The State of Student Mental Health on College and University Campuses with a Specific Assessment of the University of Minnesota, Twin Cities Campus

The Provost's Committee on Student Mental Health

Executive Summary

At its February 11, 2016 meeting, the interdisciplinary University of Minnesota Provost's Committee on Student Mental Health (PCSMH) was presented with two documents advocating for increased mental health services including the 1) Minnesota Student Association Spring 2016 Mental Health Proposal and 2) Council on Graduate Students resolution on the topic of Reasonable Access to Campus Mental Health Services. These documents were simultaneously presented to the Office for Student Affairs and University Relations. The PCSMH felt that more assessment of the state of campus mental health nationwide and the Twin Cities campus specifically, as well as possible approaches to address these issues, was necessary to better inform the University administration about its options to address unmet needs on campus. It is to this purpose that this report has been produced.

Findings

1. Mental illness and unmanaged stress are barriers to academic success.
2. Mental illness and unmanaged stress is present in a significant portion of our student population.
3. The literature on preventive measures for mental health is extremely limited whereas the literature on clinical interventions has a strong foundation.
4. Access to clinical care is the most pressing mental health issue on campus.
    a. The current demand for clinical services for mental health on campus exceeds the current capacity of mental health providers.
    b. The demand for mental health services has steadily increased and is expected to continue to increase based on current trends.
    c. Lack of access to mental health services has the potential to result in missed opportunities to identify, intervene, and prevent suicide, a leading medical cause of death for University of Minnesota students
    d. Increasing clinical services will require significant increased financial support either through new revenue streams or the shifting of existing financial resources.
    e. Although demands on clinical services could be decreased in the future through additional preventive measures, policy, and environmental change, these will not address the acute need for increased clinical capacity.
5. The University of Minnesota, Twin Cities (UMNTC) has one of the most comprehensive public-health approaches to mental health, yet those efforts are insufficient to reduce the need for clinical care.

Recommendations

The primary recommendation is to increase the University's capacity to meet the acute and increasing demand for mental health services.

1. Increase access to mental health clinical services on campus:
    a. Increase clinical staff on campus by 8 full time employees (FTEs) (4 at Boynton Health and 4 at Student Counseling Services) to address current demand, and proactively hire additional staff each year to address data driven anticipated growth in demand.
    b. Develop additional strategies involving students to expand diversity in mental health staff and to recruit therapists that represent underserved student populations.
    c. Streamline services to increase the number of access points for mental health care and to provide students with better direction to appropriate services. In addition to the work completed to accomplish this to date, a One-Stop model should be adopted to help with streamlining.
    d. Improve the patient intake process by adopting a brief consultation/access consultation model at Boynton Health (BH). This model, already being used by Student Counseling Services (SCS), allows patients to be seen on the same day as requested or within 48 hours.
    e. Expand the use of psychology graduate students at peak demand times. BH is planning to pursue a solution that SCS has found to be very helpful for the variability of demands for services during the course of the school year.
    f. Do not further restrict the number of allowable therapy sessions. BH and SCS are using a short-term therapy model of approximately 10 visits plus an intake visit per year. Although further reducing the number of allotted visits could provide some additional services to new students, the adjustment would limit the potential effectiveness of the therapy that students currently receive.
    g. Do not increase service to address all outpatient mental health needs of students. The limited-session model was adopted to increase access and is the standard across U.S. college campuses. Considering the University is located in a highly mental-health-resourced community, expanding outpatient programming and dropping the limited-session model would not be resource-appropriate for the University.
2. Leverage the availability of community therapists.
    a. Increase networking with community therapists to increase capacity for referrals by 50 percent. The University of Minnesota is fortunate to be in a large urban setting with associated mental health resources. More students could be seen in therapy if the campus increased referral into the community, particularly when it is evident that presenting issues will require more services than is allowed for in a limited-session model. This would require students to be seen outside of the Student Services Fees and SCS model and they may be required to pay co-pays and/or deductibles.
    b. Examine the impact on the Student Health Benefit Plan if benefits were enhanced for services provided off campus. Although the current benefit structure is the most

economical for students on campus, the structure creates a barrier to referrals into the community. Treatment received outside of Boynton and SCS is covered at 80 percent instead of 100 percent.

3. Implement departmental funding strategies that maximize payments from third-party payers. Mental health services across campus are funded through a variety of mechanisms. Boynton receives over 60% of its funding to cover mental health costs through third party health insurance reimbursement, with the remainder of revenue coming from student service fees. Other departments should examine the possibility of a similar funding model.
4. Continue to increase the focus on prevention and early intervention. Expand existing programs and create new programs and incentives for students to practice self-care through wellness programs, recreation, and healthy living habits. Based on limited available research, it is reasonable to focus resources on efforts that will reduce stress levels among students and enhance the community capacity to reduce the impact of mental illness on campus.
5. Evaluate opportunities for academic policy, programmatic, and cultural changes that would support student mental health.
    a. Establish positive mental health (flourishing) as a developmental outcome goal for all University students.
    b. Encourage academic departments and faculty to redesign their courses and programs in ways that would create better paced workload without compromising content.
    c. Increase faculty and advisor capacity to address student mental health. Students who receive support from staff and faculty tend to be more successful.
    d. Consider policies and practices that allow for students to practice self-care (e.g., fall break that is parallel to spring break, incentivizing self-care for student insurance benefits similar to employee benefits).
6. Increase data collection pertaining to mental health on campus by financing the University's participation in the national Healthy Minds Study. Include funding for incentives to increase student participation and for a graduate assistant or post-doctoral position to assist with data evaluation.

Background

Increased Demand for Services

During the past decade the University of Minnesota, Twin Cities has experienced consistently increasing demands for mental health services (detailed below), which is consistent with national trends (Voelker, 2003). This increase in demand can be attributed to a combination of influences: increased prevalence of mental illness in adolescents and young adults, high levels of stress (especially financial and academic stress), and increased matriculation of students with mental illness who may not have previously entered college. In addition, campaigns to reduce the stigma of mental health problems and treatment,

community training to identify and refer students in distress, and actions to reduce financial and other barriers to service, have played a role in increasing demands for clinical services.

Mental Disorders Prevalence in College Students

The PCSMH has chosen to focus this report on the two most frequent mental disorders in our students —anxiety and depression— as well as the most severe consequence, suicide, in order to contain the length of the report. In addition, data on stress are also presented, as excessive stress can be a contributing factor and/or product of mental illness. This focus should not be construed as ignoring the importance of other conditions experienced by students such as bipolar disorder, schizophrenia, attention deficit disorder, eating disorders, and alcohol and drug use disorders. One study (Blanco et al., 2008) found a 12-month prevalence of 46% for mental disorders in college students when substance-use disorders, personality disorders, depressive disorders, anxiety disorders, bipolar disorder, attention deficit disorder, eating disorders, and schizophrenia were included.

