

Suicide Prevention Training, Behavioral Health Services & Awareness Raising Among Washington State Postsecondary Education Institutions

Report to Washington State Legislature
December 2019



Forefront Suicide Prevention at University of Washington produced this report with support from the SSB 6514 Work Group.

Contents

Executive Summary	4
Findings	4
Recommendations for long-term change	5
Background	6
Additional Components of SSB 6514	7
Numbers That Help Tell Washington’s Story.....	8
Definitions	10
Summary Findings	11
Summary Recommendations	12
Methods	14
SSB 6514 Data Requirements and Survey Development.....	14
Figure 1. Substitute Senate Bill 6514 Data Requirements	14
Data Results.....	16
1. Responding institutions by sector.....	16
Figure 2. Responding and non-responding postsecondary institutions by sector	16
Table 1. Enrolled students from reporting institutions, per sector	17
2. Behavioral health & suicide surveillance in Washington postsecondary institutions.....	18
Table 2. Suicidal behavior among postsecondary students	18
Figure 3. Suicide rates for Washington college & non-college age peers, etc.	20
3. Behavioral health services in Washington postsecondary institutions	21
Table 3. General behavioral health services, sessions, student awareness, and referrals. 21	
Table 4. Health assessments, behavioral health screening & behavioral health services ..	23
Table 5. Mental health credentials and counselor-to-student ratios.....	25
Figure 5. FTEs of institutional mental health practitioners per 1,000 students	27
4. Training, Education, and Student Awareness of Behavioral Health	27
Table 6a. Suicide recognition and referral training	27
Figure 6. Training programs for students, faculty or staff on behavioral health topics	28
Table 7. Behavioral health promotion programs.....	30
Limitations:	30
Table 8. Student, faculty, and staff awareness.....	31
Figure 7. Student, faculty, and staff awareness about institutional resources for behavioral health	31
Limitation:	32
Table 9. Help-seeking behavior, stigma, peer support	33
Limitation:	33
Figure 8. Programs on help-seeking behaviors and reducing stigma	33

5. Emergency planning and management.....	34
Table 10. Emergency crisis planning, continuity of care, parental/family contacts.....	34
Table 10 a. Additional protocols: continuity of care, family communication.....	34
Findings:	35
6. Facilities safety reviews	35
Table 11. Facilities safety reviews	35
Table 11a. Firearms & medication takeback policies on campus	36
7. Veterans & other at-risk populations	37
Table 12. Students currently serving or ever served in U.S. Armed Services	37
Table 13. Support for behavioral health among specific student-populations	37
Table 13a. Supporting relationship building among student groups.	38
Appendices	39
Appendix I: Postsecondary institutions participating in SSB 6514 data collection	39
Appendix II: Postsecondary Conceptual Model to Guide Planning & Evaluation	41
Appendix III: Citations	42

Executive Summary

The 2018-2019 implementation of Substitute Senate Bill 6514 shows that Washington State's postsecondary education institutions recognize and are trying to address student behavioral health and suicide prevention needs.

Data collected from the institutions tell a story of challenges and opportunities for which additional resources are required to protect vulnerable students and support successful educational attainment.

Findings

- Good news is found in several elements of the data: Institutions and their leadership are to be commended for investment in behavioral health promotional programs (Table 7). Equally, they report working on help-seeking behaviors, destigmatizing mental health (Table 9), and empowering students' interest in mental health through involvement with clubs, committees, and innovative programming. These efforts are unevenly spread across institutions, and there is room to grow, but the levels of activity are significant.
- Most Washington postsecondary education institutions, historically, have not regularly tracked data regarding suicidal behavior, given the challenges of this data collection (Table 2). However, data on student suicide deaths and attempts collected during three months of this year represent a valuable first step in establishing a baseline. Over-reliance on the initial suicide death data is unwarranted, as small sample sizes collected over a brief period of time can be volatile. Over the next three years, with additional data, the state will see a clear baseline for postsecondary suicide deaths and attempts. While incomplete tracking and reporting of suicidal behavior remains a concern, this year of data indicates that postsecondary students' deaths by suicide are a reality in our state, and many institutions are making meaningful efforts to prevent unnecessary loss of life.
- Behavioral health staffing levels among Washington's two-year and four-year public postsecondary institutions overall fall short of the current accepted ratio range¹ of one behavioral health professional for every 1,000 to 1,500 students. None of the reporting two-year institutions meets this range of ratios (Table 5). It is entirely likely the same would be true for community colleges nationwide.

¹ The Center for Collegiate Mental Health has recently announced a new system of measuring counseling capacity for postsecondary education, the Clinical Load Index. Institutions will require some time to adjust to this system, which is designed to reflect the reality of the supply and demand inherent in college counseling.

Recommendations for long-term change

- Create and provide sustainable, long-term funding for a summer institute or similar vehicle for ongoing training, to accelerate the acquisition of expertise in suicide prevention and care among early career and all mental health, behavioral health and public health practitioners working in postsecondary education, K-12 and health care sectors.
- Prioritize the need for additional behavioral health counselors, and opportunities for telehealth at all institutions and particularly at the significantly understaffed Community and Technical Colleges.
- Serve student veterans' needs by partnering with the Washington Department of Veterans Affairs and its War Trauma Program, and the U.S. Department of Veterans Affairs and its Veterans Integration to Academic Leadership (VITAL) program, which is designed to benefit student veterans with behavioral health needs. Other potential partners include the national non-profit agencies Cohen Veterans Network and Recovery Reboot, which may be able to co-locate mental health clinicians or otherwise enhance student veterans' services on Washington campuses where needed.
- Expand Washington's behavioral health workforce. Develop a student grant and/or loan forgiveness program to benefit top-performing students earning advanced degrees in behavioral health who commit to working in the public sector, including higher education.
- Develop meaningful, accessible support for early-career Washington counselors from multicultural backgrounds. Given the increasing diversity of students attending many institutions, an initiative to connect multicultural counselors with students from all races, ethnicities, and sovereign Native American nations would ease these students' search for practitioners with whom they can connect.
- Require all institutions to update and document crisis response and postvention plans. Simply put, what's not on paper within an institution is likely not to be communicated or implemented in a consistent style during a campus crisis.

Background

Suicide rates have risen nationally and in Washington over the past 20 years (Hedegaard, Curtin, & Warner, 2018).

There is no current source of annual data on the rates of national higher education student suicide deaths. However, higher education students nationwide are seeking behavioral health services at their institution in increasing numbers that cannot be accounted for by rising enrollment alone (Locke, 2015). Anecdotally, it appears that increased demand for behavioral health services is taking place among Washington higher education institutions offering these services.

Additionally, college campuses nationwide are reporting a steady increase in the number of students arriving on campus already using psychiatric medication (Gallagher, 2015).

Though the national proportion of struggling higher education students who access mental health services on their campuses is rising, the number of students with mental health needs that receive professional support remains low. Results vary from survey to survey, but no more than 40% of students with mental health needs see a counselor on their four-year campus (Locke, 2019). The American College Counselors Association, which represents community colleges, reported that more than 60% of respondents in its 2015 survey said less than 10% of students accessed campus mental health services (Edwards, 2015). Some of these students may be seeking services elsewhere, however studies indicate that students are most likely to receive help when it is located at their institution. Delayed treatment of mental illnesses typically results in more severe conditions, which require more extensive treatment (Kersting, 2005).

We now turn our attention to the Washington legislature and its efforts to better support students. In 2016, the legislature passed House Bill 1138, creating a task force that assessed higher education needs and assets in suicide prevention. Recommendations from the report on the 2016 work formed the basis of the 2018 legislation. The bill included three elements: data collection, a grant program for low-resourced institutions, and a publicly available resource.

This report summarizes findings from the data collection of the 2018-19 academic year. The Washington Legislature asked for the cooperation of Washington postsecondary institutions in establishing an annual baseline assessment of suicide rates and attempts and identifying behavioral health and suicide prevention services and program needs. A majority of four-year and two-year institutions responded with valuable data.

Within the sector of career colleges and trade schools, institutions responding to the survey offered few positive answers, indicating that efforts toward supporting behavioral health needs of their students are in a nascent stage. Thus, these results are not included in the report.

A data analyst at Forefront Suicide Prevention, a Center of Excellence based at the University of Washington, with support from SSB 6514 Work Group members, analyzed these data with the intent to help inform how the legislature prioritizes investments in Washington's postsecondary education institutions. In addition, this work is designed to provide institutions an overview of behavioral health services, programs, and resources that exist across similar institutions of postsecondary education around the state. Finally, the data are being used to help inform the development of a publicly available resource designed to improve behavioral health among postsecondary students.

Additional Components of SSB 6514

This report focuses primarily on the data collection required by SSB 6514. Progress has been made, however, on the bill's remaining components, which are briefly addressed here:

1. Grant Program for Low-Resourced Institutions

The Washington Student Achievement Council administered a 2018-19 grant program that helped resource-challenged postsecondary education institutions create partnerships with health care entities and enhance student behavioral health and suicide prevention.

Eight grant proposals were awarded full or partial funding for their programs. The reach of these grants was unexpectedly broad. Proposals came from all regions of the state. Two of the eight proposals involved partnering with a second educational institution, and one proposal engaged 1,000 staff from 34 career schools statewide in mental health and suicide prevention trainings, and also supported 13 staff members to become master trainers, thus helping to institutionalize these training opportunities for the career school sector.

Several grants focused on suicide recognition and referral training and awareness raising. Two institutions used funding to temporarily bolster their student mental health services. Others worked on student referral agreements with their health care partners. One institute performed a facilities safety review, reducing student exposure to potentially dangerous sites, methods or lethal means.

2. Publicly Available Resource

The free, publicly available resources are to include an annual conference, a free curriculum for recognition and referral training, as well as support in its implementation, and a web-based portal with a collection of online materials.

The Washington State 2019 Conference on Suicide Prevention in Postsecondary Education, held April 15 at the University of Washington, drew 220 attendees from majorities of two-year community and technical colleges, and public and private four-year universities, as well as several vocational and professional institutions. Topics included first steps in suicide prevention for low-resourced institutions; innovative methods to maximize the number of students receiving mental health services; a national perspective on the rising student demand for mental health services; development of effective substance use disorder recovery programs; building student resilience; and best practices in postvention in the wake of a student suicide. A training day on April 16 offered a train-the-trainer for Forefront's LEARN® Saves Lives Higher Education, and half-day trainings in student veterans' needs, and culturally responsive training for Native American students. The conference was positively received by attendees, who were predominantly counselors and student services staff.

The portal and website, which will display the publicly available resources, is under development and due for launch by June 30, 2020. Materials will include a guide to developing comprehensive suicide prevention; model protocols for prevention, intervention, re-entry and postvention; model messaging to promote behavioral health; resources to support student veterans and diverse student groups, and materials to help faculty, staff, students and families support individuals who are struggling with mental health issues, life stressors, and insufficient coping skills.

In September 2019, the SSB 6514 Work Group agreed on a name for this important work: Innovative Suicide Prevention, Intervention and Education in Postsecondary Ed – or INSPIRE. Thus, the group is now known as the INSPIRE Postsecondary Education Work Group. The portal and website will carry the INSPIRE brand.

