# GUIDELINES FOR RESPONDING TO STUDENTS IN CRISIS AT THE UNIVERSITY AT ALBANY

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# GUIDELINES FOR RESPONDING TO STUDENTS IN CRISIS AT THE UNIVERSITY AT ALBANY



## STATEMENT OF PURPOSE

These guidelines are intended to assist faculty, professional staff, administrators and other University employees to address student related crises.  While some campus officials play more active roles in responding to student crises, it is important for all University faculty and professionals to have a working knowledge of these guidelines. The Campus' Clery Report (Annual Security Report) also contains valuable information for the University community when responding to a crime on Campus.   The Clery Report may be obtained at http://police.albany.edu/ASR.htm.

January 2009

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**PART I**
**INTRODUCTION**
In any setting, a crisis requires both quick thinking and a coordinated, efficient response. At the University at Albany, we may be presented with a number of such challenges, including student deaths, suicide attempts, the impact of major stressors such as the loss of friends or family members, disruptive behavior in classrooms, residence halls, and other parts of the university community, and other crises.

When a student in the university community is facing a crisis, the entire university may be affected. Therefore, it is critical that a basic framework exist to enhance coordinated efforts that protect the safety and well-being of the student in crisis and each member of the campus community. The primary goals of these crisis response strategies are:

1) To provide support and assistance to the student in crisis and to insure their safety and the safety of others.

2) To respond, as confidentiality regulations permit, to persons or groups such as:

- the student's parents, legal guardians, and/or significant others;
- the student's friends, roommates, suitemates, and hall residents;
- various University offices that may provide services and support to the student and other affected members of the University community;
- the University and surrounding Albany communities, as appropriate.

3) To address system-wide issues surrounding the crisis.

4) To work toward the prevention of similar crises in the future.

Please keep in mind that the strategies listed in Part II are not all-inclusive. As additional needs for specific intervention strategies arise, these additions/modifications will be addressed by the University at Albany's Behavioral Risk Assessment Team (Brisk), the College/University Behavioral Intervention Team (C.U.B.I.T) or the Serious Case Management Team (see Appendix A). In addition, the Campus' Clery Report (Annual Security Report) contains valuable information for the University community when responding to a crime. The Clery Report addresses a number of issues, including how to report a crime on campus, who on staff must report a crime, crime prevention programs on campus and resources and services available to students, faculty and staff who are crime victims, who have witnessed a crime or who are assisting those victims and witnesses. The Clery Report may be obtained at http://police.albany.edu/ASR.htm.

## CONFIDENTIALITY

University staff members who respond to crises must remain aware that students have a right to privacy and that, in some instances, they may not wish to have information shared with others. At the same time, there are situations in which it is necessary and legally permissible for professional staff, faculty members and other members of the community to release information. For example, information should be disclosed to appropriate individuals in connection with an emergency when the knowledge of such information is necessary to protect the health or safety of the student or other individuals. In other situations, the need to release information without the permission of the student is less clear and, in such cases, the Office of the Vice President for Student Success or the Office of the University Counsel should be consulted. In any situation, it is best to attempt to obtain the student's permission to release information.

Different University records are subject to varying standards of confidentiality. For example, University Counseling Center records are subject to stricter standards of confidentiality under state law than many other kinds of records. The general principle is that such records should not be released without the written permission of the individual to whom the record pertains. There are a few exceptions to this principle, most notably, as mentioned above, records may be released to appropriate persons and entities when necessary to prevent serious harm to the client or another person.

## JUDGMENT

Any staff member involved in a crisis at the University must use his/her own best judgment regarding how to respond. Questions which should be addressed include:

1) Which issues require immediate action?

2) What else should be done for the student in crisis?

3) Who else may be affected, and what support is available for them?

4) Who should be notified?

These questions must be answered quickly in an emergency. When in doubt, consult with other professionals.

## COORDINATION

Crisis prevention, intervention and post-intervention involve a number of different units of the University that typically communicate with each other and share responsibility for intervening and deciding who else to involve. In general, the Office of the Vice President for Student Success will coordinate notification and crisis intervention services but, in some specific cases, other offices might be more appropriate for coordination (e.g. the University Counseling Center, the Office of the Vice Provost for Undergraduate Education, the Dean for Graduate Studies, etc.).

Coordination of services involves a number of steps that include:

1) Assessing the situation, with particular attention to the nature and extent of the crisis;

2) Identifying person(s) who may need support;

3) Determining who will provide direct and indirect services;

4) Informing appropriate individuals or offices of the situation;

5) Following up with individuals and offices about what action they will take;

6) Following up to assess the impact of interventions;

7) Determining whether or not future action is necessary;

At the discretion of the Office of the Vice President for Student Success, a post-intervention review committee may be convened. If this is the case, persons who were involved in responding to this crisis, including all back-up and support services, will be involved in the review. In addition, persons affected by the crisis will be invited to provide feedback regarding the response.


## SUPPORT

Support may be provided to a student in crisis through a number of methods. Since students in crisis are often more receptive to intervention, staff members may use this opportunity to help them learn from their experiences. Students who are in crisis may benefit from personal, academic and/or financial support. Providing support is a responsibility that can be shared among staff members, family, friends, and other persons. As part of a broad-based umbrella of support, a student can be referred to such services as the University Counseling Center, the Office of the Vice Provost for Undergraduate Education, the Office of the Dean for Graduate Education, the Department of Residential Life, Financial Aid, and other units as appropriate (See Appendix B for a listing of resources).

The following steps, adapted from Suicide Prevention and Crisis Service, suggest a framework for providing support in a crisis.

1) Stay Calm. Since a person in crisis may lose perspective, it is important that the responder stay calm so that the situation can be assessed and an intervention planned.

2) Make contact at a feeling level rather than a factual level. As crises often involve loss or grief, it is important to try to identify feelings that the student may have, such as anger, sadness, and hopelessness. Keep in mind that the student has a right to experience his/her feelings, and try not to rush the student through this phase. Stay attuned to your responses to the feelings, and try to respond without being judgmental or dogmatic.

3) Explore the current problem. Focus on your past interactions with the person in crisis and try to identify what might have occurred to precipitate the onset of the crisis. Ask open-ended questions, and encourage the student to be specific.

4) Summarize the problem.  Here it is appropriate to use the form "I hear you saying…" in letting the student know how you understand the problem.  Ask the student if you are summarizing the problem correctly.

5) Focus on amelioration and explore resources.  It is important to ask the student about what resources/willingness they have to resolve the crisis.  Questions can focus on the nature of the student's support system, the positive things in their life, and their willingness to seek appropriate assistance.

6) Write it down.  Make a written summary containing steps that the student will take to help him/herself through the crisis period.  This can help the student by emphasizing options and provide a reminder that h/she can carry with them.

7) Consult.  If there are any questions, please contact the University Counseling Center (442-5800 or consultation@albany.edu) or the Chair of the C.U.B.I.T (Appendix A).

Support may also be provided to students in the academic and financial areas.  For example, if the close friend of a student dies suddenly or if the student is the victim of a fire, the Division of Academic Affairs (Dean for Graduate Studies or Vice Provost for Undergraduate Education) can be notified of this situation, which may result in the student's being permitted to take incompletes or withdraw from all or some courses.  Likewise, if the parent of a student dies suddenly, causing financial problems for the student's family, the Office of Student Financial Services can be contacted to approve alterations in the billing schedule.

Below are listed some possible methods of response to student crises that can be made by academic staff.  When appropriate, academic chairpersons and/or deans should be consulted.
1) Recommending psychological counseling services;
2) Extending a deadline;
3) Offering special tutoring, make-up work, or examinations;
4) Excluding one or more test grades from the final grade computation;
5) Computing the final grade or class standing,
    without all work being completed;
6) Facilitating a personal or medical withdrawal by contacting the Vice Provost for Undergraduate Education.

In the case of financial crisis, the Office of Student Financial Services may be able to assist by suggesting whom to notify in order to alter payment schedules, receive emergency funds, or facilitate other arrangements.

**What to do in response to immediate danger to self or others?**
The University Police Department (UPD) is responsible for maintaining the safety and well-being of all persons at the University at Albany.  In the event of a dangerous or hazardous condition, such as physical danger due to potential violence or suicide, bomb threats, or similar situations, call UPD at 911 (from an on-campus phone) or 442-3131 (from a cellular phone or off-campus phone).

**RESPONSE STRATEGIES FOR SPECIFIC CASES**

- Student Death
- Attempted Suicide In Progress
- Threat Of Harm To Self Or Others
- Arrest Or Incarceration
- Disruptive Behavior
- Other Crises

**STUDENT DEATH**

In crisis situations, the primary concern is saving human life. Therefore, first render aid and summon medical assistance for injured people at the scene. Please be aware that all deaths are viewed and investigated by the police as potential homicides until determined otherwise.

The death of any student in the campus community can be a stressful event for a wide array of individuals. Until an official determination is made, the labeling of a death as suicide or homicide may complicate the matter all the more for family, friends, and other members of the University community. For this reason, great care and discretion must be employed in such cases.

Guidelines

1. Call 911 - University Police Department will alert medical personnel as needed.
   Be prepared to report your exact location.

NOTE: DO NOT DISTURB A DEATH SCENE

Remember that, unless rendering first aid, it is extremely important not to disturb a death scene. Therefore, exit the area immediately. If at all possible, secure the area in question being careful to touch as little as possible. If there is another person with you, one of you should stay at the scene while the other calls the University Police.

2. The University Police will notify:

   a) The police agency with jurisdiction where the student permanently resides, who will then inform parents, guardians, or significant others (e.g. If a student from the Bronx passes away in the residence halls, or in a classroom on the East Campus, University Police will notify NYPD who will inform parents, guardians, or significant others).
   **NOTE:** Should the incident occur "off-campus" (non-University property), the police agency with the jurisdiction for that area will inform the police agency with jurisdiction where the student permanently resides who will then inform parents, guardians, or significant others (e.g. If a student from the Bronx passes away in

the city of Albany (non-University property), the Albany Police Department/APD will contact NYPD who will inform parents, guardians or significant others)

b) The Office of the Vice President for Student Success for notification of the President and Executive staff. When appropriate the Office of the Vice President for Student Success will also notify the Office of Media and Marketing for dissemination of information to the public.

3. As soon as possible, the Vice President for Student Success will determine the need for additional support and refer to appropriate individuals or agency resources including:

a) The University Health Center and University Counseling Center for medical/psychological concerns;

b) Chapel House, who can provide pastoral services to those affected by the death;

c) Offices within the Division of Student Success, whose staff members may be able to address specialized issues if the student is a student of color, an international student, or a disabled student. Such offices may provide assistance regarding both educational and support services for our diverse population;

d) Offices within the Division of Academic Affairs, including: the Dean for Graduate Studies or the Vice Provost for Undergraduate Education, who will notify the faculty and provide assistance with academic accommodations, and the Education Opportunities Program for support of their students;

e) The Director of Residential Life, who will notify Quadrangle Coordinators for transmission of information to their respective Quadrangle staff, such as Residence Directors and Resident Assistants. Residence Hall staff will assess the residents' response to the student's death and may request support services through their supervisory channels and/or through their Quadrangle consultants from the University Counseling Center;

f) The Office of Student Financial Services, who will notify the employer on campus if the student was employed and to insure updating and appropriate management of billing records;

g) The Registrar, to update the student information system.

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NOTE: CONSULT THE NATURAL SUPPORT SYSTEM

Made up of friends, family, mentors, etc., the natural support system is both essential in providing support to its own members, and at the same time, is likely to also be in need of services. Every effort will be made to work with the natural support system to assist its members in supporting each other and in accessing the broad range of University services listed above.

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4. The Office of the Vice President for Student Success will coordinate support offered to groups affected by the death, such as the student's friends. Outreach services will be provided, as appropriate, by units such as the Department of Residential Life, the University Counseling Center, the Disability Resource Center, the Office of International Education, Chapel House, EOP, and other offices. Outreach services should address the following points:

FOR STUDENTS:

a) Make timely contact with friends of the deceased student;

b)        Encourage expression of feelings;

c)        Promote peer support among friends of the victim;

d)        Encourage campus attendance at a memorial service as appropriate;

e)        Avoid glamorization of death;

f)        Encourage resumption of routine as soon as possible.


FOR FAMILY:

a)        Accommodate as necessary.  This may include providing appropriate housing arrangements for parents and/or other family members visiting campus;
b)        Offer pastoral care;
c)        Offer brief psychological counseling as appropriate;
d)        Provide assistance in concluding University business, i.e., gathering the student's personal effects.  In this, as in all instances, sensitivity to the family's wishes and requests will be paramount.

5.      The Office of the Vice President for Student Success will work with Chapel House staff to coordinate a university-wide memorial service for the deceased student.

