secondary level?*
 - b. *What is the appropriate content of the Intervention section at tertiary level?*

3. *What is the appropriate content of the Postvention section of the protocol according to the interviewed stakeholders?*
 - a. *What is the appropriate content of the Postvention section of the protocol at tertiary level?*
 - b. *What is the appropriate content of the Postvention section of the protocol concerning the aftercare for fellow students, family and bystanders?*

4. *How are the four types of social conditions which predispose an individual to suicide, including egoism, altruism, fatalism and anomie, distributed among Dutch students based on to the stakeholders' theories?*

4. Methods

In this chapter, the used methods for answering the sub questions will be elaborated upon. In the present study, a qualitative research design was used involving in-depth semi-structured interviews with relevant stakeholders. The motivation, the role of the researcher, the study populations, the sampling strategies and the data analyses will be discussed below.

4.1 Method motivation

The reasons for using a qualitative method for collecting data, were the abilities to use this method specifically when relatively less is known about the subject (Straus & Corbin, 1990). This is the situation in this study, since evidence-based effective suicide protocols for universities could not be found. For this reason, the present study could not be based upon former evidence-based research. Therefore, an explorative approach was used, which is considered the right strategy when less is known about the studying question (Saunders & Lewis, 2012). In the current study, this question involved the perceptions of the relevant stakeholders regarding the appropriate content of the suicide protocol for the UvA and HvA.

Gray (2014) suggests that, in this situation where understanding of factors like opinions and values are desired, interviews are the favored approach. Therefore, this method was chosen in order to gain an in-depth understanding of the perceptions of the stakeholders. The interviews were semi-structured, allowing the interviewer to ask for more detailed answers, where clarification or more depth was needed (Gray, 2014). Besides, by using this method, a list of questions and topics was present, providing some guidance.

During these in-depth interviews, the stakeholders were asked about their beliefs, theories and opinions concerning the suitable content of the protocol. This included each of the sections and the accompanying levels, covering therefore all sub questions. The first set of sub questions involving the **prevention section at primary, secondary and tertiary level** was covered by discussing possible prevention efforts and their beliefs about identifying students at particular or high risk for suicide. Through discussing what steps should be followed after this identification, the second set of sub questions was examined, involving the **intervention section at secondary and tertiary level**. Additionally, the interviewees were questioned about their perceptions of the appropriate aftercare for several people involved, after a student's suicide or attempt. This involved the **postvention section at primary, secondary and tertiary level** and, therefore, the third set of sub questions. Finally, their theories regarding suicide risk factors and causes amongst students were discussed to gain insights in the distribution of **the**

four types of social conditions which predispose an individual to suicide. This latter covered the fourth sub question.

4.2 Role of researcher

During the interviews, several efforts were applied by the researcher, contributing to the validity and reliability of the research and minimization of bias. First of all, the researcher remained neutral to the feasible extent, in both behavior, responses and questioning. This contributed to the avoidance of steering the respondents' answers and hence, to receiving the real perceptions of the respondents (Turner, 2010). Another effort involved the standardization of the interview schedule and attempts to standardize the interviewer behavior (Gray, 2014). Further, an essential element was the rapport development between the researcher and interviewee, leading to the interviewees to be comfortable and willing to openly share their perceptions (DiCicco-Bloom & Crabtree, 2006). These efforts were particularly important since this study addressed a highly sensitive topic (Lee, 1993).

4.3 Study population and sampling strategies

In this subchapter, the interviewed stakeholders will be pointed out and, subsequently, the used sampling strategy will be discussed. The interviewees consisted of professionals in this topic area and target users of the final protocol. The inclusion criterion for the professionals was having knowledge and expertise in the field of youth and/or student's suicide and suicide prevention. The inclusion criteria for the target users were being employed at a Dutch university or university of applied sciences for at least five years, and being involved in the education, safety and/or well-being of the students. The reasons for choosing these groups of stakeholders were the expertise and knowledge of the professionals and the experience and knowledge acquired in practice of the target users. These qualities together were considered the comprehensive combination, needed for getting the insights in the appropriate protocol content. Besides, the resulting protocol will be for the purpose of the target users, making their opinions and ideas of significant importance.

E-mails were sent to general e-mail addresses of study counselor's and student dean's services and the foundation for suicide prevention 113online.nl. This e-mail involved information on the research including the problem statement, objective, study period and anonymity and confidentiality preservation. The e-mail ended with the question whether they were interested in participating in an interview. Exact interview topics were excluded from the e-mail to ensure spontaneity of the answers. This sampling strategy involved purposive sampling: small samples were selected purposefully for the assumption that these samples are information-rich individuals (Gray, 2014). Purposive samples are used when certain people are chosen, for the

reason that these persons are known to possess important information (Maxwell, 1997). As illustrated before, abovementioned was the case in the present study. Four out of the twelve respondents, including one expert and three educational key players, were selected using this strategy.

The remaining eight interviewees were recruited using the subsequent snowball sampling strategy involving the identification by others (Gray, 2014). This strategy was particularly useful since this study involved a sensitive topic and Biernacki & Waldorf (1981) stated that, therefore, knowledge of insiders is required to locate respondents. Besides, this strategy was used for the reason that, with regard to the experts, no proper sampling frame was available (Eland-Goossensen *et al.*, 1997).

A total of twelve respondents were interviewed and an overview of these interviewees is provided in table 4.1. This sample size was chosen due to the achievement of data saturation: no new themes emerged. Moreover, Rowley (2012) suggested twelve interviews of about thirty minutes, or a ratio of this, as a rule-of-thumb for achieving external validity. Since this study's interviews had a duration of sixty to ninety minutes, the sample size was considered to be adequate.

Educational key players	Experts and professionals
1. Safety coordinator	7. Researcher (e.g. suicide prevention youth)
2. Study counselor	8. Employee foundation for suicide prevention 113online (specialization in educational institutes)
3. Study counselor	9. Student psychologist
4. Student dean	10. Psychologist (background as student psychologist)
5. Teacher (university of applied sciences)	11. Researcher (e.g. depression and burn-out in students)
6. Teacher (university)	12. Expert in the field of suicide aftercare in youth

Table 4.1 Overview of the interviewees

4.4 Data analysis

The interviews were recorded using a voice recorder. The recordings were transcribed and the transcripts were summarized. These summaries of the interviews were sent to the respondents for verifying correctness of understanding. The summaries are presented in annex 2. The qualitative approach used for the data analyses was coding involving the linking of raw data to theoretical concepts (Jansen, 2005). The used codes derived from the concepts of the theory and conceptual framework. Before the coding process, the researcher read the transcript to get

familiar with the data (Jansen, 2005). An initial code tree based on the concepts of the theory and conceptual framework was developed. This code tree was revised during the analysis process when new concepts emerged.

MAXQDA software version 11 was used for the data analysis. Using this software, codes were assigned to important fragments in the transcripts. Subsequently, relations between categories were recognized (axial coding) and finally, the categories were integrated to produce theories (selective coding) (Gray, 2014). Several quotes of the transcripts were used to illustrate results as represented in the next chapter. The original Dutch versions of these quotes are listed in annex 3.

This chapter has described the qualitative research design used in this study, involving in-depth semi-structured interviews with relevant stakeholders. This enabled the sub questions to be answered. The results are described in the next chapter.

5. Results

In this chapter the results of the interviews are represented. The first three subchapters provide the obtained insights in the appropriate content of each protocol section, including prevention, intervention and postvention, based on the respondents' perceptions about this content. The last subchapter shows the results concerning the distribution of the types of social conditions which predispose an individual to suicide.

5.1 Prevention

This subchapter provides the results regarding the prevention section of the protocol and the accompanying levels. First, the results concerning *suicide prevention at primary level* will be discussed, involving the suicide prevention efforts for students regardless their suicide risk. Subsequently, the findings regarding *suicide prevention at secondary* and *at tertiary level*, involving the recognition of a student at risk for suicide, will be elaborated upon.

5.1.1 Primary level

In this section, insights are provided to the sub question '*What is the appropriate content of the prevention section at primary level?*'. As mentioned, examples of suicide prevention efforts were elevating the help-seeking behavior, awareness raising and setting up a mental health team. The request to and importance of these efforts for the UvA and HvA were examined. The results of this examination, together with other themes that emerged from the interviews, will be pointed out.

Help-seeking behavior

The respondents were asked about their perceptions of elevating the help-seeking behavior amongst students. In order to enhance this help-seeking, the respondents commonly argued that it is important that students know where they can find help, for what problems, and how these services can be reached. Most interviewees considered that, to date, this is frequently unknown among the students. They suggested that therefore, the students should be better informed about the existence and scope of action of the available services, including study counselors, student deans and student psychologists. For instance that a study counselor can be visited for a diversity of problems instead of just study related difficulties. As one study counselor indicated:

"Yeah it's just very important that students know that when there are things, or personal circumstances, that they are always welcome to visit us."

Several respondents further argued that with this knowledge about the available services, the threshold for a student to seek help will be lower.

Awareness-raising

Another effort commonly suggested to lower the threshold for seeking help, involved raising the awareness of suicide and mental health problems among students. Most interviewees considered this awareness raising a highly important effort. They suggested that the students should be informed and educated, attention should be paid to this topic and there should be talked about it, as further illustrated by one of the interviewees:

"I think that that's maybe one of the most important in suicide prevention, that you just dare to talk about it with each other, that there's a sort of openness about it, and yeah maybe it is still a huge taboo, that people think it's scary, or think it's weird." (Educational key player)

Several other interviewees also indicated perceiving an existence of stigma and taboo surrounding suicide and mental health problems. Respondents with this view argued that raising the awareness, being open and talking about it would contribute to breaking this. Their perceptions are in agreement with Hashemi *et al.* (2014) who stated that awareness-raising and breaking down the taboo are important efforts for making progress in suicide prevention. Further, four respondents considered this awareness-raising and talking with one other particularly important, for the reason that this would result in students keeping an eye on each other themselves. They stated that this would be very helpful and valuable and will further contribute to lower the threshold for seeking help.

The interviewees were asked about their ideas for communicating abovementioned efforts to the students. The majority indicated that these matters should be discussed during the informing lectures at the beginning of the first year. A few respondents further suggested that in addition, informing posters and leaflets should be used to communicate the information to the students. This latter is supported by the study of Van der Feltz-Cornelis *et al.* (2011) where awareness campaigns using posters and leaflets are listed as one of the elements of best practice efforts for suicide prevention.

Taken together, it is recommended to gain the students' knowledge of the available services and to raise their awareness of suicide and mental health problems, using the informing lectures at the start of the first year and informing posters and leaflets. This is suggested to contribute to

enhancing the help-seeking behaviors, and increasing talking with, and looking after one another.

Trainings and courses

A common theory that emerged from the interviews was that it would be very helpful to learn students about topics such as dealing with study stress, pressure, fear of failure and having a low self-esteem, improving their mental health. Several of these interviewees argued that nowadays, the focus lies too much on the study and achieving good results, whereas these topics were suggested to be at least as important. Most respondents suggested that for this, trainings should be offered to the students. Some others stated that this could be educated through lectures or workgroups concerning abovementioned topics. In addition to these more academic difficulties, one respondent added:

“Maybe also lectures about much more general themes. Why don't you learn to deal with yourself? (...) [Study] There you have to know everything about, in high school too, you learn nothing about yourself, what are emotions, how to deal with it, how can you look to it, it's really bizarre!” (Expert)

Several interviewees agreed on this importance of the students' personal development, concerning dealing with emotions, problems and with yourself. Respondents with this view argued that many students do not have acquired these skills from back home, while these are of importance to function properly, now and later in life. Moreover, one third of the interviewees stated that ideally, the personal development should be implemented in a course and, therefore, be part of the students' study programs throughout the year. Considering the lower short-term feasibility and the lack of knowledge on the desirability of the latter suggestions, this will not be part of this study's recommendations. To conclude, it is suggested that various trainings in dealing with problems should be offered and promoted, including for instance study stress, pressure, fear of failure and having a low self-esteem, contributing to the students' mental well-beings.

Mental health team

Another topic that was addressed during the interviews concerns setting up a mental health team which is responsible for the development and implementations of the plans for suicide prevention and for the promotion of mental health. The majority of the respondents were highly positive about this idea. They commonly suggested that this mental health team should be multidisciplinary, and frequently reported persons were: teachers, because of their knowledge

in the field, student psychologists, study counselors and student deans. However, in contrast, one interviewee stated:

“Well, I don’t believe in committees. I believe in one coordinator.” (Educational key player)

This interviewee argued that appointing one person who is responsible for the tasks should be more adequate. However, the tasks of the team will be quite extensive and besides, deliberating about plans and decisions are considered important. Therefore, setting up a team is considered more favorable than appointing one person. Several additional responsibilities for this team were suggested by the respondents later on in the interviews and will be returned to throughout this chapter.

In conclusion, it is recommended to include in the *prevention section at primary level* to raise the students’ knowledge of the available services and their awareness of suicide and mental health problems. This may be accomplished through discussing these matters during the informing moments in the first year and through distributing posters and leaflets throughout the educational institutes. Furthermore, trainings should be offered and promoted, supporting them in dealing with various difficulties. Finally, it is recommended to form a mental health team, responsible for various mental health promoting and suicide prevention related tasks.

5.1.2 Secondary level

In this section, insights are provided to the sub question ‘*What is the appropriate content of the prevention section at secondary level?*’. As mentioned, this involves the phase of identifying students at particular risk for suicide. First, the differences between particular and high suicide risk were explained by providing examples as shown in table 3.1. Subsequently, the interviewees’ perceptions regarding recognizing a student at particular risk for suicide were asked. The most commonly mentioned signs were becoming quit, down and withdrawing into oneself. Other important signs were less-functioning, decreasing grades and absenteeism, which will be further discussed in the subsequent section. In addition, a few interviewees suggested that risk students could be recognized by changes in the student’s behavior, being mentally absent, or looking pale and neglected. All reported signs are in accordance with previous studies on suicide warning signs (Debski, *et al.*, 2007; Hosansky, 2004; Rudd *et al.*, 2006; Poland & Lieberman, 2002).

An interesting common theme that emerged from the interviews, involves the importance of trusting your gut-feeling, as illustrated by this expert:

“That you think, well something isn’t right here. And then you just have to listen to your own gut feeling very well. But for this, you do have to look. When you’re just following your teaching routines, and you don’t look to who are really sitting in your class, then you will miss it I think.” (Expert)

Respondents with this view argued that it can be hard to recognize a risk student and that it is often very intuitive. Therefore, it is suggested a significant warning sign and will be adopted in this study’s recommendations. An overview of the most important signs for recognizing a student at particular risk for suicide, is provided in table 5.1 below.

Warning signs	
<u>Gut feeling!</u>	Becoming quiet
Down	Withdrawing into oneself
Less-performing	Absenteeism
Decreasing grades	Changes in behavior
Mentally absent	Pale and neglected

Table 5.1 Overview of the most important warning signs of students at risk for suicide.

5.1.3 Tertiary level

Then, the respondents were asked about their perceptions of differences in signs between students at particular risk and at high risk for suicide. Consequently, the results provide insights to the sub question ‘*What is the appropriate content of the prevention section at tertiary level?*’. Several interviewees indicated that no differences would be noticeable between both risk levels: the signs were suggested to be equal for both groups. However, six others suggested that unfortunately, recognizing the high risk group would be even more difficult. Some of them motivated that this is due to a less visibility of signs in this group, as one of these respondents motivated:

“You often see that someone becomes very calm, right. Because the decision is made, a huge calmness appears. Because then, the threshold of the anxiety for it, is crossed. So everything will look fine then.” (Expert)

The others however, suggested that identifying would be harder, because high risk students would be more frequently absent, as one of them stated:

“I don’t know whether the student with a very high risk is, for instance, still attending education, or that he may have withdrawn by then. Then you have already lost him of course.” (Educational key player)

With regard to this statement, one study counselor explained that, in their faculty, frequent absentees are contacted and asked about the reasons for not showing up. A few more interviewees came up with this suggestion. They stated that the absence and grades should be recorded and monitored, and students should be contacted when grades get lower or when they are frequently absent. This task was suggested to lie with the study counselors. In order to attempt to avoid missing these risk students to the extent feasible, it is recommended to incorporate these efforts in the protocol.

