

# Investing in Student Mental Health

University of Washington, Seattle

February 28, 2020

A Report from the Student Mental Health Task  
Force

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## Student Mental Health Task Force Composition

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DC Dugdale, Interim Director of Hall Health

Natacha Foo Kune, Director of the Counseling Center

Meghann Gerber, Director of Hall Health Mental Health

Jeremy Moon, student, Chair of the Services & Activities Fee Committee

Farah Nadeem, student, Chair of the Provost Advisory Committee for Students

Special invitees:

Ann Culligan, Senior Lecturer in Psychology and Member of the Faculty Council on Student Affairs

Chris Laws, Principal Lecturer in Astronomy and Chair of the Faculty Council on Student Affairs

# Student Mental Health Task Force

## Executive Summary

The University of Washington Seattle is facing an increase in mental health concerns among students, yet does not have adequate mental health resources to meet existing demand. The student Mental Health Taskforce (MHTF) was charged with examining the current challenges and designing recommendations for a service model to meet the current and future needs of the UW community. This section summarizes the stakeholder engagement process, the identified pain points, and the recommendations, which are detailed later in the report.

The MHTF engaged with stakeholders across campus to solicit feedback regarding factors impacting student mental health, barriers to accessing support, and resources that would improve psychological wellness. The MHTF sought feedback from student government, relevant student groups, and through open forums. We engaged with engaged with faculty, front line staff, and other staff members.

The pain points that emerged from the feedback broadly fall into two categories:

- Challenges in accessing care, including limited health insurance, prohibitive wait times, limits on the number of visits, lack of services for online students; and
- Factors that contribute to significant mental distress, including academic pressure, capacity-constrained majors, adviser/advisee relationships, social isolation, lack of community and belonging, and discrimination and microaggressions.

The MHTF envisions the UW as a place where students' psychological wellness enables academic, social, emotional, physiological growth and success. This requires equitable access to mental health resources for all students. Recognizing that clinical care alone is insufficient to meet the mental health needs of UW's student population, the MHTF adopted a framework that aims to prevent illness through different levels of intervention, including macro-, meso- and micro-level strategies. Further, we present the recommendations from a resource requirement standpoint: a base case working with existing resources, and three options that incrementally increase the service footprint, the number of students served, and the overall impact.

### Macro and meso level recommendations

Issues that contribute to mental distress are multi-faceted and interrelated. Our **macro level recommendations** focus on the UW ecosystem - individuals, offices, policies, rules, governance, ethos and culture - that play a role in a safe, healthy and emotionally-well community. Our key **meso level recommendation** is the merger and co-location of the two existing mental health units, leveraging all existing resources currently invested in student mental health. We further recommend support for partner organizations and upstream interventions.

### Micro level service line recommendations

The **micro level recommendations** encompass day-to-day clinical care. We find that UW needs to diversify both the types of services offered and the way they are delivered in order to increase capacity, reach our

diverse student populations, and provide culturally responsive care with low barriers to access. Our recommendations include:

- Rapid access counseling as a point of entry for all students;
- Brief individual counseling sessions and group-based interventions for a range of student concerns;
- Psychiatric medication management;
- Case management to support students with complex needs;
- Expanded Let’s Talk drop-in consultation;
- Campus consultation to provide coaching for faculty, staff, and students;
- Community-based interventions to increase belonging and cultural congruence for students.

### Implementation Timeline

Implementation of the proposed service lines require additional budget and time. Option 0 works only with existing resources, and options 1-3 outline the implementation pathway we recommend based on students’ needs. The estimated annual cost is presented for each case, to the best of our ability.

#### Option 0-Base case: Insufficient to meet student needs

Consolidate the two mental health service units under a new reporting line within Student Life using all existing resources (including GOF/DOF, SAF, and insurance revenues). Implement student advisory feedback mechanism to support ongoing engagement.

FTE (current – no change)	Approximate # of students served	Current cost
<b>28.3 clinical staff</b>	4,875 (direct clinical care) 6,300 (outreach/workshops/Let’s Talk)	\$4,255,733 existing costs for both units

#### Option 1: Base case with first round of expanded services, 2-year implementation timeline

Administrative merger of the two units with co-location, addition of 6 counselors and 2 case managers to serve an additional 1000 students, and the adoption of tech-based psychoeducation tools for the whole campus at \$1/year/person. Implement student advisory feedback mechanism for expansion planning and ongoing consultation.

#### Option 2: Expanded services and increased footprint, 5-year implementation timeline

Administrative merger and co-location of the two mental health units with 6 counselors and 4 case managers in the first two years; add 3 more counselors per year during years 3-5. Increase Let’s Talk offerings, tech-based psychoeducation tools, and counselor access via telehealth. Hire a specialist to guide implementation of the Okanagan Charter. The first two years will be implementation of option 1 with additional 2 case managers, and an additional 9.0 FTE Counselors and 1.0 FTE specialist in years 3-5.

#### Option 3: Most comprehensive approach to meet student needs, 10-year implementation timeline

A planned expansion of services that will allow UW to keep pace with growing needs. This will include rapid access, individual, group, and drop-in counseling, and case and medication management. The timeline will be option 1 for years 1-2, option two in years 3-5 and the additional increase over years 5-10.

