



a guide to
***Campus Mental Health
Action Planning***



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online, click on the icon to get to the audio clip. If you are reading a printed copy of the Guide, enter the "bit.ly" link provided underneath the icon to listen to the audio. The full webinars are available at <http://www.jedfoundation.com/professionals/programs-and-research/campusMHAP-webinars>.

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Introduction

Today, mental health professionals have access to treatments that can effectively help people with a variety of mental health concerns. When young people are connected early to support and treatment, most mental health problems can be successfully managed, with symptoms reduced or even eliminated.

This is good news for college students, since many have access to low- or no-cost mental health treatment on campus. Most four-year residential colleges and universities provide at least some counseling services, and many also have established relationships with community providers. More and more community colleges also are strengthening linkages to community mental health services.

Even with services readily available, many students who need help are not asking for it directly. For example, only a small number of college students who report being depressed are receiving treatment (Eisenberg et al, 2007a). In addition, counseling center directors report that the vast majority of students who die by suicide are not clients of the counseling center (Gallagher, 2010).

Therefore, while increasing access to and providing high-quality mental health treatment services are essential, neither is sufficient to address college student mental health issues. Many colleges are going beyond simply providing treatment services by expanding efforts to *prevent mental health problems from arising and 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 (Davidson & Locke, 2010; SPRC, 2004).

A public health approach to mental health and suicide prevention on college and university

campuses must include prevention *and* treatment. Those charged with developing a mental health action plan should look to implement programs along a continuum (Institute of Medicine, 1994; National Research Council, 2009), including efforts to:

- Strengthen students' existing resources to respond to stress and that support their overall health and well-being. (*enhance and promote health of all*)
- Reduce risk factors and build protective factors for all students. (*primary prevention*)
- Identify early symptoms in individuals and intervene to prevent exacerbation of problems and their potential consequences, such as serious mental illness, academic and relationship problems, or suicidal behavior. (*early recognition and intervention*)
- Treat those who are experiencing mental health problems and identify those at risk for suicide. (*treatment*)
- When continued care is indicated, intervene to reduce relapse and recurrence, and provide after-care. (*maintenance*)
- Develop protocols and strategies to implement after a crisis or traumatic event, with the aim of alleviating the possible negative effects of the event on the campus community. (*postvention*) (SPRC, 2004).

If the campus focus is on the above range of interventions, then it becomes clear that addressing student mental health problems and suicidal behavior is the responsibility of the entire campus community, not just the counseling center staff. The purpose of this publication, which is part of the *Campus Mental Health Action Planning (CampusMHAP)* program, is to guide campuses through a step-by-step process for designing a plan to promote the mental health of all students and

get help for students who are stressed, struggling, or distressed. A list of references and resources planners can consult for additional assistance is included at the end of the guide.

Many campuses, anxious to begin addressing student mental health problems and/or suicidal ideation and attempts, immediately start to train faculty and staff to identify students who are depressed or suicidal. However, it is vitally important that critical services, policies and procedures, and institutional commitment are in place before training, screening, and social marketing interventions begin to increase the number of students asking for help (Davidson & Locke, 2010). The first section of this publication, "Building Momentum and Infrastructure," outlines the infrastructure that needs to be in place to build and sustain an effective mental health promotion and suicide prevention effort.

The second section, "Engaging in a Strategic Planning Process," guides campus planners in developing a comprehensive, coordinated set of programs and policies designed to reduce risk factors and increase protective factors among students. Using a strategic planning process will ensure that planners focus on priority problems and then choose and design programs that are likely to have an impact on those problems.

The third and final section of the guide, "Strategies for Promoting Mental Health and Preventing Suicide," describes specific strategies for addressing college student mental health. The section focuses on a *Comprehensive Approach to Mental Health Promotion and Suicide Prevention* developed by the Jed Foundation and the Suicide Prevention Resource Center (SPRC). This approach includes seven areas of intervention based on the U.S. Air Force model (Knox et al, 2003), risk and protective factors, and what is known about effective programs for college and university campuses. ●

Principles for Designing Effective Campus Mental Health Promotion and Suicide Prevention Efforts

There are several principles underlying the CampusMHAP process that can inform efforts to address campus mental health and suicide. Interventions to reduce suicide and promote mental health are most effective when they are:

- *Prevention-focused* in addition to response-focused.
- *Comprehensive*, addressing multiple behaviors and risk and protective factors, all campus constituents, and on- and off-campus settings.
- *Planned and evaluated*, using a systematic process to design, implement, and evaluate the initiative.
- *Strategic and targeted*, addressing priority problems (and their risk and protective factors) identified through an assessment of local problems and assets.
- *Research-based*, informed by current research literature and theory.
- *Multicomponent*, using multiple strategies.
- *Coordinated and synergistic*, ensuring that efforts complement and reinforce one another.
- *Multisectoral and collaborative*, involving key campus stakeholders and disciplines.
- *Supported* by infrastructure, institutional commitment, and systems (Langford, 2004).

Building Momentum and Infrastructure

Launching a campus-wide effort to promote mental health and prevent suicide requires support from senior administrators and a broad base of key stakeholders, such as staff in decision-making roles, faculty who can be change agents, and others who may benefit from improved student mental health. When there is widespread commitment to using a public health approach and many partners participate in developing a comprehensive, integrated set of activities and policies, it is much more likely that the program will attract continuing financial and staff support from senior administrators. And if the activities and policies show results, key stakeholders are more likely to want to be involved, which contributes to program sustainability.

Obtain senior administrator support

Strong leadership at all levels - from the president and top student affairs administrators to counseling center directors, campus staff, and students - is vital to effective health promotion and prevention. College presidents and senior administrators must establish suicide prevention and mental health promotion as a priority and allocate funding to develop and sustain these initiatives.

Every campus should have a dedicated office or staff person to coordinate programs, policies, and services to address suicide prevention and mental health promotion. The ability of a program coordinator to exercise leadership depends a great deal on active support from the president and other senior administrators for a campus-wide effort (DeJong et al, 2007). Also, without clear administrative support, efforts to promote mental health and reduce suicidal behavior may not be sustainable.

Many senior administrators have created the impetus for mental health promotion and suicide

prevention themselves by asking health promotion and counseling staff to step up their efforts or by establishing a task force to study campus problems and make recommendations for change. 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. For example, at Emory University, 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 (Mark McLeod, personal communication, February 28, 2008).

Engage key stakeholders in a mental health and suicide prevention task force

A comprehensive approach, involving multiple strategies operating at both the environmental and individual levels, has to be the responsibility of more than one person or department. A *mental health task force* is a type of coalition of diverse members who agree to work together to achieve changes that the members could not bring about separately (Brown, 1984; Feighery & Rogers, 1990). A mental health task force can guide and participate in a strategic planning process and oversee ongoing program efforts, which are more likely to succeed when there is broad ownership and a shared commitment to meet common goals.

