Best Practices for Supporting Suicidal Students Within a Risk Management Framework

By: Brett A. Sokolow, JD

INTRODUCTION

The settlement of the Shin v. MIT case in April was met with confusion on many campuses. The statement released by MIT gave the impression that the Shins viewed their daughter's death as an accident. The implication was that, therefore, MIT was not at fault for her death. Yet, if it was an accident, why did MIT pay an undisclosed sum to settle the case? And, even if we call that a win for MIT, might it still cost us millions of dollars to win if one of our students "accidentally" kills themselves?

Commentators added to the debate by weighing in. One noted that the settlement could still set a precedent, while another ventured that it would do the exact opposite by discouraging parents from suing colleges and universities. Another opined that Jain v. Iowa is still the leading case, holding that a college is not responsible for the intervening suicidal act of a third party. Several recent cases hold similarly, but they can be distinguished as factually dissimilar. For the same reason, I don't think Jain is the leading case. And, I think anyone who has been involved in litigation in Iowa knows this holding is very consistent with Iowa law, but not necessarily with the law in more progressive jurisdictions. If it is precedent, it appears to be eroding. Courts are willing to hold colleges responsible for student suicides under limited circumstances, and it pays us to know and understand exactly what those circumstances may be.

Here, then, is my view of what represents best practices for supporting suicidal students within a risk management framework. My thoughts are influenced primarily by the question of what is in the best interests of a student who is in dire psychological distress.

- A Suicidal Student Has a Disability

On campus visits, I often hear student affairs professionals assert--with some fatigue--that colleges are not mental hospitals. Even if it were true that a suicidal student would be better off in a hospital (and that is not always true), our ability to simply separate a student who has draining psychological support needs is limited by federal law. We realize that these students can be an immense drain on our resources, and that time spent supporting suicidal students draws resources from students with other needs. This is something we must simply accept, as students with psychological needs become ever greater presences on our campuses.

- Both the ADA and Section 504 Apply

Section 504 gives recourse to students who are discriminated against on the basis of a recognized disability. The Americans with Disabilities Act (ADA) entitles students who are otherwise qualified to participate in the programs and activities of college to reasonable accommodations once they seek qualification with the campus disability services office. Suicide and its attendant psychological distress is a qualified disability under both ADA and Section 504. The ADA requires that we provide reasonable accommodations to an otherwise qualified suicidal student.

Section 504 provides consequences if we discriminate against a student whom we know to be suicidal by trying to separate them from campus without jumping through the right hoops. Of special note is that neither law requires that a suicidal student march into the disability services office to qualify as disabled. Once suicidality is clear to college officials, our obligations under these laws are in effect. We should explore whether the disability can be accommodated, and provide whatever support we can, within reason. It is also important to recognize that it is rather difficult to accommodate a suicidal student, and that a student who is actively suicidal (and not "merely" ideating) is unlikely to be "otherwise qualified" within the meaning of ADA and Section 504. If not, the student is outside the protection of these laws, and we may act to separate a student. AS LONG AS WE JUMP THROUGH THE RIGHT HOOPS. So, what are the right hoops?

- Direct Threat Test

In decisions against Bluffton University and Guilford College, the (US Department of Education) Office for Civil Rights took issue with how these institutions separated suicidal students. In implementing corrective procedures, OCR measured the decisions of these colleges with the "direct threat" test. Here's what OCR says about making a direct threat determination. It's a four-part test with multiple sub-elements. OCR takes it seriously, and we must as well.

1) To rise to the level of a direct threat, there must be a high probability of substantial harm and not just a slightly increased, speculative, or remote risk;
2) In a direct threat situation, a college needs to make an individualized and objective assessment of the student's ability to safely participate in the college's program;
3) This assessment must based on a reasonable medical judgment relying on the most current medical knowledge or the best available objective (non-medical) evidence;
4) The assessment must determine; the nature, duration, and severity of the risk; the probability that the potentially threatening injury will actually occur; and whether reasonable modifications of policies, practices, or procedures will sufficiently mitigate the risk.

