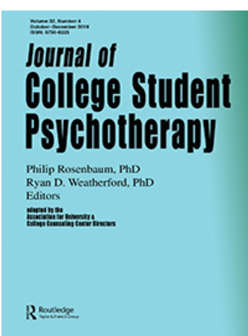

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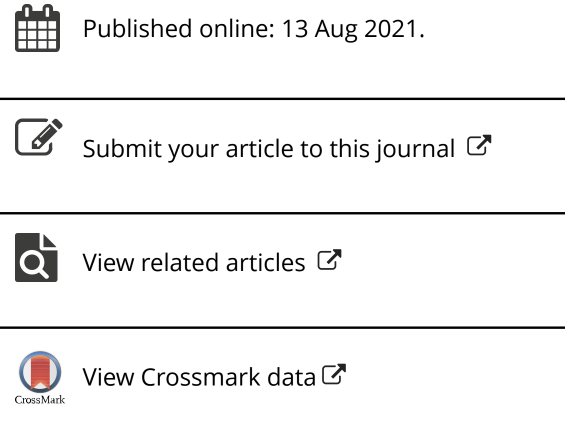

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Treating in Place: A Model of On-campus Care for Serious Mental Illnesses

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ABSTRACT

For several decades, college counseling centers have struggled to meet a steady rise in demand for services. Research suggests that therapeutic advancements, including psychotropic medication, have led to an increase in students with serious mental illnesses who now represent a significant portion of this demand. Current strategies to meet the demand for treatment have fallen short, often resulting in students with serious mental illnesses withdrawing. This composite case study introduces the Next Step Program at Rutgers University, a new program designed specifically to treat students with serious mental illnesses on campus. Using a social ecological approach, this case study traces the development of changes implemented at the macro level of the university, the meso level of the college counseling center, and the micro level of a student receiving treatment at the Next Step Program. By highlighting how on-campus treatment removes common barriers to care and improves outcomes for both students with serious mental illnesses and the universities they attend, college counseling professionals and administrators will learn of the crucial positive impacts on-campus treatment can provide.

KEYWORDS
Serious mental illness; college counseling; on-campus; treatment

Colleges and universities have been providing various forms of mental health services for students for over one hundred years. Established initially to improve retention, services have grown and expanded significantly as the demographics and needs of students have changed (Kraft, 2011). Over the past several decades, the demand for on-campus mental health services has risen steadily, frequently outpacing staffing and forcing counseling centers to adapt and adopt new systems and treatment approaches. While these efforts have provided some relief, research indicates that few have directly addressed the needs of students with the most acute issues (Morris, Feldpausch, Inga Eshelman, & Bohle-Frankel, 2019). Indeed, historically the majority of students with serious pathology have faced mandates to withdraw from their studies (Hartley, 2013). Seeking to reduce withdrawal rates the Next Step Program (NSP) at Rutgers University in New Brunswick, New Jersey,

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addresses the challenges presented by student mental health acuity by offering intensive on-campus mental health treatment. This composite case study utilizes the social ecological model, or the implications of bi-directional change between humans and their environments, to explain the multi-layered process of change required to establish NSP at Rutgers University (Rosa & Tudge, 2013). These changes, interwoven with the story of a student with a serious mental illness being treated at NSP, demonstrates the numerous benefits of on-campus treatment for the student, the college counseling center, and the university.

Literature review

Serious mental illnesses among college students

A serious mental illness (SMI) is defined by the *Diagnostic and Statistical Manual of Mental Disorders* (APA,) as a mental, behavioral, or emotional disorder resulting in serious functional impairment, lasting at least one year, and interfering enough with one or more major areas of life to be considered disabling. SMIs can have negative effects on self-esteem, cause disruptions in relationships, and limit the ability to progress in areas such as education and employment (Storrie, Ahern, & Tuckett, 2010). In the past thirty years, there have been significant advancements in the treatment of SMIs, including prescription psychotropic medications which now allow more young adults with severe anxiety, depression, and suicidal ideation to successfully attend and navigate college (Anderson-Frye & Floersch, 2011; Bishop, 2006; Eisenberg, Ketchum Lipson, & Posselt, 2016; Francisa & Hornb, 2017; Kadison, 2006; Kitzrow, 2003). The number of students on psychotropic medication has increased significantly from 9% in 1994 to 26% in 2014 (Gallagher, 2014). As approximately half (46.69%) of all individuals in the U.S. between 18 and 24 enroll in college (Blanco et al., 2008), it should not be surprising that there is a considerable demand for psychological services on campus. However, college counseling centers (CCCs) have struggled to meet the approximately 15% annual increase (Cornish et al., 2017) in treatment demand and to adequately address the increase in severity of illness (Brunner, Wallace, Keyes, & Polychronis, 2017; Kitzrow, 2003; Morris et al., 2019).

