

Scylla and Charybdis: Dual Roles and Undetected Risks in Campus Mental Health Assessments

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Recent high-profile events involving the mental health of students and the subsequent impact on the campus community have focused attention on the need for quality mental health care and informed risk assessment on college campuses. When on-campus clinicians are asked to provide direct clinical care to students and to perform objective evaluations of at-risk students at the request of university administrators, there is a potential for multiple role conflict. Campus clinicians may find themselves involved in maintaining a difficult balance between student and university interests. We describe some of the problems that arise in balancing decisions between the two, with a specific emphasis on threats to confidentiality and informed consent, dual role conflicts, and the limits of clinical expertise.

J Am Acad Psychiatry Law 41:532–9, 2013

Circe warned me of two dangerous monsters that dwell on either side of a very treacherous straight. Scylla, once a beautiful maiden loved by a sea god, was transformed by Circe into a hideous monster because of jealousy. . . . Her cave was located on a cliff overlooking the narrow passage of water. . . . Opposite Scylla, under a fig tree, lived Charybdis. This was a huge whirlpool that would suck water in and out three times a day. If any boat happened to be near, Charybdis would surely swallow it.¹

Shortly after the Virginia Tech tragedy in 2007, Scott Cowen, President of Tulane University, wrote an open letter to the Tulane community reminding us of our own struggle in the aftermath of Hurricane Katrina. He encouraged all to reach out to our friends and colleagues at Virginia Tech in the hour of their need. In that letter he also noted the following:

By their nature, college campuses are open, accessible havens that encourage the expansion of the mind and heart and the free flow of people and activities. Our challenge in the wake of this tragedy is to remain faithful to this concept of a campus, while having the necessary procedures in place to protect our people in the event campus sanctity is ever violated.²

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Disclosures of financial or other potential conflicts of interest: None.

The mass shooting at Virginia Tech and several other well-publicized incidents of violence on college campuses have prompted many universities to review their policies for responding to crises and their procedures for identifying and reaching out to students in distress. Suicide and other forms of violent behavior have become the focus of concern for university administrators and treatment providers alike. In light of the many published discussions of these concerns in both the peer-reviewed and popular literature, the challenge articulated by our president in his open letter echoed a common dilemma for college administrators: how to balance the need to provide security and safety without compromising the mission of a college campus as a safe haven for the exchange of ideas in a climate of personal freedom.

In this article we discuss cases involving violence on college campuses in the United States and the debate that they have provoked regarding what constitutes an appropriate response. We focus on mental health and the role of mental health assessments and treatment services in that response and comment on our experience at Tulane and the guidelines that we have developed to meet the dual challenge articulated by our president. Our goal is to explicate the questions and concerns involved in performing mental health evaluations at the request of university admin-

istration for the purpose of determining risk to the campus community.

Scylla

In an article in *Psychiatric Services*, Paul Appelbaum³ describes the case of Jordan Nott, a student attending George Washington University (GWU), who became depressed and sought treatment that resulted in his admission to an inpatient psychiatry unit. While still in the hospital Nott received notice from university administrators that he would not be able to return to campus housing unless he was cleared by the university counseling service as part of a campus psychological distress policy. He was also suspended pending an administrative hearing to determine whether he had violated the school's code of conduct, which prohibited behavior that imperiled any person's safety, including self endangerment. Expulsion was one of the potential outcomes. As an alternative, he could withdraw from school for six months and, at the end of that period, request consideration to resume his studies if he provided documentation that he was symptom free and able to live on his own. Rather than return to GWU, Nott decided to sue the university under several statutes, including the Americans with Disabilities Act, and also sued GWU Hospital for alleged breach of confidentiality.

Jordan Nott's case became the focus of an article in the *Washington Post* in March of 2006 entitled "Depressed? Get Out!"⁴ and the subsequent discussion in *Psychiatric Services* cited above. In discussing suicide on campus, Appelbaum³ and Pavela⁵ have encouraged college administrators not to overreact to fears of liability with automatic or blanket withdrawal policies.

