

Mental Health Issues on College Campuses

By Lydia Hoffman Meunier and Carolyn Reinach Wolf

Introduction

Several recent and much-publicized campus suicides have drawn attention to the issue of increasing numbers of students on campus with a diagnosed mental illness and highlight the challenges this issue poses to educational institutions. A less visible, but equally troubling challenge, is the increase in the number of students on campus experiencing all forms of psychiatric disorders. In a recent survey, over 90% of the directors of college counseling centers stated that the problems presented by students with significant psychological disorders are a growing concern on campus.¹ Claims data also indicates that in recent years demand for mental health services on campus has increased steadily and, in some cases, dramatically.²

This article examines the impact of the increased incidence of mental illness on campus, the inherent legal issues in managing mental illness in the campus setting, and discusses a much-anticipated decision in a Massachusetts case, *Shin v. Massachusetts Institute of Technology*. In the *Shin* case, the parents of a student who committed suicide in her dorm room sued the Massachusetts Institute of Technology. The school's motion for summary judgment was granted on several claims, but denied with respect to the claims of negligence against the counseling center's medical staff and school administrators. The *Shin* case illustrates that post-secondary institutions must now recognize, evaluate, and appropriately respond to the increasing numbers of students experiencing psychiatric problems on their campuses in a way that protects students as well as the institution.³

The Problem

Most students enter college at a developmentally pivotal time. Students are likely to be dropped at their freshman dorm by parents whom they have lived with their entire lives. Adjusting to the relative freedom and autonomy of campus life, increased academic demands, and an entirely new social milieu will be managed differently by every student. Traditionally, counseling centers have dealt with roommate disputes, relationship issues, substance abuse, academic anxieties and identity issues. More recently, campus counselors report that in addition to typical adjustment problems, counselors are increasingly seeing clients with severe psychological problems, and of those many have significant psycho-

logical disorders.⁴ While mostly anecdotal, it appears that a perfect storm of factors are contributing to placing a greater number of vulnerable people on campus.⁵

Psychiatric diagnosis and treatment have progressed rapidly in recent years. Many conditions such as mood disorders, anxiety disorders and eating disorders were barely recognized a generation ago. With recognition came treatment, especially medication, that can dramatically diminish symptoms and permit those affected to function far closer to their potential than in years past. As a result, students who would otherwise have been precluded by their mental illnesses from completing high school are able to do so successfully, and to enroll in colleges and universities.

A positive societal adjustment is also at play as the stigma of mental illness is decreasing. Awareness of the prevalence, variety, and ability to treat mental illness has increased, and the acceptance of those in our midst who are affected with mental illness has likewise increased. It is not unusual for children to be medicated at an early age for conditions such as attention deficit disorder and hyperactivity disorder. The prospect of individuals with psychiatric disorders living and working among us is no longer a frightening anomaly.

Many psychiatric conditions develop or are discovered in early adulthood. Conditions such as depression and bipolar disorder often develop at this time. Anxiety disorders, including panic disorder and obsessive compulsive disorder, may be triggered by stressors, including those typical of campus life. Eating disorders, such as anorexia nervosa and bulimia nervosa, are most likely to develop during these years. Substance abuse may also become apparent in the campus environment. More severe psychiatric disorders, including schizophrenia and other conditions associated with psychosis often develop in late adolescence.

Students may be slow to recognize the symptoms of many of these disorders. Most symptoms, such as insomnia or increased sleep patterns, weight gain or loss, restlessness, fatigue, mood swings, increased anxiety, worry and tension, inconsistent eating habits, and the use of drugs and alcohol are probably an aspect of most students' experiences at college. Often, considerable time passes before the student recognizes these symptoms constitute a problem. Once a student has come to recognize he or she needs help and seeks assis-

tance, it may be some time before a condition is stabilized. However, students who do seek help for a psychiatric disorder that develops while at college stand a very good chance of being effectively treated, and are often able to resume or maintain their presence at school.

The increased demands on college counseling centers is attributable in large part to these essential changes in the treatment and perception of mental illness. It is essential that schools recognize the issues attendant to a student population that includes those with psychiatric disorders, and develop strategies to manage mental health issues in a way that protects both the institution and the students.⁶

The Parties

College campuses are typically micro-societies consisting of students, administration, and staff functioning as a self-contained unit within a larger community. In this context, the impact of even a single student experiencing symptoms of a psychiatric disorder is likely to affect most components of the campus community.

Counselors and Counseling Centers

The range of mental health services available on campus can vary widely, but on all campuses, college counseling centers are on the front line in evaluating and responding to the increasing incidence of mental illness on campus. A core mission of college counselors has been identified as “improving retention and graduation rates” through their work.⁷ At a minimum, counseling centers must address the needs of students who come to the center seeking assistance by assessing the severity of the student’s condition and providing medically appropriate treatment. In light of the *Shin* decision, this basic activity must be re-evaluated by the counseling center and the administration. Counseling centers must now be cognizant of the duty to assure the safety of these students and even others on campus under some circumstances.

Most campus counseling centers are also actively involved in education and outreach efforts to identify at-risk students and encourage them to seek treatment. As the number of students arriving on campus with a history of a psychiatric disorder increases, the counseling center may assume an oversight role in managing these students’ illnesses and medications. As a component of the institution, campus counseling centers are also uniquely challenged to dodge potential conflicts of interest and confidentiality breaches. Campus counseling centers also may find challenges in continuity of

care, as students leave campus and possibly experience stressful situations without the benefit of ongoing counseling.

