

**Auditing the Illness: Critical Analysis of Emergent Higher Education
Mental Health Policy in Major Ontario Universities**

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Abstract

Since tragic on-campus suicides like those of Elizabeth Shin, there has been a call from the community for sensible mental health policies to be developed at Canadian universities. Mental health policies in Ontario universities are still in development and what is currently being used in place of dedicated policy documentation is often cold and legalistic, or simply inappropriate for use with mental health issues. The research surrounding mental health policy in higher education is limited, as the issue of mental health in policy appears to have only recently become a point of discussion. In this study, I attempt to create that discussion, addressing legalistic and neo-liberal trends in policy. To this end, I compiled the developing frameworks and existing policies from 13 major universities across Ontario (i.e., the institutions with more than 10,000 students) and examined them for precisely these neo-liberal trends. I conclude by arguing that current procedures for handling mental health issues (including the use of student codes of conduct and no-harm contracts) are not humanistic but, instead, bureaucratic. I also note that some of the currently developing mental health policies show many of the same tendencies. I caution policy makers to consider a more humanistic approach to mental health policies if on-campus tragedies are to be avoided.

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CHAPTER ONE: INTRODUCTION

Mental Health and Canadian Universities

Quality mental health services and viable mental health policy are major concerns for modern Canadian universities and it has become increasingly apparent that current solutions do not have long-term sustainability. At the very least, the mental health resources of most universities are not sufficient to address the problem in any meaningful way. An article by *Maclean's Magazine* notes that this last decade has seen an incredible increase in student demand for mental health services (Luneau, 2011). Suicide is still the leading cause of death in young adults in Canada, after motor vehicle accidents and on a university campus such tragedy is all the more visible (Luneau, 2011). And yet, despite the statistics, the nature of the problem is somewhat difficult to grasp. To illustrate: At Toronto's Ryerson University, counseling centres saw a nearly 200 % increase in student patients in 2011 and students faced nearly four times normal wait periods as a result (up to 8 weeks to for a first appointment with a counsellor). Ryerson is only one such instance of a nationwide problem where counseling centres are overburdened, yet researchers on the topic of mental health refer to the prevalence of suicidality among university students as "the silent problem" (Wynaden et al., 2014). The label may seem ill fitting but it is in fact quite descriptive: Despite the high numbers of incoming cases, students quickly give up on counseling centres and statistics show that few students bother to come forward with their problems at all. Surveys of university students, according to a Yale study, have shown stable proportions of mental illness since as early as the 1920s—there is no sudden crisis, merely a sudden awareness that the problem has

always existed (Wei, 2007). Assuming the quality of care is sufficient at campus mental health centres, there could be a number of reasons for the silence and why there is still trouble breaking it—among those reasons are the aforementioned wait times. With an overburdened system and wait times approaching months, students may simply grow frustrated and try to handle their issues on their own. And while counsellors report that students are coming forward with more severe illnesses than in previous years, surveys of mental health indicate that these students are not actually seeking help at counseling centres. In fact, counseling centres are being filled out by students who do not suffer from mental illnesses at all (Wei, 2007).

Let me pause here to define mental health and mental illness, an important distinction in the context of this discussion. The Canadian Mental Health Association, Ontario (CMHA, 2015) defines *mental health* as “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community” (para. 1). Conversely, the CMHA defines *mental illness* as “a recognized, medically diagnosable illness that results in the significant impairment of an individual’s cognitive, affective or relational abilities” (para. 2). Note that the CMHA definition of mental illness uses the term “medically diagnosable illness”, and this thesis concerns students with serious mental issues that may or may not be diagnosed. I am by no means making the claim that all serious mental issues are diagnosable illnesses, nor am I claiming that suicide is in and of itself a mental illness. I do make the claim that suicidality and mental illness are correlated strongly, and that suicide is often a symptom of mental illness, but suicidality is not the totality of the student wellness problem on-

campus. The important point to gather from these definitions is that suffering from mental illness does not mean one has poor mental health, indeed, one can suffer from mental illness and have good mental health. For instance, individuals with depression could still excel in managing their life and stresses that arise despite their symptoms and have little need of mental health intervention (though they would still need treatment for the symptoms of their illness). While I ascribe to a medical model of mental illness (the idea that mental illnesses have largely biological explanations and should be treated in much the same way as physical illnesses with regards to treatment and diagnosis), the distinction between mental illness and mental health is still relevant in the more popular biopsychosocial model (which is typically adopted by universities). The biopsychosocial model of mental illness argues social (cultural and environmental) and psychological (emotional and behavioural) factors play as important a role in mental disorders as biological factors. My bias towards the medical model should be noted through the course of this paper. It is not the purpose of this review to argue in favour of the medical model over the biopsychosocial model but at points I do criticize the overreliance on psychological and social explanations of student behaviour in university policy. Equating the terms mental health and mental illness runs the risk of assuming that treating one is treating the other. There is a danger for policy makers to create blanket policies (that is, an overly broad set of guidelines) that address mental health issues but fail to mention issues of mental illness. Note that while this thesis often uses the term “mental health policies,” this is only because that is how the universities themselves typically refer to these documents, despite the inclusion in these documents of issues that very much involve the mentally ill. Also note that in over 90% of suicide cases, the victims were

suffering from mental illness (Mann, 2002). Treating suicidality and self-harm in higher education needs to involve a discussion of mental illness in some way, not merely mental health.

So, to return to the problem at hand, counseling centres report that more students with serious mental illnesses are enrolling in universities than in previous years but very few of these students see them for treatment (Wei, 2007). Counseling centres are full of students with mental health issues but they treat a disproportionately low number of students with mental illness relative to the population of university students. Initiatives and programs that encourage students to come forward appear to do little to help the seriously ill if the students cannot be treated before their disorder affects their school performance. These initiatives do even less good if they are aimed solely at those suffering from poor mental health, perhaps explaining the discrepancy between the number of students with a diagnosed mental disorder and the number of mentally ill students seeking help on-campus. Despite programs and awareness campaigns promoting mental health, those with mental illnesses may feel as if the facilities are not equipped to handle the severity of their issues. There are, of course, other explanations for the lack of counseling attendance. Given the busy schedule of students, they may not even have time for regular appointments. There could even be financial reasons. Working students may be afraid that the centres will recommend medical leaves or pharmaceuticals that their insurance may not fully support. But perhaps a more likely reason that students seem to be afraid to come forward or follow up on treatment is due to stigma—both perceived stigma prior to seeking help and stigma encountered after doing so. After all, mental illness is only very slowly becoming a socially acceptable topic, and remains at the centre

of some controversy. Some universities seem to have trouble finding the right way to address the problems when they arise and understandably so—these issues can raise potentially embarrassing questions regarding the suitability of care provided by the institution.

Consider the case of Jack Windeler, a student at Queen's University in Kingston, who was the victim of suicide on March 26th, 2010. In the months that followed Windeler's death, three more cases of suicide arose at Queen's and the string of tragedies caught the public eye. The deaths of Windeler and his peers pointed to an inadequacy in counseling services at the university. Soon, students began sharing their own dissatisfaction with the school's mental health service, noting an inability to contact the office by e-mail, dismissive staff and a wait time of months (Er-Chua, 2010). Queen's, of course, had to address these issues that were now made public but even in reporting on Windeler's death, it needed to be careful. There was some commentary on the university's online report on the tragedy that criticized the university for being open with the cause of Windeler's death, which argued that suicide should not be made public knowledge and is in some way a more sensitive and private affair than other means of death. While the parents were, in fact, supportive of the university's honest stance regarding their son's death, the idea that one must tiptoe around the topic of suicide is unfortunately common.

In 2008, under the leadership of the American College Health Association, the Higher Education Mental Health Alliance was formed to address, among other things, proper responses to suicide on the part of colleges and universities and policies those institutions could then implement. Their guide, titled "Postvention," recommends having friends and roommates limit social media communications until after the death has been

officially reported and to then use “safe messaging” to reduce the risk of “contagion” (p. 11). Contagion, in this case, refers to the idea that following an incident of suicide, it is more likely for other students to also die by means of suicide. Indeed, the guide suggests that any reports within the campus itself default to not confirming that the cause of death was suicide where possible (pp. 11–12). Unfortunately, this kind of policy doesn't promote open dialogue, which is a large part of why the silent problem is, indeed, silent. One can almost understand the caution on the part of administrators and policy makers. Suicide cases can mean a lot of liability for universities if legal action is pursued and since high-profile cases like that of Elizabeth Shin in 2002, institutions have chosen to err on the side of caution—at least where it concerns their own legal safety.

As I examine policy through this paper, I intend to move from a broad discussion of policy in Ontario higher education to the means in which policy is enacted, narrowing the focus as I progress. In this way, I hope to move from a broad theoretical base to a grounded depiction of how policy functions in practice. I will introduce the nature of the problem and its origins through a case study (particularly, the case of Elizabeth Shin, whose death spawned a wave of policy reform). I will then discuss the particulars of the policies themselves, selecting from a small sample of publicly available documents from Ontario universities (and one notable document from a university in Quebec). My research has yielded only a limited number of these policy documents—however, this is to be expected. After all, mental health policy is a relatively new topic and many universities are still in the process of developing and understanding policy. The documents that I have highlighted are, I feel, representative of the fledgling and cautious nature of modern mental health policy. While I will trouble the language used in these

policies to a limited extent, I do not seek to comment on their effectiveness in this section. Instead, my intent is to illustrate the legalistic and perhaps vague nature of these policies. From there, I will use the work of theorists Michael Power and Michael Apple to help put these documents and trends into perspective. Both Power and Apple argue that neo-liberal values dictate policy decisions in higher education and I make the case that mental health policy is no exception. Bureaucratic traditions and systemic capitalist values are likely giving rise to the trends of legalistic policy discussed in later chapters. I will then tighten the focus further to discuss the concepts and values higher education institutes intend to portray through their policy documents. This discussion will take place through the lens of a single policy concept: in particular, the concept of *in loco parentis*. Finally, my argument converges on the tools used to enact the aforementioned policy concepts. I note that even reasonably presented (though legalistic) ideas like the enforcement of *in loco parentis* can be executed in ways that would seem to run counter to a well-intentioned policy. For one reason or other, the values and conceptual goals of mental health policies do not always emerge in practice. This chapter will focus on a single policy tool by way of example: the problematic antisuicide contract. Some of the issues with this tool are discussed in brief in Chapter Two of this paper.

Much of the focus in this paper is on suicide and self-harm as a representation of the kind of issues policy needs to address, because policy has been shaped around these issues on-campus. Policy reform seems to coincide with high profile tragedies on-campus, hence the discussion of the pivotal Shin case, which influenced policy across all of North America. The problem lies in what kind of policy develops in reaction to tragedy—is it policy that removes the problem from campus or policy that encourages an

on-campus resolution? Further, mental health is an area that policy seems to handle adequately, when policy exists at all. Issues such as suicide and self-harm reveal weaknesses in policy that a broader view of mental health issues would not—particularly, whether policy makers even address mental illness as a potential link to on-campus tragedy.

The broad to narrow, theoretical to concrete structure of the paper allows me to examine emergent policy, focusing on the true product that results from policy decisions on a higher level. In this way, I hope to illustrate not only the higher level neo-liberal thought that informs these documents but the very real, grounded consequences of policy decisions. When I speak of emergent policy, I refer to the informal, often unspoken and unwritten, problem-solving methods that act in place of formal, agreed-upon policies. Emergent policy is somewhat the opposite of explicit policy: commonly understood, vague, and unwritten. Emergent policy is, by and large, the current operating standard for mental health issues in Ontario Universities. I argue that emergent policy, when it comes to mental health issues, is no substitute for good policy documentation, and that the over-estimation of existing resources is ultimately detrimental to anyone seeking help for mental health issues on-campus. It is my hope that this review can help inform future policy and avoid tragic cases like those of Jack Windeler or Elizabeth Shin.

The Case of Elizabeth Shin

In 2002, the parents of Elizabeth Shin, a victim of suicide 2 years prior, sued her university (Massachusetts Institute of Technology [MIT]) over negligence regarding the death of their child. As a \$27.65 million lawsuit, it certainly attracted a considerable amount of attention and all those involved knew the outcome of the trial could deeply

impact the way universities and colleges thought about and handled mental health issues. While the trial was eventually settled out of court, the fear of legal consequences stuck with higher education institutions.

When Shin started her studies at MIT, she was already entering the school with a brief history of mental illness—minor depressive symptoms had emerged during her senior year of high school (Shin et al. v. MIT, 2002). During the first year of her program, Shin's symptoms worsened and she reported her distress to the school. Her symptoms included self-harm and suicidal ideation and it was during this time that she was hospitalized for attempting to overdose on codeine and Tylenol. Her care at MIT consisted of appointments with the campus mental health services every 2 weeks. However, the psychiatrist she was seeing dismissed Shin as having what he called situational issues—that is, mere trouble adjusting to the stresses of campus life—and recommended little more than a self-help book to assist with her difficulties. It would be another year and a considerable worsening of her symptoms before Shin was diagnosed with borderline personality disorder and depression through a new psychiatrist at MIT. Even with a more serious diagnosis and a more attentive psychiatrist, Shin's health deteriorated throughout the year, as reported through her peers and residence don. Despite expressing a wish to no longer live in the dorm, mental health services discouraged this idea and instead recommended she continue the lengthy process of being treated on-campus. Social workers at MIT began the several month process of setting Elizabeth up with therapy programs and appropriate medication, while she continued to see a psychiatrist on-campus. Elizabeth agreed to try the planned programs once they could be arranged. On the evening of April 8th, however, Shin informed another student

in her dorm that she felt she was a serious danger to herself. During this severe depressive episode, Shin was taken to mental health services. After the on-call psychiatrist evaluated her for less than 5 minutes (over the phone), he dismissed Shin on the grounds that he didn't believe she was a serious risk to herself. Shin was sent back to her dorm without any further follow-up. On April 10th, she informed a dorm resident that she was going to die that day and requested that her computer files be deleted postmortem. Alarmed, the student informed a residence don, who in turn informed the head psychiatrist. The psychiatrist was convinced that nothing serious was going on, since he believed Shin's friends had overreacted during the incident two nights prior and that Shin was not acutely suicidal. He sent the don to check on her but informed the don that there was no need to take the student in for medical care. The don remained concerned and after a troubling phone conversation with Shin (who repeated her suicidal ideation), the don once again contacted mental health services, only to be referred to a different psychiatrist that Shin had been seeing. The psychiatrist noted that he was going to be attending a meeting where Elizabeth's case would be discussed and he assured the don that the phone conversation would be brought up. The only further contact with Elizabeth that day was a voice mail message left by the psychiatrist, indicating that he would be available to contact that night. That night, Elizabeth's room was engulfed in flame. While Elizabeth likely disabled the sprinkler system in her room, as it did not activate, the smoke alarm in her room quickly alerted other students to the danger. Unfortunately, help did not arrive fast enough for Elizabeth. Suffering from extensive burns across her entire body and considerable brain damage from the fire, Shin finally succumbed to her injuries on April 14th. Her death was ruled a suicide. No other students

were harmed in the incident.

The case against MIT relied in part on the idea that the university set forth a number of expectations for their mental health services that they failed to uphold, entering into something of a verbal or implied contract with the Shin family that they did not follow through on. The court found that since MIT did not have policy outlining its responsibility to the student, it was difficult to argue that there was a specific promise or contract to Shin or her family that may have been violated. Indeed, the brochures and information provided to Elizabeth at the beginning of her studies were found to be “vague and indefinite” in what the university promised to provide students (Shin et al. v. MIT 2002, p. 14). Further, the court saw evidence to suggest gross negligence on the part of the medical staff may have been a merited charge (the defendants had called for summary judgement; this was denied in consideration of the evidence). With the medical staff facing their own charges, the question was, then, whether the administration would be absolved of the blame. The defence argued that the administration itself owed Shin no duty of care but rather this was solely the responsibility of the medical professionals on staff. And yet, while the defence's claims had merit in the eyes of the court, the court ruled that a special relationship existed between Elizabeth and the administration—members of the administration were aware of the problem and were responsible for referring the student to the campus's medical services. It was clear that the administrators would be involved in the charges levelled against MIT. If the trial had continued to completion, it is unclear what this would have meant for the level of responsibility universities have towards student well-being and mental health.

With the full benefit of hindsight, it is easy to say that Shin was suffering from much more than just situational issues and that her problem should have been treated as the serious medical issue that it was. Of course, after spending so long in the care of professionals, one would expect at least some amount of foresight on the part of her caretakers, especially considering Shin was nothing if not forthright with her intentions. Should the psychiatric professionals involved in treating Shin or the university itself be held accountable for the student's death? And if Elizabeth was deemed a significant danger to herself on April 10th, what action could (and more importantly, should) have been taken to ensure her safety both in the immediate sense and in the long term? If anything, these questions could have been answered by solid mental health policy documents. While one cannot claim policy would have prevented the tragedy, it would have aided in the mess that followed.

Mental Illness and Suicide

Before proceeding into my discussion of policy, I believe it may be helpful to elaborate on the topic of mental illness and suicide. Earlier in the introduction, I argued that any discussion of mental health policy would be lacking without some mention and understanding of suicide, especially if the goal of said policy is to curb youth suicide rates. But understanding suicide is a tall order and a topic big enough for another thesis entirely. With this in mind, I will be limiting this discussion to a few key expert opinions that have informed my understanding of suicidal behaviour and mental illness (aside from my own academic background in the subject matter).

Of note is Emile Durkheim (1897/1951), founder of the French school of sociology and author of *Suicide: A Study in Sociology*. Durkheim's text was

foundational—it was one of the first to discuss the issue of control and choice when dealing with mental illness and suicide. Durkheim toys with the idea that the perceived motivation for a suicide (or even the outright stated motivation) may not be what it appears to be. Indeed, he raises the possibility that subtle disorders of the mind may be so disorienting and insidiously tormenting that the victim, in his or her confusion, attributes his or her internal distress to some external but trivial misfortune. This is the reverse of some of the traditional sociological models, whereby a series of misfortunes coupled with poor life coping skills leads to the formation of mental disorders (in those that have the genetic predisposition for such disorders). In this model, the existing mental disorders actively impair rational thought, intensifying any emotional event, such that the eventual suicide can seem to be caused by something trivial. When a young adult fails a university class and attempts suicide, one assumes that the obvious motivating factor would be the failing grade. But this is not necessarily the case and Durkheim's idea should give pause. Of course, Durkheim entertains other possible models of suicidal behaviour and makes no solid conclusions concerning this branch of thought.

But many leading suicidologists have picked up where Durkheim left off and seem much more confident in the medical model of suicide than Durkheim (who, despite his musings, had a more biopsychosocial view of suicide). Prominent among them is Dr. Douglas Jacobs, a Harvard-affiliated psychiatrist, national expert on suicide and editor of *The Harvard Medical School Guide to Suicide Assessment and Intervention* (1998). Jacobs has argued outright that "not all depressed people have thoughts of suicide but all people who are suicidal usually are depressed, which is why treatment is essential" (Help Yourself, Help Others, 2010). He emphasized these views again in an interview for the

Globe, in response to a number of teen suicides in February 2014: "[Jacobs] stressed that teen suicide occurs primarily among a small subset of young people who suffer an underlying psychiatric illness—usually depression. And such illnesses, he said, are often treatable" (Harmon, 2014, para. 8). This muddies the idea that suicide is a choice: if illness underlies the act, what does this mean for policy? If Dr. Jacobs is correct, until the underlying mental disorder is treated, suicide is a constant threat, regardless of life circumstance.

Unfortunately, it is likely Elizabeth Shin's own motivations were misunderstood in the time leading up to her suicide. Shin's psychiatrists talked with her at length about stressors such as parental pressures and grades and when those problems were addressed, they assumed the problem had gone away. Policies that deal directly with self-harm must ensure that in addition to addressing stress and life skills (which are undoubtedly important parts of mental health in general), they also address the likely underlying mental illness. Policy must be preventative, not reactive.

Creating Policy

Historically, where there have been failings in mental health policy, student organizations have led the efforts for reform. In the early 1960s, mental health programs were practically nonexistent in Canadian universities until lobbied for passionately by students (Jasen, 2011). It is because of their efforts that a discussion of mental health policy can even be had. This connection between students and policy reform has weakened over time but has not disappeared. Students at McMaster University, for example, have developed COPE, a mental health initiative focused on awareness and education. COPE works closely with the university to promote reform and to improve

policy (Sarjoo, 2015). With this long association with mental health reform, are students once again the answer to changing policy for the better? While it may be true that students are not afflicted by the same legal caution as administrators, student unions can be as ignorant of the issues afflicting their peers as any policy maker. They are, after all, not medical professionals (even if they are the population the policy will most directly influence). One also has to wonder what power modern student organizations hold—can the mental health overhaul of the 1960s really happen again through student involvement alone? I feel that while it is not the key to the puzzle of policy reform, it is important to consider the student perspective moving forward.

