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Art: Phoebe Sparrow Wagner, Reflections on Restraint & Seclusion: There is Hope & Freedom Somewhere, collage
Goals and agenda

• Intros
• Neurodivergent/Disabled Students on Campus: Background & Rationale for a focus on involuntary interventions
• Background on involuntary holds/commitment in the US
• Experiences of and potential impact of involuntary holds on college students
• Changing Campus Policy & Systems: Recommendations
Intros

Shira
- NEC Youth Coordinator

Nev
- Assist Prof, School of Social Work, University of Pittsburgh

Bowen
- Founder of Neurodivergent-U (https://www.neurodivergentu.com/about)
Neurodivergent/Disabled Students on Campus: Background
Overview of the Problem

- College education remains one of the most reliable pathways to socioeconomic mobility
  - And yet is out of reach for large numbers of students from high poverty, first generation backgrounds and with complex, highly stigmatized disabilities
    - Including schizophrenia, Bipolar I, BPD, Autism, cPTSD
- Postsecondary institutions have traditionally responded to more serious student mental health issues via
  - Removal of the student
  - Minimization of real or perceived campus legal liability
- Dedicated educational supports for students with disabilities traditionally labelled as “Serious Mental Illness” are scarce
  - Rates of high school, college attendance & college graduation remain the lowest of any disability group
Racial Inequality & Intersectionality

- Substantially lower college enrollment & graduation among Black & Latinx (versus white & Asian) high school graduates
- All available evidence points to particularly stark inequality facing Black youth labelled with SED/SMI
Limitations of the Americans with Disabilities Act

- Now voluminous research & legal scholarship has underscored the failings of the ADA, particularly wrt ‘mental disabilities’
  - Erosion through conservative judicial rulings
    - Deferece to universities and employers
  - Loopholes & limitations build into the ADA
  - Passage and implementation in the absence of significant public support
- Mainstream university interpretations of the ADA often lead to:
  - Minimal compliance implementation
  - Accommodations processes & protocols that favor easy accommodations (extended testing time) & unwillingness to apply the ADA to policy, housing and financial aid
The Decline of Dedicated Supported Education Programs

- Supported education = dedicated multi-component programs designed to help individuals (generally categorized as experiencing ‘serious mental illness’) to enter or reenter college
  - Include: study skills, college prep, application supports, educational coaching, on-site support, peer or mutual support groups
- More such programs existed in the 1990s versus now
  - Single biggest barrier = funding (Manthey et al., 2015)
- Voc rehab funding that could support more intensive education involvement is often not sought out by MH providers or there are barriers to accessing these funds
Contemporary threat surveillance & involuntary intervention on college campuses

- Since the early 2000s, campus shootings led to federal and state policies requiring threat detection & assessment on college campuses
  - Today, virtually all campuses support online “student of concern” reporting pathways
  - Once flagged, students may be assessed, involuntarily committed, suspended or terminated, or (on campuses with stronger MH infrastructure) provided more intensive advocacy, supports and coordination
- Rates of involuntary commitment in fact peak or plateau in young adulthood; in spite of a lack of reporting our research suggests rates are pronounced among college students

Source: Allegheny County Dept of Mental Health
Student of Concern Reporting: Examples

Concern

The Student of Concern Process allows students, staff, faculty, and UCF community members to report concerning behavior or situations involving a student. If you are aware of a student experiencing challenges or difficulties, please report the concern using the Student of Concern Form.

The entire UCF community will benefit. It is our goal to intervene before the student reaches a crisis level. Examples of concern include but are not limited to the following: a student experiencing family conflict, a student exhibiting an eating disorder, a student displaying self-harm (e.g., cutting), displaying unhealthy or dangerous patterns of substance use, or a student displaying concerning behaviors.

The team assesses all information to facilitate consultation with students, staff, faculty, and the UCF community. The team determines the need for concern and makes decisions based on risk to the individual or the university community.

Both teams are comprised of representatives from Counseling Services, Student Rights and Responsibilities, Housing and Residential Services, Student Conduct, Academic Advising, and other programs. The team members include: counseling, psychology, psychiatry, and other professionals.

