

University System of Georgia

**Report of the
Student Health and Behavioral Issues
Task Force**

September 17, 2008

Table of Contents

EXECUTIVE SUMMARY	4
INTRODUCTION	6
LITERATURE REVIEW	7
INTRODUCTION.....	8
COLLEGE STUDENT BEHAVIOR AND MENTAL HEALTH.....	8
COUNSELING CENTER STANDARDS AND BEST PRACTICES	17
EMERGING INTERVENTIONS.....	22
LEGAL AND ETHICAL IMPLICATIONS OF THE POLICIES, PRACTICES, AND PROCEDURES	29
RESOURCES SURVEY	35
INTRODUCTION.....	36
STAFFING AND ADMINISTRATIVE STRUCTURE.....	36
LICENSURE	37
LIABILITY INSURANCE	37
LEGAL COUNSEL	37
BUDGETS AND STAFFING	37
UTILIZATION AND SERVICES	38
AFTER-HOURS CARE	39
REFERRALS	39
WAITING LISTS.....	39
MANDATED SERVICES	40
CHANGES IN SERVICES, PSYCHIATRIC RESOURCES AND MEDICATION	40
HOSPITALIZATION.....	41
RECOGNIZING AND RESPONDING TO TROUBLE	41
CRISIS PLANS	42
SITE EVALUATION.....	42
EVALUATION AND/OR ANNUAL REPORT	42
SWOT ANALYSIS.....	43
STRENGTHS	44
WEAKNESSES	44
OPPORTUNITIES.....	46
THREATS.....	46
RECOMMENDATIONS	48
RECOMMENDATION 1	49

RECOMMENDATION 2	49
RECOMMENDATION 3	51
RECOMMENDATION 4	51
RECOMMENDATION 5	52
IMPLEMENTATION	53
EMERGENCY PREPAREDNESS AND RESPONSE	54
TRAINING, LAWS AND INTERVENTION	54
POLICIES, PROCEDURES, GUIDELINES AND PROTOCOLS	54
ACCESS TO HEALTH INSURANCE	55
IDENTIFICATION AND PROVISION OF SERVICES AND RESOURCES	55
REFERENCES	56
APPENDIX A – CHANCELLOR’S CHARGE	65
APPENDIX B – TASKFORCE MEMBERSHIP	67
APPENDIX C – USG RESOURCES SURVEY	70

Executive Summary

Concerns are at a high point on our campuses as college students with mental health issues are being seen with greater frequency, severity, and complexity. It is recognized that depression and anxiety negatively impact social and cognitive functioning and, therefore, students' academic progress and student success. In increasing numbers, students on our campuses are taking prescribed medications for mental illness. Suicide is the second most common cause of death for college students, while substance abuse is a serious threat to campus safety. Disruptive student behavior is becoming increasingly common in our classrooms. Stress levels are high, particularly among graduate students.

Recent occurrences of deadly violence among students on college campuses are changing the paradigm of responsibility for student safety. College students are very diverse and call for more diverse health services and mental health services in a time when a substantial segment of the student population lacks health insurance.

The Student Health and Behavioral Issues Task Force studied these issues, and others, and conducted a survey of the 35 institutions of the University System of Georgia (USG) to assess the counseling centers' resources and challenges. The literature review, resources survey, and analysis of the USG's strengths, weaknesses, opportunities and threats lead the Task Force to present five recommendations which are found in their entirety in the report. These recommendations, in abbreviated form, are:

1. Protect the mental and physical health of students by implementing emerging nationwide standards of campus safety which include:
 - a.) a viable and practiced campus-wide emergency plan;
 - b.) the ability to immediately notify the campus community when a threat is activated; and
 - c.) a campus agreed-upon, centralized holder of communications regarding distressed and disruptive students.
2. Regularly offer administration-supported health and safety training for faculty, staff, students, and mental-health providers.
 - a.) Provide evidence-based, specialized training for mental-health providers in (1) crisis management (e.g. suicide, homicide, conduct disorders); (2) threat assessment; (3) health and wellness issues (e.g. substance abuse, eating disorders); and (4) cultural competency guidelines (e.g. APA, 2002; NASW, 2001).
 - b.) Clarification of FERPA, HIPAA, ADA, Clery Act and state legal regulations regarding health, safety, and confidentiality/privilege for all campus stakeholders and first responders.
 - c.) Training Gatekeepers (e.g. residential staff, dean of students office, faculty, staff, and students) in identification, response to, and referral of distressed and distressing students of concern.

- d.) Helping faculty and staff appropriately address disruptive students in and out of class.
3. Establish policies and protocols to prevent and respond to distressed and disruptive behavior by students.
4. Support Board of Regents' adoption of the "a la carte" approach to mandated student health insurance. This would allow institutions to choose the health plan best suited to the needs of their student body related to medical and mental illnesses which impact students' successful academic and social functioning.
5. Develop ways to adequately meet student service demands for mental health services by increasing and/or sharing resources across institutions in order to:
 - a.) better approach the licensed or license-eligible mental health provider-to-student ratio recommended by the USG Counseling Directors Association and accrediting agencies such as IACS;
 - b.) provide access to psychiatric and medical consultations and services; and
 - c.) respond to campus-wide disasters by activating the statewide crisis network.

Introduction

The tragic shootings on April 16, 2007 at Virginia Tech have prompted a number of statewide and institution-specific reports on student safety and mental health concerns. The University System of Georgia (USG) demonstrates a commitment to student success as evidenced by its comprehensive strategic plan and specific strategic initiatives (University System of Georgia Strategic Plan at <http://www.usg.edu/strategicplan/>). In response to **Strategic Goal #1, Renewing Excellence in Undergraduate Education to Meet Students' 21st Century Education Needs** and the tragedy at Virginia Tech, a systemwide project for improving services on student health and behavioral issues was established. The project was charged in part with assessing the state of USG and its institutions against national and USG standards for addressing behavioral health issues; establishing aspirational standards for the provision of health and counseling services; establishing a plan and schedule for achieving the desired results; and establishing appropriate assessment protocols to enable flexibility while ensuring that student and institutional needs are met. (See Appendix A for Chancellor Davis's charge). The Lead President for the project was Dr. Thomas K. Harden, President of Clayton State University.

The membership for the systemwide project/task force was representative of a wide array of individuals with various areas of expertise throughout the USG, as can be seen by the list of task force members in Appendix B of this report. The task force met regularly beginning in February, 2008, established two subcommittees to review in turn the national context surrounding student behavioral health and safety concerns and the resources currently available in the USG. After the two subcommittees presented their respective documents, the task force as a whole reviewed, made recommendations, and continued to fine tune the plans for next steps and implementation. A SWOT analysis was conducted to further elucidate the recommendations and implementation needed to achieve the goals stated in the original charge.

This report presents a literature review that examines the current state of college student mental health concerns and provides a comprehensive review of the best practices in areas pertinent to the improvement of services for students with mental health and behavioral issues. In addition, the literature review examines the standards for counseling centers using criteria common to campuses across the country, presents best and emerging practices, and addresses the legal and ethical implications we must face as we evaluate and work to improve policies, procedures, and protocols related to student mental health and behavioral issues. The literature review sets the scene for the presentation of the results and a discussion of the resources survey completed in February-March, 2008 with counseling directors across USG institutions. The final three sections of the report provide a SWOT analysis that compares the trends regarding standards of care and student needs to the current USG resources, followed by recommendations and the outline of an implementation plan to address our needs.

Literature Review

**UNIVERSITY SYSTEM OF GEORGIA (USG) SYSTEM-WIDE TASK FORCE
STUDENT HEALTH AND BEHAVIORAL ISSUES
LITERATURE REVIEW**

INTRODUCTION

The primary purposes of the literature review were to examine the current state of college student mental health concerns, and to provide a comprehensive review of best practices in areas pertinent to improvement of services for students with mental health and behavioral issues. Several documents have provided a significant amount of guidance in the preparation of this report. A number of statewide and institution-specific student mental health and safety reports have served as models to form the foundation of this report initiated by the Chancellor of the University System of Georgia. These reports include the University of California's Student Mental Health Report (2006), the University of Georgia's Evaluation of Psychological Services Protocols Report (2007), the State of Illinois Campus Security Task Force Report to the Governor (2008), the University of North Carolina Safety Task Force Report (2007), and the Florida Gubernatorial Task Force for University Campus Safety (2007).

After providing a general overview of college student mental health in Part One, Part Two examines operational standards for counseling centers using criteria common to campuses across the country (International Association of Counseling Services, Inc., 2000) and criteria specific to the University System of Georgia (Standards for Counseling Centers in the University System of Georgia, 1997; 2003). Integrated into Part Two are examples of best practices for ensuring the safety of the campus community. Part Three describes emerging practices which address current areas of special interest including campus safety/students of concern, underrepresented students, access to resources, peer education, and staff training. Part Four addresses the legal and ethical implications we must face on our college campuses as we examine and improve some of the policies, practices, and procedures that come into play related to student mental health and behavioral issues.

The material that follows, including the recommendations, highlights an overriding theme that emerged during the process of conducting and writing the literature review: that the necessary and important responses to student health and behavioral issues are institutional in nature. Although various departments and individuals on campuses have different roles to play in addressing behavioral issues, the impetus is on institutions to coordinate and communicate about the various roles and responsibilities of appropriate individuals to ensure timely, effective, preventive, and responsive measures are in place in order to ensure, as much as possible, the safety and success of all individuals who engage in the business of higher education on our campuses.

PART ONE – COLLEGE STUDENT BEHAVIOR AND MENTAL HEALTH

National data indicate that approximately 18,000,000 students were enrolled in colleges and universities during the 2007-2008 academic year (Digest of Education Statistics,

2007). Approximately 8.5 percent of students – one of every 12, or 1.5 million – sought counseling (Gallagher, 2007). The following summary outlines the scope of mental health and safety challenges presented by these students and establishes the parameters for the task force’s review of standards, best practices, and recommendations.

Premise 1: Nationwide, college students with mental health issues are presenting with greater frequency, severity and complexity (Benton, Robertson, Tseng, Newton, & Benton, 2003). The University of California’s 2006 President’s Report noted that “as a result, the workload among mental health and other professionals on our campuses is increasing, not only because they have to address directly the increasingly complex needs of greater numbers of individual students, but because they have to assist in the campus community’s collective response to these needs” (p. 5).

Supporting Evidence:

In the most recent National Survey of Counseling Center Directors (Gallagher, 2007) more than 91 percent of the 272 counseling center director responders across the United States reported seeing an increasing number of students with serious mental health problems. This percentage was up from 85 percent in the 2005 report (Gallagher, 2005). This trend was supported in recent research conducted at Kansas State University, where Benton, Robertson, Tseng, Newton, and Benton (2003) found that the proportion of students seen for anxiety disorders had doubled, depression had tripled, and serious suicidal ideation and intent had tripled over a period of 13 years.

Not only are students with more severe psychological problems coming to campus, but more of them are seeking services at counseling centers across the country. Universities are reporting between 40-55 percent increases in the number of students seeking counseling in a previous five-year period (Soet & Sevig, 2006). For example, the University of California’s President’s Report (2006) noted that Columbia University reported a 40 percent increase in the use of counseling services since 1995; MIT experienced a 50 percent increase between 1995-2000; and the University of Cincinnati reported a 55 percent increase in the number of students seeking counseling over the last six years (Berger, 2002; Goetz, 2002). More recently, after the Virginia Tech homicides in 2006, 66 percent of the counseling center directors surveyed by Gallagher (2007) reported a significant increase in calls coming from faculty members and others on campus seeking consultation about students of concern, and 61 percent reported an increased interest on their campuses in developing a crisis management team or in redesigning one that already exists.

Premise 2: Depression and anxiety account for the most common forms of mental illness requiring intervention and treatment in the college student population (Robertson, Benton, Newton, Downey, Marish, Benton, Tseng, & Shin, 2006). Depression, anxiety, and other psychological disorders have been shown to negatively affect social and cognitive functioning and thus the academic progress, retention, and success of students (Haines, Norris, & Kashy, 1996; Osfield & Junco, 2006; Spence, Duric & Roeder, 1996).

Supporting Evidence:

Nationwide data on college students has been collected by the National College Health Assessment (NCHA) in bi-annual surveys conducted by the American College Health Association (ACHA) since 1998. The NCHA survey collects data on students' habits, behaviors, and perceptions on prevalent health topics, including mental and physical health topics.

The Fall 2007 NCHA survey of 20,507 students on 39 campuses found that 43.2 percent reported feeling so depressed in the past year that they could not function, 10.3 percent reported seriously considering suicide in the previous year, and 1.9 percent reported attempting suicide in the previous year. In the Fall 2007 survey, 18.9 percent of students reported experiencing depression in the past year, 13.1 percent reported experiencing an anxiety disorder, and 6.1 percent reported experiencing seasonal affective disorder (SAD). Within the previous twelve months, 15.5 percent of students reported that depression/anxiety disorder/SAD affected their individual academic performance by causing them to receive an incomplete; drop a course; or receive a lower grade in a class, or on an exam or important project (ACHA 2007).

By comparison, the ACHA's Fall 2006 NCHA survey of 23,863 students on 34 campuses found that 42.2 percent were so depressed that it was difficult to function; 9.4 percent had seriously considered attempting suicide in the previous year and 1.4 percent reported having attempted suicide. In this survey, 17.5 percent of students reported experiencing depression in the past year, 12.7 percent reported an anxiety disorder, and 6.0 percent reported experiencing SAD. Within the previous twelve months, 15.2 percent of students reported depression, anxiety, or SAD affected their individual academic performance (ACHA 2008).

Benton et al. (2003) reported that the proportion of students who came to counseling centers with depression increased from 21 percent in 1990 to 41 percent in 1999. In addition, a 40 percent increase was found in the number of Big-10 institution students seen at counseling centers from 1992 to 2002 (Benton et al., 2003).

The impact on the academic success of students suffering from mental health issues, including depression and anxiety, is profound. A study of productivity costs of depression at Western Michigan University (Hysenbegasi, Hass, & Rowland, 2005) showed that depressed students were more likely to miss classes, assignments, and exams as well as drop courses. Depressed students also experienced a decline in grade point average of 0.49 on a 4.0 scale. Researchers at Kansas State University found that mood difficulties explained 25 percent of the variance in student learning problems, and that the difficulties interfered significantly with students' academic functioning overall (Benton, 2006). Anxiety can also interfere with students' learning, memory, and retrieval processes, affecting the amount of material they can absorb during class and recall on subsequent exams (Katahn, 1966). Osfield & Junco (2006) also note that students at institutions of higher education are exhibiting behaviors on the autistic and/or personality disordered spectrums.

Premise 3: An increasing number of students are coming to campus taking prescribed medications for mental illness (Cooper, 2006).

Supporting Evidence:

The increased number of students taking prescribed medication who enroll in college represents a significant increase over the past twenty years (Gallagher, 2007). The Student Health Committee's Final Report for the University of California Office of the President (2006) reported that about one in four students seeking campus counseling services were taking prescribed medication for psychiatric problems at the time they sought counseling. The report observed: "Prescribed psychotropic medications, in combination with psychological counseling, are allowing more and more young people to function normally and compete academically. While these students may not have been able to attend college in the past, they are now graduating from high school and going on to pursue higher education. However, these students arrive on campus with different needs and expectations for services and also with different risk factors. Sometimes, because they are in a new unstructured environment or simply because they want to experiment, they choose to discontinue their medications. The resulting behavior—including threats, assault, and self-destructive actions—can have lasting and widely reverberating impacts on the entire learning community" (p. 4).

As a result of the increased utilization and effectiveness of medications which allow more students to attend college, many campuses are experiencing significant pressure to increase availability of relatively costly services of psychiatrists or psychiatric nurse practitioners to monitor students' response to medications (Cooper, 2006). Many of these students do need continued medication consultation, relapse prevention, and support in order to be successful in college settings. Decisions about resource and personnel allocation are definitely called into question as more students who are taking psychotropic medication enroll on our campuses.

Premise 4: Suicide is the second leading cause of death among college students (Suicide Prevention Resource Center, 2006; Jed Foundation, 2008).

Supporting Evidence:

College counseling center directors reported 105 student suicides in the past year with most of the suicides (63%) occurring off campus and only 22 percent of these being current or former center clients (Gallagher, 2007). Some contend that counseling is one of the primary protective factors mitigating against the risk of student suicide.

Although the vast number of individuals with mental illnesses do not commit suicide, it is important to note that approximately 90 percent of individuals who do commit suicide have a diagnosable mental health condition, the two most common being depression and substance abuse (NIMH, *The Numbers Count*, 2006, available at <http://www.nimh.nih.gov/publicat/numbers.cfm>).

The suicide rate of traditional-age college (18-24) students has, however, remained approximately half the suicide rate of their comparable age, nonstudent peers (Schwartz,

2006). While there are likely to be multiple intervening factors, Schwartz (2006) argues that the primary protective factor is campus prohibition of firearms. Schwartz's argument is supported by the fact that while most suicides are committed by the use of firearms, college students most often commit suicide by jumping or hanging (American Foundation of Suicide Prevention, 2006, at http://www.afsp.org/index.cfm?fuseaction=home.viewPage&page_id=1)

Premise 5: Substance abuse is one of the greatest threats to campus safety (Cooper, 2006).

Supporting Evidence:

Among students who responded to the NCHA survey in Fall 2006, 3.2 percent reported experiencing a substance abuse problem within the past 12 months. The University of North Carolina Campus Safety Task Force Report to the President (November, 2007) noted that student "alcohol and drug abuse are among the greatest threats to campus safety" (p. 5). The consequences of excessive and underage drinking affect virtually all college campuses whether individual students choose to drink or not.

In a snapshot of annual high-risk college drinking consequences, statistics indicate that college students between the ages of 18 and 24 suffer from the following alcohol related consequences, reported in

www.collegedrinkingprevention.gov/media/NIAAA_Back_to_College_Fact_Sheet.pdf

1. 1,700 die each year from alcohol-related unintentional injuries, including motor vehicle crashes (Hingson et al., 2005);
2. 1.2 percent to 1.5 percent of college students indicate that they tried to commit suicide within the past year due to drinking or drug use (Leichliter, et al. 1998);
3. 696,000 are assaulted by another student who has been drinking;
4. 97,000 are victims of alcohol-related sexual assault or date rape (Hingson et al, 2005);
5. 400,000 had unprotected sex;
6. more than 150,000 develop an alcohol-related health problem;
7. about 25 percent of college students report academic consequences of their drinking, including missing class, falling behind, doing poorly on exams or papers and receiving lower grades overall (Wechsler et al., 2002).