Numbers That Help Tell Washington’s Story

National and state data help to demonstrate how students are struggling, failing to find help, turning to consideration of suicide, and in some cases suicide attempts.

National College Health Assessment²³ Spring 2019	
Students felt very lonely	65.6%
Students felt things were hopeless	55.9%
Students seriously considered suicide	11.6%
Students attempted suicide	1.8%

Thirteen Washington campuses participated in the Healthy Minds Study in 2017 as part of the Washington JED Cohort. The cohort included 4 four-year public institutions, 4 four-year non-profit institutions, and three CTCs. The Jed Foundation is the leading non-profit voice nationwide on suicide prevention in higher education. The JED Program focuses on building comprehensive suicide prevention in institutions nationwide.

Washington JED Cohort’s 2017 Healthy Minds Study Results⁴	
Students felt academic impairment from mental health issues	43%
Students seriously considered suicide	12%
Students made a suicide plan	4%
Students attempted suicide	1%

The Healthy Minds Study (HMS) directly samples postsecondary student attitudes and behaviors. It is produced annually by the University of Michigan’s Healthy Minds Network. In 2020, members of the Washington JED Cohort will receive results from their second HMS study, which is taking place during this academic year.

² The National College Health Assessment is produced semi-annually by the American College Health Association.

³ Within the past 12 months

⁴ Within the past year

U.S. 2017 Suicide Rates	
National suicide rate	14.5 / 100,000
Estimated college student rate	7 / 100,000
AI/AN ⁵ , female, 15-24	20.5 / 100,000
AI/AN, female, 25-44	20.7 / 100,000
AI/AN, male, 15-24	53.7 / 100,000
AI/AN, male, 25-44	58.1 / 100,000

Nationally, an estimated annual 1,400 college student suicide deaths would occur, based on University of Rochester researcher Allan J. Schwarz's 7.0 undergraduate suicide rate and the National Center for Education Statistics report of 16.8 million college undergraduates nationwide in 2019 (Schwartz, 2011).

Washington 2017 Suicide Rate	
State suicide rate	17.5 / 100,000
Ages 18-24, college & non-college age peers	24.2 / 100,000
Males, 18-24, college & non-college age peers	40.6 / 100,000
Females, 18-24, college & non-college age peers	6.4 / 100,000
Ages 16-44 ⁶ , college & non-college age peers	19.6 / 100,000
WA Veterans ⁷ , 18-34	46.4 / 100,000
WA Veterans, 35-54	27.4 / 100,000

Data on community colleges and their students' mental health needs is sparse. The 2016 Wisconsin Hope Lab report, *Too Distressed To Learn*, examined mental health needs among 4,000 students from 10 community colleges across the nation (Wisconsin Hope Lab, Healthy Minds Network, 2016). The study found 49% of responding community college students reported a mental health issue.

There is little, if any, data regarding a possible association between the behavioral health needs of Washington's CTC students and the graduation rates of the institutions they attend. The absence of such data about these highly utilized institutions calls for further research, both nationally and in Washington.

⁵ American Indian/Alaska Native data, National Violent Death Review System

⁶ Age range represents the traditional range of CTC students, including Running Start.

⁷ U.S. Veterans Health Administration

Definitions

Comprehension of three terms important to this report:

Mental health – Mental health disorders, mental/emotional wellbeing, and serious psychological distress. Anxiety and depression are the two most common mental health disorders among college students.

Behavioral health – Mental health and/or actions that affect wellness. Behavioral health problems include mental health disorders, substance use disorders, and eating disorders.

Suicide prevention – Surveillance for suicidal ideation and behaviors, including training in recognition and referral skills; suicide risk assessments, management of suicidal urges through safety planning intervention, and family education and/or a network of allies; therapy and/or psychotropic medication to treat suicidal urges, as well as treatment of underlying mental health and/or behavioral health conditions; crisis treatment, continuity of care, follow-up care, and postvention. Other tools for suicide prevention include Dialectical Behavior Therapy skills and Collaborative Assessment & Management of Suicidality.

Other terms:

Lethal means, means – the method, tool, or circumstances an individual may use to end their life or attempt to end their life

Postsecondary student – regardless of age, a student who attends an institution of higher learning, career school or college, or professional school

Postvention – the policies, processes, and actions that follow a student suicide to facilitate clear communication, support for short-term and long-term grief, a return to normalcy, and support for media to ensure responsible reporting on suicide. The goal of postvention is to reduce the opportunity for suicide contagion. Thus, postvention is prevention.

Recognition & Referral Training – a more specific alternative to the traditional term 'gatekeeper' training

Safety plan intervention – this tool allows clinicians to help a client gain awareness of triggers that increase their suicidal urges; and create and use a customized series of methods and resources that can help the student safely navigate acute suicidal impulses

Suicide – death caused by self-directed injurious behavior with an intent to die as a result of the behavior

Suicide attempt – self-injury that is intended to end a person's life, but does not result in death

Summary Findings

- Mental health staffing levels among Washington's two-year and four-year public postsecondary institutions overall fall short of currently accepted ratios of one mental health professional for every 1,000 to 1,500 students. None of the reporting two-year institutions meets this range. (Table 5) This is likely to be true for two-year institutions nationwide.
- Nationally and in Washington, veterans are at greater risk of suicidal behavior than their non-veteran peers (*Washington Veteran Suicide Data Sheet, 2017, n.d.*). Student veterans are found in all sectors of postsecondary education in Washington, and our Community and Technical Colleges serve them in highest number (Table 12). Unfortunately, as the data show, the CTCs also offer the fewest mental health services. (Table 3)
- Some campuses have not developed a crisis plan with protocols addressing mental health or suicide crises, support of students upon re-entry to campus following a mental health crisis, or postvention policies in the aftermath of a student suicide, designed to guard against suicide contagion. These protocols are essential to ensure each campus has clear and widely shared knowledge on how they will support students in crisis. (Table 10)
- Institutions overall tend to offer more resources in supporting students with mental health issues, than are offered in supporting students with substance use disorders. (Table 3)
- Many campuses do not solicit health history questionnaires from incoming students, thus missing an opportunity to start an early conversation with students about the availability of behavioral health resources at their institution. (Table 4)
- Across all postsecondary sectors, use of a high number of early-career, unlicensed mental health staff, combined with limited institutional training programs for such employees, may leave students who manifest serious psychological distress without access to excellent care. (Tables 5 & 6)
- While most institutions offer some recognition and referral training about suicide risk (Table 6a), the number of faculty, students, and staff receiving training is uneven. It appears that this type of training is not required of these constituent groups at any institution and that levels of urgency regarding this training are widely varied. (Table 6b)
- During the three-month data collection period (February-April 2019) reported on, more than 800 students withdrew from courses due to emotional distress, mental health or substance use disorder, among other reasons. The variation in data suggests incomplete reporting. Student retention and program completion suffer, making this another reason to invest in additional behavioral health resources. (Table 10)
- Institutions are providing support services and, in a few cases, dedicated counselors for student veterans. However, dedicated counseling for other high-risk groups including

Native Americans, violence survivors, sexual assault survivors, students of color and students in recovery from substance use disorders is far lower or non-existent. Students rarely have access to culturally specific resources. (Table 13)

- Fifty institutions stated a need for more training of faculty and staff to support their students. Many of these needs spoke to specific concerns – for example, training on the unique risks of men, veterans or culture-specific concerns with regards to suicide – and referenced specific content, such as certification training in Eye Movement Desensitization Response (EMDR) therapy and DBT skills for counseling staff.

Summary Recommendations

- Create and provide sustainable, long-term funding for a summer institute or similar vehicle for ongoing training to develop greater expertise in suicide prevention and care to train mental health and public health practitioners working in all postsecondary education sectors. The field of suicide prevention suffers from an inadequate research-to-practice pipeline. This creates a need for professional education that will build fluency in today's standard of care.
- Prioritize the need for additional behavioral health counselors and telehealth services at all institutions and particularly at the currently understaffed Community and Technical Colleges. The rising level of need among students calls for further investment.
- Expand Washington's behavioral health workforce. Develop a student grant and/or loan forgiveness program to benefit top-performing students earning advanced degrees in behavioral health who commit to working in public behavioral health, including higher education.
- Serve student veterans' needs by partnering with the Washington Department of Veterans Affairs and its War Trauma Program, and the U.S. Department of Veterans Affairs and its Veterans Integration to Academic Leadership (VITAL) program, which is designed to benefit student veterans with behavioral health needs. Another potential partner is the national non-profit Cohen Veterans Network, which may be able to co-locate mental health clinicians on Washington campuses where and when needed.
- Develop a partnership with networks of Washington therapists from multicultural backgrounds to provide meaningful, accessible support. Given the increasing diversity of students attending many institutions, an initiative to connect multicultural counselors with students from all races, ethnicities, and sovereign Native American nations would ease students' search for practitioners with whom they can connect.
- Require all campuses to develop and regularly update written crisis protocols addressing a student mental health, suicidal or substance use crisis; also protocols for supporting students upon re-entry to campus following a mental health crisis, and for postvention, which details campus responses in the event of a student suicide. These protocols need to be widely shared in order to reduce confusion during crises.

- Create stronger partnerships between CTCs and community resources. A necessary initial step will be the development of a clear understanding about what role those resources can and cannot currently fill, given health insurance restrictions and the demand for services in many communities. Developing and promoting stronger referral practices between CTCs and community resources to better ensure successful outcomes will benefit students.
- Support institutions in opening a conversation with students about help-seeking behaviors and destigmatizing mental illness. Given the low percentages of students who access mental health services and the higher percentages of students who identify with mental health concerns, culture change regarding these topics is vital. This includes ensuring student understanding that their mental health record is not part of their academic record.
- Support institutions in the development of recovery programs to help students start and stay on a path to recovery from substance use disorders. Alcohol dependence or use of other substances can raise an individual's suicide risk ten-fold (Ahmed, 2018).
- Establish a state-wide minimum expectation of annual suicide recognition and referral skills, training new students and new employees in mental health and suicide prevention, in order to increase the current pace of institutional training in these skills. (Table 6b.)
- Create a long-term annual reporting process for these and related data to be collected and analyzed. The data conveys a tremendous advantage to any single campus, offering a greater perspective on its work by measuring itself against its peers. The data also conveys value to the state as it supports evidence-driven deployment of investments.

Please Note: A synopsis of findings and recommendations follows the tables and charts found in the Data Results.

Methods

SSB 6514 Data Requirements and Survey Development

To address the lack of data regarding suicide, suicidal behavior, and behavioral health services among postsecondary students in Washington, SSB 6514 (Revised Code of Washington [28B.20.515](#) and [28B.20.520](#)) outlined 11 requirements for reporting between 2018 and 2022. The INSPIRE Work Group⁸ and a data sub-group collaborated with the data analyst to develop the survey and data collection efforts. The Work Group, which works by consensus, includes representatives of postsecondary education sectors, Alaska Native/American Indians, the Veterans Training Support Center, current students, family members of students who died by suicide, suicide prevention experts, postsecondary counseling center directors, behavioral health agencies, and the Washington State Department of Health.

