College Student Mental Health:

Current Practical, Legal, and Ethical Considerations for Student Affairs Professionals

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Abstract

Tragic violence in recent years has heightened awareness of mental health issues on college campuses. Partly as a result of the Americans with Disabilities Act, colleges now firmly recognize legal and social responsibilities to mentally troubled students. The number of students with these problems seeking help from universities continues to grow. This paper reviews the scholarly literature pertinent to the campus management of mental health issues, exploring legal, ethical, and multicultural perspectives as well as the perspectives of student affairs professionals. It concludes that mental health issues are not just the purview of the counseling center—they must be a university-wide concern.
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Statement of the Problem

In the wake of two recent, high profile campus shootings committed by mentally ill students, the nation’s colleges and universities confront with new urgency the need to keep the campus community safe, and yet to serve better an increasing number of students with mental health issues. In response to the 2007 shootings on the campus of Virginia Tech University, Dr. Jerald Kay, chairman of the American Psychiatric Association Committee on College Mental Health, stated that “the number of people coming to colleges who’ve had psychiatric treatment has increased tremendously” (Crary, 2007, para. 3). Kay added that this increase of students with severe mental health issues has strained campus resources. Further, universities face students with a great diversity of mental health disorders: depression, eating disorders, suicidal ideation, or psychosis, to name a few. Additionally, in the immediate future, campuses can expect to serve returning veterans of the Afghanistan and Iraq Wars with potential post-traumatic stress disorder, as well as students who are anxious about the depressed economy (Kadison, 2006, p. 338; Kadison & DiGeronimo, 2004).

College campuses have struggled to keep up with the demand and they confront moral and legal dilemmas involving student privacy, parental involvement, and public safety. Student affairs professionals often find themselves on the frontline, and must understand the multiple mental health issues on campus. Further, many in student affairs are also helpers of students, and as such, need to learn how to address the specific problems faced by mentally ill students. This paper seeks to guide student affairs professionals through the practical and legal aspects of
current mental health issues on college campuses, as well to encourage greater helping skills to assist and retain students.

*A Brief History of Mental Health Issues in American Higher Education*

*Evolution of counseling on college campuses.* According to the Association for University and College Counseling Center Directors, after World War II, counseling centers were “established in response to the educational and vocational needs of returning veterans” (Mack, 2004, para. 3). Eventually, the mission of counseling centers evolved to helping students with “traditional” problems common to college-aged adults, such as “[difficulty] separating from parents, romantic relationships or the choice of careers,” (Goode, 2003, para. 3). Within the last 15 years, however, the severity of problems with which students present to counseling centers has changed dramatically.

A recent longitudinal study by the Kansas State University Counseling Center, conducted between 1989 and 2001, showed that students are presenting with more complex mental health issues. The study indicates that in the 13-year period students being treated for depression doubled, suicidal students tripled, and students seen post-sexual assault quadrupled (Benton, Robertson, Tseng, Newton, & Benton, 2003, pp. 69-70). The number of students taking psychiatric medications doubled during the study period (p. 69), likely due to the rise of depression and personality/thought disorders. Not surprisingly, many of these students might also struggle as much with homesickness and relationship issues as students in the past did (p. 70), so a single student might present with multiple problems that need to be addressed.

Other research supports Kansas State University’s findings. Counseling center directors around the nation reported similar statistics on their campuses (Benton, 2006, p. 4; Capriccioso, 2006, para. 5; Gallagher, 2003). One 2007 survey of 20,507 college students conducted by the
American College Health Association (Appendix A) found that over 43% of those surveyed had felt “so depressed it was difficult to function” in the last 12 months (2008, p. 13).

Theories on the increase in the severity of mental health issues on college campuses. The prevalence of mental health issues has increased, but why? The passage of the 1990 Americans with Disabilities Act (ADA) accounts for some of the increase. By including psychologically troubled students under its umbrella, the ADA gave the mentally ill legal protections they had not previously enjoyed. The ADA, which was born out of the disability rights movement and was modeled after the civil rights movement, “reinforces the concept of reasonable accommodations in education [italics added] and mandates greater access to employment, transportation, and public accommodations for individuals with disabilities” (“ADA Legislation,” 2006, para. 2).

The ADA classified mental illness as a disability, which made previous legislation, Section 504 of the 1973 Rehabilitation Act, become more relevant to the mentally ill. Section 504 made it illegal for recipients of any federal aid to discriminate against persons with disabilities (Mayerson, 1992, para. 5), and together the ADA and Section 504 provided public colleges and universities with powerful incentive to assist students with disabilities—including mental illness—to pursue higher education.

