From Diagnosis to Treatment: Addressing Legal Issues Related to Mental Illness on Your Campus

INTRODUCTION

This paper will address some of the issues college campuses face and that individuals who suffer from mental illness create on those campuses. Mental illness still presents significant stigma to those affected by it, and engenders fear in some people who deal with those individuals. By addressing some of the issues, both legal and practical, institutions can better deal with problems before they arise and have mechanisms in place for handling problems when they arise. This paper will afford some guidance on dealing with individuals with mental illness on your campuses.

College campuses are a microcosm of the society at large; however, individuals in positions of authority on such campuses may be ill-equipped to deal with the problems people with mental illness create. Many college deans, professors and administrators believe that mentally ill students or employees either need to be guided, i.e., forced, into treatment or to be removed from the classroom or the workplace altogether. Neither of these positions may be warranted, and it is important to know when to take a posture. Paternalism can pose as many legal pitfalls as taking no action. This paper will identify some of the signs and symptoms of mental illness of which deans, administrators and professors should be aware so that, in the event they are required to handle students and employees with such illnesses, they will be better prepared. This paper will identify
the pitfalls of proactivity in light of the ADA and state privacy laws, and attempt to guide faculty and administration, as well as campus health providers, down the proper path.

STATISTICS

The National Institute of Mental Health, a division of the Department of Health and Human Services, defines mental illness as “all diagnosable mental disorders.”

Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning. During a 1-year period, 22 to 23 percent of the U.S. adult population—or 44 million people—have diagnosable mental disorders, according to reliable, established criteria. In general, 19 percent of the adult U.S. population have a mental disorder alone (in 1 year); 3 percent have both mental and addictive disorders.1

Many other individuals have a variety of other mental health problems; however, these mental health problems generally refer to conditions that do not meet the criteria set forth in the Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition (DSM-IV), published by the American Psychiatric Association, the main diagnostic reference mental health professionals use in the United States. These conditions, although affecting one’s mental health, may not constitute disabilities as defined by either the Americans with Disabilities Act of 1990 or the Rehabilitation Act of 1973. Thus, it is important to treat behaviors as behaviors and leave the determinations related to whether these behaviors constitute mental disorders or disabilities to individuals with appropriate expertise to know the difference.

Almost everyone has, at one time or another, experienced some signs and symptoms of a mental disorder; students may experience such symptoms from time to time, given the rigors of a college experience, the newness of being away from home, or they may actually experience the first onset of symptoms related to a major mental illness during their college years. The American Academy of Child and Adolescent Psychiatry created a list of mental disorders and conditions that affect primarily adolescents, focusing on the signs and symptoms related to each of these conditions.2 The list of such disorders includes: Alcohol and Drug Abuse; Anorexia Nervosa; Anxiety; Attention Deficit/Hyperactivity Disorder (ADHD); Bipolar Disorder (Manic-Depression);
Bulimia Nervosa (Bulimia); Conduct Disorder; Depression; Learning Disorders; Obsessive-Compulsive Disorder (OCD); Physical Abuse; Post-Traumatic Stress Disorder (PTSD); Psychosis; Schizophrenia; Sexual Abuse; Suicide; and Tourette’s Syndrome.

Symptoms of anxiety disorders, panic disorder, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD), phobias, and generalized anxiety disorder are set forth in the end notes to this article. In addition, depression, schizophrenia and other psychotic disorders, and bipolar disorders afflict a large number of individuals, taking their physical, mental and financial toll upon their sufferers and society at large. Students, particularly women students, may suffer from anorexia nervosa, an eating disorder in which people refuse to maintain a minimally normal body weight and have an intense fear of weight gain and distorted body image; or bulimia nervosa, which is characterized by repeated episodes of binge eating followed by episodes of compensatory behaviors such as vomiting. On college campuses, these eating disorders create intense dilemmas for caring teachers, counselors and physicians, as the condition can be self-destructive and cause permanent impairments. They may feel the need to “rescue” these students by calling parents, giving aid or mandating treatment to retain their standing. Calling parents may result in violations of the Family Education and Rights to Privacy Act, as well as other state laws governing students’ rights to privacy.

Days missed at work and at school, not only for people with mental illness, but also for their families and extended support systems, account for huge economic and emotional losses to the nation. With these statistics in hand, University administrators can better understand their legal obligations to students and to the community. Concerned individuals must also know when these obligations end and when responsibilities to others in the University community begin. Paternalism, which often is the first response by University administrators, may be both a help and a hindrance when implementing policies that affect students and employees with mental illness, especially if such individuals pose a danger either to themselves or to others.

OBLIGATIONS TO STUDENTS AND EMPLOYEES WITH MENTAL ILLNESS

Everyone on a University campus is an observer. When people observe other people engaging in bizarre or dangerous behavior, they tend to react without having enough information.
If a University administrator believes that a young coed is killing herself through self-starvation as a result of *anorexia nervosa*, does that administrator have the right, or even the obligation to intervene? If an employee who appears to be suffering from depression is not doing her work, can her supervisor demand that she seek counseling before returning to her duties? Although most people would not venture into the diagnostic world because of medical problems their employees or students may have, people tend to believe that they can “tell” when someone is suffering from a mental illness or substance abuse, and want to “jump in” to demand action.

It is when the power of observation crosses the line and becomes a perception of mental illness or substance abuse that many laws and their progeny step up to the plate. Seeing or knowing too much about your students or employees can lead to allegations of discrimination, especially if it is *because* of their condition that you take disciplinary action when they misbehave or fail to perform. The *Americans with Disabilities Act of 1990* defines disability as an impairment that substantially limits one or more major life functions; however, it also recognizes that, if an individual is *perceived* as disabled, s/he receives the same protections against discrimination as if s/he had an actual disability, whether or not the disability exists. Therefore, limiting the extent to which individuals who are untrained to diagnose medical, mental health and substance abuse problems when it is not their job to do so in the context of providing medical care to a patient, is the best insurance against claims of disability discrimination. Individuals who suffer from mental illness also may have comorbidities, including substance abuse or other medical conditions, which make both diagnosis and treatment difficult. Such diagnoses therefore should be left to medical and mental health professionals, rather than to deans, department heads and supervisors. College professors and employees’ supervisors should therefore focus on behaviors; if those behaviors do not comport with standards of conduct required of all members of the university campus, then they must be dealt with as behavior, rather than as an illness.

Most campuses provide health care to their students, and many campuses provide mental health counseling, either through student health or through some ancillary office. To the extent that those service are available to students, professors and others who observe students who appear to be in trouble can make those resources known to the students. They should not tread upon diagnosing problems or recommending treatment, because doing is outside the scope of their expertise and invades their privacy. It also creates perceptions of illness, which can trigger ADA
claims, as mentioned earlier. So often, especially in professional health-care-related schools, professors (who also might be doctors, nurses, physicians’ assistants, or pharmacists) attempt to diagnose and/or treat their students or employees, whether requested to do so or otherwise. If there is no other piece of advice that can be gleaned from this paper, it is this: Stop! Do not go there! The results can be deleterious to the health of the institution and to the financial well-being of the individual who tried to be of help.

Additionally, “medicalizing” behavior is a dangerous course. Sometimes, perhaps even most often, students who engage in bizarre or disruptive behavior are simply engaging in bizarre or disruptive behavior. These behaviors are not the result of a mental disorder or substance abuse, but may be due simply to a lack of maturity. These individuals may need to be handled through the University’s disciplinary systems. When administrators, professors or staff members at universities observe students or others engaging in inappropriate behaviors, they should refer these matters to the Dean of Students’ or appropriate Human Resources offices, rather than presume that such behaviors are the result of a mental illness or a substance abuse problem and try to step in to “save” the student or employee. Policy-makers should determine when to include police and other emergency personnel on their campuses in decision-making processes, and when not to do so. All in all, sometimes the solution is using one’s common sense.