Inadequacy of current strategies to address needs

Current literature discusses the varied strategies CCCs are using to meet the growing mental health needs of their students. Prevalent approaches include prioritizing briefer therapies, establishing wait lists, increasing group treatment options (Bishop, 2006; Kitzrow, 2003), increasing hiring and prevention efforts (Brunner et al., 2017; Smith et al., 2007), reducing the frequency of

sessions, establishing session fees, setting session limits (Cornish et al., 2017), initiating triage systems, referring students to outside providers (Francisa & Hornb, 2017; Morris et al., 2019), and, finally, reserving the right to deny services when the mental health needs of a student exceed CCC's ability to treat (Kitzrow, 2003). Despite the inefficacy of referral off-campus, 38% of CCC directors surveyed in 2019 reported an increase in the use of referral to off-campus services (LeViness, Bershad, Koenig, Braun, & Gorman, 2019). Owen, Devdas, and Rodolfa (2007) found only 43% of students of color and 58% of white students successfully established treatment outside of the CCC. Barriers to accessing care outside of the CCC include lack of motivation by the student, lack of adequate provider options, financial issues including insurance limitations, and lack of transportation (Iarussi & Shaw, 2016). When students do not connect to outside providers, they frequently resurface at the referring CCC with urgent needs, additionally taxing an already overloaded system of service.

Arguments for and against on-campus treatment

A review of the literature within college counseling journals indicates that the overwhelming reasons SMIs are not treated on campus are inadequate funding and training. Some studies link insufficient funding to the inability to hire more staff (Francisa & Hornb, 2017), while others point to inadequate resources to train existing staff (Aldiabat, Matani, & Le Navenec, 2014; Morris et al., 2019; Mowbray et al., 2006; Smith et al., 2007). Auerbach et al. (2016) confirm these limitations in an exhaustive 21-country epidemiological survey of college mental health. Only a small minority of college students, they concluded, are receiving "even minimally adequate treatment" (Auerbach et al., 2016). As a result, organizations such as Active Minds and The Jed Foundation, both national leaders in mental health advocacy for young adults, urgently recommend that college and university leaders prioritize funding to improve mental health services, including both staffing and training (Ketchen Lipson, Abelson, Ceglarek, Phillips, & Eisenberg, 2019; The Jed Foundation, 2018).

In addition, debate over potential ethical implications of treating SMIs on campus continues both anecdotally (J. Richards, personal communication, September 21, 2020) and within the literature (Gilbert, 1992; Mowbray et al., 2006). CCCs are typically staffed with psychologists and clinical social workers who are bound by the ethical standards of competence established by both the National Association of Social Workers (NASW) and the American Psychological Association (APA). Both disciplines require clinicians to know the limits of their expertise and to treat within their training, experience, and education (APA, 1992; NASW, 2017). Many college counseling professionals have not received specialized training in the distinct needs of students with

SMIs. This case study calls for and demonstrates the effectiveness of redirecting institutional funding to increase hiring and training of CCC clinicians equipped to treat SMIs (Anderson-Frye & Floersch, 2011; Smith et al., 2007).

