

**NCHERM MODEL
VOLUNTARY/INVOLUNTARY
MEDICAL/PSYCHOLOGICAL
WITHDRAWAL POLICY, PROCEDURES
AND PROTOCOL
&
NCHERM SUICIDE
PREVENTION/INTERVENTION
PROTOCOL**

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**PORTIONS OF THESE MATERIALS ARE ADAPTED WITH GRATITUDE FROM MANY
EXCELLENT SOURCES, INCLUDING:**

**LORAS COLLEGE
THE UNIVERSITY OF IOWA
NEW YORK UNIVERSITY
THE COLLEGE OF WILLIAM AND MARY
GARY PAVELA, J.D.¹
RICHARD P. KEELING, M.D.**

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¹ Pavela, Gary (1985). *The Dismissal of Students With Mental Disorders: Legal Issues, Policy Considerations Alternate Responses*. College Administration Publications, Inc.: Asheville, N.C.

Policy and Procedures for Voluntary and Involuntary Withdrawal for Medical and/or Psychological Reasons

This policy and procedures are to be used to help transition a student to a safer and/or more conducive environment when remaining at the university is not in the best interests of the student or the university community. This policy encourages a student to withdraw voluntarily when medical conditions or psychological distress make a withdrawal necessary, and seeks to ease that transition and potential eventual return to the university. This policy also recognizes that some students whose needs would be better met elsewhere and who would receive more effective support elsewhere may need to be withdrawn from the university when the university is unable to support their needs or cannot offer the resources required to allow the student to succeed within the community in their current condition. In those times, where encouragement to the student to withdraw voluntarily has not been successful, involuntary withdrawal under this policy will be implemented.

Student-Initiated Withdrawal

Students may initiate withdrawal from the university for medical or psychological reasons demonstrated to the satisfaction of the vice president for student services. At the discretion of the vice president for student services, arrangements can be made for tuition refund or crediting, incomplete grades or other academic accommodations to ease the transition of the student to resources better able to support their medical and/or psychological needs. Modifications to housing contracts may also be possible. There are three types of withdrawal possible, permanent withdrawal, withdrawal for a specified period, and withdrawal pending the satisfaction of certain conditions for return. The withdrawal agreement will specify the reasons for withdrawal, and a hold will be placed on the student's registration status until the student is eligible for reinstatement. The agreement will specify the period of withdrawal, and detail any conditions necessary for reinstatement.

University-Initiated Withdrawal

If a student is behaving in a way which is threatening to the student or others, or which significantly interferes with the student's education or the rights of others, the vice president for student services may initiate these procedures. The vice president for student services is empowered with the discretion to define within his/her professional judgment what is sufficiently threatening and/or disruptive to warrant invoking this procedure.

The first step will be to determine an appropriate initial action. The primary alternatives for initial action are as follows, but these do not preclude other actions based on a specific situation.

1. Continue at the university with no restrictions. The university may take no action if it is decided, based on review of the referral information or other information presented, that the student may be allowed to continue with no restrictions. In those cases, care should be taken to provide opportunities for the student to be advised of accommodations and supportive services that are available. In cases where there are conduct actions pending, those actions should go forward.
2. Continue in university pending further proceedings. The university may require that the student meet certain conditions regarding the student's behavior over a specified period of time if he/she is to remain enrolled. Such conditions here could include, for example, stopping classroom disruptiveness, or continuing only if the student avails him or herself of supportive services or accommodation arrangements. Failure to comply with the conditions, coupled with further disruptive behavior, may result in having additional conduct complaints added to any that were previously pending or deferred. At no point will the university engage in a behavioral contract or agreement with a student whose behaviors indicate harm or danger to themselves or any member of the community.
3. Remaining enrolled at the university subject to conditions but with eligibility for university-owned residential agreement reviewed. Under certain circumstances, where other students' living and learning environment is very likely to be disrupted by a student's behavior, the Director of Residence Life will have the option of allocating alternative and more suitable living accommodations if such are available, or of terminating the housing agreement.
4. Suspension or expulsion. If there is a pervasive pattern of disruptive or threatening behavior, or behaviors that are assaultive, suicidal, self-injurious or self-neglectful which present an imminent risk of injury to the student or others, the student may be suspended or expelled. Interim suspension may be imposed prior to a suspension/expulsion hearing.

Standard for Interim Suspension

Interim suspension, under the Code of Conduct, may be imposed by the vice president for student services when necessary to protect the health and safety of a student or of the community, when investigating a conduct violation, or to allow time for a behavioral mental health assessment or evaluation. Interim suspension will be used for short periods of time, pending a hearing for a Code of Conduct violation or Involuntary Withdrawal. Students who are suspended on an interim basis may petition the vice president for students services for a hearing to show cause why they should not be suspended on an interim basis. This proceeding will be limited to:

1. the reliability of the information concerning the student's behavior;
2. whether the student's behavior poses a danger of causing substantial, serious harm to the student or others, causing property damage, or directly impeding the lawful activities of others;
3. whether the student has completed an evaluation, in accordance with the standards and procedures.

