An empirically supported program to prevent suicide among a college population

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Three critical facts about suicide in higher education
Fact 1

The rate of suicide among college-attending young adults has been convincingly established at 7.5 per 100,000 students per year.

Fact 2

The rate of suicide among college and university students is approximately one half the rate of their non-attending peers.
Fact 3

With 14.8 million students enrolled in the nation’s colleges and universities in 2002, it is estimated that 1100 students will commit suicide.
Suicide prevention at institutions of higher education: Current status

1. At present most campuses respond to suicidal crises in the context of the limited provisions afforded by imminent risk.

2. Once the threshold for imminent risk has subsided, campuses invite and encourage suicidal students to seek professional assistance.

3. In addition, counseling centers respond to students self-presenting with suicidal intent.

4. In the absence of imminent risk, any intervention requires the student’s full cooperation.
Shortcomings of suicide prevention efforts at institutions of higher education

1. Few systematic efforts to lower the naturally occurring rate of suicide.
2. Few colleges collect data on suicidal incidents.
3. Fallacy of suicidal behavior as a “cry for help.”
4. No program to date has solid evidence to support its practice.
Fitting suicidal students into traditional resources

1. Expressions of suicidal intent are seen as a “cry for help.”

2. Once the cry has been heard, it is assumed suicidal students will seek help straightforwardly.

3. It is assumed suicidal students will find their way into traditionally configured services just as students with other types of presenting problems do.
Fitting suicidal students into traditional resources--continued

4. The goal is to have the highest quality mental health services available with the fewest possible barriers to entry.

5. Mental health services are configured as passive recipients of students in crisis.

6. Suicidal students must voluntarily conform to terms of services.
Referring Suicidal Students

“There is no one process for referring the suicidal student for help; any number of procedures can be quite effective. What is important is that the mechanisms for making such referrals should be simple and clear-cut and they should be widely publicized on campus. One efficient approach is to have a central telephone number (perhaps in a counseling center) that can be called for information on resources for the suicidal student.”

(Benard and Benard, 1985, page 75).
The problem with traditional services

1. The majority of suicidal students won’t use them.

2. Braaten and Darling (1962) reported that the students who recently killed themselves at Cornell, were not patients of the university service.

3. Schwartz and Whittaker’s (1990) meta-analysis of 99 students at four universities found only 36 had been in contact with mental health services.
Problem with traditional services—continued

4. Not all contact with the various subdisciplines of mental health have an equal impact.

5. The intervention-of-choice is four sessions with a licensed social worker or psychologist, who has an independent source of information regarding the recent threat or attempt and who is in a position to challenge the student.

6. It is estimated less than five percent of students recently threatening and attempting suicide receive intervention-of-choice.
1983 Champaign County Coroner study

- Covered eight years from 1976 to 1983.
- Found 19 students who died by suicide.
- 16 men, one woman.
- 16 undergraduates, three graduate or professional students.
- Rate of suicide 6.91 per 100,000 students.
- 55 percent of the national rate of 12.5 for those 15 to 24 years of age.
Coroner study: Prior mental health usage

• Thirteen students (68 percent) had prior contact with a psychiatrist.
• One student (5 percent) had prior contact with a psychologist.
1983 Coroner Study: Prior intent

- Coroner’s Office, in its limited investigation, found that twelve of the nineteen students (63 percent) had made prior threats or attempts.
- Seven students (37 percent) committed suicide “out of the blue.”
Suicide Prevention Program at the University of Illinois

• Mission: To engage in activities that would lead to a reduction in the naturally occurring rate of suicide.

