MENTAL HEALTH AND STUDY ABROAD

Incidence and Mitigation Strategies.

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Commentary

Dr. Quigley, Professor of Surgery and Regional Medical Director, Americas Region for International SOS has identified two trends that deserve the immediate attention of college/university officials, students, and parents:

1. The growing number of students with self-reported mental health issues and increasing use of psychotropic medications.

2. The increasing number of students enrolling in study abroad programs.

It is well documented that college and universities are struggling to understand the rising number of students who present with mental health issues, as well as to design services that adequately meet the needs of these students. Data from our institution parallels national data which indicates that at any given time, 10-12% of the student population reports symptoms consistent with diagnosis of depression and anxiety- the most common diagnosis in this age group. The prevalence of common psychiatric conditions is 20% in the college age population. Clearly, students will bring these issues with them when they study abroad.

The foundation for Professor Quigley's recommendations rests on his assertion that the student has a duty of loyalty to disclose accurate information and the institution has a duty of care to provide the campus resources domestically and abroad to protect all students, whether they have mental health issues or not. Based on these shared responsibilities, the article suggests concrete steps to ensure that both students and institutions have sufficiently assessed for possible mentalhealth issues and taken steps to prevent problems, or intervene when necessary.

Schools and students will benefit from a more proactive effort to identify and plan for students who may experience mental health problems when studying abroad. Professor Quigley recommends, at the very least, that both students

and parents engage in a web-based learning experience to help identify potential problems and even considers the merit of a pre-deployment anonymous student self-exam to determine fitness to participate in a study abroad program. His proposal(s) deserves serious consideration.

For students planning to study abroad, as for other populations, the best medicine is prevention and preparation.

Abstract

Introduction:

The transition from high school to college/university is associated with a variety of developmental challenges which can impact student mental health. In this report we, at International SOS (Intl.SOS), the world's leading medical assistance company, quantify the incidence of study abroad student repatriations for serious behavioral health issues, qualify the common underlying clinical (behavioral) diagnoses, and propose mitigation strategies for students and institutions alike.

Methods:

Between 01/01/2010 and 01/01/2012 we compared the repatriation rate of students with serious behavioral health issues to that seen with American corporate business travelers/expatriates. Using the coding system of the International Classification of Diseases (ICD-9) and cross-referencing these data with the coding system of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) enabled us to identify the closing behavioral diagnosis of each student repatriation.

Results: The incidence of student repatriation for behavioral health events was 23 times higher than that documented for American corporate business travelers/expatriates. The clinical diagnosis in >80% of the student cases was either a personality disorder or intellectual disability with contributing psychosocial/environmental factors. Major mental/learning disorders and substance abuse accounted for <20%.

Conclusion:

The success of study abroad is predicated on a preemptive, transparent, supportive and confidential environment (at home and abroad), established by the institution in the spirit of scholastic duty of care. Incorporation of e-learning tools as a component of the mandatory pretrip health evaluation/education can further limit exposure for all.

Introduction

The US Department of Education has recently published, in the Almanac of Higher Education, that in 2009 more than 18 million students attended 4,861 colleges/universities in America[1]. More than one-quarter of a million American students, that same year, participated in study abroad programs[2]. It is noteworthy that 15 of the top 25 destinations, selected by American students, were outside of Western Europe and 19 were in countries where English is not the primary language.

Recent research has indicated a rise in the incidence of mental health issues among these 18 million students attending domestic colleges and universities[3,4] (see Table I). According to Hutchinson et al[5] more than 9 million American students (51%), in centers of higher learning, have had prior psychological counseling. One quarter (almost 5 million students) have seriously considered suicide. Not surprisingly, this trend is also evident in students who participate in study abroad programs.

Since those students that enroll in study abroad programs originate from this domestic pool of students the incidence of mental health disorders, would reflect similar statistics. In other words more than 50% of the 250K students (i.e. >125,000 students) in study abroad programs, likely have, at the very least, among other interventions, received mental health counseling prior to departure. Even, this figure probably underscores the reality as many parents naively propose a study aboard "adventure" for their child with the assumption that a change in environment might actually heal any perceived behavioral health problem.