STUDENT OF CONCERN FORM

If you are aware of a WOU student who is in need of assistance, please call the Office of the Vice President for Student Affairs at 503-383-8900. If you are concerned about an on-campus emergency that requires immediate action, please contact the Monmouth Police at 911.

STUDENT OF CONCERN

Use this form for reporting any situation where you are concerned about a student relative to their mental state or well-being: disruptive or inappropriate behaviors in the classroom or on campus; or any time you believe student poses a threat to themselves or others.

If you are concerned about a WOU student, please tell us! The Office of the Vice President for Student Affairs can reach out to WOU students who seem to be having difficulty and intervene before things reach a crisis level.

If this is an on-campus emergency that requires immediate action, please contact the Monmouth Police at 911 or Campus Public Safety at 503-838-9000.

Use this form to report concerns about any of the following:
- A student's mental state or well-being
- Disruptive or inappropriate behaviors in the classroom or on campus
- A student who you believe poses a threat to themselves or others

Concerned members of the WOU community can call the Office of the Vice President for Student Affairs at 503-838-8721, or use the following form to relay information. Please be as specific as you can, including additional identifying information (such as room number, phone number, etc.) and any relevant details that could help us help the student.

Student of Concern Form
Chain of escalation

1. Student of concern report
2. Assessment or wellness check
3. Involuntary hold
4. Involuntary leave of absence / account hold / dorm block
Why focus on coercion on campus?

Involuntary interventions impact a much larger number of students than campus stakeholders generally realize. And we’re not talking about it.

Impact can be very negative (in some cases life changing or even linked to suicide). Fear of involuntary intervention leads to avoidance & non-disclosure (often never documented).

Use of threat language, surveillance, and coercive responses contributes to and reinforce a particular set of narratives about mental health/illness/disability. I.e. mental illness as a source of threat, danger, unpredictability, instability. Removal as a/the solution.
Background on Involuntary Holds & Commitment
Crisis Response, Law Enforcement & Hospitalization
Common Components of Involuntary Commitment Laws in the US

- **Length & Approval**
  - **Emergency holds or examinations**
    - Initial hold, often police initiated, generally not requiring judicial or regulatory approval; allows for immediate apprehension, transport to a facility for examination; typically 24-48 hours, sometimes 72 hours.
    - Some states require approval by a delegate of the state (can often be obtained quickly - < 30 minutes).
- **Civil commitment**
  - Commitment to a psychiatric facility beyond initial 24-48 hour hold; generally but not always requires a hearing & judicial approval.
- **Extended commitment**
  - Commitment beyond a short-term stay; always requires a hearing & judicial approval in the US.
- **Assisted outpatient treatment (AOT)**
  - Court-ordered (involuntary) treatment in the community, rather than an institution.
  - Deviance from mandated treatment protocol can lead to (involuntary) re-hospitalization.
Who can initiate emergency holds in the US

- **Individuals eligible to initiate emergency holds without judicial or third party authorization**
  - Police officers (virtually all states)
  - Physicians/psychiatrists (many states)
  - Licensed mental health providers (some states)
  - School principals (uncommon)

- **Individuals eligible to petition for a hold with judicial or third party authorization**
  - Family members
  - ‘Concerned citizens’
  - Healthcare/Mental Health Providers
Detected initiation criteria

Variations in hold criteria (Hedman et al., 2016)

- Danger to self or others (5 states)
- “Mentally ill” (1 state)
- Danger to self or others due to mental illness (46 states)
- Recent suicide attempt (5 states)
- ‘Gravely disabled’ (9 states)
- ‘Unable to meet basic needs’ (10 states)
Risks

• **Death or physical injury**
  - During wellness checks or transportation to a crisis facility/hospital
  - Inter-facility transport
  - Incidents involving force in ERs and psychiatric facilities

• **Emotional trauma**
  - During initiation or transport (eg handcuffing, use of force)
  - Experiences within psychiatric facilities, including seclusion, restraints, forced injections

• **Post-discharge**
  - Financial (cost of hospitalization)
  - Disruption (school, work, family)
  - Psychological (trauma, distrust, fear)
Table 1
Number of deaths and death rates during civilian-police interaction in 2015 by presence of mental illness and demographics.

