Introduction

College and university campuses today are faced with a rising tide of media attention and court cases regarding increased severity of student psychological problems leading to suicide. Although student suicide is roughly half the rate of suicide in the general population, trend data indicates a steady increase that is alarming. In the past ten years, numbers of students seeking services at campus counseling centers as well as the severity and urgency of their concerns have increased by thirty to fifty percent on many campuses. Associated behavioral incidents in class rooms and residence halls demonstrate parallel increases. Student affairs administrators work in a vortex of pressure on a daily basis, sorting through a confluence of law, ethics, and demands from others including anxious and intrusive parents.

In a related commentary, Levine and Cureton (1998) observed that the days of ‘in loco parentis’ have merged into the days of ‘in loco clinician’ on college and university campuses. However, administrators are discovering that campus clinicians alone (either student affairs or mental health specialists) cannot solve the complex issues associated with today’s alarming trends. Administrators, staff, faculty and students must all work together to develop proactive measures that prevent student suicide. The purpose of this paper is to discuss a systems approach to dealing with students in crisis and especially suicidal students. The scope of the discussion addresses the campus environment, various roles and functions in relation to student crisis, and the importance of clear structures that address student suicidal behaviors as behaviors and a mental health crisis. Noting the absence of a sure guide for dealing with suicidal behavior on campuses, the paper reviews current programs. It describes common sources of resistance among student affairs and counseling centers that
Today's Students and Their Impact on Campuses

It is well known that late adolescence or young adulthood in the United States is a highly volatile and experimental time period with a psychology of its own. Jeffrey Arnett (2000) depicts the time period from the late teens to late twenties as emerging adulthood. His research describes the time period as one where instability is normative and the emphasis is on change and exploration including high-risk behaviors. Traditional psychiatric/psychological research also indicates that this is the time period when serious mental health issues such as depression, anxiety, bipolar disorders and schizophrenia first begin to appear. Other researchers have documented the stressors associated with transition into the university environment (Ross, 1969; Benard & Benard, 1982, 1985; Slimak, 1990; Hirsch & Ellis, 1996; Silverman et al., 1997). The year 2000 survey by the American College Health Association said that within the last school year, 61% of college students reported feeling hopeless, 45% said they felt so depressed they could barely function, and 9% felt suicidal. The results of a Harvard School of Public Health College Alcohol Study survey showed that up to 44% of college students described themselves as binge drinkers (Wechsler & Wuethrich, 2003). Furthermore, alcohol use disorders are associated with a greater likelihood of suicide attempts with suicide mortality rates approximately six times those of the general population (Harris & Barraclough, 1997). Thus, the time period is unstable at its best, chaotic at its worst.

In a summary review of risk factors associated with suicide, Lake and Tribbensee (2003) conclude “…suicide is a cluster risk and tends to correlate with other high-risk behavior, including leading cause of death in college students.” Between the ages of 10 and 24 years, suicide rates in the general population of the United States rise sharply before plateauing through midlife. Among the 14 to 25 year old age group, suicide is now the third leading case of death with rates that are triple of those in the 1950’s (Anderson, 2001). The National Mental Health Association’s College Student and Depression Pilot Initiative lists suicide as the second leading cause of death among
college students. Although researchers have debated about the rate of suicide among students at colleges and universities, the research of Silverman, Meyer, Sloane, Raffel and Pratt (1997) established the rate of suicide to be roughly half the rate for young adults in the general population, with a higher rate among graduate students. Silverman et al. partially attribute the lower rate among college students to protective campus buffers such as strong student affairs programs including access to counseling. However, Joffe (2003) criticizes colleges and universities for being slow to respond with proactive measures to suicide among college students, stating, “…these…institutions are in a position to cut that rate in half again if they adopt the practice of challenging all students who show visible signs of suicidal intent.”

Counseling centers have been concerned about increases in numbers of students seeking services and higher rates of severity and urgency since the mid-1980’s. In 1985 Division 7 (Counseling) of the American College Personnel Association established a task force among counseling centers to examine severity and urgency among students seeking service. Approximately ten years later Archer & Cooper (1998) observed that the need to provide counseling for such a broad range of students and issues including multicultural and gender issues, career and developmental needs, life transitions, stress, violence and serious psychological problems is “daunting” at times. Levine and Cureton’s (1998) research summarized many student anxieties including fear of violence, money problems and divorce. Thirty percent of them said they had no social life because they were too busy and too tired for intimate relationships. Their number one “fun activity was drinking” and when asked why, students reported they drank to relax, to de-stress, and to escape. At that time, sixty percent of senior student affairs officers surveyed reported that a record number of students were using campus counseling services, more than ever before.

During these years, colleges and university experienced increased “consumer” pressure from students and their families who appeared more likely to believe that the university must provide comprehensive services, including counseling services. Levine and Cureton (1998) noted increased activism based on a consumer mentality which was a philosophy based on student rights versus college/university rights, and based on a buyer-seller relationship in a competitive marketplace. Activism was reframed as taking the form of petitions, litigation, threats of violence, use of email, and going ‘public’
with issues. Students increasingly wanted action and service, including mental health service.

Conditions on campuses became more challenging in the years subsequent to research cited above. Severity and urgency of student issues have peaked in the past three to five years for counseling centers. Students arrived on college campuses concurrent with the 9-11 terrorist attacks, war with Iraq and downturn in the U.S. economy. Marked increases in both the number of students with serious psychological problems and the number seeking services are well documented among colleges in general and striking at campuses that are competitive and selective. According to the National Survey of Counseling Center Directors at 333 institutions (Gallagher, 2003), 81.4% of directors report they are seeing more students with serious psychological problems than they were 5 years ago and 77% say that this increase is the number 1 service provision concern.

A recent article in the Journal of the American Medical Association (JAMA) (2003) discussed the growing numbers of students seeking help for depression and other psychiatric disorders in conjunction with concerns about campus counseling centers’ ability to address these concerns. The same article reports that Todd Sevig, Director of Counseling at Michigan State, examined 1992-2002 utilization data from counseling centers at 11 universities that comprise the Big Ten Conference, and found an increase of 42% in the number of students seen at these counseling centers. Additionally, most centers reported 18-20% of those who sought counseling were already on medication.

