Before and After Student Suicide:
Preventing Tragedies and Mitigating Liability

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Introduction

The issue of student suicide is fraught with tension for colleges and schools. Good mental health bolsters student success, and institutions may struggle to define their role in addressing students’ mental health needs. Can schools identify potentially suicidal students? Should they even try to do so? What should instructional, administrative, and residential life staff do when they believe that a student may be considering self-harm? Fundamentally the student may need treatment for a condition such as major depression, schizophrenia, or bi-polar illness. The student may resist help and, in any event, appropriate treatment may exceed the institution’s capacity.

Educational environments emphasize creativity and often tolerate idiosyncrasy. If a student pursues raw themes of death and self-harm in course work or social conversation, it can be difficult to distinguish between normal exploration and a potential suicide warning sign. Respect for a student’s privacy and autonomy may complicate steps to address concerns about a student’s welfare directly with the student or with others, including the family.

Educational institutions do well to face these tensions squarely. They can adopt programs and practices that best deploy institutional expertise and resources to meet students’ mental health needs. They can describe for students and families the available resources and the limitations. They cannot, however, solve all problems. When a student commits suicide, the possibility exists that the family will seek to hold the institution legally accountable. Some common themes in these lawsuits include:

- The institution ignored warning signs of suicide.
- The institution provided the tools that the student used for suicide.
- The institution took insufficient steps to address the warning signs.
- The institution failed to notify the family about the student’s condition.
Litigation over student suicide is becoming more common. While we cannot offer precise statistics, we can say with certainty that the 1200 member institutions of United Educators are reporting suicide claims with greater frequency today than five years ago. Yet few court decisions provide guidance about the standards of care that schools and colleges should meet. Here, nonetheless, are some very general pointers:

- Know your personal and institutional limits as a helper, stay within those limits, and rely on external resources as needed for assistance.
- An institution’s duty to intervene in preventing suicide is higher for minors and for those in custodial care, just as a juvenile detention facility or campus security holding cell.
- Privacy of student information can arise from sources including FERPA and confidential therapeutic relationships recognized under state law. FERPA, state laws, and professional ethics statements generally permit or even compel disclosure of information in emergency situations. Potential suicide can be an emergency.

Statistics on Student Suicide

National Statistics. About 30,000 Americans die annually by suicide. It is among the 12 leading causes of death. ¹ The national death rate is about 10.7 suicide deaths per 100,000 population. Rates vary widely by state. In 2000, for example, Alaska, Nevada, New Mexico, and Wyoming had rates exceeding 20 suicides per 100,000, while Massachusetts, New Jersey, and New York had rates under 7 per 100,000.²


Suicide rates among young people are substantially higher than national averages. Suicide is the third leading cause of death in each of the age ranges 10 to 14, 15 to 19, and 20 to 24. More detailed data on suicide rates, methods, and mental health indicators among college students and younger students are presented below.

**Higher Education.** Recent research on suicidal ideation and behavior among college students tells a chilling story. A spring 2000 survey of 16,000 college students from 28 campuses showed that 17% reported feeling so hopeless and depressed on at least three occasions in the past school year that it was difficult to function. Over 9% had seriously considered suicide, and 1.5% had made one or more attempts in the past year. Characteristics of college-age students particularly prone to seriously consider suicide include:

**Odds Ratio Correlation w/Serious Suicidal Thoughts**

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotionally abusive relationship</td>
<td>2.91</td>
</tr>
<tr>
<td>Non-heterosexual</td>
<td>2.57</td>
</tr>
<tr>
<td>Attempted sexual penetration victim</td>
<td>1.60</td>
</tr>
<tr>
<td>Asians &amp; Pacific Islanders</td>
<td>1.59</td>
</tr>
<tr>
<td>Victim of sexual touching against will</td>
<td>1.28</td>
</tr>
</tbody>
</table>

The most protective factor was a committed relationship or marriage. The study also concluded that, of college students who had seriously considered suicide 3 or more times in the past year, 81.6% had received neither therapy nor antidepressant medication. Thus, at least four out of five students who had seriously considered suicide had received no treatment for the problem. While the study did not include suicidal high school students,

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3 National Center for Health Statistics, Suicide, from www.cdc.gov/nchs/fastats/suicide.htm

4 Data in this section is drawn from “Suicidal Ideation and Behavior Among College Students: Spring 2000 National College Health Assessment,” paper presented at the May 2002 conference of the American College Health Association by Michael Haines, Jenny Haubenreise, and E. V. Leino.

5 Observers have suggested that Asian and Pacific Islander students may be more prone to feelings of shame but not necessarily feelings of hopelessness.
one can reasonably surmise that they would be no more likely to have received therapy or medication.

The methods that college students used for suicide were examined in the “Big Ten Suicide Study.” This collaborative research examined the extent and nature of suicide between 1980 and 1990 at 12 large Midwestern universities. It found that firearms and chemical poisoning accounted for half of the 258 suicides during the ten-year period.