It is unclear whether these alarming statistics, recently presented at the National Association of Foreign Student Advisors (NAFSA) Annual Convention, are a reflection of:

1) The destigmatization of mental health, which encourages more students to seek help/treatment;

2) Increasing dysfunction in the family unit;

3) Most major psychologic disorders (i.e., bipolar disease, schizophrenia) initially manifest themselves on or about the age of young adulthood;

4) The efficacy of psychotropic drugs -- with limited side effects -- enable young men and women with major psychologic disabilities to graduate from high school and attend college/university;

5) The glamorization of risk-taking lifestyles and substance abuse by celebrities.

Finally it is noteworthy that 50 years ago the mean age of onset for most mood disorders was age 30, while today the mean age is closer to 15 years.[7]

Behavioral health counselors suspect that the real or perceived increase in the incidence of mental illness, observed in this student population, is multifactorial and likely a consequence of all of the above7. Mental illness not only impacts the student but their family, their friends, and their center of higher learning. It is the center of higher learning that is now responsible for the welfare of students whether domestic or abroad (duty of care). Therefore, duty of care is no longer a domestic concept[8]. Due to international precedent, set in the corporate arena, colleges/universities are similarly now obligated to protect the health, safety, and security of their students in study abroad programs. Many institutions, however, wait for an incident to happen rather than proactively developing a strategy to assist a student with mental health needs while overseas. Failure to exercise duty of care can have serious consequences with regards to liability, program continuity, and even school reputation/brand.

International SOS (Intl.SOS), the world's leading medical assistance company, and in existence for more than 26 years, brings together a host of related disciplines to deliver 24/7 comprehensive, integrated solutions to our scholastic clients and to student members when they call for help. In America alone, Intl.SOS provides services to more than 90 colleges/universities all with study abroad programs (predominately large private institutions without any religious affiliations). These disciplines include but are not limited to emergency assistance: at the time of a medical/security crisis Intl.SOS offers a complete support system including hospitalization/counseling (using our own proprietary credentialed providers), and medical evacuations.

In this report we outline the disproportionate high volume of repatriations (medical evacuations) performed by Intl.SOS in the scholastic arena for behavioral health crises and discuss mitigation strategies.

Methods

In an effort to differentiate reality from perception Intl.SOS, in compliance with the Health Insurance Portability and Accountability Act[9] (HIPAA) reviewed all requests for assistance (RFA) from our American scholastic clients with study abroad programs, (n=92 colleges/universities) over a 24 month period (01/01/10 to 01/01/12). In total there were 3,214 RFA's and all came from students enrolled in study abroad programs (opportunities to study overseas for a summer, a semester, a trimester, or even 1 year). We then identified the closing diagnosis of each of these cases which were categorized using the coding system of the International Classification of Diseases (ICD-9)[10] Cross referencing the ICD-9 codes of those students repatriated for serious behavioral health issues with the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV)[11] allowed us to determine the specific mental health cases (ICD-9 codes 290-315) in this population of students studying outside the United States.

During this same 24 month period we, again with HIPAA compliance, reviewed all RFA's from our American corporate clients (business travelers/expatriates). These clients (n=1,200) represented a cross section of industries (i.e., manufacturing, oil and gas, financial, pharmaceutical, etc.). In total there were 292,000 RFA's all from members either travelling cross borders or on an international assignment. Using the aforementioned ICD-9 and DSM-IV classification systems we were able to similarly determine the specific mental health cases in this population of corporate members.

Results

Between 01/01/10 and 01/01/12 there was a 23% higher incidence of serious behavioral health cases, resulting in repatriation, among our scholastic clients, when compared to all other corporate clients combined (i.e. oil and gas, financial, pharmaceutical, etc.). The RFA spectrum for psychological cases in this student population, however, ranged from the provision of local psychological support and refilling a prescription for a psychotropic drug to a medical evacuation for the aforementioned serious mental health issue. The incidence of mental health cases in the scholastic community was only surpassed by emergency medical issues (i.e., upper respiratory complaints, and trauma) and travel advisory (i.e., immunization requirements, commercial airline schedules, ticketing). This 23% higher incidence is likely a very conservative number since many RFA's and closing diagnoses may not have been recorded as a mental health disorder however the underlying issue was clearly mental illness. For example, a fall from a deck resulting in a limb fracture would be recorded as trauma even though it may have been a consequence of substance abuse. Similarly a student could be taken to an emergency room for excessive vomiting and our records, based on the report of the treating medical officer, would classify the event as gastroenteritis even though the underlying illness was actually bulimia. The DSM