Figure 1. Substitute Senate Bill 6514 Data Requirements

Behavioral health services & suicide surveillance	Education, training, & support programs	Campus community awareness	Emergency planning & management
<ol style="list-style-type: none"> 1. Counselor-to-student ratio 2. Number of students referred to off-campus BH 3. Number of students withdrawing for emotional distress 4. Number of student suicides 5. Number of student suicide attempts (hospital) 6. Behavioral health services for Veterans 	<ol style="list-style-type: none"> 6. Cont'd Behavioral health support for Veterans 7. Confirmation of campus plans for suicide recognition and referral training that lds groups who have or will receive training 	<ol style="list-style-type: none"> 8. Students, faculty, staff awareness of behavioral health and suicide prevention resources 9. Information re: dissemination of material about behavioral health resources available on and off campus 	<ol style="list-style-type: none"> 10. Campus entities responsible for campus crisis plan 11. Campus point person

The Forefront data analyst drafted a survey instrument for review by the data sub-group, which comprised members of the overall work group and additional representatives from Washington postsecondary institution counseling centers. In addition, members of the data sub-group identified individuals from postsecondary institutions to join review of the draft survey instrument. Twelve individuals who collectively represented all postsecondary institution sectors provided feedback, with a central theme that to bolster response rate, the surveys needed to be tailored to each sector to account for inherent differences in the level of behavioral health services available on campuses. The iterative feedback process culminated in three final survey instruments for 1) 4-year public, 4-year ICW-affiliated private institutions and public and community technical colleges with behavioral health services; 2) public and community technical colleges without behavioral health services; and 3) career schools and colleges (e.g., Department of Licensing cosmetology schools, Northwest Federation of Career Colleges

⁸ Formerly the SSB Work Group

Federation, seminaries, work-force training programs, out-of-state institutions offering distance-learning programs, and others).

In September 2018, each sector representative sent a draft version of the survey to the Director of Student Services or equivalent position at their respective institutions. The purpose of this early rollout was to prepare institutions for data collection later in the academic year. The final survey was developed in REDCap, a secure web-based platform hosted at the University of Washington.

In January 2019, sector representatives sent an email letter of recruitment to the Director of Student Services or equivalent position at each of the postsecondary institutions in their respective sectors. Recruitment emails contained a link to the web-based survey and indicated the data collection window for student suicidal behaviors, which during this initial year took place between February 1, 2019 and March 31, 2019, as well as the due date of June 1, 2019, as required by SSB 6514. The decision to shorten the data collection window stemmed from concern about the challenges of expecting institutions to collect data retroactively, which they may not have been tracking previously. Sector representatives sent monthly email reminders to their institutions. The reporting deadline was extended to June 30 to maximize responses.

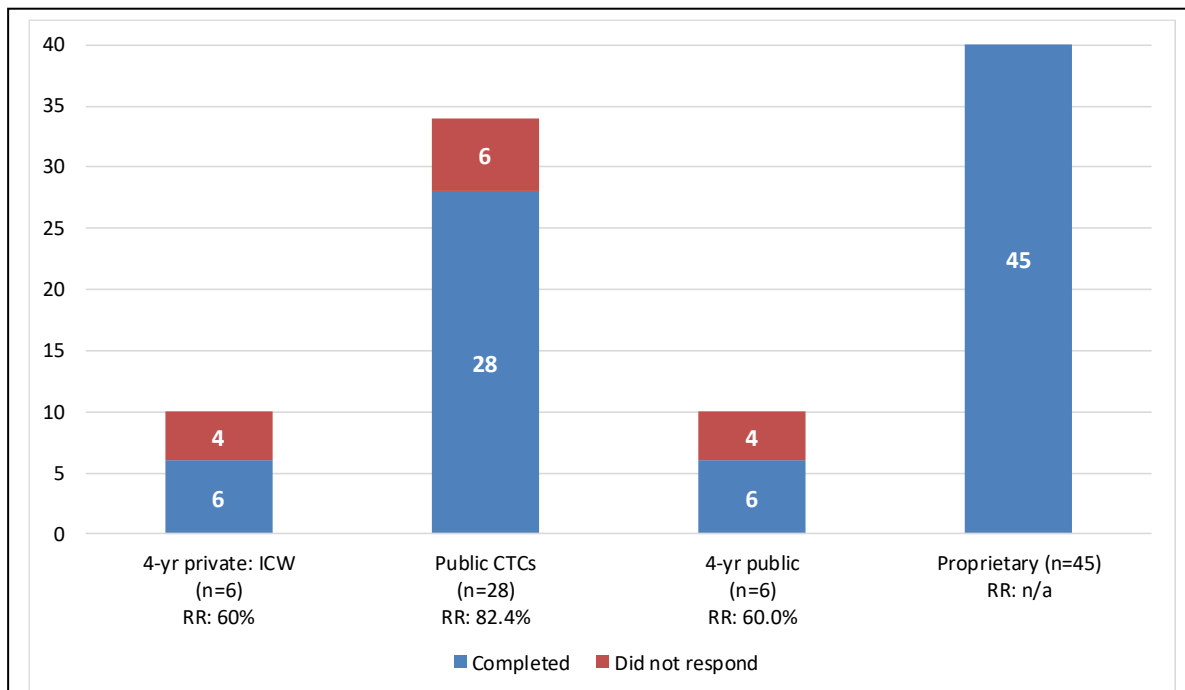
Data Results

1. Responding institutions by sector

Of Washington’s 54 public CTCs, four-year public, and four-year non-profit colleges affiliated with Independent Colleges of Washington (ICW), 40 (74.1%) completed the survey.

An additional 45 career schools and colleges completed the survey. As institutions in this sector had very little data to report, their results do not appear here. It is fair to say that these institutions, both in Washington and nationally, are in the earliest stages of addressing their students’ behavioral health.

Figure 2. Responding and non-responding postsecondary institutions by sector



Response Rate (RR): Overall response rate across sectors was 74.1%; total number of responding institutions included in this report was 85. Data were reported from 45 career schools and colleges; however, the total number of career schools and colleges receiving the survey cannot be estimated due to overlapping regulatory relationships; thus, a response rate could not be calculated. These institutions include those affiliated with Northwest Federation of Career Colleges, Department of Licensing cosmetology programs, trade schools, work-force training programs, seminaries, out-of-state institutions that offer distance programs in Washington, and others.

Table 1. Enrolled students from reporting institutions, per sector

Total student enrollment by headcount per sector					
	4-yr non-profit (ICW) (n=6)	Public CTCs (n=28)	4-yr public (n=6)	Career schools & colleges (n=45)	All institutions (n=85)
Mean (range) of students per institution	4,536 (2,666-7,563)	10,031 (2,867-28,070)	17,780 (3,327-47,392)	358 (1-10,556)	5,066 (1-47,392)
n total students per sector	27,218	270,831	106,680	15,744	420,473

These total numbers of enrolled students from reporting institutions served as the basis for calculating rates and ratios in this report.

2. Behavioral health & suicide surveillance in Washington postsecondary institutions

Table 2. Suicidal behavior among postsecondary students

Student suicide deaths reported February 1 through April 30, 2019					
	4-yr non-profit (ICW) (n=6)	Public CTCs (n=28)	4-yr public (n=6)	Career schools & colleges (n=45)	All institutions (n=85)
Suicides among active students	2	7	2	0	11
Institutions reporting 0 suicides among active students	-	-	-	-	71 (83.5%)
Institutions unsure	0 (0%)	1 (3.6%)	0 (0%)	2 (4.4%)	3 (3.5%)
Estimated annual rate of suicide per 100,000	-	-	-	-	10.9 ₉
Student suicide attempts					
Suicide attempts that resulted in ER visits for active students	8	24	23	0	55
Suicide attempts that resulted in hospitalizations for active students	5	13	7	0	25
Institutions reporting 0 suicide attempts resulted in ER visits for active students	2 (33.%)	11 (39.3%)	0 (0%)	43 (95.6%)	56 (65.9%)
Institutions reporting 0 suicide attempts resulted in hospitalizations for active students	2 (33.%)	12 (42.9%)	0 (0%)	43 (95.6%)	57 (67.1%)
Institutions unsure of number of ER visits	0 (0%)	6 (21.4%)	1 (16.7%)	2 (4.4%)	9 (10.6%)
Institutions unsure of number of hospitalizations	1 (16.7%)	6 (21.4%)	2 (33.3%)	2 (4.4%)	11 (12.9%)
Student substance use incidents					
	4-yr non-profit (ICW) (n=6)	Public CTCs (n=28)	4-yr public (n=6)	Career schools & colleges (n=45)	All institutions (n=85)

⁹ This annual estimate is based on three months of data collection on suicide deaths; it may or may not reflect the actual annual suicide rate of Washington postsecondary students.

Substance use incidents that resulted in ER visits or hospitalizations ¹⁰	9	5	9	0	23
Institutions reporting 0 substance use incidents resulted in ER visits or hospitalizations	0 (0)	15 (53.6%)	1 (16.7%)	43 (95.6%)	59 (69.4%)
Institutions unsure	0 (0%)	10 (35.7%)	2 (33.3%)	2 (4.4%)	14 (16.5%)

Findings for Table 2:

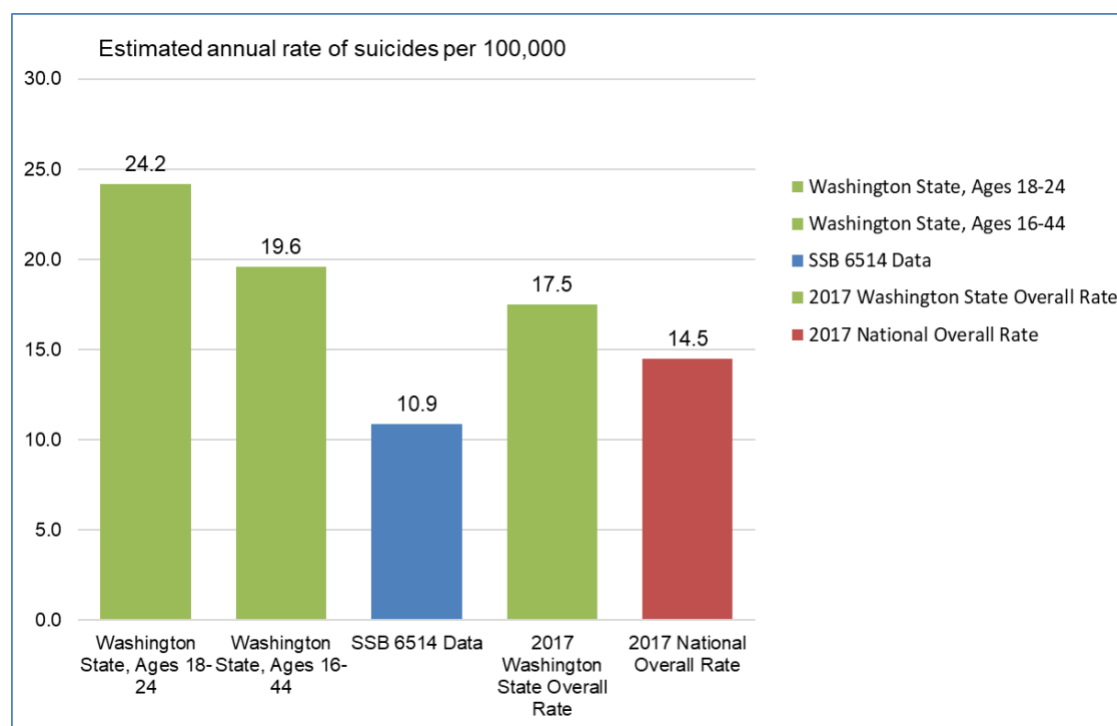
- Gaps in reporting suggest the need to enhance policies and procedures on tracking suicides, suicide attempts and substance use incidents.
- Risks of injury and death due to substance use and self-harming behaviors, are identifiable across all sectors in higher education in Washington State.
- Data of this sort are not typically collected by Washington postsecondary institutions and would not have been gathered were it not for the SSB 6514 requirement. Identification of trends and areas in need of further support will have to await subsequent data collection covering longer periods of time.
- The report of no suicidal deaths among students at career schools and colleges is more likely due to the information not being available to those institutions, rather than absence of risk in those environments.
- These data cannot convey how many students are struggling with behavioral health concerns in ways that interfere with their studies and training. Other sources suggest that a majority of students report periods of academic impairment due to such concerns (Eisenburg & Lipson, 2019, p. 2019; Hedegaard et al., 2018).
- Informative data not collected here that would shed light on ongoing risks, institutional supports, and best practices include the frequency with which campus mental health practitioners use safety plan interventions, suicide risk assessments, and other specific elements of up-to-date suicide assessment, management, treatment, and follow up with caring contact.
- All sectors were more likely to be “unsure” of the number of student suicide attempts and substance use incidents resulting in ER visits or hospitalization, indicating an opportunity for better tracking and measurement of such data.