<table>
<thead>
<tr>
<th>Student Suicide Methods At 12 Midwestern Universities 1980-1990</th>
<th>Frequency (N=258)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Firearms</td>
<td>28%</td>
</tr>
<tr>
<td>Chemical poisoning (drugs, cyanide, other)</td>
<td>22%</td>
</tr>
<tr>
<td>Hanging / Asphyxiation</td>
<td>18%</td>
</tr>
<tr>
<td>Gas</td>
<td>11%</td>
</tr>
<tr>
<td>Jumping</td>
<td>9%</td>
</tr>
<tr>
<td>Vehicle</td>
<td>3%</td>
</tr>
<tr>
<td>Knife</td>
<td>2%</td>
</tr>
<tr>
<td>Drowning</td>
<td>1%</td>
</tr>
<tr>
<td>Unknown</td>
<td>7%</td>
</tr>
</tbody>
</table>

The study found an average suicide rate of 7.5 per 100,000, which is below the national suicide rate. This fact – that college and university students are less prone to suicide than the general population – is often lost in the glare of media attention on campus suicides. The study also found that the majority of suicides, for both males and females, occurred

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6 See “The Big Ten Student Suicide Study: A 10-Year Study of suicides on Midwestern University Campuses,” by Silverman, Meyer, Slocane, Raffel, and Pratt, vol. 27 #3, Suicide and LifeThreatening Behavior, 285 (Fall 1997). Data derived from presentation by Morton Silverman, University Risk Management and Insurance Association, May 20, 2003. Institutions participating in the survey were: Indiana University; Michigan State University; Northwestern University; Ohio State University; Pennsylvania State University; Purdue University; University of Chicago; Purdue University; University of Illinois at Urbana-Champaign; University of Iowa; University of Michigan; University of Minnesota; and University of Wisconsin.
in the 20-24 and 25-29 age ranges. This suggests that upperclass undergraduates and
graduate students are at highest risk.

Extrapolating from the suicide rates found in the Big Ten Study, the Jed Foundation has
estimated that 1088 students enrolled in 2- and 4-year degree granting institutions commit
suicide annually. 7

The 2002 “National Survey of Counseling Center Directors” by Robert Gallagher found
that, of 272 institutions participating in the survey, 20% experienced the suicide of an
enrolled student during the 2001-02 school year. 8 The total number of suicides among the
respondents was 116, including 4 at one institution. A much smaller number of students
who were clients of the campus counseling center committed suicide. Only 7.4% of the
institutions reported that a student who was a client of the counseling center committed
suicide in 2001-02. On the treatment side, one university counseling center has tracked a
42% increase in the number of psychiatric hospitalizations of students in the academic
years between 1999-00 and 2002-03. 9 It now has a rate of 2 psychiatric hospitalizations
per 1,000 students. A national provider of university student health insurance reports a
rate of psychiatric hospitalizations in 2002 of 3.4 per 1,000 students, among a population
of 254,561 students.

**Younger Students.** The Centers for Disease Control offer data on the rate of suicidal
ideation and attempts for students in grades 9 through 12. 10 Based on a national sample of

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7 “Safeguarding Your Students Against Suicide: Expanding the Safety Net,” proceedings of an expert panel
co-sponsored by The Jed Foundation and the National Mental Health Association, p. 2 (2002).

8 “National Survey of Counseling Center Directors, 2002” by Gallagher and Zhang, International
Association of Counseling Services, Inc.

9 Treatment data drawn from presentation by Dr. Russ Federman, Ph.D., director of the University of
Virginia Counsel Center, at conference on “Suicide, Violence and Disruptive Behavior on Campuses;
Clinical, Legal and Administrative Issues,” June 12, 2003, Charlottesville, VA. The psychiatric
hospitalization data come from the University of Virginia and the Chickering Group.

10 Health, United States 2002, Table 60, Suicidal ideation, suicide attempts, and injurious suicide attempts
among students in grades 9-12 by sex, grade level, race, and Hispanic origin: United States, selected years
high school students, the CDC has found that nearly 20% of 9th through 12th graders seriously considered suicide in 2001. Over 8% made an attempt, and 2.6% made an attempt that resulted in injury and required medical attention. Compared to a decade earlier, fewer high school students are contemplating suicide but more are attempting it.

<table>
<thead>
<tr>
<th>Ninth through Twelfth Graders</th>
<th>1991</th>
<th>2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students who seriously considered suicide</td>
<td>29%</td>
<td>19%</td>
</tr>
<tr>
<td>Students who attempted suicide</td>
<td>7.3%</td>
<td>8.8%</td>
</tr>
<tr>
<td>Students whose suicide attempt resulted in injury requiring medical attention</td>
<td>1.7%</td>
<td>2.6%</td>
</tr>
</tbody>
</table>

At least five other epidemiological studies of adolescents have found high rates of depression and subsequent relapse.\textsuperscript{11} A longitudinal study in Oregon, for example, followed 1709 high school students ages 14 to 18, with an average age of 16.6. It found that 28% of adolescents have had a major depressive episode by age 19.\textsuperscript{12} Of those who recovered from their first depressive episode, 5% experienced a relapse within 6 months, 12% within one year, and approximately 33% within the next four years. Another national longitudinal study of 13,568 adolescents found that 10% suffered from moderate to severe depression.\textsuperscript{13} Two large studies analyzing treatment data on youths respectively under 18 and under 20 found a two- to three-fold increase in the use of psychotropic

\textsuperscript{11} Data drawn from presentation by Russ Federman, Ph.D., director of the University of Virginia Counseling Center, at conference on “Suicide, Violence and Disruptive Behavior on Campuses: Clinical, Legal and Administrative Issues,” June 12, 2003, Charlottesville, VA.


