# Editorial

## Suicide-Safer Universities in Pakistan: A Shared Responsibility

**Nazish Imran,[1] Sania Mumtaz Tahir[2]**

*[1]Chief Editor, Annals of KEMU / Professor, Child & Family Psychiatry Department, KEMU/Mayo Hospital, Lahore, Pakistan;*
*[2]Consultant Psychiatrist, Fellow, Child & Family Psychiatry Department, KEMU/Mayo Hospital, Lahore, Pakistan*

**Correspondence:** nazishimrandr@gmail.com
**How to cite:** Imran N, Tahir SM. Suicide-Safer Universities in Pakistan: A shared Responsibility. Ann King Edw Med Univ.2025;31(04):

### Introduction

Students' death by suicide is a global challenge with reported increasing rates among medical students but university students outside medical training are also vulnerable.[1] Recent events at a private university in Pakistan, where one student died by suicide and another attempted suicide within a span of less than two weeks, have sent shockwaves across academic and public circles. Such temporal clustering of suicide attempts within a single institution is a cause of concern and should not be dismissed as coincidental or purely individual acts. Instead, these incidents highlight all stakeholders to urgently reflect on systemic vulnerabilities within academic environments in the country and take preventive actions. Beyond getting the facts correct and institutional accountability, media coverage of student suicides also deserves close examination. The distribution of CCTV footage showing the student's death and attempt in the most recent instances is a grave ethical transgression and contravenes international guidelines on suicide reporting. Sensationalized or graphic reporting has well-established negative effects on public health and breaches the dignity of the deceased and their family but also risks triggering suicide contagion within the same institutional setting. Numerous studies support the Werther effect, which holds that dramatic and in-depth depictions of suicide encourage imitation, especially in young and vulnerable people. This editorial aim is to promote learning from these tragic incidents and identify broader lessons and strategies around mental ill-health and suicide in higher education institutions to help prevent future deaths.

Limited data is available from Pakistan regarding students' suicides.[2,3] Official statistics from West suggest that the suicide rate for higher education students is lower compared with the general population of the same age.[4] From August 2016 to July 2023,1108 suicides among higher education students (with male preponderance) in England and Wales were identified; calculated rate of 6.9 deaths per 100,000 students. In a study of Eleven hundred medical students in Pakistan, to assess the impact of COVID-19 on medical student's psychological well-being, One in five medical students thought that it would be better if they were dead, and 8% admitted to often think of committing suicide during the past 2 weeks.[5]

Young adulthood represents a critical developmental period and heightened vulnerability to psychiatric disorders: 50% of mental health problems are established by age 14, and 75% by age 24. There is likelihood that University students experience similar prevalence of mental health disorders. However, suicide is complex, multifactorial phenomena. Multiple factors may increase risk of mental distress and suicide (Figure 1).[6,7] Universities, while intended to foster intellectual growth, often function as high-pressure ecosystems where performance, competition, limited tolerance for deviation from rigid academic pathways, and skepticism for psychological difficulties can significantly exacerbate psychological distress and discourage help seeking. While Institutions and faculty members frequently

**Production and Hosting by KEMU**

https://doi.org/10.21649/akemu.v31i4.6319
2079-7192/

face criticism for upholding minimum requirements for attendance and examinations, at the same time, there have been instances where students exploit procedural loopholes to obtain unwarranted relaxations. Additional contributors in universities include pre-existing or undiagnosed mental health conditions, substance misuse, inadequate social support, harassment, and an institutional culture that may prioritize academic output over student wellbeing (Figure 1) Equally important are missed opportunities for early identification—students often exhibit warning signs long before a suicide attempt, yet these remain undetected in the absence of structured screening and trained gatekeepers. However, it is also important to note that some students die by suicide without any persistent distress or not belonging to recognized high-risk categories.[7,8] Two out of every three suicides occur without prior contact with mental health services.

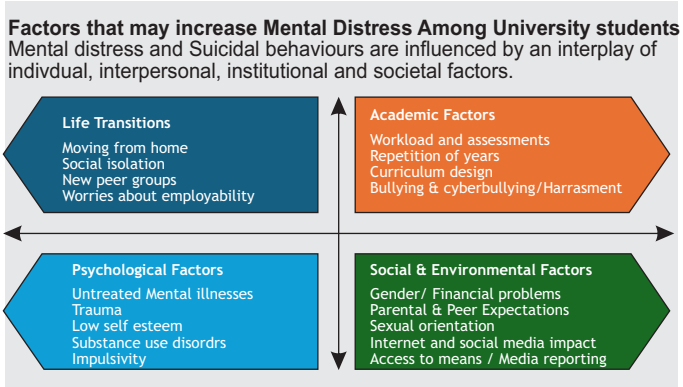


**Figure 1:** *Factors that may increase Mental Distress Among University Students*

## Collective responsibility, collective action to prevent students' suicide

Understanding and addressing death by suicide in student population and to build compassionate academic communities, Universities need to make mental health and well-being a strategic priority and adopt a whole university approach. Suicide prevention, intervention and postvention (aftercare following a suicide death to support the bereaved and reduce the risk of other deaths) must be integrated as part of overarching institutional mental health strategy.[7] There needs to be wider action to tackle the situational causes of mental anguish, as well as an individual's capacity to stay well, and have confidence to seek help when needed. Some important strategies for safer universities include:

### Awareness campaigns & addressing stigma:

Promoting awareness of mental health, encouraging individuals to talk about their struggles & challenges they may be facing in safe, confidential settings helping students develop emotional resilience and life skills , and signposting of support available (ranging from self-help, peer support, more specialized help and referral pathways including crisis intervention)are important aspects of addressing stigma related to mental health and promote help seeking behaviors in universities.

