Student Mental Health: Managing Serious Issues Through Teamwork

Webinar Transcript

Nov. 21, 2019

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Facilitator: Hello, and welcome to today’s webinar, Student Mental Health: Managing Serious Issues Through Teamwork. Note that all attendees are in listen-only mode. Today’s program is 60 minutes long, and you can submit written questions and comments at any time during the presentation. Simply enter your question or comment in the question box on the bottom of your screen and click submit. Our speakers will address questions verbally as time allows during the webinar’s two Q&A sessions. Your submitted questions will be visible only to the moderator. Webinar resources are available in the resources list to the right of the presentation. Please note that today’s program is being recorded. And now here is today’s moderator, Heather Salko.

Salko: Thank you. Welcome to everyone listening with us today. I’m Heather Salko, and I’m senior risk management counsel here at United Educators. Today I’ll be moderating our discussion of student mental health on campus. We are joined by two professionals with extensive experience in the area of student mental health, attorney Hannah Ross and Dr. Victor Schwartz. Ms. Ross is General Counsel, Secretary of the Corporation, and Chief of Staff at Middlebury College in Vermont. In addition to advising her institution on legal issues related to mental health, Ms. Ross regularly educates student affairs professionals and fellow higher education attorneys on the subject.

Dr. Schwartz is Chief Medical Officer at The Jed Foundation and an Associate Clinical Professor of Psychiatry at NYU’s school of medicine. Dr. Schwartz has worked on campus establishing a counseling center at Yeshiva University in New York, and has also been that university’s Dean of Students. He regularly speaks on issues of student mental health.

One note: Despite having a doctor and a lawyer on our webinar today, this session is designed to provide risk management advice only and not legal or medical advice.
With that caveat, we will begin our webinar with some statistics. Student mental health receives regular coverage in the news these days, often focusing on increased demand placed on university-provided counseling services. In 2018, United Educators released a mental health claims overview where we looked at student general mental health claims or those claims where a student put their own mental health condition at the center of the claim they were bringing against their institution, as well as suicide attempts and suicide deaths. In that review, UE drew lessons from the hundreds of claims we received. And just this fall, we released updated statistics in the form of an infographic we created for this webinar. From January 2011 through May 2019, UE received a total of 451 claims related to student mental health. As we did with the claims report, we divided the updated infographic into two sections. The first covers general mental health claims and the other covers suicide attempts and deaths by suicide. These resources and infographics can be found on our website, edurisksolutions.org, and are linked to in the webinar resources. Of the 451 claims we received, 73% involved student deaths by suicide and another 8% involved suicide attempts.

Victor, you were very helpfully a reviewer on our updated suicide-related publications last year and looked at the infographic. With these updated statistics, is there anything that jumps out at you?

SCHWARTZ: There are a couple of things that are worth noticing in this context. In many ways, the data that you’ve gathered really mirrors what we’ve seen nationally. Suicide attempts are much more frequent among women, by about 3-to-1, but suicide deaths are more frequent among men, which is seen in the data you’ve gathered. Also, we know that from other research, that about 20% of students who die by suicide on campus have been seen by their counseling service. So again, the information you are seeing seems pretty consistent with that. The one big area where we do see a difference on college campuses is the method of suicide. Nationally, pretty much across ages, we see that firearms are the most common method for suicide, and actually, on college campuses, hanging or asphyxiation are the most common methods. It’s worth pointing out that suicides are less frequent on college campuses than in the general population of 18-to-25-year-olds, and one of the theories is that there are fewer firearms on campuses. Most campus prohibit them or have fairly restrictive policies around them. The other thing that is on the infographic that is consistent with what we have seen is the connection between relationship breakup being the most common precipitant of suicidal acts. That comes as a surprise since so many people associate academic stress with suicide, which, it turns out certainly for undergraduates, to be consistent with what we know, that family and relationship problems do seem to be higher-risk situations.

SALKO: Hannah, do you have any thoughts about the statistics you have seen?

ROSS: The two statistics that jumped out at me are the involvement of the behavioral intervention team and, to a lesser extent, the most common diagnoses. The fact that only 8% of the cases that UE looked at had a behavioral intervention team involved is consistent with what I have experienced in the decade or more that I have been doing this work. The fact that only about 25% of the cases are accounted for with the most common diagnoses of 18% and 17% suggests we have a significant percentage of students who don’t have a current diagnosis or it isn’t known to the school at the time that the events occur. All of that suggests to me the importance of making sure our policies apply uniformly across all of our students, because this shows us that it is not always the student who has been the most obvious to administrators or residential life staff who suddenly becomes an acute risk.
SALKO: That’s a good point. I guess we will move on. More and more students are coming to campus with mental health conditions and some of that increase is shown here in this national slide. Hannah, with regard to that, how are the Office for Civil Rights from the Department of Education as well as the Department of Justice and the courts viewing an institution’s responsibility toward these students?

