



# Student Mental Health and the Law



A Resource  
for Institutions of  
Higher Education



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## Recommended citation:

The Jed Foundation, *Student Mental Health and the Law: A Resource for Institutions of Higher Education*. New York, NY: The Jed Foundation, 2008.

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# Introduction

Making decisions about students who may be distressed, suicidal, or threatening to others can be difficult on many levels. An institution of higher education (IHE) needs to balance the interests of the individual and those of the broader community. In addition, each student and situation is different, so decisions need to be made on a case-by-case basis. These decisions must take into account what is permitted by law and what is considered good practice in the field.

The Jed Foundation (TJF) convened a roundtable of legal experts and IHE professionals to explore how the law impacts these challenging decisions and how it should inform overall campus policy. **The goal of this document is to provide all campus professionals with a summary of applicable laws and professional guidelines, as well as related good practice recommendations (highlighted in text boxes), to support well-informed decision-making around students at risk.** The good practice recommendations reflect input from roundtable participants, key research findings, and previous work of TJF and other organizations.

Before convening the roundtable, TJF asked representatives from campuses in its ULifeline network, an online mental health resource for students, to identify the legal and ethical issues they found most challenging when working with students in distress. Hundreds of IHE administrators and health/mental health professionals took part in the survey, and this document was designed to address some of the key challenges, including:

- **Discussing and disclosing information about students**
- **Working with students with disabilities**
- **Providing mental health services**
- **Understanding potential liability for student suicide and violence**

Both clinical and non-clinical IHE personnel are sensitive to their obligations to comply with applicable laws and guidelines. Although these considerations are critical, the primary focus should be on making

## OUR MISSION

### The Jed Foundation

The Jed Foundation is the nation's leading organization working to prevent suicide and reduce emotional distress among college students. The organization's programs are changing the way students and parents think about mental health, paving the way for more young people to get the treatment they need, and helping IHEs create safer, healthier campus communities.

caring, well-reasoned, and clinically appropriate decisions about students. Understanding legal and professional guidelines should also be only one element of an IHE's plan for working with students in distress (see Appendix for TJF/Suicide Prevention Resource Center's *Model for Comprehensive Suicide Prevention and Mental Health Promotion for Colleges and Universities*). While an IHE's plan must incorporate preparation for incidents of student violence toward others, it is important to recognize that suicide and other self-injurious behavior are much larger public health problems on campuses today.<sup>1</sup> Any efforts directed toward preventing suicide and intervening with at-risk students can also help prevent other types of violence.<sup>2</sup>

In most situations, keeping students safe, protecting students' rights and promoting the IHE's educational mission are complementary goals. In fact, these efforts can reinforce one another when decisions about at-risk students are made in an informed and thoughtful manner. For further guidance, please see TJF's [Framework for Developing Institutional Protocols for the Acutely Distressed or Suicidal College Student \(Framework\)](#) and the Additional Resources section at the end of this document.

# Privacy and Confidentiality

There are two primary categories of legal and ethical standards that govern how campus personnel can communicate about students among themselves, to parents, or to others. One category applies to *all* campus personnel<sup>3</sup> and includes the Family Educational Rights and Privacy Act (FERPA), which protects the privacy of the student “education record.”<sup>4</sup>

**As discussed further below, FERPA allows communication about a specific student among institution of higher education (IHE) staff, faculty, and administrators who are concerned about the welfare of the student or community.**<sup>5</sup> Note that some states and IHEs have laws or policies regarding student privacy that are more limiting than FERPA.

The second category of legal and ethical practice standards applies to medical and mental health records and to communications between clients and their physical or mental health care providers. This category includes professional licensing requirements, codes of ethics, and standards of practice<sup>6</sup> as well as state<sup>7</sup> and federal laws. State laws are particularly important in this area as they may include specific requirements about persons or entities that *must be* or *may be* notified under certain circumstances.<sup>8</sup> These confidentiality obligations limit communications between campus health care professionals and others on- or off-campus, including parents, unless a student provides consent or poses a substantial risk of harm to self or others.

Both categories of legal and ethical standards are explained more fully in this section. The applicability of the Health Insurance Portability and Accountability Act (HIPAA) to student medical and mental health records is also briefly discussed. It is important to consult legal counsel for state- and institution-specific information relating to communication about students.

## Family Educational Rights and Privacy Act (FERPA)

FERPA applies to all IHEs that receive federal funds. This federal law regulates the release of student record

### GOOD PRACTICE

#### Encourage Campus-Wide Communication

In addition to having a general policy regarding student record privacy, an IHE can benefit from developing a written protocol outlining the process for campus personnel to follow if they identify a student in distress or at risk for engaging in harmful behavior. Encouraging communication about and with students of concern can be a crucial step in getting them to seek appropriate help. Such a protocol should encourage campus personnel to share concerns about students with appropriate parties, such as the counseling center or case management team. To this end, it can be helpful to include specific contact information in the protocol such as phone numbers. In order to facilitate campus-wide efforts to assist a student, the protocol might stress the value of multiple notifications to, for example, both the counseling center and student affairs staff. To ensure compliance with applicable laws, it is important to include campus legal counsel when developing policies and protocols in this area. In tandem with developing a notification protocol, an IHE should educate its faculty and staff about how to identify students who are in distress or at risk for suicide or violence and how to reach out to them when appropriate.

information by IHEs and persons or entities, such as contractors, acting on their behalf.<sup>9</sup> Students, visitors, parents, and others who are not representatives of an IHE are not subject to FERPA, except in those cases in which they are acting as volunteers or agents for the IHE. Administrators should review the policies regarding student record privacy at their institutions and consult with the registrar, FERPA

compliance officer, or campus legal counsel for further information. [Note: In March 2008, the U.S. Department of Education proposed changes to its FERPA regulations which include expanded guidance to IHEs on interpreting FERPA in emergency situations.<sup>10</sup> The proposed regulations are not yet final but are consistent with the information provided below.]

### What are a student's rights under FERPA?

Under FERPA, a student at an IHE has the right to access his/her own education record upon request, even if s/he is younger than 18.<sup>11</sup> Upon receiving a request for review, an IHE has 45 days to produce the record for the student's inspection.<sup>12</sup> In meeting this request, FERPA does not require that the student be provided with a copy of the record, although an IHE may choose to provide one. FERPA also allows a student to limit the disclosure of his/her record to third parties with certain exceptions discussed below.<sup>13</sup> Of particular note, a student may *not* limit access to his or her record by a "school official" who has a "legitimate educational interest"<sup>14</sup> in the record or in the event of a "health and safety"<sup>15</sup> emergency.

### What is an education record (i.e., what is covered by FERPA)?

An education record is defined broadly to include all records directly related to a student and maintained by or on behalf of an IHE.<sup>16</sup> Despite its name, an education record is not just a single file but the aggregate of the IHE's recorded information, preserved in written or electronic form, which identifies a student.<sup>17</sup> In addition to exams, papers, and attendance records, an education record could also include items such as emails,<sup>18</sup> discipline complaints and materials,<sup>19</sup> financial account information,<sup>20</sup> disability accommodation records,<sup>21</sup> and parking tickets.<sup>22</sup> For example, an email that a professor receives from a colleague about a student is part of that student's education record.

### What is not an education record (i.e., what is not covered by FERPA)?

1. **Notes created solely for an individual's personal use and not shared with or available to others.**<sup>23</sup> The intent to share the record determines if it is subject to FERPA.

2. **Medical and mental health records used only for the purpose of treatment and shared only with those directly involved in treatment.**<sup>24</sup>

However, once information from a student's medical or mental health record is shared or used for a purpose other than treatment (e.g., decisions about medical withdrawal or disability accommodations), FERPA applies to the shared records.

3. **Personal observations of and direct interactions with a student.**<sup>25</sup> FERPA applies only to records. So, if a professor observes a student's behavior or engages in conversation with a student, these observations and interactions are not part of the student's education record.<sup>26</sup> If the professor is concerned about the student's behavior, s/he could legally discuss it with the student's parents, although pedagogical and other considerations may affect this decision. If the professor creates a written record which s/he intends to be shared and which describes the observations and interactions, that record is subject to FERPA.

4. **Law enforcement records created for a law enforcement purpose.**<sup>27</sup> If a copy of these records is sent elsewhere on campus (e.g., the dean of student's office) for a non-law enforcement purpose such as a disciplinary hearing, that copy is then subject to FERPA.<sup>28</sup>

5. **Employment records unless student status is a job requirement such as with a teaching assistantship, resident assistant position, or work-study position.**<sup>29</sup>

6. **Alumni records unless they relate back to an individual's time as a student.**<sup>30</sup>

### When can an IHE disclose information from an education record without a student's consent?

While broadly protecting student record privacy, FERPA identifies many exceptions in which an IHE may disclose personally identifiable information about a student from his/her education record without consent. The major exceptions are listed below. For some of these, an IHE is required to state its disclosure policy in its annual FERPA notice to students.<sup>31</sup> Note that certain



state laws may be more restrictive than FERPA and prohibit disclosure under some of these circumstances.

1. **Information *may* be disclosed in emergency situations to “appropriate persons if the knowledge of such information is necessary to protect the health or safety of the student or other persons.”**<sup>32</sup> Records about a student’s unsafe conduct, statements about self-harm, and threats to others fall within this category. An IHE must state in its annual FERPA notice whom it defines as appropriate persons.<sup>33</sup> This usually includes parents or whomever the student has designated as an emergency contact.
2. **Information *may* be communicated to any school official with a legitimate educational interest in such information.**<sup>34</sup> The information is not limited to academic matters and can include any good faith communication about a student, including concerns about a student’s welfare or public safety. In addition to sharing information with each other, school officials may also share it with certain external entities, such as those related to providing financial aid.<sup>35</sup> The IHE’s annual FERPA notice should define school official and what constitutes a legitimate educational interest.<sup>36</sup>
3. **If a student is considered to be a dependent of his/her parents or guardians for federal tax purposes, information *may*, if appropriate, be disclosed to parents once this status is verified.**<sup>37</sup> The information does not need to be related to a health and safety emergency. Note that this exception will not apply to international students whose parents do not file U.S. tax returns.
4. **If a student under 21 has violated an IHE’s alcohol or other drug use policy, information about the violation *may* be disclosed to parents.**<sup>38</sup>
5. **Information *may* be disclosed to another IHE in which the student seeks or intends to enroll.**<sup>39</sup> This practice must either be printed in the IHE’s annual FERPA notice or, if a disclosure is made, an attempt must be made to notify the student of the disclosure.<sup>40</sup> This provision is important in cases in which a student engages in behavior that violates the code of conduct on one campus and then seeks a transfer to another IHE.
6. **Information about a disciplinary action taken against a student for conduct that put him/herself or others at risk of harm *may* be shared with faculty and school officials at other IHEs who have a legitimate educational interest in the student’s behavior.**<sup>42</sup>
7. **“Final results” of a disciplinary proceeding conducted against a student who is an**

## GOOD PRACTICE

### Develop an Emergency Contact Notification Protocol

If an IHE collects names of emergency contacts from its students, it should adopt a protocol that outlines the circumstances under which these contacts can be notified and the personnel who are permitted to make such a notification. An IHE’s role following notification, its expectations of an emergency contact following notification, and the person at the IHE to contact for additional information about the protocol should also be made transparent to students and parents. For more information on developing an emergency contact notification protocol, please see *Framework*.<sup>41</sup>

Good practice suggests that a student be encouraged to notify, or allow the IHE to notify, his/her emergency contact (e.g., parent, spouse) under certain circumstances, such as when a student has expressed thoughts of suicide. While students cannot be required to sign a blanket Release of Information (ROI) as a condition of matriculation, IHEs may give students the option of signing one at the beginning of the school year or upon moving into campus housing. IHEs can also consider sending an ROI to every student’s parents and asking them to discuss the issue as a family. Note that state laws may dictate the length of time that an ROI is valid.