When students do seek the assistance of counselors, whether on campus or off, or when employees reveal that they are in treatment for a medical condition or a mental health condition, supervisors, counselors and physicians employed by the institution must be certain to understand their roles. Counselors who second as professors or vice versa, who may be involved in the education process with the same students who seek out their counsel, are begging for trouble. Failure to retain information confessed by students or employees in a confidential manner will with certainty result in liability to the discloser. Counselors should not advise a referring supervisor or professor whether the individual who they referred is seeking or continuing treatment, the nature of the disorder or treatment, or whether the individual should be referred for disciplinary action, unless the student or employee gives his or her permission to do so.

Often, concerned professors will solicit information from counselors and counselors will provide that information to professors in an effort to “help” a student or employee. Believing erroneously that they are all part of the same institution and therefore can share information destroys
the trust that healthcare professionals need to do their jobs. Making disclosures not only violates the students’ or employees’ rights to privacy, e.g., under state privacy laws, University policies or the Family Education and Rights to Privacy Act of 1974, but also subjects the institution and medical provider to liability for breach of confidentiality or privilege under state law. In states that have a constitutional right to privacy, revealing confidential information rises to the level of a civil rights violation. Disclosing confidential information without the permission of the patient or student undermines the entire system that has been put in place to help those students and employees who may need the assistance of counselors and health care providers. Medical information is not student or employee information, and only those who are treating the individual and those to whom the student or employee has provided a valid release, should be privy to the information related to their mental or physical health care. State law, rather than school policy, dictates when and to whom medical information may be communicated. Therefore, it is important to ensure that, when creating policies, policy writers review state privacy laws before permitting divulgence of medical and mental health information within the organization.

The only exception to the general rule of nondisclosure is when the student or employee confesses to a mental health provider a threat to do harm to another, which may create a duty to warn. Mental health providers who treat students at University-affiliated student health centers may from time to time be concerned about the safety of the student or others. State law generally dictates how such matters must be handled, for example, when a student has made a direct threat to harm another. If a patient confesses his intention to harm another or to harm himself to a mental health provider, the mental health provider faces the dilemma of either disclosing the information to the intended or suspected victim and thereby breaching the patient-provider privilege or refusing to disclose the information and risking the consequences of legal liability for failing to protect the victim if the individual carries out the threat. Ethics rules governing mental health providers may strictly forbid the disclosure of confidential information, even when a patient has communicated a direct threat to harm another or himself. They may also spell out an exception to the general rules related to maintaining confidences. (Id.)

The most oft-cited case dealing with breaching a patient’s confidentiality in an effort to protect members of the public from possible harm is the California Supreme Court case of Tarasoff v. Regents of University of California, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (Cal. 1976).
Courts following that decision have imposed duties upon mental health providers to disclose information their patients reveal that suggest that the patient is a danger to an identified or identifiable “other.” The Tarasoff court imposed a duty upon a psychiatrist to protect others against the conduct of his own patient when the psychiatrist had reason to believe that the patient intended to cause harm to another. The Court held that the psychiatrist had a duty to warn the victim, notwithstanding the psychiatrist’s duty to maintain the patient’s confidentiality. Following the Tarasoff case’s lead, many other states’ courts imposed similar duties upon physicians and mental health providers to prevent harm of which they were aware and which they possibly could prevent by giving a warning or taking other action to seek to hospitalize the patient involuntarily. Duties sprung up like wild flowers and courts subjected physicians to liability for acts of their patients to individuals not otherwise subject to the doctor-patient privilege.

In response to these court-created duties, many states enacted “anti-Tarasoff” legislation to limit the duties placed upon mental health providers to predict the behavior of their patients and to undermine the otherwise sacrosanct confidential relationship between them. For individuals at a University, Tarasoff and similar case law present other certain dilemmas. For example, if a University-employed mental health counselor or campus physician is treating a medical student at that same campus who has revealed that he is a voyeur, must that counselor or physician reveal this information to the Dean of the medical school so that the Dean can protect prospective patients and others from potential harm? May he do so? Does this patient’s paraphilia pose the level of harm to soon-to-be patients that would sustain a petition for involuntary commitment or treatment? Because the physician, who otherwise would have a duty to report such behavior to a professional licensing board if the student were a physician, is not permitted to reveal this information because the patient is not a physician, and because the physician may not be aware of any specific victims, how does she reconcile her beliefs that the physician-in-training could be a danger to society and a disgrace to her own institution with her obligation to the patient? Can the physician require the student to withdraw from school? Seek treatment? Commit himself for treatment at a specialized inpatient facility voluntarily? Can the physician take steps to seek the commitment of this student to a secure mental health treatment facility involuntarily, without a showing of imminent harm? Can the physician call the Dean and ask that s/he take immediate steps to remove the student from his clinical course work? Impose disciplinary action? Such quandaries create the stuff of which
lawsuits are made, especially when the behavior of the patient later results in injury to another. Again, these questions may have answers under state law; however, generally, under so-called anti-
Tarasoff statutes, unless there is a known or identifiable victim, the treating physician not only has no duty to take action, but may be held liable to the mentally ill patient if she discloses confidential information about him to others.

Many professional schools, including medical schools, maintain counseling offices in their colleges for students and residents who suffer mental illness or who have marital, learning or behavioral problems. The dilemma discussed above comes into full view when a psychiatrist, who is a member of the faculty of a college of medicine, for example, also performs the function of counseling, prescribing treatment and assisting with accommodations within the college. This counselor may be aware of aberrational behaviors that could pose potential harm to future patients. In order to protect the patient/doctor relationship and to ensure that students who seek mental health treatment on campus are provided the level of confidentiality they deserve, colleges should not retain the services of mental health professionals on their staff whose loyalties would be split between their institutions/colleges and their patients. These professionals would still be governed by the laws in their states related to disclosing potential harm to others that their patients revealed during counseling sessions, but the role as faculty or “employer” would not conflict with the role as counselor/mental health provider in these situations. The mental health professionals would be obligated only to their patients as patients, rather than to their institutions; the education/employment process could then stand on its own.

It is important for colleges and universities to have resources available to students and employees with mental illness, but not to undertake the burden of ensuring that individuals take advantage of these resources. When the friendly referral to existing or outside services becomes a mandate to seek counseling or medical treatment, the institution takes upon itself the burden of policing medical treatment that is beyond its scope. Moreover, for students who refuse to seek treatment or employees who believe there is no need for treatment, insisting that there is such a need creates a potential perception that the individual is disabled. Thereafter, if the institution takes disciplinary action because the individual continues to exhibit behaviors that are unacceptable either in the school setting or in the workplace, the individual may charge discrimination based upon a perception of disability, even if the individual insisted that he or she was neither mentally ill nor in
need of treatment. It is a safer route to focus on the behavior of the individual; if the behavior does not comport with standards set by the institution, then the institution should undertake disciplinary action. If, in the context of a disciplinary proceeding, an individual reveals that he or she has a mental disability, then, as a potential alternative to imposing discipline, the individual could agree to seek counseling, the compliance with which may be communicated to the employer or educational institution. This course places the burden on the individual suffering from the disorder or disease and removes the possibility that the institution will discriminate unlawfully against the person because of his or her disease or disability — the action taken would be consistent for all individuals engaging in behaviors that were unacceptable to the standards set by the organization. This route also avoids the inevitable claims under the Americans with Disabilities Act of 1990 (hereafter ADA) and the Section 504 of the Rehabilitation Act of 1973.19

AMERICANS WITH DISABILITIES ACT IMPLICATIONS OF “HELPING AND HEALING.” DEVELOP TECHNICAL STANDARDS!

