DISCLAIMER:† This text is not a verbatim transcript.† Communication Access Real Time Translation (CART) is provided in order to facilitate communication credibility and may not be a totally verbatim record of the proceedings.†

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>> I'm going to hide nonvideo participants so this means for nonhost or panelists, the folks who do not have their videos on, their icons will not show.

>> Jennifer, is the first part the housekeeping slides you were going to cover?

>> Sorry, I was muted.

Yes.

[ Captioner on standby ]

>> DR. MICKY SHARMA: Test, test.

>> Jennifer, I'm going to hit record and start the webinar now.

>> Good morning, everyone.

We're just going to give it a moment while people get logged in.

>> DR. MICKY SHARMA: Let's go ahead and begin.

For those of you I don't know I'm Doctor Micky Sharma and I'm the Director of Student Life Counselor and Counseling Service.

Creating a Culture of Care, A Collaboration Between Ohio State Harding Hospital and the Office of Student Life. Before we get going for today in terms of welcoming you, I want to highlight and thank some of the folks who made today a reality.

I want to start with Jennifer Lang you are our Care Manager within the Office of Counseling and Consolation Service who received a grant which made this Conference a reality.

Like many things in our world over the last year plus, our planning began with this being in person at our beautiful Ohio Union and we talked about a hybrid and landed in our Zoom activity for today.

We thank all the technology difficulties that are now behind us and I think we're ready to move forward.

I want to thank our planning committee for the day.

So what we're going to focus on today -- as many of you who have heard me speak in the past I talk about, and I think that many of you are already aware that anxiety is the number one presenting prop and concern of college students both on Ohio campus and across the country and across the world.

This is the piece people struggle with.

We also know as I track the data of Pennsylvania state which has been the largest mental health data bank around the world, it used to be around a little more than 50 percent of students who came to a University Counseling Center had prior treatment.

This past year's report is now basically at 60 percent.

So this is saying that six out of ten students who come to a University Counseling Center have had treatment before.

There are more students on campus today who have had prior treatment than any time in history.

I think it means two significant things.

Higher education has become more of an apprehension for people in society and that's a good thing.

The other is how to get to graduation.

With 61,000 steeds we cannot provide individual counseling and we've evolved to multimodal services.

In terms of different things we provide other than one on one counseling.

And a main focus for today is we do have students who need higher levels of care.

Who need more than just individual counseling or seeing a clinician every two or three weeks or being in a group counseling program on a weekly basis.

We have students who would benefit from an outpatient program or a partial hospital deceleration program.

This gets to all of us being educated about the vast array of resources to help students be successful leads to this Culture of Care and that's the goal.

We will cover later in the day the original Suicide Mental Health Task Force and the result of implementation team and the things that have come from that.

The last thing I want to share with you is that Culture of Care, that number one recommendation out of the original task force report and the way that was defined is what the Culture of Care on Ohio State's campus would be faculty proactively reaching out to students and administrators and staff extended their time to students in ongoing interactions and encouraging student to see check in on their friends and peers.

This Culture of Care can be something that everybody contributes to.

Staff, faculty, and students.

I'm pleased we have people from across the institution joining us today.

Staff, faculty, university medical side of the house and medical center Harding Hospital and I think there is a wealth fortunate information you will gain today.

We are pleased you have joined us for the day and thank you and we hope you have as good a day as you choose to have today with us.

Thank you.

I'm going to turn it over to Jennifer Lang.

>> JENNIFER LANG: Thank you Doctor Sharma.

Thank you, everyone.

And welcome to today's event.

My name is Jennifer Lang and my pronouns are she, her, hers.

I work primarily with students who go to the hospital for a mental health concern.

I'm a liaison with many of the area psychiatric hospitals.

This is something I'm very passionate about and we've been planning this for about 18 months, taking it from inception of applying for a grant to all the way today so I'm excited to have everyone join us.

General housekeeping items for everyone joining us today: Just because of the large tele health tech version of this conference we're having is all mics who are not panelists will be muted.

Please us other the Q&A function and we will be able to view the questions and moderate as needed, whether that's a question for a panelist during a presentation or if you have a question about technology.

I'm going to go ahead and put in the function information that you can use, should you have any technology issues.

So there's phone numbers for our fantastic tech support, Allen and Sujan.

And a backup captioning link should you have an issue with the captioning here in the Zoom, an alternative link.

I'll put that in the chat.

Today's session is being recorded and our hope is that maybe you attend today and you were like wow this was useful and this portion is fantastic for new hires in my unit and things like that and we want it to be available to use in the future.

It's the blessing, right? Of this event being able to be online is having and using technology as being able to take it out of just the live conference setting in the room.

So, yeah.

Thank you.

And then we'll move onto our agenda for today.

So you would have received an email with a completed agenda with bios of all of our panelists and presenters today in an email related to this conference.

But just kind of an overview of the day.

So as you'll note, we'll have various presenters with breaks built in.

And this is keeping in mind, obviously, we're all used to staring at screens at this point but want to make sure you have time to get a break, take a walk, have a snack, whatever you need to do during that time period.

But certainly take breaks as needed throughout the day.

Lunch will be on your own from 12:00 p.m. to 1:00 p.m. and then the hours that you are on Zoom today for our event are being calculated so that if you are requesting CME or CEU professional credit that we are able to take that number into account when we're awarding you those certificates.

I'm going to talk about this more towards the end of the day, but those certificates will be sent to you electronically after the event is completed.

Shifting a little bit to our Learning Objectives today.

So these are sort of our objectives for the entirety of the day.

So when we're thinking about all of the different programs and presenters that we have to offer you today, these are kind of our big picture take away that we're hoping that you're able to glean from all of the information that you'll be receiving.

I do want to highlight that we have a -- as Micky said, a vast array of folks represented from across campus today.

Some of the offices I want to shout out that were registered were the office of Sorority and Fraternity Life of the Conjecture.

Student Center, Psychological Services Center.

Suicide Prevention Office.

Advisors from Music and Arts and Sciences and Dance and the Office of Student Engagement and folks from Student Health, OSU Harding.

So we have a lot of representation here, both clinical and nonclinical.

And we consider all of your presence here to be very valuable.

So when we were thinking about our Learning Objectives and our programming, we really wanted to keep that in mind that we would have both clinical and nonclinical folks represented.

So we'll be looking at -- can you go back? I'm sorry Morgan.

Thank you.

So, yeah, we'll be looking at trends, both Ohio State and nationally.

Some of which Dr. Sharma already spoke to, to keep in mind that led to the need to develop the higher level of care specific to 18 to 24-year-olds and then certainly providing some education on different levels of care for mental health treatment, right? So what are the differences? What is available out there? How to kind of distinguish between them.

And then kind of talking about, you know, what are both the health benefits and academic benefits that cause students experience when they're thinking about doing a higher level of care.

We'll look auto outcomes at our program here in Ohio State and the program that Dr. Eshelman will be speaking about at University of Texas, Austin.

I want to spend time talking today about the different cultural and financial and enrollment-based barrier that's students can experience.

It isn't just an easy track into some of these types of treatments and that's where you all come in, right? How do we navigate these different resources that are available to help students reduce these barriers so we definitely want to talk about the barriers so we can work on problem solving them together.

We're lucky today to have a student testimonial leader today.

So really hoping that you all will have a positive experience with that and really understand, you know, what that lived experience was like for our student and that can help you understand the different goals and progress that can be made on a very personal basis for students.

We'll be getting smaller picture goals as well when we're looking at the different clinical modalities that we're using in these perhaps.

What are the therapists doing in these sessions that can be helpful to students? We're going to talk about a really exciting development, kind of the start of this Culture of Care in considering part and IOP.

There's great student I've offices that we'll be talking about into today like Disability Services, Student Advocacy Center and student health that have come on board to do problem solving around the barriers that have been identified.

Our hope, of course, is that you'll be able to see where this project, partial and IOP, kind of fit within Suicide and Mental Health Task Force goals.

Those are our Learning Objectives and as the day goes on and as our presenters present, they might have smaller agenda items within each presentation but this is the big picture with where we're going.

Fantastic.

So that morning our first speaker, Dr. Shawnte Elbert joined Ohio State's Office of Student Life Leadership earlier this year as our Associate Vice President for Health and Well-being.

She was unfortunately not able to make it real time today but she recorded a fantastic talk to get us started this morning.

We are pleased to share with you this talk from Dr. Shawnte Elbert and her talk is titled Caring for the Whole Student.

