

National Association
for Behavioral Intervention
and Threat Assessment

The Role of the **Counselor** on the **Behavioral Intervention Team**

Authored by:

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INTRODUCTION

"Do you have Showtime?" he asked.

The student was tall and skinny. He wore black athletic shorts and an ill-fitting, oversized t-shirt. His eyes were dark and intense. It was our first counseling session together.

"Um, sure," I replied.

"Have you watched Dexter?" he asked.

He had spent the first 20 minutes talking about difficulties he had with meeting girls on campus, falling behind in his college math course, and some difficulty getting along with his roommate. He seemed a little socially awkward, but I was still sorting out my diagnosis. I wasn't really expecting a question about my TV viewing habits. I guess we'll see where this goes.

"I have," I answered.

He smiled at me and seemed to perk up for the first time in the session. "Well, I feel like Dexter all the time. I keep thinking about what it would be like to come into class and just walk down the side of the room and cut people's throats with a blade. I think I could get three to four easily before someone stopped me. And while they were holding me down, I think about what it would be like to listen to the screams around me. How it would feel to have my face pressed against the floor while I watched the blood pool around me from those sheep that I have slaughtered." He finished and looked at me expectantly.

"Well, that certainly creates an image in my mind," I say.

"Right? Well, it isn't like I would ever do something like that. But I think about it all the time."

Clinical staff wrestle with scenarios like this, and must decide what they can or cannot share with police and law enforcement. Where do the rights of the client end and the rights to community protection start? Is there an assessment that would be helpful in determining the level of risk for the client in terms of hurting themselves or others? Should the counselor be in contact with the client's parents? Is there a duty to warn?

The challenge in this case is the sharing of concerning material when it does not reach the level of a duty to warn others. The information potentially sits within the silo of the counseling center, and the campus BIT is limited and shielded from the fact that this student is having fantasies of killing his classmates. It places the counselor in a difficult position that could prevent forward progression.

This whitepaper seeks to explore the clinical, ethical, and scope of practice issues related to the role of a mental health counselor on a Behavioral Intervention Team (BIT). We will look at three primary areas of concern: 1) information sharing between the counselor and the BIT, 2) who should facilitate a violence risk or threat assessment, and 3) whether a school provides mandated treatment.

CLARIFYING OUR TERMS

Following the Columbine shooting on April 20th, 1999, schools looked for ways to prevent this kind of tragedy from happening again. The FBI, Department of Education, and Secret Service authorized studies to provide a template to better understand this violence and give professionals an approach to prevent targeted violence.[1] This approach was further researched and expanded upon following the April 16th, 2007 Virginia Tech massacre.[2] The National Association for Behavioral Intervention and Threat Assessment (NABITA) was formed in 2007 to train and implement teams grounded in these recommendations and the long history of literature and research developed to prevent workplace violence such as the U.S. Post Office shootings that occurred in the 1980s. The most common names of these teams are BIT and CARE (Campus Assessment Response and Education). They will be used interchangeably throughout

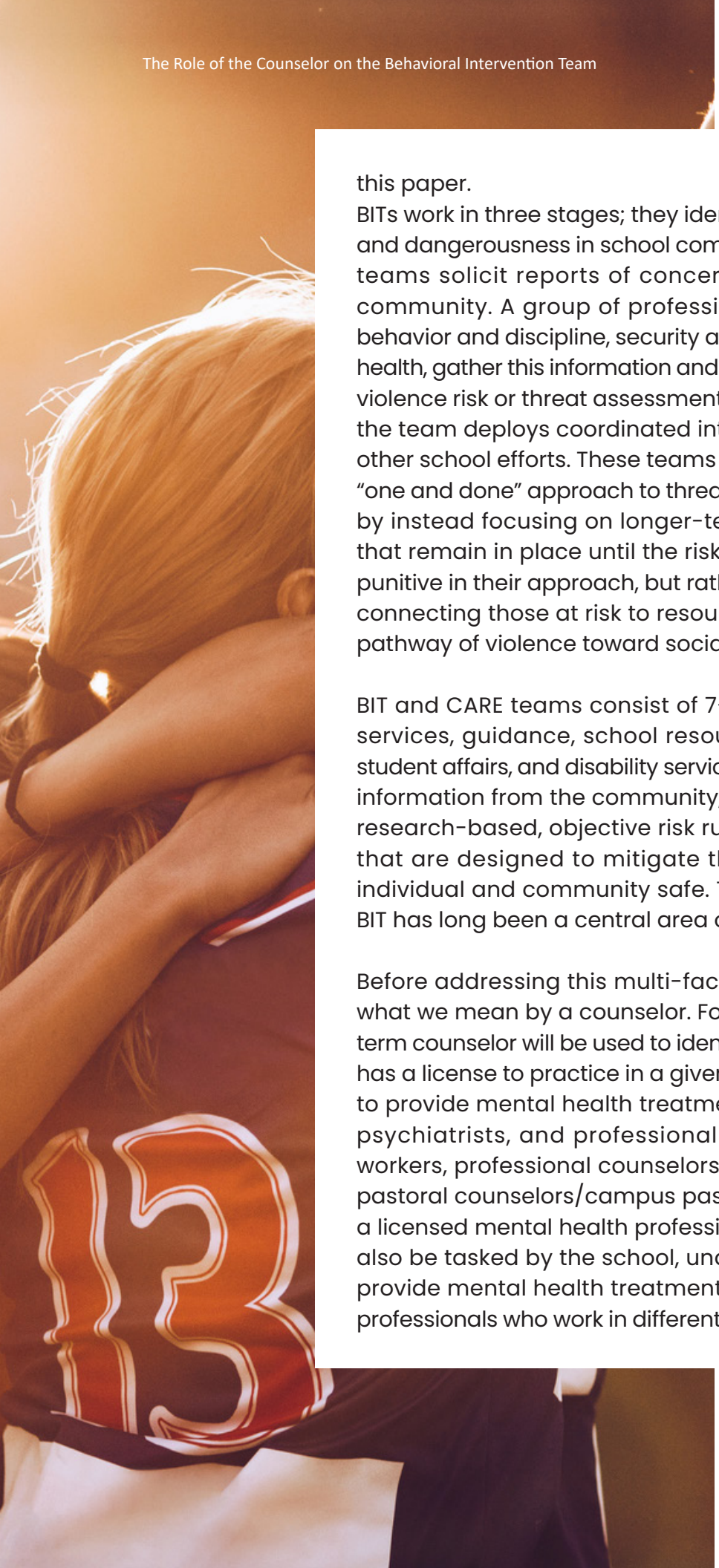
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[1] O'Toole, M. E. (2000). The School Shooter: A Threat Assessment Perspective. Quantico, VA: National Center for the Analysis of Violent Crime, Federal Bureau of Investigation.

Vossekuil, B., Reddy, M., Fein, R., Borum, R. & Modzeleski, M. (2000). USSS Safe School Initiative: An Interim Report on the Prevention of Targeted Violence in Schools. Washington, DC: US Secret Service, National Threat Assessment Center.

Vossekuil, B., Fein, R., Reddy, M., Borum, R. & Modzeleski, W. (2002). The Final Report and Findings of the Safe School Initiative: Implications for the Prevention of School Attacks in the United States. Retrieved on March 28, 2018 from https://www.secretservice.gov/data/protection/ntac/USSS_NTAC_Enhancing_School_Safety_Guide_7.11.18.pdf

[2] Virginia Tech Review Panel (2007). Mass Shootings at Virginia Tech: Report of the review panel presented to Gov-ernor Kaine, Commonwealth of Virginia. Richmond, VA: Governor's Office. Retrieved on March 28, 2018 from http://cdm16064.contentdm.oclc.org/cdm/ref/collection/p266901coll4/id/904



this paper.

BITs work in three stages; they identify, assess, and manage threat and dangerousness in school communities. These multidisciplinary teams solicit reports of concern from throughout the school community. A group of professionals with expertise in student behavior and discipline, security and law enforcement, and mental health, gather this information and apply an objective risk rubric and violence risk or threat assessment. Once the level of risk is defined, the team deploys coordinated interventions in collaboration with other school efforts. These teams offer something different from a "one and done" approach to threat and violence risk management by instead focusing on longer-term, collaborative interventions that remain in place until the risk has been reduced. BITs are not punitive in their approach, but rather preventative and focused on connecting those at risk to resources and moving them from the pathway of violence toward social integration.

