

# COLLEGE STUDENTS WITH MENTAL HEALTH DISORDERS: WHEN MAY THEIR PARENTS BE TOLD?

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## ABSTRACT

This Article discusses when parents of college students with mental health challenges may be contacted. Laws surrounding this are discussed. These laws allow more contact than many in the university community understand. But should parents be contacted when their child has a mental health challenge? On the one hand, family involvement generally leads to better outcomes. On the other, some families are toxic and we should arguably depend on the ill family member to make this decision. The question is easier or more difficult depending on how much capacity the patient has to decide; and how much contact we are talking about—from just being notified their family member is ill all the way toward forcing association. Another issue is how much evidence of harmfulness from the family there is. To focus in more narrowly, what does capacity in this context look like, and should just a bare preference be enough to keep family at arm’s distance, even if the patient is not fully competent? Further research on different approaches is needed.

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## I. INTRODUCTION

The Federal Educational Rights and Privacy Act of 1974 (“FERPA”) is the main law governing colleges releasing information about students to their parents.<sup>1</sup> FERPA, in most cases, prohibits colleges from contacting parents about their college-attending children.<sup>2</sup> Reportedly, schools feel their hands are tied and they can’t contact parents, although there are several exceptions to the rule in the law.<sup>3</sup> First, this Article briefly reviews FERPA in this context. Then, I discuss as a policy matter whether and when schools may disclose such information to parents.

## II. THE UNIVERSITY’S RESPONSIBILITIES AND RESTRICTIONS UNDER FERPA

FERPA allows the government to withdraw funds from schools that reveal any personally identifiable information in education records, subject to certain exceptions.<sup>4</sup> This law gives college-attending students a right to access their records and to prevent their parents, and others, from accessing them.<sup>5</sup> There are three categories of exceptions to this rule: when the student is claimed as a dependent for tax purposes; when a student has violated rules around drug or alcohol use if under 21 years old; and when, “in connection with an emergency . . . disclosure is necessary to protect the health or safety of the student or others.”<sup>6</sup>

Additionally, four categories of “educational record” documents are

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<sup>1</sup> See Family Educational and Privacy Rights Act (“FERPA”), 20 U.S.C. § 1232g (2012) (discussing FERPA and its exceptions); 34 C.F.R. §§ 99.1–99.67 (2015) (same). Note that FERPA governs students’ confidentiality, not HIPAA. State confidentiality laws may also come into play when the informer is a medical professional (versus a college administrator, for example).

<sup>2</sup> See 20 U.S.C. § 1232g (denying funds for institutions that release information).

<sup>3</sup> See, e.g., *id.* (b)(2)(B) (providing exceptions for judicial orders and subpoenas).

<sup>4</sup> *Id.* § (b)(1).

<sup>5</sup> *Id.* § (d).

<sup>6</sup> *Id.* §§ (b)(1)(I), (b)(1)(H), (i).

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not protected by FERPA under any circumstances.<sup>7</sup> These are (1) records in the sole possession of instructional, supervisory, and administrative personnel—such as notes from a teachers that they do not share with other employees at the institution; (2) records of a law enforcement unit which are separated from educational records and are solely for law enforcement purposes; (3) records of employees; and (4) physician, psychiatrist, or psychologist treatment records for eligible students.<sup>8</sup> The last exception, often called the “treatment records” exception, applies to records that are (1) maintained by a mental health professional (2) for the sole purpose of treatment, and (3) that include information that was not disclosed to anyone in the institution other than mental health professionals providing the treatment.<sup>9</sup>

In our context, all of the circumstantial exceptions may be at play. The primary area of focus is the “health and safety” exception, where, if there is a rational basis to believe that disclosure to a particular person is necessary to protect health or safety, the right to privacy and access vanishes and the institute may disclose the information to those “necessary” parties and withhold the contents of the disclosure from the student.<sup>10</sup>

Within the “records” exceptions, the most important category applies to physician, psychiatrist, or psychologist treatment records for eligible students, including access to mental health records.<sup>11</sup> When the exception applies, the student’s rights to privacy and access vanish and the institution may disclose the information and withhold the contents of the disclosure from the student.<sup>12</sup>

With the tax exception, students have a right to access but not to prevent transmission to their parents because parents have a right to

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<sup>7</sup> *Id.* § 1232g(a)(4)(B)(i)–(iv).