Since the conclusion of the trial surrounding Elizabeth Shin, the issue of quality mental health policy has been brought to light but much has been left unresolved. With no final ruling on the duty of care for higher education institutions, these organizations were left in fear—what was there to protect them were there to be another lawsuit in which the administration was, in fact, deemed responsible for the death of a student? If the law was unclear, there at least needed to be some measure of internal consistency in the event of another tragedy. Since the Shin case, there has been some literature (though not a great deal) surrounding what exactly effective mental health policy on-campus should look like. While the Shin case was American, Canadian universities shared much of the same reactions as American institutions well into the decade (Michaluk, 2008). The Elizabeth Shin case was monumental for university policy well beyond the United States, as it marked a change in how universities perceive the duty of care—an issue relevant regardless of the institution's location.

Currently, there exists a debate between those who would suggest it is not the

university's place to intervene in cases of suicidal and/or mentally unwell students (or at the very least, they are not legally accountable for the actions of those students) and those who insist the university must take responsibility in caring for the mental health of their students at all levels of operation. To state it less kindly, the debate is between policy that protects the institution versus policy that favours quality student care. Authors such as Susanna Dyer (2008) have said that universities must be careful to implement policy that directs students away from nonclinicians (professors and deans) and towards actual counseling services. Dyer, a doctor of law, exists firmly in the former camp, insisting that universities not be held responsible for suicides among their number. Her argument is a legal one: The ability to foresee a mental health issue is simply not enough, by the letter of the law, to hold someone accountable for not trying to prevent it. Nonclinicians should not have a duty of care and a university is not a care facility. Therefore, she concludes, mental health policy has to be implemented carefully to ensure legal ramifications are avoided. Her opponents argue through case studies and suggest that trying to avoid legal backlash is understandable, an even greater problem is created in practice. When trying to avoid a repeat of the Elizabeth Shin case, many Canadian universities (including some Ontario institutions) implemented mandatory and involuntary withdrawal policies for any student they believed showed suicidal tendencies. Some use existing policy to try to treat mental health issues with disciplinary action. Some administrators argued that students suffering suicidal ideation (or who had attempted suicide) were violating existing policy by causing harm or conspiring to harm a student, despite the fact that the only student at risk was the student him or herself (Wei, 2007). After cases emerged where several students without any actual suicidal ideation were forced to withdraw, it became clear

that these programs were more about trying to make the problem disappear than finding actual help for mentally unwell students (Baker, 2014). Authors such as Gary Pavela (2006) conclude from this that universities need to prioritize quality care over simply avoiding liability and that responding to mental distress with discipline is more irresponsible than any charge the university could seek to avoid.

The literature currently frames this debate as institutional rights versus the rights of mentally ill students. Through the literature review that follows, I intend to delve in depth into the nature of these arguments, both legal and emotional. Within the literature review and in the discussion that follows, I hope to illustrate the dangers of legalistic policy that protects only institutions. I will review policy documents that are largely still in development and highlight areas where these documents prove to be reactionary rather than preventative. It is not within the scope of this research to attempt to solve these complex legal issues or to suggest viable policy solutions (although I may note other authors who have offered some suggestions during the course of my review). While I may trouble the current dismissive language surrounding mental health in universities, my purpose is to understand what concepts and tools are currently in place to implement and enact policy. Ideally, policy serves to apply university values to programs and services carried out on-campus and to ensure these programs and services meet certain standards of quality. If there is an issue with the quality of student care, rather than manage and inform an entire network of services and departments, a formal policy document can help ensure nothing is lost in communication.

When a document of this nature exists, how does one determine the quality of that document? For that matter, how much does practice suffer without a formal policy

document? I intend to determine this through several key questions. Do the tools through which policy is enacted align with the concepts outlined in those policies? What policy concepts and theories form the basis of mental health policy in major Ontario universities (i.e., those with student populations of at least 10,000 students)? Ultimately, I hope to present an accurate picture of mental health policy in Ontario universities, note which institutions are lacking a formal mental health policy document and what guidelines may be serving in place of an overarching document.

CHAPTER TWO: LITERATURE REVIEW

Mental Health and a Duty of Care

Among scholarly literature in the field of education, mental health (especially as it concerns organizations and their policies) has only recently become a mainstream topic of concern. It may be that scholars are only now, in this decade, able to come out from the taboo surrounding mental illness and are willing to talk about the uncomfortable topic. This is especially true when university researchers must ask their own institutions the embarrassing questions concerning the quality of their mental health care policy. Mental health in education research may be emerging due to increasing public awareness surrounding campus mental health. Indeed, much of the literature that is available comes from the United States and the bulk appears to be in response to a number of high-profile tragedies: a series of school shootings and lawsuits surrounding student suicides on prestigious university campuses. These highly visible issues seem to have motivated researchers into examining exactly how institutions of higher learning have been handling issues of mental illness. The question has become increasingly public—what are colleges and universities doing to help students with mental health problems? For that matter, do these institutions, morally or legally, have a responsibility to care for those students? And while the United States has found itself rapidly changing and critiquing policies in an attempt to address these questions, Canada, too, has been swept up in the pressure. Canada has adopted much of the same reactionary policy as its southern neighbour. This silence is problematic at best—the lack of critical literature makes revising and developing new policy difficult, to say nothing of judging the effectiveness of existing policy—and this is ultimately a loss for the students. Not only does this mean that students may be receiving out of date or poor quality care but without proper policy,

nothing protects students from negligent or outright discriminatory behaviour.

And, indeed, this is precisely what has been happening. While the scholars may be silent, the news media is rife with unfortunate case studies in which failing mental health policies have made victims out of already suffering students. A recent *Newsweek* article collected quite a number of these stories from universities in the United States (Baker, 2014) and the callous policies on display are unsettling to say the least. These stories raise a number of concerns, from issues of policy overriding student privacy, to students forced to sign documentation dictating an unreasonable counseling schedule (or else be withdrawn from their studies), to schools acting harshly in response to mental health issues that may not even exist, to students simply being punished for seeking help. How can any institution valuing mental health allow such ethical failings? These case studies and the policies they highlight will be examined in greater depth later in this review to find out how such counterintuitive (yet sometimes well-intentioned) policy could come about. Indeed, through this review, I will take what little literature does exist and attempt to form a coherent picture of the state of mental health policy in Ontario universities and with this in mind, I will try to predict what any future policy reform may look like.

Despite the long silence from researchers concerning mental health, student mental health is a serious issue that could use documentation to guide the parties involved. Students with mental health difficulties are likely to have their studies severely impacted. A large portion of those afflicted with mental illness drop out of college before graduation, while in a 2010 study, 92% of students reported that their work suffered as a direct result of their mental illness (Reavley & Jorm, 2010). This is, of course, to say

nothing of the increased suicide risk for students with mental disorders—suicide remains the leading cause of death for young adults across North America, after motor vehicle accidents (Luneau, 2011). Such a highly visible problem should be a priority for higher education care facilities and indeed, universities and colleges are certainly beginning to publicly implement responses to the issue. Unfortunately, many of these undertakings are lacking in substance. Public opinion may be influenced by awareness campaigns, mental health weeks and increased mental health expenditure at universities but without solid policy to back up these initiatives, they are little more than lip service to a serious issue. Authors Reavley and Jorm have agreed that this kind of so-called treatment may be problematic at best. The researchers tested the effectiveness of a variety of postsecondary mental health programs from among the most common responses to the mental health crisis. These included online-based initiatives (including social media awareness campaigns), stress-reduction strategies and traditional on-site counseling programs. They found that:

Relatively few interventions to prevent depression or anxiety were identified and the majority of these were cognitive—behavioural/skill-based interventions.

However, there is very limited evidence that such interventions are effective in preventing depression and anxiety disorders in the long term and they are time consuming and costly to implement. (p. 139)

They examined depression and anxiety alongside alcohol abuse, the latter of which proved much more treatable through awareness campaigns and social media. Conversely, individuals suffering from mood disorders showed mixed results, at best, even when attending ordinary counseling services. Indeed, it is a mistake to think that one can

undertake a project to address mental illness the same way one would run an awareness campaign to stop students from smoking. Or, at least, it is premature to assume mood disorders respond in the same way to treatment as issues of stress and dependency.

If these initiatives are short-sighted (or at worst, impractical), how does one go about developing long-term policy solutions that don't appear to be mere band-aid fixes? First it must be determined what is inadequate about our current strategies. And with on-site counseling services seeing so poor a rate of returning patients, there is little that can be done to determine the long-term success of care. To be clear, on-campus counseling has seen a steady increase in patients across Canada in the last decade but after the first counsellor visit, student attendance drops off dramatically until, by the third visit, the likelihood of a fourth is nearly zero (Quinn, Wilson, MacIntyre, & Tinklin, 2009). This means that students are being treated superficially (it is unlikely that one, or even three counseling visits would be enough to treat anything but the most minor of issues), or else students have found reason not to continue seeking help. This is perhaps not unsurprising—maintaining commitment to one's support, among other pressures, is more likely to be a challenge for students suffering from mental health problems (Quinn et al., 2009). But the real issue here may be one of stigma. Quinn et al. also reported that students felt that even their general practitioners were dismissive of the serious nature of their mental health issues and this may create a fear of seeking help among students or the belief that their problem is not serious enough to warrant assistance. However, while this does mean that on-campus support is all the more important, as it may be the only help students are receiving, it does not explain why students abandon counseling once they (supposedly) are met with more understanding health care providers. Author Gerald

Stone (2008) has another interesting possibility: The fault lies not with the counsellors, who may well be genuinely tolerant and accepting. It may simply be that the university or college has overestimated the effectiveness of counseling and offered a limited range of options for students who may be suffering. The stigma lies with the administrators and program coordinators, who may believe mental health can be solved by counseling alone (or that more serious problems should not be treated on-campus but I will speak more to this view shortly). If the problem goes beyond the scope of stress reduction or priority management, there may be little the facility is willing (or equipped) to do. Stone argues:

The counseling centre as 'holding tank' raises the specter of magical thinking about the potency of counseling such as found in the old refrain of faculty and administrators: "We are dealing with the problem; the misfits are in counseling." Such magical expectations tend to reinforce the notion of a heroic squadron of counseling centre practitioners whose mission is to develop a therapeutic campus, curing all the ills of the student body. These expectations ignore the possible negative effect of therapy (see Smith & Glass, 1977). That is, some clients do not benefit from counseling and a few get worse. (p. 496)

One could argue, of course, that the purpose of an on-site counseling centre is to assist mentally unwell students in acclimatizing to campus life, ensure they are capable of completing their studies and refer them to outside resources if necessary—not to serve as a prevention or treatment facility. Leaving aside the legal issues this argument raises (in particular, concerning the institution's responsibility for the reasonable welfare of its students), this doesn't excuse an out-of-sight, out-of-mind mentality, nor does it excuse a passing of the blame when tragedy inevitably strikes. If the counseling centre is not

responsible for reasonable preventative measures, is the administration? The policy makers? Is anyone responsible? While the burden shouldn't lie solely on the counseling services (who are, as I've argued, underequipped to deal with serious mental health issues), it would be complacency to think that it simply isn't the university's problem.

It is important not to misunderstand—raising awareness, reducing stress and creating a strong counseling service on-campus are all noble and important goals and they are excellent first steps in creating a safer higher education environment. However, they are not as important as creating quality mental health policies and they are certainly not to be marketed as the solution to the problems. When a postsecondary institution accepts that it has a duty to reasonable care but allows the counseling centre to shoulder that burden alone, one should not expect to see results. Worse, weak or problematic policies can open the door for particularly damaging practices. Stone (2008) discusses one of the most unfortunate of these practices: when counseling becomes a substitute for discipline. He notes that some overzealous or misguided policies will give power to the counseling centres that may infringe on the freedoms of students (2008). While shocking, this certainly isn't uncommon. In 2012, Princeton University banned a student from attending classes immediately after his attempted suicide (Baker, 2014). The university forced the student to turn over his private medical records before even considering an appeal, punishing his illness and violating his privacy in one act. Many schools get away with such behaviour by creating policy that categorizes self-harm or even suicidal ideation as a behavioural issue, not a mental health issue, generally through their student codes of conduct (Baker, 2014). On these grounds, the university can take disciplinary action against students they feel may be a liability. But when policy can't be used to

directly expel students, it can be used to pressure them to withdraw on their own. Antisucide contracts are one such mechanism through which discriminatory policy can be enacted. These contracts are given to students perceived as at-risk and while more prevalent in universities in the United States, Canada has implemented them as well (including such universities as Ryerson and Brock). Typically, they are used in off-campus medical practice but have been adapted to on-campus services, where they are adjusted to fit the policy of the organization. Despite the term of contract, these are not legal documents and yet they carry with them a tremendous power if they are not adhered to. Failure to sign the contract indicates to the university an unwillingness to seek help and the university gains the power to remove the student from campus. Signing the contract may be no better, as some require the forfeiture of medical records and others force the student into a counseling schedule that (as previously discussed) may not even be helping them (Baker 2014). Antisucide contracts are even stricter when one is both a student and an employee of the university—failure to adhere to the terms may result in termination of employment, among other punishments. This is to say nothing of the fact that signing the contract (or even refusing to sign!) is all but admitting you have an illness that the university believes you to have—and counseling centres are as prone to mistakes as anyone. In fact, given their overworked schedule and underfunded resources, they perhaps are more likely to err than their off-campus counterparts. At Sarah Lawrence College in 2013, the counseling centre became convinced that a patient, a student suffering from mild schizophrenia, was an unpredictable danger due to a story containing “edgy dark humor” (Baker, 2014, para. 34) he had written for one of his classes. Though the student had his illness under control for years and was now a top student with an

active social life, the university was not convinced and would not allow him to remain on-campus. After an appeal, he was presented with an option to sign a contract: either agree to the schedule of on-campus counseling (an absurd seven days a week), or be kept from returning to the school. Even after outside medical sources sided with the student and agreed that he was no threat (and indeed, that he was high functioning), he was barred from returning to his studies. It is clear that legal liability trumped compassion. But moreover, these contracts encourage some very regrettable thinking. For the friends and family of the signer, who perhaps do not grasp the nature of mental illness, they are falsely reassured: my loved one can't commit suicide now that they've promised not to. This reassurance may even extend to the university itself, as they may assume a successful signing means the problem is no longer at a crisis. In reality, the pressure is now on the signer to prevent the symptoms of their own illness, or else they feel guilty for violating the contract (which also includes a clause forbidding self-harm). This is a pressure that those suffering from mental illness may not be equipped to bear. For that matter, it represents a poor understanding of suicidal ideation. For some patients, suicidal ideation is not a question of rational thought (i.e., It is wrong for me to kill myself because I know X and Y to be true) but one of impulsive or psychotically driven behaviour, with little regard to choice. For patients with dissociative disorders, schizophrenia, drug problems and a number of other issues linked to suicide, the very idea that their behaviour can be willed away by wanting it badly enough is patronizing. Can a university psychiatrist be expected—or indeed, does he or she have the time—to find out what drives that suicidal behaviour? What if the student hasn't had a previous diagnosis? Keep in mind the wait list for counseling centres on-campus in Canada can be

more than four months (Wynaden et al., 2014). If all the psychiatrist has to go on is the student's claim, a contract is a cheap and tempting solution to the overworked professional, if a little cold and bureaucratic. Unfortunately, the supposed solution benefits no one. Indeed, antisuicide contracts are very rarely effective: in fact, a study of inpatients found that signing the document actually significantly increased the chances that a patient would commit suicide (Kroll, 2007). Jerome Kroll (2007) hypothesized that this finding may have been a result of increased pressures placed on the patient to uphold the conditions of the contract. When mentally ill individuals manifest symptoms of their disorder, they may feel this is a failure on their part, as it is a breach of contract. Inspiring feelings of failure is hardly conducive to the treatment of a depressed or suicidal individual. Patients may feel as if the contract puts sole responsibility for their success in their hands and this may simply be an unreasonable expectation on the part of the contract provider. Kroll also notes that the contract can easily be used as a crutch in place of proper risk assessment and the collaborative development of a prevention plan, further cheapening the care of the student. He claims that there is no evidence that antisuicide contracts are beneficial in the slightest and that recent psychiatric literature has argued against their use. But when tragedy strikes on-campus, postsecondary institutes can breathe something of a sigh of relief with the document in hand—after all, they had extracted a promise from the student and so the onus was on the victim to notify emergency services before attempting the act.

Other misuses of policy have included 16-month mandatory withdrawal periods for students suspected of being a risk to themselves (Pavela, 2006) and a case where a victim of rape at Amherst University who was falsely assumed to be suicidal was forced

into a local psychiatric ward (Baker, 2014). Similar cases have occurred at such high profile universities such as Harvard and Brown (Baker 2014). Surely such callous policy must have legal ramifications for the institutions that implement them? Forcing students to accept care or forcing them to withdraw from the institution are very much against the law—antidiscriminatory laws in both the United States and Canada cover both of those cases clearly. And yet, it isn't so simple. I have noted previously that administrators can disguise involuntary withdrawal and enforced counseling schedules as disciplinary action, absolving them of wrongdoing. Some universities would argue that they don't have a duty of care at all (though this is not something that would necessarily appear in public policies). Indeed, since the 2002 legal battle of the Shin family versus MIT, many universities have used the rulings to their advantage to craft policy that absolves the institution of the most blame in the event of a tragedy. MIT's lawyers argued that the university's untrained staff had no responsibility to keep a suffering student safe—that duty fell to the counseling centre (Dyer, 2008). This has led to policies that encourage distancing the counseling centres from the rest of the university. Ultimately, the debate during the trial (and in the literature following) had become a question of *in loco parentis*. *In loco parentis* is the expectation of an organization (in this case, a university) to step in as a parental figure in the absence of an individual's actual guardians. Note that a student does not have to explicitly be a minor for *in loco parentis* to apply—if a duty of care exists, it extends to all students. *In loco parentis* has been a strange subject surrounding postsecondary institutions. For decades, *in loco parentis* did not apply to universities. Postsecondary institutions were to have no say, legally, in the private lives of their students. However, when alcohol abuse became a serious concern for a number of major

universities, *in loco parentis* was re-examined and exceptions were made. Now, some institutions (primarily in the United States but Canada has followed suit) can impose disciplinary action against students engaging in dangerous drinking behaviour off campus grounds (in dorms in particular). MIT argued that unlike cases of alcohol abuse, *in loco parentis* did not apply to instances of self-harm and mental illness. Students are adults and postsecondary institutions are not treatment facilities. If students needed treatment, the university argued, they could seek it in off-campus locations that were better equipped to handle their needs. The courts did not fully agree and ruled that while *in loco parentis* would be examined on a case-by-case basis, the university had a duty to provide reasonable care to students in need, though what constituted reasonable care was vague at best (Dyer, 2008).

While this was certainly a step forward in ensuring someone took responsibility for quality health care on-campus, it created strange legal ramifications. Essentially, for a postsecondary institution to now be accused of negligence in the care of the mentally ill, it must be determined that the ill student had a “special relationship” (p.1389) with some branch of health care at the facility and that service was in some way inadequate to meet the student's needs. Ordinarily, if the student were attending regular counseling, this would constitute such a relationship. Since some institutions pressure the most seriously ill students to withdraw instead of allowing them to seek help, it becomes much harder to argue, legally, that the duty of care exists. Students with minimal contact with the system are fine but serious cases become liabilities. Further, in the Shin case, it is interesting to note that while the counseling centre was found to be responsible for the student's care, they were not expected to disclose the illness to the student's parents. This sets a strange

precedent—campuses are certainly not treatment facilities (and are clearly able to get away with a lower standard of care while still avoiding legal action), yet are expected to maintain the same kind of confidentiality as their off-site counterparts. Does this confidentiality extend to the entire university staff, or merely the counseling services? It is something of a grey area. It is also an interesting juxtaposition—in loco parentis is partially invoked to ensure the quality care of students and yet the actual parents of those students are left out of the process. Students are left in a strange middle ground where they are too old to get family involved in their well-being, yet still have so little autonomy as to be forced into mental health decisions for their own good by the university.

I have talked at length on the state of policy as it concerns the on-site counseling centres and how they can be set up to remove students that could be a legal liability. Strong (and ethical) policy shouldn't isolate the issue to concern merely the mental health practitioners and the mentally ill. Mental health is a problem of the entire university and policy should reflect this. But does it? Educators recognize the problem extends to the classroom environment—in a 2014 study, a significant number of university professors (approximately 85% of those surveyed) reported that they have assisted others with mental health issues in their workplace and 40% of those professors reported that they have even assisted colleagues with mental health problems (Margrove, Gustowska, & Grove, 2014). And yet, despite it being a part of their workplace and classroom environment and despite having to advise and refer students, few received training in mental health: “The vast majority of respondents (71.4%) reported never having attended any form of training around mental health issues in their workplace” (p. 95). Of those that

did receive training, most did so quite recently (indicative of the changing face of mental health in higher education), having done so within five years of participating in the study. And that training is necessary—recognizing mental health problems without training is not as easy as one may think. The majority of the educators polled by the authors had trouble distinguishing ordinary symptoms of stress from more serious mental disorders when presented with case studies and had particular difficulty recognizing mood disorders other than major depression (Margrove, Gustowska, & Grove, 2014). More telling, perhaps, were the educators' opinions following the study. Most agreed that some sort of training program would be necessary and that it would assist in the daily functioning of their work, as current attempts to provide assistance were proving challenging. Caution was advised, however, in that those organizing the training must be “suitably trained” (p. 98)—as if some of the educators were unconvinced of the quality of training that current on-site services could provide them. And while the counseling service may be staffed with well-intentioned and well trained individuals (it is important to fault the policy, not the people, for the ethical failings previously discussed), this raises an interesting question: What is the current relationship between mental health services and the rest of the campus? As I alluded to previously, mental health services are often isolated from the rest of campus for legal reasons and can even be outsourced to private counseling services to further distance the centre (though a private service often has more resources to expend than a university is willing to invest in mental health). Victor Schwartz (2013), a veteran of the on-campus mental health industry echoes these feelings of isolation. While Schwartz insists that on-campus mental health service workers are well trained and compassionate, he noted that his colleagues within the university—

professors and staff—considered his efforts less valuable than what one would find from counterparts off-campus. He notes “I always felt a bit of an outsider or interloper on college campuses” (p. 97). And as for the administration, Schwartz states,

I have often thought that the attitude of many university administrators to counseling services is akin to the way many of us think of our dentists; we are happy they are around when there is a problem but we prefer not to think about them any more than absolutely necessary. (p. 96)

He argues that while mental health professionals have been trying to work around poor funding and weak policy for years, they are still stuck with the blame when tragedy invariably strikes. Considering he wrote about these concerns less than two years ago, recent trends in mental health awareness may not actually be aiding the system in the way some hope it would.