Health and Wellness Strategies for College Students.

>> DR SHAWNTE ELBERT: Good morning everyone.

I'm Dr. Shawnte Elbert, the Associate Vice President for Well-being in the Office of Student Life at the Ohio State University.

I bring greetings for you this morning.

I'm going to do a brief review on how to care for the whole student and some of the health and wellness strategies necessary for the assistance and the ability to thrive.

We know that health and wellness is critical to the overall success of every Ohio State student, faculty, and staff, but I want to emphasize that we know through a lot of data and research that students aren't able to fully engage in their higher education experience whether in the classroom or outside the classroom if they're struggling with their health and wellness or even basic needs.

Let's start out with a conversation of defining components of what wellness is.

It's a conscious deliberate active process that requires a person to become aware of and make choices for a more satisfying life.

It's about looking at the wellness of a person beyond them being free from illness and disease because it has to be a dynamic process of changing world and that is how we've looked at student Health and Well-being here at the Ohio State University.

Most variants impact students' health and wellness and their ability to have academic achievement.

Many students say their academic performance are impacted by their health.

Impacting ability to thrive the experiences are the financial pressures they face on campus and many talk about being mentally and emotionally exhausted.

Students ask that when they are on campus and they're having access to collegiate health and wellness services that they're being transparent and connected to one another and a smooth hand off and the services are flexible to meet the whole range of their needs.

To weave this we know a wholistic approach must be part of the process, including the fine scope of service.

Well documented policies and procedures centered on the equity and alignment within legal and ethical standards and last but not least cross campus communication that includes our community partners, assessment, and ongoing improvement to ensure we're meeting.

>> STUDENT: Our students' needs.

We coordinate the resources they need.

We know there's no single treatment appropriate for all students.

We know there must be a multimodal approach within the campus and community and these must be aligned within each other.

Pre-convenience and treatment and recovery must attend to the most important needs of the students and more importantly, access is critical to the care of student well-being and should be available no matter race, gender, sexual identity, economic status.

No cookie cutter approach can satisfy all students so we must tailor to these their needs.

Multimodal approach coordinate the assistance resources and education needed for students and includes the prevention, treatment, and recovery components and all of this is houses in offices and provided by a variety of services and components of practitioners and so you see within counseling and consultative services and student wellness center and recreational forts complies.

Recreational supports Student Health Service Student Advocacy Center and Disability Services and Suicide Prevention office.

No one office on or off campus can serve the students' needs comprehensively so being able to coordinate on and off campus with these extraordinary partners is why we can care for the whole student and meet some of the basic needs that have been a challenge to many of our students.

To meet basic needs and make sure health and wellness is a core component of their success.

We need to meet their needs and have a growth framework.

We can scale as needed and have the resources to do so, collaboration is a centered component of how we want to do and serve our students and we have sustainable impact on their success.

So we know through research and looking at data, here on our campus and other campuses that the common needs range from footing and clothing insecurity and housing and child care and access to health insurance and more importantly, the safety on and off campus.

We have to look at a variety of things to need student needs and look at the trends happening on our campus and the institution of other higher education.

The increased demand requires a very interdisciplinary approach to serving our students.

If we do this right we can have a sustainable impact of students on our campus but also with their loved ones and we can see change happen.

Thank you all for joining this conference and I hope you all get the information you need to continue doing the work you do to serve our campus community service populations. I hope you're able to take this information and continue to do the work needed to impact Health and Well-being on and off our campus.

I thank you for your time and energy.

I wish you well, and thank you for your time.

(Video concludes).

>> JENNIFER LANG: So a great way to get our morning started.

Her vision and I feel it very much aligns with the spirit of today's conference and a lot of the other presentations shared today.

I do appreciate her having her contact information there so if you feel inspired or jazzed by anything that is presented today and have some ideas, I'm sure she would feel free to welcome some of those her way.

Our next speaker I am very honored to present.

She is our Keynote speaker, Dr. Melissa Eshelman and she's joining us from central time.

Associate Director of Human Services at University of Austin, Texas.

She has held positions that include the Medical Director of a hospital program and an intense outpatient program which I feel makes her exceptionally equipped to speak on the benefit of this type of service for the college student population.

I could go on and on.

She has many credentials and fantastic experiences to share with us today and we're just honored to have her join us today.

I will turn it over to Dr. Eshelman for our Keynote this morning.

>> DR. MELISSA ESHELMAN: Thank you so much, Jennifer.

I'm going to share my screen and get my PowerPoint.

Thank you again.

I wanted to tell you a little bit more about me, Dr. Melissa Eshelman.

I'm excited to be here today speaking to you from Austin, Texas, from the University of Texas at Austin.

I wanted to share my identities.

I am Latina.

My parents immigrated from Peru and I was born in Texas and I identify as a native Texan and I was a first-generation college student and I struggled we were a lower socioeconomic status and I certainly understand many of the challenges our students have with our challenges.

I'm excited to talk about how our university responded to the increasing mental health needs in a unique way by initiating an IOP at our campus.

I don't have any disclosures.

I wanted to review my specific Learning Objectives today.

I wanted to assist you with identifying mental health trends and issues that college students experience which lead to the initiation of an IOP on campus and function and components and advantages of having an IOP located on campus and review successes and challenges of an IOP for students.

So like Ohio State, University of Texas at Austin is a large university.

This is a photo of our campus.

We have 18 colleges and schools.

We have about 24,000 Faculty and Staff.

We have more than 51,000 students of many diverse backgrounds and our Undergraduate Students are not required to have health insurance.

What that means is about 75 percent of our undergraduates have health insurance and that means 25 percent do not which limited their access to specific types of health care, especially those that are off campus.

I work at the Counseling and Mental Health Center and here's a photo of our front desk area.

I started at the Counseling and Mental Health Center in 2019 and what we noted just even in those first few years is that we were serving quite a few students -- about 5,000 students in the academic year of 2012 and 2013 -- and then the part I want to highlight is our crisis team.

We have a team for every day of the week that's available for any student who calls and is in crisis.

They might identify that they need to see a counselor in a same day appointment.

We were seeing we had 469 separate same day appointments that year that yields or turned into 18 hospitalizations.

I want to share with you we started tracking this and we looked within our counselor and mental health there and there is the 18 in 2012 and 2013 but to 2019 and 2020 it had already increased to 42.

After noting the increases we started tracking total known hospitalizations.

It's not the total number but the number we're aware of.

We might get information from a student emergency services, particularly if a parent called and said their adult son or daughter was hospitalized.

Or make they can come into services and say I was hospitalized.

You can see it sky rockets up to 178 from 45.

We know there's more than that.

One of our graduate students looked at psychiatric hospitalization from 2016 to 2019 and these are total hospitalizations we may be aware of.

She noted a total of 525 psychiatric hospitalizations and you can see from this graph how it's increasing.

So we have to think about -- so that's a lot of hospitalizations.

Do we have any -- why are these students going into the hospital? What are the major issues? 2012 and 2013, this is our annual report where we looked at data and back then definitely anxiety ranked highest in terms of what students were presenting with, followed by depression related symptoms.

And that really has not changed.

This is our latest impact statement from just 2019, 2020, and we're still seeing high rates of anxiety and stress as well as depression and at the top and it's remained there are academic concerns.

What I want to point out is our total number of students back in 2012/13, we served about 5,000 students and that's risen to 6400.

We had about 23,000 appointments then and now I had 26,000.

So definitely continuing to see students who are coming in with significant symptoms of anxiety and depression and how much it's definitely impacting their ability to perform optimally in terms of their academics.

Many of you are well aware of the ACHA National College Health Assessment that looks at student health reports on mental health issues.

And if you look at the 2012 and compare it to 2017 and look at specifically some factors like students were responding to felt overwhelming anxiety and that is increasing.

Felt so depressed it is difficult to function and, again, increasing.

Alarming is increasing suicide.

4 to 5.5 percent and attempted suicide.

These are trending from surveys done from students and this is for UT Austin, specifically.

And then in terms of diagnoses increase.

And then in terms of impact of mental health on their academic.

That's staying about the same from 2012 to 2017.

We're still seeing close to 50 percent of students reporting they find academics traumatic or difficult to handle and that includes things as needing to drop classes or unable to complete important projects or a pause in dissertation or practicum work.

Anxiety and depression is what we're seeing being the main factors that are making it difficult for students to do well academically.

