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Strategies for Addressing Mental Health Support on Campus

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OVERVIEW

This issue of *Policy and Practice* offers counselors and student affairs professionals strategies to effectively support the mental health needs of today's students. Students require transparent, connected, and flexible systems that meet the full range of mental health needs. To achieve such systems, institutions must have a robust infrastructure in place that includes a clearly defined scope of service that best fits the campus context; well-documented policies and procedures centered on equity and in alignment with applicable legal and ethical standards; and mechanisms for cross campus communication, assessment, and ongoing improvement. This brief overviews relevant federal legislation and liability concerns, highlights trends in counseling center practices, and offers recommendations for campus mental health policies and practices.

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Strategies for Addressing Mental Health Support on Campus

Colleges and universities across the United States are focusing attention on the increasing prevalence of student mental health needs and how to effectively provide support. According to the Center for Collegiate Mental Health's (CCMH's) 2016 annual report, the number of students who visit counseling centers has increased by an average of 30% to 40% from 2009 to 2015, which indicates growth at a rate five times greater than that of institutional enrollment. Counselors and health center staff working alongside their partners in student affairs are perhaps the most attuned to developments in student health and well-being on campus. A 2014 American College Counseling Association survey found that 94% of counseling center directors have noticed upward trends in the number of students with severe psychological problems on college campuses (Gallagher, 2014).

Recent surveys indicate that depression and anxiety are the two most common reasons why students seek counseling center services (CCMH, 2018; Reetz, Bershad, LeViness, & Whitlock, 2016). The prevalence of students with depression or anxiety has steadily increased over the past 4 years while reported rates of students who are primarily concerned about their academic performance, self-esteem, mood instability, and relationship problems have remained flat or decreased (CCMH, 2018). Similarly, the American College Health Association's (2018) annual National College Health Assessment found that approximately 60% of survey respondents reported feeling "overwhelming anxiety" and almost 40% reported feeling so depressed that "it was difficult to function" at some point over the past 12 months (p. 14). The academic, financial, and social pressures faced on campus can mentally and emotionally exhaust students, and research suggests that depression can negatively impact a student's ability to learn and persist in school (DeRoma, Leach, & Leverett, 2009).

Several interconnected factors may be driving the increase in student demand for mental health services. These factors include growing numbers of students juggling full-time work and family responsibilities, and greater use of social media and technology, which can cause heightened feelings of isolation and lower self-esteem (Primack et al., 2017). CCMH (2018) analysis revealed that the rate of students who receive mental health treatment prior to college has been mostly flat over the past 7 years, which runs counter to the explanation that more students report needing mental health services in college because a greater number of them are receiving early diagnosis and treatment recommendations. Recent cohorts of students may feel more comfortable with seeking help on campus than those in years past, perhaps due in part to greater national focus on reducing stigma surrounding and raising awareness about mental health. For example, the Garrett Lee Smith Memorial Act, first passed by Congress in 2004, has helped fund suicide prevention and mental health awareness education programs and training at colleges and universities across the United States. Approximately 747,000 individuals have participated in about 25,500 grant-funded training events or educational seminars as of June 2014 (American Psychological Association, n.d.). However, despite such efforts to promote mental health awareness and health-seeking behavior and data pointing to increased demand for mental health services, many of the students who stand to benefit the most from service utilization are the most reluctant to seek help.

This issue of *Policy and Practice* offers counselors and student affairs professionals strategies to effectively support the mental health needs of today's students. Students require transparent, connected, and flexible systems that meet the full range of mental health needs. To achieve such systems, institutions must have a robust infrastructure in place that includes a clearly defined scope of service that best fits the campus context; well-documented policies and procedures centered on equity and in alignment with applicable legal and ethical standards; and mechanisms for cross-campus communication, assessment, and ongoing improvement.

This brief overviews relevant federal legislation and liability concerns, highlights trends in counseling center practices, and offers recommendations for campus mental health policies and practices.