Another reason for the rise in the severity of mental health issues on college campuses is that many mental illnesses become evident during the college-aged years. Epidemiological studies found that “the rate of mental illness is highest (39%) for youth” of the traditional college-age (Mowbray et al., 2006, p. 227). Dr. Richard Kadison, co-author of a book on the rising mental health crisis on college campuses wrote that disorders such as depression, bipolar disorder, and schizophrenia “most commonly hit a person in his or her early to mid-twenties”

Additionally, medications designed to treat these disorders have improved, and usage has increased (Schwartz, 2006, p. 335). In fact, the use of psychotropic medications has "increased 200 to 300 percent from 1987 to 1996" (Kadison & DiGeronimo, 2004, p. 244). A University of California study conducted in 2006 showed that "one-quarter of its students arrived on campus already taking anti-depressants, lithium, or other psychoactive drugs" (Fisher, 2007, para. 6). In short, improved medication has enabled students who were not previously able to manage college to receive an education.

As the rights of the disabled become codified—ADA and Section 504—and as medications improve, the stigma surrounding mental illness has slightly improved, which caused some who had been reluctant to seek counseling to do so. Given that anti-depressant medication is the "most common [type] of medication used in college settings" (Kadison & DiGeronimo, 2004, p. 244), it seems likely that most students are either taking anti-depressants themselves, or are close to someone who is.

One final theory as to the increase in the severity of mental illness on college campuses is that students are simply under more pressure to succeed than ever before (Kadison & DiGeronimo, 2004). We are a "culture of ambition but also one of high anxiety that is shaping a kind of Generation Stress" (Sontag, 2002, para. 9). One expert, Dr. Portnoy who directs the department of Counseling and Psychological Services at the University of Nebraska, argues that while we as a nation expect that our youth will excel academically, there has been a "breakdown
in family support systems,” stating that “people just don’t seem to have the resources to draw upon emotionally to the degree they used to” (Goode, 2003, para. 8).

**Theoretical Frameworks Used**

Students with mental health conditions defy concrete categorizations. They are of every age, gender, race, ethnicity, sexual orientation, and socioeconomic status. Many will have multiple identities. As a result, a paucity of identity or development theories exists for this population.

However, Margaret Schlossberg’s theory of Marginality and Mattering serves as a strong guide for me when working with all students, and perhaps most especially with those on the periphery, such as students struggling with serious mental health issues. Schlossberg wrote that to build community, a necessary element of retention, “individuals [must be allowed] to believe in their own personal worth” (1989, p. 5). Beyond retention, she argued for the morality of bringing people from the margins towards mattering. She speculated that students suffering with depression may “rule out suicide if they feel they matter to others” (p. 9).

In addition to Schlossberg’s theory, three Educational Leadership and Policy courses informed my understanding of students’ mental health challenges, and will be incorporated into this paper: Law and Policy in Higher Education, Introduction to Student Affairs Administration, and Current/Hot Topics in Student Affairs (particularly as mental health issues relate to students of color). Further, my coursework in College Student Retention Theory, as well as Helping Skills and Interventions, influenced my learning and practice, and will be included in my analysis.

**Importance of Analysis**
Given the increased prevalence of mental health disorders among college students, educators must learn more about this population, and understand the best way to serve these students. The campus presence of students with mental health disorders also raises concerns about campus safety. These concerns are legitimate, but they cannot be addressed without due consideration of the legal issues surrounding suicidal or seriously mentally ill students. This paper turns next to the scholarly literature relevant to serving the mentally ill, as well as legal aspects of working with this population.

Review of Related Literature

Literature regarding college students' mental health, especially as it relates to student affairs professionals, can be clustered into three categories: the effects on student affairs; the experiences of multicultural students seeking mental health services; and legal and ethical perspectives on college student mental illness.

Effects on Student Affairs

Student affairs professionals as allied helpers. As noted above, more students are struggling with greater levels of mental health disorders than ever before. College counseling centers are strained meeting the demand for their services, but the nation's current economic crisis makes hiring more counselors challenging. Mentally ill students are stigmatized, and members of the campus community express concern and fear when faced with a student whose disorder causes him or her to behave erratically (Collins & Mowbray, 2005; Quinn, Kahng, & Crocker, 2004). At the same time, a positive correlation exists between students who are adequately treated for their mental illness and their retention rates (Collins & Mowbray, 2005, p. 304; Kadison, 2006, p. 340; Quinn, Kahng, & Crocker, 2004, p. 813). In the face of dwindling
resources but increased demands for counseling, several authors have argued for student affairs practitioners to assume the role of allied helping professionals.