Two cases in particular are often cited as stimulating administrators' fears of legal liability: *Shin v. MIT*⁶ and *Schieszler v. Ferrum College*.⁷ Although it is accepted that clinicians owe a duty of care to their patients based on standards of practice, nonclinicians, except in special circumstances, have generally not been found to have a duty of care to prevent suicide. However, in both *Shin* and *Schieszler*, the courts indicated that there could be a special relationship (and therefore a duty of care) if university administrators had knowledge of an imminent probability of harm.

Shin and *Schieszler* notwithstanding, Pavela presented a series of cases in support of his opinion that,

"most. . . jurisdictions have demonstrated tenacious resistance to any expansion of a nontherapist duty of care. . ." (Ref. 5, p 367). Warning against automatic dismissal policies, he suggested that fears of liability by college administrators may be unreasonable, given the precedents cited.

Jordan Nott's case was eventually settled out of court, making the details of the settlement and any resolution of the challenges to the university's stance unavailable for comment. However, most legal scholars agree that decisions about mandated withdrawals should be based on an individualized assessment of the student and situation, that policies and procedures for withdrawal allow both the university and the student to present their points of view, and that in cases where suicide is a possibility, evidence should include input from qualified experts regarding risk. There is less consensus on whether threats of suicide should be managed solely through medical policies, or as a matter of conduct, making it a disciplinary problem.^{3,8,9}

An important additional criticism of automatic dismissal policies is the implied assumption that returning home will necessarily diminish stress and therefore risk to the suicidal student.³ Again, an individualized assessment can help to clarify the potential risks associated with each available course of action. Furthermore, the importance of an individualized, open, deliberative, and transparent administrative process not only supports each stakeholder's right to present his position but also the need to get the facts straight. Jordan Nott, although depressed, claimed never to have been suicidal.

Charybdis

On February 11, 2002, Chuck Mahoney, a 20-year-old student at Allegheny College in Pennsylvania, committed suicide by hanging himself in his fraternity house. His parents sued the college, alleging that it had breached the duty of care to prevent their son's suicide, had a duty to notify them about their son's mental health problems, failed to hospitalize their son against his wishes, and failed to mandate a leave of absence for health reasons.^{10,11}

Hospitalization and mandatory withdrawal were both considered by the clinicians involved in Mahoney's care. However, in their opinion, he did not meet criteria for involuntary hospitalization and refused voluntary admission, nor was there agreement that forcing him to take a leave of absence was indi-

cated or would have been helpful. In addition, notifying his parents without his consent, which he also refused, would have been a breach of confidentiality. College administrators, aware that the student was in distress, also considered mandated withdrawal and parental notification as options. However, they repeatedly deferred to the student's clinicians regarding the appropriate actions. Among his parents' criticisms of the college were concerns about their son's therapist, who was also the director of counseling services, but was neither a psychologist nor a psychiatrist. They questioned her expertise and the judgments that guided the college's response.¹⁰

Regarding the duty of care, in contrast to the decisions in *Shin* and *Schiesler*, a Pennsylvania court ruled in *Mahoney* that college administrators did not have a duty to prevent Mahoney's suicide. Significantly, the court cited and criticized the finding in *Shin* as "steeped in hindsight" and "...an attenuated and unarticulated 'in loco parentis'".^{11,12} Citing *Jain v. State of Iowa*,¹³ the *Mahoney* court supported the general rule that nonclinicians, including university administrators, do not have a legal responsibility to prevent student suicides.^{5,12}

Nevertheless, and despite the finding of no formal legal liability, the question remained whether the college could have taken more action to prevent Mahoney's death. If, in the case of Jordan Nott, GWU overreacted to concerns about safety and liability, Allegheny's response to Chuck Mahoney's distress has been questioned for erring on the side of respecting his privacy.