Several multi-campus surveys document the prevalence of mental health problems of students on U.S. college and university campuses. These surveys consistently document depression and anxiety as the two leading mental health challenges.

Depression, Anxiety, Stress

The 2015 American College Health Association Survey (American College Health Association, 2015) revealed that one in five college students had been diagnosed with depression at some time during their lifetime. Within the previous 12 months of the survey, 13% of students reported having been diagnosed or treated for depression, and 16% had been diagnosed or treated for anxiety. Panic attacks were reported as having occurred in 7% of students. In addition, students reported high rates of negative emotions and thoughts within the previous 12 months, including feeling overwhelmed (86%), emotional exhaustion (82%), very sad (64%), very lonely (59%), overwhelming anxiety (57%), hopelessness (48%), and overwhelming anger (38%). Over a third (35%) reported that they had felt so depressed that it was difficult to function. In the same study, 54% of students reported higher-than-average stress. One-fifth of these students rating their stress as “tremendous,” 37% reported average stress, and 9% of students reported no or less-than-average stress.

The Healthy Minds Study (Healthy Minds Network, 2016) surveys students on campuses throughout the country using questions from standardized assessment instruments that incorporate criteria from the *Diagnostic and Statistical Manual* of the American Psychiatric Association (American Psychiatric Association, 2000). The survey attempts to identify students who are likely to have a mental disorder, whether or not they had been evaluated by a professional. The 2015 survey of over 16,000 students suggested that 35% of college students meet the criteria for at least one mental disorder in the prior 12 months. Moderate or more severe depression was present in one-fifth (20%) of students and 12% met criteria for major depression (two weeks or more of significant depression or loss of usual interests associated

with additional physiological and cognitive symptoms). One-fifth (20%) of students met criteria for anxiety, with 40% of these meeting criteria for severe anxiety. Of interest, 61% of those meeting criteria for a mental disorder were not receiving any treatment.

The UMNTC participated in the 2012 Healthy Minds Survey. At the time, one-fourth (26%) of our students were identified as likely meeting criteria for a mental disorder, with 15% of our students meeting criteria for depression (moderate or major), and 7% meeting criteria for major depression. Anxiety disorders (panic disorder or generalized anxiety disorder) were reported in 8% of students at the time of the survey. Of note, of those students with a positive screen for depression or anxiety, only 41% were receiving treatment (therapy or medication). In addition, compared to other surveyed schools, the University of Minnesota scored statistically lower on ability to schedule appointments without long delays.

The University of Minnesota's Student Health Survey (SHS) provides data specific to the Twin Cities Campus (Boynton Health Service, 2015). The survey includes questions about student mental health, alcohol and drug use, tobacco use, personal safety, financial health, nutrition, physical activity, sexual health, health insurance, and health care utilization. The 2015 SHS was sent to 5,940 randomly selected UMNTC students. Surveys were completed by 2,023 students (33.9% response rate) of whom 54.9% were undergraduates, 31.6% were masters, doctorate, or professional students, 0.2% were non-degree seeking, and 12.6% did not indicate their academic status. The SHS survey does not derive diagnoses from standardized instruments, but instead relies on students' reports of having been diagnosed with specific mental disorders. It can be assumed that these numbers underestimate the true rate of mental health disorders, given that a student would have had to be seen by a health care provider to report having been formerly diagnosed. Research has consistently revealed that a significant number of students who deal with mental health problems are not currently in a clinician's care. Nonetheless, one third of UMNTC students (33%) reported a lifetime diagnosis of a mental disorder, with 15% of students reporting a diagnosis of a mental disorder within the last 12 months. The lifetime rate of depression was 21%, and 8% of students reported a diagnosis of depression within the last 12 months. Likewise, 22% of University of Minnesota students reported a lifetime diagnosis of anxiety and 10% of students reported having received a diagnosis of anxiety within the last 12 months. Over half (56%) of students diagnosed with a mental disorder reported that the disorder negatively impacted their academics (Boynton Health Service, 2015).

Graduate and professional students are also at risk for mental illness, and face unique challenges compared to undergraduate students. These challenges include an increased risk for social isolation, as well as real and perceived consequences of stigma when working closely with faculty whose recommendations are crucial for career advancement or when working in an "apprentice professional" role. Nearly half of the graduate students (44.7%) surveyed by Hyun, Quinn, Madon & Lustig (2006), reported having an emotional or stress-related problem in the past year, and over half of the respondents (57.7%) reported a colleague with a similar problem. A survey of law students across 15 law schools (not including the University of Minnesota), found that 17% of law students screened positive for depression, 23% screened positive for mild to moderate anxiety, and 14% screened positive for severe anxiety (Organ,

Jaffe, Bender, 2015). Similarly, 44% of international graduate students are experiencing a stress- or emotion-related problem affecting their health and wellbeing (Hyun, Quinn, Madon, & Lustig, 2007).

Additional data are available regarding those students who present for help at student counseling services. The Association for University and College Counseling Center Directors (AUCCCD) Survey is sent to the directors of counseling services on campuses throughout the United States, and documents the issues for which students present for care. The 2014 survey revealed that the following issues and characteristics were presenting concerns for students, who have presented with more than one issue: anxiety (47.4%), depression (39.8%), relationship issues (33.7%), taking psychiatric medications (25.2%), suicidal thoughts and behaviors (18.2%), extensive or significant prior treatment histories (14.8%), self-injurious behavior (12.1%), alcohol abuse/dependence (10.7%), learning disability (9.5%), attention deficit disorder (9.5%), sexual/physical assault or acquaintance rape (9.2%), substance abuse/dependence other than alcohol (8.0%), eating disorders (7.8%), issues of oppression (e.g. racism, sexism, homophobia) (6.7%), and being stalked (2.5%) (Reetz, D., Krylowicz, B., & Mistler, B., 2014). These figures demonstrate that college- and University- student counseling services deal with significant mental illnesses in addition to student development issues. The AUCCCD study demonstrated that one quarter of students seeking care are already on or are prescribed psychiatric medication, nearly one-fifth are dealing with suicidality, and 15% already have a history of extensive treatment.

The AUCCCD survey also asks about waitlists for services. For large campuses similar to the University of Minnesota, Twin Cities (enrollment greater than 35,000) counseling centers enacted wait lists for an average of 18 weeks per year. Because it is highly unlikely that wait lists exist during summer months, this suggests that on average, wait lists are in place for 46% of the academic year September-May. The mean maximum number of students on a wait list during that time was reported to be 61 students. The University of Minnesota, Twin Cities experience with waitlists is detailed under the heading Waitlists below and in the appendix.

Suicide

Suicide is the second leading cause of death in college students (Wilcox et al., 2010) and most students who commit suicide have major mental illness (Czyz, Horwitz, Eisenberg, Kramer, & King, 2013). The above referenced 2015 ACHA survey revealed that 9% of student respondents had seriously considered committing suicide in the previous 12 months and that 1.4% acknowledged having attempted suicide. The 2015 Healthy Minds study revealed similar findings, with 10% of students reporting having seriously considered suicide, 3% having made a suicide plan, and 1% having made a suicide attempt.