Recommendations:

- Create a long-term annual report process for these data to be collected and monitored to identify risks, trends, and opportunities for improving support for students in postsecondary education in Washington.

¹⁰ On the 2019 survey, the related question combined hospitalization and Emergency Room care, precluding separate responses.

Figure 3. Suicide rates for Washington college & non-college age peers, etc.



About Figure 3:

- The Washington State ages 18-24 column represents the 2017 suicide rate for students and non-students. This age group approximates traditional four-year institution students.
- The Washington State ages 16-44 column represents the 2017 suicide rate for students and non-students. This age group approximates the spread of two-year institutions' students, including Running Start.
- The Washington postsecondary student rate (10.9 deaths per 100,000 students) represents SSB 6514 data from reporting institutions for the period February 1-April 30, 2019. The annual rate was calculated by multiplying that data by four and dividing by the reported student enrollment in each sector. The decision to collect data for just three months of the pilot year was made as many institutions do not routinely collect this data, and the Work Group believed that advance notice would be helpful. The collection period was truncated to allow for late-arriving data. The resulting suicide rate may or may not accurately represent the actual annual rate. In future surveys, this data will be collected on an annual July 1-June 30 basis.
- This chart does not include sector-by-sector student suicide rates due to the volatility of small-sample data collected during a brief timeframe.
- Interpreting the 2018-19 data or making decisions about programming or funding changes based on this data is unwarranted. This data should be considered the first step in developing a solid baseline on Washington's postsecondary student suicide rates.

3. Behavioral health services in Washington postsecondary institutions

Table 3. General behavioral health services, sessions, student awareness, and referrals

Institutional services, session limits, student awareness of resources, referrals				
	4-yr non-profit ICW (n=6)	Public CTCs (n=28)	4-yr public (n=6)	All institutions (n=40)
Institutions offering on-campus behavioral health (BH) services	6 (100%)	17 (60.7%)	5 (83.3%)	28 (70%)
Mental health counseling sessions a student is eligible for per quarter or semester	5.9 (2.5-10)	5.1 (1.5-10)	6.4 (1.3-12)	5.4 (1.3-12)
Institutions referring students to community services, among those with on-campus services.	6 (100%)	16 (94.1%)	5 (100%)	27 (96.4%)
Institutions with a protocol to inform students who self-identify with mental health or substance use histories that institutional BH services are available, among those offering on-campus BH services.	4 (66.7%)	8 (47.1%)	4 (80.0%)	16 (57.1%)
Institutions with a protocol to inform students who indicate a desire/need for behavioral health services about available community services	4 (66.7%)	16 (57.1%)	4 (66.7%)	24 (60.0%)
Total institutions in sector that do not offer on-campus BH services	0 (0.0%)	11 (39.3%)	1 (16.7%)	12 (30.0%)
Institutions that refer students to outside BH services, among those that do not offer on-campus BH services.	-	9 (81.8%)	1 (100%)	10 (83.3%)
	4-yr (ICW) (n=6)	CTCs (n=25)	4-yr public (n=6)	Total (n=37)
Students referred to mental or BH resources off campus ¹¹	108	177	334	619
Institutions that do refer students to outside resources, but do not track referrals	2 (33.3%)	17 (68.0%)	2 (33.3%)	21 (56.8%)

¹¹ Referral numbers were collected for the three-month period Feb. 1 through April 30, 2019.

Findings:

- Schools in all sectors rely on making referrals to community resources. Even those institutions that provide behavioral health treatment to their students cannot meet all student needs. Thus, strong community resources and relationships between community providers and postsecondary education institutions can be vital to supporting student mental health and program completion.
- CTCs are the least likely to offer mental health or behavioral health services, due in large part to scarce funding resources.
- The CTCs serve a high proportion of military veterans. As a result, our veterans, identified as a higher-risk population, are notably underserved by the institutions where they are most likely seeking to advance their training and education.
- Referral reports likely under-represent referrals made, due in part to gaps in tracking.
- Referrals made should not be understood to mean successful access to counseling. Significant barriers to accessing meaningful behavioral health services include discomfort and stigma of acknowledging need for mental health and substance use treatment, lack of insurance, lack of experience navigating insurance even when available, and challenges finding time and transportation to get to off-campus appointments.

Recommendations:

- Improving access to behavioral health services for CTC students should be a high priority.
- Innovative and funded partnerships between CTCs and career schools and colleges and behavioral health agencies in the communities should be explored. The California Community Colleges system has done interesting work in this area (CMHSA, n.d.).
- Institutions in all sectors should ensure that students are well-informed about behavioral health resources available on campus and in the community.
- Developing and promoting stronger referral practices to better ensure successful outcomes will benefit students.
- Surveying all student veterans upon entering postsecondary education to learn whether they prefer to use V.A. services, institution-based resources, or community-based resources for behavioral health services would allow intelligent planning of state investments in enhanced student veteran resources.

Table 4. Health assessments, behavioral health screening & behavioral health services

	4-yr non-profit ICW (n=6)	Public CTCs (n=28)	4-yr public (n=6)	Total (n=40)
Health History Questionnaires				
Institutions that require incoming and transfer students to complete a HHQ ¹²	5 (83.3%)	2 (7.1%)	0 (0%)	7 (8.2%)
HHQs that include questions about mental health and substance use, among those institutions requiring HHQs	4 (80.0%)	0 (0%)	-	4 (57.1%)
HHQs that include questions on substance use, among institutions requiring HHQs	4 (80.0%)	0 (0%)	-	4 (57.1%)
Behavioral Health Screening¹³				
Mental health screening	6 (100%)	13 (46.4%)	6 (100%)	25 (62.5%)
Substance use screening	6 (100%)	6 (21.4%)	5 (83.3%)	17 (42.5%)
Behavioral Health Services and Programming				
Mental health counseling or psychotherapy	6 (100%)	18 (64.3%)	6 (100%)	29 (72.5%)
Substance use counseling	4 (66.7%)	6 (21.4%)	4 (66.7%)	14 (35.0%)
Group therapy	4 (66.7%)	3 (10.7%)	6 (100%)	13 (32.5%)
Support groups (e.g., AA)	5 (83.3%)	2 (7.1%)	2 (33.3%)	9 (22.5%)
Skills groups (e.g., DBT)	6 (100%)	2 (7.1%)	6 (100%)	14 (35.0%)
Online, email, or chat services for behavioral health	2 (33.3%)	1 (3.6%)	2 (33.3%)	5 (12.5%)
Medication management	5 (83.3%)	1 (3.6%)	4 (66.7%)	10 (25.0%)
Other ¹⁴	0 (0%)	3 (10.7%)	0 (0%)	3 (7.50%)
Non-Western medical model				
Do you employ any non-Western medical models to address mental health, substance use, and suicidal behaviors among students?	4-yr non-profit ICW (n=6)	Public CTCs (n=28)	4-yr public (n=6)	Total (n=40)
Yes	2 (33.3%)	7 (25.0%)	2 (33.3%)	11 (27.5%)
Mindfulness/Meditation	2 (100%)	6 (85.7%)	2 (100%)	10 (90.9%)

¹² One CTC requires only student athletes to complete an HHQ

¹³ Type of screening (anonymous online, in-person) not differentiated

¹⁴ Other services reported include employee consultations, referrals and programming for employees; screening for health and safety; one CTC reported contracting with a 4-year public institution to provide services to students.

Findings:

- The 4-year private colleges are more likely than others to ask students to identify relevant health and behavioral health concerns upon entry.
- CTC students are much less likely to have the opportunity to participate in mental health and/or substance use screenings as a part of their educational experience, increasing the chances those concerns will go unidentified and treated.
- CTC students are less likely to find treatment for behavioral health, including medication management, to be available on-campus.

Recommendations:

- Make opportunities for students to participate in annual on-campus behavioral health screenings, with meaningful referrals for treatment, when appropriate, goals for all postsecondary institutions.
- For institutions without behavioral health services on campus, ensure that all students are aware of community-based resources.
- If the state chooses to fund another round of grants, allowing less rigid options for partnerships could help to prompt a search for innovative screening solutions, (e.g. a CTC partnering with a nearby nursing school to offer live screenings for mental health and suicide risk).

Limitation regarding screenings

- A lack of differentiation in the survey between anonymous, online screenings and live screenings prevents insight into whether the offered screenings simply raise awareness or actively link students to services. A reworded question will appear in the 2020 survey.

Limitation regarding wait times

- Prolonged student wait times for counseling appointments create additional stress for struggling students. Unfortunately, the wording of the 2019 question on the duration of wait times led to confusion among some respondents. Thus, the data is not clear. A reworded question will appear in the 2020 survey.

Table 5. Mental health credentials and counselor-to-student ratios

	4-yr non-profit ICW (n=5)	Public CTCs (n=19)	4-yr public (n=6)	Total (n=30)
Mean (range) number of students per institution reporting >0 FTE for behavioral health provider	3,931 (2,666-7,291)	10,217 (2,867-28,070)	17,780 (3,327-47,392)	10,698 (2,666-47,392)
Mental health provider FTE				
	Mean FTE (range)	Mean FTE (range)	Mean FTE (range)	Mean FTE (range)
Licensed behavioral health providers (e.g., psychologists, psychiatrists, social workers, licensed mental health counselors)	5.7 (2.5-8.0)	2.4 (0.2-6.0)	9.8 (3.0-24.7)	4.5 (0.2-24.7)
Unlicensed behavioral health staff (e.g., degreed provider without license)	1.1 (0.0-5.0)	0.6 (0.0-4.0)	2.5 (0.0-5.0)	1.1 (0.0-5.0)
Doctoral student or master student providing behavioral health services	3.5 (0.0-9.0)	0.4 (0.0-5.0)	2.5 (0.0-6.0)	1.4 (0.0-9.0)
All licensed or unlicensed behavioral health providers	6.8 (3.0-13.0)	2.9 (0.2-8.0)	12.31 (3.0-27.7)	5.5 (0.2-27.7)
Mental health providers per 1,000 students				
Mean (range) FTE of licensed mental health providers per 1,000 students	1.5 (0.9-2.2)	0.3 (0.0-0.9)	0.6 (0.5-1.2)	0.56 (0.0-2.17)
Mean (range) FTE of licensed or unlicensed mental health providers per 1,000 students	1.8 (1.1-3.5)	0.3 (0.0-1.3)	0.8 (0.5-1.7)	0.7 (0.0-3.5)

International Accreditation of Counseling Services¹⁵ recommends a mental health counselor-to-student ratio of between 1:1,000 and 1:1,500. The ratio includes licensed and unlicensed counselors, while excluding student and intern providers.