My colleague Amy Alexander and her colleagues at Stanford looked at a systems approach on how to address the rates of increased suicide -- many of our students have significant financial problems, especially those students uninsured and undocumented.

Loneliness has been a biggish, especially with the COVID-19 pandemic.

People are not having the social support they've had in the past.

Many of them having to be at home to be able to participate in online classes and that in itself has its own challenges because families sometimes have expectations whereas the student is trying to focus on their work while managing mental health issues.

Another important stress or to consider are racial injustices and epidemic equities and how much that impacts our students who identify with those specific identities.

And the different mental health issues all of you have seen the depression and anxiety and suicidal thinking and substance use disorders and delve definitely comorbid.

Marijuana and alcohol use and eating disorders and psychosis are not many that can result.

And treat -- needing to focus on reducing stigma as well as access to treatment which is a big point we're trying to make today.

Individual therapy and medication management definitely have a part in terms of making sure that we're treating specific mental illnesses and they also mentioned intensive outpatient programming as a measure -- treatment measure that you can provide to student that's can help with their symptoms but also help keep them in school.

So I want to talk about different levels of care.

Some of you may be aware of these but I think it bears repeating.

So there are different levels of care.

The highest level of care is hospital in patient admission and that's the highest level because it's the most restrictive.

Someone is in the hospital that cannot leave the hospital, even if you're there on a volunteer basis.

You have to make a request.

And the typical reason for hospitalization is for safety issues. Someone is suicidal or someone made a recent suicide attempt.

Typically it's very short-term.

Four to five days and very intensive assessment and initiation of treatment and then an individual is discharged.

The next level of care is residential treatment.

And residential treatment is when someone needs more than outpatient treatment but maybe they need longer than what a hospitalization involves and those are typically longer treatment settings where you actually stay there and live there.

It can be as short as a few weeks to as long as 90 days.

They're very intensive and so it's a very structured program.

You're meeting with individual group therapists, you may have occupational therapists and meet with psychiatrists and there can be an instructional level available but as you can imagine, that's a long time involved in a treatment program where you don't have access to continue participation in classes.

And then the lower level of care is outpatient treatment settings.

And within that group there are three.

There are the Partial Hospitalization Programs, PHP, intensive outpatient programs IOPs and outpatient clinics which I think most people are a little bit more aware of.

PHP and IOP are both off campus programs.

Typically, PHP involved group therapy.

Six hours a day, five days a week there is there is medical Seiler vision by a psychiatrist.

Many programs call this a day hospital because in reality an individual is participates in what would occur during a hospitalization stay with the exception they can return home in the evening.

Many times PHP is used after a hospitalization.

A patient is discharged to outpatient treatment where the next appointment may not be for two to three weeks and step-down services offers an opportunity to be involved a treatment that continues to be supportive and continues what started in the hospitalization.

Major limitations is because it's a six-hour program -- I usually see 9:00 a.m. to 3:00 p.m. -- students, it's hard for them to participate.

Many of them that's the time they have core classes.

They have make their way there so transportation issues can be a program.

Programs require someone to have health insurance and there's copays associated with that and students may see they may not have lots in common with other adults.

Some in a partial hospital program may have chronic illnesses and may be older or lower functioning.

That could be different if the PHP is focused to for example a younger adult population.

IOP is less group therapy, three hours a day, typically, and four days a week.

It can follow a hospitalization or sometimes it's offered as a step down from psychiatric admission.

Limitations, again, is getting to the IOP program, the cost, that time commitment, and I will tell you that's probably the biggest concern when we talk to them about IOP.

Because most IOPs are available -- they're usually adult IOPs with adults ranges from ages 18 to 55.

These IOPs do not offer psychiatric services and so there may be no easy access for seeing a psychiatrist.

I wanted to share with you information from Nancy downs and her colleagues where they looked at what are ideal treatment goals for college students.

And obviously identify with their mental health issues, treat it, minimize side effects and maximizing and approve academic functioning and risk assessment needed.

They broke it down to looking into different strategies.

Timing considerations.

Student centered care, and a team approach.

So timing consideration means taking into the account the academic calendar and a specific student's schedule.

Some students are working or may have outside activity or internship they want to continue.

Anticipate the differences for a college student versus a different young adult.

For example, they have academics and so certain parts of the year are very busy for them and they may have summer off and return home or they may elect to study abroad.

They talked about students with severe symptoms to consider treatment.

Many of our college students are predominantly young adults and many of them developmentally are functioning at adolescents and loss of psychoeducation and helping them understand the need for treatment and how are we trying to assist you so that you do better academically and including family members and significant others and then the team approach.

College students need support from more than the treatment providers which may involve your student health and counseling mental health center but then within the university.

Involvement -- at our campus we have student emergency services, services for students can disabilities, international office if it's an international student.

Variety of different venues that can also provide support for a student who is struggling but we're trying to assist them with improving their mental health symptoms.

All right.

Who could benefit from mean health IOP? When we started we were seeing the students with significant anxiety, depression, suicidal ideation.

When symptoms are severe, that is the time you consider that.

When a student is being discharged from a hospital or probably more often in our case itís to avoid hospital decelerations.

Student presenting with significant symptoms and they would benefit with a hospitalization but that impacts and interferes and perhaps IOP is an option.

We definitely can see when a student's anxiety and depression and suicidal thinking, how much it's interfering with their ability to perform academically.

They are not going to class are missing classes and they have anxiety symptoms and they have difficulty participating.

We see it online because it's so anxiety provoking for them to talk on screen or some are so lethargic that they're not getting out of bed or participating at all.

It's not just academic but other venues of functioning.

Are they functioning socially? We see so many student that's withdraw.

Are they socializing? Friends send texts and they're not returning messages.

Because of the pandemic, there's been so much separation given the guidelines for the protection and so looking forward for much of that being lifted in the next several months.

And the last thing we considered that there are times that outpatient so you knowing services are not enough.

At our center we might see students weekly for a few sessions.

For students with severe mental health issues, that is not enough.

We also wanted to consider, what do students need? They need a location that's accessible with little to know transportation time and something that works for a student's schedule.

So location access I believe -- nearby.

And then working for a student's schedule.

Most of our students, if you have anything at 8:00 a.m., that's challenging for them.

But if you have something in the afternoon, they're more likely to make it.

Treatment that addresses their concerns as college students.

So, again, as an alternative to hospitalization or if they're being discharged from a hospital.

The third thing we found super important is a group that's inclusive and welcoming of both their similarities and differences among college schools who identifies from different diverse identities.

I'll talk to you a little bit about feedback later but I think this has been the part most helpful is the students will say, wow, I didn't know -- everybody else in my friend group seemed to be functioning so great and now I've met other college students who struggle like me and I've met other college students who share the identities I do are struggling like me, I thought it was only me that couldn't make it and be successful.

Treatment is affordable and very much a team approach.

We looked at team approach between whoever is providing counseling services, if there's a student health doctor involved, the IOP clinician and if they're not already involved, psychiatric services, having timely access to psychiatric services which we have available at our university.

All right.

Student centered care.

I wanted to bring up -- excuse me.

This recent paper by Vivian Chen and her colleagues and what they found is that racial ethnic minority students may be at high risk of mental illness and they underscored Asian Pacific Islander and multiracial students.

Despite having lower appearing rates, they may have higher rates as compared to their white peers.

She was pressing universities need to be considering culturally informed programs and be proactive in mental health awareness and also access and improving the support for all students but especially those who identify from minority backgrounds.

So I want to shift and then talk to you about how we handled this information in our collaboration.

So prior to 2012 we would refer our students to an IOP off campus.

Ascension Seton is a not-for-profit organization.

From campus parking to their parking, about a 12-minute drive or 25-minute bus drive and not super close.

What would happen is we would refer our students to go to an IOP facility and many of them would not attend and they would cite it's too far or too inconvenient and so I wasn't able to go.

Or I missed the bugs so there were lots of different reasons since it wasn't easily accessible.

So we started having conversations with ascension Seton and they ran -- they had a behavioral health outpatient program where they ran IOP and recently added PHP.

They had several programs and we had a discussion because they had an adult IOP.

The discussion was having a Seton IOP program but located on the UT campus.

They are not for profit and their mission statement says our mission says we are care for and -- with important importance on vulnerable.

Students with financial issues and no health insurance and in essence are vulnerable because of the fact that they had less access to treatment programs where you have to pay.

So this is what we did in terms of our planning.