Counseling centers at highly selective college and universities seem to have experienced even more dramatic shifts in the nature of student concerns on campus. Harvard averaged 1 suicide per year a decade and released a report noting “…increased fragility of students and apparent higher incidence of depression and serious mental illness (Gose, 2000). Likewise, archives at MIT indicate at least 16 student suicides within15 years. MIT not only reports increases in utilization rates but also has been involved in at least two high profile lawsuits involving student deaths (Voelker, 2003). Even successful suicide prevention programs such as the one at University of Illinois that demonstrates a reduction of 55.4% in the number of suicides over an 18-year span still report 20 student suicides during that time period. (This program is discussed more fully later in this paper.) According to Mark Reed, Director of
Counseling at Dartmouth (Arehart-Triechel, 2002), most of his colleagues report a 35% increase in hospitalizations over the past 5 years. Similarly, Northwestern University has experienced a 38% increase in numbers of students seeking services over the past five years and more than a 50% increase in hospitalizations during the same time period.

Beginning in the year 2000, today’s generation of students is called “The Millennials” (Howe & Strauss, 2000). Children of the “Baby Boomers”, Howe and Strauss characterize this group of students as unlike any other youth generation memory. They are more numerous, more affluent, better educated and more ethnically diverse. They consider themselves special. They are sheltered, and have been the focus of the most sweeping youth safety movement as well as the most supervised children in American history. They are also characterized as confident, team-oriented, high achieving and pressured. Many indicate a “trophy-kid” pressure to excel. In many ways these students appear to be the generation of students for whom we have been waiting. They meet extraordinarily high standards from their parents and teachers.

However, the cultural shifts observed in this group of students have not been without cost. Howe and Strauss’ research also indicates that the Millennials have had less free time alone, more intrusive parents who have difficulty letting go, more demanding teachers and more homework and scheduled activities. Millennials are busy and have less time for what’s merely fun. Parents are more likely to impose perfectionism on their child’s education, and the majority of today’s high schoolers have detailed five and ten year plans for their future. During the Millennial child era, asthma has grown by 160%; obesity has increased dramatically as has Attention Deficit Disorder. Since 1990 Ritalin prescriptions have risen eightfold and some 3 million young adults (80% of them boys) are believed to take the drug regularly. These issues notwithstanding, Millennial children are believed to be the most cared-for from pregnancy through young adulthood.

For campus student affairs personnel, the net result appears to be dealing with increasing numbers of stressed high-achieving and extremely perfectionistic students. Mark Reed, Director of Counseling at Dartmouth, sums it up well:

…there is pressure from a very early age to get into the best kindergarten. Children are specializing in activities at a very early age so that they can excel. That pressure persists through high school to get into the best college possible. When you look at student’s resumes and personal statements, it is stunning what
they have accomplished by the time they graduate high school. But, you
sometimes wonder at what cost. (Arerhart-Triechel, 2002, p. 3)

Millennials may be the most diagnosed generation thus far. Counseling centers
are finding students who have been shuttled from specialist to specialist throughout
their childhood and adolescence. Many students and their parents bring the same
urgency to counseling that they bring to other aspects of their life, including a press for
immediate service. As freshmen, many appear with histories of mental health treatment
and psychotropic medications. Indeed, with the assistance of psychotropic medications,
many are admitted to college who previously would not have qualified. Since
noncompliance with treatment is often a feature of early diagnosis in young adults,
these students have a high likelihood of experiencing tumultuous time periods
throughout their emerging adulthood.

**Suicide Prevention Efforts on Campuses**

Joffe (2003) makes a strong case for swift intervention on the part of campus
counseling centers in cases where students express suicidal ideation or make a suicide
attempt. The model he describes consists of a four-person suicide prevention team
comprised of mental health professionals from the University of Illinois Counseling
Center. All students who are at risk for suicide are referred to this team. The team
assesses the student’s risk and, more often than not, administratively mandates a 4-
session assessment at the University of Illinois Counseling Center. Students who do not
comply risk losing their university enrollment. Joffe cites impressive statistics over an
18-year span where the rate of suicide among enrolled students decreased from
6.91/100,000 to 3.08 representing a reduction of 55.4 percent.

Joffe believes that the U of I program succeeds because it goes beyond the
typical “invite and encourage” model found on many campuses. That is, most
campuses that identify students at risk will invite and encourage the student to seek
assistance rather than mandate them to do so administratively. He also cites four other
suicide prevention approaches tried on campuses that show little empirical evidence of
the type of success demonstrated by the U of I program. These approaches to suicide
prevention include: (1) cultivation of a ‘community of caring: such as the one
implemented comprehensively on the University of Florida for over ten years; (2)
lessening the barriers on campus to professional treatment through identification and referral of at-risk students Ottens (1984) and Dashef (1984), and requiring students at risk to participate in immediate professional evaluation (Meilman et al., 1994); (3) intentionally reducing student ‘stressors’ such as lessening competitive pressures (Knott, 1973) or creating more accessible medical leave policies as recommended by the Jed Foundation (2001); and (4) working with survivors of suicide in "postvention" programs (Webb, 1986).

Joffe points out that the biggest barrier to instituting a mandated assessment response to suicidality in students may be the mental health professionals themselves. He cites eight reasons that counseling center professionals will object to such a program including reluctance to relinquish control over the campus response to emergences; reluctance of professionals to give up discretionary judgment for a mandated format; opposition to mandated treatment; reluctance to engage in power struggles with students; ethics; issues involving in loco parentis; violations of the laws of confidentiality and the Americans with Disabilities act; violations of the basic human rights of students.

Joffe is correct that many counseling center professionals have difficulty with the U of I program as it is currently constructed. However, it is also true that there are not many (or any) other proposed programs with the type data regarding reduced rates of suicide such as the program at the U of I demonstrates. Counseling centers and divisions of student affairs should pay close attention to the successful elements of both the University of Illinois program as well as the other programs cited above in four other approaches.