As mentioned above, the ADA20 provides protection against discrimination for individuals with qualifying disabilities. The ADA, which the government first implemented in 1992, guarantees that individuals with disabilities receive equal opportunities in employment, public accommodations, state and local government services, transportation, and telecommunications. This law, which covers many of the same areas as Section 504 of the Rehabilitation Act of 1973, provides protection to individuals with disabilities.

Disability, as defined by the ADA, is a physical or mental impairment that substantially limits one or more major life activities.21 A mental impairment is defined as any recognized mental or psychological disorder, including specific learning disabilities. Included as disabilities are recovery from alcoholism and addiction, as well as active alcoholism that does not adversely affect performance. Excluded are minor or temporary impairments, sex addictions, compulsive gambling, kleptomania, pyromania, and current, illegal use of prescription or illicit drugs.

The Americans with Disabilities Act and Section 504 of the Rehabilitation Act apply, with respect to post-secondary and vocational education services, to handicapped persons who meet the academic and technical standards requisite to admission or participation in an education program
or activity within an institution that receives federal funding. No qualified handicapped person shall, on the basis of handicap, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity that receives or benefits from federal financial assistance.\textsuperscript{22}

If an institution receives any financial assistance from the federal government, it is subject to the mandates of the Rehabilitation Act. Neither the Rehabilitation Act nor the ADA, however, requires an institution either to lower its educational standards or to permit students to disrupt the educational environment. Students with mental disabilities need to comport with the same behavioral standards as those without such disabilities. Before an educational institution is even required to make an accommodation, the individual must make her or his disabilities known to it and seek an accommodation. She must also establish that she is “otherwise qualified” and is able to meet the academic and technical standards required for admission or participation in the program or activity with or without such accommodation.

**Developing Technical Standards**

The Rehabilitation Act of 1973 itself defines a “qualified individual with a disability” as an individual with a disability who meets the academic and/or technical standards requisite for admission to and participation in the program or activity.\textsuperscript{23} If the individual is not “qualified,” he is not entitled to accommodations, even if he is disabled. But, to determine qualifications, the school must have standards.

The hallmark of sound planning (and thereby determining whether an individual is qualified) is the development of technical standards. Avoiding claims of discrimination starts with having written technical standards or job-related essential functions that govern expectations in courses for students and job duties for employees. These standards should be developed before they are needed. A student alleging that she cannot perform in a class without an accommodation will require a statement of the course requirements, which if developed after she makes a request for an accommodation will appear contrived if the student does not get the accommodation she desires. Without such standards, the institution that provides an accommodation without first assuring a process for determining whether the individual is disabled is another means by which an institution
can be held to a standard not otherwise required by law. Therefore, developing technical standards in every course, and particularly in those courses required by professional programs or in clinical settings, is essential.

Developing technical standards/essential competencies for students in a program requires hard work and planning in itself. Utilizing a group of faculty, students, administrators and others to assist in defining standards for those participating in programs is necessary to ensure “buy-in” from faculty and students.24 In addition to technical standards, of which students and prospective students must be informed in connection with their course of studies, an institution also should include its Code of Conduct as one of many technical standards. Behavioral deviations may make someone ineligible for participation within the program as well as creating a basis for taking disciplinary action. These standards should be distributed to all applicants to the program as well as participants in a program who have not received them prior to promulgation of technical standards, so that prospective students are on notice of what the requirements will be once they are accepted into the program on a conditional basis, and existing students will have a benchmark to follow to show their health care provider should they require an accommodation.

Technical standards are akin to essential functions of a job; they may include, for example, in a professional program, such skills as observation, communication, intellect, behavioral and social attributes and motor skills. Acceptance to programs should be made contingent upon the student attesting to his or her ability to fulfill the technical standards, with or without an accommodation. As part of the literature students receive, a college or university should address its commitment to making reasonable accommodations under appropriate circumstances based upon a case-by-case determination.

As mentioned above, Section 504 of the Rehabilitation Act provides that qualified handicapped persons may not, on the basis of handicap, be denied admission or be subjected to discrimination in admission or recruitment. Universities may not apply limitations upon the number or proportion of handicapped persons who may be admitted to a program; neither may they make use of any test or criterion for admission that has a disproportionate, adverse effect on handicapped persons or any class of handicapped persons unless: (a) the test or criterion, as used by the institution, has been validated as a predictor of success in the education program or activity in
question and (b) alternate tests or criteria that have a less disproportionate, adverse effect are not shown by the Assistant Secretary of the Department of Education to be unavailable.

Federally supported educational institutions that provide admissions tests shall assure themselves that, when a test is administered to an applicant who has a handicap that impairs sensory, manual or speaking skills, the test results accurately reflect the applicant’s aptitude or achievement level or whatever other factor the test purports to measure, rather than reflecting the applicant’s impaired sensory, manual, or speaking skills (except where those skills are the factors that the test purports to measure). Admissions tests that are designed for persons with impaired sensory, manual, or speaking skills must be offered as often and in as timely a manner as are other admissions tests and must be administered in facilities that, on the whole, are accessible to handicapped persons.

With certain exceptions, schools may not make pre-admission inquiries regarding whether an applicant is handicapped but, after admission, it may make inquiries regarding the accepted applicant’s ability to carry out the essential functions of the program, and whether the accepted applicant has a disability for which a reasonable accommodation may be required.25

After conditionally accepting an applicant who states that s/he has a disability for which an accommodation may be required in order to perform the essential requirements/technical standards of the program, the institution must have a process through which the individual can document disabilities, and from which she can access necessary accommodations. First, the student must identify the disability and document his/her limitations before seeking an accommodation. The accommodations process is an interactive process; the student and administrators need to work together to determine whether the student has a disability and whether the student is able to perform the technical standards, i.e., is a qualified individual with a disability. Often, both school officials and supervisors of employees with alleged (or perceived) disabilities jump to the accommodations process without first determining whether there is a qualifying disability. Putting the cart before the horse raises expectations and often starts a course that cannot be reversed. If a student requests an accommodation, such as “double time on tests,” before establishing that she has a learning disability, once the institution provides the accommodation, it is hard to take it back. Therefore, before anyone considers making an accommodation, someone in the institution needs to make an assessment whether there is a disability in the first instance.
Once the institution (rather than a professor or supervisor), determines that the individual is a qualified person with a disability, and that the individual can meet the technical standards with or without a reasonable accommodation, then a reasonable accommodation must be designed along with the student and offered. If a student unreasonably fails to participate in this interactive process, she cannot claim that she has been discriminated against either when she is rejected from the program or when she fails to complete the program successfully. Administrators likewise must cooperate in this process.

Professors in the course in which the disabled student is seeking an accommodation should\textit{not} review medical documentation or ask to be made privy to the opinions of the student’s health care provider. Disability determinations should be made by an independent arm of the University so that confidential medical information is not available to teachers, administrators and records custodians. Only limited information, which is necessary to design an appropriate accommodation, should be shared with professors. Accommodations can be designed without disclosing the student’s disability or diagnosis. Professors need to know what limitations the student has in order to design an accommodation; however, her diagnosis is not her professors’ business. When professors balk at not having all the information, they can be advised that “less is more;” the less they know, the less chance there is that they will be accused of discriminating against a student \textit{because} of a disability. If the professor does not know the nature of the disability, there is less chance that he will be accused of treating the student differentially because of disability. If the student fails to perform even with an accommodation, the professor is on good ground to fail the student.

