REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

Virginia College Mental Health Study

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

REPORT DOCUMENT NO. 119

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Code of Virginia § 30-168.

The Joint Commission on Health Care (the Commission) is established in the legislative branch of state government. The purpose of the Commission is to study, report and make recommendations on all areas of health care provision, regulation, insurance, liability, licensing, and delivery of services. In so doing, the Commission shall endeavor to ensure that the Commonwealth as provider, financier, and regulator adopts the most cost-effective and efficacious means of delivery of health care services so that the greatest number of Virginians receive quality health care. Further, the Commission shall encourage the development of uniform policies and services to ensure the availability of quality, affordable and accessible health services and provide a forum for continuing the review and study of programs and services.

The Commission may make recommendations and coordinate the proposals and recommendations of all commissions and agencies as to legislation affecting the provision and delivery of health care.

For the purposes of this chapter, "health care" shall include behavioral health care.

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Preface

In November 2009, members of the Joint Commission on Health Care (JCHC) approved a proposed policy option to serve as an "umbrella of oversight" for a study of mental health issues in higher education. The framework for the study included the following provisions:

- Direction would be provided by a Steering Committee with Richard J. Bonnie serving as the chair.
- Steering Committee members would include representatives of Virginia universities, the Department of Behavioral Health and Developmental Services, the Office of the Attorney General, a former Circuit Court judge and member of the Governor's Panel on the Virginia Tech Shootings, and others.
- The Steering Committee would oversee the work of two task forces; one task force would address legal issues and the other task force would address access to services.

In January 2010, the two task forces held their first meeting, identified the subjects that required further investigation, and appointed work groups to develop study proposals. At that time, the task force members also reviewed the draft of a planned survey of all Virginia colleges and universities. The Virginia College Mental Health Survey was conducted and a progress report was presented to the Joint Commission on Health Care in 2010. Over the ensuing year, task force members continued to analyze the survey responses and formulated findings, conclusions, and recommendations; their resulting report follows.

Joint Commission members and staff would like to thank the numerous individuals who assisted in this study, most notably Richard J. Bonnie, the numerous members of the Steering Committee and Task Forces, the University of Virginia and Virginia Tech for providing the core infrastructure support for the study, and the public and private college and university personnel who graciously completed the Virginia College Mental Health Survey resulting in a remarkable 98 percent response rate.

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Prepared for

The Joint Commission on Health Care

General Assembly of the Commonwealth of Virginia

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

November, 2011

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 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

[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

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.

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November 21, 2011

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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 Assessment Teams

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.

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 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

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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."

[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.

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 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.

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[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.

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 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 years18-23 are noteworthy for major life challenges and emerging psychological concerns.

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

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% 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

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[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.

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.

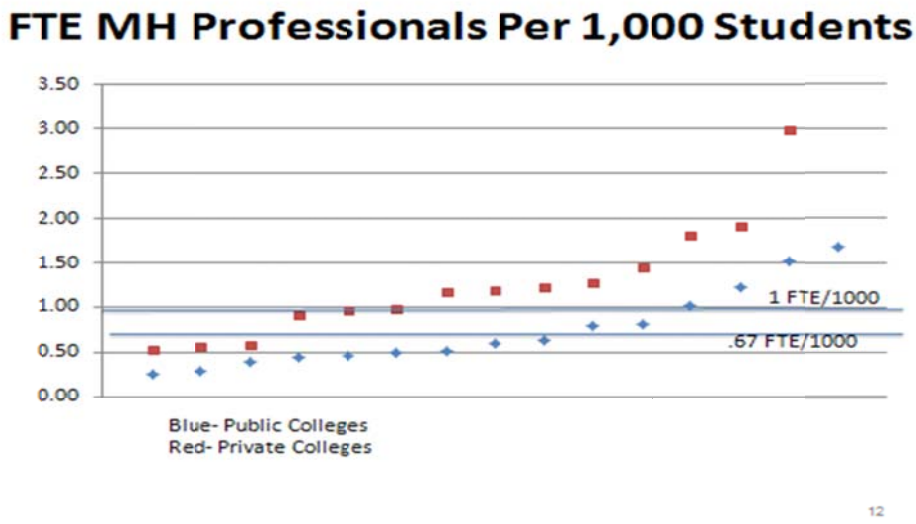
The next two sections of this chapter address the capacity of the Commonwealth's residential colleges and community colleges to serve students with mental health problems.

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.)*

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

[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.

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

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%

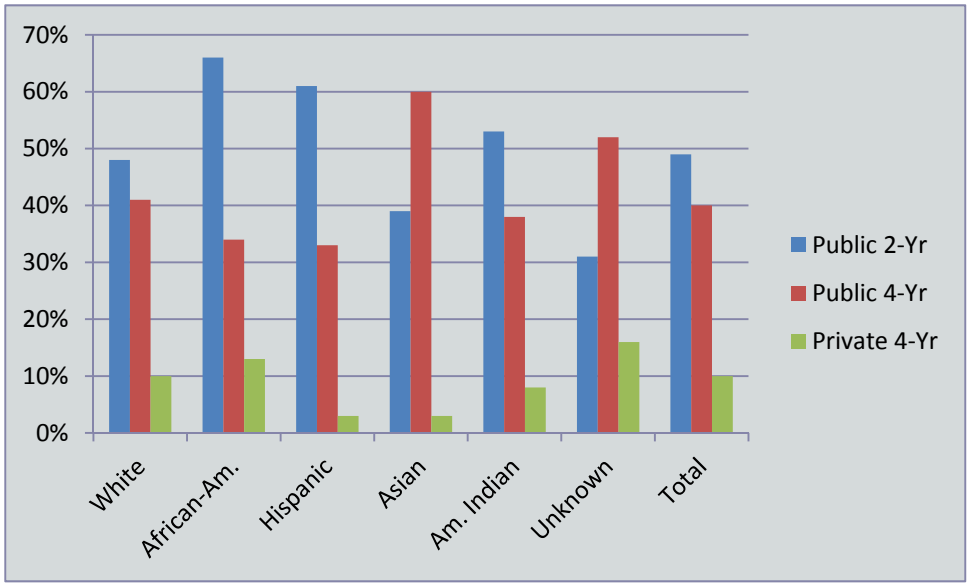
*U.S. Census Bureau, 2005, American Community Survey, Estimated Rates

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

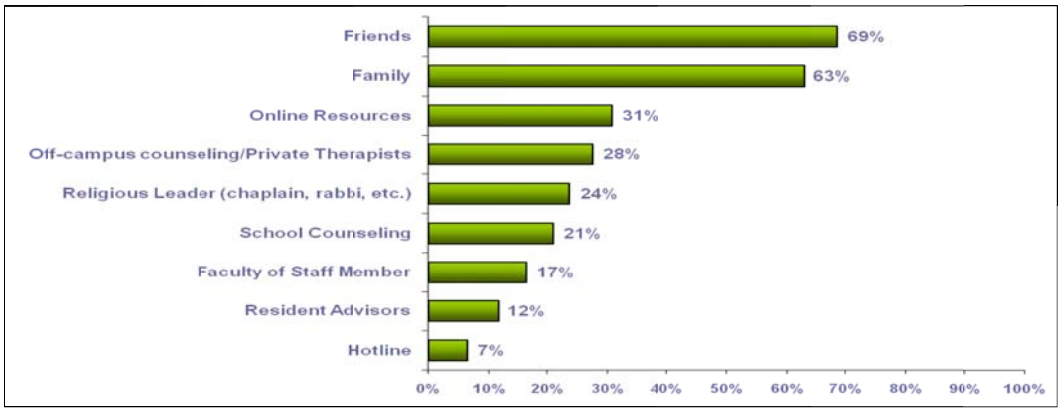
Based on inquiries made by members of the Joint Commission, the Task Force reviewed the literature on safeTALK, Campus Connect, Student Support Network and Mental Health First Aid. These are "Best Practice Programs" (sprc.org) that are used to enable students to recognize signs of mental or emotional 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.

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,

06).



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.

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. Post-Admission/Pre-Enrollment.

1. Sharing of Student Records during the Admission Process

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

> Va. Code § 23-2.1:3. Students' high school records. *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 records held by the school. These records shall be kept confidential as required by*

[10] As a starting premise, it is important to understand that HIPAA is *not applicable* 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.

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 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.

[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.

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 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

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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.

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, 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.

[13] See Appendix B.C

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

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 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.

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[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

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) 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 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

[16] "Commitment proceedings" includes ECOs, TDOs and commitment hearings.
[17] See Appendices E and Appendix 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.
[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.

willing 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.
- 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.)

Treatment Providers: 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.

College and Universities: 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.

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 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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ATTACHMENTS

Proposed Study of Mental Health Issues in Higher Education
October 7, 2009 Memorandum
Richard J. Bonnie, L.L.B.
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Virginia College Mental Health Survey Instrument

Report on the Virginia College Mental Health Survey
September 7, 2010

Virginia College Mental Health Study: Legislative Recommendations
November 22, 2011 Presentation
Susan M. Davis,
Associate Vice President for Student Affairs
University of Virginia

Progress Report on the Virginia College Mental Health Study
October 16, 2012 Memorandum
Richard J. Bonnie, L.L.B.
University of Virginia School of Law

Summary of Resulting Legislative Actions

UNIVERSITY OF VIRGINIA SCHOOL OF LAW

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Memorandum

To: Senator R. Edward Houck, Chair, Joint Commission on Health Care

Re: Proposed JCHC Study of Mental Health Issues in Higher Education

Date: October 7, 2009

This memorandum supplements my memorandum to you dated August 31, 2009, in which I described a possible study of mental health issues in higher education under the auspices of the Joint Commission on Health Care. Conducting such a study would serve the interests of the people of the Commonwealth and would be timely in light of the opportunity for coordination with the Supreme Court's Commission on Mental Health Law Reform before the Commission completes its work in 2010. I am confident that the study can be carried out successfully within the next year without any JCHC financial support and without diverting staff attention from the Joint Commission's other priorities.

Steering Committee. The proposed study would be directed by a steering committee that I would chair. The members of the steering committee would include Chris Flynn, the director of the counseling service at Virginia Tech (who would chair a task force on access to mental health services); Jim Stewart, the Inspector General for Behavioral Health and Developmental Services), Professor John Monahan, my colleague at UVA who is 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, Commissioner of Behavioral Health and Developmental Services; Ron Forehand, Deputy Attorney General; Susan Davis, an experienced lawyer who also serves as a student affairs officer at UVA (who would chair a task force on legal issues); and any others who may be suggested by the Joint Commission. Joanne Rome, a Staff Attorney in the Supreme Court, will serve as liaison from the Court, but not as a member.

Coordination with Other Agencies. The study would be formally coordinated with the State Council on Higher Education and the Department of Education as well as the Commission on Mental Health Law Reform, facilitating advice and collaboration throughout the process. The Commission will provide assistance and guidance, as needed, regarding data collection and outreach to relevant constituencies and agencies.

Task Forces. As outlined in my previous memorandum, the Steering Committee would oversee the activities of two task forces, one on Legal Issues in College Mental Health and a second on Access to Mental Health Services by College and University Students. Membership would be drawn from colleges and universities of varying sizes and locations, both public and private. The Steering Committee would develop a specific

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charge for each of the task forces. For the moment, it is perhaps sufficient to say that the task force on legal issues would be 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 services would be 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 would make recommendations for training, institutional policies and practices, and any legislative action that may be needed.

With the direction and guidance of the Steering Committee, the task forces would conduct surveys of colleges and universities in their respective domains, assemble available information regarding these issues, including experience in other states, and would prepare a report and recommendations for consideration by the Steering Committee, review and comment by the Commission on Mental Health Law Reform and other interested parties, and eventual submission to the Joint Commission.

Composition of Task Forces. Our tentative roster for the legal issues task force includes counseling center directors from George Mason and James Madison Universities, campus police officials from Virginia Tech and Christopher Newport, and student affairs officials from UVA, William and Mary, Randolph Macon, ODU, Bridgewater, VCU and Piedmont Community College. Our tentative roster for the access task force includes counseling center directors from Virginia Tech, Longwood University, VCU, Virginia Wesleyan, Virginia State University, Norfolk State, University of Richmond, Radford University, Christopher Newport University, and ODU; two officials from the community college system; and two officials from community services boards. The respective task forces will be advised by representatives of the General Counsel's offices from UVA (legal issues task force) and Virginia Tech (access task force). We will also seek to involve parent organizations and student peer counseling organizations and other stakeholders in the work of the two task forces.

Institutional Support. The legal issues task force will be headquartered at UVA and the access task force will be headquartered at Virginia Tech. I am grateful to each of these institutions for agreeing to provide the core infrastructure support for the study. The responsibility for organizing task force meetings, summarizing deliberations, conducting and analyzing the surveys and drafting and circulating reports would be borne by the respective chairs and by other willing task force members, with the support of their own institutions and agencies. The costs of attending meetings, communications and logistics, and photocopying materials generated by and circulated to task force members will be borne by their respective institutions.

Schedule. If the Joint Commission is willing to provide an umbrella of oversight for the proposed study, the target date for formal appointment of the Task Forces would be the end of October, 2009. Progress reports to the Steering Committee and the Joint Commission Council would be expected in April, 2010 and July, 2010, with the final reports being due in October, 2010.

Virginia College Mental Health Survey
Joint Commission on Health Care
Virginia General Assembly

COLLEGE/UNIVERSITY:_____

PERSON COMPLETING SURVEY: _____

JOB TITLE: _____

Phone:_____ **Email:**_____

PURPOSE OF THE SURVEY:

The Virginia College Mental Health Survey is being conducted by a study committee established under the auspices of the General Assembly's Joint Commission on Health Care (Senator R. Edward Houck, Chair) in coordination with the Commonwealth's Commission on Mental Health Reform. The purpose of the survey is to gather—for the first time—comprehensive empirical information from each public and private college in the Commonwealth regarding the adequacy of students' access to mental health services and the ways in which colleges respond to students' mental health crises. Findings from this survey will be reported to the Joint Commission and may inform recommendations for legislative or other policy changes to improve both student access to mental health services and institutional responses to mental health crises.

All 39 public and 25 private undergraduate institutions in Virginia are being surveyed. We urge you to participate in this landmark study. To save you time, we have already coded publically-available information from the website of the State Council of Higher Education for Virginia (SCHEV) on the size and demographics of each college's student body.

CONFIDENTIALITY:

The responses you provide will be reported to the Joint Commission on Health Care only in aggregated form. Your name will not appear on any document that reports results from this study, and we will not report results in categories small enough to allow any participant's identity to be inferred. Please note that information requested by the Joint Commission to carry out its legislative duties is subject to inspection under the terms of the Freedom of Information Act.

GENERAL INSTRUCTIONS:

(1) Please complete this survey using only data from the last full academic year – **that is, the 2008-2009 academic year** (including the summer of 2009). Use exact figures when they are available, but otherwise use your best estimate. If you do not have an exact figure or a reasonable

estimate, please check the "Don't Know" box. While complete information is strongly preferred wherever available, you may, of course, omit any question that you prefer not to answer.

(2) If the survey asks for information available from another source on campus (e.g., from Institutional Research, Financial Aid, or the Threat Assessment Team), we would very much appreciate it if you would contact that source to obtain the necessary information.

(3) If your institution has multiple campuses, please report figures for the institution as a whole, not just for the main campus.

(4) The preferred way to complete the survey is to (a) print the pdf file, (b) answer the questions in ink, (c) attach any requested documents that are available, (d) scan the completed survey form and the documents as one file, and (e) email the scanned information to Kim Snead, Executive Director, Joint Commission on Health Care, at ksnead@jchc.virginia.gov Alternatively, you can mail the completed survey and documents to

Kim Snead, Executive Director
Joint Commission on Health Care
900 E. Main Street, 1st Floor West
P.O. Box 1322
Richmond, VA 23218

If you choose to mail the material, *please be sure to keep a copy of everything.*

(5) Please return the completed survey and requested documents by **FRIDAY, May 14th**

(6) If you have any questions, email Kim Sneed at ksnead@jchc.virginia.gov.

Section I. Eligibility for Services on Campus

1. Number of students eligible for services at the student health center: _____
□ Don't know

2. Number of students eligible for services at the counseling center: _____
□ Don't know

3. Does your institution require that students have health insurance (please circle)?

a. Yes.

b. No

4. *If Yes to Question 3:* Do you require specific coverage levels, including for mental health coverage?

a. Yes.

b. No

5. How many students at your institution are veterans? _____ □ Don't know

Note: if you have any documents describing (a) eligibility criteria for the student health center, (b) eligibility criteria for the counseling center, (c) health insurance requirements, (d) specific coverage requirements, or (e) special services available to veterans, please attach them.

Comments on any answer in Section I:

Section II. Staffing Levels/Availability of Services on Campus

1. Does your institution have an Office/Department of Student Affairs, or an Office/Department of the Dean of Students, or a similar Office/Department?

a. Yes. [Title of the office responsible for judicial functions: _____].
Note: if you have a relevant organizational chart, please attach it

b. No

2. If Yes to Question 1: Number of paid professional staff in this Office/Department engaged in direct support/outreach to students (excluding residence assistants or paraprofessionals)?
_____ □ Don't know

3. Do any of the following student activities related to mental health occur at your institution? (Circle all that apply):

a. "peer education" or mental health awareness programs, convened by one or more student organizations [If so, check here if the Counseling Center provides advice and support: _____]

b. a hotline for troubled students established and operated by students without direct oversight of the Counseling Center [If so, check here if the Counseling Center provides advice and support: _____]

c. "peer support" or outreach programs organized by students and providing face-to-face support to troubled students without direct oversight of the counseling center [If so, check here if the Counseling Center provides advice and support: _____]

d. a hotline for troubled students under direct oversight of the Counseling Center

e. "peer counseling" programs to provide face-to-face support and referral to troubled students under direct oversight of the Counseling Center

4. Does your institution have a campus police department?

a. Yes

b. No

5. If Yes to Question 4:

a. Number of sworn officers: _____ □ Don't know

b. Number of unsworn personnel: _____ □ Don't know

c. To what office does the head of the campus police department report? _____

6. Does your institution have a campus security force?

a. Yes

b. No

7. If Yes to Question 6:

a. Number of personnel: _____ □ Don't know

b. To what office does the head of the campus security force report? _____

Comments on any answer in Section II:

Section III. Service Utilization Rates at the Counseling Center

Note: If your institution does not have a Counseling Center, please skip the questions in this Section.

1. Number of FTE mental health professionals providing services in the Counseling Center? (include only paid staff): _____ □ Don't know

2. How many mental health staff are pre-doctoral interns? _____ □ Don't know

3. How many mental health staff are post-doctoral fellows? _____ □ Don't know

4. Students who accessed care at the Counseling Center by racial/ethnic composition

a. Number of White students: _____ □ Don't know

b. Number of African-American students: _____ □ Don't know

c. Number of Asian-American students: _____ □ Don't know

d. Number of Hispanic students: _____ □ Don't know

e. Number of Native American students: _____ □ Don't know

f. Number of students of other, or undeclared, races/ethnicities: _____ □ Don't know

5. Students who accessed care at the Counseling Center by gender

a. Number of male students: _____ □ Don't know

b. Number of female students: _____ □ Don't know

6. What is the median number of counseling sessions per client? _____ □ Don't know

7. Do you limit the number of counseling sessions allowed a client?

a. Yes

b. No

8. If Yes to Question 7: What is the maximum number of sessions? _____

9. Did you have a waiting list for services in 2008-2009?

a. Yes

b. No

10. If Yes to Question 9: How many students were on the waiting list at the end of the Fall semester 2008? _____ □ Don't know

11. *If Yes to Question 9:* How many students were on the waiting list at the end of a Spring semester 2009? _____ □ Don't know

12. Do you have after-hours coverage?

a. Yes

b. No

13. If Yes to Question 12: Who provides this coverage?

a. Counseling Center

b. Community Service Board

c. Local hospital

d. Other [please specify: _____]

14. Number of students referred to other mental health providers in the community

a. Number referred because they have reached session limits: _____
□ Don't know

b. Number referred after initial assessment: _____ □ Don't know

c. Number referred for specialized evaluation or treatment (e.g., for an eating disorder): _____ □ Don't know

15. What functions beyond clinical counseling does your Counseling Center have responsibility for? (please circle all that apply)

a. Disability services

b. Assessment of LD/ADD

c. Case management

d. Career Advising

e. Academic Advising

Comments on any answer in Section III:

Section IV. Relationships with Community Service Boards and Local Hospitals

1. If your institution exhausts its own counseling services/resources, where does it first look for assistance?

a. Community Service Boards

b. Private providers

c. Other [please specify: _____]

2. What is the availability of services for your students at the local CSB?

a. minimal

b. adequate

c. extensive

3. Does your institution have a regular referral arrangement with particular private mental health service providers? *Note: If you have a written contractual arrangement, please attach it.*

a. Yes

b. No

4. Does your institution have regular or periodic meetings with representatives of the community service board (CSB) in your area to address areas of mutual interest?

a. Yes [*what is the name of this CSB?* _____]

a. No

5. Has your institution developed any type of working agreement with the CSB in your area?

a. Yes

b. No

6. If Yes to Question 5: Is it a written agreement?

a. Yes *Note: Please attach the written agreement*

b. No

7. If there is a working agreement with the CSB—whether it is written or not— please circle each area that the agreement addresses (circle all that apply):

a. Referral procedures for CSB emergency services

b. Referral procedures for CSB outpatient services

c. Prescreening protocols for temporary detention orders

d. Protocols for disaster response

e. Procedures for exchange of information regarding students who are served by the CSB

f. Protocols related to provision of medication to students who are served by the CSB

g. Designation of a person at the institution who can be contacted 24 hours/day by the CSB to facilitate the collection of information about a student who is the subject of a Temporary Detention Order (TDO)

8. Does the CSB offer any special services or programs targeted to college students?

a. Yes. *Note: Please attach a description of these services or programs*

b. No

9. Does your institution have regular or periodic meetings with representatives of any psychiatric hospital—including a general hospital with a psychiatric unit— in your area to address areas of mutual interest?

a. Yes

b. No

10. Has your institution developed any type of working agreement with a psychiatric hospital in your area?

a. Yes

b. No

11. If Yes to Question 10: Is it a written agreement?

a. Yes *Note: Please attach the written agreement*

b. No

12. Are there other programs or community organizations with which you maintain a relationship for services targeted towards college students (e.g. Partial Hospitalization, Intensive Outpatient, Eating Disorder, Substance Abuse Facility)?

a. Yes. *Note: Please list the program/community organizations:*

_____

_____

b. No.

Comments on any answer in Section IV:

Section V. Tax Dependency Status

1. Does your institution ask students about their tax dependency status?

    a. Yes

    b. No. *Note: skip to the next section.*

2. When does your institution ask about tax dependency status?

    a. on application for admission

    b. post admission/pre-enrollment

    c. post enrollment

3. How often does your institution request this information?

    a. once during a student's tenure

    b. annually

4. Does your institution have a particular form used to determine tax dependency status?

    a. Yes. *Note: Please attach the form*

    b. No

5. How many students (undergraduate or graduate) at your institution were tax dependent in 2008-09? _____ □ Don't know

Comments on any answer in Section V:

Section VI. Requests for Mental Health Information

1. Does your institution administer a health survey to students, including questions about any mental health problems they may have?

    a. Yes *Note: Please attach the relevant survey*

b. No.

2. *If Yes to Question 1:* Does your institution administer this survey to all students, or only to selected students?

a. All students

b. Only selected students

3. *If Yes to Question 1:* When do you administer this survey?

a. pre-enrollment

b. at enrollment

c. after an enrolled student has presented a concern

4. What office analyzes these surveys? [Please specify: _____]

5. Is mental health information from these surveys shared with the counseling center?

a. Yes

b. No.

6. Does your institution ever request a student's mental health records from his or her originating school prior to enrollment? *Note: if you have a written policy on requesting mental health records, or forms that you use to request such information, please attach them.*

a. Yes

b. No. *Note: Skip to the next Section.*

7. Does your institution make such a request for all students, or only for selected students?

a. All students

b. Only selected students

8. When do you request that this information?

a. pre-enrollment

b. at enrollment

c. after an enrolled student has presented a concern

9. For how many students were mental health records requested in 2008-09: _____
□ Don't know

10. What office analyzes those records? [Please specify: _____]

11. Does your institution conduct any outreach to students whose records may pose a concern?

a. Yes

b. No

Comments on any answer in Section VI:

Section VII. Concerns About Harm to Self or Others

1. Did you have an enrolled student(s) commit suicide in 2008-09?

a. Yes

b. No.

2. *If Yes to Question 1:* How many enrolled students committed suicide in 2008-09?
_____ □ Don't know

3. Did you have any student(s) who were on medical leave commit suicide in 2008-2009?

a. Yes

b. No.

