14 Using A Public Health Approach to Address Student Mental Health

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> Health care is vital to all of us some of the time, but public health is vital to all of us all of the time. (C. Everett Koop)

14.1 Introduction

Other chapters in this book examine best practices for providing mental health services to students with a range of psychological problems. While most 4-year and some 2-year colleges and universities provide low- or no-cost mental health treatment services to their students, and/or facilitate access to off-campus services, student survey data shows that many students who need help are not asking for it directly. For example, the majority of students who report being depressed are not in treatment [1,2], and most students who die by suicide are not clients of the counseling center [3]. These data show that, while increasing help-seeking and providing effective treatment are critical, campuses must not rely solely on the counseling center to address student suicide prevention and mental health promotion.

Many colleges are going beyond simply providing treatment services by expanding efforts to *prevent mental health problems from arising* and to *promote the mental health of all students*. In other words, they are adopting a public health approach to address the social and environmental risk factors that influence student mental health [4].

For example, there may be opportunities to address the risk of suicide and mental health problems *before* intensive and costly treatment services are required. In one study, students

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with current financial problems were more likely to be depressed or suicidal [5]. An early, non-clinical intervention to help these students deal with financial issues more effectively may be sufficient. (Note: The term "intervention" refers to an activity, policy, practice, or service that is designed to result in some change in people or in the environment. In public health, the term is sometimes used interchangeably with "program", which may be used to describe an integrated set of multiple interventions.)

Another study found that certain groups of students who experience a lower quality of social support are six times more likely to experience depressive symptoms [6]. This might suggest an effort to intervene with specific student populations rather than waiting until students have developed problems requiring clinical care.

A comprehensive, multi-component effort to reduce these and other risk factors may actually produce a decline in the number of students requiring intensive clinical services over time. Rather than focus on the small number of students who need counseling, a public health approach to campus mental health aims to create conditions to support the mental wellness of all students.

14.2 A Public Health Approach to Campus Mental Health

The recent Institute of Medicine (IOM) report *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities* [7] provides an extensive rationale for a public health approach, suggesting that "behavioral health could learn from public health in endorsing a population health perspective" [2009, p. 21].

In contrast to a treatment-focused perspective, the core focus of public health is on preventing health problems and promoting health in the overall population. Public health practitioners rely on data about health problems, including their frequency and impact, to plan interventions. Perhaps the most important assumption in public health is that risk and protective factors for health problems occur not only within individuals but also at the interpersonal, institutional, community, and public policy levels [8,9]. Known as a *social ecological model*, this approach asserts that health- and safety-related behaviors are shaped not only by the individual but also by that individual's environment.

The social ecological model acknowledges that context – the social, physical, economic, and legal environment – is as important a determinant of an individual's behavior as internal knowledge, attitudes, and behavioral intentions. The model is used as a framework for examining and planning prevention programs to address a wide range of health and safety problems throughout the world.

On college and university campuses, the public health approach, including the social ecological model, is at the foundation of successful alcohol prevention [10] and violence prevention [11]. Mental health promotion and suicide prevention efforts should include activities across the continuum of the social ecological model and address the complex interplay among all of the levels.

Table 14.1 lists general factors that contribute to mental health problems at each level.

The IOM report outlines the spectrum of mental health interventions that should be included in a public health approach: mental health promotion, prevention of mental illness, treatment, and maintenance [2009]. Definitions of "prevention" and "promotion" in the context of mental health are similar to those offered in the World Health Organization's (WHO) reports on each topic [12,13].

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Table 14.1	General factors contributing to mental health problems

Individual factors: Attitudes and beliefs about mental illness, help-seeking, and treatment efficacy; biological factors and family history; skills in problem-solving, relationships, and conflict resolution. Strategies addressing this level of influence are designed to affect an individual's behavior.

Interpersonal processes: Group norms regarding suicidal or help-seeking behavior; responses to individuals in distress; discrimination toward those with mental health problems. Strategies addressing this level of influence promote social support through interaction with others.

Institutional/organizational factors: Policies and procedures; existence of and availability of methods for self-harm or suicide; access to quality mental health services; high levels of alcohol consumption. Strategies addressing this level of influence are designed to change institutional conditions and environments that influence individual behavior.

Community factors: Access to quality mental health services (e.g. outpatient, inpatient, emergency hospitalization.) Strategies addressing this level of influence are designed to change conditions and environments that affect the institution; group/family/peer behavior; and individual behavior.

Public policy and societal influences: Existence of federal, state, and local laws and regulations related to restriction of lethal means, health insurance, and confidentiality; cultural contributors such as media images that portray those with mental health problems in a derogatory way or glamorize suicidal behavior [7]. Strategies at this level are designed to have wide-reaching impact through actions affecting communities, organizations, and entire populations.

McLeroy, K.R., Bibeau, D., Steckler, A. and Glanz, K. (1998) An ecological perspective on health promotion programs. *Health Education & Behavior*, **15**(4), 351–377.

Mental health promotion focuses on well-being as an end in itself rather than on preventing illness. However, there is evidence that mental health promotion is key to reducing mental health disorders as well as related problems [7].

Preventing mental disorders entails efforts to reduce the risk conditions for a mental illness; the incidence, prevalence, and recurrence of mental disorders; and the length of time that an individual experiences symptoms. Prevention also includes activities to prevent or delay recurrences of mental disorders and decrease the impact of illness on the affected person, family, and society [14]. A comprehensive prevention approach would include *universal*, *selective*, *and indicated* interventions. Universal interventions address the population at large; selective interventions target groups or individuals with an elevated risk; and indicated interventions target individuals with early symptoms or behaviors that are precursors for disorder but are not yet diagnosable [14]. In other words, a comprehensive prevention approach would include "a balance between approaches aimed at those at imminent risk, those at elevated risk, and those who currently appear risk free but for whom specific interventions have been demonstrated to reduce future risk" ([7], p. 64).

