

Suicide Screening and Surveillance of Students, Discrimination, and Privacy: The Garrett Lee Smith Memorial Act

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ABSTRACT

The Garrett Lee Smith Memorial Act (GLS) was first enacted in 2004 for the purposes of early screening, intervention, and prevention of suicide in students ten to twenty-four years of age, and to hire more college counselors. More than sixteen years later, GLS suicide prevention programs have not been found to be effective in reducing suicide rates, while their harms have not been considered. This Article reviews the state of the evidence on school suicide prevention and explores the suicide surveillance of the GLS and its peer-to-peer monitoring and reporting of marginalized students “at risk”—students with disabilities; racial/ethnic, sexual, and religious minorities; victims of bullying; students with homelessness or foster care records; and other suicide risk factors. It explores the GLS public health approach to address the burdens of suicidal students, isolate suicide risks, and avoid suicide contagion. It also describes possible harms of the GLS suicide surveillance approach: stigmatization; violated privacy; estrangement from peers, parents, therapists, and other social supports; police involvement and warrantless searches; potential exacerbation of suicidality; and restricted civil rights in non-school settings such as employment and involuntary commitment proceedings. It then compares the threats imposed by school surveillance for violence and suicide and suggests that paternalistic justifications might account for the relative lack of concerns raised so far regarding the latter. The Article then briefly considers the functions of participating in suicide surveillance for teachers and staff. It concludes with recommendations to stop surveilling these students and start including them in school and on campus in meaningful ways.

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INTRODUCTION

The Garrett Lee Smith Memorial Act¹ (“GLS” or “Act”) was first passed in 2004 for the purposes of providing early screening, intervention, and prevention of suicide in persons ten to twenty-four years of age and providing grants for high school, college, and university mental health service providers. The GLS was intended to have a three-year authorization ending in 2006 with an \$82 million price tag overall.² It now costs over \$77 million annually through 2022.³

1. Garrett Lee Smith Memorial Act, Pub. L. No. 108–355, § 2, 118 Stat. 1404, 1404-05 (2004) (“to support the planning, implementation, and evaluation of organized activities involving statewide youth suicide early intervention and prevention strategies, to authorize grants to institutions of higher education to reduce student mental and behavioral health problems, and for other purposes.”).

2. The Act authorized \$12 million for “youth interagency research, training, and technical assistance centers”; \$55 million for “youth suicide early intervention and prevention strategies”; and \$15 million for “mental and behavioral health services on campus.” *Id.* at §§ 3, 520E, 520E-2.

3. 21st Century Cures Act, Pub. L. No. 114–255 § 9008, 130 Stat. 1242, 1243, 1259 (reauthorized the GLS and appropriated \$5,988,000 annually for a “technical assistance center”; \$30 million annually for “youth suicide early intervention and prevention strategies”; and \$7 million annually for “mental and behavioral health services on campus.”). The 21st Century

Though the Act passed easily (352-64), it was not lost on the bill's opponents that many experts believed that "[s]uicide awareness programs in schools have not been shown to be effective either in reducing suicidal behavior or in increasing help-seeking behavior,"⁴ and might be counterproductive. As one representative put it:

[T]his legislation is just one more way that the government is encroaching on the lives and health care of private citizens . . . I know of no successful suicide prevention programs. We should be able to find at least one successful model program somewhere in this world before we invest \$82 million in a new, untried program . . . [W]hile I believe this bill is offered with good will and absolutely with the best intentions, and with broken hearts as well, we need to take a step back and realize that suicide is based on emotion, and it was from emotion that this bill was created.⁵

Sixteen years later, there is scant, if any, evidence to suggest that the GLS and similar suicide prevention strategies have been successful in reducing suicide rates among youth.⁶ And there is an emerging consensus among many suicide experts that:

[I]t is finally time to acknowledge that rare events such as suicide – no matter that they are tragic for all involved or how much we wish to prevent them – are impossible to predict with a degree of accuracy that is clinically meaningful . . . Patients may be detained not for treatment needs but because not detaining them produces intolerable anxiety in the staff involved in the assessment . . . [W]e need to

Cures Act also authorized \$1 million annually to establish an interagency College Campus Task Force and another \$1 million annually for a national public education campaign. *Id.* at §§ 9032, 9033.

4. 150 CONG. REC. H6865-02 (daily ed. Sept. 8, 2004) (statement of Rep. Garrett) (citing reports in the *Journal of the American Medical Association* and from the American Academy of Child and Adolescent Psychiatry); see also 150 CONG. REC. E1573-01 (daily ed. Sept. 8, 2004) (statement of Rep. Doolittle).

5. 150 CONG. REC. H6865-02 (daily ed. Sept. 8, 2004) (statement of Rep. King).

6. See *infra* Section II.

acknowledge the impossibility of predicting individual risk accurately and educate the public [about] this fact.⁷

One reason it is almost impossible to meaningfully predict who will die by suicide is that only a few clinical risk factors (e.g., prior psychiatric hospitalization, prior suicide attempt) are meaningfully associated with future suicide death.⁸ Even among those with a prior suicide attempt (the strongest single predictor), less than 2% will actually die by suicide after one year,⁹ and “the odds that a [college or university] student with suicidal ideation will actually commit suicide are 1,000 to 1.”¹⁰ Additionally, “almost half of people who try to kill themselves do so impulsively[,]”¹¹ making intervention within this

7. Roger Mulder et al., *The Futility of Risk Prediction in Psychiatry*, 209 BRIT. J. PSYCHIATRY 271, 271-72 (2017); see also Matthew Large et al., *Known Unknowns and Unknown Unknowns in Suicide Risk Assessment: Evidence from Meta-Analyses of Aleatory and Epistemic Uncertainty*, 41 BRIT. J. PSYCHIATRY BULL. 160, 162 (2017) (“We need to acknowledge our powerlessness to usefully classify individuals or groups of patients according to future suicide risk . . . [and] communicate this to health departments, to the courts, and most importantly, to our patients and their families . . . [W]e need to be very sparing in our use of involuntary treatment as a reaction to suicide risk. It is likely that very few patients who we admit to hospital would have died by suicide as out-patients over the period of time usually associated with a contemporary length of stay.”).

8. See generally Joseph C. Franklin et al., *Risk Factors for Suicidal Thoughts and Behaviors: A Meta-Analysis of 50 Years of Research*, 143 PSYCH. BULL. 187 (2017).

9. See J. Michael Bostwick et al., *Suicide Attempt as a Risk Factor for Completed Suicide: Even More Lethal Than We Knew*, 173 AM. J. PSYCH. 1094, 1094 (2016) (1.9% (27 of 1,442) of individuals who made nonfatal attempts died by suicide in the first year afterward); Sheree J. Gibb et al., *Mortality and Further Suicidal Behaviour After an Index Suicide Attempt: A 10-Year Study*, 39 AUSTRALIAN & NEW ZEALAND J. PSYCH. 95, 96 (2005) (1.41% of individuals with an index suicide attempt died by suicide after 1 year); see also Mark Olfson et al., *Suicide Following Deliberate Self-Harm*, 174 AM. J. PSYCH. 765, 765 (2017) (in the authors’ study, 0.439% of persons with nonfatal self-harm died by suicide twelve months later; the authors also summarize that “[i]n studies from other countries, the risk of suicide during the first year following self-harm varies from 0.8% to 3.0% for men and from 0.3% to 1.9% for women.”) (citations omitted).

10. Paul S. Appelbaum, “*Depressed? Get out!*”: *Dealing with Suicidal Students on College Campuses*, 57 PSYCHIATRIC SERVS. 914, 915 (2006) (citation omitted).

11. Amy Barnhorst, *The Empty Promises of Suicide Prevention*, N.Y. TIMES (Apr. 26, 2019), <https://www.nytimes.com/2019/04/26/opinion/sunday/suicide-prevention.html>; Eberhard A. Deisenhammer et al., *The Duration of the Suicidal Process: How Much Time Is Left for Intervention Between Consideration and Accomplishment of a Suicide Attempt*, 90 J. CLINICAL PSYCHIATRY 19, 19 (2009) (“Nearly half of the patients (47.6%; N = 39) reported

timeframe very difficult. Intervention may also be difficult because many persons planning to die by suicide may avoid disclosing their suicidal thoughts and intentions¹² because they know their rights may be restricted as a result of these disclosures.

Proponents of the GLS, however, see things differently. The U.S. Department of Health and Human Services (HHS), Substance Abuse and Mental Health Services Administration (SAMHSA), and the Centers for Disease Control and Prevention (CDC)—like the mental health professionals’ groups who strongly support the GLS¹³—argue that “suicide is preventable”¹⁴ and that “[s]uicide prevention is everyone’s business.”¹⁵ Accordingly, the GLS’s “public health approach to suicide prevention”¹⁶ “trains[s] teachers, coaches, clergy, emergency responders, primary and urgent care providers, and others in the community to identify people who may be at risk of suicide and to respond effectively, including facilitating treatment seeking and support services.”¹⁷ They liken potentially suicidal students to those with an

that the period between the first current thought of suicide and the actual attempt had lasted 10 minutes or less.”).

12. Katie A. Busch et al., *Clinical Correlates of Inpatient Suicide*, 64 J. CLIN. PSYCHIATRY 14, 14 (2003) (“Thirty-nine percent (30/76) were admitted for suicidal ideation, but 78% denied suicidal ideation at their last communication about this.”).

13. Letter from Mental Health Liaison Group, to Hon. Rep. David W. Jolly, Hon. Rep. Danny K. Davis (Feb. 18, 2015), https://adaa.org/sites/default/files/Garrett-Lee-Smith-Memorial-Act-Reauthorization_Letter%28House%29.pdf. Almost all signatories were organizations strongly affiliated with mental health professionals, e.g., the American Psychiatric Association, American Psychoanalytic Association, with the exception of the Bazelon Center for Mental Health Law.

14. See generally Deb Stone et al., CTRS. FOR DISEASE CONTROL & PREVENTION, *Preventing Suicide: A Technical Package of Policy, Programs, and Practices* (2017), <https://www.cdc.gov/violenceprevention/pdf/suicideTechnicalPackage.pdf> [hereinafter CDC, *Preventing Suicide*].

15. HHS.gov (@HHSGov), TWITTER (Sept. 11, 2018, 4:04 PM), <https://twitter.com/HHSGov/status/1039605612844331019> (“Suicide prevention is everyone’s business. Learn the warning signs . . .”).

16. David B. Goldston & Christine Walrath, *Overview of the Garrett Lee Smith Memorial Youth Suicide Prevention Program* 5 (Mar. 11, 2020), <https://www.nationalacademies.org/event/03-11-2020/docs/DB43DF5242809140F0A98AE31EF9B749302A29D21725> (“All GLS grantees had a comprehensive public health approach to suicide prevention.”).

17. *Id.* at 5 (“Gatekeeper training was a core part of all GLS programs: more than 96% of state, tribal, and campus grantees conducted gatekeeper trainings. In gatekeeper training programs, individuals learn about warning signs for suicide, learn to identify individuals at risk and how to approach them, and how to refer them as appropriate for needed care.”).

infectious disease, warning the public about “suicide contagion.”¹⁸ They stress that potentially suicidal students are a burden on other people because “student suicide can significantly impact other students and the entire school community.”¹⁹ They also encourage a system of peer-to-peer surveillance. Recognizing that “most youth who are suicidal talk with peers about their concerns rather than with adults,”²⁰ they recommend programs that “[i]ncrease students’ ability to recognize if they or their peers are at risk for suicide,”²¹ “identify a peer who may be at risk of suicide[,] and refer him or her to an appropriate adult.”²² They encourage schools to report potentially suicidal students to their parents.²³ And they ask everyone to be on the lookout for students with “risk factors” of suicide that often relate to experiences of trauma or being a member of a marginalized group of individuals. The following “risk factors for youth suicide” are identified in SAMHSA’s *Preventing Suicide: A Toolkit for High Schools* (“Toolkit”):

Adverse/Stressful Life Circumstances

- Interpersonal difficulties or losses (e.g., breaking up with a girlfriend or boyfriend)
- Disciplinary or legal problems
- Bullying, either as victim or perpetrator
- School or work problems (e.g., actual or perceived difficulties in school or work, not attending school or work, not going to college)

18. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (SAMHSA), *Preventing Suicide: A Toolkit for High Schools*, U.S. DEP’T OF HEALTH & HUM. SERVS. 11 (2012), https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/sma12-4669.pdf [hereinafter SAMHSA, *Preventing Suicide Toolkit for High Schools*].

19. *Id.* at 26.

20. *Id.* at 141 (“as few as 25 percent of peer confidants tell an adult about their suicidal peer.”) (citation omitted).

21. *Id.* at 150.

22. *Id.* at 143.

23. *Id.* at 12. The report reminds readers of “a provision in [the Family Educational Rights and Privacy Act, or] FERPA [that] permits school officials to disclose information on students, without consent, to appropriate parties if knowledge of the information is necessary to protect the health or safety of the student or other individuals. When a student is believed to be suicidal or has expressed suicidal thoughts, school officials may determine that an articulable and significant threat to the health or safety of the student exists and that such a disclosure to appropriate parties is warranted under this exception.” (citation omitted).