Students

An inevitable feature of the prospective freshman’s campus tour is a recitation of the resources available to meet student needs and security measures to assure student safety. Students do not typically arrive on campus concerned about their personal safety or believing that the school will fail to meet the student’s health needs.

Students who are diagnosed with a psychiatric disorder or who have experienced symptoms of mental illness before attending college or university may or may not disclose this fact to the schools. Most schools do not directly ask students to disclose information pertaining to mental health history, but may ask about prescribed medication or general ongoing health concerns. Students may not feel comfortable disclosing this information before they even arrive on campus, as they are uncertain about with whom it will be shared and whether it will affect them socially or academically.

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At most campuses students attend classes together, eat together, socialize together and live in close proximity to one another. It may be readily apparent to other students when a student is experiencing psychological problems. It is not unusual for students to assume a duty in caring for their peers who are experiencing symptoms of mental illness, particularly when the affected student is reluctant to seek counseling services. Students who share living space will inevitably be affected by the condition of their peers, and may find themselves in the demanding role of monitoring and counseling a peer. Schools may place a burden on students in a supervisory role, such as Resident Assistants, to refer students to counseling and report instances of concern, and outreach programs typically encourage students to be involved in getting others to treatment.

Parents

Most students entering college are, or soon will be, eighteen and are therefore adults for most purposes. But there is a distinct and growing expectation that parents will play a continuing role in their offsprings' lives. The phenomena of parents hovering over their adult offspring has been identified as "helicopter parenting." This emerging trend is attributable to many factors, including smaller families, the increased cost and competition of education giving rise to a sense of entitlement, increased communication modes, such as instant messaging and cell phones, that allow parents to closely track activities, and intimate parental involvement in their children's academic, sports and leisure activities throughout childhood.⁸ Helicopter parents expect to be well-informed by their children and by their children's schools. These parents expect their children's needs, as expressed by their children, to be promptly addressed and are not shy about intervening, with or without their children's knowledge. Colleges note that today's parents are not hesitant to make demands on college administration and services and expect institutions to be responsive to their concerns.

Administration

An incident involving a mentally ill student, particularly a student suicide, is devastating to the administrators and staff involved and impacts the entire campus community. The public reaction to such an event can be similarly difficult. Less dramatic, but more common and nonetheless disruptive, a student struggling with a psychiatric disorder may impact a roommate, a dormitory, a classroom or the entire campus. A student's mental illness may potentially affect the academic performance of the ill student (and those around him or her), and ultimately could affect admission, retention, and graduation rates. Campus resources must be stretched to meet these existing needs. Finally, there are many potential legal liabilities for colleges and universities related to their treatment of the mentally ill student.

The administration's approach to this issue must balance protecting the individual student with the integrity of the institution. From a public relations standpoint, prospective students may be seeking evidence that the school provides extensive counseling services. An institution's ability to address student mental health needs is even becoming a factor in college application decisions.⁹ Conversely, students may perceive incidents such as campus suicide as evidence that a college is unable to meet student needs.

Potential Pitfalls

Confidentiality and Disclosure

Campus counseling centers are uniquely challenged to meet their obligation to maintain patient confidentiality set out in professional ethical standards as well as in law and regulations.¹⁰ Counseling centers report that parents, administration, and other departments of a college or university often feel entitled to confidential information. The college community setting also presents special challenges in preventing disclosure. In contrast, recent cases have indicated that schools *should* disclose under some circumstances, and could face liability if they fail to do so. Institutions should be prepared and willing to consult legal counsel with specialized expertise in mental health, psychology, risk management, or privacy law, either alone or as co-counsel to university counsel to review present policies and address specific disclosure questions. Advice and counsel regarding these and related matters should be available and accessible to ensure preventive measures are in place and to respond appropriately in a crisis.

Applicable Regulations

The treatment relationship has long been subject to confidentiality rules. In general, providers, including psychiatrists, psychologists, and social workers, are prohibited from disclosing treatment information for adult patients. Under state licensing laws, such disclosure would constitute professional misconduct. Federal regulations also prohibit disclosure of health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Family Educational Rights and Privacy Act (FERPA). HIPAA does not apply to education records covered by FERPA.¹¹ FERPA establishes a series of privacy protections and access requirements related to educational records. FERPA defines "educational records" as "those records, files, documents, and other materials" that (1) contain information directly related to a student; and (2) are maintained by an educational agency or institution or by a person acting for such agency or institution. Records maintained by campus counseling centers are generally subject to FERPA. It is conceivable that records created and maintained by a campus-based clinic that is not funded or run by the university would not be subject to FERPA, but this material would then be subject to HIPAA. In any event, the records remain subject to state privacy rules. While there is no private right of action for violation of either HIPAA or FERPA, there are substantial civil penalties for a violation of these rules, including termination of all government funding of a college or university.

Potential Disclosures

Counseling centers report that it is not uncommon for a student's parents to expect notification of any conditions affecting their children. Parents may be dismayed to learn that if their child is eighteen, federal and state law generally provide that their child's written consent is required for disclosure of education and health information. Students who are struggling at school may be very reluctant to authorize disclosure to parents. Schools must determine whether and when it is appropriate to break confidentiality rules and communicate a student's condition to family. It has been our experience in counseling a variety of health care facilities on this issue, that the facts may dictate a "pick your liability" dilemma, and the advice of counsel is essential in weighing the choices.

