Below is a link to our attempt to set boundaries/educate our campus about our scope of care. I hope that you find it useful!

https://www.jmu.edu/counselingctr/about/scope-of-care.shtml

2-In recent years, we have adopted a short term scope of practice (emphasizing NO SESSION LIMITS J many times over). This has been quite a transition from our former model of pretty much seeing students as long as they would wish to be seen.

It sounds like you are emphasizing all of the right things to make the case for this model in your context. Since we are a Jesuit institution, I have tried to tap into our social justice missional philosophy… essentially stating that in order to provide equitable access to care, there has to be enough appts go to around. We do make exceptions to our scope of practice for students who face obstacles that would prohibit them from being referred out (family opposition, lack of transportation, limited resources, international students). We have also supported students for a larger portion of the term by transitioning appts from weekly, to bi-weekly to once per month (if clinically appropriate). We also communicate that if they are within our scope clinically, these services are available to them each academic year. Of course, this nuance becomes a little tricky, but I think that is actually a good thing in this case.

I hope this helps! Definitely open to lend an ear or process more if that would be helpful. I'm sorry that this has been such a difficult case for you to make with administration.

3-We have it written in our policies and procedures that a clinician can see up to 10% of their case load for more than 10 sessions/semester. But you're right, our average # of sessions is 5-6. I don't see how they expect you to make this happen without more staff, unless they'd be ok with cutting out 50% of the clients you see now. I'm sorry you're having to deal with this. If the need is that great, maybe the University should consider funding long term treatment for those students off campus...just saying.

4-My first thought is do you have data to show that if you did not limit your services to brief therapy you would not be able to serve all students seeking services?

If you have a session limit, do you have data that suggests students on average don't use all of their sessions anyway?

My last thought is maybe some education/info about how therapy really works. Students asking for long-term therapy, what do they want? Never ending supportive sessions with a caring professional? Who wouldn't want that. Ethically, it is not appropriate to continue to see clients who no longer need/are benefiting from treatment. (yes, treatment, not "venting" sessions, ha ha, so many of our students say that's what they want out of counseling.) We don't want to foster dependence on us either, that would be unethical too. If they needs sessions to "vent" then a therapeutic goal should be to increase their social support system.

5-I find that what can get lost in these discussions is our enthusiasm to do the work we do and that we love long-term therapy and do think it is a valuable service to offer. Too often, I think what admin/students only hear is "we don't want to, we don't think it is an important or valuable service need'. If they hear we want to and do believe it is a really good treatment option, and …. then let's work together to see if we can make that happen and under what conditions and circumstances it can! Now, there is a collaboration enthusiastically entered by all to achieve this shared goal (and informed by you regarding resource needs and realities that come with various choices). At least you're not just the bad director who just refuses to do what they all want you to do.

6-Rather than trying to make something impossible happen, could you simply put it back on administration by showing them what it would take to be able to provide what they're asking, and then leave it up to them to figure out if they want to make that happen or not? If you could demonstrate that your staff see X number of students per year for X number of sessions, then to allow for twice as many sessions (or whatever example you want to give that would be considered "long term"), it would require an additional XX number of staff.

I used to have a boss who took this stance most of the time – rather than tying ourselves in knots trying to prove we can make miracles happen with no resources (which then makes people think we can do that over and over again), she would simply demonstrate what it would take to make the request happen and if they wanted it enough they would come up with the resources to make it happen. Most of the time they realized it was not feasible or they weren't willing to take resources from elsewhere to make it happen, and that would be the end of the conversation.

One other thought – you could also make the argument that if you were to provide long-term treatment with no increase in staffing, you would no longer be able to see all the students who request therapy, and would need to refer out or put people on a wait list and some number of students who invariably go without treatment. This increases the risk to the university if there are students requesting mental health counseling who are unable to be seen, or unable to afford off-campus resources (which gets into equity issues – those who have more resources can access support and those who don't go untreated).

7-This is always a never ending complaint! I have to remind myself that even though I have been here forever, students cycle through every four years!

My glib response always is…."sure, we can do long-term therapy. However, know that this will drastically decrease the number of students we will be able to see." That usually brings a "oh, yeah, I guess so." I think that is what it boils down to….if you want long term, then students we will be able to see will be few.

We are here to serve the whole student body. Thus, to do so, we have to put a limit on the amount of services we can offer.

Not talking points, but a first thought I had.

8-It always grinds my gears when administration; who are intelligent and capable people, but more often than not are NOT mental health clinicians. Yet they like to create policy and procedure for mental health offices……. But we have to do our best. Full disclosure, this is not an area I have to defend on my campus (thank God!) but I have reasons for the scope of practice we have.