<table>
<thead>
<tr>
<th></th>
<th>Number of deaths by police% (N)</th>
<th>Death rate per milliona</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>1099</td>
<td>3.45</td>
</tr>
<tr>
<td>Mental illness (MI)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>22.8% (251)</td>
<td>19.83</td>
</tr>
<tr>
<td>No</td>
<td>77.2% (848)</td>
<td>2.77</td>
</tr>
<tr>
<td>Race/ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White (non-Hispanic)</td>
<td>48.7% (535)</td>
<td>2.70</td>
</tr>
<tr>
<td>Black</td>
<td>26.7% (293)</td>
<td>6.95</td>
</tr>
<tr>
<td>Hispanic</td>
<td>17.4% (191)</td>
<td>3.62</td>
</tr>
<tr>
<td>Otherb</td>
<td>7.2% (80)</td>
<td>3.07</td>
</tr>
<tr>
<td>Race/ethnicity*mental illness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White (non-Hispanic) MI</td>
<td>29.3% (157)</td>
<td>19.60</td>
</tr>
<tr>
<td>Not MI</td>
<td>70.6% (378)</td>
<td>1.99</td>
</tr>
<tr>
<td>Black MI</td>
<td>14.3% (42)</td>
<td>25.63</td>
</tr>
<tr>
<td>Not MI</td>
<td>85.7% (251)</td>
<td>6.19</td>
</tr>
<tr>
<td>Hispanic MI</td>
<td>18.8% (36)</td>
<td>17.90</td>
</tr>
<tr>
<td>Not MI</td>
<td>81.2% (155)</td>
<td>3.05</td>
</tr>
<tr>
<td>Otherb MI</td>
<td>25.0% (20)</td>
<td>15.81</td>
</tr>
<tr>
<td>Not MI</td>
<td>75.0% (60)</td>
<td>2.55</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>95.9% (1054)</td>
<td>6.62</td>
</tr>
<tr>
<td>Female</td>
<td>4.1% (45)</td>
<td>0.28</td>
</tr>
</tbody>
</table>
Suicide risk increases or decreases with involuntary hospitalization?

• Jordon & McNiel (2020)
  • “Patients who perceived coercion during hospitalization admission were more likely to make a suicide attempt after discharge than those who did not, even after adjusting for established covariates (OR = 1.29, |z| = 2.87, p = .004, 95% CI = 1.08, 1.54). There was no interaction between recent self-harm or suicidal ideation at time of admission and perceived coercion on postdischarge suicide attempts.”

• Goldman-Mellor et al. (2021)
  • “Emergency department personnel intend to hospitalize self-harm patients with high suicide risk; this study suggests that this goal is largely realized. Analyses that control for confounding by observable covariates did not find clear evidence that hospitalization reduces suicide risk and could not rule out the possibility of iatrogenic effects.”


Involuntary Treatment on College Campuses

Involuntary holds often initiated by campus staff

- Campus law enforcement
- Student health center staff
- Campus counseling center staff

In addition, universities can subsequently initiate

- Involuntary leaves of absence
  - Students is not allowed to enroll in courses or remain in student housing for a designated period (typically 1 – 2 semesters)
- Conditional reinstatement
  - Student can only return to campus under the condition that they agree to a treatment plan developed by (or with) university administrators
Qualitative Research on the Experience & Impact of Involuntary Commitment & Mandated Leaves of Absence

Involving Youth, Young Adults & College Students
Research Questions

What are young people’s experiences of police officers during hold initiation/transport and how are they impacted?

What is the impact of involuntary hospitalization and for those very negatively impacted, what are the specific experiences that contribute to this?