Services	Option 1	Option 2	Option 3
<b>Co-location</b> (cost pending review by Facilities)	Yes	Yes	Yes
<b>Number of new counselors</b>	6.0 FTE	15.0 FTE	59.5 FTE
<b>Number of new case managers</b>	2.0 FTE	4.0 FTE	6.0 FTE
<b>Rapid access to counseling</b>		Yes	Yes
<b>Adoption of tech-based tool</b>	Yes	Yes	Yes
<b>Increase psych. medication management</b>		.6 FTE	1.2 FTE
<b>Increase Let's Talk offerings</b>		Yes	Yes
<b>Counselor access via Telehealth</b>		Yes	Yes
<b>Specialist-implement Okanagan charter</b>		1.0 FTE	1.0 FTE
<b>Implementation Timeline</b>	2 years	5 years	10 years
<b>Students served</b> (clinical services)	5,800	12,060	35,860*
Whole campus benefits from large-scale interventions (limited in option 1, expanded in options 2 and 3)			
<b>Yearly Cost in addition to Option 0</b>	\$972,344	\$2,704,090	\$8,178,398

\*Estimated number of students served per year by year 10.

## Introduction

Each year institutions of higher education across the country report increased prevalence of mental health concerns among students along with an associated rise in the utilization of campus-based mental health services. At the University of Washington, we have seen rapid growth in the need for student mental health support, both in terms of the capacity and the range of services. Staffing levels and clinical service capacity have not kept pace with the demand, which is true for other institutions of higher education, as well as the city of Seattle as a whole. The two primary mental health service units on campus, the UW Counseling Center and the Mental Health Clinic at Hall Health Center, are not adequately resourced to meet the current or ongoing growth in demand, as demonstrated by the long wait times for services, especially at peak times in the quarter.

UW's Seattle campus needs an efficient mental health service delivery system that can provide rapid access to a range of cost-effective care options appropriate for a highly diverse student body with varying levels of need. Achievement of this aim requires a rapid, radical restructuring of the current mental health services and a significant increase in available resources.

In our examination of this topic, we have met with UW students, faculty, and staff, engaged national experts, examined local and national data, and explored the efforts of other institutions of higher education. The results of this effort demonstrate that mental health at UW is a multifaceted issue, exacerbated by external factors (national health care policies, insurance offerings, dearth of local community mental health resources), internal structural factors (competition for admission to majors, isolation for students including graduate, international, under-represented groups, fragmented and decentralized resources), individual factors (help-seeking behaviors, stigma, stressors, trauma, mental illness), and limited mental health services (limited range of offerings, insufficient resources to meet demand). In our analysis, attending to only the mental health services and clinical interventions is an inadequate solution. Instead, our recommendation is to examine the whole system, working collectively to address a wide range of factors that impact students' mental well-being. In this report we focus on the goals laid out in the charge for the MHTF; we propose updates to clinical treatment, as well as a wider range of services that will address diverse student needs and promote psychological well-being throughout the UW community. These recommendations are based on the larger picture that has emerged from student input.

### Scope of this report

This report addresses the immediate goal as defined by the charge letter, presenting a new model for a comprehensive on-campus mental health unit. This will consist of merging the two existing units into one unit under a new reporting line. To provide adequate resources for students seeking care in a timely manner, the proposed new unit will have more staff and additional services. The report seeks to contextualize the clinical treatment aspect of students' needs in the larger picture of the multifaceted issues that impact wellbeing at the University of Washington. The numbers in the report represent our best estimations with the information at hand.

## Goals

The Student Mental Health Task Force was charged on October 25th, 2019 with designing an integrated, seamless, and efficient system that serves the needs of a diverse student body and improves timeliness and student access to a broader range of mental health services. (see appendix [Student Mental Health Task Force Charge](#)).

## Vision

The task force envisions equitable, accessible mental health resources for all students on campus, as a part of the students' path to success. Students must experience the UW as a caring and psychologically safe place in order to engage in academics, grow professionally, take appropriate risks, meet challenges, serve others, and lead our community. We envision the UW as a place where students' psychological wellness serves as the foundation for academic, social, emotional, and physiological growth and success.

## Approach

In undertaking this effort, we have adopted the following frames that guide our thinking:

While the individuals in this task force have been tapped to provide recommendations to address the mental health needs of students, there are many other people – including many courageous students – who have raised their voices on this topic. We have the privilege to engage in this conversation at this time because many others have paved the way.

We believe that mental health is at the intersection of UW's priorities, including retention and success, equity and access (including the question of who gets to be well), population health, and innovation.

We recognize that our current mental health systems are inadequate, and simply doing more of the same will not significantly change the experience of our students. Instead, we recognize that we need **more of more**. We need more counseling services to be sure; but we also need a greater variety of services, a more inclusive attitude about culturally-appropriate healing modalities, resources that students can access on their own time, services that can scale, and services that are responsive to needs expressed by current students.

In order to shift our thinking from a mental illness treatment model, we borrowed from **public health** and **population health** frameworks. Public health aims to prevent illness through strategies that intervene at different levels of a population. Population health emphasizes health determinants by using outcome data to inform policy that reduces health disparities. Both disciplines help reframe mental health as a social/cultural/structural concern, rather than an individual concern. (see appendices [Public Health Framework](#) and [Population Health Framework](#))

The MHTF developed a **three-axis model** (see appendix [3-Axis Model of Care](#)) that helped us map motivation, severity, and access. This representation of both internal and external factors allowed us to recognize that current mental health services only serve students with medium severity, high motivation, and high access. Students with either low motivation, low access, or both, are represented in our recommendations.



