BRIDGING BEHAVIORAL HEALTH AND EDUCATION: ASSESSING THE ROLE OF COUNSELORS IN ADDRESSING HIGH ACUTE BEHAVIORAL HEALTH SYMPTOMS IN HIGHER EDUCATION

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DISSERTATION

Submitted in partial fulfillment of the requirement for the degree of

DOCTOR OF EDUCATION

in

EDUCATIONAL LEADERSHIP

at

CALIFORNIA STATE UNIVERSITY, SACRAMENTO

SPRING 2015
BRIDGING BEHAVIORAL HEALTH AND EDUCATION:
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A Dissertation

by

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I certify that this student has met the requirements for format contained in the University format manual, and that this dissertation is suitable for shelving in the library and credit is to be awarded for the dissertation.

______________________________, Graduate Coordinator
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Date
DEDICATION

Life is not an individual experience; it is an experience shared with others, and it is in these relationships that one is allowed to reach for higher and higher plateaus. It is with this support that I have been able to pursue and reach several personal goals, including dedicating myself to doctoral study. I dedicate this study to the behavioral health and education community, providers and consumers, for their care and compassion. To my friends and family, those who have sacrificed to support my doctoral endeavors, I also dedicate this study to you. And finally, my participants, without whom this study could not have been completed, I dedicate this study to you all. To peer into your collective lenses has been a remarkable experience that I truly appreciate. Let us all continue to advocate for students with behavioral health symptoms as they reach for higher and higher plateaus.
ACKNOWLEDGMENTS

This study was not a singular act; it was a collective effort that encompassed many brilliant minds in support of my journey. Acknowledging them does not begin to express my many thanks for all the care and compassion received while in my doctorial process. To my doctoral committee, thank you so much. Dr. David Nylund, thank you for molding me into a better everything, may we take our efforts to advocate for continued change. Dr. Carlos Nevarez, thank you for sitting me down and providing me direction at a time when I was rudderless. Dr. Rose Borunda, my dissertation chair, thank you so very much for everything. I never left your office without hope and belief, which during my dissertation process, was instrumental. To the Editorial Wizard, Meredith Linden, thank you, I am a better writer because of your critical lens. To my cohort-mates, my “three-C’s,” going through this journey without a map has been truly anxiety-inducing; thank you for propping me up and keeping me afloat. To my family and friends, thank you for the understanding while I was away, and I hope you have prepared yourselves for my re-emergence.
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Abstract

of

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Higher education institution counselors are experiencing a significant transition. Their students are showing evidence of a higher service-need, both in terms of frequency and severity. Students are exhibiting more physical violence/aggression, sexual violence and coercion, and self-harm, including suicide. At the same time, these counseling centers are experiencing an increase in legal responsibility for their students’ behavioral health along with policy that limits coordination of care and the gathering of essential collateral information. Despite this increase in service-need, higher education institution counseling centers are providing less and less service, using budget-friendly models of therapy that provide less one-on-one psychotherapy. Collectively, this downsizing limits the ability for students with high acute behavioral health symptoms to manage their symptoms and impacts their relationships and their ability to function, including academically.

Through the lens of systems theory, this qualitative study examines the narratives of six behavioral health clinicians practicing at higher education institutions, using a phenomenological approach. The participants’ stories can support findings that assist in
developing ideas related to counseling practices and the relationships between counselor and student, counselor and leadership, and counseling department and the larger campus. Insights from the findings include a current view of the services provided to higher education institution students with high acute behavioral health symptoms and the potential gap in service to students experiencing a crisis or behavioral health episode. These insights led to the development of a model that may offer a fuller, more comprehensive view of higher education institution counseling practices.
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Chapter 1
INTRODUCTION

Overview

The role of counselors at higher educational institutions has been the topic of much debate recently (Benton & Benton, 2006). Increased campus violence and campus responsibility for the student body’s behavioral health has led to the reevaluation of how higher education institution counselors address students’ high acute behavioral health symptoms. Elaboration on this increase, illustrated by a recent study conducted by Benton and Benton (2006), two leaders in the study of behavioral health practices in higher education institutions, follows.

- Higher education institution counseling departments are seeing clients/students with more complex and severe problems than a decade ago (Benton, Robertson, Tseng, Newton, & Benton, 2003).

- The increased complexity is exhibited in the transition from what was previously identified as “normal college student problems,” relationships, and developmental challenges, to anxiety, depression, suicidal ideation, and personality disorders (Benton et al., 2003, p. 72).

- The increase in complexity and severity are driving the need for increased resources; however, decreased resources have transitioned higher education institutional behavioral health services to more brief counseling practices, with limited sessions (Benton et al., 2003).
Benton and Benton’s (2006) study coincides with Gallagher’s (2009) study, reporting 93% of higher education institution counseling department directors have identified their student body exhibiting an increase in acute behavioral health symptoms. In addition, Taub and Thompson’s study (2012) identified depression and anxiety as two primary challenges facing college students, with 70% of women and 50% of men in college experiencing “hopelessness” at least once during the previous year (p. 6). In addition, studies indicate that individuals with psychotic symptoms are 8 times more likely to exhibit violence or homicidal ideation (Eronen, Hakola, & Tiihonen, 1996). Within this study, the role of higher education institution counselors and their role in addressing their students’ high acute behavioral health symptoms were explored. This is a sensitive time for higher education institution counselors, as they transition to increased responsibility for their students’ behavioral health needs and the liability that follows. This transition highlights higher education institution counselors’ current experience and the need for re-evaluation of practices and standards in the field.

The World Health Organization (WHO; 2013) recognizes that personal, mental, and social well-being is imperative if one is to reach self-fulfillment. Higher education institutions recognize the importance of these tenets as well, which led them to dedicate substantial resources to support their students’ personal, mental, and social well-being. A student’s affect impacts not only the student body, but also faculty and staff, and outward into the surrounding community (Booker, 2014). In the context of this study, exploring how behavioral health counselors at higher education institutions assess and treat students
with high acute behavioral health symptoms will support students’ self-fulfillment, may reduce frequency and severity of extreme stress experienced by these students, and lessen the impact these episodes have on the higher educational system and surrounding community. For the purpose of providing additional clarity, behavioral health is used exclusively, rather than an interchange between behavioral health and mental health. As well, traumatic incidents, which are further explored in this study, are identified as sexual assaults/coercion, suicides, murder, and aggravated assault. Alcohol and drug abuse are not considered to be traumatic incidents, as researchers associate their use to be a catalyst for traumatic incidents and not the product. Data from studies related to alcohol and drug use are presented and used as supporting data.

**Background**

The shootings at Columbine started what has been a whirlwind of media exposure around school violence. The Columbine incident on April 20, 1999 consisted of two Caucasian male students at a Littleton, Colorado high school murdering 12 students and a teacher before committing suicide (Chyi & McCombs, 2004). Most recently, on May 23, 2014, a Caucasian male murdered six students before committing suicide near the University of California, Santa Barbara. Between these incidents, several violent episodes have occurred on higher education campuses, with some campuses failing to establish a safety plan (Wood, 2012). The most recent example serves as a reminder of the increasing school violence at higher education settings (Dillon, Mendoza, & Watson, 2014). These incidents have huge secondary effects, along with the grief and loss...
experienced by the families of those lost; campuses also experience a negative effect on their reputation and campus culture as well as the impending reevaluation of their campus safety.

Along with the challenges, higher education campuses are experiencing increased legal responsibility associated with their campus safety. In July 2005, parents of Elizabeth H. Shin, a student of the Massachusetts Institute of Technology (MIT) who committed suicide, filed a lawsuit against MIT administrators and staff (Hoover, 2005). The lawsuit identified MIT administrators and staff as “failing to prevent her death” (Hoover, 2005, p. A1). This case indicates a transition in responsibility for student safety from the student to higher education institutions and their staff. In the particular case of Shin, the idea of “imminent probability” was put into question, as in, were the student’s suicidal statements enough of a threat to initiate immediate intervention (Hoover, 2005, p. A1)?

Previous to this case, Jain v. State of Iowa set legal precedence with the now dated quote, “suicide is considered a deliberate, intentional and intervening act that precludes another’s responsibility for the harm” (as cited in Pavela, 2006, p. 367). Like many similar cases, the case of Shin v. MIT was settled out of court (Benton & Benton, 2006). The consistent practice of higher education institutions settling out of court has subsequently hindered the evolution of legally defining an educational institution’s role in students’ behavioral health needs. Without legal judgment, higher education
institutions continue to lack the insight necessary to meet legal and ethical responsibilities and expectations.

Legal experts identify *Shin v. MIT* as the initial domino that resulted not only in the increased frequency of litigation, but also in the increased responsibility for student safety shifting to institutions of higher education. Examples of this shift include recent court rulings that have sided against higher education settings regarding student alcohol use. Alcohol and hazing, fraternities/sororities, and in one case, *McClure v. Fairfield University* in 2003 in which a student was injured off campus by another intoxicated student, represent recent legal dominos that have forced the transition of responsibility for student safety to higher education institutions (Benton & Benton, 2006). *McClure v. Fairfield University* cited that the institution “had a duty to protect students who traveled to and from parties;” this court case placed the responsibility of students’ alcohol use and the effectiveness of the campus policies and practices on the higher education institution (Benton & Benton, 2006, p. 62). While the current study does not examine student substance abuse, the aforementioned cases support the trend in which legal responsibility for student wellbeing has shifted from the students to the higher education institution.

Going forward, it is the practice of many higher education institutions to assume responsibility as a measure of protecting themselves from potential liability (Benton & Benton, 2006). Amidst the escalating number of traumatic incidents and the increased level of responsibility expected of higher learning institutions related to these incidents, two issues surface and remain to be legally defined:
1. Legal rulings have placed the responsibility of a “duty to prevent” on higher education institutions. Further defining what this responsibility entails would support a baseline for higher education institutions to meet going forward (Benton & Benton, 2006, p. 63).

2. In the same vein as “duty to prevent,” legal rulings have used the term “special relationship” to describe the relationship between higher education institutions and their student body. Further clarifying this term would allow such institutions to find guidelines for their counseling relationships and how to reduce liability (Benton & Benton, 2006, p. 70).

In addition to recent court proceedings, disability law has bearing on how students, specifically those diagnosed with a behavioral health disorder, may be treated. Students who have been diagnosed with a behavioral health disorder are protected under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990, prohibiting discrimination (Benton & Benton, 2006). Section 504 incorporates all higher education institutions that receive federal funding and calls for these institutions to discontinue discriminatory practices against students with disabilities (Benton & Benton, 2006). The Americans with Disabilities Act addresses services for the same institutions but provides more depth by creating more access for students with disabilities in both student services and programs while addressing access at private higher educational settings (Benton & Benton, 2006).
Whatever intervention to be enacted, it must be consistent, follow a due process, and be carefully explored by multiple stakeholders. Oftentimes, it is the higher education institution’s responsibility to provide a student with assessment and the impending accommodations (Pavela, 2006). In addition, there has been some discrepancy over Section 504, a code enforced by the Department of Education, and the Office of Civil Rights, over “direct-threat analysis” (Pavela, 2006, p. 367). “Direct-threat analysis” places higher education institutions in the middle, not discriminating against a student’s behavioral health disorder but maintaining student and campus safety. The Office of Civil Rights has noted previously that it supports higher education institutions; however, institutions express concerns related to the vagueness the Office of Civil Rights has maintained around legal responsibility and liability, for example, when a student makes a threat of suicide (Pavela, 2006).

Higher education institution counseling departments are experiencing a significant transition. An increase in violence, legal responsibility, and policy related to increasing access to and accommodation for students with behavioral health diagnosis are all creating additional variables that higher education institution counseling departments must consider. Without the proper attention, these variables may impede the institution’s safety and increase the likelihood of litigation. With the increase of these additional variables, counseling departments need to dedicate additional resources to their attention, potentially reducing the attention provided to the student’s care and treatment.
The Higher Education Institution Student

In addition to the systemic transition of higher education institutions taking on more responsibility for their student body’s behavioral health symptoms, it is important to acknowledge the experiential and developmental nature of college student transition. “Traditional” college students are developmentally transitioning from adolescence to adulthood. The college years and experience often provide the opportunity for students to develop an identity—or “fit” (Kadison & DiGeronimo, 2004, pp. 7-8). Unfortunately, it is during this transitional phase that several stressors can develop, stunting the student’s ability to function in a setting where time and task completion are of the upmost importance. Students are making choices they feel carry significant weight, including those around relationships, academics, and the development of their identity.

Accompanying students in their transition to college are academic pressures (Kadison & DiGeronimo, 2004).

Family, and the expectations they share, along with financial concerns also increase the stress and pressure placed on college students (Kadison & DiGeronimo, 2004). With the advent of newer technology (e.g., cell phones, Skype, and email), students and families have more access to each other. However, in spite of the increasing methods by which student and family can communicate, recently enacted policies intended to provide more privacy for students have also created more frustration for both student and family member (Benton & Benton, 2006). These policies, detailed in the next section, limit the higher education institution’s ability to disclose information to the
student’s supports, particularly family. This practice may increase thoughts and feelings of distance between an institution and a student’s support system.

Higher education settings’ responsibility for their students’ behavioral health is expanding, both through legal channels and policy enactment. In addition to this expansion, court rulings regarding the shift have limited institutions’ capability to address and confront the matter. The expansion is of particular concern for institutions because of the significant transition students are experiencing, which may contribute to their increasing behavioral health needs. This strain adds additional accountability and responsibility to higher education counselors regarding their ability to address a high level of acute behavioral health symptoms presented by their student body.

**Related Policies**

Policies limiting disclosure of a student’s behavioral health are aimed at protecting the student’s right to confidentiality. Oftentimes, such policies are viewed as detriments to access by students, families, and staff/faculty. Family Education Rights and Privacy Act of 1974 (FERPA), is a federal law that aims to protect student privacy with regard to their educational records (Benton & Benton, 2006). FERPA covers all higher education institutions that receive funding from specific programs within the U.S. Department of Education and all higher education students regardless of age. “Educational records” includes health records not including instances when the student is over 18 years of age and attending the higher education institution, and the records are created and maintained by a “physician, psychiatrist, psychologist, or other recognized
professional or paraprofessional serving in their designated capacity” (Benton & Benton, 2006, p. 55). However, these records fall under FERPA when a condition is met that allows the information to be shared (Benton & Benton, 2006). These exceptions include when the staff/faculty have “legitimate educational interests,” when the information is connected to a “health or safety emergency,” when there is disciplinary action, and if the student is under 21 years of age and violates the law or institution policy as it pertains to alcohol and/or drugs (Benton & Benton, 2006, p. 54). This flexibility allows for higher educational institutions to intervene as necessary when students with behavioral health challenges are in crisis (Benton & Benton, 2006).

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 defines the process by which the behavioral health practitioner can use and disclose people’s private health information (Benton & Benton, 2006). In addition to HIPAA, some states have legislation that further limits the confidentiality practices of higher education counseling and psychological services (Benton & Benton, 2006). Professional ethical codes, including those over licensed social workers, psychotherapists, psychologists, and psychiatrists, also limit the disclosure of client health information (Benton & Benton, 2006). The Diagnostic and Statistical Manual of Mental Disorders, commonly referred to as the DSM, is consistently used to assign diagnoses to individuals who meet the criteria of a specific diagnosis (American Psychiatric Association, 2000). Diagnoses include behavioral health disorders, but also expand into autistic spectrum disorders, chemical dependency, and psychosocial stressors. Students with a behavioral
health diagnosis are protected under the ADA, the American Disabilities Act, from discrimination, which places responsibility for accommodation on the higher education institution. This study primarily focuses on behavioral health disorders.

**Statement of the Problem**

This study focused on the lived experiences of higher education behavioral health practitioners as they address high acute behavioral health symptoms in students at a time when responsibility for student behavioral health is transitioning from student to institution.

**Purpose of the Study**

This study further examines for the current transition higher education counseling departments are experiencing, including the increase in complexity and severity of the student body’s behavioral health needs, the increase in liability and responsibility experienced by higher education institutions, and the decrease in services due to budgetary constraints. Benton and Benton’s (2006) research has represented a significant portion of the current research; this research aims to add to their research and provide new perspectives in how to support and possibly improve the delicate relationships of both student and counselor and counselor and campus administration. In particular, this research looks at the relationship between theory, practice, leadership, and systemic ideas. This study aimed to add to the limited research with regard to behavioral health programs on college campuses and their relationships with leadership, the larger campus climate and culture, and behavioral health practitioner’s counseling practice.
Given the recent increase in traumatic incidents at higher education institutions, thorough examination into potential barriers as well as into potential avenues for improvement is important to both the researcher and the field. The researcher aimed to deepen this discussion and provide greater understanding of the issues that may lead to improved intervention, while supporting opportunities for a large, yet underserved, community. The framework that guides this research is systems theory. Systems theory allows for the inclusion of multiple stakeholders, which coincides with how college campuses operate.

**Nature of the Study**

This qualitative study includes interviews with six counseling service practitioners on college campuses. Using a phenomenological approach, the researcher collected the experiences of the counselors, transforming their unique narratives to a deeper level of consciousness. The researcher identified strengths and challenges that exist within college counseling programs and explored their level of support for students with high acute behavioral health symptoms. Benton and Benton’s (2006) study following the Virginia Tech incident is foundational and explores similar ideas. This study adds to the limited research regarding counseling departments on college campuses and relationships with campus administration, campus climate and culture, and their behavioral health practitioners’ counseling practice. Qualitative research was used to assist in the exploration of these relationships, along with further refining what best practices practitioners and leaders can enact to support college students with behavioral
health needs. Listed below are research questions that guided the study and, when
answered, will support behavioral health practitioners at higher education institutions in
the development of their counseling practice, their department policy, and their
department goals and values. The questions are explored through the lens of higher
education institutions behavioral health practitioners and their relationships with their
student body, the larger campus culture, and leadership.

Research Questions

1. What current preventative measures and interventions do you use to address your
   student body’s acute behavioral health symptoms?
2. What role does current leadership have in addressing your student body’s acute
   behavioral health symptoms?
3. What roles do your campus’s climate and culture have in addressing your student
   body’s behavioral health symptoms?

Theoretical Framework

To support the research and provide a balanced and valid approach to the study,
multiple theoretical frameworks were examined and used. The foundational theoretical
orientation is systems theory.

Systems Theory

Systems theory is a theoretical orientation that focuses on the relationship within a
system as well as on the relationship between the system and the environment. The
relationship includes the transfer of energy from the community to the system and how
this energy can translate to progress, randomness, and eventual demise (Bess & Dee, 2008a). Energy may be represented by multiple measurements, including human energy, financial resources, and related policies. Systems theory, in this case, highlights the relationship between an organization and the environment, or that between college counselors and psychological services as outlined by Evans (1965) in Figure 1.

![Figure 1. Model of organizational systems.](image)

Source: Evans (1965)

Input set, for example, could be students, the focal organization could be the counseling services offered at a higher education institution, and the output set could include retention, safety, improved campus culture, etc. The feedback could include the attainment of campus goals (i.e., improved access), which would influence the focal organization going forward. In examining the relationship between the organization and the environment, feedback is vital to the continued improvement of this relationship (Bess & Dee, 2008a). It should also be noted that any change within the system has a ripple effect throughout the system (Bess & Dee, 2008b). This delicate balance within the system highlights the importance of each change and how each change has an effect on the entire system.
Systems theory is derived from a positivist paradigm (Bess & Dee, 2008a). This paradigm is used consistently by leaders in higher education because of the efficiency in decision making when it is used (Bess & Dee, 2008a). However, the challenge with systems theory is that often leaders’ decisions are made without being questioned (Bess & Dee, 2008a). Postmodern and social constructionist perspectives provide opportunity for questioning; however, they impose on the system’s efficiency, as each question leads to debate (Bess & Dee, 2008a). Higher education leaders’ use of positivist paradigms appears to support their preference for higher efficiency in decision making and action over the delay that questioning and checks and balances would have (Bess & Dee, 2008a). However, to offer balance, several theories outside of positivist thinking are presented as a means of questioning and providing checks and balances while also strengthening systemic principles.

In exploring how systems theory relates to this particular study, it is important to identify the multitude of programs, departments, and levels of administration within a college campus and connect these subsystems to the larger communal systems. Communal systems may include the students, private businesses, governing bodies, etc. Due to the clear cause and effect relationship between college campuses and the surrounding community, systems theory appears to correlate well with the current setting, higher education institution counseling departments. This correlation is exhibited in how campus counseling services, like systems theory beliefs, rely heavily on feedback, and if a piece of the system is shifted, the entire system is affected.
Similar to Figure 1, Figure 2 outlines how a behavioral health center may be explained by systems theory.

Adapted from Evans (1965)

Figure 2. Campus counseling services as illustrated by systems theory.

**Input:** Students, administration, academic departments, community members, private sector businesses, etc.

**Output:** Retention, academics, safety, school culture, community awareness/understanding, etc.

**Feedback:** Results related to retention, academics, and safety, meeting administrative goals, relationships with faculty and staff, including their departments, direct feedback from those using the services, etc.

Systems theory, while used in several studies, programs, and interventions prior to this study, has not been used to study the relationship between behavioral health programs in higher education institutions and policy and/or professional ethics, which, along with how systems theory aligns with both the domains of policy and counseling practice, makes this theory a natural fit as a theoretical orientation for this study.
Several additional theories supporting this foundational theory are presented in Chapter 2. Additional theories provide a balanced perspective and support for the study and include feminist theory, Erikson’s theory, and leadership theory.

**Operational Definitions**

Listed below are several terms, along with their working definition within the context of this study. This list is used as a means of enhancing understanding related to terms that may have multiple definitions in the field or may not be familiar to the reader.