**alleged perpetrator of a crime of violence or a non-forcible sex offense may be disclosed to anyone, if it is determined that the student violated the IHE's rules or policies.**<sup>43</sup> "Final results" are defined as the name of the alleged perpetrator, the nature of the violation, and any sanction imposed against the student by the IHE.<sup>44</sup> The final results of a disciplinary proceeding *may* be disclosed to the victim of a crime of violence or a non-forcible sex offense regardless of whether the alleged perpetrator was found to be in violation of the IHE's rules or policies.<sup>45</sup>

## Clinician-Client Confidentiality

In addition to FERPA, there is a second source of legal and ethical standards that govern communication about students. The limits of clinician-client confidentiality are defined by licensure rules, professional codes of ethics and standards of practice, and state and federal laws.<sup>46</sup> Confidentiality obligations are important in the clinical setting but are not absolute. The disclosure of communications with a student client to appropriate persons or entities may be permitted or required under certain circumstances, such as when the client is assessed to be at a certain level of risk of harm to self or others. Determining whether a student reaches this level of risk is a matter of professional judgment on the part of a clinician, but consultation with professional colleagues can be helpful when the answer is unclear. Each student and circumstance must be reviewed individually.

A clinician should discuss the limits of confidentiality with a student at the beginning of the therapeutic relationship as part of informed consent. A student may consent to the release of information by signing a Release of Information form (ROI). Each ROI developed for use with a student should specify what information can be released and to whom, as well as the length of time that the ROI is valid. Note that an ROI can be rescinded by a student at any time and that state law may dictate how long it is valid if not specifically stated in the document. Even if a student consents to release through an ROI (or after a student rescinds an ROI), the student and clinician should understand the circumstances under which a disclosure may be made without the student's consent. Whenever appropriate,

a clinician should encourage and provide support for a student to notify his/her emergency contact (e.g., parents). If an involuntary notification does need to take place, careful thought should be given to the scope of the disclosure.

Without a student's consent, a clinician is rarely able to discuss information learned as part of the therapeutic relationship with campus administrators or even acknowledge that the student is in treatment. If an administrator feels that it is necessary to have information regarding a student's attendance or progress in treatment, the student may be asked by a clinician or administrator to sign an ROI. However, a student who signs a release should be able to establish some limits on the scope of the communication between an administrator and the treatment provider.<sup>47</sup> In contrast, a clinician can always receive information from any source (e.g., faculty member) about a student who is currently in treatment.

## Health Insurance Portability and Accountability Act (HIPAA)

The applicability of HIPAA to student health and mental health records has become a source of confusion for IHEs. One of the major goals of HIPAA was to establish national standards for protecting medical records and other personal health information.<sup>48</sup> The HIPAA Privacy Rule covers three types of entities: health plans, health care clearinghouses, and health care providers who conduct certain types of electronic transactions.<sup>49</sup> As a result of an express exclusion in the HIPAA definition of "protected health information," **HIPAA privacy rules do not apply to student treatment records created on campus, whether they are shared with others or used solely for treatment.**<sup>50</sup> The confidentiality of these records is protected under federal and state medical confidentiality<sup>51</sup> and disability laws.

As previously discussed (see page 8), student medical or mental health records that are created solely for the purpose of treatment at an IHE's health or counseling center, and are only shared with those directly involved in treatment, are excluded from FERPA protection.<sup>52</sup> However, if campus treatment records are shared for purposes other than treatment (including for purposes of insurance reimbursement or disability accommodation), they are covered by FERPA.<sup>53</sup>

So, if a student is seen at an IHE's counseling center, and his/her treatment records are used only by professionals directly involved in treatment, neither HIPAA nor FERPA applies. If, however, part of the record is shared with the disability services office because the student is requesting accommodations, the part of the treatment record now in the possession of disability services is covered by FERPA. The record kept in the counseling center is covered by neither HIPAA nor FERPA.

## GOOD PRACTICE

### Establish a Case Management Team

A case management team (also known as a behavioral intervention team or student at-risk response team) is an multidisciplinary group that meets to discuss students of concern. Having a team can be considered good practice, because it promotes information-sharing and coordinated action to address students who may be in distress or at risk for harming themselves or others. Key members may include representatives from student affairs, health/counseling services, residence life, disabilities services, campus security, and campus legal counsel. If an IHE expects faculty and staff to contact the team when concerned about a student, they should be provided with appropriate contact information. IHEs may wish to consider the pros and cons of making students aware of the team.

A well-run case management team can avoid violating privacy and confidentiality requirements by understanding the limits that apply to each participant. Campus professionals who are not direct providers of physical or mental health services to students may share detailed information about students with team members to address a health or safety emergency<sup>54</sup> or for any other legitimate educational purpose.<sup>55</sup> Although clinicians cannot disclose confidential information about clients except under very limited circumstances, they may serve as consultants regarding strategies for responding to difficult situations. Clinicians may also receive collateral information about students who are currently in treatment.

Any notes or documentation of team meetings become part of a student's education record and are thus subject to FERPA, unless for personal use only and not shared.<sup>56</sup> There has been significant debate as to whether teams should take notes at such meetings, and, if so, what note-taking protocol should be followed (e.g., having a single, trained notetaker). All questions about documentation should be discussed with an IHE's legal counsel. Regardless of whether notes are taken, the team must have a mechanism for following-up regarding a student of concern (e.g., assigning an appropriate faculty/staff member to function as a student's "case manager"). A case management team may, as part of its mandate, be responsible for assessing (or engaging outside expertise to assess) whether a student poses a threat to others. However, it is not recommended that the term "threat assessment" be used as part of the name of the team, unless the team's sole purpose is to assess threats of violence toward others and it has the professional expertise to do so. This language stigmatizes those with mental health disorders and may make faculty, staff, and students less willing to share information about a student of concern. Note that while both case management teams and multidisciplinary task forces are valuable, they are different. They may have overlapping membership, but a multidisciplinary task force is usually responsible for creating and implementing a campus-wide plan for addressing student mental health and wellness.

# Disability Law

Federal law protects students and employees from discrimination based on disability. The Americans with Disabilities Act (ADA) of 1990,<sup>57</sup> the ADA Amendments Act of 2008 (ADAAA),<sup>58</sup> and Section 504 of the Rehabilitation Act of 1973<sup>59</sup> are the major laws in this area, although state laws may add further protection. In addition, Title VIII of the Civil Rights Act of 1968 (Fair Housing Act)<sup>60</sup> may also apply to decisions regarding students who live in residence halls or other university housing.

The Office for Civil Rights (OCR) of the U.S. Department of Education<sup>61</sup> enforces the ADA, ADAAA, and Section 504 with respect to the rights of college students. OCR has issued a series of letters to IHEs concerning their compliance with these laws. In particular, OCR letters have analyzed adverse actions that IHEs have taken regarding students with mental health problems. OCR requires IHEs to make an individualized determination in each situation, tailoring the scope of its intervention to the student's particular circumstances.<sup>62</sup> It has been most supportive of IHEs that have provided procedures associated with due process such as notice to the student identifying the problem or infraction, opportunity for the student to provide an explanation before a decision is made (e.g., in a hearing), and, typically, opportunity for the student to appeal the initial decision.<sup>63</sup> Through proper procedures, an IHE can elicit comprehensive information about a particular student and situation in order to arrive at the best decision.

While this section focuses on students with disabilities, the procedures and approaches described, such as providing due process, are good practice when working with any student.

## Which students are protected under federal disability law?

A student who meets one or more of the following criteria is protected under disability law:<sup>64</sup>

- Has a "physical or mental impairment that substantially limits one or more major life activities" (e.g., learning, caring for one's self, walking, seeing, hearing, speaking, and working)

- Has a record of having had this type of impairment
- Is regarded as having this type of impairment

A student meets the definition of "regarded as" if s/he is discriminated against because of an "actual or perceived" impairment.<sup>65</sup> The impairment does not need to limit or be perceived to limit a major life activity.<sup>66</sup> Note that "[t]he definition of disability in [the ADAAA] shall be construed in favor of broad coverage of individuals...",<sup>67</sup> although not every mental health problem is treated as a disability under the law.<sup>68</sup> It can be helpful to confer with your disability services coordinator and legal counsel for guidance about specific situations and changes to the law or related regulations.

## What does disability law prohibit?

The law prohibits an IHE from discriminating either directly or indirectly against a "qualified" student with a disability, *on the basis of disability*, in any IHE program or activity.<sup>69</sup> Direct discrimination could include preventing a specific student with a disability from participating in a program (e.g., living in campus housing) on the basis of his/her disability. Indirect discrimination could occur if certain requirements, such as those in the student conduct code, have a disproportionately adverse impact on students with disabilities.

## What does it mean to be a qualified student with a disability?

A student is qualified in the legal sense if s/he meets the "academic and technical standards" required for admission to or participation in an IHE's education program or activity, with or without "reasonable accommodations."<sup>70</sup> Technical standards "include... essential provisions found in [an IHE's] code of conduct as well as the ability to not represent a 'direct threat' to self or others."<sup>71</sup> Specific examples of academic and technical standards include:

- 1) *intellectual, conceptual, and integrative skills, such as the ability to read, conduct research, and synthesize information;*
- 2) *communication skills, such as the ability to communicate orally and in writing with others;*
- 3) *behavioral and social*

attributes, including the ability to interact civilly with others; 4) attendance and participation, including the ability to regularly and punctually attend class; and 5) time management, including the ability to meet deadlines.<sup>72</sup>

## What are reasonable accommodations for a disability?

Reasonable accommodations are modifications to an IHE's rules, policies, or practices that are designed to provide a student with a disability with an equal opportunity to meet academic and technical standards as defined above.<sup>73</sup> IHEs are required to offer reasonable accommodations when requested by a student with a disability<sup>74</sup> except when the student only meets the "regarded as" part of the disability definition (see page 12).<sup>75</sup> To some extent, whether a specific accommodation is reasonable or not can depend on the circumstances.