There are many reasons for colleges and universities to invest in the treatment of students presenting with SMIs. Research indicates the rate of withdrawal prior to completion of a degree is 45% for the general population, and an astonishingly high 86% for students with mental illnesses (Salzer, 2012). Ketchen Lipson, Gaddis, Heinze, Beck, and Eisenberg (2015) conclude that an institution's investment in student mental health is critical for the social, educational, and economic well-being of students, campuses, and broader society. Schultz (2020) urges universities to adopt both proactive and reactive approaches to avoid the deleterious costs of unmet mental health needs for both the university and students which can include lower academic performance, a diminished academic status, interrupted or decreased enrollment, and a campus culture that is pessimistic and crisis-oriented. Moreover, universities are in a unique position to identify and treat mental illness (Downs, Alderman, Schneiber, & Swerdlow, 2016; Eisenberg, Golberstein, & Gollust, 2007; Hunt & Eisenberg, 2010; Ketchen Lipson et al., 2015; Xiao et al., 2017) as the structure and special features of many college campuses "provide an insulated environment with layers of support not found in the general community" (Downs et al., 2016, p. 958).

Current on-campus programs for students with SMIs

There is a paucity of literature discussing formalized on-campus treatment for students with SMIs. Morris et al. (2019) explores a program known as iTeam, established at Colorado State University nearly ten years ago following the integration of the university's health network with the counseling center. The iTeam enables students who experience a significant mental health crisis, such as a suicide attempt or psychiatric hospitalization, to remain on campus "recovering in place." Receiving treatment on campus permits students to maintain ongoing connections with friends and local support networks and, in many cases, enables students with mental health concerns to continue to advance academically (Morris et al., 2019).

A similar program, not discussed in the literature but familiar to the college counseling community as presented at the Big Ten College Counseling Center Conference 2019 and 2020, is Michigan State University's Intensive Clinical Services Unit (ICSU). Like the iTeam, ICSU's primary focus is on treating students following a mental health crisis by providing what they call "higher frequency" integrated mental health services. ICSU's services include individual therapy, group therapy, psychiatric services, case management services, hospitalization support, and advocacy (Michigan State University, n.d.). Notably, the main therapeutic

intervention of both the iTeam and ICSU is dialectical behavior therapy (DBT). DBT is an intervention that seeks to enhance coping by teaching skills to improve emotional regulation and healthy relationships, as well as to reduce interpersonal chaos and impulsivity (Linehan, 1993); a growing body of research supports its usage in CCCs, including for students with severe and complex mental illnesses (Chugani, 2017). Qualitative outcomes of ICSU include decreased suicidal thoughts and behaviors, a restored sense of hope, and "presumably" improved retention and academic success (Morris et al., 2019).

Theories of organizational change

Students with SMIs, the CCCs who treat them, and their respective universities operate as a system of interconnecting parts. Bronfenbrenner's social ecological model (SEM) describes the interconnectedness of humans to environment as "nested structures, each inside itself like a set of Russian dolls" (Eddy, 1981, p. 3). Beginning with the layer farthest from the individual and enclosing all other layers is the chronosystem which is comprised of the internal and external elements of history, time, and policy. Moving one layer closer is the macrosystem which includes societal, cultural, and religious forces. This is followed by the exosystem, exerting positive and negative forces via community and social networks. Drawing closer still to the individual is the mesosystem, which encompasses direct contacts with others such as school, work, and church. Proximal to the individual and exerting the strongest influence is the microsystem, including family and peers. Having arrived at the individual – the innermost layer – the ecological environment is complete. This nested structure of layers has a "progressive, mutual accommodation" in which the individual and the system influence each other (Kilanowski, 2017).

Applied to changes within a CCC, a SEM model includes the following layers: the individual needs of students, the culture of the campus, the financial and resource constraints of the CCC and the broader university, the priorities and obligations of the university and its stakeholders, cultural forces, and policies and laws applying to higher education. The reader is invited to envision the SEM parallel processes of change and accommodation within the CCC at Rutgers University. On being informed of the rising numbers of students with SMIs at the university, administrators were petitioned to reallocate finances to address these needs. Once these budgetary changes were implemented, the CCC was able to design and establish NSP, resulting in the ultimate benefit of treatment for the most vulnerable students who were previously least likely to access appropriate care.

