Promoting Behavioral Health and Reducing Risk Among College Students

A Comprehensive Approach

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A Comprehensive Model to Promote Mental Health and Address Risk for Suicide

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After they lost their son Jed to suicide in 1998 while he was a student, Phil and Donna Satow set out to learn what colleges could do to prevent suicide. Intuitively, they understood that simply providing treatment through student counseling services would be insufficient to address the needs of many troubled or at-risk students like Jed who were not receiving services at the campus clinic. They learned in conversations with university leaders and clinicians that there was no consistent standard or approach to engaging students who might need care or for preventing suicide on campus. Through their ongoing research and conversations they learned of a model program for suicide prevention being implemented by the U.S. Air Force.

In the years preceding 1996, the Air Force experienced a significant increase in suicide by service members, and less than one-third of those who had died had accessed mental health services (United States Air Force, 2001). Many of those who had died had several and significant psychosocial stressors including relationship, legal, and financial problems. Over several months, Air Force leadership worked with experts from the CDC, the Armed Forces Institute of Pathology, and the Walter Reed Army Institute of Research to develop a suicide prevention plan. The plan was a multi-faceted community health model that looked to enhance protective factors, increase access and range of services, educate service members about mental health, and improve screening, follow-up, and crisis services. The program was evaluated by Knox, Pflanz, and their colleagues, who found that the rates of suicide, homicide, domestic violence, and accidental death decreased after the implementation of the program and went up during a single year in which the program had been less rigorously implemented (Knox et al., 2010; Knox, Litts, Talcott, Feig, & Caine, 2003).

The Jed Foundation (JED) was established in 2000, and among its first priorities was an attempt to establish a comprehensive plan, model, or strategy for campus suicide prevention. The model developed by the Air Force appeared to be effective and, while service members and Air Force bases were certainly different in some ways, there also appeared to be significant parallels between service members living on bases and students living and learning on college campuses. The two groups were also of similar age and were likely to share at least some overlapping life concerns and challenges. JED established a panel of advisors including several experts who had taken part in the development and assessment of the Air Force model, suicide prevention researchers from the Suicide Prevention Resource Center and higher education-based mental
health clinicians and student service professionals to consider how the Air Force model might be adjusted to the needs and contours of college life.

**The JED Comprehensive Model**

The Comprehensive Model (also known as the JED Model) includes seven strategic areas that should be addressed in any community-wide effort to support mental health and to limit substance misuse and suicide. Within each strategic area, there are multiple tactical activities and efforts that colleges can implement to support student mental health. It is also central to this model that the engagement process should be approached through the lens of strategic planning. The particular structures, problems, needs, and resources of each campus need to be examined, and thoughtful decisions should be made around prioritizing and choosing specific tactics (The Jed Foundation, 2016).

It is helpful to consider this model as broadly addressing four major thematic areas:

- Enhancing protective/preventive factors and resilience (life skills and connectedness)
- Early intervention (identifying those at risk and increasing help-seeking)
Availability and access to clinical services
Environmental safety and means restriction

These four domains provide an organizing heuristic for understanding the logical underpinnings of this model. These elements demonstrate how the model addresses everything from prevention to aftercare and can serve as a basis for planning a mental health promotion and suicide prevention system for any boundaryed community (Schwartz, 2013).

The balance of this chapter will focus on describing the research background and programming activities for each of the model’s elements.

Enhancing Protective/Preventive Factors and Resilience

Developing Life Skills—Theoretical and Research Considerations

Numerous studies show that social and emotional learning (SEL) approaches are effective at building social and emotional skills. These core skills for living not only improve social, emotional, and academic functioning, but also serve as powerful protective and coping tools modulating tough times and keeping potentially suicidal youth, adolescents, students, and adults safe. There is also evidence to suggest that anomie—the breakdown of shared values—may contribute to suicidality, whereas shared values and behavioral norms contribute to prosocial behaviors and a sense of belonging, and are thereby important protective factors. While there is a dearth of research on SEL skill-building and competencies among college students, the evidence for the impact of SEL approaches from kindergarten to high school is strong. The strong evidence for SEL efficacy suggests that SEL approaches implemented with college students may well prove to enhance academic perseverance, self-esteem, connectedness, and belonging, and thereby also play a modulating and protective role during tough times.

Children and adolescents lacking in the life skills fundamental to academic and social success are at greater risk for depression, substance abuse, antisocial behavior, and suicidality. Interventions targeting the development of fundamental skills for living have proven successful at reducing many of the antecedents of suicidality as well as suicidality itself. A meta-analysis of 213 studies in schools across the United States found strong evidence for the efficacy of social and emotional learning interventions at improving mental health, increasing prosocial attitudes (e.g., beliefs about helping others, social justice, and violence) and behavior, improving students’ social and emotional skills (e.g., getting along with others and identifying emotions), as well as improving academic achievement (Conley, Durlak, & Dickson, 2013; Durlak, Weissberg, Dymnicki, Taylor, & Schellinger, 2011). Across the 213 studies evaluated, an 11 percentile point average increase in academic achievement was observed. Zalsman and colleagues (2016) conducted a meta-analysis of 1,797 studies of various suicide prevention approaches and concluded that school-based awareness programs are effective at suicide prevention.

Wilcox and colleagues note that in the absence of targeted interventions, children with disruptive and aggressive behavior tend to struggle academically, are disliked by both teachers and peers, and also limit their friends to other disruptive children (Wilcox et al., 2008). In the absence of effective interventions, these children are at
higher risk for academic failure, substance abuse, impulsivity, antisocial behavior, and suicidality (Gould, Greenberg, Veling, & Shaffer, 2003; Reid, Pattison, & Snyder, 2002).

**Developing Life Skills—Campus Tactics**

Throughout the usual course of development, young children acquire an array of information and skills that help them to navigate life's larger and smaller challenges. Most of these skills are acquired relatively automatically and intuitively as we grow up. These skills include basic life skills like managing our time, staying organized, taking care of possessions, cooking, doing laundry, managing money, swimming, and driving. An array of more personal skills is also essential to growth and development. These include awareness of our emotions, reading social cues, sharing with others, and managing competition, conflict, and failure.

As would be clear, young people with significant deficiencies in any of these areas will find life to be more challenging and stressful. And as discussed above, those with marked deficiencies in these areas are at significantly greater risk for mental illness, substance misuse, and self-harm. While most of these skills should have been acquired prior to reaching college, there is much that can be done on campus to fill in skill gaps that may exist and bolster skills that have not been mastered. Of note, while life skill enhancement has significant impact on mental health, most of the campus activities directed at supporting these skills would not usually be performed at campus counseling centers or by the counseling center staff.