**Behavioral Health Disorder**

Disorders [are] conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever the original cause of the disorder, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual. Neither deviant behavior (e.g., political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual, as described above (American Psychiatric Association, 2000, para. 1)

**Behavioral Health/Mental Health**

Both terms are used interchangeably, with mental health considered the “dated” term. The term “behavioral health” is used to reduce stigma and increase the belief in treatment because it is easier to perceive treating a behavior than a mental disorder. While behavioral health is the current term, it still presents challenges. “Behavioral health” places the responsibility of the challenge on the
individual, rather than on the larger system. As well, “behavioral health” does not account for organic disorders (Sandler, 2009, p. 1). “Organic disorders” is a term used to describe the belief that some behavioral health symptoms are genetic and that, as a result, individuals are genetically predisposed to the behaviors they attract. In the context of this study, behavioral health is primarily used; there are instances within the literature review when secondary sources use the term “mental health.” In such instances, “mental health” will be used to maintain the author’s intention.

**Behavioral Health Practitioners**

Core [behavioral] health practitioners educated and trained to help with relationship difficulties, and diagnose and treat the mental disorders and emotional problems of individuals, couples, families and groups. [Therapy] is highly effective because of the ‘systemic’ orientation that its therapists bring to treatment. In other words, they believe that an individual's mental or emotional problems must be treated within the context of his or her current or prior relationships if the gains are to be meaningful and productive for the patient. (California Association of Marriage and Family Therapists, 2015, para. 7)

**Counseling/Therapy**

The services higher education behavioral health programs can provide vary and include, but are not limited to, individual (including personal, academic and career, couples, group, and family), chemical dependency, eating disorders and other targeted populations, psychiatric and psychological assessment and treatment, and career counseling. In addition, peer counseling and outreach are included, which may include psychoeducation and specialized consulting services may also be provided (American College Health Association, 2010).
Family Education Rights and Privacy Act of 1974 (FERPA)

FERPA is a federal law that supports the privacy of students’ educational records. FERPA is applied to all schools that receive specific U.S. Department of Education funding; however, this generally constitutes most institutions of higher learning. FERPA covers all students within these institutions, regardless of age. Institutions can share students’ educational records if consent by the student is given or if specific exemptions are met. These exceptions include “legitimate educational interests,” other institutions in which the “student seeks or intends to enroll,” “health and safety” of the student and/or student body, and disciplinary action. There are additional exceptions when related to potential legal violations. Institutions, when disclosing information, must be aware that the information disclosed must be pertinent to the exceptions presented (Benton & Benton, 2006, pp. 55-56).

Health Insurance Portability and Accountability Act (HIPAA)

HIPAA provides guidelines on the use and disclosure of Private Health Information (PHI). HIPAA is pertinent to higher education institutions because of how consistent behavioral health programs, health centers, etc. are part of higher education campuses. An important distinction is that FERPA involves only health information in electronic form and is most pertinent to financial/administration functions (Benton & Benton, 2006).
**High Acute Behavioral Health Symptoms**

1) Suicide attempt which is serious by degree of lethality and intentionality
2) Suicidal ideation with a plan and means
   a. Impulsive behaviors and/or concurrent intoxication increase the need for consideration of this level of care
3) Current assaultive/[violent] threats or behavior, [with] a clear risk of escalation or future repetition
4) Recent history immediately prior to admission, prompting evaluation or intake of significant self-mutilation, significant risk-taking, or loss of impulse control resulting in danger to self or others
5) Command hallucinations directing harm to self or others
6) Disordered/bizarre behavior or psychomotor agitation or retardation that interferes with the activities of daily living to such a degree that the individual cannot function
7) Disorientation, memory impairment, “inability to maintain adequate nutrition or self-care,” and disability to “social, interpersonal, occupational, and/or educational functioning which is leading to dangerous or life-threatening functioning” (ValueOptions, 2006, para. 1)

**Mental Status Exam (MSE)**

The mental status examination (MSE) is a component of all medical exams and may be viewed as the psychological equivalent of the physical exam. It is especially important in neurologic and psychiatric evaluations. The purpose is to evaluate, quantitatively and qualitatively, a range of mental functions and behaviors at a specific point in time. The MSE provides important information for diagnosis and for assessment of the disorder’s course and response to treatment. Observations noted throughout the interview become part of the MSE, which begins when the clinician first meets the patient. Information is gathered about the patient’s behaviors, thinking, and mood. (House, 2014, para. 1)

**School Safety**

The term “school safety” can be stringently defined; however, in the context of this study, school safety is defined as the interest of decreasing instances of preventable crisis and trauma, including, but not exclusive to, substance abuse, violence, and suicide.
Systems

“A set of components interacting with each other and a boundary which possess the property of filtering both the kind and rate of flow of inputs and outputs to and from the system” (Bess & Dee, 2008a, pp. 14-15). Open systems “accept and respond to inputs;” closed systems “function ‘within themselves’” (p. 15). In the context of this study, the system is counseling and psychological services at higher education institutions. This system is open in that it accepts and responds to inputs from multiple levels (i.e., students, budgetary, policy, leadership, community, etc.).

Traumatic Incidents

Traumatic incidents within the context of this study constitute violence, including physical and sexual as well as acts of self-harm and sexual coercion. Alcohol and drug use are discussed, along with behavioral health symptoms and diagnoses (e.g., depression); however, this discussion is explored as a means of looking at potential precipitators to more acute traumatic incidents.

Assumptions and Limitations

Several limitations exist within the context of this study. Due to the nature of phenomenological qualitative research, there are limitations to generalizability. With regard to a qualitative study, the selection of participants, along with their relationship to the researcher, may direct the results in some fashion. Likewise, the researcher’s relationship with the participants, and the data collected, can create a bias that “lends”
itself to findings. The researcher interviewed behavioral health practitioners within the behavioral health departments at higher education institutions. This population is small; hence, the researcher has connections with some participants. In addition, the researcher has strong connections to this population, which influenced the way the data were collected and interpreted. These connections are part of what makes participant protection a significant consideration. This study was conducted in part to meet the requirements of a doctoral program, which lent itself to time restrictions, influences from faculty and colleagues, and interest in program completion. Time restrictions, for example, can inhibit the ability to seek out a more diverse set of participants, research, and methodologies.

The researcher is employed in the behavioral health field and was, previously, in the education field in several capacities and agencies/programs. The connection between the participants and the researcher lent itself to biases. However, the connection allowed the researcher to build rapport with the participants, allowed for improved awareness and understanding of their reports, and assisted in development the data collection and interpretation. It has been the researcher’s experience that those within the study population were open and candid; however, given the budgetary challenges for many of the local programs, the participants’ responses may have been more directed toward program conservation.
Significance of the Study

This qualitative study will assist in the development of sound leadership, policy, and practice within higher education, specifically in behavioral health programs. Qualitative study exploring how counselors address acute behavioral health symptoms within higher education’s behavioral health programs has experienced a recent upswing, possibly due to the several traumatic, violent incidents that have recently occurred. Of these studies, very few researchers considered policy and leadership as variables with a systemic theoretical orientation. A foundational study to this point has been Benton and Benton’s (2006) “College Student Mental Health: Effective Services and Strategies Across Campuses.” In their study, Benton and Benton attempted to explore campus safety through a campus-wide support system. This study will build upon this contemporary phenomenon through new frames, using a systemic lens to examine counselors and their relationships with leadership, their student body, and the surrounding community.

Conclusion

Chapter 1 provided a brief overview validating the need for continued research. In addition, this chapter touched upon the methodology and theoretical framework, the study’s lens. These areas are further expanded upon in Chapter 2, the literature review, and Chapter 3, the methodology. In totality, this dissertation comprises five chapters. This chapter introduced the study’s focus, including identifying the problem statement, the nature of the study, the study’s significance, and an overview of systems theory, the
study’s foundational theoretical orientation. Chapter 1 also provided operational
definitions to further clarify the terminology and how they were used, and the study’s
assumptions and limitations. Chapter 2 explores the current peer research on
foundational domains: traumatic incidents driving behavioral health reassessment, current
behavioral health practices in higher education, FERPA, HIPPA, systems theory, and
additional theoretical orientations. Within the sections that further explore FERPA and
HIPPA, additional policies are examined as a means of providing a more comprehensive
view. Chapter 3 discusses in detail the methodological approach used within the study,
including the qualitative interviews. Chapter 4 reviews the findings coded from the
participant reports, summarizing the collective reports in several figures. Chapter 5
connects the findings to the literature, the systemic lens, and the researcher’s experience.
Chapter 5 closes with additional considerations and recommendations for future research.
Chapter 2

LITERATURE REVIEW

Chapter 1 explored the significant shift within higher education related to student behavioral health currently experienced within higher education institutions; a transition is rippling across the higher education system and will continue to intensify if not addressed by each institution. In addition, Chapter 1 touched upon the methodology, theoretical orientation, and potential limitations of the study. Chapter 2 further develops the initial ideas, synthesizing the current literature and research on traumatic incidents at higher education institutions, higher education institutions’ behavioral health practices, FERPA and HIPAA, systems theory, and additional theoretical orientations. Finally, several themes and patterns used to provide methodological direction are identified.

**Traumatic Incidents Driving Behavioral Health Reassessment**

A series of traumatic incidents on college campuses have led to the reassessment of behavioral health practice in higher education settings. It is important to notice these incidents, as the themes and patterns presented can assist in the development of more sound assessments and interventions. Of recent note, traumatic incidents and related responses at Columbine, Virginia Tech, Rutgers University, Case Western Reserve University in Cleveland, Louisiana Technical College, University of Arizona, Livingston College, Broward Community College, Northern Illinois University, University of Maryland, and most recently, University of California, Santa Barbara have demonstrated
the strengths and weaknesses of current behavioral health practices at these institutions. Several of these traumatic incidents are detailed in the listing below.

**Columbine**

In April 1999, two male Caucasian students entered the cafeteria and open fired on the student body after their two bombs set in the school cafeteria did not go off (Clabaugh & Clabaugh, 2005). After 40 minutes, 12 students and a teacher were killed, and another 23 people were wounded. The perpetrators committed suicide and the police spent much of the following school day unarming the 30 bombs the perpetrators had planted throughout the campus. While the incident did not occur at a higher education institution, it marked a major shift in the public’s view of school violence. Researchers point to the intense media attention the Columbine shooting received compared to that of two similar massacres at Thurston High School and Westside Middle School, a year prior to Columbine, as a turning point for school violence policy (Clabaugh & Clabaugh, 2005).

**Virginia Tech University**

In April 2007, Seung-Hui Cho killed 32 people and wounded 17 (Jenson, 2007). The events started with the perpetrator shooting two people in a residence hall at 7:00 AM (Davies, 2008). At 9:00 AM, the assailant chained the main doors to Norris Hall and entered classrooms, shooting anyone in his sight. Authorities arrived three minutes after they were called and blasted through the door within five minutes. Seung-Hui committed suicide after hearing the explosion at the door. “Depressed” and “isolated” were words
used to describe the assailant, who had been referred for behavioral health services on several occasions (Jenson, 2007, p. 131). The fast response of local authorities is credited for having saved several lives and led to an increased focus within higher educational campus on having a concrete crisis plan.

**Northern Illinois University**

In February 2008, Steven Kazmierczak entered a lecture hall and started firing. Six people, including the shooter who committed suicide, died while 21 others were injured (Dunn-Kenney, 2008). The perpetrator wore a T-shirt with the word “terrorist” above the image of an assault rifle (Barry, 2013). This shooting was identified by several press articles as being very consistent with the Virginia Tech University massacre, including the assailant having a long history of behavioral health challenges and a call for improved collaboration among community and campus behavioral health staff, police, and the perpetrator’s family.

**Oikos University**

In April 2012, One Goh, after learning the school administrator and intended victim was not on campus, open fired, killing seven and injuring three. The assailant reportedly ordered the victims to line up against a wall and then proceeded to shoot them (Sheets, 2012). At the time of the shootings, Goh had several psychosocial stressors, including frustration with several college administrators, being thousands of dollars in debt, and the recent death of his mother and brother, which may have increased the likelihood of his violent attack (Sheets, 2012).
Santa Monica College

In June 2013, John Zawahri killed six people, starting with his father and brother, and then set his house on fire (Brown, 2013). Afterward, the perpetrator carjacked a vehicle forcing the woman to drive toward Santa Monica College, with Zawahri shooting a public bus and SUV (Brown, 2013). At Santa Monica College, the assailant entered the library and shot at individuals who were taking cover in a safe room. The shooter was later shot and killed by local authorities (Brown, 2013). John Zawahri had a long history of behavioral health challenges (Brown, 2013).

University of California, Santa Barbara

In May 2014, Elliott Rodger, driven by disdain for women he felt had rejected him, killed six students and injured 13 (Feeney, 2014). The perpetrator initially killed three in his apartment by stabbing them before driving by a sorority house, a delicatessen, and then through Isla Vista, shooting at several bystanders. The assailant, after crashing his car, committed suicide (Feeney, 2014). He was receiving behavioral health treatment from several practitioners prior to the incident. Noteworthy was Rodger’s use of YouTube to express his frustration with women and men for his virginity (Feeney, 2014).

The abovementioned incidents have several themes and patterns among them, none of which include institution-specific characteristics and which emphasize the need for all campuses to be proactive in their interventions. In the incidents described above several characteristics were consistent: the assailants were teased, bullied, or both; the assailants exhibited behavioral health challenges, including social isolation; and often
these symptoms were longstanding and acute in nature (Jenson, 2007). The perpetrators often experienced untreated depression and anxiety, though several warning signs had been exhibited prior to the traumatic events (Jenson, 2007). In addition, these violent acts were often carried out by males, a gender more likely to exercise violent acts to resolve conflicts (Jun Sung, Hyunkag, & Shiulain, 2010).

The previously denoted traumatic incidents revealed several challenges across multiple systems. One positive noted was the arrival of authorities at the Virginia Tech scene around three minutes after the shooting started, their presence possibly contributing to limiting the assailant’s lethal intentions. Conversely, after Virginia Tech local authorities discovered the initial three deaths, no lockdown or alarm had been ordered/sounded to the campus, which gave the assailant time to deliver a package to the media and then initiate further violence on campus. Challenges also include the collaboration between behavioral health practitioners, family of the assailants, and other systemic stakeholders (e.g., residence hall staff, previous behavioral health practitioners, and law enforcement). Elliott Rodgers (Santa Barbara) had been assessed three weeks prior to the incident by police in what is called a wellness check. Rodgers did not present with the criteria necessary—suicidality, homicidality, or psychosis—to be placed on an involuntary hold. There is no follow-up from local authorities, higher education institutions, or community, often because these systems are not made aware of such assessments. Ideally, a college institution would connect with and assess the student, identifying if the student should address their behavioral health needs before entering or
re-entering the college (Wood, 2012). In addition, several campuses did not have or enact a safety plan during the violence. It is within the context of the aforementioned challenges that 93% of higher education counseling directors identify an increase in college students experiencing acute behavioral health challenges (Gallagher, 2009).

Additional traumatic incidents have occurred on higher education campuses, but they did not attract the same level of media attention so they did not receive the level of public attention as the aforementioned traumatic incidences. However, lethal traumatic incidents occur more frequently and have a dangerous ripple effect on those directly involved. Dr. Arnstein, Psychiatrist-in-Chief Emeritus of Yale University Health Service, reported that challenges with behavioral health at higher education campuses have been extended to substance abuse, personality disorders, and eating disorders (Kraft, 2009). Dr. Arnstein reported that sexual assault and coercion are even more pressing matters than the shootings previously described (Kraft, 2011). Regardless of the particular disorder, it is important to understand that all disorders carry with them a significant systemic impediment. As a case in point, sexual assault on women can trigger poor overall health and somatic complaints, which can then lead to an increase in morbidity, mortality, financial burdens, and social and occupational problems (Zinzow et al., 2011).

Sexual violence and coercion has been identified as the most significant challenge to campus safety; unfortunately, it is difficult to quantify, as 95% of rapes and attempted rapes are not reported (Landlow, 2006). Couple this with the inconsistent definitions of
sexual violence and the difficulties in validating any large-scale studies can be seen (Landow, 2006). In addition, victims, predominantly women, have to deal with a double standard experienced by victims (Landow, 2006). Alcohol is commonly connected with sexual violence on college campuses is (Kadison & DeGeronimo, 2004). Per one study in the 1980s, 75% of men and 55% of women were under the influence of alcohol when the assault occurred (Landow, 2006).

Suicide is also on the rise in college settings. It is estimated that 1,100 students die each year from a completed suicide (The Jed Foundation, 2006). Taub and Thompson (2013), via the American Association of Suicidology, estimated that for each completed suicide, between 100 and 200 attempts are made. As previously mentioned, in July 2005, a Massachusetts Superior Court allowed parents of a MIT student to sue the school after their child committed suicide (Benton & Benton, 2006). Depression and anxiety are the two primary problems facing college students, with 70% of college women and 50% of college men experiencing hopelessness at least once in the previous year (American College Health Association, 2006).

Traumatic incidents being on the rise may speak to a larger pandemic that is hitting higher educational institutions. The American College Health Association (2012) conducted an assessment with college students, the results of which are shown in Figure 3.
The data in Figure 3 concur with another college student mental health study, “The Healthy Minds Study,” which reported that 17% of students screened exhibited diagnosable depression (Hunt & Eisenberg as cited in Taub & Thompson, 2012).

Populations most susceptible to behavioral health concerns include student athletes, international students, students who identify as LGBT, college students younger than 21 years of age, students just starting their studies, and graduate students (Taub & Thompson, 2012). In a 13-year study conducted at Kansas State University, behavioral health challenges doubled for students with anxiety, tripled for those with depression, and tripled for those exhibiting “serious suicidal intent” (Benton & Benton, 2006, p. 4).

Combined, it appears the studies indicate increased stress in students of higher education.
institutions in general. Identifying proactive interventions that reduce stress may reduce this domino effect of increasing behavioral health symptoms.

In summary, an increase in traumatic events at higher education institutions from campus shootings, to sexual violence and coercion, to suicide is being exhibited. A possible predictor/trigger may be stress, which appears to be increasing in higher education students and may present itself, as indicated in Figure 3, with suicidal ideation, sexual violence and coercion, and physical violence. This connection may support a need to increase in a multi-level approach to behavioral health intervention, from one that supports prevention (those overwhelmed, sad, lonely, and anxious) and intervention (those hopeless and depressed, and contemplating suicide) to one of reactionary or crisis management (those attempting suicide or exhibiting violent behavior to themselves or others).

**Current Behavioral Health Practices in Higher Educational Institutions**

While the frequency and severity of traumatic incidents in higher education institutions are increasing, the solution requires more than increasing counseling services (Pavela, 2006). A study at the University of Illinois found that students who exhibited suicidal gestures or attempted suicide were inconsistent with accepting or following up with behavioral health treatment (Pavela, 2006). The study identified two primary reasons these students did not follow up with the recommended behavioral health treatment:
1. When students exhibited suicidal gestures or made attempts and then were invited to meet with a behavioral health professional, students would often deny the behavior or action, report that they had made a full and complete recovery, and/or schedule an appointment but not show up. In some instances, students would lie to their residence hall staff around following up with a behavioral health staff.

2. Students who would make it to the appointment with the appropriate professional would then not bring up the suicidal gesture or attempt or would attend the first session and not attend a second or third. Another disturbing trend was students would go missing, not answer their phones, not attend sessions, and would go absent from higher education institutions for weeks at a time.

It is estimated that 5% of students who exhibit suicidal gestures or make suicide attempts actually meet with a behavioral health profession for four sessions (Pavela, 2006).

In response to their study, the University of Illinois enacted a “mandatory assessment” policy (Pavela, 2006, p. 367). Student affairs staff are required and faculty are encouraged to complete a “Suicide Incident Report Form,” a document used when a staff or faculty has “credible information that a student is threatening or attempted suicide” (Pavela, 2006, p. 367). The mandate requires students to attend four weekly sessions of professional assessment. If students do not follow through with the weekly sessions, they receive disciplinary suspensions (Pavela, 2006). During these four sessions, the student and the behavioral health professional would address four areas (Pavela, 2006):
1. Assessing the student’s suicidality

2. Reconstructing the circumstances, the thoughts and feelings, that precipitated the initial incident

3. Construct a timeline that mirrors both the student’s suicide attempt and the student’s life

4. Going through the institution’s standard of self-welfare and the potential consequences for not following it (Pavela, 2006).

The University of Illinois also has a Suicide Intervention Team that supports the consistency of the intervention and identifies a plan if a student does not adhere to the sanctions set by the university (Pavela, 2006). The interventions enacted by the University of Illinois are increasing the frequency of sessions and participation for those exhibiting behavioral health symptoms. Their ability to create a mandate for students to attend sessions is a powerful, possibly forceful, tool to assure student participation. The results of these interventions would be of interest due to the possible ethical challenge that behavioral health clients should participate under their own free will.

Despite the lack of follow-through experienced by higher education institutions from students experiencing suicidal ideation, higher educational behavioral health centers are still overwhelmed with service need. A longitudinal study covering 12 years and over 3,200 students illustrated that 96% of college students exhibited the criteria to meet at least one diagnosable mental health disorder (Guthman, Iocin, & Konstas, 2010). Another study, the Center for Collegiate Mental Health Study of 2011 looked at the data
of 70,000 students at 97 universities and identified that 24% of the students seeking services had seriously considered suicide in their lifetimes, with 8% having attempted a suicide (Ethan & Seidel, 2013). This level of service need impacts the entire higher education system. Behavioral health symptoms, both large and small, have an impact on higher education students’ ability to concentrate, stay motivated, and experience confidence (Simpson & Ferguson, 2012). In addition, students with behavioral health symptoms have additional challenges socially, relationally, and with regard to meeting their full potential (Simpson & Ferguson, 2012). It would appear that in addition to meeting the potentially lethal behavioral health challenges of their students, higher education institutions are overwhelmed with the large influx of students with behavioral health symptoms. This large range of service needs places a significant strain on higher education systems.