Overall, the results show that, if present, the signs of students at particular suicide risk equal the signs of those at high risk. Therefore, it is recommended to fuse the two sections together and to incorporate here the signs as presented in table 5.1. Further, this *prevention section at secondary and tertiary level* should contain the efforts of recording and monitoring the students’ absence and grades.

5.1.4. Knowledge and awareness educational key players

Interestingly, a common view that emerged from the interviews, was that adequate recognizing by the educational key players, requires both knowledge of the signs and awareness about the severity of this suicide problem. Several respondents argued that to date, this awareness is too poor amongst educational key players. This was also the case amongst the educational key players, interviewed in this study: half of them were not aware of the severity of the problem. The majority of the respondents stated that, in order to gain knowledge and to raise awareness, the educational key players should be educated and trained. These trainings they refer to are present, as pointed out in the second chapter. Various studies indicate that these gatekeeper trainings can be very helpful (Isaac *et al.*, 2009; Mann *et al.*, 2005; Tompkins & Witt, 2009). Training was commonly considered most important for those who are closest to the students, such as teachers and study coaches, also reported as tutors or mentors. Most interviewees mentioned that this group has a very important signaling function, where they should become aware of. As one interviewee stated:

“And I think that, when a mentor is aware of the important role that you can play in someone’s life, then you will deal with it differently, I think. Yeah, then it becomes really your task, you know.” (Educational key player)

Another commonly argued group being important to train, involved the study counselors. Both interviewed study counselors participated in a gatekeeper training, experienced this as very helpful and would recommend this to colleagues.

When asking the respondents whether these trainings should be made mandatory, the majority of the educational key players were very supportive, while the views of the experts were divided. Box 5.1 provides two illustrations, typical of both views:

Box 5.1 Statements regarding obligating gatekeeper trainings	
Against	For
<p><i>“No, I wouldn’t make anything mandatory. You need to have people who are concerned and who care about it, and you know, enthusiastic, and those have to spread it further.”</i> (Expert)</p>	<p><i>“Then you can provide it [knowledge on suicide etc.] already in their education, so all new teachers, you know that those have already had it, and then you only need to train the old ones.”</i> (Educational key player)</p>

The few opponents motivated that it is important that people are willing to participate, otherwise it would be ineffective. The interviewees with a positive view about obligating gatekeeper trainings stated that this knowledge and expertise are part of your duties as teacher or study coach. As illustrated by the latter statement, several interviewees suggested that therefore, the signaling skills and knowledge of mental health problems should be implemented in the teacher’s study programs. However, since this suggestion concerns the content of the curriculum of the teachers’ education, this goes beyond the scope of the protocol regarding students’ suicide. To conclude, it is recommended to add in the *prevention section at secondary and tertiary level* the widely offering and promoting of gatekeeper trainings to the educational key players.

5.2 Intervention

In this subchapter the results regarding the intervention section of the protocol are shown. As mentioned, *suicide intervention at secondary and tertiary level* concerns the stepwise approach of the required procedures to follow after identifying a student at risk for suicide. This concerns the third criterion for achieving an effective intervention for tackling the suicide problem and is discussed after providing the results of the additional other three criteria. An overview of the four fulfilled criteria is presented in table 5.2.

5.2.1 Intervention criteria

The first criterion involved the establishment of a **conceptual framework**. As mentioned, this framework is based on the entire results and will therefore be presented and further elaborated upon in the last chapter. In order to fulfill the second criterion involving the **clear identification of the target users**, the respondents were asked about their perceptions of the

definition of this group: “All employees of the UvA and HvA involved in the education, safety and/or well-being of the students”. Most of the respondents considered this an adequate definition. Several respondents however, argued that the final protocol should be for the purpose of every UvA and HvA employee, as one expert said:

“Yeah, actually you could say that everybody at the university has a responsibility in this, right, so you could almost say the doormen too.”

It is considered important that every employee who is, in any manner, involved with students should be familiar with the protocol and therefore with the recognition of a risk student, what to do afterwards and what to do when a suicide attempt occurred. Further, one interviewee mentioned that the definition of the target users should include the student doctors. However, the student doctors are unrelated to the students until they visit these doctors and, by then, students already sought help. Therefore, it is suggested not to include this group in the definition. Taken together, the target users of the protocol regarding students’ suicide are identified as all UvA and HvA employees having anything to do with the students.

The fourth criterion concerned the **systemic evaluations** of the final protocol. When asking the interviewees about who should receive the responsibility for these evaluations, the majority indicated that the aforementioned mental health team should receive this task. Five of them added that a professional should participate in the evaluations. Some suggested that this should be a professional in the field of students’ suicide and another interviewee stated:

“I think that this team, that team could do this very well. But I think that I would have someone there who knows how to evaluate this kind of things properly. Because good evaluating is an art in itself” (Educational key player)

As mentioned earlier, the mental health team is responsible for the suicide prevention plans. Therefore, the systemic evaluations of the protocol regarding students’ suicide are suggested the task of the mental health team. It is further recommended to invite a professional in the field of both students’ suicide and protocol evaluations in order that the evaluations will be more efficient. An overview of the fulfilled criteria for achieving an effective intervention is represented in table 5.2 below.

Criterion 1	Criterion 2	Criterion 3	Criterion 4
Conceptual framework establishment	Target users identification	Stepwise approach after risk student recognition	Conducting systemic evaluations
See chapter 6	<i>“All UvA and HvA employees having anything to do with the students”</i>	Will be fulfilled in subchapter 5.2.2. below.	Responsibility of the mental health team, assisted by a professional

Table 5.2 Overview of the four criteria for achieving an effective intervention for tackling the suicide problem and the accompanying fulfillments.

5.2.2 Stepwise approach

This section provides insights to the sub questions *“What is the appropriate content of the Intervention section at secondary level?”* and *“What is the appropriate content of the Intervention section at tertiary level?”*. This concerns the third criterion regarding **the stepwise approach** after respectively recognizing a student at particular and at high suicide risk.

Suicide intervention at secondary level

All interviewees indicated that the **first step** for an educational key player to perform after recognizing a student at particular risk for suicide should be talking to the student. As one respondent exemplified: *“Asking to stay for a moment and asking like ‘how are you doing actually?’ And when she: ‘nah I’m ok’ then: ‘well, I do worry about you.’”* Common mentioned examples of possible questions an educational key player could ask were: asking how someone is doing; asking if everything is alright; verifying whether their fishy feeling was justified; and asking whether the study is going well.

All respondents stated that the **second step** should include making an inventory of the severity of this student’s problem through continuing asking questions, following on from the students’ responses on the former questions. However, divergent perceptions emerged regarding the role of close teachers in this situation: two respondents argued that close teachers should not perform this second step, while others, in contrast, emphasized that they have a significant role here, as can be seen in box 5.2 below.

Box 5.2 Statements regarding questioning task for teachers

For	Against
<p><i>“You need to have a confidential relationship with such a person, right, so primary, a teacher is the first channel, if he has a good relationship with this teacher, to go in conversation.”</i> (Educational key player)</p>	<p><i>“A teacher has of course a relation with a student out of which I think that you must not stir in his private live that much.”</i> (Educational key player)</p>
<p><i>“I think when he sits there, that it’s your responsibility as a teacher, that you do <u>something</u> with it, asking like ‘I don’t know if I may meddle with it, but the way you look..’”</i> (Educational key player)</p>	<p><i>“The danger is, if all close teachers go interrogating, then you enter an area where you shouldn’t actually be, there you should just stay a teacher. But you do need to see it though”.</i> (Expert)</p>

On the whole, respondents suggested that it is part of the tasks and responsibilities of every educational key player to draw up this inventory of the severity of the situation. Several of them expressed that therefore, one should literally ask about possible suicidal thoughts or plans: this questioning should be very specific. This is in accordance with Jacobs & Brewer (2006) who indicated that this specific questioning is necessary for the assessment process of suicidal individuals. Several respondents emphasized though, that it is important for educational key players to keep in mind not to act as professional aid workers. Some indicated, however, that this line may be vague and that therefore, one should, instinctively, not go too deep in questioning. Further, it was indicated that listening to the student is very important and may be very helpful for him or her.

Interviewees stated that, on the basis of the inventory of the situation, the educational key player should recommend the student the appropriate service. This providing of advice represents the **third step**. Table 5.3 provides an overview of the results regarding the appropriate services corresponding to particular situations. Since the interview results lacked clear data regarding the tasks of the student dean, this data was complemented with information on this service, provided on the UvA and HvA websites (UvA, 2015; HvA, 2015).

Severity of the student’s problem	Service
Mild (e.g. study stress, personal problems, study related questions or difficulties)	Study counselor (UvA)
Mild (e.g. all the above, expected study delay, in need for additional provisions or arrangements)	Student dean
Moderate (e.g. feeling down, fear of failure)	Student psychologist
Severe (e.g. depressed, suicidal thoughts)	General practitioner

Table 5.3 Overview of problem-service combinations (UvA, 2015; HvA, 2015).

This overview, however, should not be interpreted as a fixed combination between problem and service, as one respondent illustrated:

“I should let it depend on the student, because if he has something like ‘that student psychologist, I really don’t feel anything for that, I will go to my own GP, that will be more beneficial’.” (Expert)

The **fourth step** that emerged from the analysis involved monitoring the student. A common view amongst the respondents was that the educational key player should contact the student after a while. They suggested that it is important to ask how the student is doing now and to verify whether the student followed the recommendation. These efforts, including follow-up care providence and the close monitoring of risk students, are in agreement with those suggested in literature, as mentioned earlier (World Health Organization, 2010).

Different ideas for contacting the risk student were suggested including: in person after class (teacher/study coach); in person by making an appointment; through a telephone call; via e-mail; and through text messaging. Previous studies evaluating the effectiveness of phone calls and text messaging after attempted suicides, showed positive results regarding reattempts (Berrouiguet *et al.*, 2014; Vaiva *et al.*, 2006). These findings concerned individuals at high risk for suicide and, therefore, the tertiary level. However, the essence of this method was to express care and interest, which also encompasses the aim of the monitoring of students at particular risk. Therefore, this method is considered helpful for both the monitoring of students at secondary and at tertiary level.

Further, half of the respondents indicated that the educational key player should discuss the case with colleagues and, therefore, not to worry on their own. This involves the **fifth step** of the stepwise approach. It was suggested by some interviewees that the mental health team should be available for this discussions and, in addition, for advice when needed. Since the mental health team is responsible for the suicide prevention plans and implementations, being available for discussions and advice is considered part of their tasks too.

Taken together, the appropriate content of the *intervention section at secondary level* is recommended to contain the five steps pointed out above. These include: talking to the student; making an inventory of the situation’s severity; referring to the appropriate service; monitoring; and discuss with colleagues. These findings, combined with the adequate steps at tertiary level discussed below, are presented in an overview at the end of this subchapter in figure 5.1.

Suicide intervention at tertiary level

As abovementioned, the severity of the student's problem will emerge through the questioning of the student. Therefore, after making this inventory, it is known whether the student is at particular or at high risk for suicide. Hence, the **first two steps** are identical for both the intervention at secondary and at tertiary level. However, all interviewees argued that a student at high risk for suicide requires another subsequent step. The following comment provides an illustration of the appropriate **third step** in this situation, typical of many respondent's suggestions:

"If you are seriously worried, always to the GP. Because there, you have an appointment within two or three days. If you are even more seriously worried: the crisis center. If you are acutely concerned, if someone says "I don't want to live anymore, I jump off the roof" don't let go! Then you stay in contact, you keep someone with you" (Expert)

Here, a distinction is made in the severity of the situation, as was the case in the former section. This comment indicates that within the tertiary level, the risk can be severe and extreme requiring different actions. This was a common view amongst the respondents and most of them indicated that, as illustrated, when a student expresses actual suicidal intent, the educational key player should immediately call the crisis center. However, after examining the policy of the concerned crisis center, the Emergency Psychiatry Amsterdam (SPA), it appeared that exclusively the police and general practitioners are permitted referrers to this centre (GGZSPA, 2015). This seemed to be known to only three experts: they mentioned that calling 112 (the police) is the right action to perform in case a student is at this extremely high risk for suicide. Taken together, in case of acute psychic or psychiatric emergency one should call the police (112) or, in less critical situations, the student's general practitioner for contacting the crisis centre. Since this is the crisis center's policy, this is adopted to be the third step of the stepwise approach at tertiary level.

With regard to the subsequent step, all respondents stated that the further actions should equal the **fourth step** mentioned at secondary level, involving monitoring the risk student. The former section elaborated on the arguments and literature regarding these intervention efforts and follow-up contacting methods. These efforts concerned both students at particular and at high risk and the contacting methods, as mentioned, concerned students at high suicide risk. Therefore, the fourth step at secondary level is also considered applicable for the tertiary level.

Overall, it is suggested that the first two steps and the fourth step of the *intervention section at tertiary level* should be similar to these steps at secondary level. Further, the third step includes calling the student's general practitioner or, in case of acute psychic or psychiatric emergency, 112. The last step again should equal the fourth step of the stepwise approach at secondary level. Considering these similarities in the stepwise approaches of both levels, here too, it is recommended to fuse the two sections together. An overview of the results regarding the recommended stepwise approach is represented in figure 5.1 below.

What to do when you think you identified a risk student: a stepwise approach:

- 1. Talk to the student**
Ask for instance: How are you doing? How is your studies going? I have this feeling that you're not alright, am I right?
- 2. Make an inventory of the severity of the problem**
Continue asking questions following on from the responses of the student but keep in mind that you are not a professional aid worker.
- 3. Recommend/(call) the appropriate service using the table below**
When it concerns mild or moderate situations, consider the student's wishes and preferences.

Severity of the student's problem	Service
Mild (e.g. study stress, mild personal problems, study related questions or difficulties)	Study counselor (UvA)
Mild (e.g. all the above, expected study delay, in need for additional provisions or arrangements)	Student dean
Moderate (e.g. feeling down, fear of failure)	Student psychologist
Severe (e.g. depressed, suicidal thoughts)	General practitioner
Extreme (e.g. expressing acute suicidal intent)	Call the police (112) for contacting crisis center

- 4. Monitor the student and provide follow-up care**
Ask how the student is doing now and verify whether the student followed the recommendation. You may ask this in person, but you may use e-mail, phone or text messages too.
- 5. When needed, talk with your colleagues or ask the mental health team for advice or support**
Do not carry on worrying on your own.

Figure 5.1 Overview of the recommended stepwise approach after recognizing a student at risk for suicide.

5.3 Postvention

This subchapter provides the results regarding the appropriate content of the postvention section of the protocol. First, the appropriate actions in the situation a student attempted suicide is discussed, providing insights to the sub question "*What is the appropriate content of the Postvention section of the protocol at tertiary level?*". Second, the proper efforts towards people concerned in case a student attempted or committed suicide is pointed out. This second provides insights to the sub question "*What is the appropriate content of the Postvention section*

of the protocol concerning the aftercare for fellow students, educational key players, family and bystanders?"

5.3.1 Postvention at tertiary level

When talking about the situation a student attempted suicide at the educational institution, two divergent first thoughts emerged among the respondents. About half of the interviewees mentioned that the educational key players has to provide first aid and call 112, while the other half stated that this person should talk to the student and act upon the mentioned stepwise approach at tertiary level. Clearly, it can be stated that these interviewees had different perceptions of the severity of the attempt. Therefore, the first action is considered situation dependent and it is assumed that the educational key player will instinctively perform the proper actions, including performing first aid or calling an ambulance when the student necessities emergency care. Further, in case of acute psychic or psychiatric emergency, the educational key player should call the police (112) for contacting the crisis center and, if less severe, the student's general practitioner for contacting this service.