6.      Letters of condolence will be sent by the President's Office.

7.      At the discretion of the Office of the Vice President for Student Success, units who have played a role in crisis intervention/management of the incident will be represented to review the support strategies as well as recommendations for future response to similar crises.

## ATTEMPT AT SUICIDE IN PROGRESS

While the nature of suicide attempts varies greatly, each suicide attempt must be taken seriously.  In order to protect a student's privacy, suicide attempts should be addressed with discretion.  In all instances, the best interests of the student as well as the university's aim to protect the student's welfare must be considered paramount.

Guidelines

1. Call 911. When a suicide attempt is in progress, the University Police Department should be notified immediately by telephone.  (Issues of confidentiality do not apply when a person's life is in danger).

   In many instances a suicide attempt constitutes a medical emergency (e.g. bleeding from self-injury, confusion or coma from drug overdose).

   University Police will:
   a) Arrange for emergency medical transport by Five-Quad (call 911) or, in their absence, any one of the local ambulatory agencies which service the University or by the City of Albany Department of Fire and Emergency Services.   In most instances, the student will be transported to the Emergency Department of the Albany Medical Center Hospital.  It is the policy of the Albany Medical Center Emergency Department to assess such patients medically, and then refer them to the Capital District Psychiatric Center (CDPC) for assessment, or in some cases, to their private psychiatrist.

   b) In exigent circumstances, in order to insure the student's safety or that of another member of the campus community, a police officer may be required to take the student into custody and direct the person's transport to Albany Medical Center Emergency Department or to the Capital District Psychiatric Center (CDPC) for evaluation.  Exigent circumstances include: violence, serious injury or conduct likely to result in immediate serious harm to the student or others.

   c) In other circumstances, the police will consult with and, when possible, arrange for the Albany County Mobile Crisis Team to come to the site of the suicide attempt to conduct an evaluation. The Mobile Crisis Team is available 24 hours a day, 7 days a week.  They can be contacted at 447-9650.

   d) Notify the Vice President for Student Success, who will notify the Directors of the University Counseling Center and the University Health Center so that any necessary follow-up may be made. For example, the Director of the University Counseling Center will work with the Center staff in the event that the student who has attempted suicide might be an ongoing client of the University Counseling Center.

   Note:  Decisions about the University's notification of parents or family members will be made by the Vice President for Student Success based on:

   (1) information provided by the student about who to contact in case of emergencies, and;

   (2) the recommendations of the appropriate licensed health care practitioners as well as other professionals knowledgeable about the student and/or the circumstances.

2. After a suicide attempt, the student should be referred for appropriate follow-up mental health services.  While this is often done by the CDPC Crisis Unit, a student who is not assessed or given referrals through the Crisis Unit should be scheduled for an assessment at the University Counseling Center.  Counseling Center clinicians will, on the basis of the assessment, make treatment/referral recommendations that are in the best interest of the student.

3.  Any member of the University community who is aware of a suicide attempt is encouraged to call the University Counseling Center (442-5800 or consultation@albany.edu) for assessment of ongoing risk, assistance with follow-up treatment planning for the student and planning of appropriate interventions for those in the campus community close to the student.

4.  To provide for adequate support of the student, with the student's consent, the University Counseling Center clinician who assesses the student may do the following:
    a)  Facilitate contact with the student's parent, guardian or spouse to discuss a medical withdrawal or future treatment, if appropriate;

    b)  Consult with staff members from the Department of Residential Life if the student is living in University housing;

    c)  Consult with offices within the Divisions of Student Success, Academic Affairs, or other offices to coordinate future support services.

5.  If appropriate, the Vice President for Student Success will inform:
    a)  The President and Vice Presidents for executive notification;

    b)  The Office of Multicultural Student Services, International Education, the Disability Resource Center, EOP, or other offices as appropriate, so that further support can be provided.

    c)  The Academic Dean's Office (undergraduate and/or graduate) if special academic arrangements need to be made.

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NOTE:  Students living in the residence halls exhibiting behaviors in this category will be referred to the University Counseling Center for an evaluation within the CARENet Program (see Appendix C).

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## THREATS OF HARM TO SELF OR OTHERS

All threats of harm must be taken seriously whether the threat is assault, homicide or suicide.  It is essential that professional consultation be sought as soon as possible. No one should evaluate a threat on his or her own. Remember, when a person's life is in danger, safety takes priority over privacy.

Please note that at times threats are vague or ambiguous and/or may be aimed at a future event or time. These threats should also be taken seriously and consultation should be sought as soon as possible.

Guidelines

1. The University Counseling Center should be contacted for a consultation to assess the lethality of the threat and to coordinate a plan for intervention. Call 442-5800 or consultation@albany.edu Monday through Friday from 9:00 AM to 5:00 PM during the academic year and Monday through Friday from 8:00 AM to 4:00 PM during intersession and summer months.

2. At other times, emergency mental health consultation is available through the Albany County Mobile Crisis Team at 447-9650.  They will evaluate and dispatch a team to provide an on site assessment, as needed.  The same telephone number (447-9650) can be used to access the emergency mental health services of the Capital District Psychiatric Center Crisis Unit.  Both the Mobile Crisis Team and the Crisis Unit are open 24 hours a day 7 days a week and available to all Albany community members.

3. In all circumstances of clear and imminent danger call the University Police Department (911) for an immediate response.

4. Always remember that, when in doubt, consult with a professional.

NOTE:  Students living in the residence halls exhibiting behaviors in this category will be referred to the University Counseling Center for an evaluation within the CARENet Program (see Appendix C).

## ARREST OR INCARCERATION

When a student is arrested, such an event can precipitate a mental health crisis.  Moreover, among the student's friends and acquaintances, such a stressor may initiate a need for larger-scale crisis intervention.

Guidelines

1. Any member of the campus community who receives information about a student arrest should communicate this to the University Police Department (Please note that an arrest is considered public information.).  When the University Police make an arrest or are informed of an arrest they will notify the Vice President for Student Success, for coordination of the University's response.

2. If appropriate, the Vice President for Student Success or their designee will contact/inform the following:

   a) The student, to determine his/her need for support and/or legal counsel;

   b) The President and Vice Presidents for executive notification;

   c) The Office of Media and Marketing for public information;

   d) The appropriate offices within the University if a student is a multicultural, international, disabled, or EOP student;

   e) The Department of Residential Life if a student lives in university housing, as rumor control may be necessary;

   f) The Director of the Office of Conflict Resolution & Civic Responsibility, in the event that there is corresponding university action;

   g) Parents, guardians, or spouses as appropriate, so that they may provide assistance;

   h) The Office of Student Financial Services, so that the campus employer may be informed if the student is not returning to campus immediately.

3. If other students are affected by the arrest, the Vice President for Student Success or their designee will coordinate information and support by utilizing such resources as the University Counseling Center, the Department of Residential Life, and other offices within the Division of Student Success.

## DISRUPTIVE BEHAVIOR

Although disruptive behavior may be associated with a mental health or medical condition, it is best to focus on a student's behavior and its consequences.  This ensures that the individual's due process rights are protected.  To view the definition of disruptive conduct and the University's Community Rights & Responsibilities, please see the attached link: www.albany.edu/judicial_affairs

### Guidelines

1.   The Director of Conflict Resolution & Civic Responsibility (442-5501) should be consulted regarding the appropriateness of judicial action. He/she will provide assistance in evaluating the behavior within the context of Community Rights and Responsibilities (see Appendix D). The Director may take some ameliorative action, for example, meeting with the student to discuss a change in behavior and possible consequences should disruptive behavior continue.

2.   Except in cases of imminent danger, the University Counseling Center (442-5800 or consultation@albany.edu) should be contacted for consultation to help identify the possible presence of psychological, behavioral or substance abuse problems that may be contributing to the disruptive actions. University Counseling Center staff will facilitate intervention and support.

3.   The University Police Department (442-3131 or 911 when calling from a University phone) should be notified when a student's behavior is damaging to property or is a threat to the safety of self or other individuals.  The University Police will then take appropriate action. In some instances this might include notifying the appropriate local police force for assistance.

4.   The Office of the Vice President for Student Success should be notified by the University Police so that a coordinated response may be made regarding the student and those affected by his/her behavior.  The Vice President for Student Success or their designee will contact the following offices:

    a)   Offices of the Vice Provost for Undergraduate Education, or Dean for Graduate Studies, Residential Life, and other offices as appropriate to determine the extent of damage and disruption and to assist in identifying members of the University community affected by the disruptive behavior.

    b)   Offices within the Division of Student Success and Academic Affairs to obtain consultation if the student is a multicultural, international, or disabled student.

## OTHER CRISES

It is not possible to predict all types of crises.  In the event of a crisis that is not listed in this manual, the following general guidelines may be helpful.

Guidelines

1.  Contact the University Police at 911.  University Police, available 24 hours a day 365 days a year, will provide assistance and/or make appropriate referrals.

2.  Contact the University Counseling Center for consultation at 442-5800 or consultation@albany.edu Monday through Friday 8:30AM to 5:00PM and Monday through Friday from 8:00AM to 4:00PM during intersession and summer months.  A psychologist will respond promptly to provide consultation or other psychological services, arrange for assistance and/or make appropriate referrals.

3.  Contact the Office of the Vice President for Student Success at 956-8140 for additional assistance and support as needed.

4.  Provide whatever support you can, using the guidelines outlined in this document.

| APPENDICES |
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**Appendix A:**     **Response Teams, Telephone and E-mail List**

**Appendix B:**     **Potential Responders Telephone List**

**Appendix C:**     **CARENet Protocol**

**Appendix D:**     **Advisory on Classroom Disruption**

**Appendix E:**     **Promoting Mental Health and Preventing Suicide in College and University Settings (Suicide Prevention Resource Center Publication)**

**Appendix F:**     **Sexual Assault Protocol**

**Appendix G:**     **Responding to Victims of Crime**

## Appendix A: Response Teams, Telephone and E-mail List

BRISK

In the Spring 2008, President George Phillip appointed a Behavior Risk Assessment Committee (called BRISK), a critical decision-making and advisory group responsible for ensuring that the necessary risk assessment policies and programs are in place for the campus community.  The membership of this group extends across the University community and is chaired by Associate Vice President for Student Success, John Murphy.  This integral group has been charged with the following responsibilities:

- Develop easily accessible guides for dealing with and reporting behavioral risks;
- Ensure that a comprehensive prevention plan is developed;
- Act as a multi-disciplinary behavior assessment team for information sharing on at-risk students;
- Designate and publicize the appropriate office that should receive reports on at-risk students;
- Make clear for faculty and staff the legal and ethical guidelines for the disclosure of academic and mental health records;
- Review the current withdrawal policy for students posing an imminent risk to themselves or others and make a recommendation regarding the need for an involuntary administrative/psychiatric withdrawal policy that is consistent with legal standards;
- Review mental health training practices and opportunities for faculty and staff

These responsibilities are critical to ensuring that our University community takes every step possible to prevent violence on our campus and adequately prepares to handle emergency situations effectively.

Disruptive behaviors which do not rise to the level of a crime are best handled through a referral to the Office of Conflict Resolution & Civic Responsibility at 442-5501.  Clarence McNeill, Assistant Vice President for Student Success and Director of the Office of Conflict Resolution & Civic Responsibility is the designated point person to receive reports of disruptive behavior by students.

CUBIT

Was developed in the Spring 2008 as an ad-hoc subcommittee to the Brisk Team.  CUBIT is an early intervention team of six who meet regularly to "track" red flag behaviors with the intent on providing skilled threat assessment and intervention.  CUBIT and its membership operate within the legal parameters of Federal law (FERPA), New York State law and University policy.


Chairperson:
Clarence L. McNeill, Chair
Asst. Vice President for Student Success
Director, Conflict Resolution & Civic Responsibility
CC 361
Email: crcr@uamail.albany.edu                                                                                        442-5501

Dr. Estela Rivero, Vice-Chair
Director, University Counseling Center
Email: erivero@uamail.albany.edu or consultation @albany.edu                                     442-5800

Dr. Sue Faerman
Vice Provost for Undergraduate Education
Lecture Center 30
Email: sfaerman@uamail.albany.edu                                          442-3950

Nancy Lauricella
Asst. Director of Conflict Resolution & Civic Responsibility
CC 361
Email: nlauricella@uamail.albany.edu                                      442-5501

John Murphy
Associate Vice President for Student Success
University Hall 206
Email: jmurphy@uamail.albany.edu                                          956-8140

Janet Thayer
Associate Counsel
University Hall 105
Email: jthayer@uamail.albany.edu                                          956-8050

Serious Case Management Team

The Serious Case Management Team,  compromised of members from across both Divisions – Student Success and Academic Affairs, meets twice a month to discuss serious violations of the student code of conduct, alcohol/drug or mental health related transports and share information regarding student conduct in the residence halls.

