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U. T. SYSTEM

RECOMMENDATIONS FROM THE TASK FORCE ON STUDENT MENTAL HEALTH AND SAFETY

Prepared by the Office of Academic Affairs
The University of Texas System

June 2014

Introduction

The U. T. System places high value on the health and safety of its students and strives to be a national exemplar in providing the requisite programs and resources to facilitate student health and safety. Research shows that many students arrive on university campuses with mental health concerns that can be exacerbated by the stress and pressure of academic requirements and the challenging issues students encounter developmentally and in their transition to university life. Other students might experience symptoms for the first time while on a university campus, as 18-25 is a common age of onset for many mental health disorders.

Although faculty, staff, and administrators forge close relationships with some students on campus, it is difficult to identify the early warning signs of psychological issues. Concerns are often not visibly observable and can even be difficult for individuals to detect in themselves. While mentors, advisors, and counselors exist on every campus, rates of help-seeking are low relative to the incidence of mental health concerns. Further, a lack of resources makes it challenging to keep up with growing student demand from year to year. Due to the increasing emphasis on behavioral intervention and the growing need for mental health care and counseling at universities, the Task Force on Student Mental Health and Safety Task Force was convened by the U. T. System Board of Regents to address these growing concerns.

Task Force Charge

The Task Force on Student Mental Health and Safety is charged with reviewing current campus practices to increase the probability that worrisome student behavior is identified and that appropriate institutional responses can be initiated. The Task Force has been charged with addressing the following questions and issues:

Charge #1: Develop recommendations in the structure and process of Behavioral Intervention Teams (BITs) to ensure that timely and appropriate referrals are made with appropriate outcomes and dispositions.

Charge #2: Identify successful processes in place on campuses to identify students with mental health concerns.

Charge #3: Identify mechanisms to support students with mental health concerns.

Charge #4: Determine if additional campus data may be gathered and categorized to identify troubled students for the purposes of early intervention and outreach.

In addition to the recommendations that stem from the Task Force charge, the Task Force has developed recommendations for students at health institutions who have been less likely to seek mental health counseling and treatment due to confidentiality and licensure concerns. Finally, the Task Force has also considered the potential to leverage system resources to improve mental health among students system-wide.

Charge #1: Recommendations for the Structure and Process of Behavioral Intervention Teams

After the tragic shootings at Virginia Tech in 2007, the report issued by the Virginia Tech Review Panel provided timely and appropriate information to university campuses across the country. While some institutions had behavioral intervention initiatives already in place, as a result of the Virginia Tech Report, most campuses began to establish Behavioral Intervention Teams (BITs) to identify and intervene with students displaying disturbing behavior. BITs are now becoming a standard of care at universities across the country as a mechanism for campus constituencies to share and act on information about students of concern.

U. T. System academic institutions have instituted similar models of BITs. These teams typically consist of campus representatives from Student Affairs, Student Mental Health, Student Health Services, the University Police, Associate Deans, and faculty/academic representatives. These teams often meet on a regular basis but also convene as needed to address concerning student behavior on campus.

Although U. T. System health institutions have each developed a mechanism for responding to crises on campus or within their medical facilities, the implementation of these mechanisms varies widely by campus. At most health institutions, crisis response teams allow faculty, staff, and students to respond to emergency situations. While these teams do address the most urgent crisis situations, such as responding to an active shooter within a hospital, these teams do not take the place of behavioral intervention teams.

U. T. Southwestern Medical Center and U. T. Health Science Center at San Antonio currently have BITs that function similar to the academic institutions. U. T. Medical Branch at Galveston is in the process of developing a formal BIT, and institutional officials have implemented an operating plan that addresses specific components of BITs, such as the development of online training that informs faculty and staff about how to address students experiencing distress.

U. T. MD Anderson Cancer Center and U. T. Health Science Center at Houston currently have a type of integrated crisis response team that relies on frequent interaction among faculty, staff, and students in master advisory groups. Group members are trained to notice "red flags" and engage appropriate emergency responders. U. T. Health Science Center at Tyler has not yet developed a BIT due to the very small number of students at the institution.

Because all BITs currently differ in structure and meeting frequency, the Task Force has provided some recommendations designed to set some minimum standards for U. T. System institutions.

In general, the purpose of BIT teams should include:

- Gathering information about students of concern. This may specifically focus on threats with the potential to become violent (as is the case with threat assessment teams) or a broader range of troublesome behaviors.