The close proximity of students and the frequent contact with staff inevitably result in a community of shared knowledge. Students and staff may contact the counseling center with their concerns about a particular individual, and may feel responsible for assuring that the troubled student is receiving treatment. The small size and limited resources of many campus counseling centers may also result in unintentional disclosures. Counseling centers have described situations where confidentiality is compromised by student employment at the centers, students encountering one another when seeking treatment, and one counselor even described a practice of conducting admission tours through the counseling center.¹²

Intra-facility Disclosures

In addition to the professional and legal conflict of interest rules applicable to all counseling professionals, the accreditation standards promulgated by the International Association of Counseling Services note that,

it is critically important that the service be administratively neutral. If it is perceived as being linked with units that are involved in making admissions, disciplinary, curricular, or other administrative decisions it can severely restrict the utilization of the service. Such perceptions may prevent students from seeking services for fear that information they disclose may negatively affect their college careers.

It is not uncommon for the administration to believe that, as an entity within an institution, the counseling center is subject to the greater interests of the institution. Typically, the Dean of Students, or similar

administrative office, is charged with overseeing all issues related to students' well-being on campus. While it is natural and desirable for this office to work closely with counseling professionals, these interests may nonetheless diverge.

The administration or other departments on campus may feel entitled to confidential student information as a matter of course. Examples raised by counseling staff include requests for information for use in housing determinations, to be provided to resident advisors; for inclusion in records for special programs, such as study abroad or internships or as needed to prepare recommendations for programs, such as the Peace Corps or federal agencies; for use in preparing statistical information; and for use in readmission decisions. Counseling centers have also been requested to provide student health information in special situations. For example, counseling centers have been asked to provide information in the defense of a lawsuit brought by a former counseling client against the university in which the counseling center is not a party. Similarly, information was requested for use in investigating a sexual harassment claim by a student counseling client against a staff member. Some counselors report that deans have demanded to be provided with information on all clients who have expressed any suicidal ideation and some request forensic information on clients.

The administration may ask the counseling centers to evaluate whether a student should continue or be readmitted to school following an incident of concern to the administration. This is particularly troubling if a student had been in treatment with the evaluating counselor. A variation of this request is an administrative request for an evaluation of a student client's readiness for a particular academic program. Depending on a particular institution's policy toward students with mental illness, the counseling center may be asked to evaluate a student upon admission, if a history of mental illness is disclosed, in order to determine the reasonable accommodations the facility must or is able to provide to the student, should he or she be admitted.

In addition to penalties for violating state and federal privacy rules, the institution and/or counseling center staff could face liability and monetary penalties for damages resulting from such disclosures. If an institution violates confidentiality by improperly providing information to a potential employer or graduate school, and it can be shown this resulted in the student not obtaining employment or admission, the disclosing institution will certainly be vulnerable. Counseling staff have reported administration requests for client information for use in a client's application for admission to

the bar (the state was not specified). An illegal disclosure in this circumstance would certainly create potential liability.

While it is difficult to imagine a student prevailing against a university for damages the student incurred as a result of a disclosure that prevented the student's suicide, it is not so difficult to imagine in some of the other disclosures discussed above. Campus counseling centers and the administration must be aware of when intra-facility disclosures are necessary and permitted, or even required, and when a disclosure would violate confidentiality rules.

Americans with Disabilities Act and the Rehabilitation Act

Students with mental illness are afforded protection under both the Americans with Disabilities Act and the Rehabilitation Act of 1973. Under these laws, "reasonable accommodation" must be made for those with disabilities and an individual may not be denied participation by reason of his or her disability. Most psychiatric disorders are a disability under both laws.

Section 504 of the Rehabilitation Act of 1973 (the "Rehab Act") and implementing regulations require that all post-secondary institutions receiving federal funding (virtually all colleges and universities) must make their programs accessible to students with psychiatric disabilities who are "otherwise qualified."¹³ This rule is applicable to the admissions process, as institutions are prohibited from having eligibility requirements that screen out those with disabilities and applicants may not be asked if they have a disability, including a history of mental illness. The Rehab Act is applicable to the enrolled student, as the institution is required to make reasonable accommodation for the individual's disability, including psychiatric disabilities. Any criteria that are imposed by an institution must be based on actual risk and not on stereotypes or assumptions. The prohibition on excluding an individual from, or denying participation in, a post-secondary program by reason of his disability will also be implicated in an institution's decision to dismiss a mentally ill student.

The Americans with Disabilities Act (ADA) was enacted in 1990, several years after the Rehab Act. The ADA extended the protections of the Rehab Act to a much wider realm, and created other protections for those with disabilities. The ADA imposed administrative requirements, but had little practical effect on colleges and universities, as most institutions were required to implement the provisions of the Rehab Act

years before. Institutions that are not subject to the Rehab Act are almost certainly subject to the ADA.

A disabled person who requests and does not receive accommodation under either the Rehab Act or ADA may make a complaint to the Office of Civil Rights of the U. S. Department of Education. Both the Rehab Act and the ADA provide a private right of action. A complainant may seek injunctive relief and may even win monetary damages if the discrimination is determined to be intentional.

