

## RESOURCE DOCUMENT ON COLLEGE MENTAL HEALTH AND CONFIDENTIALITY

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Approved by the Joint Reference Committee, October 2016. This resource document replaces the prior one of the same name approved by the Council on Psychiatry and Law in 2009.

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## Introduction

College homicides and suicides often precipitate reviews of regulations, statutes and case law governing treatment and confidentiality.<sup>1</sup> In April 2007, for example, a college senior at Virginia Polytechnic Institute and State University killed 32 students and faculty, wounded many others and then killed himself. The review panel appointed by the Governor found significant confusion among university officials about the Family Educational Rights and Privacy Act (FERPA)<sup>2</sup>, the federal law governing confidentiality of educational records, leaving them uncertain about what information could be revealed to each other as well as to the student's parents.<sup>3</sup> Psychiatrists seeing students as patients in college settings, either as employees of student mental health services or as private practitioners in the community, have also been confused as to their relationship to the university and the effect of federal and state laws governing confidentiality. This resource document was prepared to give practitioners a guide to providing good clinical care within the framework of relevant law.

## Clinical Background

College students experience a variety of mental health concerns ranging from anxiety, depression, eating disorders, alcohol and substance abuse to the emergence of psychotic disorders such as bipolar disorder and schizophrenia. Colleges and universities enrolled about 21 million students in the fall of 2014, with an estimated 85% enrolled in undergraduate programs.<sup>4</sup> Surveys of 94,197 students from 168 campuses participating in the Spring 2014 ACHA National College Health Assessment revealed that 12% reported a diagnosis of or treatment for depression within the past year while 14.3% reported a diagnosis of or treatment for anxiety in the past year. Of the surveyed students, 32.6% said they "felt so depressed it was difficult to function", 54% felt overwhelming anxiety and 8.1% said they "seriously considered suicide" within the prior twelve-month period.<sup>5</sup>

Although violence towards others was prominent in the Virginia Tech case, such violence is much less common on college campuses than suicide. Suicide is the second leading cause of death among American college students.<sup>6</sup> Research indicates that young adults (ages twenty to twenty-four) are more likely to commit suicide than are adolescents (ages fifteen to nineteen). Males in each of these age groups are more likely to die from suicide attempts than females.

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<sup>1</sup> Student Mental Health and the Law, A Resource for Institutions of Higher Education--published by the Jed Foundation 2008 [http://www.jedfoundation.org/assets/Programs/Program\\_downloads/StudentMentalHealth\\_Law\\_2008.pdf](http://www.jedfoundation.org/assets/Programs/Program_downloads/StudentMentalHealth_Law_2008.pdf). This publication presents an overview of disability law and how schools should deliver mental health services including referrals, peer counseling supervision and peer hotlines. See also Campus Mental Health--Know Your Rights, A guide for students who want to seek help for mental or emotional distress by the Judge David Bazelon Center for Mental Health Law, 2008. See <http://www.bazelon.org/l21/YourMind-YourRights.pdf>

<sup>2</sup> 20 U.S.C. § 1232g. The pertinent provisions of FERPA and implementing regulations issued by the Department of Education are reproduced in Appendix A.

<sup>3</sup> Virginia Tech Review Panel, "Mass Shootings at Virginia Tech April 16, 2007: Report of the Review Panel," August 2007, <http://www.vtreviewpanel.org/report/index.html> (accessed 2 February 2009).

<sup>4</sup> National Center for Education Statistics "Back to school statistics - Fast Facts," [nces.ed.gov/fastfacts/display.asp?id](http://nces.ed.gov/fastfacts/display.asp?id)

<sup>5</sup> American College Health Association. National College Health Assessment Spring 2014 Reference Group Data Report (Abridged).

<sup>6</sup> [http://www.acha-ncha.org/docs/ACHA-NCHA-II\\_ReferenceGroup\\_ExecutiveSummary\\_Spring2014.pdf](http://www.acha-ncha.org/docs/ACHA-NCHA-II_ReferenceGroup_ExecutiveSummary_Spring2014.pdf). Because of drop in rates of homicide among non-college attending 15-25 year olds, suicide is now the second leading cause of death in general (both college and non-college attendees).

