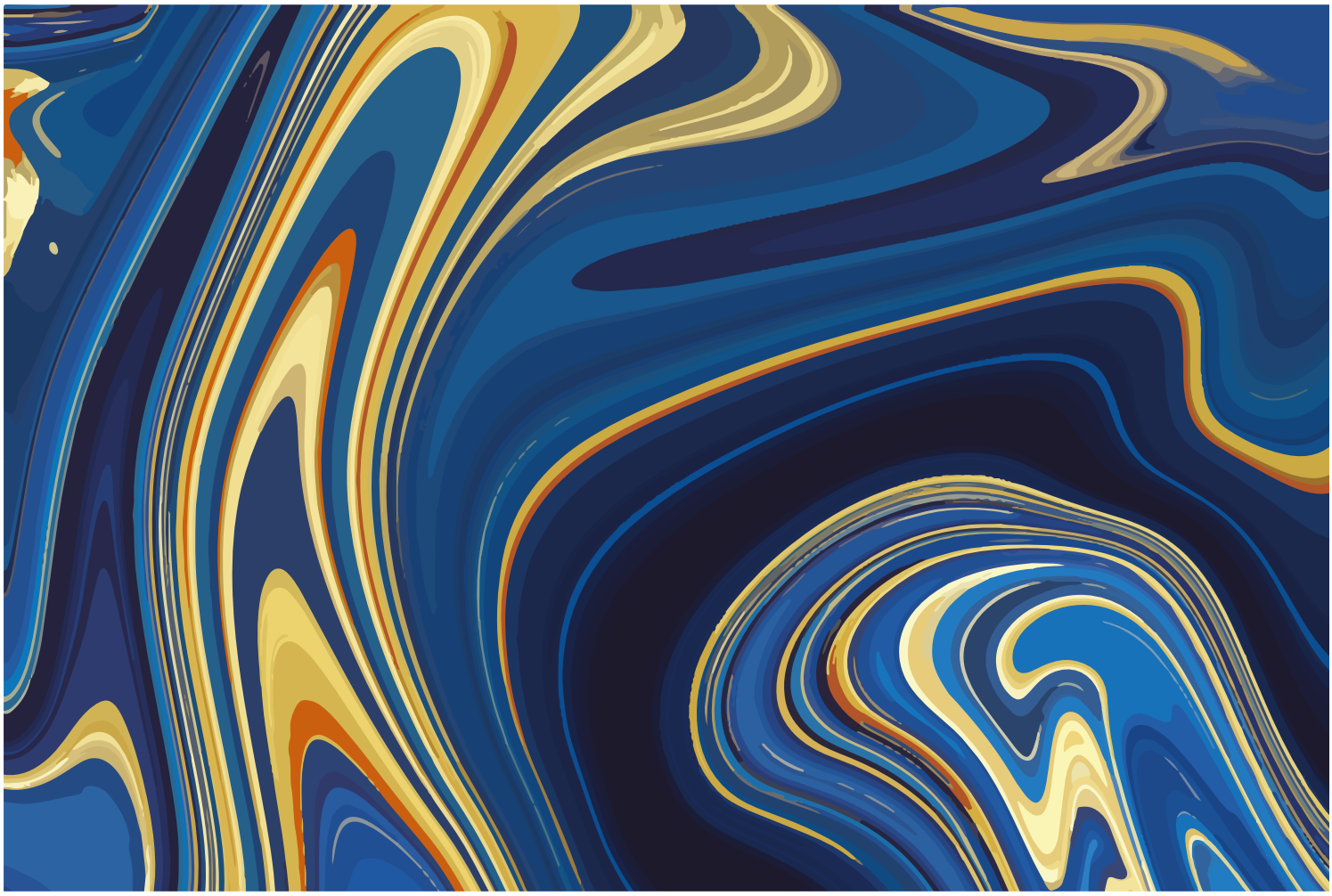
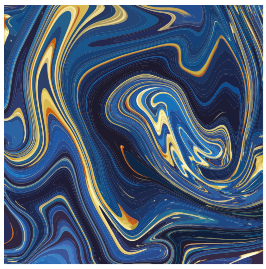


BEHAVIORAL HEALTH INTEGRATION IN THE UNIVERSITY SETTING

CONSENSUS RECOMMENDATIONS of the Florida Academic Healthcare Patient Safety Organization's Behavioral Health Integration Task Force

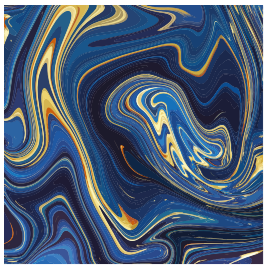
FLORIDA ACADEMIC HEALTHCARE PSO



Consensus Recommendations of the Florida Academic Healthcare Patient Safety Organization Behavioral Health Integration Task Force

These consensus recommendations, developed by the Florida Academic Healthcare Patient Safety Organization (FAH PSO) Behavioral Health Integration Task Force, are for informational purposes only and should not be construed or relied upon as the legal standards or a clinical practice guideline. The applicable standards for any particular patient is determined by many factors, including the patient-specific clinical data available and is subject to change given developments in scientific knowledge, technological advances, and the evolution of healthcare. The determination of appropriate medical care for any individual patient is subject to that patient's clinical presentation and the reasonable judgment of the individual healthcare provider, in light of all information available at that time. The ultimate decision regarding the appropriateness of any treatment must be made by each healthcare provider in light of all circumstances prevailing in the individual situation and in accordance with the laws of the jurisdiction in which the care is rendered.

The FAH PSO recommends institutions review these guidelines and accept, modify, or reject these recommendations based on their own institutional resources and patient populations. Any decision not to implement any of the recommendations herein, either fully or partially, should not be construed as evidence of negligence. Any recommendations, templates, proposed policies, or documents contained herein are solely illustrative. Additionally, institutions should continue to review and modify these recommendations as the science continues to evolve. Adherence to or adoption of the consensus recommendations referenced in this publication does not guarantee a successful outcome. These consensus recommendations do not include a comprehensive listing of all methods or models of behavioral health integration. No statement or recommendation in this report should be construed as legal advice or as the official position of any of the institutions referenced in the report. It is anticipated that these recommendations will require updating as the scientific information regarding behavioral health evolves.



Participants

The following healthcare providers participated in the development of these consensus recommendations. This publication does not necessarily reflect the views or opinions of any particular healthcare provider, university institution, or healthcare organization. Again, these recommendations do not intend to create nor should they be construed as the legal standard or care or a clinical practice guideline. None of the participants has any affiliations or financial involvement that conflicts with the material presented in this report.

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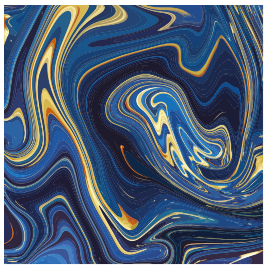
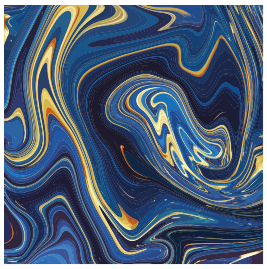


About the Florida Academic Healthcare Patient Safety Organization

In 2005, Congress developed and enacted the Patient Safety and Quality Improvement Act (PSQIA) with the intent of cultivating a culture of safety and improving healthcare, by providing federal privilege and confidentiality protections for information that is reported to a Patient Safety Organization (PSO), developed by a PSO, or which represents the analyses and deliberations of patient safety events, for the conduct of patient safety activities. The PSQIA promotes the sharing of knowledge gleaned from these patient safety activities and the sharing of best practices and recommendations that seek to improve the quality of healthcare.

The Florida Academic Healthcare Patient Safety Organization (FAH PSO), listed by the Agency for Healthcare Research and Quality on April 22, 2014, represents a significant step toward improving patient safety in the third most populous state in the United States. The PSQIA and the associated federal confidentiality protections provide the required framework to allow the sharing of sensitive patient information among medical providers located at the six different State of Florida medical universities training the next generation of healthcare providers. The FAH PSO represents Florida Atlantic University, Florida International University, Florida State University, the University of Central Florida, the University of Florida, the University of South Florida, and the respective institutions' healthcare providers working together to improve patient safety and healthcare.



Executive Summary

In 2016, at the behest of its membership, the Florida Academic Healthcare Patient Safety Organization (FAH PSO) convened a Behavioral Health Integration Task Force to arrive at an expert consensus of guidelines for effective behavioral healthcare and treatment, and integration of available services, for university students. With an expanding patient population for whom these services may be necessary, the FAH PSO sought to create these recommendations supported by a subject matter expert panel, review of the available literature, and identification of professional practices of healthcare providers actively involved in the provision of these services.

This Task Force began with a review of the latest scientific evidence, guidance, and opinion statements from relevant professional societies on the appropriate and effective use of integration of primary care and behavioral healthcare and treatment for the university student. Further insights were gathered from subject matter experts in Medicine, Psychiatry, Psychology, Student Health and Counseling.

Over the course of a year, the Task Force generated the following recommendations for the identification and management of behavioral healthcare with a focus on the integration of multiple services and providers within the university setting and surrounding area facilities and providers with the goal of developing a plan to foster a supportive environment for successful treatment. While the core focus of these recommendations is behavioral health integration, the recommendations also address several other areas critical to the treatment of behavioral health concerns, including:

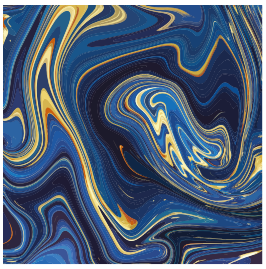
- Identification and screening of prospective behavioral health patients;
- Education and training for providers and staff likely to encounter behavioral health patients;
- Coordination of resources across campus and local community;
- Case management of behavioral health patients across multiple resource settings;
- Assessment of behavioral health concerns in all clinical settings;
- Screening of behavioral health risks and safety planning;
- Sharing of patient health information among treating services, and the documentation of this information in the medical record; and
- Sexual and gender identity sensitivities and the needs of that population, including a recognition of the stigmas associating with that underserved patient population.

Executive Summary *(continued)*

The following recommendations reflect the aim, mission, and consensus opinions of the Behavioral Health Integration Task Force. These recommendations offer guidance to healthcare providers and facilities in their efforts to provide safe, effective, and evidence-based healthcare.

University students may experience a number of challenges in their new environment outside of their usual support systems. Student Health and Counseling Centers can represent a welcoming place to address those concerns including academic pressure, relationship issues, alcohol and substance abuse issues, and depression. Student Health, Counseling and Wellness Centers, and Psychology and Psychiatric healthcare providers may be best informed and equipped to coordinate stakeholders to ensure that university students receive behavioral healthcare and resources. Specific resources will differ for and within each institution.

These recommendations are supported by the literature available at the time of publication. Recognition and treatment of behavioral health issues in the individual student continue to evolve as the science of behavioral healthcare evolves; therefore, individual management and practice decisions continue to rely on the clinical judgment of the healthcare provider evaluating the patient.



What is Behavioral Health Integration?

Behavioral Health Integration is a broad term for the care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of healthcare utilization. Florida's state university system seeks to develop a leading approach in meeting the needs of these patients through an integrated model of care. Behavioral healthcare is a responsibility of a wide variety of care settings and provided by healthcare providers of various disciplines and training, including but not limited to mental health professionals.[i] There are a number of definitions and explanations of terms commonly used in the setting of behavioral health and primary care integration. For reference, the family tree of behavioral health terms provides definitions for terms commonly used in the context of behavioral health and primary care integration.

Measuring the Issue

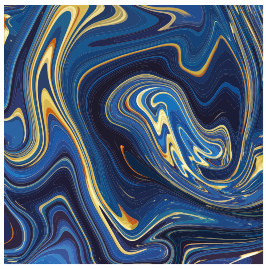
It would be ideal to establish a central registry identifying patients at risk of psychologic, pharmacologic, or physical injury. Whether identified in Student Health Services, the Counseling and Wellness Center, or a Behavioral Integration Team, this risk should be documented in a medical record available to each involved healthcare provider across these services. Doing so would allow each healthcare provider and facility to track and trend the number of patients seen for behavioral health concerns and adjust their resources accordingly.

The Office of the Dean of Students at each University is also in a position to gather information on behavioral health concerns or injuries that may have occurred outside of the University campus setting or regarding behavioral healthcare provided by an outside healthcare provider or facility. For example, the Dean of Students may become aware of involvement of local, county, or state law enforcement and may report such information to the University healthcare providers. Where University law enforcement is involved in a behavioral health incident involving a student, this information should also be reported to University healthcare providers. The Office of the Dean of Students may also be made aware of student class deferments or significant leave from school, as well as of student deaths while off campus or during holiday breaks.