Kimberly Trela, a scholar and practitioner from the University of Maine, has promoted the view that all educators must become trained as para-counselors. Echoing Nancy Schlossberg’s call to help pull students from marginalization to mattering, Trela wrote that because of student affairs professionals’ placement on the “frontline” (2008, p. 31) they are ideally placed to reach out to students who are struggling with mental health issues. Trela also maintains that we must “[support young adults’] development as a whole person by teaching them to manage stress, to cope with anxiety, and to form healthy relationships with faculty and peers” (p. 32).

To attain these goals, Trela recommended meaningful training for the frontline “noncounselors” (2008, pp. 31-32) on campus, those who are close to the students, and who are likely to notice a troubled student. Properly trained faculty and student affairs educators, according to Trela, should understand basic crisis management, and should be able to recognize the signs of “depression, eating disorders, and cutting behavior” (p. 31). Additionally, noncounselors should be familiar with basic counseling skills so that they react appropriately, and can maintain a student’s trust. Trela wrote that with a properly trained corps of frontline educators and professionals, the campus counseling center would have important assistance in helping struggling students. Further, Trela argued, appropriate training would foster a better understanding of mental illness, would lessen the stigma surrounding mental illness, and would increase mentally ill students’ sense of safety and community.

Other scholars agree. Borges and Sandler argued for “broadening the scope of advocacy” (2005, p. 10), meaning that student affairs professionals must look beyond their primary role.
They found support for taking this additional responsibility in the American College Personnel Association’s (ACPA) *Student Affairs: A Profession’s Heritage*. They noted specifically that student affairs professionals are charged with assisting students in their “intellectual, social, emotional, and physical development” as well as “performing student personnel functions [italics added]” (Rentz, 1994, p. 125). In other words, everyone is responsible for educating our students, regardless of position. Working with students suffering from mental health disorders cannot be the province of counseling centers alone.

Borges and Sandler wrote that understanding mental health issues must be an imperative of student affairs professionals in the face of increased prevalence of mental disorders, most commonly: attention deficit hyperactivity disorder (ADHD), clinical depression, bipolar disorder, and obsessive-compulsive disorder (OCD). All of these disorders can significantly impair a student’s ability to persist to graduation.

Borges and Sandler offered guidelines for support and assistance (p. 15):

1. Be observant of students who may be experiencing difficulties due to mental health challenges.

2. Focus attention on comments or concerns that may be warning signs.

3. Practice a higher level of patience when working with students who may be experiencing mental health challenges.

4. Know your abilities and limitations when assessing your involvement with students who need additional support.

5. Continually educate yourself on the latest trends and literature concerning mental health challenges in higher education.
Amy L. Reynolds, a counselor at the University of Buffalo, supported the notion of student affairs professionals as allied counselors in her book *Helping College Students*. Reynolds referred to a central tenet of the profession: We are to educate the whole student, not just “nourish her/his intellect” (2009, p. 6). Reynolds indicated that helping is a professional responsibility of everyone, regardless of position or title, as well as being a core competency of the profession.

Other scholars have written that an increased role of student affairs professionals in helping can also increase campus safety. Morton Silverman serves as a psychiatrist at the University of Chicago, as well being a student affairs practitioner and a senior advisor to both the Suicide Prevention Resource Center at the Education Development Center and at the Jed Foundation. Echoing Schlossberg’s call for community-building, in his writing, Silverman called on student affairs professionals to do more that encourage students to “get involved.” Instead, we must intentionally “create opportunities in an environment of caring and connection” (2008, para. 17), and cited living-and-learning communities, which promote connections between students and educators. Silverman argued that relationships like this can provide a “significant protective factor against depression and suicide” (para. 17).

In addition to the scholarship that supports the idea of student affairs educators as allied counselors, guiding documents of the profession also indicate that helping skills should be a core competency for those in student affairs. For example, the *Council for the Advancement of Standards in Higher Education* (CAS) states that masters-level student affairs professional preparation programs should have a required “individual and group interventions” (2006, p. 352) component. This course should teach students “strategies for the implementation of advising, counseling, disciplining, instructing, mediating, and facilitating to assist individuals and groups”
Therefore, student affairs professionals who have been educated in a masters-level program should have this skill-set and exposure to counseling practices.

Other professional organizations support para-counseling training at the master’s level as well. The Student Affairs Administrators in Higher Education organization, known as NASPA, has published several articles in its professional journal regarding the importance of helping competencies. Reflecting the modern reality of serving students with diverse needs and concerns Burkhard, Cole, Ott, & Stoflet found that surveyed student affairs administrators “expect new professionals to have skills that extend well beyond the basic skills often taught in graduate programs” (2004, p. 298). In his research, Waple also found that counseling skills competencies in entry-level staff were important to student affairs administrators, but most administrators argued for a mix of training that focused on multiple competencies, rather than intensive counseling training (2006). Despite this, some debate exists as to how entry-level employees are best trained: on the job, or through graduate preparation programs (Kuk, Cobb, & Forrest, 2007).

