COUNCIL ON MENTAL HEALTH AND WELFARE

April 19, 2004

MINUTES

Present:
Council Members: Janet Corson-Rikert, Ray Dalton, Greg Eells, Sharon Dittman, Cheryl Farrell, Ellen Gainor, Jenny Gerner, Tanni Hall, Ashley Higgins, Kent Hubbell, Don King, Tim Marchell, Susan Murphy, Lisa Ryan, Ritch Savin-Williams, Bob Smith, Linda Starr, Charlie Van Loan

Executive Committee on Campus Health Members: Mary Opperman, LeNorman Strong

Additional members of the Suicide Prevention Group: Betsy East, Kirsten Post-Eynav

Next meeting:
Thursday, May 6, 4 to 5 p.m. at Gannett, the Moore Library, on Level 5
Agenda: discussion of Joffe presentation; plans for upcoming meetings

Meeting agenda: Today’s meeting of the Council was a presentation by Paul Joffe, Ph.D., director of the suicide prevention program at the University of Illinois at Urbana-Champaign, entitled: “An Empirically Supported Program to Prevent Suicide Among a College Population”

I. Summary
A. The natural rate of suicide won’t decline unless institutions of higher education engage in systematic activities to make it decline.
B. Suicide is not so much a “cry for help” but a disorder of power, control and privilege.
C. 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.
D. Universities need to take an appropriate measure of responsibility to identify students-at-risk and apply an appropriate standard-of-response.
E. In 1984 the University of Illinois undertook such a program and it resulted in a 58 percent reduction in the rate of suicide over a 19 year period.

II. Suicide in higher education
A. Three critical facts about suicide in higher education
1. The rate of suicide among college-attending young adults has been convincingly established at 7.5 per 100,000 students per year. (Source: Big Ten Student Suicide Study, 1980-1990, Silverman, Meyer, Finbarr, Raffel & Pratt, 1997)
2. The rate of suicide among college and university students is approximately one half the rate of their non-attending peers.
3. With 14.8 million students enrolled in the nation’s colleges and universities in 2002, it is estimated that 1100 students committed suicide. (Based on this estimate, Cornell would expect an average of 1.56 students to kill themselves every year.)
B. The state of systematic suicide prevention in higher education
1. Only six published studies reporting efforts to engage in systematic suicide prevention since 1937.
2. A couple of studies have supportive data.
3. No program has solid empirical evidence to support its practice.
C. The state of systematic suicide prevention in general
1. Oast and Zintrin (1975) have called suicide a problem without a program.
2. Suicide hotlines are not associated with clear supportive data.
3. The University of Illinois program is associated with a 58 percent decline over a 19 year period.
4. The U.S.A.F. instituted a community-based program with mandatory treatment in the early 1990s and saw a decline in the rate of suicide in the neighborhood of 80 percent.

D. Suicide Prevention and the Law
1. Do institutions of higher education have an affirmative duty to prevent students from committing suicide? Traditionally, the courts have said that given the nature of the relationship between institution and student, no.
2. The impasse: should institutions of higher education engage in efforts to prevent suicide, when those efforts are of questionable effectiveness, but run the risk of creating the perception of an affirmative duty?
3. Three recent wrongful death lawsuits
   a. Michael Frentzel, died February, 2000. Family sued Ferrum College for 10 million. Settled with the college. College admitted that it was partly responsible.

III. PHASE ONE of the Suicide Prevention Program at the University of Illinois: Implementation of Suicide Incident Reporting (1977)
A. In 1977 the Vice Chancellor for Student Affairs mandated that all student affairs staff submit a Suicide Incident Report Form to the Counseling Center when they credible information that a student had threatened, attempted or committed suicide.
B. To understand more about the students who committed suicide, Paul Joffe undertook a study with the Champaign County Coroner (1983). This study covered eight years: 1976 to 1983.
   1. Found 19 students who died by suicide
      a. 16 men, three women
      b. 16 undergraduates, three graduate or professional students
   2. 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.
   3. Prior mental health usage
      a. Thirteen students (68 percent) had prior contact with a psychiatrist.
      b. One student (5 percent) had prior contact with a psychologist.
   4. Prior intent
      a. Coroner’s Office, in its limited investigation, found that twelve of the nineteen students (63 percent) had made prior threats or attempts.
      b. Seven students (37 percent) committed suicide “out of the blue.”