In Loco Parentis

The doctrine of *in loco parentis*, wherein an institution stands in the place of parents, has been much discussed in the context of an institution's responsibility and liability for student safety. The doctrine has come to be applied to the concept of colleges' and universities' responsibility for the safety of a student's character and morals, as well as the student's physical well-being.¹⁴ Although traditionally *in loco parentis* was applied as "a shield for colleges, not a sword for students" allowing institutions to impose authority on students,¹⁵ New York courts have cited this doctrine (or more accurately the abandonment of this doctrine) in discussing the absence of a duty running from the institution to their students. Under this reading of *in loco parentis* by New York courts, universities and colleges have enjoyed a general aura of protection from negligence claims. Other theories negating institutional liability include charitable immunity, governmental immunity, proximate cause rules (cases have held that injuries were not proximately caused by universities, but by intervening, superceding events, such as an attacker or the illegal use of liquor), and contributory negligence theories.

Nationally, a trend away from a general protection from liability has been identified and attributed to the erosion of immunities in tort law, the demise of contributory negligence, increased awareness and disapproval of excessive use of alcohol, and the swinging of the societal pendulum back toward parental involvement and oversight in the lives of their children, even children over the age of eighteen.¹⁶ FERPA is a signpost on this road. Passed in 1974 in the wake of student activism and the lowering of the voting age in 1972 as part of a movement to treat those over eighteen as autonomous adults, FERPA effectively codified the privacy rights of students over eighteen. However, in response to the increase in the drinking age from eighteen to twenty-one, FERPA was amended in 1998 to permit colleges to overrule students' wishes and inform parents of students under age twenty-one when a drug

or alcohol law is broken. Recently, courts in several jurisdictions have been holding that, under certain circumstances, there *can* be a duty running from an educational institution to students, and institutions should no longer rely on the absence of *in loco parentis* responsibilities to insulate them from liability when students are injured on campus. The shift toward campus responsibility has occurred incrementally, with cases looking closely at the facts leading to injury, and particularly the foreseeability of an incident.

Recent cases have held that educational institutions had a duty to students in cases involving injuries resulting from an assault in a campus dorm,¹⁷ fraternity hazing incidents,¹⁸ alcohol excesses,¹⁹ injuries to athletes,²⁰ and injuries related to a student's mental illness.²¹ In each instance, the court held that the institution was, or should have been, aware of the likelihood of injury because of the pattern of behaviors or events leading up to the injury.

Although New York cases have generally not found a duty running from the institution to individual students, these cases have uniformly noted that in those cases the institution had no notice of the conditions that led to a student's harm.²² In a factually appropriate case, it is quite possible that a New York institution could be held liable for injury inflicted by a student on him or herself or another. For example, a fact pattern in which a mentally ill student harms him or herself or another student on campus is very likely to involve the kind of behavior and contacts with administration and staff that would make such an injury foreseeable in the eyes of a court. This was precisely the case in *Shin v. Massachusetts Institute of Technology*. In this 2005 opinion, the plaintiff withstood a motion for summary judgment on a claim for wrongful death of a student who committed suicide in her dorm room following a substantial and well-documented deterioration of her mental condition. The case has significant implications for the way colleges and universities handle students suffering from a mental illness.

The Shin Case

Elizabeth Shin entered MIT in 1998.²³ The following February she was taken by ambulance to Massachusetts General Hospital when her boyfriend found Elizabeth was acting disoriented following an alleged overdose of Tylenol with codeine. According to her parents, Elizabeth denied this was a suicide attempt, and Elizabeth claimed that she took what she thought would be a sufficient dose of the prescribed medication to afford her a good night's sleep following a diagnosis of mononucleosis. During her week-long hospitalization, MIT court

papers claimed that Elizabeth revealed that she had mental health problems while in high school (her parents claim not to have known this). Elizabeth's housemaster contacted Elizabeth's parents who met with Elizabeth's treating physicians and social workers.

Before her discharge, Elizabeth's father met with Dr. Kristine Girard, one of the full-time psychiatrists at the Mental Health Services department (counseling center) at MIT, and it was agreed that, upon discharge, Elizabeth would resume classes at MIT and she would see Dr. Girard every 2-3 weeks. Dr. Girard met with Elizabeth three times between February and May. She diagnosed Elizabeth with "adjustment disorder" and later noted she was suffering from "situational issues." At the end of the term, Dr. Girard recommended more therapy upon her return to campus for her sophomore year.

Elizabeth spent an uneventful summer with her parents at home in New Jersey. She returned for the fall term at MIT and did not visit the counseling center until early October, following a break-up with her boyfriend. During this time, Elizabeth was engaged in cutting behavior, something she had done in high school. The psychiatrist who met with Elizabeth at the counseling center noted general symptoms of mood disorder, such as reduced sleep and erratic eating habits, but felt she was in no immediate danger. Elizabeth returned to the counseling center about a week later, and met again with Dr. Girard. She claimed she was feeling "significantly better," but the doctor noted an "underlying sadness."

In November, Elizabeth's friends, concerned about her cutting activity, urged her to meet with Dean Arnold Henderson, and she did so, showing the Dean the scratches on her arm, at the Dean's request. The Dean made an appointment at the counseling center, but it is unclear whether this meeting occurred. In December, Dean Henderson received an e-mail from Elizabeth that was forwarded by one of Elizabeth's professors indicating that Elizabeth said she had bought a bottle of sleeping pills with the intention of using them to overdose, but she had changed her mind. The Dean contacted Elizabeth, but she appeared to be doing well. The Dean reported the incident to Dr. Girard.

