DEPAUL UNIVERSITY
DIVISION OF STUDENT AFFAIRS

Annual Assessment Report Template: Non-Learning
Academic Year: 2015-2016

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Type of Assessment:	Benchmarking

I. Abstract

Nationwide, colleges and universities are impacted by growing mental health concerns of students. The present study sought to benchmark psychological counseling services, staffing, collaborations with health services and creative approaches to outreach and consultation. Benchmarking institutions were identified with assistance from DePaul Institutional Research & Market Analytics. Of the 17 institutions surveyed, 15 responded yielding a response rate of 88.2%. Benchmark questions aligned with department key activities, including clinical services, consultation, collaborations and outreach. The study revealed a range of staffing levels from 1 counselor to 764 students to 1 counselor to 2814 students with the mean counselor to student ratio of 1 counselor to 1677 students. Average length of available treatment ranged from 6-8 sessions/year to 45 per degree program. Number of groups per year ranged from 0 to 22. Off-campus referrals ranged from 2% to 30%. Student health insurance was available at 81% of institutions and required at 75%. A sizeable minority (39%) of respondents expressed some dissatisfaction with their health insurance plan/referral network. Regardless of the location of the counseling center with respect to health services, 80% reported the degree of collaboration as good or excellent, including numerous recommendations for enhancing coordinated care. Creative outreach programs included Question, Persuade & Refer (QPR) for suicide prevention, case managers for connecting students to off-campus referrals, and coordinated strategic planning between counseling, health services and health promotion. Recommendations included sharing results with key campus partners, developing the UCS group program, enhancing outreach initiatives and increasing collaboration with DePaul Health Services.

II. Assessment Question

What can DePaul University Counseling Services learn about best and/or promising practices in college mental health (i.e., focusing on resources,

clinical service provision, consultation and collaborations, and outreach and consultation) from our benchmark institutions?

III. Introduction & Context

University Context

In recent years, more students are presenting to university counseling centers with complex mental health issues (AUCCCD, 2015). In addition, more students are engaging in help-seeking behavior for adjustment and developmental issues (Hunt & Eisenberg, 2010). Mental health and behavioral issues present challenges not only to counseling centers, but across campus in residence halls, judicial offices, in the classroom, etc. National and local surveys indicate a growing number of students are feeling anxious and overwhelmed (NCHA, 2013). As such, it is critical that university counseling centers are positioned to provide both individual and population-based interventions to assist as many students as possible. Such assistance serves institutional mission goals, including retention, risk management and university learning goals.

University Counseling Centers are challenged to develop sound practices to meet the rising demands for clinical services, for coordination of psychological counseling services with health services, linkage to off-campus referrals and creative ways to deliver population-based as well as individual clinical interventions.

Vision 2018 Objective 1a challenges the entire university community to "expand support for high-quality, easy-to-navigate student services, including those that address student wellness and mental health, and special support services and accommodations."

Supporting Scholarship

In recent years, college student mental health has come to the forefront of discussions about health and safety on many campuses. National trends in mental health needs on college campuses have gained significant media attention in the last several years. The 2013 National College Health Assessment data reveals that 43.2% of student respondents on 39 college campuses felt "so depressed that it was difficult to function" at least once in the 12 months prior to taking the survey. Though rates of depression have been increasing over the past five years, reports of anxiety have outpaced depression as the number one presenting issue in university counseling centers (AUCCCD, 2015). Nearly a third of students report that they feel 'frequently overwhelmed.' 7% of a non-clinical sample of college students report suicidal ideation (NCHA, 2013). 25.1% of counseling center clients were taking prescribed psychiatric medications in 2015 as compared to 9% in 1994. Over 90% of counseling center directors report that the trend toward increasing numbers of students with severe problems continues (AUCCCD, 2015). In the past 5 years, more students are using the language of suicidal distress to describe their suffering, even as actual suicide rates of college students are

about one-half the non-college population (CCMH, 2015). Demand for counseling services has risen 5 times as much as enrollment in the past 5 years (CCMH, 2015). As such, counseling centers can feel strained by rising demands and limited resources. In this environment, maximizing efficiencies and best practices is critically important to reaching as many students as possible.

Benchmarking is the "continuous systematic process for evaluating products, services, and work processes of organizations that are recognized as representing best practices for the purposes of organizational improvement (Spendolini, 1992).

Benchmarking is the process of comparing one's business processes and performance metrics to industry bests or best practices in other industries. In higher education, benchmarking helps overcome resistance to change, provides a structure for external evaluation, and creates new networks of communication between schools where valuable information and experiences can be shared (NACUBO, 1994).

Benchmarking in student affairs can demonstrate or improve quality, develop strategic plans, formulate policy, aid in decision making and justify programs/services. The present study sought to incorporate *competitive* benchmarking (examining performance against peer institutions) and *functional* benchmarking (looking at high performing processes across the industry).