BIT and CARE teams consist of 7-10 individuals from counseling services, guidance, school resource officers, law enforcement, student affairs, and disability services. They meet regularly to gather information from the community, process this information with a research-based, objective risk rubric, and develop interventions that are designed to mitigate the risk over time and keep the individual and community safe. The role of the counselor on the BIT has long been a central area of debate and discussion.

Before addressing this multi-faceted issue, it is helpful to clarify what we mean by a counselor. For the purposes of this paper, the term counselor will be used to identify a mental health clinician who has a license to practice in a given state and is hired by the school to provide mental health treatment. This includes psychologists, psychiatrists, and professional clinicians (e.g., clinical social workers, professional counselors, couples and family therapists, pastoral counselors/campus pastors, etc.). It is not enough to be a licensed mental health professional; rather, the employee must also be tasked by the school, under the scope of their license, to provide mental health treatment. This does not include licensed professionals who work in different capacities such as an instructor,

academic advisor, or in other administrative positions.
With respect to the sharing of client information, there are three levels of legally-conferred protection: privacy, confidentiality, and privilege. These protections can be created by statute, by courts, or by codes of professional ethics. This paper will refer to all three, using the specific understanding of those terms elaborated below.

Private information, in a higher education or school context, is information protected by the Family Educational Rights and Privacy Act (FERPA).[3] Private information can be shared internally when there is a legitimate educational interest, often referred to as a "need-to-know." Private information can be shared externally when an exception to FERPA is met, such as in cases of emergencies, dependency, and consent. FERPA protections extend only to records kept by college officials in a written or recorded medium. Information you learn of or know of from in-person interactions that is not made into a record is not protected by FERPA. A right to privacy has also been recognized by the courts outside of statute when there is public revelation of information in which an individual would have a reasonable expectation of privacy. A lawsuit, resulting financial damages, or loss of a professional license could occur from this kind of breach of privacy.

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A more protective layer of legal insulation is ***confidentiality.*** Confidentiality, whether conferred by statute or ethical codes, is the right of a client/patient to control how information they share with a professional is protected. Because the client has the right of confidentiality, the professional has a commensurate duty to maintain that confidentiality. Confidentiality is most often conferred in the relationship between therapist and client, or between a health care provider and patient. It can also be formed between advocates and victims, or in some states, between athletic trainers and athletes. Confidentiality is more protective than privacy, because there is no authorized "need-to-know" basis for breaching confidentiality. Instead, confidentiality is bounded by consent of the client or patient, by statute and exceptions to statutes, and by court-made doctrine, as in situations of a duty to warn (e.g., the Tarasoff v. Regents of University of California, 1976 case). Exceptions to confidentiality vary from state to state and can pertain to child abuse disclosures, HIV+ status, elder abuse, substance abuse, and other statutorily-created health or safety risks. Additionally, confidential records may be subpoenaed and/or may be accessible by an employer in

[3] FERPA — Family Educational Rights and Privacy Act. https://www2.ed.gov/policy/gen/guid/fpco/ferpa/index.html

the event of litigation. A confidential relationship is often demarcated by the creation of an informed consent that explains the protections afforded by the relationship. Finally, the most sacrosanct level of protection under the law is that of ***privilege.*** Privileged communication is secret and protected from disclosure which can only be pierced by a court order or waiver of the owner of the privilege. Privilege is rarely in play for the BIT, but would readily be found in the relationship of lawyer-client, spouses, journalist sources, and the confessional (though clergy may only have the protections of confidentiality in some jurisdictions). There are many nuances to what kind of communication, even within the relationships described as privileged, can actually be legally protected. There is also some bleed between categories. For example, courts recognize doctor-patient privilege in most jurisdictions, while statutes and ethical codes may also protect the doctor-patient relationship with confidentiality. Additionally, a medical records privacy act (the Health Insurance Portability and Accountability Act or HIPAA) also confers patient privacy.[4] Privilege and confidentiality protect the relation-ship, whereas HIPAA (and FERPA in a college environment) protect only the records of that relationship.

Sometimes, the terms privacy and confidentiality are intermingled, confusingly, as in the Department of Education's Office for Civil Rights regular reference to confidentiality of Title IX proceedings. Yet, there is no statutory mandate for confidentiality under Title IX, so the protection is more accurately framed as that of privacy. Worse, some states use different terms, and interchange confidentiality for privilege. Some states confer confidentiality, while others protect the same information as privileged. So, sometimes the terminology varies. But, where the distinction is strict, the most meaningful contrast is that ethics codes can only require confidentiality but cannot confer privilege. Only courts or statutes can confer privilege. The same information could thus be confidential by ethical mandate and privileged by state or federal law. In keeping with the theme of various uses for the same terminology, the term "counselor" is often used to describe those who are neither licensed, nor hired to practice mental health treatment by the school. In these cases, communication is governed by FERPA and allows for a broader sharing of information with the BIT than is permitted by those working within the scope of professional licensure. These might include non-clinical case managers, advisors, career counselors, and athletic support specialists. Client treatment records kept by licensed counselors who were hired to provide treatment are not protected by FERPA, as those records are already protected

[4] **HIPAA** — Health Insurance Portability and Accountability Act. https://www.hhs.gov/hipaa/index.html

[5] United States Department of Education (2016). Dear Colleague Letter to School Officials at Institutions of Higher Education. https://studentprivacy.ed.gov/sites/default/files/resource_document/file/DCL_Medical%20Records_Final%20Signed_dated_9-2.pdf

by state laws and/or ethical codes that include stricter confidentiality protections for treatment records.[5]

Non-treating counselors are quite helpful to students in need of personal guidance, academic support, life coaching, and assistance in navigating crisis events and life stresses. However, they often do not possess the training, clinical experience, and state support through licensing standards to provide mental health assessment and treatment required by state law. While non-treating counselors are helpful in a large range of services offered to students, they should not replace the role of licensed mental health clinical staff, and are not the focus of this paper. PreK-12 school counselors, and those with school counseling certificates, are also guided by FERPA and ethical standards in their profession, as opposed to the higher levels of confidentiality required of those with mental health licensure.

Medical staff are similarly governed by confidentiality concepts, namely state laws and HIPAA (if the center or provider is a HIPAA-covered entity). In most cases, HIPAA does not cover school counseling centers or health centers, unless they are engaged in electronic insurance billing. Many schools over-comply with perceived HIPAA requirements that really don't apply, so legal counsel should always be consulted. Even if insurance is billed electronically, HIPAA still won't apply if only students are treated. In that case, FERPA applies.

While the non-treating counselors are helpful in a large range of services offered to students, they should not replace the role of licensed mental health clinical staff.

Much of the discussion and advice offered in this paper applies to licensed doctors, nurses, nurse practitioners, psychiatric nurse practitioners, clinical nurse leaders, physician assistants, and those medical staff members who have a license and provide clinical care to students. Like clinical staff members who are licensed and hired by the school to provide mental health care, the discussion of their role on the BIT is very similar. The caveats are licensed medical staff who are in a teaching role, or who are supervising an internship or practicum experience, and are not hired by the school to provide direct clinical service to students. These staff members are not held to the same confidentiality standards of those in clinical roles, and only the lesser protections of privacy will pertain – and only to records. The same caveats exist for licensed mental health staff members who serve in supervisory and teaching roles, student affairs leader-ship (e.g., orientation, advising, or staff overseeing a student organization), or other non-clinical roles. As we often say, having a counseling degree or license in a drawer does not protect any-thing if you are not operating within the scope of that degree or license.

THE SCOPE OF THE QUESTION

A counselor is a critical, core member of the BIT. Nationally, close to 75 percent of cases discussed by BITs involve a psychological aspect.[6] A counselor's expertise and experience are critical to the team's dialogue and providing information about psychological concerns. Their knowledge often affords them the ability to be the lead in a case management plan as the team moves toward a multi-faceted intervention. Case management integrates health care, social services, and other sector services and supports for people with complex mental and physical health conditions. There are multiple components and variations of case management, depending on the context and client population. A counselor is perhaps best positioned to understand these considerations.

