Appendix D

Student Suicide Law & Policy Perspectives: *Advice to residence life staff members.*

By Gary Pavela

[1] Is the student suicide rate increasing?

No. Public attention to a crisis sometimes intensifies after the crisis has peaked. In the case of completed suicides among teenagers and young adults, national data show a decline in suicide rates beginning in the early 1990s. The current downward trend, however, comes after a tripling of the youth suicide rate between 1950 and 1994. Youth suicide constitutes what the Centers for Disease Control and Prevention (CDC) calls "a major public health problem" in the United States—and remains the third leading cause of death in the 15-24 age group, after unintentional injuries and homicide.

News accounts of individual incidents sometimes create the impression that college students are more likely to commit suicide than their non-college attending peers. Researchers agree, however, that college students commit suicide at about half the rate of young adults who are not attending college. Reasons for the difference may include limited access to firearms in collegiate settings; stronger family support networks among college-attending youth; greater involvement by pre-college and college students in clubs and sports; greater access to antidepressant medications; and the increased availability of peer, academic, and professional counseling.

Data about completed suicides should not be confused with rates of depression and *contemplated* suicide among college students. Some observers see a significant increase in rates of depression (nearly one in two students becoming "severely depressed" during their undergraduate years) with about 10 percent of college students reporting that they had "seriously considered" suicide.

[2] What should Resident Advisors do when they learn about a suicide threat or attempt?

The cardinal rule when you hear about any threatened or attempted suicide is to seek *professional help immediately.* Suicide is often associated with clinical depression, accompanied by evasion and denial. Don't ask friends or roommates to "watch" a potential victim. Don't accept a student's assertion that a suicide threat was a joke, a "gesture," or the result of a "bad day." *Seek professional help immediately.*

Consider the following advice from psychiatrist Sam Klagsbrun, given in an interview in *Synthesis: Law and Policy in Higher Education:*

"**Synthesis:** How seriously should suicide attempts and threats be taken? Is there any danger that we'll overreact?"

"**Klagsbrun:** The sin of overreacting is a wonderful one to commit. Because what it shows is the availability of the system to react. And if the worst thing that happens is that someone says, 'you're really overreacting, get out of my life,' and pushes you away, then that's the worst that happens. We at least gave the student an option of pushing us away, as opposed to not being cared for by the surrounding community, which is what most people experience."

[3] Is there a connection between suicide and mental illness?

Generally, yes. Psychiatry professor Kay Redfield Jamison at Johns Hopkins University has written that "[t]he overwhelming majority of suicides are linked to psychiatric illnesses," especially clinical depression (*Night Falls Fast,* 1999, p. 81). Given the strong association between suicide and mental illness, suicide training should stress the need for prompt professional intervention. Gatekeepers (like resident advisors) should not regard attempted suicide or serious suicide threats simply as evidence of temporary frustration or exhaustion. It is increasingly apparent that the main obstacle to suicide prevention is *under* reaction, including the failure to hospitalize students and to assist them with appropriate medication.

A pertinent case study on student suicide can be seen at: http://www.collegepubs.com/ref/Suicide_Prevention.shtml

[4] Can more personal connection and attention reduce suicide rates?

The causes of suicide are complex and variable. In general, suicide is often associated with clinical depression. Depression, in turn, can be exacerbated by environmental factors like social isolation. The importance of personal connection and reducing depression was explored in a February 2000 article by author Tim Parks in the *New York Review of Books.* Parks told the story of a mental patient ("Robert," as described by Jay Neugeboren in his book *Imagining Robert: My Brother,*

Madness, and Survival, 1998), who seemed to be making a strong recovery using a new drug:

> Encouraged by this progress, Robert's social worker concentrates on preparing him for the move to the open ward and relative freedom. Everything seems set for at least partial recovery. But two weeks before that crucial move is due, the social worker is abruptly transferred. Despite continuing with [the drug] Robert rapidly deteriorates . . . Question . . . If the drug works, why does it appear to stop working on the departure of the social worker?