- Physical, sexual, and/or psychological abuse
- Chronic physical illness or disability
- Exposure to suicide of peer

Family Characteristics

- Family history of suicide or suicidal behavior
- Parental mental health problems
- Parental divorce
- Death of parent or other relative
- Problems in parent-child relationship (e.g., feelings of detachment from parents, inability to talk with family members, interpersonal conflicts, family financial problems, family violence or abuse, parenting style either underprotective or overprotective and highly critical)

Environmental Factors

- Negative social and emotional environment at school, including negative attitudes, beliefs, feelings, and interactions of staff and students
- Lack of acceptance of differences
- Expression and acts of hostility
- Lack of respect and fair treatment
- Lack of respect for the cultures of all students
- Limitations in school physical environment, including lack of safety and security
- Limited access to mental health care
- Exposure to other suicides, leading to suicide contagion
- Exposure to stigma and discrimination against students based on sexual orientation; gender identity; race and ethnicity; disability; or physical characteristics, such as overweight.²⁴

These risk factors are broad, nonspecific, and unlikely to identify persons who will die by suicide.

24. *Id.* at 33-35.

This Article, the first comprehensive critique of the GLS,²⁵ argues that the student suicide surveillance²⁶ communications, policies, and practices advanced through the GLS are not supported by evidence; they have no reasonable chance of meaningfully reducing youth suicide rates²⁷ and pose unacceptable risks to their targets. These strategies aim to identify, isolate, contain, control, monitor, expose, and research at-risk students, such as students with disabilities, racial/ethnic, sexual, and religious minorities. This Article argues that GLS suicide surveillance strategies making at-risk youths' suicidality "everyone's business" violates their privacy and autonomy and denies them the growth that comes from making mistakes without public shame.²⁸ These strategies stigmatize targeted students, cut them off from trusted supports, and may ironically make them more likely to die by suicide. The GLS strategies also unnecessarily involve law enforcement, and GLS research and data collection raises additional concerns about

25. To date, two other law reviews have significantly addressed the GLS: Katherine McKeon Curran, *Mental Health Screening in Schools: An Analysis of Recent Legislative Developments and the Legal Implications for Parents, Children and the State*, 11 QUINNIAC HEALTH L.J. 87 (2008) (expressed approval of the GLS; did not address peer-to-peer surveillance or suicide prevention effectiveness, and discussion limited to students in primary and secondary schools) and Vivian Le, *Fighting against the Silent Epidemic: An Imperative for a Federal Suicide Prevention Act Narrowing the Lens on Mental Health*, 25 S. CAL. REV. L. & SOC. JUST. 87, 96 (2015) (expressed approval of GLS; listed "common risk factors" and "warning signs of suicide" but did not discuss their inability or ability to predict suicide).

26. Some readers may be surprised by my use of the word *surveillance* to describe these activities. However, the word aptly describes the activities recommended by the GLS and carried out in school settings. Dictionary definitions include "close watch kept over someone or something," *Surveillance*, MERRIAM-WEBSTER'S COLLEGIATE DICTIONARY, 1802 (11th ed. 2012), and the Garrett Lee Smith Memorial Act, Pub. L. No. 108-355 § 3, 118 Stat. 1404, 1406 (2004) uses the term explicitly ("ensuring the surveillance of youth suicide early intervention and prevention strategies"; "ensuring the surveillance of suicidal behaviors and nonfatal suicidal attempts"). A public health definition of "[s]urveillance—The ongoing, systematic collection, analysis, and interpretation of health data with timely dissemination of findings," U.S. DEP'T OF HEALTH & HUM. SERVS., OFF. OF THE SURGEON GENERAL, & NAT'L ALL. ON SUICIDE PREVENTION, 2012 NATIONAL STRATEGY FOR SUICIDE PREVENTION: GOALS AND OBJECTIVES FOR ACTION 143 (Sept. 2012) [hereinafter NATIONAL STRATEGY FOR SUICIDE PREVENTION], applies regardless of the intentions of those who report and ultimately contribute to the GLS data collection efforts.

27. See Large et al., *supra* note 7, at 161 (arguing that knowing about a wider range of risk factors will not reduce uncertainty about suicide and that further suicide prediction research will not result in greater ability to predict suicides).

28. See James Bennet, Opinion, *Do You Know What You've Given Up?*, N.Y. TIMES, (Apr. 10, 2019), <https://www.nytimes.com/2019/04/10/opinion/privacy-project-launch.html>.

algorithmic predictive policing for suicide that may result in even more law enforcement involvement. This research, using students as guinea pigs,²⁹ is conducted by and for mental health professionals, with significant implications for civil rights that extend beyond the school context.

Part I describes the flawed rationale for the original GLS provided in the Congressional findings. Part II summarizes existing empirical research on school-based suicide prevention programs and suicide treatment, which strongly suggests they are not effective. Part III elucidates harms that may result from suicide screening and surveillance of students, including stigmatization; violated privacy; estrangement from peers, parents, therapists, and other social supports; police involvement and warrantless searches; and potential exacerbation of suicidality. Part IV considers harms that may result from these policies outside the school context in employment and involuntary civil commitment settings. Part V explores similarities in the threats posed by school violence and suicide surveillance and suggests that the latter may have attracted comparatively little attention because the paternalism of suicide surveillance may effectively obscure the risks that it imposes. Part VI concludes with recommendations to stop investing in suicide surveillance and start including people with disabilities and other members of targeted “at risk” communities on campus in meaningful ways.

I. THE GARRETT LEE SMITH MEMORIAL ACT RATIONALE

The GLS was named after Garrett Lee Smith, son of Senator Gordon and Mrs. Sharon Smith, who died by suicide in 2003.³⁰ Through the GLS, the U.S. HHS Secretary, acting through the Assistant Secretary at SAMHSA, awards grants³¹ targeting elementary school or secondary school³² children ten years and up for screening programs to detect youth who are at risk for mental or emotional disorders that may lead to

29. 150 CONG. REC. H6865-02 (daily ed. Sept. 8, 2004) (statement of Rep. King) (“Our children and teenagers are too valuable to be used as guinea pigs on this issue . . . While this legislation does not fund suicide education for children under the age of 10, it did start out younger than the age of 10. I do not think we need to take chances with our young people.”).

30. 150 CONG. REC. E1721 (daily ed. Sept. 29, 2004) (statement of Rep. Baldwin).

31. 42 U.S.C. § 290bb-36(a) (“[s]hall award grants or cooperative agreements to eligible entities . . .”).

32. *See* 42 U.S.C. §290bb-36(a)(1).

a suicide attempt, and that are integrated with school systems.³³ It also awards grants targeting high school, college, and university students³⁴ up to twenty-four years old by educating students, families, faculty, and staff to increase awareness of mental and substance use disorders,³⁵ administers mental and substance use disorder screenings and assessments,³⁶ and facilitates training of students, faculty, and staff to respond effectively to students with mental and substance use disorders.³⁷

Data provided by college mental health counselor organizations played an influential role in the enactment of the original 2004 GLS. The Congressional findings emphasized statistics about suicide as the rationale for the GLS. The findings emphasized that “suicide [is] the third overall cause of death between the ages of 10 and 24 . . . [and] the third overall cause of death among college-age students.”³⁸ However, these two age groups have long had, and continue to have, the lowest suicide rates of *any* population.³⁹ Even though the death rate is low, Congress relied on reports from college mental health counselors and their organizations about the rising prevalence of mental disorders on college campuses and, accordingly, the need for more funding for college mental health counselors.⁴⁰ This rationale was flawed and problematic for at least three reasons: (1) its mental disorder prevalence claims were unsubstantiated; (2) the prevalence of mental disorders (e.g., depression) is not a good indicator of the need for psychological

33. *Id.* (“develop and implement State-sponsored statewide or tribal youth suicide early intervention and prevention strategies in schools, educational institutions, juvenile justice systems, substance use disorder programs, mental health programs, foster care systems, and other child and youth support organizations”).

34. 42 U.S.C. § 290bb-36(a)(3).

35. 42 U.S.C. § 290bb-36(c)(7)-(8).

36. 42 U.S.C. § 290bb-36(c)(1).

37. 42 U.S.C. § 290bb-36(c)(10).

38. Garrett Lee Smith Memorial Act, Pub. L. No. 108-355 § 2, 118 Stat. 1404, 1404 (2004).

39. Holly Hedegaard et al., *Increase in Suicide Mortality in the United States, 1999-2018*, CTRS. FOR DISEASE CONTROL & PREVENTION, NCHS Data Brief No. 362 (Apr. 2020), <https://www.cdc.gov/nchs/data/databriefs/db362-h.pdf>. (Reporting suicides per 100,000 persons: “Suicide rates among males were lowest for those aged 10-14, decreasing from 1.9 in 1999 to 1.2 in 2007 and then increasing to 3.7 in 2018,” and “[s]uicide rates were lowest among females aged 10-14. The rate for this age group increased from 0.5 in 1999 to 2.0 in 2018.” Suicide rates among males aged 15-24 were 16.8 in 1999 and 22.7 in 2018. Suicide rates among females aged 15-24 were 3.0 in 1999 and 5.8 in 2018.)

40. See *infra* notes 42-48 and accompanying discussion.

or psychiatric treatment,⁴¹ let alone the need for suicide surveillance; and (3) other claims provided in the Act's rationale were misleading, stigmatizing, and inflammatory.

The Prevalence Claims. The conclusion that “depression among freshmen has nearly doubled (from 8.2 percent to 16.3 percent)”⁴² cannot be drawn from the study that was cited in the Congressional findings. That study found that more freshmen “reported [frequently] feeling depressed at some point during the past year.”⁴³ But this may have been the result of greater inclusion of depressed students, more students feeling comfortable *reporting* feeling depressed, or more such students participating in the survey when it was administered the following year. “[Frequently] feeling depressed at some point during the past year” is also not the same thing as having *depression* or major depressive disorder.⁴⁴

Absent Justifications for Surveillance. In addition, the prevalence of mental disorders (like depression) is not a good measure of the need for on-campus services.⁴⁵ Many students with depression, for example, may not necessarily benefit from, need, or want mental health treatment in general, let alone treatment on campus from college counselors, despite the counselors' claims to the contrary.⁴⁶ More importantly,

41. David Mechanic, *Is the Prevalence of Mental Disorders a Good Measure of the Need for Services?*, 22 HEALTH AFF. 8, 8 (2003).

42. Garrett Lee Smith Memorial Act, Pub. L. No. 108–355 § 2, 118 Stat. 1404, 1404 (2004) (citing Thomas Bartlett, *Freshmen Pay, Mentally and Physically, As They Adjust to Life in College*, 48 CHRON. HIGHER EDUC. A35, A35 (2002)).

43. The study cited in the article is Linda J. Sax et al., *The American Freshman: National Norms for Fall 2001*, HIGHER EDUC. RES. INST., UNIV. OF CALIFORNIA AT LOS ANGELES 14, 19 (2001).

44. See the criteria for “Major Depressive Disorder” in AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, FIFTH EDITION (DSM-5) 160-61 (2013), which requires “[d]epressed mood most of the day, nearly every day” or “markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day” for at least two weeks, in addition to other symptoms which may include “recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide,” “[d]iminished ability to think or concentrate, or indecisiveness, nearly every day,” “[f]eelings of worthlessness or inappropriate guilt (which may be delusional) nearly every day,” among others.

45. Mechanic, *supra* note 41, at 8.

46. See SUSAN STEFAN, RATIONAL SUICIDE, IRRATIONAL LAWS: EXAMINING CURRENT APPROACHES TO SUICIDE IN POLICY AND LAW 406 (2016) (“it may be better all around for colleges and universities to give all students vouchers for a specific number of completely confidential mental health sessions by independent community providers located convenient to the university but unconnected with it.”).

nothing in the rationale supports engaging in school or campus-wide suicide screening and surveillance of students.

Stigmatization. The GLS also invoked misleading, inflammatory claims about adolescents with depression to make the case for more counselor funding. Reflecting on “clear evidence of an increased incidence of depression among college students,”⁴⁷ the GLS stated that “[w]ithout treatment, researchers recently noted that ‘depressed adolescents are at risk for school failure, social isolation, promiscuity, self-medication with drugs and alcohol, and suicide.’”⁴⁸ This claim is misleading. Major depressive disorder or depression in adolescents has no known relationship to promiscuity⁴⁹ and is a poor predictor of suicide.⁵⁰ It has not been shown to be a demographic predictor of school failure.⁵¹ The drafters later warned that “serious mental illness is highly correlated with substance dependence or abuse . . . [and that in 2001,] 20.3% were dependent on or abused alcohol or illicit drugs.”⁵² In many ways, the reports of college counselors’ “concerns about the increasing number of students with more serious psychological problems”⁵³ may more accurately have reflected (or purposely invoked) concerns about

47. Garrett Lee Smith Memorial Act, Pub. L. No. 108–355 § 2, 118 Stat. 1404, 1405 (2004).

48. *Id.*

49. The DSM-5, *supra* note 44, mentions nothing about a relationship between major depressive disorder and promiscuity or hypersexuality, and I know of no studies suggesting such a relationship.