## What are unreasonable accommodations for a disability?

An IHE is not required to modify its rules, policies, or practices to the extent that these modifications would "fundamentally alter" the essential nature of its programs.<sup>76</sup> The U.S. Supreme Court has ruled that an IHE need not compromise essential academic and technical requirements for any student.<sup>77</sup> For example, an IHE is not required to make fundamental changes to its core degree requirements.<sup>78</sup> An accommodation is also considered to be unreasonable if it places an "undue burden" on the IHE, such as a significant difficulty or expense.<sup>79</sup>

## Does a student need to self-identify as having a disability in order to receive accommodations?

Once enrolled, a student with a disability must take the steps to self-identify and request reasonable accommodations.<sup>80</sup> Therefore, an IHE has no legal obligation to accommodate a disability of which it is unaware.<sup>81</sup> As notification, it can require that a student make a reasonable attempt to identify as having a disability but cannot require specific words or statements.<sup>82</sup> A student who does not wish to receive accommodations need not identify him/herself as having a disability.<sup>83</sup>

## Can an IHE gather and use medical information about a student's disability?

An IHE may not require that a student provide a general medical release giving complete and full access to his/her medical or mental health care records.<sup>84</sup> However, requesting certain medical information is permissible in limited circumstances such as:

- The student has self-identified as having a disability. The IHE is entitled to medical information necessary to evaluate the student's condition and, if the condition is a disability, to help shape accommodations or mitigating measures.<sup>85</sup>
- The student has raised a disability in a disciplinary hearing (or other procedure) as a mitigating factor for his/her behavior.<sup>86</sup>
- The IHE, on a nondiscriminatory basis, believes that the student represents a "direct threat" to him/herself or others. Medical information may be used to assess the circumstances under which the student may pose a direct threat and to assess the probability that these may occur.<sup>87</sup>

As stated above, once information in medical records has been used for purposes other than treatment, it becomes part of a student's education record and is subject to FERPA.<sup>88</sup>

## What is a direct threat assessment?

An IHE must apply the direct threat standard before taking action (e.g., placing a student on involuntary leave) regarding a student with a disability whose behavior poses a "significant risk to the health or safety of [the student or] others..."<sup>89</sup> According to OCR, "[a] significant risk constitutes a high probability of substantial harm, not just a slightly increased, speculative, or remote risk."<sup>90</sup> In determining whether a student poses a direct threat, an IHE "needs to make an individualized and objective assessment of the student's ability to safely participate in the [IHE's] program based on a reasonable medical judgment relying on the most current medical knowledge and/or the best available objective evidence."<sup>91</sup> Specifically, the assessment must consider the following issues:<sup>92</sup>

- Nature, duration and severity of the risk
- Probability that the risky behavior will actually occur



- Whether reasonable accommodations or mitigating measures will sufficiently reduce the risk

The assessment may also consider whether a student who poses a direct threat remains qualified for a particular education program or activity under the law.<sup>93</sup> In deciding whether a student is qualified, an IHE should consider how the student functions in different situations, as it may be that the student represents a direct threat in some situations (e.g., residence hall) but not in others (e.g., classroom).<sup>94</sup> An IHE should also consider whether the threat can be mitigated so that the student remains qualified. This may be achieved by providing the student with reasonable accommodations or through steps the student is taking or has agreed to take such as attending therapy sessions.<sup>95</sup>

## Can a student with a disability be disciplined or placed on a leave of absence (LOA)?

**A student with a disability is expected to comply with all essential academic standards and requirements of the student code of conduct.**<sup>96</sup>

Therefore, a student does not need to meet direct threat criteria for an IHE to hold him/her accountable.<sup>97</sup> In fact, a qualified student with a disability can be removed from class, housing, or the IHE altogether (via expulsion, suspension, or leave of absence) after suitable due process procedures (e.g., notice, hearing, right to appeal).<sup>98</sup> IHEs must, however, take steps to ensure that disciplinary actions and other sanctions are not a pretext for discrimination.<sup>99</sup> In other words, the student must not face an “adverse action that is based on unfounded fear, prejudice, or stereotypes.”<sup>100</sup> It is important to consider the following questions before disciplining or removing a student with a disability:

- **Would you tolerate the same behavior from a student without a disability?** An IHE cannot sanction or dismiss a student with a disability for behavior that it tolerates from others.<sup>101</sup>
- **Have you provided reasonable accommodations for the disability?** An IHE cannot sanction or dismiss a student with a disability for behavior that violates the student code of conduct if the student's inability to comply is due to the IHE's failure to provide reasonable

accommodations.<sup>102</sup>

- **Should you consider mitigating factors?** If, in disciplining a non-disabled student, an IHE takes situational mitigating factors into account, then an IHE can consider the student's disability as a mitigating factor. This includes considering whether the student could meet essential requirements in the future if provided with reasonable accommodations. An IHE can also consider whether the student is participating or willing to participate in a course of treatment recommended by a health/mental health professional.<sup>103</sup>

An IHE may offer a student the option of a voluntary LOA if s/he faces potential disciplinary removal. If the student does not agree to this, the IHE should determine the appropriate course of action only after considering the specific facts and circumstances. Dismissing a student or placing him/her on involuntary LOA requires a case-by-case analysis. For example, an automatic “zero tolerance” policy requiring dismissal or withdrawal of a student who expresses suicidal ideation or makes a suicide attempt circumvents the necessary analysis and is legally vulnerable. An IHE's actions based on concerns that a student might engage in behavior that poses a risk to his/her health or safety should be based on an individualized assessment as described in the direct threat discussion.

Note that placing a student on involuntary leave solely for non-compliance with treatment recommendations could be in violation of disability law. If a mental health professional states that treatment is required to mitigate a direct threat posed by a student and the student does not agree to treatment, the IHE could discipline or remove him/her on this basis.<sup>104</sup> However, this action should be based on the fact that the student is a direct threat and the threat has not been mitigated rather than on the failure to engage in treatment. Mandating treatment as part of a disciplinary sanction is discussed on page 16.

For a student who poses a direct threat, an IHE may suspend the student or take other interim steps for immediate safety reasons while deciding on its final action. However, it must provide minimal due process

(e.g., notice, an initial opportunity for the student to respond) at the time of the suspension and full due process (e.g., hearing, right to appeal) as soon as possible.<sup>105</sup> In this situation, the IHE should consider the appropriateness of interim steps that it would take if the student did not have a disability.<sup>106</sup> Regardless of whether a student has a legally-recognized disability, providing due process procedures before dismissing or withdrawing a student from an IHE remains a recommended good practice.

### **What procedures may be used to discipline a student with a disability?**

The campus disciplinary system is the traditional forum for handling student behavior problems, and it can also be used for a situation involving a student with a disability. However, many IHEs prefer to address certain problems through a process involving campus personnel experienced in student disability issues, a preference supported by the Office for Civil Rights (OCR).<sup>107</sup> A key reason for this preference is a desire to operate disciplinary processes that support, rather than impede, help-seeking behavior. For example, a traditional campus disciplinary system may involve other students who serve on a conduct board. If a student with a mental health condition is forced to appear in a process that involves other students, s/he may be understandably reluctant to discuss mental health issues openly in this forum.

An option favored by some IHEs is the provision of dual disciplinary procedures for student misconduct: the standard procedure and one tailored for students who have self-identified as disabled and whose disability may have factored into the misconduct. With multiple forums comes the challenge of deciding which to use in a given situation, and this may require a preliminary examination of the facts. Routing a misconduct allegation through a "disability-friendly" forum without a student's consent or an indication that a student believes that the misconduct arose from his/her disability could be viewed as creating stigma or discriminating on the basis of disability. One option is for an IHE to examine the nature of the disability and the disciplinary infraction. The disability and the infraction may be unrelated, such as a student using a wheelchair who plagiarizes a term paper. In this

## **GOOD PRACTICE**

### **Develop Leave of Absence (LOA) Protocols**

It is useful for IHEs to have protocols for placing a student, regardless of whether s/he has a disability, on a voluntary or involuntary leave of absence (LOA) and for re-entry (see *Framework*<sup>108</sup> for guidance). Ideally, the majority of students who need to take an LOA do so voluntarily, either through their own initiative or at the IHE's suggestion. It is important to point out that attending an IHE may be a protective factor for suicide<sup>109</sup> and suicidal behavior<sup>110</sup> so that leaving campus will not always be the most helpful course of action for a student with emotional problems. However, IHEs can and should consider the needs of the broader campus community as well.

As part of an IHE's protocols for both voluntary and involuntary LOA, it is recommended that an IHE develop a list of actions to take once the leave has been decided upon but prior to the student's departure. For example, IHEs should ensure that the student has a place to go and a means of transportation appropriate to his/her level of distress or suicide risk. It is also important that family members understand enough about the reason behind the LOA that they are able to seek appropriate care for the student. Given that families may not be familiar with the warning signs for suicide, including the risk conferred by access to firearms and other highly lethal means, the IHE can educate them about these issues as appropriate. Healthcare providers need to satisfy their professional obligations, including making a referral to a clinic or practitioner near to where the student will be living.

situation, the student might be required to face the traditional disciplinary forum. If, however, the disability and the disciplinary infraction are related, then an alternate forum could be more suitable. This might occur if, for example, a student with bipolar disorder

caused a disruption on campus as part of a manic episode.