Findings:

- Four-year non-profit, ICW institutions have a stronger behavioral health counselor-to-student ratio than the other postsecondary sectors.
- All Washington sectors utilize a notable number of unlicensed behavioral health staff, indicating these are less-experienced, junior staff working toward full licensure.
- The CTCs' behavioral health services, when offered, are staffed at levels significantly lower than campuses in the other categories. None of the CTCs individually meets the current IACS ratio – as would likely be true nationally. As noted earlier, these institutions are more likely to serve a higher percentage of military veterans, leaving this vulnerable population receiving less support than others.

¹⁵ The Clinical Load Index, a new system of measuring effective levels of counseling staff, is being introduced by the Center for Collegiate Mental Health, the International Accreditation of Counseling Services, and the Association of College Counseling Center Directors. A white paper on the new concept can be found at <https://ccmh.psu.edu/clinical-load-index/>

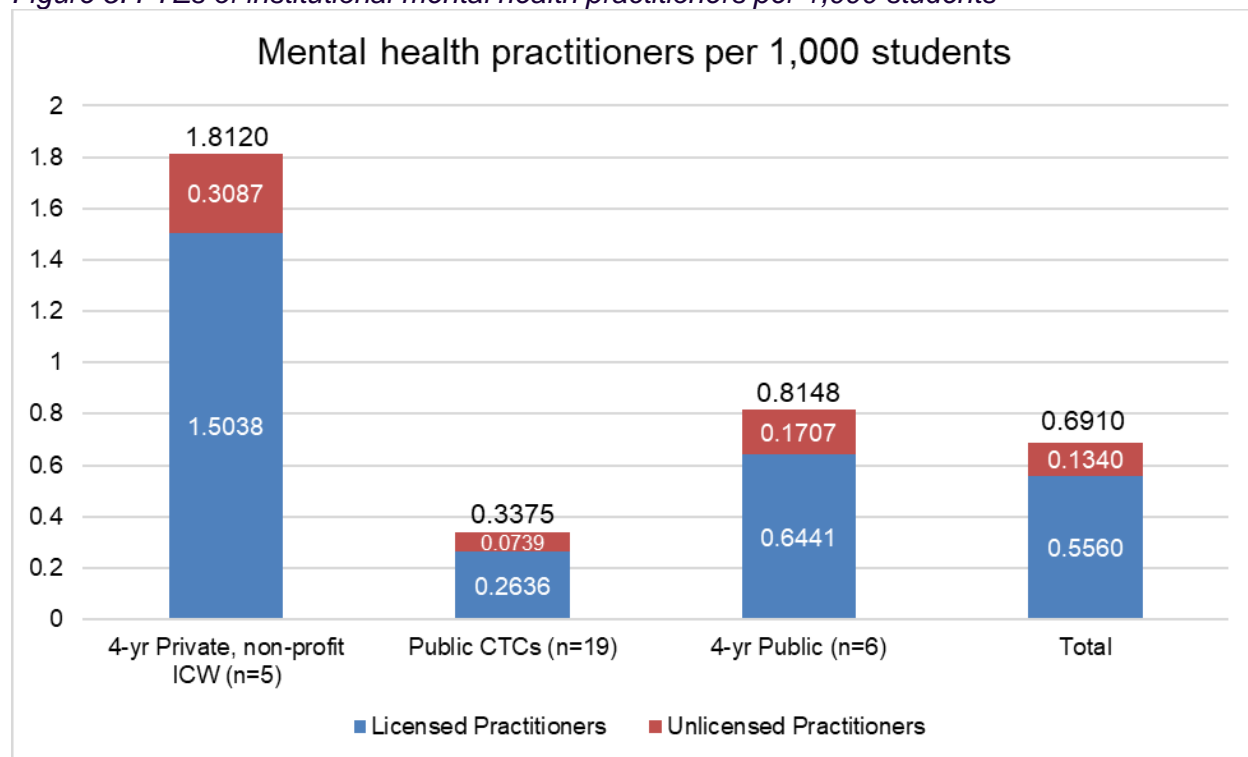
Context:

- Nationally, the Association for University and College Counseling Center Directors Annual Survey 2018 shows that small colleges (less than 5,000 students) tend to meet the 1-to-1000 ratio, while mid-size institutions (20,000 students) tend to have a counselor to student ratio of 1-to 2,251, and the largest institutions, 45,000 or more, had a ratio of 1-to-1,745.
- Two-year colleges tend to have higher counselor student ratios (1 to 5,482) than do four-year institutions (1 to 1,685), according to the National Survey of College Counseling Centers 2014.

Recommendations:

- Addressing students' behavioral health needs, particularly those attending the CTCs, is critical. To that end:
 - Funding increased support for on-campus services is a high priority.
 - All campuses, and particularly the CTCs, should develop relationships with area and regional VA services and other services in order to have meaningful referral resources, and possibly co-located resources, available for their veteran students.
 - Innovative, funded partnerships between CTCs and community-based services should be explored.
- Institutions in all sectors should ensure that students are well-informed about behavioral health resources available on campus and/or in the community.
- Given the noted proportion of early-career, unlicensed mental health staff in all categories of higher education in the state – particularly among the private, non-profit 4-year schools – ongoing supervision and training addressing crisis management, suicide assessment and treatment, and substance use assessment and treatment should be routinely provided to those staff members.

Figure 5. FTEs of institutional mental health practitioners per 1,000 students



4. Training, Education, and Student Awareness of Behavioral Health

Table 6a. Suicide recognition and referral training

	4-yr non-profit ICW (n=6)	Public CTCs (n=28)	4-yr public (n=6)	Total (n=40)
Institutions offered training programs for students, faculty or staff				
Respond to behavioral health crises (e.g., mental health emergency, drug overdose, alcohol poisoning, suicide attempt)	5 (83.3%)	12 (42.9%)	5 (83.3%)	21 (53.8%)
Identify, reach out to, or refer students who may be struggling with mental health	6 (100%)	22 (78.6%)	6 (100%)	34 (85%)
Identify, reach out to, or refer students who may be struggling with substance use disorder	4 (66.7%)	6 (21.4%)	4 (66.7%)	20 (35%)
Identify, reach out to, or refer students who may be struggling with suicidal behaviors	5 (83.3%)	23 (82.1%)	6 (100%)	34 (85%)

Figure 6. Training programs for students, faculty or staff on behavioral health topics

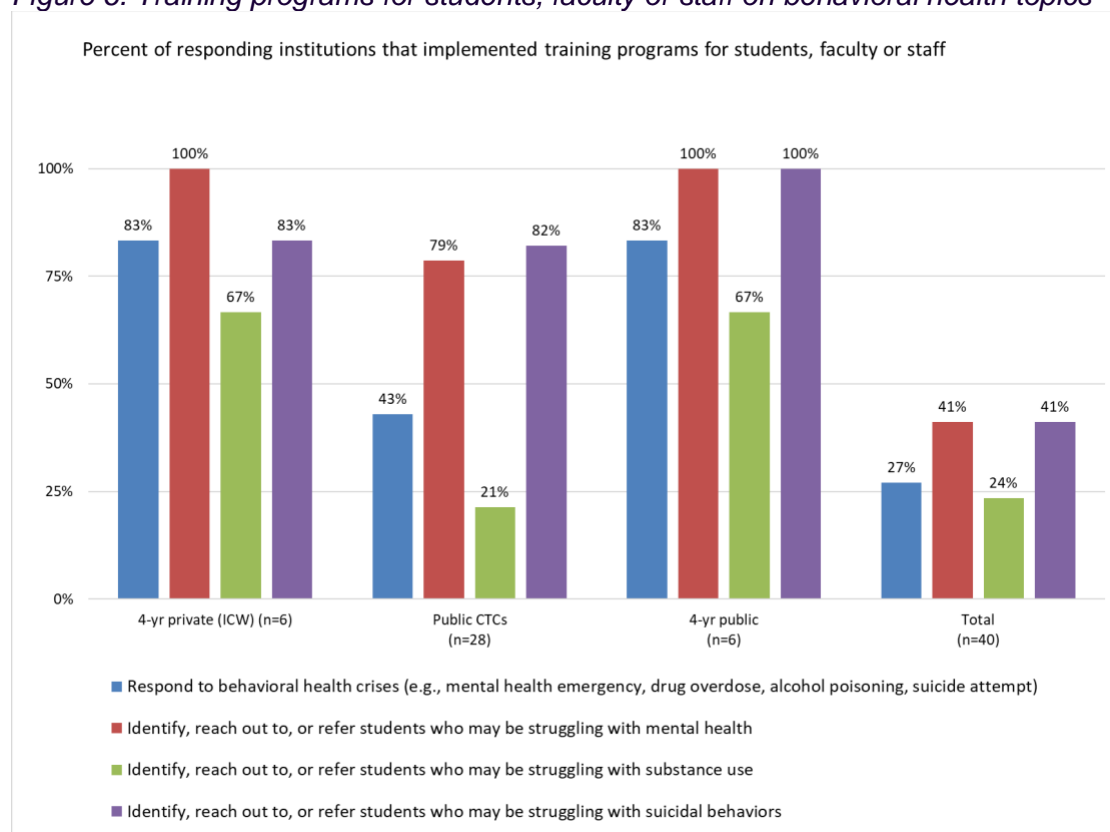


Table 6b. Number of individuals participating in suicide recognition and referral training

	4-yr private, non-profit ICW(n=6)	Public CTCs (n=28)	4-yr public (n=6)	Total (n=40)
The number of institutions training these constituencies & the number of trainees per 1,000 students				
Faculty	3 (50.0%)	15 (53.6%)	5 (83.3%)	23 (57.5%)
<i>n trained per 1,000 students</i>	59.50	2.67	1.63	7.79
Students	5 (83.3%)	8 (28.6%)	6 (100%)	19 (47.5%)
<i>n trained per 1,000 students</i>	237.57	6.29	46.82	57.34
Academic advisors	4 (66.7%)	14 (50.0%)	5 (83.3%)	23 (57.5%)
<i>n trained per 1,000 students</i>	1.81	1.05	1.33	1.25
Senior administrators	4 (66.7%)	6 (21.4%)	1 (16.7%)	11 (27.5%)
<i>n trained per 1,000 students</i>	0.90	0.50	0.05	0.48
Health services and/or counseling staff	5 (83.3%)	11 (39.3%)	4(66.7%)	20 (50.0%)
<i>n trained per 1,000 students</i>	2.15	0.42	0.37	0.53
Athletic department staff	4 (66.7%)	9 (32.1%)	3 (50.0%)	16 (40.0%)
<i>n trained per 1,000 students</i>	1.06	0.48	0.37	0.49
Residence life staff	5 (83.3%)	6 (21.4%)	6 (100%)	17 (42.5%)

<i>n trained per 1,000 students</i>	18.12	0.43	2.57	2.92
Institution safety and security	5 (83.3%)	15 (53.6%)	1 (16.7%)	21 (52.5%)
<i>n trained per 1,000 students</i>	2.30	0.67	0.07	0.70
Other institution staff	0 (0%)	4 (14.3%)	3 (50.0%)	7 (17.5%)
<i>n trained per 1,000 students</i>	--	3.15	1.73	2.15

Other institution staff receiving training included student services/life/affairs (n=5), disability support coordinator (n=2), front desk staff, administrative departments, Running Start Coordinator, Student Life Director, Satellite Campus Education Center Supervisor

Context:

- There is no existing law requiring recognition and referral skills training, or gatekeeper training, for faculty or other student-facing groups such as coaches or student services staff. Greater coverage of all constituencies, however, raises the possibility that fewer students in need of support would fall through the cracks.

