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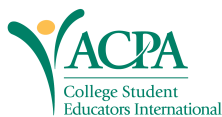# FRAMEWORK

Framework for Developing Institutional Protocols for the Acutely Distressed or Suicidal College Student

American College Health Association

ACPA
College Student Educators International

AUCCCD
Association for University and College Counseling Center Directors

NASPA
Student Affairs Administrators in Higher Education

The Framework for Developing Institutional Protocols for the Acutely Distressed or Suicidal College Student (Framework) is a product of The Jed Foundation but reflects the contributions of an expert group brought together for the purpose of creating this document. The roundtable participants are listed with their institutional affiliations (see page 1), but the ideas offered here are solely those of the individuals themselves.

This document is a tool to aid your institution in developing or revising protocols suitable to its unique environment. It does not seek to identify any particular path as the right one for all institutions or purport to offer professional guidance. For psychological and medical advice, consult with trained professionals in those fields, preferably people who know your institution well. For legal advice, consult your institution's counsel, and for insurance advice, consult your institution's risk manager and insurance broker.

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The *Framework* is available online at **www.jedfoundation.org/framework.php**

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NASPA: National Association of Student Personnel Administrators

EXECUTIVE SUMMARY

As a member of the higher education community, you have probably worked with students in extreme emotional distress; most likely, you also know a student who has attempted or died by suicide. Unfortunately, no college or university is immune to these events. It is estimated that 1,100 college students die by suicide every year - an average of three per day (National Mental Health Association/The Jed Foundation, 2002).

In response to the lack of consensus among colleges and universities about what constitutes a comprehensive, campus-wide approach to managing the acutely distressed or suicidal student, The Jed Foundation held a roundtable discussion on November 18, 2005 that included senior college administrators, college counselors and other mental health practitioners, and attorneys specializing in college issues (see page 1).

> The product of the roundtable, *Framework for Developing Institutional Protocols for the Acutely Distressed or Suicidal College Student (Framework),* provides your college or university community, regardless of its size, culture, and resources, with a list of issues to consider when drafting or revising protocols relating to the management of the student in acute distress or at risk for suicide.

The following outline lists the key topic areas of the *Framework*.

I. DEVELOPING A SAFETY PROTOCOL

A. Responding to the acutely distressed or suicidal student:
- Preparing an administrator (e.g., dean of students) or concerned other (e.g., roommate) to identify the student who may be at risk for suicide
- Making decisions once the potentially at-risk student has been identified, including when the student who needs help refuses it
- Developing Memoranda of Understanding (MOU) or other type of agreement with local police or other emergency personnel who may be involved in a mental health crisis

B. Addressing issues around voluntary or involuntary psychiatric hospitalization:
- Determining whether hospitalization is in the best interests of the student
- Developing an MOU or other type of agreement with each hospital that may receive a student for assessment or hospitalization
- Exploring non-hospitalization options for the student who may require close supervision
- Addressing key issues for the student returning to school after hospitalization

EXECUTIVE SUMMARY

- C. Developing a post-crisis follow-up plan:
    - Developing a plan that reflects the best interests of the student and the community
    - Determining the threshold for intervention if the student shows signs of distress again
    - Following-up with those who were involved with/affected by the distressed or suicidal student (e.g., friends)

- D. Documenting encounters with the acutely distressed or suicidal student:
    - Determining what should be documented in an incident report
    - Ensuring that the appropriate information is consistently documented

- E. Addressing other pertinent issues:
    - Determining whether the student, who was recently in acute distress or at risk for suicide, is able to participate in a study-abroad program, an off-campus practicum, or other program away from his/her home institution
    - Identifying and addressing considerations relating to the international, graduate, professional, distance-learning, or incoming study abroad student

II. DEVELOPING AN EMERGENCY CONTACT NOTIFICATION PROTOCOL

- Preparing for the need to notify an emergency contact
- Determining whether to involuntarily notify an emergency contact
- Engaging the emergency contact who may be in denial about the seriousness of the student's mental health issues

III. DEVELOPING A LEAVE OF ABSENCE AND RE-ENTRY PROTOCOL

- Determining whether involuntary leave is in the best interests of the student by balancing his/her desire to stay in school with what services and support your college is able to provide
- Structuring a re-entry process for the student returning from leave
- Communicating with the student, emergency contact, and other campus personnel about a leave of absence

COLLEGE STUDENT SUICIDE

As a member of the higher education community, you have probably worked with students in extreme emotional distress; most likely, you also know a student who has attempted or died by suicide. Unfortunately, no college or university is immune to these events. It is estimated that 1,100 college students die by suicide every year — an average of three per day — (National Mental Health Association/The Jed Foundation, 2002) and many times that number (1.5% of the college population) report having made at least one suicide attempt (American College Health Association, 2005).

Approximately ninety percent of those who die by suicide at any age have a diagnosable mental illness, most often depression (Goldsmith, Pellmar, Kleinman, & Bunney, 2002), making the identification and treatment of students with emotional disorders critical to suicide prevention efforts. Most college counseling center directors report that the number of students seeking help for serious emotional problems has been increasing along with the demand for crisis services (Gallagher, 2005). However, the majority of students who die by suicide have never been to their counseling centers (Gallagher, 2005).

Untreated mental health disorders can impact all areas of a student's life, including academics, interpersonal relationships, and participation in campus activities. Data from the National Comorbidity Survey suggests that college students with depression are nearly three times less likely to graduate than other students (Kessler, Foster, Saunders, & Stang, 1995). And, in addition to affecting the individual, a student's emotional distress can create problems for others in the campus community.

> Establishing a strong mental health safety net for students should be a priority for every college and university.

At its core, suicide is an escape from psychic pain or distress by a person who cannot — at that specific moment in time — find another way to cope. Although suicide is clearly a clinical issue, it is also a public health (or environmental) issue. This necessitates a shift in focus from prevention and treatment at the individual level to prevention and treatment at the community level. Therefore, suicide prevention should no longer be solely the concern of mental health professionals but also that of the entire college community.