The sole decisions to be made at the hearing are whether interim medical suspension should be continued or modified, and whether medical withdrawal should remain in consideration.

Standard for Involuntary Medical/Psychological Withdrawal

University may withdraw a student if it is determined, by a preponderance of the evidence (that it is more likely than not) that the student is engaging in or likely to engage in behavior which poses a substantial danger of causing imminent harm to the student, to others or to substantial property rights, or which renders the student unable to engage in basic required activities necessary to obtain an education, or that substantially impedes the lawful activities of others.

Standard for Separating a Student on the Basis of Behaviors Resulting from a Condition of Disability

This section applies to all involuntary separation from housing or from the university for any student who is at significant risk of harm to self or others as a result of a condition covered by disabilities law. When self-harm or the potential for harm to others is present, involuntary withdrawal actions must consider whether the endangering behavior results from a condition of disability. If so, the student will be protected by Section 504 of the Rehabilitation Act of 1973. Under this federal statute, an individual with a disability may only be separated on the basis of this disability when they are not otherwise qualified to participate in the education program of the institution.

Disability here will be unlikely be the qualified disability on record with our ADA officer. Instead, protection of disability laws here comes from institutional perception and treatment of a student as an individual with a disability, such as in cases of suicidality. The objective of this section is to determine whether it is more likely than not that a student is a direct threat. When a student is a direct threat, they are not otherwise qualified under disabilities law, and may be separated.

A direct threat exists when a student poses a significant risk to the health or safety of themselves or others. A significant risk constitutes a high probability of substantial harm. Significance will be determined by:

- (1) The duration of the risk;
- (2) The nature and severity of the potential harm;
- (3) The likelihood that the potential harm will occur; and
- (4) The imminence of the potential harm.

The university must determine whether reasonable accommodations to policies, practices or procedures will sufficiently mitigate the risk, unless those reasonable accommodations would cause undue hardship for the university.

Determining that a student is direct threat requires an objective and individualized assessment and due process hearing². The assessment must be based on a reasonable medical judgment that relies on the most current medical knowledge and/or on the best available objective evidence. This standard also applies to hearings on the reinstatement of a student who has been withdrawn.

Status of Conduct Proceedings

If the student has been accused of a violation of the Conduct Code, but it appears that the student is not capable of understanding the nature or wrongfulness of the action, this medical withdrawal policy may be activated prior to issuance of a determination in the conduct process.

If the student is ordered to be medically withdrawn from the university, or another action is taken under these provisions following a finding that the student's behavior was the result of a lack of capacity, such action terminates the pending conduct action. If the student is found not to be subject to medical withdrawal or other action under this section, conduct proceedings may be reinstated.

Referral for Assessment or Evaluation

The vice president for student services (or behavioral intervention team) may refer or mandate a student for evaluation by a campus or independent licensed psychiatrist or psychologist (LPC, social worker, LCSW, etc.) chosen by the institution if it is believed that the student may meet the criteria set forth in this policy or if a student subject to conduct proceedings provides notification that information concerning a mental/behavioral disorder will be introduced.

Students referred or mandated for evaluation will be so informed in writing with personal and/or certified delivery, and will be given a copy of these standards and procedures. The evaluation, conducted at (university or student) expense, must be completed within (2,3,4,5...10) business days from the date of the referral letter, unless an extension is granted by the office of the vice president for student services. A student who fails to complete the evaluation in accordance with these standards and procedures and give permission for the results to be shared with appropriate administrators may be withdrawn on an interim basis, or referred for conduct action, or both.

Involuntary Medical Withdrawal Hearing Procedures

If the medical evaluation or administrative assessment supports the need for medical withdrawal, a hearing will be scheduled before the vice president for student services or designee and the director of the health center. The student will be informed, in writing with certified delivery of the time, date and place, and will be given at least two business days to independently review the psychological or psychiatric evaluation prior to the hearing. In

² Even at private universities.

addition, the student will be notified of who is expected to present information at the hearing, and is expected to notify the vice president for student services or designee in advance of any witnesses the student expects to bring. The student may consult with an attorney throughout this process, and the vice president for student services has the discretion to permit counsel may be present at the hearing. The role of counsel is to advise rather than actively represent their client, unless the student is incapacitated, and unable to represent themselves.

If the evaluation does not support medical withdrawal, the student will be notified. If other action is pending, the appropriate individuals will be notified and will proceed with their actions. The student and the student's representatives may present information for or against involuntary medical withdrawal and will be given the opportunity to ask questions of others presenting information. The hearing will be conversational and non-adversarial; however the vice president for student services or other designated person in charge of the hearing will exercise active control over the proceeding, to include deciding who may present information. Formal rules of evidence will not apply. Anyone who disrupts the hearing may be excluded.