A remarkable answer, Parks suggests, is that various forms of therapy (including the help and attention of a caring staff member) influence the structure of the brain. "[W]hile the brain is indeed conditioned by genetic factors," Parks writes, "it also responds and changes according to environment and experience, the latter often being crucial in the triggering and even transformation of particular genes."

The plasticity of the brain has important implications for medical professionals. Parks wrote that:

> Leston Havens, Professor of Psychiatry at Harvard, [remarked] that despite their reputation for vanity, many mental health professionals, and medical students in particular, fail to recognize their own importance. They 'come and go among patients as if their knowledge and skills were all that counted, their persons not at all . . .' [But] [b]y suggesting that the self, patient's and doctor's, is constantly both product and producer of a group dynamic [is] to imply . . . that in the long run a patient may respond as much to a 'good morning' as to a drug . . ."

Substitute the word "students" for "patients" and the expression "[t]hey 'come and go among patients as if their knowledge and skills were all that counted, their persons not at all . . .'" could apply with equal force to resident advisors.

Bottom line: One of the most important things you can do for your residents is to get to know them as individuals. Pay attention to them. Greet them. Listen to their concerns. Develop group activities designed to help students form connections with others, including faculty mentors. Pay attention to "loners" or students who seem left out. Enhanced personal connection is not a panacea for preventing suicide, but it should be an essential component of any suicide prevention program.

[5] What kind of suicide prevention programming should I consider?

Consult with staff members in the health and counseling centers about specific suicide prevention programs they might offer. An additional way of approaching the topic is to sponsor programs about stress reduction, making sure students hear the message that it's a sign of intelligence and maturity to seek professional help if they feel

overwhelmed. Students also need to know about the signs of depression, and effective approaches available to treat it.

[6] Can suicide be predicted?

Generally, no. A definitive statement on suicide prediction and prevention was issued by the American Psychiatric Association (APA) in 2003 ("Practice Guideline for the Assessment and Treatment of Patients With Suicidal Behaviors") A review of the APA Practice Guideline (Guideline) in the July 2004 issue of *Psychiatric Times* reported that:

> Suicidal ideation occurs in about 5.6% of the U.S. population, with about 0.7% of the population attempting suicide. The incidence of completed suicide is far lower, at 0.01%. "This rarity of suicide, even in groups known to be at higher risk than the general population, contributes to the impossibility of predicting suicide," according to the [G]uideline.

One factor limiting the effectiveness of suicide prediction is the impulsive nature of most suicides. Kay Redfield Jamison has written that:

> [W]e know that suicidal acts are often impulsive; that is they are undertaken without much forethought or regard for consequence. More than half of suicide attempts occur in a context of a premeditation period of less than five minutes.

[7] Can suicide "risk factors" be identified?

Yes. The inability to predict suicide has not prevented mental health professionals from trying to identify *risk factors* for suicide. Four risk factors cited by The Jed Foundation ("a nonprofit public charity committed to reducing the youth suicide rate") are:

- "Mental Illness: 90% of adolescent suicide victims have at least one diagnosable, active psychiatric illness at the time of death—most often depression, substance abuse, and conduct disorders. Only 15% of suicide victims were in treatment at the time of death."
- "Previous Attempts: 26-33% of adolescent suicide victims have made a previous suicide attempt."
- "Stressors: Suicide in youth often occurs after the victim has gotten into some sort of trouble or has experienced a recent disappointment or rejection."
- "Firearms: Having a firearm in the home greatly increases the risk of youth suicide. 64% of suicide victims 10-24 years old use a firearm to complete the act."

Other frequently cited risk factors include:

- A family history of suicide;
- Recent suicide of a close friend or relation;

- Social stresses associated with being gay or bisexual;
- Legal problems or disciplinary incidents;
- Physical or sexual abuse in childhood;
- Persistent anxiety or panic attacks;
- Demonstrated high levels of aggression and impulsiveness;
- "Lovesickness" or emotional turmoil associated with intimate partner problems.