Further, relationships should be established with local behavioral health facilities, including hospitals with psychiatric units, psychiatric hospitals, health departments, and inpatient facilities that specialize in behavioral healthcare.

Finally, many facilities now utilize patient safety event reporting systems that can provide yet another tool to capture the number of patient safety events related to or involving behavioral health concerns. Use of consistent reporting systems allow each university to benefit from broad data collection and analysis, which helps direct workflow to support patient-centered integrated systems of care.

Each of these healthcare providers and other on- and off-campus resources may ultimately be utilized to create a registry of high risk students. A tracking tool that contains the patient's treatment status, relevant measurements, appointments, and case management notes would benefit the entire team and help provide consistency in follow up of this patient population.[ii]



What is Behavioral Health Integration?

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Increasing Need in Florida

In March 2015, staff of the Florida Board of Governors presented an information brief to the Board setting forth the critical issue of increasing concerns related to campus safety and security, which is but one data source presented in these recommendations. That brief also reported that the university presidents within the State University System (SUS) recognized a need to increase the number of professional counselors at each campus to address the growing demand for behavioral healthcare. Despite what appears to be a continuing and increasing need for behavioral healthcare, the accompanying requests for funding from the legislature in 2016 were denied. In 2017, another budget request was proposed by the SUS to address the need for increased funding from the legislature, which sought $14 million to enhance mental health counseling services through Academic and Student Affairs. This request was also denied. Finally, in 2018, the proposed budged for increased funding was approved, and universities are now shifting their aim towards maximizing resources to address the various mental health needs pressing students.

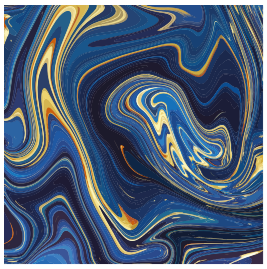
Since the fall of 2008, there has been a 48% increase in the number of students seeking counseling services at SUS institutions. There has also been a 67% increase in the number of counseling sessions. With regard to the University of South Florida system, the Tampa campus has confronted an increase in the number of students served at their counseling centers by 31% over the past two (2) academic years, collectively, in addition to increases in the number of crisis visits by 127%, and in Baker Acts by 132%. The severity of these visits is also increasing, with a number of these classified as emergency or crisis visits that involve severe depression or suicidal ideation.

According to data submitted to the Florida Board of Governors, eight of the twelve universities in the SUS struggle to fully meet recommended staffing levels because they have more than 1,500 students for each mental health professional on campus. These campuses therefore require additional mental health professionals, including psychiatrists, psychologists, counselors, psychiatric nurses, and prevention specialists to meet the rising need. These staffing shortages may also result in patients receiving treatment less often than is ideal, or waiting longer to be seen. However, it should be noted that staffing of mental health professionals at each of these varied university campuses is a complex and dynamic challenge. Such ratios measure Counselors within a CAPS facility. The data presented in the referenced report may be limited in that it does not capture the number of mental health professionals that may be available to students elsewhere on campus or in the surrounding community.

It may also be suggested that additional funding would benefit the Student Health Centers, as well as the Counseling Centers. In an integrated collaborative behavioral healthcare model, a number of patient mental health concerns may be addressed in the primary care Student Health setting, reducing the already existing strain on Counseling Centers. The referenced report to the Board of Governors discusses one funding source, but consideration should be given to a discussion of additional funding options and sources depending on each university's desire and ability to seek out alternative funding (through patient insurance, for example).

i Peek CJ and the National Integration Academy Council. Lexicon for Behavioral Health and Primary Care Integration: Concepts and Definitions Developed by Expert Consensus. AHRQ Publication No.13-IP001-EF. Rockville, MD: Agency for Healthcare Research and Quality. 2013.

ii Advancing Integrated Mental Health Solutions, University of Washington, Psychiatry and Behavioral Sciences, Division of Population Health. https://aims.uw.edu/resource-library/patient-tracking-spreadsheet-example-data



What is Behavioral Health Integration?

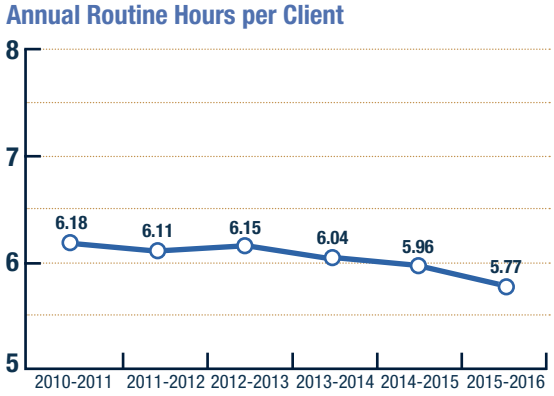
(continued)

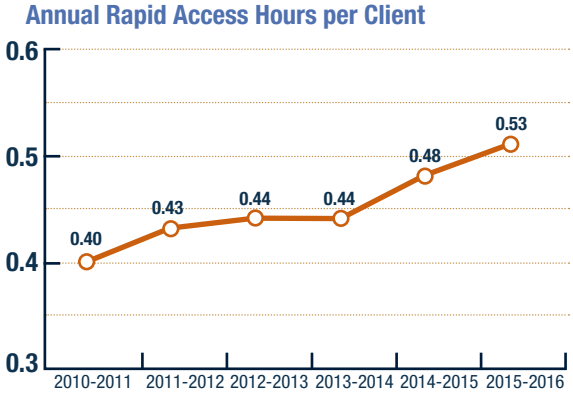
Increased Awareness and Demand

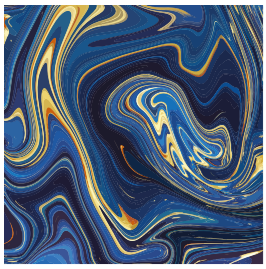
Increasing campus knowledge and organization of events and education to promote behavioral health and wellness and publicize available resources have also helped to promote the importance of positive mental and emotional health. Campus resources that promote understanding of mental health issues, provide education, and referrals for additional care and treatment include (but are not limited to) the following:

- Healthy Campus 2020
- Disability Resource Center
- Health Promotion Offices
- Question Persuade Refer
- Peer Education
- Behavioral Intervention Teams
- Student Situation Response Teams
- Academic Departments
- Routine anxiety/depression screening

With increased awareness comes increased demand, and in the most recent annual report of the Center for Collegiate Mental Health, a survey of counseling centers was conducted to include data from the last 6 years, and found that rapid-access hours have increased 28% while routine hours have decreased by 7.6%. This may show evidence of a reallocation of resources by counseling centers. However, the demand in Florida across the State University System is growing at a much higher rate.







What is Behavioral Health Integration?

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Demand in the State University System

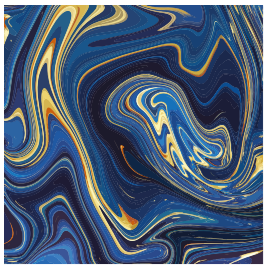
Student Demand for Counselors Continues (March 2017)

- More than 24,700 students received services from student counseling centers, approximately 55% more than the number served in 2008-09.
- More than 185,900 individual and group counseling sessions were provided, approximately 65% more than the number provided in 2008-09.
- There were more than 9,100 emergency and crisis visits and more than 440 Baker Act hospitalizations.
- More than 14,900 students were on psychiatric medication.
- More than 1,700 students reported having made a previous suicide attempt.
- Counseling centers served more than 260 veterans.

Numerous studies have shown that poor physical, mental or behavioral health can adversely affect a student's academic career and overall well-being; retention and graduation rates suffer as a result. The statistics above, presented by the Board of Governors, reflect the strain on existing resources and the need for additional funding, without which the State University System Counseling Centers may be unable to provide adequate levels of service for the many students requiring care for their behavioral health concerns.

Various counseling centers have attempted to manage the demands on existing resources by:

- Reducing the frequency and length of appointments
- Placing a limit on the maximum number of sessions
- Providing referrals to outside behavioral healthcare providers
- Hiring temporary, less experienced, or part-time counselors



What is Behavioral Health Integration?

(continued)

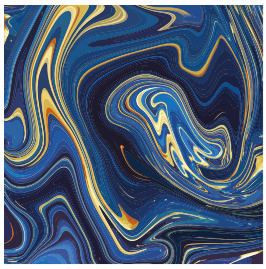
Table 1: SUS Counseling Center Utilization

	2008-09	2014-15	2015-16
# of Students Served[1]	more than 15,000	more than 20,500	more than 24, 700
# of Individual/Group Sessions[2]	more than 112,500	more than 163,000	more than 185,900

	# of Sessions 2014-15	# of Sessions 2015-16	% Increase from 2014-15 to 2015-16
Florida Agricultural & Mechanical University	2,704	2,531	-6%
Florida Atlantic University	11,631	11,205	-4%
Florida Gulf Coast University	13,689	14,424	5%
Florida International University	19,208	23,537	23%
Florida State University	15,669	19,249	23%
New College of Florida[2]	3,389	3,545	5%
University of Central Florida	23,945	28,455	19%
University of Florida	39,527	41,886	6%
University of North Florida	6,620	11,488	74%
University of South Florida	15,898	17,565	10%
University of South Florida – St. Petersburg	1,674	1,737	4%
University of West Florida	9,121	10,280	13%
SYSTEM TOTAL	163,075	185,902	14%

The number of individual and group sessions within the SUS counseling centers continues to grow, as does the number of students served during these sessions. Further, these numbers do not include students who received psychiatric care through their respective Student Health centers. Therefore, the number of university students receiving behavioral healthcare across our campuses is even larger.

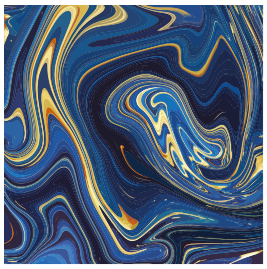
There is no national database or registry, and no study that has compiled and analyzed suicide deaths, attempts, or suicidal ideation among university students. Therefore, there is, at this time, no known association between increased staffing levels and a resulting increased demand in sessions or a decreased ratio of staffing levels to students who are awaiting sessions. A similar review should be undertaken of the number of patients seen for behavioral health concerns in Student Health, including but not limited to Psychiatry. A survey of these same institutions would assist in providing a robust portrait of the need for services in both Student Health and Counseling Centers. It may also assist to have deeper analysis of the length of these individual and group sessions across both services, and to also distinguish between the length of these sessions for new patients versus returning patients.



What is Behavioral Health Integration?

(continued)

It may also be suggested that these studies have defined staff in limited ways that may not encompass all the many resources available on campuses that offer some segment of the health care or support available to students experiencing behavioral health concerns. Additional research and study is needed to truly understand the resources available on each campus and how integrating those resources may increase availability of behavioral healthcare across campus. Depression is a multifactorial issue, and in order to truly appreciate an accurate correlation between access to care and increased numbers of reported behavioral health issues, more research should be done, including comprehensive surveys beyond select staffing rates.



What is Behavioral Health Integration?

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Demand from Students in Crisis

The numbers of students in crisis have also increased since the 2014-15 academic year when the number of emergency or crisis visits was approximately 4,200. In the 2015-2016 academic year, that number more than doubled, with more than 9,100 visits reported (a 116% increase). These numbers understate the extent of the problem, as emergency or crisis visits to psychiatrists located in the Student Health centers are not represented. Therefore, not only is the number of visits increasing, but also the acuity of the patient conditions for which students are presenting. It should be noted that patients with higher acuity issues or who present in crisis would be best served by experienced behavioral healthcare providers.

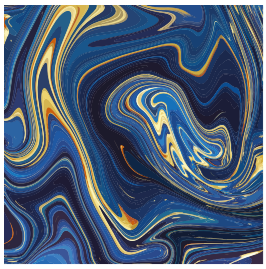
Further, the number of Baker Act involuntary admissions has also increased from a little over 300 in 2013-2014 to more than 440 in 2015-2016 (a 46% increase). These figures do not include those students who are involuntarily admitted off campus and without the knowledge of either Student Health or Counseling Centers, or any other academic office or staff.