- Assessing the information about each case in a systematic way to determine the most effective response for that particular person and situation.
- Defining the plan/response to address the needs of both the student and the safety of the community. The plan should consider specifics about who, when, where, and how the response will occur.
- Implementing the response in a way that attends to the needs of the individual who is demonstrating disturbed and/or disturbing behavior and that also de-escalates a potential crisis, and reduces or removes threats. Note that for many BITs, the actual implementation of a response may be carried out by other individuals or departments; the team itself often acts in an advisory and coordinating role.
- Monitoring the disposition of the case to gauge whether any additional follow-up is needed, whether the response was effective, and what lessons may be learned for future cases, especially in terms of implications for school policies and procedures.

Of particular importance in including these functions under one team's purview is:

- to prevent any particular instance of disturbed or disturbing behavior from falling through the organizational cracks; and
- to connect disparate (and therefore seemingly innocuous or less troubling) pieces of information that may indicate a more serious or acute problem, in the hope of preventing a dangerous or critical outcome or event.

Recommendations

It is important that U. T. System institutions adopt BIT practices which respond to all of the purposes listed above. The Task Force suggests the following recommendations be implemented at U. T. System institutions.

1. Each institution will be provided a link to a recently developed guide: *Balancing Safety and Support on Campus: A Guide for Campus Teams* compiled by the Higher Education Mental Health Alliance.[1] This is an excellent resource which provides guidelines and examples about every aspect of BIT functions and includes references and tools with additional in-depth materials.

2. Each institution will be provided a flow chart depicting concerns and issues that institutions face and designating key decision points for individual campus personnel and the BIT team. This flow chart specifically highlights the importance and immediacy of referring to police any campus incident which involves a student who is a threat to self or others.

3. The U. T. System will require all BITs to create a process to refer individuals viewed as a threat who are no longer a part of the university community to the local law enforcement jurisdiction and/or to the law enforcement jurisdiction where the person resides.

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[1] Balancing Safety and Support on Campus: A Guide for Campus Teams, A Higher Education Mental Health Alliance Project, http://www.jedfoundation.org/campus_teams_guide.pdf

4. Organizational charts for each campus BIT will be provided to and maintained by the U. T. System Office of Academic Affairs and Office of Health Affairs. U. T. System will follow-up with each institution to ensure that a team is in place and functions according to established guidelines.

5. U. T. System will also maintain a list of campus contacts and will initiate and facilitate the sharing of best practices among system institutions.

Charge #2: The On-Campus Processes in Place to Identify Students with Mental Health Concerns

U. T. System institutions currently offer a variety of mechanisms for alerting campus officials about students with behavioral concerns. These reports are generated from all parts of the campus community, and in many cases, are routed directly to the campus BIT. At some institutions, staff respond and intervene when appropriate, referring only the most serious cases to the BIT. The following are examples:

Behavioral Concerns Advice Line

The Behavior Concerns Advice Line (BCAL) is a service that provides The University of Texas at Austin's faculty, students, staff, parents, and visitors an opportunity to discuss their concerns about another individual's behavior. This service is a partnership among the Office of the Dean of Students, the Counseling and Mental Health Center (CMHC), the Employee Assistance Program (EAP) and The University of Texas Police Department (UTPD). An individual can either call the line or report their concerns using the online submission form. In most cases, the reporter can remain anonymous.

Trained staff members will assist the individual in exploring available options and strategies. Staff members will also provide appropriate guidance and resource referrals to address the particular situation. Depending on the situation, individuals may be referred to resources including but not limited to the Office of the Dean of Students/Student Emergency Services, CMHC, and the EAP. Some cases reported to BCAL will be staffed by the campus BIT team.

Email/Online reporting

Many institutions currently offer an online mechanism for reporting behavioral health concerns. At U. T. Medical Branch at Galveston, for example, students may make a report via email or behavioral health website. Issues are then forwarded to the appropriate parties who are best equipped to handle the situation.

Crisis Counseling/Telephone Counseling Lines

Telephone crisis counseling lines are an excellent resource for students who are reluctant to present to a college counseling center, need to access a counselor after-hours, wish to remain anonymous, or are concerned about the stigma of seeking services in person but

want to take the first step. This service also provides around the clock services that are more realistic to a student's lifestyle, and it is a crucial tool for a campus to be able to identify and intervene with students in crisis or at a heightened risk for harming themselves or others.