A comprehensive effort to confront the problem of suicide among college students should include three parts — prevention, intervention, and postvention — as represented in the figure on the following page. Planning around one component impacts the planning (and ultimately the effectiveness) of the other two areas. For example, programming that targets the friends of a student who has died by suicide could both

identify someone at heightened risk for suicide (intervention) and encourage help-seeking in others prior to an emotional crisis (prevention). While this document, *Framework for Developing Institutional Protocols for the Acutely Distressed or Suicidal College Student (Framework)*, was conceived primarily as a tool to aid in the development of protocols around intervention, it also plays a broader role in addressing students at risk.

PREVENTION

INTERVENTION   POSTVENTION
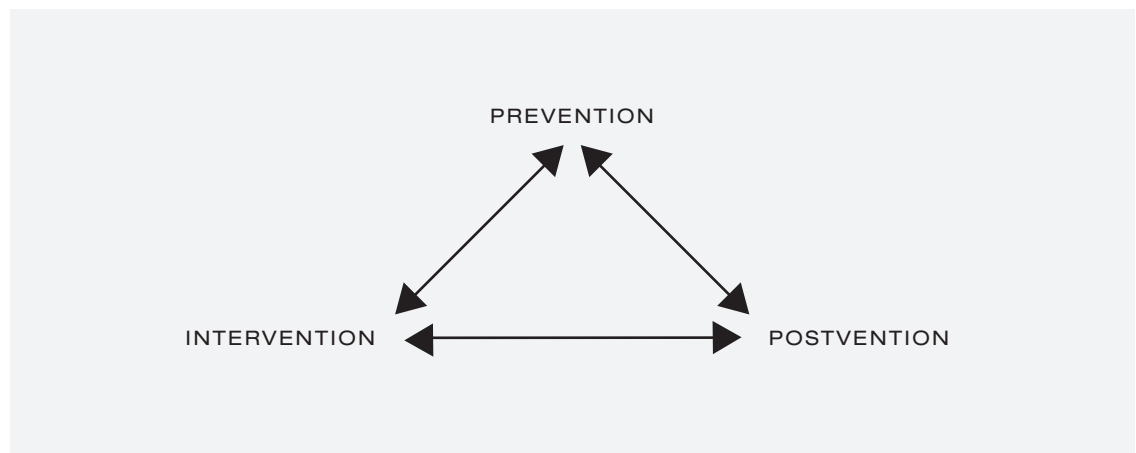
- Suicide *prevention* efforts could include: creating a mental health task force to develop and implement a campus-wide suicide prevention and mental health promotion plan; raising awareness among students, parents, faculty, and staff about the signs and symptoms of mental illness and the risk factors for suicide; restricting access to lethal means of self-harm (e.g., firearms); offering programs aimed at strengthening life skills; and matching the mental health resources on campus to the demand for services.

- Possible *intervention* efforts could include: establishing a case management committee to monitor students of concern; developing formalized crisis management protocols, including those for emergency contact notification and medical leave re-entry; and providing accessible and effective mental health services.

- *Postvention* could include: promoting responsible reporting by the media (e.g., American Foundation for Suicide Prevention's *Reporting on Suicide: Recommendations for the Media*); and providing outreach programs and mental health resources to those students, faculty, staff, and others affected by a suicide or suicide attempt (e.g., community support meetings).

DEVELOPING THE FRAMEWORK

In response to the lack of consensus among colleges and universities about what constitutes a comprehensive, campus-wide approach to managing the acutely distressed or suicidal student, The Jed Foundation held a roundtable discussion* on November 18, 2005 that included senior college administrators, college counselors and other mental health practitioners, and attorneys specializing in college issues (see page 1).

> The product of the roundtable, *Framework for Developing Institutional Protocols for the Acutely Distressed or Suicidal College Student (Framework),* provides your college or university community, regardless of its size, culture, and resources, with a list of issues to consider when drafting or revising protocols relating to the management of the student in acute distress or at risk for suicide.

In addition, some areas of the *Framework* will provide guidance about how to specifically approach certain key topics. The document is divided into the following three sections, each of which is structured as a series of questions.

    I. **Developing a safety protocol**
    II. **Developing an emergency contact notification protocol**
    III. **Developing a leave of absence and re-entry protocol**

By developing protocols in a methodical manner prior to crisis situations, you minimize the need for *ad hoc* decision-making during a crisis. Ideally, your college's protocols should be broad enough to cover many potential situations while allowing for case-by-case flexibility; they should also be sufficiently well-defined to remain meaningful and emphasize how decisions are made and by whom.

The goals of the *Framework* are to:

- Motivate colleges and universities to develop, implement, and use comprehensive crisis management protocols for students who are in distress or at risk for suicide.
- Promote collaborative decision-making around mental health issues focusing on the best interests of students.
- Promote cultural change toward strengthening the campus-wide mental health safety net for all college students.
- Promote the establishment of a collection of exemplary protocols around addressing student mental health crises.
- Encourage discussion among schools regarding the protocol development process and protocol content.

SUGGESTIONS FOR PROTOCOL DEVELOPMENT

This section provides guidance as to what overarching steps to take around protocol development before, during, and after using the *Framework*.

- Allocate sufficient resources and funds to allow for the development, implementation, use, and ongoing evaluation or review of your protocols. This may require reprioritizing existing resources.

- Consider the ethnic, racial, cultural, and spiritual diversity of your student body and create protocols that reflect and support these differences.

- Refer back to the mission/vision statement of your institution to identify its stated or implied role in managing student mental health. This will allow you to develop protocols which are grounded in your institution's unique philosophy.

- Select the process by which protocol development will take place at your college (e.g., mental health task force). This process should involve broad-based participation of key campus constituencies (see list below).