50. See *supra* notes 8-12 and accompanying discussion.

51. See Salvatore A. Barbera et al., *Review of Undergraduate Student Retention and Graduation Since 2010: Patterns, Predictions, and Recommendations for 2020*, 22 J. COLLEGE STUDENT RETENTION 227, 244 (depression was not cited as a predictor, but “[n]ational statistics show that low-income, first-generation, and underrepresented minority students are less likely to graduate . . . Higher GPA is almost invariably linked with persistence across different contexts”) (citations omitted).

52. Garrett Lee Smith Memorial Act, Pub. L. No. 108–355 § 2, 118 Stat. 1404, 1405 (2004). Linking serious mental illness with substance abuse may have brought to many readers’ minds the article Julie L. Nicklin, *Drug and Alcohol Arrests Increased on Campuses in 2000*, 48 CHRON. HIGHER EDUC. A32 (2002), which had appeared in the same issue as another article mentioned in the Congressional findings: Bartlett, *supra* note 42. See Samuel R. Bagenstos, *The Americans with Disabilities Act as Risk Regulation*, 101 COLUM. L. REV. 1479, 1484-85 (2001) (describing “systematic cognitive errors that affect the public’s perceptions of risk,” such as “overestimates of small risks and underestimates of large ones; overreaction to prominent or sensational sources of risk; . . . the irrational desire to eliminate *all* risk from a given source; and fear of ‘new’ or involuntarily imposed risks even where other risks are just as great.”) (emphasis in original) (citations omitted).

53. Garrett Lee Smith Memorial Act § 2, 118 Stat. 1404, 1405 (2004).

the prospects of a fully integrated educational system, in which students with serious psychological problems and other mental disabilities can fully participate and are fully integrated into the educational system.

II. THE EMPIRICAL EVIDENCE ON SUICIDE SURVEILLANCE AND PREVENTION

A. Almost All Psychiatric Treatments for Suicide Have Scant, If Any, Evidence of Effectiveness

The rationale for the GLS assumed (i) that it is possible to meaningfully predict and identify which students will die by suicide and (ii) that students identified and engaged in college counseling can be effectively treated for suicidality.⁵⁴ Yet interventions for reducing youth suicide have not been found to reduce suicide rates.⁵⁵ Systematic reviews of treatments for the prevention and management of suicide in adults⁵⁶ reveal only two treatments that may reduce completed suicides: (1) the World Health Organization's Brief Intervention and Contact method (WHO-BIC) in developing countries⁵⁷ and (2) lithium for patients with "unipolar or bipolar mood disorders."⁵⁸ Other treatments

54. See *supra* note 47 and accompanying discussion.

55. See Jo Robinson et al., *What Works in Youth Suicide Prevention? A Systematic Review and Meta-Analysis*, 4 ECLINICALMEDICINE 52 (2018).

56. Kristen E. D'Anci et al., *Treatments for the Prevention and Management of Suicide: A Systematic Review*, 171 ANNALS INTERNAL MED. 334 (2019).

57. See *id.* at 338, explaining that "[t]he intervention included an educational session on suicide prevention followed by regular contact with a trained provider by telephone or in person for up to 18 months. The findings suggest that WHO-BIC reduced the incidence of suicide compared with the control condition (3 of 1041 vs. 24 of 987)," and citing Natalie B.V. Riblet et al., *Strategies to Prevent Death by Suicide: Meta-Analysis of Randomised Controlled Trials*, 210 BR. J. PSYCHIATRY 396 (2017). Further details are provided in Alexandra Fleischmann et al., *Effectiveness of Brief Intervention and Contact for Suicide Attempters: A Randomized Controlled Trial in Five Countries*, 86 BULL. WORLD HEALTH ORG. 703 (2008) ("Suicide attempters ($n = 1867$) identified by medical staff in the emergency units of eight collaborating hospitals in five culturally different sites (Campinas, Brazil; Chennai, India; Colombo, Sri Lanka; Karaj, Islamic Republic of Iran; and Yuncheng, China) participated . . . in a [RCT] to receive either [treatment as usual, or TAU] or [TAU] plus brief intervention and contact (BIC), which included patient education and follow-up. Significantly fewer deaths [per family report] from suicide occurred in the BIC than in the treatment-as-usual group" (2 [0.2%] vs. 18 [2.2%])).

58. See D'Anci et al., *supra* note 56, at 339, which cited Andrea Cipriani et al., *Lithium in the Prevention of Suicide in Mood Disorders: Updated Systematic Review and Meta-Analysis*, 346 BMJ f3646 (2013) (0/244 suicides vs. 6/241 with placebo; for unipolar depression, 0/143 suicides vs. 5/137 with placebo).

have been found to reduce suicide attempts or ideation, but not completed suicides. One systematic review found that cognitive behavioral therapy (CBT) reduced suicide attempts with moderate evidence⁵⁹; that dialectical behavioral therapy (DBT) reduced suicidal ideation with low evidence⁶⁰; and that Collaborative Assessment and Management of Suicidality (CAMS) reduced suicidal ideation with low evidence.⁶¹ However, none of the three reported effects on completed suicides.

B. School-Based Suicide Prevention Programs Have Not Been Found to Reduce Suicides in Empirical Research

Despite the claims of GLS proponents and investigators, school-based suicide prevention programs still do not have evidence suggesting that they are effective more than sixteen years after the GLS became law.⁶²

59. See D'Anci et al., *supra* note 56, at 336, which cited Peter C. Göttsche & Pernille K. Göttsche, *Cognitive Behavioural Therapy Halves the Risk of Repeated Suicide Attempts: Systematic Review*, 110 J. ROYAL SOC'Y MED. 404, 408 (2017) (There were seventy-three suicide attempts among those receiving CBT-based therapy, and 146 among those receiving TAU). *But see* Keith Hawton et al., *Psychosocial Interventions for Self-Harm in Adults*, COCHRANE DATABASE OF SYSTEMATIC REV., Art. No.: CD012189 at 29 (2016) ("Fifteen trials reported data on suicides during follow-up; however, there was no evidence of a significant treatment effect for CBT-based psychotherapy [vs. TAU] on suicides by final follow-up. In [one study], there was one death in the experimental group that medical staff considered to be a suicide . . .").

60. See D'Anci et al., *supra* note 56, at 336 (citing Hawton et al., *supra* note 59, at 31, which reported that "[a]lthough a suicide occurred in the DBT arm of [one study] before the post-intervention assessment, there were no suicides in [two others]. There was therefore no evidence of a significant treatment effect for this outcome.") (citations omitted).

61. See D'Anci et al., *supra* note 56, at 337, which cited David A. Jobes et al., *A Randomized Controlled Trial of the Collaborative Assessment and Management of Suicidality Versus Enhanced Care as Usual with Suicidal Soldiers*, 80 PSYCHIATRY 339, 340 (2017) ("Those who received CAMS were less likely to report SI at 3 months; further group differences were not otherwise seen." In fact, SI was reported in 72.9% (CAMS) vs. 69.1% (control) at one month; 36.9% vs. 61.3% at three months; 35.1% vs. 38.3% at six months; and 38.6% vs. 39.7% at twelve months.).

62. The following subsections II.B.1, II.B.2, and II.B.3 summarize relevant portions of Gil Zalsman et al., *Suicide Prevention Strategies Revisited: 10-Year Systematic Review*, 3 LANCET PSYCHIATRY 646 (2016).

1. School-Based Suicide Prevention Programs

Systematic reviews of school-based suicide programs consistently indicate “no effect on actual suicidal behaviour.”⁶³ Of three large randomized controlled trials (RCTs) of school-based suicide prevention programs “emphasizing mental health literacy, suicide risk awareness, and skills training in schools,”⁶⁴ two found that students exposed to the program were slightly less likely to report having made a suicide attempt than students who were not exposed to the program.⁶⁵ One of these found that 3.0% of students who were enrolled in a school-based suicide prevention program reported having made a suicide attempt at the end of three months, compared with 4.6% of their peers.⁶⁶ A second RCT found that 0.70% of students who enrolled in a twelve-month program said that they had made a suicide attempt within the past twelve-months; slightly fewer students who had not enrolled in the program, or 1.51%, reported the same.⁶⁷ A third RCT, however, found just the opposite—students who were assigned to the suicide prevention program ended up being *more* likely to report making a suicide attempt than their peers (4.6% v. 3.0%).⁶⁸

At best, the results of these three RCTs provide only weak evidence of effectiveness for these programs. In addition, what students *report* about their suicidal behavior may not accurately reflect suicidal behavior. In the first two RCTs, slightly lower numbers of students *reported* suicide attempts among those exposed to the suicide programs,

63. *Id.* at 651 (reporting that “[s]ystematic reviews, although including few RCTs, consistently indicate improved knowledge and attitudes towards suicide but no effect on actual suicidal behaviour.”).

64. *Id.*

65. Robert H. Aseltine et al., *Evaluating the SOS Suicide Prevention Program: A Replication and Extension*, 7 BMC PUB. HEALTH 161 (2007); Danuta Wasserman et al., *School-Based Suicide Prevention Programmes: The SEYLE Cluster-Randomised, Controlled Trial*, 385 LANCET 1536, 1536 (2015).

66. Aseltine et al., *supra* note 65.

67. Wasserman et al., *supra* note 65, at 1536 (observing no effects for any of the three interventions at three months. At twelve months, fourteen (0.70%) and fifteen (0.75%) YAM students reported incident suicide attempts and severe suicidal ideation, respectively, compared to thirty-four (1.51%) and thirty-one (1.37%) students in the control group. No participants completed suicide.).

68. Holly C. Wilcox et al. *The Impact of Two Universal Randomized First- and Second-Grade Classroom Interventions on Young Adult Suicide Ideation and Attempts*, 95 DRUG & ALCOHOL DEPENDENCE S60 (2008) (observing no differences between control and intervention groups on suicidal ideation or attempts).

but this may have been because these programs *made them feel more ashamed or embarrassed about having made a suicide attempt*—not because the suicide programs were effective in reducing their suicidal behavior. Lastly, none of these studies demonstrated effects on *completed suicides*.

2. Suicide Awareness Programs

Of three “[p]rospective cohort studies assessing awareness programmes in schools,”⁶⁹ one found allegedly positive effects on “chang[ing] unwanted attitudes toward suicide and increas[ing] help-seeking attitudes,” but it did not evaluate effects on suicide attempts or completed suicides.⁷⁰ In a second study, “[s]taff did not report any increase in student help-seeking, and students’ reports of help-seeking from 11 of 12 different types of helpers did not increase.”⁷¹ The authors also did not evaluate suicide attempts or completed suicides. A third study “showed immediate and significant results in reducing suicide ideation and threats,” but the authors also did not evaluate suicide attempts or completed suicides.⁷² None of the three evaluated suicide attempts or completed suicides.

3. Gatekeeper Training

i. The Evidence

According to the CDC, “[g]atekeeper training is designed to train teachers, coaches, clergy, emergency responders, primary and urgent care providers, and others in the community to identify people who may be at risk of suicide and to respond effectively, including facilitating treatment seeking and support services.”⁷³ According to the authors of

69. Zalsman et al., *supra* note 62, at 651.

70. Jerry Ciffone, *Suicide Prevention: An Analysis and Replication of a Curriculum-Based High School Program*, 52 SOC. WORK 41, 44 (2007).

71. Stacey Freedenthal, *Adolescent Help-Seeking and the Yellow Ribbon Suicide Prevention Program: An Evaluation*, 40 SUICIDE & LIFE-THREATENING BEHAV. 628, 628 (2010).

72. Carole Hooven et al., *Long-term Outcomes for the Promoting CARE Suicide Prevention Program*, 34 AM. J. HEALTH BEHAV. 721, 726 (2010).

73. CDC, *Preventing Suicide*, *supra* note 14, at 35.

one of the most respected systematic reviews of suicide prevention programs, “[n]o RCT [has] show[n] that gatekeeper training alone affected suicide rates.”⁷⁴ A 2014 Cochrane review summarized that “[f]our [controlled before-and-after studies or] CBAs explored effects of training ‘gatekeepers’ to recognize and respond to warning signs of emotional crises and suicide risk in students they encountered,”⁷⁵ and reported that “no evidence was found evaluating its effect on suicidal behavior.”⁷⁶ There *is* evidence from these studies, however, that students, peer advisors residing in student accommodation, and faculty and staff who were exposed to these programs were generally able to remember what they were taught.⁷⁷ The gatekeepers were taught to engage in suicide screening and surveillance; however, it is debatable whether this practice is the right thing to do in the first place, is of value in actually preventing suicide, is free from unintended adverse consequences, and, ultimately, is good health policy.

ii. What SAMHSA and the CDC Say

SAMHSA’s Toolkit repeatedly recommended various forms of suicide screening and surveillance,⁷⁸ including the adoption of gatekeeper training programs,⁷⁹ but did not cite studies supporting their effectiveness. The CDC’s *Preventing Suicide: A Technical Package of Policy, Programs, and Practices* also recommended gatekeeper training,⁸⁰ but the evidence it provided does not support its effectiveness.

