Suicide Prevention Across the Educational Continuum Series

Part 4: Suicide Prevention and Intervention for Transition Age Youth on College Campuses

Video Transcript:

>> So, welcome to today's presentation, Suicide Prevention and Intervention for Transition Age Youth on College Campuses.

>> As we have noted, the work of the Mountain Plains MHTTC and Mountain Plains PTTC is supported by SAMHSA and DHHS. We would like to note that today's presentation is provided free of charge and is available in the public domain. Also, the information that's presented today are the views and opinions of Sarah Nielsen and Andrew McLean and do not reflect the official position of SAMHSA or DHHS. Please let us know if you have any questions about the information in this disclaimer.

>> It is my pleasure to introduce today our presenters. Dr. Sarah Nielsen is an associate professor at the University of North Dakota in Grand Forks and she works in the Department of Occupational Therapy at the School of Medicine and Health Sciences. Sarah has over 19 years of experience working with children, youth, and young adults with mental health issues and partial hospitalization, school, communities, and universities. Her clinical practice included developing and implementing trauma informed approaches in mental health care, in assisting students transitioning from mental health programs back to public schools where she trained and assisted schools in this effort. She currently teaches children, adolescents, and young adults psychosocial content and is an academic advisor in the Department of Occupational Therapy. Sarah is a technical trainer for the MHTTC and is developing and implementing communities of practice in rural schools. And Dr. Andrew McLean is chair of the Department of Psychiatry and Behavioral Science at the University of North Dakota School of Medicine and Health Sciences, and is also a technical trainer for the Mountain Pains ATTC, as well as the MHTTC. He obtained his medical degree from the University of North Dakota School of Medicine, completed a psychiatry residency at the University of Wisconsin, and a Masters of Public Health from the University of Minnesota. Dr. McLean previously was the medical director of the North Dakota Department of Human Services. He has served on a number of clinical, administrative, and regulatory boards, including medical licensing and professional health programs. Dr. McLean has a particular interest in working with and advocating for individuals with serious and persistent behavioral health issues. And with that, I am pleased to turn things over to Sarah and Andy.

>> Thank you, David. Our objective today will really be to understand suicidality and college students and what we can do on our college campuses to address this

important issue. I will be starting us off with a little bit of background and understanding from the lens of an academic advisor and professor.

>> I'd like to start by talking a little bit about the experience of college students. We know that college itself is a transition and a time where young adults are going through a variety of challenges. Developmentally, individuals are moving from adolescence to young adulthood. And as they do so, they continue to engage in identity exploration, forming of relationships, and establishing independence. An interesting study by Arnett found that young adults themselves describe this time as an age of identity exploration, instability, self-focus, a feeling of being in between, and a time full of possibilities. Additionally, we know that 75% of lifetime mental illness emerges by age 24 during this time period. This is why it is critical that we are monitoring and addressing mental health on our college campuses. The American College Health Association National College Health Assessment surveys students to understand their feelings related to mental health. You can see on this slide that within the last 12 months that students have experienced feelings of hopelessness, being overwhelmed, lonely, sad, depressed, and anxious. Of course, it is vital that we have services to assist students in managing these feelings and symptoms. We can also see, with respect to our topic today, that around 12 to 13% have considered suicide in the last year with approximately 2% attempting. Additionally, you can see that if students do seek assistance at our counseling centers, they primarily do so for anxiety and depression, or a combination of those two.

>> As an academic advisor, I think about student mental health as it relates to their academic performance. With this in mind, I would like to share a scenario an academic advisor might experience. John is a 21-year-old male in his third year of an academic program. You have advised John for two years and he has demonstrated up and down academic performance. He disclosed about a year ago that he was in counseling for substance use. Today, he requested an appointment because he is unsure if he wants to continue in the program. He is not failing courses, but he is falling behind. He reports he worries most of the time and this leads to difficulties with concentration. He reports he is drinking. His significant other, Mark, is supportive. He does not want to share his mental health concerns with his parents. And during the conversation, he expresses hopelessness about his situation. John is indeed experiencing a challenge. Let's keep John's case in mind as we move through our content today.