Task forces can “help mobilize more talents, resources and approaches to influence an issue than any single organization could achieve alone” and “demonstrate and develop widespread public support for issues, actions or unmet needs” (Butterfoss et al, 1993, p. 317). They encourage the expression of varied perspectives and reinforce the idea that promoting student mental health is a responsibility shared by many different campus administrators, staff, and faculty. Task forces

also can ensure efficient use of resources and elimination of duplicate efforts. Finally, using a task force to implement a program promotes the ongoing support of program goals and the achievement of program outcomes – what is known as *sustainability* (National Center for Mental Health Promotion & Youth Violence Prevention, n.d.). 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.

Data collection is another good first step. Campus or national data showing risk factors and groups and a summary of the issues of concern to key campus stakeholders can help convince senior administration that a formal task force should be formed.

A suggested strategic planning process is covered in the next section, "Engaging in a Strategic Planning Process." Here, characteristics of campus mental health promotion and suicide prevention task forces – including membership, leadership, and structure – are described (Jed Foundation, 2006a).

Task force membership. Most task forces include the counseling center director and representatives from student affairs, residence life, and health services, areas where staff have a great deal of contact with students. It also is essential to involve the director of health and wellness,

health promotion, or health education, who can bring experience with a public health approach to the effort. Including administrators with the ability to make decisions about resource allocation and staffing also makes sense.

Task force membership will vary based on the unique needs of each campus. Potential task force members may include:

- Academic affairs
- Alcohol and other drug prevention office

- Athletics
- Career services
- Campus ministries/clergy
- Campus safety/police
- Community mental health providers
- Counseling center
- Custodial services
- Dining services
- Disability services
- Facilities management
- Faculty
- Graduate student services
- Greek life
- Health education
- Health promotion/wellness
- Health services
- International student services
- Judicial affairs
- Legal counsel
- Student affairs
- Student leaders
- Student organizations and government

Task forces can have any number of members. Larger task forces demonstrate widespread support for mental health promotion and can draw on diverse points of view and staff, (both to support the task force's work and implement task force recommendations.) Task forces with a large membership also can assign assessment and planning tasks to smaller work groups to complete and report back to the larger group with recommendations. Task forces with more limited membership employ various methods to communicate with and gain input from a wider range of stakeholders – individual interviews, surveys, and focus groups, for example.

Adequate staff support can make a task force more efficient. Assigning someone to schedule meetings, produce minutes with action steps, and perform other coordinating tasks will keep things moving forward and maintain a record of task force analysis and decisions.

Mandate and timeline. Often it is the president, provost, or vice president of student affairs who orders the formation of a mental health task force and gives it a mandate. Other task forces may begin as a group of concerned staff simply

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talking about the issues, who then ask a senior administrator to create a formal task force and may even write the mandate on the administrator's behalf.

In general, the charge for a task force for mental health and wellness is to develop a strategic action plan, including an initial assessment of mental health programs, services, and campus culture. Many campuses find that there is often room to define more specific goals and objectives.

Task forces can aim to have certain tasks completed by a certain time, where others may be more open-ended. Either way, it is important not to rush the initial investigation or assessment phase (see “Describe the problem and its context” in the following section, Engaging in a Strategic Planning Process). Campuses starting a new mental health task force may need to take a year or more to gather existing data, define priorities, collect additional data, and set goals for addressing other more complex problems. To some extent, the timeline may simply be a reflection of how much time members are able to devote to the work. Certainly, the time commitment can be a barrier to some, but stakeholders will be most willing to give of their time if the expectations for their participation are clear and meetings are productive.

Once recommendations are made, the task force often takes on the responsibility for overseeing the creation of a program implementation and evaluation plan. When this shift from planning to implementation occurs, task forces may decide to reduce membership or create a smaller executive group while maintaining the larger group for less frequent meetings to review progress and reassess the overall plan.

Leadership. A strong vision at the beginning of the project sets a direction that allows prevention efforts to continue even after the original leader is no longer there. Effective task force leaders possess a range of skills related to coalition building, strategic thinking and planning, and program implementation, as well as personal qualities that enable them to serve as change agents. They identify ways to keep mental health and suicide prevention on the agenda, and think creatively

about opportunities to move existing efforts and goals forward (DeJong et al, 2007).

Some campuses have an official task force chair or co-chairs – the vice presidents of academic affairs and student affairs – as well as a “working” chair (the counseling center director, for example). Less frequently, the director of wellness, health promotion, or health education serves as co-chair with the counseling center director. This structure is highly recommended, since health promotion professionals have essential knowledge and skills in public health practice.

Communication. Communication among task force committee members is an integral part of assuring the effectiveness of the committee. Campuses have used a variety of mechanisms to keep task force members informed, such as electronic mailing lists, email, or by providing minutes on private or public websites.

Communication between the task force and the campus community is a way for the task force to demonstrate that the campus is open to addressing issues of mental health promotion and suicide prevention, which could serve to reduce the social stigma related to these issues. Task forces have requested time on department meeting agendas to give updates and hear from faculty and staff. They also have communicated issues and progress using campus media outlets, including: newsletters; websites; student newspapers, radio, and TV stations; electronic mailing lists; and flyers.

What senior administrators communicate to the campus community is important as well. Many task forces have a senior administrator send out communication, including the report of task force findings and recommendations, so that the information or instructions are received with a sense of importance. A task force member might be assigned the task of keeping the president, vice president, or provost informed of the task force's progress.

Build capacity

Capacity refers to the ability of individuals, systems, and organizations to plan, implement, and evaluate program activities. The process

Advice for Coalitions and Task Forces

The Community Tool Box, an extensive online guide to planning and evaluation, offers the following advice for community coalitions; the advice is apt for campus task forces.

- Distribute the action plan in writing to all members, with names attached to specific tasks. (Additionally, this can be a great time to ask for feedback before the plan becomes official.)
- Lead staff should make regular phone calls asking others how they are doing with their tasks and to see if the task force member or stakeholder needs any other assistance. Handled in a supportive way, a friendly call can give the member the sense that s/he is a very important part of the group and serve as a reminder to stay on track.
- Make sure timelines — with due dates — are complete, clear, and current.
- Follow up on the action plan regularly to help members be accountable and fulfill their commitments.
- Ask members to report at task force meetings on accomplishing the tasks they have set out to do. Consider making this a regular part of the meeting.
- Celebrate the accomplishment of tasks. It's important that getting something done means something and is recognized by the group as a whole.

(Workgroup for Community Health and Development, n.d.)

of starting a task force, creating a strategic plan, and implementing an integrated set of programs will highlight areas where capacity needs to be developed or strengthened, or where resources need to be added, to ensure that program goals and objectives are met. For example, individuals may need to increase their knowledge and skills in data collection, selecting best practices, and evaluation planning. The planning process may uncover gaps or problems with systems, such as omissions in procedures for referring students for help or the lack of a system for collecting data from students who are not counseling center clients. Institutional capacity may be challenged by the “siloeing” of mental health and physical health services, for example.

There are a few essential capacities that campuses must have 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 student demand for services does not outpace capacity.

- Counseling and health services clinicians are trained to assess and manage suicide risk.

