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# **Considerations for Integration of Counseling and Health Services on College and University Campuses**

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# Considerations for Integration of Counseling and Health Services on College and University Campuses

College and university counseling services and student mental health issues have garnered considerable attention over the past several years. Various studies have drawn attention to the growing mental health needs of students and the positive impact of counseling services on college student success (Sharkin, 2004). However, counseling services vary considerably with respect to administrative structures and clinical practices. Understanding the operations of an individual counseling service must occur within the context of the college or university and the administrative reporting structure.

All counseling services generally provide some form of individual counseling or psychotherapy with additional services varying tremendously among centers. Some provide couples, group, and/or family therapy; alcohol and drug treatment; eating disorders treatment; psychiatric services; psychological assessment; and career counseling. Most centers also provide some type of outreach and consultation services. Similarly, the student health service plays an important role on the college campus. Many students with mental health concerns may feel more comfortable seeing a healthcare professional rather than a mental health professional. A number of mental health concerns may initially present with physical symptoms (e.g., panic disorder) that bring them to the student health center for evaluation and treatment demonstrating how student health services is an important resource for the counseling program. For some mental health problems (e.g., depression), a medical evaluation can be important to rule out possible physical illness. In addition, certain mental health conditions (e.g., eating disorders, drug and alcohol problems) are best managed by having both student health and counseling professionals involved in a student's care. Therefore, the relationship between the student health and counseling services is an important one to understand. In recent

years, this relationship has been of growing interest and concern.

Taking a more integrated approach may provide the best foundation for providing holistic care to students. This approach is consistent with some of the societal and cultural shifts that emphasize wellness. An integrated approach between counseling and health services may allow for an alignment of support services and systems. Staff morale and professional satisfaction may be bolstered by professional training and education that enhances staff relations, improves communication, and fosters mutual respect across disciplines. Alschuler, Hoodin, and Byrd (2008) argue that integration may result in better detection and early treatment for a wide range of disorders. Collaboration between counseling and health services may be instrumental to provide leadership from a public health perspective and to address issues such as responding to students with eating disorders, alcohol and other drug concerns, and at-risk students. However, integration also involves administrative coordination, merging diverse systems, developing staff philosophical consensus, allocating resources, and developing clear communication with the university community about services.

While clearly recognized standards for college and university counseling services currently exist (e.g., guidelines from the International Association of Counseling Services (IACS) and Council for the Advancement of Standards (CAS)), an understanding of what constitutes "best practice" in merged or integrated services is evolving. This paper provides a snapshot of the current organizational structures of student health and counseling services across the country and explores the benefits and challenges various schools have encountered in the attempt to integrate valuable college and university services. Further, the paper offers recommendations for schools considering the integration of campus mental and physical health care.

## **History**

In 2006, the American College Health Association Board of Directors created and charged a Mental Health Best Practices Task Force with identifying strategies that would help Mental Health section members to function more effectively in the delivery of mental health services. While the task force initially set out to develop best practices for counseling college students, after research and debate, it concluded that best practice documents had been developed from a variety of sources (i.e., IACS, CAS) and shifted the focus to another element that was still in its naissance. Counseling and health center integration was a topic that had received little research attention, but was often a target of discussion among ACHA members. Efforts were directed toward issues related to the challenges and benefits of integrating services in college health. Task force members conducted a literature review, developed and distributed a survey, compiled the results, and conducted subsequent follow-up interviews with individual center directors.

Members of the task force, all ACHA members, represent a wide diversity of college and university settings. The group was multidisciplinary and drew from the fields of law, nursing, psychology, psychiatry, and social work. Varying levels of administrative responsibility were evident in the task force composition, involving staff personnel, associate directors, and directors. Members from both integrated and non-integrated centers were represented on the task force and shared a foundational understanding that this paper would not represent any bias towards or away from the integration of health and counseling centers. The agreed on purpose was to provide a breadth of information about the experience of integrated centers in an effort to present various models of practice and related outcomes that could serve as a guide to centers contemplating, evaluating, or undergoing integration. Members decided that in order to better learn about the experience of integrated centers, an inventory or benchmark of current practice was necessary. An action plan was devised to survey centers regarding their current organization and practices, and to follow up with individual case studies.

## **Literature Review**

The integration of primary and behavioral health care services has been the focus of recent research. For example, in the general population, such integra-

tion has resulted in cost savings and positive clinical outcomes (Walker & Collins, 2009). An additional driving force behind the merging of physical and mental health systems has been the inclination for individuals to seek care for behavioral health conditions from a primary care provider rather than the mental health system (Regier, Narrow, Rae, & Manderscheid, 1993). Blount (1998) emphasizes this trend by describing integrated primary care as the union of physical and behavioral health services to more completely confront the array of problems patients present in primary care settings. Tucker, Sloan, Vance, and Brownson (2008) suggest that the integration of mental health services into primary care practices improves access to mental health services through the removal of stigma-related barriers. The authors emphasize that the physician and the mental health clinician working as team provide a better opportunity of ensuring a positive outcome for the student. Furthermore, Mowbray, Megivern, Mandiberg, Strauss, Stein, Collings, Kopels, Curlin, and Lett (2006) advocate for a “no wrong door” approach to access of mental health services. The authors suggest that health services are positioned to be an effective referral source for a variety of mental health concerns. Despite these positive attributes of integrated care, the empirical data evidencing support for these systems and structures remains mixed. A meta-analysis conducted by Butler, Kane, McAlpine, Kathol, Fu, and Hadorn (2008) revealed that, in general, integrated care sites report positive treatment related outcomes, however, none of these studies demonstrated better clinical outcomes than those found in non-integrated care models. Further, it has been noted that outside of homogeneous health care systems (e.g., Veterans Administration, HMOs, and college and university settings), the financial and organizational barriers to integrating care prevent the widespread implementation of this model (Walker & Collins, 2009).