While treatment can prevent the exacerbation of symptoms, the emergence of new or comorbid symptoms, and relapse, the IOM report suggests that a key feature of public health prevention is that it can take place at any or all levels of the social ecological model. This type of prevention also focuses on preventing new disorders and targets a specific population for an intervention [7].

Table 14.2 summarizes the goals of promotion, prevention, treatment, and maintenance and provides examples of campus programs in each category.

14.2.1 Risk and Protective Factors for College Students

A public health approach aims to improve the health and safety of all students by identifying the risk and protective factors associated with mental health problems and suicidal behavior. Risk factors include traits, events, conditions, and situations that increase the likelihood that

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Table 14.2 Types of public health interventions

Intervention type	Goal	Campus examples
Promotion	"[T]o enhance individuals" ability to achieve developmentally appropriate tasks (competence) and a positive sense of self-esteem, mastery, well-being, and social inclusion and to strengthen their ability to cope with adversity' ([7], p. 66).	Opportunities to develop skills in relationships, conflict resolution, problem solving; courses about the first-year college experience; creation of a physical and social environment conducive to social connection
Prevention		
-Universal	To prevent disorders from developing by targeting entire population in an effort to reduce risk factors and build protective factors for all students. Focus should also be placed on preventing distress/subclinical disorders and harmful behaviors (e.g. heavy episodic drinking) [7].	Strategies to change the environment that supports high risk alcohol consumption [15,16]; restricting access to potentially lethal means of suicide
-Selective	To prevent disorders from developing in a person or group at higher risk of developing mental health disorders [7].	"Postvention" program for friends of a student who has recently died.
-Indicated	To prevent disorders from developing in individuals showing early signs or symptoms or to prevent exacerbation of existing problems [7].	Screening and referral systems; "feel better fast" psycho-educational groups
Treatment	To reduce the length of time an individual has a disorder, reduce disorder severity, and prevent recurrence [14].	Evidence-based use of psychotherapy and/or medication
Maintenance	To decrease disorder-related disability [14].	Support groups for students living with depression

an individual will develop a specific illness or behavior. Protective factors make the occurrence of the problem or behavior less likely. Risk and protective factors can be psychological, biological, social, environmental, or cultural.

Like many chronic diseases, mental health problems tend not to have a single cause, with many different factors contributing to increased risk and no single factor being either necessary or sufficient to cause a disorder [7]. Multiple risk and protective factors for mental health problems or suicide have been identified in research studies (see Table 14.3). However, the identification of a risk factor in a particular population or group does not mean that all members of the group will experience the disorder or become suicidal. Similarly, identifying a protective factor does not ensure that the population will be protected from these problems.

It is worth emphasizing one risk factor in particular: More than 90% of people across the lifespan who die by suicide meet the criteria for a psychiatric diagnosis with the majority having more than one condition, most often mood disorders and alcohol abuse [17]. Despite the key role that mental illness plays, prevention programs still need to be comprehensive, as suicide is generally the outcome of multiple risk factors.

Interventions to change these risk factors and increase protective factors are described later in this chapter. Given the range of interventions suggested – targeting the social and physical environment, campus systems, academics, and family and peer relationships – it becomes clear that addressing student mental health problems and suicidal behavior needs to be the responsibility of the entire campus community, not just the counseling center staff. Launching a campus-wide effort requires that some key infrastructure be put in place to build and sustain an effective mental health promotion and suicide prevention effort.

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Table 14.3 Risk and protective factors relevant to college students

	Risk factors	Protective factors
Suicide	• Biopsychosocial	• Strong connections to family and other supports
	• Previous suicide attempt	• Access to effective clinical interventions
	• Untreated or under-treated mental illness	• Restricted access to lethal means
	• Chronic physical illness	• Skills in problem-solving, conflict resolution
	• Alcohol or other drug use and abuse	• Frustration tolerance, ability to regulate emotions
	• Hopelessness	• Positive beliefs about future, ability to cope, and life in general
	• Impulsivity or aggressiveness	• Cultural/religious beliefs discouraging suicide
	Sociocultural and environmental	
	• Barriers to effective clinical care	
	• Isolation, lack of social support	
	• Unsupported financial/social loss	
	• Stigma associated with seeking care	
	• Access to lethal means	
	• Exposure to media normalizing/ glamorizing suicide	
	Demographic	
	• Completions: male; white race; Native American youth	
	• Attempts: female; Hispanic female youth; lesbian, gay and bisexual youth	
Mental health disorders	*Individual and family-related determinants*	*Individual and family-related determinants*
	• Academic failure	• Ability to cope with stress
	• Emotional immaturity	• Adaptability
	• Excessive substance use	• Autonomy
	• Loneliness	• Exercise
	• Family conflict	• Feelings of mastery and control
	• Personal loss	• Problem-solving skills
	• Poor work skills and habits	• Self-esteem
	• Social incompetence	• Social conflict management skills
	• Stressful life events	• Stress management
		• Social support of family and friends
	Social and environmental determinants	*Social and environmental determinants*
	• Access to drugs and alcohol	• Positive interpersonal interactions
	• Isolation and alienation	• Social participation
	• Peer rejection	• Social support and community networks
	• Work stress	

US Department of Health and Human Services (2001) National Strategy for Suicide Prevention: Goals and Objectives for Action, US Department of Health and Human Services, Substance Abuse and, Mental Health Services Administration, Rockville, MD.
National Research Council and Institute of Medicine (2009) Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities, in *Committee on Prevention of Mental Disorders and Substance Abuse among Children Youth and Young Adults: Research Advances and Promising Interventions. Board on Children, Youth and Families, Division of Behavioral and Social Sciences and Education* (eds M.E. O'Connell, Thomas Boat and K.E. Warner), The National Academies Press, Washington, DC.