- Sufficient mental health services are available on- and off-campus to handle an increase in the number of students who ask for help.
- A crisis protocol is in place and key players (e.g., resident assistants) are trained in its use. Campuses can use the *Framework for Developing Institutional Protocols to Address the Acutely Distressed or Suicidal College Student* to guide design or revision of a protocol (Jed Foundation, 2006b).
- Local, state, and national 24-hour hotlines are widely publicized on campus, including the National Suicide Prevention Lifeline number, 1-800-273-TALK (8255). ●

Engaging in a Strategic Planning Process

When the mental health needs of students are as pressing as they are on so many campuses, it can be tempting to rush to select and implement prevention, early intervention, or treatment programs. This is especially true after a suicide or suicide attempt or when student survey data on depression, anxiety, and suicidal ideation show that students are not receiving care.

For example, campuses might develop a brochure, assuming that increasing knowledge about the location and services of the counseling center would work to encourage students to seek help. But if there are other reasons why students are not seeking help, or if they are not likely to read or save a printed brochure, the effort that goes in to this activity may not have an impact on help-seeking.

For campus efforts to be *effective* — in other words, to produce hoped-for changes in individuals or their environments — they must be comprehensive, strategic, and well-planned.

A *comprehensive* mental health promotion and suicide prevention program addresses *multiple levels of influence*: intrapersonal (individual); interpersonal (group, peer, family); institutional; community; and public policy (DeJong and Langford, 2002; Langford, 2006). Known as a *social ecological framework*, this approach asserts that health- and safety-related behaviors are shaped not only by the individual but also by that individual's environment. On a campus, this would mean that efforts focused on increasing available mental health services need to be supplemented by programs and policies to bring about changes in the campus culture and environment to create a safety net for students who may not seek help at the campus counseling center.

Strategic, well-designed programs can be developed only after program planners have gained a thorough understanding of campus problems and how their programs are expected to achieve specified goals. In other words, to plan strategically is to begin with the end in mind.

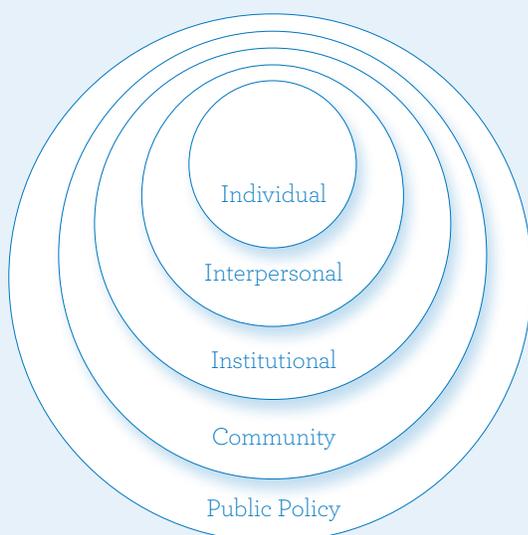
Using a systematic, data-driven process like the one described below ensures that proposed solutions are designed to address specific campus problems. Following such a process helps to build broad ownership from leaders and key stakeholders and increases the likelihood that programs are integrated with one another and sustained over time.

Although the process is often not this linear, the basic steps in a strategic planning process are illustrated on the next page. *Intervention* refers to an activity, policy, practice, or service

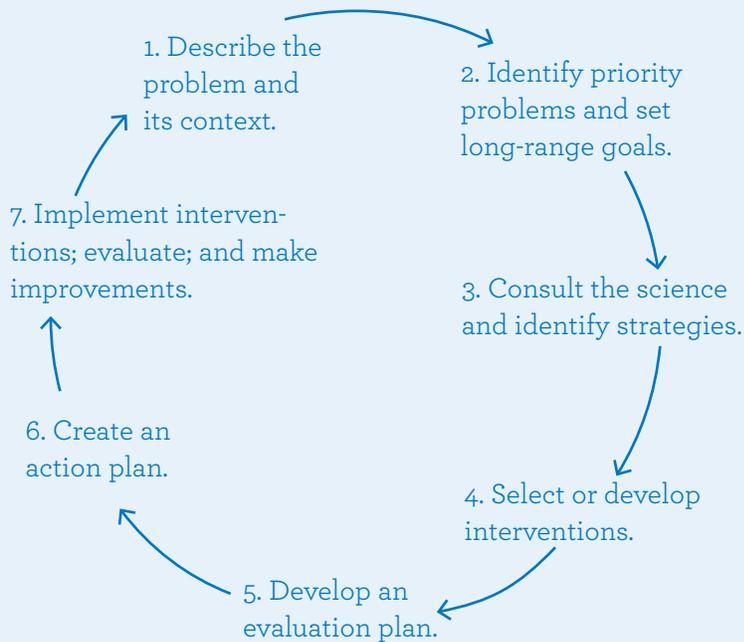
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Social Ecological Framework



Strategic Action Planning



that is designed to result in some change in people or in the environment. In public health, the term is used interchangeably with “program,” so that it refers to more than clinical interventions. Any specific intervention should be chosen in the context of a strategic thinking and planning process.

The steps in the strategic planning process are shown in the figure above.

1. Describe the problem and its context

As noted above, without a clear definition of exactly what the problem is, campuses run the risk of implementing interventions prematurely and could fail to reach their intended goals as a result. A careful and thorough problem assessment provides campus leaders with objective data about the problems students experience, the risk and protective factors linked to these problems, and estimates of how common or prevalent these issues are. A problem assessment can also help campuses identify the programs that are currently in place and assess their impact. An assessment of the campus climate and other contextual issues provides information to round out the overall problem description.

Collect and examine sources of data

There are numerous methods planners use to assess the problems of a specific campus. An examination of existing data, such as campus-specific National College Health Assessment (NCHA) data, is a good starting point to quantify the health of the student body. Many campuses also participate in surveys that provide data on risk and protective factors even though they are not health surveys per se. For example, the National Survey of Student Engagement (NSSE) asks students about their involvement in co-curricular activities and how much emphasis their schools place on helping them cope with non-academic life (Indiana University for Postsecondary Research, n.d.).

If campus-specific data is not available, you can use data from the most recent national administration of NCHA, NSSE, and the National Research Consortium of Counseling Centers in Higher Education’s 70-campus study on suicidal crisis (Drum et al, 2009; see also supplemental materials at <http://dx.doi.org/10.1037/a0014465.suppl>).

Well-designed and administered single-campus studies can also be useful sources of data. The University of Michigan’s Healthy Minds Study has generated a wealth of data on mental health and suicidal behavior and their correlates (Eisenberg et al, 2007a; Eisenberg et al, 2007b; Golberstein et al, 2008; Gollust et al, 2008; Eisenberg et al, 2009; Golberstein et al, 2009; Hefner & Eisenberg, 2009; Zivin et al, 2009; additional articles listed at <http://www.healthymindsstudy.net/additionalresources/publishedresearch.html>). A list of sources of campus data is available with the materials for the CampusMHAP webinar *Building Momentum* at <http://www.jedfoundation.com/professionals/campusmhap-building-momentum>.

Collecting new data, such as online or written surveys, focus groups, and one-to-one interviews (with faculty, staff and students), can be used to supplement existing data and yield a deeper

General Factors Contributing to Mental Health Problems and Suicide

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 (DeJong & Langford, 2002). Strategies at this level are designed to have wide-reaching impact through actions affecting communities, organizations, and entire populations.