We divided up responsibilities, although we were constantly communicating.

We started in 2011 and finalized everything in mid-2012.

Seton developed protocols for the IOP but very much in collaboration with our team which involved myself and the Clinical Directors and Director.

They agreed to provide a free IOP intake so the assessment to determine whether this was a good match would also be of no cost.

The outpatient program agreed to provide patient care and all the documentation and they also agreed to provide a dedicated IOP clinician and not shuttling in a new clinician every few weeks but one that was assigned to working with the college students who have a licensed mental health professional.

Many IOPs will use interns but they agreed to do that.

They handled all their billing and there were three scholarship spots and I'll other talk about that in a second.

Our responsibilities as a counseling center, we agreed to refer our students.

When we were on campus we agreed to provide a waiting room and a group room designated specifically for IOP during that time and we agreed to provide an office with the IOP clinician so they could conduct the intakes on campus specifically so the students would not have to go off campus to their clinic.

Our collaboration ended up into an IOP that was three hours a day, four days a week.

It ran from 3:00 p.m. to 7:00 p.m..

A typical IOP treatment is four to five weeks.

Their young adult IOP is called an epic IOP, definitely a process in skills building group meant to for ages 18 to 24 and that was started in 2012.

And that particular IOP also brought in components of self cam passion, agony five behavioral therapy, assertive communication, teaching Distress Tolerance skills and mindfulness.

That started in 2012 and was really successful.

Except then we started seeing students who had a lot of impulsive behaviors, more self-injury.

More difficulties with tolerating distress.

And those type of behaviors really respond well to Dialectical Behavior Therapy which is DBT.

Very skills focused therapy that helps an individual increase awareness of their behavior patterns and helps them manage the behaviors and intense emotions and the suicidal thinking and the relationships that can get very chaotic.

We ended up adding a second group for 2016.

Our IOP groups were for UC students only.

No other college students.

It was located on our campus and many students who we saw and referred, we would tell them it's right here on this floor.

We have the luxury of having a separate waiting room for our group therapy programs and that's consider the students would wait.

And it was located there.

I'll talk to you a little bit about how re-transitioned to telehealth with the pandemic and this is the part we're most proud of.

We negotiated for three scholarship spots and what means Seton looked for students with no health insurance and who otherwise could not receive the treatment.

That means they were not paid as much as if they had said only insurance people.

But, again, I think it was the fact of their mission of providing for those who are poor and vulnerable that inspired them to say yes.

Let's do three scholarship spots.

In reality, all three spots weren't always filled and they may have a majority of students who are using their health insurance.

So it's still working well for them in terms of cost ratio.

And then the other thing that we did within our collaboration was to designate someone who was a liaison, and I volunteered happily for that having worked with both IOP and PHP programs and I knew how they run and I knew what needed to occur.

As I was helping the IOP group clinician, two clinicians later, understand about college students because many of them didn't know for, for example, accommodations for those students with disabilities or understanding the different resources that were available on campus.

So being available to them to provide those resources and as a liaison, also being able to our clinicians.

Because one of the things that we saw is many of our counselors had no experience with IOP or PHP.

They may have heard of it but had no clients who had received that type of treatment and so they were not super aware.

And definitely some education and I think once they started having students attend the program, give feedback about the support they were feeling and then following treatment, how they improved, helped inform our counselors about IOP and helped them be more readily available to refer.

The other piece is by then they can provide more information to students about how they had seen other students respond well.

I think a great selling point for some of our students who are in great distress is to talk about how they -- because it's intensive, how symptoms can decrease faster than if you were seeing an individual therapist weekly over several weeks. And I think for some students, then they're willing to go okay, well, let me check into this.

Maybe that could be helpful.

I think once they met with the clinician at intake, then they were willing to take a chance to see if this could be helpful.

Our initial data started February 2012 and we ran until August of 2013.

Initially 122 UT students completed an IOP assessment, at UT and off campus.

I wanted to highlight the first year or not even a full year, 54 students meted an IOP -- 38 at our campus and 30 insured and 18 with a scholarship.

16 completed IOP at the off-campus option.

The next few slides were shared from Seton and the information that they included, this is for their fiscal year which runs from July 2017 to June 2018.

That year there were 98 Admissions.

74 students insured and 24 grant funded.

About twenty 5 percent were on a scholarship.

Seton does a follow-up with all of patients who participated in IOP.

They contact them 30 days after services to get feedback as to whether they feel better; if they feel worse; or there hasn't really been change.

On average 82 percent of our UT students who had completed the IOP the month prior reported feeling better.

14 percent recorded no significant change.

But that's pretty significant.

This next slide shared from our Seton partners shows the difference between the step downs from the hospital which are in blue and the directedness which are all referrals and these represent referrals not only from the counseling center -- the majority of them are from the counseling center but they could represent referrals -- it's well-known in Austin we have the IOP on campus specifically for college students.

Many providers and therapists in Austin know about it and they will refer their students and students can self-refer and there's information on it online.

Students can read about it and say I think that's something I need to do.

The other thing I want to point out from the graph they shared with us is you can see how August, September, not too business.

But then you see the spikes as I think we can all predict in October and November December and then it backs down in January and then it spikes up again for that spring semester.

So this really, I think, coincides a lot with our students and their academic schedule.

They struggle with mental health issues all year but with the stress of academics and other stresses going on, symptoms can really flair.

I want to share data that we have collected from the 2019 to 2020 and this is from him academic year.

I want to tell you a couple of things and sadly and I did mention this earlier -- we ended up seeing so many students who benefited from DBT, we actually transitioned to two BTIOP programs but under the influence in 2019 one of our IOP therapists left and so at the beginning of 2019 we only had one group.

And so we started with one group, deciding to see, did we -- and I think at the time they were looking for a specific IOP clinician that they could run a second group.

And so number one, this data only is for one group that was run.

The second thing is this spans the same amount of time as the pandemic.

So that started about in March 2020.

So this data will show you how many students participated despite the pandemic and it was all switched over to telehealth.

So that particular fall we had 38 percent of students -- so that represented 34 students -- in the spring, even though we went to telehealth, we still had more students participate in the spring semester.

So more than 50 percent.

And then a smaller percentage over the summer.

Excuse me.

Sessions attended -- typically, four to five week -- full attendance.

So we're looking at twenty plus sessions.

65 percent of our students completed 17 to 23 sessions.

So a big chunk of them completed the majority of sessions and then we have it broken down by other sessions they attended.

We looked at who referred and as I said, 54 percent of the referrals came from our counseling and mental health center.

22 percent were step down -- direct Admissions following hospital deceleration.

So just the step downs at CMHC is about 75 percent.

We definitely had a group from off campus providers and students referring themselves.

We also looked at gender.

The majority of students who participated and completed an IOP, 59 percent identified as female.

27 identified as male.

We had other students who completed who identified as gender nonconforming, nonbinary, agender and transgender and some students chose to identify as other.

Smaller percentages but we're proud to offer services for students who had other gender identities, other than binary.

We also looked at the students' self-reported ethnicity.

41 percent identified as white.

28 Hispanic, 11 percent Asian and Asian American, 13 percent Biracial and 6 percent African American.

Classification -- when we first started we anticipated that would be more first years and that's not true.

The peaks that we see is in sophomore year.

Second year students.

About 37 percent of students in IOP were in their second year and 27 percent were identified as seniors and that could be fourth or fifth years.

Then this last pie chart looks at health insurance.

We are aware that 64 percent of our students had health insurance and we know for sure that 9 percent did not.

This twenty percent which is unknown -- I think I told you that approximately, what, there was 65 percent from CMHC but that means there's a chunk from elsewhere where we don't have access to their current health insurance because we're not providing them direct services.

They may have been referred by an off-campus provider and we didn't have that information.

The next slide, we only looked at students that we know for sure had no health insurance and then we looked at their identities.

As you can see, those with no health insurance, 25 percent identified as white and 75 percent identified as nonwhite.

Again, I think we are looking at providing care for vulnerable students and students of identities who may not have had access to those services.

The last table that I want to share with you looks at the 2019 to 2020 year for the students who completed and then looking at the diagnoses.

This is listed for all the students we are aware of.

Depression diagnose, definitely 80 percent of the students had that.

And anxiety disorders were high as well as suicide or any self-injury.

Remember trauma can very much be comorbid with anxiety and depression symptoms.