What are the impacts of involuntary leaves of absence and for those negatively impacted, what underlies this?
Sample

- Involuntary hospitalization
  - 40 youth and young adults
- Involuntary leaves
  - 23 current/former college students, almost all also involuntarily hospitalized

Table 1  Youth/young adult demographics

<table>
<thead>
<tr>
<th>Category</th>
<th>Frequency (percent) or mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>28/40 (70%)</td>
</tr>
<tr>
<td>Genderfluid or non-binary</td>
<td>1/40 (2.22%)</td>
</tr>
<tr>
<td>Race/ethnicity</td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>18/40 (45%)</td>
</tr>
<tr>
<td>African–American</td>
<td>4/40 (10%)</td>
</tr>
<tr>
<td>Asian–American</td>
<td>5/40 (12.5%)</td>
</tr>
<tr>
<td>Latinx</td>
<td>12/40 (30%)</td>
</tr>
<tr>
<td>Multiracial</td>
<td>1/40 (2.5%)</td>
</tr>
<tr>
<td>Neither parent completed college</td>
<td>11/40 (27.5%)</td>
</tr>
<tr>
<td>At least one parent with a graduate degree</td>
<td>12/40 (30%)</td>
</tr>
<tr>
<td>Age at time of interview</td>
<td>19.4 years</td>
</tr>
<tr>
<td>Age at time of initial involuntary hospitalization</td>
<td>16.2 years (range 11–23)</td>
</tr>
<tr>
<td>Time between initial involuntary hospitalization and interview</td>
<td></td>
</tr>
<tr>
<td>1 month–1 year</td>
<td>27.5% (11/40)</td>
</tr>
<tr>
<td>1 year–3 years</td>
<td>27.5% (11/40)</td>
</tr>
<tr>
<td>4 years–6 years</td>
<td>30% (12/40)</td>
</tr>
<tr>
<td>More than 6 years</td>
<td>15% (6/40)</td>
</tr>
<tr>
<td>Involuntarily hospitalized two or more times</td>
<td>13/40 (28.9%)</td>
</tr>
<tr>
<td>First involuntary hospitalization in secondary school</td>
<td>20/40 (50%)</td>
</tr>
<tr>
<td>First involuntary hospitalization after high school</td>
<td>20/40 (50%)</td>
</tr>
</tbody>
</table>
1. How do police get involved?

2. Experiences of Police Involvement

2a. Criminalization & disciplinary framing of distress

- The police officer basically said, “Look, if you don’t come with me [willingly], then I’m gonna have to handcuff you.” So I rode there in the back of the police car, which very much felt like, okay, I’m being treated like a criminal now, for having a mental illness. Which is not anything in my control.

- Seeing them, how big and tall and muscular they are with their guns and all that stuff and you kind of cower in fear.

- [The officers] took me through the emergency room, in front of all these families. I was handcuffed. That was a shameful thing, seeing all these mothers shielding their kids because I’m in handcuffs. It just made me feel worse.
2b. Perceived aggression & callousness, sometimes explicitly targeting ‘mental illness’

- The sheriff’s officer was—it was just him, and he was kind of a jerk. After he told me not to touch, again, excuse my language, he’s like, “Don’t touch my [expletive] you [expletive] retard.” Then, sitting in the car with that guy for an hour and 15 minutes on the drive... he wouldn’t shut up about how much of a piece of [expletive] he thought that people like me were. And criminals, and you know... He equated me with criminals. I was numb at that point. I just looked out the window at other people, and I just thought, “Well, this is my life now.”
3. Impact of involuntary hospitalization

- Once hospitalized, most participants reported starkly negative experiences
  - The majority (70%)—but not all—also described significant negative impacts on their capacity to trust providers (or others, eg teachers, family)
  - Of these, most expressed specific unwillingness to disclose suicidal feelings

“...the worst part of it all to me is that they will [IPH] you for being suicidal but [then] you feel like a strong need to keep everything inside because you don't want to be taken away... There's so many negative consequences you might as well try to brush [the suicidal feelings] off, keep it inside or just never talk about it and that's what the worst part of [IPH] is for me.”

“...being [IPHed] that one time was enough to make me shut out all help from figures like therapists and school workers, my parents, for fear of going back to that place”

“I'm just not, I don't know, like okay. If anyone were to ask me, like I set up an appointment with the counseling center, if anyone were to ask me, I feel like I couldn't really explain what's going on just because I feel like if I say something that's even the slightest bit a problem or something that they would refer me somewhere or just notify somebody.”