14.3 Building Momentum and Infrastructure

A public health approach requires support from senior administrators and a broad base of key stakeholders (e.g. staff in decision-making roles, faculty who can be change agents). Promoting the mental health of all students is everyone's concern because of the relationship

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between mental health problems and academic success. In one study, approximately 44% of undergraduates reported that mental health issues had affected their academic performance during the past four weeks [5]. Mental health problems, specific symptoms, and possible risk factors for or consequences of both have an impact on performance as well. Stress, sleep difficulties, anxiety, depression, concern for a troubled friend or family member, and relationship difficulties are among the top factors affecting students' individual academic performance [1]. For example, 16% of students indicated that anxiety/depression/seasonal affective disorder affected their academic performance during the past 12 months [1].

There are a few essential capacities that campuses must have in place before adding new efforts to increase the identification of students at risk and/or increase help-seeking behavior. Some will take more effort to put in place than others, but all of the following are essential to ensure that demand does not outpace capacity.

- A crisis protocol is in place and key players (e.g. resident assistants) are trained in its use [18].
- Local, state, and national 24-hour hotlines are widely publicized on campus, including the National Suicide Prevention Lifeline number 1-800-273-TALK.
- Sufficient mental health services are available on- and off-campus to handle an increase in the number of students who ask for help.
- Counseling and health services clinicians are trained to assess and manage suicide and other urgent risk.

Every campus should have a dedicated office or staff person to coordinate programs, policies, and services that address suicide prevention and mental health promotion. The ability of a program coordinator to exercise leadership depends a great deal on whether there is active support from the president and other senior administrators for a campus-wide effort [10].

A key step in building momentum is to establish a mental health task force to lead a strategic planning process and oversee ongoing program efforts. Such efforts are more likely to succeed when there is broad participation and a shared commitment to meet common goals.

Many senior administrators have created the impetus for mental health promotion and suicide prevention themselves by asking health promotion and counseling staff to expand their efforts or by establishing a task force to study campus problems. In other cases, staff members have assembled data and anecdotal information and presented it to the senior student affairs administrator or the president along with a recommendation to create a task force [19]. On one campus, a student who was passionate about mental health got an appointment to meet with the president and enlisted his support for increased attention to the issues [19].

If a campus is not ready to start a task force, an individual can simply invite conversations with faculty, staff, and students to hear their concerns. Campus or national data showing the prevalence of mental health problems and suicidal behavior can also help convince senior administrators that a formal task force should be formed.

When there is widespread buy-in for a public health approach with many partners participating in an integrated set of activities and policies rather than isolated ones, it is much more likely that programs will continue to attract financial and staff support from

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senior administrators. And, if the activities and policies show results, key stakeholders are more likely to want to be involved. Using a strategic planning process will ensure that planners are prioritizing problems and choosing and designing programs that are likely to have the greatest impact.

14.4 Thinking and Planning Strategically

Interventions to promote emotional health and prevent mental health problems should be chosen in the context of a strategic thinking and planning process such as the one presented in Figure 14.1. Campuses should follow the steps described below when developing and implementing a public health approach.

14.4.1 Describe the Problem and Its Context

Without a clear definition of campus-specific problems, colleges run the risk of implementing interventions prematurely and could fail to achieve desired changes (e.g. fewer depressed and anxious students, less suicidal behavior) as a result.

A thorough problem assessment gives campus leaders objective data about the problems students experience, risk and protective factors linked to these problems, and estimates of prevalence. An examination of existing data, such as campus-specific National College Heath Assessment (NCHA) data from ACHA, is a good starting point. If campus-specific data is not available, data from the most recent national NCHA administration and the National Research

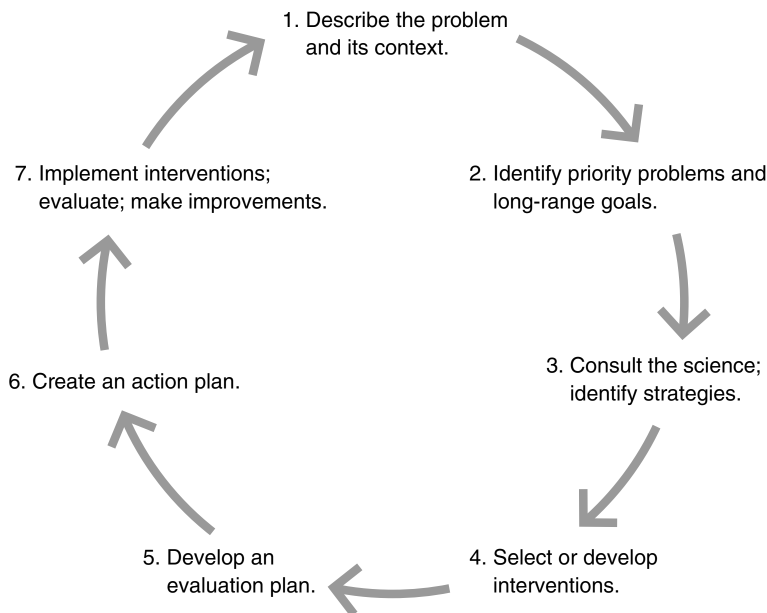

Figure 14.1 *Strategic planning process. Langford, L., Wootten, K. (2009) Strategic planning for suicide prevention. Presentation delivered at American Association for Suicide Prevention Annual Conference, San Francisco, CA, 16 April 2009.*

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Consortium of Counseling Centers in Higher Education's 70-campus study on suicidal crises [20] can be informative.

Information from focus groups and one-to-one interviews with faculty, staff, and students can supplement survey data and yield a deeper understanding of student mental health needs on campus. For example, NCHA data shows that students are not seeking help for depression, but it does not provide insight into the reasons for this finding. Focus groups conducted with students can reveal some of the barriers and facilitators to help seeking and either confirm or challenge planners' assumptions.