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Each year approximately 1500 college students commit suicide.<sup>7</sup> The majority of these students are not receiving mental health treatment at the time of their deaths. College students, however, are about half as likely to kill themselves as their age- matched peers in the community. Campus prohibitions against firearms contribute to this lower rate.<sup>8</sup> Instead of using firearms, "students who commit suicide [in college] are more likely to hang themselves, jump from unprotected buildings or ingest lethal chemicals commonly found in campus labs." Less than twenty percent of college students who commit suicide ever seek help from college counseling centers.

Since 1981, data have been compiled from directors of college counseling centers across the United States and Canada to determine trends in student counseling. According to the 2014 National Survey of Counseling Center Directors, which surveyed 275 colleges and universities across the United States and Canada, 58% of colleges offered psychiatric services on campus, often with insufficient psychiatric consultation time. Eleven percent of college students (363,000) sought counseling in 2014. Twenty- six percent of student-patients were taking psychotropic medications, which was up from 20% in 2003, 17% in 2000, and 9% in 1994. Counseling center directors reported that nearly 52% of their patients had severe psychological problems and 8% had impairment so serious that they could not remain in school or required extensive mental health treatment. In 2014, 4950 students in this survey (a rate of 1.5 hospitalizations for each 1000 students covered in survey) were hospitalized for mental health reasons.<sup>9</sup>

It is unclear whether the number of students seeking treatment is rising because the incidence of mental health problems among college students is rising or because more students are willing to talk about their problems and seek counseling. However, a recent study in which college students and their non-college attending peers were interviewed found that almost 50% of college-aged individuals and their non-college attending peers had met DSM-IV criteria for a psychiatric disorder within the past year.<sup>10</sup> The most common disorders in college students were alcohol use disorders and personality disorders. Moreover, the highest rates for treatment-seeking in the previous year were reported for mood disorders, whereas the lowest rates were for alcohol disorders.

## Transition Needs of Young Adults

College students are young adults in transition, a discrete group with specific developmental needs distinguishable from those of adolescents and older adults. An important report by Institute of Medicine & National Research Council, *Investing in the Health and Well-Being of Young Adults (2014)*, emphasized that young adulthood is a more hazardous period of the life course than is generally recognized. Moreover, even though young adults are at high risk of developing serious physical and mental health conditions (e.g., obesity/eating disorders, mood and addictive disorders) and have high rates of suicide and violence, systems of care for this population are fragmented and ill- prepared to respond to their needs:

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<sup>7</sup> Suicide Prevention Resource Center: Promoting Mental Health and Preventing Suicide in College and University Settings. Newton, Mass, Education Development Center, 2004 and the Jed Foundation, <http://www.jedfoundation.org>. The Jed Foundation was founded in 2000 by the family of Jed Satow, who committed suicide as a college sophomore. See also Paul Joffe, An Empirically Supported Program to Prevent Suicide Among a College Population 1 (2003), available at <http://www.jedfoundation.org/articles/joffeuniversityofillinoisprogram.pdf>. The estimated rates of suicide are still about 6.5-7.5/100,000/year. This estimate has increased because the number of higher education students has increased.

<sup>8</sup> American Association of State Colleges and Universities, A Higher Education Policy Brief (November 2008): Concealed Weapons on State College Campuses: In Pursuit of Individual Liberty and Collective Security by Thomas L. Harnisch.

<sup>9</sup> See Gallagher, RP, Nat'l Survey of Counseling Center Directors 2008, <http://www.iacsinc.org/2008%20National%20Survey%20of%20Counseling%20Center%20Directors.pdf>.

<sup>10</sup> Blanco C, Okuda M, Wright C et al. Mental Health of College Students and Their Non- College-Attending Peers. Arch Gen Psychiatry 2008;65 (12): 1429-1437.