[6] Van Brunt, B. & Murphy, A. (2016). Summary and Analysis of 2016 NABITA Survey. Journal of Behavioral Intervention (4), 49-61.

When considering the role of the counselor on the BIT, there are three central issues in need of a more detailed discussion. These are:

1. **Information Sharing:** What information is the counselor able to share with the team about the students they are treating, given the expectation of confidentiality? Can they let the BIT know that a student is being/has been seen? How treatment is progressing? If the student missed an appointment? Does the student pose a danger to the community? Is there truth behind the concern that a counselor sharing information will lose licensure? Some counselors are even worried about learning about their own clients from the team. Should they be? Can informed consents and/or a release of information be used to give counselors more latitude to share confidential information with the team?

A counselor's expertise and experience are critical to the team's dialogue and providing information about psychological concerns.

2. **Conducting a Violence Risk and Threat Assessment:** Under what circumstances can a counselor con-duct a violence risk or threat assessment for the BIT? Does this have a negative impact on the counseling center? Is this a dual relationship? What training requirements are needed for a counselor to do this effectively? Where do assessment results live (counseling, conduct, or BIT file)? Can this assessment scope extend beyond students to include both students and staff?

3. **Providing Mandated Assessment or Treatment:** Should a counseling center provide mandated assessments and/or treatment to students identified by the BIT or is this better done by an off-campus provider? Is it ethical to provide mandated assessments and/or treatment? What information can be shared back to the referral or mandate source? What happens if the student only shows up for the first assessment appointment or stops attending treatment? Does providing mandated assessment and/or treatment have a larger impact on how other students view the counseling center? Is there a meaningful distinction between mandated assessment and treatment? Where do assessment results live (counseling, conduct, or BIT file)? Can this assessment scope extend beyond students to include both students and staff?

As we talk about each central issue in this paper, it is helpful to mention two forms that are often used by counseling centers and clinicians to navigate these challenges. A Release of Information (ROI) is a straightforward document that outlines information sharing between the therapist/counselor and other departments or providers. An example of this document can be found at the end of the paper. An Informed Consent document is given in addition to an ROI at the start of treatment to discuss the rights and responsibilities of the client and the clinician. A more detailed version of this document might include a paragraph that gives the clinician permission to share some limited information with the BIT when there is an imminent risk or concern. NABITA refers to this as the Expanded Informed Consent (EIC) document. Both of these documents and the adjoining processes are discussed in more detail later in this paper.



1. INFORMATION SHARING

In preface, it is important to note that counselors do not jeopardize confidentiality simply by having membership on a team or sitting in on a team meeting. In fact, learning about a client during a meeting is not unethical. Some counselors consider it vital and take information from the team back to the therapeutic relationship. This flow of information from the BIT to counseling is much less contentious and it allows the clinical staff to make addendums or notations in the charts for other clinical staff.

The converse is often the most complex issue for a majority of counselors serving on a BIT, with respect to the level of information to share with the team. Confidentiality is the bedrock of the counseling profession and is often the most complex issue for a majority of counselors as they try to understand their role on the BIT. There are three primary considerations around information-sharing for licensed mental health and health care professionals.

First, as noted above, most professionals working at institutions of higher education are governed by FERPA when it comes to information sharing. State and federal laws and ethics codes, rather than FERPA, control when the information is considered part of the treatment or patient re-cord. Licensed counselors and medical professionals, however, have licensure standards that supersede FERPA regulations, and as such, they are held to more stringent standards of confidentiality than everyone else on the BIT. Second, in most states, mental health laws protect the information regarding an individual's treatment as privileged or confidential. Third, the ethics codes of mental health professionals have standards protecting the confidentiality of clients' treatment records, but also go beyond the legal standard to include participation in treatment (so-called "contact confidentiality"). This is addressed in the American Counseling Association (ACA) ethics code (B.1.b. & B.1.c.) requiring counselors to respect the privacy and confidential information of prospective and current clients.[7]

Confidentiality is the bedrock of the counseling profession and is often the most complex issue for most counselors as they try to understand their role on the BIT.

[7] "2014 ACA Code of Ethics" (2014). American Counseling Association. https://www.counseling.org/resources/aca-code-of-ethics.pdf.

When exploring the issue of clinical staff sharing information with the BIT, it is helpful to understand the various legal and ethics standards involved so that the full spectrum of options can be considered. To this end, let us review five possible stances or roles a mental health clinician or health professional might take on a CARE team or BIT.

1. **"Disconnected and Silent":** The counselor will not attend the BIT meeting, consult on cases, or be involved in any way. Additionally, as the result of the limits of confidentiality, the counselor is not allowed to offer any information and therefore does not need to attend. They prefer to work in the confidential counseling center and view BIT work as outside their scope or role as a school employee. Alternatively, the counselor attends the BIT meeting, but refuses to participate actively. They ac-quiesce to attendance as it is a job requirement, but share nothing and take nothing away from the meeting. Needless to say, this is not the most well-regarded approach.

2. **"Consulting Counselor":** The counselor attends the meeting and speaks only in hypotheticals. They consult on cases and share information about general mental health topics (e.g., the risk of a suicidal student after an inpatient hospitalization, the best treatment approaches for eating disorders, or how Autism Spectrum Disorder responds to medication). They do not talk about active or past clients with the BIT or make diagnoses of students being evaluated by the BIT.



3. **"Sharing Helper":** The counselor makes use of an Expanded Informed Consent (EIC) that students can choose to sign, allowing counselors to have a wider latitude to share information with the BIT when the counselor determines it would be in the best interests of the client. Sometimes, the counselor will inform the client of the decision to share before doing so. The counselor shares information as outlined in the informed consent to support the work of the BIT and keep the community safe, while also valuing the confidential nature of the relationship with clients. The counselor may go so far as to offer the team hypotheses about concerning behaviors related to mental health or share informal assessments about student subjects of the BIT who are not clients.

4. **"Out on the Limb":** The counselor may or may not use the EIC, knowing that they may risk censure, but probably not loss of licensure. If they use the EIC, they use it more expansively and share information with the team that is not just in the best interest of the client, but also for protection of the community. This professional speaks in hypotheticals that are obviously not hypothetical, uses the "cannot confirm or deny" code, backchannels information, and is often willing to share confidential information about whether someone is known to the counseling center and is attentive to their treatment program. They may hear a roadmap for an intervention, and simply signal assent or objection without offering much more. Alternatively, they may help to frame a roadmap for a student without letting the team know the student is a client. They mean well, trying to ensure their client is safe, but also share with the BIT in a way beyond which a typical client would likely be comfortable (regardless of the presence of an EIC).

5. **"Unconditionally Open":** Some counselors may not give their client a choice about an EIC, or don't create an EIC with the client, or act in violation of the terms of an informed consent. The counselor shares everything they know about a client with the BIT, usually without the knowledge of their client, without any deference to their license or state laws. They see job security as paramount and comply with whatever is required by the BIT, or they imaginatively view the BIT as a "treatment team" within the bounds of their confidentiality. This counselor may earnestly believe that ethical rules were framed for private practitioners, not those in a campus context, where overzealous protection of information can get people killed. Or, the counselor may It would be reasonable to argue that the first and last stances are the least desirable from the team perspective. "Disconnected and Silent," the first stance, is extreme, engenders problems with job compliance, and undermines the role of the BIT. If the school needs a counselor on the BIT, the counselor has some duty to comply. Likewise, showing up to the meeting and doing nothing is equally problematic in terms of work performance, team effectiveness, and the relationship with the BIT. "Unconditionally Open," the fifth stance, could violate state law and/or ethical practice guidelines for licensed clinicians, or at least subject the clinician to an ethics inquiry.

This leaves conversation associated with the question, "What can a counselor share with the BIT?" centered around three positions: 1) the "Consulting Counselor" (second stance), which allows the counselor to share hypothetical and consultative information, 2) the "Sharing Helper" (third stance), which creates a special condition that allows the counselor to practice within their scope of licensure, and 3) "Out on a Limb" (fourth stance), which may be highly desirable to the team, but too risky for many counselors or health providers. As a result of the proliferation of BITs at schools, we would argue that it is now the standard of care for counselors who have a responsibility to sit on the BIT to minimally adopt the Consulting Counselor stance. This allows the team to benefit from the counselor's expertise and allows them to speak broadly about mental health issues, using their experience to better inform the team without running afoul of their client's expectations, ethical boundaries, and/or state law.