<sup>8</sup> *Id.*

<sup>9</sup> *Id.* (a)(4)(B)(iv); *see also* 34 C.F.R. § 99.3 (2015).

<sup>10</sup> *See* Emily Gold Waldman, *Show and Tell?: Students’ Personal Lives, Schools, and Parents*, 47 CONN. L. REV. 699, 713 (2015) (discussing public school information extraction and providing the example of a swim coach who feared a swimmer was pregnant and would harm herself by continuing to swim).

<sup>11</sup> *See* Bryan Thurmond, Recent Development, *Dismantling A Dual-Headed System of Governance: How A Regulatory Overlap Undercuts the Security of Student Health Information in Public Schools*, 64 ADMIN. L. REV. 701, 712 (2012) (discussing a situation in which FERPA does not protect these records).

<sup>12</sup> *See* Tessa Heller, *Mandatory School-Based Mental Health Services and the Prevention of School Violence*, 24 HEALTH MATRIX 279, 314 (2014) (noting how information can be disclosed when “necessary”).

access, and both parents and students can prevent the disclosure to all others bound by FERPA.<sup>13</sup> With the alcohol and drug exception, the parents have a right to access the information, though the student continues to have a right to access.<sup>14</sup> It should be noted, however, that in some of the provisions, any disclosure, such as when a psychiatrist discusses a student's mental health treatment beyond the treatment team, revives the privacy and access rights of the student.<sup>15</sup>

While the Act allows withholding of federal funds from schools that violate FERPA, the Department of Education has limited means to withhold funds from an institution under FERPA, and in fact has never done so.<sup>16</sup> There is nevertheless considerable evidence that schools fear FERPA enforcement and consequent loss of funds, and are reluctant to disclose information they have a right to disclose.<sup>17</sup>

For a time, the norm was "strict construction" of the "health and safety" clause.<sup>18</sup> After the Virginia Tech shooting, a study of the people employed by Virginia Tech revealed that they had employed a strict approach to FERPA that prevented the actors from working together and recruiting the shooter's parents to address his issues.<sup>19</sup>

Indeed, President George W. Bush sent his Attorney General to travel around the country to investigate problems educators face in preventing violence.<sup>20</sup> The panel found university administrators believed far too often that communications were illegal that were not actually prohibited by FERPA or any other law.<sup>21</sup>

FERPA, however, has not been interpreted to mandate disclosure to

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<sup>13</sup> See 20 U.S.C. § 1232g (2012) (providing privacy for educational information).

<sup>14</sup> *Id.*

<sup>15</sup> See, e.g., *Electronic Privacy Info. Ctr. v. U.S. Dep't of Educ.*, No. CV 12-0327 (ABJ), 2014 WL 449031 (D.D.C. Feb. 5, 2014) (explaining that unauthorized use of individual's personal information pursuant to FERPA was a concrete injury that affected the individual personally and distinctly).

<sup>16</sup> See *Gonzaga Univ. v. Doe*, 536 U.S. 273, 279 (2002) (discussing the standard for withholding funds).

<sup>17</sup> *Id.* at 289-91.

<sup>18</sup> *United States v. Miami Univ.*, 91 F. Supp. 2d 1132, 1137 (S.D. Ohio 2000), (quoting *Walker v. Luther*, 830 F.2d 1208, 1211 (2d Cir. 1987)), *aff'd* 294 F.3d 797 (6th Cir. 2002).

<sup>19</sup> See Katrina Chapman, *A Preventable Tragedy at Virginia Tech: Why Confusion over FERPA's Provisions Prevents Schools from Addressing Student Violence*, 18 B.U. PUB. INT. L. J. 349, 349-50 (2009) (noting how the school's departments did not communicate or understand FERPA).

<sup>20</sup> *National Dialogue on Safe Schools*, U.S. DEP'T OF EDUC. (last updated Dec. 20, 2007), <http://www2.ed.gov/admins/lead/safety/dialogue.html>.

