Virginia College Mental Health Study

Prepared for

The Joint Commission on Health Care

General Assembly of the Commonwealth of Virginia

FINAL REPORT

Richard J. Bonnie, Chair
Susan M. Davis, Chair of Task Force on Legal Issues
Christopher Flynn, Chair of Task Force on Access to Services

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Virginia College Mental Health Study

Preface

On April 16, 2007, in two separate attacks on the Virginia Tech campus, Seung-Hui Cho killed 32 people and wounded many others before killing himself. Less than one year later, the Virginia General Assembly responded with sweeping legislation aiming to enhance mental health services, reform the civil commitment process, and improve campus security across the Commonwealth.[1] Virginia's colleges and universities have now operated under this legislation for three academic years. Believing the time was ripe for a comprehensive study of mental health services and crisis response on Virginia's campuses, the Joint Commission on Health Care commissioned the Virginia College Mental Health Study.

The study was initiated in October 2009 under the direction of a steering committee, whose members included Christopher Flynn, director of the Cook Counseling Center at Virginia Tech; Jim Stewart, then Inspector General for Behavioral Health and Developmental Services, subsequently appointed by Governor Bob McDonnell as Commissioner of Behavioral Health and Developmental Services; Professor John Monahan of the University of Virginia, an expert on empirical research in mental health law; Diane Strickland, a former Circuit Court judge and member of the Governor's Panel on the Virginia Tech Shootings; Jim Reinhard, then Commissioner of Behavioral Health and Developmental Services; Ron Forehand, Deputy Attorney General; and, Susan Davis, an experienced lawyer who also serves as a student affairs officer at UVA. Joanne Rome, a staff attorney in the Supreme Court, served as liaison from the Supreme Court and the Commission on Mental Health Law Reform.

The Steering Committee oversaw the activities of two task forces, one on Legal Issues in College Mental Health, chaired by Susan Davis, and a second on Access to Mental Health Services by College and University Students, chaired by Christopher Flynn. Task Force membership was drawn from Virginia colleges and universities of varying sizes and locations, both public and private.

The Task Force on Legal Issues was charged with addressing the roles and responsibilities of colleges in responding to possible student mental health crises, including notification and sharing of information, threat assessment, initiation and participation in commitment proceedings and follow-up. The Task Force on Access to

[1] See Appendix A for press release issued by Governor Timothy M. Kaine on April 9, 2008, outlining state legislation passed in response to Virginia Tech shootings. For the reports of the Commission on Mental Health Law Reform bearing on enactment and implementation of the reform legislation, see http://www.courts.state.va.us/programs/cmh/home.htmlhttp://www.courts.state.va.us/programs/cmh/home.html

Services was charged with assessing the current need for mental health services among Virginia's college and university students, and the current availability of services to address these needs. Each task force was asked to make recommendations for training, institutional policies and practices, and any legislative action that may be needed.

At their first meeting in January 2010, the task forces identified the subjects requiring further investigation and appointed work groups to study the issues and develop proposals. In addition, task force members reviewed a draft of a planned survey of all of Virginia's colleges and universities. The Virginia College Mental Health Survey was conducted during the spring and summer of 2010, and a full report was presented to the Joint Commission on September 7, 2010. Over the ensuing year, the two task forces studied the results, deliberated, and formulated their findings, conclusions and recommendations. Their combined report follows.

It should be emphasized that the conclusions and recommendations in this report represent the opinions and positions of the members of the task forces and do not necessarily reflect the views of their employers and sponsoring organizations, the members of the Steering Committee, or the members of the Joint Commission. Further, the report has not been reviewed by, and therefore not approved by, any of the Commonwealth's governing bodies for higher education.

I am grateful to the University of Virginia and Virginia Tech for providing the core infrastructure support for the Virginia College Mental Health Study and to the Joint Commission for requesting and supporting this important project.

Richard J. Bonnie
Chair, Virginia College Mental Health Study
November 21, 2011

Table of Contents

Preface ……………………………………………………………………. 2

Study Participants…………………………………………………………. 5

Executive Summary ………………………………………………………. 9

1. Virginia College Mental Health Survey …………………………………. 15

2. Report of the Task Force on Access to Services …………………………. 19

3. Report of the Task Force on Legal Issues ……………………………… 39

Summary of Recommendations ……………………………………………. 59

References ………………………………………………………………… 61

Appendices

Appendix A: Press Release from Office of the Governor, April 9, 2009

Appendix B: Campus Suicide Prevention Center of Virginia, *Peer involvement in Campus-Based Suicide Prevention: Key Considerations* (2011)

Appendix C: State of New Jersey, Department of the Public Advocate, Division of Mental Health Advocacy, *College Students in Crisis: Preventing Campus Suicides and Protecting Civil Rights* (2009)

Appendix D: National Association of College and University Administrators, *New Title II Regulations Regarding Direct Threat* (November 1, 2011)

Appendix E: Memorandum of Understanding between Virginia Tech and New River Valley Community Services Board (June, 2008)

Appendix F: Schematic Outlines of Civil Commitment Proceedings for Adults and Juveniles ion Virginia (2011)

Appendix G: Contact List for CSB-College Coordination (2011)

Virginia College Mental Health Study Participants

Members of Steering Committee

Richard J. Bonnie, Chair
Harrison Foundation Professor of Medicine and Law
Professor of Public Policy
Professor of Psychiatry and Neurobehavioral Sciences
Director of Institute of Law, Psychiatry and Public Policy
University of Virginia School of Law

Susan M. Davis
Associate Vice President for Student Affairs/Liaison to the General Counsel
University of Virginia

Christopher Flynn, Ph.D
Director, Cook Counseling Center
Virginia Tech

Ronald C. Forehand
Senior Assistant Attorney General and Chief
Office of Attorney General

John Monahan, Ph.D.
John S. Shannon Distinguished Professor of Law
Professor of Psychology
Professor of Psychiatric Medicine and Neurobehavioral Sciences
University of Virginia School of Law

James S. Reinhard, M.D.
Former Commissioner, Department of Behavioral Health and Developmental Services
Associate Director and Medical Director
Cook Counseling Center
Virginia Tech

Joanne B. Rome
Staff Attorney
Supreme Court of Virginia

James W. Stewart, III
Former Inspector General for Behavioral Health and Developmental Services
Current Commissioner, Department of Behavioral Health and Developmental Sciences
Commonwealth of Virginia

Hon. Diane M. Strickland
Retired Circuit Court Judge and Member, Governor's Panel Va. Tech. Shootings

Members of Task Force on Legal Issues

Susan M. Davis, Chair
Associate Vice President for Student Affairs/
Liaison to the General Counsel
University of Virginia

Virginia M. Ambler
Vice President for Student Affairs
The College of William and Mary

Grant L. Azdell, Ph.D.
Dean of Students
Randolph-Macon College

Jewell B. Worley, Ed.D., LPC
Dean of Students
The University of Virginia's College at Wise

Jeffrey S. Brown
Chief of Police
Christopher Newport University

Michael M. DeBowes
Director, Student Judicial Affairs
Old Dominion University

Gene Deisinger, Ph.D.
Major, Deputy Chief of Police & Director, Threat Management Services
Virginia Tech

Barry T. Meek
Associate General Counsel
University of Virginia

William D. Miracle
Dean of Students
Bridgewater College

David Onestak, Ph.D.
Director, Counseling & Student Development Center
James Madison University

Jeffrey W. Pollard, PhD, ABPP
Director, Counseling and Psychological Services & Professor of Psychology
George Mason University

Reuban Rodriguez
Associate Vice Provost & Dean of
Student Affairs
Virginia Commonwealth University

Cedric Bernard Rucker
Dean of Student Life
University of Mary Washington

Mary Lee Walsh
Dean of Student Services
Piedmont Virginia Community College

Dawn Watkins
Vice President for Student Affairs &
Dean of Students
Washington & Lee University

<u>**Members of Task Force on Access to Services**</u>

Christopher Flynn, Ph.D., Chair
Director, Cook Counseling Center
Virginia Tech

Jennifer D. Allman
Director of Student Services
Virginia Community College System

Jihad N. Aziz, Ph.D.
Director, University Counseling Services
Virginia Commonwealth University

Harvey Barker, Ph.D.
Executive Director
New River Valley Community Services

Bill Brown, LCSW
Director of Student Counseling Services
Virginia Wesleyan College

Christine H. Diggs
Director, Counseling Center
Virginia State University

Russ Federman, Ph.D., ABPP, Director
Lenny Carter, LPC , Assistant Director
Counseling and Psychological Services
University of Virginia

Curtis K. Greaves, Ph.D.
Director Counseling Center
Norfolk State University

Donna Haygood-Jackson
Assistant Director, Counseling Center
The College of William and Mary

Kay Heidbreder
University Legal Counsel
Virginia Tech

MAJ Clarissa J. Griffin, LPC
Institute Counselor
VMI Health Center

Peter LeViness, Ph.D.
Director, Counseling and Psychological Services
University of Richmond

Patricia Lunt, Ph.D.
Special Assistant, Student Mental Health & Behavior
Northern Virginia Community College

Tim J. Pierson, Ph.D.
Vice President for Student Affairs
Longwood University

Bill Ritchey
Counseling Center Director
Christopher Newport University

Colleen G. Slipka
Psychiatrist, Counseling Center
James Madison University

James W. Stewart, III
Commissioner, Department of Behavioral
Health and Developmental Sciences
Commonwealth of Virginia

Erin Sullivan, Director
Student Counseling Services
Radford University

Lenora H. Thompson, Ed.D.
Director, Counseling Services
Old Dominion University

Jane Wiggins, Ph.D., Director
Campus Suicide Prevention Center of Virginia
James Madison University

Members of Virginia College Mental Health Survey Team*

Richard J. Bonnie, Chair
Harrison Foundation Professor of Medicine and Law
Hunton & Williams Research Professor
Professor of Psychiatry and Neurobehavioral Sciences
Director of Institute of Law, Psychiatry and Public Policy
University of Virginia School of Law

Susan M. Davis
Associate Vice President for Student Affairs/Liaison to the General Counsel
University of Virginia

Christopher Flynn, Ph.D
Director, Cook Counseling Center
Virginia Tech

John Monahan, Ph.D.
John S. Shannon Distinguished Professor of Law
Professor of Psychology
Professor of Psychiatric Medicine and Neurobehavioral Sciences
University of Virginia School of Law

*The team gratefully acknowledges the assistance of Jennifer Allman, M.S., Patricia Lunt, Ph.D., Natalie Morris, M.P.P., Kim Snead, B.S.W., M.P.A., and Michael Turner, M.Ed.

Virginia College Mental Health Study
Executive Summary

Almost half a million students attend Virginia's colleges and universities. About 45% attend one of the 15 four-year public colleges, 17% attend one of the 25 four-year private colleges, and 38% attend one of the 24 public two-year colleges (including the 23 community colleges). It is well known that young adulthood is the period of onset for major mental disorders and is often characterized by intensive use of alcohol and other drugs. Based on national data as well as the data available in Virginia, it is likely that at least 46,000 of Virginia's college students are experiencing significant mental health concerns and are in need of psychological assistance at any given time. According to the Virginia College Mental Health Survey (VCMHS), at least 11 Virginia college students committed suicide and at least 86 more attempted suicide during 2008-09. However, based on national data, we estimate that there were approximately 2300 attempted suicides and approximately 30 completed suicides among college students that year.

Prevention

Each college and university that has not already done so should establish a planning group for involving and guiding students in clinically, culturally, ethically and legally appropriate roles in campus-based mental health awareness and suicide prevention.

Access to Services in Residential Colleges

The best way of preventing mental health crises is to assure that people experiencing mental or emotional stresses or disturbances have expeditious access to mental health services before events spiral out of control. This challenge is no less important in a college environment than it is in the community at large. Research shows that participation in college counseling services increases student retention and graduation rates.

All of the 15 four-year public colleges and 22 of the 25 private colleges offered mental health counseling services to enrolled students (generally full-time students). Using the International Association of Counseling Services standards as a guide, the majority of private colleges in Virginia meet the minimum requirement of one counselor per 1,500 students while the majority of counseling centers in the public colleges do not meet the requirement. Most counseling center directors report that they lack adequate psychiatric coverage. The percentage of the student body served by Virginia's college counseling centers parallels the staffing pattern. In the public colleges and universities, 6.3% of the student body utilized services in the counseling center during academic year 2008-09, compared with 11.1% of the student body in the private colleges and universities.

Health Insurance

Health insurance, including adequate behavioral health benefits, is an important part of the equation for assuring adequate access to mental health services for college students. Although the proportion of students covered by insurance could not be ascertained in the VCMHS, most private colleges (about 60%) and about one-quarter of 4-year public colleges require all of their students to have health insurance. As a result, counseling centers at the four-year colleges customarily refer their students to private providers when they are unable to meet the students' mental health needs. By contrast, none of the community colleges requires its students to have health insurance; instead, community colleges rely mainly on the services provided by the Commonwealth's community services boards (CSBs) to assist troubled students.

Access to Services for Community College Students

One of the most important issues considered in our deliberations concerned the mental health needs of students enrolled in the Commonwealth's 23 community colleges. National survey data suggest that at least a quarter of all the country's community colleges offer full or part-time services by clinically trained providers. However, according to official policy, Virginia's community colleges do not currently provide mental health counseling services. Moreover, it appears that very few community colleges in Virginia have clinically trained counselors on their staff.

Unfortunately, there is reason to believe that a significant portion of community college students do not have access to off-campus mental health services because they are more likely than students in the 4-year colleges to be uninsured or under-insured and because most community services boards lack capacity to provide timely counseling and psychiatric assistance to college students. Task Force members regard the current gap in accessible mental health services to community college students as a serious problem. Failure to respond to this problem aggravates the already substantial disparities in educational achievement among people of color.

Although community colleges do not currently offer mental health counseling services, their governing policy does require them to develop "proper procedures for addressing the needs of a student who may pose a threat to him/herself or to others." However, task force members believe that capacity to prevent and respond successfully to mental health crises depends on timely access to clinically trained professionals who are able to screen and refer troubled students and to facilitate adequate crisis response. In our judgment, current capacity to do this among the community colleges is uneven at best.

The task forces recommend that the Commonwealth embark on a sequential plan, as resources permit, to assure that every community college has the capacity to provide brief screening and referral services for students who appear in need of mental health intervention; to maintain fully staffed threat assessment teams; to conduct risk assessment screenings in cases that may pose a risk of harm to campus safety; and to coordinate with

CSBs, law enforcement agencies and families to carry out emergency interventions and other types of crisis response when necessary.

