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## Suicide Risk and Ideation within Higher Education

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### **Introduction**

*The American Psychiatric Association reports that suicide is the third leading cause of death for persons fifteen to twenty-four years of age (APA, 2009). Even more frightening, the Jed Foundation reports that suicide is the second leading cause of death for college-aged students (The Jed Foundation, 2010). Sadly, these population groups are highly susceptible to depression and other mental health ailments. Higher education policy makers and university administrators should make it a priority to increase access to mental health services and expand understanding for the growing mental health needs of college students. Without raising awareness, developing interventions, and effectively addressing the social problem of suicide within higher education, the mental and physical well being of college students may be jeopardized during this critical adjustment period in the life course. Therefore, in light of current initiatives, it is proposed that more needs to be done on both systemic and social work practice levels in higher education to reduce barriers and expand current service models for student needs.*

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### **Literature Review**

Within the higher educational context, adjusting to a college environment and undergoing a significant life course transition may be challenging for some students. College students encounter a variety of biopsychosocial, environmental, and/or sociocultural factors, which could increase risk for developing depression, anxiety disorders, substance abuse, and suicidal behaviors (SPRC, 2001). Specifically, increasing autonomy from parents/guardians, relocating nationally or internationally, having disruptive sleep habits, learning to time-manage responsibilities, developing social networks, and experimenting with drugs, alcohol, and sex are just a few possible transitioning factors that may negatively impact student mental health. Other suicidal risk factors identified by Paladino & Minton (2008) include “low self-esteem, student stress, depression, loneliness, hopelessness, academic problems, relationship and family issues, financial concerns...” (p. 643).

Moreover, some individuals may have a genetic predisposition for a mental health disorder or a preexisting mental health diagnosis, which in combination with psychological and environmental factors heightens suicide risk (NAMI, 2009). Universities are seeing an increase in incoming students with previous mood disorder diagnoses. The National Center on Addiction and Substance Abuse at Columbia University reports that, "due to the increased availability and efficacy of psychoactive medications, students with pre-diagnosed mental illnesses are entering college in higher numbers (CASA 2003, p.10-11). As further support, in 2006, a social worker at the University of Michigan estimated that, "30% to 40% of students seen at the University of Michigan counseling center are already taking antidepressant medications," (Sisk, 2006). These reports are not surprising, considering that the 2004 National Survey on Drug Use and Health, "estimated 14 percent of youths aged 12 to 17 (approximately 3.5 million youths) had experienced at least one major depressive episode (MDE) in their lifetime," (NSDUH, 2005).

Research has also identified diverse student populations of interest in regards to suicide and help-seeking behaviors. For example, in a report produced by the Suicide Prevention Resource Center, lesbian, gay, and bisexual youth (defined as 15-24 year olds) were identified as being, "nearly one and a half to three times more likely to have reported suicidal ideation than non-LGB youth," (SPRC, 2008, p.5). Some of the specific risk factors identified for this community include, but are not limited to, victimization, lack of familial support, psychosocial stressors affiliated with one's sexual orientation identity, substance abuse, and previous suicidal attempts (SPRC, 2008). Additionally, the Centers for Disease Control and Prevention reports that suicide is the third leading cause of death for African Americans between the ages of fifteen and twenty-four (CDC, 2005). The fear of possessing a mental health stigma is thought to be a critical barrier, preventing some African Americans from seeking necessary mental health services (Walker et al., 2006). Similarly, Shea & Yeh (2008) studied how cultural values, stigmas, and attitudes toward mental health can affect Asian American students and their help-seeking behaviors. Specifically, they found a difference across males and females where, "Asian males in general have more negative attitudes than Asian females toward seeking professional help," (Shea & Yeh, 2008, p. 169). Shea and Yeh (2008) speculate that this difference may be a result of culturally constructed gender roles around expression and disclosure of emotion. Lastly, student

veterans also have recently been identified as a growing population across universities, with specific needs for dealing with combat, reintegration, and Post Traumatic Stress Disorder (PTSD) issues (Half of Us, 2008). Without the proper mental health services available to them in a university setting, reoccurrences of untreated heightened anxiety, stress, and flashbacks could put them in a downward spiral.

The purpose of the above overview is to illustrate that suicide and help-seeking behaviors are prevalent issues across diverse student populations. The presentation of suicide risk factors and affected student populations within a higher educational context is by no means exhaustive. Nevertheless, it is important to present a few barriers to mental health services within university environments and how these barriers could impact student mental health. As previously presented, the fear of possessing a mental health stigma is one barrier to seeking mental health services for students. The National Mental Health Awareness Campaign reports that “over 2/3 of young people do not talk about or seek help for mental health problems,” (NMHAC, 2009). Self-disclosure of suicide ideation and/or needing mental health services is a second barrier closely tied with the fear of being stigmatized. Morrison & Downy (2000) found that in particular, “ethnic minority clients may not self-disclose suicidal ideation as readily as Caucasian clients in the counseling setting,” (p. 383). Moreover, some college campuses have utilized (and revised) mandatory absence policies and sanctions against students who disclose their suicidal ideation, which could deter some students from seeking treatment (Associated Press, 2006). Lastly, within the counseling setting, Sue & Sue (1977) discuss how language variables, class-bound values, and culture-bound values can inhibit effective cross-cultural counseling, indicating the need for culturally competent counseling practices.