Premise 6: Reports of distressing and disruptive student behavior, no matter the underlying cause, are becoming increasingly common in college classrooms and on campuses across the country (Owen, Tao, & Rodolfa, 2006).

Supporting Evidence:

Even before Virginia Tech (2006), colleges and universities reported increasing concerns regarding the incivility and more disruptive behaviors among their students (Owen et al., 2006). Coping with such behaviors on both practical and legal fronts continues to present challenges and engender policies, procedures, and training efforts to deal with the behaviors (Noonan-Day & Jennings, 2007). Questions and concerns about the appropriate

faculty, administrator, and staff responses to disruptive student behavior have engendered efforts to define disruptive behavior and manage the affronts to the campus climate when it occurs. The need for legal procedures arises as colleges grapple with understanding the rights and responsibilities of all parties concerned and the liabilities a college may face for any failure to take appropriate steps to effectively manage student behavior (Noonan-Day & Jennings, 2007).

Owen et al. (2006) argue for “clear policies regarding the exceptions to confidentiality when counseling is provided by the college or university staff” (p. 26), encourage campus communities to inform not only Counseling Center staff but department chairs and the Dean of Students’ Office when they are concerned about a distressed or distressing student, and recommend that campuses “develop informational resources (e.g. web sites) and opportunities (e.g. orientations, focus groups, parent associations) for parents to discuss concerns about their children’s transition to campus” (p. 25). In addition, campus officials need to apply policies and procedures consistently, ensure students’ rights to due process, and train faculty, staff, and administrators to identify warning signs and report concerns promptly and effectively. Finally, the U.S. Department of Education has issued a report identifying those risk factors in the campus environment that foster or perpetuate violence, such as alcohol use, fraternity hazing practices, and intolerance of individual differences including identifying individuals who are most likely to be most affected by various types of interpersonal violence (<http://higheredcenter.org/services/publications/interpersonal-violence-and-alcohol-and-other-drug-use>). As Greenberg (2007) notes, colleges and universities should use the results of such reports to inform policies and protocols designed to address campus violence.

Premise 7: Emotional stress levels of graduate students are high, yet often overlooked Soet & Sevig, 2006).

Supporting Evidence:

In the Final Report of the Student Mental Health Committee for the University of California (2006), graduate students participating in a UC-Berkeley study reported higher levels of stress, perceived mental distress, and suicidal risk than undergraduates, and indicated that their distress significantly affected their well-being and/or academic performance in the last 12 months. However, these students perceived no need and no time to use mental health services, which may be why they can be overlooked in institutional evaluation of student service needs. These graduate student needs were found to be significant in another recent study by Soet & Sevig (2006) which used the Counseling Center Assessment for Psychological Symptoms (CCAPS) to assess a range of mental health concerns in a large Midwestern university. They found graduate and professional students almost twice as likely to report depression as undergraduate students. Their findings have resulted in several initiatives by the graduate school at the university to address stress and coping for graduate students, including the hiring of a health coordinator for graduate students, launching of media and education campaigns, and scheduling several campus symposia (Soet & Sevig, 2006).

Premise 8: The relatively recent pattern of deadly violence against students on college campuses is changing the paradigm of responsibility for student safety.

Supporting Evidence:

Shooting violence on college campuses is a relatively recent problem. Statistically, campuses are still safer than off-campus areas. College students aged 18 to 24 experience lower violent crime rates than non-students of the same age, with 93 percent of the crimes that students experience occurring off campus, according to National Crime Victimization surveys (Reaves, 2008). Additionally, according to the U.S. Department of Education (<http://www.ed.gov/index.jhtml>), 95 students were murdered on college campuses from 1999 to 2004; during that period 2,713 student murders occurred in surrounding communities, making the murder rate about 28 times higher off campus than on campus. Finally, based on available data from the United States Department of Education, an average of 16 murders occurred per year on college campuses from 1999 to 2004. Since there are 4,200 colleges in the United States, the average college can expect a murder on campus about once every 265 years (ACHA, 2005). This perspective led Dewey Cornell in the *NASPA Leadership Exchange* (2008) to argue that resources should be allocated in proportion to the seriousness of the risk since violence on college campuses, while certainly an important problem, “must be placed in perspective with the larger problem of violence in American society” (Dewey Cornell, Winter 2008, “Threat Assessment on the College Campus,” *NASPA Leadership Exchange*, p. 10).

The culture of responsibility between student and university has shifted at least once before. As Benton (2006) noted, “From the 1700’s through the 1950’s, students were primarily viewed as adolescents whose unruly tendencies needed to be controlled. Universities were viewed *in loco parentis* and had wide latitude in regulating and managing student behavior. From the 1960’s through the 1980’s students’ rights and freedom were established through a series of court cases. *Dixon vs. Alabama State Board of Education*, 1961, (294 F.2d 150) successfully abolished the concept of *in loco parentis*. Following several Supreme Court rulings which established that students over the age of 18 were adults and had the right to make their own decisions (Bickel & Lake, 1994), universities had far less capacity to regulate students and were not held responsible for most misbehavior,” (p. 5). The current press for change thus harkens back to the pre 1960’s, but with the added twist of escalated, although relatively rare, deadly violence.

Additionally, the changing paradigm of responsibility is complicated by intervening and evolving case law, state laws regarding client privilege, and regulations put forth in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Family Educational Rights and Privacy Act (FERPA), Americans with Disabilities Act (ADA) regulations and the Jeanne Clery Disclosure of Campus Security Policy and Campus Crime Statistics Act (Clery Act). Clarifying standards of care and expectations regarding campus communications are increasingly important due to this shift in responsibility. Even though statistics for campus violence may not support the perception of widespread, increasing danger to the campus population, public perception and an emphasis on

accountability across all areas of higher education make it incumbent on us to address these concerns.

Premise 9: Today's college students are more diverse in many ways, thus calling for more diverse services (Brent, Cornish, Leslie-Toogood, Nadkarni, & Schreier, 2006; Cooper, 2006).

Supporting Evidence:

The literature cites a number of reasons for the increasing needs for expanded mental health services on campus, including the gradual de-stigmatization of mental health issues; better training of gatekeepers resulting in earlier detection; increased, post-Virginia Tech sensitivity of faculty and administration which has led to increased referrals (two-thirds of directors reported increases, Gallagher, 2007); increasing stress associated with greater emphasis on academic achievement and career successes, and increasing academic competition at earlier ages; and the generally decreasing stability of the nuclear family (Kadison & Digeronimo, 2004; Federman, 2008). There are also better assessments, interventions, and management of adolescents with psychological disorders, allowing many students who would not have been able to further their educations in the past to do so (Cooper, 2006).

In addition, the demographics of today's college student population continue to change, reflecting the demographic shifts across our nation and the consequent enrollment of students who identify with non-dominant cultures. As our student populations become more diverse, their needs change as well (Kitzrow, 2003). Students are diverse along many dimensions, including age, race and ethnicity, disability, gender identity, sexual identity, international status, rural/urban, social class, and spirituality/religion (Brent, Cornish, Leslie-Toogood, Nadkarni, & Schreier, 2006). Each campus must address unique issues depending upon the degree of its diversity, including the appreciation and implications of cultural differences in communication, learning and teaching styles, the effects of oppression and intercultural stress, and the signs and symptoms of mental health and illness. Students will increasingly benefit from stress management, help-seeking, and intercultural communication skills. Thus, changing student demographics reflect changing student needs, and require providers to alter the ways in which they provide support to allow these students to achieve and maintain academic and eventual career success. In order to address the needs of increasingly diverse student populations, university professionals, particularly those engaged in providing mental health and wellness services, may need initial or advanced training in cultural competencies in order to effectively educate, assess, and treat students whose cultural identification is different than their own.

Premise 10: A substantial segment of the college student population, like the national public, lacks health insurance (*Health Coverage Often Stops at the Campus Gates*, New York Times, February 2008).

Supporting Evidence:

Today, there are more than 45 million uninsured individuals within the United States (*Income Stable, Poverty Up, Numbers of Americans With and Without Health Insurance Rise, Census Bureau Reports*, U.S. Census Bureau, August 30, 2004, retrieved from http://www.census.gov/Press-Release/www/releases/archives/income_wealth/index.html). The cost of caring for the uninsured currently approaches \$99 billion per year; Stephen C. Caulfield, chairman of the Chickering Group, a unit of the Aetna Company, indicated that nearly 4.5 million of the nation's uninsured are college students (New York Times, 2008).

Health insurance is one of the most important factors influencing access to health and mental health care services. An increasing number of students are arriving at today's college campuses with mild to severe needs for mental health services. Mental health coverage often includes the following services: (1) hospital and other 24-hour services (e.g. crisis residential services); (2) intensive community services (e.g. partial hospitalization); (3) ambulatory or outpatient services (e.g. focused forms of psychotherapy); (4) medical management (e.g. monitoring psychotropic medications); (5) case management; (6) intensive psychosocial rehabilitation services; and (7) other intensive outreach approaches to the care of individuals (*The Surgeon General Report, Financing and Managing Mental Health Care*, <http://www.surgeongeneral.gov/library/mentalhealth/chapter6/sec3.html>).

A lack of coverage affects a student's ability to access and obtain necessary treatment and care. The data reveal that when the uninsured eventually seek needed care, they generally receive such crisis care at a hospital emergency room (New York Times, 2008). Emergency room physicians become primary care physicians. The resulting costs for the uninsured/underinsured are ultimately borne by the taxpayer. The costs of emergency/crisis treatment often exceed the costs of managed care.

The provision of coverage assists with the retention and eventual graduation of students. A study performed by the California Board of Regents found the number one reason that students left school was unpaid medical bills (University Business, 2004). Students who receive treatment for their psychological problems, have a better chance at academic success. Moreover, mental health problems may also have a negative impact on the student's academic performance during enrollment. In addition, a student's mental health issues impact many other people on campus, including roommates, classmates, faculty, and staff.

Summary Statement for Part One

The frequency and complexity of students' mental health and wellness needs on our campuses has steadily increased over the last decade. The Virginia Tech shootings and other incidents of campus violence has galvanized attention and prompted responses to student safety issues; the impetus is on the University System to find ways to better address the widening range of concerns currently related to student health and wellness.

PART TWO – COUNSELING CENTER STANDARDS AND BEST PRACTICES

The International Association of Counseling Services, Inc. [IACS] typically accredits counseling centers in larger institutions. The significant expense of that process, particularly for smaller centers, coupled with a desire to promote standards statewide, led the Counseling Directors' Association of the University System of Georgia [CDAUSG] to develop its own set of counseling center standards which reflect those developed by both IACS and the Council for the Advancement of Standards (CAS). Although CAS, like CDAUSG, does not accredit centers, it represents a nationally recognized entity working to develop standards for many functional areas of Student Affairs, including counseling services.

Both IACS and CDAUSG standards speak to the complexity of determining an ideal staff to student ratio. Among the issues to consider are the scope of services offered, availability of other services in the college and the community, size and nature of the institution, and the training responsibilities of the center's staff. The recommended range is one counselor for every 1000-1500 students (IACS) or one counselor for every 500-1000 students (CDAUSG).

The nature of the institution can have a major impact on the need for services. Residential programs can dictate the need for more staff, as can multiple campuses. Students in particular developmental periods or involved in certain types of programs typically use services at different rates. The missions of the institution and of the center play a role in determining who is served and in what ways. The ability of other service providers, either on- or off-campus, to provide for student needs is an additional factor in determining the level of service needed from a counseling center.

The sections below will integrate a discussion of the counseling standards noted above along with examples of empirically supported or professionally recognized "best practices" of ensuring campus safety and security as they relate to the essential components of the standards. A number of the standards speak to issues relevant to the safety of students, staff, and others in the campus environment and address concerns regarding student behavior and mental health as noted in the introduction. Where possible and appropriate, the evidence for support for "best practices" will be included. Emerging practices that speak directly to current issues of campus safety will be discussed in Part Three.

Crisis Intervention

Counseling Centers provide a wide variety of services. However, both IACS and CDAUSG standards speak to the importance of providing emergency services and crisis intervention for students who are experiencing acute emotional distress, are a danger to self or others, or are in need of immediate hospitalization. IACS (2000) notes these services must be provided "either directly or through cooperative arrangements with other resources on campus or in the surrounding area" (p. 4). In addition, psychiatric services must also be available either on campus or in the community. These services are

of particular concern given the recent increases in the severity of student symptomology and demands for crisis services (Gallagher, 2007).

In response to the need for a common framework for gaining skills in suicide assessment, the American Association of Suicidology's (AAS) Core Competencies Curriculum for the Assessment and Management of Individuals at Risk was developed through the support of the Suicide Prevention Resource Center (SPRC) under a federal grant. The competencies were based on current empirical evidence and expert opinion. The core competencies are intended to provide the foundation for developing courses and continuing education specific to the assessment and management of individuals at risk for suicide.

Additionally, the JED Foundation (<http://www.jedfoundation.org>) works with other institutions and agencies across the country to identify the underlying causes of suicide and produce effective prevention, awareness, and intervention programs. The Foundation developed a *Framework for Developing Institutional Protocols for the Acutely Distressed or Suicidal College Student* that provides colleges and universities with a list of issues to consider when drafting or revising protocols related to the management of students in acute distress or at risk for suicide. Notably, the *Framework* was the culmination of a roundtable held in November 2005 that included senior college administrators, college counselors, and other mental health practitioners and attorneys who specialized in college issues. The resulting document is divided into three sections that colleges can download and use to develop a safety protocol, an emergency notification protocol, and a leave of absence and re-entry protocol.

In 2007, in response to the need for a framework for addressing disruptive students and campus violence, the National Association for Student Personnel Administrators (NASPA) convened a working group and drafted a report on "In Search of Safer Communities: Emerging Practices for Student Affairs in Addressing Campus Violence." The NASPA working group was charged with a) examining various post-Virginia Tech reports and best practices, and b) developing guiding principles for practice for student affairs. The working group brought the report to the 2008 NASPA conference in Boston and solicited feedback from student affairs leaders. The draft report outlined a Crisis Management Model designed to address campus violence. This model may eventually serve as a best practices paradigm for student affairs in particular and campuses in general.

Finally, the National Center for Higher Education and Risk Management (NCHERM, www.ncherp.org/policies.html) develops and sells a number of best practices and model policies for student health and safety. These include: NCHERM Model Sexual Misconduct Policy, Conduct Procedures and Rights Statement, NCHERM Model Developmental Student Code of Conduct, NCHERM Model Student Suicide Intervention Protocol/NCHERM Model Voluntary/Involuntary Medical Withdrawal Policy and Procedure, and NCHERM Model College and University Behavioral Intervention Team Formation and Operation Protocol. Institutions may review any of NCHERM's documents with no obligation after signing a non-disclosure agreement. For \$10,000 an

institution may purchase a license to use all of NCHERM's proprietary models or purchase individual segments.

Individual and Group Counseling/Psychotherapy

Both IACS and CDAUSG standards cite the necessity of Counseling Centers to provide individual and group counseling. IACS requires that these services are “responsive to the diverse population of students experiencing ongoing or situational or behavioral difficulties.” Staff must be trained not only in the educational, career, personal, developmental, and relationship assessment and counseling they provide, but also in the diverse issues reflective of the students they serve, including sexual identity, racial, cultural, disability and ethnic diversity.

The standards require that all counseling services staff members –Licensed Clinical Social Workers (LCSWs), Licensed Professional Counselors (LPCs), and Licensed Psychologists (PhDs) – adhere to ethical standards, such as those approved by the American Psychological Association (APA), American Counseling Association (ACA), American College Personnel Association (ACPA), American Mental Health Counselors Association (AMHCA), or National Association of Social Workers (NASW), and guidelines for working with student diversity such as APA's guidelines on multicultural education, training, research practice and organizational change for psychologists (APA, 2003) and NASW's standards of cultural competency in social work practice (NASW, 2001). CDAUSG (2003) notes that all personnel at counseling centers should be “thoroughly trained regarding relevant federal, state and social statutes which govern the delivery of counseling and psychological services” (p. 12). Continuing education in these areas is thus a professionally recognized best practice, reinforced by the State of Georgia licensing board requirements for licensure renewal. Furthermore, CDAUSG (2003) notes that “according to Georgia state licensure laws, any staff members working in the area of personal counseling should hold a professional license or be on record, once hired, as in the process of obtaining licensure” (p. 10). Licensure is thus seen as a protective factor, serving to help ensure quality of service through professional ethics, legal codes, and continuing education.

CDAUSG recognizes the value of referral resources which can supplement services provided by counseling centers. Professional staff must be knowledgeable about resources on and off campus that are appropriate “to meet the needs of students whose problems are outside the scope of services of the counseling center” (p. 6). Additionally, administrative tasks, particularly reporting requirements and the evaluation of needs, clinical outcomes, and client satisfaction are critical to providing optimal levels of care.

Outreach and Educational Programming

IACS (2006) and CDAUSG standards (2003) also cite the need for educational or outreach services to students. Most Centers provide general educational outreach programming for academic classes, student organizations, new student and family orientations, and other campus entities and initiatives. Most also participate in providing

training to groups on campus, ranging from student residential staff to faculty. Fewer Centers offer credit-bearing courses, either of a more general developmental nature (e.g. student success) or in particular disciplines of study (e.g. psychology).

More specific to Counseling Centers' outreach missions, the Florida Gubernatorial Task Force for University Campus Safety (2007) noted that "prevention of mental illness and crisis situations should be the major focus of each university's efforts. A comprehensive campus mental health program, including efforts to prevent underage drinking, alcohol and other substance abuse, suicides, bullying, and domestic and dating violence, as well as providing for appropriate intervention, is necessary for a positive, healthy institutional climate" (p. 12).

