

**THE UNIVERSITY OF MICHIGAN**

**Report of the  
Mental Health Work Group**

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**May, 2003**

# Report of the Mental Health Work Group

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## **Executive Summary of the Report of the Mental Health Work Group**

**The Charge:** The Mental Health Work Group was charged by Vice President Royster Harper to review the current status of mental health preventive and treatment services for the students at The University of Michigan, Ann Arbor Campus, and to identify qualities of an optimal system of care, major barriers to such a system, options to correct or reduce these barriers, and finally to recommend ways to ensure on-going oversight of such services. The workgroup was convened in September, 2001, and was composed of senior representatives from all units supplying mental health care to students on the central and medical campuses. The work group interviewed students from the undergraduate and graduate programs, and senior staff that work closely with students, from various areas within the University, including Academic Advising, University Housing, the International Center, and Services for Students with Disabilities. (See Section 1.0)

**Mental Health Issues on Campus:** College-age students are more likely to experience mental illness than other age groups, in part because many mental illnesses become symptomatic during these years. It appears that colleges and universities have experienced increasing enrollment of students with pre-existing mental illness and concurrently the number of students with more complex and severe mental health problems has increased. In addition, a linear increase and a doubling of the numbers of students seen with depression over the past decade has been described. Over the course of a single year, 1 in 12 college students in the United States will make a suicide plan, and 7 of every 100,000 college students die each year from suicide. Moreover, the presence of psychological difficulties may not be easily recognized by staff and faculty, as there are significant motivators for students to deny or hide symptoms of mental illness. Students may come from families or cultures that have strong prohibitions with respect to admitting the presence of mental illness, and these students tend to visit mental health professionals at lower rates. One barrier for these students may be the fear of ostracism from friends and social groups, or family shame. They also may be unwilling to confide in teachers and advisors whom they look to for graduate or job recommendations. (See Section 4.0, and Appendix C)

**Parameters of Optimal Mental Health Care for Students:** The characteristics of optimal mental health care for students should include: the reduction of stigmatization of mental illness; the training of staff and faculty to assist students with mental illness in obtaining assistance; the reduction of barriers to access of mental health services; adequate staffing of mental health agencies for students; excellent communication and cooperation between various agencies providing mental health care to students; and the active involvement of providers in the community who provide on-going care to students. There needs to be both an individual and a coordinating group that have the responsibility and authority to ensure that these goals are pursued continuously. ( See Section 5.0)

**Mental Health Services on Campus:** The University of Michigan offers a substantial selection of mental health care agencies and providers to serve the mental health needs of students. In addition, the surrounding community offers many mental health specialists that supplement these campus resources. Mental health services and agencies on campus have developed historically due to a variety of service and training needs on both the central and medical campuses. Primary entry into the mental health system, at no cost to the student, is available at the Counseling and Psychological Services (CAPS), the University Health Service (UHS), the

Sexual Assault Prevention and Awareness Center (SAPAC), and Services for Students with Disabilities (SSD) which are units within the Division of Student Affairs. In addition, the Psychological Clinic, and the University Center for the Child and the Family (UCCF), which are training and service sites within Rackham School of Graduate Studies, offer both primary, ongoing, and referral care on a fee-for-service basis. On the medical campus, the Michigan Center for Diagnosis and Referral (M-CDR) directs patients to a broad range of providers, primarily affiliated with the University of Michigan Health System (UMHS). In addition, the Psychiatric Emergency Service (PES), the Riverview Outpatient Clinic, the Chelsea-Arbor Addiction Treatment Center, and the Department of Psychiatry Medical Student Program are units or programs within the Department of Psychiatry. Until the formation of the Mental Health Work Group, cooperation between these units was informal. There is no oversight or functional coordinating body. Referral and cooperation between units in coordinating the care of patients is also informal in nature. (See Section 6.0)

### **Findings and Recommendations:**

- **Stigmatization of Mental Illness** is a powerful barrier to students, especially affecting those from other cultures, preventing them from reaching out for help and obtaining mental health services. The group recommends that a University-wide commitment be made to address this issue. Two recommendations are envisioned: first, to identify or hire a staff person responsible for addressing these matters using contemporary public health and social change skills, endorsed and supported by high-level executives within the University; and, second, to create a systematic way in which all mental health programs on campus participate in addressing these issues. (See Section 8.1)
- **Prevention of Suicide and Harm** should become a long-term goal for the University. This is currently represented by outreach and training programs offered by CAPS, but should be expanded to target high-risk students and high-risk groups. Alcohol use, academic difficulty, and origin from certain high-risk cultural groups are specific risk factors for suicide and self-harm. (See Section 8.2)

**Access to Mental Health Services** has multiple determinants. Each agency providing mental health services will need to determine the specific areas for improvements in service delivery, communication, and collaboration.

- **Contacting a Mental Health Provider** may present substantial difficulties for a student who is in distress and unfamiliar with the variety of resources available. It is recommended that two recommendations be considered: first, to create a centralized web site that includes discussion of all campus mental health resources, including detailed description of services and costs; and second, to establish a 24-hour phone number where a student may obtain advice or directions for obtaining mental health services, specifically taking into account the variety of resources available to students on campus. (See Section 8.3.1)
- **Hours of Access** appear to be comparable to other Universities, and include evening hours. It is recommended that students receiving care be surveyed periodically regarding adequacy of hours. (See Section 8.3.2)
- **Staffing** was considered in the context of the increasing complexity of mental illnesses among students, the waiting time for appointments, and current external standards. Counseling and Psychological Services, the University Health Service, and Sexual Assault Prevention and Awareness Center staffing are currently adequate to meet the primary mental health care access needs. Funding for staffing needs of international students in North

Campus Family Housing is inadequate. All of the agencies serving the University remain under pressure from the increasing severity of mental health issues presented by entering students, and this will need continual monitoring. This will require a commitment to collection of student visit data at all University agencies providing mental health services to students. (See Section 8.3.3)

- **Cost of Care** presents a barrier to care when on-going therapy or medications are necessary. Policies should be put in place to guarantee that no student will be denied care because of lack of appropriate local insurance coverage. Proof of such coverage should be a condition for matriculation, and should be considered in financial aid calculations. (See Section 8.3.4)
- **Staff and Faculty Training** would improve the recognition of mental health issues that arise with respect to students, and would facilitate timely and appropriate referral to mental health professionals. While the staff of University Housing undergoes such training, no other units have guidelines or programs meeting this need. It is recommended that a systematic training program be created and required for new and current faculty and staff who are in contact with students. (See Section 8.4)
- **Referral and Use of Community Resources** are key elements to the coordination of care. Referral processes between University mental health providers are not systematized and, while they usually work adequately, these processes should be improved and formalized. Community providers are an important resource for on-going care of some patients. It is recommended that the University work more closely with community providers to create a list or group of such providers who will assure timely access and care to students at a reasonable cost, including reduced fees if the situation warrants. See Section 9.0)
- **Communications Regarding Students** who have mental health issues is regulated by the Michigan Mental Health Code, the Health Insurance Portability and Accountability Act (HIPAA), and the Family Educational Rights and Privacy Act (FERPA). These laws give students assurances of a high degree of privacy under most circumstances; however, they may also restrict appropriate communication between caregivers, and between caregivers and select faculty and staff. It is recommended that a standard release form be created and used diligently by all mental health providers, medical providers, and administrators when referring or communicating regarding students with mental health issues. (See Section 10.0)
- **Withdrawal and Matriculation Policy** allows for standardization and fairness in the managing of issues with respect to the mental health of students and associated disruptive or harmful behaviors. Such a policy exists only in draft form, developed by a committee within the Division of Student Affairs. It is the recommendation that this policy be formalized. In addition, it is recommended that a University wide policy regarding withdrawal and re-matriculation for mental health reasons should be put in place, including an evaluation prior to the return of the student to assure that they are ready to return to the University and that they have an adequate support system in place. (See Section 11.0)
- **Mental Health Organizational Structure** offers a wide array of choices for students seeking mental health care services on the campus. Each unit has its own mission and structure, and there is a strong need for better coordination of care among the units, and between the units and other campus services such as academic advising and University Housing. At present, no structure exists to promote such coordination. The MHWG recommends that a high-level role or position within the Division of Student Affairs be established to facilitate accomplishing this task. The group recommends that this individual be charged to establish a formally organized student mental health coordination group, whose mission would be to

meet regularly to create and maintain optimal coordination of care for students. This group should have a membership that includes representatives of campus mental health services, other units concerned with student mental health such as University Housing and academic advising, students, faculty and staff. (See Section 12.0)

# Complete Report of the Mental Health Work Group

## **1.0 Charge of the Mental Health Work Group**

The Mental Health Work Group (MHWG) was convened in September, 2001, under the charge of Vice President Royster Harper, to review comprehensively the current status of mental health preventive and treatment services for the students at The University of Michigan, and to make recommendations for improvements in the current programs. The group was asked to: describe the qualities of an optimal system of care particularly with respect to students; to identify the major barriers to achieving such a system; to identify options and resources needed to correct or reduce these barriers; and, finally, to consider ways to ensure on-going oversight of the various mental health services for students. It was understood from the outset that this task was substantial and that the final result would serve as a map for future work.

## **2.0 The Committee**

The membership of the MHWG was composed of representatives from all major components of the mental health providers serving students within the University of Michigan Ann Arbor campus. Robert Winfield, M.D., Director of University Health Service, chaired the Committee. Other members included: Duane DiFranco, M.D., Director of the Michigan Center for Diagnosis and Referral, Department of Psychiatry; Robert Hatcher, Ph.D., Director, Institute for Human Adjustment and the Psychological Clinic; David Knesper, M.D., Director of Quality Assurance, Department of Psychiatry; John Kettley, M.S.W., Clinical Director of Psychiatric Emergency Services, Department of Psychiatry; Juliette Larsen, Risk Management Consultant for Health Care, University of Michigan Health System; Jerry Miller, Ph.D., Director of University Center for the Child and the Family; Stephanie Pinder-Amaker, Ph.D., Associate Dean of Students; Bryan Rogers, Dean of the School of Art and Design; Todd Sevig, Ph.D., Director, Counseling and Psychological Services; Daniel Sharphorn, J.D., Associate Vice President and Deputy Counsel, Office of the General Counsel; Ken Silk, M.D., Associate Chairman, Department of Psychiatry.

Several groups did not have representation on, but were interviewed by, the work group: Academic Advising, the International Center, Services for Students with Disabilities, Undergraduate and Graduate Students, and University Housing. These groups will need to be considered in the membership of teams charged with addressing these issues in the future.

## **3.0 The Process**

The Work Group met monthly, for two-hour sessions, over a period of 18 months. The group reviewed the current structure of mental health services at the University, identified gaps in the delivery of care, and barriers to optimal care, and interviewed selected individuals with specific areas of expertise and

experience. Subgroups were established to consider various issues in greater depth, and these topics and recommendations were then reported to the entire group. Telephone interviews were conducted with several relevant mental health programs at other universities. The pertinent literature was reviewed.

Meetings were individually devoted to exploring the experiences and viewpoints regarding mental health issues and services from the perspectives of Academic Advising (Assistant Dean Esrold Nurse and Helen Olson, both representing LS&A, and Lisa Payton, Program Director, Undergraduate Education, College of Engineering), international students (represented by Rudi Altamirano, Director of the International Center, and Daniel Pak, MD, of the Department of Psychology), disabled students (Sam Goodin, Director of Services for Students with Disabilities), students (Mentality, represented by Cara Sandelands and Laura Shereda, and Rackham Student Government, represented by DeAunderia Bryant), and University Housing (represented by Darlene Ray-Johnson, Housing Program Director, University Housing).