In addition to the large range of symptom severity, the age of onset, the age at which the behavioral health symptoms are introduced has a large impact on the level of behavioral health services a student may need. Students with behavioral health challenges can range from students whose behavioral health has been identified early, and intervention and treatment has been appropriate for years, to those who are experiencing behavioral health symptoms for the first time and are not receiving treatment or practicing the self-care necessary to manage their symptoms (Benton & Benton, 2006). Several behavioral health diagnoses exhibit an onset in late adolescence to early adulthood (e.g., schizophrenia) and often students do not seek out higher
education counseling centers until symptoms have impacted their functionality. Studies indicate that late onset of high acute behavioral health symptoms correlates with increased aggressive behaviors (Montanez, 2000). Higher education institution counseling centers need to be prepared for students with challenges ranging from decreasing concentration and motivation, to traumatic pasts, to experiences of an onset of psychotic symptoms, like auditory hallucinations. These symptoms often ripple, negatively impacting a student’s relationship with peers and family and self-care, while contributing to psychosocial stressors, including a student’s finances, and stress in their academics and occupations (Benton & Benton, 2006). The domino effect that ensues brings additional challenges for any behavioral health treatment, as often behavioral health practitioners have to provide treatment and support not only in response to the behavioral health symptoms but also to the various relational and psychosocial stressors. The level of complexity, when it comes to college students, is significant, and counseling centers need to be fluid to meet the needs of each student where they are.

Despite traumatic events and the change in demographics dictating increased services, budgetary constraints have triggered a transition from individual psychotherapy to brief solution-focused forms of therapy, group therapy, peer-counseling, and an increase in psychotropic medications (Kraft, 2011). The reduction in one-on-one therapeutic sessions is a consistent practice despite studies correlating the number of sessions a college student has with their likelihood of retention (Simpson & Ferguson, 2012). Students utilizing college counseling services show an increase in the use of
psychotropic medications, from 4% in 1992 to 23% in 2002 (Kraft, 2009). Peer counseling has been shown to be an easier medium by which to discuss sensitive issues, as college students feel the peer-counselor understands their perspective (Catanzarite & Robinson, 2013). Peer counseling has shown successes in supporting students with eating disorders and alcohol abuse; however, it has exhibited limited success in supporting students with gender identity challenges and partner abuse (Kraft, 2009).

This transition to more budget-friendly services has helped ease understaffing; however, students in crisis and students with significant and continual behavioral health needs will not receive the appropriate level of treatment (Kraft, 2011). This more budget-friendly level of service may be appropriate for students who enter the higher education system with previous behavioral health treatment, are experienced at receiving treatment, and or are on an effective medication regiment (Taub & Thompson, 2013). On the other hand, students experiencing behavioral health symptoms for the first time during college will suffer from the transition to lower service levels (Kraft, 2009). This is largely due to the need for the individual and the behavioral health practitioner to have several behavioral health sessions to develop the appropriate treatment for a student’s individual needs. The budgetary challenges also decrease preventative intervention and place a heavy reliance on reactionary intervention. Unfortunately, reactionary intervention is particularly challenging for behavioral health practitioners at higher educational settings due to the lack of collaboration and collateral information to support a more comprehensive treatment/safety plan.
Despite higher education institutions’ transition from longer-term therapy to shorter-term therapy, students continue to experience a lack of access to behavioral health services on college campuses. Reasons given for a lack of access include actual or perceived barriers to treatment, stigma, and lack of awareness regarding the treatability of behavioral health symptoms (Zinzow et al., 2011). The lack of access can also be divided by race. African Americans, Asian Americans, and Latinos accessed behavioral health services on campus less often than European Americans (Zinzow et al., 2011). It is be important for higher education institutions to identify how to increase the use of behavioral health services for various races, as Latinas represent the highest percentage of suicide attempts in high schools (Centers for Disease Prevention and Control, 2009). As well, the African American adolescent male suicide rate is the fastest growing rate (Day-Vines, 2007); and through the lifespan, gay/bisexual males attempt suicide four times higher than their heterosexual counterparts (King et al., 2008). Reasons for this division may include socioeconomic status, parent education levels, discrimination, and cultural and community perceptions of behavioral health disorders and treatment (Zinzow et al., 2011).

When students do not connect with behavioral services, they will often confer with friends and family (Sharkin, Plageman, & Mangold, 2003). In fact, most minority students who seek counseling services do so because of a friend’s referral (Davidson, Yakushka, & Sanford-Martens, 2004). Along with friends, families are a consistent support for college students. On average, college students communicate with parents
10.41 times per week (Grace as cited in Taub & Thompson, 2013). In addition to family and peers, there have been some studies exploring the possibility that college students seek out the counsel of their professors. A University of California Los Angeles study found 38% of the 200,000 students surveyed had connected with their professors for support (Higher Education Research Institute, 2011). There is much debate about using such connections to support student behavioral health, as professors often do not have the training to meet a student’s behavioral health needs (Ethan & Seidel, 2013). Unfortunately, there is little research on how students cope when they choose not to attend the college’s counseling center (Ethan & Seidel, 2013).

Interventions to support college students with behavioral health needs have been identified. Given the change in increased violence on campus, transition of legal responsibility toward higher education institutions, and increased stressors in students’ lives, Benton and Benton (2006) believe it is in the best interests of these institutions to at least revisit their policies and procedures regarding their practices when addressing students with acute behavioral health needs. Some institutions have adopted the practice of withdrawing students who, for example, exhibit suicidal threats and or make attempts (Pavela, 2006). The concern with this intervention lies in the timing. If a student is withdrawn immediately, the student was not privy to their due process, which would include interviewing staff, reviewing previous behaviors, and gathering contextual information (Pavela, 2006). As well, the immediacy of the act may bring unnecessary
consequences, including litigation and damage to the individual and institution’s brand (Pavela, 2006).

Faculty and staff, along with students, should understand how to respond to a student or staff member who is emotionally overwhelmed (Wood, 2012). Many institutions have reviewed with faculty and staff their institution’s counseling services and have counselors connected to each department to act as liaisons, providing more focused referrals and increased training and understanding of current policy and procedures related to their students’ behavioral health (Ethan & Seidel, 2013). When professors were surveyed regarding their experiences with students with behavioral health challenges, many professors emphasized the importance of having a known safety plan, particularly during the hours the counseling centers are closed (Ethan & Seidel, 2013). To address their professors’ concerns, many institutions have contracted mental health providers, including tele-counseling (counseling over phone, Skype, internet), which allows more access and flexibility to meet campus behavioral health needs (Wood, 2012). Benton and Benton (2006) identified five actions that would increase campus-wide behavioral health support addressed toward higher education institutional administrators:

1. Knowing the extent to which behavioral health challenges are impacting the college system
2. Knowing the legal implications, and potential financial implications, of students with behavioral health challenges and how institutions can protect and meet these students’ needs

3. Develop theory and intervention to support students with behavioral health challenges

4. Implementation of theory and intervention that student affairs can learn and apply

5. Administrations understanding and awareness of the needs these students have.

Social workers Jun Sung et al. (2010), through their work on the Virginia Tech shootings, developed several additional considerations for intervention. They noted that faculty and staff should be observant of students who exhibit erroneous beliefs with regard to gender, caregiver relationships, and acute behavioral health symptoms. Also, when assessing an individual with behavioral health challenges, it is recommended that one explore the student’s relationship with caregivers, their gender, and their mental status exam.

The current behavioral health practices in higher education institutions are quite diverse. Several barriers currently exist, including lack of follow-through by students, increase in students with more acute behavioral health challenges, diversity of behavioral health symptoms, budgetary constraints, access, racial/cultural insensitivity, and how to support those students who seek out alternative supports. Despite this long list of challenges, several higher educational campuses have developed encouraging interventions. In addition, higher education counseling centers, in general, have shown to
improve student retention and graduation rates, along with their standing in comparison to other institutions (Kadison & DiGeronimo, 2004). A 1995 study indicated that 5% of students discontinue their education because of behavioral health needs. This amounts to roughly 4.3 million young adults (Kadison & DiGeronimo, 2004). The ripple effect of these 4.3 million students on society, emotionally and fiscally, is critical to the vitality of our culture. Counselors and behavioral health centers at higher education institutions have the unique opportunity to support these students, increasing their retention and supporting the larger campus culture as a whole. Several supportive programs are introduced in the Systems Theory section of this chapter, but before exploring those programs, the next two sections speak to what Benton and Benton (2006) believe are imperative for addressing the behavioral health challenges at higher education institutions in relation to policy.

**FERPA/HIPAA**

Concerns with FERPA and HIPAA have been well documented; an extensive study after the shootings at Virginia Tech identified how the assailant’s behavioral health records from the institution were protected under FERPA, while the assailant’s behavioral health records from the community were protected under HIPAA (Davies, 2008). While the community program was allowed to share the perpetrator’s records with the institution, FERPA’s ambiguity led the institution to withhold the perpetrator’s records from the community (Davies, 2008). HIPAA is also not without concerns. While the assailant received behavioral health treatment, there was no collateral
assessment between the practitioners and the assailant’s family (Davies, 2008). In this section, both FERPA and HIPAA are further explored, connecting these policies to the practice of counseling higher education students with acute symptoms.

**Federal Educational Rights and Privacy Act (FERPA)**

FERPA was developed in response to the immense amount of data about students regarding how information and data were shared, maintained, and stored (Ramirez, 2009). Data include any identifiable information, such as a student’s name, address, date of birth, or any other identifiable information that could lead an individual to identify a student (e.g., physical descriptors) (Ramirez, 2009). FERPA covers institutions that receive federal money, including grants and financial aid; hence, FERPA guidelines are often followed consistently by institutions for fear of losing these financial benefits (Ramirez, 2009). To be protected under FERPA, students must meet one of either criterion: attend a postsecondary institution or reach the age of 18 (Ramirez, 2009). Most higher education students are covered under FERPA, including minors who attend a higher education institution. In this instance, higher education institutions can share information with, for example, a high school, because it falls under the student’s “educational interest” and parents must go to the high school for the student’s information (Ramirez, 2009, p. 32).

Exceptions to FERPA are limited and include records related to sole possession, law enforcement, employment, medical, alumni, and grades on peer-graded papers (Ramirez, 2009). Sole possession would include the sharing of grades from a faculty
member to another faculty member or student assistant. Law enforcement and employment are not covered by FERPA until they are placed in a file related to the student’s education (Ramirez, 2009). Psychological and medical records are covered by FERPA unless the access is maintained and managed by only those administering treatment; once the records are shared with those outside the student’s treatment, they fall under FERPA. Instances in which institutions disclose a student’s psychological and medical records include if the student plans to attend another institution and safety of the student and the campus community; once this disclosure takes place, these records would be covered by FERPA (Ramirez, 2009). It is common for institutions to keep students’ psychological and medical records separate from their education records (Ramirez, 2009). In exploring FERPA, it is important to acknowledge the many different protocols for each category of information; for example, records related to law enforcement have different standards than those related to psychological/medical history. The differing protocols would likely create confusion when multiple departments are called upon to share pertinent information, such as if the higher education institution law enforcement team wanted to coordinate with the higher education institution health center.

Higher education institutions can also disclose information as long as the information provided is in the student’s “legitimate educational interest” (Ramirez, 2009, p. 131). “Legitimate educational interest” has not been defined by governing officials and has been left to the discretion of the higher education institution (Ramirez, 2009, p. 131). “Student behavior,” included under “legitimate educational interest,” has also been
left to the discretion of the higher education institution, allowing these institutions to
disclose information pertaining to a student’s behavior (Ramirez, 2009, p. 131).
“Legitimate educational interest” appears to provide higher education institutions much
latitude in their sharing of information, especially that related to campus safety. It is
important to identify whether higher education institution staff and administration would
have the training necessary to identify what information would be important to share with
local authorities, the campus medical/psychological department, and the surrounding
community.

FERPA allows disclosure to parents on a one-time basis under three conditions:
that the student is a dependent, for “emergencies” related to health and or safety, and
legal violations related to drugs and alcohol. The third disclosure calls for the student to
be under the age of 21 (Ramirez, 2009, p. 138). As a result of the Virginia Tech
shootings in 2008, the president amended FERPA, allowing parents to be included in a
coordinated behavioral health plan if doing so could support health and safety of either
the student or the student body (Ramirez, 2009). “Emergency” was also amended to the
term “level of threat” due to the fear of higher education administrators misinterpreting
FERPA and HIPAA, and disclosure under this clause is permissible to any party whose
knowledge may protect the health and safety of others (Ramirez, 2009, p. 142). It would
appear that an institution’s financial aid department, those who can identify whether a
student is a dependent, is now included in the discussion of disclosure. Coordinating
with caregivers, which was a concern in several of the traumatic incidents, appears to
have been made easier and may provide valuable insight around the student’s behavioral health history.

With regard to sex crimes/violence, FERPA allows the disclosure of the perpetrator if the perpetrator is a student and has violated the institution’s rules or policies. Victim and bystander identities are protected unless a prior consent has been signed (Ramirez, 2009). Higher education institutions, if interested in disclosing protected information, will need prior written consent, specifying what will be disclosed, reason for disclosure, and who will be privy to the disclosure (Ramirez, 2009). Sex crimes/violence did not receive the leniency that “threats to health and safety” received when FERPA was amended. The limited discussion in FERPA pertaining to sex crimes/violence may be an oversight; however, it may likely be a response that sex crimes/violence may fall under “threats to health and safety.”

**Health Insurance Portability and Accountability Act (HIPAA)**

HIPAA was developed in response to a health industry that was 10 years behind in health claims management (Hartley & Jones, 2004). The initial focus of HIPAA was on administration and their protection of individuals’ identifiable health information; this understanding assists in comprehending the context of HIPAA and its focus and frame. Healthcare providers, including those practicing at a higher education institution, are included under those who need to comply. The information covered under HIPAA includes that created or received by a healthcare provider and contains identifiable information such as name, birthday, telephone numbers, etc., similar to what was
presented under FERPA (Hartley & Jones, 2004). Besides this overlap, there is significant difference between the language and culture presented in both policies; this creates additional challenges for behavioral health providers, as they must be cognizant of both policies and both cultures, education and health.

A stark contrast between HIPAA and FERPA is that HIPAA disclosure for “public good” is more defined, including when required by law, when required by a public-health authority or food and drug administration, and when involving child abuse/neglect, elder abuse, and a court order/subpoena (Hartley & Jones, 2004, pp. 91-92). Disclosures are limited to specific circumstances and are limited to the “minimum necessary,” meaning the disclosure is limited to the information necessary to complete the task. FERPA allows more disclosure under “level of threat” and “educational interests,” which is vague and can support a broader scope of people and information with which to share, meaning higher education institutions can use these exceptions to justify disclosure. In addition, HIPAA calls for the person disclosing the information to obtain verification that the individual receiving the information is who they say they are (Hartley & Jones, 2004). This practice places significant risk and liability on the individual disclosing the information, especially during a crisis when time may be limited.

Overall, both FERPA and HIPAA can appear as tangled webs of circumstance as they attempt to define who can receive information and what and under what context can be shared. Add in the differences in language, culture, and policy between higher
education institution staff, the institution’s medical/psychological services, and the institution’s law enforcement and it would be easy for practitioners to defer to legal authorities. Unfortunately, especially during times of budgetary concerns such as these, the time to be both trained and to gain an understanding of other departmental requirements is limited. The concerns are exacerbated during times of crisis. Finally, due to the limited discussion on both FERPA and HIPAA pertaining to community collateral, it would seem that all practitioners would require a prior written consent/release to obtain information from an outside provider, including a psychiatric hospital or an outpatient behavioral health provider. This is particularly concerning given that several of the assailants in the traumatic incidents previously discussed had substantial behavioral health history. Their history would have been pertinent information when developing a plan for addressing any behavioral and/or behavioral health concerns presented to the higher education institution.

**Systems Theory**

“A causes B causes C” is less likely than “A interacts with B to produce AB, which changes both A and B, and results in C, which is partly A, B, and AB.” Certainly, this [is a] more complex description, but it [is] also closer to reality, particularly the reality of human relationships, that is, systemic relationships. (Anderson & Carter, 1999, p. 17)

Systems theory was developed with the belief that each subsystem’s contribution is unique, with each contribution being minor; however, when combined, the subsystems generate major change (Nevarez, Wood, & Penrose, 2013). In this vein, higher education leaders and policymakers must understand each subsystem within the area they aim to
change, their relationship with other subsystems, and how each subsystem fits in the larger macrosystem’s bureaucratic structure (Nevarez et al., 2013). Within this section, I review systems theory and address its application in higher educational systems, which starts with the historical relationship and transitions to the current relationship. At the conclusion, I introduce several programs currently incorporating systemic ideas as a means of identifying current practices.

A system is a set of variables, both physical and metaphysical, that construct a larger whole. Systems theory then allows for developing understanding and connectedness from “parts” to “whole” (Anderson & Carter, 1999, p. 3). When applying systems to a higher education institution, it may include the behavior of individuals, possibly students, faculty/staff, and leadership and lead to the construction of their society, in this case, their higher education institution (Anderson & Carter, 1999; see Figure 4).

![Diagram](image)

*Figure 4. Individual behavior collectively defines society/community.*

Organizations, including higher educational institutions, often work from this continuum looking at case management to community organization and individual to social change (Anderson & Carter, 1999). Each variable included in the system is considered both a single entity and a part of larger system.

As well, the system is constantly looking inward at its variables, while at the same time, looking outward at its relationship with other systems (Anderson & Carter, 1999).
Similarly, a system like a higher education institution is constantly looking at the institution and all its variables, along with larger systems, the relationship with other institutions, governing bodies, and local community. It would be important to add that systemic values are contextual; the meaning derived from the assessment of these relationships are relative to the lens under which they are observed (Anderson & Carter, 1999). As seen in Figure 5, the perception of the system has a direct impact on the understanding of the system (Bailey, 1994).

Perception of the System \[\rightarrow\] Model of the system \[\rightarrow\] Actual Systemic Result

*Figure 5.* Results are influenced by the power of definition.

Along with the identifiers (e.g., “perception of the system” and “actual systemic result”) shown above, each system incorporates energy. Energy is experienced both within the system and between the system and its environment. Energy within systems like higher education systems may include information and resources (Anderson & Carter, 1999). When energy within a system is left unsupported, the energy can increase disorganization and decrease connection among its parts, a process called entropy. Entropy has also been described as the “degree of disorder” (Bailey, 1994, p. 44). Conversely, synergy is defined as an “amplification of goal-oriented activity where there was a fit between persons’ individual goals and the goals of their culture” (Anderson & Carter, 1999, p. 11). It is important for higher education institution counseling
departments to promote “synergy,” connecting the motivations of the behavioral health practitioners and the staff, with those of the leadership.

In addition to energy, each system must be efficient in its organization. “Organization” is the arrangement of the system’s parts to maximize the procurement, expenditure, and conservation of energy (Anderson & Carter, 1999, p. 14). Systems theory breaks “organization” down to the individual, identifying Erikson’s “identity,” as an example of how a person effectively functions within their environment (Anderson & Carter, 1999, p. 15). Erikson’s identity model is discussed further in the context of the study in the next section.

In addition to presenting systems theory and the connections it has to the study, it is important to provide historical context and several promising practices as support for how to enact theory into practice. Benton and Benton (2006) discussed the transition colleges have been experiencing from 1950, when colleges were viewed as *loco parentis* and privy to more control over student behavior. After 1950, a series of court cases focusing on student rights and freedoms shifted the responsibility of student behavior onto the student (Benton & Benton, 2006). The transposition carries on today as the financial responsibility of the college experience is placed on the family and student; college, ergo, is transitioning to the role of the “product” (Benton & Benton, 2006, p. 5). Currently, higher education institutions are experiencing a bind in that they have the responsibility of managing student behaviors (e.g., student alcohol and drug use and
behavioral health) while at the same time not having the legal rights to manage it (Benton & Benton, 2006).

Due to the multiple variables presented—student body, faculty/staff, administration, policy, community—and the significant transition and breadth of the current challenges, a systemic lens was used. Systems is suited for organizations that must consider multiple domains, which is a constant for counseling departments at higher education institutions. Several studies recommend intervention through a systemic lens, including those conducted by the National Mental Health Association and The Jed Foundation (2002), which indicate that interventions should encompass all subsystems, especially social outlets, and should include a diverse number of staff and faculty. Kadison and DeGeronimo (2004) stated that all employees, faculty, staff, and administration should know what to do if they were confronted with a student who is experiencing behavioral health challenges.

Extending beyond the realm of higher education institutions, Benton and Benton’s (2006) studies conducted after the Virginia Tech shootings identified several concerns with the surrounding communities. Public behavioral health programs are underfunded and lack the resources to treat those with significant behavioral health symptoms, perpetuating the likelihood of future traumatic incidents (Davies, 2008). Gun laws are ambiguous, particularly between federal and state governmental entities, and they often lead to inconsistent enforcement, including the ability to purchase firearms at gun fairs without a background check (Davies, 2008). In addition, K-12 institutions do not share
information with higher education institutions, including IEPs and 504 plans (Davies, 2008). Jun Sung et al. (2010) added the importance of collateral information gained from coordinating with the student’s caregivers and connect improved parenting to a reduction in school violence.