What we can at least conclude from all this is that postsecondary mental health policy is more legalistic than humanistic. And this is perhaps understandable given tight budgets and an only recently lifting taboo surrounding the entire issue. That does not mean discriminatory policy is excusable. Looking at the areas where policy has failed, I believe it is possible to salvage something of a workable model policy for sustainable mental health services. Foremost, what the university needs is a policy that encourages the integration of counseling centre and the rest of the university staff. Training should be available to make as much of the staff aware of mental health problems, how to recognize them and how to refer students—the literature seems to indicate professors would take such training if offered. Counsellors should not be considered the end of the line for care, nor should they be responsible for the needs of a severely ill student but should instead

serve as referrals for off-campus care and treatment centres for minor health problems. As long as students are receiving some kind of accommodation on-campus and the university is assisting in providing the student off campus care, there is to be no witch hunt or inquisition and no need to punish students for their bravery in seeking help. Students are indeed, as MIT argued, adults and if these reasonable steps are taken to ensure their safety, they should be free to take those opportunities. This is, of course, with the understanding that students are often receiving health insurance only from the institution itself and that there are thus limitations on where and how they can seek help if not from the school. Finally, it should be expected that tragedy will still happen, no matter how good one's policy may be. Believing that one can prevent suicide on-campus shows a poor understanding of mental illness and is an entirely unrealistic expectation. The bottom line is that policy should exist to create an environment that genuinely cares about students. It should not be used as an excuse to turn them away.

CHAPTER THREE: THEORETICAL PERSPECTIVE

Policy and Theory

To help explain why mental health reform is only now taking hold, where it is taking hold and why many efforts appear to be half-hearted, I'd like to turn to a theoretical perspective that can give some insight into the concerns of policy makers. After reviewing the policy documents and noting the case studies in which more appropriate policy was clearly needed, I am left with a number of questions I believe theory can answer. In particular, are the recent missteps in mental health policy (as outlined in the literature review) intentional marginalization of the mentally ill, or a series of benevolent but utilitarian decisions? Are policy makers more concerned with student safety, or the overall integrity (or even image) of the university? Despite the legal liability, are the two concepts—that is, quality mental health service and legal culpability—mutually exclusive in the eyes of policy makers? In this chapter, I will use the work of theorists Michael Apple (2001) and Michael Power (1994) to answer these questions. Central to the arguments of both these authors (and indeed, an important part of my own argument) is the idea of the bureaucratization of higher education. Power and Apple both agree this bureaucratization and, indeed, commercialization is a result of a modern trend towards neoliberalism and capitalist values. Of course, the idea that neoliberal ideas are at work in higher education is not unique to these theorists. Another theorist whose work I considered focusing on in this chapter was Henry Giroux. Giroux's work dealt with neoliberalism and market forces as well. In particular, I enjoyed Giroux's talk (2014) for the TAFT Research centre, "Neoliberalism, Youth and Social Justice." He gave a notable call to action, which in the same breath denounced what Giroux sees as a war on youth: "No society can make a claim to being a democracy as long as it defines

itself through shared hatred and fears, rather than shared responsibilities” (Giroux, 2014). The hate and fear he references here are close-minded conservative leanings and the democratic integrity he wishes to uphold is the kind of democracy Giroux feels belongs in higher education and government alike. Giroux’s powerful argument helps to confirm the idea that youth are often at a significant disadvantage from bureaucratic policies and practices, which is a useful pointer to keep in mind when reading legalistic modern policy documents. Where policy has created an oppositional relationship between students and administrators, Giroux’s idea of a democracy in peril may be helpful in framing the problem.

Indeed, though criticism of modern neo-liberal thought is not hard to come by, the arguments of Power (1994) and Apple (2001) together form a more cohesive picture of the problem I am trying to address. I feel that Power’s concept of the audit explosion helps explain why higher education chooses to adopt policy that is legalistic in nature. Meanwhile Apple’s concern with neo-liberal influence pushing organizations towards a safe, moderate middle ground may explain why universities are reluctant to draft policy at all.

The Audit Explosion

Michael Power’s (2001) *The Audit Explosion* makes clear that audits are a self-sustaining tool for creating and maintaining a structure of control. They represent a kind of neo-liberal bureaucratization of an organization and Power finds them a poor solution to a problem that no one needed them to solve. Audits, he argues, are systems of control that act without having to be present, such as through the fear of being tested or through surprise inspections. In this way, they are a means to decentralize control, to distance

oneself from a given organizational problem. They are solutions delivered from afar, with limited internal trust. Solutions involve obtaining private experts and outside sources to inform decisions, with internal actors often left in the dark as to developments in policy or protocol until they are already implemented. Power notes that the audit is a particularly stubborn concept and that even when the system explicitly causes inconvenience or outright fails to solve the problem it is purporting to solve, the audit culture remains intact. This pervasiveness is difficult to explain, as I discuss in the next section of this chapter.

To return to the concept of audits themselves, it is hard to miss the potential benefit for certain powerful individuals given a system that practically regulates itself and that is highly susceptible to influence from outside forces. This hands-off approach to policy control is particularly appealing to administration seeking to avoid legal consequences from a student population that it doesn't fully trust. The audit culture encourages a distancing approach and rather than foster trust and open dialogue, it would sooner see a system of policy makers create a standardized solution. The system of thought under an audit culture is one of mistrust and in the case of higher education, students take the place of the workers on the lowest rung of trust. In a system where professionals review professionals and the authority of others is influenced by layered systems of control, is the student left with any authority by which he or she may be trusted? This is reminiscent of what we are seeing in modern mental health policy. Many of the policy documents (I must look once again towards Carleton and Queen's) make claims towards creating an open discussion but despite this, the goals and scope of their proposed programs have already been decided.

Neoliberalism and Higher Education

While Power's work is strong, several questions remain unaddressed in relation to higher education and auditing. For instance, who is responsible for ensuring these audits maintain their power? As Power notes, the audit loses potency without fear of (or respect for) the audit within the system being influenced and suggests systemic neo-liberal ideology as an explanation as to why there is continued compliance and why the audit seems resistant to critique from within. There is little doubt he is correct but perhaps the full answer is still more complex. Michael Apple (2001), in his article "Educational and Curricular Restructuring and the Neo-liberal and Neo-conservative Agendas," argues that there are three or four main ideological groups who promote the modern advancement of policy in institutions like higher education. These groups have reason to utilize and trust a system like the audit, both from outside an organization and from within. He notes that all four groups, through various motivations, move policy towards a more politically conservative standpoint. They represent a movement, a wave of modernization that seeks to find a new purpose for education and new goals for its policies. While Apple acknowledges that most of his experience lies with institutes in the United States, he has noticed these trends certainly exist beyond those borders, particularly in Canada and the United Kingdom. For my purposes, I will focus on three of Apple's four primary groups of actors. The fourth group, which Apple identifies as fundamentalist Christians, traditionally have strong opinions on mental illness and suicide but I believe there is too much overlap with the neo-conservative group to warrant discussion. The motivations of both groups are largely the same, except one stems from politics and the other stems from religion. It is also important to note that the universities in this review are secular, and so

religion is not (at least in theory) a motivating factor for these policy-makers.

A familiar group from Power's text, the neo-liberals are among the chief groups Apple claims are responsible for policy reform and unsurprisingly their ideal reform strategy (according to Apple) is centered around economic objectives. They would like to see schools becoming more competitive with one another (not unlike corporate systems) and would like curriculum to train students for real world work experience. Policy introduced by this group would set schools up in a market-like structure, with students treated as consumers of education, much as Power noted. In the context of our discussion on mental health, then, does funding for mental health services fit a neo-liberal agenda? It seems unlikely, as quite a number of universities (such as Carleton and Brock) have cited the high costs of mental health service reform, a cost that is likely difficult to subsidize. If entire academic departments can be endangered for failing to turn a profit, what can be said for comparatively expensive psychiatric care, the function of which is arguably secondary to the school's primary academic goals? Humanistic policy makes little sense from an economic standpoint.

Apple goes on, however, to cite another player in higher education policy (and policy ideas in general): neo-conservatives. While they are as economically minded as their neo-liberal bedfellows, they arrive at this goal through a different path altogether. Apple describes their motivation thus: "their main agenda is cultural 'restoration.'...They wish a return to teacher dominated, high status knowledge, largely based on the traditions that have historically been seen as the most legitimate knowledge at elite universities" (Apple, 2001, p. 175). This push towards conservative thought obviously opposes reform strategies that deviate from what they perceive are traditional values. For this group,

policy extraneous to creating a high value product out of education is likely unnecessary. This is to say nothing of the fact that for this group, the marginalized (and among them, the mentally ill) are an “other” that do not mesh with their traditional view of a homogenized, standardized classroom. Outlier groups are a bane to standardization and are unlikely to fare well in policy changes spearheaded by neo-conservatives.

The last group of policy collaborators I will mention are what Apple refers to as “members of the professional and managerial new middle class” or “experts for hire” (p. iii). While Apple speaks only briefly on their motivations (noting, indeed, that they would not necessarily self-identify with a particular ideology), they are a common fixture within audit-driven models of control. Their interests are largely self-serving, as they have, through expertise, carved out niches where they may act as figures of authority to organizations from outside the organization itself. This is a balance they are keen to maintain and conservative, audit-centric stratagems help keep the power in their hands.

All of these groups, Apple argues, share a collaborative control over the direction of education and policy. When policy makers (or, indeed, policy-influencers) are challenged by those who demand reform (as we see in the current mental health movement), if the outcry cannot be silenced, there is a clear threat to the leadership of these groups should they not comply with public demand. Apple notes that policy makers’ responses to these situations (in his example, the issue is multiculturalism in the curriculum) is a particularly manipulative one.

Now, in order for dominant groups to maintain leadership, they must incorporate some limited segments of that [opposing] agenda into their own position. And what dominant groups did do, quite remarkably and very successfully in some

ways, was to take (how can I put this?) both the most moderate and safest forms--and often the most conservative forms--of multiculturalism and put them into schools and curriculum. (Apple, 2001, p. v)

This tactic seems all too familiar, as many of the policy documents collected for this review seem to only scratch the surface of the real problem at hand. This is to say nothing of the grandiose sounding announcements of reform from some universities that appear to have no real follow-through. This is not to say that higher education administrators are malevolent, on the contrary, merely that their understanding of what is best for their institution is often highly utilitarian rather than empathic. This utilitarianism can also be partially self-serving, of course, when it means that outliers can be silenced at the most effective cost and with minimal public backlash.

Apple also concerns himself with the kind of pedagogy this kind of conservative modernization is creating. Particularly, he mentions that it may well change the way democracy is talked about. It appears to Apple that democracy in higher education (and in other social policies) has become fragmented and compartmentalized. There are no communal problems in this model but rather, problems for departments and even individuals and problems should be referred and sorted accordingly. This kind of pedagogy may be influencing mental health issues in universities. Given the incredibly active role that student unions are playing in the development of mental health policies and frameworks, mental health might be thought of as a largely student problem rather than an institution-wide problem. More to the point, the idea that faculty are often encouraged to maintain a hands-off approach to dealing with mental health issues in

students and colleagues, serving merely as a means of referral to the proper channels seems to reinforce this line of thinking.

Power and Apple's thoughts on neo-liberal (and associated groups) control over education and social policy share common ground in that both theorists understand that market-centric policies and audit-driven systems of administration are pushing educational reform in unhealthy directions. Together, these theorists note the loss of transparency and accountability (as policy decisions move to the more privatized experts), as well as a weakening of trust and democracy. That said, for the purposes of this paper, my arguments align primarily with Apple. His more complex theory of the actors involved paints a more complete picture of how this kind of incomplete or questionable policy could come to exist. With these concepts in mind, I wish to focus now on the raw data, the policy documents themselves. While I believe that neo-liberal values are inherent in these policies, it is also very telling should the institution have little to no policy surrounding mental health. After all, why would a neo-liberal system create policy to foster a closer connection to a group of students it would categorize as a liability? This is particularly jarring if physical health issues are represented in policy and if other kinds of policy are readily available. In Chapter Four, I will note the considerable number of major universities without policy at all and for those that do, I will highlight the legalistic nature of those policies.

Narrative Policy Analysis

Identifying neo-liberalist tendencies is, of course, not the same as performing policy analysis. It is an excellent theoretical framework to help explain why modern university policy looks the way it does but questions remain. In particular, does neo-

liberalism necessarily make for bad policy? Of course not—possessing legalistic qualities may in fact make administrations run more efficiently, if a little less empathetically.

Given what few documents that I could uncover, how could it possibly be determined what was effective? Unfortunately, without speaking directly to the students affected by the policies in question, it is difficult to say for certain (though this is certainly an area for future research). However, in cases of controversial or incomplete policies (especially when there is a lack of raw statistical data or expert consensus surrounding the issues the policy addresses), analysts turn to narrative policy analysis. Narrative policy analysis relies on examining the stories, sometimes in the form of anecdotes, on all sides of a policy issue. Major parties in the issue often have their own narratives that they are using to exemplify their argument. For example, a Republican senator may tell the story of a man who defended his home from intruders through the use of a gun. The senator would be using the narrative to further his pro-gun argument. If the story spreads and enters the public consciousness, it becomes harder to distinguish the argument from the narrative put forward to support it. It is the job of narrative policy analysts to determine what the stories involved in an issue are and which story, if any, has merit, or if an entirely new meta-narrative must be constructed to facilitate positive change in policy. In using narrative policy analysis, this study has relied heavily on author Emery Roe (1994), a practicing policy analyst. His text, *Narrative Policy Analysis*, is an in-depth guide to the use of the analytic technique. Roe's examples draw a great deal from the economic and political spheres but his theories on narrative policy analysis are applicable to all kinds of policy. The primary methods of analysis, Roe argues, are those of literary theory. An analyst examines stories for their logical consistency, structure but mostly for their ability

to create emotional impact. This latter quality is the most important for Roe, because memorable stories seep into public consciousness and help to promote action on controversial policy issues where it would otherwise stagnate. Obviously, this is imperfect (and likely unpalatable for the more scientific minded who prefer quantifiable analysis). Yet, Roe notes that even when the best narrative that can be found is a factually inaccurate one, “we keep to the narrative anyway in absence of a better story and because, again, decisions have to be taken now. Waiting is not possible, or when we do wait for better information ... that research all too often raises further questions and problems said to require urgent answers as well” (p. 8). Surely, if mental health is reaching a crisis and if universities find themselves lacking any mental health policy at all, then we require analysis that promotes decision making.

So how have these techniques been used in this paper to examine policy? The counter-administrative narrative was clear: the stories of Elizabeth Shin and others like her, are powerful. They tell a story of suffering youth who are denied access to quality care because administrators seemingly care more for protecting themselves than their students. Similarly, it is a story of those same administrators who saw fit to ruin the academic careers of students rather than risk the remote possibility of legal difficulties. Whether these stories held truth, of course, remained to be seen. It was also clear the kind of narrative administrators were trying to tell. Theirs is a story of an overburdened and underfunded school system, trying to care for the needs of as many students as possible but facing an increasing number of students with mental health problems that they are not equipped to handle. Even if the students could be accommodated, the school would be held legally responsible if something went wrong and that would break an already

strained budget. Worse, the tragedy would certainly disrupt the academic lives of other students, to say nothing of their own mental health. Of course both narratives hold truth and both contain exaggeration. Only by examining both narratives could I determine the course that was best for university mental health policy.

One could argue at this stage that the meta-narratives may have been misidentified. Indeed, it is not as though administrators have put forward a deliberately neo-liberal story—it is often quite the opposite, with a number of surface-level programs put forth to create a narrative of empathy and caring. Aside from the warning signs of neo-liberalism that Apple and Giroux espouse, how can one be sure the policies that were found are indeed neo-liberal and that a fair comparison has been made? Once again, I look to Roe. When an analyst looks for evidence of an existing narrative where one is not explicitly stated (or is in some way obfuscated due to an unpalatable nature), Roe suggests looking to the language being used by the party involved for clues. For example, in the case of the controversy surrounding animal testing, Roe notes that practitioners of animal testing use terms such as “sacrificed” and “harvested,” (p. 81) which imply the researchers view the animals more as tools or crops than living organisms. These words are important elements to the researchers’ narrative, even though it may not be what the researchers intended to portray. Following this example, this study has paid careful attention to the language of the policy documents that could be found. Though the policy documents themselves contained some examples of neo-liberal language (which I note in the review of each document), the most damning examples of neo-liberal language were found in the tools used to enforce these policies. By this I refer to the no-harm contracts used by residences and mental health centres in a number of Ontario Universities. The

language of these contracts is discussed further in Chapter Six.

The analysis itself came after the collection of data. The lack of policy documents uncovered was more damning to the case of policy makers than inept or inadequate documents would have been. The narrative of caring but overburdened administrators stuck facing a mental health crisis is harder to swallow when there are no documents in the works to address that crisis. If they were doing all they could to ease the burden on the system, they would engage in better communication with students and make any existing documentation easier to find. While there is undoubtedly truth to the claim that universities face a potential powder keg of legal issues when dealing with mentally ill students, their desire to excise the problem completely cannot be disguised. Their narrative is one without emotion, with a complex argument and is a plight that is difficult to empathize with. The narrative that must inform policy is the one that the students themselves are putting forward. It is a simple yet powerful message: give those who are suffering the help they need.

To the reader of this thesis, this conclusion may feel somewhat unsatisfying. Shouldn't the dominant narrative (that of the policy makers) be proven incorrect in some fashion? Shouldn't it be thoroughly refuted before calling for a change in policy? I don't believe so, and Roe has the explanation here:

What displaces a policy narrative ... is not a negative finding that seems to refute it. Refutation of a decision maker's argument for action doesn't mean you have taken away her or his perceived need to act. Rather, displacing a discredited narrative requires an equally straightforward narrative that tells a better story.

(p.40)

What we see in cases like Elizabeth Shin and those like her is precisely that: a better story. They are tragic stories, for which there can be little excuse. When examining the policy documents in detail in the next chapter, my comments are made with the administrative narrative in mind. In particular, my consideration is of how the document contributes to or harms the overarching narrative that the university is trying to present.

CHAPTER FOUR: POLICY DOCUMENTATION

Policy Collection Methods

Data collection for this study was performed primarily online. I had an interest in which documents were publicly accessible and so began my search in publicly accessible channels. In my search process, I attempted to mirror the search for information by a student of a given university who would be curious about how his or her mental illness would be handled on-campus. While I found differing results for each university, the search process was consistent. The first search would be for any mental health and wellness pages, taking note of any contact information found there. Also of interest on these pages are privacy information, referral guidelines, tools used by the health and wellness centre and operating standards and procedures. I then moved the search to a general search for policy pages and lists. I began by using the website's own search engine, then manually searched each website in places policy would commonly be found (e.g., the office of the Vice President and the university Secretariat in particular). Of interest in this search was any document containing the keywords mental health, mental illness, or code of conduct. Finally, one last search of the website was conducted for anything that may have been missed, or anything relevant that may not have appeared to be a policy document at first glance. A search of programs and initiatives on-campus, as well as of student unions and their internal policies sometimes turned up additional information about mental health. Of particular interest were residence guidelines, campus news (notably recent suicides) and references to developing documents and frameworks that may be hosted off-site.

After exhausting all web-based options for finding policy, I began to contact the universities for further policy information using contact information gathered in my

search. I began by e-mailing the mental health and wellness centres, if the university provided the contact information. If not, I attempted to contact the next logical on-campus student service. If a policy document was found, typically the authors of that document were contacted if possible. Then, if no reply was received within two weeks, I sent a second e-mail to another department that I felt could direct me towards mental health information, including mental health coordinators, policy makers and student group leaders (if they had been cited in the creation of policy or frameworks). Each university received a total of two e-mails this way. In my e-mails, I explained that I was seeking mental health policy, or any formal guidelines that govern mental health issues on-campus. I requested that if they were unable to provide policy, or if they were unaware of policy that existed, they refer me to another department they thought may be able to direct me (but I noted that absent policy was still useful information). Only three of the 13 universities responded to either of my two e-mails.