This recommendation is meant to declare a goal without prescribing a one-size-fits-all approach for achieving it. It envisions flexible responses in what services are provided and in the staffing needed to deliver them, depending on the size, financial capacity, and location of the particular community college. The immediate aim of this recommendation is to establish a minimum capacity for screening and referral in every community college

It is not necessary for every community college to provide direct counseling services. However, community colleges that are able to provide direct counseling services should be encouraged to do so (and should not be precluded from doing so as a matter of policy).

For the foreseeable future, CSBs will likely be the primary providers of safety net services for uninsured college students. It is hoped, however, that economic recovery will eventually allow the Commonwealth to fund CSB services at a sufficient level to increase their capacity to provide timely outpatient services.

Review of 2008 Legislation in Operation

The Task Force on Legal Issues was charged with ascertaining how the legislation enacted in 2008 in the wake of the Virginia Tech tragedy has been operating in practice. Although most of the new policies and procedures have had positive effects, the Task Force concluded that several clarifications and adjustments would be helpful.

Sharing of Information in Admission/Enrollment Process

Va. Code § 23-2.1:3 permits colleges to seek mental health records of applicants or admitted students from originating schools. The survey data indicated that no institution in Virginia currently requests mental health records for all its incoming students and that only a handful of colleges have requested such records. Although the task force proposes no significant legislative change, it recommends clarification of the meaning of "originating school" to ensure it includes transferring institutions of higher education, and not only high schools.

Interventions for Suicidal Students

All of Virginia's four-year public institutions have developed and implemented policies for identifying and addressing the needs of suicidal students as required by the first sentence of Va. Code § 23-9.2:8. This is a welcome mandate as these policies are a critically important aspect of protecting the mental and emotional well-being of Virginia college students. However, only 38.1 percent of community colleges reported in the survey that they have such policies, reflecting the current reality that community colleges do not provide mental health services to their students and that most of them do not have

the expertise to implement suicide prevention policies. Until these circumstances change, the Task Force recommends revising the first sentence of Va. Code § 23-9.2:8 to release community colleges from this legislative mandate.

In addition, the Task Force recommends legislative clarification or repeal of the two remaining sentences in the provision because they are contradictory, simultaneously directing colleges not to penalize students for being suicidal while also permitting them to deal "appropriately" with students who pose a danger to themselves or others. If the intention was to protect students with disabilities, federal law (ADA and Rehabilitation Act) already provides this protection. In terms of clarity, it would be best to leave this to federal disability discrimination standards. The added sentences to state law, while well intentioned, create added confusion for student affairs officials in these complicated cases.

Parental Notification

The perceived legal impediments to parental notification described in the Virginia Tech Panel's report in 2007 appear to have been lessened by clarification of federal law and by Virginia. Code § 23-9.2:3.C, which requires colleges to establish policies and practices regarding notification of parents of dependent students when the student receives mental health treatment at the student health or counseling center and certain criteria are met. Although an exception is provided if the treating physician or clinical psychologist believes notification would be harmful, there is some lingering concern that this notification requirement could deter students from accessing care at the campus counseling center and uncertainty whether the General Assembly intended for community colleges to be subject to this notification requirement. It may be advisable to amend the statue to make it clear that the provision is permissive, not mandatory, for community colleges. Also many smaller schools do not have a physician or clinical psychologist on staff. Accordingly, Va. Code § 23-9.2:3.C should be amended to permit any available school health professional to authorize the exception not to notify a parent. This can be accomplished by changing the phrase "physician or treating clinical psychologist" to "health care professional."

Threat AssessmentTeams

Virginia Code § 23-9.2:10 provides a good framework for establishing and operating threat assessment teams. It does not dictate how schools should run their teams. It gives them flexibility to design their own mission statement and operations. In 2010, the General Assembly authorized threat assessment teams to receive health and criminal history records of students for the purposes of assessment and intervention, and largely exempted records of threat assessment teams from the Freedom of Information Act.

Virginia's public four-year institutions have all implemented threat assessment teams on their campuses. Despite the absence of a statutory mandate, the majority of Virginia private institutions have also done so. Implementation of the requirements of §

23-9.2:10 among community colleges appears to be uneven, however, largely due the lack of clinically trained staff and other personnel needed for a fully staffed team. It seems likely that the General Assembly was focusing primarily on four-year colleges when it enacted § 23-9.2:10. The Task Force recommends that the staffing requirements prescribed by § 23-9.2:10 be loosened to take account of the wide variation in staffing capabilities among community colleges However, the Task Force hopes it will be possible within a few years for all colleges, including community colleges, to employ or retain the necessary clinically trained personnel to maintain a fully staffed threat assessment team and carry out risk assessments in appropriate cases.

Cooperation by Colleges, CSBs and Hospitals in Emergencies

Working agreements with local CSBs have been established by two-thirds of public four-year colleges, about half of private colleges, and about 70% of community colleges. In addition, working agreements with local psychiatric hospitals have been established by about half of public four-year colleges, one-third of private colleges and one community college. The task forces identified a number of major concerns about the sharing of information between colleges, CSBs and hospitals regarding students needing or receiving acute mental health services. For example, most colleges reported that they were not notified when a commitment proceeding involving a student was initiated by someone other than the college or when their students were admitted to or discharged from a hospital. The task forces recommended solutions to allow for improved communication in these situations.

The Task Force identified significant information gaps between college and university officials, CSBs, and psychiatric hospitals during the processes of emergency evaluation (ECOs & TDOs) and commitment of students. This issue requires priority attention. Colleges and universities are key stakeholders whenever their students are subject to these state processes. They often have significant mental health and behavioral information that would aid state officials involved in these proceedings. Residential colleges are also the homes to which many discharged students return. Accordingly, colleges and universities should be notified and involved in these proceedings to ensure community safety and appropriate continuity of care when a discharged student returns to campus.

The Task Force recognized that CSBs have limited resources at their disposal and limited time to act during the ECO and TDO stages. Colleges and universities do not wish to burden CSBs with additional responsibilities. On the contrary, the Task Force believes that colleges and universities could become a helpful partner to CSBs throughout these proceedings. To that end, the Task Force recommends pursuing each of the steps below: :

- Each college should establish a written MOU with its respective CSB to ensure both parties have the same understanding of the scope and terms of their operational relationship.
- Each college should establish a written memorandum of understanding for use with local psychiatric hospitals to assure inclusion of colleges, where appropriate,

in the post-discharge planning of student patients, whether admitted voluntarily or involuntarily.

- Working together with the colleges in their catchment areas, Virginia's CSBs should establish a reliable system for assuring that a designated contact person at each Virginia institution is notified whenever one of its students is the subject of commitment proceedings and for assuring exchange of information among institutions, providers and the legal system in a timely fashion.
- The Office of the Executive Secretary of the Supreme Court, the Department of Behavioral Health and Developmental Services, the Virginia Association of Community Services Boards, the Office of the Attorney General and Virginia's colleges and universities should conduct collaborative training activities to assure that all participants in commitment proceedings are familiar with special issues arising in cases involving college and university students.

1
The Virginia College Mental Health Survey

Almost half a million students attend Virginia's colleges and universities. About 45% attend one of the 15 four-year public colleges, 17% attend one of the 25 four-year private colleges, and 38% attend one of the 24 public two-year colleges.
In October, 2009, the Joint Commission on Health Care agreed to undertake a study of mental health issues in the Commonwealth's colleges and universities. The study was conducted by two task forces – one to assess students' access to mental health services and the other to analyze legal issues surrounding colleges' responses to students' mental health needs. In the spring of 2010, the Joint Commission, in coordination with the Commission on Mental Health Law Reform, conducted a survey of Virginia's public and private colleges to collect relevant data bearing on these issues. Data was requested for the 2008-09 academic year. The survey response rate was a remarkable 98%. The full report is available at: http://services.dlas.virginia.gov/user_db/frmjchc.aspx?viewid=754
The key findings are summarized below.

Access to Services

The survey indicates that counseling centers in the private colleges have about 70% more staff capacity than counseling centers in the four-year public colleges. Similarly, controlling for size, about 70% more students are served by counseling centers in the private colleges than in the four-year public colleges. While these findings may not be surprising, they highlight the challenge of addressing mental health needs of students in the four-year public universities.

One of the most important issues considered in our deliberations concerned the mental health needs of students enrolled in the Commonwealth's 23 community colleges. According to official policy, Virginia's community colleges do not currently provide mental health services. As will be discussed in the next section, both task forces favor some modification of this policy.

Health insurance, including adequate behavioral health benefits, is an important part of the equation for assuring adequate access to mental health services for college students. Although the proportion of students covered by insurance could not be ascertained in this survey, most private colleges (about 60%) and about one-quarter of 4-year public colleges require all of their students to have health insurance. As a result, counseling centers at the four-year colleges customarily refer their students to private providers when they are unable to meet the students' mental health needs. By contrast, none of the community colleges requires its students to have health insurance; instead, community colleges rely heavily on the services provided by the Commonwealth's community services boards (CSBs) to assist troubled students.

Frequency of Hospitalization and Withdrawal for Mental Health Problems

The survey data indicate that four-year colleges rarely initiated either an ECO or a TDO to detain students for emergency mental health evaluation in 2008-09, doing so for only two out of every 10,000 students. However, the initiation of involuntary commitment proceedings is meant to be a last resort. Better indications of the frequency of severe distress experienced by Virginia's college students are the rates of medical withdrawal for mental health reasons and psychiatric hospitalization. An average of 56 students per four-year public college and six students per private college withdrew from school in 2008-09 for mental health reasons. The average number of students admitted to a psychiatric hospital in 2008-09, regardless of legal status, was about ten per four-year public college and three per private college.[2] Overall rates of medical withdrawal and psychiatric hospitalization in Virginia's four-year colleges in 2008-09 were 35 per 10,000 students and 12 per 10,000 students respectively.

Student Suicides and Attempts

During 2008-09, at least 11 Virginia college students committed suicide[3] and at least 86 more attempted suicide. One-third of all public colleges experienced a student suicide, and about three-quarters experienced a student suicide attempt. The numbers of suicide attempts were lower at private colleges (an average of one attempt per college) than at public colleges (an average of 6 attempts per college) because of the smaller average size of the private colleges. All public four-year colleges, 80% of private colleges, and almost 40% of community colleges, have guidelines for identifying and addressing the needs of students exhibiting suicidal ideation or behavior. This is an example of how policies and practices required for public four-year colleges by law,[4] have been embraced by private colleges and even by community colleges.

Parental Notification

The perceived legal impediments to parental notification described in the Virginia Tech Panel's report in 2007 appear to have been lessened by clarification of federal law and changes in the Code of Virginia. Public colleges notified a student's parents because they were concerned about the student's becoming harmful to him or herself or others a

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[2] The survey data indicate that an average of 4 students per community college withdrew for mental health reasons and about one person per community college required psychiatric hospitalization. However, most of the colleges were unable to provide the requested data and these figures are probably not reliable indicators of the prevalence of substantial mental health distress among community college students.

[3] Only 2 colleges reported that one of their students was arrested for killing someone else during 2008-09 (in one of these cases the victim was another student).

[4] See Virginia Code § 23-9.2:8: "The governing boards of each public institution of higher education shall develop and implement policies that advise students, faculty, and staff, including residence hall staff, of the proper procedures for identifying and addressing the needs of students exhibiting suicidal tendencies or behavior."

total of 68 times in 2008-09.[5] Private colleges did so 70 times, and community colleges six times. In addition, public colleges notified a student's parents because they were concerned about the student's mental health more broadly, even without a concern that the student would harm him or herself or others, a total of four times in 2008-09. Private colleges did so 80 times, and community colleges once.

Threat Assessment Teams

All public colleges, as well as three-fourths of private colleges and community colleges, have established threat assessment teams charged with assessing individuals whose behavior may pose a threat to campus safety and recommending appropriate interventions. Mental health issues were believed to be a significant factor in most of these cases. The average number of active cases considered by threat assessment teams in 2008-09[6] was 20 times at public colleges, nine at private colleges, and five at community colleges.

College Requests for Mental Health Information

One issue raised in the wake of the tragic shootings at Virginia Tech was whether colleges should seek, and have access to, information about the mental health histories of students prior to or after enrollment. The General Assembly authorized Virginia's colleges to require admitted or enrolled students to provide mental health records from the originating school. This authority has been used by only eight colleges (four four-year public colleges, two private colleges, and two community colleges), who indicated that they sometimes requested information about selected students. In addition, about half of the four-year colleges administered health surveys to enrolled students that included questions regarding mental health, and shared the information with the counseling center.

Cooperation by Colleges, CSBs and Hospitals in Emergencies

Working agreements with local CSBs have been established by two-thirds of public four-year colleges, about half of private colleges, and about 70% of community colleges. In addition, working agreements with local psychiatric hospitals have been established by about half of public four-year colleges and one-third of private colleges.[7] Our task forces identified a number of major concerns about the sharing of information between colleges, CSBs and hospitals regarding students needing or receiving acute

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[5] This was the first academic year following the 2008 General Assembly's adoption of Virginia Code § 23-9.2:3.C, which requires Virginia public institutions to notify parents of tax-dependent students whenever students who receive mental health treatment at the institution's student health or counseling center meet state commitment criteria.

[6] This was the first academic year following the 2008 General Assembly's adoption of Virginia Code § 23-9.2:10, which requires Virginia public institutions to establish threat assessment teams to include members of law enforcement, mental health professionals, representatives of student affairs and human resources, and, if applicable, college or university counsel.

[7] Only one community college reported having such an agreement.

mental health services. For example, most colleges reported that they were not notified when a commitment proceeding involving a student was initiated by someone other than the college or when their students were admitted to or discharged from a hospital. The task forces recommended solutions to allow for improved communication in these situations.

2
Report of the Task Force on Access to Mental Health Services in Higher Education

The best ways of preventing mental health crises is to assure that people experiencing mental or emotional stresses or disturbances have expeditious access to mental health services before events spiral out of control. This challenge is no less important in a college environment than it is in the community at large, especially given the fact that young adulthood is often the period of onset for major mental disorders. This chapter reviews what is known about the need for services among college students and reports the findings and conclusions of the Task Force on Access to Services regarding availability of services to students enrolled in public and private residential colleges and in the Commonwealth's community colleges.

I. Mental Health Needs of College Students

A. Mental Health Concerns of Late Adolescence/Early Adulthood

The transition from late adolescence to early adulthood is beset by a host of challenges; these include major life events such as leaving home, making decisions regarding possible vocations, and forming intimate relationships. These challenges may be complicated for a significant number of the population by emerging mental health concerns.