## Appendix B: Listing of Potential Responders to Students In Crisis

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|---|---|
| CAMPUS EMERGENCY | 911 |
| (from on-campus phone) | |

| | |
|---|---|
| Academic Support Services/EOP: | 442-5180 |
| Chapel House: | 489-8573 |
| Conflict Resolution & Civic Responsibility: | 442-5501 |
| Disability Resource Center: | 442-5490 |
| Five-Quad Ambulance Service: | 911 |
| Graduate Studies: | 442-3980 |
| International Education: | 442-5495 |
| Middle Earth Peer Assistance Program Hotline: | 442-5777 |
| Police Department (UPD)          Campus emergency only | 911 |
|                                   Non-emergency | 442-3131 |
| Residential Life: | 442-5875 |
| Student Financial Services: | 442-3202 |
| Student Involvement & Leadership: | 442-5566 |
| University Counseling Center (UCC): | 442-5800 |
| University Health Center (UHC): | 442-5455 |
| Office of Undergraduate Education: | 442-3950 |
| Vice President for Student Success: | 956-8140 |

Community

| | | |
|---|---|---|
| Albany Fire Department | Emergency only ………………….. | 911 |
| | Non-emergency ………………….. | 438-4000 |
| Albany Police Department | Emergency only  ………………… | 911 |
| | Non-emergency ………………... | 438-4000 |
| Cellular Phone Emergency Calls: | | 911* |
| Capital District Psychiatric Center (CDPC) Crisis Program …………………… | | 447-9650 |
| Albany County Mobile Crisis Team…………………………………………………… | | 447-9650 |

*NOTE:  Cellular phone 911 number will ring at the State Police.  To call UPD or Albany Police directly from a cellular phone, dial the non-emergency number.

What is "CARENet"?

 "CARENet" is the acronym for a program of consultation and resource evaluation required for students who live in residence who display suicidal intent, defined as either a public suicide threat, tangible evidence that the student is making plans or preparing for suicide, or manifestations of serious self-inflicted injury.

What are the objectives of the CARENet Program?
The CARENet Program provides...
- An assessment of present suicidality;
- An evaluation of a student's willingness and ability to refrain from threatened and actual self-injurious behaviors;
- Consultation regarding needed psychiatric, psychological, and educational services;
- A procedure that intends to minimize the disruption of normal functioning for roommates and suitemates in the residence community

The CARENet Program augments existing…
- Crisis intervention services
- Psychological treatment resources for students
- Consultation with Residential Life staff and students

**Why does the University need CARENet?**
Typically, students who threaten or engage in self-injurious behaviors do so either as a form of self-management, as a mechanism for influencing others, and/or to leave an unwanted circumstance or setting. Work with college students who threaten or gesture suicide indicates that contrary to popular and conventional beliefs, often self-harm is less the product of desperation and more an issue of control. Suicide rate data indicate that a completed suicide occurs for every 12,000 students per year. Other research has demonstrated that 40 to 65 percent of those who eventually succeed in killing themselves had given clear warning of their intent in the form of having made a prior serious suicide attempt that failed, thus making demonstration of "prior suicidal intent" one of the most potent predictors of eventual suicide.  Sadly, experience with college students who threaten or gesture suicide has shown that, left on their own, an enormous number will never pursue, and sometimes reject outright, offers of help.  Again, often instead of seeing suicide as itself a problem, they use it as a viable (albeit misguided) solution to experienced problems. The University wishes to take such steps as are reasonably available to address situations that are possibly life threatening.

**How does the CARENet program work?**
In the proposed program, University residence hall students who evidence suicidal intent (as defined above) are mandated by the Director of Residential Life to participate in a single 2 hour-long session of assessment and evaluation with a University Counseling Center psychologist (with the option of a follow-up session, if needed). As indicated earlier, the CARENet program is not designed to replace existing crisis intervention services. Nor is it intended to undertake the psychological treatment of suicidal students. Rather, its purpose is to help students identify the crisis, treatment, and educational services that are available on campus and in the larger community and begin to access needed assistance so that they may remain viable campus residents. Further, it is designed to minimize the disruptive effects that suicide-like behaviors have on roommates and suitemates in the residence community. Sometimes the best option for a troubled student is to medically withdraw and, in these cases, CARENet psychologists can provide assistance with this process.

The initial consultation session must occur within one week of the student's notification by the Director of Residential Life of mandatory assessment. Failure to pursue or complete the assessment will be conveyed by the CARENet psychologist to the Director of Residential Life and may, in turn, result in judicial referral. CARENet psychologists will inform the Director of

Residential Life, or designee, of the student's scheduled appointment and whether or not the student successfully completed the program of assessment. "Successful completion" is defined in the final section below. There is no absolute limit on the number of times a student is required to take part in a two-hour CARENet assessment. The Director of Residential Life will be notified, however, of a student's failure to keep a scheduled appointment (including rescheduling an existing appointment) as this may indicate a need for crisis intervention.

In addition, because of the impact that a troubled student may have on the residence community the Director of Residential Life will request that the Quadrangle Coordinator meet with the roommates/suitemates of the troubled student and offer assistance as appropriate.

**How do students "get to" the CARENet program?**
Residence hall staff, required to file a report on manifestations of suicidal intent, will initiate the process through the Director of Residential Life. The critical event that triggers a referral is when a student "crosses the line" from having passive thoughts of suicide (e.g., "Maybe I'd be better off dead", "Would people care if I died?") to taking concrete action on their thoughts by publicly threatening suicide (e.g., telling someone verbally, or in writing, that they may kill themselves), making overt plans and preparations for self-harm (e.g., purchasing a firearm or stockpiling pills), or actually deliberately injuring themselves in an apparent suicide gesture (e.g., serious cutting, overdosing on pills).

While the obvious distal objective is to prevent student suicide and maintain a residence environment that is conducive to the academic success of all students, the proximate or most immediate objective is to evaluate the referred student's willingness and ability to refrain from self-injurious behaviors.  AN additional objective is to assist them in identifying and gaining access to a network of specific others who might provide needed services and assistance. Students who successfully complete the CARENet program receive a collaboratively developed "CARE Plan" that identifies specific sources of assistance tailored to their particular needs.

**How are Parents and/or Family involved?**
Among the responses available to the University to address suicidal behavior of students is to notify the parents of these students regarding the University's concerns.  Procedure dictates that the Director of Residential Life will notify the parent(s) of mandated students of a student's required participation in the CARENet program. However, after consultation with the Vice President for Student Success (or designee), the Director may defer or waive parental notification if such contact is determined not to be in the best interest of the student. (In these instances, a psychologist may be consulted regarding parental notification.) The Director of Residential Life will provide parents with an explanation of the circumstances surrounding the referral and a description of the program.  Participating students are encouraged to involve parents as sources of support and assistance.

**What is likely to happen during a CARENet consultation session?**
The objectives and components for the two-hour consultation session are as follows:

- Students will be provided with a written informed consent stipulating the limits of confidentiality and the specific information to be released;

- An orientation to the CARENet program and review of Residential Life policy regarding self-injurious behaviors;

- A review of the circumstances surrounding the recent development of suicidal ideation and intent;

- Assessment of present/immediate danger (i.e., evidence of on-going suicidal intent and the means "on hand") and undertaking appropriate steps to safeguard students who are determined to remain "in crisis";

- Assessment of the student's willingness and ability to look for alternatives to threatened or actual self-injurious behaviors as manifested in the collaborative development of a safety plan identified as a "CARE Plan";

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- Collaborative development of a "CARE Plan", identifying general and specific potential sources of psychiatric, psychological, and academic assistance tailored to the student's particular needs;

- Referral for additional needed services such as, for example, alcohol assessment or treatment, couples counseling, academic support services, psychiatric assessment;

- In usual circumstances, written notification to parents and/or other emergency contacts and existing treatment providers of the student's "safety net" plan;

The CARENet program does not provide for the implementation of the student's "safety net plan" or for any monitoring function. Once this plan is put in place, implementation is the responsibility of the individual student, his or her family, and mental health treatment providers.

**Are students required to participate in the CARENet Program?**

Active participation in all phases of the program, including collaborating on the development of a "CARE Plan", is required for successful completion.  Students who are referred to CARENet by the Director of Residential Life, or designee, but who refuse to participate or who do not complete the program, will be referred to the Office of Conflict Resolution & Civic Responsibility by the Department of Residential Life for compliance and disruptive behavior.  Each case will be reviewed by the Director of Conflict resolution & Civic Responsibility on a case-by-case basis.  Sanctions will range from University Disciplinary Probation to Removal from the Residence Halls to Disciplinary Suspension.  Successful completion of the CARENet program does not preempt a judicial referral for related disruptive behaviors (e.g., underage use of alcohol, or unlawful possession of illegal or controlled substances, used to inflict self-harm).

**AN ADVISORY ON**
**CLASSROOM DISRUPTION AND THREATENING BEHAVIOR BY STUDENTS**

**From the Vice Provost's Office for Undergraduate Education**
**and the Vice President's Office for Student Success, University at Albany**

All student conduct at the University at Albany is governed by the policies outlined in the handbook entitled Community Rights and Responsibilities (CRR). This handbook is available on the web at http://www.albany.edu/judicial/standardsofconduct.html. Classroom disruption and threatening behavior by students is a rarity at UAlbany but when it happens it is important to know how to deal with it. The following advice is offered to assist classroom instructors and staff members who are looking for guidance in dealing with a disruptive or threatening student.

1.      Classroom instructors are responsible for the management of their classroom environment, including the Web environment. It is suggested that behavioral standards, tolerances, and expectations be clearly defined to students at the beginning of each semester through a course syllabus and reinforced through verbal explanation. Instructors should also be cognizant of the written behaviors of students if utilizing the Web as part of the teaching environment. Any behavior that would not be seen as appropriate in the traditional classroom is not appropriate in the Web environment and may lead to disciplinary action. It is suggested that open Web discussions, such as bulletin boards, be monitored for inappropriate behavior/use.

Remember, both classroom instructors and students have some measure of academic freedom. University policies on classroom disruption cannot be used to punish lawful classroom dissent. The lawful expression of a disagreement with the teacher or other students is not in itself "disruptive" behavior.

2.      Examples of classroom disruption that should be viewed as a disciplinary offense as defined by Community Rights and Responsibilities, UAlbany's Code of Student Conduct. The term "classroom disruption" means behavior a reasonable person would view as substantially or repeatedly interfering with the conduct of a class. Examples include:  refusal to comply with reasonable faculty directions, repeatedly leaving and entering the classroom without authorization, making loud or distracting noises, posting inappropriate messages electronically, persisting in speaking without being recognized, repeatedly interrupting others, audio or video recording of classroom activities or the use of electronic devices (cell phones and beepers) without the permission of the instructor, or resorting to physical/verbal threats or personal insults or insulting gestures. Classroom instructors are urged to promote civility in the classroom environment and to include in their course syllabus their expectations with respect to the use of cell phones and beepers as well as reminding students to report perceived problems with classmates in the classroom. If a student is behaving in a way described above and does not heed the warning of the classroom instructor the student should be directed to leave pending a meeting with the Office of Conflict Resolution & Civic Responsibility.

3.  The Office of Conflict Resolution & Civic Responsibility can help by reviewing university disciplinary regulations with you, and meeting with accused students formally, or informally.  It's better to report disruptive incidents promptly, even if they seem minor.  One of our preferred strategies is to develop behavioral contracts with students, so they have clear guidelines about what behavior is expected of them. At times, the University Counseling Center will coordinate a case conference involving faculty and staff who are concerned

about a student's behavior.  The purpose of the case conference is in part to share information, determine the degree of potential risk the student may represent to self and/or others and to develop a strategic intervention as appropriate.  In the most serious cases, we can suspend students temporarily, pending disciplinary proceedings or medical evaluation (**CR&R, Section VIII; page 11, # 1**).