When describing the documents gathered from this research, I use three key terms: policy document, policy framework, and policy tool. Policy documents are formal, written guidelines for management and problem-solving. They are not necessarily immutable, but are carefully worded to minimize confusion and standardize the behaviour of individuals in an organization. Policy frameworks exist to help develop policy documents. They are sets of recommendations, compilations of research, and structural outlines meant to aid in the construction of a finished policy document. Most of the documents discussed in this review are frameworks. Finally, policy tools are the means by which policy is enacted. Policy tools are the practice to a document's theory.

Policy tools were not included in the initial research, but are discussed in chapter six as a means of examining emergent policy that may not otherwise have been apparent.

All research was carried out between March and September of 2015. Frameworks and policy documents presented later in the chapter are the entire accumulation of these efforts. No documents were uncovered but excluded from the review.

Policy Data

Policy is a set of procedures that govern actions taken by an individual or organization. This thesis is interested primarily in formal, written, policy documents. This way, the language of the policy can be analyzed in a way that would not be possible with informal policy (informal policy consisting of practices and procedures known to staff but not recorded). Recorded policy is necessary for accountability and communication, both to staff who are working directly with the policy and to students whom the policy is concerning. In order to organize and manage a network of care services on-campus, a set of general procedures and guidelines must be in place for staff to understand what is expected of them. Similarly, if students are to understand how their university will accommodate them (or not, as the case may be), the university must be able to communicate their intention clearly. Further, if students suffering mental illness are to feel as though their issues are being addressed, representation in policy documents is an excellent way for the university to show these students they care about providing treatment for their issues specifically, not merely for the vague concept of mental health problems.

I would now like to turn the discussion towards the specific policy documents I have collected in the course of my research. In particular, I have highlighted areas of the

documents where the language and ideas are troubling or patronizing, suspiciously legalistic and protective of administrators, or merely impractical. In finding appropriate documents for policy analysis, I limited my search to universities with a student population of over 10,000. These population data were gathered from the Ontario Council of University Libraries, updated July 2015 (Retrieved from: <http://www.ocul.on.ca/node/21>). The universities included in this review are as follows, in order of size (largest student population to smallest): University of Toronto, York University, University of Ottawa, University of Western Ontario, University of Waterloo, Ryerson University, McMaster University, University of Guelph, Carleton University, Queen's University, Wilfrid Laurier University, Brock University and University of Windsor. Although I have restricted much of my research to Ontario universities as a case study, I have also included a single document from a university outside the province for the sake of comparison.

This policy review is concerned with whether documents are publicly available. By this I mean documents to which students and faculty alike should have access, whether through the university's website or other channels. During the research process, I was reminded once again of the court case surrounding Elizabeth Shin, in which information on MIT's promise of care was vague at best. If these documents have the goal of preventing another tragic death like that of Shin and if they are truly representing an administration that desires openness and accountability, the documents should be easy to find and access. With this in mind, I paid particular attention to how the documents were retrieved. I initially wished to restrict the study to include only documents that were hosted on the university's official website, in a section where students (and indeed,

faculty) could reasonably expect to find policy. However this proved nearly impossible. Only five of Ontario's major universities offered a framework, a series of recommendations meant to inform policy—but none offered finished policy documentation. Very few hosted even these fledgling policies from their main website, or even provided a link to a document. Students and faculty would have a difficult time attempting to discover exactly how their institution addresses mental health problems through any casual search and in the case of many Ontario universities, they would have no luck with publicly available documents at all. This may well be because some campuses simply haven't drafted policy and have been using peripheral documents and judgment calls to deal with mental health issues for years.

Some of the framework documents were only available after contacting the university and despite efforts, some universities simply could not be reached for further information. For students inquisitive about policy that could affect them personally, it may often be best to look at existing documents that could be filling the role of mental health policy. This includes documents such as the student code of conduct (though not all Ontario universities have one) or accessibility services documentation. Unfortunately, universities will often be vague about procedures surrounding mental health issues on-campus or which policies are actually used to govern mental health. This could allow the university to use the policy as it benefits them, citing it to deal with a potential liability, or ignoring it so that their hands are not tied on a sensitive issue.

Table 1 outlines the data from all 13 universities in the review. Student populations were gathered from Ontario Council of University Libraries. The table allows one to discuss the commonalities and interesting emergent themes in the mental health

Table 1
Overview of Data

University name	Student population	Primary policy document	Alternative mental health policy	Primary document availability	Authorship
University of Toronto	76,954	University of Toronto Student Mental Health Strategy and Framework (2014)	Various; under review	Online	Provostial Advisory Committee on Student Mental Health
York University	48,809		Code of conduct/residence guidelines (vague)		
University of Ottawa	37,227		Code of conduct/residence guidelines (vague)		
University of Western Ontario	36,203	Western Mental Health Assessment	Code of conduct/residence guidelines (vague)	Available after being requested	Assorted student service providers (campus recreation, chaplaincy, etc)
University of Waterloo	33,555		Unclear		
Ryerson University	30,665	Ryerson Mental Health Advisory Committee—Appendix	Student Code of Conduct	Available after being requested	Ryerson Mental Health Advisory Committee

(2013)

McMaster University	30,117		COPE, Student Code of Conduct, Connections IV Orange Reference Folder		
University of Guelph	25,948		Code of conduct/residence guidelines (vague)		
Carleton University	24,161	Student Mental Health Framework (2009)	Student Code of Conduct	Online	Unclear (presented by the office of the Associate Vice President of Students and Enrollment)
Queen's University	23,049	Student Mental Health Framework (2012)	Code of conduct/residence guidelines (vague)	Online	Principal's Commission on Mental Health
Wilfrid Laurier University	17,246		Unclear		
Brock University	16,574		Student Code of Conduct		
University of Windsor	15,083		Unclear		

policy development strategies of each of these major universities. Of note is the apparent fact that university size does not seem to have an effect on the rate at which policy is being developed or the availability of a public framework. This is curious, as one would have suspected larger institutions with greater resources (and a potentially larger in-need student population) would be more likely to have produced a comprehensive framework. While it is clear that the University of Toronto has constructed a higher quality (or at least more in-depth) framework than many of its peers, there does not appear to be any pattern among other institutions. As all the documents are works in progress, it is understandable that the frameworks are not always available through intuitive channels.

The column detailing the availability of the primary policy documents helps to illustrate how difficult it would be for the average student to find information on mental health policy. The authorship of these documents is also comparable. All the frameworks have been created by some sort of mental health review team, the composition of which varies. Most commonly, teams are staffed by administrative positions like residence life managers, directors of university safety and deans. In the case of the University of Toronto, there is also some involvement from the student union. Actual mental health service representatives are often only a fraction of the authorship team. Clearly these men and women have an important advisory role but often community members and campus security have as much representation, which may well equate to a more limited voice for on-campus mental health in informing policy decisions. The alterative mental health policy documents column refers to university policies that may not directly relate to mental health but currently support or fully handle decisions related to mental health

issues. These typically include student codes of conduct, disability services policy and residence life agreements. Clearly, those universities without active mental health policies are relying on some preexisting policies to handle mental health issues on-campus. Unfortunately, it is often unclear exactly what universities are relying on to handle these issues, as their policies are sometimes vague or informal. I have included policies here that appear to have ties to mental health or have been amended to include allowances for mental health issues.

University of Toronto

Like many of the other frameworks in this review, the University of Toronto Student Mental Health Strategy and Framework (2014) could not be found by navigating the University of Toronto website. While it appears to be hosted from the Office of the Vice-President's page, it cannot be found among any of the available links, even on the page collecting policies and frameworks. The page could be easily found, however, using search engines not bound to the university's website. It appears to also be hosted from its own dedicated webpage, where the important points of the framework are summarized.

Though I will raise questions on the language and concepts other policies seem to be employing, this framework seems to be surprisingly less troubling than others in its wording. Particularly impressive is the recognition that mental health is a continuum and that programs to address one range of problems may not be suitable for the entire spectrum. It also is one of the few frameworks to make the distinction between mental health (an overall state of well-being and contentment with life) and mental illness (medical conditions of varying severity that impair cognitive function in some way), a distinction that is crucial to the discussion. A student with suicidal ideation may have

poor mental health, or he or she may suffer from a mental illness, or some combination of the two. It is, after all, possible for a person with a mental illness to have good mental health—to be content and happy, despite coping with a disability. In making these distinctions, the goal of creating accessible mental health services for the seriously ill and the goal of building coping skills and “resilience” among students can be put into perspective. It is one of the few frameworks that does not discuss the prohibitive cost of upgrading mental health services, thereby allowing it to entertain the idea that accessible mental health can be a reality. From there, the document thoroughly outlines potential policy changes that can have a positive impact on the mental health system, including voluntary medical leave (and subsequent ease of re-entry) and promotion of inclusive curriculum. Further, it points to specific, existing policy within the university that can be interpreted (and amended) to help suffering students. It is one of the most comprehensive documents on mental health policy in higher education available.

The framework places great importance on language and pedagogy—the framing of the discussion can be as important as its content. This is evident in a graphical framework model the university adapted from a similar model by Cornell University (Cornell University, 2012). The graphic displays the framework's core ideas and in adapting Cornell's model, the University of Toronto kept many of the principles Cornell identified but framed them in softer or more appropriate language. Cornell's "increasing help-seeking behaviour" becomes "promoting help-seeking behaviour," a subtle change that seems more humanistic—we do not need to increase help-seeking behaviour to meet an expectation or quota, we promote it in the hopes that it empowers students. "Restrict access to suicide methods" (a reactive, symptom-treating approach, surely) becomes

"policies through an equity and diversity lens"—a commitment to changing and evolving policy that the Cornell model lacks. "Identify people in need of care" becomes the more specific "campus-wide mental health literacy," the means by which those in need of care can be identified by faculty or through which students can be informed and empowered to come forward themselves. Clear language and pedagogy at the classroom level continues to be a theme in the document, as the framework devotes a section to the topic.

When addressing policy reform, the university first detailed its existing policies that handle mental health:

The University currently has policies and statements which support student mental health and safe and healthy learning environments: Policy on Academic Appeals within Divisions (December 12, 2005); Code of Student Conduct (February 14, 2002); Statement of Commitment Regarding Persons with Disabilities (November 1, 2004); General Principles Regarding Discipline in University Residences (April 18, 1985); Policy with Respect to Workplace Violence (May 13, 2010); Statement on Equity, Diversity and Excellence (December 14, 2006); Statement on Human Rights (July 12, 2012); and the Statement of Institutional Purpose (October 15, 1992). (p. 23)

Of course, of these listed policies, none make explicit mention of mental health—unsurprisingly, as they are mere stand-in for more appropriate procedure, a fact the university acknowledges. It is interesting that the university's student code of conduct is included among the documents governing mental health issues. This disciplinary framework could potentially be cited to take action against students with suicidal ideation—codes like these have been cited to justify involuntary leave for suicidal

students at other institutions (Baker, 2014). However, after perusing the policy, one notes that the university is careful to define the offense of violence as an act against another person, unlike the codes of conduct at Ryerson and Carleton, which use language to suggest that self-harming behaviour could be met with punishment. Even the University of Toronto's residence discipline policy, which one would suspect to be outdated (given it hasn't been updated since 1985), remains sensible in its wording in comparison to other Ontario institutions. The policy calls for informal procedure wherever possible, where often the opposite is the first instinct of other universities (of particular note is the multiple stage review process carried out by Brock). While one cannot be sure an informal approach is necessarily effective (the document neglects to mention exactly what is meant by an informal approach), handling cases informally may encourage students to seek help, or at least helps to prevent them from feeling the process is uncaring and legalistic. Further, it may discourage contracting behaviour on the part of residence administration, a common practice with a variety of issues discussed later in the paper.

Sadly, this is merely a framework and while the document recommends that policy should be developed, there is no evidence from the University of Toronto that any such policy is currently in place. The policies the document calls attention to are well worded but have not been designed necessarily with mental health issues in mind and are perhaps ill-suited to handle the complexities inherent in mental health procedures. However, at the time of writing this thesis, the framework has been released for less than a year and one can remain hopeful that developments are in the works. The university notes that it has policy concerning the accommodation of mentally ill students but was

vague as to what that level of accommodation may entail. Accessibility services seem aware of the gap, however and expects that policy reform will come in the fall of 2015.

A final but minor note: student residence at the University of Toronto has no centralized governing office and each residence don is free to implement or adapt policy as they see fit for their residence building. The framework discussed here makes no mention of whether it is something that residence dons have to answer to, or if they have their own set of regulations. However, after contacting some of the residences, I was informed that they were indeed unfamiliar with the framework and that mental health issues in residence were handled on a case by case basis.

York University

York University has seemingly abundant services available for students, though the exact nature of these services remains vague, given the information on their mental health services page. What is particularly striking is that York takes pains to note that mentally ill students can be supported through the university's disabilities program—a service many universities imply but few actually claim outright. However, like most other universities on this list, York has little, if any, policy documentation available. Without policy, it is hard to know if these services are acting adequately to help students in need, or if faculty members are competently referring students to these services. Given that in 2013, York announced it “seeks to move from the more traditional response of providing care after a mental health crisis” (Rider, 2013, para. 1) to a more proactive approach (which it hoped to develop over the next year), it would appear that the decision to develop working policy has been made quite recently indeed. One imagines that such policy is still in the works, though no framework has emerged at the time of writing.

It is unclear what policies York is relying on in lieu of proper mental health policy. Likely, disability services and their accommodation policies pick up some of the slack but without outlining the procedures involved, it is unclear whether accommodation is sufficient—and it is surely not enough to handle all the mental health policy needs of the university. The university's student code of conduct does mention involuntary leave periods like those discussed in the literature review but this is only for a ten-day period by default and is limited to 60 days in cases where no criminal charges are involved. Indeed, it is unclear whether the student code of conduct is intended to be used with mental health issues at York that are not actively destructive or harmful to peers. There is no explicit mention of self-harm or mental illness.

Given York's claims to support mentally ill students through disability accommodations (and this accommodation is likely their primary mental health policy source), I wanted to learn more—in particular, if there were any policies governing this practice, or if there were interactions with university privacy policies and how the average student could find this information. While information gathering would be difficult or perhaps unintuitive for students via online channels, the university is not without relevant contacts. York mental health wellness committee, for instance, works closely with mental health services (and shares some of the same staff) and have been responsible for the organization of mental health programs and awareness campaigns at the university. Mental health services itself is without contact information but the wellness committee is available for contact, as is accessibility services.

University of Ottawa

The University of Ottawa appears to have limited mental health services. Their website outlines the functions of the Counseling and Coaching service, which appears to be the primary mental health resource on-campus. Health Services evidently has on staff psychiatrists (and an on-staff mental health research team) but students must first register with health services, see a doctor, then be referred to mental health services—only a referral from a university Family Health Team member can get someone an appointment. Students can book appointments only from the Counseling and Coaching service—there is no contact information available for Health Services on the website. From the Counseling and Coaching service’s own FAQ, they note that counseling exists primarily for “temporary life difficulties,” and coaching services are for those students with normal mental health functioning but who wish to achieve optimal academic success. Professionals on staff are psychologists with graduate degrees, not psychiatrists or psychologists with terminal degrees. Emergencies, they note on their main mental health page, are dealt with hopefully on a same-day basis (but if not, they can be referred to an off-campus emergency service). Further, the FAQ ensures that sessions are confidential but the link to access more information about the extent of this confidentiality simply doesn’t exist (as is the policy form for granting students academic accommodations for their difficulties, which simply reads “PDF missing” at the time of writing). More critically, another missing document is the How to Refer PDF, which would supposedly outline what to do when faced with a crisis situation (though the university seems to recommend first talking to the person with compassion and caring before bothering to refer an individual in crisis).

Beyond the service provided, however, the website provides a genuinely helpful and in-depth guide to identifying and referring mentally unwell students under its faculty and parents section. Of course, it may not be clear to students to look here for information or how to use this information to assist their peers. While this all may be adequate (arguably) for general mental health concerns, those with mental illness would have to rely solely on support from health services. This is unfortunate, because from the vague coverage provided online, mental health is a peripheral function for campus health services. Indeed, if mentally unwell individuals must waste time moving through the system and talking to people untrained in their form of illness to get to the professionals they actually need to see, there is a serious problem.

The mental health service could not provide policy documentation, nor could any other portion of the website. For that matter, no peripheral policy seemed to pick up the slack for the lack of mental health policy documents—even the oft-relied-on student code of conduct is absent at the university. The institution has attempted to implement a code of conduct several times over the last decade but have not been successful.

University of Western Ontario

The University of Western Ontario devotes a significant portion of their web page to mental health, even going so far as to have guidelines for referring potentially ill students for counseling. Though often vague, this is a step up for students seeking information, to say nothing of confused faculty unsure of how to deal with these issues in their classrooms. However, it is not policy and the University of Western Ontario does not provide the same level of policy detail for mental illness on-campus that it does for physical illnesses, at least through easily accessible means. Of note for this institution is

what little policy exists is, unsurprisingly, privacy information for the campus mental health services. The centre operates largely under “implied consent,” where the personal information provided by students can be disclosed to any parties the centre feels may be relevant to the patient’s care (including outside facilities, professors, family, etc) on the grounds that the student had not indicated otherwise and that by volunteering for help he or she would not object to such disclosure. Their referral guidelines (itself a separate, five-page document) notes that information is shared freely within the campus to “maintain a safe campus community.” Perhaps this might not be the case when handling more sensitive student information, or when dealing with a more serious psychiatric illness but the privacy information did not indicate what would happen in such cases.

Western was able to provide a word document containing their policy, which is still in development. The document, simply entitled Western Mental Health Assessment, is derived from a template provided by the Canadian Association of College and University Student Services (CACUSS). It is important to note that this guiding document has not been published and could not have been accessed without the assistance of the mental health service. Authors of the document were plentiful, including members of such services as Student Health Services, Housing and Ancillary Services, Western International, Campus Recreation Centre and the Chaplaincy, among others (though there is no indication of the proportion of representation among these departments, or who exactly had taken part). The document is particularly useful in identifying existing policies and programs (something few other universities have actually been clear on) and areas that are still in development. The framework identifies existing programs as “strengths,” and includes their code of student conduct, harassment

policy and Student Success Centre programs among their current relevant mental health tools. Of course, these services relate to mental health only peripherally (and the mention of the code of student conduct is questionable—is the code of conduct being used against students who would self-harm, as has been seen in other universities, or is the code of conduct being used for mentally ill students who would harm others?). The Student Success Centre is responsible for ensuring academic success—it is not a mental health service and has no trained health professionals on staff. Many of these strengths are also in the university's residence based-programs, creating accessibility issues for those living off campus. Among the identified weaknesses were a need for more international student support, mental health education for educators and students and a voluntary/involuntary leave policy. The latter in-development area is mentioned twice in the framework, leading one to suspect that like Ryerson and other universities in Canada, Western may have encountered legal difficulties in the recent past regarding the involuntary suspension of mentally ill students.

Evidently, in the area of mental health awareness, there is no recommended policy change, nor is there anything in development. The authors note that there exists mental health training for residence staff (not for other faculty, mind), a mental health app (bundled with the Western University app), several brochures, a mental health awareness week and annual fairs that focus on stress reduction. Indeed, the framework seems to emphasize the university's strengths but few sections can point to weaknesses in their existing policies. Nor does it indicate how far along in development these policies may be. The authors seem to want only to ensure students and educators are made aware of the evidently perfectly adequate systems that are already in place. Further, there remains

a clear focus on stress and personal responsibility (it has its own section in the document and many listed assets are stress related in some way, such as fall and spring study breaks) rather than on illness treatment and professional services. This may be a mistake—or, at least, a misleading representation of the problem. While there is a documented link between academic stress and suicidality, this does not mean that one should be satisfied with attending only to that aspect of mental health. Moreover, said documented link is controversial: it is, for one, correlational. An increased sensitivity to stress and suicidality can, after all, be caused by depression and other mental illnesses, rather than the converse (which seems to be the impression the authors of the framework were under). Some researchers suggest that stress and suicide risk have a U-shaped relationship (Feskanich, Hastrup, Marshall, Colditz, Stampfer, Willett, & Kawachi, 2002). That is, some individuals with minimal levels of stress also exhibit increased suicidality, a paradox that researchers attribute to some unidentified risk factor for suicide.

Further in the framework, it becomes obvious why a more holistic approach to mental health was evidently not considered. Much of the document's data come from a health survey conducted at Western, the National College Health Assessment. The response rate for the survey was low (13% of the population), with the respondents being overwhelmingly White females. They reported that stress and anxiety were by far the most common hindrances to their academic success, almost exclusively so (however, the rates of self-reported depression were higher than the illnesses prevalence in the general population, though this may be a result of a poor understanding of what constitutes depression). Aside from the obvious respondent bias (are students who suffer from

mental distress more or less likely to complete the survey?), looking at the survey itself reveals issues that may have skewed the results. First, the survey is clearly not designed with a focus on mental health—less than two pages of the 12-page survey are devoted to the topic of mental health. And it is little wonder stress and anxiety dominated the results, as the survey questions focused on determining students' general stress levels and the presence of difficult life events. The survey asked the respondents whether or not they had felt a number of negative feelings in the last 12 months—most of which are symptoms of depression or anxiety—before going on (in a later section) to ask about the impacts on the respondents' academic performance. This sequence of stress-related questioning could prime the respondents for answers related to stress and anxiety (to say nothing of the fact that depression and anxiety were the only two mental disorders represented in this latter question). One wonders if a more focused test, such as a screening test for mental health disorders may have been of more use. As it stands, one cannot be sure existing or upcoming policy will address the true nature of the problem.