Critique of literature. Certainly, student affairs professionals represent the frontline, as Trela suggested. As a result, these educators are likely to notice aberrant behavior, and put it into context—if properly trained—as opposed to panicking, avoiding distressed students, or passing them off. We are obligated by the dictates of our profession to educate the whole student, regardless of our primary role within student affairs. Finally, given the constraints and demands on counseling centers, becoming allied helping professionals makes sense for institutions and for students.

Despite this, the literature does not suggest that campuses are actually training their student affairs professionals to act as meaningful helpers, save for those who were trained in a graduate program. Further, as the discipline of student affairs evolves, disagreement exists
between student affairs administrators and faculty in graduate preparation programs about how
every-level professionals should be trained, at the exact time that more students find themselves
in crisis. To the extent there is consensus that student affairs professionals should be trained as
allied helpers, who assumes responsibility for the training? The counseling centers, the student
affairs units, graduate preparation programs, or does the responsibility fall to individual
educators? I fear complacency on behalf of institutions in the absence of any very recent critical
incident. Perhaps as bad, I can foresee well intentioned but poorly trained educators stumbling
through helping interventions that leave the educator drained, and the student poorly served.
National professional organizations, such as NASPA and ACPA should work on a common set
of competencies—including counseling skills—for all professionals.

Experiences of Multicultural Students Seeking Mental Health Services

Students who struggle with mental health issues are already part of a class of people who
are oppressed by society (Abberly, 1987). The mentally ill are stigmatized, and some in society
believe that people who struggle with depression are weak (Collins & Mowbray, 2005; Quinn,
Kahng, & Crocker, 2004). Students of color are another historically oppressed population, and
in many cases, living day-to-day in a world awash in systemic racism increases mental health
disorders, such as anxiety and depression. Additionally, different cultures do not necessarily
share the same perspectives, or suffer from depression or anxiety for the same reasons, as does a
western person (Brent, Erickson Cornish, Leslie-Toogood, Nadkarni, & Schreier, 2006). The
current counseling centers on college campuses may not be enough to reach and serve
multicultural students, as this section will show.

Family expectations. The familial pressure to succeed academically is a common factor
among all races. However, students of color, immigrants, and international students face unique
family and cultural pressures. Kadison and DiGeronimo noted that cultural differences between historically “white colleges”—which have really only integrated only in the last 25 years—and that of the home life of many students can be jarring and mentally distressing (2004, p. 49). For some students of color, not only is there pressure to live with racism and to conform at predominantly white college campuses, but they may face resentment of friends back home, particularly if the student is perceived to be “acting white” (Kadison & DiGeronimo, 2004, p. 52). Some students of color—especially those coming from immigrant parents, who may have sacrificed significantly to give their sons and daughters the best education—are seen as saviors who will bring honor to the family. The subtle—or perhaps overt—message is that the student should not mess up the best opportunity to raise the family’s standard of living (p. 56).

Ling-Chi Wang, a professor of Asian-American studies and ethnic studies at the University of California at Berkeley, advises students of color who are depressed or anxious because of the high familial expectations to seek assistance or support at the counseling center. However, he has found that when counselors are faced with cultural issues, they may be “unsympathetic,” and “unable to understand [the student’s] predicament and [to] offer appropriate advice” (Kadison & DiGeronimo, 2004, p. 59).

*Underutilization of services by some populations.* Sullivan, Ramos-Sanchez, and Melver (2007) found that despite having similar rates of symptomatology, white and Asian/Pacific Islander women used college counseling centers at a much higher rate than did Latinas or second-generation American women (African-American and Native American women were not included in the study). They found that Latinas and second-generation Americans perceived that their needs differed, and could not be met by college counseling centers.
Constantine, Fuertes, Roysicar, and Kindaichi had similar findings (2008). They argued that the counseling field, historically dominated by a base in “Western, Eurocentric cultural values” (p. 98), is poorly positioned to serve an increasingly diverse population and student body. For example, independence is a western cultural value. However, interdependence is a value that many other cultures share. If a counselor does not understand that, then he or she could be causing the student seeking help more stress and frustration. Because the counseling field is predominately white the authors promoted intensive multicultural competence training for current and future counselors, in addition to recruiting students of color into the field. The authors’ research showed improved outcomes for the therapists who were trained in multicultural competencies, but did not evaluate outcomes for the clients.

Critique of literature. Although the above literature referenced counseling centers specifically, in my opinion, the same principles hold true for student affairs professionals. Multicultural competence represents a significant aspect of being a successful helper. While colleges and universities promote multicultural understanding and awareness, I would argue that institutions could do more to foster competence in their staffs. Schlossberg’s theory strikes me as especially relevant here; we need to take care not to further marginalize our students of color who struggle with mental health challenges, and demonstrate that they matter through our actions.