ROSS: That’s a great question that I know a lot of people are focused on. I am going to start by saying I am a lawyer, but this discussion isn’t about avoiding lawsuits. What we are talking about today on this webinar is about keeping our students alive. That is not about trying to avoid legal risk. We have seen several recent cases getting national press coverage, the UCLA case, the MIT case, there are cases going forward at Penn and Harvard. I view these cases as a reminder, not a sea change in the way courts are looking at the relationship between institutions and their students, but just a reminder that our communities expect us to work hard to protect our students, and we know how hard institutions and their staff members work all the time every day to protect students. The MIT case really showed us that MIT did everything they could and they did everything that the Supreme Judicial Court of Massachusetts felt was appropriate and expected, and it shows us that there is a path here.

I think that there was a point in the early part of this decade, from 2010 to 2015, where many of us may have felt that the federal government was not speaking clearly to institutions of higher education about how to deal with students who were a threat to themselves but not to others. Over the course of this past decade, we have seen a series of OCR resolutions. We have seen several settlements of the Department of Justice with individual institutions, and that body of work shows a consistent understanding of the way to engage with students whose mental health makes the institution concerned. In January of 2018, the Office for Civil Rights articulated principles or best practices for handling these cases, and we included those principles in the resources, published by the American Council on Education recently in a written form. I want to emphasize three core values that those principles articulate, and we will talk more as we continue about unpacking what’s in the principles. The three core values I think will be familiar to many of us on campuses. The first principle is that students must be treated as individuals. That is the gold standard of ensuring that we are not discriminating against individuals. The second principle is to focus on individual assessment of health and safety risks. We are moving away from the language of direct threat, but individual assessment of health and safety risks is appropriate and necessary. The final core principle is prioritizing voluntary actions while understanding that involuntary separation can be an option, you can write it into your policies, and it is permissible. It has been done by multiple schools. We have seen those policies blessed in OCR resolutions and DOJ settlements. I think we will continue to see reinforcement from the courts on that issue. There are publicly available policies as examples for schools who would like to take a new look at their policies. The Rutgers safety intervention policy was included in the materials. That was published in connection with the resolution between Rutgers and the Office for Civil Rights in April of 2018. It is quite fresh. It is a very good, thoughtful policy. We also have the new Stanford leave policy that was published as part of their resolution of a lawsuit with disability rights advocates. Those are both great examples of publicly available policies that show you ways to balance the student’s interest in continued enrollment with the institution’s interest in making sure the student is well enough to safely and effectively participate in their education.
So, the core obligation that I think schools can communicate to their student body and the parents and loved ones that are worried about them is that we may have basic safety requirements for being enrolled. And this is consistent with 28 CFR §36.301. You will see it in the settlement agreements … that says that public accommodations can impose legitimate safety requirements that are necessary for safe operation. Being alive and safe in a dorm room on a college campus may appropriately be a requirement for your educational program.

I want to take another minute to talk about the OCR principles you can see. They announced nine principles — we put five here on this slide. We start again with that principle that we are looking at an individual, and we are assessing health and safety risks. That analysis should be thorough and kind of a 360-degree look. We should be considering the totality of the facts and circumstances for a particular student. In addition to engaging and cutting behavior, do they also abuse alcohol? If they also sometimes overdose on the recommended amount of a painkiller like Tylenol or Advil, are they doing all three of these things together? That may be a very different case from someone who is engaging in self harm without combining it with other risk factors. That second principle — the third line here on our slide — is prioritizing voluntary actions. We all know that we have a lot of talented staff members in student life, in our counseling centers, in all sorts of parts of a campus where a lot of their job depends on counseling and advising students. That day-to-day counseling and advising work is so essential to helping students live and learn and thrive on our campuses. That space is where a lot of the kinds of conversations about voluntary actions take place. And they already take place. Because we all have policies on all of our campuses that already allow students to take time away, to step back, maybe to do a short-term withdrawal if an unexpected health problem has come up. All of those voluntary separations or moments of pause, or ways to create space in the period of enrollment. All of those voluntary actions are strong tools to help students get a better understanding of what they are struggling with and whether it is impeding them in their education.