74. Zalsman et al., *supra* note 62, at 654. (“Gatekeeper training is usually implemented along with other initiatives, making it difficult to identify the effect of this specific intervention on suicide rates.”).

75. Curtis S. Harrod et al., *Interventions for Primary Prevention of Suicide in University and Other Post-Secondary Educational Settings*, COCHRANE DATABASE OF SYSTEMATIC REVIEWS, Art. No.: CD009439 at 2 (2014).

76. *Id.*

77. *Id.* (“Limited evidence suggested minimal longer-term effects of gatekeeper training on suicide-related knowledge.”).

78. *See e.g.*, SAMHSA, *Preventing Suicide Toolkit for High Schools*, *supra* note 18, at 13 (describing “How Schools Can Help Prevent Suicide,” including “Training, for all staff, on recognizing and responding to students who may be at risk of suicide,” “[o]ne or more programs to engage students in suicide prevention” of their peers, and “[a] suicide screening program.”).

79. *See id.* at 114-17.

80. CDC, *Preventing Suicide*, *supra* note 14, at 35.

The CDC report stated that counties that implemented community gatekeeper training “had significantly lower youth suicide rates one year following the training implementation. This finding equates to a decrease of 1 suicide death per 100,000 youth ages 10 to 24.”⁸¹ However, the study cited by the CDC did not evaluate gatekeeper training “in isolation but rather in concert with other prevention strategies selected by grantees to be consistent with their locale and cultural context.”⁸² In addition, the 0.001% difference in completed suicide rates between counties implementing gatekeeper training and those without might be explained by differences between gatekeeper and control counties that have nothing to do with gatekeeper training.⁸³ The CDC also described a study on suicide attempts⁸⁴ with the same methodological limitations⁸⁵ and several others.⁸⁶ Neither study cited by the CDC attempted to evaluate unintended consequences of suicide screening and surveillance, nor did the CDC consider or discuss them in its report.

The selective reporting of the U.S. HHS, SAMHSA, and CDC suggest that the GLS suicide surveillance research may function to drum up support for more suicide surveillance policies, practices, and further research. Opponents of the original GLS may have been right to be concerned about lack of oversight for the GLS, with “virtually no

81. *Id.* at 37 (citing Christine Walrath et al., *Impact of the Garrett Lee Smith Youth Suicide Prevention Program on Suicide Mortality*, 105 AM. J. PUB. HEALTH 986 (2015)).

82. Walrath et al., *supra* note 81, at 987.

83. *See id.* at 992 (“unaccounted-for differences between exposed and control counties may possibly have influenced the results.”).

84. CDC, *Preventing Suicide*, *supra* note 14, at 37 (citing Lucas Godoy Garraza et al., *Effect of the Garrett Lee Smith Memorial Suicide Prevention Program on Suicide Attempts Among Youths*, 72 JAMA PSYCHIATRY 1143 (2015)).

85. The intervention included not just gatekeeper training but “[c]omprehensive, multifaceted suicide prevention programs, including gatekeeper training, education and mental health awareness programs, screening activities, improved community partnerships and linkages to service, programs for suicide survivors, and crisis hotlines.” Garraza et al., *supra* note 84, at 1143. In addition, the authors acknowledged that “there could be unaccounted differences between intervention and control counties that are influencing the results. For example, it is plausible that the location and timing of implementation may have been influenced by the level of readiness of the local child-serving agencies and administrative entities to participate in the GLS program. In such scenarios, the estimated effect may overstate the potential effect of implementation.” *Id.* at 1148.

86. *E.g.*, youth *self-reports* of suicide attempts may not reflect actual suicide attempts made with 100% accuracy.

mechanism to measure effectiveness or actual benefit of new services.”⁸⁷ Meanwhile, the stigmatizing communications arising from the GLS may have important adverse effects on schools, public opinion, and policies related to employment and involuntary commitment discussed *infra* that have attracted very little commentary or attention.

III. HARMS OF SCHOOL SUICIDE SCREENING AND SURVEILLANCE TO STUDENTS

A. Discrimination and Dismissal from School

1. College/University Case History

Extensive case history suggests that college or university involvement in student suicidality—rather than helping the students—often leads to automatic dismissals to help the colleges and universities avoid negligence liability.⁸⁸ Complaints filed by the Department of Education’s Office of Civil Rights against Georgetown⁸⁹ and Mount Holyoke,⁹⁰ among others, find colleges and universities summarily kicked out suicidal students under student disciplinary codes and imposed extra requirements, such as “submit[ting] letters of recommendation from an employer as a condition for return” or “demonstrat[ing] amelioration of disability-related behavior.” Disability attorney Susan Stefan observes that “[i]ronically, these policies were implemented and enforced by the school’s mental health staff and disability offices: the very people that suicidal students might expect would be on their side.”⁹¹

One student at Princeton attempted suicide, immediately changed his mind, was hospitalized, discharged, and explicitly found *not* to be a

87. 150 CONG. REC. E1573-01 (daily ed. Sept. 8, 2004) (statement of Rep. Doolittle).

88. STEFAN, *supra* note 46, at 395.

89. Letter from Office of Civil Rights, Dep’t of Educ., to Georgetown Univ., Complaint No. 11-11-2044 (Oct. 13, 2011), <http://www.bazelon.org/wpcontent/uploads/2017/01/10.13.11-Georgetown-OCR-Letter.pdf>.

90. Letter from Office of Civil Rights, Dep’t of Educ., to Mt. Holyoke Coll., Complaint No. 01-08-2024, (July 18, 2008), <http://www.bazelon.org/wp-content/uploads/2017/01/7.18.08-Mount-Holyoke-OCR-Letter.pdf>.

91. STEFAN, *supra* note 46, at 396.

danger to himself or others.⁹² The University, however, called his mother and banned him from his dorm and classes unless he agreed to “voluntarily” withdraw for a year.⁹³ To be readmitted, he had to comply with all the University’s psychiatric treatment recommendations and evaluations.⁹⁴

In another case, a straight-A student at George Washington University visited the University’s Hospital after feeling suicidal.⁹⁵ “Within about 12 hours of his hospital admission, [he] was given a disciplinary letter barring him from his dorm.”⁹⁶ Within thirty-six hours, the University charged him with a disciplinary infraction for “endangering behavior” and threatened him with “suspension, expulsion and/or criminal charges” if he did not withdraw⁹⁷—“if you come onto campus for any reason, you will be trespassing and may be arrested.”⁹⁸

In another case not the subject of litigation, a student at the University of California Santa Barbara (UCSB)

got scared after she cut herself deeper than she had intended in the shower and texted a friend, who told their resident advisor. Soon after, UCSB Housing and Residential Services slipped an envelope under [her] door, notifying her of her ‘alleged involvement’ in a housing policy violation . . . By cutting herself in the bathroom, [she] had taken part in ‘actions which disrupt

92. Complaint at 2, 9, *W.P. v. Princeton Univ. et al.*, No. 3:14-cv-01893-JAP-TJB (D.N.J. Mar. 26, 2014), <https://online.wsj.com/public/resources/documents/princetonsuit.pdf>.

93. *Id.* at 3, 8-9.

94. *Id.* at 13 (“On April 9, 2012, W.P. was informed by Princeton that his readmission, which could not take place before spring 2013, would be subject to ‘serious conditions’ which would include evaluation by CPS and a ‘treatment plan which you must engage in during your absence’ . . . [which] included ‘at least weekly’ individual psychotherapy sessions, compliance with his medication regimen, and regular consultations with a psychiatrist for medication management . . . As part of the readmission process, W.P. also was required to submit to a readmission evaluation at CPS for which he was required to authorize treatment providers to discuss his progress with CPS clinical staff and to authorize CPS clinical staff to discuss his readmission evaluation with Princeton administration.”).

95. Complaint at 5, *Nott v. George Washington Univ.*, No. 05-8503 (D.C. Super. Ct. Oct. 2005), <http://www.bazelon.org/wp-content/uploads/2017/03/nottcomplaint.pdf>.

96. *Id.* at 4.

97. *Id.* at 6.

98. *Id.* at 12.

the normal functioning and operation of the residence hall' and 'actions which pose a significant risk of harm to self or to the community.'⁹⁹

Her resident hall's "assistant director told her she could be suspended or expelled and that she had put the entire high-rise in danger. He allegedly said it was possible [she] would become so emotionally unstable that she might start running around the halls, threatening her floormates with a knife."¹⁰⁰ He said "she could only stay in school if she waived her confidentiality and allowed her therapist to provide weekly reports to the administration."¹⁰¹ According to the student, the therapist "told me they were watching me, and if anything I said sounded in any way dangerous, they had the authority to kick me out of school . . . Everyone kept telling me I was on their radar. They said "on their radar" over and over and over."¹⁰²

2. Analysis

These and many other cases demonstrate the real risks of expulsion posed to these students by school suicide surveillance and the extreme biases of college and universities. There are no costs to colleges and universities of allowing students to remain enrolled, come back to campus, or continue with a lighter load.¹⁰³ The cases also appear to reflect a misunderstanding of college and university responsibilities for student suicidality. As the Massachusetts Supreme Court summarized in a 2018 case involving an MIT student:

Nonclinicians are also not expected to discern suicidal tendencies where the student has not stated his or her plans or intentions to commit suicide. Even a student's generalized statements about suicidal thoughts or ideation are not enough, given their prevalence in the

99. Katie J.M. Baker, *How Colleges Flunk Mental Health*, NEWSWEEK (Feb. 11, 2014, 11:13 AM), <https://www.newsweek.com/2014/02/14/how-colleges-flunk-mental-health-245492.html>.

100. *Id.*

101. *Id.*

102. *Id.*

103. STEFAN, *supra* note 46, at 398.

university community. The duty is not triggered merely by a university's knowledge of a student's suicidal ideation without any stated plans or intentions to act on such thoughts.¹⁰⁴

As one mourner observed, students known by school administrations to have mental health problems risk being asked to leave, yet “[a]t Brown, if a student rapes a colleague, the university will bend over backwards to ensure that said student stays enrolled and remains on campus.”¹⁰⁵ Colleges and universities may also expel students who engage in suicidal behavior perceived by colleges and universities as disruptive, while tolerating protests and activism typical of any American college or university that some might consider equally disruptive, but which do not result in discipline or requests for withdrawal.¹⁰⁶

B. Studies Evaluating Unintended Consequences of School Suicide Screening and Surveillance

“Several [studies have] noted some evidence that programs focused on raising awareness of suicide resulted in harmful effects on suicide-related attitudes, hopelessness, and coping,”¹⁰⁷ particularly on male students.¹⁰⁸ One study also found that 50% of males with a history of a prior suicide attempt did not think that other students should participate in these programs, and 50% felt the “program[s] will make it harder to

104. *Dzung Duy Nguyen v. Mass. Inst. of Tech.*, 96 N.E.3d 128, 144 (Mass. 2018) (discussing universities' possible duties *in loco parentis* to prevent student suicide).

105. Letter to Brown Community on the Death of Michael Dawkins 4 (Nov. 2, 2013), https://issuu.com/okezienwka/docs/letter_to_the_brown_community_-_11-.

106. NAT'L COUNCIL ON DISABILITY, MENTAL HEALTH ON COLLEGE CAMPUSES: INVESTMENTS, ACCOMMODATIONS NEEDED TO ADDRESS STUDENT NEEDS 83 (July 21, 2017), https://ncd.gov/sites/default/files/NCD_Mental_Health_Report_508_0.pdf [hereinafter NCD, MENTAL HEALTH ON CAMPUS] (criticizing colleges/universities for too often imposing discipline when students with mental disabilities “are presumed to be ‘acting out’ or presenting some form of disruption that is out of the norm.”).

107. Harrod et al., *supra* note 75, at 20.

108. James C. Overholser et al., *Suicide Awareness Programs in the Schools: Effects of Gender and Personal Experience*, 28 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 925, 930 (1989) (“[t]he curriculum was found to have a slight negative effect on the level of hopelessness of the male students.”).

deal with [their] friends' problems,"¹⁰⁹ suggesting that males with a prior suicide attempt are more likely to have negative reactions to these programs. Unfortunately, this group is also more likely to die by suicide.

Proponents of suicide screening, when confronted with the studies discussed *supra*, often respond by citing another study, which found that high school students who specifically agreed to participate in the suicide prevention program (35.6% did not) did not experience adverse psychiatric symptoms at the end of the study period.¹¹⁰ Overall, the effects of student suicide screening on short-term suicidality are somewhat unclear.

In general, however, very few studies have attempted to evaluate potential adverse consequences from school suicide screening and surveillance, and suicide researchers have not considered many other short-term and long-term harms that might result from school suicide surveillance. No attempts have been made to determine, for example, whether claiming (incorrectly) that most if not all suicides can be prevented with sufficient surveillance and effort, leaves victims' peers, teachers, and families unfairly blaming themselves when a suicide death occurs by no fault of their own. The harms discussed *infra* and the long-term impact of these procedures on policy and practices have also not been investigated.