Table 2: Number of Emergency/Crisis Visits[1] and Number of Baker Act Hospitalizations[2]

	Number of Emergency Visits		Number of Hospitalizations	
	2014-15	2015-16	2014-15	2015-16
Florida Agricultural & Mechanical University	N/A	16	0	*
Florida Atlantic University	222	317	22	29
Florida Gulf Coast University	104	179	*	*
Florida International University	41	245	25	26
Florida State University	1,021	1,105	70	101
New College of Florida[3]	42	43	16	*
University of Central Florida	1,636	2,598	40	139
University of Florida	220	3,135	57	62
University of North Florida	321	395	25	*
University of South Florida	392	891	22	51
University of South Florida – St. Petersburg	23	41	*	*
University of West Florida	176	232	11	12
SYSTEM TOTAL	4,198	9, 197	304	446

Source: Data as submitted by SUS institutions (January 2015 & February 2017)

[1]Does not include emergency or crisis visits to student health center psychiatrists



What is Behavioral Health Integration?

(continued)

Suicide on Campus

In 2015-2016, fewer than 10 suicides occurred on state university campuses. The number of student suicides off campus is unknown, as officials are not always aware, or these deaths may be reported as accidents. However, the rate of suicide is increasing in America and is now the 10th leading cause of death. In 2016, 3,122 individuals in Florida took their own lives. Clinicians in emergency, primary, and behavioral healthcare settings are often uniquely positioned to detect suicide ideation and facilitate appropriate evaluation. Behavioral health professionals play an additional important role in providing evidence-based treatment and follow-up care. For all clinicians working with patients with suicide ideation, care transitions are very important.

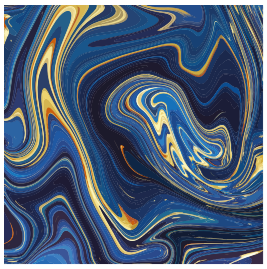
Suicide is the second leading cause of death for Americans between the ages of 15 and 24, as well as within the college student population, with 10% of college students reporting seriously considering an attempt at suicide. The percentage of adults having serious thoughts about suicide was highest among adults aged 18 to 25 (7.4%). In addition, among students in grades 9 through 12, 17% seriously considered attempting suicide in the previous 12 months.

A number of psychosocial concerns may also predispose this patient population to an increased risk of suicidal ideation, including social isolation, sexual orientation, conflicts with family or friends, and the pressures of academic performance. These patients are also noted to show a lack of resiliency when dealing with these setbacks.

The risk of suicidal ideation is also sometimes increased by the use of antidepressants in young adults ages 18 to 24 years. By request of the FDA in 2004, manufacturers of antidepressant medications added a warning to the labeling of their products, informing consumers of the increased risk of suicidal thinking or suicidal behavior in children and adolescents taking antidepressants during initial treatment and with dose increases.

This patient population may also be susceptible to use and abuse of drugs and alcohol, which are known to alter brain functioning, emotions, and judgment, and may increase risky behaviors. The use of drugs or alcohol is often associated with completed suicide, and persons with history of substance abuse were more likely to engage in suicidal behaviors.

Depression is a serious public health problem for the college student population, as it has consistently been considered a risk factor in suicide. Based on findings from the American College Health Association (ACHA) National College Health Assessment (NCHA), the rates of students reporting having been diagnosed with depression has increased from 10% in 2000 to 18% in 2008. The NCHA reveals that 6.1% of female and 6.4% of male respondents have seriously considered suicide in the past year, and 1.2% of female and 1.5% of male respondents have seriously considered suicide in the past 2 weeks. Further, 11% of students reported current (past 4 weeks) suicidal ideation. An analysis of the Spring 2000 NCHA data revealed that less than 20% of students reporting suicidal ideation or attempts were receiving treatment.



What is Behavioral Health Integration?

(continued)

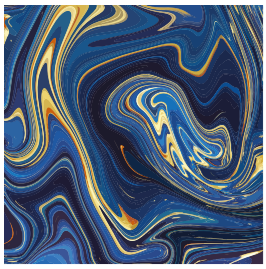
Addressing Demand for Counselors	
Florida Agricultural & Mechanical University	1:1,923
Florida Atlantic University	1:2,014
Florida Gulf Coast University	1:1,324
Florida International University	1:2,449
Florida Polytechnic University	1:618
Florida State University	1:1,908
New College of Florida	1:1,182
University of Central Florida	1:1,828
University of Florida	1:1,660
University of North Florida	1:1,508
University of South Florida	1:2,044
University of South Florida – St. Petersburg	1:1,900
University of West Florida	1:1,625

Source: Data as submitted by SUS institutions (February 2017)

Staffing levels at several SUS institutions struggle to achieve the ideal levels recommended by the International Association of Counseling Services (IACS). IACS recommends 1 counselor for every 1,000 to 1,500 students enrolled. Various counseling centers have attempted to balance the demands and the lack of resources by:

- Reducing the frequency and length of appointments
- Placing a limit on the maximum number of sessions
- Providing referrals to outside behavioral healthcare providers
- Hiring temporary, part-time, or provisional counselors

Student Health Centers are also addressing the demand for behavioral healthcare by utilizing behavioral health coaches who focus on wellness and support, online education modules addressing common issues like depression and anxiety, and personal therapy sessions via webcam. It should be noted that other resources on university campuses, not captured by the data submitted to the BOG regarding counselor demand and availability, are also available to provide behavioral healthcare, including the Student Health Center. This may offset some of that demand based on population needs on certain campuses, and which may also be further offset by a shift toward greater integration.



What is Behavioral Health Integration?

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It may be argued that the suicide rate on university campuses is lower because of the education and services provided by a number of university resources, including Counseling Centers and Student Health. University institutions are able to provide a number of services that the students need, resulting in a suicide rate that is lower on university campuses. Reduction or elimination of the occurrence of suicide necessitates additional and more collaborative services.

	Undergrads only[3, 4, 5]	Undergrads and grads combined[6, 7, 8]	Not enrolled in college full-time, ages 18-22[9**]
Seriously considered suicide	**6.6%-7.5%**	**7.1%-7.7%**	**9.0%**
Made a plan	**2.2%-2.3%**	**2.3%**	**3.1%**
Attempted suicide	**1.1%-1.2%**	**0.6%-1.2%**	**2.2%**

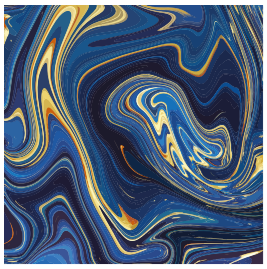
Source: Suicide Prevention Resource Center, Suicide among college and university students in the United States, 2014

Findings from a study published in the Journal of General Internal Medicine titled "Health Care Contacts in the Year Before Suicide Death," summarized below, illustrate this need:[ii]

- The majority of those who died by suicide received health services in the year prior to death;
- On average, 45 percent of individuals had contact with primary care within a month before suicide;
- Over 60 percent of individuals made primary care and medical specialty visits without mental health diagnosis in the year before death; and
- Psychological autopsy studies demonstrate that over 90 percent of those who die by suicide have mental health problems.

Like risk factors referenced in a number of studies, the protective factors that help to reduce the likelihood of suicide may also vary depending on that patient's individual characteristics and social support networks. University and campus community factors may also play a role as a protective factor:[ii]

- Supportive and inclusive peer and mentor environment
- A sense of connectedness to school and of belonging within the school community
- Availability and accessibility of student support services and personnel
- Involvement in extracurricular activities, e.g., joining a student club or organization
- Access to effective care for mental, physical, and substance abuse disorders
- Restricted access to lethal means, especially firearms (e.g., firearms are not allowed on campus)
- Monitoring and control of alcohol and drug use



What is Behavioral Health Integration?

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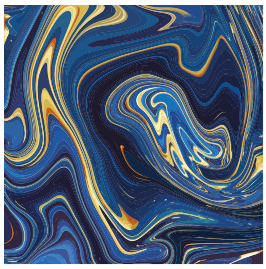
Continuum of Integration

Substance Abuse and Mental Health Services Administration (SAMHSA) describes a conceptual framework for integration with varying levels of collaboration. These range from minimal collaboration to full collaboration with a merged and integrated practice where patients experience their care in a single system. The mental and physical health needs of the specific patient population should first be identified, then matched to the appropriate level of collaboration and the specific behavioral health integration model best suited to those needs.

- Coordinated care
  Level 1: Minimal collaboration — patients referred to another practice site.
  Level 2: Basic collaboration — providers periodically communicate about shared patients.
- Colocated care
  Level 3: Basic collaboration on-site — providers at the same site periodically communicate but maintain separate cultures and separate treatment plans for patients.
  Level 4: Close collaboration on-site with some system integration and shared records — providers have some face-to-face communication about shared patients and feel part of a team.
- Integrated care
  Level 5: Close collaboration approaching an integrated practice — collaborative treatment planning for shared patients, but separate planning for other patients.
  Level 6: Full collaboration in a merged integrated practice for all patients — a team of providers jointly develops a single treatment plan for patients. Patients experience their care as a single system treating the whole person.

REFERRAL		CO-LOCATED		INTEGRATED	
Key Element: Communication		**Key Element: Physical Proximity**		**Key Element: Practice Change**	
Level 1 Minimal Collaboration	**Level 2** Basic Collaboration at a Distance	**Level 3** Basic Collaboration On-Site	**Level 4** Close Collaboration On-Site with Some System Integration	**Level 5** Close Collaboration Approaching an Integrated Practice	**Level 6** Full Collaboration in a Transformed/Merged Integrated Practice
Behavioral health, primary care and other healthcare providers work:					
In separate facilities	In separate facilities	In same facility not necessarily same offices	In same space within the same facility	In same space within the same facility (some shared space)	In same space within the same facility sharing all practice space

Coordinated care is the most basic and limited level of coordination. **Co-located care** represents another level of collaboration between behavioral health and primary care providers wherein both services are delivered within the same practice. This refers to working in a shared space to one extent or another, and may include both a physical or virtual shared space. This may be an evolution for healthcare providers who are separated by distance within the same healthcare institution. This may also include the evolution of increasingly shared workflows, medical records, culture, and levels of collaboration.[ii]



What is Behavioral Health Integration?

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Varying levels of integration may exist across and within each university campus. Physical proximity may not be possible, but changes in communication levels and manner of practice can be addressed with an integrated behavioral health model that utilizes the same medical record system and similar clinical pathways for patients presenting at any of the integrated healthcare locations.

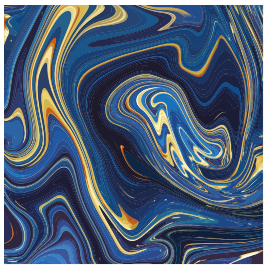
As each of the models describe, including a referral or coordinated care, co-located care, or fully integrated care, there is a great deal of variety in the level of collaboration between primary care and behavioral health care providers and facilities. These recommendations are fully supportive of the concept of a close collaboration between primary care and behavioral health care providers. However, there is limited data regarding improved outcomes of a fully integrated model compared to a Collaborative Care model. Depending on the patient's primary complaint and the availability of resources, the spectrum of models utilized and the determination of the best course of care may be highly variable. Therefore, though full integration is optimal in theory, it may not be feasible in practice, depending on the patient's condition.

Addressing Demand through an Integrated Collaborative Care Model

Though the request for additional funding is supported by the increasing needs of the university student population and the demand for additional behavioral healthcare providers, those requests have been denied and legislative budget funding is not guaranteed. The ability to deliver innovative and integrated behavioral healthcare is of great importance. Efficiency and effectiveness of behavioral healthcare can be accomplished through integrated clinical pathways that reduce waste and provide a greater number of behavioral healthcare providers to optimize the healthcare of patients with behavioral healthcare conditions.

The Collaborative Care model, in general, describes an ongoing relationship between clinicians over time. It is team-driven and provides for a multidisciplinary group of healthcare delivery professionals that may provide coordinated care to a defined patient population pursuant to their professional training, while assisting with quality improvement efforts. This model seeks to integrate behavioral health into the primary care setting and thereby normalize and destigmatize behavioral health issues. This model also seeks to increase access for patients by making behavioral health services more readily available, increasing convenience, and encouraging familiarity with the providers and services available. Collaboration allows multiple providers to combine their perspectives to understand and identify the problems, opportunities, and treatments, often within an ongoing relationship with each other and with the patients, to continually revise treatment as needed to meet treatment goals, e.g., the Collaborative Care of depression among primary care providers, care coordinators, and consulting psychiatrists.[ii] Further, the Collaborative Care Model has the most support among integration models to demonstrate its effective and efficient integration in terms of controlling expenses, improving access, improving clinical outcomes, and increasing patient satisfaction in a variety of primary care settings.

The Collaborative Care management model is the dominant model utilized for the enhanced coordination of care. "Collaborative Care" has been defined as the linking of patients with primary care and mental health providers in a joint management effort. Often, this joint effort is coordinated by a care or Case Manager.