There is scant literature describing organizational mergers between university student counseling centers and student health services. However, the few resources available indicate that mergers have been happening for more than two decades. Foster (1982) describes the process of merging a traditional counseling center with a comprehensive student mental health unit at the health center. His review of the literature at that time pointed to key elements necessary to an integrations effort. Four variables were seen as key: the existing relationships between involved agencies; the awareness of partial interde-

pendence among agencies; the resource asymmetry between the involved units; and lastly, the type of task to be coordinated. Foster promotes the use of “supplemental integrating devices,” such as interdisciplinary teams, clinical seminars and coordinators for research, training, and developmental services to foster fuller integration of highly differentiated centers. Even in 1982, Foster wrote about budget crises, decreasing resources, and increasing administrative review as on-going concerns. The benefits of merger, per Foster, include a broader, more energetic clinic with less confusion on campus about services, and no competition between the two groups.

Alternatively, in a paper presented to the 1994 Annual Convention of the American Psychological Association, Gillespie and Morgan (1994) recommended that university counseling centers retain autonomy, citing issues of administrative challenges in the medical hierarchy, a devaluation of mental health services as compared to medical services, and issues regarding supervision and leadership. Gillespie also noted that organizational mergers might become common given the economic climate. Morgan, presenting along with Gillespie, advised that thought be given to several factors: the physical environment, the client’s first contact, and the medical staff’s perceptions of the mental health services during the planning stages of a merger.

Federman and Emmerling (1997) presented the results of an outcome survey of organizational mergers of student counseling centers and student mental health services. The survey compared outcome ratings as well as narrative responses regarding: quality of clinical service, ability to meet needs of students, morale of staff at merged services, university community’s utilization of available services, administrative structure, available funding and other related budgetary issues, and processes that may have facilitated or hindered the mergers. The authors concluded that there were no clear trends in organizational mergers nor did it appear that one configuration was more effective than another. While one hypothesized motivation for merger was reduced cost related to duplication of services, the authors found that costs were not reduced but there was a decrease in the ambiguity of two services in separate locations. Finally, Federman and Emmerling noted that the desire to ameliorate problems associated with duplicated services reflected an interest in lessening the tensions between a medical model and a developmental model approach to student mental

health. They suggest that clear and differentiated role definitions between mental health and counseling facilitate stronger departments and services, and that effective preparation and management of the merger process is critical.

Data from the Association for University and College Counseling Center Directors (AUCCCD) survey (Rando & Barr, 2009) may provide the most accurate assessment of current practice. It is an annual questionnaire sent to its members (approximately 700 directors) which has been collecting data over the past 15 years. The 2009 survey (391 respondents) found that most centers (66.5%) report having no degree of integration with the health service, a slight increase from the previous year. The percent of counseling centers reporting being fully integrated with health centers remained the same, 15.6% in 2009 as compared to 15.3% in 2008. In the 2008 survey, 15% reported sharing the same building but not being administratively merged. In the 2009 survey, 4.3% reported being partially integrated, that is having some offices in the health center and some offices elsewhere on campus, and 11.5% reported sharing resources while maintaining separate offices in separate buildings. Many counseling and health centers do operate within the same division and/or under the purview of the same senior administrator and are being tasked to find creative ways to work together. This approach appears consistent with the economic and social objectives that foster the alignment of resources to simultaneously save costs and meet patient needs.

## **Methodology and Demographics**

This project consisted of three parts. The first part was an overall attempt to understand the structure and organization of student health and counseling services at universities and colleges across the country. After reviewing this information, the task force identified centers defined as integrated and queried them more in depth, focusing on the issue of integration. The third part consisted of follow-up case study interviews with selected center directors.

Using the findings from the literature review, the task force developed a web survey consisting of 111 questions. The survey contained demographic information as well as questions relevant to counseling and health center integration. The survey also contained questions about the structure, rationale, and subsequent impact of integrating health and counseling services. A copy of the survey is avail-

able by contacting the ACHA national office. In the fall of 2007, members of the American College Health Association (ACHA), Association of University and College Counseling Center Directors (AUCCCD), and Student Health Services (SHS) listserv recipients were invited to complete the

survey. The survey was sent electronically to approximately 1,800 individuals.

The task force compiled data from 359 completed surveys with respondents representing all 11 ACHA regional affiliate areas (see Table 1).

**Table 1. Regional Affiliate Area**

	Unique Institutions (N = 359)	Percent
Southwest College Health Association	31	8.6
Southern College Health Association	51	14.2
North Central College Health Association	20	5.6
Central College Health Association	16	4.5
Rocky Mountain College Health Association	8	2.2
Mid-America College Health Association	31	8.6
Ohio College Health Association	14	3.9
Mid-Atlantic College Health Association	49	13.6
New York State College Health Association	33	9.2
New England College Health Association	30	8.4
Pacific College Health Association	76	21.2

**Table 2. Undergraduate Enrollment**

	Unique Institutions (N = 359)	Percent
No Undergraduates	2	.6
Under 1,000	22	6.1
1000-1,999	44	12.3
2,000-4,999	82	22.8
5,000-9,999	59	16.4
10,000-14,999	55	15.3
15,000-19,999	39	10.9
20,000-24,999	27	7.5
25,000-29,999	15	4.2
30,000-39,999	11	3.1
40,000+	3	.8

## Overall Results

Approximately 59% of the respondents were from public colleges and universities, and 41.5% represented private institutions. The majority of respondents (79.7%) were from urban or suburban campuses, and 20% were from rural locations. Approximately 73% of respondents had an undergraduate enrollment of less than 14,999 (see Table 2). Eighteen percent of the participating institutions

had no professional or graduate students. Community colleges represented 9% of the responding institutions. Individuals completing the survey were from a variety of disciplines in college health (see Table 3). In those instances where multiple surveys were received from one campus, the responses provided by the mental health staff were selected for the survey results.

