AGENDA

COMMITTEE ON EDUCATIONAL POLICY

Meeting: **4:00 p.m., Tuesday, May 11, 2010**
Glenn S. Dumke Auditorium

8:00 a.m., Wednesday, May 12, 2010
Glenn S. Dumke Auditorium

Roberta Achtenberg, Chair
Carol R. Chandler
Debra S. Farar
Kenneth Fong
Margaret Fortune
George G. Gowgani
Melinda Guzman
William Hauck
Raymond W. Holdsworth
Linda A. Lang
Robert Linscheid
Peter G. Mehas
Henry Mendoza
Lou Monville
Russel Statham
Glen O. Toney

Meeting: **4:00 p.m., Tuesday, May 11, 2010**
Glenn S. Dumke Auditorium

Consent Items

Approval of Minutes of Meeting of March 16-17, 2010

Discussion

1. Community Engagement in the California State University, *Information*
2. Teacher Preparation Program Evaluation, *Information*
3. California State University Mathematics and Science Teacher Initiative, *Information*
4. California State University Education Doctorate, *Information*
5. Report from the Select Committee on Mental Health, *Information*

***Note**

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5. Report from the Select Committee on Mental Health, *Information*

**Note: Depending on the length of discussions on Tuesday, May 11, 2010, Educational Policy items may have to be carried over to Wednesday for consideration.

Trustee Roberta Achtenberg called the meeting to order.

Approval of Minutes

The minutes of January 27, 2010, were approved as submitted.

Early Start Program

This item, presented by Dr. Jeri Echeverria, Executive Vice Chancellor and Chief Academic Officer, responded to the resolution that Academic Affairs was charged with, in developing a full implementation plan for an Early Start Program for pre-matriculating freshmen. Dr. Echeverria provided background on previous remediation programs that have been very successful in remediating students during the first year but have not been successful in reducing the overall demand for makeup work, nor have been successful in developing a program that assists students in getting remediated before they enter their first year in the CSU. That is the reason that the there needs to be a new approach to dealing with deficiencies in math and English. Dr. Echeverria emphasized that Early Start proposes that all students begin making up deficiencies before matriculation. It does not deny students admission if they do not complete the deficiency before joining the CSU or matriculating.

Dr. Echeverria provided a set of general recommendations and a general timeline for Early Start and campus administration of the program. Dr. Echeverria presented three recommendations to the Board for consideration and adoption of an Early Start program.

The following public speakers posed questions related to the Early Start program: Julie Rivera, CFA faculty, CSU Long Beach; Chris (no last name provided), former student, CSU Dominguez Hills; Javier Rodriguez, CFA staff, CSU Fullerton; Anthony Francoso, CFA faculty, CSU Los Angeles, Lionel Mandy, CFA faculty, CSU Long Beach; and Diana Hines. Dr. Echeverria responded to the speakers' questions.

The board and Dr. Echeverria discussed and clarified the Early Start program further.

Chair Carter thanked the taskforce for their hard work on a challenging subject as well as the public speakers for the care and passion they have on the subject. Chair Carter acknowledged that some of the questions posed do not have answers to them yet, but assured that everything will be done to ensure that what is done is to the benefit of the students of the CSU.

The committee recommended approval of the resolution (REP 03-10-01).

Academic Planning and Program Review and Changes to the Campus Academic Plans

This item, presented by Dr. Christine Mallon, California State University Dean, summarized the California State University academic planning process and reported the program planning, review, learning-outcomes assessment efforts, and regional accreditation activity that took place over the past year. The item also proposed a resolution for approved additions and modifications to campus academic plans and the CSU Academic Master Plan.

The committee recommended approval of the resolution (REP 03-10-02).

CalStateTEACH Multiple Subject Credential Program

This item, presented by Dr. Beverly Young, Assistant Vice Chancellor, Teacher Education and Public School Programs, provided an update on the CalStateTEACH program after its first ten years of operation. Dr. Young provided a video that showed how CalStateTEACH works and also a presentation of how students interact with the CalStateTEACH curriculum and faculty and how the CalStateTEACH website is designed to support faculty interaction with students. Dr. Young noted that CalStateTEACH is moving toward an e-book format as one of the pioneering programs in the state.

Trustee Fortune asked about the availability of e-books; Dr. Young replied that there are four e-books available and fourteen additional books for the entire eighteen month program period. The faculty that determine the curriculum for CalStateTEACH also determine what books to use. Trustee Fortune also inquired about the difficulty in transitioning from sites like Blackboard to a

self-supported site. It was noted that CalStateTEACH is unique in that it has a centralized curriculum, as time has gone on systems have been replaced, purchased and licensed with CalStateTEACH's own course management system.

Chair Carter commended the CalStateTEACH program and asked what the possibility was of expanding the program to the middle and high school levels.

Dr. Young responded that the CalStateTEACH program office has been approached about expanding into special education and into math and science, but at this time, CalStateTEACH as a centralized program out of the Chancellor's Office hasn't planned to expand.

Trustee Achtenberg asked if there was an opportunity to become a licensor of the technology to others who might be able to utilize it and pay the CSU a fee, would it be something the program would consider. Dr. Young responded that it has not been considered but she would be willing to look into it and would speak with the appropriate people about the possibilities of doing so.

Dr. Young pointed out a handout on CSU Fresno in the Trustee packets, clarifying miscommunication in a prior Board of Trustee meeting.

Proposed Title 5 Revision: Student Housing Priority for Former Foster Youth

This item proposed Title 5 language to implement the provisions added by the Skinner Bill (AB 1343) to the California Education Code. Academic Senate Chair, John Tarjan, stated that the academic senate supports both the proposed Title 5 Revision as well as the proposed repeal of Title 5 section 40503.

The committee recommended approval of the revision (REP 03-10-03).

Proposed Repeal of Title 5 Section 40503 Relative to Bachelor of Vocational Education Degrees

This item proposes to repeal Title 5 Section 40503 Bachelor of Vocational Education [BVE] Degree. These degrees are no longer offered at any campus within the California State University, having been replaced by bachelor's degree programs in Career and Technical Studies. Those newer programs respond to labor market needs and the educational needs of the state. As with the Bachelor of Vocational Education degree programs, students in the Career and Technical Studies programs can earn academic credit based on the learning they have acquired through work experience, which is allowed under Executive Order 1036.

Trustee Guzman stated that in some areas, especially in agriculture, there is a dearth of people who can teach technical education. Guzman asked if the new degree would be a pathway for graduates to earn a credential and go into education. State University Dean Chris Mallon noted that that is exactly describing what the programs can do, however, not everyone will earn a credential, and some will teach and provide training in different workplaces.

The committee recommended approval of the proposed repeal (REP 03-10-04).

COMMITTEE ON EDUCATIONAL POLICY

Community Engagement in the California State University

Presentation By:

Jeri Echeverria
Executive Vice Chancellor
and Chief Academic Officer

Judy Botelho
Director
Center for Community Engagement

Elaine Ikeda
Executive Director
California Campus Compact

Summary

In March 2000, the California State University Board of Trustees passed a landmark resolution in response to a request from the governor for a community service requirement for all students in California's public institutions of higher education. In a strong display of support for community engagement, the CSU Board of Trustees' resolution called for the chancellor and each CSU president to "ensure that all students have opportunities to participate in community service, service learning (deemed academically appropriate by faculty), or both."

In response to CSU's commitment to ensure all students have opportunities to participate in service, the State of California has authorized $1.1 million each year over the last decade to support the expansion of service opportunities on all CSU campuses.

In 2008/2009, CSU campuses reported that more than 170 new service-learning courses were created, with the total number of service-learning courses offered reaching more than 2,575. Service learning is a teaching method that promotes students learning through active participation in meaningful and planned service experiences in the community that are directly related to course content. Nearly 65,000 CSU students provided more than 1.2 million hours of service to their communities through service-learning courses in 2008/2009.

Additionally, a 2007 CSU survey revealed that more than 194,000 CSU students performed community service totaling 32 million hours, representing a 43 percent increase in the number of students involved in service from a decade ago. If service learning, community service and civic

engagement hours were totaled for the nearly half of CSU's students who provide some type of service, the total economic impact approaches $650 million (based on the accepted national volunteer rate).

These efforts supported by the State of California have been strengthened with external support as well. Across the system, $3,935,880 in grants from external sources was secured in 2008/2009 to support community engagement, a return on investment of nearly $4 for every dollar invested by the state.

The CSU's great success in providing service opportunities for students has been possible because of valuable and enduring partnerships with local community organizations, businesses, government and the philanthropic sector. In 2008/2009, CSU campuses reported partnerships with more than 5,794 sites for student placement, compared with 3,560 in 2007/2008.

During the challenging economic times California now faces, partnerships are more crucial than ever to sustaining communities, helping students access higher education and providing high-quality learning opportunities that meet the ever-changing needs of California and its residents.

For more than 20 years, a highly productive and successful partnership between CSU and California Campus Compact (CACC) has existed to ensure university students are engaged in service to their communities.

California Campus Compact, founded in 1988, is a coalition of California's leading colleges and universities. CACC builds the collective commitment and capacity of colleges, universities and communities to advance civic and community engagement for a healthy, just and democratic society. Through innovative programs and initiatives, grant funding, training and technical assistance, professional development, and influential research studies and publications, CACC each year invests in and champions more than 500,000 students, faculty members, staff, administrators and community members involved in diverse and groundbreaking civic and community engagement activities.

The benefits of partnership with CACC have been tremendous for the CSU. In 2009/10, the average cash value received from CACC in student education awards and grants to fund service-learning and civic engagement programs per CSU member campus was $24,885--60 percent more than the average cash value received among all member campuses in California ($14,863).

In return, CSU presidents have demonstrated their support, leadership and collective commitment to community engagement by serving on the CACC Executive Board. Dr. Richard Rush, CSU Channel Islands, is the current chair of the Executive Board. San Francisco State University, under the leadership of Dr. Robert Corrigan, has hosted CACC since 1995, and the vast majority of CSU campuses have been active, involved members of CACC since its founding.

COMMITTEE ON EDUCATIONAL POLICY

Teacher Preparation Program Evaluation

Presentation by

Jeri Echeverria
Executive Vice Chancellor and
Chief Academic Officer

Beverly Young
Assistant Vice Chancellor
Academic Affairs

Introduction

Recent results of the *CSU Systemwide Evaluation of Teacher Preparation* show sustained, accelerating progress by CSU campuses in preparing K-12 teachers who are effective and successful in California schools. Most of the new evidence of campus improvement comes from the professional judgments of experienced school leaders who supervise CSU's first-year teachers. The CSU Center for Teacher Quality (CTQ) is also analyzing and summarizing evidence of K-12 student learning that results from CSU programs for new teachers. This report discusses both sets of evaluation evidence.

Results from the Annual Systemwide Evaluation of Teacher Preparation

For several years the Committee on Educational Policy has reviewed annual reports of the *CSU Systemwide Evaluation of Teacher Preparation.* For the first time this year, evaluation results indicate that many improvements in the outcomes of CSU teacher preparation are systemwide (not limited to a few campuses), sustained (more durable than year-to-year fluctuations), and accelerating (rates of systemwide improvement are quickening).

In California's public schools, experienced leaders annually evaluate the performances of first-year teachers. Then these same administrators answer CSU questions about each CSU teacher's prior preparation. To obtain valid, reliable evidence, the Center aligns its evaluation questions with the adopted California Academic Content Standards for curriculum, and reports only the judgments of school supervisors who (1) have worked with six or more new teachers in their careers, (2) have observed each individual CSU teacher's classrooms, and (3) have talked about instructional issues with each teacher on four or more occasions. Additionally, The Center for Teacher Quality encourages supervisors to not answer a particular evaluation question if they do not have sufficient first-hand evidence to answer it reliably.

CSU's Responsibilities and Recent Systemwide Evaluation Results

Every new CSU teacher should be well-prepared to fulfill the major professional responsibilities that are commonly assigned to new teachers. Novices are not typically expected to provide leadership in their schools, or to develop curriculum materials that serve as models for their colleagues. But instructional skills, classroom management, and content knowledge are critically important for novice as well as experienced teachers. In a typical school year, first year and second year teachers from CSU campuses provide instruction in the core subjects of reading, writing, math, science, and/or history to more than 750,000 students in grades K-12. Campuses are committed to the goal of producing increased numbers of well-prepared new teachers who enable all students to ready themselves for college and careers. Recent *Systemwide Evaluation* results reflect this commitment in both elementary and secondary schools, as outlined below.

Sustained CSU Improvements in Preparing Teachers for Elementary Schools

When new students are admitted to the CSU, all of them should demonstrate college-level proficiencies in math, writing, and other language skills, which should begin to develop in the earliest grades. For California pupils, CSU prepares more teachers of these skills than all other institutions combined. The Center for Teacher Quality is examining reading, writing, and math *test scores* by K-8 pupils of new CSU teachers, which CTQ will report to Trustees as soon as possible. In the ongoing evaluations of CSU programs, principals of K-8 schools take these scores into account when they assess the preparation of each new K-8 teacher.

Several CTQ evaluation questions pertain to the critical subject of reading and language arts. Assessments by K-8 principals clearly show sustained growth in CSU's year-to-year production of new teachers who are well prepared to be effective in reading-language arts instruction. The upcoming presentation will include the strides that CSU campuses are making in the following seven major domains of K-8 reading instruction:

    (1) Teaching *phonemic awareness* and other essential *decoding skills*.
    (2) Teaching *vocabulary* and *concept development* skills in English.
    (3) Teaching *comprehension* of narrative and literary reading selections.
    (4) Teaching *grammar*, spelling, punctuation and sentence structure.
    (5) Teaching *oral speaking* skills and *listening comprehension* skills.
    (6) Increasing the *fluency* and *automaticity* of students' reading skills.
    (7) Using specific *reading-language arts textbooks* adopted by a school district.

CTQ also is analyzing the mathematics learning scores of K-8 students taught by new CSU teachers. Meanwhile, K-8 principals continue to assess math instruction by CSU graduates, based on actual observations of that instruction. For nine years, according to these assessments, campuses annually produced increasing numbers of new teachers who taught K-8 math skills

effectively. The Committee will view CTQ graphs that illustrate this overall trend as well as specific CSU improvements in three major domains of K-8 math instruction, specified below:

(1) Teaching the essential computational and procedural skills of basic arithmetic.
(2) Teaching pupils to conceptually understand the logic of mathematics and its operations.
(3) Instruction in problem-solving skills enabling students to use multiple solution strategies.

The presentation to the Committee will also include graphic evidence of similar CSU progress in preparing K-8 teachers for instruction in science, history, and 21st century thinking skills.

Addressing Traditional Challenges in Preparing Teachers for Secondary Schools

CSU programs for prospective teachers have critical roles in helping to close K-12 achievement gaps and preparing all students for higher education and productive careers. The Chancellor's Office measures and reports the effectiveness of these programs, and holds each campus accountable for improved effectiveness. The CO's most recent accountability measures focused on aspects of teacher preparation that are challenging for all universities. Two of these challenges are preparing secondary school teachers of all subjects to (1) meet the academic needs of students who are at risk of leaving school without graduating, and (2) develop students' reading skills while teaching courses that focus on academic disciplines such as science, history, music, and physical education. Recent evaluations of these two areas are summarized next.

Many organizations in education and outside of education offer resources to support and assist students (and their families) who are losing interest in education and are tempted to leave school without earning diplomas. Teachers in grades 7-12 must be familiar with these resources and must know how individual students can access them before the students leave school. When the *Systemwide Evaluation* began, campuses were not sufficiently effective in preparing teachers to meet the academic needs of students at risk of dropping out of school, so the Chancellor's Office identified this aspect of teacher preparation as a priority for the system. Campuses responded constructively to this challenge by expanding content for successive cohorts of teacher candidates. The report to the Committee will highlight recent increases in evaluations of new high school teachers who are prepared to help retain students and reduce serious local drop-out rates.

In grades 9-12, it is challenging for students to overcome poor literacy skills. Teenagers with literacy problems contend with (a) the widespread expectation that reading skills should develop fully and successfully in elementary schools, (b) the tendency of high school English curricula to emphasize forms of literature that are difficult for many students to understand, and (c) the inability of high schools to hire reading specialists and assign them to classes focusing on basic literacy skills. To resolve these challenges, an important University responsibility is to prepare secondary teachers of science, mathematics, history, and other subjects to develop students'

academic reading skills in classes that primarily focus on content areas. When prospective secondary teachers enroll in teacher education programs, however, they expect to focus their instruction on the specific subjects that they expect to teach. ("I majored in biology but you want me to teach reading?") To emphasize the importance of developing the literacy skills of all students, the Chancellor's Office provided professional development for faculty members from all campuses, expanded the *Systemwide Evaluation* to measure program effects in multiple areas, and has focused campus accountability reporting on this issue for a sustained period of time. CSU has not yet reached a high level of effectiveness, but recent results show substantial progress. The presentation will introduce the Committee to these results, and will invite a CSU campus that became especially effective to describe its successful strategies briefly to the Trustees.

Measuring the Effects of CSU Teacher Preparation on K-12 Student Learning

Through targeted funding from the Carnegie Foundation and the Chancellor's Office, the Center for Teacher Quality obtained K-12 data to address three urgent evaluation questions:

(1) What is the relative impact of university-based teacher preparation on the academic growth of K-12 students in California, compared with the relative strength of other factors that are known to influence student learning such as individual factors, school factors and community factors?

(2) In relation to teachers prepared outside the CSU, how well do CSU-prepared teachers foster learning gains by their K-12 students, particularly in core subjects of reading, writing, mathematics, and science, and especially on behalf of student groups that have long been underserved by our elementary, secondary, and postsecondary schools?

