Ethical Issues and the Delivery of Mental Health Services to College Students

>> Jeffrey Guina, M.D., Jerald Kay, M.D.

As college mental health services expand and become more sophisticated, special attention should be given to the ethical issues involved in the delivery of these services. College mental health care providers have a responsibility to help colleges develop policies and services that assure the best interests of students. Ethical and legal standards must be understood and applied to college policies for the mentally ill, the delivery of mental health services, confidentiality guidelines, parental notification guidelines, and provider-patient relationships.

Mental health services in institutions of higher education (hereafter referred to as “colleges”) have grown dramatically in recent years. This growth has resulted from increased mental health awareness and health care advances, and, unfortunately, has often resulted in response to tragedies. Although rare, prominent murder-suicides have shocked the public, leading to calls for colleges to protect the mentally ill and potential victims. These public demands have also resulted in improved services for more common, though less publicized, mental health concerns such as depression, substance use and eating disorders, which can also be responsible for devastating tragedies.

Expansions in college mental health services necessitate increased attention to ethical issues involving college policies for the mentally ill and the delivery of these services. The structure of services, confidentiality, parental notification guidelines, and provider-patient relationships should be under constant review. Psychiatrists, psychologists, counselors, social workers, and nurses (hereafter referred to as “providers”) have a responsibility to help colleges assure that ethical and legal standards are met.

Policies for Mentally Ill Students

Colleges have been increasingly called to manage mentally ill students, especially those at risk of suicide or violence. While appropriate interventions can reduce these risks, it can be difficult to balance student safety and independence. Providers are bound by ethical principles to respect patient independence (autonomy) and avoid prejudicial bias (justice). Autonomy and justice have been legislated in the Americans with Disabilities Act (ADA) so that public institutions, including colleges, must enact policies that respect these principles for mentally ill students.

The ADA is a federal law which prohibits institutions receiving federal, state, or local government funding from discriminating against any “qualified individual with a disability… by reason of such disability” and requires these institutions to support the ability of disabled individuals to participate in provided services or activities. Because “qualified individual” is defined as meeting “essential eligibility requirements” for activities, disabled students cannot be considered discriminated against if excluded from college activities for not meeting academic criteria or technical criteria, or difficulty concentrating due to Attention Deficit Hyperactive Disorder). If an accommodation is requested, colleges are required to meet with the student to determine “reasonable accommodations… to provide students who have disabilities with an equal opportunity to meet academic and technical standards so that they remain and succeed in school.” Accommodations that fundamentally change an activity or cause undue financial burden are not considered “reasonable.”

Ineffective and Unethical Policies

Fear or misunderstanding of mental illness and fear of liability sometimes cause colleges to question the clinical judgment of providers, inappropriately interfere with treatment, or impose harsh disciplinary policies. These actions can harm students and discourage others from seeking help. They are often ineffective, unethical, and even illegal.

Some colleges have enacted disciplinary policies for students reporting suicidal thoughts or behaviors. Colleges may argue that disciplining self-harm behaviors (e.g. cutting, purging) is based on conduct, but this reasoning ignores that behaviors can be symptoms of mental illnesses (e.g. mood disorders, eating disorders), which makes the ADA applicable. While colleges may believe they are acting in students’ best interests, they are often increasing risk of harm by punishing students for being honest about troubling thoughts, which college officials may find to be surprisingly common (about 10% of college students report suicidal ideations). Suspending suicidal students isolates them from friends, providers, the college structure, and other support systems during crises, and may actually increase suicide risk.

There have been several lawsuits challenging college policies of involuntary leaves of absence for mental illness. Both Doe v. Hunter College in 2004 and Nott v. George Washington University in 2005 involved students who were placed on involuntary leaves after being admitted to psychiatric hospitals for suicidal thoughts or behaviors. Both cases were settled out of court. Since Nott v. GWU, Virginia law now prohibits disciplining students for suicidal attempts, thoughts, or behaviors.

Automatic, absolute, and “zero tolerance” policies regarding mental health should be avoided in favor of case-by-case assessments of students. Involuntary leaves of absence, mandatory assessments, and mandatory treatment are ADA violations if a student is not a “direct threat.” Colleges often misinterpret suicidal thoughts or self harm behaviors as sufficient to be deemed a “direct threat,” but individual assessments are still necessary. Sufficient assessments are performed by objective providers without conflicts of interest who consider duration, severity, probability, and immi-

2012 Spring Issue, Volume 13 7
Severe measures like involuntary leaves should only be taken when, despite accommodations, consideration of less restrictive alternatives (e.g., encouraging voluntary leaves) and after due process, students are determined to pose a direct threat to themselves or others. If decision-makers are well trained and foresight is put into guidelines, these requirements can be met in cases of imminent threats.