IHEs that opt for dual disciplinary procedures might ask the student for his/her consent to use the alternate process or allow the student to select the forum, provided that s/he has already self-identified as having a disability. Whatever process is used, students with disabilities are entitled to comparable disciplinary procedures as other students.<sup>111</sup>

### Can an IHE require that a student with a disability undergo mental health assessment or treatment?

As a condition for either remaining in school or returning from a leave of absence (LOA), it is legally permissible for an IHE to require a student with a disability to be assessed for risk of self-harm or harm toward others (see page 13 for discussion of direct threat assessment).<sup>112</sup> However, an IHE is not required

to rely solely on the opinion of a mental health professional regarding a student's readiness to return to or remain in school.<sup>113</sup> Non-healthcare professionals are entitled to make their own judgments, as long as their assessments are fair, stereotype-free, and based on reasonably reliable information from objective sources.<sup>114</sup>

State laws vary as to whether an IHE can mandate that a student with a disability receive treatment for a mental health problem, and there are few court decisions relating to college students per se. (Note that this issue differs from an IHE providing court-ordered outpatient treatment). Some courts have rejected disciplinary sanctions requiring that students obtain mental health treatment. Other jurisdictions accept such a requirement as a condition of returning from an LOA or of remaining at an IHE or in a residence hall. The Office for Civil Rights (OCR) has said that, if a student has been assessed as a direct

## GOOD PRACTICE

### Avoid “Zero Tolerance” Policies for Self-Harm

In addition to being legally problematic, a “zero tolerance” policy requiring automatic dismissal or withdrawal for a student who has expressed suicidal ideation or made a suicide attempt is clinically questionable and ethically dubious. It can also have the unintended consequence of discouraging students from seeking treatment. Students often know more than faculty members or administrators do about other students who may be at risk, and their assistance is an essential component of any effective suicide prevention program. But, students are unlikely to alert campus officials or refer their peers for help if they believe that a suicidal student will be disciplined or subject to mandatory withdrawal. In addition to not being good practice, such policies may be flawed on statistical grounds as well:

*Combining data from the available studies suggests that the odds that a student with suicidal ideation will actually commit suicide are 1,000 to 1. Thus, policies that impose [mandatory withdrawals] on students who manifest suicidal ideation will sweep in 999 students who would not commit suicide for every student who will end his or her life—with no guarantee that the intervention will actually reduce the risk of suicide in this vulnerable group. And even if such [mandatory withdrawals] were limited to students who actually attempt suicide, the odds are around 200 to 1 against the [IHE] having acted to prevent a suicidal outcome.<sup>115</sup>*

As a related issue, it is recommended that an IHE not include statements in the student conduct code (or its equivalent) that prohibit suicidality or self-injurious behavior. Such statements stigmatize students with mental health problems and discourage help-seeking. As mentioned previously, such provisions may violate disability law. Many IHEs prohibit “threats to the health and safety of self or others” through their conduct code, allowing disciplinary action to be taken against a student who violates this standard. However, if this broad language is used, IHEs should avoid using it to discipline students who may, for example, attempt suicide or engage in self-injury.



threat and a mental health professional states that a particular course of treatment will mitigate the threat, an IHE can require the student to participate in this treatment as a condition of remaining in or returning to school.<sup>116</sup> In such a situation, the length and scope of the treatment should be at the discretion of the mental health professional in consultation with the student. Requiring treatment for a student whose disability-related behavior violates the conduct code, but does not rise to the level of a direct threat, as a condition of remaining in school may violate disability law. It is important to remember that students who decline mandated treatment (or assessment) are still protected under disability law and, therefore, have the right to due process procedures (e.g., notice, hearing, opportunity for appeal).

### **What information can college administrators require about a student's mental health treatment?**<sup>117</sup>

If a student with a disability has been determined to be a direct threat and a mental health professional recommends that the student seek treatment, an IHE can require the student to provide documentation that s/he is attending counseling sessions. However, any such Release of Information (ROI) must be *limited* both in scope and length of time. As mentioned previously, an IHE may *not* require that a student provide a general medical release giving complete and full access to his/her medical or mental health records.

### **What requirements can an IHE establish for a student returning from an LOA?**

When establishing re-entry requirements, an IHE must not discriminate on the basis of disability.<sup>119</sup> Requirements for re-entry should be tailored to each

## **GOOD PRACTICE**

### **Understand the Complexities of Mandating Assessment and Treatment**

Apart from legal considerations, there are other issues to consider regarding mandated assessment and treatment, especially if the mental health professional who is assessing or treating a student works for the IHE. Having campus clinicians play the dual role of serving as a resource to students *and* judging a student's fitness to be on campus or providing mandated treatment could negatively affect students' perceptions of mental health providers and services. This can impact the willingness of students to seek treatment or recommend treatment to their friends. One alternative is for the IHE to rely on off-campus mental health professionals for mandated assessment or mandated treatment. However, transportation or insurance issues may complicate such arrangements.

Mandated treatment has a greater potential to negatively impact help-seeking than mandated assessment. For this reason alone, there are many who argue against using the approach. Mandated treatment can also reinforce the unrealistic expectation among campus administrators that counselors are able to "fix" every student with whom they work. In addition, if the goal is to help enable a student to meet academic and technical standards, many IHEs feel that the student should select the path to achieve this result.

Strong arguments also exist in support of mandated treatment. For example, if a student is assessed to be at risk for self-harm, treatment by a health or mental health professional will be critical to promoting that student's safety. In the context of re-entry from an LOA, a student's "home" mental health provider may recommend that a student only return to campus if s/he continues to receive services. (Note that the IHE always has the option of not following this recommendation and allowing the student to return without mandating treatment.)<sup>118</sup> IHEs that favor mandated treatment will need to decide how to determine the appropriate duration of treatment (e.g., when it is no longer medically necessary) as well as how to enforce the requirement. IHEs that are considering mandating treatment for the first time should carefully weigh the pros and cons prior to making a decision and proactively address how the counseling center's new role could impact students' views of campus mental health services.

individual student and, in fact, *must* be tailored if they are part of a student's accommodations for his/her disability. The requirements must also be related to the issues that necessitated the leave in the first place. The IHE cannot require that an illness be cured or that the disability-related behavior never recur, unless that behavior creates a direct threat that cannot be addressed by means of reasonable accommodations.<sup>120</sup>

An IHE may want to compare its requirements for a student who returns after a leave due to physical illness (whether a disability or not) to requirements for a student returning from leave due to mental health problems.<sup>121</sup> Although the overarching criteria for returning from leave for a mental or a physical health problem should be similar (i.e., the student can meet academic and technical standards with or without accommodations), the evidence required to demonstrate this may be more extensive for a student with a mental health-related disability.

If a student took or was placed on an LOA because s/he was a direct threat, the IHE must determine on a case-by-case basis what requirements a student must meet to demonstrate that s/he no longer poses a threat.<sup>122</sup> For example, the student might be required to supply documentation from a mental health professional citing evidence that the student is taking steps to reduce the threat, such as participating in appropriate treatment or taking advantage of available accommodations.<sup>123</sup> An IHE could, if this were the case, require that the student agree to continue these steps as a condition of readmission.<sup>124</sup> An IHE might also require that a student undergo an evaluation by a mental health professional selected by the IHE as a condition of return. Note that, whether or not the student requested accommodations for a disability prior to taking an LOA, his/her needs in this area may be different upon re-entry.

### **Is it legal to use a behavioral contract with a student who has a disability?**

Whether behavioral contracts are useful or even represent good practice has been widely debated among IHE professionals. In understanding the legal issues, it is important to distinguish among three different types of "contracts" that are often referred to interchangeably:

- **No-harm contract/no-suicide contract:** Some clinicians may ask a client to enter into a verbal and/or written agreement that the client will not harm him/herself. Given that there is no evidence of efficacy, but there is the risk of false assurance that the client is not in imminent danger of self-harm, no-harm contracts are no longer recommended for clinical use.<sup>125</sup>
- **Safety plan:** Clinicians use these plans, typically developed jointly with a client, to outline what s/he should do if feeling distressed or suicidal. When clinically indicated, safety plans can be helpful to clients.
- **Behavioral contract:** Some student affairs professionals and other non-healthcare administrators will enter into a contract with a student whose behavior is of concern. These contracts usually list conditions (e.g., not engaging in certain behaviors, having a mental health assessment) with which a student must comply in order to stay in school or in a residence hall and the consequences for non-compliance.

Many IHE attorneys advise against repeating in a behavioral contract any requirements that already appear in the student handbook or conduct code, as students are already accountable for complying with these existing requirements. Singling out certain provisions for special attention can create legal problems if, for example, the student later violates a code of conduct provision that was not mentioned in the behavioral contract. It is also possible that the student's situation may change, and it may not be appropriate for the IHE to abide by the agreement under these new circumstances. Although a student may believe that a signed behavioral contract is legally enforceable, contract law varies by state. It is difficult to generalize about the legal effect of a behavioral contract without examining its exact wording in light of state law.

As mentioned previously in the context of re-entry requirements, behavioral contracts cannot require that an illness be cured or that a student guarantee that disability-related behavior will never recur, unless this behavior creates a direct threat that cannot be addressed through reasonable accommodations.<sup>126</sup>

## Does there need to be someone on campus in charge of compliance with disability law?

Although federal law does not require every IHE to establish a disability services *office*, each IHE must appoint a disability services *coordinator* who is responsible for compliance with the law.<sup>127</sup> In addition, every IHE that receives federal funds must have “grievance procedures that incorporate appropriate due process standards and provide prompt and equitable resolution of complaints.”<sup>128</sup> A student may use grievance procedures to challenge an IHE’s determination that s/he does not have a disability, is not qualified, or poses a direct threat. Every IHE must make certain information readily available to all students, such as its grievance procedures, contact information for the disability services coordinator, and the location where a student can receive disability services.<sup>129</sup>

### GOOD PRACTICE

#### Establish Individualized Re-Entry Requirements

Whether or not a student has a disability, re-entry requirements should be reasonably related to the reasons for the student’s LOA. It is productive for the student to be involved in shaping these requirements prior to leaving the IHE. The student should understand that the requirements may change in response to developments during the leave. It is useful for faculty and staff to understand the re-entry process, and it can be helpful to have one contact on campus who serves as an entry point for all returning students, such as the dean of student’s office. IHEs should assist each student with the transition back to campus and develop a plan for intervening early should the student begin to experience problems.

# Delivering Mental Health Services

IHEs are not obligated to offer mental health services but should be transparent with both current and prospective students and their families about what services are in place. In addition, any services an IHE does provide must be delivered in keeping with professional codes of ethics and standards of practice<sup>130</sup> and in a non-discriminatory manner.<sup>131</sup> Providers should, for example, have current licensure, and professionals-in-training should receive meaningful oversight. Campus providers should also discuss best practices in the context of available resources with their supervisors as well as with campus risk managers and legal advisors.

## How should a referral be made from the health/counseling center to a community provider?

A student might be referred to a community provider for continued treatment for any number of reasons, including personal choice. Most counseling centers have limits on the number of sessions they are able to provide per student and the types of services they can offer. These limits and the referral process should be discussed with students at the beginning of treatment. Financial resources may limit a student's options for treatment in the community, and some regions may have limited options for community providers.

Professional standards suggest that any student referred out of the campus health or counseling center should be given the names of two or three community treatment providers, assuming that eligible providers are available in the area. Ideally, the referring provider should maintain an updated list of appropriate providers (e.g., licensed clinicians) and consider whether a student should be matched with specific providers based on their expertise or practice area. Once a referral has taken place, it is good professional practice to make at least one attempt to follow up with the student about whether s/he has seen the new provider.

Any decision to terminate the care of a student

### GOOD PRACTICE

## Encourage Students to Be Proactive about Their Mental Health

Effective outreach by health and counseling centers begins with educating all students about available campus services. Providing a list of local community resources can also be helpful. Health/counseling professionals can also consider asking *enrolled* students to share information about their current or past mental health history and treatment in the same way that they submit their immunization records. This information, like other health record information, would be collected and maintained by the health/counseling center and remain confidential. For students in on-going treatment, facilitating continued care may decrease the number of students who find themselves in crisis during the semester. This may reduce, in turn, the number of urgent assessments that mental health professionals may need to make. College mental health providers may also want to engage in additional outreach to those incoming students who disclose a history of more serious mental health problems such as psychiatric hospitalizations or suicide attempts. Again, given the stressors associated with starting college, early efforts to connect students to available services may prevent them from reaching the point of crisis later. Prior to requesting this information from students, it is recommended that an IHE consult with legal counsel.

in distress should be made in consultation with a supervising clinician or colleague and legal counsel, if available, since providers may have on-going obligations in such situations. If the student's care must be transferred when the student is unstable (e.g.,

at significant risk for suicide), the referring provider should take steps to see that care is successfully transferred and the new provider sees the student. In addition, the new provider should have the professional capacity to address the student's specific concerns or needs.