<sup>21</sup> See *id.* (noting the desire for additional guidance).

parents when a student is in trouble.<sup>22</sup> Because schools do not have a duty to report, they may follow the troublingly conservative path of not reporting when their students are in trouble.

### III. SHOULD UNIVERSITIES BE REQUIRED TO DISCLOSE STUDENT TROUBLES?

The rest of this Article asks whether colleges should involve parents when their college-attending children are showing signs of mental illness, and whether this school-parent relationship is generally good or bad. Moreover, this Article asks when colleges may involve parents. There are similar questions presented in other venues—when doctors may or must notify next of kin that their family member has been involuntarily hospitalized or has received emergency treatment of other kinds. Similar questions can be asked about workplaces and when police bring in young adult family members.<sup>23</sup>

This Article focuses on higher education. These issues are somewhat unique because young adults, who may be being supported financially by their families may be involved; also, these young adults are in a somewhat protected environment. Indeed, the last cannot be overemphasized.<sup>24</sup>

Should universities give young adults the power to exclude their family's participation in their illness journey? There are a number of relevant considerations. For example, there is considerable evidence that people with mental health disorders do better when their families are involved in their recovery.<sup>25</sup> So if maximizing patients' recovery potential

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<sup>22</sup> See, e.g., *Schaefer v. Las Cruces Pub. Sch. Dist.*, 716 F. Supp. 2d 1052, 1084 (D.N.M. 2010) (noting how disclosure was not required).

<sup>23</sup> A number of papers have been written discussing the ability of colleges to notify parents consistent with FERPA, as well as the desirability of doing so. See generally, e.g., Stephanie Humphries, *Institutes of Higher Education, Safety Swords, and Privacy Shields: Reconciling FERPA and the Common Law*, 35 J.C. & U.L. 145 (2008); Joey Johnsen, *Premature Emancipation: Disempowering College Parents Under FERPA*, 35 DRAKE L. REV. 1057 (2007); Susan P. Stuart, "Hope and Despondence": *Emerging Adulthood and Higher Education's Relationship with its Nonviolent Mentally Ill Students*, 38 J.C. & U.L. 319 (2012). There is also a bill in Congress (the "Murphy Bill") that "proposes amending federal medical privacy protections—the now-familiar HIPAA laws—to allow parents or other caregivers access to a patient's medical information." See Benedict Carey, *Mental Health Groups Split on Bill to Overhaul Care*, N.Y. TIMES, April 2, 2014, at A4, available at <http://www.nytimes.com/2014/04/03/health/mental-health-groups-split-on-bill-to-revamp-care.html>.

<sup>24</sup> See *infra*, on the doctrine of in loco parentis.

<sup>25</sup> See generally, e.g., David J. Miklowitz & Jill M. Hooley, *Developing Family Psychoeducational Treatments for Patients with Bipolar and Other Severe Psychiatric Disorders: A Pathway from Basic Research to Clinical Trials*, 24 JOURNAL OF MARITAL AND

is desirable, involving their families may be necessary, even if it is without their consent.<sup>26</sup>

Furthermore, college-aged students are somewhat less mature and more dependent than they were when FERPA was passed.<sup>27</sup> Certainly, especially with the advent of cell phones and greater frequency of contact, more college students are part of their family of origin than four decades ago.<sup>28</sup> They may need their family members' help more so than past generations did.<sup>29</sup>

Indeed, perhaps we should revive the doctrine of *in loco parentis*.<sup>30</sup> This doctrine formerly held sway—and was held to insulate the schools from liability in the same way that privacy of family life did for claims