Data Collection & Methodology

Data Collection

Benchmarking institutions were identified using a document on benchmarking from DePaul's Institutional Research and Market Analytics, 'DePaul Peer Sets for Benchmarking,' (2012). 17 institutions were selected based on having some (but not all) combinations of similar characteristics: urban, Catholic, primarily commuter, multi-campus. The size of institutions was variable, but included some institutions with similar residential populations.

The study included both '*reference peers'* (i.e., similar in most major ways) and '*aspirational peers'* (i.e., organizations that have best practices and/or superior outcomes).

27% of respondents were from public institutions. 60% of respondents were from private institutions while 40% of respondents were from Catholic institutions.

National norms were also incorporated using large data sets from the Association of University & College Counseling Center Directors (AUCCCD), the National College Health Assessment (NCHA), and the

Center for Collegiate Mental Health (CCMH), and the American College Freshman Survey (CIRP).

A survey instrument was developed to assess several counseling center resources and practices in 4 key areas (mirroring key domains of the UCS key area analysis), including:

Resources

- Number of FTE clinicians and counselor to student ratios
- Availability and/or requirement of student health insurance

Clinical Services

- Average length of treatment
- Training and adherence to time-limited or brief therapy models
- Utilization of group counseling

Consultation and collaborations around service provision

- Administrative location of health services
- Collaborative partnerships with health services
- Facilitation of off-campus mental health referrals

Outreach and Consultation

- Innovative practices in community outreach

The survey was designed to be consistent with key area mapping domains (except for clinical training).

The UCS team was consulted in a 'professional observation' session regarding what areas and issues would be most helpful or noteworthy to benchmark in preparation for departmental retreats and strategic planning.

A draft of the benchmarking survey was distributed to the UCS team for comments and edits.

The survey was then sent to a small group of counseling center directors (N=3) for commentary and feedback. Directors had extensive feedback and suggestions which resulted in significant refinements.

In order to maximize the chance of survey completion, the surveys were sent along with both a personal email message and follow-up phone call to 17 counseling center directors.

15 directors responded, yielding a response rate of 88.2%.

Data Analysis

Benchmarking institutions were identified using a document from DePaul's Institutional Research & Market Analytics (2012). Because such a large number of institutions were potential peer or benchmark institutions, the pool was narrowed down by similarity to DePaul University in terms of characteristics such as enrollment, mission, urban or primarily commuter status, etc.

Data points for benchmarking were determined by the UCS staff, utilizing the key areas of clinical services, consultation, collaboration and outreach. Student health insurance and collaboration with health services was a special focus, since these issues have significant impact on the work of UCS and longer term health and wellness outcomes for students.

Frequencies and average scores of survey items were calculated via Qualtrics. Survey items relating to programs and services Yes/No questions and checkboxes. Satisfaction questions employed 5-point likert scales. Text boxes were also used for qualitative data. Some of the data was rank ordered for clarity of presentation (i.e., to see how DePaul compared).

Follow-up phone-up phone calls and emails (for further elaboration and clarification of items) were employed with 4 benchmarking institutions.

Participant Consent

Participants were free to complete the survey or not. In addition, participants were given the option of de-identifying their institutional data/responses. Six institutions chose to have their data de-identified. Because some of the data is perceived to be sensitive, efforts were taken to keep some level of anonymity among the participating institutions.

IV. Data & Results

Participating Institutions, included

Loyola University Chicago (Catholic, urban)
University of Illinois at Chicago (urban, diverse, primarily commuter)
University of Dayton (Catholic, urban)
Rush University (private, urban, commuter)
Catholic University of America (private, Catholic)
University of Notre Dame (private, Catholic)
Boston College (urban, Catholic)
Fordham University (urban, Catholic, multi-campus)
University of San Francisco (Catholic, urban)
University of San Diego (Catholic, urban)
University of Wisconsin-Milwaukee (public, primarily commuter)

University of Iowa (public, urban)
Marquette University (Catholic, urban, primarily commuter)

Resources (Staffing)

Staff Ratios from most favorable to least favorable

Among benchmark respondents, the average counselor to student ratio was 1 to 1677 students.

DePaul ratios are 1 counselor to 2359 students (highlighted in bold print)

26.3 FTE clinicians for 20,100 students	1 counselor to 764 students
13 FTE clinicians for 12,300 students	1 counselor to 946 students
7 FTE clinicians for 8,300 students	1 counselor to 1186 students
9 FTE clinicians for 11,300 students	1 counselor to 1256 students
6.5 FTE clinicians for 8,500 students	1 counselor to 1308 students
11 FTE clinicians for 16,000 students	1 counselor to 1455 students
2 FTE clinicians for 3,050 students	1 counselor to 1525 students
10 FTE clinicians for 16,437 students	1 counselor to 1644 students
6.6 FTE clinicians for 11,000 students	1 counselor for 1667 students
6.3 FTE clinicians for 10,900 students	1 counselor to 1730 students
24.3 FTE clinicians for 50,500 students	1 counselor to 2078 students
10 FTE clinicians for 23,539 students	**1 counselor for 2359 students**
12 FTE clinicians for 33,000 students	1 counselor for 2750 students
9.6 FTE clinicians for 27,018 students	1 counselor to 2814 students

DePaul ranked 12th out of 14 institutions in terms of favorability of staff ratios. (One respondent did not specify staff ratios).