A problem assessment can also help campuses identify which programs are already in place, how effective they are, and what gaps may exist. Campuses that are very decentralized in decision-making may find that many offices and departments are implementing program elements related to student mental health, so planners should be sure to investigate beyond counseling, health services, and health promotion. The Suicide Prevention Resource Center's (SPRC) *Inventory of Programs, Policies and Services* can assist planners with this part of the assessment. The *Inventory* and other strategic planning tools are available as part of the *CampusMHAP (Mental Health Action Planning)* webinar series archived on TJF's web site.

An assessment of the campus climate and other contextual issues provides information to round out an overall problem description. This should include an honest assessment of the individual and institutional factors that are likely to facilitate or resist change. A readiness assessment does not need to take a great deal of time, but it can help to identify community support for and obstacles to accepting mental health promotion and suicide prevention as issues that need attention [21].

14.4.2 Identify Priorities and Set Long-Range Goals

Resources are almost always limited and every campus has multiple and competing concerns, so planners must make difficult decisions about which problems to focus on first. Having data on risk and protective factors and those populations at highest potential risk will help support decision-making, but planners should be sure to consider risk and protective factors across the entire social ecological model rather than just individual factors.

Creating good problem definitions from the outset supports the process of setting appropriate long-term goals. A goal statement should articulate specific, measurable goals whose achievement can be readily observed and measured. A focus on conditions or behaviors targeted for change will help planners avoid a common pitfall in goal-setting: describing the completion of a program as a goal, such as "conduct gatekeeper training". A more useful goal statement would be "increase the number of faculty trained to identify and refer students in distress". Achieving many goals may take time, but the planning group or task force may want to demonstrate early successes by prioritizing some quick fixes to easily remedied problems.

14.4.3 Consult the Literature to Identify Relevant Research, Theory, and Best Practices That Address the Targeted Problem

Identifying problems and setting goals (Steps 1 and 2 above) provide the basis for choosing programs that will make desired changes. It is important to choose evidence-based practices whenever possible to ensure that you are investing time and other resources on programs that are likely to achieve those changes. Section 14.5 below will discuss specific interventions.

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Although practitioners at other campuses can be a valuable source of ideas for programs, planners should keep in mind that programs and policies from other campuses need to be critically examined. Before adopting a program that may be popular, well-known, or seem promising, campus leaders should determine whether it has strong empirical or theoretical support and addresses the specific problems of students on their campus.

The research on mental health promotion and prevention for adolescents and young adults, in both the college and non-college populations, is limited. The online Best Practices Registry (BPR), a collaboration of SPRC and the American Foundation for Suicide Prevention (AFSP) is one helpful tool. The BPR provides information about three categories of practices: (1) those that have been reviewed for the quality of the scientific evidence to support their use; (2) consensus statements that summarize the best knowledge in the field in the form of guidelines or protocols; and (3) programs and materials that have been reviewed by experts and determined to adhere to current program development standards and recommendations.

An evidence-based program may not exist for certain identified needs, target populations, and/or campus cultural contexts. In this case, campus planners can get assistance in several areas. A fundamental principle in developing any new program is to base the program content and process on health behavior change theory, which attempts to explain and predict health behaviors. Planners should look at what has worked in other areas of campus health promotion, such as the prevention of high-risk alcohol use or violence prevention. Best practices in these two areas of campus health and safety highlight the environment as an influence on individual behavior, and approaches developed in those fields can inform mental health promotion and suicide prevention efforts. Programs tested in community settings can also be adapted to the campus environment.

14.4.4 Select or Develop Programs

Regardless of the source of program ideas, planners should choose programs based on the likelihood that the activities, policies, messaging campaigns, or other interventions will achieve the defined goals and objectives.

As with any area of campus health and safety, many campus teams find it useful to create a “logic model”, a diagram illustrating how each planned activity will contribute to their long-term goals (e.g. reduce mental health problems, suicidal behavior, and suicide) [11]. By using a logic model, campuses can articulate how and why each activity will result in specific outcomes, increasing the likelihood that these outcomes are achieved. There are several logic model formats planners can use as a guide, including the one shown in Figure 14.2.

The term *inputs* refers to the investment of resources in the program (e.g. staff time, volunteers, and funds). *Activities* are the actual programs to be implemented, such as a training, screening program, or awareness campaign. *Outputs* refers to the number of activities or the level of activity achieved. If the activity is a communications campaign, for example, then outputs might be the number of public service announcements (PSAs) aired, the number of brochures distributed, and the number of students exposed to the message [22].

Short-, intermediate-, and long-term outcomes are the attitudes, knowledge, skills, and behaviors that are expected to change as a result of inputs, activities, and outputs.

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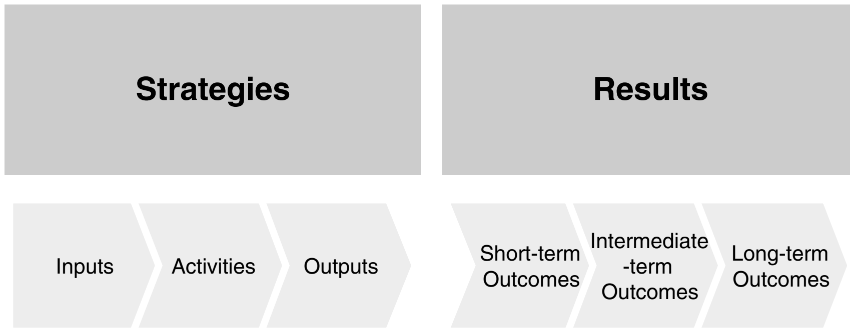

Figure 14.2 *Logic model format. W.K. Kellogg Foundation (2004) Using Logic Models to Bring Together Planning, Evaluation, and Action: Logic Model Development Guide, W.K. Kellogg Foundation, Battle Creek, Michigan; University of Wisconsin-Extension (2009) Enhancing Program Performance with Logic Models. Online self-study module accessed 19 June 2009 at http://www.uwex.edu/ces/lmcourse/.*

There should be a *logical* connection between program activities and desired results [11].