The common threads for successful intervention with suicidal students described above include (1) educating the community so that a network of informed helpers exists who are able to identify students at risk, and (2) creating a structure for mandated referral and follow-through with each suicidal student. Focusing on these two elements will assist campuses in locating common sources of resistance to formulating successful programs.

Resistance to the creation of mandated programs from administrators and staff in student affairs as well as deans and faculty in general tend to result from factors that are difficult to admit. These include genuine confusion, fear and intimidation. It is not uncommon for staff, administrators and faculty to feel intimidated and confused by the
confluence of law in this area (e.g. FERPA, American with Disabilities Act, among many others) as well as active litigiousness of today’s students and parents. Not all institutions have close and useful guidance from institution attorneys. And, there are currently no model suicide prevention programs nationally that are considered ‘tried and true.’ Additionally, dealing with a student in a mental health crisis who may be or is suicidal is an intimidating and fearful situation for even the most seasoned non-mental health professional. Above all, care for the student’s safety becomes the chief concern. In most instances, this becomes a strong motivation to somehow persuade or require the student to be assessed at the counseling center. The common error made is believing that successfully connecting the student to the counseling center is the conclusion of the administrative intervention.

Resistance from counseling center staff tends to result from two factors including a reluctance to perform psychological consultation as active leaders on campus. This resistance has several sources including lack of training and preparation in consultation, avoidance of role confusion, a lack of clarity about the multiple roles and functions of counseling center staff, and a basic fear of being overwhelmed by associated press for service. Secondly, counseling center staff justly wish to avoid mixing their role and function with the disciplinary process, and will likely view the U of I model as doing so. For example, accreditation standards for the International Association of Counseling Services (IACS) clearly state, “…it is critically important for the service to be administratively neutral. If it is perceived as being linked with units that are involved in making…disciplinary…decisions, it can severely restrict the utilization of the center (2003, p. 2). Both factors result in the center’s retreat to an isolative stance shielded by confidentiality. In this stance, the counseling center professionals will often receive mandated referrals, but will not actively initiate a comprehensive response that includes obtaining informed consent from the student with comprehensive systems follow-up as a psychological consultant.

What is missing in both cases is a parallel process that is activated immediately in response to a student’s active (making statements, gestures or attempts) or passive (cutting, eating disorders, other high risk behaviors such as alcohol abuse) suicidal behavior. Ursela Delworth (1988) called these behaviors “disturbed and disturbing behaviors” that call for a strong administrator response. Several invaluable resources contain guides to counseling centers and student affairs staff working together as
partners in recognizing and treating students in distress. Three of these include Gary Pavela (1985) who also edits the quarterly *Synthesis: Law and Policy in Higher Education* as well as a sister publication, *Synfax Weekly Report*; Gerald Amada (1994), and William Kibler (Paterson and Kibler, 1998). A core assumption of all three experts in this area is that student affairs administrators other than counseling center staff must assist in dealing with distressed and suicidal students based on principles of disruptive behavior that is subject to a compassionate disciplinary process. Essentially the protocol described in these documents set up a dual but parallel process for the suicidal student: (1) Activation of the disciplinary system that deals with disruptive behavior that threatens student safety and welfare, and includes a referral for mental health assessment, treatment recommendations, and a request for the student to authorize consultation; and (2) psychological consultation from the counseling center (see Appendix p. 29 depicting the parallel process). A parallel process such as this calls for collaboration and a clear understanding of the role and function of all parties. In practice, it is hard to do. Programs such as the one described in Joffe (2003) appear cleaner, swifter and more to the point. However, the benefits of a dual process are many. They require continuous dialogue and collaboration that create consistent procedures and shared understanding. Most importantly, shared approaches establish responsibility for suicide prevention among all parties who deal with students. They offer each ways to creatively examine how best to meet legal and ethical standards while also dealing with vulnerable student populations proactively.

Within the past eight years, Northwestern University has instituted a total system’s approach to dealing with students in crisis and particularly suicidal students. The system which incorporates aspects of all five approaches discussed by Joffe (2003) will be described below. As with the U of I program, Northwestern finds that graduate and professional students are at particular risk of completing suicide. Since the inception of the U of I program, over 18 years there have been 20 student deaths due to suicide including 8 years where there were no deaths. Since the inception of the Northwestern program eight years ago, there have been 5 student deaths due to suicide, only 1 of whom was an undergraduate. There were three years during this time period when there were no suicides. These data occurred during an eight year period when the counseling center experienced a 79% increase in emergencies, more than a 50% increase in rate of hospitalizations and a 38% increase in total numbers of
students seeking services at a school of roughly 15,000 students. We believe these data are comparable to the U of I program.

**Dealing with Students in Crisis: Building Campus Systems**

Student affairs administrators in general and chief student affairs administrators in particular must be willing to make suicide prevention a top priority in several essential ways. Suicidal behavior should be clearly addressed in the Student Code of Conduct as a violation of institutional policy. Suicidal behavior should be clearly recognized as behavior that is disruptive to the community and one that threatens the safety and well-being not only of the student, but all who associated with the suicidal student. Active administrative procedures should be created to ensure an immediate response that secures the student and the community. Partners in the creation of policy and procedure should include all responsible parties including the institution’s security force/police and attorneys. All role and functions should be carefully delineated with an understanding that the structure needs to assess each case individually. Above all, the institution should administer the policy and procedure with careful attention to student rights and the law without accompanying intimidation that results in either a knee-jerk response mandating that all suicidal students take an involuntary medical leave for example, or passively lets the situation progress without definitive action.

Student affairs administrators active in suicide prevention efforts recognize the need for the creation of a caring community of trained helpers and a process addressing suicidal behavior as disruptive behavior and including mental health assessment and treatment recommendations. Campuses that are successful appear to be ones where campus leaders are not afraid to speak about suicide and its successful prevention. Leaders in the area of suicide prevention break the silence that shrouds these issues on campus and involve others in dialogues about building a campus community that initiates interventions with students who communicate distress verbally or nonverbally.