Epidemiologic research (Kessler, Berglund, Demler, Jin, Merikangas & Walters, 2005) reveals that the onset of a number of psychological disorders occurs during late childhood through late adolescence (see table 1). The median age of onset for anxiety and impulse control disorders is age 11 with inter-quartile (middle 50%) of ages 6-21 for anxiety disorders and ages 7-15 for impulse control disorders. Substance abuse and mood disorders may have a later onset but inter-quartile ranges of 18-27 and 18-43

Table 1

Median Age of Onset (NCS-R)	Median Age	25-75%	Range
Anxiety Disorders	11	IQR	6 to 21
Impulse Control Disorders	11	IQR	7 to 15
Substance Abuse Disorders	20	IQR	18 to 27
Mood Disorders	30	IQR	18 to 43

50% of individuals with any disorder will have symptoms by age 14, 75% by age 24.

Inter-quartile Ranges = Years between 25th and 75th percentile

respectively provide evidence that many in early adulthood will be afflicted by these problems. Kessler notes that 50% of individuals with any disorder will have symptoms by age 14 and 75% by age 24. The period in which this transition occurs has been called "emerging adulthood" (Arnett, 2000) and, far from being a time of carefree joy, the years 18-23 are noteworthy for major life challenges and emerging psychological concerns.

Given that students may experience mental health challenges between elementary school and college, it is relevant to ask how many college students may be suffering from a mental health diagnosis during a given year. The seemingly simple question is deceptively hard to answer for a number of methodological reasons.[8] A search of the epidemiologic literature yields different findings depending on the methodology of the study. A large scale study (NCS-R) of the general adult population utilizing face-to face interviews with a structured assessment measure found that 18.1% of the population had an anxiety disorder, 9.5% had a mood disorder, 8.9% had an impulse control disorder, and 3.8% had a substance disorder; these results found that 26.2% of the measured group had some disorder, with 14.4% having one concern, 5.8% with two concerns, and 6% with three or more concerns (Kessler, 2005) Contrast these numbers with those reported in a study attempting to compare college students with their non-college peers over the past 12 months (Blanco et al, 2008) where substance abuse in college students was found to be 29.15%; however this number included 14.55% with nicotine dependence which is unlikely to impair daily functioning. In this study, the rate of mood disorders was 10.6% and the rate of anxiety disorders was 11.9%.

The NCS-R study (Kessler 2005) also rated those interviewed on the severity of the disorders reported, using categories of mild, moderate, and severe, indicating the extent to which the respondent may be functionally impaired. For anxiety disorders, 77% of those interviewed were in the mild-moderate categories, 55% of mood disorders were in the mild-moderate range, 67% of impulse control disorders, and 70% of substance abusers were also in the mild-moderate range. Individuals with only one disorder were much more likely to be in the mild-moderate range (90%), while those with two, or three or more disorders were less likely to be in the mild to moderate range at 75% and 50% respectively.

A conservative estimate of the number of college students who experience a significant mental disorder during a given year would be about 25%. Many of these students experience mild to moderate symptoms. It is likely, however, that about 10-15%

[8] These include:

- How the information is gathered – studies which use self-report measures will obtain different results than those in which face-to-face interviews are conducted.
- What is the period of time in question – a study that asks: "Have you ever had this problem?" will yield a different number than one that asks "Have you had this problem in the past 30 days or the past 12 months?"
- Does the study report the cumulative numbers of individuals and/or the number with multiple diagnoses – if the report just adds the numbers cumulatively, than those with more than one disorder will be counted more than once; counting individuals rather than diagnoses will result in fewer overall individuals in the total.
- What is the severity of the disorder – most studies report on the existence of a concern without attention to whether this disorder may be disabling, e.g. having a fear of heights (a specific phobia) may be uncomfortable at times but may not impair daily functioning.

of college students experience impairment in their academic functioning as a result of a mental disorder.

This estimate converges with other prevalence data. The Center for Collegiate Mental Health, established at Penn State, is a consortium of colleges and universities that provides research data regarding the current mental health concerns of college students (2009). In a large-scale survey of college students, CCMH reported that over 10% of college students reported currently receiving mental health services on or off-campus. Further, over 9% reported taking medication for a mental health concern.

B. Specific Issues of Concern Among College Students.

Suicidality. There is significant literature focused on suicidality in college students; this literature reviews suicidal ideation, suicide attempts and completed suicides (Schwartz, 2007; Schwartz 2006; Silverman, Meyer, Sloane, Raffel & Pratt, 1997). There have been several recent large scale surveys of suicidal ideation in college students (ACHA, 2009; CCMH, 2010). In a survey of 80,121 students (including students from a number of Virginia colleges and universities) conducted by the American College Health Association, 9% of students responded affirmatively to "seriously considered attempting suicide" in the past 12 months, with 1% of these considering an attempt nine or more times. For one large public university in Virginia taking part in the ACHA study, 4.5% considered attempting suicide in the past 12 months. In the same survey, college students were asked if they made a suicide attempt in the past 12 months; of the sample assessed, one-half of one percent made an attempt in the past year. While one-half of one percent may seem to be a low rate in absolute terms, there are 460,000 students enrolled in Virginia's colleges and universities. *Based on national data as well as the data available on Virginia college students, a reasonable estimate of the actual number of Virginia's college students who attempt suicide within a given year is about 2,300; in a university with 20,000 students, 100 would be expected to attempt suicide in a year.*

As may be expected, far more students attempt suicide than succeed in doing so. A benchmark study of the "Big Ten" universities (Silverman, 1997) found the annual rate of completed suicides to be 7.5 per 100,000 students, while the comparable rate of suicide for their non-college peers was 15 per 100,000. Students older than 25 (largely graduate students) have a suicide rate of roughly 10 per 100,000.

In a review of suicides in the Commonwealth of Virginia from 2003-2007 (Leslie, 2009), the Office of the Chief Medical Examiner reported a suicide rate of 11.7 per 100,000 for individuals aged 20-24 years; this rate was almost double that of individuals 15-19 (6.8 suicides per thousand) but was consistent with the common finding that the suicide rate increases as the population ages, reaching a peak above 18 per 100,000 for individuals 75 and above. The medical examiner gathered information on a range of circumstances for each deceased individual including whether they were enrolled in college at the time of death; of the individuals who completed a suicide, 36% were enrolled in a college at the time of death. This number likely represented an

underestimate, given that some students may have been on medical leave or may have been part-time students at the time of death (Leslie, personal communication).

The Virginia College Mental Health Survey (VCHMS) surveyed counseling center directors and student affairs personnel at each of the public and private universities, as well as the community colleges, asking if they knew how many student suicide attempts and completed suicides occurred in their student bodies during the academic year 2008-2009. Based on the data presented above, the expected values were calculated for both of these and are contrasted with the reported cases of which the college or university were made aware in that year.

Table 2

	Public	Private	Community	Total
Enrollment	206,338	76,752	177,121	460,211
Expected Suicide Attempt (1/2 of 1%)	1032	384	886	2302
Attempts Known to School	67	12	12	81
Expected Suicide Rate (7.5 per 100,000)	15	6	13	34
Suicides Known to School	8	1	2	11

Given the discrepancy between the expected values and the numbers known to the college or university, it appeared that most attempts and completed suicides were not reported to the school. A number of reasons could account for this, including the following:

- Many students live off-campus in apartments or at home with families and therefore the college would not have a way of having this information funneled to them;
- Families of students who commit suicide may not want to share that information with the school;
- It is unclear how to define when a student is counted as enrolled; is it only when they are attending in the current semester or if they are on medical leave or if they have been enrolled in the past 12 months (which would cover recent graduates as well);
- Occasionally, it is unclear when a death is a suicide, e.g. many single car fatalities may be the result of suicide, but this is not clear in the absence of any other confirmatory evidence, and;

- Many students who attempt suicide are not receiving counseling services and their difficulties may not come to the school's attention.

While it may appear that any person who commits suicide is "mentally ill," that is not apparent from the data presented by the Office of the Medical Examiner (Leslie, 2009). In the OME report, information was collected regarding (a) whether the victim had any known history of mental illness, (b) when a physician found any evidence in an investigation, and (c) when the individual was known to have been in current or past mental health treatment – and it was acknowledged that mental health records were not always available. Under these criteria, of the known suicides from 2003-2007 in the 20-24 age range, almost 60% did not have mental health problems when they committed suicide. Factors such as impulsivity, access to weapons, recent stressful events, and substance abuse may contribute to the number of suicides in this age group. The majority of suicides are committed by individuals who are unknown to mental health professionals.

Alcohol Use. The use of alcohol on college campuses presents significant concerns for a variety of reasons including the following:

- With the uniform drinking age of 21 in the United States, 18-20 year-old students consume alcohol illegally; this is a particular problem for colleges and universities if the students are in residence and violate both the law and student conduct policies;

- Students who drink will often drink to intoxication with possible direct threats to their health from excess use as well as negative consequences of drinking including driving under the influence, and accidents resulting from excess use (ACHA, 2009), and;
- Excessive alcohol use has negative effects for college students including their interactions with peers and academic progress (ACHA, 2009).

Large-scale, government-funded studies of alcohol use revealed an inverse relationship with age; frequency of alcohol use and excessive use rose for 18-20 year-olds, peaked at 21-25 and then dropped over time with increasing age (NSDUH, 2009). Full-time college students were more likely to reach criteria for an alcohol abuse diagnosis than were their part-time or non-college attending peers and very few of them perceived the need for treatment or receive treatment for alcohol abuse (Wu, Pilowsky, Schlenger & Hasin 2007); however, their increased drinking did not make them at risk for higher rates of alcohol dependence (Slutske, 2005). In the years after completing their studies, college graduates were more likely to drink than are non-college graduates, but they were also less likely to have alcohol dependence and a need for treatment.

Mental Health and Educational Attainment. As might be expected, adolescents and young adults who experience psychological disorders experience more difficulty in reaching appropriate educational milestones. Breslau and colleagues (2008) utilized data from a large scale, interview-based study to examine school terminations due to

psychological concerns. Graduation from primary school and high school, entrance to college, and graduation from college were all affected by the presence of psychological disorders. Students who finished high school but abused substances or had impulse control problems were less likely to enroll in college and to graduate from college. College students with panic disorder and/or bipolar disorder were significantly less likely to graduate from college. In general, students with one disorder were no more likely to be affected than their peers with no disorder but two or more disorders predicted failure to reach the educational milestone; the more complex the problems, the more likely students were to not complete educational goals.

Once in college, students may experience physical and psychological challenges that affect their individual performance. The National College Health Assessment II (American College Health Association, 2010) surveyed students from a wide range of colleges; students in this study reported negative academic effects from the following concerns: anxiety (20.8%), depression (12.4%), alcohol and drug use (7.8%), and stress (31.1%). Other concerns, including relationship difficulties (12.6%), worry over family and friends (11.6%), and sleep difficulties (23%), also led to difficulties in academic performance. As noted above, at least 10-15% of college students experienced impairment in their academic functioning as a result of a diagnosable mental disorder.

Clearly, mental health concerns affect likelihood of attending college, doing well in college, and likelihood of graduating from college.

C. Summary

Based on the data and studies reviewed above, the Task Force estimates at least 10% of Virginia's college students are experiencing significant mental health concerns at any given time. Since over 460,000 students are enrolled in Virginia colleges and universities, the Task Force estimates that at least 46,000 students are in need of psychological assistance.

Are the colleges in the Commonwealth prepared to assist this many students through counseling services? Answering this question requires attention to a number of issues, including the following:

- What is the percentage of students living on-campus or commuting from home? Students living on-campus are more likely to utilize services while students who commute may be more likely to utilize resources in the community. Colleges that recruit a significant number of students from out-of-state are more likely to have a great percentage of students in residence;

- What percentage of students enter college having been in treatment, either counseling or medication, previously? Students entering on medication or having been in counseling may already have providers with whom they intend to continue treatment; and,

- College students seek assistance for a range of situational concerns including homesickness, relationship issues, academic stress, and developmental concerns – none of which are considered psychological disturbance. Thus the potential demand for services exceeds the 10% of students who are struggling with significant psychological disturbances.

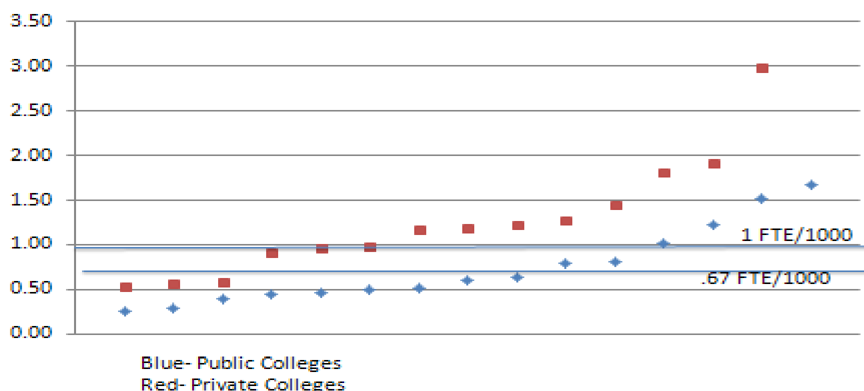
The next two sections of this chapter address the capacity of the Commonwealth's residential colleges and community colleges to serve students with mental health problems.

II. Mental Health Services in the Commonwealth's 4-year Residential Colleges.

The Virginia College Mental Health Survey (VCMHS) collected data on counseling services available at each college and university in the Commonwealth, with the exception of one school. Figures are available regarding mental health counseling services at the majority of schools.

All of the 15 four-year public colleges and 22 of the 25 private colleges offered mental health counseling services to students who were enrolled (generally full-time students). In the state, 206,338 students were enrolled in public four-year colleges at the time of the study parameters (2008) and 76,752 were enrolled in private four-year colleges. (An additional 177,121 were enrolled in community colleges.) Given that average enrollment at public colleges was four times as great as average enrollment at private colleges, the actual number of professional counseling staff at public colleges and universities (7.7) was greater than that at private institutions (1.9). However, a better measure of the amount of counseling services offered was the number of counselors for every one thousand students enrolled.

Figure 1



As is evident in Figure 1, the ratio of counselors per 1,000 students was much higher for the private colleges on average than for the public colleges.

