

STUDENTS WHO POSE A RISK OF SELF HARM: INDIVIDUALIZED ASSESSMENTS, LEAVE, AND CONDITIONS FOR RETURN

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On February 8, 2018, Paul Lannon, Hannah Ross, and Madelyn Wessel delivered a NACUA webinar titled, “Students Who Pose a Risk of Self-Harm: What Can Institutions Do?” During the webinar, presenters described a set of principles, distilled from various OCR and DOJ enforcement actions, to guide colleges and universities as they endeavor to lawfully and meaningfully address the very serious issue of self-harm among college students. This outline addresses questions that were asked and answered during the live webinar.

1. An emerging recommendation within the legal community is to offer other channels to accommodate students who pose a risk of self-harm, other than institutional policies on student discipline. Can someone in the conduct office be the person to author or coordinate accommodations?

Having conduct officers coordinate accommodations and administer leave policies seems to be a perilous move. Disabilities services staff are uniquely trained and have the requisite expertise to assess and provide accommodations, and the protocols and practices of that office are set up to protect confidentiality. To the extent that exceptional accommodations are called for—such as modifications to standard academic policies or lengthy leaves of absence—the Dean of Students or Dean of a particular academic program are best positioned to conduct an accommodations’ analysis, in consultation with Disability Support Services.

2. What are examples of accommodations for suicidal students?

Preliminarily, “suicidal” students are not monolithic; unpacking what “suicidal” means for a particular student is the first step in a disabilities and accommodations analysis. The key focus is the behavior. What is the behavior that is manifesting itself? If the behavior is suicidal ideation, for example, that’s much more likely to be something that an institution can accommodate, either through intermittent leave, counseling and therapy, a behavioral plan that’s linked to a treatment plan, or some other tailored accommodation.

Where a student repeatedly engages in self-harming behavior and seems absolutely bent on suicide, a reasonable accommodation may not exist. If it’s not possible to counsel the student to voluntarily withdraw for a period of time, the institution may need to initiate an assessment to ascertain whether the student should be involuntarily separated from the institution.

3. Is it important for institutions to have adopted and written down minimum health and safety standards for participation in an education program? If so, how should these standards be worded?

While there are no specific guidelines, generally applicable health and safety guidelines are preferable, since the specifics of each situation will vary. Some examples are:

Example 1: A student who poses an unreasonable risk of harm to anyone in the community may be removed or separated from the institution.

Example 2: If a student is unable or unwilling to carry out substantial self-care obligations and poses an actual risk to their own safety not based on mere speculation, stereotypes, or generalizations, and the student does not want to take leave, then the dean of undergraduate students has the authority to place the student on leave.

Institutional Policies that have been negotiated with OCR and DOJ—such as the Princeton, Georgetown, and the University of Tennessee Health Sciences Center policies—may be regarded as model policies that have been deemed by federal agencies to be facially non-discriminatory. Regardless of the policy language adopted, the policy should relay the core expectation that participation is based on a student’s ability to safely participate in an education program or residential environment.

In addition to generally applicable health and safety guidelines, professional programs may have additional standards. For example, clinical medical programs may require students to exhibit certain behavioral standards or satisfy various physical requirements. Teaching programs may require attendance or public speaking. These additional standards may not need to be separately listed by the institution, as long as they are understood by the programs and referenced and applied when they are appropriate.

4. Should Residence Life or the Dean of Students be given access to medical or specific mental health information pertaining to a student?

Decisions about student status belong properly in the hands of those in Student Life roles. Clinicians often do not feel that it is their role to determine student status; rather, their role is limited to making clinical assessments about a student’s safety, along with recommendations about the level of treatment needed to maintain a student’s safety. The Dean, then, considers this clinical information, along with other information that is relevant to the safety assessment, to make a determination about student status.

5. You have made a point to treat disabled and nondisabled students similarly. Can colleges or universities provide special treatment to disabled students at risk of self-harm, such as relaxed financial aid requirements or tuition reimbursement?