An example of a Consulting Counselor would be one who says, "Typically, students who [specific information about the client's situation] do [this]." This allows the clinician to speak hypothetically about students, within the context of a specific case. It could offer some specific guidance or insight about the student's situation that is couched in a broader context. Counselors adhering to this approach can even share broad comments about mental health behavior and diagnoses throughout the meeting, rather than just when specific clients are mentioned.

The Sharing Helper strikes a balance between the obligations of the counselor to maintain confidentiality and the team's need for information. The simplest and most streamlined way to achieve this is through asking the student in question to sign a ***Release of Information (ROI)*** form. This release of information allows the counselor to share attendance information, treatment, and clinical details within the client's expressed and detailed permission. This can take the form of a full release of all information or a limited release of information to share things like attendance and an overall statement of progress.

One challenge associated with the "Sharing Helper" stance is the timeliness of information needed by the BIT. Often, BIT members want to know whether a student has followed up with the counseling center in order to decide the next best course of action. If the Expanded Informed Consent has not already been signed, this information will not be available in real-time. One way to address this challenge is by managing how students "arrive" on your BIT list. For instance, the counseling center could give copies of an *ROI* to the Dean of Students, CARE manager, counseling center, etc. for students who come into contact with their office, anticipating they may be called upon to give/receive information about a student. Multiple points of entry (asking for full or limited information) would make it less likely that a release would need to be signed on the spot.

A potential complication occurs when a faculty member refers a student to a BIT via a web-based anonymous "care report" that outlines the problematic or concerning behaviors. The members of the BIT have no way of knowing if that student has already accessed the services of the counseling center. Sending a student an *ROI* from the BIT, with or without explanation, might engender confusion or promote feelings that "big brother" is watching, and create greater alienation at a time when help is needed the most. Caution should be taken to ensure the department obtaining the release fully explains the document in a meaningful way and does not pressure or coerce the student into signing, but rather underscores the limitations and right of refusal. An example of this document is provided at the end of this paper.

Another way to approach this challenge is by providing all students who enter treatment the opportunity to sign an ***Expanded Informed Consent (EIC)*** form. The use of this form is a point of contention in the field and, as such, a pro/con list is provided in Table 1.1. More narrowly, an *EIC* could be used selectively with only those clients the counselor anticipates might need to come to the attention of the BIT, or could be offered later in the treatment process, if the student's condition is not stabilizing. This stance is challenging, given that it may be hard for the counseling staff to assess this prior to the initial intake.

Most informed consent documents cover issues of cost of treatment, session limits, cancellation policies, what to do in case of an after-hours emergency, mandatory reporting laws related to minor and elder abuse, and how records are kept.

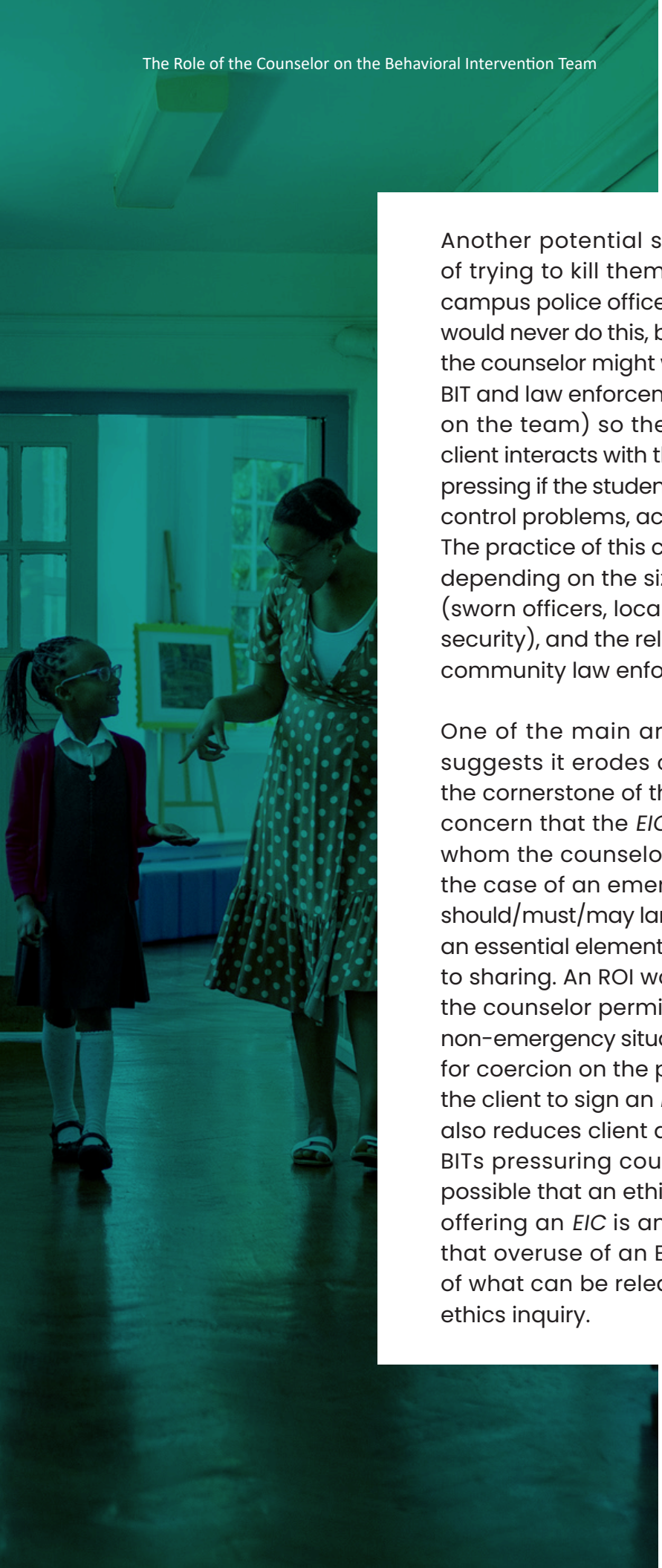
From a pro-*EIC* position, this form allows the student's counselor to share information with the BIT to keep the client and/or others safe, even though the situation has not met the imminent "duty to warn" threshold. That said, it is not recommended to have all students sign such a release upon admission to the school, as true consent can only be given at the onset of treatment. An informed consent document explains the nature of the counseling relationship and spells out the rights and responsibilities of both parties in the relationship (clinical staff and client). Most informed consent documents cover is-sues of cost of treatment, session limits, cancellation policies, what to do in case of an after-hours emergency, mandatory reporting laws related to minor and elder abuse, and how records are kept.

The expanded consent supports the student's journey through counseling and can mitigate issues that may arise in the greater community, or that could impact student success. It provides the student with the knowledge there will be a broader safety net should they spiral out of control. It allows for a "may share" condition for the clinical staff rather than an obligation; meaning they can share information if that makes sense in the clinical scenario, but they are not obligated to. It would also be advisable to give the consent a date of renewal that allows for a new consent to be obtained each year, providing the student a chance to be reminded of the process.

Example language of an *Expanded Informed Consent (EIC)* document:

> *Counseling and Psychological Services (CaPS) will release information from counseling sessions to outside parties at the request of the client. Records are confidential and will not leave CaPS unless there is an emergency situation. CaPS will not answer questions about any client from parents, family, friends, significant others, professors, employers, or anyone else outside of CaPS staff without permission from you. The only exceptions to this policy are for limited emergencies outlined below.*
>
> *Parents and guardians are not contacted unless we have permission from the client or if there is a credible risk to the safety of the client or another member of the campus community (i.e., suicide risk/attempt, emergency room evaluation, and/or a threat to themselves or others), and CaPS has a reasonable belief that involving parents or guardians will aid the situation. If there is a risk, information may only be shared that aids in obtaining ongoing care and ensuring safety. In rare cases where there is a risk to the student or the community, CaPS reserves the right to notify the Behavioral Intervention Team, especially if the student is an active danger to themselves and/or to others. In case of such a release, the information shared will be limited to only as much as is necessary to mitigate the risk. Where possible and practical, the client will be informed of such a release in advance.*

An *EIC* may be put into use in response to the scenario used to begin this paper, where a client talks about being like Dexter and has recurrent fantasies about going to class and stabbing all the other students with his knife. He talks about this desire for 20 minutes with his counselor and alludes to a journal he keeps where he scripts what the attack would look like. He then assures the counselor that he would never do this, but just thinks about it a lot. This would be an instance where the counselor may wish to share information with the BIT to ascertain if the student is having problems in other areas around campus. Alternatively, the counselor could share a general concern and seek input from the team, allowing them to know the student is on the radar. No confidential information may be shared other than "I know this person." While the BIT might not take any action, the information sharing may help initiate discussions about the client's behaviors in other aspects of his student experience or round out information that has been previously brought to the team's attention.