**Effective and Ethical Policies**

Ethical policies for mentally ill students consider the best interests of students and are based on individual assessments of student safety. Colleges that implement responsible suicide prevention programs, provide employees with suicide prevention training, and provide employees access to providers for consultation are unlikely to be found liable for failure to prevent suicide. Moreover, professors, resident advisors, and students should have a mechanism for reporting suicidal concerns. Training must be adequate as not to shift the burden of suicide screening to the untrained (e.g., residence hall advisors). Providers can help with this training. Finally, colleges should encourage student support groups (such as those advocated by Healthy Minds). These groups create a support system for students, allow them to learn about helpful resources from each other, and can prevent tragedies (students are often aware of problems before providers or college officials).

In order to specifically assess high-risk students, colleges have begun to use risk management committees more frequently. Membership on the committee varies based on a college’s decision-making structure, but helpful members may include student affairs, disabilities services, student support services, legal counsel, campus police, and providers. Committees often meet weekly to collaboratively prepare guidelines for crises, gather information, follow high risk students, refer students to resources, intervene to prevent crises, and intervene during crises. The Department of Education encourages colleges to have these committees.

While providers should be involved in risk management committees, their involvement should be limited by ethical considerations. Providers should be involved with helping colleges develop policies that improve student wellbeing (beneficence), avoid harm (nonmaleficence), and meet legal standards. However, providers must be mindful of ethical and legal restraints, realizing they often can only serve as a liaison providing general guidance. “Dual relationships” – acting as both provider and college decision-maker – are unethical. Providers cannot gather patient information for treatment purposes and then use that information to make administrative decisions for the college. When providers act as college decision-makers, the ethical principle of veracity requires truthfulness with patients, making contractual arrangements explicit, making the limits of confidentiality clear, and not suggesting that the meeting is for treatment purposes.

Many argue that providers have an obligation to seek changes to harmful policies. Providers can serve in educational and consultation roles to colleges. In cases of conflict, it is appropriate for providers to remind college officials about professional obligations, ethical standards, and legal requirements. Various options should be explored and possible outcomes considered. Open communication is the best way to assure students’ best interests are the top priority.

**Structuring Services**

When delivering mental health services, colleges may either provide integrated or separate services (e.g., psychiatric, psychological, counseling, social work, medical, and nursing services). Each poses unique problems and benefits, but the primary concern should always be patient care.

Integrating can provide cost savings by improving efficiency and providing students with the simplicity of a “one-stop shop” that is less likely to deter seeking care or following up. However, varying professional philosophies can sometimes cause conflicts (e.g., counseling staff may feel resentful if treated like an ancillary service rather than an integral part of the health care team). Nonetheless, conflicts can be mitigated to a large extent with a clear, coherent administrative reporting structure that fosters communication, mutual respect, and a shared mission statement.

Providing separate, parallel services allows for separate mission statements based on varying philosophies and goals. Employee morale may improve, but accessibility can suffer for students seeking multiple services in a seemingly disjointed system. Students may “fall through the cracks” if referrals fail or important information is not communicated from one service to another. Problems can be prevented, in part, with active communication between services and integrated electronic record systems.

**Confidentiality**

Privacy is a chief concern for students seeking mental health care. Students may avoid services if they fear private information will be given to or taken by unintended recipients such as college officials, parents, other students, or even other providers. Public concerns about mental health have put pressure on providers to disclose student information to parents and college officials. Because of confusion about what legal rights students have, providers must educate themselves and college officials about the importance of and exceptions to confidentiality.

It is important to remember, first and foremost, that maintaining confidentiality can save lives. Students should feel safe to share personal and sometimes painful or embarrassing information with providers. In small communities like many colleges, there can be deep fears that information will be shared with others. Students will be unlikely to seek help if afraid it will impact their social lives, educations, or ambitions. If mentally ill students fail to seek treatment, their symptoms may worsen and increase safety risks. If students seek help and an inappropriate breach of confidentiality occurs, the added stress may increase safety risks and can deter others from seeking help.