Clinical Services

Session Limits

- 8 of 14 benchmark institutions (57%) had session limits.
- 14 of 15 benchmark institutions (93%) indicated that they practice within a norm of brief therapy.
- Length of available treatment ranged from 6-8 sessions per year to 45 sessions per degree program.

Group Counseling

- Number of groups range from 0 to 22 groups per quarter or semester.

- Successful practices included keeping groups 'open' to some extent and having some groups start mid-semester, making sure one group launches before starting others

Consultation and collaboration for service provision

Student Health Insurance

- Student health insurance was ***available*** 13 of 16 (81%) of benchmark institutions.
- Student health insurance was ***required*** at 12 of 16 (75%) of benchmark institutions. Student health insurance is thus normative at benchmark institutions.
- 7 of 11 (64%) of benchmark institutions rated the degree of satisfaction with their student health insurance plan as ***good or excellent.***
- 6 of 11 (55%) described the degree of satisfaction with their student health insurance plan as ***neutral.***
- Only 1 benchmark institution (9%) rated the degree of satisfaction with the student insurance plan as ***poor.***
- While a majority of respondents rated satisfaction with their student health plan as good or excellent, 4 institutions (36%) reported that their student health plan was not fully satisfactory (i.e., responding 'neutral, fair or poor').

Collaboration with Health Services, including best or promising practices

- Whether counseling services were delivered in a free-standing location, co-located or fully integrated with health services, 11 of 15 benchmark institutions (73%) of respondents described their degree of collaboration with health services as good or excellent.

The following were cited as best or promising practices for collaboration:

- Multidisciplinary eating disorder treatment teams (e.g., physician, psychiatrist, psychologist, nutritionist)
- Regular meetings between health services, counseling services and health promotion and education and/or collaborative approaches to strategic planning
- Integrated health records when counseling and health are co-located
- Screening for mental health issues in the primary care setting

Off-Campus Referrals

- Off-campus referrals ranged from 2% to 30%.
- Only 1 benchmark institution (7%) indicated that their ability to refer off-campus was 'excellent.'
- 5 of 14 benchmark institutions (36%) indicated that their ease of making off-campus referrals was 'good.'
- 6 of 14 benchmark institutions (43%) indicated that their ease of making off-campus referrals was "Neutral" (the largest percentage of participants).
- 2 of 14 benchmark institutions (14%) indicated that their ability to refer off-campus with ease was 'poor.'

Outreach and Consultation

- 10 of 14 (71%) benchmark institutions employed outreach to higher risk student populations.

  The outreach practices included:

- Question, Persuade & Refer (suicide prevention)
- Canine therapy (therapy dogs)
- Depression and Eating Disorder Screening Days
- "Let's Talk" (placement of counselors outside of the counseling service)

V. Discussion & Interpretation of Results

Resources

FTE counselor to student ratios
DePaul tends to have more modest staff ratios that most of our benchmark institutions.

Availability and/or requirement of health insurance
A large majority of benchmark institutions have some type of student health insurance plan available. A smaller number (though still a solid majority of benchmark institutions) require enrolled students to have health insurance.

It might be noted that the Affordable Care Act (with its large deductibles and often defaulting lower income students into Medicaid manage care plans) does not eliminate the need for a viable student health insurance plan. Based on these data (and other data sets in the university) a longer term discussion about health services and health insurance options for students may be indicated. Disparities in health resources impacting students tend to have more adverse impact in lower socioeconomic status more 'at risk' students. As such, this may be seen as an issue which relates to both social justice and retention and persistence.

Clinical Services

Session Limits
Session limits within UCS are within the norm of university counseling centers. Some centers offer more sessions within a degree program (up to 45). However, UCS clients may be seen for up to 20 consecutive sessions (though we try to treat at least 80% of our clients within 6 to 10 sessions consistent with national norms). Only 9% of UCS clients use more than 15 sessions, so the culture of brief therapy is strong within UCS.

DePaul's 20 sessions per degree program is on the more generous end of the spectrum (if sessions are used consecutively) and perhaps on the more restrictive end when considered over the course of the entire degree program. However, many

DePaul students lack private mental health coverage as well as access to a viable student health insurance plan. Thus, DePaul students' ability to access viable behavioral health services off-campus may be restricted.

Group Counseling
There is a wide range of group programs and success with group counseling among benchmark institutions (from no group counseling to robust programs). UCS has been consistently running 4 to 5 groups per year – about average when compared to benchmark institutions.

Though having a viable group counseling program on a primarily commuter campus is challenging, there is room for improvement in our group program.

Getting more people into group as a primary treatment modality has been an area of focus for the past few years. Since UCS has no limit on group counseling, group can serve as a treatment modality which affords a longer term treatment experience, including eligibility for continued psychiatric services.