In addition to the reasons you cited, I have the following to add:

- ethically, because of the eligibility to use the service is directly tied to being a student; it is not appropriate to engage in long term counseling in the event that the student abruptly leaves the university,
- we do not have 24/7 availability which those needing longer term counseling might require,
- inability to provide service to a greater number of students, and
- the potential for creating dependence during a stage of development when fostering and developing one's own agency and autonomy are part of the college experience.

9-I'm sorry you are in this position.

I have not had to argue this position (so far), but I think if I had to argue it I would take a couple of approaches.

One approach, which I learned from another director, is to start every conversation with "Well, we could do that…" and then walk the administrators through what that would look like. How many new requests for service do you get every week? Supposing each student stayed for 30 weeks of service, how long would it take you to get to waitlist? I we know that students, on average, use about 4 sessions, but you can't count on that. You could maybe make some modeling guesses based on your own utilization stats. What would you have to stop doing in order to provide every student long term therapy? Groups? Outreach? Why would it be bad to give up those things?

Does your administration want you to give up those things? Our center gave up outreach for years in order to just manage the clinical demand. Is that something "innovative" that your administration/students want you to do?

Or, is another innovative approach that you do long term, but you only see the student every 3-4 weeks? That would help you manage the flow. Probably not what your students have in mind when they ask for long-term therapy.

You can also have long-term group work. We let our students do group for as long as they want. That's long-term therapy. Again, probably not what your students are envisioning.

Or, you could make students wait longer for intake. Some places don't even let you in the door until they have space for you. You call for an intake, they put your name on a wait list, when a counselor has an opening for a new client, someone is pulled off the wait list and that counselor does the intake. Much like a private practice model.

Just help your administrators imagine what like would look like if you did what they want. The phrase "pick your poison" comes to mind.

Another approach I might take is to use the Clinical Load Index data from CCMH (https://ccmh.psu.edu/assets/docs/2020%20CCMH%20Annual%20Report.pdf) Administrators love

benchmarking with other institutions. What are other institutions with your CLI doing in terms of brief or long-term therapy? Educate your administrators about what staffing would need to look like to put you in the "low" CLI, which is where most of the long-term individual therapy services are happening.

I often emphasize with administrators that there is only so much available time in the week and we have "buckets" that we need to fill with that time. Our big buckets are "access", "treatment", "prevention". You can have smaller buckets within each. So, for "access" we have "intakes" and "crisis". Treatment has individual, couples, group, testing. Prevention has outreach and support groups.

Since I've been director, I've put more emphasis on access, keeping our wait time for intake to less than a week and our crisis response to pretty much same day. But that means I have fewer resources to put into treatment and prevention. My institution has valued rapid access and I've played on their risk management concerns about letting a student in distress hang out without eyes on them. I would put it back on your administration and have them tell you what they want. They can't have it all. It is a pie chart that has to add up to 100%. You can walk them through why you like your pie chart and think it is best practice. When they ask to change it, tell them the consequences of the change and ask if they are willing to accept that.

10-We had the opposite problem. We were engaging students longer than we probably should have and maintained an astonishing waitlist with some high risk students on it. Then we switched to more of a Brown University model. It turns out students hate waitlists more than not getting long-term therapy (at least at our university). It is also higher risk to the student and the institution to wind up with waitlists. We have successfully used the risk argument to backfill vacant positions. I wonder if that would work for you in some form.

11-This is such a common challenge right now. I worked on this same problem when I was at Brown with some success, and I'd be happy to talk about it. To me, the whole thing requires a significant rethinking of services in general, as well as looking at what is really meant by "long term".

12-Oh the joys of student complaints and administrators who are quite unable to see what we do because they just don't do it! I am sorry that you are being asked to pursue this despite providing clear evidence that without adjustments to your staffing, it's just not something you are able to provide for the entire student body. This has come up for us from time to time, typically resulting from student requests.

Talking points we have used in addition to ones you have mentioned:

- Liability! If our campus were to offer long term individual therapy to every student, that would SERIOUSLY compromise the number of students we are able to see. What does the university suggest you do with students in crisis/suicidal students who present to the counseling center but are unable to get in because your caseloads are already full, and not going to open up before the end of the semester? When we adhere to a short term model (which IACS recommends), we know that after x sessions or x amount of time, we'll be able to get more students in. IMO it's far better to see many students for a short period of time than a few students for long periods of time. How many students does the university want to turn away who are in crisis, but can't get in to see your staff and just don't seek help?
- Scheduling. If your campus is anything like ours, students would jump at the chance to do long term therapy, and wouldn't be inclined to give it up. Prior to session limits, we had students who just kept coming back. Because they liked it, not because they needed it. When we aren't busy, I

don't mind that model, but we haven't been "not busy" since 2005! Halfway through the semester you would not be able to get really any additional students in for counseling and would have to turn them all away (see liability, above).