- Identify the relevant stakeholders and define their expected roles in protocol development, implementation, use, and review. Stakeholders may include: president, provost, vice presidents, deans, academic affairs, athletics, residence life, career services, counseling services, health services, student affairs, disability services, judicial affairs, legal counsel, international student services, graduate student services, campus security/police, dining services, custodial services, facilities management, alcohol and other drug (AOD) office, Greek life, student government and other student organizations, and campus ministries. It is important to acknowledge the potential for stakeholders to have conflicting roles.

- Establish an ongoing dialogue with local community entities who could potentially be involved in caring for a student at risk (e.g., local police, emergency care providers, community mental health providers) and consider consulting with them when appropriate during the protocol development process.

- Select and define the terminology you will use in your protocols (e.g., suicidal threat, suicide attempt). *[See O'Carroll et al, 1996, and U.S. Public Health Service, 2001.]*

- Develop a plan for reviewing the protocols after they have been implemented, including how often they will be reviewed and by whom.

- Define the circumstances under which each of your protocols could be set in motion. To this end, it may be helpful to create a "job description" for what it means to be a student at your institution that includes expectations for self-care.

- Be transparent with students and parents about the content of the protocols and the circumstances under which they could be invoked. It is suggested that these protocols be introduced within an established system for communicating with families (e.g., orientation, handbooks, and Web sites).

- Identify a "point person(s)" for individuals both inside and outside of the college community to contact with questions about the protocols, including those relating to legal issues.

- Consider using your protocols to create (or augment) a procedural "Crisis Checklist" that provides those involved in student crises with a way to ensure that appropriate actions are taken. It may also be helpful to list separately the expectations of each entity during a crisis situation (e.g., on-call counselor, counseling center director, campus security).

- Engage in regular table-top exercises to "practice" your crisis protocols. Please see Appendix A for some potential scenarios.

Notes: In order to familiarize yourself with the scope of this document, it is suggested that you read the entire Framework before you begin developing your protocols. The answers to many of the questions in this document should become part of your protocols, while others may serve a broader role in stimulating discussion. Both types of questions are crucial to the protocol development process.

Although the majority of the document refers to developing "protocols," the Framework was designed to assist in the development of any documents (e.g., policies, procedures, processes.) that address the issues listed. Similarly, this document applies equally to colleges, universities, and other institutions of higher education even though "college(s)" is used as the generic term.

Appendix B contains questions relating to legal issues that will affect how you answer some of the questions in this document. It is suggested that you consult legal counsel to ensure that the protocols you are developing comply with applicable laws.

Client–clinician confidentiality poses an important consideration in addressing some of the questions. You may find it helpful to consult legal counsel regarding how client–clinician confidentiality limits a clinician's communication about potentially at–risk students with members of the college administration. This issue should also be addressed during orientation for new clinicians as well as for other appropriate new faculty or staff.

MAXIMIZING THE EFFECTIVENESS OF YOUR PROTOCOLS

In addition to developing crisis protocols, it is important for your college to address some of the broader issues relating to college student mental health and suicide prevention. Efforts in these areas, such as those listed below, can provide a solid foundation for your crisis management protocols.

- Ensure that protocol development takes place as part of a campus-wide suicide prevention and mental health promotion strategic planning process. For further guidance, please see The Jed Foundation/Education Development Center's *Prescription for Prevention: Model for Comprehensive Mental Health Promotion and Suicide Prevention for Colleges & Universities* (Appendix C), a model that can help you to assess your college's array of mental health promotion and suicide prevention efforts and to identify gaps and areas for improvement.

- Create an environment on your campus that encourages help-seeking for emotional issues.

- Determine whether the process used to address disruptive student behaviors includes the identification and treatment of underlying emotional disorders.

- Ensure that campus-wide protocols are consistent with intra-school protocols (e.g., alcohol/drug, residence life, counseling center, academic affairs, graduate/professional school), which, in turn, should be consistent with each other.

- Consider establishing a case management committee or team to monitor students of concern.

- Establish a comprehensive, transparent postvention protocol that includes identifying and offering services to those affected by the crisis.

- Advocate for adequate mental health services to be covered under both the mandatory student health fee and supplemental student health insurance. To this end, it may be helpful to consult members of the counseling and health centers on all decisions relating to mental health coverage.

I. DEVELOPING A SAFETY PROTOCOL

A. RESPONDING TO THE ACUTELY DISTRESSED OR SUICIDAL STUDENT:

1. **How does your college prepare an administrator (e.g., dean of students or vice president for student affairs) to identify the student who may be at risk for suicide?**

   a) What education does the college provide an administrator about how to identify the student who may be at risk for suicide (e.g., warning signs for suicidal risk)?

   b) What education does the college provide an administrator about how to help the student who may be at risk for suicide?
      1) If the student needs a mental health assessment, how does an administrator decide whether someone should accompany the student to the clinician's office (i.e., should the student ever be left alone)?
      2) If the student needs a mental health assessment, how does an administrator decide what information about the student to provide to the clinician?
      3) What education is provided about what actions to take when a student has attempted suicide (i.e., the situation is a real or potential medical emergency)?
         (a) What emergency response training, such as CPR, is provided to college personnel with frequent student contact?

2. **How does your college prepare a concerned other (e.g., a roommate, peer, or professor rather than an administrator or mental health professional) to identify the student who may be at risk for suicide?**

   a) What education does the college provide a concerned other about how to identify the student who may be at risk for suicide (e.g., warning signs for suicidal risk)?

   b) What education does the college provide a concerned other about how to help the student who may be at risk for suicide?
      1) Do different concerned others have different responsibilities in terms of responding to the distressed student?
      2) What are the appropriate actions to take if the concerned other learns directly or indirectly that the student is in acute distress?
         (a) Who, specifically, should the concerned other contact initially about the student (e.g., counseling center, student affairs, campus safety)? *[Because of the bounds of confidentiality between a mental health professional and a student client, it may be useful to suggest to a concerned other that s/he notifies both the counseling center and a campus administrator to facilitate their ability to communicate with each other.]*

> (b) If the student is physically present with the concerned other, what should happen to the student during and after a report is made (i.e., should the student ever be left alone)?
>
> (c) What education is provided about what actions to take when a student has attempted suicide (i.e., the situation is a real or potential medical emergency)?
>
> > (1) What emergency response training, such as CPR, is provided to college personnel with frequent student contact?

c) How and by whom is the student approached or assessed after a report has been made (e.g., "welfare-check," phone call)?

d) What kind of follow-up communication takes place with the concerned other after s/he makes a report?