It was not until several months later that Elizabeth's behavior again began to worry those around her. Just before spring break, early in the morning on March 18, 2000, following another break-up with a boyfriend, a student notified the housemaster that Elizabeth was extremely upset and was cutting herself. She was taken immediately to the MIT campus infirmary, where the physician who examined Elizabeth contacted the on-call

psychiatrist. The psychiatrist admitted Elizabeth to the infirmary, as it was determined it would not be safe to return Elizabeth to her dorm.

The following day, Elizabeth was discharged back to her dorm, where students reported she remained distraught. Shortly thereafter, her parents arrived to bring her home for spring break. Elizabeth's parents were informed that she had been admitted to the infirmary, but they contend they were not told why she had been admitted, and Elizabeth refused to discuss it. Her parents stated that she appeared to be fine while she was home for break, and they saw no reason to keep her home. Upon her return to school however, her housemaster received numerous reports from students and graduate resident tutors in her dorm that her condition was deteriorating. Friends were staying up with her at night to assure her safety.

On March 23, Elizabeth was seen by a new psychiatrist at the center, Dr. Linda Cunningham, who noted she was experiencing a "severe" depressive episode, and prescribed anti-depressant medication. On subsequent visits through the end of March, Dr. Cunningham noted that Elizabeth might require hospitalization. During the first week in April, Elizabeth contacted Dean Henderson's office about rescheduling exams and the Dean agreed, remaining in contact with her housemaster about her condition. Elizabeth also had several therapy sessions with Dr. Cunningham at the MIT Mental Health Department, and arrangements were made for Elizabeth to be evaluated for therapy at a clinic off campus. On April 5 and 6, two of Elizabeth's Spanish instructors expressed concern about cuts on Elizabeth's arms. After one instructor placed four calls to Dean Henderson, she was informed there was no need to be concerned because action was being taken to assure Elizabeth's safety.

On the evening of April 8, 2000, Elizabeth informed another student in her dorm that she intended to kill herself with a knife. The student called campus security, and Elizabeth was taken to the Mental Health Center. The staff physician contacted the on-call psychiatrist, Dr. Anthony Van Niel, who spoke with Elizabeth briefly on the phone, and determined that Elizabeth was not acutely suicidal. Elizabeth was returned to her dorm with no restrictions or follow-up planned.

On April 9, 2000, Elizabeth's parents visited her for the afternoon. They noted that Elizabeth looked a bit tired and harried, but nothing about her appearance or behavior led them to be concerned. She discussed plans for the week ahead and plans for the future. No one at MIT disclosed to Elizabeth's parents her frequent visits

to the counseling center or their concerns about her recent behavior.

About 12:30 a.m. on April 10, 2000, two students notified the housemaster that Elizabeth requested that a student erase her computer files, as she planned to kill herself that day. The housemaster called the Mental Health Center and her call was returned by Dr. Van Niel. Dr. Van Niel told the housemaster to check on Elizabeth, but that it was not necessary to bring her to the Center as Elizabeth had assured Dr. Van Niel that she was fine and Elizabeth's friends had overreacted two days before. The housemaster checked on Elizabeth at 6:30 a.m., and decided not to wake her, as all was quiet. The housemaster conveyed these events to Dean Henderson, as a "deans and psychs" meeting was scheduled later that morning. A little later, around 9:45 a.m., Elizabeth called the housemaster and accused her of wanting to send her home, and stated words to the effect that the housemaster would not have to worry about her anymore. The housemaster again called Dean Henderson, and he assured the housemaster that the conversation would be mentioned at the meeting.

Elizabeth's case was discussed at the "deans and psychs" meeting held at 11:00 a.m. on April 10, 2000. An appointment was made for Elizabeth at an off-campus facility, and a message was left with Elizabeth notifying her of the appointment.

Shortly before 9:00 p.m. that same day, the smoke alarm in Elizabeth's room went off. Campus police and the Cambridge Fire Department found Elizabeth engulfed in flames. She was transported to Massachusetts General Hospital, with third degree burns over 65% of her body. Four days later, her parents were told that she had suffered irreversible neurological brain damage and life support was terminated.

Two years later, in 2002, Elizabeth Shin's parents filed a lawsuit against MIT, as well as the clinicians at the MIT Mental Health Center, two Deans, and the housemaster, claiming breach of contract, gross negligence, negligent infliction of emotional distress, and a violation of the Massachusetts' consumer protection statute. The plaintiffs contended that defendants failed to inform them of their daughter's condition and the opportunity to oversee her care, and that the defendants failed to provide adequate coordinated care for her. The defendants moved for summary judgment dismissing the claims. The Court granted summary judgment on the breach of contract, consumer protection and negligent infliction of emotional distress claims, but denied summary judgment on the claim of gross negligence against the dean, the housemaster, and the psy-

chiatrists. The defendants claimed that there was no duty running from the defendants to Elizabeth Shin. However, the Court held that the number and nature of contacts between defendant physicians, administrators and housemaster was sufficient to establish that defendants “could reasonably foresee that Elizabeth would hurt herself without proper supervision. Accordingly, there was a ‘special relationship’ between the MIT Administrators, Dean Henderson, [the housemaster], and Elizabeth imposing a duty [on the defendants] to exercise reasonable care to protect Elizabeth from harm.”

The *Shin* court cited *Schieszler v. Ferrum College*, in which the court also found a special relationship running from the institution to the student which was sufficient to meet the burden on summary judgment of the existence of a special relationship between the college and the student, giving rise to a duty of care. The Court denied defendant’s summary judgment motion, holding that the student’s several contacts with the campus police, the dean and the dormitory resident assistant indicating the student’s intent to take his life, could lead a trier of fact to conclude that there was “an imminent probability” that the student would try to hurt himself, and the defendants had notice of this specific harm. The defendant’s failure to contact the student’s guardian with information about threats to harm himself supported the plaintiff’s allegation that the college breached a duty of care to the student. This case was eventually settled.