>> Let's talk about a few terms to understand suicidality. Suicide is defined as death caused by self-directed injurious behavior with intent to die as a result of the behavior. When we talk about people dying by suicide, it is important to know that this can be a result of a very impulsive or a temporary cognitive change in how the person views the world. A suicide attempt is a nonfatal, self-directed, potentially injurious behavior with intent to die as a result of the behavior. A suicide attempt might not result in injury. You may also see a person injure themselves with the intention to die by suicide -- excuse me, without the intention to die by suicide. What is important to understand is that if individuals do harm themselves, they do have a higher risk of suicidality, but they may indeed not have an intent to die. Suicidal ideation refers to thinking about, considering, or planning suicide. Sometimes the term suicidality is used to encompass all of these terms. and Dr. McLean will talk more about this later in the presentation.

>> Let's take a minute to look at some statistics about suicide in college-age students. Between 2009 and 2018, suicide rates increased among all age groups, including our college-age students, with death by suicide being the second leading cause of death in college-age students.

>> When we think about students experiencing suicidal thoughts or attempts, you can see the national data collected by age is very similar to the data I presented from the ACHA earlier. You can see in comparison of age, our 18 to 25-year-olds have more suicidal thoughts, plans, and attempts than other age groups.

>> Additionally, we can see that our American Indian and Alaska native adults are at the highest risk for past-year suicidal related thoughts and for past-year suicide attempts.

>> So, the question might be, as an academic advisor, how can I be a part of suicide prevention? My role really is to know the facts, listen, and observe my students. As students naturally talk about academic performance and what is interfering with that performance, we will hear key important factors that help us understand our students' current mental health. It is also important to know that we are interested in the keyword of prevention. So, today, we are going to talk about risk factors and protective factors that we can listen for. We also want to keep in mind that as a part suicide prevention we want to connect our students to services and supports on our campuses early, hopefully before they have experienced suicidal ideation. Risk factors are characteristics associated with suicide. If an individual has more risk factors, they have a greater probability of suicidal behavior. It is important that we understand that there is no single agreed-upon list, and I'm going to be presenting just a few examples here today. The first one I want to talk about is behavioral health issues or disorders. Key in college-age students is that we know mental health issues often first appear between the ages of 18 and 24. So, colleges are uniquely situated to help these young people. And as advisors and instructors, we can connect our students to these resources. Sometimes we won't hear these risk factors in conversation, but we might see these. Fr example, if I notice the student has decreased in attendance, disheveled appearance, failing or changed academic performance, I might reach out to them. Second, I think about individual characteristics. I watch and listen for feelings of hopelessness, loneliness, social isolation, isolation, lack of belonging, risky behavior. If a student demonstrates low frustration tolerance, difficulty problem-solving or feeling like they are a burden to others. Next, I think about adverse and stressful life circumstances. In particular, I might listen for relationship difficulties. Did the student have a recent breakup? Have they experienced dating violence? I, of course, am listening for school failure. That's most likely why I am seeing the individual, because they are having a decline in their academic performance. Sometimes we still hear students complain about financial difficulties, physical or sexual abuse, chronic physical illness or disability, or insomnia. Next, we think about family characteristics. And we know increased risk factor is family suicide history or mental health problems. As academic advisors, we may not hear about this, but certainly our counseling centers will be asking questions about that. What we may hear about are things like lack of family support or fear of disappointing a family, and these are typically the concerns that I would hear about. Next, we look at school and community factors. Does the student have limited access to physical, mental

health, or substance abuse service and care? Do they experience stigma associated with seeking care? My experience has been that students have an increased likelihood of seeking services now than they did 10 years ago, but sometimes they're still unwilling to use those services provided. We're also listening for stigma and discrimination a student might experience secondary to sexual orientation, gender identity, race and ethnicity, and disability. So, all of these factors play a role from the advising standpoint. If I am meeting with a student, for example, who is failing academically or having professional behavior issues and may be at risk for termination from a program, I need to understand these risk factors and ask appropriate questions. For example, a key question that I will ask if a student is failing is, have you shared your situation with a friend or family member? If a student indicates that they have not shared, or they're uncomfortable sharing, that's a good cue for me to think about talking with them about going to the counseling center to visit further with a mental health professional.

