



Fall 9-1-2010

Detecting and Engaging At-Risk Students

Ann P. Haas

Follow this and additional works at: <https://scholarlycommons.law.wlu.edu/crsj>



Part of the [Education Law Commons](#), [Juvenile Law Commons](#), [Law and Psychology Commons](#), and the [Mental Disorders Commons](#)

Recommended Citation

Ann P. Haas, *Detecting and Engaging At-Risk Students*, 17 Wash. & Lee J. Civ. Rts. & Soc. Just. 79 (2010).
Available at: <https://scholarlycommons.law.wlu.edu/crsj/vol17/iss1/6>

This Article is brought to you for free and open access by the Washington and Lee Journal of Civil Rights and Social Justice at Washington and Lee University School of Law Scholarly Commons. It has been accepted for inclusion in Washington and Lee Journal of Civil Rights and Social Justice by an authorized editor of Washington and Lee University School of Law Scholarly Commons. For more information, please contact christensena@wlu.edu.

Detecting and Engaging At-Risk Students

Ann P. Haas*

Following campus tragedies at Virginia Polytechnic Institute in 2007 and Northern Illinois University in 2008, there has been increasing recognition of serious untreated mental health problems among college and university students.¹ Although it has been commonly assumed that college students generally have better mental health than their peers who do not attend college,² a recent analysis of data from a large national epidemiological health survey found mental disorders to be present in roughly equal proportions of eighteen to twenty-four-year-olds who attend, and do not attend, college.³ Over forty-five percent of respondents in each group were reported to have at least one disorder in the year prior to the survey, in most cases, a mood, anxiety, or substance use disorder.⁴ Further,

* Director of Prevention Projects at the American Foundation for Suicide Prevention. Dr. Haas has directed the Interactive Screening Program since its inception in 2001.

1. See Rebecca Voelker, *Campus Tragedy Prompts Closer Look at Mental Health of College Students*, 297 J. AM. MED. ASS'N 2335, 2335 (2007) ("[T]he tragic shootings at Virginia Polytechnic Institute and State University . . . raises broader questions about how students' mental health care is being monitored and whether schools are adequately equipped to oversee their students' mental well-being."); see also Aaron Levin, *Addressing Students' MH Needs a Balancing Act for Colleges*, 42 PSYCHIATRIC NEWS 6, 6 (2007) ("The Virginia Tech shootings in April highlight the need for colleges to adopt consistent, nondiscriminatory approaches to helping students who have mental health problems."); Elia Powers & Elizabeth Redden, *6 Killed in Northern Illinois Shooting*, INSIDE HIGHER ED, Feb. 15, 2008, <http://www.insidehighered.com/news/2008/02/15/niu>. (last visited Sept. 18, 2010) ("The tragedy reemphasizes the intense focus on emergency response and communications systems that emerged after the April shootings at Virginia Tech University.") (on file with the Washington and Lee Journal of Civil Rights and Social Justice).

2. See Morton M. Silverman et al., *The Big Ten Student Suicide Study: A 10-Year Study of Suicides on Midwestern University Campuses*, 27 SUICIDE & LIFE-THREAT. BEHAV. 285, 299 (1997) ("Our data suggests that the overall student suicide rate is indeed 50% of the nationally matched samples for age and gender.").

3. See Carlos Blanco et al., *Mental Health of College Students and Their Non-College-Attending Peers: Results from the National Epidemiologic Study on Alcohol and Related Conditions*, 65 ARCH. GEN. PSYCHIATRY 1429, 1430 (2008) (observing that college-attending eighteen to twenty-four-year-olds demonstrated no significant difference in the proportion experiencing mental health conditions and receiving treatment from those not enrolled in college).

4. See *id.* at 1432 ("The highest rates for treatment seeking in the previous year were reported for mood disorders, whereas the lowest rates were for reported for alcohol and drug

this analysis showed that, among those with mental disorders, a smaller percentage of students (eighteen percent) than non-students (twenty-one percent) had received mental health treatment in the past year.⁵ Notably, although students reported alcohol use disorders at a significantly higher rate than non-students, they were less likely than non-students to receive treatment for such disorders.⁶ The National College Health Assessment, a large-scale national survey of college students,⁷ also found that less than one-fourth of students with diagnosable mental disorders seek treatment.⁸ In one of the few longitudinal surveys conducted on the topic of college mental health, Zivin and colleagues found that even when symptoms of mental disorders persisted over two years, fewer than half of students sought treatment.⁹

Because untreated or inadequately treated mental disorders are the leading cause of suicide in adolescents and young adults,¹⁰ these survey findings point to college students as an at-risk population for intentional self-harm behavior.¹¹ Information on suicide rates among college students is limited, however, by the omission of school enrollment from officially collected data on suicide deaths. A suicide rate of 7.5 per 100,000 among

use disorders.").