**Table 3. Professional Discipline of Respondents**

	Individual Respondents (N = 356)	Percent
Physician (non-Psychiatrist)	38	10.7
Psychiatrist	7	2
Psychologist	83	23.3
Counselor/Social Worker/MFT/LPC	31	8.7
Nurse	68	19.1
Nurse Practitioner/Physician Assistant	57	16
Pharmacist	0	0
Health Educator	4	1.1
Health Administrator	48	13.5
Other	20	5.6

**Integrated Center Results\***

*Administrative Structure and History*

The task force was primarily seeking data from health and counseling centers that operated within a “merged/integrated” model. Because there is no consistent definition of a merged/integrated system, the survey required an initial self-assessment that the task force used to delineate integrated or non-integrated status. This self-assessment consisted of the presentation of four schematic administrative models from which respondents were asked to select the one that most accurately described their center’s administrative structure. Based on that choice, 92 respondents (25.6%) were from centers that the task force considered to be integrated. Only these 92 respondents were directed to complete the final appropriate survey questions, which provided insight into the degree and effects of merger/integration through analysis of administrative structure, clinical services, operational processes, and fiscal elements.

**Survey Results of the 92 Integrated Centers**

Four administrative models were identified, by the task force, as descriptive of integrated centers. In the most commonly reported model, 29 of the merged/integrated centers (34.9%) indicated that assistant directors for health and counseling each reported to a center director who reports to a senior student affairs officer. Twenty-seven centers (35.1%) indicated that their counseling services director reports to a health

services director who reports to senior administrator. Another 20 (24.7%) indicated that a chief health and counseling director reports to a single administrator. In the least representative model, 16 centers (21.3%) reported that their health services director reports to a counseling services director who reports to a senior administrator.

*Demographics*

Of the integrated centers, 42.6% (n = 38) were located in schools with undergraduate enrollments of under 5,000; 18% (n = 16) were from schools with enrollments ranging from 5,000-9,999; and 29.3% (n = 26) from schools with populations of 10,000 to 19,999. Finally, large schools — those with populations over 20,000 students accounted for 10.1% (n = 9) of the integrated centers. It is evident that smaller schools were more likely to have an integrated center, perhaps evidence of using integration to fulfill otherwise unmet needs for service on these campuses.

Respondents indicated that their current administrative model had been in place for seven or more years in 63.1% (n = 58) of the respondent centers, and for six years or less in the remaining 37% (n = 34). The vast majority (95.5%, n = 84) of centers reported no current plans for future changes in administrative structure.

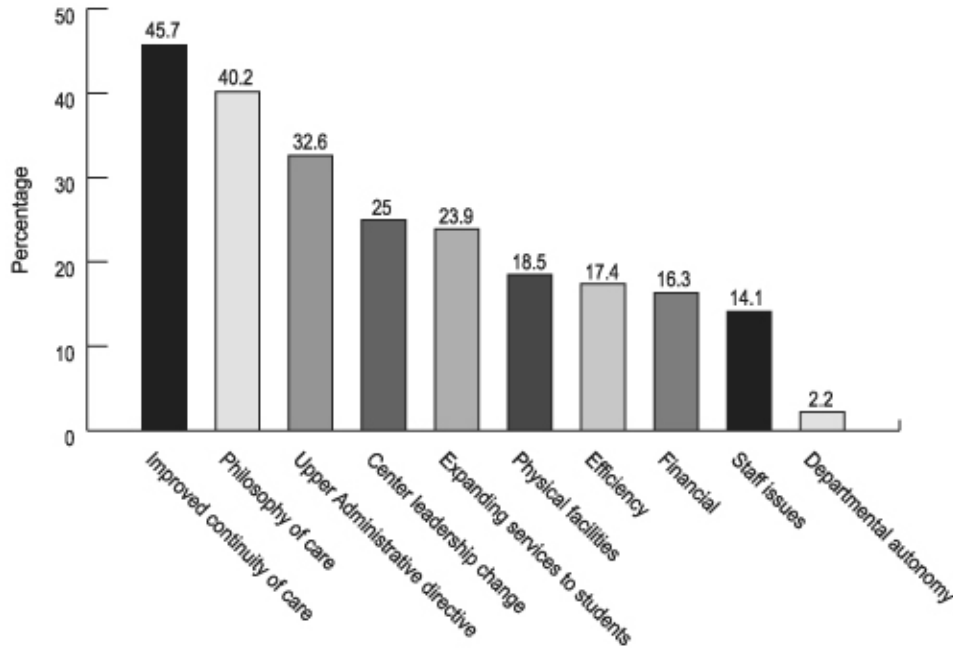
**Health and Counseling Structure and Operations**

**Impact of Integration**

The most frequently reported factors that led to the development of the current model were a desire to

\* In calculating the percentages, the denominator may vary from question to question depending upon the number of schools that responded to each question.

