SPRC • Suicide Prevention Resource Center

Promoting a public health approach to suicide prevention

SPRC Research to Practice Webinar Q&A with the Panelists
Promoting Help-Seeking Among College Students:
Strategies for Suicide Prevention

On May 22, 2014, SPRC hosted a "Research to Practice" webinar entitled, "Promoting Help-Seeking among College Students: Strategies for Suicide Prevention." The panelists generously agreed to respond to selected questions from people who attended the webinar and people who submitted questions on the SPRC Training Institute website. We hope that you find this information helpful in your suicide prevention efforts.

Research to Practice Panelists

Marilyn Downs, PhD, LICSV
Director of Outreach, Counseling and Mental Health Service, Tufts University

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Marilyn Downs, PhD, LICSW, Director of Outreach, Counseling and Mental Health Service, Tufts University, Medford, Massachusetts

How can I access the interactive, on-line suicide screening program that you mentioned?

The Interactive Screening Program (ISP) is a project developed by the American Foundation for Suicide Prevention (AFSP). You can find more information about that resource here: http://www.afsp.org/the-interactive-screening-program.

Did these programs start through a grant or private funding?

We received a Garrett Lee Smith grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) from 2008 - 2011. This funded our initial efforts, but we have sustained those by building them into existing programs and activities. For example, the depression screening in primary care, gatekeeper training (GKT), and the use of the film on our website and at first-year orientation have all become routine components of our outreach work. We decided early on to approach our efforts in this way, in order to ensure sustainability once the grant funding ended. (See below for more information specifically about GKT and depression screening.)

For your social norms campaign, did you use specific data (i.e. from Healthy Minds or NCHA) or did you use a general message?

We did a combination. We took data from the Healthy Minds Study (HMS) (collected every other year), the National College Health Association (NCHA) survey (collected in alternate years from Healthy Minds), referral source data (gathered at intake) and client satisfaction surveys and attempted to translate them to convey key messages. For example:

1) *"About half of Tufts students said that mental health difficulties hurt their academic performance in the last month" (HMS). This helps to make the point about problem prevalence and impact.*
2) *"More than half of students who sought Counseling came due to encouragement from others" (from both HMS and referral source data) was used to underscore the value of reaching out to assist someone who might be struggling.*

3) *Because we know that students in particular can worry that this type of reaching out will be too intrusive, we add this data point: "87% of students said they were glad that someone else reached out to check in with them and offer emotional support" (HMS Tufts custom question).*
4) *From other research: "Most people who have died by suicide showed some warning signs beforehand." In our GKT, this message precedes a brief film clip from a suicide attempt survivor who talks about wishing that someone else had reached out to him. Then we deliver the messages about warning signs, followed by specific skills in how to ask about suicide, etc.*
5) *Two examples used to convey messages about the counseling utilization and client attitudes: "1 in 4 Tufts students used counseling or mental health services in the past year" and "93% of students who used Tufts CMHS would recommend the services to a friend."*

Can you talk more about your specifically-tailored gate-keeper training? How similar is it to QPR?

We decided to design our own gatekeeper training (GKT) program for several reasons:

1) *We wanted something that was intended for a college population, as we felt there were unique aspects to this age group and context;*
2) *We wanted control over the message content and, at the time we were looking at QPR (in 2008), making content changes was not possible;*
3) *We felt it was important to have the content be specifically relatable to Tufts students. It's much more interesting for them to have the data and resources be about them, their peers, and their school;*
4) *We decided that we wanted to address a broad range of students and mental health. Like most campuses, there are many students we are concerned about reaching in addition to those with suicide risk -- such as those experiencing symptoms of psychosis or mania, eating disorders, interpersonal violence, drug and alcohol problems, etc. So we crafted the content to address this broader set of concerns and also included content specifically related to suicidal students. This tends to make it more compatible with our general outreach activities (orientations, peer leader*

training, etc.). I would be glad to provide a lengthier description about the rationale, objectives or content of our GKT, if people are interested.

