

# Task Force on Student Mental Health and Well-being

February 2018



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# Introduction and Executive Summary

**A**fter hearing concerns from the Student Government Association regarding the stressful academic environment on campus and the availability of mental health resources, President Ronald J. Daniels committed to conduct a thorough review of the factors having an impact on the well-being of students at Johns Hopkins University, at both the undergraduate and graduate level. In response, Provost Robert Lieberman convened the Task Force on Student Mental Health and Well-being in March 2016 to assess the current state of mental health services and resources for students, canvass current research on effective strategies for mental health promotion, and make recommendations for effective services that could lead to an enhanced climate of health.

The task force was composed of 28 faculty, staff, and student members from across the university, including the directors of the three mental health service providers at Johns Hopkins: The Johns Hopkins Counseling Center (Counseling Center), the Johns Hopkins Student Assistance Program (JHSAP), and the University Health Services Mental Health Clinic (UHS-MH) (see Appendix A for the full committee roster). During the first meeting, Provost Lieberman delivered the charge to the task force and stated:

The university seeks to instill a culture of care by sending a clear and consistent message about the importance of wellness and self-care. We want to promote an environment that encourages healthy choices and supports students in successfully managing situational crisis, stress, and psychological issues. The university is committed to ensuring that outreach and support programs, policies, and practices regarding student psychological well-being meet the diverse needs of our students and reflect the current state of scientific knowledge and national best practices.

Universities face distinct challenges related to the mental health and well-being of their students. The transition to college or graduate school can be inherently stressful, as students adjust to significant life changes and the pressure to succeed. These stressors are often compounded at Johns Hopkins where there is a highly competitive academic and co-curricular atmosphere. In addition, mental health issues are quite common on university campuses. Mental illness affects one in five adults in the United States, and up to half of Americans will meet criteria for a mental health condition at some point in their lifetime (Kessler et al., 2005). Three-quarters of those individuals will develop symptoms by age 24 (Kessler et al., 2007). In a national survey, the American College Health Association found that more than 50 percent of undergraduate and graduate students

reported feeling overwhelming anxiety in the past year, and more than 30 percent felt so depressed at times that it was difficult to function (ACHA 2017 (a) and ACHA, 2017 (b)).

In addition to the prevalence of mental health conditions among college-age students, there is also a growing demand at university campuses across the country for mental health services. The Center for Collegiate Mental Health (CCMH) found that in 2015, counseling center utilization had grown by 30 percent over the previous six years while the average institutional enrollment grew by only 5 percent (CCMH, 2015). A similar trend has been observed at Johns Hopkins. The number of students served by the Counseling Center has increased each of the past six years, and it grew from 1,244 in 2013–14 to 1,404 in 2016–17. The rising utilization of services creates the need for a broad university response that elevates the importance of mental health and is proactive at all levels across the institution.

The task force sought the input of students in formulating its recommendations by holding numerous listening sessions and conducting a universitywide mental health survey. The results of these efforts show that students are often unaware or misinformed about the mental health services available to them and that additional outreach and marketing are a critical step for improvement moving forward. However, with an already steady increase in demand for mental health services, the university should continuously take steps to ensure there are adequate resources available to properly serve the psychological and psychiatric needs of its students before initiating a more targeted awareness campaign to utilize those services. The task force found a need for each provider to be more accessible in its operations, better accommodate students' schedules, and in some cases, increase staff for more effective service delivery. For students not located on the Homewood or East Baltimore campuses, resources can be particularly difficult to access.

It is also clear that a successful mental health strategy at JHU cannot rely solely on educating students about the services available to them or by increasing resources for providers. Survey data show that students concerned about their mental health are far more likely to turn to their friends and family for assistance rather than seek professional support. Therefore, the task force calls for the university to empower every student to address his or her unique mental health needs by: (1) reducing the stigma of mental health issues through a long-term communications strategy that keeps the topic at the forefront of university priorities, (2) providing training opportunities for students, faculty, and staff to better understand mental health issues and coping strategies, (3) increasing resources to support health and wellness programming, and (4) making it easier to find assistance and student support groups through a central mental health website. In addition, and as previously mentioned, the task force found there is an intense level of academic stress at Hopkins, even compared to peer institutions. A portion of this pressure is inherent and expected, but students consistently called for leadership to take action by acknowledging the problem and reducing unnecessary academic stressors wherever possible.

The task force can affirm that the university has leaders across its divisions who are dedicated to creating a healthy learning environment for students and addressing their mental health needs. A majority of students are pleased with the support they receive from mental health providers on campus, and many provided powerful accounts of how counselors and psychiatrists have dramatically improved their quality of life at the university. One of the great benefits of convening this task force was getting motivated student, faculty, and staff into the same room to discuss ongoing mental health challenges at the university and how to solve them. In fact, the kickoff meeting in March was the first time the directors of the Counseling Center, JHSAP, and UHS-MH met in person.

A key recommendation of the task force is to create a standing mental health committee not only to help implement the recommendations in this report but also to share best practices within the institution and encourage coordination moving forward (Recommendation 1.a). During the course of this process, JHU applied for, and was awarded, a three-year campus-based suicide prevention grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) that will greatly assist the university's efforts to address the mental health needs of students. While this grant proposal was not an official task force effort, it only occurred because key stakeholders were in close contact through these meetings.<sup>1</sup> This example demonstrates the potential effectiveness of creating a permanent universitywide mental health committee.

The task force acknowledges that improving student mental health must be a universitywide effort; it is not an issue that the administration can solve alone. Progress will require the cooperation of students, faculty, and staff at all levels to create an environment that is supportive, understanding of mental health issues, and encouraging of open dialogue.

<sup>1</sup> The Task Force would like to thank Sue Porterfield, associate vce provost for research, for her assistance in submitting the SAMHSA grant.

# Summary of Recommendations

**Recommendation 1: The university should promote a climate of awareness and support for student mental health, wellness, and stress reduction. It is essential to create a campus climate that values inclusion of all students and overall wellness, and that promotes resilience in the context of stressful situations and life events common among undergraduate and graduate student experiences.**

The task force recommends the creation of a standing universitywide student mental health committee (MHC) to monitor progress toward implementation of the task force recommendations and advise the president, provost, and vice provost for student affairs on student mental health and wellness issues in a sustained manner. The MHC should include leadership from the Counseling Center, JHSAP, UHS, the Office for Student Disability Services, deans for diversity and inclusion, and an expert on alcohol and drug addiction as standing members appointed by the provost, as well as rotating members who are students, faculty, staff, and alumni to reflect diverse interests across the university. There are also recommendations for creating a JHU-wide communication strategy on student mental health, including website development, health education, and targeted outreach to various special populations. Part of a cultural change includes a reduction of stigma, an increase of awareness, and attention to academic stressors and coping strategies in the context of a rigorous university environment. To help enact a cultural change, the task force recommends that the university encourage students to prioritize their health by permitting excused absences from class to seek treatment during an acute mental health issue. In addition, there is a call for greater attention to partnerships with student government organizations and other university initiatives that interrelate with student mental health and wellness.

**Recommendation 2: The university should take necessary steps to improve student care at JHU mental health service providers and provide greater access to mental health services.**

The task force recommends that the university examine the three mental health providers as a whole, as well as individually, to ensure the optimal organizational structure and staffing levels are in place to provide students with greater access to care. We found an immediate need to increase staffing at JHSAP and recommend that it employ an additional psychiatric provider to reflect the increase in demand for services. JHU should provide resources that allow for the

expansion of service provider options to better accommodate students' schedules when they are not in class and during peak periods throughout the academic year. The task force also recommends that health insurance coverage plans be reviewed to ensure that students receive excellent behavioral health coverage and inconsistencies in mental health coverage across divisions are minimized. There is a call for increased coordination among the three mental health service providers to provide effective and efficient service delivery to students and to ensure that policies and protocols for responding to emergency or crisis situations are consistent and promote mental health. The task force also recognizes a need for better communication with students with disabilities to ensure they are properly informed of the process for receiving appropriate accommodations.

**Recommendation 3: The university should offer, and in some cases require, training on mental health awareness and resources for faculty, staff, and students.**

Students reported through both quantitative and qualitative data that there is a lack of knowledge across the JHU community about mental health and how to effectively assist individuals in crisis. To address these important concerns, the university should provide trainings to raise awareness about mental illness and reduce stigma, help individuals identify struggling students and learn how to support them, and help encourage suicidal or distressed students to seek help from professional mental health services. In particular, students believe faculty often do not understand or give proper weight to mental health issues. The task force recommends required online module trainings for all teaching faculty and student-facing staff, including JHU deans of education, academic coordinators, advisers, coaches, and security officers. In order to provide additional context, the online modules should include information on how to support specific populations (student with disabilities or existing mental health challenges, international students, members of the LGBTQ community, etc.) Importantly, the trainings are not intended to encourage faculty and staff to act as counselors or mental health professionals but rather to enable them to identify, support, and refer students to appropriate JHU services. In addition, the task force recommends that optional workshops, trainings, and activities focused on mental health and wellness be offered to students, family members, and non-student-facing staff.

# Description of the Task Force Process

Provost Lieberman convened a task force in March of 2016 and specifically charged it to:

- Consider the environments across JHU that affect the well-being and mental health of students, including supporting needs related to cultural diversity and identity;
- Evaluate the need for mental health services and the capacity for JHU services to meet current and future demand in order to identify potential gaps in service;
- Review policies and practices designed to encourage students in seeking assistance such as leave of absence and return, and academic and support service accommodations; and
- Evaluate efforts for increased awareness of mental health issues and educational and training opportunities to foster both resilience and early assistance.

The task force, co-chaired by Daniele Fallin, professor and chair, Department of Mental Health at the Bloomberg School of Public Health, and Terry Martinez, associate vice provost and dean of students at Homewood Student Affairs, worked with subgroups in two separate phases.

During the first phase, one subgroup focused on gathering data and information on the student experience and barriers to mental health. This occurred by holding listening sessions across campuses and conducting a universitywide survey. While attendance at the listening sessions was small, the meetings provided insight into perceptions and real individual student experiences. The survey provided the task force with overarching themes and insight into the experiences of the different populations the institution serves. The survey was completed by more than 2,200 students with a response rate of 14.1 percent.

The second subgroup focused on infrastructure at JHU and current knowledge surrounding burden and risk. It gathered information regarding the structure and services of each of the mental health service providers at JHU as well as other sources of mental health support across the university. This subgroup also researched the national context for campus mental health interventions, current JHU policies relevant to student health, and communication and educational practices.

The second phase of the task force's work focused on developing recommendations based on the information gathered and benchmarking across national efforts, including other institutions and agencies that focus on various aspects of mental health for college students. After completing its draft set of recommendations in May 2017, the task force sought additional input from students by posting its recommendations to the Provost's Office website for public comment. The task force received feedback and suggestions from more than 70 students, which helped amend the final recommendations in this report.



# Background Information

## Importance of Mental Health in a University Student Context

### Key points:

- The prefrontal cortex, implicated in higher-order executive functions, emotional control, impulsivity, and decision making, continues to mature into a person's mid-20s.
- In addition to being more impulsive, young individuals tend to be more vulnerable to contagion after exposure to suicide within their community.
- The first onset of symptoms that develop into major mental disorders often occur in childhood or adolescence, and suicide risk is often highest in the early stages of onset of major psychiatric conditions.
- Fifty to 75 percent of disorders emerge between the ages of 14 and 24.

Mental illness affects one in five adults in the United States in a given year, and up to half of Americans will meet criteria for a mental health condition at some point in their lifetime (Kessler et al., 2005). Of these, half will develop symptoms by age 14, and three-fourths will develop symptoms by age 24 (Kessler et al., 2007). Further, the prefrontal cortex, implicated in higher-order executive functions, emotional control, impulsivity, and decision making, continues to mature into the mid-20s (Gogtay et al., 2004), making this age group vulnerable to mental and behavioral changes that could be detrimental to health and wellness. Suicide risk is often highest in the early stages of major psychiatric conditions (Hawton, 1987) and suicide is the second leading cause of death for people ages 15 to 34, reflecting the majority of college student ages (CDC, 2016). In addition to being more impulsive, young individuals tend to be more vulnerable to contagion after exposure to suicide within their community (Insel & Gould, 2008).

For these reasons, emerging and young adulthood is a critical time for mental health prevention and intervention strategies. This background section describes the scope of the challenge in addressing mental and behavioral health in university settings based on national and local information, including distribution and risk factors for mental health symptoms and outcomes, specific services, infrastructure, policies and procedures in place at JHU, and current knowledge about evidence-based best practices for prevention and treatment service provision in a university setting.