A common view amongst the respondents emerged, concerning the longer-term actions. These actions correspond with those actions to perform when the attempt took place elsewhere. The following comment provides a typical illustration of the action suggested by these interviewees:

"Yeah, I think it will be good to offer, for example by the dean at HvA or the study counselor, you know, like 'Would you like it to have some appointments the coming period? Shall we just check how everything is going, it's quite something what 's happened.' And well, you offer that." (Expert)

This respondent, together with several others, recognized this monitoring task for the study counselor (UvA) and student dean (HvA). Other mentioned persons were the mentor or, if the attempt occurred at the institution, the educational key player who found the student. It is considered important to have clarity about who should have this responsibility. Therefore, it is recommended that this responsibility lies with the concerned educational key player who initially found out about the event; thereafter this individual is allowed to delegate this responsibility to the study counselor (UvA) or student dean (HvA).

The content of these monitoring actions suggested by the interviewees were in line with the monitoring step described in the former subchapter. However, several respondents suggested that it is important to take the risk student's wishes and needs into account. As one of them said:

“ ‘Are you in need for anything?’ Yes is a yes and then you can discuss further ‘what do you need for?’ And no is just a no and then you shouldn’t further meddle with it, I think.” (Expert)

Especially in this situation where it concerns a student who attempted suicide, it was considered important to verify whether the student is receiving therapy. Literature shows that half of the suicide attempters was receiving mental health care during that period (Kerkhof *et al.*, 2003). Therefore, it is recommended to motivate the student to visit the general practitioner in order to be referred to professional help. Taken together, it is recommended to include in *the postvention section at tertiary level*: calling 112 and/or general practitioner; contacting and discussing student’s needs or delegating this to study counselor/student dean; acting upon the fourth step of the stepwise approach mentioned in the intervention section.

5.3.2 Postvention peer students

The respondents were subsequently asked about their perceptions of the appropriate actions regarding the peer students in case a student attempted and subsequently, in case a student committed suicide. It emerged from the data that the actions in both situations broadly overlap, and therefore, these actions are discussed together.

Most respondents indicated that *something* needs to be organized for the peer students in case a student attempted or committed suicide, as one of them stated:

“Make sure that they have somewhere they can go with their story and thoughts. Because it does something with them.” (Expert)

This is in agreement with previous studies which revealed, as discussed earlier, that suicide and suicide attempts may have serious consequences for people involved (Kerkhof *et al.*, 2003; Magne-Ingvar & Öjehagen, 1999). In case of an attempt, the interviewees suggested that these peer students involve the affected close peers who know of the event and possible witnesses: it was commonly suggested that when a student attempted suicide, this event should be attempted to be kept silent to the feasible extent, preserving the student’s privacy. When it concerns a succeeded suicide, this meeting was suggested to be organized for all students in need for this aftercare.

Interestingly, interviewees appeared to be divided in the views of inviting a professional to attend this meeting. A quarter of the respondents mentioned that a professional should be

invited, while others expressed the opposite opinion. The latter can be illustrated by the two comments below.

“No, No, then it’s immediately like ‘oh, this will be traumatic, guys, here’s the psychologist!’” (Expert)

“Well, first of all, you must not be too fast in throwing professional aid on it (...) people don’t really need all those professional aid immediately.” (Expert)

One of the respondents with this view further motivated that the extensively elaboration on ones experiences after such an event, would be ineffective. This is in agreement with a study of McNally *et al.* (2003) which shows that this so called psychological debriefing after traumatic situations, may lead to the overwhelming of someone’s natural recovery process. Therefore, it is suggested that this conversation will not necessitate attendance of a professional and should be informal. Taken together, it is recommended to provide proper aftercare for the involved peer students and students who witnessed the event. This aftercare should include the organization of an opportunity where students can discuss with one another and where information is provided regarding the support services available at the educational institution.

Responsibility

With regard to the responsibility for the organization of this meeting, the study counselor (UvA) or student dean (HvA) were most frequently mentioned. Some respondents thought of the mental health team for receiving this task, which is, as mentioned, responsible for the plans for suicide prevention and for the promotion of mental health. Inviting through e-mail was exclusively suggested by the respondents as contact method, and therefore, this is adopted and recommended. Overall, it is recommended that the involved study counselor (UvA) or student dean (HvA) should receive the responsibility to organize a conversation. He or she should then contact the team who should assist in this organization and during those meetings.

Bystanders

Further, when discussing the situation a student committed suicide near to the educational institution and bystanders were involved who are not related with this institution, all respondents stated that this is the responsibility of the police/government. It was considered that the institution is unrelated to those bystanders. Moreover, these individuals were considered hard to reach. Therefore, it is recommended to exclude aftercare for these bystanders from the postvention section.

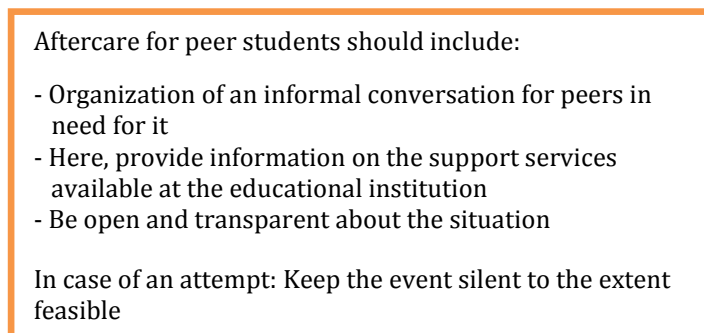
Transparency and clarity of the event

A few respondents suggested that all efforts in the situation a student committed suicide, such as abovementioned meeting, should equal the efforts after other causes of death. In contrast to them, the majority indicated that it is important to be clear and transparent about the situation, as illustrated by the comment below.

*“What I find important, especially in case of suicide, that it’s being discussed.
Also because people may get stimulated, you know.”* (Educational key player)

This respondent seems to refer to the phenomenon of suicide contagion which is, as discussed previously, the increased suicide ideation among peers in the event a student’s suicide has occurred (Debski *et al.*, 2007; Poland & McCormick, 1999). Besides, this interviewee expressed the importance of being transparent by explaining that otherwise, the taboo surrounding suicide would be maintained. For these reasons, this suggestion is adopted and therefore, it is recommended to be open, clear and transparent about the situation.

An overview of the recommendations emerging from the data regarding the appropriate aftercare for peer students is presented in figure 5.2 below. These efforts are recommended to be included in the *postvention section regarding the aftercare for peer students*.



Aftercare for peer students should include:

- Organization of an informal conversation for peers in need for it
- Here, provide information on the support services available at the educational institution
- Be open and transparent about the situation

In case of an attempt: Keep the event silent to the extent feasible

Figure 5.2 Overview of the recommended aftercare for peer students in case a student attempted or committed suicide.

5.3.3 Postvention parents

With regard to the actions to be taken towards the parents, in case a student attempted suicide, two divergent perceptions emerged. While about two third of the interviewees argued that the parents should be contacted, others stated that this should depend on the wishes of the student. Box 5.3 provides an overview of the comments concerning this issue.

Box 5.3 Statements regarding discussing with student prior to contacting parents

For

“Yes but you have to mind the privacy very well. So only when the student wants it. There it starts.” (Expert)

“Yes I think you have a responsibility as educational institution to inform the parents, when such a thing happens. If that student says like, ‘I absolutely don’t want that my parents will be there’, yeah then you have to respect that I think.” (Expert)

“Well I think, if you discuss it rightly with the student, like ‘well I think that it’s very .. that your parents know about this’, so you don’t ask it but you say more like ‘it’s important that’. And when he just consents, you can do it. But you can never do it without permission of course.” (Expert)

Against

“Look, it will be more obvious when it concerns minors, than when it concerns an older student, but I just think, that when an attempt occurred, that you have to contact the family, because it concerns a life-threatening situation.” (Expert)

“These are bad news conversations, but it’s commitment too, and I want to have those parents too.” (Educational key player)

“Talk about it with the parents, they aren’t always aware of it.” (Expert)

In contrast to the remaining, the respondent who commented the upper right statement seems to refer to a situation in which the student attempted suicide at the educational institution and where a life-threatening situation arose. Further, all statements suggest that the interviewees are assuming a healthy student-parent relationship. However, Strang & Orlofsky (1990) revealed that students suffering from suicidal ideation, commonly have poorer parental relationships compared to non-suicidal-ideaters. Therefore, it is suggested that actions towards the student’s parents should depend on the severity of the situation: when the situation is life-threatening, the parents should be called immediately; in all other cases, considering the student’s age of maturity and privacy and the unfamiliarity of the student’s parental relationship, it is recommended to discuss the student’s wishes. After the student’s permission, the parents can be informed about the incident. Here too, the responsibility is suggested to lie with the educational key player who initially found out about the student. It is suggested that, when it concerns a non-life-threatening situation, this person is allowed to delegate this task to the study counselor (UvA) or student dean (HvA).

In the case a student committed suicide, all interviewees agreed that his or hers parents should be contacted. Common suggestions concerning this contact with the parents include: expressing support, asking to their wishes, needs and their expectations of the educational institution, inviting them for a conversation, providing all known information and explaining that the educational intuition will always be available for their questions and needs. Most of them suggested that calling would be the best contact procedure. However, it was considered

important that the parents have been personally informed by the police, prior to this phone-call. With regard to the responsibility for conducting the phone-call, the faculty director was most frequently suggested. In addition, other persons responsible were mentioned, as one respondent motivated:

“Dean or study counselor I think. Because he can tell something about whether that person still was there, he can ask for information from the teachers, and he has the information then, and he can again pass this on to the parents.”
(Expert)

This interviewee’s motivation is considered important, however, the faculty director is considered to be able to gain this knowledge of the student too. Therefore, it is recommended that in the situation a student committed suicide, the involved faculty director calls the parents where aforementioned questions concerning this phone-call should be discussed. On overview of these recommendations for the content of the *postvention section regarding the aftercare for the parents* is presented in figure 5.3 below.

Aftercare for the student’s parents should include:

In case of an attempt:
The parents can be called after discussing the student’s wishes and receiving his/hers permission.

In case of an succeeded suicide:
Call the parents and express support, ask to their wishes, needs and expectations, explain that you will always be available for their questions and needs

Figure 5.3 Overview of the recommended aftercare for the student’s parents in case a student attempted or committed suicide.

5.3.4 Postvention personnel

Remarkably, a commonly considered significant group in need for postvention emerged from the interviews involved the personnel. All interviewees considered it important for the personnel to come together and that they receive aftercare, since such an event may have serious impact on them too, as an educational key player illustrated:

“We are also just people of course, so in that sense, that team should also provide a sort of aftercare to us again. Yes I think that that’s part of their package. Yeah that you also check: well ok, we all survived, the student survived, the parents survived, friends and family survived, did you all survived, too!?”

This respondent suggested that the mental health team should perform a role in the postvention towards the personnel. As mentioned, the mental health team is responsible for suicide prevention efforts and mental health. Therefore, it is recommended to charge the aftercare in case a student attempted or committed suicide with the mental health team. This task should include being available for those personnel in need for aftercare or advice and is recommended to include in the *postvention section regarding the aftercare for the personnel*.

[General protocol regarding deaths](#)

Interestingly, two respondents indicated that a standard protocol is available at the UvA and HvA, instructing what to do after someone passes away. However, the existence of this protocol seems to be widely unknown among educational key players, since only two respondents were familiar with this. Moreover, one educational key player illustrated about this protocol's presence:

[Referring to a situation a student passed away]

"I know that we really had something like 'O help, what do we actually need to do now!?' And then we all went looking very hard for a sort of protocol or something, on what to do when a student! (...) So that are then that kind of things! There does exist a sort of protocol on deaths by the way, we found out back then, after a lot of searching and struggling, ha-ha!" (Educational key player)

Therefore, it is recommended to evaluate and revise this protocol and to enhance the familiarity and availability. As mentioned, most respondents suggested that postvention efforts in case a student committed suicide, should differ from those in case it concerned other causes of death. Therefore, a general protocol regarding deaths, is considered inadequate in case the death concerned a suicide, indicating the importance of the current study's postvention section of the suicide protocol.

5.4 Types of suicide

This subchapter provides insights into the last sub question: *'How are the four types of social conditions which predispose an individual to suicide, including egoism, altruism, fatalism and anomie, distributed among Dutch students based on the stakeholders' theories?'* These insights, as described previously, are suggested to contribute to the comprehensiveness of the protocol content, adjusting to the students. Consequently, the educational key players will be familiar with the most common type and its characteristics leading to a more adequate and efficient recognition and care providence.

The respondents were asked about their theories regarding causes and risk factors for students to develop suicidal thoughts. A frequently stated theory involved the experience of pressure to perform, including in particular study pressure, causing distress. Most of these respondents motivated this theory by pointing to the considerable demands students currently need to comply with, in relatively little time. This pressure was suggested to be exacerbated by the relating financial consequences students will encounter when failing to comply with these demands. In addition, several interviewees further motivated that students may impose high pressure on themselves too, for instance due to perfectionism. Further, two respondents indicated that students may also suffer from parental pressure. These findings emphasized the importance of the recommendation concerning the offering of trainings in dealing with problems, such as study stress and pressure, provided in the prevention section.

Another common theory that emerged from the interviews involved loneliness and having insufficient social ties and, therefore, a lack of supportive relationships. Table 5.4 presents an overview of the causes and risk factors, accompanied with a bar indicating the number of respondents reporting that factor. In addition, each factor is illustrated with a statement.



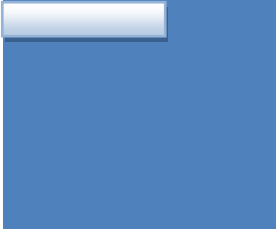





Weight	Risk factor	Statement
	Pressure to perform	<i>"And that pressure is becoming ever higher of course, due to the performance rules and graduating as soon as possible." (Educational key player)</i>
	Loneliness, weak social ties	<i>"The most severe cases are those people who don't have social contacts (...) And then the question is, who care about you, who worry about you." (Educational key player)</i>
	Phase of life	<i>"Well yeah those are of course in the phase of life in which they will discover a lot, have to take account of several things, their study, but also their own life (...) you suddenly have to be able to a lot too (...) <u>so much</u> is happening in that period, that's quite heavy." (Expert)</i>
	Sudden severe life event	<i>"It can sometimes be very acute, as a consequence of the death of beloved one, in the environment of a student." (Educational key player)</i>
	Low self-esteem	<i>"So negative self-image is actually the main reason. But ok, if you then could yet talk about it..." (Expert)</i>
	Traumatic event in the past	<i>"Traumatic moments, often from the early childhood" (Expert) "Being bullied in the past, (...)" (Expert)</i>
	Parenting	<i>"Well I think that, if you never had difficulties and was raised as a little princess or little prince, and then you face difficulties, <u>then</u> it will be hard (...) So I think that it has to do a little with parenting too." (Expert)</i>
	Substance use	<i>"We see an increase in substance use related psychoses which lead to suicide or attempts (...) that's another type, another cause, and what you see is that the reaction time is much faster, the pathway is shorter." (Educational key player)</i>

Table 5.4 Overview of the suicide risk factors for students, accompanied with the report incidence and an illustration.

With the exception of parenting, in the form described by the respondents, all risk factors reported by the interviewees are in accordance with literature (Beautrais, 2000; Fergusson *et al.*, 2000; Heisel *et al.*, 2003; Roberts *et al.*, 1998; Tompkins & Witt, 2009; Westefeld *et al.*, 2006; Wilbum & Smith, 2005). The mentioned phase in life and the accompanying factors elevating the risk of suicide, were elaborated upon in chapter two. When applying the theory of Durkheim, regarding the four types of social conditions predisposing an individual to suicide, to this study's results, it can be stated that the egoistic type is considered to be most common among students. As mentioned, this type involved having inadequate social ties. The anomic type

appeared to be another, less frequently occurring, type in students. This type involved experiencing a sudden damage or destruction, such as the loss of significant others. The remaining types, including altruism and fatalism, seemed not to appear among students. These results are in agreement with previous studies which indicated that egoism and anomie are the two dominant types (Bowring, 2015) and currently most relevant and recognized (Young *et al.*, 2011). Overall, considering that the egoistic type is most common, the following is recommended to enhance the recognition and care providence of the risk students: the educational key players should take particular care of those students often sitting alone and verify the strength of the social network of the risk student during the questioning.