\textsuperscript{13} “Epidemiology of Depressive Symptoms in the National Longitudinal Study of Adolescent Health,” Journal of the American Academy of Child and Adolescent Psychiatry, February 2002. Researchers adjusted the definition of depression to account for the adolescent tendency to “over-endorse” or exaggerate their feelings.
medication.\textsuperscript{14} These rates of depression and relapse pose significant challenges for high schools and also for colleges, where many of the students are headed.

**Suicide Warning Signs**

Some student suicides occur with few or no warning signs observable to the school. In other cases, though, the student may give signals of emotional distress. These signals may be explicit and direct or less obvious. Here are some key warning signs of suicide.

- A suicide threat, whether direct or indirect.
- A past suicide attempt.
- Obsession with death manifested in poems, essays, drawings, songs, conversation or other means.
- Dramatic changes in personality or appearance. Note that the mood of a depressed person may improve after he or she formulates a suicide plan.
- Irrational, bizarre behavior.
- Overwhelming sense of guilt, shame, or rejection.
- Statements about getting even or getting attention.
- Changed eating or sleeping patterns.
- Severe decline in school performance.
- Giving away belongings, arranging affairs for death.

A past suicide attempt is a very strong indicator of potential suicidality. Virtually everyone has fleeting thoughts of suicide at some time, but suicidal tendencies may become chronic in some individuals.

\textsuperscript{14}“National Trends in the Use of Psychotropic Medications by Children,” Journal of the American Academy of Child and Adolescent Psychiatry, May 2002; Psychotropic Practice Patterns for Youth,” Archives of Pediatric Adolescent Medicine, January 2003.
Outreach and Screening Programs

Many institutions offer screening programs to help identify suicidal students and encourage them to seek treatment. In a 2002 survey of college and university counseling center directors, forty percent reported that their centers held a Depression Screening Day and fifteen percent held an Anxiety Screening Day.\textsuperscript{15} Two of the leading sources of screening programs are:

\textbf{Screening for Mental Health.} In addition to community-wide screening tools, Screening for Mental Health offers programs tailored specifically to high schools and colleges. Participating institutions receive tools for in-person screening which may be conducted, for example, through a table set up in the student union on a special date and staffed by counselors. In the screening process, students take a short, anonymous, self-scoring quiz. If they wish, they can obtain information about treatment resources. The group also offers high-quality videos on depression and suicide, with discussion guides for teachers or other leaders. The latest addition to the program is an on-line screening tool that can be customized with information on, and links to, the institution’s own counseling center. For further information on these reasonably-priced resources, visit www.mentalhealthscreening.org or call 781-239-0071.

\textbf{The Jed Foundation.} Established in memory of a university student who committed suicide, the Jed Foundation offers U-Lifeline. This on-line screening tool, currently used by over 60 colleges and universities, is for students only. Users can find information, ask questions, and take a self-diagnostic quiz. Visit www.jedfoundation.org, which includes useful suicide facts and articles, and www.ulifeline.com, which offers a guest password to examine the student program.

The National Academy of Sciences has cited the usefulness of school-based suicide intervention efforts, while cautioning that these should not take the form of a brief

\textsuperscript{15} “National Survey of Counseling Center Directors, 2002” by Gallagher and Zhang, International Association of Counseling Services, Inc., p. 7.
didactic lecture without connections to services. Another important caution is that any screening program that is not anonymous carries with it an obligation to follow up. If, for example, a student health service offers a suicide self-test to patients in the waiting area and the information is provided to the treating physician, the physician and the institution could be held liable for failing to act appropriately to warning signs. Other useful programs in middle and high schools can include self-esteem and social skill building, which may be coupled with advice about how to talk to a friend who may be suicidal and how to seek help from adults.

Some universities have developed special outreach programs to address problems of student suicide. Described below are illustrative programs from four institutions: the University of Illinois, SUNY-Stony Brook, Arizona State University, and the University of North Carolina at Chapel Hill.

University of Illinois. In 1984 the university launched a formal program to reduce suicides among its students. At the core of the program is a requirement that any student who threatens or attempts suicide must attend four mandated sessions of professional assessment with the counseling service. The consequences for failure to comply can include withdrawal from the university. The director of the program, Dr. Paul Joffe, suggests that suicidal behavior among college students is not a “cry for help” but rather a method for students to assert control and express power. The program focuses on student conduct, makes no assumptions about psychological disorders, and avoids in its intake mechanisms any second-guessing about the meaning and seriousness of self-destructive acts.

16 Reducing Suicide: A National Imperative, supra note 1, at page 317.

17 See Reducing Suicide: A National Imperative, supra note 1, at pp. 293-297 for a discussion of awareness and skills training.

In an early stage of the program, counselors had contact with students who had made a suicide threat or attempt and encouraged them to seek assistance. Some of the students denied ever having been suicidal (despite the existence of suicide notes, eyewitnesses, or other contrary evidence), other claimed a total recovery, and, of the few who did make counseling appointments, many failed to appear. Other students lied to residence hall directors, claiming to be under treatment with professional counselors when in fact they were not. These factors led to a system in which sessions at the counseling center, termed assessment rather than treatment, are mandatory rather than optional.