Safety or Privacy

At the 2008 winter meeting of the American Psychoanalytic Association (APsaA), the Wall Street Journal (WSJ) reporter Elizabeth Bernstein accepted APsaA's Award for Excellence in Journalism for her article on the *Mahoney* case.^{10,14} In her acceptance speech, Bernstein challenged mental health providers to think carefully about the matter of privacy and the possibility that, in some cases, the decision to breach privacy may be lifesaving. She explained her interest in writing about college mental health: "I set out to explore the issue of how colleges balance the responsibility of protecting the privacy of students with mental health problems while still ensuring the safety of young people, whom most agree are still 'emerging' adults" (Ref. 14, p 17)."

Responsibility for protecting the confidentiality of information imparted in the course of treatment is a core ethics-based obligation for mental health as well as other clinical care providers. This duty is no different for clinicians practicing in a college setting than for clinicians practicing in any other treatment situation, although on college campuses, there are enhanced pressures involving answering to parents and administrators.¹⁵ In mental health treatment, confidentiality is necessary to promote help-seeking, maintain the treatment relationship, and encourage openness and self-disclosure of information that is often of a highly personal nature. To the extent that clinical interventions can diminish distress and ameliorate behavioral risks, confidentiality also serves the potential social benefits of clinical care by promoting meaningful engagement in treatment. It is important to recognize, however, that in the clinical situation, the potential social benefits of treatment are operant through the therapeutic work itself. By improving health status, well-being, and self-care, effective treatment may in fact improve social functioning and risk-related behavior, but only as a secondary consequence of the primary objective of good clinical care.¹⁶

Treatment providers must, of course, be ready to take action when it is a question of saving someone's life. This question is not only one of professional ethics or of the local and federal laws that govern the actions that may be taken; it is also a question of personal conscience. However, in their capacity as on-campus advisors to university administrators, campus mental health clinicians are responsible for initiating and maintaining an ongoing dialogue that draws explicit attention to the limits of a traditional clinical role in managing certain types of risk. Those discussions should clarify the limits of confidentiality and the respective roles and responsibilities of administrators and mental health experts in three different contexts.

Confidentiality and Its Limits

Academic Privacy and Administrative Responsibility

After the Virginia Tech tragedy, several discussions appeared in the literature regarding the limits of academic confidentiality^{14,17-19} under the Family Educational Rights and Privacy Act (FERPA),²⁰ which protects the privacy of a student's education records. In those discussions, the consistent observa-

tion was made that FERPA was never intended to block administrators from responding to situations involving imminent risk. The related concern is also expressed that misunderstanding or confusion on this point may have caused some schools to err on the side of inaction or limited response in emergent situations in which intervention would have been appropriate. This debate represents an important focus for the administrative side of the dialogue that we referred to earlier, because, without a clear understanding and commitment by college administrators about what they are or are not authorized to do, the entire enterprise of reducing risk on campus will be constrained.

Furthermore, in the absence of fully explicated administrative procedures, referral for treatment runs the risk of becoming, inappropriately, the primary option or default position for managing students at risk who are perceived to have either health or mental health problems. Administrative policies for at-risk situations must therefore be both separate from referral for treatment and well developed and defined.

All mental health policies and procedures must be consistent with the law, including the Americans with Disabilities Act (ADA),²¹ when relevant health-related conditions are involved, but there is room for variance among institutions, depending on the university climate and tolerance of or confidence in responding to various types of distressed or distressing behavior by students. Limitations in available resources must also be considered. One question that often arises is whether a school's response to suicidality should be codified in disciplinary rules and rules of conduct or in medical policies. In our view, where these policies are located is less important than that they serve the goal of protecting the university's right to set and enforce standards for on-campus behavior. These include basic standards for self-care. Suicide policies should also be nonpunitive, protect the student's privacy by limiting the number of decision-makers involved in the process of review, allow consideration of information that the student may wish to submit, and include input by qualified mental health experts.