(3) Does evidence of K-12 student achievement help to identify specific programs of teacher preparation that are particularly effective and, if it does, can the effective features and characteristics of these programs be identified? For university students who want to teach in the future (and for their eventual students), would it be feasible for campuses to extend and enlarge their most effective programs?

To report sound results to Trustees, CTQ is organizing the K-12 data so (a) information about each student's academic progress forms a single electronic record, (b) each student's record includes information about each teacher's preparation, and (c) all student records have a uniform data structure. No California school districts or state agencies have previously organized K-12 data in this way. As a result, CSU and other universities have not been able to assess their effects on K-12 achievement. Five urban districts transferred the needed data to CTQ almost two years after they promised to do so. No agencies or companies offer computer programs to electronically format K-12 data as needed; CTQ is writing its own programs. The Committee's next report will examine CSU effects on reading, writing, math, and science achievement for the

first time, and will compare these test-based findings with assessments of CSU teacher education by school supervisors whose judgments were summarized above and in a series of prior reports.

The Duration of the Systemwide Evaluation

Faculties in postsecondary institutions keep academic programs current and effective by drawing on ideas and information from many sources. Historically, however, institutions have not been able to acquire evidence about the *outcomes* of their academic programs. The CSU is a pioneer in doing so in teacher education. The *Systemwide Evaluation's* initial findings created anomalies that campuses had not previously encountered, resulting from the fact that evidence of *outcomes* cannot be assembled until the *outcomes* occur. When initial evidence of *outcomes* is reported, it describes the effects of academic instruction two to three years earlier. But CSU programs for prospective teachers were dynamic before the *Evaluation* began. When its initial results revealed disappointing levels of effectiveness in some areas, the sources of ineffectiveness may have been corrected in prior program changes. Only a series of measurements linked to a series of changes could reliably be regarded as demonstrating the *effects* of reforms. CSU faculties needed *cumulative evidence of outcomes* to rely on the evidence in making new academic decisions.

During the *Evaluation's* initial years, University administrators scanned the field and determined that the CSU system was the first group of universities to investigate the *outcomes* of its teacher programs systematically. The Chancellor's Office has now supported the *Systemwide Evaluation* for nine years. The available literature reveals no prior evaluations of this duration. It is the longest-running initiative of its kind in the history of American teacher education. And because the *Evaluation* focuses on outcomes, its duration is critically important because data-driven decisions on the basis of initial samples of evidence are not likely to be academically sound. The *Systemwide Evaluation's* duration is a primary reason why improvements in the academic *outcomes* of CSU teacher education are becoming more sustained and are occurring more rapidly as *cumulative annual results* can be used in increasing numbers of campus decisions.

COMMITTEE ON EDUCATIONAL POLICY

California State University Mathematics and Science Teacher Initiative

Presentation By

Beverly Young
Assistant Vice Chancellor
Academic Affairs

Summary

This information item will provide an update on the CSU Mathematics and Science Teacher Initiative (MSTI). In 2004, the Chancellor established a goal for the CSU to double its mathematics and science teacher production to address critical state needs. Although the state initially provided the CSU with only $250,000, after our initial success, the Legislature now provides funding of $2.713 million annually for the program, with CSU campuses increasing production of math and science teachers by 80% in the first five years, with another year to reach our targeted goal.

Background and Overview

MSTI was launched in 2004-05, in response to California's need for more than 33,000 new mathematics and science teachers over the next decade. Due to the absence of sufficient numbers of qualified mathematics and science teachers, large numbers of students in the state, particularly low-income and minority students, have been taught by out-of-field and underprepared teachers. The state's lowest performing and highest poverty secondary schools are three to four times as likely as other schools to have underprepared math and/or science teachers.

CSU has implemented a multi-faceted strategy to expand preparation of outstanding math and science teachers and is now recognized nationally for its success. The strategies have included (1) comprehensive recruitment, (2) innovative credential pathways, (3) financial support through scholarships and student loan cancellation, (4) alignment with community college pathways, (5) online preparation tools, (6) partnerships with federal laboratories in research opportunities for future science teachers, and (7) identification and scaling up of effective approaches.

All CSU campuses now have prestigious NSF Robert Noyce scholarship programs, providing up to $30,000 for candidates. Six campuses have NSF Master's Degree Fellowships, with support of $50,000 provided as students earn a master's degree and serve as beginning teachers.

COMMITTEE ON EDUCATIONAL POLICY

California State University Education Doctorate

Presentation By

Beverly Young
Assistant Vice Chancellor
Academic Affairs

Summary

This information item is presented to provide an update on the CSU Education Doctorate (Ed.D.). The program implementation has been highly effective, with 11 campus programs now serving 576 students; 333 preparing to be P-12 educational leaders and 243 preparing for community college leadership positions.

Background and Overview

In September of 2005, Governor Schwarzenegger signed into law Senate Bill 724 (Scott), which for the first time allowed the California State University to offer an independent doctoral degree. Prior to SB 724, CSU could only offer joint doctorate programs with the University of California or with a private university. Recognizing the urgent need for well-prepared administrators to lead public school and community college reform efforts, the state supported CSU's request to offer graduate level instruction that would lead to the Doctorate of Education degree. The Doctorate of Education degree offered by the California State University is focused on preparing administrative leaders for California public school districts and community colleges, providing the knowledge and skills needed by administrators to be effective leaders for California public schools and community colleges.

The program is serving a diverse group of candidates: more than 20% are Latino, over 15% are African American, 7% are Asian American, and about half are white. In the first offering, in 2007, 150 candidates entered the program. This group is now completing their third year, and just over 100 are projected to earn their Ed.D. degree by this summer.

The program has had unusually low attrition rates--only approximately 5%. The high persistence reflects in part the strength of the cohort model of the program and the study of problems relevant to candidates' work. In addition, CSU has worked to keep fees moderately priced, providing greater access to high quality preparation throughout the state.

COMMITTEE ON EDUCATIONAL POLICY

Report from the Select Committee on Mental Health

Presentation By

Charles B. Reed
Chancellor

Jeri Echeverria
Executive Vice Chancellor
And Chief Academic Officer

Allison G. Jones
Assistant Vice Chancellor
Academic Affairs, Student Academic Support

Lori Varlotta
Vice President for Student Affairs
California State University, Sacramento

Martin Bragg
Director, Health and Counseling Services
California Polytechnic State University, San Luis Obispo

Executive Summary

The California State University (CSU) Select Committee on Mental Health was charged with reporting to the Board of Trustees the appropriate level of mental health services necessary to address student needs and to review and identify the resources necessary to provide those services. To assess need, the committee spent the last fourteen months studying and surveying CSU directors of counseling, health, disability services, and housing. These studies form perhaps the largest compilation of data on student mental health needs ever carried out. The committee also researched national trends in collegiate mental health and used national surveys to benchmark its CSU data. The attached report summarizes and analyzes this extensive research. Additionally, the final section of the report contains eight recommendations—all of which are unanimously supported by committee members.

The CSU Select Committee on Mental Health

In early 2009 the CSU Office of the Chancellor created a 15-person CSU Select Committee on Mental Health (hereafter the "Select Committee") that was composed of members of various CSU campuses, in a variety of positions, including: provost, vice president of student affairs, counseling center therapist, counseling center director, health center director, disability services

director, faculty, and student. The committee was co-chaired by Dr. Lori Varlotta, Vice President of Student Affairs, California State University, Sacramento, and Dr. Martin Bragg, Director of Health and Counseling Services, California Polytechnic State University, San Luis Obispo. During the fourteen months that the committee worked, members gathered for six face-to-face meetings and conducted several teleconference meetings to address the multifaceted charge articulated in their appointment letters. Components of the charge included:

- Surveying, collecting, and analyzing overall campus data on mental health services currently provided to CSU students;
- Assessing trends in student mental health specific to CSU, e.g., increases in demand due to CSU initiatives such as the veterans initiative, and foster youth initiative, as well as a general increase in mental health issues due to stresses in the lives of today's students;
- Reviewing how increased demand is being addressed nationally and at CSU campuses;
- Identifying the appropriate level of mental health services to address student needs;
- Reviewing and identifying the resources necessary to provide appropriate services; and
- Providing counsel regarding a Student Mental Health Services Implementation Oversight Committee that would execute recommendations of the Select Committee that may be adopted by the CSU Board of Trustees.

As this final report to the CSU Board of Trustees demonstrates, the committee made great progress in meeting its charge.

Committee Membership
Co-chair
Dr. Lori E. Varlotta, Vice President for Student Affairs
CSU Sacramento

Co-chair
Dr. Martin Bragg, Director, Health and Counseling Services
Cal Poly San Luis Obispo

Mr. Drew Calandrella, Vice President for Student Affairs
CSU Chico

Dr. Paul M. Oliaro, Vice President for Student Affairs
CSU Fresno

Dr. Marten DenBoer, Provost and Vice President for Academic Affairs
Cal Poly Pomona

Dr. Jerald Shapiro, Professor, School of Social Work
San Francisco State University

Dr. Marshelle Thobaben, Professor, Department of Nursing
Humboldt State University

Ms. Celeste Pilegard, California State Student Association
CSU Fresno

Dr. Cathleen U. Coulman, M.D., Associate Vice President, Health and Wellness
Services/Director Student Health and Counseling Services
CSU East Bay

Dr. Brad Compliment, Director, Counseling and Psychological Services
CSU Long Beach

Mr. John Segoria, Director, Disabled Student Services
CSU San Marcos

Dr. Anne Eipe, Counselor, University Counseling Services
CSU Northridge

National Trends

Today's counseling centers struggle to concurrently meet the needs of both the numbers of students with serious psychological issues as well as those with milder concerns, a predicament magnified by decreasing community referral options and declining campus budgets. In addressing this conundrum, college counseling centers across the country confront several challenges:

- Risk management concerns stemming from high-profile campus tragedies along with cutbacks to needed community referrals
- The increased emphasis on academic success and retention, which prompts centers to see students with mild psychological issues who may achieve academic success if provided with assistance
- Economic conditions leading to campus and community budget reductions
- Higher demand for services at some campuses
- The complexity and severity of issues, including higher rates of psychotropic medication usage and the very serious problem of college suicide

CSU Survey Data

The committee's survey data show these national concerns are prevalent on CSU campuses. Anxiety and depression are the most common reasons why CSU students seek treatment. Of CSU students in treatment at CSU counseling centers, 50% experience anxiety, 40% have depression, 15% struggle with alcohol abuse, 15% face other addictions, and over 10% have suicidal thoughts. Compared to national norms, CSU counseling center students more often have issues of depression, suicide attempts and deaths, anxiety, oppression, and sexual assault, and less often with issues of current or past use of psychiatric medication, harming oneself (e.g.,

cutting, biting), needing hospitalization, considering suicide, considering injuring or actually injuring another person, experiencing a traumatic event, previously attending therapy, and having a learning disability (e.g., attention deficit disorder). The median number of students per CSU campus that attempt suicide yearly is four, compared nationally to three. The larger average size of CSU campuses, and their largely commuter character, may explain some of these differences.

Overall, there has been an increase in the number of students seen at CSU counseling centers for mental health services and in the severity of their issues. Wait times between an initial assessment and the start of ongoing therapy average 1.5 weeks during most of the year and double to 3 weeks during the busiest months near the end of the term.

CSU centers employ 15% less staff per student than the average four-year public university. Counseling staff are classified as Student Service Professionals-Academic Related, and as such are non-instructional faculty. In these roles they have many duties on campus beyond seeing individual clients, such as providing educational outreach and crisis intervention for the campus community, conducting program evaluation, and providing training. Retention, tenure, and promotion requirements also add other responsibilities on top of those duties. CSU full-time clinicians see 3.4 students per day during peak periods and 2.6 during non-peak periods.

Recommendations

Members of the CSU Select Committee on Mental Health <u>unanimously</u> make the following recommendations:

Recommendation 1:   Develop an Executive Order for counseling centers

Recommendation 2:   Identify adequate resources for basic services

Recommendation 3:   Review the classification and bargaining unit placement of CSU mental health counselors

Recommendation 4:   Require a campus review of counseling center structure and work distribution

Recommendation 5:   Obtain clarification regarding release of student health information

Recommendation 6:   Constitute an Implementation Committee hereafter referred to as the "Mental Health Services Committee"

Recommendation 7:   Structure and coordinate data collection

Recommendation 8:   Better integrate counseling services with other campus departments in an effort to promote overall wellness

Acknowledgements

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Impressively, the Select Committee achieved a 100% return rate for the three primary surveys, a 96% return rate for the supplemental survey sent to counseling directors, and a majority response rate for the questionnaire sent to housing directors. These return rates helped to generate a vast amount of data—data that likely constitute the country's most comprehensive data set of its type.

The successful generation and collection of this data are attributed in large part to the diligence of counseling center directors, health services directors, and disabilities services directors. Amid furlough and budget challenges, these systemwide colleagues logged numerous hours identifying, recording, and verifying the information they used to respond to questions on the aforementioned surveys. The Select Committee appreciates the significant contributions these directors made in completing and submitting surveys. Their responses were extremely valuable to this Committee's work and should assist any future committee that is charged with identifying the type of common data points that facilitate systemwide comparisons.

In addition to summarizing and analyzing CSU data on student mental health, the Select Committee, again aided by Dr. Epstein, along with Dr. Marjorie Bommersbach, Chico State, and Dr. Michele Willingham, Cal Poly Pomona, spent several months researching national data on this same topic. Dr. Varlotta consulted with them as they organized their research into a document that could be used to inform the work of the Select Committee.

Final Report

The full report from the Select Committee on Mental Health is included as Attachment A and is referenced in several sections of this report.

Select Committee on Mental Health

Report to the CSU Board of Trustees

May 2010

Written and Prepared by:

Lori Varlotta, Ph.D.
Vice President for Student Affairs
California State University, Sacramento

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With assistance from the members of the Select Committee on Mental Health and Dr. Bert Epstein

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Created in 2009, the California State University (CSU) Select Committee on Mental Health has been charged with reporting to the Board of Trustees the appropriate level of mental health services necessary to address student needs and to review and identify the resources necessary to provide those services. To assess need, the committee has spent the last fourteen months studying and surveying CSU directors of counseling, health, disability services, and housing. These studies form perhaps the largest compilation of data on student mental health needs ever carried out. The committee also researched national trends in collegiate mental health and used national surveys to benchmark its CSU data. The attached report summarizes and analyzes this extensive research. Additionally, the final section of the report contains eight recommendations—all of which are unanimously supported by committee members.

National Trends

Today's counseling centers struggle to concurrently meet the needs of both the numbers of students with serious psychological issues as well as those with milder concerns, a predicament magnified by decreasing community referral options and declining campus budgets. In addressing this conundrum, college counseling centers across the country confront several challenges:

- Risk management concerns stemming from high profile campus tragedies along with cutbacks to needed community referrals;
- The increased emphasis on academic success and retention, which prompts centers to see students with mild psychological issues who may achieve academic success if provided with assistance;
- Economic conditions leading to campus and community budget reductions;
- Higher demand for services at some campuses;
- The complexity and severity of issues, including higher rates of psychotropic medication usage and the very serious problem of college suicide.

CSU Survey Data

The committee's survey data show these national concerns are prevalent on CSU campuses. Anxiety and depression are the most common reasons why CSU students seek treatment. Of CSU students in treatment at CSU counseling centers, 50% experience anxiety, 40% have depression, 15% struggle with alcohol abuse, 15% face other addictions, and over 10% have suicidal thoughts. Compared to national norms, CSU counseling center students more often have issues of depression, suicide attempts and deaths, anxiety, oppression, and sexual assault, and less often with issues of current or

past use of psychiatric medication, harming oneself (e.g., cutting, biting), needing hospitalization, considering suicide, considering injuring or actually injuring another person, experiencing a traumatic event, previously attending therapy, and having a learning disability (e.g., attention deficit disorder). The median number of students per CSU campus that attempt suicide yearly is four, compared nationally to three. The larger average size of CSU campuses, and their largely commuter character, may explain some of these differences.

Overall, there has been an increase in the number of students seen at CSU counseling centers for mental health services and in the severity of their issues. Wait times between an initial assessment and the start of ongoing therapy average 1.5 weeks during most of the year and double to three weeks during the busiest months near the end of the term.

CSU centers employ 15% less staff per student than the average four-year public university. Counseling staff are classified as Student Service Professionals-Academic Related, and as such are non-instructional faculty. In these roles they have many duties on campus beyond seeing individual clients, such as providing educational outreach and crisis intervention for the campus community, conducting program evaluation, and providing training. Retention, tenure, and promotion requirements also add other responsibilities on top of those duties. CSU full-time clinicians see 3.4 students per day during peak periods and 2.6 during non-peak periods.

