Strategies for Effective Psychiatric Hospitalization of College and University Students

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ABSTRACT. University and college counseling services face growing demands for services and self-reported increases in the level of presenting psychopathology, including need for psychiatric hospitalization. However, challenges in communication often occur between the systems of an inpatient psychiatric unit and an outpatient college and/or university counseling service. Concerns include students being sent back to the college or university with no communication, premature discharge, and lack of understanding by hospital staff of the college environment. The present article discusses critical components of developing effective collaborative relationships, protocols for assessing and transporting students, and ways to facilitate good aftercare.

KEYWORDS. Psychiatric hospitalization, college students, university health services

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INTRODUCTION

Counseling services in higher education settings are increasingly treating students presenting with well-established mental health concerns. In conjunction with this trend are also reports of increased acuity in presenting problems (Benton, Robertson, Tseng, Newton, & Benton, 2003). At times these students' presentations include suicidal ideation and intent as well as active psychoses sufficient to warrant inpatient psychiatric treatment. College and university counseling service staffs can and do often feel "deskilled" when confronting psychiatric emergencies and being required to interact with a hospital environment. Counseling center directors, at a national meeting (Rockland-Miller, 2000, 2003), frequently reported feeling that they have little to no ability to communicate effectively and partner with local hospital emergency rooms or psychiatric inpatient departments. Common complaints include students being sent back to the college or university with no communication; premature discharge; and a lack of understanding of the college environment. This article will offer a practical guide to the complex considerations before, during, and after the hospitalization of the college student.

The scope of the issue is significant. In the 2006 Association of University and Counseling Center Director's (AUCCD) survey, it was reported that 2,069 students were hospitalized for psychological disorders. Of the schools surveyed, 66% reported at least 1 hospitalization, with an average of 8.6 hospitalizations per school (National Survey, 2006). In large universities, such as those where the authors practice, it is common for 50–60 hospitalizations per year to occur, but there is a paucity of literature specific to college-student hospitalization. An online literature review of the medical, psychological, and nursing databases revealed only a few articles. Kuehn and Burton (1969) described issues in hospitalization with college students who have homicidal impulses. Rosecan, Goldberg, and Wise (1992), in a pilot study, described the demographic characteristics of students hospitalized at Georgetown University. They found a correlation between hospitalization and increased distance from home, presence of substance abuse, and prior psychiatric history. They described some of the unique challenges with college students, and the need for multidisciplinary work to address these challenges.

Close collaboration and communication between the college or university and the hospital are clearly needed to ensure the safety of all involved. When there is close collaboration there is an increased

likelihood of successful reintegration of the student back into the college environment, effective communication regarding precipitants to and aftercare from the hospitalization, and robust communication about the potential for voluntary mental health leaves or involuntary withdrawals.

The optimal working assumption for establishing close collaborations in psychiatric hospitalizations is that both the hospital and the university will benefit from such a relationship. While college and university counseling staff often do not actively perceive this, hospitals greatly benefit from receiving reliable referral information, from having an active partner during the course of the hospitalization, and from having the knowledge and confidence that there will be swift and effective post-discharge intervention. Such partnerships are possible and desirable for the student, the college or university, and the hospital clinical staff.

The authors, both directors of counseling/mental health departments within large university health services, have extensive experience in developing such partnerships and working in both environments. Moving between these two worlds allows for comfort in facilitation of effective collaborative strategies. Three primary components will be addressed related to optimizing the hospitalization process. These include discussing critical components of developing effective and close collaborative relationships between colleges or universities and local hospitals, discussing protocols for assessing and transporting students to local hospitals, and review of important considerations after the student has been hospitalized, including ways to facilitate optimal aftercare.

COMPONENTS OF COLLABORATIVE RELATIONSHIPS BETWEEN UNIVERSITIES AND HOSPITALS

The first strategy is developing relationships with key hospital personnel. It is our position that the onus for forming these relationships should be with the counseling center director and staff at the university or college. Ideally directors would view reaching out to the local hospitals and arranging meetings with critical personnel as an essential component of their jobs. University administrators would benefit from making this work an explicit part of the job description for counseling center directors as a matter of practice.