Many of our students may have experienced trauma in childhood or trauma prior to coming to college and its -- they may have done a lot of avoidance and it's in college where you start seeing a lot of the symptoms.

We saw lots of comorbid alcohol and drug use as well as bipolar disorder and less so, eating disorder.

We did have those students personality disorder diagnosed with borderline personality disorder and a smattering of other diagnoses.

As I was preparing for this talk, I was looking for information on IOP and James and his colleagues looked at a DBT IOP for adolescents and looked specifically at those with insurance and no insurance and they saw 80 percent of private insurance graduated and completed the IOP whereas only 60 percent of their grant funded students completed.

Pointing out that some students who don't have private insurance might need extra engagement efforts.

I'm not certain we saw that -- I don't know that we tracked that well enough to be able to say that we didn't see that but seeing this type of study is helpful for us because it informs us what we should look at moving forward.

And then the other program I wanted to bring up is something that's called costar.

And again, as I was preparing I was looking to see what does everybody else do around the nation.

Another program out of Western Psychiatric Hospital at the University of Pittsburgh Medical Center.

Co/STAR is an IOP at local universities.

What they do -- and I read this and thought we're going to do this.

They do measurement care before the impact pre and post IOP.

Quick inventory of depression symptomology and the Patient Health Questionnaire PHQ9 and they look at general anxious it disorder and suicide.

What they found is improvement in symptoms but they specifically looked at measurement-based care.

So I found this also great information informing us what we can look at for the future in terms of how we can continue to improve.

All right.

So our challenges and successes.

I think our biggest challenge was educating our staff about the benefits of IOP, just because they weren't aware of what IOP was.

Which would help inform them of exactly what's involved, what their client would go through if they were involved in IOP treatment and what improvement they could expect.

And that helped encouraged them to refer more and more students. Advocating for IOP to students and providing IOP education.

Earlier a student would have said that's too much time and I'm failing classes already and you want me to go to a program three hours a day, four days a week? Part of that is them seeing instructing their day can be beneficial.

Getting that extra support versus staying in their apartment all day.

Getting the support and skills can help them and being in a support group of other students who are also struggling.

Encouraging each other to hey we're wrapping up with IOP.

Let's study and tomorrow we'll check in with each other.

The other way we've advocated for IOP for our student -- helping them see that if they can drop a class, that would give them a little bit more band width, keep them in school.

They can complete other classes but have a little more time to add in this intensive treatment into their lives.

With the pandemic, a shift to the virtual and telehealth format.

That has been exceptionally challenging in group settings: For those of you who run groups, you get it.

Challenging for IOP clinicians.

I have to give kudos for them.

They have adjusted how they make sure they're checking in our how to make sure students online are participating and pointing out different things to make sure that everyone is chiming in in terms of how they're doing.

They do symptom cards to explain whether they're taking their medication, whether they're compliant with their appointments.

They've done, I think, a really good job of managing despite the fact that we've switched over to all online services.

We're being looking forward to the fall where we're going to be in person.

They're trying to discuss whether they offer both an in-person group and then maybe a separate group that's virtual.

>> Doctor Eshelman appears to be having technical difficulty.

Jennifer Lang will be with you in just a moment while we resolve this issue.

>> JENNIFER LANG: Yes.

So will -- I'm hoping that Dr. Eshelman will be able to reestablish her connection here shortly.

Of course, it comes right at the very end of her talk.

I would encourage folks, if you have not done so already, if you do have some questions, go ahead and put those in the Q&A chat box.

I see a couple so far.

I do want to draw your attention if you haven't noticed, that we had a question from Charlie -- I hope I'm saying this correctly.

Nerit at the couple family therapy clinic regarding data that Doctor had shared earlier and that is in the chat box and I see a couple of other questions up.

But hopefully we will have Dr. Eshelman address them --

>> DR. MELISSA ESHELMAN: I am back on.

I apologize.

I don't know what happened.

There was a hiccup and suddenly I was gone.

>> JENNIFER LANG: It's okay.

You're back and better than ever.

>> DR. MELISSA ESHELMAN: I don't know if I can go back to sharing my screen? Okay.

So I was just letting you know when I think the camera went off I was seeing a student who thanked me for referring her to DBT IOP and we received this Tuesday and I'm like wow this is all happening right before this presentation.

I'm going to read this to you.

This is a student who completed DBT IOP in 2017, someone still thinking about it in 2021.

I'm reaching out to say thank you for being patient with me during a time when I was at my lowest and most from Jill.

I've been doing therapy since then and have learned better skills to manage my depression and anxiety.

>> It appears Dr. Eshelman is having connection issues.

One second, please.

>> JENNIFER LANG: In this moment I may encourage to consider she was talking about challenges to doing group virtually.

You can imagine this probably happens multiple times over the course of groups and we just have to roll with it and we really appreciate your patience.

>> DR. MELISSA ESHELMAN: I am back on.

Should I proceed?

>> JENNIFER LANG: Yes, you're back.

Thank you so much.

>> DR. MELISSA ESHELMAN: Okay.

I'm at my conclusion part. I

Maybe rather than trying to share I'll do a summary.

Over all, depression, anxiety, suicide and self-injury -- these were the issues that IOP addressed and IOP provides services in a way that's supportive for our students.

We were able to provide services and provide equity inclusion for students who could not have otherwise participates and we've had challenges along the way and yet our successes have been great.

I am so pleased to have had the opportunity to tell you about our experience and I am happy -- oh, I'm right on time, even with technical challenges.

Right on time because I had hoped to make sure it to finish before 8:50 so I could address any questions.

>> JENNIFER LANG: Yes, thank you so much, Dr. Eshelman and really, really appreciate that student feedback that you received.

I think a number of us who have worked with students in programs like this have heard feedback via email or in person or even if we've seen another student who comes to us and says my roommate did such and such and they benefited.

I'm going to take a look at some questions that I think we've received.

Dr. Eshelman, are you still interest? It appears we're having a connection issue.

Hopefully she'll be right back on.

So for two questions in the chat and I know one of our panelists is also hope to go ask a question.

So if folks have questions, go ahead and put it in the Q&A box and Morgan Blumenfeld and I will be monitoring those and hopefully we'll have Dr. Eshelman back in a second to help address some of those.

>> Jennifer, I believe she's attempting to rejoin now.

>> JENNIFER LANG: Okay.

>> DR. MELISSA ESHELMAN: I am back on.

>> JENNIFER LANG: Fantastic.

We have a couple of questions, Dr. Eshelman.

Our first one is from Dr. Barbara Erbansheck who is a Psychologist in our Counseling Center.

I'm curious about students not being required to sign up for health insurance.

Are you aware of UT Austin's rationale behind that?

>> DR. MELISSA ESHELMAN: University of Texas state university system comes from the State Legislators and because of the constituents they wanted to not require health students for undergraduates but graduates and professions are required to have it.

I don't think we've battled pressing on that.

In the last few years it's probably going to come up again because it does make it challenging.

We see students and it's so difficult to refer them because they have no health insurance and it limits options.

That is not a UT Austin decision.

That's a state of Texas.

>> JENNIFER LANG: Thank you very much.

We appreciate that.

I have a question here from Chris Wethington.

Feel free to put it in the box what office you're come figure so we can give it context as well.

This says I apologize if I missed this but during the pandemic was the IOP facing higher demand and was the program able manage it and if so was the clinic able to handle it or refer to other resources.

>> I think she'll be back with us momentarily.

>> JENNIFER LANG: Sorry for the delay, everyone.

Thank you for your patience.

>> Jennifer, would you like to move to break until we're able to connect to Dr. Eshelman and then we can finish the Q&A session?

>> JENNIFER LANG: That would be fantastic.

Why don't we go ahead and take a ten minute or so break and we can reconvene around 10:05 and hopefully we will have Dr. Eshelman back to join us to answer just a couple of remaining questions that we have.

I really appreciate your patience through this whole morning already so far and some of the difficulties we're having.

But thank you.

(on break).

>> JENNIFER LANG: All right.

So it is about 10:05.

Thank you, guys, for your patience, and I am pleased to welcome Dr. Eshelman back.

And I'm hoping that we can proceed with our Q&As here now.

With some of those remaining questions.

Are you here?

>> DR. MELISSA ESHELMAN: I am here.

I've been advised to keep my camera off to hopeful he not contribute to more instability.

>> JENNIFER LANG: All good.

I'm not sure if you heard the other question?

>> DR. MELISSA ESHELMAN: If you would repeat it, that would be great.