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“The transition from child to adult medical and behavioral health care often is associated with poor outcomes among young adults. Challenges include discontinuities in care, differences between the child/adolescent and adult health systems, a lack of available adult providers, difficulties in breaking the bond with pediatric providers, lack of payment for transition support, a lack of training in childhood-onset conditions among adult providers, the failure of pediatric providers to prepare adolescents for an adult model of care, and a lack of communication between pediatric and adult providers and systems of care.” (p. 219)

Transitioning from high school to college with a psychiatric diagnosis can be an especially challenging task. Psychiatrists treating youth entering college should take proactive efforts to facilitate their successful transition and to advocate for supportive professional practices, campus practices and public policies. Specifically, college and university officials should make information available to applicants concerning mental health resources at their institutions, including clinical, preventive, supportive services and any necessary educational accommodations. In addition, they should provide clear administrative information on confidentiality and academic leave or disciplinary policies in relation to mental health conditions.

Both sending and receiving educational institutions and clinicians before and after college should coordinate clinically appropriate transition (or sharing) of care, with active involvement of the student and interested adults. Training programs in both general psychiatry and child and adolescent psychiatry should devote a significant amount of their didactic and clinical training time to the unique developmental and clinical needs of transitional age youth on college campuses.<sup>11</sup>

## Legal Issues

The Family Educational Rights and Privacy Act (FERPA) was enacted in 1974 to protect the privacy of parents and students regarding outside access to student educational records. FERPA states "no funds shall be made available under any applicable program to any educational agency or institution which has a policy or practice of permitting the release of educational records ... of students without the written consent of their parents to any individual, agency, or organization." Once a student reaches the age of eighteen, the rights accorded to the student's parents, including authority to permit access to records, are transferred to the students themselves. After the student becomes eighteen, even the parents no longer have access to these records without the student's consent.<sup>12</sup>

FERPA allows university officials to disclose otherwise protected information to parents or others when "knowledge of the information is necessary to protect the health or safety of the student or other individuals."<sup>13</sup> Unless state laws are more restrictive, this means that university officials are permitted but not required to inform appropriate individuals when a student's behavior is thought to indicate a risk to health or safety. There remains some uncertainty whether a suicide attempt per se qualifies for disclosure. Since notice under FERPA is discretionary, universities often decide not to make disclosures without student consent. Because this was the Virginia Tech policy at the time of the 2007 shootings, Seung Hui Cho's parents were never notified of the escalating concerns among his teachers and others. Virginia enacted legislation following the Tech shootings requiring state colleges to notify a parent of a

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<sup>11</sup> JED currently has a website dedicated to transition issues, <http://transitionyear.org>. A successor website, *Set to Go*, being developed with guidance from AACAP and the American Academy of Pediatrics, is expected to be launched in 2015.

<sup>12</sup> There is an exception under FERPA, that schools may release any and all information to parents, without the consent of the eligible student, if the student is a dependent for tax purposes under the IRS rules.

<sup>13</sup> 34 CFR 99.36

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dependent student who receives mental health treatment at the school's student health or counseling center, if it is determined that there is a "substantial likelihood" that the student will, in the near future, cause serious physical harm to himself or others.<sup>14</sup>

FERPA does not apply to records of the treatment of students that are made or maintained by an independent physician, including psychiatrist, or a psychologist acting in his or her professional capacity that are used only in connection with treatment of the student and disclosed only to individuals providing the treatment.<sup>15</sup> Once information from the mental health or medical record is shared with or used by the institution for a purpose other than treatment (e.g., decisions about disability accommodations or medical withdrawal), FERPA applies to the shared records. In December 2008, the U.S. Department of Education amended its regulations implementing FERPA to provide additional guidance regarding sharing of information within the university and its disclosure to parents in emergency situations. The agency emphasized that institutions have a lot of leeway in making these determinations:

(c) . . . [A]n educational agency or institution may take into account the totality of the circumstances pertaining to a threat to the health or safety of a student or other individuals. If the educational agency or institution determines that there is an articulable and significant threat to the health or safety of a student or other individuals, it may disclose information from education records to any person whose knowledge of the information is necessary to protect the health or safety of the student or other individuals. If, based on the information available at the time of the determination, there is a rational basis for the determination, the Department will not substitute its judgment for that of the educational agency or institution in evaluating the circumstances and making its determination.<sup>16</sup>

Another federal statute with implications for the confidentiality of medical records is the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Regulations based on HIPAA apply if a health service or practitioner uses electronic billing, on-line insurance verification, or other specified electronic transactions and therefore is a covered entity.<sup>17</sup> However, treatment records covered under FERPA are excluded from coverage under the HIPAA regulations. In general, HIPAA requires patient authorization prior to release of information, but like FERPA, it contains an exception for emergency situations. A summary of the HIPAA regulations can be found on the APA website, [www.psychiatry.org](http://www.psychiatry.org), under the search term "HIPAA."