IMPLICATIONS OF LAW ON PRACTICE

Mental health professionals, both on and off campus, must be prepared to navigate the legal and ethical issues related to serving students who experience mental and emotional distress. Although this brief does not offer legal guidance, it does overview the key federal laws governing the decisions made by campus health professionals and counselors regarding students' health, privacy, and safety.

BALANCE BETWEEN STUDENT PRIVACY AND HEALTH CONCERNS

At the federal level, requirements regarding confidentiality and privacy of student mental health records are primarily driven by the Federal Education Rights and Privacy Act of 1974 (FERPA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The application of these laws is further complicated by individual clinician licensure requirements governed by states or by individual professional associations, such as the American Psychological Association or the National Association of Social Workers.

FERPA requires institutions to receive written consent from students before disclosing their educational records and personally identifiable information to a third party. Student medical record information becomes subject to FERPA when it is used for purposes other than treatment, such as for disability accommodations (Jed Foundation, 2008). However, in the event of an emergency and when the health and safety of others is of concern, FERPA allows the disclosure of a student's educational record to appropriate parties—such as law enforcement officials, public health officials, parents or guardians, or trained medical personnel—without the student's permission (U.S. Department of Education Family Policy Compliance Office, 2007).

HIPAA is the federal confidentiality law governing the sharing of patient and health care professional communications and records. HIPAA's Privacy Rule sets strict limits on the use and disclosure of personal health information without patient authorization, but in most cases it does not apply to education or treatment records of students at health clinics run by postsecondary institutions. However, HIPAA does apply to the records of students who seek treatment at an off-campus facility or at a hospital affiliated with a university (Jed Foundation, 2008; U.S. Department of Education Family Policy Compliance Office, 2007; U.S. Department of Health and Human Services Office for Civil Rights, n.d.). Under HIPAA, university hospitals differ from campus health clinics in that they provide services to students independently from and without regard to a university's educational mission (U.S. Department of Health & Human Services Office for Civil Rights, 2008). A campus health center may opt to comply with HIPAA's

Privacy Rule if the institution with which it is affiliated requires stricter protections for insurance filing reasons (Jed Foundation, 2008).

Lack of clear protocols for campus and hospital interaction can lead to ambiguous interpretations of how HIPAA and FERPA rules apply in specific situations. For example, Yale University received criticism for disclosing medical treatment information to a student's family members without that student's permission. The student was initially treated by the Yale health center, but was determined to be at risk for self-harm and involuntarily sent to a private, off-campus hospital. Although a student's medical records at an off-campus hospital are typically subject to HIPAA's Privacy Rule, some information was subject to FERPA's emergency safety exception because the student was sent to the private hospital on behalf of Yale clinicians, who also visited the student there (Ornstein, 2015). Risk of confusion regarding disclosure of student information can be reduced if institutions and private or off-campus hospitals establish a memorandum of understanding that outlines expectations and protocols for communication, as well as policies that dictate when, how, and with whom student health information may be shared. For example, in response to lawsuits against colleges for failing to forewarn parents about a student's risk for self-harm, many institutions have a written emergency contact notification procedure that encourages students to sign a release of information at the beginning of each school year (Jed Foundation, 2008).

Recognizing the possible role of privacy laws in protecting students' health and safety can help inform institutional policies and processes as professionals decide when it is appropriate to share the information of a student in need of intervention. Outside of individual circumstances, ensuring the confidentiality of counseling services visits should be a priority for colleges and universities.

INTERACTION OF DISABILITY LAW WITH LEAVE OF ABSENCE AND READMISSION POLICIES

The Americans with Disabilities Act (ADA) of 2007 and Section 504 of the Rehabilitation Act of 1973 are the key federal laws governing the rights of students with disabilities. Section 504 of the Rehabilitation Act prevents any college that receives federal financial aid from discriminating against an individual because of disability. Title II of the ADA extends the protections of Section 504 and requires public services, programs, and activities to be accessible to individuals with disabilities. As a result, institutions must make reasonable modifications to policies and practices in order to avoid discrimination

against students on the basis of their disability, unless that accommodation would "fundamentally alter" the nature of the service, program, or activity, or creates an "undue burden" on the institution in terms of difficulty or financial expense (ADA, 2007).