#### **4.0 The Nature of the Mental Health Problem in the Student Population**

The definitions of mental health, wellness and, conversely, mental illness, are complex (see Appendices A and B). There is a wide range of adaptive behaviors that allows individuals to function creatively and energetically in the multifaceted academic environment of the University. The group concluded that it is important that, while this range of behaviors may appear at times outside of the main stream of the community, they should be supported as long as they are not harmful to the individual or the community. Such tolerance for diversity is intrinsic to the well-being of the Institution.

While this broad range of behaviors may be adaptive on the university campus, many college students are impaired by mental disorders during some portion of their college years. Some students are severely disabled by depression, manic-depressive disorders, psychotic disorders, anxiety states, alcohol and substance abuse, or other mental illnesses. Epidemiological surveys have shown that 30% of respondents meet diagnostic criteria for mental illness in the past 12 months (Kessler, 1994). This number, however, does not reflect the respondents' relative level of distress, level of function, or need for treatment. In a single year, college-age students are more likely to experience mental illness than are other age groups (Morwsky & Ross, 1999). This is because many mental illnesses become symptomatic during these years. Anecdotal accounts from a variety of colleges and universities cite increasing numbers of students arriving at college with serious pre-existing mental health problems. Reports also note the increasing academic demands placed upon students, at a time in their lives when they are living apart from family and established friends, may be additional vulnerabilities or stressors that can lead to an episode of mental illness. This is a time when students are surrounded by new individuals who may not notice or recognize early and important behavioral changes until they become extreme.

Suicide is one of the most tragic consequences of mental illness. All of the mental disorders that are prevalent among college students have been found to be risk factors for suicide. Over the course of a single year, 1 in 12 college students in the United States makes a suicide plan. College age students consider suicide more often than any other age group. For Americans between the ages of 15-24, suicide is the second leading cause of death. About 7 of every 100,000 college students die each year from suicide, but this average figure masks the fact that some institutions have a rate at least three times as high (Barrios, et. al., 2000; Silverman, et. al., 1997; Pruett, 1990). Persons with an active mental disorder have about a 7 to 10 times increased risk for suicide; moreover, due to known forms of under-counting, this figure underestimates the true risk (Tanney, 2000). For college-age students, alcohol is the major risk factor for suicide, and alcohol is or will be a problem for as many as 1 in 10 college students (Rivinus, 1993). Alcohol is the strongest single predictor of subsequent completed suicides (Beck & Steer, 1989).

There are substantial motivators for students to deny or hide symptoms of mental illness. The stigma that our society places on individuals with psychiatric disorders creates an atmosphere of hesitation to reveal such problems to others. For example, while 7% of incoming freshman report being depressed prior to coming to campus, it is uncommon that students reveal mental health problems on their housing application. Many students come from cultural or family backgrounds that have even stronger prohibitions than society in general against admitting or being treated for mental illness. This is especially true for students from other countries. Moreover, students may be suspicious or confused regarding confidentiality with respect to their contacts with mental health care providers. They are threatened by the possibility of revelation of these difficulties to their families, their teachers and staff, and to future employers. Students at Harvard University expressed concern over the negative consequences that may result from seeking care, and pointed out that students are often unwilling to confide in teachers and advisors who may eventually write graduate school or job recommendations (Harvard Provost Study, Student Mental Health, 1999).

## **5.0 Parameters of Optimal Mental Health Care for Students**

The group was asked to describe the characteristics of optimal mental health care for students. These include:

**5.1** The general attitudes on campus should reduce the stigmatization of mental illness, in order to facilitate access to care.

**5.2** Staff and faculty should be trained to recognize behavioral signs of mental illness, and assist students in making contacting mental health services on campus.

**5.3** Barriers to access should be minimal. This should include adequate staffing with appropriately trained providers, easy access to information about resources, readily available advice by telephone, minimal out-of-pocket costs for care, and physical location of services within the general vicinity of the day-to-day activities of students.

5.4 Communication and referrals between the various agencies delivering mental health services should be standardized, and designed to promote student safety and continuity of care.

5.5 Discussion of on-going issues between the various agencies delivering mental health services should occur on a regular basis, in order to optimize the care of students.

5.6 Mental health providers in the community should be identified that are committed to working with existing University agencies to optimize communication, cooperation, and access for students.

## **6.0 Overview of Current Mental Health Services Network**

Mental health services for students are distributed among a variety of health facilities and academic departments. The primary supplier of initial mental health evaluations, short-term therapy, and referrals is Counseling and Psychological Services (CAPS), located in the Michigan Union. The second major entry point into the mental health care system for students is at the University Health Service (UHS), located one block from the central campus. Both of these units operate under the auspices of the Vice President of Student Affairs. The Sexual Assault Prevention and Awareness Center (SAPAC), located on North University Avenue, one block from State Street, saw 296 individuals in 2001-2002, has someone on call 24 hours a day, 7 days a week for assisting individuals in crisis, and giving information and referral. SAPAC areas of expertise are sexual assault, dating and domestic violence, sexual harassment, and stalking. Services include short and ongoing counseling and academic, legal and medical advocacy. 24 hour outreach teams meet victims at hospital emergency rooms, the police department, residence halls, or any other campus office. They also offer workshops and training (both peer education workshops and staff professional training for university units). During an average year 50% of clients seek services related to sexual assault, 11% dating/domestic violence, 8% sexual harassment, 8% stalking, and 8% child sexual abuse/incest. SAPAC works closely with Counseling and Psychological Services, the Psychiatric Emergency Services, and the Psychological Clinic.

While the UHS is open 9-12 AM every Saturday, most after-hours and weekend emergency mental health care is offered primarily through the University of Michigan Health System, Department of Psychiatry, Psychiatric Emergency Services (PES), which is located adjacent to the University Hospital Emergency Department.

Initial evaluations and on-going therapy are also offered at Riverview Outpatient Clinic in the Department of Psychiatry, part of the University of Michigan Health System, and through the Institute for Human Adjustment, at both the Psychological Clinic and the University Center for Child and Family, which are part of the Rackham School of Graduate Studies.

Referrals are made by all of the above university providers to a wide variety of health care professionals within the Ann Arbor and Ypsilanti communities. Students may also, independent of any of the above programs, seek mental health services from professionals outside of the university community.

### **6.1 Division of Student Affairs**

The Division of Student Affairs offers mental health services at two campus locations: Counseling and Psychological Services (CAPS) in the Michigan Union and, to a lesser degree, at the University Health Service on Fletcher Street.

**6.1.1 Counseling and Psychological Services** is the cornerstone for the mental health services available to students at the Ann Arbor Campus. There is no visit fee. The clinic is located in an easily-accessible, central location on the main campus, on the third floor of the Michigan Union. There is relatively light student traffic on this floor, which enhances privacy. In addition, CAPS currently provides consultation and programming for Family Housing on North Campus. CAPS is currently reviewing other ways to meet the needs of students who primarily study and live on North Campus. The central facility is open Monday, Wednesday, Thursday and Friday, 8 AM to 5 PM, and Tuesday, 8 AM to 8 PM, during the Fall and Winter terms. Tuesday evening hours are suspended during the Spring and Summer terms. Urgent visits are accommodated immediately (or within 1 hour), while routine visits are usually scheduled to be seen within 2-5 days. During certain weeks of the year, in high-demand times, the wait for a non-urgent appointment may be up to 7-8 working days. For emergency telephone calls during regular business hours, students may speak to the Counselor on Duty. For emergency help during evening or weekend hours, students are encouraged to contact Psychiatric Emergency Services (PES), by phone or in person, at the University of Michigan Medical Center. Visits to the PES are fee-for-service.

Staffing at CAPS includes 18 professional staff, including psychologists, social workers and psychiatric staff. In addition, it is a training site for 4 half-time Social Work interns, 1 psychology Consortium intern, 3 Pre-doctoral psychology interns, 2 Post-doctoral scholars, and 3 support staff.

In FY 2001, CAPS saw 2131 students in individual counseling sessions: 57% were seen for 1-3 sessions; 24% for 4-7 sessions; and 16% for 8-15 sessions. These visit tallies do not include students seen during group sessions. Primary reasons for being seen are: 26% were seen for depression; 19% for anxiety; 17% to improve self-esteem; 15% for relationship problems; 12% for academic standing issues; 6% to increase ability to handle responsibilities; and 5% for eating/body image concerns. Referrals of patients are made both within the University and to providers within the community.

**6.1.2 The University Service Health**, while primarily designed to provide a range of primary care medical services for students, also frequently serves both as a site for their first entry into the system for psychological and psychiatric treatment, as well as a dispenser of ongoing medications for psychiatric illnesses. Some students come to the UHS because they do not recognize their symptoms as mental health-related, while others are hesitant to seek mental health care because of associated stigma. Some students are seeking pharmacological treatment of depression, anxiety, or other mental health disorders, and these students do not want to be seen in the conventional counseling model. Some are sent to UHS by referral from CAPS to receive evaluation for medication. There is no visit fee for students to be seen at UHS. The UHS is located on Fletcher Street, one block from the center of the main campus. During the Fall and Winter terms, hours are Monday, Tuesday, and Wednesday, 8-5:30; Thursday, 9-5:30; Friday, 8-4:30; and Saturday urgent care only 9 AM to 12 Noon. Weekday hours are reduced during Spring and Summer terms. After-hours on-call telephone service by one of the primary care clinical staff is available year-round, whenever the UHS building is closed.

Primary Care staffing is made up of 6 (4.7 FTE) Internal Medicine Specialists; 5 (4.7 FTE) Family Practitioners; 1.0 FTE General Practitioner; 1 (0.6 FTE) Gynecologist; 2 (2.0 FTE) Physician Assistants, and 6 (5.0 FTE) Nurse Practitioners. Six hours weekly of on-site psychiatric liaison consultation is available, by referral only.

During FY 2000, 996 of approximately 50,000 student visits to the UHS were classified as mental health visits. Many of these were for medication management of psychiatric illnesses, requiring more than one visit over the year. 571 undergraduate and graduate students accounted for these 996 visits. Sixty-eight percent of these visits were for depression or anxiety, 16% for unspecified counseling, 15% for eating disorders, and 1% for substance abuse. Collaboration with CAPS is particularly effective for patients with complex eating disorders. There remains room for improvement in other areas of cooperation in managing patients who are receiving counseling in CAPS and pharmacological or medical management at the UHS. Communication between the two provider groups is impaired by lack of familiarity between the staff members, treatment privacy issues, and by communication difficulties impairing ease of communications.

**6.1.3 The Sexual Assault Prevention and Awareness Center** is located on North University Avenue, one block from State Street. SAPAC saw 296 individuals in 2001-2002, and has someone on call 24 hours a day, seven days a week for assisting

individuals in crisis, and giving information and referral. SAPAC areas of expertise are sexual assault, dating and domestic violence, sexual harassment, and stalking. Services include short and ongoing counseling and academic, legal and medical advocacy. Twenty-four-hour out-reach teams meet victims at hospital emergency rooms, the police department, residence halls, or any other campus office. They also offer workshops and training (both peer education workshops and staff professional training for university units). During an average year, 50% of clients seek services related to sexual assault, 11% dating/domestic violence, 8% sexual harassment, 8% stalking, and 8% child sexual abuse/incest. SAPAC works closely with Counseling and Psychological Services, the Psychiatric Emergency Services, and the Psychological Clinic, and takes referrals from multiple agencies, including UHS.

**6.1.4 Services for Students with Disabilities** is located on the first floor of Haven Hall. Hours are 8-5, five days weekly. No evening or weekend hours are offered. SSD saw 102 students overall in 2002, with multiple visits for each student. Students may self-refer, or are referred directly to SSD when their mental health difficulties reach the level of a psychological disability, substantially limiting one or more major life activities. In such a situation, the individual may be eligible for special academic accommodations under the Americans with Disabilities Act.

