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Community Consultation and Intervention: Supporting Students Who Do Not Access Counseling Services

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Although the severity of psychological problems among college students and the demand for campus counseling services has increased, many students who could benefit from mental health services still do not access them. This article describes Community Consultation and Intervention, a program designed to support students who are unlikely to access professional help despite the best efforts of traditional counseling center outreach. Community Consultation and Intervention reaches into the campus community to intervene by advising faculty and staff who may be the only contact for a distressed student, taking on a nontraditional "student support" role in direct interactions with students, offering advocacy when university systems or other environmental stressors precipitate psychological problems, and providing case management and crisis intervention services on behalf of the university when troubled students are especially concerning and disruptive to their communities. The most novel element of the program—the student support role—is distinct from conventional counseling in that it privileges problem solving, support, advice, and advocacy over focusing on emotions and other traditional mental health interventions. Case studies and programmatic challenges are described.

KEYWORDS *outreach, counseling, utilization, consultation*

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INTRODUCTION

A majority of counseling center directors and American College Counseling Association members believe that the number of students with severe psychological problems has increased in recent years (Gallagher, 2006; Smith et al., 2007). Benton, Robertson, Tseng, Newton, and Benton (2003) have offered empirical support for this position, finding increases in 14 of 19 problem categories in a 13-year longitudinal study of students seeking counseling at a large Midwestern university. Some of the most dramatic increases were in depression, suicidal ideation, and sexual assault. Many others have documented this trend as well (Arehart-Treichel, 2002; Haas, Hendin, & Mann, 2003; Pledge, Lapan, Heppner, Kivlighan, & Roehlke, 1998; Kitzrow, 2003). Perhaps inevitably, counseling centers have noted an ever-increasing demand for counseling services (Berger, 2002; Kitzrow, 2003; Smith, et al., 2007). High profile cases of students with mental illness harming themselves (e.g., Elizabeth Shin at MIT) or others (e.g., Seung-Hui Cho at Virginia Tech) have drawn attention to the mental health needs of college students and scrutiny of mental health service delivery at colleges (e.g., Virginia Tech Review Panel, 2007).

Kadison and DiGeronimo (2004) attribute this rise in distress among college students to a "multitude of hidden problems" (p. 5), including normal developmental issues such as establishing autonomy and identity; academic, parental, and cultural pressures and expectations; financial worries in the face of mounting educational debt; and fears of campus violence, among others. Haas and colleagues (2003) assert that the increase can also be attributed to the "increasing number of students entering college with a history of prior psychiatric treatment" (p. 1229). The widespread use of psychotropic medication means that "seriously troubled students are more likely to graduate from high school and go on to college" (p. 1229).

Kadison and DiGeronimo (2004) observe that ethnic minority students and recent immigrants may experience unique pressures related to racism in the United States and higher education's history of unequal access. Being a minority on a predominately White campus may make students more vulnerable to stress experienced in their daily lives:

> Although many minority and immigrant students have experienced bias assaults before arriving at college, the hurt can be especially acute in the academic environment. Often these students expect things to be different in what they think will be an educated and unbiased college community, and so they are especially hard hit by the reality of continued prejudice. This huge disappointment can lead to self-doubt and emotional difficulties. (p. 51)

If campus support services—including counseling services—are considered part of an environment tainted by prejudice, accessing help might be particularly hard.

International students also experience unique stresses. In addition to facing the same developmental, academic, and parental pressures encountered by all students, as well as confronting similar racial discrimination and language barriers faced by ethnic minorities and immigrants, international students must contend with the vicissitudes of studying in a new country (Kadison and DiGeronimo, 2004). This may mean adapting to new education formats, operating constantly in a second language, accommodating unfamiliar food and social interaction styles, and negotiating visa constraints that have arisen since September 11, 2001. As a result, international students may be especially at risk for emotional difficulty.