3. What is the process by which the student's risk for suicide is assessed by a mental health professional?

a) Who is responsible for the initial assessment (e.g., any counselor, counseling center director)?

b) Is there a standardized method or form used in the assessment?
[For validated risk assessment instruments, see Brown, 2002, and Goldston, 2000.]

c) If a phone triage system exists, what qualifications and training do the triage staff have?

d) Have Memoranda of Understanding (MOU) or another type of agreement (e.g., affiliation agreement, business agreement) been developed with each hospital or community mental health practitioner who may be asked to carry out a risk assessment or intervention?

4. What is the decision-making process at your school when the potentially at-risk student has been identified?

a) What are the roles of pertinent campus officials (e.g., deans, vice presidents for student affairs, residence life staff, campus safety/police, on-call counselors, other health services staff), and who is the lead (with ultimate responsibility and accountability for the response)?

b) How do you determine whether additional sources of information (e.g., roommates) should be contacted when investigating a report of acute student distress, and who is responsible for reaching out to additional contacts when necessary?

c) How do you decide when the student should be asked to sign a Release of Information (ROI)?
[State law typically dictates the length of time that an ROI can be valid.]

> 1) How do you determine the type of ROI (e.g., institutional, medical) and the specific communications it should cover? (e.g., counselor to administrator, administrator to concerned other, administrator to parent)?

d) If a Commitment to Treatment or Safety Plan is developed with the student, how do you determine its content?

e) If the student has an off-campus mental health practitioner, how do you determine whether to bring him/her into the crisis response process, and what is the role of the college's counseling/health services?

f) What overall system is in place to respond to the student outside of standard business hours?

   1) How is the response affected by incident timing (e.g., weekday, weekend, evening, just prior to a vacation, during vacation)?

5. **Have MOU or another type of agreement (e.g., affiliation agreement, business agreement) been developed with local police or other emergency personnel (e.g., emergency medical services) who may be involved in a mental health crisis?**

   [It is suggested that some type of agreement be in place prior to a crisis situation.]

6. **How do you determine what to do when the student who needs help refuses it?**

   a) How does this change if the student is not deemed to be at heightened risk for suicide (acknowledging that the student may be minimizing his/her symptoms)?

   b) How do you balance the rights of the student with concerns for his/her safety?

B. **ADDRESSING ISSUES AROUND VOLUNTARY OR INVOLUNTARY PSYCHIATRIC HOSPITALIZATION:**

   1. **What is the decision-making process for determining whether hospitalization is in the best interests of the student?**

   2. **Have MOU or other type of agreement (e.g., affiliation agreement, business agreement) been developed with each hospital that may receive a student for either assessment or hospitalization?**

   3. **What options besides hospitalization have been explored for the student who may require close supervision?**

   a) What options exist if, for example, there is no nearby hospital with a psychiatric ward (e.g., intensive outpatient treatment)?

   b) What provisions can be made for supervision of the at-risk student if the hospital decides not to admit the student or the student refuses voluntary admission but does not meet criteria for involuntary hospitalization (e.g., having parents stay with the student)?

   c) Is the feasibility of these provisions affected by whether the student lives in a college residence versus off-campus housing?

4. **Is psychiatric hospitalization covered by the student health insurance offered by your college?**

   a) If not, or for those institutions that do not offer student health insurance, are there sources of financial assistance available to the student?
   b) What alternatives exist for the uninsured or underinsured student if no other financial assistance is available?
   c) For the student who remains on his/her parents' health insurance, does the student health insurance waiver contain a portability requirement that psychiatric hospitalization be covered?

5. **What are the mechanics of the hospitalization process at your college?**

   a) What is the process for initiating voluntary and involuntary hospitalization?
   b) How can the student be transported to (and from) the hospital (e.g., campus safety/police, emergency personnel)?
   c) Does someone from your college accompany the student to the hospital?
   d) How does your college establish and maintain communication with the hospital?
      1) Who from the college initially communicates with hospital staff?
      2) Who from the college regularly communicates with hospital staff?
      3) Does the hospital ask the student to sign an ROI to authorize the treating practitioner to speak with the counseling center or other college personnel?
   e) Are there additional considerations if the student is first admitted to a medical ward in the event of a suicide attempt?
   f) How do you notify appropriate campus personnel (e.g., professors, coaches) that the student will not be fulfilling his/her commitments?

6. **What issues must be addressed before the student can return to school after discharge from the hospital (e.g., plan for follow-up care, administrative meetings, discussions with roommates)?**
   [It is recommended that discharge planning begin at the time of admission.]

   a) How do you decide whether it is in the best interests of the student and the community for s/he to remain enrolled, attend classes, and/or return to the residence hall?
      1) What is the process by which the student can appeal the decision?
   b) Does the college provide specific forms for the treating practitioner to fill out and return to college personnel (e.g., counselors, student affairs personnel, residence life) upon discharge ?
   c) Are the issues different if s/he lives in a college residence versus off-campus or if s/he is an undergraduate versus a graduate student?

C. DEVELOPING A POST-CRISIS FOLLOW-UP PLAN:

[This section is applicable to all students who are post-crisis, not just those who have been hospitalized.]