Nevertheless, there are appropriate exceptions to confidentiality. In general, exceptions involve risks of harm to the patient or others. These exceptions depend on federal laws, state laws, case law, and professional ethics. Among the laws, colleges must comply with whichever has the strictest requirements.

Patients should be told the limits of confidentiality in advance. Colleges in Colorado and North Carolina have done this with “psychiatric advance directives” which patients can sign at the onset of therapy to consent for disclosure to emergency contacts in the event that they become safety risks.

Providers can help ensure that ethical and legal standards are met by taking an active role in developing college confidentiality procedures and training college employees. This can prevent confusion, legal misconceptions, and mistakes during crises. When in doubt, responsible providers always err on the side of safety.

**Confidentiality in Federal Law**

While confidentiality should generally be preserved, both the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act (HIPAA) do allow for disclosure of information to protect health and safety. This is true despite common misperceptions.

FERPA is a federal law that restricts educational institutions receiving federal funding from disclosing education records without student consent. However, there are several exceptions, and some apply to mental health: to comply with judicial order or subpoena, to parents if a student is confirmed to be a dependent for federal tax purposes, and “disclose reasonably directed toward avoiding harm to the student or others.” Moreover, “education record” does not include health care records that are “made, maintained, or used only in connection with treatment,” making most student patient records exempt from FERPA. However, if information from a record is used for anything other than treatment (e.g. college requested risk assessments), FERPA applies.

HIPAA is a federal law granting the federal government the power to regulate the use of personal health information by health care services.
Hippa also has exceptions for the disclosure of information without consent: child abuse or neglect, domestic violence, criminal investigations, judicial proceedings, and for public health and safety. However, it is important to note that HIPAA only applies to health care services that collect fees or submit insurance claims electronically. Because most college mental health services do not bill for third party reimbursement, HIPAA does not apply.

Confidentiality in State Law, Case Law, and Professional Ethics

While FERPA and HIPAA are often cited, the above exemptions indicate their limited role in college mental health. Therefore, it is important to understand state laws, case law, and professional codes of ethics, which together are the primary protections of student patient privacy.

Because laws vary between states, it is important for colleges and providers to have legal counsel. There are some similarities among the states. For example, like federal law, all states allow disclosure of confidential information for risk of harm to the patient or others.

Case law has often challenged societal assumptions about who is responsible for college student safety. The most well-known case is Tarasoff v. Regents of the University of California, which set the legal precedent for disclosure of confidential information to prevent patients from harming others. After a college student told his psychologist that he intended to kill Tatiana Tarasoff, a girl he had been stalking, the psychologist called the police and the patient was hospitalized. However, upon release, the student murdered Tarasoff. Her parents sued the psychologist for not warning their daughter. The Virginia Tech shooting in 2007, Virginia College in 2005, Mahoney v. Allegheny College in 2005, but none have deemed a college liable for a suicide or drug overdose (though some have settled out of court).

Parents often expect to be informed about mental health issues involving their children, even if they are legal adults. This places providers in the difficult position of balancing the rights and expectations of patients, parents, colleges, and the public.

Most college students are legal adults, protected by confidentiality laws. Nevertheless, parents typically remain involved in students’ lives and have a high expectation of colleges regarding safety. Sometimes this expectation includes wanting access to student information. Since the Virginia Tech shooting in 2007, Virginia state law has required parental notification when students seek college mental health services and are deemed a safety risk. Many argue that the recent anxiety-driven push to relax confidentiality is shortsighted and likely to have unintended consequences. Students are less likely to seek care if they believe discussing troubling thoughts will result in unwanted parental involvement.

There are appropriate reasons for disclosing confidential information to parents. Under most laws, student patient records can be disclosed to parents if students are a safety risk, if there is a high likelihood that telling parents will decrease the risk, and if there is a low likelihood that telling parents will increase the risk (nonmaleficence). Many providers find that students will agree to parental notification if there is a strong therapeutic relationship and good communication.

However, in the rare exceptions that students will not agree, the foresight of providers and college officials designing guidelines for parental notification based on ethical and legal standards can prevent confusion and mistakes during crises.