University of Waterloo

Mental health services, a small division of Waterloo's health services, provided little information as to what its services actually entailed, much less its internal guidelines and procedures. The page of collected university policies was as informative as its mental health services page, in that students would be able to find nothing regarding tragedy response, program guidelines, or even disability accommodation policies here. The only mention of mental health that could be found was a brief nod to mental health in the university's privacy policy, which makes reference to the Ontario Mental Health Act (of 1990) as a basis for its confidentiality policies. However, it should be noted that the

Ontario Mental Health Act provides guidelines for psychiatric institutions, not academic institutions, which may not meet the act's definition of a care facility. Other universities that have made mention of this act (in particular, Wilfrid Laurier University and to a much lesser extent, the University of Ottawa) note the particular policies they are appropriating from the act and exactly what this entails for students. That level of clarity is absent at Waterloo.

Like the University of Toronto and York University, the mental health services portion of the university website did not provide adequate contact information. However, there are other alternative contacts for students curious about policy. The privacy officer at Waterloo is responsible for enforcing policy surrounding privacy concerns at the university. The question remains as to how much of that work extended into mental health and how heavily the university relied on the Ontario Mental Health Act for policy. For instance, how accessible are student mental health records at the university? Do they operate under a system of "implied consent," like other universities and could potential employers at the university access these records when choosing which students to hire? Under what circumstances could professors disclose information to mental health centres without student consent? For that matter, under what circumstances could mental health centres disclose information to outside parties (and parties of what sort—parents, outside mental health organizations, other universities the student may attend)?

Waterloo's privacy policies regarding mental health were informed by a document from the Information and Privacy Commissioner of Ontario called "Disclosure of Information Permitted in Emergency or other Urgent Circumstances" (2005). Under this document, disclosure of student's information to outside parties should theoretically

be rare and would only be done in the interest of public safety or other life-threatening circumstances. These, are, of course, minimum legal obligations on the part of the university. Waterloo does make some exceptions to the document: information could also be released to any party deemed relevant in an effort to eliminate or reduce a significant risk of serious bodily harm to a person. There exists no document to define what is considered “significant risk” or “serious bodily harm,” but the university does indicate that the harm mitigation clause applies to any harm the student may possibly inflict on themselves and does not solely refer to the student’s potential risk to others. Co-op employers at the university would not be allowed access to records under any circumstances and counseling services would retain student records on file for up to 10 years after last contact with the patient. Mental health policy in general at the university is in a constant state of development and Waterloo expects to have some kind of guiding document of its own in the near future. The university recommended contacting counseling services to inquire as to the progression of that policy, as well as information regarding practices of the service, including operational definitions of key terms. Counseling services did not respond to my request for further information.

Ryerson University

Ryerson’s policy is intriguing, as it is clear that there are policies in place at the university governing mental health but they are not publicly available. The university’s mental health awareness committee in 2013 published a review of those policies and made recommendations for reform but that report was not made available online. It was noted that a second, follow-up report would be published in 2014 but no mention of this report could be found. Like other universities, these elusive policies are not located on

any master policy list. Residence Community Standards mention self-endangerment but it is unclear if intentional self-harm could be disciplined under this policy, or if action would be limited to reckless behaviour (likely the intent of the provision). For that matter, both the Community Standards and the Student Code of Conduct fail to mention how violations that may be a result of mental illness would be approached. It remains likely, of course, that the code of conduct and residence community standards are the primary governing documents for mental health issues. Mental health services contain only basic referral guidelines, to say nothing of more in-depth policy, with many pages still under construction. The services pages make little mention of mental illness in favour of stress-reduction techniques and services. As media have reported troubling interactions between Ryerson and mentally ill students (in particular, involuntary withdrawal policies and practices that make it difficult to resume studies after a leave of absence), clearly some policy is being enacted here—but perhaps it is an embarrassingly less than humanistic policy.

Mental health services had only a crisis line and appointment booking number (notably, urgent care was only available from 2-3 p.m.), with no contact information for inquiries. However, I was provided with what the university referred to as a lens that will be used to inform Ryerson's policy, created in 2013 by the Ryerson Mental Health Advisory Committee. This policy lens (simply titled "Ryerson Mental Health Advisor Committee—Appendix") is not to be confused with a policy document but indeed, is a precursor to the creation of policy. The purpose of the lens is to create policy that the Committee feels will "find the right balance between required rigor and standards in the classroom and the workplace and the needs of those who require flexibility, accessibility

and accommodation” (p. 3). That is to say, it intends to strike a balance between the rights of the student and the legal concerns of the university—not, as the document warns against, finding “which rights and responsibilities ‘trump’ one another” (p. 3). The four-page document is comprised almost entirely of bulleted lists of broad guidelines and goals for policy creation (and only two pages of which contain any of these recommendations). This includes calls for greater accountability (for all parties, they suggest), clarity of policy and the equitable treatment of all students—much of which have indeed been missing from other policies I’ve examined. Considering the length of the text (four pages), as well as its nature as a preliminary review, very little else can be said about the document. The policies it informs could look very different depending upon policy makers’ interpretations of the guidelines.

Ryerson's development of the policy lens was guided by an urgent need to act. The university had become aware of problems with its current policies based on first-hand reports from facilitators across the institution, who reported adverse effects on student mental health. Following the publication of this lens, the committee decided to deliberate further before pushing for policy reform, as they felt (rightfully so) that the literature surrounding mental health policies in postsecondary institutions was still extremely limited. The document remains the primary piece of work the Committee has put forth (despite the claim in the document itself that a new report would be published in 2014) and this fall (2015), they intend to present the lens to policy makers at Ryerson (along with any modifications they may have added since their two-year literature review). As the majority of the lens’ guidelines are sensible (though, again, broad and open to a

great degree of interpretation), one can hope that clear and accessible policies can be formed this very year.

McMaster University

McMaster has no documentation related to mental health crisis management, or the procedures involved in treating mentally ill students on-campus. It does, however, have detailed procedures on how to refer students to mental health services on-campus (just not any information on what goes on once the students are there). McMaster has collected this information in a document they call the Connections IV Orange Reference Folder, which is hosted from the mental health services resources page. The Orange Reference Folder is meant for staff and faculty and contains information on identifying and responding to symptoms of mental illness that may be visible in students. A physical version of the document is made available to all staff that interact directly with students. The information is certainly comprehensive, providing the contact information for individuals who are not only involved in mental health treatment but in legal affairs as well. The website also recommends students take concerns to the disability services office in addition to seeking help at the wellness centre. While the disability services webpage offers no information about exactly what support is offered for students with mental health issues, it is comforting that the university has acknowledged mental illness as a disability. Not all disability services documents I have examined include any mention of mental health whatsoever.

McMaster (like many other universities) uses its code of conduct to address students engaging in self harm or suicidal thoughts. However, in 2013, McMaster updated their policy concerning code of conduct violations. If it is determined that the

code of conduct has been violated due to a student's disability or illness (mental or physical), a different set of procedures apply. These exact procedures are not available online but McMaster claims they will take efforts to ensure the student can continue their studies if possible. It would seem the university is making a distinction between behaviour caused by a mental illness and behaviour caused by temporary mental health issues. This is a rare distinction to make for universities and it is made even more clear through the wellness centre website, which devotes a page to the definition and comparison of mental illness and mental health. While there may not be a publicly available, overarching policy document at McMaster, the recent changes to its code of conduct suggest a willingness to reform and its acknowledgement that mental illness is no reason to penalize students seems a fine foundation for policy.

Also of note is the existence of the student-run organization COPE, which has spearheaded the creation of mental health events and mental illness educational seminars on-campus. Further, two McMaster students (Shema Tamboly, Bachelor of Health Sciences and Francois-Pierre Gauvin, PhD student in Health Research Methodology) led a 2013 mental health review entitled "Addressing Student Mental Health Needs at McMaster University." This 63-page document is not hosted on McMaster's website and indeed, was not connected to administration at McMaster at all. These students identified the same gaps in their university's policy and practices that I have noted in other universities. Namely, a lack of communication between on-campus psychiatrists (who identify mental illness issues in students) and other staff (who, without training, may perceive symptoms as "behavioural problems" (p. 12)) can lead to students being penalized for suffering from their illness. This lack of communication between mental

health staff and other faculty is only made more difficult by privacy and confidentiality policy (which is why it is important to make note of when universities make exceptions to privacy regulations in their policy). Moreover, the students identify the absence of an overarching, formal policy document for the university. I believe such a formal document could serve as the basis for organizing initiatives and programs on-campus and ensuring services are adequately addressing the problems they were designed to handle.

University of Guelph

While no proper policy document could be found through publicly available channels, the University of Guelph's website contains some procedural information regarding mental health services and faculty referrals. Guelph uses a framework they refer to as A.L.E.R.T to handle professor--student mental health interactions. The acronym breaks down to: Acknowledge, in which faculty recognize a problem; Listen, in which the faculty member allows the student to explain the issue; Engage, in which the faculty member expresses concern and reassurance; Refer, in which the faculty member directs the student to mental health services on-campus; and Talk, where the faculty member follows up on the student's progress by speaking with counseling services. The specifics of these steps remain vague, however. Impressively, like York University, Guelph also advertises its inclusion of mental health difficulties in its disability accommodation policy. Application forms for the program are available online and the service differentiates between mental illness (providing full disability accommodation) and temporary mental health difficulties (covered on a two-semester basis). Once again, the exact nature of this accommodation is unclear but in this case the omission is

purposeful—the university notes, perhaps appropriately so, that accommodations are highly individualized.

Carleton University

The Student Mental Health Framework (2009) was found in the Office of the Vice President (Students and Enrolment) section of Carleton's official website. Notably, the framework is absent from the university policies list in the University Secretariat section of the website and cannot be found when one uses the site's search feature keyed to “policy” or “mental health” (which finds only the university’s environmental health policies). Only through manual navigation through the site could the document be found, where it is made clear that the framework is being used to inform current decisions at the university. No other policy documents occupy the Office of the Vice President’s section of the website, though the Vice President's office appears to function as a student aid service, which would at least explain why the framework is located here. To the university's credit, a link to the framework can be found under “Quick Links” on the Student and Enrolment web page.

The language of this document relies heavily on the concepts of risk mitigation and responsibility to students. It acknowledges early in the text that the university puts itself at legal risk when assisting students in need but claims that the risk can be lessened through training of faculty and administration in mental health care and through solid policies and procedures. While this certainly seems to be an admirable stance, they are also quick to point out that mental health services are not the primary responsibility of the university and that legally, “the university is not held to the same provision of service standard as are organizations whose primary function is to assist people with mental

health problems” (p. 16). For a policy that assures legal consequences can be minimized by genuine quality care (and that humanitarian concerns are "over and above" legal requirements), this paragraph explaining how the administration should not be held legally accountable is particularly conspicuous. This is after several additional paragraphs outlining the legal risks and potential damage to the university's reputation when assisting in cases of mental illness.

Further, the framework discusses the inherent limitations of its own mental health services: evidently, they are intended for on-campus emergency service rather than long-term care. If the situation is not an emergency but requires more than mere guidance, the university suggests off-campus help may be more appropriate. With all the effort this document puts into mental health reform, evidently expansion of services and accessibility isn't part of the plan. Carleton is turning away a large portion of mentally ill students with this narrow focus and it may be best for suffering students to look elsewhere for treatment as they suggest—Carleton goes on to discourage help seeking by citing its long wait times for nonemergency situations. The university itself acknowledges the difficulty inherent in this plan: psychiatrists are not often covered by provincial health insurance (and if they are, it is rarely in full) and not at all by the Ontario Health Insurance Plan. Students paying for Carleton's already considerable tuition fees may be unable to afford seeking help off campus. Still, the framework recommends students "check their private health benefits for coverage" (p.18), as they are surely not one to provide a suitable alternative. If the mental health services are so poor, through the document's own admission, why is it the policy largely addresses referral strategies and emergency aid, rather than addressing the failing of the existing system? For that matter,

quality staff training and emergency aid will likely do very little to prevent tragedy if the system is not designed for long term treatment. Their subsequent explanation of on-campus services confirms the university's focus on stress-reduction programs, academic guidance and lighter forms of counseling. There are only a handful of psychologists in their employ and no mention of any psychiatrists at all.

Interestingly, Carleton notes that for privacy concerns, they are legally bound to adhere to Ontario's Freedom of Information and Privacy Act and the Personal Health Information Protection Act. These are documents the other frameworks neglect to mention. And while Carleton's policies on privacy are not unlike those of other institutions, it is clear Carleton is concerned about the legal obligations surrounding the handling of information. So much so indeed that administrators have been put in charge of the decision surrounding when an exception to the privacy policy is appropriate:

A senior Carleton University official such as Director of University Safety, Director of Housing and Conference Services, Assistant Director of Residence Life, Director of Health and Counseling Services, Associate Vice President (Students and Enrolment) or their designates who employs appropriate judgement and who carefully considers the implications of informing a third party about a Carleton student's health or other personal information can elect to disclose personal information without consent. (pp. 29-30).

Among these administrators who can make these exceptions, it is notable that no medical professionals are present (who could sufficiently judge the level of severity in a given case and recommend if outside intervention is necessary or even helpful). Even the university Privacy Officer is absent from this list, though the position plays a critical role

in creating privacy policy and interpreting the legal obligations put forward by Ontario's information privacy acts. The acts in question are indeed up for some amount of interpretation, especially in academic settings. This could explain why other universities do not refer to them: the documents are clearly designed for use in a clinical environment—an environment that academic institutions traditionally claim to have little to do with in their own campuses. The provisions for nonhealth care professionals' potential handling of sensitive information is complex to say the least. Generally, health care professionals are also regulated by the College of Physicians and Surgeons when it comes to disclosure of information; these are regulations academic institutions are obviously not bound by. Primarily, disclosure of information for clinicians is handled by a "circle of care," which is loosely defined as those individuals who have some relation to the primary well-being of the patient. What this means in an academic sense is up for debate. Are professors a part of a student's circle of care? Their residence administrators? The dean of student affairs? Mentioning Ontario's confidentiality documents here raises a number of problems for Carleton and it calls attention to the apparent lack of the university's own privacy policy to cover the gaps left behind by the government frameworks.

The Carleton framework goes on to outline genuinely quality advice for faculty to identify and recommend students to the mental health services (which, remember, exist primarily for emergency or guidance purposes). It encourages faculty to remain in contact with both the student and the mental health offices to check on the student's progression but stumbles at the last hurdle when it advises against getting too involved in the student's problems—likely for legal reasons. In general, Carleton's policy appears to be one in

which surface-level attention is given to the problem of mental health, largely through awareness campaigns and faculty training programs, all while their existing mental health services flounder. It is a cost-effective solution to be sure, though it would appear it is much more talk than it is action.

Queen's University

The Student Mental Health Framework (2012) was found on the Queen's University website, though like Carleton, required some amount of counter-intuitive navigation. The page cannot be navigated to through links on the home page but rather, by using the built-in search engine to locate the Principal's Commission on Mental Health, which hosts the document. It is worth noting that the document cannot be found on the pages for Health, Counseling and Disability Services; Administration and Governance; nor even the University Wide Policy Library, all of which can be found much more easily than the Principal's Commission on Mental Health. It may be worth noting that through the aforementioned Policy Library, the public is encouraged to view and even comment on policy as it develops. For whatever reason, this framework, being located elsewhere, is presumably exempted from that practice.

After the series of on-campus suicides at Queen's in 2010 (particularly after the tragic case of Jack Windeler, mentioned previously), the attention of the university had turned to mental health. This document was likely drafted as a response to critics of their 2010 mental health services, an assumption reinforced by the mention of the 2010 and 2011 deaths in the framework's introduction and the fact that the document had only been in development for a year prior to publishing. Of key importance to this framework is the concept of transitions. To Queen's, most mental health challenges on-campus arise from

stressful transitions (rather than genetic or biological factors, as substantive research suggests), transitions such as high school to university and undergraduate to graduate studies. “Transitions” exists as one tier of a four-tiered pyramid structure that the framework puts forth. The authors insist that no one tier of the pyramid is more important than any other (though one must then question why a pyramid structure would be used at all). Despite the claim, the authors devote more pages to the topic of transitions than any other in the document.

Providing support during challenging times is undoubtedly the focus of the framework's authors. This strangely specific focus calls to mind the case of Jack Windeler, as one of the issues leading to Windeler's suicide was, as peers noted, a stressful transition from high school to university. Once again, this is further evidence that Queen's policy is reactionary, not proactive. One can understand the danger in focusing solely on the failures of the past—after all, does Windler's experience typify suicidal ideation, or should we look to a more complex range of causes and possibilities? Is it possible that instead of working from a single oversimplified cause (and there are many causes), we can find a solution that attends to a more diverse population? Indeed, following from the stressful transition theory, the solutions outlined by the framework are more of the same stress-reduction programs seen elsewhere. While surely well and good, these programs perhaps do not have the same benefits as an increase in available mental health resources, nor do these programs help those with serious issues feel legitimized or taken seriously when no alternative program is provided for more serious illness. Indeed, much of the problem seems to be that the authors of the framework have bought into the notion that mental health problems arise simply because students can't handle the stresses

of everyday life, that they are not tough enough, or lack “resilience” (something that, presumably, healthy individuals have more of). The authors note, “The commission recommends formal and informal programs be encouraged and developed in recognition of the need to foster resilience, so that students become equipped to address the various challenges that are inevitable during and beyond, this stage of their lives” (p. 36). This is not to say that stress-related mental health issues are not a reality, merely that those who suffer from clinical (undiagnosed or diagnosed) mental disorders may grow frustrated in programs that insist recovery is a matter of willpower, when what they really need is medical care.

When useful advice arises, it arises in the form of “recommendations,” which are merely that: vague goals such as “The commission recommends the university, faculty and staff associations and unions consider a program in which trained and identified faculty/TA/staff contacts exist in each department to assist their colleagues (like First Aid/Occupational Health and Safety/Equity)” (p. 21) or “the programs should be oriented so that everyone knows how to identify and refer a [person] in need,” (p. 21) which, while genuinely useful and admirable goals, provide little information on how one can go about achieving them. In the case of the latter recommendation (faculty should have programs to identify and refer students in need), no referral or identification procedure was ever identified. To Queen's credit, the commission also recommends increasing the number of on-staff psychiatrists; however, it is unclear if this recommendation will ever be followed up on. Recommendations, of course, are not policy but merely exist to inform it. The document itself illustrates how slowly Queen's is adopting the

recommendations outlined here: “Queen’s has started to move to this model but not strategically or systematically” (Queen’s, 2012, p. 42).

Neoliberalism is not absent from the framework. Early on in the document, it is made clear that certain accommodations will not (or cannot) be made for mentally ill students with sudden, undiagnosed, or misdiagnosed problems. The university notes it is “legally obligated under the Accessibility for Ontarians with Disabilities Act” to accommodate those registered with their Disability Services Office (which requires internal recommendation and has already seen a 243% increase in student activity in the last four years—one can imagine the wait times). However, they go on to say “there is no policy or process to guide professors, staff and students for nonDSO cases” (p. 14). The implication, then, is that the university is doing only what they are legally obligated to and nothing further. Though the DSO is overburdened and is still operating without strict guidelines (the framework recommends the office create reasonable and consistent accommodations in the future, implying they had been operating more or less on a case-by-case basis) and there is simply nothing in place to help students left out of the system, the concern appears to be meeting minimum legal requirements. Indeed, as is the case in many of the universities without clear policy in this area, professors and staff generally use their own discretion when handling mental health issues in the classroom, usually without the benefit of guidance or training in the area. While the framework may have set out to correct this kind of thinking in policy (that is to say, taking the responsibility off the educators, though not necessarily allocating it anywhere else), nothing has changed as of yet.

Wilfrid Laurier University

Once again, in searching primary lists of policy at Wilfrid Laurier, I came up empty handed. This was perhaps unsurprising, as many of their policies haven't been updated since 1996 or earlier. The mental health services information proved equally troubling. Sparse information aside, the centre has only a single on-staff psychiatrist to service the university's entire population. Even then, the psychiatrist only sees students on referral from the Wellness centre physician and only by appointment. There was no indication of how long the process of arranging an appointment would take. Despite this shortcoming, the centre did have a remarkably clear and sensible privacy policy. Disclosure to parties outside the university for any reason can only be done through signed written consent from the student and while there is some amount of "implied consent" for noncrisis situations, the university outlines exactly what is meant by this. The university's "implied consent" can allow communication between disability services and mental health services, which is not always possible in universities. Without this communication, students may have difficulty getting academic help for their mental disabilities. Of note is the university's behavioural intervention team, which responds to crisis situations on-campus involving mental health. It was unclear to me, however, in what circumstances a faculty member would call this team instead of campus security or even the mental health centre itself. For that matter, the team's operating hours do not extend beyond ordinary operating hours for the mental health centre, so it is not for the benefit of after-hours emergency response. It is possible this is a suicide intervention team but the university is hardly forthcoming in admitting to that, for whatever reason.

