Opening Statement Testimony for the Committee on Homeland Security and Governmental Affairs

“Security on America's College Campuses”

Committee Chair: Senator Joseph Lieberman

Testifying Professional:

Russ Federman, Ph.D., ABPP
Director, Counseling and Psychological Services
Department of Student Health
University of Virginia
Charlottesville, Virginia

April 23, 2007

Introduction

Universities need your help. Universities and our surrounding communities need more mental-health resources. Conflicts between FERPA, HIPPA and mental health licensing codes need to be lessened. Universities do an excellent job of managing high risk patients but we strive to do better.

Distinguished senators, Senate staff, members of the media and others attending today's hearing, as a clinical psychologist and Director of the Counseling and Psychological Services at the University of Virginia, I'm here today to provide an overview of the current state of mental health issues and responses on University campuses across the United States.

The college represent a complex period of human development. Individuals within this age range are no longer children, though they have not yet fully completed the transition into adulthood and full autonomy. They exist in the period of development we refer to as "late adolescence" with the inherent tension of continued dependence vs. strivings towards autonomy. This is a transitional time where core values and mores, emotional states, day-to-day functioning and the broad spectrum of interpersonal relationships undergo considerable change. University students are faced with many new challenges and must learn to manage these, without the parental support they had relied upon during earlier years. These elements lead to significant vulnerability and potential turbulence in students' psychological well-being.

Utilization of services

According to The Department of Education, there were 17.3 million students enrolled in over 4500 colleges and universities nationwide in 2004. The Chronicle of Higher Education projects 2007 enrollment figures at nearly 18,000,000. From the 2006 National Survey of Counseling Center Directors which surveyed 376 Counseling Center Directors, we see that 8.9 percent or one in every 11 enrolled students has sought counseling or psychological help within the past year. When this 8.9% is applied to the current projected national enrollment, it yields a total of 1.6 million students having sought counseling or psychological help within the past year.

Overview of the Clinical Landscape

Since 2003 the American College Health Association has been conducting the National College Health Assessment. The most recent 2006 survey involved the largest randomized sample since the survey's inception - 94,806 students, from public and private universities across the country. This survey reports some striking data. Within the past year:

- 94 out of 100 students reported feeling overwhelmed by all they had to do.
- 44 out of 100 - almost half - have felt so depressed it was difficult to function.
- 18 out of a 100 or close to one out of every five reported having a depressive disorder.
- 12 out of 100 had an anxiety disorder.
- 9 out of 100 or approximately 1 out of every 11 students reported having seriously considered suicide within the past year.
- 1.3% actually did attempt suicide. That's 13 out of every 1000 students. If we have 18,000,000 million enrolled students, this means 234,000 suicide attempts every year, 19,500 every month or 642 attempts every day.

Why stop suicide? We save students lives. But also, we know that some students become suicidal before they become homicidal … before they act on their murderous wishes.

In the past 10 to 15 years, we have seen a significant sea change with University counseling center work. More effective psychotropic medication, improved education of primary care providers in childhood and adolescent disorders and gradual destigmatization of treatment allow for the enrollment of far more students with pre-existing psychiatric disorders than would have attended 10 to 20 years ago. The traditional University counseling center has become a University community mental health center.

At University of Virginia, 1750 students, or one out of every eleven students, are seen each year at our center. One third of our patients present with depression and one of five with anxiety disorders. We psychiatrically hospitalize 40 to 60 students every year, most of them for acute depression, suicidal ideation and bipolar disorders. Most of our work is devoted to crisis intervention with acute and complex psychopathology. Both nationally and at UVa We are faced with high volume, high-risk, and very serious illnesses.

Potential Violence Due to Mental Illness

While University counseling centers have seen more and more students struggling with mental health issues, it is important to note that the frequency with which University communities are faced with students posing significant danger to others as a result of serious mental illness is very small. Many forms of violence such as incidents of robbery, simple assault, sexual assault, stalking, and hazing do not necessarily emerge from a psychological disorder. Indeed, the single factor that contributes most to intermittent aggressive conflicts, assault and violence on campus is the use of alcohol. And most forms of psychological disorder carry no increased risk of violence. University police departments are working assiduously to lessen campus violence, and according to a 2005 Violent Victimization of College Students report, the violent crime rate of universities declined 54% between 1995 and 2002.