The only standards for staffing ratios in counseling centers are provided by the International Association of Counseling Services, Inc. (IACS), an independent accreditation agency. The IACS recommendations are as follows:

> "Every effort should be made to maintain minimum staffing ratios in the range of one F.T.E. professional staff member to every 1,000 to 1,500 students [i.e., from 0.67 to one F.T.E. professional staff member per 1,000 students], depending on services offered and other campus mental health agencies."

While not all counseling centers are accredited by IACS, most use the IACS standards as aspirational. *Using the International Association of Counseling Services standards as a guide, the majority of private colleges in Virginia meet the minimum requirement of one counselor per 1,500 students while the majority of counseling centers in the public colleges do not meet the requirement.* These findings correspond with national data (AUCCCD, 2010) for public and private colleges, where private colleges and universities have greater numbers of counselors per student than do the public colleges and universities; these data are confounded to some extent by the fact that smaller schools (largely private) had more counselors per thousand students than did larger schools (largely public).

Counseling Center Utilization by Students

In the Commonwealth, the percentage of the student body served by the counseling centers parallels the staffing pattern. *In the public colleges and universities, 6.3% of the student body utilized services in the counseling center during academic year 2008-09, compared with 11.1% of the student body in the private colleges and universities.* A comparison of national data showed that private universities and public universities served equal numbers of students for schools under 10,000 but, as the number of enrolled students grew larger, the public universities dropped to between 6-7% while the private universities continued between 9-14.5% (AUCCCD, 2010). In general, smaller private colleges and universities saw a greater percentage of the student population than did larger public colleges and universities.

It is unclear what factors determined staffing and usage patterns. It is likely that counseling usage at public universities was affected by lower staffing patterns -- although some have argued that the demand for such services was higher among students who attended smaller private colleges and universities. The extent to which on-campus residential housing affected usage was not clear. Perhaps, the safest assumption is that, *if you build it, they will come*, and, at this time, private colleges and universities devote more resources to the counseling center than public universities are able to provide.

Access to counseling services is demonstrably beneficial. Use of counseling services has been shown to increase retention and graduation rates (Lee, Olson, Locke,

& Michelson 2009; Flynn, Flynn & Cornwell, 2005) Students receiving counseling are more likely to remain in school and are more likely to graduate within five years of enrollment. Colleges and universities seeking to improve retention and graduation rates would benefit by providing counseling services to students at risk of academic failure).

Interestingly, the number of times a student visited the counseling center was fairly consistent. The median number of counseling sessions per students averaged five for Virginia public colleges and universities and 5.4 for Virginia private colleges and universities. Nationally, mean number of visits for public and private colleges and universities was between 4.8 and 6.0, so these numbers, at face value, are quite similar (AUCCCD, 2010).

Psychiatric Resources on the College Campus

With about 5-10% of the college population taking prescribed medication for a mental health problem, on-campus access to psychiatric services is clinically important for students in residential colleges. The standards for psychiatrists on the college campus are less defined than the standards for counselors issued by IACS. Factors affecting the need for psychiatrists include:

- The Canadian Psychiatric Association recommends one psychiatrist for every 7,500 individuals in the community and while this is generally helpful, it is less clear for the college campus since students may reside off-campus, and if residing on-campus, may obtain their prescription from a treating physician in their hometown;

- Many family physicians and pediatricians are comfortable prescribing medication for attention-deficit disorder, as well as the SSRI's for anxiety and depression, and;
- In general, psychiatrists are located in larger urban areas, so psychiatric practitioners are less accessible in rural areas.

A brief overview of the psychiatric coverage from the last AUCCCD (2010) report may provide some context for this discussion. In smaller colleges and universities (under 2,500), roughly half of the reporting schools offered psychiatric hours. As schools increased in size, they were much more likely to have some psychiatric availability on campus; at 10,000 and larger, the vast majority offered psychiatric assistance. Similarly, the average amount of psychiatric hours offered increased with the size of the institution. When private universities were contrasted with public universities, many more psychiatric hours were offered by the private universities.

Gallagher (2010) reported that of the schools offering psychiatric consultation, the average number of weekly hours per 1,000 students was 1.8, so on average, a university with 10,000 students would have 18 hours of psychiatric coverage. *When the nation's counseling center directors are queried if the psychiatric hours available are sufficient, only 10-30% report that they have adequate coverage.*

Access to Off-Campus Mental Health Services

In the Virginia College Mental Health Survey, the public, private, and community colleges were asked where they turned for help when their resources were exhausted; the private colleges were most likely to turn to private providers (58%), the community colleges to the local community service board (83%), while there was a greater variation among the public colleges. The challenge in utilizing community service boards (CSBs) for psychiatric assistance was that of the 72 psychiatric positions in CSBs across the state, roughly 10-15% of the positions were vacant at any one time and the vacancies were more likely to be in rural areas. Further, psychiatric turnover in the CSBs may be as great as 28% per year (Workforce Development Committee of the Task Force on Access to Services, Commission on Mental Health Law Reform, 2010). In Virginia, most CSBs have sufficient capacity to treat only the most severely ill clients, leaving most college students dependent primarily on private practitioners if they are insured or can afford to pay out-of-pocket. As will be discussed below, students in the community college system cannot obtain either psychiatric treatment or counseling services on campus, and may have difficulty accessing services in the community as well.

A major challenge in receiving counseling or psychiatric care in the private sector is that many young adults are uninsured and may have limited funds for accessing mental health care. Young adults (19-24) are the group least likely to have health insurance of any age group in the Commonwealth of Virginia; 2010 figures indicate that 27.5% of young adults lack insurance and this group includes over 170,000 young Virginians.[9] *With limited insurance, coupled with a lack of resources in the private sector, access to mental health care off-campus is severely constrained for many (The Commonwealth Institute, 2011).*

III. Mental health Services in the Commonwealth's Community Colleges

The mission of community colleges in the Commonwealth is broader in scope than the mission of four-year colleges and universities; the community colleges offer services to advanced high school students, to students who seek a workforce credential, to students whose desire for higher education may be limited by finances, to adults seeking to increase their skills, and to persons under criminal justice supervision who are planning for work opportunities after completing their sentences. By definition, these colleges serve the communities in which they are located and aim to increase access to higher education for all. The strategic plan for community colleges sets a goal of *"increas[ing] the number of students graduating, transferring or completing a workforce credential by 50 percent, including increasing the success of students from underserved populations by 75 percent."* *(Achieve 2015, 2011.)*

[9] It does not appear that this number has been significantly reduced by the recent change in federal law under the Affordable Care Act because the families of the great majority of these uninsured students are not covered by the employer-based group health plans to whom the law is applicable.

Community colleges in the Commonwealth are asked to do a tremendous amount and serve a very large number of citizens. Their staff does a great deal without resources comparable to those often available to the four-year schools. However, the community colleges are in a bind when expectations of service delivery far exceed the resources of the colleges.

Mental Health Service Capacity in Community Colleges in Other States

In 2006, Gruner and colleagues looked at the websites of 1056 community colleges in the U.S. and territories to see what mental health services were advertised. Surprisingly, 52.8% of those community colleges advertised some type of personal counseling, ranging from a counselor or faculty member providing services to having licensed mental health providers offering formal treatment. By region, the percentage ranged from 45% in the western states to 66% in the northeastern states. One wonders what services were actually being provided and by whom. As part of the same project, Gruner et al (2009) sent a survey to the nation's community colleges and received 143 responses (13.5% response rate), finding that:

- 35% of community colleges offered formal, full-time clinical services with trained providers;
- 13% offered part-time clinical services with trained providers;
- 4% had contracts with community providers;
- 9% offered informal services provided by academic counselors or faculty members;
- 15% referred out only;
- 1% offered no mental health services or referral whatsoever, and;
- 23% indicated some "other" combination.

It is likely that these responses were skewed in the direction of colleges who provide counseling services (as opposed to those who don't) and therefore were not representative of all the nation's community colleges. Even so, two findings stand out: About half of the responding community colleges (perhaps representing a quarter of all the country's community colleges) offered full or part-time services by clinically trained providers. Second, students enrolled in a significant portion of the nation's community colleges were receiving informal counseling by staff members who are not trained clinically.

Mental Health Service Capacity in Virginia's Community Colleges

As a matter of policy, Virginia's community colleges do not provide counseling services. The *Policy Manual for Virginia Community Colleges* (http://www.vccs.edu/WhoWeAre/PolicyManual.aspxcolleges (http://www.vccs.edu/WhoWeAre/PolicyManual.aspx states the following:

> "6.4 Student Development
> 6.4.0 Counseling (C)
> VCCS colleges shall maintain a staff of academic counselors and/or advisors to assist students in making decisions regarding career, educational, and personal/social plans. *VCCS colleges do not provide mental health services*. However, VCCS colleges shall develop and implement guidelines that advise students, faculty, and staff of the proper procedures for addressing the needs of a student who may pose a threat to him/herself or to others." [Emphasis added]

Based on the Task Force's investigation, it appears that very few community colleges in Virginia have clinically trained counselors on their staff – a much smaller proportion than in most other states.

Findings and Observations

Based on the Virginia College Mental Health Survey and other information obtained during the study, the following findings and observations are offered by the Task Force:

1. While at least one fourth, and perhaps half, of community colleges in the United States may have mental health counseling available on campus, Virginia's community colleges do *not* offer mental health counseling services at the present time.

2. Virginia's community colleges have far fewer staff in student affairs to reach out to students who may be struggling with personal, behavioral, or mental health issues while enrolled in school. As indicated in Table 3, community college resources lag behind other public colleges and universities, and far behind the private colleges and universities.

3. Community college students are no less at risk of mental health concerns than are other students in the Commonwealth – as noted earlier, fully 10% of college students are in need of mental health services.

4. Given that community colleges do not have students in residence, it might be expected that students obtain mental health services from public and private agencies in the greater community. However, there is reason to believe that a significant portion of community college students do not have access to off-campus mental health services because they are more likely than students in the 4-

year colleges to be uninsured or under-insured and because most community services boards lack capacity to provide timely outpatient services.

5. Community colleges rely heavily on relationships with the local community service boards to provide services to students, often seeing the CSB as the nearest resource for mental health concerns – however, the CSBs are often constrained in their staffing and capacity for providing counseling and psychiatric assistance to college students, even though they have no access to counseling services on campus or to private providers.

6. Although community colleges do not currently offer mental health counseling services, the governing policy does require them to develop "proper procedures for addressing the needs of a student who may pose a threat to him/herself or to others." The capacity of each community college to prevent and respond successfully to mental health crises depends on timely access to clinically trained professionals to conduct screening and referral as well as to undertake or coordinate adequate emergency services response. Current capacity is uneven.

Table 3

Paid Professional Student Affairs Staff Engaged in Direct Support to Students

College	Mean N Staff Per College	Mean N Staff Per 1,000 Students
Public	28.8	3.6
Private	17.9	14.0
Community	12.2	1.9

8

7. Community colleges often serve a greater proportion of people of color than do private and public four-year schools and people of color are half as likely to have adequate insurance to seek mental health resources in the community when necessary.

8. Community colleges have far lower retention and graduation rates than do four-year colleges and universities and students in community colleges are at higher risk of experiencing substantial educational disruption due to acute mental health problems. *Disparities in educational attainment among minority students are*

probably magnified by lack of access to mental health services.. (See Section IV below)

IV. DIVERSITY ISSUES IN HIGHER EDUCATION IN VIRGINIA

As is evident from the above discussion, there are significant discrepancies in the support services available to students depending on where they attend college; in general, private colleges and universities offer more resources than do the public four-year colleges and universities which, in turn, offer more than the community colleges. By almost all measures, graduation from any college has a direct impact on later earnings in the workplace, and a more educated populace benefits the individual and society as a whole. Virginia, in comparison with the other states, has a relatively well-educated population, ranking 12th (American Community Survey, US Census Bureau, 2007) overall among the states in proportion of the population with a college degree. However, this favorable situation is offset in part by significant discrepancies according to race and ethnicity among the citizens of Virginia. Disparities in educational attainment limit potential individual success and contributions to the larger society. Further, support services that are known to increase retention and graduation should be available particularly to the students most at risk of not completing school. In the following, a brief review of educational attainment by race and ethnicity in the Commonwealth may be helpful in delineating some of these issues.

Path to Higher Education in Virginia

Table 4

Virginia Drop-out Rate and High School Completers Enrolling in College*

	High School Dropout Rate	Percent of H.S. Completers Enrolling in 2- Year College	Percent of H.S. Completers Enrolling in 4-Year College
White	5.4%	25%	41%
African-American	12.4%	22.6%	29.3%
Hispanic	18.3%	28.4%	19.5%
Asian	3.7%	25.8%	50.8%
American Indian	10.3%	20.0%	32.3%
Native Hawaiian	6.5%	28.0%	37.8%
Other	5.0%	24.6%	43.6%
All	8.2%	24.6%	37.4%

*Institute for Education Sciences, 2011

Table 5

Graduation Rates within 150% of Time*

	2-Year College	4-Year College
White	17%	68%
African-American	8%	47%
Hispanic	10%	59%
Asian/Pacific Islander	18%	70%
All	15%	54%

*Complete College America, U.S. Department of Education, IPEDS Graduation Rate File; gr2008 Early Release Data File Download

Table 6

Educational Attainment in the Commonwealth of Virginia – Age 25 and Above*

	No High Degree	High School Degree Only	Some College	Associates Degree Only	Bachelor Degree	Grad/Prof Degree
White	12.2%	26.5%	18.6%	6.6%	21.5%	14.6%
Af/Am	20.2%	32.1%	22.3%	6.5%	12.0%	6.9%
Hispanic	31.5%	25.3%	17.0%	6.4%	11.3%	8.5%
Asian/PI	12.1%	15.3%	11.2%	6.1%	31.2%	24.1%
AI/AN	20.1	21.5%	25.2%	10.3%	16.5%	6.3%
Other	15.1%	20.1%	27.0%	7.7%	15.9%	14.3%
All	14.6%	26.8%	18.9%	6.5%	19.7%	13.4%

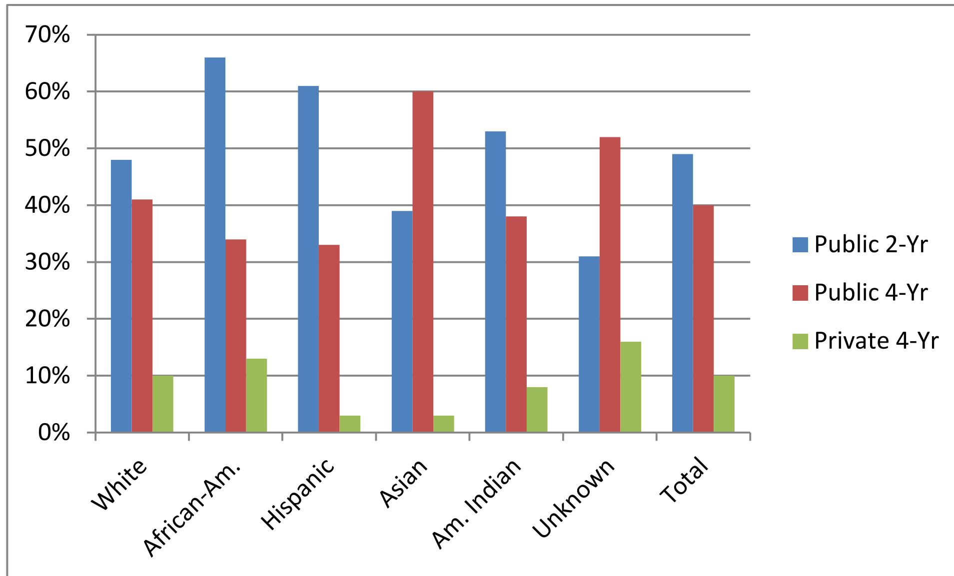
*U.S. Census Bureau, 2005, American Community Survey, Estimated Rates

As Tables 4, 5 and 6 illustrate, people of color (apart from Asians) do more poorly on almost every measure of educational success. Hispanics are most likely to drop out of high school, more likely to enter a community college, least likely to enter a four-year school, and least likely to graduate on-time. In the general population over 25, Hispanics are least educated with a majority having a high school degree or less. African-Americans fare little better by educational measures. A majority of African-Americans have a high school degree or less. The high school dropout rate is greater than average, while entering college and completing a degree are below average. In the population of 25 and over, less than 20% of Hispanics or African-Americans hold a bachelor's degree or higher, as compared with 36% of whites. American Indians/Alaskan Natives also do more poorly across the board in comparison to the average citizen of the Commonwealth.