Clinical care alone is inadequate for addressing the needs of UW’s diverse student populations. Instead, a more comprehensive **continuum of care**, which includes promotion, prevention, and recovery offers a more integrated approach to student needs, is more developmentally appropriate, and efficiently directs appropriate resources to students. The continuum of care is both a meso-level recommendation and a foundational assumption. (see appendix [Continuum of Care](#))

Campus-based counseling services are perennially balancing access and treatment. In settings with limited resources, greater access means fewer sessions for more students; likewise, longer-term treatment consisting of more sessions per student means fewer students will gain access. UW students have largely rejected this dichotomy – they want both access and sufficient therapy. The MHTF, however, recognizes that this tension is real, and budget realities require compromises.

## Background

We drew upon national studies on the incidence and trends of mental health challenges students face, information from peer institutions, and studies specific to UW as part of our background research. Current national trends show that the number of college students who report mental health concerns has grown considerably in the last decade with more significant negative outcomes for minoritized populations ([ACHA/NCHA reports](#); [AUCCCD annual survey](#); [Healthy Minds survey](#)), making mental health a rising concern among college presidents ([ACE survey of presidents](#)). In 2016-2017, the UW participated in the Healthy Minds Study (see addendum [UW Healthy Minds Study](#)), which provided evidence that UW trends mirror national trends. Moreover, data from the national 2018-2019 Healthy Minds Study demonstrate continued upward trends. The UW will participate in the survey again in April 2020.

Categories	2016-2017 UW	2016-2017 National	2018-2019 National
Major depression	11%	14%	18%
All depression	28%	31%	36%
Anxiety	23%	26%	31%
Eating Disorder	10%	9%	10%
Non-suicide self-injury	20%	21%	24%
Suicidal Ideation	12%	11%	14%

Moreover, among students seeking Counseling Center services during 2018-19, 44% reported that they are suicidal (ranging from mild to severe) on the CCAPS, a valid and reliable assessment instrument used nationally by university-based counseling services. Nationally, 36% of students seeking counseling on university campuses report suicidality.

Increased utilization of campus counseling services may be due in part to the success of campaigns to decrease stigma attached to mental health concerns and seeking help. However, the clinical capacity to serve the growing number of students has not kept pace with the increase in demand. Given this trend, there has been an increased focus on making care accessible for students across the country. The 2019 report by Mental Health America presents several student-led initiatives across college campuses to support students. From the report, “students deserve inclusive, healthy environments that empower them to succeed in higher education and beyond.”

At UW, the Healthy Minds Study conducted for the 2016-17 academic year indicates that of the students surveyed (17% of the 4000 randomly sampled students), 27% have been diagnosed with a mental disorder at some point. While this is a small sample, the observed trend is consistent with national data. Additionally, there will be another Healthy Minds Study in Spring 2020 with a random sample of 12000 students at UW.

## Stakeholder engagement process

The MHTF made an intentional effort to engage with students, staff and faculty at all points of the process. Our engagement process was iterative, with feedback shaping our recommendations at three key points of our process: initial analysis of existing resources and needs, the three-axis model, and the proposed service lines. In keeping with our efforts to promote transparency, we also plan to post and share this report.

The primary stakeholders for this effort are students. The MHTF engaged with students through student groups including the Provost Advisory Committee for Students (PACS), the Associated Students of the University of Washington (ASUW; including historic documents; see appendices [ASUW Mental Wellness and Education Access Task Force 2017-2018](#) and [2018-2019](#)), the Graduate and Professional Student Senate (GPSS), the Office of Minority Affairs and Diversity Student Success Team, the Services and Activities Fees Committee (SAFC), an open forum, online surveys and polls. The MHTF also sought feedback from a wide range of faculty and staff, particularly those on the front lines with students in Undergraduate Academic Affairs (UAA), the Campus Care Team, the Office of Minority Affairs and Diversity (OMAD), the Faculty Council on Student Affairs (FCSA), the Race & Equity Initiative, Student Well-Being Collaborative, College of Engineering Advisers, the UW Resilience Lab Advisory Board, and the Indigenous Wellness Research Institute. Finally, we are very grateful for consultation with colleagues in the Graduate School, Intercollegiate Athletics, Department of Psychiatry and Behavioral Sciences, Student Life, Human Resources, UW Experience Project, Population Health Initiative, Hall Health, and community agencies.

The engagement process was structured to solicit feedback along the following dimensions:

- What barriers do students face in accessing care?
- What factors contribute to mental health challenges?
- What aspects of accessing the existing system have worked well?
- How do students identify when they are struggling?
- What are the challenges specific communities might encounter?
- What would improve the situation?

The feedback allowed us to identify the common challenges faced by students seeking care, as well as aspects of the current system that are working well and “pain points” where our current system is not providing adequate support. The feedback shaped the dimensions along which we considered services, resulting in the three-axis model.

During the process, we engaged with faculty and staff members, who provided valuable feedback based on their experiences with students. Advising staff members, in particular, often interact with students of

concern and can be the first point of access for students who have low motivation to seek care and/or low access to care. The engagement process with advising staff consisted of both 1-1 meetings and a presentation at the regular advising staff meeting. The MHTF worked closely with the Faculty Council on Student Affairs throughout the process, which allowed for continuous feedback from faculty.

The stakeholder engagement process adopted by the MHTF was impacted by our short timeline. Meaningful engagement with students was prioritized as a key aspect of designing and implementing service lines that will best serve students. Additionally, student advisory is integral since student fees (a sizeable portion of the Services and Activities Fees) are used to fund current and proposed services. We recommend establishing a student advisory body in the short term, to provide feedback as the mental health units merge and work progresses on the implementation of the recommendations in this document. For the long term, we recommend that this unit establishes a student advisory board.

The MHTF created a [website](#) to share the scope of this work, encourage engagement, and share historical documents. We plan to make this report available on this website when it is submitted.