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FAMILY THERAPY 419 (1998) (discussing how family psychoeducational treatment improves outcomes for severely ill patients, such as superior employment rates, greater likelihoods of receiving state disability payments, and lower relapse rates with multi-family groups); William C. Nichols, *Family Therapy and Serious Mental Disorders: A Retrospective and Prospective View*, 20 JOURNAL OF FAMILY PSYCHOTHERAPY 344 (2009) (explaining the role of family therapy in treatment). These articles talk about formal family interventions rather than just having a family member as part of the treatment team. There is also considerable literature on the salutary effects of having social relationships on one's recovery. *See generally, e.g.*, Jennifer Hefner & Daniela Eisenberg, *Social Support and Mental Health Among College Students*, 79 AMERICAN JOURNAL OF ORTHOPSYCHIATRY 491 (2009); Michael Hendryx, Carla A. Green & Nancy A Perrin, *Social Support, Activities, and Recovery from Serious Mental Illness: STARS Study Findings*, 36 JOURNAL OF BEHAV. HEALTH SERVS. AND RESEARCH 320 (2009); Francessa Pernice-Duca, *Family Support Network and Mental Health Recovery*, 36 JOURNAL OF MARITAL AND FAMILY THERAPY 13 (2010).

<sup>26</sup> I refer to students in this context either as “students” or as “patients.” Some who suffer with mental illness object to the latter and prefer to be called “consumers.” I believe the term “patients” is most descriptively accurate—mental illness is a medical condition and those who suffer with it are “patients.” As well, “consumers” makes it sound as if getting treatment is like getting one's car serviced. I do appreciate that others have a different view and hope not to offend anyone.

<sup>27</sup> *See* Stuart, *supra* note 22, at 330 (noting the problems faced by college students).

<sup>28</sup> *See* MADELINE E. SMITH ET AL., GOING TO COLLEGE AND STAYING CONNECTED: COMMUNICATION BETWEEN COLLEGE FRESHMEN AND THEIR PARENTS 2 (Univ. of Cornell Press 2012), available at [http://leshed.comm.cornell.edu/pubs/paper230\\_Smith.pdf](http://leshed.comm.cornell.edu/pubs/paper230_Smith.pdf) (noting increased reliance on cell phones).

<sup>29</sup> Note that relevant laws go both ways. Under Obamacare, parents' insurance may cover their children until the age of 26. This suggests they are younger than in the past. Conversely, children under the age of majority are often given authority to consent to mental health or substance abuse treatment without their parents' consent. *See, e.g.*, CAL. FAM. CODE § 6924 (B) (2015); WASH. REV. CODE ANN. § 71.34.500 (2015). The latter laws seem to suppose that even fourteen-year-olds are competent enough to know when they need psychiatric help, and that sometimes parents reject treatment that the teenager or young adult recognizes he or she should have.

<sup>30</sup> *See* IN LOCO PARENTIS, BLACK'S LAW DICTIONARY (10th ed. 2014).

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against family members.<sup>31</sup> Just as families are now scrutinized and intervened into, colleges arguably should be held to an obligation to take care of their students without insulating them from liability.

Some may ask why should colleges be held accountable, and not places of employment? Students in college are in a transitional, insular space; they are protected and nurtured by their families and school. Many live on campus and depend on resident advisors to manage their dorms, are provided three meals a day, meet with an advisor to discuss the classes they will take, meet with their advisor to discuss class progress, and visit health services that are available on campus (rather than having to find and evaluate a doctor independently).<sup>32</sup> Informally, many are in close contact with their parents.<sup>33</sup> The school does really stand in loco parentis to their students.

We might also want a narrower rule: therapists may not disclose student information but other college actors may. Thus, with this proposed narrow rule, only in the most extreme circumstances, when a duty to warn is triggered, may therapists intervene in the therapy. Otherwise, confidentiality would reign supreme. Others, of course, would advocate for the status quo by maintaining that therapists should be subject to the same rules around disclosure as other college actors.<sup>34</sup>

The content disclosed by a university may logically dictate the desirability of keeping that information confidential. College students may have a greater interest in keeping their grades from their parents than in keeping them ignorant of their illness. This is a controversial issue. Students, however, should be entitled to not care much about their grades, harsh parental judgment notwithstanding. Serious illness, by contrast, is potentially much more devastating, and the student may need more help to merely survive.<sup>35</sup>

On the other hand, some family members might be quite toxic to the ill member, and perhaps the student is in the best position to decide if his

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<sup>31</sup> See Fowler V. Harper & Posey M. Kime, *The Duty to Control the Conduct of Another*, 43 YALE L.J. 886, 899 (1934) (discussing in loco parentis).