1. How do you develop a follow-up plan with the student?

a) Which college personnel are involved in developing the student's follow-up plan (e.g., counselors, deans, medical staff, RAs), and who is the lead decision-maker?

b) How do you decide whether it is in the best interests of the student and the community for s/he to remain enrolled and/or living in campus housing?
1) What is the process by which the student can appeal the decision?

c) Are the issues different if s/he lives in a college residence versus off-campus or if s/he is an undergraduate versus a graduate student?

d) Through what process (e.g., case management committee) do all parties involved in a student's follow-up plan (e.g., deans, counselors) communicate with each other about how the student is doing?

e) What consequences could the student face for not complying with the follow-up plan (e.g., can the student then be asked or mandated to take a medical leave)?
1) What is the process by which the student can appeal the decision?

f) Are there special considerations regarding the follow-up plan if the crisis or hospital discharge occurred prior to a weekend or vacation period?

2. How do you determine the threshold for intervention if the student shows signs of distress again?

3. How do you follow-up with those who were involved with/affected by the distressed or suicidal student (e.g., friends, roommates, faculty, RAs)?

a) How do you identify them?

b) Who communicates with them?

c) What, specifically, is offered to them?

4. Is outpatient mental health treatment covered by the student health insurance offered by your college?

a) If not, or for those institutions that do not offer student health insurance, are there sources of financial assistance available to the student?

b) What alternatives exist for the uninsured or underinsured student if no other financial assistance is available?

c) For the student who remains on his/her parents' health insurance, does the student health insurance waiver contain a portability requirement that outpatient mental health treatment be covered?

D. DOCUMENTING ENCOUNTERS WITH THE ACUTELY DISTRESSED OR SUICIDAL STUDENT:

1. **What specifically about the encounters should be documented in an incident report?**

   a) How are the expectations for documentation communicated to the appropriate people?

2. **If multiple people write "incident" reports, is one comprehensive report created?**

   a) If not, is there at least one person who sees the reports from all involved persons?

3. **Where, and for how long, are the reports kept?**

   a) Does the encounter become part of the student's "academic record"?

4. **How do you ensure that the appropriate information is being documented?**

E. ADDRESSING OTHER PERTINENT ISSUES:

1. **How do you determine if the student who was recently in acute distress or at risk for suicide, but is no longer in crisis, can participate in a study-abroad program, off-campus practicum, or other program away from his/her home institution?**

   a) What advance steps are taken to assist the departing student who may have mental health issues?

2. **What steps are taken — if any — around restricting access to lethal means of self-harm at the individual level when the student is identified as being in acute distress or at risk for suicide?**

3. **Are there special considerations relating to the international student (e.g., language and cultural barriers during assessment)?**

   a) Have translators or a translation service been identified in advance of a crisis involving the student for whom English is a second language?

4. **Are there special considerations relating to the graduate student, professional student, distance-learning student, or incoming study abroad student?**

5. What is your college's policy about speaking to the media around issues of student mental health (e.g., suicide attempt)?

    a) Under what circumstances is the campus media relations officer notified?

    b) Are those charged with media relations familiar with the American Foundation for Suicide Prevention's *Reporting on Suicide: Recommendations for the Media*?

    c) Are there different rules when speaking to student versus non-student media?

II. DEVELOPING AN EMERGENCY CONTACT NOTIFICATION PROTOCOL

It is recommended that every college have a written emergency contact notification protocol that clearly defines the circumstances under which notification will take place, the college's role following notification, the college's expectation of an emergency contact following notification, and the contact person at the college who can answer questions regarding the protocol. This information should be directly communicated to students and emergency contacts (e.g., during orientation) as well as be published in appropriate handbooks and Web sites. It is also essential that these expectations be reviewed with an emergency contact during a crisis period.

Note: *The term "emergency contact" is used to reflect the fact that not every student's next of kin is his/her parents.*

A. How do you prepare for the need to notify an emergency contact?

1. What guidance do you provide about whom the student should choose as an emergency contact?

2. Where is emergency contact information (e.g., address/telephone number/ primary language spoken for both the emergency contact and the student) maintained?
   [It is recommended that this information — along with the contact information for key administrators, faculty, and staff — be accessible to appropriate college personnel 24 hours a day.]
   a) How frequently is the information updated?

3. Have translators or a translation service been identified in the event that an emergency contact is non-English speaking?

4. Which college personnel are permitted to notify an emergency contact?
   a) How are those involved in notification educated about how to do this?

5. Does the student sign any type of ROI (e.g., institutional, medical) upon matriculation that remains on file throughout the student's career at the college?
   [State law typically dictates the length of time that an ROI can be valid.]
   a) If so, how much flexibility is built into the ROI regarding what circumstances could prompt a notification?
   b) If not, is there a standard ROI for the student to sign before voluntary notification can take place?

B. If your counseling (or health services) center or residence life office (e.g., through campus housing contracts) has an emergency contact notification protocol, is the issue addressed in a manner consistent with your college's general protocol for emergency contact notification?

C. Under what circumstances is the student expected to disclose information to his/her emergency contact?

1. How do you communicate this expectation to both students and emergency contacts at the time of matriculation (e.g., a paragraph in the student handbook)?

2. What strategies can be used to encourage the reluctant student to allow notification to take place when the school deems notification necessary?

D. How do you determine what information should be disclosed to an emergency contact?

1. How is this discussed with the student prior to notification?

2. What information, specifically, must be disclosed to a legal guardian if the student is a minor?

3. Does the information disclosed vary depending on who is making the notification?

E. What is the procedure for determining whether information should be disclosed involuntarily in an individual case?
[It is recommended that your protocol does not unilaterally mandate or prohibit notification. The decision to involuntarily notify is best made on a case–by–case basis with the best interests of the student in mind.]

1. Who is specifically involved in this process?

2. How is the need to notify the emergency contact balanced with concerns about potential consequences of notification for the student?
   a) What factors might give rise to exceptions to normal notification practices (e.g., if parents are part of the problem for the student), and who makes the final determination?

F. How do you engage the emergency contact who may be in denial about the seriousness of the student's mental health issues?

G. How can discussions be navigated with the emergency contact if s/he initially brought the student's distress to the attention of the college and wants to be kept "in the loop"?

H. How do you decide whether it is appropriate to notify someone other than the named emergency contact – either voluntarily or involuntarily – during a crisis?

