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Practice Pathways for Graded Closed-Loop Intervention in Psychological Crises Among College Students: An Analysis of Three Typical Cases

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Abstract: Psychological crises among college students are often characterized by concealment, cumulative stress, and sudden escalation. Single-session interviews, one-off referrals, or experience-based responses are therefore insufficient for systematic prevention and intervention. Based on three anonymized typical cases, this paper examines yellow, orange, and red risk levels and reconstructs a closed-loop intervention pathway consisting of multi-entry screening, structured assessment, graded intervention, and dynamic follow-up. The analysis suggests that yellow-risk students should be supported through preventive care, enhancement of counseling motivation, and consolidation of social support systems; orange-risk students require stronger identification of hidden warning signs, professional assessment, school-family-medical collaboration, and continuous monitoring; and red-risk students must be managed under the principles of life safety first, medical referral priority, and full-process risk control. The study further argues that psychological crisis intervention in higher education should not be treated as an isolated emergency response. Instead, it should integrate early risk identification, unified assessment criteria, risk-matched intervention strategies, clearly defined responsibilities, and continuous review and improvement. Such a framework can improve the standardization and practical effectiveness of warning, referral, intervention, and follow-up procedures for student psychological crises.

Keywords: College students; Psychological crisis; Graded intervention; Closed-loop management; Case study

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1. Introduction

In recent years, mental health problems among college students have shown increasingly complex sources of stress, more concealed risk presentations, and faster escalation from distress to crisis. College students are in a critical developmental period involving physical and psychological maturation, academic adaptation,

interpersonal relationship building, and identity formation. Romantic setbacks, academic difficulties, family changes, financial stress, and relapse or deterioration of mental disorders may accumulate and transform general emotional distress into self-injury, suicide attempts, or other high-risk events.

National policy documents in China have emphasized the need to improve student mental health prevention, monitoring, early warning, referral, and intervention mechanisms, while promoting collaboration among schools, families, medical institutions, and social resources [1–5]. These requirements indicate that psychological crisis intervention in higher education should not remain at the level of a temporary response after a problem is discovered. Rather, it should be developed into an operational system that is identifiable, assessable, executable, traceable, and reviewable.

In practice, students in crisis do not always present through high screening scores or active help-seeking. Some students may be classified as low risk in routine psychological screening, yet their history of self-injury, previous suicide attempts, and current stressors indicate the possibility of recurrence. Others may not show prominent abnormal results on standardized scales, but hidden risks may become visible through autobiographical materials, social media posts, physical scars, dormitory interactions, peer reports, or counselor observations. Still others may already have recent suicidal behavior, intense suicidal ideation, refusal of treatment, or poor treatment adherence, and therefore require immediate emergency intervention.

Research on latent suicide risk among college students also indicates that suicide risk should be assessed through multiple indicators rather than single symptom-based screening alone [6]. Against this background, this paper uses three anonymized cases to summarize the practical pathway of graded closed-loop intervention for psychological crises among college students and to provide a reference for mental health education and crisis management in similar higher education settings.

2. Methods: Case sources and analytical procedure

The cases discussed in this paper were drawn from university mental health education and crisis intervention practice. All case materials were anonymized, and necessary details were modified or omitted to prevent personal identification. The study adopted a typical case analysis approach. Student risk was divided into three levels (yellow, orange, and red), with suicide risk as the core criterion and with consideration of previous self-injury or suicide attempts, psychiatric diagnosis, current stressful events, family and peer support, help-seeking willingness, and treatment adherence.

The purpose of this paper is not to reconstruct all details of each case, but to extract the identification channels, assessment priorities, intervention strategies, and follow-up requirements for students at different risk levels. This approach is consistent with the policy orientation of moving prevention forward, improving monitoring and early warning, and strengthening referral and intervention procedures in schools [1–3]. It also corresponds to evidence that comprehensive indicators are necessary for identifying college students at elevated suicide risk [6].

3. Results: Core characteristics of the three risk cases

3.1. Yellow risk: Preventive care type

Xiaohua, a first-year female student, was identified as a yellow-risk student during freshman psychological screening. During a care-oriented interview, the counselor learned that she had a history of self-injury and a

suicide attempt in junior high school. Although she had no clear suicidal ideation at the time of the interview, she reported a high level of anxiety and was affected by romantic conflict and family discord. She had a high level of trust in the counselor but remained hesitant about professional psychological counseling, which delayed professional involvement at the early stage.