Recommendations

Members of the CSU Select Committee on Mental Health <u>unanimously</u> make the following recommendations:

Recommendation 1: Develop an Executive Order for counseling centers

Recommendation 2: Identify adequate resources for basic services

Recommendation 3: Review the classification and bargaining unit placement of CSU mental health counselors

Recommendation 4: Require a campus review of counseling center structure and work distribution

Recommendation 5: Obtain clarification regarding release of student health information

Recommendation 6: Constitute an Implementation Committee hereafter referred to as the "Mental Health Services Committee"

Recommendation 7: Structure and coordinate data collection

Recommendation 8: Better integrate counseling services with other campus departments in an effort to promote overall wellness

THE CSU SELECT COMMITTEE ON MENTAL HEALTH

In early 2009 the CSU Office of the Chancellor created a 15-person CSU Select Committee on Mental Health (hereafter the "Select Committee") that was composed of members of various CSU campuses, in a variety of positions, including: provost, vice president of student affairs, counseling center therapist, counseling center director, health center director, disability services director, faculty, and student. The committee was co-chaired by Dr. Lori Varlotta, Vice President of Student Affairs, California State University, Sacramento, and Dr. Martin Bragg, Director of Health and Counseling Services, California Polytechnic State University, San Luis Obispo. During the fourteen months that the committee worked, members gathered for six face-to-face meetings and conducted several teleconference meetings to address the multifaceted charge articulated in their appointment letters. Components of the charge included:

- Surveying, collecting, and analyzing overall campus data on mental health services currently provided to CSU students;
- Assessing trends in student mental health specific to CSU, e.g., increases in demand due to CSU initiatives such as the veterans initiative, foster youth initiative, as well as a general increase in mental health issues due to stresses in the lives of today's students;
- Reviewing how increased demand is being addressed nationally and at CSU campuses;
- Identifying the appropriate level of mental health services to address student needs;
- Reviewing and identifying the resources necessary to provide appropriate services; and
- Providing counsel regarding a Student Mental Health Services Implementation Oversight Committee that would execute recommendations of the Select Committee that may be adopted by the CSU Board of Trustees.

As this final report to the CSU Board of Trustees demonstrates, the committee made great progress in meeting its charge.

Acknowledgements

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Committee Membership

Co-chair
Dr. Lori E. Varlotta
Vice President for Student Affairs
CSU, Sacramento

Co-chair
Dr. Martin Bragg
Director of Health and Counseling Services
Cal Poly San Luis Obispo

Vice President of Student Affairs
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Counselor, Counseling Center (SSP-AR)
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NATIONAL TRENDS

College Students' Mental Health—A National Perspective
(for a detailed overview of student mental health nationwide, see Appendix A)

For almost all students the college experience is a period marked by significant academic learning and personal growth; however, the learning and academic growth invariably come with a measure of stress from varying sources. In addition to the routine stress of academics, the ideological, social, and cultural diversity that characterizes many institutions of higher learning can be disorienting to new students (particularly those who are first generation college students). Transitional issues also impact students' stress levels. For example, students entering college directly from high school face several challenges: living on their own or more independently than they had before, making new friends, creating new social and academic networks, and taking much greater accountability for their own learning. Returning students (those who worked before entering college or attended a community college in the near or recent past) may be challenged by re-entry issues, remembering relevant content from prior courses, fitting in with younger classmates, and balancing college expectations with multiple other demands on their time and attention (as a husband or wife, a father or mother, a full- or part-time worker, and myriad other roles).

Cognizant of this reality, most university administrators generally agree that collegiate stressors emerge from two broad-based sets of demands:

- The routine demands of academic life augmented by the cyclical stressors of writing assignments, examinations, midterms, and finals, many of which are scheduled for the same week in multiple classes; and

- The demands of one's personal life, particularly those related to financial issues, health concerns, relationship challenges, identity issues or family "juggling acts."

The degree and overlap of these stressors, coupled with the fact that many major psychiatric disorders first appear during adolescence and young adulthood,[1] make some students especially vulnerable. Therefore, it is predictable that large numbers of students are already being treated for mental health problems when they arrive on campus. In these cases, the stressors of college can overwhelm these students' current treatment, resulting in an exacerbation of an existing condition; in contrast, other students may come to campus with no such history and find themselves in the throes of an emerging mental health problem and unsure how to manage it.

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[1] American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV-TR* (Washington, DC: American Psychiatric Association, 2000).

While some students suffer from major psychiatric disorders, numerous others are affected by milder psychological concerns that nonetheless impact their academic status or progress. Concerns related to routine youth-to-adult transitions (leaving home, living in a different location, ending/changing of friendships or romantic relationships, taking more control of one's life) and to adult expectations (managing credit card debt, making the mortgage, obtaining childcare, and performing well at work) affect one's ability to concentrate and excel in class. Even routine problems can quickly impede a student's academic progress if left untreated.

In addition to issues that can delay timely progress toward degree, much more serious—possibly deadly—challenges confront some young people. Accident, homicide, and suicide, in that order, are the leading causes of death for young people age 15-24, while suicide is the second leading cause of death for those 25-34 and the fourth leading cause of death for those 35-44.[2] Other forms of self-harm, like self-mutilation and cutting, though less deadly, can cause significant disturbances in classroom and college residential settings.

Traditionally, harm to others is a rarer occurrence, but the recent high-profile episodes at Virginia Tech and Northern Illinois have raised national awareness about campus violence. There have been serious attacks within the CSU, too, including a student charged in the killing of a fellow student this academic year.

Collegiate Counseling Centers—A National Overview
(For a detailed overview of counseling centers nationwide, again see Appendix A)

To address the mental health issues that students bring with them or develop on campus, most universities have traditionally maintained on-campus counseling centers. Given the myriad student issues described above, these centers have a weighty responsibility. Meeting this responsibility has become even more formidable today as national trend research identifies five challenges confronting most contemporary collegiate counseling centers.

Challenge One – Increased Risk Management Concerns
With tragedies at Virginia Tech, Northern Illinois, and other universities, members of the campus community, parents, politicians, and attorneys are looking to counseling centers to help identify and intervene with students who are considered a threat to themselves or others. There is an increased expectation that counseling center staff will treat more severe psychopathology, while simultaneously spending more time also on preventative and consultative work.

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[2] Melanie Heron and Betzaida Tejada-Vera, "Deaths: leading causes for 2005," *National Vital Statistics Reports 58,* no. 8 (2009): 21-22.

To address these expectations, many campuses have formed crisis or behavioral intervention teams to help identify and intercede when students are causing disruption or threatening harm. This approach is facilitated through structured and coordinated processes that allow various campus constituents to communicate with each other and initiate timely actions or interventions. At-risk students who are identified through these processes create tremendous challenges for university offices across campus, including counseling centers, residential life, judicial affairs, the university police, etc.

When dealing with students who come to the attention of campus intervention teams, the brief therapy model used by most collegiate counseling centers is often inadequate since these students are dealing with complex or severe mental health issues. As such, their conditions usually require more extensive treatment––the type that is typically not available on campus. Due to substantial reductions in many community mental health programs, students whose needs exceed campus capacity are also unlikely to receive assistance from off-campus entities.

Another risk management concern is suggested in recent legal cases that show campuses may be found liable when information regarding at-risk students is not disseminated and acted upon in a timely manner.[3] While the sharing of mental health information is limited by a variety of federal statutes such as the Health Insurance Portability and Accountability Act (HIPAA) and the Family Educational Rights and Privacy Act of 1974 (FERPA), California's own state privacy laws add yet another layer of "privacy protection" to those who receive services. Given the concurrent calls to release and withhold the same information, there is widespread confusion regarding what mental health information can be shared and with whom.[4,5]

Challenge Two – Increased Focus on Academic Success and Retention

Although counseling centers may be perceived as ancillary to university goals related to academic success, retention and degree completion, they have been shown to positively contribute to success in those areas. One prominent study, for example, shows that students with personal issues who attend counseling are retained at the university at a higher rate than those who do not.[6] Another study confirms that most students cannot afford—in terms of continued academic progress—any significant period of dysfunction.

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[3] Cho Hyun Shin et al. v. Massachusetts Institute of Technology et al., Opinion No.: 89553, Docket Number: 02-0403, SUPERIOR COURT OF MASSACHUSETTS, AT MIDDLESEX, 19 Mass. L. Rep. 570; 2005 Mass. Super. LEXIS 333, June 27, 2005, Decided.

[4] California Department of Mental Health, "California Strategic Plan on Suicide Prevention: Every Californian Is Part of the Solution," (Sacramento, CA: California Department of Mental Health, 2008,) 30.

[5] Commonwealth of Virginia, Virginia Tech Review Panel, "Mass Shootings at Virginia Tech, Report of the Review Panel Presented to Governor Kaine", (April 16, 2007): 66-67
(http://www.governor.virginia.gov/TempContent/techpanelreport.cfm) (accessed March 17, 2010).

[6] Andrew L. Turner and Thomas R. Berry, "Counseling Center Contributions to Student Retention and Graduation: A Longitudinal Assessment," *Journal of College Student Development* 41, no. 6 (2000): 627-635.

Since many academic departments offer courses sequentially, failing to complete a single course can delay a student's graduation for up to a year or more. Still, between 25% and 35% of students will experience at least one mental health episode during a 12-month period.[7] As centers must focus limited resources on treating students with more complicated issues, this can translate into longer wait-times for those with milder personal problems or academically-related concerns resulting in a significant impact on a student's academic progress.

Challenge Three – Indirect and Direct Impact of Economic Conditions

Though all collegiate counseling centers are directly affected by the economic conditions of their campus and local communities, nationwide there is great variability in their budget situations. In terms of overall funding sources, a slim majority of centers nationwide are funded exclusively through state funds, 29% receive a mix of state funds and students fees, and 16% are funded entirely via student fees. In terms of increasing or decreasing campus support, some campuses have increased the fees or allocations to more robustly support their centers; others have held funding steady or reduced it. A recent national survey conducted in 2007-2008 revealed that more centers experienced budget increases than decreases.[8] Such was the case at the UC after its regents voted to increase the student registration fee and allocate a portion of the increase to counseling centers.

During the last few years, most county and state officials have been forced to cut community mental health resources. Likewise, the proliferation of cost containment strategies has prompted some insurance plans to reduce coverage for mental health services particularly for milder conditions. Together, all of these variables limit a student's options for accessing and securing mental health services.

Challenge Four – Increased Demand

It is difficult to measure accurately student interest in and demand for mental health services. Frequently, demand measures focus on the number of counseling sessions delivered or the number of students seen. Both sets of numbers, however, are affected ultimately by the actual and perceived numbers of appointments available. In addition, new and potential users may shy away from accessing the services in the first place if they perceive long wait times and other barriers to be at play.

While some national surveys of counseling center directors present a picture of stable demand, other campus and regional surveys show large increases in the number of

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[7] Ronald C. Kessler, Wai Tat Chiu, Olga Demler, and Elle E. Walters, "Prevalence, Severity and Comorbidity of 12-month DSM-IV Disorders in the National Comorbidity Survey Replication," *Archives of General Psychiatry 62*, (2005): 617-627.

[8] Robert R. Rando and Victor Barr, "The Association of University and College Counseling Center Directors Annual Survey 2007-08," (Association of University and College Counseling Center Directors, 2009).

students coming to the counseling center.[9,10,11,12] For example, during the 2000-2005 period that the UC marked an enrollment increase of 13%, their counseling centers reported an increase of 23%.[13]

In response to increased demands, centers are taking a variety of actions:
- educating faculty and staff on how and to whom to make referrals,
- working more closely with campus crisis teams,
- offering psycho-educational assistance on their web sites, and
- providing innovative training for the counseling staff.

Challenge Five – High Complexity of Student Problems

A substantial percentage of the student population has significant mental health needs:
- One recent survey showed that 15% of students had been treated for anxiety and 18% for depression.[14]
- Nearly 1 in 10 students seriously considered killing themselves in the last year.[15] Research shows, however, that students who receive counseling are six times less likely to follow through with suicide.[16]
- The median number of students per campus who attempt suicide each year is three.[17]
- The majority of students who died by suicide had not accessed campus counseling services.[18]

Suicidal ideation and completion are not the only conditions contributing to the growing complexity of counseling center workload. Increased use of psychiatric medications is another factor leading to increased complexity in treatment. On average, 25% of the student population takes psychiatric medications, requiring a greater amount of clinical and case management time per case.[19] Clinicians spend a good percentage of their time documenting these complex cases, as

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[9] Martha A. Kitzrow, "The Mental Health Needs of Today's College Students: Challenges and Recommendations," *NASPA Journal*, (2003): 169.

[10] Ilene Rosenstein, Personal correspondence. (2009).

[11] UC Regents, Report of the University of California Committee on Mental Health Services, (2006).

[12] Rebecca Voelker, "Mounting Student Depression Taxing Campus Mental Health Services," JAMA, (2003): 2055-2056.

[13] UC Regents, Report of the UC Committee on Mental Health Services.

[14] NASPA, "Profile of Today's College Student," (NASPA: 2008) http://www.naspa.org/divctr/research/profile/results.cfm (accessed March 17, 2010).

[15] Rando, Directors Annual Survey.

[16] Ibid.

[17] Ibid.

[18] Allan J. Schwartz, "College student suicide in the United States: 1990-1991 through 2003-2004," *Journal of American College Health 54, no. 6 (2006):* 341-352.

[19] Rando, Directors Annual Survey.

well as consulting with referral sources, doctors, hospitals, other student services, academic departments, and families.

And, while the research is mixed, it also appears that for some universities, the severity of students' problems has also increased. As a result of the increased complexity/severity of issues, length of treatment per student is increasing. In the last seven years, the average number of sessions per student nationally increased from 5.2 to 5.6.[20,21] For a center that sees 1000 students per year, this amounts to an extra 400 sessions. It is also important to note that increased complexity of symptoms (in addition to severity of symptoms) may impact the entire campus community, not just those experiencing psychological problems. The time spent on complex and severe cases usually limits the amount of time that can be dedicated to students who are experiencing less traumatic issues—ones that nonetheless can quickly and dramatically affect academic performance and grow into much larger problems. [22]

Summary of National Trends

Many counseling centers in 2010 find themselves at a crossroads. They feel pressured by the public, parents, politicians, and the campus community to take the planning approach most likely to reduce crises (e.g., campus violence and suicide). In this sense, they are operating on a model structured around deficits, disorders, or pathology. The "deficit model" is in opposition to a wellness model that focuses on prevention and education—one that works proactively to address the less visible, seemingly less pressing mental health issues that can impede student retention and timely progress toward degree. To move toward the "destination" desired on most campuses, one that is marked by increased safety and wellness, counseling centers ideally should prioritize both. Striking a balance and addressing these dual priorities can be very difficult.

To address this challenge, national organizations, such as the American Psychological Association (APA), are organizing summits to help providers 1) adapt to the rapidly changing collegiate environment, 2) deliver efficient and timely services, 3) identify alternatives to the traditional 50 minute session, and 4) focus on evidence-based practice.[23] Accordingly, many centers are instituting a variety of policies and procedures to simultaneously control usage and manage risk. Some strategies include: instituting session limits; developing "triage" programs to identify students that are perceived as unable to wait; and setting time aside daily to see students who are in crisis.

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[20] Robert P. Gallagher, "National Survey of Counseling Center Directors," (International Association of Counseling Services: 2002-2009).

[21] Rando, Directors Annual Survey.

[22] Turner, Counseling Center Contributions to Student Retention, 627-635.

[23] American Psychological Association, "Presidential summit on the future of psychology practice: Collaborating for change," (APA: 2009). http://www.apa.org/practice/leadership/summit.aspx (accessed March 17, 2010).

CSU DATA

CSU Student Demographics—A General Overview

Overall, the California State University system enrollment continues to reflect the distinctive diversity of the general California population in terms of race and many other factors.[24] As shown in the most recent demographic data available, more than half of currently enrolled CSU students are students of color. In terms of future enrollments, California Postsecondary Education Commission has released a statement which estimates that by 2019, Latino demand will increase by 42%, African American by 7.5%, and Asian by nearly 17%. The significant number of students who are classified as "unknown" represents, at least partially, the growing number of bi-racial and multi-racial students currently enrolled across the CSU. In addition, over 16% of CSU students do not speak English as a first language and many in this group (and others as well) are first generation college students, situations each with their own set of unique expectations, challenges, and obstacles.

Abbreviated Report for CSU Enrollment by Ethnic Group, Fall 2009
Systemwide and Campus

Systemwide IPEDS-Label	Fall 2008	Fall 2009	Systemwide IPEDS-Label	Fall 2008	Fall 2009
White	157,748	152,531	White	36.1%	35.2%
Black	26,193	24,591	Black	6.0%	5.7%
American Indian	2,956	2,372	American Indian	0.7%	0.5%
Asian Only	73,225	70,856	Asian Only	16.8%	16.4%
NHPI	2,955	2,597	NHPI	0.7%	0.6%
Hispanic	104,202	109,347	Hispanic	23.8%	25.3%
Unknown	49,826	50,563	Unknown	11.4%	11.7%
Non Resident Alien	19,903	20,197	Non Resident Alien	4.6%	4.7%
Total	437,008	433,054	Total	100.0%	100.0%

In addition to the CSU's ethnic diversity, there is a wide diversity of constituent age and familial status present as well. The median student age is 24.4; there are 66,663 students who fall within the age range of 25 – 29, and 35,127 students within the 35 – 59 year range. There are no hard data available on the sexual identification or relationship status of students, but many CSU students are married or in a domestic partnership, and many others are divorced, separated, or widowed.

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[24] California State University, "Abbreviated Report for CSU Enrollment by Ethnic Group, Fall 2009," (California State University: 2010).
http://www.calstate.edu/as/stat_reports/2009-2010/ethnicity.shtml (accessed March 17, 2010).

In contrast with other higher education demographics, CSU students are also much more likely to work part- or full-time while attending college. Almost 70% of CSU students are working while they attend school, and on average, they work 20 hours per week. Additionally, 40% of students do not have health insurance. (Note: These statistics are derived from surveys of counseling center clients; it is likely, though, that they generalize to the entire student population.)

Finally, conversations with campus personnel across the system indicate that the CSU student population reflects a growing number of veterans, former foster care system recipients, individuals with a history of involvement with the criminal justice system, immigrants and refugees, and individuals with disabilities.

All these factors are important as they demonstrate that the CSU student body is highly diverse. This rich diversity lends itself to differing mental health issues and needs. Thus, this diversity is important to consider when looking at the ways to provide optimal mental health services to CSU students.