We can impose individual conditions to support a student’s success. That’s another one of OCR’s principles. again, to ensure that is not done in a discriminatory fashion, it needs to be tailored to the individual circumstance. Not all forms of self-harm are the same. Not all behaviors that look like a suicide attempt are the same. We need to have a nuanced, contextualized look at what is this student struggling with? What is the way their behavior puts them at risk? What are the things that might protect them or mitigate those risks? In that process, we will be thinking about, are there reasonable accommodations? Running behind all of these is the question of ensuring that you think about reasonable accommodations. All of that is guided by the overarching expectations from both of the federal agencies, OCR and DOJ, and the courts, that our relationship with our students has to be nondiscriminatory.

SALKO: Victor, do you have any thoughts on institutional expectations?

SCHWARTZ: I want to just sort of recast a couple of the comments or things that Hannah touched on in her comments. Maybe this should have been talked about before, but I think it’s useful for people to remember, just as a kind of level-setting exercise, that on the one hand, we know from the American College Health Association’s twice-a-year research that now something like 12% or 13% of university students will report serious thoughts of suicide in the prior year. About 2% will report a suicide attempt. At the same time, we should not lose sight of the fact that the actual rate of suicides — and I want to emphasize, every suicide is obviously a tragic event, but just to keep matters in perspective, because I think it impacts with policy and our judgment around these things — that the rate of suicides on campus is lower than one per 10,000 students per year. Which means that there are a thousand people with serious thoughts of suicide for each suicide death, and well over 100 to 200 attempts for each suicide death. We need to keep in perspective that there is a significant gap between people who have significant suicide risk — and those things obviously need to be taken very, very seriously and addressed clinically — but at the same time, the vast, vast majority of people at risk will not go on to die by suicide.
If you look at the next metric of data about how many legal actions or suits or claims come out of those things, it is yet again, a very small portion of incidents. The fact that Hannah could basically rattle off the well-known lawsuits, I think tells us something. They are actually quite infrequent. I think that emphasizes the fact that it is a mistake to make clinical decisions based on either fear of litigation or based on the legal policies and legislation and protocols that Hannah spoke about really fit an outer guardrail for decision-making, but it is important, as we say here, that your decision-making be driven by good clinical judgment in consultation with colleagues and associates and tripwire policies that any student with suicidal thoughts needs to be off-campus are unhelpful because they may discourage students from coming forward when they are in distress. And, it’s important for the policies and the universities to convey that things are being driven by an attempt to be helpful and supportive of student well-being and success, and there not be a sense that these things are being driven by either self-protective or punitive motivation.

SALKO: How can schools early on set both student and perhaps parent expectations, even before a student comes to campus or before there is a crisis situation — especially when we have a lot of parents who are very used to being involved with students at the high school level.

SCHWARTZ: It’s an important question, and I think we all need to do a better job educating families, educating young people and applicants even through the high school process of searching out colleges. You know, the high school counselors and clinicians who are working with high school kids in the community need to be communicating to them that, you know, thinking about the resources that are available on campus can make a really big difference to student success if a student is going to school with a history of — and this is true of health concerns as well — if there are serious or chronic health concerns, a history of serious or chronic mental health concerns, that you need to think about how things change, the fact that the school will no longer be able to communicate in the way they might with a high school-aged young person.

There need to be transition of care plans so parents of students applying need to educate themselves about what is available at the campuses they are looking at, and decisions about whether to go away to school or stay home may actually be relevant here to consider, for a student who really has a serious problem, has a good care system in place. There might be an argument for staying at a school closer by where those resources would be available. But you know, you still need to think about what are the options for the student in the community where they are looking at schools? What array of services are available through the counseling service, how well-versed is the disabilities office in working with students who may have mental health concerns? Luckily more and more of those pieces of information can be found ahead of time. And as people go on their school visits, you don’t have to identify yourself in asking questions about what sorts of support services are available on campus. That can be done really sort of quietly and anonymously.
Once a student has made a decision and accepted admission to an institution, they really should be thinking about what parts of their care will continue to be back with their original clinicians. What things should be moved to the locale of the school if they are going away? They need to understand what the counseling service can provide and what might need to be done in the community. So, it’s great and many schools actually welcome families and students reaching out before they come to campus to find out how they can be connected to the services that they may need. They can make thoughtful decisions then about insurance.

And also, as we mention here, the idea of advanced directives. Thinking about an emergency plan that includes what are the circumstances in which the school can reach out to the family or back home clinicians. These directives are available. JED did one with NAMI, which you can find on our Set to Go website. If you go to Set to Go and look at the resources, there’s a kind of template for doing this. Many schools have them on their own. Also, finding out from the school, who are the local providers? If a student has, for example, a severe eating disorder, you want to be thinking about whether there are clinicians either in the counseling service or in the community who are well-versed in specialty care that might be necessary.

SALKO: Hannah, do you have any thoughts on this?