Remarkably, a common theme in the interviews was the suggested increased risk of, in particular female, immigrants and foreign students. The majority of respondents with this view stated that this is due to the culture differences these students experience. Another commonly suggested explanation involved the presence of a greater taboo in foreign cultures. Further, applying exclusively to foreign students, a few respondents indicated that they are particular vulnerable, due to their possible loneliness here. This latter refers again to Durkheim's egoistic type of predisposing conditions. Box 5.5 provides three illustrative statements concerning these motivations.

Box 5.5 *Motivations for immigrants and foreign students being at elevated risk for suicide*

"They are struggling a lot with the free culture here in the Netherlands, struggle with the choice: well, do I comply with the rules of home or am I going to enjoy the freedom here? You see in some situations, that this confronts with each other that much, that it goes wrong." (Educational key player)

"The taboo is greater there, and more difficult than in the more autochthonous population, because when you talk about it there, then you have also to deal with a whole family honor, and that's just much heavier, and thus, there you have to be aware of." (Expert)

"The main difference with the Dutch students, is that they [foreign students] don't have a support system (...) in the worst case, it can be that those don't relate to anybody (...) and that's quite risky I think, nobody who keeps an eye on them or who sees them regularly." (Expert)

The interviewees suggested several cultures being at increased suicide risk. The Islamic culture was most frequently indicated as risk group, followed by the Hindustan/Surinamese culture and the Asian culture was least frequently indicated. The results did not show any relations between the mentioned causes and cultures. The findings are, to a certain extent, in line with the literature regarding suicide rates and suicide risks of the reported immigrant groups, as will be discussed below. Garssen *et al.* (2006) show higher suicide rates among East and South-East Asian females compared to the native Dutch population, confirming this study's finding. However, these researchers reveal a significantly lower suicide mortality among migrants from

West-Asian and North-African countries, including Turkey and Morocco, than among the autochthonous population (Garssen *et al.*, 2006; Garssen & Hoogenboezem, 2007). This seems to contrast the results of this study, however, with regard to the risk for suicide, the findings are consistent with literature: previous studies indicated a considerable higher number of suicide attempts among young female immigrants, in particular Turkish and Surinam/Hindustan, compared to Dutch females this age (Bergen, 2009; Kerkhof *et al.*, 2003).

With these insights, it can be concluded that educational key players should also be aware of the increased risk of immigrants and foreign students. To conclude, it is recommended to be particularly attentive to immigrants, foreign students, and students often sitting alone. Besides, the strength of the social network of this latter group should be verified during the questioning step. With these efforts, the protocol content is considered more comprehensive, resulting in an adequate and efficient identification of risk students and the subsequent care providence.

The results of this subchapter together with the results of the warning signs and the stepwise approach, are combined in an overview and presented in annex 1. This overview is suggested to be, when printed and laminated, a practical, easy accessible version for educational key players, facilitating and enhancing the recognition of risk students and knowing what to do afterwards.

6. Discussion & conclusion

The aim of this study was to provide recommendations for the content of a protocol regarding students' suicide for the UvA and HvA, based upon the perceptions of relevant stakeholders in order to contribute to the prevention of students' suicides and suicide attempts at these institutions and to the defining of proper aftercare in these situations. This protocol can be organized in three sections, including prevention, intervention and postvention, and for each section recommendations were provided. This chapter begins with presenting the conceptual framework of this research. Then, the aims regarding each section and the most important findings, which involve the recommendations, are pointed out, fulfilling the internal research objective. Subsequently, the relatedness of the results with literature are discussed and the theoretical background is reviewed. Thereupon, the strengths and limitations of the present study are provided and this chapter ends with practical implications and recommendations for further research.

Below, the conceptual framework of this research, based on the results of this study, is provided. As aforementioned, this fulfils the first criterion of an effective intervention for tackling the suicide problem. This framework is a brief schematic representation of the results regarding the content of the protocol. The green, blue and orange boxes represent outlines of the recommendations for respectively, the prevention, intervention and postvention section of protocol. The red box below shows the recommended table involving the advices for the appropriate service for different degrees of the problem's severity. The red arrow connects the identification phase, including risk factors and signs, to the actions to follow afterwards: the stepwise approach. Thereafter, the results and accompanying recommendations for the protocol content are further elaborated upon in more detail.

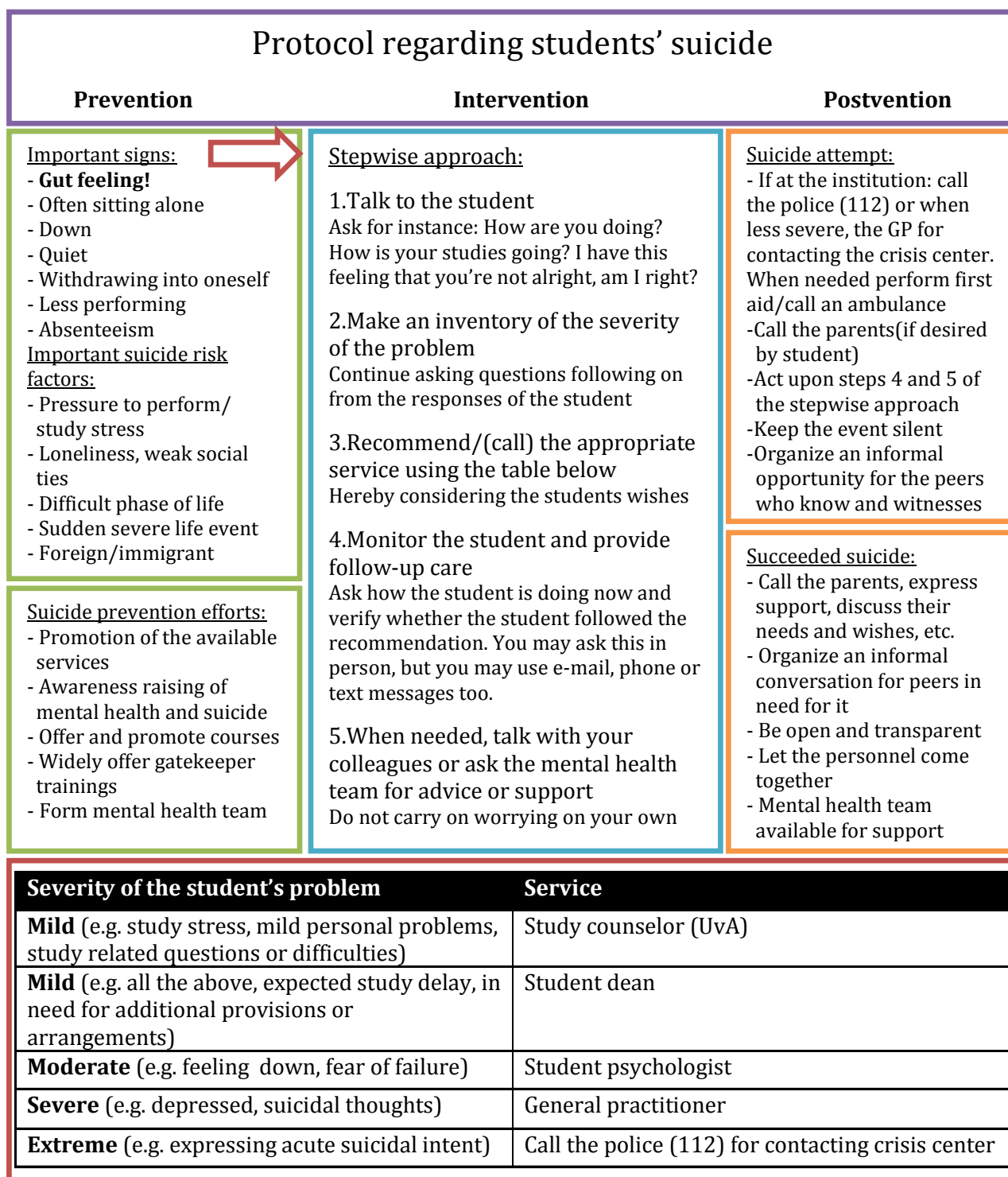


Figure 5.4 Conceptual framework concerning the recommended content of the protocol regarding students' suicide

6.1 Prevention section

The first set of sub questions concerned the efforts that can be made for the suicide prevention amongst UvA and HvA students (primary level) and the timely recognition of students at risk for suicide (secondary and tertiary level). The results regarding these questions show that the

knowledge of students regarding the available services at the educational institutes should be raised, in order to increase their help-seeking behaviors. This could be accomplished through distributing posters and leaflets in the institutions and discussing the services, and their scope of actions, during the introduction period and other information moments at the beginning of the first year. In addition, posters, leaflets and these occasions should be used to raise the awareness among students regarding suicide and mental health problems, in order to break the taboo and to lower the threshold for seeking help. Further, various trainings concerning dealing with (study) difficulties should be available and promoted and the student's grades and absenteeism should be monitored. Another finding involved the formation of a mental health team which is responsible for the development and implementations of the plans for suicide prevention and for the promotion of mental health.

With regard to the recognition of risk students, the results indicate that students at risk for suicide could be identified by educational key players by the signs as represented in table. 5.1. The most important sign appeared to be the presence of a gut-feeling. In addition, in order to achieve awareness about the severity of this suicide problem and timely and adequate risk student identification, gatekeeper trainings should be widely offered to the educational key players. Furthermore, findings suggest that teachers and study coaches should be made aware of their important signaling function.

6.2 Intervention section

The subsequent set of sub questions involved the stepwise approach to follow after identifying a student at risk for suicide at secondary and tertiary level. The current study found that the first two steps should involve talking to the student and making an inventory of the severity of the situation. Based on this, the student should be referred to the appropriate service as presented in table 5.3, hereby considering the wishes of the student. In respect to the tertiary level, if the inventory indicates that the student is at extremely high risk for suicide, the police (112) should be called for contacting the crisis center. Findings further suggest that the general practitioner should be called, when the situation is less severe, but still psychiatric care is needed. This study indicates that the last step should involve monitoring the student and providing follow-up care.

6.3 Postvention section

The third set of sub questions concerned the appropriate actions to perform after a suicide or suicide attempt. With regard to a severe student's suicide attempt occurring at the educational institution, first aid should be performed and an ambulance, the parents and the police should be called, the latter for contacting the crisis center. Findings suggest that the risk students

should be monitored and should receive follow-up care. For those near peers who know about the event and for possible witnesses, an informal conversation should be organized.

The results show that in case a student committed suicide, an informal conversation should be organized and there should be clarity and transparency about the situation. In addition, the parents should be called to express support and to discuss their needs and wishes. Further, the findings indicate that the personnel should come together for discussing the event and supporting each other and the mental health team should be available for support and advice.

6.4 Types of suicide

On the last question regarding the distribution of the types of social conditions which predispose an individual to suicide, this study found that the egoistic type, involving loneliness and having weak social ties, is most common among students. Besides, the results show that immigrants and foreign students are at increased risk for suicide. Therefore, it was suggested that educational key players should take particular care of immigrants, foreign students and those students often sitting alone. Additionally, they should verify the strength of the social network of this latter group during the questioning.

6.5 Literature relatedness

Literature comparisons and argumentations regarding various elements of the interview results has been discussed in the former chapter. In this section, the results regarding the protocol contents as a whole are elaborated upon, whereby the aim of this study is divided into two parts, including: 1) contributing to the prevention of students' suicides and suicide attempts; and 2) contributing to the defining of proper aftercare in these situations.

The first part of the aim relates to the results of the prevention and intervention section. The prevention section concerns the prevention efforts and the identification of students at risk for suicide. The suggestion for this to contribute to suicide prevention, is in line with the idea of Gould *et al.* (2003) who stated that the identification of individuals at risk for suicide and knowledge about suicide prevention efforts, is part of the crucial efforts in designing educational suicide prevention programs. The prevention section encompasses these efforts by presenting suicide risk identification signs and recommending several suicide prevention efforts (e.g. gatekeeper trainings).

With regard to the procedures to carry out after the identification, the current study suggested a stepwise approach to follow. However, the presence of a stepwise approach informing educational key players what to do, does not per definition imply that they are capable of

performing those actions properly. This requires competences that are not possible to gain through this study; these need to be trained. However, in the prevention section it has been recommended to widely offer gatekeeper trainings, and in addition to improving the identification of risk students and gaining knowledge about suicide and mental health, these trainings teaches listening to problems, questioning suicidal intent, and referring for help (Isaac *et al.*, 2009; Tompkins & Witt, 2009). Therefore, the capability of educational key players for properly performing the stepwise approach is considered to be covered. As mentioned, several studies suggest that gatekeeper trainings can be helpful, however, more research need to be conducted examining the effectiveness of these trainings in educational institutions (Isaac *et al.*, 2009; Mann *et al.*, 2005; Tompkins & Witt, 2009).

The second part of the aim involved contributing to the defining of proper aftercare in case of a student's suicide or attempt. This relates to the results regarding the content of the postvention section. As discussed previously, the recommended efforts towards the risk students, including follow-up care providence and the close monitoring, are in agreement with those suggested in literature (World Health Organization, 2010). With regard to the proper aftercare in case a student committed suicide, several findings are in agreement with previous studies including: contacting the family; offering group counseling to peer students; providing assistance to the personnel; and informing openly (American Association of Suicidology, 1998; Brock, 2002; Debski *et al.*, 2007; Poland & Lieberman, 2002). However, these studies suggested that the personnel should debrief frequently, which differs from the finding of the current study, where psychological debriefing had been discouraged. However, as mentioned, this finding is consistent with that of McNally *et al.* (2003) who examined the effectiveness of psychological debriefing after traumatic situations. Further, Poland & McCornick (1999) suggested that the meeting for peer students should take place in scheduled classes. This differs from the results presented here, where it has been recommended to organize a meeting. This inconsistency is likely to be due to the fact that their study involved postvention in schools, whereas the current study involves a university and a university of applies sciences, where scheduled classes are far less common. Furthermore, as aforementioned, it is important to bear in mind that little research has been done to the effectiveness of those postvention efforts (Debski *et al.*, 2007).

Finally, this study found that in particular cases, educational key players should verify the strength of the student's social network during the questioning. However, the current study has been unable to demonstrate the exact content of the actions to perform when a strong social network appears to be lacking. Therefore, further work is required to determine these actions.

6.6 Theory reflection

The theoretical model developed for structuring the current research, allowed to make clarifying divisions within the research aim, by dividing the protocol into three clear protocol sections: identification of risk students (prevention), the steps to follow afterwards (intervention) and defining proper aftercare (postvention). In addition, each section was subdivided into risk levels, allowing to adjust the protocol contents to particular risk groups. However, with regard to these levels, the results showed that the findings regarding the secondary level and tertiary level overlap. Hence, this subdivision in secondary and tertiary level turned out to be redundant for the current research.

Further, the theoretical model lacked information on the correct allocations of responsibilities for the various protocol contents. However, these responsibility allocations did have been examined in the present study, for the reason that it is considered essential to know who is responsible for what tasks. This was further supported by the study of Hendriksen *et al.* (2005) in which they stated that clearly defining the responsibilities is one of the key elements of a successful institutional policy. The results section has provided several recommendations for tasks to perform in particular situations. These recommendations were accompanied with suggestions regarding which educational key player should be responsible for that task. Besides, situations in which the responsibility may be delegated, together with the person ultimately responsible, were indicated. Taken together, this theoretical inadequacy is considered to be overcome.