## Scope of the Challenge

### Key points:

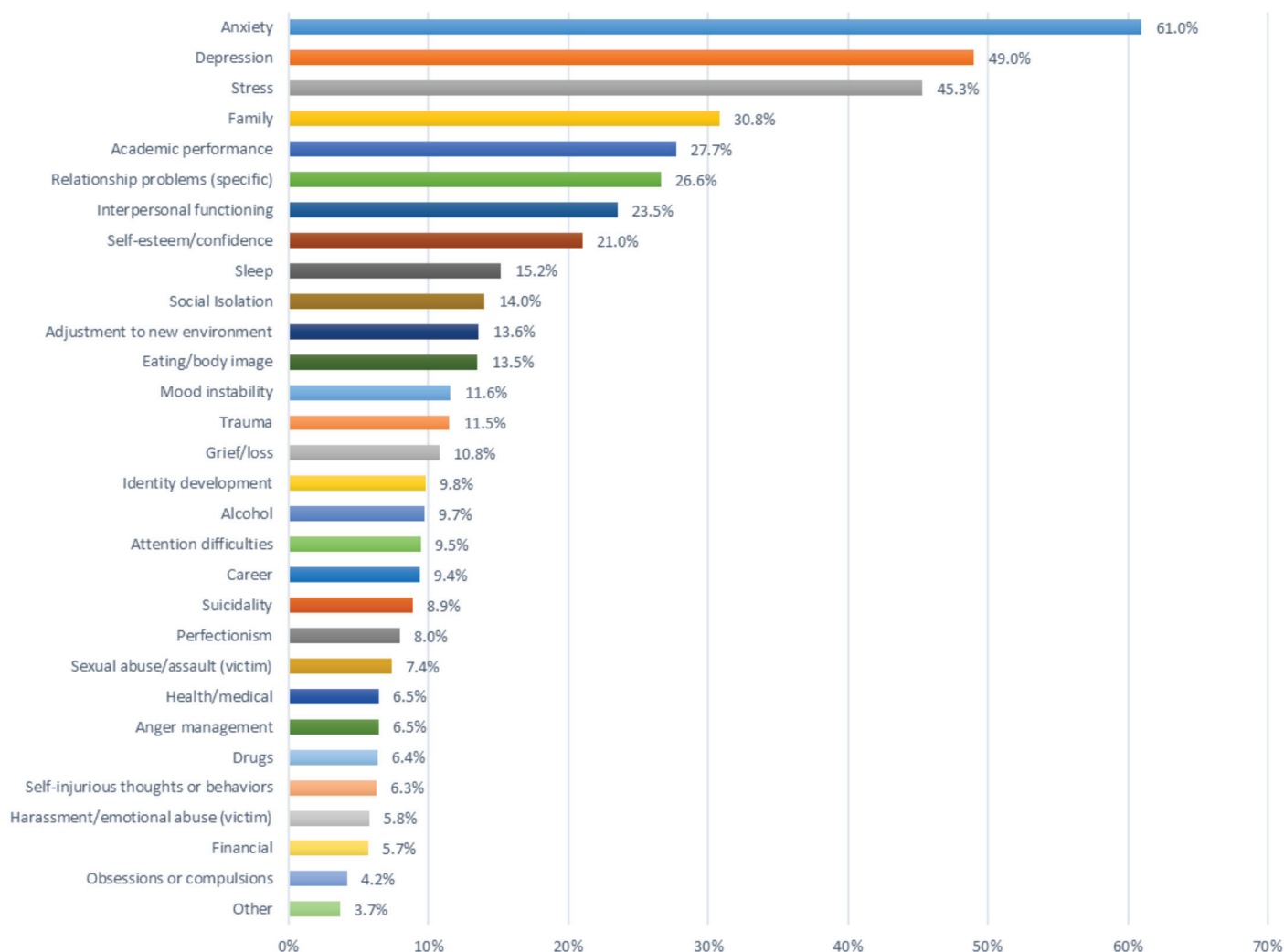
- Several psychiatric and behavioral health conditions are quite prevalent among college students
- In a national survey of college students:
  - Over half of undergraduate and graduate students reported feeling overwhelming anxiety in the past 12 months
  - Approximately 40-50 percent of students felt so depressed it was difficult to function
  - Approximately 5-10 percent reported consideration of suicide

Mental health issues are quite common among American college students. As illustrated by Table 1, the prevalence of students being diagnosed or treated for mental health disorders is high (ACHA, 2017 (a) and ACHA, 2017 (b)). When considering symptoms rather than diagnoses, substantially more students report mental health problems such as hopelessness, anxiety, and depression (Ibid.). It is also informative to see the primary health concerns among students seeking counseling services (Figure 1), which again attests to the level of symptom burden on college campuses (CCMH, 2017).

**Table 1. Prevalence (percentage) of students with a diagnosis or symptom in last 12 months, based on national data, American College Health Association, 2017**

Conditions:	Undergraduate	Graduate
Anxiety	20.9	19.7
Depression	17.0	15.6
Panic disorder	10.6	7.3
Insomnia	5.1	5.5
ADHD	6.8	5.1
Obsessive compulsive disorder	3.5	2.4
Anorexia	1.8	1.3
Bipolar disorder	1.8	1.5
Bulimia	1.3	1.1
Substance abuse or addiction	1.2	1.1
Phobia	1.4	1.1
Schizophrenia	0.4	0.3
Symptoms:	Undergraduate	Graduate
Overwhelming anxiety	62.0	57.2
Overwhelming anger	41.1	35.1
Hopelessness	53.2	44.0
So depressed it is difficult to function	40.2	35.7
Very sad	68.8	62.3
Serious consideration of suicide	11.5	6.1

**Figure 1 - Frequency of Concerns Reported by Students at University Counseling Centers (CCMH, 2016 Annual Reprt)**



These data suggest that national surveys that report by diagnosis rather than by symptoms may underreport many of the mental health concerns affecting students. Also, though prevalence rates for most types of mental health problems and for prior mental health treatment appear to be fairly stable, there has been an increase of nearly 30 percent in the number of students seeking services at counseling centers in the past five years and a greater than 38 percent growth in counseling center appointments. These growth rates are more than five times the rate of growth in university enrollments (CCMH, 2015). Importantly, the majority of counseling centers' operating budgets (62.7 percent) had not changed from prior years though most (54.2 percent) had added more clinical and psychiatric staff (Reetz et al., 2015).

At JHU specifically, undergraduate students report a high frequency of symptoms consistent with the national data and with peer institutions, although slightly higher in some areas such as feeling overwhelmed (Table 2). The distribution of these symptoms can be quite varied across multiple factors including gender, race, sexual orientation, disability status, country of origin, and program

**Table 2. Frequency of symptoms for undergrad students at JHU and peer institutions  
(Enrolled Student Survey, April 2016)**

During the current academic year, how often, if ever, have you....		Hopkins	Ivy League Universities	Overall Among Peer Universities
<b>Feel out of place</b>	Rarely or never	41.4%	38.0%	37.7%
	Occasionally	36.4%	37.2%	37.3%
	Often	14.2%	14.4%	14.65%
	Very Often	8.1%	10.4%	10.4%
<b>Feel overwhelmed</b>	Rarely or never	9.1%	8.2%	8.2%
	Occasionally	32.5%	36.5%	35.7%
	Often	29.9%	31.6%	31.7%
	Very Often	28.5%	23.7%	24.4%
<b>Pulled all-nighter</b>	Rarely or never	35.6%	40.9%	41.9%
	Occasionally	34.6%	34.6%	34.2%
	Often	16.2%	14.6%	14.3%
	Very Often	13.6%	9.8%	9.6%
<b>Feel very sad</b>	Rarely or never	32.1%	32.3%	31.0%
	Occasionally	42.3%	43.0%	42.8%
	Often	17.1%	15.6%	16.3%
	Very Often	8.5%	9.1%	9.9%
<b>Difficult to function</b>	Rarely or never	59.2%	61.9%	59.8%
	Occasionally	25.5%	23.9%	24.8%
	Often	9.2%	8.0%	8.6%
	Very Often	6.1%	6.1%	6.9%

of study, among others. Data separated by such factors are not as readily available but will be important in identifying high-risk groups for prevention and treatment intervention. It is important to note that student workload is a bigger source of potential stress for JHU undergraduates than for students at peer institutions (Table 3). The intensity of the academic culture at Johns Hopkins referenced earlier is supported by data from the 2016 Enrolled Student Survey showing that nearly 30 percent of undergraduates report “pulling all-nighters” often or very often, far exceeding the average at other schools.

**Table 3. Potential sources of stress for undergrad students at JHU and peer institutions  
(Enrolled Student Survey, April 2016)**

How much has each affected you during the current academic year		Hopkins	Ivy League Universities	Overall Among Peer Universities
<b>Workload</b>	Not a source of stress	3.6%	3.7%	4.1%
	Slightly stressful	16.2%	18.9%	19.2%
	Moderately stressful	40.6%	43.1%	42.1%
	Very stressful	39.6%	34.3%	34.5%
<b>Relationships</b>	Not a source of stress	26.9%	24.8%	24.2%
	Slightly stressful	32.7%	33.1%	32.8%
	Moderately stressful	24.9%	25.4%	25.5%
	Very stressful	15.6%	16.7%	17.5%
<b>Balancing</b>	Not a source of stress	7.0%	6.4%	6.9%
	Slightly stressful	23.7%	21.4%	22.5%
	Moderately stressful	35.6%	37.7%	37.3%
	Very stressful	33.7%	34.5%	33.4%
<b>Money</b>	Not a source of stress	30.7%	36.7%	34.5%
	Slightly stressful	30.1%	28.7%	29.1%
	Moderately stressful	20.3%	19.4%	19.7%
	Very stressful	18.9%	15.2%	16.7%
<b>Future</b>	Not a source of stress	5.9%	7.4%	6.9%
	Slightly stressful	18.9%	22.5%	21.5%
	Moderately stressful	32.4%	32.8%	33.0%
	Very stressful	42.8%	37.3%	38.6%

Concerns about physical safety can also contribute to poor mental health by raising anxiety and isolation. In a national survey of graduate students, most of whom live off campus, only 60 percent report feeling “very safe” in the community surrounding the university during the day, and only 24 percent report feeling “very safe” at night (ACHA, 2017 b). Safety in interpersonal relationships may also be of concern; 13 percent of graduate students report experiencing a verbal threat, and 6.9 percent report being in an emotionally abusive intimate relationship in the last 12 months (Ibid.).

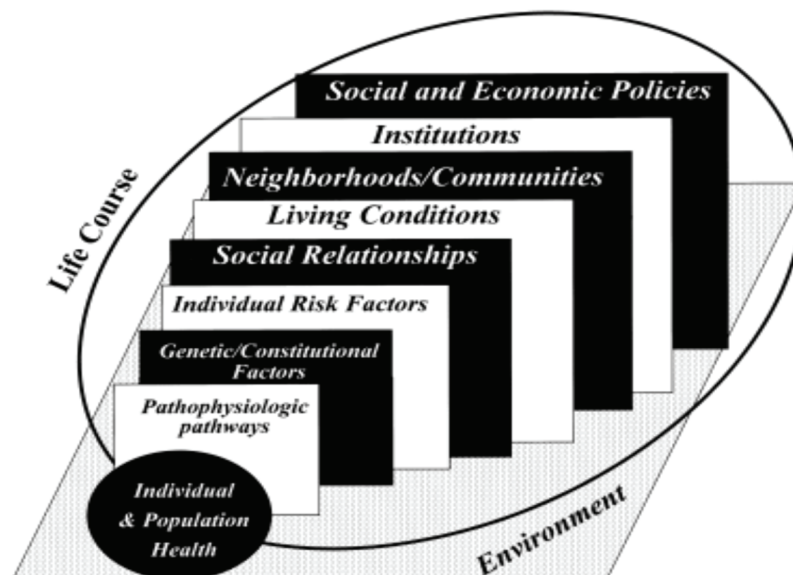
## Knowledge About Risk Factors

### Key points:

- Context is critical for targeting outreach, prevention, treatment, and health promotion.
- The ages of typical university students correspond to the highest risk groups for first episodes of mental illness, common experiences of mental health symptoms, and suicide.
- The environment of a rigorous university is often stressful, which can increase risk for mental health issues if resilience strategies and supports are not in place.
- Some demographic and culturally defined subgroups are at high risk for particular conditions, including women, students from minority race/ethnicities, students identifying as LGBTQ, first-generation college students, students with existing addiction or mental health issues, students exposed to violence, and students under financial or family hardship.

There are many possible frameworks for considering the causes and contributing factors to mental illness and mental and behavioral health symptoms. Biological, psychological, and socio-logical contexts each contribute (Figure 2) and should be considered in prevention and intervention strategies. Some specific contexts relevant to the university setting are described below.

Figure 2 – Upstream and downstream determinants of population health



Source: Institute of Medicine. 2000. *Promoting Health: Intervention Strategies from Social and Behavioral Research*. Washington, DC: The National Academies Press.

As mentioned previously, age is a critical context. Most lifetime mental illnesses have their first onset by an individual's mid-20s (Kessler et al., 2007), placing college-age students at very high risk for first onset of symptoms or diagnosis. Suicide risk is high in this age group, and in addition to being impulsive, young individuals tend to be more vulnerable to contagion after exposure to suicide within their community (Insel & Gould, 2008).

The type of academic institution is also an important context: Mental health problems are more prevalent at (a) large academic institutions, (b) public academic institutions, and (c) schools with a high proportion of nonresidential students (Lipson et al., 2015). These are also the characteristics of academic institutions with the lowest treatment utilization rates. In addition, lower treatment utilization rates are associated with lower graduation rates (Ibid.).

Gender and sexual orientation are important considerations for mental health vulnerability. Prevalence rates for major depression, anxiety, and any mental health problem are higher among women than men, highlighting the need for specific outreach or service strategies for female students. Importantly, bisexual, gay/lesbian, and transgender students have greater odds of having mental health problems than heterosexual and cisgender students based on national data (Eisenberg et al., 2013). Reports from our own JHU students revealed similar themes (see section on the JHU student survey, page 23).

Risk for certain symptoms and conditions also varies by race/ethnicity. In a mental health survey across American colleges and universities, all racial/ethnic minority groups had 30 to 70 percent greater odds for screening positive for depression relative to white students. Depression was higher among Asian (22 percent), black (19.7 percent), Hispanic (22.2 percent), and multiracial students (21.8 percent) compared to white students (14.9 percent). Mental health problems were also reported to affect academic performance for more days per month for black, Hispanic, and multiracial students compared to Asian and white students (Ibid.).

Mental health challenges commonly co-occur, such that students with behavioral health and existing psychiatric conditions are at greater risk for additional mental health issues. For example, students with addiction problems are more likely to need mental health services and experience mental illness symptoms. This is a significant proportion of college students. In a national survey of U.S. college students, 18 to 20 percent met the criteria for an alcohol use disorder (Slutske, 2005; Blanco et al., 2008). Students with depression are also more likely to have symptoms of anxiety, to report nonsuicidal self-injury, and to have at least one co-occurring mental health problem.

First-generation college students are also at high risk. There is a growing number of first-generation students on college campuses (Stebbleton and Soria, 2012), and they are more likely to be older, immigrant, nonnative English speakers, and single parents. They are also more likely to come from racial/ethnic minority backgrounds, be low-income, receive little or no financial support from their parents, and live off campus compared to non-first-generation college students (Bui, 2002; Engle & Tinto, 2008). Data suggest that first-generation college students have significant counseling and mental health needs but have greater difficulty accessing these services because they are more likely to live off campus and juggle multiple competing responsibilities unrelated to school.



Other contextual considerations include family and financial strains. The majority of students use loans to pay for college. Students with financial struggles, both current and in the past, have a greater risk for depression (Eisenberg et al., 2013). Also of note, students who grew up in rich or more affluent homes report higher frequency of anxiety than those who grew up in “comfortable” financial circumstances (Ibid.).

Finally, risks associated with personal safety are a factor. Trauma experience, including exposure to violence such as sexual assault, interpersonal violence, gun violence, muggings, etc., increases fear and anxiety and is related to depression and post-traumatic stress disorder. Students who have experienced violence should be an important focus of outreach and service efforts for student mental health and well-being.