C. Suicide Contagion Rhetoric and Stigmatization

Consistent with the GLS's public health approach to suicide prevention,¹¹¹ GLS initiatives problematically invoke suicide contagion rhetoric portraying suicidal students as burdens and infectious diseases. According to the SAMHSA Toolkit, "[a] student suicide can significantly impact other students and the entire school community,"¹¹² and "[a]dolescents can be susceptible to suicide contagion (sometimes called the 'copycat effect'),"¹¹³ resulting in suicide clusters. Even by SAMHSA's account, however, "groups of related

109. David Shaffer et al., *Adolescent Suicide Attempters. Response to Suicide-Prevention Programs*, 264 JAMA 3151, 3153 (1990).

110. Madelyn S. Gould et al., *Evaluating Iatrogenic Risk of Youth Suicide Screening Programs: A Randomized Controlled Trial*, 293 JAMA 1635, 1635-36 (2005).

111. Goldston & Walrath, *supra* note 16, at 5.

112. SAMHSA, *Preventing Suicide Toolkit for High Schools*, *supra* note 18, at 11.

113. *Id.*

suicides . . . [represent only] 1-2 percent of all adolescent suicides in the United States.”¹¹⁴ SAMHSA’s suicide rhetoric is concerning because when students at risk are treated as burdens and infectious diseases, they may be shunned by their schools and their peers and perhaps made even more likely to die by suicide.

A 2009 GLS project evaluation report that primarily described GLS initiatives in Maine high schools¹¹⁵ reveals a hypochondriacal preoccupation with containing, isolating, and monitoring not only the student first exposed to suicide risk, but everyone exposed to the first student. One of the *two main goals* of the Maine GLS initiative was to “manage the environment in the event of a suicide in order to prevent contagion.”¹¹⁶ High schools “prepared announcements in the event of a student death by suicide.”¹¹⁷ A postvention protocol also explained “how to identify students who may be at high risk for ‘copycat’ behavior . . . [and] cover[ed] appropriate and inappropriate memorial activities including directing the media to the superintendent for comment.”¹¹⁸ Some staff suggested that schools might be more concerned about containing and controlling suicidality in the event of a suicide death than in preventing incident suicides.¹¹⁹ Asked how she would respond in the event of a suicide, one Maine respondent replied that ““when there is a suicide it does have an impact on other people potentially. Those others would be monitored closely.””¹²⁰ Even assuming the validity of suicide contagion, these framings might be counterproductive and ultimately stigmatize and further isolate students perceived as being at risk for future suicide.

114. *Id.* at 86.

115. Mary Madden et al., *Garrett Lee Smith Memorial Project Evaluation Report Memorial Project Evaluation Report*, MAINE YOUTH SUICIDE PREVENTION PROGRAM, MAINE CTRS. FOR DISEASE CONTROL & PREVENTION (Nov. 2009), <https://www.maine.gov/suicide/docs/samhsa-ll-proj-eval.pdf> [hereinafter MAINE GLS REPORT].

116. *Id.* at 3.

117. *Id.* at 36.

118. *Id.* at 61.

119. *Id.* at 77 (noting that a staff member said “that this school is trying to get the protocols for youth suicide into a ‘nice looking package to float around’ and that the staff and teachers have been ‘shown’ the protocols but that they currently have a flow chart with directions regarding contact information and guidelines in the event of a student suicide and that the risk factors and warning signs were on the back of this chart.”).

120. *Id.* at 94-95.

D. “Once They Have Been Identified . . . Everybody Becomes Aware of Them”

At schools participating in the GLS, once a student has been identified as “at risk,” the consequences may be negative and long-lasting. In the words of a teacher at one GLS grant recipient high school in Maine, “youth were being ‘watched’ during their three year cohort at this high school . . . [and] ‘once they have been identified as long as they are here in the school, they’ve got people watching . . . Everybody becomes aware of them.’”¹²¹ At some schools under the grant, even bus drivers and kitchen staff members underwent suicide awareness training.¹²² Though GLS proponents may be confident that such surveillance of at risk students is ultimately in their best interests, it seems likely that some identified at risk students might find it impossible to remain in such an environment.

E. Notifying Parents

Although GLS initiatives encourage notifying parents of students determined to be at risk, notifying parents is not required under the Family Educational Rights and Privacy Act (FERPA).¹²³ Notifying parents is also not likely to be in a student’s best interests (1) because parents may be the cause of students’ suicidality, and (2) because notification may cut students off from key social supports, therapists, and other relationships of trust.¹²⁴

1. Not Required Under FERPA

The SAMHSA Toolkit encourages notification of parents by specifically reminding readers of a provision in FERPA permitting school officials to disclose information on students without consent in an emergency, if necessary, to protect the health or safety of the student

121. *Id.* at 43.

122. *Id.* at 31.

123. Family Educational Rights and Privacy Act, 20 U.S.C. § 1232g (2013).

124. Colleges and universities should make students aware of the FERPA exception so that they may make an informed decision to remove parent emergency contact information or take other action to avoid school use of the FERPA exception if they desire.

or others.¹²⁵ The SAMHSA Toolkit also warns that “[s]chools have been sued for negligence . . . [for f]ailure to notify parents if their child appears to be suicidal.”¹²⁶ However, the emergency exception permits but does not require disclosure.¹²⁷ Accordingly, schools risk violating FERPA and withdrawal of federal funding by notifying parents in these circumstances.

2. Parents May Be the Cause of Students’ Suicidality

Since parents may be the cause of students’ suicidality,¹²⁸ notification may make matters worse. Among the Maine GLS staff, there was a “general consensus among the interviewees that many of their students’ home lives are ‘not conducive to being supportive.’”¹²⁹ According to one staff member, “‘Whether it’s involvement with drugs or alcohol, the parents are often the biggest hindrance to the kids. You don’t want them more involved in the lives of the kids . . . ’”¹³⁰ Staff also reported that parents reacted negatively and became defensive when informed that staff had identified their child as potentially at risk for suicide.¹³¹ Some may feel that staff are impugning them as parents in these circumstances and may resent being called out or identified themselves.

3. Notifications May Cut Students Off from Social Supports and Psychotherapy

Notifying parents may also violate students’ confidences, impairing their abilities to maintain trusting relationships and to benefit from counseling and therapy. Whether a student’s trusted confidant is a peer, a school staff member, a counselor, or therapist, the ultimate effect when that confidant violates the student’s trust may be the end of a trusting

125. 34 C.F.R. § 99.36 (2021); SAMHSA, *Preventing Suicide Toolkit for High Schools*, *supra* note 18, at 12.

126. SAMHSA, *Preventing Suicide Toolkit for High Schools*, *supra* note 18, at 11.

127. 20 U.S.C. § 1232g(b)(1)(I) (2010); *see also* Aaron Konopasky, *Eliminating Harmful Suicide Policies in Higher Education*, 19 STAN. L. & POL’Y REV. 328, 334 (2008).

128. *See* Konopasky, *supra* note 127, at 335.

129. MAINE GLS REPORT, *supra* note 115, at 83.

130. *Id.* at 84.

131. *Id.* at 106-07.

relationship. Research demonstrates that confidentiality is important to maintaining trusting relationships in psychotherapy; that persons are much more likely to disclose in therapy when confidentiality is assured¹³²; and that a sizeable proportion of the population may avoid seeking therapy because of concerns about the possibility that a psychiatrist might divulge confidential information.¹³³ Evidence also suggests broad public support for unqualified confidentiality in psychotherapy, a position endorsed by 74% of high school students and undergraduates¹³⁴ and 85-90% of adults.¹³⁵ The results from these studies should also give pause to those who would dismiss the significance of violated confidences in other trusting relationships.

132. Jennifer Evans Marsh, *Empirical Support for the United States Supreme Court's Protection of the Psychotherapist–Patient Privilege*, 13 ETHICS & BEHAV. 385, 389, 393 (2003) (respondents presented with hypothetical of a patient who was suicidal to the point of being a possible candidate for involuntary civil commitment; they reported believing the patient would be substantially more willing to disclose if a psychotherapy-patient privilege existed); Kathryn M. Woods & J. Regis McNamara, *Confidentiality: Its Effects on Interviewee Behavior*, 11 PROF. PSYCHOL. 714, 718 (1980) (undergraduate (i) interviewees told sessions would be confidential were substantially more likely to disclose compared to (ii) interviewees given no expectations, who were substantially more likely to disclose compared to (iii) interviewees told sessions would not be confidential); *Functional Overlap Between the Lawyer and Other Professionals: Its Implications for the Privileged Communications Doctrine*, 71 YALE L.J. 1226, 1255 (1962) (For every two laymen claiming they would not be affected by the lack of a therapist privilege, five laymen claimed they would be less likely to make a full disclosure.).

133. Jacob Jay Lindenthal & Claudewell S. Thomas, *Psychiatrists, the Public, and Confidentiality*, 170 J. NERVOUS & MENTAL DISEASE 319 (1982) (22.0% of patients and 33.0% of nonpatients reported that the possibility that a psychiatrist might divulge confidential information held them back from seeking therapy).

134. David J. Miller & Mark H. Thelen, *Knowledge and Beliefs About Confidentiality in Psychotherapy*, 17 PRO. PSYCH. RSCH. & PRAC. 15, 15 (1986) (Respondents comprised mostly of high school, undergraduate students; 69% “believed that everything discussed in the context of psychotherapy is considered confidential by psychologists. In addition, most of the respondents (74%) maintained that there should be no exceptions to the proposition that all information should be confidential.”).

135. John Ormrod & Laura Ambrose, *Public Perceptions About Confidentiality in Mental Health*, 8 J. MENTAL HEALTH 413, 418 (1999) (percentage believing what is discussed is completely confidential and should be completely confidential for priest (77.1; 93.8), private psychotherapist (64.6; 89.6), clinical psychologist (50.0; 85.4), lawyer (47.9; 87.5)).

F. Police Involvement

1. Referrals from Schools, Emergency Call Centers, and Crisis Services

Police may be asked to apprehend students suspected of being at risk of suicide. In one case reported by Maine GLS staff, “a student, who had since gone home from school, ideated about a death by suicide.”¹³⁶ The school could not reach crisis providers, so they “called the County Sheriff to do a welfare check.”¹³⁷ Though the school did attempt to reach crisis providers before calling police, police involvement in these situations is not unusual. In fact, leading crisis guidelines from SAMHSA and other organizations designate *the police as the preferred first responders*—rather than the crisis providers—when a person in crisis is determined to be a danger to him or herself,¹³⁸ even when these individuals do not pose harm to other people and are not under suspicion of criminal activity. Every year, the U.S. National Suicide Prevention Lifeline (NSPL), which is managed by the nonprofit Vibrant Emotional Health under contract to SAMHSA, “covertly trace[s] tens of thousands of confidential calls, and police come to homes, schools, and

136. MAINE GLS REPORT, *supra* note 115, at 62.

137. *Id.* at 63. Staff from one of the case management agencies also reported that “if there is concern that a child is at risk for suicide, staff members will call crisis, then call the police as the latter will respond immediately.” *Id.* at 55.

138. U.S. Dep’t of Health & Hum. Servs., Substance Abuse & Mental Health Servs. Admin. (SAMHSA), *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit Executive Summary*, (Feb. 24, 2020) (“When a call goes into the Emergency Communication Center—911 dispatch—operators can be trained to triage those calls and identify whether the person in crisis is a danger to her or himself or an immediate threat to someone else. If not, then the person can be passed along to appropriate care in the mental health crisis system through a warm handoff to the crisis line. At that point, says Bruno, the crisis line can also do a secondary triage and determine whether it’s still a safe situation. If they decide that it’s unsafe, Bruno says they can do a warm handoff back to law enforcement, and law enforcement can send out Crisis Intervention Team (CIT) trained officers to go out and respond to those situations.”); CIT INT’L, CRISIS INTERVENTION TEAM (CIT) PROGRAMS: A BEST PRACTICE GUIDE FOR TRANSFORMING COMMUNITY RESPONSES TO MENTAL HEALTH CRISES 61 (Aug. 2019) (giving the Broome County 911 risk assessment, which asks, “Are you (or the person you are calling about) ATTEMPTING to hurt or kill yourself or anyone else RIGHT NOW?” If the person says s/he is attempting to harm him/herself (and not anyone else), law enforcement is dispatched.). These guidelines should be amended so that police are no longer dispatched in cases of suspected suicidality with no suspected risk of harm to others or criminal activity.

workplaces to forcibly take callers to psychiatric hospitals.”¹³⁹ The presence of the police will almost certainly be coercive and create risks of additional law enforcement involvement. The involvement of police in cases of suspected suicidality may also permit the police to conduct warrantless searches of the homes of students and their families under the doctrine of exigent circumstances.¹⁴⁰

2. Risks of Suicide Algorithms and the Use of School Data

Many reasons exist to suspect that the school data being collected for the GLS will lead to greater involvement of the police in apprehending at risk students. One of the stated objectives of the U.S. HHS National Strategy for Suicide Prevention was to “[i]mprove data linkage across agencies and organizations, including hospitals, psychiatric and other medical institutions, and *police departments*, to better capture information on suicide attempts.”¹⁴¹ Other cause for concern about the potential for algorithmic predictive policing based on GLS data include (1) meticulous GLS data collection; (2) a 2019 violence surveillance incident in Florida; and (3) the example of Facebook’s artificial intelligence (AI)-based suicide prediction algorithms and collaborations with law enforcement ongoing since 2017.