**STRATEGIES TO PREVENT AND RESPOND TO DISRUPTIVE BEHAVIOR**

| A. | Clarify standards for the conduct of your class in a syllabus and/or verbally. |
|---|---|
| B. | Serve as a role model for the conduct you expect from your students. |
| C. | If you believe inappropriate behavior is occurring, consider a general word of caution, rather than warning a particular student (e.g. "we have too many contemporaneous conversations at the moment; let's all focus on the same topic"). |
| D. | If the behavior is irritating, but not disruptive, try speaking with the student after class.  Most students are unaware of distracting habits or mannerisms, and have no intent to be offensive or disruptive. |
| E. | There may be rare circumstances when it is necessary to speak to a student during class about his or her behavior.  Try to do so in a firm and friendly manner, indicating that further discussion can occur after class.  Public arguments and harsh language must be avoided. |
| F. | A student who persists in disrupting a class may be directed to leave the classroom for the remainder of the class period.  Whenever possible, prior consultation should be undertaken with the Department Chair, Vice Provost for Undergraduate Education (2-3950) and the Director of Conflict Resolution & Civic Responsibility (2-5501). |
| G. | If a disruption is serious, and other reasonable measures have failed, the class may be adjourned, and the campus police summoned.  Teachers must not use force or threats of force, except in immediate self-defense.  Prepare a written account of the incident (a sample incident report may be found on the Web at http://www.albany.edu/judicial/classroomsafety/samplereport.html).  Identify witnesses for the Campus Police or the Office of Conflict Resolution & Civic Responsibility, as needed. |
| H. | If it is suspected that an incident of classroom disruption is either associated with or is a result of a mental health condition or alcohol or other substance abuse, you are encouraged to contact the University Counseling Center (2-5800) for consultation. |

| **STRATEGIES FOR REPORTING OF THREATENING AND ABUSIVE BEHAVIOR** | |
|---|---|
| A. | If possible, leave the area immediately. |
| B. | Call the University Police by dialing 9-1-1 from any campus phone or 442-3131 from any cell phone to request that an officer come to the location.  Inform the Police if it is a repeat occurrence. |
| C. | Anyone who observes what appears to be threatening behavior should report it to the University Police and in appropriate cases file a student incident report with the Office of Conflict Resolution & Civic Responsibility. |
| D. | University employees who observe what appears to be threatening behavior should also report it to their supervisor or Department Head, who should report it to the University Police and/or the Office of Conflict Resolution & Civic Responsibility. |

This information was compiled and reviewed by members of the Classroom Safety Task Force, an entity of the University's Task Force on Campus Safety.  The Classroom Safety Committee wishes to thank

the following Universities whose existing policies on classroom disruption and threatening behavior served as a guide in the development of this resource:

University of Maryland - College Park, University of Arizona, Auburn University and Colorado University.

Resources : A Quick Reference

University Police Department
        Emergency…………………………………………..    442-3131 or 911*
        Non-Emergency…………………………………...    442-3132
5-Quad Volunteer Ambulance (on campus 24 hours/day)...    442-3131 or 911*

**University Counseling Center………………………………. 442-5800**
**Office of Conflict Resolution & Civic Responsibility………… 442-5501**

Vice Provost for Undergraduate Education…………………. 442-3950

*When dialing 911 from any campus phone on the uptown and downtown campuses your call will be directed to the University Police Department for response.  If you are located on the East Campus your call will be directed to the East Greenbush Police Department. If you are calling from a phone located in CTG (187 Wolf Road) your call will be directed to Colonie Police.  If you are calling from the Stress Disorder Clinic (1535 Western Ave.) your call will be directed to Guilderland Police.

When dialing 911 from a cell phone your call is directed to the nearest State Police agency who then redirects your call to the University Police Department for dispatching.

Helpful Tips:
Familiarize yourself with the University's guide to student code of conduct, Community Rights and Responsibilities (http://www.albany.edu/judicial/standardsofconduct.html).
Hard copies of this handbook are available in the Office of the Vice President for Student Success (UH 206), the Office of Conflict Resolution & Civic Responsibility (CC 361), University Police, and the Department of Residential Life (Eastman Tower/State Quadrangle).

*Know the nearest location of an Emergency Call Device*

Emergency call devices can be found in the form of Blue Light Telephones, red wall mount phones in some women's restrooms or red phones located in Lecture Center lecterns.  Emergency phone calls may also be placed from most elevators located throughout campus.  Blue Light Telephones are located all around the University grounds. They can be found in parking lots, residence halls, on the academic podium, and along roadways. They are easily recognized by the blue light just above the phone box. In an emergency, all a person has to do is open the phone box, pick up the phone, and talk to the University Police Dispatcher on the line. Along with the 911 Emergency System, the Blue Lights give any person immediate phone access to police, fire, and emergency medical services.

*FAMILIARIZE YOURSELF WITH THE UNIVERSITY BUILDING EVACUATION GUIDE*

**The University's Department of Environmental Health and Safety provides and maintains information regarding building evacuation procedures.  The University's building evacuation guide may be found on the web at http://www.albany.edu/ehs/fire_evacuation.html.  This guide provides insight on what to do if an incident is discovered, what to do if a building alarm is activated, how to handle disabled occupant evacuation, and what to do in the event of an evening evacuation.**

### *How to identify a student with potential mental health issues*

Mental health issues and concerns may manifest themselves in a number of ways within the classroom environment. To learn more about resources that might assist in addressing mental health situations and associated behaviors that may occur in the classroom, please consult http://www.albany.edu/counseling_center/faculty_staff/ or contact the University Counseling Center for consultation at 2-5800.

**Sample Template for faculty reporting problem behaviors in class**

Date of report                                 _____
Student's name                              _____
Student ID#                                    _____
Instructor's name                           _____
Instructor's phone number               _____
Instructor's email address              _____
Title of course                                _____
Course number and section            _____
Date/time and location of incident   _____

Witnesses                                       _____
                                                        _____
                                                        _____

Detailed summary of the incident, including a description of the specific disruptive or threatening behavior. Action, if any, taken by the instructor (e.g. student warned, asked to leave the class, etc.). What is your recommended course of action and reasons for this recommendation?

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Instructor's signature                                          Date

**Appendix  E**
**Promoting Mental Health & Preventing Suicide in College/University Settings**
**Suicide Prevention Resource Center Publication**

Prepared for Center for Mental Health Services, Substance Abuse
and Mental Health Services Administration,
U.S. Department of Health and Human Services
Supported by Grant No. 1 U79 SM55029-01

October 21, 2004

  **SAMHSA**

# Acknowledgments

Suggested citation:

Suicide Prevention Resource Center. (2004). Promoting mental health and preventing suicide in college and university settings. Newton, MA: Education Development Center, Inc.

# Table of Contents

# Introduction

The National Strategy for Suicide Prevention's Objective 4.3 calls for increasing "the proportion of colleges and universities with evidence-based programs designed to address serious young adult distress and prevent suicide" (U.S. Department of Health and Human Services [DHHS], 2001, p. 66). Among college-age youth (20–24 years) in the United States, suicide is the third leading cause of death (Centers for Disease Control and Prevention [CDC], 2003).

Homicide is the second leading cause of death among college-age youth. However, risk for homicide is much lower among college students compared to the general population of similar age. To date, no studies of death among college students allow a comparison between homicide and suicide as causes, yet many people concerned about suicide prevention believe that suicide is likely the second leading cause of death, with an estimated 1,088 suicides occurring on campuses each year (National Mental Health Association [NMHA] & The Jed Foundation [JED], 2002). Approximately 12.5 million college and university students attend more than 3,400 schools in the United States (Brindis & Reyes, 1997). Campus counseling centers have reported increased demand and shifting needs of students seeking counseling services (Kitrow, 2003). Data about the prevalence of depression and suicidal ideation among college students (e.g., Furr, Westefeld, Gaye, McConnell, & Marshall, 2001), several high profile campus suicides, lawsuits related to on-campus suicides (Lake & Tribbensee, 2002), and media coverage of college suicides have highlighted the need for comprehensive, multifaceted efforts to promote mental health, provide mental health services, and prevent suicides at colleges and universities.

Although the suicide rate of college students is only about half the national rate for a sample matched by age, gender, and race (Silverman, Meyer, Sloane, Raffel, & Pratt, 1997), suicide and attempted suicide are the tip of the iceberg of a larger mental health and substance abuse problem among college students. A national survey of college counselors found that 84 percent perceived an increase in students with more serious psychological problems over the past five years (Gallagher, 2002). Almost 16 percent of college women and 10 percent of college men report having been diagnosed with depression at some time in their lives (American College Health Association [ACHA], 2001). Forty-four percent of students surveyed at four-year colleges reported drinking heavily during the two weeks prior to the survey (Wechsler, Lee, Kuo, & Lee, 2000). These problems have significant implications for students' lives, academic performance, and behavior.

This paper, produced by the Suicide Prevention Resource Center (SPRC) at Education Development Center, Inc. (EDC), summarizes what we know about suicide and suicide prevention among college and university students, describes a sample of current suicide prevention efforts, and recommends ways in which colleges and universities can promote mental health and prevent suicidal behavior among their students.

# Suicide Among College Students

Epidemiological health surveys often fail to accurately gauge the extent of mental health problems among college students, both undergraduate and graduate (Patrick, Grace, & Lovato, 1992). This is largely because these students straddle the conventional age-reporting categories for adolescents and young adults (i.e., 15–19, 20–24, and 25–29 years of age). However, some current studies can shed light on the problem of suicide among college students.

Data collected by the Centers for Disease Control and Prevention (CDC) indicate that suicide emerges as a significant problem during the high school years, increases among young adults 20–24 years of age, and continues to increase marginally over the next two decades of life. For 2001, CDC (2002) reported the following suicide rates for young adults:

- 7.95/100,000 for the 15–19 year age group

- 11.97/100,000 for the 20–24 year age group

- 12.56/100,000 for the 25–29 year age group

- 12.89/100,000 for 30–34 year age group

(Note that these rates are for the general population, most of whom are not college students.)

The Big Ten Student Suicide Study (Silverman et al., 1997), undertaken from 1980 to1990 to determine the suicide rate on Big Ten campuses, was the most comprehensive report on the incidence of suicides in undergraduate and graduate school populations by age, gender, and race. The study collected demographic and correlational data on 261 suicides of registered students at 12 Midwestern campuses.

The Big Ten Student Suicide Study reported a rate of completed suicide for college students of 7.5/100,000. The largest number of suicides for both males and females was in the 20–24 year age group (46 percent) and among graduate students (32 percent). The overall student suicide rate of 7.5/100,000 was half the national suicide rate (15.0/100,000) for a sample matched by age, gender, and race.

Thirty-one percent of female and 25 percent of male students are in the 17–19 year age range. Yet this age range accounts for only 9 percent of the female suicides and 14 percent of the male suicides. Forty-eight percent of college females and 45 percent of males are in the 20–24 year age range, in which the suicide rate is more proportional, accounting for 49 percent of female suicides and 45 percent of male suicides.

The statistics shift dramatically for the older students. The Big Ten study revealed that students 25 and over (regardless of whether they are undergraduate or graduate students) had a significantly higher risk of suicide than younger students. Although women's suicide rates were roughly half those of men throughout the undergraduate years, women in graduate school died by suicide at rates not significantly different from their male counterparts (9.1/100,000 for women and 11.6/100,000 for men) (Silverman et al., 1997).

This suggests that the suicide rate among female students in their mid- to late-20s and older is higher than the national rate, and higher than the rate among female students of typical undergraduate age (18–23 years). The Big Ten data also suggest that the suicide rate for female college students is below the national rate during the first two years of college, about even during the junior and senior years, and above the national rate during graduate school.

Data obtained through the American College Health Association's Mental Health Annual Program Survey conducted during the 1970s found a remarkably similar rate of completed suicide of 7.53/100,000 (Schwartz, 1995). Silverman et al. (1997) found that college students completed suicide at approximately half the rate of peers (matched for age, gender, and race) who do not attend college. In another study, Schwartz (1995) found no differences between the rates of suicide at colleges rated in terms of selectivity, competitiveness, or prestige of the school.

The University of Maryland's College and University Counseling Center directors' data bank reported 163 suicides in 78 large and 85 small colleges (Magoon, 2000). These colleges had a combined population of approximately 1,730,000 students. Thus, the suicide rate for these schools is 9.4/100,000, somewhat higher than the rates reported in the data from the previous two studies. However, this reporting system is not as epidemiologically rigorous as that of the Big Ten Suicide Study.

Furthermore, as discussed above, suicide is the tip of an iceberg of mental health issues. Studies point to serious mental health problems among college students. A research consortium of 36 counseling centers estimated recent increases in anxiety, fear, and worries, as well as dysfunctional behavior including eating disorders, alcohol and substance abuse, and anger/hostility among college students. These studies also reported increases in the impact of violence, family dynamics, depression, and bipolar disorder (as reported by Louise Douce, Ph.D., to the Subcommittee Hearings for the Campus Care and Counseling Act, April 28, 2004).

There is clear evidence of increased incidence of depression among college-age students. Researchers at Kansas State University conducted a 13-year study (1989–2001) of 13,257 students who sought help at a large Midwestern university counseling center. They found that "students experience more stress, more anxiety, and more depression than a decade ago. Some of these increases were dramatic. The number of students seen each year with depression doubled, while the number of suicidal students tripled, and the number of students seen after a sexual assault quadrupled" (Benton, Robertson, Tseng, Newton, & Benton, 2003, p. 69).