Confidentiality of the Treatment Relationship

The privilege of confidentiality in treatment is not absolute. The American Psychiatric Association has published guidelines on confidentiality and its limits

in the college mental health setting.¹⁵ Assessment of risk and appropriate intervention in situations that represent dangerousness is part of the clinician's duty of care. Historically, a clinician's duty was limited to the patient, including situations involving suicidality. Since *Tarasoff*,²² the clinician's duty has been extended through the patient to third parties that might be in danger of harm. Other examples are mandated reporting of suspected child or elder abuse, but the fact that clinicians have a duty of care in clinical situations where a client represents a potential danger may mislead nonclinicians into thinking that the duty extends to the institution and its interests. What constitutes appropriate action in at-risk situations by treatment providers is often left to standards of practice. All jurisdictions in the United States have mental health statutes authorizing involuntary intervention where there is imminent danger to self or others and where the patient is unwilling to comply with an appropriate level of care. However, until the moment of imminent danger, the clinician typically focuses on the therapeutic work within the treatment. These within-treatment efforts are in the service of helping patients by alleviating their distress and, one hopes, their risk, but they may preclude external actions that affect the therapeutic alliance, such as disclosure of a patient's status to anyone outside the circle of treatment. University administrators who rely on campus clinical services and university clinicians for input on health-related matters, may not appreciate that it is precisely when clients become more vulnerable, approaching but not at imminent risk, that clinicians may be least likely and able to function as university advisors, since the clinician's primary duty of care is to maintain client confidentiality as integral to the therapeutic work. The clinician's duty may therefore preclude disclosures about the client that may be in the university's best interest to know, but would threaten the clinical alliance. The situation is further complicated by the fact that the move from general or potential risk to imminent risk often occurs outside the clinician's office and may or may not be known to the clinician.

In college settings, on-campus clinicians must also make judgments regarding parental notification. Modern mental health laws have been criticized as overly rigid, sometimes delaying necessary action and interfering with the use of family input as an early warning system.²³ Guidelines for confidentiality in college mental health settings recommend that noti-

Dual Roles in Campus Mental Assessments

Table 1 Differences Between Treatment and Forensic Roles of the Expert Consultant

	Therapists	Forensic Examiners
Who is the client?	Patient	Attorney or the court
Goals	Provide treatment and support	Objectively evaluate a defendant or claimant
Data	Accept what the client says	Corroborate examinee's statements with collateral information
Emphasis	Treatment, helping	Assessment of psycholegal matter at stake
Trust	Assume basic honesty	Assess for malingering or attempts to create a positive impression
Accountability	Anticipate little challenge to conclusions, diagnoses	Anticipate cross examination, consider alternative hypotheses, explanations
Privilege	Governed by therapist-client privilege	Governed by attorney-client privilege, if any
Knowledge of legal matters	May be unaware of legal standards, rules of evidence	Familiar with case law governing the matter at hand. <i>Daubert</i> and <i>Frye</i> standards of evidence
Attitude	Avoid court appearances	Accept legal proceedings as part of the work; develop testimony skills

Data adapted from Greenberg and Shuman.²⁶

fication of parents, even for students at risk, should not be mandated, but should be guided by within-treatment knowledge of the case, standards of practice, and the clinical best interests of the patient-student.¹⁵ These decisions must also be informed by university policy and local laws and must consider the student's age and the extent to which confidentiality and informed consent are legally authorized as autonomous decisions by the patient.

Role of Expert Consultants

Mental health evaluations can occur for purposes other than treatment. Those that take place at the request of third parties may be nonmandated or mandated, differ from treatment in their standards for informed consent and confidentiality, and require specialized expertise in the type of assessment being conducted. Clinical training and experience as a treatment provider alone may not provide sufficient preparation for performing nontreatment assessments or consultations, although forensically trained clinicians may be more sensitized to the need for separate roles and competencies.^{24,25} Table 1 outlines the essential differences between treatment and forensic roles for the expert consultant. These differences are both implicit and explicit and should be considered carefully before undertaking either role, especially when cases teeter between nonmandated and mandated or otherwise blur the lines between the traditional clinical treatment role and the role of expert consultant to a third party. Mandated third-party evaluations have characteristics that are more similar to forensic mental health evaluations than do nonmandated evaluations.