### **How should a referral from a third party to the campus health/counseling center be handled?**

It has become increasingly common for a third party, such as a peer, resident assistant, or professor, to contact the health/counseling center about a student of concern. In general, if a third party notifies the counseling center that a student has been referred, the counseling center has no obligation to follow up with the referred student if s/he does not make or keep an appointment. However, some consider it good professional practice to reach out to the student. If the third party indicates that the safety of the student or others may be at risk, a qualified professional should attempt to contact the student and conduct a clinical risk assessment as soon as possible. If an IHE has a case management team or its equivalent, the health/counseling center can bring the student to the team's attention, provided that the student is not already a client. The team may have additional information about the student that could be helpful in guiding a response. Regardless of the protocol, health/counseling center staff should understand and follow the IHE's procedures for handling third-party referrals.

When a clinician meets with a referred student, any discrepancies between the concerns expressed by the referring party and the student's statements should be addressed. Confidentiality laws will generally preclude informing the referring source, without the student's consent, if the student sought treatment and about the content of the sessions or the clinician's impressions. It is both good professional practice and appropriate risk management to document conversations with third parties, attempts to contact the student, and results of any risk assessment.

### **What efforts should be made to obtain a student's past treatment records?**

A mental health professional should make reasonable

## **GOOD PRACTICE**

### **Offer Insurance with Mental Health Coverage**

Student health insurance has become a key issue for IHEs. As discussions about requiring all students to have health insurance continue, the importance of providing mental health benefits in IHE-sponsored plans should be part of the conversation. With few exceptions, federal law now mandates parity between medical/surgical benefits and mental health or substance abuse disorder benefits in group health plans that offer both types of coverage.<sup>132</sup> There are sound policy reasons to offer student health insurance plans with mental health benefits. For example, as a growing number of students have sought help at counseling centers, many have set limits on the number of sessions they provide to each student. Counseling centers thus face a growing need to refer a student who has reached his/her campus limit to a community provider; however, many students cannot afford to continue treatment off-campus without insurance. Offering insurance plans that cover treatment for mental health and substance abuse disorders makes a statement about the importance of protecting students' mental and physical health. In order to work toward the goal of providing mental health benefits in IHE-sponsored insurance plans, it is recommended that professional health and counseling staff be involved in insurance-related decisions.

efforts to obtain the past treatment records of a student client, provided that the student gives consent. If the past treatment provider does not respond to the first request, at least one additional attempt (e.g., phone call) should be made. Enlisting the student's assistance may be helpful. The provider should document any efforts to obtain past records, including efforts to gain the student's permission to access them. If the records cannot be obtained, it is a matter of professional judgment whether to continue treating that student.



## What is appropriate follow-up when a student discontinues treatment?

It is not uncommon for a student who has expressed suicidal ideation or thoughts of harm toward others to drop out of treatment. Applicable IHE policies or procedures should be followed in these situations. In general, professional standards suggest that the provider should attempt to contact the student at least once. Avenues for contact may include email or the student's on-campus address. If the student is at significant risk for suicide or violence, more extensive follow-up attempts are indicated.

When uncertainty exists about the appropriate response, the provider should consider consulting with professional colleagues before deciding on a course of action. Professional standards also call for documentation of all conversations with or attempts to contact a student who has discontinued treatment as well as any professional consultations. When following up with a student, it can be helpful to discuss past triggers for concerning thoughts or behaviors and to identify potential actions that the student could take should the triggers arise.

## What is appropriate follow-up when a student has been discharged from a hospital?

If a student poses a serious risk of harm to self or others, a campus health/mental health professional may admit the student directly to a psychiatric unit or may send the student to the emergency room (ER) of a hospital for further evaluation. In some ERs, a student may not receive an evaluation by a mental health professional. With or without such an evaluation, the hospital may decide that admission is not warranted. The result can be that a student whom a campus professional deemed at imminent risk returns to campus within a few hours. This can also occur if a student seeks treatment at a hospital on his/her own initiative.

When a student has been discharged from emergency or inpatient care, a health professional has deemed him/her safe to return to the community and worked with the student to create a follow-up plan. However, suicidal thoughts tend to wax and wane and inpatient

### GOOD PRACTICE

## Promote Appropriate Boundaries

One part of creating a strong mental health safety net is educating students, faculty, staff, and families about the signs and symptoms of emotional problems and actions to take if they are concerned about a student. However, an IHE should not ask or encourage faculty, students or other non-healthcare personnel to serve in the capacity of a health/mental health professional. In particular, an IHE should avoid asking untrained individuals to assume responsibility for a student who poses a risk of suicide or violence. For example, it is neither legally advisable nor good practice to ask resident assistants, friends, or roommates to “watch” a student who may be at risk. Similarly, faculty and staff should avoid taking on a professional role for which they are not trained. Non-mental health professionals need to understand the limits of what they can provide to students and focus on making appropriate referrals. Reaching out to a student of concern is an important element in creating a caring community, but well-intentioned informal counseling efforts may delay the student's receipt of professional services.

hospitalizations are often brief, so IHEs may consider requiring another mental health assessment upon the student's return to campus. This may help determine whether there are supports and services that can help the student to remain at the IHE. Among the variables to be considered in deciding if and when to conduct such an assessment are the reason for the student's ER visit or hospital admission, whether the student was assessed at the hospital by a professional with mental health training, and whether there was communication between the campus provider conducting the original assessment and the hospital.

These considerations also apply to a student who lives off-campus, although it may be less likely for an IHE to learn about such a student's hospitalization

or discharge. If a student needs to notify the IHE upon return from an ER visit or hospitalization, the IHE should convey this requirement to students in its conduct code or similar policy.

### **How should web-based screening and counseling be provided?**

Web-based screening and counseling provide additional points of contact for students who may be most comfortable communicating online. They may also facilitate an interaction or preliminary assessment that might supplement, but not replace, face-to-face services. Concerns have been raised about potential liability in the event that a student discloses thoughts of self-harm or harm toward others in an online screening program and no timely intervention is made to prevent the harm. Any mental health screening program, whether conducted online, at the student union, or by other means, should clearly indicate whether it is anonymous. If it is, the program should state that no follow-up will be provided unless directly requested by the student (e.g., by contacting the health/counseling center). A good program will also suggest resources (e.g., 911, National Suicide Prevention Lifeline at 800-273-TALK, or a campus emergency number) in the event that the student is suicidal or experiencing another type of emergency. There is no indication that an IHE faces any liability risk by offering an anonymous screening program that follows the advice listed above (see TJF's screening tool on [ULifeline.org](http://ULifeline.org)).

If the screening is not anonymous, its purpose should be clearly explained along with how the IHE will respond, including the average amount of time it takes for a professional to view the screening results. Also, the same list of emergency resources mentioned previously should be provided. If a student is identified by a non-anonymous online screening program as being at risk for self-harm or harming someone else, health/mental health professionals should take reasonable steps to address the risk. Consultation with legal staff can be helpful in establishing procedures and guiding a response.

As with face-to-face counseling, there should be informed consent when engaging in web-based

## **GOOD PRACTICE**

### **Develop a Memorandum of Understanding (MOU)**

It is recommended that an IHE develop an MOU, affiliation agreement, or similar document with any local hospital that may receive a student for either assessment or hospitalization. Parties to an MOU could include the IHE's dean of students and counseling center director and staff from the hospital's ER or psychiatric unit. Such an agreement could stipulate that a student will be asked by hospital staff to consent to a discussion between a campus mental health professional and the attending hospital physician prior to the student's discharge. This can minimize the risk that a student will return to campus housing without anyone notifying IHE counseling or other staff. However, a formal agreement by itself may be insufficient. Meeting on a regular basis with directors of local emergency rooms and psychiatric units to establish and foster good relationships can facilitate such collaboration. For more information about developing MOUs, please see *Framework*.<sup>133</sup>

counseling. If a therapeutic relationship is established, a clinician has a duty to the student and, therefore, accepts liability risk as in any such relationship.

### **What is appropriate supervision of peer hotlines or peer counseling services?**

The advisability of using peer-run hotlines or counseling services is a subject of debate among IHEs. From a legal standpoint, if an IHE implements such services and then fails to operate them with reasonable care, it may be liable for resulting harm. It is essential that students and other volunteers who provide peer counseling or who staff emergency or suicide hotlines receive appropriate training and supervision. It is also important that they be able to access their supervisors easily and that they consistently follow formal, regularly reviewed procedures. Since student volunteers may be unavailable to staff a hotline at certain times of the year, such as during finals or

around holidays, care should be taken to represent accurately the availability of services to the campus community. It would be prudent for legal counsel to review procedures related to any peer-run hotlines or counseling services and ensure that they undergo periodic operational checks.

### **How should an at-risk student be transported to a hospital?**

Risk management concerns suggest that, unless unfeasible due to the location of an IHE, an at-risk student should be transported to the hospital under the supervision of emergency personnel, preferably by ambulance but with the assistance of the police if necessary. Often, emergency personnel have received special training in transporting persons in distress.

### **Can mental health treatment be provided to a minor without parental consent?**

Consent-to-treat laws for minors differ by state. In some states, students may be able to consent to some types of treatment, including mental health and substance abuse treatment, prior to turning eighteen. Campus legal counsel can provide state-specific information.

## **GOOD PRACTICE**

### **Proactively Address Potential Conflicts**

If a conflict arises between a campus mental health professional and an IHE administrator regarding the appropriate response to a student in distress, every effort should be made to discuss available options in light of the best interests of the student and community and in the context of applicable laws and professional practice standards. Mental health providers may need to remind non-health professionals about their professional obligations to at-risk clients, and administrators may need to remind mental health providers about institutional interests. In all cases, the clinician should carefully document the decision-making process, including all options discussed with the administration. To avoid this type of conflict, it can be helpful for campus mental health providers, campus counsel, and administrators to discuss a variety of hypothetical scenarios in advance. Without the pressure of an actual situation, they can explore multiple options and clarify their respective roles.