Other researchers have also noted "that high levels of psychological distress among college students is significantly related to academic performance. Students with higher levels of psychological distress are characterized by higher test anxiety, lower academic self-efficacy, and less effective time management of study resources" (Brackney & Karabenick as cited in Kitzrow, 2003, pp. 171–172). Studies have found that "mental health problems may also have a negative impact on academic performance, retention, and graduation rates" (Kitzrow, 2003, p. 171).

High-risk alcohol use and other drug use also take a toll on student health and academic performance. The Harvard School of Public Health College Alcohol Study Survey (Wechsler et al., 2000) found that 44.4 percent of college students describe themselves as binge drinkers. The National Institute on Alcohol Abuse and Alcoholism (2002) reported that 1,400 college students die each year from alcohol-related injuries and that alcohol abuse is associated with diminished academic performance. But studies also have shown that intervention can have an impact upon these issues. The retention rate for students who received counseling was 14 percent higher than for students who didn't receive counseling (Kitzrow, 2003).

## Suicidal Behavior Among College Students

Suicide has been described as the end of a continuum that begins with suicidal ideation, continues with planning and preparing for suicide, and ends with threatening, attempting, and completing suicide (Kuchar, Potter, Powell, & Rosenberg, 1995). Although some young people make impulsive attempts, many more have suicidal thoughts and engage in behaviors along this continuum before attempting suicide or without ever attempting suicide.

Although some researchers believe that attempted suicide may be a phenomenon separate from completed suicide, there are risk factors in common. A history of suicide attempts is statistically correlated with an increased risk for further attempts that may result in death. Thus, professionals seeking to prevent suicide focus on groups and individuals with an increased risk for suicide, particularly those reporting suicidal ideation, intent, plans, and prior attempts, as well as symptoms of depression.

Surveys of self-reported behaviors along the suicide continuum (not including completed suicides) are one method used to define suicide risk. In 1995, CDC conducted the first National College Health Risk Behavior Survey (NCHRBS) among a representative sample of about 5,000 undergraduate students in both two-year and four-year institutions (CDC, 1997; Brener, Hassan, & Barrios, 1999). This study revealed that 10.3 percent of respondents reported seriously considering attempting suicide during the 12 months preceding the survey. Students who had seriously considered suicide were also more likely to report use of alcohol, tobacco, and illegal drugs. Furthermore, 6.7 percent of students surveyed reported that they had made a suicide plan and 1.5 percent reported that they had attempted suicide one or more times in the previous 12 months. Only 0.4 percent reported that their suicide attempts required medical attention.

The spring 2000 National College Health Assessment (NCHA), conducted by the American College Health Association (ACHA), measured depression, suicidal ideation, and suicide attempts (and other health indicators) among 15,977 college students on 28 campuses (ACHA, 2001). Its findings were comparable to those from the NCHRBS. The NCHA found 9.5 percent of its respondents had seriously considered suicide and 1.5 percent had attempted suicide within the past school year. One-half percent of those who reported suicide attempts reported that they had made attempts on three or more occasions. Another small study of depression and suicidal ideation on college campuses found that about 9 percent of students reported thinking about attempting suicide (Furr et al., 2001).

Self-reported symptoms of depression and mental distress are much more widespread than either suicide or suicide attempts (ACHA, 2001). Of the NCHA respondents, 61.6 percent felt "hopeless" at least once during the past school year; 33.4 percent reported experiencing "hopelessness" three or more times during that period; 44.4 percent felt "so depressed it was difficult to function;" and 22.1 percent reported feeling this way on three or more occasions during this period.

Among students who seriously considered suicide, 94.8 percent reported that, at least once in the previous year, they felt so sad that they could not function and 94.4 percent reported feeling hopeless. Only 23.8 percent of students who reported feeling hopeless and 33.4 percent of those who reported feeling depressed seriously considered suicide (ACHA, 2001). Thus, while feeling depressed, unable to function, and/or hopeless does not necessarily mean that a student is seriously considering suicide, feeling suicidal often includes depression and hopelessness.

The relationship of suicide, depression, and other mental illnesses to the abuse of alcohol and other drugs should be given serious attention. An analysis of data from the NCHRBS found that students who reported suicidal ideation were significantly more likely than other students to carry a weapon, engage in a physical fight, boat or swim after drinking alcohol, ride with a driver who had been drinking alcohol, drive after drinking alcohol, and rarely or never use seat belts (Barrios, Everett, Simon, & Brener, 2000).

## Factors That May Contribute to Suicidal Behavior Among College Students

Major life transitions—such as leaving home and going to college—may exacerbate existing psychological difficulties or trigger new ones. Moreover, leaving family and peer supports to enter an unfamiliar environment with higher academic standards can deepen depression or heighten anxiety.

A number of recent articles in the lay and professional press have drawn attention to the growing number of students with serious psychological problems and the increase among those seeking counseling on campuses (Kitzrow, 2003; Voelker, 2003; Berger,

2002; Caulfield, 2000). While we await a science-based explanation, the following have been suggested as driving the increased demand for services:

- _Better assessment, intervention, and management of psychiatrically ill adolescents during high school, allowing them to further their educations
- _Decreased stigma associated with mental illness and help-seeking on college campuses
- Increased accessibility of health services on college campuses
- _More limited payments by third-party and managed care health insurance plans for private treatment outside of network areas, resulting in increased reliance on campus health services to treat chronic conditions
- Better assessment and referral of students by college faculty and staff

Some researchers suggest that college campuses may inadvertently contribute to the development and exacerbation of students' stress disorders—including suicidal behaviors—that are consequences of perceived or real stress (Seiden, 1971). These researchers suggest that parental pressure to succeed and economic pressure to successfully complete a course of education and training in a shorter period of time also increase stress.

The Big Ten Student Suicide Study suggests that graduate students have the highest rates of suicide and that women in graduate school are at greatest risk. It appears that older students who are returning to school after being out of school for a significant period have the highest rates overall. Many female graduate students fall into this category.

Graduate students may experience more stress than undergraduates (Silber et al., 1999). Some additional stressors in graduate school include the following:

- _Mounting financial burdens
- _Worries about time away from careers and being out of the workforce
- _Uncertainties about the future job market (particularly for those pursuing research and academic careers)

# Working with Special Populations

Efforts to promote mental health and prevent suicide in colleges and universities must respond to the needs of each campus and its student population. The increasingly diverse atmosphere of higher education campuses presents challenges for preventing suicides and meeting the mental health needs of students. In the 1980s, the number of U.S. high school students declined, and colleges and universities began recruiting nontraditional students, focusing on graduate, older, and international students (Brindis & Reyes, 1997). In addition, gay, lesbian, bisexual, and transgender students are increasingly visible on campuses as social stigma against homosexuality has diminished and gender roles have relaxed. It appears that the trend towards older and more diverse student populations will continue, and campuses and their surrounding communities must be sensitive to the special circumstances and needs of these students.

Most schools have an administrator who oversees programs for special populations and minorities. This administrative staff person and perhaps student representatives from key groups must be involved in the planning and implementation efforts for mental health promotion and suicide prevention. Characteristics of the student population must be considered, along with the barriers (and opportunities) that these characteristics might provide for suicide prevention and mental health promotion.

Commuter Students

Community and two-year colleges are likely to serve the greatest numbers of commuter students. These institutions also have fewer resources to meet the health and mental health needs of students. Community and two-year college health services are more likely to be provided by a nurse and supported solely by student health fees (Brindis & Reyes, 1997). Therefore, they rely heavily on community health and mental health resources. While schools in large metropolitan areas have a wide range of health and mental health referral options, rural campuses have very limited referral resources available.

Commuter campuses tend to have a greater percentage of students who are part-time, older, and working, who have children or other care giving responsibilities, who live at home with parents, rarely identify with the school, and have little "school spirit." Commuter schools are often more like workplaces than college campuses, and students may only appear on campus for classes and to use the library, and are thus difficult to reach with school-based programming. There is no sound information about suicide rates among these students and little to no information about efforts to promote mental health or prevent suicide in these types of schools.

Older Students

The Big Ten study indicated that students 25 and over (undergraduate or graduate) had a significantly higher risk of suicide than younger students. While male suicide rates are higher than female rates in the general population, female graduate students have suicide rates close to their male classmates (9.1/100,000 for women and 11.6/100,000 for men). While only 10 percent of female college students and 14 percent of male college students fall into the 25–29 year age range, they account for 22 percent of the female suicides and 23 percent of the male suicides. In fact, 39 percent of all female suicides occur among graduate students, who comprise only 19 percent of all female students (Silverman et al., 1997).

This suggests that the female graduate student population has greater risk for suicide compared to the female undergraduate population. Older female students who may be returning to college later in life also appear to be at greater risk relative to the typical undergraduate population. Relatively higher rates of suicide were also seen for older male students (ages 35–39 and 45–49). This indicates the need for targeted suicide prevention efforts for older students—especially for those over 30.

Both male and female older students can be harder to reach through the usual campus care resources and face different pressures than the typical college-age population. Older students are more likely to commute instead of live on campus. If they have left the workforce to return to school, they may experience a loss of status and increased anxiety about this 'time out' from their careers (Silverman, 2004). Those attending school part-time while still working might suffer stress from competing responsibilities. They are more likely to have partners and/or dependents who may also need services. If they are returning to school after an absence of several years, they may find the academics more demanding than anticipated.

Returning to school appears to be a major stress on older undergraduate and graduate students alike. Both types of students must make major life transitions and accommodations in pursuit of education and training. The financial and personal investment coupled with the sacrifices made to return to school may place these students at increased risk for suicidal behavior (Silverman et al., 1997).

As students age, they may perceive academic experiences differently and respond to challenges and stresses with different strategies and coping mechanisms. Even if all the resources traditionally available on university campuses remain constant for all students, older students may access them differently—or not at all. Universities might well consider developing new and targeted intervention programs for older students at both undergraduate and graduate levels.

Gay, Lesbian, Bisexual, and Transgender Students

While it can be assumed that gay, lesbian, bisexual, and transgender (GLBT) students have always been part of colleges and universities, their presence has become increasingly visible as social stigma and barriers against homosexuality have lessened and gender roles have relaxed. There is no concrete information about suicide rates among gay, lesbian, and bisexual (GLB) college students and little to no information about efforts to promote their mental health or prevent suicide. There is even less information about the behavior and needs of transgender students, though we can assume they face somewhat similar risks.

Despite widespread belief that GLB youth have higher suicide rates, until recently there was only anecdotal information about this population. Information cannot be drawn from death certificates, and psychological autopsy studies involving interviews of the subjects' family and peers would not identify homosexuality or bisexuality unless the subjects were open about it prior to their suicides. Since much of what is known about GLB youth in the past came from studies of youth who presented at sexually transmitted disease clinics or programs for runaway and homeless youth, the belief that GLB youth had a greater tendency to suicidal behavior may have grown from a skewed sample of subjects.

However, in the 1990s data on high school students added to the evidence indicating an elevated risk for suicidal behavior among GLB youth compared to youth who do not identify themselves as GLB. The CDC's Youth Risk Behavior Survey (YRBS)

began including questions about suicidal behavior in the 1990s, and Massachusetts incorporated statewide questions on sexual orientation for all YRBS participants. The Massachusetts YRBS data indicated that GLB students were more likely to have experienced suicidal ideation and attempts, with 35.3 percent of GLB respondents reporting suicide attempts in the past 12 months compared with 9.9 percent of their peers (Garofalo, Wolf, Kessel, Palfrey, & DuRant, 1998). GLB youth were also more likely to have been victimized and threatened, and to have multiple experiences with using one or more substances (Garofalo et al., 1998). The risks appear greater for gay or bisexual males than for lesbian or bisexual females. Other studies in the United States and Canada report that young gay and bisexual males are 14 times more likely to report a suicide attempt than their straight peers (Tremblay & Ramsay, 2000).

GLB students who transition from high school to higher education may bring some of the same suicidal behavior to their new environment. One study attempted to measure the suicidal risk among a small sample of GLB college students compared with a sample of their heterosexual peers (Westefeld, Maples, Buford, & Taylor, 2001). Researchers administered a paper and pencil assessment of suicidal risk called the College Student Reasons for Living Inventory (CSRLI). GLB students were more depressed, lonelier, and had fewer reasons for living than a control group of their peers, and depression and loneliness correlated positively with suicidal tendencies. In addition, GLB students in this study experienced prejudice and related issues (Westefeld et al., 2001).

Many campuses are increasingly open to and supportive of inclusion of GLBT students, but homophobia remains a problem. Promoting a positive environment that includes gay, lesbian, bisexual, and transgender students, staff, and faculty can go a long way towards supporting the mental health and well-being of GLBT students. Wellness programs can incorporate education that promotes positive attitudes towards homosexuality, bisexuality, and gender minority status. Campuses need to ensure student safety in residence halls and in the classroom by being accepting of all students.


International Students

The number of international students studying at U.S. colleges and universities has grown steadily since the 1950s. The Institute of International Education reports that 582,996 students from at least 186 countries attended an American college or graduate school in 2001 (Misra & Castillo, 2004).