Based on evidence from published work as well as student and faculty experiences gathered by the task force, recommendations, particularly Recommendation 1, include paying specific attention to students in these high-risk groups through outreach efforts, training, and services provision (see Recommendations 1.a [create a standing JHU Mental Health Committee that includes deans for diversity and inclusion and a representative from Student Disability Services], 1.b.2 [develop and implement frequent cultural messaging across JHU and within divisions that promotes mental health and wellness], 1.b.3 [coordinate with diversity officers to tailor communication for student populations at higher risk for mental health challenges], and 1.b.5 [develop and disseminate JHU-wide protocols and best practices, in consultation with corporate security and mental health providers, for appropriately following up with and supporting victims of crime]).

## JHU Student Population

Johns Hopkins is a highly decentralized university with students in nine academic divisions and campuses located in Baltimore; Montgomery County, MD; Washington, DC; Nanjing, China; and Bologna, Italy. Students learn across more than 260 available programs in the arts and music, the humanities, the social and natural sciences, engineering, international studies, education, business, and the health professions.

There were approximately 22,800 students enrolled in programs across the university in 2016. Although the majority of students in most divisions are from the United States, a large proportion of students are from China, India, Canada, and South Korea, with small proportions from many other countries. The proportions differ by program and division. Most of the background information provided here does not specifically cover online students, postdoctoral fellows, or medical residents (who are in transition from being labeled as students to being employees per federal designation changes), but our recommendations are generally applicable to these populations as well.

As mentioned above, symptoms and illness are highly context-dependent. Consideration of JHU initiatives and responses to improve the mental health and wellness of its students should include multiple factors, such as division, program of study, gender, race, sexual orientation, disability or current mental health treatment status, country of origin, and geographic proximity to family, among many others.



## Mental Health Services at JHU

There are three main sources of mental health-related services at JHU. These are the Johns Hopkins Student Assistance Program (JHSAP), the Counseling Center, and the University Health Services Mental Health Clinic (UHS-MH). Detailed descriptions of mission, students covered, services provided, utilization, and management are provided in Appendix B. Table 4 shows essential elements of information across the three entities.

The task force learned that many faculty, staff, and students are not aware of, or do not have accurate information about, the types of mental health services available at the university and the eligibility requirements to be seen by each provider. In fact, a chart like the one above did not previously exist. The task force process also highlighted gaps in coverage. For example, several divisions are not covered by JHSAP, and different services are provided on the East Baltimore and Homewood campuses. We found a clear need for a universitywide communications strategy to explain available mental health resources and reduce the stigma of seeking out counseling. The task force recommends developing and maintaining an easily navigated JHU-wide website that

**Table 4. Populations served and services provided at JHSAP, the Counseling Center, and UHS-MH**

	JHSAP	COUNSELING CENTER	UHS-MH
<b>POPULATIONS SERVED:</b>			
Schools and programs served	SOM/SON/BSPH/CBS/EP/SOE/SAIS	KSAS/WSE/Peabody	SOM/BSPH/SON
Undergraduate students		Yes	
Graduate students	Yes	Yes	Yes
Fellows (Doctoral)	Yes/FASAP		Yes
Fellows (Medical)	Yes/FASAP		Yes
JHH and Bayview house staff	Yes/FASAP		Yes
Faculty	Yes/FASAP		
Staff	Yes/FASAP		
Family members	Yes (living in household)		Adult dependents if enrolled in SHP
<b>SERVICES:</b>			
Individual counseling	Yes	Yes	Yes
Couples counseling	Yes	Yes (if both students)	
Group counseling		Yes	
Primary prevention/outreach	Yes	Yes	Yes
Daytime walk-in/crisis	Yes	Yes	Case by case
After-hours crisis coverage	Yes	Yes	Yes
Referral assistance	Yes	Yes	Yes
Days and times of normal operations	M, T, Th: 8:30-7:00	M, Th: 8:30-6:00; T, W, F: 8:30-5:00 (academic year)	M-F: 8:00-5:00 (exceptions may occur by certain providers on a case-by-case basis)
	W, F 8:30-5:00	M-F: 8:30-5:00 (between semesters)	

provides much needed clarity on what to expect from each provider and would serve as a central hub of information for students, faculty, staff, and families (Recommendation 1.b.1).

**JHSAP's** primary mission is to provide crisis response, short-term counseling, life-coaching support, educational workshops, and awareness events related to mental health and wellness for graduate students who are not in regular mental health treatment (see Appendix B.1 for more details). To meet clinical demands, the university combines support for both the faculty/staff assistance program (FASAP) and students (JHSAP) to deliver clinical services. Programmatically, JHSAP operates as a distinct entity.

In fiscal year 2017, JHSAP served 643 students with 2,111 direct service counseling hours. This is in addition to 24/7 on-call services, consultation services, and outreach programming in excess of 1,700 hours annually. JHSAP places a priority on providing students with an in-person appointment within three business days, and it achieved this goal more than 80 percent of the time in fiscal years 2016 and 2017. However, the task force found that with JHSAP's administrative and professional staffing levels, it is currently working at capacity and is not in a position to meet a growing need for mental health services and outreach programs.

Therefore, the task force identified an immediate need to increase staffing at JHSAP to assist in service delivery and provide a more clear delineation between counselors who serve students and those who serve faculty/staff. Student responses call for JHSAP to expand the depth and breadth of its services, but with only two full-time equivalents, it lacks the staff support to do so (see Table 5). Additionally, there is a particular need for JHSAP to add a psychiatric provider, particularly to serve the Washington, D.C. area more effectively.

**Table 5. Staffing and basic service statistics at JHSAP, the Counseling Center, and UHS-MH**

	JHSAP	COUNSELING CENTER	UHS-MH
<b>STAFFING:</b>			
Therapists FTE	2.1	10	3.75
Psychiatrists FTE	Consultant on retainer	1.4	1.54
Administrative staff FTE	0.4	3	2
<b>BASIC SERVICE STATISTICS:</b>			
Approximate # of eligible students	12,841	8,000	5,976
# of students receiving clinical services (2014-15)	643 (doesn't count outreach; indiv only)	1307	709
Average number of counseling/therapy sessions per client	2	6.1	7.69
Average number of psychiatry sessions	N/A	4	4.48
Average number of sessions combined	N/A	7.2	9.31

**The Counseling Center** provides individual counseling (short-term oriented with an average of six sessions per client but with no specified session limit); group counseling (including general psychotherapy groups, identity-focused support groups such as an LGBTQ support group, and groups focused on particular presenting concerns such as eating disorders and substance abuse); consultation to students, faculty, and staff regarding students of concern; and on-site psychiatric assessment and medication management. The Counseling Center also provides psycho-educational, skills-based workshops on topics such as anxiety/stress management and coping with difficult emotions, as well as training for professional and student staff, such as QPR gatekeeper suicide prevention training. Both JHSAP and the Counseling Center provide referrals for care that is beyond the scope of their services.

The Counseling Center provided services to approximately 1,400 students in 2016–17, and the numbers are growing each year. It is important to note that other institutions with similar student population sizes saw an average of 678 students last year. The Counseling Center provided 8,214 individual sessions to students in 2016–17, compared to 3,376 individual sessions at similarly sized institutions. The average wait time for a first appointment last year was six to seven business days (compared to a national average of seven business days). Counseling Center service utilization by diverse groups generally reflects the proportion of the general student body, and this is consistent with national utilization trends. The number of students seen, number of encounters, hours of service provision, and other utilization statistics can be found in Appendix B.2.

The Counseling Center includes a staff of in-house psychiatrists (nationally, 61 percent of schools reported that psychiatric services are offered on their campuses, of which 36.3 percent were housed in a counseling center). It does not have any satellite service locations, but staff provide workshops, group sessions, and trainings at locations around campus. Similar to a little more than half of counseling centers nationwide, the Counseling Center offers hours outside normal business hours. Beginning fall 2017, the Counseling Center is open from 8:30 a.m. to 6 p.m. Monday through Thursday and on Friday from 8:30 a.m. to 5 p.m. The Counseling Center has long provided after-hours on-call coverage, and it has recently contracted with ProtoCall Services Inc. to provide these services with a Counseling Center staff member as backup. Nationally, 28 percent of schools contract with an after-hours on-call service, and 85 percent of those contract with ProtoCall.

**University Health Services–Mental Health (UHS–MH)** is located on the East Baltimore medical campus. UHS–MH provides confidential outpatient mental health services including psychiatric assessment, medication evaluation and management, and individual goal-oriented short term therapy. Long term therapy is available if medically indicated. The program provides care and treatment to students with a wide range of mental health concerns including management of chronic and complex psychiatric conditions.

UHS–MH serves as an advocate for learners. The program is geared toward students and trainees who are facing mental health needs or crisis resulting in impairment and its goal is to help them resolve that crisis and return to their usual level of functioning.

UHS–MH offers same-day phone triage appointments with licensed clinicians who conduct a preliminary assessment of the student's needs. Following triage, students are scheduled for an in-person intake appointment with a psychiatrist, psychotherapist, or both as nec-

essary, anywhere from a same-day to a two-week time frame depending on the urgency of the situation. In order to meet patients' individual needs, clinicians often flex their schedules and make early morning and evening appointments available. UHS-MH offers 24/7 on call service with a psychiatrist, as well as crisis response and assistance with hospitalizations.

Conditions outside the scope of practice are referred externally. UHS-MH staff provide assistance with identifying and connecting students to outside resources on campus or in the community.

In fiscal year 2017, the program provided 6,669 individual patient visits, where 4,459 (67 percent) of them were therapy visits, and 2,210 (33 percent) psychiatry visits. Further utilization statistics can be found in Appendix B.3.

The task force found there is often confusion among students and staff regarding the different services provided at JHSAP and UHS-MH. We received multiple reports of students being frustrated after waiting for an appointment at JHSAP only to be referred to UHS-MH or an outside provider for the type of care they were seeking. Recommendation 2.a.1 calls for better coordination and communication with students, faculty, and staff to ensure students are referred appropriately to avoid creating additional distress. In addition, the task force found that students on campuses other than Homewood and East Baltimore, particularly at Peabody, the Carey Business School, and SAIS, find it difficult to access services. Therefore, Recommendation 2.d calls for dedicated counselors assigned to visit each campus, in coordination with the divisions, for a minimum of eight to 16 hours per week to ensure students have a better opportunity to receive care.

With a growing increase in demand for services, the task force recommends the university conduct a broad analysis of staffing levels at service providers and examine the mental health coverage structure across the institution in order to ensure students have timely access to care, identify potential gaps in coverage, and ensure optimal operational efficiencies across the institution. In addition to recommending additional staff support for JHSAP, the task force recommends hiring a clinical practice analyst that would be shared by the Counseling Center and UHS-MH to provide data analysis and quality improvement projects on an ongoing basis to keep up with evolving standards and improve workflow practices (Recommendation 2.b.1).

It is important to note that the missions and services provided by each of the mental health provider offices at JHU are very different from one another, and there are significant differences among the populations served by each office. This is perhaps especially true of the difference between JHSAP and UHS-MH, on the one hand, and the Counseling Center, on the other. The Counseling Center, which is designed to provide a wide range of services to a largely undergraduate population (70 percent of clients are undergraduate students), is more easily and logically compared to the national counseling center data presented below.

The task force finds that the mental health services provided at the Counseling Center are consistent with those on other college campuses, and the quality of care is generally viewed as helpful. However, the increasing number of students seeking care in recent years calls for the university to be proactive in ensuring that organizational structures are optimal and staffing levels keep pace with the change in demand.

**National Trends in University Mental Health Services:** In the Association for University and College Counseling Center Directors 2015 Annual Survey, 61 percent reported that psychiatric services are offered on their campuses, of which 36.3 percent were housed in a counseling center (Reetz et al., 2016). Twenty-eight percent of directors reported their centers were administratively integrated with a health service. Most provide personal and group counseling, consults, workshops, and suicide prevention. Only one-fifth to one-fourth of the centers provided testing or assessments of mental health conditions (Ibid.). Few had some form of tele-psychology, with 9.1 percent offering this service, up from 6.6 percent the prior year.

The full list of types of services and proportion of centers providing each service is provided in Appendix C. A little less than half of counseling centers nationally do not offer services outside the normal 8 a.m. to 5 p.m. hours. Among those that do, there is an approximately equal spread across how many days per week extended hours are offered (Ibid.).

Overall, 29 percent of students reported attending counseling while in college in 2015, though this figure was higher among females and transgender students (CCMH, 2016). Service utilization by diverse groups was generally proportional to that of the general student body, as it had been in previous years. Notable deviations between counseling client and student body demographics include male (33.7 percent among clients, but 42.7 percent overall), student athletes (9.3 percent versus 14.1 percent) and Greek affiliated (8.9 percent versus 11.1 percent) (Reetz et al., 2016). Nonwhite students were less likely to use services, as were males, international students, married students, off-campus residents, graduate students, and self-identified “religious” students. Students of older ages are more likely to use services, as are LGBTQ students and students with a higher number of mental health symptoms (Hunt et al., 2015). The average number of sessions per client is between five and six, although this is right-skewed; the most common number of appointments per client per year is one (Reetz et al., 2016). Twenty percent of clients account for more than 50 percent of appointments. Approximately half of the centers place a limit on the number of counseling session allowed per student, though that number is flexible in many cases (Ibid.). The average wait time for a first appointment is approximately seven business days. On average, 24.4 percent of students take a prescribed medication for a mental health concern during college, and of students seeking counseling services, 26 percent take psychotropic medications. Approximately 10 percent of students in 2015 were hospitalized at least once for mental health concerns; 18 percent among transgender students (CCMH, 2016).

**JHU Disability Services:** Each division provides disability services that are managed somewhat similarly, though the specific names and types of leadership responsible for providing and overseeing services vary. Each division has a designated disability coordinator who is responsible for meeting students’ disability-related needs. As an example, the Office for Student Disability Services (SDS) on the Homewood campus assists the university regarding disability accommodations for full-time undergraduate and graduate students in the Krieger School of Arts and Sciences and the Whiting School of Engineering. It provides, among other things, advice for prospective students, current students, and parents on the services available to students with disabilities at JHU; assistance with SDS’ registration process and review of documentation required for the authorization of any requested accommodations; and provision of all authorized accommodations. Specific to mental health services, SDS provides mentoring to address both personal and academic issues throughout students’ matriculation. SDS employs a graduate assistant who

offers advice on time and stress management on a one-on-one basis, and advises the SDS Student Advisory Board. The advisory board can be a source of support and social interaction for students with disabilities and serve as a vehicle for advocacy and awareness efforts on and off campus.