IV. PHASE TWO of the Suicide Prevention Program at the University of Illinois: “Invite and Encourage” (1983)
A. 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.
B. Program: Invite and encourage
   1. 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.
   2. Lasted three months.
   3. Completely ineffective at increasing the rate of post-threat and post-attempt contact.
C. Phenomena noted in students contacted with the “invite and encourage” approach?
   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.

V. Questioning the “Distress Model of Suicide”
A. A common model for understanding why people commit suicide is the “Distress Model of Suicide.”
   1. Suicide is about distress, despair and frustration.
   2. No one, outside of those with a terminal illness, would want to die.
   3. The help-seeking inclinations of the suicidal are intact and operative.
B. The distress gradient
   1. All distress is relative.
2. Death and dying are associated with a fixed level of distress that naturally deters self-harm.
3. If distress in other areas of a person’s life increases to a level above the distress associated with death, then suicide may become an attractive option.
4. As soon as the distress in these other areas diminishes, the distress associated with dying reasserts itself and suicide ceases to be an option.

C. Corollaries of the Distress Model of Suicide
1. All suicidal intent is distress-driven.
2. All suicidal intent is temporary in nature.
3. All suicidal intent is self-correcting.
4. People in distress can be expected to naturally seek and obtain the assistance they need to lower their distress.

D. Challenges to the Distress Model
1. Doesn’t account for persisting suicidal intent, sometimes lasting years.
2. Doesn’t account for the identification many students have with suicide.
3. Doesn’t account for the absence of appropriate help-seeking.
4. Doesn’t account for the entrenched resistance to meeting with a therapist after a threat or attempt.

E. “Suicide Is a Cry for Help”
2. “The title, The Cry for Help, is meant to convey our feelings (from our work with suicidally disturbed persons) about the messages of suffering and anguish and the pleas for response that are expressed by and contained within suicidal behaviors (page xi).”

F. Empirical evidence finds that people who are suicidal tend not to seek help
1. Empirical evidence among those who commit suicide
   a. Schwartz and Whittaker (1991) meta-analysis of four studies reported among 99 college students who committed suicide, only 36 had prior professional contact.
   b. Lecomte and Fornes (1988) studied 392 cases of suicide among Parisians between the ages of 15 and 25 and found the majority had no professional contact.
   c. Seager and Flood (1965) investigated 345 suicides in Bristol and found less than 1/3 had evidence of psychiatric treatment.
2. Empirical evidence among those who attempt suicide
   a. Moeller (1989) notes that research on the effectiveness of post-attempt aftercare is made difficult by the low rate of treatment compliance.
   b. Hoffman (2000) cited these statistics and suggested that most suicide prevention centers and the traditional provision of mental health resources will “miss” the majority of those most at risk.
3. What we knew statistically about the one year risk
   a. The odds of dying by suicide during the year after a suicide attempt or threat was 1 in 80.
   b. The odds of dying by suicide for students who had not threatened or attempted suicide was 1 in 36,000.
   c. Students who threatened or attempted were 450 times more likely to die in the year after than students who did not—”Anniversary risk.”