Telephone crisis counseling is provided by counselors who are specifically trained to deal with crisis situations as well as the variety of concerns that are experienced by university students. Telephone Counselors can listen and talk confidentially about students' concerns, discuss options and strategies, and if needed, refer to appropriate counseling and mental health services on campus or in the community. The counselors document their counseling sessions and these notes are available for download into the electronic health record of the campus.

Some of the U. T. System institutions have these lines in place, but as the call volume increases after-hours call lines are increasingly difficult to afford for the institutions that do have them. For example, U. T. Austin has had a telephone counseling line in continuous operation for over 40 years. It was the first such service at an institution of higher education, and was started shortly after the U. T. Tower shooting. In 2010, U. T. Austin outsourced this service to ProtoCall Services, a company specializing in telephone crisis intervention on college campuses.   This is a confidential service that offers an opportunity for U. T. Austin students to talk with trained counselors about their problems and concerns. A counselor is available 24 hours a day, every day of the year, including holidays.

Recommendations

1. Each campus will have a mechanism to provide after-hours telephone crisis counseling to students with the capability of assessing for level of acuity, connecting students to both campus and community resources, and responding to urgent situations appropriately, up to and including hospitalization. This service should be connected to the campus counseling center so that counselors can be notified of student callers and follow up as appropriate. The task force recommends that the U. T. System contract for these services on behalf of institutions across the System and make the funding available for the next five years.

2. Both crisis counseling and campus reporting mechanisms for students of concern should be appropriately advertised on each campus, with staff members effectively trained in responding to behavioral health concerns on campus. The U. T. System should consider making funding available for five years to fund the advertising, promotion, and training for these services and mechanisms.

Charge #3: On-Campus Mechanisms to Support Students with Mental Health Concerns

While responding to reported behavioral concerns on campus is of the highest importance, institutions must also provide a mental health support structure for students to access in times of need, including crises.

Counseling and Mental Health Support Improves Persistence and Academic Outcomes

Numerous studies and reviews of the literature show that students who receive counseling are more likely to stay enrolled/graduate than their counterparts who do not receive counseling (Bishop, 2010; Illovsky, 1997; Lee, Olson, Locke, Michelson, & Odes, 2009; Sharkin, 2004; Turner & Berry, 2000; Wilson, Mason & Ewing, 1997). Across studies, the impact of counseling on retention ranged from 7% - 15% (Illovsky, 1997; Turner & Berry, 2000; Wilson, Mason & Ewing, 1997) with one study reporting that the odds of staying enrolled for students who received counseling were just over 3 times greater than the odds for students who did not receive counseling (Lee et al., 2009). In a study of students seeking counseling, 70% reported that their personal problems were impacting their academic performance (Turner & Berry, 2000). A survey of withdrawing students revealed that 20% of prematurely exiting students had GPAs above 3.0 and 45% had GPAs above 2.0. Among those students, "personal reasons" was the most commonly cited reason for withdrawing (Rummel, Acton, Costello & Pielow, 1999). Findings support the efficacy of brief counseling, with increased retention rates of 14% for students who received 1 – 7 counseling sessions compared to those who did not receive counseling (Wilson et al., 1997). After accounting for pre-college academic performance (high school GPA, SAT and ACT scores) counseling does not appear to increase GPA (Lee et al., 2009); rather, counseling may increase retention by improving life satisfaction and reducing social and emotional adjustment difficulties, both of which have been found to predict retention as well as or better than measures of academic success (Clark, Wetterson & Mason, 1999; Gerdes & Mallinckrodt, 1994).

Nationwide, college students have identified stress as the number one impediment to academic performance (ACHA-NCHA-II, 2012). Ronald Ehrenberg of the Cornell Higher Education Research Institute (CHERI) demonstrated that institutional spending on student services has an equal or greater impact on graduation and persistence rates compared to instructional expenditures (Webber & Ehrenberg, 2009). The impact of increasing spending on student services is most significant for students who, based on indicators of academic and economic disadvantage, have the greatest risk for leaving college prematurely.