So what are universities doing to safeguard their students from succumbing to suicide and suicide ideation in the face of barriers to mental health services? First, universities across the nation are working towards increasing awareness of mental health issues and reducing stigmas on campus. Approaches vary across schools on how this initiative is achieved. On a grand scale, the University of Michigan Depression Center annually hosts a national conference, which is open to students, faculty/staff, and clinical professionals who are interested in collaboratively addressing college depression (UMDC, 2009). Additionally, more than 1,200 universities and colleges have teamed up with the Jed Foundation to

promote *ULifeline*, an online resource center for college students that provides a self-assessment questionnaire and information on suicide prevention and mental health issues (ULifeline). On a smaller scale, many individual universities support a variety of student organizations that address mental health issues. These universities sponsor a variety of suicide prevention workshops and awareness weeks to continuously work towards improving student outreach.

Second, research has been conducted on how to reach, assess, and encourage students at risk for suicide to seek help. A recent study illustrates the promising approach of utilizing an interactive web-based method of outreach for potentially at risk students. Haas et al. (2008) developed a web-based questionnaire that assessed and scored the mental health and suicidal behavior for 1,162 students across two universities. Submitted questionnaires went to counselors at the respective schools to evaluate student responses and to initiate web dialogue with each student regarding their online assessment and services available to them. The goal was to encourage students to either keep an open web dialogue with the counselor or to come in for an in-person evaluation and possibly treatment. Nearly half (49.2 percent) of the participants were assessed as “high risk for suicide,” compared to 35.2 percent for “moderate risk,” and 15.6 percent for “low risk” (Haas et al., 2008). Fortunately, “high risk students were the most likely to engage in dialogues...” (Haas et al., 2008, p. 17). Furthermore, the research shows that for the “high risk” or “moderate risk” sample groups, the students who did engage in online dialogues with a counselor (compared to those who did not), were 37.7 percent more likely to seek an in-person evaluation (Haas et al. 2008). Moreover, 13.5 percent of these students ultimately entered treatment (Haas et al., 2008). Even though this intervention model has not been tested against a control group, it still sheds promising light on a new innovative way to reach out to students in future practice.

Third, in terms of addressing mental health barriers due to mandatory absence policies and sanctions, many universities have begun to reconsider their stance on the issue of suicidal ideation and behavior. This is partly attributed to the 2002 lawsuit, *Shin v. MIT* and the Department of Education’s Office of Civil Rights stance that, “eviction or imposition of mandatory leave of absence for self-injurious thoughts or behavior violates Section 504 [rehabilitation act of 1973, precursor to Americans with Disabilities Act]” (Disabilities Law Practice, 2006). For example, the state of

Virginia is the first state to outlaw “public colleges and universities from punishing or expelling students ‘solely for attempting to commit suicide, or seeking mental-health treatment for suicidal thoughts or behaviors,” (Smith & Fleming, 2007). Even though there is no national law imposed on mandatory absences, individual colleges such as Hunter College, Bluffton University, and Massachusetts Institute of Technology (MIT) have worked towards reforming policies and developing additional accessible mental health resources for their students (WIHE, 2006).

Finally, from a clinical perspective, a relatively new proposal for identifying and assisting students with suicide ideation is the utilization of Paladino’s & Minton’s (2008) comprehensive college student suicide assessment tool. Paladino & Minton (2008) proposed applying Arnold Lazarus’s multimodal BASIC ID to a suicide assessment framework. The BASIC ID model is an acronym for behaviors, affect, sensation, imagery, cognitions, interpersonal relationships, and drugs or biology. Paladino & Minton (2008) illustrate how each component of the BASIC ID model may provide insight into a student’s risk of suicide and suicide ideation. For example, under *behaviors*, they discuss how feelings of hopelessness or depression may be risk indicators, which ties nicely into their discussion of *affect* and correlations of depression and suicidal thought/ behaviors. For *sensations*, they identify physical symptoms of suicidal ideation ranging from nausea, headaches, fatigue, rapid heartbeats, and muscle tensions. In terms of *imagery*, they argue that it may be difficult for someone who is in a crisis state to formalize safe imagery when *cognitions* are clouded or disoriented. Additionally, regarding *interpersonal relationships* and *drugs or biology*, Paladino & Minton (2008) suggest that, when perceiving lack of support from family or friends, alcohol, drugs, dieting, or exercise patterns may drastically change (Paladino & Minton, 2008). Overall, the researchers argue for a holistic approach to assessing student suicidal ideation in combination with post-assessments and safety plans that provide follow-up supportive services.