Extrapolating data from the Healthy Minds Study to the current enrollment of 38,000 fee-paying students at the UMNTC would suggest that 3,800 students will have experienced thoughts of suicide in the last 12 months and that 380 students will have attempted suicide. The University of Minnesota 2012 Healthy Minds Survey found that 6.0% of UMNTC students had experienced suicidal ideation, 2.0% had made a suicide plan, and 0.5% had attempted suicide. These numbers may not apply to the current state of our campus given that rates of

reported suicidal ideation in the Healthy Minds study have been increasing from 6% in 2007 to the current rate of 10% in 2015.

The 2015 University of Minnesota Student Health Survey (SHS) found that 0.8% of University students reported an attempted suicide in the last 12 months. Extrapolating this figure to UMNTC campus enrollment suggests that 304 students likely **attempted suicide** in the last year. Fortunately, the majority of suicide attempts do not result in death. However, the UMNTC has lost two to six students to suicide in each of the last five academic years, for a total of 18 students. This represents 26% of all student deaths (which include accidents/injuries, physical illness, homicide, and unknown causes). There have already been two documented suicides for students in academic year 2015-2016.

All members of the University of Minnesota Police Department (UMPD) are trained to respond to mental health crisis situations that frequently involve suicidal ideation and transport to emergency rooms for additional assessment for safety reasons. These interventions have been steadily increasing. There were 93 mental health interventions between 02/01/2015 and 01/31/2016, representing a 43% increase from the same period just two years earlier.

Stress

Stress is a major factor in the development and persistence of mental health problems. Stress in itself is not bad and indeed is necessary for motivation, skill development, and academic success. However, high levels of stress, particularly in those who may be vulnerable due to historical circumstances and/or genetic predisposition, can result in significant morbidity. The 2015 UMN Student Health Survey (SHS; Boynton Health Service, 2015) revealed that the most common stressors reported by UMN students on the Twin Cities Campus in the prior 12 months were roommate/housemate conflict (19.1%), the death of someone close (15.6%), termination of a personal relationship (excludes marriage) (15.3%), a serious illness in someone close (13.7%), parental conflict (12.6%), and excessive debt (excludes credit card debt) (11.4%).

Stressful events are more challenging when compounded by others. One or two of these stressors have been experienced by 41.6% of UMN-TC students within the last year, and 18.4% report having experienced three or more stressors. An association appears to exist between the number of reported stressors and risk-taking behaviors (tobacco use, high risk drinking, marijuana use, credit card debt).

The 2015 SHS survey also derives a measure of how students handle stress. Inability to manage stress was reported in 34.7% of students. There also appears to be an association between unmanaged stress and higher rates of diagnosis of acute conditions and various mental health conditions (anxiety, panic attacks, social anxiety, and depression). On the positive side, 65.3% of students report that they are able to manage their stress.

The 2015 SHS added questions regarding a history of adverse childhood experiences (ACES). These experiences include someone in their household who was incarcerated, abusive or addicted to drugs. Over one quarter (27.6%) of students reported that before the age of 18 they had lived with someone who was depressed, mentally ill, or suicidal. Approximately 40% of

University students identified two or more ACES before the age of 18. This provides additional support for the claim that students are coming to campus having already dealt with mental health issues, if not in themselves, in family members. Childhood adverse experiences are known to be correlated with higher rates of mental illness, unintended pregnancy, sleep difficulties, financial difficulties, days of illness, relationship difficulties, and acute and chronic illnesses.

Academic Impact

University of Minnesota students are accepted to the University because they have demonstrated the competencies needed to succeed in their program. Students' difficulties are often due to factors not directly related to academic ability, but instead they struggle with issues related to health, and particularly mental health. The 2015 SHS report on Health and Academic Impact identified health factors associated with negative academic impact. Mental health conditions are strongly associated with lower grade point averages (GPA). These conditions include depression, anxiety, PTSD, and other serious diagnoses. In addition, lower GPAs are associated with multiple stressors, the inability to manage stress, sleep difficulties, days ill due to mental health difficulties, and other symptoms related to mental health.

Critical health and academic disparities can be seen in students with disabilities, students who identify as gay, lesbian or bi-sexual, and students who identify as transgender. National data have repeatedly identified the differences in social determinants of health and mental health among traditionally underserved populations. Mental health diagnosis rates are almost double in some of these populations, and the need for mental health resources is of even greater concern, given that education attainment is one of the most important social determinants of health and longevity, income, and overall health.

Excessive stress and mental illness impact academic performance. An examination of students leaving during the fall semester of 2015 revealed that 13% had been seen in Boynton Health's Mental Health Clinic. It is unclear how many additional students may have been receiving mental health services at SCS or off campus. Over one third (232 of 603) of tuition-refund requests for 2015 were for mental health issues.

Additional information specific to the Twin Cities campus comes from the Fall 2014 survey of 3,073 Graduate Students in which 51% of respondents answered affirmatively to the question: *Have you experienced incidences of stress, anxiety or other mental health ailments while being a graduate/professional student in your current degree program that have made it difficult to complete your work, take care of things at home, or get along with other people?*

Flourishing

Although the focus of this report is on evidence for mental health needs of students, it is important to note that at least half of students appear to have positive mental health. According to the 2015 Healthy Minds study, 53% of students met criteria for flourishing, which was defined as positive mental health (Healthy Minds Network, 2016). Almost half (47%) of University students indicated positive mental health on the Healthy Minds study flourishing

scale in 2012. This still indicates that one in two students are not flourishing. Flourishing would be a reasonable developmental outcome to which to aspire for all college students.

UMNTC Campus Service Demands

Mental health services are primarily provided at two locations, Boynton Health and Student Counseling Services. Both locations have witnessed a consistent increase in demand for services. It is likely that the increased demand for services reflects both an increase in mental illness diagnoses along with the effects of stigma-reduction campaigns, greater awareness of mental health on campus, and faculty, staff, and student intervention training.

Over the past twelve years, the Mental Health Clinic at Boynton has experienced an increase in demand for services unlike any other clinical area of the health service. The total number of visits increased by 66% from approximately 9,500 visits in fiscal year (FY) 04-05 to nearly 16,000 visits in FY 14-15. The number of students treated each year also increased by 66% from 2,056 in FY 04-05 to 3,429 in FY 14-15. Increases have been consistent although variable. For example, unique patients seen during fall semester increased by only 1% in FY 12-13 but increased by 12.5%, 11.6%, and 5.9% in the subsequent three years. The corresponding numbers for increase in total visits was 7.3%, 10.5%, 20.3%, and 1.9%. These numbers are limited by capacity, with large increases corresponding with increased FTEs in those years.