A key ethics-based responsibility of the examiner in third party assessments is to inform the examinee that he is not entering into a treatment relationship

and that the usual rules of confidentiality do not apply. Informing the examinee of the limits of confidentiality and obtaining informed consent is a prerequisite to conducting the evaluation.

An important aspect of the consent process in mandated evaluations is informing the evaluatee of the consequences of refusal or noncompliance with the evaluation. These may differ, depending on the institutional context, reasons for referral, and other factors related to the third party's interest and authority in mandating the assessment. Clinicians may be uncomfortable participating in mandated evaluations because of the inherently adversarial nature of the role and the impact that informed consent for participation may have on rapport and disclosure.

Mental health experts acting as consultants to third parties are functioning in a forensic role, whether they are aware of it or not, and should have the specialized training and expertise necessary for performing forensic mental health assessments. On-campus clinicians need this training, as do forensic consultants working in other contexts. Professional standards and applicable forensic guidelines²⁶ therefore apply to on-campus clinicians who function as mental health consultants for administrative purposes and must be considered by those performing consultative duties.

Dual Agency as a Symptom

In the context of the university community, mandated mental health evaluations represent a complex intersection between administrative policies and procedures and traditional mental health services. The salience of informed consent is accentuated in university settings where student health and counseling centers often function in both roles: as treatment

providers to students and as expert consultants to university administrators. University administrators will understandably turn to their on-campus clinical colleagues for input on a range of mental health-related topics, as clinicians are a valuable university resource. However, this natural reliance creates the potential for dual role conflicts when clinicians are asked to function in both therapeutic and consultant roles. It is essential that on-campus clinicians inform their nonclinician colleagues about the potential for role conflict and the impact that it may have on the quality of assessments and feedback that the clinician can offer. In this sense, university administrators also need a sort of informed consent about the scope and limitations of the process. Not having sufficient information can leave the administrative referral source unprepared to deal with the types of risk that may unfold and unprepared to take effective action to avert a negative outcome. Alternately, policies and procedures for mandated referrals, although intended to respond to safety concerns, may have the unintended consequence of co-opting the clinician's stance in a direction that diminishes effective rapport and therefore the efficacy of treatment in those patients who are most vulnerable and in need of effective intervention.

Separate roles and diverse referral concerns also require specific forms of expertise. In evaluating high-risk students, specific training and experience in basic risk assessment are needed, as is knowledge of the laws that may be operant in determining what actions may be taken, including an understanding of how the ADA and other federal and state laws apply.²¹ Also important is skill and comfort in writing forensic reports and, if necessary, defending opinions in court or before formal administrative bodies.

These are not the typical skill sets that most clinicians recruited to provide treatment services in college counseling or clinical settings possess. Supervision by a senior clinician-administrator within the clinic may improve the quality of nontreatment evaluations and administrative consultations, but the real problem is the question of specific expertise and competence, not just seniority or administrative control. Clinic directors themselves may not have the training or experience to function in a forensic or consultant role and should not be relied on to do so merely as a function of their administrative position.

Navigating Treacherous Waters: the Tulane Experience

At Tulane, we have adopted the following guidelines to clarify roles and responsibilities for campus mental health assessments and the role of on-campus clinicians in third-party evaluations:

A forensic psychologist and forensic psychiatrist serve as consultants to the University's Department of Student Affairs. Both are qualified forensic experts who have training in forensic mental health assessment and violence risk assessment. Their primary role is to provide recommendations to the Department of Student Affairs via Tulane's Behavioral Intervention Team (BIT). Their role as forensic consultants is distinct from on-campus clinical services, as neither consultant is a treatment provider at the University's Counseling and Psychological Services Center (CAPS). Their responsibilities include review of administrative requests for evaluation of at-risk students, to provide input on the appropriate direction for triage of mandated referrals: either a formal forensic evaluation by one or both of the consultants or referral for a more routine clinical evaluation by one of the clinical service providers at CAPS.