## **GOOD PRACTICE**

### **Reach Out to Affected Students**

Students who have been impacted by another student's death (by suicide or other means), suicide attempt, or concerning behavior (e.g., cutting) should be made aware of the services available at the health/counseling center. Being proactive about reaching out to affected students and encouraging help-seeking will decrease the likelihood that these students will suffer in silence.<sup>134</sup>



# Liability for Student Suicide and Violence

The potential for an IHE to be held liable for a student's suicide is a recent phenomenon. For decades, suicide was considered to be a wrongful act, solely the fault of the suicidal individual. Therefore, IHEs historically faced no significant risk of litigation regarding a student's suicide. Recently, a few courts have begun to consider lawsuits alleging that an IHE has a responsibility to provide some level of care to prevent suicide or to mitigate suicide risk. However, the law in its current state is largely inconclusive regarding such responsibility. Note that most cases settle before the courts are afforded the opportunity to make pronouncements of law.

There is no immediate legal movement to impose broad-based suicide prevention responsibilities on colleges, despite the fact that there have been several highly publicized lawsuits. Issues of potential liability are further complicated by competing policy considerations that must be taken into account when deciding whether colleges have a "duty of care" to prevent suicide. Courts will be cautious in defining such a duty, for reasons stated in *Mahoney v. Allegheny College*:

*Concomitant to the evolving legal standards for a 'duty of care' to prevent suicide, are the legal issues and risks associated with violations of the therapist-patient privilege, student right of privacy and the impact of mandatory medical withdrawal 'policies' regarding civil rights of students with mental disability. In effect . . . courts are facing a multiplicity of public policy issues involving the legal and ethical dilemmas of student privacy and welfare concerns within the context of causes of action involving the best interests and rights of students, parents, and the University.*<sup>135</sup>

The law does provide some guidance for IHEs, who could conceivably be held legally responsible in the following situations:

- The IHE caused the suicide or serious injury of a student by illegally or negligently prescribing, dispensing, or giving access to medication.<sup>136</sup>
- The IHE caused emotional distress and suicide through some exceptionally abusive and deliberate process, such as knowingly and maliciously prosecuting a clearly innocent student under the discipline code.<sup>137</sup>
- The IHE caused physical trauma that resulted in physical and mental health consequences, including suicide (e.g., a negligently-caused vehicular accident that results in pain, depression, and suicidal ideation).<sup>138</sup>
- The IHE failed to use reasonable care to prevent the suicide of an individual under "suicide watch" (i.e., the constant monitoring of a person known to be at significant risk for suicide in order to prevent suicidal behavior). Occasionally, the police have been held responsible when individuals under arrest have caused themselves harm, but it is clear that merely providing non-negligent health/mental services or other interventions short of custodial suicide watch will not trigger liability.<sup>139</sup>

The most complicated legal liability issues, which campuses should closely monitor for further developments, are described below. Each one may see further litigation, and the law relating to potential responsibility for suicide prevention will develop in light of such activity.

First, the law relating to medical malpractice for suicide will continue to be tested. Providers of health/mental health services, subject to professional standards of care, will likely face increasing litigation over treatment, intervention, and medication issues. The law will assess responsibility under such standards by asking, "Was the care that was given reasonable and customary for that type of professional?" Note that there is also the possibility that non-health care professionals who participate in decision-making concerning students at risk will face responsibility as part of a multidisciplinary team. However, concerns about liability should not control professional decision-making. IHE employees should understand that appropriate professional decisions, made in good faith and with the interests

of the student and the community in mind, are very unlikely to result in individual liability. All campus employees should talk to their risk managers and campus counsel to learn about issues such as indemnification, immunity, and insurance coverage for decisions made within the scope of employment.

Second, there has been recent litigation claiming that IHEs have an independent duty to notify parents of a student's dangerous, suicidal, and/or self-destructive behavior. To date, the courts have not offered consistent guidance about this, but the proposed amendments to the FERPA regulations<sup>140</sup> may help clarify an IHE's discretion in notifying parents in emergency situations. It is clear, however, that the law does not require an IHE to warn parents about what it does not know nor could not reasonably have known. See pages 8-9 for the discussion of FERPA and the circumstances under which emergency contact notification can take place without a student's consent.

Third, an IHE's responsibility regarding a student who threatens violence toward others and/or recklessly puts the lives of others at risk is significant. In this regard, the law since *Mullins v. Pine Manor College*<sup>141</sup> has been clear. As landowner and landlord, IHEs must use "reasonable care" to protect against "foreseeable danger," but an IHE essentially has two distinct, yet sometimes overlapping, responsibilities. It must use reasonable care to protect against background risk such as the risk of rape in dormitories. But, an IHE must also use reasonable care when a specific individual presents a foreseeable danger to others, which could be mitigated by using reasonable care. This often involves what has come to be known as a "threat assessment."

In sum, the scope of an IHE's legal responsibility for the prevention of violence toward others is clearer than for the prevention of suicide. Unfortunately, such legal uncertainty hinders the development of best practices, as there can be an inclination not to shoulder responsibility that might fall elsewhere. It also fuels concern by some IHEs that, by engaging in suicide prevention or intervention activities, they are assuming legal duties. This concern is likely unwarranted. One of the specific areas that seems to cause the most apprehension is deciding whether to have written versus unwritten protocols relating to at-risk students. Some IHEs fear that if they have written protocols and do not follow them, they could be liable in the event of a student death. Although this may be true, it is also true that following unwritten protocols or having no protocols at all could create liability risk. It is good practice for IHEs to have and follow protocols, whether written or not, relating to students at risk.

Ultimately, litigation risk can be substantially reduced by following some simple advice:

- *Use good professional judgment.*
- *Develop a comprehensive suicide/violence prevention program.*
- *Follow written and/or unwritten policies and protocols.*
- *Ensure that available mental health services are in keeping with professional codes of ethics and standards of practice. Be sure to accurately portray the services available.*
- *Work with resident advisors, faculty members, and other "gatekeepers" to encourage distressed students to seek professional help.*
- *Avoid "zero tolerance" policies that eliminate the individualized assessment of students in distress.*

## GOOD PRACTICE

### Establish and Follow Appropriate Policies and Protocols

Whether written or unwritten, it is recommended that policies and/or protocols:

- Reflect input from all appropriate individuals on campus including students (see *Framework*<sup>142</sup> for complete list),
- Define the expectations for all professional or student staff named in the policies,
- Are provided to all appropriate faculty and staff along with necessary training,
- Are clearly communicated to students and parents,
- Are always followed, and
- Are reviewed and updated regularly.

# Endnotes

- <sup>1</sup> Morton M. Silverman et al., “The Big Ten Student Suicide Study: A 10-Year Study of Suicides on Midwestern University Campuses,” *Suicide and Life-Threatening Behavior*, 27, no. 3 (1997): 285-303.; National Center for Education Statistics, “Digest of Education Statistics: 2007.” U.S. Dept. of Education, “Summary Crime and Security Statistics – Criminal Offenses.”
- <sup>2</sup> Eric Hoover, “Q&A: Expert on Campus Safety Has Advice for Colleges,” *Chronicle of Higher Education*, February 15, 2008, online edition.; Bryan Vossekuil et al., *The Final Report and Findings of the Safe School Initiative: Implications for the Prevention of School Attacks in the United States* (Washington, D.C.: U.S. Department of Education, Office of Elementary and Secondary Education, Safe and Drug-Free Schools Program and U.S. Secret Service, National Threat Assessment Center, 2002), 32-37.
- <sup>3</sup> 20 U.S.C. § 1232g; 34 C.F.R. § 99.3
- <sup>4</sup> 20 U.S.C. § 1232g; 34 C.F.R. § 99.3
- <sup>5</sup> 20 U.S.C. § 1232g (b)(1)(A); 34 C.F.R. § 99.31 (a)(1)
- <sup>6</sup> For example, see American Psychological Association, “Ethical Principles of Psychologists and Code of Conduct,” *American Psychologist*, 57, no. 12 (2002): 1060-1073.
- <sup>7</sup> See [Health Privacy Project](#)
- <sup>8</sup> See Claudia Kachigian and Alan R. Felthous, “Court Responses to *Tarasoff* Statutes,” *Journal of the American Academy of Psychiatry and the Law*, 32 (2004): 263-273.
- <sup>9</sup> 20 U.S.C. § 1232g; 34 C.F.R. § 99.1 and 99.3
- <sup>10</sup> Family Educational Rights and Privacy, 73 Fed. Reg., 15,573, 15, 589 (proposed March 24, 2008).; response of American Council on Education to proposed changes to FERPA regulations
- <sup>11</sup> 20 U.S.C. § 1232g(d); 34 C.F.R. § 99.5
- <sup>12</sup> 20 U.S.C. § 1232g(a)(1)(A) and (B); 34 C.F.R. § 99.10
- <sup>13</sup> 20 U.S.C. § 1232g (a)(5)(A), (b)(1), (b)(2), (b)(4)(B), and (f); 34 C.F.R. § 99.30-31
- <sup>14</sup> 20 U.S.C. § 1232g (b)(1)(A); 34 C.F.R. § 99.31 (a)(1)
- <sup>15</sup> 20 U.S.C. § 1232g (b)(1)(I); 34 C.F.R. § 99.31(a)(10) and 99.36
- <sup>16</sup> 20 U.S.C. § 1232g (a)(4); 34 C.F.R. § 99.3
- <sup>17</sup> 20 U.S.C. § 1232g (a)(4); 34 C.F.R. § 99.3
- <sup>18</sup> *Trustees of Bates College v. Congregation Beth Abraham*, 2001 WL 1671588 (Me. Super. Ct. Feb. 13, 2001).
- <sup>19</sup> Letter from LeRoy S. Rooker, Dir., Family Policy Compliance Office, U.S. Dept. of Education, to Attorney for School District (October 31, 2003).
- <sup>20</sup> Letter from LeRoy S. Rooker, Dir., Family Policy Compliance Office, U.S. Dept. of Education, to Ardith Lynch, Assoc. General Counsel, Univ. of Alaska (May 23, 2005).
- <sup>21</sup> Letter from LeRoy S. Rooker, Dir., Family Policy Compliance Office, U.S. Dept. of Education, to David Cope, Asst. Professor, Univ. of North Alabama (November 2, 2004).
- <sup>22</sup> 20 U.S.C. § 1232g (a)(4)(A)
- <sup>23</sup> 20 U.S.C. § 1232g (a)(4)(B)(i); 34 C.F.R. § 99.3
- <sup>24</sup> 20 U.S.C. § 1232g (a)(4)(B)(iv); 34 C.F.R. § 99.3
- <sup>25</sup> Letter from LeRoy S. Rooker, Dir., Family Policy Compliance Office, U.S. Dept. of Education, to J. Chris Toe, President, Strayer Univ. (March 11, 2005).
- <sup>26</sup> However, if the personal knowledge was gained as part of making an official determination (e.g., faculty member knows a student’s grade because s/he awarded it), it is considered part of the education record. See Letter from LeRoy S. Rooker, Dir., Family Policy Compliance Office, U.S. Dept. of Education, to Elvira Strehle-Henson, Assoc. University Counsel, Univ. of Colorado at Boulder (February 11, 2005).
- <sup>27</sup> 20 U.S.C. § 1232g (a)(4)(B)(ii); 34 C.F.R. § 99.8
- <sup>28</sup> 20 U.S.C. § 1232g (a)(4)(B)(ii); 34 C.F.R. § 99.8
- <sup>29</sup> 20 U.S.C. § 1232g (a)(4); 34 C.F.R. § 99.3
- <sup>30</sup> 20 U.S.C. § 1232g (a)(4); 34 C.F.R. § 99.3

<sup>31</sup> 20 U.S.C. § 1232g (e); 34 C.F.R. § 99.7; see also Family Policy Compliance Office, [Model Notification of Rights under FERPA for Postsecondary Institutions](#). U.S. Dept. of Education.