IV organizes each psychiatric diagnosis into 5 dimensions (axes) relating to different aspects of the mental disorder. We were able to further dissect our data to reveal that >80% of the RFA's were limited to Axis II and IV (personality disorders/intellectual disabilities with contributing psychosocial/environmental factors). Less than 20% were limited to Axis I (major mental/learning disorders and substance abuse). (See Table II)

The vast majority of these cases resulted in repatriation either on a commercial carrier with medical escort(s) or, in extreme cases, (risk of harm to self or others) an air ambulance. Either option can be a costly endeavor, both emotionally for the student/family and financially for the third party payor.

Discussion

Domestic Front:

Leaving home and going to college represents a major life transition which can exacerbate existing psychological difficulties or even trigger new ones. Furthermore, leaving family/peer support structures to enter an unfamiliar environment, with higher academic standards than what students might have been used to in the past, can deepen depression or heighten anxiety.

Over the last decade many campuses have committed funds to conduct ongoing education of its students/faculty/administrators. They are also moving towards informational campaigns to recognize mental health issues and how to access and utilize campus services[12]. Today's students are most comfortable communicating via social media networks, and experts recommend the utilization of high profile vehicles (i.e., Facebook, Twitter, blogs, 24 hour hotlines, etc.) to disseminate relevant information. In most institutions, student mental health issues have become a shared concern and responsibility within the college/university. Consequently, from the Dean to the student residence proctor there exists a network of individuals, on campus, trained in recognition of signs/symptoms of mental illness, as well as familiarity with the campus resources available to treat the afflicted students.

Today, most campuses include a University Counseling Center (UCC) which typically interfaces with as many as 20% of the general student population[13]. Common complaints include anxiety/depression, physical self-abuse, substance (including alcohol) abuse, and eating disorders (anorexia nervosa/bulimia). These evidence-based programs are designed to address serious young adult distress and prevent suicide. According to the National Mental Health Association (NMHA)[14] suicide is the second leading cause of death among the college population.

Although on most campuses basic student health services are usually available without restriction mental health visits are typically limited. According to a 2008 study by the Government Accountability Office thirty percent of colleges/universities require students to have health insurance as a condition of enrollment. Despite the fact that many institutions strongly encourage students to carry supplemental insurance plans, to cover those services which are only conditionally available (i.e., psychologic services), there is limited compliance among students. To compound the matter, most insurers exclude students over a certain age from their parents' policies. Some schools have their own supplemental insurance plans offered to incoming students; however those premiums can be quite costly, particularly for incoming students with chronic or pre-existing illness (i.e., mental disorder). Even students still under their parents' plans face challenges. Some may not want to divulge their situation to their parents and/or their college/university, especially in regions where they would be out of the HMO's network, precluding access to the policy[15]. Table III outlines a student's options for health insurance.

To add another dimension to an already complex process, the UCC's are also required to support international students studying on American campuses (almost 700K) [2], who often bring to the arena a whole host of psychological problems, usually based on cultural maladjustment. Many students come from countries where misinformation and misconception cover the public's recognition and acceptance of mental illness in a shroud of social stigma. Almost 60% (>400K) of the foreign students studying abroad on American campuses are Asian. The unique needs ofinternational students attending American colleges/universities, further tax the limited resources on domestic campuses[12]. More than 20% (150K) of these foreign students seek psychological support but the actual number is likely much higher since many are unaware of the services provided by UCC's and for cultural reasons many will not seek psychological assistance[15]

FERPA (The Family Education Rights and Privacy Act)[17] is a federal law administrated by the Family Policy Compliance Office in the US Department of Education. FERPA applies to all educational agencies and institutions that receive funding under any program administered by the Department (i.e. most colleges/universities). Once a student reaches 18

years of age or attends a college/university he/she becomes an “eligible student” whereby all rights previously given to parents under FERPA transfer to the student. This includes the right to have control over the disclosure of personally identifiable information from the records (with a few exceptions including a health or safety emergency). Similarly, Section 504 of the ADA (Americans with Disability Act)[18] states that “no qualified individual with a disability (i.e. mental illness) in the US shall be excluded from, denied benefits of, or be subject to discrimination under” any program or activity that receives federal financial assistance (i.e. most colleges/universities). Finally even though HIPAA (Health Insurance Portability and Accountability Act)[9] only applies to health plans, healthcare clearing houses, and healthcare providers, colleges/universities are, considered third party administrators of a health plan (that typically includes a counseling center). The plan contract with the third party administrators requires the handling of information in accordance with HIPAA.