\textit{If} a student is a qualified individual with a disability, and \textit{if} a reasonable accommodation can be designed, it must be offered. It need not be the Cadillac of accommodations, but one reasonably designed to ensure the student equal access to the educational process. Once given, the student will be required to perform the technical standards and can be failed if she cannot meet those standards. However, if no reasonable accommodation can be made, or if an accommodation presents an undue hardship to the institution, it need not be provided. The student then may be rejected if he has been conditionally accepted to a program of study, or dismissed if he is unable to meet or has failed to meet the technical standards of the program.
An undue hardship is an action requiring significant difficulty or expense when considered in light of: the nature and cost of the accommodation; the overall financial resources of the unit providing the accommodation; the number of individuals participating in the program, and the effect on the expenses and resources; the overall financial resources of the University and the effect on its expenses and resources; the effect of such accommodation upon the operation of the University or the providing unit, including the effect upon academic integrity requirements, and the effect on the nature of the program or activity; the type of operation or operations, including the composition, structure, and functions of the workforce; and the geographic separateness, administrative, or fiscal relationship of the facility or facilities in question to the University. Financial hardship arguments probably will be unsuccessful if the institution, as a whole, has resources that may be tapped to accommodate students or employees with disabilities.

MANDATING TREATMENT VS. DEALING WITH INAPPROPRIATE BEHAVIORS THROUGH THE DISCIPLINARY PROCESS

A University is expected to maintain a safe environment for its students, faculty, staff and visitors. Students who exhibit inappropriate behaviors, whether those behaviors are the result of a mental illness or not, must therefore be handled appropriately. It is not reasonable for a student to request an accommodation that allows him to continue to misbehave or merely “accepts” as part of his illness his outbursts in class, his refusal to comply with reasonable requests, or his violent behaviors. If students violate codes of conduct or fail to achieve program objectives because of behavioral problems, they should be disciplined through appropriate channels, using published disciplinary procedures.

Taking disciplinary action against an individual with a disability, if it is related not to the individual’s disability, but to his misbehavior, is defensible and appropriate. Students may choose to disclose a disability in the heat of a disciplinary process and in so doing may request an accommodation. The law does not require the institution to make accommodations for past transgressions; however, creative disciplinary action can be designed based upon the student’s stated willingness to engage in therapy or to seek treatment, if the student reveals a mental disorder. The Dean of Student’s office should never suggest that the student has a mental disorder for which
treatment would be “helpful” or “necessary;” however, if the student volunteers that he suffers from a mental disorder and is willing to seek treatment in an attempt to mitigate his behavior, then the school could design a disciplinary plan that includes a treatment component, presuming that this would ameliorate the behavior. Thus, the institution could gain compliance with behavioral requirements by writing conditions into a “contract” in lieu of taking more serious disciplinary action, assuming that such treatment would effectively curtail the offensive behavior. Even then, reports from physicians describing the mental disorder or outlining the course of treatment are unnecessary. It should be sufficient to require the student’s physician to report compliance with treatment, rather than to detail such treatment.\(^{26}\) This same approach works with employees who suffer mental disorders, have behavioral problems, and face disciplinary action as a result.

**AVOIDING WORKPLACE VIOLENCE**

A related issue involves workplace violence. According to the United States Department of Labor, Occupational Safety and Health Administration:

Workplace violence has emerged as an important safety and health issue in today’s workplace. Its most extreme form, homicide, is the third-leading cause of fatal occupational injury in the United States. According to the Bureau of Labor Statistics Census of Fatal Occupational Injuries (CFOI), there were 674 workplace homicides in 2000, accounting for 11% of the total 5,915 fatal work injuries in the United States. (Footnote omitted.) Environmental conditions associated with workplace assaults have been identified and control strategies implemented in a number of work settings. OSHA has developed guidelines and recommendations to reduce worker exposures to this hazard but is not initiating rulemaking at this time.\(^{27}\)

Universities must implement workplace violence policies to set standards for behavior in the workplace, which apply to the students, faculty, staff and visitors. Campuses cannot assure these constituencies that such policies will *protect* them from the harms that workplace violence creates; however, institutions can, by having such policies, convey that, if such incidents occur, swift remedial action will be taken to discipline the offenders. Institutions also should have resources in place to which to refer individuals who may be the victims of workplace violence. Avoiding workplace violence altogether may not be possible; however, designing education programs for administrators, student affairs deans and campus leaders can help to identify those individuals who...
may be targets of violence or perpetrators of that violence. Universities must be prepared to deal with campus emergencies, whether the result of violence or other causes. 9-11, tornados and other disasters require disaster/crisis preparedness plans, in addition to plans for campus violence incidents. Public and private universities alike should define workplace violence in terms that all persons affected by such policies can easily understand, and disciplinary measures should be taken when individuals engage in violent behavior on campus. Everyone, irrespective of their stature or rank, should be held to the same standards and disciplined if they breach these standards. Institutions should be mindful of due process requirements when implementing disciplinary action in all public colleges and universities; however, due process should not deter such institutions from taking appropriate action in a timely fashion. Nor should professors’ tenure deter an institution from taking appropriate action, should that professor breach standards of conduct on campus. Tenure is not a license to misbehave. Safety must come first.

Often, police must respond to situations in which workplace violence occurs and may be called upon to respond to students or employees who are not violent, but whose behavior is contrary to the public peace. Although common sense dictates that individuals affected by workplace violence would call the police, often people are unsure about whether to call police or other campus officials. Calling Human Resources, for example, before calling the police is not the recommended course of action in a workplace violence situation. Police can help to assess whether an individual who has engaged in threatening or violent behavior may need to be referred for mental health treatment, or for involuntary evaluation. This is not the job for campus administrators. Campus authorities, such as Human Resources offices, should be advised of such incidents as soon as possible thereafter, so that appropriate disciplinary action will follow.

Campus administrators must consider implementing educational programs and perhaps consult with experts who specialize in workplace violence so that they are not forced to scramble after a campus disaster occurs. The not-so-recent events at Columbine High School and the more recent shootings at the University of Arizona demand that institutions take a look at interdisciplinary education programs. Early intervention, rather than crisis management, should be the goal of institutions when they consider developing policies related to workplace violence. Safely managing the risks of violence in the workplace, as well as developing policies to deal with the offending employee or student, are equally important. Having appropriate education programs in place before
violence breaks out will discharge the duties imposed upon employers to maintain a safe work environment that encourages productivity and that will help to quell fears that violence in the workplace necessarily engenders.

CONCLUSION

The following table summarizes the points in this paper, and may serve as a guide to analyzing the institution’s obligations and where the institution should not go in dealing with students and employees with mental disabilities.
### STUDENTS AND EMPLOYEES WITH MENTAL DISABILITIES