>> Next, we think about protective factors. These are characteristics that reduce the likelihood of suicide and they can buffer the effects of risk factors. The capacity to cope positively in the face of talent and adversity is something that we call resilience. And what we can do, as campus staff, is enhance protective factors that are essential element of resiliency and suicide prevention. Strengthening protective factors include things such as decreasing other risks like violence, substance abuse, and academic failure. As an academic advisor and instructor, I can make sure that I facilitate a safe and nonjudgmental classroom and advisement meeting process. I can assist students early when they are experiencing academic difficulties, connecting them to academic supports, and I can make them aware of our other services on campus, such as mental health supports or make referrals as appropriate. Like risk factors, there is no single agreed-upon list of protective factors, but here are a few examples I listen for. One is individual characteristics or behaviors. Does the student present as positive? Do they have positive beliefs about the future? If they're failing, are they able to make a plan to move forward? Do they have social emotional skills, like problem-solving, coping, and ability to regulate their emotions as they're experiencing this school failure? Also, we listen for, do they have spiritual beliefs or connections to a spiritual community, which we know is a protective factor, through their cultural or religious beliefs from life and discourage suicide? Do they have a sense of responsibility to others? And then, lastly, are they engaged in physical activity, especially aerobic, which we know can be a protective factor? Next, I think about social support. Do they have a connectedness to their family? Do they have connectedness to friends or a romantic relationship? Also, we know that a big indicator of students being successful on college campuses is connections to teachers, mentors, and leaders who show concern for them and their academic and emotional well-being. So here, again, as a protective factor, I can be eyes, ears, and help the student get the support they need. Next, I think about school and community factors. Is that student connected to their peers? For example, in our academic program, I'm looking to see if they have connection to their communities of learners. Are they connected to the larger university? Are they aware and available and connected to resources on campus? Are they involved in extracurriculars? Do they have restricted access to lethal means, especially firearms? And are we monitoring and controlling alcohol use? So again, as an advisor, when I see someone like John, I am

listening for protective factors, such as -- such as, is he sharing with somebody about his current situation? There is also a supplemental handout with this webinar that has a link to a faculty resource sheet that you may also find helpful if you are a faculty member or academic advisor.

>> I'd like to go back to the case of John. You can see that I've highlighted the things that I was listening for. In green are protective factors. He apparently feels like he has a connection to his advisor. He has used counseling in the past. He has sought out help. He is currently not failing academically. And he does have a support in his significant other. We do know risk factors include that he's falling behind. He's using alcohol again. He doesn't want to share with his parents. And he is experiencing some hopelessness. So, as the academic advisor, I've listened and I've noted that there are concerns. I am not a therapist, so I have some next steps that I can take. And at this point, I'm going to turn it over to Dr. McLean and he's going to discuss some next steps. Thank you.

>> Thanks, Sarah. So, many of you are wondering, you know, I'm a teacher, not a therapist. There might be a few therapists out there. But it's important as we move forward when we're working with students to remind ourselves of, you know, what is our agency? What's our role? And it doesn't mean you can't have more than one role. But, as you know, as an academician, I can -- I can teach and grade students, but I can't be their therapist at the same time. And so, it's just important to remind ourselves, you know, how are we acting? What hat are we putting on here? But in some circumstances, you might be deemed a responsible employee, such as for Title IX regulations. But I always liked Carl Menninger's quote, when in doubt, be human. And I teach my students that, my residents that. When we're really wondering about the dotting the i's and crossing the t's, you know, when in doubt, be human.