**Chart 1. Factors Driving Change to Integration**



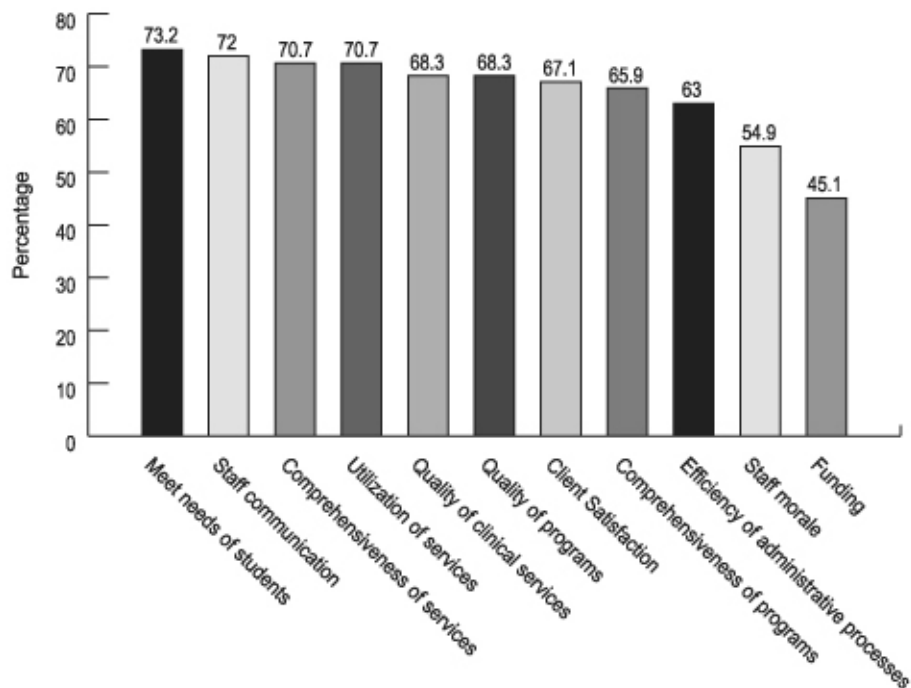
improve continuity of care (45.7%,  $n = 42$ ), a philosophy of care (40.2%,  $n = 37$ ), and an upper administrative directive (32.6%,  $n = 30$ ) (see Chart 1).

Centers were asked to rate the impact of the merger on various aspects of service provision. A Likert scale (Unknown, Distinctly worse, Worse, No change, Improved, and Distinctly improved) was used to measure the impact of integration. The majority of centers reported that staff communication,

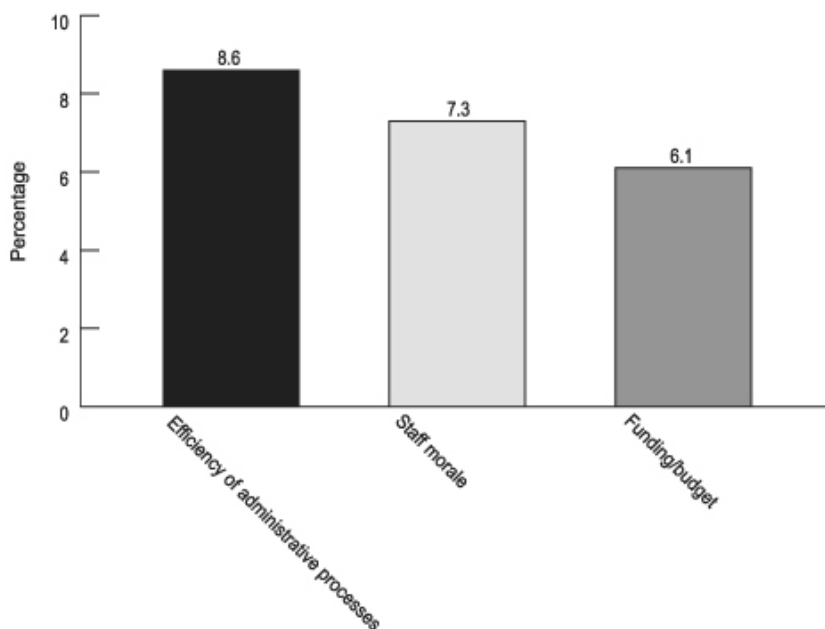
quality of clinical services, quality of programs, comprehensiveness of services and programs, client satisfaction, utilization of services, efficiency of administrative processes, and ability to meet the needs of students had “distinctly improved” or “improved” after the integration (see Chart 2).

A decline of efficiency of administrative process was reported by 8.6% ( $n = 7$ ) of the respondents. Likewise, 7.3% ( $n = 6$ ) reported worse staff morale

**Chart 2. Percentage Reporting Improvement after Integration**



**Chart 3. Percentage Reporting Decline after Integration**



and 6.1% ( $n = 5$ ) reported worse funding/budgets (see Chart 3). However, approximately 31.7% ( $n = 26$ ) of the centers reported no change in funding/budget and 23.2% ( $n = 19$ ) reported no change in staff morale since the administrative change.

### Mission and Strategic Planning

The survey revealed a range of differences among integrated centers. The differences noted included the presence or absence of a shared mission statement, a shared budget, and a strategic planning process. A single formal mission statement is noted in 61.6% of the merged centers, with the other merged centers having separate statements. This trend is also noted in the strategic planning process, with 47.8% of the merged centers engaged in a single strategic planning process. A subgroup of centers, 29.3%, have a separate planning process for the health and mental health areas in addition to a central strategic planning process for the entire center.