Four different models for identifying and assisting students at risk for suicide and/or suicide ideation were presented. These models encompass large-to-small scale information campaigns, a promising innovative outreach approach to reaching at risk students through a web-based questionnaire, university policy over suicide ideation and behavior within a university environment, and a clinical approach to screening and assessing suicide risk. Although not all current models could be

adequately presented, these four examples illustrate positive strategies for reducing student barriers to mental health and mental health services across a variety of realms. However, it is important to note a few of the gaps that still currently exist in service models and resources.

Mental health advocates and university administrators still face an ongoing battle of reducing stigmas around mental health and mental health services. Even if students see past the stigmas, administrators are still competing against years of engrained negative attitudes towards mental health in a variety of cultures, societies, and upbringing (Progressive U, 2007). Moreover, students need to feel that they can turn to their university support networks for help without facing repercussions for disclosing their mental health issues. Without a national stance on university mandatory absence policies, some students may have the privilege to safely seek out mental health services, while others remain untreated out of fear of expulsion. For some students, the lack of equal treatment across higher education institutions on mental health issues only reinforces the barriers to seeking mental health treatment.

Furthermore, none of the approaches presented even addressed the increase in the number of incoming students with pre-existing mental health concerns. Clearly, there is a bridge within the educational realm between secondary and post-secondary schooling approaches to mental health. Collaboration and understanding of the various factors that may influence student mental health across educational realms *could* have major implications for higher education mental health services, as well as on both an individual and broader level. Regarding clinical practice gaps, more extensive work is needed to ascertain whether or not specifically the research of Haas et al (2008) and Paladino & Minton (2008) are effective tools for identifying and assisting student needs on larger scales. Lastly, developing more long-term mental health services for students is needed, rather than just solely focusing on short-term crisis intervention services.

### **Social Work Implications**

Currently, there is no single fixed model for addressing suicidal risk and ideation in the higher education setting. Models can take a variety of approaches ranging from a legal, clinical, or educational perspective. Ultimately, it seems there is a “trial and error” stance in discovering what is effective and ineffective for working with students who have mental health needs. Therefore, on a systemic level, it is proposed that the U.S.

Department of Education takes a national stance on higher education mental health policy. Mandating equally available services and university suicide policies to all college students across universities will help to offset the inequality of services that currently exist. It is also proposed that an increase in federal money be allocated to researchers to develop large scale effective suicide prevention, education, intervention, and assessment models, with particular attention to diverse student needs. Lastly, education policy makers in general should collaborate to begin addressing stigma reduction around mental health in primary and secondary schooling. That way, if students experience mental health challenges in a university setting, they will have prior exposure to mental health services and hopefully will not be deterred from seeking help as a result of stigma.

Furthermore, it is important to present social work recommendations for those working within higher education. A number of universities provide short-term counseling, crisis intervention services, and referrals for enrolled students, including the University of Wisconsin-Green Bay, Minnesota State University Mankato, Northern Arizona University, and Texas A&M University. In these economic times, the lack of availability and accessibility to low-cost long-term mental health services may deter many students from seeking help. For some students and families, even a sliding scale rate may not be affordable. The consequences for not seeking out or receiving long-term treatment, as a result of poor access or financial constraints, are significant concerns that universities need to address. Therefore, higher education social workers should be change agents for college students. Social workers should advocate to universities and mental health policy makers for (1) more representation within higher education counseling centers to meet growing student needs and (2) for a service-delivery model that specifically provides long-term mental health services for enrolled students.

Also, as presented in the literature, there are language and cultural barriers to seeking mental health services. These same barriers can exist within the helper-client relationship within a higher education context. The National Association of Social Workers (NASW) declares that, "collaboration with consumers, families, and cultural communities is a precondition for creation of culturally and linguistically competent services, reasonable accommodations, interventions, programs, and policies," (NASW, 2009). It is proposed that higher education social workers continue to be mindful of cultural barriers of both domestic and



international students and present these barriers to those researching and devising service models for their clients. Ensuring that universities are appropriately staffed with bilingual professionals and/or translation services based on student body composition is also recommended. Lastly, it should go without saying that practicing cultural humility with clients is necessary in order to help foster safe and open spaces for treatment. Therefore, it is recommended that clinical professionals attend yearly workshops or trainings on cultural competency and diversity specific to suicide prevention.

### Conclusion

In conclusion, suicide and suicide ideation are prevalent issues across universities. Suicide does not just affect one specific population within higher education, but diverse groups. Approaches for disseminating mental health information to students vary, along with individual university stances on suicidal behaviors. Likewise, the lack of a single model for identifying and assessing student needs ultimately allows for innovative outreach, intervention, and assessment models. However, further empirical research is needed in order to determine the large-scale validity and effectiveness of the approaches presented. Ultimately, to combat rising suicide rates, systemic and social work practice change is needed within higher education. Universities need to keep working towards reducing mental health stigmas and barriers to encourage students to seek treatment. Higher education social workers should also advocate for more representation and long-term services in counseling centers, work towards reducing cultural and language barriers within the helper-client relationship, and practice from a cultural humility perspective. Only through collaboration and expansion on diverse service-modalities can society hope to reduce suicide and suicide ideation amongst college students.

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