Consultation and Collaboration around Service Provision

Off-Campus Referrals
In the past, UCS has referred about 14% of students to off-campus resources. However, this number increased to 21% for the 2015-16 academic year.

Most institutions are able to refer into the provider networks of their student insurance plan (a disadvantage for DePaul). UCS is on the higher end of average as benchmark institutions tend to refer about 20% of students off-campus.

Off-campus referrals have fluctuated over the course of the history of UCS. When the program first started, about half of students were referred off-campus. In recent years, 10% on average have been referred off-campus. One benefit of the Affordable Care Act (despite sometimes cost prohibitive deductibles and co-payments) is that more students are covered under their parents' insurance. Thus, UCS has a greater option to refer off-campus for students who may not be amenable to brief therapy and for students who have a richer health plan.

A clear trend among benchmark institutions is hiring social workers or case managers to assist with linkages to off-campus referrals. With the Assistant Dean for Community Resources taking on more administrative duties within the Dean of Students office, there has been less active case management available in the past couple of years. This may be in need of review in light of best practices and divisional strategic planning.

Student Health Insurance
Other than purchasing a plan off the exchange (often with high deductibles or with lower income students defaulting into Medicaid plans), DePaul is an outlier in not

providing a student health insurance plan. [It should be noted that health insurance is now mandatory at DePaul for international students].

DePaul is in a minority of institutions that do not have a viable student health insurance plan. The decision to have students go through the state exchanges has some significant drawbacks for students and creates disparities between students who are defaulted into Medicaid plans (which often have very minimal behavioral health resources and confusing and cumbersome access procedures) vs. students with private health insurance. This can create a significant strain on UCS as off-campus referrals for the most acute students are often complex and difficult (and sometimes not workable).

Collaboration with Health Services
Despite some tensions between medical models of health service delivery and a more typical developmental model with college counseling personnel, most institutions find ways of bridging the gap in service of students.

Among benchmark institutions, DePaul is the only university that has an outsourced health service. There are often tensions between health and counseling (even when services are integrated or co-located due to differing philosophies of care such as the developmental model vs the medical model). Nonetheless, peer institutions demonstrate a number of creative ways to communicate and collaborate on patient care.

Outreach and Consultation
Several institutions commented that there was overlap and lack of clarity between outreach conducted by the counseling service vs. outreach conducted by health promotion. Nonetheless, a number of promising practices were articulated. Given rising student mental health concerns, outreach and consultation (i.e., specifically the opportunity to deliver community or population-based interventions) are arguably more important than ever.

VI. Recommendations and Plans for Action

Recommendations

Resources

- Based on benchmarking institution data, advocate for and additional FTE staff position

- Develop a clear 'scope of service' statement for the UCS website and publications

- Develop relationship with the DOS social work intern and raise awareness of the growing and important role of student affairs case managers (either within UCS,

DOS or both) in working with higher-risk students, including increasing numbers of DePaul students enrolled in Medicaid

Clinical Services

- Increase the percentage of students referred for group counseling at initial consultation for the 2016-17 academic year

- Keep current session limits while striving to maintain and invigorate our brief therapy culture

Collaboration with Health Services

- Have regular quarterly meetings between UCS (including Dr. Harris), HPW and Dr. Odland and/or other physicians at Presence/SAGE Medical group focusing on cross-referrals, identifying and referring students and collaborating on treatment plans when appropriate.

- Enhance relationship with Emergency Department physicians and other crisis management staff members at Advocate Illinois Masonic Medical Center via more frequent communication.

Outreach & Consultation

- Develop an intentional approach to outreach, including an outreach curriculum and an outreach component of the department's strategic plan.

- Pilot a staff training on 'Question, Persuade & Refer' (evidence-based suicide prevention training) for staff, faculty and student leader trainings

Action Plan

Resources

A proposal for additional staff resources was submitted to Division leadership (August 2016).

Clinical Services

- Enhance UCS fall quarter trainings in brief therapy for UCS staff and externs (by October 2016).

- Strengthen staff trainings in the fall quarter on the use of the CCAPS in tracking outcomes and in treatment planning (by September 2016).

- Incorporate guest speakers and trainers with specific expertise in brief treatment models during fall and winter quarters. (by March 2017).

- Provide initial consultation clinicians and other staff members with consistent feedback on group times, # of group openings, etc. to facilitate additional group referrals (by September 2016).

Collaboration with Health Services

- Create a contact (liaison relationship) with Advocate Illinois Masonic to help assist UCS with referrals to Medicaid providers (by September, 2016).

- Collaborate with social work intern in Dean of Students office to assist students with Medicaid referrals (by October 2016).

Outreach & Consultation

- Create and roll out a dedicated Outreach Coordinator position (by August 2016).