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<th>WHAT TO DO?</th>
<th>WHAT NOT TO DO?</th>
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<td>Have resources available on campus for students and employees with mental disabilities to which to refer people.</td>
<td>Do not self-diagnose students and employees with mental disabilities, and assume they need “help.”</td>
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<td>Deal appropriately with misconduct and violations of student and employee codes of conduct and take appropriate disciplinary action.</td>
<td>Do not assume that misconduct is the product of a mental illness or substance abuse problem.</td>
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<td>Develop technical standards and essential functions of jobs before students and employees seek accommodations for alleged disabilities.</td>
<td>Do not engage in scrambling activities when a student or employee seeks an accommodation to determine the essential nature of the job or the technical standards for completing course work.</td>
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<tr>
<td>Have mental health counselors available on campus to assist students and employees who suffer mental illness.</td>
<td>Do not employ such counselors in the colleges in which those counselors may have split loyalties; do not allow counselors to share information with professors or supervisors unless the student or employee provides his/her permission.</td>
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<td>Have a central office to assist with making disability determinations and to assist in developing accommodations for students and employees with mental disabilities. Develop procedures for identifying qualified individuals with disabilities and designing accommodations for qualified individuals seeking them.</td>
<td>Do not allow professors and supervisors to be privy to confidential medical information about students and employees. Do engage professors and supervisors in the interactive accommodations process to develop appropriate accommodations after disability determinations have been made by an independent arm of the university.</td>
</tr>
<tr>
<td>Have policies in place that address students and employees with disabilities, whether mental or physical, and offices on campus that can handle appropriately requests for disability determination and accommodations.</td>
<td></td>
</tr>
<tr>
<td>WHAT TO DO?</td>
<td>WHAT NOT TO DO?</td>
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<td>----------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Ensure that campus counselors and mental health professionals understand their duties to warn others or to seek voluntary or involuntarily hospitalization when patients disclose intentions to harm themselves or others. Educate police and others about their respective roles.</td>
<td>Do not assume individuals who engage in bizarre behavior are mentally ill or dangerous, but do engage appropriate campus personnel when students or employees are engaging in bizarre behavior. Do not suggest that students or employees are mentally ill or use terms to describe such behavior as &quot;crazy&quot;, &quot;insane&quot;, or similar disparaging or conclusory terms.</td>
</tr>
<tr>
<td>Have an educational process in place to identify roles of various campus constituencies. Have a campus preparedness policy and procedures in place for emergency situations, whether involving individuals with mental illness or other emergencies involving multiple players on campus.</td>
<td>Do not try to reinvent the wheel. Call upon seasoned professionals who have experience in dealing with campus emergencies to conduct education programs on your campus.</td>
</tr>
<tr>
<td>Know enough, but . . .</td>
<td>Don’t know too much about your students’ or employees’ mental illnesses.</td>
</tr>
<tr>
<td>When individuals with mental disabilities violate standards of conduct, engage disciplinary process and design appropriate discipline.</td>
<td>Do not allow misbehavior to go unchecked. Failing to act appropriately to curtail bad behavior or assuming that such behavior is because of a mental illness can lead to liability for the institution. Treat everyone consistently, irrespective of rank or position.</td>
</tr>
<tr>
<td>Develop policies with respect to workplace violence; know when to engage the police and when to engage the disciplinary process on your campus.</td>
<td>Do not attempt to define policy based upon a single incident or develop policies when a crisis is underway. Use education as a basis upon which to advise campus groups of policy and procedures to follow when dealing with misbehavior and illness on campus.</td>
</tr>
</tbody>
</table>


2. See [http://www.aacap.org/about/glossary/](http://www.aacap.org/about/glossary/).

3. These would include constant feelings of panic, apprehension, or crippling fears. Anxiety disorders are the leading forms of mental illness in the U.S., affecting more than 20 million...
4. Panic disorder is marked by “panic attacks or sudden attacks of terror and irrational fear, feelings of impending doom, and physical symptoms such as palpitations, shortness of breath, sweating, weakness, and feelings of unreality. Individuals with panic disorder are seven times more likely to attempt suicide than those without a history of mental illness. However, medication and behavioral therapy are effective in treating 70-90% of people who suffer from panic disorders. Each year, panic disorder affects 1.3% of the population, or 2.4 million people, and often occurs in combination with other mental disorders.” Id.

5. OCD is characterized by “recurrent, intrusive and senseless thoughts, images or ideas (obsessions) and unnecessary, ritualized, and repetitive actions (compulsions). Obsessive thoughts often involve contamination, violence, or doubt, and persist even though they are irrational or unwarranted. Compulsions, such as excessive hand washing, repeated checking (e.g., to see if the doors are locked), and counting rituals, are often carried out in an attempt to prevent some unwanted event. OCD can cause much distress, guilt, and disability. In a 1-year period, 2.1% of the adult U.S. population, nearly 4 million Americans, was diagnosed with OCD.” Id.

6. PTSD is the “inability to escape memories and thoughts about horrifying past experiences. PTSD, earlier recognized as “shell shock” or “battle fatigue,” came into public consciousness after Vietnam veterans reported flashbacks of their wartime experiences, but can follow any traumatic event, such as violence, natural disasters, rape, or abuse. Recollections of the event affect everyday functioning and appear in disturbing dreams. PTSD produces several kinds of symptoms, such as avoiding important activities, feeling emotionally numb, or experiencing sleep difficulties or hypervigilance.” Id.

7. Phobias are “persistent, irrational fears of an object or situation, coupled with a compelling desire to avoid that fear. In many instances, phobias are seriously disabling, keeping those affected from engaging in normal activities. There are many different types of phobias. Simple phobias are specific fears, like fear of flying, snakes, or heights. Social phobia (a fear of public humiliation or embarrassment) and agoraphobia (the fear of being in open places) are distinguished from simple phobias because they usually prevent people from engaging in routine activities. Taken together, phobias affect about 10.9% of the population in a given year.” Id.

8. “(GAD) is a persistent condition marked by exaggerated or unrealistic worries, coupled with physical symptoms of tension, such as trembling, heart palpitations, or difficulty concentrating and sleeping. Generalized anxiety, which often accompanies other illnesses, can be sufficiently severe and prolonged to be diagnosed as a separate disorder. Unlike the structured and specific worries that characterize OCD, those seen in generalized anxiety disorder are diffuse, non-specific, and cover many themes.” Id.

10. *Id.*, at 256, *et seq.*

11. A recently completed National Institute of Mental Health study found that, in 1992, mental disorders cost the U.S. $94 billion in indirect costs and $66.8 billion in direct costs (under managed care) for a total of $160.8 billion.

12. *Diagnostic and Statistical Manual of Mental Disorders Fourth Edition*, American Psychiatric Association, 1995, at 539, *et seq.* Anorexia is seen mainly in Caucasian women who are high academic achievers and have a goal-oriented family or personality. However, this eating disorder is not more common in higher socioeconomic groups. See [http://health.yahoo.com/health/dc/000362/0.html](http://health.yahoo.com/health/dc/000362/0.html).


14. Following the *Tarasoff*, *supra*, case, many professional codes of ethics and statutes governing professional discipline, have incorporated a duty to warn, thereby waiving the confidentiality of the patient in those limited instances. See, e.g., A.R.S. § 32-2061, which defines unprofessional conduct for a psychologist to include failing to take appropriate steps to ensure that someone who is believed to be a danger to others or to warn an individual who is the target of a direct threat to do harm.

15. Professor Bickel’s contribution includes a discussion of the *Tarasoff* case; however, to put the discussion in this paper in context, the author is briefly discussing this case as well.

16. Confidentiality is the essence of the patient-physician relationship. The related concept of privilege is a creature of statute in most states. Without the privilege that the law imposes, patients would be reluctant to fully disclose to their physicians their symptoms, behaviors and other issues that would aid in the diagnosis and treatment process. *Tarasoff* undermined the relationship in favor of the “greater good of society” and the need to protect the public against known potential harms contemplated by mentally ill individuals.

17. See, e.g., A.R.S. § 36-517.02, which requires disclosure by a mental health provider of an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim or victims, and the patient has the apparent intent and ability to carry out such threat. In these limited situations, and in situations where the mental health provider believes that failure to take appropriate action may result in serious injury or death, the health provider may disclose information related by the patient to a third party.

18. The Liaison Committee for Medical Education’s Accreditation Standards includes, among other things, a requirement that: Each school must have an effective system of personal counseling for its students that includes programs to promote the well-being of students and facilitate their adjustment to the physical and emotional demands of medical school. See [http://www.lcme.org/functionslist.htm](http://www.lcme.org/functionslist.htm). Some medical schools have taken this requirement to extremes, appointing psychiatrists on their faculty to take on the role of counselors, to whom medical students can go free of charge for mental health counseling, medication management, etc. When the role of faculty and counselor become blurred, a prescription for disaster follows.