ROSS: Yes. Picking up on one of the things that Victor said, having intentional work around helping set expectations is incredibly valuable in the long term. It can be hard to create space and time for it, but it’s worth doing. It is preventative. It avoids misapprehension, misunderstanding, a sense of having been surprised by something down the road. I think a lot of institutions are shifting to understanding that we cannot endlessly add counseling staff, and we can’t respond to the very high numbers of students on our campuses who want the kind of counseling support that we provide in our counseling center. We can’t just endlessly hire counselors. We have to start thinking of a shift of focus to teaching well being as part of adulthood. I think that’s in line with taking a step back, thinking about how well you communicate to students and their families as you welcome them to your campus community about all the parts of being a member of your college or university community. I think students and their families need to know what are the fundamental aspects of being a student in your educational program. American higher ed follows the model of letting 1,000 flowers bloom. It’s very different to be a student at Julliard than it is to be a student at MIT than it is to be a student in a vocational school. We embrace all of that variety, but it means that there is not a single model for what it means to be a successful college student, and we should state clearly what those core elements are. Is there, for example, a minimum course load below which you do not allow students to drop? Maybe that is informed by your liberal arts philosophy that students should be engaged in the simultaneous study of multiple subjects. Maybe that’s based on having equity across the student experience. You may have a requirement of residency for one or all four years. Thinking about what those elements are of your education and articulating those in a place that students and families are likely to come across as they are considering your institution, or enrolling and matriculating, can be really valuable. Those are often related to our academic standards, and they may belong as part of your academic policies or in your student handbook around standards for students.

Secondly, we need to be clear about what is our particular model of living and learning on our campus. Most colleges are a model of independent adult living with certain support systems that may be stronger than if a person were living alone in an apartment in New York City. But we are different from residential care facilities. Our student life staff are not health professionals. Our dorm rooms are not hospital rooms. In the cases where a student — and they are very rare, as Victor was saying—in my experience, looking at a population of about 5,000 undergraduate students, the number of students you are going to have this level of interaction with because they need a level of care that you can’t provide is very, very small. Less than five in a year, maybe even less than that. Maybe you don’t see it every year. But if a student needs a 24-hour program to supervise their eating, if they need a one-to-one suicide watch, colleges are not designed or set up to provide that level of care. We have to be helping our communities, both our students and their communities understand that it’s great to do it when they enrolled. It’s important to empower our staff to speak about that in ways that are consistent with the overall institutional messages we are giving.
Lastly, I think it’s important to educate families and their enrolling students about the way FERPA works. Many parents are surprised, as we were alluding to — they have been very engaged with their student’s education, they have had access to all information through the K-12 education system, and many parents are not anticipating, and never run across the information that would tell them, that the FERPA system, the FERPA legal framework makes a student the owner of their records the minute they enroll in a college program, whether or not they are a minor. That is an adjustment that students and parents need to be prepared for. The Department of Education has a transition document on their website to help people understand that legal framework and think about how to prepare for it. I think Victor has given great suggestions about how to prepare for it. One of the things I always want to remind folks about as we talk about FERPA is FERPA is a permissive statute that allows institutions in their judgment to make choices about when they need to share information. The vast majority of the exceptions for permitting disclosure without consent is at the institution’s discretion. You can choose to have broad discretion, you can choose to have narrow discretion, you can have context-sensitive discretion. But you are always permitted to share information with parents in a health and safety emergency. You are always permitted to share with the student’s consent. You are always permitted to choose to share — and this is an important aspect of discretion — if the student is a tax dependent, if they do not satisfy the IRS’ requirements to be financially independent of their parents regardless of the level of financial aid they receive, regardless of what their teenage years were like. If they do not satisfy that legal framework for financial independence, they are a tax dependent, and FERPA says you can choose to discretionarily choose to share information with them. Finally, keep in mind that information that may be observed by a student life staff when they meet with the student or see a student in a dining hall, a personal observation is not an education record. An education record is a written document — or a digital document, in our current world — but there’s a lot of information that we get that may not meet the standard of an education record, and we are free to share that kind of information as well.

SALKO: Thank you. We are going to pause to take one or two participant questions. Victor, the first one for you is, we hear a lot about a mental health emergency plan on campus. Can you talk a little bit about what that is and whether or not you have seen that in practice?

SCHWARTZ: A mental health emergency plan is typically part of a behavioral intervention team or activity. There needs to be a protocol for how when there is an emergency or serious problem, how did the various components of the campus meet up with each other? If an RA becomes aware of a problem, he or she needs to know who is the person they go to in the system and how that’s dealt with. The proliferation of behavioral intervention teams has made this a lot more available. There needs to be a communications plan. When does the campus health and safety office get involved? When does campus communication get involved? This should also involve — unfortunately it’s a reality — a postvention plan if there is a crisis or a death either by suicide or other circumstances. The campus should have protocols laid out so they are not trying to figure these things out on the fly in what are very often complicated and fraught circumstances.