<sup>32</sup> See, e.g., UNIV. OF S. CAL., LIVING AT USC: FRESHMEN 2013–2014, available at [http://housing.usc.edu/forms/13\\_FreshmanLiving%28FNL%29LR.pdf](http://housing.usc.edu/forms/13_FreshmanLiving%28FNL%29LR.pdf) (discussing college life).

<sup>33</sup> SMITH, *supra* note 28.

<sup>34</sup> See 20 U.S.C. § 1232g (2012) (discussing disclosure rules).

<sup>35</sup> Imagine asking students on enrollment into school to name an “emergency contact.” One can imagine many would want their families contacted in a health crisis but would not consent in advance to the family’s getting the student’s transcripts.

or her family members should be informed about their condition.<sup>36</sup> In addition, students may be embarrassed; they may not trust family with the information—the families may tell people the students do not want to know; and students may want to not worry them.

In my own history, I kept most information from my parents.<sup>37</sup> I am close to them. We speak pretty much every day. But I don't want them involved when I am ill. I became ill after living independently for some years and did not want to go back to being a kid in my family of origin. Also, my family worries a lot. And they don't "do supportive" very well. It is not always a bad idea to keep your family at a distance around these issues.

Two central issues may be implicated when evaluating college disclosure. First, if we allow parental involvement, what kind and degree of involvement should be permitted? Second, who should make the ultimate decisions, and at what level of competence? In terms of degrees of involvement, at the far end, parents could be given minimal disclosure (for example "your child is mentally ill and receiving treatment"), alerting them so that they may try to become more involved and keep the treatment team honest. The doctors could then listen to the parents' side of the story, gleaning important information for future treatment: What have they noticed? What seems to help and to harm their kid? Can they provide support for them? Further along, the doctors could relay important information about the student-patients to their family members. Again, knowledge is power and knowing option may help parents keep the medical staff honest. The parents could encourage treatment and make sure it is as least coercive as effectively possible. Further down the road, student-patients could be required to meet with their parents, whether they want to or not.

Actually forcing association is a difficult issue.<sup>38</sup> We do require kids to stay with their parents, visit noncustodial parents, and so forth.<sup>39</sup> We certainly coerce association in the criminal justice context: you must see

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<sup>36</sup> See, e.g., *Newmark v. Williams*, 588 A.2d 1108 (Del. 1991) (discussing how parents refused to administer medical treatment for three-year-old child with cancer because of religious beliefs).

<sup>37</sup> I have my own history of schizophrenia. See generally ELYN R. SAKS, *THE CENTER CANNOT HOLD: MY JOURNEY THROUGH MADNESS* (2007).

<sup>38</sup> Cf. Scott E. Byers, Freddy Funes & Allison V. Perez, *Mama Knows Best: Frazier v. Winn Says Do As You're Told!*, 63 U. MIAMI L. REV. 905, 925 (2009) (discussing whether parents have the power to compel their children's speech).

<sup>39</sup> See David B. Thronson, *Choiceless Choices: Deportation and the Parent-Child Relationship*, 6 NEV. L.J. 1165, 1174–75 (2006) (discussing the importance of family).



(associate with) your parole officer or the prison psychiatrist.<sup>40</sup> If you force contact, the person may protest by getting totally out of control or thoroughly decompensating, which is obviously a bad outcome as well. Requiring adults to be with a family member whom they want to avoid, then, seems most problematic.<sup>41</sup>

The second issue is who should decide if patients should have their parents involved, and with what level of capacity? That is, given that there are cases where family involvement is good and cases where it is not,<sup>42</sup> the question arises as to who gets to decide this in a given case? One view is the patients themselves know this best;<sup>43</sup> another is that the patients may be making a bad decision; another is that the patients may even lack capacity to make this decision—they may be somewhat decisionally impaired.<sup>44</sup>

Confidentiality laws seem to presume that the patient knows best, or at least that schools should not breach confidentiality without the student's consent, unless he is dangerous to self or others.<sup>45</sup> For example, even if a doctor thinks it would be helpful to patients to involve their parents in their treatment, the doctor may not contact the families without patients' consent.<sup>46</sup> In more serious cases, however, family may be contacted—for example if the person is hospitalized, and with younger patients parents may be contacted.<sup>47</sup>