III. DEVELOPING A LEAVE OF ABSENCE AND RE-ENTRY PROTOCOL

The goals of having a formal leave and re-entry protocol are to both normalize leave-taking, so that students feel that this is a viable option, and to make the process itself less intimidating (e.g., by providing a checklist of what to do prior to taking a leave). Hope-fully, this will encourage those students who may need to be on leave — for mental health or other reasons — to either initiate the process themselves or be willing to pursue leave as an option if suggested by a campus authority. Information about the leave and re-entry process should be easily accessible to students in appropriate handbooks and Web sites.

Note: There are many different names for leave of absence protocols (e.g., medical, administrative, academic, hardship, personal). The issues below are pertinent to any leave process that could be used by students having emotional problems.

A. What are the positive and negative consequences for the student taking a leave of absence for mental health reasons?

1. What happens to the student academically depending on when s/he goes on leave during a semester?
   a) Do details about why the student has taken a leave become part of his/her "academic record"?

2. Are there financial repercussions to taking a leave of absence?
   a) Does your institution provide prorated tuition and fee refunds based on how many weeks into the semester the student begins his/her leave?
   b) What are the ramifications of taking a leave for the student who receives financial aid?
   c) If your school offers tuition insurance, does it cover financial loss due to leave?

3. How do you assist the student who may lose his/her health insurance by taking a leave of absence (e.g., by writing a letter to the insurance company)?

4. How does leave-taking affect the international student's ability to remain in the U.S. or the graduate student's ability to remain funded?

B. What is the structure of your leave of absence process?

1. How does the student initiate leave for mental health reasons?
   a) Does s/he need to undergo an evaluation (e.g., psychological assessment) before leave is approved?
   b) Does the evaluation have to be independent (e.g., not by the student's existing mental health counselor)?
   c) Would a recommendation for leave be accepted from an off-campus mental health provider?
      1) Have you developed MOU or another type of agreement (e.g., affiliation

agreement, business agreement) with off-campus providers to complete student leave-related assessments?
[It is suggested that some type of agreement be in place to cover such circumstances.]
d) Under what circumstances would college administrators deny a request for leave?
1) What is the process by which the student can appeal the decision?

2. Is the leave process affected by whether the student is a graduate, undergraduate, or minor (under 18) student?

3. How do you determine the appropriate length of a leave of absence?
a) Can the student extend his/her leave?
b) Can the student return early from leave?
c) Could the student be automatically withdrawn from school after being on leave for a certain period of time?
d) Can the student take an unlimited number of leaves?

4. How do you determine the circumstances, if any, under which the student can return to campus while on leave (e.g., to visit friends, attend campus events)?

5. How do you determine when the student must vacate student housing after beginning a voluntary or involuntary leave?

6. What options exist if the student needs to take a leave but is unable to go home, either because the parents refuse to take the student or the home environment is unhealthy?

7. If there are multiple types of leave on your campus (e.g., medical, administrative, academic, medical, hardship, personal), who determines what type of leave the student can take for mental health reasons?
a) What is the decision-making process?
b) If there is discretion about what type of leave can be taken, how is this flexibility communicated to pertinent campus personnel (e.g., counseling center)?

C. In determining whether an involuntary leave of absence is in the best interests of the student, how do you balance his/her desire to stay in school with what services and support your college is able to provide?

1. Is the student always given the option of taking a voluntary leave?

2. What strategies can be used to encourage the reluctant student to consider taking a leave?

3. What is the decision-making process for placing a student on involuntary leave?

    a) How does the distress the student is causing to others in the college community influence the decision?

    b) What is the process by which the student can appeal the decision?

D. What is the structure of your re-entry process?

1. How do you determine the requirements for the student to return from leave?
    a) Are the requirements for re-entry different for the student returning from his/her first leave than for the student who has taken more than one?

2. How much notice must the student give the school that s/he wishes to return?

3. Prior to the student returning from leave, how does communication take place between college personnel and the student, parents/significant other, "home" mental health practitioner, etc.?

4. How is re-entry coordinated among college personnel (e.g., deans, counselors, residence life, roommates)?
    a) How do you promote continuity of mental health services after re-entry?
    b) How do you enforce the re-entry requirements?

5. Are there special services offered for the student returning from leave (e.g., group therapy, life skills development training)?

E. How do you communicate with the student, emergency contact, and other campus personnel about a leave of absence?

1. How are decisions about a leave (e.g., approval or disapproval) communicated to the student?
[It is recommended that compassionate and supportive language be used to convey the decision.]

2. How are issues of safety (e.g., restricting access to lethal means of self-harm such as firearms) discussed with whomever is taking responsibility for the student?

3. How do you let the student know what is required prior to beginning a leave of absence and prior to returning from one (e.g., by providing a checklist)?

4. How is the student's leave communicated to relevant campus personnel (e.g., RAs, professors, coaches)?
    a) What guidance is given to these involved parties regarding the discussion of the student's absence with other students?

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Available on the Internet at no cost.

APPENDIX A – TABLE–TOP EXERCISES

■ 1. MW is a 17 year-old college freshman who was found binging and purging in her dorm bathroom by her friends. Multiple recent lacerations were observed on her arms and thighs. The Dean of Students thinks that she needs further evaluation, but she initially refuses, saying that these problems were addressed in high school and that she has things under control. Because she is a minor, there is a signed waiver in her health records indicating that her parents have the authority to make medical decisions for her.

- How can the Dean try to overcome MW's reluctance to be evaluated?
- Under what circumstances should her parents be contacted and by whom? What should be conveyed to them?
- What, if any, outreach is provided to the friends who have been impacted by her behavior?

■ 2. ET's roommates are concerned about his escalating references to suicide and his preoccupation with death and dying. However, he has not revealed a plan and has not engaged in any known self-injurious behaviors. Although both the Dean of Students and the Counseling Center Director have requested that the student undergo a mental health evaluation, he has not scheduled an appointment. The Dean has suggested that ET tell his parents about the situation, but he says that they "won't understand."