Over the past 10 years Student Counseling Services (SCS) experienced a 33% increase in counseling sessions attended, (from 5,492 in FY 06-07 to 7,299 in FY 14-15) and a 24% increase in the number of students served (1,322 in FY 06-07 to 1,640 in FY 14-15). Reflecting a service-delivery model change, SCS increased group counseling offerings from 32 groups in FY 06-07 to 50 in FY 14-15 and experienced a corresponding 65% increase in clients attending group counseling (163 for FY 06-07 vs. 269 in FY 14-15). SCS refers approximately 20% of personal counseling clients to Boynton Health for medication evaluations. SCS policy does not allow students to receive simultaneous personal counseling at both the Boynton Mental Health Clinic and SCS, but these students can be seen at SCS for academic skills or career counseling.

Boynton and SCS have steadily increased resources to address increased demands. Boynton Mental Health Clinic FTE providers increased from 12.5 to 20 between 2011 and 2015, representing a 60% increase in clinical staff over four years. Likewise, SCS has increased the number of service providers to its current high of 18.0 FTEs. Direct service is also provided at SCS by trainees, who account for approximately 50% of care. SCS added two additional permanent positions, resulting in a 14% increase in staff and has also hired 2-4 additional counselors in temporary positions in each of the last three years. SCS has compensated for financial limitations in expanding paid FTE by increasing both the number of trainees and direct service-hour expectations for permanent counseling staff.

Waitlists

Both Boynton Health and SCS currently resort to waitlists when demand for therapy exceeds available resources. A description of how the waitlists function at both sites is available in the appendix.

The waitlist for Boynton began on October 1, 2015, less than one month after the start of the fall semester. The last addition to the fall waitlist was November 24, 2015. The increase in demand for mental health services is correlated with an increase in the number of students who were placed on the Boynton waitlist. For fall 2015, there was a 51% increase in students who were placed on the waitlist (254 compared to 172 for fall 2014). Of these, 138 were on the list for fewer than three work days before a future appointment was scheduled. Another 59 were on the wait-list for 11 or fewer before a future appointment was scheduled. Fifty-seven were on the waitlist more than 11 days. Of the 254 total students, 11% (28 students) dropped from the waitlist after being waitlisted one month and failing to recontact Boynton. This compares to 13% (22 students) who dropped from the waitlist in fall 2014. The highest number of students on the Boynton waitlist at any one time during fall 2015 was 72 on November 24, 2015. All students were off the waitlist by December 18, 2015. Of note, there were only three days in which no new appointments become available within 15 days. The waitlist resumed on February 10, 2016, and is expected to continue for the duration of the semester. This means that the waitlist was in existence during approximately 80% of both semesters. Being on a waitlist means that a student's appointment to see a therapist will be at best 15 days out, but could easily be a month out or longer. Considering the relative short duration of each semester, the likelihood that the issue for which students seek therapy will negatively impact academic performance, and that students often reach out for help well after they first begin to struggle, the current need to resort to waitlists is inconsistent with the academic mission of the University.

Student Counseling Services has also had to create waitlists for accessing ongoing counseling, and like Boynton, has seen these start earlier in recent semesters.

Visit Frequency

An evaluation of Boynton therapy service data (limited to 11 months due to conversion between two electronic health records) demonstrates that the modal, or most common frequency, for therapy visits is one visit, with an average of 3.6 visits per student in therapy. The mode of one is common for therapy in the community and could reflect a number of outcomes, including sufficient advice on the presenting problem, testing out the therapy option, or dissatisfaction with services and subsequent lack of follow-up. In regards to the Boynton data, those students visited only once represented 29% of students using therapy services, but account for 8% of all therapy visits. An evaluation of approximately 600 Boynton therapy encounters that were limited to a single visit is currently underway to identify the most common presenting problems and recommended follow-up or referrals, if any.

On the other end of frequency, 70 students (3% of all students seen) used more than the session limit of one initial evaluation plus 10 follow-ups (11 visits total). These students' visits account for 13% of all therapy visits; however, the total number of sessions exceeding session limits was only 192 out of 7,616 (3%). These data are confounded by a number of factors, including a practice of waiving the counting of summer visits toward the total allowed visits per 12 months, given an historical underuse of services during the summer. Summer utilization of services has increased over time, and Boynton will start counting summer appointments toward yearly session limits beginning this year. In addition, some cases of increased session use are attributable to approved additional visits to complete a therapy series or to assist with transfer off campus due to graduation or referral.

Concerns have been raised regarding length of time between initial therapy intake and first follow-up. Calculating the average time between initial intake and follow-up is challenging, and the most meaningful number would be to calculate the mean time to first available follow-up, which is not possible to reconstruct from existing schedules. The actual distance between first intake and follow-up proves to be highly variable. Eight percent of follow-ups occur more than six weeks out, but follow-up visits would, with few if any exceptions, be available within that time frame. Assuming that these outliers reflect other factors — an initial intention not to return, a return only after certain objectives were met, or cancellations or failed appointments in the interim — the distance between initial intake and follow-up was calculated based on those accomplished within six weeks of the initial intake for Boynton for FY14-15. The mean time between these visits varied during the semester, and was 15 days in July, 16 days in August, 14 days in September, 16 days in October, 20 days in November, 21 days in December, 15 days in January, 18 days in February, 21 days in March, 19 days in April, 17 days in May, and 12 days in June. A similar calculation of mean time between request for an intake and being seen for first visit revealed the following: 6 days for August, 8 days for September, 13 days for October, 13 days for November, 10 days for December, 6 days for January, 9 days for February, 15 days for March, 14 days for April, 9 days for May, and 4 days for June. However, these data would not take into account the time spent on the wait list once it was established for the year.

At Student Counseling Services the modal number of sessions is also 1, experienced by 28.8% of counseling clients in 2014-2015. Nearly 74% of counseling clients used 1-5 sessions and 3.1% used more than 16 appointments. The mean number of sessions was 4.5 sessions.

As noted above, both Boynton and SCS have therapy session limits for students. This is true for 50% of counseling services throughout the United States (Reetz, Krylowicz, & Mistler, 2014). Boynton uses one intake plus 10 follow-up appointments for a total for 11 visits in a 12-month period.

SCS has a required session review at 15 sessions with termination and/or referral expected for most clients reaching this number. A utilization review committee reviews all counselor requests for more than 15 sessions, with a limited number of extenuating circumstances allowing for additional sessions. Research using the phase model of psychotherapy outcome has suggested that for clients engaged in shorter-term therapy most

behavioral improvement occurs within the first 10-15 sessions of treatment (Budge et al., 2012; Howard et al., 1993; Kopta et al., 1994).