Individual risk factors can be exacerbated by general environmental conditions, especially seasonality (peak months for suicide are late spring and summer) and dramatic or romanticized publicity about recent suicides.

[8] Should "risk assessment" scores be used to remove students from the residence halls?

No. The APA document "Assessing and Treating Suicidal Behaviors: A Quick Reference Guide" cautions that:

> [S]uicide assessment scales have very low predictive values and do not provide reliable estimates of suicide risk. Nonetheless, they may be useful in developing a thorough line of questioning about suicide or in opening communication with the patient.

Suicide risk assessment protocols used by mental health professionals are not designed to serve the administrative purpose of screening out potentially suicidal students. Guidelines and questions that might be helpful in "opening communication" with students and establishing baseline therapeutic responses (subject to review and modification during the course of counseling and treatment) do not have sufficient predictive value to dismiss students deemed to be "at risk" of suicide. Administrative decisions of that nature are better grounded on demonstrable behavior (e.g. overt suicide threats or attempts), not "predictions" or "risk assessments" about what a student might do in the future.

[9] Are colleges liable when a student suicide occurs?

Liability risks for suicide remain low, at least outside custodial settings where a "special relationship" is likely to arise (e.g. hospitals or inpatient facilities) or when the suicide is "caused" by a defendant (for example, by "illegal and careless" dissemination of drugs) or when a mental health professional fails to meet established standards of diagnosis or care. Current law in the higher education setting was summarized by the Supreme Court of Iowa in *Jain v. State of Iowa* (2000), when it held that knowledge by university officials of a prior suicide attempt in the residence halls by an 18 year old freshman (Sanjay Jain) did not create a "special relationship" giving rise to "an affirmative duty of care." The Jain court observed that "[i]n Iowa and elsewhere,

it is the general rule that ... the act of suicide is considered a deliberate, intentional and intervening act that precludes another's responsibility for the harm."

The issue of liability for student suicide in the college and university setting is in flux. While established legal precedent clearly limits the risk, signs of change are on the horizon, intensified by growing activism among parents on the issue of campus safety and security. There is no indication courts or legislatures will impose a requirement that colleges randomly screen and predict which students will commit suicide and make timely interventions to save their lives. Nor will administrators or counselors (who are not mental health professionals) be expected to know and respond to all of the evolving and frequently ambiguous "warning signs" of suicide. Instead, institutions of higher education face heightened risk of liability for suicide when they ignore or mishandle *known suicide threats or attempts.* The immediate practical lesson for resident advisors is to refrain from treating suicide threats or attempts as temporary episodes of depression or disorientation, likely to "go away" on their own. Remember the cardinal rule: When you hear about any threatened or attempted suicide *seek professional help immediately.*

[10] Could liability risks be reduced by dismissing students at risk of suicide?

No. One of the worst things a college or university could do as a "risk management" measure is routinely dismiss students at risk of suicide. Not only would such a practice be ethically questionable, it might also violate the Americans with Disabilities Act, thereby producing *more* litigation. The right educational policy—and the right risk management practice—is to make sure students who threaten or attempt suicide obtain immediate professional help (even if an assessment has to be required, or enforced through the college disciplinary process) and that they remain in school.

[11] Are there any model suicide prevention programs?

The University of Illinois has developed what many observers regard as a model suicide prevention program. Paul Joffe, director of the University of Illinois suicide-prevention program, and a counselor in the University Counseling Center, described the Illinois approach in "The Illinois Plan, Part II," *Synfax Weekly Report* (November, 2003):

> For the last 18 years, the University of Illinois has held its students to a standard of self-welfare and mandated all students who have threatened or attempted suicide to attend four sessions of professional assessment. The most appropriate evidence, which compares the rate of suicide at locations within Champaign County between the eight year pre-program study period with the 18 years