Recommendations:	Does this currently exist?
Make this report available online and solicit student/staff/faculty feedback	N/A
Implement student advisory body for consultation on both short-term changes to services and long-term input.	No

## Needs analysis

### Pain Points

We had many conversations with students and listened carefully to challenges they experienced in seeking care. These issues included, but were not limited to, insufficient health insurance, long wait times, limits on the numbers of visits, and lack of access to services for online students. Students also consistently cited concern over issues that contribute to mental distress. We draw attention to these campus pain points because any effort to address symptoms without addressing root causes will be inadequate.

UW undergraduate students indicate that there are significant negative impacts on individual mental health, as well as campus culture, as a result of **academic pressure** and **competitive stress**. Students identified the admission process, registration for limited class space, competition for **capacity constrained majors**, and competitive grading practices (grading on a curve) as contributing to their mental distress.

UW graduate and professional students identified similar concerns about competitive stress, but also had some unique concerns: **problematic adviser/advisee relationships**, social isolation in latter stages of graduate study, extreme expectations of time and energy dedicated to labs and projects, imposter syndrome, and significant responsibility for undergraduates (teaching and mentoring) without adequate training, support, or compensation.

All students reported that **discrimination and microaggressions** take a toll on well-being, particularly when incidents in classrooms and departments are unchecked. Students seek to promote and increase helping behaviors, such as interrupting bias. Students also named a **lack of sense of belonging** and a **lack of sense of care** from the UW as contributing factors.

## Recommendations and Service Lines

### Macro Level Recommendations

As a Task Force, we were often asked WHY there has been a large increase in numbers and complexities of mental health concerns. As our engagement with stakeholders confirmed, the issues that contribute to the growing mental health crisis are multi-faceted and interrelated, ranging from national political vitriol to inefficient and inadequate health care and insurance coverage, to Washington State's insufficient number of mental health facilities, to the role of social media in providing a platform for anonymous bullying and attacks. The more the MHTF attempted to narrow its scope to only concerns related to mental health service delivery, the more we were reminded that the UW ecosystem – individuals, offices, departments, policies, rules and governance, ethos and culture – all play a role in establishing the campus culture. And each bears responsibility for cultivating a safe, healthy and emotionally-well community. Our vision is that of a campus where students feel that the university cares about them and is giving them the tools to become engaged and caring community members and leaders.

To advance the institution's commitment to support healthy communities, we recommend the following, for adoption by the University of Washington.

Adoption of the [Okanagan Charter: An International Charter for Health Promoting Universities & Colleges](#), which provides a framework and unifying call to action that ensures that mental health is not addressed in isolation from overall well-being, and asserts that healthy people strengthen the ecological, social, and economic sustainability of our communities and our planet. This Charter serves as the embodied **culture of care and enterprise-wide call to action**. As [research](#) from the UW suggests, wellness and planet health are interdependent and mutually beneficial. The UW is uniquely poised to serve as a national and international leader for wellness and mental health.

Per the Okanagan Charter, we also recommend that policy decisions at all levels – academic, enrollment, marketing, etc. - are subjected to analysis of impact to mental health of students. In our analysis of pain points, we consistently heard that students bear the emotional **cost of being number one**. Even as the University of Washington rises in rank, the nature of competitive stress and perfectionism erode student experience and well-being.

Adoption of a **universal student health insurance plan** with special attention to the coverage provided for behavioral/mental health services. Issues of who has insurance, what the insurance will cover, gaps in coverage (particularly for graduate and professional students and those whose position and income fluctuate), insufficient coverage for behavioral health services, and lack of transferability across states creates a significant resource deficit and specifically disadvantages vulnerable populations.

We recommend concurrent planning for a new construction capital project to house a comprehensive **Wellness Center that centralizes resources** by co-locating mental health with recreation, nutrition, alcohol-free programming, meditation, sexual health, and other wellness-focused programs and services. In order to proactively address growing demands, we should also be planning now for 10-20 years into the future. An endeavor of this scale would serve as a lasting legacy for the current

administration and student body. [Many](#) institutions of higher education have demonstrated the fiscal wisdom of collaboration and integration of these resources. Whereas attending to mental health has been stigmatized, we imagine such a significant shift in culture at the University of Washington that by virtue of being a member of our community, integrated wellness is easily accessible, a top priority, and a point of pride.

Macro Recommendations:	Does this currently exist?
Adoption of the Okanagan Charter	No
Systematic review of policies/procedures and impact to mental health of students	No
Adoption of universal student health insurance plan	No
Embark on Wellness Center capital project	No

### Meso Level Recommendations - Existing Mental Health Services

In our conversations with all stakeholders, we heard consistently that the current bifurcated model of mental health services does not serve students. Instead, it creates confusion, reduces access, and creates frustration on the part of students who are already vulnerable. At a minimum, we recommend a merger of the two mental health units.

#### Merger of two existing mental health units

We recommend the **merger of the two existing mental health units**, Hall Health Mental Health and the Counseling Center. Establishing a new unit with this scope is a significant undertaking, and we will work with Hall Health, the Student Activities Fee Committee, the Provost’s Office, and others to create a plan that will ensure optimal services to meet student needs. In order to maximize opportunity for success, the MHTF identified several key elements to include in this recommendation.

#### Reporting Line

We recommend that this unit reside within the Division of Student Life, which will provide the organizational structure for integration with existing student-facing services and programs, as well as a connection to the underlying priorities of student retention and success. Most importantly to this new unit, Student Life is entirely focused on the student audience and needs, which gives the new mental health unit the infrastructure to support its client base.