The task force found, through focus groups and student surveys, that many students and faculty have limited awareness about whom to contact and what services are available through disability services. Some students reported that faculty members used different policies with respect to granting testing accommodations, a practice that creates additional confusion. Other students reported difficulty obtaining a new diagnosis or documenting existing diagnoses, including high costs associated with testing, that would allow them to qualify for disability services. This creates further stress on the students and is a barrier to getting services that could maximize their academic experience and minimize negative mental health outcomes.

As noted in Recommendation 2.f.3, the task force recognizes the need for easier access to disability services in each division, better transparency about what is available from SDS, and available assessment opportunities to help disabled students qualify for services. We also recommend the university investigate the possibility of contracting with a single source provider to find an affordable arrangement for students who may need updated documentation.

**Additional Sources of Support Across JHU Related to Mental Health Services:** The task force recognized many additional sources of mental health and wellness support for students besides mental health providers, but noted that many of these organizations are not integrated or even aware of each other and that they arise from different mechanisms. On the Homewood Campus, the Center for Health Education and Wellness (CHEW) is the promotional arm of the Student Health and Wellness Center. CHEW provides health education programming and services to undergraduate and graduate students, with an emphasis on the prevention of illness and risk reduction practices. CHEW consists of professional staff and students that offer a variety of programs that support and affirm student health and wellness.

Additionally, University Health Services established the Office of Wellness and Health Promotion (UHS Wellness) on the East Baltimore campus in early 2017. The mission of the office is to enrich the experience of students and trainees in East Baltimore by creating a “home” for wellness, developing new wellness programming, connecting learners with beneficial resources and services across the university, and fostering an environment that supports multiple dimensions of health—including physical, emotional, intellectual, interpersonal, community, and financial well-being. UHS Wellness is currently focused on building and implementing a strategic program to coordinate East Baltimore wellness efforts for students and trainees. The office is also partnering with other wellness champions across the university to maximize impact.

Other sources of support are run by student government or affiliated with JHU service centers (e.g., A Place to Talk). Some student groups are chapters of national organizations (e.g., Active Minds), and some are grass-roots efforts of specific student groups (e.g., Stressbusters, Yesplus, SWI). Examples of these student groups are listed in Appendix D.

The task force recognizes the critical value of these organizations across the university, but calls for an increase in university-facilitated connections to fully utilize their mental health support

potential (Recommendation 1.d). In addition, we found a lack of JHU staff dedicated specifically to health education and wellness. For example, CHEW currently has only three full-time staff members, which limits potential opportunities for proactive educational campaigns and targeted outreach. Additionally, UHS Wellness has just one full-time staff member. Therefore, we recommend that JHU increase resources to support health and wellness programming (see Recommendation 1.c.8). Additional staff in this area will also be critical to the successful implementation of many of the recommendations in this report.

The task force also examined the various strategies currently used across divisions to inform students about available mental health services. Some programs include information about JHSAP and other resources on websites that students are directed to browse prior to orientation/arrival on campus. Beyond orientation and outreach efforts by JHSAP and the Counseling Center, the task force found communications to be limited, difficult to find, and not coordinated. This finding, in concert with consistent reports from faculty, staff, and students about a lack of awareness and information, led the task force to Recommendation 1.b: that the university develop a specific communications strategy with oversight by the Student Mental Health Committee that covers broad areas of awareness, health education, and service access and includes an easily discovered and navigable website, to quickly locate available programming and mental health student groups across the university.

## JHU Student Mental Health Survey

### Key points:

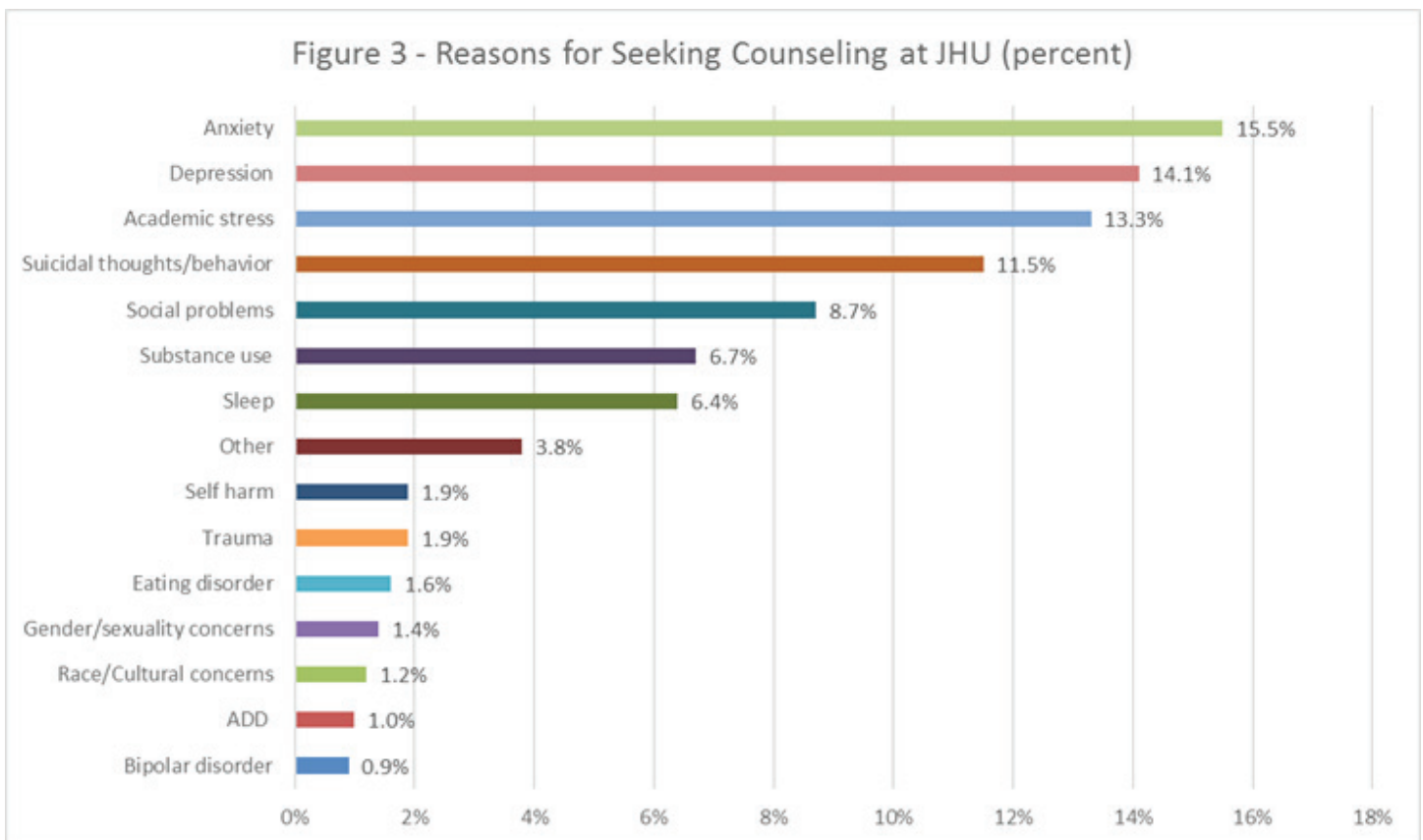
- Response rate was similar across divisions, but low at 14 percent, so representativeness cannot be assured.
- Depression, anxiety, stress due to academics, suicidal thoughts and behaviors, social problems, and sleep problems were frequently reported by students who had sought counseling across divisions and programs
- Specific student populations, such as racial, gender, and sexual minorities as well as students with disabilities, reported higher levels of symptoms, different barriers to care, and important connections between mental health and cultural sensitivity on campus in both quantitative and qualitative data.
- LGBTQ students, students with existing mental health conditions, and female students reported the highest levels of depression and anxiety on campus.
- While students reported general satisfaction with quality of care across service providers, specific areas of concern were confusion about types of services provided and the expectations created by that confusion, the need for flexibility of services, and the timeliness of response and availability of service hours.
- Major barriers to care seeking include limited knowledge of services and how to access them, challenges of scheduling, and denial about need for treatment or belief that treatment will not help.



The task force distributed an online survey in September 2016 via an email from the vice provost for student affairs to registered students across all divisions that host on-campus courses, excluding first-year students and transfer students. These populations were not included because service delivery at JHU was a focus of many of the questions. The survey collected both quantitative and qualitative data regarding the student experience. The email soliciting feedback from students and the survey questions can be found in Appendix E. In order to encourage participation, \$20 Visa gift cards were offered to 100 randomly selected students who completed the survey. Two of the student members of the task force analyzed and summarized the results. Their full analysis and results are available in Appendix F. Out of approximately 16,014 total students surveyed, 2,260, or 14.1 percent, submitted responses. While results of this survey may not be representative of the entire JHU student population, they nonetheless reflect important issues and needs as reported below.

The task force recommends that regular surveys of the student population should be carried out by a standing student mental health committee in consultation and cooperation with divisions (Recommendation 1.a).

General themes resulting from the open comments section of the survey touched on many issues. The most frequent themes included a “toxic culture,” stress, need for awareness of and access to resources, lack of faculty literacy about mental health, and stigma associated with seeking professional care. These comments also had common themes suggesting that while many students found existing services to be beneficial, adequacy of staffing and quality of individual services were at times concerning. Results of quantitative survey questions and qualitative themes emerging from the survey are described below.





**Symptoms among students seeking counseling:** In general, issues and concerns identified were consistent across university divisions. In line with national and JHU data presented above, anxiety and depression were the two most common mental health conditions reported by students who sought treatment at JHU, with stress due to academics, suicidal thoughts and behaviors, social problems, and sleep problems also being frequently reported (Figure 3). Many students reported being treated for these conditions and symptoms prior to JHU (see Appendix F, Figure F3).

A striking proportion of respondents reported feeling overwhelmed or depressed in the last year to an extent that made it difficult to function. This varied by demographic group, with the highest reports among LGBTQ students, students who had previously been treated for a mental health condition, and female students (Appendix F, Table F10 and Figure F4). Other symptoms varied by racial group. African-American and multiracial students were more likely to report feeling overwhelmed or depressed, and American Indian individuals were more likely to report feeling anxious and having sleep issues. Multiracial individuals were more likely to report depression, social concerns such as loneliness or isolation, and substance use disorder treatment or substance misuse. The distributions of these symptoms by race are summarized in Appendix F, Table F11.

While the survey did not attempt to systematically oversample specific subpopulations, answers to the survey's open-ended questions made it clear that special populations should be surveyed in greater depth to understand the challenges they face and how to better support them. The quotes below speak to issues of stigma, disability, and violence against racial and sexual minorities.

*I don't feel like I could email a professor and say 'I can't come to class today because my depression is flaring up'...having a more open dialogue between professors and students about the validity of mental illness would help to legitimize the issues many students experience.*

*I didn't know where/what the JHU services were...I was afraid I wouldn't be able to afford it.*

*They need to be better trained in LGBTQ issues.*

*We need to create a culture on campus where people can openly talk about mental health and rape culture.*

*I wish someone had told me about Student Disability Services and how to document my mental health issues...my life would have been easier.*

*There needs to be more attention placed on intersectional identities...having more counselors who are representative of minority students...can meet the needs of students facing more than one facet of oppression.... A lot of faculty members do not understand my experience or current events that may affect my general ability to concentrate, focus, and perform well in my classes...[issues of police brutality, violence against QTPOC across the country, and general xenophobia]... if I told anyone, they would throw me into the hospital involuntarily.*

As previously stated, given this information, the experiences of the task force members, and national data, the task force recommends in multiple places that special attention be paid to particular subpopulations of students who would benefit from prevention interventions, health education, and increased outreach, and that diversity offices and organizations within the universi-

ty be directly engaged with mental health communication and oversight at the university level. Mental health service providers should take steps to ensure their counselors are representative of the diverse populations on campus, with particular attention to addressing the needs of the LGBTQ community, students with existing mental health conditions, female students, and racial minorities.

**Sources of stress:** Graduate, professional, and undergraduate students differed in terms of the types of stressors (Figure 4) they reported. Course workload, consideration of future plans, and other commitments were among the highest sources of stress in all groups.

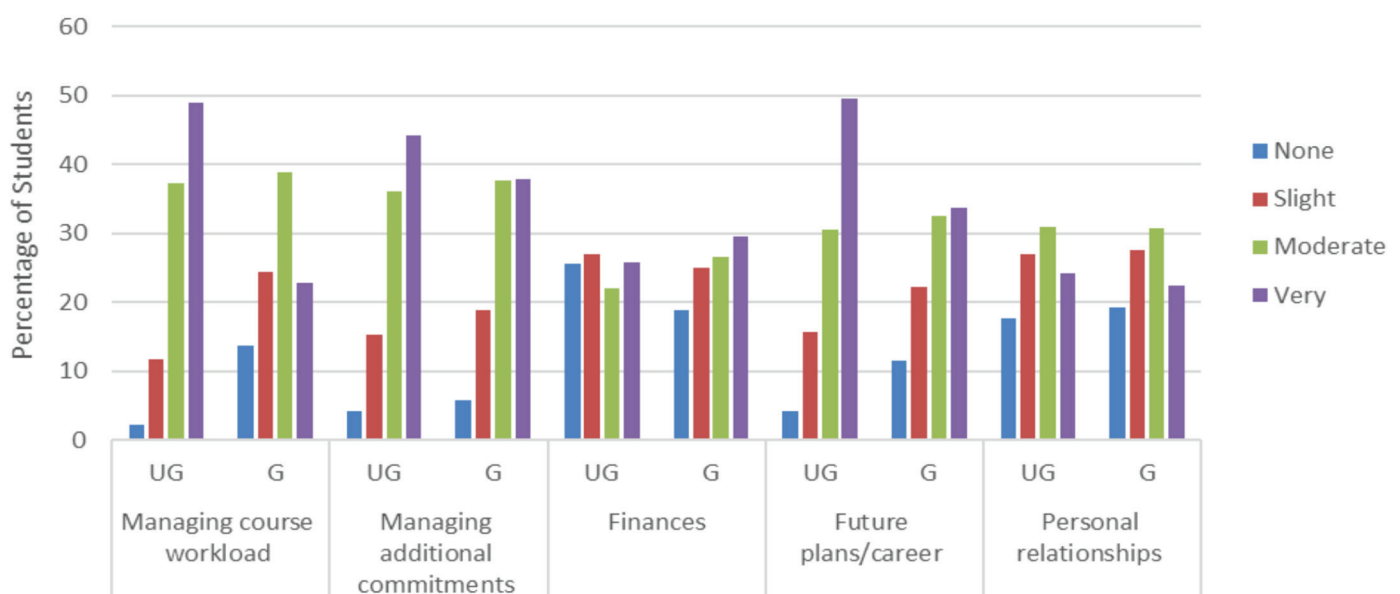
Some stressors, such as doctoral research deadlines, were not queried but were reported by students in answers to the open-ended questions, indicating that future surveys should gather quantitative data on these issues in order to better understand challenges. In qualitative responses, several students indicated a desire for more opportunities to interact within the student community that were not directly tied to academics or parties centered around drinking alcohol. For example:

*An emphasis on community—it would be really wonderful to have a student center where we could hang out...a central place for students to just go and relax or decompress...not the library.*

*This school often feels like a pressure cooker...there is a common perception among graduate students that one needs to eat/sleep/breathe one's research.*

Given comments like this and national data reporting loneliness as a common symptom among college students related to mental health, the task force recommends that JHU provide more opportunities for student socialization, including physical spaces for social gathering (Recommendation 1.e).