4. *If Yes to Question 3:* How many students who were on medical leave committed suicide in 2008-09? _____ □ Don't know

5. Do you have policies or guidelines for identifying and addressing the needs of students exhibiting suicidal ideation or behavior?

a. Yes. *Note: please attach the policies or guidelines*

b. No

6. Does your institution have mandated follow-up procedures following a student's suicidal ideation or attempt?

a. Yes. *Note: Please attach a description of these procedures*

b. No

7. How many students seen in the counseling center in academic year 2008-2009 reported suicidal ideation? _____ □ Don't know

8. How many students attempted suicide in 2008-09 (do not count parasuicidal behavior such as cutting)? _____ □ Don't know

9. Of those students who attempted suicide in 2008-2009

a. How many voluntarily withdrew from your institution and did not return in the following year? _____ □ Don't know

b. How many involuntarily withdrew from your institution and did not return in the following year? _____ □ Don't know

c. How many withdrew from your institution—voluntarily or involuntarily—and eventually returned for a subsequent semester? _____ □ Don't know

d. How many did not withdraw from your institution, but were required to participate in outpatient treatment as a condition of remaining a student in good standing? _____ □ Don't know

10. Did you have a student arrested for killing anyone in 2008-09?

a. Yes

b. No

11. *If Yes to question 10*: How many students were arrested for killing someone in 2008-09? _____ □ Don't know

12. *If Yes to question 10*: How many of the victims were other students at your institution? _____ □ Don't know

13. How many students seen in the Counseling Center in 2008-2009 reported ideation that included violence towards others? _____ □ Don't know

14. How many students seen in the counseling center in academic year 2008-2009 had been referred due to aggressive or violent behavior toward others (including stalking)? _____ □ Don't know

a. Of these, how many were required to participate in outpatient treatment as a condition of remaining a student in good standing? _____ □ Don't know

b. Of these, how many were referred to the Counseling Center by the campus Threat Assessment Team? _____ □ Don't know

Comments on any answer in Section VII:

Section VIII. Commitment Proceedings

1. How many students were subject to Emergency Custody Orders (ECOs) initiated by your institution in 2008-09? _____ □ Don't know

2. How many students were hospitalized under Temporary Detention Orders (TDOs) initiated by your institution in 2008-2009? _____ □ Don't know

3. *If the answer to Question 2 was greater than zero:* How many of these students continued hospitalization (voluntarily or involuntarily) after the Temporary Detention Order expired? _____ □ Don't know

4. To your knowledge, how many of your students were hospitalized in psychiatric hospitals, whether or not the judicial process was involved, in 2008-2009? _____ □ Don't know

5. To your knowledge, of those students hospitalized, what was the average length of stay (in days)? _____ □ Don't know

6. Can you determine if the number of Emergency Custody Orders has increased or decreased over the past two academic years? *Note: please attach any available figures on ECOs over the past two years*

a. Increased

b. Decreased

c. Remained about the same □ Don't know

7. Can you determine if the number of Temporary Detention Orders has increased or decreased over the past two academic years? *Note: please attach any available figures on TDOs over the past two years*

a. Increased

b. Decreased

c. Remained about the same □ Don't know

8. Are you notified of a commitment proceeding involving a student?

a. Yes

b. No

9. *If Yes to Question 8:* How many times were you notified in 2008-09? _____
□ Don't know

10. *If Yes to Question 8:* In how many of these cases was your institution asked to provide information in connection with the proceeding? _____ □ Don't know

11. *If Yes to Question 8:* In how many of these cases did your institution send a representative to commitment hearings? _____ □ Don't know

12. In how many cases in which students were committed and returned to campus after hospitalization were you involved in their post-commitment mental health care in 2008-09? _____ □ Don't know

13. Do you provide mental health services to a student when these services are required by a court as a part of a mandatory outpatient treatment order?

a. Yes

b. No.

14. *If Yes to Question 13:* In how many cases did you provide mandatory outpatient services in 2008-09? _____ □ Don't know

Comments on any answer in Section VIII:

Section IX. Parental Notification

1. Does your institution typically seek a waiver or release from a student to allow contact with the student's parents when concern is raised about the student's mental health?

a. Yes

b. No

2. Does your institution have a parental notification policy?

a. Yes. *Note: if so, please attach the policy to this form*

b. No

3. How many times in 2008-09 did someone on behalf of your institution notify the parents of a student because you were concerned about the student's becoming harmful to him or herself or to others? _____ □ Don't know

4. How many times in 2008-09 did someone on behalf of your institution notify the parents of a student because you were concerned about the student's mental health more broadly, independent of a concern about the student's becoming harmful to him or herself or to others?? _____ □ Don't know

Comments on any answer in Section IX:

Section X. Medical Withdrawal for Mental Health Reasons

1. Does your institution allow for Voluntary Medical Withdrawal (or Voluntary Administrative Withdrawal, or similar procedures) for mental health reasons?

   a. Yes. *Note: please attach any written procedures*

   b. No

2. *If Yes to Question 1*: How many students received a Voluntary Medical Withdrawal for mental health reasons in 2008-09? _____ □ Don't know

3. *If Yes to Question 1*: What office makes the ultimate determination of whether a student who has received a voluntary medical withdrawal can be re-admitted? [Please specify: _____]

4. *If Yes to Question 1*: Does your institution require a medical/psychological examination?

   a. Yes, upon departure

   b. Yes, upon re-entry

   c. Yes, upon both departure and re-entry

   d. No

5. *If Yes to Question 4:* Who performs the required medical/psychological examination?

   a. Counseling Center

b. Community Services Board

c. Private Provider

d. Other [Please specify: _____]

6. *If Yes to Question 4:* Are the results of this examination conveyed to any campus or academic administrators (e.g., the Dean of Students)?

a. Yes

b. No

7. Does your institution allow for Involuntary Medical Withdrawal (or Involuntary Administrative Withdrawal, or similar procedures) for mental health reasons?

a. Yes. *Note: Please attach any written procedure*

b. No

8. *If Yes to Question 7*: How many students received an Involuntary Medical Withdrawal for mental health reasons in 2008-09? _____ □ Don't know

9. *If Yes to Question 7*: What office makes the ultimate determination of whether a student who has received an involuntary medical withdrawal can be re-admitted? [Please specify: _____]

10. *If Yes to Question 7*: Does your institution require a medical/psychological examination?

a. Yes, upon departure

b. Yes, upon re-entry

c. Yes, upon both departure and re-entry

d. No

11. *If Yes to Question 10:* Who performs the required medical/psychological examination?

a. Counseling Center

b. Community Services Board

c. Private Provider

d. Other [Please specify: _____]

12. *If Yes to Question 10:* Are the results of this examination conveyed to any campus or academic administrators (e.g., the Dean of Students)?

a. Yes

b. No

13. If you have procedures for voluntary or involuntary withdrawal for mental health reasons, do you ever require that the student participate in any recommended inpatient or outpatient mental health treatment before being readmitted?

a. Yes

b. No

14. *If Yes to Question 13:* In how many cases was mental health treatment required before a student was readmitted in 2008-2009? _____ □ Don't know

15. If you have procedures for voluntary or involuntary withdrawal for mental health reasons, do you maintain contact with students who remain in the area while they are withdrawn from your institution?

a. Yes

b. No

16. Do you ever require that a student who has withdrawn for mental health reasons agree to continue in outpatient mental health treatment as a condition of readmission?

a. Yes

b. No

17. *If Yes to Question 16:* In how many cases was a student required to continue in mental health treatment as a condition of readmission in 2008-2009? _____ □ Don't know

18. Does your institution have procedures whereby a student may be excluded from residing in campus housing for mental health reasons, even if the student has not be subject to voluntary or involuntary medical withdrawal?

a. Yes

b. No

Comments on any answer in Section X:

Section XI. Mental Health Evaluation and Treatment in Connection with Disciplinary Proceedings

1. If a student is charged with engaging in a disciplinary violation that could lead to suspension or expulsion, and there is reason to believe that the disciplinary violation is related to a mental health condition, is a formal mental health evaluation ever sought to aid in reaching a decision in the case?

    a. Yes, but only if requested by the student

    b. Yes, if mandated by the institution or requested by the student

    c. No

2. *If Yes to Question 1:* Who would usually conduct such an evaluation?

    a. Counseling Center

    b. Community Services Board

    c. Private provider

    d. Other [please specify: _____]

3. If a student has engaged in a disciplinary violation that could lead to suspension or expulsion, and the disciplinary violation is determined to be related to a mental health condition, does the institution ever require the student to participate in mental health treatment as part of a disciplinary sanction?

    a. Yes, but only if this disposition is sought by the student

    b. Yes, if either mandated by the institution or sought by the student

    c. No

4. *If Yes to Question 3:* Who would usually provide such treatment?

    a. Counseling Center

    b. Community Services Board

    c. Private provider

d. Other [please specify: _____]

5. How many students subject to disciplinary proceedings were referred to the counseling center for an evaluation in 2008-2009? _____ □ Don't know

6. How many students receiving treatment services at the counseling center in 2008-2009 were required to do so as part of a disciplinary sanction? _____ □ Don't know

Comments on any answer in Section XI:

Section XII. Threat Assessment Team

1. Does your institution have a Threat Assessment Team (even if its formal title differs from this)?

a. Yes

b. No. *Note: please skip the rest of this section.*

2. Are the meetings of the Threat Assessment Team documented in writing?

a. Yes

b. No

3. *If yes to Question 2:* Where is the documentation stored?

a. Counseling Center

b. Campus Police Department

c. the office of a campus administrator (e.g., Dean of Students)

d. Other [please specify: _____]

4. How many active cases did the threat assessment team at your institution have during 2008-09? _____ □ Don't know

5. *If the answer to Question 4 is greater than zero:* In how many of these cases were mental health issues a significant factor? _____ □ Don't know

6. *If the answer to Question 4 is greater than zero:* In how many of these active cases was the individual being evaluated by the threat assessment team not a student? _____

□ Don't know

7. What department serves as team leader/chair of your institution's team? Please specify: _____

8. What other offices are represented on the threat assessment team? Please specify:
_____

_____

9. Does your Threat Assessment Team have a written mission statement and/or written procedures?

a. Yes. *Note: please attach a copy of the statement and procedures*

b. No

Comments on any answer in Section XII:

Section XIII. Open Questions

(1) Aside from "more resources," what changes in policy or in state law would you recommend to better address the mental health of Virginia's college students?

(2) What are the principal roadblocks your institution has encountered in working with students with mental health conditions?

(3) Do you have any policies or procedures not listed above that you think might be helpful to other Virginia colleges in dealing with distressed or distressing students?

Feel free to attach additional sheets as necessary. Thank you very much for your help.

COMMONWEALTH of VIRGINIA

Joint Commission on Health Care

Delegate Benjamin L. Cline
Chairman
Kim Snead
Executive Director

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REPORT ON THE VIRGINIA COLLEGE MENTAL HEALTH SURVEY

Conducted by

THE JOINT COMMISSION ON HEALTH CARE

In coordination with

THE COMMISSION ON MENTAL HEALTH LAW REFORM

September 7, 2010

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The Virginia College Mental Health Survey was conducted by the Joint Commission on Health Care of the Virginia General Assembly, in coordination with the Commission on Mental Health Law Reform. Consultation on the design of the survey was provided by Richard Bonnie, Susan Davis, Christopher Flynn and John Monahan.

Jennifer Allman, Patricia Lunt, and Michael Turner of the Virginia Community College System, and William Miracle of Bridgewater College provided great assistance in achieving a high response rate. Natalie Morris expertly analyzed the survey data.

EXECUTIVE SUMMARY

Background: In the spring of 2010, the Joint Commission on Health Care of the Virginia General Assembly, in coordination with the Commission on Mental Health Reform, conducted a survey "to gather—for the first time—comprehensive empirical information from each public and private college in the Commonwealth regarding the adequacy of students' access to mental health services and the ways in which colleges respond to students' mental health crises. Findings from this survey will be reported to the Joint Commission and may inform recommendations for legislative or other policy changes to improve both student access to mental health services and institutional responses to mental health crises." The complete survey instrument is appended to this report. Information was requested for the 2008-2009 academic year. The response rate from Virginia's 64 colleges was a remarkable 98 percent.

Size of the College Student Population: Close to half a million students (460,211) attended one of Virginia's 64 colleges in 2008-09. This number—larger than the population of Virginia Beach, the largest city in the state—consisted of 206,338 students in one of the 15 four-year public colleges, 76,752 students in one of the 25 four-year private colleges, and 177,121 students in one of the 24 public two-year colleges. The college student population is projected to grow substantially over the next five years. Northern Virginia Community College alone projects its student body to grow from 72,000 today to 84,000 by 2015.

Staffing Levels: The number of Student Affairs professional staff who are engaged in direct support or outreach to students is higher in private colleges (12.6 staff members per 1,000 students) than in public four-year colleges (3.6 staff members per 1,000 students), or in public two-year colleges (1.9 staff members per 1,000 students). The number of mental health professionals who are engaged in providing treatment at campus counseling centers is higher in private colleges (1.2 mental health professionals per 1,000 students) than in public four-year colleges (0.7 mental health professionals per 1,000 students).[1] The Virginia Community College System (VCCS) Policy Manual states that "VCCS colleges do not provide mental health services."

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

[1] The International Association of Counseling Services offers the following standards: "Every effort should be made to maintain minimum staffing ratios in the range of one F.T.E. professional staff member (excluding trainees) to every 1,000 to 1,500 students [i.e., from 0.7 to 1.0 F.T.E. professional staff member per 1,000 students] depending on services offered and other campus mental health agencies."

Information Requested from Originating Schools

Mental health records from a student's originating school were requested prior to enrollment by 26.7 percent of public colleges, by 8.7 percent of private colleges, and by 9.1 percent of community colleges. Such requests were made only for a small number of selected students.

Access to Services: Overall, 8.9 percent of all four-year college students—6.3 percent of students at public colleges, and 11.1 percent of students at private colleges—accessed services at campus counseling centers during 2008-09. Students who accessed care at counseling centers varied little by race or ethnicity from the general composition of the student body. For example, at public colleges, white students constituted 62.2 percent of the student body and 63 percent of the students who were treated at counseling centers. At public Historically Black Colleges and Universities (HBCUs), African American students constituted 89.7 percent of the student body and 89.6 percent of the students who were treated at counseling centers. At public non-HBCU colleges, African American students constituted 8.1 percent of the student body, and 9.7 percent of the students who were treated at counseling centers. Women, however, were somewhat overrepresented among students who accessed care at counseling centers. For example, at public non-women's colleges, women constituted 54.9 percent of the student body and 61.7 percent of the students who were treated at counseling centers.[2] The findings for private colleges on both race/ethnicity and gender are similar to those for public colleges.

Back-Up Services: Colleges vary in terms of where they first look for assistance when their own mental health resources are exhausted. Public and private four-year colleges are much more likely to look first to private providers (33.3 and 58.3 percent of the time, respectively), while community colleges look to the local community service boards (CSBs) (83.3 percent of the time).

Relationships with Community Service Boards: The availability of mental health services for college students at local CSBs was rated as adequate or better by 33.3 percent of the respondents from public colleges, 38.1 percent of the respondents from private colleges, and 63.6 percent of the respondents from community colleges. Working agreements with their local CSBs have been established by 66.7 percent of public colleges, 45.8 percent of private colleges, and 70.8 percent of community colleges. These working agreements—only one-third of which are written—usually address issues of emergency services, including pre-screening for a Temporary Detention Order (TDO), and may also cover the provision of outpatient services and procedures for exchanging information about CSB clients who are college students. In addition, working agreements with local psychiatric hospitals have been established by 46.7 percent of public colleges, 33.3 percent of private colleges, and 4.2 percent of community colleges.

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[2] According to the 2009 Annual Survey of the Association for University and College Counseling Center Directors, nationally 64.2 percent of campus Counseling Center clients are female. See http://aucccd.org/img/pdfs/directors_survey_2009_nm.pdf

Student Suicide or Attempts: During 2008-09, 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 1 attempt per college—than at public colleges—an average of 6 attempts per college—in large part because of the smaller average size of the private colleges. All public colleges,[3] 82.6 percent of private colleges, and 38.1 percent of community colleges, have 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 are in place at 57.1 percent of public colleges, 79.2 percent of private colleges, and 9.1 percent of community colleges.

Student Violence to Others: Only 2 colleges reported that one of their students was arrested for killing someone during 2008-09 (in one of these cases the victim was another student). Less than half of the counseling centers recorded the reasons for student referrals. Among those that did record such information, public colleges reported that an average of 9 students accessing care had been referred due to aggressive or violent behavior toward others; private colleges reported that an average of 3 students were referred for this reason. These figures represent 0.5 and 1.8 percent of the students accessing services at public and private colleges, respectively. At public colleges, half of the students referred to counseling centers due to aggressive or violent behavior toward others were required to participate in outpatient treatment as a condition of remaining a student in good standing. The corresponding figure for private colleges was 5.9 percent.

Parental Notification: 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 in 2008-09.[4] Private colleges did so 70 times, and community colleges 6 times. Public colleges notified a student's parents because they were concerned about the student's mental health more broadly, independent of a concern about the student's becoming harmful to him or herself or others, a total of 4 times in 2008-09. Private colleges did so 80 times, and community colleges once.

Civil Commitment and Hospitalization: Forty percent of public colleges, 14.3 percent of private colleges, and no community college reported that they initiated at least one Emergency Custody Order (ECO) to hold a student in 2008-09. Seventy percent of public colleges, 9.5 percent of private colleges, and 7.1 percent of community colleges initiated at least one Temporary Detention Order (TDO) to detain a student. These differences between public and

[3] 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."

[4] 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.

private colleges were strongly related to size of enrollment. For example, larger colleges (over 5,000 students) were twice as likely to have initiated at least one ECO, and six times as likely to have initiated at least one TDO, as were smaller colleges (fewer than 2,000 students). The number of students for whom colleges initiated either an ECO or a TDO represents 0.02 percent of the students in both public and private colleges. Most colleges report that they are not notified when a commitment proceeding involving a student is initiated by others; notification is reported by 33.3 percent of public colleges, 25 percent of private colleges, and 15 percent of community colleges. The average number of students admitted to a psychiatric hospital in 2008-09, 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 colleges. Of those colleges providing treatment under MOT orders in 2008-09, the average number of cases per college was approximately 2.

Medical Withdrawal from College: *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 2008-09. *Involuntary medical withdrawal* from college for mental health reasons was allowed 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.

Disciplinary Violations: If a student is charged with engaging in a disciplinary violation that could lead to suspension or expulsion, and there is reason to believe that the disciplinary violation is related to a mental health condition, a formal mental health evaluation can be sought to aid in reaching a decision on the case at 78.6 percent of public colleges, 69.5 percent of private colleges, and 39.1 percent of community colleges. If a student has engaged in a disciplinary violation that could lead to suspension or expulsion, and the disciplinary violation is determined to be related to a mental health condition, the student can be required to participate in mental health treatment as part of a disciplinary sanction at 85.7 percent of public colleges, 87 percent of private colleges, and 69.6 percent of community colleges.

Threat Assessment Teams. All public colleges, 77.3 percent of private colleges, and 75 percent of community colleges have established Threat Assessment Teams. The average number of

active cases considered by Threat Assessment Teams in 2008-09[5] 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.

Responses to Open-Ended Questions: Several themes emerged in response to open-ended questions regarding improving the manner in which Virginia's colleges deal with distressed or distressing students, including the need for students to have health insurance, the need for colleges to be notified when a student is hospitalized, and the need for clarity on the liability of college staff for student violence to self or others.

[5] 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.

Publically-available descriptive information on Virginia's colleges, from the State Council of Higher Education for Virginia (SCHEV), is contained in Appendix A to this report. The Virginia College Mental Health Survey instrument is contained in Appendix B.

TABLE A- TOTAL NUMBER OF STUDENTS IN VIRGINIA COLLEGES (2008-2009)

	Total number of students
4-year Publics (15)	206,338
4-year Privates (25)	76,752
Community Colleges (24)	177,121
Total (64)	460,211

SECTION I. ELIGIBILITY FOR SERVICES ON CAMPUS[6]

1. Number of students eligible for services <u>at the student health center (SHC)</u>:

	Total N students eligible	Mean % of students per college who are eligible	S.D.	Range	DK[7]	DNA[8]
4-year Publics (13)[9]	138,708	93.8	12.1	58.6-100	2	0
4-year Privates (21)	44,001	83.0	24.3	25.4-100	1	2

[6] According to Virginia Community College System Policy 6.4.0, found at www.vccs.edu/Portals/0/ContentAreas/ Policy Manual/Sec6.pdf, "VCCS colleges do not provide mental health services." Therefore, questions involving mental health counseling on-campus will not display data from community colleges.

[7] DK refers to the number of colleges for which the person responding to the survey did not know the answer to the given question. These colleges are not included in the calculation of means or percents.

[8] DNA refers to the number of colleges that did not answer the question. These colleges are not included in the calculation of means or percents.

[9] The number in parenthesis after each college grouping is the number of colleges in that group responding to the given question. The size of the total sample for each group is: 4-year publics (15; 100% of colleges surveyed); 4-year privates (24; 96% of colleges surveyed); and community colleges (24; 100% of colleges surveyed). The overall response rate for all 64 Virginia colleges was 98%.

2. Number of students eligible for services at the counseling center (CC):

	Total N students eligible	Mean % of students per college who are eligible	S.D.	Range	DK	DNA
4-year Publics (15)	191,890	94.5	7.9	78.1-100	0	0
4-year Privates (23)	48,537	87.9	20.0	35.1-100	1	0

3. Does your institution require that students have health insurance?

	N colleges requiring insurance for all	% of colleges requiring insurance for all	N colleges requiring insurance only for international	% colleges requiring insurance only for international	DK	DNA
4-year Publics (15)	4	26.7	2	13.3	0	0
4-year Privates (24)	14	58.3	1	4.2	0	0
Community Colleges (24)	0	0	0	0	0	0

4. *If Yes to Question 3[for either all students or only international students]:* Do you require specific coverage levels, including for mental health coverage?

	N colleges requiring coverage levels	% of colleges requiring coverage levels	DK	DNA
4-year Publics (6)	1	16.7	0	0
4-year Privates (14)	2	14.3	0	1
Community Colleges (0)	-	-	-	-

5. How many students at your institution are veterans?

	Total N veterans	Mean % of students per college who are veterans	S.D.	Range	DK	DNA
4-year Publics (8)	3,096	2.0	2.2	.16-6.5	7	0
4-year Privates (15)	472	1.3	1.5	0-4.8	8	1
Community Colleges (19)	7,392	3.5	2.8	1.13-12.7	5	0

Comments from Survey Respondents[10]

04: Health insurance is "strongly encouraged" but not required.

10: It would be my sincere hope that the Commonwealth would require all students to be covered by health insurance.

9: All enrolled students are eligible for both services.

38: Enrolled as a [university] student full or part time, undergrad or grad.

13: Veteran status is disclosed on a voluntary basis.

05: Students who pay the comprehensive student fee are eligible to receive care at the Student Health Center. Non-degree-seeking students and students on non-resident leave are not eligible for Student Health services. Students enrolled in [certain certificate and graduate programs] are also not eligible for Student Health services.

All students are required to have health insurance pursuant to a [Board] resolution. Incoming students are required to provide information regarding their health insurance coverage as part of their Pre-Entrance Health Form. Returning students are [required] to continue to comply with the University's requirement that all students carry health insurance. All incoming and returning international students are subject to a hard waiver program in an effort to ensure they have adequate coverage. The specific coverage requirements for the hard-waiver program are posted here: [website redacted].

32: On #4: Every student is charged for the school's insurance policy. They can opt out of this coverage and charge only if they have current insurance that matches or exceeds it.

02: Part-time students are also eligible for the student health center if they pay a health fee. International students are required to have health insurance

[10] Code numbers 1 through 15 apply to 4-year public colleges; numbers 16 through 40 apply to 4-year private colleges; numbers 41 though 65 apply to community colleges. Within the college groupings, code numbers have been randomly assigned. The same code numbers apply to each college throughout the report.

26: International students are required to have health insurance.

14: We now have the ability to offer health insurance but Board of Visitors voted on a voluntary basis rather than mandated coverage.

All enrolled students are eligible for the above services. There is a professional located in the Financial Aid Office dedicated to veteran services. [S/he] has been working with approximately 260 veterans/family members.

45: [According to policy, the institution does not] provide mental health services. [The institution] shall develop guidelines that advise students, faculty, and staff of proper procedures for addressing needs of students who may pose a threat to self or others.

19: 6 are receiving VA benefits (some are dependents).

SECTION II. STAFFING LEVELS/AVAILABILITY OF SERVICES ON CAMPUS

1. Does your institution have an Office/Department of Student Affairs, or an Office/Department of the Dean of Students, or a similar Office/Department?