What is Behavioral Health Integration?

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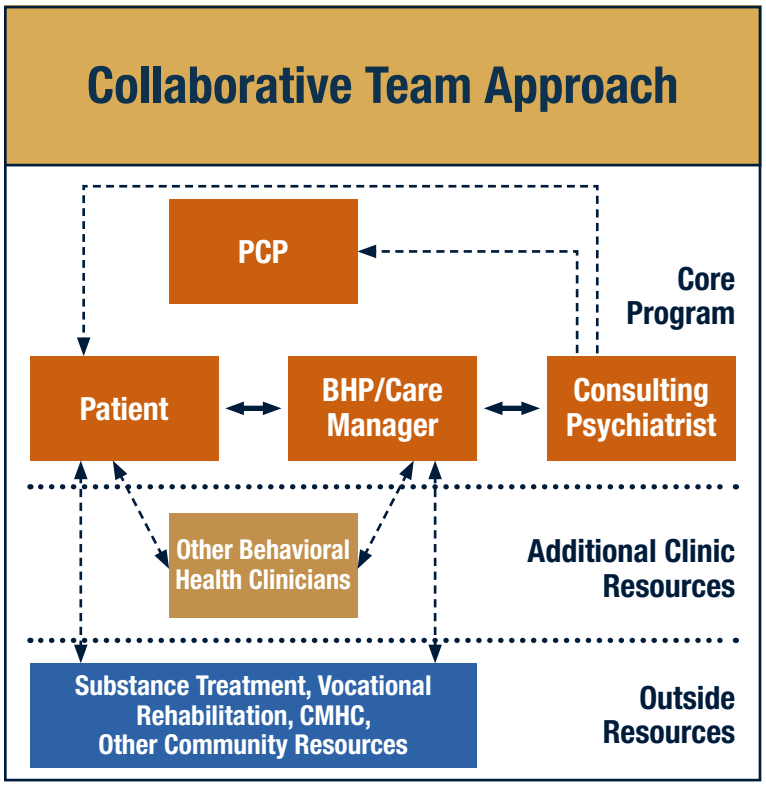
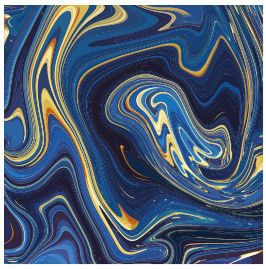


This model provides structured communication and increases the frequency of communication among patients and their treating clinicians. A large number of patients will have presented to their primary care healthcare provider for other health concerns prior to attempting suicide. For depression and anxiety disorders, some studies estimate that 80% of patients could be managed by primary care providers with the support of a Case Manager, while the other 20% of patients need the direct involvement of a mental health specialist.

Effective management of the Collaborative Care model may also require the ability to track outcomes in order to support changes in individual treatment and allow for the proper allocation of resources. A registry of patients identified in the medical record would allow for:

- Tracking of clinic outcomes;
- Tracking of departmental and individual provider caseload levels;
- Facilitation of regular (weekly) case review, which would allow the behavioral intervention team to prioritize patients for changes in treatment;
- Follow up for regular or as needed evaluations/PHQ-9;
- Confirmation of regular visits with mental health providers;
- Monitoring of treatment adherence by care managers; and
- Regular supervision of care managers by mental health specialists.



What is Behavioral Health Integration?

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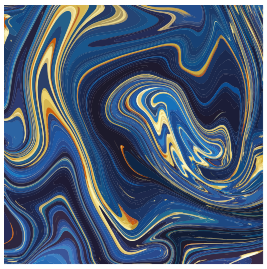
Patient Tracking Registry

The effective management of a collaborative and integrated behavioral health model is highly dependent on the organization and tracking of these patients' needs across and within healthcare systems. It is a measurement-based, team approach to the management of the patient and requires the tracking of not only the patient, but the healthcare providers who are providing their care. In order to organize what are potentially multiple services and providers, the Case or Care Manager is of vital importance. Though full integration may not be possible at every institution, the Case Manager may be in the best position to provide a bridge between the patient, the other healthcare providers, and what may be several physical locations. The use of a Patient Tracking Registry would assist the Case Manager in organizing and tracking the patient's care and the workload of each of the healthcare providers in both Counseling Centers and Student Health. The sharing of healthcare information and medical records is also critical and can be facilitated by the inclusion and integration of a Case Manager.[ii]



Addressing Behavioral Health Concerns

Screening for Behavioral Health Concerns

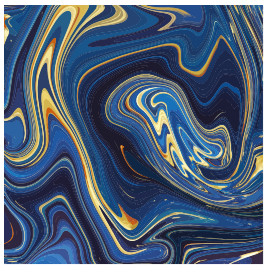
Upon presentation to Student Health Services or the Counseling and Wellness Center, every student should receive a universal routine screening of behavioral health concerns, including depression. This screening should be performed at the time of the initial enrollment and, if there are no concerns at that time, yearly thereafter during well visits.

Upon initial presentation, the patient should receive the Patient Health Questionnaire 2 (PHQ-2), questioning whether the patient has, in the last two weeks, experienced little interest or pleasure in doing things, and whether they feel down, depressed, or hopeless. It should be noted that the PHQ-2 may have high sensitivity, but a lower degree of specificity.

If the patient answers affirmatively to any of these questions, then the Patient Health Questionnaire 9 (PHQ-9) is administered. This tool measures the presence, duration, and frequency of depressive symptoms and allows for the rating of the severity of the patient's depression, suicidal ideation or other high risk disruptive behaviors. If the PHQ-9 is also indicative of increased depression severity, the healthcare provider may also consider administering additional screening tools such as the Columbia-Suicide Severity Rating Scale that also assists in an assessment of whether someone is at risk for suicide, the severity and immediacy of that risk, and the level of support that the person needs.

Patient and family history of suicidal ideation, prior suicide attempts, depression or bipolar disorder can increase the likelihood of future attempts; therefore, each patient should also be questioned about their history of suicidal ideation and that of their family.

This history should be solicited in conjunction with a review of the screening tools, which may include the PHQ-2 and the PHQ-9, or the Columbia-Suicide Severity Rating Scale, as well as with guided interview questions, all prior to the patient's discharge. Variations of the PHQ have received a Grade B recommendation by US Preventive Services Task Force (USPSTF) for both adult and adolescent screening of depression. As to the screening of Suicide Risk in Adolescents, Adults, and Older Adults, the USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service, meaning that, "Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined."



Addressing Behavioral Health Concerns

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Safety Planning for Suicidal Ideation

Once a patient has been identified through screening to have suicidal ideation, regardless of the severity of risk, a behavioral health clinician should be consulted.

For patients in an acute suicidal crisis, the patient should be kept in a safe environment with one-to-one observation until transfer to critical resources, i.e., inpatient psychiatric facility or emergency room.

For patients with lower risk of suicide, a direct referral to a behavioral health specialist should be made for follow up within one week. If a behavioral health specialist is not available within one week, every effort should be made to provide the patient with a referral to an outpatient behavioral health provider.

For all patients who screen positive for suicidal ideation, the following should be accomplished prior to discharge:

- Provide contact information for national and local crisis support
- Conduct a safety plan, provide coping strategies to reduce risks
- Restrict access to lethal means
- Consider contacting the patient's family

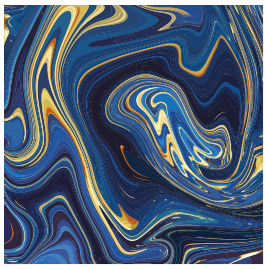
Documentation of Suicidal Ideation

Thoroughly document all decisions by healthcare providers regarding the referral of at risk patients, including all healthcare decisions, and communication with the patient, their family, and other caregivers. In addition, carefully document why the patient was deemed to be at risk and how the determination of suicidal ideation was made, specifying the screening tools utilized and the severity risk rating. The healthcare provider should also document that a safety plan was discussed, the details of that safety plan, and how the patient reacted to the safety plan. In the event of suicidal ideation or low risk of suicide, document those plans for follow up with the patient, including any referrals or appointments made or treatment administered. Finally, a safe discharge to home and with whom (if applicable) should also be documented.

Documentation of Suicidal Crisis

In the event of an acute suicidal crisis, the healthcare provider should also document that the patient has been placed under observation, without access to lethal means that may be injurious to them or others. If the patient requires transfer to an inpatient psychiatric facility, detailed documentation of the basis for this decision, and documentation of the patient's safe transfer to University Police or other form of transport should be included in the medical record. The patient's physical and mental health at time of transport should be carefully recorded.

Recommendations for a voluntary admission to an inpatient psychiatric facility or transfer by a patient's family member are advised against, and should be undertaken only under the rarest of circumstances as determined on a case-by-case basis. It is suggested that this determination be made following a thoughtful discussion with other staff involved in that patient's care, whenever possible. Detailed documentation of this decision and the deliberations should be included in the medical record.



Addressing Behavioral Health Concerns

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In addition to documentation of the suicidal crisis in the medical record, members of the integrated behavioral health team should also be advised of the patient's condition and transfer. This should include the Dean of Students, when legally permissible, so that their office may communicate the development to the patient's family or caregivers, to University Police if not already aware, and to Residence Staff if the patient resides on campus.

Behavioral Health Integration team members should communicate to other treatment facilities on campus, and other team members, in the event of an acute suicidal crisis so that the patient may receive appropriate follow up care upon their return to campus with the appropriate healthcare providers. Again, Case Managers may serve as an effective bridge between the Counseling Centers, Student Health, the Dean's office, and any other members of the Behavioral Health Integration Team.

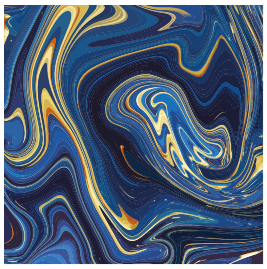
Return to Campus

If the patient is admitted by an inpatient psychiatric facility, following discharge from that facility, the patient should be referred back to a member of the Behavioral Health Integration Team. Ideally, Student Health and the Counseling Center will have a memorandum of understanding with all local hospitals regarding the patient's referral back to Student Health Services or the Counseling Center. This may be significantly more difficult in higher density population areas with a large number of local facilities. In addition, the patient may return with a copy of his or her discharge summary and/or psychological assessment for continuity of care. This discharge summary may serve as an assessment that will allow the patient to return to campus.

If, despite an appropriate referral, the patient is not admitted by the inpatient psychiatric facility, the patient must establish contact with Student Health or the Counseling Center to receive another risk assessment. This reassessment of the student's mental health would allow for a renewed evaluation of that patient's condition and whether they can tolerate a return to academic and campus stressors. The results of this encounter will determine whether the patient will again be referred to an inpatient psychiatric facility. The patient may also obtain an assessment from an outside provider that will allow the patient to return to campus upon production of appropriate documentation and a visit with Student Health or the Counseling Center. Consideration should be given to the patient's specific issues and a determination should be made on a case-by-case basis regarding the need for a second assessment, so as not to create an undue burden to the student, and to encourage student success upon return. The health care provider may not want to mandate a second assessment, unless the student is perceived as an imminent threat to himself or others.

Further, if the patient is referred to an inpatient psychiatric facility for suicidal ideation or attempt, or as a threat to himself others, whether admitted or not, return to academic and campus activities may be contingent upon a number of visits to Student Health and/or the Counseling Center, to be determined by the Behavioral Health Integration Team. The number and types of sessions and requirements should not be stipulated, as each individual patient presents with specific issues, and each health care provider is governed by specific laws and guidelines. In order to avoid a conflict of interest between the patient and the university, it is helpful to have a designated health care provider to assess the patient who is not part of the psychology department or the counseling center.

The purpose of these visits is not to determine their ability to return to academic and campus activities, but rather to determine whether the patient, following their most recent assessment, will have the health care resources and providers they require at Student Health and/or the Counseling Center. If so, the health care provider should



Addressing Behavioral Health Concerns

(continued)

document that they have performed an assessment and/or have had the opportunity to review the patient's most recent assessment by the inpatient psychiatric facility and that the patient has been deemed to be well served by the resources available on campus. If not, referral to an outside provider should be secured and documented.