Relaxed financial aid requirements and tuition reimbursements may or may not be deemed a reasonable accommodation at an institution level. If your institution offers these types of accommodations, officials should not differentiate between mental health issues and other medical issues in administering these policies. If the institution is prepared to make financial or

academic accommodations for students, it's important on both a policy and practice level that these accommodations are applied across the board for students who have a variety of challenges or needs, rather than singling out one particular subset for special treatment, whether it is positive or adverse. In developing and administering policies related to financial aid and tuition reimbursement, be mindful of the financial aid regulations, which contain various nondiscrimination provisions and require students to be treated similarly.

6. Where separations from programs are called for, should institutions have an explicit involuntary medical leave policy, as opposed to a conduct process, as an approach that is more likely to be considered appropriate by OCR?

Yes. Most self-harm cases are better handled as medical issues than as disciplinary issues. Having an explicit policy—even a very simple one that authorizes the university to take action when someone is unable to care for themselves—is preferable to resolving these matters through the conduct system, although there may be some occasions, where a weapon is used or a student exhibits violent behavior, where the conduct system would be a more appropriate forum for redress.

7. When, if ever, is it appropriate for an institution to temporarily hold a student's psychotropic medications due to concerns about overdose?

This question raises issues that fundamentally implicate the self-care question. If a student requires certain types of medications and is not able to manage them individually because of a concern of abuse, it seems that the student may be incapable of self-care and safety. There may be some exigent circumstances that might warrant a temporary hold on a student's psychotropic medication, but generally, the question implicates the broader question of self-care, and institutional policies and protocols should give some insight on how the university may proceed.

Institutional policies also can be helpful in terms of putting students on notice of expectations. In addition to general statements that members of your community are not allowed to harm people, including themselves, institutional policies may make reference to the independent living environment and associated expectations. When a student cannot be trusted to manage their own medication, or can't maintain their engagement with their academics if they are not seeing counselors for multiple hours each day, they may not be meeting expectations of independent living.

8. If a student presents as having a risk of self-harm only in counseling, how do you then involve a team to conduct an individualized assessment?

In most states and under most ethical guidelines, a clinician will have an obligation to warn if they believe the student is an imminent risk. If the risk is acute, the counselor may not be breaching confidentiality or ethical standards by bringing others into the conversation.

If the risk is less acute, there are plenty of circumstances where student life, faculty, or others in the university community may have observed troubling behavior even if it does not rise to the level of self-harm. It may make sense to convene this group to consider, based on an individualized assessment and the totality of circumstances, whether some sort of intervention is

warranted and ultimately whether this student is able to safely participate in the institution's programs.

Notably, counselors, especially at educational institutions, are usually knowledgeable about other support services on campus, and regularly advise student clients to consider availing themselves of some of those services. If a student expresses a desire for a counselor to connect him/her with those services, and consents to a limited release of information to make these connections, a counselor may be able to involve other support individuals without breaching confidentiality.

9. Can the institution require students to execute a FERPA or HIPAA waiver, authorizing the institution to speak with the student's healthcare provider?

An institution may require a student to execute a waiver, under reasonable circumstances where there is a need for the institution to have access to that information as part of the interactive process. For example, if self-harming behavior required someone to be separated from campus, then as a condition of return to campus, information from a medical healthcare provider would be necessary to assess whether the student can safely return to campus. In that instance, a waiver would be appropriate. By contrast, it would likely not be appropriate to request any sort of privacy waiver in the absence of a threat of imminent harm. For example, at the beginning of an assessment, a student may be disinclined to provide certain information for privacy reasons; in the absence of actual and imminent risks, the institution should acquiesce to the student's desire to protect confidential health information, at least up until the point where there is an imminent health risk.