At the same time that the level of psychological distress among students appears to be increasing, college counseling centers see only a small percentage of students who could benefit from their services. Kisch, Leino, and Silverman (2005) compiled results from the spring 2000 National College Health Assessment Survey. Depression, suicidal ideation, and number of suicide attempts were examined among over 14,000 college students. Although almost 1,500 students in the sample reported having serious suicidal ideation, only 13.4% of them reported being in treatment at the time. Of respondents to the 2006 National College Health Assessment, 40.5% reported feeling so depressed in the previous 12 months that it was difficult to function. Yet, on average, counseling centers see just 9% of enrolled students (Gallagher, 2006). Eisenberg, Golberstein, and Gollust (2007) found that most students at a large Midwestern university who screened positive for apparent mental disorders did not receive any services. Furthermore, international students have been shown to utilize university counseling centers at even lower rates than other students (e.g., Hyun, Quinn, Madon, & Lustig, 2007), as have racial and ethnic minority students (e.g., Davidson, Yakushka, & Sanford-Martens, 2004; Kearney, Draper, & Baron, 2005). A full examination of the causes of underutilization is not within the scope of this article; however, some causes suggested in the literature have included the stigma attached to mental illness in the United States (e.g., Wahl, 1999), mistrust of White service providers among Black students (Nickerson, Helms, & Terrell, 1994), and a lack of culturally appropriate services for international students (Hyun et al., 2007).

These data beg the question: how do we support the mental health of students who do not come to counseling? One answer to this question has been outreach. Counseling centers have typically utilized outreach programs to promote prevention, raise awareness, and reach students who might not be aware of counseling services (Archer & Cooper, 1998; Arehart-Treichel, 2002). These programs often take the form of psychoeducation, where students and staff are presented with information on time management, anxiety, suicide prevention, and other relevant concerns.

Other outreach efforts are more comprehensive. The American Foundation for Suicide Prevention (AFSP) pilot tested a suicide prevention program at Emory University in 2002 (Haas et al., 2003). Students were invited via e-mail to anonymously complete a modified version of the PRIME-MD Patient Health Questionnaire. Counselors reviewed responses and returned personalized assessments. If the student's score suggested a psychological difficulty, a meeting to discuss treatment options was encouraged. Students were also able to communicate online about any concerns regarding the evaluation or future treatment.

Similarly comprehensive outreach efforts—involving faculty and staff training and clinical services provided in the campus community—have been implemented at other universities. Nolan, Ford, Kress, Anderson, and Novak (2005) describe a model for addressing severe and persistent mental illness that includes training to destigmatize mental illness among faculty and staff and strategies for identifying and referring students who are having emotional difficulty. Rawls, Johnson, and Bartels (2004) describe a counselor-in-residence program in which counselors offer staff consultation, crisis intervention, brief walk-in counseling, and prevention services in residence halls.

Kisch and colleagues (2005) suggest outreach program development that addresses the "stigmatization associated with accessing mental health care" (p. 11). They further recommend that counseling centers develop better methods of identifying at risk or vulnerable students. It is imperative to have outreach programs that utilize the entire campus community as essential resources for helping students who might be vulnerable to emotional and/or psychological difficulties who otherwise may not initiate coming into the counseling center on their own. No matter what is done, however, there will always be students who are suffering but unwilling or unable to come to the counseling center. To our knowledge, no counseling center outreach program has created a system of care for students who are reluctant to come to counseling and who may *never* access counseling services through the front door.

At Cornell University, where the authors work, outreach has evolved to do just that. In addition to offering what might be considered the "best practices" of outreach—psychoeducation, faculty and staff training, early intervention screening, consultation to the campus community, and access to counselors outside of the counseling center—Cornell has implemented Community Consultation and Intervention (CCI), a unique program within the counseling center that supports students who are unlikely to access traditional mental health services, no matter how strongly they are encouraged. CCI focuses specifically on helping staff and faculty support reluctant students in an ongoing way and by taking on roles that expand on, and in some cases are different from, the conventional counselor role of intrapsychic intervention. CCI is staffed by two full-time counselors who devote

their time exclusively to the primary components of the program: intensive faculty and staff consultation, nontraditional student support, crisis intervention, counseling, advocacy, and case management. What follows are descriptions of these components followed by two extensive case studies. Finally, challenges to the ongoing growth of the program are explored.

CONSULTATION

A consultation begins with a telephone call from a faculty or staff member who is concerned about a student. The student may have revealed a personal problem, suffered an unexpected deterioration in academic functioning, or withdrawn from friends and responsibilities. Throughout the consultation process, the caller is considered "the client"; the counselor's job is to assess how to best aid the caller in assisting the troubled student.