6.7 Strengths and limitations

A strength of this study involves the knowledge and expertise of the respondents. The incorporation of the perceptions of stakeholders from both the more practical point of view (educational key players) and the professional and academic point of view (experts), and hence, from multiple disciplines, strengthened the outcomes (Weaver, 2008). Moreover, in addition to this, half of the respondents appeared to have backgrounds in both stakeholder groups. As a result, these respondents were able to share their perceptions, based on both their professional knowledge and their practical experiences and expertise, enhancing this study's data. Table 6.1 provides an overview of these respondents and their former or additional professions.

Stakeholder group	Former/additional profession (in)
Expert	University of applies sciences teacher
Expert	Study counselor
Expert	University teacher
Educational key player	General practitioner
Educational key player	Psychologist
Educational key player	Psychiatry

Table 6.1 Overview of respondents with supplementary value-adding backgrounds.

Another strength involves the awareness of the role of the researcher and the accompanying efforts as discussed in the fourth chapter. These efforts enhanced the validity and reliability of the research and minimized bias. One of these efforts involved remaining neutral, in order to avoid influencing the responses of the interviewees (Turner, 2010). Another effort concerns the rapport-building leading to the interviewee to be comfortable and willing to openly share their perceptions with the researcher (DiCicco-Bloom & Crabtree, 2006). This was particularly important since the interview discussed a highly sensitive topic (Lee, 1993). In addition, respondents were commonly pleased to contribute to this research, due to their believe that the development of a suicide protocol is very important. Their enthusiasm led to an enhanced willingness to share their ideas.

Further, considering that the educational key players and experts with educational backgrounds were not merely employed at the UvA or HvA, it is suggested that the results of this study may apply for other universities and universities of applied science too. When this is the case, the findings of the current study will also have implications for these other educational institutions, and therefore, for all Dutch students and educational key players. However, first more research should be carried out, in order to determine this generalizability of the protocol.

A limitation of this study involves the impossibility to incorporate the perceptions of students at risk for suicide in this study. It is expected that the students' perspectives may have made a valuable contribution to the determination of the appropriate protocol content, since they involve the main target population. Besides, incorporating the students' perceptions will further contribute to the multiple disciplinarity of the research and, therefore, the strength of the results. However, due to the high sensitivity of the research topic, this was not possible to perform. As a consequence, the results might differ from the results in case the perspectives of the risk students were included. More research should be carried out investigating the risk

students' perspectives to complement this study's results. A possibility for this research, could be gaining insights into the perceptions of students who attempted suicide, by recruiting them on the basis of hospitalizations for suicide attempts.

Further, this explorative research attempted to contribute to the determination of the content of a protocol regarding students' suicide for both the UvA and HvA. However, it can be expected that both institutions will need different protocol contents due to the differences in students and study programs. Further research is recommended, to determine the possible differences in the protocol content between universities and universities of applied sciences.

6.8 Practical implications and suggestions for further research

Taken together, the recommendations provided in this study can be used to develop a protocol regarding students' suicide for the UvA and HvA. This protocol will have various practical implications for several interest groups. First of all, the findings regarding common risk factors among students and regarding the groups being at increased risk for suicide, may have potential implications for (student) psychologists and (student) doctors. This knowledge may help them in their suicide risk assessment and determining the suitable care providence.

Further, the suicide prevention efforts will contribute to the mental well-beings of all UvA and HvA students, disregarding their suicide risk. This subsequently has implications for both the students themselves as well as the educational institutions, since a good mental health contributes to better performances of the students (Keogh, *et al.*, 2006). In addition, those risk students who do not seek help themselves will particularly benefit from the protocol, due to their reference to the appropriate service they need.

In addition, through this protocol, UvA and HvA educational key players will have guidance for the recognition of students at risk for suicide and the appropriate actions to follow afterwards. Furthermore, the protocol provides clear steps to follow, for instance the stepwise approach and the actions to take when a student attempted or committed suicide. As a consequence, the educational key players will no longer experience vagueness regarding the extent of their rights and responsibilities in these situations. In addition, it was recommended to produce and distribute laminated versions of the guidelines as presented in annex 1, including the risk factors, signs and the stepwise approach. As a result, the guidelines are easily accessible for the educational key players, enhancing the use of the guidelines, and therefore, increasing the probability of timely identifying and referring risk students.

Finally, the protocol will have implications for those people concerned in a students' suicide or suicide attempt. The protocol contains the information on the providence of proper after care in these situations. This providence of the optimal aftercare is suggested to contribute to lessen the impact of the event on those people involved.

On order to realize these protocol implications, first the protocol need to be implemented in the UvA and HvA. This points to further research investigating the correct implementation of the protocol at these institutes. Using a case study approach for conducting this research is recommended, allowing for studying the protocol implementation within its context: the UvA and HvA (Baxter, 2008). In order to ensure that the implementation is explored from a variety of angles, multiple data sources should be used (Baxter, 2008; Boeijs, 2005). A first suggestion for this, is addressing questionnaires to educational key players, including questions on the adequate distribution of the protocol and on the attaining of a wide familiarity of the protocol among them. This familiarity is important, since this will contribute to an enhanced awareness of the suicide problem and, therefore, in an increased alertness on possible risk students. A second suggestion involves conducting in-depth interviews with the persons responsible for policy implementations at the UvA and HvA. As mentioned, the further studies should take into account the possible differences between the UvA and HvA, the perceptions of risk students and the possible generalizability of the protocol to other educational institutions. Hopefully, the protocol will help lowering the suicide problem among students and will have as a consequence that the risk students, peers, family and personnel will receive the aftercare they need.

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Annex 1: Guidelines for risk student identification and subsequent steps

Guidance for recognizing a student at risk for suicide:

Important risk factors of students at risk for suicide:

- Pressure to perform
- Loneliness, weak social ties
- Low self esteem
- The phase of life
- Sudden severe life event
- Being foreign student
- Being immigrant
- Traumatic event in the past
- Parenting
- Substance use

Important warning signs of students at risk for suicide:

- Gut feeling!
- Down
- Less-performing
- Decreasing grades
- Mentally absent
- Becoming quiet
- Withdrawing into oneself
- Absenteeism
- Changes in behavior
- Pale and neglected

What to do when you think you identified a risk student: a stepwise approach:

1. Talk to the student

Ask for instance: How are you doing? How is your studies going? I have this feeling that you're not alright, am I right?

2. Make an inventory of the severity of the problem

Continue asking questions following on from the responses of the student, but keep in mind that you are not a professional aid worker.

3. Recommend/(call) the appropriate service using the table below

When it concerns mild or moderate situations, consider the student's wishes and preferences.

Severity of the student's problem	Service
Mild (e.g. study stress, mild personal problems, study related questions or difficulties)	Study counselor (UvA)
Mild (e.g. all the above, expected study delay, in need for additional provisions or arrangements)	Student dean
Moderate (e.g. feeling down, fear of failure)	Student psychologist
Severe (e.g. depressed, suicidal thoughts)	General practitioner
Extreme (e.g. expressing acute suicidal intent)	Call the police (112) for contacting crisis center

4. Monitor the student and provide follow-up care

Ask how the student is doing now and verify whether the student followed the recommendation. You may ask this in person, but you may use e-mail, phone or text messages too.

5. When needed, talk with your colleagues or ask the mental health team for advice or support

Do not carry on worrying on your own.

Annex 2: Summaries interviews

Samenvatting Interview

Het herkennen van studenten met een suïcide risico is erg lastig, bij sommige studenten heb je helemaal niet in de gaten dat er wat aan de hand is. Eventuele signalen zijn teruggetrokken gedrag, veel afwezig zijn en lagere cijfers halen. Dit laatste zou structureel in de gaten gehouden moeten worden, echter is dat lastig te realiseren. Onzekerheid, slecht om kunnen gaan met stress en druk, van niet-Nederlandse (o.a. Aziatische, Turkse, Marokkaanse) komaf zijn, zwakke sociale banden hebben en het meegemaakt hebben van heftige dingen, zouden risicofactoren kunnen vormen.

Studenten leren omgaan met studiestress en druk is belangrijk. Hier bestaan cursussen voor, echter zouden deze beter gepromoot moeten worden en tevens in het Engels beschikbaar moeten zijn voor de internationale studenten. Het hulpzoekgedrag onder studenten verhogen is belangrijk. Het zou beter zichtbaar moeten zijn voor de studenten waar ze terecht kunnen als ze ergens mee zitten. Hieronder valt o.a. het onder de aandacht brengen van (het bestaan van) studieadviseurs en studentenpsychologen, wat zij voor jou kunnen betekenen en hoe je ze kunt bereiken. Dit kan bijvoorbeeld middels folders/flyers en op de voorlichtingsmomenten waaronder de introductiedagen.

Het aanstellen van een team dat verantwoordelijk is voor de geestelijke gezondheid van studenten wordt gezien als een goed idee. Onder andere omdat het opvalt dat er veel studenten zijn met psychische klachten, angstaanvallen, etc.

Wanneer een studieadviseur een student met een suïciderisico opmerkt, wordt hij/zij doorgestuurd naar de huisarts of psycholoog. De studieadviseur kan hierin wel een aanvullende rol spelen door contact met ze te blijven houden. Bijvoorbeeld door het sturen van een mailtje of het maken van afspraak waarin gevraagd wordt hoe het nu gaat. Mocht het zo zijn dat de student een ernstig suïcide risico heeft, dan is het belangrijk een noodnummer te bellen. Ook is het dan belangrijk om de student helemaal uit te vragen. Er bestaan professionaliseringcursussen waar onder andere dit uitvragen behandeld wordt. Deze cursussen worden vanuit de UvA geregeld en zijn als zeer nuttig ervaren door de respondent.

In het geval er een suïcidepoging van een student heeft plaatsgevonden, zou een studieadviseur deze student moeten blijven monitoren en regelmatig spreken. Indien de student nog nergens in behandeling is, zou er gezorgd moeten worden dat dit gebeurt. Of en wat er voor medestudenten gedaan moet worden is afhankelijk van de situatie en de wensen van de student. De opleidingsdirecteur of -coördinator zou contact op moeten nemen met de ouders. Ook wanneer er een suïcide heeft plaatsgevonden, is het de taak van de opleidingsdirecteur of -coördinator om de ouders steun te betuigen en te overleggen wat er voor de medestudenten gedaan zou moeten worden.

Samenvatting interview

Het zou goed zijn als het onderwerp suïcidaliteit meer onder de aandacht zou komen en dat er meer over gepraat wordt. Zowel bij de docenten en andere onderwijsleutelfiguren als bij de studenten. Onder deze eerste groep wordt de ernst van het probleem veelal nog niet beseft. Bij

de studenten heerst er nu nog een groot taboe dat doorbroken zou moeten worden. Onder allochtone studenten (bijvoorbeeld Islamitische en Orthodox Christelijke) is het taboe vaak nog groter. Dit onder de aandacht brengen zou van bovenaf moeten komen, bijvoorbeeld door het organiseren van een project.

Determinanten voor het ontwikkelen van suïcidale gedachten zijn de levensfase waar ze als adolescent in verkeren, de grote stad/grote invloeden, drugs, weinig sociale contacten, ernstige levensgebeurtenis, studie-/prestatiedruk en de vele eisen waar je in deze wereld aan moet voldoen. Vrouwelijke studenten kunnen er over het algemeen makkelijker over praten, zodra een mannelijke student over suïcide praat, is het vaak ernstiger. Hoe er met dergelijke uitingen om zou moeten worden gegaan, zou aan onderwijsleutelfiguren getraind kunnen worden. Een andere vaardigheid die getraind kan worden is het luisteren naar je gut-feeling. Deze vaardigheden horen thuis in het vakkenpakket van een docent. Ook deze scholing moet vanuit hogerhand aangeboden moeten worden. Ook zou het onderwerp plaats moeten krijgen in de opleidingen/handleidingen van de onderwijsleutelfiguren, met als belangrijkste groep de studieloopbaanbegeleiders.

Als er zorgen worden gemaakt over een student, dan zou deze student aangesproken moeten worden en moet ermee gepraat worden. Als het echt ernstig was en de student is geadviseerd naar een psycholoog of psychiater te gaan, zou dit ook even geverifieerd moeten worden bij de student of hij/zij daadwerkelijk gegaan is. Als het heel erg ernstig is of als er zelfs een poging is gedaan, zou er met de crisisdienst geschakeld moeten worden. Echter is het momenteel onduidelijk hoever de verantwoordelijkheden moeten gaan, omdat hier geen beleid in is. Hierom zou een protocol uitkomst bieden. Wanneer er volgens het beleid gehandeld is, heeft diegene alles gedaan wat hij/zij binnen zijn/haar professe kon doen.

Universiteiten en hogescholen zouden hun studenten beter in de gaten moeten houden en betere zorg moeten bieden. Dit laatste ook met het oog op het feit dat de druk voor de studenten steeds hoger wordt. Momenteel zijn de onderwijsinstellingen teveel bezig met efficiëntie en rendementsdenken.

Wanneer een student een suïcide poging gedaan heeft, zal hier in een college of werkgroep over gepraat moeten worden. Hierdoor wordt het taboe minder, wordt het genormaliseerd en het is ook meteen een vorm van slachtofferhulp. De ouders van de student zouden gebeld moeten worden. Het is in deze situatie en in de situatie van een geslaagde suïcide erg belangrijk dat ook het personeel nazorg krijgt. Bijvoorbeeld doordat er een team is waarbij ze terecht kunnen.

Wanneer er een suïcide heeft plaatsgevonden is het belangrijk dat hier transparant over wordt gedaan en dat er veel en open over gesproken wordt. Mede met het oog op de eventuele suïcidale besmetting en ook weer omdat er anders een taboe gecreëerd wordt. Het is belangrijk dat er met de ouders besproken wordt waar zij behoefte aan hebben. Ook voor deze situatie zou er een beleid moeten komen, zodat alles beter wordt gecoördineerd.

Samenvatting interview

Psychische problemen en depressieve klachten zouden aanleidingen kunnen zijn voor zelfdoding. Oorzaken kunnen heel acuut zijn, bijvoorbeeld het overlijden van een dierbare. Ook kan het een opeenstapeling van factoren zijn, waardoor een student opeens heel veel op

zijn/haar bord heeft liggen. Een sociaal vangnet hebben zou gezien kunnen worden als beschermende factor.

Om het probleem aan te pakken zouden gatekeepertrainingen uitkomst kunnen bieden. Hierin wordt o.a. geleerd om iemand aan te spreken en echt door te vragen. Deze trainingen zouden best verplicht mogen worden, vooral voor de docenten die tevens een mentorfunctie hebben. Het is heel belangrijk dat zij er zich bewust van zijn dat zij een hele belangrijke rol hebben: zij hebben een signalerende functie en kunnen echt het verschil maken voor iemand.

Het is belangrijk dat studenten er meer bewust van worden dat de nare gevoelens en gedachtes niet voor altijd zijn en dat heel veel studenten hiermee zitten. Zelfmoord en –gedachtes zitten momenteel nog erg in een taboesfeer. Dit zou doorbroken moeten worden: er moet meer openheid over zijn, er moet ruimte zijn om erover te praten en de studenten zouden dit ook moeten durven. Dit zou door middel van voorlichtingen bewerkstelligd kunnen worden, bijvoorbeeld door het er over te hebben tijdens een algemene werkgroep/college in het eerste jaar. Ook zou hier duidelijk gemaakt moeten worden waar studenten terecht kunnen met problemen.

Idealiter zou er geïnvesteerd moeten worden zodat studieadviseurs de studenten intensiever kunnen begeleiden en meer controleafspraken in kunnen plannen. Het gaat hierbij dan niet om echte hulpverlening, maar er wordt opgemerkt dat alleen een luisterend oor bieden al heel fijn kan zijn. Omdat een afspraak of telefoontje met een studieadviseur een laagdrempelige manier van hulp zoeken is, zouden zij op alle faculteiten goed gepromoot moeten worden. Zich voorstellen tijdens de introductiedagen en tijdens een werkgroep in het eerste jaar is hier een onderdeel van.