21. With respect to employees, the ADA defines disability as:
   a. A physical or mental impairment that substantially limits one or more of the major life activities of such individual;
   b. Having a record of such an impairment; or
   c. Being regarded as having such an impairment.

22. 34 CFR § 104.4.

23. 34 CFR 104.3(k)(3).

24. For example, with respect to medical students, *The Disabled Student in Medical School: an Overview of Legal Requirements*, advises that, “Under the ADA, medical schools are required to demonstrate that a particular required activity is ‘essential’ to the completion of the M.D. degree.” For medical schools, the publication recommends “that school policy address essential functions and eligibility requirements relating to: The use of motor skills such as palpation, auscultation, percussion, and other diagnostic maneuvers; the use of sensory skills such as observing demonstrations and experiments in the basic sciences, obtaining a medical history directly from the patient, and directly observing a patient’s medical condition; communication with patients, physicians, and others on the medical team about a patient’s condition, in settings where communication typically is oral, in settings where communication typically is written, and in settings where the time span available for communication is limited; intellectual-conceptual, integrative, and quantitative abilities necessary for problem-solving and diagnosis; activities that have a behavioral and/or social context, including professional responsibility to patients, typical daily workloads, working in an environment that may change rapidly without warning, and/or in unpredictable ways.”

The Disabled Student in Medical School can be ordered from the AAMC Publications Section, (202) 828-0416; fax (202) 828-1123. Member price, $25; non-member price, $50. For further reading, the AAMC recommends “The Americans with Disabilities Act: Implications and Suggestions for Compliance for Medical Schools,” by Diana Essex-Sorlie, Ph.D., and “Medical Education and Disability Discrimination: The Law and Future Implications,” by Lelia B. Helms, Ph.D., J.D., and Charles M. Helms, Ph.D., M.D., both in the July 1994 issue of Academic Medicine.

The Liaison Committee on Medical Education, which accredits medical schools, has a provision in its Full Text of LCME Accreditation Standards stating: “While physical disability should not preclude a student from consideration for admission, each school should develop and publish technical standards for the admission of handicapped applicants, in accordance with legal requirements.” The full text of these standards can be found at http://www.lcme.org/standtext.htm#full_text.

25. Exceptions exist with respect to recipients of federal funds who are taking remedial action to correct effects of past discrimination for disability that resulted in limited participation by disabled individuals. The recipient must state in the written questionnaire that the purpose for seeking the
information is consistent with remediating past discrimination and intended for use solely in connection with its remedial action obligations or its voluntary action efforts; and state that it is voluntary whether to respond; and must state that the information will be kept confidential, that refusal to provide it will not subject the applicant to adverse treatment and that it will be used only in accordance with the regulation. 34 CFR 104.42(c)(2).

26. A sample “Reentry Agreement,” which was designed for medical residents at the University of Arizona College of Medicine, is attached to this paper as “Exhibit A.” This agreement has been used after a medical resident has taken a leave of absence to receive treatment for a mental disorder or substance abuse, and allows some flexibility not only with respect to taking future disciplinary action if the behavior recurs, but also in dealing with the returning resident. Exhibit “B” is a sample agreement that has been used for a medical student who suffered from an addiction, who requested to return from an approved leave of absence, providing certain conditions for return.


stetson conference written materials2.wpd
Exhibit “A”

RE-ENTRY AGREEMENT
IMPOSITION OF PROBATION

This agreement is entered on the date set forth below, between the College of Medicine’s Department of __________________________ (hereafter “Department”), and _______________, Resident/Intern in said Department (hereafter “resident”).

RECITALS

1. The College of Medicine desires to hire/rehire Resident in the program of __________________________:

2. The parties acknowledge that Resident has received treatment for the disease of chemical dependency/drug abuse, and agree that continuing treatment is required to maintain abstinence from use of any such substances, and that Resident’s treating physician believes that, as a part of recovery, it is important for Resident to return to practice;

3. The parties acknowledge that, in order to confirm compliance with whatever aftercare program shall be established for Resident, s/he may be required to confirm with his/her treating physician or other professionals with whom s/he is receiving counseling, and Resident agrees to provide documentation of continuing compliance with all aspects of the treatment and recovery program to the University of Arizona College of Medicine, as necessary.

4. It is acknowledged that random drug screening is a necessary part of continuing employment with the University of Arizona College of Medicine.

5. It is further acknowledged that, in order to ensure compliance, Resident shall be hired on a probationary status, the terms of which are set forth below.

NOW, THEREFORE, in consideration of employment with the University of Arizona College of Medicine, the parties agree to the following terms:

1. Resident agrees that s/he will provide the Department with the name of his/her physician or other healthcare professional, which may include an addictionologist (hereafter referred to as “primary physician”) who is treating him/her for the disease of chemical dependence/substance abuse. The Department must agree that the primary physician is qualified in chemical dependence/substance abuse or addictionology. If the Department finds the treating primary physician unacceptable, Resident agrees to seek treatment from another healthcare professional or qualified addictionologist acceptable to the Department. Resident must give the primary physician permission to share all information and/or records about his/her recovery from chemical dependence/substance abuse with the Department on a confidential basis.

2. Resident agrees that the primary physician chosen to treat him/her for the disease of chemical dependence/substance abuse shall coordinate all other treatment received by Resident, and shall be advised of the names of other physicians or healthcare providers who may be treating Resident for any other condition.

3. The primary physician will coordinate any and all medications taken by Resident to ensure that there are no adverse drug interactions, to avoid false positives on random urine or blood screening assays, and to ensure continuity of care for Resident. Resident shall take no medication, including over-the-counter medication, without first receiving approval from his/her primary physician as to both type and dosage. Any and all drug therapy, including both prescription and over-the-counter medication, shall be individually approved by the primary physician.

4. The primary physician shall not be a member of the Resident’s Department. The primary physician must agree to perform appropriate random drug screens and to provide the results to the Departmental Chair.

5. Resident shall be assigned a “physician monitor,” who shall be responsible to observe Resident’s behavior over an extended period of time to ensure compliance and abstinence from chemical dependence/substance abuse.
abuse, which physician may or may not be a member of the Department.

6. Resident agrees to follow the recommendations of the primary physician, including “after care” programs, Narcotics Anonymous or Alcoholics Anonymous meetings, and to remain abstinent from substances of abuse.

7. Resident agrees that s/he shall be solely responsible for the costs connected with his/her continuing medical treatment for chemical dependence/substance abuse.

8. Resident agrees that, upon request of any faculty member in his/her Department, s/he will submit to a random blood and/or urine screen, which shall be processed in accordance with generally accepted procedures at a laboratory qualified to provide such services and that regularly performs such screening services. The University of Arizona College of Medicine shall be responsible for the cost of any such screenings.

9. If Resident performs satisfactorily under this Agreement and is otherwise in compliance with the requirements of his/her training program for a period of ___ months/years, his/her employment status shall be changed from “probationary” to “regular.”

10. If Resident violates the terms of this agreement, including, but without limitation, evidence of unauthorized or non-pre-approved self-medication of any type, or substantiated positive drug screens while on probationary status, such event shall constitute cause for the Department to terminate the Resident’s employment with the University of Arizona College of Medicine without the need for compliance with the terms of the University of Arizona College of Medicine Resident Physicians Suspension, Probation or Dismissal Procedures.