#### Space

This merged unit will ideally be co-located. It is also helpful to maintain the close relationship with medical services required to provide high-quality collaborative care to UW students. Many students with mental health conditions initiate services with a medical provider. The benefit of being in close proximity to Hall Health’s primary care unit is that students who first seek care in that setting can more seamlessly access care from a mental health provider as appropriate. Psychiatric medicines are often initiated and continued by primary care and some categories of mental illness are also addressed as medical concerns, such as eating disorders. We recommend that Facilities undertake a space analysis regarding co-location.

### *Budget*

We recommend that this unit combine all current mental health investments, which includes approximately 28.3 clinical FTE and 6.75 non-clinical/support FTE, \$4.255M in total costs (see appendix [CC HHMH budgets](#)).

The MHTF has been encouraged to leverage every possible source of funding. However, many of the recommended service lines will not be billable to insurance and it is a priority to continue offering low-cost or free services. To that end, the task force recommends insurance billing for some services and using SAF funds to cover the out-of-pocket cost to students, which may be a copay for students with insurance and entire cost of care for students without insurance. The goal in this billing/subsidy model is to maintain the low- or no- out-of-pocket cost for students. Not included in the budget analysis are estimations of cost of yearly merit raises, administrative, billing, professional development, capital investments, and other unknown costs.

### *Infrastructure*

As with any merger, there are a wide array of systems to be created that will require substantial investment on the front end, including electronic health records, billing systems, payroll, etc. (see appendix [Efficiency Overview](#)). In particular, we recommend additional comprehensive analysis of an electronic health records system that will meet the needs of the newly merged unit and is specifically designed to support behavioral/mental health (see appendix for [EHR Assessment](#)).

## Additional Meso Level Recommendations

Services and programs that support mental health are delivered across the UW and may be localized to a very small cohort, may be directed at every entering undergraduate, or may claim no direct relationship with mental health services. Even as we seek to provide seamless provision of care, we recognize the practical reality of a decentralized and diffuse duty of care. In this section, we endorse the good work of colleagues across the campus and offer recommendations to bolster the relationship between their work and mental health. We also identify valuable services that do not currently exist but would contribute to mental health and wellness of students.

An unexpected and remarkable finding that emerged from our stakeholder engagement process was the breadth, diversity and sheer number of efforts unfolding across campus to study and support student mental health. As a result of bringing together parts of campus that do not routinely interact, we learned of exciting and innovative work as well as opportunities for partnerships and collaboration. The MHTF recognized that if these efforts became coordinated around shared goals, the impact of any one unit or department's work would be exponentially increased. Thus, we recommend the adoption of a **continuum of care** model, which distributes responsibility for student well-being across the institution. This is both a philosophical and cultural shift that promotes communication, sharing of information, and duty of care to faculty, fellow students, and staff. In order to identify these opportunities in an ongoing manner, as well as facilitate coordinated effort, we recommend an administrative infrastructure or **backbone**. Housed in the Provost's office, this infrastructure would be responsible for unifying and coordinating mental health-promoting services and programs across the institution, in order to maximize institution-wide impact. This approach ensures that existing and new efforts to support student well-being are maximally leveraged by increasing their reach. Moreover, the backbone will bring

together parts of the institution that could benefit from partnership. Oversight for building and systematizing the continuum of care is critical to extending support to students for whom seeking mental health care is stigmatized, or who face other high barriers to access (cost, transportation). This backbone will be positioned to coordinate and promote the protective factors inherent in higher education (see appendix [Continuum of Care](#)). Institutions such as the [University of Southern California](#) and [University of Michigan](#) have adopted similar **collective impact** models.

The MHTF recommends the widespread adoption and expansion of the Resilience Lab's **Well-Being for Life and Learning (WBLL)** initiative, which helps faculty adopt well-being content and activities into classroom spaces and teaches skills such as social connectedness, resilience, and growth mindset. More than two decades of research demonstrate that education promoting social and emotional learning (SEL) results in better outcomes for students.

From the standpoint of collaborations, several units and services are noteworthy because they intersect and overlap significantly with student mental health concerns: disability resources, alcohol and drug education, peer support, and increased adoption of trauma-informed approaches to working with students. Disability Resources for Students (DRS) has seen a 300% increase in psychological disabilities over the last 5 years. As these disabilities tend to be more complex to accommodate and must be renegotiated frequently, this adds to the significant burden faced by DRS. Alcohol/drug misuse education and prevention are provided by LiveWell, and we recognize the challenge of meeting the prevention demands of a large and diverse campus community. Additionally, we acknowledge the need to implement substance abuse treatment in mental health services. Peer support is a service that many campus partners offer and has proven to be a cost-effective and high-impact resource for certain topics. The task force received frequent suggestions for peer support models. And finally, we want to recognize the trauma-informed approach of many of our campus resources and endorse this framework in approaching student services. For each of these areas, we would like to recognize their significance and commit to future partnership and collaboration to amplify existing efforts and extend reach.

We support continued partnerships with community mental health services, particularly those that are in the U District, are free or inexpensive, and accept Medicaid. We consider this to be a multi-level effort. The mental health units should develop good referral relationships, and the University should consider business development efforts to make sure that community mental health agencies find the U District to be an appealing place to offer services.