That said, it is interesting that this team should exist but nowhere does it outline how they operate or what regulations govern their behaviour.

Brock University

Like most universities on this list, Brock University does not have definitive mental health policy, despite hosting a number of active mental health programs and awareness campaigns. To the credit of the university, it developed a tentative mental health framework in 2012 but not only was the document unfinished, it has presumably been abandoned completely. The mental health commission assembled to complete the framework no longer exists and the framework is no longer hosted on the main website. Mental health services information is slim but this is perhaps understandable: all of Brock's counseling is provided by a third-party psychiatric company with its own set of policies and guidelines. Not only does this allow the university to operate without policy in this area, it also distances the university from legal repercussions in the event of a tragedy. This is not a complaint—operating through an outside firm allows Brock's mental health service to have some of the most student-friendly and accessible privacy information of all the universities in Ontario. The service can appropriate their policy from the Ontario Mental Health act without having to worry about concerns such as in loco parentis, or if they are a true care facility. The two psychiatrists and one mental health nurse the company provides work alongside the 14 other physicians in Student Health Services.

Notably, Brock is among the universities to practice the use of antisuicide contracts in its residences (and also its counseling centres), which will be discussed in Chapter Six. This policy of issuing contracts is largely handled through residence

guidelines and policies, rather than any mental health policy. Given the university's lack of mental health policy, it is often these peripheral policies that pick up the slack. Brock's student code of conduct seems to play a critical role in guiding the institution's responses to mental health. The university's code of conduct explicitly refers to cases in which mental illness may be addressed using a disciplinary system. Indeed, students in this model are referred to as "at-risk" individuals and threats against oneself are clearly included in the code's definition of at-risk behaviour to be addressed. This suicidal ideation (or mere self harm) is a Level 3 threat, the highest priority tier (on the same level as violence against another student), wherein the student may face consequences such as involuntary leave for one academic year or longer. Students are considered at-risk even if it is believed they may at some future point become a threat to themselves. Issues are meant to be decided by a Students-at-Risk Case Team, the membership of which is unclear. It is unlikely they are associated with the mental health service and the team meets and discusses cases with the Manager of Residence Life and Student Affairs, ensuring the process has strong ties to administration. While this may seem cold and legalistic, especially considering mental illness and delinquent behaviour are being unfortunately associated, Brock explains that attending to at-risk behaviour isn't straightforward and that the possible contribution of mental illness to student behaviour has been considered:

Addressing the conduct of a student-at-risk can pose unique challenges to the University where that student has a mental or physical disability that is contributing to the "at-risk" behaviour. The University acknowledges that it has a duty to accommodate a student with a disability, in accordance with provincial

law and University policy. (Brock University, 2010, para. 79)

This level of accommodation, the university notes, may not be possible given limited resources or available services. Further, its duty to accommodate (legally, they note) extends only to the point of "undue hardship," and hence it can be influenced by factors such as cost and perceived continuation of risk. It cannot be overstated, however, how a disciplinary code is not to be relied on as a primary means of handling issues of suicidal ideation on-campus. Clearly the goal when mentally ill students are caught in this system is to accommodate the student rather than punish them—the policy is far from malevolent—but students in the system may rightfully wonder why they are dealing with code of conduct violations when they have done nothing wrong. It also ultimately leaves administrators who are used to dealing with delinquent students with ill students they may not be trained to handle and may find it easier to ignore the mental health component of their actions. Both the case review process and the appeals process seem complicated (and multi-staged) and it would not be difficult to imagine students getting lost in the bureaucracy involved.

Finally, it should also be noted that while Brock has publicly announced it is undergoing mental health reform, this largely amounts to the formation of a committee (whose sole purpose is to regulate the additional funding collected from graduate students and ensure it is spent on some form of mental health service) and a number of proposed stress-management programs.

The student union does not expect new policy will be developed in the coming year, despite the increase in mental health funding and despite having no dedicated mental health documents beyond an unimplemented 2012 framework. The student union

is also not involved in any upcoming policy decisions. A more active group in policy making would be on-campus residence services, who, unlike the student union, see representation on review boards and crisis response teams. The Student Health Service operates under stricter policies than does residence (primarily, the strong privacy policy that was made available on their website). That said, where serious mental health issues arise, it still runs largely on a case-by-case basis, using the Ontario Mental Health act as a loose guide.

University of Windsor

Mental health is not mentioned among the university secretariat's list of policies at Windsor, which is otherwise quite exhaustive. Their mental health services page is unfortunately quite bare bones, with little to help inquisitive students, let alone those curious about policies and practices. While fairly sparse, the university Student Wellness Centre page did include a contact e-mail for inquiries concerning practices and policies. However, the Wellness Centre did not respond to my request for more information.

Other Universities

The McGill University SSMU Mental Health Policy (2014) is included in this review for its interesting connections to other policy documents and its core concepts that are indicative of the direction mental health policy is developing. This is despite the document being from a university outside Ontario. Unlike most of the other documents in this review, it is referred to as a policy, not a mere framework. This is another important distinction and a key reason why McGill was chosen for inclusion in this paper. I wished to compare a completed policy document to the frameworks collected in this review and I could not do so given the lack of mental health policy at Ontario universities.

The McGill University SSMU Mental Health Policy could not be found on McGill's website proper, even under the university's official policy listings on the Secretariat's page. However, a check of McGill's organizations and associations revealed that its student society webpage hosts the document, where it was much easier to find than many of the other policy documents on this list. One wonders, however, if students and faculty would know to turn to the student organizations for policy information.

Unfortunately, the policy document still builds off much the same flawed structure as the previously discussed frameworks. In fact, it makes explicit mention of the Queen's University framework and uses much the same language in its statement of purpose. This is somewhat troubling, even if both institutions are genuinely well-intentioned—illnesses and issues that have caught the administration's eye at one location may not be as prevalent in another. This is not to say that good policy is not generalizable, merely that the ability to generalize is hindered if one institution is creating policy that is in some respect reactionary. One institution may find itself addressing problems it isn't actually facing. This is to say nothing of the fact that borrowing elements from another institution's framework may indicate the university was unwilling to create a policy tailored to their own environment (though not necessarily). While the borrowing is surely not extensive and much of the policy remains unique to McGill, the document itself is a mere eight pages, including several pages of references. Filling space with reference to other university plans does not go unnoticed.

More to the point, McGill goes on to comment on its own existing mental health service. The university regretfully notes that it can't expand the operation of the overburdened campus mental health service due to “budgetary and governmental

restrictions” (p. 4)—though it doesn't specify what kind of restrictions the latter might refer to. Instead, several programs and initiatives are to be put in place and governed through this policy—though no rules or guidelines actually exist in the document, rather, broad “goals” are presented that outline what the programs hope to achieve. One such goal is attention to resources. While new resources evidently can not be generated, the university is willing to work on expanding access to, improving the quality of and fostering collaboration between existing resources. For which, of course, a fee will be collected to fund the programs that allow such a change to occur. The act of expanding access to campus resources seems to rely on mere awareness on the part of the students that these (overburdened) resources exist—which is understandable. After all, let us not forget that the services themselves cannot expand to accommodate a larger student population. Awareness, then, is the second overarching goal of the reform. The third and final goal is advocacy and solidarity, through which programs will be created to encourage students to take the initiative and take the fight for mental health care into their own hands. It also includes group therapy programs and research programs; however, it is the promotion of student advocacy that intrigues me. It implies that the policy is subject to change at the collective will of the student population, which is likely a strength of the sparse document. It is possible the policy is vague for exactly this reason—McGill intends to forge the details as they go along.

The document also suggests the university provide a platform for suffering individuals so that they may be given a voice. This proposition may be a strong ending for the document but it remains unclear thanks to the point-form text and vague language if this is what McGill, in fact, intends to provide students. Given their inclusion of student

organizations in other areas of policy, it seems likely this interpretation is correct. Still, this is an example of a document that is not sure where it is going, with broadly defined goals, unsure of what kind of specific policy may be appropriate. It borrows language from other frameworks to assist it in its efforts to understand the issues. If anything, this supports the idea that mental health is uncharted territory for many policy makers. Absent here is mention of procedures or training for faculty, or protocol for acutely distressed or actively suicidal students.

Discussion

Finding definitive policy through publicly available channels at Ontario universities proved to be challenging and it would appear (as suggested previously in my literature review), that many higher education institutions are handling instances of mental illness on-campus on a case-by-case basis with only minimal guidelines. Where documentation can be found, it is in preliminary stages of development and not currently being used to inform policy decisions.

This lack of accountability on the part of many Canadian universities is frankly disturbing. Why would documents outlining protocol in the case of physical illness be available for students and faculty but not mental illness? The only plausible explanations seem to be that the policy isn't available because it simply does not exist, or where it does exist, the institution is aware of its controversial and somewhat less than humanistic nature. I am inclined to believe the former explanation (although the practically hidden nature of some of these documents perhaps points to the latter), as most Ontario universities have announced that an effort will at least be made for reform of some kind, though such efforts have clearly only just begun.

The incomplete nature of these documents makes deduction of an argument difficult. I believe one would be incorrect to, for instance, use these policy frameworks as examples to prove Apple (2001) and Power's (1994) theories of neoliberalism correct. While these documents do contain strong elements of neoliberal thought, there is simply not enough to form a complete and solid argument. This is the reason I turned to narrative policy analysis to review these documents. Narrative policy analysis allowed me to look at the document holistically to determine the underlying narrative, which is useful in predicting how the documents may look when completed. Ultimately, this method has led to a more complex argument: The lack of interest university administrators seem to show for these documents and their completion is as damaging for students as overly neoliberal policy would be. While the conclusion is similar, the difference, here, is that the process is inductive, not deductive. Neoliberalism is still useful as an explanation for why the policy is developing the way it is, but it is not presumed in advance that the policies are, in fact, neoliberal.

Of particular interest was the finding that many universities rely on peripheral documents such as student codes of conduct and residence guidelines as a form of mental health policy. While there is perhaps little else that can be relied on while waiting for policy to be developed, these documents are often not designed to handle mental health issues, to say nothing of mental illness, leaving much to the interpretation of the administrators or faculty at the time of incident. However, while waiting for major policy reform to take place, many of these peripheral documents have been updated to account for the burden placed upon them.

In early 2013, McMaster University introduced revisions to its Student Code of

Conduct that create new processes for students whose breach of the code is thought to be primarily health related. In circumstances where student behaviour is primarily related to a health condition, the Dean of Students may divert the student to a different set of procedures. While many of the same procedures apply, the student attends a review meeting rather than a formal hearing. If the behaviour in question is determined to be primarily related to a health condition, the university commits to making “reasonable efforts” to enable the student to continue their studies, including provision of accommodations. In some cases, the student may be asked or required to temporarily discontinue studies until certain conditions are met or a certain amount of time has passed. (Olding & Yip, 2014, p. 17)

While not ideal, there is recognition that quality policy is urgently needed and any steps to accommodate students while policy makers are still testing the waters are likely a positive change.

CHAPTER FIVE: POLICY CONCEPT—IN LOCO PARENTIS

The debate surrounding mental health policy reform (particularly following the Shin case) and the reluctance of some institutions to implement policy that truly aids the mentally ill, boils down to an issue of whether there exists a duty of care on the part of universities. Legally, this duty of care is referred to as *in loco parentis*, meaning "in place of the parent." It refers to the responsibility on the part of an institution to act in the best interests of those in their care, to regulate their actions for moral or safety reasons as if the institution were a parental figure. Typically, *in loco parentis* is used in cases involving the care of a legal minor but it has a long and involved history at postsecondary institutions. Considering modern universities have a great number of nontraditionally aged or graduate students, *in loco parentis* and its parent-like policies may seem outdated. However, *in loco parentis* is not a mere historical policy anomaly but indeed, it has seen a resurgence in modern postsecondary policy (Stoehr, 2011; White, 2007). So much so, in fact, that the idea is now a key part of any legal discussion where the university finds itself being held responsible for on-campus tragedy—clearly it is has become a key force once again in driving university policy decisions, with clear implications for developing mental health policy.

During its evolution as a policy concept, *in loco parentis* has changed somewhat in appearance to take on legalistic tone—no longer a humanistic concept but a wholly neo-liberal one (Stoehr, 2011). To this end, understanding the history of *in loco parentis* is critical in understanding what has shaped the policy, what it looks like now and how it is affecting university policies. In what follows, I will outline the evolution of the idea of *in loco parentis*, show how it is still relevant to the discussion today and show how it has

become part of a new contracting and audit centric culture. *In loco parentis* is the core stated value behind much of the mental health policy reform seen today—though the desire to maintain a duty of care is not always expressed clearly by the policy tools used to put the concept into practice.

Early in the history of the North American university, the concept of *in loco parentis* was at its strongest. In the mid to late 1800s, the philosophy of *in loco parentis* influenced policies on ethical and moral standards for university students—students could be penalized to the point of expulsion for not measuring up to their institution's standards in their personal lives, or for displaying a perceived weakness in character. These policies included curfews and even regulations on which eating establishments were acceptable for students to give patronage (Lee, 2011). University administrators argued that they were responsible for the moral development of their students as much as they were the academic development and courts agreed. A 1913 ruling stated:

College authorities stand *in loco parentis* concerning the physical and moral wellbeing and mental training of the pupils and we are unable to see why, to that end, they may not make any rule or regulation for the government or betterment of their pupils that a parent could for the same purpose. Whether the rules or regulations are wise or their aims worthy is a matter left solely to the discretion of the authorities or parents. (Bowden, 2007, p. 482)

In loco parentis trumped even constitutional rights in both private and public institutions, with courts confirming that accepting entry into postsecondary institutions is an inherent agreement that one relinquishes some amount of control to the university (Lee, 2011). But this was not merely extension of university values, it was a legal tool. *In loco parentis*

was, after all, not being cited to protect the rights of students as a parent would protect their child from harm (and indeed, was never intended to serve a truly protective function) but rather, as a legal defense when universities chose to discipline their students as they saw fit (Henning 2007).

The 1960s brought change to the long-standing *in loco parentis* era, as students contested the heavy-handed regulation inspired by *in loco parentis*. With this unease came lawsuits—universities in the United States were taking disciplinary action against protesters and the students fought back with legal action. *Dixon v. Alabama State Board of Education* (1961) set the precedent for the discrediting of *in loco parentis* in secondary schools, which spelled the beginning of the end for the concept in postsecondary institutions. In this case, the court ruled that educators of secondary school children and younger did not have the right to punish students in the same way a parent would for misbehavior—a ruling in direct opposition to one made decades earlier.

The protesters would eventually get their wish and by the late 1970s the pendulum had swung the other way. Rather than a university culture where students were seen as persons in the care of mentors and superiors, now students were completely independent in all but their academics and universities became uncomfortable in responding to any issue unrelated to academics. Institutions would not accept responsibility for any tragedy occurring on-campus and courts, once again, supported the universities, noting a few exceptions. This began what scholars such as Phillip Lee (2011) refer to as the bystander era. This new era brought with it new issues for students. Even in cases where hazing and underage drinking were proving dangerous issues on-campus, universities refused to get involved with what they felt was the student's

responsibility, rather than a lack of rigidity or supervision. A 1981 ruling (to contrast the ruling from decades prior) stated, in response to a case of underage drinking on-campus that led to a student becoming a quadriplegic: "Only by giving them responsibilities can students grow into adulthood. Although the alleged lack of supervision had a disastrous result to this plaintiff, the overall policy of stimulating student growth is in the public interest" (Lee, 2011, p. 78).

Yet, it became clear that hazing rituals and other dangerous behaviour on-campus could not be ignored and that some kind of regulation or supervision needed to occur to prevent undue tragedy. This revelation was not unprompted—a shift in court rulings suddenly had universities being held responsible for injuries sustained on-campus, shattering the bystander model of student-administrator relationships (Henning, 2007). It is important to note that these rulings were made based on what the courts found to be negligence, rather than a change in the way the courts viewed *in loco parentis*—nonetheless, these rulings indicated that universities could in fact be held responsible for injuries. Further, as universities became more like businesses seeking customers, it was necessary to appeal increasingly to both potential students and their parents. As parents began to take a greater interest in college-aged children's activities, so too did universities find a renewed interest in keeping those students safe (and parents placated; Bowden, 2007). And so, the bystander era would not be the death of *in loco parentis*. While scholars are quick to point out that we have not seen a full return of *in loco parentis*, there has been recent recognition among courts and universities alike that there is some duty of care owed to students (Bowden, 2007). Indeed, elements of the philosophy have been brought back cautiously and with a new legalistic framework. Universities now have a

duty of care where it can be proven reasonable. Cases where underage drinking on-campus resulted in injury would still be likely ruled in favour of the university, as they were in the bystander era but a more thorough investigation into the reasonable preventative measures taken by the institution would be in order before such a ruling would be made (Lee, 2011). The concept does make appearances in modern court cases and though it is usually cited only in cases involving primary and secondary education, increasing regulations on alcohol use and residence conduct bring the concept into play at a postsecondary level (Bowden, 2007).

With increasing pressure from parents, postsecondary institutions are accepting a greater level of responsibility for their students, even if the concept of *in loco parentis* is not being mentioned by name. What has resulted is a kind of contract model, whereby administrators create a set of regulations (typically through a student code of conduct) on the nonacademic lives of students. One agrees to the nonnegotiable terms that the institution has put forward merely by agreeing to attend the school. In this way, administrators can say that students are being protected (rules have been put in place for their protection, after all) without the need for constant supervision.

What does this mean for developing mental health policy in Ontario? It is clear that questions of *in loco parentis* and its modern relevance are not limited to the campuses of the United States. While the key case for mental health and *in loco parentis* may have been *Shin v. MIT*, Canadian universities have had their share of similar lawsuits and public tragedies. The death of Jack Windeler at Queen's, as previously discussed, has been so influential as to be mentioned as a key factor in that university's policy development. Tragedies like these have not only prompted calls for reform, for

adequate services and competent policy to govern them but also, perhaps unfortunately, pointed fingers of blame. The danger comes into play when one confuses reckless behaviour (often the result of poor decision making on the part of the student, a legal adult) with mental health issues (where it is problematic to shift responsibility onto the sufferer and legal age has little to do with the issue). The call for greater duty of care and accountability for mentally ill students may echo the call for supervision of hazing and underage drinking but the issue of mental health proves more complicated, at least in a legal sense. While some scholars associate suicidality with underage drinking and disorderly conduct (in that these activities are a conscious choice on the part of the individual to break established codes of conduct for some reason or other) (Sweeton & Davis, 2004) and it is clear like-minded individuals exist among policy makers, suicide should be considered foremost a health problem. Further, to assume those with suicidal ideation are making a choice to feel the way they do, when it may instead be a symptom of mental illness (over which the individual has little control) is troubling to say the least. In this review, every available policy framework document indicated that accommodation for mentally ill students where possible was not only necessary but in keeping with the core values of the university. But with high risk of tragedy involved with mentally ill students (and by extension, legal backlash from parents or classmates) and a lack of clear policy precedents for identification, treatment and accommodation, it is tempting for universities to play the bystander once again and simply avoid liability.

Unfortunately, even for universities that actively seek to improve policies and better accommodate students, there are no easy answers. Researcher Randall Bowden (2007) outlines several ways universities can create policy to address the issue of duty in

his text "Evolution of Responsibility: From *In Loco Parentis* to *Ad Meliora Vertamur*." The frameworks discussed in this review have this very goal, often stated explicitly as a duty of care: a sometimes legal, sometimes humanitarian effort to accommodate and protect students in need. Bowden states that the first goal in creating modern policy that addresses a reasonable duty of care is to define what the policy makers view as a student. The student-administration relationship cannot be built upon without this key defining of terms. Is the student a consumer in a capitalist model of education? Is a student merely any individual completing coursework? Each definition comes with its own inherent expectations and rights (the right to a quality product, etc.). Among the frameworks, student as a definition appears to be assumed. Some differentiate between student and nonstudent care levels but hardly linger on the definition. Second, Bowden suggests, there should be campus-wide distribution of information regarding the full extent of academic and nonacademic relationships. In this, many of the frameworks make a clear effort, suggesting a network of informed and trained individuals in each faculty that could serve this purpose. Third, Bowden calls for policy that is comprehensive but not so rigid as to interfere unduly with students' personal lives. This is of course a difficult balance and recognized as a primary concern in the policy frameworks of Ontario's major universities. The University of Toronto's framework notes it will be adopting a systems model to help it with exactly this difficulty. That is, it will address multiple facets of policy on multiple levels to attend to a variety of possible mental health issues. Fourth, Bowden argues for clear lines of authority. Who has the authority to enact policies put in place? Even in universities where mental health training is provided to professors or other staff, actual procedure or authority to act is not always clear. What authority do

instructors have in assisting with mental health issues? Or other faculty, for that matter? Are mental health professionals given authority over mental health issues, or are these issues largely handled by administrators? While many frameworks touch on referral guidelines for instructors or residence staff, none truly break down the hierarchy of the proposed policy changes. As a parting note, Bowden cautions students to be aware of the limitations of the university in accommodating students and for policies to make clear to students that they must be held responsible for their actions where appropriate. I will say simply that most frameworks examined do, indeed, highlight the limitations of the university's care system and promote students to take responsibility for their own help where possible.