Notification of Family

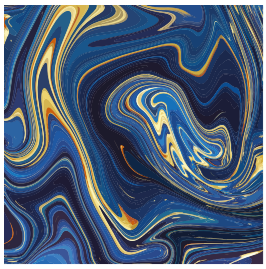
Consent in the mental health treatment context must be voluntary, by a person who is competent to choose, and who is fully informed and understands the consequences of that choice. Individuals competent to consent to treatment are also competent to refuse or revoke consent to treatment. At each encounter, the health care provider must determine whether the patient being treated is competent to provide express and informed consent to his or her treatment. If the patient is not competent to choose, or becomes incompetent during the course of treatment or an evaluation, the patient must be considered to be under an involuntary status. The determination of ability to consent is dependent on a health care provider's evaluation and should be documented. If possible, questions of consent and competency may be discussed with the General Counsel of the institution to assist in the determination.

Each patient receiving treatment, other than those who are incapacitated or incompetent to consent to treatment, must be asked to give express and informed consent for that treatment. If the patient is a minor, express and informed consent for treatment is required from the parent or guardian. No patient can be administered treatment without express and informed consent to the treatment by the patient or a legally authorized individual, except in documented cases of imminent danger when a health care provider orders emergency treatment. Generally, patients under the age of 18 cannot consent to their own treatment because they are presumed to be legally incompetent as a result of their age or presumed immaturity of judgment.

During an emergency medical situation, including those where the patient is a danger to herself or others, a health care provider may render emergency medical care or treatment to any minor suffering from an acute illness, disease, or condition if, within a reasonable degree of medical certainty, delay in initiation or provision of emergency care or treatment would endanger the health or physical well-being of the minor patient. This applies only when parental consent cannot be immediately obtained for one of the following reasons:

- **The minor's condition has rendered him/her unable to reveal the identity of their parents/guardian; or**
- **The parents/guardian cannot be immediately located by telephone at their place of residence or business.**

Notification must be accomplished as soon as possible after the emergency care or treatment is administered to a minor patient. Medical records should reflect and document the reason such consent was not initially obtained and must contain a statement by the health care provider that immediate emergency care or treatment was necessary for the patient's health or wellbeing. The notification of the family or health care surrogate of an adult patient may present a greater challenge. There may be challenges presented by the need to review existing medical records, and additional challenges depending on designations the patient may have made regarding their wishes that specific individuals be contacted. In the event of an involuntary transfer, the Dean of Students may contact the patient's next of kin, likely following a call from the university police department regarding a transport being initiated.



Addressing Behavioral Health Concerns

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Postvention

Each University should establish a Postvention Committee, i.e., an interdisciplinary team of individuals and departments to coordinate and communicate regarding the following:

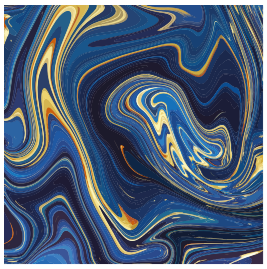
- Reducing risk of suicide contagion
- Support to survivors
- Support to healthcare providers
- Dissemination of factual information as appropriate
- Condolences to family
- Coordination of information and records to next of kin
- Consideration of legal issues

A great deal of variability exists among available postvention plans, and these may vary further depending on the specific circumstances involved. The Postvention Committee may also perform as a subset or overlap of other established teams like the Behavioral Intervention Team or a Second Victims program, which may already be aware of the student or providers involved.

Mental Health Education

The transition to college involves personal growth, greater independence, and academic demands that may cause stress to both students and families and may result in, or further impact, mental health issues. Efforts should be made to reach students and families prior to orientation. These efforts may be coordinated with the orientation committees of each University, in order to provide not only education, but a list of available campus and community resources. Where there is an existing behavioral health issue, this will provide time and an opportunity for transition of care and reduce those stressors for students.

On-campus orientations of newly enrolled students should also involve coordination with orientation committees to emphasize the importance of promotion of mental health resources, including the integration and coordination of mental healthcare across campus and surrounding areas. Coordination with orientation committees should include a discussion of the importance of behavioral health issues and obtaining a reasonable amount of time to discuss these issues with incoming students. Attention should also be paid to graduate programs that also experience a high rate of behavioral health issues to ensure orientation programs reference available resources on campus. It is important to consider a mental health outreach program at new student orientation and to advise of the behavioral health options available. Advance mailings should also be considered as part of the orientation to campus resources.



Addressing Behavioral Health Concerns

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The promotion and education of primary healthcare providers regarding behavioral health issues is also important to the integrated care of patients. A knowledgeable provider is better able to diagnose behavioral health issues and make the patient more comfortable by using supportive language and prompts. In addition, utilizing a screening tool as part of the routine clinical practice can make the patient more comfortable and normalize the discussion of behavioral health concerns. Further, a knowledgeable provider should have access to campus and local resources for behavioral health concerns.

Integration of Information in the Medical Record

Dissemination of information about behavioral health diagnoses and treatment remains sensitive and is sometimes stigmatized, and requests to share those medical records amongst providers, often within the same healthcare system, can be met with resistance. Therefore, it would be beneficial, at the time of initiation of treatment in Student Health Services, Counseling Center, or any other behavioral health provider on campus, to include language in consents for treatment and counseling permitting the disclosure of this information amongst healthcare providers.

Ideally, each of these behavioral health providers would document in the same electronic medical record, which would be accessible to all healthcare providers and affiliated health systems.

SHS Consent

Informed Consent for Treatment

I understand that Student Health Services works in conjunction with Counseling Center. I authorize the release of information between these entities based on the need for diagnosis and treatment. I further authorize release of any information to county, state, or federal public health agencies, as required by law.

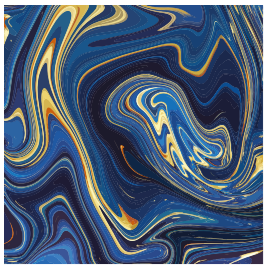
I agree that my patient information (including, but not limited to, my medical records, billing information, and information I disclose to a healthcare provider in the course of my care) may be disclosed to employees, officers, agents, and legal representatives of the University, for purposes of risk management, and formal and informal dispute resolution processes (including, but not limited to, litigation, and mediation) involving the University or other entities.

CWC Consent

Informed Consent for Counseling

I am authorizing the disclosure/release/exchange between Student Health Services and Counseling Center of all records and information generated by Student Health Services and Counseling Center and its providers, including confidential and Protected Health Information (PHI) as defined under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), specifically including but not limited to:

- MEDICAL
- PSYCHIATRIC/PSYCHOLOGICAL/MENTAL HEALTH (including psychotherapy session notes)
- ALCOHOL/SUBSTANCE ABUSE



Addressing Behavioral Health Concerns

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Considerations for Policies and Procedures for Suicide Risk Assessment, Screening, and Management

Despite all the information and care available to individuals who exhibit suicidal behavior, suicide behavior remains complicated and unpredictable. To assist in preventing suicide, prompt identification of and intervention for individuals at risk of suicide is a necessity. A well-devised and thorough clinical assessment of the individual remains the most effective manner of determining suicidal risk. Evaluations of individuals at an increased risk of suicide are based on fact-specific assessments of the individuals utilizing a combination of patient history and existing stressors. Such assessments include, but are not limited to, evaluation of previous suicide attempts, history of mental illness, past and current drug use, current physical state, and social influencers. All individuals suspected of being at an increased risk for suicide should receive a comprehensive suicide risk evaluation by the behavioral health care providers.

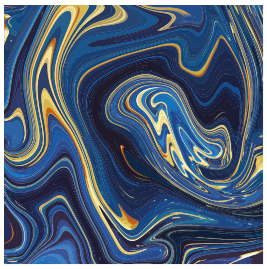
Moreover, it is imperative that individuals demonstrating suicidal behavior and ideation receive a prompt suicide risk screening and a referral for a complete mental health assessment, if appropriate. The objective of these screenings is to calculate the level of suicide risk at a particular time and arrange for the proper clinical health supervision and care. Deploying a collaborative team approach, a thorough assessment of suicidal behavior in individuals is an ongoing process from the individual's first appearance with a behavioral health care provider to his eventual discharge. A collaborative team approach ensures that there is concerted effort from all parties involved. It may also be appropriate to provide information to the families of the individuals at risk of suicide to supplement their involvement in the health care provided.

As discussed previously, at each stage of the evaluation, there must be documentation of the treatment provided to the individual. A well-documented evaluation and management strategy is indispensable to the effective supervision of the person's suicide risk, and this documentation should be accessible in the individual's medical record. Due to the nature of the health care being provided, confidentiality with regards to any personal information within the documentation of the evaluation and screening must be discreetly maintained to secure the person's privacy.

Positive Suicide Risk Screening

While assessing suicide risk in individuals remains a challenge for health care providers, it is important to detect risk factors when considering suicide risk, particularly when individuals do not voluntarily divulge any suicidal ideations they may have. Factors suggesting an individual may be at an increased risk of suicide include:

- Mental illness, specifically depression and bipolar disorder
- Past suicide attempts or self-inflicted injury
- Family history
- History of abuse or trauma
- Medical history including chronic pain and/or impairment
- Past and current drug/alcohol use
- Antisocial behavior and/or pattern of aggression



Addressing Behavioral Health Concerns

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Suicidal Precautions

Suicide precautions are considered to be constant interventions designed to provide a safe setting for patients recognized as demonstrating suicidal ideations or behavior. Patients appearing in a healthcare setting should be assessed for suicidal ideation as part of the routine admission procedures. Behavioral health care providers must continue to evaluate the patient's risk on a constant basis, and patients presenting with a behavioral, drug abuse, or emotional concerns should undergo a suicide risk screening.

If the results of the suicide risk evaluation directs that the patient may have suicide ideation, health care providers must initiate suicide precautions and advise the faculty provider for supplementary assessment.

If, at any time during the clinic visit, behavioral health care providers have apprehensions about any behavioral or emotional disturbances demonstrated by a patient, or if results of the suicide risk evaluation warrant additional action, the providers should notify a faculty provider to determine if further assessments and suicide precautions are required.

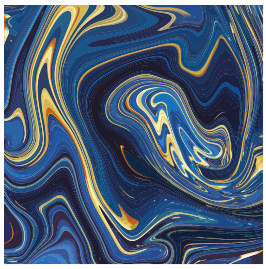
Patient Care Guidelines

After a thorough suicide risk screening has been performed by a qualified provider, the provider must then analyze the results and estimate the individual's risk of dying by suicide. Even though suicidal ideation and suicide attempts are connected with increased suicide risk, most individuals with suicidal ideation or attempts will not die by suicide. It is projected that suicide ideations and attempts occur in approximately 5.6% and .7% of the general U.S. population per year, respectively; however, .0107% of the total U.S. population dies by suicide per year. This disparity in suicide ideation and attempts versus deaths resulting from suicide demonstrates that even in populations recognized to be at a higher risk than the general population, the variance of suicide contributes to the difficulty of predicting suicide.

Due to the infrequency of correctly predicting suicide solely on the identification of risk factors, the healthcare provider's primary purpose must be to reduce the possibility of successful suicide through a comprehensive assessment of the patient's suicide risk. When evaluating risk factors for a patient, it may be appropriate to give the following factors consideration:

- Presence of psychiatric illness
- Specific psychiatric symptoms such as hopelessness, anxiety, agitation, or intense suicidal ideation
- Psychosocial stress and availability of methods
- Other relevant clinical factors such as genetics and medical, psychological or psychodynamic issues

It is significant to understand that determining the presence, or absence, of any of the above factors is not the aim of the healthcare provider when attempting to evaluate risk of suicide, but rather to determine the severity of the factors. Furthermore, it is not uncommon for certain factors to surface only while in the presence of other particular psychosocial stressors.



Addressing Behavioral Health Concerns

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After risk factors have been identified, the healthcare provider must then determine if the identified factors are modifiable in order to reduce a patient's suicide risk. While immutable characteristics such as family history and personal demographics are important, the treatment should attempt to alleviate or strengthen those suicide risk and protective factors susceptible to modification and support.

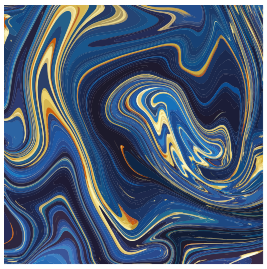
In addition to evaluating an individual's suicide risk, psychiatric management should be implemented for patients who report having suicidal ideation, plans, or behaviors. Often consisting of a variety of therapeutic interventions that can be tailored to the individual, psychiatric management comprises a collaborative relationship, attention to the safety of the patient, and development of a setting conducive to treatment and supervision. Once a patient has been in ongoing treatment, psychiatric management will continue to focus on coordinating treatment between healthcare providers, consistent reviews of the patient's safety and functioning, and providing education to the patient and the patient's family regarding treatment adherence and benefits.