Student Access

The Disability Resource Center (DRC) has also observed increased demand for accommodations related to mental illness. Of the 2,311 students registered with the DRC in 2015, 44.9% experienced a mental health condition as their primary disability. Although the DRC has experienced an increase in the number of students registered (from 1,208 in 2005 to 2,311 in 2015) the number of students registered with the DRC with a mental health condition as their primary disability increased exponentially from 355 to 1218 (243%) during this time period. DRC attributes the increase in service demand to an increase in the number of students who qualify for disability services under the Americans with Disabilities Act as Amended, as well as to the reasons previously outlined under the section entitled "Increased Demand for Services." However, as the number of students seeking therapy for depression and anxiety grows, so does the need for disability accommodations. Boynton and SCS are the primary providers of disability documentation for students with mental health conditions when they register with the DRC. As Boynton and SCS ramp up services to meet the needs of more students, these students will become aware that they may qualify as having a disability, and therefore, may be entitled to disability accommodations. From 2009 to the present, the number of DRC access consultants has increased from 15 to 17 employees. However, even with the increase in staffing, the DRC continues to see an increase in demand that leads to longer waits for initial appointments than students would like. In fall 2015, during peak time, students had to wait 2-3 weeks for an initial appointment. The DRC does provide provisional disability accommodations for one semester while waiting for disability documentation. The provisional accommodation process does alleviate wait time for students whose disability documentation does not arrive in a timely manner.

Investment

The University of Michigan, Healthy Minds calculator provides a formula for estimating the lost tuition for campuses due to student depression. This calculation is based on students paying full undergraduate tuition and on a four-year graduation rate. The approximate loss of tuition revenue for the University of Minnesota Twin Cities Campus is calculated as $4.6 million over a four-year period. This figure does not include the costs associated with those students extending their undergraduate education beyond four years. The primary reason for a refund request at the UMNTC campus is withdrawal for Mental Health reasons. At UMNTC, 38.5% of tuition refunds requests are related to mental health concerns.

The availability of mental health resources increases the likelihood of academic success. Turner and Berry (2000) found retention rates for students who sought counseling were superior to the retention rates for the general student population during a six-year period.

The Minnesota Student Association surveyed undergraduate students in December 2015 (*N*=2,595 respondents). A large number of students (*n*=669; 29.7%) indicated that mental

health had impacted their timely degree completion, with the percentage increasing for each year a student is on campus; 40% of 5th year students or beyond stated that mental health delayed or impacted their academic performance. Nearly half of students (48.0%) who indicated that their mental health had negatively impacted degree completions reported that they had never used campus mental health resources. Of those respondents who indicated use of a campus mental health resource (*n*=629), 44.0% said that mental health had not delayed or impacted their timely degree completion. These findings suggest a potential relationship between seeking services and timely graduation. Within the subset (*n*=319) of all students who had never utilized mental health resources on campus and who also stated that their degree completion was delayed/impacted by mental health, 34.2% stated that the leading reason for not using services was that they didn't feel they were necessary, whereas 23.2% indicated concern about stigma, 21.0% reported that they did not know where to look for resources, and 16.3% stated that they had attempted to access resources but were unable to make an appointment in a timely fashion. Nearly half of students who indicated that they did not receive access to resources in a timely fashion thought that their mental health had a negative impact on their degree completion.

AAAHC Standards

Boynton is one of only two institutions in the United States that have been continuously accredited by Accreditation Association for Ambulatory Health Care (AAAHC) since its origin in 1979. Standards 17.C of the AAACH refer to behavioral health. The most recently proposed standards include that "the organization has sufficient and appropriate resources to support the delivery of quality behavioral health services," that "services are readily accessible and conveniently located," that "staffing patterns are adequate to provide services in a timely manner," that "case load assignments allow for a balance between direct service hours, administrative time, and case management time," and "that appointments are scheduled at intervals consistent with client needs/severity of symptoms." AAAHC standards also require that referral resources are consistently evaluated for availability and affordability to meet the needs of the population. The current existence of large waitlists suggests that compliance with AAAHC is at jeopardy despite Boynton's best efforts.

Staffing Standards/Recommendations

In the International Association of Counseling Services, Inc. Standards for University and College Counseling Services (2014), Standard V.C.1 recommends that colleges maintain mental health services at a minimum ratio of counseling professionals to students of 1:1000-1500.

Recently, the University of California System announced the hiring of 85 additional mental health clinicians to the 197 already in their 10 campus system, for a total of 282 for a current enrollment of 238,700 students (Rosenberg, 2016). This will bring their current ratio of mental health clinicians from 1 clinician for 1212 students to 1 clinician to 826 students. The UMN will have a total of 40.05 FTE mental health clinicians (6.05 BH psychiatry, 16.0 BHS therapy, 18.0 SCS therapy) dedicated to student mental health following the start of the two recently hired therapists at BHS. Using the Spring 2016 enrollment of 48,321 on the UMTC

campus, this would place our ratio of providers to students at 1:1207. The ratio of therapists to students is 1:1421 and the ratio of psychiatric clinicians to students is 1:7987.

University of Minnesota, Twin Cities Response

The UMNTC has taken significant strides toward addressing mental health issues on campus. Some UMNTC approaches, such as stigma reduction campaigns, special events such as Cirque de-Stress and Music and Mind, and training of staff, faculty, health advocates, and students to recognize possible mental health issues in students and to refer them to resources have likely increased demand on services. An example of the last is the half-day *UMTC Advisor Training: Focusing on Student Mental Health* held in December 2015 (to be repeated in May 2016). In addition, barriers to treatment have been reduced by eliminating co-pays at Boynton and extending the Student Benefit Plan to cover the summer months; these changes have likely increased service demands. The Provost's Committee on Student Mental Health has worked to centralize and coordinate services and programs on campus and to enhance awareness of resources on its UM website, www.mentalhealth.umn.edu. The UMPD has trained all officers in mental health interventions. UMNTC now has a 24-hour crisis and text service contracted through Crisis Connection and has initiated a trial of web-based therapy (SilverCloud). Special stress reduction programs such as Pet Away Worry and Stress, and the student peer group, de-stress, aim to provide additional preventive approaches to mental illness and stress management. Two mental health forums have added additional input from students, staff, and faculty. The UMNTC is also working with the JED foundation toward a comprehensive mental-health approach on campus. Clinical staff has been increased at both Boynton and SCS. Students have been very active in mental health efforts as demonstrated by Active Minds "Don't Sit in Silence" campaigns, the recent Minnesota Student Association (MSA) "How are you?" campaign and strong advocacy for mental health by Active Minds, MSA, and Council Of Graduate Students.

In 2015, the national organization Active Minds presented the UMNTC with one of five inaugural Healthy Campus Awards in recognition of our comprehensive approach. Despite the hard work and national recognition, there remains work to do as long as some students continue to struggle with unmanaged stress and mental illness without timely access to resources.

Discussion

Numerous data sources are consistent and compelling in demonstrating that mental illness and stress are common in the college student population, including here on the Twin Cities Campus of the University of Minnesota. Data also demonstrate that demand for clinical services is increasing despite efforts to increase available clinical services. The rate of suicidal thought, and suicide attempts and completion demonstrates that this is a problem with significant morbidity and mortality. The fact that one-third of our student population has required mental health services at some time in their lives suggests that addressing mental health on campus is essential. We should not accept that only a half of our students report positive mental health and are flourishing.