11. In the event Resident has fulfilled the applicable probationary period prior to breaching this agreement, the College of Medicine shall convene its Graduate Medical Education Committee to discuss whether another period of probation would be appropriate or whether termination of employment is the appropriate remedy. In the event the Graduate Medical Education Committee recommends either probation, suspension or dismissal, it shall follow the procedures set forth in the University of Arizona College of Medicine Resident Physician Suspension, Probation or Dismissal Procedures.

12. The parties agree that it may be necessary from time to time to re-evaluate the terms of this agreement and to modify any terms deemed unnecessary or to add terms to ensure performance hereunder. The parties hereby agree to regularly review the terms of this agreement and to modify it as necessary to accomplish the goals of continued recovery.

13. In the event it is determined that a Resident shall be terminated for failure to comply with the prescribed treatment and aftercare, The Department, at the discretion of the Department Chair, may rehire the Resident under the same or stricter probationary terms as those set forth in this agreement. No such hire shall occur unless the Department or a successor department has assurance that the Resident has undergone further treatment and is, as of the date s/he is hired, no longer using substances of abuse. The Graduate Medical Education Advisory Committee must approve any such rehires under this paragraph.

DATED this ______ day of ________________, 1996.

__________________________________________
Resident

__________________________________________
Department Chair
STIPULATED REENTRY AND REHABILITATION AGREEMENT

This Agreement is entered on the date set forth below, between the Dean of the College of Medicine on behalf of the University of Arizona College of Medicine (hereafter “Dean”), and _____, a student at the College of Medicine (hereafter “_____”). When referring to the Dean and _____ collectively, they may be referred to as “Parties.”

RECITALS

1. ____ presently is a student at the College of Medicine, who was scheduled to begin his/her fourth year of medical studies on _________;

2. That, prior to________, ______ disclosed that s/he has an alcohol/substance abuse problem, and that s/he desired to withdraw from the clerkships in which s/he was participating in order to receive treatment for that problem;

3. That, on or about _________, _______ requested a medical leave of absence from the College of Medicine Student Progress Committee, with the intention of entering a rehabilitation program for treatment for substance/alcohol abuse. In connection with his/her request for leave, s/he submitted verification from his/her health care provider that s/he required such a leave, which certification was communicated to the Student Progress Committee by Campus Health;

4. That, on or about _________, in a meeting of the Student Progress Committee, ________’s request for a medical leave of absence was approved, effective June 2, 2000 through _________, 2000;

5. That, in accordance with the College of Medicine’s standard procedures, the Student Progress Committee directed that, prior to returning to his/her studies, _____ would be required to provide a statement to Campus Health from his/her health care provider that s/he was able to return to his/her studies, that s/he would not be a danger to himself or to others, and that s/he could fulfill the technical standards of the College of Medicine;

6. That, in accordance with those instructions, _________ presented a letter from his/her health care provider to Campus Health indicating that s/he has completed an inpatient program, that s/he is able to resume his/her studies and perform the technical standards required of all students at the College of Medicine with or without a reasonable accommodation, that s/he will not be a danger to himself or to others, and that s/he desires to return to his/her studies at the College of Medicine under the conditions set forth below;

7. That, in connection with his/her request to return from his/her medical leave of absence, _________ acknowledges that, given the nature of his/her studies and his/her need to interact safely both with patients and others, and given that, if s/he were a practicing physician, s/he would be required to participate in a monitoring program in order to ensure his/her continuing safety and sobriety, s/he desires to enter into a similar Agreement with the College of Medicine in order to assist him/her to remain compliant with his/her recovery program, to ensure his/her safety and the safety of others, and to enable him/her to remain free of substances and safely engage in his/her medical school studies;

8. The College of Medicine desires to assist _________ in his/her recovery and to enable him to finish his/her studies at the College of Medicine, and agrees to do so under the conditions set forth below to ensure that s/he remains compliant with his/her rehabilitation program and to ensure patient safety;

9. _________ acknowledges that, in order to complete his/her training as a medical student and to continue his/her studies as a physician, s/he must comply with the requirements of the maintenance program, which, in addition to requiring periodic random biological fluid collection and drug testing, s/he must actively participate in an approved 12-step or other self-help program;
10. The Parties further acknowledge that ________ may be required to confirm with his/her health care provider or other professionals with whom s/he is receiving counseling that s/he is in compliance with the conditions placed upon him/her by his/her health care provider and his/her after-care program;

11. ________ understands that this Stipulated Agreement (Agreement) is effective upon its acceptance by the Dean of the College of Medicine, the Chair of the Student Progress Committee, and by _____, as evidenced by their respective signatures hereto. The effective date of this Agreement is the date it is signed by the Dean, the Chair of the Student Progress Committee, and by _____ If the Agreement is signed by the parties on different dates, the later date is the effective date;

12. While this Agreement is not a disciplinary action and therefore is not being submitted, approved or monitored by the Student Progress Committee, ________ acknowledges that any violation of this Agreement shall be considered misconduct and may result in disciplinary action and referral to the Student Progress Committee pursuant to the rules applicable to the College of Medicine;

13. The parties hereto mutually understand and agree that this Agreement does not constitute a decision regarding any matter related to misconduct that may have been referred to the Student Progress Committee or to any matter involving failure to progress of which the Student Progress Committee might have been taking separate action. Therefore, the College of Medicine is not limited in its authority to take appropriate disciplinary action or pursue academic dismissal or other sanctions should such be appropriate in the circumstances, unless expressly stated otherwise herein;

14. ________ expressly waives any rights to appeal this action that otherwise would apply if it were considered a disciplinary matter under the procedures governing the Student Progress Committee and the Student Appeals Committee;

15. ________ agrees that, upon signing this Agreement, and returning this document or a copy thereof (which shall be considered as effective as an original so long as it bears signatures of all parties), to the Dean, ________ may not revoke acceptance or make any modifications to the document without the express agreement of the Dean;

16. ________ ACKNOWLEDGES THAT S/HE HAS READ THIS AGREEMENT, UNDERSTANDS ITS TERMS, AND AGREES TO COMPLY.

REVIEWED AND ACCEPTED this ______ day of ________, 200__.

________________________________________

Student

Based upon the foregoing, it is hereby agreed as follows:

AGREEMENT

1. Definitions

“Emergency” means a “serious accident or sudden illness that, if not treated immediately, may result in a long-term medical problem or loss of life.”

“Medication” means “prescription-only drug, controlled substance, and over-the-counter preparation, other than plain aspirin and plain acetaminophen.”
II.

**Standard Terms**

1. **Participation.** _______ acknowledges that s/he has enrolled and participated in an inpatient substance/alcohol abuse rehabilitation and treatment program (hereafter “program”). As part of said participation and ongoing monitoring from that program, _____ agrees to cooperate with the Dean’s staff and contracting program supervisors.

2. This Agreement is subject to modification by mutual consent unless otherwise specified herein. If the parties cannot mutually agree to future amendments of this Agreement, or, alternatively, if the Dean concludes that ______ has failed to comply with the terms of this Agreement, or modification of this Agreement is inappropriate, this matter may be referred for proceedings before the Student Progress Committee to consider all relevant issues of _______’s conduct and ability to safely and ethically engage in the practice of medicine and in his/her medical studies.

3. **Group Therapy.** _______ shall attend the program’s group therapy sessions in accordance with the specific recommendations of the program, which shall be communicated to the Dean, for the duration of this Agreement, unless excused by the group therapist for good cause such as illness or vacation. _____ shall instruct the program group therapist to release to the Dean, upon his request, a report of _____’s progress in the program, but shall submit monthly reports to the Dean regarding attendance and progress whether or not requested. The reports shall be submitted on or before the 10th day of each month.