14.4.5 Develop an Evaluation Plan

To be most effective and useful, the evaluation should be planned as the program is being developed [11], with the logic model as a foundation. Including a professional evaluator – perhaps a faculty member in public health, health education, psychology, or social work – on a project team helps to ensure that outcome-based thinking is an integral part of the project's design and implementation [23].

There are myriad reasons to evaluate campus programs, including to:

- Add to the body of knowledge about which interventions work.
- Show that programs are achieving their intended outcomes, thereby demonstrating that campus resources are being used wisely.
- Determine whether a program was implemented as intended and provide information to revise and improve its quality.
- Communicate successes to key stakeholders and senior administrators.
- Attract long-term financial support for programs.

14.4.6 Create an Action Plan

Given the expectation that no single program will reduce risk and provide protection for mental health problems and suicide, campus planners will need to integrate a somewhat complex set of interventions to make an impact. To stay on track, campuses may want to create a detailed work plan that lists specific tasks, who is responsible for each, and a timeline for completing those tasks.

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14.4.7 Implement Programs, Evaluate, and Make Improvements

Following all of the previous steps should make it possible to implement high quality programs and allows planners to answer the basic questions that senior administrators and other stakeholders are likely to ask [24]:

- What activities were implemented?
- What were the strengths and weaknesses of the implementation?
- Was the program implemented as planned?
- Was the program implemented with quality?
- Was it effective?
- Should we continue the program?
- What can be modified to make the program more effective?
- What evidence proves that funders should continue to spend their money on this program?

Using a strategic planning process to adopt a public health approach helps to ensure that campus efforts will be effective in addressing student mental health problems. When selecting interventions, as described in 14.4.3, colleges should include a continuum of programs that address multiple levels of the social ecological model. Having a combination of activities, policies, and interventions working together is more likely than any single intervention to produce results and sustain mental health promotion, prevent and treat mental health problems, maintain mental wellness, and prevent suicide over time.

14.5 Strategies for Promoting Mental Health and Preventing Suicide Among College Students

To guide colleges in developing a campus-wide, public health approach, TJF and SPRC have formulated a *Comprehensive Approach to Suicide Prevention and Mental Health Promotion* that comprises seven strategic areas for intervention (see Figure 14.3). Each strategic area is discussed in detail below.

This comprehensive approach is drawn primarily from the overall strategic direction of the United States Air Force (USAF) Suicide Prevention Program, a population-based strategy to reduce risk factors and enhance protective factors for suicide. The program components included: commitment of Air Force leadership to suicide prevention and communication about this commitment throughout the ranks; efforts to strengthen social support and promote the development of adaptive coping skills; training non-health professionals in identifying and referring at-risk individuals; and changing policies and norms to encourage effective help-seeking [25].

By implementing eleven initiatives and policy changes, the program reduced the rate of suicide among USAF personnel by 33% during the first 5 years of the program [26]. The program also reduced homicides by 51% and accidental deaths by 18% [26]. In short, "[as] a "model of cultural change', the Air Force prevention program potentially serves as the first demonstration of the relevance of Rose's Theorem for preventing suicide: improving overall

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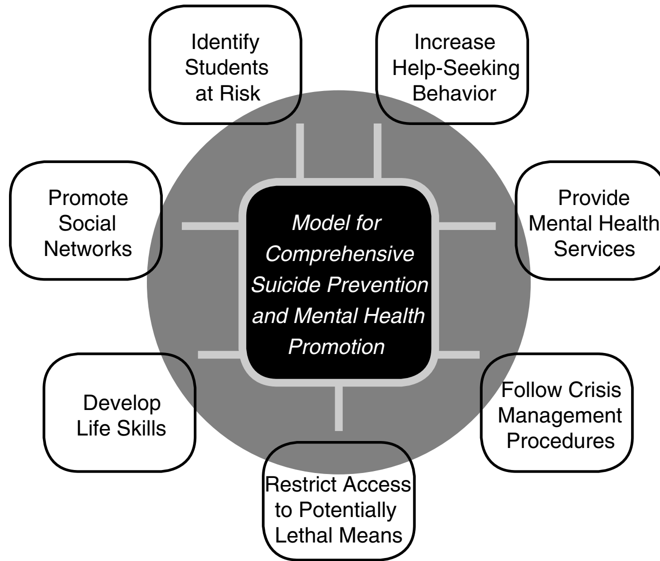

Figure 14.3 *Comprehensive approach to suicide prevention and mental health promotion. Silverman, M.M., Locke, J., Davidson, L. (2007) Using a campus task force to develop a comprehensive, strategic approach to mental health promotion and suicide prevention. Presentation delivered at National Association of Student Personnel Administrators Mental Health Conference, Houston, TX January 12, 2007.*

community mental health can reduce the events of suicide more effectively than extensive efforts to identify the imminently suicidal individual' [27].

In addition to drawing on lessons from the USAF program, the TJF/SPRC approach is also based on decreasing risk factors and increasing protective factors for mental health and suicide among adolescents, college students, and the general population; an understanding of the student mental health problems that campuses face; and existing best practices.

While some examples of programs that fall under each strategic area have been provided below, campuses are encouraged to implement programs that are appropriate to their campus-specific problems. Campus planners are cautioned to ensure that adequate institutional capacity exists and that linkages to community services are in place before they create programs that will significantly increase the number of students seeking services (see p. 243 for a bulleted list of critical capacities).

14.5.1 Promote Social Networks That Reinforce a Sense of Community on Campus and Strengthen Social Relationships Among Students, Faculty, and Staff

In both the general and college student population, research has consistently shown that loneliness and isolation are risk factors for suicide, suicidal behavior, and mental health problems, while supportive social relationships serve as a protective factor against these outcomes [4,6,7]. In adolescents, feeling connected to their school is also protective against suicidal thoughts and behaviors [28]. The CDC considers "connectedness" to be so critical

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that its 5-year strategic direction for preventing suicidal behavior is focused on "building and strengthening social bonds within and among persons, families and communities" [p. 1].

