*By Brian Van Brunt*

I realize that by writing this column, I will sound exactly like that kid in high school who reminds the teacher to assign homework before a long holiday weekend. Regardless, I want to make an unpopular argument. It's unpopular because it involves college counselors' and psychologists' having to work harder with a high-risk group of students. It's unpopular because it requires counseling directors to argue and advocate with their deans, vice presidents, and lawyers for permission to make their jobs more difficult.

But it's the right thing to do. So, here goes: An ideal, successful, well-functioning college counseling center must serve a wide range of clients. I want to push back on the latest trend in the journals, at the professional conferences, and in online discussion groups, in which institutions seek to limit campus counseling to students who are in need of short-term, developmental care, and "refer out" those who are at higher risk or require more specialized treatment.

We've all said or heard comments like this lately:

* "Our center is really dedicated to short-term, solution-focused treatment. We offer students eight sessions before we refer them out."
* "Your problems are beyond our center's treatment mission. We have a list of community providers who can better serve your needs."
* "It would be unethical for our clinicians to continue to treat you, given the severity of your symptoms. Perhaps it is time to take a break from college and seek treatment, get better, and then return to school."
* "We refer out those clients."
* "I mean, really, I don't know why these kids come to college. It seems like they are here just to get therapy. It's a place to learn, not a social-work clinic. There is only so much we can do with the resources we have."

Those students who struggle with diagnosed disorders, who have frequent suicidal thoughts, or who have the unfortunate luck to experience a bipolar or schizophrenic episode around the time that some other troubled student decides to shoot up a college—all of those students are ones that many campus counseling centers are telling to seek help somewhere else.

The trend is a modern-day version of the old not-in-my-backyard movement, which argued against allowing mentally ill individuals to live in residential neighborhoods—except this time, some counselors and psychologists who fought for inclusion are now leading the charge for exclusion.

I'm not without empathy. It's hard to treat students who hear voices. You'll get no argument from me that treating patients with chronic disorders can be difficult and time-consuming. Trying to treat a student with an eating disorder requires additional training and can involve lengthy work with medical staff as well as the student's parents.

It's easier to help a student who is upset about his roommate overusing his snooze alarm or the young lady who is struggling to work through her parents' divorce. It doesn't take as much time to talk with a student overwhelmed with organizing his academic schedule. Most clinical-staff members are well trained to assist a student through the basics of handling her anxiety related to public speaking.

But we can't simply point students to the door when their problems don't happen to coincide with the limited mission of our counseling center or when we arbitrarily draw a line in the sand and say, "We will treat these students, but not those over there."

We shouldn't accept the premise that college counseling should be offered only to students whose problems can be neatly resolved in eight to 10 sessions. We shouldn't tell Sarah, who struggles with chronic suicidal behavior, that we can't treat her, because she has tried to kill herself too many times. We shouldn't tell Mike, who struggles with borderline personality disorder, that we can't treat him, because he can't keep his appointments and frustrates the office staff. That is what they do. That is who they are. That is why they come to us for help.

I had a recent conversation with a student-affairs friend about a frustrating student I'm treating: "He is just mean and grumpy all the time. Would it kill him to smile?" While I understand my friend's impatience, the student's behavior and attitude is part of his disorder. Everyone thinks the student is grumpy and mean. And that's why I'm seeing him. I'm trying to fix that.

Too many campus counseling offices seem to be misusing the term "referral." Most of the time—not all of the time, but most of the time—a referral is an excuse to transfer a difficult, high-risk, annoying, frustrating, scary, time-sapping, complicated student somewhere else. The problem is that referrals rarely result in the student's forming another therapeutic connection. Here's why:

* A student who doesn't have money to buy food or make rent isn't going to spend $25 a week on a co-pay for therapy. Perhaps he should, but it is my experience that he does not.
* A student who falls into the "high-risk, chronic, refer-out" category often doesn't have private insurance, helpful parents, or transportation to get to the outpatient clinic.
* In the rare case that a student does have insurance, she is often worried about her parents' finding out that she is going to therapy when the insurance bills arrive at home. That stops the student from attending off-campus treatment and billing insurance.
* A therapy relationship doesn't transfer easily. How long have you worked with your bank? How about your dry cleaner? How much harder do you think it is for a student who has bared her soul to simply "do it all again" with another treatment provider at the community mental-health center?
* Off-campus therapy options can be seriously limited in terms of access. Students can wait months for a first appointment.
* Outpatient clinicians sometimes lack a solid understanding of the developmental needs of college students.

Some skeptics might counter: "These are problems the student has. The school is not responsible. We can't fix everything. We have limited resources."