It is not uncommon for some patients to continue self-harming behaviors during treatment. While some of these patients do display or report suicidal ideation, each instance must be reevaluated to determine if a different treatment plan should be implemented. In providing treatment to patients with repeating or severe self-harming behavior, healthcare providers need to be cognizant that their reactions may disrupt treatment, and supervision by additional healthcare providers may further reaffirm the appropriate treatment plan.

Related Policies and Procedures

With the goal to provide students an environment that nurtures and supports their growth, universities are becoming increasingly aware of the demand for more comprehensive mental well-being programs. Since the fall of 2008, there has been a 48% increase in the number of students seeking counseling services at SUS institutions. There has also been a 67% increase in the number of counseling sessions in the past 6 years for issues of anxiety, depression, academic stress, and relationship issues. The SUS centers have also recorded 4,200 emergency or crisis visits during 2013-2014. In response to the growing demands for student mental health services, many universities, such as UF, FAMU, FAU, FGCU, FSU, USF, New College, UCF, UNF, and Florida Polytechnic University, have submitted proposals requesting additional funding in order to address this critical need. The primary objective of these proposals is to directly support students in their mental and behavioral health needs, to assist them in meeting their academic goals. While increasing access and providing high-quality mental health treatment services to students are crucial, expanding efforts to prevent and promote mental health of all students is essential. For this reason, many universities are embracing a systems- thinking public health approach. This approach includes tiered prevention strategies that address multi-level factors that impact student mental health and ensures the best services are in place to meet the various mental health needs of the students.

Overall, the collaborative system-thinking and public health approach to mental well-being among students focuses on meeting an individual student's needs. Using a three (3) tiered approach (Universal, Targeted, and Intensive, respectively), the approach works to increase the mental health literacy among students and staff and to increase the capacity for identifying signs and symptoms of poor mental well-being. To attain this goal, the approach advocates creating a tailored marketing campaign to improve mental health literacy among students especially among priority populations, such as racial and ethnic minorities, transfers, males, and international students. Furthermore, it promotes



Addressing Behavioral Health Concerns

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increasing office availability to improve access to licensed mental health providers. Together, these tiers work in concert to establish effective coping mechanisms and resiliency among the student body.

The Florida Academic Healthcare Patient Safety Organization is committed to patient safety and quality improvements, made possible by the members of the PSO and for the benefit of the patients they care for. Through continued collaboration of subject matter experts and sharing of lessons learned by our healthcare providers, we hope to move toward model of integration that better serves our patients.

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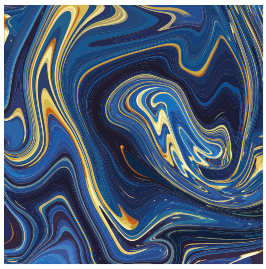

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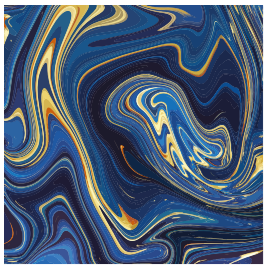


Resources

National Suicide Prevention Lifeline

Crisis support 24 hours a day, 7 days a week by phone and live chat
1 (800) 273-8255
www.suicidepreventionlifeline.org

Centers for Disease Control Division of Violence Prevention

www.cdc.gov/violenceprevention/suicide/riskprotectivefactors.html
https://www.cdc.gov/violenceprevention/pdf/suicide-datasheet-a.pdf

American Psychiatric Association

https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/get-trained/about-collaborative-care

The Florida Suicide Prevention Coalition

www.floridasuicideprevention.org

The Florida Department of Children and Families

Statewide Office for Suicide Prevention
www.myflfamilies.com/service-programs/mental-health/suicide-prevention/about-suicide

Florida Department of Health

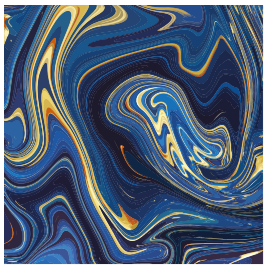
http://www.flhealthcharts.com/charts/DataViewer/DeathViewer/DeathViewer.aspx?indNumber=0116

Federal Drug Administration

https://www.fda.gov/Drugs/DrugSafety/InformationbyDrugClass/ucm096273.html

Substance Abuse and Mental Health Services Administration – Health Resources and Services Administration Center for Integrated Health Solutions

https://www.integration.samhsa.gov/integrated-care-models/behavioral-health-in-primary-care#integrated%20models%20of%20BH%20in%20PC



Funding and Research Opportunities

AHRQ has also identified “Future Research Needs for the Integration of Mental Health/Substance Abuse and Primary Care” noting that existing studies contained multiple research gaps and limitations, including conditions other than depression or care integration in younger populations. One of the largest gaps was on integrating medical care into mental healthcare for patients with serious and persistent mental illness.

https://integrationacademy.ahrq.gov/resources/latest-news/new-research-opportunities-4

http://www.effectivehealthcare.ahrq.gov/index.cfm/search-for-guides-reviews-and-reports/?pageaction=displayProduct&productID=534

Baker Act Consent and Admission for Treatment of Minor

http://www.cchrflorida.org/wp-content/uploads/2015/04/Myers_Workgroup_2009.pdf

Baker Act, The Florida Mental Health Act, User Reference Guide, 2014

http://www.dcf.state.fl.us/programs/samh/mentalhealth/laws/BakerActManual.pdf

Patient Health Questionnaire-2 (PHQ-2)

Instructions:
Please respond to each question.

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Give answers as 0 to 3, using this scale:

0 = Not at all; 1 = Several days; 2 = More than half the days; 3 = Nearly every day

1. **Little interest or pleasure in doing things**

   ☐ 0 ☐ 1 ☐ 2 ☐ 3

2. **Feeling down, depressed or hopeless**

   ☐ 0 ☐ 1 ☐ 2 ☐ 3

Instructions:

Clinic personnel will follow standard scoring to calculate score based on responses.

Total score: _____

Patient Health Questionnaire (PHQ-9)

Name _____ **Date** _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	☐ 0	☐ 1	☐ 2	☐ 3
2. Feeling down, depressed or hopeless	☐ 0	☐ 1	☐ 2	☐ 3
3. Trouble falling or staying asleep, or sleeping too much	☐ 0	☐ 1	☐ 2	☐ 3
4. Feeling tired or have little energy	☐ 0	☐ 1	☐ 2	☐ 3
5. Poor appetite or overeating	☐ 0	☐ 1	☐ 2	☐ 3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	☐ 0	☐ 1	☐ 2	☐ 3
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐ 0	☐ 1	☐ 2	☐ 3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	☐ 0	☐ 1	☐ 2	☐ 3
9. Thoughts that you would be better off dead, or of hurting yourself	☐ 0	☐ 1	☐ 2	☐ 3
add columns		+	+	
TOTAL:				

*(***Health care professional:** *For interpretation of TOTAL, please refer to accompanying scoring card.)*

10. If you checked off **any problems**, how ***difficult*** have these problems made it for you to do your work, take care of things at home, or get along with other people?

- ☐ **Not difficult at all**
- ☐ **Somewhat difficult**
- ☐ **Very difficult**
- ☐ **Extremely difficult**

Suicide among College and University Students In the United States

Suicide Prevention Resource Center

Suicide is a leading cause of death among college and university students in the United States.[1,2] In addition, many other college and university students have suicidal thoughts and attempt suicide. Suicide and suicidal behaviors are a major concern for colleges and universities, and efforts are underway to introduce suicide prevention programming on many college and university campuses.

This information sheet summarizes the data available on suicidal thoughts, attempts, and deaths, and describes risk and protective factors that are common among college and university students.
Since there are no national databases or registries, and no single study compiling and analyzing suicide deaths, attempts, and/or thoughts among college and university students, the data presented here are from sources that have been selected as the most comprehensive and up to date.

Suicidal Thoughts and Attempts

The following chart shows rates of suicidal thoughts and attempts among young adults in the past 12 months for the year 2012.*

	Undergrads only[3, 4, 5]	Undergrads + grads combined[6, 7, 8]	Not enrolled in college full-time, ages 18–22[9]**
Seriously considered suicide	6.6%–7.5%	7.1%–7.7%	9.0%
Made a plan	2.2%–2.3%	2.3%	3.1%
Attempted suicide	1.1%–1.2%	0.6%–1.2%	2.2%

*A range of rates means two sources were included. A single rate means only one of the sources had that data.
** Matched by age, sex, and race

Suicide Deaths

The following chart draws on three studies of college and university students and compares their suicide rates to those of the general population, matched by age, sex, and race.

All numbers are per 100,000 people.

Study	Dates studied	Students (undergrads and grads)			General population		
		Total	Males	Females	Total	Males	Females
Big Ten Student Suicide Study[10]	1980–1990	7.5	10.0	4.5	15.0	23.7	6.4
Schwartz[11]	1991–2004	6.6	N/A	N/A	12.6	N/A	N/A
Schwartz[12]	2004–2009	7.0	10.9	3.1	12.1	20.5	3.7

In all three studies, college and university students had about half the rate of suicide per 100,000 people compared to a matched sample in the general population. Male students accounted for the majority of the

suicides and had about half the rate of suicide compared to males in the general population. The rates for female students did not differ much from those of same-age females in the general population.

Risk Factors

Risk factors for suicide refer to characteristics that are associated with suicide. People who are affected by one or more risk factors may have a greater probability of suicidal behavior. Some risk factors cannot be changed—such as a previous suicide attempt—but they can be used to help identify someone who may be vulnerable to suicide.

There is no single, agreed-upon list of risk factors; however, the list below summarizes the risk factors identified by the most recent research.[13,14,15,16,17,18,19,20,21]

Behavioral Health Issues/Disorders

- Depressive disorders
- Substance abuse or dependence (alcohol and other drugs)
- Delinquency/Conduct disorders
- Other disorders (e.g., anxiety disorders, eating disorders)
- Previous suicide attempts
- Self-injury (without intent to die)

Note: The presence of multiple behavioral health disorders (especially the combination of depressive and disruptive behavior problems or substance use) increases suicide risk.

Individual Characteristics

- Hopelessness
- Loneliness
- Social alienation and isolation, lack of belonging
- Anger, hostility
- Risky behavior, impulsivity
- Low stress and frustration tolerance
- Poor problem-solving or coping skills
- Perception of being a burden (e.g., to family and friends)

Adverse/Stressful Life Circumstances

- Interpersonal difficulties or losses (e.g., relationship breakup, dating violence)
- School or work problems
- Financial problems
- Physical, sexual, and/or psychological abuse (current and/or previous)
- Chronic physical illness or disability
- Insomnia and nightmares

Family Characteristics

- Family history of suicide or suicidal behavior

- Parental mental health problems
- Family violence or abuse (current and/or previous)
- Family instability and/or loss
- Lack of parental support

School and Community Factors

- Limited access to effective care for health, mental health, or substance abuse disorders
- Stigma associated with seeking care
- Negative social and emotional environment, including negative attitudes, beliefs, feelings, and interactions of staff and students
- Exposure to stigma and discrimination against students based on sexual orientation, gender identity, race and ethnicity, disability, or physical characteristics (such as being overweight)
- Access to lethal means
- Exposure to media normalizing or glamorizing suicide

Protective Factors

Protective factors are characteristics that reduce the likelihood of suicide. They can buffer the effects of risk factors. The capacity to cope positively in the face of challenges and adversities is called *resilience*. Actions by campus staff to enhance protective factors are an essential element of a suicide prevention effort. Strengthening protective factors also protects students from other risks, including violence, substance abuse, and academic failure.

Like risk factors, there is no single, agreed-upon list of protective factors; however, the following list summarizes the protective factors identified by the most recent research.[22,23,24,25,26,27]

Individual Characteristics and Behaviors

- Psychological or emotional well-being, positive mood
- Positive beliefs about and hopes and plans for the future
- Desire to finish school
- Internal locus of control, i.e., feeling like one has an impact on one's world and the world of others
- Problem-solving and coping skills, including conflict resolution
- Frustration tolerance and ability to regulate emotions
- Self-esteem
- Spiritual beliefs or regular church attendance
- Cultural and religious beliefs that affirm life and discourage suicide
- A sense of responsibility to family or friends, not wanting to hurt family or friends
- Physical activity, especially aerobic activity

Social Support

- Family: Support from and connectedness to family, closeness to or strong relationship with parents, parental involvement
- Friends: Social involvement and support from friendships and romantic relationships

- Teachers, mentors, and other adults, such as student group leaders, coaches, faith leaders, and workplace supervisors: Concern, understanding, and caring
- Ongoing support and support to call on in times of crises

School and Community Factors

- Supportive and inclusive peer and mentor environment
- A sense of connectedness to school and of belonging within the school community
- Availability and accessibility of student support services and personnel
- Involvement in extracurricular activities, e.g., joining a student club or organization
- Access to effective care for mental, physical, and substance abuse disorders
- Restricted access to lethal means, especially firearms (e.g., firearms are not allowed on campus)
- Monitoring and control of alcohol use

For More Information

The Suicide Prevention Resource Center's website contains many resources on suicide prevention for colleges and universities. See the following:

- Colleges and Universities pages
- College-University resources in the library
- College-University resources in the Best Practices Registry

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May 2014

This fact sheet was produced by the Suicide Prevention Resource Center (SPRC), which is supported by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) under Grant No. 1 U79 SM059945. The opinions, conclusions, and recommendations expressed are those of SPRC and do not necessarily reflect the views of SAMHSA or any of the reviewers.