>> So, in the scenario, the student has presented to you. So, John has trusted you. He's let you know that he has concerns. But in a lot of other cases, you might be just seeing somebody in the classroom that you have gotten to know them and things just don't seem right. And if you notice those things, you can simply reach out in a private, nonjudgmental fashion. You don't call them out in front of a class, but you might just, you know, pull them aside and say, I was just wondering how you're doing. When Sarah was talking about, you know, caring nonjudgmental comments and relationships, that's really important, and listening objectively. So again, hearing what they have to say, not jumping in with your own solutions, but just wanting to hear what their concern might be. And reminding you that you don't need to be a mental health professional, you don't need to be a mental health expert, but you should be aware of what the resources are on your campus or in your community.

>> So, in terms of active listening, you know, building trust, establishing rapport. The case that we referenced with John is that relationship is already there. But as you're well aware on campus, you're being watched whether you know you're being watched or not. I mean, people have a sense of who you are as a teacher, who you are as an administrator. Are you approachable? Are you not? And so, we want to demonstrate concerns. We'll talk about the specific questions that you might ask, but one of the most

important things is that individuals don't feel like they're alone, that they know that somebody is paying attention to them, that they're actually being heard or being seen.

>> So, John mentioned that he's had past counseling for substance use. He is drinking now. He's falling behind in school and he's feeling hopeless. The other thing he mentioned is, he's having difficulty concentrating. And so, there are a number of things that are not only symptoms, but things that are getting in the way of his being successful. And so, those are all concerns in terms of his reaching his goals. You know, he wants to be doing well in school. But those are the sorts of things in terms of risk factors that Sarah had also talked about.

>> So, what might you do next, and so, besides runaway? It's always anxiety provoking for us all when we're met with a concern that we don't really know how to address, which is the reason why all of you are signed up for this webinar. And many of you may already have experience in dealing with situations like this. But as we talked about, acting human, being human, showing concern, but then figuring out, you know, is this kind of just a worry? Is this maybe something urgent? Is this perhaps something emergent? And what's my role in this?

>> So, there are few emergencies in mental health, but one of them is high suicide risk. And so, even if you're not a therapist, there's something called the Lighthouse Project from Columbia University, and we'll be referencing that. And they've put out a lot of information for non-clinicians on how to talk to individuals about suicide. And these are people -- these are professionals who may be out in firefighters, they may be first responders, they may be teachers. And the website that we'll show you actually has references for all of those different professions in terms of, you know, how you might use these tools to ask. So, we know that asking a depressed person about suicide doesn't put the thought in their heads. And so, it's certainly appropriate and actually right to ask about that if you have someone who you're concerned about. And then there's the old, well, if somebody's going to do it, they're just going to do it. Nothing I can do is going to make a difference. And that's really not true. For the vast majority of people who are suicidal, it's very time-limited. There are -- there are points, there are thresholds that when you intervene it's a significant impact on future risk. And so, the majority of people who attempted suicide say that they wish that they hadn't. They were happy that they didn't succeed. They were happy that if somebody actually did step in and intervene that that occurred. So again, these are time-limited problems. But again, when students, when individuals who are depressed are seeing the world negatively, it's tough in that moment for them to see the future. And so, you know, our role is to get them past that situation so that they get better, that they're able to concentrate, they're able to see things more positively, that cognitively they're able to function better. And so, inner being is really important. And so, the idea that someone makes suicidal threats won't really do it. We certainly have heard of people who do, quote unquote, gestures, but as Sarah had mentioned, individuals who have been planning, thinking, actually acting in self harmful ways actually are at higher risk anyway. So, even those individuals who have a track record of self-injurious behavior, they are at higher risk for a number of different reasons for suicide completion. So, we don't want to minimize that. And every situation is different, so we want to keep that in mind.