A 4-person suicide prevention team receives Suicide Incident Reports from student affairs staff and other campus personnel. The team meets biweekly to review reports on student suicide threats and attempts and contacts the individuals about the required assessments. The team follows up vigorously to ensure that students make and keep their appointments. At each session the therapist and student address:

- The student’s current ideation, intent, and access to suicide means
- A reconstruction of the circumstances, thoughts, and feelings connected with the original incident
- The student’s lifetime history of the student’s suicidal intent and its meanings and origins
- The university’s standards for self-welfare and the consequences for failing to adhere to them.

Dr. Joffe describes the process as a “balancing act between patience and the application of force.” The goal is to “assert the university’s position without being overpowering, to be patient but not too patient.” The team receives an average of 85 Suicide Incident Reports annually. Since 1984, not one of the 1531 students who has been reviewed by the committee has gone on to commit suicide. Twenty other students, not the subject of Suicide Incident Reports, who were enrolled or enrolled within the past six months have committed suicide in the county during this period. All were male, and 12 of the 20 were

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19 Id. At page 11.
graduate or professional students. Eight other students, also not the subject of Suicide Incident Reports, committed suicide in other locales. Costs for the program are about $10,000 per year for training and administration and $40,000 for treatment, averaging $1.35 per enrolled student at the university.

Dr. Joffe surmises that the greatest barriers to implementing this type of program elsewhere arise not from students but from campus mental health professionals. He explains:

*Psychiatrists are generally reluctant to relinquish control over the campus’ response to emergencies, an area they dominate on many campuses. Therapists are reluctant to give up the privilege of discretionary judgment and to being forced to meet with students in a mandated format. Counseling Centers are generally opposed to mandated treatment, as well as engaging in the type of power struggle necessary to make contact with suicidal students. The program’s focus on administrative controls and its active monitoring of both students and therapists is at odds not only with the internal culture of most college counseling centers but with the reputations most centers strive to cultivate among the student body. The experience at the University of Illinois is the suicide prevention program is largely self-contained and has not led to an erosion of either the center’s culture or of its reputation among students.*

**SUNY – Stony Brook.** The State University of New York at Stony Brook includes in its student conduct code a provision that any individual whose behavior “appears to pose a serious threat to the health and safety of themselves or others” may be in violation of the code. The student may be subject to steps including: medical or psychological evaluation; withdrawal prior to evaluation; withdrawal by administrative action; and parental notification. A psychological evaluation advisory committee reviews approximately 40 to 50 cases per year and may obligate the student to be evaluated at the counseling center. Student conduct in a recent year that led to required or mandated evaluations included: delusional threats to faculty, a suicide attempt, a threat to kill the judicial director, continuous vomiting in a resident hall, and a hallucinatory suicide

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20 *Id.* At page 24.

21 “Mandated Psychological Evaluations,” Anne Byrnes, Ph.D., presentation at conference “Suicide, Violence, and Disruptive Behavior on Campus,” June 13, 2003, Charlottesville, VA.
attempt that included walking on a highway. Students were taken to the hospital for conduct including: overdoses of Tylenol, Zoloft, Motrin, and other drugs; slashed wrists; delusions; and severe depression. Approximately a quarter to a third of the students who were evaluated also receive therapy. The counseling center director suggests that international students are at particular risk, evaluations are time consuming, flexibility in policies is necessary to address the needs of individual cases, and decision-making authority is critical.

**Arizona State University.** In 1993 the associate vice president for student affairs established a program to address students at risk for various types of problems. At the center is a Student Assistance Coordinating Committee. Meeting monthly, the committee includes staff from the dean of students office, counseling center, student health, disability resources office, student housing, campus security, and the legal office. It shares nonprivileged information and coordinates services for students who may be raising issues with multiple offices across campus.

**University of North Carolina at Chapel Hill.** In 1995 a 26-year old third year law student fatally shot two people on a public street – the manager of a local McDonald’s and a university undergraduate student. He was eventually tried and found not guilty by reason of insanity. The wrenching episode motivated the university to revise its policies on student conduct and mental health. The central actor is the Counseling and Psychological Service (CAPS), which partners with the dean of students office. Members of the university community may report concerns about student conduct to CAPS or the dean of students office. Some students may also self-report dangerous ideation to a mental health provider and then may, or may not, cooperate with treatment recommendations.

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Illustrative Judicial Decisions on Liability for Student Suicide

Over the past forty years, state and federal courts have addressed various cases in which families have sought to hold an educational institution liable for a student’s suicide. Each of these situations is tragic and complex. The families often claim that the institution should have seen more clearly the depth of the student’s distress and should have taken more vigorous steps to protect the student. A lack of institutional notification to parents is a recurring theme. Recent years have brought a small but steady increase in the number of these lawsuits. The reported judicial decisions on student suicide are, however, not as numerous as a layperson might expect, and the legal principles are still evolving.

Below are some case summaries that illustrate the complexities of the facts and law. In reading the descriptions, please bear in mind that state law principles tend to predominate in these cases and that they vary around the country. A court in Florida, for example, may reach a different outcome than a court in another state even on identical facts. Another key distinction is whether the institution is public or private, because legal principles vary considerably depending on the type of institution. Consider these cases as examples of what a court might do in a case involving your institution, but not dispositive of what a court would do.