- Develop a strategic plan specific to community outreach which addresses relevant campus climate issues and responds to the needs of specific groups and populations of students, in alignment with the university and divisional strategic initiatives (by Dec 2016)

- Pilot the Question, Persuade & Refer (QPR) approach to train RAs and RDs, groups of student leaders and target groups of faculty/staff on suicide prevention over the next three years (by May 2017)

- Pilot a "Let's Talk" program with the International Student Office of Office of Multicultural Student Success (by February 2017)

Sharing the results

- Results will be shared at departmental staff meetings and in summer retreats and planning sessions.

- Share results of the benchmarking survey with the Dean of Students Direct Report Group which includes directors and/or assistant directors from University Counseling Services, Health Promotion & Wellness, Center for Students with Disabilities and the Dean of Students office.

- Share results with Divisional Council and divisional leadership.

- Arrange for meeting/consultation with the International Student Office (which has recently required that all international students purchase a health insurance plan).

- Schedule regular consultative meetings between UCS and DePaul Health Services as well as frequent referral sources for higher levels of care (e.g., Advocate Illinois Masonic Crisis and Emergency Room team, Lakeshore Hospital assessment and case management teams).

- Prioritize 2 – 3 larger scale outreach projects for each year based on Divisional priorities, empirical data such as NCHA and salient campus climate issues.

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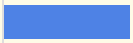
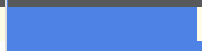
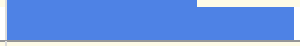
Appendix I: 2015-2016 Student Satisfaction Survey data

Type of Institution (check all that apply):

#	Answer		Response	%
1	Public Institution		4	27%
2	Private Institution		9	60%
4	Catholic Institution		6	40%
5	Other Faith-Based Institution		0	0%

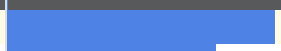
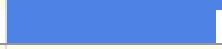
Would like your institution to be de-identified?

#	Answer		Response	%
1	Yes		6	40%
2	No		9	60%
	Total		15	100%

Average # of individual counseling sessions per treatment episode - please include a decimal point:

Text Response
5
data not available
4.2
4.5
7.0
5
6.9
6.0
3.6
7.6 -- this figure excludes all clients whose utilization exceeds 50 sessions
7
3.0
8.5

Do you have a session limit for individual counseling?

#	Answer		Response	%
1	Yes		9	56%
2	No		7	44%
	Total		16	100%

If so, what is the limit?

Text Response
20 sessions per degree
6 to 8 visits per calendar year
roughly ‘a semester’
12/ academic year, additional if enrolled in summer
Brief Model. No number limit.
45 session limit per degree
10-15
10-12

Practices your center employs to strengthen the culture of brief therapy:

The 3 session per student is misleading. Our utilization rate is so high (14.4%) that many students who come our way received referrals and ‘care coordination’ (i.e., case management) vs. treatment as such, and care coordination may occur over just one or two sessions. For students in treatment, the average number of sessions is about 6.

Any therapist needing sessions beyond the 10-12 sessions of brief therapy (or psychiatry appointments) must staff the case with all staff in our clinical consultation meeting. Compliance with the brief treatment model is checked within the peer review process. Staff are encouraged to consult individually or within clinical meetings to share cases in which the brief treatment model is challenging. Hiring of staff with, and dedicated to, working within a brief treatment model.

We don’t do this. Students and house staff have access to the services as long as they are currently enrolled.

Advertise ourselves this way on marketing materials.

Staff must be accountable to peers regarding the disposition of any new case.

Develop a scope of service treatment.

Staff training on inclusion/exclusion criteria for brief treatment.

Training on brief treatment modalities.

Continuous development of referral network to refer students who need longer term treatment.

Reliance on group

Referral for longer term or specialized issues.

Advertise in all public materials. Information is shared through standardized process during initial assessment. Case manager on staff to assist with those desiring longer term care to help assist therapists make appropriate deliberations during initial assessment not intake clients into brief model incorrectly.

We are changing our service delivery model in the fall. Each staff member will have a required number of weekly intakes and will have to decide disposition – refer off-campus, see for individual, refer to group, refer to Coping Skills module with possibility of 8 sessions individual following Coping Skills. There will be 3-5 Coping Skills, 4 session workshops each week. These will be the

jumping off point for most clients; we hope it will provide baseline skills. Additional support is possible after completing the group module.

Clearly advertise as time-limited

Review any case over 10 sessions

Deliberate discussion of time-limited treatment in session, with options to refer to group after a reasonable duration

Professional development around brief models of therapy.

How many groups does your center offer per quarter or semester?

Text Response
22
11
4-5
6
we offer more than we fill---8-10; typically fill 6
12
4
3
18
None. Our university currently has 7 academic calendars. Within these, clinical rotations are of varying lengths. It would be impossible to put together a group with stable membership.
10
5
It varies, but at least 3, and usually it's 4 or 5; this semester though we offered a record number (7)
6
3

Lessons learned about successful group programs:

Most group members join because of in-house referrals. Our most popular group is “Anxiety Workshop,” which runs 3 sessions is very structured, and is offered several times throughout the semester.