Adapted from McLeroy, K.R., Bibeau, D., Steckler, A., & Glanz, K. (1998). An ecological perspective on health promotion programs. *Health Education & Behavior*, 15(4), 51-377.

understanding of student mental health needs on campus. For example, NCHA data shows that many students are not seeking help for depression, but it does not provide insight into the reasons. Key informant interviews with staff and faculty and focus groups conducted with students can reveal some of the barriers to help-seeking and either confirm or challenge planners' assumptions about those reasons.

Assess existing resources. It is important to begin with a good sense of which programs are already in place, how effective they are, and any gaps that might exist. Looking at program gaps alongside relevant survey and other data can point to a need for adjustments. For example, a campus may have several programs aimed at getting more students to ask for help, and at the same time, data may reveal that certain groups of students at higher risk are less likely to do so. Focus group data can

reveal the reasons for the lack of help-seeking, suggesting a more targeted approach. Similarly, data may show that a significant problem exists for which a campus has no targeted intervention.

Campuses that are very decentralized in decision-making may find that many offices and departments are implementing program elements related to mental health promotion, so planners will want to investigate beyond counseling, health services, and health promotion. SPRC's *Inventory of Programs, Policies and Services (Long Form)* and a short-form version are available with the *CampusMHAP Webinar Identifying Priorities* at <http://www.jedfoundation.org/professionals/campusmhap-identifying-priorities> to assist planners with this part of the assessment.

Assess the climate for campus-wide change. An honest assessment of the individual and institutional factors that are likely to facilitate or

Risk and Protective Factors Relevant to College Students

	Risk Factors	Protective Factors
<p>Suicide</p> <p>(National Strategy for Suicide Prevention, 2001)</p>	<p>Bio-psycho-social</p> <ul style="list-style-type: none"> • Previous suicide attempt • Untreated or under-treated mental illness • Chronic physical illness • Alcohol or other drug use and abuse • Hopelessness • Impulsivity or aggressiveness <p>Socio-cultural and environmental</p> <ul style="list-style-type: none"> • 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 <p>Demographic</p> <ul style="list-style-type: none"> • Suicide deaths: Male; White race; Native American youth • Attempts: Female; Hispanic female youth; lesbian, gay, and bisexual youth 	<ul style="list-style-type: none"> • Strong connections to family and other supports • Access to effective clinical interventions • Restricted access to lethal means • Skills in problem-solving, conflict resolution • Frustration tolerance, ability to regulate emotions • Positive beliefs about future, ability to cope, and life in general • Cultural/religious beliefs discouraging suicide
<p>Mental Health Disorders</p> <p>(Institute of Medicine, 1994 & 2009)</p>	<p>Individual and Family-Related Determinants</p> <ul style="list-style-type: none"> • Academic failure • Emotional immaturity • Excessive substance use • Loneliness • Family conflict • Personal loss • Poor work skills and habits • Social incompetence • Stressful life events <p>Social and Environmental Determinants</p> <ul style="list-style-type: none"> • Access to drugs and alcohol • Isolation and alienation • Peer rejection • Work stress 	<p>Individual and Family-Related Determinants</p> <ul style="list-style-type: none"> • Ability to cope with stress • Adaptability • Autonomy • Exercise • Feelings of mastery and control • Problem-solving skills • Self-esteem • Social conflict management skills • Stress management • Social support of family and friends <p>Social and Environmental Determinants</p> <ul style="list-style-type: none"> • Positive interpersonal interactions • Social participation • Social support and community networks

resist change – sometimes called a “readiness” assessment – can help to identify resources and obstacles ahead of time. This kind of assessment

does not need to take a great deal of time, but it can indicate how ready the community is to accept mental health promotion and suicide prevention

Typical Campus Goals

Mental Health Promotion/Prevention

- Decrease the number of students with untreated mental health problems
- Decrease barriers to receiving care
- Decrease alcohol and other drug use
- Increase problem-solving skills

Suicide Prevention

- Decrease deaths by suicide
- Decrease suicide attempts
- Decrease injuries from suicide attempts
- Decrease suicidal ideation

as an issue that needs attention. For example, a readiness assessment can supplement your inventory of existing resources by helping to identify the types of programs that are appropriate to initiate, based on the stage of readiness of administrators and stakeholders (Edwards et al, 2000). A brief discussion of one readiness assessment model appears in the archived CampusMHAP webinar *Building Momentum*, and additional resources are listed at the end of this publication.

2. Identify priority problems and set long-range goals

A good problem definition is the foundation for setting appropriate long-term 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. Data on risk and protective factors and populations at highest potential risk can support

priority setting, but planners should be sure to consider risk and protective factors across the entire social ecological model. Changing environmental factors, such as restricting access to potentially

lethal means of suicide (e.g., lab chemicals, rooftops, firearms), can have large effects on the rates of suicidal behaviors.

A goal statement articulates specific, measurable goals whose achievement can be readily observed and measured. Goal statements use change language such as “increase the number of students who receive help for personal problems,” “decrease rooftop access,” or “revise crisis response policy to improve clarity of staff roles.” A focus on *conditions or behaviors* that are being 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.” Key questions to ask in setting goals include:

- What will change?
 - For whom?
 - By how much?
 - When will the change occur?
 - How will it be measured?
- (Chinman et al, 2004, p. 35)

Achieving most goals will require some thought and planning, but the planning group or task force may also want to demonstrate some early successes. Planners can prioritize some quick fixes to easily remedied problems. For example, as a first step to address a lack of 24-hour clinical coverage, a campus could immediately start to publicize the availability of the National Suicide Prevention Lifeline, a free, 24-hour hotline available to anyone in suicidal crisis or emotional distress. Working together on an early effort can help build relationships among collaborators and provide an easy success to motivate further action.

Get More Online

To hear how Pikes Peak Community College identified priority problems and set long-range goals, go to <http://bit.ly/CMHAP3>

3. Consult the science to identify strategies and interventions

Identifying problems and setting goals (Steps 1 and 2 above) provide the basis for choosing programs to make desired changes. It is important to choose evidence-based practices whenever possible, to ensure that time and other resources are invested in programs that are likely to achieve those changes. A thorough review of the research on both campus and community interventions can help campuses identify evidence-based programs.

While practitioners at other campuses can be a valuable source of ideas for programs, programs and policies from other campuses need to be critically examined before they can be adopted. Before implementing a program that may be popular or well known, or that seems promising, it is essential to explore whether a program has strong empirical or theoretical support and addresses the unique problems on a specific campus.

What if research is lacking? An evidence-based program may not exist for certain identified needs, a selected target population, and/or a specific campus cultural context. A fundamental principle in developing any new program is to base the program content and process on health behavior change theories that attempt to explain and predict health behaviors. Planners can also look at what has worked in other areas of campus health promotion such as the prevention of high-risk alcohol use or violence. Best practices in these two areas of campus health and safety highlight the environment as an influence on behavior, and approaches developed in those fields can inform mental health promotion and suicide prevention efforts.