“I definitely didn't ever wanna get [IPHed] again. ...if I ever got to a point where I was suicidal again, I think I would be too scared to get help because the whole experience terrified me. And I always tell my parents, "No, that didn't scare me. I'd be fine. I'd get help if I do it again." But I don't think I would. I don't think I would, it was terrifying.”

“After the first time I was [IPHed], I felt like if I confided in someone that I was upset, that they would, even if I wasn't suicidal, that they would [hospitalize] me. I felt almost like I was being punished for my feelings. So that would be another thing if we go back to what I could change is, you should be able to feel confident in saying that you're sad without fearing that you're gonna be locked up. 'Cause as a 15 year old through 17 that's exactly what I thought.”

“I think with [IPH] it just makes it worse and makes people more likely to want to keep things inside because of this fear and it's kind of one of the biggest reasons I don't seek therapy much anymore because I have so much fear that's "Hey I might be sent away"
### 3a. Why distrust?
**Dehumanizing treatment**

<table>
<thead>
<tr>
<th>Theme</th>
<th>Example quotations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Analogies to prison or jail</td>
<td>“It was like a prison. You wake up at this time, they come in to wake you up, if you want to shower they have to be [there] monitoring. We would ask, &quot;When are we going to do this? When are we going to do that?&quot;. It wasn’t like [we were] talking to them, it was like they were just standing guard and just very cold.”</td>
</tr>
<tr>
<td>Dehumanization</td>
<td>“After lunch, maybe, they’d take us outside [to] this little enclosure that was all fenced in. Felt like little animals on display there. After that, a few hours until dinner. All the time, you were just nothing. You’d sit there and watch the television like if you weren’t insane before, you would go insane at this place.”</td>
</tr>
<tr>
<td>Moral judgement</td>
<td>“…they didn’t see us as people. It was just another patient coming in and out. The staff would kind of make jokes to one another, think they were above us because we were in the facility and they were in the staff”</td>
</tr>
<tr>
<td>[At the hospital] I just really noticed a lot of power trips... It’s really easy to slip into a mindset of judgment when you’re interacting with mentally ill people, because it’s... it felt like they wanted that career not to help people, but to feel better than people”</td>
<td></td>
</tr>
<tr>
<td>Learning to lie</td>
<td>“The mindset you get into there, at least what I got into was like, ‘Okay, I need to pretend I’m okay so that they’ll let me out.’ Because you aren’t going to get better in that situation. You’re just gonna pretend to be better, so they’ll let you out, so you can go back to an easier life.”</td>
</tr>
<tr>
<td>[One of the other patients said] ‘Hey, you need to stop crying,’ and I was like, ‘Why? I don’t care. Why?’ And one of them is like, ‘Well, they won’t let you out unless you show emotional stability,’ and I was like, ‘Oh my God, Okay.’</td>
<td></td>
</tr>
<tr>
<td>‘Learning to Lie’ carrying over to post-discharge behavior</td>
<td>“…the first thing I learned as soon as I was put into the hospital was that I couldn’t actually talk about what was wrong. Because then I would be taken against my will somewhere, and my parents would have to pay for it… So as soon as I was told I couldn’t leave, then I shut out even more. And I’d already been reluctant to hand out information, but at that point it was, I’m just going to say whatever I need to get out. To anyone, to my parents, to therapists, whatever I need to do to make them think nothing is wrong.”</td>
</tr>
<tr>
<td>“Well…you learn really easily. You learn really easily. Unless you have some [condition] where you actually don’t understand what it is that the person could be looking for from you, of course you know. Do you want to kill yourself today? ‘No, I would never want to kill myself. I would never do that.’ Are you depressed? ‘No, I’m not depressed. Everything’s great. Of course, I’m not going to ...’ [If] you show your honesty, you get sent away. So from that point on, you’re done [being honest].”</td>
<td></td>
</tr>
</tbody>
</table>
# 3b. Why distrust? Unmet Expectations & Unaddressed Needs