What should be done if patients lack the capacity to decide whether to contact their parents? A sensible approach would be for the psychiatrist to evaluate the situation. Does the patient seem to be decisionally intact when making the decision to exclude family? Does the family seem

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<sup>40</sup> Thomas L. Hafemeister & John Petrila, *Treating the Mentally Disordered Offender: Society's Uncertain, Conflicted, and Changing Views*, 21 FLA. ST. U. L. REV. 729, 856 (1994) (discussing situations where mentally disordered offenders have a more difficult time securing release).

<sup>41</sup> We may take a different view regarding this series of escalating involvement depending on how competent the patient is to decide how much involvement to have. *See infra*.

<sup>42</sup> *See Newmark*, 588 A.2d at 1109 (involving a family that refused to allow their child to be given chemotherapy).

<sup>43</sup> Lourdes C. Corman, *The Patient Knows Best*, 257(9) JAMA 1225, 1225 (1987).

<sup>44</sup> *See* Glyn Elwyn et al., *Shared Decision Making and the Concept of Equipose: The Competences of Involving Patients in Healthcare Choices*, 50 BRITISH J. OF GENERAL PRACTICE 892, 892–97 (2000) (discussing models for patient decision-making).

<sup>45</sup> Janet Leach Richards & Professor Sheryl Wolf, *Medical Confidentiality and Disclosure of Paternity*, 48 S.D. L. REV. 409, 420 (2003).

<sup>46</sup> Lawrence Schlam & Joseph P. Wood, *Informed Consent to the Medical Treatment of Minors: Law and Practice*, 10 HEALTH MATRIX 141, 151, 167 (2000).

<sup>47</sup> *Id.* at 168.

helpful or toxic to the patient in the view of the psychiatrist? Observing the family interacting may give additional information—what are the family dynamics? If the doctors think family involvement is the best outcome, they might try to work with their patients on this issue and help the patients work through the issues that make them want to exclude their families. This would involve at least postponing family involvement. Still, there would need to be a way to decide what to do if the patient continues to resist family involvement even after work on this issue and the situation demands it.

What should the policy be if the patient lacks capacity to understand the benefits of family involvement, but they would actually be very helpful? As is often the case when capacity is lacking, the decision must be what the patients would have wanted if competent, and/or what would be in their best interests. This, again, would involve a careful evaluation of the patient's family dynamics.

Another view is that we do not need a competent choice for patients to be able to exclude their family; what they want is more important than how competent they are to want it.<sup>48</sup> With this view even incapable decisions to exclude family should be honored as one has an absolute right to keep private information private that does not risk harm to others because everybody has a right to preserve their privacy, even if one would not have made the same decision if competent.<sup>49</sup> The argument is even stronger when we are contemplating enforcing association. Even incompetent persons know when they do not want to be with someone, and will react accordingly.<sup>50</sup>

Note that in the ordinary outpatient treatment context, confidentiality is a central tenant of practice.<sup>51</sup> Most doctors would not contact family without the patient's consent.<sup>52</sup> If a patient is truly incompetent to decide, and at risk in some way, doctors might contact next of kin as a first step before institutionalizing the patient.<sup>53</sup>

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<sup>48</sup> See Corman, *supra* note 43, at 1225 (discussing how doctors can make mistakes).

<sup>49</sup> *Id.*

<sup>50</sup> See, e.g., Hafemeister & Petrila, *supra* note 39 (discussing the consequences of such a situation).

<sup>51</sup> See 42 U.S.C. §§ 1320d, 1320d-1, 1320d-5, 1320d-6 (2012) (preventing mental health professionals from releasing any information about a patient to anyone without a valid release and consent form); see also Reese McKinney, Jr., *Involuntary Commitment, A Delicate Balance*, 20 QUINNIPIAC PROB. L. J. 36, 44–45 (2006) (discussing how family members can be stopped from learning about one another).