This test tells us that a student who is ideating, threatening or who is making non-specific gestures without a plan or means to carry though may not represent a high probably of substantial harm. When George Washington University recently separated a student who reported suicidal thoughts at a hospital, it clearly overreacted. It did not make a finding that met the four elements of the direct threat test. OCR is, by practice, deferential to our determination of direct threat, but they insist that we make one.

The test requires an assessment. This is not a therapeutic assessment, but an overall assessment of a student's ability to function effectively and safely in a campus environment. In my opinion, that determination will be stronger if it is supported by a psychological assessment. We are to use objective evidence, and if possible, the most current medical knowledge available. If, for example, the on-call psychiatrist at the local emergency room releases a student to return to campus, that medical clearance is something we need to consider. If we are not comfortable with it, we can ask for an assessment by a therapist of our choosing, who may be more familiar with the pressures and support resources of the campus environment. Hopefully, the student will

cooperate with your desire to support them, and permit you to talk with the counselor about the assessment.

- Failure to Comply

If the student will not share medical records from the hospital, and is not cooperative with your efforts to have him or her assessed, the law permits you to require the student to be assessed. I recommend that you choose the therapist. I would also impose the condition that the student waive confidentiality in writing, permitting you to communicate with the therapist about the student's welfare. If the student refuses, I recommend that you use your conduct code (or at least the threat of it). We should all have and use policies addressing a student's failure to comply with the directives of a college official. If you then sanction, and even separate a student, it will not be on the basis of their disability, but on the basis of their conduct. This approach is fraught with potential to push a fragile student over the edge, so I really entreat you to do everything you can first to ensure voluntary cooperation.

You are required to consider whether reasonable accommodations can help the student to successfully continue on campus, if you have not done so already. You are also required to make some guesses about the potential for future harm. Psychological assessments are really not meant to do this, and any therapist who tells you with confidence that a student will or will not do something in the future is either covering their backside or making an educated guess with millions of your dollars. How confident are you in their guess? Make your best judgment call, support it with objective evidence, and trust OCR not to second guess your determination.

- Contracts with Residential Treatment Facilities

This process I have outlined is not intended to separate students from colleges with the fewest legal repercussions. It assumes that you have a good faith belief that your campus is not the right place for that student, and that they will be BETTER helped and supported elsewhere. I insist that you have a duty to do more than separate a student. You need to deliver them to support resources who can give them the best potential chance at life, treatment, recovery and wellness. This best chance may be their parents, custodians, friends, or off-campus private psychotherapeutic practitioners. The best option may be a residential (in patient) treatment facility. I have recommended to all my clients that if they have not done so already, they establish contractual relationships with local facilities that can be used to support students. They are also seeking to make sure that facilities accept student health plans. Elizabeth Shin needed a residential treatment facility. She needed it earlier in her downward spiral, and she needed a push from MIT in that direction. It might not have kept her alive, but it might have given her more support and supervision and a break from the pressure cooker that MIT was for her.

- MIT Represents the Large or Affluent University Approach

I have written in a previous CCC that MIT did more to support Elizabeth Shin than most colleges. In fact, they did too much. It is not our job to keep a student alive. I'm not sure we're good at it either. That is the job of custodial treatment facilities. They are better at it than colleges, at least. There are a number of campus approaches currently being touted as models.

Paul Joffe from the University of Illinois at Urbana-Champaign has had impressive results. Richard Kadison at Harvard has a sound approach as well. The Behavioral Intervention Team at the University of South Carolina is asking important questions about how we distinguish between a student bingeing on alcohol and a suicidal student using alcohol as a means of self-destruction. Yet, these are all models that work well at large universities. Mandating four assessment sessions for each potentially suicidal student requires a counseling staff. Many small campuses do not have the staff to make such a mandate feasible. The nearest residential treatment facility is hundreds of miles away, and there is no student health plan. These campuses may be in towns where there is no on-call psychiatrist at the local emergency room. Who will help them guess whether a student will be a harm to him or herself in the future?