>> So, this is the -- one of the tools that I had mentioned. And this is from, again, the Columbia Lighthouse Project. And as you'll see on the left, it's specific to schools, this particular pamphlet, this handout. And so, some of the things that they do in training, and you can use these little cards, you can print these out, but the recommendations are in terms of screening. And so, again, this is screening. This is not a mental health assessment. This is not an evaluation done by a mental health professional. This is a screen that can be done by any individual. So, the recommendations are when you have concerns that you would ask three questions at least. And the first is, have you wished you were dead? Wish you could go to sleep, not wake up? Professionally, we call this passive resignation. Oh, I wish, you know, I wouldn't mind if I got cancer. I wouldn't mind if I didn't wake up from, you know, my nap, etcetera, but it's not an active wish. And so, you then go on to the next one. Have you actually had any thoughts about killing yourself? And that is certainly more of an active concern. So, even if they say no to those two questions, it is recommended that you ask the last one. Have you done anything, started to do anything, prepare to do anything to end your life? And so, the first questions we want to look at in the last month. This last question, we look at in the last three months, you know, have you done this? And, you know, if they've had those thoughts within the last three months, that's significant risk. That's high risk, but we want to be mindful. So, if you hear, yes, I -- you now, the last two times I went home I attempted suicide, but that was six months ago. That doesn't mean that's not high risk if you know that the break is coming up, they're feeling depressed, and they're going to be heading home. So, you know, it's important for us to be mindful. So, even if we're scoring this, if we have concerns, we refer them on. If they're feeling great, you know, if they're saying no to one and two, or even yes to one and two, but no to six, then we want to make sure that in the future if they have concerns that they have the resources to access those. But if it's four, five, and six, then we have significant concerns for high risk and want those individuals to be assessed and evaluated formally. And so, some of the recommendations at the bottom of that pamphlet are, if you can immediately escort them to a healthcare provider or call or text, that's the suicide hotline. You can call and text both. If the person is not able, not willing, and you are significantly concerned, you can always call 911. And we'll talk a little bit more about how you might give people the access to care that they need. But it's important not to just leave a high-risk individual alone. Now, if there's danger to yourself, if someone is violent, then you need to make sure that you go to safety, but then you alert the proper authorities. That should be a very rare situation. Perhaps some of you have experienced that. But the important thing is, you have some sort of handoff.

>> So, what about virtually? We're all doing in this time of COVID-19, you might find out this concern via videoconference, you know? And so, what we would've done in the past is maybe asked the student to make the appointment for the counseling center or the healthcare center, walked them over, as said, escorted to the centers from your office. Now, we can't do that. And so, what do we do now? Well, again, we try to figure out through the screening how much of a risk is this? Are they able to, you know, understand our concerns, what they need to do, do they have the information that they need access care? Can we follow through and find out that actually occurred? Do they have someone else in the home that they are willing to have you talk to about the

concern with the individual that you're seeing? Or, they may be doing it by App. Are they near a friend who you could talk to as well? So that's, you know, one of the ways in which we might deal with more concerns at a higher level of risk.

>> And in terms of urgent care, so student counseling centers are usually able to visit with students or clients face-to-face. So, the student counseling centers typically have on-call numbers, hotline type numbers, people on call after hours, and they can sometimes see people face-to-face. However, if the individual is high risk and it's emergent, they may be able to help coordinate, but it's unlikely that they may be able to take care of the situation at hand if the individual needs a higher level of care, but they can certainly assist in making that happen. The other part is student health center. So, some campuses, they are merged, counseling and health centers are merged. Some are separate. Some are separate in the same building. Some are separate, you know, across campus or in different parts of the community. So, they have -- student health centers have trained medical providers who can do these screenings, and routinely they do as well for both particular medical and behavioral health conditions. But again, if it's emergent, they may or may not be able to take care of the mental health crisis and deal with that to the point of disposition back home or whatever. Sometimes they can, but oftentimes they'll have to also assist the individual in getting to a higher level of care for assessment.

>> So, you can do so via family, via friend. I had a call last week from the east coast, a friend of a friend who had a relative who was suicidal. And that person was alone, graduate school, just finished, wondering what can I do. And so, I talked with them about, you know, the on-campus options, even though the person had recently finished. I talked with them about community options. It turns out that the individual wasn't totally alone, that there was a friend who could actually come over and be with the individual and then make sure that they got the help that they needed. So, it's really a matter of what resources are available where the individual is. So, family, friends, other non-provider supports. On campus or in communities, there are oftentimes community mobile crisis teams or behavioral intervention teams. And so, we would utilize those. Law enforcement, as we mentioned, 911, which could be a welfare check by law enforcement or calling the ambulance.