4. Select or develop interventions

The online *Best Practices Registry* (BPR) administered by SPRC and the American Foundation for Suicide Prevention is a helpful tool for finding programs, policies, and activities to consider. The BPR is a searchable database containing 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 in the field. The BPR provides a fact sheet and links to additional information for each practice.

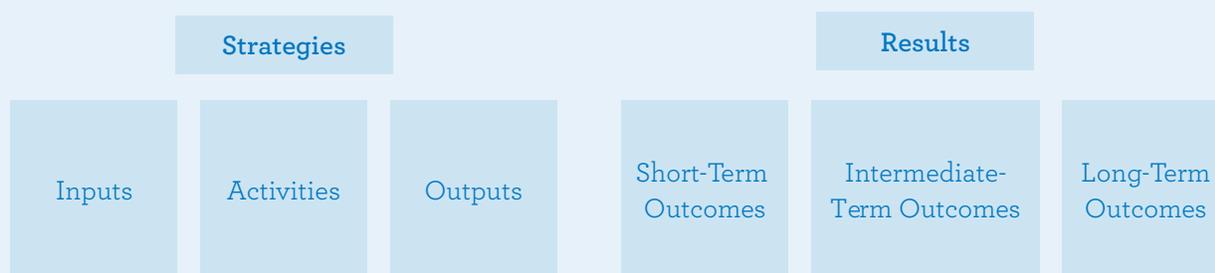
In addition to providing listings of best practices, the online BPR materials can be used to support new program development or the examination of a program not listed on the BPR for possible implementation on a specific campus. The application guidelines for Section III of the BPR, and the application itself, include a series of questions that planners can address in reviewing or planning a specific program, such as:

- Is the program content accurate?
- Does the program follow safe messaging guidelines for suicide prevention?
- Was program content based on a literature review or behavioral theories?
- Was evaluation or testing conducted and materials revised based on results?
- Did program developers create a clear program logic model that specifies how the program activities achieve program goals or outcomes? (SPRC, 2007)

Whatever 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. In other words, how is each program activity expected to create change?

Create a logic model and program plan. A *logic model* is a diagram illustrating how each planned activity will contribute to long-term goals (Langford, 2004; Weiss, 1998), such as reduce mental health problems, suicidal behavior, and suicide. By using a logic model, campuses can articulate how and why each activity will result in specific outcomes, increasing the likelihood that these outcomes will be achieved. A program logic model is the basis for developing an evaluation plan.

Sample Logic Model Format



(W.K. Kellogg Foundation, 2004)

There are several logic model formats planners can use as a guide, including the one shown above.

In this format, the term *inputs* refers to the investment of resources in the program – staff time, volunteers, and funds, for example. *Activities* are the actual programs to be implemented, such as a training, a screening program, or a media campaign. *Outputs* refers to the number of activities or the level of activity achieved. If the activity is a

gatekeeper training, for example, then outputs might be the number of trainings conducted and the number of community members trained (DiFulvio & Rutz, 2009).

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. There should be a *logical* connection between program activities and desired results (Langford, 2004). The CampusMHAP webinar *Measuring Impact* provides a more detailed description of how to use a logic model, including two examples of specific program logic models. Several excellent guides to logic model development are included in the Resources section of this publication.

5. Develop an evaluation plan

Evaluation is a systematic process for collecting, analyzing, and reporting information to

determine whether programs are effectively reducing mental health problems and other risk factors for suicide (DeJong & Langford, 2006). Because research on preventing mental health problems, promoting mental health, and preventing suicide is sparse, it is important to evaluate campus programs.

Another compelling reason for evaluation is to show that programs are achieving their intended outcomes, which demonstrates that resources are being used wisely. An evaluation can also show whether a program was implemented as planned and provide information to improve the quality of the program. Long-term financial support for programs, whether it comes from outside sources or is part of a college's regular budget, is likely to be available only if evaluation results warrant it. If a program has published research demonstrating its efficacy, it still is advisable to evaluate results, especially when it is being implemented in new contexts (e.g., from one type of campus to another, or from community or high school to campus).

To be most effective and useful, the evaluation should be planned as the program is being developed (Langford, 2004). Including a professional evaluator on a project team – perhaps a faculty member in public health, health education, psychology, or social work – helps to ensure that outcome-based thinking is an integral part of the project's design and implementation. (Langford & DeJong, 2001).

There is a vast literature on evaluation planning, and providing a comprehensive guide to the topic is beyond the scope of this publication. The CampusMHAP webinar IV *Evaluating Impact* describes types of evaluation (e.g., process,

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To hear how the University of Wisconsin - Oshkosh developed a logic model to test how their gatekeeper training would produce desired outcomes, go to <http://bit.ly/CMHAP4>

outcome). It also provides a step-by-step process planners can follow to develop and implement an evaluation plan, and resources to support evaluation planning.

6. Create an action plan

To stay on track, campuses may also want to create a detailed work plan that lists specific tasks, notes who is responsible for each, and sets timelines for completing those tasks. The best action plans are “complete, clear, and current” with a clear outline of:

- All of the *actions or changes* that will occur
- *Who* will carry out these changes
- *By when* they will take place, and *for how long*
- *What resources* (i.e., money, staff) are needed to carry out these changes
- *Communication and information sharing* (who should know what?) (Workgroup for Community Health and Development, n.d.).

7. Implement interventions; evaluate; make improvements

To achieve program goals, the program should be appropriate for the setting and based on the underlying causes of the problem and a scientific rationale or theory of change. High-quality program implementation is equally important (Chinman et al, 2004). Following the previous steps in the strategic planning process provides a foundation for quality implementation and allows planners to answer the basic questions that senior administrators and other stakeholders are likely to ask:

- Are we doing what we said we would do?
- Are we doing it well?
- Is what we are doing advancing the mission of our institution? (Workgroup for Community Health & Development, n.d.)

Now is the time to use data from a process evaluation to improve the program and, if it has achieved the desired outcomes, to consider how to keep it going (Chinman et al, 2004). As

Outcome and Process Evaluation

(Chinman et al, 2004)

Outcome Evaluation:

Gauges *effects*

Did the program work? Why? Why not?

Should we continue the program?

What can be modified that might make the program more effective?

Why should funders continue to spend their money on this program?

Process Evaluation:

Monitors *implementation*

What activities were implemented?

What was the quality of the implementation?

What were the strengths and weaknesses of the implementation?

Was the program implemented as planned?

Was the program implemented with quality?

mentioned previously, planners are more likely to receive long-term financial support for this work if the evaluation results demonstrate success. (Langford, 2004). Planners may want to develop a strategy for communicating successes to senior administrators and key stakeholders, which could include implementation case studies and data on program results. Marketing successes to campus staff, potential partners, and possible funders is also critical to sustainability (Langford, 2004; National Center for Mental Health Promotion & Youth Violence Prevention, n.d.). ●

Strategies for Promoting Mental Health and Preventing Suicide

Prevention strategies should include a continuum of programs that address multiple levels of the social ecological model described above. A combination of activities, policies, and interventions working together is more likely to produce results than any single intervention, and also more likely to sustain mental health promotion and suicide prevention efforts over time.