The role of technology is a double-edged sword. While technology may help deliver psycho-education at scale, and external vendors could provide text-based counseling that significantly increases the numbers of students served, we also recognize that technology plays a role in mental health concerns. Navigating online relationships and influences are factors that UW students identified as contributors to their mental distress. Additionally, the UW is currently unable to meet the mental health service demands of undergraduate and graduate students enrolled in online programs, at offsite locations, or whose work and class schedules make it impossible to seek care during available business hours. Telehealth is a growing field with both promising and cautionary tales. We recommend a deeper **analysis of telehealth options**, including cost, quality, reach, and outcomes along two different lines of inquiry: psycho-education at scale and text-, app-, and/or web-based counseling that meets the consumer demands of students and extends services to those whose access to campus is limited.

We recognize that there are pockets of students at the UW who experience both real and perceived barriers to accessing services on “main campus” or “upper campus.” While the bulk of the service lines recommended are offered in a centralized format, there are several services that are especially well-suited to dispersed student pockets. A future offering of telehealth may address the needs of this population. We also recommend collaborations between units to host Let’s Talk once or twice a week to address drop-in needs. And finally, with the recognition that some units will want to hire mental health professionals who are specifically dedicated to their student communities, we recommend that all mental health professionals are provided clinical oversight centrally, so as to reduce individual risk and provide the best likelihood of success, back up, and consistency. Some units, such as Intercollegiate Athletics already have robust programs and clinical supervision provided through UW Medicine. Our recommendations are not meant to run against existing services currently meeting student needs.

<b>Meso Recommendations:</b>	<b>Does this currently exist?</b>
Merge Counseling Center and Hall Health Mental Health into a single mental health unit under the direction of Student Life	No
Locate the new mental health unit to maximize coordination with urgent care and primary care; with Facilities, determine optimal location and footprint	Yes, for HHMH
Implement a Counseling Reimbursement Model	Yes, in a limited fashion for HHMH
Adoption of a health record designed for behavior health services and provides capacity for billing	No
Adoption of the continuum of care, including implementing a “backbone” structure that supports integration across the enterprise	No
Widespread adoption of the Well Being for Life and Learning initiative	Yes – in pilot
Continued partnerships with community mental health services	Yes
Deeper analysis of telehealth options including cost, quality, reach, and outcomes, along two different lines of inquiry: psycho-education at scale and limited “seats” for text-based counseling or similar	No
Coordination across campus of mental health services	Yes

### Micro Level Recommendations (day-to-day clinical care)

Between the Counseling Center and Hall Health Mental Health Clinic, the primary clinical services offered to address the mental health needs of students include short-term individual counseling, group counseling, referral services, crisis intervention, and psychiatric medication management. In recent years, as both units have experienced a dramatic increase in requests for care, services have grown to include brief assessment and support appointments, workshop series, Let’s Talk drop-in consultations, case management, and single-session appointments. These newer services have been added *ad hoc* in an attempt to reduce wait times and stretch existing resources to reach greater numbers of students. While helpful, few were formed in coordination with other resources and, in some cases, have further complicated the systems students must navigate to connect with care.



The work of the Task Force provided the opportunity to examine our service lines from a bird's-eye view and re-conceive a coherent, streamlined system that aims to meet students where they are and provide them with the type of support that will maximize their opportunity for success. Many of our student stakeholders expressed preference to focus resources on increasing capacity for ongoing individual counseling such that any student who requested could be seen on a weekly basis for an unlimited duration. The Task Force calculated that 535 FTE new counselors would need to be added to meet this goal, and concluded that this goal is neither practical, given our resources, nor effective for addressing the range of needs presented on campus.

Furthermore, in keeping with our goal of reaching students from backgrounds under-represented in higher education, those who struggle with motivation, face multiple barriers to access, or who would benefit from more culturally-responsive forms of care, we need to diversify both the types of services offered and the manner in which they are delivered.

The services detailed below are coordinated, nonduplicative, diverse forms of care designed to meet varying levels and types of mental health needs, with the specific intention of reaching students from traditionally underserved or marginalized communities that may face additional obstacles to getting connected to support. In recognition that symptoms of the very conditions that prompt the need for intervention often become obstacles in themselves, lowering barriers to access and streamlining student navigation are priorities.

#### Proposed Service Lines

**Rapid-access counseling:** Delivered from a single point of entry, initiating support will be a straightforward process that students can access on a drop-in or same-day/next-day appointment basis. Immediate needs can be assessed, and options discussed. Students will leave this initial visit with an individualized plan to address their concerns.

This service will utilize a stepped care model that collaborates with the student to match them with a type of intervention that meets their type and level of need. The plan may consist of a range of supportive interventions and services beyond clinical care in the mental health unit such as a mindfulness class, self-care regimen supported by a wellness app, or referrals for off-campus care.

The success of this service will rely on having a robust menu of options outside the range of traditional clinical services as many, if not most students will not be automatically referred on for additional sessions of individual counseling. However, without a substantially increased number of counselors from the current FTE, offering a rapid-access one-time appointment to a number of students that greatly surpasses the capacity of brief counseling services will result in waitlists and poor student satisfaction.

**Brief individual counseling:** Students will be able to access short-term counseling using a "one-session-at-a-time" model, meaning counseling is delivered via stand-alone sessions and the impact of each session is assessed before another appointment is scheduled. Thus, counseling is delivered in an episodic manner on an as-needed basis, and builds on the students' strengths. Sessions are not limited to a specific number, and counselors will not assume that ongoing counseling is needed to address a student's concerns. Many students receive sufficient help in one session to improve their ability to address a challenging situation.

**Group counseling:** Group-based interventions will continue to be offered as effective options for addressing a wide range of student concerns. Students provided us with feedback that they wanted more group services. Types of group interventions range from process group therapy, which is particularly helpful for interpersonal difficulties to skill-based groups that offer tools for enhanced coping and resilience. Depending on type, groups might require commitment for a full quarter, attending a series, and/or accessed on a drop-in basis.