<sup>32</sup> 20 U.S.C. § 1232g (b)(1)(I); 34 C.F.R. § 99.31(a)(10) and 99.36

<sup>33</sup> 20 U.S.C. § 1232g (e); 34 C.F.R. § 99.7; see also Family Policy Compliance Office, [Model Notification of Rights under FERPA for Postsecondary Institutions](#). U.S. Dept. of Education.

<sup>34</sup> 20 U.S.C. § 1232g (b)(1)(A); 34 C.F.R. § 99.31 (a)(1)

<sup>35</sup> 20 U.S.C. § 1232g (b)(1)(D); 34 C.F.R. § 99.31(a)(4)(i)

<sup>36</sup> 20 U.S.C. § 1232g (e); 34 C.F.R. § 99.7

<sup>37</sup> 20 U.S.C. § 1232g (b)(1)(H); 34 C.F.R. § 99.31(a)(8)

<sup>38</sup> 20 U.S.C. § 1232g (i); 34 C.F.R. § 99.31(a)(15)(i)

<sup>39</sup> 20 U.S.C. § 1232g (b)(1)(B); 34 C.F.R. § 99.31(a)(2)

<sup>40</sup> 20 U.S.C. § 1232g (b)(1)(B); 34 C.F.R. § 99.34

<sup>41</sup> The Jed Foundation, *Framework for Developing Institutional Protocols for the Acutely Distressed or Suicidal College Student*. (New York: The Jed Foundation, 2006).

<sup>42</sup> 20 U.S.C. § 1232g (b)(1)(I) and (h); 34 C.F.R. § 99.31(a)(10) and 99.36

<sup>43</sup> 20 U.S.C. § 1232g (b)(6)(B); 34 C.F.R. § 99.31(a)(14)

<sup>44</sup> 20 U.S.C. § 1232g (b)(6)(C)(i) ; 34 C.F.R. § 99.39

<sup>45</sup> 20 U.S.C. § 1232g (b)(6)(A); 34 C.F.R. § 99.31(a)(13)

<sup>46</sup> See notes 6-8.

<sup>47</sup> See [Letter from Robert E. Scott, Team Leader, Office for Civil Rights, U.S. Dept. of Education, to Kenneth Nielsen, President, Woodbury Univ. \(June 29, 2001\)](#).

<sup>48</sup> See U.S. Dept. of Health and Human Services, [“About the Privacy Rule FAQs.”](#)

<sup>49</sup> 45 C.F.R. § 164.104

<sup>50</sup> 45 C.F.R. § 164.501

<sup>51</sup> See [Health Privacy Project](#)

<sup>52</sup> 20 U.S.C. § 1232g (a)(4)(B)(i); 34 C.F.R. § 99.3

<sup>53</sup> 20 U.S.C. § 1232g (a)(4)(B)(i); 34 C.F.R. § 99.3

<sup>54</sup> 20 U.S.C. § 1232g (b)(1)(I); 34 C.F.R. § 99.31(a)(10) and 99.36

<sup>55</sup> 20 U.S.C. § 1232g (b)(1)(A); 34 C.F.R. § 99.31 (a)(1)

<sup>56</sup> 20 U.S.C. § 1232g (a)(4)(B)(i); 34 C.F.R. § 99.3

<sup>57</sup> 42 U.S.C. §12131-12134; 42 U.S.C. §12181-12189; 28 C.F.R. §35; see also “The Americans with Disabilities Act Technical Assistance Manuals” for Title II and Title III

<sup>58</sup> ADA Amendments Act of 2008, S.3406, 110<sup>th</sup> Cong. § 4(a) (2008)

<sup>59</sup> 29 U.S.C. §794; 34 C.F.R. §104

<sup>60</sup> 42 U.S.C. §3601-3631

<sup>61</sup> See [Office for Civil Rights](#)

<sup>62</sup> OCR Letter to Woodbury University (see note 47)

<sup>63</sup> See [Letter from Stefan M. Rosenzweig, Director, San Francisco Enforcement Office, Western Division, Office for Civil Rights, U.S. Dept. of Education, to Jerry Lee, President, National Univ. \(March 23, 2000\)](#).; see also [OCR Letter to Woodbury University \(see note 47\)](#)

<sup>64</sup> ADA Amendments Act of 2008, S.3406, 110<sup>th</sup> Cong. § 4(a) (2008); 42 U.S.C. §12102(2); 28 C.F.R. Part 35.104; see also “The Americans with Disabilities Act Technical Assistance Manuals” (II-2.6000 or III-2.6000); 29 U.S.C. §705(20); 34 C.F.R. §104.3(j)

<sup>65</sup> ADA Amendments Act of 2008, S.3406, 110<sup>th</sup> Cong. § 4(a) (2008)

<sup>66</sup> ADA Amendments Act of 2008, S.3406, 110<sup>th</sup> Cong. § 4(a) (2008)

<sup>67</sup> ADA Amendments Act of 2008, S.3406, 110<sup>th</sup> Cong. § 4(a) (2008)

<sup>68</sup> For a list of exclusion diagnoses, see 42 U.S.C. §12211 and 29 U.S.C. §705(20); see also “The Americans with Disabilities Act Technical Assistance Manuals” (II-2.7000 or III-2.7000); 28 C.F.R. §35.104

- <sup>69</sup> 42 U.S.C. §12132; 28 C.F.R. §35.130(a); 29 U.S.C. §794(a); 34 C.F.R. § 104.43; 34 C.F.R. § 104.45; 34 C.F.R. § 104.47; 45 C.F.R. § 84.4
- <sup>70</sup> 42 U.S.C. §12131(2); 28 C.F.R. §35.104; 34 C.F.R. §104.3(k)(3)
- <sup>71</sup> OCR Letter to Woodbury University (see note 47)
- <sup>72</sup> Darby Dickerson, "Mandatory Withdrawal and Leave of Absence Revisited," *NASPA Leadership Exchange* Fall (2007): 28-29.
- <sup>73</sup> 42 U.S.C. §12111(9); 29 U.S.C. §1630.2(o); 29 U.S.C. §1630.9; 34 C.F.R. §104.44; see also "The Americans with Disabilities Act Technical Assistance Manuals" (II-3.6100 or III-4.2100); for examples of potential accommodations, see policies from the University of Michigan and Pace University and the Judge David L. Bazelon Center for Mental Health Law's "Campus Mental Health: Know Your Rights!"; see also Office for Civil Rights, "Transition of Students With Disabilities To Postsecondary Education: A Guide for High School Educators." U.S. Dept. of Education.
- <sup>74</sup> 42 U.S.C. §12111(9); 29 U.S.C. §1630.2(o); 29 U.S.C. §1630.9; see also "The Americans with Disabilities Act Technical Assistance Manuals" (II-3.6100 or III-4.2100)
- <sup>75</sup> ADA Amendments Act of 2008, S.3406, 110<sup>th</sup> Cong. § 6(a) (2008)
- <sup>76</sup> ADA Amendments Act of 2008, S.3406, 110<sup>th</sup> Cong. § 6(a) (2008); 28 C.F.R. §35.164; 28 C.F.R. §41.53; see also "The Americans with Disabilities Act Technical Assistance Manuals" (III-4.2100)
- <sup>77</sup> *Southeastern Community College v. Davis*, 442 U.S. 397 (1979).
- <sup>78</sup> *Southeastern Community College v. Davis*, 442 U.S. 397 (1979).
- <sup>79</sup> 42 U.S.C. §12181(9); 28 C.F.R. §35.150
- <sup>80</sup> Letter from Sheralyn Goldbecker, Team Leader, Office for Civil Rights, U.S. Dept. of Education, to Kent Chabotar, President, Guilford College (March 6, 2003).
- <sup>81</sup> 45 C.F.R. § 84.12(a)
- <sup>82</sup> OCR Letter to Guilford College (see note 80)
- <sup>83</sup> For more information, see Office for Civil Rights, "The Civil Rights of Students with Hidden Disabilities under Section 504 of the Rehabilitation Act of 1973." U.S. Dept. of Education.
- <sup>84</sup> OCR Letter to Woodbury University (see note 47)
- <sup>85</sup> See Office for Civil Rights, "Transition of Students With Disabilities To Postsecondary Education: A Guide for High School Educators." U.S. Dept. of Education.
- <sup>86</sup> OCR Letter to Guilford College (see note 80)
- <sup>87</sup> OCR Letter to Woodbury University (see note 47)
- <sup>88</sup> 20 U.S.C. § 1232g (a)(4)(B)(iv); 34 C.F.R. § 99.3
- <sup>89</sup> *School Board of Nassau County v. Arline*, 480 U.S. 273, 107 S.Ct. 1123 (1987) in OCR Letter to National University (see note 62); see also "The Americans with Disabilities Act Technical Assistance Manuals" (III-3.8000)
- <sup>90</sup> OCR Letter to National University (see note 63)
- <sup>91</sup> OCR Letter to Guilford College (see note 80)
- <sup>92</sup> OCR Letter to National University (see note 63)
- <sup>93</sup> OCR Letter to Woodbury University (see note 47)
- <sup>94</sup> OCR Letter to Woodbury University (see note 47)
- <sup>95</sup> OCR Letter to Woodbury University (see note 47)
- <sup>96</sup> OCR Letter to Woodbury University (see note 47); OCR Letter to National University (see note 63)
- <sup>97</sup> OCR Letter to Woodbury University (see note 47)
- <sup>98</sup> Letter from Rhonda Bowman, Team Leader, Cleveland Office, Midwestern Division, Office for Civil Rights, U.S. Dept. of Education to Lee Snyder, President, Bluffton University (December 23, 2004).
- <sup>99</sup> OCR Letter to Woodbury University (see note 47)
- <sup>100</sup> OCR Letter to Bluffton University (see note 98)