First, the meticulous collection of student data through the GLS with unclear justification begs the question of how it will be used. The Maine GLS report, for example, explains that SAMHSA conditioned receipt of GLS grants on the promise to “[i]mplement a Data Ticker System, a systematic collection of individual student level data (e.g., grades,

139. Ron Wipond, *Suicide Hotlines Bill Themselves as Confidential—Even as Some Trace Your Call*, MAD IN AMERICA 1, 6 (Nov. 29, 2020), <https://www.madinamerica.com/2020/11/suicide-hotlines-trace-your-call/>. This excellent article explains how “SAMHSA, the American Association of Suicidology [AAS], and Vibrant/NSPL began to push call-tracing” and “apparently never told legislators [during federal 988 hearings] about the scientific unreliability of risk assessments, large numbers of callers whose lives have been upended after their calls were traced, or how hospitalizations and treatments may be making people more suicidal rather than less so.” *Id.* at 13-14. It also describes, at 4-6, cases of police involvement, involuntary interventions, and trauma resulting from NSPL calls by law and Ph.D. graduate students.

140. See Mason Marks, *Artificial Intelligence-Based Suicide Prevention*, 21 YALE J.L. & TECH 98, 120 (2019).

141. NATIONAL STRATEGY FOR SUICIDE PREVENTION, *supra* note 26, at 74 (emphasis added).

absences, detentions, etc.) that may indicate risk for a host of academic and mental health problems.”¹⁴² Throughout the report, school staff complained that the Data Ticker System “was not effective due to several factors which made such a system unnecessary and ‘cumbersome.’”¹⁴³

In addition, recent proposals to use student data to predict violence in collaboration with the police raise concerns about whether student data collected through the GLS (allegedly for the purposes of predicting suicide) might also be used in the same way. And the data sought to predict future violence and future suicide may be the same. Florida Governor Ron DeSantis’ proposal in July 2019 to build a massive database “to try to prevent school shootings by tracking students who may become violent”¹⁴⁴ was based on data such as “instances of [being] bull[ied] based on protected characteristics, foster care records and homelessness status, history of mental illness and substance abuse, social media posts, and feelings of anger and persecution,”¹⁴⁵ resulting in outcry from 33 civil rights, disability, and privacy advocacy groups, for labeling students as safety threats based on data with no predictive ability.¹⁴⁶ The plan also called for “collect[ing] information about children and young people’s social media activity and other sensitive topics, and stor[ing] it in a state database to be shared with state employees, schools, and law enforcement.”¹⁴⁷

Lastly, the experience with Facebook, which partnered with the SAMHSA-funded NSPL in 2011,¹⁴⁸ suggests that the potential development and use of suicide-prediction algorithms in collaboration

142. MAINE GLS REPORT, *supra* note 115, at 4.

143. *Id.* at 38.

144. Valerie Strauss, *Civil Rights, Disabilities Groups Urge Florida to Stop Building Student Database They Call ‘Massive Surveillance Effort’*, WASH. POST (July 10, 2019), <https://www.washingtonpost.com/education/2019/07/10/civil-rights-disabilities-groups-urge-florida-stop-building-student-database-they-call-massive-surveillance-effort/>.

145. *Id.*

146. *Id.*

147. Letter from ACLU Florida et al. to Gov. Ron DeSantis (July 9, 2019), <https://www.acluf.org/en/highlighting-risks-arising-floridas-proposed-school-safety-database> [hereinafter Letter to Gov. DeSantis].

148. *New Partnership Between Facebook and the National Suicide Prevention Lifeline*, FACEBOOK SAFETY (Dec. 11, 2011), <https://www.facebook.com/notes/facebook-safety/new-partnership-between-facebook-and-the-national-suicide-prevention-lifeline/310287485658707/>.

with the police is very real. Since 2017, Facebook has been using AI to “to identify posts from people who might be at risk, such as phrases in posts and concerned comments from friends and family” and assign a suicide risk-rating to words, word pairs, or phrases suspicious for suicidal intent, such as “goodbye,” “[w]here are you??” or “[s]o much sadness.”¹⁴⁹ According to Facebook, “posts that [its] reviewers determined were serious cases of people in imminent harm tended to have comments like, ‘Tell me where you are’ or ‘Has anyone heard from him/her?’”¹⁵⁰ As the company announced on February 21, 2018: “Facebook may contact local authorities. Since these efforts began last year, we’ve worked with first responders on over 1,000 wellness checks based on reports we’ve received from our proactive detection efforts.”¹⁵¹ Facebook also released a promotional video on November 26, 2017, in which the Chautauqua County Sheriff’s Department in Upstate New York praises Facebook for alerting it to a potential suicide, which enabled officers to intervene.¹⁵² Though suicide prediction algorithms based on GLS data might not be any more accurate than those derived through Facebook’s AI, they are more likely to be respected, not just by the police, but by the U.S. HHS, SAMHSA, the CDC, and through their endorsement, Congress and the judiciary. The veneer of respectability makes these algorithms more dangerous.

IV. HARMS OF SCHOOL SUICIDE SCREENING AND SURVEILLANCE OUTSIDE THE SCHOOL CONTEXT

The influence of GLS school suicide screening and surveillance initiatives may extend beyond school and effectively erode civil rights in the workplace and in civil commitment proceedings.

149. Dan Muriello et al., *Under the Hood: Suicide Prevention Tools Powered by AI*, FACEBOOK (Feb. 21, 2018), <https://engineering.fb.com/2018/02/21/ml-applications/under-the-hood-suicide-prevention-tools-powered-by-ai/>.

150. *Id.*

151. *Id.*

152. *Getting Our Community Help in Real Time*, FACEBOOK SAFETY (Nov. 26, 2017), <https://www.facebook.com/fbsafety/videos/1497015877002912/>.

A. Employment

The recommendations and communications of the U.S. HHS, SAMHSA, and the CDC; the adoption of school policies and “education” about suicide screening and surveillance; and other aspects of the GLS are likely to have a significant impact outside school in the workplace. If students are taught to engage in suicide screening and to report at risk peers in school, they may be more likely to engage in suicide screening and to report at risk coworkers, and employers may be more likely to ask their employees to engage in suicide screening and report other employees on their behalf. Though these practices might run afoul of Americans with Disabilities Act (ADA) prohibitions on medical inquiries and examinations of employees,¹⁵³ the ADA’s rules cannot protect employees if no one is aware they exist. The U.S. HHS also explicitly advises that “[b]usinesses and [e]mployers [c]an [t]rain employees and supervisors to recognize coworkers in distress and respond appropriately,”¹⁵⁴ despite the ADA’s prohibitions on medical inquiries.

153. They would violate the spirit, if not the letter, of the law. *See* U.S. EQUAL EMP. OPPORTUNITY COMM’N, ENF’T GUIDANCE: PREEMPLOYMENT DISABILITY-RELATED QUESTIONS AND MEDICAL EXAMINATIONS, Notice 915.002 (1995); 42 U.S.C. § 12112(d)(4)(A). An exception may apply in certain situations where an employee (1) is unable to perform essential job functions because of a disability; or (2) poses a high risk of substantial, imminent harm to self or others because of a disability. *See id.*; 29 C.F.R. § Pt. 1630, App. *See also* Nicholas D. Lawson, “*To Be a Good Lawyer, One Has to Be a Healthy Lawyer*”: *Lawyer Well-Being, Discrimination, and Discretionary Systems of Discipline*. 34 GEO. J. LEGAL ETHICS 65, 100 (2021) (“The ADA prohibits only *employers* from making inquiries and exams, not *peer employees*; however, the ADA does prohibit the employers’ agents from making inquiries and performing exams of employees on employers’ behalf. If employers mandate that peer employees make medical inquiries and perform examinations of other employees . . . the reporting employees might be regarded as agents of the employer, and the employer may be liable.”) (emphasis in original) (citations omitted).

154. NATIONAL STRATEGY FOR SUICIDE PREVENTION, *supra* note 26, at 49; *see also* U.S. DEP’T OF HEALTH & HUM. SERVS., PROTECTING YOUTH MENTAL HEALTH: THE U.S. SURGEON GENERAL’S ADVISORY 232 (2021), <https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf> (“Provide managers and supervisors with training to help recognize negative mental health symptoms in themselves and colleagues and encourage employees to seek help” (citing CTRS. FOR DISEASE CONTROL & PREVENTION, *Mental Health in the Workplace* (2021), <https://www.cdc.gov/workplacehealthpromotion/tools-resources/workplace-health/mental-health/index.html>)); Wipond, *supra* note 139, at 3-4 (describing “A Police Visit at Work”).

B. Involuntary Commitment

Public perceptions that suicide is preventable and treatable through interventions including inpatient hospitalization may make it more likely that suicidal persons resisting these treatments and hospitalizations will be perceived as irrational; they will be perceived as irrationally resisting an effective approach to prevent suicide death.¹⁵⁵ They also make it more likely that psychiatrists will involuntarily hospitalize or commit persons at risk in order to avoid liability for not preventing suicide.¹⁵⁶ Studies have found, however, that involuntary commitments have little to no demonstrated benefits¹⁵⁷; that “involuntary admission [is] associated with lower levels of satisfaction”¹⁵⁸; that there are only “limited symptom improvements after coerced hospital admission”¹⁵⁹; and that community treatment orders are experienced as stigmatizing and disempowering.¹⁶⁰ Unfortunately, “[t]he majority of our suicide prevention resources seem

155. See Rocksheng Zhong et al., *Decision-Making Capacity Will Have a Limited Effect on Civil Commitment Practices*, 19 AM. J. BIOETHICS 86, 86 (2019) (arguing that “[r]ational suicide’ seekers seldom show up to the psychiatric emergency room.”); SAMHSA, *Preventing Suicide Toolkit for High Schools*, *supra* note 18, at 104 (“In most cases, suicide is caused by mental health disorders like depression or substance abuse problems. Mental health disorders affect the way people feel and prevent them from thinking clearly and rationally. Having a mental health disorder is nothing to be ashamed of.”).

156. See Mulder et al., *supra* note 7, at 271-72; Large et al., *supra* note 7, at 162.

157. See, e.g., Steve R. Kisely et al., *Compulsory Community and Involuntary Outpatient Treatment for People with Severe Mental Disorders*, COCHRANE DATABASE OF SYSTEMATIC REVIEWS, Art. No.: CD004408 at 2 (2017) (finding that compulsory community treatment “results in no clear difference in service use, social functioning or quality of life compared with voluntary care or brief supervised discharge”); Phoebe Barnett et al., *Compulsory Community Treatment to Reduce Readmission to Hospital and Increase Engagement with Community Care in People with Mental Illness: A Systematic Review and Meta-Analysis*, 5 LANCET PSYCHIATRY 1013, 1013 (2018) (“We found no consistent evidence that CCT reduces readmission or length of inpatient stay, although it might have some benefit in enforcing use of outpatient treatment or increasing service provision, or both.”).

158. Victoria Bird et al., *Factors Associated with Satisfaction of Inpatient Psychiatric Care: A Cross Country Comparison*, 50 PSYCHOLOGICAL MED. 284, 284 (2020) (in a study of psychiatric inpatients across five European countries, “involuntary admission [was] associated with lower levels of satisfaction.”).

159. Thomas W. Kallert et al., *Coerced Hospital Admission and Symptom Change—A Prospective Observational Multi-Centre Study*, 6 PLOS ONE e28191 (2011) (finding European psychiatric patients showed “limited symptom improvements after coerced hospital admission”).

160. Lisa Brophy & David Ring, *The Efficacy of Involuntary Treatment in the Community: Consumer and Service Provider Perspectives*, 2 SOC. WORK MENTAL HEALTH 157, 157 (2004).

concentrated on identifying a potential suicide and restraining that person.”¹⁶¹

V. THE THREATS POSED BY SUICIDE SURVEILLANCE, UNLIKE THE THREATS POSED BY VIOLENCE SURVEILLANCE, ARE DISGUISED THROUGH PATERNALISM

A. Similarities Between School Violence and Suicide Surveillance

School safety and security measures that surveil students for potential future violence have aroused considerable ire, objections, and public commentary.¹⁶² In comparison, school suicide surveillance is infrequently discussed and less often objected to.¹⁶³ Yet both school violence and suicide surveillance may (1) target the same data and risk factors; (2) lead to expulsion or exclusion from school; (3) deter marginalized students from seeking services and reporting abuse; and (4) offend dignity. Advocates should vigorously oppose both.