	N colleges with such an office	% of colleges with such an office	DK	DNA
4-year Publics (15)	15	100	0	0
4-year Privates (24)	24	100	0	0
Community Colleges (24)	23	95.8	0	0

a. Title of the office responsible for judicial functions:

4-Year Publics:

- Office of Student Conduct (2)
- Office of the Dean of Students (5)
- Judicial Affairs/Services (5)
- Division of Student Affairs (1)
- Student Life (1)
- Commandant of Cadets (1)

4-Year Privates:

- Dean of Students (7)
- Student Life (4)
- Office of Student Development (2)
- Office of Student Affairs (5)
- Director of Residence Life and Judicial Affairs
- Residence Life and Housing (2)
- Dean of Men and Women (1)
- Office of Campus and Residential Services
- Student Conduct (2)
- Office of Judicial Affairs (1)
- Curricular Life (1)

Community Colleges:

- Office of Student Services (11)
- Student Activities (1)
- Enrollment Management (1)
- Office of Student Affairs (1)
- Student Success and Academic Advancement (3)

2. If Yes to Question 1: Number of paid professional staff in this Office/Department engaged in direct support/outreach to students (excluding residence assistants or paraprofessionals)?

	Total N paid prof staff	Mean N of paid prof staff per college	S.D.	Range	Mean N of paid prof staff per 1,000 students	S.D	Range	DK	DNA
4-year Publics (12)	346	28.8	50.7	1-170	3.6	5.1	.04-15.9	2	1
4-year Privates (20)	348.1	17.4	13.2	4-50	12.6	11.6	1.2-41.6	0	4
Community Colleges (20)	244	12.2	14.4	0-50	1.9	2.1	0-9.2	1	2

3. Do any of the following student activities related to mental health occur at your institution?

a. "peer education" or mental health awareness programs, convened by one or more student organizations [If so, check here if the Counseling Center provides advice and support: _____]

	N colleges with such an activity	% of colleges with such an activity	N colleges with CC support	% of colleges w activity w CC support	DK	DNA
4-year Publics (15)	12	80	9	75.0	0	0
4-year Privates (24)	19	79.2	16	84.2	0	0
Community Colleges (24)	6	25	1 (5 do not know)	100	0	0

b. a hotline for troubled students established and operated by students without direct oversight of the Counseling Center [If so, check here if the Counseling Center provides advice and support: _____]

	N colleges with such an activity	% of colleges with such an activity	N colleges with CC support	% of colleges w activity w CC support	DK	DNA
4-year Publics (15)	1	6.7	1	100	0	0
4-year Privates (24)	0	0	0	0	0	0
Community Colleges (24)	0	0	0	0	0	0

c. "peer support" or outreach programs organized by students and providing face-to-face support to troubled students without direct oversight of the counseling center [If so, check here if the Counseling Center provides advice and support: _____]

	N colleges with such an activity	% of colleges with such an activity	N colleges with CC support	% of colleges w activity w CC support	DK	DNA
4-year Publics (15)	3	20	3	100	0	0
4-year Privates (24)	8	33.3	4	50	0	0
Community Colleges (24)	2	8.3	0	0	0	0

d. a hotline for troubled students under direct oversight of the Counseling Center

	N colleges with such an activity	% of colleges with such an activity	DK	DNA
4-year Publics (15)	1	6.7	0	0
4-year Privates (24)	0	0	0	0

e. "peer counseling" programs to provide face-to-face support and referral to troubled students under direct oversight of the Counseling Center

	N colleges with such an activity	% of colleges with such an activity	DK	DNA
4-year Publics (15)	1	6.7	0	0
4-year Privates (24)	6	25.0	0	0

4. Does your institution have a campus police department?

	N colleges with campus police	% of colleges with campus police	DK	DNA
4-year Publics (15)	15	100	0	0
4-year Privates (24)	11	45.8	0	0
Community Colleges (24)	9	37.5	0	0

5. If Yes to Question 4:

a. Number of sworn officers:

	Total N sworn officers	Mean N sworn officers per college	S.D.	Range	DK	DNA
4-year Publics (14)	470	33.5	22.4	8-84	0	1
4-year Privates (11)	144	13.1	10.8	0-31	0	0
Community Colleges (9)	94	10.4	13.5	1-45	0	0

b. Number of unsworn personnel:

	Total N unsworn personnel	Mean N unsworn personnel per college	S.D.	Range	DK	DNA
4-year Publics (12)	160	13.3	21.7	0-79	2	1
4-year Privates (11)	60	5.5	7.6	0-25	0	0
Community Colleges (5)	19	3.8	2.3	1-6	0	4

5. To what office does the head of the campus police department report?

4-Year Publics:

- Administration and Finance (3)
- VP/Vice Chancellor for Administration (4)
- VP for Finance (3)
- Office of the President (1)
- Executive Vice President and Chief Operating Officer (1)
- Public Safety and Community Support Services (1)
- VP of Student Services (1)

4-Year Privates:

- VP for Student Life (1)
- VP for Administration (2)
- Facilities (1)
- Dean of Students (1)
- Business/Financial Affairs (4)
- Human Resources (1)
- VP for Student Affairs (2)

Community Colleges:

- VP Finance and Administration (8)

6. Does your institution have a campus security force?

	N colleges with security force	% of colleges with security force	DK	DNA
4-year Publics (13)	6	46.2	0	2
4-year Privates (22)	17	77.3	0	2
Community Colleges (22)	14	63.6	0	2

7. If Yes to Question 6:

a. Number of personnel:

	Total N personnel	Mean N of personnel per college	S.D.	Range	DK	DNA
4-year Publics (3)	33	11	5.6	5-16	2	1
4-year Privates (15)	201	13.4	7.1	2-24	1	1
Community Colleges (14)	177	12.6	18.6	1-70	0	0

b. To what office does the head of the campus security force report?

4-Year Publics:

- Police Department (5)

4-Year Privates:

- VP for Student Life (1)
- Office of Student Development (2)
- Facilities (1)
- Dean of Students (3)
- Campus Physical Plant (1)
- VP of Finance and Administration (4)
- Human Resources (1)
- VP for Enrollment and Student Services (1)
- VP for Student Affairs (2)
- Operations (1)

Community Colleges:

- Facilities Manager (2)
- Finance and Administration (10)

Comments from Survey Respondents

29: We have a campus police/security office that utilizes sworn officers and security personnel. We have [number redacted] full-time employees plus numerous part-timers.

45: [The institution does not] provide mental health services – [policy number redacted]

SECTION III. SERVICE UTILIZATION RATES AT THE COUNSELING CENTER

1. Number of FTE mental health professionals providing services in the Counseling Center? (include only paid staff):

	Total FTE mh profs	Mean FTE mh profs per college	S.D.	Range	Mean FTE mh profs per 1,000 students	S.D	Range	DK	DNA
4-year Publics (15)	115.5	7.7	6.2	2-25	.7	.44	.3-1.7	0	0
4-year Privates (22)	40.05	1.8	1.1	.75-5	1.2	.63	.3-3.0	0	2

2. How many mental health staff are pre-doctoral interns?

	Total N pre-docs	Mean N pre-docs per college	S.D.	Range	DK	DNA
4-year Publics (15)	18	1.2	1.5	0-4	0	0
4-year Privates (22)	6	.27	.63	0-2	0	2

3. How many mental health staff are post-doctoral fellows?

	Total N post-docs	Mean N post-docs per college	S.D.	Range	DK	DNA
4-year Publics (15)	5	.33	.62	0-2	0	0
4-year Privates (22)	0	0	0	0	0	2

4. Percent of total student population accessing care at the Counseling Center:

	Total N students Accessing care	Mean % of student population accessing care	S.D.	Range	DK	DNA
4-year Publics (14)	11,117	6.3	3.1	1.9-12.7	0	1
4-year Privates (17)	2,800	11.1	7.7	2.3-28.8	0	7

5. Students who accessed care at the Counseling Center by racial/ethnic composition-

a. Number of White students:

	Total N white students	Mean % of students accessing care who are white per college	S.D.	Range	DK	DNA	Mean % of students who are white
4-year Publics (13)	7060	63.0	28.4	2.5- 88.2	2	0	62.2
4-year Privates (14)	1604	66.0	30.6	0-94.4	7	3	67.6

b. Number of African-American students:

	Total N Af Am students	Mean % of students accessing care who are Af Am per college	S.D.	Range	DK	DNA	Mean % of students are Af Am per college
4-year Publics (13)	1344	21.9	30.7	2-91.5	2	0	19.0
4-year Privates (14)	388	23.7	32.0	3.4-100	7	3	20.2

b.i- Number of African American Students at non-historically black colleges or universities (HBCUs)[11]

	Total N Af Am students	Mean % of students accessing care who are Af Am per college	S.D.	Range	DK	DNA	Mean % of students who are Af Am per college
4-year Publics (11)	897	9.7	7.2	2 -27.0	2	0	8.1
4-year Privates (12)	216	11.4	6.9	3.4-26.8	7	3	14.0

b. ii- Number of African American Students at HBCUs

	Total N Af Am students	Mean % of students accessing care who are Af Am per college	S.D.	Range	DK	DNA	Mean % of students who are Af Am per college
4-year Publics (2)	447	89.6	2.8	87.6-91.5	0	0	89.7
4-year Privates (2)	172	97.6	3.4	95.2-100	0	0	94.8

c. Number of Asian-American students:

	Total N As Am students	Mean % of students accessing care who are As Am per college	S.D.	Range	DK	DNA	Mean % of students who are As Am per college
4-year Publics (12)	725	5.0	4.2	0-13.4	2	1	4.7
4-year Privates (13)	45	1.8	1.6	0-5.4	7	4	1.9

[11] List of HBCUs from the U.S. Department of Education, http://ed.gov/about/inits/list/whhbcu/edlite-list.html#list

d. Number of Hispanic students:

	Total N Hispanic students	Mean % of students accessing care who are Hispanic per college	S.D.	Range	DK	DNA	Mean % of students who are Hispanic per college
4-year Publics (12)	381	3.5	1.7	.65-6.1	2	1	2.9
4-year Privates (13)	64	2.8	2.4	0-6.7	7	4	2.6

e. Number of Native American students:

	Total N Nat Am students	Mean % of students accessing care who are Nat Am per college	S.D.	Range	DK	DNA	Mean % of students who are Nat Am per college
4-year Publics (10)	27	.28	.32	0-.98	3	2	.4
4-year Privates (12)	4	.11	.27	0-.75	8	4	.4

f. Number of students of other, or undeclared, races/ethnicities:

	Total N other students	Mean % of students accessing care who are other per college	S.D.	Range	DK	DNA	Mean % of students who are other per college
4-year Publics (13)	944	7.0	3.7	0-11.8	2	0	10.8
4-year Privates (10)	120	8.3	14.7	0-48.3	7	7	7.2

6. Students who accessed care at the Counseling Center by gender

a. Number of male students:

	Total N male students	Mean % of students accessing care who are male per college	S.D.	Range	DK	DNA	Mean % of students who are male per college
4-year Publics (14)	4269	38.3	17.8	22.2-86.2	1	0	45.1
4-year Privates (18)	810	28.8	22.2	0-100	3	3	38.8

b. Number of female students:

	Total N female students	Mean % of students accessing care who are female per college	S.D.	Range	DK	DNA	Mean % of students who are female per college
4-year Publics (14)	6908	61.7	17.8	13.8-77.8	1	0	54.9
4-year Privates (18)	1990	71.2	22.2	0-100	3	3	61.2

b.i- Number of female students at non-women's colleges

	Total N female students	Mean % of students accessing care who are female per college	S.D.	Range	DK	DNA	Mean % of students who are female per college
4-year Publics (14)	6908	61.7	17.8	13.8-77.8	1	0	54.9
4-year Privates (16)	1740	67.6	20.8	0-89.9	3	3	58.3

b.ii- Number of female students at women's colleges

	Total N female students	Mean % of students accessing care who are female per college	S.D.	Range	DK	DNA	Mean % of students who are female per college
4-year Publics (0)	-	-	-	-	-	-	-
4-year Privates (2)	250	100	0	100-100	0	0	95.1

7. What is the median number of counseling sessions per client?

	Mean of median N of sessions per college	Range in median N of sessions per college	DK	DNA
4-year Publics (15)	5.0	3-8	0	0
4-year Privates (17)	5.4	1.4-20	4	3

8. Do you limit the number of counseling sessions allowed a client?

	N colleges that limit sessions	% of colleges that limit sessions	DK	DNA
4-year Publics (15)	6	40	0	0
4-year Privates (22)	6	27.3	0	2

9. *If Yes to Question 8:* What is the maximum number of sessions?

	Mean maximum N of sessions per college	SD	Range in maximum N of sessions, per college	DK	DNA
4-year Publics (6)	13.7	8.0	10-30	0	0
4-year Privates (6)	8.2	3.5	6-15	0	0

10. Did you have a waiting list for services in 2008-2009?

	N colleges with waiting list	% of colleges with waiting lists	DK	DNA
4-year Publics (15)	3	20	0	0
4-year Privates (22)	0	0	0	2

11. *If Yes to Question 10:* How many students were on the waiting list at the end of the fall semester 2008?

	Total N on waiting list	Mean N of students on waiting list per college	S.D.	Range	DK	DNA
4-year Publics (2)	20	10	14.1	0-20	1	0
4-year Privates (0)	-	-	-	-	-	-

12. *If Yes to Question 10:* How many students were on the waiting list at the end of the spring semester 2009?

	Total N on waiting list	Mean N of students on waiting list per college	S.D.	Range	DK	DNA
4-year Publics (2)	20	10	14.1	0-20	1	0
4-year Privates (0)	-	-	-	-	-	-

13. Do you have after-hours coverage?

	N of colleges with after- hours coverage	% of colleges with after-hours coverage	DK	DNA
4-year Publics (15)	14	93.3	0	0
4-year Privates (22)	20	90.9	0	2

14. If Yes to Question 13: Who provides this coverage? (a) Counseling Center, (b) Community Service Board, (c) Local hospital, (d) Other , (e) More than one form of coverage for after-hours service provision

	% Counseling Cntr	% CSB	% local hosp	% other	% more than 1	DK	DNA
4-year Publics (14)	57.1	0	0	7.1	35.7	0	0
4-year Privates (20)	55.0	0	0	25.0	20.0	0	0

Description of "other":

4-Year Publics:

- Connect Assessment and referral Service with Carillion (1)
- Off campus security initially, then local hospital and/or CSB (1)
- Residential Life Staff/Campus Police are often the first contact (1)
- Nurse/infirmary (1)

4-Year Privates:

- Residence Life (3)
- Minister and Counselor on call who refer to local hospital (1)
- Student Affairs staff (1)
- Chaplain or professors as appropriate (1)

15. Number of students referred to other mental health providers in the community

a. Number referred because they have reached session limits:

	Total N referred per session limits	Mean N of students referred per session limits per college	S.D.	Range	DK	DNA
4-year Publics (6)	44	7.3	17.9	0-44	5	4
4-year Privates (16)	6	.37	1.1	0-4	2	6

b. Number referred after initial assessment:

	Total N referred after initial	Mean N of students referred after initial, per college	S.D.	Range	DK	DNA
4-year Publics (5)	207	41.4	49.4	0-116	9	1
4-year Privates (15)	46	3.1	6.7	0-25	6	3

c. Number referred for specialized evaluation or treatment (e.g., for an eating disorder):

	Total N referred for specialized	Mean N of students referred for specialized, per college	S.D.	Range	DK	DNA
4-year Publics (7)	144	20.6	15.1	3-39	7	1
4-year Privates (15)	88	5.9	8.7	0-28	6	3

16. What functions beyond clinical counseling does your Counseling Center have responsibility for? (please circle all that apply)

a. Disability services

	N colleges providing disability serv	% of colleges providing disability serv	DK	DNA
4-year Publics (15)	1	6.7	0	0
4-year Privates (22)	4	18.2	0	2

b. Assessment of LD/ADD

	N colleges providing LD/ADD serv	% of colleges providing LD/ADD serv	DK	DNA
4-year Publics (15)	4	26.7	0	0
4-year Privates (22)	2	9.1	0	2

c. Case management

	N colleges providing case manag serv	% of colleges providing case manage serv	DK	DNA
4-year Publics (15)	8	53.3	0	0
4-year Privates (22)	10	45.5	0	2

d. Career Advising

	N colleges providing career adv serv	% of colleges providing career adv serv	DK	DNA
4-year Publics (15)	0	0	0	0
4-year Privates (22)	2	9.1	0	2

e. Academic Advising

	N of colleges providing acad adv serv	% of colleges providing acad adv serv	DK	DNA
4-year Publics (15)	0	0	0	0
4-year Privates (22)	3	13.6	0	2

Comments from Survey Respondents

10: We provide Academic Services – study skills, workarounds for LD/ADD – etc.

15: Other offices on campus handle Career Advising, Academic Advising and Disability Services.

17: Programming and advising is also a part of the director's responsibilities.

29: Counseling is housed in our [resource center]. The [resource center] is responsible for the additional services listed above but not circled.

14: The # of internships from the Counseling or Psychology Department vacillates so each semester is different. [identifying information redacted].

24: Numbers given at the beginning of this section are minimums.

26: We have a care office that provides [counseling]. We do not have a counseling center staffed by LPCs/clinical professionals.

19: Utilization and demographic information is not available for 2008-09 due to administrative support staffing issues.

31: Clinical Counseling resided within [office name redacted] until the 2009-2010 academic year, at which time it became an independent department within student affairs.

SECTION IV. RELATIONSHIPS WITH COMMUNITY SERVICE BOARDS AND LOCAL HOSPITALS

1. If your institution exhausts its own counseling services/resources, where does it first look for assistance? (a) Community Service Boards, (b) private providers, (c) other, (d) more than one

	% CSB	% Private	% Other	% more than 1	DK	DNA
4-year Publics (15)	13.3	33.3	13.3	40	0	0
4-year Privates (24)	16.7	58.3	4.2	20.8	0	0
Community Colleges (24)	83.3	12.5	0	4.2	0	0

Description of "other":

4-Year Publics:

- Eastern Virginia Medical School clinic (1)
- Other on-campus clinics (2)
- Practitioners in the student's home town (1)

4-Year Privates:

- Hospital (2)
- Add part-time help/contracted off-campus counselor (2)
- Non-profit counseling agencies (1)

Community Colleges:

- Any local provider (1)

2. What is the availability of services for your students at the local CSB? (a) minimal, (b) adequate, (c) extensive

	% Minimal	% Adequate	% Extensive	DK	DNA
4-year Publics (15)	66.7	33.3	0	0	0
4-year Privates (21)	61.9	38.1	0	0	3
Community Colleges (22)	36.4	59.1	4.5	0	2

3. Does your institution have a regular referral arrangement with particular private mental health service providers?

	N colleges with such an arrangement	% of colleges with such an arrangement	DK	DNA
4-year Publics (15)	3	20	0	0
4-year Privates (24)	2	8.3	0	0
Community Colleges (23)	5	21.7	0	1

4. Does your institution have regular or periodic meetings with representatives of the community service board (CSB) in your area to address areas of mutual interest?

	N colleges which meet with CSB	% of colleges which meet with CSB	DK	DNA
4-year Publics (15)	9	60	0	0
4-year Privates (24)	10	41.7	0	0
Community Colleges (22)	6	27.3	0	2

What is the name of this CSB?

4-Year Publics:

- Norfolk CSB (1)
- Woodburn (1)
- CSB of NRV (1)
- Region Ten (1)
- Rappahannock Area CSB (1)
- New River Valley CSB (1)
- Planning District 1 (1)
- Rockbridge Area CSB (1)

4-Year Privates:

- SARA (1)
- Blue Ridge Community Crisis Center (1)
- Highlands CSB (1)
- Piedmont Community Services (1)

- Hampton/Newport News CSB (1)
- Central Virginia CSB (3)
- Hanover CSB (1)
- Henrico Emergency Services (1)
- Rockbridge Area CSB (1)

Community Colleges:

- LO CSB/PW CSB (1)
- Danville-Pittsylvania Community Services (1)
- Highlands CSB (1)

5. Has your institution developed any type of working agreement with the CSB in your area?

	N colleges w working agreement w CSB	% of colleges w working agreement w CSB	DK	DNA
4-year Publics (15)	10	66.7	0	0
4-year Privates (24)	11	45.8	0	0
Community Colleges (24)	17	70.8	0	0

6. If Yes to Question 5: Is it a written agreement?

	N colleges w written agreement w CSB	% of colleges w written agreement w CSB	DK	DNA
4-year Publics (9)	3	33.3	0	1
4-year Privates (10)	3	30.0	0	1
Community Colleges (15)	5	33.3	2	0

7. If there is a working agreement with the CSB—whether it is written or not— please circle each area that the agreement addresses (circle all that apply):

a. Referral procedures for CSB emergency services

	N colleges w agreement re CSB emergency serv	% of colleges w agreement re CSB emergency serv	DK	DNA
4-year Publics (10)	9	90	0	0
4-year Privates (11)	9	81.8	0	0
Community Colleges (17)	12	70.6	0	0

b. Referral procedures for CSB outpatient services

	N colleges w agreement re CSB outpatient serv	% of colleges w agreement re CSB outpatient serv	DK	DNA
4-year Publics (10)	5	50	0	0
4-year Privates (11)	5	45.5	0	0
Community Colleges (17)	8	47.1	0	0

c. Prescreening protocols for temporary detention orders

	N colleges w agreement re TDO prescreen	% of colleges w agreement re TDO prescreen	DK	DNA
4-year Publics (10)	8	80.0	0	0
4-year Privates (11)	8	72.7	0	0
Community Colleges (17)	4	23.5	0	0

d. Protocols for disaster response

	N colleges w agreement re disaster protocol	% of colleges w agreement re disaster protocol	DK	DNA
4-year Publics (10)	4	40.0	0	0
4-year Privates (11)	4	36.4	0	0
Community Colleges (17)	2	11.8	0	0

e. Procedures for exchange of information regarding students who are served by the CSB

	N colleges w agreement re exchanging info	% of colleges w agreement re exchanging info	DK	DNA
4-year Publics (10)	7	70.0	0	0
4-year Privates (11)	6	54.5	0	0
Community Colleges (17)	5	29.4	0	0

f. Protocols related to provision of medication to students who are served by the CSB

	N colleges w agreement re meds to students	% of colleges w agreement re meds to students	DK	DNA
4-year Publics (10)	1	10.0	0	0
4-year Privates (11)	0	0	0	0
Community Colleges (17)	2	11.8	0	0

g. Designation of a person at the institution who can be contacted 24 hours/day by the CSB to facilitate the collection of information about a student who is the subject of a Temporary Detention Order (TDO)

	N colleges w agreement re info on student TDO	% of colleges w agreement re info on student TDO	DK	DNA
4-year Publics (10)	3	30.0	0	0
4-year Privates (11)	5	45.5	0	0
Community Colleges (17)	0	0	0	0

8. Does the CSB offer any special services or programs targeted to college students?

	N colleges w CSBs offering special serv	% of colleges w CSBs offering special serv	DK	DNA
4-year Publics (15)	0	0	0	0
4-year Privates (24)	1	4.2	0	0
Community Colleges (21)	1	4.8	0	3

9. Does your institution have regular or periodic meetings with representatives of any psychiatric hospital— including a general hospital with a psychiatric unit— in your area to address areas of mutual interest?

	N colleges w regular meetings w psych hosp	% of colleges w regular meetings w psych hosp	DK	DNA
4-year Publics (15)	7	46.7	0	0
4-year Privates (24)	10	41.7	0	0
Community Colleges (22)	2	9.1	0	2

10. Has your institution developed any type of working agreement with a psychiatric hospital in your area?

	N colleges w working agreement w psych hosp	% of colleges w working agreement w psych hosp	DK	DNA
4-year Publics (15)	7	46.7	0	0
4-year Privates (24)	8	33.3	0	0
Community Colleges (24)	1	4.2	0	0

11. If Yes to Question 10: Is it a written agreement?

	N colleges w written agreement w psych hosp	% of colleges w written agreement w psych hosp	DK	DNA
4-year Publics (7)	2	28.6	0	0
4-year Privates (7)	2	28.6	0	1
Community Colleges (1)	0	0	0	0

12. Are there other programs or community organizations with which you maintain a relationship for services targeted towards college students (e.g. Partial Hospitalization, Intensive Outpatient, Eating Disorder, Substance Abuse Facility)?

	N colleges w other relationships for services to students	% of colleges w other relationships for services to students	DK	DNA
4-year Publics (14)	5	35.7	0	1
4-year Privates (24)	10	41.7	0	0
Community Colleges (20)	4	20.0	0	4

a. Please list the program/community organizations:

4-Year Publics:

- Local hospitals (2)
- Tidewater Pastoral Counseling Services (1)
- Blue Ridge First Step Intensive Outpatient Program for Chemical dependency/substance abuse (1)
- Community grief group (1)
- Life recovery program (1)
- Crisis Support Services (1)
- Project Horizon (1)
- Substance Abuse treatment group (1)

4-Year Privates:

- Associates in mental health/Diamond Healthcare (1)
- Police Department (1)
- Forensic Nurses (1)
- Partial Hospitalization program (2)
- Family counseling centers (1)
- Suicide Hotline (2)
- AA/Al-anon (1)
- Local crises center (1)
- YWCA (1)
- Turning Point (outpatient substance abuse program for college students)(1)

Community Colleges:

- Snowden at Fredericksburg, Inc. (1)
- AA (1)
- Substance Abuse Anonymous (1)
- Piedmont Access to Health Services (1)

Comments from Survey Respondents

37: We contract with a psychiatrist as a consultant who sees students privately, admits to hospital, and meets with counseling staff on case management and other issues.