Figure 2 reveals ethnic differences in enrollment patterns across colleges and universities in the Commonwealth. Students of color (apart from Asians) are more likely to be enrolled in community colleges which have the lowest retention and graduation rates. While African-Americans are slightly more likely than the average student to be enrolled in private colleges and universities, the private historically black colleges and

universities rank among the lowest in graduation rates within 150% time (Complete College America, 2011).

Figure 2



As the Commonwealth becomes more diverse in population, the need to address disparities in education becomes crucial for all citizens. The gap between whites and Hispanics and African-Americans is widening with profound effects for the individuals and the state as a whole.

The main conclusion is that people of color have the greatest need for support services and the least access to those support services. As noted above, mental health services are in greatest supply in private four-year institutions of higher education, less so in public four-year institutions and least so in community colleges. Although it is known that access to mental health counseling improves retention and graduation rates, people of color are less likely to have access to mental health counseling and psychiatric services on campus, increasing the risk of educational failure. Hispanics, African-Americans, and American Indians are half as likely to have health care coverage compared to the average American; therefore they are less likely to have access to mental health coverage in the private sector. The rate of being uninsured is greatest among young adults 19-24; access to services at community service boards and at mental health associations is very constrained, leaving many young adults, especially those of color, without recourse for mental health assistance. Earning power is clearly correlated with amount of education and greater financial success means greater access to health care.

V. Campus-Based Mental Health Awareness and Suicide Prevention

Despite the severity and prevalence of suicidal ideation and depression, 80% of students who die by suicide are not known to the campus counseling center. Most

students who did utilize on- and off-campus counseling services reported satisfaction with the services provided (Healthy Minds Virginia, 2009) and students who sought counseling were six times less likely to die than students who did not. In addition, 52% of students who confided in others about their suicidal ideation reported that telling the first person was helpful in dealing with their suicidal thoughts. These findings suggest that **strategies to promote *early identification and help-seeking* are an essential part of a campus' suicide prevention plan**.

The Campus Suicide Prevention Center of Virginia is a valuable resource for the Commonwealth's colleges and universities and is available to provide consultation and technical assistance. The Task Force regarded early identification of students with mental health problems and active efforts to provide opportunities for assistance and referral as a basic obligation of colleges and universities. As will be explained below, the Task Force also believed that students themselves, as well as teachers and staff must be engaged proactively in these efforts. Although these activities will depend on the availability of resources, every institution should make some effort to raise student awareness and harness student energies.

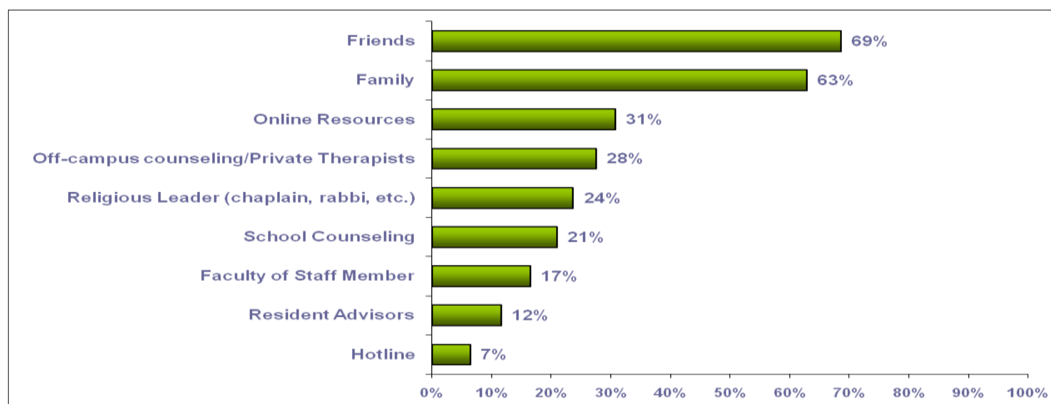
Natural Helper and Mental Health Awareness

Based on inquiries made by members of the Joint Commission, the Task Force reviewed the literature on safeTALK, Campus Connect, Student Support Network and Mental Health First Aid. These are "Best Practice Programs" (sprc.org) that are used to enable students to recognize signs of mental or emotional distress or dysfunction. These programs can be a valuable addition to a comprehensive campus plan. However, it is essential to first understand, build and streamline the response capacity of a campus and/or community mental health services. Additional program details are available in Appendix B.

Peer Participation

Research consistently reported that distressed college students first turn to friends for help (see Figure 3). Two-thirds of college students who disclosed suicidal ideation first chose to tell a peer, such as a romantic partner, roommate or friend. Similar findings were reported among middle and high school aged youth. Also, because they interact throughout the day and night as well as weekends, students were often the first to recognize health and safety risks among one another.

Figure 3. Where Students Turn When in Distress* (*JED, 2006).



With these findings in mind, we *concluded* that **peer involvement in campus based suicide prevention *is a given***. Students' interactions are natural and on-going, inc*luding during times of distress.* The challenge to campus leaders, therefore, is not to determine whether peers *should* be involved in suicide prevention efforts. Rather, it is to *promote involvement that is both safe and effective*. (italics added for emphasis)

There are many existing campus-based models for peer helper programs (e.g., peer educators, peer counselors, peer mentors). These approaches were described by Hakkuvan et al (2011) in a special study prepared for the Virginia College Mental Health Study by the Campus Suicide Prevention Center of Virginia and published as Appendix B to this Report ("Peer Involvement in Campus-Based Suicide Prevention: Key Considerations"). As Hakkuvan and colleagues emphasized, peer involvement in suicide prevention planning warranted special considerations, as peers may become involved in ways that can inadvertently increase risk for vulnerable youth. Involving peers to promote student mental health and safety must be part of a comprehensive, campus-wide plan that uses carefully selected strategies in combination over time. A comprehensive plan includes universal strategies to promote mental health and social connectedness for all students, training for identification, early intervention and help seeking for students at risk, crisis intervention and emergency safety strategies for students in distress, plans for relapse prevention following a crisis and post-crisis plans to protect and support students after a completed suicide.

There is currently very little research on the roles, risks and benefits of involving peers in campus-based suicide prevention. Since data is essential for planning safe and effective programs, it is especially important to develop, implement and share data as well as evaluation strategies. Aggregate data across multiple campuses allows for more meaningful evaluation and conclusions about program impact over time. There is also little research on creating culturally competent peer helper training for campus based suicide prevention. We know that individuals within some sub cultures have higher levels of risk for suicide and are less willing to acknowledge or seek help for personal distress. We need to develop strategies for obtaining information to guide the development of messages and programs that are culturally sensitive and that promote safety and wellness among minority cultures.

VI. CONCLUSIONS AND RECOMMENDATIONS

The Task Force regards the current lack of accessible mental health services to community college students as a serious problem. Epidemiological data reviewed earlier suggests that even if the prevalence of mental health problems is no higher among community college students than among students in the Commonwealth's residential colleges, a significant portion of enrollees in community colleges (at least 10%) experience mental or emotional distress or dysfunction during a given academic year; and that a substantial portion of these students (higher than in the residential colleges) is uninsured and lacking access to mental health services in the community (except in

emergencies). The need to respond to this problem is accentuated by the fact that failure to do so aggravates the already substantial disparities in educational achievement among people of color.

Increasing numbers of Virginia's young adults are enrolled in community colleges and spending a substantial portion of their time attending classes and interacting with their peers on the community college campuses. These activities provide natural opportunities for (i) educational and outreach efforts to raise awareness of mental health problems and to facilitate case-identification, (ii) preventive interventions, and (iii) screening and referral services. However, without clinically trained employees or consultants, community colleges are not in a position to undertake screening, counseling and referral measures that can prevent crises. Their ability to coordinate knowledgably with community service boards or families in the event of emergency interventions will also be limited.

Recommendation 1: The Commonwealth should embark on a sequential plan, as resources permit, to assure that every community college has the capacity to provide brief screening and referral services for students who appear in need of mental health intervention; to maintain fully staffed threat assessment teams; to conduct risk assessment screenings in cases that may pose a risk of harm to campus safety; and to coordinate with CSBs, law enforcement agencies and families to carry out emergency interventions and other types of crisis response when necessary.

This recommendation is meant to declare a goal without prescribing a one-size-fits-all approach for achieving it. It envisions flexible responses in what services are provided and in the staffing needed to deliver them, depending on the size, financial capacity, and location of the particular community college. To be clear, it is not necessary for every community college to provide direct counseling services. ***However, community colleges that are able to provide direct counseling services should be encouraged to do so (and should not be precluded from doing so as a matter of policy).*** For the foreseeable future, the Task Force assumes that community services boards will be the primary provider of safety net services for uninsured college students, and hopes that economic recovery will eventually allow the Commonwealth to fund CSBs at a sufficient level to increase their capacity to provide timely outpatient services.

The primary aim of this recommendation is to establish a minimum capacity for screening and referral in every community college. A variety of staffing mechanisms are available to enable the smaller community colleges to enhance their mental health service capacity. The options include:

- *Devote one or more full-time positions to mental health duties.* At least in the short term, this option may be possible only for a small proportion of community colleges;

- *Combine mental health duties with academic counseling in an existing position*. With the usual expected turnover in administrative staff, one or more positions in the sphere of student affairs or academic counseling could be redefined to include the mental health duties (screening, referral and coordination) described above, and the necessary qualifications for such a redefined position could include a master's degree in counseling or equivalent mental health training with appropriate licensure;

- *Contract with a licensed provider for mental health consultation and liaison services as needed.* This is a feasible option for a significant number of community colleges, and;

- *Devise creative arrangements with community services boards to leverage service capacity*. For example, paraprofessional and trainee services can be available to the students in connection with certification and degree programs in which instructors and supervising clinicians are drawn from the CSB staff.

Recommendation 2: Each college and university that has not already done so should establish a planning group for involving and guiding students in clinically, culturally, ethically and legally appropriate roles in campus-based mental health awareness and suicide prevention.

The planning group's charge should include:

- Reviewing the *Key Considerations for Peer Involvement in Campus Based Suicide Prevention* developed by the Campus Suicide Prevention Center of Virginia (attached to this report as Appendix B).

- Identifying current programs on their campus, if any, in which students are engaging in mental health awareness and early detection of risks to determine whether these programs are in line with guidelines for "safe and effective" work set forth in the *Key Considerations* document;

- Formulating a strategy for involving student peers in mental health awareness and suicide prevention in a way that best fits the needs and resources of the particular college or university and that avoids putting students in roles that are clinically, legally, ethically or culturally inappropriate;

- Appointing a working group of faculty, administrators and students to develop a specific program for implementing the strategy, and;

- Carrying out and evaluating the program with the consultation and advice of the Campus Suicide and Prevention Center of Virginia.

3
Report of the Task Force on Legal Issues

I. INTRODUCTION.

The Task Force on Legal Issues ("Task Force") set out to evaluate the impact of recent Virginia legislation and to (a) identify any remaining gaps in state law, (b) discover implementation challenges faced by Virginia schools, and (c) promote best practices among Virginia institutions. The Task Force relied on the findings of the Virginia College Mental Health Survey ("VCMHS") to inform its work.

II. STATUTORY FRAMEWORK.

There was considerable interest in federal legislation in the aftermath of the Virginia Tech tragedy. Federal laws governing health records privacy ("HIPAA") and disability discrimination (the "ADA" & Section 504) received significant media attention. The Family Educational Rights and Privacy Act ("FERPA") entered common American parlance. Without question, these federal laws play a significant role in college mental health issues. But they are only one part of the conversation. State laws, particularly in Virginia, are equally significant.[10]

College mental health laws impact three stages of a student's tenure: (1) Post-Admission/Pre-Enrollment; (2) Enrollment; and (3) Post-Enrollment. The Task Force evaluated relevant state laws within this same sequential framework. The Task Force's findings and recommendations are outlined below with references to supporting data from the VCMHS.

A. <u>Post-Admission/Pre-Enrollment</u>.

1. <u>Sharing of Student Records during the Admission Process</u>

Va. Code § 23-2.1:3, enacted in 2008, provides as follows:

> Va. Code § 23-2.1:3. <u>Students' high school records</u>. *Each public and private institution of higher education* ***may require*** *that any student accepted to and who has committed to attend, or is attending, such institution provide, to the extent available, from the originating school a complete student record, including any mental health*

[10] As a starting premise, it is important to understand that HIPAA is *<u>not applicable</u>* to the vast majority of campus counseling centers. HIPAA is applicable to hospitals and private health providers. When students access mental health services off campus, HIPAA becomes very relevant to college mental health issues. However, when students access services in a counseling center on campus, HIPAA is largely irrelevant. Most campus counseling centers are exempt from HIPAA; they are governed by FERPA and state health care privacy laws. The Virginia Health Records Privacy Act, Va. Code §32.1-127.1:03, is the primary governing statute for Virginia campus counseling centers.

records held by the school. These records shall be kept confidential as required by state and federal law, including the Family Educational Rights and Privacy Act, 20 U.S.C. § 1232g. (Bold added for emphasis)

Statutory History: Passed by General Assembly, 2008. Formerly SB 636 (Cuccinelli). Signed into law by Governor Kaine on April 9, 2008. Effective: July 1, 2008.