Hospital personnel whom counseling service directors would consider meeting with may include a vice president or director of a behavioral health unit at the hospital, the director of the inpatient unit, a representative

from the intake staff in the inpatient unit, the director of the hospital and the community crisis team, the director of the partial hospitalization or intensive outpatient program (if available), together with the medical director or nurse manager of the emergency department.

Prior to this meeting, the director and counseling staff would benefit from preparing a card or information sheet that can be distributed to all students of the college or university who are hospitalized. The card might be given by hospital staff at the time of discharge, or by counseling center staff who might visit the inpatient unit. This card would include options for students to contact Residence Life Staff, Academic Advisors, and significant others if desired. Ideally it will also include clarifications of confidentiality provisions, options for transportation back to campus, and expectations for follow-up with the university or college health services and/or counseling services. This card can serve as a guide for hospital staff and can assist them in communicating expectations of the college or university to their patients.

Another important component of effective relationship building with local hospitals is being familiar with the major managed care companies represented within the student body. The university counseling service can take a leadership role in determining if these companies have contracts with local hospitals. Having such knowledge readily available can facilitate a rapid and effective inpatient referral. If a large number of students are on a student health insurance plan offered by the college or university, the counseling center director can serve as an advocate to ensure that these policies include parity benefits for psychiatric hospitalization.

PROTOCOLS FOR ASSESSING AND TRANSPORTING STUDENTS TO LOCAL HOSPITALS

One of the best ways for university and college counseling centers to be prepared for the process of hospitalizing students is to develop well-articulated protocols within the counseling service. The first question that needs to be asked in these protocols when considering hospitalization is, “Does the student meet the criteria for an inpatient level of care?” These criteria vary from state to state but common criteria include acute danger to self or others, acute need for medication stabilization that cannot be done on an outpatient basis, acute need for medically supervised detoxification, as well as having ruled out the safe use of a less intensive level of

care such as a crisis stabilization bed, respite bed, partial hospitalization, or intensive outpatient treatment.

When the decision to hospitalize has been made, the clinician managing the case should ask the student to sign a release of information for the hospital. Once this is obtained the clinician should phone the local hospital and ask for their behavioral health response or crisis team who coordinate admissions. Ideally, as previously discussed, a collaborative discussion should have already taken place with the staff that is responsible for admissions. Initially you may ask if a bed is available before proceeding with any further more detailed descriptions. Be ready with clinical and insurance data. Have all demographic, clinical, and insurance information readily available. In such dialogues, it is important to recall that hospitals operate at a rapid pace and generally will not want to take time at this point for any detailed conversations around psychodynamics. Rather, they will be looking for a succinct description of need for inpatient level of care, a very brief history, presenting problem, a description of what has already been tried, and a description of having ruled out a less restrictive level of care, plus insurance information.

A key question is whether the hospitalization should be done on a voluntary or involuntary basis. When a student appears to meet the criteria for hospitalization and is deemed to be stable enough to follow through with this and get to the hospital safely, a voluntary hospitalization is appropriate. Voluntary hospitalizations are important to consider given the often large expense of being transported by ambulance and the potential for continued experience on the part of the student of a sense of control and empowerment in a situation that lends itself to an erosion of this sense.

A key component of this process is to discuss with the patient in a transparent way the recommendation of hospitalization, which should be done in a manner that is clear, calm, respectful, and yet firm in position. Once the decision to hospitalize is made, in the presence of imminent risk, it should be communicated to the patient that not going to the hospital is not up for negotiation. The student needs to know why you are making such a recommendation, which may facilitate their process of accepting it even if they do not initially agree with it or are resistant to it. This is not the time for complex descriptions. The recommendations should be straightforward and concise. When communicating a decision around involuntary hospitalization to the student, communications should be done in a nonjudgmental way, firmly yet calmly focusing on safety concerns.