**Psychiatric medication management:** Provision of medication management is essential for students with significant psychiatric disorders who rely on regular access to a psychiatric provider to support and/or alter a medication regimen as needed. Psychiatric providers also treat students who initiated a trial of medication with their primary care provider but have not achieved the expected response.

**Case management:** A portion of students seeking counseling are facing financial difficulties, housing and food insecurity, childcare needs, lack of health insurance, etc. Currently, many students facing these stressors turn to therapists to help them cope. By hiring case managers who specialize in helping clients address these concerns, we can more quickly direct students to the actual care they need. Case managers can also assist students who need ongoing or longer-term psychotherapy get connected to off-campus therapists.

**Let's Talk:** This program provides drop-in consultation with a counselor in locations where students already feel comfortable. Already a successful program since this collaboration between Hall Health and the Counseling Center started in January 2017, two hours each weekday are made available at five locations on campus. The plan is to expand this service further.

**Campus Consultation:** Faculty, staff and peers report increased need for consultation regarding student behavior related to mental illness. This program will continue to offer coaching on how to address a specific student of concern and mitigate negative impact on the learning environment.

**Coordinated dissemination of psychological skills & mindsets:** In collaboration with the continuum of care partners, provide mental health expertise in creating coordinated content/curriculum for campus presentations, outreach and marketing materials, as well as campaigns and initiatives that address student wellbeing. The [University of Texas](#) provides an example of a strategic set of psychological skills and growth mindset to be disseminated to the whole campus. Healthy mindset and coping skills would be the focus for students, and skills that contribute to a community of care would be the focus for faculty and staff. Outreach and building relationships with underserved communities will be crucial as part of a population health approach.

**Behavioral Health/Primary Care Liaison:** An embedded mental health counselor within the primary care setting to create a low-barrier access point that allows for "warm handoff" with students who present to a medical provider with symptoms that may have a mental health component (e.g., insomnia, panic attacks, headaches, etc.). This position also provides support to primary care providers in a manner consistent with "curbside" consultation that frequently occurs in medical settings. Because a large proportion of mental health care occurs in the primary care setting, this position will facilitate collaboration and coordination between medical and mental health units.

**Community-based interventions:** Programming in this area would help strengthen a sense of belonging for students at UW. A stronger sense of belonging to one's university contributes to better mental

health as well as academic performance (Walton & Cohen, 2011). With emphasis on supporting the needs of our diverse student body, we recommend including on-campus access to indigenous ways of healing and body-based healing, allowing students to receive culturally relevant care. Possible forms may include time and space dedicated to regular offerings such as Talking Circles facilitated by elders, curandera visits, and acupuncture clinics.

**Expanded Training Programs:** Robust training programs for psychology doctoral interns and psychiatry residents already exist. Expanding them to include psychiatric nurse practitioner students and master’s level counseling trainees follows UW’s commitment to public well-being by contributing to the production of well-trained mental health professionals who will go on to provide needed care in our greater community, state and region, and help address the [wide-spread mental healthcare shortage](#).

Micro Recommendations	Does this currently exist?
Rapid access counseling	Limited. Currently available for crisis
Group and brief individual counseling	Yes. Needs expansion
Psychiatric medication management	Yes. Needs expansion
Case management	Yes, very limited
Let’s Talk	Yes, only 2 hours/day
Campus consultation	Yes, limited
Coordinated dissemination of psychological skills & mindset	Yes, limited
Community-based interventions	No
Expanded training programs	Yes, limited

### Implementation timeline

#### Option 0: Basic first step of reorganizing current resources

This option represents the basic step of consolidating campus mental health services through the administrative merger of the two main mental health service units, the UW Counseling Center and the Mental Health Clinic at Hall Health Center. The most effective merger from an operational perspective as well as user perspective would include co-locating the units into a single physical space on campus.

This option does not include any substantive changes to service lines or delivery but does offer the benefit of improved navigation for students and eliminates time-consuming coordination efforts between the units. Primary services would continue to be brief individual and group counseling, crisis intervention, and psychiatric medication management. Existing outreach programs including workshops, panels, and Let’s Talk would continue, but with no expansions.

Difficulty accessing care due to availability of service providers and significant constraints on amount of service available would likely remain unchanged as proportion of students seeking to access services is likely to continue increasing.

FTE (current – no change)	Approximate # of students served	Current cost
<b>33.3 clinical staff</b>	4,875 (direct clinical care) 6,300 (outreach/workshops/Let’s Talk)	\$4,255,733 existing costs for both units

*Option 1: Merged mental health unit with first round of expanded services*

Option 1 would be implemented over years 1-2, with a limited expansion of offered services, including:

- Administrative merger (and ideally, co-location) of the two mental health units
- Hiring 6 counselors and 2 case managers would help us provide services to approximately 1000 more students through initial assessment, Behavioral Health liaison assessments, individual therapy, group therapy and somewhat expanded Let's Talk services. This represents a 25% increase in number of students served.
- Select tech-based psychoeducation option for the whole campus. There are existing ready-made products that generally cost \$1 per year per student (and per faculty/staff if we want to make the product available to them as well). The advantage of this option is that this can be implemented rapidly. A second option would be to invest in developing such a product using UW resources. The advantage of this second option is that the product could promote the psychoeducational skills and mindset the campus agrees upon, for increased collective impact. Further, the product would be available to all students, faculty and staff without additional cost, thereby promoting wellness for the entire campus, and faculty and staff could reinforce these skills and mindset when they interact with students in distress.
- Engage in plan for academic coaching for students with disabilities.
- Support ASUW, GPSS, SAF and State Relations in legislative work and other steps needed to consider a universal student health insurance.
- In partnership with campus partners, increase trainings for faculty and staff to help them know how to respond to students in distress. Consider whether there is a more efficient way to administer this training.
- In collaboration with campus partners, implement social belonging interventions on campus.