Also, administrators actively share concern and take responsibility for parental notification in these cases. Lake and Tribensee (2003) remind administrators that while FERPA protects the privacy of student educational records, law and ethical obligations do not prevent a college or university from disclosing information that suggests the student may be suicidal. In fact, FERPA provides an express exception for disclosures
made in a health or safety emergency. Based on a discussion Jain v. Iowa\(^1\), White v. University of Wyoming\(^2\) as well as upcoming results of the Elizabeth Shin case (also, see Sontag, 2002), these authors predict that future courts will begin to distinguish clearly between a duty to prevent suicide (that may be heightened in the future) in relation to the duty to notify family members of potential danger. They state: “The duty to notify parents or others is far less difficult to discharge than a comprehensive duty to prevent suicide.” Modern prevention theory regarding involvement of family is cited as a key factor in preventing or lowering the risk of harm (Lake & Tribbensee, 2003, p. 142).

**The Essential Role of Consultation In a Campus Counseling Center**

The counseling center staff is often a highly educated, trained, and stable cohort in the division of student affairs. It is positioned to know more about students in distress than many others in the institution, and to share that knowledge with others. In order to assume a role of leadership and initiative on campus in terms of suicide prevention, the counseling center must see itself as inexorably connected to the mission of student affairs and the institution as large, and prepare its staff for their essential role as campus consultants.

At the heart of the current crisis in student mental health on campuses, counseling centers have experienced dramatic increases in numbers of students seeking counseling as well as the urgency of their concerns. At the same time, the media have ‘discovered’ student stress and distress as a result of several highly publicized legal cases, and the public has been inundated over the past five years with media stories concerning the increased need for student counseling and heightened severity and urgency of their concerns. Counseling center staff have discovered that the days when counseling centers operated just outside the messy daily life of student affairs are long gone.

Directors are faced with strikingly complex compliance issues, multiple roles, boundary questions and a press for solutions from all stakeholders, including students, their parents, faculty, staff and fellow administrators. In a recent article in the NASPA Journal, Martha Anne Kitzrow (2003, p. 171) summarizes well the modern dilemma of contemporary college and university counseling centers:

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\(^1\) 617 N.W.2d 293 (Iowa 2000)
\(^2\) White v U. of Wyo., 954 P.2d 983 (Wyo. 1998)
Many counseling centers have been forced to make a philosophical shift from a developmental, holistic and preventive model of counseling towards a more clinical and crisis-oriented model in order to meet the needs of students with serious psychological concerns.

Counseling centers on college and university campuses must have a firm grasp of best practice standards and guidelines; laws governing practice and confidentiality not only for mental health providers but also for others in the university community; organizational dynamics including consultation skills; crisis protocols; and research including local clinical research about the institution’s vulnerable student populations. The counseling center mission must be firmly linked to the mission of the division of student affairs and to the university. Their role and function must be clearly defined to themselves and others; and, they must view themselves as part of a system charged with the well being of students. Nowhere are these functions more necessary than in provision of services for suicidal students. Especially within these circumstances, counseling centers are living laboratories of legal and ethical dilemmas as well as psychological quandaries.

**Need for resolution of multiple roles.** In order to provide the best clinical approaches to students in crisis, the counseling center must resolve aspects of the professional role of its clinicians. Clearly linking the mission of the center to the mission of student affairs and the university should be established through intensive dialogues and strategic planning. The director sets the tone in these discussions by being very clear about core expectations and competencies of all professional staff: The counseling center staff are mental health professionals who have clear-cut specializations in working with university/college student populations including psychological consultation to the community. Core competencies in staff are a necessity and in-service training is continuously informed by the local clinical research generated by the center.

Role clarity is important to distinguish in policy and procedure. Some co-existing roles of staff create dual relationships. These include the roles of (a) clinician, (b) staff member of the counseling center and the division of student affairs, (c) consultant to the university, and (d) member/official of the university community. The center must resolve the inherent responsibilities of these roles versus the inherent conflicts related to the privacy and trust of the individuals it serves. Priorities of confidentiality and informed
consent related to role clarity are essential. Resolution is best achieved by an overarching concept of psychological consultant. Counseling center staff will always approach the role of psychological consultant conservatively. Only training and experience will enable them to transcend the role of individual clinician to one as a consultant who knows and understands the associated ethics and legal responsibilities of various roles. Knowing when and how to perform as psychological consultants while explaining the limits of confidentiality to all parties (informed consent) is key to establishing a successful suicide prevention program.

These are not simple tasks. However, it is their very complexity that creates a dynamic laboratory for legal and ethical issues such as described in the above sections. Knowing that clear expectations exist regarding their various roles motivates staff to examine existing law and ethics, to study local clinical research, and to creatively examine and contribute to internal structures, policies and procedures.

Performing as psychological consultants to the community and communicating accessibility does increase a press for service. The need for revisions in clinical approaches as well as maintenance of a strong referral network is ever present for a counseling center involved in the daily life of the college/university. However, the challenge also offers the opportunity for a meaningful involvement in suicide prevention and thoughtful creation of best practice structures related to students in crisis. In the end, this is the best approach to mitigating liability.

**Local clinical research.** The counseling center is positioned to collect valuable data about students in distress and their concerns. Depending on the size of its staff, a large center may have a major research program while a smaller center simply collects data. However, no matter what its size, the examination of the center data is a valuable aspect of suicide prevention.

Local clinical data is the core foundation of all programmatic aspects of the counseling center. Examination of the needs and experiences of the students it serves allows the counseling center to design internal systems that correspond to student needs as well as to keep other university systems informed about vulnerable student populations and trends. As such, it forms the basis for outreach and consultation services including the director’s interactions with other key administrators including other directors, deans and the Vice President of Student Affairs.
At Northwestern University, data is collected about all students seeking service at the counseling center by asking them to complete a “preliminary information” form where they rate their distress about various problems on a scale of 1 – 5. This data is entered anonymously into a computer program that generates a wealth of data about the reasons students are seeking counseling at our university. It can be sorted by college or department, academic class, gender, race and ethnicity or other variables of interest by a simply SPSS program. In addition to the large database collected each year, the center also studies the clinical files of all severe and urgent students in a separate study. These data are combined each year into the center’s annual report. Over time the data have allowed development of important trend information. These two activities have yielded invaluable information for the center, the division of student affairs, various colleges and departments, especially in the arena of suicide prevention.