- How is a decision made about whether ET's preoccupation with death and dying requires immediate intervention?
- How can the Dean try to overcome ET's reluctance to involve his parents?
- Under what circumstances should his emergency contact be notified and by whom? What should be conveyed to this person?
- What, if any, outreach is provided to the roommates who have been impacted by his behavior?

The situation improves, and ET begins to see a counselor regularly. At his most recent visit, he reports escalating suicidal thoughts over the last week. Upon closer questioning, he admits to episodes of rehearsing and experimenting with taking over-the-counter (OTC) medications in larger-than-recommended amounts. However, he denies a specific plan or access to a lethal means of suicide, although he does have access to OTC drugs. The next day, the Director of Campus Life calls the Counseling Center to report some concerning behavior by ET in the residence hall and asks if he is currently a client.

- How can information be shared between the Counseling Center and Campus Life staff?
- In general, what role does the Counseling Center play in working with other departments (e.g., Campus Life, Student Affairs) around students of concern?

■ 3. PR is a 25 year-old undergraduate with a history of several extended hospitalizations in his twenties for mania complicated by poly-substance abuse. He has been successfully stabilized for periods on lithium but experienced a manic episode two months ago, only coming to the Counseling Center for occasional medication management. Now, PR is severely depressed and reports frequent thoughts of suicide, even admitting that he's been looking on the Internet for "instructions" on how to kill himself. His grades are falling, but he is reluctant to take a leave of absence.

• How are the positive and negative consequences of leaving school to get more intensive treatment presented to PR?
• What factors would support placing PR on involuntary leave?

Eventually, it is learned that PR's main concern about taking a leave of absence is losing his health insurance.
• Under what circumstances should the school assist in helping PR retain existing, or find new, health insurance?
• What responsibility does the Counseling Center have for arranging ongoing treatment once the student has taken a leave of absence?

Prior to leaving campus, PR tells you that he is going to stay with his sister, who, according to the student, does not know that he has bipolar disorder.
• Is there an obligation to inform the sister about PR's reasons for taking a leave of absence?
• How can the sister be educated about her brother's illness and risk for suicide?

The next day, one of PR's professors calls Student Affairs, concerned that he hasn't shown up for class.
• Whose responsibility is it to contact relevant faculty members when a student goes on leave, and what should be shared with them regarding the reasons for leave-taking?

After undergoing three months of treatment, PR writes a letter asking to return to school to complete his undergraduate degree.
• How is PR's readiness to return to school assessed?
• How is his re-entry coordinated across different campus departments (e.g., Counseling Center, Student Affairs, Campus Life)?

■ 4. JB, a 20 year-old biology major, was recently discovered by her friends to be drinking before class in the morning. On Monday morning, they were so concerned that they brought her to the Counseling Center. During subsequent visits, she describes episodes of suicidal ideation when drinking alcohol but denies any current thoughts of suicide. One night, the on-call counselor is paged by JB's roommate who reports that she interrupted JB as she was about to take an entire bottle of Tylenol. The counselor believes that she needs to be hospitalized.
• What steps must the counselor now take to pursue this course of action?
• If the student will not go to the hospital voluntarily, how does the counselor pursue involuntary commitment?
• Whose responsibility is it to notify the student's emergency contact if JB is hospitalized?

After 48 hours in the psychiatric unit of the local hospital, JB is released with a follow-up plan in place for outpatient treatment.
• How is a decision made regarding whether she can remain enrolled or return to the residence hall?
• How is her alcohol use addressed?

■ 5. Four weeks after the beginning of the fall term, TW, a freshman living on campus, has had two disciplinary contacts with Residence Life staff for getting into physical fights while intoxicated. As a result, Residence Life refers TW to Judicial Affairs which, in turn, refers him for a mandated psychological assessment. However, TW does not make an appointment for the assessment within the required one-week timeframe.
- What are the next steps that should be taken?
- How is information about TW, such as his lack of follow-through, shared among relevant parties (e.g., Residence Life, Judicial Affairs, Counseling Center)?

A few weeks later, the on-call counselor is notified that TW has been taken to the local hospital's emergency room (ER) for an overdose of alcohol and prescription medicine.
- What steps can the counselor take to stay "in the loop" about whether the student is admitted to the hospital or discharged from the ER?
- What arrangements need to be in place to allow the Counseling Center to have a working relationship with the local hospital during a crisis?
- What responsibility does the counselor have to inform others about TW's visit to the ER?

One week later, TW is again taken to the hospital for an overdose of alcohol and sleeping pills following a breakup with his girlfriend. He is very vague about the intent of the overdose and adamantly opposes having anyone notify his parents. A check of his health records indicates that he did not sign a Release of Information to allow them to be contacted. In addition, he listed a high school friend as his emergency contact.
- How should TW's reluctance to involve his parents be overcome?
- Under what circumstances should his parents be contacted and by whom? What should be conveyed to them?

■ 6. SD, a freshman, is noticed by her Resident Assistant (RA) to be sleeping a lot, missing meals, not socializing with her friends, and not bathing regularly. The RA tells SD's Class Dean about her concerns.
- Does the Class Dean have a responsibility to make contact with the student?
- What mechanism is in place to monitor whether SD is improving or exhibiting more concerning behaviors?

■ 7. A faculty member contacts a member of the Counseling Center, because he is concerned about what a student wrote in a paper for his introductory English course. He then reads the part of the paper that concerns him:

"Ever since I was twelve I have thought about death. At times, I fantasize about what it would be like to die. I have occasionally thought about taking my dad's gun and using it. But that seems so messy. Once I started driving, I thought it might be easier to just drive off the road or hit a tree. But I have never done anything like that, because I don't want to hurt my parents and friends. But lately these feelings are growing stronger. I wonder what it is like to die."

The faculty member wonders whether this is teen angst or something more serious and asks for guidance about what to do.
- How should the counselor work with the faculty member around his concerns?
- Who is responsible for following up with the student?