SALKO: Hannah, do you have any thoughts on what might be a threshold risk factor or a threshold in practice for notifying a family with regards to FERPA issues?
ROSS: That varies a lot depending on the institution. That’s consistent with how we think about higher education in general and FERPA. An institution that has a process of issuing, say, course warnings when a student is at the midterm point in the course, not achieving a passing grade, an institution might choose, what is our level of concern when we get one course warning? Maybe we don’t want to notify at one course warning because maybe our history teaches us that a number of students experience one course warning and never have a final grade that puts them at risk of being separated for academic failure. You might say once they get to two or three course warnings then we really probably do want to have an escalated response so that if there is something deeper going on than, you know, a first-year student struggling to complete work that was all due at the same time or something like that, if it’s a deeper challenge, you have the opportunity to engage their family and get the support system that has traditionally supported the student engaged, and that may help them connect with supports of the school. Maybe they haven’t connected with those yet. I think it can certainly vary by institution, and you probably have some practices that if a student is on the verge of academic failure or if a student is suspended, you do notify parents as a matter of course. I think thinking about all the critical moments where you are concerned about a student and trying to make sure you have a balance, an equitable way of communicating with parents, makes sense. They don’t want to be called about a little thing and not a big thing, so you need to look at your spectrum of issues where you contact.

SCHWARTZ: If I could just make one more quick point about that, Heather, again, we are focused on FERPA and the outer guardrails and boundaries, and I think Hannah is correct to point out that FERPA is only one of the considerations. But administrators have plenty of latitude in making thoughtful decisions about what to do, but we shouldn’t lose sight of the fact that if there is too low threshold for contacting outsiders, for contacting family, it might again discourage students coming forward with concerns. That needs to be also woven into the considerations in deciding when to reach out to others.

SALKO: Excellent point, thank you. In the interest of time, we are going to move on. We are seeing a lot of good questions. We will try to get to them more toward the end.

I want to turn the discussion toward a team approach to managing students with serious mental health conditions, including suicidal ideation or suicide attempts, and how that approach can benefit students. We talked about the many expectations. It seems sometimes like a no-win situation if a student’s mental health condition or deterioration begins to interfere with that student’s studies or their social life on campus, disrupting their roommates, etc. How do you think the team approach — specifically good communication — can help manage these situations on campus?

SCHWARTZ: I will take a first stab at that. This is something — JED has a whole program that we work with college campuses called … the JED Campus Program. The basic framework of this program is to help campuses understand, like what Hannah said before, that you can’t hire your way of counselors into dealing with this in a comprehensive, well-thought-out way. We realize that given the age of college students and university students, many of them are not necessarily going to have the experience or the comfort reaching out for help from a counseling service when they are in need.

The whole campus needs to be thinking about what role they can play in this kind of a situation. Things like gatekeeper training programs with faculty advisors and with staff, training chaplains and coaches and people like that, the awareness that the staff and other students on campus are in a position often to recognize when someone is in distress. Also, the fact that not every kind of problem needs clinical intervention. It’s important to recognize that there are many things that can be done through student affairs, through academic advising, helping students with study skills and time management kinds of things. Things can be coordinated well outside of just the bounds of the counseling and the assumption that the health services ought to be actively engaged in this, too. So, really, we need to think about a system public health approach. The one added comment that it’s important to remember that the ability to share information differs across the campus. Within FERPA, there is a lot of latitude. Not every—behavioral observations are not even covered by FERPA. So, there’s lots of room in the student affairs universe for people to be talking about concerns about a student, but it’s important to remember that clinicians are actually more limited in what they can share because of state laws that govern their ability to talk about things. So, this stuff needs to be integrated and thought through, and I think we are going to talk about the details of that as we go along.
ROSS: I will jump in and echo that point. From a legal standpoint, there may be layers of confidentiality protections. Health care providers in your community likely have the most restrictive rules. Talk to those colleagues and talk to your counsel in advance to understand what they can share, when they can’t share, and what their thresholds are. As the slide says, individualized assessments are group work. You need multiple perspectives to assess where an individual is at a particular moment, what accommodations might allow them to stay enrolled and address their health challenges, what conditions will set them up for success. You want to be able to look at that totality of circumstances that I mentioned earlier. You want to think what are all the risk factors, maybe not just the ones that you understand as medical, but other things that have been observed in the residential life setting or student affairs world. There is a lot of knowledge about how our students are coping and dealing with things. What are the mitigating factors that may be protective of someone? The more information you have, the better your decision-making will be and the better your communications with the students and their families will be, and that’s an important part of finding successful outcomes here.