All professional staff at a university or college counseling services should be very familiar with the statutes and procedures for involuntary hospitalizations in their state. We recommend that if there is any reluctance on the part of the student to go to the hospital, despite imminent risk factors, then an involuntary hospitalization be conducted. While generally most states use the tripartite criteria (danger to self, danger to others, and/or grave disability), specifics do vary state to state as to who can write an emergency commitment and length of stay. Generally, hospitalization is appropriate if the mental health professional has reasonable cause to believe that the student has a mental illness for which immediate observation, care, and treatment in a hospital is appropriate and where there is high risk of serious harm to the student or others. This criterion is often defined as a substantial risk of physical harm to the person as manifested by threats of or attempts at suicide or other conduct demonstrating that the person is dangerous to himself/herself, which includes the person's refusal or inability to meet his or her essential need for food, shelter, clothing, or health care, or if there is a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm.

All counseling services staff should have a basic understanding of protocols for transporting students to the hospital, especially in cases of involuntary hospitalization. One way of approaching these situations is to have all staff be aware of their specific roles in what can be a stressful process. For example the mental health professionals, who are responsible for providing treatment services for a student, should have clear options regarding how to initiate a hospitalization. One option can include contacting the counseling center Director or Clinical Director and informing him/her that there is a student that meets the criteria for hospitalization. The Director or Clinical Director of the college counseling center must be willing to prioritize and reschedule other meetings and commitments at this point to facilitate the hospitalization. Clinical staff ideally will have the license (and state designation if required) to legally request the transport of the student to the hospital. Emergency commitment paperwork should be readily available and staff should be fully familiar with laws and procedures regarding hospitalization. Depending on local statutes, this may require the Director or Clinical Director to meet the student to briefly evaluate him/her to confirm the criteria have been met for involuntary transport.

If the counseling service has a psychiatrist on staff, the psychiatrist can assist other mental health professionals in the hospitalization

process. Most states empower psychiatrists to complete papers that allow for an involuntary transport. Some state laws require that the psychiatrist meet and evaluate the student to confirm that the criteria have been met for involuntary transport, although many states allow psychologists and independently licensed social workers to complete the process independently.

The counseling service clinician who signed the form authorizing transport should involve an administrative support/front desk staff member and give them the form. The administrative support/front desk staff member can then notify the transport team, which usually would include an ambulance and campus police. The clinician should then call the hospital and convey the essential facts of the case needed to help facilitate admission, calling either the Chief of Psychiatry, who could facilitate a direct admission to the Mental Health Unit, or the Mental Health Evaluator or Nurse in charge in the Emergency Room. Ideally, protocols should be established with the local hospital defining specific processes and contact people. Information given in this call should include basic data as to demographics, mental status, and level of agitation, whether the student needs a secure room, presence of psychosis, substance use, interventions already tried, risk of violence, and insurance status. Under the Health Insurance Protection and Portability Act (HIPPA) clinicians are authorized to provide any information deemed necessary to all parties involved in order to support transition to a hospital setting in an emergency situation, which is the case by definition for involuntary hospitalizations. Documentation of these contacts should be completed before departing for the day.

The counselor who initially saw the student should remain with the student for support and monitoring, either in the counselor's office or in another space deemed more appropriate given the needs of the situation. In the event the counselor is unable to remain with student, he or she may ask another counselor to remain with the student until the transport team arrives. The counselor can then facilitate a clear handoff to the transport team. The counselor should continue to be clear and firm and can inform the student, "You are going to be evaluated further for safety. You are going to the hospital for further evaluation. These officers and ambulance staff are now going to escort you to the ambulance." After the student has been transported the counselor can call the hospital to convey any additional facts of the case that are needed to help facilitate admission or treatment. These contacts should also be documented before the end of the working day.