The kinds of mental disturbances which yield extreme violence are very rare. Individuals with this level of disturbance typically experience a degree of impairment that is inconsistent with the requirements of University life. Given the ongoing interactions with peers, faculty and residence life staff, when a student's functioning deteriorates within a University setting, the student's aberrant behavior is usually observable and distressing to others. In most instances University faculty, deans and/or administrators in addition to University mental health professionals are notified of these instances and appropriate attention and limits are brought to bear upon the individual.

Available Resources and the Provision of Services

Counseling centers have received increased resources over the last 10 years in an effort to keep up with student need. But the gradual expansion of resources has also corresponded with ever increasing student enrollment. From the National Director Survey we see that in 1996 we had a ratio of one FTE clinical staff per 1598 students. This past year, in 2006 we see a ratio of one per 1697. We are not getting ahead of the curve; if anything, we are sliding behind. With limited resources University counseling services are usually directed towards crisis intervention, stabilization and brief treatment approaches. Many students may need more than brief approaches and when resources are stretched to meet the greater needs of more acutely disturbed students this consumes important hours that could be used to treat larger numbers of students.

University mental health clinicians devote considerable amount of time towards consultation with University administrators, deans, faculty, staff and parents creating an interconnected web of resources. Although confidentiality laws generally prevent University counseling centers from sharing confidential information without the student's permission, in most instances students are quite willing to provide this permission, as they recognize the helpful intent of our efforts. It is said that it takes a village to raise a child. My experience is that within Divisions of Student Affairs the village is a very interactive one where students' well-being is our primary concern.

Within today's proceedings there is an elephant in the room; that is - the recent shooting at Virginia Tech University. What we must keep in mind is that this was one incident. Its proportions were greater and more tragic than we've ever witnessed on a university campus, but it was one incident. The frequency of a mentally disturbed student perpetrating senseless violence on a university campus can almost be counted on one hand. The Virginia Tech shooting does not bring our attention to large numbers of students falling through the cracks. In actuality, it was an extreme exception to the norm and as such it illustrates that University officials in collaboration with mental health professionals are doing an exceptional job managing those mentally ill students who do represent a threat to University communities.

Current Challenges

The most obvious challenge faced by University counseling centers involves funding to adequately meet the increasing demand for mental health services across the country. Those resources currently available do allow us to be responsive to high need students. However this capacity is quite variable from one university to the next. Most university counseling staffs' are overworked. During peak times of the semester we all are barely able to keep up with the influx of new students. Furthermore, as long as resources are consumed with clinical treatment and case management, University counseling centers cannot do an adequate job with the preventative work of outreach and education. Most directors feel they are only scratching the surface with regard to the delivery of truly effective preventative educational services. More is needed.

Earlier I had discussed current available psychiatric resources. Six out of 10 Directors report that their university does fund the provision of psychiatric services on campus at an average of 22 psychiatric consultation hours per week. This still leaves 42% of universities without available on-campus psychiatric resources. Charlottesville, Virginia, the home of UVa, is a unique community. For a university town that has yet to become a bustling urban setting, we are fortunate to have many off-campus referral resources for students needing extended help. This is not the case for universities across the country. Nor is it the case that many students have the economic means to easily receive treatment within the private sector. There exists a large gap between universities' capacities to manage complex mental health issues and communities' capacities to receive and respond to the longer-term treatment needs of University students. This is an unacceptable state of affairs.

We are faced with the dilemma of how University communities can best work together to identify and manage those students with complex mental health needs. The issue of communication among campus officials pertaining to disturbed students is a complex one. Mental health licensing laws prohibit clinicians from communicating about patients without a signed release. To those who are not regularly engaged in mental health work, the limitations of patient confidentiality may seem frustrating and counterproductive. However, from the point of view of the patient, confidentiality is one of the salient factors that allow them to reach out in the first place. Students need to be able to express their most disturbing and frightening thoughts without fears of unwanted consequence. If students perceive confidentiality as permeable and easily dispensable, then large numbers will not come for help and our ability to protect the community will become further diminished. Confidentiality saves lives. Confidentiality doesn't place more lives at risk. Confidentiality is essential to good psychotherapy.

Having said that, it is clear that University officials also need to be able to communicate to one another, and sometimes with parents, when student threat of harm reaches a threshold the University community is no longer safe. Here lies the rub.

FERPA or The Federal Educational Rights and Privacy Act of 1974 is intended to protect the confidentiality of student records and define under what instance parents can have access to student information and grades. Access is given "in connection with an emergency, [to] appropriate persons if the knowledge of such information is necessary to protect the health or safety of the student or other persons." This definition is vague and left to the interpretations of individual universities. A more liberal interpretation which does allow for open communication of high-risk issues comes into direct conflict with mental health ethics and licensing codes pertaining to patient confidentiality. Unless “imminent danger” to self or others is at hand, then clinicians’ capacities to communicate with other University personnel or even patients’ families are limited. If and when we do choose to breach patient confidentiality in order to address issues of safety, then we risk violating mental health ethics and licensing codes. Essentially we are faced with circumstances where we are damned if we do and damned if we don't.