There is much that can be done to promote and support life skills among students—most of it though outside the classroom activities. At the start of college, many schools have instituted orientation programs and courses, which seek to provide useful information and active opportunities to cement these skills. Many student services activities, student clubs, and organizations help young people to explore and improve on organizational and interpersonal skills. Many colleges are instituting programs and activities to help students enhance mindfulness and empathy (James, 2017).

Of particular concern is the need for support for students' competency in managing their financial needs both on the personal level and in relation to increasing college tuition. There is copious data demonstrating the severity of this challenge and the importance and value of support in this domain (Pain, 2016).

Campus student services and student life provide many opportunities for students to explore self-awareness, relationships, group participation, leadership, conflict resolution, and personal goals and values. It is of great value for campus student affairs and mental health leadership to approach student life programming in a strategic and intentional manner to ensure the greatest breadth of programming and thoughtful oversight of student life activities, so that these programs become a fertile ground for student growth and development.

JED's Set to Go resource provides an excellent overview of life skills for college students (retrieved from www.settogo.org/for-students/basic-life-skills/).

**Connectedness—Theoretical and Research Considerations**

An extensive body of literature has documented the strong association between connectedness, social support, and mental health (Berkman, Glass, Brissette, & Seeman,
Social support is particularly important on college campuses where students have left home and frequently experience homesickness, “friendsickness,” and isolation (Buote et al., 2007; Hefner & Eisenberg, 2009; Leung, Chen, Lue, & Hsu, 2007). Hefner and Eisenberg surveyed 1,378 students at a large public university and found that students with lower-quality social support had more mental health problems in general as well as a sixfold increase in depressive symptoms. Furthermore, students with low social support had a tenfold increase in suicidal thoughts in the prior month when compared to students with high perceived social support (Hefner & Eisenberg, 2009).

Loneliness is a multi-faceted condition with highly detrimental effects on physiological, emotional, and cognitive functioning. Paradoxically, lonely people may also become harder to be around, as chronic loneliness is associated with negativity and defensiveness (Mental Health Foundation, 2010). Lonely people also die sooner. In a study of nearly 3,000 nurses with breast cancer, women who had no close relatives had a twofold increased risk of breast cancer mortality as compared to the nurses who reported 10 or more close relatives. Nurses who had no close friends had a fourfold increased risk of breast cancer mortality as compared to the nurses who reported 10 or more close friends (Kroenke, Kubzansky, Schernhammer, Holmes, & Kawachi, 2006). A meta-analysis of 148 prospective studies investigating mortality as a function of social relationships found that people with stronger social relationships had a 50% increased likelihood of survival than those with weaker social relationships (Holt-Lunstad, Smith, & Layton, 2010).

In a study of 26,000 students from 70 colleges nationwide, Drum, Brownson, Denmark, and Smith (2009) focused on the nature of suicidal crises among college students and found clear evidence of the critical role of connectedness in periods of suicidality. Sadness, loneliness, and hopelessness were the most frequently endorsed moods during periods of suicidal ideation. Among students seriously considering suicide, the most prominent contributing antecedents were romantic problems, academic problems, family problems, and friend problems, further illustrating the strong association between connectedness—be it romantic, social, or familial—and suicidality (Drum et al., 2009). Beyond personal connections, participation in groups and organizations is also protective. Students belonging to campus organizations and sports teams, which increase the sense of belonging to a caring community, are less likely to have suicidal thoughts (Brown & Blanton, 2002; Drum et al., 2009). Participation in sports on campus is protective against suicidality. In a survey of 4,728 students, male students who did not participate in sports were 2.5 times more likely to report suicidal thoughts or behavior when compared to male peers who were sports participants. Female students not participating in sports were 1.67 times more likely to report suicidality than their female peers who were sports participants (Brown & Blanton, 2002). Investigators explored a potential association between religious service attendance and deaths by suicide in a sample of approximately 90,000 nurses across the United States. Data from the Nurses’ Health Study found a fivefold increase in deaths by suicide among nurses with little or no religious attendance when compared to nurses attending services at least weekly. Therefore, beyond personal connections, connection to the community through participation in and belonging to various groups and organizations is also protective (VanderWeele, Li, Tsai, & Kawachi, 2016).
More Americans are living alone then at any time in the last century (Henderson, 2014). Sociologists McPherson, Smith-Lovin, and Brashears (2006) investigated data from both the 2004 and the 1985 General Social Survey, a large survey exploring social and economic trends. They reported a threefold increase since 1985 in the number of Americans who say they have no close confidants. Remarkably, having no close confidants is now the most frequent response (McPherson, Smith-Lovin, & Brashears, 2006). Social isolation and living alone were found to increase risk of death by 29% and 32%, respectively (Holt-Lunstad, Smith, Baker, Harris, & Stephenson, 2015). On college campuses, 52% of male students and 62% of female students report feeling very lonely at some point in the past 12 months (ACHA, 2016b).

For almost 80 years since 1938, the Harvard Grant study has followed the lives of 268 Harvard men. The best predictors of success and well-being among the Harvard men were a childhood where one felt nurtured, an empathic coping style in their 20s and 30s, and warm adult relationships (Vaillant, 2012). Reviewing data from the Grant study, psychiatrist Charles Barber concludes that the secret to a happy life is “relationships, relationships, relationships” (2013).

**Promoting Social Connectedness—Campus Tactics**

Human beings begin our lives inexorably connected and dependent on others for survival. We are also psychologically dependent on human contact and connection for emotional nourishment and development throughout our lives. For many, the high school and college years are highly focused on a variety of relationships and social connections. Friendships (both old and new), memberships in groups and clubs, and romantic and sexual relationships are among the ways young students connect. In a survey of first-year college students, The Jed Foundation found that loneliness was the most common unexpected stressor for these students and that, when feeling stressed or distraught, young people most often turned to friends and family for support (The Jed Foundation, 2017a).

It should also be noted that connections and relationships can be sources not just of support and emotional nourishment but can also present challenges and problems as well. Young people who struggle with relationships and feel desperate to hold onto others can engage in destructive and problematic attachments with others. This is common among those with borderline personality disorder, for example. Strong social networks can leave those excluded feeling worse about themselves. We also know that relationship breakups can be a precipitant to suicidal behaviors and suicide (Drum et al., 2009). Further, there is reason to think that more intensely connected and structured social groups—especially of young people—can increase the risk of suicide contagion (Gould & Lake, 2013).

There is much that colleges can do to support healthy connections and relationships and to support those who struggle with connectedness. Again, many of these activities are likely to happen outside of the counseling or mental health system.

There are many group and social activities that take place in the context of student life. Greek Life—when properly supervised and monitored—can help support and cement strong social ties among members. Multiple campus clubs, residence hall-based activities, and religious and interest groups sponsor activities that provide students with opportunities to connect in structured and supportive settings. Campus
student life professionals should consider which groups of students may need particularly focused support to meet and forge positive connections with others.