No matter how a center decides to approach local clinical research, it is an essential aspect of suicide prevention. As a result of our data, we know that students seeking counseling report high rates of severity and urgency about the crucial relationships in their lives, isolation and loneliness, and concerns about body image and eating. We know that women are more likely than men to seek counseling, but that among our severe and urgent cases both are equally represented. We know that our students experience difference as difficult because racial and ethnic minorities (including international students) as well as students with gay, lesbian and bisexual orientations are over-represented among our severe and urgent cases. Additionally, we know other factors such as any type of previous suicide attempt, current alcohol or substance abuse, mood disorders (especially bipolar disorder), or eating disorders are prominent among high urgency at-risk students. We know that all of these factors alone comprise risk, but when combined into a cluster of risk behaviors such as Lake and Tribenese (2003) describe, they comprise a cumulative risk factor that heightens the likelihood and need for immediate interventions such as hospitalization, partial hospitalization, and/or involvement of others who are responsible parties in the student’s life.

In a separate study about severe and urgent cases (Dunkle & Hollingsworth, 2004), severe and urgent students are compared to others seeking counseling by defining severity and urgency defined along three dimensions: (1) students referred to the hospital; (2) students referred to partial hospital programs; and/or (3) students who
voluntarily sought a medical withdrawal for psychological reasons. The purpose of the study was to better predict severity and urgency. We discovered that third party referral accounted for 91% of the variance in these cases. That is, third party contact (for example, an RA, a dean, a faculty member, administrator or even a parent) with the counseling center about a student in distress, accurately predicts which cases will fall into the severe and urgent category with 91.2% accuracy. Other statistically significant factors included student’s self-report of urgency (on preliminary information forms) and prescribed psychotropic medication. This is critical information that cannot be ignored. It has implications for crisis coverage, assessment, the importance of establishing a ‘helper’s network’ or safety net across the university/college campus, and the essential role of psychological consultant to others who are concerned about students in distress.

**Law and Ethics.** Most directors of contemporary counseling centers find that they need to know more about law than they could have imagined during earlier years of training and experience. The counseling center director and staff need to understand a vast array of compliance issues related to law and ethics. Nowhere is this more vital than in dealing with students in crisis and those concerned about them. These include laws related to Tarasoff (duty to warn), battery and stalking laws, mandated reporting laws (abuse), mental health confidentiality and informed consent laws, laws concerning alcoholism and other drug abuse including federal regulations regarding confidentiality, the AIDS confidentiality act, laws regarding storage of records, laws governing licenses. If psychiatrists are on staff, there is a need to know medical practice laws, laws governing board certification, drug enforcement and credentialing drug standards. Additionally there is a need to know ethical codes for all mental health professionals that are employed in the center, best standards for practice, among many other standards and guidelines.

Certainly the center must be maintain awareness of laws governing discrimination such as those found in Title VII of the Civil Rights Act, Title IX, the Age Discrimination Act of 1975, and Section 504 Rehabilitation Act. Not only must a counseling center know mental health law and ethics, staff must also be well acquainted with other law of higher education especially FERPA. On a daily basis, they will be consulting with other professionals in higher education who will base many of their decisions on their understanding of these laws.
Ongoing training for all staff in application of relevant law is essential for making timely decisions about hard choices. This knowledge establishes a sound sense of responsibility and limits of competence among staff. Knowledge of evolving law is also critical, for it yields important markers for development of future practice. The counseling center director is well served by developing a collaborative relationship with the institution’s attorneys. As a consultant to the university community, the director has critical information to offer university attorneys about mental health practice in dialogues about the application of law within the counseling center setting.

**Organizing internal systems for crisis.** Local clinical research informs the center about all aspects related to internal organization. Clinical service in all of its aspects is the core function of the counseling center. This includes third party consultation including to others in recognizing and handling students in distress. In many counseling centers there is a tension between approaches clinicians prefer in providing clinical service versus meeting the needs/demands of students as well as others who are concerned about them. The best way to resolve this tension is through clear evidence related to data.

For example, our clinical data demonstrates a clear need for crisis services (e.g., a 79% increase in emergencies over an eight year span). Involving the staff in on-going study of severe and urgent cases has yielded several changes in policy and procedure through staff task committees. Examples of these include a centralized intake system, staffing teams that review all cases, a twenty-four hour on-call crisis system, and daily walk-in hours. It includes a protocol for initial and on-going risk assessment, guidelines for documentation, and treatment recommendations based on best practice standards and cumulative risk factors such as those found in *Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors* (2003). These are combined with counseling center data associated with local clinical research about our student’s behaviors, self-assessment, and cumulative risk factors.

Because the data about third party contact is so convincing (in predicting acute cases), the staff understands and has become invested in providing consultation to others in the community about students in distress. In the year 2003, our center handled more than 2000 calls involving this type of psychological consultation.

With so much information about students flowing through the counseling center, there is a strong need for clear communication and consultation internally. Certainly the
centralized intake system and staffing teams are useful in this respect. However, we also find that strong norms about internal consultation are essential. A daily morning report to the clinical director by any clinician concerned about a student assists in directing flow of internal information about students-at-risk. Permanent case management supervisors meet weekly and are available for daily consultation to psychology interns who are handling acute cases. Staff regularly consult with one another, the clinical director and director as well as staff psychiatrists about aspects of assessment and treatment decisions.

Additionally, the weekly staff meeting begins with a summary of all critical cases that any staff member handled within the past week. The director and clinical director routinely select high risk cases to review in depth with staff at these meetings—charting all contacts with the student and others concerned about him/her, discussing decision points, asking opinions about alternatives that could have been pursued, discussing legal and ethical issues. Internal consulting norms such as the ones described above are especially important during emergencies when urgency equals speedy response. Teaming with each other within a consultative framework adds clarity to the decision process.