Confidentiality of health records is also regulated by state law, case law (e.g., duties to protect potential victims of patients' violence), and professional ethics. State health information privacy laws sometimes preclude disclosures that would otherwise be authorized under both FERPA and HIPAA. Practitioners therefore need to be familiar with how state laws apply in their own jurisdictions.

## Conclusions and Recommendations

Confidentiality is a core principle upon which trust in the treatment process is based. This concern is especially urgent for college students because colleges are relatively self-contained communities and college students are developmentally transitioning from adolescence to adulthood and just growing into

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<sup>14</sup> Va. Code Ann. § 37.2-815 (2009)

<sup>15</sup> 20 USCS § 1232g

<sup>16</sup> 34 CFR Part 99 FERPA; Final Rule Dec. 9, 2008. Excerpts from the regulations are reproduced in Appendix A.

<sup>17</sup> 45 CFR 164.501

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their sense of themselves as independent individuals. Parents also have a strong interest in being involved in their children's health care-- even when their child might legally be an adult. In rare cases of potentially dangerous students, the university administration also has a strong interest in being aware of the student's status. The primary regulations governing privacy in college mental health settings are FERPA, HIPAA, state confidentiality statutes, and codes of professional practice. The perceived impediments to disclosures by college officials in situations in which the health or safety of students may be endangered seem often to be the result of a misunderstanding of FERPA and other relevant laws and regulations. The federal laws and regulations, including updated guidance on FERPA, generally provide an adequate framework for thoughtful clinical decision-making.

#### **A. Guidance to Clinicians Regarding Disclosures of Students' Mental Health Status**

1. Excellent clinical judgment, a thorough understanding of the needs of the various parties in college mental health systems (including parents, roommates/other students, and university administrators), and good common sense--in the context of a good understanding of the law-- should be the primary determinants of decision making in college mental health settings (as in all settings).
2. Parental notification should not be mandated, even when students' health or safety may be at risk. The nature of the student's relationship with his or her parents needs to be explored and assessed prior to a decision about disclosure. These are common clinical judgments that often are made in emergency rooms and inpatient settings, requiring careful consideration in collaboration with the patient. Automatic notification may be clinically inappropriate.
3. In most cases, students with serious mental health problems will be prepared to cooperate with their therapist and involve parents and others as clinically indicated. When students refuse to allow disclosures to parents or school authorities, the initial attempts at resolving the problem should flow from clinical exploration and the therapeutic process, e.g., if students are hospitalized, it is in their interest to inform the school that they will be absent from the dorms or classes so that their failure to appear will be explained.
4. Recent initiatives aiming to educate parents and university administrators about the proper understanding of FERPA and other relevant laws have been salutary. However, there has also been a worrisome tendency to overreact to recent campus tragedies by weakening confidentiality requirements and even mandating parental notification. These changes could have unintended deleterious impacts on the care of college students. If students believe that discussing troubling thoughts, feelings, fantasies or impulses will result in unwanted parental or administrative involvement, they will be significantly less likely to seek assistance from college counseling services.
5. In almost all circumstances, the best interest of the patient/student should be the primary concern of college mental health clinicians. Policies encouraging or even mandating evaluations for treatment should be considered with homicidal or suicidal students but with a reasonable threshold. Sometimes sending a student home may increase suicide risk; decisions regarding withdrawal from school should take into account all relevant considerations.
6. Student Health Services need to be clear with students and families when they are not in a treatment relationship but are acting as an agent of the university, e.g., when doing assessments about whether a student may reenter the University after a medical leave or risk assessments at the request of university officials when students are thought to be a danger to their own or others' health or safety.

