



*Trigger warning: discussions of suicidality*

Like many students, the first time I had access to therapy and other mental health services was when I studied at a university that had those services on campus (which was, for lots of complicated reasons, not until graduate school). Like many students, I've spent about as much time on various mental health waitlists as I have in any kind of treatment. Like many students, I've pulled up the number a professor put in their syllabus to a suicide prevention line and wondered if I'm suicidal enough to call it. I've pressed call at 2 a.m. and immediately hung up. I've logged onto a crisis or warmline chat only to close the window when someone actually responded. I've packed up and gone to class the next day because I didn't know what else to do.

Like many instructors, I understand my syllabus as the first piece of framing for a new class. As a scholar of both feminist theory and the health humanities, I understand the need for the class to engage students as whole people rather than simply as intellects (see Charon, hooks). And so, when I write my syllabi, I am always thinking of students who, like I did, come to class with invisible disabilities, illnesses, and mental health struggles. I design a document that is just as much about getting students to remember where to turn in crisis as it is about getting them to remember key course deadlines. And at the end of this semester, like at the end of most semesters, I found myself looking back at that document and feeling like it's not nearly enough.

## **Waitlists and Suicide Lines: Mental Health in an Overburdened System**

When I write my syllabi, I encourage students to save numbers to suicide prevention lines, to campus mental health, to the community mental health clinic. Like my professors told me, I tell them those numbers could save someone's life, and I believe that, because they saved mine. I tell them if they need help starting the process, I'm more than happy to use every tool at my disposal to do so. At the end of my syllabus section about mental health, in keeping with university practice, I put, "If it is an emergency, please call 911."

But what I don't put in my syllabi is all the reasons students might not feel safe calling 911 in a crisis, especially given the high number of instances of police responding violently to calls for mental health help—including a recent case in my university's closest major city (see also Ben-Moshe and Schenwar et al.). What I don't put in my syllabi is that I know full well that every local mental health provider I mention, including the campus clinic, has a waitlist that is longer than the duration of the class. What I don't say is that students mustering the courage to reach out for help isn't actually going to get them care—and isn't going to get their university to invest in it, either. Unfortunately, I know my university isn't alone in these issues.

## **Autonomy and Access: Reframing Syllabus Policy**

Beyond simply having resources, there is the issue of making them accessible, and it is here that syllabi can do important work. Following disability activists like Mia Mingus, access isn't simply about listing resources (as stock mental health language for syllabi tends to do), but is *enacted* "in the service of love, justice, connection and community," an effort that "not only meet the immediate needs" of people today "but also work(s) to make sure that the inaccessibility doesn't happen again" ("Disability Justice' is Simply Another Term for Love"). That is, giving information in a syllabus doesn't mean it's accessible (something my students, for example, commented on in a class activity analyzing various offices on campus—including the mental health center. While many offices give resources and information on their websites, we discussed, it's often difficult to understand or wade through, and may not even be available to the student in the end anyway. That is, it's inaccessible).

Giving only limited information also risks promoting a one-size-fits all approach to mental health in the course, rather than positing access as a way of being with each other, of seeing and working to meet people's self-defined needs (see Sins Invalid's "10 Principles of Disability Justice"). Right now, then, as I look back at my syllabi from 2021-2022 and start to think about changes for the fall, I'm thinking about two praxis questions related to mental health and access: how can my syllabi move beyond giving information about mental health and instead move toward access? And, in what ways can my framing of mental health set a precedent for students' self-determination?

As I explore how my syllabus can respond to those questions, what comes to mind are:

- Flexible deadline policies with no questions asked (because students shouldn't feel like they have to justify their mental health as "bad enough" to ask for more time).
- Collective access practices (see Piepzna-Samarasinha), such as shared class notetaking, where everyone participates in creating access for/with each other.

- Participation policies that do not prioritize one form of participation (e.g., verbal participation in class discussion) that may not always be accessible to all participants, for reasons related to mental health or otherwise.
- Proactive feedback mechanisms for students to discuss their needs, co-create syllabus language with me, and return to and adjust that language as needs change.

I also think about offering resources beyond campus clinics and 911. Recently, I've included a line after the one about calling 911, explaining that I respect students' autonomy to choose options that are right for them, and that if they're looking for resources beyond what I've listed, they might check a list of additional resources—which include:

- Peer support from groups led by psychiatric survivors like Project LETS or campus peer support groups.
- Lifelines by and for trans folx, such as Trans Lifeline.
- Mental health resources for BIPOC individuals, such as, in my area, the Kansas City Black Mental Health Initiative and the Color Collective.
- Safety planning resources beyond 911, such as Fireweed Collective's toolkit.
- Mutual aid hubs and housing resources that can provide resources including assistance with mental health as well as assistance for issues related to food and housing (which, of course, have substantial impact on mental health).
- Warmlines and hotlines, with an in-syllabus explanation of each.

I'd also love to hear from other teachers about how they're thinking about the framing of mental health and access in their courses—particularly framing beyond standard language like campus clinics and “if it is an emergency, please call 911.” What policies, language, and practices supported students and created access last year? What are you hoping to do differently this fall?

Featured Image by by K. Mitch Hodge on Unsplash

#### Works Cited

Ben-Moshe, Liat. *Decarcerating Disability: Deinstitutionalization and Prison Abolition*. University of Minnesota Press, 2020.

Charon, Rita. *Narrative Medicine: Honoring the Stories of Illness*. Oxford University Press, 2006.

hooks, bell. *Teaching To Transgress*. Routledge, 2014.

Mingus, Mia. “Disability Justice” Is Simply Another Term for Love. Disability Intersectionality Summit, 2018. *YouTube*, <https://www.youtube.com/watch?v=lm21KpsNk1s>.

Piepzna-Samarasinha, Leah Lakshmi. “Creating Collective Access: Crip Made Brilliance in Detroit and Beyond.” *Allied Media*, Oct. 2020, <https://alliedmedia.org/wp->

content/uploads/2020/10/creating\_collective\_access.pdf.

Schenwar, Maya, et al. *Prison by Any Other Name: The Harmful Consequences of Popular Reforms*. The New Press, 2020.

Sins Invalid. "10 Principles of Disability Justice." *Sins Invalid: An Unshamed Claim to Beauty in the Face of Invisibility*, 17 Sept. 2015, <https://www.sinsinvalid.org/blog/10-principles-of-disability-justice>.