**Figure 4 - How stressful were the following during the prior academic year?**



**Timing of vulnerability:** Not surprisingly, midterm and final exams were the most reported times of high stress (Table 6). Several students commented on the challenges of having multiple exams in one day and lack of coordination by program or across faculty to accommodate this type of exam saturation. The beginning of the academic year was also frequently cited. These results inform multiple task force recommendations regarding the importance of increasing awareness about mental health resources for new students during orientation (Recommendation 1.b.2) and in course syllabi (Recommendation 1.c.5), as well as attention to student mental health during academic calendaring and exam planning (Recommendation 1.c.6). It also informed timing recommendations for health promotion campaigns at the beginning of each semester (Recommendation 1.b.2).

**Table 6. Times of highest stress level during academic year (%)**

Time	Overall	Among grad students	Among professional students	Among undergrad students
Beginning of new academic year	25%	27%	23%	22%
During mid-term exams	43%	27%	32%	66%
During final exams	57%	55%	60%	59%
Other	18%	23%	17%	11%

**Quality of support services and barriers to treatment:** Among students who sought services at JHU in the last year (n=516, 22.8 percent), a majority reported high-quality care (Table 7). Of the main sample, about a third of students responded that they wanted immediate or short-term support (Table 8), which is what our service providers can offer. Importantly, over half reported wanting long-term care, which is not typically available through our service models.

**Table 7. Perception of quality of care across schools among students who have used JHU services (%)**

	CBS	KSAS	Peabody	SAIS	SOE	SOM	SON	SPH	WSE
Quality of care good or very good	33.3%	60.5%	78.6%	58.3%	66.7%	71.7%	66.7%	68.2%	66.2%
Felt understood by counselor	75%	69.6%	78.6%	36.4%	50%	78%	72.2%	74.2%	71.4%
Given flexibility to change counselors	50%	60.5%	44.4%	20%	50%	41.7%	41.7%	57.4%	56.1%

Note: Sample size varied by question; percentages represent proportion of “yes” responses among students who answered “yes,” “no,” or “unsure.”

**Table 8. Support duration desired from service providers across schools (%)**

	<b>CBS n=85</b>	<b>KSAS n=674</b>	<b>Peabody n=59</b>	<b>SAIS n=90</b>	<b>SOE n=127</b>	<b>SOM n=182</b>	<b>SON n=56</b>	<b>SPH n=327</b>	<b>WSE n=545</b>
<b>Want immediate support</b>	23.5%	38.3%	42.2%	30.1%	19.7%	35.7%	30.4%	35.5%	30.1%
<b>Want short term support</b>	27.1%	34.3%	37.8%	30.3%	28.3%	39%	35.7%	34.6%	30.3%
<b>Want long term support</b>	34.1%	59.3%	37.8%	42.9%	39.4%	59.3%	48.2%	56.3%	42.9%

Qualitative analysis revealed a more nuanced student experience. While many students expressed very positive statements, others did not believe their needs had been met. Selected quotes found in Appendix F, Box F1, illustrate key ongoing issues regarding the need for increased flexibility of service providers, clearer explanation of services, and ensuring prompt service responsiveness.

The reasons for not scheduling a mental health appointment at JHU were, in order of frequency, issues with scheduling, perception that treatment will not help, denial about needing treatment, the long wait between making an appointment and being seen, and privacy concerns (Appendix F, Figure F7). Responses were similar across students receiving care from each of the three main JHU service providers. Further, qualitative feedback highlighted limited knowledge of services as an important barrier. With respect to sources of knowledge, students felt that orientation, RAs, and Student Affairs were either slightly helpful or not helpful in providing information about available resources to address mental health concerns (see Appendix F, Figure F8).

These responses, and discussion among the task force members, led to recommendations regarding improved communication of services in multiple venues (Recommendation 1.b) and via better training of faculty and staff (Recommendations 3.a, 3.b). The task force also made recommendations to specifically improve the availability and quality of care (Recommendation 2).

**Crises and co-occurring conditions:** Nearly 30 percent of undergraduates, about 25 percent of professional students, and over 15 percent of graduate students reported having seriously considered suicide (Appendix F, Figure F9). Furthermore, 1 percent to 4 percent of students reported experiencing a trauma, 13 percent to 23 percent reported substance abuse treatment or misuse of prescription drugs, and 15 percent to 22 percent of students would be considered high-risk based on a constellation of co-occurring conditions and risk factors. Specific experiences provided in response to the survey (see Appendix F, Box F4) revealed mixed experiences of students during crisis situations; some were very satisfied with the immediate help provided while others felt they were not taken seriously or were directed to inappropriate services.

Given the frequency of high-risk situations among students, the task force believes there is a crucial need for crisis and emergency response systems. Recommendation 1.b.4 is to develop and disseminate JHU-wide protocols and best practices on crisis and suicide responses. Recommendation 2.a.2 is that service providers should develop a coordinated plan to provide additional support in the event of an emergency or traumatic event to prepare for a sudden increase in

demand. Recommendation 2.f.2 is to ensure that policies and protocols for responding to students in distress are consistent with a climate that supports and promotes mental health.

**Students' recommendations and positive feedback:** When asked directly, the majority of respondents (52 percent) agreed that a more open dialogue about student mental health on campus would be beneficial toward improving student mental health at JHU. Many respondents also endorsed increasing access to mental health services (44 percent), having more opportunities to socialize (36 percent), and having student support groups for specific concerns (23 percent). The quantitative data reflected that the majority of students were satisfied with the care they received; but much of the free text responses highlighted challenges or critiques. It is also important to note that many students reported extremely positive experiences with the JHU mental health system in their free text. A few examples are listed below.

*I have had very positive experiences with the mental health care at JHU...the therapist at the Counseling Center truly saved my life.*

*I tried medication...it worked well...my psychiatrists have been very responsive...my counselor was excellent.*

*I can't thank UMH enough for the support that I received and for improving my quality of life.*

## Policies Relevant to Student Mental Health

**Insurance Policies:** As described in early sections, students can seek services at JHSAP, the Counseling Center, and UHS-MH when eligible. These services do not require student insurance coverage since they reflect care provided directly through university mechanisms. However, many mental and behavioral health needs of students, in addition to physical health needs, are outside the scope of university mechanisms and require additional care.

All full-time registered domestic students are required to purchase the Student Health Benefit Plan unless proof of comparable coverage is furnished. All international students are required to enroll in the Student Health Benefit Plan. All students enrolled in part-time programs, non-resident graduate students, and graduate study abroad students are also eligible to enroll in the Student Health Benefit Plan. Details of plans offered are in Table 9 below. The task force noted that the costs, deductibles, and coverage are different by campus. This is partly to accommodate the different reproductive health needs of an older East Baltimore campus student body; however, mental health care coverage is also different across the groups. The table below does not reflect the particular providers included in network for each plan, which is a source of consternation reported by task force members and students, since many co-located providers at Hopkins are not covered by these plans as in-network. For example, none of the outpatient or inpatient departments within the Department of Psychiatry accepts Cigna insurance, which includes the CHP student insurance plan. These services are considered "out of network," resulting in much higher out-of-pocket costs that are out of reach for many students and their families. In addition, task force members reported inconsistency in referral benefits: if covered students first seek treatment at a JHU service entity, their deductible can be reduced if they obtain a referral to an outside provider. However, this benefit appears, based on anecdotes, to be implemented inconsistently.

The landscape of available plans and the discrepancy between coverage offered to students led the task force to recommend a review of coverage plans and waiver policies across the university to ensure inpatient, outpatient, and pharmaceutical coverage are not overly financially burdensome, are readily accessible, and are consistent among the schools wherever possible (see Recommendation 2.c).

Table 9. Review of mental health offerings in student health plans				
Provisions	East Baltimore Student Plan		Homewood Student Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Eligibility</b>	Full time School of Medicine, School of Public Health, or School of Nursing student, a Johns Hopkins Hospital and Bayview Hospital house officer or a postdoctoral fellow		Full time students of the Homewood school divisions - Krieger Schools of Arts & Sciences, Whiting School of Engineering, Carey Business School, School of Education, SAIS, and Peabody	
<b>Provider</b>	EHP		CHP	
<b>Historical provider</b>	EHP		Cigna	
<b>Deductible</b>	\$150/\$450		\$250/\$500	
<b>Out-of-pocket maximum</b>	<b>For Medical</b> Family: <b>\$9,000</b>  <b>For Pharmacy</b> Family: <b>\$3,700</b>	Individual: <b>\$3,000 /</b>  Individual: <b>\$3,350 /</b>	Individual: <b>\$5,250</b> Family: <b>\$12,700</b>	Individual: <b>\$7,750</b> Family: <b>N/A</b>
<b>Inpatient mental health – facility</b>	100% of allowed amount for first 30 days, then 80% of allowed amount; deductible applies (pre-auth. required)	100% of R&C for first 30 days, then 80% of R&C; deductible applies (pre-auth. required)	80% of preferred allowance	64% of R&C
<b>Inpatient mental health – prof. srv.</b>	80% of allowed amount; deductible applies	80% of R&C; deductible applies	80% of preferred allowance	64% of R&C
<b>Outpatient mental health – facility &amp; prof. srv.</b>	90% of allowed amount; deductible applies	90% of R&C; deductible applies	80% of preferred allowance	64% of R&C
<b>Inpatient substance abuse care – facility</b>	100% of allowed amount for first 30 days, then 80% of allowed amount; deductible applies (pre-auth. required)	100% of R&C for first 30 days, then 80% of R&C; deductible applies (pre-auth. required)	80% of preferred allowance	64% of R&C
<b>Inpatient substance abuse care – prof. srv.</b>	80% of allowed amount; after deductible	80% of R&C; after deductible	80% of preferred allowance	64% of R&C
<b>Outpatient substance abuse care – facility</b>	90% of allowed amount; deductible applies	90% of R&C; deductible applies	80% of preferred allowance	64% of R&C
<b>Outpatient substance abuse care – prof. srv.</b>	100% of allowed amount; deductible applies	80% of R&C; after deductible	80% of preferred allowance	64% of R&C

**Medical Leave of Absence Policies:** The task force calls on the university to be proactive in ensuring students have access to mental health counseling and treatment before a crisis or emergency situation develops. This response includes increasing awareness about available resources, providing more scheduling flexibility for students to see counselors and psychiatrists, and permitting excused absences from class during an acute mental health issue. One important goal of increasing opportunities to seek help is to get students into treatment early enough to potentially avoid the need to take a medical leave of absence (MLoA).

However, in certain instances it will be in the best interests of students to take a MLoA from school if mental health issues are significantly impacting their ability to participate in academics for an extended period of time. The decision to take leave and the process of returning to school represent sources of extreme stress for students.

We found that the MLoA policies vary significantly among the schools, including large differences in the length of time a student is eligible to be on leave. Some have intentional protocols about outreach during the MLoA and which faculty or staff should be in contact with the student or his/her family, while others have no clearly defined protocols. JHU service entities also have different policies about service eligibility during and after a MLoA. Importantly, this also affects student insurance coverage eligibility, potentially limiting their treatment options during a particularly vulnerable time. For this reason, some students reported not taking a MLoA during a mental health crisis, even when this was the best strategy for their long-term success.

In addition, many faculty, staff, and students are not familiar with their school's policy and cannot easily find information about the requirements for MLoA. It is important to make these policies accessible in order to enable informed decisions. In fact, some students may not be inclined to seek information about MLoA given the privacy issues and potential for stigma-related consequences. The task force recommends that all JHU divisions increase transparency about their MLoA policies and work closely with mental health providers to ensure continued contact with students before, during, and after taking leave to help them re-enter the university successfully with ongoing mental health support (Recommendation 1.c.7). The information provided for undergraduate students by the Office of the Dean of Student Life (<https://studentaffairs.jhu.edu/student-life/support-and-assistance/medical-leave-absence/>) could serve as an example of how to clearly describe the process for requesting leave and readmission.

**Policies for Student Death Response:** Because college-age students are vulnerable to contagion following suicide, and because peer death is naturally a traumatic experience for many students, it is important to have a student death response policy and implementation plan in place that covers any student death, including suicide. This was recommended in student responses in the survey, and also by task force members. Students and faculty reported experiences where rumors regarding a death occurrence exacerbated their negative mental health experiences. They encouraged better communication, while protecting privacy. Further, students reported experiences where other students, staff, or faculty were trying to help support students following a death but unintentionally increased stress and other negative mental health outcomes. For example, holding a "listening" session post-event without appropriate psychological counseling support and guidance is not typically advised but does occur and can cause harm. Best practices in response to a student death have been developed. For example, the American Foundation for



Suicide Prevention published a thorough guidance document titled *After a Suicide: A Toolkit for Schools*, on how to respond to a suicide.

At JHU, a student death protocol was developed for the Homewood campus in the 2015–16 academic year. The protocol was disseminated to each of the divisions so that they could use it as a template for implementation on their campuses. The policy includes crisis response, outreach and follow-up for affected students, and communication templates. Awareness and implementation of this, or another school-specific, policy does not appear to be consistent across divisions. The policy also does not directly address training of faculty, staff, or students on best practices. The task force recommends requiring a policy and implementation plan across divisions and further educating faculty and student-facing staff about that plan (Recommendation 1.b.4).