Usually better to offer a specific or general time frame for groups being advertised and not try to find a time within the schedules of interested students.

Start group recruitment heavily in the first two weeks of the semester.

Offer open-ended groups or those in which students can join at a point after the beginning of the group (when possible)

Regularly remind all staff of groups with openings

Allow staff to try any group that they want. Permit failure in group therapy, even encourage it.

We tried a “Feel Better Fast” group for those on our waiting list: four sessions of Mindfulness and other distress-tolerance strategies. Despite a long (sometimes 50) waiting list, we had almost no takers, though we moved scheduling around to accommodate.

Internally referred groups for specific issues (i.e., Grief, Mentally Ill Parents)

Most important was getting counseling staff buy-in to consider some issues as being best addressed by group. We had a consultant come in to address this issue.

Recruiting for group experience, interest and skill; offering student-friendly (e.g., late afternoon) and consistent times; marketing/branding thoughtfully (e.g., “transitions group” versus “homesickness group”).

Exhaustive process which truly helps us make use of all of our groups, including groups which start mid-semester when all beginning of the semester groups are full.

It has hurt our efforts to reach critical mass in groups when we have offered too many groups from the outset. We do better when we offer a smaller number of core groups, then add additional groups once the original core groups are up and running.

Staff willingness to put aside an individual therapy bias. Strong advocates for group therapy on the staff and someone to take the lead. A cultural shift in the center to lead this option.

Group coordinator a necessity

Group discussed during initial assessment

Professional development on group approach

Deliberate approach to focus on groups in advertising

Range of group formats: skills, workshops, process/support

Discussion of transition to group during individual counseling

What percentage of students do you refer to off-campus providers?

Text Response
exact data not available--but a high number
less than 5%
19.5
7% in 2015-16
30%
About 2%
11.4%
20--25%
Less than 5%
24%
3.4 (average over the past 5 years; we intend to increase this number in the future)
15%
don’t have reliable data on this without additional analyses

Is student health insurance available at your institution?

#	Answer		Response	%
1	Yes		13	81%
2	No		3	19%
	Total		16	100%

Is student health insurance required at your institution?

#	Answer		Response	%
1	Yes		12	75%
2	No		4	25%
	Total		16	100%

What is the degree of satisfaction in working with your student health insurance carrier (i.e., quality and accessibility of behavioral health clinicians/network referral options)?

#	Answer		Response	%
1	Poor		1	8%
2	Fair		0	0%
3	Neutral		4	31%
4	Good		7	54%
5	Excellent		1	8%
	Total		13	100%

Availability and ease of making off-campus referrals (i.e., for psychotherapy and psychiatry) at your institution for students with private health insurance coverage?

#	Answer		Response	%
1	Poor		2	13%
2	Fair		0	0%
3	Neutral		7	47%
4	Good		5	33%
5	Excellent		1	7%
	Total		15	100%

Please add additional comments about your experience in referring to Medicaid, public sector mental health resources and/or lower cost sliding scale agencies:

Many more successes in referring to lower cost sliding scale providers though this remains a challenging problem not only in locating providers but in having a fairly high percentage of students who would struggle to pay even a sliding scale fee.

Almost no success with referrals to Public Aid and Medicaid.

Public mental health center does not accept students unless they have history of multiple hospitalizations.

Limited availability of sliding scale agencies.

We make the referrals in a few cases, but the students rarely go to outside providers from our referral. Most students expect to get services from campus agencies. Insurance is not the obstacle. Difficulty of getting to the providers and lack of motivation for treatment are the main obstacles.

Currently our center does not have an in-house case manager to follow up with off-campus referrals for mental health. We are working towards obtaining such a position.

The challenge, overall, isn't identifying providers, but working with student and family resistance to being referred off-campus.

We have a couple of good options for low cost services including two local training clinics.

Case manager handles much of this for our system, including compiling information about private and group practices in town, what insurance they take, and working with student health insurance companies.

Always more difficult, but we do have a network of community mental health centers in the surrounding communities which serve as a resources in these cases. In reality, these are students we are more likely to hold in longer term therapy ourselves.

Next to impossible to expediently assist students on Medicaid, horrible process. Easier access with low fee counseling, but most do not have highly trained clinicians to address the difficult cases we are referring.

How would you assess the degree of collaboration with student health services at your institution?

#	Answer		Response	%
1	Poor		0	0%
2	Fair		1	7%
3	Neutral		2	13%
4	Good		7	47%
5	Excellent		5	33%
	Total		15	100%

Are there any practices which your institution employs to promote collaboration between counseling and health services? (please specify):

Text Response

multidisciplinary treatment team for eating disorders;

electronic mechanism to share records (with ROI's)

regular conversation and collaboration

Ongoing Eating Disorder treatment team meetings. We used to have our psychiatrist spend an hour a month there but it wasn't used well. We have standardized forms and protocol for referring back and forth.