- Disruption as Pretext

It can be easier for these smaller or less affluent campuses to look to shift the burden elsewhere. They may be more likely to try to separate a suicidal student. They often look to use their code of conduct to address behaviors, which has long been considered a best practice. I challenge that. A suicidal student may be disruptive, that is true. But, today there are only limited circumstances in which OCR will find that our decision to separate a student for disruptive behavior is not a violation of Section 504. The only instance I am aware of that might pass muster would be a decision to separate a student for disrupting the academic environment, made in an absence of knowledge that the student was suicidal. Any other separation based on a disruption policy--where officials are aware of suicidality or the disruptive behavior occurs not in the classroom but in a residential setting--is highly likely to be seen by OCR as a pretext for discriminating against a disabled student.

I have similar concerns for using a conduct code provision on "threat of harm to self or others" as the basis for separating a student. Certainly, it can be used for an interim suspension, because an interim suspension is not subject to the direct threat test. The problem with the "threat of harm to self" policy is that it is not usually backed up by the four elements of a direct threat finding. It it were, I think it would satisfy OCR. But, if not, I recommend instead that you develop and utilize a medical withdrawal procedure, with both voluntary and involuntary options. I read recently that some commentators fear that involuntary medical withdrawal policies have been abused by some campuses, and so as I recommend this, it is with the assumption that you would have already exhausted accommodation options, that you will use the direct threat test as the standard for your medical withdrawal policy, and that you would have in place a requirement that you do not separate a student unless you have a plan for where they will go when they are separated, and have made appropriate efforts to see that support mechanisms are in place for that student.

My other reason for preferring a medical withdrawal policy is because disabled students are entitled to heightened due process rights--according to OCR--and I fear that our conduct processes may not meet those requirements. For example, OCR states that a student who is being withdrawn for medical reasons is entitled to an appeal. Our conduct procedures may cover that, but may not. A student is also entitled to present medical evidence countering the finding of a direct threat. Our conduct procedures may not permit that. Address the behavior, not the disability has always been our best practice. But, I argue that no longer holds at the extremes of

student psychological distress. At the margin of life or death, our normal procedures may not offer enough protection to us or to students.

- Protocol

We should all be implementing comprehensive suicide protocols on our campuses, and training key personnel on those protocols. These should cover everything from a potentially suicidal email away message to a completed suicide. Protocols should be tied to your treatment model and your medical withdrawal procedure, and not just apply to immediate crisis response. Protocols are solid risk management. For example, I want you to ask your legal counsel tough questions about whether your protocol ought to include the use of behavioral contracts, issued by whom, in what form, and for what purposes. Behavior contracts are treatment tools for therapists. Somehow, they have been co-opted into one-sided contracts being used by student affairs professionals to control suicidal students. While this is a well-meaning effort to support a student in need, it is in my view a bastardization of a therapeutic tool into a context where it was never meant to apply and should not be used. Making a contract with a student has the potential to create a legal special relationship, and to impose duties on us to that student. Yet, the contract never spells out our side of the duties, just the student's. If the student dies, his or her survivors will argue that we did not keep to our side of the agreement. Take a copy of Schieszler v. Ferrum College to your counsel, and ask him or her for advice on how you should be using behavioral contracts.

The protocol should also spell out when and how we take a suicidal student into a custodial relationship. Should an RA or RD be checking in on a suicidal student? Should that student be in a campus residential environment? Taking a student into custody (or perhaps even quasi-custody, which might be another lesson of the Shin case) should only be done when we can ensure that once in custody, we can control the situation. A good protocol will spell out how this is to be done. Once a student is in our care and custody, our legal duties are different. An RA needs to know if approached by a suicidal resident whether they ought to leave that student alone to go get help, or whether they ought to stay with them and how they can keep an eye on them while at the same time obeying the prime dictate of RA training, "call your supervisor."

- Communicate with Parents

Finally, a protocol ought to govern how, when and if we communicate with parents, guardians, friends and family regarding a student in extreme psychological distress. FERPA is rather flexible when the health and safety exception is in play, and we need to be willing to use it when it applies or when a student is a dependent. Parents, friends and family resources can be vital supports, and can make all the difference. They can also be the catalyst that triggers a suicide. Protocols need to be in place to help us communicate appropriately to parties who need to be in the loop.

Best practices are still emerging on this issue, and my thoughts are not definitive. I hope they inform your judgment as you struggle to do the right thing and not get sued for it.

All information offered in this publication is the opinion of the author, and is not given as legal advice. Reliance on this information is at the sole risk of the reader.

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