**Hanging in university holding cell.** In October, 1982, a Michigan State University public safety officer observed a student driving erratically on campus at about 1 a.m. After making a stop and administering sobriety tests, the officer arrested the student for drunken driving. The student, who appeared to be in a good mood with a generally positive demeanor, was placed in a campus holding cell designed for short-term detention. While alone there for about 35 minutes, the student hanged himself by his belt and socks from a metal bracket. Regulations in effect at the time provided that:

No prisoner shall be left unattended unless he is first searched and secured in a segregation room. All offensive and defensive weapons or other objects which could harm an officer, the prison, or other prisoners shall be removed and properly secured.
The family filed suit the month after the death, and the legal proceedings took a decade to resolve. Legal issues included the scope of governmental immunity, the student’s own responsibility for the intentional act of suicide, the personal responsibility of the officer, and the university’s and officer’s negligence. The Michigan Supreme Court ruled in 1992 that the university could bear responsibility and ordered additional proceedings in the trial court on damages. The crux of the ruling turned on the custodial relationship between the officer and the student, which created a special duty of care. The jury had found the officer negligent in not removing the student’s belt and in failing to supervise his detention. These shortcomings enhanced the likelihood of the student’s intervening act of suicide. The court struggled with the application of the concept of comparative negligence – whether the university was 100% responsible or whether the student bore some portion of the responsibility. A majority of the justices decided that the jury should have been asked to apportion responsibility, potentially reducing the university’s damages to less than 100% of the total. Hickey v. Zezulka, 440 Mich. 1203, 487 N.W.2d 106 (Mich. 1992).

**Gunshot death in home after student dropped off by counselor.** A sixteen-year-old special education student was suspended from school for threatening a teacher and was dropped off at home by a school counselor. The student had previously made comments about suicide and school personnel knew that the home contained guns. Alone at home, the student shot himself. The school had made no effort to contact the parents before dropping the student off. The federal court of appeals ruled that the school and the counselor could be responsible for placing the student in an unreasonable zone of danger and remanded the case for further proceedings. Armijo By and Through Chavez v. Wagon Mount Public Schools, 159 F.3d 1253 (10th Cir. 1998).

**Intervention efforts and later suicide.** A freshman at the University of Wyoming was found intoxicated at night. The residence hall director contacted the university police because the student was an underage drinker and might, she feared, asphyxiate himself in his sleep. After several hours in the local hospital, the student returned to campus, where
in the early morning he made superficial cuts on his wrists. The residence hall director talked with the student and judged him not to be suicidal but contacted the university police and requested involvement of the university counseling center’s crisis intervention team. A crisis intervention volunteer, from the university’s office of student life, spoke with the student for an hour the following day and determined that the student did not have a plan for suicide or access to means for doing so and had a good support system of friends. The staff member encouraged the student to avail himself of campus counseling services. The university did not inform the student’s parents of the incident.

Two years later, the student committed suicide and the family brought suit alleging that the university and its personnel breached a duty to the family “by failing to adequately monitor, treat, counsel, or give notice” in response to the earlier incident. The university filed a motion for summary judgment before the case went to trial, arguing that the residence hall director and student affairs staff member, who was assistant director of fraternity and sorority life, were not health care providers, rendering them protected by governmental immunity under state law. Note the training that each received. The residence hall director gave deposition testimony that she was trained to:

- Examine whether an individual had a plan to commit suicide
- Examine the individual had access to a means of committing suicide
- Examine the lethality of those means
- Contact campus police when necessary in dealing with student alcohol problems
- Contact both the campus police and the crisis intervention team when dealing with individuals who might pose a threat to themselves or others

The student life staff member had a masters degree in counseling. In her student life work and in her crisis intervention work she had received training to:

- Assess suicide risk
- Deal with crisis and emergency situations
- Make referrals to support services
The court agreed with the university’s position, finding that the two individuals were not health care providers. The court noted that while both individuals were responsible for assessing suicide risk and making referrals to appropriate support services, neither position involved “curing and preventing impairments of the normal state of the body” or “treating or diagnosing mental illness.” *White v. University of Wyoming*, 954 P.2d 983 (Wyo. 1998).

**Parental notification by high school counselor.** A ninth grade student in Minnesota who had stayed home from school with her parents’ knowledge fatally shot herself with a loaded gun from the basement of her home. Five months earlier she had expressed suicidal thoughts to a school guidance counselor, who had informed her parents and recommended professional counseling. The counselor advised the parents that the student was suffering from clinical depression and was in some danger of suicide. The parents did not share this information with school personnel.

Several months later the student wrote an essay for an English class in which she described a teenage girl committing suicide by shooting herself in the chest. The teacher reported the incident to the guidance counselor, who did not provide information to the parents. A month later a friend of the student called another school guidance counselor at home to report that the student had sent the friend a letter expressing an intention to get a gun from her basement and kill herself. The original guidance counselor was informed and spoke to the student. The student told the counselor that “she only considered suicide when she was fighting with a parent and that she was not thinking about it now.” The student also reported that she was in counseling. The counselor asked the student to seem him the following week and did not contact the parents about the letter or the conversation.