Groups that might experience exclusion or isolation on campus include student veterans, international students, first-generation college students, students of color/ethnic minority students, LGBTQ+ students, commuter students, and transfer students.

There should also be efforts to actively identify those who may be particularly isolated because of emotional/psychological vulnerabilities. Students on the autism spectrum or those with anxiety disorders, depression, or psychotic illnesses may need supportive services, which should be developed in coordination with disabilities services, counseling, student life, and residence life. RAs, advisors, and relevant other gatekeepers should receive adequate training in identifying and at the very least initially engaging with students who may be isolating themselves on campus. Peer mentoring programs, residence life, and advising programs can help new students, at-risk students, and other vulnerable students adjust to campus and receive direction in forming positive connections on campus. Finally, campus counseling services should make treatment available that is geared to supporting students who experience relationship breakups and other losses and to helping students who have chronic relationship problems enhance their skills (typically interpersonal and dialectical behavior therapy groups).

**Early Intervention**

**Identifying Students at Risk—Theoretical and Research Considerations**

The U.S. Preventive Services Task Force (USPSTF) has noted the high rates of depression as well as the heavy costs, including loss of life, associated with untreated or inadequately treated depression (T those, 2016). The USPSTF noted the availability of accurate and practical screening methodologies and recommended screenings to identify those in need of treatment and care (Siu et al., 2016). The USPSTF also noted that it is critical that such screenings be directly linked to mental health treatment resources so that those suffering from depression can be connected to effective treatments (Siu et al., 2016). Ketchen Lipson, Gaddis, Heinze, Beck, and Eisenberg (2015) note the high rate of mental health problems and the low rate of treatment utilization on college campuses. With respect to students taking their own lives, the situation is particularly troubling. Over 80% of those who die by suicide have never been seen by their campus mental health service (Ketchen Lipson et al., 2015). Consequently, it is imperative to effectively identify those at risk for suicide and link them to appropriate treatments.

Both universal screenings as well as targeted screenings of higher-risk groups are effective at identifying those at risk for suicidality. When screenings are integrated with effective methods of linking identified persons to needed treatments, lives are saved and rates of death by suicide decline. Gatekeeper training is effective at increasing the ability of gatekeepers to recognize signs and symptoms of suicidality, and also increases the confidence of gatekeepers in using their suicide prevention training. However, gatekeeper training conducted in isolation and without ongoing complementary suicide prevention efforts (such as linkage to care, repeated booster trainings, screenings, and awareness campaigns) do not appear to result in decreases in mental
health utilization. Therefore, it is vital that gatekeeper training be conducted as one component of a comprehensive and ongoing suicide prevention program.

Both Web-based and in-person screenings have demonstrated to be highly effective at linking at-risk persons to needed treatments. Studies suggest that groups such as men as well as Blacks, Asians, and Hispanics have higher internalized stigma and other barriers to care, and may need additional outreach and prevention efforts before they seek help (Eisenberg, Hunt, & Speer, 2012). Efforts to identify those at risk for suicidality are most effective when employed as part of a comprehensive and ongoing suicide prevention program.

Many students suffering from depression do not utilize their college counseling centers (Shepardson & Funderburk, 2014). However, since the majority of college students do utilize their college health service (Eisenberg, Golberstein, & Gollust, 2007), Shepardson and Funderburk investigated and concluded that universal mental health screenings for all students accessing the college health service could be effective at identifying depressed and suicidal students (2014). ULifeline is a Web-based service offering anonymous online screenings for a variety of common mental health disorders. ULifeline is provided at no charge to any college or university by The Jed Foundation, with over 1,500 colleges and universities participating (Schwartz, 2016). A similar (but paid) Web-based service, Screening for Mental Health (MentalHealthScreening.org), partnered with 660 colleges and universities across the nation in the 2015–2016 academic year and screened 210,913 college students. Eighty-seven percent of students screened consistent or highly consistent for depression, 89% of students screened “suggestive” of generalized anxiety disorder, and 93% of students screened moderate or high-risk for substance abuse (MentalHealthScreening.org, 2016).

Identifying Students at Risk—Campus Tactics

Many, if not most, mental health problems develop over some time and many have manifestations observable to others. As noted previously, there is substantial benefit in finding people likely to develop mental health concerns or crises before these become full blown or severe. There are many opportunities to attempt to notice students who may be struggling or are developing symptoms of a mental illness. Further, many students have distressing symptoms: 60% of students complained of overwhelming anxiety at some point in the prior year, and 38% felt so depressed it was difficult to function (ACUHA, 2016a). Nevertheless, campus counseling centers see only about 10% of students on campus nationally. Thus, many students experiencing significant distress are not presenting for help. Therefore, it is incumbent on campus leaders to develop tactics to increase the likelihood that those in most distress will connect to clinical services.

It is important to note that many of these tactics address both identifying those at risk and increasing help-seeking activities. These areas are not mutually exclusive and can be considered two sides of the program of promoting early intervention.

Identifying those at risk can occur through several channels. Distressed students and their families, campus staff and/or faculty, or the student’s friends may all be in a position to notice a problem and support a referral or provide help. The goal of these tactics is to increase to the greatest extent the likelihood that a distressed student will be noticed and that someone will attempt to connect this student to needed support or clinical care.
Schools can begin to help in identifying those at risk before they even come to campus. Entering students with past histories of mental health concerns can be encouraged to contact the campus counseling or disability services to discuss transition of care planning (The Jed Foundation, 2017b), and colleges can gather health and mental health histories from entering students planning to live in campus housing. This information can provide the campus’s health and counseling centers with background information about potential health concerns for students who present for care. Campuses can also conduct mental health/substance misuse screening days as a way of helping students identify possible mental health concerns in themselves. We know that many primary care visits are at least partly precipitated by emotional concerns (Centers for Disease Control and Prevention, 2014). Hence, doing brief screening for major mental health concerns when students present to campus health services can identify many students who may be struggling (National College Depression Partnership–Network for Improvement and Innovation in College Health, n.d.).

A core tactic for identifying at-risk students on campus are the so-called gatekeeper training programs. These programs attempt to teach those likely to interact personally with students to identify signs of distress and encourage them to intervene. There are several structured training programs available, including Mental Health First Aid, QPR, Campus Connects, and Kognito. While many of these programs have been shown to affect awareness and knowledge about suicide prevention, they are still lacking robust support for the claim that they affect likelihood of intervening.