1. Similar “Risk Factors” and Data

Violence and suicide surveillance target similar risk factors.¹⁶⁴ Data said to be collected for the purposes of suicide surveillance may in fact be collected for the purposes of violence surveillance, or vice versa. As a practical matter, opposing data collection for the purposes of violence surveillance while embracing data collection for the purposes of suicide surveillance may not make sense.

161. STEFAN, *supra* note 46, at 415.

162. See *supra* notes 144-47 and accompanying discussion; see also Jason P. Nance, *Implicit Racial Bias and Students’ Fourth Amendment Rights*, 94 IND. L.J. 47, 86 (2019).

163. In 2019, however, the Consortium for Citizens with Disabilities (CCD), the largest coalition of national disability rights organizations, recommended “requiring that higher education institutions receiving Garrett Lee Smith Memorial Act grants return those grant funds if they are found to have discriminated against students based on a psychiatric disability.” Letter from the Consortium for Citizens with Disabilities regarding Higher Education Act Reauthorization Principles and Recommendations (June 20, 2019), <https://council-for-learning-disabilities.org/wp-content/uploads/2019/07/1.-June-20-2019-CCD-Higher-Education-Act-Reauthorization-Principles-and-Recommendations.pdf>

164. *E.g.*, experience with stigma, discrimination, and frustration.

2. *Similar Risks of Expulsion and Exclusion*

Violence and suicide surveillance both may lead to expulsion and exclusion from school. Potential for violence and suicide have historically been two of the most common justifications for incarcerating, institutionalizing, excluding, and segregating people, particularly persons of color and persons with disabilities.

3. *Similar Deterrence from Services and Supports*

Both violence and suicide surveillance force marginalized students underground and deter them (1) from seeking needed services and (2) from reporting abuse. Violence and suicide surveillance initiatives both treat the act of seeking needed services (e.g., social services for homelessness, psychotherapy) as warning signs, thereby deterring students from seeking these services.¹⁶⁵ Violence and suicide surveillance initiatives also both treat being a victim of abuse and exposure to stigma and discrimination (e.g., on the basis of race, ethnicity, disability, sexual orientation, or religion) as warning signs, thereby deterring these students from reporting abuse and discrimination.¹⁶⁶

4. *Similar Risk of Dignitary Harms*

Violence and suicide surveillance both impose significant dignitary harms to marginalized students. Violence surveillance in schools

165. See Letter to Gov. DeSantis, *supra* note 147 (arguing that “if the state collects and stores some of this information, many students and their families will be deterred from seeking the services they need in school. Students who are homeless or in the foster care system, or those who have mental health disabilities, may limit the services they use out of concern that the state may use the information to flag them as potential threats.”); CDC, *Preventing Suicide*, *supra* note 14, at 35 (listing homeless status as a suicide risk factors); SAMHSA, *Preventing Suicide Toolkit for High Schools*, *supra* note 18, at 33 (listing mental health disorders as suicide risk factors).

166. See Letter to Gov. DeSantis, *supra* note 147 (“students who are bullied because they are LGBT, have a disability, or have a minority religious affiliation may choose not to report the abuse to their schools if they fear the schools will respond by identifying them as threats. This could create a perverse incentive, leading students to avoid reporting serious or life-threatening behavior because they don’t want to be labeled as a potential school shooter.”); SAMHSA, *Preventing Suicide Toolkit for High Schools*, *supra* note 18, at 33 (listing “[e]xposure to stigma and discrimination against students based on sexual orientation; gender identity; race and ethnicity; disability” as a suicide risk factor).

“disrupt[s] feelings of cooperation, trust, and respect among members of the community by sending a clear signal to students that they are prone to illegal activity, dangerous, and violent.”¹⁶⁷ Suicide surveillance policies in schools that make at risk youths’ suicidality “everyone’s business” create expectations of limited rights for targeted students and deny them the right to live their own lives and make their own life choices, while entrusting school, college, and university administrations; management; and mental health professionals with unwarranted discretion and control to choose for them.

B. Paternalistic Justifications May Obscure the Threats Imposed by Suicide Surveillance

Considering the similarities between school violence and suicide surveillance, why school suicide surveillance policies have not faced similar opposition is unclear. One possible explanation might be greater knowledge and acceptance of the impossibility of predicting future acts of violence¹⁶⁸ and lesser knowledge and acceptance of the impossibility of predicting future suicides.¹⁶⁹ SAMHSA and CDC publications and outreach may be partly to blame for the latter. The Maine GLS experience also suggests that paternalistic justifications may help insulate suicide surveillance policies from criticism and challenge.

1. Blithe Acceptance of Suicide Surveillance on the Part of Participating Staff

The Maine GLS report suggests some level of awareness and acceptance on the part of participating staff that the suicide risk factors they were asked to watch out for might not predict future suicides. As one staff member put it, “[o]ur kids have all of the risk factors. Their families, they’ve got substance abuse, they’ve got mental illness, they got abandonment, they got abuse, they got you know they got

167. Nance, *supra* note 162, at 74.

168. The American Psychiatric Association and other mental health professional groups, for example, have agreed that psychiatrists cannot predict violence. Brief for the American Psychiatric Association et al. as Amici Curiae Supporting Respondents, *Tarasoff v. Regents of Univ. of California*, No. SF 23042 (Cal. Jan. 7, 1975).

169. *See supra* notes 6-12 and accompanying discussion.

everything. So we're starting with the very high risk."¹⁷⁰ Another commented that "some students are always in some form of crisis."¹⁷¹ And "[w]hen asked how youth were typically identified for suicide risk [one] Gatekeeper answered, 'That I wouldn't know.'"¹⁷²

Accordingly, the Maine GLS report revealed that there may be very little rhyme or reason to staff members' decisions to report potentially at risk students to school administration. One staff member said that "assessing the risk often depends on the student's 'body language,'"¹⁷³ and another claimed she reported "youth if she notices changes in behavior or social changes. She stated that these are typically changes 'in temperament, sometimes a change in friends, or sometimes not necessarily a change in friends, but sort of a sudden separation from friends, that kind of thing.'"¹⁷⁴ Another said that she looks out for "anything uncharacteristic in behavior."¹⁷⁵

2. The Paternalistic Functions of Participating in Suicide Surveillance for Staff

Responses from Maine staff¹⁷⁶ suggested that at least two paternalistic impulses may have motivated their participation in GLS suicide surveillance: (1) their desire to shape student "well-being," and (2) their desire to follow a regimented protocol purported to prevent student suicides.

The desire to shape student "well-being" appears to motivate some staff members to participate in GLS suicide surveillance. One appeared to view the initiative as an expansion of the health class concept into a kind of educational instruction and supervision over many different areas of an adolescent's life:

170. MAINE GLS REPORT, *supra* note 115, at 55.

171. *Id.* at 67.

172. *Id.* at 68.

173. *Id.* at 62.

174. *Id.* at 76.

175. *Id.* at 113.

176. Not all Maine staff choose to participate in GLS initiatives. To the consternation of one participating GLS staff member, there "was an overall staff attitude that there was no 'need' for a suicide prevention/intervention project in the school because there had not been a student suicide . . . ideation was not perceived as a problem." *Id.* at 86.

[She] saw the school as “a first step into further treatment for a student.” She also stated that along with academic preparation of students, another component of a “modern” high school that has become clear is “that we need to take into consideration students” well being and quality of life issues and personal issues in order for them to achieve academically. So suicide prevention is a key component of the well-being piece of education.¹⁷⁷

The desire to follow a regimented protocol purported to prevent student suicides motivated other staff members to participate in the GLS. Some staff seemed to take comfort in being told that they could effectively prevent student suicides with expert suicide training and guidance provided as part of the GLS: “There aren’t these big question marks in the back of my head and this kind of like fear that, oh my God, I hope today is not the day that something tragic happens and I don’t know what to do.”¹⁷⁸ Such sentiments recall the observations of some commentators that inaccurate and exaggerated beliefs about the effectiveness of suicide prevention strategies on the part of clinical staff may lead to unnecessary confinement—because doing otherwise would lead to “intolerable anxiety in the staff involved in the assessment.”¹⁷⁹

3. *Support Within the Disability Advocacy Community*

Though some disability advocates advise against suicide surveillance,¹⁸⁰ some of the most respected disability advocacy

177. *Id.* at 117.

178. *Id.* at 58.

179. See Mulder et al., *supra* note 7, at 272; see also Wipond, *supra* note 139, at 10 (interview with former NSPL crisis center worker: “‘There’s definitely people who would call the police pretty quickly,’ sa[id the worker]. ‘Some people just got really panicked; they felt like it would be their fault if the person killed themselves.’”)

180. See, e.g., STEFAN, *supra* note 46, at 415 (“The effectiveness of other efforts receiving federal funding is controversial: the seemingly endless catalog of questionnaires and checklists to determine suicidality, which research repeatedly shows to be ineffective. Our society currently spends millions of dollars on suicide prevention and research, much of it in an unending quest for the holy grail of a suicide assessment instrument that would enable evaluators to predict which suicidal people will actually attempt or complete the act.”) (citation omitted).

organizations, such as the National Council on Disability (NCD)¹⁸¹ and the Bazelon Center for Mental Health Law—which opposed school surveillance for violence in Florida—have endorsed “education and training so that students, resident advisors, campus police, and teaching, administrative and other staff [are] familiar with signs of mental illness, depression, self harm and suicide risk.”¹⁸² On October 29, 2021, however, the NCD endorsed a different approach in a report providing mental health and suicide recommendations:

Rather than promoting screening and identification of individuals who may be suicidal and involuntarily hospitalizing them, Congress should promote suicide prevention efforts focusing on approaches that address the underlying problems that cause people to consider suicide. These should include helping individuals secure housing, preventing evictions, and helping individuals secure and maintain employment. They should also include peer-run support services for individuals who are experiencing suicidal thoughts.¹⁸³

Support for suicide surveillance policies among some disability advocates might partially reflect overestimates of the effectiveness of suicide surveillance and limited consideration of their effects on all those who might be targeted. Many disability organizations today advocate for persons with disabilities in greater need of services, such

181. See NCD, MENTAL HEALTH ON CAMPUS, *supra* note 106, at 57, 86 (“Train faculty, staff, administrators, resident advisors, and students to recognize symptoms of mental health disorders”; “training should help students recognize warning signs, question suicidal intent.”).

182. BAZELON CTR. FOR MENTAL HEALTH LAW, SUPPORTING STUDENTS: A MODEL POLICY FOR COLLEGES AND UNIVERSITIES 10 (Apr. 2017), <http://www.bazelon.org/wp-content/uploads/2017/04/SupportingStudentsCampusMHPolicy.pdf>; see also BAZELON CTR. FOR MENTAL HEALTH LAW ET AL., CAMPUS MENTAL HEALTH: KNOW YOUR RIGHTS 14 (June 2017), <https://secureservercdn.net/198.71.233.254/d25.2ac.myftpupload.com/wp-content/uploads/2017/01/2017-06-28-Revised-YourMind-YourRights-word-final.pdf> [hereinafter BAZELON, CAMPUS MENTAL HEALTH] (recommending “training staff to recognize warning signs” and that “students receive[] training and information about how to recognize warning signs in themselves or others”).

183. NAT’L COUNCIL ON DISABILITY, THE IMPACT OF COVID-19 ON PEOPLE WITH DISABILITIES 198 (Oct. 29, 2021), https://ncd.gov/sites/default/files/NCD_COVID-19_Progress_Report_508.pdf. The NCD convening on Mental Health, Suicide Prevention Policy included two individuals from Bazelon in addition to Susan Stefan. *Id.* at 201-02.

as children and adolescents with learning disabilities.¹⁸⁴ The importance of broadly screening for children or adolescents with learning disabilities and special education needs makes intuitive sense. But the implications of asking all members of an entire college or university community to screen adults for signs of mental illness, depression, self-harm or suicide risk, need to be carefully considered. Advocates may also have misguided faith in the ability of mental health literacy campaigns (e.g., mental health first aid¹⁸⁵) and other educational approaches¹⁸⁶ to reduce mental health stigma.

184. 20 U.S.C. § 1412 requires “[a]ll children with disabilities . . . regardless of the severity of their disabilities, and who are in need of special education and related services, are identified, located, and evaluated . . .” The term “child with a disability” means “a child—(i) with intellectual disabilities, hearing impairments (including deafness), speech or language impairments, visual impairments (including blindness), serious emotional disturbance (referred to in this chapter as ‘emotional disturbance’), orthopedic impairments, autism, traumatic brain injury, other health impairments, or specific learning disabilities; and (ii) who, by reason thereof, needs special education and related services.” 20 U.S.C. § 1401(3)(A).

185. Brief for the American Psychiatric Association, Bazelon Ctr. for Mental Health Law et al. as Amici Curiae at 14, *Judith Gray v. Thomas A. Cummings*; Town of Athol, Massachusetts, No. 4:15-cv-10276-TSH (1st Cir. Sept. 6, 2018) (recommending “‘mental health first aid’ training, [which] provide[s] basic mental health training to a broader segment of police officers. Such training focuses on increasing understanding of mental illnesses, decreasing stigma, and promoting early access to help for individuals with mental illness”); cf. Jan Nadine Defehr, *Inventing Mental Health First Aid: The Problem of Psychocentrism*, 10 *STUD. SOC. JUST.* 18 (2016).