Possible Gaps: Colleges and universities have long been advised against seeking student mental health information as part of the admissions process due to legal concerns created by the ADA. In this regard, Va. Code § 23-2.1:3 properly times receipt of any subject mental health records ***after*** a student's ***admission*** and ***before*** his/her intended ***enrollment***. The statute does, however, have some significant shortcomings. In the majority of cases, when a student enrolls directly from high school, there are likely to be few, if any, mental health records held by the originating school. High school counselors do not typically provide mental health treatment for the most severe conditions; in such instances, the student likely accesses private or community-based mental health services outside the school setting. In cases where a student is transferring from one institution of higher education to another, there is a much greater likelihood that the originating institution might have a significant mental health record. However, because this statute is titled "Students' high school records," there is some confusion regarding whether it authorizes receipt of records beyond high school.[11]

Implementation Challenges: Va. Code § 23-2.1:3 initially caused little concern among Virginia schools due to its permissive text. It *permits* colleges and universities to seek school mental health records; it *does not require* them to do so. Still, this statute has caused Virginia school officials mild consternation. There has been considerable discussion among school officials regarding whether to collect such records from all incoming students. On a practical level, most college counseling centers are challenged to meet the needs of their current student population. At larger Virginia institutions, it is unrealistic to believe that a counseling center could review complete records for 3,000+ new students.

Furthermore, even if a school were to attempt to do collect records, what could/should institutions do with the information? If schools collected records from every incoming student, was there a legal duty to review all the records and/or monitor certain incoming students? If schools identified an incoming student of concern, could they do anything other than provide outreach in the hope that the student would establish a good, voluntary relationship with the counseling center from the start? There are clear

[11] Under standard rules of statutory interpretation, the title of a section does not displace or alter the clearly operative language of the provision itself. Caminetti v. United States, 242 U.S. 470, 489-90 (1917) (""…[T]he name given to an act by way of designation or description, or the report which accompanies it, cannot change the plain import of its words. If the words are plain, they give meaning to the act, and it is neither the duty nor the privilege of the courts to enter speculative fields in search of a different meaning."). However, the misleading title of § 23-2.1:3 creates confusion and uncertainty that can easily be erased by modifying the title.

ADA impediments that prevent schools from taking involuntary adverse action against a student who poses only a general concern, particularly one that has yet to step onto your campus and cause behavioral problems.

Despite these practical realities and legal barriers, school administrators still find themselves in a "damned if you do; damned if you don't" position with respect to this statute. School officials know they cannot possibly review every incoming student's complete mental health record. Yet, school administrators struggle with this decision and ask themselves: "If we do not review every record, and there is one "Cho" with a rich mental health history in our midst, won't we be blamed for not finding the proverbial needle in our incoming class haystack?"

VCMHS Findings: The VCMHS results confirmed that no institution in Virginia currently requested mental health records for all its incoming students. Although four public institutions, two private, and two community colleges reported that they had requested mental health records from an originating school, they did so only for particular students. During the 2008-2009 academic year, only one public institution, one private, and one community college requested such records. The public institution requested records on 20 students; the private on 13 students; and the community college on 64 students.

Conclusion: There was no clear consensus among Virginia schools regarding how best to respond to this statute. Based upon our survey results, a handful of colleges and universities concluded there was some added value in requesting such records in certain cases. However, the requested records were small in number.

Legislative Change: Since the statute is permissive and has proven worthwhile in select instances, the Task Force proposes no significant legislative change. However, the Task Force recommends clarification of the meaning of "originating school" to ensure it includes transferring institutions of higher education, not only high schools.

Recommendation 3: Va. Code § 23-2.1:3 should be amended to make it clear that "originating school" includes transferring institutions of higher education, not only high schools. This can be accomplished by striking the statute's internal title, "Students' high school records," and defining or revising "originating school" to include "secondary school and/or transferring institution of higher education."

B. Enrollment.

1. Interventions for Suicidal Students.

Va. Code § 23-9.2:8, enacted in 2007, provides as follows:

> Va. Code § 23-9.2:8. Policies addressing suicidal students. *The governing boards of each public institution of higher education shall develop and implement policies that advise students, faculty, and staff, including residence hall staff, of the proper*

procedures for identifying and addressing the needs of students exhibiting suicidal tendencies or behavior. The policies shall ensure that no student is penalized or expelled solely for attempting to commit suicide, or seeking mental health treatment for suicidal thoughts or behaviors. Nothing in this section shall preclude any public institution of higher education from establishing policies and procedures for appropriately dealing with students who are a danger to themselves, or to others, and whose behavior is disruptive to the academic community. (italics and underlining for emphasis)

Statutory History: Passed by General Assembly, 2007. Governor Kaine signed bill into law three weeks before the Virginia Tech tragedy. Known as the "Jordan Nott law," it became effective on July 1, 2007.

Jordan Nott: Based upon information from public court records, Nott was a sophomore and allegedly straight-A student at George Washington University ("GWU"). In April of 2004, Nott's friend killed himself by jumping out of his residence hall room window while Nott and two other friends were in the hallway. Nott had intended to become roommates with the decedent for the upcoming 2004-2005 school year. In the Fall of 2004, Nott experienced depression when he returned to GWU. He sought and received counseling from the GWU Counseling Center. He was prescribed Zoloft on a daily basis and Ambien, as needed.

On October 27, 2004, Nott voluntarily checked himself into the GWU Hospital. That day, GWU notified Nott he could not return to the residence hall. The next day, GWU notified Nott he was placed on interim suspended and charged with a disciplinary violation related to endangering behavior. Nott sued GWU, alleging discrimination under the ADA and unlawful sharing of information between the counseling center and University officials. The suit was settled for an undisclosed sum. Nott later transferred to the University of Maryland. He is known as the poster boy for the campaign against: "Depressed…Get Out!"

Implementation Challenges: Although Va. Code § 23-9.2:8 is well-intentioned legislation, there is general confusion among Virginia schools regarding its impact. All schools have great difficulty reconciling the last two sentences. The underlying legislative intent is straightforward: On the one hand, students should not be disciplined or expelled solely for attempting suicide or seeking treatment for suicidal ideation or behavior – which amounts to penalizing them for symptoms of emotional disturbance and discourages students from getting the help they need. On the other hand, colleges must have ample authority to protect the student and others from harm and to assure campus order.

However, reconciling the actual statutory language has proven problematic. First, the last sentence expressly permits institutions to intervene only if a student is a danger to him or herself or others *and* his or her behavior is disruptive to the academic community. This text has led school officials to question whether the General Assembly intended for school officials to parse the various types of suicidal behavior and intervene only when

those behaviors prove disruptive to the greater community (and not simply to prevent harm to the student him or herself). If the language was meant to be conjunctive, the suicidal student who brings a gun into a residence hall or repeatedly runs out into busy traffic would clearly pass the statutory test. However, the student who overdosed on pills in the quiet of her own off-campus room or suffers from a life-threatening eating disorder presents a more challenging case. If this type of behavior is not disruptive to the academic community, school administrators are prohibited from penalizing the student under Va. Code § 23-9.2:8, an implication that has created even more confusion regarding the appropriate methods of intervention.

A college's interventions with suicidal students are also constrained by federal law, particularly the Rehabilitation and Americans with Disabilities Acts (ADA). Recent changes to ADA regulations have led to further confusion regarding the appropriate circumstances under which a college or university may take adverse action against a student who poses a threat to him or herself. [12]

VCMHS Findings: During the 2008-2009 academic year, at least 11 Virginia college students committed suicide and at least 86 more attempted suicide. One-third of all public colleges experienced a student suicide, and about three-quarters experienced a student suicide attempt. The rates of suicide attempts were lower at private colleges—an average of one attempt per college—than at public colleges—an average of six attempts per college—in part because of the smaller average size of the private colleges. All public colleges, 82.6 percent of private colleges, and 38.1 percent of community colleges, had

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[12] For many years, the federal Department of Education's Office of Civil Rights ("OCR") advised colleges and universities that such actions are permissible under federal disability discrimination law in severe cases where students pose a "direct threat" to themselves or others. See, e.g., Letter from Sheralyn Goldbecker, Team Leader, Office for Civil Rights, U.S. Dep't of Educ., to Dr. Kent Chabotar, President, Guilford Coll. 4 (Mar. 6, 2003); Letter from Michael Gallagher, Team Leader, Office for Civil Rights, U.S. Dep't of Educ., to Dr. Jean Scott, President, Marietta Coll. (Mar. 18, 2005); Letter from Louann Pearthree, Team Leader, Office for Civil Rights, U.S. Dep't of Educ., to Father Bernard O'Connor, President, DeSales Univ. (Feb. 17, 2005). In these letter opinions, OCR stated that potentially suicidal students would be considered "individuals with a disability," protected by the ADA and Rehabilitation Act, whenever a college treated the student as having an impairment and took an adverse action against the student on that basis. However, OCR maintained that this did not prohibit a college from taking such action to address a "direct threat." OCR defined "direct threat" as a "significant risk to the health or safety of the student or others" and clarified that "significant risk constitutes a high probability of substantial harm and not just a slightly increased, speculative, or remote risk." Removal actions, under the "direct threat" test, could only be taken after the University performed an individualized assessment of the student, based upon current medical knowledge and/or the best available objective evidence, taking into consideration ***each*** of the following ***three*** factors: (1) the nature, duration and severity of the risk of harm; (2) the probability that potentially threatening injury actually will occur; and (3) whether reasonable modifications of University policies, practices, or procedures will sufficiently mitigate the risk of harm. In 2011, the ADA Title II regulations were revised to make the direct threat test applicable only when a student presents a direct threat to others. Threats to self are now excluded. This revision took effect on March 15, 2011. Schools are now reevaluating their policies in light of this very significant change.

guidelines for identifying and addressing the needs of students exhibiting suicidal ideation or behavior. Mandated follow-up procedures after a student's suicide attempt or expression of suicidal ideation were in place at 57.1 percent of public colleges, 79.2 percent of private colleges, and 9.1 percent of community colleges.

Conclusion: All of Virginia's four-year public institutions complied with the first sentence of Va. Code § 23-9.2:8 by developing and implementing policies for identifying and addressing the needs of suicidal students. This is a welcome mandate as these policies were a critically important aspect of protecting the mental and emotional well-being of Virginia college students. However, only 38.1 percent of community colleges reported in the survey that they had such policies, reflecting the current reality that community colleges do not provide mental health services to their students and most of them do not have the expertise to implement suicide prevention policies. Until these circumstances change, the Task Force recommends revising the first sentence of Va. Code § 23-9.2:8 to release community colleges from this legislative mandate. In addition, the Task Force recommends legislative clarification of the two remaining sentences, as outlined below.

Previous Best Practice: The New Jersey Department of Public Health, Division of Mental Health Advocacy, outlined best practices in this area in its 2009 report, College *Students in Crisis: Preventing Campus Suicides and Protecting Civil Rights*.[13] The report outlined relevant federal legislation, most notably the ADA and Rehabilitation Act, and advocated for voluntary intervention with students before exercising a last-resort option of involuntary medical withdrawal provided the former OCR "direct threat" test is met.

The VCMHS survey confirmed many of Virginia's schools had already implemented these practices: *Voluntary medical withdrawal* from college for mental health reasons was given to an average of 55.6 students per public college, 5.5 students per private college, and 3.8 students per community college in 2008-2009. *Involuntary medical withdrawal* from college for mental health reasons was a recognized procedure in 46.7 percent of public colleges, 90.9 percent of private colleges, and 27.3 percent of community colleges. On average, only one student per college was subject to an involuntary medical withdrawal. The readmission to college of a student who had medically withdrawn for mental health reasons—voluntarily or involuntarily—was contingent on the student participating in recommended inpatient or outpatient mental health treatment before returning to college for 91.7 percent of the public colleges, 87 percent of the private colleges, and 58.8 percent of the community colleges. Readmission to college could be made contingent on the student's agreeing to continue in outpatient treatment after returning to college for 85.7 percent of the public colleges, 78.3 percent of the private colleges, and 42.1 percent of the community colleges. In light of the new Title II ADA regulations, which exclude threats to self as part of the direct threat test,

[13] See Appendix B.C

schools will now need to reevaluate the viability of any involuntary/adverse actions against suicidal students who do not pose a threat to others.[14]

Legislative Change: The Task Force recommends striking or revising the two final sentences (italicized above) of Va. Code § 23-9.2:8 as they are confusing for schools and potentially contradictory. School officials are currently seeking guidance from the Federal Departments of Education and Justice regarding the impact of the new Title II ADA regulations. The Task Force recommends revisiting the text of Va. Code § 23-9.2:8 once such federal guidance is clear. At minimum, Virginia state law should not contradict federal law in this area.

Recommendation 4: Va. Code § 23-9.2:8 should be revised (i) to relieve community colleges of the obligation to develop suicide prevention policies until such time as they have the mental health resources to carry it out and (ii) to delete the confusing and contradictory language in the last two sentences.

2. Civil Commitment and Hospitalization:

Criteria: In 2008, House Bill 559 changed the state criteria for Emergency Custody Orders (ECOs), Temporary Detention Orders (TDOs), and involuntary commitment so that a person may be taken into custody, temporarily detained, or involuntarily committed if the person is mentally ill and there existed a "substantial likelihood that, as a result of mental illness, the person will, in the near future, cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any."

VCMHS Findings: During the 2008-2009 academic year, 40 percent of public colleges, 14.3 percent of private colleges, and no community college reported that they initiated at least one ECO to hold a student. Seventy percent of public colleges, 9.5 percent of private colleges, and 7.1 percent of community colleges initiated at least one TDO to detain a student. The number of students for whom colleges initiated either an ECO or a TDO represented 0.02 percent of the students in both public and private colleges. Most colleges reported that they were not notified when a commitment proceeding involving a student was initiated by others; notification was reported by 33.3 percent of public colleges, 25 percent of private colleges, and 15 percent of community colleges.