Suicide Education and Prevention Best Practice Examples

The Best Practices Registry for Suicide Prevention at http://www.sprc.org/featured_resources/bpr/index.asp provides a myriad of resources and publications aimed at the awareness and prevention of suicide. The Best Practices Registry (BPR) is a collaboration between the Suicide Prevention Resource Center (SPRC), and the American Foundation for Suicide Prevention (AFSP), and is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). The BPR provides information on evidence-based programs that have undergone evaluation and demonstrated positive outcomes, offers expert and consensus statements, and contains a section on suicide prevention programs, protocols, and policies that have been implemented in specific settings, including those that promote effective practices for suicide prevention in college and university settings. In addition, their online library contains resources for developing cultural and linguistic competence in engaging minority populations in suicide prevention activities.

The JED Foundation also has a wealth of resources and program information available on their web site (<http://www.jedfoundation.org>). For example, their *ULifeline* project is an anonymous, confidential, online resource center where college students can search for information they need on mental health and suicide prevention. The information on the JED Foundation web site notes that more than 1,200 colleges and universities participate in the ULifeline Network and that it is provided free of charge to all colleges and universities who request it.

In addition, the JED Foundation and the American Psychiatric Foundation are currently completing a Transition Year Project to help ensure the safe and healthy transition of students from high school to college and to lay the groundwork for productive years beyond college. The ultimate goal of the program is to create guides for parents and students that will be available both online and in print. The Parents Resource Guide will cover the warning signs for mental health problems, issues of mental health and well-being that should be considered when selecting colleges, and other relevant topics. The Student Resource Guide will cover typically challenging transition issues such as stress management, adjusting to college, friends and roommate issues, sleep, and academic performance, among others. The JED Foundation believes these materials fill an

informational gap because they focus specifically on mental health and the transition to college life and address these topics in a comprehensive manner.

All of the resources cited above are readily available and useful to campuses and mental health professionals. They are thorough, based on expert consensus, and are relevant to the issues addressed by this task force.

Alcohol and Other Drug Education Best Practice Examples

The use and abuse of alcohol and other drugs on college campuses directly affect students' mental health and coping strategies and contribute to increased disruptive behavior and possible violence (Cooper, 2006). Dickerson (2006) recommends that universities should seriously consider implementing an environmental management plan which might include using "the Core Alcohol and Drug Survey to determine the extent of high risk drinking on campus, collaborative risk-management teams to identify risk and solutions to the campus culture, campus-community coalitions to involve the greater community in the fight against high-risk drinking, longitudinal social-norming campaigns to help students understand statistics about drinking among peers and various education and program options that would help invade the time and space currently consumed by the alcohol culture..." (p. 66). Numerous programs and activities attempt to stem the tide of this problem on campuses. A few of them are highlighted below.

Campuses across the country are using a number of different instruments and interactive programs to help assess the use of substances by individuals and across targeted campus groups such as sorority and fraternity members (Greeks), first-year students, athletes, etc. Currently, Alcohol EDU, eChug, eToke, MyStudentBody, CHOICES, and BASICS are among the most popular. Many of the assessments are available online, give a usable printout, and range in cost.

The Network at <http://www.thenetwork.ws/standards.html> has been in existence since 1987. Originally formed in partnership with the U.S. Department of Education, The Network is a voluntary membership organization whose member institutions agree to work toward a set of standards aimed at reducing alcohol and other drug problems at colleges and universities. It now has approximately 1,600 members nationwide. The standards serve as durable guidelines for institutions of higher education addressing alcohol and other drug issues on their campuses and in surrounding communities. During the last 10 years, The standards have provided a framework for institutional activities and task force initiatives, models for federal and state legislation, and a focal point for action on reducing alcohol, other drug, and related violence (AODV) problems among students. These standards reflect current research on effective prevention approaches that include individual, educational, and environmental strategies. Standards are organized within five areas: policy, education and student assistance, enforcement, assessment, and community collaboration. They are downloadable at the web address above.

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) provides abundant resources and comprehensive research-based information on issues related to alcohol

abuse and binge drinking among college students at <http://www.collegedrinkingprevention.gov/>. Among other publications, the resource provides *What Colleges Need to Know Now: An Update on College Drinking, A Call to Action: Changing the Culture of Drinking at U.S. Colleges, College Fact Sheet for Parents*, and access to a prevention curriculum. Statistics on college drinking, research reports, and alcohol policies listed by state and institution are also provided.

Consultation and Community Relations

IACS and CDAUSG standards specifically note that counseling services must provide consultative services to members of the university community, taking “an active role in advocating for the needs of students to administrators, faculty and staff,” (p. 6) as well as parents, spouses, and other agencies. However, these consultations must always be conducted in such a way as to protect student confidentiality requirements and in general adhere to state law and professional ethics.

Training

IACS and CDAUSG standards require Counseling Centers to provide staff members and trainees with professional development and continuing education experiences. As previously stated in the section on Individual and Group Counseling Services, professional staff should be supported in activities required to achieve and maintain licensure. Specifically, staff members need sufficient training to be familiar with and have the competencies to satisfy the ethical guidelines (e.g. APA, ACA, ACPA, NASW), including those related to working with clients of diverse backgrounds (e.g. APA Guidelines on Multicultural Education, Training, Research Practice, and Organizational Change for Psychologists, 2002) and NASW’s standards of cultural competency in social work practice (NASW, 2001).

A number of Georgia counseling centers provide supervised internship and practicum sites for students (as well as postdoctoral fellows) in mental health disciplines. This commitment includes rigorous requirements for clinical supervision of students by the more experienced staff members. Several sites in the state provide psychology internships approved by the American Psychological Association, which has especially high standards for training. Fewer sites provide training programs for postdoctoral fellows. APPIC membership provides standards and practices to which postdoctoral programs should adhere.

PART THREE – EMERGING INTERVENTIONS

Changing student demographics and the recent escalation of violence on college and university campuses, along with other factors, have given rise to a number of significant emerging policies, protocols, and services. This section cites examples of trends and ideas which are currently being given special attention by higher-education professionals.

Campus Safety/Students of Concern Committees/Threat Assessment

Student safety has always been a priority for mental health professionals in terms of identifying and intervening to protect students who were a danger to self or other. The issue of protection has broadened since the tragedy at Virginia Tech. A common recommendation emerging from committees and task force reports has been the creation of a team on campus to regularly review disturbing or disruptive student behavior and make recommendations about appropriate interventions. The Virginia Tech report (2007) recommends that “institutions of higher learning should have a threat assessment team that includes representatives from law enforcement, human resources, student and academic affairs, legal counsel, and mental health functions. The team should be empowered to take actions such as additional investigation, gathering background information, identification of additional dangerous warning signs, establishing a threat potential risk level (1 to 10) for a case, preparing a case for hearings (for instance, commitment hearings), and disseminating warning information” (p. 19). The establishment of a multi-disciplinary behavioral assessment committee or students of concern team has likewise been recommended in *The State University of New York’s Chancellor’s Task Force on Critical Incident Management* (2007), *The University of North Carolina Campus Safety Task Force Report* (2007), *The Florida Gubernatorial Task Force for University Campus Safety Report* (2007), and *The University of Georgia Evaluation of Psychological Services Protocols Committee Report* (2007), among others.

These teams are supported by standards focusing on crisis intervention and training that addresses the continuum of distressing and disruptive student behavior, as well as consultation and collaboration between counseling center staff and other campus stakeholders. The post-tragedy Virginia Tech findings underscored the need for communication between faculty, staff and the dean of students, as allowed by FERPA in order to ensure service of student health and safety. The new FERPA proposals addressed in the next section of this report further clarify the conditions under which non-mental health staff can and should communicate regarding students whose behavior is of concern.

A review conducted by a subcommittee of the task force of 15 behavioral intervention or threat assessment teams across various campuses found many similarities among the teams that currently exist. Most of these teams function as informal consultation bodies that provide feedback on student behavioral issues when requested by faculty or staff. This limits their effectiveness to some extent, and the ability to accomplish the two main tasks agreed on by most proponents of threat assessment teams: (1) to ensure that students in distress or those who are disruptive are afforded the care and consequences needed to address their behaviors; and (2) to ensure coordinated communication across campuses. Additional recommendations for the establishment and implementation of comprehensive behavioral intervention and threat assessment teams can be found in a recent white paper published by Brett A. Sokolow and Stephaine F. Hughes for the National Center for Higher Education Risk Management (NCHERM, 2008). The paper highlights the composition, goals, procedures, and protocols for threat assessment teams,

and offers explicit recommendations for integrating these teams with emergency operations and incident response teams on campus.

An example of a new collaborative program designed to meet a range of campus safety needs has been developed by the University of Oregon and its “Healthy Campus Teams” (www.healthymindsstudy.net) which is described on its web site (<http://oregonstate.edu/deanofstudents/hcilt.html>) as “a collaborative approach to prevention initiatives and response efforts. A coalition of service providers offers strategic planning, policy review and development, ongoing training and development, assessment of situations and outcomes, and comprehensive, interconnected leadership for the campus community. The coalition will develop common resources for faculty, staff, and students. The Healthy Campus Teams include:

- A critical incident response team – to assess and coordinate the response to significant campus situations and events which require intervention in order to assist the community and its members to return to a more homeostatic state of functioning;
- A bias response team – to assess and coordinate the student services response to campus bias incidents;
- An infectious diseases incident response team – to collaboratively determine and implement strategies for prevention, control, and preparedness of communicable disease issues and health threats to the university community;
- A sexual assault response and prevention alliance – to strengthen collaboration and coordination of sexual violence response and prevention initiatives;
- A health and wellness task force – to review policies and make recommendations on issues related to a healthy campus community, identify environmental factors that detract from, or contribute to, a healthy university climate, advise and inform the President's Cabinet concerning issues of campus health and support the work of Campus Prevention and Incident Response Teams;
- A suicide awareness task force; and
- An alcohol work group – to address underage and excessive alcohol use issues at Oregon State University by developing a comprehensive strategic plan for creating a safe and healthy environment on campus and in the surrounding community.”

Special Counseling Programs for Underrepresented Students

A review was conducted of 26 different counseling centers to assess the extent to which they offered services and programs to underrepresented populations, broadly defined. Our conclusion based on this review is that many services and programs are provided to underrepresented populations; however, depending on the size of the institution and its staff, quantity and content vary.

Services and programs for underrepresented groups appear to be divided into two categories: programs designed for specific populations (women, international students, LBGTQ students, adult learners) or issue-specific programs (eating disorders support group, dissertation/thesis support group, sexual identity group, first generation college

student group). Support groups that are common to most campuses and serve specific populations address issues that face women, LBGQTQ persons, stressed and anxious individuals, graduate students, students of color, and students in relationships. These offerings make sense in light of developmental issues facing traditional college-age students during their college years. On some campuses, non-traditional age students have access to support groups that deal with transition back to school, adult issues groups, stress, and parenting. Universities that provide a vast array of programs include North Carolina State University, Penn State, UCLA, University of Texas-Austin, and the University of Georgia.

Accessibility to Resources

Online resources provide additional means of accessing information and counseling services, especially for students who are reluctant to seek face-to-face services. Most campus counseling centers and health centers have websites outlining services offered, hours, location, contact information, and staff. Several have online screening tools, virtual libraries, parent and family links, and resources for faculty and staff. Few sites reviewed had all of these features, and many were difficult to navigate.

Examples of comprehensive websites featuring an array of counseling service resources include The University of Florida, Emory University, and Pennsylvania State University. All three websites have virtual libraries with extensive lists of brochures that are easily downloaded, as well as self-help resource pages with online screening tools which students can take anonymously and receive immediate feedback. Counseling is not provided online, but students receive instructions to access counseling services or other appropriate services as indicated. Online screening tools provide another means of access for those students who may not recognize symptoms of depression, anxiety, alcoholism, or eating disorders and who may be reluctant to access the counseling center.

Parents and family members are important stakeholders who want and need access to information on available counseling and health resources. As noted on the University of Florida's parent resource site "parents may also be called upon to help the student adapt to stressful events and navigate the challenges of being away from home" (http://www.counsel.ufl.edu/parentsResources/parents_resources.aspx). The University of Florida, Emory University, and Pennsylvania State University have robust parent and family sites that provide quick links to campus resources. These parent and family links also have information to help parents understand challenges their students may be facing and tips on how to help students effectively problem-solve.

Emory's website has an easily accessible centralized list of emergency numbers and resources titled "Emory SafetyNet" (<http://www.emory.edu/safetynet.cfm>). This list includes phone numbers for campus police, security escorts, medical and psychological emergencies as well as resources for sexual assault and alcohol problems.

Penn State has a "Private Practice Database" (<http://www.sa.psu.edu/caps/ppd/>) link that provides a search function for private mental health care providers in the communities

surrounding the Penn State campuses and “Students in Distress Workshop Guidelines” for faculty and staff interventions. The workshop is offered live, but the online version provides most of the material as an immediate resource, a preview, or a “refresher.”

For campuses with few resources, virtual libraries and web-based information and screening tools could be one means to augment existing staff and services. Indeed, it is becoming more common for counseling centers and/or student affairs offices to provide information for faculty and staff on recognizing and responding to distressing and disruptive student behavior. References to “red flags” or warning signs when dealing with student behavior are communicated on web sites and in brochures and trainings.

Peer Education and Training

Several recent surveys have noted that many students in distress turn to friends first when they encounter problems (American College Health Association, 2006; National Alliance on Mental Illness, 2004). In the ACHA survey, almost 20 percent of the students indicated that during the past 12 months, they had become so concerned about a friend that their own academic coursework had suffered. Likewise, the NAMI survey found that 62 percent of the students were most likely to turn to friends if they encountered a serious emotional difficulty while at school, followed by 46 percent accessing a parent for assistance, and 30 percent turning to a campus counseling center. This makes it incumbent on colleges and universities to educate all students on the resources and prevention strategies needed to help themselves and others if needed. Established programs at campuses across the country illustrate the efficacy of peer education and training for the purposes of this report.

Programs tailored specifically for students assisting other students include The University of California, San Diego’s (UCSD) “Wellness Peer Education Program.” As described on its webpage, the “Wellness Peer Educators are a group of UCSD students who go out to the UCSD community and educate other students about mental health and wellness.” The website also makes the very poignant observation that “[w]ellness in life is not just the absence of mental illness, it's the positive creation of a life committed to balance—balance of the physical, mental, emotional, and spiritual.” (UCSD Counseling & Psychological Services, *at* http://psychservices.ucsd.edu/peer_ed_web/peer_ed_wellness.html.)

The University of California-Davis Counseling and Psychological Services (CAPS) oversees the activities of two peer counseling programs, The House and the Multicultural Immersion Program. According to the CAPS web site, <http://caps.ucdavis.edu/peer/index.htm>, students who participate in these programs receive extensive training and then provide educational and peer counseling to students. The House is a drop-in and phone counseling service where students can talk to another student about personal and academic problems such as relationship concerns, loneliness, depression, and personal growth. The Multicultural Immersion Program appears to be broader in scope, and is described as a partnership between CAPS and the Department of Sociology focusing on campus programming on wellness, race relations, and intercultural

communication. The students are paid interns; once trained, they work together to design, coordinate, and implement workshops to educate other students and the campus community about fostering wellness in diverse communities.

Additionally, universities like Georgia State use peer educators as intercultural ambassadors, part of an intercultural dialogue program on campus. Cultural awareness and skill development is becoming more important as part of leadership, team, work place, and social competency development for our diverse society. The Intercultural Ambassadors group is a paraprofessional organization supported by the Office of Student Life and Leadership (SLL)/Intercultural Relations (IR) that plans and develops cultural programs and assists in training students on issues related to cultural awareness.

George Washington University also has a peer educator program. Its peer educators are required to attend a year-long series of academic seminars that focus on psychological topics relevant to college students (*See* George Washington University Counseling Center, at <http://gwired.gwu.edu/counsel/UCCPeerEducatorProgram>). The goal of the program is to “provide an outlet for the campus community to talk about the impact of mental health issues on students’ academic and personal success at GW.” (George Washington University Counseling Center, at <http://gwired.gwu.edu/counsel/UCCPeerEducatorProgram/MissionStatement/>).

Active Minds at www.activemindsoncampus.org is a peer-to-peer organization dedicated to raising awareness about mental health among college students. Founded in 2001 by a student at the University of Pennsylvania following the suicide of her older brother, the organization has grown to 112 chapters on campuses across the country. In addition to increasing students’ “awareness of mental health issues,” the chapters “provide information and resources on mental health and mental illness, encourage students to seek help as soon as it is needed, and serve as liaisons between students and the mental health community.” The organization is mindful of the fact (and states clearly) that they are not a clinical service, but notes that the organizations listed on the "Links" page are some of the most respected scientific resources about mental illness in the country, and can provide the most up-to-date information that is especially pertinent to college students. According to the list of chapters by state and school on the Active Minds website, there are five chapters at college campuses in Georgia: Agnes Scott College, Emory University, Georgia Tech, Georgia State, and the University of Georgia.

Faculty and Staff Education and Training

A burgeoning area of campus outreach focuses on educating college communities about mental health warning signs, protective factors, how to talk to distressed students and/or intervene, and available resources on and off campus. For example, the Georgia Institute of Technology (www.counseling.gatech.edu under “Info for Faculty Regarding Student Stress”) developed a short but informative training video in which key student affairs officers offer information on warning signs, intervention and referral suggestions, and resources on campus. The video is prominently available on the Counseling and Psychological Services web site with multiple links across campus.

The University of California, Berkeley's "Look for Signs" campaign reports having trained "nearly 600 administrators, faculty, graduate student instructors, resident advisors and peer counselors" to recognize and properly respond to the warning signs of someone in mental or emotional distress (Anwar, 2007). A sticker is given to those who complete the training. The sticker can be placed on work spaces or campus doors to identify individuals who are trained to lend assistance. In addition to the stickers, posters listing the major indicators of depression were distributed throughout the campus to further promote university awareness. UC-Berkeley is also in the process of developing an on-line educational workshop supporting this training (Anwar, 2007.)