The student subject to either an Interim Suspension Hearing or an Involuntary Medical Withdrawal Hearing may be assisted in the hearing by a family member and/or a licensed psychologist or psychiatrist, or in lieu of a licensed psychologist or psychiatrist, by a member of the faculty or staff of the university or other support person at the discretion of the vice president for student services or designee.

A written decision will be rendered by the committee within two business days, stating the reasons for its determination. The decision will be delivered to the student directly or by certified means. If the student is withdrawn, the notification will include information concerning when reapplication may be made, as well as specifying any conditions of reinstatement. The decision of the vice president for student services, or designee, is subject to appeal to. A written and taped record of the proceeding will be kept and a copy made available to the student.

A student seeking readmission who has been medically withdrawn must reapply, and may not reenter the university without providing competent medical evidence that:

- the medical/psychological condition no longer exists;
- the medical/psychological condition is sufficiently under treatment so as to remove any substantial likelihood of reoccurrence of the situation which caused medical withdrawal; or
- the student is no longer a direct threat.

In addition to the information that a reapplying student submits, the university may require the student, at the student's cost, to undergo a medical evaluation by a licensed mental health professional of the university's choosing. The results of such evaluation must be disclosed to appropriate university personnel.

A medical withdrawal is not considered a conduct action, though a prior medical withdrawal may be considered in subsequent conduct hearings involving the student.

**THE UNIVERSITY SUICIDE/THREATS/IDEATION
PROTOCOL CHECKLIST FOR COUNSELING CENTER ON CALL STAFF**

Situations where a student is deceased:

- _____ Contact campus police.
- _____ Contact the VPSS
- _____ Secure the area and any evidence from tampering

Situations that are life threatening:

- _____ Assess the situation, asking questions and obtaining information.
 - Assess the physical space and person for possible dangers such as sharp objects, weapons, open windows, drugs/medication, etc.
 - If you cannot safely remove/disarm the student and secure the scene, contact Campus Police.
 - Retain any items removed from the scene, if possible.
- _____ Remain with student unless it would be unsafe to do so.
- _____ Assure that Rescue has been called and that student has been transported to ER.³
- _____ Accompany student or arrange support if wanted/necessary at hospital.
 - Ask the student if you can notify anyone on their behalf.
- _____ Notify Vice president for student services Office and Student Health Center.⁴
 - Assess need to notify parent/guardian⁵

³ Under this protocol, taking custody of students in crisis is to be avoided when that responsibility can be best placed with local medical personnel. If a university employee takes custody over a student, the university assumes responsibility for the health and welfare of that student, and may be liable for any harm that might come to that student while in custody. If it is necessary to establish a custodial situation, all efforts must be taken to monitor and control that environment for safety.

⁴ If it is after regular business hours, reach the VPSS or office staff member at home or by cellphone.

⁵ FERPA does not bar release of information to parents/guardians of dependent students, or in emergency health and safety situations. Where a situation is potentially life-threatening, and it is your professional judgment that parental or friend involvement would help, do not hesitate to involve them. At this level of crisis, parents/guardians should be notified as quickly as possible unless it is your determination that their presence would not be beneficial to the student in crisis.

- Is student a minor?
- Is student a dependent?
- Is there an emergency health/safety concern?
- Assess need to notify roommates/friends
- Ensure university representative will be present at hospital, if needed
- Assess need to involve university PR staff.
- Assess need to mobilize police, CISDT or other crisis response personnel

_____ Return from the hospital by the student, including the ER, requires implementation of the suicide policy for clearance to return to campus, including but not limited to classes and student's residence.⁶

Situations needing assessment (Suicide threat, physical gestures, no drugs/alcohol):

_____ Upon contact by Campus Police, Residence Life, or other persons, on call, counselor will follow up with phone call to student for an initial assessment.

_____ Check with referral source and student being assessed whether or not alcohol or other drugs have been ingested. If so, instruct referral source to immediately contact **911** for transport to the hospital.

_____ For current Counseling Center client of another therapist, on call counselor may choose to call the client's therapist for consultation and/or delegation of assessment.

No immediate safety concern/no activation of the suicide protocol when telephone assessment has been completed:

_____ Confirm verbal "no harm" understanding with student.

_____ Review on call and emergency (911) procedures.

_____ Arrange for next working day follow-up appointment at Counseling Center as needed.

_____ Make follow-up phone call to referral source within 24 hours to inform of disposition of situation, as permitted by law. Referral source, depending upon the situation, may need follow-up at time of disposition.

_____ Complete paperwork at office next day (or complete online incident report if

⁶ Because of HIPAA, you will need written consent from the student if you want information from the hospital.

available)

_____ Note student name and service hours on daily appointment schedule for date of contact.

_____ Complete crisis reports to be placed in file of current or previous Counseling Center clients.

_____ Complete crisis report and place in confidential file if “ new client.”

Activation of suicide crisis protocol when telephone assessment has been completed:

Uncooperative student:

_____ If determined that the student needs to be further assessed under the suicide protocol and the student is uncooperative (refuses to voluntarily come to the Student Health Center), notify vice president for student services Office on call staff for their administrative action/support to implement the suicide protocol.