Een student met een suïcide risico is niet specifiek ergens aan te herkennen, het is vaak heel intuïtief. In de les zouden eventueel het zich terugtrekken, moeilijk contact krijgen, overprikkeld reageren en absentie signalen kunnen zijn. Zodra je als onderwijsleutelfiguur het idee hebt iets te merken, moet je gewoon gaan praten met de student, peilen hoe ernstig het is en checken of er een vangnet is. Afhankelijk van de (ernst van de) situatie moet de student worden doorverwezen naar de huisarts, studentpsycholoog of de studieadviseur. Een docent of werkgroep-begeleider zou na een paar weken ook weer even moeten vragen hoe het nu gaat, de student blijven volgen.

Het zou fijn zijn als er een team wordt aangesteld, waar je als onderwijsleutelfiguur terecht kan voor vragen en advies, wanneer je te maken krijgt met een student met mentale problemen. Een soort volgsysteem waarin wordt bijgehouden of en waar een student onder behandeling is, zou handig zijn om iemand met een suïcide risico op afstand in de gaten te kunnen houden.

Wanneer een student een zelfmoordpoging gedaan heeft, zou hij/zij om de zoveel tijd even een afspraak met de studieadviseur moeten hebben. Zowel in het geval van een poging als bij een geslaagde suïcide is het belangrijk dat er vanuit de opleiding contact met de ouders wordt opgenomen en dat er iets voor de medestudenten georganiseerd wordt. In deze situatie zou het fijn zijn om terug te kunnen vallen op het team en een protocol. Tot slot is het belangrijk dat er ook voor nazorg voor de medewerkers zelf gezorgd wordt.

Samenvatting interview

Studenten zijn in een levensfase gekomen waarin ineens veel op hun dak terecht komt (studie, op kamers gaan, financiën, veel zelf uitzoeken/regelen, etc.) wat best heftig kan zijn voor iemand. Ook het drankgebruik kan een issue zijn bij studenten. In de Hindoestaanse en Moslim culturen is het moeilijker om over problemen te praten, het taboe is er groter. Het is belangrijk om hier enigszins bewust van te zijn.

De onderwijsleutelfiguren die veel contact hebben met de studenten (docenten, mentoren, etc.), hebben een signalerende en optredende functie. Zij zouden bijvoorbeeld moeten letten op veranderingen zoals het ineens veel stiller of juist veel extravert worden. Echter zijn signalen van iemand met een suïcide risico heel wisselend en zeker niet zwart-wit te noemen. Het belangrijkste is dan ook dat de onderwijsleutelfiguren hun voelsprietten uitzetten en op hun onderbuikgevoel vertrouwen. Ook zouden de docenten en mentoren zich meer in hun studenten moeten verdiepen en weten wie ze in hun klas hebben.

Wanneer een onderwijsleutelfiguur iemand met een suïcide risico denkt te herkennen, zou meteen het gesprek moeten worden aangegaan. Hierdoor laat je zien dat je je zorgen maakt en geef je de betreffende student aandacht, wat heel erg belangrijk kan zijn. Ook zou er gewoon gevraagd moeten worden of de student weleens aan zelfmoord denkt. De ernst van de situatie kan dan ingeschat worden en afhankelijk daarvan kan gekeken worden wat er vervolgens gedaan moet worden: meteen 112 bellen/ doorverwijzen naar de huisarts/ behandelaar bellen/ binnen de instelling doorverwijzen (studieadviseur/studentenpsycholoog)/ slechts zorgen dat je contact houdt/ etc. Er zou, ongeacht de ernst van de situatie, contact met de student gehouden moeten worden, bijvoorbeeld in de vorm van een mail waarin gevraagd wordt hoe het bij de huisarts ging.

Het is belangrijk om de bewustwording van het probleem te verhogen: het onderwerp moet spelen binnen de organisatie, het komt veel vaker voor dan de meeste mensen denken. Er kunnen bijvoorbeeld folders verspreid worden of voorlichtingen gegeven worden. Hierbij is het vooral aanhoren, maar dan staat het in ieder geval even op de agenda. Een intensievere optie is het organiseren van gatekeeperstrainingen, waarbij er echt dingen geleerd worden, zoals hoe je het gesprek met iemand aan moet gaan. Om de bewustwording onder de studenten zelf te verhogen zou een awareness raising programma uitkomst kunnen bieden, waarbij er o.a. geleerd wordt hoe om te gaan met moeilijke situaties.

Het is belangrijk dat de studenten weten dat ze over hun problemen kunnen praten, dat er oplossingen zijn en dat ze weten waar ze terecht kunnen voor hulp. Ook zouden posters van 113online nuttig kunnen zijn om het hulp-zoekgedrag te verhogen, omdat dit laagdrempeliger en anoniemer is dan wanneer je naar je mentor zou gaan. Indien een student niet de stap naar de mentor durft te zetten, kan 113Online een eerste stap zijn.

Voor een onderwijsleutelfiguur die te maken heeft (gehad) met een student met een suïcide risico, zou het goed zijn om hierover te praten met zijn/haar collega's en er niet alleen mee te blijven zitten.

Wanneer een student een zelfmoordpoging ondernomen heeft, zou de mentor contact met deze student op moeten nemen, checken of de student al in de hulpverlening zit en vervolgens contact moeten blijven houden. Voor de medestudenten zou er duidelijk moeten zijn dat ze erover kunnen praten en bij wie ze terecht kunnen. Als de situatie het toelaat zou het goed zijn om contact op te nemen met de ouders. Mede omdat zij er wellicht niet eens bewust van waren en hiermee het netwerk van de student versterkt wordt.

Als het een geslaagde suïcide betreft, is het belangrijk dat er een bijeenkomst wordt georganiseerd voor iedereen. Voorafgaand aan deze bijeenkomst zou er extra aandacht aan de studenten gegeven kunnen worden die dichterbij het slachtoffer stonden. Ook hier zou weer duidelijk gemaakt moeten worden dat ze erover kunnen praten, in eerste instantie met de eigen mentor, die vervolgens verder kan kijken wat nodig is. Het is belangrijk in deze situatie de ouders te contacteren, alle informatie te geven die ze willen, uitnodigingen op de universiteit, open staan voor vragen en aangeven dat de deur altijd voor ze open staat. Ook in deze situatie is het belangrijk dat je als medewerker ook met elkaar gaat praten, ook voor hen is het een heftige situatie.

Verder is het zo dat er wordt opgemerkt dat de vraag naar een protocol ter bevordering van de suïcidepreventie erg hoog is voor onderwijsinstellingen. Er wordt dan ook gehoopt dat de aanbevelingen ook verder verspreid mogen worden.

Samenvatting interview

Het hebben van een laag zelfbeeld wordt gezien als belangrijkste risicofactor voor suïcide onder studenten. Verder is ook het hebben van een sociaal isolement, dus eenzaamheid, een belangrijke aanleiding. De aanleidingen zijn in principe altijd trauma gerelateerd en veelal zonder dat ze dit zelf door hebben, dit gevoel wordt onderdrukt. Het trauma uit de jeugd ligt tijdloos opgeslagen en kan, door een relatief kleine aanleiding zoals het uitgaan van een relatie, worden aangewakkerd wat kan leiden tot bijvoorbeeld hopeloosheid, burn-outs of depressie. Hooggevoelige hoogbegaafde studenten zijn met name gevoelig voor deze ontwikkeling.

Een belangrijk kenmerk waar een student met een suïcide risico aan herkend zou kunnen worden, is wanneer de student matheid en levenloosheid uitstraalt en wanneer je ook zelf dit levenloze gevoel krijgt bij deze student. Verder kan de student paniekerig of agressief zijn en/of minder goed functioneren. Een student met een hoog suïcide risico, zal moeilijk te herkennen zijn, aangezien zij er op het eerste gezicht heel rustig uitzien alsof er niets aan de hand is. Dit omdat er een gevoel van rust ontstaat, omdat het besluit al genomen is en de angst voor de poging weg is.

Wanneer een onderwijsleutelfiguur een student denkt te herkennen, zou er contact gemaakt moeten worden en worden gevraagd hoe het met de student gaat. Hij/zij zou bijvoorbeeld samen met de student een afspraak kunnen maken met de studentenpsycholoog of met de huisarts of de tip geven om dit te gaan doen. Mocht de situatie heel ernstig zijn dan zou de huisarts gebeld moeten worden en mag de student niet alleen gelaten worden. Ook is het belangrijk als de onderwijsleutelfiguur met collega's de situatie gaat bespreken, hij/zij moet er niet alleen mee blijven lopen.

Het is belangrijk dat er veel over het onderwerp gepraat wordt, zodat het ook normaler wordt. Verder werkt het goed om met groepen te werken, zo er zijn bijvoorbeeld groepen voor studenten met weinig zelfvertrouwen. Om dit onder de aandacht te brengen, zouden er folders verspreid kunnen worden en kan er op de websites ruimere bekendheid aan gegeven worden. Ook zou de universiteit meer verantwoordelijkheid moeten nemen voor de persoonlijke ontwikkeling van studenten. Bijvoorbeeld door het geven van colleges over algemene thema's zoals hoe om te gaan met emoties en met jezelf. Idealiter zouden deze thema's plek krijgen in een leerlijn, waarbij elke student in een groep stapt waar deze thema's behandeld worden. Dit omdat het succes van nu en in het latere leven, afhangt van bijvoorbeeld je social skills en zelfvertrouwen van nu.

Als een student een suïcidepoging heeft ondernomen, zou een decaan of studieadviseur de student afspraken moeten aanbieden om erover te praten en omdat er wellicht regelingen nodig zijn voor vertraging e.d. Wanneer het een geslaagde suïcide betreft, zou er in een geplande les over gepraat moeten worden met de medestudenten. Dit kan gewoon laagdrempelig en hier zou even gemeld moeten worden waar studenten terecht kunnen als ze ermee blijven zitten. Verder zouden de ouders gebeld moeten worden, waarbij wordt aangegeven dat ze open staan voor een gesprek en dat ze alle informatie kunnen krijgen die ze zouden willen.

Samenvatting interview

De belangrijkste aanleiding voor een verhoogd suïciderisico is het hebben van een psychische stoornis, met name depressie. Een eerdere suïcidepoging is de belangrijkste risicofactor en ook kunnen zaken als hopeloosheid, stress en spanningen, cultuurverschillen, eenzaamheid en de specifieke problematiek die komt kijken bij de levensfase waarin een student is gekomen, een rol spelen. Verder wordt opgemerkt dat bij suïcide(pogingen) onder jongeren, impulsiviteit mee kan spelen.

Het zou een goed idee zijn om één keer in de zoveel tijd de studenten een online screeningstestje te laten doen. Zo kunnen studenten met psychische klachten vroeg opgespoord worden en kan de prevalentie in kaart gebracht worden. De studenten die hoog scoren moeten vervolgens proactief benaderd worden en hierna moet er vinger aan de pols gehouden worden. Een ander goed idee is het implementeren van integrale suïcidepreventie programma's zoals een awareness-raising programma, welke goede effecten blijkt te hebben. Ook zouden de E-learning-module en een gatekeepertraining voor onderwijsleutelfiguren uitkomst kunnen bieden, welke ook gerust verplicht gesteld zouden mogen worden. Verder zou het hulp zoeken laagdrempeliger en uitnodigender moeten zijn en zou er meer gebruik gemaakt moeten worden van moderne technologieën zoals social media e.d.

Als onderwijsleutelfiguur kan het lastig zijn om de studenten met een suïcide risico eruit te pikken, waardoor er heel veel gemist worden. Hier zouden de gatekeepertrainingen goed voor zijn. Eventuele signalen zijn somberheid, zich terugtrekken, stil worden en het zichzelf verwaarlozen, echter kun je als onderwijsleutelfiguur ook gewoon een niet-pluisgevoel bij iemand hebben, ook al kun je dat nergens op baseren. Zodra gedacht wordt een student met een suïciderisico te herkennen, moet er proactief gehandeld worden. De student aanspreken, inventariseren wat er aan de hand is, bekijken naar wie eventueel het beste doorverwezen kan worden en ook zorgen dat de student daar daadwerkelijk aankomt. Wanneer bijvoorbeeld een

lichte interventie voldoende geacht wordt, zou de student op 113online gewezen kunnen worden, waar een zelfhulp cursus of online therapie gedaan kan worden. In het geval de student een ernstig risico loopt, moet er geschakeld worden met de crisisdienst, de behandelaar of de huisarts, afhankelijk van de situatie en de wensen van de student. De onderwijsleutelfiguur zou daarna de student regelmatig moeten terugzien en bij voorkeur ook aangeven dat de student altijd bij hem/haar binnen kan lopen.

Wanneer er een suïcidepoging heeft plaatsgevonden, zou er in principe contact opgenomen moeten worden met de ouders, omdat het om een levensbedreigende situatie gaat. Er zou iemand aangesteld moeten worden die proactief contact houdt met de student in kwestie. Verder is het belangrijk dat er in deze situatie, maar ook bij een geslaagde suïcide, de eventuele getuigen opgevangen worden en dat zij weten waar ze terecht kunnen als ze er last van blijven houden. Ook in het geval er een suïcide van een student heeft plaatsgevonden moet er met de ouders contact opgenomen worden. Het is belangrijk om persoonlijk met ze af te spreken en hun wensen te bespreken. Het hangt af van de situatie en de wensen van de nabestaanden wat er qua communicatie naar de medestudenten gedaan zou moeten worden.

Samenvatting interview

De aanleidingen/risicofactoren voor een zelfdoding kunnen heel verschillend zijn, aangezien er veel factoren zijn die invloed hebben op de psyche van de mens. Voorbeelden zijn een vervelende jeugd of thuissituatie, studiedruk en het verbreken van een relatie. Met name gevallen met buitenlandse studenten zijn voorgekomen, waarbij het cultuurverschil een zekere rol speelde. De Orthodoxere religies en de Aziatische cultuur worden geassocieerd met een verhoogd suïciderisico.

Het zou voor studenten makkelijker en toegankelijker moeten zijn om informatie te kunnen vinden, hulp te zoeken en zijn/haar verhaal kwijt te kunnen, 24/7. Hiervoor zou bijvoorbeeld gebruik gemaakt kunnen worden van online tools en sociale media, waardoor ook de drempel verlaagd wordt. Ook voor de omgeving (medestudenten, huisgenoten, etc.) zou het makkelijker gemaakt moeten worden om een signaal af te geven wanneer ze merken dat iemand problemen heeft. Buitenlandse studenten zouden meer en beter geïnformeerd moeten worden over het studeren, hoe alles geregeld is en over het reilen en zeilen in Nederland. Deze taak is voor Bureau Studievoorzichting en degene die de intakes met deze studenten doet.

Onderwijsleutelfiguren die de student met enige regelmaat zien (docenten, studiebegeleiders, etc.) hebben een signalerende functie. Zij zouden hierin ook getraind moeten worden. Een student met een suïciderisico zou bijvoorbeeld herkend kunnen worden aan het vertonen van raar en afwijkend gedrag of aan het zich isoleren van de groep. Bij studenten met een ernstig risico zijn deze signalen hetzelfde, echter sterker aanwezig.

Wanneer een student gesignaleerd is, moet diegene een gesprek aangaan met deze student. Hij/zij kan vragen of het klopt dat de student inderdaad ergens mee zit en of hij/zij kan helpen. Ook voor dit aanspreken en aangaan van een gesprek, zijn trainingen belangrijk. Indien nodig kan diegene de student helpen om in contact te komen met de tweede lijn (huisarts/studentenpsycholoog). Mocht de student de hulp afwijzen, dan moet hij/zij in de gaten gehouden worden, bijvoorbeeld door op een herhalingsgesprek uitgenodigd te worden.

Ook zou degene die de student gesignaleerd heeft, advies in kunnen gaan winnen bij de tweede lijn.