A number of universities across the country have invested in training campus gatekeepers (e.g. RAs, faculty, staff, students) through curricula such as QPR (Question, Persuade, Refer, <http://www.qprinstitute.com/>) or suicideTALK (Tell, Assist, Listen, Keep safe, <http://www.chooselife.net/Training/ASIST/SuicideTALK/SuicideTALKHome.asp>). Both programs are recognized by the Joint Commission as "Best Practices" programs. MIT uses QPR along with a program that assigns experienced health care professionals and counselors to the various residence halls to interact with and maintain a watchful eye on students (Kadison & DiGeronimo, 2004, p. 178; McGinn, 2007, p. 71). In addition, some of MIT's graduate departments utilize students who have been trained as mediators to provide assistance to troubled students, listening to them and perhaps directing them to a counseling resource (Pavela, 2006).

Since 2000, Texas Christian University has used the Joint Commission approved ASIST (Applied Suicide Intervention Skills Training, <http://www.livingworks.net/AS.php>) curriculum from LivingWorks to educate more than 250 faculty and staff in suicide prevention and first aid. In 2006, when LivingWorks developed safeTALK, the TCU Counseling Center professionals began training campus leaders, staff departments, and organizations to become suicide alert helpers. SafeTALK training helps the participant focus on the steps to connect a person with thoughts of suicide to a person who can offer suicide first aid intervention. Similar to ASIST, this program also provides opportunities for the participant to practice and experience the steps of suicide alert helping.

In addition to the trainings described above, a number of other universities offer or host educational trainings about mental health issues for university faculty, staff and students. The offices of Judicial Affairs, Counseling Services, Student Life, and Legal Affairs at Baylor University recently hosted a campus-wide mental health summit as a collaborative vehicle to educate faculty, staff, and students about mental health issues from counseling, disciplinary, and legal perspectives. Stetson University College of Law and the National Association of Student Personnel Administrators collaborate to offer an annual national conference on Law and Higher Education. This year at their 29th conference, the pre-conference workshop focused specifically on best practices to create safer campuses, especially during high-risk crisis events.

PART FOUR – LEGAL AND ETHICAL IMPLICATIONS OF THE POLICIES, PRACTICES, AND PROCEDURES

Myriad laws, regulations, rules, and policies address students who are distressed, disturbed or mentally ill, or whose behavior is threatening or difficult. Laws and regulations are enacted by federal and state governments. Many institutions and governmental entities create policies, rules, guidelines, and procedures to address issues associated such students. These requirements address behavior that runs the continuum from general misconduct to student violence to self-destruction.

Campus officials must recognize and respond to distressed or violent student behavior. However, we must operate within the confines of the law, and should not penalize those who are merely eccentric or unconventional, or discriminate against those who are different but pose no harm to self or others (Americans with Disabilities Act of 1990 (ADA) (Pub.L. 101-336, 104 Stat. 327, enacted 1990-07-26), codified at 42 U.S.C. § 12101 et seq.). At the same time, we must be ready to respond to threats or behavior that could endanger individuals or a community.

In the college setting, there is an alphabet soup of laws, rules, and regulations that protect student’s educational records (Family Educational Rights and Privacy Act of 1974, also known as (FERPA or the Buckley Amendment); federal and state laws (20 U.S.C. § 1232g; 34 CFR Part 99); and regulations regarding medical records (Health Insurance Portability and Accountability Act of 1996 or HIPAA; [Pub.L. 104-191](#)), and regulations regarding dissemination of law-enforcement records, court or judicial records, and other governmental data. Many of these laws and regulations provide privacy and confidentiality, prohibit discrimination, and try to provide for the appropriate sharing of information in a few limited instances when there is danger or a threat of harm. However, there are other records, such as law enforcement records or Campus Crime Act records, which require or permit the release of criminal or inappropriate behavioral data on students and others.

Colleges themselves develop student codes of conduct, handbooks outlining student’s rights and responsibilities, student judicial codes, and other administrative policies and procedures to regulate the behavior of faculty, staff, and students; these documents create additional duties and responsibilities. There are other rules and standards that govern the responsibilities for individuals who seek to intervene to prevent harm to the student, campus community, or the public. Many of the interveners or responders have ethical or other standards they must adhere to, from a “duty to warn” – suspending confidentiality in the event of imminent danger to oneself or others – to a requirement to maintain the highest level of confidentiality and privileged communication.

Finally, an additional ethical question to be addressed is whether the college or university has the ability to provide services described in catalogs and brochures. Misrepresenting the availability of resources, competency of staff, and ability to treat students could lead to adverse legal consequences; and, more importantly, could lead to tragedy.

Mandatory Assessment for Suicidal and Other Behavioral Concerns

As noted in the recent UGA report, “Evaluation of Psychological Services Protocols” (www.uga.edu/EPSP_Report.pdf, 2007), an approach some universities have adopted for dealing with student behavior that is suggestive of potential mental health issues is to require psychological assessment. The University of Illinois was one of the first to do so in the area of suicide prevention. It developed a program centered around a policy that mandated four professional assessment sessions for any student who threatened or attempted suicide. A failure to comply fully with the program could result in mandatory withdrawal from the university. (See Counseling Center at <http://www.couns.uiuc.edu/suicidePolicy.html>; see also Paul Joffe, *The Illinois Plan: An Empirically Supported Program to Prevent College Student Suicide* (2003), available at <http://jedfoundation.org/articles/joffeuniversityofillinoisprogram.pdf>).

Some of the behavioral assessment and intervention teams discussed in a prior section may also require that a student undergo a psychological assessment. If the student refuses, he/she is considered to have violated a university directive, which constitutes grounds for dismissal. A mandatory assessment program is also utilized by North Carolina State University and by a number of universities within the state of Georgia.

It is important to emphasize that these universities, and others that employ similar programs, focus on “mandatory assessment” rather than “mandatory therapy or counseling” because of the long-held belief that effective treatment requires the cooperation and readiness of the client. Required assessment rests on the premise that students who are initially resistant to therapy will become more receptive and engaged in the counseling process, moving from an external motivation to a personal desire to change (Kiracofe, 1993).

In a recent email to the Association of University and College Counseling Center Directors (AUCCCD) listserv, the President of the International Association of Counseling Services (IACS) clarified the revised IACS Standards, stating that the IACS Standards were “revised to allow for Centers to provide mandated assessments. However, the Standards still do not allow for mandated counseling.... IACS makes a distinction between providing mandated assessment and mandated counseling -- allowing the former, but not the latter” (Jeffrey P. Prince, personal communication).

Involuntary Separation Policies for College Students

The increased levels of aberrant behavior often resulting in violence or threats of violence or harm on the nation’s college campuses continue to generate grave concern among campus administrators, law enforcement personnel, faculty, students, and parents. Institutional awareness, planning, and response to the actions of students who engage in aberrant behavior must balance the needs and interests of the individual student against those of the campus community.

An institution is obviously concerned with limiting its legal exposure while showing care and compassion to students to enable them to be successful in the university environment. Responding to student behavioral health issues without violating the law or someone's legal rights is especially crucial when dealing with these issues. It is critical to strike the appropriate balance between the needs of the campus community, the needs of the student, and the need for privacy while also engaging in appropriate communication for assessment, accommodation, or protection. The goals in such situations must include efforts to avoid stigmatizing the student or discouraging students from seeking assistance because of fears of dismissal from school or eviction from university housing, or even pushing the student toward more problematic behaviors.

This section highlights involuntary leave, one of the current practices being used by institutions to deal with students who exhibit harmful or threatening behavior toward themselves or others. More than twenty institutional policies, ten national associations and foundations, and numerous higher education publications were consulted to assess the various institutional leave policies.

Over the course of the last several decades, the courts have recognized a student's right to continue in school as either a contractual right at a private institution or a property interest in continued enrollment in a public institution (*Boehm v. University of Pennsylvania School of Veterinary Medicine*, 573 A.2d. 575; Pa. Super. Ct. 1990 and *Dixon v. Alabama State Board of Education*, 294 F.2d 150 (5th Cir. 1961). Moreover, students with psychiatric illness are protected against discrimination by a federal law, the Americans with Disability Act (ADA).

Thus mandatory withdrawal policies may face legal liability concerns that voluntary withdrawal policies avoid (Pavela, 1982-1983). However, in certain states, such as Washington, the involuntary leave policies of Western Washington University are a matter of state law. WAC 516-28-015 (<http://apps.leg.wa.gov/WAC/default.aspx?cite=516-28-060>).

Another concern is the practicality of using such policies. Studies show that 10 percent of college student respondents indicated that they had thought about suicide in the past year (*The Journal of Psychiatric Services: 'Depressed? Get Out!'* July 2006, Vol. 57, No. 7, 914-916). The nation's campuses would lose thousands of students each year if institutions removed each student who voiced a thought about suicide.

It is estimated that more than 75 percent of college institutions have some sort of mandatory leave policy to deal with students who engage in certain behaviors (Pavela G: *Therapeutic paternalism and the misuse of mandatory psychiatric withdrawals on campus*, *J Coll and Univ Law* 9:102, 1982).

Many of these policies, such as those at Duke University and Eastern Michigan University, are governed by Judiciary Affairs. Similar to the process at many institutions, the University of Illinois-Champaign's policies are in its Student Code of Conduct; the involuntary-leave policies at University of North Carolina-Pembroke, Harvard

University, and Millersville University are contained in their Student Handbooks. Many of the policies are outside of the judicial code and addressed by administrative policies, including those at Yale University, University of Pennsylvania, University of Michigan Cornell University, and the University of Massachusetts-Amherst.

In order to pass legal muster and avoid potential liability, the Department of Education's Office of Civil Rights (OCR) letter to Bluffton University provides guidance (Capriccioso R: Counseling crisis. Inside Higher Ed, Sept 20, 2006. Available at <http://www.insidehighered.com/news/2006/09/20/counseling>. Accessed Feb 20, 2008 and <http://www.bazelon.org/pdf/OCRComplaintBluffton.pdf>). In 2005, the university involuntarily withdrew a student after a suicide attempt without consulting a medical professional or reviewing any objective information. When challenged, the institution relied upon the defense that the mandatory withdrawal was because of fear of another suicide attempt. OCR rejected this defense, stating that the institution must conduct an analysis of direct threat. A "direct threat" analysis requires the university: 1) to determine the nature, duration, and severity of the risk; 2) to assess the probability that the potentially threatening injury will actually occur; and 3) to determine whether reasonable modification of policies, practices, or procedures will sufficiently mitigate the risk. The institution settled the matter with the student (Fordham University School of Law. Keeping Students Alive: Mandating On-campus Counseling Saves Suicidal College Students' Lives and Limits Liability, Valerie Kravets Cohen <http://law.fordham.edu/publications/articles/500flspub8302.pdf>).

In addition to conducting a "direct threat" analysis, institutions must also have sufficient due process safeguards. Some involuntary separation policies, such as those at Duke University or the University of Pennsylvania, provide few due process mechanisms, while others provide procedural safeguards throughout the process that allow a student to question the determination (e.g. Iowa State University and East Stroudsburg University).

The OCR does recognize the need for emergency action and allows temporary or interim steps. The University of Illinois Medical School has developed processes that allow immediate action to be taken after consultation with mental health professionals, with the student being able to question or dispute the action within 26 hours. The student also has the ability to have a true hearing (UIC Academic Promotions Policies, <http://www.med.uiuc.edu/sa/Policies/AY%2008-09/promoguidelines08-09aug08-2.pdf>).

Policies that support early intervention services appear to be beneficial, given their proven record of accomplishment (e.g., the approach used by the University of Illinois at Urbana-Champaign (University of Illinois at Urbana-Champaign http://www.admin.uiuc.edu/policy/code/StudentCode_07.pdf; and http://www.admin.uiuc.edu/policy/code/article_2/a2_2-105.html; and <http://www.med.uiuc.edu/sa/Policies/AY%2008-09/promoguidelines08-09aug08-2.pdf>). Any student who engages in defined behavior is required to attend four mandatory assessment sessions at the institution's counseling center. The requirement to attend the four professional assessments is not appealable. However, if the student disputes whether his/her actions constitute a suicide threat or attempt or whether the professional's review

is accurate, he or she may appeal. The institution reports that none of the students involved in some 1,670 reported suicide threats or attempts later committed suicide while a student at the institution.

One final issue associated with involuntary dismissal is the approach used for the student's return to campus after the crisis. Most policies require the student to sever ties with the institution. This can mean the student cannot attend classes, must leave university housing, can no longer use university facilities, and in some instances, be barred from campus. Many times the student can lose insurance coverage or the right to obtain services from university health or counseling.

In June, 2004 a Hunter College student took several Tylenol and called 911. When she was released from the hospital, she was unable to get into her room because the institution had changed the locks. She was evicted from her dorm but allowed to take classes. She sued the institution for violating the ADA and Fair Housing Act after she presented medical evidence that she was not a danger to herself or others. In August of 2006, Hunter settled her lawsuit and repealed the immediate eviction policy (Hunter Settles Suicide Suit, Inside Higher Education, <http://www.insidehighered.com/news/2006/08/24/suicide>).

When a student is withdrawn for psychiatric reasons, the withdrawal remains in effect until such time as the student adequately demonstrates that the problems that caused the withdrawal are no longer in existence, or when the student no longer engages in the troubling behavior. Many of the policies require students to apply for readmission, consult with the administration and undergo an on-campus mental health assessment (e.g. Cornell University, University of Massachusetts-Amherst). In other instances, the student must provide a letter from his or her treating physician that the condition no longer exists and the student does not pose a threat to self or others (for instance, Millersville University). Other conditions that must be met include requiring a continued course of treatment (University of North Carolina: http://www.nacua.org/lrs/Policies/docs/UNCPembroke_InvoluntaryWithdrawal.htm#Involuntary%20Medical%20Withdrawal).

One interesting approach discussed by a Yale Law School student was the possible use of a mediation process between the institution and the student before the implementation of involuntary withdrawal. Such an approach would theoretically be less corrosive to the student and institution's continued relationship (University Policy and Procedural Responses to Students at Risk of Suicide, Marlynn Wei, Yale Law School Student Scholarship Series Year 2007 Paper 35 <http://lsr.nellco.org/cgi/viewcontent.cgi?article=1035&context=yale/student>).

In light of the recent escalation of mental health-related events, several organizations have proposed model policies to address involuntary leave. The policies must be fair, allow an individual assessment, solicit the input of mental health professionals, and allow the student an opportunity to be heard (Bazelon Center for Mental Health Law, <http://www.bazelon.org/newsroom/2007/STUDENTMENTALPOLICY051607.htm>).

The Jed Foundation (which was founded by the parents of a student who completed suicide) promotes the goal of leave protocols, and suggests their purpose should be “to both normalize leave-taking, so that students feel that this is a viable option, and to make the process itself less intimidating” (Framework for Developing Institutional Protocols for the Acutely Distressed or Suicidal College Student <http://www.jedfoundation.org/framework.php>).

Finally, in part because of the confusion and various interpretations associated with the ability of campus officials to disclose information about students that might pose harm to themselves or others, the U.S. Department of Education issued proposed new regulations to govern federal educational privacy law (FERPA). On March 27, 2008, the Secretary of Education “determined that greater flexibility and deference should be afforded to administrators so they can bring appropriate resources to bear on a circumstance that threatens the health or safety of individuals. To provide for appropriate flexibility and deference, the Secretary has determined that if, based on the information available at the time of the determination, there is a **rational basis** [emphasis added] for the determination, the Department will not substitute its judgment for that of the educational agency or institution in evaluating the circumstances and making its determination” (<http://www.ed.gov/legislation/FedRegister/proprule/2008-1/032408a.html>).

The new regulations make it clear that if college officials make good-faith decisions and have a “rational basis” for their decisions, they will comply with FERPA’s requirements. The proposed changes also address other areas. A few proposals that will impact the behavioral health discussion are as follows: 1) allowing a school or college to share information about a student without the student’s consent with officials at another institution in which the student has enrolled; 2) allowing the release of information to contractors, consultants, and others who work with a college or school, the exception that allows educational institutions to disclose personally identifiable information about a student to school officials who have “legitimate educational interests” in the information; 3) clarifying the current law that allows disclosure to parents of financially dependent students and to other parents under applicable exceptions to the law; 4) aligning FERPA with the Campus Sex Crimes Prevention Act, so that a campus can release information it received from a state community notification program about students registered as a sex offenders; and 5) making clear that FERPA applies to students who study online or who are not physically present in the classroom. These changes should help campus officials to share information with all the stakeholders involved in assessment and intervention in behavioral incidents and should better serve the needs of the at-risk student and the campus community.

Resources Survey

**STUDENT HEALTH AND BEHAVIORAL ISSUES
USG COUNSELING CENTER RESOURCES SURVEY SUMMARY
REPORT YEAR: 2006-2007**

Introduction

The next two sections regarding the results of the Resources Survey and the SWOT analysis are intended to highlight the current counseling center resources and challenges across the University System of Georgia which addresses the premises outlined in the literature review. The USG Counseling Center Resources Survey (February-March, 2008) section summarizes the results of 36 respondents from 31 USG institutions regarding staffing and administrative structure, licensure, liability insurance, budgets and staffing, utilization services, after-hours care, waiting lists, mandated services, psychiatric services, hospitalization, recognizing and responding to trouble, crisis plans, and site evaluation. Furthermore, the SWOT analysis compares the trends regarding standards of care and student needs to the current USG resources and summarized strengths, weaknesses, opportunities, and threats. These two sections prepare the reader for the following section on recommendations and finally implementation.

Staffing and Administrative Structure

Thirty-six respondents from 31 University System of Georgia institutions responded to the Behavioral Health and Student Issues Task Force Survey. Compiled results showed that although staffing and resources differ according to institutional type, all but four schools provide services in addition to those in mental health. The majority of centers wear multiple hats, especially at the two-year and state college level. The most common services provided in addition to counseling (mental health) are:

<i>Service</i>	<i>Research universities</i>	<i>Regional universities</i>	<i>4-year universities</i>	<i>State colleges</i>	<i>2-year colleges</i>	<i>Total</i>
Mental Health (only)	1	1	4			6
Career Counseling	1	1	6	3	12	23
Testing	1		6	1	7	15
Advisement			2	2	8	12
Disability			1	3	6	10
Physical Health	2				4	6

Additional services include: substance abuse/alcohol and other substances; new student orientation; teaching/coordinating student success course; tutoring; and career services.