With regard to students, connections are paramount to their belief that they are safe and secure (Kadison & DeGeronimo, 2004). If connections are displaced or lacking altogether, college students may develop feelings of vulnerability and insecurity, which may lead to anxiety and depression. Finding secure relationships is difficult for college students, as they often experience several new forms of relationships, such as roommates, intimate relationships, and an increased exposure to human diversity (Kadison & DeGeronimo, 2004). Insecurity often can lead students to succumb to peer pressure (Kadison & DeGeronimo, 2004).

In looking at the gaps in the relationships among higher education behavioral health programs, the community’s larger systems, and students’ social supports, there have been several systemic models adopted to strengthen behavioral health among higher education students. Benton and Benton (2006) adopted the Cube Model, a campus-wide strategic plan for distressed students. This model has been used predominantly to develop programs and support departmental collaboration. The Cube Model, in addressing campus safety, has identified the need for the development of a “collaborative campus-wide strategic mental health plan” (p. 16). The cube model emphasizes the relationship between subsystems, supporting reciprocal relationships and feedback loops
as well as placing the responsibility of the students on the larger community, including
the family; the larger student body, faculty, and staff; and community leaders. In
emphasizing the larger community, including family, this model may support the
inclusion of students, particularly from populations who do not aim to address behavioral
health challenges with counseling.

The Jed Foundation (2006), an organization founded on protecting college
students’ emotional health, is attempting to reduce instances of suicide attempts. As part
of this pursuit, The Jed Foundation had a roundtable with national experts on how to
develop protocols for institutions when responding to students who were “acutely
distressed or suicidal” (p. 2). The plan calls for memorandum of understandings (MOUs)
with local law enforcement, other emergency personnel, and local hospitals, including
hospitals specializing in acute psychiatric emergency. In addition, non-hospitalization
options should be explored, including low-cost counseling and psychiatric supports.
MOUs should be developed for these options to connect support systems to distressed
students. When developing follow-up plans, The Jed Foundation recommends finding a
solution that meets both the needs of the student and the surrounding community,
including identifying supports such as family, friends, and community. Developing
MOUs with outside resources can start the rapport-building process and lead to
partnerships in the community. This practice may increase understanding and awareness
of the resources on both sides, along with how to incorporate these resources in gaps that
exist within the current system. Developing partnerships with surrounding hospitals can be crucial during times of crisis intervention and reassessment.

Environmental management (EM) has been increasingly useful as a systemic approach to addressing alcohol challenges at college campuses. A model of EM was practiced at the University of Rhode Island (URI), which at the time had been identified as the top party school three consecutive years by Princeton Review (Wood et al., 2009). Several interventions followed, including alterations to campus policy. For example, URI developed a “three strikes” policy, a two-semester suspension after a third violation, requiring a student to participate in a chemical dependency evaluation and/or treatment, and parent notification if a student was arrested for underage drinking or for having false identification (Wood et al., 2009, p. 97). URI stopped all use of alcoholic beverages at their events. As for the community, URI teamed with local law enforcement and community leaders and developed a hotline to respond to community concerns in a more timely fashion; developed a guide with local laws and ordinances to educate the student body; and had their hands in community leasing agreements, keg registration, designated driving programs, and training of bartenders to cut off patrons who were intoxicated (Wood et al., 2009). After a telephone survey of their students, URI then developed a media campaign that reinforced that their student body was for the new initiatives and emphasized the school’s efforts as a means of addressing the student concerns (Wood et al., 2009). URI appears to have taken partnerships further with their interventions related to policy, community partnerships, intervention, and incorporating media into their
strategic plan. Their plan represents a significant undertaking, looking not only at
different systems, but layers within the system.

The Assessment-Intervention of Student Problems model (AISP) was developed by Ursula Delworth in 1989. Since the model was introduced, it continues to be a foundational model. The model focuses on three areas: assessment, the intervention team, and the intervention itself (Delworth, 1989). The assessment includes the student, the individual who initially reported the student, and other relevant parties; the assessment is often conducted by the staff member’s supervisor, and aims to identify the appropriate referral for the student (Delworth, 1989). The intervention team consists of several departments, including the campus behavioral health program, campus security/law enforcement, student services, legal, and disciplinary (Delworth, 1989). Besides developing plans for students referred to them, the team’s responsibilities also include developing and educating staff on related policies and procedures, and it alters policy accordingly (Delworth, 1989). Follow-up is extensive and is done to support student follow-through with interventions that reduce escalation of challenges and provides alternative referrals as new challenges arise (Delworth, 1989).

The final piece of AISP is the intervention. Two primary areas of intervention are the socio-interpersonal piece and the building of skills and competencies. The socio-interpersonal piece includes connecting students to groups, campus activities, mentors, faculty members, or staff members. This connection is an attempt to increase student bonds with those of the campus community. The building of skills and competencies
include several domains: academic/study, career, interpersonal, and behavioral coping skills are the primary. However, students may also benefit from financial counseling, assertion training, and anxiety reduction skills (Delworth, 1989). It is important to note that throughout the AISP process, several systemic practices take place. From the group used for assessment, the intervention team, educating faculty and staff, and policy, systemic practices are used to improve decision making and develop more accurate intervention. Systemic ideas are also incorporated into the interventions, strengthening relationships and identifying an appropriate skillset to meet the student’s needs, both pillars in systems theory. This model appears to support systemic practices within a higher education system, which involves multiple stakeholders along with an increased collaborative intervention and incorporation of education and training to staff.

Historically, higher education institutions have moved up and down the continuum of systemic responsibility for their students’ well-being. Currently, the institutions appear to be attempting to increase their power as legal systems have increased institutional responsibility for student safety. Within the community, the ambiguity of gun laws and challenges of obtaining collateral information between K-12 and higher education institutions and students’ family and higher educational institutions have not assisted higher educational institutions in providing behavioral health treatment for their student body. Despite these concerns, several promising practices that have shown a roadmap to improved campus safety and student behavioral health treatment
exist. It is within such examples that more can be learned and foundational understanding can be added to this study.

**Additional Theoretical Considerations**

**Erikson**

“At no other phase of life cycle, then, is the promise of finding oneself and the threat of losing oneself so closely allied” (Erikson, 1962, p. 19). Erikson’s ideas on child development provide greater context related to the dominant population at higher education institutions. In “Phase V” of Erikson’s Psychoanalytic theory, he explored the transition adolescents go through as they enter adulthood, which he defined by their attempt to develop their identity (Maier, 1965, p. 55). At this time, the transitioning adolescent attempts to restructure all previous beliefs through the lens of their prognosticated future (Evans, 1965). The transitioning individual must develop an identity while redirecting “childlike” beliefs and connecting with new identifications, all while the body is morphing into a “new self” (Maier, 1965, p. 56). The new self is characterized as a heightened sexual drive, openness to exploring relationships outside immediate supports, and the transitioning of relationships to include more balance; during this time, both the individual and society support the transition by encouraging experimentation (Maier, 1965, p. 58). It would be important for higher educational institution counselors to understand their students’ attempts at developing their identity and that their students, while experiencing stressors that come with social and academic demands, are also experiencing significant personal transition. Psychoeducational
opportunities that promote appropriate social relationships, especially those relating to
sex, building support networks, and appropriate social experimentation, may address the
confusion students may face. Erikson’s theory assists in building awareness that while
students are experiencing the weight of developing their self, they are also being pulled
by their multiple selves.

Erikson identified several areas he believes would support the person’s transition.
Supports, particularly those of the same sex and age group, offer the individual the
opportunity for the individual to think aloud, and assist in the individual’s practice of
“articulating and meditating” (Maier, 1965, p. 60). The college-going age also
encourages a transition from traditional practices of “play” to role playing and verbal
exaggeration (Maier, 1965, p. 61). Often these practices are exhibited by individuals
through social modeling and ego mechanisms that provide a bridge from the individual to
social experimentation, with the social experimentation often pertaining to a future-
oriented self (Maier, 1965). The individual goes through much anxiety during this phase;
adults will connect the individual’s identity to the cultural beliefs of what an adult should
be and will attempt to modify the individual to these cultural assignments after (Maier,
1965). Challenges would also exist for individuals who do not commit to potential
“identities,” and rather, will preoccupy themselves with an unquestioned “ideal”
(Stevens, 1983, p. 50). Without faith to explore identity, an individual can succumb to
their weak ego and connect to deviant groups (Evans, 1965).
Erikson appears to support peer mentors, those who would present as similar in age, sex, and standing (as a student). These peer mentors, along with counselors, also appear to benefit from presenting information and intervention through role playing, modeling, and language that emphasizes the student’s future self. Providing awareness around anxiety, its indicators, symptom management, and coping skills may reduce the impact anxiety has on an institution’s student body. To reduce the likelihood that students feel pushed by practitioners toward cultural assignments, or stereotypical behaviors, counselors should be weary not to convey judgment that the student interprets as directive. Rather, practitioners would best be served to promote experimentation and curiosity, though this encouragement should be weighed against potential misinterpretation.

**Feminism**

Women’s experiences, she asserts [Catherine MacKinnon], takes place within a (gender) hierarchy in which women always exist as subordinates. Indeed, the very process of becoming a woman is the process of learning how to exist for men. (Grant, 1993, p. 76)

In actuality the relation of the sexes in not quite like that of two electrical poles, for man represents both the positive and the neutral, as is indicated by the common use of man to designate human beings in general; whereas woman represents only the negative, defined by limiting criteria, without reciprocity. (Simone de Beauvoir as cited in McCann & Kim, 2010, p. 35)

Feminist theory looks through a gender-focused lens. One of its main tenets is the idea that the world is seen differently by gender, and the way these differences play out has implications for conceptions of knowledge (Grant, 1993). Knowledge, for example, is often held as “truth” by a male, when in fact, it represents “male opinion” (Grant, 1993,
Feminist theory was used because of the strong gender influence discussed within both the problem statement and the literature. As previously presented, the perpetrators of school violence are commonly males, and it has been noted that males are more likely to resolve challenges with violence. Males are also more often perpetrators of sexual coercion and violence and completed suicides. It is important to note that the trends and the use of feminist theory do not represent an absolute idea that males are perpetrators and that women do not resolve challenges through violence.

Women are more likely to be victims of rape, sexual violence and coercion, and domestic violence; in addition, women live in a contemporary culture that often portrays women as sex objects (Stone, 2007). Due to this commonality across most cultures, these challenges can be identified as systemic (Stone, 2007). By systemic, the literature identifies challenges with individual behavior, policy, and leadership (Stone, 2007). The potential cause for these systemic practices may arise from the rise of patriarchy (Stone, 2007). Higher education institution counselors’ inclusion of feminist theory in their counseling practice may increase understanding and awareness of gender and sexual injustices that may reduce instances of these behaviors. Counselors may also aim to use a social justice or postmodern perspective, a model that challenges norms and oppressions.

Nancy Chodorow, a feminist sociologist and psychoanalyst, noted that the thought processes of men are different, starting with differing developmental practices by caregivers (Stone, 2007). Chodorow contended that young boys are led to detach from their mothers and develop a sense of inner dependency early on, reducing their
connection to bodily sensations and emotionality (Stone, 2007). These ideas are reinforced by Bonnie Kreps’s ideas that boys are influenced by experimental, control-focused toys, like rockets, tractors etc.; conversely, women are influenced by role-playing toys, dolls, and vacuums (McCann & Kim, 2010). This perspective supports the reasoning regarding the behaviors that may lead males to elicit more aggressive practices.

Again, it would be important to present these ideas to students both in a counseling relationship and to the student body as a whole to increase insight. In connecting feminist theory with Erikson’s development model, it would be important to present psychoeducation related to the promotion of egalitarian values and connect these values with students’ experimentation with their identity. This practice may support the likelihood that students adopt feminist ideas, thereby decreasing previous “identities” that support violence and oppression. Women groups, peer supports, and feminist theoretical practice and use of language may support all students in their development of advocacy, support networks, and reframing patriarchal perspectives.

Feminist theory’s broad nature has provided several ideas that may support counselors in addressing students with acute behavioral health symptoms. By adding a lens that addresses sex and gender, it may support a reduction in violence, based on sex and gender and women’s advocacy. It would be important to note that the ideas presented in feminist theory can be applied to many other underserved oppressed populations. Several additional theoretical models may also be incorporated that may add culturally competent counseling practices and potentially increase access to other
oppressed populations. Counselors should assess for their own cultural competency and attempt to present their counseling through a culturally supportive lens.

**Leadership Theories**

Erikson’s theory and feminist theory explored the counseling practice and the relationship between the counselor and clients. Leadership theory attempts to provide a balance, looking at counselors’ relationship with their leaders. The relationship may represent an important variable in assessing counselors’ relationships with their student-body clients and how they address students with acute behavioral health needs. These leaders may be interpreted as colleagues, clinical directors, medical directors, departmental chairs, or deans. It would be important to note that administrative leaders’ responsibilities extend beyond their department and include the institution’s student body and faculty and staff as well as the campus’s policies, mission/vision, and governing bodies (Nevarez & Wood, 2014). Administrative leaders must also account for the local community, the profession’s standards and ethics, K-12, other higher education institutions, and their own personal values (Nevarez & Wood, 2014). In many respects, administrative leaders are systemic in their responsibilities and considerations; and transformational leadership was explored as a brand of leadership most applicable. Systems leadership was considered; however, transformational leadership has strong relational components, including transactional and transformational considerations and is driven by psychological processes, a language and culture that may best suit counselors in higher education institutions (Nevarez et al., 2013).
Transformational leadership is defined as the “act of empowering individuals to fulfill their contractual obligations, meet the needs of the organization, and go beyond the ‘call of duty’ for the betterment of the institution” (Nevarez & Wood, 2010, p. 59).

Within this definition lie several underlying variables that may exist within the relationship between higher education institution counselors and their leaders. These potential variables are discussed further within each section below.

**Contractual obligations.** These may include policies, campus and departmental mission statements, visions and goals, job descriptions and responsibilities, policies and procedures, and the larger campus’s and profession’s ethical and professional practices.

**Needs of the organization.** This may also include immediate goals, e.g., increased retention, transfer, etc.; budgetary constraints; administrative practices; and duties outside the scope of the counseling position.

**Going beyond the call of duty.** The call of duty represents metaphysical characteristics that support the employee, the counseling department, the higher education system, and systems outside the campus. These characteristics may include motivation and relationships with colleagues, student body, campus, and community.

In identifying the three variables, a counselor and department may be able to measure the level of systemic efficiency present in their system. Transformation leadership attempts to inspire staff by communicating their value, potential, and support while maintaining high expectations. They act as role models and create an environment that strengthens team, empowerment, and insight around individual and organizational
change (Nevarez & Wood, 2010). Leaders develop solution-building skills through innovation and creativity and monitor the pulse on their affiliate’s socio-emotional well-being. Potential benefits to practicing transformational leadership include improved morale, organizational commitment/loyalty, and increased efficiency (Nevarez & Wood, 2010). Conversely, challenges may include leadership and follower burnout, given the substantial responsibility and commitment each member of the team assumes. In addition, if the environment/organization is not supportive of a transformational leader, the organization may actually regress (Nevarez & Wood, 2010). The emphasis on communication, modeling, and developing and maintaining a healthy environment are synonymous with counseling techniques and practices. The promotion of problem-solving skills, or solution-building, aligns well also, and the practice of these leadership techniques sets a culture within the system that may trickle down to the counselors’ interventions.

**Conclusion**

This chapter synthesized the current literature related to the study. In doing so, several themes surfaced. Traumatic events are not limited to the shootings that have dominated the media and include suicide and sexual coercion and violence. As well, it would appear that the perpetrators of these traumatic events experience additional stress during their college experience. Several challenges have been placed on higher education institutions’ shoulders, with these institutions unable to carry the weight of the current need. These needs extend beyond the amount of students requesting services, as access,
diversity (both in terms of race and psychological symptoms), and budget are concerns. Budgetary concerns impact the ability of behavioral health programs to address students with acute behavioral health symptoms. There is evidence that students do turn to other supports outside the behavioral health system, including professors, family, and friends; however, there is a continued concern if these supports meet the needs with which the students are presenting.

Current policy can be perceived as equally confusing, with differing requirements given the individual providing the information, receiving the information, the information provided, and the circumstances surrounding the disclosing of the information. FERPA and HIPPA have some exceptions that can support disclosures during times of crisis; however, additional barriers remain regarding sharing and receiving information outside the boundaries of the higher education institution. One barrier is the current culture that promotes limiting disclosure rather than promoting collaboration. Collectively, these multiple concerns support a systemic lens. Systems theory indicates the multiple relationships exhibited at a higher education institution and may offer a greater understanding and awareness when addressing higher education students’ acute high behavioral health symptoms. A systems approach would support the multiple layers presented in the literature review from the parties involved, to the higher education institution and the several departments included, to families and the surrounding communities and interventions and policies. Several programs and models indicate a systemic approach has been successful. Erikson’s theory and feminist theory may add
more insight into how to address counselors’ assessments of students with behavioral health needs. Transformational leadership may add insight into the relationship between counselors and their leaders. Although there is previous research, a gap exists in connecting higher education institutional behavioral health programs with policy in an effort to support campus safety.
Chapter 3

METHODOLOGY

Introduction

Chapter 3 explores the study’s research design, identifying the process by which the study was conducted. This chapter also details the data collection process and provides initial background information regarding the participants of the study. This chapter begins with the research methodology and study design. For this study, qualitative research was selected because of the “interest in understanding how people interpret their experiences, how they construct their worlds, and what meaning they attribute to their experiences” (Merriam, 2009, p. 5). In the context of this study, the interest lies in counseling practitioners at higher education institutions and how they interpret their experiences within their practice with students who exhibit high acute behavioral health symptoms. Research related to traumatic incidents, current behavioral health practices at higher education institutions, policy, and theoretical frames, assisted in focusing this study. Chapter 3 discusses the relationship the researcher has with the study and the relationship between the researcher and the study participants. It continues with the selection of the participants and closes with how participant anonymity was supported.

Research Design

Phenomenology is the research design. Phenomenology attempts to bring into focus the “experience” of a phenomenon, heightening the awareness of it (Merriam,
Phenomenological research connects with the human experience; in this study, it is connection with the experience of behavioral health practitioners at higher education institutions (Creswell, 2009). Through this study, the researcher aimed to extract the lived experiences of the practitioners and identified shared experiences. The experiences of higher education practitioners at higher education institutions are critical, as they represent an important tie between the students who exhibit high acute behavioral health symptoms and the educational and counseling systems. Phenomenology fits the current study, as it allows current behavioral health practitioners at higher education institutions to express their varied perspectives, allowing a shared experience to develop and creating a deeper understanding of the role of counselors in addressing acute behavioral health symptoms.

This study presents a phenomenological look into the participants’ experiences, beliefs, values, and ideas. The focus of this study was on what preventative measures and interventions counselors at higher education institutions use to address the needs of students with acute behavioral health, emphasizing the counselors’ counseling practice, their relationship with policy and ethical/professional standards, and their relationship with leadership. What led to the study, besides the researcher’s interest, is the timeliness. There is interest and need for increasing both an awareness and understanding of the phenomenon, while increasing safety at higher education institutions. Case study and narrative research methodologies were considered; however, case study did not represent the breadth or depth necessary to support multiple service providers and higher education
institutions. Narrative may encourage researcher bias, which was not the researcher’s desire.

**Role of Researcher**

“The researcher is the primary instrument for data collection and analysis” (Merriam, 2009, p. 15). Per Merriam (2009), qualitative study supports the researcher as the primary tool for collecting and analyzing data for the following reasons:

6. Researchers can respond and adapt when both collecting and analyzing data.

7. Researchers are better able to understand the verbal and nonverbal communication, and respond appropriately, including focusing the information presented and meeting any unforeseen circumstance.

In the context of this study, the researcher’s ability to adapt and respond appropriately to differing forms of communication should support the study going forward. Given the researcher’s background as a behavioral health therapist, he has appropriate experience in both adapting as needed, and has insight in the receiving of multiple forms of communication. In addition, Merriam (2009) identified challenges associated with the researcher as the primary tool for collecting and analyzing data, particularly the dual relationship the researcher plays by collecting data and analyzing it objectively while attempting to not allow bias to interfere with the results and/or findings. The researcher is in a unique position in that the field being studied calls for objectiveness and retains an emphasis on the importance of reducing transference and counter-transference, along with practitioner bias. To support a more objective study, the
researcher had the oversight of the dissertation chair, Dr. Rose Borunda, and two additional committee members, Dr. Carlos Nevarez and Dr. David Nylund. The researcher’s cognitive and neurological standing has, to this point, been unremarkable. With regard to the participants, interaction was limited to the initial introduction, the interview, and the follow-up, which again is expounded upon in the “Setting, Population, and Sample” section.

**Research Questions**

In this section, the research questions are revisited, specifically in how they were addressed through the interview questions. Research questions acted as guides, along with the support of the theoretical orientation and literature review, when designing the interview questions. Solid interview questions validate the findings and the connection back to the research objective. Presented below are the research questions, as found in Chapter 1. Chapter 3 provides further detail regarding these questions.

1. What current preventative measures and interventions do you use to address your student body’s acute behavioral health symptoms?
2. What role does current leadership have in addressing your student body’s acute behavioral health symptoms?
3. What roles do your campus’ climate and culture have in addressing your student body’s behavioral health symptoms?

The interview questions provided in the next section were created to extrapolate the necessary data related to the research question they support. The interview questions
and themes are guided by the research questions, the theoretical orientations, and the literature review; this association was made to assist in further supporting the research process, research questions, data collection, findings, and the study’s potential application.