Findings:

- Among institutions that provided training to various campus constituencies regarding mental health, substance use concerns, and suicidal risk, the CTCs reported those trainings reach fewer individuals.
- Identified campus constituencies were not universally trained in any sector, leading to the conclusion that such trainings are not required.

Recommendations:

- All campuses should be expected to provide meaningful training to all campus constituencies related to crisis intervention, suicide prevention, mental health, and substance use concerns found on every campus.

Table 7. Behavioral health promotion programs

	4-yr non-profit (ICW) (n=6)	Public CTCs (n=28)	4-yr public (n=6)	Total (n=40)
Institutions reporting programs designed to support the following areas				
Build communication skills	6 (100%)	23 (82.1)	5 (83.3%)	34 (85.0%)
Identify and regulate emotions	6 (100%)	19 (67.9%)	6 (100%)	31 (77.5%)
Promote resilience	5 (83.3%)	21 (75.0%)	6 (100%)	32 (80.0%)
Resolve conflict	5 (83.3%)	22 (78.6%)	5 (83.3%)	32 (80.0%)
Improve relationship skills	6 (100%)	18 (64.3%)	6 (100%)	30 (75.0%)
Practice mindfulness or meditation	6 (100%)	18 (64.3%)	6 (100%)	30 (74.4%)
Address sexual harassment and/or relationship violence	6 (100%)	24 (85.7%)	6 (100%)	36 (90.0%)
Address bullying	1 (16.7%)	13 (46.4%)	3 (50.0%)	17 (42.5%)
Develop study skills and manage time	6 (100%)	28 (100%)	6 (100%)	40 (100%)
Manage finances	6 (100%)	21 (75.0%)	4 (66.7%)	31 (77.5%)
Manage stress and anxiety	6 (100%)	25 (89.3%)	6 (100%)	37 (92.5%)
Plan for the future (incl. transition after graduation)	5 (83.3%)	27 (96.4%)	6 (100%)	38 (95.0%)
Address excess alcohol use	6 (100%)	16 (57.1%)	6 (100%)	28 (70.0%)
Address cannabis or other substance use	6 (100%)	14 (50.0%)	6 (100%)	26 (65.0%)

Findings:

- Behavioral health promotion programs of a wide variety are offered on most campuses. Many are routine offerings on nearly all 4-year non-profit and 4-year public institutions.

Limitations:

- It is unclear what percentage of the student populations received these opportunities.

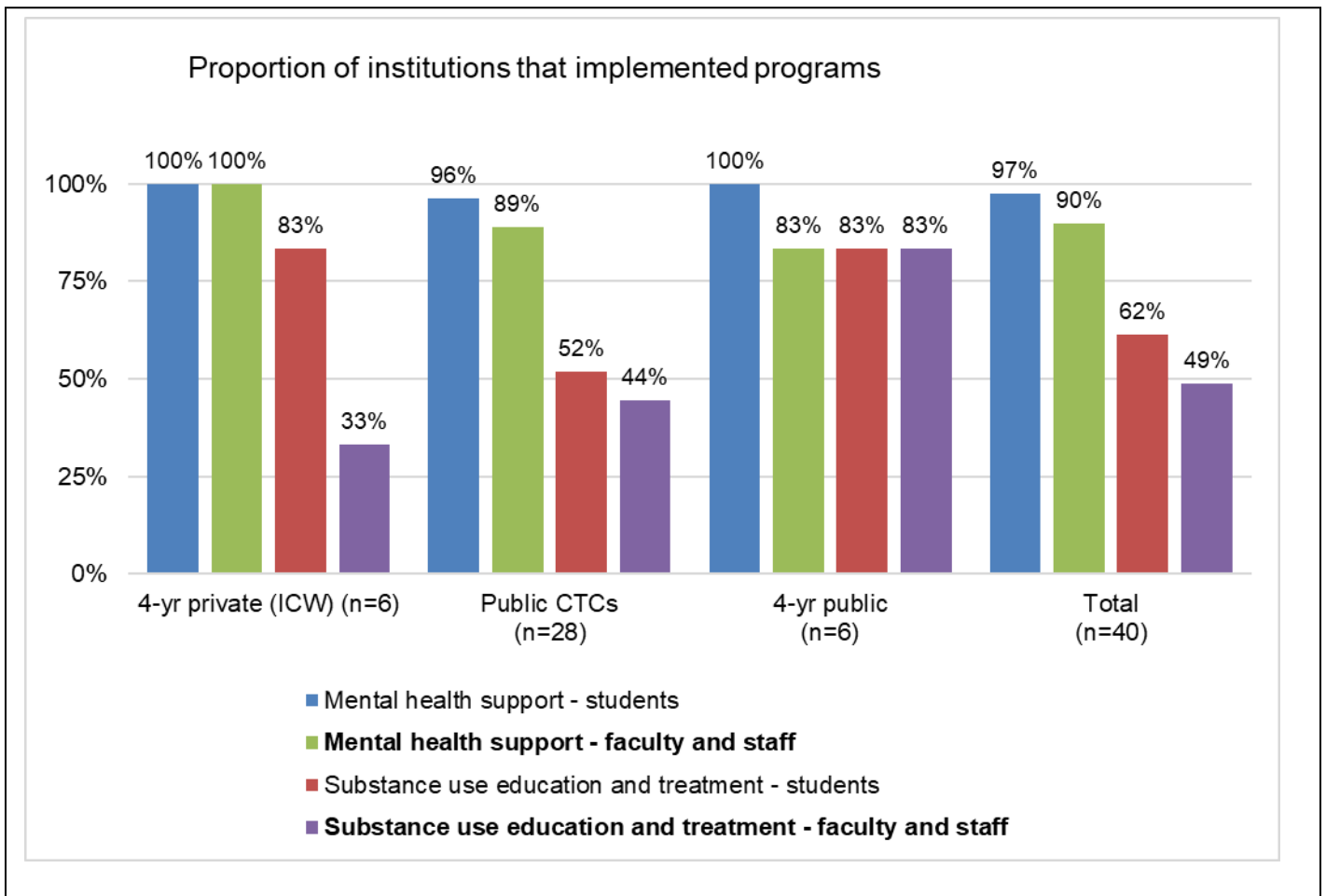
Recommendations:

- All campuses should be expected to provide meaningful behavioral health promotion programs.

Table 8. Student, faculty, and staff awareness

	4-yr non-profit (ICW) (n=6)	Public CTCs (n=28)	4-yr public (n=6)	Total (n=40)
Institutions reporting implementation of awareness efforts				
Inform students about institutional resources for mental health support	6 (100%)	27 (96.4%)	6 (100%)	39 (97.5%)
Inform students about institutional resources for substance use education and treatment	5 (83.3%)	14 (50.0%)	5 (83.3%)	24 (60.0%)
Inform faculty and staff about institutional resources for mental health support	6 (100%)	25 (89.3%)	5 (83.3%)	36 (90.0%)
Inform faculty and staff about institutional resources for substance use education and treatment	2 (33.3%)	12 (42.9%)	5 (83.3%)	19 (47.5%)

Figure 7. Student, faculty, and staff awareness about institutional resources for behavioral health



Findings:

- Institutional efforts to inform students about campus resources supporting student behavioral health are nearly universal on campuses across the state.
- This data is unable, however, to show how many distressed students learn where and how to find resources at their institution – or how many succeed in accessing those services.
- Lower levels of CTCs communicating about institutional support for substance use and treatment likely reflect the relative absence of those services at these institutions.
- The data is unable to assess to what extent faculty and staff actually know about these resources.

Limitation regarding methods of dissemination:

- The data does not include information about multiple, specific methods of reaching students with this information, such as posters, reader boards, course syllabi, emails or social media campaigns to reach students and parents. Repetition of such messaging is important.
- The data is unable to assess to what extent faculty and staff actually know about these resources.

Recommendations:

- Institutions are to be commended for ongoing efforts to increase student awareness about campus mental health resources available on campus.
- Four-year nonprofit colleges and the CTCs can benefit their students through more consistent education of their constituencies about available student support related to substance use education and treatment.
- To the degree that substance use prevention and treatment are not offered by CTCs and other campuses, developing meaningful resources with community-based agencies for referral could help serve students address significant barriers to program completion.
- Increase access to substance use treatment utilizing newly available resources for collegiate recovery programs.

Table 9. Help-seeking behavior, stigma, peer support

	4-yr non-profit ICW (n=6)	Public CTCs (n=28)	4-yr public (n=6)	Total (n=40)
Institutions implementing efforts to support the following				
Encourage help-seeking behavior	6 (100%)	24 (85.7%)	6 (100%)	36 (90.0%)
Destigmatize mental illness	4 (66.7%)	14 (50.0%)	6 (100%)	24 (60.0%)
Connect those students who may be struggling with mental health, substance use, or suicidal behaviors, to peers	5 (83.3%)	6 (21.4%)	3 (50.0%)	14 (35.0%)
Involve students in planning mental health, behavioral health and suicide prevention/postvention efforts	6 (100%)	9 (32%)	5 (80%)	20 (50%)

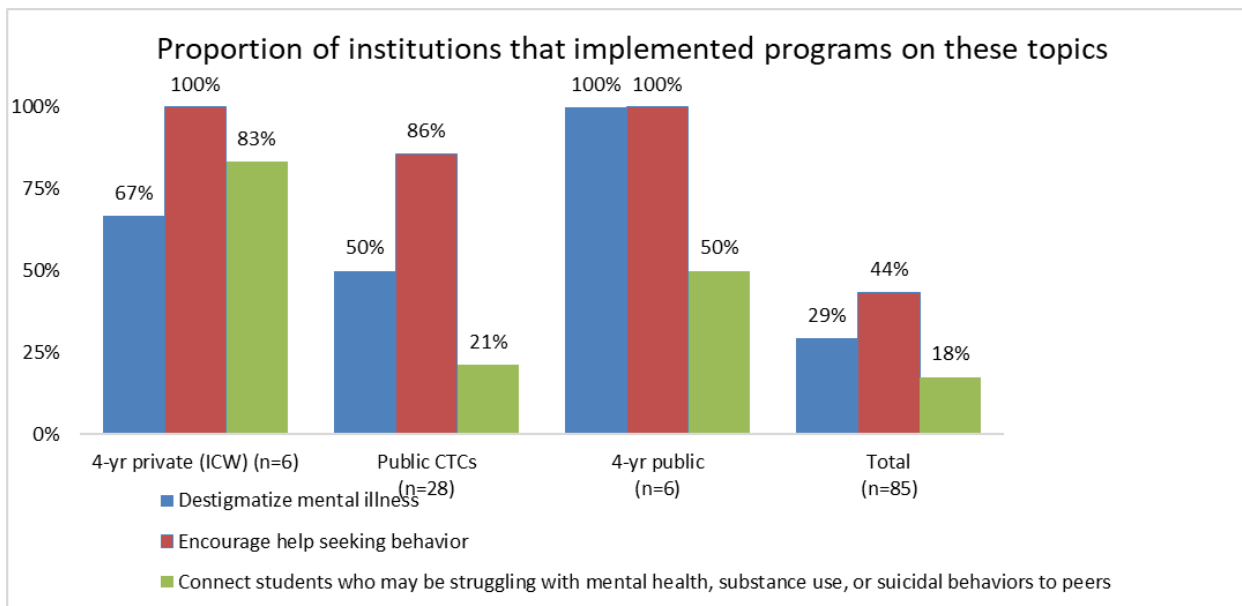
Findings:

- A majority of institutions are taking measures to encourage help-seeking behavior and destigmatizing mental health. It would be valuable to learn how this work is being done.
- Many institutions engage their students in involvement with mental health issues; fewer have created peer-to-peer opportunities. Those experiences are often healing and empowering for students who help and those who receive help.