When an institution does request a student to execute a waiver, the waiver should be reasonably tailored to the need for the information, and the number of people who need access to the clinical information should be thoughtfully managed, such that access is limited to university officials directly involved in supporting the student and/or making a decision about whether the student can be safe and remain on campus, or safely return to campus.

A student's refusal to provide the appropriate professionals access to the information that they need to address accommodations' requests limits the responsibility to provide accommodations. Determining whether a student can safely remain on campus or return to campus is determined through the interactive process between the individual and the institution. A student's refusal to provide adequate and relevant information calibrates institutional responsibilities in a different direction.

Even without medical documentation, it is important to keep in mind that FERPA never prohibits institutions from collecting information about individuals based on personal observations from direct contact with students. Personal observations are not education records, and setting aside the question of healthcare provider-privileged communications, many other people on the campus may have interactions with students that raises concerns. All of that information is legitimate information to take into consideration.

10. If the institution's medical professional disagrees with the opinion of the treating professional, is it important for the institution's clinician to have assessed the

student directly rather than rely on other available information, and if so, what if the student refuses to meet with the institution’s clinician?

It is preferable but not necessary for the institution’s clinician to assess the student directly. That being said, it is very important that if the institution’s counseling professional disagrees with the student’s treatment provider, and the institution takes action based on the recommendation of its own professional, that the institution can demonstrate that there was a true evaluation consistent with the professional standards of the relevant discipline, whether its psychology or medicine, and that the disagreement is one that the institution can defend as empirically well-founded.

Just as an institution can require a student to provide medically-relevant information to aid a university in its assessment of whether a student can safely return to campus, an institution can express a very strong expectation/requirement that a student actually has some contact with a medical professional of the institution’s choosing. A number of the OCR resolution agreements have endorsed this practice.

Whether or not the recommendations of the institution’s medical professional and the student’s treatment provider align, it can be helpful to request that the student authorize their treatment professional to speak by phone to the institution’s professional. Written correspondence can feel scripted, having undergone review by the student or family advocates; sometimes a more candid conversation can take place between two health professionals on the telephone.

11. What types of conditions for return may be imposed?

There is no standard set of conditions for return. Conditions for return are decided based on individualized assessments that take into account the totality of the circumstances. Consistent with the overarching principle of individualized assessments, the most common conditions for return will reflect the clinical recommendations of the student’s healthcare provider.

Flipping the question, there are some theoretical conditions for return that would assuredly raise red flags with enforcement agencies:

- An affirmation that the student is “cured” or no longer symptomatic
- An affirmation that the student is no longer depressed
- An affirmation that suicidal ideation has ceased

Enforcement agencies would likely deem these conditions for return to be discriminatory. Instead, tailor recommendations so that they address behaviors of concern that correspond with well-founded clinical recommendations.

In thinking about conditions for return, be mindful of unique circumstances that may necessitate a modification to clinical recommendations, especially where a recommendation calls for a particular type of therapeutic engagement that may not be accessible in a student’s geographic home area. There may be modifications (e.g. mindfulness meditations instead of cognitive behavioral therapy) that, although they deviate from the exact form of the clinical recommendation, may nonetheless help the student to manage symptoms and succeed.

12. Can a college or university prohibit a student from drinking alcohol upon return if their behavior is connected to alcohol use?

Yes. Where a student exhibits a significant pattern of risky behavior involving alcohol (i.e. multiple alcohol-related transcripts to the hospital), and where a clinician recommends that the student refrain from consuming alcohol as part of the treatment plan, it seems reasonable and non-discriminatory for a university to craft a condition of return tailored to address this safety issue.

13. Is the student allowed to contest conditions for return?

Yes. Generally, this is done at the same time that the student is voluntarily or involuntarily separated from the university. As with the underlying decision to separate the student from the university, a student should have notice and an opportunity to be heard on any barriers that would keep them separated from the university, although the university itself still has discretion to make the final determination. As a practical matter, where you obtain clinical recommendations and make recommendations for return during an exigent circumstance (e.g. a suicide attempt resulting in hospitalization), you may need to provide an after-the-fact opportunity for the student to contest the conditions for return.