5. *See id.* at 1432–33 ("College students were significantly less likely to receive past-year treatment for alcohol or drug use disorders than others in both the adjusted and unadjusted analyses.").

6. *See id.* and accompanying text.

7. AM. COLL. HEALTH ASS'N, AMERICAN COLLEGE HEALTH ASSOCIATION—NATIONAL COLLEGE HEALTH ASSESSMENT SPRING 2007 REFERENCE GROUP DATA REPORT (ABR. 2008), 56 J. AM. COLL. HEALTH 469, 469 (2008) ("The Spring 2007 reference group includes ACHA-NCHA data from 71,860 students at 107 institutions of higher education.").

8. *See id.* at 447 ("24.8% . . . reported being currently in therapy for depression.").

9. *See* Kara Zivin et al., *Stigma and Help Seeking for Mental Health Among College Students*, 66 MED. CARE RES. & REV. 522, 524 (2009) ("One community-based study found that one in four people who perceived a need for help did not seek services.").

10. *See* David Shaffer et al., *Psychiatric Diagnosis in Child and Adolescent Suicide*, 53 ARCHIVES OF GEN. PSYCHIATRY 339, 348 (1996) (finding that while most suicide victims experienced mental health treatment, many did not receive treatment through antidepressants or participation in a substance abuse program); *see also* Berit Groholt et al., *Suicide Among Children and Younger and Older Adolescents in Norway: A Comparative Study*, 37 J. AM. ACAD. CHILD ADOLESC. PSYCHIATRY 473, 477 (1998) ("Only a minority of the children and young adolescents (29%) and older adolescents (23%) had received any treatment for psychiatric disorders."); J. John Mann et al., *Suicide Prevention Strategies: A Systematic Review*, 294 J. AM. MED. ASS'N 2064, 2065 (2005) ("[A] key prevention strategy is improved screening of depressed patients by primary care physicians and better treatment of major depression.").

11. *See* Mann et al., *supra* note 10, at 2071 (identifying college students as a known population at risk for suicide).

college students is frequently cited—half the rate among comparably aged young adults in the United States overall.¹² This figure was derived from a comprehensive study of suicide deaths among students at twelve Midwestern universities during the 1980s¹³ and its applicability to current college students throughout the country is not known.

Regardless of the frequency with which college students die by suicide, there is compelling evidence that those who are most at risk for suicide have low rates of utilizing campus mental health services.¹⁴ The National Survey of Counseling Center Directors, which has been conducted annually since 1980, has consistently shown that fewer than twenty percent of college students who die by suicide had sought services from their campus counseling center.¹⁵ In 2008, for example, only fourteen percent of students who died by suicide were reported to be current or past clients of the counseling center.¹⁶ Another recent survey of 26,000 students attending seventy colleges and universities across the United States reported that while eighteen percent of undergraduate and fifteen percent of graduate students had seriously considered attempting suicide,¹⁷ only half had revealed this to anyone—and two-thirds of those told only a peer.¹⁸

Many factors appear to contribute to students' reluctance to seek mental health services. Negative attitudes toward mental health treatment, sometimes rooted in past experiences, have been found in a surprisingly

12. See Steven J. Garlow et al., *Depression, Desperation, and Suicidal Ideation in College Students: Results from the American Foundation for Suicide Prevention College Screening Project at Emory University*, 25 DEPRESSION & ANXIETY 482, 483 (2008) ("The Big-10 Student Suicide Study conducted from 1980 to 1990 reported an annual overall suicide rate for college students of 7.5 suicides per 100,000, half the rate of 15 per 100,000 for age, gender and race matched individuals in the general population.").

13. See Silverman et al., *supra* note 2, at 285 ("The 10 year study collected demographic and correlational data on 261 suicides of registered students at 12 Midwestern campuses.").

14. See ROBERT P. GALLAGHER, INT'L ASS'N OF COUNSELING SERVICES, INC., NATIONAL SURVEY OF COUNSELING CENTER DIRECTORS, 2008, MONOGRAPH SERIES NUMBER 8Q 7 (2008), <http://www.iacsinc.org/2008%20National%20Survey%20of%20Counseling%20Center%20Directors.pdf> (reporting that health center patients represented only 13.6% of college suicides).