The application of disability laws in the context of a student receiving disciplinary action or a mandatory leave of absence is murky and has been the subject of several high-profile lawsuits. Although Title II of the ADA allows removal of students who pose a direct threat to themselves or others, there is a lack of federal guidance about how to determine when a situation poses such a threat (National Council on Disability, 2017). In 2012, Quinnipiac University was charged for violating the ADA when it placed a student on mandatory medical leave after that student's first visit to the campus counseling center for depression (Mulhere, 2015; U.S. District Attorney's Office District of Connecticut, 2015). In 2006, a similar lawsuit was filed against George Washington University by a student whose voluntary visit to emergency care for depression subsequently led to the university suspending and evicting the student from campus housing (Bazelon Center for Mental Health Law, 2006). These cases illustrate the legal risk of having blanket involuntary leave of absence or suspension policies and the importance of creating solutions commensurate to the risk of a situation. Institutions should take considerable care to individually assess whether a student is a significant risk to himself or herself or to others and whether that risk can be mitigated through alternative accommodations (National Council on Disability, 2017).

Institutional readmission policies are also subject to liability and ethics concerns. Students who are seen as a direct threat to themselves or others and voluntarily or involuntarily take a medical leave of absence may be required by the institution to undergo a mental health assessment or agree to comply with certain conditions before being readmitted into residence life or reenrolled. Legal experts caution institutions to ensure parity between physical health and mental health reentry requirements. Reentry requirements for students returning from a medical leave of absence for mental health–related reasons should be no more than those for students returning from medical leave for physical reasons (Bazelon Center for Mental Health Law, 2008). Without carefully considering the impact and framing of reentry requirements, institutions may risk violating the law and may inadvertently create a negative campus culture regarding mental health.

IMPLICATIONS OF INCREASED DEMAND ON PRACTICE

Campus counseling centers have experienced increased pressure to serve the influx of students who present varying levels of emotional and psychological distress, resulting in a widened scope of care and mission that may not match resource capacity levels. In response to overwhelming increase in demand for services in the context of fixed or declining resources, institutions have explored a variety of approaches.

TRIAGE

In recent years, colleges and universities have dedicated more resources to "rapid-access" services—such as crisis, walk-in, on-call, or triage/screening services typically available within one to five days—than to more expensive long-term treatment services such as specialized counseling or reoccurring appointments (CCMH, 2018). The concept of triage refers to an intake system that allows for rapid sorting of patients' needs to determine the appropriate level of service or care that should be provided (Robertson-Steel, 2006). If a triage assessment determines that a student is of high risk of harm to himself or herself or others, that student will either be seen immediately or be referred to an off-campus service provider or specialist, depending on the policies set by the institution.

When implemented effectively, triage can help counseling centers strategically match students to the resource that best fits their needed level of care with little to no wait time and lead to creative counseling solutions. For example, a student in crisis with major depressive disorder and suicidal ideation should receive immediate individual counseling, while another student with major depressive disorder who has already seen a counselor and completed cognitive behavioral skill-building exercises may be better served by group therapy or extra-session assignment work.

Without robust strategies in place, low-functioning triage may result in placement of students who are not of immediate risk on lengthy waiting lists for center services. Triage is a good strategy for identifying students who need services most immediately and for effectively tailoring resources to specific needs, but overreliance on short-term appointments may fail to address reoccurring issues that can worsen over time and lead to more costly, emergency situations.

WAITLISTS

The Association for University and College Counseling Center Directors (AUCCCD) annual survey indicates that more than a third of counseling centers waitlisted students to receive treatment at some point between July 1, 2015, and June 30, 2016 (Reetz et al., 2016). Depending on the time of

year—especially the weeks near final exams and the end of the semester—the average waitlist time can range from two days to more than nine weeks (Reetz et al., 2016). For centers that do not utilize a triage intake system, a student may have to wait weeks to even have an initial intake appointment scheduled. Having a waitlist for students seeking care at a counseling center is often seen as a necessary practice for campuses with a set number of staff who typically exceed the recommended ratio of 1,000 to 1,500 students per full-time counselor (International Association of Counseling Services, Inc., n.d.; Reetz et al., 2016).