### Education & Training:

All students and staff of institutions including academic department team and support staff (security, catering, domestic staff who often are likely to have regular daily contact with students) should be appropriately trained in mental health and suicide literacy, including recognizing signs of distress, responding empathically and actions that need to be taken. Confidential mental health screening and it being promoted as supportive rather than punitive can help with referrals. Mechanism for sharing information between services and departments regarding individuals needing support should be developed.

### Reducing access to means of suicide:

Restricting access to means of suicide is an effective suicide prevention strategy. Modifications in environment like securing rooftops, barriers installation at high-risk locations, limiting access to tall buildings can all significantly reduce impulsive suicide attempts. If suicide happens on campus, universities should discourage placing tributes drawing attention to sites as suicide location.

### Humanistic Academic Approach:

Rigid academic policies with "one size fits all" often fail to account for grief, trauma, and neurodiversity. Compassionate approach balanced with accountability, temporary flexibility and reasonable academic adjustments should be considered as key pillars for addressing psychological distress in institutional and accrediting bodies level.

The safety of university managed hostels should also be regularly reviewed including physical safety and encouraging social connectedness and signposting for support, especially out of hours.

### Post-vention Plans & Support:

Suicide prevention activities should be enhanced following a single death and one need to be alert for possibility of cluster. It is important to consider in advance what support is needed. Postvention support for friends, peers, staff affected by death is essential alongside communication by family. All communication related to student death need to be dealt with extreme sensitivity.

Following an initial suicide, subsequent risk of contagion needs careful consideration.

Also, policies and procedures need to be regularly reviewed and following any critical incident it is important to reflect and do a thorough "lessons learnt exercise" for any changes needed at any level.

**Handling the media:**

News about suicide spreads very quickly. Institutions communication and media teams should communicate early to reduce misinformation and advise against potentially harmful posts. Existing literature on suicide reporting in Pakistan has highlighted significant gaps in media adherence to international guidelines, including the World Health Organization's recommendations on responsible reporting.[9,10]

**Follow evidence-based approach:**

There is much that we do not know about suicide in student population. The need to collect and analyse appropriate systematic and accurate data and evaluate different suicide prevention strategies to understand what works best and identify areas for improvement, cannot be emphasized enough.

**Work in partnership with the wider community:**

Suicide prevention efforts should also include developing links with other educational Institutions, local services and support organizations, engaging them for a more holistic approach with students and staff as centers of all policies and procedures.

To conclude, every student death by suicide is a reminder that silence, delay, and inaction are choices, we can no longer afford. Suicide is a preventable cause of death - but prevention is not an act of crisis response alone, rather requires sustained commitment to care, compassion, and accountability, evidence based, proactive reforms in our educational system, policies and institutional culture.

## References:


1. Frajerman A, Chaumette B, Krebs MO, Morvan Y. Mental health in medical, dental and pharmacy students: a cross-sectional study.J Affect Disord Rep. 2022; 10: 100404. https://doi.org/10.1016/j.jadr.2022.100404,
2. Shakil M. A qualitative analysis of suicides committed by the students in Pakistan. Pakistan J med res. 2019; 58(1):35-40. https://doi.org/10.1177/002076402211 06683
3. Tahir SM, Omer M, Nawaz A, Imran N. Medical students' deaths by suicide in Pakistan: An alarming trend and a Call for Action; JCPSP .2026 (epub ahead of print)
4. Office for National Statistics (ONS) (2025). Estimating suicide among higher education students, England and Wales: August 2016 to July 2023. Available from https://www.ons.gov.uk/releases/estimatingsuicideamonghighereducationstudentsenglandandwales2017to2023 (Accessed on 7th January 2026)
5. Imran N, Haider II, Mustafa AB, Aamer I, Kamal Z, Rasool G, et al. The hidden crisis: COVID-19 and impact on mental health of medical students in Pakistan. Middle East Curr Psychiatry. 2021;28(1):45. doi: 10.1186/s43045-021-00123-7.
6. Luceño-Moreno L, Vázquez-Estévez D, Martín-García J, Talavera-Velasco B. Factors Associated With Suicidal Ideation in College Students of Health Sciences. Depression and Anxiety. 2025;2025(1):4397417. https://doi.org/10.1155/da/4397417
7. Universities UK (UUK)/PAPYRUS (2018). Suicide-Safer Universities.
8. Rodway C, Tham SG, Turnbull P, Kapur N, Appleby L. National review of higher education student suicide deaths. National Confidential Inquiry into Suicide and Safety in Mental Health. Department for Education/ University of Manchester. 2025 . Available from https://assets.publishing.service.gov.uk/media/68304edcbaff3dab9977529f/National_review_of_HE_student_suicide_deaths.pdf
9. Imran N, Ayub M. Mental Health and Suicide Decriminalization: Connecting the Dots. Ann. King Edw Med. Univ. 2024 ;30(1):1-3. https://doi.org/ 10.21649/akemu.v30i1.5691
10. Ayub M, Rafiq B, Tahir SM, Imran N, Naveed S, Haider II. Assessing the quality of media reporting of suicide deaths in Pakistan against international guidelines. Int J Soc Psychiatry. 2023 ;69(2):406-11. https://doi.org/10.1177/00207640221106683