## **6.2 Academic Units: Institute for Human Adjustment**

Two central campus academic units within the University serve the Ann Arbor community, as well as the campus, in offering care to students who represent a portion of their patient population. These units serve as academic graduate student training sites, as entities under the Institute for Human Adjustment, and include the Psychological Clinic, and the University Center for the Child and the Family. These units derive their funding from patient fees, general funds through the Rackham School of Graduate Studies, and research grants.

**6.2.1 Psychological Clinic** is located in East Hall on Central Campus. Seven psychologists (2.0 FTE), and 2 social workers (0.5 FTE), supervise 11 psychology and social work interns (5.5 FTE), and 4 post-doctoral fellows, who see patients for intermediate and long-term therapy. One consulting psychiatrist (0.1 FTE) and one clinical nurse specialist (0.1 FTE) are also on staff. Service hours are M-TH 8 AM – 9 PM, and F 8 AM – 6 PM. The Clinic frequently accepts referrals from CAPS and M-Care. The Clinic is easily accessible to people on campus, and a variety of insurance is accepted, including the two student policies with Chickering and Grad Care (excluding BCBS for counseling care). A sliding scale of fees is offered, with a minimum of \$28 per session. Approximately 370 patients per year are seen, composed of approximately 25% undergraduate students, 25% graduate

students, and 50% University staff and townspeople. After hours, an answering service will contact the clinician.

**6.2.2 University Center for the Child and the Family** is located both in East Hall on Central Campus and in a housing unit in the Family Housing on North Campus. Service hours are Monday through Thursday 8 AM to 9 PM, Friday 8 AM to 5PM. Staffing is 3.5 FTE supervising psychologists, social workers, and psychiatrist, and 7.0 FTE interns in psychology and social work. UCCF does not track UM student status. Nineteen Family Housing student families (students, spouses and children) were provided with 320 hours of child/family mental health service during the 2000-2001 academic year (subsidized by the Division of Student Affairs on a temporary basis). It is believed that the level of need for child/family mental health services in the families of international graduate students is considerably higher than this first year of subsidized service reflects.

### **6.3 University of Michigan Health System, Department of Psychiatry**

The University of Michigan Health System Department of Psychiatry has multiple, inter-related units: Psychiatric Emergency Services located next to the Emergency Department of UM Hospital; the Department of Psychiatry-Michigan Center for Diagnosis and Referral; the Riverview Outpatient Clinic; and the Chelsea-Arbor Substance Abuse Program.

#### **6.3.1 Department of Psychiatry: Psychiatric Emergency Services**

The Psychiatric Emergency Services (PES) is a joint program of the University of Michigan Department of Psychiatry and Washtenaw Community Health Organization (WCHO, Community Mental Health). Located in University Hospital, adjacent to the Emergency Medicine Department, it provides services 24 hours a day, 7 days a week, 365 days a year. Its clinical mission is to facilitate crisis resolution for individuals and their support system, with as little disruption to community functioning as possible. It provides evaluation, hospital screening, crisis intervention, and consultation services within the Hospital and community at large. The program provides educational training for medical students, residents in psychiatry, family practice residents, graduate social work and nursing students in Emergency Psychiatry. In FY 2001, PES evaluated nearly 5,000 persons and handled 100,000 mental health-related calls. No statistics are available with respect to PES usage by University of Michigan students. Staff include masters level-

trained psychiatric social workers, clinical nurse practitioners, and psychiatrists.

### **6.3.2 Department of Psychiatry: Michigan Center for Diagnosis and Referral (M-CDR)**

The M-CDR's main function is centralized intake into the UM Department of Psychiatry, via a call center. Other functions include serving as a managed behavioral health care organization for M-CARE members, including triage, referral and utilization management of mental health services. Many graduate students are covered by Grad Care, an M-CARE HMO product, and these students may utilize either CAPS, or go through the M-CDR to identify a mental health provider. This unit received 21,182 calls during the FY 00-01. During this same year, 1,715 adult appointments were arranged in the Department of Psychiatry. 20.5% of these appointments were made for individuals in the 19-25 year age group. Student status is not determined at intake.

### **6.3.3 Department of Psychiatry: Riverview**

Riverview Outpatient Psychiatric Clinic is currently located approximately one mile from the central campus area. It is staffed by psychiatrists, psychologists, social workers, and psychiatric house officers under supervision. All types of insurance are accepted, although Riverview does not participate in HMO's other than M-Care. This presents a barrier to some students requiring on-going care within the Department of Psychiatry. There is a sliding fee scale, as well as a visit limit, for those with limited resources and without insurance. While access for students is seen as a priority, no statistics specific to students are available. Careful attention is given to ensuring that appointments are made in a timely manner. Because of the strong psychiatric presence at this site, CAPS and UHS refer some patients who have complex management issues and needs for on-going therapy to Riverview. This clinic will be relocated in July, 2003 to a site off Plymouth Road near Huron Parkway and Commonwealth, and in 2005 to the East Ann Arbor Medical Campus. Both of these relocations will present transportation problems to students requiring this level of care.

### **6.3.4 Department of Psychiatry: Chelsea Arbor Addiction Treatment Center**

Chelsea Arbor Addiction Treatment Center is a joint program between The University of Michigan Department of Psychiatry, and Chelsea Community

Hospital, located in Ann Arbor at the corner of Eisenhower Parkway and Ann Arbor-Saline Road. There are specific programs for young adults (18-25 years). Most of the University students that enter care via court referral are there for education about substance use, if they are first time offenders, or for more formal treatment, if they are recurrent offenders. Approximately 30-40 students per year have used these services. Chelsea Arbor also offers a partial hospital program (during the day) and two intensive outpatient programs (one during the day and one in the evening) for severely-addicted patients that require rehabilitation (in last year, about five students were treated in that program). The program has a specific track for all health professionals and health professional students: Medical students, Nursing students, social work, pharmacy etc., working closely with the Michigan Health Professional Recovery Program (a monitoring agency hired by the State of Michigan). The program accepts all major insurance including Grad-Care and M-care, and are able to offer discounts of up to 15% of billable services for out-of-pocket treatment, if family income is lower than \$40,000 per year. The program also participates with the State of Michigan and the Washtenaw County referral agency for people without insurance who cannot afford outpatient treatment (inpatient rehab is not covered).

### **6.3.5 Department of Psychiatry: Medical Students**

The Medical School offers initial psychiatric evaluation, brief treatment, and referral for MD, MD/Ph.D., and Ph.D. students within the Medical School. This service is funded by the Medical School, but students are responsible for fees for longer-term care.

## **7.0 Information From Other Universities**

A comprehensive survey of other universities was beyond the scope of this group's resources and time. Pertinent data is available from the International Association of Counseling Services (IACS), which accredits university and college counseling services.

The IACS standard for provider student ratio is 1:1000 to 1:1500 full-time providers, excluding trainees. This ratio would be reduced, if there are additional campus resources available to students, as exist on the University of Michigan campus. The current provider-to-student ratio at Counseling and Psychological Services is 1:2375, representing 16 full-time counseling staff. CAPS also has two full-time, post-doctoral fellows and additional social work and masters-level trainees. As described in Section 5.0, the campus has substantial additional resources in various sites.

The study National Survey of Counseling Center Directors, 2001, compiled by Robert Gallagher and published by IACS, surveyed 250 college and university counseling services. The overall provider-to-student ratio was 1:1639, if all 250 sites are included. For schools with more than 15,000 students, the average provider-to-student ratio was 1:2116.

In this same study, only 54% of counseling services offer any walk-in hours available to students. CAPS offers walk-in hours for urgent problems during all service hours.

Visit limitations were also studied in this national survey. When considering schools with more than 15,000 students, 23% have a set limit of 6-10 visits; 28% have a limit of 11-15 visits; 8% have a limit of 16-20; 4.5% have no limit; and 36.5% have no predetermined limit, but counselors are encouraged to limit the number of on-going cases. At The University of Michigan, CAPS counselors have no predetermined visit limit, but, as in the latter category, are asked to limit their longer-term caseload.

This survey also looked at the number of hours of psychiatric consultants. Again, only looking at schools with more than 15,000 students, the average number of consultation hours per week is 33.6 hours. CAPS currently has 50 hours weekly of psychiatrist and psychiatric nurse practitioner coverage, while the University Health Service has a consulting psychiatrist six hours weekly.

No data are available from IACS or the Director's Survey, 2001, regarding counseling service outreach and training programs for students and faculty. Nevertheless, all accredited counseling centers are expected to do outreach to students, in the form of group sessions in residence halls and other venues. CAPS is invited to provide two to three such sessions each week during the Fall and Winter terms. With respect to faculty interactions, the CAPS staff are frequently involved in direct consultation with faculty, academic advisors, and administrators regarding individual students who have mental health issues that are affecting their behavior. There are currently no established training programs at The University for the faculty with respect to student mental health issues.

Limited telephone interviews were performed by work group members. Harvard University, Ohio State University, University of California, Berkeley, University of Wisconsin, Madison, and Yale University were selected either on the basis of a known characteristic that was of interest (e.g., Yale's withdrawal for mental health reasons policy) or because of expected similarities with The University of Michigan campus. Further systematic benchmarking is needed.

Harvard University has a unique, multi-layered and interconnected counseling and academic advising system. They have a ratio of providers-to-students of 1:1000. The Harvard system is integrated with the HMO that cares for faculty and staff. There is substantial use of community providers for on-going counseling.

Ohio State University reported that their Health Service Mental Health unit became part of the counseling center. This unit is the primary source of mental health services on campus.

University of California, Berkley, indicated that the Student Counseling Center and the Psychiatry Service are both housed in the University Health Service. The university has mandatory health insurance which assists students in obtaining off-campus care; however, there are long waits for on-campus psychiatric care, and the health service clinical staff of MD's and nurse practitioners supply much of the routine medication management for depression. The counseling staff plays an important role in a multidisciplinary team (BRAT – Behavior Risk Assessment Team) that helps to bring together relevant administrators, faculty, or staff, whenever multiple parties on campus are affected by aberrant student behaviors.

University of Wisconsin, Madison, reported that the health service and the counseling service were combined eight years ago. Each service has its own director, with an executive director of the combined program, who reports to the Vice Chancellor. There is one central access number for health and counseling services. Students are offered up to eight sessions. There are four outpost programs at residence halls, each staffed by a counselor who provides hours as needed.

At Yale University, the mental health clinic is housed in the University Health Service. Students who withdraw from classes should give a reason and, if for a mental health cause, are required to take two courses at a college or community college as a prerequisite for returning to Yale. Moreover, such students should have a treatment and care plan upon return to the University.

**8.0 Strengths, Weaknesses and Recommendations:** Mental health care is delivered to students in a variety of settings, each with specific characteristics, as noted in Section 6.0, above. The various agencies will need to identify specific actions that can be taken to deliver mental health care services with optimal service, communication and collaboration. The following analysis highlights many of these concepts.

### **8.1. Stigma of Mental Illness**

**8.1.1 Strengths and Weaknesses:** Members of the MHWG, along with students, and a wide cross-section of interviewed staff, concur that the stigmatization associated with mental illness constitutes a substantial barrier for students who might benefit from mental health care services. This is particularly powerful in the international student

community, where stigmatization is much more prevalent than is typically the case in our culture. CAPS currently provides 3-5 student oriented programs every week, designed to help destigmatize mental health problems and to offer preventive interventions designed to help students acquire new knowledge, skills and behaviors. Very few other resources have been focused on this until recently. In the past year, Dean Earl Lewis and Professor John Greden, in conjunction with Pat McCune, have produced an hour-long video focusing on depression. This video is to be shown widely on campus, with the intent of destigmatizing this illness. In addition, they are leading the effort to create an annual meeting on campus and in other venues, to promote awareness of depression for students, faculty and staff, as well as access to care resources.