Which tool did you use for the Universal Depression Screening?

Around the time we were funded by the SAMHSA grant, we also participated in the National College Depression Partnership developed by NYU. (You can learn more about that project here: http://www.ncdp.nyu.edu/about.) An important outcome of this was our adoption of a depression screening tool in our health service setting. We use the Patient Health Questionnaire (PHQ-9) and have the goal that every student who uses the Health Service will be screened once annually. There is also the PHQ-2 which is a briefer version often used in primary care settings. This two-question version has been shown to be extremely effective in identifying those with depression.

Health Service staff have been trained how to ask follow-up questions when there is a "positive" PHQ screen. We have also developed internal mechanisms for referral of students to counseling when there is a high score. We no longer participate in the campus Depression Screening Day activities, as we feel this universal screening tool is more effective at reaching and engaging many more students.

Key rationales:

1) *Many more students use the health service than use the Counseling Service;*
2) *Screening for depression as a routine part of health care communicates that mental health is part of overall health (which fits our "normalizing" message);*
3) *We can reach students who would not typically seek out counseling on their own.*

Some professors want a counselor to "cold-call" a student to inquire if they are suicidal. Do you have any recommendations on this?

At Tufts we have a variety of ways of trying to connect with students when there is some evidence of safety concerns, but this direct outreach ("cold calling") is not typically done by the Counseling and Mental Health Service (CMHS) unless the student asks for that (see below). We routinely train faculty and staff on how to ask these tough questions themselves, yet we know they don't always feel equipped to do so. If a faculty or staff member calls us for a consult, we try to assess whether they might be able to have an initial conversation with the student and would coach them on how to do this. This is not a "clinical risk assessment," but rather a

gatekeeper function. Depending on the evidence of risk, we might advise them on how to encourage a student to make an appointment with us (in the case of low risk). If they are in touch with the student (by phone or e-mail, or if the student is in their office), we might suggest they ask the student if they would like to speak with a CMHS clinician, in which case we can then arrange a call (including after-hours, using the on-call clinician). This is outreach from us, but it's not a "cold call." If there's more concerning data, we send the faculty/staff person to the Dean of Students, who will contact the student of concern and send them to us for a "required evaluation." Thus, CMHS is not mandating this appointment; the Dean is. We generally have very good luck engaging those students in treatment. Obviously, in the highest risk situation (student making a direct threat), we might bypass the dean and simply have the campus police transport the student either for an evaluation with us or directly to the hospital (depending on the situation).

Charlie Morse, MA, LMHC, Assistant Dean for Student Development & Director of Counseling, Worcester Polytechnic Institute, Worcester, Massachusetts

I am wondering how you interpret the phrase "academic support." That concept came up in various ways. Are you willing to share how academic support ties into help-seeking?

I interpret academic support to mean addressing the strategies, skills, and work habits inherent in being a successful student. Time management, study skills, organizational skills, work habits, test preparation, writing skills, etc. On our campus, this type of support is typically provided by our Office of Academic Advising, with whom we work very closely because mental health issues are often interfering with success. For instance, students may be struggling with time management due to motivational issues associated with depressive symptoms. Students may be missing classes due to anxiety/panic attacks or symptoms of Post-Traumatic Stress Disorder (PTSD). In light of this, I think it's very important for counseling and academic advising to have very close ties to promote referral and support help-seeking. With appropriate releases, these offices can work together and be instrumental in support of student success.

How do you select students to participate in the Student Support Network and receive training?

Students are both recruited and welcomed into SSN. Recruited students are typically student leaders and perceived helpers (the kind of people others just seem to go to) nominated for the training by others within the community. We also advertise the training and provide opportunities for students who are interested to join: No one is excluded from the training, if they are interested. It's important to remember these students are not peer educators or peer counselors: Once they're in SSN, they have no formal roles beyond being good friends who are more skilled at supporting their friends and helping them connect with professional resources when needed.