**Substance Use Policy for Homewood Undergraduate Students:** Substance use and addiction are often intertwined with mental health. The task force recognizes the additional mental health challenges faced by students with substance use issues and the increased risk for mental health outcomes related to substance use generally. In our student survey, some respondents expressed frustration that they did not know how to help their friends who were excessively drinking and using drugs, and noted that substance use typically increased in response to academic stress and declining mental health. The Counseling Center, JHSAP, and UHS-MH provide support for substance use and addiction issues, though it is not a primary theme on their websites or other advertisements of services, as noted by several students. The task force encourages service providers, and student life offices at each division, to proactively advertise available resources and support mechanisms to address substance use, and provide information on how students should appropriately respond if they have concerns about a peer’s alcohol or drug use.

The university developed an *Alcohol and Alcohol Amnesty Policy* for undergraduate students in 2015 based on recommendations from the Alcohol Strategy Working Group and its student subcommittee (see Appendix H). The document outlines progressive sanctions for violating the Student Conduct Code on alcohol and drug use, but it importantly includes an amnesty policy to encourage students to immediately seek necessary medical attention or assistance for themselves or others in emergency situations. The policy states that under specified circumstances, “the university will not impose disciplinary action for a violation of student alcohol or drug policies against individuals ... when they report to seek assistance from the university or law enforcement for a medical emergency or condition.” The task force believes it is crucial that students be made aware of this policy, particularly to encourage reports of suspected sexual assault at parties and in recognition of the rising frequency of opioid overdoses in recent years.

The task force also heard concerns from students that using punitive measures for alcohol or drug violations of the Student Conduct Code can sometimes exacerbate mental health issues or substance use for students struggling with addiction. The university recognizes that alcoholism and drug addiction are not easily resolvable by personal effort alone and may require professional assistance and/or treatment. We encourage administrators to consider rehabilitative measures, when appropriate, in response to conduct code violations to help ensure the long-term health of a student.

The task force recommends that an expert on substance use be included as a standing member of the MHC to ensure a consistent analysis of how JHU’s policies and support for students with



dependence on drugs and alcohol align with a climate that promotes mental health (Recommendation 1.a, 1.b.2).

## Mental Health Training Practices at JHU

**Faculty and Staff Training:** As mentioned, the task force found that faculty and staff were generally confused about or unaware of the available mental health service options for students, with the exception of first responders, on-call professionals, residential advisers, and health professionals. Further, many students reported disappointment with the university culture in terms of mental health awareness and experiences of stigma and discrimination. When students were asked to submit recommendations at the conclusion of the JHU Student Mental Health Survey, increased education and training on mental health literacy and student well-being was one of the most common suggestions. Students also indicated that communicating with faculty about their academic struggles as they relate to their mental health would prove less intimidating if they knew that faculty were informed or trained in some capacity.

The task force found no required trainings of faculty or staff by any school or the overall institution that were specific to mental health awareness and access to services or other resources. Once per year, the provost and senior vice president for finance and administration, in consultation with the Counseling Center and JHSAP, distribute to all faculty and staff across the university an email providing guidance on how to identify and support distressed students. This email also explains how faculty and staff should respond to a student who reports that they have been a victim of sexual assault or harassment. JHSAP, Disability Support Services, the Counseling Center, and other units consistently attend faculty meetings or hold informational panels across respective divisions to provide information on recognizing signs of distress, appropriate responses, support services available on campus, and referral processes.

When optional workshops or trainings were offered to faculty and staff, they were sparsely attended. Thus, the task force members felt strongly that changing the university culture and facilitating faculty and staff assistance in directing students to the appropriate resources will take mandatory training (Recommendation 3.a).

Ultimately, teaching faculty, academic coordinators, teaching assistants, deans of education, and other student-facing staff will better serve their respective student populations if they receive required mental health resource trainings. The content should be distributed in an online format, with various platforms under contract with the institution. Non-student-facing staff, administrators, and even families, would also benefit from workshops or trainings on various topics surrounding mental health awareness and resources. Trainings and workshops on mental health awareness, resources, and best practices can also aid in the shift to transparency and inclusivity around mental health.

**JHU Security Training:** Campus security officers are often among the first responders for a student in mental health crisis and routinely engage with students who are experiencing mental or behavioral health symptoms. A review of the current training for Johns Hopkins University Campus Security members reveals that campus police officers receive crisis response training during their initial training and follow-up training annually during the in-service training. In addition, as a part of their roll call training sessions, officers discuss and revisit multiple topics

related to mental health. While the trainings are relevant to dealing with situations that a campus police officer would encounter, a more comprehensive team-based approach to dealing with mental health and crisis intervention for our security staff members is appropriate.

The task force found that one of the most widely recognized and nationally accepted best practices for law enforcement officers for dealing with mental health crisis situations is the establishment of a crisis intervention training (CIT) program. A CIT program is a team-based approach including law enforcement officers, mental health providers, local National Alliance on Mental Illness chapters, and other community members and organizations. Law enforcement officers go through a 40-hour training program designed to help them better respond to a mental health crisis or situation. The program educates these officers on mental illnesses, behaviors, medications, and how mental illness affects those around people who live with the illness. This training helps prepare officers to respond, recognize, and react accordingly for the safety and well-being of everyone involved. On a university campus, CIT-trained officers could work with the Residential Life Office, disability services, Student Affairs, and mental health service providers to de-escalate mental health crises safely and effectively, as well as provide assistance with follow-up and future crisis plans for each situation. This collaborative approach brings the resources and expertise necessary to effectively serve the needs of the university community in this area.

In order to increase coordination among security officers and mental health staff on campus and be better prepared to respond to emergency situations, the task force recommends required mental health awareness and crisis intervention trainings for JHU security officers (Recommendation 3.b).

**Student Mental Health Training:** Results of the JHU Student Mental Health Survey show that students overwhelmingly turn to friends for support, as opposed to JHU staff or counselors, when they are particularly concerned about their mental health (Appendix F, Figure 6). Therefore, students can play a critical role in helping peers through difficult times of elevated stress or anxiety and can provide important encouragement to seek out professional assistance. However, students also reported a lack of knowledge about how to provide that help or respond to a friend in crisis.

JHU undergraduates are required to complete numerous online and in-person trainings relating to identity and inclusion, sexual assault prevention, alcohol and substance use, and bystander intervention, but there are no specific mental health-focused trainings required for students. Resident advisers on the Homewood and Peabody campuses receive tailored mental health trainings as a result of their increased level of responsibility and mandated reporter status as representatives of Homewood Student Affairs (see Table 10). These trainings could be made available to other populations and are open to those who may be interested in learning more.

There are numerous optional opportunities for students to attend workshops on mental health and wellness topics beyond this RA training. Students in organizational leadership roles are uniquely positioned to emphasize the importance of self-care, mental health awareness and resources, and general student well-being to their members and peers. Student leaders with support from administrators could gain information and develop as resources and advocates for mental health awareness on their respective campuses. Beyond student leadership, specific populations of students at times may need more adequate or specialized workshop or training

**Table 10. Counseling Center training for Residential Life resident advisers (RAs) - 2016**

<b>Training</b>	<b>Duration</b>
<b>Introduction to CC Staff and Services</b>	45 minutes
<b>Being a Helper</b>	90 minutes
<b>QPR Training - Suicide Prevention</b>	75 minutes
<b>Emotional Distress/Boundaries</b>	60 minutes
<b>Sexual Assault Prevention</b>	90 minutes
<b>Assisted in Residential Life Behind Closed Doors Role Play Training - Anxiety</b>	120 minutes
<b>Assisted in Residential Life Behind Closed Doors Role Play Training- Risk</b>	120 minutes
<b>Total</b>	<b>10 hours</b>

offerings depending on the topic or time, as mentioned in earlier sections about specific sub-populations at high risk of mental health issues. These topics, while currently offered on some campuses, could range from mental health first aid, crisis response, bystander intervention, time management, mindfulness, life planning, responsible substance use, healthy relationships, nutrition, meditation, study skills, and others based on need. These workshops or trainings are sometimes led by content experts, professional staff, outside facilitators, or students and could be structured differently depending on the school.

Recommendation 3.c calls for an increase in mental health training opportunities for students on all campuses, particularly for those in leadership positions with responsibilities to the student body. Links to training opportunities should also be included in the proposed student mental health website (Recommendation 1.b.1).

## Prevention Practices

Current prevention programs employed by JHU include the e-Checkup to Go (alcohol), e-Checkup to Go (marijuana), Brief Alcohol Screening and Intervention for College Students (BASICS) (utilized at the Center for Health Education and Wellness, which is part of Student Health), ULifeline, Mental Health First Aid (used to train APTT peer listeners), and QPR (training provided to Residential Life, SHWC, Dean of Student Life Office, case managers, Athletics, academic advisers, etc.).

Suicide prevention strategies are of critical importance for college campuses. Many suicide prevention models are available and in place across national academic settings (see Appendix H). The Counseling Center currently uses an evidence-based suicide tracking system for the assessment and management of its suicidal clients. This system incorporates the Collaborative Assessment and Management of Suicidality (CAMS) noted in Appendix H, Table 1. This approach would be considered secondary prevention, targeted to students at risk of suicide. The only suicide prevention program tailored to university adults with documented efficacy recognized by the

National Registry of Evidence-Based Programs and Practices (NREPP; <http://www.samhsa.gov/nrepp>) is problem-solving therapy, a brief psychosocial treatment for prevention of depression and depressive symptoms and promotion of personal resilience in this age group. However, other programs have shown prevention efficacy although they are not listed in NREPP or not specific to university students (Appendix H, Table 2). Of these, the Interactive Screening Program (ISP) has promise as a universal prevention program that initially reaches out to all students. The ISP provides an anonymous, web-based method of outreach that starts with a confidential online stress and depression questionnaire. Universities can send invitations containing links to the organization's customized ISP website to all students via a designated official. The link further explains the program and provides participants with an opportunity to sign up with a self-assigned user ID and password. The 10-minute questionnaire asks about suicidal ideation and attempts, problems related to depression such as anger and anxiety, alcohol and drug abuse, eating disorder symptoms, PTSD and TBI.

Based on responses, students are classified by risk. High-risk students are contacted within 24 hours at the email they provide, which is encrypted in the system and not available with identifiers to the counselors reviewing responses. Other levels of risk are also contacted in a stepped expectation of response time. Counselors prepare emails based on responses that provide contact information for in-person meetings if the student chooses, as well as options for website communication that allow them to remain anonymous. This anonymous dialogue can continue, but the student is encouraged at all times to seek in-person counseling. The goal is to identify students who are at-risk and encourage them to seek treatment. Universities pay an annual fee for the software tools, and provide the counselors and in-person services. JHU recently received federal funds, matched by the Office of the President, to implement ISP on JHU campuses.

The task force recommends further monitoring and evaluation of the utility of this program for JHU and regular monitoring of available evidence-based prevention practices that the university may employ (Recommendation 2.e.1).

# Task Force on Student Mental Health and Well-being Recommendations

Mental health issues are quite common among American university students, including depression, anxiety, and substance use disorders. Undergraduate and graduate education at a rigorous university is by its nature a challenging and potentially stressful experience that often coincides with the onset of psychiatric illness, and with other critical life course events such as emerging adulthood, new independence, adult relationships, and family responsibilities. The university cannot entirely remove these sources of stress, but can offer a supportive academic environment that recognizes these challenges and supports students' well-being.

The task force gathered extensive information on the experience of JHU and other collegiate institution students, as well as on the current infrastructure for health promotion and mental health treatment. After careful consideration and discussion of this information, the task force makes specific recommendations with the goals of health and wellness promotion, increasing resilience in the context of stress, mental illness prevention, and ensuring adequate mental health services are provided for students.

It is important to note that the task force was charged with making recommendations for all students.<sup>2</sup> An overarching sentiment surrounding these recommendations is the consideration that each division of the university, and, in some instances, specific programs within divisions, face distinct student mental health challenges. This arises in part because student mental health and well-being are context-dependent—based on age, sex, cultural origin, gender identity, existing mental health challenges, and other factors—and these demographics vary by program across the university. As a result, the tools and infrastructure opportunities for implementing recommendations also vary by division, as do the financial implications. Thus, while the task force has taken seriously the charge to make recommendations applicable across the university, some are division-specific and others will likely be implemented at varying degrees depending on divisional needs and resources.

## Recommendation 1:

**The university should promote a climate of awareness and support for student mental health, wellness, and stress reduction. It is essential to create a campus climate that values inclusion of all students and overall wellness, and that promotes resilience in the context of stressful situations and life events common among undergraduate and graduate student experiences.**

1.a The university should create a standing committee for mental health programming across Johns Hopkins called the JHU Mental Health Committee (MHC). MHC would serve to monitor the implementation of recommendations made by the task force, monitor the mental health programs across JHU, and provide advice to the president, provost, and vice provost for student affairs.

2 Students enrolled in Advanced Academic Programs (AAP) within KSAS were not part of the initial task force survey. There are plans underway to conduct a separate review for AAP. In addition, this report does not specifically cover medical residents or postdoctoral fellows, though some responses were received from these groups.

#### Membership:

We recommend that this standing committee include representation from across JHU, including staff responsible for monitoring and evaluating student mental health service delivery within and across divisions. Permanent members should include leadership of the Counseling Center, JHSAP, UHS, Office for Student Disability Services, deans for diversity and inclusion, and an expert on drug/alcohol addiction, appointed by the provost. Additional rotating members should include students from each school, as well as faculty, staff, and alumni members reflecting diverse interests across the university. We recommend open applications and communication of a clear process for selecting rotating members based on qualifications and diversity of representation. In addition, interested alumni with mental health and wellness expertise may be beneficial in this regard, particularly as engaged students graduate. Members would be expected to act as liaisons for their division/program to enable effective communication of their unit's activities to the committee and the committee's activities to their unit. Representatives from related JHU initiatives and offices should be invited to ensure consistency with mental health-related efforts such as substance use (e.g., Alcohol Strategies Working Group at Homewood), sexual violence (Provost's Sexual Violence Advisory Committee), etc., as these activities are known to relate to student mental health and wellness.