The Jed Foundation and SPRC have formulated a comprehensive approach to college student mental health promotion and suicide prevention based on what is currently known about how to decrease risk factors and increase protective factors among adolescents, college students, and the general population; an understanding of the problems that campuses face; and existing best practices (Jed Foundation and SPRC, 2009).

This comprehensive approach is drawn from the overall strategic direction of the United States Air Force Suicide Prevention Program, a population-based strategy to reduce risk factors and

enhance protective factors for suicide. The program components of the Air Force program include: 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 (Substance Abuse and Mental Health Services Administration, 2006). The Air Force program succeeded in reducing the suicide rate among Air Force personnel by 33 percent during the first five years of the program.

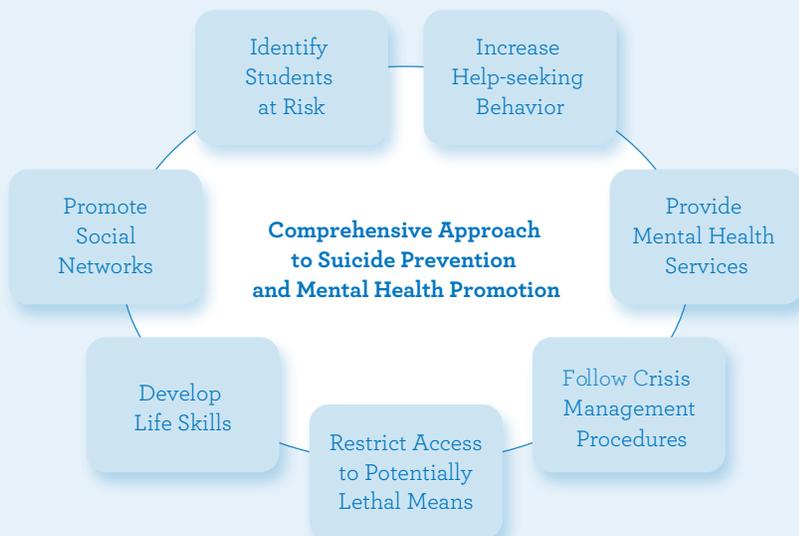
Get More Online

To hear how a Massachusetts Maritime Academy administrator encouraged campus stakeholders to think strategically about mental health promotion and suicide prevention, go to <http://bit.ly/CMHAP5>

The program also reduced homicides by 51 percent, severe and moderate domestic violence by 54 percent and 30 percent, respectively, and accidental deaths by 18 percent (Knox et al, 2003).

When combined in a planned and concerted effort, the seven areas of strategic intervention constitute a comprehensive approach to promoting student mental health, preventing the exacerbation of existing mental health problems, and preventing suicidal behavior and suicide. Campus planners are cautioned to ensure that adequate institutional capacity exists and that linkages to community services are in place before they create

The Jed Foundation/Suicide Prevention Resource Center Comprehensive Approach to Suicide Prevention and Mental Health Promotion



programs that will significantly increase the number of students seeking services.

Promote social networks

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 (SPRC, 2004; National Research Council & Institute of Medicine, 2009; Hefner & Eisenberg, 2009). The experience of strong social support reduces student isolation, promotes feelings of belonging, and encourages the development of small, connected groups within the larger campus community.

According to the Healthy Minds study conducted at the University of Michigan, experiencing a higher quality of social support is more important than having a large number of contacts. Students in that study who perceived a higher quality of social support were less likely to be depressed, anxious, or suicidal, independent of the frequency of social contacts and other individual characteristics (Hefner & Eisenberg, 2009).

Efforts to facilitate social connection can go beyond simply encouraging individual students to “get involved.” For example, many larger 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. In addition to the increased social connection, more frequent contact with other students, faculty, and staff can result in increased identification of students who are in distress.

Help students develop life skills

Relationship difficulties and financial problems are risk factors for both depression and suicidal behavior (Drum et al, 2009; Eisenberg et al, 2007a). However, one survey found that 40 percent of seniors say that their college or university places very little emphasis on helping them cope with

Examples of Critical Life Skills

(Picklesimer et al, 1998)

Interpersonal communication/ human relations

- *Establishing 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*

non-academic life (Indiana University Center for Postsecondary Education, 2007).

The college experience is far more than just an intellectual one. An approach that embraces this tenet would include efforts to foster the development of necessary life skills in all students. Programs for first-year students are now offered by hundreds of campuses, sometimes as a semester-long course. Many campuses also offer health education workshops to help students develop a variety of life skills. (See the list of critical capacities above.)

Administrators might also consider how day-to-day experience itself offers students opportunities to develop their ability to cope with and respond to an array of challenges. Whether involved in a class project, playing team sports, working through issues with a new roommate, or figuring out summer work plans, students frequently encounter situations where they can learn adaptive ways to negotiate conflict, solve problems, or handle financial responsibilities.

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 experiencing depression or anxiety at a level that would require treatment. Life skills education can be provided by non-clinical staff such as health educators, student affairs staff, or staff specializing in helping students resolve financial problems, for example.

Identify students at risk

The responsibility for identifying students who have untreated mental health problems, exhibit early signs of mental health problems, or are at risk for suicide is not limited to mental health professionals. According to one study, 36 percent of students who screened positive for major depressive disorder had not received medication or therapy during the past year (Eisenberg et al, 2007a). On a daily basis, more students come in contact with student personnel staff, residence hall staff, academic deans and advisors, faculty, campus clergy, coaches, bus drivers, and cafeteria workers than with counselors. All of these people can help to identify and refer a student in distress to the people who can help that student.

Campuses are using a variety of methods to identify students at risk and reach out to students in need, 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 or offer assistance.
- Participating in screening activities such as Screening for Mental Health's College Response program, which includes National Depression Screening Day.
- Screening students for symptoms of depression or other mental health problems when students seek primary care services (Chung & Klein, 2007; Klein & Chung, 2008).
- 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 is perhaps the most widely used strategy to recognize and refer distressed or distressing students. The purpose of gatekeeper training is to “develop the knowledge, attitudes, and skills to identify [those] at risk, determine levels of risk, and make referrals when necessary” (Gould et al, 2003).

For example, Syracuse University's Campus Connect gatekeeper training, created specifically for college campuses, is a three-hour experientially based crisis intervention and suicide prevention training program for resident assistants. Another program, Kognito Interactive's At-Risk: Identifying and Referring Students in Mental Distress, is a 45-minute interactive web-based simulation of a classroom where users assume the role of a faculty member who is concerned about some of the students.

Both the Syracuse and Kognito programs are listed in Section III of SPRC's Best Practices Registry (BPR), along with many other gatekeeper training programs. Section III of the BPR includes programs, practices, protocols, and awareness materials that have been reviewed for adherence to current program development standards and recommendations in the field. Some gatekeeper

Cross-cutting Strategy: Case Management Team

One method of identifying students at risk, increasing help-seeking, and connecting students with services is 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” (Jed Foundation, 2009). Key members generally include representatives from student affairs, health services, counseling center, residence life, disabilities services, campus security, and campus legal counsel (Davidson & Ayash, 2008).

training programs have demonstrated short-term increases in knowledge and confidence. However, there is currently very little published research assessing whether staff are more likely to ask students about their distress or thoughts of suicide after being trained (Wyman et al, 2008). SPRC offers a Comparison Table of Suicide Prevention Gatekeeper Training Programs that compares the cost, implementation requirements, program highlights, and objectives of all gatekeeper training programs listed in Section III of the BPR.