Later, after a period of marked emotional fluctuation, Xiaohua gradually entered counseling and medical follow-up with the joint support of the counselor, roommates, and parents. Her condition subsequently stabilized. This case shows that yellow risk does not mean no risk. Students without a current suicidal plan may still have potential escalation risks if they have a previous risk history, current stressors, and unstable support systems. Therefore, prior risk history, current stress events, and changes in support resources should be actively and systematically monitored.

3.2. Orange risk: Key follow-up type

Student Z, a first-year female student, showed no obvious abnormalities in routine scale results, but frequent self-injury was identified through daily observation. Her autobiographical materials indicated that she had attempted suicide by taking medication in junior high school and had long used self-injury as a way to regulate emotional distress. She also reported feelings of hopelessness and self-negation.

Family background was an important contextual factor: her parents were divorced, communication with her father was conflictual, and stable support was insufficient. Subsequent medical assessment suggested the risk of a mood disorder. Although Student Z did not have an immediate suicide plan, long-term self-injury, previous suicide attempts, weak family support, and possible illness fluctuation together placed her in a moderate-to-high risk group. This case suggests that university crisis identification cannot rely solely on standardized scales. Qualitative texts, peer feedback, counselor observations, physical scars, and family trauma should also be incorporated into the early warning system.

3.3. Red risk: Emergency intervention type

Xinyu, a first-year male student, was identified as having high-risk signals through a freshman growth report. In high school, the death of an important family member caused a significant traumatic reaction and suicidal ideation. Before returning to school, he had experienced a suicide attempt that was not detected in time. After entering university, romantic loss, examination pressure, family economic difficulty, and strong self-blame further accumulated.

Medical diagnosis indicated a relatively severe depressive episode and mood instability. Xinyu had strong suicidal intent, poor treatment adherence, and a cognitive tendency to rationalize suicide. His primary guardian was unable to arrive at school promptly because of distance and work constraints, but one relative had a stable and trusting relationship with him and could provide substitute support. This case indicates that red-risk intervention must place life safety first and rapidly implement safety monitoring, medical referral, school-family collaboration, and full-process documentation (**Table 1**).

Table 1. Summary of risk levels, core features, and intervention priorities

Risk level	Case type	Core risk features	Main intervention priorities
Yellow	Preventive care	Previous self-injury or suicide attempt; current anxiety; no clear current suicidal ideation; available peer and school support	Preventive care, counseling motivation, family-school communication, support consolidation, periodic follow-up

Orange	Key follow-up	Frequent self-injury; previous suicide attempt; weak family support; possible mood disorder; hidden risk not captured by routine scales	Professional assessment, school-family-medical coordination, self-injury management, continuous monitoring, structured follow-up
Red	Emergency intervention	Recent or previous suicide attempt; strong suicidal ideation; depressive episode; poor treatment adherence; multiple acute stressors	Life safety first, urgent monitoring, medical referral priority, family or substitute guardian involvement, full-process risk control

4. Discussion: Practice pathway for graded closed-loop intervention

Closed-loop intervention should be guided by timeliness, risk matching, and traceability. Timeliness means that once crisis-related clues appear, a verification process should be initiated rather than waiting for the student to request help. Risk matching means that intervention intensity should correspond to the risk level: low-risk students should not be over-managed, while moderate- and high-risk students should not be underestimated. Traceability means that interviews, assessments, referrals, school-family communication, and reassessments should be recorded with clear information about time, responsible personnel, student status, and follow-up measures. Embedding these principles in daily work helps transform crisis intervention from individual experience-based judgment into a stable institutional capacity [1–3].

4.1. Multi-entry screening: From scale-based screening to comprehensive identification

Psychological screening is an important entry point for university crisis warning, but it should not be the only entry point. Yellow risk can often be identified through standardized scales, initial interviews, and adaptation surveys. Orange risk depends more heavily on hidden clues such as autobiographical texts, physical scars, peer reports, dormitory changes, unusual leave requests, and online expressions. Red risk requires heightened sensitivity to recent suicidal behavior, clear suicidal ideation, access to lethal means, severe psychiatric symptoms, and refusal of treatment.