**8.1.2 Recommendation:** A University-wide commitment to destigmatization of mental illness should be made, and an on-going program, utilizing contemporary public health strategies, should be instituted. Particular attention should be given to international students and other groups that are known to be more deeply affected by stigmatization. The group recommends that this should be managed by an additional staff person committed to organizing and promoting such programs, and should be endorsed and supported by the President, the Provost, and the Deans of the Schools and Colleges of the University. An additional recommendation is that a systematic process be created in which all mental health programs on campus participate in addressing the issues of stigmatization.

## **8.2 Prevention of Suicide and Harm**

**8.2.1 Strengths and Weaknesses:** The group was in agreement that creation of a climate of prevention for mental illness and its harmful consequences should be adopted as a long-term goal of the University. This concept has been explored through general outreach and training programs offered by the staff of CAPS, and in select subgroups of high-risk students, (such as the Korean student community, which has been thoughtfully reviewed by Dr. Daniel Pak). In addition, interventions have been made with residential educational programs and specific individual residents in University Housing, within the Division of Student Affairs. Prevention of harm has also been pursued by some academic advising units; however, it has not been previously discussed or implemented within the broad University community. In practical terms, an operational model of prevention identifies some target groups for “universal” interventions, and other target groups for

more “selective” interventions (Gordon, 1983). A selective intervention would target students who are at greater risk for suicide, such as students who have an alcohol problem, or international students who are failing academically. This approach to prevention seeks to alter the campus environment to protect individuals at increased risk, by enhancing wellness, building competencies, strengthening coping skills, increasing protective factors, and facilitating access to services.

**8.2.2 Recommendation:** Selective interventions for harm and suicide prevention should be identified and pursued for high-risk members of student communities, with special attention to identified risk factors such as alcohol usage, students with prior suicide attempts, and students from high-risk cultural groups. Model programs at other institutions should be considered.

**8.3 Access Issues:** Accessibility to mental health services has multiple determinants. It is a big step for a student to seek services, and impediments to access, however small, make it all too easy for students to rationalize their delay or inability in obtaining services.

### **8.3.1 Contacting a Mental Health Provider**

**8.3.1.1 Strengths and Weaknesses:** The current distributed system of mental health agencies presents both advantages and disadvantages to students. There are multiple sources of mental health care on campus, which can frequently be confusing and overwhelming. For a student in distress, finding the best place to enter the system is problematic. Moreover, interviews with students revealed that students prefer a variety of methods to access advice, depending upon their need for privacy versus their need for human contact. Information regarding how to make an appointment, hours of service, qualifications and backgrounds of counseling staff, appropriateness of the match for a student’s needs, and cost of care, is often not easily available to a student. There is currently no centralized location, phone number, or brochure for students to review these options. While most students are heavy users of the Internet, the UM home page does not have simple and direct access to a central web page for mental health problems. Once the CAPS web site has been identified, a student will find that it includes excellent web-based self-assessment tools for depression and anxiety, along with detailed information regarding CAPS services and access. During regular service hours,

students who contact CAPS may speak with a trained provider for assistance in discussing options for obtaining mental health care from University providers. There is no after-hours telephone coverage for students calling CAPS. Students calling the CAPS telephone line after hours are encouraged to use the Psychiatric Emergency Services 24-hour crisis number, if necessary. While such calls are currently handled by trained staff of the Psychiatric Emergency Services, they do not have the optimal, seamless orientation to students' needs and the available campus resources. Students may also make first contact with the on-call staff of SAPAC, who specialize in assisting victims of sexual assault. This service is available 24 hours a day, 7 day a week, and is staffed by professionals familiar with the wide range of University mental health resources available to students.

**8.3.1.2 Recommendations:** The group recommends establishment of a centralized web site which should include discussion of all campus mental health resources. This page should be directly accessible from an easily-identified link from the University Home Page. This web page should include links to crisis help, and to self-test materials similar to that on the CAPS web page, to assist students in determining the type of mental health problem they are experiencing, and the relative urgency of their obtaining help. In addition, because some students prefer talking to an individual, a person should also be available by telephone to give similar information and guidance. The group recommends the establishment of a 24-hour phone number where a student may obtain advice or direction for obtaining all types of mental health services. A single, centralized daytime and after-hours telephone line dedicated to student mental health needs should be investigated and considered for funding. It is also recommended that a paper map with color coding be created and made widely available to serve as a resource guide to the various mental health care facilities on campus, including services, fees, and hours.

### **8.3.2 Hours of Access**

**8.3.2.1 Strengths and Weaknesses:** CAPS currently offers regular weekday hours, 8 AM to 5 PM, and additional evening hours until 8 PM once weekly. UHS is available for urgent walk-in visits until 5:30 Monday-Thursday, until 4:30 Fridays, and Saturday 9-12. SAPAC hours are 8-5 Monday through Friday, with evening counseling hours by appointment only. Staff and volunteers are on

call 24 hours a day, 7 days a week, to answer the crisis line and handle emergency outreach requests. For CAPS, these hours are similar to other campuses, and appear to be adequate. For SAPAC, most campuses of similar size, do not have free standing units for assisting sexual violence survivors.

**8.3.2.2. Recommendations:** CAPS, UHS and other sites offering mental health care services should periodically survey patients to determine whether offered hours are adequate.

### 8.3.3 Staffing

**8.3.3.1 Strengths and Weaknesses:** Current staffing levels in CAPS are adequate to meet present demand for enrolled students. Furthermore, under present conditions, CAPS is constrained by lack of additional space. Waits for urgent evaluations are consistently less than one day. Waits for routine evaluations vary according to demand, but are between three and seven working days. It is anticipated that increasing awareness, destigmatization of mental illness, and improved awareness and training of faculty and staff will increase demand. In addition, certain high-risk groups, identified earlier, will require additional staff support. CAPS is currently committed to short term therapy. Current research suggests that intermediate term therapy of 10-20 sessions may be more effective in facilitating mental wellness. If the current paradigm were to be changed, this would entail additional staffing.

Staffing levels at UHS are adequate for meeting the medical needs of students, but there are currently long waits for consultation with the psychiatrist regarding psychopharmacologic management issues. The complexity of psychopharmacologic treatments exceeds the training of some of the primary care staff.

Staffing levels at SAPAC are currently insufficient. Initial evaluations and advocacy occur within one week of the student's call to set up an appointment. Volunteers are sent to emergency rooms, residence halls, police departments, or other campus offices, 24 hours a day, 7 days a week. SAPAC staff have a waiting list for ongoing student counseling related to sexual violence or assault.

Analysis of staffing levels at the other mental health care sites, as related to the care of students, is not possible due to insufficient data on student usage at sites other than CAPS and UHS.

**8.3.3.2 Recommendation:** Wait times at CAPS and SAPAC for urgent, routine, and medication evaluations, as relevant, should be monitored regularly, and additional staff added if standards are not met. All mental health agencies on campus should modify their data collection instruments, in order to monitor student usage, wait times and other parameters of access. This will facilitate data-driven decisions regarding staffing and funding decisions for the future.

### 8.3.4 Cost of Care

**8.3.4.1 Strengths and Weaknesses:** Students have no fees for visits to CAPS. CAPS is committed to short-term interventions and, while there are no absolute limits on visit frequency, most students do not exceed ten visits per semester. When on-going therapy is indicated, patients are referred out, at their own expense. The UHS has a semester student fee that includes unlimited visits, laboratory, and other services. SAPAC has no fees for any services. The other mental health care sites on- or off-campus have associated fees. University Center for the Child and Family was subsidized in past years to serve the international students living in family housing on North Campus; however, funding is no longer available for this group. Some, but not all, of these additional sites are able to take insurance reimbursement. Students at the University are not required to have health insurance. In 1999, approximately 5-10% of undergraduate students and 3% of graduate students do not have health insurance. A substantial portion of those who do have health insurance, have either out-of-area HMO or indemnity coverage, and these students do not have coverage for routine mental health care services in the Ann Arbor area.

**8.3.4.2 Recommendations:** Policies should be put in place to guarantee that all students have an appropriate level of mental health insurance coverage. This can be accomplished by making a condition for matriculation evidence by the student that there is insurance that will pay for care at UM, or require that the student purchase such insurance through UM. If such coverage is required for all students, this expense should be included in financial aid calculations and scholarships. This recommendation is currently scheduled to be pursued by the University Health Service in 2003-2004. In addition, consideration should be made for resuming

funding of special family services for international families on North Campus.

**8.4 Staff and Faculty Training to Facilitate Access:** In order to facilitate timely referral of students with mental health issues, it is necessary to have a well-informed academic and non-academic staff who are aware of mental illness, and who are able to recognize the early signs of mental health difficulties in their students. Similarly, every member of the campus community should be familiar with how students may obtain mental health care and counseling services and this information should be easily available.

**8.4.1 Strength and Weaknesses:** The University does not currently have a mental health training program or current guidelines for academic faculty, graduate student teaching assistants, or most University staff that come into frequent contact with students. Housing staff undergo substantial training designed to prepare residence hall advisors and hall administrators to recognize and refer students with mental health problems to appropriate resources. The Division of Student Affairs also offers limited staff development programs of a similar, but less comprehensive, nature. This includes both Counseling and Psychological Services and the Sexual Assault Prevention and Awareness program, both offering staff training programs upon request. Rackham Dean Earl Lewis, and Psychiatry Chairman, Professor John Greden are currently in the process of initiating programs for recognition of depression, which have included the production of a video on depression, and the creation of a March 2003 conference focused on depression amongst college students.

**8.4.2 Recommendation:** A systematic training program should be created and required for new and current faculty and staff who have contact with students. Revision of the handbook for academic faculty for handling and referring students with mental health issues is necessary, and has been discussed by the Academic Review Board. Both the training program and the handbook should include: the recognition of signs of mental distress; training of how to assist students to overcome the various psychological barriers to obtaining help; orientation to the various campus resources available to students on campus; the availability of special assistance from the office of Services for Students with Disabilities. Options for this recommendation include responsibility for such programming falling

under CAPS, the Provost's Office, or through an expansion of the work being done on depression by Dean Lewis and Dr. Greden.

**9.0 Referral and Use of Community Resources:** When the primary site of access must make a referral for emergency management, consultation, medication management, or on-going therapy, referral is made to other agencies or to private providers within the community. CAPS and SAPAC frequently refer patients, after appropriate assessment and/or intervention, for urgent or on-going therapy to one of the various options within the Department of Psychiatry, to the Psychological Clinic, the Center for Child and Family, or to a list of approved providers within the community. While there are general guidelines for interagency and private practice referrals, there are no formal procedures, forms, or protocols for referral of students between the various components of the mental health providers and agencies at the University. In the case of a severely distressed patient, where a referral is made to Psychiatric Emergency Services, there is telephone communication prior to the referral, and follow-up with PES by telephone. In the case of a very distressed patient, assistance in arranging a visit to CAPS or transportation to PES is supplied. After routine referrals, CAPS providers will often ask the patient to return for one additional visit after completing the first referral visit, in order to be sure that the patient is getting the necessary help.

At UHS, routine follow-up visits for patients placed on medication are the standard of practice. Arranging for UHS follow-up visits after making a routine referral for counseling are left to the judgment of the UHS provider. The UHS clinical staff may use a referral form to refer some patients to CAPS or private providers, but staff more commonly give the student only verbal instructions and telephone numbers regarding contacts. The UHS provider is not usually notified that a patient has completed contact with the mental health provider, unless special effort or contact has been made in the initial referral process. Patients report that, when referred to community providers, it is sometimes difficult to get an appointment. This appears to be especially true for referrals to psychiatrists and to select individuals with special expertise in fields such as eating disorders.

Referral and follow-up of students from PES or the psychiatric inpatient unit, to the campus sites or to community providers, is also informal in nature and dependent upon the care provider and the perceived requirements of the situation. While some aspects of this have improved in recent years, there are significant opportunities for improvement.