Increase student help-seeking

A significant number of distressed students do not seek help from mental health providers or other supportive adults (American College Health Association, 2009b; Drum et al, 2009). Many campuses are engaging in strategies to increase the likelihood that a student who needs supportive services or counseling will seek out and secure assistance.

The process of help-seeking is complex, with several stages and many possible factors influencing the decision to take action to get help (Sussman et al, 1987). For example, Eisenberg and colleagues (2007b) identified factors that negatively affect college students' help-seeking behavior, including not perceiving a need, being unaware of available mental health services or insurance coverage, skepticism about the effectiveness of treatment, low socioeconomic status growing up, and identifying as Asian or Pacific Islander.

Recent findings suggest that the relationship of stigma to help-seeking in college students is also complex. While half of college students would encourage a friend to seek help for emotional issues, fewer than one-fourth would seek help themselves (Jed Foundation & mtvU, 2006). "Perceived public stigma," defined as "the extent to which an individual perceives the public to stereotype and discriminate against a stigmatized group," has been found to be higher among some student groups, but perceived stigma was not a factor in whether or not students with depression or anxiety disorders sought treatment (Golberstein et al, 2008).

There are several different strategies available for campuses wishing to overcome some of the barriers to help-seeking. 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 (Garlow et al, 2008; Haas et al, 2008). U Lifeline, The Jed Foundation's online resource, provides anonymous screening and information about campus resources (www.Ulifeline.org).

Many campuses are using communication campaigns that include brochures, posters, and a variety of web-based content to address specific facilitators and barriers to help seeking. Using a strategic planning process to create a campaign, informed by campus-specific data if possible, will 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.

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 The Jed Foundation's Half of Us campaign at www.halfofus.com, which features public service announcements, personal stories from students and high-profile recording artists, and information about different mental health problems. 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.

Get More Online

To hear how the University of Wisconsin-Oshkosh pretested messages for a poster campaign aimed at increasing student help-seeking behaviors, go to <http://bit.ly/CMHAP6>

Multiple studies show that students go first to friends, family, or a significant other, much more often than first seeking professional help (Drum et al, 2009; Jed Foundation, & mtvU, 2006). Students often get health-related information from their friends, although friends have not been seen as a believable source of health information by most (American College Health Association, 2009a). 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 as soon as it is needed, has chapters on hundreds of campuses.

Restrict student 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 the lethality of different methods may also play a role in the decision (Harvard School of Public Health, 2009a).

In the general population, guns are the most lethal means of suicide, resulting in a fatality rate of more than 90 percent compared to a 3 percent fatality rate for suicide attempts by drug overdose (Miller et al, 2004). One reason the rate of suicide among college students is only half the rate of same-age peers who are not in college (Silverman et al, 1997) may be that only about four percent of students have a gun at school (Miller et al, 2002), because firearms are not allowed on most campuses.

For college students who die by suicide, firearms and overdose are the most commonly used methods. In a study that asked students who had thought about attempting suicide what method they considered using, 51 percent of students named overdosing and 15 percent named firearms (Drum et al, 2009).

Methods of means restriction include limiting student access to sites, weapons, and agents that may facilitate their ability to harm themselves

or others. Specific efforts can include restricting access to and/or erecting fences on roofs of buildings, replacing windows or restricting the size of window openings, restricting or denying access to chemicals such as cyanide that are often found in laboratories, prohibiting guns on campus, and reducing consumption of alcohol and other drugs.

Researchers have investigated the possible effect of alcohol availability on suicide. Nearly two-thirds of students with guns at college report heavy drinking (Miller et al, 2002). Between 1970 and 1990, the suicide rate of 18- to 20-year-old youths living in states with a minimum legal drinking age of 18 was eight percent higher than the suicide rate among 18- to 20-year-olds in states where the drinking age was 21. Researchers estimate that lowering the drinking age from 21 to 18 in all states could increase the number of suicides in the 18- to 20-year-old population by approximately 125 each year (Brickmayer & Hemenway, 1999).

Because the specific campus setting can influence the type of means restriction needed, each campus will want to conduct a formal scan of the campus environment 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.

Guidance for colleges and universities wishing to conduct a scan for lethal means is available on the website of the Means Matter Campaign (www.meansmatter.org), a national effort to reduce access to lethal means. SPRC contributed a set of recommendations for colleges and universities, located in the "Taking Action" section of the Means Matter website.

The U.S. Department of Education's Higher Education Center for Alcohol and Other Drug Abuse and Violence Prevention provides guidance for addressing alcohol use. Drawing on more than two decades of prevention research, the Higher Education Center urges campuses to adopt a comprehensive approach that addresses five key factors in the campus environment:

- Lack or lack of awareness of adequate social, recreational, and extracurricular options.
- Perceptions that heavy drinking is a normal part of the college experience.
- Aggressive marketing and promotion tactics by the alcohol industry.
- Abundant availability of alcohol in and around campus.
- Lack or inconsistent enforcement of campus policies and community laws (DeJong & Langford, 2002; Higher Education Center for Alcohol and Other Drug Prevention, 2002; DeJong et al, 1998).

Increase access to effective 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 [mental health] services, so colleges need to develop creative approaches to respond to those students in ways that they will find helpful and nonthreatening" (Silverman, 2008). These students may instead seek help from primary care clinicians or from a tribal elder, cultural healer, clergy, academic advisor, or staff member in international services or student culture center.

Many campuses collaborate with both on- and off-campus religious leaders to ensure that students receive appropriate and helpful services and that clergy members know how to assess suicide risk.

Other students may be experiencing life problems that could put them at risk for a mental

health disorder or suicide if left unresolved. For example, in one study the majority of students who had seriously considered attempting suicide during the past year reported romantic relationship problems as having a large impact on their thinking about the attempt (Drum et al, 2009). Efforts could be made to help students who have experienced a recent loss, such as an important relationship, or other stressors to prevent the development of depression or suicidality.

The counseling and/or health center plays a critical role in a comprehensive approach by providing treatment to students who need it. Although counseling center directors often convey a need to hire additional staff, "simply adding more therapists isn't always the best way to improve access to high-quality services" (Silverman, 2008). Approaches campuses can employ to meet service demand and strengthen service delivery while using existing staff and resources more efficiently 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 – sometimes referred to as "triage" (Rockland-Miller & Eells, 2006).
- Offering four-session psycho-educational groups – sometimes called "Feel Better Fast" – for students who may not need more intensive therapy.
- 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, such as conducting psychoeducational workshops or classes, developing self-help information, or

conducting media campaigns to increase help-seeking.

- Forging agreements with community organizations that complement campus resources by providing longer-term treatment services.