The parents alleged that the school district should have had a policy on suicide prevention and also breached its duty to notify them of the student’s expressed suicidal thoughts. The Minnesota appeals court ruled that the development of a suicide prevention policy is a discretionary, rather than mandatory, function. It would, the court noted, involve
balancing many competing interests. “The decision whether to create a policy on student suicide would require the district to carefully weigh considerations about the role and function of guidance staff, the financial resources available for training, privacy of students, intimacy of student-teacher relationships, district involvement with mental health-care providers, educational methods, public attitudes, and the efficacy of particular approaches.” So-called discretionary function immunity protected the school district from liability for the lack of a suicide prevention plan.

As to parental notification, the court concluded that the counselor’s actions were based on his professional judgment. He relied on his education and training, past experience in dealing with troubled teenagers, and his observations of and knowledge about the student’s problems. The court explained:

The tragedy of the student’s death is even more painful with the possibility that more communication or differently timed communication might have prevented it. But the facts demonstrate the many factors that affect such a decision, and the issue is not whether, in hindsight, a different decision might have averted the tragedy. The question is whether the alleged failure to act is discretionary, to which official [governmental] immunity applies, or ministerial, to which immunity does not apply.

Killen v Independent School District No. 706, 547 N.W.2d 113 (Minn. App. 1996).

**Issue for trial on dispensing controlled substances.** The mother of a University of Arkansas varsity football player sued the university and other parties after his death by a self-inflicted gunshot wound. She alleged that the university was negligent in carelessly dispensing large quantities of prescription medicines, including Darvocet and Tylenol 3, through the athletics trainers without adequate recordkeeping or regard to the potential harm to student athletes. After a shoulder injury her son received heavy doses of Darvocet, which may have depressive effects and be linked to suicide. The university sought to show that preceding his suicide the son had consumed large amounts of alcohol but had not ingested Darvocet. Given the factual questions including the length of time
that the drug’s effects could last in the body, the state supreme court sent the case back to the trial court for further proceedings. Wallace v. Broyles, 961 S.W.2d 712 (Ark. 1998).

**No duty to implement suicide prevention program.** In two cases, courts in Idaho and Illinois have ruled that high schools do not have a duty to implement a suicide prevention program for students. In the Idaho case, an English teacher required students to keep journals, agreeing not to read them but only to check for length and dates. After a student committed suicide, the teacher read his journal and found discussion of depression and death. The state supreme court ruled that implementing a suicide prevention program was a discretionary act, which the school was not obliged to take. It also ruled that the teacher and the school district were protected by immunity for any liability arising out of her actions. Brooks v. Logan, 906 P.2d 73 (Idaho 1995). Of similar effect is the case from Illinois, in which other students reported to a school counselor that their friend was discussing a plan to commit suicide and was writing suicidal notes. The counselor informed the mother and encouraged her to take her son to the hospital for a drug overdose. While in the car, the student jumped out and, later the same day, jumped to his death off a highway overpass. Again, the court found no duty to implement a suicide prevention program and immunity protection for the counselor and the district. Grant v. Board of Trustees of Valley View School District, 676 N.E.2d 705 (Ill. App. 1997).

**Mandated counseling and “no harm” agreement.** According to facts as alleged by the family, a freshman college student was required, in connection with some disciplinary issues, to attend anger management counseling. After admitting to self-inflicted wounds, he was required by the dean to sign a “no harm” agreement. Several days later he committed suicide in his dormitory room. The family brought suit under the state wrongful death statute, maintaining that the college through its officials “knew or personally should have known” that the student was likely to attempt to hurt himself if not properly supervised, that they negligently failed to protect him from himself, and that the death resulted directly from this negligence. The college argued that the wrongful death statute did not apply to suicide and that it bore no legal duty to protect the student from this harm. The federal district court decided that, while the college did not stand in
loco parentis to the student, the plaintiffs had alleged sufficient facts to deserve a trial on the merits of the nature of the relationship and possible negligence. The case was, however, settled before trial. Schieszler v. Ferrum College, 236 F.Supp. 2d 602 (W.D.Va. 2002).

Prior suicide attempt. A freshman at the University of Iowa kept his moped in his dormitory room, in violation of university rules. On one occasion in the presence of his girlfriend he sought to kill himself by running the motor indoors. Various university staff were aware of the attempt, encouraged the student to seek counseling, and, in keeping with the student’s wishes, did not notify his family. On a subsequent occasion he did kill himself through precisely the means attempted earlier. The Iowa Supreme Court ruled that the university owed no affirmative duty of notification to the parents. Jain v. State, 617 N.W.2d 293 (Iowa 2000).

Notification Policies and Practices

The parents of students who committed suicide may bring a legal claim that the institution failed to notify them about indications that the student was at risk. Many legal and practical complexities arise in the discussion of sharing information about student mental health and suicide threats. We offer some short scenarios to illustrate common situations.

Please do not construe these comments as legal advice. Consult your own counsel about the development of your notification procedures and about how to proceed in any situations you may face.

A 16-year-old student makes a suicide threat in the hallway at an educational institution that an instructor overhears. Should the school notify the parents?
Prompt disclosure to the minor’s parents is both legal and prudent. If, however, a rare situation arises in which the responsible administrator feels that parental notification is not in the student’s best interests, he or she should consult immediately with counsel. Notification to child welfare authorities may be a legally appropriate alternative.
An 18-year-old student writes an essay on an admissions application that suggests she has made a past suicide attempt. May the admissions director share the essay with the counseling center director?