The counselor's first objective is to assess the level of urgency of the situation and determine if an immediate intervention is required. If nothing immediate is necessary, the counselor offers advice on how to support the student and refer him or her to appropriate resources. Often a caller contacts CCI only after unsuccessfully referring a student to the counseling center. Many students are reluctant to seek counseling because of cultural barriers or the stigma attached to seeking professional help. In these cases, the counselor encourages the caller to maintain periodic contact with the student. Over time, as the caller develops a stronger relationship with the student, the counselor offers suggestions for providing support, assessing the student's functioning, and providing advocacy when university policy or red tape may be inadvertently contributing to distress.

In situations in which very little information is known about the student—for example, when a concern is vague or lacks sufficient detail—the counselor will contact faculty advisors, residence hall directors, and other professionals in the student's life to see what is known about the student and if other concerns exist.

CRISIS INTERVENTION

In a number of cases each year, faculty or staff members call CCI with a concern that warrants immediate attention. Examples include students sending e-mails suggesting an imminent suicide attempt, unexpectedly disappearing from class and social networks, or acting in ways that appear threatening to others. In these cases, the counselor works with the campus police, the Office of the Dean of Students, and others to locate the student and provide assessment for care. Occasionally, the counselor will accompany the police to a residence to check on a student's welfare and determine

whether the student is stable, would benefit from further assessment at the counseling service, or needs hospitalization. Often the counselor acts as a point person, collecting information from various parties and guiding a team of campus staff in the implementation of an intervention.

STUDENT SUPPORT

CCI counselors offer in-person meetings with students who are not willing to use the counseling service but are open to speaking to another person on campus about an emotional problem or environmental stressor (e.g., a conflict with a professor, a death of a family member, or a lack of sufficient financial resources). CCI counselors describe their role as providers of "student support" rather than counseling. The student support role is distinct from the role of counselor. Though essential mental health practitioner skills like empathic listening and assessing for suicidal risk are mandatory, the focus of a meeting with a CCI counselor is on problem solving, connecting with needed resources, and intervening in the student's environment (e.g., financial aid, academic advising, residence life) through advocacy.

Meetings with CCI counselors are student-centered encounters where students are provided a space to speak about what is troubling them or to test the waters to begin to develop a safe relationship where some disclosure may happen in time. Initial discussions often center around academic concerns and other nonthreatening subject matter as a way to build trust before attempting to explore more vulnerable (e.g., emotional) subject matter. Formal mental health assessments are not routinely conducted as part of this process, which is a distinct difference from a meeting at the counseling center.

The student support role is consistent with a social justice perspective that encourages the "expansion of the concept of individual practice to include less traditional roles (e.g., educator, consultant, community advocate) and language to make services more relevant and accessible to all students" (Smith, Baluch, Bernabei, Robohm, & Sheehy, 2003, p. 9). The professions from which many counselors come support this adoption of varying roles and interventions. In psychology, the American Psychological Association (APA, 2002) encourages psychologists to broaden their repertoire of interventions to meet the needs of diverse client populations. In social work, "generalist" social work practice encompasses not just counseling but also advocacy, brokering of resources, and case management, among other interventions (Kirst-Ashman & Hull, 2006). Advocacy and brokering in particular dovetail with the multicultural counseling/therapy perspective outlined by Sue and Sue (2003), which suggests that "the focus for change must shift to altering client systems rather than individual clients" (p. 17) when environmental factors influence client problems.

A first contact with a CCI counselor is always initiated by a campus professional who has been consulting with CCI. Students cannot refer themselves to the program; those who can easily seek help are more appropriate for the counseling center. The faculty or staff member asks the student for permission to pass his or her name on to CCI, which is described as a campus support program that can provide additional help. If the student agrees, the counselor reaches out via phone or e-mail to arrange a first meeting. If the student says no, the counselor will continue to consult as before, encouraging the faculty or staff member to give the student time and avoid being intrusive. This honors the student's autonomy in seeking his or her own way in dealing with stressors.