While some inconsistency exists in position titles (e.g. Director of Counseling Services, Director of Counseling and Testing, Director of Student Development), almost all Directors of Mental Health Services/Counseling report directly to a Vice President. Thirty of the thirty-six Counseling Center respondents reported their center was the only department on campus that provides counseling services to students. Titles of the other departments and/or personnel that offer Counseling Services were: Disability Service Providers, Career Counselors, and Graduate Student.

Eight institutions reported having only one FTE Counselor. The ratio of FTE Counselors to students across all institutions (except Georgia Perimeter colleges) had a mean of 1:2960 and a median of 1:2457; the recommended USG Counseling Directors Association Standards is 1:1700. The recommended range is one counselor for every 1000-1500 students (IACS) or one counselor for every 500-1000 students (CDAUSG). Regarding clerical support, four Counseling Departments reported not having any clerical support and four only have part-time clerical support.

Licensure

Thirty-five Psychologists reported holding a license and 12 reported no license. Thirty-one Personal Counselors reported holding a license and 15 reported no license. Six Master or Clinical Social Workers reported holding licenses.

Liability Insurance

Sixteen institutions reported that a percentage of their staff members carry mental-health provider liability insurance other than that provided by their institution. Twenty institutions' Counselors/Psychologists reported not carrying liability insurance other than that provided by their institution. Percentages ranged from 20 percent-100 percent of professional staff covered by other insurance. Only two institutions reported that a legal complaint about counseling staff and/or services provided was filed during the reporting period.

Legal Counsel

Less than half of directors reported they are provided with adequate legal counsel through their institution. Eighteen reported *not* feeling they are provided with adequate legal counsel through their institution.

Budgets and Staffing

Most directors were responsible for the administration of the department's budget although six were not. A great deal of inconsistency was reported in budgets due to the different staff sizes, departmental responsibilities and type of institution. One consistency, however, is that Directors, Counseling staff, and Psychologists are expected to hold and maintain appropriate state licensure yet sufficient travel money does not exist to support the necessary travel for the continual training required to do so.

Overall, few mental-health focused positions were gained within the system in the last year. Only one institution gained a Personal Counselor and one anticipated funding for a Personal Counselor. Three schools gained a total of four Psychologists. Two Social Worker positions were gained, and one campus gained a half-time Alcohol and Other Drug/Wellness Counselor. Within Counseling Departments, three schools gained a total of eight Academic Advisors; one school gained a Learning Support Counselor, and a half-time Administrative Assistant (clerical support) was gained at one institution. A total of two and one-half Professional Counseling positions were lost during this time.

Utilization and Services

A great deal of inconsistency exists over the average percent of time providers spent on mental health and wellness related activities (ranging from 10%-100% with an average of 63%). It should be noted that need for mental health counseling tends to increase consistently and proportionately with on-campus residency increases. The average percent of time spent on Career/Academic was 31 percent with a range of 2 percent to 100 percent. The average percent of time spent on Other Services was 34 percent with a range of 10 percent-100 percent.

Counselors logged more than 1,536,580 hours during the 2006-2007 year. Thirty-four percent of the time was spent in direct client contact for individual counseling and/or group counseling (personal, career, couples, and/or academic) sessions. Outreach to students (educational, preventative seminars) was a significant part of counselors' workload with 182,283 contacts made while providing these services.

Additional Tasks

As mentioned previously, time is often divided in multiple tasks, including but not limited to:

1. Academic advising and accommodation and other services for students with disabilities – a significant portion of the work performed by those at two-year and state colleges
2. Academic counseling services (i.e., test anxiety reduction, time management, etc.) – a service provided by more than half (19) of the reporting institutions
3. Career services (job search and employment activities) – most often performed in a separate department at the majority of USG schools (9% of the reporting counseling centers perform this service).

Service Provision

Departmental services were primarily devoted to full- and part-time students. Counselors also served the following groups:

1. Prospective Students – 13 institutions
2. Faculty/Staff - 12 institutions (note: primarily consultation)
3. Student Spouses and Children – seven institutions (note: these included spouses/partners of current students for couples counseling).

Services provided to non-students further dilutes the amount of time available to students. The service period for counseling centers varies by institution; however, the majority of the centers (especially those engaged in academic advising) continue to see students between semesters.

After-Hours Care

Regarding after-hours mental health services availability, almost one-half (17) of the centers have staff on call to provide emergency services (non-emergency services are scheduled the next business day). Close to half of the centers (14) refer students to local emergency rooms for after-hours care, and at least nine centers have no after-hours resources for students (seven two-year colleges and two state colleges).

Referrals

In examining referrals to counseling services, it was found that referrals made to the majority of centers are a result of informal calls or emails about students (22). At approximately one-half of the institutions (18), students are accompanied to the counseling center to make the first contact. A significant number of institutions (15) reported students are referred for counseling services by suggestion only, with hopes they will go. Additionally, 13 institutions reported having a formal protocol in place that involved telephone or email communication, while only seven institutions reported having a formal protocol for referrals, including a form and verification. Only one school reported having no referral protocol in place whatsoever.

Waiting Lists

Waiting lists were also examined (students waiting more than 10 days for an appointment, either initially or after intake), especially during busy parts of terms. Most centers reported not having a waiting list problem. The 11 centers reporting the need for a waiting list use the following primary methods to resolve the problem:

1. Increased counselor's case loads during busy periods (10)
2. Increased the number of referrals to outside (10)
3. Established a limit on the number of counseling sessions (six)
4. Established an intake system (three)
5. Other (two) (established more efficient intake/case assignment system, and held open screening hours with 15-20 walk-in sessions so that students can be triaged).

Overall changes related to personal counseling were observed. Directors reported a significant increase in the average number of hours spent providing personal counseling services in recent years (75%) and a significant increase in the amount of time their staff spent providing crisis counseling in recent years (64%). The types of issues or disorders with the most noticeable increases regardless of institution type (in order of frequency):

1. Anxiety/Stress
2. Depression
3. Anger management

4. Distress tolerance
5. Impulse-control problems
6. Adjustment disorders
7. Substance abuse
8. Self-mutilation behaviors
9. Psychotic disorders
10. Eating disorders.

Mandated Services

Roughly 75 percent of institutions allowed for mandated visits to counseling. Of those, there appeared a nearly even spread regarding the level of services mandated (i.e. evaluation only, evaluation plus therapy, or evaluation followed by discretionary services). Institutions varied in the level and type of information disclosed after mandated services as well. Roughly similar numbers of institutions disclosed to non-counseling staff the following information: attendance only, attendance plus critical information, and progress/participation with minimal detail. No schools reported providing detailed student information about mandated visits to non-counseling staff. Mandating officials, the primary recipients of disclosure information, were generally senior level administrators, judicial officers/committees, and crisis response teams. Several institutions conducted sessions mandated through residence life and athletics.

Changes in Services, Psychiatric Resources, and Psychiatric Medication

Given the increases in crisis-related counseling, as well as increases in severity of case presentation, psychotropic medication is frequently considered a primary treatment option. Unfortunately, the availability of psychiatric medication resources appears to be particularly problematic. The majority of counseling centers had no funds available for psychiatric back-up services, nor timely access to psychiatric care. Only two centers have full-time psychiatrists and six have part-time psychiatrists.

Among centers with full- or part-time psychiatrists, students generally wait about a week to be seen, although the wait can reach up to five weeks for non-emergencies. Three have physicians on staff although the wait to be seen tends to be limited to a few days at the most. Most campuses must seek psychiatric resources in the community, and well over half of centers did not have psychiatrists available in the community. Among those who did, the average wait was a month and a half, although for some centers, the wait was up to three months. Referrals to local community counseling resources (12 schools had access to these) carried a one- to two-month wait. Remaining schools predominantly relied on referrals to community physicians or the student's attending physician. Although wait times were generally shorter in such cases (one to three weeks), much less communication or collaboration regarding the student's care was reported to be possible.

When psychiatric referrals are made to off-campus psychiatrists, only about a quarter of schools had any ability to fund such services. Remaining students paid out of pocket. It should be noted that first visits with psychiatry often cost several hundred dollars.

Regarding student ability to pay for mental-health services, a relevant component is student health-insurance coverage. Six of the reporting institutions do not mandate that students carry health insurance. With overlap, types of insurance required by the remaining institutions are: all students (four), graduate students (four), athletes (eight), international students (16), and other (14). Other includes: nursing students, specific majors including Allied Health Professional, Dental Hygiene, Respiratory Therapy, Health Services, and residence assistants and teaching assistants (RAs and TAs). Having health-insurance coverage does not guarantee that students will have the ability to pay for mental-health treatment, however. A recent trend among psychiatric-services providers that has significant ramifications for college students is the movement toward refusing many insurance plans in lieu of fee-for-services payment.

Hospitalization

About half of counseling centers had to hospitalize a student for psychological reasons in the past year. Among those, a total of 97 students were admitted for suicidality, 4 for homicidality, 28 for acute instability, five for self-harm, and two for other reasons. Most centers either conducted the preliminary or full evaluation to determine hospitalization need. About a third of schools relied on either hospital staff or other outside providers to conduct the evaluation. Students were generally responsible for costs of evaluations provided outside of counseling centers. For students who are resistant to hospitalization, centers rely on involuntary admission (called a 1013 order). These forms are typically signed by licensed clinical social workers, licensed psychologists, law enforcement officers, or hospital/medical staff. Fewer than half of campuses had professionals legally authorized to sign a 1013. Campus police, local law enforcement, or emergency services generally provide transportation to the hospital although in some cases family, friends, or even the counselor or students themselves do so. Upon release from the hospital, most centers offer counseling services. Less than half require documentation of stability to return to campus. A few centers mandate continued counseling. Only five institutions employ a crisis response team follow-up to determine future needs and resources.

Recognizing and Responding to Trouble

About two-thirds of schools made decisions to notify a third party about a potentially suicidal student during the past year while only five did so regarding a potentially dangerous student. Multidisciplinary crisis response teams are employed in a little more than half of responding schools to make decisions or recommendations in critical situations. Nearly all responding counseling centers were involved in training faculty to recognize/refer troubled or troubling students. Somewhat fewer provided the same training for staff, and only about half provided such training for student leaders.

It should be noted that half of responding counseling centers have had to provide crisis related services to acutely distressed faculty/staff. Although almost two-thirds of schools had Employee Assistance Programs (EAPs, counseling services for individuals employed by an institution) available, most provided services off campus or had no involvement

with counseling. Only three EAPs involved the counseling center. Although college counseling centers are primarily focused on addressing student need, faculty and staff are likely to seek services at the center or to be brought there by concerned colleagues.

Crisis Plans

Among the vast majority of counseling centers, at least one or more staff members had been trained in some mainstream approach to crisis responding (e.g. Red Cross, Acute Traumatic Stress Management, and/or Critical Incident Stress Management). Additionally, more than half of the institutions included counseling in the school's crisis response plan. However, about half of the institutions did not involve counseling in crisis-response plans or were unsure of its involvement. Most respondents indicated that such plans were only implemented "sometimes," and were generally judged by counseling staff to only be "somewhat effective."

Site Evaluation

To ensure consistency and quality of mental-health services for students across the state's higher-educational system, the USG Counseling Directors Association (CDA) launched a site-evaluation process for counseling centers comprising self-evaluation and peer-review components; the site review is currently in the planning stage. When center directors were queried about completing any site-evaluation activities during the July 1, 2006-June 30, 2007 period, 22 directors reported their institution did not complete a CDA-sponsored site visit (peer review) checklist; three completed the CDA site visit checklist self-evaluation; 23 reported not completing the CDA site visit checklist self-evaluation; three reported never having a site visit and seven did not respond. (One self-evaluation had been completed and one peer review has been completed. Two other institutions reported being in the process of self-evaluation.)

Evaluation and/or Annual Report

The majority of the institutions engaged in some form of evaluation of their services. Student satisfaction surveys were the most common method, followed by client use of counseling services. Seventy-eight percent of the directors reported developing an annual report for the survey period.

SWOT Analysis

SWOT ANALYSIS

Strengths

- Counseling Directors Association – an asset of the system is an active and vital counseling directors group which has held regular meetings since the 1990's. This allows for members to share knowledge, resources, and serve as a strong peer-support network.
- Development of Crisis Response Network – the network allows even the most isolated institution to have the security of relying on crisis response by competent peers who have undergone initial and/or advanced training in crisis response. This collective-expertise component is an especially strong asset to the system.
- Multidisciplinary Crisis Response Teams – more than half of our institutions have already implemented the use of multidisciplinary teams (e.g. residence life, counseling, public safety, health, Dean of Students, etc.) to make collaborative decisions regarding serious decisions about critical students (e.g. hospitalization, medical withdrawals, etc.).
- Outreach – Psychoeducational seminars, workshops, and other forms of outreach programming represent a significant part of counselors' workloads. This wellness/prevention focus has potential ultimately to decrease the need for reactive services focused on restoring stability. As time spent in crisis-related services increases, time available for outreach progressively diminishes.
- Faculty Training – nearly all institutions are involved in at least some level of training faculty to recognize and effectively respond to troubled or troubling students.

Weaknesses

- Provider to Student Ratio – the ratio of FTE Counselors to students is above national levels and above all recommended national and state standards for providing services on college/university campuses. This staffing issue appears to be the greatest challenge facing centers in providing adequate services (both preventative and reactive) to meet students' needs. Few mental health-focused positions were gained within the system in the last year, which is especially troubling given the progressive increases in enrollment.
- Competing Responsibilities – the majority of directors and counseling center staff wear multiple hats, especially at the two-year and state college level. Additionally, other duties such as committee/task force representation increase workloads enormously, often with demanding time constraints. Another seldom recognized responsibility, providing after-hours crisis care, can significantly impact workload and energy. Counselors seldom receive any form of release time from typical responsibilities, compensation time, or any other form of extra compensation, and routinely work schedules far in excess of a traditional 40-45 hour week (especially given the lack of back-up counselors to provide services in the absence of regular staff). This staffing issue effectively limits a strong and invested focus on the mental-health needs of students, which, in turn, increases liability risk for the institution and communicates to students that their mental health needs are relatively unimportant.
- Medication Availability – given the increases in crisis-related counseling, as well as increases in severity of case presentation, psychotropic medication is frequently considered as a necessary treatment option. Unfortunately, the paucity of psychiatric

medication resources appear to be particularly problematic. The majority of counseling centers had no funds available for psychiatric back-up, nor did they have access to psychiatric care.

- Clerical Support – four counseling departments reported not having any clerical support and four only have part-time clerical support. This staffing issue causes an inability for students to schedule appointments and/or obtain service information, and for faculty and staff to make referrals or confer with counselors. A predictable outcome is the phenomenon of trouble students “slipping through the cracks.”
- Budgets – a great deal of inconsistency was reported in budgets due to the differing staff size, departmental responsibility, and institution type. One notable problem appeared to be the lack of available professional-development funding. Mental-health service providers are expected to be licensed, requiring them to attend many hours of annual continuing education; yet, few providers received adequate travel/development funds to maintain their licenses and crisis-response training. (Many mental-health providers in the system bore the cost of continuing-education licensure requirements.)
- Mandatory Hospitalization – there appears to be a distressing lack of professionals on campus who are legally authorized to sign 1013’s, the order used to involuntarily hospitalize someone who is at imminent risk of harming self or others. While licensed clinical social workers (LCSWs), psychologists, psychiatrists, and police officers can issue 1013’s, licensed professional counselors (LPCs) are not authorized to do so by state law. Many USG Counseling Centers are staffed solely by LPCs; thus, these centers can involuntarily hospitalize a student only with the assistance of a law-enforcement official. Seeking such assistance can only extend the time element of a high-risk campus event and increase risk. Additionally, police officers are authorized by state law to sign 1013’s only when they judge a student to be suffering from a mental illness and the student is violating a penal code (O.C.G.A. 37-3-42). Thus, when these USG campuses encounter students who are an imminent threat to self or others, but not in violation of a penal code, the campuses do not have the appropriate resources to maintain the safety of the identified student as well as the safety of others on campus. Once hospitalization is determined to be the most suitable course of action, there is also significant inconsistency in the method of transportation to the hospital and where such responsibility lies. This ambiguity risks delaying or even preventing a student from accessing imminently needed medical assistance, especially given that many students cannot afford treatment/medication needs.
- Multi-site and Distance Learning Campuses – institutions increasingly utilize learning environments in which students are not present at the “main campus.” Counseling centers are challenged with meeting the needs of students they have no access to students who reside in other cities and states (where mental health law can differ from Georgia’s). Coordinating services or other resources for such students would require a disproportionate amount of time, further increasing the risks both to the student and to the institution.
- Diversity – there is a clear need both for diverse providers and for providers competent in serving diverse populations, including providers or interpreters for non-English-speaking or English as a Second Language (ESL) students or students with disabilities.
- Legal Support – less than half of institutions reported that their access to legal counsel was adequate.

- Institutional Ramifications of “Value Added” Connotation of Counseling Services – National outcome studies are clear that positive mental health outcomes are synonymous with positive academic outcomes. Yet, because mental-health outcomes are rarely linked explicitly in administrative reports to direct academic goals or “value-added” institutional goals (e.g., retention or academic success), the impact of counseling on student success is largely unrecognized and may be undervalued. Counseling centers would benefit from better strategic translation of this information to upper-level administrators to assist their understanding and recognition of the value added by mental-health services. Better assessment of counseling outcomes would assist this process.

Opportunities

- Gatekeeper Training – expand training on how to recognize and respond to at-risk behavior and communication should include more faculty, staff members, and student leaders (e.g. administrative assistants, resident assistants, recreation staff, etc.).
- CDA Databank Expansion – expand and utilize the valuable base of information regarding the current status of college counseling within the USG created by this task force to allow for comparison and measurement of growth/improvement, as well as future utilization of additional resource lists, sample protocols, and other helpful materials.
- Regional Centers Collaboration – develop regional centers to allow counseling centers to access resources from collaborative sources and provide greater consistency in knowledge, process, protocol, and availability of information.
- Critical-Incident Research Application – apply to the USG system the findings and suggestions of recent critical-incident self-studies conducted at numerous universities, including UGA, which provide many insights into potentially problematic scenarios and suggestions for managing them.