Most colleges/universities interpret ADA, FERMA, and HIPAA through their own counsel. That interpretation may be influenced by the college/university ethos, culture, and tolerance of risk. Without a standard, country-wide approach, the interpretations can be quite varied. Specifically, the practice of sharing a students' mental health issue with his/her parents or even school administrators is inconsistent across the country, particularly if the student is older than 18 years.

International Front:

College and university educators need to recognize that a student studying on American soil

typically faces multiple new challenges, not previously experienced when in high school (i.e. homesickness, increased academic demands, multiple temptations, etc.). These same stressors are only compounded for the same student studying abroad. The study abroad student may lack the emotional, cross-cultural coping skills to adapt/function in the study abroad program. The student could have an unknown genetic predisposition to serious mental illness (i.e., bipolar, schizophrenia) and the stress of the “new” environment may actually trigger a decomposition with serious emotional consequences.

While some institutions attempt to screen and prepare their students for study abroad, many simply do not have the knowledge or resources. Mental health screenings are frequently overlooked. Ironically, even those schools with established UCC's do not typically provide screenings for students about to enroll in the study abroad program. When away from home, study abroad students, without pre-screening or education, can be suddenly faced with living apart from family/friends, which can easily result in separation anxiety[19]. Culture shock can be unpleasant in any foreign country, particularly in the context of the United States' foreign policies, which are not universally accepted. This is compounded by local living conditions which typically pale in comparison to facilities at home that are usually taken for granted (i.e., computer access, health clubs, air conditioning, etc.). Even if the student attempted to seek help more likely than not a language barrier would preclude the effort. Without fluency in the local languages/culture subtle signs/symptoms may not be easily communicated to the potential provider who in turn may not be able to focus in on the correct diagnosis. Students dependent on psychotropic drugs, who participate in study abroad programs, may not realize that their medication(s) is/are not available in foreign countries or they may unilaterally decide that in this changed “new” environment they can discontinue their regimen[20].

Usually it is a non-medical person (i.e., a site team leader) who is the first to know of a student's mental illness while abroad. The team leader typically has not been trained and is ill-equipped to know the policy/procedure (if one even exists) regarding intervention and notification. Due to the sensitivity of the subject matter, frequently the home college/university, in the absence of any infrastructure or response plan abroad, acts in loco parentis (in the place of a parent) believing their approach is in the best interest of the student. Such an unrehearsed approach, although without any intentional malice, can have permanent consequences on the future mental health of the student as well as liability exposure for the American institution.

It is unclear to most colleges/universities with study abroad programs whether ADA compliance is applicable overseas, since it is a law passed in the United States. Consequently, the applicable procedures for accommodating a student abroad with a mental illness vary from campus to campus. The majority of psychological breakdowns, experienced by students abroad, which can occur at anytime during the time away from home, are typically triggered by some crisis (i.e., assault, bad news from home, inadvertent overdose, etc.). Most colleges/universities are not equipped, or even aware of how to provide mental health services “off campus” in another country. Furthermore, the response to the needs of a distressed student, in real-time, can be complicated by local language barriers and cultural differences. Even if a

mental health service is available overseas and counseling is provided, the "temporary fix" can actually exacerbate the condition in a vulnerable student who will need a new counselor/therapist on his/her return home.

Just as domestic mental health care can be challenging to finance, the case is the same when such care is required overseas. Even with the recommended purchase of travel/accident insurance, mental health services are frequently excluded from the policy. Similarly, domestic policies rarely include a clause covering mental health treatment(s), therefore it is highly unlikely to include a clause for overseas misadventures.