_____ Do not attempt to talk a student through a crisis over the telephone unless that is the only alternative available.

Cooperative student who agrees to further assessment at the Student Health Center:

_____ Contact physician on call (after hours use home phone before use of beeper) to arrange after hours opening of Student Health Center. If during open hours, call front desk staff of Student Health Center and ask for the on call physician.

_____ If physician unavailable or student prefers, arrange transport to (local) hospital. (If you have a transport policy, note limitations and transport preferences here). Use the most unobtrusive means of transport possible, to ensure privacy of student.

_____ (If your local hospital has a transport or triage preference, note it here)

_____ Contact referral source to report disposition of on call telephone assessment and to arrange transportation/escort by Campus Police, Residence Life, or City Police (for off campus students).

_____ On call counselor will provide Counseling Center initial contact paperwork to be used in evaluation process:

_____ Counseling Center/Disclosure Statement

- _____ Client Data Form
- _____ Suicide Status Form (Optional)
- _____ Information Release Form

Assessment at Student Health Center:

- _____ Consultation meeting with on call counselor, physician, referral source (if present) for factual account and assessment plan.
- _____ Student asked to complete Counseling (and/or Health) Center initial contact paper work.
- _____ Team assessment interview conducted by on call counselor.
- _____ Assessment team may request further diagnostic evaluation and consultation by psychiatrist (do you have one on contract with the university or one staff?), (name of individual). Dr. ?? is expected on site for evaluation soon as possible but no more than 14 hours from being called. If /she is not reached at his/her home or office numbers (include numbers here), contact his/her answering service and state the situation is an emergency (include number here).
- _____ On call counselor contacts Dr. ??.

Disposition:

No immediate safety concern/no activation of the suicide protocol when assessment has been completed; student is allowed to leave the Student Health Center:

- _____ Confirm verbal “no harm” understanding or implement written “no harm” contract as appropriate.⁷
- _____ Review on call crisis procedures with client.
- _____ Obtain a release of information for the VPSS.
- _____ Arrange for next working day follow-up appointment at the Counseling Center as appropriate.
- _____ Inform VPSS immediately if student does not attend follow-up session.

⁷ Not to be used in life-threatening or extreme injury situations.

_____ Arrange for additional referrals and appointments as needed, e.g., psychiatric evaluation for diagnosis or medication evaluation with psychiatrist or physician or psychologist of student’s choice.

_____ Make follow-up phone call to referral source within 24 hours to inform of disposition of situation, as permitted by law. Referral source, depending upon the situation, may need follow-up at time of the disposition.

_____ If referral source is Residence Life, discuss need for any follow-up contact with roommates, other students.

_____ Physician notifies VPSS office of outcome of assessment.

_____ Contact the VPSS Office Monday – Friday following the Health Center evaluation. No need to notify during the weekend. DO NOT leave a message on voice mail.

_____ Complete paperwork at office next day:

_____ Note student name and service hours on daily appointment schedule for date of contact.

_____ Complete crisis report and place in confidential file if “new client.”

_____ Send copy of crisis reports to attending physician next day in sealed envelope marked confidential, either hand delivered or by Campus Mail.⁸

_____ Notify the Counseling Center Director next weekday morning. No need to notify during the weekend.

Activation of Suicide Policy after assessment is completed:

_____ On call counselor agrees to place the student under the suicide policy.

_____ Attending physician contacts VPSS Office.

_____ Attending physician contacts parents. Exceptions can only be made by the VPSS.

Arrangements to meet with parents are made, if needed.

⁸ These may not be transmitted by email.

- If parents are unreachable, check student emergency contact information.

_____ On call counselor contacts the referral source for follow-up.

_____ VPSS contacts Residence Life (if not referral source and if student resides on campus) regarding student not being allowed on campus until cleared by the medical team.

_____ VPSS determines need to contact Campus Police (if not referral source) regarding student not being allowed on campus until cleared by the medical team.

_____ Refer to Student Health Center checklist for management of student safety pending student's clearance to return to campus, classes and on campus housing.

_____ Attending physician coordinates arrangements for "disposition meeting."

_____ After hours and weekends contact the VPSS by cell phone (#)

_____ Use cellphone (beeper) if no answer at home telephone. If VPSS is out-of-town, VPSS on call staff will have the beeper. If no response, contact ??.

After Disposition under Suicide Policy:

_____ Make follow-up phone call to referral source to inform of disposition of situation, as permitted by law.

_____ If referral source is Residence Life, discuss need for any follow-up contact with roommates, other students.

_____ Inform Counseling Center Director of all situations where a student is evaluated at the Health Center or transported to hospital. Weekends or after hours call any time as needed for consultation. To inform only weekends call after 7:00 AM; weekdays 8:00 AM at office.