According to one study, experiencing a higher quality of social support is more protective than having a large number of social contacts [6]. For example, students who perceived a higher quality of social support were less likely to be depressed, anxious, or suicidal, independent of how frequently they interacted with their social contacts [6]. Notably, certain subgroups of students reported lower quality of social supports including men, Asian/Asian-American students, those who classified themselves as being in "multiple" racial/ethnic categories, international students, and those with financial problems [6].

Efforts to facilitate social connection should go beyond simply encouraging individual students to "get involved". For example, many campuses have developed smaller "living and learning communities", where students have the opportunity to live with other students who share their interests and have increased interactions with faculty outside the classroom. Other schools have dedicated space in their student unions or equivalent for specific groups (e.g. international students) to meet and socialize together.

14.5.2 Help Students Develop Skills to Face Life Challenges in College and Beyond

Table 14.4 lists some of the key life skills that students should be developing or refining during their time in college. Whether or not students have these skills can either confer protection against or increase the risk for suicide and mental health problems (see Table 14.3). In the college population specifically, relationship difficulties and financial problems have been identified as risk factors for both depression and suicidal behavior [5,20]. Even so, one survey found that 40% of seniors say that their college or university does not place much importance on helping them cope with non-academic life [29].

Since the college experience serves to develop more than just the intellect and professional skills, colleges are increasingly making efforts to foster the development of necessary life skills in all students. For example, programs for first-year students, sometimes in the form of a semester-long course, are now offered by hundreds of campuses. Many campuses also offer health education workshops around developing a variety of life skills.

Table 14.4 Examples of critical life skills
Interpersonal communication/human relations
• Establishing and maintaining relationships
Physical fitness/health maintenance
Problem solving/decision making
• Assessing and analyzing information
• Identifying and solving problems
• Setting goals
• Managing time
• Resolving conflicts
Identity development/purpose in life
• Developing awareness of personal and emotional identity
• Maintaining one's self esteem
• Clarifying values
• Developing meaning of life

Picklesimer, B.K., Miller, T.K. (1998) Life-skills development inventory-college form: An assessment measure. *Journal of College Student Development*, 39(1), 100–110.

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In addition, campuses should consider how day-to-day experience itself offers students opportunities to develop their ability to cope with and respond to an array of challenges. Students frequently encounter situations where they can learn adaptive ways to negotiate conflict, solve problems, or handle financial responsibilities. The expectations for how students will behave academically or personally, and the consequences for not meeting these expectations, may have an even more profound effect on developing students' life skills than formal workshops and courses.

An increased focus on life skills development may also ease the burden on counseling centers. Providing students early assistance with life problems may prevent them from becoming acutely distressed and experiencing depression or anxiety at the level that would require mental health treatment. This type of assistance can be provided by non-clinical staff such as health educators, student affairs staff, or financial services staff.

14.5.3 *Identify Students Who May Be at Risk for Suicide, Have Untreated Mental Health Problems, or Exhibit Early Signs of Mental Health Problems*

Research on the college student population has shown that many students who need help do not, for a variety of reasons, seek it out on their own. For example, according to one study, 36% of students who screened positive for major depressive disorder had not received medication or therapy during the past year [2]. Therefore, the responsibility for identifying students at risk cannot fall only on the shoulders of campus mental health professionals. On a daily basis, more students come in contact with student personnel staff, residence hall staff, academic deans and advisors, faculty, campus clergy, coaches and cafeteria workers than with counseling center staff. Every member of the campus community can help to identify and refer a student in distress to the people best able to help that student.

Campuses are using a variety of methods to identify and reach out to at-risk students including:

- Asking questions about mental health on medical history forms completed by incoming first year students to identify high-risk or potentially high-risk students and encourage help-seeking.
- Participating in screening activities such as Screening for Mental Health's College Response program (http://www.mentalhealthscreening.org/college/), which includes National Depression Screening Day.
- Screening students for symptoms of depression or other mental health problems when students seek primary care services [30,31].
- Creating an interface between the disciplinary process and mental health services in order to identify students who may need treatment and promote help-seeking.

Gatekeeper training (GKT) is perhaps the most common campus program designed to identify and refer students in distress. The term is used to describe a range of activities from a one-hour presentation on the warning signs for suicide to an 8-hour skills-based workshop where attendees participate in role plays.

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Syracuse University's *Campus Connect* gatekeeper training, created specifically for college campuses, is a 3-hour experientially-based crisis intervention and suicide prevention training program for resident assistants (RAs) [32]. After the training, RAs reported an increase in their ability to connect to students in crisis, comfort in asking students about suicidal thoughts, and ability to help distressed students to find available resources [32]. The program evaluation also found that the RAs demonstrated significant improvement in their suicide intervention skills [32]. Of course, campus staff must state clearly the expectation that student gatekeepers are not meant to provide counseling and other assistance that health and mental health professionals are trained to do offer. The aim is for students to help their peers access those services.

It is important to be realistic about the desired outcomes from a GKT program before designing one. For example, a recent study assessed the impact of providing a GKT program to staff at middle and high schools in Georgia [33]. After one year, trained staff members were no more likely than non-trained staff members to ask students about suicide or refer them for help, even though trained staff members had demonstrated significantly improved gatekeeper knowledge, preparedness, and efficacy over non-trained staff members [33]. In fact, the program was found to benefit only those staff that were asking students about their distress or thoughts of suicide prior to the training [33]. Short-term goals related to gains in knowledge and confidence are appropriate, but the end result of GKT should be increased referrals, help-seeking, and utilization of appropriate services [34].

Another method of identifying students at risk is the use of a case management team, also known as a student-at-risk response team or a behavioral intervention team. A case management team "promotes information-sharing and coordinated action to address students who may be in distress or at risk for harming themselves or others" [35]. Key members generally include representatives from student affairs, health services, counseling center, residence life, disabilities services, campus security, and campus legal counsel [36].