The average number of students known by the school to have been admitted to a psychiatric hospital in 2008-2009, regardless of legal status, was 9.7 per public college, 3.0 per private college, and 0.7 per community college. The average length of hospitalization was approximately 5 days. Outpatient mental health services required by a court as a part of a mandatory outpatient treatment (MOT) order were provided by campus counseling centers at 38.5 percent of public colleges and at 20 percent of private

[14] See Appendix CD for recent guidance issued on this topic by the National Association for College and University Attorneys ("NACUA").

colleges. Of those colleges providing treatment under MOT orders in 2008-09, the average number of cases per college was approximately two.

Access to Hearing Records

Va. Code § 37.2-818 provides as follows:

> Va. Code § 37.2-818: Commitment hearing for involuntary admission; recordings and records. *A. The district court judge or special justice shall make or cause to be made a tape or other audio recording of any hearings held under this chapter, with no more than one hearing recorded per tape, and shall submit the recording to the clerk of the district court in the locality in which the hearing is held to be retained in a confidential file. The person who was the subject of the hearing shall be entitled, upon request, to obtain a copy of the tape or other audio recording of such hearing. These recordings shall be retained for at least three years from the date of the commitment hearing.*
>
> *B. Except as provided in this section and § 37.2-819, the court shall keep its copies of recordings made pursuant to this section, relevant medical records, reports, and court documents pertaining to the hearings provided for in this chapter confidential. The person who is the subject of the hearing may, in writing, waive the confidentiality provided herein. In the absence of such waiver, access to the dispositional order only may be provided upon court order. Any person seeking access to the dispositional order may file a written motion setting forth why such access is needed. The court may issue an order to disclose the dispositional order if it finds that such disclosure is in the best interest of the person who is the subject of the hearing or of the public. The Executive Secretary of the Supreme Court and anyone acting on his behalf shall be provided access to the court's records upon request. Such recordings, records, reports, and documents shall not be subject to the Virginia Freedom of Information Act (§ 2.2-3700 et seq.).*

State Law Gaps: This statute limits public access to records of commitment proceedings to the dispositional order and then only upon a showing that disclosure is in the interest of the respondent or that the public interest overrides the respondent's privacy interest. If the respondent is a college or university student, the student's institution is certainly among the "persons" who, upon the requisite showing, are entitled to access to the order. However, the practical reality of the current law is that the institution must have knowledge of the commitment proceedings to request the order. As demonstrated by the VCMHS results, most colleges were not notified when a commitment proceeding involving a student was initiated by others; such notification was reported by 33.3 percent of public colleges, 25 percent of private colleges, and 15 percent of community colleges. *This is a significant information gap*. Colleges and universities are key stakeholders in commitment proceedings involving their own students. Residential colleges often have significant mental health and behavioral information that would aid state officials involved in these proceedings. They are also the home to any discharged student;

accordingly, colleges and universities should be notified of such proceedings to ensure community safety and appropriate continuity of care when a student returns to campus.

Conclusion: The Legal Issues Task Force spent considerable time discussing how to eliminate communication gaps in the commitment process. The Task Force believes this was the single largest gap in the area of Virginia college mental health.

Legislative Change: At some point in the future, it may become necessary to seek legislative change to ensure that colleges and universities are notified of any proceedings involving their students. However, the Task Force recommends first attempting the non-legislative steps outlined in Section III of this Report before considering legislative options.

3. Parental Notification.

> Va. Code § 23-9.2:3.C: Institutions of higher education; notification of mental health treatment. *Notwithstanding any other provision of state law, the board of visitors or other governing body of every public institution of higher education in Virginia shall establish policies and procedures requiring the notification of the parent of a dependent student when such student receives mental health treatment at the institution's student health or counseling center and such treatment becomes part of the student's educational record in accordance with the federal Health Insurance Portability and Accountability Act (42 U.S.C. § 1320d et seq.) and may be disclosed without prior consent as authorized by the federal Family Educational Rights and Privacy Act (20 U.S.C. § 1232g) and related regulations (34 C.F.R. Part 99). Such notification shall only be required if it is determined that there exists a substantial likelihood that, as a result of mental illness the student will, in the near future, (i) cause serious physical harm to himself or others as evidenced by recent behavior or any other relevant information or (ii) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs. However, notification may be withheld if the student's treating physician or treating clinical psychologist has made a part of the student's record a written statement that, in the exercise of his professional judgment, the notification would be reasonably likely to cause substantial harm to the student or another person. No public institution of higher education or employee of a public institution of higher education making a disclosure pursuant to this subsection shall be civilly liable for any harm resulting from such disclosure unless such disclosure constitutes gross negligence or willful misconduct by the institution or its employees.*

Statutory History: Passed by General Assembly, 2008. Formerly HB 1005 (Bell). Signed into law by Governor Kaine on April 9, 2008. Effective: July 1, 2008.

State Law Gaps: Notification to parents of tax-dependent students under Va. Code § 23-9.2:3.C only applies when a student seen at the college counseling center meets the new state commitment criteria. Many students choose to access mental health services off campus; hospitals and private providers are not subject to this statutory notification,

presumably due to HIPAA constraints. Moreover, because this statute applies only to tax-dependent students, it does not cover international students; students from low-income families whose parents do not file U.S. tax returns; or graduate students, who are often financially independent.

Implementation Challenges: Virginia public institutions have faced many challenges implementing § 23-9.2:3.C, including (a) how to collect tax dependency data on all students; (b) how to interpret the notification standard when a student is not a current patient or not hospitalized; and, (c) how to implement the exceptions clause when an institution has no physician or clinical psychologist on staff.

VCMHS Findings: During the 2008-2009 academic year, public colleges notified a student's parents because they were concerned about the student's becoming harmful to him or herself or others a total of 68 times. This was the first academic year following adoption of this statute. Private colleges, although exempt from this statute, did so 70 times, and community colleges six times. Seventy-three percent of public colleges, 43.5% of private colleges, and 58.3% of community colleges collected tax-dependency data from their students at various stages of a student's tenure.

Conclusion: Despite some implementation challenges, most four-year Virginia public institutions have had little difficulty incorporating this statutory duty into their standard operating protocols. There is some lingering concern that this notification requirement could deter students from accessing care at the campus counseling center. There is also uncertainty whether the General Assembly intended for community colleges to be subject to this notification requirement. Since community colleges do not currently provide mental health services or operate counseling centers on campus, the conditions that trigger the statutory obligation to formulate notification policies under Va. Code § 23-9.2:3.C do not appear to apply to them. It does appear, however, that a few of the community colleges have formulated a policy and chosen to notify parents.

Best Practice: To comply with Va. Code § 23-9.2:3.C, and to permit more open communication with parents generally by maximizing the tax-dependency exception under FERPA, each Virginia institution should establish a reliable process for collecting tax dependency information from students on an annual basis, or, at minimum, once prior to enrollment. The U.S. Department of Education's Family Policy Compliance Office ("FPCO") posts a model collection form on its website: http://www2.ed.gov/policy/gen/guid/fpco/ferpa/safeschools/modelform.html. According to the VCMHS findings, a number of Virginia schools already meet this best practice: 73.3% or public institutions, 43.5% of private institutions, and 58.3% of community colleges collected tax dependency status from their students in 2008-2009.

Legislative Change. Many smaller schools do not have a physician or clinical psychologist on staff. Accordingly, Va. Code § 23-9.2:3.C should be amended to permit any available school health professional to authorize the exception not to notify a parent. This can be accomplished by changing the phrase "*physician or treating clinical*

psychologist" to "*health care professional*." It may also be advisable to amend the statue to make it clear that the provision is permissive, not mandatory, for community colleges.

Recommendation 5: Va. Code § 23-9.2:3.C should be amended (i) to permit any available school health professional to authorize and document a decision to refrain from notifying a parent and (ii) to make the entire provision permissive, not mandatory, for community colleges.

4. Threat Assessment

Va. Code § 23-9.2:10. Violence prevention committee; threat assessment team.

A. Each public college or university shall have in place policies and procedures for the prevention of violence on campus, including assessment and intervention with individuals whose behavior poses a threat to the safety of the campus community.

B. The board of visitors or other governing body of each public institution of higher education shall determine a committee structure on campus of individuals charged with education and prevention of violence on campus. Each committee shall include representatives from student affairs, law enforcement, human resources, counseling services, residence life, and other constituencies as needed. Such committee shall also consult with legal counsel as needed. Once formed, each committee shall develop a clear statement of: (i) mission, (ii) membership, and (iii) leadership. Such statement shall be published and available to the campus community.

C. Each committee shall be charged with: (i) providing guidance to students, faculty, and staff regarding recognition of threatening or aberrant behavior that may represent a threat to the community; (ii) identification of members of the campus community to whom threatening behavior should be reported; and (iii) policies and procedures for the assessment of individuals whose behavior may present a threat, appropriate means of intervention with such individuals, and sufficient means of action, including interim suspension or medical separation to resolve potential threats.

D. The board of visitors or other governing body of each public institution of higher education shall establish a specific threat assessment team that shall include members from law enforcement, mental health professionals, representatives of student affairs and human resources, and, if available, college or university counsel. Such team shall implement the assessment, intervention and action policies set forth by the committee pursuant to subsection C.

E. Each threat assessment team shall establish relationships or utilize existing relationships with local and state law enforcement agencies as well as mental health agencies to expedite assessment and intervention with individuals whose behavior may present a threat to safety.

Statutory History: Passed by General Assembly, 2008. Formerly SB 539 (Obenshain). Signed into law by Governor Kaine on April 9, 2008. Effective: July 1, 2008.

State Law Gaps: Va. Code § 23-9.2:10 provides a good framework and best practice as to which University parties should be part of a school's threat assessment team. It does not dictate how schools run their teams. It gives them flexibility to design their own mission statement and operations. When first adopted in 2008, the statute did not consider the state law restraints prohibiting campus law enforcement and mental health professionals from sharing relevant information to fellow team members. In 2010, the General Assembly amended several pieces of state law to authorize threat assessment teams to receive health and criminal history records of students for the purposes of assessment and intervention, and to largely exempt records of threat assessment teams from the Freedom of Information Act.

Implementation Challenges: Virginia's community colleges have had great difficulty implementing this statute. As public institutions, they are required to have a threat assessment team. However, they are not currently staffed to achieve best practices envisioned under Va. Code § 23-9.2:10. Community colleges do not have mental health staff nor do they have many of the other classifications of designated team members on individual campuses.

VCMHS Findings: All public colleges, 77.3 percent of private colleges, and 75 percent of community colleges reported that they had established Threat Assessment Teams. The average number of active cases considered by Threat Assessment Teams during the 2008-2009 academic year was 20.4 at public colleges, 9.2 at private colleges, and 5.5 at community colleges. Mental health issues were believed to be a significant factor in 59.8 percent of the cases dealt with by the Threat Assessment Team at public colleges, 48.2 percent of the cases dealt with at private colleges, and 33.3 percent of the cases dealt with at community colleges.

Conclusion: Virginia's public four-year institutions have all implemented threat assessment teams on their campuses. Despite the absence of a statutory mandate, the majority of Virginia private institutions have also done so. Implementation of the requirements of § 23-9.2:10 among community colleges appears to be uneven, largely due the lack of clinically trained staff and other personnel needed for a fully staffed team. Most schools have taken advantage of the threat assessment trainings offered through the Virginia Department of Criminal Justice Services.

Legislative Change: The Task Force recommends that the staffing requirements prescribed by § 23-9.2:10 be loosened to take account of the wide variation in staffing capabilities among community colleges. It seems likely that the General Assembly was focusing primarily on four-year colleges when it enacted § 23-9.2:10. However, the Task Force hopes it will be possible for all colleges, including community colleges, to employ or retain the necessary clinically trained personnel to maintain a fully staffed threat assessment team and carry out risk assessments in appropriate cases. For this reason, the

General Assembly might want to consider setting a date (for example July 1. 2016) by which fully staffed teams must be in place.[15]

Threat assessment teams from private institutions have voiced an interest in having access to the same health and criminal history information under state law as teams at public institutions. Private schools may wish to seek such a change in the future.

Recommendation 6: The General Assembly should consider amending § 23-9.2:10 to make the personnel requirements of that section dependent on availability of clinically trained staff.

Suggested language follows:

Va. Code § 23-9.2:10. Violence prevention committee; threat assessment team.

A. Each public college or university shall have in place policies and procedures for the prevention of violence on campus, including, to the extent resources are available, assessment and intervention with individuals whose behavior poses a threat to the safety of the campus community.

B. The board of visitors or other governing body of each public institution of higher education shall determine a committee structure on campus of individuals charged with education and prevention of violence on campus. Each committee shall include, to the extent available, representatives from student affairs, law enforcement, human resources, counseling services, residence life, and other constituencies as needed. Such committee shall also consult with legal counsel as needed. Once formed, each committee shall develop a clear statement of: (i) mission, (ii) membership, and (iii) leadership. Such statement shall be published and available to the campus community.

C. Each committee shall be charged with: (i) providing guidance to students, faculty, and staff regarding recognition of threatening or aberrant behavior that may represent a threat to the community; (ii) identification of members of the campus community to

[15] This option might be accomplished by adding the following paragraph to § 23-9.2:10:

F. The board of visitors or other governing body of each public institution of higher education shall assure that the institution is capable of carrying out all the requirements of this section, including assessment and intervention with individuals whose behavior may pose a threat to the safety of the campus community, by July 1. 2016

whom threatening behavior should be reported; and (iii) as resources permit, policies and procedures for the assessment of individuals whose behavior may present a threat, appropriate means of intervention with such individuals, and sufficient means of action, including interim suspension or medical separation to resolve potential threats.

D. The board of visitors or other governing body of each public or private institution of higher education shall establish a specific threat assessment team that shall include, to the extent available, members from law enforcement, mental health professionals, representatives of student affairs and human resources, and college or university counsel. Such team shall implement the assessment, intervention and action policies set forth by the committee pursuant to subsection C.

E. Each threat assessment team shall establish relationships or utilize existing relationships with local and state law enforcement agencies as well as mental health agencies to expedite assessment and intervention with individuals whose behavior may present a threat to safety within the capability of these agencies.

5. Health Insurance

§ 38.2-3430.1:1. Health insurance coverage not required.