15. See *id.* and accompanying text.

16. *Id.*

17. See David Drum et al., *New Data on the Nature of the Suicidal Crises in College Students: Shifting the Paradigm*, 40 PROF. PSYCHOL.: RES. & PRACTICE 213, 215 (2009) (finding that eighteen percent of undergraduates and fifteen percent of graduate students admitted to considering suicide).

18. See *id.* at 218 ("Two thirds of those who disclosed their suicidal ideation first chose to tell a peer, such as a romantic partner, roommate, or friend.").

high percentage of young adults.¹⁹ Other barriers to treatment among young people include the fear of being stigmatized by peers,²⁰ cultural beliefs that equate mental health problems with weakness,²¹ and a lack of prodding from parents, especially when students live away from home.²² In addition, students who are considering suicide or engaging in self-harm behaviors may be deterred from seeking help by involuntary removal or mandatory leave-of-absence policies that some colleges and universities have enacted in an effort to protect themselves from the lawsuits that followed student suicides at other institutions.²³ In 2004, a widely publicized case of a student who was dismissed from George Washington University after seeking hospital admission for suicidal ideation²⁴ appeared to have a particularly chilling impact on students across the country.²⁵ These and other barriers to seeking mental health services clearly need to be addressed and resolved if treatment rates are to be increased among students who are at risk for suicide.

Urged by families who had lost a child to suicide while in college, in 2001 the American Foundation for Suicide Prevention began developing the Interactive Screening Program (ISP) (initially called the College Screening Project), a web-based approach to identifying and encouraging

19. See Benjamin W. Van Voorhees et al., *Beliefs and Attitudes Associated with the Intention to Not Accept the Diagnosis of Depression Among Young Adults*, 3 ANNALS FAM. MED. 38, 42–43 (2005) (determining that beliefs and social norms represented an important factor based on the forty-eight percent of respondents who cited its importance in their decisionmaking).

20. See Zivin et al., *supra* note 9, at 523 ("Stigma associated with mental illness has been identified as a key attitudinal factor that may impede mental health service use.").

21. See Abigail K. Mansfield et al., *Measurement of Men's Help Seeking: Development and Evaluation of the Barriers to Help Seeking Scale*, 6 PSYCHOL. OF MEN & MASCULINITY 95, 105 (2005) (identifying men's apprehension of appearing vulnerable as an element functioning as an obstacle to seeking help).

22. See Blanco et al., *supra* note 3, at 1432 (commenting that the tendency for college-aged students to live apart from their parents served to increase their risk for suicide).

23. See Paul S. Appelbaum, *"Depressed? Get Out!": Dealing with Suicidal Students on College Campuses*, 57 PSYCHIATRIC SERV. 914, 914 (2006) [hereinafter *Depressed? Get Out!*] ("[I]mmediate suspension or mandatory withdrawal . . . generally reflect administrators' fears of legal liability if students commit suicide on campus.").

24. See STATE OF NEW JERSEY, DEP'T OF THE PUB. ADVOC., *COLLEGE STUDENTS IN CRISIS: PREVENTING CAMPUS SUICIDES AND PROTECTING CIVIL RIGHTS 2* (2009), <http://www.state.nj.us/publicadvocate/mental/pdf/College%20Suicide%20Report%20FINAL-8-10-09.pdf> (reporting that after a psychiatric unit released John Nott in 2004 following his voluntary commitment, George Washington University told him that the University's "psychological distress policy" disallowed Nott from returning to campus).

25. See *id.* at 5 ("Critics argue that involuntary removal policies deter students and witnesses from reporting suicidal behavior, for fear of removal.").

at-risk students to seek help.²⁶ From the outset, the core aim of the ISP was to use the internet to anonymously connect students in need with a campus mental health professional, who could engage them to look at and resolve barriers and resistances to treatment.²⁷

The ISP typically begins with an email invitation to students to participate in the program, which is sent from a college or university official.²⁸ Usually, students are targeted by class or other subgroup within the general campus population, rather than by presumed risk, and invitations are sent in batches at a rate consistent with the availability of campus mental health professionals to respond.²⁹ In the invitational email, the program is briefly described and students are given a link to a secure website, customized for each participating institution, where program details are provided and students are encouraged to register using a self-assigned user ID and password.³⁰ Once registered, access is provided to an online Stress and Depression Screening Questionnaire, which takes about ten minutes to complete.³¹ The questionnaire begins with items dealing with stress-related behaviors (such as arguments or fights) and intense emotional states including rage, desperation, or feeling out of control,³² which have been found to distinguish depressed individuals who are suicidal from those who are not.³³ The next set of items covers substance abuse and eating disorder symptoms.³⁴ Depression is then measured using

26. See Garlow et al., *supra* note 12, at 483 (describing how the College Screening Program uses the internet as an aid in suicide prevention).