Certain other structures are essential in the center’s internal organization including clear policies and procedures that are based upon best practice, the center’s data, state and federal laws and institutional policy. Rather than a stagnant collection of rapidly outmoded descriptions of operations, the policy and procedure manual should be a living document that is constantly reviewed and revised. It reflects the best judgment of all staff based on the center’s experience in dealing with students. In its best sense, a policy and procedure manual provides guidelines for all center activities, especially the protocol for recognizing, assessing, documenting and managing students in crisis. Additionally, it provides detailed guidance for charts and documentation, charts and decision trees regarding crisis intervention including consultation to university administrators (see Appendix pp. 30-31 for charts depicting on-call decision trees), university police and local hospitals both initially and for follow-up including discharge planning; procedures for medical withdrawal including referral to outside providers, obtaining authorization for exchange of information, and conditions for medical clearance upon re-entry; all aspects of informed consent; and all of the essential aspects of daily operations in the center. Legal counsel should review the
policy and procedure manual periodically. In fact, such a review offers the center
director an opportunity to begin and continue an important relationship with institution
attorneys. Again, the type of internal consultation described above invests the staff in
knowing policy, procedure, and related law and ethics that is all detailed in the policy
and procedure manual.

**Emergency protocol.** With firm internal structures in place, clear policies and
procedures, and the roles of all concerned clarified, emergency situations do not have
to become systemic crises. Considerations for emergency situations include all aspects
of clinical consultation such as:

- Contact with third parties who are concerned and/or intimidated by an emergent
  situation. Staff recognize that there are essentially three clients in contacts such
  as these, including the caller, the student, and the university.
- Ensuring that written authorization is obtained to access all previous treatment
  records, and that these records are reviewed (Stone, 2003) and incorporated into
  current assessments and treatment plans.
- Ensuring that all staff and community consultees understand the importance of
  releases of information and informed consent.
- Ensuring that the importance of confidentiality does not deter third party contact,
  information sharing and requests for guidance with students in crisis
- Providing consultation about chronically distressed students who drain other staff
  members and faculty
- Maintaining linkages to other emergency resources such as hospitals, university
  police, sliding scale clinics and community therapists, emergency funds within
  the university. In our center’s case, the director of the counseling center
  authorizes activation of student insurance for mental health benefits such as
  hospitalization, partial hospitalization, and outpatient follow-up. This procedure is
  extremely beneficial to suicide prevention efforts. It enables the center to initiate
  immediate treatment intervention and follow-up for continuity of care.
- Negotiating voluntary authorizations for parental contact, hospitalizations, and
  medical withdrawals. In these matters, our center finds that most students will
  voluntarily authorize these actions after establishing a relationship of trust with a
  skillful clinician. At Northwestern, the counseling center may authorize retroactive
  medical withdrawals to the beginning of the academic quarter, enabling the
family to receive financial reimbursement for the quarter that can be applied to the student’s continued treatment at home.

- Negotiating with or advising others in authority about need for parental contact.
- Ensuring at medical clearance that all treatment records are reviewed for assessment and treatment. Ensuring that continuity of care is provided.
- Obtaining written authorization from the student for on-going consultation with future treatment providers and concerned parties in the university system.
- Being clear about which parts of the system administer behavioral contracts (e.g. the offices of residential life, deans, Vice President of Student Affairs) versus the role of the counseling center as consultant. Clarifying the consultant role as part of informed consent including authorization for consultation with other offices. In our case, we work with others who mandate a high-risk student whose behavior creates safety concerns to seek an assessment and treatment recommendations from the counseling center (see below).

When aspects of crisis work include careful delineation of the role of psychological consultant that is explained to all parties, it frees the counseling center to maintain a strong alliance with the student in crisis while also providing essential consultative communications with concerned parties about the student’s safety and treatment needs. Even when the student is referred to the hospital for inpatient treatment and eventually to outside providers locally (or at home if the student elects to take a medical withdrawal), the center continues its communication with all parties. Performing as a psychological consultant allows the clinician to obtain authorization from the student to communicate with the treatment resource. The counseling center maintains knowledge of outcomes of the referral process and/or participates in the discharge planning process in cases where students are hospitalized.

As described above, when the student returns to school after hospitalization or a medical leave (and the majority of our students do), the center provides a medical clearance that includes assessment, treatment recommendations and referrals for continued treatment if the student does not already have outside providers. The best-case scenario calls for the counseling center’s complete knowledge about the student’s treatment throughout the process. As psychological consultants, and with informed consent, we maintain contact with the student throughout the process reinforcing their motivation to re-achieve stability and return to school. Over time, we find that students
respond positively to the counseling center’s involvement. Many students are able to continue their studies without taking medical leave. However, a quarter system at an academically competitive school such as Northwestern offers little leeway for recovery from a mental health crisis. Therefore, many students are encouraged to take a voluntary medical leave for rest, recovery and treatment.

Utilizing the concept of psychological consultant, counseling centers can directly address situations involving high urgency clients whose behavior is a safety concern to other parts of the system. Procedures often include a written letter from an administrator (e.g., dean, director of residential life, VP of Student Affairs) stating clear consequences connected to the student’s disruptive and disturbing behavior. Often, the administrator requires the student to obtain a safety assessment from the counseling center as well as follow treatment recommendations. This provides a structure for both the counseling center and the student. The counseling center clinician obtains a release from the student in order to provide psychological consultation to the administrator regarding the student’s safety, treatment recommendations and to notify the administrator if the student does not follow-through (see Appendix p. 29 for chart depicting this parallel process). These procedures need to be carefully constructed in consultation with university attorneys to conform to existing law. There are many variations of this approach; however, the key concepts involve the role and function of the counseling center clinician as psychological consultant in relation to other concerned administrators who are dealing with the disruptive conduct of the student. Both are focused on the safety and well being of the student and the academic community.