18: Relationship with consulting psychiatrist and a hospital inpatient social worker have resulted in clear (but unwritten) protocols.

07: We tried to develop an MOU with [a] hospital but received no response from them.

05: The University has no formal working agreement with its CSB [region redacted]. However, the University's [counseling staff] occasionally participates in prescreening protocols for temporary detention orders. The CSB typically calls the [counseling center's] on-call system to facilitate the collection of information about a student who is

the subject of a TDO. The University cannot confirm this happens in every instance. However, this contact is happening with some degree of regularity.

29: The intensive outpatient services offered by [name redacted] CSB are not just for college students. We have been able to refer students to it.

45: [Program name redacted] provides reintegration, evaluation and treatment to veterans and their families.

19: There are no psychiatric hospitals or units in our community; there are no partial hospitalization, intensive outpatient, eating disorder or substance abuse facilities in our community.

SECTION V. TAX DEPENDENCY STATUS

1. Does your institution ask students about their tax dependency status? *If no, Skip section.*

	N colleges which ask re tax status	% of colleges which ask re tax status	DK	DNA
4-year Publics (15)	11	73.3	0	0
4-year Privates (23)	10	43.5	1	0
Community Colleges (24)	14	58.3	0	0

2. When does your institution ask about tax dependency status? (a) on application for admission, (b) post admission/pre-enrollment, (c) post enrollment

	% apply for admit	% post admit/pre enroll	% post enroll	% more than once	DK	DNA
4-year Publics (11)	63.6	18.2	18.2	0	0	0
4-year Privates (9)	0	55.6	22.2	22.2	1	0
Community Colleges (14)	92.9	7.1	0	0	0	0

3. How often does your institution request this information? (a) once during a student's tenure, (b) annually

	% once	% annually	DK	DNA
4-year Publics (11)	54.5	45.5	0	0
4-year Privates (9)	11.1	88.9	1	0
Community Colleges (13)	92.3	7.7	0	1

4. Does your institution have a particular form used to determine tax dependency status?

	N colleges with form re tax status	% of colleges with form re tax status	DK	DNA
4-year Publics (10)	7	70	0	1
4-year Privates (10)	5	50	0	0
Community Colleges (14)	9	64.3	0	0

5. How many students (undergraduate or graduate) at your institution were tax dependent in 2008-09?

	Total N tax dependent	Mean % of students per college who are tax dependent	S.D.	Range	DK	DNA
4-year Publics (3)	18,784	73.9	19.9	56.7-95.7	7	1
4-year Privates (5)	4,708	61.1	25.4	30.4-92.1	5	0
Community Colleges (3)	12,775	43.4	19.5	21.2-57.0	10	1

Comments from Survey Respondents

01: The Counseling Center collects data on the dependency status of our clients so that this information is available to us in the event that the student's condition is such that we are required to implement [policy number redacted].

02: We ask for information about tax dependency on the application for in-state status, so only collect the yes/no response. We do not collect any 1040 or state filed tax forms unless the student appeals the decisions we do not enter tax dependency status in our system and do not know how many students are claimed as tax dependents.

05: The University collects tax dependency data each year beginning move-in weekend (mid-to-late August). The data is collected electronically. Students who fail to complete the electronic form are blocked from the University's electronic mail service. This ensures nearly 100% compliance.

15: [The institution] uses a "Consent to Disclose" form that addresses […] tax dependent status (attached)

03: Students may self-disclose on FERPA form. Of the [number redacted] that apply for aid, they fill this out but it is only 2/3 of students.

29: Question is asked on the disclosure form included with this survey. In addition, students are asked if they are selected for a Financial Aid audit.

14: Many of the comments would be in the Enrollment Management section of the University. Received comments from Registrars Office.

39: This info is gathered via the FAFSA; the University does not gather this information separately/specifically, other than via the FAFSA (which is not required of all students).

45: Students are asked about tax dependant status as a condition of domicile and financial aid.

SECTION VI. REQUESTS FOR MENTAL HEALTH INFORMATION

1. Does your institution administer a health survey to students, including questions about any mental health problems they may have?

	N colleges which administer health survey	% of colleges which administer health survey	DK	DNA
4-year Publics (15)	8	53.3	0	0
4-year Privates (23)	13	56.5	1	0
Community Colleges (24)	1	4.2	0	0

2. *If Yes to Question 1:* Does your institution administer this survey to all students, or only to selected students?

	N colleges which administer survey to all	% of colleges which administer survey to all	DK	DNA
4-year Publics (8)	2	25	0	0
4-year Privates (12)	10	83.3	0	1
Community Colleges (1)	1	100	0	0

3. *If Yes to Question 1:* When do you administer this survey? (a) pre-enrollment, (b) at enrollment, (c) after an enrolled student has presented a concern

	% pre-enroll	% at enroll	% after enroll	% more than once	% every few yrs	DK	DNA
4-year Publics (6)	16.7	16.7	0	16.7	50	0	2
4-year Privates (10)	20	60	0	10	10	0	3
Community Colleges (1)	0	0	100	0	0	0	0

4. What office analyzes these surveys?

4-Year Publics:

- The Southern Illinois University Core Institute (1)
- Counseling/Health centers (3)
- Health Promotions (1)
- External organizations administering the survey (1)
- National College Health Assessment (1)
- Office of Health Education (1)

4-Year Privates:

- Department of Institutional Research (1)
- Campus Health/Counseling Center (9)
- Student Affairs (2)
- University of Michigan, Center for Student-Studies (1)

Community Colleges:

- Office of Student Development (1)

5. Is mental health information from these surveys shared with the counseling center?

	N colleges sharing mh info	% of colleges sharing mh info	DK	DNA
4-year Publics (8)	8	100	0	0
4-year Privates (12)	11	91.7	0	1

6. Does your institution ever request a student's mental health records from his or her originating school prior to enrollment? *If No, Skip to the next Section.*

	N colleges requesting mh records	% of colleges requesting mh records	DK	DNA
4-year Publics (15)	4	26.7	0	0
4-year Privates (23)	2	8.7	0	1
Community Colleges (22)	2	9.1	0	2

7. Does your institution make such a request for all students, or only for selected students? (a) all students, (b) only selected students

	N colleges which request mh records for all	% of colleges which request mh records for all	DK	DNA
4-year Publics (2)	0	0	0	2
4-year Privates (2)	0	0	0	0
Community Colleges (2)	0	0	0	0

8. When do you request that this information? (a) pre-enrollment, (b) at enrollment, (c) after an enrolled student has presented a concern

	% pre-enroll	% at enroll	% after enroll	% more than once	DK	DNA
4-year Publics (2)	50	0	0	50	0	2
4-year Privates (2)	50	50	0	0	0	0
Community Colleges (2)	100	0	0	0	0	0

9. For how many students were mental health records requested in 2008-09?

	Total N student mh records requested	Mean N of student mh records requested per college	S.D.	Range	DK	DNA
4-year Publics (1)	20	20	-	-	1	2
4-year Privates (1)	13	13	-	-	1	0
Community Colleges (1)	64	64	-	-	1	0

10. What office analyzes those records?

4-Year Publics:

- Counseling (2)
- Admissions/ Threat Assessment Team (1)

4-Year Privates:

- Admissions (1)
- Student Development (1)
- Disability Services (2)

Community Colleges:

- Disability Services (1)

11. Does your institution conduct any outreach to students whose records may pose a concern?

	N colleges conducting outreach	% of colleges conducting outreach	DK	DNA
4-year Publics (2)	1	50	0	2
4-year Privates (2)	2	100	0	0
Community Colleges (1)	0	0	0	1

Comments from Survey Respondents

18: 6a mental health records are requested but rarely sent.

15: The Admissions process to [institution] is considered two-step and does include a medical eligibility component. Applicants are accepted conditionally and then required to submit a health history and record of a physician's examination. If the applicant reports a mental health history the information is referred to the Counseling Center where a review of the case is conducted. Typically this involves securing releases of information from the applicant to gather treatment records and often results in consultation with the treatment providers. On rare occasions consultation with a high school guidance counselor has been appropriate. Depending upon the nature of the concern the applicant may be required to complete a medical waiver review, and if admitted generally enrolls with a requirement to make contact with the Counseling Center.

03: When a student indicates a history of arrests/hospitalizations or other troubling matters, they may be asked for more information to be revealed by different departments.

14: Going back and forth as to if we want to request such records. Not sure who would do the analyzing of data if we did.

24: A survey is not conducted but health records including immunizations are requested; students share medications they are currently on; mental health information may present itself.

26: We administer a survey called “Healthy Minds” to a random sample of students. This survey instrument is available from the University of Michigan Survey Sciences Department

45: The mental health records are collected primarily as documentation of psychological disability.

We may request information from practitioners when student has behavioral issue at College, but do not request high school or other college information at time of admission.

[Identifying statement redacted]. The [institution] will have a webpage that allows students to complete an anonymous mental health screening assessment to determine, based upon their answers, if they should meet with a clinical counselor or psychologist to assist them in dealing with their challenges.

31: Survey administered mid-Spring.

SECTION VII. CONCERNS ABOUT HARM TO SELF OR OTHERS

1. Did you have an enrolled student(s) commit suicide in 2008-09?

	N colleges w a student suicide	% of colleges w a student suicide	DK	DNA
4-year Publics (15)	5	33.3	0	0
4-year Privates (24)	1	4.2	0	0
Community Colleges (24)	5	20.8	0	0

2. *If Yes to Question 1:* How many enrolled students committed suicide in 2008-09?

	Total N student suicides	Mean N of student suicides per college	S.D.	Range	DK	DNA
4-year Publics (5)	8	1.6	.55	1-2	0	0
4-year Privates (1)	1	1.0	-	-	0	0
Community Colleges (2)	2	1.0	0	1-1	2	1

3. Did you have any student(s) who were on medical leave commit suicide in 2008-2009?

	N colleges w student on medical leave suicide	% of colleges w student on medical leave suicide	DK	DNA
4-year Publics (15)	1	6.7	0	0
4-year Privates (24)	0	0	0	0
Community Colleges (24)	0	0	0	0

4. *If Yes to Question 3:* How many students who were on medical leave committed suicide in 2008-09?

	Total N students on med leave suicide	Mean N of students on med leave suicide per college	S.D.	Range	DK	DNA
4-year Publics (1)	1	1	-	-	0	0
4-year Privates (0)	-	-	-	-	-	-
Community Colleges (0)	-	-	-	-	-	-

5. Do you have policies or guidelines for identifying and addressing the needs of students exhibiting suicidal ideation or behavior?

	N colleges w suicide policies	% of colleges w suicide policies	DK	DNA
4-year Publics (15)	15	100	0	0
4-year Privates (23)	19	82.6	0	1
Community Colleges (21)	8	38.1	0	3

6. Does your institution have mandated follow-up procedures following a student's suicidal ideation or attempt?

	N colleges w mandated follow-up	% of colleges w mandated follow-up	DK	DNA
4-year Publics (14)	8	57.1	0	1
4-year Privates (24)	10	79.2	0	0
Community Colleges (22)	2	9.1	0	2

7. How many students seen in the counseling center in academic year 2008-2009 reported suicidal ideation?

	Total N students reporting suicidal ideation	Mean N students reporting suicidal ideation per college	S.D.	Range	Percentage of those seen at the CC reporting suicidal ideation	Percentage of total student population reporting suicidal ideation	DK	DNA
4-year Publics (12)	1035	86.3	74.5	10-261	15.4	1.2	3	0
4-year Privates (12)	181	15.1	13.6	0-44	11.6	.74	9	3

8. How many students attempted suicide in 2008-09 (do not count parasuicidal behavior such as cutting)?

	N colleges w a student attempting suicide	% colleges w a student attempting suicide	Total N student attempted suicides	Mean N student attempted suicides per college	S.D.	Range	DK	DNA
4-year Publics (11)	8	72.7	67	6.1	12.4	0-43	4	0
4-year Privates (16)	6	37.5	17	1.1	1.8	0-5	6	2
Community Colleges (3)	1	33.3	2	.67	1.2	0-2	16	5

9. Of those students who attempted suicide in 2008-2009

a. How many voluntarily withdrew from your institution and did not return in the following year?

	Total N vol withdrew and not return	Mean N vol withdrew and not return next yr, per college	S.D.	Range	DK	DNA
4-year Publics (6)	8	1.3	1.6	0-4	7	2
4-year Privates (3)	3	1.0	0	1-1	7	14
Community Colleges (1)	2	2.0	-	-	11	12

b. How many involuntarily withdrew from your institution and did not return in the following year?

	Total N invol withdrew and not return	Mean N invol withdrew and not return next yr, per college	S.D.	Range	DK	DNA
4-year Publics (7)	3	.43	.51	0-1	6	2
4-year Privates (3)	0	0	0	0-0	7	14
Community Colleges (1)	0	0	-	-	11	12

c. How many withdrew from your institution—voluntarily or involuntarily—and eventually returned for a subsequent semester?

	Total N withdrew and eventually return	Mean N withdrew and eventually return per college	S.D.	Range	DK	DNA
4-year Publics (4)	1	.25	.5	0-1	8	3
4-year Privates (4)	5	1.3	.96	0-2	7	13
Community Colleges (1)	0	0	-	-	11	12

d. How many did not withdraw from your institution, but were required to participate in outpatient treatment as a condition of remaining a student in good standing?

	Total N not withdraw but tx required	Mean N not withdraw but tx required per college	S.D.	Range	DK	DNA
4-year Publics (7)	28	4.0	7.2	0-20	6	2
4-year Privates (3)	9	3.0	4.4	0-8	6	15
Community Colleges (1)	0	0	-	-	9	14

10. Did you have a student arrested for killing anyone in 2008-09?

	N colleges w a student arrested for killing	% of colleges w a student arrested for killing	DK	DNA
4-year Publics (15)	1	6.7	0	0
4-year Privates (24)	1	4.2	0	0
Community Colleges (22)	0	0	0	2

11. *If Yes to question 10*: How many students were arrested for killing someone in 2008-09?

	Total N students arrested for killing	Mean N student arrested for killing per college	S.D.	Range	DK	DNA
4-year Publics (1)	1	1	-	-	0	0
4-year Privates (1)	1	1	-	-	0	0
Community Colleges (0)	-	-	-	-	-	-

12. *If Yes to question 10*: How many of the victims were other students at your institution?

	Total N victims other students	Mean N victims other students per college	S.D.	Range	DK	DNA
4-year Publics (1)	1	1	-	-	0	0
4-year Privates (1)	0	0	-	-	0	0
Community Colleges (0)	-	-	-	-	-	-

13. How many students seen in the Counseling Center in 2008-2009 reported ideation that included violence towards others?

	Total N students reporting violent ideation	Mean N students reporting violent ideation per college	S.D.	Range	Percentage of those seen at the CC reporting violent ideation	Percentage of total student population reporting violent ideation	DK	DNA
4-year Publics (11)	334	30.4	56.6	0-183	3.5	.31	4	0
4-year Privates (13)	17	1.3	3.2	0-11	.66	.06	8	3

14. How many students seen in the counseling center in academic year 2008-2009 had been referred due to aggressive or violent behavior toward others (including stalking)?

	Total N students referred due to violence	Mean N students referred due to violence per college	S.D.	Range	DK	DNA
4-year Publics (6)	53	8.8	10.2	1-27	9	0
4-year Privates (16)	51	3.2	4.5	0-16	6	2

a. Of these, how many were required to participate in outpatient treatment as a condition of remaining a student in good standing?

	Total N students required to be in tx	Mean N students required to be in tx per college	S.D.	Range	DK	DNA
4-year Publics (6)	27	4.5	5.5	0-15	5	4
4-year Privates (10)	3	.3	.48	0-1	7	7

b. Of these, how many were referred to the Counseling Center by the campus Threat Assessment Team?

	Total N students referred to CC by TAT	Mean N students referred to TAT per college	S.D.	Range	DK	DNA
4-year Publics (7)	16	2.3	5.6	0-15	3	5
4-year Privates (10)	7	.7	1.3	0-4	7	7

Comments from Survey Respondents

18: Student in Q14 voluntarily withdrew in Fall 2008.

22: Worked directly with the counselor on campus.

03: We know how many students were "shared" by counseling and threat assessment, but not for violence or stalking separately.

32: Question #5 – in process of developing and formalizing procedures for adoption in 2010-2011 academic year.

14: [Judicial Affairs office has] referred several students for aggressive/violent behaviors mostly in terms of fighting for counseling considerations. Students who have threatened or hurt other students were suspended by Judicial Affairs. Also those who have stalked students. They have not come through the [counseling center]. Have not computed numbers in this category as yet.

39: The University does not mandate counseling.

24: We've had several staff changes since 2008/09 and are unable to confirm/verify some of this information.

45: General process for students that express suicidal ideation or attempt – Office of Student Affairs staff meet with student to assess situation and (where needed) have a threat assessment conducted by a psychologist. Students that have been referred to psychologist or social worker, who have separated from College must meet with Office of Student Affairs staff (VP of Student Affairs or Dean of Students)

SECTION VIII. COMMITMENT PROCEEDINGS

1. How many students were subject to Emergency Custody Orders (ECOs) initiated by your institution in 2008-09?

	Total N college initiated student ECOs	Mean N college initiated student ECOs, per college	Mean ECO per 1000 students	S.D.	Range	DK	DNA
4-year Publics (10)	16	1.6	.36	.80	0-2.6	5	0
4-year Privates (21)	11	.52	.15	.54	0-2.5	2	1
Community Colleges (13)	0	0	0	0	-	8	3

2. How many students were hospitalized under Temporary Detention Orders (TDOs) initiated by your institution in 2008-2009?

	Total N college-initiated student TDOs	Mean N college-initiated student TDOs per college	Mean TDO per 1000 students	S.D.	Range	DK	DNA
4-year Publics (10)	42	4.2	.41	.50	0-1.4	5	0
4-year Privates (21)	3	.14	.02	.08	0-.37	2	1
Community Colleges (14)	1	.07	.006	.02	0-.08	7	3

3. *If the answer to Question 2 was greater than zero:* How many of these students continued hospitalization (voluntarily or involuntarily) after the Temporary Detention Order expired?

	Total N students continued hosp after TDO	Mean N students continued hosp after TDO, per college	S.D.	Range	DK	DNA
4-year Publics (7)	29	4.1	6.3	0-18	1	7
4-year Privates (3)	1	.33	.58	0-1	4	17
Community Colleges (1)	0	0	-	-	3	20

4. To your knowledge, how many of your students were hospitalized in psychiatric hospitals, whether or not the judicial process was involved, in 2008-2009?

	Total N students in psych hosp	Mean N students in psych hosp, per college	S.D.	Range	DK	DNA
4-year Publics (11)	107	9.7	11.3	0-39	4	0
4-year Privates (16)	48	3.0	3.4	0-12	6	2
Community Colleges (6)	4	.67	.82	0-2	15	3

5. To your knowledge, of those students hospitalized, what was the average length of stay (in days)?

	Mean days of hosp stay	S.D.	Range	DK	DNA
4-year Publics (9)	5.2	3.5	2.5-14	5	1
4-year Privates (11)	4.6	3.8	0-15	7	6
Community Colleges (4)	4.0	6.7	0-14	10	10

6. Can you determine if the number of Emergency Custody Orders has increased or decreased over the past two academic years? (a) increased, (b) decreased, (c) remained about the same

	% increased	% decreased	% remained same	DK	DNA
4-year Publics (9)	55.6	0	44.4	4	2
4-year Privates (17)	5.9	5.9	88.2	6	1
Community Colleges (5)	0	20	80	14	5

7. Can you determine if the number of Temporary Detention Orders has increased or decreased over the past two academic years? (a) increased, (b) decreased, (c) remained about the same.

	% increased	% decreased	% remained same	DK	DNA
4-year Publics (9)	44.4	0	55.6	4	2
4-year Privates (15)	6.7	13.3	80.0	6	3
Community Colleges (5)	20	0	80.0	14	5

8. Are you notified of a commitment proceeding involving a student?

	N colleges notified of a commitment proceeding	% of colleges notified of a commitment proceeding	DK	DNA
4-year Publics (15)	5	33.3	0	0
4-year Privates (20)	5	25.0	1	3
Community Colleges (20)	3	15.0	0	4

9. *If Yes to Question 8:* How many times were you notified in 2008-09?

	Total N times colleges notified	Mean N times notified, per college	S.D.	Range	DK	DNA
4-year Publics (3)	32	10.7	13.4	1-26	2	0
4-year Privates (5)	2	.4	.9	0-2	0	0
Community Colleges (3)	2	.7	1.2	0-2	0	0

10. *If Yes to Question 8:* In how many of these cases was your institution asked to provide information in connection with the proceeding?

	Total N cases colleges asked for info	Mean N cases colleges asked for info, per college	S.D.	Range	DK	DNA
4-year Publics (3)	29	9.7	14.2	0-26	1	1
4-year Privates (2)	2	1.5	.71	1-2	0	3
Community Colleges (2)	0	0	0	0-0	1	0

11. *If Yes to Question 8:* In how many of these cases did your institution send a representative to commitment hearings?

	Total N cases colleges sent rep to hearing	Mean N cases colleges sent rep to hearing, per college	S.D.	Range	DK	DNA
4-year Publics (4)	28	7.0	12.7	0-26	1	0
4-year Privates (2)	1	.5	.71	0-1	0	3
Community Colleges (3)	0	0	0	0-0	0	0

12. In how many cases in which students were committed and returned to campus after hospitalization were you involved in their post-commitment mental health care in 2008-09?

	Total N cases involved in post commitment mh care	Mean N cases involved in post commitment mh care, per college	S.D.	Range	DK	DNA
4-year Publics (6)	21	3.5	2.2	1-6	5	4
4-year Privates (12)	33	2.8	3.3	0-10	1	11

13. Do you provide mental health services to a student when these services are required by a court as a part of a mandatory outpatient treatment order?

	N of colleges tx under MOT order	% of colleges tx under MOT order	DK	DNA
4-year Publics (13)	5	38.5	0	2
4-year Privates (20)	4	20	0	4

14. *If Yes to Question 13:* In how many cases did you provide mandatory outpatient services in 2008-09?

	Total N cases provided MOT	Mean N cases provided MOT, per college	S.D.	Range	DK	DNA
4-year Publics (5)	11	2.2	4.9	0-11	0	0
4-year Privates (4)	0	0	0	0-0	0	0

Comments from Survey Respondents

10: We will not always know when a student withdraws because of emotional/psychiatric issues – therefore some of these questions are not answerable. We have a large commuter population and it's completely possible for an individual to been seen off-campus, withdraw, and then return without our knowledge.

05: In theory, mandated outpatient treatment can be provided. [The counseling center] can confirm that there have been no cases in the last nine years.

03: ECO increased this year because psych hospitals are requiring medical clearance so an ECO is required to keep them in custody.

09: Mandated treatment is provided if a student chooses to use our services and we are capable of providing the needed services. It has primarily been the result of alcohol-related incidents.

38: Our office has never been asked to provide court-ordered mandated treatment.

35: I have never been contacted about a commitment proceeding. I don't know if this is due to not having any students in commitment proceedings, or whether they had a proceeding but we were not notified about it.

33: No mandated follow-up for suicidal ideation; mandated follow-up for suicidal attempt.

14: This section was somewhat confusing in that the University Counseling Center, even though always notified, isn't necessarily the ones to initiate ECO's or TDO's. Our campus police have initiated both. Most of the students we've had have gone voluntarily to the nearest hospital, at which point the CSB is called in. If we know a student is being seen, we make attempts to obtain information from the admitting service delivery.

45: The questions are not part of our purview. #13 provided through local CSB.

SECTION IX. PARENTAL NOTIFICATION

1. Does your institution typically seek a waiver or release from a student to allow contact with the student's parents when concern is raised about the student's mental health?

	N colleges seeking waiver	% of colleges seeking waiver	DK	DNA
4-year Publics (15)	10	66.7	0	0
4-year Privates (23)	14	60.9	0	1
Community Colleges (23)	13	56.5	0	1

2. Does your institution have a parental notification policy?

	N colleges w a parental notification policy	% of colleges w a parental notification policy	DK	DNA
4-year Publics (15)	12	80	0	0
4-year Privates (23)	14	60.9	0	1
Community Colleges (22)	3	13.6	0	2

3. How many times in 2008-09 did someone on behalf of your institution notify the parents of a student because you were concerned about the student's becoming harmful to him or herself or to others?