While all students experience academic and personal pressures, international students face particular academic and social challenges that increase their potential for stress. International students in the United States tend to be among the top students in their countries of origin, yet if English is not their native language they may have unanticipated academic difficulty (Mori, 2000). They may experience isolation, being far removed from their traditional social supports including friends and family—possibly for the first time.

International students also face added financial pressure. There are fewer sources of financial aid available to non-U.S. citizens, and they are generally prohibited from

working outside of the school they attend (Mori, 2000). Students struggling to support themselves and their studies may feel they cannot afford a supplemental health insurance plan and must rely on campus health services. International students often fail to understand the U.S. system of health care coverage and reimbursement, and usually have no health insurance from their home country. Fee-based community health and mental health providers may be reluctant to accept them as clients, knowing they cannot collect on a debt if the student leaves the country.

Culturally appropriate health and mental health services may not be available on campus or in the community. Since the stigma of mental illness is greater in many countries than it is in the United States, culture may be an added barrier to students accessing mental health services (Yi, Lin, & Kishimoto, 2003). It is essential that campus mental health staff understand how culture may influence students' orientation to mental health and well-being.

# Insurance Coverage and Access to Mental Health Care

About 80 percent of college and university students attend schools that offer some direct health care, and students visit student health centers between 20 and 25 million times annually (Brindis & Reyes, 1997). Financing of student health care varies according to the type of school. Four-year colleges and universities tend to support health services through a combination of funds from the school's general fund, grants and gifts, direct student payments, and  fees (either a student affairs fee or separate health services fee). Community college health services are more likely to be supported solely by student health fees (Brindis & Reyes, 1997).

Virtually all colleges and universities that offer student health and mental health services charge fees to support these services. Theoretically, this ensures that all students have access to health services and parity is not an issue as long as the student is enrolled. Yet many medical procedures are not usually covered by student health services without supplementary insurance coverage, including the following:

- X-ray, imaging, and scanning

- Prescription medication

- Emergency department visits and emergency treatment

- _Specialty medical consultations (psychiatry, orthopedics, obstetrics/gynecology, dermatology)

- Diagnostic blood tests

- Toxicology screening

- Hospitalization and related costs

- Surgery

- Private psychotherapy

Between 5 and 25 percent of students seek mental health services from their campus counseling centers. This range reflects the schools' population and the availability of

mental health services in surrounding communities. Graduate students utilize mental health services significantly more than undergraduates, so schools with a greater percentage of graduate students are likely to have a greater demand for campus counseling services. Schools located in communities rich in mental health resources may experience less demand for campus-based services (Brindis & Reyes, 1997).

While basic student health services are usually available without restriction, campus mental health benefits tend to be limited to a specific number of annual visits. Students in crisis may receive extended counseling services, but long-term psychiatric care of students within a student mental health clinic setting is the exception rather than the rule.  This poses challenges for students with more serious mental health problems who may be more prone to suicide.

It is estimated that 18 to 24 year olds are the largest uninsured population in the United States (Molnar, 2002), though not all in this age group are students. Only 40 percent of schools require students to provide proof of insurance coverage (Brindis & Reyes, 1997). Colleges and universities strongly encourage students to carry sufficient third-party insurance plans to cover procedures not included through the student health services fee.  Younger students may be eligible for coverage under their families' health insurance policies. But most insurers exclude students over a certain age (23–25) from their parents' policies, and some exclude students as young as 18. Students are also generally ineligible for participation in public medical assistance programs.

Students usually qualify for coverage through their schools' supplemental insurance plans.  Schools contract with third-party insurance companies to offer "student health insurance" that covers most, but not all, additional medical expenses students may encounter. Cost of coverage is based on actuarial tables for the demographics of each campus and on past insurance claims and experiences. Though not inexpensive (some plans cost thousands of dollars annually if a student elects spousal or family coverage and is pregnant or anticipates a pregnancy), they are designed to cover most medical costs. However, students with pre-existing conditions (including mental illness) and those who have attempted suicide may be deemed 'high risk' and therefore excluded from student health insurance plans (Brindis & Reyes, 1997).

ACHA has developed standards for student health insurance programs. These standards include the following:

   • _Students are required to present proof of insurance as a condition of enrollment in school.

   • _An appropriate scope of coverage for mental health care should be included in health insurance programs.

   • _Benefits should be made available to all students regardless of age, gender, sexual identity, marital status, race, ethnicity, or physical or psychological disability (ACHA, 2000).

Unfortunately, most students—and their parents—do not purchase the college-sponsored supplemental health care insurance because of the expense, or under the

assumption that they will not need medical services, or because they believe their families' existing health insurance will cover them while at school, or because they don't qualify. Many students have no health insurance at all.

And even with health insurance, students may not be able to access mental health care. Deductibles, co-payments, and caps on mental health services can pose significant barriers. Privacy concerns may prevent students from accessing insurance benefits through their parents—they may not want their parents to know they are in counseling or on medication. And many health plans have waiting periods of up to nine months, during which enrolled participants cannot qualify for reimbursement.

Students covered by their parents' insurance may have only limited benefits if they attend school out of that insurer's care network. While most HMOs and managed care plans reimburse for out-of-network emergency room care, they generally do not cover in-patient medical or psychiatric treatment, or any medical procedures not deemed to be life-saving. Therefore, medications, any follow-up, monitoring after an emergency procedure, and hospitalization are not usually covered. Students requiring significant care may be forced to return home for ongoing services or monitoring. Their parents' health insurance may authorize students to be seen in the local campus community through an authorized care network, but this is the exception rather than the rule.

When campuses rely on community hospitals or local mental health centers to serve their students, the providers expect to be reimbursed for services. Students without insurance will be personally billed, and clinics and hospitals may not be able to collect on these debts—especially if a student leaves school or moves away (Molnar, 2002).

Consequently, students without insurance rely almost exclusively on the student health center resources. Campus mental health clinics face an increasing burden to see and monitor larger numbers of students for longer periods of time, while offering more intensive, specialized, and diverse services. They are subject to constant administrative pressure to locate low-fee referral services, provide free medication monitoring (when students are in private psychotherapy with a non-M.D. and on medication), provide free diagnostic testing, and provide long-term care for those students with the most severe psychopathologies and/or the gravest financial situations—while simultaneously containing costs.

## Media Coverage and Suicide on Campuses

Any death of a college student can generate media coverage, and a suicide may result in sensational coverage in the campus or community media. Experts in suicide prevention believe that media coverage of suicide can increase the potential for imitation behavior or "contagion." The media reporting about suicide should take care to ensure that the coverage is responsible.

Reporting on Suicide: Recommendations for the Media  was developed by government and private leaders in suicide prevention both in the United States and internationally

(CDC et al., 2001). According to these guidelines, suicide may increase under the following circumstances:

- When the number of media stories about individual suicides increases
- _When a suicide is reported in detail or repeatedly (at the start of a broadcast or on the front page)
- When media reports of suicides are given dramatic headlines

The American Foundation for Suicide Prevention's (AFSP) Web site (www.AFSP.org) includes a section on media coverage of suicides. A number of examples of media coverage of college suicides on the AFSP site substantiate the potential significance of irresponsible reporting (American Foundation for Suicide Prevention [AFSP], 2001).

Reporting on Suicide: Recommendations for the Media acknowledges that suicide is newsworthy, but suggests story angles, interview tips, and characteristics of coverage that will minimize the risk of contagion (AFSP, 2001). Reporters may reduce the potential for imitation suicides by using the following recommendations:

- Specific information about the means of suicide should be excluded.
- Those who die by suicide should not be glorified.
- _Stories should include information on whether the victim was ever treated for mental illness or involved with substance abuse.
- _Reporters should be aware that most victims do exhibit warning signs, yet friends and relatives may not identify warning signs of suicide when interviewed.

- Referring to suicide in the headline should be avoided when possible.
- _Suicide should be portrayed as a complex, multifaceted issue and not resulting from a single cause.

## Prevention Strategies for College Campuses

A comprehensive approach to suicide prevention on college and university campuses should employ multiple strategies targeted at both the general campus population and identifiable at-risk populations (Surgeon General of the United States, 1999). Such a comprehensive approach will be more effective when it includes consistent and coordinated activities in all the social spheres in which the target audience (in this case, college students) live, study, work, and play. A coordinated approach needs to engage key players in the college community in a planning process that focuses on assessment, design, implementation, and evaluation of suicide prevention activities. The U.S. Air Force developed, implemented, and evaluated one such comprehensive, multifaceted effort to address suicide and promote mental health (Knox, Litts, Talcott, Feig, & Caine, 2003). This effort provides a sound basis for considering a similar, customized approach for college and university communities. Elements of a comprehensive suicide prevention program include leadership to promote mental health and suicide prevention, screening, crisis management, educational programs, mental health services, life skills development, means restriction, social marketing, and social network promotion (NMHA & Jed, 2002) (see Figure 1).

Leadership

Systemic change requires leadership. Leadership from central college and university administrators is critical to generating significant and sustainable efforts on college campuses. College and university presidents need to commit to creating a comprehensive, systemic effort to promote mental health and prevent suicide if such an effort is to succeed.

Efforts to address alcohol abuse can serve as a model for how strong leadership can create positive changes on college campuses. With support from the Robert Wood Johnson Foundation, the Center for College Health and Safety established the Presidents Leadership Group (PLG) to recognize the important role college and university presidents serve in successful alcohol and other drug (AOD) prevention efforts on campus and in the community. PLG was created to bring national attention to campus AOD issues and highlight ways college presidents can serve as effective catalysts for change. In 1997, its first year, the six PLG founding members published Be Vocal, Be Visible, Be Visionary: Recommendations for College and University Presidents on Alcohol and Other Drug Prevention, a report that urged college presidents to become more active leaders.

The report included 13 proposals for effective prevention and identified specific steps presidents can take. In 1998, PLG produced a video to accompany this report. Since then, PLG has expanded its membership and activities, implementing a recruitment process that asks new members to participate in a set of activities, including the following:

> • Providing support and leadership for existing statewide and regional initiatives

> • _Working with single-state substance abuse agencies to establish state-level funds earmarked for college AOD prevention

> • Generating support for AOD prevention efforts among higher education officials

> • _Serving as advisors to other college and university presidents interested in AOD prevention

> • _Giving permission for their names and quotes to appear in ads that the Center places in magazines and newsletters

> • _Serving as spokespeople for the effectiveness of environmental prevention strategies, campus and community coalitions, and statewide and regional initiatives (Presidents Leadership Group, 1997).

A similar effort to engage campus administrative leaders around mental health promotion and suicide prevention programs would facilitate an expansion of these efforts to other colleges and universities.

Screening

Unfortunately, it is often difficult to identify individuals at greatest risk for suicidal behavior. Current screening techniques used for the general population lack the precision needed to identify those who will actually attempt or complete suicide. However, screening for specific disorders associated with suicide, such as depression or substance abuse, can identify those who are at risk so that they can be referred to appropriate treatment. A screening instrument might be administered at colleges and universities as part of the first year orientation and the collection of health-related information about students. A screening instrument might also be administered when students visit the student health center for primary care (Zygowicz & Saunders, 2003). Similar strategies are employed by TeenScreen (Shaffer et al., 2004) and other programs (Reynolds, 1991) among high-school-age youth.

However, implementing a screening program without access to professional services for persons who screen positive for risks is pointless. When screening for AXIS I DSM-IV diagnoses, these programs should be prepared to treat conditions identified, including eating disorders, post-traumatic stress disorder, alcohol and drug abuse, schizophrenia, anxiety and panic disorders, affective disorders, and developmental disabilities (including attention deficit/hyperactivity disorder, and emotional and learning disabilities). Very few college mental health centers have the personnel and/or programs in place to professionally respond to all these diagnoses.

A number of efforts provide screening services over the Internet. The Jed Foundation developed Ulifeline (www.ulifeline.org), a Web-based version of a validated Duke University Medical School screening instrument that provides a self-screening test with referrals for students who report risk characteristics. The Ulifeline screening tool allows students 24-hour, confidential screening for eight DSM categories including depression, eating disorders, drug and alcohol abuse, and other emotional disorders. Students can self-screen or use the site to identify friends who may need help and to link directly to their schools' campus mental health or health centers. It is being used at over 370 campuses and serves almost two million students.

AFSP is developing and pilot testing a Web-based screening effort at a small number of universities. Students are directed to a secure Web site to complete a Depression Screening Questionnaire that has been adapted from the Patient Health Questionnaire, a validated instrument for identifying depression and related problems. An experienced clinician reviews responses and sends a personalized, confidential assessment to the student's self-assigned user name on the Web site. Students whose responses suggest significant psychological difficulties are urged to meet with the clinician for an evaluation. A "dialog" feature on the Web site allows students to exchange messages with a clinician in advance of a face-to-face meeting. Then, at the initial meeting, students are referred for treatment if necessary. In addition to the Depression Screening Questionnaire data, AFSP is collecting follow-up data on students referred into treatment through the project as a measure of project effectiveness (Haas, Hendin, & Mann, 2003).