<sup>52</sup> *Id.*

<sup>53</sup> Robert Sadoff, *Ethical Obligations for the Psychiatrist: Confidentiality, Privilege, and*

We must next consider what it means to have capacity to engage or resist engagement with one's parents. The patient may have frankly psychotic views—"my parents are instrument of the devil trying to bring me down," or "they have magical powers and can kill me with their thoughts." Other views are less psychotic but still evidence significant impairment: "my parents want to kill me or turn me in to the FBI." What do we do with possible mild distortions? For example, "my parents are furious at me and think of me as the black sheep of the family" or "they are trying to declare me incompetent to get my money." Even if these beliefs are untrue, they may not be severe enough distortions to take away the patient's right to decide.<sup>54</sup>

When we contemplate family involvement in students' mental health, does it matter what problems the student is having? At the far end, students may have serious Axis I diagnoses that cause them to be dangerous to themselves or others. This would justify hospitalizing them against their will and possibly involving their families.<sup>55</sup> What if they are not dangerous but are being disruptive in class and causing their classmates to fear and denigrate them? What if they have a severe illness that is interfering with their ability to perform adequately on schoolwork? What if their only problem is having a severe mental illness and suffering gravely, but not being dangerous or disruptive or nonfunctional?

Some regulations speak of an "articulable and significant threat to the health or safety of the student."<sup>56</sup> What if the decrement to one's health significantly impacts the person's quality of life but impacts his or her schooling in a minor way? Imagine a student who washes his or her hands a lot, which makes them red and crackly and takes time away from his studies. Is this enough to be considered an articulate and significant threat? The language of the exception is too vague to answer this.

Another way to approach this issue is to ask what would be done if students develop a severe physical illness, even a life-threatening one? Suppose they say they do not want their families to know, even though they would be much better off if they did? What would be done in this case?<sup>57</sup>

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*Privacy in Psychiatric Treatment*, 29 LOY. L.A. L. REV. 1709, 1711 (1996).

<sup>54</sup> McKinney, *supra* note 51, at 44–45.

<sup>55</sup> *See id.* (discussing the difficulties families face in being involved).

<sup>56</sup> 34 C.F.R. §99.36(c) (2015); *see also* 23 ILL. ADMIN. CODE § 375.60 (discussing when information can be released).

<sup>57</sup> The type of language offered by a college or university regarding when it will disclose medical emergencies to parents generally state to the effect that: "All health records of students

Arguably, physical health and mental health contexts are different because in the mental health context there may be a degree of decisional impairment which we would not expect in physically ill persons. As in the mental health context, the physically ill persons may be incapable of keeping up with school work. But is it not their choice to try regardless?

Another related issue concerns persons who do not have a mental illness but are disruptive in some way. They may be annoying in class or may threaten harm. If the behavior is bad enough, the case for removing these students from school would be even stronger. They would be guilty of misconduct without the mitigation of mental illness.<sup>58</sup>

While I said I would focus on college students, it is worth noting that some jurisdictions have laws that next of kin must be notified when their family member is involuntarily hospitalized.<sup>59</sup> Some of the same issues arise—the family may be toxic, people should have a right to keep certain information private; but in this context, it is thought that the patient’s rights and interests are best protected by having a concerned other aware of the situation and what is happening.<sup>60</sup> Hospitals may be less likely to maltreat a patient if their family is observing the care.<sup>61</sup> The same may be true in our context.

Another issue is whether schools *should* have a duty to notify parents when their child is severely ill. As discussed above, FERPA does not

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age eighteen and over are private and confidential. No medical information can be released to any party without the expressed written consent of the student, unless state or federal laws mandate the release. In the event of a life threatening illness, the attending physician will notify parents or legal guardian.” See *Health Services: Information For Parents*, W. KY. UNIV. (last visited March 25, 2015), <http://www.wku.edu/healthservices/top-menu/parents-page.php>.

<sup>58</sup> See, e.g., TEX. EDUC. CODE ANN. § 37.002 (2015) (“A teacher may remove from class a student . . . (2) whose behavior the teacher determines is so unruly, disruptive, or abusive that it seriously interferes with the teacher’s ability to communicate effectively with the students in the class or with the ability of the student’s classmates to learn.”).