Another potential scenario could be a client who talks of trying to kill themselves by grabbing the gun out of a campus police officer's holster. The student later says they would never do this, but just has these thoughts. In this case, the counselor might want to share this information with the BIT and law enforcement (if a representative is not already on the team) so the officers are aware in the event this client interacts with them. This sharing would be even more pressing if the student has a history of depression, impulsive control problems, access to weapons, or suicide attempts. The practice of this concept is certainly more complicated depending on the size of the institution, the type of police (sworn officers, local department, security, private armed security), and the relationship between the school and the community law enforcement agency.

One of the main arguments against the use of an *EIC* suggests it erodes client autonomy and confidentiality, the cornerstone of the therapeutic relationship. There is a concern that the *EIC* is used to make the client aware of whom the counselor should/must/may legally inform in the case of an emergency or duty to warn situation. This should/must/may language shifts from state to state and is an essential element for clinical staff to understand related to sharing. An ROI would be the sole document that gives the counselor permission to share specific information in non-emergency situations. Another concern is the potential for coercion on the part of the licensed provider requiring the client to sign an *EIC* as a condition of treatment, which also reduces client autonomy. There is another issue with BITs pressuring counselors to use *EICs*, as well. It is also possible that an ethics board might take the position that offering an *EIC* is an ethical breach by the counselor, or that overuse of an EIC, or an overly broad interpretation of what can be released under an *EIC*, would also risk an ethics inquiry.

While there may be arguments that medical settings use a single release to share information with the entire department, a BIT is a closed system of professionals who also have an obligation to maintain privacy. Records of the BIT are governed by FERPA, and those records are only permeable to those who have a legitimate educational interest, internally, or those who meet a FERPA exception, externally. Clinical treatment information shared with a BIT, with or without the *EIC,* becomes part of the educational record and protected by FERPA. The information is effectively removed from the protection of state mental health laws, and moving forward the BIT can use that information at its discretion without the counselor's input. While some may argue it is the counseling center's right to set the limits of confidentiality for the clients they serve, others would suggest this is an overreach and that boundaries of confidentiality should be limited to those mandated by state law.

Clinical staff have long struggled with the ethics and ambiguity of when to share information in the interest of protecting the client and the community. Some argue the aspirational use of an ROI is the most appropriate path, as staff already have disclosure laws in place that allow for sharing in emergency situations to create safety. Clinical staff would see the *EIC* as chipping away at confidentiality by expanding minimal disclosure, threatening autonomy, and diluting transparency. Trust between the client and therapist is paramount in the relationship, and the *EIC* shakes the foundation of the therapeutic alliance by starting the relationship with a heightened potential of a breach of trust. This could also limit what a student will share in therapy, making the treatment less effective.

Counselors, as with all members of the BIT, should have access to the BIT recordkeeping system. Similar to information sharing and interactions in a BIT meeting, counselors need to determine the appropriate level of recordkeeping in the BIT database. Information included in BIT records is protected by FERPA. Thus, if privileged clinical information is shared with the BIT, it is no longer protected by privilege. To this end, counselors should be cautious of the level of detail of the notes they record for the BIT.

Table 1.1 *The Expanded Informed Consent*

Reasons to use an Expanded Informed Consent (EIC)	Reasons not to use an Expanded Informed Consent (EIC)
Allows clinical staff the choice to share subimminent risk with the BIT, to allow for collaborative intervention.	May erode the privacy of information sharing between client and therapist, a cornerstone of the relationship. Might cause the client to with-hold their most candid thoughts or fears.
It is a common practice in other medical set-tings where a single release creates the ability to share with a multi-disciplinary staff (e.g., hospital E.R. or residential care).	Schools differ greatly from medical settings and the EIC could cause a slippery slope between client and therapist relationship that erodes the privacy of the relationship.
It is reasonable for the clinical staff to set some limitations on confidentiality and services such as: abuse to an elder or child, insurance billing, session limits, scope of practices, psychological testing, and information sharing with the BIT.	Lack of clarity and understanding about what it means to sign the "informed consent" could lead the student to sign on for something they do not completely agree with. Student could also feel coerced to sign.
Offers legal protection for clinical staff who may otherwise have to hold onto subclinical threatening information (e.g., a student who has fantasies about killing others, but no plan to act upon this).	Even when the EIC is limited to a single person in student affairs, it will likely be shared with the entire team (re-disclosure concern). Once information leaves the confidentiality of the clinical relationship, it may become protected only by FERPA, a weaker standard of disclosure.
Gives the counseling center an opportunity to be seen as solution-focused and working toward a common, collaborative goal with student affairs.	Could create a stigma around the counseling center sharing information that may lead to disciplinary responses, and thus create a hesitation for others seeking services.

Ways to use an *Expanded Informed Consent (EIC)* document well:

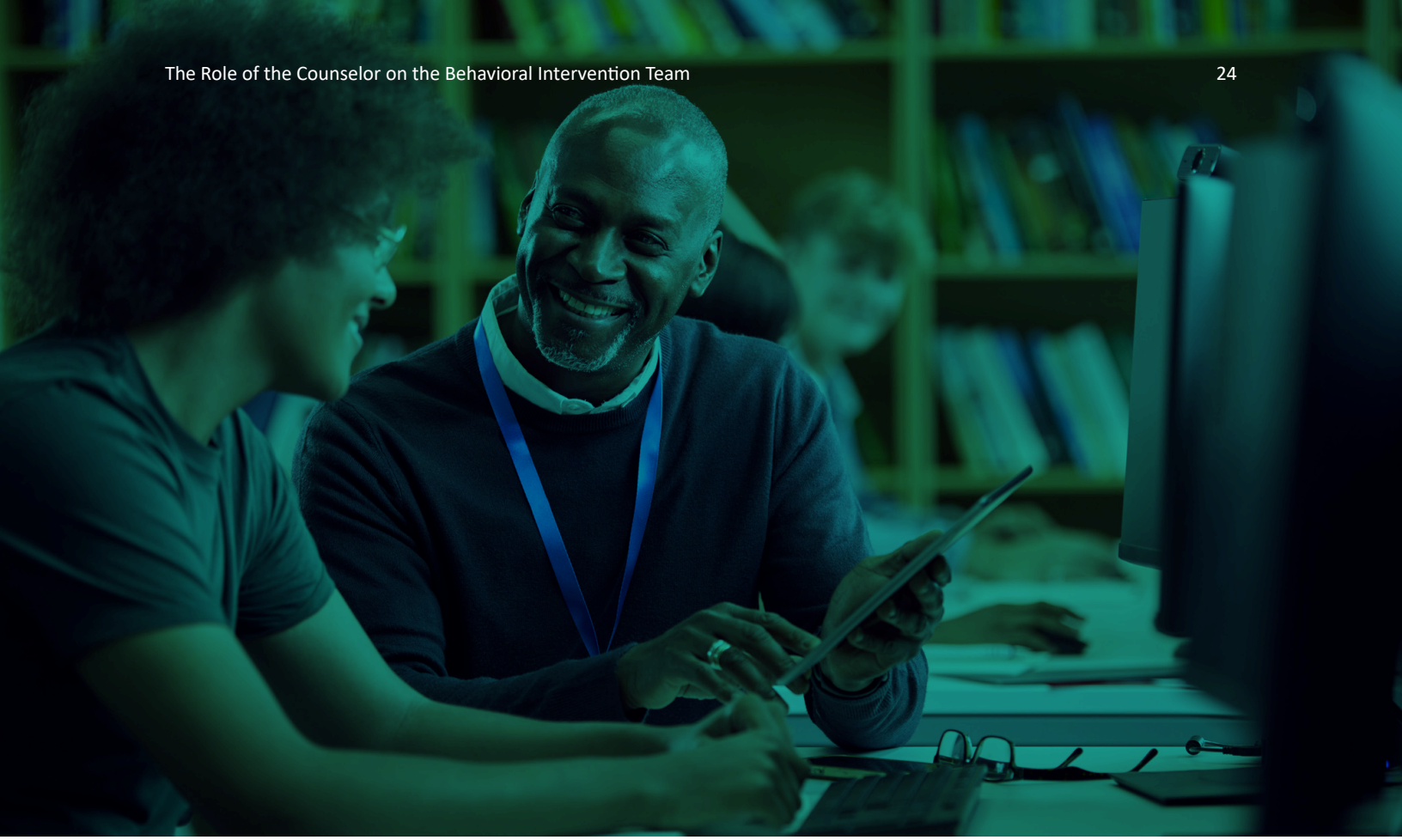
- Empower offices such as student conduct, BIT, disability services, and the Dean of Students office to discuss the limited need for *ROI* and *EIC* documents.
- Clearly explain the *EIC* so the client understands what the expectations are around information sharing, and review expectations as needed throughout treatment.
- Define the role and purpose of the BIT and how the multidisciplinary team approach can be helpful to the client.