Om risicostudenten nauwlettend in de gaten te kunnen houden, zou het ontwikkelen van een persoon-volgsysteem een uitkomst bieden. Hierin worden bijvoorbeeld signaleringen, studieresultaten en afspraken met de huisarts/decaan en dergelijke bijgehouden. De verantwoordelijkheid van de evaluaties van het uiteindelijke protocol ligt bij de studentenartsen en studentendecanen. Zij hebben de meeste feeling met wat er gebeurt en met wat werkt en niet. Het uiteindelijke protocol moet goed vindbaar zijn en voor iedereen beschikbaar, bijvoorbeeld via intranet/extranet en de UvA site.

Voor het geval dat een student een suïcide gepleegd heeft of poging hiertoe gedaan heeft, is een protocol beschikbaar in het crisishandboek. Er wordt in deze situatie onder andere een gesprek gearrangeerd voor de directe studiegenoten om erover te praten. Naar de ouders toe wordt onder andere sympathie geuit en een luisterend oor geboden.

Tot slot is het zo dat er momenteel een toename wordt gezien in drugs/psychose gerelateerde pogingen en suïcides. Hierbij is de doorloop veelal korter, waardoor sneller in actie komen gewenst is. De omgeving (huisgenoten, medestudenten, etc.) heeft hier een belangrijke rol.

Samenvatting interview

Zaken als psychische klachten en zelfmoordpreventie vallen in principe niet onder de verantwoordelijkheid van de universiteit of hogeschool. Echter kan een onderwijsleutelfiguur de student wel op weg helpen als er een vermoeden is dat een student ergens mee zit: aanspreken, vragen stellen, het probleem een beetje normaliseren en daarna eventueel doorverwijzen. Voor het stellen van de vragen, zou het handig zijn om een standaard lijstje te hebben wat afgegaan kan worden. Het is echter voor een docent niet gepast om deze vragen te stellen, als docent kan er beter niet teveel met het privéleven van een student bemoeid worden. Ook is het belangrijk ervan bewust te zijn dat niet elke persoon hier geschikt voor is.

Mocht er meer gedaan worden vanuit de universiteit, dan zou het een goed idee zijn om onderwijsleutelfiguren, en dan met name de docenten/werkgroep-begeleiders/mentoren, te onderwijzen in het herkennen van een student met psychische problemen en hoe vervolgens te handelen. Het hebben van een laag zelfbeeld, een heel zacht stemmetje hebben, heel stil zijn en teruggetrokken gedrag zouden mogelijk tekenen kunnen zijn.

Het zou beter zijn om globaal aandacht te besteden aan de ontwikkelingsfase waarin studenten zich bevinden. Idealiter zou er een cursus ontwikkeld worden voor de eerstejaarsstudenten waarin niet alleen studievaardigheden behandeld worden, maar wat ook een stukje cognitieve therapie bevat met zaken als wat je moet doen als iets een keer niet lukt, hoe om te gaan met jezelf. Veel studenten hebben dit niet van huis uit meegekregen, bijvoorbeeld doordat alles voorheen door de ouders geregeld werd en/of doordat ze überhaupt nooit eerder tegen problemen zijn aangelopen. Ook zouden studentenbegeleiders (adviseurs, decanen, etc.) de studenten hierin moeten helpen en oog moeten hebben voor het moeilijke proces waarin ze zitten. Ook de regels van het ministerie en de colleges hebben een negatieve uitwerking op die ontwikkeling van studenten.

(Mentale) problemen zouden bijvoorbeeld kunnen ontstaan bij studenten die: zichzelf een hele hoge druk opleggen; perfectionistisch zijn; eenzaam zijn en/of slechte sociale vaardigheden hebben. Hier zou de bovengenoemde cursus op in moeten spelen. Ook het in staan tussen twee culturen zou tot problemen kunnen leiden.

Wanneer een student een zelfmoordpoging ondernomen heeft, is het belangrijk dat dit zo veel mogelijk anoniem gehouden wordt. Mocht dit niet mogelijk zijn, dan is het wellicht een goede optie voor deze student om naar een andere universiteit te gaan, om op die manier een frisse start te kunnen maken. Indien een poging geslaagd is, kan het beste, waar mogelijk, zoveel mogelijk het protocol voor overlijdensgevallen gevolgd worden.

Samenvatting interview

Stress, en dan met name in combinatie met een verkeerde copingstyle, is in principe altijd de beweegreden voor suïcide onder studenten. Het heeft te maken met iemands karakter, hoe sterk is iemand en hoe gaat iemand om met tegenslagen. Er wordt vermoedt dat wellicht de opvoeding hier ook een rol in speelt: als ouders alle probleempjes weghalen, leert iemand nooit met bepaalde frustraties om te gaan. Ook is de levensfase waar studenten in verkeren erg moeilijk, ze zitten als het ware tussen het kind zijn en echt volwassen zijn in. Verder zijn de prestatiedruk vanuit de studie, de vele keuzemogelijkheden die studenten hebben en een hoge push vanuit huis factoren die mee kunnen spelen.

Bij allochtone mensen heerst er een groter taboe en is er meer schaamte, wat erg lastig is aangezien zij om die reden niet over problemen praten.

Over het algemeen gezien hebben mannen en vrouwen een andere copingstyle. Vrouwen zullen zich eerder hulpeloos voelen en zijn qua poging voorzichtiger, waar mannen zich eerder radeloos voelen en agressievere en stevigere pogingen doen.

Om de zelfmoordproblematiek aan te pakken zou het onderwerp plaats moeten krijgen in het curriculum van zowel docentenopleidingen als van de studenten. De docenten zullen immers de risicostudenten moeten kunnen herkennen. Ook is het belangrijk dat er duidelijk wordt gemaakt aan studenten wat er allemaal aan voorzieningen zijn en voor welke problemen en deze voorzieningen moeten laagdrempelig benaderbaar zijn. Verder zou het goed zijn als het onderwerp onder de aandacht komt bij het hogere personeel binnen de instelling.

Naar binnen gekeerd zijn en somberheid kunnen signalen zijn waar een student met een suïcide risico zou eventueel herkend zou kunnen worden. Als dit vermoeden er is, zou de student aangesproken moeten worden en moet de ernst van de situatie in kaart worden gebracht, 'de ui moet worden afgepeld'. Vervolgens is het ook goed als deze persoon met zijn/haar collega's zou praten en overleggen. Het is belangrijk dat iemand nagaat of hij/zij stevig genoeg is om een dergelijk gesprek met een student aan te gaan. Mocht dit niet het geval zijn dan zou het overgedragen kunnen worden aan iemand van het eventuele zorgteam/mental health team. Als het een docent was die veel lesgeeft aan deze student dan is het beter om het meteen aan het team over te dragen, de docent kan er dan beter verder buiten blijven.

Wat er vervolgens moet gebeuren is afhankelijk van het probleem. Is het bijvoorbeeld een studieprobleem dan zou het naar de studieadviseur verwezen moeten worden en betreft het persoonlijkheidsproblematiek dan moet de student naar de hulpverlening geholpen worden. Hierna zou de student nog af en toe gevraagd moeten worden hoe het nu gaat, dit kan bijvoorbeeld via een mailtje.

Wanneer er hele ernstige zorgen gemaakt worden moet meteen 112 gebeld worden. Ook de ouders moeten, mits goed beargumenteerd, benaderd worden. Zorg gaat boven privacy. Als een student een suïcide poging heeft gedaan zou ook hier die ui weer afgepeld moeten worden. Niet iedereen kan dit, maar daar zou dan ook in getraind moeten worden. Medestudenten die het gezien hebben kunnen individueel even benaderd worden om te bespreken hoe het met hen gaat. Met de betreffende student moet besproken worden of de ouders gebeld mogen worden.

Als er een suïcide heeft plaatsgevonden is het belangrijk dat er goede, korte en duidelijke berichtgeving naar de studenten is en er moet ook aangegeven worden dat het om een suïcide ging. Door deze duidelijkheid voorkom je ruis, vragen en gedoe. Medestudenten die dichtbij de student stonden, moeten worden uitgenodigd voor een gesprek. I.v.m. de mogelijke suïcidale besmetting moet er extra goed gelet worden op andere risico studenten. Ongeacht wat de leeftijd van de student was, zou iemand uit de directie de ouders moeten bezoeken. Hier moet besproken worden wat de ouders van de universiteit verwachten.

Samenvatting interview

Een mogelijke aanleiding voor studenten om suïcidale gedachten te ontwikkelen betreft het ervaren van prestatiedruk: er moeten hoge cijfers gehaald worden en de collectieve norm wordt steeds verder opgeschroefd. Deze druk wordt voornamelijk door de universiteit geïnduceerd, echter zou deze druk ook vanuit de ouders kunnen komen. Verder speelt het mee dat studenten weinig op elkaar letten. Er wordt dan ook verwacht dat er een lager risico is binnen culturen waar een de sociale cohesie sterker aanwezig is.

Als er zorgen worden gemaakt over een student, bijvoorbeeld omdat hij/zij er somber uitziet en een laag optimisme heeft, zou deze student aangesproken moeten worden. Er zou gevraagd moeten of de zorgen terecht waren en vervolgens kan er verder gevraagd worden. Met name voor docent-coaches behoort dit tot het takenpakket. Het zou dan ook goed zijn deze groep te leren over het herkennen van risico studenten, wat je als docent kunt doen en hoe je kunt verwijzen.

Aangezien er is gebleken dat studenten met mentale klachten vooral naar medestudenten gaan, zou het goed zijn om interventies hierop te richten. Dit zou kunnen door aan het begin van de studie een college te geven waar onder andere gesproken wordt over mentale klachten en over de taak om op elkaar letten. Ook de mentorgroepen met de docent-coach zou een goede gelegenheid zijn om het hier, op een speelse manier, over te hebben. Door deze interventies zullen de studenten er meer over praten, zal de bewustwording verhoogd worden en het taboe verlagen. Deze gelegenheden zouden ook een goede plaats zijn voor het inlichten van de studenten over de sociale kaart van de instelling. Hierbij zou onder andere de reikwijdte van de taken van de studieadviseur uitgelegd moeten worden.

Momenteel wordt de nadruk gelegd op de studie en op het goed presteren hierin. Idealiter zou er een leerlijn geïmplementeerd worden, waarin op een meer spiritueel niveau, onderwerpen bestreken worden zoals je doelen in het leven, je roeping en je persoonlijke ontwikkeling.

Een andere idee is het informeren van ouders over mentale klachten en hun kenmerken. Verder zou het krachtig kunnen zijn wanneer docenten als rolmodel optreden, waarbij ze over hun mentale problemen hebben en vertellen wat zij hieraan hebben gedaan.

Wanneer een student suïcide heeft gepleegd, is het belangrijk dat hier anders mee omgegaan wordt dan wanneer het een andere doodoorzaak betreft. Er moet ruimte gegeven worden aan de studenten om er met elkaar over te praten.

Samenvatting interview

Aanleidingen voor studenten om zich te melden bij een studentenpsycholoog verschillen over het algemeen niet van de aanleidingen voor de algemene Nederlandse bevolking om zich bij de GGZ te melden. De belangrijkste zijn depressieve klachten en angstklachten. Depressieve klachten kunnen door tal van factoren ontstaan, dit is heel divers. Verder wordt studieproblematiek zoals faalangst, studiestress en uitstelgedrag veel gezien.

Het hebben van suïcidale gedachten komt voor onder studenten en wordt over het algemeen niet als heel zorgwekkend ervaren. Het is ook de leeftijd waarop mensen met existentiële vragen kunnen komen, welke raakvlakken zouden kunnen hebben met deze gedachtes. Echt acuut suïcidale studenten worden weinig tegengekomen, maar dat wil niet zeggen dat ze er niet zijn.

Er zou veel voorkomen kunnen worden als er meer over gepraat durft te worden en als er bekend is wat er gedaan moet worden als iemand te maken krijgt met een student met suïcidale gedachten. Hiervoor is het belangrijk dat er heel breed gatekeepertrainingen worden aangeboden. De studieadviseurs zijn de belangrijkste groep. Voor de studenten is het belangrijk dat er ruime bekendheid komt aan waar ze terecht kunnen als ze problemen hebben. De introductieweek zou een goed moment kunnen zijn voor deze voorlichting. Om meer zichtbaarheid aan studentenpsychologen te geven en om studenten te ondersteunen, zou het een idee kunnen zijn voor hen om op locatie te gaan werken. Hier kunnen bijvoorbeeld faalangsttrainingen of voorlichtingen over depressieve klachten gegeven worden.

Over het algemeen is het helaas heel onvoorspelbaar, maar in de voorspelbare gevallen zouden bleek, onverzorgd, stil, vlak, somber, terugtrekken en langzaam niet meer komen/deadlines niet halen tekenen kunnen zijn waar je iemand aan kan herkennen aan wie geadviseerd zou moeten worden om hulp te gaan zoeken. Een dergelijke student zou na de les even gevraagd kunnen worden hoe het gaat. De student zou vervolgens geïnformeerd moeten worden over de opties (studieadviseur, studentenpsycholoog, studentarts, etc.) waarna de student zelf kan bepalen of en wat hij of zij wil.

Wanneer echter een student zich serieus en acuut suïcidaal uitlaat, zou er direct met de huisarts of crisisdienst gebeld moeten worden en zou de student niet alleen gelaten mogen worden. Zodra de student binnen is bij de GGZ is het verder hun verantwoordelijkheid. Het zou echter

wel vriendelijk zijn als er vanuit de universiteit nog eens gevraagd werd hoe het met de student gaat. Dit zou een taak voor de studieadviseur kunnen zijn.

Als een student een suïcidepoging heeft gedaan, is het belangrijk zoveel mogelijk de privacy te waarborgen. De studieadviseur zou de student naar zijn/haar wensen en behoeftes kunnen vragen. Een dergelijke gebeurtenis kan medestudenten een aantal weken flink bezig houden en dit is normaal. Mochten ze er langer last van houden dan zouden ze uit eigen initiatief hulp kunnen zoeken. Als de student het wil zouden de ouders gebeld kunnen worden, echter is dit de verantwoordelijkheid van de GGZ wanneer de student daar onder behandeling is.

Ook wanneer het een geslaagde suïcide betreft, zou er niet te snel professionele hulp bij moeten worden gehaald. De studieadviseur zou een samenkomst kunnen organiseren voor de medestudenten, zodat er een gelegenheid is om er met elkaar over te praten. Verder zou er wegens privacy redenen en voor zover mogelijk, gedaan moeten worden zoals ook bij een ander overlijden gedaan zou worden. Er valt te overwegen om de ouders uit te nodigen voor een gesprek.

Verder zijn internationale studenten nog een bijzondere groep. Zij zouden extra kwetsbaar kunnen zijn, doordat zij hier alleen zijn en sneller eenzaam kunnen worden. Als zij hier geen contacten vinden, missen zij een steunsysteem en is er niemand tot wie hij/zij zich verhoudt of wie hem/haar in de gaten houdt. Ook zouden de studenten uit met name Aziatische culturen last kunnen hebben van het feit dat het hier anders is wat betreft het onderwijs zoals de cijfergeving (soms lager) en tentameneisen (soms hoger). Ook is er in deze culturen meer schaamte over psychische problematiek, waardoor ze minder snel om hulp zouden roepen. De universiteit zou wel wat meer kunnen zorgen voor meer begeleiding voor deze studenten.

Annex 3: Quote translations

“Ja, dat is gewoon heel belangrijk dat studenten dat weten dat als er dingen zijn, of persoonlijke omstandigheden dat ze altijd bij ons terecht kunnen.”

“Yeah it’s just very important that students know that when there are things, or personal circumstances, that they are always welcome to visit us.”

“Ik denk dat dat misschien wel één van de belangrijkste is van suïcidepreventie, dat je er gewoon een soort van gewoon over durft te praten met elkaar, dat er een soort openheid over is, en ja misschien zit het nu toch nog wel heel erg in een soort taboesfeer, dat mensen het toch wel eng vinden of ráár vinden.”