Many college counseling services have developed their own training programs. It is worth noting that ongoing consultation and discussion between counseling center clinicians and campus staff and faculty can help to encourage active intervention by gatekeepers. It is also valuable for those who are coordinating gatekeeper training efforts to focus their training activities on those most likely to interact in personal ways with students. This might include faculty who teach freshman writing, orientation courses, and psychology; academic advisors; chaplains; residence life staff; student affairs staff; health services staff; campus safety and security; athletics department staff, especially trainers; Greek organization staff; and custodial and dining hall staff (who may be well positioned to notice students struggling with an eating disorder).

Beyond the campus gatekeepers who might be trained, it is helpful for students to receive information about identifying when they or a friend might be struggling and also making them aware of campus support resources. These efforts could be directed particularly at resident assistants and campus leaders. Campuses also benefit from encouraging an attitude of mutual responsibility and care as promoted by bystander training programs. Programs such as Jed’s ULifeLine and Half of Us provide students and campuses with tools for identifying those at risk and how they might intervene to support a friend.

Increasing Help-Seeking—Theoretical and Research Issues

Most adolescents and young adults do not receive care for suicidality or self-harm behaviors. When they do reach out for help, adolescents and young adults are far more likely to turn to informal friend and family groups than to faculty or mental health professionals. Attitudes and beliefs that one should solve problems on one’s own, that it is weak to have problems, that one might be judged by others, and that friends and
family may not see help-seeking as legitimate are the barriers that reduce help-seeking behavior.

Help-seeking intentions are culturally mediated and vary by age, sex, minority status, and rural versus urban location. Consequently, interventions may be more effective when specifically targeted to particular groups.

The Internet can drastically increase accessibility and due to its anonymity can engage those for whom stigma is a barrier. Young people often turn to online sources where they self-disclose or seek support. However, reactions on the Internet are unpredictable and sometimes dangerous and may not result in referrals to care.

Mental health literacy comprises knowledge about mental health problems as well as mental health treatments and where and how to find them. Emotional competence comprises the ability to recognize and describe feelings as well as the capacity to adaptively regulate emotions in a non-defensive manner. Poor mental health literacy and inadequate emotional competence both form barriers to help-seeking (Rickwood, Deane, & Wilson, 2007). On average, emotional competence appears to be less well developed among young men (Rickwood et al., 2007) and may help to explain why males are less likely to reach out for help.

Evidence suggests that help-seeking behavior in adolescents is not a unitary construct but is mediated by three separate factors (Schmeekl-Cone, Pisani, Petrova, & Wyman, 2012). A large study of 6,370 students in 22 rural and urban high schools in Georgia, North Dakota, and New York found that help-seeking incorporates the following three factors:

1. Perceptions of the acceptability of seeking help.
2. Perceptions of the availability of trustworthy and capable adults to turn to.
3. "Rejecting codes of silence"—that is, attitudes about overcoming suicidal peers' secrecy requests.

The authors note that risk factors and protective factors are anchored in norms and attitudes of small friendship groups. This clustering of attitudes about mental health stigma and help-seeking in small peer affiliation groups may be a fruitful area for further research and prevention efforts (Schmeekl-Cone et al., 2012).

A review of the international literature on help-seeking among young people up to age 26 who were experiencing either suicidality or self-harm behaviors clearly suggests that self-harming and suicidal adolescents and young adults turn to informal peer and family networks in greater proportions than turning to mental health professionals (Michelmore & Hindley, 2012). Michelmore and Hindley identified 17 studies investigating either suicidality or self-harm and help-seeking. Rates of informal help-seeking varied from 40 to 68%, whereas help-seeking from mental health professionals was below 50%. Females were significantly more likely than males to seek help from their informal social networks, and males were more likely to turn to emergency services. Ethnicity also affects help-seeking behavior, with minority groups less likely to reach out for help.

Associations between extreme self-reliance, help-seeking, and mental health symptoms were investigated among a sample of 2,342 adolescents in six New York high schools (Labouliere, Kleinman, & Gould, 2015). Extreme self-reliance was defined as solving problems entirely on your own all the time. Youth endorsing extreme
self-reliance were three times more likely to meet criteria for clinically significant levels of depression, and their odds of meeting criteria for clinically significant levels of suicidal ideation were nearly 2.5 times greater than for those not endorsing extreme self-reliance (Labouliere et al., 2015). Adolescents with extreme self-reliance experience a “self stigma” where their misguided and extreme independence prevents them from adaptive help-seeking, even in the face of dangerously elevated mental health symptoms. Education about the risks of extreme self-reliance may be an important focus of suicide prevention programming (Labouliere et al., 2015).

Help-negation refers to the observation that those going through a suicidal crisis and most in need of support are less likely to seek it. Students with emotional difficulties as well as those going through a suicidal crisis are particularly unlikely to seek help from adults (Schmeelk-Cone et al., 2012). To further understand help-negation, researchers gathered data on the help-seeking attitudes, stigma concerns, and perceptions of social support among 321 undergraduates at an urban Midwestern university. A negative association was found between suicidal ideation and intentions to seek help from either professionals or informal peer and family networks (Yakunina, Rogers, Waehler, & Werth, 2010).

Paradoxically, suicidal ideation itself may serve as a barrier to help-seeking (Yakunina et al., 2010). Yakunina and colleagues (2010) cite a cultural taboo against talking about suicide, which according to Shea is heavily stigmatized in American culture (Shea, 2002).

Nearly 80% of students who later die by suicide are never seen by counseling services (Drum, Brownson, Denmark, & Smith, 2009). Therefore, a clear understanding of the various barriers to help-seeking and promising strategies to increase help-seeking behavior are key.

Interventions to Increase Help-Seeking

A recent review of Web-based interventions targeting psychological distress among college students found 17 pertinent studies and concluded that Web-based and computer delivered interventions can be effective at improving students’ anxiety, depression, and stress when compared to inactive controls (Davies, Morris, & Glazebrook, 2014). The authors noted that Web-based approaches may be an effective option for students with higher levels of internalized stigma around help-seeking but caution that the best improvements in mental health outcomes may be achieved by combining Web-based approaches with face-to-face support (Davies et al., 2014).

ManTherapy.org is a free online, confidential resource, begun in Colorado, offering an interactive and humorous approach targeting men at risk for depression and suicide. A fictional online therapist, Dr. Rich Mahogany, cuts through the stigma of mental health with straight talk and practical advice (Colorado.gov, 2017). ManTherapy.org works specifically to reduce stigma and increase help-seeking. A survey of their help-seeking intentions indicate that 51% of men utilizing ManTherapy.org stated they were more likely to reach out for help (CDC Public Health Grand Rounds, 2015).