There are a lot of different folks who may have valuable perspectives. It depends on the student and the campus. Consistent participants should almost always be some clinicians, folks who have medical expertise. They may not be the person treating the individual. It might be that your director of your counseling center is a valuable partner and they can talk to you about what the bigger contextual picture looks like. They can help you assess risk when you get some medical records. You should always have student affairs folks in these conversations, people who know and work with the student. Sometimes you have campus security, who have had interactions or who have perspective. Sometimes you have an athletic coach or a chaplain. Sometimes you have a faculty member they are very close to. Legal counsel is here only to point out that this team is entitled to legal advice. These are not legal decisions, but the team is entitled to understand what are the relative pros and cons as we think about the choices we have before us and how might the student and their family think about this. You might need legal advice for that.

You should have a policy that articulates how you do your individualized assessment so that it is clear and transparent to students and their families as they look at your policies about how you think about issues of a student safely and effectively engaging in your academic program. You might articulate what behavior will trigger a review. You might be clear about when and how students would have opportunities to provide information. Fundamentally, the Office of Civil Rights has communicated that they expect us to provide fair process to our students. Fair process is a flexible standard. It means there are a variety of things that could meet that expectation. They won’t all necessarily look the same. The Rutgers safety intervention policy, for example, has a very prescriptive policy about how quickly decisions will be made and having face-to-face meetings at particular moments in the timeline. That is not required. The Office for Civil rights does not have a one-size-fits-all policy that says you have to always do it exactly like Rutgers. We have to provide a fair process, and fundamentally a fair process means the student has to understand the process they are in. They have to have the opportunity to contribute to it. And if it alters their status or their situation, they have to have the right to challenge that and question whether it is correct. So no dissent appeal for those of you who are lawyers on the call.

One thing people sometimes ask is, “Is it OK to have a consistent policy that we check in with students who have been hospitalized?” and the SUNY Purchase agreement with OCR, the Princeton agreement with OCR, other cases all demonstrate that’s fine. As I said at the outset, we need to have policies that apply to all of our students, so this can’t be based on a particular condition like a psychiatric hospitalization. It should be a check-in, a clearance to return to residency if the student is in residency, that’s simply based on an objective measure like were they hospitalized? It might be that your check-in for somebody who broke their leg and needs a cast and stayed overnight in a hospital to do that — that your check-in looks a little bit different than for that student than the student who was held for 72 hours involuntarily because they were at risk of suicide. Your policy should put them through a similar process, but what you actually say in the check-in meeting looks different.
The last thing I just want to say is I referenced medical records and I want to be clear that the Office for Civil Rights and the Department of Justice have affirmed processes where schools are asking for and receiving some medical records. You don’t need every medical record for all treatment a student has had. You need in general an overview or a summary of the treatment and progress they have been making. You may need some information about whether they comply with treatment. You don’t need session notes from psychotherapists. You don’t need to know the ins and outs of what somebody is telling their counselor. I will stop there and let others chime in.

SALKO: Victor, I just wanted to know that you mentioned earlier that clinicians on campus are limited about what they can say and disclose. Hannah touched on this a little bit. How do you think they can meaningfully participate in a group discussion about a particular student? Can you share your thoughts on that quickly?

SCHWARTZ: Just a couple of quick comments. It’s important to remember that confidentiality is a one-way street, and this applies across the board. Even people who are bound by FERPA, but the clinicians who are bound by both FERPA often and also local and state law about handling of therapy and medical information, they can listen to anything about anyone. They are able to hear even though they may not be able to share information about a student being in treatment or not. The other thing is, the important role they can play is as a kind of consultant and advisor to the team. So, without necessarily disclosing whether or not a particular student is receiving care at the counseling service, they can still make comments, provide advice, provide direction about interventions on campus or the level of urgency or acuity that a situation might imply that can be extremely helpful to the team. It would be a serious mistake not to use the hopeful expertise of counseling center leadership to help inform decisions that are about made about how to handle students who might have mental health, behavioral problems or substance abuse problems on campus.

SALKO: I just want to turn now to involuntary leave policies. Sometimes, despite everyone’s best intentions and attempts to intervene, sometimes things are — it’s just not right for the student to be on campus for their health, not for the institution, but for the student’s own health. If a student doesn’t want to voluntarily leave, Hannah, what can institutions do when they’re in a position where they can’t provide perhaps the level of care or support that a student needs?