- Consider limiting release to a specific person, position, or department, rather than the entire CARE team or BIT. This could create a challenge if the person is out sick or away and would necessitate the identification of an alternate designee that the student understands would serve in this role during these times.
- Allow a client to "opt out" when it comes to this section of the *EIC*. The *EIC* can be amended if the student is particularly concerned about this provision.
- Have a timeframe associated with the *EIC* so that it must be renewed and is not durable. It is reasonable to ask a student to sign a new *EIC* at the start of each academic year.

Instead of using an *Expanded Informed Consent (EIC)* document for all clients, the clinical staff could:

- Speak in hypotheticals all the time for all cases, which allows the clinician to give guiding insight without specifics. By speaking in hypotheticals for all cases, the counselor avoids the risk of only sharing information when the student is a client and essentially confirming services without explicitly saying so.
- Use the *EIC* document only for higher-risk cases identified during the intake or those involving referrals from inpatient units or other higher-risk scenarios (e.g., transfer from another school with chronic, high-risk psychological history). Caution should be applied to ensure the rubric is created and applied in a manner that does not discriminate or inaccurately imply the presence of a diagnosis equated with a higher risk for violence.
- Automatically request an *ROI* to the BIT for all higher-risk cases that come in on intake or those involving referrals from inpatient units or other higher-risk scenarios (such as a transfer from another school with a chronic, high-risk psychological history).
- Use an *ROI* when there is a need to share information with a third party.

There is an inherent tension between the rights of the client and the rights of the community to be kept safe when a client shares a risk. This tension never dissipates, and a good counselor learns how to practice with this tension, doing their best to keep their client's information privileged and the trust of the relationship paramount, while keeping an eye toward the greater community and working collaboratively with the BIT. A frequent request of teams is to facilitate assessments to help the BIT make better informed intervention decisions. In the next section, we discuss the role of the counselor in the performance of a violence risk and threat assessment.



2. VIOLENCE RISK AND THREAT ASSESSMENT

The BIT often requests that clinical staff provide an assessment for a student, faculty, or staff member who makes a threat or poses a concern of violence. A threat assessment seeks to assess the risk of violence following a threat. A violence risk assessment is a broader term used to assess any potential violence or danger, regardless of the presence of a vague, conditional, or direct threat. Violence risk and threat assessments are not to be confused with suicide risk assessments, which are performed much more commonly by counseling center staff and present much less of a bone of contention than assessments that look at harm to others. Several common suicide assessments include Counseling Center Assessment of Psychological Symptoms (CCAPS),[8] the Beck Depression Inventory (BDI-2),[9] Beck Suicide Scale (BSS),[9] or the Beck Hopelessness Scale (BHS).[9]

The violence risk and threat assessment process is intended to prevent future acts of violence, rather than respond to an existing act by looking into who might have committed it (which is the function of profiling).

[8] https://ccmh-s.psu.edu/ccaps-web/

[9] https://beckinstitute.org/get-informed/tools-and-resources/professionals/patient-assessment-tools/

The misconception that a violence risk or threat assessment is a means to profile an individual must be put to rest. The violence risk and threat assessment process is intended to prevent future acts of violence, rather than respond to an existing act by looking into who might have committed it (which is the function of profiling). The BIT should cultivate a violence risk assessment capacity within the team. NABITA recommends training the entire team and then selecting 3-4 members who can perform a violence risk assessment as the need arises. By doing this, several members of the team are able to conduct the assessment and the team can nominate who might be best to conduct a particular assessment depending on the specific nature of the case or concerns. This approach works well because these assessments are not psycho-logical in nature, but rather are focused on violence risk and threat assessment risk fac-tors.[10] Examples of these measures include: The NABITA Threat Assessment Tool,[11] Structured Interview for Violence Risk Assessment (SIVRA-35), Violence Risk Assessment of the Written Word (VRAW2), Extremist Risk Intervention Scale (ERIS), Workplace Assessment of Violence Risk (WAVR-21), Historical Clinical Risk Management (HCR-20), and MOSAIC.[11,12,13,14]

Ideally, a violence risk assessment is conducted by a trained and experienced counselor, case manager, law enforcement officer, director of student conduct, or other administrator. Counseling staff should not be the only individuals able to perform a risk assessment. However, counselors do possess helpful skills related to intake, rapport building, conducting a defensive interview, and suicide assessment, that may prove useful. A central issue is how well the person performing the assessment is trained in interviewing, rapport building, determining truthfulness, and overcoming impression management. Additionally, there should be steps put in place to address cases with more complex mental health issues that may complicate the assessment. There would be a higher chance of a Dean of Students or conduct officer overlooking these is-sues when compared to a mental health clinician.

At schools where the violence risk or threat assessment is outsourced to an off-campus provider, the school should ensure the assessment is not merely a psychological assessment focused on diagnosis, inpatient admission, or developing a mental health treatment plan or medication referral. The assessment should use research

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[10] National Threat Assessment Center. (2018). Enhancing school safety using a threat assessment model: An operational guide for preventing targeted school violence. U.S. Secret Service, Department of Homeland Security.

Van Brunt, B. (2015). Harm to Others: The Assessment and Treatment of Dangerousness. Alexandria, VA: The American Counseling Association.

[11] The National Association for Behavioral Intervention and Threat Assessment. https://NABITA.org

[12] The WAV-R 21 Threat Assessment App. http://www.wavr21.com

[13] The Historical Clinical Risk Management-20. http://hcr-20.com

[14] MOSAIC Threat Assessment Systems. https://www.mosaicmethod.com

and methodology developed by the workplace violence field, law enforcement, and criminal assessment procedures to ascertain the risk of violence or danger to others — a determination that goes beyond establishing a mental health diagnosis.

The main concerns regarding a college counseling center using a violence risk assessment are: 1) they are not something clinical staff are trained to perform, 2) it creates a dual relation-ship, or 3) it conflicts with the counseling center mission, scope of practice, or ethical codes. Each concern is addressed below.

1. **Training:** Any staff members, including clinical counseling staff, conducting a violence risk or threat assessment must be trained in these assessment techniques and have experience conducting these assessments.15 They should draw from existing research in violence risk and threat assessment. They should have the ability to build rapport, assess truthfulness and attempts at impression management, and be skilled at developing a simple report that includes clear and re-search-supported recommendations. Violence risk and threat assessments are not limited to clinical staff. A well-balanced BIT should have multiple options to choose from when selecting a team member to conduct an assessment.