CSU Students' Mental Health—Data Analyses from Multiple Surveys

To identify issues in a comprehensive and scholarly way, the Select Committee organized the system's largest-ever mental health research initiative. As part of this initiative, the committee created and delivered the five surveys mentioned earlier whose summary data alone exceeds 150 pages; [25] additionally, the Select Committee ensured that the surveys would be useful as comparison tools at both a national and local (CSU) level.[26]

This and the following sections present the Select Committee's analyses of data collected from the multiple surveys. Despite the data's considerable volume and utility it has certain limitations. As with any assessment, this analysis acknowledges that not all conclusions will be applicable at the national level, or even to individual CSU campuses, due to the inherent diversity of the CSU system.[27]

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[25] The initial three surveys to counseling center, health center, disability service centers were conducted using a Student Voice web survey and sent to the respective campus offices in the summer of 2009. The follow-up counseling center survey and residence life survey were collected in early 2010.

[26] In order to compare current CSU counseling data with national data, many of the questions on the Select Committee's counseling survey duplicated those included in the field's three most commonly referenced surveys. Further, to compare current CSU data with past CSU data, the Select Committee's survey also duplicated several questions included on the 2007 CSU counseling center directors survey, a brief survey of 20 CSU counseling center directors conducted in the summer of 2007.

[27] The CSU is comprised of a wide range of campuses with varying demographics. This may make some cross-campus comparisons within the CSU and some CSU comparisons to "national averages" not applicable. For these

Counseling Center Clientele

On average, 5% of the CSU students are seen in counseling annually. This is well below the average of 8% reported for 4-year state universities.[28] Overall, female students are seen at CSU counseling centers at a greater rate than male students, and most ethnicities use counseling centers proportionally, with the exception of Asian students (who use it less). These patterns are consistent with national data.

The most common factors for which CSU students seek treatment at CSU counseling centers are anxiety and depression. Of the students in treatment at CSU counseling centers, over 40% have depression, and over 10% are having suicidal thoughts. Half of CSU clients are experiencing anxiety. About 15% are struggling with alcohol abuse, and 15% are struggling with other addictions. Between 5-10% have been sexually or physically assaulted, and 10% have been stalked.[29]

In comparison to national averages, the percentage of CSU counseling center clients who present with severe issues is higher in some cases and lower in others.[30] Specifically, the percentages are substantially greater for anxiety, and issues of oppression. Conversely, percentages for students at the CSU centers are substantially lower for current or past use of psychiatric medication, harming oneself (e.g., cutting, biting), experiencing an unwanted sexual or other traumatic event, and previously attending therapy. Rates for consideration of suicide were also substantially lower, although actual deaths by suicide are higher.

To attach actual numbers to the aforementioned trend data, consider the following: The median number of students per CSU campus that attempt suicide yearly is four, compared to three nationally (with both CSU and national data including estimated figures).[31] The median number of students per CSU campus who die by suicide yearly is one (with a mean of .92) compared to a national median of zero (with mean of .42.)[32]

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reasons, the Committee urges some caution in comparing national averages to the CSU and even more caution to a single campus' operation. To limit the impact of outlier data, where appropriate, writers of this report use the *median* as the measure of central tendency. All of the data below is for the 2008-09 year unless otherwise specified.

[28] Rando, Directors Annual Survey.

[29] Each category can include some of the same students, as they may have multiple issues.

[30] Center for the Study of College Student Mental Health, "2009 Pilot Study," (Center for the Study of Collegiate Mental Health: 2009). http://www.sa.psu.edu/caps/pdf/2009-CSCMH-Pilot-Report.pdf (accessed March 17, 2010).

[31] Victor Barr, Robert R. Rando, Brian Krylowicz, and Evelyn Winfield, "The Association of University and College Counseling Center Directors Annual Survey 2008-2009," (Association of University and College Counseling Center Directors, 2010).

[32] Ibid.

Generally there has been an increase in the number of CSU students seen for mental health issues. The increase, however, is not a unanimous one: two campuses actually saw a decrease in utilization; others saw huge increases.

In addition to students seeking assistance at counseling centers in greater numbers, there are data to show increased complexity of the cases being treated. While the number of same-day crisis appointments changed little from 2007-08 to 2008-09, there was a substantial increase from 2005-06. In addition, the number of CSU clients on psychiatric medication increased by 20% in the last three years.[33] In addition, those students coming to health centers for psychiatric purposes increased dramatically in the last year. Data also show substantial increases in numbers of students coming to Disability Service Centers with psychological issues.

CSU Counseling Centers—Data Analyses from the Primary and Supplemental Counseling Center Surveys
(for details see Appendix B)

Services Offered
CSU counseling centers provide a variety of services on campus, with the primary modality being individual counseling. Group sessions are offered on most campuses. All CSU centers also provide consultations to faculty and staff regarding students in distress and assist in crisis response; most provide outreach and prevention programming. At some of the CSUs, the centers also provide:

- mandated services to students who have violated campus policies;
- training for graduate students in counseling and psychology programs; and
- coordination of treatment with community agencies, such as county mental health departments.

Utilization Trends
Twelve campuses maintained data that compared the number of students seen in 2008-09, 2007-08, and 2005-06.[34] These comparisons reveal that all 12 campuses experienced an increase in the number of students seen during that three year period. Combined, there was an increase in students seen of 16.5%. During the same period the enrollment at these 12 campuses increased 7.6%.[35] Utilization is not the same as demand, given that a change in number of counselors

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[33] A caveat: this increase could be due to factors other than increased severity.

[34] Some survey questions asked respondents to provide data for the past year, the year before, and four years prior, as a way to obtain data from a reasonable time period.

[35] California State University, "Statistical Reports: CSU Fall Term Enrollment Summary," (California State University: 2010) http://www.calstate.edu/as/stat_reports/fall_summary.shtml (accessed March 22, 2010).

impacts number of appointments available. Over this same period at these 12 campuses, counselor FTE increased 10.6%.

Surge
Students' utilization of counseling services is not uniform throughout the year. Demand is higher during certain periods (e.g., midterms, finals, etc.) and is lower during others (the beginning of the semester). According to data collected in the supplemental counseling survey, during the two busiest months of the year CSU centers see 37% of their total annual clients, provide 33% of all sessions, log in 25% of all regularly-scheduled intakes, and manage 15% of same-day crisis appointments.[36]

As might be expected, wait time between the first (typically an intake) appointment and the second (typically a scheduled) appointment during surge periods is longer than at non-surge periods. Throughout the normal course of the year, for example, the wait is 1.5 weeks, doubling to three weeks during the busiest months. Similarly, the wait for a regularly-scheduled intake increases from about two weeks to about three weeks in busy periods.

Delivery Modes
According to survey responses, CSU counseling centers rely primarily on the field's most traditional delivery mode: providing individual, face-to-face therapy sessions that typically last 50 minutes. Most centers have mission statements that state they work in a brief therapy modality. In fact, 74% of CSU counseling centers have session limits. This compares to a national average of 51%.[37] The median number of sessions utilized by CSU students who seek services is 3.75, under the national average of 5.0.[38]

Staffing
The CSU predominantly hires doctoral level counselors to provide services, although many centers also use graduate-level trainees (at the pre- or post-doctorate level) to augment care. Unlike the national norm, however, where professional counselors are classified as staff, counselors in the CSU are classified as Student Services Professional-Academically Related (SSP-AR). As such, they are considered non-instructional faculty. This classification will be discussed further below.

A commonly cited way to identify staffing levels is to compare the ratio of professional staff to enrolled students (headcount). According to the International Association of Counseling Services (IACS), the major accrediting board for collegiate counseling centers, universities should strive

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[36] Each campus defined their own two-month period, as differences particularly between quarter and semester campuses exist.
[37] Rando, Directors Annual Survey.
[38] Ibid.

for a 1:1000 or 1:1500 ratio. The national norm of all centers (those accredited and those not) is approximately 1:2000 and the national norm of 4-year public universities is 1:2607.[39] The average CSU counselor-to-enrolled-students ratio of 1:2933 compares negatively to each of these other measures. The single average CSU ratio, however, hides the variability within the CSU. For example, one campus marks a ratio of 1:1624 students per counselor, while another posts its ratio as 1:10,500. The California Maritime Academy, meanwhile, maintains a ratio of 1:425 on its unique campus.

Despite this variability, recent staffing patterns in CSU counseling centers appear to have lagged slightly compared to enrollment growth. During the period of 2001 to 2008, for example, enrollment increased 12.5% and counselor FTE increased approximately 8%. The campuses that have increased the number of counselors on staff have done so primarily by using a portion of the campus' Health Services Fee to fund the positions.

Productivity Issues
Since CSU counselors have a variety of assignments, a review of their productivity is complex. Some elements of the counselor's job are relatively measurable, such as the number of clients seen or the number of face-to-face visits provided. However, the delivery of counseling services includes not only direct counseling, but also case management related to clients. Clients may need help identifying on-and-off campus resources and assistance in talking about their issues with faculty, staff, or family members. Clients who are a danger to self or others require the counselor to engage immediately and, sometimes extensively, with a variety of agencies such as the university police and county mental health.

Aside from these direct clinical responsibilities, many counselors are expected to provide educational outreach to the campus community, making people aware of mental health resources both on campus and in the community. Others may be expected to assist with duties related to the counseling center operation, such as participating in staff meetings, program evaluation and improvement, and professional development. Many CSU counseling centers also have intern training programs, and counselors are required to observe or review counseling sessions and assist trainees in the case or crisis management of their clients.

Given these competing demands, the committee was very interested in identifying the actual amount of time counselors spent seeing students. Rather than identify a single "average" the committee examined this issue by looking at the number of clients seen during peak and non-peak periods. During peak demand, reports showed that the average CSU counselor sees 3.4

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[39] Rando, Directors Annual Survey.

clients per day (with a range of 2.74-5.06 clients), and during non-peak periods 2.6 clients per day (with a range of 1.85-4.55 clients).[40]

A separate question that asked for the percentage of time clinicians spent providing direct service (therapy, intakes, and crisis work) revealed that CSU clinicians, as well as clinicians nationally, average 60% of their time, equivalent to 24 hours per week or 4.8 hours per day, performing direct clinical service.[41] Thus, an examination of CSU counselor schedules showed an average of 2.6 clients per day at non-surge times, in contrast to the findings from the question on direct clinical service, which would predict 4.8 clients per day.

In regard to this discrepancy, the capacity to see clients is affected by the following: 1) while the question regarding direct clinical services asks for time "spent," many directors refer to time scheduled and do not include the CSU (and national) cancellation rate of 24% into their calculations, 2) CSU campus enrollments skew towards the larger end, meaning that we would expect less than 24 hours of direct service, 3) the 2.6 figure includes vacation and other leave, 4) the 2.6 figure also includes directors and others with administrative duties that are excluded in the other question, 5) the term "direct clinical service" often includes time clinicians are scheduled to be available for walk-in crisis clients, with a three hour block potentially occupied only by one or two students, and 6) increasingly complex client issues are requiring more case management and consultation per case, effectively increasing indirect service hours and reducing direct service hours. Further examination of this issue by the Mental Health Services Committee (see Recommendation 6) can shed additional light on this issue.

There are also additional factors that restrict the hours available to see clients or otherwise limit clinical productivity:

- Surges in demand for appointments may be accompanied by increased calls for consultation regarding students and/or a concomitant increase in the need for case management for these clients.
- Most counselors are hired into SSP-AR counselor faculty positions. Each campus has standards for retention, tenure, and promotion (RTP) that require counselors to do more than counseling. On some campuses such duties include making contributions to the overall field of counseling. The development and maintenance of the RTP-required Working Personnel Action File is in itself quite time consuming.

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[40] These ranges show considerable variability among campuses. Given the range of campus characteristics, the implications of these ranges are difficult to interpret. These figures were obtained through director review of clinician schedules.

[41] National figures show that counselors at campuses with less than 2500 students spend an average of 70% of their time providing direct clinical service, while those at campuses with over 35,000 students spend less than 50% of their time in direct clinical service.

- The Committee found that the systemwide no-show or cancellation rate is near 25%, similar to the national rate. Many counseling centers are taking steps to address this issue by: sending out reminders prior to student appointments, filling cancellations with new appointments, and charging no-show fees.

Counseling Center Directors
As part of its research, the Select Committee asked counseling center directors to delineate the greatest issues facing their counseling center. Several directors identified the following: increased student demand, severity/complexity of student issues including increased use of psychiatric medication, reduced resources, lack of community referral resources, and reduced ability to provide outreach and other prevention programming. Some directors also noted difficulties with staff morale and burnout, furloughs, lack of psychiatric hours, RTP demands, low salary levels, and struggles in attracting diverse counselors. (See Appendix F for descriptions of poignant examples of CSU counseling center interventions.)

Other CSU Departments—Data Analyses from the Health Center, Disability Services and Residential Life Surveys
(for details see Appendices C, D and E)

Students with mental health issues come into contact with and may require attention from a variety of departments on campus. Often the best response requires the coordination of multiple offices or multiple "responders."

Faculty and Staff in General
A key responsibility of the counseling center is to provide counsel to faculty and staff who have academic or behavioral concerns about a student. The counseling center can play a role in helping students withdraw from classes when there are serious and compelling mental health issues.

Vice President for Student Affairs/Crisis Intervention Teams
The Office of the Vice President for Student Affairs is frequently the contact point for parents, faculty, and staff who are concerned about students. As mentioned earlier, many of these offices coordinate cross-departmental teams that identify (and if appropriate intervene on behalf of) students in need or at-risk. While the counseling center is a valuable participant in these efforts, they must maintain confidentiality in this role. In other words, while counseling center staff are often at the crisis intervention table, in many cases they mostly listen, provide general commentary, assess threat levels, and help determine what community and police options are required for appropriate response. They do not share specific information about a student in treatment (unless consent has been granted or harm to self or others is deemed imminent). Counselors, however, can bring pertinent information back to the center and share it with other counselors in ways that promote problem solving techniques.

Health Centers
At many CSU campuses, student health services and the counseling center share physical space. On several campuses they share a common administrative director and portions of the health fee revenue, as well as in many cases sharing clientele. Student health services within the CSU provide, typically via their primary care physicians, a significant amount of patient care and psychiatric medication evaluations and follow-ups. The recent survey of health center directors showed that between 5-6% of health center visits were for strictly mental health issues. In 2008-2009 alone, the survey showed that on average 6% of medications dispensed by student health services pharmacies were for psychotropic medication.

Services to Students with Disabilities (SSWD)
Requests for mental health-related disability accommodations are on the increase according to the CSU directors of services to students with disabilities. According to the survey administered for this report, eight campuses had data for 2008-09, 2007-08, and 2005-06. On each of those campuses, there was a sizeable increase in the number of students requesting accommodations for psychological disabilities. Some of the SSWD centers employ their psychological counselors to work with students seeking SSWD services or ADA accommodations.

University Police Department
Campus police departments routinely work in multiple ways with students affected by mental health issues. They may, for example, assist the counseling center in conducting an assessment for danger to self or others. They may transport students to local mental health inpatient facilities if they meet mandated criteria. (These transports and subsequent waits in emergency rooms can be extremely time-consuming.) Campus police may also be involved in making legal notifications if and when students (or others) articulate specific threats of harm. In addition, the police also help devise strategies to address fears that are generated by at-risk individuals or groups. Frequently, campus police do welfare checks on students that have been identified as at-risk.

University Housing
The number of students living on CSU campuses throughout the system has been growing over the last decade and housing professionals are a great resource for identifying students in need. Mental health-related issues, many of which occur after business hours, can be particularly disruptive in densely populated living environments. Campus-to-campus, there is a range of after-hours response to university housing problems. University housing directors recommended several ways mental health services in university housing could be improved. They suggest that additional after-hours and weekend support would be of value; in addition, more training for residence hall staff from campus psychologists on mental health issues is necessary (See Appendix E). Also, increased availability of a counselor or psychiatrist who could serve as a

liaison to the residence halls for consultation would assist them in dealing with the more serious behavior issues they face with students who have mental health issues.

Judicial Affairs
Counseling centers interact with campus judicial affairs offices in a variety of ways. Some judicial offices require students who violate campus policies to participate in mandated assessment, counseling or other types of programs. Judicial Affairs officers may be involved in removing disruptive students from campus if they are disturbing the learning environment.

Summary of CSU Findings

CSU campuses, like many others in the country, face dilemmas in how best to serve the mental health needs of their students. Data show a substantial percentage of today's CSU students have significant mental health needs. California, perhaps more than some other states, has been massively impacted by the economic downturn such that referral options, already slim, are very difficult to find. Counseling operations at different campuses even within the CSU varied significantly. While the ratio of counselors to students was on average worse in the CSU when compared to national norms, that was not true for each individual campus. Compared to nationwide statistics, CSU campuses are more likely to have session limits. It is also the case that the average number of sessions that a CSU student receives is lower than national averages. During periods of high demand, CSU students encounter significant wait times for assessment and treatment.

RECOMMENDATIONS

Recommendation 1: Develop an Executive Order for Counseling Centers

The California State University's policy on student health services is described in Executive Order 943, *Policy on University Health Services*, issued May 28, 2005. This policy governs the provision of health services in the CSU, but it does not describe mental health services that campuses should provide to students. The Select Committee recommends the development of an executive order that describes mental health services. The following template, which parallels the description of the CSU policy on student health services, should be considered.

I. Required Basic Services

    A. Counseling/Psychotherapy
    Campuses shall offer short-term psychotherapy services that are responsive to the diverse population of currently enrolled students experiencing the types of psychological or behavioral difficulties that limit their academic success.

    B. Emergency/Crisis   Services
    Counseling centers shall develop protocol for addressing mental health crises during hours of operation and after hours.