University of Texas at Austin student mental health statistics

In addition to the well-documented need for mental health services for campus health and safety reasons outlined above, mental health services can also have a strong impact on a student's academic success. Forty-nine percent of respondents (110 out of 225) in the U. T. Austin Exit Survey agreed or strongly agreed that "personal, physical, mental or emotional health concerns" influenced their decision to withdraw. This was a higher level of agreement than was given to any other category (personal, academic, or financial reasons). From a Spring 2012 survey

conducted by U. T. Austin colleges and schools related to student withdrawal, 54% were for mental health, medical, or personal concerns. Thirty-four percent of students withdrew specifically for mental health/medical reasons, which is more than financial emergencies, academic problems, transferring to another school, housing issues, transportation issues, legal issues, military service, and being the victim of a crime all added together. The next closest reason (14%) was for caring for a family member/family emergency. Seventy-four percent of Counseling and Mental Health Center (CMHC) clients who identified a negative impact of their presenting problems on their academic performance or degree progress agreed or strongly agreed with the statement "counseling is helping me improve my academic performance/progress towards my degree." Eighty-eight percent of CMHC clients who were initially considering withdrawing from school reported that CMHC services helped them remain in school.

Clinical Services

Students often struggle with issues such as anxiety, depression, family or relationship difficulties, academic pressures, concerns about friends and roommates, or worries about the future. Counseling and Mental Health Centers at institutions of higher education typically provide time-limited individual and crisis counseling for students in order to address these concerns and they also provide consultation to faculty and staff. Some centers also provide group counseling, psychiatric services, and integrated health services in collaboration with the campus primary care clinic. Counseling centers do not typically have the resources to provide substantial treatment to students, so the nature of the counseling is short term, often between three to five sessions. Most centers ensure that clinicians are available immediately for students in crisis. Wait times for a first appointment for non-crisis situations can be as much as three weeks, and time between appointments can vary between one and three weeks. Students with needs that require weekly counseling or higher levels of care are often referred to community resources. The success of this varies by campus, depending on the location and availability of mental health resources in the community. Because Texas ranks 50th among the states on per capita spending for mental health for the 2012 – 2013 biennium, resources can be incredibly scarce across the state, especially for students who are uninsured or underinsured.[2]

A national trend that has been evident in U. T. System schools is the increasing severity of mental health concerns each year and the increasing demand for these services. More students come to campus on psychiatric medications than ever before. According to the American College Health Association, suicide is the second leading cause of death for college students. A majority of college students recently surveyed have reported feeling hopeless, exhausted, overwhelmed, anxious, and lonely within the past year. Six percent of undergraduate students report having seriously considered suicide in the past 12 months, with nearly 1 in 5 having seriously considered suicide at some time in their life.[3] Of those who were suicidal in the past

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[2] Mental Health America of Texas, "Overview of the 2011 Legislative Session," http://www.mhatexas.org/wp-content/uploads/2012/08/Trifold.pdf
[3] Drum, Brownson, etc.

year, nearly 75% of them have had a previous episode of suicidality before coming to college, and less than half actually seek help on their college campus.

Prevention and Outreach Efforts

The students who are most at risk for self-harm or for harming others often have no contact with on-or off- campus mental health systems. In fact, three-quarters of students who die by suicide have not received mental health services. This highlights the crucial role that our institutions play in doing prevention and outreach. Prevention and outreach allows staff to operate outside of the walls of the counseling and mental health centers to reach students who don't seek available services. This includes education about wellness, emotional fitness, resiliency, and recognizing the warning signs of distress in others. Common prevention programs address the issues of suicide, interpersonal violence and sexual assault, drug and alcohol abuse, and eating disorders. The increasing demand for counseling services can drive down the availability of funding for prevention and outreach services, but these services are every bit as important as the clinical services that institutions provide.

Recommendations

1. Each institution should effectively advertise entry points to mental health support structures on campus.

2. Institutions should develop mechanisms for addressing the unique needs of specific student groups, such as international students, veterans, students studying abroad, and historically marginalized student groups.

3. Institutions should ensure that reciprocal agreements for students involved in study abroad or other campus residency opportunities include provisions for mental health resources when available. Additionally, institutions should effectively make students aware of such opportunities and should provide a secure information exchange for sharing relevant information regarding concerning behavior of visiting students.

Charge #4: Identification of On-Campus Data-Gathering that Would Improve Early Intervention and Outreach for Students with Mental Health Concerns

In the past decade or so, predictive data analytics, such as predicting trends in health care utilization and the relationship between demographics, genetics, and health, have become a valuable tool in some health care settings. Although some health care data can be used to predict general trends in mental health care services, unfortunately, there is little to no predictive relationship between available data on an individual's mental health, student demographic variables, and violent/crisis situations.