1. Restrict access to means (e.g. laboratory cyanide).

2. Increase the percentage of students meeting with social workers and psychologists after threats and attempts.
Program: Invite and encourage

- Enlisted friends, family, residence hall staff, and faculty to make contact with suicidal students and invited and encouraged them to meet with a social worker or psychologist to explore the roots of their suicidal intent.
- Lasted three months.
- Completely ineffective at increasing the rate of post-threat and post-attempt contact.
Invite and encourage: Noticed phenomena

1. Power struggle, contest of privilege.
2. Deny threat/attempt occurred despite evidence to contrary.
3. Suicide threat/attempt in the past/ancient history.
4. Acquiesce but not make appointment.
5. Make appointment but not keep it.
6. Keep appointment but not talk about suicide incident.
7. Complete disappearance.
Policy of mandated assessment

2. Mandated any student who threatened or attempted suicide to attend four sessions of professional assessment with a licensed social worker or psychologist or run the risk of being withdrawn from the university.
3. First appointment within a week of the incident or release from hospital.
4. Subsequent appointments ideally spaced a week apart.
Filled a gap inherent in “imminent risk”

1. Imminent risk allows community leverage when there is imminent intent of self-harm.
2. Imminent risk affords strong leverage. Allows the community to confine a student against his or her will (involuntary hospitalization).
3. The leverage afforded by imminent risk is short-lived. Typical duration is a few hours or a few days.
4. It is easy to “pose” as not being at imminent risk.
Proximal risk

1. Proximal risk refers to increased risk of suicide in year following a threat or attempt.
2. Proximal risk at U of I estimated at 1.5 percent.
3. Assumes suicide occurs as the result of a career lasting years, with active and dormant periods.
4. Affords weak leverage. U of I suicide policy affords leverage that is less powerful than that afforded by imminent risk (Outpatient appointments vs. inpatient hospitalization).
5. Long-lived. U of I suicide policy affords leverage of longer duration (A month or more vs. a few days).
6. “Posing” as not at risk becomes irrelevant.
Suicide Prevention Team

- Established to monitor compliance.
- Cross between a conduct and discipline office and credit card collection agency.
- Up to 20 separate contacts to insure completion.
- Staffed by three mental health professionals and an administrative specialist.
Suicide Prevention Team: 
Operation and function

1. Structured in command and control format.
2. Reports to Dean of Students. Nothing is left to chance or good-will.
3. University’s single registry for information regarding threats and attempts.
4. Adjudicates disputes over threshold of a valid report.
5. Adjudicates disputes over what constitutes valid assessment.
6. The University’s sole authority in establishing sanctions regarding suicidal students.
Suicide program: Results

- Eighteen full years (1984 to 2001).
- 1531 reported incidents.
- 20 student deaths by suicide.
- 20 men, zero women.
- 8 undergraduates, 12 graduate students.
Results--continued

- Overall decline: 55%
- Decline among female students: 100%
- Decline among male students: 44%
- Decline among undergraduates: 78%
- Increase among graduate students: 62%
Results including deaths that occurred out of Champaign County

- Eight additional students died by suicide at locations outside of Champaign County during program period.
- Apples to oranges comparison. Pre-program coroner study period included only students who died at locations within Champaign County.
Ruling out other explanations

1. National rate of suicide for those 15 to 24 increased two percent during study period.

2. Rate of suicide within Big Ten increased nine percent from 1984 to 1990 at a time when the U of I rate decreased 75 percent.

3. Only one student was withdrawn for a three month period during the 18 years of the program.

4. Rate of self-initiated withdrawal, nine percent, is at the low end of published findings.

5. Anecdotal evidence suggests the policy leads to greater retention.
Institutions of higher education don’t take appropriate responsibility

1. Don’t train reporting network.
2. Don’t keep records.
3. No mandated reporters.
4. No standard-of-response for those evidencing suicidal intent.
5. No attempts to make contact with those who evidence suicidal intent.
Seven interlocking realities regarding suicide in higher education
Reality 1

The majority of those who die by suicide have a history of previously displayed intent.
Reality 2

Suicidal intent is self-hardened against appeals to the contrary.
The majority of those students who die by suicide will have advanced through the stages of their suicide careers, from initial intent to grave, without having stepped into a single therapist’s office.
Reality 4