27. See *id.* ("This project is a suicide prevention outreach effort that utilizes the Internet to identify at-risk students and encourage them to enter into treatment.").

28. See *id.* ("Once each academic year, all undergraduate students at Emory aged 18 and over . . . were invited to participate through an email message from the Principal Investigator (Dr. Nemeroff) and the Director of Student Health.").

29. See *id.* at 487 ("The email solicitations were sent out to each undergraduate only once in each school year so the sample is cross-sectional in a limited time frame.").

30. See *id.* at 483 ("The email contains a link to a secure web server through which an automated assessment is conducted. The student submits the screening questionnaire using a self assigned user name and password.").

31. See *id.* at 487 ("[T]he web-based interface was designed to be a convenient, broad-based screening tool, easy to access and complete.").

32. See *id.* at 484 (describing the progression of emotional states explored during the stress test).

33. See *id.* at 485 ("In particular, anxiety, irritability, rage, desperation, and feeling out of control were significantly more common in the students with suicidal ideation.").

34. See *id.* at 483 (describing how the screening questionnaire includes questions regarding eating behavior as well as alcohol and drug use).

the PHQ-9,³⁵ a standard screen for depression that has been extensively validated among community samples.³⁶ Several questions related to suicide follow, including items on current suicidal ideation, suicide planning, and self-harm behaviors, as well as past suicide attempts.³⁷ The questionnaire then asks about any treatment the student is currently receiving, including counseling or therapy, or medications that have been prescribed for stress, depression, anxiety, or sleep.³⁸ A few basic demographic questions are then asked such as age, gender, and class in school.³⁹ The questionnaire concludes with an item that asks for an email address that will be used to notify the student when a personalized response from a campus counselor has been posted on the website.⁴⁰ In the instructions that precede the questionnaire, students are told the email address will be encrypted and stored in the computer system, and will not be made available to anyone; this information is repeated at the end of the questionnaire.⁴¹ Students are not required to complete this item, or any other in the questionnaire.⁴²

After submitting the questionnaire, students receive a message screen telling them when they can expect the counselor to post the response.⁴³

35. See *id.* ("The screening instrument consists of the PHQ-9.")

36. See Robert L. Spitzer et al., *Validation and Utility of a Self-Report Version of PRIME-MD: The PHQ Primary Care Study*, 282 J. AM. MED. ASS'N 1737, 1743 (1999) ("The self-administered PHQ has diagnostic validity . . . [and] is efficient, requiring much less of a clinician's time than the original PRIME-MD."); see also Robert L. Spitzer et al., *Validity and Utility of the Patient Health Questionnaire in Assessment of 3000 Obstetric-Gynecologic Patients: The PRIME-MD Patient Health Questionnaire Obstetric-Gynecology Study*, 183 AM. J. OBSTETRICS & GYNECOLOGY 759, 768 (2000) ("Each of the 11 psychological stressors assessed with the PRIME-MD PHQ was associated with a substantial increase in the likelihood of psychiatric diagnosis."); Kurt Kroenke et al., *The PHQ-9: Validity of a Brief Depression Severity Measure*, 16 J. GEN. INTERNAL MED. 606, 606 (2001) ("The diagnostic validity of the PHQ has recently been established in 2 studies involving 3,000 patients in 8 primary care clinics and 3,000 patients in 7 obstetrics-gynecology clinics.")

37. See Garlow et al., *supra* note 12, at 483 (describing questions relating to "current suicidal ideation and past suicide attempts and deliberate self-harm").

38. See *id.* (discussing how the screening questionnaire asks students whether they currently receive any treatment through psychotherapy or pharmacology).

39. See *id.* (stating that students also receive questions relating to demographic factors).

40. See *id.* ("Students whose questionnaire responses or other communications indicate significant depression or potential suicide risk are urged to come in for face to-face evaluation.")