A working example of crisis intervention and consultation from a system’s perspective. Because the counseling center maintains a 24-hour on-call emergency system, all third parties concerned about students in distress can easily access psychological consultation. For example, an RA who becomes concerned about active or passive suicidal behavior of a student may call the counseling center any time night or day. Last year our counseling center received 680 after-hours calls; more than 400 of them were from third parties concerned about students in crisis. RA’s are also taught to call the university police immediately if there are safety concerns about a student. Therefore, the on-call counseling center therapists may consult with all parties including the RA, the university police and the student in question. University police are available
to transport students to the emergency room for suicide and other safety assessments when the on-call therapist determines this is necessary. Each on-call therapist has a back-up psychiatrist available, and all are backed up by the Director or Associate Director. In most cases, when the on-call therapist determines that a student needs an ER safety assessment, they engage the student voluntarily in this task. Although the center is prepared to make involuntary commitments, there is rarely a need to do so. The on-call therapist also calls ahead to the ER and prepares crisis personnel to receive the student. By now, hospital crisis personnel and inpatient providers often initiate authorizations from the student to continue communicating with the Counseling Center because they have recognized the importance of our involvement. In cases where we deal with new personnel, the on-call therapist requests that the authorization be obtained and explains the benefits of our participation in treatment and discharge planning as well as consultation to the student throughout.

In scenarios such as the one described above, key student affairs administrators outside the counseling center are immediately involved. RA’s simultaneously consult with their supervisors in residential life and file an incident report. If the university police are involved, the office of VP and residential life receive incident reports from the police. The counseling center is contacted by others who already know about the student’s trip to the ER and safety concerns. Other administrators immediately write letters to the student stipulating medical clearance from the counseling center and requesting authorization for the counseling center to communicate about the student’s readiness to return, safety concerns, and treatment recommendations. These letters are copied to the counseling center. The appointment at the counseling center is often the first stop for students on their return from a hospital stay. In most cases, we have been involved throughout and we are in a position to ally with the student in roles of psychological consultants concerned with their well being, continued treatment, and ultimate success in school.

**Outreach and liaison work.** Essential to all aspects of suicide prevention and follow-up in counseling centers is the development of a strong program of outreach and liaison work. Indeed, in considering how to handle emergencies, the best preventative steps for a counseling center to take involve building essential external structures that create networks of helpers that constitute a safety net for vulnerable students.
The counseling center should establish permanent liaison connections to others in the university. Outreach and liaison work are forms of psychological consultation that expand and clarify the role of the counseling center, and create a real perception of accessibility. Permanent liaisons provide consistent friendly consultation that builds long-lasting relationships of trust. Liaisons help to provide systemic interventions to assist university staff and faculty to create communities that meet student needs. Through consistent interactions, such as attending staff and faculty meetings, liaisons gain an understanding of the real needs of others so that the center may customize outreach interventions. Liaisons provide others with essential data related to the local clinical data the center has gathered about vulnerable student populations, and provide training to others in how to recognize and deal with students in distress. Liaison interactions are the easiest ways for the center to clarify counseling center roles as consultants in emergencies, center policies about confidentiality, center willingness to consult with and coach others regarding students in crisis to help them access needed services. By communicating accessibility, liaisons invite collaboration with the center when others have any question about student safety.

Through its outreach programs, the center may provide training to residential life and other peer helper programs in how to recognize students in distress. It may provide staff programs about critical issues, trends and vulnerable student populations based on its local clinical research. Center staff may join with others in designing in-service events for all student affairs staff and interested faculty about student development issues, especially about vulnerable student populations.

At Northwestern, the counseling center maintains more than 45 permanent liaisons to different components of the university. These relationships have built over time, and have resulted in the center staff being invited to provide presentations at student orientations, faculty and advisor meetings, and to participate on key university committees. Counseling center staff also participate on the Student Affairs staff development committee, and provides essential information based on its local clinical research that contributes to planning in-service training for all staff.

The center also offers a “Contact and Connections” meetings to all deans, concerned faculty, and others who work with distressed students. This meeting offers others a forum for discussion about students in distress, and an opportunity to learn not only about the counseling center’s role in such cases but also the experiences of others.
in the university. Because of confidentiality concerns, the counseling center makes it clear that the group meeting is not a forum for discussion of particular cases. Instead, we provide “hypothetical” cases that combine aspects of many student experiences and safety concerns. This offers an opportunity to ‘walk through’ situations with others who engage in a lively discussion about their own experiences.

The center also initiates task committees with others. One example is a suicide prevention task committee involving several cross-divisional representatives. Committees such as these enable the center to expand responsibility beyond legalistic and clinical approaches. In a recent audio conference, Gary Pavela (2003) noted the need for strong campus role models and meaningful dialogue with others that constitutes caring attention within a community that encourages balance and reflection. Task committees such as these offer the counseling center opportunities to encourage others to continue developing programs where students connect in authentic ways. The creation of a strong caring community may be the best deterrent to suicide available. Outcomes of this particular committee included (a) integration of the JED Foundation into prevention planning with all incoming freshmen and all peer helpers; (b) the creation of an ongoing “Connections” campaign that identifies key offices that will assist lonely students in becoming involved with others as well as a new university web site that includes the Ulifeline offered by the JED Foundation; (c) the establishment of post-suicide protocol for community debriefing; and (d) the initiation of contact with parents of incoming freshmen regarding anticipation of mental health needs for students who already have identified treatment needs.

Another example of a task committee initiated by the center involves key university administrators who are concerned with disruptive behaviors of distressed students. Among others, the committee includes a university attorney, the vice president of student affairs, the associate vice president of student affairs, the director of the counseling center, the director of the health service and the director of residential life. The purpose of the committee is to examine the behaviors of students-at-risk and to review and design appropriate structures for intervention. Again, the counseling center’s experiences and local clinical research form a foundation for this discussion.