The role of administrative support/front desk staff should not be overlooked or underestimated when facilitating a hospitalization. As previously mentioned, they can play a key role in notifying the ambulance squad and police for safety backup. Administrative support/front desk staff can also provide needed support with paperwork. They can give the original transport form to ambulance staff (for the hospital) and copies to campus police, counseling administration, and to the student's file. Administrative support/front desk staff can also play a key role in communicating with police and the ambulance squad. In addition to providing each with copies of the transport order, they can provide each with basic facts of client identity and description and even frame the student as "sick or ill," not "bad or criminal," especially important with the police who may have varying degrees of comfort and training in dealing with students with mental illness. Administrative support/front desk staff can also play key roles in structuring the hospitalization through clearing the waiting room as needed, directing pedestrian traffic in affected hallways, and informing the counselor by phone as soon as the transport team has arrived.

How the patient will get to the hospital is an important consideration. In the case of a voluntary hospitalization of someone who is deemed to have relatively good impulse control (which may be infrequent by definition in the case of a hospitalization), a friend may be appropriate. If the student's family is local and available, then a family member should be considered. Another option is for the student to take a cab if this service is available in the local community, though only after careful consideration of potential safety risks. Universities and colleges can work with local cab companies to allow students to bill the cost of their transportation to their bursar account.

Given the frequency of acute risk factors at the time of hospitalization, however, ambulance transport is often indicated. In working with emergency medical technicians (EMTs) in the ambulance, it is suggested that brief identifying information be given to them so they can do their best job transporting the patient. EMTs transporting a student to the hospital need to know what the situation is currently, especially if the student is at risk of elopement or violence so they can respond appropriately. Furthermore, if the student is especially frightened, talking to the ambulance professionals in advance will help them to be more supportive and facilitate an effective, secure, and comfortable transport. As with any transportation issue, if it is deemed that the student is a safety or elopement concern, campus police should be called for backup.

AFTER HOSPITALIZATION–WAYS TO FACILITATE GOOD AFTERCARE

Following inpatient admission, it is essential that counseling service staff coordinate the student's treatment and follow-up care with hospital social workers and psychiatrists. University and college counseling services staff are the experts on college-specific issues such as medical leaves of absence, course considerations, residence life issues, etc. The hospital staff will want their expertise. Similarly, hospital staff will offer expertise on pharmacological issues, diagnostic considerations, and risk management issues. It is essential to have systematic ways to prioritize appointments for follow-up care after hospital discharge, which can come in the form of daily designated urgent and emergency slots in the counseling services' schedule.

Another key issue in aftercare is considering communications with significant others and family members. With students, pros and cons of contacting family must be part of the dialogue, and in many cases students may want the clinician to call family. In other cases the student will object. Judgements must be made on the basis of consultation with colleagues as to situations where safety considerations mandate contacting family in an emergency even beyond the student's wishes. For a student who is hospitalized and who lives in the residence hall there may be some need to communicate with residence life as to the location of the student. If the student just suddenly seems to disappear, that can create a crisis in and of itself, even resulting in the filing of a missing persons report. Optimally, the student will give permission for contacting residence life or the student may agree to contact someone in the residence hall to let them know that they will be gone for some time. There may be other offices that need to be contacted depending on the situation, including the Dean of Students, Health Services, and at times faculty, among others. All decisions about overriding confidentiality to call significant others should involve consultation with a colleague or supervisor and documentation of this process.

In sum, by utilizing the above strategies the university counseling center and the hospital emergency and psychiatric inpatient units can develop close working partnerships that will facilitate the work of all clinicians involved in supporting, treating, and maintaining the safety of the student. When it is clear what hospitals need from counseling services and what counseling services need from hospitals, both parties benefit from the communication. The dialogue around aftercare arrangement, and

consultation on college and university specific issues such as medical leaves of absence, family involvement, course considerations, residence life issues, and issues coming up in interface with the Dean of Students office, will help meet the ever increasing needs of the students we work to serve.

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