The relationship between student and administration is one that has undergone a considerable back and forth over the history of postsecondary institutions. We are poised now in the middle of a strange era for concepts like *in loco parentis*: not quite gone but clearly the relationship does not resemble what it once was. With policy makers unsure of what will become of the student-administrator relationship less than a decade into a postbystander era of legal policy, it is little wonder reform is slow and cautious. Moreover, the sudden change in legal procedure bears a strong correlation to the change in the student-administrator relationship from academic to consumer-like. As one scholar explains, “[the trend] reflects the intense marketplace competition among institutions and a recognition that students have economic and property interests which deserve legal protection” (Melear, 2003, p. 125). No longer is *in loco parentis* concerned with protection of the moral integrity of the student but rather, the financial interests of the university as a business and in upholding the rights of the consumer. What has become

clear is that administrators are taking no chances with potential lawsuits. Where in loco parentis can be found, it is as a policy concept divorced, at least partially, with practice—a friendly idea, a concept of parental care to present to potential consumers of education. The real ideology emerges in practice.

CHAPTER SIX: POLICY TOOL—ANTISUICIDE CONTRACT

If the long-standing application of *in loco parentis* has moved from a strict, controlling parental model to a neo-liberal model (where administrators take partial responsibility for student care but do so very carefully and from behind formal legal policy), what does this mean specifically for the student? That is to say, when a university extends its duty of care to a student in mental distress, what does it look like? In student residences and mental health centres alike, a given university's go-to initial policy tool is unsurprisingly a very bureaucratic one. Practically embodying the contracting and auditing culture, the antisuicide contract is a faux-legal document administered as a first line of care to students who self-harm or who administrators suspect of suicidal ideation. The antisuicide contract is a difficult tool to discuss, as research surrounding its use (particularly in an academic setting) has been limited. More readily available is literature regarding the controversy and effectiveness of the contract, detailing the growing professional distaste for such documents. As it is important to the understanding of how universities carry out policy ideas, the administration of antisuicide contracts merits an in-depth exploration. The documents themselves go by a number of names: the suicide-prevention contract, no-harm contract, contracting for safety, among others. I will be using these names interchangeably throughout this chapter. Due to its informal nature, there is no standard name or form for no-harm agreements and rarely can mention of them be found in policy documents (either those of medical or academic institutions). And yet, such an agreement can be used as an enactment of policy, a diagnostic tool through which policy decisions can be carried out. In essence, the antisuicide contract is an informal agreement between caretaker and patient that has the

appearance of a more formal document. The wording of the document can vary but by nature, it has the patient agree that they will not self-harm, nor will they take their own life, by way of signature. It is generally administered soon after suicidal ideation is made apparent (or is suspected) and in a clinical environment, is a lead-in to proper assessment, followed by therapeutic treatment. Should the patient refuse to sign the document, this indicates that the patient can not be trusted with their own safety and immediate intervention must be considered. If signed, the document allows for the responsibility of safety to be placed, in part, in the hands of the patient and follow-up treatment may be less urgent.

In practice, at the university level, the contract is not only administered by the mental health service but can be administered by people other than health care professionals—residence dons and deans are among those who have administered such documents in Canadian universities, as I've discussed in the literature review. In short, the antisuicide contract is a tool that allows institutions to take a legalistic approach to mental health and pass responsibility for the student's well-being to the student. It is through this practice that neo-liberal values that may not have been evident in the university's stated policy come forward.

The antisuicide contract was first put to clinical use in the late 60s to early 70s and was developed based on theories of Eric Berne, who had published on the topic in the early 50s through the early 60s (the most prominent work being *Games People Play – The Basic Handbook of Transactional Analysis* [1964]). Berne theorized that people communicate primarily through assumed roles and states of being. There exist three primary roles: adult, parent and child. All communication patterns are based on some

interaction between these roles. For instance, adult-to-adult communication is done through an exchange of logic and reasoning. In this model, confronting someone about a gambling addiction could be phrased as *We should figure out why you keep falling back into this problem before you hurt the people around you* and the expected response would be one of understanding: *Yes, I'd like to find out why this is happening*. Child responses would be those of defiance (*You don't understand!*), while parent responses would be those of concern (*I don't want to hurt anyone but I don't know how to stop*). Berne argues that those suffering from a mental illness are operating in the child state and are appealing to a protective caretaker in the parent state for assistance. The contract he devised is based around the premise that if the patient is brought into an adult-adult conversational mode, they will be more rational concerning their own safety. As long as this adult state holds, he reasons, the contract will act as a "holding device," keeping the patient alive until further intervention can occur (Berne, 1964). What is troubling is that over the past three decades (or more), the form of the contract and the ideology surrounding it has not evolved beyond this original work. In hindsight, surely, the notion of conversational states is as outdated as Freudian thought and is not without its patronizing language (one does not typically think of modern patients as childlike).

While the language of the no-harm contracts varies from document to document, there is a focus that remains consistent across cases. While hardly any Canadian university provides samples of the contract for the public, there are plenty of publicly available contracts from psychiatric firms and clinics that can be used for comparison (for example, Paraklesis Counseling in Calgary hosts an excellent example on their website). Between these sample documents and the contracts discussed by researchers such as

Buelow and Range (2001), it is evident that there is common language between clinical contracts and those used in university settings.

I would like to discuss an example of an antisuicide contract provided by one of the universities investigated for this thesis. The university in question uses two forms of the contract: one for students who live outside the campus residence and one for students who live on-campus. I was provided with the latter document by the coordinator of the university residences (my request for the former document through the university's mental health centre received no response). According to the university's residence guidelines website, the contract is put to regular use as a prominent step in intervention for mental health cases in residence. Note that this document was not publicly available and needed to be requested specifically. Items enclosed in triangle brackets (i.e., <text>) are common throughout all versions of the residence no-harm contract. Text enclosed in curly brackets (i.e., {text}) are present in the contract only if they are deemed applicable to the situation at hand. The only modification I made to the contract from the version that was presented to me was that I excluded any information identifying the university or staff involved.

Of note in this document is the intimidating language that threatens eviction for failure to comply with the contract's terms: "in order for you to remain living in residence, I need you to adhere to the following conditions" and the more explicit "Possible consequences of violating this behaviour contract include suspension or eviction from residence." The contract seems to be written with the notion that the student the contract is intended for is in complete control of their behaviour and that the offending incident was not a symptom of an illness. The contract refers to itself as a

<date>

<full name>

<residence address> <extension>

PERSONAL AND CONFIDENTIAL

Dear <first name>

As per our discussion <date of meeting>, I am outlining our expectations of you for your continued stay in residence. You recently <details of incident i.e. made an attempt to take your own life; harmed yourself> and <responder i.e. roommates, RLS member, CSS> came to your aid. <They/he/she have/has> expressed concern for you.

I really would like to see you continue living in residence and your situation is important to me. I want to make you aware of the services available to you that will be able to offer you appropriate support. I need for you to accept and use that support so that we can be assured that you are getting the assistance you need and are more able to cope with the difficulties you're experiencing. As such, in order for you to remain living in residence, I need you to adhere to the following conditions:

<You must agree, with your signature, that you will not make an attempt to take your own life; should you feel that you want to do so, you are to seek professional support or contact a member of the RLS. If you are distressed and it is after hours, you will call the regional crisis line number, *****, or use any of your other outlets as discussed.>

- { You must agree, with your signature, that you will not expose other residence students to your thoughts of suicide. }
- { You must agree, with your signature, that you will not expose other residence students to your self-harm behaviour. }
- { You must agree, with your signature, to refrain from the consumption of alcohol in residence until <date>. }
- { You must agree, with your signature, to attend at least one session with a personal counsellor in the Student Development Centre (SDC). Their extension is ****. You must make this appointment within the next 24 hours. }
- { You must agree, with your signature, to continue to attend sessions with your present counsellor or health-care provider. }

- { You must agree, with your signature, to attend at least one appointment with a healthcare professional at Student Health Services. Their extension is ****. You must make this appointment within the next 24 hours. }
- { You must agree with your signature, that the Student Development Centre has permission to share, with me, the status of your attendance at the appointment you have agreed to above. They will only be asked to verify that you have made and attended your appointment; they are not required to disclose any other information to me. }

If any concern is raised again about your behaviour, including any violation of the above conditions and/or violations of the Residence Agreement or the Residence Community Guiding Principles, we will re-assess whether or not residence is the place for you. Possible consequences of violating this behaviour contract include suspension or eviction from residence.

<first name>, I was very glad to have the opportunity to meet with you the [*sic*] today. I hope that our meeting helped you to feel heard and will help get you on the road to better health. We have put these conditions in place because we are concerned about you and wish to support you. These conditions will remain in place for the duration of your stay in residence. It is my sincere hope that you are able to get the help that you need in order to continue to be successful, both in residence and at ***. If you have any questions, don't hesitate to call me at extension <extension #>.

I wish you the best of luck for the future.

Sincerely,

<full name>

Residence Life Coordinator

My signature below indicates that I have read, understand and agree to abide by the conditions as set out in this letter.

<name>

Date

Please keep your copy of this letter and return the signature page in the enclosed envelope to my mailbox.

Figure 1: Residence antisuicide contract.

“behaviour contract,” and makes repeated mention of “your behaviour.” The student is being asked to take full responsibility for their actions and their own safety, though the student may not be responsible nor able to seek further help of their own volition. And while the student is required to make appointments with care facilities within 24 hours, this certainly does not mean the appointment will actually occur within a 24-hour period (this seems incredibly unlikely, in fact, given the overburdened system). In the meantime, the contract makes clear the student in crisis is now the one responsible for their own safety. It is interesting that the student being given the contract is trusted to be responsible for managing their illness as a fully competent adult but their peers and classmates, in full in loco parentis, are in need of the university’s protection from the student’s offensive behaviour. To that end, the language being used in the contract can quite possibly evoke shame in the student the contract is directed towards, as it encourages the student to hide their difficulties from others in residence (“You must agree, with your signature, that you will not expose other residence students to your thoughts of suicide”). Note that this is not suicide or even self-harm behaviour but merely thoughts of suicide. While students could be disturbed by exposure to self-harm behaviour or suicidal ideation, one wonders if attempting to shelter others from the troubled student is worth causing further distress to the student who has already engaged in self-harm or has attempted suicide. Likely the student’s actual suicide would disturb dorm-mates more than the student’s attempts to discuss the problem. I imagine students with physical illnesses are not asked to similarly hide possibly distressing symptoms from other students and while I am genuinely curious, I am aware of no documentation to this effect.

Ultimately, the emphasis in this document, as in all no-harm contracts, is on the prevention of death, as most documents expressly forbid harm or death by suicide under any circumstances. Obviously there is nothing inherently wrong with wishing to prevent further harm to students, provided, of course, that the document actually has preventative ability. Unfortunately, despite its widespread use, it remains unclear whether the no-harm contract is useful in actually preventing harm. While some studies have found beneficial results from using the contracts, these studies are done (out of ethical and logical necessity) without random sampling and without a control group, so it is impossible to differentiate between positive effects of the document and the treatment immediately following it. Some researchers have supported longer, more legalistic contracts as a means to ensure patients understand what is required of them. In a study of college students, participants were asked to rate a number of suicide prevention treatments on their effectiveness (Buelow & Range, 2001). Among the treatments were medication, talk therapy, self-help methods and a variety of antisuicide contracts that varied from very simple and informal to complex and legalistic. A majority of students were found to be in favour of longer, more complex and legally phrased documents, preferring them over simple, one to two sentence agreements in preventing suicidality and (paradoxically), students perceived longer documents as providing the patient a greater level of personal control than simpler documents. It is possible the students had simply associated longer and more legalistic contracts with professional and therefore effective tools.

Unfortunately for the validity of this study, only 40% of the 112 respondents had ever experienced suicidal thoughts or knew someone who did and it was unclear if any of them had any experience with suicide contracting. Interestingly, the students still ranked

antisuicide contracts as the weakest tool for suicide prevention available (medication being ranked the highest).

In the last decade, as more research has emerged, more recent authors have disagreed with the practice of contracting, arguing the document may even have a counterproductive effect (Rudd, Mandrusiak, & Joiner, 2006). One author points to a 41% fatality rate following the administration of the contract at a university over the period of 5 years (it is far from infallible, as even the contract's defenders have agreed) and goes on to suggest that the contract is a potentially coercive administrative tool rather than a clinical tool (Weiss, 2001). This latter point is perhaps the most relevant here: Does this discussion boil down to an issue of legal liability?

To answer that question, we must explore the possibility that no-harm contracts are indeed used as effective clinical tools. It is rare to find a study that endorses the contract's effectiveness without some kind of caveat. "No-Suicide Contracts: An Overview and Recommendations" is one such cautiously optimistic study (Range et al., 2002). The authors claim that no-harm contracts have the potential to "deepen commitment to a positive action, strengthen the therapeutic alliance, facilitate communication, lower anxiety, aid assessment and document precautions" (p. 51). Despite this extensive list of endorsements, the authors also concede that completely contrary attributes of the contract may exist: "They can anger or inhibit the client, introduce coercion into therapy, be used disingenuously and induce false security in the clinician" (p. 52). Indeed, it is difficult to imagine a document that is both coercive and yet able to facilitate communication, or both anger the patient and reduce anxiety. Obviously, these qualities must be mutually exclusive.

Range et al. (2002) ultimately endorse the limited use of antisuicide contracts, so I examine the proposed advantages they identify in these contracts. They argue that because the formulation of the contract includes alternative coping plans, the documents help clients commit to positive action. I would note, however, that while it is undeniable that contracts help patients agree to positive courses of action, what is at question is how much is truly agreement and how much is coercion, as authors such as Weiss (2001) have suggested. Range et al. also argue that contracts are useful as a measure of suicide risk. They claim that hesitation and reluctance are indicative of a high suicide risk and confidence and eye contact indicate a low risk. This is a dangerous assumption for clinicians to make. By the author's own admission that contracts may be coercive if only due to the power differential between patient and therapist (p. 66), a lack of hesitation may simply be an indication that patients are simply trying to please the clinicians.

Practicing psychologist and researcher Lisa Lewis (2007) conducted an excellent literature review on the topic of no-harm contracts, finding that the overwhelming majority of literature came down against the use of contracts despite their widespread use. In her review, she claimed, "the existing research does not support the use of such contracts as a method for preventing suicide, nor for protecting clinicians from malpractice litigation in the event of a client suicide" (p. 50).

Even if it could be proven that no-harm contracts are effective, they remain problematic. It isn't just independent researchers criticizing the documents. The Centre for Addiction and Mental Health (CAMH; Canada's largest mental health and addictions hospital, as well as a world-leading research institution in the field of mental health) argues that the use of these contracts should be discouraged for clinical use wherever

possible (*Suicide Prevention and Assessment Handbook*, 2010). Their conclusion is drawn not only from the lack of evidence surrounding the contract's effectiveness in reducing the risk of suicide but also logistical factors. They note that administrators of the no-harm contract can derive little information from a signed contract. Patients may agree to the terms out of a wish to hide signs of suicidality, or out of perceived obligation, or merely to please the clinician but with no genuine belief that they can meet the terms of the contract and keep themselves safe. Further, whether signed or not, antisuicide contracts are not legal documents, though they can misleadingly appear as such to an uninformed patient (or even uninformed care provider). Most shockingly, the CAMH points out that the contracts "are sometimes used without evaluation by psychiatrist or assessment, a practice that is not suggested" (Centre for Addictions and Mental Health, 2010, p. 24).

University researchers are quick to address other issues inherent in these documents. For instance, the review "The 'No Suicide Contract': Helpful or Harmful?" presents the following concern: "The patient may be experiencing command hallucinations to kill himself or herself—a fairly common phenomenon in schizophrenia, which has a suicide rate of approximately 10%. Would we be contracting then with the individual or with a hallucination?" (Egan, Rivera, Robillard, & Hanson, 1997, p. 32). In the same vein, are we holding mentally ill patients responsible for their impulsivity or lack of control? Must we introduce another level of stress, guilt and obligation to an already traumatic illness? Let us not forget that 90% of those who complete suicide have some form of diagnosable mental disorder (Weiss, 2001). In cases of depression, the intensity of the illness can vary wildly as episodes come and go. Dissociative, borderline

disorders and active psychosis pose similar problems during a variety of altered states. This is not to say that victims of mental disorders cannot be contracted with effectively. My point is merely that the most at-risk group for suicide (the mentally ill), for whom the contract is intended, is also the most problematic for the contract to adequately service.

Why, then, have these documents continued to see use in institutions both medical and academic despite the controversy? The simple explanation is that many practitioners are under the impression these documents will aid in the prevention of malpractice suits (Lewis, 2007). Of course, there is little research to indicate that the documents are effective at doing even this—indeed, quite the opposite has been found (Gutheil, 1992). They are, after all, not legally binding documents and they afford practically no legal protection despite the apparent hope that they will. Yet, there is no doubt that these contracts have been seen as a protective practice. For instance, Farrow (2002) asked nurses about their use of the contract. The nurses' responses were telling: The mitigation of liability was one of the most common responses. As one nurse responded, "I mean the thing about contracting for safety [NSCs] is for us it's butt covering . . . the person has verbally contracted, so in a way if they go ahead and kill themselves we have done our bit" (p. 216). In the case of nurses, their fear would not be of malpractice allegations but of Serious Incident Review inquiries. Administrators who audit the nurse's behaviour through SIR inquiries are evidently, according to the nurses themselves, put at ease by the mention of the contract being used: "Certainly when it comes to a SIRPs [Serious Incident Review] panel, they like to see it [the presence of a NSC] in the notes. They like to see that this person has been offered a contract" (p. 216). It is worth noting that in Farrow's study, none of the nurses in question had received any formal training on the

use of antisuicide contracts, yet all formulated and administered the contracts in a similar way, suggesting the skill was learned through the culture at the hospital.

In addition to “butt covering,” there is some long-standing perception among some health care professionals that the no-harm contract is empowering to the client in some way, which could also help explain its prevalence. In a study by Tony Farrow, Alexander Simpson and Helen Warren (2002) entitled "The Effects of the Use of 'No-Suicide Contracts' in Community Crisis Situations," a number of nurses were again asked their thoughts on the no-harm contract. The results were tremendously positive: “They [the patient] have some control of what is happening and it’s about the fact that we can trust them—we are not going to pick them up and take them to hospital. There is some trust; they are taking responsibility” (p. 243). The no-harm contract, to their mind, allows the patient to take charge of his or her own feelings, reduces anxiety and aids in rapport building between patient and caretaker. Yet, this potential strength of the contract disappears when examined too closely.

As a follow-up to this study, Farrow et al. (2002) interviewed patients at the same institution at which the nurses were employed. Patients overwhelmingly found the antisuicide contracts intimidating, anxiety inducing and disempowering. The transferral of responsibility to the patient that nurses saw as a positive factor, the patients saw as overwhelming and a particularly uncaring act on the part of the professionals. The patients felt as if they were being held solely responsible for their own care and safety, when they had expected a professional to assist them further. One patient noted: “It [the introduction of the NSC] made them [the crisis team clinicians] seem very cold and just there to do their job and that is it . . . just ‘hurry up and get out of the way’” (p. 243).

Further, all patients interviewed believed that the contracts were really a false choice, as refusing to sign the contract would have meant some kind of escalated intervention. In their case, at the institution in question, they would have been correct. To refuse the contract would have been an indication that further intervention was required, which is the generally held practice with no-harm contracts. Of little help are the preconceptions of the very term “contract,” which bring to mind legal procedure and serious consequences. The patients voiced their fears and concerns: “You know what’s going to happen if you say no . . . It’s like they pretend to give you a choice” (p. 243). Other patients agreed that they felt compelled to sign the contract. “I thought this [agreeing to the NSC] was the only choice . . . I didn’t know I could refuse, or what other choice there was” and “It was like, this is what happens now . . . what other choice was there?” (p. 244). Other concerns included not being taken seriously enough and a feeling of forced distance from the administering caretaker.

Though the no-harm document is more informal than the legal contracts it apes, clearly there are ethical issues inherent in a contract that an individual feels he or she must sign under duress, be it for the patient’s own good or not. The authors commented on the phenomenon, “It appears that the very formulation of the NSC [no-suicide contact] reduced their ability to receive full information about their treatment possibilities and their right to refuse or accept these treatments as they saw fit.” (p. 246). They also saw the idea of entrusting patients with their own care before determining their existing coping skills—and before providing them with those skills through treatment—as absurd. As a diagnostic tool, then, to separate urgent care (those who refuse to sign) from the calm and manageable patients, the contract runs into more problems. The authors explain:

Persons who are at serious risk of suicide and with whom a NSC could be considered as useful for management, are less likely to be truly competent to enter a NSC. Yet persons at low risk of suicide and who may be considered competent, are not likely to need a contract at all. (p. 248).

Again, we have seen that patients can easily sign antisuicide contracts for a number of reasons, including perceived obligation or a desire to avoid hospitalization, among other reasons. To those who need the document, signing indicates nothing. For that matter, refusal to sign may simply indicate a fear of the contract, distrust of the administrator, an inability to trust one's own actions at a future time (but feeling safe in the short term), or the understanding that the distress is temporary and no contract is needed. These scenarios may not be the norm but they are plausible enough that contracting as a diagnostic tool should be supplemented with a professional eye and a series of nonthreatening questions. Clinicians (ideally) can use the patient's body language and situational context to help with preliminary diagnoses. One wonders, then, what information the patient's signature adds to the process that the clinician's training cannot discern.