A case management team differs from a planning task force, which creates and implements a campus-wide plan for addressing the mental health and wellness of all students [35]. A case management team also differs from a threat assessment team, which assesses threats of violence toward others and includes members with appropriate expertise in this area [35]. The three types of groups may have overlapping membership and, on small campuses, be less formal [35]. Nevertheless, it is important for each group to have a clear mandate that differentiates its purpose and methods [35].

14.5.4 Increase the Number of Students Who Seek Help for Emotional Distress

The process of help-seeking is complex with many possible factors influencing whether or not someone takes steps to get help. For example, one model breaks down seeking treatment into four related steps: acknowledging that one feels badly enough to need treatment and that the problem is a medical or mental health one; deciding to get help and from whom; getting treatment; and deciding to continue treatment [37]. When designing programs to increase student help-seeking, campuses should seek to understand the barriers and facilitators to students taking each of the four steps listed above. Eisenberg and colleagues [2] found that predictors of college students not receiving care include not perceiving a need, being unaware of available mental health services or insurance coverage, skepticism about the effectiveness of treatment, low socioeconomic (SES) status growing up, and identifying as Asian or Pacific Islander.

The research data as to whether stigma prevents college students from seeking help is limited and the findings are inconsistent [38]. For example, one survey found that while 50%

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of college students would encourage a friend to seek help for emotional issues, only 22% would seek help themselves [39]. Almost 60% of students in another study thought that people would see someone in a less favorable light if they knew that the person had been in treatment for psychological problems [38]. This same study found that perceived public stigma, "the extent to which an individual perceives the public to stereotype and discriminate against a stigmatized group", ([38] p. 392) is higher among men, older students, Asian or Pacific Islanders, international students, students with current mental health problems, those without family and friends who have used mental health services, students with low SES backgrounds, and students who do not think treatment is effective [38]. However, among students with probable depression or anxiety disorders, perceived stigma was not associated with whether or not the students sought treatment [38].

Multiple studies have shown that students go first to friends, family, or a significant other when they are struggling, rather than seeking professional help [1,20,37]. Understanding the reasons for this *on a particular campus* will help program planners better address their students' barriers to help seeking. Many schools have instituted peer counseling or peer education programs to take advantage of students' willingness to talk to their peers. Active Minds, a national peer-to-peer organization dedicated to raising awareness about mental health among college students and encouraging students to get help, has chapters on approximately 200 campuses (www.activeminds.org).

Campuses are engaging in a variety of activities designed to increase the likelihood that a student who needs supportive services or counseling will seek out and secure assistance. The Interactive Screening Program developed by the American Foundation for Suicide Prevention targets students who may be reluctant to seek traditional psychological services but who may respond to offers of anonymous assessment and counseling via the internet (www.afsp.org). ULifeline, TJF's online resource, provides an anonymous screening tool and information about campus resources (www.ulifeline.org).

Many campuses are also using communication campaigns that include brochures, posters, and a variety of web-based content to increase help-seeking. Prior to creating a campaign, campuses should embark upon a strategic planning process, using campus-specific data if possible, to focus the campaign goals and identify specific target audiences. The National Cancer Institute's *Making Health Communication Programs Work*, also known as the "pink book", is one of the best resources available to guide health communication planning and evaluation (http://www.cancer.gov/pinkbook).

Several national campaigns, targeting the general public or college students specifically, promote student help-seeking behaviors and attempt to reduce the stigma associated with mental health issues. One example is TJF's Half of Us campaign, which features public service announcements, personal stories from students and high-profile artists, and information about different mental health problems (http://www.halfofus.com/). Other examples include SAMHSA's Campaign for Mental Health Recovery, which aims to decrease negative attitudes surrounding mental illness by encouraging young people to support friends with mental health problems (http://www.whatadifference.samhsa.gov/).

14.5.5 Restrict Access to Potentially Lethal Means of Self-Harm and Suicide

An individual's intention is only one factor in whether he or she attempts suicide. The availability and acceptability of various methods of self-harm and the attempter's knowledge about how lethal different methods may be also play a role in the decision.

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In the general population, guns are the most lethal means of suicide, resulting in a fatality rate of more than 90% compared to a 3% fatality rate for suicide attempts by drug overdose [40]. One reason the rate of suicide among college students is only half the rate of same-age peers who are not in college [41] may be that firearms are not allowed on the vast majority of campuses. For college students who die by suicide, firearms and overdose are the most commonly used methods [41]. In a study that asked students who had thought about attempting suicide what method they considered using, 51% of students named overdosing but only 15% named firearms [20].

Researchers have investigated the possible effect of alcohol availability on suicide. Between 1970 and 1990, the suicide rate of 18–20-year-old youths living in states with an age-18 minimum legal drinking age was 8% higher than the suicide rate among 18–20-year-olds in states where the drinking age was 21 [42]. Researchers estimate that lowering the drinking age from 21 to 18 in all states could increase the number of suicides in the 18–20-year-old population by approximately 125 each year [42]. Alcohol abuse may facilitate suicidal behavior by promoting depression and hopelessness, impairing problem solving, and facilitating aggression [43]. In studies of deaths by suicide, alcohol use was a proximate risk factor – found to be present in more than 50% of deaths [44].

Limiting students' access to sites, weapons, and agents that may facilitate their ability to harm themselves or others are all methods of means restriction. Specific efforts may include restricting access and/or erecting fences on roofs of buildings, replacing windows or restricting the size of window openings, restricting or denying access to chemicals like cyanide that are often found in laboratories, prohibiting guns on campus, and reducing consumption of alcohol and other drugs (e.g. enforcing underage drinking policies).

The specific setting of the campus can influence the type of means restriction needed, so each campus should do an "environmental scan" for potential access to lethal means. One campus is working with facilities management, the campus safety committee, and student groups to review institutional and national data about the most common means used in suicide attempts and studying other colleges" firearms policies. The campus is also conducting an inventory of toxic chemicals, including reviewing policies for their storage, and surveying buildings to identify where students have access to high places. Since hanging was a method that students had been most likely to use in prior suicide attempts, the campus group researched break-away clothes rods for residence hall closets.