Yes. FERPA does not prohibit the disclosure of information within the institution to individuals with a legitimate educational interest in the information.

A professor consults with a psychiatrist at the university counseling service about a graduate student who seems very depressed. May the counselor contact the student’s spouse?

The psychiatrist has no therapeutic relationship with the student, so the information is not legally protected by a privilege. Contacting the student, though, may be clinically preferable to contacting the spouse.

A 19-year-old student tells a college psychologist that she wants to kill herself tonight. May the psychologist notify the parents?

Yes. This appears to be an emergency situation. Legal rules and professional ethical standards contain exceptions for emergencies. Voluntary or involuntary hospitalization may be necessary.

**Other Pointers on Notification**

- Limit disclosure to those with a “need to know.” Wider dissemination may infringe the student’s privacy.

- In developing your counseling center notification policies and releases, think through the appropriateness of external notification in mental health emergencies. Share accurate information about your policies with prospective students, families, and clients. Then ensure that your notification practices are consistent with your policies and releases.
• Be aware that, in court, your policies on emergency mental health notification may be compared against your policies on parental notification of drug and alcohol disciplinary matters. Be prepared in advance to explain any differences.

• You may wish to create an option to notify parents that does rise to the level of a duty to notify. Your lawyer can help with the drafting to capture the difference.

• Do not consider FERPA as an obstacle to sharing information about student suicide. Even if you have not obtained a blanket consent to parental disclosure from college-age students, which are popular with small private colleges, the statute contains exceptions for emergencies, including emergencies involving student health and safety. An institution can reasonably apply this to threats of self-inflicted injuries. Disclosure may be made to individuals in a position to assist, including families. Since there is no longer a private right of action for FERPA violations, enforcement rests in the hands of the Department of Education. The Department would be disinclined to sanction an institution for a reasonable disclosure about a suicide threat or attempt.

• Anticipate the possibility that the parents of an international student may have limited English skills. Arrange for an interpreter, if necessary, to assist with notification.23

• State law may not grant counselors, in contrast to psychologists or physicians, a legally privileged relationship with their clients. Do not assume that counselors operate under an equivalent legal privilege without first checking your state law.

Here are two sample policies on notification:

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23 To locate an interpreter consult with your foreign language departments or international student services office, or engage a commercial entity such as Language Line Services, www.languageline.com.
If it develops in the course of treatment that the student is likely to cause injury to him/herself or others, pertinent information may be released for the protection of others or the student.

One community medical facility offers this disclosure under the HIPAA privacy requirements:

*Others Involved in Your Health Care. Unless you object, we may disclose to a member of your family, a relative, a close friend, or any other person you identify, your personal health information that directly relates to that person’s involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose personal health information to notify or assist in notifying a family member, personal representative, or any other person who is responsible for your care of your location, general condition, or death.*

Do not, however, copy these examples verbatim. In consultation with counsel, develop an approach that fits your own needs.

- Try to get more than one professional involved in decisions about notification. If, for example, a therapist believes that family notification about a suicide threat or attempt could be clinically harmful to the student, the therapist would do well to discuss the situation with the counseling center director or other responsible individual. Joint decisionmaking, and good documentation, help justify decisions should they later be challenged.

- Clinicians should maintain their client files with the possibility of bad outcomes in mind. If a client commits suicide, the files may be disclosed in litigation. Be mindful, for example, of the importance of documenting the resolution of open clinical issues.

- Sometimes institutions find themselves caught amid competing policy and legal requirements. After consultation with counsel, the responsible administrator may
need to “pick you lawsuit.” Would you, for example, prefer to be sued for a
violating a student’s privacy or for negligence in failing to notify the parents of a
student who committed suicide about an earlier suicide attempt?
Safeguarding Your Students Against Suicide:
A Checklist for Your Institution

The following checklist emerged from an expert panel convened by The Jed Foundation and the National Mental Health Association in 2001. It is geared to the college and university level. Not all elements may apply to your institution, and the checklist does not purport to reflect legal requirements. Nonetheless it may be a helpful resource for schools and colleges evaluating their mental health policies, programs, and practices.

<table>
<thead>
<tr>
<th>Administrative Practices</th>
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<tbody>
<tr>
<td>Yes</td>
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<tr>
<td>- Do we have a mental health management plan in writing?</td>
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<td>- Have we allocated enough financial resources to accommodate the plan and all of its components?</td>
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<tr>
<td>- Do we have a medical leave policy in place that includes mental health problems?</td>
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<th>Risk-Identification Programs</th>
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<tr>
<td>- Do we have a screening program in place?</td>
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<td>- Do we have a transitional support program in place for parents and families of incoming students who have already been diagnosed with mental health disorders?</td>
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<tr>
<td>- Have we trained our faculty, coaches, clergy, and student/resident advisors to identify students who may be at risk for suicide and/or suicidal behaviors?</td>
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<tr>
<td>- Have we educated our students so that they are able to identify at-risk behaviors within themselves and among their peers?</td>
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<th>On-Campus Support Services</th>
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<tr>
<td>- Do we have an on-site mental health services center?</td>
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<td>- Have we hired providers who are appropriately trained to handle suicidal clients? If not, are we willing to train them?</td>
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<tr>
<td>- Do we have an on-site medical center with personnel who can prescribe the appropriate psychotropic agents?</td>
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<tr>
<td>- Do we have a 24-hour emergency service that is accessible to students?</td>
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</table>
- Do we have a crisis-management plan in place in the event of a suicide or other trauma on campus?
- Do we provide students with support programs (social, academic, etc.)?
- Have we made our students and faculty aware of exactly what services are offered on campus and in the community?
- Have we publicized the names and numbers of on-campus and off-site support providers?