Methodology

As a long-term CCC clinician and the director of the NSP, I will use the case study method, a long-standing qualitative research tool among the social sciences, to illustrate how shifts beginning at the organizational level of a large university can result in benefits for a historically underserved population of students. Whereas Morris et al. (2019) discusses a model of "recovery in place," this case study will discuss "treatment in place" by introducing the Next Step Program (NSP) at Rutgers University Counseling, Alcohol and other Drug Assistance Program and Psychiatry (CAPS). NSP is designed specifically to meet an increase in demand for services from students with SMIs. For this study I use a fictional composite case narrative with all identifying information removed, to demonstrate how "Tess," a student with worsening symptoms of an SMI, came to be referred to and treated at the NSP. While case studies can contain limits for generalization, the goal of presenting Tess and the NSP is to demonstrate innovations in on-campus treatment models for students with SMIs. As Gerring (2006) proposes, a deeper understanding of a single example is often more valuable than a shallow understanding of many.

Case study

CAPS at Rutgers University, New Brunswick currently serves a student body of approximately 50,000 (Rutgers, 2021). Close to 4000 students per year seek mental health treatment at CAPS, and thousands more are served through community-based services and prevention efforts with campus partners (Counseling, Alcohol and Other Drug Assistance Program and Psychiatric Services (CAPS), 2016). Seeking to evolve to better meet what was described as the "seemingly relentless demand for mental health support" (Richards, 2016) the CAPS director and vice chancellor of Health and Wellness lobbied university administrators for several years to expand mental health care on campus. According to Richards (2016), the most critical concern was the 350 + "acutely distressed high risk" students per year referred from CAPS to higher levels of care (HLOC). The main argument against expansion – that Rutgers was an educational institution, not a treatment center – could not outweigh the counter arguments that finally led to development of NSP. Stakeholders ultimately agreed that student needs did not disappear just because services were not provided, that a disproportionate amount of staff resources were being devoted to a small percentage of cases, and that staff were suffering a heavy toll of fatigue and low morale as a result (Richards, 2016). Approval for NSP came in 2018, followed by budgetary modification within CAPS, hiring of clinicians experienced in treating SMIs, and programmatic design. NSP officially opened to Rutgers students in January of 2019.

Tess

As is true of the majority of NSP referrals, Tess was referred due to insufficient time in her CAPS clinician's schedule to adequately meet her clinical needs. Identifying as Latina, female, and lesbian, Tess was a sophomore majoring in Cell Biology and Neuroscience. Tess was diagnosed with bipolar disorder during her junior year of high school after developing a plan to kill herself by jumping from a bridge. Tess was hospitalized for one week, participated in an Intensive Outpatient Program (IOP) for six weeks, and was then treated by both a psychiatrist and an individual therapist for the remainder of high school. Fier and Brzezinksi (2010) report that many young adults with SMIs often discontinue medication when they transition to college as they see the transition as a fresh start or think their issues have passed. Feeling free of her parent's control upon arriving at school, Tess discontinued both therapy and her psychotropic medication. Tess made a smooth transition from high school to freshman year of college, achieving a stellar GPA, making new friends, and reveling in the new-found independence of college life.

By her sophomore year, however, Tess saw an increase in conflicts with her parents, academic pressure, and overall stress. Several months in, she began noticing that she lacked motivation and interest in academics and friends. Tess's sleep became extremely disrupted and she struggled to stay awake during classes. Just as she had in high school, she started to experience mood fluctuations, intense feelings of irritation, and frequent inappropriate outbursts of anger. Research indicates untreated psychiatric illnesses result in greater numbers of episodes, higher rates of relapse, and an increase in functional impairment. For students this frequently translates into poor academic performance, social problems, and an increase in suicidal thinking (Hamrin, McCarthy, & Tyson, 2010). Fearing mostly for her grades, Tess pursued mental health treatment at CAPS and began bi-weekly individual therapy sessions. Despite compliance with these sessions, however, Tess's mood continued to worsen and she once again developed suicidal thoughts with a plan, but without intent, to jump from a parking garage.