Other examples of consultation and outreach include pre-established and thoughtful links to community resources such as hospitals, partial hospital programs and community providers. Many Centers such as ours devote intensive efforts to the
identification and cultivation of community resources. Although location has a definitive impact on results, these efforts often yield a surprising number of qualified therapists who are interested in offering services to students at a sliding scale rate. Centers establish a systematic process for assessing the credentials and experience level of community therapists including maintaining a credentials file including the vita, copies of the therapist’s license, liability insurance, a sliding scale fee agreement, the therapist’s specializations, and contact information. Intentional exploration of available avenues for strong relationships with local hospitals is common. In the current economic climate, counseling centers are often able to negotiate stronger relationships that yield better hospital response to specific student needs. Many hospitals are interested in obtaining more information about student needs (i.e., substance/alcohol abuse, eating disorders, and the needs of severe personality disorders) that they can take into account as they structure intensive day treatment programs.

Because the counseling center is intimately involved in crisis coverage, it is essential for staff also to be trained in crisis debriefing and trauma related to suicide. In the case of student suicide, all systems are immediately involved and on-site including counseling center personnel. In general, the counseling center is available for all parts of the system. Crisis debriefing and on-going therapy is offered to students who were immediately involved. The counseling center also researches less visible parts of the deceased student’s life such as student organizations, friends and romantic interests. The center initiates contact with these parties either directly or through other administrators in order to offer additional support. In most cases, the counseling center teams with the chaplain’s office in these efforts, but there may also be others who work with us as partners. If the student was a center client, the chart is immediately sealed and university attorneys are involved. There is a need to sort through which staff should be involved in campus debriefing and which staff (i.e. the therapist) needs to be buffered. The counseling center also reviews caseloads to identify current or former clients who may be vulnerable themselves and adversely affected by a campus suicide. Individual therapists contact these students. In many cases, and not just when a center client is directly involved, the counseling center staff will need additional assistance from others such as employee assistance or other community resources.
Summary

This paper describes best practice approaches to preventing suicide on campus. In particular, it is proposed that rather than centering total responsibility on the university counseling service, the entire campus system shares responsibility for the student at risk. More specifically, the paper attempts to describe how this is done from a counseling center director’s viewpoint. It is suggested that the best approach to dealing with suicide prevention involves one that (1) creates a network of helpers on campus; (2) creates a parallel set of procedures for the system at large and the counseling center in dealing with students in crisis (where suicidality is dealt with as disruptive behavior by student affairs administrators who mandate suicidal students to receive mental health assessment, intervention, treatment recommendations and follow-up); and, (3) a corresponding role for counseling center staff as psychological consultants to university systems within an atmosphere of appropriate confidentiality and informed consent. Northwestern data are similar to the U of I program data in that the program is effective in reducing rates of suicide among undergraduates but not graduate and professional students. For this reason, the counseling center initiated a task committee that is currently discussing the best approaches for graduate student suicide prevention. In spring 2004, the counseling center and the staff development committee for the division of student affairs will host a conference for Northwestern graduate and professional administrators, staff and faculty that will cover legal and ethical issues involved in working with students in distress.

In order to best prepare for the essential role of psychological consultant on the campus, the counseling center will need to develop and train its staff in law and ethics of psychological consultation; perform local clinical research about vulnerable student populations and trends; understand and implement best practice standards for the creation of crisis response systems, suicide assessment and associated documentation; understand best practice standards for consultation; recognize the importance and value of outreach and liaison training of a network of helpers; be ready and willing to coach others regarding crisis interventions including respective roles and functions; and, demonstrate accessibility through outreach, liaison, training others, and provision of emergency access to service.

Working together in this way, campus administrators and the counseling center create a caring and informed environment of helpers that comprise a safety net for
vulnerable students. We believe this approach combines the best of all methods of suicide prevention reviewed by Joffe (2003) by aspiring to create a total approach through all systems. The factors outlined are not easy to establish on a campus. However, the yield of working toward the goals outlined in this paper are inestimable in terms of creating a caring, proactive environment with a high awareness of suicide prevention as well as the needs of all vulnerable students. Over time, collaborative dialogues create working relationships among staff, administrators and faculty that are based in trust and understanding of one another’s role and associated ethics. All students benefit from the safety net, and especially the students who may have otherwise been sad statistics at an impulsive time in their lives.
References


Disruptive Behavior Occurs 
(Mental Health Issue Involved)

UP
Third Party
Identified Student

Mental Health Track

1. Counseling center (CC) informed; student mandated
2. Crisis intervention/Consultation done
3. Consult with systems as needed and with Release of information (ROI)
4. Action plan: e.g., ER
5. Coordinate treatment planning with ER/family/and other relevant parties
6. Inform SA regarding Actions taken and treatment recs
7. Medical clearance inc. Contact with all providers; ROI’s completed, inform relevant SA offices of recommendations
8. Connect student to cont. services

Behavior Track

1. Appropriate Student Affairs (SA) office informed, e.g., Res Life, Graduate Housing, VPSA
2. Consult with Counseling
3. Proceed with P & P around disruptive behavior, e.g., letter to student about requirements/sanctions, decision to contact parents, follow-up meeting with student to reiterate requirements.
4. Follow up with CC re: recommendations.
5. VPSA informed in major incidents and may need to send letter to student and contact parents.
Figure 1. Daytime On-call Procedure Flow Chart

Student Comes to CC

Telephone Call from student, faculty, staff, and/or

Walk-in team contacted

Assess Situation:

Consult team leader

Nothing Further

CC Appt

Emergency Room

Reconnect to Services

On-call must follow

Complete Emergency documentation and notify appropriate parties; obtain ROIs; consult re: discharge planning; assist with referrals for cont. trtmnt; medical withdrawal; consult with other systems if needed; informal internal admin.
Figure 2: After Hours On-Call Flow Chart

Student comes to health service

Telephone call from nurses’ station or answering service

1st level on-call contacted

Assess Situation.

Consult 2nd level and 3rd level if needed

Nothing Further

CC Appt

Emergency Room

Reconnect to Services

On-call must follow

Complete Emergency documentation and notify appropriate parties; obtain ROIs; consult re: discharge planning; assist with referrals for cont. trtmnt; medical withdrawal; consult with other systems if needed; informal internal admin.

1st level = on-call therapist

2nd level = back-up psychiatrist

3rd level = Director or Assoc. Director