**Interview Questions for the Qualitative Interviews**

**Demographics.** To protect participant anonymity, questions related to their identification are not included in the transcription.

**Systems.**

1. Describe your counseling program’s relationship with your campus, including your student body.

2. What is the ripple effect that students’ high acute behavioral health symptoms have on the campus culture?

3. How would you describe access to your campus’s behavioral health services for students with high acute behavioral health symptoms?

4. How has the counseling department’s budget impacted treatment for students with high acute behavioral health symptoms?

**Policy.**

5. How has policy, including FERPA and HIPAA impacted your treatment for students with high acute behavioral health symptoms?
Leadership.

6. How do your department’s leaders impact your counseling department’s culture and your treatment of students with high acute behavioral health symptoms?

7. What are the goals and values promoted in your counseling department?
   a. How are these goals and values expressed in your counseling practice with students with high acute behavioral health symptoms?

Practice.

8. Describe your experience as a clinician with students with high acute behavioral health symptoms.
   a. Have you found students’ symptoms to be acute or chronic?

9. During a crisis, what interventions and/or techniques have you found helpful in de-escalating or managing crisis?
   a. What promising practices have you considered in addressing students’ high acute behavioral health symptoms?

10. Could you discuss how you address physical violence, sexual violence and coercion, and suicide?

11. How do you address students with high acute behavioral health symptoms who do not attend their therapeutic sessions?
Erikson/Feminist.

12. When working with students with high acute behavioral health symptoms, do you consider developmental aspects, and, if so, how do you incorporate these aspects in your practice?

13. When working with students with high acute behavioral health symptoms, do you consider gender aspects, and, if so, how do you incorporate these aspects in your practice?

Participant Samples and Setting

Interviews. The six participants who were interviewed were behavioral health practitioners currently practicing at a higher education institution. Participants were provided a $30 gift card, for their campus bookstore, for participating in the study as an incentive. The researcher began by initiating contact through email with would-be participants with the idea of transitioning to active participants. Would-be participants were initially contacted through email correspondence exploring their interest in participating (see Appendix A). Purposeful sampling was used in this study as a means of gathering insight in a balanced manner, including from different higher education institution sites and from practitioners from different backgrounds. All participants were over the age of 18 years old and acted as behavioral health practitioners at a higher education institution. Academic Advisors, Career Counselors, and Counseling Faculty, for example, were ruled out, as people in these positions, while supportive of behavioral
health, do not act as behavioral health practitioners. Practitioners include those who use psychotherapy in their work with the student body.

Upon agreement of participation, interviews were scheduled. The participants were allowed some initial discussion regarding the topics and questions prior to their interviews. All interactions were one-on-one, with interviews lasting between one and two hours. Each participant determined the site and time of the interview, and the researcher met the scheduling needs of each participant. The participants were voluntary and each interview consisted of 13 interview questions. The researcher asked clarifying questions to support the research questions, gathering additional detail and supporting what the participants intended to say. These clarifying questions were asked from a place of curiosity and did not aim to pull information from or pressure the participant. The researcher attempted to make each participant comfortable in their process, by using similar language and nonverbal communication to support participant rapport.

Each interview started with the participant sharing their name, position, and higher education institution, attempting to ensure their participation was appropriate for the study. This information is not included in the participant’s transcription as a measure to ensure participant confidentiality. In addition, the researcher introduced himself, disclosed his experience in both education and behavioral health, and described the lack of power and connection the researcher had regarding each participant’s current position. The interviews were recorded using a laptop, and each interview was transcribed through
a transcription service. A copy of the interview questions can be found in Appendix B as well as earlier in this chapter.

**Data Collection and Analysis**

The interviews were conducted with a laptop acting as a video recorder. Recording interviews allowed for the observation of nonverbal communication, including posture and nonverbal gestures (i.e., hand movement). Each interview, upon its completion, was transcribed and provided to each participant for their review, a process called member-checking (Merriam, 2009). If, during this review, the participant was interested in making alterations to support their intended meaning then they could be made at this time. This additional step is aimed at increasing accuracy and validity of the data gathered. Each participant was allowed two weeks to complete their transcription alterations. Upon the completion of this process and the participant agreeing to the revised transcription, the data were coded for specific themes and patterns. One year after the conclusion of the research, estimated at June 2016, all recordings and transcriptions will be destroyed.

The researcher coded each transcription using the process of open coding. Open coding allows for the data to direct the coding, rather than allowing researchers to direct the coding. The researcher looked for words, phrases, and concepts that recurred throughout the transcripts and highlighted and color-coded them into classified schemes and thematic threads. The data were then divided into general themes related to the literature, theoretical framework, and research questions. This information was
organized using a spreadsheet. The dissertation committee, in addition, reviewed the data collection and analysis procedures, supporting consistency and validity.

Validity is an essential part of every study. The researcher’s intent is to increase validity through evidenced-based and ethical practices. Validity determines accuracy of the findings and reliability means the study can be replicated and be consistent across different researchers (Creswell, 2009, p. 190). To support validity, member checking was used, allowing the participants to review their interview transcription and altering their report to meet their intended account. Finally, throughout the process, the dissertation committee members reviewed the collected data and subsequent analysis and assisted in increasing the reliability within the study.

**Protection of Participants**

Protection of participants is a vital piece of any study. To meet this goal, each stage of the study was monitored and approved by the dissertation chair and committee, along with California State University, Sacramento’s Human Subjects Committee. The researcher interviewed participants from other higher education institutions outside California State University, Sacramento, and their institution’s participation was also approved. All data collected from the participants were kept at the researcher’s home in a locked filing cabinet and will be destroyed one year after the completion of the study, estimated at June 2016. It is the researcher’s goal to not cause harm to the participants, their institutions, and their student bodies.
Participant protection is of particular importance in this study. The population of higher education institution counselors is small, and it would be possible to identify participants given the details of the stories they presented. To meet these concerns, each participant selected their own pseudonym, and pseudonyms were created to represent the name of their behavioral health site and higher education institution. Every participant received a hard copy of the informed consent form (see Appendix C), and each participant provided consent for their participation. Upon completion of their interview, the researcher emailed their transcript and provided the opportunity to expand or alter the original report. The participants were allowed two weeks to respond with comments and/or edits. The consent form denoted that their participation was voluntary and that at any point within the study they could have discontinued their participation. In addition, participants were allowed to not participate in parts of the study if they were not comfortable and could express any concerns they had with any part of the study. Each participant was provided the contact information of the dissertation chair in case the participant did not feel comfortable disclosing their discomfort with the researcher.

Conclusion

This chapter discussed the research design, identifying the study’s phenomenological lens involving exploring the lived experiences of the participants, behavioral health practitioners at higher education institutions. The researcher was the primary tool for collecting and analyzing data. Based on the researcher’s experience in both education and behavioral health, the researcher should be able to respond and adapt
appropriately to the many forms of communication. The study’s theoretical orientation, literature review, and research questions will also act as tools, guiding the study’s 13 interview questions, and the data collection and analysis. Protection of the participants was considered, and providing pseudonyms for both the participant’s name and institution should support their anonymity. Given the small population of behavioral health practitioners at higher education institutions and the sensitive population with which they work, participant anonymity was appropriate. In Chapter 4, the data are presented along with the identification of themes and patterns.
Chapter 4

FINDINGS AND INTERPRETATION

Introduction

The purpose of this study was to explore the role of counselors when they address students with high acute behavioral health symptoms. Data were collected from interviews conducted with six participants, all behavioral health practitioners at higher education institutions currently practicing with the institution’s student body. Each participant was interviewed individually and recorded using a recording device. These recordings were then transcribed using a transcription service. The transcribed interviews were emailed to the participants who were provided two weeks to review the transcription and make alterations to support capturing their intended narrative; this process is known as member checking. The transcriptions were analyzed using open coding, the identification of themes and patterns that emerged and that addressed the following research questions:

1. What role do current preventative measures and interventions have in addressing your student body’s acute behavioral health symptoms?

2. What role does current leadership have in addressing your student body’s acute behavioral health symptoms?

3. What roles do your campus’s climate and culture have in addressing your student body’s behavioral health symptoms?
**Participant Narratives**

Behavioral health practitioners at higher education institutions make up a small community that works with a population that benefits from the confidential policies afforded it. To support this endeavor, participants were notified that their name and institution would remain confidential and pseudonyms would be provided to protect their and their institution’s identities. Table 1 outlines the six participants’ limited demographic information.

Table 1

*Participant Information*

<table>
<thead>
<tr>
<th>Participant (pseudonym)</th>
<th>Gender</th>
<th>Higher Educational Institution (synonym)</th>
<th>Type of Institution</th>
</tr>
</thead>
<tbody>
<tr>
<td>David</td>
<td>M</td>
<td>Stockton College</td>
<td>CSU</td>
</tr>
<tr>
<td>Stacy</td>
<td>F</td>
<td>McClatchy College</td>
<td>Private</td>
</tr>
<tr>
<td>Aldo</td>
<td>M</td>
<td>Broadway College</td>
<td>CSU</td>
</tr>
<tr>
<td>Richard</td>
<td>M</td>
<td>MLK College</td>
<td>Community College</td>
</tr>
<tr>
<td>William</td>
<td>M</td>
<td>Land College</td>
<td>CSU</td>
</tr>
<tr>
<td>Steven</td>
<td>M</td>
<td>Broadway College</td>
<td>CSU</td>
</tr>
</tbody>
</table>

In looking at the participant demographics, a potential limitation is that five of the six participants are male, and four of the six participants are behavioral health clinicians at a California State University (CSU). The researcher explored each research question individually and identified and processed the themes presented by each participant. Each
research question is then summarized along with a brief analysis. A more thorough analysis is presented in Chapter 5, connecting the literature review, the data, and theoretical orientation to future application.

**Research Question One: What current preventative measures and interventions do you use to address your student body’s acute behavioral health symptoms?**

Research question one asked what interventions the counselors used with regard to their ability to deescalate and/or manage crisis and how they address suicide, sexual violence and coercion, and physical violence. In addition, it questioned how practitioners address students with high acute behavioral health symptoms who do not attend their sessions, and the use of developmental and gender theoretical practices were explored. This first question aligns with the research that explores specific interventions that are supportive of addressing high acute behavioral health symptoms in higher education students.

**Counselors employ foundational counseling skills and crisis assessment.** The participants presented an overall balanced approach to addressing student high acute behavioral health symptoms. David and William discussed the importance of foundational counseling practices, and Stacy and Aldo emphasized crisis assessment. David discussed the ability to shift mindsets when a student with high acute behavioral health symptoms came in for a session, emphasizing foundational counseling skills: “empathy, understanding, being able to listen and hear, but being able to communicate well and clearly.” He emphasized the importance of valuing the student for seeking help
and being open to their needs by “making sure they feel heard, they feel valued, they feel respected” and identifying the students’ resources. When working with a student who is experiencing, or engaging in, violence, David attempts to support the student’s processing of thoughts and feelings, specifically the self-beliefs they internalized from the violence. David looks to strengthen the student’s self-esteem and allows the student to express the emotion they may be carrying with them. If the student is a victim of a sexual assault, David attempts to reestablish the student’s locus of control, their trust, their sense of self, their view of sex, and their relationships, including the relationship with the perpetrator. With all students, David supports processing the trauma, the student’s self-validation, and their sense of safety.

William started his discussion with “That’s when you got to be on your ‘A’ game.” William discussed several foundational counseling skills, including being engaged, not overreacting, and remaining vigilant. He discussed the importance of consulting, following up with the student, and being organized, like developing a plan and collaborating, either with the Behavioral Intervention Team (BIT) or the student’s academic advisor. William discussed the importance of providing the student a confidential space for students to process and connecting students with community resources.

Stacy discussed her counseling department’s process for assessing for crisis and psychiatric hospitalization. Stacy often initially refers the student to the Victim Advocate, who explores the student’s legal plan with them. She added that her
The counseling department has a policy related to a potential student psychiatric hospitalization in which every counselor must have a second counselor substantiate the presenting concerns and the initiation of the psychiatric hospitalization. Stacy stated:

My experience is that I will be very direct and open with someone, in the context of course, being empathetic, you know. I’m not judging you for that, but I really want to know straight out, is that [suicidal ideation] that’s happening here?

If the student is not meeting the criteria for the initiation of an involuntary psychiatric hold, Stacy develops a safety plan with the student.

Aldo reported that working with students with high acute behavioral symptoms is not alarming to him due to his previous experience working in a psychiatric hospital. Aldo stated that due to this experience, he can often conduct assessments quickly and determine the risk presented by the student. Aldo also encourages student coordination with their Victim Advocate and assesses for suicide, calling campus police if a student needs to be hospitalized for their psychiatric symptoms. Aldo stated that their campus has a partnership with a local hospital, which helps support the transfer of a student exhibiting high acute behavioral health symptoms. He emphasized the department’s goal of short-term therapy: “bring the person in, stabilize them, give them resources, give them coping skills, and at some point encourage them to start seeking it [outside resources].” Aldo closed with “But again, it’s – of course, we’re not going to turn anybody away either.”

Steven and Richard discussed their students’ responses to the foundational counseling skills and crisis assessment, identifying a notable difference between the
services provided at community colleges and 4-year institutions. Steven discussed his experience with students with chemical dependency, domestic violence relationships, suicidal ideation, and one student with psychotic symptoms. According to Steven, often students are able to respond to treatment, as they come to the higher education institution with a set of coping skills they have used to obtain admission to college. Richard stated he provides the student with support and strategies to manage symptoms during the crisis and then connects the student to community resources for follow-up treatment. Of note are the differences between the practice of Richard, who works at a community college, of referring students with high acute behavioral health symptoms to outside resources and the standard practice of Steven, who works at a 4-year institution, indicating that students have pre-existing coping skills and will respond to their counseling department’s treatment.

The participants’ responses exhibit a noticeable split between providing foundational counseling skills and crisis assessment. Foundational counseling skills included empathizing with the student, active listening, and being a clear communicator. Crisis assessments, by contrast, emphasized direct questioning and identifying the current risk by the student. In addition, Steven and Richard explored the treatment and care a student receives after providing foundational counseling skills and crisis assessment, examining the differences in services provided by community colleges and 4-year institutions.
Foundational counseling skills, including emotional regulation, crisis assessment, safety planning, and providing community referrals, as current practices. David discussed the importance of building rapport and trust and having good communication with students with high acute behavioral health symptoms. He emphasized the importance of these skills and believes “techniques, or an intervention, I feel, diminishes what I do, because I feel like it’s very human, and I’m responding as a human being to another human being.” David identified the importance of a counselor monitoring their tone of voice, word usage, and how the student is responding, both through body language and their level of arousal. David later discussed specific interventions, including the development of a safety plan, and exploring the student’s interest in reporting the incident to the authorities. David reported that he preferred students “leave here feeling like they have a plan,” and “help[s] them feel like they’ve been able to reach a point that they’re a collaborator in the plan that’s going to help them deal with the crisis over time.” David discussed de-escalating the student through breathing/relaxation techniques, positive self-talk, reframing situations, and coping strategies. “I give them permission to stop and slow down . . . adjusting to the person, and their needs.” He reported that he may discuss psychotropic medication with students and refer them to the student health center.

Stacy emphasized earlier points regarding the importance of assessing for crisis, and being both direct and empathetic, adding that she tried to be “an anchor for that person.” Stacy stated that her emphasis, therapeutically, is to re-empower the student,
allowing the student to process freely. Stacy discussed the importance of validating the student’s experiences and coordinating with other service providers. She mentioned the counselors fulfill different expectations than the staff/faculty do; they do not report sexual assaults to the police, which allows the student to have a confidential space.

Aldo discussed his use of meditation, including breathing exercises, conducting crisis assessments, and providing the student with resources and a plan for what to do next. Aldo discussed the importance of maintaining safety in the counseling office. For example, if a couple comes in to the counseling center to work on issues of domestic violence, he sees the couple individually. Aldo emphasized the importance of his counseling department working as a team and supporting each other.

Richard discussed his experience with a student who was self-mutilating and experiencing suicidal ideation. Richard provides an initial crisis assessment, identifying if the student presents with the capacity to problem solve. Richard reported that he attempts to identify whether the student has the capacity to follow up with his referrals, recommendation, and/or intervention. Regarding the student who presented with self-mutilating behaviors and suicidal ideation, Richard referred her to both a women’s support group and the department that supports students with disabilities. If Richard determines that the student cannot follow up with their needs, the student may need to be supported to connect with a higher level of care.

William supports the use of grounding techniques, specifically with panic and anxiety attacks, and also emphasized foundational counseling skills: active listening,
validation, and being present. William discussed “building safety planning for sure, building the support network, giving additional resources where they can call, [and] follow-up counseling.” William discusses with the student that if they do not show for the follow-up session and do not notify him of their absence, he will call the police and have them conduct a welfare check. William stressed the importance of consulting with the student health center and partnering with local hospitals and psychiatric facilities, in the event these higher-level services are required.

Steven initially connects the student with the Victim Advocate. After, Steven helps them process their thoughts and feelings around the violence/trauma, meeting them where they are emotionally. Steven discussed the importance of listening to the student, restating what the student reported, practicing Applied Suicidal Intervention Skills Training, and developing a safety plan. Steven also attempts to refer the student to local community agencies.

The interventions and techniques for students with high acute behavioral health symptoms appear to mirror general counseling practice: provide foundational counseling skills/techniques; assess the student’s symptoms; de-escalate the student’s overwhelmed emotionality/mood if needed; develop a plan with the student, including, if applicable, initiation of an involuntary psychiatric hold; and provide community referrals. While each participant reported a variety of behavioral health techniques and interventions, several fall under the umbrella of emotional regulation. These techniques attempt to
reduce overwhelmed emotions and increase a student’s ability to think through their crisis.

Additional considerations include partnering with local hospitals, including psychiatric hospitals, which may support a more immediate plan if time is a consideration, as William mentioned. As well, William’s practice of discussing with students the possibility of a welfare check may support the student’s awareness of their symptoms as well as intervention for a student experiencing a high level of stress. Another common theme among the participants was the collaboration with a Victim Advocate and the unique position these participants are in with regard to providing confidentiality for students who are victims of sexual assault. Behavioral health practitioners do not fall under Title IX’s requirement that they must report to authorities when their students are victims of sexual violence and coercion. This additional confidentiality allows students a safe place to explore their thoughts and feelings around the incident, including their inclusion of legal authorities.

**Counseling services for students with high acute behavioral health symptoms are voluntary.** In identifying how each participant addresses students who do not attend therapeutic sessions, it was discovered that all candidates allow their students the right, as adults, to determine their level of participation in their behavioral health treatment. David attempts to contact the student and is open to discussing the lack of follow-through with the student, including student beliefs around counseling and the student and counselor relationship. David stated that if the student is not willing to discuss the
matter, “they’re an adult, and they have the right to choose a service or not choose a service.” David continued, “We want to leave it to them, so that they don’t feel that we’re harassing them by calling them, you know, many times, or overdoing the whole idea that we think they need to come in for counseling.” Stacy’s response aligned with David’s, though she added that only if a student is not following the code of conduct can she intervene.

People can be odd, and people can be different, whatever, but it has to be that they have in some way – they’re not following the code of conduct, it might be that they’re a disruption to the community, it might be that they are making their suicidal intentions known, again, which goes back to public safety.

Stacy added, “We don’t do mandated counseling, we’re not the prison system . . . the [counseling] process doesn’t work very well anyway if the person’s not invested.” In response to students who do not voluntarily follow up with behavioral health treatment, Stacy attempts to find an “in” with the student, finding a faculty or staff member who has good rapport with the student to encourage the student to connect with behavioral health treatment.

Aldo emails the student through a secure messaging system and follows up with a phone call if the student does not get in touch. Aldo acknowledged, “most of the time they have more important things to do . . . counseling is not at the top of their list . . . we can’t force anybody to be here.” When students do not attend sessions at Richard’s institution, he often refers students to outside resources, encouraging them to seek out services that may be a better fit. William takes the absence to the BIT and consults with colleagues in the health center. William often initiates a welfare check if the student
presents with high acute symptoms and if attempts to make contact with the students have not worked. This plan is usually reviewed with the student during a session prior to it being initiated. Steven concurred with the other participants, stating that he emails and then calls, and if needed, initiates a welfare check.

There seemed to be a consensus among the participants in that the student has the right to choose whether to attend therapeutic sessions or not; however, if the level of acuity is high enough, the behavioral health practitioner may email, call, or in some cases initiate a welfare check. Stacy and Richard explore a student’s on-campus support system, those who may have an “in” with the student and outside supports, including community behavioral health agencies. When William discussed behavioral health practitioner support, he recommended they consult with staff to strengthen their behavioral health treatment.

**Focus on a student’s high acute behavioral health symptoms rather than on developmental aspects during a crisis assessment.** Each participant discussed the use of developmental models to support their student’s behavioral health treatment, though Stacy was the only one who connected the use of development theory to practice with students with high acute behavioral health symptoms. David discussed how behavioral health symptoms can stunt a student’s development. “We’d want to find out where developmentally, they experienced interference with their normal development and what would be involved in remediating that.” Stacy discussed the need to direct students’ treatment rather than the use of Socratic questioning. “The reality is, some of these are
young people who just don’t have experience, they don’t even know what their choices are.” Stacy recommended providing the student with choices, unless they are experiencing a high acute behavioral health episode. “Then I’m going to be like, no, you have to do what I tell you.” Stacy maintained high acute behavioral health episodes carry with them a level of dysfunction.

Aldo equated developmental aspects with disabilities. He coordinates student care with student disability support departments that assess learning disabilities. Richard includes consideration of developmental aspects in a initial student assessment. William explored “how much maturity they have, from ego strength or other types of readiness to meet their basic needs.” Steven reported, “the principles of dealing with someone who’s in an acute crisis are very similar regardless of where they are at developmentally.”