There is no research evidence to suggest the possibility of accurate identification of a single individual's likelihood to be in crisis or to be violent based on generally available demographics or health/mental health variables. A clinical interview by a mental health professional or a case review by a behavior intervention team has a greater chance of anticipating crises or recognizing the propensity for violent or suicidal behavior, but that is predicated on the gathering of information that is clinical, intensive, individually focused, time-specific, and often dynamic. Seventy-five percent of student deaths by suicide are individuals who don't ever come to a college counseling center to seek help, so the type of data needed to adequately predict and prevent such occurrences could not be known in the majority of these circumstances.

Research also suggests that there are many obstacles that prevent accurate identification and predictability of students who are likely to engage in violent events on campus. Because of the age of most college students, their personalities and mental health characteristics are not yet fully formed, and scientists lack diagnostic tools capable of detecting the likelihood that individuals may harm themselves or others. Further, violent events on campuses are often "embedded in a social and transactional sequence of events" involving many actions, reactions, and potential outcomes.[4]

Despite the lack of predictive data models, some institutions are developing ways of utilizing campus mental health clinical data to identify mental health population trends. For example, some U. T. System institutions monitor and report the means or locations that students mention as part of suicidal ideation. When trends emerge, campuses respond by placing increased security in locations that are mentioned more frequently or suicide prevention barriers in locations such as parking garages.

Recommendations

1. Institutions should monitor available information for mental health trends and take preventative action when appropriate.

2. Institutions that currently monitor mental health trends should share best practices with other institutions, especially in developing strategies for analyzing trends in counseling center student data.

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[4] Edward P. Mulvey and Elizabeth Cauffman, "The Inherent Limits of Predicting School Violence," *American Psychologist* (October 2001)

Mental Health and Health-Related Institutions

Throughout the research process, the Task Force discovered that students at health-related institutions often face a different set of opportunities and challenges when faced with a decision to seek mental health care. In addition, there is a variation in opportunities available to address the unique needs of medical students. The Task Force agreed that formulating recommendations to address the needs of this unique student group required a dedicated report section to fully articulate the scope of the issue and provide suggestions for improved access and sensitivity around the stigma of seeking mental health care.

Students preparing for a career in the medical field often face higher rates of depression, burnout, and even suicide rates due to the stress, fatigue, and academic intensity. At the same time, these same students, especially those preparing for medical licensure, have unique issues and concerns about seeking counseling and mental health care.

Although mental health conditions do not automatically preclude anyone from obtaining a medical license, confidentiality concerns and the stigma associated with seeking mental health care remain obstacles to accessible mental health care for many students.

Because the current medical licensure application in Texas requires students to report detailed and sensitive information regarding past treatment of mental health care, medical students are less likely to seek care. Since most institutions provide medical services "in house," many students are reluctant to seek counseling and medical services from physicians with whom they may potentially have a conflict of interest with in the future, especially if they serve in a faculty or teaching role that might be responsible for academically or professionally evaluating a student.

The medical school accreditation process requires that there be no potential conflict of interest among mental health providers and students. In addition, health institutions must provide timely access to diagnostic and preventative health services, including mental health care, to maintain their accreditation.

Recommendations

1. Health institutions should provide mental health care in such a way that allows students to be referred to non-teaching clinicians to prevent any conflict of interest, confidentiality, and trust issues that might emerge between students and current or future teaching faculty. Health professionals who provide any type of psychiatric or mental health services should have no potential for involvement in the academic work of any student treated. When necessary, a referral network outside of the health institution should be utilized.

2. Health institutions should take steps to reduce the stigma of seeking mental health care on campus. U. T. Systems Office of General Counsel and Health Affairs are exploring the current requirements for medical students' licensure reporting of previous mental health treatment and will make recommendations on how to limit barriers to care for medical students based on their concerns about this process.

3. Health institutions should allocate resources to develop proactive stress management, suicide prevention and the prevention of other common campus student issues, and mental health wellness programs that are also designed to reduce the stigma of seeking mental health treatment. Each institution should effectively advertise entry points to mental health support structures on campus.

4. Unique training should be given to mental health providers who treat this student population with an emphasis on confidentiality and privacy. Billing practices should be designed so that students' information is protected.

Conclusion

In addition to these recommendations, the U. T. System will work closely with institutions to ensure that system resources are effectively leveraged as described above.

The Task Force recognizes the tremendous importance that U. T. System and its institutions place on providing mental health resources for students. Protecting students, faculty, and staff from potential crisis situations is paramount. The Task Force recommendations provide additional guidance to the outstanding programs and services that campuses already employ to ensure that U. T. System institutions are safe and that students feel healthy and secure as they pursue their academic careers.

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