    C. Outreach
    The counseling centers shall provide psycho-educational workshops and programs and services that address both critical student issues and wellness. Programs must be responsive to the diversity of the CSU student population and enhance the ability of students to develop healthy and effective styles of living and learning.

    D. Consultation
    Counseling centers shall provide mental health consultation services to members of the university community regarding student mental health issues.

II. Referral Resources

    Centers should identify appropriate referrals both within the institution and the local community to assist students whose problems are outside the scope of campus services. Centers should also make an effort to ensure that students follow up on those referrals.

III. Augmented Services

    Centers may offer augmented services, those elective or specialized ones not included in

basic services. Augmented services (e.g., services to students' partners, family members) must be approved by the President, and user fees should be charged for supporting them.

IV. Qualifications of Counseling and Psychological Services Staff at CSU Campuses

   A. Counselors
   Those hired after July 1, 201X, in the classification of SSP-AR must be currently licensed or licensed within 18 months of their first employment. Those hired after that date must maintain their licensure to continue employment in the SSP-AR classification.

   Staff who are currently licensed are recommended to maintain their licensure. The Mental Health Services Committee should consult with systemwide Human Resources for collective bargaining impact.

   B. Trainees
   For campuses with training programs, professional ethics and state statutes mandate that licensed staff members select and supervise trainees, thereby assuring quality service to students and minimizing campus risk.

   C. Psychiatrists
   Psychiatrists working in a counseling center shall meet all requirements set forth in the Union of American Physicians and Dentists (UAPD) collective bargaining agreement and those set forth in Executive Order 943 or its successor.

   D. Other   Client   Service   Personnel
   Other personnel that have client care responsibilities (e.g. case managers) shall have qualifications that meet community standards for such positions.

V. Program Evaluation

   A. Internal   Program   Evaluation   and   Review
   CSU Counseling Centers shall undergo regular program reviews as part of an ongoing assessment program directed toward program improvement. As part of this review, centers will participate in the common data collection described below.

   B. External   Program   Review
   Counseling centers shall undergo regular external review. This can be accomplished by maintaining accreditation by the International Association of Counseling Services (IACS), Accreditation Association for Ambulatory Health Care, or other external accrediting group. Alternatively, an external review may be conducted using applicable

standards set by a professional organization such as Council for the Advancement of Standards in Higher Education. The first round of external reviews should be completed by December 2013 and then conducted on a regular basis thereafter.

VI.   Counseling   and   Psychological   Records

Counseling and psychological records shall be secured and retained in compliance with state and federal law. The records shall also conform to standards of practice set by appropriate professional bodies.

Recommendation 2: Identify Adequate Resources for Basic Services

At minimum, each campus shall identify adequate staffing and funding for mental health services so that all students have "timely access" (to be defined by the Mental Health Services Committee (MHSC), proposed in Recommendation 6) to the basic services described in Recommendation 1. Towards that end, the Select Committee recommends that a study using common, systemwide data points be undertaken by each campus to evaluate the adequacy of current mental health staffing levels in its counseling center as well as other campus venues where mental health services may be provided (e.g., housing, Wellness Centers) by June 2011. The results of that study and the steps taken to identify adequate resources will be due to the MHSC by MM/DD/YY (date to be set by MHSC). Once baseline data are collected, annual or biennial studies will ensue.

To facilitate these ongoing studies, the Select Committee further recommends that adequate funding be identified for counseling centers to participate in this systemwide benchmarking, data collection, and analysis, which is likely to include the implementation of electronic medical records technology.

Finally, the Select Committee recommends that the CSU system provide regular trainings for mental health staff on issues identified by the MHSC. The trainings should address both the types of mental health issues CSU counseling centers are likely to face and research/best practices issues related to developing, utilizing and implementing technologies that will improve service delivery, data collection and administrative efficiencies. The trainings can be delivered using a variety of methods such as regional seminars, webinars and other e-learning tools.

Campuses may support these services by using General Fund allocations and/or by assessing a mandatory campus-based fee that is either part of the current health services fee or a new counseling service fee. In addition, future funding sources should be considered as they emerge. Additional fees for basic services may not be charged except for the cost of materials (e.g., testing materials or books). Any fees assessed for basic services shall not exceed substantially the cost of services and materials provided.

Recommendation 3: Review the Classification and Bargaining Unit Placement of CSU Mental Health Counselors

The review of national and systemwide information indicates that the collegiate counselor role has become increasingly broad. While International Association of Counseling Services (IACS) and the Council for the Advancement of Standards in Higher Education (CAS) have guidelines that describe the roles collegiate counselors assume, there are few widely accepted measures that are used to gauge one's success in these roles. Given the paucity of such measures, the Select Committee recommends a systemwide human resources review of the classification standards for the SSP-AR as related to psychological counselors. The review will address many issues including, but not limited to, the following:

A. First, the review should determine whether the SSP-AR classification and Unit 3 placement remain the most relevant ones for counseling professionals. Should a unit change be desired, systemwide Human Resources will need to secure a bargaining unit modification.

B. If the Unit 3 placement remains appropriate, then systemwide and campus Human Resource Offices should work with counseling centers and appropriate shared governance structures to develop guidelines for evaluating counselors for retention, tenure, and promotion.

C. The Select Committee recommends making licensure a requirement for new SSP-ARs hired as counselors. That standard should establish a timeline for new hires to obtain licensure as well as the expectation that a counselor would need to maintain licensure as a condition of employment, regardless of tenure status.

D. The Select Committee also recommends that other new job classifications such as "case manager" and "post-doctoral trainee" be considered.

Recommendation 4: Require a Campus Review of Counseling Center Structure and Work Distribution

The Select Committee recommends that counseling centers review their organizational structure and work distribution to enable counselors to spend more time providing direct clinical service to students, particularly during surge periods. In alignment with, or perhaps as an extension of, the aforementioned IACS standards, the guidelines proposed in Recommendation 1, Section V.B, may go so far as to recommend (after consultation with the counselor employee) the number/range of students a counselor should strive to see each week and/or define what the CSU system considers to be "direct clinical service." In addition, these guidelines may detail hours for other important counselor services, e.g., those necessary for wellness services.

Recommendation 5: Obtain Clarification Regarding Release of Student Health Information

To maximize the appropriate sharing of student information between campus departments, other CSU campuses, and others regarding at-risk students, the Select Committee recommends that the Chancellor's Office staff develop a systemwide statement on the permissible release of student physical and mental health information and the circumstances under which they can be released. This release must be based on the regulations set forth by HIPAA, FERPA, and other related California privacy laws.

Recommendation 6: Constitute an Implementation Committee

Over the last year members of the Select Committee have developed a clear understanding of the mental health issues confronting the CSU. Hence, the Select Committee recommends that its current members continue to serve the CSU by participating, for one year, on the proposed Implementation Committee, with the additional recommendation that it be named the Mental Health Services Committee (MHSC). After its inaugural year, the Mental Health Services Committee would replace its members over a three-year period: moving one third of the members off the committee each year. In addition to its current members, the Select Committee recommends adding a representative from university police, university housing, and veterans affairs.

In its work the Select Committee has generated a large amount of analyses which should be useful to the MHSC. The MHSC, working with campus counseling centers, should further explore and implement procedures in regard to the work of the Select Committee. In particular, the MHSC needs to better define the mission of CSU counseling centers, particularly in meeting the dual priorities of crisis intervention/reduction and wellness. Towards that end, the MHSC should explore issues related to the amount of time centers need to dedicate to meeting the needs of students with chronic and/or serious mental health issues versus the time they should take in meeting the needs of students with milder concerns that may impact retention and/or escalate into more serious conditions. The MHSC also should examine alternative methods of service delivery, given that the traditional 50-minute, weekly face-to-face session with students is taxing resources extraordinarily. As noted previously, the MHSC should assist in determining time allocations for various duties for counselors, as well as ensuring expanded accountability measures.

Recommendation 7: Structure and Coordinate Data Collection

The Select Committee recommends that the proposed MHSC establish, early in its tenure, a common set of CSU data points and a regular schedule of reports. To start, these common data points should reveal: the percentage of students using services, the average number of visits per student user, the number of clients each counselor sees per day, the number of attempted and completed suicides, the number of police transports, and the number of Tarasoff notifications (notifications of persons who have been threatened by a mental health client). Data that allow the

CSU to assess access, quality, satisfaction, and efficiency of counseling center services should also be collected and analyzed. After this information is gathered, organized and analyzed, it should be used to develop CSU benchmarks and promising practices. Eventually, the MHSC should also coordinate the development of systemwide best practices that may be used to revise future iterations of the proposed executive order.

Recommendation 8: Better Integrate Counseling Services with Other Campus Departments in an Effort to Promote Overall Wellness

The Select Committee recommends improving efficiencies and clarifying mission and tasks so that time is made available for the important area of reaching constituencies that may otherwise not seek services at the counseling center. The MHSC should identify organizational models and/or procedures for dealing proactively with students' overall health and well-being and the health and well-being of special groups (e.g., foster youth, student veterans). Where appropriate, formal partnerships between the counseling center and emerging program centers should be established or bolstered. It is anticipated that the influx of incoming veterans with mental health impairments into the CSU will require a different approach in providing counseling services to this newly emerging student population. In preparation to meet the anticipated mental health needs of our veterans, the Veterans Affairs representative from the Chancellor's Office will be asked to become a member of the MHSC. These various partnerships will promote a wellness model that focuses on prevention and education rather than a reactive model that is structured around deficits, disorders, or pathologies. Campuses that construct integrated models and document their contributions to the campus should be recognized at the system level.

APPENDIX A: NATIONAL TRENDS - THE STATE OF COLLEGE STUDENT MENTAL HEALTH, 2009

Bert H. Epstein, California State University, Sacramento
Marjorie Bommersbach, California State University, Chico
Michele Willingham, California State Polytechnic University, Pomona

"I was trained in a classical counseling center that did career and low level pathology with no diagnoses ever. Referral for medication was so rare it was unusual.

Today I run a center that does no career work, sees a very high level of pathology, and does a diagnosis on everyone who goes into ongoing counseling. Forty percent of our clients are on medication. I recently hired someone who spent three years in community mental health. He is surprised how similar the level of pathology is to his prior clients. What I run is closer to a community mental health clinic than a [traditional college] counseling center."

- Message posted on the Association of University and College Counseling Center Directors (AUCCCD) listserv, by the director at a large, Midwestern University, May 2009 (reprinted with permission).

Introduction and Executive Summary

On today's college campus, the combination of constricting budgets and the growing need to accomplish more have led many counseling centers to become more evolutionary than revolutionary (Cooper, Resnick, Rodolfa & Douce, in Walsh, 2008). Current trends, both of the "evolutionary" and "revolutionary" type, will be discussed here, with a focus on specific trends that are causing the greatest impact on today's university counseling center.

The counseling center of 2009 often finds itself in a conundrum regarding its mission and service delivery systems due to five factors that, in combination, lead to multiple (and sometimes conflicted) priorities, increased demands, and reduced resources:

Factor One – Increased Risk Management Concerns
With campus tragedies at Virginia Tech and other institutions, members of the campus community, parents, politicians, and attorneys are looking to the counseling center to work with students who may be bordering on violence toward others or themselves. In addition, economic conditions have led to dramatic cutbacks in community referral options, creating greater pressure for center personnel to invest time and resources in students with more severe pathology. In better times, at least some of these students would be referred to outside resources.

Factor Two – Increased Focus on Academic Success and Retention

In an age of heightened accountability, greater focus on learning outcomes, more sophisticated data analysis, and decreased state funding, universities are placing increased emphasis on retention and academic success. With budget cuts threatening various campus departments, counseling centers are striving to align their work as closely as possible to the core mission of the university and to focus on retention. There is pressure to devote resources to students and programs supporting developmental and milder psychological concerns that specifically impact academic work.

Factor Three – Increased Demand (at some campuses)

Research shows that at some universities students are coming to the counseling center in greatly increased numbers. At these campuses, increased demand can put a strain on center personnel, particularly those who continue to provide services in mostly traditional, individual modalities.

Factor Four – Increased Complexity (and sometimes Severity) of Student Problems

A significant number of college students bring with them substantially more complex problems than in the past, and with vastly increased frequency they take psychiatric medications, requiring a greater amount of clinical and case management time per case. In addition, while the research is mixed, it also appears that for some universities, the level of severity of students presenting problems has also increased.

As a result of time needed for complex and severe cases, and assuming no substantial change in service delivery models or resource allocations, the resulting decrease in availability of services for students who experience less severe developmental challenges and emotional stressors leaves them at risk for developing more severe pathology themselves or going into crisis. This situation significantly affects retention, creates risk management and liability issues, and impacts the overall health and safety of the campus community.

Factor Five – Indirect and Direct Economic Impact

Economic conditions are an overarching factor that influence and interact with these factors. As noted above for Factor One, reduced community resources create liability issues. In regard to Factor Two, more austere economic realities lead to an increased focus on accountability. Relevant to Factor Three, some students are actually attending college in order to obtain psychological services they otherwise could not afford, leading to increased demand. Finally, the complexity and severity of issues is magnified by financial stress. Aside from these indirect impacts, the counseling center of 2009, like all other university departments, is directly impacted by the budget climate in facing potential cuts.

Thus, the need to help potential increasing numbers of students in crisis, as well as foster overall student academic success, all in the context of difficult economic times and reduced internal and external resources, can pull the center in different directions. Centers currently look to strike a balance in resource allocation for the more and less severe cases. In summary, the counseling

center of 2009 is at a crossroads, with contradictory external pressures on its mission, expanded clinical demands due to increased complexity and severity of student issues, and reduced resources due to economic conditions.

These dilemmas have parallels in other mental health settings. Some mental health experts are questioning traditional models. In a variety of settings nationally, many are advocating for change, while others, especially front-line clinicians, tend to value the more traditional models in which they were trained. Dominant organizations, such as the American Psychological Association (APA), are organizing summits to assist and promote adaptation to modern times. Some proposals suggest modifying the traditional individual therapy, weekly 50-minute session and increasing focus on evidence-based practice. Thus, both at the college counseling center and beyond, there are voices advocating rethinking standard practice. Given these contemporary factors, centers must look to create innovative service delivery models for current times.

A Note on the Organization of this Paper

This paper reviews the above five factors in greater detail, as well as provides more detailed discussion of ways college counseling centers may change in the future. Because risk management concerns are closely tied to working with students who have complex or severe problems, discussion of risk management is included in the section on Complexity of Student Issues. That topic is saved for last and examined in greatest detail, as there is substantial data and controversy regarding research studies. Thus, the paper will first discuss retention concerns, then increases in demand, budget and fee issues, and finally, complexity, severity, and risk management issues.

Retention and Graduation Rates

Increasingly, colleges and universities are focusing on retention and graduation rates, as demands for accountability from outside sources expand. Students selecting a college to attend now have more information about retention and graduation rates, and the inclusion of this information likely sends the message to applicants that these factors are important to consider. Applicants now have access to retention information from the U.S. Department of Education, the website College Results Online (www.collegeresults.org), and the Voluntary System of Accountability program (www.voluntarysystem.org), in which each campus creates a similar website "College Portrait" (www.collegeportraits.org). In addition, Washington Monthly magazine published a new college ranking based in part on graduation rates (Washington Monthly, 2009). This focus on retention and graduation rates pushes college counseling centers to place higher priority on working with students' issues that most directly connect to their academic success. These issues are typically developmental in nature and not as severe as those of some other students who come to the counseling center for assistance.

The types of issues that impact academic success are delineated in several studies. Students completing the ACHA's National College Health Assessment (2004, 2005, 2006, 2007, 2008) note factors within the last school year that negatively affected their individual academic performance. Eight of the top ten factors identified every spring for the past five years involve signs of emotional or interpersonal difficulty and psychological distress. The impact of counseling on academic performance is also shown by Turner & Berry (2000), who report that an average of 70% of university students seeking counseling center services at one university said their personal problems were affecting their academic progress, and nearly one in five reported that they were considering withdrawing from the university due to personal problems. Over 60% of students reported that counseling was helpful in maintaining or improving academic performance, with nearly half reporting it helped them decide to continue their enrollment (Turner & Berry, 2000).

When counseling centers are able to devote time to these issues, the impact on academic success is significant. A study that evaluated the impact of psychological counseling on academic progress and retention over a six year period revealed that on average, counseling center clients achieved a total retention rate that was at least 11% greater than the general student population retention rate at the same university (Turner & Berry, 2000). Similarly, a small study at California State University, Sacramento found that students who sought counseling were retained at a rate 8% higher than students overall (Epstein, Turner, & Dovan, 2008).

Increased Demand for Services

National surveys of counseling center directors present a picture of stable demand, in contrast to multiple individual and regional surveys that show large increases. The national surveys show the average college counseling center's number of clients keeping pace over the last seven years with enrollment gains. Yearly surveys of directors during this time period consistently show the number of students using counseling services as a percentage of all enrolled students to be in the 9%-10% range (Gallagher, 2002; Gallagher, 2003; Gallagher, 2004; Gallagher; 2005; Gallagher, 2006; Gallagher, 2007; Rando, Barr & Aros, 2008; Rando & Barr, 2009). (Note: Campuses with larger enrollments see a significantly smaller percentage of students. For example, in 2007-2008, centers at campuses with enrollment between 20,000 and 35,000 saw 5% of the student population (Rando & Barr, 2009.)