**9.1 Strengths and Weaknesses:** There are a variety of mental health resources available to students, both on and off campus. The variety and great number of providers should allow quicker access to on-going therapy and referral care. There appears to be good protection of patient privacy and confidentiality within the referral process, but this high level of attention to confidentiality may impair the referral process in some instances. Because there is no formal organization to follow-up care, such care may be incomplete. In addition, there are no access expectations for any agency or individual who may provide follow-up care, creating a situation where a patient may be referred to an outside provider, but may not be seen in a timely manner. There are no formal feedback mechanisms from either the provider or the individual accepting the referral. Moreover, there is a lack of adequate processes to insure coordination between University providers, to allow forwarding of information and/or feedback when appropriate, and no mechanism to ensure that the referral has been completed and that the student has been seen by the person to whom they were referred. In addition, there are no formal protocols in place for referrals between campus mental health care organizations.

**9.2 Recommendations:** The group recommends that there needs to be a formal mechanism for referral and information sharing between the UM agencies providing mental health care for students. This policy needs to ensure that communication will occur between the referring provider and the referred-to provider, and that care is managed in a coordinated manner. An additional recommendation is that a list of providers in the community who are willing to facilitate and ensure access to students for follow-up care should be developed. These providers need to be willing to: provide urgent, as well as routine, access; to provide information regarding follow-up to the referring individual or agency; to meet regularly (possibly biannually) with UM personnel to evaluate and refine the community referral process; to see students for reduced fees, if the situation warrants; and to agree (if the student agrees) to provide UM with documentation of the student's continued attendance at sessions, should the University deem this as necessary.

**10.0 Communications Regarding Students:** Confidentiality for patients seeing mental health care providers is governed primarily by the State of Michigan Mental Health Code, and the federal Health Insurance Portability and Accountability Act (HIPAA). Both of these sets of laws provide a high degree of privacy (regarding their records) for patients who are emancipated minors or who are 18 years of age or older. These rules require specific release and

permission for a health care provider to communicate, discuss, share, or even access a patient's medical information. The Family Educational Rights and Privacy Act (FERPA) protects documents, but not verbal communications, giving students protection, rights, and privacy regarding access to documents related to their education and university experiences. The "need to know" provision of FERPA for University officials may be interpreted broadly in the context of a student in distress. There is also an exception to the FERPA privacy provisions for health or safety emergencies.

Open communication between the treating mental health provider, the family, relevant faculty, and relevant housing staff may, in appropriate circumstances, optimize a student's care and safety. However, it is common for the student to not permit such interactions, for fear of stigmatization, loss of independence, and loss of respect by members of their community or faculty. Without such permission, with the rare exception of very profound emergencies entailing significant risk of harm to self or others, or involving child abuse, the mental health care provider may not, in compliance with State of Michigan laws, violate this privacy requirement. Despite such legal constraints, in circumstances where it is recognized that the safety of a student with mental health issues is in serious jeopardy, communication with the parent or guardian may take place, without permission of the student. This typically will occur when it is deemed appropriate by the therapist, in consultation with administration and/or legal counsel. The benefits of violating the student's privacy must be carefully weighed against the potential damage this will do to trust within the therapeutic relationship that has been established with the health care provider. Non-health care staff at the University, such as residence hall staff, academic advisors, and faculty, are not restricted by these laws, and may communicate amongst themselves and to mental health professionals regarding concerns about a student.

**10.1 Strengths and Weaknesses:** The relevant laws give substantial flexibility to the management of a student in crisis. However, the student's wishes and rights for privacy and confidentiality may impair communication between the mental health care provider and relevant staff and faculty. In circumstances when the student's life is in danger, the General Counsel's Office has been available to discuss and approve necessary options.

**10.2 Recommendations:** In order to improve communication between providers, and between providers and relevant administrators, it is recommended that a standard release form be created and used diligently by all of the mental health providers, medical providers, and administrators when referring or communicating regarding students with

mental health issues. In particular, this should include communications with the Dean of Students Office, Academic Advising units, and faculty.

## **11.0 Withdrawal and Re-matriculation Policy**

**11.1 Strengths and Weaknesses:** Approval for withdrawal from the University after a student has enrolled and initiated a semester is processed through academic advising. If withdrawal is due to a mental health reason, and the withdrawal is late in the term, the academic advisor may require a mental health care provider attestation as to the need for withdrawal. There is no requirement that this be reviewed by CAPS, the Dean of Students, or the Vice-President of the Division of Student Affairs. Re-enrollment after a mental health absence is also not subject to review by CAPS, the Dean of Students or the Vice-President. The absence of such a re-matriculation review permits students who may not yet be capable or ready to return to campus, or who have not arranged on-going care, to return to the University without adequate support. The committee believes that both of these situations (at the time of withdrawal and re-matriculation) present serious gaps in caring for the student with mental health issues. (See Appendix E for a draft of the re-matriculation policy.) While there are a few schools and colleges at The University of Michigan that have similar policies in place, the absence of relatively uniform guidelines creates inconsistencies and vulnerabilities in the handling of students with mental illness.

**11.2 Recommendations:** (a) Data should be collected on the incidence of mental health issues as cause for withdrawal from the University. From these data, and through exploration of policies at other comparable universities, recommendations should be made regarding any policies requiring mental health evaluation or approval for such a withdrawal.

(b) Re-enrollment for a student who has withdrawn due to mental health issues should be reviewed in accordance with a campus policy that assures the student's ability to cope both academically and socially upon their return to campus. This review should provide assurance that the individual will be obtaining appropriate on-going care and, when necessary, medication. (c) The draft Mental Health Withdrawal Policy and Procedures (see Appendix E), which applies to students when their behavior demonstrates a direct threat of harm to self or others, or the student's behavior is disruptive, should be adopted as a formal policy. (d) The University should develop a comprehensive withdrawal and re-matriculation policy for absences due to mental health reasons, including an evaluation of the readiness of the student to return to the

University, and an assessment of their support system upon return. Alternatively, similar policies should be mandated for, and developed by, each of the schools and colleges of the University.

**12.0 Mental Health Organizational Structure:** The availability of multiple agencies on campus provides a wide array of psychological and psychiatric services for students. The system currently divides the mental health providers into three separate units: CAPS, UHS, and SAPAC within the Division of Student Affairs; the Psychological Clinic and the University Center for Child and Family within the Institute for Human Adjustment; and Psychiatric Emergency Services, Riverview, Chelsea Arbor Substance Abuse Program and the Medical Student Counseling Program, all within the Department of Psychiatry.

**12.1 Strengths and Weaknesses:** The various mental health services on campus were established over time, in different settings, and to serve different purposes. When it comes to student mental health, they share a common purpose to provide the best possible care for students. However, the diversity and independence of the campus mental health services compromises some aspects of this effort, particularly the need for coordination of care between the units. In addition, there are many other units and services in the University that do or could identify and make referrals for individual students' mental health problems. These include University Housing, the International Center, Services for Students with Disabilities, and academic advising units. There is no office or individual responsible for promoting the coordination of student mental health care among these mental health services, or among the mental health services and the other units that serve students on campus.

**12.2 Recommendations:** The MHWG believes that coordination of care among campus units and services concerned with student mental health is a most important goal. The fact that the campus services are independent and diverse means that a strong effort to enlist these units in a cooperative effort to coordinate their care of students is needed. We recommend that a job role be defined in the Division of Student Affairs, with the responsibility for promoting the coordination of student mental health care among campus units and services concerned with student mental health. The MHWG recommends that this individual representing the Division of Student Affairs work to establish a formally organized student mental health coordination group, whose mission would be to create and maintain optimal coordination of care for students. We recommend that the group meet frequently at the outset to address the issues raised in this report, and, once policies and procedures are established, we recommend that the group continue to meet at least quarterly. This group should consider carefully how best to address the various problems in coordinating mental health care for students; an early and urgent task is to develop effective methods of communication and feedback among the mental health providers responsible for student mental health care on campus. We recommend that the coordination group be broadly-based, with a mandate to create working subgroups as needed, to address particular issues. The group should include campus mental health services (e.g., CAPS, SAPAC, PES, UHS, IHA etc.); other campus units with significant roles in detecting students' mental health issues, guiding students to appropriate care, and managing mental health risk factors such as University Housing, the International Center, Services for Students with Disabilities, major academic advising units such as LS&A and Engineering; the Campus Coordinator for Alcohol and Other Drugs; and representatives of other important campus constituencies

that have a strong interest and role in coordination of care, such as graduate and undergraduate students and faculty members.

## APPENDIX A

### DEFINITIONS OF MENTAL HEALTH

#### Executive Summary

- **Definition:**

For the purposes of the University of Michigan Mental Health Work Group and its charge the definition of Mental Health and Mental Illness will be defined with the University population in mind. Mental Illness and Mental Health are the opposite ends of a continuum that extends from total mental health to severe mental illness. Along this continuum are individuals who are functioning well or those with minimal difficulties to those individuals with moderate or extreme difficulties. The resources currently available at the University of Michigan provide services to the entire spectrum of individuals, from short-term treatment to referral for long-term out-patient or in-patient services.

- **Mental health** is the state in which individuals feel comfortable about their life situation. Mentally healthy individuals are able to achieve a reasonable balance among multiple expectations so as (1) to live in a manner in which their behavior is not in conflict with either their associates, society, or their own expectations and (2) to grow and to adapt to new experiences or situations in order to continuously improve and, by so doing, reach their own inherent potential. These individuals are free from any clinically significant behavioral and/or psychological syndromes or patterns typically associated with either distressing symptoms or impairments of function. This includes (but is not limited to) being free from alcohol and drug abuse, difficulties in dealing with sexual orientation issues, difficulty in controlling anger, and relationship issues including violence towards self and others and physical and sexual abuse. (See appendices for additional definitions)
- Mental Illness is a broad range of mental and emotional conditions that refers collectively to all mental disorders. Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning. Often they involve feelings of anxiety, depression and confusion. All individuals experience these feelings on some occasions. With mental illness however, these feelings are present to such an extent or for such a long time, that coping with everyday life is difficult or impossible.

- **Issues for Prevention:**

- Should the UM have a mental health/mental wellness philosophy of the University of Michigan? Which aspects on the continuum, from helping people move from great distress to less distress, will be targeted. What are the resources committed to this endeavor?

- Vulnerabilities unique to this particular population.
- Protective factors for this population.
- Multiple entries to access mental health services.
- Availability of Mental Health Information.
- Education re. availability of services to Department Chairs, Support Staff, and Students.
- **Recommendations:**
  - Student member on future Committee.
  - Definition of Mental Wellness philosophy.
  - Central Access to Mental Health and Medical Services.
  - Define and publicize availability of services.
  - Educational program regarding the identification/recognition of the need for mental health services.
  - Educational program for Faculty, Staff, and Students regarding the availability of services and their location.

## APPENDIX B

### STUDENT MENTAL WELLNESS PHILOSOPHY

Overall Aim: The University of Michigan aims to assist its students in achieving successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity (1).

Role of Mental Health Services: The University aims to assist students in reaching these goals with accessible, expert mental health services as needed.

6.0 From the Surgeon General's Definition of Mental health, in Mental Health: A Report of the Surgeon General. <http://www.surgeongeneral.gov/library/mentalhealth/home.html>

Prepared by Robert L. Hatcher, Ph.D. Approved April 23, 2002 by the MHWG

## APPENDIX C

### LITERATURE REVIEW

Among the most important and demanding challenges facing any college or university is preserving and enhancing the mental and physical health of students. The challenge from the increasing numbers of students with serious mental illness is of inescapable importance. While this review addresses many dimensions of mental health, including stigmatization, prevention, and provision of mental health care services on the college campus, suicide receives special emphasis because it may be the most preventable outcome of a student's mental illness.