_____ Complete paperwork at office next day:

_____ Note student name and service hours on daily appointment schedule for date of contact.

_____ Complete crisis reports to be placed in file of current or previous Counseling Center clients.

_____ Complete crisis report and place in confidential file if “ new client.”

_____ Send copy of evaluation report to attending physician next day in sealed envelope marked confidential, either hand delivered or by Campus Mail.

Medical and Emotional Emergency Protocol

The Medical and Emotional Emergency **Protocol** is the university's response to cases that might involve violation of the Medical and Emotional Emergencies section of the Student Code of Conduct. It is put into effect when a student attempts **suicide** or makes a threat or gesture of **suicide**, harm or attempt to harm him/herself.

The procedure starts with the initial awareness that a student may have caused harm, or is talking about harm to self. There are two possible pathways. [Note that, because of the unique nature of each case, professional judgment will be used appropriately if the protocols don't necessarily conform to the emerging situation.]

5. *Situations where there is imminent danger require an immediate response.*

These include the following situations:

- The student threatens or has inflicted harm to self that a reasonable person would regard as serious.
- The student is believed to have ingested potentially dangerous substance(s) the amount and effect of which is uncertain.
- The student has threatened harm to self and has been using any alcohol/drugs.
- The extent of self-injury is unknown and the student is unresponsive to stimuli.

Responses to the above situations involve contacting the Campus Police and the Rescue Squad via 911. The student is taken to the ER and the Medical and Emotional Emergency **Protocol** is implemented.

A reporting call must be made to the counselor on-call who informs the VPSS Office. This call should be made by the professional residence life staff member responding, Campus Police, or other college official present in that order and if applicable. As time permits, notice should be relayed to all CISDT members (identified to include...).

*If the student is judged to be at-risk by the prescriber at the Hospital, the student must be cleared before being allowed to return to campus. (See **Medical and Emotional Emergency Protocol** below)*

If the Hospital prescriber clears the student, the on-call counselor will either (a) require an assessment at the Health Center or (b) set an appointment at the Counseling Center with the student during the next working day, informing the student that he/she is expected to attend it (depending upon which is deemed most appropriate given the clinical situation).

Non-compliance may be considered a conduct violation. The on-call counselor makes appropriate notifications and completes paperwork according to the Counseling Center **protocol**.

2. ***Suicide*** gestures or threats where imminent danger is unclear, including evidence of recent self-inflicted superficial scratches or cuts, and/or statements of an intention to harm oneself.

Responses to the above situations involve contacting the on-call counselor and the VPSS office. The on-call counselor conducts an initial assessment to determine if safety is an issue.

- *If safety is not an issue* the on-call counselor will set an appointment at the Counseling Center with the student during the next working day, informing the student that he/she is expected to attend it, if appropriate. Non-compliance may be considered a conduct violation. The on-call counselor makes appropriate notifications and completes paperwork according to the Counseling Center **protocol**.
- *If the student is uncooperative*, and fails to respond when informed that his/her cooperation is required, the VPSS is contacted.
- *If the on-call counselor determines that safety is or may be an issue*, the physician on-call is contacted. An assessment is conducted at the Health Center to determine if the student's safety is at risk. If no risk is determined, the student will be scheduled for an appointment during the next working day at the Counseling Center as above. If risk is determined, the **Medical and Emotional Emergency Protocol** is implemented (see below).

Medical and Emotional Emergency Protocol

If a student has been determined to be at risk of harm to self, the attending physician contacts the VPSS and the student's parents or legal guardians. If the physician has not had clinical contact with the student (e.g., when the student has been taken directly to the ER and then hospitalized), the VPSS will make the call. Exceptions to contacting the parents or legal guardians can only be made by the VPSS or her designee.

The on-call counselor and/or on-call physician will contact the referral source and Residence Life (if not the referral source and the student resides on campus). The student is not allowed to return to residence, classes, or activities until cleared.

The Student Health Center checklist for management of student safety is followed.

The on-call physician coordinates arrangements for a "disposition meeting." This meeting involves the student, his/her parent(s) or legal guardian, the on-call counselor, the on-call physician, and the VPSS.

Students who leave the campus under the Medical and Emotional Emergency **Protocol** must have a clearance meeting before they may return to campus. Ideally, this clearance meeting is with the same team that conducted the disposition meeting. The purpose of the clearance meeting is to determine the student's safety and readiness to return, plus conditions that will support the student's success.

Contact Numbers

Residence Life

???-???? (during office hours)

Residence Life On-Call pager:

???-????

Counseling Center:

???-???? (During office hours)

Counselor On-Call pager:

???-????

Health Center:

???-???? (During office hours)

Health Center after hours:

???-????