A number of larger campuses separately report significant increases in counseling center use in recent years. Some universities report a 40–55% increase in students coming to counseling over the last five years (Soet & Sevig, 2006). More specifically, Columbia University reported a 40% increase in counseling center clients from 1995-2005; the University of Pennsylvania reported a 125% increase from 2000-2006; MIT noted a 50% increase between 1995 and 2000; the University of Cincinnati saw a 51% increase from 1996-2002, and the number of students who came to counseling centers at Big 10 universities increased by 40% from 1992-2002 (Kitzrow, 2003; Voelker, 2003; Rosenstein, 2009). A University of California (UC) study (UC Regents, 2006)

included enrollment increases and found the number of students utilizing campus counseling centers in the UC system increased 23% from 2000-2005, while enrollment increased only 15.5% over the same period. An analysis at California State University, Sacramento (Epstein, 2009) showed 18% more students used their counseling center from 2000-2009, while enrollment increased 13% over the same time period.

Fees and Funding Sources

Center budgets have fluctuated in recent years, often in response to national events, with increases in response to campus tragedies and decreases due to economic conditions. Some centers have seen increases in staffing and funding due to heightened awareness of campus and student vulnerabilities made salient by events such as the tragic shootings at Virginia Tech. However, this trend of increased awareness and funding for mental health is balanced against decreased budgets and loss of resources tied to the current economic downturn. Cooper, Resnick, Rodlfa, and Douce (in Walsh, 2008) state, "Justification for the existence of campus counseling services is rarely questioned, but the level of support and ability to demonstrate positive effects varies considerably. The latter is particularly difficult because showing that something bad did not happen (e.g., avoiding disruptions and tragedies) is significantly harder than showing that something good happened" (p. 219). In 2007-08, directors indicated that 17% of centers received decreased funding, 46% stayed the same, and 36% received increased funding. (Rando & Barr, 2009). Official data are not yet available for the 2008-09 academic year; however, anecdotal reports on the national directors' listserv appear to indicate that fewer centers are seeing increased funding and more are seeing decreased funding.

There are a number of methods for funding counseling centers, including institutional (state) funding, grants, charging a fee for service, and charging all students a counseling (or health and counseling) fee (Sandeen & Barr, 2008). Currently, 22% of centers nationwide receive funding from grants. However, the median amount received is $15,000, typically a very small part of a counseling center's budget. There are few grants applicable for counseling centers, and many centers lack the time or expertise required to successfully complete the extensive application processes (Rando & Barr, 2009).

As shown in Table 2 below, 13.6% of centers nationwide charge a fee for all counseling sessions (Rando & Barr, 2009). There are constraints with this funding source. As noted by Bishop (2009), students are limited in what they can afford to pay for sessions, and the funds generated typically will not cover the cost of service provision. Keeling & Heitzmann (2003) argue against the fee-for-service model as a direct funding source, given that today's counselors are expected to provide much more than individual therapy sessions, as they typically also have responsibility to provide outreach and consultation, training, and other educational programming.

Table 1 – Services Incurring Utilization Charges

Specific Service Incurring a Fee	% of Centers Charging
Personal counseling for all students	13.6%
Personal counseling after a certain number of sessions	7.2%
Career counseling	6.6%
Career testing	13.8%
Structured groups	20.2%
Psychological testing and assessment **	22.5%
Teaching (salary comes back to the center)	6.6%
Consultation	22.8%
Workshops	21.5%
Psychiatry	22.8%

** This fee for "Psychological testing and assessment" typically refers to personality testing. There are also a small number of centers who provide Learning Disability testing, which is extremely time intensive, typically requiring 15-18 hours of counselor time. Most centers charge at least several hundred dollars for this testing, although there are some that provide the service at no cost.

Universities have moved toward student-fee based funding in recent years. Seven years ago, 35% of centers were funded at least in part by student fees, with that percentage today at 45% (Gallagher, 2002; Rando & Barr, 2009). Currently, 55% of centers are funded exclusively from general or state funds, while 29% are funded by varying combinations of state funds and student fees, and an additional 16% are funded exclusively by student fees (Rando & Barr, 2009). In recent years the University of California system significantly boosted their student fee for mental health services, and Stanford University began charging a health and counseling fee in fall 2009. While the shift towards more student fees made fiscal sense in a time of growing enrollments, given reductions to the campus student population due to economic conditions in coming years, it is possible that this shift may stop or even reverse.

Complexity and Severity of Psychological Problems

Research on Increased Severity and Complexity of Student Cases
There is conflicting research regarding a trend toward increased severity of client pathology seen at college counseling centers. Surveys of counseling center personnel have consistently shown their perception to be that severity is increasing (Robbins, May, & Corazzini, 1985; O'Malley, Wheeler, Murphey, O'Connell, & Waldo, 1990; Gallagher, 2006). In fact, each year there is an increase in the percentage of counseling center directors who respond in a yearly survey that students seen have increased pathology, to the point that in the most recent survey 96% of directors endorsed the belief that there is an increase in severity of psychological problems among the students seen at their centers (Rando & Barr, 2009; see Chart 1).

Chart 1 – Percentage of Counseling Centers Reporting an
Increase of Students with Severe Psychological Problems
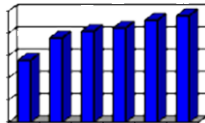
However, research that has examined longitudinal data from symptom inventories completed by counseling center students demonstrates mixed results. Specifically, there are two noteworthy experimental studies supporting the increased severity trend (Benton, Robertson, Tseng, Newton, & Benton, 2003; Erdur-Baker, Aberson, Borrow, & Draper, 2006). The Benton et al. (2003) study is perhaps the most frequently cited in the literature and popular press. The researchers showed that one counseling center's personnel, over a 13-year period, increasingly rated numerous client problem areas more severely. However, the research was criticized on a variety of methodological issues (Sharkin, 2004; Sharkin & Coulter, 2005).

The second study in support of increasing severity (Erdur-Baker, et al., 2006) is significant for several reasons. First, it stands as the sole unquestioned methodologically sound experimental study in support of this thesis. Second, it takes its data from the National College Counseling Center Research Consortium, hosted at the University of Texas and composed of 50 campus counseling centers across the nation, varied in size, type, and geographic location. The authors looked at symptom inventory data in 1991 and again in 1997 and found a small but significant increase in severity of client issues.

In contrast to these two studies, four other studies found no overall trend of increased severity (Pledge, Lapan, Heppner, Kivlighan, & Roehlke, 1998; Cornish, Riva, Henderson, Kominars, & McIntosh, 2000; Schwartz, 2006a; Kettman, Schoen, Moel, Cochran, Greenberg, & Corkery, 2007). Each of these studies looked only at data from one counseling center, respectively. The Schwartz (2006a) study is noteworthy as data were obtained by administering a 344-item instrument to every counseling center client over a 10-year period, yielding extensive diagnostic data. Also noteworthy in the group of studies indicating no overall trend in increased severity is the Kettmann et al. (2007) study. This study is unique in its thoroughness as researchers used multiple measures, including both client symptom inventories as well as clinician ratings over a seven-year period.

Given the mixed results, one could make a case either way that research has shown or not shown there is increased severity. It might well be the case that there is increased severity of student symptoms in some locations and not in others.

One area in which many of the authors agreed, including those who found no overall severity trend, was an increase in the complexity of cases and a rise in a small number of severe cases (Cornish, et al., 2000; Benton, et al., 2003; Kettman, et al., 2007; Schwartz, 2006a). A byproduct of this increase in complexity, and perhaps severity, is a significant increase in the time counselors need to spend providing case management. Benton et al. (2003) state, "The percentage of time we spend doing individual psychotherapy has actually decreased relative to the percentage of time we spend on report writing and consultation with referral sources, doctors, hospitals, other student services, academic departments, and families" (p. 71). Risk management concerns have also increasingly led to more documentation and consultation time, particularly with complex cases.

Similarly, Grayson & Meilman (2006) note, "In addition to their more conventional roles as counselors or psychotherapists, college clinicians are variously called on to do triage, manage referrals, provide reassurance, feedback, and information; serve as long term supports and patient advocates; conduct consultations; and handle crises…College clinicians must handle tricky phone calls from parents and deans, balance patient's needs against the community welfare, and judge when to make exceptions to therapist neutrality and confidentiality" (p.1).

One possible indicator of this increased complexity is an increase in average length of treatment per client over the last 15 years. As reported by directors in surveys from 1996-2002, the average number of sessions per client was consistently 5.2-5.3 (Gallagher, 1997; Gallagher, 2000; Gallagher, 2002; Gallagher, 2003). In the last four years, however, directors now consistently report the average is 5.5-5.6 sessions per client (Gallagher, 2006; Gallagher, 2007; Rando, Barr & Aros, 2008; Rando & Barr, 2009). While the difference appears small, the increase for a center that sees, for example, 1000 students per year, would amount to an extra 300 sessions per year.

General High Levels of Severity - Causes
Whether or not there has been a large increase in severity, there is no dispute that some clients at college counseling centers bring very significant issues to therapists and psychiatrists. There are a number of reasons for a higher level of pathology in some clients. Late adolescence and young adulthood have always been periods of high risk for "first break" episodes of psychosis and other major mental illnesses, as well as the onset of eating disorders and substance abuse issues. Insel and Fenton (2005) note that mental disorders are "the chronic diseases of the young."

Rodolfa (2004) grouped reasons for current increased use of campus mental health services into four categories (see Table 1).

Table 2 – Four Categories of Factors that Have Led to Increased Usage of Counseling Centers

Mental Health	Personal	Family	Environmental
Earlier Diagnosis	Isolation	Expectations	Stressful World
Earlier Treatment	Relationship deficits	Safety concerns	Outcomes-focus
Better Treatment	Stress	Involvement	Career-focus
Better Medicines	Anger expression		Pressure/Intensity
Reduced Stigma	Substance use		Mental health focus
ADA	Eating Disorders		
Reduced insurance	Gender issues		

Severity Indicated by Increased Hospitalizations
Hospitalizations for psychiatric purposes increased 60% from 2001 to 2006 (Gallagher, 2006). In the last several years, the change in number of student hospitalizations fluctuated depending on the size of the institution. There were relatively small changes at most institutions; however, for schools with an enrollment between 25,000 and 35,000 (as represented by 30 universities in a national survey), hospitalizations increased from 2006 to 2008 by a whopping 380% (Rando and Barr, 2009). This remarkable increase appears to be continuing into 2009. Recently, Carnegie Mellon reported their annual psychiatric hospitalizations doubled, Temple University's went up by 150%, and Western Washington University rate's tripled (AUCCCD Listserv, May 2009).

Severity Indicated by High Levels of Pathology
Surveys of the general student population, counseling center student surveys, and director surveys all indicate substantial levels of psychopathology in today's college students. This section provides details of these findings, separated by type of survey.

Surveys of the General Student Population
Eisenberg, Golberstein & Gollust (2007) conducted a study of nearly 3000 randomly-selected undergrad and graduate students, attending a large, public university (Michigan State University), demographically similar to the overall national college student population. In general, 30% of these students reported needing mental health services; among those who screened positive for depression, anxiety or both (roughly 17%), perceived need ranged from 51% to 89%. A 2008 study at 45 U.S. colleges and universities (NASPA, 2008) surveyed nearly 12,000 students and found that a substantial portion of the student body had been diagnosed or treated for various mental health disorders (see Table 3).

Table 3 – Percentage of All University Students Reporting Diagnosis or Treatment for Various Mental Disorders

University Students Diagnosed or Treated for:	Percentage
Depression	18
Anxiety	15
Eating Disorders	4
Bipolar (Manic-Depressive) Disorders	2
Seasonal Affective Disorders	2
Obsessive Compulsive Disorders	2
Schizophrenia	.24

The two most recent American College Health Association's National College Health Assessments (2008) reported findings from over 80,000 students at 106 colleges (Spring) and from nearly 27,000 students at 40 universities (Fall). Table 4 lists the percentage of surveyed students who reported experiencing the circumstances listed at least once within the past year.

Table 4 – Spring and Fall 2008 National College Health Assessment Data

CIRCUMSTANCE	Spring 2008	Fall 2008
Felt overwhelmed by all they had to do	93%	87%
Felt so depressed it was difficult to function	43%	31%
In an abusive intimate relationship (emotional, physical, sexual)	16%	14%
Death of a family member or friend was traumatic or difficult to handle	n/a	16%
Diagnosed by a professional for Depression	9%	10%
Diagnosed/treated by a professional for Anxiety	n/a	10%
Was a victim of stalking	n/a	7%
Intentionally cut, burned, bruised, or otherwise hurt themselves	n/a	6%

Surveys of Clients at Counseling Centers

The Center for the Study of Collegiate Mental Health (CSCMH) conducted a pilot study in Fall 2008 relying on standardized data collected from nearly 27,000 clients at over 60 university counseling centers across the U.S. The study's Executive Summary (CSCMH, 2009) reports that 51% of clients utilized mental health services prior to coming to the counseling center, including 19% prior to attending college. Other data from this survey show that 5% of clients were hospitalized for psychiatric reasons prior to attending college and 2% since being at college, 39% of clients experienced a traumatic event, 21% had an unwanted sexual experience, 8% seriously considered harming another, and 5% had harmed another.

Surveys of Counseling Center Directors
A 2009 survey of counseling center directors (Gallagher, 2009) reported a high percentage of the students seen in university centers nationwide as having substantial psychological difficulties. The directors noted that while 52% of clients experience mild-to-moderate problems (e.g., relationship problems, procrastination, mild mood disorders, etc.) and can be treated successfully and fairly rapidly with available treatment modalities, 41% of clients have major problems with anxiety disorders, depression, suicidal thoughts, impulse control issues, and other concerns that can be helped with available treatment modalities, but require significant time and attention. Additionally, 7% of clients are impacted so seriously that they cannot remain in school, or they can only do so with extensive psychological and /or psychiatric help.

Severity Indicated by Use of Psychiatric Medication
Recent surveys have shown a significant percentage of college students are taking medication for psychiatric reasons. NASPA's 2008 Profile of Today's College Student found that 15% of college students had been prescribed medication for a mental health issue (NASPA, 2008 The number of students at counseling centers taking psychotropic medication has increased substantially in the last 20 years (Rando & Barr, 2009; Gallagher, 2006; see Chart 2).

Chart 2 – Percentage Counseling Center Students Reported

Using Psychiatric Medication
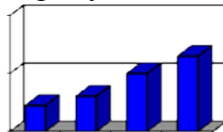
At University of California campuses, about one in four students who seek counseling services present with previously diagnosed mental disorders and are already receiving psychotropic medications (UC Regents, 2006). The more recent CSCMH study (2009) reported 34% of students utilizing campus mental health services used psychiatric medication prior to beginning counseling services at the university. The most recent directors survey (Rando & Barr, 2009) reports that 24.6% of counseling center clients are currently taking psychotropic medications, yet 31% of responding directors report students have no access to psychiatric services on their campus (only through referral to private practitioners). Approximately 42% of directors on campuses where students do have access to psychiatric services say they need more hours of psychiatric availability to adequately address student needs.

In roughly the same time period, use of antidepressant medication in the overall national adult population has greatly increased, from 5.84% in 1996 to 10.12% in 2005 (Olson & Marcus, 2009). Thus, some of the increase on campus parallels that of national trends; yet, as the figures above indicate, the campus increase appears to be even greater than that of the general population.

Whether this increase in medication use is due to increased severity of psychopathology or other factors such as greater acceptance of medication by a younger population is uncertain. What is clear is that a much more highly psychotropically-medicated student body creates substantial complexity for counseling center and other university personnel in regard to both clinical and risk management issues.

Severity Indicated by High Levels of Suicidal Risk
There are data showing significant risk of suicide at college campuses; however, where treatment is available, students can be helped. The majority of students who kill themselves never received counseling services (e.g., over 80% in 2002, 2003, and 2004). Suicidal students who receive counseling are six times less likely to kill themselves (Schwartz, 2006b). Among the students completing the ACHA's National College Health Assessment (ACHA, Spring 2008), 9% reported seriously considering suicide at least once in the past 12 months, and 1.3% reported attempting suicide. In their interviews with undergraduate students at 40 U.S. colleges and universities (mtvU & the Associated Press, 2008) researchers found that 16% have a friend who has talked about wanting to end their life in the past year, and 11% have a friend who made a suicide attempt in the past year. Among the student interviewees themselves, 9% have seriously thought about ending their own life in the past year, and among those with a diagnosed mental health condition, 23% report seriously considering suicide.

The recent CSCMH study (2009) reported 25% of students utilizing campus mental health services seriously considered suicide either prior to starting college, since starting college, or both, and 8% made a prior suicide attempt. Data from the 2008 survey of counseling center directors (Rando & Barr, 2009) show that the median number of students attempting suicide in 2007-08 on responding campuses was three, with the maximum number of suicide attempts for any one campus being 100. Directors also reported that one student, on average, died by suicide that year, with the maximum number of deaths by suicide for any one campus being eight.

Implications for and Challenges in Providing Appropriate Risk Management and Meeting Student Mental Health Needs
Increased complexity of symptoms (in addition to severity of symptoms) impacts the campus climate for all students, not just those experiencing psychological problems (Archer & Cooper, 1998). All students are distracted, some even negatively affected, by episodes of psychological distress exhibited by fellow students. Bystander students are often left with feelings of fear, concern, and confusion. The increase in untreated stress and psychological dysfunction on campus negatively impacts the level of all services, from teaching to parking, as faculty and staff across campus spend inordinate amounts of time dealing with untreated students experiencing stress and distress. In addition, a significant increase in calls from faculty, residence hall staff and others on campus seeking consultation about students of concern has further strained existing resources. Some centers have dealt effectively with this challenge by increasing efficiencies and other by

increasing personnel. At some campuses, though, the case complexity and/or severity may be so high and resources allocation so low, that even a maximally efficient clinical delivery system will not be sufficient to adequately handle the increase in case complexity and reduced resources.