Students harboring suicidal intent are vehemently opposed to making any professional contact that might challenge the foundation of that intent.
Reality 5

Of all the different types of professional contact a suicidal student might have with mental health professionals, not all are equally effective at dismantling suicidal intent.
Reality 6

The intervention-of-choice would appear to be weekly assessment appointments with a social worker or psychologist spread out over a month or longer.
Reality 7

The intervention-of-choice will rarely occur on its own. In order to insure that it occurs consistently, administrative controls must be placed on both the student and the professional.
Costs of program

• Administrative (training, monitoring compliance, Team): $10,000.00/year.
• Assessment: $40,000.00/year.
• Suicide prevention: $1.35/student.
• Flu vaccination: $2.03/student.
• Meningitis vaccination: $3.43/student.
Eight barriers to implementing the University of Illinois’ Suicide Prevention Program on other campuses
Barrier 1

- Psychiatrists
- Reluctant to give up control they currently exercise over emergency services.
Barrier 2

• Social workers and psychologists

• Averse to participating in treatment that is leveraged or mandated.
Barrier 3

- Social workers and psychologists
- Averse to losing privilege of discretionary judgment regarding whom they meet with and for how long.
Barrier 4

- Social workers, psychologists and psychiatrists
- Averse to engaging in power struggles with students. Particularly averse to engaging in power struggles with those recently making suicide threats and attempts.
Barrier 5

- Counseling Centers

- Concerned that a program of mandated treatment will lead to an erosion of their internal culture.
Barrier 6

- Counseling Centers
- Concerned that a program of mandated assessment will hurt their reputation among students.
Barrier 7

- Higher administrators
- Concerned about the increased liability associated with greater knowledge of and greater involvement with suicidal students.
Barrier 8

- Higher administrators
- Concerned about the negative impact to the institution’s image that might result from paying more attention to suicidal students.
Eight reasons mental health professionals at your college/university will tell you why the University of Illinois’ Suicide Prevention Program won’t work on your campus
Reason 1

- The program violates state laws regarding confidentiality.
- The U of I’s Suicide Prevention Program adheres to all laws regarding confidentiality.
Reason 2

- The program violates the Americans with Disabilities Act.
- By focusing on a standard of conduct and applying it uniformly to all students, the U of I’s program works in accordance with the ADA.
Reason 3

- The program violates a student’s right to non-interference.
- The U of I’s program balances a student’s rights with his or her appropriate responsibilities.
Reason 4

- Mandating suicidal students into treatment won’t work.

- The results at the U of I would suggest that mandated treatment does work in deterring suicidal intent.

- Specifically, 1531 reported incidents without a subsequent suicide.

- Overall reduction of 55 percent.
Reason 5

- It’s impossible to stop someone who really wants to kill himself or herself from doing so.
- The U of I’s program was effective at preventing those displaying suicidal intent from subsequently killing themselves.
- It was ineffective at reducing the rate of “out of the blue” suicide.
Reason 6

• It’s unethical to interfere with the lives and choices of students.

• It’s unethical to stand back and do nothing given the dynamics underlying suicidal intent.
Reason 7

• It’s a return to in loco parentis

• The U of I’s program represents an appropriate degree of concern and involvement by members of the student’s primary community.
• “It’s just not something we do.”

• Counseling centers should do whatever it takes, within legal and ethical bounds, to be effective in addressing the needs of students in critical areas, including depression, substance abuse, and suicidal intent.
Summary

1. Natural rate of suicide won’t decline unless institutions of higher education engage in systematic activities to make it decline.

2. Suicide is not so much a “cry for help” but a disorder of power, control and privilege.

3. Traditional provision of mental health services backed by traditional philosophies result in less than five percent of students most at risk, receiving the standard-of-intervention.
Summary-continued

4. Universities need to take an appropriate measure of responsibility to identify students-at-risk and apply an appropriate standard-of-response.

5. In 1984 the University of Illinois undertook such a program and it resulted in a 55 percent reduction in the rate of suicide over an 18 year period.