	Total N parents notified of harm	Mean N parents notified of harm, per college	S.D.	Range	DK	DNA
4-year Publics (7)	68	9.7	6.7	3-18	7	1
4-year Privates (15)	70	4.7	4.8	0-16	7	2
Community Colleges (11)	6	.55	.82	0-2	8	5

4. How many times in 2008-09 did someone on behalf of your institution notify the parents of a student because you were concerned about the student's mental health more broadly, independent of a concern about the student's becoming harmful to him or herself or to others?

	Total N parents notified of mh concern	Mean N parents notified of mh concern, per college	S.D.	Range	DK	DNA
4-year Publics (3)	4	1.3	2.3	0-4	11	1
4-year Privates (11)	80	7.3	13.6	0-45	10	3
Community Colleges (11)	1	.09	.3	0-1	8	5

Comments from Survey Respondents

29: Parents are notified as a regular practice when concerns arise regarding behavior, alcohol use.

07: We don't track #4. We always try to activate support systems when students are struggling.

38: We do not call parents unless situation is an emergency – we are drafting a more detailed policy which is not yet available.

05: The University has two published parental notification policies, one relating to Alcohol and Other Drugs, and the other to Mental Health concerns. The statistic cited above does not reflect notifications relating to Alcohol and Other Drugs. [website redacted]

14: The Counseling Center has notified parents and has worked jointly with parents on behalf of the student. [Identifying statement redacted…] our Vice President of Student Affairs has notified parents of students who are having both academic and mental health difficulties. Cannot put a # on the amount of students.

45: For #2; Will notify if student is threatening to harm self or others as allowed under FERPA.

Under FERPA, we reserve the right to notify the parent of a mental health situation when the student is at risk. However it is not in its own separate and distinct policy.

31: The Counseling Center and Health Center would seek a release of information.

SECTION X. MEDICAL WITHDRAWAL FOR MENTAL HEALTH REASONS

1. Does your institution allow for Voluntary Medical Withdrawal (or Voluntary Administrative Withdrawal, or similar procedures) for mental health reasons?

	N colleges allowing for vol withdrawal for mh reasons	% of colleges allowing for vol withdrawal for mh reasons	DK	DNA
4-year Publics (15)	14	93.3	0	0
4-year Privates (24)	24	100	0	0
Community Colleges (24)	13	54.2	0	0

2. *If Yes to Question 1*: How many students received a Voluntary Medical Withdrawal for mental health reasons in 2008-09?

	Total N students vol withdrawal for mh reasons	Mean N students vol withdrawal for mh reasons, per college	S.D.	Range	DK	DNA
4-year Publics (5)	278	55.6	56.1	10-146	7	2
4-year Privates (11)	60	5.5	5.6	0-19	9	4
Community Colleges (4)	15	3.8	4.8	0-10	9	0

3. *If Yes to Question 1*: What office makes the ultimate determination of whether a student who has received a voluntary medical withdrawal can be re-admitted?

4-Year Publics:

- Dean of Students (4)
- VP of Student Affairs (1)
- Academic Dean (1)
- Behavioral Intervention Team (1)
- Counseling/Health Center (2)
- Admissions (1)

4-Year Privates:

- Dean of Arts and Sciences (1)
- Academics/Academic Affairs (5)

- Dean of Students (6)
- Administration-Provost (2)
- Student Life (2)
- Student Affairs (5)
- Admissions (1)
- Counseling and Health (1)
- Dean of Student Development (1)

Community Colleges:

- Admissions (1)
- Academic Affairs (1)
- VP of Instruction/Student Services (2)

4. *If Yes to Question 1*: Does your institution require a medical/psychological examination? (a) Yes, upon departure, (b) Yes, upon re-entry, (c) Yes, upon both departure and re-entry, (d) No.

	% yes, departure	% yes, re-entry	% yes, both	% no	DK	DNA
4-year Publics (14)	7.1	35.7	35.7	21.4	0	0
4-year Privates (24)	0	62.5	20.8	16.7	0	0
Community Colleges (11)	0	18.2	9.1	72.7	2	0

5. *If Yes to Question 4:* Who performs the required medical/psychological examination? (a) Counseling Center, (b) Community Services Board, (c) Private Provider, (d) Other

	% CC	% CSB	% private	% other	% more than 1	DK	DNA
4-year Publics (11)	9.1	0	9.1	18.2	63.6	0	0
4-year Privates (19)	0	0	31.6	21.1	47.4	0	1
Community Colleges (4)	0	25	0	0	75	0	0

Description of "other":

4-Year Publics:

- Treating Provider (1)

4-Year Privates:

- Whomever the student is seeing for counseling (1)

- Medical physician (1)
- Licensed medical provider (4)
- Psychiatric Hospital (2)

6. *If Yes to Question 4:* Are the results of this examination conveyed to any campus or academic administrators (e.g., the Dean of Students)?

	N colleges conveying results to admin	% of colleges conveying results to admin	DK	DNA
4-year Publics (9)	7	77.8	0	2
4-year Privates (18)	16	88.9	0	2
Community Colleges (4)	4	100	0	0

7. Does your institution allow for Involuntary Medical Withdrawal (or Involuntary Administrative Withdrawal, or similar procedures) for mental health reasons?

	N of colleges allowing for invol withdrawal for mh reasons	% of colleges allowing for invol withdrawal for mh reasons	DK	DNA
4-year Publics (15)	7	46.7	0	0
4-year Privates (22)	20	90.9	1	1
Community Colleges (22)	6	27.3	0	2

8. *If Yes to Question 7*: How many students received an Involuntary Medical Withdrawal for mental health reasons in 2008-09?

	Total N students invol withdrawal for mh reasons	Mean N students invol withdrawal for mh reasons, per college	S.D.	Range	DK	DNA
4-year Publics (4)	4	1.0	2.0	0-4	2	1
4-year Privates (15)	10	.67	1.2	0-4	3	2
Community Colleges (3)	2	.67	.58	0-1	3	0

9. *If Yes to Question 7*: What office makes the ultimate determination of whether a student who has received an involuntary medical withdrawal can be re-admitted?

4-Year Publics:

- Student Affairs (2)
- Dean of Students (4)
- Behavioral Intervention Team (1)
- Counseling/Health center (1)

4-Year Privates:

- Academic Dean (3)
- Dean of Students (9)
- Student Affairs (4)
- Student Life (2)
- Conduct Office (1)
- Dean of Student Development (1)

Community Colleges:

- Dean of Student Services (3)
- Admissions (1)
- Student Success (1)
- Student Affairs (1)

10. *If Yes to Question 7*: Does your institution require a medical/psychological examination? (a) Yes, upon departure, (b) Yes, upon re-entry, (c) Yes, upon both departure and re-entry, (d) No

	% yes, departure	% yes, re-entry	% yes, both	% no	DK	DNA
4-year Publics (7)	14.3	42.9	42.9	0	0	0
4-year Privates (19)	0	57.9	26.3	15.8	0	1
Community Colleges (6)	0	33.3	16.7	50	0	0

11. *If Yes to Question 10:* Who performs the required medical/psychological examination? (a) Counseling Center, (b) Community Services Board, (c) Private Provider , (d) Other

	% CC	% CSB	%private	% other	% more than 1	DK	DNA
4-year Publics (6)	0	0	16.7	16.7	66.7	0	1
4-year Privates (17)	0	0	35.3	11.8	52.9	0	0
Community Colleges (3)	0	33.3	0	0	66.7	0	0

Description of "other":

4-Year Privates:

- Medical Physician (1)
- Licensed medical provider (2)

12. *If Yes to Question 10:* Are the results of this examination conveyed to any campus or academic administrators (e.g., the Dean of Students)?

	N colleges conveying results to admin	% of colleges conveying results to admin	DK	DNA
4-year Publics (6)	6	100	0	1
4-year Privates (16)	15	93.8	0	1
Community Colleges (3)	3	100	0	0

13. If you have procedures for voluntary or involuntary withdrawal for mental health reasons, do you ever require that the student participate in any recommended inpatient or outpatient mental health treatment before being readmitted?

	N colleges requiring tx before readmit	% of colleges requiring tx before readmit	DK	DNA
4-year Publics (12)	11	91.7	0	3
4-year Privates (23)	20	87.0	0	1
Community Colleges (17)	10	58.8	0	7

14. *If Yes to Question 13:* In how many cases was mental health treatment required before a student was readmitted in 2008-2009?

	Total N cases tx required before readmit	Mean N cases tx required before readmit, per college	S.D.	Range	DK	DNA
4-year Publics (7)	167	23.9	53.9	0-146	4	0
4-year Privates (12)	59	4.9	7.7	0-23	5	3
Community Colleges (6)	2	.33	.52	0-1	3	1

15. If you have procedures for voluntary or involuntary withdrawal for mental health reasons, do you maintain contact with students who remain in the area while they are withdrawn from your institution?

	N colleges maintaining contact w withdrawn students	% of colleges maintaining contact w withdrawn students	DK	DNA
4-year Publics (14)	4	28.6	0	1
4-year Privates (23)	9	39.1	0	1
Community Colleges (14)	2	14.3	0	10

16. Do you ever require that a student who has withdrawn for mental health reasons agree to continue in outpatient mental health treatment as a condition of readmission?

	N colleges requiring continued tx for readmit	% of colleges requiring continued tx for readmit	DK	DNA
4-year Publics (14)	12	85.7	0	1
4-year Privates (23)	18	78.3	0	1
Community Colleges (19)	8	42.1	0	5

17. *If Yes to Question 16:* In how many cases was a student required to continue in mental health treatment as a condition of readmission in 2008-2009?

	Total N students required tx for readmit	Mean N students required tx for readmit, per college	S.D.	Range	DK	DNA
4-year Publics (5)	20	4	2.9	0-8	7	0
4-year Privates (13)	38	2.9	5.9	0-21	3	2
Community Colleges (6)	0	0	0	-	2	0

18. Does your institution have procedures whereby a student may be excluded from residing in campus housing for mental health reasons, even if the student has not been subject to voluntary or involuntary medical withdrawal?

	N colleges excluding from campus housing for mh reasons	% of colleges excluding from campus housing for mh reasons	DK	DNA
4-year Publics (14)	5	35.7	0	1
4-year Privates (23)	12	52.2	0	1
Community Colleges (12)	0	0	0	12

Comments from Survey Respondents

01: In answer to #18, a student may be removed from housing for "behavioral" reasons, not "mental health reasons".

15: All [students] must reside [on-campus] and must be able to fully participate in all aspects of [student life].

03: For students who withdraw for mental health reasons, we require mental health treatment for all students receiving academic relief.

14: The student can voluntarily withdraw for personal reasons at any time. [Center name redacted] facilitates that process. Regarding [Question 4 and following]: Procedures have been developed but has not been consistently utilized because it still is in attorney's office for further review. However, for question 4, the response would be "c" and to question 5, the response would be "all of the above." To question 6, the response would be to the Vice President of Student Affairs.

[Re exclusion from housing,] usually these cases go through judicial affairs who makes a determination whether a student remains or not in housing. An appeals process is in place for the student to address the charges.

[These are] issues we have considered but are still on the drawing board as to how to proceed.

45: #2. Voluntary withdrawals are part of the College's withdrawal policy. In some instances, students may request a late withdrawal for as far as a year past the incident. The College does not collect this type of data at the time. #7. Involuntary withdrawal situations are generally behavioral in nature and we would make the decision based on conduct reasons, not mental health alone. #16. We only recommend that a student sees a professional.

SECTION XI. MENTAL HEALTH EVALUATION AND TREATMENT IN CONNECTION WITH DISCIPLINARY PROCEEDINGS

1. If a student is charged with engaging in a disciplinary violation that could lead to suspension or expulsion, and there is reason to believe that the disciplinary violation is related to a mental health condition, is a formal mental health evaluation ever sought to aid in reaching a decision in the case? (a) Yes, but only if requested by the student, (b) Yes, if mandated by the institution or requested by the student, (c) No

	% yes, if student requests	% yes, if mandated or student requests	% no	DK	DNA
4-year Publics (14)	0	78.6	21.4	0	1
4-year Privates (23)	4.3	65.2	30.4	0	1
Community Colleges (23)	8.7	30.4	60.9	0	1

2. *If Yes to Question 1:* Who would usually conduct such an evaluation? (a) Counseling Center, (b) Community Services Board, (c) Private provider, (d) Other

	% CC	% CSB	% private	% other	% more than 1	DK	DNA
4-year Publics (12)	16.7	0	41.7	8.3	33.3	0	0
4-year Privates (15)	20	0	20	13.3	46.7	0	2
Community Colleges (9)	0	33.3	0	11.1	55.6	0	1

Description of "other":

4-Year Privates:

- Student's choice of licensed medical provider (2)

3. If a student has engaged in a disciplinary violation that could lead to suspension or expulsion, and the disciplinary violation is determined to be related to a mental health condition, does the institution ever require the student to participate in mental health treatment as part of a disciplinary sanction? (a) Yes, but only if this disposition is sought by the student, (b) Yes, if either mandated by the institution or sought by the student, (c) No

	% yes, only if student sought	% yes, if either mandated or student sought	% no	DK	DNA
4-year Publics (14)	7.1	78.6	14.3	0	1
4-year Privates (23)	0	87.0	13.0	0	1
Community Colleges (23)	8.7	60.9	30.4	0	1

4. *If Yes to Question 3:* Who would usually provide such treatment? (a) Counseling Center, (b) Community Services Board, (c) Private provider, (d) Other

	% CC	% CSB	% private	% other	% more than 1	DK	DNA
4-year Publics (12)	33.3	0	33.3	8.3	25.0	0	1
4-year Privates (19)	10.5	0	31.6	10.5	47.4	0	2
Community Colleges (15)	0	33.3	13.3	13.3	40.0	1	1

Description of "other":

4-Year Privates:

- Licensed medical provider (1)
- Substance use educator (1)

Community Colleges:

- Provider of student's choice (1)

5. How many students subject to disciplinary proceedings were referred to the counseling center for an evaluation in 2008-2009?

	Total N students subject to discipline referred to CC	Mean N students subject to discipline referred to CC, per college	S.D.	Range	DK	DNA
4-year Publics (5)	99	19.8	19.6	5-53	9	1
4-year Privates (15)	310	20.7	45.7	0-179	5	4

6. How many students receiving treatment services at the counseling center in 2008-2009 were required to do so as part of a disciplinary sanction?

	Total N students at CC required by disciplinary sanction	Mean N students at CC required by disciplinary sanction, per college	S.D.	Range	DK	DNA
4-year Publics (7)	168	24	49.3	0-135	6	2
4-year Privates (11)	251	22.8	52.9	0-179	8	5

Comments from Survey Respondents

29: 42 referrals involves mainly alcohol programming/counseling services due to campus alcohol violations.

01: The numbers provided above reflect not mandated treatment but two-session mandated assessment appointments conducted by the Counseling Center.

13: When students are sanctioned through disciplinary proceedings to attend counseling at the [counseling center] they are required to attend an initial evaluation at the Center and to follow the recommendations that come out of this evaluation. The recommendations may include continuation in counseling and/or consultation for psychotropic medication to treat their problems.

35: The counseling center does not accept referrals for students sanctioned to counseling; we see counseling as an inherently voluntary, collaborative process that is at cross-purposes with mandated sanctions.

In our view, mandated sanctions need to focus on behavioral change, rather than mandate HOW that behavioral change is to occur. Counseling is only one of many options available to students to work on changing their behavior.

09: Mental health treatment: if the judicial board requires it, they let the student choose the practitioner who will provide the treatment.

45: Treatment could be through CSB or private provider. Our counseling center does not provide mental health treatment.

We see these students in the Counseling Center, but not part of a disciplinary protocol.

SECTION XII. THREAT ASSESSMENT TEAM

1. Does your institution have a Threat Assessment Team (even if its formal title differs from this)? *If no, skip the rest of this section*

	Total N colleges with TAT	% of colleges with TAT	DK	DNA
4-year Publics (15)	15	100	0	0
4-year Privates (22)	17	77.3	0	2
Community Colleges (24)	18	75.0	0	0

2. Are the meetings of the Threat Assessment Team documented in writing?

	Total N colleges documenting meetings	% of colleges documenting meetings	DK	DNA
4-year Publics (15)	14	93.3	0	0
4-year Privates (17)	8	47.1	0	0
Community Colleges (17)	14	82.4	0	1

3. *If yes to Question 2:* Where is the documentation stored? (a) Counseling Center, (b) Campus Police Department, (c) the office of a campus administrator (e.g., Dean of Students), (d) Other

	% CC	% campus police	% administrator	% other	% more than 1	DK	DNA
4-year Publics (14)	0	50	21.4	14.3	14.3	0	0
4-year Privates (8)	0	12.5	62.5	12.5	12.5	0	0
Community Colleges (12)	0	50	33.3	16.7	0	0	2

Description of "other":

4-Year Publics:

- General Counsel (1)
- Secure server for University administrators (1)

4-Year Privates:

- Campus security (1)

Community Colleges:

- Electronic shared drive (1)

4. How many active cases did the threat assessment team at your institution have during 2008-09?

	Total N active TAT cases	Mean N active TAT cases, per college	S.D.	Range	DK	DNA
4-year Publics (10)	204	20.4	29.9	0-95	5	0
4-year Privates (9)	83	9.2	19.3	0-60	7	1
Community Colleges (11)	60	5.5	6.6	0-15	4	3

5. *If the answer to Question 4 is greater than zero:* In how many of these cases were mental health issues a significant factor?

	Total N cases mh a sig factor	Mean N cases mh a sig factor, per college	S.D.	Range	DK	DNA
4-year Publics (8)	122	15.3	22.7	1-65	3	0
4-year Privates (6)	40	6.7	7.1	1-20	5	0
Community Colleges (6)	20	3.3	2.8	0-8	1	0

6. *If the answer to Question 4 is greater than zero:* In how many of these active cases was the individual being evaluated by the threat assessment team not a student?

	Total N cases not students	Mean N cases not students, per college	S.D.	Range	DK	DNA
4-year Publics (8)	23	2.9	3.5	0-11	3	0
4-year Privates (5)	2	.4	.55	0-1	1	5
Community Colleges (7)	1	.14	.38	0-1	0	0

7. What department serves as team leader/chair of your institution's team?

4-Year Publics:

- Chief of Police and HR Director co-chair (1)
- Police and Dean of Students Co-Chair (1)
- HR and Dean of Students (2)
- Dean of Students (3)
- Police and Counseling director (2)
- Office of Emergency Preparedness (1)
- Chief of Police (2)
- Student Life (1)
- Office of Administration (1)
- Deputy Superintendent for Finance and Administration (1)

4-Year Privates:

- Office of Student Success (1)
- Dean of Students (8)
- Student Affairs (2)
- VP for Student Life (1)
- Police Department (1)
- VP for Administration (1)
- Campus Security Director (1)
- VP/Dean for Student Development (2)

Community Colleges:

- Student Services (10)
- Planning and Advancement (1)
- Instruction and Finance (2)
- Counseling (1)
- Student Success (1)
- Chief of Police (1)

8. What other offices are represented on the threat assessment team?

4-Year Publics:

- Academic Affairs (1)
- Student Affairs (6)
- Student Conduct and Academic Integrity (1)
- Counseling (13)
- Diversity and Equity (1)
- Legal Counsel (6)
- Police (7)
- Housing/ Residence Life (7)
- Provost (2)
- Judicial Affairs (2)
- Disabilities (3)
- Health (5)
- Risk Management (1)
- Alcohol/drugs and sexual assault program coordinator (1)
- Faculty (3)
- HR (6)
- Technology (1)
- Public Safety (2)
- Dean of Students (4)
- Registrar (1)

4-Year Privates:

- Counseling (14)
- Residence Life (9)
- Athletics (4)
- Police/Security (10)
- Student Affairs (4)
- HR (4)
- Faculty Rep/Dean of Faculty (3)
- President's Office (1)
- Business Office (1)
- Chaplain (3)
- Academic Services (3)

Community Colleges:

- Counseling (6)
- Instruction (3)
- HR (7)
- Security (7)

- Disability (1)
- Student Activities (1)
- CSB rep (1)
- Faculty (2)
- Development (2)
- Student Services (4)
- Finance (2)
- Enrollment (1)
- Academic deans (3)

9. Does your Threat Assessment Team have a written mission statement and/or written procedures?

	Total N colleges w written statement	% of colleges w written statement	DK	DNA
4-year Publics (12)	7	58.3	0	3
4-year Privates (17)	3	17.6	0	0
Community Colleges (15)	11	73.3	0	3

Comments from Survey Respondents

36: Written procedures are still being drafted.

03: Campus threat assessment and management teams is our guide.

14: Statement, policy and procedures are being reviewed by university attorney.

45: [Identifying statement redacted]. The [institution's] program includes campus and college-wide assessment of concerning and/or threatening behavior plus crisis response and suicide prevention education

The Threat Assessment Team is currently in the formulation stage, and will be effective 2009-2010 academic year. The Student Development department will serve as team leader/chair. The offices represented on the team are: VP of Academic Affairs and Student Success Services, VP of Financial and Administrative Services, Human Resources, Public Relations, the local police, and the Community Services Board. Once formed, minutes will be formally recorded at each meeting and stored in the office of a campus administrator. We anticipate developing a mission statement and goals after formal training provided by [institution's] system office.

ANSWERS TO OPEN-ENDED QUESTION XIII (1): "ASIDE FROM 'MORE RESOURCES,' WHAT CHANGES IN POLICY OR IN STATE LAW WOULD YOU RECOMMEND TO BETTER ADDRESS THE MENTAL HEALTH OF VIRGINIA'S COLLEGE STUDENTS?"

04: Academic credit for self-care knowledge as part of curriculum. Mental health, in my opinion, is always connected to numerous factors. Without an ability to coordinate all of those needs, mental health needs will continue to remain under-addressed both on the individual and system/organizational level.

09: I am not sure that more policy or state law changes are the solution. More communication/collaboration between people on campus is what is needed. Money spent on electronic warning systems and increased campus police do not address the real issues. Could some standard be set of counselors-to-students ratio that would help insure adequate staffing. Case managers would also be helpful, esp. tracking sources of information about students.

17: Ensuring that mental health practitioners are protected if it becomes necessary to disclose information to parents, administrators, often medical personnel to protect the safety of students.

07: Mandate health insurance.

11: All universities need care managers positions funded through the state to better assist in coordination of services through the CSB.

02: An affordable mandated student health insurance policy with good mental health coverage subsidized/provided by the commonwealth. Subsidized prescription. Broader Medicaid eligibility for students.

13: A state requirement that when a student is administered a TDO or ECO that the courts be required to report this to the university that the student is attending if the student is attending a public university. Similarly if a student is convicted of a violent crime the courts should be required to inform state universities about this conviction.

47: It would be helpful if the Commonwealth would require new and transfer students with psychological disorders to provide colleges with documentation certifying their ability to function in the collegiate environment.

18: "Something" to curb binge drinking college culture but I don't know what that is. Mandated parental notification effective (at publics)?

38: Better continuity of care between ER, CSB – there should be release forms on charts to make it part of discharge. Too often we are in the dark about students leaving for treatment and then returning to us the same semester.

35: Some kind of mandate or legal "encouragement" for hospital staff who are releasing a college student from a psychiatric unit to contact appropriate university staff to

coordinate discharge planning (instead of treating the college student patient as "any other adult" might be treated) – esp. since the student will typically be returning to a relatively unsupervised, unstructured university environment, and does not have immediate family nearby to help monitor compliance, e.g., a roommate is not going to, and should not be expected to, take responsibility for a discharged student the way a family member would if that student were living at home.

Maybe hospitals could be "encouraged" in one way or another to develop memoranda of understanding with each college and university in their immediate area (again, in my view currently, college counseling centers are much more interested and motivated to do this than the hospital staff are; legislative encouragement may be needed to expedite this process).

Also, the recommendation that colleges obtain mental health records from previous providers is not a realistic option in the vast majority of cases. On our campus about 24% of our students have had some kind of previous mental health treatment. Even if we knew in advance who these students are, no college has the capacity o collect, read, and store this volume of records, esp. since most of them will end up being un-useful, irrelevant, and/or obsolete. Even if we read and saw a record that was disturbing, what then can be done? Offers of admission cannot be rescinded on that basis, and, unless the student's current behavior is problematic, it is not appropriate to drag students in for mandated treatment. It seems that in many cases having that info, but not being able to do something clearly about it may put institutions in more of a legal jeopardy.

Currently most college counseling centers only request records from students who 1) come in seeking services and 2) self-identify that they have had previous treatment, and 3) when that treatment record seems likely to be relevant or important to the current situation, few of us routinely ask for all records from every client who has ever had previous treatment because these are not usually helpful and are often irrelevant to what is going on for the student now. And even when we do ask, it typically takes weeks, months, or longer to get a reply from the previous treating professional (who understandably has more pressing things to do, and no incentive to respond quickly). So even if my staff needed a particular student's previous treatment record, there is only a small chance that we would be able to obtain it in a timely fashion (even a few weeks delay may be too long for situations where the record seems highly relevant).