>> And this is one of the most important things I ever learned was, when I was in training my attending told me, whenever you're stuck expand the field, which essentially means you'll never feel like you're alone in making this decision. So, if you have concerns, talk with a colleague, talk with another professional. If the student leaves your office and you're wondering what to do, you know, don't feel that everything rests on you. And you can even call up a hotline yourself and say, I've got this situation, what should I do? So, it's just a reminder, never feel like you have to bear this alone. It's a whole other talk on what happens if there's a completion, if there's significantly negative outcome. How do we deal with that as teachers, as academicians, as providers of care? This, we don't have time to talk about that, but it's just important to take care of yourself when you're feeling stressed and dealing with situations like this.

>> So, as Sarah had alluded to, college is a time where we see the resurgence -- or, actually, the beginnings of many mental health disorders. Commonly, early teen -- or,

late teens or early adulthood major depressive disorder occurs. Bipolar affective disorder occurs. And oftentimes, it starts out with depressive symptoms. We don't know that somebody actually has both the highs and the lows. And bipolar I is the classic stories you hear about overt mania, where people are, you know, not needing to sleep for days on end, out doing really, quote unquote, crazy sorts of things, and it's very apparent that they are disturbed. Bipolar II, it can sometimes be more subtle where people certainly get depressed, but they don't get as high as someone with bipolar I disorder. They may have problems sleeping, may have problems concentrating. It can sometimes look like anxiety. It's not mutually exclusive from that. But interestingly, there's a higher incidence of bipolar II among women and there's a higher incidence of suicide in bipolar II individuals. And so, getting people help and a proper assessment is important. Other disorders we see during college, certainly eat disorders, binge eating, bulimia nervosa, anorexia nervosa. Anxiety disorders, as Sarah had mentioned in her slide, are really common, whether we're talking about panic disorder, whether we're talking about social phobia, other sorts of anxiety disorders. Attention deficit hyperactivity disorder is certainly a problem. Obsessive-compulsive disorder is a concern that occurs in young adulthood. Posttraumatic stress disorder. Sarah had mentioned that individuals who have had trauma may be more risk. We know all about the risks in terms of adverse childhood experiences and substance use and mental health issues. Sleep disorders are very common in college-age students. And prolonged poor sleep is actually a risk factor in terms of suicidality if you add in all of these other stressors. So, you know, asking about sleep, asking about, you know, lifestyle, asking about, you know, wellness activities is important. It's not a benign thing to go without sleep for a long period of time. I remember very well back in college when I was cramming or doing other things, my sleep was disrupted. But if you're seeing someone who is extremely depressed, extremely anxious, and they are having really, really poor sleep, despite the fact of if they're not suicidal, getting them in to see someone to assist with that can be very useful. And then substance use disorders, as Sarah had mentioned, those are commonly a concern in college students, and certainly they reduce impulse control. And if people have access to lethal means, that's oftentimes a very deadly combination. Psychotic disorders are less common, such as schizophrenia, schizoaffective disorder. Sometimes somebody who is so severely depressed they can have psychotic symptoms. If somebody is manic, they can have psychotic symptoms. So, that does occur, but less often than some of these other issues that I mentioned.

>> So, we're in the midst of the COVID situation, and I just wanted to bring up this slide about phases of disaster, and you can say phases of pandemic. So, mitigation is planning and trying to prevent. We're passed that point. Preparedness, we're kind of passed that point. We're in the -- we're in the response phase. And different parts of the country are in different parts of that response phase. And so, people are stressed. You are stressed, I'm stressed, students are stressed with all of the changes going on and social isolation, etcetera. Campuses will have to plan as we move towards recovery. And communities will have the plan in terms of who is going to need ongoing crisis counseling and how are we going to prevent, as Sarah had mentioned, how are we going to minimize the trauma and individual angst and moving into actually having disorders. And part of how we do that is community supports. Once there's a declaration

of disaster, there are oftentimes crisis counseling opportunities that arise in communities with funds. And so, identifying people who might be at higher risk, and not necessarily doing therapy per se, but adding in supports to reduce the likelihood of them going on to have, you know, mental disorders. So, we're going to be active, not only now in the response phase, but as we look at the impact on the economy, the impact on budgets, as you're all concerned about, the impact on return to school successes upon return to school, the changes in delivery of education. We'll have to be looking at planning for supporting students from a mental health standpoint as well.