>> JENNIFER LANG: Chris Webbington, a long time Academic Advisor here asked a question about during the early pandemic was the program facing a higher demand and -- Chris gave context to that.

I guess there were aware of someone in a hospital here locally and in PHP as well due to some, I guess, back-ups in them being able to get into our program here at Harding.

>> DR. MELISSA ESHELMAN: Our experiences initially is we have increased demand.

Texas is a big state and a lot of our students returned home.

Even though we had telehealth for IOP, many of them may not have known about it.

It gets tough in different time zones.

Depending on what part of west Texas you're in it might have been an hour earlier.

I don't know we saw increasing demand.

I think once everyone was well using telehealth in late April, then we just resumed with our usual referrals we had with students that we were managing via telehealth.

>> JENNIFER LANG: Thank you.

Another question that we have is from Dr. Ryan Patel who is a Psychiatrist here in our counseling center.

You mentioned scholarship assistance for student to see anti IOP -- how were those funds?

>> DR. MELISSA ESHELMAN: The funding was through Seton and what they did is if the student was a resident of Travis county, they had eligibility for hospital district funding which is available for residents here in our county and so Seton would apply for that and they would get a portion of what they was needed for payment; however, since then they have had -- they no longer do that because they have had donors.

There are people in the community very much wanting to help young adults and so they have donated to the scholarship fund and there are donations have funded scholarships for students to attend.

>> JENNIFER LANG: That is fantastic.

We have a question from Bailey who is one of our fantastic young adult PHP clinicians.

>> BAILEY DeBLASIS: Thank you so much for your presentation and I thought it was cool and really cool what you're doing.

My question compared to ours, do you have worked into your treatment goals class attendance or anything work related?

>> DR. MELISSA ESHELMAN: Thank you for bringing that up.

The IOP runs from 3:00 to 7:00.

Most IOPs are pretty strict.

If you miss two times, you're out.

Whereas if our clinicians -- if it's class related, they will give them an excuse.

There are students who might have a class that may not end until 4:00 p.m., for example.

So we will allow them one day a week to come in late or if they have an exam, for example, the next day and they go I have an exam and I really want to study for it and I promise I'll really be studying for it and not just playing, then they will allow them to miss IOP groups.

They will do that for academic issues or a late lab.

They don't do the allow answers for students with work.

They will provide students with written documentation that the student is in a temporary program and please provide allowances so they're not working these hours they will provide things like that but the allowances for people being late or missing groups are done for academics.

Thanks.

>> JENNIFER LANG: I think that's fantastic to think about and talk about, right? Like, both systems needing to be flexible, especially work width this population that that's an important comment.

>> DR. MELISSA ESHELMAN: Trying to very much student-centered care, very much not just treating them within a protocol and a program but recognizing that they have unique challenges and responsibilities that get pretty tough at certain times in the semester.

>> JENNIFER LANG: Fantastic.

I don't see any other questions in the chat box but I know that more gone Blumenfeld who is my cohost on this event, she has a question and so I'll turn it over to her.

>> MORGAN BLUMENFELD: Thank you.

I feel that was interesting.

I was hoping you could speak more to the questions on data you presented.

One being why about 14 percent of students who attended the program might not have found it help., if you had done research into that and the other is why sophomores were your biggest population of students who attended the program.

>> DR. MELISSA ESHELMAN: I'll start with the second question.

Not sure why.

Prior years had has flopped between seniors and sophomores.

Seniors, I think it's easy because they're trying to complete things and getting ready for transition and that creates a lot of distress, especially when they don't have plans for following graduation.

I think this is the first year where sophomores are prominent.

We're not sure what the other factors are for them.

I apologized.

The first question?

>> MORGAN BLUMENFELD: If you conceptualize why 14 percent of the population didn't find the program to be as effective photographer them.

>> DR. MELISSA ESHELMAN: Not sure.

14 reported no change whereas other people said they were better.

We're not a hundred percent sure -- they're not continuing treatment and so I think that's probably our best theory but we're not sure.

>> JENNIFER LANG: Thank you and so we have one last question and I want to be mindful of your time Dr. Eshelman and I'll be presenting for folks coming up next.

I have a question from Allen.

I and I believe four of my fellow police officers in this university are present in this conference as we take an active role with our students with mental health although when they are in campus.

How is your relationship with University police or Austin police?

>> DR. MELISSA ESHELMAN: We have a good relationship with our UT Police department that we have on campus.

That's something I'm involved in and I'm the correctly a son with the police department and they have been involved and I have a contact with one specific officer where I provide feedback both positive interactions officers have had with students well any concerns and just our UT police just this year have set up a crisis intervention team.

So specific officers to respond to mental health issues.

All of the officers are mental health officers and so they get mental health training and these specifically have been chosen because of interest and feedback they've gotten in terms of good interactions with students and they are also offerings with diverse identities.

So I would say over all we have -- the counseling center has a really good relationship.

I will say within the community a lot of students, I think, and this is common throughout the US, a lot of concerns about police.

And so that has been challenging, especially when you have a student who's declining to go for an assessment.

(Captioner's Transitioning)

>> That has been challenging, especially when you have declining to go for an assessment but contacting police to make contact with those students. This change to having crisis intervention officers available who are dedicated, I think, will create positive change. I am hopeful for future advances that the campus is looking at.

>> JENNIFER: Thank you so much, Dr. Eshelman, for your time and patience and answering questions. As well as your fantastic presentation and the glimpse into what you are doing and how you have modeled around your system and University. We really appreciate your time and expertise.

>> DR. ESHELMAN: Thank you very much for the opportunity.

>> JENNIFER: Okay. I am mindful that we previously had a break during this time. We will be mindful of time for the next presentation. Again, if you need to break in between now and when we have lunch, please do so. I will go ahead and share my screen.

Morgan, are you able to see that?

There it is.

>> JENNIFER: Fantastic. I am really pleased to be presenting the next talk with two respected colleagues at OSU Harding. Bailey, licensed social worker and clinician in the young adult hospitalization program. Previously, had been in one of the young adult intensive outpatient programs at Harding. Arianna, associate director of the STAR program impartial hospitalization and IOP programs at OSU Harding Hospital. I am pleased to have them join us today. And being co-presenters with me on this presentation.

These are the goals and objectives for our time with you for the remainder of this morning. You just got to hear during Dr. Eshelman's talk of what did the context in the picture look like that UT Austin in terms of collaboration and IOP coming to fruition. Some data they had in terms of what their center was seeing. Then what their unique relationship looks like with their IOP's. Today, in our talk we will give you review of the timeline and context more specific to Ohio State. It looks both similar and different. How did the programs develop here and what do the programs look like for us? It's going along with this idea is one size doesn't fit all and the need to be flexible.

We will do an overview of those programs and what that schedule looks like. We will talk specifically about what referrals look like to the program for students who are referred from counseling and consultation services, and how that relationship is unique with OSU Harding adult program.

We will share data and outcomes from CCS and Harding with these programs that we are exciting about. I think it demonstrates the need, value, importance of having programs like this available to college age students and OSU students. We will be talking about considerations moving forward. Certainly, as you see in today's presentation, there has been a lot of growth in these programs. A lot of the growth has been because of the hard work that a lot of attendees have done with you are a clinician, advisor, Dean of student's office promoting this culture of care into checking in with students and getting help. A lot of this work we present today is because of your influence and passion for serving students.

I also wanted to honor that as well. When we think about the factors at OSU that I think are at interplay coming together that led to the development of this young adult program at OSU Harding and collaboration with CCS and other offices on campus, I think one piece is as you heard, Dr. Sharma and Dr. Elbert, this multimodal service at CCS. Therapy is not one-size-fits-all. Just like our student value population is diverse in terms of identities, they are coming to us with different needs. Some students coming in with a lot of treatment history, a lot of symptom history. At some students with very little. Maybe their first symptoms while here on campus.

Making church services we have available are reflective of that need and demand. Certainly, that includes the need to be collaborative with other offices and agencies on campus. Being aware of resources so if CCS does not offer those services, looking to colleagues and know the work they are doing so we can make sure students are getting connected with what they need.

Similar to what Dr. Eshelman was talking about in terms of demand for services, during this time period leading up to the development of the young adult program, Harding and the emergency room as well on campus were noting seeing increased demand for services. That is not just the student population. Just like Frank the County, more folks showing up in the emergency department experiencing mental health crisis. More call volume to establish services whether it's outpatient, and seeing in patient demand as well.