Sexual Misconduct

The ethical principle of nonmaleficence prohibits providers from exploiting patients or engaging in inappropriate relationships. Therapeutic boundaries must be maintained to prevent boundary violations that cause harm to patients. To assure competent care, it is the responsibility of providers to examine their own conduct and its effect on patients. Engaging in sexual behaviors with current or former patients is unethical. Even in cases that are seemingly consensual, the power differential and asymmetric level of knowledge in therapeutic relationships make any sexual contact exploitation. These violations interfere with treatment and the patient’s ability to recover from what brought them to seek help in the first place. The trauma of such violations can result in increased rates of depression, suicide, anxiety, patients entering other abusive relationships, and an inability to ever seek help in the future. Providers engaging in sexual misconduct inevitably ignore the patient’s needs in favor of their own.

Most psychotherapists are sexually attracted to a patient at least once in their careers – which is normal – and most never act on their feelings – which would be abnormal, unethical, and illegal in nearly every state. These feelings can evoke anxiety, confusion, guilt, and even anger or resentment. It is helpful for providers to be aware of their own feelings (countertransference) to prevent inappropriately acting on them. It is also helpful if training programs prepare trainees for the likely occurrence of these natural feelings. Despite attempts to remove the taboo status for the likely occurrence of these natural feelings. Despite attempts to remove the taboo status
Training Programs

Colleges with mental health care training programs (e.g. psychiatry, psychology, counseling, social work, and nursing) offer the chance for mutual benefit for patients and trainees. It is the responsibility of training programs to help familiarize trainees with ethical and legal standards as well as college policies regarding high risk students.

Professional expectations should be explicitly communicated to trainees (as well as staff). Because trainees are often attending the same college as their patients, there are increased possibilities for interactions outside treatment. This makes education about ethical and legal standards (especially confidentiality and sexual misconduct) even more important.

While trainee education is important, patient care must always be the primary concern. Programs can prevent inadequate care with active supervision, regular evaluations, and by screening patients. Knowledgeable supervisors should oversee care, be on-call to provide assistance, regularly evaluate trainee competence and intervene when appropriate. Potential patient screening by supervisors can prevent trainees from seeing cases deemed inappropriate for their training level, which can then be seen by more experienced trainees, staff, or referred to appropriate services. However, overprotective screening can leave trainees less capable of handling difficult cases in their future careers, so they should be allowed to earn more complex cases as they gain experience and demonstrate competency.

Trainees must learn to identify and assess risks. When patients have safety risks, trainees must be comfortable with referring to appropriate services (e.g. community crisis care, emergency medical services, police). It can be helpful to provide trainees with seminars and handbooks including information about appropriate conduct, confidentiality, proper reporting of safety risks, and resources for less acute cases (e.g. tutoring services).

Research

Research can be important for the advancement of knowledge, treatment, professional improvement and education purposes in training programs. In clinical research, the primary concern should be patient safety. A student’s role as a patient should supersede the role as a research subject. Providers must avoid a dual relationship that places their responsibility to the patient in conflict with research goals. This necessitates that all research be voluntary, not a requirement for students to be treated, and strictly follows legal and college standards for research.

Conclusion

College can be a stressful time for any student, but it is also the most common time of onset for many mental health concerns (e.g. schizophrenia, bipolar disorder, major depression and substance use, to name a few). Because of the high prevalence of depression, eating disorders, anxiety, and substance use (most notably, binge drinking) among students, colleges should put considerable foresight into decisions regarding how to deliver mental health services.

The purpose of college is to allow students to learn and grow. Simultaneously, there is a public expectation that colleges will keep students safe. It can be difficult for colleges — the same way it is for parents — to balance safety and structure with autonomy and privacy. Finding this balance should be guided by ethical and legal standards. Providers can help college be familiar with these standards and assure that colleges implement policies based on the best interests of students.

References


Authors

Jerald Kay, M.D., has served as chair of the Department of Psychiatry at Wright State University Boonshoft School of Medicine for over 20 years. He received his B.A. in religious studies and classics from Washington University in St. Louis, graduated from the University of Maryland School of Medicine, and completed his general and child and adolescent psychiatry residencies at the University of Cincinnati. He has published numerous papers, book chapters, and books on various topics.

Jeffrey Guina, M.D., is a Psychiatry Resident at Wright State University Boonshoft School of Medicine in Dayton, Ohio and Wright-Patterson Air Force Base Medical Center. He received his B.S. in biochemistry and B.A. in history from the University of Detroit Mercy and graduated from Wayne State University School of Medicine in Detroit.