VI. If suicide is not primarily a cry for help, then what is it?
A. Suicide is an act of violence.
B. Suicide is an act of self-directed violence.
C. Suicide is unique in that it is the one form of violence in which the same person is the perpetrator and the victim.
D. Suicide is different from other forms of violence because I own myself
E. A person can exist in either one of two competing states of mind
   1. A person can experience himself or herself as “in charge” of some domain.
   2. A person can experience someone or something else to be in charge of this domain and defer to him/her or it.
F. What do we do, when in our opinion, a person inappropriately experiences himself or herself to be in charge of a domain?
   1. We contest their “in-chargeness.”
   2. We attempt to leverage them. If they don’t give up their “in-chargeness,” we will deprive them of something else by virtue of our in-chargeness.
   3. If you continue to deem yourself to be in charge of your continued existence, we will deprive you of your student status by virtue of the fact that we are in charge of your continued status as a student.

VII. PHASE THREE of the Suicide Prevention Program at the University of Illinois: “Policy of Mandated Assessment” (1984 to present)
A. Basics
1. Any student who threatened or attempted suicide is mandated to attend four sessions of professional assessment with a licensed social worker or psychologist or run the risk of being withdrawn from the university.
2. First appointment within a week of the incident or release from hospital.
3. Subsequent appointments ideally spaced a week apart.

B. Suicide Prevention Team
1. Established to monitor compliance (may take many contacts to assure compliance)
2. Staffed by three mental health professionals and an administrative specialist.
3. Operation and function
   a. University’s single registry for information regarding threats and attempts.
   b. Reports to Dean of Students. Nothing is left to chance or good-will.
   c. Adjudicates disputes over threshold of a valid report (was there really a threat/attempt?).
   d. Adjudicates disputes over what constitutes valid assessment (especially if an outside therapist is involved).
   e. The University’s sole authority in establishing sanctions regarding suicidal students.

C. Four differences from typical approach to suicide prevention
1. We view suicide as an act of self-directed violence and not as a desperate escape from distress.
2. We “re-criminalize” suicidal behavior by attaching standardized consequences to its occurrence.
3. We don’t assess for future suicide risk. Instead, we determine if a standardized threshold has been crossed at any point in the last three months.
4. We respond to small-scale suicidal incidents that traditionally fall between the cracks.

D. Results: data from nineteen full years (1984 to 2002)
1. 1670 reported incidents.
   a. 20 student deaths by suicide.
   b. 20 men, zero women.
   c. 8 undergraduates, 12 graduate students.
2. Overall decline: 58%
   a. Decline among female students: 100%
   b. Decline among male students: 44%
   c. Decline among undergraduates: 78%
   d. Increase among graduate students: 62%
   e. Decline of foreseeable suicides: 100%
3. Results including deaths that occurred outside of Champaign County
   a. Nine additional students died by suicide at locations outside of Champaign County during program period.
   b. Apples to oranges comparison. Pre-program coroner study period included only students who died at locations within Champaign County.

E. 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.

VIII. Seven interlocking realities regarding suicide in higher education
A. Reality 1: The majority of those who die by suicide have a history of previously displayed intent.
B. Reality 2: Suicidal intent is self-hardened against appeals to the contrary.
C. Reality 3: The majority of those students who die by suicide will have advanced through the stages of their suicide careers, from initial intent to death, without having stepped into a single therapist’s office. At the University of Illinois 1976-1984, 95 percent of the 19 students who committed suicide did so without having met with a therapist.
D. Reality 4: Students harboring suicidal intent are vehemently opposed to making any professional contact that might challenge the foundation of that intent.
E. 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.
F. 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.
G. 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.

IX. Costs of program
   A. Administrative (training, monitoring compliance, Team): $10,000.00/year.
   B. Assessment: $40,000.00/year.
   C. Suicide prevention: $1.35/student.
   D. Flu vaccination: $2.03/student.
   E. Meningitis vaccination: $3.43/student.

“Homework” assignment for all Council members:
- The primary agenda for the Council meeting on May 6 will be discussion of the ideas presented by Paul Joffe.
- Please consider ways in which they might inform our thinking and strategies here at Cornell.
- Send your ideas to Greg Eells (GTE3; 255-5208).

Minutes based on Paul Joffe’s powerpoint presentation, recorded by Sharon Dittman