I have no major critique of the above literature, except that I would like to see research on the perceptions of students who have received treatment from multiculturally competent counselors, to see if the rate of utilization increases. However, I do have concerns about some of the statistics used to describe the prevalence of depression. For example, referring to Appendix A, the American College Health Association’s 2007 National College Health Assessment, over
75% of the respondents identified as white. However, according to the U.S. Department of Education, only about 65% of the nation’s college students are white ("Fast Facts," 2008). While I do not doubt the veracity of the depression statistics as it relates to white students, I wonder if the needs of students of color are underreported. Further research is clearly needed.

*Legal and Ethical Perspectives on College Student Mental Illness*

In addition to the ethics surrounding learning good helping skills, as well as becoming a practitioner who is multiculturally competent, student affairs professionals are confronted with legal considerations and constraints. Suicidal students and the proper role of campus administrators relative to parents and confidentiality requirements, all represent important considerations for student affairs professionals. Gary Pavela, JD, scholar, and nationally recognized expert in higher education law and policy, deeply informed my perspective on these matters.

*Suicidal students and the dilemma of parental notification.* In the first half of the 20th Century, higher education administrators and student affairs professionals traditionally served in the place of parents, a concept known as *in loco parentis*. According to an article in *EduExec*, women were especially closely monitored and “guarded” ("When In Loco Parentis," 2005, para. 1), although men seemed to enjoy more freedom. The socially progressive reforms of the 1960’s and 70’s brought changes to college campuses, and students of that generation had less “patience for parental university policies” (para. 3), especially ones that were gender-biased. Further, these students wanted their privacy.

At the same time, the 1974 Family Educational Rights and Privacy Act (FERPA) mandated that public colleges and universities strictly protect students’ privacy rights. Even parents who may be paying for the tuition do not have automatic access to their child’s record or
information ("When In Loco Parentis," 2005, para. 4). A new ethic of student privacy swept over campuses, and it changed the way higher education administrators and student affairs professionals communicated with parents.

This shift away from *in loco parentis* may have served the students of previous generations well. Unfortunately in a modern context, faculty, administrators, and student affairs professionals can feel reticent to share any information with parents. This can be especially problematic when working with students who struggle with mental illness or who have suicidal ideations. As suicide is the second leading cause of death among college students (Dickerson, 2006, p. 67), it begs the question: when do institutions involve the parents?

The Elizabeth Shin tragedy illustrates the problems institutions face. According to an extensive article by *The New York Times*’s Deborah Sontag, Elizabeth Shin, an immensely bright and talented Massachusetts Institute of Technology (MIT) student, committed suicide in her dorm room by setting fire to herself in April 2000 (2002, para. 1). Throughout her years in college, Elizabeth had been struggling against her perfectionism and her exceptionally high standards; she tried to ease her anxieties through self-injurious cutting. Elizabeth had been treated by an MIT psychiatrist who recommended that she read *Feeling Good*, a book that bills itself as a "drug-free treatment" for "anxiety, guilt, pessimism, procrastination, low self-esteem, and other 'black holes' of depression" (para. 56).

Elizabeth told her friends she was going to kill herself. Eventually, she attempted suicide by overdosing on Tylenol with codeine, and she was admitted to a psychiatric hospital. After Elizabeth’s hospitalization, her residence hall advisor called Elizabeth’s parents to notify them, although it was at Elizabeth’s request, not at the instigation of the residence hall officials. The university established no plan of action; there was no further follow-up.
Despite FERPA, colleges and universities are under ethical and necessary obligations to “break a student confidence if it appears that the student will do harm to him- or herself or others,” according to EduExec (“When In Loco Parentis,” 2005, para. 7), according to the “direct threat” principle (Pavela, personal communication, June 15, 2008).

After Elizabeth’s eventual suicide, the Shins brought a wrongful death suit against MIT, claiming that:

MIT, overly concerned with protecting Elizabeth’s confidentiality, failed to inform them of their daughter’s precipitous deterioration in the month before her death. This, they say, robbed them of a chance to oversee her care or perhaps even to save her life. MIT, the Shins claim, made matters worse by failing to act in their place, “in loco parentis to the deceased” (Sontag, 2002, para. 5).

The Shins were partly successful, and settled out-of-court for a confidential amount (Capriccioso, 2006, para. 7). Although MIT as an institution was cleared of any wrongdoing, the court allowed the Shins to sue individual MIT student affairs employees. As a result of the Shin’s settlement, the court did not rule whether an individual student affairs employee could be held liable for a student’s death. However in a separate case, Pavela stated that the 2000 Jain v. Iowa case remains a viable precedent. In that case, the courts ruled that college administrators have no general duty of care to prevent student suicide.