The program structure also allows us to track which networks we're tapping into (and missing) and to recruit specifically within those networks. For instance, early on we noted that we weren't having much success recruiting international students. In partnership with our office of International Students, we held a six-week training just for a group of international students and successfully tapped into this network.

If these students are trained and are "agents" of the counseling center, how do you deal with mandatory reporting issues?

SSN-trained students are not agents of the counseling center. As stated above they have no formal role after the training. They were already there in the community trying to support their friends; after the training they're better at it and better supported in it. They are not agents and there are no "mandatory reporting" requirements. Note though, a core part of the SSN training is to promote consultation when they're concerned about a friend, so we do encourage them to let us know of concerns, especially if there are any concerns about safety.

Are male students receptive to this training? How can we help get men more involved and empower them with the vocabulary to speak about emotional struggles?

Males have been very receptive to this training, though we have to work a bit harder to get them involved in the group. Fraternities have been an excellent source of men who are interested in talking about mental health topics, especially those in helping roles such as risk manager or house chaplain. I think our approach is appealing to men. We talk about mental health topics and supporting others in very practical terms.

What incentives are used to recruit students to participate in the Student Support Network? Do they receive credit for participating? Are they paid?

We use no incentives to recruit students and I'd be opposed to doing so. Students join because they genuinely want to be better at helping their friends and these are exactly the students we want in the training. Offering them credit and/or other reward would only take away from this very powerful intrinsic motivation.

In fact, one of our bigger challenges is being able to meet the requests to participate in the training from our student body. There have been wait-lists for the training every time we recruit. It really has become that popular on campus

What kind of funding does your program receive?

The program was developed with grant funding from SAMHSA. We've been training about 100 students a year (six cohorts of 15-18 students) for the past two years without any outside funding. The program does not "cost" anything to run beyond the time staff put into it to keep it going. When we did have funding, we spent it on food for training sessions and SSN

hoodies (sweat tops), which are very popular on campus. We still provide every trainee with a hoodie which help to market the program and students self-identify as members. Money for these hoodies comes from the counseling center budget, money that was once used to bring speakers to campus; now it is student groups (we advise) going to student government to support bringing speakers to campus, freeing up some funds for other uses. If we've learned anything from this training, it's that students, with the proper training and support, will take on tremendous projects in support of causes they are passionate about.

With this being a six-week training, are you able to retain a majority of the students in each cohort who want the training? If so, how?

95% of the students who start the SSN training complete it. There are several factors which I believe account for this high rate. First, we make it work in their busy schedules. Trainings are during the day, like another class, so it fits without other outside interferences which would occur during evenings. There are multiple training sessions going on during the same period, so if a student misses a class they have the opportunity to make it up in another group. I think also students are well aware that this is a very popular training program. Many of them are coming in off a wait list so they definitely appreciate this. Finally, I think the training sessions are interesting, interactive, experiential, practical, and often fun. Students want to be there and are disappointed if they miss.

Please give examples of functional vs diagnostic language.

On a basic level:
Diagnostic = "He is depressed." "She is bipolar."
Functional = "He has symptoms of depression." "She experiences mood swings."

We emphasize that it's not so much the existence of a diagnostic label as how they are functioning with their "stuff." Stuff=things on the inside that we may or may not like. Thoughts, feelings, memories that we're all bound to have at one point or another. We demonstrate that strategies used to "get rid of" our stuff often lead to more suffering (alcohol, drugs, major avoidance, etc.). Improved mental health can be seen as learning how to make room for our stuff, while focusing our energies on the things that are most important to us.

Alma Rosa Silva-Bañuelos, Director, LGBTQ Resource Center, Division for Equity & Inclusion, University of New Mexico, Albuquerque, New Mexico
Frankie Flores, Caring @ Every Connection Coordinator, LGBTQ Resource Center, Division for Equity & Inclusion, University of New Mexico, Albuquerque, New Mexico

Can you give additional examples of good social norms messages?