<sup>59</sup> For some statutes that mandate that family be notified of the person’s evaluation and/or hospitalization, see, e.g., ARIZ. REV. STAT. ANN. §§ 36-528, 36-504 (2015); MICH. COMP. LAWS ANN. § 330.1431 (2015); MINN. STAT. ANN. § 253B.10 (2015); NEV. REV. STAT. § 433A.190 (2015); and N.Y. MENTAL HYG. LAW § 9.29 (2015). For jurisdictions that require patient consent before notifying family, see, e.g., CAL. WELF. & INST. CODE §§ 5256.4, 5328.1 (2015); FLA. STAT. ANN. § 394.4599 (2015); MONT. CODE ANN. § 53-21-166 (2015); and N.M. STAT. ANN. § 43-1-19 (2015).

<sup>60</sup> Zachary Groendyk, “*It Takes a Lot to Get into Bellevue*”: A Pro-Rights Critique of New York’s Involuntary Commitment Law, 40 FORDHAM URB. L.J. 549, 557 (2012).

<sup>61</sup> *Addington v. Texas*, 441 U.S. 418, 428–29 (1979) (“[T]he layers of professional review and observation of the patient’s condition, and the concern of family and friends generally will provide continuous opportunities for an erroneous commitment to be corrected.”).

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require this.<sup>62</sup> There have been actions when a family wasn't notified of the suicidality of their family member who does commit suicide and the family brings a *Tarasoff*-type case.<sup>63</sup> These cases generally fail.<sup>64</sup> Yet, there can be other kinds of actions against schools when their students commit suicide, for example a claim of negligent medical care.<sup>65</sup> I do not address here the issue of whether family must or should be notified when their ill members are a danger to themselves.

## IV. CONCLUSION

In light of the context in which FERPA has been analyzed herein, the statute should not be read to generally prevent colleges from contacting family members of their ill students. Families can be extremely helpful (except in cases where they are clearly toxic, such as when a parent is guilty of abuse), and we should arguably try to help patients work through their issues by allowing their families to be involved. The issue gets a lot trickier when the patient's decisional abilities are impaired. Should we do what they would have wanted if competent, or what they want now even though incompetent?

It's worth noting that families often serve as informal proxies for consent to treatment and/or research in the case of Alzheimer's patients.<sup>66</sup> Typically, in the involuntary mental health treatment context we do not let families do this—they must go the route of becoming a formal proxy, namely a guardian.<sup>67</sup> There is less of a belief that the patient and family members' interests are aligned and more of a concern that the family may be part of the problem.<sup>68</sup> In addition, the Alzheimer's patient may be more clearly incompetent than the patient with psychosis so the lack of a formal process to abrogate their choice feels less problematic.<sup>69</sup> On the other hand, with the mentally ill person the family is more like another set of eyes than another decision maker. If family of Alzheimer's patients can be proxy decision makers, perhaps family of psychotic patients can serve

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<sup>62</sup> See 20 U.S.C. § 1232g (2012) (failing to require disclosure).

<sup>63</sup> See *Jain v. State*, 617 N.W.2d 293, 294 (discussing such a situation).

<sup>64</sup> *Id.*; see also *Bogust v. Iverson*, 102 N.W.2d 228 (Wis. 1960).

<sup>65</sup> See, e.g., *Humphries*, *supra* note 23, at 164 (discussing possible claims).

<sup>66</sup> For a review of proxy consent laws around the country, including informal family consent, see Elyn R. Saks, et al., *Proxy Consent to Research: the Legal Landscape*, 8 *YALE J. HEALTH POL'Y, L. & ETHICS* 37 (2008).

<sup>67</sup> *Id.* at 67–68.

<sup>68</sup> *Id.* at 69–70.

<sup>69</sup> *Id.* at 74.

essentially as protectors of their well-being.

In conclusion, family involvement when a student decompensates mentally in college is an important, interesting, and difficult issue. Families can help patients but they can also harm them. Finding the right balance of when patients should be allowed to exclude their families, and when not to, should be the object of careful study that needs more research.