41. See *id.* at 384 (discussing the anonymity of the survey).

42. See *id.* (stating that consent was implied from the student's choice to commit the survey).

43. See Steven J. Garlow et al., *An Interactive Web-Based Method of Outreach to*

This is based on the student's "risk tier" as it has been determined by an algorithm programmed into the computer system.⁴⁴ Four risk tiers are used: 1A (high risk based on indication of suicidal thinking or behavior), 1B (high risk without indication of suicidal thinking or behavior), 2 (moderate risk) and 3 (low risk).⁴⁵ The protocol calls for Tier 1A and 1B students to be responded to within 24 hours, Tier 2 students within 36 hours and Tier 3 students within 48 hours.⁴⁶ The message screen reminds students who have provided an email address that as soon as the counselor's response is posted, they will receive an email notification with a link back to the secure website.⁴⁷ Those who have not provided an email address are urged to make a note of the website URL and return to it on their own after the specified number of hours.⁴⁸

Once the questionnaire has been received and classified by risk tier, the ISP system immediately generates a notification email to the counselor, which includes a link to the secure website with a unique suffix identifying the student's questionnaire.⁴⁹ Once the counselor has logged in with his or her user ID and password, the student's record appears and the counselor is able to review the completed questionnaire, and prepare a personalized response to the student using a tier-specific template.⁵⁰ In the response, the counselor introduces himself or herself by name and title, and provides an office location and phone number.⁵¹ The counselor then comments on

College Students at Risk for Suicide, 57 J. AM. COLLEGE HEALTH 1, 16 (2008) [hereinafter *An Interactive Web-Based Method of Outreach*], available at http://www.afsp.org/files/Misc_haasetalcollegescreening.pdf ("Immediately after . . . the computer program displayed a screen that told students when to expect a personal assessment from a counselor.").

44. See Ann Pollinger, SPRC Discussion Series: Identifying and Treating Students at Risk for Suicide: The AFSP College Screening Project (Oct. 7, 2004) ("System classifies respondents into: Tier 1A (suicide risk), Tier 1B (other high risk), Tier 2 (moderate risk) or Tier 3 (low/no risk).").

45. See *id.* and accompanying text.

46. See *An Interactive Web-Based Method of Outreach*, *supra* note 43, at 16.

47. See *id.* (noting that a final option in the survey permits a student to provide an e-mail address, which is then encrypted in the computer system).

48. See *id.* (noting a student's choice in submitting his or her e-mail address).

49. See *id.* ("When a questionnaire was received, the computer system generated an email to a screening counselor on each campus, indicating the student's tier and providing a link to the questionnaire.").

50. See Garlow et al., *supra* note 12, at 483 ("The project clinician reviews the student's responses, and posts an assessment on the website where it may be retrieved by the student.").

51. See *An Interactive Web-Based Method of Outreach*, *supra* note 43, at 16 (noting that during one assessment observed by the author, "the counselor introduced herself by name and position at the university and gave complete contact information, including office

issues of particular concern in the student's questionnaire and expresses willingness to explore these problems in further detail with the student.⁵² Templates for Tier 1 and 2 students urge the student to contact the counselor to set up an in-person meeting.⁵³ Tier 1A students are also given information about available crisis or emergency services.⁵⁴ All students, regardless of tier designation, are invited to "dialogue" with the counselor on the website, using their user ID as their only identification.⁵⁵ The dialogues proceed much like an email exchange, with each new note generating a notification email to the intended recipient.⁵⁶

All students in Tiers 1 and 2 automatically receive periodic reminders for a 30-day period, urging them to access the counselor's response and follow the recommendations if they have not done so already.⁵⁷ The last reminder requests that those who have not yet contacted the counselor answer a few questions about how they are doing and provides a link to an "update questionnaire."⁵⁸ This brief instrument also asks whether the student has received any treatment since completing the Stress and Depression Questionnaire, presents a check-off list of reasons for not contacting the screening counselor, and provides a text box for the student to indicate what he or she feels would be most helpful at this time.⁵⁹ All data exchanged over the website are stored and organized into a series of reports that can be used for quality control and monitoring purposes as well as outcome evaluation.⁶⁰ Quantitative data are tabulated and all narrative information is captured verbatim.⁶¹

address, e-mail address, and phone number").

52. *See id.* (noting that when responding to Tier 1 and 2 students, counselors "expressed empathy and concern and offered to help the student find relief").

53. *See id.* at 17 ("All Tier 1 and 2 students were urged to call or e-mail the counselor to schedule an in-person evaluation.").