Crisis Management

Crisis management is the capability to respond to a suicidal crisis appropriately and to provide support to persons affected by the loss of someone to suicide—survivors. Crisis management can take several forms. One strategy is providing services through crisis centers and hotlines through which trained volunteers and/or staff provide counseling and other services for suicidal persons. Such programs also may offer a drop-in crisis center and referral to mental health services. Some campuses find creating and maintaining crisis services challenging, although some schools have succeeded in these efforts (Ottens, 1984; Coulter, Offutt, & Mascher, 2003). Crisis management also requires that the clinical staff is equipped and trained to manage potentially and acutely suicidal persons. In addition to these services, colleges and universities need a comprehensive and coordinated collaborative plan to respond to a student suicide or attempted suicide. Schools should be prepared to implement outreach efforts in the event of a suicide or other traumatic death of a student (Webb, 1986).

Most university counseling centers do not have a 24/7 crisis management response system in place. In fact, the majority of counseling services do not have emergency walk-in hours during the day or staff members on call after hours or on weekends. Although most counseling services use a crisis intervention model for managing student emergencies and other crises, formal staff training in the basic theories, principles, and approaches to crisis intervention is usually lacking. University counseling centers usually lack psychiatric coverage, especially sufficient coverage to address the numbers of students who enter college already taking prescription psychotropic medications.

Mental health emergencies are often handled by campus security or college administrators in place of trained clinicians or health care providers. The local emergency room is often used for psychiatric assessments in evenings and or on weekends, when campus health services may be closed. Yet most local or community hospital emergency rooms do not have on-site psychiatric services available during these periods. If the student is not admitted to the hospital (which often lacks a separate psychiatric unit), he or she is escorted back to campus. If the crisis occurs on a weekend, the student will not be seen by a mental health professional until Monday morning. Since most university counseling centers lack a formal working relationship, or medical liaison, with the local emergency room or community hospital, confidentiality issues can impede responding to a crisis if the original assessment was made off-campus.

Many university counseling centers and administrative units did not start developing policies and procedures for dealing with behavioral problems such as disruptive students, physically threatening students, date rape, vandalism, murder, and suicide until the 1990s. Even today, campus counseling centers are just beginning to develop formal policy and procedure manuals that include sections addressing emergencies during the day, at night, and on the weekends. Disaster planning, in general, is also lagging on most college campuses.

Confidentiality issues, including those stemming from the Family Educational Rights and Privacy Act (FERPA) and Health Insurance Portability and Accountability Act (HIPPA) regulations, also have implications for the management of mental health

crises. Most college mental health professionals look to their university's general counsel for guidance. University counsels interpret these regulations differently, in often idiosyncratic ways fitting the general ethos and tenor of their college communities. The only area that seems to be unambiguous concerns situations in which there is a clear and imminent danger to self or others (often interpreted as when a student is suicidal or homicidal). However, there is no uniform definition for most suicidal behaviors, including suicide attempts.

Thus, whether a student's actions are to be considered "suicidal behavior" is often a judgment call—one that is often not made by a mental health professional, but by an administrator. The concepts of intent, lethality, and temporality can blur when assessments are done by one set of professionals and decisions about notification of parents, administrators, or others is left to another—especially those not trained in mental health. Despite some published recommendations and guidelines, each college and university generally addresses the issue of parental notification following suicidal behavior in its own way.

Longer-term follow-up to mental health crises on college campuses is also a problem. Many suicidal and behaviorally disordered students are asked to take medical leaves of absence, with the expectation that they will receive appropriate treatment prior to applying to return to campus. Unfortunately, many of these students face obstacles and challenges in seeking appropriate mental health care in their local communities, and there are few systems or policies in place to help them return to school once they have stabilized. (These same medical leave policies may prevent students from coming forward for help in the first place.)


Mental Health Services

Untreated mental illnesses—specifically depression, bipolar disorder, schizophrenia, and substance abuse—are the leading contributory causes of suicide in young adults (Goldsmith, Pellmar, Kleinman, & Bunney, 2002). These disorders are common among youth (Shaffer et al., 1996; King, 1997). Progress has been made in the scientific understanding of suicide, mental disorders, and substance abuse, as well as in developing interventions to treat these disorders.

For example, the ability to identify, treat, and support students who are suffering from depressive illnesses is a critical strategy for campus suicide prevention. Recent research on brain systems holds promise for greater understanding of the biological underpinnings of depression, anxiety disorders, impulsiveness, aggression, and violent behaviors (Stoff & Mann, 1997). The impact of some risk factors can be reduced by interventions such as providing effective treatments for depressive illness (Isacsson, Holmgren, Druid, & Bergman, 1997).

With the increase in demand for clinical mental health services, many colleges and universities find their resources stressed, and are working to expand and make services more efficient (Kitrow, 2003). Most college mental health centers are understaffed, and the available resources are spread dangerously thin. Associated with a shortage of

professional staffing is the need for more sophisticated training in assessment, diagnosis, treatment, and management of an increasingly difficult population of students with major psychiatric disorders and dysfunctions. Four-year colleges and universities are more likely to have access to licensed clinicians, but community colleges and two-year institutions often rely on nurses to provide most health services, and therefore place more of a burden on local community health and mental health services (Brindis & Reyes, 1997).

Many college counseling centers rely heavily on community services such as community mental health centers, rape crisis services, emergency/mobile units, local crisis hotlines, and, now, national 1-800 help lines. Colleges and universities are fairly consistent in relying on the local mental health practitioner community of psychiatrists, psychologists, social workers, and other licensed mental health professionals for services. This reliance can place a burden on these services. Clinics designed to serve the low-income and working community can be overwhelmed by student clients.

In 1984, the University of Illinois instituted a formal program to reduce the suicide rate among its students (Joffe, 2003). At the core of this program is a policy that required any student who threatened or attempted suicide to attend four sessions of professional assessment. Consequences for failing to comply with the program included mandatory withdrawal from the university. In the 18 years since the program has been in effect, reports on 1,531 suicide incidents have been submitted to the Suicide Prevention Team. The suicide rate decreased from 6.91 per 100,000 enrolled students during the eight years before the program started to 3.08 during the 18 years of the program—a reduction of 55.4 percent. This reduction occurred against a backdrop of stable rates of suicide, both nationally and among 11 Big Ten peer institutions.

Colleges and universities should assess the adequacy of available mental health services and referrals to ensure that these services are capable of meeting the demands of their student populations.

Means Restriction

Restricting access to lethal means involves efforts to limit students' access to handguns, drugs, and other common means of suicide. Many campuses have tall buildings and other high places that are used as a means to attempt suicide. Restricting access to high places on or near campuses may also be an effective strategy to prevent suicides.

It has been estimated that between 3 and 5 percent of college and university students possess firearms on campus (Miller, Hemenway, & Wechsler, 1999 & 2002). Some schools have policies about firearms on campus, although it is unclear how consistent these policies are or whether they are enforced. One strategy to prevent firearm suicide might be to establish guidelines for working with high-risk students that focus on removing access to firearms and other highly lethal items.

Most campuses have risk management officers who are concerned about injury liability issues. Their concerns include access to lethal chemicals and students jumping or falling

from bridges, windows, and roofs. University risk managers should be involved in college suicide prevention efforts, especially those using environmental strategies, including the restriction of access to lethal means.

Social Marketing and Education

While there is no evidence base supporting the efficacy of social marketing approaches at present, many suicide prevention practitioners believe that campus social marketing campaigns can stimulate cultural changes that destigmatize mental health problems, remove barriers to accessing appropriate care, and encourage help-seeking. To date, there are no evaluated programs on college campuses specifically addressing these issues in terms of mental health. EDC's Higher Education Center for Alcohol and Other Drug Abuse and Violence Prevention (HEC) is a national leader in promoting social marketing approaches to prevent the abuse of alcohol and other drugs among college students.

An important element of a campus social marketing strategy is making students, faculty, staff members, and administrators aware of the problem and the resources to promote mental health and prevent suicide. An example of such an effort is The Truth About Suicide: Real Stories of Depression in College, a short film for college students developed by AFSP. The film's primary goal is to present a realistic and recognizable picture of depression in college-age youth, to encourage those suffering from depression and other psychiatric disorders to seek treatment, and to encourage those recognizing the signs of mental disorders in a friend, classmate, or charge to help them seek treatment. Target audiences for this film include residence hall advisors, health education faculty members, freshman orientation staff members, student counseling center personnel, and students. A package of supplemental educational materials for students is in development, with instructional materials to assist faculty and others in presenting the information, guiding student discussions, and answering specific questions about suicide.

Some colleges utilize the Internet as a tool to disseminate information and education about mental health issues and suicide prevention. One of the most comprehensive collections of virtual pamphlets is maintained by the University of Chicago (counseling.uchicago.edu/vpc/). Most college counseling unit Web sites feature National Institute of Mental Health (NIMH) materials on how to recognize and respond to the warning signs of depression and suicide, as well as faculty guides on identifying and referring youths at risk, and materials teaching parents how to monitor their children and talk to them about common college problems, such as loneliness, adjustment disorders, time management issues, and negotiating issues with roommates.

Efficacy and Effectiveness of Specific Strategies

There is limited information about the efficacy and effectiveness of suicide prevention strategies. There have been no specific treatment outcome studies that enroll only college and university students. However, most treatment research studies do include

subjects in this age group. Current research indicates that certain interventions have been shown to be effective for the treatment of psychiatric disorders often seen among college-age students, including depression—which is the most common psychiatric disorder associated with suicide—bipolar disorder, schizophrenia, and eating disorders. These interventions also have been demonstrated effective for generalized anxiety disorders, including PTSD. Promising interventions fall into two categories:

- Somatic interventions, including SSRIs, Lithium, and Clozapine

- _Psychosocial interventions, including dialectical behavioral therapy (DBT), cognitive behavioral therapy (CBT), and interpersonal therapy (IPT).

These treatments and the evidence for their effectiveness have been reviewed extensively in two major publications:

- _Practice guidelines for the assessment and treatment of patients with suicidalbehaviors. (2003). American Journal of Psychiatry, 160(Suppl. 11), 1–60.

- _Practice parameters for the assessment and treatment of children and adolescents with suicidal behavior. (2001). Journal of the Academy of Child and Adolescent Psychiatry, 40(Suppl. 7), 4S–23S.

In addition, there is a growing literature on the need to limit quantities of certain prescription psychotropic medications to prevent the possibility of lethal overdoses. These guidelines apply to all patients receiving psychotropic medications. Hawton (2002) demonstrated that limiting the number of tablets in packages of acetaminophen resulted in fewer suicidal overdoses with acetaminophen without an increase in other forms of over-the-counter drug overdoses.

In addition, a number of published studies have established the effectiveness of school-based prevention and intervention programs. There is ample literature on school-based interventions addressing violent behavior and alcohol and drug abuse. The literature is just emerging for self-destructive behaviors. Such programs are being reviewed by SPRC's Evidence-Based Practices Project. The results will be released in fall 2004. Some preliminary evidence is available from other studies including Kalafat (2003), Grossman and Kruise (2000), and Gould and Kramer (2001).

We also know a great deal about how to implement prevention programs to increase their effectiveness. Principles of effectiveness from other prevention topics have been adapted for implementing suicide prevention efforts. For example, Metha, Weber, and Webb (1998) identified elements of effective school-based preventive intervention programs. The Maine Youth Suicide Prevention Program developed guidelines to help Maine schools develop school-based suicide prevention, crisis management, and postvention protocols (DiCara & O'Holloran, 2002). And the CDC published school health recommendations to prevent unintentional injuries, violence, and suicide (2001). The challenge is to "translate" these successful intervention and implementation strategies to the college environment.

# Preventing Suicide Among College Students:
# A Comprehensive Approach

The complex problem of suicide and suicidal behaviors on campuses demands a multifaceted, collaborative, coordinated response, and cannot be left solely to counselors and mental health centers. College administrators need to ensure that all elements of the campus and community work together. Experts in mental health and suicide prevention agree that a systemic set of interventions that include efforts aimed at changing social norms about help-seeking as well as suicide prevention training are needed (NMHA & Jed, 2002).

Many campus mental health services are struggling to meet an increased demand for their services (Kitrow, 2003). While many colleges and universities are expanding efforts to meet this demand, others struggle with balancing the cost with the need. There are few specific suicide prevention efforts on college and university campuses.