CCI counselors routinely offer a first meeting outside of the CCI office. Some students find it easier to meet in the faculty advisor's or staff member's office. In most cases, once a connection has been made, students are willing to meet in the CCI offices, which are located in the same health center as the counseling center but on a different floor. In the first meeting, the CCI counselor explains that he or she works for a program run by the counseling center but he or she provides "student support," a service different from counseling. For students who are anxious about the stigma of counseling or fear being judged as having a mental health problem, the language of "support" and a more informal entry into services is key to their willingness to accept an offer of assistance. The counselor considers the first meetings as the beginning of an engagement period. During this phase, the counselor determines whether a brief problem-solving intervention (including a referral to other resources) is warranted or more intensive support via formal counseling or advocacy is necessary.

COUNSELING

If the student's problem appears to be primarily psychological (e.g., depression not triggered by a specific environmental stressor) and the student becomes open to counseling, the counselor will offer counseling with himself or herself or another person on the counseling service staff. The CCI counselor's caseload is restricted to a small number of students each semester as significant work time is needed for consultation, advocacy, and crisis intervention.

ADVOCACY

In many cases referred to CCI, the signs of the student's stress (e.g., poor academic performance, irritability, depressed mood, lack of concentration) are responses to environmental rather than psychological stressors. Examples

of environmental stressors include financial problems, sexual harassment by a fellow student or staff member, or racial bias.

If the counselor believes it is possible to eliminate the cause or reduce the magnitude of the stressor, he or she will advocate for the student with his permission. For instance, if a student reports that she has not been able to concentrate because she lacks the resources to pay her rent and buy groceries, the counselor may call the financial aid office to determine if there are any short-term solutions. Sometimes the counselor discovers resources that the student simply does not know about. In one recent case, the student of concern had a thousand dollar refund for a Pell grant available to her within 48 hours of filling out the correct paper work. In a university as large and decentralized as Cornell, it is often hard for students—and staff—to be aware of all the available resources.

Advocacy becomes especially important, but particularly complex, when a student is being exploited. These situations are some of the most delicate, and CCI counselors have learned to explore all of the implications and possible repercussions of an intervention before moving ahead. In one such case, a female graduate student reported having a dysfunctional relationship with a demanding advisor who required her to work constantly without a break and forbade her to take any time off. She was exhausted from the emotional stress and barely able to function. She was afraid to tell anyone for fear of retaliation by her professor and the possibility of deportation if she lost her position. The counselor worked with the student over a period of 12 months until she had the confidence to report this and other violations in the workplace. With the help of the graduate school, meetings were held between the chairman of the graduate field of study and the faculty member to rectify the situation and to protect the student. This allowed for an improvement of conditions for the student, who was then able to continue toward her degree.

CASE MANAGEMENT

On occasion, a student's behavior is erratic and disruptive and the campus community is justifiably concerned, but the situation exists in the anxiety-provoking gray area before crisis intervention is optimal or legally viable. In these cases, CCI counselors provide oversight and case management of the university's response. As "point person," the counselor keeps track of multiple strands of information about the student and provides ongoing assessment of what level of intervention is needed. The counselor may begin to develop an intervention plan to be carried out on short notice if the student's behavior deteriorates.

For example, a top student who had a history of schizophrenia but who was not in treatment began exhibiting signs of deterioration. He was

getting into arguments about simple rules and academic expectations with staff and faculty, leaving them feeling both confused and uneasy. He had turned down multiple referrals for treatment. His parents had expressed concern to the university and were not successful in convincing their son to resume medication that he had discontinued. CCI developed a plan to monitor the student on campus and worked with the family to develop a strategy for hospitalization with police support if his behavior slipped further. When a window of opportunity opened, the university was ready to facilitate a hospitalization.

Although the student's behavior did not reach the level of campus code violation, it's worth noting that similar situations occasionally require CCI counselors to consult with faculty and staff about students whose behavior has breached the campus code of conduct. These students are often referred to the judicial administrator and can be required to face hearing boards to determine sanctions. In such cases, CCI counselors advise faculty and staff, along with the judicial administrator, on mitigating factors, including mental health issues and environmental stressors.

In some cases, a faculty or staff member refers a student directly to CCI for support before the judicial administrator becomes involved or concurrently with the judicial administration process. In these situations, the CCI counselor takes on a role similar to that of a traditional counselor and is bound by ethical principles of confidentiality. The CCI counselor does not serve as an informant or expert witness at the hearing, but continues to provide support for the student throughout the proceedings. In most cases, the CCI counselor does not attend the hearing but makes himself or herself available outside the hearing or shortly thereafter if the student requests it.