54. *See id.*

55. *See id.* (emphasizing that "[a] key goal was to open the door to further communication by asking questions or inviting the student to elaborate on a particular problem or situation. [Students] were also given the option of participating in an online anonymous dialogue with the counselor").

56. *See id.* at 16–17 (describing the process of the exchange).

57. *See id.* at 17 ("Over the next 6 weeks, Tier 1 and 2 students who provided an e-mail address received multiple reminders to view the counselor's assessment and follow the recommendations.").

58. *See id.* (describing the ISP process).

59. *See id.* and accompanying text.

60. *See id.* (noting that the institutional review board at each university "reviewed and approved data projects").

61. *See* Garlow et al., *supra* note 12, at 484 (describing the data collection process).

From 2002 to 2005, the program was extensively evaluated among undergraduate students at two universities, and detailed results have been reported elsewhere.⁶² In brief, eight to ten percent of students invited to participate in the screening submitted a questionnaire,⁶³ representing a considerable proportion of the ten to fifteen percent of college students estimated to have depression and other serious problems that put them at risk for suicide.⁶⁴ The very large majority (over eighty-five percent) were classified as Tier 1 or 2, and fewer than ten percent of these students were receiving any form of treatment.⁶⁵ About one quarter of the students engaged in one or more online dialogues with the counselor, which, as anticipated, centered heavily on the students' reasons for not wanting treatment.⁶⁶ The evaluation further confirmed the expectation that the dialogues would be the "active ingredient" of the approach: students who engaged in one or more dialogues were three times more likely to come for an in-person meeting with the counselor, and three times more likely to enter treatment.⁶⁷ Across the three years of the evaluation, a manageable number of new students were brought into treatment each semester.⁶⁸ With

62. See *An Interactive Web-Based Method of Outreach*, *supra* note 43, at 16 (stating that the test took place on two campuses: "a private university in the southeastern United States with an undergraduate population of approximately 6,000 students, and the main campus of a large state university, also in the southeastern United States, with about 17,000 undergraduates"); see also Garlow, et al. *supra* note 12 (following Emory University's study).

63. See *An Interactive Web-Based Method of Outreach*, *supra* note 43, at 17 (specifying that approximately eight percent of students participated at the large state university).

64. See Kara Gavin, *Heading Back to Campus? Watch for Depression Triggered by College Stresses*, *U-M Expert Advises*, UNIV. OF MICH. HEALTH SYSTEM, <http://www.med.umich.edu/> (last visited August 5, 2010) (citing the American College Health Association's estimation that ten percent of college students arrive on campus with a prior diagnosis of depression or other mental illness) (on file with the Washington and Lee Journal of Civil Rights and Social Justice).

65. See *An Interactive Web-Based Method of Outreach*, *supra* note 43, at 21 (noting a "disproportionate percentage of respondents [that were] designated as Tier 1 or 2 (85%) and the low rate of current treatment these respondents reported (6% to 13%)").

66. See *id.* at 17 (emphasizing that high-risk students were the most likely to engage in anonymous dialogs with online counselors, as well as observing that "[m]any students used the dialogues to elaborate the problems they ere experiencing and frequently expressed a desire to remain anonymous").

67. See *id.* at 20 ("Among students designated to be at-risk, the rates of coming for in-person evaluation and entering treatment were 3 times higher for those who did not.").

68. See *id.* (noting that approximately eighty new students were brought in each year over the three-year period).

few exceptions, these students indicated significant mental health problems and were not currently receiving any mental health services.⁶⁹

Focus groups of students, who were randomly selected from among those who had been invited to participate in the program and interviews with campus officials, showed other positive results.⁷⁰ Regardless of whether they had submitted the screening questionnaire, students were overwhelmingly favorable in their assessment of the program, and in their perceptions of university administrators for offering this service.⁷¹ Across the several-year study, campus administrators appeared to become increasingly comfortable with the program.⁷² Some had been initially apprehensive that the program might increase institutional liability if at-risk students who were identified did not respond to the counselor's urgings to come in and an adverse event ensued.⁷³ Through experience with the program, most came to regard the ISP as a valuable tool in their efforts to keep students safe.⁷⁴ Based on evaluation results, in 2009, the program was listed in the Best Practices Registry for Suicide Prevention, which is

69. Garlow et al., *supra* note 12, at 487. The evaluation found that:

Remarkably, 84% of the students with suicidal ideation and 85% of the moderately severe to severely depressed students were not receiving any form of psychiatric treatment. Almost one quarter (23%) of all respondents had PHQ-9 scores of 15 or greater, but only 14.5% of this group was in some form of treatment.