*Option 2: Merged mental health unit providing true rapid access to counseling*

Option 2 would build on option 1 over years 3-5, offering more expanded services and increasing the number of students served as well as the campus-wide impact. The annual costs are based on increasing personnel costs but do not account for increasing overhead/administrative costs, which we can anticipate will grow in Option 2. The timeline and service lines are detailed below.

- Administrative merger and co-location of the two mental health units
- Hire 6 counselors and 4 case managers in the first two years, followed by 3 more counselors each year during years 3, 4 and 5. This will allow the center to provide rapid access (same-day or next-day access).
- Double Let's Talk offerings to include locations in areas of campus where access to counselors may be more challenging (e.g., south campus).
- Hire a specialist who can help the university implement steps needed to respond to the Okanagan Charter's calls to action. This specialist coordinates among units to develop a strategic plan to improve health and wellbeing on campus while embodying principles of equity and social justice. This includes increasing accessibility to green spaces on campus as well as promoting a supportive organizational culture for students, as well as the staff and faculty. Ideally, this person would help coordinate the psychoeducational skills and mindset the campus agrees upon, for increased collective impact.

- Select tech-based psychoeducation option (see above), and purchase a service for students to access counselors via telehealth (via online chat or phone options)
- Develop partnerships with community mental health agencies and UW Psychiatry & Behavioral Sciences department to expand mental health treatment options in the University District.
- Coordinate with indigenous healers for on-campus programming.
- In collaboration with campus partners, create Wellness Center infrastructure and capital plan.
- Develop peer support or peer coaching offerings.

### *Option 3: Most comprehensive approach*

Increasing trends in mental health symptoms and service utilization indicate that student needs for mental health support will continue to increase and the resources we plan for today will not be sufficient in the coming years. A planned expansion of our set of services will allow us to keep some pace with growing needs, spanning a ten-year implementation period. The annual costs are based on increasing personnel costs but do not account for increasing overhead/ administrative costs, which we can anticipate will grow in Option 3. These expansions include:

- *Rapid Access*: Capacity to meet the requests for services of 18,000 students.
- *Individual counseling*: Estimate approximately 45% of students who seek rapid access will be referred for brief individual counseling, accessing on average 6 sessions.
- *Group counseling*: Increase capacity to accommodate approximately 6% of those students who are assessed in rapid access.
- *Medication management*: Capacity for 10% of students seen in rapid access.
- *Case management*: Expand to support approximately 10% of students assessed in rapid access
- *Let's Talk*: Expanded locations, staffing, and hours to offer approximately 70 hours of drop-in consultations with a counselor per week in multiple places on campus to increase accessibility. Aim to serve approximately 75% of the students who report having an MH concern but do not present to rapid access to get connected to MH services.
- *Wellness Center*: Central location for multiple wellness-related services and activities on campus. This center would foster collaboration and coordination among wellness units, offer students ease of navigation to access comprehensive array of services and resources to support their well-being. In addition to office and clinical space for wellness units, the center could offer resources such as space for mindfulness classes, prayer/contemplative practice, self-help library, among others. A wellness center in an easily accessible location on campus would make it easier for students to get connected with support as well as demonstrate the University's commitment to supporting health and wellness as a core feature of engaged and effective students, scholars and leaders. Costs associated with a Wellness Center entail a significant amount of uncertainty and are therefore excluded from table below.

Services	Option 1	Option 2	Option 3
<b>Co-location</b> (cost pending review by Facilities)	Yes	Yes	Yes
<b>Number of new counselors</b>	6.0 FTE	15.0 FTE	59.5 FTE
<b>Number of new case managers</b>	2.0 FTE	4.0 FTE	6.0 FTE
<b>Rapid access to counseling</b>		Yes	Yes
<b>Adoption of tech-based tool</b>	Yes	Yes	Yes
<b>Increase psych. medication management</b>		.6 FTE	1.2 FTE
<b>Increase Let's Talk offerings</b>		Yes	Yes
<b>Counselor access via Telehealth</b>		Yes	Yes
<b>Specialist-implement Okanagan Charter</b>		1.0 FTE	1.0 FTE
<b>Implementation Timeline</b>	2 years	5 years	10 years
<b>Students served</b> (clinical services)	5,800	12,060	35,860*
Whole campus benefits from large-scale interventions (limited in option 1, expanded in options 2 and 3)			
<b>Additional Yearly Cost</b>	\$972,344	\$2,704,090	\$8,178,398
<b>Existing Costs (Option 0)</b>	\$4,255,733	\$4,255,733	\$4,255,733
<b>Grand Total for Yearly Cost</b>	\$5,198,077	\$6,959,823	\$12,434,131

\*Estimated number of students served per year by year 10.

## References

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## Appendices

[Student Mental Health MHTF Charge](#)

[Public Health Framework](#)

[Population Health Framework](#)

[3-Axis Model of Care](#)

[Continuum of Care](#)

[University of Washington – Seattle Healthy Minds Study 2016-2018](#)

[ASUW Mental Wellness and Education Access Task Force 2017-18](#)

[ASUW Mental Wellness and Education Access Task Force 2018-19](#)

[CC HHMH budgets](#)

[EHR Assessment](#)

[Efficiency Overview](#)