2. **Dual Relationship:** It is essential that, prior to the violence risk or threat assessment, the staff clarify any conflicting relationships which could interfere with the threat assessment. This is important for law enforcement officers who have Miranda requirements, conduct officers who may have to act on code of conduct violations, and clinical staff who may have pre-existing clinical treatment relationships with the student. Clinical staff should not conduct a threat or violence risk assessment on their own previous or existing client. Clinical staff should use a specifically designed informed consent document that clarifies, at minimum: 1) the process, 2) who receives the in-formation, 3) how this differs from therapy, 4) limits of confidentiality, and 5) any costs or testing that may be required. This is different than the *EIC* for BIT information sharing described earlier in this whitepaper. Once these clarifications are made, clinical staff can perform this additional and separate duty for the school in the same way they may teach, work with student orientation events, or advise a club or organization. A school employee conducting an assessment concerning a student's violence risk toward the school community could pose a conflict of interest. Some argue there may be pressure to have the assessment results support the school's position of removal. However, the alternative creates a similar conflict. When the school pays for an assessment from an off-campus provider, a conflict of interest is also possible. If the school does not agree with the results, the assessment professional may feel obligated to provide results in line with what the school wants in order to keep their contract or retainer. Dual relationships, especially those that create bias, cannot always be eliminated, but can be mitigated through transparency and the application of a fair process.

3. **Beyond the Scope:** It is reasonable for a counseling center to define a violence risk or threat assessment as beyond the scope of its practice or mission. The treatment recommendations resulting from the assessment may also be beyond the scope of a school's counseling center. Each school is unique and has limitations within its resources, budget, and staffing levels.

To maximize the effectiveness of a violence risk assessment, consider the following elements:

- The BIT should clearly outline the nature of the requested assessment. Is this a suicide risk assessment or a violence risk assessment?
- Be cautious about expecting an assessment to predict future violence. The assessment is more likely to contain information about potentially exacerbating factors which could lead to an increase in problematic or dangerous behaviors. It may also identify recommended supports and stabilizing schemes to help mitigate the risk of future dangerous or risky behavior.
- We should address how to communicate the requirement to the student through con-duct and whether or not the assessment is voluntary or mandated.
- What materials should be provided for the assessment?
- When conducting a staff or faculty evaluation, how will Human Resources be included in the sharing of results? What adjustments should be made given privacy and the location of the assessment? What steps should be taken to limit BIT awareness of the results or address potential conflicts when BIT members are connected to the staff or faculty in question?
- Request a written report that succinctly answers the risk assessment referral questions in clear and practical language. For example, *"The following are some of the potential exacerbating factors we should be aware of that could lead to an increase in dangerous or problematic behavior…the following resources, treatment, and stabilizing schemes should be put into place to help mitigate the risk of future dangerous or risky behavior."*
- Where do assessment results live?

Clinical staff are ideally suited to conduct these assessments given their ability to build rapport, write reports, assess truthfulness and impression management, and conduct a structured interview. Conducting a threat assessment is not an ethical violation when the counselor is appropriately trained, and the student or staff member has consented to the assessment process. Additionally, mandated assessments and treatment are very common in other contexts. For example, the court system mandates assessment for alcohol and drugs or sex offenses, and Human Resources may mandate assessment as part of employment applications and/or fit for duty determination.

Conducting a threat assessment is not an ethical violation when the counselor is appropriately trained, and the student or staff member has consented to the assessment process.

In terms of the assessment results, the school should consider whether the records will be kept within the counseling center record system (such as Titanium), in the BIT record systems (such as Maxient), or within the Human Resources files or the record keeping system of an off-campus provider for faculty and staff assessments. Where the records are kept is related to the nature of the results, who has access, and privacy, confidentiality and/or privilege of the records. Ideally, the full assessment results and testing data would be kept within the counseling center or an off-campus provider's recordkeeping system. A summary of the results would be shared with the BIT to be kept in the BIT record system.

In the following section, we will review another area where counseling staff struggle to determine how to work collaboratively with the BIT while maintaining counseling standards. Mandated treatment is often requested by a BIT that is interested in seeing a change in behavior by a student.

3. MANDATED ASSESSMENT AND TREATMENT

There has long been a debate in the field about the viability and ethics behind mandated assessment and treatment. Mandated assessments focus on determining risk, diagnoses, treatment plans, and assessing the current risk for violence. Mandated treatment seeks to change existing behaviors rather than assessing what behaviors are present. There is a bit of divide in the counseling field between those who see the utility of mandated assessments and treatment and those who see this as beyond the scope of what a college counseling center should provide.

In terms of assessment, data is limited on how many centers offer assessment for suicide, harm to others, or violence risk/threat. The most recent data comes from the 2014-2015 American College Counseling Association Community College Survey and the 2006-2009 Association of University and College Counseling Center Directors (AUCCCD) survey.[16] The data shows over half of centers (53%-78%) offered this service. AUCCCD last asked this question around 2008-2009, so further data would be useful to assess current trends.

In terms of mandated treatment, the "against" side argues for client autonomy and free will when entering treatment. Clients who are committed to change and willing to seek treatment are often seen as prerequisites for treatment. They argue that mandating treatment chips away at this cornerstone of the therapeutic relationship and causes a chilling effect for others who may be more hesitant to seek care. They argue centers are already at capacity with those seeking voluntary treatment, and providing this service is a violation of the International Association of Counseling Services (IACS) standards, the accrediting body for counseling centers. In a statement released following the Virginia Tech massacre, they write: "While AUCCCD is opposed to ongoing man-dated treatment, we recognize the value of mandated assessment when it is precipitated by clear problematic behavior and violation of college and university conduct codes."[17]

For those who see mandated treatment as an important part of the counseling center mission, they argue it can be a useful tool in helping students to address concerning behaviors on campus and remain within the expectations of the school code of conduct. This mandated treatment seeks to change behavior by increasing impulse control, improving frustration tolerance, and teaching better anger-management skills. The treatment can be short-term, based on behaviors and not diagnoses, and has a clear place in the overall services offered by a college counseling center.

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[16] Barr, V., Rando, R., Krylowicz, B, Winfield, E. (2010). The Association for University and College Counseling Center Directors Annual Survey. http://files.cmcglobal.com/directors_survey_2009_nm.pdf

American College Counseling Association (2014). Community Colleges: Meeting the Needs of Today's Students in a Changing and Complex World. www.collegecounseling.org/resources/Documents/ACCA-Community-College-Survey-2014-15-Final.pdf

[17] Association for University and College Counseling Center Directors (AUCCCD) Statement on Parental Notification, Mandatory Counsel-ing and Counseling Center Director Status (2007). http://files.cmcglobal.com/Statement_Parental_Notification_Mandatory_Counseling.pdf

As previously mentioned, mandated treatment may be something beyond the scope or mission of an individual counseling center; however, it should not be considered an unethical action given the sheer number of licensed clinical staff that engage in this work and the supporting literature on mandated treatment efficacy.[18] There are many approaches to treatment that work with defensive, unwilling, or difficult clients. These include Gestalt therapy, reality therapy, trans theoretical change theory, and motivational interviewing. Mandated treatment is typically ordered by a court to help mitigate future behaviors and further penalty. This is an objective of a BIT as well. Some schools even provide support to students ordered by the courts to receive counseling support.

Data are equally limited on how many centers perform mandated treatment, with the most re-cent coming again from the 2014-2015 American College Counseling Association Community College Survey and the 2006-2009 Association of University and College Counseling Center Di-rectors survey.[19] The data shows that about one-third of centers (25%-38%) offered this service. AUCCCD last asked this question around 2008-2009, so further data would be useful to assess current trends.

Mandated treatment is typically ordered by a court to help mitigate future behaviors and further penalty.

To offer the issue fair treatment in the wake of limited data, it is reasonable to consider that mandated treatment may shift the basic tenet of the non-offender work on campus. Mandated treatment provided elsewhere is court-ordered or legally-compelled, so there is a penalty when those mandated don't comply. That may be more contextually appropriate to criminal matters, however there is no reason that a college's conduct process can't provide the same leverage outside a criminal context. Another concern is that mandated treatment can potentially shift how students see the center resources, as it might with mandated assessments and psycho-educational groups. There could be a chilling effect on students seeking treatment if they knew this treatment could be mandated. There is no clear research

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[18] Cohen, V. (2007). Keeping Students Alive: Mandating On-Campus Counseling Saves Suicidal College Students' Lives and Limits Liability, 75 Fordham L. Rev. 3081-3135.

Snyder, C. & Anderson, S. (2009). An Examination of Mandated Versus Voluntary Referral as a Determinant of Clinical Out-come. Journal of Marital and Family Therapy, 35, 278-292.