#### Responsibilities:

MHC would serve to monitor the implementation of recommendations made by the task force, monitor the mental health programs across JHU, and provide advice to the president, provost, and vice provost for student affairs. We recommend this standing committee meet on a specific schedule and provide annual reports to university leadership. Other tasks for this committee could include engaging with the JED Foundation regarding best practices; monitoring services and policy integration across divisions, in collaboration with division or campus-specific advisory groups that oversee their specific needs; monitoring the design and implementation of a communication strategy for student mental health; capturing student feedback via real-time survey methods (with both anonymous and signed options); partnering with divisions to develop and distribute annual student mental health surveys with universitywide questions and additional school-specific items to identify trends and measure the success of task force recommendations; and engaging with student groups (including those outside JHU) regarding student mental health. This last point is critical given that student groups are involved in grassroots work to improve student mental health, and collaboration would support these existing efforts.

1.b The university should develop and implement a universitywide communication strategy for student mental health. One of the key findings from the task force's background investigations was the lack of knowledge among faculty and students about mental health generally, and more specifically, what resources are available, and from whom. It was also clear that to make a cultural change across the university, deliberate and coordinated messaging is necessary. Specific recommendations include:

1.b.1 Develop and maintain an easily navigated JHU-wide website on student health and well-being. A central landing spot for student mental health is needed that contains immediate information for students experiencing crisis, as well as general information about resources across the university. We recommend developing and maintaining a website that is easy to find (via search engine optimization) and serves as a hub of information for all JHU students,

staff, faculty, and families. Careful attention should be paid to overlap with other websites and efficient linkages to those websites embedded. We recommend a university-level manager be responsible for development and oversight of this site, with monitoring by the MHC.

Suggestions for important content include:

- Crisis direction as an immediate banner. This should include specific directions about whom to contact if someone has immediate concerns about himself/herself or other students. Other ideas expressed by committee members included having a pointer to closest physical health care location (e.g., via ZIP code entry).
- Lists and contacts for service providers, partners (e.g., security), student organizations, campus disability and academic support services, and other campus resources for students that relate to mental health or overall wellness.
- Link to the list of confidential resources on the Office of Institutional Equity website for victims of sexual assault.
- Information regarding general awareness and communication of concerns such as “what to look for, what to do.”
- Options for anonymous and signed feedback about student mental health on campus to be communicated to the MHC.
- A mechanism for students to anonymously report staff or faculty misconduct as it pertains to mental health issues (i.e., discrimination against students with mental illness or not providing required accommodations for students with disabilities).
- Available resources to help students cope with substance abuse and promotion of responsible use.
- A calendar of events that could include campus speakers related to mental health, training events, and social events related to wellness and stress reduction. This should be directly modifiable by appropriate staff at each division so as to eliminate a centralized bottleneck to communication.
- Printable brochures/posters regarding mental health and wellness.
- Information about eligibility and costs linked to services available to students.
- Information about, and links to, training modules available to students, staff, and faculty (specific trainings are discussed in Recommendation 3).
- Link to a toolkit or app for self-help strategies, if such a toolkit can be identified that has an evidence base of utility and effectiveness.

1.b.2 Develop and implement frequent cultural messaging across JHU and within divisions that promotes mental health and wellness. Changing the cultural norms regarding student health expectations is critical to promoting resilience. Improving perceptions surrounding inclusion and acceptance of mental illness by providing education and destigmatizing professional



support can also greatly improve student outcomes. With this in mind, the task force recommends several communication initiatives:

- Ensure frequent and consistent statements of JHU leadership’s commitment to student mental health.
- Expand mental health and well-being content and emphasis in orientations for all students. Content should set the tone of a wellness culture and wellness strategies in the context of a highly rigorous academic setting in collaboration with communication strategies above. This should include content and structured interactions on respect and inclusion of diverse student populations, in collaboration with diversity initiatives.
- Communicate the confidential nature of psychiatric services to increase the willingness of students to seek mental health services.
- Design and promote specific topic or subgroup-informed campaigns throughout the year. Examples include (1) anxiety and harm reduction in a high-stress academic setting (not cool to avoid sleep, to compete for hardest working, etc.), (2) mental health stigma reduction, (3) perception of structural racism and bias against high-risk populations, (4) “look up” campaigns, (5) substance use awareness and safety (e.g., perceptions versus reality).

Strategies should consider mode, frequency, and target locations/populations for these campaigns. For example, modes of communication could include (1) information about mental health crisis contacts for faculty, staff, students on JHU identity badges, (2) brochures or cards located at highly frequented student locations, (3) magnets, pins, and stickers distributed at orientation, (4) strategic use of social media, and (5) mental health banners across campuses on lamp posts or other highly visible locations to convey the university’s commitment to this issue.

Frequency and target populations should be informed by known risk factors for mental health crisis such as (1) times of high stress around exams and transitions to college or holidays and (2) high-risk populations.

- Engage and collaborate with other JHU offices and initiatives regarding communication strategies on topics related to wellness and mental health such as sexual assault, substance use, and diversity and inclusion.

1.b.3 Coordinate with diversity offices to tailor communication for student populations at higher risk for mental health challenges. Based on the literature and JHU student surveys, these include students with existing mental health challenges or disabilities, LGBTQ students, underrepresented minority students, international students, students in financial hardship, military-affiliated students, first generation college students, students who are parents, students experiencing disciplinary action, and students experiencing violence in the community.

1.b.4 Develop and disseminate JHU-wide protocols and best practices on crisis and suicide responses. All divisions should develop and implement protocols for addressing crisis situations on campus and specific responses to student suicides, including following up with classmates and faculty members.



1.b.5 Develop and disseminate JHU-wide protocols and best practices on how to support students who experience crime/trauma. All divisions should implement protocols, in consultation with corporate security, the Counseling Center, student deans, JHSAP, etc., to follow up with students on campus who have been victims of a crime.

1.b.6 Hire or designate a communications coordinator in the Provost's Office to direct the communication strategy and website development and maintenance. Implementation of these extensive communication strategies will require intentional coordination. The committee recommends institutional support for a university-level coordinator responsible for these initiatives.

1.c The university should foster a supportive academic culture through faculty awareness, supportive faculty-student interactions, appropriate academic programming, and opportunities for healthy social and stress-reducing activities. With the goals of health and wellness promotion, particularly increasing resilience in the context of stress, as well as mental illness early recognition and treatment, the committee recommends the following faculty and academic approaches:

1.c.1 Require faculty to maintain training on student mental health. This recommendation is elaborated in Recommendation 3.a.

1.c.2 Engage the MHC to collaborate with the newly formed Second Commission on Undergraduate Education (CUE2) to inform and highlight academic and campus climate initiatives that will promote wellness and prevent mental health challenges.

1.c.3 Facilitate and incentivize more frequent student/faculty engagement as a tool for promoting a supportive culture. Students consistently reported a desire for more frequent faculty engagement in social and personal settings to promote a culture of support and understanding. Faculty reported interest in this, but they have many demands on their time. Some incentives for faculty could help raise this as a priority, such as university-funded student/faculty lunches or dinners and/or faculty awards for student engagement.

1.c.4 Promote high-quality faculty advising through (a) dissemination of best practices and (b) active monitoring, evaluation, and enhancement of advising to align with best practices. Specific tools will need to be implemented by divisions and programs. For example, faculty evaluations and recognition awards are tools to consider for advising quality promotion and correction. Several divisions already have student mentoring and advising awards that could be modeled.

1.c.5 Facilitate and require mental health and wellness sections of syllabi (as recently implemented by the Whiting School of Engineering). Content for these syllabus sections would include standard language on mental health, stress management and well-being, as well as links to the mental health website (recommendation 1.b.1.). JHU can provide the template for such language, similar to sections on academic ethics that already exist. The sections should also include information on access and eligibility for disability services. For some JHU Divisions, this can be automatically added to electronic syllabus templates. Some committee members also expressed that faculty should be encouraged to clearly articulate verbally during their courses that the instructor is open to being approached for guidance to resources.

1.c.6 Create subcommittee of the MHC that will engage with JHU divisions regarding academic and funding policies that affect student mental health. Several academic policies exacerbate mental health issues and should be considered in this regard. These include course calendaring (including beginning and end-of-term dates and spacing of terms), policies on number of exams per day/week, grading schemes within departments, extensions for course work due to family emergencies or mental health concerns, limiting conflicts between classes and practices/games for student athletes, and allowing for excused absences to attend mental health appointments as necessary during the academic year. The task force noted the student recommendations to reinstate covered grades for first-year students; given this, a continued and enhanced focus on academic and mental health support, particularly among first-year undergraduate students, may be prudent. We recommend convening a committee of deans of education regarding structural solutions such as policies on number of exams per day or week and implementation strategies for such plans. Such implementation would presumably include faculty and TA training.

We also encourage this subcommittee to work with student scholarship, stipend, and assistantship policies at the university and division level to examine the impact of financial hardship on student mental health and the additional vulnerability incurred by students. For example, many students expressed concern about lack of university financial support for scholarships and student insurance that led to stress or exacerbated student mental illness. Students also highlighted hourly pay standards as a source of stress and inequity contributing negatively to mental health.

1.c.7 Effectively communicate medical leave of absence (MLoA) policies to students, faculty, and staff and ensure that students, in collaboration with JHU mental health service providers, are properly supported while on leave and when returning to campus. The task force found that medical leave of absence policies varied significantly among the divisions, and both students and administrators often found them difficult to locate. While the task force found important reasons for each school to identify its own MLoA policy, the terms of those policies should be more easily accessible online to both students and administrators. In addition, each division, in consultation with the Counseling Center, UHS-MH, and/or JHSAP, should have consistent procedures in place to communicate with students on MLoA to check on their progress and ensure they understand what is required to re-enroll.

1.c.8 Increase resources and staffing for mental health education and wellness programming. A significant majority of students do not seek care from JHU service providers for a variety of reasons. Therefore, it is critical that the university be proactive in finding alternative ways to empower students to reduce stress and promote a healthy lifestyle. The task force found a lack of dedicated staff and resources to carry out this mission, which also limits the university's ability to implement many of the recommendations in this report.

1.d Create partnerships and organize student government organizations to facilitate collaboration or grouping of student-led entities that focus on health and wellness. For example, Homewood divisions currently have subgrouping by other non-health issues. In this case, the task force recommends that the SGA and student governments of each graduate program (GRO) create a new subgroup for health and wellness. The groups included in this category could be Active Minds, A Place to Talk, and CHEW. By splitting off health and wellness groups into their own

category that is directly sponsored by the Office of Student Life, these groups could get more direct support (financial, marketing, counsel, or otherwise), and students would more easily be able to learn about existing mental health groups.

1.e Provide opportunities for students at each campus to gather socially and engage in healthy stress-reducing activities. In order to reduce academic pressure and the potential for student isolation, student life offices at each division should consistently promote healthy social activities throughout the year. Students also called for a central location on campus to gather socially in a nonacademic or study environment, similar to student union models at other universities. Divisions should also work with student organizations and other entities to promote stress-reducing activities and encourage healthy exercise and nutritional habits, especially around exam times. For example, JHU could further promote availability of on-campus gym activities, and negotiate reduced membership fees with off-campus gym partners, particularly for non-Homewood students, to increase access for fitness opportunities.

## Recommendation 2:

### **The university should take necessary steps to improve student care at JHU mental health service providers and provide greater access to mental health services.**

More than 60 percent of respondents to the JHU Student Mental Health Survey described the quality of care they received at the Counseling Center, JHSAP, and UHS-MH as “good or very good.” However, many students become discouraged about long wait times to schedule an initial appointment and are dissatisfied with the lack of flexibility to change counselors. The survey was limited to campus-based students, and further survey and analysis of the online student population are still needed. The task force believes the university should make strategic investments in its service providers to increase their ability to support students as demand for services continues to grow.

2.a Create optimal organizational structures for mental health at JHU. To keep pace with changing needs and increasing requests for mental health services, the university should examine the three service providers, both as a whole and individually, to ensure that optimal organizational structure and staffing levels at each provider are in place. Service providers should actively monitor access including appointment wait times, demand for services, and staffing ratios. When demand for services increases, each service should have an established mechanism for evaluating whether additional staffing is required and have the ability to request resources for such staffing.

While the committee believes each service provider would benefit from an increase in staff in response to an increase in demand, we have identified an immediate need for additional staffing at JHSAP. The committee has outlined the specific staffing request for JHSAP in recommendation 2.b.2.

2.a.1 Increase understanding among divisions about the differences in care provided by UHS-MH and JHSAP. We recommend that there be continuing discussions between the services and communication with faculty and staff to ensure that students are referred appropriately to the service that would best meet their needs. In particular, for the schools of

Medicine, Public Health, and Nursing, JHSAP and UHS-MH should work together closely to coordinate referrals to and from each service so as to direct patients to the service best suited for the student's individual problem. This includes the timely sharing of medical information/ records between services to ensure that treating providers have all the information necessary to assess and treat each student.

2.a.2 The three service providers should develop a coordinated plan to provide additional support in the event of an emergency or traumatic event to prepare for a sudden increase in demand. The committee found that UHS-MH is particularly not prepared for short-term surges directly resulting from a sentinel event, so we recommend that resources be shared among the three providers should such an event occur, and that mechanisms be put in place that allow for the quick recruitment of mental health providers at all levels, if needed.

2.a.3 JHSAP, UHS-MH, and the Counseling Center should offer timely appointments based on urgency. These appointment options should be clear on websites and other materials. Further, staff answering phones should be able to communicate to any student callers the different types of appointment options with respect to timing. Each entity should work to ensure this process is being carried out with fidelity.

2.b Increase staffing to improve access within JHU. The committee recognizes a critical need for additional psychiatric providers within the JHMI network to ensure quicker access to psychiatric treatment. It can be very difficult to identify psychiatric providers in the community whom students can see in a timely manner. In addition, the task force makes the following recommendations to improve service delivery:

2.b.1 Provide the Counseling Center and UHS-MH with staff support to ensure optimal operational efficiencies. To maintain acceptable standards and enhance quality, it is recommended that a clinical practice analyst be hired to advance the program needs of the Counseling Center and UHS-MH. This person would help the Counseling Center and UHS-MH keep up with evolving standards, conduct surveys and quality improvement projects, and provide periodic data analysis and reports that would be incorporated into the work of the MHC. Where appropriate, this person would also share reports with JHSAP and coordinate with its staff on projects.