- Student development. This is not a popular rationale, but might be effective with administration. Our university mission is basically to prepare students to be successful adults, and I would imagine yours is similar. How are we developing adults who can recognize when they need help, seek help when appropriate, and advocate for themselves if we're busy coddling them during college?
- Mission of your center. Is your mission to provide services to ALL students, or only a small portion of students who have significant mental health needs? On our campus, the portion of students who NEED long term therapy is quite small. IMO it is not an effective use of Counseling Center time and resources to gear our services for less than 15 percent of the student body.
- Mental health treatment WANT versus NEED. If your campus is like ours, neither students nor administration will be able to define which students NEED ongoing mental health treatment and which students WANT it. What I find so interesting is that often when this kind of stuff comes up, administration typically does NOT ask the mental health experts (i.e., you and your staff) if this is an appropriate request – they just ask that it be done. Why are we as the experts not consulted in the same way that teaching faculty would be if students decided they need unlimited mental health days every semester? Administration would never go to your faculty body and say make this happen, right? Just because a student WANTS long term therapy does not mean they NEED it. Or that your center should provide it. YOUR office would be the ones to determine if this is a necessary service, not students, and not administration.
- Statistics. What is your average length of treatment for clients under your current model? I bet it's less than 10 J This does not provide evidence that a long term model is appropriate for student mental health needs.

If it helps any, we just transitioned to a stepped care model two years ago, and had to sell the entire university that students who need long term ongoing mental health treatment would no longer be served at our center (aside from an initial screening appointment to help find a referral or if the student was in crisis). We knew this would be a hard sell for some folks, as our old model was 10 sessions of individual counseling and then refer to community. A big part of how we sold this model is that with our "episodes of care" stepped care model, we can see many more students (we had struggled with massive wait lists before going to this model). Take one student who has ongoing mental health concerns that necessitates long term treatment. They come to the counseling center for 4 years, spread out their sessions each academic year to make them last, and never follow through on a community referral. They do not get the treatment they need, and continue to struggle throughout their college years. This is a person who does not make much change and will continue to struggle with their mental health – we aren't really helping them with this model at all. Yes they like the support, but they are not improving. Or doing better academically. On average we see students 2-5 sessions (not because of session limits). That's two to three students we would see (and make a difference for) for 4 years – so 8 – 12 students who get help versus the one student who is likely not going to improve as they are not getting the treatment they really need.

13-I'm not sure if this will be helpful, but we shifted our scope of service model last year from "short term/time limited" counseling/therapy to one that is "customized and equity based." What this translated into on the ground were disposition decisions that allowed for some students to receive longer term tx based on their clinical concerns AND their capacities to access care elsewhere. In other words, those with the most concerning clinical presentations AND the least access to care were prioritized for longer term tx in our office. In order to actualize this approach (and since we didn't

receive any additional resources), we had to make the decision to offer even shorter "shorter-term" care for students with less concerning presenting problems and/or had access to other services. We essentially integrated equity and access considerations into the traditional step care approach.

BTW, here's a link to great article by Richard Eichler over at Columbia University's counseling center that speaks to some of the benefits of brief (and flexible) tx for college students:

https://www.wawhite.org/uploads/Journals/CPS047-feature1.pdf

14-Addressing this concern with students, parents, and administration is tricky. I suspect that CCMH has data on best practices for a school with a student body of your size. This data helps me speak to how universities our size are currently able to balance demand for services for all students basic needs. Some small private well-funded colleges are able to offer long term treatment for all who need it, but most of us are clearly not staffed to do so. We have a clearly defined scope of service, which I have found helpful for the conversations. I use it to draw a parallel to the fact that those seeking medical care are often referred to specialists as it is beyond the scope of their primary care provider's area of expertise. I see us a part of the solution but not the whole solution for all students. In addition, I note that we do support students who have a desire or need for long term services; we provide names and phone numbers for clinicians in our area who do provide treatment for students needing a higher level of care. Finally, I noted that the data indicate that on average college students attend somewhere in the area of 4.5 sessions in any year and that the national average for all adults is somewhere in the range of 5.6, which means that our short term model of 8 sessions a year provides ample support for our students. (I would encourage you to check those numbers as that is my best recollection off the top of my head).

15- I've spent >30 years dealing with this. Right now the CCMH data is reporting long term is more effective for some, which is something we always knew and no surprise. Students know to make noise when they want something whether they are representative of the student body or not. In my small schools, we have worked with the 10% who might attend >6 - 10 sessions by developing a groups culture and sending those who are therapy-seeking for individual care beyond our capacity into Process groups. These are typically led by a licensed provider and a grad student trainee. We also have groups for trauma survivors and conversation that cover many of the wants for relationships that long term provides. The other thing we do is allow the grad clinical trainees to have caseloads of students who seek weekly sessions. They receive good supervision and the students are often very satisfied – esp with the Clinical Social work grads and the 3rd year doctoral psych students. It's been complicated but it works out because our psychiatry care is limited to part time. If you have unlimited me/doc opportunity that makes it harder. Good luck!