14. If a student is dismissed involuntarily, can the institution apply its routine tuition fees and refund policies, or should there be a special policy for those leaves?

Distinguishing between voluntary and involuntary leave in the context of tuition fees and refund policies could expose the institution to risk. If the institution has a well-founded and appropriate medical withdrawal policy, it's not necessary to differentiate between exits that were voluntary and exits that were involuntary.

That having been said, some institutions treat withdrawal on a medical basis differently than a withdrawal from campus for any other types of reasons, with the institution recognizing that a medically-required withdrawal can be difficult for the student and may warrant some level of institutional assistance. As a practical matter, the fewer disincentives you can have for students to take a voluntary leave, the more it will aid you in counseling people through the voluntary process and reduce the number of times that you use the very strong tool of involuntary separation (which should only be invoked as a last resort).

15. When a student voluntarily admits themselves to a hospital based on self-harm related issues, what can the campus require for the student's return to campus and class?

A policy or institutional protocol on post-hospital evaluation is a very wise practice. This policy/protocol would authorize the institution to conduct a post-hospitalization evaluation through campus health services, or perhaps through a student's treatment provider, to determine whether the student can safely return to campus. Whether an official policy or institutional protocol, it should be accessible to the university community and uniformly applied.

QUESTIONS POSED DURING SELF-HARM WEBINAR BUT NOT ANSWERED

February 8, 2018

1. Will you speak to health/safety risk of self-harm as it relates to students with eating disorders?

Colleges and universities should address serious eating disorder cases under the same principles discussed in the webinar. Eating disorders, in their most serious forms, are very serious threats to a student's health and safety. Note that Princeton's policy—as approved by the Department of Justice – references being “unable or unwilling” to carry out essential self-care. This definition would plainly include a student who is unwilling to eat adequate food to sustain his/her body. In our experience, the difficult issues arise where a student with an eating disorder (and such students are very often in good academic standing) is of high concern to clinicians who see long-term harms as all but inevitable, but is not deemed medically at immediate risk such that a dean could make decisions regarding the student's status. These can be heartbreaking cases and we encourage schools to cast a wide net to gather information about the student's functioning and health, as well as to consider advising the student – from the dean's perspective -- about the longer-term impacts of, for example, amenorrhea, decreased bone density, etc. In eating disorder cases it is particularly crucial to ask the institution's clinician: “What level of treatment is recommended to adequately reduce the risk to the student's health?” Clinicians will tell you that in serious cases, that is typically inpatient treatment at a specialized facility, where food and activities can be monitored around the clock and that such treatment is incompatible with enrollment in any residency-based academic program. That said, there may be differences of opinion about whether a student at no imminent risk of harm can or should be forced into an involuntary leave. If such a student is not failing academically or presenting other neutral bases for removal from campus and is not willing to take a leave, we recommend caution in moving towards involuntary removal unless the medical case is exceptionally strong. It is often helpful in eating disorder cases to get a written agreement with the student about maintaining a healthy BMI, and then specify the consequences if he or she does not. It is also important to consider the effects on roommates and others.

2. Understandably on the first attempt/concern, judicial/involuntary measures should not be the first response but what if additional attempts occur?

In most cases, multiple attempts at serious self-harm will warrant involuntary measures, but as we responded during the webinar, the specific facts and circumstances of each case matter immensely. In this question, it would be important to understand what new attempts have actually been undertaken, and whether they are reasonably deemed to be serious or merely a gesture for help and attention. A student who makes repeated tangible attempts at self-harm can certainly be assessed for involuntary withdrawal action if voluntary measures have failed. But, the steps from support & attempted accommodations to voluntary withdrawal, to involuntary withdrawal should always be based on facts not fears.