Additional investment in the mental health of students will contribute to the University's strategy of increasing graduation rates and will decrease the costs associated with class withdrawals and tuition refund appeals. It will decrease the burden on faculty associated with frequent absenteeism and the need to arrange for opportunities to make up assignments and tests. Most important, it will support the investment made by students, the University, and the state of Minnesota toward future contributions to society.

Addressing mental health should include both preventive and intervention approaches. Although much is known about the determinants of mental illness (State & Geschwind, 2015) very little is known about preventive approaches. More is known about intervention and treatment and because the acute demand on services is a current focus of concern, the strategies offered below will focus on how to best address this demand. It is commonly claimed that it is not possible to "staff ourselves" out of this challenge. We reject this assumption. However, we accept that the finances and resources required to address the full needs of our students are likely to be prohibitive.

Initiatives and Strategies to Address Demands for Mental Health Clinical Services:

The PCSMH presents the following options, along with projected costs (when available), and pros and cons to assist with decisions regarding how to best align existing and/or new resources to address the clinical needs of student mental health.

1. Increase access to mental health services on campus.

a. Increase therapy staff.

Based on fall peak wait list, it would require four master's level counselors for Boynton to eliminate the current waitlist. Similar to SCS, annual growth would be managed by an additional counselor every two years (a slightly higher growth rate than at SCS) until demand subsides. Excess capacity for intakes during non-peak periods might be used to increase session limits and /or frequency of visits. Boynton would not have space to accommodate any further growth from FY17 FTEs until fall of 2018, assuming that the Department of Environmental Health and Safety vacates the 1st floor of Boynton. Other space accommodations are possible to facilitate the addition of at least four new counselors, but would require reducing space for other services. Boynton is also exploring the possibility of offering telemedicine therapy services, which provides opportunities to use space that is not immediately contiguous with the mental health clinic. The cost of hiring the first four counselors would be $280,000 salary plus $95,000 benefits (based on 2016 rates) for a total of $375,000. Cost would be inflated for merit and fringe benefit increases going forward. Boynton's model utilizes third-party health insurance revenues to cover approximately 50% of the cost, with the remainder supported by student service fees; therefore the total cost to students = $187,500. Subsequent costs every other year would be 50% of $93,750 = $46,875 inflated to market compensation.

For SCS, four master's level counselors would be necessary to eliminate their waitlist based on the fall peak wait list. Given an annual service demand growth rate of 5%, SCS would need to add another counselor every three years to meet demand. SCS would not have the

space to accommodate four additional counselors, though SCS could possibly accommodate two additional part-time counselors with the current shared-office arrangement. It is challenging to hire counselors for short (peak) time periods although there is a small pool of graduate students who are more likely to be available for shorter-term employment. SCS uses this strategy. (Graduate students are not an inexpensive option, given that the University must pay a portion of tuition/benefits as well as salary). The cost for adding four counselors at current rates would be $214,000 salary, $83,000 benefits (based on 2016 rates) for a total = $297,400. Cost of hires in further years would have to factor in merit and benefit cost increases following first-year hires.

An alternatively strategy would be for current and additional Boynton therapists to provide some therapy through telemedicine such as Doctor on Demand. This still would require the expense of hiring more FTE therapists, but would save on overhead costs and mitigate some of the need for expanded space on campus.

Any effort to increase staffing should be coupled with efforts to increase the diversity of mental health staff as discussed in b. below.

b. Develop additional strategies involving students to expand diversity in mental health staff and recruit therapists that represent underserved student populations.

Increasing the diversity of mental health staff has been a long-held goal that has been challenging to realize. Several issues have been identified as barriers to this goal, including competition with many other employers for a smaller pool of candidates, salary limitations, and a mismatch of the demographics of the campus with the population on which potential candidates believe they could make the greatest impact. It is proposed that the best appeal for potential mental health clinicians to work at the UMN is not from the hiring units but instead from students who represent diversity on campus. To that end it is suggested that a group of representatives from student diversity groups be convened to craft a recruitment letter from students with input from the hiring units.

c. Streamline access to mental health services.

Steps have already been taken to streamline service access, including implementation of common intake paperwork for Boynton and SCS. Additional streamlining can be accomplished by expanding access points for students seeking mental health services, including the newly filled Care Manager position in the Office for Student Affairs, and the development of a partnership between One Stop and Student Affairs to expand the scope of One Stop to include a student assistance model. The new Care Manager position is charged with using a variety of interventions, referrals, and follow-ups to address the needs of students who have problems in areas such as academics, physical and psychological health, economic challenges, discipline, family relationships and social adjustment. Referrals to and coordination with campus mental health services is one of the significant roles for the Care Manager. The Care Manager is also charged with collaboration and consultation with faculty, staff, academic departments, health-

care providers, parents, and colleagues within the Office for Student Affairs to minimize academic disruptions and to resolve problems affecting students.

The One Stop Student Assistance model would address the fact that currently, there is not a centralized location to provide connection and support to students who are seeking help for a variety of related issues, such as mental health, stress, and other personal issues. With record numbers of students utilizing mental health resources, there is growing need to provide touch points early in stressful situations so that students are introduced to resources before crisis occurs. Students are asking for a more centralized connection to resources beyond the registration, financial aid, student records, and billing services currently provided at One Stop, evidenced through communication with student government groups on campus, particularly the Minnesota Student Association and the Council Of Graduate Students.

The Student Assistance model is a streamlined process designed to help students navigate the challenges they may encounter at the institution. Student Assistance staff would have backgrounds in case management, social work, and/or counseling and would support, not replace, other University staff serving in these roles. Student Assistance staff would often refer students back to the appropriate campus resources and provide guidance on how best to access care and support. Student Assistance helps students understand the University's systems, explore resolution options, and make informed decisions. Student support through care managers, student assistance staff, and faculty and staff training could lead to early identification of and interventions for mental health stressors.

d. **Adopt a brief consultation/access consultation model at Boynton.**

SCS is already using a version of this model that consists of 45-minute initial consultation (IC) appointments scheduled the same day as requested (when possible) or within 48 hours. In the IC students are screened for risk, asked about their presenting concerns, and when appropriate, are given written or internet-based resources to begin addressing their concerns. The IC outcome can include a referral for ongoing counseling, medication evaluation at Boynton, and/or referral to another campus office such as DRC.

Boynton will implement a brief consultation model in their Mental Health Clinic in the summer of 2016. Within the context of this new model, each student presenting for therapy or medication evaluation would meet for 15-20 minutes with a licensed clinician within 24-48 hours of presenting to the clinic. The clinician will assess the student's concerns and discuss recommendations that may include following-up for individual or group therapy, medication evaluation at Boynton, or a referral to a community provider. In some cases the student's concern might be adequately addressed in this brief consultation.