It can be helpful to view treatment services within the context of the continuum of campus-wide efforts toward promotion, prevention, treatment, and postvention. Counseling centers might consider a stepped care model frequently employed to address many behavioral health issues, including the reduction of college student alcohol use (Marlatt et al, 1998; Borsari & O’Leary Tevyaw, 2005).

The premise of stepped care is to provide the most effective, yet least resource-intensive, intervention first (Sobell & Sobell, 2000). 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 depression symptoms was inexpensive to implement yet reduced depressive symptoms and feelings of hopelessness (Geisner et al, 2006). Of course, criteria must be carefully crafted to facilitate decision-making about which students need more intensive care (Borsari & O’Leary Tevyaw, 2005).

Develop and follow crisis management procedures

When a student is acutely distressed or suicidal, clear protocols should be in place to address the crisis. It is even more 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.

The Jed Foundation’s *Framework for Developing Institutional Protocols for the Acutely Distressed or Suicidal College Student* provides a blueprint for campus officials to use in developing or revising crisis procedures in three key areas: safety, emergency contact notification, and leave of absence and re-entry. Crisis procedures should also include a comprehensive “postvention” program

designed to help students deal with their grief and confusion following the death of a student by suicide and to prevent suicide contagion, a process by which exposure to the suicide or suicidal behavior of one or more persons influences others to attempt or die by suicide (Davidson, Lucy E. & Gould, 1998). Postvention involves coordinated, rapid outreach to help specific students and the entire campus community, and may involve community support meetings to facilitate the grieving and recovery process (Meilman & Hall, 2006).

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. Callers to the National Lifeline are helped by trained crisis workers who provide immediate assistance and mental health services referrals if needed.

In addition, colleges should ensure that all faculty and staff understand the laws and professional guidelines that can affect decision-making involving students at risk. One resource is The Jed Foundation’s *Student Mental Health and the Law: A Resource for Institutions of Higher Education*. This report provides guidance on privacy and confidentiality, disability law, delivery of mental health services, and liability for student suicide and violence. The document also contains related good practice recommendations. ●

Conclusion

Making the kinds of changes recommended in this guide is a long-term process – there are no easy answers to the challenges campus personnel face. Success is more likely if you use the principles and methods described in the guide to create a mental health promotion and suicide prevention program that meets the unique needs of your campus environment and student body.

All of the research and resources referenced in the guide are listed in the next two sections, Bibliography and Resources. Several of these sources of guidance and information are worth special recognition:

- The *Campus Mental Health Action Planning (CampusMHAP)* webinar series, created by The Jed Foundation and EDC, Inc. (<http://www.jedfoundation.org/professionals/programs-and-research/campusMHAP-webinars>)
- *The Community Tool Box* (<http://ctb.ku.edu/en/>) and *Getting to Outcomes™* 2004 (http://www.rand.org/pubs/technical_reports/TR101/). These resources provide more extensive guidance in all of the aspects of the strategic planning process described in the guide.
- SPRC's *Colleges and Universities* web pages, which cover much of the same information as the guide with direct links to web-based references and resources. ●

Resources

The Jed Foundation www.jedfoundation.org

The Jed Foundation/Education Development Center, Inc. *Campus Mental Health Action Planning (CampusMHAP) webinars*: <http://www.jedfoundation.org/professionals/programs-and-research/campusMHAP-webinars>

Framework for Developing Institutional Protocols for the Acutely Distressed or Suicidal College Student: <http://www.jedfoundation.org/professionals/programs-and-research/framework>

Student Mental Health and the Law: A Resource for Institutions of Higher Education: <http://www.jedfoundation.org/professionals/programs-and-research/legal-resource>

Half of Us Campaign: <http://www.halfofus.com>

Transition Year: <http://www.transitionyear.org>

ULifeline: <http://www.ulifeline.org>

Suicide Prevention Resource Center www.sprc.org

SPRC Colleges & Universities Web Pages: <http://www.sprc.org/collegesanduniversities/>

SPRC Online Library: http://www.sprc.org/library_resources

SPRC/AFSP *Best Practices Registry*: <http://www.sprc.org/bpr>

Fact Sheets, including contact information and Websites for:

- ASSIST (Livingworks), QPR (QPR Institute), and other gatekeeper training programs
- Assessing and Managing Suicide Risk: Core Competencies for Mental Health Professionals (SPRC)
- At-Risk (Kognito Interactive,)
- Campus Connect (Syracuse University)
- *Framework for Developing Institutional Protocols for the Acutely Distressed or Suicidal College Student* (The Jed Foundation)
- Interactive Screening Program (American Foundation for Suicide Prevention)
- Sources of Strength (Mark LoMurray)
- *Student Mental Health and the Law* (The Jed Foundation)
- Student Support Network (Worcester Polytechnic Institute)
- Warning Signs for Suicide Prevention (American Association of Suicidology)

Comparison Table of Suicide Prevention Gatekeeper Training Programs: http://www.sprc.org/library/SPRC_Gatekeeper_Matrix.pdf

Organizations and Programs

Active Minds: <http://www.activeminds.org>

Higher Education Center for Alcohol and Other Drug Abuse and Violence Prevention: <http://www.higheredcenter.org>

Higher Education Mental Health Alliance: <http://www.hemha.org>

Means Matter: <http://www.hsph.harvard.edu/means-matter/>

National College Depression Partnership: <http://www.nyu.edu/ncdp/>

National Suicide Prevention Lifeline:
<http://www.suicidepreventionlifeline.org>

SAMHSA Campaign for Mental Health Recovery:
<http://www.whatadifference.samhsa.gov>

Screening for Mental Health, Inc.: <http://www.mentalhealthscreening.org>

American Association for Suicidology: <http://www.suicidology.org>

American Foundation for Suicide Prevention: <http://www.afsp.org>

Sources of Data

American College Health Association –
National College Health Assessment
<http://www.acha-ncha.org/>

Center for the Study of Collegiate Mental
Health: <http://ccmh.squarespace.com/>
Healthy Minds Study:
<http://www.healthymindsstudy.net/home.html>

National Survey of Student Engagement:
<http://nsse.iub.edu/>

See also the List of Data Sources at this link
to the Campus Mental Health Action Planning
webinar Identifying Priorities:
[http://www.jedfoundation.com/professionals/
campusmhap-identifying-priorities](http://www.jedfoundation.com/professionals/campusmhap-identifying-priorities)

Planning and Implementation

Community Tool Box: [http://ctb.ku.edu/en/
Default.htm](http://ctb.ku.edu/en/Default.htm)

*Getting to Outcomes™ 2004: Promoting Ac-
countability through Methods and Tools for
Planning, Implementation, and Evaluation:*
[http://www.rand.org/pubs/technical_reports/
TR101/](http://www.rand.org/pubs/technical_reports/TR101/)

Legacy Wheel: [http://sshs.promoteprevent.
org/implementing/sustainability/legacy-
wheel](http://sshs.promoteprevent.org/implementing/sustainability/legacy-wheel)

*Making Health Communication Programs
Work (the “Pink Book”):* [http://www.cancer.
gov/pinkbook](http://www.cancer.gov/pinkbook)

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