Sources of Strength is built on a universal school-based suicide prevention approach designed to build protective influences, including help-seeking, across an entire student population. Youth opinion leaders from diverse social cliques, including at-risk adolescents, are trained to change the norms and behaviors of their peers
by conducting well-defined messaging activities with adult mentoring (Wyman et al., 2010). The purpose is to modify the norms within peer groups to alter perceptions of what is typical behavior as well as to increase and legitimize positive coping behaviors. The authors concluded that an intervention delivered by adolescent peer leaders can modify norms across the entire school population that are conceptually and empirically linked to reduced suicidal behavior (Wyman et al., 2010). Peer leaders’ referral of suicidal friends to adults was over four times more likely in schools receiving the Sources of Strength intervention as compared to schools that had not yet received the intervention.

Signs of Suicide (SOS) is a school-based prevention program that combines awareness raising and screening into a single suicide prevention program. SOS participants learn that suicidality is directly related to mental illness, usually depression. Participants are taught about signs and symptoms of depression and suicidality and also take a depression screening (Aseltine & DeMartino, 2004). In addition, SOS participants are taught that suicide is not a normal reaction to stress, and more adaptive coping such as help-seeking is prescribed. Students are taught the ACT action steps: Acknowledge the signs of suicidality in others by taking the signs seriously; let the person know you Care and you want to help; and Tell a responsible adult. While increases in help-seeking did not reach statistical significance, students in the SOS group were 40% less likely to report suicide attempts (Aseltine & DeMartino, 2004).

Increasing Help-Seeking—Campus Tactics

As noted previously, many students with significant anxiety, depression, substance misuse, and even suicidal thoughts and behaviors are not receiving clinical services either on or off campus. It is important that those who are experiencing significant distress or are likely to have a mental health crisis be encouraged to seek out necessary clinical support. Largely, these activities overlap with those focused on identifying those at risk.

Nevertheless, there are several tactics that campuses can employ to ease barriers to help-seeking among students. Student mentoring programs and groups focused on educating students about mental health problems, the value of help-seeking, and informing them about campus resources can be helpful in lowering barriers to reaching out for help. Groups such as Active Minds and the National Alliance on Mental Illness have sponsored campus events such as these. Some schools also support peer counseling/advising services to establish a more engaging entry into receiving clinical services.

The health, counseling, and health education offices can also do much to educate students about mental health through health fairs and messaging campaigns. A number of colleges have found that having counseling center staff interact in informal educational and group settings can diminish some reluctance to visiting the counseling service. Other colleges have set up walk-in hours in residence halls and other areas closer to where students might congregate as a way to remove geographic barriers to help-seeking. Along similar lines, it can be helpful to make the counseling office seem as homey as is realistic and to have open houses at health and counseling offices during orientation so that students can become aware of the location of these offices.
Availability and Access to Clinical Services

Providing Mental Health, Substance Abuse, and Crisis Services—
Research and Theoretical Issues

A large majority of Americans with mental illness are not receiving professional care. Even among the minority who do receive treatment, most are not receiving minimally adequate care. On college campuses, most students needing care are not in treatment. Moreover, most students in higher-risk categories, including those with serious suicidality, do not receive treatment and, even if they do, too often do not receive minimally adequate treatment. Historically, suicidality has been seen as a symptom of an underlying condition with treatment directed at alleviating the underlying problem, not the suicidality. Best practice guidelines from organizations such as the National Action Alliance for Suicide Prevention now recommend that suicidality always be directly targeted in addition to treating the underlying condition. Targeting suicidality directly with evidence-based approaches ameliorates suicidal thinking and behavior and prevents deaths by suicide. Understanding of suicidality and its effective treatment has come a long way. It is now well established that effective care and treatment of suicidal persons includes a systematic and collaborative approach, which incorporates thorough assessment, timely access to care, safety planning, evidence-based treatments, and caring follow-up. Isolation and loneliness are understood to be prominent risk factors, and the need among suicidal persons for a sense of connectedness as well as caring follow-up contacts guides effective care.

A survey of 26,000 students at 70 campuses nationwide showed that fewer than half of students who had seriously considered suicide in the past year had received any kind of professional care (Drum, Brownson, Denmark, & Smith, 2009). A second survey of over 13,000 students at 26 campuses indicated that only 36% of participants were receiving mental health care for problems including anxiety, depression, and suicidal thoughts (Eisenberg, Hunt, & Speer, 2012). Among students receiving treatment for depression, only about half were receiving levels of care deemed minimally adequate according to evidence-based guidelines (Eisenberg et al., 2012; Wang et al., 2005). Unfortunately, students with higher levels of depression and greater suicide risk were not more likely to be receiving treatment. In fact, only 39% of students in these higher-risk categories were in treatment (Eisenberg et al., 2012). From data provided by 40 universities among respondents to the annual counseling centers directors’ survey, Schwartz (2006) noted that the median number of sessions after intake is just 2.8, and that the modal number of sessions attended is only one. Half of all clients were seen in just four or fewer sessions, and less than 10% were seen for eight or more sessions (Schwartz, 2006).

Noting that treatment for suicidality is only effective if the patient is active, involved, and invested, M. D. Rudd, Cukrowicz, and Bryan call for treatment compliance, engagement, and motivation to be targeted in a specific and consistent fashion. According to the authors, effective treatments of suicidality have specific interventions and techniques that target poor compliance and motivation for treatment (2008).

Allan Schwartz (2006) from the University of Rochester argued cogently that university counseling centers are highly effective at reducing deaths by suicide among students who attend counseling. Schwartz utilized data among hundreds of 4-year
colleges for the 14-year period culminating in 2004 and estimated that, while the risk of suicide among students attending counseling services is 18 times greater than the risk of students in the student body as a whole, actual deaths by suicide among counseling center clients are far lower. Schwartz posits that if counseling centers were completely ineffectual at reducing deaths by suicide, then the rate of deaths by suicide among those attending counseling services would actually be 18 times greater than the student body as a whole. Since the rate of deaths by suicide is only three times greater among students attending counseling services when compared to the student population as a whole, Schwartz (2006) has therefore concluded that college counseling centers are highly successful at reducing the rate of death by suicide—by a factor of six (Schwartz, 2006).

As many as 70% of patients discharged from the hospital never attend their first therapy appointment (Hogan & Grumet, 2016; Luxton, June, & Comtois, 2013). First tried four decades ago, studies show that simple and brief but caring contacts with patients discharged from the hospital can have an ongoing immunizing effect preventing deaths by suicide (Motto & Bostrom, 2001). Researchers attribute the protective effect gained from caring follow-up to the sense of connectedness and support the discharged suicide attempters gained from the follow-up contacts (Fleischmann et al., 2008).

Established in 2005, the National Suicide Prevention Lifeline is a network of over 160 local crisis centers. Lifeline had responded to 3 million calls by 2011 and now answers over a million calls per year. By providing well-trained counselors, hotline staff stay on the phone providing critical hope and emotional support to suicidal callers emotionally lost in an impulsive sense that taking their lives is the only way out. Hotlines additionally reduce emotional distress and suicidal ideation among callers, and provide linkage with referrals to community resources.