But when a college fails to treat a student, the student's problems remain at the college. Many students who are "referred out" do not actually get treatment in the community. Instead they recycle the problems (only now without any therapeutic support) back into the classroom and the dorms. While those students may no longer be the problem of the counseling center, they are still experiencing their symptoms and often causing problems around the campus.

"Scope of practice" limits are another way college-counseling centers and administrators attempt to limit access to care. They say, "We don't treat substance abuse, eating disorders, borderline personality disorder, psychotic disorders, bipolar, ADD/ADHD, (insert your disorder du jour), because we don't have the training and expertise in that area. It is beyond our scope of practice."

Counseling centers need to expand their scope of practice. Counselors, psychologists, and social workers need to obtain additional training if they lack the expertise needed to work with high-risk or difficult students. If a campus counseling center is getting an increase in substance-abuse referrals, it should seek to increase training or hire someone with that expertise. If a center is struggling with an increase of Asperger's students seeking care, it should invest in training or find a way to offer a clinical group to deal with this growing population.

Some may suggest, "What about child molesters? What about chronic heroin addicts? How about students with traumatic brain injury?" I would agree that there are times when a referral to an expert or an off-campus community mental-health treatment center is important. We don't need psychologists and counselors reaching that far beyond their expertise and doing harm to students who need very specialized assistance.

I am concerned, however, that some of us are crafting mission statements and treatment protocols to limit our services. And our reasons sometimes have more to do with time, budgets, and "I don't want to" rather than the more-reasoned arguments related to training and clinical expertise. We shouldn't pick and choose the mental illnesses that we treat in our centers. We can't develop policies and procedures that systematically take one group of students with high-risk mental-health problems and refuse care while focusing on those who respond well to short-term, time-limited treatment.

Investing in more-comprehensive care is not only a question of professional ethics but also financially sound. There have been several lawsuits filed against college counseling centers after a student committed suicide after the center refused care on the basis of short-term-care limits, scope of practice and training, or availability of resources. Most of the suits were settled at a significant cost to the institutions.

We shouldn't take the easy path. We need to treat students who are in danger of being "policy-and-procedured" out of our offices by risk-adverse administrators and overwhelmed clinical staff workers too tired or poorly trained to work with high-risk, difficult students. We need to advocate for those in need. We need to stand against those clinicians and administrators who are concerned only about a student's not committing suicide on their watch. Those students lack the voice or ability to speak for themselves.

*Brian Van Brunt is director of counseling at Western Kentucky University and a past president of the American College Counseling Association. He can be contacted at**brian.vanbrunt@wku.edu**.*

Rebuttal:

**How do we ration rationally?**

We would all love to have the luxury of adequate resources to provide high quality, empirically supported treatment to all of our students regardless of their diagnosis or the severity of their symptoms.  Unfortunately, most Counseling Centers are not so well resourced and we are forced to find a way to ration the resources we do have to meet as much of the demand as possible.    However much we might wish we could treat everyone with the optimal treatment for their disorder, we simply are not in a position to do that so we must make hard choices.  The question becomes:   How do we ration rationally.  The solution we choose is highly related to the context.   Each surrounding community is different with unique configurations of available services in the surrounding area.  Counseling Center directors have taken many approaches to distributing resources and there are advantages and disadvantages to each.

Limit Scope of Service

The advantage of eliminating the Scope of Service is that we could serve the segment of the population who have chronic and severe problems, and are uninsured.  Right now, we provide crisis services for these students and some maintenance level support, but we do not provide long-term counseling.  We have experimented with providing a group co-facilitated by a psychologist and nurse practitioner to help maintain some of these students in school.  This has gone well.

The advantage of retaining our scope of service:   The issue of Scope of Service and capacity are unavoidably tied.   A scope of service is a major help in managing supply and demand while getting the best treatment for the most students using the many excellent resources at our local hospital, in the College of Medicine, and in the surrounding community.   We have a fixed capacity given our staffing, funding, and space.

Students who need more long-term treatment, who have insurance, quickly get started with the best resources in the community while students who would be best treated at the CWC get very high quality and effective treatment of sufficient frequency and duration to maximize efficacy.  All medical centers including student health care centers have a scope of service.  We would not expect our student health care center to roll out a guerney and perform an appendectomy because a student was reluctant to go to the local hospital.    Furthermore, if our health center only had enough antibiotic to treat half of the students who develop an infection we would be appalled if they provided each student with half of a therapeutic dose rather than using resources in the surrounding area to insure that everyone gets a full therapeutic dose.   Our situation has direct parallels.  For example, the clinic associated with our medical school has excellent DBT programs, and intensive treatment for OCD.  I believe it would be a serious disservice to our students to fail to refer to these excellent resources and it would be a waste of money to replicate these programs when they are well funded and available 6 blocks from our office.  It is probably malpractice to provide treatment in insufficient quantity and frequency to achieve clinically significant change when sufficient treatment is available nearby.