> of the program, showed a 55.4 percent reduction in the rate of suicide. To rule out the possibility that this decrease was part of a larger decrease in the rate of suicide, either nationally or at mid-western universities, these results were compared with suicide rates both nationally and at 11 peer institutions in the Big Ten. Both comparisons showed that the rate of suicide at the University of Illinois was declining at that same time rates nationally and within the Big Ten were essentially stable . . .
>
> Of all the myriad risk factors identified to date, none comes close to matching the expression of prior suicidal intent either in predictive power or in potential for leverage. The present program shows that focusing precisely and relentlessly on this single risk factor and creating an elaborate system of reporting and mandated intervention, the rate of suicide can be cut in half.

[12] Should parents be notified when a student threatens or attempts suicide?

Parental notification polices differ. Resident advisors should not contact parents unless directed to do so by a supervisor. Also, in some cases, a mental health professional will advise against parental notification.

As a general rule, parents or other persons identified by students as "emergency contacts" should be notified by designated staff members in cases of threatened or attempted suicide. Experience has shown that families usually come together in a crisis, and that parents see their students holistically in ways college and university staff members are likely to miss. A resident advisor might know a student for a few months. That's no substitute for the knowledge, insight, and devotion of the student's parents. Likewise, it's unwise for college officials to make quick and superficial judgments based on limited evidence that any particular family is "dysfunctional." Families aren't perfect, but neither are college administrators, and (in terms of what a student is truly thinking and feeling) they usually know less than a student's parents.

Consider the following observation from Paul R. McHugh, former chairman of the department of psychiatry at Johns Hopkins School of Medicine (cited in the article "Parents were the last to know" by columnist Eileen McNamara in the January 30, 2002 *Boston Globe*):

> Privacy isn't everything; life is everything. We lock people up, we take their civil liberties away if they are a danger to themselves. But we can't call the parents? What kind of nonsense is that?

[13] Where can I go for additional information?

The first place to go for guidance on the subject of college student suicide is your own counseling center. You can also find general advice at this website: http://www.jedfoundation.org/

To learn more about clinical depression (and the feelings of those who experience it) read Kay Redfield Jamison's book *An Unquiet Mind* (Vintage, 1995).

Dr. Jamison also explores the connection between depression and higher levels of personal insight and creativity. Sometimes our best and brightest students will experience sharp swings in moods. It's not our aim to make them "normal" or "conventional" (and certainly not to dismiss them from school), but to help them understand, adjust, and manage their emotions in ways that allow them to achieve their highest potential. Mental health professionals are trained to seek this result, usually through a process that combines carefully dosed medication and some form of cognitive therapy.

Summary and Overview

[a] suicide threats or attempts should be treated as medical emergencies. Seek professional help immediately.

[b] Pay attention to your residents. Be a good listener. Develop group activities designed to help students form connections with others, including faculty mentors.

[c] Sponsor programs about stress reduction and signs of severe depression. Make sure students hear the message that it's a sign of intelligence and maturity to seek professional help.

[d] Suicide is often impulsive. Assisting students in obtaining professional help (especially during a personal crisis) can allow them to acquire resources, insights and skills that sharply lessen the risk of suicide later.

[e] Suicide cannot be predicted, but "risk factors" for suicide can be identified. Risk factor scores should be used by mental health professionals for treatment, not by college officials for administrative action (e.g. a "mandatory medical withdrawal").

[f] Approaches to college student suicide should not be driven by liability concerns. The right educational policy and the right risk management practice is to make sure students who threaten or attempt suicide obtain immediate professional help, even if an assessment has to be required, or enforced through the college disciplinary process.

[g] In most cases of threatened or attempted suicide, parents or other persons identified by students as "emergency contacts" should be notified. Such notification, however, should only be done after consultation with and authorization by your supervisor.

[h] Sometimes the best and brightest students will experience sharp swings in moods. It's not our aim to make them "normal" or "conventional" (and certainly not to dismiss them from school), but to help them understand, adjust, and manage their emotions in ways that allow them to achieve their highest potential.