186. Campaigns to reduce mental health stigma through education have a mixed record and sometime backfire. One study, for example, found that public service announcement-like messages that, “You are not to blame for the cause of your depression. Depression is treatable if you are willing to seek help,” and listing indicators of depression such as persistent sad mood, feelings of hopelessness, and decreased energy, actually led to increased agreement with statements such as “I would feel inadequate if I went to a therapist for psychological help” and “Seeking psychological help would make me feel less intelligent,” and less willingness to seek help if depressed. See Brianna A. Lienemann et al., *Persuading People with Depression to Seek Help: Respect the Boomerang*, 28 *HEALTH COMM.* 718, 724 (2013).

Other studies have found that health communications that people do not choose to be schizophrenic but rather are the victim of a biological disease, also led to greater stigma. See John Read et al., *Prejudice and Schizophrenia: A Review of the Mental Illness Is an Illness Like Any Other Approach*, 114 *ACTA PSYCHIATRICA SCANDINAVICA* 303 (2006) (finding that “[b]iogenetic causal theories and diagnostic labelling [of schizophrenia] as illness, are both positively related to perceptions of dangerousness and unpredictability, and to fear and desire for social distance”); see also Georg Schomerus et al., *Evolution of Public Attitudes About Mental Illness: A Systematic Review and Meta-Analysis*, 125 *ACTA PSYCHIATRICA SCANDINAVICA* 440, 303 (2012); Keith S. Dobson & Savannah Rose, “*Myths and Facts*”

VI. GOING FORWARD

This Article should make clear that the risks of harms that may result from GLS school suicide screening and surveillance policies are substantial while their potential for any meaningful reduction in suicide rates is remote. The GLS and other similar suicide surveillance research should not receive further funding. These projects are designed and controlled by the U.S. HHS, SAMHSA, the CDC, and the National Institutes of Health (NIH), using their medical metrics, and their reports of success.¹⁸⁷ These agencies have almost entirely excluded persons with disabilities, especially psychiatric disabilities, from their workforce and leadership¹⁸⁸; they do not effectively advance the priorities of those purported to benefit from these projects.¹⁸⁹

The success of any efforts to change course from the GLS approach of screening and identifying students who may be suicidal will likely depend on the success of (1) efforts to change course from the dominant screening and identification approach in mental health policy today; and (2) efforts to ensure that policies affecting people with suicidal

Campaigns Are at Best Ineffective and May Increase Mental Illness Stigma, 7 STIGMA & HEALTH 27 (2021).

NAT'L ACADEMIES OF SCIS., ENG'G & MED., ENDING DISCRIMINATION AGAINST PEOPLE WITH MENTAL AND SUBSTANCE USE DISORDERS: THE EVIDENCE FOR STIGMA CHANGE 78 (2016) explains that "[t]hroughout this report, the committee stresses the importance of addressing stigma at the structural level . . . [P]eople with mental illness favor approaches that address institutional and structural discrimination over those that focus on public education . . . Addressing sources of structural stigma can also promote mental and physical well-being." The committee elaborates that "[t]o fully address stigma at this level, research is needed to identify and target manifestations of structural stigma that are less easily recognized, such as the unintended consequences of anti-stigma effort . . . One potential, but largely untested, target group is government officials." *Id.* at 105-07; see also David L. Conley, *The Impact of Structural Stigma and Other Factors on State Mental Health Legislative Outcomes During the Trump Administration*, 6 STIGMA & HEALTH 476 (2021).

187. See *supra* notes 14-24, 31-37, 78-87, 112-14, 125-27, 138-39, 141-42, 152, and accompanying discussion.

188. In 2018, persons with disabilities comprised roughly 30.30% of the general U.S. population, but only 6.09% of employees at the U.S. HHS. Persons with schizophrenia, bipolar disorder, major depression, or PTSD comprised over 12% of the general U.S. population, but only 0.47% of employees at the U.S. HHS, 0.45% at NIH, 2.65% at SAMHSA, and 0.91% at the CDC. See U.S. EQUAL EMP. OPPORTUNITY COMM'N, ANNUAL REPORT ON THE FEDERAL WORK FORCE FISCAL YEAR 2018, <https://www.eeoc.gov/federal-sector/reports>; Ronald C. Kessler et al., *Prevalence, Severity, and Comorbidity of 12-Month DSM-IV Disorders in the National Comorbidity Survey Replication*, 62 ARCH GEN. PSYCHIATRY 617, 620 (2005);

189. See generally Nicholas D. Lawson, *Disability Affirmative Action Requirements for the U.S. HHS and Academic Medicine Centers*, 52 HASTINGS CTR. REP. 21 (2022).

experiences and psychiatric disabilities are developed with “their perspectives and input at the center of policy solutions.”¹⁹⁰ Although there is much to commend about the Biden administration’s “strategy to address our national mental health crisis” that was announced on March 1, 2022,¹⁹¹ it strongly endorsed mental health “screening and identification” in students, and across many other segments of society.¹⁹²

Rather than continue to fund the GLS, future research should be dedicated to finding out what those who are affected by suicide surveillance really want.¹⁹³ Those who are affected, however, include

190. Letter from Bazelon Ctr. for Mental Health Law et al. to Sen. Ron Wyden, Chair, and Sen. Mike Crapo, Ranking Member, Senate Fin. Comm., regarding Request for Stakeholder Input on Improving Access to Behavioral Health Services 1 (Nov. 15, 2021), <https://www.finance.senate.gov/imo/media/doc/2021%2011%2015%20Feedback%20on%20Senate%20Finance%20BH%20RFL.pdf> (“Far too often, federal policy concerning services for these individuals is developed with the near-total exclusion of the perspectives of the very individuals who are the recipients of such services. Just as Congress would not make policy aimed at benefitting women by talking primarily to their husbands, children, and others involved with them, it should not make policy affecting people with psychiatric disabilities without having their perspectives and input at the center of policy solutions.”).

191. Such as its support of the peer mental health workforce, crisis and community mental health services, tele- and virtual mental health care options.

192. The White House Press Briefing, *Fact Sheet: President Biden to Announce Strategy to Address Our National Mental Health Crisis, as Part of Unity Agenda in His First State of the Union* (Mar. 1, 2022), <https://www.whitehouse.gov/briefing-room/statements-releases/2022/03/01/fact-sheet-president-biden-to-announce-strategy-to-address-our-national-mental-health-crisis-as-part-of-unity-agenda-in-his-first-state-of-the-union/> stated: “It’s not enough to train health care providers to deliver mental health care; social and human services providers must also be equipped to identify, understand, and respond to signs of mental illness and addiction among those they serve. To this end, the Department of Housing and Urban Development will launch a national effort to train housing counselors, housing-based services coordinators, and Fair Housing grantee staff to recognize the signs of emotional distress and to connect residents with mental health resources. The U.S. Department of Agriculture will provide training on mental health resources and communication strategies to Farm Production and Conservation Mission Area field employees, who serve farmers and ranchers, as well as incorporate updated mental health information into its online resource center for State, local and clinic staff administering the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). ED will continue to highlight the effectiveness of Mental Health First Aid training for educators, so that they can better support their students and one another. And the Department of Health & Human Services will provide additional training support to Head Start, Early Head Start, and home visiting grantees to spot and address mental health challenges among children.” The strategy also “include[s] \$50 million to pilot models that embed and co-locate mental health services into non-traditional settings like libraries, community centers, schools, and homeless shelters.”

193. See *supra* notes 157-60 and accompanying discussion.

not only potentially suicidal students, but also those who are not suicidal but still might be harmed by surveillance and stigmatization. Rather than concentrate our efforts on identifying and reporting students potentially at risk for suicide, we should listen to what suicidal students have to say. If a suicidal student says he wants someone to stay by his side, stay by his side. If he says he does not want his parents to be notified, do not notify his parents.

Though the suicide surveillance policies and research of the GLS are too problematic to continue, the GLS funds for student mental health services may be helpful, and students should be offered vouchers to engage with mental health providers off-campus.¹⁹⁴ All students should be clearly informed that their school may use their emergency contact information to notify their parents so that they can decide whether or not to make that information available. They should be informed how mental health information known to their school may be misused and how “confidential” services including the NSPL may lead to police involvement. Reforms on leaves of absence and coerced school withdrawals are also important.¹⁹⁵ It is also time to question whether the focus on disability support services¹⁹⁶ might be causing other school “supports,” such as the visible presence of faculty and leaders with disabilities, to be overlooked.

The suicide surveillance of the GLS and other dominant suicide prevention strategies are also hard to defend when there are policy candidates for funding with equivalent chances of reducing suicide rates and excellent chances of resulting in *positive* externalities.¹⁹⁷ Schools,

194. See *supra* note 46 and accompanying discussion.

195. See BAZELON, CAMPUS MENTAL HEALTH, *supra* note 182 (despite its recommendations to raise awareness of warning signs, the report offers very helpful advice on justified expectations for students regarding privacy, academic accommodations, discipline, involuntary leave of absence, going to a psychiatric hospital, and forced medication).

196. See Andrew Scheef et al., *Disability as Diversity: Perspectives of Institutions of Higher Education in the U.S.*, 33 J. POSTSECONDARY EDUC. & DISABILITY 49, 55 (2020) (“Because of their need to focus on compliance with legally mandated supports, [college/university] disability services (DS) may be supporting a deficiency model of disability and reinforcing the notion that students who access the services are ‘needy and burdensome’”) (citation omitted).

197. See Alex K. Gertner et al., *Association Between State Minimum Wages and Suicide Rates in the U.S.*, 56 AM. J. PREVENTIVE MED. 648 (2019); William C. Kerr et al., *Economic Recession, Alcohol, and Suicide Rates: Comparative Effects of Poverty, Foreclosure, and Job Loss*, 52 AM. J. PREVENTIVE MED. 469 (2017); STEFAN, *supra* note 46, at 417 (2016) (“Prevention means ensuring that people who are suicidal do not automatically lose access to

colleges, and universities could consider abiding by their legal obligations under the Rehabilitation Act¹⁹⁸ to engage in affirmative action to hire and promote faculty with disabilities. Learning environments with no full-time faculty¹⁹⁹ with mental disorders or disabilities, no disability studies courses²⁰⁰ or departments, and no meaningful disability inclusion²⁰¹ at school or on campus, are not supportive. Increased representation of visible persons with mental disorders, disabilities, and suicidal experiences among faculty and leadership, may empower these students, make their school environments less oppressive of their perspectives, and more likely to listen.

education, employment opportunities, or their children, which only exacerbates suicidality . . . In a broader way, we need as a society to consciously understand the link between losing a job, being evicted, being subjected to domestic violence, and suicide.” (citations omitted)).

198. Section 503 of the Rehabilitation Act of 1973, 29 U.S.C. § 793, requires affirmative action in employment for persons with disabilities by Federal government contractors with contracts of more than \$10,000, such as colleges and universities. 41 C.F.R. § 60-741.40(b). Section 503 requires contractors to adopt the goal of having 7% of its workplace be persons with disabilities. 41 C.F.R. § 60-741.45(a). The 7% goal also applies to each job group, with efforts directed “at all levels, including the executive level.” 41 C.F.R. § 60-741-43.

199. See Joseph Grigely, *The Neglected Demographic: Faculty Members with Disabilities*, CHRON. HIGHER EDUC. (Jun. 27, 2017), <https://www.chronicle.com/article/the-neglected-demographic-faculty-members-with-disabilities/> (describing prevalence estimates between 1.5% and 4%); Paul Harpur & Michael Ashley Stein, *Universities as Disability Rights Change Agents*, 10 N.E. U. L.J. 542, 567-68 (2018) (“Employing academics and staff members with disabilities can transform the lives of those who are employed, as well as having wider transformational implications. Mentors and role models are important for everyone, but even more so for marginalized populations, such as people with disabilities. Students with disabilities often need to operate differently than the wider student cohort. Being an outsider can have practical challenges, such as how to find a means to manage disabling barriers, as well as emotional challenges. For example, mentors and role models with disabilities can play an important and empowering role in the development and aspirations of students with disabilities—even in the face of social and familial naysayers . . . American law schools [nevertheless] have uniformly ignored their legal four-decade obligations under the Rehabilitation Act to engage in affirmative action hiring, including academic instructors.”).

200. Arlene S. Kanter, *The Law: What’s Disability Studies Got to Do with It?*, 42 COLUM. HUM. RTS. L. REV. 403, 455 (2011) (“Many faculty who are very progressive on issues of race, gender, and sexuality, for example, are resistant to promoting affirmative action based on disability—even though people with disabilities are grossly underrepresented in the academy.”).

201. See Scheef et al., *supra* note 196, at 55 (“Only 4.6% of the 300 [institutions of higher learning] randomly selected for this study included disability within their mission or vision statement in which half of them discussed disability at a surface-level using wording similar to a non-discrimination statement.”).