#### **The Size of the Mental Health Problem on Campus**

Suicide is one of the many tragic consequences of mental illness, and adolescents and young adults are among the most vulnerable and susceptible. Indeed, more adolescents and young adults die from suicide than from all medical illness combined (Center for Disease Control, 1995). Over the course of a single year, 1 in 12 United States college students make a suicide plan, and 1.5 percent attempt suicide—approximately, 1,200 student suicides per year. College-age students consider suicide more often than any other age group (American College Health Association, 2001; Barrios, et al., 2000; Silverman, et al., 1997; Pruett, 1990).

For Americans between the ages of 15 and 24, suicide is the third leading cause of death, and suicide is the second leading cause of death for college students. About 7 of every 100,000 college students per year die from suicide, but this average figure masks the fact that some institutions have rates at least three times as high (Barrios, et al., 2000; Silverman, et al., 1997; Center for Disease Control, 1995; Pruett, 1990).

Mirroring these facts, college counseling services report increases in the number of suicidal students. For example, Kansas State University has experienced a three-fold increase in the number of suicidal students between 1989 and 2001 (Benton, et al., 2003). Similarly, the national suicide rate for adolescents has increased three-fold over the past 60 years (Center for Disease Control, 1995).

However alarming is the tragedy of suicide, many, many more college students are damaged by alcohol and substances, and students are disabled by severe depression, manic depressive disorders, psychotic disorders, anxiety states and other mental illnesses. About one in three Americans has a diagnosable mental illness (Kessler, 1994). In a single year, college-age students are more likely to experience mental illness than are other age groups (Morwsky & Ross, 1999); this is because many mental illnesses become symptomatic during these years. Moreover, all the mental disorders that are prevalent among college students are risk factors for suicide. For example, feelings and thoughts about suicide are combined usually with symptoms of depression and feelings of hopelessness.

Increasing numbers of college students with serious depression are going to university counseling services. Kansas State University found a linear increase and a doubling of the number of students seen with depression for the 13-year period ending with 2001. Concurrently, the number of students with more complex and severe mental health problems increased (Benton, et al, 2003). Persons with an active mental disorder have about a 7 to 10 times increased risk for suicide. Due to known forms of under-counting, this figure underestimates the true risk (Tanney, 2000). For college-age students, alcohol is the major risk factor for suicide, and alcohol

is or will be a problem for as many as one in ten college students (Rivinus, 1993). *Alcohol is the strongest single predictor of subsequent completed suicides* (Beck & Steer, 1989).

No national data exists to quantify numerous anecdotal accounts of increases mental health services demand on the part of college students. Nevertheless, the fact that so many college students have or are at risk for having a mental disorder explains why several institutions have reported a significant increase in the use of counseling services (Berger, 2002). Columbia University reports a 40 percent increase since the 1994-95 academic year. Over the same period, the Massachusetts Institute of Technology (M.I.T.) reported a 50 percent increase in the use by students of mental health services and a 69 percent increase in student psychiatric hospitalizations. This high hospitalization rate is attributed to the growing number of students with severe mental illness. The State University of New York at Purchase reports a 48 percent increase over the last three years (Berger, 2002).

## **A Comprehensive Prevention Paradigm**

Because the burden of mental illness is so common among college-age students, it is essential that detection, treatment and prevention programs be more proactive than reactive. Any one tragedy may compel a redoubling of our efforts to prevent any similar tragedy; however, any prevention program needs to be nested within an overall paradigm with much more comprehensive goals. The goal of prevention must consider any single tragedy within a thoughtfully considered framework of mental health services having the necessary means to incorporate risk reduction and problem prevention strategies across the expanse of mental health issues that are so prevalent among college-age students.

To illustrate the need for a comprehensive prevention paradigm, consider the tragedy of suicide. Suicidal behavior results from both long- and short-term predisposing and precipitating circumstances. For example, suicidal behavior might well be the outcome for a perfectionist student with self-perceived academic under-performance and associated clinical depression; the student then "self-medicates" with excessive alcohol and has interpersonal conflicts leading to the ending of a relationship. In this context, the mechanisms producing self-destructive behavior are more universal in nature, and prevention programs must consider a wide range of responsive services. To make this example more complex (but equally realistic), consider another result: Reckless, impulsive behavior resulting in a motor vehicle accident and associated injuries. Because of the relationships between suicides and accidents, The Centers for Disease Control and Prevention now sub-divides injuries into one of two classes: unintentional injuries (e.g., accidents) and intentional injuries (e.g., suicides) (Centers for Disease Control and Prevention, 1994).

An operational model of prevention identifies some target groups for "universal" interventions and other target groups for more "selective" interventions (Gordon, 1983). Improving easy access to mental health and counseling services is an example of a universal intervention. A selective intervention would target students who are at greater risk for suicide; for example, students who have an alcohol problem. This approach to prevention seeks to alter the campus environment to protect individuals at risk by, for example, enhancing wellness, building competencies, strengthening coping skills, increasing protective factors, and facilitating access to services. A complementary approach seeks to provide suicide postvention to help the survivors of suicide and to minimize suicide imitation (Maris, et al., 2000).

More traditional, and often less successful, approaches to prevention make use of education and information. Prevention via education attempts to persuade students to change their behavior (e.g., avoid alcohol). The education-based approach needs to have sustained and

frequent messages that attend to the force of countervailing messages (e.g., alcohol use is glamorized). Maintaining an educational approach is a high-effort, expensive and time-consuming endeavor that may produce limited gains (Maris, et al., 2000).

In 1999, the U.S. Public Health Service issued the *Surgeon General's Call to Action*, which is the first step in establishing a national strategy for suicide prevention that is based on a comprehensive prevention paradigm. In 2001, another major step produced *The National Strategy for Suicide Prevention* that gives a specific framework for taking action. These action plans contain 15 key recommendations categorized under the following three major headings:

- Awareness: Appropriately broaden the public's awareness of suicide and its risk factors.
- Intervention: Enhance services and programs, both population-based and clinical care.
- Methodology: Advance the science of suicide prevention.

Without much difficulty, these strategies for prevention may be applied to campus communities.

## **Stigmatization of Mental Illness: An Impediment to Prevention and Treatment**

"When my depression was first diagnosed, I felt both relief and shame—relief that my condition had a name, and possibly a cure; shame that I was afflicted with a mental disorder. I still felt that I should have been able to rise above it, to use my will to overcome it on my own, and that my inability to do so was proof of my weak nature. I kept the diagnosis and my condition a secret from all but my husband and family at first." These words from Kathy Cronkite typify societal stigmatization of mental illness in general, and major depression in particular. Kathy Cronkite is Walter's daughter; in her book, *On the Edge of Darkness: Conversations about Conquering Depression*, celebrities tell about their experiences of depression and stigma.

Stigma is the major impediment to strategies aimed at the prevention and treatment of mental illness. Of course, stigma is not unique to mental illness; issues of stereotyping prejudice and labeling are features of all chronic illnesses (Saylor, 2002; Goffman, 1963). So what's so different about mental health? Depression, for example, is considered a character flaw—your body is fine, it's your personality that is weak. Your identity is spoiled. Those who have achieved and been successful have much to lose by disclosing their stigmatized mental disorder. In *Telling is Risky Business*, Otto Wahl summarizes what patients have to say about their personal experiences of stigmatization. This book is the result of a year-long, nationwide study of over 1,300 survivors of mental illness. *Telling is Risky Business* eloquently describes the double burden of mental illness—disability and stigmatization. Stigmatization plays itself out in all health care provision systems. For example, primary care physicians point to patient attitudes and beliefs about depression as the major barrier to diagnosis and initiating treatment (Nutting, 2002).

Founded in 1979, NAMI, the National Alliance for the Mentally Ill, was among the first advocacy group to be formed. The National Stigma Clearinghouse; the Carter Center Mental Health Program; DBSA, Depression and Bipolar Support Alliance; NMHA, the National Mental Health Association Program; the National Empowerment Center; the National Mental Health Consumers Self-Help Clearinghouse; and GAMIAN, Global Alliance of Mental Illness Advocacy Networks are national resources that fight stigma and advocate strongly for the mentally ill. Agencies of national and state government are involved as well. All of these organizations contribute to the fight against stigmatization, the provision of equitable and fair services, and to

the prevention and treatment of depression and mental illnesses, in general. Surely, some of the methods used by these organizations are applicable to a campus community.

## **Challenges of Providing Mental Health Services to Asian College Students**

The provision of mental health services to students of Asian descent is complicated, because Asian and Western perspectives differ considerably. Asians comprise numerous and diverse cultures. Accordingly, understanding the unique needs of any one Asian student requires a dialogue about the student's perspective. Stereotypical thinking interferes with this discussion. For example, Daniel Pak (2002) pinpoints the common perception that students of Asian descent are highly successful and go on to achieve economic successes, making Asians a "model minority." Pak asserts that the "model minority" stereotype is both unfounded and is probably the single most important factor contributing to and sustaining institutional gaps in services for the many Asian students who may not conform to the model. The widespread belief that Asians deny depressed feelings and experience depression in terms of physical symptoms (Rack, 1982) is another mistaken stereotype. Recent research finds no differences in the ways Asians and Americans report the experience of depression in primary care settings (Simon, 1999).

However, compared to Western patient populations, numerous studies have found that Asians tend to visit mental health professionals at much lower rates (Hsu, 1999; Waza, 1999). This may stem from distinct differences in values. In general, Asian cultures emphasize the stable, harmonious integrity of the family network. This strong emphasis tends to discourage the admission of deficits that may reflect poorly on the entire family. For example, a daughter's mental illness may make her less likely to marry and may bring disgrace to the family business (Furnham, 1994; Parekh, 2002). Even when an Asian patient is diagnosed as having a mental illness, there is a high likelihood of non-adherence to treatment recommendations (Kirmayer, 2001; Parekh, 2002).

Japan serves as one illustration of these issues. New antidepressants, like Prozac, that have been available for well over a decade in the United States are now just being introduced in Japan. Because the Japanese perception of depression is so negative, until most recently pharmaceutical companies have not even tried to market antidepressants in Japan (Landers, 2002).

## **Organization and Provision of Health, Mental Health, and Counseling Services**

### *Access to Care and Appointments*

*Every member of the campus community must be familiar with how students go about obtaining mental health and counseling services, and this information must be easily available (Machenhoupt, 2000). As a first step, students with stress reactions, substance use/abuse and/or symptoms of a mental disorder may reach out to other students, work-study supervisors, departmental secretaries, coaches, faculty, teaching assistants, and others (Machenhoupt, 2000; Pruett, 1990). Because of this form of case identification, all members of the campus community must know the route for students to take to access mental health and counseling services.*

When students are afflicted with symptoms of stress and/or mental illness, they must have ready access to care. It is a big step for a student to seek services; impediments, however small, to access make it all too easy for students to rationalize their delay in obtaining services. *A major*

*impediment is multiple routes to mental health services and no central access point.* Accordingly, a campus community needs to have one or two central access points such as: (1) Counseling and Mental Health Services and (2) the Campus Infirmary (Machenhoupt, 2000).

It is the responsibility of counseling and mental health personnel to become visible to students (Machenhoupt, 2000). “Invisible” clinicians are another impediment to access. In this regard, Harvard University is developing a “face book” of mental health and counseling professionals. The “face book” provides students with information about professional specialties and even some personal data – all in an effort to make mental health and counseling services more accessible (Provost’s Committee on Student Mental Health Services, 1999).