- <sup>101</sup> OCR Letter to Woodbury University (see note 47); Letter from Stefan M. Rosenzweig, Director, San Francisco Enforcement Office, Western Division, Office for Civil Rights, U.S. Dept. of Education, to Augustine F. Gallego, Chancellor, San Diego Community College District (December 30, 1999).
- <sup>102</sup> OCR Letter to San Diego Community College District (see note 101)
- <sup>103</sup> OCR Letter to San Diego Community College District (see note 101); OCR Letter to National University (see note 63)
- <sup>104</sup> OCR Letter to Woodbury University (see note 47)
- <sup>105</sup> Letter from Team Leader, Philadelphia Office, Office for Civil Rights, U.S. Dept. of Education to Father Bernard O'Connor, President, DeSales University (February 17, 2005)
- <sup>106</sup> OCR Letter to Guilford College (see note 80)
- <sup>107</sup> OCR Letter to Woodbury University (see note 47)
- <sup>108</sup> See [www.jedfoundation.org/framework](http://www.jedfoundation.org/framework)
- <sup>109</sup> Morton M. Silverman et al. "The Big Ten Student Suicide Study: A 10-Year Study of Suicides on Midwestern University Campuses," *Suicide and Life-Threatening Behavior* 27(3)(1997): 285-303.
- <sup>110</sup> Morton M. Silverman, "Suicide and Suicidal Behaviors," in *College Mental Health Practice*, ed. Paul A. Grayson and Philip W. Meilman (New York: Taylor & Francis Group, LLC, 2006), 303-323.
- <sup>111</sup> OCR Letter to Woodbury University (see note 47)
- <sup>112</sup> OCR Letter to Guilford College (see note 80)
- <sup>113</sup> Letter from Office for Civil Rights, U.S. Dept. of Education to Skagit Valley College (April 21, 1993).
- <sup>114</sup> OCR Letter to Skagit Valley College (see note 113); Letter from Gary D. Jackson, Regional Civil Rights Director, Office for Civil Rights, U.S. Dept. of Education to Kenneth Mortimer, President, Western Washington University (June 19, 1991).
- <sup>115</sup> Paul Appelbaum, "Law & psychiatry: 'Depressed? Get out!': Dealing with suicidal students on college campuses," *Psychiatric Services* 57 (2006): 914-916.
- <sup>116</sup> OCR Letter to Woodbury University (see note 47)
- <sup>117</sup> OCR Letter to Woodbury University (see note 47)
- <sup>118</sup> OCR Letter to Skagit Valley College (see note 113)
- <sup>119</sup> OCR Letter to Guilford College (see note 80)
- <sup>120</sup> OCR Letter to Guilford College (see note 80)
- <sup>121</sup> OCR Letter to Bluffton University (see note 98)
- <sup>122</sup> OCR Letter to Guilford College (see note 80)
- <sup>123</sup> *Doe v. New York University*, 666 F.2d 761 (2nd Cir. 1981) in OCR Letter to Woodbury University (see note 47)
- <sup>124</sup> OCR Letter to Woodbury University (see note 47)
- <sup>125</sup> M. David Rudd, Michael Mandrusiak, and Thomas Joiner, "The Case against No-Suicide Contracts: The Commitment to Treatment Statement as a Practical Alternative," *Journal of Clinical Psychology* 62(2) (2006): 243-251.
- <sup>126</sup> OCR Letter to Guilford College (see note 80)
- <sup>127</sup> 34 C.F.R. § 104.7; OCR Letter to Bluffton University (see note 98); OCR Letter to Guilford College (see note 80)
- <sup>128</sup> 34 C.F.R. § 104.7; OCR Letter to Bluffton University (see note 98); OCR Letter to Guilford College (see note 80)
- <sup>129</sup> OCR Letter to Guilford College (see note 80)
- <sup>130</sup> See American Psychological Association, "Ethical Principles of Psychologists and Code of Conduct," *American Psychologist*, 57, no. 12 (2002): 1060-1073.
- <sup>131</sup> OCR Letter to Guilford College (see note 80)
- <sup>132</sup> Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, H.R.1424, 110<sup>th</sup> Cong. § 511-512 (2008)
- <sup>133</sup> See [www.jedfoundation.org/framework](http://www.jedfoundation.org/framework)
- <sup>134</sup> Alan L. Berman, David A. Jobes, and Morton M. Silverman, *Adolescent Suicide: Assessment and Intervention*, 2nd ed. (Washington, DC: American Psychological Association, 2006).
- <sup>135</sup> *Mahoney v. Allegheny College No. AD 892-2003* (Pa. Ct. Com. Pl. Dec. 22, 2005).

<sup>136</sup> [Wallace v. Broyles](#), 961 S.W.2d 712 (Ark. 1998).

<sup>137</sup> *Cauverien v. De Metz*, 188 N.Y.S.2d 627.

<sup>138</sup> *Orcutt v. Spokane County*, 364 P.2d 1102 (Wash. 1961).

<sup>139</sup> *Litz v. City of Allentown*, 896 F.Supp 1401 (1995).; Restatement (Second) of Torts s 314A

<sup>140</sup> [Family Educational Rights and Privacy, 73 Fed. Reg.](#), 15,573, 15, 589 (proposed March 24, 2008).; response of [American Council on Education](#) to proposed changes to FERPA regulations

<sup>141</sup> *Mullins v. Pine Manor College*, 389 Mass. 47, 449 N.E.2d 331, 1983.

<sup>142</sup> See [www.jedfoundation.org/framework](http://www.jedfoundation.org/framework)

# Additional Resources

For information about a variety of legal issues, please see The Catholic University of America's [Campus Legal Information Clearinghouse](#).

## Privacy and Confidentiality

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Family Policy Compliance Office. [Parents' Guide to the Family Educational Rights and Privacy Act: Rights regarding Children's Education Records](#). U.S. Dept. of Education.

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## Other

American Foundation for Suicide Prevention.

[Reporting on Suicide: Recommendations for the Media.](#)

Dickerson, Darby. Lessons in Collaboration: Learning from the Post-Virginia Tech Task Force Reports. *Campus Activities Programming* October (2007): 21-25.

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Langford, Linda. [Preventing Violence and Promoting Safety in Higher Education Settings: Overview of a Comprehensive Approach.](#) Washington, DC: U.S. Department of Education, Office of Safe and Drug-Free Schools, Higher Education Center for Alcohol and Other Drug Abuse and Violence Prevention, 2004.

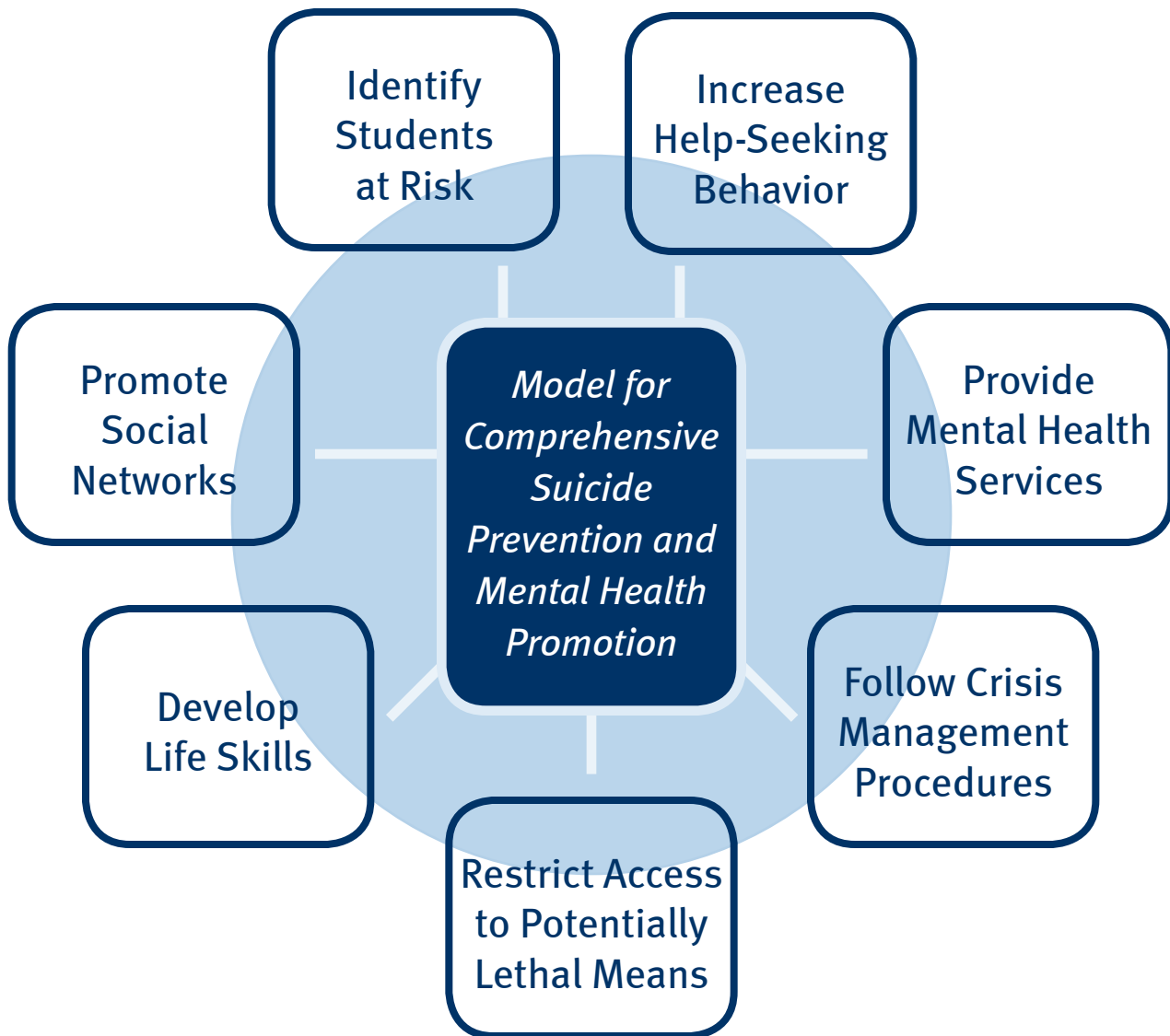
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# Appendix

## The Jed Foundation/Suicide Prevention Resource Center's **Model for Comprehensive Suicide Prevention and Mental Health Promotion**



# Model for Comprehensive Suicide Prevention and Mental Health Promotion

## Identify Students at Risk

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**GOAL:** To identify those students who may be at risk for suicide through the use of outreach efforts, screening, and other means (e.g. gatekeeper training)

## Increase Help-Seeking Behavior

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**GOAL:** To educate students about mental health and wellness, encourage seeking appropriate treatment for emotional issues, and reduce the stigma surrounding mental illness

## Provide Mental Health Services

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**GOAL:** To accurately diagnose and appropriately treat students with emotional issues, including assessing for and managing suicide risk

## Follow Crisis Management Procedures

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**GOAL:** To address the safety of distressed, distressing, or suicidal students using institutionalized processes around issues such as emergency contact notification and medical leave/re-entry

## Restrict Access to Potentially Lethal Means

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**GOAL:** To limit access to potential sites, weapons, and other agents that may facilitate dying by suicide

## Develop Life Skills

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**GOAL:** To promote the development of skills that will assist students as they face various challenges in both school and in life

## Promote Social Networks

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**GOAL:** To promote relationship-building between students as well as a sense of community on campus