Threats

- Service Demands – a significant increase in demand for personal counseling. Directors (64 percent) reported a significant increase in the amount of time their staff spent providing crisis counseling in recent years. Directors (75 percent) also reported a significant increase in the average number of hours spent providing personal counseling services in recent years. Many providers describe feeling as if they are “just hanging on” during periods of the semester with the highest student stress. Such increases risk problems with quality of services provided, timeliness of service, provider burnout, and retention of competent providers.
- Legal Liability – half of the mental-health providers reported having insufficient access to legal advice (less than 50 percent reported feeling they had adequate legal counsel at their institutions); this perception suggests a potential increase in the institution’s and USG’s potential liability in regard to their role in future at-risk events.
- Media Focus – campus violence is a popular topic in the media. Students with mental-health needs are at risk of being portrayed as potentially violent or dangerous. This has the potential trickle-down effect of even greater rejection and isolation of troubled students by the institution (student body, faculty, etc.), and may present violence as a plausible choice for troubled students who might not have considered such action under

other circumstances. As such, counseling centers are striving to focus outreach on destigmatizing mental health conditions and service provision, and on providing outreach programs and materials as preventative measures. However, as pointed out previously, time available for effective outreach is progressively diminished by increases in acute service demands.

- **Budgetary Priorities** – as the system struggles to maintain academic offerings within current economic limitations, “value-added” mental-health service provision may be jeopardized when compared with academic service-provision issues such as student-to-faculty ratios. Counseling centers consistently fall short in communicating mental-health outcomes in academic-outcome language and in competitively seeking budgetary resources to provide personnel, materials, and other necessary resources. Multiple years of this trend have resulted in centers being understaffed and underfunded. Economic trends indicate a continuation of current and substantial funding limitations, increasing the risk of counseling centers in Georgia continuing to fall behind state and national standards if they continue to be viewed and supported as a non-essential, “value-added” resource in the USG system.

Recommendations

RECOMMENDATIONS

Recommendation 1: Protect the mental and physical health of students by implementing emerging nationwide standards of campus safety which include:

- a.) a viable and practiced campus-wide emergency plan;**
- b.) the ability to immediately notify the campus community when a threat is activated; and**
- c.) a campus agreed-upon, centralized holder of communications regarding distressed and disruptive students.**

Individual campuses should determine the most appropriate structure for centralizing communications regarding students of concern. State law restrictions regarding confidentiality and ethical issues for counseling center personnel should be taken into consideration.

Individual campuses will also differ in safety plan strategies depending on their need and ability to secure the campus perimeter; alternatives to campus “lock down” should be investigated when not feasible given campus design or resources. Make available, on a timely basis, information about scheduled training opportunities.

Recommendation 2: Regularly offer administration-supported health and safety training for faculty, staff, students, and mental-health providers.

Specific training recommendations are as follows:

- a.) Provide evidence-based, specialized training for mental-health providers in (1) crisis management (e.g. suicide, homicide, conduct disorders); (2) threat assessment; (3) health and wellness issues (e.g. substance abuse, eating disorders); and (4) cultural competency guidelines (e.g. APA, 2002; NASW, 2001)**

Changing student profiles have altered the campus landscape and affected the services and programs offered on campuses. To meet the changing needs of today’s students, which increasingly include psychiatric and therapeutic services, health professionals need continuing training in crisis prevention and response, psychopharmacology, and specialized areas of substance abuse, anger management, eating disorders, and personality disorders. Given the increase in campus violence, training in threat assessment seems imperative.

Additionally, the increasingly diverse demographics of our student populations are requiring additional training in cultural competencies in order to be effective health providers and classroom instructors. In 2003, Kitzrow reported that 30 percent of college students were minorities, 20 percent were international or first generation, 55 percent were female, and 44 percent of undergraduates were under

the age of 25. The State of Georgia has seen an explosive growth in the Latino population. According to the 2000 census, the Latino population has increased by 474 percent since 1990. The University of Georgia, Georgia State University and others have developed Latino Initiatives in anticipation of this demographic shift. Returning veterans from the Iraq War will introduce yet another demographic with specific mental and physical health needs.

Minimally, counseling center mental health professionals need to be trained in the professional guidelines available for working with the diverse populations they serve. These include, but are not limited to, guidelines on multicultural education, training, research, practice, and organizational change (APA, 2002), recommended guidelines for working with GLB populations (Biaggio, et al., 2003) as well as articles written to assist mental-health providers in examining situations when standard guidelines may conflict with cultural values (i.e., Morris, 2001).

b.) Clarification of FERPA, HIPAA, ADA, Clery Act and state legal regulations regarding health, safety, and confidentiality/privilege for all campus stakeholders and first responders.

Such clarification would be supported by:

- The Secretary of Education issuing clarifications to professionals affected by these laws AND recommending extensive training for lay persons and college administrators with regard to the meaning and effect of laws which currently exist. Persons interested in these issues should be referred to NACUA Notes, August 6, 2007, Vol. 5, No. 4.
- Sending campus and system professionals to key conferences and trainings
- Developing a shared data bank of best practices information for University System of Georgia members
- Hosting a summit on mental health on college campuses across the USG, technical college, and private colleges in Georgia
- Encouraging use of the University System of Georgia Counseling Directors' Association's web site for sharing documents regarding policy, education, and intervention related to campus mental health concerns
- Encouraging utilization of the Directors' Association listserve to share information
- Establishing a regional health and safety network
- Identifying appropriate ways to provide legal consultation services.

c.) Training Gatekeepers (e.g. residential staff, dean of students office, faculty, staff, and students) in identification, response to, and referral of distressed and distressing students of concern.

Training would comprise:

- Train trainers (staff in housing, counseling center, dean of students' office) in a recognized, effective identification-and-referral protocol for suicide and violence prevention (at-risk behavior toward self or others)
- Establish and implement a plan for trainers to educate campus stakeholders (faculty, staff, students, housing staff, judicial).

d.) Helping faculty and staff appropriately address disruptive students in and out of class.

Initial and subsequent training would be provided as follows:

- Annual training for new, full-time and adjunct faculty and new full- and part-time staff would be provided when they begin their work on campus
- Ongoing training for faculty and staff would be provided throughout the academic year to provide new and/or relevant information
- Special-topic seminars during the year would supplement basic training with in-depth topics and information, and provide opportunities and a forum for faculty and staff to raise and discuss troubling issues.

Recommendation 3: Establish policies and protocols to prevent and respond to distressed and disruptive behavior by students.

Policies and protocols should address the following:

- Threat and Violence Policies
The University System may find it advisable to establish an explicit threat and violence policy as recommended by Nicoletti, Spencer-Thomas, & Bollinger (2001) and adapted by institutions such as Illinois University. One example is: "Our policy is to strive to maintain a campus environment free from intimidation, threats, and violent acts. This includes but is not limited to: intimidating, threatening, or hostile behaviors, physical abuse, vandalism, hazing, sexual assault, hate crimes, arson," (p. 85).
- Voluntary vs. involuntary hospitalization policies
- Uniform transportation protocols
- Interim suspension policies
- Campus-wide wellness programming
- Local standards of care policies.

Recommendation 4: Support Board of Regents' adoption of the "a la carte" approach to mandated student health insurance. This would allow institutions to choose the health plan best suited to the needs of their student body related to medical and mental illnesses which impact students' successful academic and social functioning.

Student access to affordable and comprehensive healthcare is one service that should be considered by the University System of Georgia. The Task Force recommends that the University System of Georgia empanel a new committee to explore a universal student health insurance program for all undergraduate and graduate students.

A state's intellectual capital is one of its most critical strategic resources. The ability to compete in an ever-growing, knowledge-based economy depends upon investing resources to recruit and retain individuals with exceptional academic, entrepreneurial, and intellectual promise. Systems of higher education must offer strong packages of educational support to their existing and prospective student populations in order to position themselves competitively in the marketplace, and to recruit and retain our country's emerging thinkers, researchers, and leaders in the sciences, technology, engineering, humanities, health, education, and business.

Recommendation 5: Develop ways to adequately meet student service demands for mental health services by increasing and/or sharing resources across institutions in order to:

- a.) better approach the licensed or license-eligible mental health provider-to-student ratio recommended by the USG Counseling Directors Association and accrediting agencies such as IACS;**
- b.) provide access to psychiatric and medical consultations and services; and**
- c.) respond to campus-wide disasters by activating the statewide crisis network.**

While IACS recommends a counselor to student ratio of 1:1500, the Association for University and College Counseling Center Directors Annual Survey (2008) reported an average national ratio of counselors to students as 1:1941. The average paid staff and intern-to-student ratio was 1:1552. In comparison, a survey conducted by the Student Health and Behavioral Issues Task Force resulted in a University System of Georgia institution average of 1: 2360 (not including Georgia Perimeter College). This number is well above the recommended counselor-to-student ratio noted above. In addition, the number is also affected by the breadth and depth of additional services counselors provided in areas including career counseling, testing, advisement, disability services, and others. Given the increasing numbers of students presenting with mental health and behavioral concerns, the counselor-to-student ratio, more than any other statistic, highlights the need to increase or share resources as described in this recommendation. The necessity of making those determinations and moving forward cannot be delayed.

Implementation

IMPLEMENTATION

Emergency Preparedness and Response

- Complete implementation of the recommendations identified by the Emergency Operations Committee (chaired by Dr. Everette Freeman).
- Assess current emergency and safety plans; identify baseline preparedness of each institution and any gaps contained in current plans. Set additional safety criteria based on gaps.
- Determine needs for each location, including satellites.
- Submit each institution's evaluation for review to designated safety experts.
- Require institutions to disseminate revised emergency plans in multiple formats and conduct campus-wide training of all campus personnel.
- Require institutions to conduct periodic and mandatory drills and coordinate with local police, fire safety, and other individuals.
- Designate the duties of the centralized holder of communications and the Crisis Response Network regarding distressed and disruptive students; and inform/educate campus personnel about their roles in crisis response.

Training, Laws and Intervention

- Inventory each institution's current training and development programs. Determine if any could be models for system-wide implementation.
- Identify current system expertise and resources to assist with training.
- Work with Vice Chancellor to develop shared training modules.
- Set institutional targets for training personnel and students and prioritize training for each institution based on gap analysis of training needs.
- Establish a regional health and safety network. Work with regional centers to develop and carry out training. Develop training programs and submit proposals for funding to USO. Seek alternative funding resources for campus safety.
- Establish a budget at each institution to fund professional development and training.
- Develop a shared data bank of best practices information for University System of Georgia members.
- Host annual summit on mental health on college campuses across the USG, technical colleges, and private colleges in Georgia.
- Encourage use of the University System of Georgia Counseling Directors' Association's web site for sharing documents regarding policy, education, and intervention related to campus mental health concerns.

Policies, Procedures, Guidelines and Protocols

- Inventory each institution's current policies, procedures, guidelines, and protocols. Determine if any could be models for system-wide implementation.
- Identify any gaps, conflicts, or critical needs and prioritize them. Revise as needed and implement new policies. Disseminate information and conduct appropriate training.

- Develop a pamphlet for faculty and staff on FERPA, HIPAA, Clery Act, and Open Records Laws.
- Identify a systemwide team to set criteria for development and implementation of policies and protocols and explore the adoption of model policies.
- Develop wallet card for campus on tips and numbers to call.

Access to Health Insurance

- Request that the Chancellor's staff empanel a system-wide committee to explore the procurement of insurance coverage for physical and mental health and other needs.

Identification and Provision of Services and Resources

- Identify the most effective/appropriate way to provide psychiatric, medical, and legal consultation services.
- Explore greater collaboration across colleges and universities to eliminate gaps in services and resources.
- Seek funding from general assembly or use strategic allocations to focus on increasing number of mental health service providers in order to meet national standards.

References

REFERENCES

- Accreditation Standards for Universities and College Counseling Centers. (2000). Alexandria, VA: International Association of Counseling Services, Inc
- American Association of Suicidology (2005). *Core Competencies Curriculum*. Retrieved on March 10, 2008, from <http://www.suicidology.org/associations/1045/files/CoreCompetencies.pdf>
- American College Health Association. American College Health Association - National College Health Assessment (ACHA-NCHA) Web Summary. Updated August 2007. Available at http://www.acha-ncha.org/data_highlights.html
- American College Health Association, (2006). *National College Health Assessment, Reference Group Executive Summary*. Retrieved on March 10, 2008, from http://www.achancha.org/docs/ACHA-NCHA_Reference_Group_ExecutiveSummary_Fall2006.pdf
- American College Health Association, American College Health Association - National College Health Assessment: Reference Group Executive Summary Fall 2007. Baltimore: American College Health Association; 2008
- American Foundation of Suicide Prevention, (2006). *Fact Sheet: The truth about suicide: Real stories of Depression in College*. Retrieved on March 10, 2008, from http://www.afsp.org/files/College_Film//factsheets.pdf
- American Psychological Association. (2002). *Guidelines on multicultural education, training, research, practice, and organizational change for psychologists*. Washington DC: American Psychological Association
- Anwar, Y. (2007). *Training Taking Place to Spot Depression*. Retrieved March 10, 2008, from University of California, Berkley: http://www.berkeley.edu/news/media/releases/2007/04/30_health.shtml
- Benton, S.A. (2006). The scope and context of the problem. In Benton, S.A. and Benton, S.L. (Eds.). *Student mental health: Effective services and strategies across campus*. Washington, DC: NASPA, pp. 1-14..
- Benton, S.A., Benton, S.L., Tseng, W.C., Newton, F.B., Benton, K.L., & Robertson, J.M. (2003). Changes in client problems: Contributions and limitations from a 13-year study. *Professional Psychology: Research and Practice*, 34, 66-72.
- Benton, S.A., Benton, S.L., Newton, F.B., Benton, K.L. and Robertson, J.M. (2004). Changes in Client Problems: Contributions and Limitations from a 13 Year Student. *Professional Psychology: Research and Practice*, 35, 317-319.

- Benton, S.A. & Benton, S.L., (Eds.) (2006). *College student mental health: Effective services and strategies across campus*. Washington DC: NASPA.
- Berger, L. (2002, January 13). The therapy generation. *New York Times*.
- Biaggio, M., Orchard, S., Larson, J., Petrino, K., & Mihara, R. (2003). Guidelines for gay/lesbian/bisexual-affirmative educational practices in graduate psychology programs. *Professional Psychology, Research and Practice*, 34, 548-554.
- Brazelon Center for Mental Health Law, <http://www.bazelon.org/newsroom/2007/STUDENTMENTALHEALTHPOLICY051607.htm>
- Brent, M.E., Cornish, J.A., Leslie-Toogood, A., Nadkarni, L.I., & Schreier, B. (2006). College student mental health and special populations: Diversity on campus. In S.A. Benton & S. L. Benton (Eds.), *College student mental health: Effectives services and strategies across campus*. Washington DC: NASPA.
- Capriccioso R: Counseling crisis. Inside Higher Ed, Mar 13, 2006. Available at http://insidehighered.com/news/2006/03/13/counseling_ Accessed Feb 20, 2008 and <http://www.bazelon.org/pdf/OCRComplaintBluffton.pdf>
- Carletta, C. F., Lawson, R. G., & Villahermosa. (Feb. 16, 2008). *Workshop on campus security 2010: What colleges and universities should be doing to advance campus safety*. 29th National Conference on Law and Higher Education, Clearwater, Fl.
- College Health Association. (2007). *American College Health Association-National College Health Assessment: Reference Group Executive Summary*. Baltimore: American College Health Association.
- Campus Mental Health: What College & University Administrators Need to Know. A Student Affairs White Paper. Paper Clip Communications. 2007.
- Cooper, S. E. (2006). Counseling and mental health services. In Benton, S.A. and Benton, S.L. (Eds.), *Student mental health: Effective services and strategies across campus*. Washington, DC: NASPA.
- Cornell, D. (2008). *Threat assessment on the college campus*. NASPA Leadership Exchange.
- Council for the Advancement of Standards in Higher Education. Retrieved March 10, 2008 from www.cas.edu
- Counseling Directors' Association (2003). *Standards for counseling centers in the university system of Georgia*. Regents' Administrative Committee of Student Affairs: University System of Georgia.