Work at Harvard (Provost’s Committee on Student Mental Health Services, 1999) concludes that accessibility is not just about location. Harvard’s Provost’s Committee identifies the following reasons that make counseling and mental health services somewhat inaccessible to students: (1) Insufficient focus on the needs and issues relevant to students; (2) Unavailable appointments, especially during demand peaks such as midterms and final exams; (3) No evening and weekend appointments; and (4) Untrained and insensitive receptionists who work in situations where conversations can be easily overheard. According to one study, almost 50 percent of college- and university-based student counseling centers had significant waiting lists during the school term (Witchel, 1991). During times of peak demand mental health services personnel should be prepared to work extra hours (Machenhoupt, 2000).

Both the availability of appointment time and the expense of services are impediments to access. The Massachusetts Institute of Technology (M.I.T.) has recently announced plans to overhaul that institution’s mental health services provision system and, thereby, attack the impediments of lengthy waits for appointments and the associated expenses (Berger, 2002). M.I.T. has been associated with one of the highest rates of student suicide in the United States. Perhaps in response to a highly publicized suicide and surely motivated by the growing need for services, M.I.T. plans to extend appointment hours, provide 100 percent insurance coverage for off-campus services, and develop an education and outreach program. The education and outreach program will be designed to make students seeking service more comfortable using the campus mental health services provision system.

### *Referral*

There are many situations requiring rapid access to services, but members of the campus community fail to recognize and to respond to students who exhibit symptoms of mental illness. For example, “norm violations” may be one of the first signs of trouble. The student is behaving in ways that are distinctly not the pattern of other students. When a student’s behavior is part of a long-term profile of unusual behavior, concern is unjustified, generally. However, relatively sudden and significant changes in an established pattern of behavior may be one of the first warnings of a student in trouble (Monahan, 1992). Where does a member of the campus community turn when confronted by situations like this? Some institutions use the Internet and their Home Page to place easy-to-find information and guidance about identifying, interacting, assisting, and referring at-risk students (Machenhoupt, 2000).

### *Confidentiality*

The confidentiality of mental health services records raises a number of difficult issues for any single facility. At any major university there may be several semi-autonomous facilities providing services. While the principle of confidentiality is easily recognized, the practical, day-

to-day delivery of services by several mental health services facilities creates problematic tensions.

Among the many considerations, consider the following: Referrals between and among facilities and providers must be tracked, if for no other reason than to be certain the student made it to his/her referral appointment. Mental health services providers desire to maintain continuity of care by sharing information. Difficult student behaviors, discipline, performance, and associated interruptions in attendance motivate requests for release of selected information to deans, committees, and faculty. In these situations, do students really have a choice about giving consent? Voice-mail, e-mail and related technologies present a related set of issues. Aware of these problems, some students will avoid seeking mental health services until their symptoms are too severe to be ignored.

Because of these issues, James Archer, Jr., and Stewart Cooper suggest the following guidelines (1998) that are duplicated below:

1. Maintain copies of applicable state laws and ethical codes as part of the center's operating procedures. Hold regular training sessions with staff and reception personnel and discuss cases and problems that have arisen.
2. Include a clear and honest statement about the limits of confidentiality in the informed-consent form all clients sign.
3. Inform members of the university community about confidentiality and maintain a unified approach when asked for information.
4. Develop a standard consultation process with the director or a senior clinician for questionable cases.
5. Maintain a close liaison with the college or university attorney and ensure that he or she understands the applicable law and the ethics codes.
6. Help clients understand the importance of feedback to referral resources and, unless inappropriate, encourage them to sign a release allowing appropriate feedback.

#### *Withdrawal and Re-entry*

Students with mental and substance-use disorders may fail to meet academic standards and/or may exhibit disruptive behaviors that violate institutional codes of conduct. Such students may be asked to withdraw from school, and institutions have a set of procedures to accomplish this. Re-entry is another matter. There appears to be no "standard practices" literature specifically relevant to re-entry. However, there are numerous practical issues of which the following is a sample. Students may re-enter and remain in some form of treatment. If treatment was provided in the student's home community, treatment may need to continue when the student returns, and there needs to be an institutional process to ensure continuity of care and to minimize risk of adverse events. Assessment procedures need to be in place to determine if the student is ready to return. All too often, students wish to return before they are ready because they are under intense pressure from their families and/or they want to escape being sick (Gift & Southwick, 1988).

When the student does return there may need to be various forms of *reasonable* accommodation. The Americans with Disabilities Act and Section 504 of the Rehabilitation Act of

1973 apply to accommodating students with psychiatric disabilities (Flygare, 2000). Accommodations may, for example, lengthen the time permitted to complete a degree requirement (Flygare, 2000).

## **Functional Mergers to Make a Unified Organization**

The relationships between and among facilities providing mental health and health services is most often the result of historical, funding and cost considerations. The organization of health services in colleges and universities require a clear vision of how mental health services can be provided best on campus (Drum, 1998). Drum asserts that “functional mergers” are most desirable and effective. A comprehensive realignment of the means of coordination and contractual relationships encourages a more integrated health and mental health care provision system under the leadership of an overall administrator who has campus health and mental health services as his or her primary job. Such realignment does not mean a loss of identities; on the contrary, a “functional merger” permits current units to maintain their unique campus roles and identities.

## **General Recommendations for Addressing Suicidal Behaviors and Mental Health on Campus**

Responding to *The National Strategy for Suicide Prevention* (2001), the National Mental Health Association and the Jed Foundation convened a panel of leading experts to specifically address the issues of suicidal behaviors on the college campus. The products of this expert panel are contained in *Safeguarding Your Students Against Suicide* (2002). These proceedings produced recommendations and general implementation strategies pertaining to 12 essential services for addressing suicidal behaviors on campus. Hereafter, each recommendation category is listed.

- Screening program(s)
- Targeted educational programs for faculty, coaches, clergy, and student/resident advisors
- Broad-based, campus-wide public education
- Educational programs and materials for parents and families
- On-site counseling center with appropriately trained providers
- On-site medical services
- Stress-reduction programs
- Non-clinical student support network
- Off-campus referrals, if available
- Emergency services
- Postvention programs
- Medical leave policies

## **Specific Programs for Reducing Suicidal Behaviors and Improving Mental Health on Campus**

Most commonly, suicide prevention is nested within systems for the provision of health and mental health services. For example, a program to diminish the use of alcohol and drugs on campus is of substantial general value and, concurrently, this sort of program serves to undermine one of the factors predisposing to suicide. Reducing access barriers to health and mental health services by means of a single, well-advertised, after-hours telephone number increases the likelihood that students with depression (and at risk for suicide) will receive

professional services. This form of prevention is based on motivating students (and their parents) to voluntarily seek services. Because these types of prevention efforts are components of large systems of care with multiple objectives, their specific effects on reducing baseline suicide rates are difficult to measure.

The University of Illinois has the most successful and longest running (1984 to present) organized program with the explicit purpose of reducing the baseline suicide rate among its enrolled students. During 18 years of operation, the Suicide Prevention Program's activities are reported to have produced a 55.4% reduction in the comparative baseline suicide rate (Joffe, 2003).

The administrative support for the program stems from the University of Illinois' policy pertaining to withdrawal due to psychiatric problems. This policy establishes continued attendance as a privilege granted as long as the student's behavior conforms to explicitly-stated standards of conduct. A suicide threat or attempt is evidence of a breach of the standard for self-welfare and self-care. By so doing, the University of Illinois policy makes deviations in self-care behaviors a disciplinary concern. This route may avoid the immediate application of the Americans with Disabilities Act of 1990 and the Section 504 of the Rehabilitation Act of 1973 (Gotkin, 2003).

Assertions about suicide behavior and/or intent are reported to the Suicide Prevention Team that has the authority to mandate the student's attendance as four sessions of professional assessment. Adherence is monitored closely. During the presentation of the University of Illinois Suicide Prevention Program at the February, 2003, Annual Law & Higher Education Conference, Paul Joffe, a clinical psychologist and program representative, asserted the Suicide Prevention Program "adheres to all laws regarding confidentiality." Moreover, "by focusing on standard of conduct and applying it uniformly to all students, the University of Illinois program works in accordance with the Americans with Disabilities Act of 1990."

(NOTE: Whether or not and/or to what extent an institution of higher education should insist students receive certain health and mental health services and take upon itself policing adherence are considerations beyond the scope of this review.)

## Conclusion

There is one common theme that runs across all the publications mentioned in this literature review and all the recommendations made by national organizations – *the problem of suicide and mental health on campus is of crisis proportions*. The task for every college and university is to take the information that is easily available and combine this information with specific knowledge about the unique institutional features and produce and implement comprehensive strategy for addressing the crisis of suicidal behaviors and mental health on campus. In this environment, colleges and universities have two missions at which they must excel – provide an excellent education and prevent death from suicide and disability from mental illness. Of course, exclusive focus on suicide ignores the vast bulk of students who have mental illness but never have suicidal behaviors. The lives of all students are improved by a campus-wide, comprehensive mental health care provision system that includes the overarching goals of eradicating stigmatization and fostering prevention.

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The following sources were used extensively. Although "cosmetic" changes have been made to the texts, many of the central themes are derived from these sources.

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The National Mental Health Association & The Jed Foundation. (2002). *Safeguarding Your Students Against Suicide*. These organizations convened an expert panel and this publication contains the proceedings. The 12 categories of recommendations all have an explicit discussion of specifics and actions. The proceeding may be downloaded from: <http://www.nmha.org/suicide/index.cfm>.

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## APPENDIX D

### **MENTAL HEALTH CARE ORGANIZATION AND FOLLOW-UP**

This subgroup report combines the subgroup of “Mental Health Care Organization” (Larsen & Silk) with the subgroup “Follow-Up” (Sevig & Silk). The reason why this is combined is because it is our belief that the organization of mental health services as it currently exists and perhaps as it might be reorganized directly impacts upon how referral (self or other) and follow-up is currently practiced and how, under a new organization, it might be facilitated in a more optimal fashion.

**Current Organization:** Currently there is little formal organization of mental health care at The University of Michigan (UM). While there may be a great deal of organization within any given segment of mental health care at UM, there is limited coordination across different “agencies” or programs or departments. The following “organizations” are involved in providing mental health care at UM.

A. **Department of Psychiatry:** Most of its activities are located within the medical campus which is directly adjacent to, but not part of, the main UM campus. The Department of Psychiatry does not have any programs that are organized to serve students except through a part-time clinical nurse specialist and a part-time psychiatrist who provide medication evaluations, management and follow up to Counseling & Psychological Services (CAPS). The Department of Psychiatry also provides a consulting psychiatrist for less than one full day to University Health Services (UHS).

The Department of Psychiatry runs or maintains

1. Psychiatric Emergency Services (PES), a 24 hour emergency psychiatry service located next to the Emergency Department of University Hospital (UH) and run conjointly with Washtenaw Community Health Organization (WCHO, Community Mental Health).
2. Ambulatory outpatient services for both adolescents (currently at the medical center but soon to move out to Commonwealth Avenue which is about one mile north and one mile east of the most northeastern part of the North Campus of UM) and adults (currently located about 1/3 mile north of the main medical campus but within 3 years to be located one mile north and 3 miles east of the most northeastern part of the North Campus of UM). These ambulatory services provide a full range of psychiatric services including psychotherapy and psychopharmacology but they do not have specific programs for eating disorders or substance abuse). Social workers, psychologists and psychiatrists (both staff/faculty and trainees) provide services.
3. Substance abuse services are located at Briarwood which is about 2 miles south of the most southern part of UM main campus.

B. **Institute for Human Adjustment:** The Institute of Human Adjustment (IHA) is an affiliated unit of the Rackham School of Graduate Studies. Within IHA are the Psychological Clinic (PC) and the University Center for the Child and the Family (UCCF). Both PC and UCCF serve the University community and the public, and both are training sites for graduate students in clinical psychology and social work. There are part-time psychiatric services provided at each venue, but the sites primarily train graduate students in a variety of psychotherapeutic interventions. .