## **B. Guidance Regarding University Policies Affecting Student Mental Health**

1. Whenever possible, schools should require students to carry health insurance.
2. Clinicians should be aware of health insurance consequences of not being a full-time student. Some students may find themselves without insurance if they take a leave from school. Some school-based health insurance plans provide ongoing health insurance for a year.
3. Policies should be developed so as not to discourage students from seeking treatment. For example, forcing students to take a medical leave solely on the basis of seeking treatment for suicidal thoughts or attempts is likely to be counterproductive in encouraging students to seek needed care.
4. Mental health staff should provide education and consultation to appropriate faculty committees dealing with students' educational and disciplinary issues.
5. When the school requests or mandates a mental health evaluation, it is important to have explicit policies about what will be disclosed to the university. Generally the school is interested in whether the student is safe to be in school, and more detailed clinical information need not be revealed.
6. Schools should encourage active student-to-student involvement, peer counseling, and student support groups. Students are frequently aware of problems before the administration becomes aware of them and before they spiral out of control, and they are in a good position to encourage their colleagues to seek appropriate treatment. Schools should also give concerned students a contact-point for discussing their concerns within proper legal and ethical boundaries.
7. There can be real conflicts of interest between schools and students; what may be in the individual student's best interest may conflict with the school's obligation to provide a comfortable and safe environment for other students. Difficult balancing decisions require case-by-case consideration rather than rigid policies.
8. Serious consideration needs to be given by university and college administrations to how mental health services are provided to their students. As many as 40% of colleges and universities have no on-site psychiatric services, often making it difficult and expensive for students to obtain treatment.
9. Mandated withdrawals or leaves of absence can be appropriate in dangerous situations where the safety of the student cannot be managed in the school environment or when the student presents a danger to others on the campus. However, students cannot be removed from school involuntarily simply on the basis of suicidal ideation or attempt and the Department of Education's Office of Civil Rights issued a policy guidance on this topic in 2014. Withdrawal should be required only if the appropriate officials have determined, based on thorough evaluation, that there is no reasonable way that the student's problems can be managed adequately with campus-based or local resources and that remaining on campus presents an acute and unmanageable risk to this student. Students should have appropriate due process protections in these determinations.
10. The question of when to invoke a disciplinary proceeding instead of, or in addition to, a mental health referral can be a complicated administrative challenge. Consultation with mental health and legal affairs staff may be appropriate.
11. Mental health education and training with a focus on identifying pathology and knowing how to make referrals should be provided to campus police, faculty, student life, residence hall staff, and other institutional offices likely to come into contact with troubled students.
12. Since the Virginia Tech tragedy in April 2007, many colleges have established multidisciplinary committees charged with assessing threats of harm to self or others by students and formulating appropriate interventions. Some legislatures have directed colleges to create such "threat

assessment teams.” The composition and activities of these teams vary, with some focused solely on threat assessment and others dealing more broadly with struggling or at-risk students.<sup>18</sup> Notwithstanding their proliferation, use of these teams cannot yet be characterized as an evidence-based practice. Although some positive evidence has been published regarding threat assessment teams in secondary schools, the literature on threat assessment in colleges is largely descriptive and anecdotal.

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<sup>18</sup> A review of campus behavioral intervention teams has been published by the Higher Education Mental Health Alliance. [http://www.jedfoundation.org/campus\\_teams\\_guide.pdf](http://www.jedfoundation.org/campus_teams_guide.pdf)  
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## Appendix A: Excerpts from FERPA and Applicable Regulations

The relevant portions of FERPA and the interpretive guidance issue by the Department of Education governing disclosures for behavioral and health-related information are set forth below:

### 20 USCA §1232(g):

(6) (A) Nothing in this section shall be construed to prohibit an institution of postsecondary education from disclosing, to an alleged victim of any crime of violence (as that term is defined in section 16 of title 18, United States Code [18 USCS § 16]), or a nonforcible sex offense, the final results of any disciplinary proceeding conducted by such institution against the alleged perpetrator of such crime or offense with respect to such crime or offense.