[19] Association for University and College Counseling Center Directors (AUCCCD) Statement on Parental Notification, Manda-tory Counseling and Counseling Center Director Status (2007). http://files.cmcglobal.com/Statement_Parental_Notification_Mandatory_Counseling.pdf

American College Counseling Association (2014). Community Colleges: Meeting the Needs of Today's Students in a Changing and Complex World. www.collegecounseling.org/resources/Documents/ACCA-Community-College-Survey-2014-15-Final.pdf

on this assumption, but it bears mentioning and should be an area of future exploration. One area of agreement between both sides of the debate is the importance of looking at how the counseling center is structured and how the BIT requests for mandates fit into its mission and staffing.

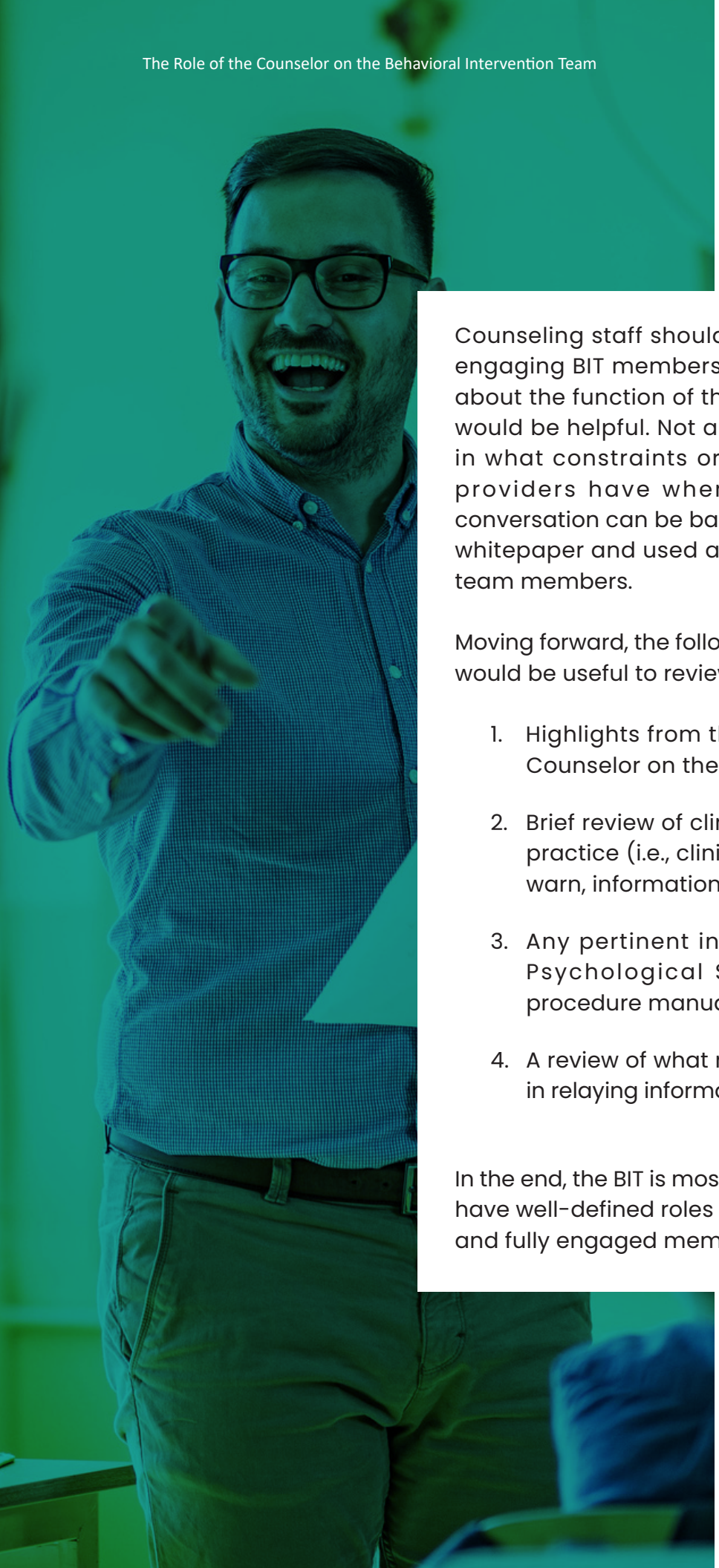
For clinical staff considering developing a mandated therapy model, consider the following list to help maximize efficiency and avoid potential pitfalls:

- Care should be limited to behaviors, not diagnoses. It would be unreasonable to expect a student to no longer be depressed, no longer have a personality disorder, or struggle with schizophrenia. It would be reasonable to help them improve their frustration tolerance, impulse control, and appropriately access help when in crisis.
- Care should be short-term and solution-focused. It would be unreasonable to require a student to be in mandated treatment for the entire time they are at school or even for several years. The better approach would be to require five to six sessions and then review progress as part of the case management process.
- Care can also come in the form of recommended counseling, as a conduct sanction, to identify the potential need for treatment or require an assessment and the completion of treatment recommendations.
- Students should not be required to be medication-compliant. It would be more reason-able to require a medication evaluation and encourage them to follow through with recommendations, rather than creating a potential special relationship where the school or staff now have to assess or monitor medication compliance.
- Have a plan in place to notify the referral source if the student required to complete the assessment or treatment does not show up for appointments. This can be included in the initial informed consent or release of information document or through a conversation with the referring source that they should assume the student has stopped complying if the counseling center is no longer able to communicate.

FINAL THOUGHTS

Counseling staff are critical to the successful development, application, and intervention approaches of a BIT. They are useful in providing consultation, assessment, and ongoing intervention. Given their special status related to information protection and the limits associated with this, it is equally critical that schools understand the boundaries that accompany clinical staff as they participate on the team. It is essential to separate personal feelings or preferences from ethical and state law decisions on how licensed clinical staff may assist with the BIT process, such as the assumption that involvement of counseling staff lends itself to a therapy-based solution, rather than a predominantly conduct-related approach.

Counseling staff are critical to the successful development, application, and intervention approaches of a BIT.



Counseling staff should clarify their role on the BIT by engaging BIT members immediately in conversations about the function of the team and how a partnership would be helpful. Not all BIT members are fully versed in what constraints or opportunities mental health providers have when sharing information. This conversation can be based on topics gleaned from this whitepaper and used as a way to provide clarity to all team members.

Moving forward, the following documents and processes would be useful to review:

1. Highlights from this whitepaper, The Role of the Counselor on the BIT

2. Brief review of clinician obligation to license and practice (i.e., clinician/client relationship, duty to warn, information on need to know basis)

3. Any pertinent information in Counseling and Psychological Services (CaPS) policy and procedure manual

4. A review of what role release/consent forms play in relaying information to some or all BIT members

In the end, the BIT is most effective when counseling staff have well-defined roles on the BIT and are collaborative and fully engaged members of the team.

AUTHORIZATION FOR LIMITED RELEASE OF INFORMATION

[Office of the Dean of Students and/or Director of Student Care Services/Title IX Coordinator] for Students is requesting authorization for a limited release of information. By signing this document, I am authorizing the following information to be released:

- ☐ That I have scheduled a counseling appointment for the future
- ☐ The name of my counselor
- ☐ Dates and times of past appointments
- ☐ Whether I have attended or missed appointments
- ☐ Disclosure of referrals to other offices or services on and/or off campus

I authorize Counseling Services to provide attendance information to the Dean of Students and/or Director of Student Care Services/Title IX Coordinator as requested. My authoriza-tion will automatically expire within one year of the date signed unless otherwise specified by me below.

- ☐ When the information is no longer requested by the [Dean of Students and/or Director of Student Care Services/Title IX Coordinator]

- ☐ Other: _____

I understand that:

- I do not have to sign this authorization and my refusal to sign will not affect my abilities to obtain treatment at Counseling Services.
- I may cancel this authorization at any time by submitting a written request to Counseling Services, except where a disclosure has already been made in reliance on my prior authorization.
- The [Dean of Students/Director of Student Care Services/Title IX Coordinator], as requested representatives receiving this information, are not health care or medical providers covered by HIPAA privacy regulations, thus the information stated above could be re-disclosed, only as permitted by FERPA.

Department or person requesting authorization: (e.g., Dean of Students or Director of Student Care Services/Title IX Coordinator)

_____

Printed Name of Student and ID#: _____

Signature of Student: _____
Date

Request reviewed by: _____
Date