■ 8. RF, a junior, has decided that he needs to take some time off before completing any further studies and has taken a voluntary leave of absence. However, he continues to live with enrolled students in off-campus housing as well as visit friends in the dorms. He also frequently waits outside of class to see a student whom he considers to be his girlfriend. She does not consider him to be her boyfriend and has informed him that she does not want to see him. She speaks with both Counseling Center staff and the Dean of Students about how to deal with this situation, reporting that RF has threatened to harm himself unless she "takes him back."
- How should this situation be handled?

■ 9. In the Sunday newspaper, the Vice President for Student Affairs (VP) reads that a 21 year-old student at his university made a serious suicide attempt the day before that involved the community police. The local newspaper describes the sequence of events that brought the police to the student's off-campus residence. The VP immediately calls the Counseling Center to inform the Director of the information learned through the newspaper.
- What are the next steps to be taken and whose responsibility is it to coordinate the response?

A P P E N D I X   B – L E G A L   I S S U E S

For the convenience of counsel, the following is a summary of key legal issues that may arise while developing crisis management protocols.

Memoranda of Understanding (MOU): The college may enter into MOUs, affiliation agreements, or business agreements with external entities or individuals who may, in an emergency, assess or care for a student at risk for suicide. External entities can include local hospitals, police, community mental health centers, and emergency medical services. (Sections I.A., I.B., and III.B.)

Involuntary Hospitalization: State law criteria and procedures for involuntary hospitalization can become important. Research these in advance of a crisis and share the information with the counseling center, campus safety, dean of students, and others who play a role in crisis intervention. Decide in advance whether legal counsel would participate in making decisions about seeking a student's involuntary hospitalization. (Section I.B.)

Documenting Encounters with Acutely Distressed Students: The college should consider developing protocols on documenting encounters with acutely distressed students. What would legal counsel suggest recording in such incident reports? How should reports be shared internally, used, and stored? (Section I.D.)

Student Privacy: Legal standards for student privacy are relevant to protocol development. It is recommended that HIPAA, FERPA, and state laws creating privacy rights for students be reviewed. Another privacy consideration is state law protection for clinician-client communications. Most privacy statutes create exceptions for emergencies that are particularly germane. It is suggested that college materials usefully explain campus policies on privacy and disclosure to students, parents/family members, and significant others.

Emergency Contact Notification: If a student appears to be at high risk for suicide, the issue of notifying parents or other emergency contact individuals arises. Should college officials be unable to persuade the student to initiate contact, the officials may wish to do so, even over the student's objections. Legal counsel will want to assess the privacy standards and exceptions discussed above. Also check housing contracts for any notification provisions. (Section II.)

Nondiscrimination and Leaves of Absence: The ADA or state disability discrimination laws may influence decision-making around the potentially suicidal student. Consider whether a student at risk for suicide is disabled under statutory definitions. If so, compare procedures for involuntary leaves of absence as applied to students with disabilities and students without disabilities.

APPENDIX C — *Prescription for Prevention*

Prescription for Prevention: Model for Comprehensive Mental Health Promotion and Suicide Prevention for Colleges & Universities

Means Restriction to:
- Limit access to potentially lethal means
- *Lead: Buildings & Grounds, Public Safety, Residential Life, Chemistry Dept., Athletic Dept., Alcohol & Substance Abuse Office*
- *Target: Entire campus community*

Life Skills Development (Protective Factors) to:
- Improve students' management of the rigors of college life
- Equip students with tools to recognize and manage triggers and stressors
- *Lead: VP of Student Affairs, Deans of Students, MHS, Faculty & Staff, Advisors, Residential Life*
- *Target: Students*

Social Network Promotion to:
- Reduce student isolation and promote feeling of belonging
- Encourage the development of smaller groups within the larger campus community
- *Lead: Deans of Students, Faculty & Staff, Residential Life, Student Gov't, Student & Greek Orgs., Chaplainry*
- *Target: Students*

Mental Health Service (MHS) to:
- Train MHS providers to identify and treat depression, threats of suicide, and other emotional disorders
- Refer cases as appropriate
- Institute procedures (e.g., intake form)
- Enhance accessibility of MHS
- Engage in prevention & outreach activities
- *Lead: Suicide prevention experts*
- *Target: MHS, community resources, local hospitals*

Promote Mental Health Awareness & Well-Being & Prevent Suicide
- *Coordinate and communicate across campus departments & organizations*
- *Develop and/or revise institutional policies and operating procedures*
- *Institute campus–wide risk surveillance system, tracking all fatal & non–fatal self–injuries and safety– and health–related indicators (e.g., violent behavior, criminal activities, & substance abuse)*
- *Leadership: President's Office*

Social Marketing to:
- Stimulate campus–wide cultural change that de–stigmatizes mental health, removes barriers, and encourages help–seeking behavior
- Target both high–risk students and general campus community
- *Lead: VP Student Affairs, Deans of Students, MHS, Marketing Department, Campus Media*
- *Target: Entire campus community*

Questionnaire/Screening to:
- Identify high–risk and potentially high–risk students
- Provide landscape of mental health on campus
- Proactively work (programs, treatment) with identified students
- *Lead: Admission Office or Freshman Dean with MHS and the Health Service*
- *Target: Students*

Crisis Management to:
- Establish policies and implement programs (including medical leave and re–entry) that respond to suicide attempts and high–risk behavior
- Respond with comprehensive postvention program
- Create interface between disciplinary process and counseling/MHS
- *Lead: VP Student Affairs, MHS, Disciplinary Committee*
- *Target: Students; gatekeepers (with implementation responsibility)*

Educational Programs to:
- Train gatekeepers and students to:
  (1) identify signs of individuals in distress;
  (2) take the steps that get them help
- Train personnel on confidentiality, notification, and legal issues
- *Lead: Provost, VP Student Affairs*
- *Target: Students and gatekeepers (Deans of Students, Faculty & Staff, Advisors, Residential Life, Student Gov't, Student & Greek Orgs., Athletic Dept., Dining Services, Public Safety, Chaplainry)*