The mandate in mandated referrals is meant for the student, not for the clinical service provider. In other words, the student is responsible for complying with the request for evaluation and is responsible for the consequences of noncompliance. When the clinician is involved, it is to provide information to the university within the scope of the clinical relationship and the bounds of confidentiality and informed consent. Placing the mandate on the student focuses attention on the student who is exhibiting the behavior. This process also allows clinicians to feel less pressured if there is a potential conflict with their primary role as a treatment provider.

Determining and implementing the consequences for noncompliance are the responsibilities of the referring administrative department, not of the medical service. This requirement encourages recognition that university administrators bear the ultimate responsibility for safety on campus and supports the value of effective ad-

ministrative case management of at-risk students.²⁷⁻²⁹

The mandated context and the potential for administrative consequences outlined in the guidelines described above can sometimes be used by skillful clinicians to motivate initially unmotivated individuals to engage in a meaningful way with the process of assessment and intervention, but not always. This use of the mandate is consistent with essential clinical skills and use of basic motivational enhancement strategies for behavior change. Clinicians may make use of teachable moments with students.

There is always the risk of low-frequency but high-risk situations in which the process of routine mandated referral will not suffice. These include situations that raise concerns about dual agency or other conflicts for the treatment service. It may also include cases of noncompliance with the initial referral, itself a potential indicator of high and continuing risk. In those cases where a routine referral has been unsuccessful or is insufficient, administrators have access to a formal forensic evaluation. This tool is necessary from the perspectives of both expertise and prompt, meaningful feedback to the university on the nature of the risk and recommendations regarding appropriate action.

Conclusions

What kind of university do we want? A campus community is a microcosm of the community at large. Communities thrive where there is openness, but structure. Campuses must maintain a balance between these two seemingly disparate characteristics so as to allow for academic freedom and creativity but promote health, wellness, and requisite standards for community membership. A campus community benefits from its diversity and the participation of all its members and must not exclude the potential contribution of individuals who currently have or may have overcome the symptoms of a mental illness.

Risk management and the health of the college community are goals shared by university administrators and campus clinical health services. To achieve both goals, administrators and clinical services must work together in risk-prevention efforts. They must also stay out of each other's way. Administrative policies and procedures that are overly con-

cerned about the potential for negative publicity or strict legal liability in at-risk situations can inadvertently constrain treatment services at those moments and in those patients for whom effective treatment intervention may be most likely to ameliorate risk. Conversely, policies for managing high-risk students that focus solely on traditional clinical duties of care are insufficient for certain types of risk.

Universities must navigate between the Scylla of automatic withdrawal policies and other actions that may negatively affect the well-being of students who have mental illness and the Charybdis of failing to take prompt action in situations that represent a threat to the sanctity of the campus community or the safety of any of its members. This requires two separate parallel processes: one that protects a clinician's need to make autonomous judgments within the therapeutic alliance about what is prudent in a particular clinical case and another that fulfills the university's ultimate responsibility to manage health and safety on campus. The importance of informed consent for the student-patient in both treatment and nontreatment situations is well recognized. What is less recognized is the need for informed consent for college administrators in situations where role conflicts or available level of expertise may limit the quality of the information they are receiving from on-campus mental health services. When administrators are left unaware, the need for action in some situations may be underestimated.

In summary, campus clinical providers should advocate for confidential, accessible, quality treatment services and be prepared to provide them to students. Campus clinicians must also recognize the inherent dangers in adopting multiple roles and the limits of their professional competencies. Clinicians should be mindful of pressure by university administrators to serve in dual roles, which can compromise clinical care and professional standards of ethics. When role conflicts arise, clinicians must be prepared to explain the rationale for access to forensic evaluators and other qualified consultants to university administrators and leadership who may question the need for additional resources when a fully staffed treatment clinic is available and accessible on campus. Ultimately, the goal of college mental health care is to support a safe and healthy campus where all individuals, including those with mental illness, can participate and make positive contributions to the community.

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