Most students cannot afford any significant period of dysfunction. Those on the quarter system face even more challenges when trying to resume their academic work after a significant period of mental or emotional difficulties due to the short duration of the term. Given that some academic departments offer classes sequentially, in some cases failing one class can delay a student's graduation for up to a year or more. According to Kessler, between 25% and 35% of all college students experience at least one episode of a mental disorder during a 12-month period of time. These episodes are significantly disabling, with 20% of them being of a nature that the individuals are unable to carry out their normal activities 88 days out of the year, on average (Kessler et. al., 2005).

Colleges and universities are under significant pressure to address student mental health problems, particularly in light of recent tragedies at Virginia Tech and Northern Illinois University. Fear of violence and rising suicide rates have been added to concerns regarding school ratings and competitive recruiting, retention and graduation. The practice of college student mental health, in this post Virginia Tech era, is characterized by changing roles for counselors and center directors and "heightened – and often unrealistic – demands to predict and control student behavior" (Grunloh, Huang, Kaiser, Karamooz & Rowe, 2007). Many institutions acted quickly to expand capacity of mental health services on their campuses, as successive post-incident review reports called for coordinated institutional communication and response to students with behavioral or mental health concerns. Others waited or sought to maximize off-campus referral sources given a lack of resources to support additional psychological services on campus.

Particularly in the current budget climate, higher education institutions are struggling to meet the mental health needs of their students, and external budget cuts or reductions in resources can have an equally detrimental impact as those happening on campus. An example of external reductions exists in County Mental Health Systems, particularly in California. As these "fail-safe" institutions are discontinuing counseling support, even for the very poor and chronically mentally ill, wait times to be seen for psychiatric medication can be as long as six months. Thus, off-campus referrals for students with severe pathologies or medication needs are becoming less accessible. Even for those with private health insurance, referral to other resources may not provide better options, due to session limits and managed care pressures (Benton, et.al. 2003). One small study found that 42% of clients (all of whom had private insurance) were unsuccessful in connecting with an off-campus provider when referred by a university counseling center, with financial issues being the primary inhibitory factor in the referral process (Owen, Devdas & Rodolfa, 2007).

Counseling Center Responses to Increased Complexity/Severity
Counseling directors were asked in a recent survey (Rando & Barr, 2009) what steps their centers had taken in response to increased severity of student psychopathology (see Table 5).

Table 5 – Counseling Center Response Strategies to Increased Levels of Severity

Response Strategy	% of Centers Using It
Trained faculty and others on campus to help them make more timely and appropriate referrals	62.8%
Served on a student assistance committee that included varied campus personnel	61.2%
Offered psycho-educational assistance on a web page	53.5%
Increased training for staff in working with difficult cases (in-services or external workshop)	50.5%
Expanded external referral network	50.0%
Increased counseling staff	33.2%
Increased psychiatric consulting hours	29.4%
Increased part-time counselors during busy time of year	22.7%
Increased training for staff in time-limited therapy to help manage case loads better	19.8%
Provided psychologically-oriented columns for the student newspaper	15.5%

Benton et al. (2003) discuss changes made at their counseling center in reaction to increased numbers of students and severity of problems. Specifically, they increased the number of staff experienced with more severe disorders, and crisis work is now more of a priority. They summarize, "As the number of sessions per clients increases [due to client complexity issues], students can quickly reach the point where they are receiving, dollar for dollar, more in psychological services than they paid in tuition and fees … [Yet] with session limits and managed care pressure outside the counseling center, referral to other resources may not provide better options" (p. 71).

The University of California (UC) system recently reviewed their mental health services (UC Regents, 2006). In response, the UC system increased their registration fee by 7%, allowing a large in-flow of dollars specifically targeted at increasing mental health services. In similar fashion, Stanford University undertook a review of its mental health services provision in 2006 (Stanford University Board of Trustees, 2008). Like the UC system, Stanford began charging almost all students a specific medical and counseling fee beginning in fall 2009.

Additional Counseling Center Issues

While the key issues of increased demand, complexity/severity, liability risk, and budget issues are most salient in any discussion of the current state of college mental health, there are a number of other issues impacting today's university counseling center. These include accreditation and training, whether to issue diagnoses, provision of mandatory counseling, eligibility and termination criteria, student health insurance, parental notification, integration of counseling and health services, diversity, technology, research, learning outcomes, and outcome assessment. Discussion of these issues is beyond the scope of this paper.

Conclusion

Today's college counseling center operates in an environment quite different than in the past. At some campuses more students are coming to the center, and these students show increasingly complex psychopathology. More students take psychiatric medication and need to be monitored by campus psychiatrists. Campus crises involving mental health issues are becoming all too familiar, and more students than ever report having suicidal thoughts. Parents increasingly expect to be notified. Hospitalizations for psychiatric purposes are increasing. Off-campus referral options are shrinking. While some universities have increased the size of center staffs, others have not, faced with state budget cuts. Meanwhile, the impact of increased mental health issues on campuses is impacting retention and graduation rates, and counseling centers are increasingly seen as a place for containment of high risk students. Thus, counseling centers face five key factors in 2009: potentially increased student demand, more complex student problems, a priority on working with high-risk students and a priority on working with students to achieve academic success and increased retention, all within a constricted budget environment.

Archer & Cooper (1998) discuss some of these topics in their book devoted to the dilemmas faced by college counseling centers, which focuses on the challenges brought by increased severity and reduced resources. In the last 10 years those challenges have increased, and others have emerged. Archer & Cooper (1998) make three key recommendations: increased brief therapy, group therapy, and coordination with other university departments. In addition they suggest using self-help material, medication as appropriate, outreach, and consultation. Most university counseling centers followed this advice; however, since that book was written, difficulties, as noted in this article, have increased. Centers likely need to increase efforts in those areas and also go beyond what are now considered traditional solutions.

In fact, centers and universities are responding by adding new counseling fees and narrowing counseling center eligibility requirements. Larger centers are increasingly adding the position of

Case Manager to assist with high-risk individuals. More attention has been given to on-line resources, and in some centers sessions are provided at less frequent intervals.

Still, as contemporary challenges intensify, college counseling centers will likely need to further modify service delivery models. This challenge pervades the larger world of psychology. The APA convened a "2009 Presidential Summit on the Future of Psychology Practice" in May 2009.

Speakers at the Summit noted that practitioners will need to be more accountable for the services they provide. "It's all going to be about outcomes, evidence-based practice and pay-for-performance," said psychologist Katherine Nordal (Martin, 2009). APA's President-elect, Carol Goodheart, outlined the four dominant forces that will drive the future of psychology practice (all of which can easily be applied to the college counseling setting): 1) Changing economics, 2) Advances in technology and science, 3) Increasing diversity, and 4) Collaboration with other professionals.

By necessity, college counseling is slowly reinventing itself. Key in this transformation is the use of technology (e.g., on line social networking sites and prevention efforts), increased data and outcome measurement via technological advances, greater collaboration with Academic Affairs, and more innovative models of service delivery and referral. By necessity, the counseling center of the future will be different than today's center, likely not only in "evolutionary" but in "revolutionary" forms. Our current economic environment provides the opportunity to examine not only where we are but where we would like to be in our effort to sustain and educate our students.

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APPENDIX B - SUMMARY OF PRIMARY AND
SUPPLEMENTAL CSU COUNSELING CENTER SURVEYS

Introduction

In early 2009 the CSU Office of the Chancellor created the CSU Select Committee on Mental Health (hereafter the "Select Committee"). The charge of the committee was to assess mental health needs at the CSU campuses and make recommendations for improvements. The committee is composed of members of various CSU campuses, in a variety of positions, including Provost, Vice President of Student Affairs, Counseling Center Therapist and Director, Health Center Director, Academic Faculty, and Student.

As part of its mission, the Select Committee created several mental health surveys: an initial, large survey of CSU counseling center directors, smaller surveys of health center directors, of disability services directors, and of housing directors, and a follow-up survey of counseling center directors. The first three were conducted in the summer of 2009 and the follow-up survey was conducted in the fall and winter of 2009. The housing survey was conducted in early 2010. Except for this housing survey, which was conducted via listserv and email, thee other studies were conducted using a Student Voice web survey. All 23 campuses provided data. Directors were instructed not to "guesstimate" but to provide data-driven responses, data or context-informed estimates, or else leave questions blank. Unless otherwise indicated, results are derived from data-driven responses and are from the initial counseling center survey.

In order to develop comparative data, we specifically designed the survey to use questions matching those on other national surveys. Specifically, there are four surveys from various organizations used for data comparison: 1) The Association of University and College Counseling Center Directors (AUCCCD), a national survey of over 300 counseling center directors conducted in 2008, 2) The Center for the Study of Collegiate Mental Health (CSCMH), a national survey of intake data conducted in 2008, 3) The American College Counseling Association(ACCA)/International Association of Counseling Services (IACS) survey, also a survey of 300 counseling center directors conducted annually, and 4) The 2007 CSU Counseling Center Directors Survey, a brief survey of 20 CSU counseling center directors conducted in the summer of 2007.

The following narrative presents a summary of major findings for the main categories of the two 2009-2010 CSU counseling center studies.

Magnitude of Severity

Many of the survey responses show the magnitude of the complexity and severity of problems presented by students at CSU counseling centers. Each center hospitalizes approximately five students each year and treats another five students who had just been hospitalized by others. Approximately 7% of all CSU counseling center clients have been hospitalized sometime in their

life for psychiatric reasons. More than 20% of clients currently or previously used psychiatric medication. Almost 20% have considered suicide, and close to 10% have attempted suicide. Four percent considered intentionally injuring someone else, and more than 3% had intentionally injured another. Approximately 20% have experienced a traumatic event. More than one third of CSU clients have previously attended therapy.

Of CSU students in treatment at CSU counseling centers, over 40% have depression, and over 10% are having suicidal thoughts. Half of CSU clients are experiencing anxiety. About 15% are struggling with alcohol abuse, and 15% are struggling with other addictions. Between 5-10% have been sexually or physically assaulted, and 10% have been stalked. These percentages may reflect multiple diagnoses of a single client.

In comparison to national averages, the percentage of CSU counseling center clients who present with severe issues is higher in some cases and lower in others. Specifically, the percentages are substantially greater for anxiety, and issues of oppression. Conversely, percentages for students at the CSU centers are substantially lower for current or past use of psychiatric medication, harming oneself (e.g., cutting, biting), experiencing an unwanted sexual or other traumatic event, and previously attending therapy. Rates for consideration of suicide were also substantially lower, although actual deaths by suicide are higher.

Severity: Campus Data

This section provides data from the entire campus, not just the health, disability, or counseling center. Data shows substantial mental health issues on CSU campuses. (Because complete campus data are not always available, the following statistic from CSU and national campuses includes estimated data.) The median number of students per campus that attempt suicide yearly is four (compared to a national median of three), and the median number who die yearly is one (compared to a national median of zero). Deaths overall, whether by suicide, accident, or other means, were substantially higher at CSU campuses than the national average.

Severity: Potential Increase

Generally speaking, throughout the CSU there has been an increase in student demand for mental health services. The increase, however, is not a unanimous one: a couple of campuses actually saw a decrease in utilization; others saw huge increases. Nonetheless, the overall system data show the increase in the number of students using counseling services over the last seven years is greater than the increase in enrollment, as well as the increase in counselor full-time equivalent (FTE). More specifically, there were 18.7% more clients using CSU counseling centers in 2008 compared to 2001. During that period, enrollment increased 12.5% and counselor FTE increased approximately 8%.

In addition to students coming to counseling centers in greater numbers, there are data to show that many arrive with more severe pathology. While the number of same-day crisis appointments

changed little from 2007-08 to 2008-09, there was a substantial increase from 2005-06. In addition, the number of CSU clients on psychiatric medication increased by 20% in the last three years. (A caveat: this increase could be due to factors other than increased severity.)

In support of the majority of data showing increases, most directors of CSU counseling centers report believing that more students are seeking services for psychological issues and that the severity of those issues has increased. They report changing their service delivery methods to accommodate these changing needs.

Counseling Center Response to Severity

CSU counseling center directors are using all the methods noted on national surveys to deal with potential increased severity concerns. Most frequently, centers are increasing staff training, participating in campus crisis teams, training faculty and other campus staff, offering self-help material on websites, referring more students to the community/expanding referral networks, adding or expanding wait lists, offering more groups, and increasing intervals between sessions.

Diversity and Demographics

The survey examined differences in percent of various ethnic groups among counseling center clients in contrast to the percent at CSU campuses. The only group that significantly under-utilizes counseling services is Asian-Americans, a finding similar to those in other community sample surveys. In addition, the survey found 40% of CSU students do not have health insurance. Approximately 68% of clients are working while they attend school, and those who work are logging in an average of 20 hours of work a week. There are also a number of differences between CSU students who utilize counseling services and their counterparts across the nation. For example, the vast majority of students enrolled in the CSU are commuters; and large numbers of them are older than the "traditional"-aged 18-22 year old.

Institutional Issues

The commuter nature of CSU students seems to have a large impact on the use of campus mental health services. Overall, the percentage of CSU students who utilize mental health services is about half that of national averages. This is not the case, however, on three of the CSU's more residential campuses. Students at Humboldt, Maritime and Monterey Bay, for example, use their counseling centers at rates that exceed the national average. Overall, almost half of CSU students live more than 10 miles from campus. This section also examined medical withdrawal policies and found that such policies on most CSU campuses are silent or vague in terms of addressing mental health issues with any degree of specificity. Most campuses do not have written policies in connection with mental health issues.

Fees and Funding

A substantial majority of CSU counseling centers are funded via general fund dollars, compared to student fees. To augment their general fund budgets, a number of CSU centers applied for and

received small grants in recent years. Nationally, the majority of centers are also funded via the general fund, but it is a slimmer majority. Few CSU campuses are currently charging user fees, but several are exploring the possibility. CSU centers, like centers elsewhere, are increasingly charging for no-shows and late cancellations. To address recent and heightened concerns about funding levels and sources, many CSU directors are pursuing more grants, fundraising, the use of lottery funds, and in a few cases, the implementation of a mental health student fee.

Personnel

In regard to personnel, CSU centers differ from national averages in a number of ways. Compared to centers elsewhere, CSU counseling centers have fewer associate directors on staff but more training directors. The CSU has more Asian-American and Latino clinicians and fewer European-American/Caucasian clinicians compared to centers outside the system. Directors at CSU centers generally have fewer years of director experience than their national counterparts. Among CSU centers there is substantial variability in clinicians working academic year versus 12-month schedules, as well as variability amongst those working part-time and full-time. The staffing at CSU centers differs from the national averages as well. The CSU average clinician-to-enrolled-students ratio is 15% worse than the national four-year, public university average (2933:1 to 2607:1), 50% worse than the overall national average (2933:1 versus the national average of 2000:1), and 100% worse than the national accrediting agency's (IACS) recommended ratio (2933: 1 compared to the recommended 1500:1).

Psychiatry

The amount of psychiatric service provided at CSU campuses, including that provided in both counseling and health centers, is 25-50% of that provided nationally. Compared to national averages, CSU campuses provide more psychiatric services in health centers, whereas nationally the service is provided in greater numbers in counseling centers.

Productivity

CSU centers appear to have similar late cancellation and no-show rates as centers nationally. This combined rate is high at 24% of all appointments scheduled. CSU centers are providing very brief therapy, about four sessions per student, which is a little less than the national average of 5.5 sessions. (Session length can be determined by client factors such as dropout rates, administrative factors such as referral rates, and clinical factors such as clinician's therapeutic choices). Additionally, substantially more CSU centers have session limits than national counterparts. There is tremendous variability among CSU centers in regard to proportion of time seeing clients weekly, with some centers seeing 10% of clients weekly and others 90%. In the last two years, wait times at CSU centers do not appear to have increased substantially. The organization of time for clinicians at CSU centers tends to focus more on clinical and clinically-related work than at centers nationwide, where there are higher averages for administrative/preventive work.

CSU centers see 37% of their total annual clients during the two busiest months of the year. (These months vary from center to center.) Throughout the normal course of the year the wait time between an initial intake/assessment session and the first ongoing therapy sessions is 1.5 weeks, doubling to three weeks during the busiest months. Similarly, the wait for a regularly-scheduled intake increases from about two weeks to about three weeks in busy periods.

Since CSU counselors have a variety of assignments beyond direct clinical service, a review of their productivity is complex. In regard to number of clients seen, during peak demand reports showed that the average CSU counselor sees 3.4 clients per day (with a range of 2.74-5.06 clients), and during non-peak periods 2.6 clients per day (with a range of 1.85-4.55 clients). These ranges show considerable variability among campuses. In addition, analyses showed that the 2.6 figure determined from reviewing clinicians' actual schedules contrasted with reports from a separate question that inquired regarding the proportion of clinicians' direct service hours. Translating figures reported by both CSU and national counseling center directors of an expected 60% direct clinical service per clinician, and subtracting for no-shows and cancellations expected, yields a daily average of an expected 3.84 clients.

The committee was interested to understand why there was a discrepancy between the typical 2.6 clients per day seen and the 3.84 one might expect given average counselor schedules. Some factors that may explain the discrepancy include: 1) CSU campus enrollments skew towards the larger end, and clinicians at larger schools see fewer clients, 2) the 2.6 figure specifically accounts for vacation and other leave time while the larger figure does not, 3) the term "direct clinical service" often includes time clinicians are scheduled to be available for walk-in crisis clients, with a three-hour block occupied only by one or two students, and 4) increasingly complex client issues are requiring more case management and consultation per case, effectively increasing indirect service hours and reducing direct service hours.