Doctor On-call pager:

???-????

VPSS Office:

???-???? (During office hours)

VPSS home:

???-???? (After hours; call before using pager)

Vice president for student services pager/cellphone:

???-???? (If no answer at home)

Campus Police:

???-???? or 911

Responding to Students in Distress

The staff role in responding

As a university staff member you are in an excellent position to recognize behavioral changes that characterize the emotionally troubled student. A student's behavior, especially if it is inconsistent with your previous observations could well constitute an inarticulate attempt to draw attention to his or her plight, (i.e., a "cry for help"). Your ability to recognize the signs of emotional distress and courage to acknowledge your concerns directly to the student are often noted by students as the most significant factor in their successful resolution of their problems.

Signs of Distress

Look for and be aware of any of the following signs of distress:

- Confusion, indecisiveness, inability to concentrate
- Persistent worrying
- Social isolation, depression
- Increased irritability, restlessness
- Bizarre or dangerous behavior, mood swings
- Missed class/assignments, procrastination
- Disheveled appearance
- Change in prior level of functioning, such as sleep patterns, appearance, eating, classroom attendance
- Traumatic change in personal relationships
- Drug and/or alcohol abuse

Your Response

Involve yourself only as far as you are willing to go. At times, in an attempt to reach or help a troubled student, you may become more involved than time or skill permits. It is important to know the boundaries and limitations of your intervention. If you decide to take action, you should follow these guidelines when approaching a distressed student:

- Request to see the student in private. This may help minimize embarrassment and defensiveness.
- Openly acknowledge to the student you are aware of their distress.
- Speak directly and honestly and acknowledge you are sincerely concerned about their welfare and you are willing to help them explore their alternatives.
- Strange or inappropriate behavior should not be ignored. Comment directly on what you have observed.
- Listen carefully to what the student is troubled about and try to see the issue from

his/her point of view without necessarily agreeing or disagreeing.

- Attempt to succinctly identify the student's problem or concern and explore alternatives to deal with the problem.
- Refer the student to professional help when appropriate.
- Inform your supervisor

Supporting different types of students:

The Anxious Student

For these types of students, danger is everywhere, even though what makes students anxious is often unknown. Not knowing what is expected and conflict are primary causes of anxiety. Unknown and unfamiliar situations raise their anxiety; high and unreasonable self-expectations increase anxiety also. These students often have trouble making decisions.

Do:

- let them discuss their feelings and thoughts - this alone often relieves a great deal of pressure.
- reassure when appropriate.
- remain calm.
- be clear and explicit.

Don't:

- make things more complicated.
- take responsibility for their emotional state.
- overwhelm with information or ideas.

The Depressed Student

Typically, these students get the most sympathy. They show a multitude of symptoms, e.g., guilt, low self-esteem, feelings of worthlessness, and inadequacy as well as physical symptoms such as decreased or increased appetite, difficulty staying asleep, early awakening, low interest in daily activities. They show low activity levels because everything is an effort and they have little energy.

Do:

- let student know you're aware he/she is feeling down and you would like to help.
- reach out more than halfway and encourage the student to express how she/he is feeling, for he/she is often initially reluctant to talk, yet others' attention helps the student feel more worthwhile.
- tell student of your concern.

Don't:

- Minimize the student's feelings, (e.g., "Don't worry," "Crying won't help," or "Everything will be better tomorrow.")
- be afraid to ask whether the student is suicidal if you think he/she may be..

The Student in poor contact with reality

These students have difficulty distinguishing fantasy from reality, the dream from the waking state. Their thinking is typically illogical, confused, disturbed; they may coin new words, see or hear things which no one else can, have irrational beliefs, and exhibit bizarre or inappropriate behavior. Generally, these students are not dangerous and are very scared, frightened and overwhelmed.

Do:

- respond with warmth and kindness, but with firm reasoning.
- remove extra stimulation of the environment and see them in a quiet atmosphere (if you are comfortable in doing so).
- acknowledge your concerns and state that you can see they need help, (e.g., "It seems very hard for you to integrate all these things that are happening and I am concerned about you. I'd like to help.")
- acknowledge the feelings or fears without supporting the misperceptions, (e.g., "I understand you think they are trying to hurt you and I know how real it seems to you, but I don't hear the voices (see the devil, etc.).")
- reveal your difficulty in understanding them (when appropriate), (e.g., "I'm sorry but I don't understand. Could you repeat that or say it in a different way?")
- focus on the "here and now." Switch topics and divert the focus from the irrational to the rational or the real.
- speak to their healthy side, which they DO have. It's O.K. to joke, laugh, or smile when appropriate.

Don't:

- argue or try to convince them of the irrationality of their thinking for it makes them defend their positions (false perceptions) more.
- "play along", (e.g., "Oh yeah, I hear the voices (or see the devil).")
- encourage further revelations of craziness.
- demand, command, or order.
- expect customary emotional responses.