(B) Nothing in this section shall be construed to prohibit an institution of postsecondary education from disclosing the final results of any disciplinary proceeding conducted by such institution against a student who is an alleged perpetrator of any crime of violence (as that term is defined in section 16 of title 18 [18 USCS § 16], United States Code), or a nonforcible sex offense, if the institution determines as a result of that disciplinary proceeding that the student committed a violation of the institution's rules or policies with respect to such crime or offense.

### 20 USCA §1232(i): Drug and alcohol violation disclosures

(1) In general. Nothing in this Act or the Higher Education Act of 1965 shall be construed to prohibit an institution of higher education from disclosing, to a parent or legal guardian of a student, information regarding any violation of any Federal, State, or local law, or of any rule or policy of the institution, governing the use or possession of alcohol or a controlled substance, regardless of whether that information is contained in the student's education records, if—

(A) the student is under the age of 21; and

(B) the institution determines that the student has committed a disciplinary violation with respect to such use or possession.

**34 CFR § 99.31** (Effective Jan. 8, 2009) Under what conditions is prior consent not required to disclose information?

(a) An educational agency or institution may disclose personally identifiable information from an education record of a student without the consent required by § 99.30 if the disclosure meets one or more of the following conditions:

(1)(i) (A) The disclosure is to other school officials, including teachers, within the agency or institution whom the agency or institution has determined to have legitimate educational interests.

(B) A contractor, consultant, volunteer, or other party to whom an agency or institution has outsourced institutional services or functions may be considered a school official under this paragraph provided that the outside party--

(1) Performs an institutional service or function for which the agency or institution would otherwise use employees;

(2) Is under the direct control of the agency or institution with respect to the use and maintenance of education records; and

(3) Is subject to the requirements of § 99.33(a) governing the use and redisclosure of personally identifiable information from education records.

(ii) An educational agency or institution must use reasonable methods to ensure that school officials obtain access to only those education records in which they have legitimate educational interests. An educational agency or institution that does not use physical or technological access controls must ensure that its administrative policy for controlling access to education records is effective and that it remains in compliance with the legitimate educational interest requirement in paragraph (a)(1)(i)(A) of this section.

(2) The disclosure is, subject to the requirements of § 99.34, to officials of another school, school system, or institution of postsecondary education where the student seeks or intends to enroll, or where the student is already enrolled so long as the disclosure is for purposes related to the student's enrollment or transfer.

*Note: Section 4155(b) of the No Child Left Behind Act of 2001, 20 U.S.C. 7165(b), requires each State to assure the Secretary of Education that it has a procedure in place to facilitate the transfer of disciplinary records with respect to a suspension or expulsion of a student by a local educational agency to any private or public elementary or secondary school in which the student is subsequently enrolled or seeks, intends, or is instructed to enroll.*

**34 CFR § 99.36** (Effective Jan. 8, 2009) What conditions apply to disclosure of information in health and safety emergencies?

(a) An educational agency or institution may disclose personally identifiable information from an education record to appropriate parties, including parents of an eligible student, in connection with an emergency if knowledge of the information is necessary to protect the health or safety of the student or other individuals.

(b) Nothing in this Act or this part shall prevent an educational agency or institution from—

- (1) Including in the education records of a student appropriate information concerning disciplinary action taken against the student for conduct that posed a significant risk to the safety or well-being of that student, other students, or other members of the school community;
- (2) Disclosing appropriate information maintained under paragraph (b)(1) of this section to teachers and school officials within the agency or institution who the agency or institution has determined have legitimate educational interests in the behavior of the student; or
- (3) Disclosing appropriate information maintained under paragraph (b)(1) of this section to teachers and school officials in other schools who have been determined to have legitimate educational interests in the behavior of the student.

(c) In making a determination under paragraph (a) of this section, an educational agency or institution may take into account the totality of the circumstances pertaining to a threat to the health or safety of a student or other individuals. If the educational agency or institution determines that there is an articulable and significant threat to the health or safety of a student or other individuals, it may disclose information from education records to any person whose knowledge of the information is necessary to protect the health or safety of the student or other individuals. If, based on the information available at

the time of the determination, there is a rational basis for the determination, the Department will not substitute its judgment for that of the educational agency or institution in evaluating the circumstances and making its determination.