Prior to the establishment of NSP, Tess's CCC clinician would have likely invested considerable time and encountered significant resistance in attempting to refer Tess to an IOP off campus. Typical IOPs require patients to attend treatment at least three mornings per week, often from 9 AM to 1 PM. Even if she had agreed to miss classes to attend, Tess did not own a car and did not have the resources to make treatment at an IOP possible. Instead, Tess's clinician worked with Tess to quickly refer her to NSP, emphasizing how the treatment was right on campus and was designed with students' academic schedules in mind. Finally, she was informed that neither her parents nor her insurance provider would be notified about her treatment unless her suicidal ideation grew worse. Tess, demonstrating independent decision making,

a critically important skill for emerging adults to develop (Arnett, 2000), contemplated all this information, ultimately agreeing to pursue treatment at NSP.

A few days, later Tess showed up for her intake appointment appearing nervous. She wrung her hands, paced, and bounced her leg when seated. As the Director of NSP, part of my responsibilities includes maintaining an active role as a clinician. I perform intakes, provide individual therapy, intervene with crises, and lead groups. Knowing I would work with Tess as her individual therapist if admitted, I had reviewed her treatment history and spoken briefly with the referring clinician before the intake. Seeking to build rapport and to begin to lay the groundwork for therapeutic gains, I made sure to spend time validating and normalizing Tess's feelings. "Welcome to Next Step, Tess. We are glad you are here. How are you feeling about being a part of our program?" Tess didn't hold back, bursting out with, "Well, my other therapist told me there would be a lot of groups. I feel nervous about that because of time. And also, I don't really want other kids to know about my problems. I am embarrassed. I bet no one else is failing or struggling like I am." As I have heard these exact fears from almost every student at NSP, I thanked Tess for being candid and moved the conversation toward joining. NSP is a predominantly group-based program and is built around the belief that group treatment holds unique therapeutic benefits. According to Yalom (1970), universality, the feeling of belonging and "we are all in the same boat," is a key curative factor (p. 10). I assured Tess that every student she had encountered in the waiting room once felt the same way and simply asked her to give NSP a try. Tess nodded, tacitly signaling both an agreement to proceed with the intake and to try NSP.

Course of treatment

Immediately following her intake and a tour of the building, I took Tess to meet the NSP case manager to establish her action plan. Having a designated case manager who clarifies concerns, identifies resources, and prepares action plans is one of the major advantages offered to students at NSP (Zdziarski, Dunkel, & Rollo, 2007). As NSP follows the DBT hierarchy of targeting life threatening behaviors first (Andreasson et al., 2016), Tess's first action plan goal was to reduce suicidal thoughts and behaviors. Tess reported her second goal was "wanting to feel better and be able to be myself again." The case manager then helped Tess schedule her first weekly individual therapy session, her next case management session, and an immediate intake with psychiatry. Prioritized access to psychiatry, like designated case management services, were innovative structural changes made at the meso level of CAPS to better accommodate NSP students.

Tess and the case manager finished their initial session by choosing groups. Tess pulled up her class schedule on her phone and began to find times for her required weekly DBT and Interpersonal Process groups. As both groups are offered several times per week at varying times of the day, Tess managed to fit both into her schedule. Next, Tess looked for at least three more weekly groups to round out her treatment week. Group offerings at NSP illustrate the bidirectional nature of students influencing the treatment environment and the treatment environment influencing the students. In designing NSP curriculum, we first included offerings common in CCCs such as Behavioral Activation for Depression, Anxiety Management, and Artistic Expression. As the program has grown, however, we have combined quantitative data on symptomology with qualitative input and suggestions from students. Offerings now include Executive Functioning Skills, Queer Study Space, Co-occurring Disorders, Yoga, and Adulting 101. We revisit offerings each semester to reflect the ever-changing needs of NSP students and the environment at Rutgers. These offerings augment the main therapeutic focus of DBT by targeting additional areas in student's lives that benefit from support and skill building.