Disadvantages of a Scope of Service:  In some instances students have not been happy with being referred to other providers.  Frequently, this is related to our services being free while other providers may have a small co-pay.

Develop strict session limits

Advantages:  Many counseling centers have adopted this strategy.  Most of our students receive intermittent brief therapy over the course of their time in school with most receiving 5.5 or fewer sessions per year.  Our modal number of sessions is one (this is typical for all counseling centers).  It allows for more students to get in, get through and complete treatment thus increasing capacity.  Some centers limit sessions to 5 per year and then refer out.  This clearly increases capacity and provides everyone with something.

Disadvantages:   While a portion of our students achieve clinically significant change in this very short-term treatment, many students who have diagnosable mental health problems including anxiety and depression (our largest reported student diagnoses), are not likely to achieve sufficient symptom reduction,  sustainable over time, with very short term treatment.   Research completed at BYU has shown that when a student changes therapists in treatment, it increases the time and number of sessions required to achieve clinically significant change.  So, providing short term treatment and then referring out may actually prove counterproductive for our students.

Increase clinicians case load and eliminate other activities             [No way I could do this!]

Advantages:  This could create more clinical hours with our senior staff.

Disadvantages:  Any time we change something there are ramifications elsewhere.  If we reduce teaching, it would impact our accreditations in 2 academic departments in 2 different colleges, Counselor Education and Counseling Psychology.  If we reduce supervision and training, we lose the clinical service hours provided by our trainees and we force the Counseling Psychology department to develop their own training clinic at an expense of several hundred thousand dollars to keep their accreditation.   Given the number of hours of clinical service by trainees and the number of hours of supervision and training provided there would be no net gain in clinical service hours.  If we eliminated outreach efforts on campus, we would gain a total of 4 hours per week total.  In addition, we would decrease our visibility and campus awareness of our services .  As a result, fewer students who are in crisis would know about us and seek our services.  If we decrease our crisis and emergency response time, we might create more clinical hours but we would be less responsive to our campus.   Right now our contracts require that all staff provide the maximum percentage of their time in direct service allowed by IACS (65%).  Research evidence indicates that psychotherapists effectiveness begins to deteriorate when they exceed this threshold.

Have each counselor see more total  students, but see each student  less frequently      [We are already doing this, and obviously, it is NOT ideal.]

Advantages:  This allows all students to get some services and to remain somewhat connected with the CWC.

Disadvantages:  We would quickly arrive at a point where any student would receive one counseling session per month.  This was quite typical in our old Student Mental Health Center prior to our merger and resulted in students getting some minimal support but not effective treatment that would result in clinically significant change that is sustainable over time.  In many ways, this gives the illusion of providing help when we are really providing treatment that we know will be ineffective and unlikely to lead to improvement.  It is ethically questionable to encourage students to use a treatment protocol with no empirical support for its efficacy (I know of no behavioral change treatment that is effective when delivered on a once per month schedule) when more effective treatment is available in the surrounding area.  This is particularly true when students have the ability and willingness to pay.

Institute fee for service and use revenue to increase counseling staff as needed

Advantages:  We do have a portion of our students who warrant an Axis I diagnosis that would be reimbursable by health insurance.  This would generate some revenue.

Disadvantages:  The majority of the students we see in counseling would not warrant an Axis I disorder; although all of the students seen by psychiatry would.  We have a significant portion of our population who would be unlikely use our services because of fears about the consequences of diagnosis on their future careers.   Typically their fears about this are exaggerated, but that is irrelevant if it prevents them from seeking help.  Students fear that diagnosis will hurt their chances of getting into law school, medical school or other professional schools.  Schools who have attempted to fund counseling services through fee for service have not had good success.  In several universities instituting fee for service led to loss of student fee support and substantial loss of resources for counseling and psychological services.

At the University of Florida we have the luxury of having a resource rich community, so for us the most reasonable solution was to use a scope of service.  We provide case management through the Dean of Students Office and some limited contact and crisis support with some problematic students.   This allows us to provide strong empirically supported treatment for the majority of students who come into our center (4800 last year).    Other centers will arrive at other solutions based on their own individual circumstances and the resources available to them.

 Sherry Benton, Ph.D., ABPP

Director and Clinical Associate Professor

Counseling and Wellness Center

3190 Radio Road

PO Box 112662

Gainesville, FL  32611-2662