FEES AND SERVICE LIMITATIONS

Although most institutions include fees related to campus counseling center services in every student's up-front annual bill, some campuses choose to charge additional counseling session fees to students who use certain services. CCMH (2018) survey data showed that about 17% of campus centers charge students for initial psychiatric evaluations and 18% charge for ongoing psychiatric follow-ups. Charging students for mental health counseling sessions can marginally lower the overall cost of college for students who do not utilize such services (Eisenberg, Golberstein, & Hunt, 2009).

Institutions may also choose to place a cap on the number of individual counseling sessions a student can receive per year at no additional cost. Institutions without the capacity to offer long-term, intensive outpatient care may refer students to off-campus mental health providers once the session cap is reached. Such session limits can help reduce the excessive workloads that can contribute to staff burnout. However, these practices raise accessibility concerns for students who do not have insurance and cannot afford to pay for services out of pocket and are in need of individualized care.

REFERRALS

Referring students to suitable off-campus mental health service providers is a popular practice that can potentially benefit both the student and the institution, as long as the student has sufficient insurance coverage, the ability to afford copayments, and access to a low-cost method of transportation. For students on rural campuses as well as students with limited financial means and time constraints, utilization of off-campus services is not always a viable option. Institutions on more urban campuses and in close proximity to reliable public transportation may be better suited to engage in this approach. Institutions must be realistic about the extent of services that they can provide. If deemed appropriate for the setting, referrals to outside providers can help resource-constrained institutions meet student demand.

INCREASE AND DIVERSIFY STAFF

Hiring additional counselors, and hiring counselors who are more reflective of today's increasingly diverse student population, are up-front, cost-intensive ways to increase the capacity of an institution to meet student demand. According to a recent AUCCCD survey, more than 53% of counseling centers added new staff in 2016 (Reetz et al., 2016). The survey also found that, in 2016, of clinical staff, 70.9% were White, 10.1% were Black, 7.9% were Asian, 7.3% were Latino/a, 1.7% were multiracial, 1.6% were another race, and 0.9% were Native American. In addition to diversifying staff in terms of hiring more people of color, campuses may seek providers with experiences similar to those of students or who identify with underserved student populations on campus such as LGBTQIA students, international students, or student veterans. Having a diverse counseling staff can help campus centers better address the lived experiences and needs of all students.

Investment in additional counseling center staff could mean fewer resources dedicated to other vital student services; on the other hand, hiring additional staff can serve as a long-term investment and help an institution increase the number of students a center can serve. Research indicates that students who receive campus mental health services have a greater quality of life and are more likely to persist from one year to the next, which results in added tuition revenue for the institution and a positive return on investment (Eisenberg et al., 2009). Increasing and diversifying staff is not a panacea for addressing student demand and it is not a financially feasible option for all institutions, but it can serve as an impactful investment when combined with other creative campus solutions.

TELEMENTAL HEALTH SERVICES

Telemental health (TMH) refers to online mental health services provided to students remotely (Higher Education Mental Health Alliance, 2018). TMH can provide services to students at their convenience, and it may also help increase access to care for students who are reluctant to receive face-to-face counseling. A major limitation to the use of TMH is the lack of research on the effectiveness of its various applications and the quality of electronic clinician–student interactions. Without sufficient standards and practices guiding the use of TMH, institutions may be vulnerable to malpractice claims (Kramer, Kinn, & Mishkind, 2015). Additionally, TMH services may pose equity concerns if an institution cannot ensure that all students will have sufficient access to reliable broadband when they are not on campus (Higher Education Mental Health Alliance, 2018). TMH services and the use of technology to assist with mental health support efforts serve as a promising, cost-effective approach to serving student needs.

Implementation of such services, however, will require considerable amounts of planning time, consultation, and commitment from a broad group of campus stakeholders.