Universities should establish a multi-entry warning mechanism that integrates scale screening, growth reports, daily observation, peer feedback, and school-family information. Counselors should be allowed and encouraged to report abnormal clues rapidly to the psychological counseling center for professional review. This helps reduce missed screening and delayed response, and it is consistent with policy requirements for standardized mental health monitoring and early warning [1–2].

4.2. Structured assessment: Improving consistency in risk judgment

Crisis assessment should move from experience-based judgment to structured evaluation. For yellow-risk students, assessment should focus on emotional distress, previous risk history, current triggers, willingness to seek counseling, and available support resources. For orange-risk students, assessment should focus on the frequency, function, and escalation conditions of self-injury; previous suicide attempts; psychiatric diagnosis; family support availability; and treatment adherence. For red-risk students, immediate assessment is needed regarding the intensity of current suicidal intent, suicide plan and method, access to dangerous tools, recent behaviors, psychiatric symptoms, guardianship capacity, and feasibility of medical referral.

Assessment results should be documented in written form and should identify the risk level, responsible parties, follow-up frequency, school-family communication approach, and emergency plan. This structured approach is also aligned with the finding that multiple indicators are necessary to identify latent suicide risk among college students [6].

4.3. Graded intervention: Matching intervention intensity to risk level

Yellow-risk intervention should emphasize preventive care and developmental support while avoiding excessive control and stigmatization. Counselors can use stable, supportive conversations, empathic responses, and resource introduction to strengthen help-seeking motivation. The psychological counseling center can provide counseling assessment when appropriate, and medical support should be facilitated when necessary. In school-family communication, parents should be helped to understand the student's condition, reduce blame and simple moralizing, and strengthen family and peer support.

Orange-risk intervention should emphasize professional support and continuous monitoring. The psychological counseling center should lead special assessment; the counselor should monitor daily dynamics; parents or substitute family members should undertake guardianship cooperation; and medical institutions should provide diagnosis and treatment. For students with self-injury, staff should help them identify warning signs of self-injurious impulses, develop alternative emotion regulation strategies, and implement crisis notification and safety management within the minimum necessary scope.

Red-risk intervention must follow the principles of life safety first, medical priority, and full-process control. The university should immediately activate an emergency plan, arrange continuous accompaniment, remove dangerous objects, prevent the student from staying alone in enclosed spaces, and contact family members or trusted relatives to assume guardianship responsibilities. For students who refuse treatment, refuse urgent referral channels, or show poor treatment adherence, the university should work with family members, medical institutions, and relevant internal departments to develop a protective intervention plan on the basis of legal compliance and adequate documentation [1–3].

4.4. Dynamic follow-up: From "case closure" to continuous reassessment

Crisis intervention cannot end with a single interview, a single referral, or a written commitment. Yellow-risk students may be followed weekly to monthly, depending on their state, and the follow-up frequency can be gradually reduced after symptom relief while maintaining accessible support. Orange-risk students may initially require one or two follow-ups per week, with monthly special reassessment focused on self-injury, emotional fluctuation, medication adherence, and family conflict. Red-risk students should receive daily safety confirmation and continuous records, with emergency reassessment at key points.

Removal from key attention or crisis management should be based on professional assessment, medical recommendations, family feedback, functional recovery, and a sustained period of stability. Management should not end merely because a student verbally states that everything is fine. Continuous review and improvement are essential for building an accountable and effective crisis intervention system [1, 3].

5. Practical implications

First, risk classification should take suicide risk as the core while incorporating contextual conditions. Scale scores, interview performance, and students' verbal assurances should not be used as the sole basis for judgment. Previous self-injury or suicide attempts, psychiatric diagnosis, current stress, support systems, and treatment adherence should be analyzed dynamically.

Second, intervention strategies should be matched with the risk. Low-risk students need to be seen and supported; moderate-risk students need to be assessed and continuously followed; and high-risk students need to be protected and referred for timely medical care.