Cite as: Suicide Prevention Resource Center. (2014). *Suicide among college and university students in the United States.* Waltham, MA: Education Development Center, Inc.

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POLICY:

_____ will follow recommended guidelines for the appropriate care and then transfer of patient(s) to an appropriate facility in compliance with the statutory requirements of the "Baker Act", Florida Statues Chapter 394 and 395.

PROCEDURE:

According to s. 394.463, F.S. Chapter 65E-5.280, F.A.C: A person may be taken to a receiving facility for involuntary examination if there is reason to believe that s/he has a mental illness (as defined in the Baker Act) and because of her/his mental illness. This may occur when:

- The person has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination; or the person is unable to determine whether examination is necessary;
- Without care or treatment, the person is likely to suffer from neglect or refuse to care for himself or herself; such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services;
- There is a substantial likelihood that without care or treatment the person will cause serious bodily harm to self or others in the near future, as evidenced by recent behavior.

1. A psychiatrist, physician (but not a psychiatrist), clinical psychologist, clinical social worker, mental health counselor, marriage and family therapist, physician's assistant, or psychiatric nurse practitioner (each as defined in the Baker Act) may execute a "Certificate of Professional Initiating Involuntary Examination" (CF-MH 3052b) stating that s/he has examined the person within the preceding 48 hours and finds that the person appears to meet the criteria for involuntary examination and stating the observations of the authorized professional upon which that conclusion is based. The CF-MH 3052b is found at: https://eds.myflfamilies.com/DCFFormsInternet/Search/OpenDCFForm.aspx?FormId=1063
2. After completion of a "Certificate of Professional Initiating Involuntary Examination" (CF-MH 3052b), the form is copied and the original is placed in an envelope for the police.
3. The copy of the "Certificate of Professional Initiating Involuntary Examination" (CF-MH 3052b) will be forwarded to HIM for scanning into the patient's EHR.
4. Campus Police will be notified and informed of the Baker Act. A CIT (Crisis Intervention Trained) officer should be requested.
5. The Nurse Facilitator will be notified and informed of the Baker Act to ensure campus police are directed appropriately upon arrival.
6. Following the organization chart, appropriate executive staff, including the _____ Director, will be notified of the Baker Act.
7. A law enforcement officer must take the person named in the certificate into custody and deliver her/him to the nearest receiving facility for involuntary examination.
8. Whenever possible, the patient awaiting Baker Act will be roomed in the exam room closest to the ambulance bay.
9. The patient awaiting police escort will need continuous supervision by an appropriate _____ staff member.
10. The patient's provider shall make the patient aware of the transportation process through campus police. The patient shall be informed of the police policy to use handcuffs.
11. _____ personnel shall not attempt to restrain any such patient. If such a patient leaves the premises before the police have arrived, the police will be notified of the situation. The _____ provider will record in the EHR history of patient leaving prior to police transport. The Refusal of Care form will be completed and forwarded to HIM for scanning into the patient's EHR.

12. The _____ Incident Report form (See Chapter 2: Governance, Subchapter I General Requirements, Incident Reporting policy) will be completed and forwarded to the _____ Risk Manager.

According to _____ policy, a student who is returning to campus after a Baker Act must complete a "Mandated Assessment" (refer to the Golden Rule Student Handbook: 5.006 Student Rights and Responsibilities).

1. Whenever the _____ Police provide transportation of a _____ student to the hospital for involuntary examination, the police will file a report with the Office of Students Rights & Responsibilities. Once a report is received, the Director of OSRR or designee may notify and consult with designated representative of _____ to review the severity of the student's behavior. A determination will be made whether a mandated assessment and/or physical assessment is needed to help the student in their specific situation.
2. All students identified as threatening self-harm or having attempted suicide, must complete a mandated assessment with a licensed mental health professional and/or a physical assessment with a licensed medical provider.
3. Students have the option of completing the assessment with a _____ provider. Before the mandated assessment is conducted, the Director of OSRR or designee will first obtain an *Authorization to Release/Exchange Confidential Information* form from the student to provide the licensed mental health professional and/or licensed medical health professional conducting the assessment with background information relevant to the reason for the mandated assessment. The Director of OSRR or designee will require proof of participation for the mandates assessment with an appropriate medical provider. See attached template letter which will be completed by provider and presented to student at the time of the completed assessment. The student will be responsible for delivering the mandated assessment letter back to the office of OSRR.

REFERENCE: Clinical Operations Manual

ATTACHMENTS: Refusal of Care form
_____ Mandated Assessment Policy
Incident Reporting form
Authorization to Release/Exchange Confidential Information form
Template letter

_____ Refusal of Care – Medical/Behavioral

Patient Name *(print)* _____

Date _____ **PID#** _____ **Date of Birth** _____

(Provider's Name) _____ has recommended that I undergo the following

medical care: _____

The Provider has explained the condition to me and discussed with me the potential risks and intended benefits of this medical/behavioral care, as well as the potential risks associated with not having this medical/behavioral care. The risk(s) include, but are not limited to:

1. _____

2. _____

3. _____

I AM AT LEAST 18 YEARS OF AGE AND CONSIDER MYSELF MENTALLY COMPETENT. I have been advised the medical/behavioral care on my behalf is recommended. I currently decline the provider's recommendations.

My stated reason is: _____

The risks of this discussion have been reviewed with me and I understand that refusal of the recommended care could be hazardous to my health, and under certain circumstances, cause disability and/or death. I decline this recommended medical/behavioral care. I understand and accept these risk(s).

_____

Patient's Signature

Provider's Signature **Provider's Printed Name**

_____

Witness Signature **Witness Printed Name**

Permission is given to notify parent, guardian or next of kin. ☐ Yes ☐ No

INSTRUCTIONS: If you change your mind, or your condition changes, call 9-1-1 (in an emergency) or go to an emergency department in your area.

- Name and phone number of relative(s) or other(s) notified of patient's decision.

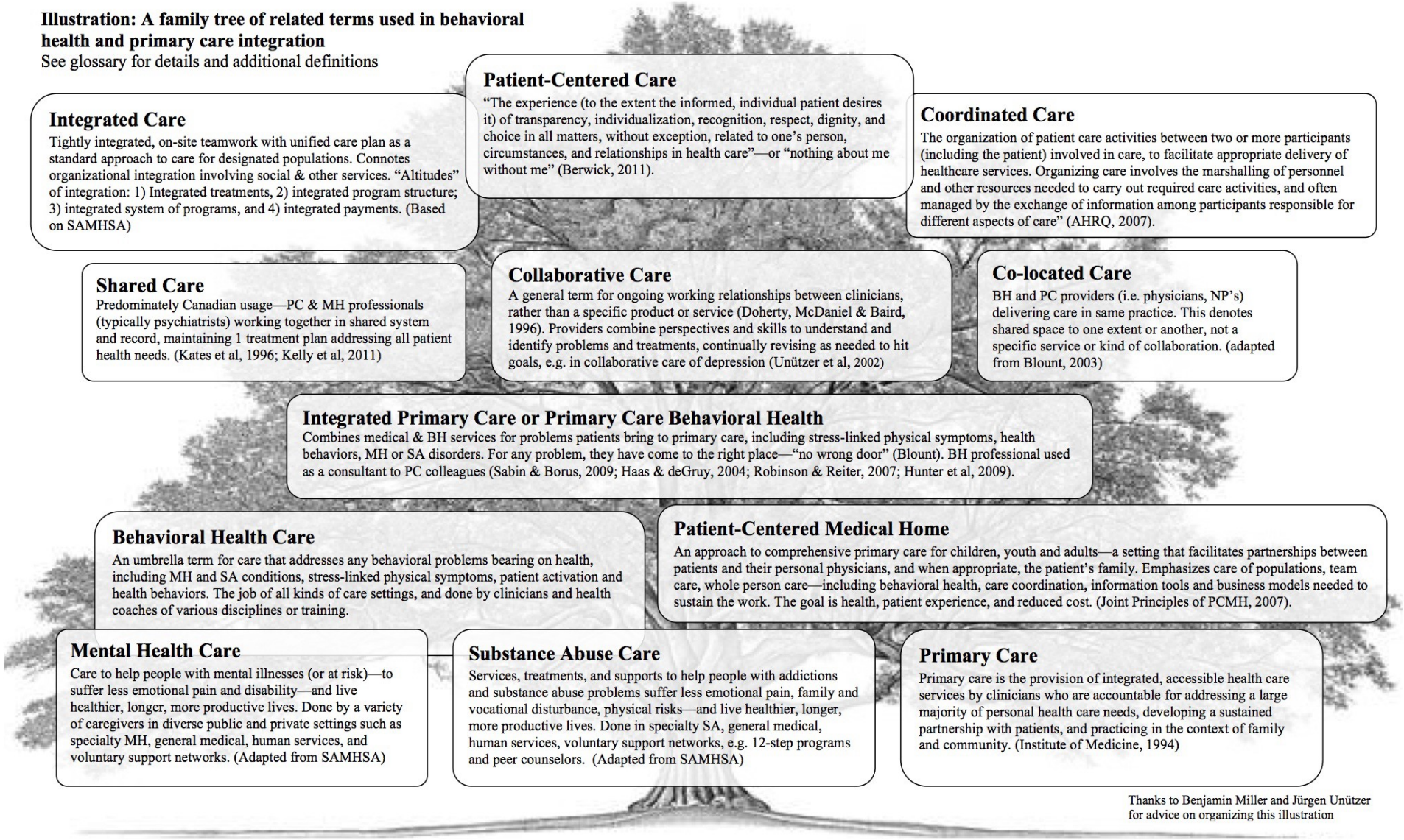
  _____

- List of individual(s) accompanying the patient and any instructions given to them.

  _____

Patient given a copy of this form. ☐ Yes ☐ No

Illustration: A family tree of related terms used in behavioral health and primary care integration
See glossary for details and additional definitions



From: Peek CJ and the National Integration Academy Council. Lexicon for Behavioral Health and Primary Care Integration: AHRQ Publication No.13-IP001-EF. Rockville, MD: Agency for Healthcare Research and Quality. 2013.Available at http://integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf.

Informed Consent for Brief Counseling

At _____, Counseling Services are provided by Post-Doctoral Psychology Residents who work under the direct Supervision of Licensed Psychologists at the Counseling Center. The initial session focuses on obtaining information about your concerns as well as those of the Medical Providers at _____. Typically, students will return for an additional (4) sessions of brief solution focused therapy.

The information discussed in sessions will be included in your records at _____, discussed with the _____ provider who referred you, and placed in your records with the Counseling Center (CC) if you seek counseling services at the CC.

If you have any questions about this process, please do not hesitate to ask the staff at _____.

_____ _____

Student Signature **Date**

CONSENT TO EXCHANGE HEALTHCARE INFORMATION

This form, when completed and signed by you, authorizes the release of confidential information from your clinical records to the Counseling Center.

_____

Name *(please print)*

_____ _____

Date of Birth **Student ID#**

In order to ensure collaborative health care, I authorize the Release and Exchange of counseling and medical information between the _____, the Counseling Center (CC).

Your Rights with Respect to This Authorization:

- **Right to Refuse to Sign This Authorization** – I understand that signing this authorization is voluntary and my treatment at _____ and the Counseling Center is not conditional based upon my signing this authorization.
- **Right to Limit the Information to be Released** – I understand that information will be exchanged only when deemed relevant to my ongoing treatment.
- **Right to Withdraw This Authorization** – I understand that I have the right to cancel this authorization at any time.
- **Payment for Treatment** – I understand that payment for my treatment, enrollment in a health plan or eligibility for benefits will not be conditional upon my signing this form.
- **Expiration** – This authorization will expire one (1) year from the date set forth below.
- **Disclosure** – The disclosure of information may be in the form of photocopies, verbal or fax.