DBT

Tess's treatment needs matched well with the primary treatment modality of DBT at NSP. As DBT does not automatically assume that skills learned in session will generalize to everyday life, it is important to actively utilize real life examples to reinforce skills and enhance their generalizability (Linehan, 1993). During one session of Artistic Expression, Tess reported using the "STOP skill" to handle an urge to lash out at her roommate, saying, "My roommate really gets under my skin. I think she does things on purpose to make me angry. Last week she ate my leftovers and then left the dirty dishes *of my leftovers* in the sink for three days. I wanted to scream at her and maybe even throw the bowl at her." Recognizing that Tess had made an advancement in skill usage by resisting these urges and wanting to make sure the other group members also noticed, I jumped on her comment: "Wow! Did you all hear what Tess said?! Tess, tell us more about how you did this!" Tess went on to explain, saying that "last week in DBT we all learned the STOP skill. The group leader told us to try and remember a stop sign, which somehow was an easy thing to do. I am not sure if I got all the steps right, but when I wanted to scream and throw the bowl I stopped, took a deep breath, and thought about it. I decided that even if it felt good to yell and throw the bowl, I was going to have to still live with her for a long time, so it actually wouldn't be worth it." I thanked Tess for sharing and praised her for remembering and being willing to use these skills outside of group.

Outcomes

Tess ultimately spent eight weeks in treatment at NSP. During the first month, Tess met with psychiatry and restarted psychotropic medication to help manage her mood. She soon saw improvements in both sleep and motivation. Tess and I used her weekly individual therapy sessions to explore personal issues and gain coping skills. One afternoon, Tess recounted how she had been able to challenge some problematic thoughts from a phone call with her mother. “My mom has this way of saying things and I get upset really easily when talking to her. This past weekend I was feeling really scared and worried after we talked. I’ve been working so hard to keep my mood up and I really didn’t want to feel scared and ruin my whole day.” I nodded, signaling that I was listening and waited for Tess to tell me the outcome. “I remembered how we talked about how my thoughts and feelings work together. I asked that question on the worksheet you gave me- ‘is there any evidence for these thoughts?’ I thought about it and there wasn’t, and it really helped!” I smiled as I knew Tess had indeed been working hard. I felt happy that she was learning new ways to help herself that she would carry beyond her time at NSP.

As I had hoped upon her admission, Tess did eventually report feeling understood and accepted by the other NSP students who shared similar diagnoses and challenges. Upon discharge, Tess reported no suicidal ideation, plans, or intent. Tess’s discharge plans included completion of her DBT skills group, returning to bi-weekly individual therapy sessions with her referring CAPS clinician, and a continued connection to psychiatry for medication management.

In her discharge paperwork Tess acknowledged that without NSP, she would likely not have been able to finish the semester. Tess wrote, “I’ve learned how to be more kind to myself, how to take my power back, practice better boundaries, and cope in terms of crisis. I’ve also realized I’m still human so I definitely need to continue to practice the skills I’ve learned here.”

Discussion

The case of Tess and her time at NSP illustrates the benefits of making macro-level changes for CCCs to provide on-campus mental health treatment for students presenting with SMIs. In October 2020, 53% of college administrators ranked student mental health as their top concern, recognizing the profound impact mental health issues have on all aspects of university life (Brown, 2020). Research examining college mental health recommends a paradigm shift to broaden access to resources (Cornish et al., 2017). The few existing programs such as NSP are examples of such paradigmatic shifts, systemic changes, and broader access to resources that positively impact the mental health of students and the university at large.

Lest this case study present too rosy a view of NSP, readers should know that students do present resistance to NSP, most significantly in the form of attendance. For some students, attendance is inhibited by the symptoms of their SMI such as low energy, interest, and motivation. For others, attendance begins to suffer as their mood, sleep, and functioning improves throughout treatment and they channel their improved functioning into academics and their social life. The staff at NSP walks a fine line here. We are always truly excited about progress, but we are also the treatment team armed with the knowledge that discontinuing treatment prematurely often leads to setbacks, even relapse. We have learned to actively encourage students to keep their commitment to the program and to engage them frequently in discharge planning. When students like Tess know they have a finite number of weeks left to finish NSP, they experience a sense of relief and are more likely to complete the program.