C. Division of Student Affairs: Both Counseling and Psychological Services (CAPS) and University Health Service (UHS) fall under the Office of Student Services. CAPS provides a wide array of counseling and psychological services (individual, group, family) to UM students, and psychiatric consultation and evaluation is available. CAPS works closely with UHS although UHS does not set itself forth as a mental health resource. Rather, UHS is a general medical facility for staff and students of UM, and patients who present with a need for psychiatric or psychological services may be evaluated there but are often referred out to one of the above resources within UM.

Strengths of the Current System:

- The current system provides a wide array of psychological and/or psychiatric services to students at UM. There are individual and group and family treatments available at a number of "sites", and there are outreach services available especially through UCCF and CAPS that make contact with the International Center, academic advisors, TA's and RA's.
- There are provisions, especially through CAPS, for students to receive care regardless of their ability to pay.
- Psychiatric care is available at each site even though the psychiatric care may be on consultative basis and is not full - time.
- Access to this care, except perhaps for some limitations imposed by insurance restrictions, is usually readily available.
- Emergency services are available through Psychiatric Emergency Services 24 hours a day.
- Clinicians are on call for each of the agencies.

Weaknesses of the System:

- The system is divided into at least 3 separate systems, the psychiatry department, IHA (PC, UCCF), and the Division of Student Affairs (CAPS, UHS), and there is little formal coordination among the systems. Existing coordination is informal and funding is separate for each of the 3 systems.
- Not all students who wish to utilize services have the insurance coverage that would allow such utilization. The UM has no policy that guarantees that the insurance product with which a student arrives at UM (if any) will pay for any or all types of treatment (both medical and mental health) in Ann Arbor. UM has no policy that all students should be insured.
- There is no formal structure or policy re coordination between the various mental health care agencies within the UM.
- There is no central intake number for a student to call where the student would be directed to the most appropriate site for care.
- There is no formal method to refer a student from one site of care to another
- There is no overall director or committee that oversees the care or the coordination of care to UM students.

## **Follow-Up**

The lack of formal organization and coordination among the various sites where mental health care is delivered translates directly into problems with follow-up of care. Structural and insurance coverage problems create barriers to an effective follow-up process. There is no formal method to pass information among or between sites or agencies, and there is no method of "feedback" to know whether a student referred, either to an agency within UM or to a provider in the community, arrived at that provider referred to. At present, follow-up is "spotty" and there

is no formal cohort of providers in the community who have been identified as individuals who are available to provide follow-up, rapid access to that follow-up, and feedback to the referring agency and perhaps to student services should the situation call for such feedback.

Follow-up is not simply a matter of picking up a telephone and speaking with someone on the other end. Factors such as insurance coverage, need for concurrent psychotropic medication, easy access to facilities that would be willing to hospitalize the student, and other “back-up” support or access to back-up support services come into play.

There is much richness and talent within the mental health services provided at UM, but lack of coordination and integration fail to allow us to mine the richness of those resources. In addition, there is talent and richness as well among the providers in the community, but the informal way we have of referring patients to them, the varied expectations a given referral might have for them, and the lack of organized feedback prevents us from taking full advantage of those talents.

#### Strengths of the Current System:

- There are a variety of mental health services both within UM and in the community available to students and to providers for follow-up care.
- There is protection of information or at least the impression of confidentiality when providers of follow-up care are mental health professionals outside UM.
- There is the ability to achieve quicker access to follow-up care by having a variety of sites as well as an unlimited number of community providers for follow-up care.

#### **Weaknesses of the Current System**

- There is no formal organization to follow-up care, causing follow-up care that can be incomplete; a student can be referred to a UM provider or a community provider with no explicit expectations in either situation.
- There are no access expectancies of any agency or individual providing follow-up care.
- There are no formal feedback mechanisms from the provider being referred to back to the provider making the referral.
- There is a lack of adequate processes to insure coordination between UM providers to allow regular forwarding of information and/or feedback of information when appropriate; i.e., when a referral is made, there is no mechanism to insure that the referral has been completed and that the student has arrived at and been seen by the provider referred to.

#### Recommendations:

- The UM needs to have some overarching structure of student mental health care. This overarching structure can be in the form of a single individual or a committee. Whatever the shape of the structure, it should provide
  - Clear, formal and logical guidelines as to how the various agencies and sites at UM that currently provide care can be more efficiently organized and more formally integrated. This integration may not need to include loss of local autonomy but must include formal arrangements and agreements among the various agencies that clearly outline these agencies’ relationships in the provision of mental health care.
  - Consideration of more integration between the current mental health services if no formal structure is developed. There need to be formal mechanisms wherein students who move from one care site to another care site can be assured that information will move between

sites and that feedback will occur between the sites to insure that the care continues in a coordinated fashion.

- Policies must be developed and put in place to guarantee that no student will be denied care or follow-up care because of lack of appropriate insurance coverage. This can be accomplished by making a condition for matriculation evidence by the student or the student's family that there is insurance that will pay for care at the UM; or require that students who do not meet the above criteria purchase some insurance through UM; or by UM insuring that it will reimburse a pre-determined negotiated amount for a limited number of appointments for care to each agency that provides care to a student.
- Implementation of a central phone number that can help facilitate referral to appropriate follow-up care.
- Development of a list of providers in the community who are willing to insure access to students for follow-up care when that care is needed. These providers need to be willing
  - to provide urgent as well as regular access
  - to provide information back to a central UM site that oversees follow-up (if appropriate)
  - to meet regularly with UM personnel (perhaps biannually) to evaluate and refine the community referral processes
  - to see students for a reduced fee if the financial situation of the student calls for such a fee reduction
  - to agree (if the student agrees) to provide UM with documentation of the student's continued attendance at sessions should UM deem that necessary.

N.B.: Most of the policies and procedures and changes discussed here, if a decision is made to implement them, are designed to help the student with significant difficulty functioning in the University setting. Most students are certainly organized and resourceful enough to negotiate the current structure of mental health care as provided currently at UM, though adopting some of these principles will ultimately be helpful to all users of mental health care.

A similar statement can be made with regard to follow-up. Most students are capable of taking a referral and following up with that referral as he or she wishes, and the need to know whether the student has actually made it to the referral is not important or necessary for UM or any of its agencies to know. It is only when there is at least moderate to severe mental illness that such policies need to be implemented, but such policies can only be implemented if they are in place.

APPENDIX E

**DRAFT, WITHDRAWAL POLICY AND PROCEDURES**  
**Drafted by a Committee of the Division of Student Affairs**

**NOTE: THIS POLICY AND RELATED PROCEDURES HAVE NOT YET BEEN APPROVED.**

I. POLICY

A. *The University of Michigan Regents' Bylaw 2.01* and the *Code of Student Conduct* authorize the President of the University and Vice President for Student Affairs respectively to remove a student from the University. In addition to disciplinary action that may be taken under other University policies and procedures, the University reserves the right to request or require students to withdraw from the University for reasons pertaining to mental or physical health when the student's behavior is a direct threat of harm to themselves or others or when a student's mental or physical health-related behavior significantly disrupts the ability of other students, faculty or staff to participate in the educational programs or employment opportunities offered by the University. This policy does not supplant any academic performance or discipline based withdrawal or dismissal policies maintained by academic units.

B. Students who withdraw or are withdrawn from the University by the Vice President for Student Affairs or designee pursuant to this policy may be considered for readmission following a determination by the Vice President for Student Affairs or designee that the behaviors requiring withdrawal are, for the most part, eliminated. The determination of readmission is made in conjunction with the Mental and Physical Health Advisory Team (Team) which will be appointed by the Vice President for Student Affairs or designee in accordance with the needs of each individual case. In making the determination on readmission, the Team will consider information from campus professionals and relevant material submitted by the petitioning student.

II. PROCEDURES

A. Emergency Interim Withdrawal

1. If, for reasons pertaining to mental or physical health, a student's behavior poses an immediate and direct threat to themselves or others, the Vice President or designee may withdraw the student or restrict the student's access to the university campus, university housing, services, and activities, as appropriate, for an interim period before a final determination of the matter.
2. Every attempt will be made by the Vice President for Student Affairs or designee to meet with the student before deciding on an interim withdrawal of the student. If the student is to be withdrawn the decision will be communicated in writing to the student, the Dean of the student's academic unit, and other units as appropriate.
3. The emergency withdrawal or restricted access will remain in effect until a final decision has been made pursuant to the procedures below, unless, before a final decision is made, the Vice

President or designee determines that the reasons for imposing the interim withdrawal no longer exist.

## B. Withdrawal

A withdrawal may be considered when the University has substantial evidence that:

- a student's behavior demonstrates a direct threat of harm to self or others;
- or the student's behavior significantly disrupts the ability of other students, faculty or staff to participate in the educational programs or employment opportunities offered by the University.

An individual wishing to explore the appropriateness of a withdrawal or wanting to initiate a withdrawal should contact the Office of the Vice President for Student Affairs. When circumstances merit, the Vice President for Student Affairs or designee will:

- arrange for an appropriate review process to include receiving, investigating, and examining appropriate records and documentation;
- provide an opportunity for the student to meet with the Vice President or designee to discuss the withdrawal; and
- document the findings of the review process and any relevant recommendations.

The student may be restricted from campus and/or University services and activities during a voluntary or involuntary withdrawal period. The student will receive written notice of the withdrawal as well as the conditions for readmission.

### 1. Voluntary Withdrawal

If the student is eligible for and wishes to pursue voluntary withdrawal, the Vice President for Student Affairs or designee will:

- counsel the student regarding voluntary withdrawal;
- consult with the student's academic unit and other units as appropriate;
- discuss the circumstances with the student's family, as appropriate;
- refer the student to appropriate resources for evaluation or treatment; and
- initiate voluntary withdrawal.

### 2. Involuntary Withdrawal

If the student does not voluntarily withdraw, the Vice President for Student Affairs or designee will:

- consult with the Mental and Physical Health Advisory Team. Members of the team will often include representatives from the Office of the Vice President and General Counsel, Office of the Dean of the student's academic unit, University Housing, Health Services, Counseling and Psychological Services, Dean of Students and Public Safety. Other members can be added at the discretion of the Vice President;
- contact the student's parents, if appropriate;
- if appropriate, initiate the involuntary withdrawal process and advise policy adjudicators in the University community with regard to the student's capacity to participate in academic or nonacademic reviews of the student's conduct.

## C. Readmission

1. A student removed from the University under this policy may be considered for readmission only with the written approval of the Vice President for Student Affairs or designee, and if eligible, based on the student's academic record, in accord with the readmission policies and practices of the student's academic unit.
2. A student wishing to be considered for readmission should contact the Vice President for Student Affairs or designee according to the written conditions for readmission and provide appropriate documentation of behavioral change, and resolution of the initial problem, including compliance with the conditions of readmission.
3. The Vice President for Student Affairs or designee will:
  - consult with the Mental and Physical Health Advisory Team;
  - consult with the student's academic unit;
  - contact the student's parents, if appropriate;
  - receive, investigate, and examine relevant documentation;
  - provide an opportunity for the student to meet with the Vice President or designee to discuss readmission;
  - if appropriate, initiate the readmission process, provide the student with written conditions for continued attendance and inform any relevant policy adjudicators of the student's readmission; or
  - deny the student's request for readmission and specify when and if the next request for readmission will be considered and notify the student's academic unit and other units as appropriate of the decision regarding readmission.

#### D. Effect on Academic Status

In the event of a withdrawal pursuant to this policy, a notation of withdrawal will appear on the student's transcript for all classes taken during that semester. All tuition paid for courses not completed during the term in which the withdrawal occurred will be refunded.

#### E. Effect on Housing Status

If the student has been living in the residence halls and will not continue to do so, the contract will be canceled and fees refunded on a pro-rated basis.