4. **12-Step or Self-help Group Meetings.** _______ shall attend 12-step meetings or other self-help group meetings appropriate for substance abuse as directed by the program, which shall be communicated to the Dean. Such participation shall begin not later than either (a) the first day following _____’s discharge from chemical dependency treatment or (b) the date of this Agreement. To the extent possible, and to the extent _____ would not otherwise be able to attend such meetings because of his/her medical school duties, the College of Medicine will attempt to facilitate such attendance.

5. Following completion of the meetings described in paragraph 4 above, ____ shall participate in a 12-step recovery program or other self-help program appropriate for substance abuse as recommended by the group therapist and communicated to the Dean. ____ shall attend a minimum of three (3) 12-step or other self-help program meetings per week.

6. **Primary Care Physician/Addictionologist.** _____ shall establish a relationship with a qualified addictionologist/primary care physician in Tucson, Arizona, no later than ______, and shall provide him/her a copy of this Agreement. _____ shall advise the Dean of the College of Medicine of the name of the addictionologist/primary care physician selected no later than ______ and the Dean shall approve the selection of such individual. Should _____ desire to change addictionologist/primary care physicians, s/he shall immediate inform the Dean of any such changes in health care providers. As part of the prescribed therapy, this individual shall design a fluid-collection and drug-testing and monitoring program to identify any inappropriate uses or abuses of substances and to report positive findings to the Dean.

7. The addictionologist/primary care physician shall be in charge of providing and coordinating all of _____’s medical care and treatment. Except in an Emergency, _____ shall obtain his/her medical care and treatment only from the approved addictionologist/primary care physician and from health care providers to whom the addictionologist/primary care physician refers _____ from time to time. ____ shall request that the addictionologist/primary care physician document all referrals in the medical records.

8. _____ shall promptly inform the addictionologist/primary care physician of _____’s rehabilitation efforts and provide a copy of this Agreement to that physician. _____ shall also inform all other health care providers who provide medical care or treatment that _____ is participating in a rehabilitation program and that s/he is governed by this Agreement.

9. **Medication.** Except in an Emergency, _____ shall take no Medication unless the Medication is
prescribed by _____’s addictionologist/primary care physician or other health care provider to whom the addictionologist/primary care physician makes referral. _____ shall not seek or fill any prescriptions provided by an individual other than his/her addictionologist/primary care physician or another health care provider to whom s/he has been referred by his/her addictionologist/primary care physician.

10. If a controlled substance is prescribed, dispensed, or is administered to ____ by any person other than the addictionologist/primary care physician, ____ shall notify the addictionologist/primary care physician in writing within 48 hours. The notification shall contain all information required for the medication log entry specified below. ____ shall request that the notification be made a part of the medical record. This paragraph does not authorize ____ to take any Medication other than in accordance with paragraph 9 above.

11. Medication Log. _____ shall maintain a current legible log of all Medication taken by or administered to ____ and shall make the log available to the Dean and his staff upon request. For Medication (other than controlled substances) taken on an ongoing basis, _____ may comply with this paragraph by logging the first and last administration of the Medication and all changes in dosage and frequency. The log, at a minimum, shall include the following:

a. Name and dosage of Medication taken or administered;

b. Date taken or administered;

c. Reason Medication was prescribed or administered.

This paragraph does not authorize _____ to take any Medication other than in accordance with paragraph 9.

12. No Alcohol or Poppy Seeds. _____ shall not consume alcohol or any food or other substance containing poppy seeds.

13. Biological Fluid Collection. During all times that ____ is physically present in the State of Arizona and such other times as the Dean may direct, ____ shall promptly comply with requests from the Dean or his designee, the group therapist, or the program director to submit to witnessed biological fluid collection. If ______ is directed to contact an automated telephone message system to determine when to provide a specimen, ____ shall do so within the hours specified by the program staff. For the purposes of this paragraph, in the case of an in-person request, “promptly comply” means “immediately.” In the case of a telephonic request, “promptly comply” means that, except for good cause shown, ____ shall appear and submit to specimen collection not later than two hours after telephonic notice to appear is given. The Dean or his designee or program staff, in their sole discretion, shall determine good cause.

14. _____ shall provide the program and the Dean’s staff in writing with one telephone number that shall be used to contact ____ on a 24-hours per day/seven days per week basis to submit to biological fluid collection. For the purposes of this section, telephonic notice shall be deemed given at the time a message to appear is left at the contact telephone number provided by _______. _______ authorizes any person or organization conducting tests on the collected samples to provide testing results to the Dean or his designee and the program director.

15. _____ shall cooperate with collection site personnel regarding biological fluid collection. Repeated complaints from collection site personnel regarding _____’s lack of cooperation regarding collection may be grounds for termination from the program and will be considered a violation of this Agreement, which may subject _____ to disciplinary action before the Student Progress Committee.

16. Payment for Services. _____ shall pay for all costs, including personnel and contractor costs, associated with participating in this program and in fulfilling the terms of this Agreement. The College of Medicine shall have no obligation to, nor shall it provide reimbursement for any expenses incurred by _______ for his/her participation in any rehabilitation program or for the implementation of this Agreement.

17. Examination. _____ shall submit to mental, physical, and medical competency examinations at such
times and under such conditions as directed by the program staff or the Dean to assist the Dean in monitoring _____’s ability to safely continue in his/her medical studies and to comply with the terms of this Agreement. In any such reports to the Dean, only information relevant to treatment compliance, and safety to engage in medical studies and work with patients and others, shall be included. No information related to diagnosis shall be included in such reports.

18. **Treatment.** _____ shall submit to all medical, substance abuse, and mental health care treatment directed by his/her primary care physician/addictionologist, or recommended by the program director. Any failure to comply with recommended treatment shall be communicated immediately to the Dean or his designee.

19. **Obey all Laws.** _____ shall obey all federal, state and local laws, and all rules of the College of Medicine, the University of Arizona, and the Arizona Board of Regents.

20. **Interviews.** _____ shall appear before the Dean, the Associate Dean for Student Affairs, or their designees for interviews upon request and upon reasonable notice.

21. **Address and Telephone Number Changes.** _____ shall immediately notify the Dean in writing of any change in address and telephone number. _____ shall provide the Dean’s staff at least three business days advance written notice of any plans to be away from home or school for more than five (5) consecutive days.  The notice shall state the reason for the intended absence from home or school and shall provide a telephone number that may be used to contact _____.

22. **Return to the College of Medicine.** (Add paragraphs about return to the College of Medicine, including any special program for class attendance, etc.)

23. **Relapse, Violation.** In the event of chemical dependency relapse by _____ and use of drugs or alcohol by _____ in violation of this Agreement, this matter shall be referred to the Student Progress Committee immediately and this Agreement will terminate. In this event, the Dean of the College of Medicine shall notify any clinics, hospitals or affiliates with which _____ has been working of the relapse and the termination of this Agreement.

24. **Notice Requirements.** Upon his/her return to his/her studies at the College of Medicine, _____ shall immediately provide a copy of this Agreement to all hospitals, clinics and affiliates with which _____ is engaging in clinical clerkships. Within 30 days of returning and beginning his/her clerkship, _____ shall provide the Dean with a signed statement that _____ has complied with this notification requirement.

25. **Non-disciplinary Matter.** This Agreement is not a disciplinary action; it may only be disclosed to third parties not otherwise named or referenced by title or designation in this agreement in accordance with the provisions of the Family Education Rights and Privacy Act of 1974, or by specific release by _____.

26. **Voluntary Agreement.** This Agreement is a voluntary monitoring agreement to rehabilitate _____, and to ensure _____’s ability to safely study and engage in the training in medicine. It also supersedes all previous agreements and amendments thereto between the College of Medicine and _____.

DATED and effective this _____ day of ___________, 200__.

________________________________________
Student

________________________________________
Dean, College of Medicine

Acknowledged:

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