Steven does not differentiate treatment when conducting an assessment with a student who is presenting high acute behavioral health symptoms, as the primary objective is to keep the student safe. Overall, how participants take developmental aspects into account is unclear due to the varying responses.

**Focus on a student’s high acute behavioral health symptoms rather than on gender aspects during a crisis assessment.** David connected gender to culture and disability and emphasized the need to consider all aspects of the individual. Stacy discussed the importance of acknowledging that if an individual does not “fit the stereotype, that doesn’t mean that’s a dysfunction.” Stacy discussed people’s assumptions and the importance of being aware and challenging your multicultural
competence, challenging societal norms, and “look[ing] at how have you been socialized based on gender, or your gender expression.” Aldo considers gender aspects in every session and, similar to David, ties gender aspects to culture. Richard added that being aware of his own sex and gender and how this may impact the student’s experience, including aspects of power and privilege, is important.

William discussed the on-campus discrimination experienced by women and how that has triggered episodes of internalized sexism, including women emulating traditional masculine ideas. William attempted to develop a women’s support group and partnered with a female staff member on campus; however, the group has not been well attended. Steven discussed domestic violence and the importance of considering safety, but admitted that “it’s [gender] not necessarily one thing that – is the first thing through my mind when someone comes in, in a crisis, is how is this person’s gender impacting it?”

Participants considered gender and development when presented with a student with high acute behavioral health symptoms similarly. While gender is a consideration, it would not be the initial focus of treatment. Treatment would primarily be focused on the acute symptoms and the need to increase the student’s safety. All participants connected gender to multicultural competence.

**Summary.** The current behavioral health preventative measures and interventions participants use to address their student body’s acute behavioral health symptoms are not widely different from those practiced in the community. The participants used foundational counseling techniques (e.g., active listening, validation,
and empathy) throughout their work with the student body. They assess students’ behavioral health symptoms and identify the level of service-need for which the student meets the criteria. If the student meets the criteria for an involuntary psychiatric hospitalization, the participants recommend initiating the involuntary hold. Conversely, if the student does not meet the criteria, a safety plan should be developed; in either case, the student should receive appropriate campus and community referrals. Follow-up care is encouraged by the participants, and participants may engage in plans to support student follow-up (e.g., welfare checks); however, students are adults and are provided personal freedom with regard to their continued therapeutic treatment. During this process, the participants identified developmental and gender aspects as minimal considerations, and appear to connect these considerations to multicultural practices and tied to the initial assessment process, not the crisis assessment. Figure 6 summarizes the data presented for Research Question 1. The figure is a representation of the participants’ perspectives on the current crisis assessment practice at higher educational institutions. Developmental theory and multicultural perspectives were not significant considerations for the participants during a crisis.
Figure 6. Plan for assessing students with high acute behavioral health symptoms.

**Research Question Two: What role does current leadership have in addressing your student body’s acute behavioral health symptoms?**

Research Question 2 asked about the relationship between the counselors and their leadership, emphasizing the counseling department’s culture and promoted goals and values and how this relationship affects the therapeutic practice. This second question aimed to add context to the first question, bridging the relationships between student and counselor (highlighted in question one) and counselor and leadership (highlighted in question two). This bridging was in support of systemic principles that emphasize the importance of exploring both top-down and down-up relationships. Listed
below are several themes and patterns that developed from analyzing the transcribed interviews.

**Leadership emphasizes multicultural sensitivity/competence.** All participants discussed their leaders’ emphasis on providing culturally appropriate care to the student body except for Aldo and Steven, the two participants from Broadway College. Steven discussed cultural sensitivity in the context of not making assumptions, with the emphasis placed on the counseling department conducting a thorough assessment with each student. Stacy identified cultural competence as one of the counseling department’s “biggest values that we promote and I think, really, enact.” Stacy added, “really the value of the center is you’ll see that multicultural competence is really weaved into pretty much everything we do.” Stacy discussed her campus’s diverse student body and the relationship her department has with the American Psychiatric Association as reasons for her department’s emphasis.

Richard also discussed his campus’s diversity in that “being culturally competent is important, that’s the goal is that, you know, we’re all general counselors, but we’re also aware that our institution has a student demographic that is very different.” William also strongly emphasized his department’s focus on multicultural competence, adding descriptors including *equity, inclusivity, social justice, unity,* and stating that these values are emphasized in the department’s updated policies and procedures. William added that his department emphasizes workshops that support inclusiveness, tolerance, and care, and has goals/ideas around supporting women, underserved/underrepresented minority
groups, and the LGBT community. All four participants who shared the leadership’s emphasis on multicultural sensitivity/competence connected their statements to their student body and exhibited an increase in tone of voice when presenting these values.

**Leadership also emphasizes academics.** In contrast, Aldo, Steven, and Richard discussed leadership’s emphasis of academics when they work with students with high acute behavioral health symptoms. Aldo stated:

> Our goal as the counseling department is to serve our students in the best way possible so that they’re able to, again – and the way I personally think about my job in here is to make sure my students are able to do their job once they get out of the office. So whatever’s going to keep them concentrated on their studies... Ultimately without the students, without them doing their schoolwork there’s really no point in us being here. So we’re all really pretty clear on our goal is to support them whatever they need.

Richard started his narrative stating, “we really focus on the academic part, and it’s really about access to student success, so we are also facilitators of student success.” Steven added:

> I think our goals, our values are to really support the students to get through school, to meet the challenges they’re having and get over the barriers that they are facing. One of the underlying goals is I think helping student succeed in school and we’ve provided support for that but staying in school is not always the best option for every student and supporting them in that decision. Generally we want people to succeed at school and graduate, that’s the over-arching.

There appears to be a stark contrast between the participants who reported their leaders’ values tied to multicultural sensitivity/competence and those who tied them to academics. While each institution represented in this study supports multicultural sensitivity/competence and academic success, it would be an important insight to identify
how this particular emphasis impacts the treatment of their students with high acute behavioral health needs.

**Leadership is tied to resources.** David, Aldo, Richard, William, and Steven all tied leadership’s interests to what resources their department had. David connected leadership to the allocation of money to his counseling center and that what the leadership communicates is a reflection of what they believe “the needs of the campus are.” David continued, stating that the counseling department is affected by the leaders’ messages, specifically looking at the department’s relationship with the larger campus. David stated:

> The culture of the counseling center can be affected by leaders in ways that could potentially cause negativity if we don’t feel appreciated, or valued, or funded, if we let people know about kinds of severity of symptoms that some students are dealing with, but it doesn’t seem to be heard or accounted for adequately, and there could be demoralization. I feel like there was a period when I don’t think we were as valued as we could be, and the budget cuts really were hampering us, also in addition to the kind of mood, and the way the culture was being focused on.

Aldo and Richard also connected the leadership’s focus on the allocation of resources, noting that for their respective counseling departments, training was emphasized. When asked about how this allocation translates to his work with students with high acute behavioral health symptoms, Aldo stated, “In terms of leadership they’re always really good about encouraging us to – they’re like if you see a training you want, if you see something you want to specialize in we have full range to do whatever we want.” Richard also discussed training stating that their leadership:
has been pretty much following the trends of what has been happening statewide, you know? And nationally, too, especially, you know, what happened at Virginia Tech, at LSU, and other places. We actually had a mock situation where we had an active shooter reenactment, and how we’d respond if someone came in threatening to shoot folks, how we would handle that situation, and emergency procedures, and what not. That’s coming down from district leadership, our chief of police, as far as our – and as well as our deans and vice presidents. So this is something that we’re actually not just in counseling but overall, as a campus are looking at trying to train folks to be aware of our surroundings, aware of safety, aware of what to do in an event something like this were to happen.

William and Steven emphasized resources provided to their departments as well, with both of them discussing the services. William discussed his department’s services, “supporting the after-hours line, protecting my walk-in hour,” and when discussing how leadership supported the student body during a crisis, “bringing in other counselors and providing budgetary support for them in those cases.” William added that when the extra counselors were removed rather quickly after the crisis, he had felt the support was “quite limited in my estimation.” William also discussed his counseling department’s leader’s not being included in many of the leadership groups on campus and, as a result, his counseling department does not have “as large a voice compared to other schools.”

Steven discussed his department’s urgent care and how leadership supports “an environment in which we stress the importance of always being able to see a student with highly acute needs timely.” Conversely, Steven added that leadership has emphasized short-term therapy, and that this may impact a student with acute behavioral health symptoms. “One way you can look at it is potentially being negative is that we’ve chosen the model of therapeutic shorter term therapy.” Steven also stated, “acute [symptoms] need I think, can last a few months and that can still be acute given the
person’s lifetime history and we are not really set up to see people for months on end.”

Steven reported that if a student’s “needs” are too demanding, it puts him in a

position of referring people with acute needs or maybe more severe needs out into
the community and that’s something that I guess is decided partly by the powers
that be, partly by the fact that we have a greater need and we can really
accommodate.

Leadership influence counselors and their departments through mission messages,
communication, and financial allocation of resources. The participants noted trainings
and services were critical, though David’s discussion around the meta-communication
received is an important takeaway as well. Steven’s statement around the restructuring of
the counseling services offered, focusing on shorter-term therapy and transferring of
students to community resources when students are too acute as a decision by the
“powers that be, partly by the fact that we have a greater need than we can really
accommodate,” emphasizes a disconnect between behavioral health practitioner and
leadership. It would also be interesting to note that the participants’ interest in additional
resources often was due to interest in offering additional support and services to their
student body; there was no mention of the participants’ salary.

Leadership emphasizes the practice of soft skills. The final theme related to
Research Question 2 relates to leadership’s emphasis on behavioral health clinicians’
practice of soft skills with their clients, as discussed by all participants. The values
associated with each participant’s behavioral health program are organized in Table 2.
Table 2

Values Emphasized by Counseling Department Leaders

<table>
<thead>
<tr>
<th>Participant</th>
<th>Soft skills presented</th>
</tr>
</thead>
<tbody>
<tr>
<td>David</td>
<td>David discussed his counseling department having a “team” mentality, being respectful to everyone, respectful of differences, as well as commonalities. David discussed the importance of valuing openness, transparency, valuing human capability. David discussed the value of having knowledge of the field, empathy, perceptiveness, relational acceptance “of students and the difficulties they come in with.” David’s department supports a collaborative relationship with the student/client, sharing an equal partnership in treatment.</td>
</tr>
<tr>
<td>Stacy</td>
<td>Stacy discussed the importance of acknowledging that students may not possess resources, including financial constraints and transportation, and that this may be a challenge when referring a student out. As well, students may not be familiar with therapy, and the importance of providing understanding. Stacy added that they value every individual and offer an open and welcoming environment.</td>
</tr>
<tr>
<td>Aldo</td>
<td>Aldo discussed overall wellness, and that his department supports their students’ overall health, including nutrition, sleep habits, mental health, and physical health, with cross-promoting with nutrition and physical health.</td>
</tr>
<tr>
<td>Richard</td>
<td>Richard discussed the importance of assessing and listening, providing support, but also identifying if they have access to other supports, assisting with information, motivation, and providing a safe space.</td>
</tr>
<tr>
<td>William</td>
<td>William discussed professionalism in the context of how the counseling services they receive can serve their career, their ability to cope, maintaining healthy relationships with family, and building a global perspective. William was also open about rapport, and how he may present to his students, being “someone of white male, heterosexual, married, kids, bringing my identities, so I try to self-disclose as a way to just be open and honest and talk about things.”</td>
</tr>
<tr>
<td>Steven</td>
<td>Steven discussed leadership’s values are shaped by the staff, by the people who go into the counseling field, “compassion,” and “caring.”</td>
</tr>
</tbody>
</table>
It is interesting to note the overlap of the participants’ descriptions of the values shared in their counseling departments. Several of the values shared connect with foundational counseling beliefs as well as with providing excellent customer service.

**Summary.** In assessing the role of current leadership in addressing the student body’s acute behavioral health symptoms, there appear to be two sides, counseling and academics. Participants who emphasized the counseling side, discussed multicultural competence/sensitivity, and the participants who emphasized academics discussed the importance of supporting the students’ behavioral health so they may return to the academic baselines. The participants also connected leadership with resources and soft skills. The participants see leadership from a top-down perspective, which supports a divide between the counselor and leadership. Figure 7 is a visual summary of the data collected for this research question and illustrates how leadership may view counseling departments in higher education institutions. It may offer a perspective that allows leadership to visualize the balance that should exist between academic and behavioral health, accounting for how the goals and practices are similar, despite the differences in language and culture.
Research Question Three: What roles do your campus’s climate and culture have in addressing your student body’s behavioral health symptoms?

Research Question 3 questioned the relationship between higher education institutional counselors and their campus, focusing on budget, policy, and their student body, including access to their behavioral health programs. Also explored was the potential ripple effect that may exist when students exhibit high acute behavioral health symptoms on campus. The aim of these questions was to connect relationships discussed in the previous two research questions, counselor and student/client (research question one) and counselor and leadership (research question two), with that in this research question: counselor and higher education campus.


**Relationships outside the counseling department are outreach.** All participants except Richard described their relationships with their campus as outreach opportunities. David defined the institution’s counseling department’s relationship with the campus as how students connect to the campus counseling services. David identified word-of-mouth, students informing other students, and outreach as the main connectors. In addition, David stated that he presented in classrooms; conducted workshops and new faculty orientation; and connected with faculty departments, residence halls, the student health center, and disability resource services. Stacy also immediately discussed her rapport with “our student life partners, you know, that’s always important because that way we get a lot of referrals from different folks that they help students get here who wouldn’t necessarily otherwise.” Stacy discussed her outreach, getting in front of students and faculty, noting the challenges of keeping adjunct faculty informed and supporting students’ awareness that they can receive counseling services at their college campus. Aldo identified his department’s relationship with the larger campus as “open,” “the entire campus is very receptive to our services, we have people that are constantly seeking us out to come out and provide trainings for students.”

William provides outreach by sitting on several committees and councils, consulting, training resident assistants, collaborating with the international students department, and having “informal consultations with faculty members, staff members, [and] our behavioral intervention team.” William added that he “consult[s] medically with the health providers here dealing with patients who have anxiety or other types of
stress-related concerns. I consult with disability services related to ADHD and other type of [disabilities], mental-health related.” Steven also tied his connection with the campus to the outreach he provides, “We do trainings, we do like two-day Assist trainings for students, faculty, staff, which (Assist) is like suicide prevention staff.” Steven added, “Frequently, we’ll go to classrooms and do talks on stress management, for beginning students in particular. We are trying to get our name out there as much as we can, but as you know with counseling, there’s stigma with it still.” Steven explored his “liaison-relationships” with multiple departments and how the department attempts to attend campus events, including freshman seminars, programs that support the underserved, and residence hall staff and students.

Behavioral health practitioners at higher education institutions connect their relationships with the larger campus as opportunities for outreach. This may be an emphasis for several reasons, including political (e.g., increasing numbers that indicate service-need on the campus) and altruistic (e.g., providing students awareness of a possible support). In addition, the participants identified tasks such as consultation, trainings conducted, and participating in councils under the umbrella of outreach.

Not much experience working through the effects of behavioral health crises. Every participant except William and Steven presented scenarios or examples of how to intervene with students with high acute behavioral health symptoms rather than offering first-hand accounts. David discussed students’ concerns when they see another student distressed, especially in the residence halls, or when professors observe their students’
distress through schoolwork or office hours. Stacy discussed the fear experienced when a student exhibits high acute behavioral health symptoms, impacting the student’s roommates, friends, professors, and staff. Stacy believes the stigma surrounding individuals with behavioral health challenges increases people’s anxiety. “Most of the time, whenever it’s somebody who has done something awful, and they try to link that to, oh, they had some, you know, challenges with their mental health, then it makes people anxious.” Stacy identified people’s desires to do the right thing in these encounters but their uncertainty of the correct action may lead to increased aggravation.

The next two participants did not identify larger campus challenges related to students with high acute behavioral health symptoms. Aldo stated:

I’ve seen very little of the high acuity stuff, in terms of a single crisis since I’ve been here, I don’t think one time. So in term of how it affects the campus culture, if it does it would be under – not something you actually see, I don’t think.

Richard discussed their counseling department’s being a safe place, “We primarily do academic kind of counseling, but we are all trained in personal – in counseling. Our job in that respect is to really refer students to community resources that are available to them.” Richard continued, “I don’t think it really has a significant effect, I mean, it has, I mean, it’s affected – there has been cases of faculty – instructional faculty being affected.”

William and Steven both discussed direct experiences related to crises at their higher education institutions, with different perspectives. William, in discussing a suicide that occurred at his campus reported, “There was high use of the services, there
was high use of the walk-in services, there were presentation of suicidal thoughts and copycat behavior feelings.” William further discussed the incident of copycat behavior and additional threats to self and others, which he added had an additional impact on the campus at large. It “creates this, just an impact of emotional instability, mental instability, increased stress, lack of perception of lower support when you feel like others are going through and not being able to handle their stuff, so to speak.” William also stated that even some faculty and staff have a

deer in the headlights look. . . . even on the Behavior Intervention Team, folks were familiar with some of this, not knowing how to respond in a crisis, and I just see that as a lack of practice or experience as well as a denial within the culture around dealing with real stuff that students are dealing with.

William went on about the campus culture, stating, “people just aren’t comfortable confronting the emotional reality of the stress and struggle that young people are under today.” William, in exploring this incident, appeared to be identifying a significant ripple effect of a crisis. In addition to a higher service-need within the counseling department, there was an underlying emotional instability from the student body to the faculty.

Steven discussed a suicide that occurred on his campus, noting the effects were most noticeable in the students’ classrooms; a behavioral health practitioner went to the class to introduce their services and how they could be supportive. Steven stated that the behavioral health practitioner will support dialogue and awareness; however:

I don’t know if I can say it affects the culture at large, I think again there’s just still so much stigma, there’s still so much hush-hush around behavioral health issues and on psychiatric issues that I think a lot of it gets muted.
The crisis presented by Steven appears to have been limited to the student’s classroom and did not appear to impact the larger campus.

The participants’ experiences with crisis due to students’ high acute behavioral health symptoms appears to be limited. Potential reasons for the participants’ lack of experience may include behavioral health stigma, leading students to seek support from their friends and family, or the infrequent exhibition of these behaviors/symptoms for these participants.

**Students with high acute behavioral health symptoms not receiving treatment that meets acute service-needs.** David discussed access for students with high acute behavioral health symptoms, noting that he has students complete an intake “so we could assess if someone was in serious need.” David stated that this process is part of their counseling department’s policy; however, David is concerned that students may “not say that it’s urgent.” David reported that through Prop 63, the Mental Health Services Act, he was able to secure a grant earmarked for behavioral health projects. This grant funded a peer project along with suicide prevention activities. Students were hired to act as peer educators, going to classrooms, showing videos, conducting workshops, facilitating discussion groups, and being available for individual education consultation. David reported their purpose “was to provide information about mental health issues, and to help de-stigmatize mental health symptoms, and mental health services.”
Stacy outlined her institution’s plan for when students exhibit high acute behavioral health symptoms on campus, outside the counseling department:

1) Call to the campus public safety department because “they are actual peace officers.”

2) The officers will assess the student for “imminent danger,” and if the counseling department is open, the officers will bring the student to the counseling department for “confirmation or opinion.”

3) The peace officers will transport the student to a behavioral health hospital if needed.

Stacy’s plan aligns with what is expected if a member of the public exhibits high acute behavioral health symptoms within the community.

Aldo also started off with the ease of access to services, stating that students with high acute behavioral health symptoms have access to their campus health center, and can walk in when it is open. If the student presents themselves as too acute they will refer the student to their primary care physician or a hospital “once they reach a certain level there’s limitations here within – since we don’t have a psychiatrist on staff.” This is in stark contrast to his colleague Steven who reported that his department prioritizes students with high acute behavioral health symptoms. Steven stated that his department offers a counselor available five days, 40 hours a week, that meets with students with acute behavioral health needs. Steven identified this service as a luxury given that often
counselors are booked. Though “if someone contacts us and it seems like they are in a more acute need, we obviously, we definitely bump them in the list and we get them in.”

Similarly to Aldo, Richard’s campus also does not provide treatment to students with high acute behavioral health symptoms. “We really don’t have any of that, we don’t have any behavioral health type of services here. If there’s specific type of issues that come up, we provide referrals.” Richard was quite open when discussing the differences between the community college system and that of 4-year institutions:

We haven’t really equipped ourselves with the type of mental health services that you would get at a 4-year university in psych services, where you have clinicians working on campus, or maybe a clinician that works onsite, say, at a health center providing that type of mental health service, we just, you know, community colleges don’t provide that.

William’s counseling department offers a walk-in hour each day to help facilitate care for students with high acute needs and has an after-hours line that can connect a student to a health professional “who can provide mental and physical intervention and support over the phone.” William added the importance of having a campus presence, “So they know where we are, they know who I am, I try to make myself high profile, like I said, consultation, guest speaking, guest lecturing, etcetera, small campus helps get my face around.”

Several ideas were presented for assessing students’ behavioral health symptoms, including providing an intake, providing a counselor dedicated to serving students who come in with acute needs (triaging), a dedicated walk-in time, an after-hours phone line to support both mental and physical health of a student, and having peace officers assess
students on the campus. After this initial assessment, if the student presents themselves as too acute for the counseling department’s services, the student is referred out either to a physician, emergency room, or psychiatric facility. Richard emphasized that they do not provide even these initial services. Other participants discussed additional practices (e.g., peer educators) that include de-stigmatizing behavioral health, making students aware of services, and providing education that support general accessibility to counseling departments. Such practices do not address the high acute behavioral health students’ needs.