GUIDING PRINCIPLES FOR PRACTICE

The prevalence of students seeking on-campus mental health services is an important issue that requires institutions of all types and sizes to rethink policies, practices, and overall systems of care. Despite differences in contexts and conditions, effective college and university approaches should be grounded in a common set of guiding principles. Below are three guiding principles for practice, drawn from a review of existing literature, frameworks and toolkits developed by experts in the field, and elements of promising campus models.

CLEARLY DEFINE THE SCOPE OF SERVICE

Limited resources should not serve as a rationale for leaving the mental health needs of students unaddressed, especially if demand continues to grow over time; however, it is misguided to expect campuses to hold all the responsibility for student mental health needs and preferences. Colleges and universities should establish practical expectations aligned with values and ethics about the level of care that they are responsible for providing to students. Institutions may wish to provide students with wrap-around, comprehensive mental health support services, but feasibility of providing a wide scope of care depends on treatment capacity levels. For example, Jefferson Community College (JCC), a two-year institution in Watertown, New York, clearly states on its website that it does not offer long-term counseling or psychiatric services in-house. However, students do have access to a licensed clinical social worker who can provide short-term personal counseling services at no cost. JCC focuses its resources on suicide prevention and outreach efforts as well as on managing an online referral system (JCC, n.d.). An institution should explicitly communicate the type and length of services that it can offer to students in need of mental health supports (Mowbray et al., 2006).

Determining an appropriate scope of care requires consideration of many factors, including the campus context and values, and the needs of students. Assessments of student mental health needs, key challenges, and the spread of available on-campus and community resources can help campus leaders identify priority populations and determine the level at which services can and should be provided. Institutions may state a specific commitment to concerns, such as supporting survivors of sexual assault, students with suicidal ideation, student veterans, and students with sexual orientation minority identities (CCMH, 2018). Funding decisions should be aligned with stated priorities to ensure

that counseling centers are equipped and able to minimize wait times and provide a sufficient number of service sessions for priority populations (CCMH, 2018). Moreover, if the institution's priority population includes students who have children or who work full-time jobs, it should consider offering flexible or extended center hours or other case management offerings related to such needs. Institutions with tight resource constraints and limited access to quality community service providers may offer a narrow scope of services and choose to invest in mental health wellness promotion, suicide and crisis prevention education efforts, peer counseling, and/or supportive mobile technology. Such institutions may also decide to hire therapists or social workers to focus on triage and short-term interventions as opposed to on-site psychologists who focus on more severe cases and require higher salaries.

PROVIDE NO-WRONG-DOOR ACCESS TO CARE

To remain true to the "no-wrong-door" adage, a campus must seamlessly lead students, regardless of entry point, to appropriate services and care (Mowbray et al., 2006). Areas on campus that primarily support or interact with students (e.g., faculty, academic departments, peer leaders, health services, counseling and advising centers, residence life, campus security, library staff) should receive relevant and ongoing training for how to identify, support, and assist students in accessing appropriate mental health supports and resources. Programming for campus entities may include gatekeeper training, mental health first-aid programs, and cultural competency training.

Institutions may also create interdisciplinary behavioral intervention or case management teams that formally engage in information sharing and coordination of cross-campus response to students in distress. These teams may include representatives from student affairs, academic affairs, disability services, counseling centers, campus legal counsel, and campus security (Higher Education Mental Health Alliance & Jed Foundation, 2012). On-campus entities should also engage with family members and other off-campus entities and service providers as necessary to enhance a student's continuity of care, especially if the student requires intermittent campus support (National Council on Disability, 2017).

Information about counseling services and other mental health resources should be disseminated through a number of channels, including the campus website, e-mails, social media, advising offices, presentations during new student and faculty orientations, and fliers in high-traffic locations.