The accumulating evidence for the preventative efficacy of post-crisis follow-up contacts on subsequent suicidality has led to the inclusion of follow-up contacts among the evidence-based best practices recommended by the National Action Alliance for Suicide Prevention (Covington, Hogan, Abreu, Berman, & Breux, 2011; Gould et al., 2018). Callers to Lifeline experience a reduction in hopelessness as well as suicidal intent even during the course of a single hotline call. However, almost half of suicidal callers experience subsequent suicidality in the ensuing weeks after their initial hotline call (Gould, Kalafat, Harris-Munfakh, & Kleinman, 2007). Moreover, fewer than a quarter of suicidal callers go on and connect in the ensuing weeks with the mental health care agency to which they are referred (Gould et al., 2007). Consequently, caring follow-up calls provide critical and life-saving continuity of care to suicidal callers who continue to negotiate their emotional turmoil and suicidality alone and without professional support. Illustratively, in a study of 550 callers who received caring follow-up contacts at six different crisis centers, 79.6% reported that the follow-up calls stopped them from killing themselves, and 90.6% reported that the follow-up calls kept them safe (Gould et al., 2018).

Treatment for suicidal patients has typically focused on the underlying mental health disorder in the hope that this will by itself reduce suicidal thoughts and feelings. The evidence now suggests that treatment should also directly target and treat suicidal thoughts and behaviors, using evidence-based interventions. Controlled trials show that cognitive behavior therapy for suicide prevention, dialectical behavior therapy,
and Collaborative Assessment and Management of Suicidality (CAMS) are more effective than usual care (that is, traditional therapies that seek to treat mental disorders but do not focus explicitly on reducing suicidality) in reducing suicidal thoughts and behaviors (Hogan & Grunet, 2016).

Treatment is highly effective and access to care is critical. Illustratively, a study strongly suggests the efficacy of accessing mental health services among adolescents with mental health disorders as compared to adolescents who do not receive treatment. British researchers utilized a longitudinal repeated measures design to evaluate changes in adolescent depressive symptoms from ages 14 to 17 following contact with mental health services (Neufeld, Dunn, Jones, Croudace, & Goodyer, 2017). In all, 1,238 adolescents from 18 secondary schools in Cambridgeshire, United Kingdom, participated in the study, and their depressive symptoms were repeatedly assessed between ages 14 to 17. Results indicated that among adolescents with a mental disorder but no mental health support at age 14, the odds of having clinical depression by age 17 were more than seven times greater when compared to adolescents who had been similarly depressed at baseline but who did access mental health services (Neufeld et al., 2017). Moreover, contact with mental health services was so effective that after 3 years, depressive symptomatology among those with disorders was similar to those of unaffected individuals (Neufeld et al., 2017).

The National Action Alliance for Suicide Prevention has offered best practice guidelines for the treatment of those at risk for suicidal behavior (Covington, Hogan, Abreu, Berman, & Breux, 2011):

1. Persons at risk for suicidal behavior should always be treated in the least restrictive setting.
2. Suicidal persons must have immediate access to care. Sixty-six percent of those who take their own lives were not receiving treatment at the time of death. Moreover, many people seek treatment only when they are in a crisis (Covington et al., 2011).
3. Suicidality must be addressed directly. It is too often assumed that the suicidality is a symptom of the underlying condition and treatment efforts are directed mostly toward alleviation of the underlying condition. Treatment must directly address the suicidality in addition to any underlying condition.
4. Suicidal patients should have a safety plan that is created collaboratively between caregiver and patient.
5. For hospitalized patients, the first follow-up appointment post discharge must occur within 24 to 72 hours after discharge.
6. There is only limited evidence to support the efficacy of hospitalization as a treatment for suicidality without follow-up care with evidence-based treatments.
7. There is only limited evidence to support the efficacy of pharmacotherapy as a treatment for suicidality without additional evidence-based treatments.
8. Evidence-based treatments such as Cognitive-Behavior Therapy for Suicide Prevention (CBT-SP), Dialectical Behavior Therapy (DBT), and Collaborative Assessment and Management of Suicidality (CAMS) are highly recommended.

9. It is important to recognize the need of frequently isolated suicidal persons for connectedness. After a suicidal person reaches out to a crisis hotline, caring contacts such as caring letters or caring follow-up calls are strongly recommended (Covington et al., 2011).

10. Trusting therapeutic alliances are fundamental to reducing suicide risk and promoting recovery and wellness. Such alliances are most productive when the care is collaborative, where the client is actively engaged in making choices that will keep him/her safe, and when the clinician feels confident that he/she has the training and skills to manage the suicide risk and support their clients’ safety (Covington et al., 2011).

Providing Mental Health and Substance Abuse Services—Campus Tactics

Students should have access to adequate health and mental health care while attending college. How that happens will differ based on several considerations. Not all care needs to be available on campus and, for commuter colleges, most students will not be expecting their school to provide comprehensive human services. However, colleges should be able to direct students to affordable and accessible care. For residential schools in rural areas, it will be more necessary for the college to provide more services on campus since it is unrealistic for students to travel long distances for off-campus care.

There are several overarching characteristics or goals that campus counseling services should try to meet:

- Care should be accessible—as much as possible, services should be conveniently located on campus but should provide an adequate degree of privacy for students coming for care. As noted previously, many larger campuses have several offices to make it easier for students to attend. Also, there should be adequate staffing and efficient triage to limit long waits and allow for rapid intake of students in crisis. Many schools have walk-in hours so a student can be seen right away for at least a brief assessment and visit.

- Care should be affordable—most campus counseling services see students for a limited number of sessions but do not charge for individual visits. At the same time, for colleges that have limited offerings on campus or for those that refer students off campus for ongoing or specialty services, it is helpful to identify low or flexible fee clinicians and/or clinical services near campus where students can find affordable care. Ideally, the college should require that students carry health insurance while matriculated and that off-campus providers participate in most major insurance plans.

- Care should be comprehensive—students should have access to mental health and substance misuse care, including a broad array of services that provide support for
students with eating disorders and borderline personality disorder should be available. Group therapy and psychoeducation groups and programs are of great utility with the college student population (some of these services might even be provided by non-counseling center-based staff). Further, students should have access to psychiatric medication management while at school.

- Care should be evidence based—students should have access to cognitive behavior therapy and dialectical behavior therapy. Substance services should be informed by the Screening, Brief Intervention, and Referral to Treatment approach. Staff should be trained in identifying and managing students with suicidal ideation and staff should be aware of basics of suicide management approaches such as Problem Solving Therapy and Collaborative Assessment and Management of Suicide (www.sprc.org/resources.programs).