**Budget equals more staff.** All participants, except William, discussed budgetary constraints, with three participants specifically discussing the need for a psychiatrist on staff to support students with high acute behavioral health symptoms. William stated that there is a gross need for psychiatrists in their institution’s county: “the available psychiatric appointments are so far and few between, it's a real problem.” David identified the main impact the budget has on serving students with high acute behavioral health symptoms regards staff numbers. “If we had a bigger budget, we’d have more staff.” David reported that more staff would reduce the wait time for students with high acute behavioral health symptoms. David also noted an interest in having a group room and a free-standing counseling center to increase confidentiality. David also would like to have a psychiatrist on staff. Currently, if the health center refers a student to an outside psychiatrist, the health center will pay for the service. David shared, “Well actually, if it [the referral] goes through the student health center, the student, it will be
funded through the health center, not by the student.” Stacy stated that with additional budgetary support, she would like to bring in peer educators and have a secure server and a case manager who would be able to follow up with clients and be a bridge for the student to community supports. Stacy acknowledged that these additional supports would not be specifically supportive of students with high acute behavioral health symptoms. “The budget, it doesn’t allow us to do a number of things, but I don’t think it’s specifically based on high acuity [students].” Stacy, like David, stated that she would like to add a psychiatrist to her counseling department who would provide students with high acute behavioral health symptoms more direct care at the institution. Aldo shared David’s and Stacy’s beliefs that adding a psychiatrist would benefit students with high acute behavioral health symptoms.

Richard discussed the need for additional staff, stating that when the budgetary shortfall occurred, there was “a critical mass of students coming in with limited resources already.” William discussed several resources allocated to him that support his work with students with high acute behavioral health symptoms: professional development, conferences, trainings, materials, mental health screenings, after-hours line (a phone service that brings mental and physical health support to students on a 24-hour basis), and peer health educators. William did not identify any additional program needs. But Steven stated:

We need more counselors, I think we need more space, and I think there is a ripple effect for the folks who have high acute needs, like I said, we are all so jam packed with people and there is a wait list.
Steven also believes additional budgetary support would help with outreach because students with high acute behavioral health needs may not seek out services. “They know they’re not going to get more than maybe a short handful of sessions, or maybe have heard that there is a waitlist and they get dissuaded.”

All participants, except William, reported a need for additional staff as part of their counseling department. Psychiatrists was the most reported need, even when the participants mentioned that their counseling programs offer referrals or have a health center staff that prescribes a tightly controlled level of psychotropic medications. Also noteworthy was the consistent connection between a department’s budget and available resources.

**Little concern for HIPAA/FERPA.** All six participants expressed limited concern over either HIPPA or FERPA. David expressed more concern with laws governing confidentiality and behavioral health treatment than either HIPAA or FERPA:

> It’s good for us to know about HIPAA and be aware of HIPAA, but legally, we’re not a HIPAA covered entity. Our records of medical treatment, to my understanding, are exempt from FERPA unless we share them with someone who’s not directly responsible for treating them.

David identified primary concerns related to ethical behavioral health treatment, supporting the client’s understanding of their treatment, informed consent, and their therapeutic goals. Stacy shared similar ideas, stating, “We do follow HIPAA standards, I mean, we certainly aren’t, we don’t do any billing in the ways that some others might.”

Stacy, like David, emphasized confidentiality:
I’m not willing to lose my license in order to have this conversation with you or whatever, you know, share this information that you think you should have. And particularly when, you know, it’s just a matter of does the student/client have – do they give their permission for that information to be shared or not? I think an awful lot of times, people think oh, you just possibly can’t – you can’t say anything at all, and I try to remind people, there are two really easy options. First is you could actually talk to the person, you know? There’s an idea. If they give their permission, then we can certainly share information or help facilitate the conversation, or whatever is the best thing. But if they say no, then the answer is no. Until and unless they become a danger to themselves or someone else.

Aldo mirrored the previous two participants:

HIPAA, not so much. The FERPA one, that’s one we’ve recently had some discussions about, that, to where understanding that our mental health records are not part of the FERPA. So in terms of how has it impacted my specific treatment with the students, doesn’t seem to be any impact that I can think of off the top of my head.

Richard, when asked about HIPAA/FERPA, reported, “It really hasn’t been a big issue, I mean, I think we’re pretty much clear about policies.” Richard also transitioned the discussion to confidentiality:

If an issue comes up where we have to release information, especially when it comes to threatening situations, where a student is threatened, or there’s abuse, I mean, we’ve had trainings on child abuse around reporting, and we’re mandated reporters.

William reframed the challenges to HIPAA and FERPA, discussing the frustrations of others unfamiliar with HIPAA and FERPA who expect to receive confidential information. Aldo stated that it can be frustrating explaining privacy and confidentiality to those who are unfamiliar with the policies. Steven was concern that:

If I had a student who had high acute needs and who’s family and support system was really important in their treatment but if they didn’t give or release the information obviously then I can’t talk. I’ve been lucky, whenever I’ve had
someone who does have a higher acute need, I’ve had them sign release information, [and] they’ve always been willing.

The data suggest that HIPAA and FERPA are not concerns of behavioral health practitioners at higher education institutions. Steven brought up a conundrum mentioned in the literature in that in the event of a crisis, the inability to secure a release of information could delay a reaction or keep intervention from being initiated altogether. The participants expressed more concern over confidentiality and disclosing students’ confidential information.

**Summary.** There is limited connection between campus climate and culture and addressing students with high acute behavioral health needs. The participants’ connection with the larger campus appears to be through outreach and interventions that act as preventative measures: psychoeducation, trainings, and awareness around behavioral health. This lack of connection may stem from a lack of first-hand crisis episodes with students with high acute behavioral health symptoms. Due to the focus on preventative measures and behavioral health supports that assist the whole student body, students with high acute behavioral health symptoms may not be receiving the attention necessary to support their treatment and care.

Several themes were identified, including outreach, increased staff, and assessment, which may benefit students with high acute behavioral health symptoms; however, it appears the common practice of the participants is to refer the student to the community where a higher level of care can be provided. Figure 8 summarizes the data related to Research Question 3. The diagram connects to the literature and the idea of a
multi-level approach to behavioral health intervention: prevention, intervention, and reactionary, or crisis, management. Of the six participants, only Stacy and William discussed the use of a BIT, which would leave the other participants without intervention for a student presenting with high acute behavioral health needs or a crisis.

*Figure 8. Summary of participant counseling department’s behavioral health treatment.*

**Other Findings**

Throughout the data analysis process, several additional ideas and beliefs were presented. While not falling under the umbrella of the previously mentioned research questions, their presence is accounted for in this section. The data presented in this section are outliers or exceptions that may have been shared by one or two participants; however, the researcher identified the idea or value as profound. It is important to
acknowledge the researcher’s bias with the presumption of “profoundness,” and what the researcher has identified as profound may not be so by others.

**Incongruence in Service and Service-Need**

David reported that the number of students being served has increased over the last five years, along with the number of students in crisis being served. Despite this increase in service-need, David’s counseling department had to decrease services, as behavioral health practitioners were laid off due to budget cuts. These positions were eventually refilled, though the challenge exists of providing a level of care to a student body that is exhibiting a greater need for the service when the budget is not designed for the presenting need. This dynamic is shared by most campus departments, though these particular services at some point may directly impact campus safety and a student’s health and welfare and have a dramatic ripple effect throughout the campus.

**Eating Disorders**

Stacy discussed the challenge in serving students with eating disorders. “If you send someone to the hospital because you say oh my goodness, they haven’t eaten in three days, well, guess what? They’re going to send them right back.” Individuals with eating disorders often do not meet the criteria for an involuntary hold unless they are actively reporting that their not-eating is an attempt to commit suicide or their lack of eating has initiated an onset of acute psychotic or medical symptoms. Students with acute eating disorders may fall in the proverbial “cracks,” as they may only qualify for treatment-specific care if they have private insurance or a higher education institution has
provided training to a counselor (Aldo discussed this training being offered through his counseling department) to conduct this specialized treatment.

**Holistic Care**

Aldo discussed at length his counseling department’s values, particularly the intent of the campus to support the student’s overall health. Aldo was the only participant to discuss this level of holistic care. William discussed consulting and collaborating with his campus’s health center, but did not specifically describe it as a value. Aldo’s discussion included a desire to support the student’s nutrition, sleep, mental and physical health, and the use of the campus’s gym. This holistic view would appear to support the student more than provide an exclusive behavioral health service; though there may be a separation from other counseling departments due to the level of confidentiality necessary to protect students.

**Community College Access Creates Need for Services**

Richard discussed the challenges with being an open-access campus, with “no specific criteria for admission to community colleges, it’s pretty much open to anybody, and oftentimes we can get individuals that have mental health issues.” Richard went on to report:

You’re looking at maybe folks with a socioeconomic background that maybe don’t have access to mental health care, you may find that here at community colleges where the irony is that this may be the population that would probably have the most need versus maybe a four-year institution.

This is in line with Steven’s comment when discussing the students at his institution and how they respond after discharge from a psychiatric hospital:
Most people I think come out and could, stable for quite a while, because they usually have a decent amount of coping skills being that they are here at university; they’re succeeding at a particular level of life, they’ve developed some skills to be able to deal with it.

Richard raised an interesting point; the students at a community college may be experiencing increased psychosocial stressors, decreased access to appropriate (mental) health care while these services, which may be accommodations necessary for them to succeed, are not available to them.

“Future-Culture”

William discussed “professionalism” as a consideration he makes in his counseling practice. William attempts to connect the therapeutic work he does alongside his students to their career, to times in their lives when they may feel isolated and need to cope, maintain healthy relationships, and perform at their best. The term “future-culture” was used to describe what William was supporting in his students through their work together. This focus on a students’/clients’ future is not a new practice for behavioral health practitioners, though it was unique in the participants’ reports, and students at higher education institutions may benefit from language and behavioral health treatment that promotes their future-culture.

Chemical Dependence

Steven discussed his work with students with “high risk substance abuse and dependence, methamphetamine, that type of thing, heroine.” Similar to Stacy’s students experiencing eating disorders, students who abuse drugs and/or alcohol rarely meet the criteria for an involuntary psychiatric hold and are left to the limited services available to
them in the community. For students who may not have the financial capacity, time or private insurance to secure chemical dependency treatment, they may rely solely on services provided to them by their higher education institution. Students with chemical dependency challenges is a population that higher education institutions may need to account for, as this potential barrier has consistently been linked to higher education students. Though, like with an eating disorder, higher education institutions must decipher which specific populations may necessitate additional training/consultation and which do not.

**Conclusion**

This chapter analyzed the collected data with the intent of answering the research questions and building understanding and awareness from the participant narratives. The participants discussed their experiences as behavioral health practitioners in higher education institutions, as well as shared their perspectives and insights on the current climate and culture within their counseling department and higher education institution. Their reports were analyzed using an open-coding practice, which allowed for the data to direct more of the presenting findings. Much of what was learned from the data revealed gaps between academic and counseling cultures, an emphasis on preventative interventions, and conversely, inconsistent messages around treatment for students with high acute behavioral health symptoms. As well, there is a resistance that exists in terms of addressing current behavioral health challenges, possibly triggered by behavioral health stigma within the larger community, faculty/staff, and students. This challenge is
exacerbated by the likelihood that these individuals are often the initial contact to the student exhibiting high acute behavioral health symptoms. There is a strong desire to provide these students further support and a large breadth of ideas, from providing psychiatric care, partnering with local hospitals, referring to local counseling agencies, to having an after-hours line that can assess both students’ physical and mental health (see Figure 9).

Figure 9. Connecting the participant counseling department’s treatment with tier-delivered service.

The figure attempts to combine the findings of all three research questions and is explored further in Chapter 5 as a possible application for current counseling practices at higher education institutions.

The next chapter interprets the data, connecting the data to the literature and theoretical orientations. The chapter uses this analysis for the development of a new model related to providing behavioral health treatment to students with high acute
behavioral health symptoms. Future research and recommendations are discussed, followed by the final reflections of the author. Chapter 5 is aimed at improving the relationships among students with high acute behavioral health symptoms, behavioral health practitioners, higher education institution behavioral health departments, the larger campuses, and their surrounding communities.
Chapter 5

INTERPRETATION OF FINDINGS, RECOMMENDATIONS, AND CONCLUSION

Overview of Study

Higher education institutions are experiencing an increase in behavioral health service-need, both for the amount of service and the severity of symptoms presented, for their student population (Benton et al., 2003). Higher education institutions are transitioning from responding to the relational and developmental challenges to responding to anxiety, depression, suicidal ideation, and personality disorders in their student body (Benton et al., 2003). Despite this increase in service-need, higher education counseling departments have transitioned to briefer models of psychotherapy, including solution-focused or client-centered theoretical models, group counseling, peer counseling, and increased use of psychotropic medication (Benton et al., 2003). During this time, violent episodes, both self-directed and toward others have been increasing at higher education institutions, including deadly shootings at UC Santa Barbara and Virginia Tech (Dillon et al., 2014). Higher education institutions are also experiencing a transition and legally assuming more responsibility for student safety. The case of Shin v. MIT (2006) identified MIT as “failing to prevent her [Elizabeth Shin] death,” after Elizabeth committed suicide. This case acted as a first domino in increasing litigation and liability against higher education institutions.

In addition to these challenges, several policies have increased protections for students with high acute behavioral health symptoms. Section 504 of the Rehabilitation
Act of 1973 and the Americans with Disabilities Act of 1990 prohibit discrimination against individuals with disabilities, including students with a behavioral health diagnosis (Benton & Benton, 2006). This protection provides additional access to students with behavioral health symptoms (Benton & Benton, 2006). The Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the Family Education Rights and Privacy Act of 1974 are policies that support higher education students’ confidentiality, specifically as it relates to their education and medical records. Oftentimes, however, students, families, and staff/faculty have identified these policies as detriments to coordinating and collaborating supports, particularly during times of crisis (Benton & Benton, 2006).

Given the barriers presented, three research questions were developed attempting to explore the multiple facets of the presenting challenges.

1. What current preventative measures and interventions do you use to address your student body’s acute behavioral health symptoms?
2. What role does current leadership have in addressing your student body’s acute behavioral health symptoms?
3. What roles do your campus’s climate and culture have in addressing your student body’s behavioral health symptoms?

The study focused on behavioral health practitioners serving at higher education institutions and how they are addressing high acute behavioral health symptoms in their student body. To meet this task, a qualitative study was conducted, with interviews from
six participants, using a phenomenological lens. Phenomenology allowed for the participants’ stories to be extracted.

Systems theory was the foundational theoretical lens used, as it is most conducive to the higher education culture and accounts for the multiple systems for which higher education campuses must account (Bess & Dee, 2008a). Systems theory focuses on the relationships within a system, between a system, and outside the system. It looks at the transfer of energy from one system to another and how the energy affects these systems after this transfer. The resultant affect is observed/monitored and helps inform future action, a process known as feedback. This feedback can then strengthen the relationships between the systems and the transfer of energy, thus increasing efficiency throughout the system.

This study attempts to reduce the gap in the research, focusing primarily on the counselors’ perspectives and insights into how they are experiencing students with high acute behavioral health symptoms on their campus. The study will support the development of policy, leadership, and counseling practice within higher education counseling departments.

**Interpretation of Findings**

This section summarizes and interprets the findings identified in Chapter 4. The research questions are presented, followed by a summary of the related findings, and then a correlation of the findings with the literature and theoretical orientation.
Research Question One: What current preventative measures and interventions do you use to address your student body’s acute behavioral health symptoms?

The participants’ responses provided significant data as they related to Research Question 1. The participants emphasized both foundational counseling skills and conducting crisis assessments in their counseling practice with students with high acute behavioral health symptoms. The foundational counseling skills discussed include: providing empathy and understanding, building rapport and trust, being engaged and vigilant, and valuing the student for seeking help, “making sure they feel heard, they feel valued, they feel respected” (David). The participants discussed providing their students with de-escalation and grounding interventions and identifying/building a student’s support network. During crisis assessments, the importance of being “direct and open” was discussed as well as the development of a safety plan, particularly if the behavioral health practitioner was not going to initiate an involuntary psychiatric hold.

My experience is that I will be very direct and open with someone, in the context of course, being empathetic, you know, I’m not judging you for that, but I really want to know straight out, is that [suicidal ideation] what’s happening here. (Stacy)

Additional considerations included having a second clinician substantiate the treatment plan for students who present with high acute behavioral health symptoms, consulting with staff, and connecting the student with appropriate community referrals.

The participants identified several interventions they found helpful in supporting students with high acute behavioral health symptoms. In addition to the foundational behavioral health skills already discussed, the participants added the need to make the
interventions specific to the student and allowing the student the space to process their symptoms or trauma. The participants consistently use a safety plan with students who are in crisis. David stated, “Helping them (students) feel like they’ve been able to reach a point that they’re a collaborator in the plan that’s going to help them deal with the crisis over time.” The inclusion of a Victim Advocate, a position at some higher education institutions that can assess for suicide, coordinate with campus police, and support the student through the legal process, was discussed. Additional considerations include partnering with local hospitals in the event a student needs emergency psychiatric care.

Regardless of a student’s level of care, the implication for after treatment is left to the student to determine. Students may receive additional coordination of care if the student violates the code of conduct; however, if a student were to be discharged from a psychiatric hospital for example, the student’s after-care would be voluntary. “They’re an adult, and they have the right to choose a service or not choose a service” (David). “We don’t do mandated counseling; we’re not the prison system” (Stacy). “We can’t force anybody to be here” (Aldo). Finally, participants discussed the potential for initiating a welfare check if the student’s symptoms were acute and their absence from session was concerning enough.

When providing treatment to students with high acute behavioral health symptoms, the participants minimized developmental and gender-focused theories, instead focusing on maintaining a student’s safety. Concerns addressed by the participants with regard to development include:
1. Looking at how the students’ symptoms may disrupt a student’s overall development
2. The concern for the students’ maturity level, specifically how they may respond to intervention during a crisis
3. Assessing for learning disabilities
4. Providing a thorough assessment so as to not miss potential developmental challenges
5. Keeping the primary focus in treatment on keeping a student safe.

Concerns addressed by the participants with regard to gender aspects include:

1. Placing these elements as a multicultural consideration
2. To be aware of one’s (the counselor) own assumptions
3. The power and privilege that may exist between a behavioral health practitioner and a student based on gender/sex
4. Reducing discrimination experienced by female students
5. Maintaining the primary focus of treatment on keeping the student safe.

When correlating the participants’ responses with the literature review, significant overlap, as well as gaps, exist. The literature notes that higher education institution counseling departments are experiencing an increase in both the complexity and severity of behavioral health problems while at the same time experiencing a decrease in resources (Benton et al., 2003). In addition, reports suggested suicide, violence to others, and sexual violence and coercion are on the rise. Participants did note the increase in
service-need at their institutional counseling departments and the decrease in resources; however, there was significant belief that high acute behavioral health does not have a significant effect on the larger campus.

Participant reports regarding their treatment model also aligned significantly with the multi-level treatment approach to behavioral health intervention discussed in Chapter 2. Per the participant responses, there is heavy focus on preventative services: outreach to faculty/staff, peer educators, trainings/workshops, and consulting. The next level, intervention, includes individual and group therapy, though individual therapy may be limited due to the transition to briefer models of therapy discussed by both the literature and participants. The final level, reactionary or crisis, is limited to crisis assessment and then safety planning/community referrals or initiation of an involuntary hold, with the responsibility often placed on the campus/community police.

In looking at the participants’ perspectives on addressing students with high acute behavioral health symptoms who do not attend their therapeutic sessions, there appears to be a consensus that the student treatment is voluntary. This idea runs contrary to Wood (2012), who stated that the best practice is having an institution connect and assess the returning student, identifying if the student should address their behavioral health needs further before re-entering the campus. The University of Illinois Suicide Intervention Team does appear to mirror the BIT, though it seems the Suicide Intervention Team is focused on behavioral health treatment rather than on discipline.
The research discussed developmental aspects that exacerbate student stress, including transition from adolescence to adulthood, the development of an “identity,” and the belief by students that their decisions carry significant weight. These aspects may exacerbate symptoms experienced by students, and may need to be assessed during crisis. The participants did express consideration for developmental aspects, however, not during times when students exhibited high acute behavioral health symptoms. The participants identified the importance of focusing on the students’ high acute symptoms rather than on their developmental level and connecting development aspects with the students’ initial assessment, conducted during the early stages of counseling.

When looking at the several violent episodes that occurred on higher education campuses, the assailants were male, teased and/or bullied, and had long-standing behavioral health challenges, including depression and anxiety. A profile could be explored that would support the identification of such a presentation as a potential red flag for increased behavioral health treatment. As well, women are more likely to be victims of rape, sexual violence and coercion, and domestic violence (Stone, 2007). It is in this vein that gender was explored as a possible tenet for behavioral health practitioners to explore when addressing students with high acute behavioral health needs. Similar to developmental aspects, gender was not a primary, or a secondary, consideration of the participants when providing treatment to students with high acute behavioral health needs. Gender was a consistent consideration during the assessment
phase of counseling; however, when a student exhibits high acute behavioral health symptoms, safety is the primary concern.