### Fiscal

The survey queried centers about the budget operation and sources of funding. Centers were nearly evenly divided in terms of budgeting process. Thirty-four percent of the centers operate under one budget, and 33% of the centers report one overarching budget which is divided into individual budgets for separate functional areas. A separate, stand-alone budget for each function was reported by 31.9% of the respondents. Respondents were also asked to

report the percentage of the total department budget that was derived from seven different sources (institutional funds, health fee, activity/other student services fee, fee-for-service, grants, endowments, other). The funding source which was reported to fund the largest percentage of center budgets was the student health fee. On average, 70.8% of budget allocations reportedly came from student health fees. Fifty-eight percent, on average, of budget allocations were reported to be from institution funds. The third largest reported budget source was activity/other student services fee (34.7% on average). The average reported funding levels of the remaining budget sources were: fees-for-service (19.9%), other sources (12.4%), grants (5.3%), and endowments (3.5%).

### Staffing and Training

The participants were asked to indicate the discipline of their directors. Psychologist was the most represented with 23.4% ( $n = 22$ ), followed by master-level counselors, nurses, nurse practitioners/physician assistants, physicians (non-psychiatrists), and health administrators. Note that five directors reported multiple professional disciplines (see Table 4).

### Physical Space and Records Access

The reception/check-in areas are shared spaces by 43.5% ( $n = 40$ ) and separate by 56.5% ( $n = 52$ ). A majority of the centers have combined websites (62.6%), advertising (66.3%), and name (70.7%).

**Table 4. Professional Affiliation of Center Director**

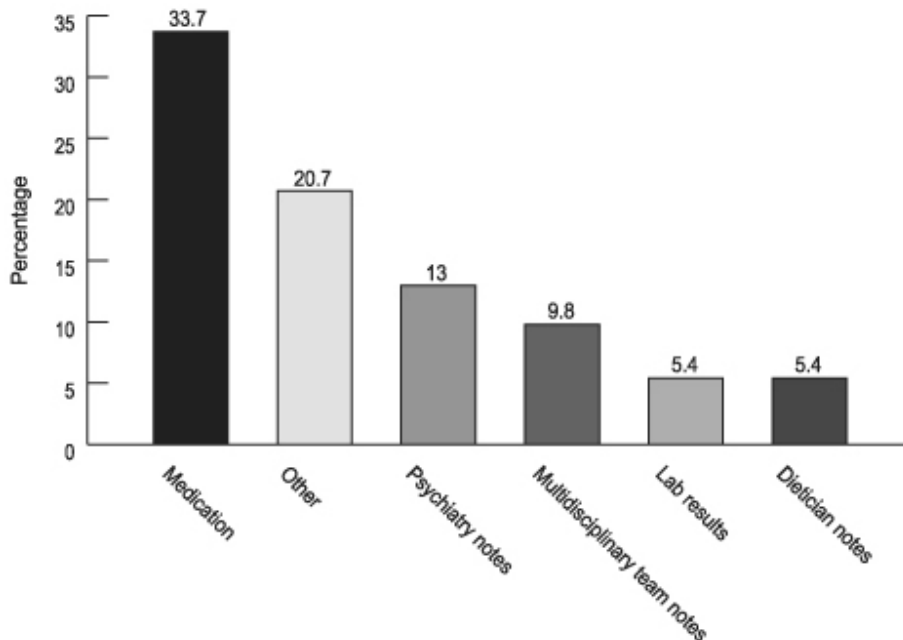
	Unique Institutions (N = 97)	Percent
Psychologist	22	23.4
Counselor/Social Worker/MFT/LPC	15	16.0
Nurse	14	14.9
Nurse Practitioner/Physician Assistant	14	14.9
Health Administrator	12	12.8
Physician, (non psychiatrist)	12	12.8
Health Educator	3	3.2
Psychiatrist	2	2.1
Other	3	3.2

**Note that five center directors were identified as multi-disciplinary**

One area of interest, often a concern for mental health and primary care personnel, focuses on record keeping. Survey results indicate that records/charts areas are predominantly located in separate spaces (79.3%,  $n = 73$ ) and 93.4% ( $n = 85$ ) of clinical areas are separate when reviewing data on the health and counseling physical layout. While 15.2% ( $n = 14$ ) of

the integrated centers report that they maintain joint health and counseling records/charts, the remaining 84.8% ( $n = 78$ ) reported that charts are maintained separately. For those centers that indicated that they maintain separate records/charts, Chart 4 indicates the most common duplicative information in both records.

**Chart 4. Duplicated Information in Separately Maintained Charts**



**Forms and Information Sharing**

Consent for treatment forms are administered separately by the services in 77.2% ( $n = 71$ ) of the centers. Surprisingly, 3.3% ( $n = 3$ ) of the centers reported that they do not utilize consent to treatment

forms at all. Students sign separate student health and counseling authorization forms for release of information in 62.2% ( $n = 56$ ) of the merged centers, but sign one form for release of information from both health and counseling units in 37.8% ( $n = 34$ ) of the merged centers.

Respondents were asked how students are informed of, or give consent to, the sharing of confidential information between health and counseling service staff. Approximately 51.7% ( $n = 45$ ) responded that this is accomplished through the initial consent form, while 36.8% ( $n = 32$ ) utilize a separate written authorization, and 9.2% ( $n = 8$ ) have no written form. Only 2.3% ( $n = 2$ ) of the participants indicated that their services do not share information. The methods of information sharing include “informal individual verbal communication” (88.5%,  $n = 77$ ), multidisciplinary clinical care conferences (46%,  $n = 40$ ), and written communications (46%,  $n = 40$ ). Clinical information is not routinely shared in 17.2% ( $n = 15$ ) of the reporting centers.