Another outcome of the Shin case relevant to higher education was that the legal concept of in loco parentis, while weakened, still stands, although its implications for any given institution remains unclear. Because of this, the case does have major implications for higher education administrators. Parents generally trust colleges and universities to care for their children. Sontag points out that most parents do not understand FERPA, and are puzzled that an
institution cannot share information freely with them. Immigrant parents are especially susceptible to confusion on this point. Student affairs professionals can mitigate confusion for all parents with better education at admission and orientation. These professionals must have cross-cultural training.

When asked about the dilemma of student privacy and parental notification as it pertains to student mental health, Dr. Mary Doty, the Utah State University Counseling Center Director, indicated that institutions are caught in an interesting time (personal communication, June 29, 2007). On the one hand, parents want their children to be adults, but on the other hand, the incidence of 'helicopter parenting,' used to describe a parent 'hovering' over offspring, is increasing. Doty and her colleagues know first hand that students are entering college with an increased severity of mental health issues relative to a decade ago. There is a sense among these professionals that a few parents are looking to institutions of higher education to provide a kind of "day treatment program" for "intellectual, yet psychologically troubled students." She points to decreased funding from state and local government for mental health services, and indicates that students and their families might not be able to afford adequate private care. At the same time, most college and university counseling centers are not staffed, funded, or equipped to handle the most chronic and severe of mental illnesses.

While there is not necessarily an uneasy alliance between parents and the institution, there are mutual expectations and delicate boundaries. Doty said that practitioners in Utah, like most states, can and will break confidentiality when a student is perceived to be a threat. Doty laments that knowing when someone is truly a threat is a bit of a "moving target." In striving to find the right balance, she prefers to encourage an at-risk student to sign a release of information, and then the psychologist can partner with the parent.
Involuntary removal of suicidal students. College campuses make it clear to students that they should seek help when feeling depressed or suicidal. Some students, however, believe they have paid a price for taking the school up on that offer, having been involuntarily evicted from campus housing for seeking counseling for suicidal ideation or attempted suicide. Others report they have been suspended because they sought treatment for severe depression (Capriccioso, 2006, para. 2). This raises disturbing ethical questions about possible civil rights violations of mentally ill students.

Jordan Nott is one such student. In 2005, he felt suicidal, and went to the hospital on the campus of George Washington University (GWU), where he was a student (Capriccioso, 2006, para 12). The hospital staff was in touch with university administrators. Shortly after his admission, Nott was told by GWU administrators that he needed to leave his dorm room. Nott was then told, just 36 hours after his admission, “he had to withdraw from the university or face suspension, expulsion, or criminal charges” (para. 13). GWU felt that Nott had been in violation of the Code of Conduct, which prohibits “endangering behavior,” which could be in the form harm to others or oneself (para. 14).

As a result, Nott brought a lawsuit against GWU for violating federal antidiscrimination laws. The university settled in a confidential agreement (Lewin, 2007, para. 10), so regrettably, this suit did not create case law that could inform the practices for other colleges and universities. Were Nott’s best interests served? Were those of his classmates? Nott’s lawyers at the Bazelon Center for Mental Health Law in Washington believe that the best solution is to “encourage students to seek mental health treatment if they need it, to remove any barriers to their getting help, destigmatize it, and make it safe so they know there won’t be negative consequences” (para. 15).
According to Gary Pavela, college administrators must “focus on the best practices in preventing student suicide without resorting to the hair trigger response of removing students who make any suicidal gesture” (Capriccioso, 2007, para. 12). Pavela added that “our primary job is to educate students, not devise creative ways to dismiss them” (para. 12).

**Critique of the literature.** I strongly endorse Gary Pavela’s perspective on working with and helping suicidal students, rather than punishing them by summarily dismissing them. I recognize that there must be a balance between campus safety and a suicidal student’s right to remain on campus. However, I believe that if campus administrators better educate their staffs on mental health issues and the instances when one may break FERPA, students will be better served.

**Implications of the Literature**

The only bright side to the tragedy at Virginia Tech is that the incident forced a much-needed national discussion about students with mental health issues. This review of a diversity of literature regarding current practical, legal, and ethical considerations related to mental health issues should be used by student affairs professionals, who are on the frontlines of this discussion, to shape proactive policies at colleges and universities around the nation. At the same time, this review of the literature shows there are several areas that stand to benefit from further study.