(BTW, the "more resources" issue is huge – I'm hoping the reason you don't want us to comment on that is because it's so obvious to everyone already, and not because no one plans to do anything to try to obtain more resources; the CSB's are under-resourced and the inspector general encouraged all university counseling center to try to provide all needed mental health services for their students on campus; at the same time, campus budgets are being cut, and few university counseling centers in Virginia are adequately staffed to meet 100% of student need; this is a recipe for another disaster down the road when another Cho-like student falls through the cracks in the system; it's more than a little disingenuous for legislators to pass various laws impacting college mental health without also providing adequate resources to accomplish the new mandates).

05: Revisions to state law to ensure colleges and universities are notified whenever a student enrolled at a Virginia institution is subject to commitment proceedings. Perhaps this could also be achieved through a universal working agreement with all CSBs statewide. Currently, we believe we are receiving notifications on all students committed locally. However, we have no guarantee that is the case. We have never received notice of a student committed outside the local area. Almost 70% of our students are Virginia residents who return home over holiday and summer breaks. IF a student were committed in his/her home jurisdiction, we would not be notified.

15: (a) Resources are a key issue if Institutions of Higher Education, especially public institutions, are to adequately meet the mental health mandates and needs of individual students and safeguard those individuals and the community.

(b) Increased accessibility to public resources through organizations such as Community Service Boards is integral to managing students with long term care needs, or those who must be assessed for hospitalization and monitored following discharge. Perhaps it would make sense to consider college students, especially those without health insurance, as a "Priority Population" given increased concern for individual and public safety.

(c) Clearer delineation within the law of liability for: (1) Mental Health Professionals working at campus counseling centers, (2) Members of the Threat Assessment Team, (3) Public and private institutions (for example, what are the liabilities involved in separating a student who poses a danger to self/others or significantly disrupts the community for public institutions? For private institutions?), (d) Clearer delineation within the law of what constitutes discrimination pursuant to suicidal ideation and what constitutes reasonable accommodations, (e) Clearer delineation of the rights of institutions as they discharge duties related to public safety. For example, can a public or private institution legally mandate assessment? Can treatment be legally mandated as a condition of enrollment?

03: Longer time period for ECO's; Longer time until hearing for TDO

32: Establish a standard of care that indicates an appropriate number of FTE staff for a certain number of students … to help guide institutions.

26: Notification from law enforcement agencies when arrests occur for violent behavior, when those arrests occur outside the confines of the University.

45: [Identifying statement redacted] Students would be better served with assessment and counseling services available on the campuses.

Community colleges are not allowed by law to provide mental health services. This limits our ability to respond to students' needs.

More partnerships with community mental health providers.

Better guidelines for community colleges that cannot provide direct student mental health services.

Continue to expand powers of TAT

The opportunity to have "shared" positions among community college. For example a counselor who is on more than one campus on specific days and maintains counseling.

Communicate & increase awareness of mental health while decreasing the stigma associated with mental health

27: None at this time

31: Do not mandate us to take specific actions with students or otherwise as an institution. Instead, authorize us to act without liability upon a particular situation.

ANSWERS TO OPEN-ENDED QUESTION XIII (2): "WHAT ARE THE PRINCIPAL ROADBLOCKS YOUR INSTITUTION HAS ENCOUNTERED IN WORKING WITH STUDENTS WITH MENTAL HEALTH CONDITIONS?"

33: Complexity of issues: not everyone has the understanding of the primary conditions. Getting everyone up to speed in upper administration when we are at the point of needing to notify parents, etc.

04: Universal care is not available to comprehensively address needs. We do not have an integrative system, and thus many with mental health needs do not enter into a treatment system that can adequately address the full range of mental health needs

29: Delayed treatment access due to limited professionals in the area; Delay from other colleges/universities to release information about students without a signed release from the student.

07: Having enough external resources.

01: Parents who are either 1) unwilling to acknowledge the severity of their student's condition and assume responsibility for the student in a more suitable setting (e.g. home, in-patient setting) or 2) hyper-involved and unable/unwilling to allow their students to develop the coping skills that are required for effective living in a modern society.

11: At times having students assessed by the CSB for a TDO and released and we have no way of monitoring them, as we are not notified unless they are admitted to a local psych hospital. CSB turns folks away too easily even if student told licensed professionals they stated they were suicidal or homicidal.

13: We do not have enough funding to support service demand. When legislation passed as a response to the tragic Virginia Tech shootings the expectations for the provision of mental health services to Virginia's college students increased greatly. However, no additional funding was earmarked to assist universities in meeting these new experiences. It would be worthwhile to have at least some funds that can be attained through grant applications.

37: Resistance of students to receive help, failure to use meds as prescribed, cost of psychiatry, inadequacy of insurance, erratic lifestyles of students (sleep, substance abuse).

03: Lack of intensive outpatient programs in the community.

09: Sometimes students have difficulties navigating the system (low self-reliance skills) lack of an early warning system focused on less threatening behavior. Students having academic difficulties are directed to [center name redacted] or Career/academic advising when psychological issues are underlying problems. Men pose special challenge.

02: Long wait to access community mental health resources. Some students with health insurance can't afford their co-pays/deductibles. Many students do not want to use

family insurance. Also, referral resources for underinsured students and students with no insurance coverage.

47: The principle roadblocks include lack of funding and personnel.

26: Patient privacy.

18: Student resistance to counseling; Student non-compliance with medications; Access to psychiatry – hard if don't want to use insurance, keeping private from parents; Lack of substance abuse tx available locally appropriate for student age; Lack of on-campus MD for more significant mental health issues (e.g., bipolar, ADD); Small college fear of loss of anonymity precludes group tx

38: 5-6 week waiting period for psychiatric appointment; Psychiatric fees in [town name redacted] $310 (only 3 take new clients); Poor family support; Some parents expect us to see their student twice/week for counseling. We don't have resources for that level of treatment

08: (a) When wait times exceed 1.5-1 weeks for initial (non-crisis) appointments there are greater no show rates for intakes; (b) Several groups (e.g. international students) may be underrepresented as far as receiving services. We see a need for greater, focused outreach to these populations.

35: (a) Shortage of psychiatric beds at local hospitals, both for short-term (i.e., overnight) and longer-term (i.e., days or, rarely, weeks) in-patient care.

(b) All too frequently, students are being released from psychiatric hospitals while they are still too impaired to function adequately academically, and thus are not appropriate to return to campus. If the students' parents are not immediately available to bring the student home for appropriate after-care, there are no good alternatives for where the student can go while waiting for the parents to get there. Most colleges do not have the staff or facilities to monitor a student 24/7 while waiting for days until a family member can get to campus to take the student home. This is another disaster waiting to happen when a student too impaired to function in school, but does not meet criteria for hospitalization wanders off and has something bad happen to them.

(c) All too frequently, when hospitals release a college student from a psychiatric unit, the discharge plans are not at all appropriate for residential college students who do not live with family. It would greatly help if there were some kind of system (legal or otherwise) that strongly encouraged hospital staff to contact appropriate university staff for discharge planning (assuming the hospital is aware that the patient is a university student).

(d) Shortage of off-campus, low-cost, sliding fee scale mental health resources for students with limited resources and/or no insurance. The CSB's are not a realistic option for many colleges due to long waiting lists, and being under-resourced themselves. (e.g., putting a psychiatrically impaired college student on a waiting list for services for a few weeks or more effectively means they may be unable to salvage their academic term, and

the college may have no choice but to medically withdraw them from school and send them home – assuming parents can come get them in a timely fashion).

(e) I'm not sure if this belongs in #1 above, as a legal issue, or not, but I have concerns about the involuntary commitment process being able to obtain up-to-date treatment information from current providers in a timely fashion; e.g., if a student from our institution were to be TDO-ed and have a commitment hearing at night or on the weekends, even if they had the phone number of an appropriate university staff member to call (which is not a sure thing), the staff member that is called would be highly unlikely to be at a place where s/he can access the current treatment records (without taking an hour or so to get dressed, drive to the office, unlock the doors and confidential files, retrieve the file, read the info therein, and then call the evaluator back). Unless the commitment process can afford those kinds of delays, it is likely than in many cases decisions will end up being made without adequate input from professionals who might know the student's situation best.

05: Lack of resources. Student enrollment increases every year; yet, we have added only 2.5 FTEs in the past 10 years. The number of psychiatric beds in [region name redacted] will also be decreasing in the near future.

15: (a) lack of insurance coverage for specialized referrals

(b) Parents who may be in denial about the severity of concerns and/or expect the college to be able to treat and supervise a student who is unsafe. [Identifying statement redacted].

(c) Stigma regarding treatment [identifying statement redacted] …and ultimately the potential for treatment to impact financing for education and later career options

32: Lack of psychiatrist or psychiatric time to address medication issues/evaluations.

14: Although the University Counseling Center has policies and procedures in place as to how we proceed in assisting students with mental health conditions, the University administrators consistently struggle with the idea of expelling, withdrawing, suspending students with such issues. Protocols are written with reference to administrative withdrawals of students with mental/emotional health issues as well as policy and procedures for the threat assessment committee. Will attempt to attach the Administrative Withdrawal Policy.

24: Not having enough staff to work with students.

45: Changes in medication that leads to worsening of condition. Failure to take medication.

Availability of resources for students who are not in emergency situations; working with 5 CSB jurisdictions

Some students are unwilling to take their prescribed medications or follow their treatment plans. Lack of understanding within the college community about the nature of mental illness.

Lack of documentation

[Identifying statement redacted].

Lack of local resources. CSBs are full and don't provide the type of services our students need. Early intervention could help.

[Institution policy] does not allow us to provide mental health services, better documentation, and community referrals

Time to work with student and lack of follow-up as student doesn’t return; student perception of confidentiality; view of mental health in our service area.

Since we have no dedicated counseling center there is often confusion about responsibilities and referral methods.

It is difficult at the community college level to require students to seek treatment. If a student receives a disciplinary suspension and it is related to mental health issues then the student just falls back into society and doesn’t attempt to regain entry into the college.

Not having a systematic approach

Lack of counseling or police office on campus. We rely very heavily on local MOUs to provide services to our students.

Not having mental health information on students from other four-year institutions, community colleges or high schools.

19: a. The mental health concern allows the student to remain at the institution, whereas, other students without mental health issues are treated differently
b. Too much emphasis on mental health as an excuse for behavior.

27: Students lack appropriate medical insurance to cover recommended outpatient psychological or psychiatric services.

31: The ECO/TDO system is cumbersome to the point of being dangerous when compared to states that more directly authorize police and mental health professionals to involuntarily commit for evaluation.

ANSWERS TO OPEN-ENDED QUESTION XIII (3): "DO YOU HAVE ANY POLICIES OR PROCEDURES NOT LISTED ABOVE THAT YOU THINK MIGHT BE HELPFUL TO OTHER VIRGINIA COLLEGES IN DEALING WITH DISTRESSED OR DISTRESSING STUDENTS?"

01: We have received good feedback from students, faculty, and staff related to the "Resources" section of our website. It can be found [website redacted].

38: No notification when student comes and go for mental health care.

08: (a) Our psychological staff usually accompanies students when they are being hospitalized (local hospital is within 5 min of campus). This has proven to be a great benefit for students. Our transport policy and relationship with the Police Department is beneficial as well.

(b) Our [office name redacted] meetings are individualized and can generally be arranged the same day. This has helped alleviate stress and increase student's options.

35: In my view, one of the great structural things our university does is to have one dean who receives both academic and residential life information about each student, and thus there is one office with a holistic picture of what is going on for each student. On too many campuses (esp., larger ones), the academic and residential life functions are in separate "silos" which makes it much more difficult to "connect the dots" when a student is beginning to have difficulty.

05: See Student Health Policy, attached as Exhibit D, for our practice of establishing liaison with hospital units to begin coordination of treatment before students are discharged. [Identifying statement and websites redacted].

15: We have enclosed the relevant policies for your review. Included in these is our Workplace Violence Prevention Policy. While the predominant emphasis of this survey and study is on college students we believe it is important to consider the mandate for institutions, particularly Threat Assessment Teams, to also assess and intervene with employees or anyone from the general public who may pose a threat. This increased vigilance requires resources and a multi-disciplinary perspective, which means that College Counselors are often engaged in consultation around complex issues involving non-student mental health concerns.

14: We truly need a one-stop center for our veterans especially. There are too many options that they have not been prior advised in. Many students have not been in school for a long time and have no idea how to get started.

We still have a long way to go to institutionalize policies and procedures that would reflect all the concerns outlined in this survey

45: We have an online reporting program that helps identify students with concerning behavior. We also have a fulltime position, and an advisory committee, identified to work

with student mental health and behavior. We are a ULifeline school that offers resources to students faculty and staff.

Written agreement with the CSB; A clinical coordinator or a contracted clinical coordinator available to access and provide consultation regarding all mental health issues on campus; Create an online mental health training tool for faculty and staff in the [institution].

27: None at this time.

Appendix

Data from Fall 2008 State Council of Higher Education for Virginia (SCHEV) E2 Report

Abbreviations

Four-Year Public Institutions

College	Abbreviation
Christopher Newport University	CNU
College of William and Mary	CWM
George Mason University	GMU
James Madison University	JMU
Longwood University	LU
Norfolk State University	NSU
Old Dominion University	ODU
Radford University	RU
University of Mary Washington	UMW
University of Virginia	UVA
University of Virginia's College at Wise	UVA-W
Virginia Commonwealth University	VCU
Virginia Military Institute	VMI
Virginia State University	VSU
Virginia Tech	VT

Two-Year Public Institutions

College	Abbreviation
Blue Ridge	BRCC
Central Virginia	CVCC
Dabney S. Lancaster	DSLCC
Danville	DCC
Eastern Shore	ESCC
Germanna	GCC
J. Sargeant Reynolds	JSRCC
John Tyler	JTCC
Lord Fairfax	LFCC
Mountain Empire	MECC
New River	NRCC
Northern Virginia	NVCC

College	Abbreviation
Patrick Henry	PHCC
Paul D. Camp	PDCCC
Piedmont	PVCC
Rappahannock	RCC
Richard Bland	RBC
Southside	SSVCC
Southwest	SWVCC
Thomas Nelson	TNCC
Tidewater	TCC
Virginia Highlands	VHCC
Virginia Western	VWCC
Wytheville	WCC

Four-Year Private Institutions

College	Abbreviation
Averett University	AVC
Bluefield College	BLC
Bridgewater College	BRC
Eastern Mennonite University	EMU
Emory and Henry College	EHC
Ferrum College	FEC
Hampden-Sydney College	HSC
Hampton University	HU
Hollins University	HOU
Jefferson Col. Health Sciences	CHRV
Liberty University	LU
Lynchburg College	LBC
Mary Baldwin College	MBC

College	Abbreviation
Marymount University	MU
Randolf College	RC
Randolf-Macon College	RMC
Roanoke College	ROC
Saint Paul's College	SPC
Shenandoah University	SHU
Sweet Briar College	SBC
University of Richmond	UOR
Virginia Intermont College	VIC
Virginia Union University	VUU
Virginia Wesleyan College	VWC
Washington and Lee University	WLU

Table 1: Type of Student, Ethnicity, and Gender by Headcount and Percentage

Abbreviation	Type of Student			Ethnicity							Gender	
	Undergrads	Grads	Total	Foreign/ International	African American or Black	American Indian/Native American	Asian/Pacific Islander	Hispanic	White, Caucasian American	Unknown/ Unreported	Men	Women
Four-Year Public Institutions												
CNU	4763.0	141.0	4904.0	17.0	369.0	29.0	143.0	131.0	4048.0	167.0	2204.0	2700.0
	97.1	2.9	100.0	0.3	7.5	0.6	2.9	2.7	82.5	3.4	44.9	55.1
CWM	5850.0	2042.0	7892.0	341.0	606.0	60.0	510.0	365.0	4878.0	1132.0	3627.0	4265.0
	74.1	25.9	100.0	4.3	7.7	0.8	6.5	4.6	61.8	14.3	46.0	54.0
GMU	18809.0	11905.0	30714.0	1709.0	2108.0	87.0	3666.0	1598.0	14009.0	7537.0	13715.0	16999.0
	61.2	38.8	100.0	5.6	6.9	0.3	11.9	5.2	45.6	24.5	44.7	55.3
JMU	16916.0	1538.0	18454.0	220.0	742.0	49.0	867.0	431.0	15146.0	999.0	7321.0	11133.0
	91.7	8.3	100.0	1.2	4.0	0.3	4.7	2.3	82.1	5.4	39.7	60.3
LU	4024.0	703.0	4727.0	57.0	297.0	25.0	71.0	87.0	4040.0	150.0	1472.0	3255.0
	85.1	14.9	100.0	1.2	6.3	0.5	1.5	1.8	85.5	3.2	31.1	68.9
NSU	5653.0	672.0	6325.0	57.0	5503.0	17.0	71.0	104.0	287.0	286.0	2279.0	4046.0
	89.4	10.6	100.0	0.9	87.0	0.3	1.1	1.6	4.5	4.5	36.0	64.0
ODU	17330.0	5756.0	23086.0	868.0	4701.0	118.0	1139.0	825.0	14377.0	1058.0	9862.0	13224.0
	75.1	24.9	100.0	3.8	20.4	0.5	4.9	3.6	62.3	4.6	42.7	57.3
RU	8155.0	1002.0	9157.0	74.0	512.0	34.0	207.0	247.0	7937.0	146.0	3744.0	5413.0
	89.1	10.9	100.0	0.8	5.6	0.4	2.3	2.7	86.7	1.6	40.9	59.1
UMW	4231.0	853.0	5084.0	49.0	257.0	23.0	193.0	199.0	3281.0	1082.0	1678.0	3406.0
	83.2	16.8	100.0	1.0	5.1	0.5	3.8	3.9	64.5	21.3	33.0	67.0
UVA	15207.0	9331.0	24538.0	1763.0	1679.0	51.0	2083.0	849.0	14859.0	3254.0	10757.0	13781.0
	62.0	38.0	100.0	7.2	6.8	0.2	8.5	3.5	60.6	13.3	43.8	56.2
UVA-W	1964.0	0.0	1964.0	12.0	173.0	13.0	19.0	36.0	1711.0	0.0	879.0	1085.0
	100.0	0.0	100.0	0.6	8.8	0.7	1.0	1.8	87.1	0.0	44.8	55.2
VCU	22792.0	9492.0	32284.0	1770.0	5354.0	177.0	3130.0	1025.0	16999.0	3829.0	13296.0	18988.0
	70.6	29.4	100.0	5.5	16.6	0.5	9.7	3.2	52.7	11.9	41.2	58.8

Abbreviation	Type of Student			Ethnicity							Gender	
	Undergrads	Grads	Total	Foreign/ International	African American or Black	American Indian/Native American	Asian/Pacific Islander	Hispanic	White, Caucasian American	Unknown/ Unreported	Men	Women
VMI	1428.0	0.0	1428.0	24.0	82.0	5.0	60.0	62.0	1195.0	0.0	1317.0	111.0
	100.0	0.0	100.0	1.7	5.7	0.4	4.2	4.3	83.7	0.0	92.2	7.8
VSU	4489.0	553.0	5042.0	13.0	4656.0	7.0	20.0	0.0	184.0	162.0	1926.0	3116.0
	89.0	11.0	100.0	0.3	92.3	0.1	0.4	0.0	3.6	3.2	38.2	61.8
VT	23566.0	7173.0	30739.0	2234.0	1319.0	99.0	2114.0	810.0	21567.0	2596.0	17582.0	13157.0
	76.7	23.3	100.0	7.3	4.3	0.3	6.9	2.6	70.2	8.4	57.2	42.8
Two-Year Public Institutions												
BRCC	4466.0	0.0	4466.0	0.0	215.0	19.0	87.0	170.0	3832.0	143.0	1962.0	2504.0
	100.0	0.0	100.0	0.0	4.8	0.4	1.9	3.8	85.8	3.2	43.9	56.1
CVCC	5412.0	0.0	5412.0	1.0	770.0	30.0	71.0	66.0	4315.0	159.0	2517.0	2895.0
	100.0	0.0	100.0	0.0	14.2	0.6	1.3	1.2	79.7	2.9	46.5	53.5
DSLCC	1272.0	0.0	1272.0	0.0	61.0	4.0	6.0	11.0	1136.0	54.0	534.0	738.0
	100.0	0.0	100.0	0.0	4.8	0.3	0.5	0.9	89.3	4.2	42.0	58.0
DCC	4026.0	0.0	4026.0	0.0	1449.0	14.0	33.0	48.0	2443.0	39.0	1726.0	2300.0
	100.0	0.0	100.0	0.0	36.0	0.3	0.8	1.2	60.7	1.0	42.9	57.1
ESCC	939.0	0.0	939.0	1.0	334.0	8.0	12.0	32.0	541.0	11.0	291.0	648.0
	100.0	0.0	100.0	0.1	35.6	0.9	1.3	3.4	57.6	1.2	31.0	69.0
GCC	6515.0	0.0	6515.0	12.0	922.0	31.0	213.0	321.0	4799.0	217.0	2437.0	4078.0
	100.0	0.0	100.0	0.2	14.2	0.5	3.3	4.9	73.7	3.3	37.4	62.6
JSRCC	13079.0	0.0	13079.0	82.0	4241.0	86.0	550.0	406.0	7304.0	410.0	5480.0	7599.0
	100.0	0.0	100.0	0.6	32.4	0.7	4.2	3.1	55.8	3.1	41.9	58.1
JTCC	8776.0	0.0	8776.0	13.0	2202.0	51.0	253.0	317.0	5715.0	225.0	3436.0	5340.0
	100.0	0.0	100.0	0.1	25.1	0.6	2.9	3.6	65.1	2.6	39.2	60.8
LFCC	5867.0	0.0	5867.0	3.0	284.0	29.0	108.0	192.0	5115.0	136.0	2245.0	3622.0
	100.0	0.0	100.0	0.1	4.8	0.5	1.8	3.3	87.2	2.3	38.3	61.7
MECC	3075.0	0.0	3075.0	1.0	49.0	6.0	13.0	9.0	2991.0	6.0	1177.0	1898.0
	100.0	0.0	100.0	0.0	1.6	0.2	0.4	0.3	97.3	0.2	38.3	61.7
NRCC	4889.0	0.0	4889.0	29.0	256.0	17.0	89.0	72.0	4347.0	79.0	2414.0	2475.0
	100.0	0.0	100.0	0.6	5.2	0.3	1.8	1.5	88.9	1.6	49.4	50.6
NVCC	42663.0	0.0	42663.0	1555.0	6629.0	318.0	6177.0	5710.0	19328.0	2946.0	19762.0	22901.0

Abbreviation	Type of Student			Ethnicity							Gender	
	Undergrads	Grads	Total	Foreign/ International	African American or Black	American Indian/Native American	Asian/Pacific Islander	Hispanic	White, Caucasian American	Unknown/ Unreported	Men	Women
	100.0	0.0	100.0	3.6	15.5	0.7	14.5	13.4	45.3	6.9	46.3	53.7
PHCC	3109.0	0.0	3109.0	0.0	709.0	2.0	21.0	38.0	2314.0	25.0	1212.0	1897.0
	100.0	0.0	100.0	0.0	22.8	0.1	0.7	1.2	74.4	0.8	39.0	61.0
PDCCC	1628.0	0.0	1628.0	1.0	617.0	8.0	16.0	22.0	947.0	17.0	569.0	1059.0
	100.0	0.0	100.0	0.1	37.9	0.5	1.0	1.4	58.2	1.0	35.0	65.0
PVCC	4874.0	0.0	4874.0	44.0	651.0	17.0	161.0	117.0	3647.0	237.0	1949.0	2925.0
	100.0	0.0	100.0	0.9	13.4	0.3	3.3	2.4	74.8	4.9	40.0	60.0
RCC	3307.0	0.0	3307.0	0.0	588.0	24.0	34.0	52.0	2529.0	80.0	1217.0	2090.0
	100.0	0.0	100.0	0.0	17.8	0.7	1.0	1.6	76.5	2.4	36.8	63.2
RBC	1634.0	0.0	1634.0	0.0	426.0	12.0	45.0	54.0	1097.0	0.0	594.0	1040.0
	100.0	0.0	100.0	0.0	26.1	0.7	2.8	3.3	67.1	0.0	36.4	63.6
SSVCC	5606.0	0.0	5606.0	0.0	2196.0	10.0	45.0	70.0	3238.0	47.0	2134.0	3472.0
	100.0	0.0	100.0	0.0	39.2	0.2	0.8	1.2	57.8	0.8	38.1	61.9
SWVCC	3984.0	0.0	3984.0	0.0	107.0	14.0	16.0	10.0	3822.0	15.0	1828.0	2156.0
	100.0	0.0	100.0	0.0	2.7	0.4	0.4	0.3	95.9	0.4	45.9	54.1
TNCC	10557.0	0.0	10557.0	5.0	3741.0	66.0	474.0	482.0	5426.0	363.0	4250.0	6307.0
	100.0	0.0	100.0	0.0	35.4	0.6	4.5	4.6	51.4	3.4	40.3	59.7
TCC	26898.0	0.0	26898.0	125.0	8400.0	162.0	1532.0	1159.0	14745.0	775.0	10259.0	16639.0
	100.0	0.0	100.0	0.5	31.2	0.6	5.7	4.3	54.8	2.9	38.1	61.9
VHCC	2650.0	0.0	2650.0	0.0	57.0	5.0	17.0	19.0	2538.0	14.0	1187.0	1463.0
	100.0	0.0	100.0	0.0	2.2	0.2	0.6	0.7	95.8	0.5	44.8	55.2
VWCC	8532.0	0.0	8532.0	35.0	827.0	36.0	220.0	122.0	7129.0	163.0	3785.0	4747.0
	100.0	0.0	100.0	0.4	9.7	0.4	2.6	1.4	83.6	1.9	44.4	55.6
WCC	3363.0	0.0	3363.0	1.0	91.0	8.0	34.0	62.0	3147.0	20.0	1288.0	2075.0
	100.0	0.0	100.0	0.0	2.7	0.2	1.0	1.8	93.6	0.6	38.3	61.7
Private Institutions												
AVC	813.0	29.0	842.0	30.0	239.0	6.0	10.0	23.0	534.0	0.0	444.0	398.0
	96.6	3.4	100.0	3.6	28.4	0.7	1.2	2.7	63.4	0.0	52.7	47.3
BLC	749.0	0.0	749.0	1.0	126.0	2.0	4.0	12.0	559.0	45.0	300.0	449.0
	100.0	0.0	100.0	0.1	16.8	0.3	0.5	1.6	74.6	6.0	40.1	59.9