### Collaboration and Consultation

There are many factors in the provision of clinical services in a merged center that provide interesting insight not only into the degree of integration, but also the challenges centers confront in deciding which elements of service warrant cross-consultation and collaboration in some form. This information may be particularly useful to those health and counseling centers considering moving towards integration and/or the development of disorder-specific treatment teams. Participants were queried about the degree of clinical consultation and collaboration in general between the health and counseling services. The highest category of response (42.2%,  $n = 38$ ) was that there is “frequent clinical collaboration and

some interdisciplinary treatment teams.” “Extensive collaboration and use of interdisciplinary teams” was reported by 22.2% ( $n = 20$ ) of the centers, and 20% ( $n = 18$ ) indicated that there is “frequent clinical collaboration with no interdisciplinary treatment teams” in place. The category described as “occasional consultation and referral” received a 15.6% ( $n = 14$ ) response rate, and no centers indicated “little or no clinical consultation and/or collaboration.”

The survey revealed that the degree of collaboration varied according to the condition/issue being treated. In general, participants who reported less general collaboration or no use of treatment teams revealed increased use of collaboration in the treatment of specific conditions. The use of “frequent collaboration with some interdisciplinary teams” in general was reported by 42.2% of the respondents, while the highest utilization (33.7%) of “frequent clinical collaboration with some interdisciplinary teams” was reported in the treatment of eating disorders. The percentage of schools reporting “frequent clinical collaboration, but no interdisciplinary teams” increased from an overall rate of 20% to 44.6% for depression/anxiety. The percentage reporting “occasional clinical collaboration and referral” also went up to 44.6% in the treatment of personality disorders. Table 5 provides results for the level of collaboration in general and in treating specific conditions/issues.

**Table 5. Percentage of Centers Reporting Level of Collaboration**

	Extensive collaboration; interdisciplinary teams	Frequent collaboration; some interdisciplinary teams	Frequent collaboration; no interdisciplinary teams	Occasional collaboration; referral	Little or no collaboration/consultation
Describe overall degree of clinical consultation/collaboration in general	22.2%	42.2%	20%	15.6%	0%
High-risk Suicide/Violence	19.6%	23.9%	29.3%	23.9%	3.3%
Depression/Anxiety	13%	22.8%	44.6%	18.5%	1.1%
Substance Abuse	15.4%	18.7%	16.5%	44%	5.5%
Eating Disorders	20.7%	33.7%	25%	17.4%	3.3%
Sexual Assault	18.5%	17.4%	29.3%	31.5%	3.3%
Promotion of Sexual Health	6.5%	15.2%	23.9%	39.1%	15.2%
Personality Disorders	6.5%	13%	22.8%	44.6%	13%
Self-injury	12.2%	14.4%	30%	37.8%	5.6%

## Psychiatric Services

The respondents were asked a series of questions which were designed to provide data about which personnel in merged centers provide psychiatric services and details regarding the types of services performed by psychiatric clinicians. Psychiatric services are performed by 53.3% ( $n = 49$ ) by on-campus or contractual psychiatrists while 33.7% ( $n = 31$ ) of the participants reported that primary care physicians/nurse practitioners in the health service provide psychiatric services. Twenty-two centers (23.9%) do not provide psychiatric services in-house, and refer students to providers in the local community for this care.

The four most common services performed by in-house psychiatrists are medication management with psychiatrist, case consultation with psychiatrist, and psychiatric evaluation with psychiatrist (all three with 53.3%,  $n = 49$ ), and staff training with psychiatrist (35.9%,  $n = 33$ ). Both “outreach” and “individual psychotherapy” are services provided primarily by “other” psychiatric clinicians (26.1%,  $n = 24$  and 22.8%,  $n = 21$ ) respectively.

## Qualitative Interview Results

Following initial analysis of data gathered via the survey, interviews were conducted with select participants. The task force hoped that this data would provide greater depth of explanation about survey results, particularly in terms of the impact of integration on clinical services. Based on the survey results, three centers were identified as having more positive responses on integration and three were identified as having less positive responses to integration. Of the six centers contacted, all agreed to participate in the follow up study. Case studies interviews were conducted with the directors of these six centers. Questions (See Appendix A) in the qualitative interviews included probes of the factors that drove the integration of services (e.g., financial, practical, philosophy of care, or other), what issues supported or hindered the integration and what aspects of the services were improved or diminished as a result of the merger. Additional questions concerned the reactions of student, staff, and the campus community to the merger, and how decisions regarding the sharing of client information (such as medical records) are made. Qualitative survey results can be obtained in Appendix B.

## Synopsis

### Survey method

A web based survey of 111 items was sent to approximately 1,800 individuals with a response rate of 20% ( $N = 359$ ). The survey focused on those schools that were considered to have an integrated health and counseling center. Of the 359 respondents, 25.6% ( $n = 92$ ) were from integrated centers. The integrated centers were predominantly from schools with smaller student bodies. Approximately 60% of integrated centers were in schools with fewer than 10,000 students, while 10% were from schools with populations of over 20,000+ students.

### Structure/operations

Among the survey respondents, 25.6% ( $n = 92$ ) were identified as being an integrated or merged center. The most common structure identified was one in which assistant directors of the health center and counseling center reported to a center director and that person reported to a senior student affairs officer. The second most common was the structure in which the chief counseling position reported to the center director who was the chief health director. Respondents indicated that their current administrative model had been in place for seven or more years in 63% of the centers, and for six years or less in the remaining 37%.