ROSS: It’s a question that institutions struggle with because as we have said a couple of times, it is quite rare. It is important to have a written policy, and that helps ensure consistency and equity in how you treat individual cases. That policy is one of the ways that we give notice to students and their families about how the process works. The focus in the policy should be on a student’s behavior, not on a diagnosis or a label. The test is whether the student can safely and effectively engage in your academic program. So, we have talked about the importance of letting the student know and having those advising and counseling conversations. That’s where we’re talking about the voluntary moments where they can say, “You know what? I need to focus on my health for a little while.” We have talked about individualized assessment.

One of the things I often recommend as a practical tip is it can be really helpful to have a phone conversation between your clinician — whoever it is that’s giving you advice as the team assessing this — and the student’s preferred provider. Those phone conversations are sometimes more frank. That’s premised on the assumption that there may be moments in this process where you require the student to allow you to talk to their preferred provider. I am not suggesting anyone engage in a practice of having a blanket waiver, but there are moments and times where it’s important to have that comprehensive look at how a student is doing, where you need to be able to talk to a student’s their home provider or preferred provider in the community and you need to be able to share information with deans or student life or staff.

The question at these moments when you are facing a student who may not be able to safely and effectively participate in the program, the question for clinicians, in my mind, is what is the level of treatment that you clinically recommend to meaningfully reduce the student’s risk? This is not about what insurance will cover. This is not about where there will might a bed. The kinds of answers you should hear from a clinician sound like this: “I recommend inpatient hospitalization” or “I recommend partial hospitalization” or “I recommend intensive outpatient treatment.” Those are the levels of care. If they say,
“The level of care I recommend is weekly psychotherapy,” we are probably not talking about an involuntary leave. Because as many of us know, we have lots of students engaged in psychotherapy. That doesn’t mean they need to leave. The level of care will help you understand how acute is this issue and what kind of supports does this student need? If the student needs partial hospitalization and you have a full-time enrollment model or a minimum course load of three, whatever it may be, that level of treatment may be incompatible with your full-time enrollment.

It’s important to be prepared for that moment, as rare as it may be, where the strongest message we can give to a student that we need them to protect their health is that we care more about their life than their uninterrupted enrollment. That is not a decision that we make without input from the student, without hearing from the student’s preferred provider, we take all of that into consideration in that group work of looking at it holistically.

We also have to be open to the fact that we got it wrong and we have to provide an avenue for an appeal. The last thing that you need to think about in an involuntary leave policy is if you feel like it is appropriate to impose a condition on their return, whatever you call that, reinstatement or readmission, that condition should be written and it should be provided to them at the time of departure, not decided on later in the timeline. Those should be conditions for success. That is not a barrier we are trying to create. It is a condition aimed at ensuring that the student will be able to come back and learn and thrive.

SALKO: Victor, do you have any thoughts you would like to share?

SCHWARTZ: I think it’s important to realize there are several reasons a student might need to take a leave and why a university might need to impose involuntary leave. In terms of taking a leave, one is the inability to function academically. You know, obviously that would imply either anxiety or depression or psychotic illness where the students simply can’t do their work. The other circumstance is where it really is unsafe. The person’s judgment is so impaired. The person is potentially harmful to self and others in a way that can’t be managed on campus. That second category is where you may wind up getting into an involuntary leave situation.

We need to also be thoughtful. Sometimes, what feels like you may be heading toward an involuntary leave, if we are good enough at exploring a student’s hesitancy and sometimes families’ hesitancy as well, if they don’t understand the conditions for return, what the process looks like, what the ramifications are in terms of taking time off — for international students, for example, they may need to leave the country and return to a home country. For other students as well, there actually may be less access to care near their home than there is at the university. So, we really need to consider what the hesitancies might be about taking some time off, and really thinking through whether there is some wiggle space to negotiate a voluntary leave. For some students who might not be functioning but might not be at risk, so students who might be failing, sometimes the right decision is to let them continue in school, keeping open the option of taking a leave. If they’re not psychotic or their judgment isn’t substantially impaired, if they choose to stay in school and fail, at some point, that’s on them if there’s no immediate and direct risk to their well-being.
It's also, again, really important to have student-friendly policies, for the policies to be as flexible and individualized as possible. And to really where you can have parallel thinking around how you would handle a serious medical problem and really limit the involuntarily leaves to the necessary — when there is risk to life or limb.

SALKO: I appreciate that. We are running up against time. Hannah, I just want to ask you and Victor very quickly, what are your thoughts on returning to school and imposing conditions?

ROSS: Whether a student can safely and effectively engage in the education is the same whether you are having a conversation about they they might need to leave as when you want to help them return. You want to be looking at, have they gained better coping mechanisms. It is not a question of is somebody cured. It’s a question of are they learning and developing strategies to manage it so that it won’t impede their education?