**Recommendations for Further Study**

*Identity theories tailored to college student students with mental health challenges.* As noted earlier, the spectrum of mental health disorders, and well as the complete diversity of students struggling with the disorders, make concrete categorization difficult. Further, some students will have a permanent psychological condition, whereas others face situational mental
health challenges. Despite this, some commonalities exist, especially with respect to identity issues. Scholars trained in psychology are best suited to explore the development of a broad identity theory that will assist student affairs professionals in their helping roles. For example, an depression identity theory might assist student affairs educators when consulting with a student who may be displaying signs of depression.

_Data sets that correlate with the population._ Referring to the American College Health Association’s 2007 National College Health Assessment (Appendix A) again, not only did the data over-represent white students, the data over-represented younger, traditionally-aged students, too. Scholars point to the changing population (Silverman, 2008), and express concern that current data does not accurately represent the reality on many campuses, where students are older and multi-racial and ethnic.

Empirical research studies are long and expensive, and because of this, they cannot account for every population shift. Further, other scholars can often find legitimate problems with even well respected research, such as the 2003 Benton et al. study (Sharkin & Coulter, 2005). Despite this, I argue for focused studies on specific populations within the broad category of mentally ill college students. Specifically, I would recommend a national survey of students of color and their experiences seeking treatment for mental health concerns. Additionally, I would conduct smaller surveys that evaluate non-traditional students.

_Support for basic counseling training for non-counseling staff._ Counseling centers are overwhelmed with students, and wait times are often long. Undoubtedly, some students who struggle with a mental health challenge do not seek treatment because they cannot be seen in a timely fashion, or because they are embarrassed or ashamed to seek help due to the stigma
surrounding mental illness. Campus non-counselors can fill an important niche in this regard—not to supplant counseling centers, but to supplement them.

At the same time, most campuses do not seem motivated to enlist an organized corps of frontline help. Even graduates of professional preparation programs would benefit from continued education on counseling skills, which should be coordinated through the campus counseling center. Regrettably, for the most part, schools seem to react after a critical incident. Then they become motivated to implement certain strategies, such as behavioral intervention teams (BITs) that usually consist of the campus judicial officer, the campus police, someone from residence life, and a representative of the counseling center (Lewis, 2007). While BITs represent an important preventative component of campus safety, I argue campuses would be well served to train their staffs as another preventative—and helping—measure.

A self-motivated student affairs practitioner can find some literature to assist them when helping a struggling student (Appendix B). However, campuses should initiate training that also includes a thorough discussion of legal issues.

One way to implement an ongoing counseling skills training would be to offer a one-week summer workshop to faculty and student affairs professionals, conducted by the counseling center and in conjunction with members of the campus BIT. Counseling micro-skills, such as listening, demonstrating empathy, and knowing when to refer a student to the counseling center, would be taught. A pilot of this program could be initiated with campus advisors, given their proximity to and close working relationships with students. After an initial pilot, the training would be offered to other interested educators.

Additionally, students who have bipolar disorder or schizophrenia likely face more of a stigma than does someone with an eating disorder or depression. Helping to reduce the stigma
associated with less common but serious mental health issues is an area where student affairs professionals can be effective. Educating other members of the campus community, being sensitive to the needs of mentally ill students, and knowing campus resources can effect positive change on the campus climate for all students.

In a pilot program at Utah State University, a Web site is being created that will offer resources to faculty and staff. Additionally, a marketing campaign that will be presented to students and other campus constituents will attempt to create awareness of the breadth of the mental health issue, and at the same time, reduce the stigma associated with mental health disorders.

Conclusion

This paper has served to address legal, ethical, and practical issues surrounding students who struggle with mental health challenges. Students with mental health issues are not just the purview of the counseling center. Student affairs professionals in advising, the student conduct office, housing, and financial aid—those on the frontline—may be the first to recognize that a student is in trouble; we are all close to the ground to students. We can also help by becoming educated and not stigmatizing mental illness. While the shootings at Virginia Tech were shocking and tragic, they were the exception, thankfully. Student suicide is all too common, however. As student affairs professionals, we must work to help our most vulnerable students, and move them from the margins to a place where they feel they matter, whether they suffer from mental illness or not.
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Appendix A: American College Health Association, 2007 National College Health Assessment

**Depression Survey** (20,507 respondents nationally)
Students reported experiencing the following within the last 12 months:

<table>
<thead>
<tr>
<th>Feeling overwhelmed by all they had to do</th>
<th>Percent%</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>14.5</td>
<td>5.0</td>
<td>8.4</td>
<td></td>
</tr>
<tr>
<td>1-10 times</td>
<td>65.7</td>
<td>63.9</td>
<td>64.5</td>
<td></td>
</tr>
<tr>
<td>11+ times</td>
<td>19.9</td>
<td>31.2</td>
<td>27.1</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Feeling exhausted (not from physical activity)</th>
<th>Percent%</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>17.8</td>
<td>7.6</td>
<td>11.2</td>
<td></td>
</tr>
<tr>
<td>1-10 times</td>
<td>62.3</td>
<td>65.5</td>
<td>64.4</td>
<td></td>
</tr>
<tr>
<td>11+ times</td>
<td>19.9</td>
<td>26.9</td>
<td>24.3</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Feeling very sad</th>
<th>Percent%</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>32.5</td>
<td>18.6</td>
<td>23.5</td>
<td></td>
</tr>
<tr>
<td>1-10 times</td>
<td>57</td>
<td>67</td>
<td>63.5</td>
<td></td>
</tr>
<tr>
<td>11+ times</td>
<td>10.5</td>
<td>14.4</td>
<td>13</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Feeling things were hopeless</th>
<th>Percent%</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>45.2</td>
<td>34.8</td>
<td>38.5</td>
<td></td>
</tr>
<tr>
<td>1-10 times</td>
<td>45.9</td>
<td>54.9</td>
<td>51.7</td>
<td></td>
</tr>
<tr>
<td>11+ times</td>
<td>8.9</td>
<td>10.3</td>
<td>9.8</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Feeling so depressed it was difficult to function</th>
<th>Percent%</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>62.1</td>
<td>54</td>
<td>56.8</td>
<td></td>
</tr>
<tr>
<td>1-10 times</td>
<td>31.5</td>
<td>38.6</td>
<td>36.2</td>
<td></td>
</tr>
<tr>
<td>11+ times</td>
<td>6.4</td>
<td>7.4</td>
<td>7</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Seriously considering attempting suicide</th>
<th>Percent%</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>90</td>
<td>89.7</td>
<td>89.7</td>
<td></td>
</tr>
<tr>
<td>1-10 times</td>
<td>9</td>
<td>9.3</td>
<td>9.3</td>
<td></td>
</tr>
<tr>
<td>11+ times</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Attempting suicide</th>
<th>Percent%</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
College students reported diagnosed with depression

<table>
<thead>
<tr>
<th>Percent%</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>10.9</td>
<td>18.8</td>
<td>16</td>
</tr>
</tbody>
</table>

*Of those students reporting ever having been diagnosed with depression in the item above...*

<table>
<thead>
<tr>
<th>Percent%</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosed with depression in the last 12 months</td>
<td>34.2</td>
<td>40.4</td>
<td>39.2</td>
</tr>
<tr>
<td>Currently in therapy for depression</td>
<td>17.3</td>
<td>25.8</td>
<td>24.2</td>
</tr>
<tr>
<td>Currently taking medication for depression</td>
<td>27.5</td>
<td>37.9</td>
<td>35.8</td>
</tr>
</tbody>
</table>

**Demographics**

- **Age:**
  - Average Age: 22.6
  - Median: 20
  - Std Dev: 7.33

<table>
<thead>
<tr>
<th>Age</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-22</td>
<td>53%</td>
</tr>
<tr>
<td>21-24</td>
<td>28.5%</td>
</tr>
<tr>
<td>25-29</td>
<td>8.1%</td>
</tr>
<tr>
<td>30+</td>
<td>10.4%</td>
</tr>
</tbody>
</table>

- **Sex:** Female, 63.2  Male, 33.1  Missing, 3.6

- **Students describe themselves as:**
  - White 75.2%
  - Black 4.7%
  - Latino or Hispanic 6.9%
  - Asian or Pacific Islander 9.3%
  - American Indian/Alaskan Native 1.6%
  - Other 3.9%
Appendix B: Range of Advising and Counseling Interventions

Range of Advising and Counseling Interventions

If Concern Is Developmental
• Assist in self-exploration.
• Explore alternatives.
• Assist in identifying desired goals.
• Assist in devising a plan of action to accomplish goals.
• Identify resources and services.
• Provide information.
• Teach specific strategies or techniques.
• Refer to established program especially designed to address issue.
• Provide encouragement, reassurance, and support.
• Provide positive feedback.

If Nature of Concern Is Unclear
• Act as a sounding board as a means of facilitating exploration of the concern.
• Respond to student in ways that communicate empathy, respect, genuineness, and concern.
• Encourage active problem solving.
• Confront student about incongruence between behavior or talk and actions.
• Decide whether concerns are basically developmental or remedial in nature and proceed appropriately.

If Concern Is Remedial
• Show concern and willingness to listen.

Source: Adapted from Ender and Winston (1982)

addressing concern.
• Describe available resources for dealing with concern.
• Offer information and assistance in initiating contact with appropriate referral source.
• Offer encouragement and support.

If there appears to be a danger to self or others, take extraordinary measures to assure that student receives assistance from appropriate professionals.
• If there appears to be danger to self or others, take extraordinary measures to assure that student receives assistance