To bring these results to the forefront and to consider mitigation solutions we need to answer two fundamental questions:

1) Since mental illness applies to both domestic and study abroad students, what steps are taken on the domestic campus to address these issues and can these steps be applied to these students who choose to study abroad?

2) Does duty of care play a role, and if so can centers for higher learning act as "in loco parentis" without violating the laws.

Mitigating the risk of mental "breakdowns" in study abroad programs (the student, the institution, the site):

Despite the increasing incidence of mental illness in the college/university population, the existence of such a disorder should in no way preclude the student from participating in a study abroad program. Now that mental illness has been somewhat destigmatized, at least in America, strategies to reduce the incidence of adverse outcomes for study abroad participants need to focus on the student, the institution, and the site(s) for study abroad. All are not mutually exclusive. Addressing this issue on the "front-end" versus the "back-end" is essential. These same young men and women enter and perhaps will even control the corporate workforce upon completion of their studies.

1) The Student:

Any individual with an interest in a study abroad program, in the spirit of their "duty of loyalty," needs to be forthcoming and transparent[8]. They need to disclose to college and university authorities whether they have received or are receiving mental health care (therapy +/- medicines). The student also needs to discuss his/her intention with their treating physician/counselor, as well as with their parent(s)/guardian. The decision to participate in the study abroad program should be thoroughly discussed among the aforementioned stakeholders with a unanimous decision to participate.

Regimens of treatment (therapy and/or medicines) should not be altered or discontinued prior to the study abroad adventure. The student needs to ascertain that the medicine(s) is/are available and legal in their destination country (i.e. certain anti-depressants are only available in America) and if not available he/she, in consultation with their physician, must determine a legal way toacquire the drug(s) overseas. Students crossing borders with prescription medicines must handcarry them with a current prescription signed by their treating doctor.

Clearly the student has to take ownership of his or her mental disorder and the decision to study abroad must be taken very seriously. The student needs to be aware of the fact that challenging programs overseas can easily exacerbate psychological diseases. Therapists should pose thesesorts of questions: "If you had recently been diagnosed with a major physical illness (i.e., lymphoma, inflammatory bowel disease), which would require ongoing or long-term treatment, is it wise to participate in a study abroad program? If not, then why should you go abroad with a recently diagnosed mental illness? "

Although culture shock is considered a normal developmental phase of adjustment to a new environment, it can trigger dormant or previously treated mental illnesses. Ironically, "re-entry" culture shock experienced when the student returns home can be equally emotionally traumatic.

Students need to be aware of this continuum of culture shock as well as the stress associated with integration into the new environment.

Prior to travel, the student needs to confirm that his/her health insurance provides both mental health and general health benefits (cashless access) abroad. The student needs to arrange a contingency plan with his/her therapist in the event an intervention is required overseas. Mental health resources (counselors/facilities, etc.) may be extremely limited, if available at all. Even when services are available, the local language/cultural barrier can easily preclude access.

Finally, each student should create a written emergency action plan (EAP) outlining contacts and support networks. At the very least, this EAP should be shared with family, college/university officials back home, as well as officials at the hosting institution.

2) The Institution:

Just as the student has a duty of loyalty to disclose accurate information, the institution has aduty of care to provide the campus resources domestically and abroad to protect all students, whether they have mental health issues or not[8]. Both environments (domestic and abroad) need to be designed to encourage dialogue between students and officials/counselors while maintaining confidentiality.

Domestically, the college/university should provide easy access to educational vehicles for all students who intend to study abroad (predeparture orientation). Such education can be incorporated into a mandatory visit to student health facilities where pre-trip vaccinations are typically provided. Ideally, the student as well as the parent(s)/guardian should take an elearning course that outlines the destination country cultural issues, laws, and practices as well as the signs/symptoms of common mental illnesses (i.e., depression/anxiety, grief, eating disorder, self-harm, sexual harassment/assault, psychosis, substance abuse, and suicidal ideation). Familiarity with such illnesses helps students identify at-risk behaviors in themselves and their peers. Embedded within this e-learning course could be an anonymous student self-exam to determine fitness to participate in a study abroad program. Each student and parent(s)/guardian should sign a record that they have completed the e-learning (web-based) program on behavioral health.