The following are two in-depth case examples that further highlight the services CCI provides. As in the previous examples, identifying information and case details, including names, countries of origin, fields of study, and students' issues of concern, have been changed to protect the confidentiality of the parties involved.

CASE EXAMPLE: SUPPORT AND ADVOCACY

An academic advisor called CCI with a concern about Tadesse, a student with permanent residency status in the United States who was originally from Ethiopia. He had been a straight-A student for three years, but grades from midterm exams in the fall of his senior year were near failing. The advisor made numerous attempts to contact him but received no response for several weeks. Tadesse eventually returned the advisor's e-mail and consented to a meeting. In person, he was largely unresponsive, commenting vaguely that he was "okay" and that "things would be taken care of." Fearing Tadesse might be dealing with some sort of emotional distress, the advisor

recommended a consultation with the counseling center. He declined, saying he was not "crazy." Not knowing what else to do, the advisor enlisted a CCI counselor to reach out to him.

After the advisor had gotten Tadesse's permission, the CCI counselor e-mailed him, noting his recent academic difficulty and saying she provided "support for students who are having difficulty of one kind or another." She suggested they meet in a place convenient to him, offering one of the offices she uses outside of the health center. He agreed to a first contact in a quiet room in the student union. Outside of his college and free from the stigma a visit for "counseling" might engender, he opened up and explained what had happened.

His family had come to the United States from a refugee camp in Ethiopia when he was in his teens. On top of the stress of immigration, the family had endured numerous difficulties since arriving in the United States. Among these were Tadesse's sister being harassed and beaten in the small town where they had first settled. As a result, the family moved to a large city in the Northeast. There, his mother developed chronic health problems. His father could not find work and slipped into a deep depression. Just before Tadesse returned to school in the fall, his father committed suicide.

As the eldest son, Tadesse had taken on the role of the head of the family after his father's death. He had been using his book money for bus fare home each weekend to attend to family matters. He had to borrow his textbooks from the library and lost valuable study time going back and forth every weekend. As a result, his mother was pressuring him to transfer to a college closer to home. He had been planning to graduate in the fall and go to graduate school, but his prospects were beginning to look dim and he was feeling hopeless. He was becoming resigned to dropping out and trying to finish college at a later date but was afraid to tell his advisor for fear of making it more real.

With Tadesse's permission, the counselor advocated on his behalf to his college and to the office of financial aid. He was provided deadline extensions and the option of taking incompletes in some of his classes, and financial aid located additional resources. As his immediate financial and academic problems subsided, his confidence returned. The counselor helped him find ways to speak to his family about the long-term benefits of completing his degree at Cornell. He began to reduce his visits home from once a week to once a month while still maintaining his role as head of the family. Interestingly, throughout the course of what were primarily problem-solving meetings with the counselor, Tadesse found space to begin to grieve the loss of his father. In our experience, the "student support" relationship often opens up room for the work of more conventional counseling. With this support, Tadesse was able to focus again on his studies and graduate with his class.

The success of this intervention depended on a number of factors. First, Cornell's seven colleges routinely screen students' midsemester grades

for anomalies like Tadesse's. This process identified Tadesse as a potential student in distress. Second, the advising office of his college had a close relationship with CCI and routinely sought consultation on cases like this. Third, the CCI counselor was willing to assume a role different from the traditional counseling role and make first contact outside of the counseling center. Finally, though the CCI counselor was working in conjunction with the advisor, she made it clear she was not a part of the college. Often students trust their advisors but are too ashamed or worried to disclose sensitive personal information with people who are monitoring their grades. However, that trust helps them accept a referral to another helping professional who is not a "counselor."

CASE EXAMPLE: CASE MANAGEMENT AND CRISIS INTERVENTION

A residence hall director (RHD) called CCI about William, a student in the sciences. Amy, a friend of William's, had complained that his behavior was becoming increasingly intrusive. He came to her room at all hours and refused to leave. He showed up at her classes (none of which he was registered for) to sit with her. Shortly after Amy's complaint, an advisor in William's college called, saying another friend had confided that William frequently skipped classes to spend time with Amy, rambled in his conversations, and sometimes shouted at no one in particular.