Limitation regarding specific efforts:

- This data does not show what these efforts look like on campus.

Figure 8. Programs on help-seeking behaviors and reducing stigma



5. Emergency planning and management

Table 10. Emergency crisis planning, continuity of care, parental/family contacts

Behavioral health crisis protocol, re-entry, postvention				
Institutions with an emergency plan that includes a protocol to address behavioral health (BH) crises	4-yr private (ICW) (n=6)	Public CTCs (n=28)	4-yr public (n=6)	Total (n=40)
Institutions that include a plan for student re-entry after a BH crisis, among institutions with such an emergency plan.	6 (100%)	15 (53.6%)	3 (50%)	24 (60.0%)
Institutions with a postvention protocol to address student death including suicide	6 (100%)	5 (33.3%)	2 (66.7%)	13 (54.2%)

Number of offices responsible for developing and maintaining postvention (student death) plans	4-yr non-profit ICW (n=6)	Public CTCs (n=28)	4-yr public (n=6)	Total (n=40)
Health and/or counseling	2	5	3	14
President's Office/Sr. Administration	2	1	0	3
Academic Affairs	6	4	3	13
Student Services ¹⁶	18	23	5	46
Other/None	1	4	0	5

Table 10 a. Additional protocols: continuity of care, family communication

	4-yr private (ICW) (n=6)	Public CTCs (n=28)	4-yr public (n=6)	Total (n=40)
Does a protocol exist at this institution to ensure continuity of care for students who receive BH assessment, management, stabilization, and/or treatment services off campus?	4 (66.7%)	6 (21.4%)	3 (50.0%)	13 (32.5%)
Does a protocol exist at this institution to communicate with families in the event of a mental health, substance use, or suicide attempt-related emergency?	6 (100%)	8 (28.6%)	5 (83.3%)	19 (47.5%)

¹⁶ Answers exceed the n, as institutions could choose multiple answers among 17 possible options.

Findings:

- Non-profit ICW-affiliated schools report having more consistently developed crisis plans and plans related to student mental health crisis.

Recommendations:

- All campuses should have developed written crisis protocols addressing a student and employee mental health crisis, and supporting students upon re-entry to campus following a mental health crisis, and postvention, which focuses on campus responses to a student suicide.
- These written plans should be reviewed and revised annually by campus leadership.
- Training on continuity of care practices should be developed and offered widely. Continuity of care refers to ensuring that an individual being treated for suicidal urges or behavior undergoes seamless transitions when moving from one care setting to the next. Practices in this area range from timely transfers of electronic health records, to supporting a student released from an acute care setting in their transition to an out-patient provider and more (Knesper, 2013). Transitions in care settings are associated with heightened suicide risk.

6. Facilities safety reviews

Table 11. Facilities safety reviews

Has your institution ever conducted facility safety reviews?	4-yr non-profit ICW (n=6)	Public CTCs (n=28)	4-yr public (n=6)	Total (n=40)
Yes	3 (50.0%)	17 (60.7%)	2 (33.3%)	22 (55.0%)
If yes, when was your most recent facility safety review?	4-yr non-profit ICW (n=3)	Public CTCs (n=17)	4-yr public (n=2)	Total (n=22)
2010	0 (0%)	1 (5.9%)	0 (0%)	1 (4.5%)
2016	0 (0%)	1 (5.9%)	0 (0%)	1 (4.5%)
2017	1 (33.3%)	2 (11.8%)	1 (50.0%)	4 (18.2%)
2018	2 (66.7%)	8 (47.1%)	1 (50.0%)	11 (50.0%)
2019	0 (0%)	5 (29.4%)	0 (0%)	5 (22.7%)
If no, does your institution have plans to do one?	4-yr private ICW (n=3)	Public CTCs (n=9)	4-yr public (n=4)	Total (n=16)
Yes	1 (33.3%)	4 (44.4%)	1 (25.0%)	6 (37.55%)
How often do you anticipate such a review will take place?	4-yr private ICW (n=6)	Public CTCs (n=28)	4-yr public (n=6)	Total (n=40)
Annually	1 (16.7%)	11 (39.3%)	0 (0%)	12 (30.0%)
Every 3-5 years	2 (33.3%)	7 (25.0%)	1 (16.7%)	10 (25.0%)
There is no planned schedule	1 (16.7%)	1 (3.6%)	1 (16.7%)	3 (7.5%)

Table 11a. Firearms & medication takeback policies on campus

Does a policy exist at this institution to address firearms on campus?				
	4-yr non-profit ICW (n=6)	Public CTCs (n=28)	4-yr public (n=6)	Total (n=40)
Yes	6 (100%)	26 (92.9%)	5 (83.3%)	37 (92.5%)
<i>Are prohibited at the institution</i>	6 (100%)	14 (53.8%)	4 (80.0%)	24 (64.9%)
<i>Not prohibited, but carry and storage policies exist</i>	0 (0%)	7 (26.9%)	0 (0%)	7 (18.9%)
<i>Not prohibited, and the institution provides lockers for safe firearm storage</i>	0 (0%)	0 (0%)	0 (0%)	0 (0%)
<i>Other¹⁷</i>	0 (0%)	5 (19.2%)	1 (20%)	6 (16.2%)
Does this institution use a prescription & over-the-counter drug take back program?				
	4-yr non-profit ICW (n=6)	Public CTCs (n=28)	4-yr public (n=6)	Total (n=40)
Yes	3 (50.0%)	0 (0%)	2 (33.3%)	5 (12.5%)

Findings:

- There are gaps in reported facilities safety reviews, which are designed to ensure that students are in safe surroundings, reducing the opportunity for suicide.
- A small number of CTCs allow the presence of firearms on campus, using various forms of storage.
- Very few institutions have developed or participate in drug take-back programs.

Recommendations:

- All institutions should schedule and implement facilities safety reviews on a regular cycle to reduce opportunities for suicide.
- The discussion of best practices for reducing access to lethal means on campus should inform upcoming opportunities to revisit these policies.
- Decreasing the ability for students to access a firearm, whether stored in their vehicle or elsewhere on campus, may be an effective way to reduce suicide risk.
- Ensuring that students have appropriate ways to turn in unused prescription and over-the-counter drugs is another effective way to reduce suicide attempts and deaths.
- Ensuring limited access to chemicals commonly used in poisonings found in science labs is another opportunity to reduce suicide risk.
- Limiting access to balconies, bridges and rooftops may reduce suicide risk.

¹⁷ Other policies include the following: concealed carry with permit is allowed; may be locked in car but not otherwise on campus; firearms for hunting and sporting activities allowed on campus but must be stored with campus Department of Public Safety; allowed locked and out of sight in vehicles on campus.

7. Veterans & other at-risk populations

Table 12. Students currently serving or ever served in U.S. Armed Services

Active duty service members, Reserve members & veterans				
	4-yr non-profit ICW (n=5)	Public CTCs (n=18)	4-yr public (n=3)	Total (n=26)
Mean n (range) of students who ever served in U.S. Armed Services	118 (12-157)	345 (58-922)	333 (165-588)	300 (12-922)
Mean proportion (range) of reported student enrollment ever served in U.S. Armed Services	2.8 (0.5-5.1%)	3.8 (0.9-14.1%)	1.14 (1.1-1.2%)	3.3 (0.5-14.1%)

This table reflects only those institutions reporting both their total enrollment and the number of students who have ever served in the U.S. Armed Services.

Table 13. Support for behavioral health among specific student-populations

	4-yr non-profit ICW (n=6)	Public CTCs (n=28)	4-yr public (n=6)	Total (n=40)
Institutions reporting employing a staff member with a specific role to address behavioral health among the following vulnerable student groups				
Veterans	2 (33.3%)	3 (10.7%)	3 (50.0%)	8 (20.0%)
LGBTQIA+	3 (50.0%)	5 (17.9%)	3 (50.0%)	11 (27.5%)
American Indian/Alaska Native students	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Student athletes	3 (50.0%)	0 (0%)	2 (33.3%)	5 (12.5%)
Students of color	2 (33.3%)	2 (7.1%)	2 (33.3%)	6 (15.0%)
Survivors of sexual assault	4 (66.7%)	5 (17.9%)	4 (66.7%)	13 (32.5%)
Dual enrolled (Running start) students	0 (0%)	3 (10.7%)	0 (0%)	3 (7.5%)
Youth re-engagement	0 (0%)	1 (3.6%)	0 (0%)	1 (2.5%)
None of these	1 (16.7%)	8 (28.6%)	1 (16.7%)	10 (25.0%)

Table 13a. Supporting relationship building among student groups.

Institutions implementing programs to support relationship-building in these student groups				
Veterans	5 (83.3%)	28 (100%)	6 (100%)	39 (97.5%)
LGBTQIA+	6 (100%)	25 (89.3%)	6 (100%)	37 (92.5%)
Students of color	5 (83.3%)	24 (85.7%)	6 (100%)	35 (87.5%)
TRIO students	1 (16.7%)	19 (67.9%)	3 (50.0%)	23 (57.5%)
American Indian/Alaska Native students	4 (66.7%)	11 (39.3%)	4 (66.7%)	19 (47.5%)
First-generation students	6 (100%)	16 (57.1%)	5 (83.3%)	27 (67.5%)
Economically disadvantaged students	2 (33.3%)	16 (57.1%)	3 (50.0%)	21 (52.5%)
International students	5 (83.3%)	23 (82.1%)	6 (100%)	34 (85.0%)
Undocumented students	4 (66.7%)	14 (50.0%)	6 (100%)	24 (60.0%)
Commuter students	5 (83.3%)	6 (21.4%)	2 (33.3%)	13 (32.5%)
Transfer students	6 (100%)	10 (35.7%)	4 (66.7%)	20 (50.0%)
Students diagnosed with mental health conditions	6 (100%)	13 (46.4%)	4 (66.7%)	23 (57.5%)
Survivors of violence	3 (50.0%)	8 (28.6%)	5 (83.3%)	16 (40.0%)
Survivors of sexual assault	4 (66.7%)	8 (28.6)	5 (83.3%)	17 (42.5%)
Students in recovery from substance use disorders	3 (50.0%)	5 (17.9%)	3 (50.0%)	11 (27.5%)
Dual enrolled (Running Start) students	2 (33.3%)	19 (67.9%)	2 (33.3%)	23 (57.5%)
Students with disabilities	5 (83.3%)	19 (67.9%)	5 (83.3%)	29 (72.5%)

Findings:

- Institutions are implementing programs to help students connect within many specific student communities. However, certain populations, particularly students who are recovering from a substance abuse disorder, are often unable to access these services on their campus.