3. What does a reasonable process look like for involuntary separation? Can the appeal follow an initial separation?

We believe this question largely was answered in the webinar. For specific policies we recommend reviewing the resolution agreements included in the webinar materials.

4. How might these principles apply to substance use disorders? Does this shift the line between "behavior" and "disability?"

In a technical sense, it does shift the line. The ADA exempts current substance (or alcohol) abuse from the definition of "disability". However, having a history of such abuse and no current abuse would presumptively be a disability (alcoholism and addiction are recognized mental health diagnoses). From the practical standpoint, we believe institutions should treat such behavior under the same health and safety policy and protocols, because these are all health and safety risks. That means we should use the same counseling and intervention tools to express concern, encourage the student to engage with treatment, etc. Finally, clinicians will say that substance abuse (as well as "cutting") is often a manifestation of underlying mental health disorders such as bipolar disease or depression. Unless the substance abuse is harming others or proves intractable, we see no benefit in getting stuck on the legal technicalities. One practical way to address substance abuse is through a hospitalization policy that uniformly requires medical clearance after hospitalization and compliance with ongoing treatment plans. Behavioral contracts can also work with substance abuse problems.

5. How to handle when a student submits confidential medical documentation to the dean in support of a medical leave and then other campus departments (i.e. registrar) request this documentation from the dean's office?

We believe that medical information is best directed to health care providers in the first instance (or to disability services offices when they are the decision-makers), and can be shared with the dean(s) as needed and as consistent with the student's authorization. The dean has a legitimate professional need for information that could impact a student's enrollment status, but should not disclose information to other administrative offices unless it is necessary. We cannot conceive a scenario where the college registrar would have a reasonable need to access actual health records, versus being told that a medical leave had been authorized. In other words, when it is necessary to share status information, there is ordinarily no need to share the underlying (health) information for the status.

6. Do you have any recommendations for implementing leave policies if a university's enrollment policy permits students to withdraw and then re-enroll for any term within three semesters without needing a leave of absence?

Realistically, an institution which freely allows students to take leaves and return for any reason without process does face some additional hurdles in placing special "burdens" on students who take medical leaves and then seek to return. However, as long as all students who leave for medical reasons are treated similarly and reasonably, we think the "equal treatment" principle is not violated per se. Where there is a reason for serious concern – either academic or health-related – the institution can have a policy of requiring a return process for those students. The process should be

reasonable, fair and non-discriminatory, but should allow the institution to assess whether a student is returning in an improved situation where the serious problems are less likely to recur. It also provides an opportunity to connect the student to supports and systems on the way back in to maximize their chance for success. Finally, it may make sense to offer some benefits to students who take medical leaves versus leaves of absence that are available for any reason. By creating a supportive incentive (for example, some level of tuition remission), students with genuine medical leave needs may be more likely to select this option – including return requirements – versus simply withdrawing.

7. Is it equal treatment if we require a student to be compliant with mental health treatment but not, for example, apply the same requirement for compliance with other health conditions, such as diabetes?

While different health conditions warrant different treatment and may carry different risks relating to treatment compliance, the fundamental obligation is to treat students fairly, meaning imposing reasonable conditions that are based on objective information about risk, and using similar processes for all students. The Department of Education has been concerned that colleges may closely scrutinize students with mental health conditions, while rarely or not looking closely at certain medical condition such as broken limbs or cancer, so it's prudent to review policies with an eye toward having the same process for physical and mental health issues. In some ways, this question also raises issues similar to those presented in question #1. A student with untreated or poorly treated diabetes is likely to be a significant risk of future health harms. However, if the student's failure to manage the diabetes does not cause immediate significant harms (coma), compelling a student to withdraw medically simply because of a concern about future health effects is not an action to be taken lightly.

8. What is a reasonable timeframe for a student to have met with a provider so that a provider can sign off on a release?

In our experience, a few days to a week is fair in emergency situations and longer in less urgent circumstances. In each case, the institution should consider reasonable extensions of time on a case by case basis.