There deftly was a time period I would say probably around 2016, 2018, where we were also seeing an increase in number of students hospitalized. That was only the students that CCS were made aware of. Let alone students who perhaps for whatever reason were connected with the office when they were hospitalized. That was all taken place. The importance of the student. The student groups on campus. The undergraduate student government, the president and vice president are running on platforms that were very much emphasizing the importance and need for mental health services.

There was demand and need and desire. They made that front and center. And what they wanted, the president office to be aware of. This was also evident in articles and discussions happening across campus in student groups. It's important to be responsive to that.

Certainly, some high-profile student tragedies that took place. For example, we had some tragedies involving parking garages on campus, as well as the unfortunate murder of Reagan. The attack on campus as well. When things like that happen, there are obviously specific students who may have been present for work involved in the actual incident that their mental health is impacted. Especially social media and how connected students are to one another. We see this ripple effect.

It's not just that group. Students who may be didn't know Reagan specifically, but have experienced trauma themselves, grief and loss themselves. It can be triggering for them to maybe be reflective or thinking of their own experiences of similar. We are going to see these things impact student's mental health in more global ways than just these isolated situations or experiences.

As we were speaking earlier this morning in 2018, President Drake suicidal mental health task force was reviewing prevention and efforts around suicide. It was a really important recommendation made specifically around increased collaboration and communication. The development of new partnerships. OSU is a huge campus and I often tell people and I think it's funny we had someone from UT Austin since I think UT is the largest campus in the country?

We are a huge campus. There are so many different resources and folks doing different things. If we are all sideloading and separated and not aware of what those resources are, or how we can work together, that's our own barrier. We are getting in our own way. Is push for collaboration and communication is really important and invaluable. I think this program we are talking about today and the young adult collaboration between Harding and offices of student life and CCS, it is breaking down of these silos that get in the way of students getting needs met.

In the same year in 2018, Department of psychiatry at Harding Hospital have an annual suicide prevention conference. In 2018, it was specifically centered around campus and educational settings. I think it was very poignant at the time given some of the work of the task force and tragedies that we had seen both locally and within the state and those types of frameworks.

I think -- and certainly Bailey and Arianna, if you have things to add, certainly hot in. These were some of the things going on in the environment that were coming together that fostered climate that despite these being potentially negative or challenging things, created something really fantastic with the young adult program.

Shifting a bit, I will not belabor this because this was something that Dr. Eshelman went over and explained very eloquently. This is a triangle reinforcing that concept of levels of care that exists. I do want to say too that this information is new for a lot of us and new for a lot of students. Yes, some students have had previous involvement in these levels of care, but a lot of students who have different cultural backgrounds or access to insurance or economic resources, they may not be aware of many of these.

It's important for us to know about this and consider that when talking to students. It might feel very ingrained in us that this exists, but for students, they may not be aware as well. This triangle is going among the bottom level, least intensive, to highest level of intensity. When we are talking about the attentiveness of different levels of care, we are thinking about both time and intervention that would probably be involved.

I would say to be frank, cost as well, if we are thinking about some barriers and considerations that folks may be thinking about. I think one thing that's really important to know is clients can move up and down through these different levels on the triangle. They may enter at the CCS provider level of care, and depending on different stressors that come up or responsiveness to treatment, they may need more. Or they may improve and symptoms may remit and they need less. This is something that can be fluid and change over time.

For those in the audience who might be looking at this information or hearing what Dr. Eshelman was speaking to him thinking gosh, I'm an advisor or what would I tell somebody? Am I supposed to guess at this? I would say no. My push would be it's important to get somebody to a mental health professional that can certainly advise them. It's typically clinicians or physicians who is making assessment recommendations around these pieces.

The other piece too is students and parents may also identify finding one of these things helpful. They may refer themselves. Ultimately, the physician or clinician may make recommendations about what might be most useful. If we are looking at this triangle thinking about how do we localize this to Columbus? Or to campus here? We have self-help psychoeducation at the bottom. I would include offices on campus like some resources available through wellness coaching, student wellness center, or for instance, counseling service offers drop-in workshops.

They are skills based and offer ideas and certainly not considered treatment necessarily. Then we moved to counseling and consultation service. Similar to what Dr. Eshelman was stating at their center, the scope of practice here is brief. We do have frequency of sessions that we are typically seeing people. It's not something considered for long-term care. Then we have outpatient community providers. This may be private practice or agency within the community that offers therapy. They may build insurance and see folks with frequency may be weekly and be seen people on more long-term basis. You can probably call to some places around Franklin County who offer these services. Providers for healthy living is an example of one coming to mind. Then we have the partial hospitalization and intensive outpatient levels of care. We will go more in-depth to those, but those are offered at OSU Harding. There are also other hospital systems in Franklin County that offer those services.

They are not for 18 to 24-year-old specifically, but they do serve at that level of care. The residential level of care and we don't have any residential treatment right here locally to my mind, but we certainly also do have inpatient medical detox available within Franklin County. Bailey or Arianna, did you have anything to add to that?

>> ARIANNA: No, that is comprehensive just going over what needs are met at each level and you did a great job.

>> JENNIFER: Thank you. I will throw it over to Arianna to talk about the benefits. It it's not one-size-fits-all so how was it helpful for students to do something that is not weekly individual therapy?

>> ARIANNA: I think this got touched on this morning as well, but one of the major benefits of either partial hospital or intensive outpatient level of care, is it can help when there has been a hospitalization to transition back toward outpatient level of care. As you are thinking about the pyramid that Jennifer shared, really looking at it as a letter that you can ascend or descend. That partial hospital level of care is meant to be an intermediate level of care either or folks that outpatient is not sufficiently meeting needs based on the level of severity of the symptoms, or the person is coming from the hospital following an acute crisis.

They have since stabilized in the hospital which is the goal of treatment at that level of care, but it's reasonable to think that returning simply to once a week 60-minute outpatient appointment isn't going to be the level of support needed. Taking a look at what are the needs right now realistically? Partial hospital or intensive outpatient can meet the need either as transition away from the hospital or prevent need for inpatient hospitalization.

It also helps individuals participating reset with a healthy structure. There are built-in structures to the day in partial and intensive services. A lot of people that come through the program have been lacking healthy structure in their lives and that's one of the things contributing to symptoms. There are also built into the program access to medication. And a psychiatrist or nurse practitioner that will have closer eyes in terms of the medication profile the regimen that person has been prescribed. It is possible to more quickly make adjustments to those regiments. Maybe someone's on dose is not sufficient, or maybe they are not on the right medications. Perhaps they have never been on medications before and they are considering taking that step for the first time.

That access to medication management component of treating mental health symptoms is really important. Participants in partial and intensive programs are monitored more frequently than you typically would be on an outpatient basis with providers.

The other piece of partial hospital and intensive hospital services is we really emphasized skills. Not only is someone coming to therapy and discussing their particular stressors, the psychotherapy group portion of the program, they are also learning concrete skills and having an opportunity to discuss amongst themselves and facilitators how those particular skills will apply in their lives. If they struggle with particular skills, getting back about different ways to incorporate or adjust so they can utilize that skill more effect leave.

>> JENNIFER: One thing I wanted to add that I think is important is a lot of students from a lot of different cultural backgrounds and maybe family systems have had high-level stigma around medication. I have heard feedback from students saying because I met with my prescriber regularly, that level of high collaboration with that prescriber, I think breaks down a lot of stigma around taking medication. They feel very involved in planning around their care.

The other piece too which I think we talk about with students is for cultural or religious reasons you do not want to take any medication; it is not required. In some ways, if somebody doesn't want to take medication, IOP and PHP can be helpful because you are getting a lot of skill building. You might not be getting the medication to manage the symptoms, but you are getting so much skill building, support, and feedback. Sometimes it mitigates piece of the person that has specific barriers for not taking medication.

>> ARIANNA: Absolutely. We really emphasize in partial and IOP sense of agency over the choices you make about your own body and help. One thing we do require is consultation with prescribers. Even if you are starting the beginning saying I don't think medication is for me for a variety of reasons we will not force you but we ask you to have a conversation. Be open to hearing information about how medication might be able to support you with your symptoms. Or not. There are some instances where the prescriber will meet with someone and say I don't think medication is indicated in this case.