I am authorizing the disclosure/release/exchange between _____ and CC of all records and information generated by _____ and CC and its providers, including confidential and Protected Health Information (PHI) as defined under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), specifically including but not limited to:

- **MEDICAL**
- **PSYCHIATRIC/PSYCHOLOGICAL/MENTAL HEALTH** (Including psychotherapy session notes)
- **ALCOHOL/SUBSTANCE ABUSE**

Mandated Reporting:

_____ Behavioral Health Staff adhere to professional, ethical and legal guidelines established by the State of Florida and Federal Laws. Your counseling information will not be discussed with anyone outside _____ or the Counseling Center without your permission. The following circumstances are however, exceptions to the law and could result in a call being placed to the Department of Children and Family's Abuse Registry:

- You are considered to be harmful to yourself or others
- Child Abuse is disclosed
- Elder Abuse is disclosed
- Abuse of a Disabled person is disclosed
- A court order

Purpose of this Information Release: coordination of health care services between _____ and CC.

I understand the Informed Consent and Mandatory Reporting Guidelines and also agree to the terms of the Consent to Exchange Healthcare Information.

_____ _____

Student Signature **Date**

STATE UNIVERSITY SYSTEM of FLORIDA
Board of Governors

Information BRIEF

www.flbog.edu

The Mental and Behavioral Health of Students and the Need for Increased Counseling Services

September 2016

HIGHLIGHTS

- Student demand for counseling services exceeds the current capacity of SUS counseling centers, and demand for services continues to grow.
  - The number of counseling service clients at SUS institutions has increased 48% since 2008-09 and the number of counseling sessions provided has increased by 67%.
  - Counselors at ten of Florida's state university counseling centers serve more than the minimum recommended number of clients due to inadequate staffing levels and increasing demand for services.
  - Centers now maintain waiting lists, reduce the frequency of sessions, and refer students to clinicians in the community.

Introduction

In March 2015, Board staff presented an *Information Brief* on the critical issues related to campus safety and security in response to increasing concerns about student behavior and campus safety. That information brief reported that the State University System (SUS) university presidents recognized a need to increase the number of well-trained, professional counselors in order to adequately address the growing demand from students with mental and behavioral health issues. In 2016, the SUS requested funding from the legislature to support an increase in the number of counselors, as well as additional law enforcement staff. That request was not funded, although the demand for counselors remains -- and continues to grow.

National Counseling Center Activity Data

Annual national surveys of counseling center directors find that the vast majority of directors have been reporting increases in the number of students entering postsecondary education already taking psychiatric medication for at least a decade.[i] From the latest survey, directors reported that 41% of all eligible students, across all institutions participating in the survey, sought either individual or group counseling. This is up from 9% in the 2006 survey. The directors also reported that 52% of clients have serious psychological issues, up from 41% in 2003. They also reported that 26% of clients were on psychiatric medication, up from 9% in 1994. The

most commonly documented problems included anxiety disorders, pressing crises, issues with psychiatric medication, clinical depression, learning disabilities, sexual assaults on campus, and self-injury issues. While the number of students seeking counseling has increased, the number of counselors available to support these students has not. The 2004 survey found that the ratio of counselors to clients, on average, was 1 to 1,511. In the 2014 survey, the ratio was 1 to 2,081.

The American College Health Association (ACHA) found in a spring 2015 survey that approximately 19% of students report that they had received psychological or mental health services from their current institution's counseling center or health service center.[ii] ACHA also found that 57% of students felt overwhelming anxiety at some point during the previous year, and 35% felt so depressed that it was "difficult to function." These percentages are up from 51% experiencing overwhelming anxiety and 31% who felt so depressed that it was "difficult to function" on the spring 2012 survey.[iii] Further, the national American Freshman Survey from 2014 found that students' ratings of their emotional health were the lowest ever reported.[iv]

An array of explanations for the increasing incidences and severity of psychological problems on postsecondary campuses are being offered by mental health professionals. A frequently asserted view is that these trends are resulting from larger societal tendencies toward increasing levels of anxiety and depression resulting from information and technology overload, increased financial stress, and an ineffectual mental health care system. In addition to the increasing numbers of students arriving on campus with pre-existing emotional and behavior health issues, university counselors are also finding that the current generation of students lacks the coping skills and resiliency demonstrated by previous generations.

The State University System

SUS institutions maintain counseling centers with licensed, highly-trained professionals who provide comprehensive services for students. Services include the evaluation of student concerns and behaviors and the development of individualized treatment plans that promote mental and behavioral health, as well as academic success. Center personnel are also involved in the education and training of students in leadership positions to enable them to recognize student behaviors that may signal a need for professional intervention. Many universities now maintain *Students of Concern Committees* and *Threat Assessment Teams* that identify and monitor students with serious mental or behavioral problems. Counseling centers also provide mental health outreach and prevention programs to students and training for faculty and staff, though these activities are provided with less frequency due to the increase in demand for counseling services.

Nine SUS counseling centers are accredited by the International Association of Counseling Services (IACS), the accreditation association for over 200 university and college counseling centers worldwide. IACS standards state that minimum staffing ratios should strive to be "in the range of one FTE professional staff member to every 1,000 to 1,500 students, depending on services offered and other campus mental health agencies." Currently, counselors at ten of the 12 SUS counseling centers are serving more than the IACS standard for minimum staffing of one staff member per 1,000 students.

Counseling Center Activity

All SUS counseling centers strive to respond to the mental and behavioral health needs of their students. However, similar to national trends, the demand for counseling and related services has increased significantly in a short period of time. The number of student clients has increased 48% since 2008-09, and the number of sessions has increased by 67% during the same timeframe. The most common issues students cited when requesting services were anxiety, depression, relationship issues, and academic stress – all of which are consistent with national findings.

In addition to the growing numbers of clients and counseling sessions, there has also been a significant increase in the severity of student problems as evidenced by an increase in emergency or crisis visits. During the 2013-14 academic year, nearly 4,200 visits to SUS counseling centers were classified as emergency or crisis visits. Most of these visits were due to severe depression, acute anxiety, and suicidal ideation. Centers have also recorded an alarming increase in Baker Act hospitalizations, with over 300 student hospitalizations during the 2013-14 academic year.

Summary

Student demand for counseling services has outstripped the capacity of the SUS counseling centers. Student client surveys show that university counseling services enable students to successfully address their issues and remain enrolled. However, as a result of the increased demand for services and the complexity of the problems that students are experiencing, SUS counseling centers may maintain waiting lists, reduce the frequency of appointments for students with ongoing issues, or refer students to clinicians in the community that could in turn saturate community resources. As a result, less staff time is available for preventive programs that would benefit the larger campus community and support student success. The SUS counseling centers provide services that are critical to student retention and success and the need to address the mental and behavioral health of SUS university students has never been more critical.

Staff Contact

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[i] Gallagher, R. P. (various). *National Survey of College Counseling Centers*. Retrieved from http://www.collegecounseling.org/surveys

[ii] American College Health Association. (2015). *American College Health Association National College Health Assessment II Spring 2015 Reference Group Executive Summary.* Retrieved from http://www.acha-ncha.org/pubs_rpts.html

[iii] American College Health Association. (2012). *American College Health Association National College Health Assessment II Spring 2012 Reference Group Executive Summary.* Retrieved from http://www.acha-ncha.org/pubs_rpts.html

[iv] Eagan, K., Stolzenberg, E. B., Ramirez, J. J., Aragon, M. C., Suchard, M. R., & Hurtado, S. (2014). *The American freshman: National norms fall 2014*. Retrieved from http://www.heri.ucla.edu/tfsPublications.php

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version

SUICIDE IDEATION DEFINITIONS AND PROMPTS	**Past month**	
Ask questions that are bolded and <u>underlined</u>.	**YES**	**NO**
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***<u>Have you wished you were dead or wished you could go to sleep and not wake up?</u>***		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/commit suicide, "*I've thought about killing myself"* without general thoughts of ways to kill oneself/associated methods, intent, or plan. ***<u>Have you actually had any thoughts of killing yourself?</u>***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*" ***<u>Have you been thinking about how you might kill yourself?</u>***		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having <u>some intent to act on such thoughts</u>, as opposed to "*I have the thoughts but I definitely will not do anything about them*." ***<u>Have you had these thoughts and had some intention of acting on them?</u>***		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. ***<u>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</u>***		
6) Suicide Behavior Question: ***<u>Have you ever done anything, started to do anything, or prepared to do anything to end your life?</u>*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask: *<u>How long ago did you do any of these?</u>*** · Over a year ago? · Between three months and a year ago? · Within the last three months?		

For inquiries and training information contact: Kelly Posner, Ph.D.
New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; posnerk@nyspi.columbia.edu

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version

SUICIDE IDEATION DEFINITIONS AND PROMPTS	**Since Last Visit**	
Ask questions that are bold and <u>underlined</u>	**YES**	**NO**
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***<u>Have you wished you were dead or wished you could go to sleep and not wake up?</u>***		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/die by suicide, "*I've thought about killing myself"* without general thoughts of ways to kill oneself/associated methods, intent, or plan. ***<u>Have you actually had any thoughts of killing yourself?</u>***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*" ***<u>Have you been thinking about how you might kill yourself?</u>***		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having <u>some intent to act on such thoughts</u>, as opposed to "*I have the thoughts but I definitely will not do anything about them*." ***<u>Have you had these thoughts and had some intention of acting on them?</u>***		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. ***<u>Have you started to work out or worked out the details of how to kill yourself and do you intend to carry out this plan?</u>***		
6) Suicide Behavior ***<u>Have you done anything, started to do anything, or prepared to do anything to end your life?</u>*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.		

For inquiries and training information contact: Kelly Posner, Ph.D.
New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; posnerk@nyspi.columbia.edu

Referral to Psychiatry

POLICY:

Any patient referred to the _____ Psychiatrist will be entered into the EHR, receive assistance with obtaining pre-authorization from the insurance company (if applicable) and receive an appointment schedule for treatment.

PROCEDURE:

1. Consultation with a _____ Psychiatrist requires a referral from the _____ Counseling Center, a _____ Primary Care Provider, or an outside provider. Because of limited psychiatric availability, patients may not self-refer.
2. The Primary Care Providers are expected to treat conditions such as non-complicated depression, anxiety, eating disorders and insomnia. The Psychiatrist shall serve as a consultant for more complex cases such as recalcitrant depression/anxiety, manic-depressive disorder and schizophrenia.
3. The referred patients will present to the_____ a completed referral form or medical records from a previous doctor. The clerk will verify any medical insurance pre-authorization for treatment, if applicable. The clerk will assist with scheduling the appointment.
4. The _____ clerk will verify the in-house psychiatry referral, appointment day and time. The psychiatry referrals will be tracked in the PyraMED Referral Manager system by the _____ Referral staff (See Chapter 6: Clinical Records & Health Insurance, Tracking of Patient Medical Referrals policy). It is the responsibility of the Psychiatrist to follow-up, at the best of his/her discretion, on cases of more urgent concern (i.e. suicidal).
5. Patients who are issued a psychiatry referral, but do not schedule, will be contacted by a Referral Coordinator the following business day to offer assistance with scheduling. The patient will be contacted again 5-7 days later in the event the patient was non-responsive to the initial contact attempt. All interactions with the patient will be notated in the electronic referral and tasked to the referring provider using the PyraMED Outbound Referral Editor.
6. The primary patient care responsibility remains with the Primary Care Provider until the consultation with a Psychiatrist takes place.
7. Urgent referrals need to be communicated directly from the referring provider to a Psychiatrist. Outside resources will be sought for psychiatric conditions considered beyond the scope of our Psychiatrists or facility. _____ does not reimburse for such care.
8. If the patient is referred to an off-campus psychiatrist due to eligibility issues or personal preferences, the patient shall be directed to the _____ referral staff for coordination of care. Appointment details and pertinent information regarding the continued care of the patient will be notated in the electronic referral and tasked to the referring provider for review.
9. Any patient who has not been seen by a _____ psychiatry provider in the past year (or sooner depending on the psychiatry provider's discretion) of the last appointment but still falls within three years of their last appointment, the patient will be scheduled for a one hour appointment. If the time between appointments is more than 3 years, a new referral is required in order for the patient to be seen by a _____ psychiatry provider.

REFERENCE: Clinical Operations Manual

Florida Academic Healthcare Patient Safety Organization
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PS141114-10/4/18