3) Study Abroad Site:

Working with the students, in the spirit of bilateral transparency, home campus officials need to determine, in advance, the study abroad site that best serves the students' special needs. If the student has disclosed his/her mental illness history, the college/university should recommend a program with an infrastructure that has appropriate support. Again, respecting confidentiality, the study abroad site will require staff trained to at least recognize tell-tale signs of mental illness. It is important that ALL students be educated prior to travel, since typically students in a crisis will reach out to a peer prior to seeking support from an official. The hope is that the peer brings the issue to the attention of the local leader(s).

If the study abroad program includes "outward bound" missions where the students will be separated from the host country facilitators, the college/university should provide training to those team leaders accompanying the students. Such training should include, but not be limited to, recognition of basic signs/symptoms of mental illness. Concerned team leaders will need to have their own EAP in the event that on-site support is not adequate. The same team leaders need to be educated on the subject of confidentiality (FERPA and HIPAA).

Conclusion

Although the incidence of repatriations for serious behavioral health issues is disproportionately higher in students (23x) then all other business sectors combined it should be noted that the study abroad students are much more closely supervised than the corporate business travelers/expatriates. Such supervision could arguable lower the threshold for diagnosis and subsequent repatriation for behavioral health issues. Furthermore, the population of corporate business travelers is emotionally more mature and more experienced in world travel and therefore more adaptable to the challenges of travelling/living abroad.

As more and more students enroll in study abroad programs the absence of an infrastructure to support mental health issues at the time of enrollment, while on-site and upon return will only result in more exposure for both the student and the institution.

The majority of students, with or without a history of mental illness, should be able to participate, and even thrive, in study abroad programs. The success of the student, however, is predicated on a preemptive, transparent, supportive and confidential environment. Prior to travel, the student should develop self-awareness, with or without the assistance of a professional. E-learning tools, and even anonymous student self exams can assist in determining fitness for study abroad. Simultaneously, the college/university must educate their local and distant faculty/team leaders, as well as other students, to recognize and react appropriately to a mental health crisis.

Scholastic duty of care is not a static responsibility, but rather a dynamic one. The home college/university is expected to continue to provide ongoing education to the students, as well as to the accompanying local faculty, in the recognition and management of mental illnesses. Adherence to such a strategy will certainly help to mitigate the risk of a failed study abroad experience.

Although this study is limited to American students traveling overseas, behavior health is an issue with students globally. American institutions, hosting foreign students should therefore reevaluate their existing domestic resources to accommodate the psychological needs of their visiting students.

Table I[6]

Prevalence of Mental Illness on Domestic Campuses

National Prevalence

- Prior counseling 51%
- Prior meds 34%
- Prior psych hospitalization 9%
- Non-suicidal self injury 21%
- Seriously considered suicide 25%
- Prior suicide attempt 8%
- Seriously considered harming another 7%
- Intentionally harmed another 5% ui.

Table II

Diagnoses of Those Students Repatriated for Behavioral Health Issues

(01/01/10 -01/01/12)

Percentage

- Mood Disorders (including bipolar, anxiety, depression) 30%
- Personality Disorders 25%
- Substance Abuse Disorders 20%
- Eating Disorders 15%
- Schizophrenia and Other Psychotic Disorders 10%

Table III

Options For Student Health Insurance (Healthcare.GOV)

Option 1: Parents employer provided plan:

Advantage – no exclusions for pre-existing health issues

Disadvantage – attendance of a college/university outside of the provider network associated with this plan will require a higher deductible and co-insurance.

Option 2: The college/university plan:

Advantage – this plan exists in >50% of American colleges/universities and represents a low-cost option (particularly if the student does not qualify for the parents plan)

Disadvantages – The priority of this plan is preventative measures to mitigate against communicable diseases. This plan does not offer adequate coverage for major medical issues as typically it has a maximum benefit amount. Many do not cover pre-existing illnesses or coverage for prescription drugs.

Option 3: Individual insurance plan:

Advantages – very affordable and usually available on the internet (i.e. eHealthInsurance.com) providing

Disadvantages – Deductibles and co-payments may be higher than those for a college-sponsored health plan. Chronic or pre-existing conditions may preclude purchase of this type of plan.

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