### Results of clinical relevance

Results of the current study suggest that these centers have found integration to result in an improvement in many aspects of clinical service. Centers reported that they were more easily able to meet the demands of their students and had a more efficient utilization of their services. Most reported that their services were more comprehensive and reflected a more seamless approach to health and mental health care. While staff morale was initially sometimes negatively affected, as the model persisted, turf concerns and other related issues were subsumed by the perceived improvements in service to students. Overall, satisfaction by the consumers was reported to be very high.

### Results of case studies

Six survey participants agreed to participate in a follow-up case study. Telephone interviews were conducted to further explore the issues of integration. In an effort to present an unbiased perspective, the group of six was evenly divided among those

who reported more positive consequences of integration and those who reported more negative consequences. Of the schools reporting more positive consequences some of the general themes embraced the concept of improved patient care. They noted timely and efficient referrals as well as general satisfaction by students. In addition, schools cited improvement in professional development and training, an increase in team focus and collaboration with quality assurance activities and peer review.

Schools interviewed also noted some of the challenges to integration. Several schools addressed the initial resistance voiced by clinicians and the turf issues that arose based on a new philosophy of care. There were also debates over access to records and the sharing of records between services. The main motivators for integration related to financial and administrative directives, although one school related that the initial motivation rose out of the acknowledged demand for mental health services within primary care.

### **Study Limitations**

This study has a number of limitations. While attempting to reach as many colleges and universities in the United States as possible, only 359 of approximately 1,800 institutions were completed reflecting a response rate of 20%. Therefore, the results clearly reflect a minority of the colleges and universities in the United States. To what extent they are representative is unknown. More importantly, only 92 survey respondents were from integrated centers further challenging the ability to draw conclusions about center integration throughout the United States. However, given the limited research and literature on this topic, we believe that the current study helps to shed light on college health care practice. Another limitation was the questionnaire that was used. While the task force endeavored to be thorough and clear with the items included in the survey, it is quite possible significant issues were left out or that respondents understood questions differently and answered accordingly leading to confusing results. In an attempt to correct for these potential problems, the task force conducted individual case study interviews with center directors. Due to limitations, six centers were chosen to be studied. This selection, too, might be biased. While these case studies were helpful in better understanding issues related to the specific institution, they cannot be generalized to other institutions.

### **Conclusions and Recommendations**

While the majority of college and university campuses have discrete mental health and medical services, the integration of the two areas has been subject of increased discussion among student health and counseling professionals. The push to integrate counseling and health services is motivated by a variety of reasons: a philosophical desire to provide holistic care, a wish to emphasize wellness, as well as a thrust to streamline resources.

Integration, however, does not look or mean the same on each campus that has merged services. This paper has outlined many of the ways that student health and counseling services have developed their relationships at a variety of institutions of higher education and provides some guidance in terms of effective practices in these areas.

Merged services share common aspects related to a goal of enhanced care and improved outcomes; although there are often distinct differences in administrative structure, in access to records, and even in how the service is presented to the campus. Even though many centers reported that they became integrated because of upper administrative directives, most of the centers reported that the primary driving force was an effort to improve continuity of care. It is important to note that most of the centers cited improvement in communication, quality of services, client satisfaction, and utilization of services and efficiency of administrative processes. Many centers cited issues related to the sharing of records and confidentiality. Approximately 27%-37% of both counseling staff and medical staff have access to each other's pertinent treatment notes.

Merged centers all have some level of collaboration, although the models vary greatly. The highest category of response (42.2%) was that there is frequent clinical collaboration with some interdisciplinary teams. Participants who reported less general collaboration or no use of treatment teams revealed increased use of collaboration in the treatment of specific conditions.

Alternatively, the data suggest that collaboration by multidisciplinary teams in the area of outreach programming is low (73.3% reporting no collaboration in this area).

Merged services share common aspects but differences in administrative structure, in access to records, and even in how the service is presented

to the campus run the gamut. Therefore, the decision to integrate appears to be an individual one that an institution must grapple with given the institutions, goals, mission, needs, and resources. Given that the goal of continuing to provide quality physical, behavioral and public health services is one that can be facilitated from counseling and health services developing closer working relationships and that many colleges and universities are considering enhancing these working relationships through an integrated service model, the task force recommends the following process be followed should an institution wish to consider merging medical and counseling services.

1. A meeting of stakeholders should be convened to discuss the implications of the merger, the logistics of the merger, and the goals. Stakeholders should include, but not be limited to: administrators at the center level as well as from the larger institution, direct care providers including nurses, physicians, psychologists, counselors, ancillary care providers (e.g., educators, outreach workers), and administrative assistants (e.g., office managers, secretaries).
2. Stakeholders should have input into the mechanism and logistics of the merger so that their buy-in will allow for a smoother integration.
3. The following questions will need to be addressed:
  - A. To what extent will the services be integrated and merged? What will the administrative and clinical care structure look like?
  - B. Will the reception areas and reception staff be shared or separate?
  - C. How will consent for treatment and release of information be handled?
  - D. How will clinical records be kept, and who will have access to which parts?
  - E. Will there be joint or separate staff meetings and in-service training?
  - F. What will be the mission and goals of the new service?
  - G. Will the name reflect a more holistic/wellness approach?
  - H. Will advertising and outreach be integrated or separate?
  - I. How will finances/funding be handled?

### **Recommendations for Future Study**

Little is known about the structure and function of integrated medical and counseling services at colleges and universities. This paper has endeavored to investigate the administrative structures and clinical and prevention practices of integrated centers. Future research should expand on this work to better understand the motivations for merger as well as the mechanics of such a merger. Studies to better understand the advantages and disadvantages of merger are needed. The ultimate goal should be the development of standards for providing the highest quality of care to the students we serve; regardless of the setting in which it takes place.