- Care should be well organized and integrated—whether or not campus health, counseling, and health education services are administratively integrated, it is still important for there to be coordination and effective communication among these functions and services. As resources are typically limited for health and mental health care on campus, having well-thought-through communications and systems in place can lead to greater efficiency and improved patient care (Eells & Schwartz, 2010; Kay & Schwartz, 2010).

It is also important to facilitate communication and integration between campus and community providers. As many campus counseling services provide limited periods of care, it is essential to have a robust and smooth process for referrals and transferring care for those who need ongoing support or specialty care not provided on campus. Campus-based mental health training programs (graduate programs in social work and psychology and resident training programs based at medical school departments of psychiatry) can provide good conduits for inexpensive ongoing care for students in need. Ensuring that those clinicians providing clinical care to large numbers of students are well versed in issues relevant to student mental health and also understand the medico-legal and administrative issues related to student life (such as leaves of absence or accommodations) can be very helpful.

- Care should be flexible—students come to counseling services with a broad range of concerns and problems and extremely varied ideas about what counseling can provide or what they need. For many who come for care, this may be the first time they are managing their own health or mental health care needs. There is no “one style fits all” approach to engaging and supporting students. Many will benefit from psychoeducation approaches while some may be experiencing lapses in experience or life skills that can be addressed with information or support not typically considered to be therapy. Care needs to focus on assessing what the student needs, what can be provided in which setting, and often in helping prioritize among multiple problems. Many students might have clinicians back at home with whom they are still in touch. Efforts should be made to decide who will handle which aspects of care. Many students who need medication will also be cared for by several clinicians on campus. Finally, some students might receive care off campus but still have a campus-based case manager who helps with student life, human services, and managing the sometimes confusing or challenging campus system. The counseling system should be able to integrate the wide-ranging needs of the college student.
Crisis Management Services—Campus Tactics

Given rates of mental illness and substance use among college students, it is inevitable that every campus will be faced with health and mental health emergencies. The effective management of student crises is not simply a matter of providing clinical care for serious or acute problems. Rather, we can think of crisis management as comprising several components:

- Policies relevant to students experiencing mental health- or substance-related crises
- Support and clinical services for students experiencing an acute crisis
- Campus-wide emergency and postvention protocols

Policies

There are a number of policies that every college should have in place to protect the welfare of their students. Students who are unable to handle their academic work or independent living on campus as a result of a health or mental health problem should be able to obtain a medical leave of absence. The school policy for medical leaves should be flexible and individualized to the student's clinical and personal needs. Since a mental health crisis and disruption of one's academic progress is highly stressful, the campus administration should be supportive of students and their family through this time and as much as possible create a transparent, student friendly, and simple process (Suicide Prevention Resource Center [SPRC], 2017).

Binge drinking and illicit drug use are common problems on college campuses. It is estimated that nearly 2,000 college students die each year from alcohol-related accidents and alcohol poisoning (Wechsler, Dowdall, Maenner, Gledhill-Hoyt, & Lee, 1998). When a student is experiencing an episode of alcohol poisoning or other dangerous outcome related to substance use, it is imperative that campuses have in place a well-understood and broadly publicized medical amnesty policy. Such policies limit disciplinary sanctions for students responding to a health emergency in the context of substance use. This policy can save lives by reducing hesitancy around seeking emergency help.

In the aftermath of the Virginia Tech tragedy, many campuses established student at-risk teams. These teams gather information about students who might be struggling or showing signs of deteriorating function or other evidence of impending emotional crisis. These teams can help coordinate a supportive and “upstream” response to students and help ensure that information is being communicated effectively among campus health, mental health, student services, and academic areas (Higher Education Mental Health Alliance, n.d.).

Policies for handling communication with students' families and off-campus clinicians and clinics are important to have in place when faced with student crises. For students coming to campus with a history of health or mental health problems, plans should be established to make sure students have adequate clinical care in place and a plan should be set to manage emergencies as well. These plans should include discussion about when and how family members should be contacted in the event of an emergency. It is important for campus-based clinicians and administrators to be well
versed in the legal issues relevant to sharing clinical information and handling emergencies (Bower & Schwartz, 2010).

Clinical Emergencies and Crisis Support

Every campus should have a process for handling clinical emergencies that might emerge for a student on campus. This typically includes training campus security, clinical staff, and, for campuses with residence halls, residence life staff to identify and coordinate management of campus emergencies. Colleges also need to have access to emergency and inpatient care for students who may need to be assessed in a hospital setting or to be hospitalized as a result of a serious or acute mental health problem. It is most helpful to have good lines of communication among offices and entities that may be faced with managing student crises and a clear plan for who takes responsibility for what aspects of the crisis. Many campuses have begun to hire case managers who can play a central role in coordinating campus crises. As noted previously, it has become increasingly clear that the period after an emergency room visit or inpatient stay is a time of particularly high risk for suicide. Thus, a process for coordination of aftercare for students is crucial and another role that can be played by a campus case manager.

Students should have access to crisis support at all times. This might be done through a campus-based "on-call" service through which students in acute distress can access a campus clinician or contracted emergency service by phone. For campuses that do not have access to a campus-based resource, there should be an option to access a local or national crisis hotline such as the National Suicide Prevention Lifeline or Crisis Text Line services. Whatever crisis service is available, information for accessing these services should be widely available on campus communications and websites. Many colleges have adopted the practice of having students input emergency numbers on their phones during school orientation.

Campus-Wide Protocols

Crises do not occur according to a plan or on a schedule and often affect both individuals and the campus as a whole. A student mental health emergency for one student might affect friends, roommates, and others on campus. Sometimes, campuses will also experience a campus-wide event: a flood, fire, or student death. As a result, it is valuable for campuses to have a crisis management plan in place to heighten effectiveness and efficiency in dealing with a campus-wide crisis. There should be a crisis management group in place and a series of general guidelines established to address as wide an array of potential problems as possible. Tabletop exercises and regular discussions and refreshers can help to ensure that stakeholders are prepared to manage emerging problems.

Sadly, we know that suicides and other deaths occur on campus and that these tragedies strain campus personnel and resources. In the case of suicides, the management of the aftermath may increase or decrease risk for subsequent student suicides (The Jed Foundation, 2015). Campuses should have an established protocol for postvention in the event of a suicide or other campus death (HEMHA, 2014). This protocol needs to consider challenges of communicating to those on campus, friends and family of the
deceased, and local media. The plan also needs to consider how to provide support and care for those affected by the student death both directly and indirectly.

Environmental Safety and Means Restriction

**Means Restriction—Theoretical and Research Considerations**

Numerous studies document means restriction as a powerful method of suicide prevention. The overwhelming majority of people who attempt suicide survive for decades following an attempt not leading to death. Attempters prevented from their chosen means of suicide do not simply substitute an alternate method of suicide but overwhelmingly survive and endure.