The Suicidal Student

Suicide is the second leading cause of death among college students. Most people who contemplate suicide are ambivalent about killing themselves and typically respond to help. Suicidal students usually attempt to communicate their feelings prior to attempting suicide.

High risk indicators include:

- feelings of hopelessness, helplessness, and futility.
- a severe loss or threat of loss
- a detailed suicidal plan
- history of a previous attempt

- history of alcohol or drug abuse, and
- feelings of alienation and isolation
- Giving away personal possessions
- Talking about death

Do:

- take the student seriously - 80% of suicides give warning of their intent.
- acknowledge that a threat of or attempt at suicide is a plea for help.
- be available to listen, to talk, to be concerned, and contact a professional team member as soon as possible. Contact Campus Police @ ????. They can get immediate help while you remain with resident (as long as it is safe for you to do so)
- take care of yourself. Helping someone who is suicidal is hard, demanding, and draining work.

Don't:

- minimize the situation or depth of feeling, e.g. "Oh it will be much better tomorrow."
- over commit yourself and, therefore, not be able to deliver on what you promise
- ignore your limitations
- leave the student alone if concerned there is substantial or imminent risk

Confronting a Student

Confronting a student does not require judging, blaming, or attacking the person. It does not require demeaning or forcing the person to take action. Confronting someone means that you have the courage to let the student know what you have seen and heard, that you are concerned about them and that you are willing to help. Listed below are some practical tips on confronting a resident, a friend, or anyone else you care about.

Be HONEST and SPECIFIC:

Explain why you want to have a serious talk and what you hope will happen...(and what you hope doesn't happen).

Example: "I am really worried about your drinking and I hope you won't just blow me off or think I am just putting you down...I don't want to wreck our friendship..."

Describe your OBSERVATIONS:

It is important that you describe your observations in a non-judgmental way and express concern in your observations.

Example: "Since last Friday night you have come back to our room really drunk four times, twice you said you drove home drunk and last night you threw-up all over our floor..."

Express your FEELINGS:

Example: "I am really worried about you...I am scared to talk to you in a serious way because I think you don't believe you have a problem...and bringing it up might just piss you off..."

Offer your **RECOMMENDATIONS**:

Example: "I really wish you would go talk to someone about your drinking...see if you do have a problem. You could either talk with a physician at health services or a counselor at the University Counseling Service... whoever you would be most comfortable with... I'll go with you... The services are free and they are on campus."

LISTEN actively to what your resident says:

Listening "actively" does not require that you necessarily agree or disagree with your friend. The important part is that you accurately hear what your friend is saying so he or she feels heard and understood. One way to communicate that you are listening and understand is to paraphrase what your friend says, from their point of view, and to then to restate your observations and recommendations.

Always call for help:

Never, never put yourself in an unsafe position. Know when to get help. Your supervisor is your first line of assistance and support. ***ALWAYS share your concerns about students with your supervisor.*** ALWAYS work with your supervisor when you need support for yourself. In addition, we can consult with an on-call psychiatrist, who can speak with a student by phone.

You are NEVER alone!

Below are a few campus resources to always have at your disposal:

VPSS _____ contact info: _____

Dir. of Res. Life _____ contact info: _____

University Counseling Service ???

Department of Public Safety ???

Health Center ???

Psychiatrist on Call ???

Supporting Resident Students

When to make the initial contact with residents:

- When a resident initiates contact with you
- When you observe behavior(s) of a resident that worries or concerns you
- When a resident tells you about concerning behavior of another resident

When a resident initiates contact with you:

- Assess if you have time to meet with the resident, e.g. you have 15 to 30 minutes in which you can offer your undivided attention to the resident
- Choose a place to talk where you will not be interrupted frequently, e.g. you may have to close your door if you are in your room
- Actively listen to the resident by allowing him or her to explain the reason he or she is coming to you
- If the resident requires further intervention beyond talking with you at this time, discuss options of what the resident can do
- Make sure those options are realistic
- You may suggest options; however, keep your suggestions to a minimum to encourage the resident's independence and to empower the resident
- Establish a time frame as to when the resident will accomplish the option he or she has chosen.

How to initiate contact with residents:

- Tell the resident that you would like to talk to him or her
- Go ahead and talk with resident at that time if he or she is alone
- Otherwise, arrange a time and place to talk with the resident one on one

Talking to residents about their concerning behaviors:

- Point out the concerning behavior(s) – be sure to be specific and non-judgmental
- Explain why this behavior concerns you, if it is not obvious to the resident
- If relevant, explain how others have been affected by his or her behavior
- Actively listen to the resident by allowing him or her to explain his or her point of view
- Discuss options of how the resident can stop or decrease his or her concerning behavior
 - Make suggestions of what the resident can do
- Establish a time frame as to when the resident will accomplish the option he or she has chosen

When to refer a resident to a mental health professional:

The following list is not comprehensive of all reasons to refer a resident; though, the list should be used as a guideline for the kind of issues and problems that you will refer out to a professional staff person.