“I think that that’s maybe one of the most important in suicide prevention, that you just dare to talk about it with each other, that there’s a sort of openness about it, and yeah maybe it is still a huge taboo, that people think it’s scary, or think it’s weird.”

“Misschien ook colleges over veel algemenere thema’s, maar waarom leer je niet met jezelf omgaan? (...) [Study] daar moet je álles van weten, op de middelbare school ook, je leert níets over jezelf. Wat zijn emoties, hoe ga je daarmee om, hoe kan je dr naar kijken, echt bizar!”

“Maybe also lectures about much more general themes. Why don’t you learn to deal with yourself? (...) [Study] There you have to know everything about, in high school too, you learn nothing about yourself, what are emotions, how to deal with it, how can you look to it, it’s really bizarre!”

“Nou ik geloof niet in commissies, ik geloof in een coördinator.”

“Well, I don’t believe in committees. I believe in one coordinator.”

“Dat je denkt van nou hier klopt iets niet, en daar gewoon héél erg goed naar je eigen onderbuik gevoel luisteren, maar daarvoor moet je wel kíjken. Als je alleen maar je riedeltje afdraait van je les, en je kijkt niet echt naar wie je in de klas hebt zitten, dan mis je het denk ik.”

“That you think, well something isn’t right here. And then you just have to listen to your own gut feeling very well. But for this, you do have to look. When you’re just following your teaching routines, and you don’t look to who are really sitting in your class, then you will miss it I think.”

“Je ziet ook vaak dat iemand dan heeel rustig is hè, omdat het besluit echt genomen is, komt er een enorme rust, want dan is het zeg maar de drempel genomen van de angst ervoor. Dus dan lijkt er niks aan de hand.”

“You often see that someone becomes very calm, right. Because the decision is made, a huge calmness appears. Because then, the threshold of the anxiety for it, is crossed. So everything will look fine then.”

Ik weet niet of de student met een heel ernstig risico of die nog bijvoorbeeld onderwijs volgt of misschien zich al teruggetrokken heeft, dan ben je hem natuurlijk al kwijt.”

“I don’t know whether the student with a very high risk is, for instance, still attending education, or that he may have withdrawn by then. Then you have already lost him of course.”

“En ik denk dat als een mentor zich ook bewust is van de belangrijke rol die je in iemands leven kan spelen, dan , dan ga je er denk ik anders mee om. Ja. Dan wordt het ook echt een taak zeg maar ja”

“And I think that, when a mentor is aware of the important role that you can play in someone’s life, then you will deal with it differently, I think. Yeah, then it becomes really your task, you know.”

“Nee ik zou niks verplicht stellen. Je moet mensen hebben die betrokken zijn en begaan zijn en als het ware enthousiast en die moeten het verder weer verspreiden.”
“No, I wouldn’t make anything mandatory. You need to have people who are concerned and who care about it, and you know, enthusiastic, and those have to spread it further.”

“Dan kun je dat daar in die opleiding eh al meegeven, dus alle nieuwe docenten weet je dat die het gehad hebben en dan hoef je alleen maar de oude te trainen.”
“Then you can provide it already in their education, so all new teachers, you know that those have already had it, and then you just only need to train the old ones.”

“ja eigenlijk zou je kunnen zeggen iedereen op de universiteit heeft daar een verantwoordelijkheid in hè, dus je zou bijna ook de portiers kunnen zeggen”.
“Yeah, actually you could say that everybody at the university has a responsibility in this, right, so you could almost say the doormans too”

“Ik denk dat het op zich dat team, dat heel goed zou kunnen doen, maar ik denk dat ik dan iemand erbij zou willen hebben die weet hoe je dat soort dingen goed kan evalueren. Want goed evalueren is ook nog een kunst op zich”.
“I think that this team, that team could do this very well. But I think that I would have someone there who knows how to evaluate this kind of things properly. Because good evaluating is an art in itself”

“Vragen om even te blijven en vragen van nou hoe gaat het eigenlijk met je? En als ze dan ‘nah eh gaat wel’ van nou ik maak me wél zorgen.”.
“Asking to stay for a moment and asking, well how are you doing actually? And when she ‘nah I’m ok’ then ‘well, I do worry about you”

“Je moet ook een vertrouwensrelatie met zo iemand hebben, hè dus primair is een docent het eerste kanaal, als ie daar een goede relatie mee heeft om daar het gesprek mee aan te gaan.”
“You need to have a confidential relationship with such a person, right, so primary, a teacher is the first channel, if he has a good relationship with this teacher, to go in conversation.”

“Ik denk als ie daar zit, dat het jou verantwoordelijkheid is als docent, dat je daar iets mee doet, vragen van ik weet niet of ik me ermee mag bemoeien maar zoals jij er bij zit.”
“I think when he sits there, that it’s your responsibility as a teacher, that you do something with it, asking like ‘I don’t know if I may meddle with it, but the way you look..’”

“Een docent heeft natuurlijk wel een eh ja, die heeft een verhouding met een student waarvan ik niet vind dat je, dat die teveel moet gaan poeren in zijn privéleven.”
“A teacher does of course have a relation with a student out of which I think that you must not stir in his private live that much.”

“Het gevaar is als lesgevende docenten allemaal gaan uitvragen, dan begeef je je op een vlak waar je eigenlijk niet moet zitten, daar moet je gewoon docent blijven. Maar je moet het wel kunnen zien.”

“The danger is, if all close teachers go interrogating, then you enter an area where you shouldn’t actually be, there you should just stay a teacher. But you do have to see it though”.

“Ik zou dat ook af laten hangen van de student, want als die zoiets heeft van die studentpsycholoog daar heb ik helemaal geen zin in, ik ga wel naar mijn eigen huisarts daar heb ik veel meer aan.”

“I should let it depend on the student, because if he has something like that student psychologist, I really don’t feel anything for that, I will go to my own GP, that will be more beneficial.”

“Als je je ernstige zorgen maakt, altijd naar de huisarts. Omdat je daar gewoon binnen 2, 3 dagen een afspraak hebt. Als je nog ernstigere zorgen maakt naar de crisisdienst. Als je acute zorgen maakt, als iemand zegt ik wil niet meer ik spring van het dak af, níét laten gaan. Dan hou je contact, hou je iemand bij je.”

“If you are seriously worried, always to the GP. Because there, you have an appointment within two or three days. If you are even more seriously worried: the crisis center. If you are acutely concerned, if someone says “I don’t want to live anymore, I jump off the roof” don’t let go! Then you stay in contact, you keep someone with you.”

“Ja ik denk dat het wel goed is als er aangeboden wordt om eh bijvoorbeeld door de decaan een HvA of de studieadviseur of weet je wel van vind je het prettig om komende tijd even een paar afspraken te hebben. Zullen we even kijken hoe het allemaal gaat. Is toch niet niks wat er is gebeurd en nou, bied je dat aan.”

“Yeah, I think it will be good to offer, for example by the dean at HvA or the study counselor, you know, like ‘Would you like it to have some appointments the coming period? Shall we just check how everything is going, it’s quite something what ‘s happened.’ And well, you offer that.”

“ ‘heb jij behoefte aan iets?’, ja is een ja en dan kan je verder praten ‘waar heb je behoefte aan?’ en een nee is gewoon simpelweg een nee en dan moet je je er verder ook niet mee bemoeien vind ik.”

“ ‘Are you in need for anything?’ Yes is a yes and then you can discuss further ‘what do you need for?’ And no is just a no and then you shouldn’t further meddle with it, I think.”

“Geef een weg waar ze heen kunnen met hun verhaal en gedachten. Want het doet iets met ze.”

“Make sure that they have somewhere they can go with their story and thoughts. Because it does something with them.”

“Nee, nee. Dat maakt het meteen al van oh dit wordt nu traumatisch jongens, hier is de psycholoog”.

“No, No, then it’s immediately like ‘oh, this will be traumatic, guys, here’s the psychologist!’”

“Nou ja ten eerste moet je daar ook weer niet al te snel zijn met professionele hulp daarop gooien (...) mensen hebben niet echt helemaal meteen professionele hulp nodig.”

“Well, first of all, you must not be too fast in throwing professional aid on it (...) people don’t really need all those professional aid immediately.”

“Wat ik belangrijk vind vooral bij een suïcide is dat het besproken wordt. Ook om eventuele eh mensen kunnen ook aangezet worden hè.”

“What I find important, especially in case of suicide, that it's being discussed. Also because people may get stimulated, you know.”

“Ja, maar dan moet je de privacy ook wel heel erg goed weer in de gaten houden. Dus alleen als de student dat wil. Daar begint het al mee.”

“Yes but you have to mind the privacy very well. So only when the student wants it. There it starts.”

“Ja ik denk wel dat je een verantwoordelijkheid hebt als onderwijsinstelling om ouders in te lichten, ja, als er zoiets gebeurt. Als diegene zegt van ik wil p er se niet dat mijn ouders erbij zijn, ja dan moet je dat respecteren denk ik.”

“Yes I think you have a responsibility as educational institution to inform the parents, when such a thing happens. If that student says like, ‘I absolutely don’t want that my parents will be there’, yeah then you have to respect that I think.”

“Nou ik denk dat als je het op een goede manier met een student bespreekt, van goh ik denk dat het heel verstandig is dat je ouders het weten, dus dat je het niet vraagt maar meer zegt, van h  het is belangrijk dat. En als die dus gewoon toestemming geeft dat je het moet doen. maar je kan het natuurlijk nooit zonder toestemming doen”.

“Well I think, if you discuss it rightly with the student, like ‘well I think that it’s very .. that your parents know about this’, so you don’t ask it but you say more like ‘it’s important that’. And when he just consents, you can do it. But you can never do it without permission of course.”

“Kijk als het minderjarige jongeren betreft dan zal dat meer voor de hand liggen dan als een oudere jongere betreft, maar ik vind gewoon dat als er een poging is geweest dat je contact moet opnemen met familie, omdat het om een levensbedreigende situatie gaat.”

“Look, it will be more obvious when it concerns minors, than when it concerns an older student, but I just think, that when an attempt occurred, that you have to contact the family, because it concerns a life-threatening situation.”

Het zijn slechtnieuws gesprekken, maar het is ook betrokkenheid, en ik wil die ouders ook hebben.

“These are bad news conversations, but it’s commitment too, and I want to have those parents too.”

Heb het er ook met die ouders over. Die zijn zich er niet altijd bewust van

“Talk about it with the parents, they aren’t always aware of it.”

“Decaan of studieadviseur denk ik. Want die kan ook iets vertellen over of die persoon er nog was, d e kan zich inmiddels informeren bij de docenten. En die heeft dan informatie en die kan dat weer doorgeven aan de ouders.”

“Dean or study counselor I think. Because he can tell something about whether that person still was there, he can ask for information from the teachers, and then he has the information and he can again pass this on to the parents.”

“Wij zijn natuurlijk ook gewoon mensen, dus in die zin zou dat team ook een soort nazorg weer voor ons, ja dat denk ik wel dat dat in het pakket hoort. Ja dat je ook even checkt van ok we hebben het allemaal overleefd, de student heeft het overleefd, de ouders hebben het overleefd, vrienden en familie hebben het overleefd, hebben jullie het ook overleefd!?”

“We are also just people of course, so in that sense, that team should provide a sort of aftercare again to us. Yes I think that that’s part of their package. Yeah that you also check, well ok we all survived, the student survived, the parents survived, friends and family survived, did you also survived!?”

“Ik weet wel dat we toen ook heel erg zoiets hadden van O help wat moeten we nou eigenlijk gewoon doen!? en toen zijn we allemaal ontzettend op zoek gegaan naar een soort protocol, van wat te doen als er een student! (...) ja dus dat zijn dan een soort van die dingen! Ja, dat is er trouwens er is wel een soort protocol voor overlijden zeg maar, kwamen we toen achter, na veel zoek en gedoe, haha!”

“I know that we really had something like ‘O help, what do we actually need to do now!?’ And then we all went looking very hard for a sort of protocol or something, on what to do when a student! (...) So that are then that kind of things! There does exist a sort of protocol on deaths by the way, we found out back then, after a lot of searching and struggling, haha!”

“En de druk wordt natuurlijk steeds hoger door de prestatie regels en zo snel mogelijk afstuderen”

“And that pressure is becoming ever higher of course, due to the performance rules and graduating as soon as possible.”

“De ernstige gevallen zijn de mensen die geen sociale contacten hebben (...) En dan is de vraag wie geven er om je of wie zorgen er om je”

“The most severe cases are those people who don’t have social contacts (...) And then the question is, who care about you, who worry about you.”

“Nou ja die zitten natuurlijk in de levensfase waarin ze toch veel gaan ontdekken, eh met allerlei verschillende dingen rekening moeten gaan houden, hun studie maar ook hun eigen leven (...) je moet ook opeens wel heel veel kunnen (...) er gebeurt zó veel in die periode, dat dat toch best heftig is.”

“Well yeah those are of course in the phase of life in which they will discover a lot, have to take account of several things, their study, but also their own life (...) you suddenly have to be able to a lot too (...) so much is happening in that period, that’s quite heavy.”

“Het kan soms heel acuut zijn, naar aanleiding dat een dierbaar iemand overleden is in de omgeving van een student.”

“It can sometimes be very acute, as a result of the death of beloved one, in the environment of a student.”

“Dus negatief zelfbeeld is eigenlijk de hoofd reden. Maar goed als je daar nog maar over kunt praten...”

“So negative self-image is actually the main reason. But ok, if you then could yet talk about it...”

“Traumatische momenten vaak uit vroege jeugd”

“Traumatic moments, often from the early childhood”

“Gepest zijn vroeger, (...)”

“Being bullied in the past, (...)”

“Ja ik denk als je nooit tegenslagen en als een prinsesje of als een prinsje bent opgevoed en je komt dat met tegenslagen, dat het dan moeilijk is (...) Dus ik denk dat het ook een beetje met de opvoeding te maken heeft.”

“Well I think that, if you never had difficulties and was raised as a little princess or little prince, and then you face difficulties, then it will be hard (...) So I think that it has to do a little with parenting too.”

“We wel een toename zien in druggerelateerde psychoses die leiden tot zelfdoding, of pogingen (...) Dat is toch andere type of andere oorzaak, en wat je wel ziet is dat de reactiesnelheid veel groter wordt, de doorloop korter.”

“We see an increase in substance use related psychoses which lead to suicide or attempts (...) that’s another type, another cause, and what you see is that the reaction time is much faster, the pathway is shorter.”

“Die worstelen erg met de vrije cultuur hier in Nederland, worstelen met de keuze van goh hou ik me aan de regels van thuis of ga ik genieten van de vrijheden die hier zijn? Je ziet in enkele situaties dat dat dus zo confronteert met elkaar dat dat fout gaat.”

“They are struggling a lot with the free culture here in the Netherlands, struggle with the choice well, do I comply with the rules of home or am I going to enjoy the freedom here? You see in some situations, that this confronts with each other in such a way, that it goes wrong.”

“Het taboe is daar groter en moeilijker dan bij de wat meer autochtone bevolking, want ehm als je daar dus over gaat praten dan heb je ook nog met een hele familie eer te maken, en dat is gewoon veel heftiger en daar moet je dus ook bewust van zijn.”

“The taboo is greater there, and more difficult than in the more autochthonous population, because when you talk about it there, then you have also to deal with a whole family honor, and that’s just much heavier, and thus, there you have to be aware of.”

“Het grootste verschil met de Nederlandse studenten is dat ze geen steunsysteem hebben (...) in het ergste geval kan het zijn dat die zich eh met niemand verhoudt (...) en dat is redelijk riskant denk ik, niemand die ze in de gaten houdt of die ze regelmatig ziet.”

“The main difference with the Dutch students, is that they don’t have a support system (...) in the worst case, it can be that those don’t relate to anybody (...) and that’s quite risky I think, nobody who keeps an eye on them or who sees them regularly.”