The ability to establish on-campus treatment for students like Tess, a fictional example highlighting common presenting symptoms at NSP, may not be generalizable for other CCCs. Research indicates that nearly twenty-five percent of college students have experienced suicidal thinking, a significantly higher rate than the general public. Of this twenty-five percent, 65% report that the suicidal thinking occurred within the past year (Mortier et al., 2018). In spring 2019, the first semester of NSP operation, the self-reported rate of suicidal thinking in the past two weeks among NSP students was 87% (Mason, B., personal communication, June 2020). Mental health symptoms, including suicidality, are fluid, not static, often changing frequently. If suicidal thinking worsens, students like Tess may require immediate transfer to HLOC to address the safety concerns adequately. At Rutgers University, NSP is in a densely populated, urban area in direct proximity to various crisis resources, easing the transfer of care in a crisis. But such crisis resources may not be available to students attending universities located in remote or sparsely populated locations. A lack of adequate resources to mitigate risk could potentially disqualify some CCCs to provide on-campus treatment.

Another possible limitation of this case study for other universities is funding. Given the necessary capital expenditures for staffing, training, and treatment space, many CCCs may not have the financial or therapeutic resources to invest in such programs. CAPS has had an active DBT consultation team and group program for over ten years. Nine years ago, I joined this team after completing the full DBT intensive training. Professional training, support, and expertise in treating severe and complex mental illnesses (Chugani, 2017) allowed me to establish a viable evidence-based treatment model for NSP. In addition, Rutgers made a substantial financial investment in NSP when they agreed that “this program could be a model for the field as there is no currently identifiable intentional programming to meet the needs of

these students" (Richards, 2016, p. 2). Many smaller or poorly funded CCCs may not be able to convince stakeholders to make the same investment decisions.

Finally, this case study highlights how providing on-campus treatment for students with SMIs is an ethical and social justice issue with far-reaching impact. Research suggests students with marginalized identities are more likely to suffer from high rates of stress from multiple sources, leaving them more vulnerable to negative mental health outcomes (Schultz, 2020). Moreover, as discussed above, students of color are less likely than white students to successfully establish treatment outside a CCC. In its first two years of operation, NSP treated significantly higher rates of students of color and students identifying as LGBTQ than compared to the general university population, or even the population seeking treatment at CAPS. Tess, for instance, a true composite case, had the intersectional identities female, Latina, and lesbian. Expanding the services of CAPS via NSP aligns with our ethical commitment to honoring the dignity and worth of all individuals (NASW, 2017). By removing barriers to care which are often greatest for students with marginalized identities, we are providing more equitable access to mental healthcare, thereby reducing the disparities in negative outcomes. Such investment in student mental health extends beyond the individual students like Tess who receive the care, positively impacting the broader university and society as a whole (Ketchen Lipson et al., 2015)

Conclusion

Tess's referral and treatment at NSP demonstrates innovative changes driven by the increasing numbers of students with SMIs seeking treatment at their CCCs. Instead of the current standard of referral to treatment off campus, the changes made at the macro level to implement NSP enabled Tess to achieve her personal/micro level goal of remaining enrolled, while also stabilizing her mental health. Although finances and budgets are a perennial concern for stressed CCCs, universities can no longer justify allocating such a significant proportion of their mental health resources to send students elsewhere. CCCs play an integral role in the mission and well-being of the entire university. It is therefore imperative that finances are realigned to fund treatment options that address the actual needs of the students who now populate our campuses and require our services. Programs such as NSP confirm the benefits of reallocation of resources to these high-need, high-intensity cases.

Several questions remain. Have other universities examined the feasibility of implementing on-campus treatment programs in their CCC? What changes need to be implemented on the macro level of other universities and the meso level of their CCCs to provide students with SMIs on-campus treatment? Understanding these specific challenges along with suggestions on how to

minimize obstacles to implementation would be a great contribution to this topic. The few on-campus treatment programs, like NSP, already in place now need to disseminate outcome data to elucidate the many benefits of their programs, including reducing strain on the overall CCC and positive impacts on student success. Finally, administrators and college counseling professionals need to consider how access to adequate support services impacts more than just individual academic success or the climate of a specific university. The ability to do well in the university setting and to graduate from college is an ethical issue at the core of a just society. We must not stop simply at improving the capacity to be admitted to college but must continue to innovate and support students through their full experience of higher education. The needs of students like Tess are not going away. We owe Tess the dignity and respect to help her be as successful as she can be.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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