- Poor emotional control
 - Uncontrollable crying or laughing at inappropriate times for a prolonged period
 - Hostile or belligerent behavior for no apparent reason
 - Exaggerated outbursts of emotion disproportionate to the event
 - Excessive worry and anxiety, especially about things that generally people don't worry about so much
- Sleeping and eating habits that change dramatically
 - Sleeping throughout the day or for much longer than usual
 - Not sleeping at all or very little
 - Eating a lot of food in a short period of time or continually eating
 - Eating very little food or abstaining from eating for a prolonged period of time (which could be as short a period of time as a few days)
- A preoccupation with personal health
- Frequent distrust of others and paranoia
- Hearing voices or having visual hallucinations (seeing things that aren't there)
- Persistent and ongoing depression (i.e. resident is expressing hopelessness, extreme lack of motivation, sleep problems, and withdrawal)
- Suicidal ideation

Ask yourself the following questions to determine if you need to refer the resident for professional help:

- Does the behavior the resident exhibits seem out of the ordinary?
- Do you believe you can deal with the particular problem, or do you believe it is beyond your skills at this time?
- Is the resident's behavior getting worse?
- Does the behavior place anyone, including the resident in question, in physical danger?

If at anytime you are with a resident and you are concerned about your safety, the safety of the resident, or the safety of others, call the RD for immediate help.

Process of referring a resident to a mental health professional

1. Point out to the resident his or her concerning behavior(s) – be sure to be specific and non-judgmental
2. Talk to the resident about going to see a mental health professional (counselor)
3. Emphasize that going to see a counselor does not mean that a person is mentally ill
4. Explain that meeting with a counselor is confidential, which means that the counselor will not tell you, the school, or the resident's family what the resident and the counselor discuss in their meetings; unless, the resident is likely to harm him or herself or someone

else.

5. Give and/or tell the resident a list of mental health resources at NYU
6. Offer to be present when the resident makes an appointment and/or when he or she seeks out counseling
7. It is better to make an appointment or seek out counseling sooner than later.
 - a. Or, offer to make a counseling appointment for the resident with the resident present
8. If you feel comfortable, offer to accompany the resident to their first visit with a counselor
9. Tell your supervisor about the resident in question's situation, about your concerns for this resident, and that you referred the resident to counseling

Follow-up with the resident

- Follow-up with the resident in a timely manner, i.e. within a week, though sooner if the concern with the resident was very serious
- Initiate contact with the resident, e.g. stop by his or her room, ask him or her to have a meal with you
- Check to see that the resident implemented or at least attempted to implement the plan that he or she chose in your presence
 - o If the resident has not attempted to implement the plan, discuss the barriers and how to minimize those barriers
- Express care and continued interest
- Make sure to work closely with your supervisor

You will likely only need to follow-up once with most incidents. However, you may need to follow-up a few times with a resident who has more severe problems.

COUNSELING SKILLS

The following counseling skills are to be utilized any time you are talking with a resident about something that is concerning you about the resident or the resident is expressing concerns to you.

Active Listening

Active listening lets the person you are with know that you are truly listening to what it is he or she is saying.

- Non-verbal techniques
 - o Eye contact
 - o Open body language (e.g. crossing legs and arms at the same time is not open body language)
 - o Nodding your head to communicate that you understand what is being said
- Sub-verbal communication includes saying "uh-huh" to signify that you

understand what you are hearing

- Paraphrasing
- Using your own words, summarize what the person just said to you to clarify what was said and/or to show that you understand what was said

Additional Counseling Skills

- Ask clarifying questions.
 - This shows the person that you are interested and keeps him or her focused on the issue at hand
 - Examples of clarifying questions:
 - “What I hear you saying is....”
 - “What did you mean when you said...?”
 - “If I understand you correctly, you are saying....”
 - “Did you say...?”
- Ask open-ended questions
 - Open-ended questions elicit more information, much more information than a yes or no questions does
 - Examples of open-ended questions:
 - “Could you tell me more about...?”
 - “How might the situation have been different if you had ...?”
- Empathize
 - Focus on how the person is feeling
 - Try to put yourself “in his or her shoes”
 - Attend to and reflect on those feelings
 - Examples of empathizing are:
 - A resident is talking to you about her boyfriend breaking up with her. You show empathy by saying, “You’re feeling hurt.”
 - A resident is telling you that she has a paper due on Monday, her parents are visiting this weekend, and her roommate left the room a complete mess. You show empathy by saying, “You’re feeling overwhelmed because you have so much going on at once.”

You will likely find that your active listening and the questions that you ask will help the person to think about his or her problem more thoroughly. He or she may gain a better understanding of how to handle his or her problem just because you listened and asked questions. Listening helps others feel like you care about what they are saying and expressing empathy validates their feelings about their experiences.