SCHWARTZ: It’s perfectly permissible and valuable not to just say OK, you are better now, come back to school. There really ought to be a communication of what is the ongoing plan of support and care so that we maximize the opportunity and the likelihood that you are going to continue to succeed. We don’t want to make this feel like a series of hoops that a student needs to jump through. But it really should be part of a coherent, thought-through process. There are times you are struggling. People with chronic illness may need to be out of school to get treatment for some periods of time and then will be back in school when the illness is controlled sufficiently and they really can perform and benefit from the experience of being back in school in a way that is safe and progressive.

SALKO: I do want to just spend one or two minutes getting to some of the very good questions we have. I am getting a number of questions about students with mental health challenges studying abroad. Do you have any advice on how to support students when they are away?

ROSS: I have encountered that question multiple times. I think we need to make sure that we are talking within the institution. If there is a student who’s on the radar screen for some of our student affairs staff that they are very high risk, I think we need to be communicating across units to make sure that we understand if they are planning to study abroad the following semester or be in a remote location over the summer on a funded program that we are participating in. I think we need to be attentive to understanding that.

And having the kind of transition and preparation conversations that we’ve referred to several times throughout the webinar, to make sure the student is engaged in thinking about what support they need and how they will access that. It can be very difficult when a student develops a challenge overseas to find adequate supports for them based on where they are. We are at a significant disadvantage in trying to support them remotely from our campus. We cannot see them. We cannot necessarily observe how well they are doing. And we can’t get them into a medical office where we can test their blood levels or something. It is important to think about it in advance. There are tools online that are making remote treatment a little easier, resources for students managing depression and anxiety that they will be able to access 24/7 as schools are increasingly adopting those.

SCHWARTZ: The comments I made before about making the transition from high school to college pretty much apply here as well. You need to be really diligent think about where are you going? and will you be able to get access to the care that you need? , and that includes whether it is therapy. In some places you may not be able to easily access medications because not every country has the same medication availability. If it is a serious or significant problem, you really need to be deliberate and convey to the student that we are not trying to close down opportunities for you, but why would you want to put yourself in a setting or situation where you won’t succeed or might make yourself unsafe?

SALKO: I would like to see if we can sneak in one other question because I thought it was really good. It’s about returning to campus. What if you have placed a condition of treatment or progress on them, and it is clear they have not met it or are not taking their advisor’s advice? What do you recommend in that situation?
SCHWARTZ: This is one of these questions, the kind of balancing act I alluded to before. It depends on whether the lack of follow-up may be potentially putting health and safety at risk. If you think the student is really at high risk for self-harm or for psychotic illness, you may want to follow up and say, if you cannot agree to the agreements stipulated, you may need to leave school again. You should try to find as much wiggle space and use the latitude and leverage to get the student into the care that hopefully is in their best interest.

The other thing to suggest to the student is what I suggested before. Why would you want to put yourself in the situation where you may again be either failing out or having a recurrence of your illness? And if there are explanations — if you don’t have the financial resources, if you can’t find someone to work with, we can help you do that, but you need to make sure that you’re safe. It would be the same as if you had a student with serious diabetes who was not taking care of their health care and was in a coma once a week. You would probably have real concerns about letting that student remain on campus.

SALKO: Thank you. Hannah, do you have any last thoughts on that last question? Otherwise, we will wrap this up.

ROSS: I echo Victor’s point, and I will end on a happy story. I have seen cases, one case that stands out for me, where the recommendation the student engage in a regular form of therapy. He went away to a place where it was not easy to get the kind of Western psychotherapy that was recommended, but upon his return, he described a very robust mindfulness meditation practice that he had engaged with. And when he was assessed by the institution’s clinicians, their conclusion was he had gained better tools to manage his depression and anxiety, and that the mindfulness meditation was an effective intervention. I hope all of us as institutions are thrilled to be able to say, “Great. I’m glad it worked for you. Let’s make sure we connect you to the supports that will help you thrive as you return.”

SALKO: Thank you everyone. I appreciate everyone sticking with us. We ran over a bit. I’m sorry we could not get to all of your questions. One question is, “Will the slide deck be available?” Yes, we will post that when we post the recording of the webinar to www.edurisksolutions.org, our risk management website here at UE. That should be done within the next five to seven days. You can find the slides there. In the meantime, if you have questions, email risk@ue.org. We will be happy to answer those or get you connected to UE resources. With that, I would like to thank you both, Victor and Hannah, for joining us today and sharing your amazing expertise. We really appreciate it. Thank you. And with that, the webinar is concluded and you may now disconnect.