**Community-Based Support Services**

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<td></td>
<td>Do we have working relationships with community mental health providers to ensure appropriate off-site referrals? Do we know their appointment hours and fees? Have we arranged for a sliding scale? Do they accept insurance?</td>
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<tr>
<td></td>
<td>Have we identified which hospital/center in the community is on call to handle any campus emergencies?</td>
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<tr>
<td></td>
<td>Does our university Web site offer links to mental health information and services?</td>
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Resources

Suicide Prevention Programs
*Screening for Mental Health*
One Washington Street
Suite 304
Wellesley Hills, MA 02481
781-239-0071
www.mentalhealthscreening.org

This nonprofit organization developed the concept of screening programs more than a decade ago. Programs tailored to specific groups are designed as proactive early intervention tools. Suicide and depression screening for college-age and high school students are available. Formats include videos, online screening, and materials to use with in-person screenings.

*The Jed Foundation*
583 Broadway, Suite 8B
New York, NY 10012
212-343-0016
www.jedfoundation.org

Two parents who lost a university-age son to suicide started this nonprofit foundation. Its mission is to prevent suicide among college and university students and also to improve the mental health support available on campuses across the country. Its offerings include the online screening program ULifeLine and the report “Safeguarding Your Students Against Suicide.” For more information on the screening tool, visit www.ulifeline.org.

State-level suicide prevention programs, often directed to adolescents, exist in jurisdictions including
*Washington State*, www.yspp.org,
*Idaho*, www.boisestate.edu/suicideprevention/

Organizations
*American Association of Suicidology*
4201 Connecticut Avenue, NW, Suite 408
Washington DC, 20008
202-237-2280
www.suicidology.org.

Resources including a leading journal, newsletters, and a comprehensive bookstore. Of particular interest are:


Center for Mental Health in Schools
Department of Psychology
University of California at Los Angeles
P.O. Box 951563
Los Angeles, CA 90095-1563
310-825-3634
smhp.psych.ucla.edu/describ.htm

Focused on primary and secondary schools, the Center’s web page includes extensive resources on suicide. Materials include slides and a script for teacher in-service training, self-tutorials, technical assistance materials, and other articles and web links.
smhp.psych.ucla.edu/qf/p3002_02.htm

ERIC Clearinghouse on Counseling and Student Services
School of Education
201 Ferguson Building
PO Box 26171
University of North Carolina at Greensboro
Greensboro, North Carolina 27402-6171
800-414-9769
ericcass.uncg.edu

The clearinghouse, supported by the U.S. Department of Education, has a useful virtual library of resources on depression and suicide. Materials include “Preventing Suicide: A Resource for Teachers and Other School Staff,” from the World Health Organization.
Visit ericcass.uncg.edu/virtuallib/depress/prevent.html

International Association of Counseling Services
101 South Whiting Street, Suite 211
Alexandria VA 22304.
703-823-9840
iacsinc.org

Resources include:

• “National Survey of Counseling Center Directors,” by Robert Gallagher and Bo Zhang, International Association of Counseling Services, Inc. 2002. $10 prepaid.

Offers a pamphlet on teen depression and suicide ($17) and fact sheets on youth suicide which can be downloaded at www.nmha.org/suicide/youngPeople.cfm

**Government Resources**

*National Institute of Mental Health*

Booklets, fact sheets, and summaries for the public on suicide and suicide prevention, as well as resources for clinicians and researchers.

www.nimh.nih.gov/publicat/depsuicidemenu.cfm

*Centers for Disease Control*

CDC offers many fact sheets and statistical summaries on youth suicide. Visit www.cdc.gov to browse. Of special interest are:


- National Youth Violence Prevention Resource Center, co-sponsored by CDC, includes a good overview on youth suicide. www.safeyouth.org/home.htm

**Books**


**Articles and Reports**


“Catch Them Before They Fall: How to Implement Mental Health Screening Programs for Youth,” Carmel Hill Center, Columbia University, at www.TeenScreen.org.


“Safeguarding Your Students Against Suicide,” report of an expert panel co-sponsored by the National Association for Mental Health and The Jed Foundation (2002).


**Campus Materials**

Here are some examples of the many useful materials available on the web sites of educational institutions.

*California State University, Northridge.* Suicide: It Doesn’t Have to Happen, brochure., www.csun.edu/counseling/suicide.html
Cal Poly Pomona. Helping the Emotionally Distressed Student: A Guide for Faculty and Staff. 21 pages. www.csupomona.edu/~caps/helping.PDF


University of Illinois at Urbana-Champaign. Suicide Prevention, brochure. www.couns.uiuc.edu/Brochures/suiprev.htm. The brochure is also posted at Texas Women’s University, Southwest Texas State University, and the University of New Hampshire, among others.

University of Michigan. Depression Resource Guide. 52 pp. www.dialogues.umich.edu


University of South Carolina. Administrative policy on student suicide attempts, threats, or gestures. www.sc.edu/policies/staf/staf107.html