Id.

70. See Ann Haas et al., The American Foundation for Suicide Interactive Screening Program: Implementation & Utility for Campuses, 33 (Jan. 5–9, 2009), <http://www.sprc.org/grantees/campus/2009/PDF/C3ARodgersAFSP.pdf> ("Focus group respondents had positive reactions, regardless of whether they submitted questionnaire.").

71. See *id.* and accompanying text.

72. See *An Interactive Web-Based Method of Outreach*, *supra* note 43, at 15 (recognizing the growing pressure for administrators to accept the ISP program, noting that "[i]n recent years, community and legal standards have been shifting toward placing an increasing burden on universities to implement interventions that protect students from self-harm").

73. See generally Karin McAnaney, *Finding the Proper Balance: Protecting Suicidal Students Without Harming Universities*, 94 VA. L. REV. 197 (2008) [hereinafter *Finding the Proper Balance*] (discussing the concern that ISP and other pre-suicidal screening methods will increase school liability, as well as how the fear of liability has shaped university policy in addressing the needs of suicidal students); see also *Depressed? Get Out!*, *supra* note 23, at 915 (noting that the responses of administrators have ranged from "refusing to allow the gathering of identifiable information concerning students who manifest suicidality—for fear that this knowledge would provoke a corresponding duty to protect them—to beefed-up policies requiring mandatory leaves of absence [for suicidal students]").

74. *Depressed? Get Out!*, *supra* note 23, at 915.

maintained by the Suicide Prevention Resource Center.⁷⁵ Between 2005 and 2009, several additional pilot ISP programs were implemented at different institutions, targeting different campus groups including graduate students and medical students.⁷⁶ At one medical school, medical residents and faculty were also invited to participate in the ISP.⁷⁷ Since 2009, the program has been made available to a broader range of institutions throughout the country, primarily through sponsorship by local American Foundation for Suicide Prevention (AFSP) chapters.⁷⁸ By the end of the 2010–2011 academic year, it is anticipated that the ISP will be in place in thirty U.S. colleges and universities, with all expenses except program personnel supported by AFSP.⁷⁹

In the process of implementing the program in a variety of contexts, it was recognized that the ISP contributes to campus suicide prevention in ways that go beyond supporting at-risk students to get mental health treatment, although this remains a key intent of the program.⁸⁰ As currently implemented by most colleges and universities, ISP intervenes at many different levels that have been recommended to be addressed as part of a comprehensive paradigm for preventing suicide among college and university students.⁸¹ Specifically, ISP contributes to primary prevention

75. See Paula J. Clayton, *Suicide Prevention: Saving Lives One Community at a Time*, 38 (October 2009), available at http://webcache.googleusercontent.com/search?q=cache:9uCjOoNSiLcJ:www.afsp.org/files/Misc_//standardizedpresentation.ppt+suicide+prevention:+saving+lives+one+community+at+a+time&cd=1&hl=en&ct=clnk&gl=us ("Based on evaluation findings, ISP was included in the Suicide Prevention Center's Best Practice Registry in 2009. It is currently in place in 16 colleges, including four medical schools.").

76. See AM. FOUND. FOR SUICIDE PREVENTION, <http://www.afsp.org> (last visited Sept. 23, 2010) ("Beginning in 2006, the program has been expanded to include graduate and professional students at the Massachusetts Institute of Technology, the University of Pittsburgh Medical School, the University of Maine, and the University of Puget Sound and Heritage University in Washington state.") (on file with the Washington and Lee Journal of Civil Rights and Social Justice).

77. See *id.* ("The program is about to begin at the University of California, San Diego, where the target groups for the screening initiative will include medical students, medical residents, Fellows and medical school faculty.").

78. See generally *id.*

79. See *id.* ("AFSP is looking to expand the program—through a dissemination effort that is utilizing AFSP chapters—to 30 sites nationwide by 2010.").

80. See David Drum et al., *New Data on the Nature of Suicidal Crises in College Students: Shifting the Paradigm*, 40 J. PROF. PSYCHOL.: RES. & PRAC. 3, 213 (2009) (noting that current studies suggest that there is a "need to go beyond the exclusive reliance" on an individual-focused model of treatment).