The model should improve the ability to assess students' needs more quickly and to make appropriate referrals sooner. The offset is that this model will require reallocation of a fair amount of therapist FTE in order to staff both the access consultation and urgent counseling. Without additional staff, success of this model will depend on more referrals to the community for ongoing therapy.

e. **Expand the use of psychology graduate students at peak demand times.**

Boynton is planning to pursue a solution that SCS has found to be very helpful for the variability of demands for services during the course of the school year. Boynton would hire psychology graduate students or licensed graduate social workers (LGSWs) on an hourly basis during our peak seasons to pick up access work and free up therapist time. If Boynton were able to hire two persons for a total of 40 hours/week for 20 -24 weeks/year, the total costs would be $20,000 - $25,000. Boynton should be able to bill for some of those encounters under the supervisor's credentials (depending on the plan). Those additional billings would provide some offset to the cost. The result would be the gain of a full therapy FTE during our busiest time. This model could be explored for the DRC as well to address increased demand during peak times. However, because of the length of time it takes to train access consultants, it may be more feasible to hire ongoing staff as needed.

f. **Do not further restrict the number of allowable therapy sessions.**

In theory, a decrease in the number of allowable therapy services would increase the capacity to see more students. This is a challenging proposal, as the potential benefit of seeing more patients is countered by the disadvantage of not being able to see patients who require more than the minimal allowed sessions. For example, limiting therapy services to a maximum of eight visits at Boynton (one intake plus seven follow-ups) would free up 8% of appointment slots but would decrease the number of clinically indicated visits that were otherwise utilized by 9% of students. Likewise, allowing for one more visit (nine total) would free up 6% of available visits and effect 6% of students by restricting the number of sessions that they would otherwise utilize. A reduction in the current number of allowed visits would align with the current pattern of use by most students who are already using five or fewer sessions per year. However, this would contradict the literature on best practice. Research suggests that optimal benefits for student therapy is achieved in the 10 to 15 session range (Budge et al, 2012; Howard et. al, 1993; Kopta et. al, 1994).

Limiting therapy sessions is akin to rationing antibiotics. One would not hand out five pills for an illness that requires ten or accept one pill every week when the research supports daily treatment. At some point, limiting sessions and/or increasing the time between visits amounts to offering ineffective interventions for a significant portion of the student population. The numbers do not show that further decreases in allowed sessions provides enough gains in appointment slots to justify this approach.

An additional down side to further therapy session limits is that staff would be required to increase the number of initial therapy intakes and experience greater client turn-over. Staff members are already expected to see more intakes than what is typical for the community and this has a negative effect of job satisfaction and morale.

g. Do not increase service to address all outpatient mental health needs of students.

This would include services via which students could access both frequent therapy visits throughout the year and more specialized services such as DBT (Dialectical Behavior Therapy), eating disorder treatment, chemical dependency treatment, and culturally-specific mental health programs. This would require extensive program development and resources. To change from a limited-session model to an unlimited-session model would exponentially increase the demand on current services and more than likely double required resources. The limited-session model was adapted to increase access and is the standard across U.S. campuses. Considering the UMNTC location in a highly mental-health-resourced community, expanding outpatient programming and dropping the limited session model would not be resource-appropriate for the University.

2. **Leverage the availability of community therapists.**

   a. **Increase networking with community therapists to increase capacity for referrals by 50 percent.**

The UMNTC is fortunate to be in a large urban setting with associated mental health resources. More students could be seen in therapy if the campus increased referral into the community, particularly when it is evident that presenting issues will require more services than is allowed for in a limited-session model. Therapy is currently accessible in the community within a week or two, and both Boynton and SCS have worked at developing lists of therapists who will take University students. Such referrals can be associated with less convenient locations than services offered on campus and can introduce transportation challenges. Those students who have insurance network restrictions and/or high deductibles would also be subject to additional out-of-pocket costs. In addition, non-UMN therapists may be less aware of campus systems, processes, and resources, and the UMN would not be able to control for quality as it does when providing services itself. Finally, it is more difficult to coordinate care if students are under psychiatric care for medication management at Boynton in additional to therapy in the community. It may be necessary to refer the management of both to an external coordinated system. However, this would likely introduce longer wait times to access psychiatric services, which are more limited than therapy in the community.

   b. **Examine the impact on the Student Health Benefit Plan if benefits were enhanced for services provided off campus.**

Although the current programs are most economical for students, they create a barrier to referrals into the community. Treatment received outside of Boynton is covered at 80% instead of 100%. Redefining the network for the SHBP to include select therapy services in the community could be explored. Depending on the extent of expansion, this could significantly drive up the premium and threaten the viability of this low-cost insurance option.

3. Implement funding strategies for departments that maximize payments from third-party payers.

Mental health services across campus are funded through a variety of mechanisms. Boynton receives over 60% of its funding to cover mental health costs through third-party health insurance reimbursement, with the remainder of revenue coming from student service fees. Student Counseling Services and the Disability Resources Center receive the vast majority of their funding through central cost-pool allocations charged to other units that receive income. The Provost's Committee supports a sustainable and stable source of funding for campus mental health services that allows students to remain engaged in the process and that covers the uncompensated cost of providing service to match demand. The President has recently committed to a revised funding model that campus mental health units would be happy to help develop. In addition, part of MSA's proposal is to shift the budget model for campus mental health services toward alternative central funding sources such as tuition. This suggestion was made based on the premise that a central source of funding for mental health services will be more stable than the current model. Boynton administration believes that there is more risk to the stability of funding for the provision of mental health services via this proposed reorganization.

Although more study is needed to determine the most effective stabilization strategy for mental health service funding, it should be noted that even with improved minimum essential benefits under health care reform (the Affordable Care Act or ACA), third-party insurance reimbursements to Boynton are reduced by plans with high deductibles and narrow provider networks. This is a trend that has been growing.

At the present time, the institutional mandate is working to ensure that students have minimum essential health insurance coverage *somewhere* but unless the University can support a requirement to have students carry health insurance that includes Boynton in its mental health provider network, third-party health insurance reimbursement will likely to continue to decline. Student Service Fees have traditionally covered these health insurance denials, including 100% insurance denials for no coverage at Boynton (out of network). Guaranteed funding for these balances from other stable sources could be advantageous and provide a continuous revenue stream between fee requests or when students suddenly became unsupportive of fee increases to fund mental health.

Some campus student counseling services collect third-party payments for counseling which would represent a funding stream that could add capacity to hire additional FTEs at SCS. However, this is a rare practice among counseling services. The 2014 AUCCCD survey (Reetz, Krylowicz, & Mistler, 2014) revealed that only 16 (3.7%) of 433 four-year institutions billed insurance. The continued practice of not billing insurance has the advantage of students not needing to be concerned with the privacy of their visits in situations in which they are covered under their parent's insurance. It also reflects the traditional developmental model of counseling services as opposed to a medical-model approach. However, students are increasingly presenting to counseling services with issues more typically seen in medical

settings and the interventions would be reimbursable if billed out. The AUCCCD survey revealed that 65% of counseling services use medical diagnostic coding systems.