With this information, the counselor set up a meeting with the RHD and members of the advising office. Because William had been missing exams, the group decided the counselor should contact him regarding his academic concerns. She e-mailed, stating she provided student support in conjunction with his advising office and understood he might be struggling. William agreed to meet in an advisor's office. He presented as calm and somewhat engaged but said no more than that he had had some difficulty but was now back on track. He agreed to meet for a second meeting within the week. He did not show; on the same day the RHD called to say that William had posted disturbing messages on Amy's Facebook page. More friends contacted various campus staff members about William's increasingly bizarre behavior and disturbing e-mails conveying hopelessness. The counselor attempted further outreach, but William did not respond, and he appeared to have moved out of the dorms suddenly.

In consultation with the Office of the Dean of Students, the counselor contacted William's parents in California and urged them to come to campus to help intervene and, if necessary, bring him home for longer-term care. They reported they were also having trouble making contact with him. While they were en route, the counselor enlisted William's friends to maintain contact with him via e-mail. Soon a friend reported that he was in a computer lab

instant messaging Amy. The counselor notified the police, who had been standing by in the event he was located. The counselor and a colleague went to the lab to talk with him; the police were nearby in case assistance was needed. They found him in a disheveled state, shoeless and incoherent. They prevailed on him to come to the counseling center for a psychiatric assessment. He was found to be acutely mentally ill and was hospitalized as his parents arrived in town. Care at home was arranged following discharge, and he eventually recovered enough to attend community college nearby.

It is with these sorts of crises that CCI has proven to be especially useful to the university and garnered its reputation as the "go to" department when a student has raised the anxiety of faculty, staff, and students.

CHALLENGES

As CCI enters its seventh year, it has inevitably begun to experience growing pains. The Virginia Tech tragedy has heightened awareness on campus of the need to identify distressed students and reach out to them. Requests for consultations and interventions from faculty and staff have multiplied significantly on top of an already yearly increase in demand. As might be expected in the context of limited resources, questions emerge about how much staff time should be available for this unique work. At the same time that the demand for CCI has increased, the counseling center as a whole has experienced significant growth in requests for traditional counseling services from students. In response to this, the staff has more than tripled in the last 10 years. Deciding how to best allocate resources to serve the needs of multiple outreach programs (including CCI) and a thriving clinical program will continue to be a challenge.

Resource allocation within CCI itself requires constant vigilance. CCI counselors meet individually with approximately one-third of students about whom they consult. Most students come for one or two meetings. Some students want to continue meeting for therapy. At this point, it is often hard to refer a student to another counselor because a connection has been established, often in the face of significant reluctance to access help. The CCI counselors need to juggle a high workload of consultations, student support meetings, and community interventions; providing therapy for all who request it is not possible.

Another challenge arises in documenting the effectiveness of CCI. Since its inception, the focus of CCI has predominately been on the work of helping faculty, staff, and students. Though anecdotal data and interviews conducted during the pilot year of the program suggest a high level of satisfaction from community partners, thus far few resources have been available to collect outcome data. CCI staff are now in the beginning stages of planning a program evaluation for the 2008–2009 academic year. Qualitative

data will be collected from faculty and staff to determine their impressions of the usefulness of consultations and their suggestions for improvement.

In approximately one-third of consultations, students are referred for direct support from a CCI counselor. Collecting data from these students may be more complicated than collecting data from staff. Some methods, such as pretest/posttest assessments, could potentially interfere with engaging students. CCI thrives on its relative lack of emphasis on diagnoses and categorizing student problems and its focus on intervention strategies other than counseling. It seems unlikely that hard-to-reach students could be engaged with one hand while being asked to fill out a pretest with the other. However, students could be interviewed following a direct intervention to determine their impressions of the outcome. Also, pre- and posttest assessments could be given to students who are willing to move into a formal counseling relationship with a CCI counselor.

What is known is that CCI has consulted on well over 1,000 students of concern since its inception in 2001. The number of consultations has risen every year except for 2006–2007, when the program was not fully staffed. Though CCI serves far fewer students than the counseling center, the percentage of CCI clients who are international and ethnic minority students is much higher than that of the counseling center.

It is impossible to say how many students who have connected with CCI might have never accessed the counseling center. Yet, there are numerous cases in which CCI consultations and interventions have led to students themselves expressing gratitude for being helped to move from a precarious state to a place of safety.

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