81. See *id.* (proposing a paradigm that "encompasses and expands on the current model of treating individuals in crisis in order to act preventively to reduce both prevalence and incidence of all forms of suicidality among college students").

by encouraging students to think about mental health issues before specific needs for services arises and letting them know that help is available, if needed.⁸² For students who are beginning to feel disconnected from campus life or experience difficulties, ISP provides a message of caring and concern and a proactive offer of assistance.⁸³ Further, the program facilitates early intervention by identifying many student problems at a stage when they can be helped through peer support and non-clinical student services.⁸⁴

Despite its demonstrated successes, ISP faces a number of challenges.⁸⁵ Counseling centers on most campuses are under-resourced for the number of students who are already seeking services, which can discourage directors and staff from engaging in efforts to increase utilization among underserved students.⁸⁶ Relatively few institutions have dedicated resources for suicide prevention activities, and campus mental health budgets are rarely keeping pace with student needs.⁸⁷ In addition, concerns remain among some college and university administrators about potential legal problems related to identifying at-risk students.⁸⁸ In particular, some worry about potential liability in the case of students who indicate high suicide risk on the ISP screening questionnaire or through

82. See generally *An Interactive Web-Based Method of Outreach*, *supra* note 43 (noting a high number of students diagnosed with depression by ISP counselors who did not previously realize that they have a treatable problem).

83. See *id.* at 219 (noting further that "aspects of campus life that increase students' sense of belonging to a caring social network . . . are associated with decreased suicidal behavior").

84. See *id.* at 220 (emphasizing that early intervention helps to "boost recovery from negative life events that correlate highly with suicidality and thereby to proactively counteract the worsening of suicidal thoughts among [students]").

85. See generally Suicide Prevention Resource Center, *Promoting Mental Health and Preventing Suicide in College and University Settings*, U.S. DEP'T HEALTH AND HUM. SERVS., 21–22 (Oct. 21, 2004), available at http://www.sprc.org/library/college_sp_whitepaper.pdf (acknowledging challenges faced by mental health services on college campuses).

86. See *id.* at 21 ("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. Most college mental health centers are understaffed, and the available resources are spread dangerously thin.").

87. See *id.* at 22 (noting that budgeting makes four-year colleges and universities "more likely" but not absolutely certain to have access to licensed clinicians, while community colleges and two-year institutions "often rely on nurses to provide most health services").

88. See generally *Finding the Proper Balance*, *supra* note 73 (discussing the need to protect suicidal students balanced with the legal liability faced by universities offering depression screening).

subsequent anonymous online dialogues, and do not respond to the counselor's recommendations to come in or seek alternative mental health services.⁸⁹

Following recommendations for anonymous screening programs made by an expert panel assembled by the Jed Foundation in 2008, the ISP makes clear to students, first, that their anonymity will be maintained even if they provide an email address; and second, that no follow-up services will be provided unless the student specifically requests them.⁹⁰ This serves to clarify that the student is responsible for deciding whether to follow up with recommended actions, and that the counselor or other campus personnel will not intervene to force the student to comply.⁹¹ Given these provisions, discussion among legal experts at the Symposium, where the papers in this volume were presented, suggested a lack of legal foundation for concerns about potential liability as a result of implementing the ISP.⁹² The consensus among Symposium participants was that the ISP does not involve a voluntary assumption of duty or establish a special relationship between the student and the counselor that would be the basis for a lawsuit in the event that a student identified as high risk by the program failed to comply with the counselor's recommendation and went on to die by suicide.⁹³ There was also agreement that rather than constituting a legal risk, the program could be a protective factor in the event of a student suicide, in that its implementation demonstrates the institution's awareness that at-risk students may not be seeking treatment on their own, and its willingness to expend clinical resources to reach out and engage such students in getting needed help.⁹⁴

89. *See generally id.*

90. *See generally* The Jed Foundation, *Student Mental Health and the Law: A Resource for Institutions of Higher Education*, THE JED FOUND. (2008), available at http://www.jedfoundation.org/assets/Programs/Program_downloads/StudentMentalHealth_Law_2008.pdf.

91. *See id.* at 21 (noting the voluntary process by which a student can choose to contact a counselor).

92. *See id.* at 23.

Concerns have been raised about potential liability in the event that a student discloses thoughts of self-harm or harm toward others in an online screening program and no timely intervention is made to prevent the harm. Any mental health screening program . . . is anonymous [and] no follow-up will be provided unless directly requested by the student.

93. *See id.* (stressing that "[t]here is no indication that an IHE faces any liability risk by offering an anonymous screening program that follows the advice listed above").

94. *See generally id.*