Recommendations:

- Institutions should take advantage of targeted substance abuse funding opportunities and ensure they build relationships with community resources.
- Institutions should examine what other groups on campus need with regard to behavioral health support.

Appendices

Appendix I: Postsecondary institutions participating in SSB 6514 data collection

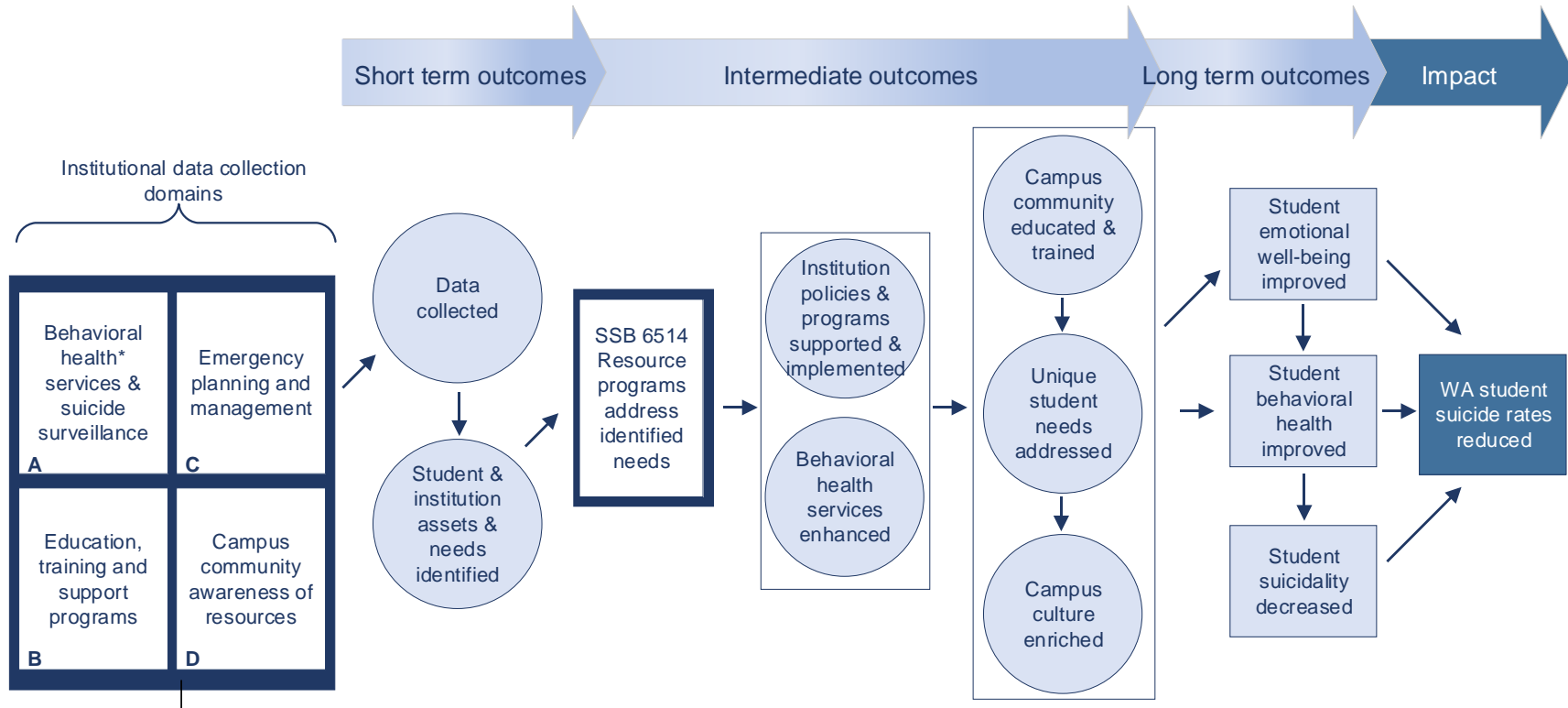
Non-profit Independent Colleges of WA (6/10)	Career Schools & Colleges
Gonzaga University	A Professional Gaming Institute, Inc.
Pacific Lutheran University	American Alpine Institute
Seattle Pacific University	American Energy School of HVAC
Seattle University	Ancient Arts Massage School
University of Puget Sound	Bastyr University
Whitworth University	Bluestone Academy
	Brandman University
Community & Technical Colleges (28/34)	Canby Bible College
Bates Technical College	Central Washington School of Dental Assisting
Bellevue College	Cloud Genius
Bellingham Technical College	Columbia College of Missouri
Cascadia College	Cornish College of the Arts
Centralia College	Divers Institute of Technology
Clark College	DT&T NA Training School
Clover Park Technical College	Epicodus
Columbia Basin College	Equine Natural Movement School
Everett Community College	Freedom Covenant Seminary
Grays Harbor College	H&K International Academy
Green River College	Institute for Therapeutic Learning
Highline College	Northwest NAC Training
Lake Washington Institute of Technology	Joel Perez Barber Academy
Lower Columbia College	Legal Care Center Academy
North Seattle College	Martinez Technical Institute
Peninsula College	DermaTech Permanent Cosmetics
Pierce College Ft. Steilacoom	New Horizons Computer Learning Center
Pierce College Puyallup	New York University
Renton Technical College	Northcentral University
Seattle Central College	Northshore Dental Assisting Academy
Shoreline Community College	Northwest College of Art + Design
Skagit Valley College	Northwest School of Wooden Boatbuilding
South Puget Sound Community College	Nutritional Therapy Association
Spokane Community College	Paul Mitchell The School Spokane
Walla Walla Community College	Phlebotomy Training Specialists
Wenatchee Valley College	Product School Inc.
Whatcom Community College	Professional Grooming Academy
Yakima Valley College	Professional Momentum Partners, LLC
Four-year public institutions (6/10)	ProTRAIN
Eastern Washington University	Reiki Training Program
The Evergreen State College	Sage Academy of Massage
University of Washington Bothell	Seattle Reflexology & Massage Center
University of Washington-Seattle	Seattle Theological Seminary

Washington State University-Pullman	Sunrise Caregiver Training
Western Washington University	The Hair School
	Three Trees Yoga Teacher Training Program
	Washington School of Dental Assisting
	West by Northwest School of Massage, LLC
	Wilderness Awareness School
	Zenith Maritime

**Note: Of the 48 responding career schools and colleges, 3 miscategorized their institutions, and were consequently directed to a version of the survey whose answers were not comparable across institutions in their sector. They were removed from analysis for this report.*

Appendix II: Postsecondary Conceptual Model to Guide Planning & Evaluation

Conceptual model of a multi-stage approach to reduce suicidality among postsecondary students in Washington State



*Behavioral health encompasses mental health, substance use, and suicide prevention efforts.

This model was developed by integrating Washington State Substitute Senate Bill 6514 requirements, current evidence, and INSPIRE Work Group brainstorm and feedback.

Model components in dark navy boxes illustrate SSB 6514 programs and requirements or other legislative actions anticipated to result from this work.

Model components in light blue circles or rectangles illustrate outcomes identified by INSPIRE Work Group members as relevant to improving postsecondary students' behavioral health outcomes, including reducing suicidality.

Questions? Contact Larry Wright at wrightl@uw.edu.

Appendix III: Citations

- Ahmed, S. (2018). Addiction and Suicide: An Unmet Public Health Crisis. *The American Journal of Psychiatry Residents' Journal*. <https://doi.org/10.1176/appi.ajp-rj.2018.130603>
- CMHSA, C. (n.d.). *Collaboration Toolkit: California Community Colleges and California County Behavioral and Mental Health Departments*. Retrieved from <https://www.sprc.org/resources-programs/collaboration-toolkit-california-community-colleges-california-county-behavioral>
- Edwards, J. (2015). *American College Counseling Association, Survey of Community/Two Year College Counseling Services, 2014-2015*. Retrieved from <http://www.collegecounseling.org/resources/Documents/ACCA-Community-College-Survey-2014-15-Final.pdf>
- Eisenburg, D., & Lipson, S. (2019). *The Healthy Minds Study, 2018-2019 Report*. Retrieved from Healthy Minds Network website: https://healthymindsnetwork.org/wp-content/uploads/2019/09/HMS_national-2018-19.pdf
- Gallagher, R. (2015). *National Survey of Counseling Center Directors 2014* (p. 11) [Project report]. Retrieved from International Association of Counseling Services website: http://d-scholarship.pitt.edu/28178/1/survey_2014.pdf
- Hedegaard, H., Curtin, J., & Warner, M. (2018). *Suicide Mortality in the United States, 1999-2017*. Retrieved from https://ccmh.psu.edu/files/2017/10/2015_CCMH_Report_1-18-2015-yq3vik.pdf
- Kersting, K. (2005). Study Indicates Mental Illness Toll on Youth, Delays in Treatment. *Monitor on Psychology*, 36(8).
- Knesper, D. (2013). *Suicide Prevention Resource Center. (2013). Continuity of care for suicide prevention: The role of emergency departments. Waltham, MA: Education Development Center, Inc.*
- Locke, B. (2015). *Center for Collegiate Mental Health 2015 Annual Report* (pp. 2, 7). Retrieved from Penn State University website: https://ccmh.psu.edu/files/2017/10/2015_CCMH_Report_1-18-2015-yq3vik.pdf
- Locke, B. (2019). *Clinical Load Index* (p. 2). Retrieved from CCMH, AUCCCD, IACS website: <https://ccmh.psu.edu/>
- Schwartz, A. J. (2011). Rate, relative risk, and method of suicide by students at 4-year colleges and universities in the United States, 2004-2005 through 2008-2009. *Suicide & Life-Threatening Behavior*, 41(4), 353–371. <https://doi.org/10.1111/j.1943-278X.2011.00034.x>
- Washington Veteran Suicide Data Sheet, 2017*. (n.d.). U.S. Department of Veterans Affairs.
- Wisconsin Hope Lab, Healthy Minds Network. (2016). *Too Distressed to Learn: Mental Health Among Community College Students* (p. P11). Retrieved from https://hope4college.com/wp-content/uploads/2018/09/Wisconsin_HOPE_Lab-Too_Distressed_To_Learn.pdf

NOTE: For further information on the 2019 SSB 6514 Data Collection, please contact Larry Wright, wrightl@uw.edu.