Third, collaborative work should have clear responsibility boundaries. Counselors are responsible for daily observation, information communication, and supportive accompaniment; psychological counseling centers are responsible for professional assessment and intervention planning; parents or substitute guardians are responsible for guardianship and life support; medical institutions are responsible for diagnosis and treatment; and peers should only provide companionship, observation, and timely reporting rather than professional intervention.

Fourth, school-family communication should balance confidentiality and safety. When a student has actual self-injury or suicide risk, confidentiality exceptions should be activated within the minimum necessary scope. Relevant guardians and responsible parties should be informed of risk factors, intervention recommendations, and guardianship requirements while avoiding intensification of parent-child conflict.

Fifth, institutional development should emphasize review and improvement. After each crisis event, an anonymized review should examine whether early warning was timely, assessment was sufficient, referral was smooth, records were complete, and follow-up was continuous. Case experience should be transformed into process optimization, staff training, and institutional refinement.

Taken together, these implications correspond to national policy directions that emphasize prevention, monitoring, early warning, referral, and coordinated intervention, as well as empirical evidence supporting multi-indicator assessment of suicide risk among college students [1, 5–6].

6. Conclusion

Psychological crisis intervention among college students is a highly professional, collaborative, and continuous task. The three cases analyzed in this paper show that yellow, orange, and red risks differ in urgency, but all should be incorporated into a closed-loop system of multi-entry screening, structured assessment, graded intervention, and dynamic follow-up. Yellow risk focuses on prevention and consolidation; orange risk focuses on identification and prevention of escalation; and red risk focuses on emergency control and medical referral.

For higher education institutions, especially those with large student populations, limited full-time mental health professionals, and counselors who undertake substantial frontline student work, this framework has practical applicability. By designing screening entry points, reporting procedures, assessment criteria, intervention intensity, and follow-up frequency according to risk level, universities can prioritize limited resources for students with higher risk, more urgent needs, and weaker support systems while still providing continuous but non-excessive care for lower-risk students.

The core value of the framework is not to increase administrative burden, but to reduce information omission, unclear responsibility, and repeated communication through standardized procedures. In this way, crisis intervention can shift from post-event remediation to front-end prevention, process coordination, and outcome review. This paper is based on practice cases, and the number of cases is limited. Future studies may combine psychological screening data, follow-up records, and intervention outcome evaluation to further examine transition patterns and effective intervention factors among students at different risk levels.

Disclosure statement

The author declares no conflict of interest.

References

[1] Ministry of Education of the People's Republic of China, Supreme People's Procuratorate of the People's Republic of China, Publicity Department of the CPC Central Committee, et al., 2023, Notice on issuing the Special Action Plan for Comprehensively Strengthening and Improving Student Mental Health Work in the New Era (2023–2025). Accessed on May 11, 2026. https://dxs.moe.gov.cn/zx/a/jj/230512/1839562.shtml

[2] Leading Party Members' Group of the Ministry of Education of the People's Republic of China, 2018, Guidelines for Mental Health Education for Students in Higher Education Institutions. Accessed on May 11, 2026. https://www.moe.gov.cn/jyb_xxgk/gk_gbgg/moe_0/gb_2018/2018_gb0106/18gb0106_zh/

[3] General Office of the Ministry of Education of the People's Republic of China, 2011, Basic Construction Standards for Student Mental Health Education in Regular Higher Education Institutions (Trial). Accessed on May 11, 2026. https://ncmhc.org.cn/channel/downfile/fxyyVkjeg

[4] CPC Central Committee and State Council, 2016, Outline of the Healthy China 2030 Plan. Accessed on May 11, 2026. https://www.nhsa.gov.cn/art/2016/10/25/art_104_6428.html

[5] State Council of the People's Republic of China, 2019, Opinions of the State Council on Implementing the Healthy China Initiative. Accessed on May 11, 2026. https://www.nhc.gov.cn/guihuaxxs/jkzcwj/201907/e5720cde669347c48cf82f050c253f9c.shtml

[6] Su B, Guo Q, Xie B, et al., 2024, The Measurement Index Identifying College Students at High Risk of Suicide: From Personal-centered Perspective. Psychological Development and Education. 40(4): 572–588. https://doi.org/10.16187/j.cnki.issn1001-4918.2024.04.12