Ideally, a comprehensive campus mental health promotion and suicide prevention program would facilitate development of resilience and identify and resolve mental health problems. The integration of suicide prevention activities into mental health, wellness, injury prevention, and public safety programs not only deters the most extreme and irrevocable risk to a young person's well-being, but adds value and effectiveness to these other efforts.

In 2001, NMHA and The Jed Foundation cosponsored Expanding the Safety Net: A Roundtable on Vulnerability, Depressive Symptoms and Suicidal Behavior. This discussion included a broad range of national experts who recommended strategies that might enhance intervention and ultimately reduce the rate of suicide, suicide attempts, and related behaviors among college students. One product of their discussions was a list of essential services for addressing suicidal behaviors on campus (NMHA & Jed, 2002). These essential services are described in Figure 1 on page 18.

Colleges and universities need more than services to adequately address suicide and related mental health problems. They need an operating structure in which to develop, implement, and coordinate these services and a conceptual framework in which to implement these activities as effectively as possible.

The following are requirements for the creation of such a structure and framework to support suicide prevention on campuses:

  • _Engage a broad and diverse group of participants representing relevant campus and off-campus partners, including students and their families.

  • _Specify strategy aims, goals, and measurable objectives integrated into a conceptual framework for suicide prevention.

  • _Sustain a functional operating structure with authority, funding, responsibility, and accountability for strategy development and implementation.

  • _Facilitate agreements among administrative, academic, and health units

outlining and coordinating their appropriate segments of the strategy to address specific targets of intervention.

- •  _Define appropriate activities for administrators, faculty, staff, students, families, clinicians, and other participants that can be evaluated.

- •  _Develop a data collection and evaluation system to track information on suicide prevention and benchmarks for strategy progress.

- •  _Integrate suicide prevention into existing health, mental health, substance abuse, education, and student services activities. Settings that provide related services, such as clinics, faith-based institutions, and student and community centers are all important venues for seamless suicide prevention activities.

- •  _Guide the development of activities that will be tailored to the cultural contexts in which they are offered. Attention to the cultural and developmental appropriateness of suicide prevention activities is key to success. Ethnic, religious, and gender diversity need to be considered, as do the different risk factors at work in younger and older students.

- •  _Emphasize early interventions to reduce risk factors for suicide and promote protective factors. As important as it is to recognize and help suicidal individuals, progress depends on measures that address problems early and promote strengths so that fewer people become suicidal.

## Strategies to Support Efforts of Colleges and Universities to Prevent Suicide

Some colleges and universities are taking steps to prevent suicide and respond to suicidal ideation and other mental health issues. But many require assistance.

A number of efforts could contribute significantly to increasing "the proportion of colleges and universities with evidence-based programs designed to address serious young adult distress and prevent suicide" (Objective 4.3 of the National Strategy for Suicide Prevention, DHHS, 2001). These include the following:

- •  _Establishing a centralized registry for suicides and suicidal behavior among college and university students in order to provide sound and consistent information about the magnitude and trends of the problem.

- •  _Developing a guide to college suicide prevention that provides a synthesis of what is known about the problem and successful efforts related to student mental health and suicide prevention. The guide could offer a general set of policies and practices that schools should consider in mounting efforts to promote mental health and prevent suicide.

- •  _Developing and disseminating a comprehensive framework to guide campuses in improving systems and services. This might take the form of guidelines or a tool for implementing mental health promotion and suicide prevention programs in colleges and universities that are culturally appropriate and adaptable to the type of school and associated student body.

• _Creating a leadership group consisting of presidents and others who can provide leadership on implementing model college and university mental health promotion and suicide prevention programs.

• _Conducting two to five demonstration projects with schools of varying sizes and student body compositions that would implement and evaluate comprehensive mental health promotion and suicide prevention programs. This would help create a flexible model that could be promoted at other colleges and universities.

• _Providing seed/leverage grants to schools to facilitate development and implementation of comprehensive plans to provide incentive and create a network of early adopters. A small incentive for schools to adopt established model programs would expedite the replication of such programs.

• _Developing standards for college and university mental health promotion and suicide prevention practices (based on a comprehensive framework) and establishing a process by which school programs would be reviewed by an expert panel that would provide feedback and suggestions for improvement.

• _Creating a centralized resource center/clearinghouse to provide leadership, information, and technical assistance to colleges and universities on designing, implementing, and evaluating comprehensive mental health promotion and suicide prevention programs. This center might also manage the process by which existing programs would be reviewed (as above).

• _Including a designated administrative staff person and student representation from key racial and ethnic groups in planning and implementation efforts for mental health promotion and suicide prevention.

• _Adopting the ACHA's standards for student health insurance/ benefits programs to ensure that all students have access to appropriate care for their physical and mental well being.

# Conclusion

In 2004, the U.S. government expects to spend nearly $70 billion on student financial assistance—the Federal government's most significant contribution to our nation's post-secondary school students. However, it is an investment that may not always yield anticipated results. Undiscovered, unaddressed, and unmet mental and behavioral health problems among college students can interfere with academic success as surely as a lack of computers, competent staff, or textbooks.

Investing in college campus mental health programs and suicide prevention programs can yield benefits far beyond the contribution these programs make to the personal well-being of students. They can help ensure that the Federal investment in post-secondary education is returned to the taxpayers in the form of academically successful and emotionally sound college graduates ready to contribute as members of families, communities, and the workforce.

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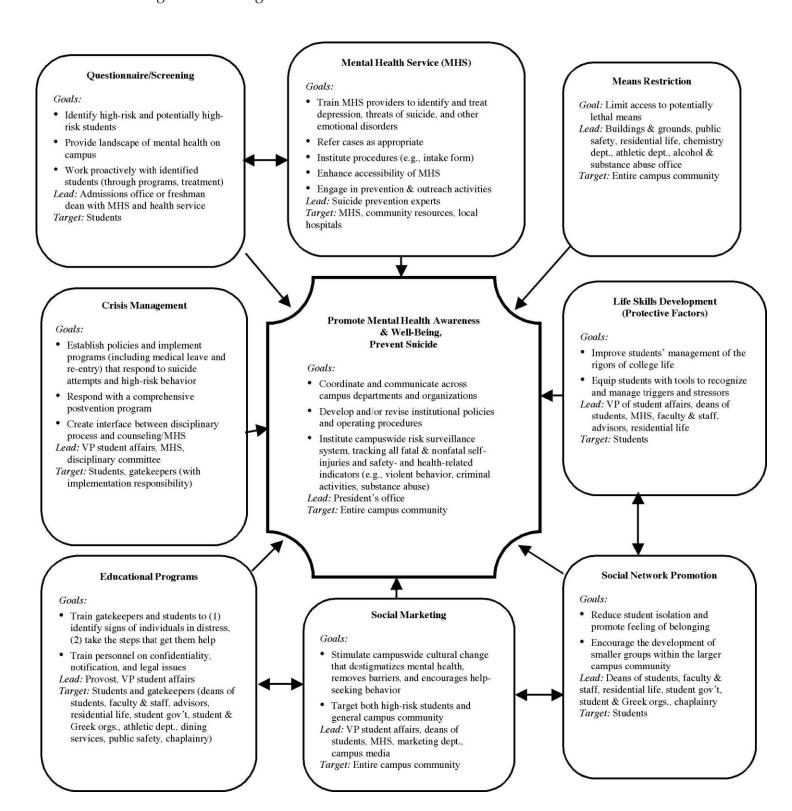
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Figure 1

Jed/EDC Partnership Model: Elements of a Comprehensive Suicide PreventionProgram for Colleges and Universities

**Questionnaire/Screening**

*Goals:*
- Identify high-risk and potentially high-risk students
- Provide landscape of mental health on campus
- Work proactively with identified students (through programs, treatment)

*Lead:* Admissions office or freshman dean with MHS and health service
*Target:* Students

**Mental Health Service (MHS)**

*Goals:*
- 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

**Means Restriction**

*Goal:* 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

**Crisis Management**

*Goals:*
- Establish policies and implement programs (including medical leave and re-entry) that respond to suicide attempts and high-risk behavior
- Respond with a comprehensive postvention program
- Create interface between disciplinary process and counseling/MHS

*Lead:* VP student affairs, MHS, disciplinary committee
*Target:* Students, gatekeepers (with implementation responsibility)

**Promote Mental Health Awareness & Well-Being, Prevent Suicide**

*Goals:*
- Coordinate and communicate across campus departments and organizations
- Develop and/or revise institutional policies and operating procedures
- Institute campuswide risk surveillance system, tracking all fatal & nonfatal self-injuries and safety- and health-related indicators (e.g., violent behavior, criminal activities, substance abuse)

*Lead:* President's office
*Target:* Entire campus community

**Life Skills Development (Protective Factors)**

*Goals:*
- 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

**Educational Programs**

*Goals:*
- 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)

**Social Marketing**

*Goals:*
- Stimulate campuswide cultural change that destigmatizes 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 dept., campus media
*Target:* Entire campus community

**Social Network Promotion**

*Goals:*
- 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

## Sexual Assault Protocol

The University at Albany has programs in place to protect all members of the University at Albany community from sexual assault, including programs for prevention and prosecution of these crimes that occur within the jurisdiction of University at Albany Police.

NYS Law contains the following legal provisions defining the crimes related to sexual assault:

**Section 130.20 – Sexual Misconduct**. This offense includes sexual intercourse without consent and deviate sexual intercourse without consent. The penalty for violation of this section includes imprisonment for a definite period to be fixed by the court up to one year.

**Section 130.25/.30/.35 – Rape**. This series of offenses includes sexual intercourse with a person incapable of consent because of the use of forcible compulsion or because the person is incapable of consent due to a mental defect, mental incapacity, or physical helplessness. This series of offenses further include sexual intercourse with a person under the age of consent. The penalties for violations of these sections range from imprisonment for a period not to exceed four years up to imprisonment for a period not to exceed 25 years.

**Section 130.40/.45/.50 – Criminal Sexual Act**. This series of offenses includes oral or anal sexual conduct with a person incapable of consent because of the use of forcible compulsion or because the person is incapable of consent due to a mental defect, mental incapacity, or physical helplessness. This series of offenses further includes oral or anal sexual conduct with a person under the age of consent. The penalties for violation of these sections range from imprisonment for a period not to exceed four years up to imprisonment for a period not to exceed 25 years.

**Section 130.52 – Forcible Touching**. This offense involves the forcible touching of the sexual or other intimate parts of another person for the purpose of degrading or abusing such person or for the purpose of gratifying the actor's sexual desire. Forcible touching includes the squeezing, grabbing, or pinching of such other person's sexual or other intimate parts. The penalty for violation of this section includes imprisonment for a period up to one year.

**Section 130.55/.60/.65 – Sexual Abuse**. This series of offenses include sexual contact with a person by forcible compulsion, or with a person who is incapable of consent due to physical helplessness, or due to the person being under the age of consent. The penalties for violation of these sections range from imprisonment for a period not to exceed three months up to imprisonment for a period not to exceed seven years.

**Section 130.65-a/.66/.67/.70 – Aggravated Sexual Abuse**. This series of offenses occurs when a person inserts a finger or a foreign object in the vagina, urethra, penis or rectum of another person by forcible compulsion, when the other person is incapable of consent by reason of being physically helpless, or when the other person is under the age of consent. The level of this offense is enhanced if the insertion of a finger or foreign object causes injury to the other person. The penalties for violation of these sections range from imprisonment for a period not to exceed seven years up to imprisonment for a period not to exceed 25 years.

## Disciplinary Action

Where there is reason to believe the University's regulations prohibiting sexual misconduct have been violated, the University will pursue strong disciplinary action through its own channels. This discipline includes the possibility of suspension or dismissal from the University.

An individual charged with a crime related to sexual assault may be subject to University disciplinary procedures, whether or not an individual is prosecuted under the New York State Penal Code.

The University will make every effort to be responsive and sensitive to the victim of these serious crimes. Protection of the victim and prevention of continued trauma is the University's priority. When the victim and the accused live in the same residence hall, an immediate hearing with the Director of the Office of Conflict Resolution & Civic Responsibility will be held to determine the need for modifying the living arrangements.

Assistance for any other personal or academic concerns will be reviewed and options provided.

During the disciplinary process, the victim's rights are:

- To have a person of the victim's choice accompany the victim throughout the disciplinary hearing.
- To remain present during the entire proceeding.
- As established in state criminal code, to be assured that his/her irrelevant past sexual history will not be discussed during the hearing.
- To make a "victim's impact statement" and to suggest an appropriate penalty if the accused is found in violation of the code.
- To be informed immediately of the outcome of the hearing.
- During the disciplinary process, the rights of the "accused" are as described in Community Rights and Responsibilities.

**Additional information and Educational Programs**
are available at http://albany.edu/studentaffairs/ovpsa/whatyoucando.html
Or
http://albany.edu/counseling_center/memain.html