No resident of this Commonwealth, regardless of whether he has or is eligible for health insurance coverage under any policy or program provided by or through his employer, or a plan sponsored by the Commonwealth or the federal government, shall be required to obtain or maintain a policy of individual insurance coverage except as required by a court or the Department of Social Services where an individual is named a party in a judicial or administrative proceeding. No provision of this title shall render a resident of this Commonwealth liable for any penalty, assessment, fee, or fine as a result of his failure to procure or obtain health insurance coverage. This section shall not apply to individuals voluntarily applying for coverage under a state-administered program pursuant to Title XIX or Title XXI of the Social Security Act. ***This section shall not apply to students being required by an institution of higher education to obtain and maintain health insurance as a condition of enrollment.*** *Nothing herein shall impair the rights of persons to privately contract for health insurance for family members or former family members.*

Statutory History: Passed by General Assembly, 2010. Formerly HB 10 (Marshall). Signed into law by Governor McDonnell on April 21, 2010. Effective: July 1, 2010.

VCMHS Findings: Most (58.3 percent) private colleges and about one-quarter of public colleges (26.7 percent) required all of their students to have health insurance. Only international students were required to have health insurance at 13.3 percent of public colleges and 4.2 percent of private colleges. None of the community colleges required any of their students to have health insurance.

Conclusion: The General Assembly adopted Va. Code § 38.2-3430.1:1 in an effort to nullify the operation of a federal legislative mandate requiring every American have health insurance by 2014. In doing so, however, the General Assembly adopted an express provision permitting Virginia colleges and universities to require health insurance as a condition of a student's enrollment. A minority of Virginia schools currently mandate health insurance. The Task Force encourages schools to consider mandating coverage as a condition of enrollment. The option is preserved in state law, and it ensures students who are living away from home ready access to health care services and prescriptions within the local community network. It also provides college counseling centers an available network for referring students. Perhaps this argument is less compelling for community colleges, where students tend to live within or near their home health network and the school provides no mental health service on campus.

Enforcement: Schools that mandate health insurance coverage utilize different methods of enforcement. Many colleges and universities sponsor student health plans to provide their students access to affordable health coverage, usually in coordination with existing student health clinics or university medical centers. Some institutions sponsor a student health plan but do not require students to enroll in the plan nor show proof of other health coverage through their parents or employment. To ensure that students have adequate coverage, other institutions require that students enroll in the college or university's student health plan unless the students show proof of other health coverage, a concept called a hard-waiver health insurance program. A few institutions require students to enroll in the student health plan regardless of whether the student is covered by, or has access to other health coverage, perhaps to control costs by ensuring sufficient participation in the student health plan. Regardless of the method used – some or no enforcement – it is still worthwhile for a school to have a policy mandating coverage.

C. Post-enrollment

There is an emerging discussion among Virginia school officials regarding whether to disclose relevant behavioral information to an institution to which a student is planning to transfer. It is not uncommon for a student with behavioral concerns to transfer from one Virginia institution to another. Under FERPA, a student's consent is not required when the disclosure is made to officials of other schools or school systems in which the student seeks or intends to enroll and the disclosure is initiated by the student or is provided pursuant to the request of the recipient school. However, sometimes the University has information that would be relevant to the recipient school that has not been specifically requested, and it is unclear whether the University is required to make a reasonable attempt to notify the student of the planned records transfer in such a case. No clear consensus has emerged on this topic.

III. BEST PRACTICES FOR ACHIEVING EFFECTIVE INTERVENTIONS

The Task Force identified significant information gaps between college and university officials, community service boards ("CSBs"), and psychiatric hospitals during

the processes of emergency evaluation (ECOs & TDOs) and commitment of students. This issue requires priority attention. Colleges and universities are key stakeholders whenever their students are subject to these state processes. They often have significant mental health and behavioral information that would aid state officials involved in these proceedings. Residential colleges are also the home to any discharged student. Accordingly, colleges and universities should be notified and involved in these proceedings to ensure community safety and appropriate continuity of care when a discharged student returns to campus.

The Task Force recognizes that CSBs have limited resources at their disposal and limited time to act during the ECO and TDO stages. Colleges and universities do not wish to burden CSBs with additional responsibilities. On the contrary, the Task Force believes that colleges and universities could become a helpful partner to CSBs during the front and back end of these processes. To that end, the Task Force recommends pursuing each of the non-legislative steps below before considering legislative mandates:

1. Memoranda of Understanding (MOU) between Schools and CSBs

Recommendation 7: Each Virginia institution should establish a written MOU with its respective CSB to ensure both parties have the same understanding of the scope and terms of their operational relationship.

Model terms should cover (a) referral procedures for CSB emergency services; (b) referral procedures for CSB outpatient services; (c) procedures for exchange of information regarding students who are served by the CSB; (d) prescreening protocols for TDOs (e) a designated contact person at the institution who can be contacted 24h/d by the CSB to facilitate collection of information about a student who is subject to a TDO; (f) protocols related to provision of medication to students who are served by the CSB; and, (g) protocols for mutual aid in the event of a crisis or disaster response (Note: This may include a pact with CSB and other agencies such as Mental Health Association or the American Red Cross). The MOU used at Virginia Tech is reproduced in Appendix E.

VCMHS Findings: The survey results confirm that work is needed in this area. Only 66.7 percent of public colleges, 45.8 percent of private colleges, and 70.8 percent of community colleges have established working agreements with their local CSBs. Only one-third of these working agreements are currently written.

2. Memoranda of Understanding between Schools and Local Psychiatric Hospitals.

Recommendation 8: Each Virginia institution should establish a written memorandum of understanding for use with local psychiatric hospitals to assure inclusion of universities, where appropriate, in the post-discharge planning of student patients, whether admitted voluntarily or involuntarily.

VCMHS Findings: The survey results confirm that even more work is needed here. Only 46.7 percent of public colleges, 33.3 percent of private colleges, and 4.2

percent of community colleges have established working agreements with their local psychiatric hospitals.

3. Coordination and Information Exchange

Recommendation 9: Working together with the colleges and universities in their catchment areas, Virginia's Community Services Boards should establish a reliable system for assuring that a designated contact person at each Virginia institution is notified whenever one of its students is the subject of commitment proceedings[16] and for assuring exchange of information among institutions, providers and the legal system in a timely fashion.

The Task Force focused most of its attention in this area with the aim of designing a reliable, voluntary system of information sharing between schools and CSBs. The Task Force believes such a system can be developed by pursuing each of the steps outlined below:

- CSBs and colleges within their catchment areas should develop protocols for timely notifying schools when their students are involved in commitment proceedings. It is important to notify schools as early in the process as possible so that information can be lawfully disclosed by the schools to the participants in the commitment process when it can have a bearing on the their decision-making.[17] Presumptively, schools should be notified by the CSB at the time the TDO is issued unless the individual's student status is discovered at a later time;

- The Department of Behavioral Health and Developmental Services (DBHDS) should revise current forms (e.g., adult & juvenile prescreen forms; initial assessment forms) to include a short question inquiring whether the subject person is currently enrolled, or has been enrolled within the past year, at a public or private college in the Commonwealth of Virginia, and the name of the institution;

- DBHDS should develop and circulate contact list for each public and private institution to be provided to all CSBs. The list will identify the individual/office to call. Institutions will be advised to list only one individual/office with 24/7 on-call service;[18]

- CSBs and independent examiners should seek relevant information from colleges and universities regarding students who are involved in commitment proceedings. Colleges and universities should share relevant information and records (e.g., student's counseling center & disciplinary records) with CSBs, independent examiners and special justices to the maximum extent permitted by FERPA in

[16] "Commitment proceedings" includes ECOs, TDOs and commitment hearings.
[17] See Appendices E andAppendix F for charts depicting the commitment process and the mandatory outpatient treatment process for juveniles and adults.
[18] See Appendix G for current contact list developed as part of this study.

order to assure protection of the student or others, to facilitate informed decisions in the commitment process, and to assure appropriate discharge planning, to the extent the subject student intends to return to campus post-discharge or at a future date; [19]

- CSBs should ascertain whether colleges within their catchment areas are willing to provide mandatory outpatient treatment. According to the VCMHS findings, 38.5% of public colleges and 20% of private colleges indicated that they are willig to provide mental health services to a student when these services are required by a court as a part of a mandatory outpatient treatment order, and;

- CSBs should ascertain how community colleges can best be engaged in commitment proceedings given that they currently do not have treatment professionals on staff.

4. Train appropriate parties/entities to eliminate information gaps.

The Task Force believes that one of the best ways to facilitate better communication between University/College officials and CSBs and psychiatric hospitals is to address the unique issues surrounding college mental health at the annual trainings conducted for all the regular participants in the civil commitment process.

Recommendation 10: The Office of the Executive Secretary of the Supreme Court, the Department of Behavioral Health and Developmental Services, The Virginia Association of Community Services Boards, the Office of the Attorney General and Virginia's colleges and universities should conduct collaborative training activities to assure that all participants in commitment proceedings are familiar with special issues arising in cases involving college and university students.

Judges and Special Justices: All adult commitment hearings are presided over by either a district court judge or a special justice. District court judges and special justices are required to attend an annual training program put on by the Supreme Court of Virginia's Office of the Executive Secretary. It is recommended that the annual training programs in 2012 include a presentation of the Virginia College Mental Health Study. Basic training of new judges and special justices should include the following key points:

- Judges and special justices should regularly ask respondents if they attend a college or university. If the respondent is a student, the judge or special justice should ensure that the CSB representative and/or the independent examiner have contacted the school to determine whether the school has any relevant information, such as treatment records from a counseling center.

[19] FERPA permits sharing of information during a health or safety emergency and does not impede disclosures bearing on the need for an ECO or TDO or on the suitability of acute intervention through a commitment order.

- If the respondent is a student, the judge or special justice should question the CSB representative about whether mandatory outpatient treatment through the school's counseling center is available as a less restrictive alternative to inpatient treatment. Judges and special justices should be informed that college and university counseling centers often have more treatment resources than the local CSB. (Some schools even have MOUs with their local CSBs to provide treatment under MOT.)

<u>Treatment Providers</u>: The DBHDS and the Attorney General's Office have been providing annual training on commitment procedures to treatment providers, including CSB personnel, independent examiners, and facility representatives. The Virginia Association of Community Service Boards also has an annual meeting every year that includes training components. It is recommended that these annual trainings for 2011-2012 include a presentation of the Virginia College Mental Health Study. In addition to the study results, the following points should also be emphasized:

- Whenever a CSB prescreener or an independent examiner is evaluating a person, they should determine whether the person is a student at a college or university. CSB prescreeners and independent examiners are both required to review a person's prior treatment record. In order to ensure that they have a full picture, they should ascertain whether the person is a student and, if so, they should contact that college or university's counseling center to obtain the student's treatment records;

- CSB personnel should be informed of the new contact list for colleges and universities. This list will identify one individual/officer that is available 24/7 to assist with record retrieval when a student has entered the commitment process; and,

- Facility representatives should also be educated about the need to determine if a patient is a student in order to obtain prior treatment records. Facility representatives should also be educated about the need to include the college or university in the student's discharge planning.

<u>College and Universities</u>: All colleges and universities should train the appropriate personnel in their counseling centers and/or offices of student affairs to be familiar with the civil commitment process in Virginia and related laws. The following points should be emphasized:

- Personnel need to be aware of the exceptions to the state's health privacy act so that they know that they can (and must) share a student's treatment records with participants in the civil commitment process (i.e., CSB representatives, independent examiners, special justices, and attorneys);

- Personnel need to be aware of the extremely tight time constraints surrounding the commitment process and be available to assist with information sharing on a tight timeline;

- An individual or office with 24/7 coverage needs to be clearly identified on a contact sheet for CSBs so the various CSBs know whom to contact when they encounter a student in crisis, and;
- The appropriate person needs to be identified who can attend commitment hearings involving a student. This person needs to be educated regarding the procedures involved in a commitment hearing and the various participants.

Colleges and universities should also reach out to student and mental health advocacy groups on campus and in their communities to educate them about the benefits of involving the college or university during the commitment process. Many college and university counseling centers have a greater array of services available than the local community, and by involving the college or university in the commitment process, the student has a much greater chance of avoiding inpatient commitment and being able to obtain needed treatment in an outpatient setting, either voluntarily or under a mandatory outpatient treatment order.

Virginia College Mental Health Study
Summary of Recommendations

Recommendation 1: The Commonwealth should embark on a sequential plan, as resources permit, to assure that every community college has the capacity to provide brief screening and referral services for students who appear in need of mental health intervention; to maintain fully staffed threat assessment teams; to conduct risk assessment screenings in cases that may pose a risk of harm to campus safety; and to coordinate with CSBs, law enforcement agencies and families to carry out emergency interventions and other types of crisis response when necessary.

Recommendation 2: Each college and university that has not already done so should establish a planning group for involving and guiding students in clinically, culturally, ethically and legally appropriate roles in campus-based mental health awareness and suicide prevention.

Recommendation 3: Va. Code § 23-2.1:3 should be amended to make it clear that "originating school" includes transferring institutions of higher education, not only high schools. This can be accomplished by striking the statute's internal title, "Students' high school records," and defining or revising "originating school" to include "secondary school and/or transferring institution of higher education."

Recommendation 4: Va. Code § 23-9.2:8 should be revised (i) to relieve community colleges of the obligation to develop suicide prevention policies until such time as they have the mental health resources to carry it out and (ii) to delete the confusing and contradictory language in the last two sentences.

Recommendation 5: Va. Code § 23-9.2:3.C should be amended (i) to permit any available school health professional to authorize and document a decision to refrain from notifying a parent and (ii) to make the entire provision permissive, not mandatory, for community colleges.

Recommendation 6: The General Assembly should consider amending § 23-9.2:10 to make the personnel requirements of that section dependent on availability of clinically trained staff.

Recommendation 7: Each Virginia institution should establish a written MOU with its respective CSB to ensure both parties have the same understanding of the scope and terms of their operational relationship.

Recommendation 8: Each Virginia institution should establish a written memorandum of understanding for use with local psychiatric hospitals to assure inclusion of universities, where appropriate, in the post-discharge planning of student patients, whether admitted voluntarily or involuntarily.

<u>Recommendation 9</u>: Working together with the colleges and universities in their catchment areas, Virginia's Community Services Boards should establish a reliable system for assuring that a designated contact person at each Virginia institution is notified whenever one of its students is the subject of commitment proceedings and for assuring exchange of information among institutions, providers and the legal system in a timely fashion.

<u>Recommendation 10</u>: The Office of the Executive Secretary of the Supreme Court, the Department of Behavioral Health and Developmental Services, the Virginia Association of Community Services Boards, the Office of the Attorney General and Virginia's colleges and universities should conduct collaborative training activities to assure that all participants in commitment proceedings are familiar with special issues arising in cases involving college and university students.

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