4. Continue to increase the focus on prevention and early intervention.

Expand existing programs and create novel programs and incentives for students to practice self-care through wellness, recreation, and healthy living habits. Managing stress before it becomes unmanageable may be an important strategy in developing life-long skills for healthy futures. These would be expected to eventually result in taking some pressure off the current demand for clinical services, but would not address the immediate lack of sufficient clinical services.

5. Evaluate opportunities for academic policy, programmatic, and cultural changes that would support student mental health.

a. Establish positive mental health (flourishing) as a developmental outcome goal for all University students.
b. Encourage academic departments and faculty to redesign their courses and programs in ways that would create better paced workload without compromising content.
c. Increase faculty and advisor capacity to address student mental health.

According to data from the College Student Health Survey, students who receive support from staff and faculty tend to be more successful. Staff and faculty should be trained and encouraged to recognize students who are struggling with mental health, to realize that they have a role in assisting students, and to reach out to students who may be having difficulties. In addition, faculty and advisors may be able to refer the student to mental health resources. The PCSMH is moving forward with the development of a college mental health liaison program that aligns with this recommendation.

d. Consider policies and practice that allow for students to practice self-care.

Policies could prohibit assignment deadlines over Spring Break, and encourage the alteration of online assignment submission times (e.g., noon compared to midnight), class offerings in the evenings and on weekends, and the examination of student leave policies. Similar policy to final exams could be enacted for midterms, where students can have no more than two exams in a certain time period. Furthermore, a fall break to parallel Spring Break could be implemented, and self-care for student insurance benefits similar to employee benefits could be incentivized.

6. Increase data collection pertaining to mental health on campus.

Specifically, finance UMN's participation in the national Healthy Minds Study $3,000 for the two cycles, including funding for incentives to increase student participation ($1,000) and

for a graduate assistant or post-doctoral position to assist with data evaluation ($37,000). In-kind support for setting objectives, administering the survey, and statistical analysis and reporting would be provided by campus partners such as BH and the Department of Psychiatry.

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Appendix

About the Provost's Committee on Student Mental Health

The PCSMH is composed of 21 members, representative of key campus offices, departments, programs, and interests including the Minnesota Student Association, Council of Graduates Students, Professional Student Organization, the Academy of Distinguished Teachers, Center for Educational Innovation, Housing and Residential Life, International Student and Scholar Services, Graduate School, University Police, Office of Student Affairs, Office of Equity and Diversity, Psychology Department, Department of Psychiatry, Academic Advising Network, Disability Resource Center, Boynton Health, and Student Counseling Services.

The interdisciplinary UMN Provost's Committee on Student Mental Health (PCSMH) was established in 2005 and charged to: 1) Raise awareness about issues related to student mental health, 2) Effect policy change, 3) Improve conditions on campus for students with mental

health conditions, and 4) Serve as a model of collaboration for our campus and other universities.

About the White Paper

The PCSMH assigned a subcommittee to evaluate the state of mental health in students on US campuses and the UMTC campus in particular and to produce a white paper on this topic. A draft of the white paper was presented to the committee at their monthly meeting on 3/24/16. Suggested revisions were incorporated and the final version was accepted by the PCSMH on April 14, 2016.

White Paper Subcommittee Members:

- Gary Christenson, MD (Chair), Chief Medical Officer, Boynton Health
- Glenn Hirsch, PhD, LP, Assistant Vice Provost, Office for Student Affairs, and Director of Student Counseling Services
- Laura Knudson, PhD Assistant Vice Provost for Student Advocacy and Support, Office for Student Affairs
- Michelle Trotter-Mathison, Assistant Director of Mental Health, Boynton Health, Co-Chair, Provost's Committee on Student Mental Health
- Dave Golden, Director of Public Health and Communication, Boynton Health

Additional input and support provided to the subcommittee by:

- Carl Anderson, Assistant Vice Provost, Office for Student Affairs, Director and Chief Health Officer, Boynton Health Service
- Steve Hermann MD, Director of Mental Health, Boynton Health
- Heidi Reick, Graduate Student, School of Public Health

Waitlist Description and Process

The waitllist at Boynton Health was designed to balance the need for students in therapy to have access to return visits and to track students who request a therapy intake when none are available, so as to provide them with first access to intake appointments as they become available. Anyone presenting with urgent needs can be seen the same day by the urgent counselor.

The Boynton waitlist is activated whenever a request for a therapy intake cannot be fulfilled with an intake appointment in the next two weeks. Intakes are limited to two per day per therapist and may be used for follow-ups of established patients if a return in the next two weeks is necessary and otherwise unavailable. This results in fewer intakes becoming available as the semester progresses. In past years, the Boynton students began being placed on the waitlist only toward the end of each semester. However, increased demands for therapy services have both moved the time that the waitlist begins earlier into the semester and has

increased the number of students on the waitlist. Students on the Boynton waitlist receive daily emails informing them of any cancellations, and identifying new appointments that become available 15 days out. Students can then call the clinic to request one of these intakes on a first-come basis. Waitlist students are also called weekly to remind them to check their messages and to call if an appointment works for them. Boynton is able to fill about 60% of late cancellations (cancellations made within 24 hours of scheduled appointment) using this system. The no-show rate for Boynton is 7.5% for therapy and 9.8% for medication evaluation and management. Students on the waitlist are also provided with a thorough listing of external resources as well as crisis management options.

Class schedules, preference for a specific provider, and other student preferences may limit the intake choice for a student. Unexpected provider absences can also push a scheduled appointment out further than had been initially arranged. These "bumped" appointments are prioritized for rescheduling into the first available appointment.

At SCS, all students requesting a first-time appointment can schedule an initial consultation appointment with a counselor same-day or within 2-days as requested. However, the SCS service-delivery model standard is for ongoing counseling clients to be able to schedule with their counselors at least every other week, meaning that as the semester progresses, some students receiving an initial consultation appointment join a waitlist. SCS scheduling staff monitor daily openings and email students on the waitlist with a specific proposed appointment time, and ask the student to respond within 24 hours to hold that time. Students can decline the appointment without losing their place in the appointment cue and are offered other appointment options as they arise. A student who does not respond to the scheduling email is emailed again when another appointment becomes available. Students who do not respond to the second email are removed from the waitlist, but can be added back at their request. Through most of the semester, students are typically assigned to an ongoing counselor within 2-4 weeks of their initial consultation appointment. However, students added to the waitlist within 3-4 weeks of semester end may not be able to begin ongoing counseling. These students are offered other options, including break/summer appointments and community referrals. For the 2014-2015 academic year the SCS appointment no-show rate was 5.9% and the late-cancel rate was 3.2%.