- Digest of Educational Research. (2007). Retrieved March 10, 2008 from <http://nces.ed.gov/programs/digest/d07/>
- Fein, R., Vossekuil, B., Pollack, W., Borum, R., Modzeleski, W., & Reddy, M. (2002). *Threat assessment in schools: A guide to managing threatening situations and to creating safe school climates*. US Secret Service and US Department of Education: Washington, DC.
- Federman, R. (2008). *University Mental Health National Data*, Retrieved March 2008 from <http://www.the-american-interest.com/ai2/article-bd.cfm?Id=472&MIId=21>
- Florida Gubernatorial Task Force for University Campus Safety Report. Findings and recommendations. Retrieved March 10, 2008 from http://www.info.ethicspoint.com/pvw9deaf0/files/PDF/webseminars/ACUA_Crisis_Management/Governor_TaskForce_final_report.pdf
- Friedman, R.A. (Nov. 16, 2006). Violence and mental illness—How strong is the link? *New England Journal of Medicine*, 355, 2064.
- Gallagher, R. P. (2007). *National survey of counseling center directors*: Monograph Series Number 8Q. IACS: Pittsburgh, PA.
- George Washington University Counseling Center, Retrieved on March 10, 2008 from <http://gwired.gwu.edu/counsel/UCCPeerEducatorProgram>
- Goetz, K. (2002, March 19). Counseling demands overwhelm colleges. *The Cincinnati Inquirer*.
- Gomez, C. (2006). *Crisis on campus: Preparing for and dealing with disasters and violence*. LRP Publications.
- Gonzales, A.R., Leavitt, M.O., & Spelling, S.M. (2007). US department of health and human services report to the President on issues raised by the Virginia Tech tragedy. Retrieved March 10, 2008 from <http://www.hhs.gov/vtreport.html>
- Greenberg, S.F. (2007). Active shooters on college campuses: Conflicting advice, roles of the individuals and first responders, and the need to maintain perspective. Editorial. *Disaster Medicine and Public Health Preparedness*, s57-s61.
- Haines, M.E., Norris, M.P., & Kashy, D.A. (1996). The effects of depressed mood on academic performance in college students. *Journal of College Student Development*, 37, 519-526.
- Healy, S.J. (May 15, 2007). Best practices for making college campuses safe. Prepared Statement to U.S. House of Representatives Committee on Education and Labor. Retrieved March 10, 2008 from <http://edworkforce.house.gov/hearings/fc1507.shtml>

- Hingson et al. (2005). Magnitude of alcohol related mortality and morbidity among US college students age 18-24: Changes from 1998-2001. *Annual Review of Public Health*, 26, 259-279.
- Hysenbegasi, A., Hass, S. Rowland, C. (2005). Impact of depression on the academic productivity of university students. *Journal of Mental Health Policy and Economics*, 8, 145-151.
- Infofacts Resources: Interpersonal Violence and Alcohol and Other Drug Use. *United States Department of Education*. Retrieved March 10, 2008 from <http://higheredcenter.org/services/publications/interpersonal-violence-and-alcohol-and-other-drug-use>
- Jablonski, M., McClellan, G., & Zdziarski, E. (Eds.). (2007). *In search of safer communities: Emerging practices for student affairs in addressing campus violence*. NASPA.
- JED Foundation (2006). *Framework for developing institutional protocols for the acutely distressed or suicidal college student* Retrieved March 10, 2008, from <http://www.jedfoundation.org/framework.php>
- Joffe, P. (2003). *The Illinois plan: An empirically supported program to prevent college student suicide*. Retrieved March 10, 2008 from <http://jedfoundation.org/articles/joffeuniversityofillinoisprogram.pdf>
- Kadison, R. & Digeronimo, T.F. (2004). *College of the overwhelmed: The campus mental health crisis and what to do about it*. San Francisco: Jossey-Bass.
- Katahn, M. (1966). Interaction of anxiety and ability in complex learning situations. *Journal of Personality and Social Psychology*, 3, 475-479.
- Kiracofe, N. M. (2003). Changing demands on counseling centers: Problems and possibilities. *Journal of College Student Psychotherapy*, 7, 69-83.
- Kitzrow, M.A. (2003). The mental health needs of today's college students: Challenges and recommendations. *NASPA*, 41, 167-181.
- Leichliter, J.S., Meilman, P.W., Presley, C.A., Cashin, J.R. (1998). Alcohol use and its associated consequences among students with varying levels of involvement in college athletics. *Journal of American College Health*, 46, 257-262.
- McGinn, D. After Virginia Tech, *Newsweek*, p. 70-71 (Aug. 27, 2007).
- Morris, J.E. (2001). African American students and gifted education: The politics of race and culture. *Roeper Review*, 24(2), 59-62.

- National Alliance on Mental Illness (2004). Mental illness prolific among college students: Parents underestimate prevalence, preparedness of students. On-line report. Retrieved March 10, 2008 from http://www.nami.org/Content/ContentGroups/Press_Room1/20041/August3/Mental_Illness_Prolific_Among_College_Students.htm
- National Association of College and University Attorneys (2005). *Dealing with distressed and suicidal students: Legal and policy issues*. Virtual Seminar presented by NACUA (National Association of College and University Attorneys).
- National Association of Social Workers (2001). The Standards for Cultural Competence in Social Work Practice. Retrieved September 13, 2008 from www.socialworkers.org/pressroom/2001/090601.asp
- National Institute of Mental Health (2006). *The Numbers Count*. Retrieved March 10, 2008 from <http://www.nimh.nih.gov/publicat/numbers.cfm>
- Nicoletti, J., Spencer-Thomas, S., Bollinger, C. (2001). *Violence goes to college: The authoritative guide to prevention and intervention*. Springfield, ILL: Charles C. Thomas Publisher
- Noonan-Day, H. L. & Jennings, M. M. (2007). Disruptive students: A liability, policy, and ethical overview. *Journal of Legal Studies Education*, 24(2), 291-324.
- Otompke, J., *University Business*, (December, 2004). Health care needs and America's college students: public health dilemma or opportunity?
- Owen, J.J., Tao, K.W., Rodolfo, E.R. (2006) Distressed and distressing students: Creating a campus community of care. In Benton, S.A. & Benton, S.L., (Eds.) (2006). *College student mental health: Effective services and strategies across campus*. Washington DC: NASPA , pp.
- Paperclip Communications. (2007), *Heeding Virginia Tech's lessons: How key recommendations of the Virginia Tech report can help create a safer, more secure campus*. Little Falls, NJ: Paperclip Communications White Paper.
- Pavela, G. (1982 – 1983). Therapeutic paternalism and the misuse of mandatory withdrawals on campus. *Journal of College and University Law*, 9, 101–147.
- Pavela, G. (2006). *Questions and answers on college student suicide: A law and policy perspective*, 26.
- Prince, J. B. (2008). President, International Association of Counseling Services, Inc. (IACS); Director, Counseling and Psychological Services; University Health Services; 2222 Bancroft Way; University of California, Berkeley; Berkeley, CA 94720

- Reaves, B.A. (2008). Campus law enforcement: 2004, 2005. Published by the Bureau of Justice Statistics. Retrieved March 10, 2008 from <http://www.ojp.usdoj.gov/bjs/pub/pdf/cle0405.pdf>
- Robertson, J.M., Benton, S.L., Newton, F.B., Downey, R.G., Marsh, P.A., Benton, S.A., Tseng, W., & Shin, K. (2006). K. State Problem Identification Rating Scale (K-PIRS) for college students. *Measurement and Evaluation in Education*, 39, 141-160.
- Schwartz, A. (2006). College student suicide in the United States: 1990-1991 through 2003-2004. *Journal of American College Health*, 54(6), 341-352.
- Shuchman, M. (2007). Falling through the cracks—Virginia Tech and the restructuring of college mental health services. *The New England Journal of Medicine*, 357:105-110.
- Soet, J.& Sevig, T. (2006). Mental health issues facing a diverse sample of college students: Results for the college student mental health survey. *NASPA*, 43(3), 410-431.
- Sokolow, B. (2008). National center for higher education risk management: Best practices for student health and safety. Retrieved March 10, 2008 from <http://www.ncherp.org/policies.html>
- Understanding mental illness: Factsheet. Retrieved March 10, 2008 from http://www.samhsa.gov/MentalHealth/understanding_MentalIllness_Factsheet.aspx
- U.S. Census Bureau, (2004). Income Stable, Poverty Up, Numbers of Americans With and Without Health Insurance Rise, Census Bureau Reports, Retrieved from http://www.census.gov/Press-Release/www/releases/archives/income_wealth/index.html
- University of California, Office of the President. (2006). *Report of the University of California Student Mental Health Committee*. University of California. www.ucop.edu/sas/student_affairs_and_services/SMHCommittee2006.pdf
- University of California at San Diego, Counseling & Psychological Services, Retrieved March 10, 2008 from http://psychservices.ucsd.edu/peer_ed_web/peer_ed_wellness.html
- University of Georgia Evaluation of Psychological Services Protocols Committee Report (2007).
- University of Illinois at Urbana-Champaign, Retrieved March 10, 2008 from http://www.admin.uiuc.edu/policy/code/StudentCode_07.pdf; and http://www.admin.uiuc.edu/policy/code/article_2/a2_2-105.html; and <http://www.med.uiuc.edu/sa/Policies/AY%2008-09/promoguidelines08-09aug08-2.pdf>
- University of North Carolina Campus Safety Task Force Report to the President (Nov. 2007)
- Virginia Tech Review Panel. (2007). Mass shootings at Virginia Tech, April 16, 2007. Retrieved March 10, 2008 from <http://www.governor.virginia.gov/TempContent/techpanelreport.cfm>

Voelker, R. (2003). Mounting student depression taxing campus mental health services. *Journal of the American Medical Association*, 289 (16), 2055.

Wechsler, H., Lee, J.E., & Nelson, T. (2002). Underage college students drinking behavior, access to alcohol, and the influence of deterrence policies. *Journal of American College Health*, 50, 223-236.

OTHER RESOURCES

American Foundation of Suicide Prevention. (2006). *The truth about suicide: Real stories of depression in college (Facilitator's Guide)*.

Brazelon Center for Mental Health Law, *Supporting Students: A Model Policy for Colleges and Universities*. Retrieved March 10, 2008 from <http://www.bazelon.org/pdf/SupportingStudents.pdf>>

Drake, R.E., Torrey, W.C., and McHugo, G.J. (2003). Strategies for implementing evidence-based practices in routine mental health settings. *Evidence Based Mental Health*, 6(1): 6 - 7.

Eells, Gary. (July 26, 2007). Identifying and responding to students at risk (Paperclip Com, audio-conference)

Investigations of April 16, 2007 Critical Incident at Virginia Tech. Virginia Office of the Inspector General for Mental Health, Mental Retardation & Substance Abuse Services. <http://www.oig.virginia.gov/documents/VATechRpt-140.pdf>

Lewis, W. S. & Sokolow, B., (July 10, 2007). A Framework for Student Mental Health & Violence Prevention. (Magna Online Seminars, Web/Video-Conference)

Magna Publications, National Center for Higher Education Risk Management, (July 10, 2007). A Framework for Student Mental Health Violence Prevention, Webinar, <http://www.magnapubs.com/calendar/139.html?s=tm&p=el>

Mueser, K.T., Torrey, W.C., Lynde, D., Singer, P. and Drake, R.E. (2003). Implementing evidence-based practices for people with severe mental illness. *Behavior Modification*, 27(3): 387 - 411.

New York Times, (February 23, 2008). Health Coverage Often Stops at the Campus Gates, Retrieved from http://www.nytimes.com/2008/02/23/business/yourmoney/23money.html?_r=1&scp=1&sq=Health%20Coverage%20Often%20Stops%20at%20Campus%20Gate&st=cse&oref=slogin

- Pavela, G. (2007). School shooting copycats. The Pavela Report. 10-12-07, http://docs.google.com/view?docid=dfdpvzp9_474cpszg3fp
- Pavela, G. (2007). Memorandum for the faculty: Teaching troubled students after the Virginia Tech shootings, Synfax Weekly Report, week of May 14, 2007, Report Number 07.17: Safety and Security.
- Simons, A. (May 11, 2007). Major shootings on American college campuses. Federal Bureau of Investigation, National Center for the Analysis of Violent Crime, Behavioral analysis Unit-1, PowerPoint presented at the Crisis on Campus seminar, Atlanta, Georgia.
- Sokolow, B.A. (June 2007). The benefit of hindsight: What colleges and universities can learn from the tragedy at Virginia Tech. Retrieved March 10, 2008 from <http://www.magnapubs.com/catalog/cds/600307-1.html>
- Understanding Mental Illness Factsheet*. Retrieved March 10, 2008 from http://www.samhsa.gov/MentalHealth/understanding_Mentalllness_Factsheet.aspx
- Using the Web to Prevent Suicide, *Inside Higher Ed* (Sept. 20, 2006). Retrieved March 10, 2008 from <http://www.insidehighered.com/news/2006/09/20/counseling>
- Workman, T.A. (2007, December). Addressing violence on campus: Five lessons learned from AOD. NetResults On-Line Journal. National Association of Student Personnel Administration (NASPA)

Appendix A
Chancellor's Charge

**CHARGE FOR USG SYSTEMWIDE PROJECT FOR
STUDENT HEALTH AND BEHAVIORAL ISSUES
Lead President: Tom Harden**

Background and Rationale

In response to *Strategic Goal #1, Renewing Excellence in Undergraduate Education to Meet Students' 21st Century Educational Needs* and the recent tragedy at Virginia Tech, we propose the establishment of a systemwide project for improving services on student health and behavioral issues.

Institutional capability to address student needs, including referral, recognition, counseling, behavior management, and anger mitigation, has become more critical than ever. The USG needs to assure that all institutions have or have access to such capability. And further, that they are engaged in best and most appropriate practices in service to their student bodies and that they hold themselves appropriately and transparently accountable for programs and policies in this area. Reporting, counseling and separation policies should be clear and oriented to the protection of individuals, as well as the collegiate community.

Members of the entire university community must be led to understand their roles as members of a community for reporting, acting and assisting. We must find ways to remove the barriers from providing assistance to troubled individuals and, at the same time, provide protection for the university community.

The President and team are charged with the following outcomes:

1. Assess the current state of institutions and the USG against national and USG standards for addressing physical and mental health issues
2. Establish aspirational standards for the provision of physical and mental health and counseling services on all USG campuses. The standard must also consider costs to students and to the USG. Standards will vary from institution to institution dependent on availability and access to services. One size clearly does not fit all.
3. Determine the services that can be efficiently provided to each campus from a system unit for referral, consultation, crisis intervention, and assessment. While all institutions may not be able to afford solutions, all, however, can define the best access paths to available solutions, if any.
4. Establish an implementation plan and schedule for achieving the desired practices.
5. Establish an annual assessment protocol with appropriately transparent metrics that enables broad campus flexibility while assuring provision of working programs and services within the capacity of the institution and the USG.
6. Establish appropriate institution training working with the Vice Chancellor for Human Resources.

Target Date for Draft report: May 1, 2008

Appendix B

Taskforce Membership

**STUDENT HEALTH AND BEHAVIORAL ISSUES TASK FORCE
MEMBERSHIP**

Jacqueline Awe ¹	Director, Counseling and Disability Services Savannah State University
Jean Chin ¹	Executive Director, UGA Health Center University of Georgia
Corlis Cummings ¹	Special Assistant to the President Clayton State University
Laverne Gaskins	University Attorney Valdosta State University
Jerry Hall	Director of Student Development Center University of West Georgia
Melinda Hawley ²	Coordinator of Personal Counseling and Wellness Gainesville State College/Oconee Campus
Thomas Harden, Chair	President Clayton State University
Kristina Henderson ²	Director of Counseling Services Gordon College
Bruce Holmes ²	Director of Safety & Security University System of Georgia
Joyce Jones	Dean of Students & Vice President for Student Services Augusta State University
Alma Keita ²	Director of Counseling Services Georgia Southwestern State University
Tonya Lam ¹	Associate Vice Chancellor, Student Affairs University System of Georgia
Valerie Lancaster	Administrative Support Executive Secretary to the President Clayton State University
Georj Lewis	Dean of Students Georgia Southern University
Elaine Manglitz ¹	Co-chair, Literature Review Sub-committee Assistant Vice President for Student Affairs Clayton State University

Mac Martin ²	Co-chair, Resource Identification Sub-Committee Director of Student Counseling North Georgia College and State University
Maggie Martin ²	Co-chair, Resource Identification Sub-Committee Director of Student Development Abraham Baldwin Agriculture College
Dave Matthews ²	Director of Counseling Center Georgia Southern University
Bob Mattox	Director of Counseling & Advising Program Services Kennesaw State University
Betsey Neely ¹	Legal Affairs University System of Georgia
Joe Odom ²	Student Alternate Dispute Resolution Coordinator Georgia Perimeter College
Mary Jane Phillips ¹	Director of Counseling Services Georgia College and State University
Dan Rose ²	Director of Counseling Center Columbus State University
John Stein ¹	Dean of Students & Assistant Vice President for Student Affairs Georgia Institute of Technology
Phyllis Weatherly ²	Director of Career and Counseling Center Southern Polytechnic University
Marolyn Wells ¹	Co-chair, Literature Review Sub-committee Director of Psychological and Health Services Georgia State University
Martha Ellen Wisbey	Director of Student Affairs University System of Georgia

1 - Literature Review Sub-committee Member

2 - Resource Identification Sub-Committee Member

Appendix C

USG Resources Survey

**STUDENT HEALTH AND BEHAVIORAL ISSUES TASK FORCE
RESOURCES SURVEY
of the University System of Georgia's College and University
Counseling Centers July 2006 - June 2007**

1. 36 Responses from 31 Colleges/Universities (includes multi-campus sites)
 4 - Research University 2 - Regional University 11 - State Universities
 3 - State College 11 - Two-Year College

30 responses from Follow-up Questions:
 19-institutions are residential (includes on-campus residence halls and/or apartments and a significant concentration of student apartments close by).
 11-campuses are commuter

2. Fall 2006 student enrollment: range from 824 – 34,500

3. Name of your department:

Counseling Center (5)	Counseling Services (4)
Advising & Counseling Services (5)	Student development (2)
Academic Resources	Academic Success Center
Counseling and Advising Services	Career & Counseling
Counseling and Career Development Center	Counseling and Disability Services
Counseling and Psychiatric Services	Counseling, Career, & Disability Services
Counseling, Testing and disability	Personal Counseling and Wellness
Student Counseling	Student Disability and Personal Counseling Services
Student Services	Student Success
Student Health	Testing and Counseling
University Counseling Services	

- 3a. Services Provided:

6 - Mental Health	23 - Career
10 - Disabilities	17 - Testing
14 - Advisement	6 - Physical Health

Additional services include: Substance abuse/Alcohol and other substances; New Student Orientation; teaching/coordinating Student Success Course; Tutoring; and Career Services

4. Your title:

Director	6 Institutions
Director of counseling	4 Institutions
Director of counseling services	3 Institutions
Director of counseling & Testing	2 Institutions
Director of advising and counseling services	5 Institutions
Other titles only used once	
Coordinator	Coordinator of Student Disabilities & Personal Counseling Services
Counselor	Counselor & Disability Services Provider
Director of CAPS	Director, Career & Counseling Center
Director Counseling Center	Director of Student Development
Director of Student Life	Director of Student Success
Director of Student Services	Executive Director
Psychologist	Student Counseling Director

5. Title of individual to whom you report:

CSAO (incl. Enrollment Mgmt)	20 Institutions
Breakdown:	
Vice President of Student Affairs	10 Institutions
Dean of Students	5 Institutions
VP Student & Enrollment Services	3 Institutions
Other titles only used once	
VP of Enrollment Management	VP Student Services
Asst VP Student Affairs	VP for Student Development Services
Director of Academic Resources	Associate VP for Academic Affairs
VP St Dev & Enrollment Mgmt	VP, St Affairs & Enrollment Mgmt
Assoc. Vice Pres/Dean of Students	VP For Student Success and Enrollment
M.D	Director of Student Services
Exec. Dir., Univ. Health Ctr.	Dir Student Dev & Enroll Mgmt

6. **Counselor to student ratio:**

Of the hours devoted to providing mental health/personal counseling, **how many hours per week** are provided by a licensed member of your staff (this would include licensed associates and those under direct supervision for licensure; include yourself but do not include interns or practicum students): Ratio of 1 counselor to ____ students.