General Clinical Services
CSU centers are generally open similar hours, most commonly 8-5, with some centers offering a few evening hours. There is large variability in number of groups provided and in number of students served via group therapy. About half the centers formally diagnose students, using DSM-IV diagnostic codes (Diagnostic and Statistical Manual-IV, APA). Two centers provide Learning Disability (LD)/Attention Deficit Disorder (ADD) testing.

Eligibility
All CSU campuses provide mental health services to their currently enrolled (part and full-time) students. Applicants who are soon-to-be enrolled and those who have stopped out but are in the midst of re-entering are eligible for services at a third of CSU centers. Most centers provide a few "bridge" sessions of therapy or psychiatric services to a student who has withdrawn suddenly or graduated until the student is connected to a provider in the community. A non-

student partner of a couple is eligible for therapy at three-fourths of CSU centers but other non-student family members are typically ineligible.

Referrals and Community Providers

Approximately 20% of CSU clients are referred to community providers at some point in the treatment process. One CSU campus determined that only 40% of those referred actually saw an outside therapist.

Outreach, Consultation & Relationship to Other Campus Departments

Counseling centers reach thousands of students through their outreach programming. Most CSU counseling centers are in the same building as health centers but are independently run by management-level directors.

Accreditation and Training

In regard to overall center accreditation, six CSU centers are accredited by the International Association for Counseling Services (IACS), and two centers are accredited by the American Association for Ambulatory Health Care (AAAHC). In addition, the American Psychological Association accredits center's paid internship training programs. Currently, one center (Long Beach) is accredited, and another (Sacramento) is pending. Many other centers provide unpaid training for master's level students.

Assessing Satisfaction and Outcomes

CSU counseling centers use a variety of satisfaction and outcome measures, generally of the nature and frequency used nationally. However, CSU centers only use half as many pre and post testing outcome measures compared to national averages. In comparison to national averages, CSU students indicate on evaluation forms in a higher percentage that counseling is helping with academic performance but in a lower percentage that counseling is impacting their decision to remain enrolled. These differences are not precise because center evaluation forms use different wording on these questions.

Technology

CSU centers use email less to contact clients than their national counterparts but use computers at a higher rate for scheduling clients. CSU centers use on-line resources, such as webpage assessments and self-help material, at lower rates than national averages. More than half of CSU centers have moved to partial or full electronic storage of client records. Just over half of CSU centers use the same database/scheduling system, but of those centers, only 25% use a component that permits direct student input of intake data, allowing for greater comparison of data.

Administrative Issues

Directors have a number of concerns regarding counseling center issues. Key challenges include increased student demand, severity/complexity of student issues, reduced resources, lack of community referral resources, and reduced ability to provide outreach and other prevention programming. In regard to severity issues, directors express concern about liability, as well as the impact on marginalized students, especially first-generation students. Directors also are concerned with treating and caring for increased number of students taking psychiatric medication. In addition, directors note difficulties with staff morale and burnout, furloughs, lack of psychiatric hours, RTP demands, low salary levels, and attracting diverse counselors.

APPENDIX C - SUMMARY OF CSU HEALTH CENTER SURVEY

Pharmacy Services

Health Centers at most CSU campuses provide pharmacy services for students, including medications specifically for mental health disorders. At the San Diego campus in 2007-08, 4000 such prescriptions were filled. The average campus fills 850 mental health prescriptions. These prescriptions account for 6% of all types of medications filled.

Psychiatric Diagnoses

Aside from students who visit the health center to see a psychiatrist, other students who seek medical services may receive a psychiatric diagnosis from a general practitioner. Across campuses, 4% of such visits result in a psychiatric diagnosis. Data show no increase in this percent over the last three years. However, a number of campuses did not have this data, and of the 23 health center directors, 15 believe this percentage has increased.

Student demand and staffing for psychiatric/psychological issues

Students seeking psychiatric services (medication from a psychiatrist or other provider) at the health center increased substantially, doubling from 2007-2008 to 2008-2009. Ten percent of students who come to the health center for any reason are subsequently referred to the counseling center. Most campuses provide a small number of hours of coverage by psychiatrists in the health center, with a range from 0-2.3 FTE and a median of .08 FTE. Two of the CSU campus health centers employ (or share) a psychologist for some hours per week: Northridge for (4) hours per week, and Sacramento for 20 hours per week.

Specific psychological issues

CSU health centers report significant mental health issues for students who have an appointment in a number of areas:
- 10 % had taken medication for psychological issues
- 9 % had previously attended therapy
- 6 % had experienced a traumatic event
- 4 % had experienced unwanted sexual contact(s)
- 3.5 % had been hospitalized for psychiatric reasons
- 4 % had considered suicide
- 1 % had attempted suicide
- 1 % had harmed themselves by cutting or biting
- 0 % seriously considered injuring another person
- 0 % had intentionally injured another person

In regard to involuntary hospitalization, there is a wide range in number of students hospitalized yearly at each campus. While most campuses do not have to involuntarily hospitalize students, several hospitalize one yearly and several others close to 10 yearly.

Ramifications of large numbers of psychiatric/psychological issues

Health center directors indicate that increased time spent on psychological issues drains resources for primary basic health and preventative services. They note that there are frequently chronic psychological conditions needing medication but that EO-943 limits the health center from managing chronic conditions. Finally, they report their practitioners have had to expand their knowledge base further into mental health areas.

Response to large numbers of psychiatric/psychological issues

Health center directors also report additional steps to respond to significant numbers of psychological medication needs and patient visits, including adding personnel with mental health specialties and more coordination with the counseling center and community providers. Health center directors also note that their practitioners are now spending more than eight hours a day providing service and that there is less administrative time for the health center director. Additionally, some centers are providing more self-help materials.

Appendix D – Summary of CSU Disability Services Survey

CSU disability services centers report significant mental health issues for some students who come to the center:

- 21% previously attended therapy
- 11% took medication for psychological issues
- 7 % were hospitalized for psychiatric reasons
- 5 % experienced a traumatic event
- 5 % considered suicide
- 5 % harmed themselves by cutting or biting
- 4 % experienced unwanted sexual contact(s)
- 2 % seriously considered injuring another person
- 1 % attempted suicide
- 0 % intentionally injured another person

Number of Students Seeking Assistance with Psychological Disabilities Over Time

Eight campuses had data for the academic years 2008-09, 2007-08, and 2005-06. On each of these campuses, there was a sizeable increase in the number of students requesting accommodations for psychological disabilities. From 2005-06 to 2008-09 the average number of students with psychological disabilities at these campuses' centers increased 75%, from 104 students to 182 students per year. Four campuses had data as far back as 2001-02. From 2001-02 to 2008-09 the number of students seeking such assistance increased even more substantially, from an average of 63 to 177, a 180% increase.

Percentage of All Students Seen Requiring Assistance with Psychological Disabilities Over Time

Nine campuses had data for the academic years 2008-09, 2007-08, and 2005-06. On each campus there was a sizable increase in the percentage of students seen at the center that required assistance with psychological disabilities. From 2005-06 to 2008-09 the average percent increased from 20% to 30%. Four campuses had data as far back as 2001-02. From 2001-02 to 2008-09 the percentage of students seen who required such assistance increased from 21.5% to 31%. If the four campus sample can be generalized, this data would show little change in percentage from 2001 to 2005, but a 33% increase from 2005 to 2008.

Impact of Increases in Students with Psychological Issues on Services

Directors report the impact of an increase in students on services is: students have to wait longer to access services; more time is necessary with students; each advisor sees more students; more urgent care is required; and more consultation with other departments is necessary. Directors reported mixed opinions regarding their ability to handle students requesting services for

psychological disabilities. The majority said they were well-equipped to handle such student requests, while a minority stated that staffing was inadequate to deal with the student volume.

Steps Taken by Centers to Address These Increases

In response to these changes, some centers reduced appointment times from 60 to 30 minutes. Centers also increased collaboration with campus and community resources. Finally, centers provided staff with more training and professional development opportunities.

Current Collaboration

All but three campuses have reciprocal referral processes between the counseling center and disability services. Disability centers collaborate regarding mutual clients who have psychological disabilities. Many centers obtain an authorization to release information so that each department may speak with one another. A number of centers have regular meetings with counseling center staff. Almost 34% of students with psychological issues seen at the disability services center later seek assistance at the counseling center. Eighteen centers have staff trained and competent to advise/consult with other student counselor/advisors regarding appropriate case management of student presenting with psychological disabilities. Just over half the disability centers have a designated liaison in the counseling center, and 39% have such a liaison in the health center. Over 60% of disability centers have a link with the campus health center in terms of psychiatric medication management. Almost 70% of centers are represented on campus-wide committees discussing student conduct and at-risk students. Just over 86% of centers are represented on a campus-wide Troops to College committee. Most center directors (15) report receiving insufficient documentation by health care professionals (on and off campus) for students who need accommodations. More detailed reports would be beneficial.

Psychological Service and Campus Policies

Six centers provide direct psychiatric or psychological services in the disability center office. Ten campuses have a policy for the disposition of disruptive behavior in accommodated testing environments where students present with psychological disabilities.

APPENDIX E - SUMMARY OF CSU RESIDENTIAL LIFE QUESTIONNAIRE

Five questions regarding key mental health issues were posed in a survey of housing directors within the CSU. Eleven of the 23 campuses responded. The questions were:

1. What mental health issues are you currently facing and how has it changed in recent years?
2. What are the challenges you face as a residential community in dealing with mental health issues?
3. What resources are available to assist in meeting those challenges and what resources are needed?
4. If you could create a "Best Practice" in this area, what would you implement?
5. Are there any additional ideas you want to share?

The overall key results are as follows:

-   The visibility of mental health issues in the residence halls are on the increase in a manner that parallels the rest of the campus; in addition, the nature of those mental health issues are also similar and focus on anxiety/stress, depression, alcohol related concerns, increasing numbers of students on medication, and students exhibiting Attention Deficit Disorder (ADD) issues.
-   The residence hall environment reflects greater parental involvement.
-   Residence halls are also seeing an increasing number of veterans who are living on campus and exhibiting stress related to mental health issues.
-   Residence hall staff see more mental health issues given their close and frequent proximity to students. Some of these students who are identified as having mental health issues may never go to the counseling center despite referrals. Thus, the number of reported cases at the counseling center is smaller than the true prevalence rate of mental health disorders on campus.
-   Resources are good but not sufficient to provide the support that residence hall staff need for handling mental health issues, especially for those that occur after 5:00 p.m. and on weekends.
-   Some students who are referred to the counseling center have to wait considerable periods of time for service.
-   Privacy laws preclude residence hall staff from having information regarding medication that students take. However, having this information when students arrive on campus would provide direction when residence hall staff sees students exhibiting improper behavior.

- Increased training, support, and communication with counseling center staff would be helpful to distinguish mental health issues from pure conduct issues, as well as dealing with combined mental health and conduct issues.
- Students who are involuntarily hospitalized are often returned to the residence hall very quickly and without notice to the staff.
- Almost all residence hall staff reported having adequate campus support from the Police, Student Health Center, Psychological Services, Disabilities Services, Veterans Office, and the Judicial Affairs Office. Some residence hall staffs also work with the International Students Office, Women's Resource Center, and Multi-Cultural Student's offices.
- It was noted that there was a lack of accessible, off-campus referral resources.
- Several respondents noted that an on-campus Behavioral Assessment Team (crisis prevention team) was a useful resource for them.
- In the area of resources for potential Best Practices, a number of significant recommendations were offered:

    - Have cultural centers assist in providing help and consultation for multi-cultural students.
    - Have campus health and counseling services expand their hours.
    - Have a liaison between the Health Center/Psychological Services and residence hall.
    - Have more training from the counseling center for both residence life staff and the rest of the campus on mental health issues.
    - Have a "tool box" for residence hall staff containing techniques for coping with mental health issues.
    - Have a specific protocol for handling students with behavioral mental health issues. The protocol would ensure better communication flow between offices, as well as ensuring the student fully understands their responsibility to themselves and to their community.

APPENDIX F - CAMPUS VIGNETTES

Counseling center directors were asked to describe in a paragraph any poignant examples of Counseling Services intervening in an urgent situation to help assess, defuse, or resolve a highly difficult situation (e.g., student deaths, campus events, events affecting departments uniquely, such as the death of a professor, involvement on Crisis Teams).

Summary: All centers were able to recount situations where they assessed, diffused and/or resolved difficult situations. Most revolved around incidents of attempted or completed suicide, violence, and death. Center staff served as valuable resources in providing skillful, humane assistance to students, faculty, and staff in difficult and dangerous situations. Note: the last vignette is from a director of Services to Students with Disabilities.

We had a young man in a fraternity hang himself in the basement of the fraternity house. He was discovered by his fraternity brothers. The whole Greek system was devastated. Counseling Services provided several interventions to various parts of the Greek system, including having a counselor be present at the frat house for many nights following the suicide.
Last Wednesday we hospitalized a student after two previous suicide attempts. We had been contacted by two faculty members who had been concerned about violent themes in this student's writings. He talked about violent fantasies which included killing others. There was evidence of substantial risk of this student killing himself. I got several calls, after the situation was taken care of, thanking me for the intervention that resulted in the hospitalization of this student.
During the fall semester of 2008 Personal Counseling Services (PCS) was involved with a student who had a psychotic break and became a threat to the campus. By working in collaboration with the campus Threat Assessment Team, a counselor who was involved with this student was instrumental in having the student hospitalized due to extremely volatile threats to staff and students. Due to the follow-up by the counselor, the hospital was informed of the danger and the student was treated for two additional weeks and suspended from the university resulting in a potentially dangerous situation being diffused.
We had an increase in cyber stalking, with faculty members receiving veiled or direct threats via e-mail. In several instances, the cyber threats have come from students in on-line distance courses who the faculty member has never met in person. In another, a student created a fake e-mail account to send specific death threats to a faculty member. Some of these situations have required police involvement, but in all of them, counseling services has spent considerable time assessing the situation, monitoring recommended action plans, and helping to allay faculty anxiety, which is frequently quite high.
The coordinator, a member of the campus C.A.R.E. Team (crisis team), conducted several assessments as part of the team. One 18 year old male living in the residence hall was of

particular concern and had caused problems in his living unit and some of his classrooms with his behavior. The coordinator was instrumental in helping his parents find appropriate diagnosis and treatment of his Bipolar Disorder which had been undiagnosed. The coordinator also consulted with the various departments to facilitate a smooth transition for his complete withdrawal from the university.

We have two examples. 1) In the case of a sudden death of beloved faculty member--staff did debriefings in her classes; 2) Did a consultation with Health Education professionals on how to respond to sexually explicit phone calls ostensibly asking for health education information

We initiated a 5150 for a student that posed a danger to the campus (he was following students around while carrying a knife in his pocket) and then helped him to take a medical withdrawal following his hospital release.

Following the untimely murder of an undergraduate student in an off-campus apartment near campus, CAPS was involved in the mental health aftercare of students within the victim's major, both individually as well as providing group processing and in-classroom meetings. In addition, CAPS worked with affected faculty and staff as they too grieved the untimely death of the student.

During the 2008-2009 academic year, our campus had two accidental student deaths. Both students were extremely well-known on campus and the entire campus community was deeply impacted. Under the direction of the Director of the Personal Growth and Counseling Center, the Division of Student Affairs coordinated an effective response to these student crises. She acted as the university liaison to parents, families, and faculty, and the lead in the planning of all services offered to students, staff, and faculty. The Personal Growth and Counseling Center houses the Campus Ministry program and coordinates memorials and memorial services. Two memorials were planned, organized, and coordinated by the Personal Growth and Counseling Center for the entire campus community. Ongoing individual and group intervention was provided to the students. (One student was extremely active in her sorority, and group grief counseling was offered to the entire sorority.)

Counseling services is seen as the go-to place to help deal with a variety of campus emergencies and crises. We are often called in to help students, staff, and faculty deal with events such a death and other types of trauma. We were also quite involved in a number of venues to help administrators (deans, chairs) to help deal with the psychological impact of budget uncertainties and furloughs.

A residential student suffered a fatal head injury while skateboarding over a weekend. Clinicians organized group and individual therapy options for res life staff, his roommates, and hall-mates when students returned to the halls Monday and learned of his death.

There was a suicidal student in residence on campus. Consultation between Residential Education and Counseling & Psychological Services resulted in the student being walked over by staff. The

student was seen for an emergency assessment at C&PS that resulted in voluntary hospitalization and ongoing treatment. The student was able to continue at the university.
At the death of a student athlete, counselors participated in same day grief counseling, made hours available for walk in appointments, and provided brochures and other educational materials about the grief process.
A student committed suicide. She was a much-loved student in a sorority. Counseling Services reached out to the sorority and worked with a number of the students, two who found the young woman's body, as well as other members of the sorority who were grieving the loss.
There was an apartment fire in a complex near campus early one morning. The initial reports were that one of the students was severely injured in the fire. The campus established a crisis tent that was staffed with our senior counselor to perform crisis counseling as the fire was being dealt with and as additional information regarding the injured/deceased student became available.
Psychological Counseling Services played an active role in assisting with the repercussions of a suicide attempt by a student in Housing. Several other students were affected. In addition to providing counseling for the students involved, we consulted with administrative staff, and had a meeting with affected students.
I had a Marine that walked into my office and broke down in front of me. This person had gotten back from Iraq 9 months prior and had been arrested for a DUI. In addition, this person was actively looking for a way to commit suicide. It took me a couple of hours but I managed to get this person stabilized enough to see my senior psychologist for immediate follow-up. I made the referral to the VA for a PTSD evaluation. The student was eventually diagnosed with PTSD. This student did graduate and still checks in with me periodically. This case had a good outcome and it illustrates that not all active duty military personnel will go through their primary base to receive counseling assistance.