2.b.2 JHSAP staffing levels should be reviewed immediately in order to maintain quality service to BSPH, SOM, and SON and provide service for the four schools or programs that do not have access to UHS-MH or the Counseling Center (SOE, CBS, SAIS, EP). We recommend that in addition to current staffing needs, JHSAP add a psychiatric provider for students in these additional divisions, particularly in Washington, D.C. where JHSAP serves SAIS and CBS students. We also recommend that JHSAP add staffing support to assist in clinical supervision as well as outreach and relationship building with the schools.<sup>3</sup>

2.b.3 Expand capacity by creating greater collaborative arrangements with JHMI departments and programs, such as the JHH Department of Psychiatry and Behavioral Sciences. The Counseling Center frequently refers students to off-campus psychiatric providers, and open-

3. Since the drafting of our recommendations, we understand that there have been some transitions within JHSAP/FHSAP. We see this as an optimum time to undergo a complete analysis of the services and staffing of JHSAP to determine the best staffing for that unit, in addition to the recommendations above.

ing access to JHMI-affiliated departments and programs would reduce wait times in scheduling appointments and further educational opportunities for residents.

2.c Ensure that students and trainees on both the Homewood and East Baltimore campuses have insurance plans that provide excellent behavioral health coverage. There are currently significant inconsistencies across divisions regarding mental health insurance coverage for students. When individuals become ill and require inpatient hospitalization or more complex medication regimens, it can be a major financial burden on the individual if there is inadequate coverage. Financial strain on an individual who is ill, in addition to the burden of the illness and stigma, can significantly exacerbate mental health problems. The task force recommends a review of coverage plans and waiver policies across the university to ensure that inpatient, outpatient, and pharmaceutical coverage are not overly financially burdensome for students, are readily accessible, and are consistent between the schools wherever possible. For example, none of the outpatient or inpatient departments within the Department of Psychiatry accepts Cigna insurance, which includes the CHP student insurance plan. These services are considered “out of network,” and students/patients are expected to self-pay at the time of services with a reduced rate of reimbursement from the insurer.

2.d Expand the current service hours of providers and explore opportunities for greater flexibility to accommodate student needs. Most of the service hours at each mental health provider are between the hours of 8 a.m. and 5 p.m. Students have expressed concerns through the JHU Student Mental Health Survey regarding finding time to schedule appointments during business hours. Access to and coordination of care may be improved by expanding service hours in some cases, taking advantage of alternative modalities of follow-up where possible, and allowing students the flexibility to seek necessary mental health services during the academic day. Therefore, we recommend that JHU provide resources to allow for the expansion of service-provider options to better suit the hours when students are not in class and during peak periods throughout the academic calendar. We also recommend that schools and academic departments allow students to seek treatment during acute mental health issues by permitting excused absences from class between the hours of 8 a.m. and 5 p.m. In addition, there should be dedicated counselors on each campus for a minimum of eight to 16 hours per week; this is particularly critical for divisions not on Homewood or East Baltimore campuses and will require partnerships with divisions to allocate resources according to campus need. For example, the task force heard from numerous students at Peabody and the Carey Business School that finding time to travel to service providers can be challenging and often prevents someone in crisis from getting necessary support.

2.e Increase communication about opportunities for anonymous contact with mental health resources during crisis situations and opportunities to anonymously report concerns about the mental health of classmates. Many respondents of the JHU Mental Health Survey cited concerns about anonymity or confidentiality as a primary reason for not seeking counseling services. In addition, students overwhelmingly reported that they are more likely to discuss their mental health concerns with friends as opposed to professional counselors at JHU. Therefore, the committee specifically recommends the following actions:

2.e.1 Advertise, and create where necessary, opportunities for students to engage anonymously with mental health resources during mental health crisis situations. While ongoing

treatment at JHU service providers cannot remain anonymous, initial and emergency consultations/assessments occur over the phone, and hotlines are advertised as resources. Links to text and chat services should be further explored as options. The university should also evaluate the utility of the grant-funded ISP program awarded in 2017, which provides anonymous consultations with mental health professionals.

2.e.2 Advertise, and create where necessary, opportunities for reporting student concerns about peers experiencing mental health challenges. Examples of tools for emergency reporting of peer concerns include the LiveSafe app through the Apple Store and Google Play that was piloted on the DC campus in 2015 and made available to Homewood students in 2016. Access to this app should be expanded to include campuses across the university. Examples of tools for non-emergency reporting include Homewood's HopReach website, which provides an easy-to-use online platform to anonymously report concerns about a classmate. The task force notes that these examples have not been thoroughly evaluated for effectiveness on student mental health specifically. We recommend the MHC consider monitoring the evidence base for peer-reporting effects on student mental health and/or carrying out JHU-specific evaluations of that aspect of these apps.

2.f Increase coordination among mental health service providers. One of the positive outcomes resulting from the task force process has been the conversation, communication, and information sharing among the three service providers. This important relationship should continue to be supported and reinforced through the MHC discussed above. The task force identified the following three areas in which increased coordination among the providers would create efficiencies in the delivery of services for students:

2.f.1 Develop a centralized referral list for local health care providers. It is critical to have an excellent network of local health care providers to whom JHSAP, the Counseling Center, and UHS-MH can refer. It would benefit all three providers if the university had an up-to-date centralized/shared database of community providers that is regularly vetted and updated to ensure quality. This can also facilitate transitions for students who are graduating and will no longer be eligible for JHU-led services. The task force recommends that a FTE position be added that can be shared by all three providers to facilitate student referrals by assisting targeted recommendations based on insurance type, geographical location, and provider expertise. This person would work in consultation with the Counseling Center's referral coordinator.

2.f.2 Ensure that policies and protocols for responding to students in distress are consistent with a climate that supports and promotes mental health. The committee recognized that emergency or crisis situations involving students are often handled on a case-by-case basis, without consistency or coordination. A more structured operating procedure format should be created in all divisions to increase communication among relevant offices, protect the safety of students in distress, and ensure protocols are applied fairly. For emergency situations, a set of protocols should be developed that ensures proper coordination among mental health providers, disability services, security, and administrators. These protocols should be easily accessible to students and should offer clear guidelines that help students understand their various options to access care at the school, including the option to select taking medical leave of absence if applicable.

2.f.3. Ensure students with disabilities are properly informed of the process to receive appropriate accommodations. Every effort should be made to provide information on this process through admissions, orientation, and student services websites, course syllabi, and other printed materials. In addition, students should be encouraged to seek help early, as the process may take an unexpectedly long time to complete. In some cases, students may need to submit updated documentation. A referral list for the Baltimore/DC region of practitioners who can provide updated documentation or testing, including information on those offering sliding scale fees, should be maintained by the Office of Student Disability Services and made available through the disability coordinators and their websites.

The task force recommends that the university investigate the possibility of contracting with a single source provider to find an affordable arrangement for students who may need updated documentation. In addition, disability services should regularly conduct assessments to determine the level of student and faculty satisfaction with their services and to gather recommendations for improvement.

### Recommendation 3:

#### **The university should offer, and in some cases require, training on mental health awareness and resources across faculty, staff, and students.**

Approximately 90 percent of suicides are committed by individuals suffering from untreated mental health disorders who are unlikely to self-refer for treatment (Indelicato et al., 2011). Mental health trainings increase the probability that a suicidal or distressed student would be identified by a member of the JHU community and referred to appropriate professionals for an assessment. Trainings also raise awareness about mental health and reduce stigma, and can help encourage suicidal or distressed individuals to seek professional mental health services for themselves.

3.a Require all teaching faculty to maintain training on student mental health (SMH) resources. Frequently, students with mental health difficulties show signs of distress in the classroom or begin to accumulate unexcused absences. The task force believes it is critical for faculty to become informed about mental health and the available resources at JHU if they are concerned about a student. Student responses from the JHU Student Mental Health Survey, particularly in the qualitative data, indicate that faculty generally do not understand or give proper weight to mental health issues.

- The content of the trainings should include information on available resources for students, identification of struggling students and how to engage with them, how to direct students who have concerns about fellow students, best practices for regular “check-ins” with advisees, best practices for crisis and death response, risk factors (transition times, at-risk populations), and information on how to support specific populations (students with disabilities or existing mental health challenges, international students, members of the LGBTQ community, etc.). Importantly, this training is not intended to encourage faculty to act as counselors or service providers but rather to enable faculty to identify, support, and refer students to appropriate JHU resources.



- Training should be an online module with a supplementary document about the content to be posted on our central website. Online options might include Kognito at Risk Program, Campus Connect, and Campus Clarity.

3.b Require academic coordinators, teaching assistants, deans of education and students, JHU security officers, coaches, and student-facing staff (if not faculty covered above) to take mental health training. Recognizing that not all students may feel comfortable addressing mental health concerns with faculty, the task force believes it is necessary to provide mental health training to additional individuals within schools and departments who have frequent face-to-face interactions with students.

- The task force calls for an immediate need to require mental health awareness and crisis intervention trainings to JHU security officers. JHU Corporate Security should provide mental health training to all JHU proprietary campus police officers on an initial and annual in-service basis to help ensure that these officers are prepared to recognize and properly respond to mental health crises incidents involving JHU students. The proposed training would be coordinated by the Corporate Security Training Division in consultation with the JHU Counseling Center.
- The Office of Residential Life should continue to require all resident advisers to receive training on student mental health resources and strategies and emphasize the importance of these topics, particularly during orientation. The trainings should include information on bystander help and peer supports.

3.c Offer workshops and training regarding mental health and wellness to students, family members, and non-student-facing staff members, and provide continuing education and training opportunities for mental health providers on campus. Results from the Mental Health Survey show that students are significantly more likely to discuss concerns about their mental health with friends or family members than with university officials. The task force believes it is important to give students and family members the opportunity to learn more about mental health and how we can support each other. In addition, the research surrounding counseling and therapy techniques for best addressing mental health issues continues to evolve. It is important that JHU mental health providers be given an opportunity to continue their education through CE courses and additional training opportunities. Therefore, the task force calls for the university to make available:

- Student mental health training modules for all students and emphasize their importance to those in student organization leadership;
- Student mental health training modules for family members (introduced at orientation and via distribution); and;
- CE courses and additional training opportunities to mental health providers to ensure they are adequately trained in evolving evidence-based practices.

The university should offer specific workshop and training opportunities for students tailored to specific populations on wellness topics such as: mental health first aid and crisis response, bystander intervention, time management, mindfulness and stress coping techniques, life planning/management, responsible substance use (details on how this is connected to current strategies in place), study skills, conflict resolution, and general classes on mental well-being, such as self-care, yoga, etc.

# References

- ACHA (American College Health Association). 2017a. *American College Health Association—National College Assessment II: Reference Group Undergraduate Executive Summary Spring 2017*. Hanover, MD: American College Health Association.
- ACHA. 2017b. *American College Health Association—National College Assessment II: Reference Group Graduates Executive Summary Spring 2017*. Hanover, MD: American College Health Association.
- Blanco, C., Okuda, M., Wright, C., et al. 2008. Mental health of college students and their non-college-attending peers. *Archives of General Psychiatry*, 65(12), 1429-1437.
- Bui, K.V. 2002. First-generation college students at a four-year university: Background characteristics, reasons for pursuing higher education, and first-year experiences. *College Student Journal*, 36(1), 3-11.
- CCMH (Center for Collegiate Mental Health). 2016. *2015 Annual Report* (Publication No. STA 15-108).
- CCMH. 2017. *2016 Annual Report* (Publication No. STA 17-74).
- CDC (Centers for Disease Control and Prevention). 2016. *10 Leading Causes of Death by Age Group, United States—2015*. National Vital Statistics System. National Center for Health Statistics, CDC.
- Eisenberg, D., J. Hunt, and N. Speer. 2013. Mental health in American colleges and universities: Variations across student subgroups and across campuses. *The Journal of Nervous and Mental Disease*, 201(1), 60-67.
- Engle, J. and V. Tinto. 2008. *Moving beyond access: College success for low-income, first-generation students*. The Pell Institute: Washington, DC.
- Gogtay, N., Giedd, J.N., Lusk, L., et al. 2004. Dynamic mapping of human cortical development during childhood through early adulthood. *Proceedings of the National Academy of Sciences* 101(21), 8174-8179.
- Hawton, K. 1987. Assessment of suicide risk. *The British Journal of Psychiatry*, 150(2), 145-153.
- Hunt, J.B., Eisenberg, D., Lu, L., et al. 2015. Racial/ethnic disparities in mental health care utilization among U.S. college students: Applying the Institution of Medicine definition of health care disparities. *Academic Psychiatry*, 39, 520-526.
- Indelicato, N.A., A. Mirsu-Paun, and W.D. Griffin. 2011. Outcomes of a suicide prevention gatekeeper training on a university campus. *Journal of College Student Development*, 52(3), 350-361.
- Insel, B.J. and M.S. Gould. 2008. Impact of modeling on adolescent suicidal behavior. *Psychiatric Clinics of North America*, 21(2), 293-316.
- Institute of Medicine. 2000. *Promoting Health: Intervention Strategies from Social and Behavioral Research*. Washington, DC: The National Academies Press.
- JED Foundation & Education Development Center, Inc. 2011. *A guide to campus mental health action planning*. New York, NY: Jed Foundation Campus MHAP and Waltham, MA: Education Development Center.
- Kessler, R.C., Amminter, G.P., Aguilar-Gaziola, S., et al. 2007. Age of onset of mental disorders: A review of recent literature. *Current Opinion in Psychiatry*, 20(4), 359-364.
- Kessler, R.C., Berglund, P., Demler, O., et al. 2005. Lifetime prevalence and age-of-onset

## References, *continued*

distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, 62(7), 768.

Lipson, S.K., Gaddis, S.M., Heinze, J. et al. 2015. Variations in student mental health and treatment utilization across US colleges and universities. *Journal of American College Health*, 63(6), 388-396.

Reetz, D.R., Krylowicz, B., and B. Mistler. 2015. *The Association for University and College Counseling Center Directors (AUCCCD) Annual Survey, Reporting period: September 1, 2013 through August 31, 2014*. Aurora, IL: The Association for University and College Counseling Center Directors.

Reetz, D.R., Krylowicz, B., Bershad, C., et al. 2016. *The Association for University and College Counseling Center Directors (AUCCCD) Annual Survey, Reporting period: September 1, 2014 through August 31, 2015*. Aurora, IL: The Association for University and College Counseling Center Directors.

Slutske, W.S. 2005. Alcohol use disorders among US college students and their non-college-attending peers. *Archives of General Psychiatry*, 62(3), 321-327.

Stebbleton, M.J. and K.M. Soria. 2012. Breaking down barriers: Academic obstacles of first-generation students at research universities. *Learning Assistance Review*, 17(2), 7-20.