A similar limitation is seen where restrictions of HIPAA (Health Insurance Portability and Accountability Act) disallow communication between health care facilities and an educational institution. When a student is treated and released from a psychiatric hospital, a university has no way of receiving the student’s discharge records without said records being released by the student. Continuity of care is impeded as is the university’s ability to be informed of the vulnerabilities and special needs of particular students.

The complex interplay between students’ right to confidentiality, University personnel’s need to communicate, families inclusion in this communication and the inherent conflicts of our health care, educational, and confidentiality policies requires serious consideration and revision.

Conclusion and Recommendations

Universities must be able to get ahead of the curve with resources devoted to the mental health needs of their students. The cost of University education is more than many families can bear. We cannot add to tuition or student fees as a solution.

In 2003 during the 108th Congress, Members of the U.S. Senate and the U.S. House of Representatives introduced bi-partisan legislation that was designed to help centers on college

campuses that provide mental and behavioral health services meet the increasing needs of students. Provisions of this important legislation were included as part of the Garrett Lee Smith Memorial Act, a law named after Sen. Smith's son who committed suicide.

The Campus Suicide Prevention program exists now as a competitive grant program administered by the Substance Abuse and Mental Health Services Administration (SAMHSA). Since its creation, the program has supported 56 counseling centers on campuses around the country. Funded at $5 million, it is a small program but one whose value has become more evident in the past few years. While the Campus Suicide Prevention program did integrate many of the important provisions of the Campus Care and Counseling Act, it did not provide the authority that would allow campus counseling centers to expand their staff, internship or residency slots -- an option that would ensure that students seeking help are seen and provided help. Further, the authorization of appropriations was capped at $5 million.

The Campus Suicide Prevention program must receive an increase in appropriations. The use of funds must be broadened to allow centers to strengthen long term staffing and to expand training opportunities in internship and residency programs.

New funding for student outreach, education and prevention is absolutely necessary. We cannot remain in our offices providing outpatient treatment. We must join the academic community in teaching students about healthy lifestyles which are truly the strongest protective factors against depression and other mental illnesses.

Educational efforts must also extend to involve student peer connections. Students know students. They know when students are doing well and they typically know when they are not. We need to do a better job of partnering with students and utilizing their own awareness of their troubled friends in bringing those students to our attention and in facilitating their receipt of appropriate help.

The Legislature needs to attend to the important intersect of FERPA, HIPAA and confidentiality codes. Greater consistency between laws and policies is needed while also maintaining sharp focus upon that which is in the best interests of University students.

Within recent years we also seen numerous initiatives and foundations created in response to the growing awareness of University mental health issues. Research endeavors and policy development initiatives such as those being conducted by the Association of University and

College Counseling Center Directors (AUCCCD), the Jed Foundation, the National Research Consortium of Counseling Centers in Higher Education (University of Texas, Austin) and the Center for the Study of College Student Mental Health (Penn State University) are all essential to our understanding and response to University mental health issues. And we need more.

In closing I appreciate this Senate committee's attention to these pressing problems. We face urgent challenges and unmet needs. Please consider the issues. Our university students are our nation's future. We must insure they receive the help they need.

References

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Bio of Presenter:

Russ Federman Ph.D., ABPP is the Director of Counseling and Psychological Services, Department of Student Health, University of Virginia. Dr. Federman is a license psychologist in the state of Virginia and a Diplomate in Clinical Psychology through the American Board of Professional Psychology. He is a Clinical Assistant Professor of Psychiatric Medicine in the Department Of Psychiatric Medicine at the University of Virginia and is currently on the editorial board of the Journal of College Counseling. Dr. Federman has been in his current role at the University of Virginia since the fall of 2000. Previously he had been Director of Mental Health Services at East Carolina University for nine years. Prior to engaging in university mental health work he had been in full-time private practice in San Diego, California for approximately 13 years. Dr. Federman received his doctorate in clinical psychology in 1982 from United States International University, San Diego campus. He did his pre-doctoral internship through the University Of California San Diego Counseling and Psychological Services. He has also completed training in psychoanalytic psychotherapy through the San Diego Psychoanalytic Institute.