Means restriction is also critically important because the suicidal process is so frequently both ambivalent and impulsive, particularly among younger people. Elapsed time from first suicidal thought to the attempt is often 10 minutes or less. Since interventions such as identification, assessment, and treatment are too late to help in this short suicide "hot" period, means restriction is critical.

Suicide by gas oven was the most popular method of suicide in England in the 1950s. Starting at that time, England switched from highly toxic coal gas with a carbon monoxide content of 12% to the far less toxic natural gas. Removal of the far more lethal coal gas resulted in thousands of lives saved (Hawton, 2007). The overall rate of suicide in the population fell substantially (down by one-third), indicating the power of means restriction as well as providing powerful support to the idea that most people surviving a non-lethal attempt do not simply substitute another more lethal method (Daigle, 2005).

Death by highly toxic agricultural pesticides is the most common form of suicide in Asia, resulting in an estimated 300,000 suicides each year (Gunnell & Eddleston, 2003). Agricultural pesticides vary significantly in their toxicity from a case fatality rate over 60% for paraquat to 8% for chlorpyrifos (Gunnell et al., 2007). In Sri Lanka, where ingestion of toxic pesticides is common, suicide rates increased eightfold to a rate of 47 per 100,000 between 1950 and 1995, but then halved from 1995 to 2005 as pesticide toxicity was reduced. In 1995, Sri Lanka banned all World Health Organization class 1 ("extremely or highly toxic") pesticides, resulting in nearly 20,000 fewer suicides from pesticides in the ensuing 10 years as compared to the previous 10 years (Gunnell et al., 2007). The overall rate of suicide also fell drastically, indicating that removal of popular methods of suicide does not result in equivalent increases in rates of suicide via alternate means.

Paracetamol (acetaminophen) is a popular over-the-counter analgesic in the United Kingdom that is often lethal in overdose. Its easy over-the-counter availability has resulted in many suicide deaths. Legislation was introduced in 1998 limiting access to paracetamol by lowering packet sizes and making it harder for the public to accumulate a sufficiently lethal dose. Following the legislation, rates of paracetamol-related suicide declined, and little evidence of displacement to other analgesics was observed. K. Hawton and colleagues estimated that 200 lives were saved in the 3 years following the legislation (2004).

In his review of the literature on means restriction, K. Hawton concluded that an impulsive response to an acute personal crisis and availability of a firearm in the household were key features leading to suicidal acts by shooting (2007).
Miller and Hemenway (2008) note that guns account for 53% of all suicide deaths in the United States. Having a gun at home increases the risk of suicide from twofold to tenfold depending on the age of the sample population and on the way in which the gun is stored (Miller & Hemenway, 2008). And the higher risk associated with homes with guns extends not only to the gun owner but also to the gun owner’s spouse and children. Adolescent suicide is four times as likely in homes where firearms are loaded and unlocked as compared to homes where they are locked and unloaded (Miller & Hemenway, 2008).

When the anti-suicide barriers at an Australian central city bridge were removed in 1996, suicides at the bridge rose fivefold from 3 in the 4 years prior to removal of the barriers to 15 in the 4 years following (Beautrais, 2001). Installation of a safety net at a popular jumping site in Berne, Switzerland, reduced suicides at the site to zero with no concomitant increase in suicides from jumping at alternate high places in Berne (Reisch & Michel, 2005).

Numerous bridge studies from multiple locations worldwide document the efficacy of means restriction as a critical suicide prevention tool (Beautrais, 2007; Cantor & Hill, 1990).

Studies of survivors of the most serious suicide attempts strongly illustrate the importance of means restriction. O’Donnell, Arthur, and Farmer (1994) followed 94 people who jumped in front of subway trains in London and survived. The attempters were completely convinced they would die, but survived because there is a deep well between the rails. After 10 years, 9.6% of the 94 people who survived such subway jumps had gone on to end their lives, but 90.4% were still alive (O’Donnell, Arthur, & Farmer, 1994). K. Hawton reports on a study of 515 people prevented from jumping off the Golden Gate Bridge in San Francisco. At a median follow-up period of 26 years, only 4.9% of the 515 study participants had ended their lives and the overwhelming majority—some 489 out of the 515—had not ended their lives. Reviewing the literature on means restriction, K. Hawton concluded that the majority of survivors of even the most serious attempts do not go on to die by suicide and furthermore do not turn to another method of suicide (2007). While the vast majority of survivors live and endure for decades and do not die by suicide, a relatively small minority of people prevented from ending their lives by one method—and apparently more invested in ending their lives—go on to die by suicide via other means.

**Means Restriction—Campus Tactics**

In considering how to limit access to means for self-harm on campus, a good starting place is to perform a campus scan. This is an exercise in which the physical structures, spaces, and policies are reviewed with an eye to their potential for limiting or preventing self-harm. Typically, campus facilities and security officers will need to be involved in this process, among others. Students can harm themselves in numerous different ways; common methods for suicide on campus include jumping, asphyxiation/hanging, poisoning or overdose, and shooting (Schwartz, 2011).

Colleges should work to secure high places, such as building rooftops, bridges, and parking lots with barriers and alarms so as to limit opportunities for jumping. Hangings commonly occur in residence hall rooms. These can be limited by using breakaway (or simply relatively flimsy) closet rods in dorm rooms and limited-weight
bearing shower components. Poisonings can be limited by keeping chemistry labs and other areas on campus where there may be toxic chemicals locked when there is no supervision present. Students who are prescribed potentially toxic or misused drugs should be advised to keep them locked away from other students. Many schools have drug take-back programs for students who have unused prescription drugs.

Many campuses across the United States outlaw firearms on campus, and Schwartz (2011) has argued that the relative limit of firearm availability on campus is one reason for the lower risk of suicide among college-attending young people, since firearms are the most common method of suicide in the United States among the general population (Schwartz, 2011). There are several states that have recently relaxed restrictions on firearms on their campuses. At the very least, campuses that allow firearms should have access to lockers or other safe storage facilities, and consideration should be given to how to keep firearms out of the hands of students who might be intoxicated or at risk for suicidal behavior.

Summary

This chapter has provided a comprehensive overview of The Jed Foundation's Comprehensive Model for Mental Health Promotion and Suicide Prevention. The theoretical and practical underpinnings of the model, as well as its applicability for both individual and population-level change, have been addressed. Strategies to decrease risk factors and increase protective factors among college students as well as an understanding of the student mental health problems and related risks that campuses face, and existing best practices to address these, have been explored across four thematic areas: enhancing protective/preventive factors and resilience; early intervention; availability and access to clinical services; and environmental safety and means restriction.

References