Institution	Mental Health Counselors (licensed, licensed associate or under supervision)	Counselor/Student Ratio	Weekly Hours Available for Mental Health Counseling by Licensed/Associate Licensed or Supervised Staff
AASU	2	1/3250	80
ABAC	2	1/1825	35
Albany	2	1/2000	n/a
Atlanta Metro	2	1/1000	40
Augusta	1	1/1643	35
Clayton	2	1/3500	54
Columbus	2	1/1985 (includes supervised staff)	140 (20 per staff)
Dalton	0	1/4300	15
Darton	1	1/4600	20 (varies due to advising)
FVSU	0	n/a	0
Gainesville	[REDACTED]		
---Oakwood Campus	1	1/4902	25
---Oconee Campus	1	1/2461	36
GC&SU	0	1/1657	80
GHC	3	1/1283	100
GT	8.5	1/2110	28 for intake/emergency 12-15 for individual client hours
Georgia Perimeter	[REDACTED]		
---Clarkston	1	1/5500	2-4
---Decatur	0	n/a	0
---Dunwoody	1	1/6704	20
---Lawrenceville (closing 5/08)	0	0	0
Georgia Southern	9	1/1825	145
Georgia Southwestern	1	1/2457	20
GSU	13	1/2000	333
Gordon	2	1/1800	15-20 (varies due to disabilities services,

			career fairs, student employment services)
KSU	6	1/3500	120
Macon State	1	1/6464	35
MCG	1	1/3051	30
NGCSU	1.75	1/2813	37.7 (does not include summer hours)
Savannah	0	1/3000+	28
SPSU	2 under supervision	1/2103	55
Valdosta	5	1/2200	25

Note: some centers have staff providing counseling that are not licensed and have been grandfathered into the System.

7. Is your department the only department that offers counseling services to students on your campus? 30 - Yes 7 - No

8. If your answer was no to question #8, please list the titles of the other departments that offer counseling services on your campus and indicate the number of FTE counselors employed in each one.

Department Disability #FTE Counselors 5
 Department Career #FTE Counselors 2
 Department Psychology #FTE Counselors 1- graduate
 Department Behavioral Health #FTE Counselors 2

9. What is the number of your department's staff that are licensed/not licensed by the State of Georgia **and** What is the average percent of time each spends on mental health & wellness related activities, career/academic related activities, and other activities (**Note: break-down does not equal 100% because it is a compilation across institutions; some do only one or two of these functions**)

	Licensed	Not Licensed	Mental	Career/ Academic	Other
48 - Psychologist	36	12	72%	14%	39%
51 - Counselor (Personal)	33	18	50%	32%	33%
5 - Counselor (Career)	2	3	46%	42%	24%
6 - Social Worker	6	0	84%	20%	20%
6 - Rehab. or LD Counselor	0	6	75%	42%	79%
9 - Academic Advisors	1	8	0%	58%	75%
5 - Psychiatrists	5	0	100%	0%	0%
2 - Others:			76%	10%	37%

Marriage & Family Therapist 1 0
 AOD-Wellness .5 .5
 No Response - 5

10. What is the number of clerical/support staff in your office?
 44 - Full-time* 14 - Part-Time 5 - No Support
 average per office is 1 FT; 13 schools have more than 1; high of 6 FT
11. Are you (Director) responsible for the administration of your department's budget? 30 - Yes 6 - No
12. If you answered yes, please complete the following questions using your department's 2006 - 2007 fiscal year data.
- a. Total budget - \$4,000 - \$1,784,037
 - b. Personnel (including benefits) - \$89,992 - \$1,734,087
 - c. Supplies - \$1,000 - \$43,335
 - d. Travel* - \$900 - \$31,550*
 - e. Equipment* - \$200 - \$22,275 (No funding =16)
 - f. Other - \$4,645 - \$149,200 (10 schools reporting)
 ** (included in supplies)**
13. If known, please indicate the number of clients* and number of contacts utilizing your department's services during the 2006-2007 academic year in the following service areas:

Contacts (average)	Total Contacts	
<u>1120</u>	<u>32483</u>	Personal Counseling
<u>350</u>	<u>4197</u>	Group Counseling
<u>500</u>	<u>899</u>	Career Counseling
<u>615</u>	<u>12909</u>	Educational/Academic Counseling
<u>759</u>	<u>15934</u>	Testing
<u>318</u>	<u>2861</u>	Special Student Services/Disability Services
<u>1425</u>	<u>27077</u>	Psycho-educational Workshops/Programs
<u>3127</u>	<u>37519</u>	Academic Advising
<u>129,631</u>	<u>1,425,543</u>	Job Search Services
<u>14/112</u>		Total number of credit courses taught
<u>198</u>	<u>198</u>	Total number students enrolled/credit courses
<u>559</u>	<u>3354</u>	Other (Faculty, Student Training, Not explained)

* individual client (student) contact info not available for this academic year

14. Have you gained a staff position in the past year? **16.5 (2 No Response)**

Psychologist	4 -	Yes ___ No	4 -	# positions gained
Counselor (Personal)	1 -	Yes ___ No	1 -	# positions gained
Counselor (Career)	___	Yes ___ No	___	# positions gained
Marriage & Fam.Thep.	___	Yes ___ No	___	# positions gained
Social Worker	2 -	Yes ___ No	2 -	# positions gained
Rehab/LD Counselor	___	Yes ___ No	___	# positions gained

- | | | | | |
|----------------------------|------|------------|------|--------------------|
| Academic Advisors | 9 - | Yes ___ No | 9 - | # positions gained |
| Other <u>LS Counselor</u> | 1 - | Yes ___ No | 1 - | # positions gained |
| Other <u>AOD Counselor</u> | .5 - | Yes ___ No | .5 - | # positions gained |
15. Have your lost a staff position in the past year? **2.5**
- | | | | |
|-----------------|-----------|-----------|------------------------|
| a. Professional | 2.5 - Yes | 31.5 - No | 2.5 = # positions lost |
| b. Clerical | 0 - Yes | 33 - No | 0 = # positions lost |
16. Where does career counseling take place on your campus?
- 19 - Primarily in counseling center
 - 14 - Primarily in a separate career development or placement program
 - 3 - Shared equally between a. and b.
17. Are your department's services available to:
- 36 - Full-time Students
 - 36- Part-time Students
 - 4- Non-Students
 - 13 - Prospective Students
 - 15 - Alumni
 - 14 - Faculty/Staff
 - 4 - Faculty/Staff Spouses and Children
 - 7 - Student Spouses and Children
 - 25 - Between Regular Semesters
 - 8 - Other (The advising center is open between semesters. Students who want to get a head start on study skills or test anxiety are seen between semesters; Prospective students for the fall are seen during the summer for consultation. One session consultation is also provided for faculty and staff as time permits during breaks; We will see the 11th & 12th grade students of a faculty or staff member for career assessment).
18. What is the practice for after hours mental health needs?
- 1 - Staff on call who can provide regular services
 - 17 - Staff on call who provides emergency services; regular services wait until next business day
 - 14 - Students referred to local emergency room
 - 4 - Students referred to crisis line
 - 11 - No after hours resources (2-Year Colleges = 9; State Colleges = 2)
19. Are students mandated to receive Counseling services?
- 10 - evaluation only
 - 9 - evaluation and therapeutic services
 - 12 - evaluation then at discretion of Counseling staff

- 10 - no mandated visits
 - 1 - no response
20. If mandated, what is reported?
- 8 - not mandated
 - 11 - Attendance
 - 11 - Attendance and critical information
 - 13 - progress/participation (minimal detail)
 - 0 - detailed information about sessions
21. Who can/does mandate services?
- | Office/Person | No. of Schools |
|--|----------------|
| Judicial Officer/Disciplinary Committee | 3 |
| CSAO (VP) | 2 |
| Dean of Students | 2 |
| VP Academic Affairs | 1 |
| Senior Staff | 1 |
| Athletics/Coaches | 1 |
| Combination of Above (includes President,
Judicial, CSAO, athletics, student court, residence Live
Student Court | 13

1 |
| No Response | 10 |
22. When students are referred to Counseling, is there a protocol to follow? (Check all that apply)
- 7 - Formal protocol including a form and verification
 - 13 - Formal protocol involving telephone or email communication
 - 24 - Informal call or email about student
 - 19 - Accompany student to office to make first contact
 - 15 - Send students and hope they go
 - 1 - No protocol
 - 3 - Other (Professor sends student and center notifies professor if student meets w/center; all of the above applies except sending the student and hoping they go)
23. Is your department involved in training other entities on campus to recognize/refer troubled or troubling students?
- 25 - Faculty
 - 22 - Staff
 - 14 - Student leaders
 - 6 - No Response
 - 2- No
24. Have you had to provide crisis related services to acutely distressed faculty/staff?

19 - Yes 17 - No

25. Is there a Faculty/Staff Employee Assistance Program available to campus employees?
3 - On campus and involves your department
4 - On campus and does not involve your department
16 - Off campus
13 - None
26. If the EAP is not administered by your department, do you have any role in the program? 4 - Yes (Faculty/Staff referred to Director for counseling/referral; Referral source; Provide resource information and brief emotional support as needed; HR anticipates contracting with an outside vendor for EAP services, and we will participate in selecting the vendor; We assume crisis coverage when EAP)
21 - No 7 - N/A
27. If your center hired a professional staff member in the past year, please list their salary under the appropriate category. If you hired more than one individual in a category, use the most recent hire:
Administrative:
a. \$52,700 Director
b. n/a Associate Director
- Counseling Staff:
a. \$48,914.50 Ph.D./Ed.D and experience
b. \$46,831.00 New doctorate
c. \$37,750 ABD
d. \$39,900 Master and experience
e. \$37,666.67 New Master
f. \$36,000 Not specified
 \$25,000 Part-time AOD
 \$35,000 Learning Support Counselor
28. Has anyone filed a legal complaint about your staff and/or services provided during the past year?
2 - Yes 34 - No
- If yes, what was the nature of the complaint? Named in a suit against the University and other administrators; Did not elaborate.
29. Do you feel you are provided with adequate legal counsel through your school?
18 - Yes 18 - No
30. What percentage of your staff members who do "personal counseling" carry liability insurance other than that provided by your institution? 1 = < 1% 4 = 20-35% 4 = 50-60% 5 = 100% 2 = No % given

31. Does your department provide release time for staff to engage in consulting or private practice during normal working hours?
 2 – Yes 34 - No
- If yes, how much time? 1-3 hours consulting & 4 hours
32. Do you have a waiting list problem during busy terms (students waiting more than 10 days for an appointment, either initially or after intake)?
 11 - Yes 25 - No
33. If yes, what steps have you taken to cope with your waiting list problems? Check all that apply.
- a. 10 - Increased the number of referrals to outside agencies/practitioners
 - b. 6 - Established a limit on the number of counseling sessions
 - c. 10 - Increased counselor's case loads during busy session
 - d. 1 - No session limits but expect each counselor to open up certain number of hours each week
 - e. 1 - Charge a fee after limited number of hours
 - f. 2 - Hire part-time help
 - g. 3 - Establish an intake system
 - h. 1 - Eliminate an intake system
 - i. 1 - Do telephone interview with people on waiting list
 - j. 2 - Other (established more efficient intake/case assignment system; open "screening hours" with 15-20 walk in sessions so that students can be triaged)
34. Has the amount of time your staff spends doing crisis counseling changed in recent years?
 a. 23 - Yes, a significant increase
 b. 0 - Yes, a significant decrease
 c. 13 - No, has stayed the same
35. Has the average number of hours for personal counseling changed in recent years?
 a. 27 - Yes, the average number of hours has increased
 b. 0 - Yes, the average number of hours has decreased
 c. 7 - No, has stayed the same
36. Have you seen an increase during the past several years in the number of students with more severe issues and/or disorders?
 ____ 2005 Approximately what percent increase? ____
 ____ 2006 Approximately what percent increase? ____
 ____ 2007 Approximately what percent increase? ____

***NOTE: answers not reported the same by enough institutions to report**

37. Types of issues or disorders seem to be increasing most noticeably:
- | | |
|-------------------------------------|--|
| 25 - Depression | 11 - Psychotic Disorders |
| 30 - Anxiety/Stress | 8 - Eating Disorders |
| 12 - Personality Disorders | 13 - Substance Abuse |
| 14 - Adjustment Disorders | 12 - Self-mutilation behavior |
| 19 - Anger management | 18 - Distress tolerance |
| 15 - Impulse control problems | 19 - Suicidal behavior (ideation, threat, etc) |
| 4 - Post Traumatic Stress Disorder | |
| 5 - Other Disorders (not specified) | |

38. Does your center have psychiatric medication resources? Waiting time till appt?
- 7 - Psychiatrist on staff (2 - full time 5 - part time)
 - 4 - Physician on staff (2 - full time 2 - part time)
 - 12 - Psychiatrist in community
 - 10 - Physician in community
 - 15 - Community mental health clinic
 - 8 - Student's attending physician

NOTE: Waiting time ranged from 3-4 days to one month for all above

39. How are psychiatric medication visits paid? (Multiple answers given by some)
- 1 - From Counseling budget
 - 7 - From Student Health budget
 - 2 - From other university budget
 - 29 - Student self-pay

39b. Do you have a fund for psychiatric back-up? 3 - Yes 20 - No

40. Does your campus mandate health insurance for students?
- 4 - All students
 - 4 - Graduate students
 - 10 - Athletes
 - 18 - International students
 - 6 - None
 - 14 - Other (required for specific majors like Allied Health Professions- Nursing students, Dental Hygiene students, Respiratory Therapy students; TA's; Graduate Assistants)

41. Has your staff had to hospitalize a student for psychological reasons during the past year?
- 18 - Yes 19 - No How many of each:
- 99 - Suicidal
 - 5 - Homicidal
 - 6 - Self-harm (cutting, burning or other needing medical intervention)
 - 30 - Actively or acutely unstable (psychotic, acutely manic, other extreme)

distress, etc)
2 - other (AOD)

42. Who completes the mental health evaluation to determine need for hospitalization?
- 11 - Counseling Staff
 - 14 - Hospital Staff upon arrival
 - 7 - Off campus assessment person/team (who? Counseling staff completes initial assessment. If client must be transported involuntarily, we either contact parents or have consulting psychologist sign 1013. Hospital staff completes more thorough assessment; Local community mental health will send someone to do assessment at hospital as part of commitment procedure; Mobile Assessment Team used)
 - 14 - Counseling Staff does evaluation and submits to hospital who also does its own.

43. If off-campus evaluation services are used, who pays the cost?
- 0 - University
 - 24 - Student
 - 4 - Government Funded
 - ___ Private Funded _____

NOTE: many left blank; 3 listed "student and government funded

44. Does anyone at your institution have the legal authority to sign 1013 forms (involuntary hospitalization)?

11 – Yes (if yes, indicate all departments who have the authority)

17 – No (if no, who signs?)

9 Counseling Staff
6 Campus Police Staff
4 Campus Medical Staff

3 Local Law Enforcement
13 Off-campus medical/mental health staff

2 - N/A

45. Who transports students to hospital for mental health treatment?

22 - Campus Police
15 - Local Law Enforcement

11 - Students' families
8 - Other students (friends, etc.)
7 - Students themselves

13 – other (Ambulance/EMS = 6; this area is a gray area because it varies with each case; local law enforcement and campus police are one in the same; friend; counselor)

46. When a student is released from the hospital, what follow up care is in place?

- c. 15 personal, academic, career)
Client presenting problems upon intake (i.e., from center Intake form)
- d. 5 Symptom severity at intake using standardized measure (e.g. OQ-45.2, SCL-90, BSI)
- e. 2 Assessment of counseling related outcomes using post-therapy standardized measure
- f. 24 Student satisfaction surveys (evaluation of satisfaction with counseling center services)
- g. 14 Evaluation of other counseling center programs (e.g. outreach programming)
- h. 11 Impact of counseling services on student satisfaction with University and retention.
- i. 15 Staff activity (e.g. time spent in clinical, administrative, or outreach activities).
- j. 9 Assessment of client and non-client counseling related concerns and needs.
- k. 3 Other (Plan to increase assessment, particularly clinical assessment and retention plan; Needed a none in the above choices; alcohol use inventory)

50. Did/will your center develop an Annual Report for the survey period?
28 - Yes 8 - No

51. Has your center completed any of the following Site Evaluation activities during the period July 1, 2006 and June 30, 2007? (2 did not respond)

Completed a CDA- sponsored Site Visit (Peer Review)	0 – Yes	28 - No
Completed the CDA Site Visit Checklist (Self-Evaluation)	5 – Yes	23 - No
Completed an IACS sponsored Site Visit Team in the past five years	5 – Yes	23 – No

52. How many counselors completed the following training at any time prior to the end of the survey period (July 1, 2006 and June 30, 2007)?
Counselors/Schools

<u>51 / 18</u>	Red Cross Intro to Disaster Services Training
<u>23 / 18</u>	Red Cross Disaster Mental Health Services Training
<u>18 / 12</u>	Advanced Crisis Response Training in ATSM (or equivalent)
<u>22 / 14</u>	Advanced Crisis Response Training in CISM (or equivalent)

53. Does your campus have a crisis response plan in place?
19 - Yes and it includes Counseling
8 - Yes but doesn't include involving Counseling
3 - Yes, but I don't know if it includes Counseling
4 - No, but one is being developed

2 - None that I know of

54. Is it followed?

2 - No

14 - Sometimes

7 - Always

55. How well does it work?

2 - Ineffective

14 - Somewhat effective

5 - Very effective

10 - Unknown

56. What record-keeping system is used to track services provided (includes type of service, walk- in services, etc) and demographics of those seen by counseling staff?

6	Titanium
12	In-house System
9	Paper/Pencil
2	Other computerized system
1	N/A