## Table 4: Distrust group: unmet expectations and unaddressed needs

<table>
<thead>
<tr>
<th>Theme</th>
<th>Example quotations</th>
</tr>
</thead>
</table>
| Unmet expectations| “My only experience with inpatient stuff was from movies, which was not accurate. I expected it to be more like ['To the Bone' on Netflix]. You were just kind of at a hotel, and you were allowed to do your own thing and...in the movie they had their phones. So I expected, I was like I’ll be able to have my computer and all this stuff. It shouldn’t be too bad. I won’t get behind in school. [But] It was not like the movie at all, obviously.”  
“I didn’t know what involuntary inpatient even was. What I thought something like that would be, would be more like a lot of counseling, a lot more help in that sense. But, it was less of help and more of like, ‘Oh, we’re just going to keep you for 72 [hours] ...’” |
| Unaddressed needs | “…that’s the thing, it makes you feel worse afterwards than you did before. I’m sitting here, I’m more depressed and stressed coming out of that, and freaked out, than I was going in before”  
“It was so unhelpful. There wasn’t any kind of psychological help really to it. It wasn’t like therapeutic in any way.” |
## 3c. Why trust intact? Indirect Benefits

<table>
<thead>
<tr>
<th>Theme</th>
<th>Example quotations</th>
</tr>
</thead>
</table>
| Greater family support | “It made me a lot closer to my family because it made me see how much they actually did care about how I was doing and I got a lot closer with my parents, I got a lot closer with my sister. So, in that sense, it was a benefit.”  
|                   | “[it] definitely [affected] my relationship with my parents. It really opened up the conversation for what can we do, because I don’t want to say they were ignoring it, but it was definitely hard for them to think about their child being in such distress. After…they were like, something clearly is not right in your life and we want to help you with that. That really … that was a big change in my relationship with my parents” |
| Wake up call      | “I’ve become a much more like independent person, and I’m working towards being a lot more positive, because that was kind of like, just a big low period for me. Seeing what it was like inside the facility, and seeing some of the other patients and stuff, it kind of just made me want to get better because I don’t want to go back to something like that.”  
|                   | “The [involuntary hospitalization] was definitely a motivating factor to change within myself. Instead of railing against everything in my life that was staying the same. I just kind of wanted to do things for myself, and be able to say that I was dealing with it. It motivated me to not do the things I was doing to not handle things in the same way. To stop harming myself.” |
| Perspective taking | “[Most other inpatients] were significantly younger than me. It made me realize how lucky I was in my situation because they were these 10-year-old kids that had abusive parents and things like that and it just made me more grateful for what I had and where I was coming from.”  
|                   | “In retrospect, [it] did give me insight into – “okay, there’s a lot of people here who have much worse lives than me.” ” |
4. Mandated Leaves

- Overwhelming majority (87%) of those interviewed described deeply negative experiences & impacts

- Mandated leave process
  - No forewarning, feeling blindsided
  - Callousness & indifference from school administration
  - Akin to “discipline”
  - ‘Due process’ either absent or “a performance”

- “[In the hospital] I was determined to go back. I kept asking for my school work, and stuff to be sent to me, and it was, but then one day they sent me a letter and they said "We have withdrawn you from your classes." I was still in the hospital at the time.”

- “I also don’t believe it was explained to me exactly what was happening. It was literally like I was told that I had to be out [of campus housing] in three days. There was no explanation. There was no explanation of a process of how this was to work. It was basically like one person made a decision, and that was law. “

- I got checked in [into the hospital] and spent a couple weeks getting stabilized and recovering there. Then started the whole process of, meeting with the Dean of Students, tried to get back to campus, etc. I had been coordinating with my professors, [and] my psychiatrist at the time and the doctor from the hospital, all wrote a note saying "We all think it would be good [for Participant] to go back to school, get back in the dorm, have the social support from that structure, etc." But the Dean of Students would not let me come back, and forced me to withdraw the whole semester; I was not allowed back into the dorms.
4a. Impact: Shame

P4: In the immediate aftermath of being told I can't return to my apartment, I felt really ashamed. I felt like there was something wrong with me and that people looking at me would just know that I was labeled as dangerous or a liability and I wasn't allowed to live on campus. And I was walking around from appointment to appointment, trying to get back into my apartment. I felt like everyone I passed was like looking at me and staring. Obviously that wasn't the case. Nobody knew who I didn't tell. But I just felt an overwhelming sense of shame and that lasted for like several months afterwards.