Some of the social norm messaging that are used on our campus follow our Caring at Every Connection campaign. For example, L.O.V.E. Listen, Observe, Validate & Engage, UR LUVD, and You Are Not Alone, messages of PRIDE are just a few examples of the messaging we use on the University of New Mexico campus. Also, accompany your messaging with a rainbow or some kind of identifier for the LGBTQ community.

How can we as clinicians decrease the victim blaming of LGBT individuals who are experiencing mental health-related concerns (e.g., depression/suicidal ideation), by acknowledging many of the health-related concerns are a result of systemic concerns (i.e., micro-aggressions), rather than something inherent in individuals from this population?

Clinicians need to continue LGBTQ education to understand that identifying as LGBTQ is not a pathology; it is how society treats the LGBTQ community that increases rates of mental-health concerns (e.g., depression/suicidal ideation). Additional trainings on micro-aggressions are critical to ensure that this behavior does not play out with clients or colleagues. Other trainings recommended are Safe Zone, LGBTQ 101 or cultural competency trainings.

Working at a counseling center, I'm interested in how we can increase the knowledge that we're an LGBT-friendly center in the college community?

Campus counseling centers can display a rainbow flag, Safe Zone stickers, resources for LGBTQ clients to reflect a LGBTQ-friendly environment. It is also recommended that there are "Out" counselors so that LGBTQ clients have the option to see someone that reflects their identity. The University of New Mexico Student Health and Counseling collaborates with the LGBTQ Resource Center to provide life-skills trainings and has developed a series of healthy relationship workshops.

How is the LGBTQ Resource Center funded?

The LGBTQ Resource Center is primarily funded through student fees and this is how the Resource Center was established. Since its opening, the Director has further integrated the

LGBTQ Resource Center with the University and has secured recurring Fiscal Year Instruction & General Funding for professional staff. We continue to fundraise for programmatic work through external sources such as SAMHSA, foundations, grassroots organizations, and individual donors.

Eugenia Curet, PhD, MSW, LCSW, Assistant Dean of Students for Support Services, The University of Texas Pan American, Edinburg, TX

You mentioned that many of your Hispanic students were raised to believe that problems, including mental health problems, should be resolved within the family. How do you address that in your campus awareness campaigns to de-stigmatize mental illness?

We conduct mental health forums which provide the opportunity for students, staff, and faculty to clarify perceptions and/or myths about mental health/illness and to discuss the importance of mental health counseling and timely psychiatric and medication evaluations. We offer mental health education activities on campus (e.g., in October during Depression Week). We also address the issue of mental health disorders during our suicide prevention workshop trainings. In addition, we conduct orientation with parents. We show a video produced with and by students conveying messages to the parents about adjustment issues that they face when entering college, for which we have support services on site, such as the counseling and psychological services. Important as well is using the term "emotional health" rather than mental health to de-stigmatize treatment services seeking when indicated.

Since your students often utilize natural support systems (e.g., priests, *curanderos*, etc.) before consulting with counselors at campus counseling centers, do your counselors seek permission from students to confer with those other sources of support in the their lives? If so, have you experienced any challenges with that?

Utilization of natural support systems is prevalent in the Hispanic communities. We don't have any data regarding the frequency of the utilization of support systems by our students. It would be important to explore if and when students and/or their families consult others in their community natural support systems; however, we don't make it part of our mental health intakes or counseling interventions.

You've been successful in developing collaborative partnerships with community-based mental health agencies. What advice would you give to other campuses interested in developing similar partnerships?

We invite community agencies to our campus-wide activities and to our Student Health Services' Open House. In addition, we belong to various associations of providers of mental health and physical health in the community. Furthermore, we have written grant proposals that include community agencies as partners: The latest one was the SAMHSA Minority Serving

Institutions (MSI) Partnerships with Community-Based Organizations (CBO) Grant which calls for collaboration between the university and community-based organizations for the reduction of substance abuse and the prevention of HIV. Another way is to collaborate in the planning and implementation of mental health conferences. When we received the Garret Lee Smith grant, we saw the need to extend the suicide prevention workshops to our surrounding community agencies and local education districts.