Abbreviation	Type of Student			Ethnicity							Gender	
	Undergrads	Grads	Total	Foreign/ International	African American or Black	American Indian/Native American	Asian/Pacific Islander	Hispanic	White, Caucasian American	Unknown/ Unreported	Men	Women
BRC	1514.0	0.0	1514.0	9.0	107.0	8.0	11.0	24.0	1205.0	150.0	629.0	885.0
	100.0	0.0	100.0	0.6	7.1	0.5	0.7	1.6	79.6	9.9	41.5	58.5
EMU	995.0	392.0	1387.0	59.0	82.0	4.0	16.0	45.0	1152.0	29.0	524.0	863.0
	71.7	28.3	100.0	4.3	5.9	0.3	1.2	3.2	83.1	2.1	37.8	62.2
EHC	941.0	32.0	973.0	3.0	59.0	6.0	11.0	5.0	842.0	47.0	486.0	487.0
	96.7	3.3	100.0	0.3	6.1	0.6	1.1	0.5	86.5	4.8	49.9	50.1
FEC	1385.0	0.0	1385.0	15.0	371.0	16.0	7.0	15.0	961.0	0.0	742.0	643.0
	100.0	0.0	100.0	1.1	26.8	1.2	0.5	1.1	69.4	0.0	53.6	46.4
HSC	1120.0	0.0	1120.0	11.0	57.0	2.0	14.0	14.0	969.0	53.0	1119.0	1.0
	100.0	0.0	100.0	1.0	5.1	0.2	1.3	1.3	86.5	4.7	99.9	0.1
HU	4701.0	727.0	5428.0	45.0	5025.0	16.0	49.0	49.0	244.0	0.0	1954.0	3474.0
	86.6	13.4	100.0	0.8	92.6	0.3	0.9	0.9	4.5	0.0	36.0	64.0
HOU	798.0	260.0	1058.0	45.0	87.0	6.0	20.0	34.0	866.0	0.0	60.0	998.0
	75.4	24.6	100.0	4.3	8.2	0.6	1.9	3.2	81.9	0.0	5.7	94.3
CHRV	907.0	88.0	995.0	4.0	112.0	3.0	17.0	11.0	813.0	35.0	162.0	833.0
	91.2	8.8	100.0	0.4	11.3	0.3	1.7	1.1	81.7	3.5	16.3	83.7
LU	21851.0	12381.0	34232.0	662.0	4977.0	216.0	639.0	1141.0	22315.0	4282.0	16548.0	17684.0
	63.8	36.2	100.0	1.9	14.5	0.6	1.9	3.3	65.2	12.5	48.3	51.7
LBC	2183.0	389.0	2572.0	37.0	172.0	17.0	32.0	60.0	1970.0	284.0	987.0	1585.0
	84.9	15.1	100.0	1.4	6.7	0.7	1.2	2.3	76.6	11.0	38.4	61.6
MBC	1537.0	201.0	1738.0	17.0	285.0	12.0	38.0	65.0	1321.0	0.0	119.0	1619.0
	88.4	11.6	100.0	1.0	16.4	0.7	2.2	3.7	76.0	0.0	6.8	93.2
MU	2193.0	1355.0	3548.0	215.0	526.0	13.0	268.0	333.0	1802.0	391.0	869.0	2679.0
	61.8	38.2	100.0	6.1	14.8	0.4	7.6	9.4	50.8	11.0	24.5	75.5
RC	563.0	6.0	569.0	66.0	52.0	0.0	25.0	41.0	385.0	0.0	103.0	466.0
	98.9	1.1	100.0	11.6	9.1	0.0	4.4	7.2	67.7	0.0	18.1	81.9
RMC	1201.0	0.0	1201.0	30.0	134.0	8.0	19.0	32.0	965.0	13.0	562.0	639.0
	100.0	0.0	100.0	2.5	11.2	0.7	1.6	2.7	80.3	1.1	46.8	53.2
ROC	2021.0	0.0	2021.0	41.0	67.0	9.0	24.0	52.0	1828.0	0.0	905.0	1116.0
	100.0	0.0	100.0	2.0	3.3	0.4	1.2	2.6	90.5	0.0	44.8	55.2

Abbreviation	Type of Student			Ethnicity							Gender	
	Undergrads	Grads	Total	Foreign/ International	African American or Black	American Indian/Native American	Asian/Pacific Islander	Hispanic	White, Caucasian American	Unknown/ Unreported	Men	Women
SPC	645.0	0.0	645.0	1.0	626.0	0.0	4.0	4.0	10.0	0.0	332.0	313.0
	100.0	0.0	100.0	0.2	97.1	0.0	0.6	0.6	1.6	0.0	51.5	48.5
SHU	1720.0	1791.0	3511.0	171.0	237.0	7.0	104.0	75.0	1600.0	1317.0	1289.0	2222.0
	49.0	51.0	100.0	4.9	6.8	0.2	3.0	2.1	45.6	37.5	36.7	63.3
SVU	682.0	0.0	682.0	11.0	22.0	6.0	12.0	18.0	590.0	23.0	307.0	375.0
	100.0	0.0	100.0	1.6	3.2	0.9	1.8	2.6	86.5	3.4	45.0	55.0
SBC	799.0	15.0	814.0	24.0	21.0	6.0	11.0	31.0	696.0	25.0	25.0	789.0
	98.2	1.8	100.0	2.9	2.6	0.7	1.4	3.8	85.5	3.1	3.1	96.9
UOR	3327.0	920.0	4247.0	228.0	336.0	14.0	143.0	108.0	3094.0	324.0	1968.0	2279.0
	78.3	21.7	100.0	5.4	7.9	0.3	3.4	2.5	72.9	7.6	46.3	53.7
VIC	552.0	0.0	552.0	4.0	29.0	1.0	2.0	8.0	495.0	13.0	146.0	406.0
	100.0	0.0	100.0	0.7	5.3	0.2	0.4	1.4	89.7	2.4	26.4	73.6
VUU	1150.0	352.0	1502.0	16.0	1410.0	1.0	3.0	10.0	36.0	26.0	733.0	769.0
	76.6	23.4	100.0	1.1	93.9	0.1	0.2	0.7	2.4	1.7	48.8	51.2
VWC	1381.0	0.0	1381.0	8.0	271.0	2.0	30.0	51.0	975.0	44.0	521.0	860.0
	100.0	0.0	100.0	0.6	19.6	0.1	2.2	3.7	70.6	3.2	37.7	62.3
WLU	1693.0	393.0	2086.0	0.0	93.0	6.0	121.0	51.0	1777.0	38.0	1105.0	981.0
	81.2	18.8	100.0	0.0	4.5	0.3	5.8	2.4	85.2	1.8	53.0	47.0

Table 2: Student, Housing and Residency Status by Headcount and Percentage

Abbreviation	Student Status		Housing Status		Residency Status	
	Full-Time	Part-Time	On-Campus	Off-Campus	In-State	Out-of-state
Four-Year Public Institutions						
CNU	4656.0	248.0	2786.0	2118.0	4672.0	232.0
	94.9	5.1	56.8	43.2	95.3	4.7
CWM	7351.0	541.0	4568.0	3324.0	5080.0	2812.0
	93.1	6.9	57.9	42.1	64.4	35.6
GMU	16685.0	14029.0	4725.0	25989.0	25312.0	5402.0
	54.3	45.7	15.4	84.6	82.4	17.6
JMU	17098.0	1356.0	5816.0	12638.0	13069.0	5385.0
	92.7	7.3	31.5	68.5	70.8	29.2
LU	3934.0	793.0	3013.0	1714.0	4436.0	291.0
	83.2	16.8	63.7	36.3	93.8	6.2
NSU	5109.0	1216.0	2464.0	3861.0	5152.0	1173.0
	80.8	19.2	39.0	61.0	81.5	18.5
ODU	14403.0	8683.0	3812.0	19274.0	20383.0	2703.0
	62.4	37.6	16.5	83.5	88.3	11.7
RU	8213.0	944.0	3042.0	6115.0	8462.0	695.0
	89.7	10.3	33.2	66.8	92.4	7.6
UMW	3747.0	1337.0	2432.0	2652.0	4099.0	985.0
	73.7	26.3	47.8	52.2	80.6	19.4
UVA	20700.0	3838.0	6144.0	18394.0	15504.0	9034.0
	84.4	15.6	25.0	75.0	63.2	36.8
UVA-W	1451.0	513.0	676.0	1288.0	1873.0	91.0
	73.9	26.1	34.4	65.6	95.4	4.6
VCU	23420.0	8864.0	4822.0	27462.0	27585.0	4699.0
	72.5	27.5	14.9	85.1	85.4	14.6
VMI	1428.0	0.0	1428.0	0.0	857.0	571.0
	100.0	0.0	100.0	0.0	60.0	40.0
VSU	4221.0	821.0	2795.0	2247.0	3463.0	1579.0
	83.7	16.3	55.4	44.6	68.7	31.3
VT	27539.0	3200.0	9090.0	21649.0	21337.0	9402.0
	89.6	10.4	29.6	70.4	69.4	30.6
Two-Year Public Institutions						
BRCC	1715.0	2751.0	0.0	4466.0	4368.0	98.0

Abbreviation	Student Status		Housing Status		Residency Status	
	Full-Time	Part-Time	On-Campus	Off-Campus	In-State	Out-of-state
	38.4	61.6	0.0	100.0	97.8	2.2
CVCC	1333.0	4079.0	0.0	5412.0	5320.0	92.0
	24.6	75.4	0.0	100.0	98.3	1.7
DSLCC	477.0	795.0	0.0	1272.0	1241.0	31.0
	37.5	62.5	0.0	100.0	97.6	2.4
DCC	1286.0	2740.0	0.0	4026.0	3930.0	96.0
	31.9	68.1	0.0	100.0	97.6	2.4
ESCC	295.0	644.0	0.0	939.0	920.0	19.0
	31.4	68.6	0.0	100.0	98.0	2.0
GCC	1967.0	4548.0	0.0	6515.0	6443.0	72.0
	30.2	69.8	0.0	100.0	98.9	1.1
JSRCC	3383.0	9696.0	0.0	13079.0	12738.0	341.0
	25.9	74.1	0.0	100.0	97.4	2.6
JTCC	2076.0	6700.0	0.0	8776.0	8685.0	91.0
	23.7	76.3	0.0	100.0	99.0	1.0
LFCC	1765.0	4102.0	0.0	5867.0	5726.0	141.0
	30.1	69.9	0.0	100.0	97.6	2.4
MECC	1260.0	1815.0	0.0	3075.0	3030.0	45.0
	41.0	59.0	0.0	100.0	98.5	1.5
NRCC	1756.0	3133.0	0.0	4889.0	4714.0	175.0
	35.9	64.1	0.0	100.0	96.4	3.6
NVCC	14966.0	27697.0	0.0	42663.0	38918.0	3745.0
	35.1	64.9	0.0	100.0	91.2	8.8
PHCC	1297.0	1812.0	0.0	3109.0	3072.0	37.0
	41.7	58.3	0.0	100.0	98.8	1.2
PDCCC	404.0	1224.0	0.0	1628.0	1593.0	35.0
	24.8	75.2	0.0	100.0	97.9	2.1
PVCC	1186.0	3688.0	0.0	4874.0	4721.0	153.0
	24.3	75.7	0.0	100.0	96.9	3.1
RCC	702.0	2605.0	0.0	3307.0	3291.0	16.0
	21.2	78.8	0.0	100.0	99.5	0.5
RBC	1038.0	596.0	241.0	1393.0	1612.0	22.0
	63.5	36.5	14.7	85.3	98.7	1.3
SSVCC	1649.0	3957.0	0.0	5606.0	5575.0	31.0

Abbreviation	Student Status		Housing Status		Residency Status	
	Full-Time	Part-Time	On-Campus	Off-Campus	In-State	Out-of-state
	29.4	70.6	0.0	100.0	99.4	0.6
SWVCC	1344.0	2640.0	0.0	3984.0	3864.0	120.0
	33.7	66.3	0.0	100.0	97.0	3.0
TNCC	3063.0	7494.0	0.0	10557.0	10014.0	543.0
	29.0	71.0	0.0	100.0	94.9	5.1
TCC	9900.0	16998.0	0.0	26898.0	25215.0	1683.0
	36.8	63.2	0.0	100.0	93.7	6.3
VHCC	975.0	1675.0	0.0	2650.0	2438.0	212.0
	36.8	63.2	0.0	100.0	92.0	8.0
VWCC	2299.0	6233.0	0.0	8532.0	8396.0	136.0
	26.9	73.1	0.0	100.0	98.4	1.6
WCC	1100.0	2263.0	0.0	3363.0	3329.0	34.0
	32.7	67.3	0.0	100.0	99.0	1.0
Private Institutions						
AVC	757.0	85.0	437.0	405.0	526.0	316.0
	89.9	10.1	51.9	48.1	62.5	37.5
BLC	614.0	135.0	196.0	553.0	595.0	154.0
	82.0	18.0	26.2	73.8	79.4	20.6
BRC	1497.0	17.0	1233.0	281.0	1223.0	291.0
	98.9	1.1	81.4	18.6	80.8	19.2
EMU	1056.0	331.0	592.0	795.0	669.0	718.0
	76.1	23.9	42.7	57.3	48.2	51.8
EHC	886.0	87.0	646.0	327.0	701.0	272.0
	91.1	8.9	66.4	33.6	72.0	28.0
FEC	1360.0	25.0	0.0	1385.0	1222.0	163.0
	98.2	1.8	0.0	100.0	88.2	11.8
HSC	1116.0	4.0	1065.0	55.0	763.0	357.0
	99.6	0.4	95.1	4.9	68.1	31.9
HU	4935.0	493.0	2572.0	2856.0	1854.0	3574.0
	90.9	9.1	47.4	52.6	34.2	65.8
HOU	840.0	218.0	633.0	425.0	610.0	448.0
	79.4	20.6	59.8	40.2	57.7	42.3
CHRV	702.0	293.0	111.0	884.0	936.0	59.0
	70.6	29.4	11.2	88.8	94.1	5.9

Abbreviation	Student Status		Housing Status		Residency Status	
	Full-Time	Part-Time	On-Campus	Off-Campus	In-State	Out-of-state
LU	19745.0	14487.0	6520.0	27712.0	9870.0	24362.0
	57.7	42.3	19.0	81.0	28.8	71.2
LBC	2132.0	440.0	1682.0	890.0	1763.0	809.0
	82.9	17.1	65.4	34.6	68.5	31.5
MBC	1168.0	570.0	665.0	1073.0	1422.0	316.0
	67.2	32.8	38.3	61.7	81.8	18.2
MU	2368.0	1180.0	733.0	2815.0	2098.0	1450.0
	66.7	33.3	20.7	79.3	59.1	40.9
RC	554.0	15.0	484.0	85.0	249.0	320.0
	97.4	2.6	85.1	14.9	43.8	56.2
RMC	1176.0	25.0	994.0	206.0	815.0	386.0
	97.9	2.1	82.8	17.2	67.9	32.1
ROC	1927.0	94.0	1195.0	826.0	1079.0	942.0
	95.3	4.7	59.1	40.9	53.4	46.6
SPC	624.0	21.0	459.0	186.0	491.0	154.0
	96.7	3.3	71.2	28.8	76.1	23.9
SHU	2319.0	1192.0	830.0	2681.0	2083.0	1428.0
	66.0	34.0	23.6	76.4	59.3	40.7
SVU	571.0	111.0	441.0	241.0	101.0	581.0
	83.7	16.3	64.7	35.3	14.8	85.2
SBC	777.0	37.0	802.0	12.0	364.0	450.0
	95.5	4.5	98.5	1.5	44.7	55.3
UOR	3450.0	797.0	2546.0	1701.0	1675.0	2572.0
	81.2	18.8	59.9	40.1	39.4	60.6
VIC	0.0	552.0	211.0	341.0	343.0	209.0
	0.0	100.0	38.2	61.8	62.1	37.9
VUU	1148.0	354.0	675.0	827.0	865.0	637.0
	76.4	23.6	44.9	55.1	57.6	42.4
VWC	1156.0	225.0	717.0	664.0	1079.0	302.0
	83.7	16.3	51.9	48.1	78.1	21.9
WLU	2083.0	3.0	1051.0	1035.0	376.0	1710.0
	99.9	0.1	50.4	49.6	18.0	82.0

Table 3: Student Age by Headcount and Percentage

Abbreviations	Age Brackets										
	Under 17	17-21 years	22-24 years	25-34 years	35-44 years	45-59 years	60 years and above	Age Unknown	Total 25 and above	Total 24 and under	All
	Four-Year Public Institutions										
CNU	0.0	4081.0	616.0	129.0	45.0	27.0	6.0	0.0	207.0	4697.0	4904.0
	0.0	83.2	12.6	2.6	0.9	0.6	0.1	0.0	4.2	95.8	100.0
CWM	7.0	5332.0	1134.0	1064.0	226.0	118.0	11.0	0.0	1419.0	6473.0	7892.0
	0.1	67.6	14.4	13.5	2.9	1.5	0.1	0.0	18.0	82.0	100.0
GMU	56.0	10267.0	6129.0	8913.0	2899.0	2220.0	230.0	0.0	14262.0	16452.0	30714.0
	0.2	33.4	20.0	29.0	9.4	7.2	0.7	0.0	46.4	53.6	100.0
JMU	45.0	14609.0	2416.0	861.0	262.0	237.0	24.0	0.0	1384.0	17070.0	18454.0
	0.2	79.2	13.1	4.7	1.4	1.3	0.1	0.0	7.5	92.5	100.0
LU	0.0	3369.0	673.0	344.0	188.0	146.0	7.0	0.0	685.0	4042.0	4727.0
	0.0	71.3	14.2	7.3	4.0	3.1	0.1	0.0	14.5	85.5	100.0
NSU	6.0	3396.0	1132.0	1020.0	428.0	317.0	26.0	0.0	1791.0	4534.0	6325.0
	0.1	53.7	17.9	16.1	6.8	5.0	0.4	0.0	28.3	71.7	100.0
ODU	9.0	9246.0	4553.0	5416.0	2267.0	1518.0	77.0	0.0	9278.0	13808.0	23086.0
	0.0	40.1	19.7	23.5	9.8	6.6	0.3	0.0	40.2	59.8	100.0
RU	1.0	6373.0	1614.0	717.0	243.0	197.0	12.0	0.0	1169.0	7988.0	9157.0
	0.0	69.6	17.6	7.8	2.7	2.2	0.1	0.0	12.8	87.2	100.0
UMW	2.0	3301.0	586.0	535.0	370.0	277.0	13.0	0.0	1195.0	3889.0	5084.0
	0.0	64.9	11.5	10.5	7.3	5.4	0.3	0.0	23.5	76.5	100.0
UVA	47.0	13368.0	3404.0	5039.0	1361.0	1200.0	119.0	0.0	7719.0	16819.0	24538.0
	0.2	54.5	13.9	20.5	5.5	4.9	0.5	0.0	31.5	68.5	100.0
UVA-W	14.0	1196.0	288.0	188.0	127.0	139.0	12.0	0.0	466.0	1498.0	1964.0
	0.7	60.9	14.7	9.6	6.5	7.1	0.6	0.0	23.7	76.3	100.0
VCU	143.0	14311.0	7086.0	6917.0	2050.0	1646.0	131.0	0.0	10744.0	21540.0	32284.0
	0.4	44.3	21.9	21.4	6.3	5.1	0.4	0.0	33.3	66.7	100.0
VMI	0.0	1273.0	149.0	6.0	0.0	0.0	0.0	0.0	6.0	1422.0	1428.0
	0.0	89.1	10.4	0.4	0.0	0.0	0.0	0.0	0.4	99.6	100.0
VSU	27.0	3494.0	731.0	419.0	188.0	169.0	14.0	0.0	790.0	4252.0	5042.0
	0.5	69.3	14.5	8.3	3.7	3.4	0.3	0.0	15.7	84.3	100.0
VT	8.0	19926.0	4880.0	4161.0	1128.0	587.0	49.0	0.0	5925.0	24814.0	30739.0
	0.0	64.8	15.9	13.5	3.7	1.9	0.2	0.0	19.3	80.7	100.0

Abbreviations	Age Brackets										
	Under 17	17-21 years	22-24 years	25-34 years	35-44 years	45-59 years	60 years and above	Age Unknown	Total 25 and above	Total 24 and under	All
	Two-Year Public Institutions										
BRCC	207.0	2415.0	529.0	686.0	316.0	285.0	28.0	0.0	1315.0	3151.0	4466.0
	4.6	54.1	11.8	15.4	7.1	6.4	0.6	0.0	29.4	70.6	100.0
CVCC	323.0	2654.0	508.0	820.0	570.0	464.0	73.0	0.0	1927.0	3485.0	5412.0
	6.0	49.0	9.4	15.2	10.5	8.6	1.3	0.0	35.6	64.4	100.0
DSLCC	123.0	629.0	104.0	178.0	129.0	102.0	7.0	0.0	416.0	856.0	1272.0
	9.7	49.4	8.2	14.0	10.1	8.0	0.6	0.0	32.7	67.3	100.0
DCC	439.0	1837.0	289.0	553.0	424.0	428.0	56.0	0.0	1461.0	2565.0	4026.0
	10.9	45.6	7.2	13.7	10.5	10.6	1.4	0.0	36.3	63.7	100.0
ESCC	57.0	463.0	92.0	148.0	93.0	78.0	8.0	0.0	327.0	612.0	939.0
	6.1	49.3	9.8	15.8	9.9	8.3	0.9	0.0	34.8	65.2	100.0
GCC	432.0	3512.0	680.0	967.0	551.0	352.0	21.0	0.0	1891.0	4624.0	6515.0
	6.6	53.9	10.4	14.8	8.5	5.4	0.3	0.0	29.0	71.0	100.0
JSRCC	975.0	5616.0	1602.0	2555.0	1284.0	984.0	63.0	0.0	4886.0	8193.0	13079.0
	7.5	42.9	12.2	19.5	9.8	7.5	0.5	0.0	37.4	62.6	100.0
JTCC	719.0	4320.0	867.0	1449.0	895.0	490.0	36.0	0.0	2870.0	5906.0	8776.0
	8.2	49.2	9.9	16.5	10.2	5.6	0.4	0.0	32.7	67.3	100.0
LFCC	597.0	3152.0	564.0	735.0	441.0	360.0	18.0	0.0	1554.0	4313.0	5867.0
	10.2	53.7	9.6	12.5	7.5	6.1	0.3	0.0	26.5	73.5	100.0
MECC	322.0	1461.0	262.0	470.0	274.0	257.0	29.0	0.0	1030.0	2045.0	3075.0
	10.5	47.5	8.5	15.3	8.9	8.4	0.9	0.0	33.5	66.5	100.0
NRCC	320.0	2393.0	573.0	759.0	449.0	343.0	52.0	0.0	1603.0	3286.0	4889.0
	6.5	48.9	11.7	15.5	9.2	7.0	1.1	0.0	32.8	67.2	100.0
NVCC	307.0	18498.0	6753.0	9505.0	4243.0	2966.0	391.0	0.0	17105.0	25558.0	42663.0
	0.7	43.4	15.8	22.3	9.9	7.0	0.9	0.0	40.1	59.9	100.0
PHCC	268.0	1294.0	278.0	534.0	352.0	301.0	82.0	0.0	1269.0	1840.0	3109.0
	8.6	41.6	8.9	17.2	11.3	9.7	2.6	0.0	40.8	59.2	100.0
PDCCC	234.0	660.0	113.0	270.0	181.0	151.0	19.0	0.0	621.0	1007.0	1628.0
	14.4	40.5	6.9	16.6	11.1	9.3	1.2	0.0	38.1	61.9	100.0
PVCC	324.0	2377.0	482.0	809.0	466.0	375.0	41.0	0.0	1691.0	3183.0	4874.0
	6.6	48.8	9.9	16.6	9.6	7.7	0.8	0.0	34.7	65.3	100.0
RCC	693.0	1686.0	192.0	343.0	204.0	165.0	24.0	0.0	736.0	2571.0	3307.0
	21.0	51.0	5.8	10.4	6.2	5.0	0.7	0.0	22.3	77.7	100.0