>> Most people in, you know, post disaster, they don't develop mental illness or substance use disorders. In the first few weeks, they might manifest symptoms of that, but many, many people, you know, struggle like everyone else does and don't go on to develop other disorders. However, with the sorts of things that Sarah had mentioned, if you add on substance use, if you add on the economic difficulties, if you add on the academic difficulties, those sorts of things can certainly add up to the point where people are struggling to be able to cope and may develop mental illness or substance use disorders. The other interesting point, though, is that, you know, people can come through this, and I think Sarah had mentioned, there can be some, you know, some silver linings to this. There's something called post dramatic growth, which I'm sure all of you have heard of, and that's where people come through a difficult time with a new way of looking at the world, a new way of dealing with stresses, a change in their lifestyle and well-being. And so, even people who have had previous trauma, if they've been able to deal with that well, they actually may function quite well or even better than someone who might not have gone through that. So, it's not always a certain thing that somebody who has had trauma is going to have more trouble, you know, the next week or the week after that. They may have learned such good coping skills that they're ahead of the game. So, we don't want to pathologize an abnormal response -- or, a normal response to an abnormal situation. But at the same time, as we talked about with students who are more at risk for developing mental disorders and substance use disorders, we want to make sure that people do get identified and get the professional help that they need.

>> This is just one of those examples. It's a busy slide. I don't want you to memorize it. You'll have access to the slides. But in the recovery phase post disaster, these are the sorts of things for communities that are brought forth. So, psychological first aid for general population and people who are more at risk. A little bit higher level of access to care is the crisis counseling. And again, it's community-based, outreach based. It's not therapy, but it's a little more robust. And then there's something called critical incident stress debriefing, and this is only intended for specific groups. And I say it's controversial because sometimes it's been misapplied to the general population. But this is really much more for first responders, military groups that are already tight and cohesive. But, so you may hear about those sorts of things.

>> I always like this slide. This was from a colleague in Australia -- or, excuse me, in New Zealand. He was the health director of Christchurch where they had earthquakes. And he had this slide on a holistic framework for recovery. So, as we move forward with this pandemic, we're talking not about our academic community, our students, you

know, we're talking about the communities in general. And so, it's important to keep that in mind when we talk about resilience and moving forward.

>> So, what about non-urgent or emergent resources in the time of COVID? So, we can still do therapies. And so, if we're talking more about individuals with significant problems, we're talking about formal therapy. And that can include one-to-one, virtually that can include group. But then, as you're well aware, there are lots of other virtual support groups out there right now, including peer supports. And there are plenty of apps out there, and I would say let the buyer beware, but there are a number of good resources for apps for the general public in dealing with stress. And then there's, obviously, the normal supports, family, friends, others, the routines that Sarah had mentioned in terms of if you're an individual who is a person of faith, or is there a way to continue with your daily routines, your weekly routines to make things as normal as possible. What things do you have control over that you can really lean upon versus the -- just nebulous, generalized worry? And that's one of the most difficult things right now, is the uncertainty. And so, latching onto things that you're sure of, and part of that certainty is what your working program has been in terms of staying well, that includes healthy habits.

>> So resources, as businesses, including those involved in education and health are reducing their workforces right now. Hopefully, that's temporary. You know, how are we going to manage as we move back? We've got now the 21st century cares dollars that are coming into states. Those will be forwarded to campuses as well. And so, hopefully, those resources will be available in terms of dealing with the stresses around COVID. And so, that's actually what I wanted to just touch on, finish up. And then David, can I stop sharing and send this over to you?

>> Yeah, that's fine, Andy. And we can answer questions. That sounds great. Well, thank you both so much. That was a really wonderful overview.