Cross referral, annual meeting to update on services; consulting relationship; good "schmooze" with the Program Assistant

Health and Counseling services share a front desk and waiting area. We occupy the same suite of offices.
Although separate agencies with separate identities, the providers collaborate going both directions.

When students check in for counseling for the first time they are asked if they will sign a permission (release) for health and counseling to collaborate in their treatment if needed. Almost all students grant this permission. Health and Counseling meet monthly to review joint cases and consult with the psychiatrist who works out of counseling.

We have regular meetings between directors of Health Services, Counseling Service, and Office of Health Promotion. We respect both the differences and cross-over between our services. We are clear that directors are available to each other at any time to resolve dilemmas of difficult cases.

We share psychiatry services, though these services are all paid by the Counseling Center budget. We are structurally organized under a Health and Wellness Unit with the same AVP supervisor. The Unit has a Strategic Plan to which we both contribute. The leadership of the Counseling Center and Health Services are more collaborative than the staff members.

Although we are separate departments, we share the same electronic record system, share the same informed consent forms/process, and have weekly case conference meetings during which we discuss clients in common. From a student's perspective we appear as if we are essentially one department.

We are an integrated unit so that offers many opportunities for positive collaboration right from the start. Cannot comment much beyond that

Are there any programs, services or collaborations in your center (e.g., outreach to higher risk or under-served populations) which you feel are best or promising practices?

#	Answer		Response	%
1	Yes		10	63%
2	No		6	38%
	Total		16	100%

Appendix II
DePaul Specific Data
National College Health Assessment (NCHA, 2013), N=736

H. Mental Health

Students reported experiencing the following within the last 12 months:

Felt things were hopeless

Percent (%)	Male	Female	Total
No, never	39.7	25.6	30.2
No, not last 12 months	21.5	21.5	21.3
Yes, last 2 weeks	13.5	19.2	17.4
Yes, last 30 days	11.0	10.8	10.9
Yes, in last 12 months	14.3	22.9	20.2
Any time within the last 12 months	38.8	52.9	48.5

Felt overwhelmed by all you had to do

Percent (%)	Male	Female	Total
No, never	13.6	4.8	7.7
No, not last 12 months	6.4	5.4	5.7
Yes, last 2 weeks	37.3	52.0	47.3
Yes, last 30 days	16.9	18.5	18.0
Yes, in last 12 months	25.8	19.3	21.3
Any time within the last 12 months	80.1	89.8	86.6

Felt exhausted (not from physical activity)

Percent (%)	Male	Female	Total
No, never	16.9	7.1	10.4
No, not last 12 months	11.9	6.5	8.2
Yes, last 2 weeks	37.3	51.3	46.8
Yes, last 30 days	19.5	17.7	18.1
Yes, in last 12 months	14.4	17.5	16.5
Any time within the last 12 months	71.2	86.5	81.4

Felt very lonely

Percent (%)	Male	Female	Total
No, never	26.7	17.7	20.6
No, not last 12 months	21.2	19.5	19.9
Yes, last 2 weeks	22.0	27.2	25.7
Yes, last 30 days	11.9	13.3	12.7
Yes, in last 12 months	18.2	22.2	21.0
Any time within the last 12 months	52.1	62.8	59.5

Felt very sad

Percent (%)	Male	Female	Total
No, never	25.8	15.2	18.7
No, not last 12 months	21.2	15.6	17.3
Yes, last 2 weeks	22.5	28.3	26.6
Yes, last 30 days	12.3	15.2	14.3
Yes, in last 12 months	18.2	25.6	23.1
Any time within the last 12 months	53.0	69.2	64.0

Felt so depressed that it was difficult to function

Percent (%)	Male	Female	Total
No, never	46.0	38.5	40.7
No, not last 12 months	22.4	24.7	23.9
Yes, last 2 weeks	11.0	10.2	10.6
Yes, last 30 days	7.2	8.9	8.3
Yes, in last 12 months	13.5	17.7	16.4
Any time within the last 12 months	31.6	36.8	35.4

Felt overwhelming anxiety

Percent (%)	Male	Female	Total
No, never	38.6	22.3	27.6
No, not last 12 months	16.9	13.5	14.5
Yes, last 2 weeks	16.1	25.8	23.1
Yes, last 30 days	8.5	16.7	13.9
Yes, in last 12 months	19.9	21.7	20.9
Any time within the last 12 months	44.5	64.2	57.9

Felt overwhelming anger

Percent (%)	Male	Female	Total
No, never	41.3	32.7	35.5
No, not last 12 months	23.4	22.6	22.7
Yes, last 2 weeks	8.5	12.8	11.7
Yes, last 30 days	7.2	10.5	9.5
Yes, in last 12 months	19.6	21.4	20.6
Any time within the last 12 months	35.3	44.7	41.8

Seriously considered suicide

Percent (%)	Male	Female	Total
No, never	73.8	76.0	75.2
No, not last 12 months	16.5	16.3	16.2
Yes, last 2 weeks	1.7	1.7	1.7
Yes, last 30 days	2.5	1.0	1.7
Yes, in last 12 months	5.5	5.0	5.3
Any time within the last 12 months	9.7	7.7	8.6