The factual basis for the holding in these cases should give institutions of higher learning pause. It is clear that courts will look specifically at how a student’s needs are handled by a particular administration and counseling center, and lofty concepts, such as *in loco parentis*, will not protect an institution where the facts indicate the institution knew of a threat and did not act to prevent harm. The summary judgment rulings in *Shin* and *Schieszler* did not address the difficult issue of whether defendants were actually responsible for preventing the troubled students’ suicides as the Court did not reach the question of causation on summary judgment. However, the holding that the schools had a duty to the students is significant. Both *Shin* and *Schieszler* plaintiffs alleged that the schools’ failure to notify the students’ parent/guardian was a factor in causing each student’s death. Both Courts agreed, holding that there was an obligation to notify the students’ parents and guardian of an imminent potential threat of which the school is aware and which the parent or guardian may be able to prevent. The duty to notify is in direct contravention of confidentiality requirements, and schools

must tread a careful path in the decision to disclose confidential patient information. While duty is just one element of a negligence claim, the acceptance of a duty running from the institution to a student is a substantial change in the law with significant consequences.

Responding to the Issue

Post-secondary institutions must recognize and respond to the increased number of students with psychiatric disorders on campus. The possibility of liability arising from a duty to respond to foreseeable injuries requires institutions of higher learning to examine what would constitute a breach of this duty and how to reduce this liability. Even as most institutions report stepped-up efforts to meet student mental health needs—such as increasing staff training, more counseling staff, adding counseling hours, and part-time counseling staff during peak demand periods—these efforts are not enough, as about 75% of counseling centers surveyed believed that their centers continue to require more hours based on client needs, stating that present psychiatric hours were “woefully inadequate.”²⁴ In addition, institutions have begun to intensify outreach programs, including providing information on mental health services at orientation; training for faculty, staff, and residence personnel; regular education programs, education materials sent to students and parents; and mental health screening days in an effort to identify and serve those on campus with psychiatric issues.²⁵ Despite these efforts, it appears that many institutions have not reconciled their policies with the reality of a responsibility to protect students from foreseeable harm.

In an on-line forum discussing the *Shin* case, some participants strongly expressed the feeling that institutions should bear no responsibility for the mental health of their students, that students at risk of harm should be removed from campus housing, and possibly from the institution entirely. Some noted that the case would have a chilling effect on the admission of students with certain disorders, or worse yet, would prevent students from getting the help they need.²⁶ Some institutions have taken a tack of essentially weeding out students as soon as their symptoms become manifest by imposing a choice between an involuntary medical leave or a voluntary leave of shorter duration.²⁷ Students experiencing psychiatric disorders may also engage in behavior that violates the rules of student conduct, and colleges may offer a “choice” between voluntary medical leave or disciplinary action. This course of action could constitute “intentional” discrimination under the Rehab Act and ADA and legal counsel should certainly be con-

sulted if an institution elects to remove risky students in this manner.

A far more effective and practical solution is to address the issue directly so that the institution is in a position to demonstrate that even if there is a duty to an injured student, the institution will not be in breach of that duty. The administration must demonstrate a recognition that mental health services are a critical component of caring for today's student and must assure that every member of the campus community recognizes the signs and symptoms of a mental illness and knows when and how to respond. In accomplishing this, the institution must evaluate its particular needs and implement an effective risk management program in consultation with clinicians and attorneys experienced in mental health law, college campus liability, risk management, and related areas of practice. Existing policies and procedures should be carefully reviewed by the administration and expert legal counsel. The administration and counsel should identify, compose, and implement any new procedures necessary to assure that confidentiality and accommodation rules are preserved at the same time mechanisms are in place to protect the students and campus from harm. The administration should conduct regular reviews of these procedures and actively assure that the procedures are implemented, and that the mechanism for implementing these is sufficient. The following are considerations in constructing a strategy for protecting an institution from liability:

- Clear directives and procedures must be established for assuring that any concerns raised about a student's mental health are addressed promptly and appropriately.
- The administration must recognize the counseling center's role in fulfilling the mission of the university to retain students and help the students meet their academic goals.
- The counseling center and the administration must understand the limits of the counseling center's abilities, establish clear policies to protect students whose needs exceed the resources of the campus counselors, and establish protocols for promptly meeting the students' and the community's needs in any way necessary. This must include clear policies for disclosure including contacting parents, warning those at risk, or making arrangements for hospitalization or other care, if indicated.
- The university must identify off-campus resources for addressing those in crises, including law enforcement, treatment providers, and hospitals, and must

identify the circumstances where it is appropriate or necessary to avail itself of these resources.