## Appendix A

Follow up phone survey interview questions:

*Questions for Sites with Positive Experience:*

1. If the integration of services was not done for financial or practical reasons, what was the underlying philosophy of care that drove the decision to integrate services?
2. What factors facilitated the integration of services?
3. What factors hindered the integration of services?
4. What has been the reaction of students (clients) to the integration of services?
  - of staff?
  - of the broader campus community (faculty, deans, etc)?
5. What aspects of integrated services contributed to the improvement in
  - clinical care/services?
  - staff morale/relationships?
6. How have decisions regarding sharing of client chart information been made?

*Questions for Sites with Negative Experience:*

1. What drove the decision to integrate services?
  - What impact, if any, did the reason for the decision have on how the process went?
2. What factors hindered the integration of services?
3. What, if any, aspects of service/operations were improved by the integration of services?
  - What factors facilitated those improvements?
4. What, if any, aspect of the service/operation declined with the integration of service.
  - In your opinion what factors caused this decline?
5. What has been the reaction of students (clients) to the integration of services?
  - of staff?
  - of the broader campus community (faculty, deans, etc)?

6. What aspects of integrated services contributed to the decline in:
  - clinical care/services?
  - staff morale/relationships?
7. How have decisions regarding sharing of client chart information been made?

## Appendix B

### School A

School A is a small rural school reporting fewer improvements through integration. It integrated about two years ago when upper level administration chose a new director to head both units. Physically, health and counseling have separate waiting rooms and separate charts. Through the interview process, the director of this service described the center as not being “as integrated as we should be.” The director reported that, in general, medical staff has embraced the change while counseling staff resisted the change. Despite the lack of congruity, improvements were reported in the areas of patient care (timely and efficient referrals) and professional development (mid-level medical providers being exposed to more behavioral health issues). Further, it was reported that a planned move to an electronic medical record system would eliminate concerns over sharing records. Regarding student and community reactions to the merger, the director reported that students and upper administrators have been supportive of the merger.

### School B

School B is a larger urban private institution that had been integrated for six years. It uses a shared waiting room and joint records. Integration was initially resisted by both offices; the decision to integrate was driven primarily by financial concerns. The process of integration was difficult with turf issues common between health and counseling center staff. There were some initial concerns about the issue of confidentiality of records. As time has passed, the integration was reported as being smoother. With staff turnover, they have found integration easier for the new staff members. The counseling center is now offering a group for students with medical problems and outreach services have expanded to include more health related topics. Advertising now focuses on a holistic health message which has apparently resulted in a destigmatization of mental health care. Staff training has

included the use of the Myers-Briggs Type Indicator in an effort to better understand each others' strengths. Students report very positive responses to integration, report that referrals are easier, and report a feel of "one stop shopping."

### **School C**

School C is a small school located in a small town. The center has been integrated for 10 years and has a shared waiting room but separate charts. While the charts are separate, all staff has access to charts as needed. This site reported a generally positive response to integration. The underlying reason driving integration was a directive from the administration based on their desire to provide "seamless services" to the students. Prior to integration, both health and counseling centers had a mind-body philosophy of care; this common ground resulted in very little resistance to integration. Since integration, the staff feels that they are providing better care. The referral process is simpler which has led to more students receiving comprehensive care. The center's reputation has also improved, which has made it more likely that the center will receive increased referrals from faculty and staff. Students were surveyed two years after the integration; results suggested that their only dissatisfaction focused on having a shared waiting area. However, students also appreciate the staff being able to easily communicate with one another.

### **School D**

School D is a small private institution located in a small very rural town and has been integrated for four years. The primary change to an integrated model was initiated by the health service. As primary care providers realized that many students were presenting for medical treatment with related mental health concerns, they began to focus on a bio-psycho-social model that included mental health services. Prior to the current model, no mental health services were offered and as a result primary care providers were the principal point of intervention, with the only alternative being academic advisors or an off campus referral network. At the onset of integration, there were concerns about budget issues as well as uncertainty about finding a physical location that would provide anonymity of services. Students' reactions have been very positive with increasing numbers of students accessing health and mental health services. Primary care providers do not feel as though they are practicing outside the scope of their

practice. At the initiation of service, students sign a comprehensive waiver that allows sharing of information within the integrated center. The center has separate waiting rooms.

### **School E**

School E is a large state-operated university, located in the suburban area of a small city. The center has a 13 year history of merged health and counseling services. The director reported that the integration began when budget cuts led to the use of health fees to fund counseling services. This connection has been predominantly administrative and budgetary in nature, with the focus of their integration over the past three years on coordinating care. The director described the transition to a more integrated model as initially difficult but becoming smoother once staff witnessed some benefits of joint quality assurance and peer review processes and monthly clinical support meetings. The reported benefits of the integration included an improved referral process, enhanced care outcomes, and an increased team focus. The reported challenges surrounding the integration process included staff disagreements related to the extent of access each group would have to electronic records and schedules of the other group. The director reported that both students and administrators have been supportive of the merger.

### **School F**


School F is a small liberal arts college located in an urban environment. This school has a long history of integrated operations, but recently (in 2005) began to outsource medical services. While staff members still provide mental health services, contracted physicians lease space on campus and charge health insurance plans for payment. There are separate health and counseling records. Medical records are owned by the off-campus provider. Referrals to each service are accompanied by a signed release of information. The medical director is seen as a member of the clinical team. Student reaction to the merger and outsourcing was initially negative due to reduced availability of medical appointments. However, the administrative change allowed the college to hire a full time health educator. The shift to prevention and wellness services was seen as positive for the campus.

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