P7: [W]hen it happened, immediately all these people sort of getting involved and not knowing what to do. I just really felt like dying. Like I didn't have thoughts of like a plan or so, but that's the only way I can describe it, was like the shames was very very big, so I just wanted to ... yeah. I just wanted to die.
My identity, it made me feel like a sick person. Sick in a very negative sense of that word. Not just mentally ill, but just a sick person, someone who can't be trusted with children, can't be trusted with any responsibility, someone who's just messed up in the head. All the negative connotations that come with being a sick person in this society. All the negative stereotypes, I internalized that and I felt like I'm this sick person who doesn't really have a future.

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More broadly, very quickly I went from being somebody who was doing very well in my Ph.D. to not believing that I would ever work again. Work of any kind, let alone academia. That was absolutely absurd. Just totally absurd. It completely changed my view of who I was.
4c. Distrust of academic institutions, as well as providers

- [[The forced leave] made me really detached from the school, and really mistrustful of any relationships with school administrators, with professors there. So I didn't feel like I could go to people for help, whether that be emotional, or school help.

- I didn't trust any [professors or administrators] ever again. There was that. I felt like I couldn’t.

- It’s something I will always struggle with, I think. I have deep wounds from how I was treated, and I will never, ever trust any administrative people at universities again.
Questions this Research Raises
Punishment versus support

- Parallels and overlap between responses to distress (institutional policy, law enforcement, providers, administrators, hospital staff) & ‘punishment’
  - Reliance on processes & systems (law enforcement, campus police, lockouts) that are in fact primarily constituted to respond to misconduct or violations of the law
- What changes would be needed to fundamentally alter the “logics” of response, not just remove particular actors (ie remove police, leave the mental health system otherwise intact)
Aftermath and post-vention

- Across 63 interviews, virtual absence of attempts or policies aimed at providing support in the processing of the actual/potential harms of involuntary commitment and/or mandated leaves of absence
  - Overwhelmingly youth, young adults and students were left to come to terms with these experiences on their own
Data & Transparency

• In spite of the magnitude of potential impacts
  • No known research or reporting on mandated leaves of absence
  • Only a handful of US states report statewide data on involuntary hospitalizations
  • No comprehensive public reporting of law enforcement involvement in disability-related deaths, injury or legal escalation
  • Across the board, negative impacts unresearched and/or absent from the literature
Our Recommendations

• Increase public understanding and awareness of the realities of ableism, coercion and exclusion on college campuses
  • Including impacts on students with less common, stigmatized, complex diagnoses including schizophrenia, DID, personality disorders, complex PTSD

• Address the complex forms that direct & indirect gatekeeping takes in higher education
  • Exclusion because of restrictive admissions criteria
  • De facto exclusion because of socioeconomic, family responsibilities, etc.
  • Weak implementation and interpretation of the ADA (leading to inadequate supports)
  • Stigma and exclusionary attitudes
    • Policies & procedures that couple violence, dangerousness & ‘mental illness’
  • Use of direct or indirect coercion
  • Failure to invest in more comprehensive supported education programs
Recommendations cont’d

• **Alternatives to coercive interventions**
  • Learn from peer mentoring and community building models as are commonly found in campus LGBTQ+ centers, campus intimate partner violence support programs & Disability Cultural Center models
  • Holistic support programs that focus on integration/reintegration rather than removal and exclusion
  • Student, faculty and staff trainings focused on increasing understanding and support & decreasing unnecessary escalation of crisis situations
  • Dedicated facilitation/mediation/de-escalation roles

• **Supports beyond Minimal Compliance**
  • Universal design
  • Radical access
Thank you!!

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