Attempted suicide

Percent (%)	Male	Female	Total
No, never	92.8	89.1	90.3
No, not last 12 months	6.3	10.2	9.0
Yes, last 2 weeks	0.0	0.0	0.0
Yes, last 30 days	0.4	0.0	0.1
Yes, in last 12 months	0.4	0.6	0.6
Any time within the last 12 months	0.8	0.6	0.7

Intentionally cut, burned, bruised, or otherwise injured yourself

Percent (%)	Male	Female	Total
No, never	85.7	79.6	81.5
No, not last 12 months	10.5	14.1	13.0
Yes, last 2 weeks	0.4	1.5	1.1
Yes, last 30 days	0.8	0.8	0.8
Yes, in last 12 months	2.5	4.0	3.6
Any time within the last 12 months	3.8	6.2	5.5

Within the last 12 months, diagnosed or treated by a professional for the following:

Percent (%)	Male	Female	Total
Anorexia	0.4	1.3	1.0
Anxiety	10.6	19.9	17.1
Attention Deficit and Hyperactivity Disorder	5.5	4.6	5.0
Bipolar Disorder	0.4	1.5	1.1
Bulimia	0.0	0.6	0.4
Depression	8.9	16.2	13.8
Insomnia	5.1	4.0	4.3
Other sleep disorder	1.7	2.5	2.2
Obsessive Compulsive Disorder	0.8	2.1	1.7
Panic attacks	5.9	10.0	8.9
Phobia	0.4	1.3	1.0
Schizophrenia	0.0	0.4	0.3
Substance abuse or addiction	1.3	1.0	1.1
Other addiction	0.8	0.0	0.3
Other mental health condition	1.7	2.7	2.7
Students reporting none of the above	82.3	71.5	74.7
Students reporting only one of the above	6.8	9.2	8.3
Students reporting both Depression and Anxiety	5.5	12.8	10.3
Students reporting any two or more of the above excluding the combination of Depression and Anxiety	5.5	7.3	6.8

Within the last 12 months, any of the following been traumatic or very difficult to handle:

Percent (%)	Male	Female	Total
Academics	35.0	46.1	42.7
Career-related issue	35.4	42.1	39.7
Death of family member or friend	14.3	18.4	16.9
Family problems	24.1	35.7	31.7
Intimate relationships	27.8	36.7	33.8
Other social relationships	22.4	31.3	28.5
Finances	34.3	42.5	39.6
Health problem of family member or partner	19.0	24.9	22.7
Personal appearance	17.3	29.2	25.5
Personal health issue	12.7	23.6	20.2
Sleep difficulties	26.2	31.5	29.8
Other	10.0	14.2	13.0
Students reporting none of the above	30.0	14.6	19.7
Students reporting only one of the above	16.9	13.8	14.7
Students reporting 2 of the above	11.4	12.9	12.3
Students reporting 3 or more of the above	41.8	58.7	53.3

Findings continued

Within the last 12 months, how would you rate the overall level of stress experienced:

Percent (%)	Male	Female	Total
No stress	1.7	0.6	1.1
Less than average stress	8.1	5.0	6.0
Average stress	39.1	31.0	33.5
More than average stress	38.3	51.9	47.4
Tremendous stress	12.8	11.5	12.0

Comments

Jackie Posek

- As a benchmarking study, this covers a wide variety of institutions and does a good job of situating DePaul among those institutions, while retaining an awareness of the aspects of DePaul that are unique (particularly the issues of mandatory health coverage and university health services).
- Data is presented in a clear and efficient way, which will be helpful in potentially carrying out the action plan.
- My one concern is the lack of specificity with regard to the steps of the action plan. There are a lot of steps listed, and they all sound great. However, the fact that there are so many, and the lack of a specific timeline to guide which will be done first and when they should be carried out, creates a risk that they won't all happen, or won't be effectively prioritized.
- I would suggest selecting a few of the steps on the Action Plan as first priority items, and develop more specific descriptions of how to carry them out, and a timeline for carrying them out.
- It also might help to identify how many staff members would be needed for each item, so that the responsibilities can be divvied up effectively. This would increase accountability.

Ellen Meents-DeCaigny

- Nice job developing and implementing a solid benchmark study. It is very clear as to what type of benchmark study this is and it is also very clear as to what type of comparative data you were looking for.
- I agree with Jackie that the next steps section could be strengthened by being more specific as to when and how you will implement the steps. It would be helpful to list the steps in order of importance or in order as to how they will be executed.
- Overall, nice job!

David

- Overall this is a well produced and comprehensive benchmarking assessment. I really like the way the topics of question were sourced from the practitioners themselves
- There were a few sections that were unclear and did not necessarily adhere to the template, but overall I enjoyed reading and learning about this project
- It sounds like you got some great information that will be able to inform your practices and initiatives