Abbreviations	Age Brackets										
	Under 17	17-21 years	22-24 years	25-34 years	35-44 years	45-59 years	60 years and above	Age Unknown	Total 25 and above	Total 24 and under	All
RBC	119.0	1255.0	116.0	91.0	30.0	23.0	0.0	0.0	144.0	1490.0	1634.0
	7.3	76.8	7.1	5.6	1.8	1.4	0.0	0.0	8.8	91.2	100.0
SSVCC	952.0	2414.0	445.0	749.0	492.0	469.0	85.0	0.0	1795.0	3811.0	5606.0
	17.0	43.1	7.9	13.4	8.8	8.4	1.5	0.0	32.0	68.0	100.0
SWVCC	259.0	1643.0	329.0	665.0	443.0	464.0	181.0	0.0	1753.0	2231.0	3984.0
	6.5	41.2	8.3	16.7	11.1	11.6	4.5	0.0	44.0	56.0	100.0
TNCC	965.0	4236.0	1233.0	2242.0	1046.0	785.0	50.0	0.0	4123.0	6434.0	10557.0
	9.1	40.1	11.7	21.2	9.9	7.4	0.5	0.0	39.1	60.9	100.0
TCC	183.0	10893.0	3770.0	6809.0	3103.0	1989.0	151.0	0.0	12052.0	14846.0	26898.0
	0.7	40.5	14.0	25.3	11.5	7.4	0.6	0.0	44.8	55.2	100.0
VHCC	268.0	1307.0	229.0	413.0	255.0	162.0	16.0	0.0	846.0	1804.0	2650.0
	10.1	49.3	8.6	15.6	9.6	6.1	0.6	0.0	31.9	68.1	100.0
VWCC	838.0	3651.0	801.0	1490.0	924.0	728.0	100.0	0.0	3242.0	5290.0	8532.0
	9.8	42.8	9.4	17.5	10.8	8.5	1.2	0.0	38.0	62.0	100.0
WCC	434.0	1575.0	252.0	456.0	364.0	252.0	30.0	0.0	1102.0	2261.0	3363.0
	12.9	46.8	7.5	13.6	10.8	7.5	0.9	0.0	32.8	67.2	100.0
	Private Institutions										
AVC	0.0	591.0	121.0	66.0	33.0	25.0	6.0	0.0	130.0	712.0	842.0
	0.0	70.2	14.4	7.8	3.9	3.0	0.7	0.0	15.4	84.6	100.0
BLC	5.0	302.0	83.0	140.0	124.0	92.0	3.0	0.0	359.0	390.0	749.0
	0.7	40.3	11.1	18.7	16.6	12.3	0.4	0.0	47.9	52.1	100.0
BRC	0.0	1360.0	138.0	10.0	5.0	1.0	0.0	0.0	16.0	1498.0	1514.0
	0.0	89.8	9.1	0.7	0.3	0.1	0.0	0.0	1.1	98.9	100.0
EMU	1.0	670.0	181.0	259.0	119.0	144.0	13.0	0.0	535.0	852.0	1387.0
	0.1	48.3	13.0	18.7	8.6	10.4	0.9	0.0	38.6	61.4	100.0
EHC	3.0	794.0	102.0	29.0	24.0	20.0	1.0	0.0	74.0	899.0	973.0
	0.3	81.6	10.5	3.0	2.5	2.1	0.1	0.0	7.6	92.4	100.0
FEC	1.0	1224.0	106.0	30.0	15.0	9.0	0.0	0.0	54.0	1331.0	1385.0
	0.1	88.4	7.7	2.2	1.1	0.6	0.0	0.0	3.9	96.1	100.0
HSC	1.0	999.0	119.0	1.0	0.0	0.0	0.0	0.0	1.0	1119.0	1120.0
	0.1	89.2	10.6	0.1	0.0	0.0	0.0	0.0	0.1	99.9	100.0
HU	2.0	3896.0	703.0	423.0	188.0	197.0	19.0	0.0	827.0	4601.0	5428.0
	0.0	71.8	13.0	7.8	3.5	3.6	0.4	0.0	15.2	84.8	100.0

Abbreviations	Age Brackets										
	Under 17	17-21 years	22-24 years	25-34 years	35-44 years	45-59 years	60 years and above	Age Unknown	Total 25 and above	Total 24 and under	All
HOU	2.0	641.0	116.0	140.0	74.0	77.0	8.0	0.0	299.0	759.0	1058.0
	0.2	60.6	11.0	13.2	7.0	7.3	0.8	0.0	28.3	71.7	100.0
CHRV	0.0	290.0	193.0	249.0	173.0	90.0	0.0	0.0	512.0	483.0	995.0
	0.0	29.1	19.4	25.0	17.4	9.0	0.0	0.0	51.5	48.5	100.0
LU	66.0	9584.0	4205.0	8693.0	6855.0	4555.0	274.0	0.0	20377.0	13855.0	34232.0
	0.2	28.0	12.3	25.4	20.0	13.3	0.8	0.0	59.5	40.5	100.0
LBC	10.0	1815.0	282.0	236.0	133.0	91.0	5.0	0.0	465.0	2107.0	2572.0
	0.4	70.6	11.0	9.2	5.2	3.5	0.2	0.0	18.1	81.9	100.0
MBC	72.0	686.0	210.0	333.0	243.0	178.0	16.0	0.0	770.0	968.0	1738.0
	4.1	39.5	12.1	19.2	14.0	10.2	0.9	0.0	44.3	55.7	100.0
MU	2.0	1273.0	743.0	982.0	302.0	227.0	19.0	0.0	1530.0	2018.0	3548.0
	0.1	35.9	20.9	27.7	8.5	6.4	0.5	0.0	43.1	56.9	100.0
RC	2.0	481.0	44.0	20.0	14.0	7.0	1.0	0.0	42.0	527.0	569.0
	0.4	84.5	7.7	3.5	2.5	1.2	0.2	0.0	7.4	92.6	100.0
RMC	0.0	1117.0	67.0	13.0	1.0	3.0	0.0	0.0	17.0	1184.0	1201.0
	0.0	93.0	5.6	1.1	0.1	0.2	0.0	0.0	1.4	98.6	100.0
ROC	0.0	1730.0	209.0	54.0	12.0	9.0	7.0	0.0	82.0	1939.0	2021.0
	0.0	85.6	10.3	2.7	0.6	0.4	0.3	0.0	4.1	95.9	100.0
SPC	2.0	419.0	92.0	57.0	32.0	39.0	4.0	0.0	132.0	513.0	645.0
	0.3	65.0	14.3	8.8	5.0	6.0	0.6	0.0	20.5	79.5	100.0
SHU	12.0	1200.0	652.0	867.0	423.0	345.0	12.0	0.0	1647.0	1864.0	3511.0
	0.3	34.2	18.6	24.7	12.0	9.8	0.3	0.0	46.9	53.1	100.0
SVU	18.0	476.0	128.0	54.0	0.0	5.0	1.0	0.0	60.0	622.0	682.0
	2.6	69.8	18.8	7.9	0.0	0.7	0.1	0.0	8.8	91.2	100.0
SBC	0.0	729.0	52.0	16.0	9.0	7.0	1.0	0.0	33.0	781.0	814.0
	0.0	89.6	6.4	2.0	1.1	0.9	0.1	0.0	4.1	95.9	100.0
UOR	5.0	2551.0	607.0	598.0	256.0	208.0	22.0	0.0	1084.0	3163.0	4247.0
	0.1	60.1	14.3	14.1	6.0	4.9	0.5	0.0	25.5	74.5	100.0
VIC	0.0	286.0	99.0	89.0	56.0	21.0	1.0	0.0	167.0	385.0	552.0
	0.0	51.8	17.9	16.1	10.1	3.8	0.2	0.0	30.3	69.7	100.0
VUU	3.0	873.0	208.0	112.0	89.0	178.0	39.0	0.0	418.0	1084.0	1502.0
	0.2	58.1	13.8	7.5	5.9	11.9	2.6	0.0	27.8	72.2	100.0

Abbreviations	Age Brackets										
	Under 17	17-21 years	22-24 years	25-34 years	35-44 years	45-59 years	60 years and above	Age Unknown	Total 25 and above	Total 24 and under	All
VWC	0.0	983.0	133.0	116.0	83.0	61.0	5.0	0.0	265.0	1116.0	1381.0
	0.0	71.2	9.6	8.4	6.0	4.4	0.4	0.0	19.2	80.8	100.0
WLU	2.0	1596.0	303.0	177.0	6.0	2.0	0.0	0.0	185.0	1901.0	2086.0
	0.1	76.5	14.5	8.5	0.3	0.1	0.0	0.0	8.9	91.1	100.0

VIRGINIA COLLEGE MENTAL HEALTH STUDY

LEGISLATIVE RECOMMENDATIONS

Joint Commission on Health Care: Healthy Living/Health Services Subcommittee

November 22, 2011

Susan M. Davis
Associate Vice President for Student Affairs
University of Virginia

General Assembly, 2008

- More than 25 bills signed into law in response to the Virginia Tech tragedy (Source: Governor Kaine press release, 4/9/08)
- Included the Omnibus Mental Health bills, which revised commitment criteria and proceedings.

2

Legal Issues Task Force

- State laws ripe for review: Virginia's colleges and universities have operated under the 2008 legislation for three academic years.
- Charge: Task Force sought to evaluate impact of recent Virginia legislation with three goals in mind:
  - (a) Identify any remaining gaps in state law
  - (b) Identify any implementation challenges
  - (c) Promote best practices among Virginia schools
- Aim: Identify non-legislative solutions wherever possible.

3

Relevant Federal Law

- Federal Laws governing aspects of student mental health crises:
  - Health Records Privacy: HIPAA
  - Disability Discrimination: ADA & Rehabilitation Act
  - Education Records Privacy: FERPA

4

The Three Little Pigs: FERPA , HIPAA & State Law

5

FERPA: The House of Straw

- No Private Cause of Action
- No Loss of Federal Funding for Single Violation
- Need Practice or Policy of Violations to Lose Funding
- Tax Dependency Exception
- Broad Health & Safety Exception: If an educational agency or institution determines that there is an articulable and significant threat to the health or safety of a student or other individual, it may disclose the information to any person, including parents, whose knowledge of the information is necessary to protect the health or safety of the student or other individuals.

6

FERPA: The Wolf Blowing Down the House of Straw

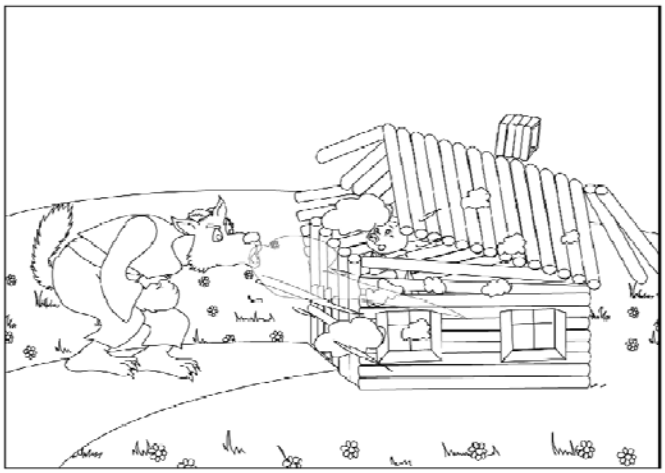
7

HIPAA: The House of Sticks

- Not applicable to the vast majority of campus counseling centers.
- Applicable to hospitals and outside providers.
- When applicable, permits unauthorized release of protected health care information where necessary to prevent or lessen a serious or imminent threat to a person or to the public, when such disclosure is made to someone the health care worker believes can prevent or lessen the threat.

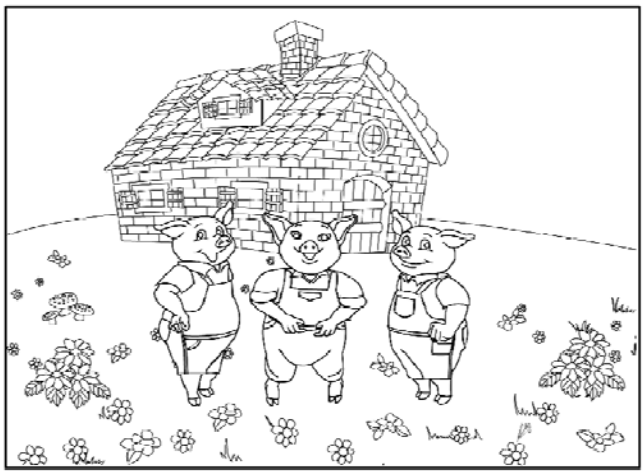
8

HIPAA: The Wolf Blowing Down the House of Sticks



9

Virginia Law: The House of Bricks



10

Virginia Health Records Privacy Act

- No clear health & safety emergency exception applicable to kinds of cases we work in higher education.
- Health care entities may, and, when required by other provisions of state law, shall, disclose health records as required or authorized by law relating to public health activities, health oversight activities, serious threats to health or safety, or abuse, neglect or domestic violence, relating to contagious disease, public safety, and suspected child or adult abuse reporting requirements, including, but not limited to, those contained in §§ 32.1-36, 32.1-36.1, 32.1-40, 32.1-41, 32.1-127.1:04, 32.1-276.5, 32.1-283, 32.1-283.1, 37.2-710, 37.2-839, 53.1-40.10, 54.1-2400.6, 54.1-2400.7, 54.1-2403.3, 54.1-2506, 54.1-2966, 54.1-2966.1, 54.1-2967, 54.1-2968, 63.2-1509, and 63.2-1606.
- State law also requires a health care provider to warn of an immediate threat by a patient to harm an identifiable individual, but the warning may be made only to the police or the intended victim. Va. Code 54.1-2400.1.

11

Numerous Other Virginia Statutes Adopted Pre-and-Post Va. Tech Tragedy

STAGES OF STUDENT TENURE

1. Post-admission/pre-enrollment: THEY'RE YOURS & THEY'RE COMING!

2. Enrollment: THEY'RE HERE!

3. Post-enrollment: THEY'RE GONE…MAYBE!

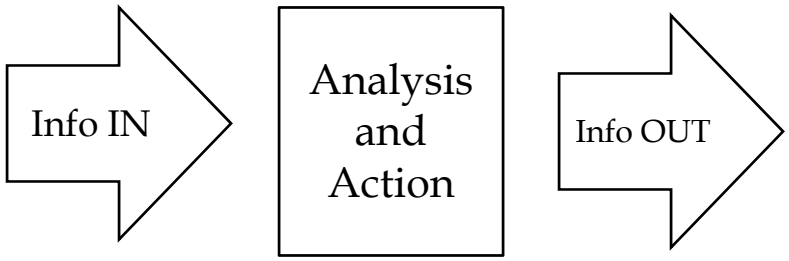
12

Post-Admission/Pre-Enrollment

- Va. Code § 23-2.1:3. Students' high school records. *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 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.*

  (General Assembly, 2008; SB 636 (Cucinelli))

13



14

Information IN

1. Is the information available? (e.g., do "originating high schools" keep such records?)
2. Is the source credible/reliable?
3. Is the information objective or subjective?
4. Do we need all the information available or are there certain pieces that are more valuable than others?

15

ANALYSIS & ACTION

1. Are we adequately staffed to analyze the information?
   a. If mass information, do we have sufficient staff to analyze it?
   b. If technical information, do we have the expertise?
2. What can/should we do with the information? Can we take any action?
   a. By collecting the records, is there a legal duty to review all of them and/or monitor certain incoming students?
   b. Are there legal impediments to taking action?

16

INFORMATION OUT

1. Can we share our analysis and/or actions with other interested parties?
   a. Are there legal impediments, e.g., Virginia Health Records Privacy Act?
   b. Are there ethical impediments, e.g., licensure standards?
2. Is there any added value in those parties having this information? Can they take any appropriate action?

17

Legislative Recommendations

- Survey Findings: No Virginia school is currently requesting mental health records for all incoming students. In 2008-2009, one public, one private, and one community college requested records on specific students.
- Permissive not mandatory text
- Title has caused confusion
- Recommendation: Amend title to clarify "originating school" includes high school or transferring institution of higher education.

18

Enrollment

Suicide: 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.*

19

Legislative Recommendations

- Sentence One: All four-year public institutions have developed and implemented the mandated suicide prevention policies. Only 38% of community colleges have done so. Recommend revising text to release community colleges from this mandate until circumstances change.
- Sentence Two: Clarify or repeal final two sentences. Let ADA and Rehabilitation Act guide schools in this complicated area.

20

Enrollment

Commitment

Criteria: In 2008, House Bill 559 changed the state criteria for ECOs, 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 exists 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."

21

Enrollment

Commitment

2. Va. Code § 37.2-818: Commitment hearing for involuntary admission; recordings and records.

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.).

22

Needs Priority Attention

- Most significant information gap in college mental health crises.
- Current reality: College or university must have knowledge of the commitment proceedings to obtain order.
- Survey findings: Most schools not notified of commitment proceedings involving their own students. Schools are key stakeholders. They may have mental health or behavioral information that would aid officials involved in proceedings. Also home to discharged student.

23

Non-Legislative Recommendations

- CSBs already burdened; Limited time and resources in these proceedings.
- Colleges and universities looking to become helpful partners in front and back end.
- Pursue these steps before legislative reform:
  (1) Written MOUs b/w school & CSB
  (2) Written MOUs b/w school & hospital
  (3) 24/7 school contact list
  (4) Collaborative trainings

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Enrollment

Disclosure/Sharing of Information to Parents

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.*

25

Legislative Recommendations

- Area of Improvement: Schools understand that FERPA not an obstacle; state law requires parental notification.
- Implementation Challenges: Exception Clause; Not all schools have a "treating physician" or "treating clinical psychologist."
- Recommend changing text to "health care professional."

26

Enrollment

Threat Assessment

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

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.

27

Legislative Recommendations

- Positive Improvement; TATs active on all four-year public campuses.
- General Assembly, 2010: Revisions to allow better health care & criminal record information to flow to TATs.
- Implementation uneven on community college campuses.
- Community colleges and smaller four-year publics do not have staffing of all categories.
- Loosen text to reflect that staffing is not same across all campuses.

28

Conclusion

- Virginia as a model for the nation.

29

UNIVERSITY OF VIRGINIA SCHOOL OF LAW

Richard J. Bonnie
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

To: Joint Commission on Health Care
Re: Progress Report on College Mental Health Study
Date: October 16, 2012

Dear Senator Puller and Members of the Joint Commission,

I presented the Virginia College Mental Health Study to the Joint Commission in October, 2011. Among other issues, the Task Force expressed concerns about whether the Commonwealth's community colleges currently have sufficient capacity to respond to students who appear to be experiencing mental health crises, including the expertise required for participation on threat assessment teams. Recognizing the wide variations in size and resources among the colleges, the Study urged the Community College System to consider how individual colleges and campuses might increase their capacity for screening and referral, either by adding these duties to existing positions or contracting with a CSB or other community mental health providers to provide the necessary services. The Study specifically recommended that each institution of higher education in the Commonwealth, including community colleges, enter into a memorandum of understanding with the local CSB to facilitate evaluation and referral of students who might be experiencing a mental health crisis. The Study also recommended that the Community College Board modify its policy manual to permit colleges to provide mental health evaluation and counseling services to their students if they chose to do so.

Several bills were introduced in the 2012 session to implement the recommendations set forth in the College Mental Health Study. All of these bills were enacted except for the bills -- introduced by Senator Barker and Delegate Surovell -- that were designed to address the Task Force's concerns relating to mental health capacities of community colleges. Representatives of the community colleges did not support these bills based on concerns that community colleges would eventually be required to provide mental health counseling services to their students, despite assurances that this was not the intention of the College Mental Health Study or the patrons of the respective bills. In retrospect, I believe that this misunderstanding could have been avoided if the VCCS had been given more time to review and comment on the Study before I presented it to the Joint Commission. Be that as it may, I am pleased to inform you that substantial progress has been made in reaching a consensus position since the General Assembly adjourned last spring.

First, I understand that representatives of the VCCS are meeting with Senator Barker and Delegate Surovell to work out a successor bill that will include language requiring the colleges to designate a contact person to coordinate with CSBs (or other providers) for screening and referral, one of the key recommendations of the College Mental Health Study, I also understand that representatives of the VCCS and the VACSB have already been meeting to work out these arrangements.

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Second, I understand that the presidents of the community colleges are meeting this week to consider two proposed changes to the Board policy manual that would not only require designation of such a contact person to coordinate with CSBs but would also allow qualified staff at community colleges to provide initial assessments and referrals to appropriate mental health services when necessary.

As you can see, if brought to fruition, these initiatives will successfully address the two main concerns identified in the College Mental Health Study.

Sincerely,

ENACTED COLLEGE MENTAL HEALTH LEGISLATION

2012 Session	
SB 374 (Barker) **HB 900** (Brink, Filler-Corn, Yost)	Added behavioral health care providers to the professionals (physicians and clinical psychologists) who may withhold parental notification of a student's mental health treatment if such notification may result in harm.
SB 375 (Barker) **HB 852** (Yost, Brink)	Clarified that colleges and universities may require an accepted student to provide his/her complete record from any other college or university attended (and not just from the high school attended).
SB 458 (Barker) **HB 853** (Yost, Brink)	Removed repetitious, confusing language regarding the ability of colleges and universities to establish policies regarding students who may be suicidal.
2013 Session	
SB 1078 (Barker) **HB 2322** (Surovell)	Requires the State Board of Community Colleges to "develop a mental health policy directing community colleges to designate at least one individual at each college to serve as a point of contact with an emergency services system clinician" to facilitate student screening or referral for emergency or urgent mental health needs.
SB 1342 (Peterson) **HB 1609** (Hugo, Anderson, Richard P. Bell, Robert B. Bell, Byron, Comstock, Cosgrove, J.A. Cox, Farrell, Garrett, Greason, Iaquinto, Knight, May, Miller, Rust, Watson)	Requires the governing board of each public four-year institution of higher education to "establish a written memorandum of understanding with its local community services board or behavioral health authority and with local hospitals and other local mental health facilities in order to expand the scope of services available to students seeking treatment….[including] a contact person to be notified when a student is involuntarily committed, or when a student is discharged from a facility and consents to such notification."

Legislation introduced in 2012 but not enacted sought to address:

- Requiring that the State Board of Community Colleges "develop standards and policies directing community colleges to adopt, incrementally and as resources dedicated to the purpose become available, a mental health services plan." **SB 372** (Senator Barker) and **HB 662** (Delegate Surovell, Delegate Bulova, Delegate Filler-Corn, Delegate Kory, Delegate Plum, Delegate Watts, Senator Barker, Senator Favola)

- Clarifying that violence prevention committees and threat assessment teams, as already required by statute of public colleges and universities, could be established as resources allow. **SB 373** (Senator Barker) and **HB 851** (Delegate Yost)

- Requiring the governing boards of public four-year colleges and universities "to establish written memorandum of understanding with their local community services boards or behavioral health authority; local hospitals; and other local mental health facilities in order to expand the scope of services available to students seeking treatment." **SB 623** (Senator Peterson, Delegate J.M. Scott) *(Note: SB 1342 enacted in 2013 also addressed the requirements for a memorandum of understanding.)*

- Requiring public colleges and universities to notify parents to the extent allowed by federal law, of any reports that their child may be suicidal. **SB 624** (Senator Peterson, Delegate J.M. Scott)

- Clarifying that two-year colleges and universities are included in the requirement to have policies and procedures addressing violence prevention on campus. **HB 116** (Delegate Morrissey)

- Requiring the governing boards of public colleges and universities "to develop and implement a policy requesting each student to identify points of contact to be notified should the student experience a mental health crisis…." **HB 697** (Delegate Filler-Corn, Delegate Plum, Delegate Surovell, Delegate Watts)

The bills addressing college mental health services introduced in 2013 were enacted.

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