**Research Question Two: What role does current leadership have in addressing your student body’s acute behavioral health symptoms?**

Leadership at the participants’ higher education institutions emphasized one of two tenets regarding the mission of the counseling departments. One tenet was the emphasis on multicultural counseling practice and the behavioral health practitioner not making assumptions/generalizations, being culturally competent, and incorporating these values into the counseling department’s policies and procedures. “You’ll see that multicultural competence is really weaved into pretty much everything we do” (Stacy). The other emphasis was academics and supporting the student’s ability to continue their educational goals, including graduation and retention. “We really focus on the academic part, and it’s really about access to student success, so we are also facilitators of student success” (Richard). Participants also discussed their leadership’s allocation of resources, specifically additional services and resources they believe their counseling departments would benefit from, but also resources/services currently provided that they appreciate.

In addition, David discussed his department’s reaction to the leadership’s communication, interpreting the campus leader’s messages as they relate to the counseling departments relationship with the larger campus.
Benton and Benton (2006) identified five actions that support administrators in their campus-wide behavioral health support; the top three related directly to behavioral health and are presented here, followed by how the participants related to each.

1. Knowing the extent to which behavioral health challenges are impacting the college system

Leaders, from the participants’ perspectives, appeared to identify behavioral health challenges as impacting access, multicultural competence, and academics. The two tenets were resounded consistently by the participants and represent the current focus of leaders at this time. With regard to students with high acute behavioral health symptoms, there was nothing specifically noted regarding how their cultural needs are being met or how their behavioral health treatment may strengthen their academics.

2. Knowing the legal implications, and potential financial implications, of students with behavioral health challenges and how institutions can protect and meet these students’ needs

Several participants noted trainings they had attended on policy and legal implications, with one participant noting his participation in a training that had a mock shooter on campus. The participants illustrated a sense of comfort around their understanding and the implementation of policy and legal responsibilities. This comfort was exhibited in participants’ limited concern regarding HIPAA and FERPA and general lack of relationship to their behavioral health practice and policy and legal implications.
When asked about budgetary considerations, most participants noted the interest in adding additional staff and consistently identified the need for a psychiatrist to meet students’ high acute behavioral health needs. These feelings of “need” would lead the belief that the participants may not feel students with high acute behavioral health needs are protected and that their needs may not be met.

3. Develop theory and intervention to support students with behavioral health challenges

The interventions discussed support students with behavioral health challenges, though they may not meet the additional needs of students whose behavioral health symptoms are high acute. There is significant reliance on community supports, including law enforcement, to intervene if a student’s high acute behavioral health symptoms were too acute. Theory development was not discussed and may be a byproduct of the positivist culture at most higher education institutions.

**Research Question Three: What role do your campus’s climate and culture have in addressing your student body’s behavioral health symptoms?**

Most participants indicated their relationship with the surrounding campus offered outreach opportunities in addition to providing trainings, consulting/collaborating with other staff/faculty, and participating on councils. “Our student life partners, you know, that’s always important because that way we get a lot of referrals from different folks, that they help students get here who wouldn’t necessarily otherwise” (Stacy). When a student exhibits high acute behavioral symptoms within the campus, concern is common
in peers, professors, and staff. However, the participants’ overarching belief was that, predominantly, their campuses were not affected by students with high acute behavioral health symptoms or that stigma keeps much of the student’s high acute behavioral health symptoms in the shadows.

I don’t know if I can say it [students’ high acute behavioral health symptoms] affects the culture at large, I think again there’s just still so much stigma, there’s still so much hush-hush around behavioral health issues and on psychiatric issues that I think a lot of it gets muted. (Steven)

When students exhibit high acute behavioral health symptoms, they have access to a clinical assessment by the institution. The assessment consists of measuring the crisis or acuity of symptoms, and then directing the student to the appropriate level of care. If a student presents with symptoms or a crisis that is too acute for treatment at the higher education institution, the institution will contact law enforcement to have the patient transported to a local hospital and/or refer him or her to community resources.

The participants viewed their counseling department’s budget as limited and as an opportunity to discuss the addition of staff and services, including for psychiatric care. Additional staff would reduce students’ wait time for behavioral health services, and a psychiatrist would provide psychotropic medication management, which would support the treatment of students with high acute behavioral health symptoms. Finally, the participants all shared a limited belief that HIPAA and FERPA are a current concern. “We’re not a HIPPA covered entity” (David). “In terms of how has it impacted my specific treatment with the students, doesn’t seem to be any impact that I can think of off
the top of my head” (Aldo). Participants identified more concern with securing a client’s release of information and being a mandated reporter.

The literature discussed the ripple effect of students with high acute behavioral health symptoms, impacting the students’ relationships with peers, family, and self and increasing psychosocial stressors, including financial, academic, and occupational (Benton & Benton, 2006). Contrary to this report, the participants did not identify a significant ripple effect from students with high acute behavioral health symptoms. This may be due to the limited first-hand experience presented by the participants; several participants did note the continued existence of behavioral health stigma, which may keep a student from seeking support from friends and family or community resources.

The research discussed barriers to access: behavioral health stigma, lack of awareness of the treatability of behavioral health symptoms, and the lack of use of services by African Americans, Asian Americans, and Latinos (Zinzow et al., 2011). The participants’ responses predominantly connected to the breadth of access afforded to students, the constant outreach to the student body and faculty/staff, and the ease of scheduling appointments as well as the comfort of receiving services on campus. As well, the participants were adamant that their counseling departments focused on being culturally sensitive/competent. Participants did identify behavioral health stigma as a barrier to students seeking services. Other considerations include the participants’ belief that students with high acute behavioral health symptoms do have access to a behavioral health crisis assessment and are often prioritized to assist in their connecting with
services sooner. This “prioritization” is conducted by an intake counselor or nurse triaging students to an appropriate level of service. As well, William’s institution has a dedicated walk-in time and an after-hours phone line that can provide mental and physical assessment over the phone when the counseling department is closed.

Kraft (2011) reported that despite the increased service-need of higher education students, budgetary constraints are triggering a transition from individual psychotherapy to brief models of therapy, including solution-focused models, group therapy, peer counseling, and an increase in psychotropic medications. These models can have a significant impact on providing an appropriate level of behavioral health treatment for students with high acute behavioral health symptoms. The participants’ responses aligned consistently with the research, identifying a current understaffing and interest in increasing staff and services. The transition to more “budget-friendly” models of therapy was also reported by the participants, with several participants noting the challenges with how these models may not address students with high acute behavioral health symptoms. With regard to the research related to policy, not only were HIPAA and FERPA not identified as a concern, but no policy was really identified as pivotal to the services provided to students with high acute behavioral health symptoms. Several participants did note they received training or instruction related to HIPAA and FERPA.

**Higher Education Institution Counseling System**

To support the application of this study to future action and research, a model was developed to allow researchers, practitioners, and counseling department leaders to
negotiate additional considerations. The overarching design was from Evans’s (1965) Model of Organizational Systems, a systems model. In this model, students with high acute behavioral health symptoms are the “input,” and the behavioral health treatment they receive at their institution’s counseling department is the “focal organization.” The output is the department’s and higher education institution’s goals, which may include improved access to behavioral health treatment, improved multicultural counseling practice, retention, or academic performance. “Feedback” includes the inclusion of new perspectives, including psychosocial aspects, gender and developmental theories, additional theoretical lenses, academics, and additional multicultural perspectives (e.g., behavioral health and students of that higher education institution). As well, feedback may consist of perspectives from individuals, including staff and faculty, community partners, and/or a Suicide Intervention Team/Behavioral Intervention Team. The circles represent constant considerations and will continue to expand to meet each counseling department’s unique culture.
Figure 10. Systems perspective on higher education’s high acute counseling treatment.

**Future Research**

Behavioral health practitioners at higher education institutions are experiencing a significant transition. This transition will lead to the redevelopment of higher education institutional counseling programs and it is imperative to the higher education institutions and their surrounding communities that the most efficient system possible is supported.

In that vein, several research opportunities exist related to this study, which are presented in this section.
The Responsibility of Higher Education Institutions for their Students’ Behavioral Health

This study would have benefited from a clearer scope as to what higher education institutional responsibility for their students’ behavioral health is. A future study may possibly be presented as a qualitative study, with interviews of the higher education staff responsible for policies and procedures related to campus safety and student supports. As well, a policy analysis, analyzing both higher education institutional policies and legal documents would beneficial. This study would be supportive of higher education institutional staff’s understanding and awareness and their role in their students’ behavioral health. In addition, it would help clarify the relationships and behavioral health supports needed within the community, including local hospitals.

The Gap in Behavioral Health Services at the Community College Level

Throughout this study, Richard, a behavioral health practitioner at a community college, discussed his counseling department’s inability to serve students with behavior health symptoms. Their counseling department refers students to community counseling agencies. This practice is appropriate given the level of care needed to serve the students is currently not present at the community college. However, Richard noted that community colleges, due to their open access to the community, often enroll students with more significant psychosocial stressors than 4-year institutions do. This gap in service, the lack of behavioral health services at community colleges, would limit access for students with high acute behavioral health symptoms, as they may not have the funds,
health care, or supports necessary to succeed at a community college. The proposed study may explore students with high acute behavioral health symptoms who attend both community college and 4-year institutions, identifying the differences in the level of service and the effects of these differences.

**Identifying Underserved Populations**

Stacy and Steven discussed two additional populations that also may not be receiving the level of care appropriate for their symptoms: students with eating disorders and students with chemical dependency. Both populations can be studied either through the lens of the behavioral health practitioner, similar to this study, or through the lens of the student with the prevailing symptom. To take the study further, it would be important to develop a model that supports the process at which a higher education institution’s counseling center may need to start to accommodate said population, possibly through training or specialized services.

**Students with High Acute Behavioral Health Symptoms**

Research looking at the perspective of the students who are experiencing high acute behavioral health symptoms would be an extension of this study. Such a study may be risky in that the population may be unstable and potentially dangerous, which would impact the study’s reliability. The study would provide new insights into the services provided, identifying strengths and challenges from the consumer’s lens. The study would build awareness in the preferred service model for higher education institutional
counseling departments, and the behavioral health practitioner’s best-practices related to rapport building, theoretical orientation, and counseling interventions.

**Recommendations**

Recommendations are presented based on the data gathered from the participants, the literature review, and the writer’s experience, and are organized into three categories: Counseling, Leadership, and Campus Climate and Culture.

**Counseling**

**Increase community partnerships.** Several participants discussed the importance of having established community partnerships during a crisis. In the event of a crisis, time and efficiency are important considerations. It is important for both the student and the behavioral health practitioner to feel comfortable with the safety plan. To support comfort and increase the likelihood of keeping the student safe, higher education institution counseling departments should have partnerships with local counseling agencies and hospitals. Having partners that are consistent and supportive provide the behavioral health practitioner the opportunity to focus on the student’s symptoms rather than the referral process. It also allows the practitioner to relay important information to the student without having to check with the agency or assume services are provided. Hospitals are imperative in this process, as having a firm process by which to collaborate and share a student’s health information, legally and ethically, is a practice that is both ethical and aimed at providing the student the appropriate level of care. Partnerships
would not mirror a referral sheet, as partnerships would add consistency, relationship, and review/evaluation.

**Increase the practice of obtaining and applying feedback.** Counseling departments would benefit from evaluation that incorporates theory, consultation, and collaboration. This practice is adopted from Evans’s (1965) Organizational Systems model and William, who strongly emphasized the benefits of consulting and collaborating with faculty and staff. This transition would represent a shift from the positivist approach of higher education institutions and adapt aspects of a postmodern approach. Incorporating theory, consultation, and collaboration would challenge the efficiency of higher education institutions and their use of positivist perspectives. However, it would be important to balance this initial inefficiency with the long-term effects of providing additional lenses, lenses that may identify current inefficiencies that exist in the system.

**Explore how training is being conducted for practitioners in crisis assessment.** The participants’ reports deviated significantly from what was presented in the literature review regarding training for crisis assessment. The varied responses with regard to crisis assessment and intervention, along with limited services offered to students with high acute behavioral health symptoms, would support further research in the education and training behavioral health practitioners receive. An emphasis would be on adapting crisis intervention to include cultural aspects, including the student culture and the culture of the institution’s surrounding community. As well, increasing the
practice of building community partnerships, MOUs, and program development would support practitioners in their macro-counseling practice.

**Leadership**

**Emphasize collaboration between counseling and academic goals.** The goals presented by the participants, when discussing both counseling and academics were quite similar, and it appears that the primary difference between the two cultures is language. One domain describes multicultural competence and inclusiveness; the other domain discusses access and providing accommodations and supports. It is important that, symbolically, these two domains appear aligned so as to unite understanding and a relationship within the counseling department and the larger campus. Continued separation may translate to counseling staff feeling disconnected from education staff, which in effect may increase competition rather than collaboration.

**Deconstruct the idea that leadership is tied to resources.** This concern relates to the participants identifying leadership as the gatekeeper to what resources and services are to be provided. Leadership can lead through power and allocation of resources; however, openness to collaborating with staff and identifying a decision-making process that accounts for multiple stakeholders creates buy-in, which may translate to a buy-in to the departmental and institutional policies, mission statements, visions, and goals, as well as supporting staff’s desire to go beyond the call of duty.
Campus Climate and Culture

Increase policy and develop a model to support students experiencing a crisis. The participants presented several models and interventions related to supporting a student who is in crisis. Increased structure and consistency would strengthen the efficiency with which the services would be provided as well as provide a roadmap to connecting the student with the appropriate level of care and community referral. Students with high acute behavioral health symptoms are often experiencing an impaired state of judgment and insight, and modeling structure and consistency may provide the “anchor” that supports their stabilization.

Increase staff. Both the literature and the participants noted understaffing as a concern, impacting wait times for students with high acute behavioral health symptoms. A counseling department must be able to provide adequate care for their clients/students, as the care they provide has a marked impact on the student’s functionality. Providing inadequate care can be as harmful as providing no care at all; it opens the higher education institution to possible litigation and could create a contentious culture within the counseling department. Identifying a counselor-student ratio that is appropriate meets the students’ service-need and supports good customer service and therapeutic treatment is ideal.

Reflections and Conclusion

The role of counselors at higher education institutions is in a state of transition. They are experiencing an influx of students with behavioral health needs, both in terms of
numbers and severity. This severity includes increases in physical violence/aggression, sexual violence and coercion, and self-harm behaviors, including suicide. Despite this service need, counseling departments are experiencing a transition to more budget-friendly behavioral health treatment modalities, limiting treatment to students with high acute behavioral health symptoms. Additional barriers for higher education institution behavioral health practitioners include the increase in legal responsibility for students’ behavioral health, policy that supports higher education’s responsibility for increased access and student accommodation, and increased psychosocial stressors in the lives of their student body. It is in light of these challenges that higher education practitioners can shine and provide the bridge between students’ high acute behavioral health symptoms and their educational goals. Through the lens of systems theory, the current literature, and the study participants, this study attempted to add to the current research new perspectives regarding the relationships between student, counselor, leadership, the larger campus, and the surrounding community.

Several insights were provided by the participants, including current plans and interventions for addressing students with high acute behavioral health symptoms, predominantly consisting of foundational counseling skills, de-escalation techniques, and crisis assessment. A gap may exist when the crisis assessment determines a student is experiencing a high acute psychiatric episode because although students may be connected to emergency care if needed, follow up to this care is inconsistent. This inconsistency extends to the coordination between the behavioral health providers on
campus and the community provider as well as to the lack of follow-through by students to receive behavioral health treatment.

Within the higher education institution, counseling departments experience two cultures: counseling and education. While similar in many ways, there are distinct goals and language for both. It is important for higher education institution leaders to bridge these two realms as well as emphasize collaboration and teamwork. A possible avenue to practice this emphasis would be in the allocation of counseling department resources and the direction of counseling services. Leadership may also invest resources and counseling services in students with high acute behavioral health symptoms, including reassessing their department’s crisis management policy and models.

While counseling departments consistently provide outreach throughout campus, connecting and partnering with local counseling agencies and hospitals may support their practice during times of crisis. Despite participants’ reports that they do not consistently experience students with high acute behavioral health symptoms, a developed plan to support these students would be proactive in terms of de-escalating the crisis. These plans should consider policy related to coordination of care, staff roles, and after-care.

These insights from the participants offer rich opportunities for additional research and action. The potential for using this study to support other marginalized underserved populations is possible; however, it is important to be aware that while students with high acute behavioral health symptoms may be a small community, it is growing. The models presented may support additional considerations that higher
education institutional counseling departments can make to meet and accommodate the services that these students need to support their access to higher education.

Finally, while the study presents behavioral health practitioners’ narratives, it is important to acknowledge the consumers of these services, the students with high acute behavioral health symptoms. These students, despite their symptoms, despite the additional psychosocial stressors, stressors that may impact their relationship with people, their studies, time, and financial standing, they continue to push forward toward their educational goals. Their struggles are to be commended, and with each success, they open opportunities for others. A study focusing on these successes would be paramount in identifying what characteristics, behaviors, beliefs, and values support these students’ academic goals.
APPENDICES
APPENDIX A

Invitation Email

To Whom It May Concern:

As a doctoral student at Sacramento State University, I am conducting a study assessing the role of behavioral health clinicians in addressing high acute behavioral health symptoms in higher education students. I received IRB approval and am currently scheduling interviews for this qualitative study. I contacted you due to your meeting the criteria for selection:

1. Be a current behavioral health practitioner,
2. Practice at a higher educational setting, and
3. Be employed by the higher educational institution at which you are practicing.

Below are several potential questions the answers to which may help you decide whether you want to be included in this study.

1. How much time would I dedicate to the study?
   The interview portion will last 1 to 2 hours, after which you will be emailed or mailed (your preference) a transcript of your interview to allow for any edits/corrections you feel would support your intended message.

2. Where do the interviews take place?
   The study would be best supported in a confidential, quiet location. So study participants are as comfortable as possible, each participant may choose a preferred interview room.

3. Am I allowed to remove myself as a participant at any time? Voice my discomforts?
   Absolutely. This study is aims to provide insights and awareness around clinical work performed at higher educational institutions, but not at the expense of the participants’ comfort. At any time, any participant is able to opt out of the study without providing grounds for their removal.

4. Will I be compensated?
For the time and energy provided to the study, a $30 gift card your institution’s bookstore will be provided.

To participate in the study, please email me. Your inclusion is supportive of the study and the practice as a whole. I want to thank you for reading this email and for sharing it with colleagues you believe may meet the criteria and may be interested in being a participant. Take care.

Chris Knisely
APPENDIX B

Interview Protocol

Interview Questions for the Qualitative Interviews

Systems:

1. Describe your counseling program’s relationship with your campus, including your student body?

2. What is the ripple effect that students’ high acute behavioral health symptoms have on the campus culture?

3. How would you describe access to your campus’ behavioral health services for students with high acute behavioral health symptoms?

4. How has the counseling department’s budget impacted treatment to students with high acute behavioral health symptoms?

Policy:

5. How has policy, including FERPA and HIPAA impacted your treatment with students with high acute behavioral health symptoms?

Leadership:

6. How do your department’s leaders impact your counseling department’s culture and your treatment of students with high acute behavioral health symptoms?

7. What are the goals and values promoted in your counseling department?

   a. How are these goals and values expressed in your counseling practice with students with high acute behavioral health symptoms?
Practice:

8. Describe your experience as a clinician with students with high acute behavioral health symptoms?
   a. Have you found students’ symptoms to be acute or chronic?

9. During a crisis, what interventions and/or techniques have you found helpful in deescalating or managing crisis?
   a. What promising practices have you considered in addressing students’ high acute behavioral health symptoms?

10. Could you discuss how you address physical violence, sexual violence and coercion, and suicide?

11. How do you address students with high acute behavioral health symptoms who do not attend their therapeutic sessions?

Erikson/Feminist:

12. When working with students with high acute behavioral health symptoms, do you consider developmental aspects, and if so, how do you incorporate these aspects in your practice?

13. When working with students with high acute behavioral health symptoms, do you consider gender aspects, and if so, how do you incorporate these aspects in your practice?
APPENDIX C

Consent Form

By signing this form you are consenting to being a participant in a research study conducted by Chris Knisely, Educational Leadership and Policy doctoral student at California State University, Sacramento. The study assesses the role of behavioral health practitioners in addressing high acute behavioral health symptoms in higher education.

The assessment will include the participant participating in a recorded interview regarding the relationship between addressing high acute behavioral health symptoms and leadership, culture, and practices, both “best practices,” and “promising practices.” Interviews will range from one to two hours and will be conducted at a location agreed upon by you and the researcher. A pseudonym will be used to identify both the participant and the campus they practice at to support the confidentiality of the participant and allow for increased disclosure. At no time during the interview will identifying information be recorded. A transcriber may be used to transcribe the interview. The questions may present the participant with some discomfort, if so, please feel free to not answer these questions. Answering interview questions are always at the discretion of the participant.

Exploring the topics presented in the interview may support the participant’s insight and awareness regarding their behavioral health program’s addressing of students with high acute behavioral health symptoms. The study’s aim is to bring these insights to the larger community.

For your efforts you will receive a $30 gift card. The gift card will be for the participant’s campus’ bookstore. This incentive is provided to the participant regardless of how much of the interview is completed. The data collected from this study is confidential information, and as such, will be locked in a filing cabinet behind three locks. The data will be destroyed no later than June of 2016. In the event the participant opts to no longer participate in the study, their information will be destroyed in one weeks time.

If you have any additional questions please feel free to call Chris Knisely at [redacted] or email at [redacted]. The chair of my dissertation committee is Dr. Rose Borunda, who may be reached at 916.278.6310 or rborunda@csus.edu.

Participation is voluntary and every participant is open to opting out of the study at their discretion at any time. The researcher is also privy to discontinuing a participant’s inclusion in the study at any time.
In signing this document you understand of the risks associated with the research study and agree to participate.

_________________________________  _____________________________
Signature of participant                         Date

_________________________________  _____________________________
Signature of researcher                         Date
REFERENCES


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