- The counseling center and the administration should assure there is a well-established and regular communication between the various departments of the institution, including the deans' offices, residential services, the health center, any disciplinary board or entities, and campus security, that allows all who could potentially come in contact with a student in crisis to raise concerns. A mechanism should be in place for developing an action plan to protect the affected student. These interactions between departments must be consistent with confidentiality strictures.
- There must be ongoing efforts to educate the entire campus community to recognize those struggling with psychiatric issues, the resources available to assist such individuals, and how and when to connect these individuals with the assistance they need.
- Preventive and developmental activities, including outreach, consultation, personal growth issues, and education activities, must be dynamic and ongoing. Counseling centers should be a visible presence at orientation, freshman seminars, activity fairs and campus residences.
- Counseling centers must be adequately funded. The financing of mental health services should be analyzed and issue of access balanced with funding. For example, the institutions should assure that no student will be turned away if they are unable to pay for services. A careful evaluation may reveal that counseling centers are even able to generate revenue for much needed services through co-pays.
- The counseling center's ability to appropriately manage clinical needs should be evaluated regularly and adjustments made to assure the most effective delivery of services to students. The importance of meeting student needs by providing immediately accessible appointments, phone and internet consultations, evening and drop-in appointments should be considered and addressed. Some universities are experimenting with placing counselors in residences periodically in the evenings to encourage accessibility to services. Resources may be stretched by appropriate peer counseling programs, the use of graduate interns, group therapy, and developing self-help programs, such as pamphlets, videos, books, and access to Internet resources. Caseload management should be regularly evaluated and adjustments to staffing should be made when necessary. Diversity

in counselors' background, culture and training also should reflect the composition of the student body.

- The administration must consider and adopt a policy for when and how to identify and contact students at risk while preserving confidentiality.
- The administration should provide an opportunity for parents to approach the institution's counseling center about their children's mental health concerns both as incoming students with a history of mental health treatment or with concerns that develop in the course of their college years.
- The counseling center's role in "bailing out" students, as in making arrangements for deferring assignments or exams or facilitating a change in residence, must be delineated, and the procedure for doing so clearly established.
- Whether and when disciplinary proceedings should be initiated against a student experiencing psychiatric symptoms should be determined.
- Disclosure and confidentiality rules should be reviewed and understood by everyone concerned with the counseled individuals. Policies, including student staffing at campus counseling centers, should be developed and reviewed for potential breaches of confidentiality.
- All policies addressing disclosure should identify to whom disclosure may be made under relevant circumstances.
- The administration and the counseling center should set a policy and procedure for when and how to obtain "prospective" disclosures from students authorizing the institution to contact family. The policy (and the disclosure forms) should also address the circumstances that would allow the use of these disclosures.
- There should be disclosure policies for immediate/emergency disclosures, and less immediate but nonetheless pressing disclosures. For example, students showing signs of an eating disorder that gradually becomes critical may be identified and the issue effectively addressed if disclosed well before the student reaches a crisis.
- A policy should be developed for evaluating and documenting alternatives to disclosure.
- A policy should be developed addressing circumstances when disclosure will not be appropriate and the alternatives available under these circumstances.

- Appropriate disclosure forms should be drafted, reviewed by legal counsel, and made a part of the policies and procedures.
- Counseling staff should be thoroughly educated regarding legal and ethical issues and should have access to legal counsel when necessary. Administration should consult with legal counsel whenever a question arises regarding a student's behavior on campus.

"Universities and colleges must recognize the dramatic increase of those with psychiatric disorders on campus and their exposure to liability if they fail to act."

Conclusion

Universities and colleges must recognize the dramatic increase of those with psychiatric disorders on campus and their exposure to liability if they fail to act. It is essential that colleges and universities conduct a careful evaluation of their practices and policies, ideally in consultation with legal counsel who have expertise specific to these issues, to assure the protection of these students, the campus community, and the institution itself.

Endnotes

1. *The 2004 National Survey of Counseling Center Directors* (International Association of Counseling Services, Inc.). The survey included responses from 339 directors of college counseling centers, including 34 colleges and universities in New York State.
2. Bennett Kaplan & Maura Reed, *College Student Mental Health: Plan Designs, Utilization, Trends and Costs*, STUDENT HEALTH SPECTRUM, March 2004. Although some variations among campuses are noted, virtually all campuses reported a double-digit increase in utilization of psychological services over the ten-year reporting period.
3. The *Shin* case was settled in April 2006. The significance of the case is reflected in the fact that twenty-three universities and eight national higher education associations filed amicus briefs in the case. An administrator with the University of Maryland was quoted as saying the settlement "gives us more time in higher education to examine our policies . . . without the specter of legal fear that people have today." Marcella Bomardieri, *Parents Strike Settlement with MIT in Death of Daughter*, THE BOSTON GLOBE, April 4, 2006.
4. *The 2004 National Survey of Counseling Center Directors*, *supra* note 1.
5. There appears to be no formal analysis available of the causes of the increased incidence of mental illness on campus or of the actual number of students on campus with psychological issues. There has been a flurry of discussion in the press and profes-

- sional journals and the information in this section is drawn from these sources: Suicide Prevention Resource Center, *Promoting Mental Health and Preventing Suicide in College and University Settings*, Newton, MA: Education Development Center (2004); Martha Anne Kitzrow, *The Mental Health Needs of Today's College Students: Challenges and Recommendations*, NASPA Journal, Vol. 41, No. 1 (Fall 2003); Peter Lake, Nancy Tribbensee, *The Emerging Crisis of College Student Suicide: Law and Policy*, Stetson Law Rev. Vol. XXXII (2002).
6. Kitzrow, *supra* note 4, 172–173.
 7. Stephen Caulfield, Chickering's Fifth Leadership Forum: Depression on College Campus, Student Health Spectrum, Winter 2002. Summary of two forums with participation by a total of 22 colleges and universities. Quoting this characterization by a physician affiliated with the University of Virginia of the mission of counseling centers (as well as the student health service and the university) as the consensus of the participants.
 8. Sara Schweitzer, *Case of the Hovering Parents: Universities Laying Ground Rules to Give Freshmen More Independence*, THE BOSTON GLOBE, August 20, 2005; Justin Pope, *Hovering Parents Problematic for Colleges*, THE ASSOCIATED PRESS, August 29, 2005. This article describes an incident where parents contacted the school's administration to convey their child's dissatisfaction with the sanitary facilities on a trip to China, Jean Marie Angelo, *Privacy or Peril? University Business*, January 2004.
 9. Karen W. Arenson, *The Dorms May be Great, But How's the Counseling?*, N.Y. TIMES, October 26, 2004, at F1.
 10. Section C(2) of the Accreditation Standards promulgated by the International Association of Counseling Services provides:

The confidential nature of the counseling relationship must be consistent with professional ethical standards and with local, state, provincial and federal guidelines and state statutes. Information should be released only at the request or concurrence of a client who has full and informed knowledge of the nature of the information that is being released. Appropriate information is then to be released selectively and only to qualified recipients. Instances of statutory limits to confidentiality and other appropriate restrictions (e.g., policies related to observation, audio and video taping) need to be clearly articulated and implemented only after careful professional consideration.
 11. 45 C.F.R. § 164.501.
 12. *The 2000 National Survey of Counseling Center Directors*, Appendix A.
 13. 29 U.S.C. § 794 and 34 C.F.R. Pt. 104.
 14. *Eiseman v. State of New York*, 70 N.Y.2d 175 (1987) (doctrine of *in loco parentis* is basis for holding that "colleges today in general have no legal duty to shield their students from the dangerous activity of other students," holding university had no duty to shield students from an ex-felon who was admitted under a special program); *Ellis v. Mildred Elley School, Inc.*, 245 A.D.2d 994 (3d Dep't 1997) (rejecting that college stood *in loco parentis* to students, giving rise to a special duty); *Rothbard v. Colgate University*, 235 A.D.2d 675 (3d Dep't 1997); *Talbot v. New York Institute of Technology*, 225 A.D.2d 611 (2d Dep't 1996).
 15. Peter F. Lake, *The Rise of Duty and the Fall of In Loco Parentis and Other Protective Tort Doctrines in Higher Education Law*, 64 Mo. L. Rev. 1, 6 (1999).
 16. *Id.* at 23.
 17. *Mullins v. Pine Manor College*, 389 Mass. 47 (1983).
 18. *Knoll v. Board of Regents of the University of Nebraska*, 258 Neb. 1, 601 N.W.2d 757 (1999); *Furek v. University of Delaware*, 594 A.2d 506 (Del. 1991).
 19. Dana Levine, *Institute Will Pay Kruegers \$6M for Role in Death*, THE TECH, Vol. 120, No. 42, September 15, 2000 (reporting the settlement of a wrongful death claim filed by the parents of a student following a hazing incident at a fraternity on the campus of the Massachusetts Institute of Technology).
 20. *Davidson v. University of North Carolina at Chapel Hill*, 142 N.C. App. 544 (2001) (university had a special relationship to injured cheerleader); *Kleinknecht v. Gettysburg College*, 989 F.2d 1360 (3d Cir. 1993) (there was a special relationship between college and student athlete who died due to a fatal heart arrhythmia during practice).
 21. *Shin v. Massachusetts Institute of Technology*, 2005 Mass. Super. LEXIS 333 (2005); *Schieszler v. Ferrum College*, 236 F. Supp. 2d 602 (WD VA 2002).
 22. Cases cited at *supra* note 11.
 23. This narrative of the facts of the *Shin* case are drawn from the opinion of the Superior Court and from Deborah Sontag's article *Who Was Responsible for Elizabeth Shin?* THE NEW YORK TIMES SUNDAY MAGAZINE, April 28, 2002.
 24. *The 2004 National Survey of Counseling Center Directors*, *supra* note 1.
 25. *Id.*
 26. Chronicle of Higher Education, Chronicle Forums, An Ounce of Prevention, August 5, 2005, et seq., available at <http://chronicle.com/forums/colloquy/read.php?f=1&i=5393&t=5393>, visited December 27, 2005.
 27. Jason Feirman, *The New College Dropout*, PSYCHOLOGY TODAY, May/June 2005; Karen W. Arenson, *Worried Colleges Step Up Efforts Over Suicide*, THE NEW YORK TIMES, December 3, 2004; Daniel McGinn and Ron Depasquale, *Dealing With Depression*, NEWSWEEK KAPLAN COLLEGE GUIDE, 2004.

Lydia Hoffman Meunier is an associate attorney with Iseman, Cunningham, Riester & Hyde, LLP, a general practice law firm with many individual and institutional clients involved in the provision of health care, including health systems, hospitals, nursing homes, managed care organizations and physicians. Ms. Meunier has lectured on guardianship, advanced decision-making and Medicaid regulatory requirements. Ms. Meunier's practice includes extensive experience with the unique legal issues inherent in treating mental illness.

Carolyn Reinach Wolf is a partner in the firm of Reinach Wolf, Rothman & Stern which concentrates in the area of Mental Health/Health Care Law, providing legal representation and consultation to hospitals, skilled nursing facilities, outpatient centers, families, individuals, mental health practitioners and attorneys. She is the firm's founding partner and has lectured, counseled, provided advice and written extensively in these areas to mental health and health care medical and legal professionals.