By communicating about available services in a transparent and multimodal fashion, institutions can ensure that faculty, staff, and students are aware of procedures and resources

available. For example, the University of North Texas (UNT) Division of Student Affairs (n.d.) created a public awareness campaign to market its interdisciplinary campus CARE team responsible for responding to "students exhibiting behaviors of high risk" (para. 8) and "protecting the health, safety, and welfare of students and members of the UNT campus community" (para. 6). As part of this effort, UNT created a website to educate the campus community about how the CARE team operates and to connect individuals with available on- and off-campus resources. The website includes a CARE team flowchart that guides the reader to the appropriate action step in response to concerns about a student's behavior. Breaking down complex or ambiguous processes into a simplified flowchart can offer much needed clarity to those unsure of how to refer a student who may be a threat to himself or herself or to others.

LEVERAGE STUDENT VOICES

Students should be integrated into as much of the decision-making processes related to mental health support services as possible. As potential or actual recipients of an institution's mental health care, students can offer valuable perspectives to practitioners designing services, programs, and messaging strategies. Some institutions directly involve students in counseling center strategic planning as well as outreach strategy design (Reetz et al., 2016). For example, peer mentors are an integral component of the University of West Georgia's mental health support and outreach effort. Through the Prevent@UWG program, student volunteers assist with mental health education and training programs and work with professional staff and faculty to implement campus outreach initiatives (University of West Georgia, n.d.).

Student-led mental health clubs, committees, and advisory boards can facilitate peer-to-peer and student-to-staff communication. With over 450 student-led chapters at high schools and colleges in the United States and abroad, Active Minds is a far-reaching nonprofit organization dedicated to supporting mental health awareness and peer education for young adults aged 14 to 25. Although Active Minds chapters do not formally serve as peer support groups, student members work alongside other students and collaboratively with campus health and counseling services to plan educational programs and serve as mental health policy advocates (Active Minds, n.d.). Student-led organizations can communicate with other students to better understand and support their needs, share common experiences, and raise awareness about available resources (Gillard, Gibson, Holley, & Lucock, 2015). For example, at the University of Michigan, the Counseling and Psychological Services student group produces and edits a video series, The Real Stories of Leaders at Their Best, that is featured on the university's website and highlights

stories about how "mental health plays out in [students'] day to day lives" (University of Michigan Counseling and Psychological Services, n.d.). Listening to student voices can help counseling centers respond to student needs and keep institutions accountable for their stated commitments to care.

In partnership with student organizations, institutions should give students who have received campus mental health services the opportunity to provide feedback on their experiences in terms of quality and timeliness of services. Data collection strategies can be used to gather input from students and identify those who may feel their needs are being unmet and who may have insight into possible policy or practice improvements.

CONCLUSION

Investing in student mental health supports and services is a consequential investment in student learning, development, and success. There is no one best model of care; the design of an institution's mental health support efforts will depend on the specific campus context and the realities faced by its students and campus practitioners. Effective systems of campus mental health support require a thorough understanding of relevant laws, areas of liability, student needs, and institutional capacities; strategic planning and implementation of student-centered processes and policies; and a campuswide commitment to collaboration and communication. This brief has explored some of the complex, interweaving aspects of campus mental health supports. The information and recommendations outlined in this document should serve as a resource for campuses to consider as they continue to advance the health and well-being of their students while grappling with limited resources.

ADDITIONAL RESOURCES

FRAMEWORKS AND GUIDES

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STUDENT ORGANIZATIONS

◊ **Active Minds**

ASSESSMENT TOOLS

◊ **Suicide Assessment Five-Step Evaluation and Triage**

◊ American Foundation for Suicide Prevention **Interactive Screen Program**

HELPLINES

◊ **Suicide Prevention Lifeline**: 1-800-273-8255

◊ **Trevor Project Lifeline**: 1-866-488-7386

◊ **Trans Lifeline**: United States: 1-877-565-8860; Canada: 1-877-330-6366

◊ **National Sexual Assault Hotline**: 1-800-656-HOPE (4673)

◊ The Steve Fund's **Crisis Text Line**: Text HELLO to 741741

◊ **National Alliance on Mental Illness Helpline**: 1-800-950-NAMI (6264) or info@nami.org

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