If these contracts are perceived by all except those who administer them as cold and legalistic, or as blatantly ineffective, where is the miscommunication? Or are the best interests of the patients being ignored for the sake of protecting against legal backlash? Rudd et al. (2006), authors of "The Case Against No-Suicide Contracts," offer an easy, sensible alternative to the existing document, which they call a commitment to treatment statement. In this model, the term "contract" is removed to avoid negative connotations. More importantly, the commitment to treatment statement (CTS) does not deny the

patient the option of suicide, as this, the authors feel, is an unreasonable request of an early clinician–patient relationship and one that, they note, results in an increase in suicidality. Trusting a patient, the authors suggest, involves not saddling them with responsibility but trusting that they can take care of themselves without the use of a patronizing or anxiety-inducing document. A CTS instead states the goals of treatment in clear language and has the patient agree only to a duration of treatment they feel is appropriate and that their clinician will be contacted in case of emergencies. This is not to say a CTS solves all the issues of contracting—in particular, it can still be seen as a largely administrative procedure, though now its clinical intentions are more apparent. It would nevertheless be a step forward in the field. Unfortunately, however, no such model has been adopted in over 50 years of using contracts, so it seems unlikely that the practice will change soon.

While the clinical world is one thing, the use of antisuicide contracts in postsecondary institutions is even more problematic. Care professionals know to follow up the document with proper assessment (ideally) and may even be aware of growing clinician distaste for the practice but deans and administrative officials, attracted to the legalistic nature of the contract, may not be aware that further follow-up is needed. Worse, believing that symptoms of mental illness derive solely from stressful environments (discounting the possibility that mental illness increases sensitivity to stress), administrators (or overworked campus mental health staff) may feel students in need may have all the skills required to take their safety into their own hands after a mere promise and some time off. Even assuming administrators are knowledgeable enough to overcome these difficulties, the academic environment features unique challenges to

contracting. One such challenge and perhaps the reason why the academic world took so readily to the use of legalistic contracts, is the deep-rooted tradition of using informal contracts to treat delinquent behaviour (Buelow & Range, 2001). There is evidence to suggest low academic productivity, truancy and disruptive behaviour have been treated successfully by contracting not unlike no-harm contracts and there exists a tradition of their use that predates the no-suicide agreement. The problem, of course, lies in the belief that suicidal ideation is in some way a delinquent behaviour that benefits from client-patient negotiations. It is not the case that the mentally ill are acting out of rebellion or need for attention (an outdated but still extant model of the problem) and until assessment can be completed, it should not be assumed as such. Overcoming this tradition, lacking in the clinical world (save, perhaps, for addictions treatment—though even this kind of contracting is a less common practice than no-harm contracts), is a challenge for administrators unfamiliar with mental illness, or who are stuck in a behavioural model of disorders. We have no reason to believe administrators or even on-campus mental health staff understand the limitations of the no-harm contract. In a survey of Harvard's own mental health faculty, it was found that 61% of psychiatrists and 71% of psychologists who used contracting were not trained in their use at any point in their careers (Weiss, 2001). Expecting residence dons or nonmedical staff to have any kind of training on the document's use is unreasonable and yet, the practice of nonmedical faculty to administer no-harm contracts is still common.

With questionable use as a suicide prevention tool and unclear utility as a diagnostic tool, what use is the no-harm contract? While it evidently holds no weight in court as a legal tool, I have discussed how the form (and name) of the document has

served to intimidate patients and lead them to believe the contract is somehow binding. I would argue that administrators can use the no-harm contract as a tool to dissuade legal action through sheer bluff. Families of suicide victims could be just as easily fooled by such a contract into believing therapeutic efforts were further underway than they were in reality (after all, the suicide victim had enough of a therapeutic rapport to enter into the agreement), or that the institution has possession of a legal document that could be used in court. Should the administrator of the contract be more genuine in his or her concern, it is no less a display of neo-liberal values. The form of the contract has remained a legalistic one, despite critics' attempts to soften or humanize the language, with some authors even pushing for more bureaucratic language. The act of bureaucratizing mental health is an audit of our very therapeutic tools and even the patient is lured into the anxiety and responsibility surrounding a legalistic audit.

CHAPTER SEVEN: CONCLUSIONS

Policy is one of the most important tools administrators have for establishing (or at least, defining) a relationship with their student population. Author Michael Apple (2001) believes that the neo-liberal (and neo-conservative) model adopted by policy makers in higher education has changed this relationship between student and administrator and not for the better. His idea that neo-liberal values are at play at all levels of the institution helps to make sense of the move towards legalistic mental health policy, as well as trends in existing policy. Legalistic policy such as contracting and policy construed to mitigate liability, by necessity, distances university staff from their students. This is while, paradoxically, the institution advertises the quality of their on-campus care. As competition between increasingly capitalist universities escalates, it is all the more important that institutions protect their reputations—they wish to present an image of care and responsibility while simultaneously taking on only the minimal level of responsibility for mental health issues, in fear of legal backlash. Another element of policy that has clear hallmarks of neo-liberal thought is a repeated mention of cost as a limitation on the improvement of services. This is apparent in developing frameworks like those of Carleton University and while there can be little doubt that cost is a factor for all university programs, it should perhaps be less of a concern where services to save lives could be integrated or improved.

This tension between keeping up appearances with their consumer base and maintaining a legalistic stance on the institution's responsibility to students is evident in current policy concepts. Modern policy concerning the extent of a university's duty of care is a careful hybrid between *in loco parentis* ("in place of the parent," where the

university holds many of the same rights and responsibilities towards students that parents would) and a more distant, bystander-like framework. It is perhaps no coincidence that the evolution of policy from *in loco parentis* to a bystander era to a cautious rehash of *in loco parentis* once more mirrors Power's (1994) history of the evolution of capitalist thought in higher education. As the age of the bystander ended, so too did universities begin to adopt more businesslike tactics and policies. *In loco parentis* became a demand of the consumer (or in some cases, the parents of the consumer), one that could be placated, at least in part, through policy. Recall from my previous discussion that this does not mean that universities necessarily adopted *in loco parentis* but rather created policies to attempt to satisfy customers' needs for safety and still keep themselves at arm's length from potentially damaging backlash.

When university policy is put into practice through the use of policy tools, the neo-liberal values are much more straightforward and visible. In this review, I looked at the policy tool of the no-harm contract. Among the problems of the practice (not the least of which was a lack of medical credibility) is the use of the contract by administrators rather than medical professionals and the cold legalistic nature of the contract (off-putting to students in need). Safety contracting is a form of auditing behaviour directed at mentally ill students, a means of controlling what some administrators view as undesirable or delinquent behaviour. The preference for this quick, cheap, easy, yet coldly legal procedure over more humanistic alternatives (improvements to overburdened health care services, for instance) points to an audit culture inherent in higher education.

The vast majority of mental health policy remains in development and there is little to no mental health policy precedent in Canada for universities to follow. Because

there is little history to guide the formulation of policy documents in Ontario and many frameworks seem to have already fallen into troubling language, it is unclear if the final product will have the quality it needs, or if mere lip service will be paid to the problem at hand. However, some developing policies are quite promising and it gives one hope that with further refinement, these policies will change the face of mental health in Ontario universities.

After reading what limited literature is available, reviewing existing policy documents, and researching the real-life consequences for students caught up in an ineffective system, I do have some insights on what effective mental health policy may look like. Effective, here, means simply that the policy document helps to ensure that the issues of students who are suffering from a mental illness are not exacerbated by the actions of the university, and ultimately reduces the likelihood of student suicide (and by extension, reduces the likelihood of lawsuits against the university). While I believe that there simply isn't enough research to provide a definite solution to the problem of policy, I would like to use this space to speculate. I have identified what I believe are three of the most important attributes of an effective policy document. There is some overlap with Bowden's (2007) theorizing on the same issue, much (but not all) of which I agree with. My suggestions are presented in no particular order (they are all equally important).

First, an effective mental health policy document should address the entire campus, not merely upgrade or renovate existing mental health resources. Remember that while counseling centres are overburdened, they are often not treating the most vulnerable group of students: the mentally ill (Wei, 2007). This is likely a problem with identification and referral of students in need. Students who already feel like outsiders

because of their illness are hardly encouraged by faculty who may not know how to address their problem. Effective policy would address the problem at a departmental level, providing basic mental health training to faculty, including what mental health resources exist and when it is appropriate to refer students to them. Training is even more important in campus residences. This is where the symptoms of a student's illness are all the more visible, and it falls to residence dons to understand what the student is going through and the best way to assist them. Operating on a case-by-case basis is simply not good enough, and introduces personal bias into the system. Administrators are not mental health experts, and they will need a clear guideline for operating procedure. In short, it is important that the document does not focus solely on the counseling centre, but how the entire university can work towards solving mental health problems.

Secondly, I believe it is important that policy makes a distinction between mental illness and mental health, with at least consideration given to medical models of treatment being implemented on-campus. Students cannot be expected to have access to outside help—experts should be available on-campus who can offer treatment beyond talk therapy. If these experts must be kept at arm's length from the university for legal reasons, so be it. Ideally, it would be preferable if the university could keep in close communication with its experts to better monitor a student's state of mind and how it may impact their academic career, but there must be some concession to legal concerns. Related, the language used in the policy document should make clear that issues like depression and suicidality are health issues, not disciplinary problems. The policy document should take pains to divorce itself from the university's code of conduct, and particularly from the idea that mentally ill people are dangerous and should be isolated.

Policy makers should remember that pedagogy shapes thought, and an effective policy document frames the issue in a way that does not alienate or insult students.

Finally, effective policy must outline what responsibility the institution has to addressing the mental health needs of a given student, and to what extent the university will take action to protect itself from legal repercussions. I do not mean to say that universities cannot use policy to protect themselves legally, but I do believe the primary purpose of the document should be to ensure that all reasonable efforts are being taken to accommodate students who suffer from mental illness. It should not set out to be a legal shield—doing so sets up an opposition between students and administrators, which is counter-productive to providing reasonable levels of care. At bare minimum, the authors of the hypothetical policy document should make a commitment to addressing mental illness problems on-campus, rather than removing the student from it. Other primarily legalistic practices, like the anti-suicide contract, would not be part of standard operating procedure on any level. Of course, the document should recognize that less obvious legalistic practices exist, but are equally dangerous: in particular, the use of the counseling centre as a holding-tank. A mental health centre should not be expected to solve all of a mentally ill student's woes, especially if its primary means of treatment is counseling. Counseling alone cannot be considered an adequate level of care. While a university may not be a health care facility (and I am in no way expecting it to be), it is that very lack of expertise that leads to false positive identification and, moreover, campus tragedy. Effective policy would examine care options that provide some middle ground between counseling as a first response and hospital-level care, while still providing some degree of legal protection for administrators and faculty. Ideally, policy-

makers would minimize neoliberal influence and open the institution up to some amount of legal liability in exchange for a more comprehensive level of student care.

To conclude, it is the hope of this review that policy of some sort will soon be in place to replace existing practices, many of which are clearly problematic. While I understand that my study has not put forward a definite solution to problematic policy, I feel that given the lack of literature on the subject, identifying that the problem exists is valuable. I also hope that I have identified gaps in the research, as there are a great number of questions that remain unanswered. What are the opinions of students on mental health policy? What do policy makers have to say on policy development? Future research should expand upon this work, especially to test whether my findings hold true across all of Canada. Further, I believe this paper serves an archival purpose, documenting the state of university mental policy in Ontario in early 2016. Considering the developing state of mental health policy, these documents may look very different in the years to come.

References

- Apple, M. (2001). Educational and curricular restructuring and the neo-liberal and neo-conservative agendas. *Currículo sem Fronteiras, 1*(1).
- Baker, K. (2014, February 14th). How colleges flunk mental health. *Newsweek*. Retrieved from: <http://www.newsweek.com/2014/02/14/how-colleges-flunk-mental-health-245492.html>
- Berne, E. (1964). *Games people play: The basic handbook of transactional analysis*. New York, NY: Ballantine.
- Bowden, R. (2007). Evolution of responsibility: From in loco parentis to ad meliora vertamur. *Education, 127*, 480–489.
- Brock University. (2010). Code of conduct. Retrieved from: <https://brocku.ca/student-discipline/code-of-conduct>
- Buelow, G., & Range, L. M. (2001). No-suicide contracts among college students. *Death Studies, 25*, 583–592.
- Canadian Mental Health Association, Ontario. (2015). *Workplace mental health promotion: A how-to guide*. Retrieved from: <http://wmhp.cmhaontario.ca/workplace-mental-health-core-concepts-issues/what-is-mental-health-and-mental-illness>
- Carleton University. (2009). *Student mental health framework: A guide for supporting students in distress*. Retrieved from: <http://carleton.ca/student-support/wp-content/uploads/Carleton-University-Student-Mental-Health-Framework1.pdf>

- Centre for Addiction and Mental Health. (2010). *Suicide prevention and assessment handbook*. Retrieved from: http://www.camh.ca/en/hospital/health_information/aion/a_z_mental_health_and_addiction_information/suicide/documents/sp_handbook_final_feb_2011.pdf
- Cornell University. (2012). *CU mental health framework*. Retrieved from: <https://www.gannett.cornell.edu/cms/pdf/cmhw/upload/mental-health-framework.pdf>
- Durkheim, E. (1951). *Suicide: A study in sociology*. Toronto, Canada: Simon & Schuster (Original work published 1897)
- Dyer, S. (2008). Is there a duty?: Limiting college and university liability for student suicide. *Michigan Law Review*, *106*(7), 1379–1403.
- Egan, M., Rivera, S., Robillard, R., & Hanson, A. (1997). The ‘no-suicide contract’: Helpful or harmful? *Journal of Psychosocial Nurses Mental Health Service*, *3*, 31–32.
- Er-Chua, G. (2010). Remembering Jack Windeler. *Queen's University Journal*. Retrieved from: <http://www.queensjournal.ca/story/2010-04-01/news/remembering-jack/>
- Farrow, T. (2002). Owing their expertise: Why nurses use 'no suicide contracts' rather than their own assessments. *International Journal of Mental Health Nursing*, *11*(4), 214–219.
- Farrow, T., Simpson A., & Warren H. (2002). The effects of the use of ‘no-suicide contracts’ in community crisis situations: The experience of clinicians and consumers. *Brief Treatment Crisis Intervention*, *2*, 241–46

- Feskanich, D., Hastrup, J. L., Marshall, J. R., Colditz, G. A., Stampfer, M. J., Willett, W. C., & Kawachi, I. (2002). Stress and suicide in the nurses' health study. *Journal of Epidemiology & Community Health, 56*, 95–98.
- Giroux, H. (2014). *Neoliberalism, youth and social justice*. Retrieved from: <http://www.truth-out.org/opinion/item/22425-henry-giroux-neoliberalism-youth-and-social-justice>
- Gutheil, T. (1992). Suicide and suit: Liability after self-destruction. *Suicide and Clinical Practice*. Washington, DC: American Psychiatric Press, 147–67.
- Harmon, L. (2014, Feb. 15th). Teen suicide's tragic lure. *Globe*. Retrieved from: <https://www.bostonglobe.com/opinion/columns/2014/02/15/teen-suicide-looks-and-feels-contagious/HsWnICQySeYJYJyZNM5wJP/story.html>
- Help Yourself, Help Others. (2010, Sept 22). *Dr. Doug Jacobs discussing depression* [Video file]. Retrieved from <https://www.youtube.com/watch?v=8-b61X0xawg>
- Henning, G. (2007). Is in consortio cum parentibus the new in loco parentis? *NASPA Journal, 44*(3), 538–60.
- Higher Education Mental Health Alliance. (2008). *Postvention*. Retrieved from: http://hemha.org/postvention_guide.pdf
- Jasen, P. (2011). Student activism, mental health and English-Canadian universities in the 1960s. *Canadian Historical Review, 92*(3), 455–480.
- Kroll, J. (2007). No-suicide contracts as a suicide prevention strategy. *PsychiatricTimes*. Retrieved from: <http://www.psychiatrictimes.com/articles/no-suicide-contracts-suicide-prevention-strategy/page/0/2>
- Lee, P. (2011). The curious life of in loco parentis in American universities. *Higher*

Education in Review, 8, 65–90.

Lewis, L. M. (2007). No-harm contracts: A review of what we know. *Suicide & Life-*

Threatening Behavior, 37(1), 50–57. doi:10.1521/suli.2007.37.1.50

Luneau, K. (2011). The mental health crisis on-campus. *Maclean's Magazine*. Retrieved

from: <http://www.macleans.ca/education/uniandcollege/the-mental-health-crisis-on-campus/>

Mann, J. (2002). A Current Perspective of Suicide and Attempted Suicide. *Ann Intern*

Med. 136, 302–311. doi:10.7326/0003-4819-136-4-200202190-00010

Margrove, K., Gustowska, M., & Grove, L. (2014). Provision of support for

psychological distress by university staff and receptiveness to mental health training. *Journal of Further and Higher Education*, 38(1), 90–106

Melear, K. B. (2003). From in loco parentis to consumerism: A legal analysis of the

contractual relationship between institution and student. *NASPA Journal*, 40(4), 124–148.

Michaluk, D. (2008). Privacy law, students at risk and the safe campus. *University*

Manager, 2008(2), 64–65.

Olding, M., & Yip, A. (2014). *Policy approaches to post-secondary student mental*

health: A scan of current practice. OCAD U and Ryerson University Campus Mental Health Partnership Project.

Pavela, G. (2006). Should colleges withdraw students who threaten or attempt

suicide? *Journal of American College Health*, 54(6), 367–371.

Power, M. (1994). *The audit explosion*. London: Demos.

Queen's University. (2012). *Student mental health framework*. Retrieved from:

<http://www.queensu.ca/principal/sites/webpublish.queensu.ca.opvcwww/files/files/MHC-Resources-July-2015.pdf>

- Quinn, N., Wilson, A., MacIntyre, G., & Tinklin, T. (2009). 'People look at you differently': students' experience of mental health support within higher education. *British Journal of Guidance & Counselling*, *37*(4), 405–418
- Range, L. M., Campbell, C., Kovac, S. H., Marion-Jones, M., Aldridge, H., Kogos, S., & Crump, Y. (2002). No-suicide contracts: An overview and recommendations. *Death Studies*, *26*(1), 51–74.
- Reavley, N., & Jorm, A. F. (2010). Prevention and early intervention to improve mental health in higher education students: a review. *Early Intervention in Psychiatry*, *4*(2), 132–142.
- Rider, J. (2013). *York University approves mental health strategy for students, faculty and staff*. Toronto, Canada. York University.
- Roe, E. (1994). *Narrative policy analysis: Theory and practice*. Durham, NC, Duke University Press
- Rudd, M. D., Mandrusiak, M., & Joiner, T. E. Jr. (2006). The case against no-suicide contracts: The commitment to treatment statement as a practice alternative. *Journal of Clinical Psychology*, *62*(2), 243–251.
- Ryerson University. (2013). Ryerson Mental Health Advisory Committee—Appendix.
- Sarjoo, B. (2015). *COPE McMaster: A student mental health initiative*. Retrieved from: copex.weebly.com
- Schwartz, V. (2013). College mental health at the cutting edge? *Journal of College Student Psychotherapy*, *27*(2), 96–98.

- Shin et al. v. MIT et al. (2002) Memorandum of decision and order on defendants' motions for summary judgment. Retrieved from:
http://www.nacua.org/documents/Shin_v_MIT.pdf
- Stoehr, T. (2011). Letting the legislature decide: Why the court's use of in loco parentis ought to be praised, not condemned. *Brigham Young University Law Review*, 2011(5), 1695–1741.
- Stone, G. (2008). Mental health policy in higher education. *The Counseling Psychologist*, 36(3), 490–499.
- Sweeton, N., & Davis, J. (2004). *The evolution of in loco parentis*. Retrieved from:
http://www.sahe.colostate.edu/Journal_articles/Journal2003_2004vol13/Loco_Parentis.doc
- University of Toronto (2014). *Student mental health strategy and framework*. Retrieved from: <http://www.provost.utoronto.ca/Assets/Provost+Digital+Assets/REPORT+OF+THE+PROVOSTIAL+ADVISORY+COMMITTEE+ON+STUDENT+MENTAL+HEALTH.pdf>
- Wei, M. (2007). University policy and procedure responses to students at risk of suicide. *Student Scholarship Papers*. Retrieved from: http://digitalcommons.law.yale.edu/student_papers/35
- Weiss, A. (2001). The no-suicide contract: Possibilities and pitfalls. *American Journal of Psychotherapy*, 55(3), 414–419.
- White, B. (2007). Student rights: From in loco parentis to sine parentibus and back again? Understanding the Family Educational Rights and Privacy Act in higher education *Brigham Young University Education & Law Journal*, 2, 321–350.

Wynaden, D., Mcallister, M., Tohotoa, J., Omari, O., Heslop, K., Duggan, R., & Byrne, L. (2014). The silence of mental health issues within university environments: A quantitative study. *Archives of Psychiatric Nursing*, 28, 339–344.