Colleges and universities wishing to conduct an environmental scan can find guidance on the web site of the *Means Matter Campaign*, a national effort to reduce access to lethal means. The "Taking Action" section of the web site includes recommendations for colleges and universities provided by the Suicide Prevention Resource Center (http://www.hsph.harvard.edu/means-matter/recommendations/colleges/index.html).

14.5.6 Develop Policies and Procedures That Promote the Safety of all Students on Campus and Guide the Response to Campus Crises

When a student is acutely distressed or suicidal, it is important that clear protocols are in place for addressing the crisis. It is also critical that all of the administrators and staff who have a role in addressing the needs and safety of the student and the campus community understand what actions they are expected to take.

TJF's *Framework for Developing Institutional Protocols for the Acutely Distressed or Suicidal College Student* [18] provides a blueprint for campus officials to use in developing

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or revising crisis procedures in three key areas: safety, emergency contact notification, and leave of absence and re-entry. With the proliferation of "threat assessment" and other emergency preparedness procedures, administrators should ensure that all protocols are appropriately linked but that efforts to address suicidal behavior and other mental health problems do not suggest that mentally ill students are a threat to the campus community.

Crisis procedures should also include a comprehensive "postvention" program designed to help students deal with their grief and confusion, and prevent suicide contagion, following the death of a student by suicide. Postvention involves coordinated, rapid outreach to help specific students and the entire community, which may involve "community support meetings" to facilitate the grieving and recovery process [45].

Campus-wide dissemination of state or local 24-hour hotlines, plus the National Suicide Prevention Lifeline (800-273-TALK), is also a critical part of every campus crisis management effort. In addition, colleges should ensure that all faculty and staff understand the laws and professional guidelines that can affect decision-making around students at risk. One resource is TJF's *Student Mental Health and the Law: A Resource for Institutions of Higher Education* [35]. This report provides guidance in the following areas: privacy and confidentiality, disability law, delivering mental health services, and liability for student suicide and violence. The document also contains related good practice recommendations. (Chapter 7 provides discussion of legal issues in college mental health.)

14.5.7 Increase Student Access to Effective Mental Health and Other Support Services

Although the counseling center is central to providing treatment to students with mental health problems:

> [students] from cultures that do not understand or acknowledge mental illness, or that discourage revelations of personal problems, are not likely to seek services, so colleges need to develop creative approaches to respond to those students in ways that they will find helpful and nonthreatening [46].

These students may seek help at health services or from a tribal elder, cultural healer, clergy, academic advisor, or staff member in international services or student culture centers.

Many campuses are collaborating with both on- and off-campus religious leaders to ensure that students receive appropriate and helpful services and clergy members know how to assess suicide risk. Engaging in activities that fall under all six strategic areas discussed above is critical to ensuring that these students do not fall through the cracks.

Other students may be experiencing "life" problems that, if left unresolved, could put them at risk for a mental health disorder or suicide. For example, in one study, 59% of students who had seriously considered attempting suicide during the past year reported romantic relationship problems as having a large impact on thinking about the attempt [20]. Efforts should be made to help those students who have experienced a recent loss, such as an important relationship, as a potential way to prevent the development of depression or suicidality. Similar logic can be applied to helping students experiencing other stressors, such as academic difficulties.

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As stated earlier, the counseling and/or health center plays a critical role in providing treatment to students who need it. Although many campuses express the need to hire additional counseling staff, "simply adding more therapists isn't always the best way to improve access to high-quality services" [46]. Approaches campuses can employ to meet service demand while using existing staff and resources more efficiently while strengthening service delivery include:

- Instituting brief, same-day appointments by phone or in person for quick assessment and referral to either campus or community providers based on established criteria [47].
- Offering four-session psycho-educational groups – sometimes called "Feel Better Fast" – for students who may not need more intensive therapy [John Hoeppel, personal communication].
- Ensuring that mental health clinicians are adequately trained to:
  - Accurately diagnose students and provide appropriate treatment or referral
  - Use goal-oriented, time-limited treatment modalities
  - Assess and manage suicide risk
  - Follow laws and professional guidelines that govern student privacy and confidentiality.
- Partnering with wellness/health promotion staff who can assume outreach duties.
- Complementing campus resources with longer-term treatment services available in the community.

Treatment services should be viewed within the context of the continuum of campus-wide efforts toward promotion, prevention, treatment, and postvention. Counseling centers should consider a stepped care model frequently employed to address many behavioral health issues including the reduction of college student alcohol use [48,49]. The premise of stepped care is to provide the most effective yet least resource-intensive intervention first [50]. For some students, a "minimal intervention" will be enough, while others will need to "step up" to increasingly more intensive levels of care. For example, a mailed intervention providing students with personalized feedback and information about their symptoms for depression was inexpensive to implement yet reduced depressive symptoms and feelings of hopelessness [51]. Of course, criteria must be carefully crafted to facilitate decision making about which students need more intensive care [49].

14.6 Conclusion

Untreated mental illness on the nation's campuses is problematic. An increasing number of institutions of higher learning are correctly taking the position that treatment alone is not the answer and asserting that the burden of solving student mental health problems should not be solely on the shoulders of the college mental health service or counseling center.

An approach that focuses solely on getting more students into treatment, no matter how effective the services, relies on the flawed assumption that counseling centers will be

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provided the resources to support an expanding number of students seeking care. Student mental illness is a public health problem, and promoting the mental wellness of students is the responsibility of everyone on campus.

Changing how administrators respond to student mental health problems requires a paradigm shift much like the one that campuses have experienced regarding alcohol and other drug prevention during the last 20 years. We must go beyond simply providing education and treatment services by adding efforts to prevent mental health problems from arising and promote the mental health of all students.

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