Having that conversation as well. It's really meant to be collaborative conversation and it is dictating care. What are the benefits from student perspective or from young adult perspective? Many people as they are hearing about partial and IOP for the first time are a little anxious about the group setting and idea that I'm going to be participating with other people and will that be enough focus attention on the issues that bring me to treatment? What we hear over and over from participants that have gone through the program, is the format is incredibly helpful. Particularly for this age range of from nearly 18 to 24-year-old students.

Having peer interaction and ability to socialize and supportive and healthy ways is incredibly beneficial. Folks at this age, this stage of development in their lives are still forming their identity. There's a lot of social pressure to figure it out very quickly. A group setting for treatment can be really helpful is folks are navigating and exploring those identity questions.

We also have built in our structure in partial and IOP, and very much in particular in one of our treatment tracks that is more dual diagnosis track, conversation about any kind of substance use concerns. We really hesitate to label substance use disorder, particularly with this age range. If someone is sort of just exploring and experimenting with use of substances, but we do incorporate into the treatment planning process how is the use of substance or is your use of substances impacting your mental health symptoms?

Really taking a look and focused attention in that space in a really nonjudgmental way. We are not here to say that you absolutely cannot engage in substance use if you will participate in our program. It's really about empowering the student to look at their specific situation and being honest with themselves and maybe getting feedback from other peers about how their use of substances might play a role in symptoms.

There is some benefit to striking while the iron is hot. Anyone that is familiar with change theory, really looking at crisis as an opportunity for change. Most of us will not initiate change when everything is going well in our lives. It's typically when things are uncomfortable or going wrong where we are open to making shifts. Is someone symptoms are escalating to the point of such discomfort that they are considering hospitalization or coming out the hospital because they were in such crisis that the level of care was necessary, this is a really important critical moment for intervention and really helping people walk through that change process in supported ways. They don't have to try to navigate changes all on their own.

It also can normalize and validate the need for treatment and support to be able to have that conversation that it is okay to need support. You are deserving of that support and it's available. That group setting and peer environment is a really wonderful space to have those conversations. Anything else I am missing?

>> BAILEY: Most people I think have probably in working with young adults in this conference and I don't know if anyone else notice there is us and them mentality. Something I have noticed is maybe in my assessment, young adults will try to sugarcoat something because they are worried I will judge them because I'm an adult. Once we get into the group, they will be more open because they see other people being open and not judged. It allows them to be more honest with clinicians and moving forward with outpatient clinicians to see ways clinicians are reacting to other people when they share something they assume they will be judged for. That's really cool part that they get to see how the clinician reacts before being vulnerable and it motivates them to be vulnerable in other settings.

>> JENNIFER: I would say too prior to the development of these programs, very similar to what Dr. Eshelman was describing, we didn't really have the barrier as much with location because as Bailey and Arianna and I know, I can walk to the Harding programs from my office here. We are very lucky with our physical proximity.

What we ran into a lot of times is I would refer students to programs and Harding has amazing programs. We speak highly of them and they would go and maybe sometimes have sessions and say Jennifer, I am 19 and I am in there. No offense with people your age talking about getting divorced. Having kids and that is a very different developmental set of concerns and influencing factors compared to the 24-year-old population.

We would see people complete programs even during that time and benefit for sure. I feel like having this program specifically, it is very affirming for them and they are in spaces where there are similarities and also difference and that is fantastic too. That is one piece.

The other piece is some students do come in to CCS or other offices and you might make recommendations that they need in IOP or partial. Sometimes I think students are like gosh, is there something wrong with me that I need treatment or something like that? The fact that we are able to speak to if you were the only OSU student who is dealing with these concerns, there would not be multiple IOP's and partials available for this population.

I think knowing that is available feels very validating, reassuring, taking some of the stigma out of it for sure. I don't know if you have other thoughts on that?

>> ARIANNA: Excellent point and one that we make for folks as well, that idea that if these problems you are experiencing were uncommon, we wouldn't have a program to address them. If your problems were so unique and severe and so beyond hope, we wouldn't have a program. That is very validating for a lot of participants and in some ways very relieving, I think. We can move to the next slide and talk about the timeline for how our programs in the current treatment tracks we are able to offer for this specific age range developed and evolved. We began developing in collaboration with CCS, our first treatment tracks specifically for this age group. That actually coincided with me taking on this role as the leader of this division of Harding. The initial planning stage actually occurred with former manager, Miles, who had discussions early on about maybe it would be benefit to carve out specific treatment track to address concerns for younger adults that are also struggling with problematic patterns substance use.

We were seeing in the general programs higher rate of folks that fell into that each demographic that have those specific concerns. We started to develop this intensive outpatient program for 18 to 24-year-olds that had primary mood disorders so struggling with depression, anxiety, or bipolar illness, posttraumatic stress disorder. Those are probably the highest incidence of diagnoses that we were serving. Co-occurring they were struggling with problematic substance patterns. We did research to look at what might be the most effective approach in that situation where there are emerging substance use problems and mood disorder playing roles.

We try to develop our curriculum to support harm reduction model that also builds in discussions around if it turns out it's harder than you thought it was going to be to reduce your consumption, let's look at what that might mean for you. Is harm reduction going to be possibility for you? Is this more specific problem that might follow you throughout your life if you continue to use? Might it be important for you to get some support links? Fortunately, we have great programs on campus. There is campus recovery community that has tons of support for students here on campus. Building connection with some folks over there is students are transitioning out of IOP, what else can you engage in socially that doesn't center around substance use?

We launched that program in August of 2017. The program runs three days per week, Monday, Tuesday, Thursday, from 10 AM until 1 PM. We chose that time very specifically. We didn't want it too early in the morning because folks struggling with substance abuse will probably be hung over in the morning. We also didn't want it too late in the day because we also recognize habit of procrastination as the day moves on. We wanted to make sure we were creating structure at the beginning of the day, not too early because we want people to show up. 10 AM to 1 PM, and we had a solid year or little more than that before we decided to launch our next IOP.

The program was meant to focus on students that were only dealing with mood disorders. The substance use component was not important for them. They didn't struggle in that domain. We wanted to make sure there was space for those students that didn't struggle with substances, but did need the IOP level of care and fell into that each demographic. We had seen such an effect from the peer support within a program where the age range was limited in that way.

We launched the next program in November of 2018 and that program met in the afternoons. We recognize patients being referred to that program tended to be higher functioning in terms of maintaining course load and many had classes in the morning but not afternoon. We launched that program in November, 2018. Almost exactly one year later, we launched were created collaboration or more formalized collaboration between the young adult's treatment team here at Harding and offices at the University. The student life disability service, student advocacy, counseling consultation, we really wanted to try to develop closer relationship and the feeling was mutual across all of these entities to make sure students were getting the wraparound support they needed.

We were going to take care of the mental health component while they were participating in IOP. We also needed to understand the process for helping students access accommodations. Making sure we had good aftercare plan for outpatient linkage once the student was finished with intensive outpatient treatment. We started to meet on fairly regular basis to discuss and troubleshoot and problem solve some barriers that are inherent in working in different spaces along the parallel track with the same population.

In September 2019, we added the second mood disorder only treatment track for our 18 to 24-year-olds. That program meets in the evenings. From 5 PM to 8 PM. Again, those are students that tend to be functioning higher. They may be at work during the day or class during the day and able to maintain in those spaces without taking full breaks. Although we do have students that do take breaks from work or classes to participate in these programs even if the hours don't intersect. That has more to do with just how are symptoms affecting you? And are you functioning in the spaces? If the answer is no, we will make sure to advocate for accommodations to help you be successful.

In August, 2020, we made the decision and noticed a lot of students and folks that were not students that fell into this age demographic, IOP wasn't quite enough. We wanted to make sure that students had access to the same age peer element of treatment that we knew was beneficial. They were attending the proper level of treatment. Some of the patients we were serving, we were having to weigh is the same age peer element more important than the level of care component? Is IOP going to be enough for this person?

More and more we were up realizing we had a base of patients that IOP was not going to be sufficient. We developed partial hospital intensive combination program that mirrors the program we already have in existence for the general adult population. In order to do that and you will notice the timeframe. This is the middle of 2020 and not too far from the beginning of the COVID-19 pandemic so we had to do quick rearranging. We actually eliminated the afternoon mood IOP in favor of staffing this partial hospital intensive outpatient combination program that launched in August, 2020 in the virtual format.

Have not had an opportunity to host that one live, so we will see as it becomes safer and more recommended to gather in groups again, transitioning back to in person model of care for personal and IOP. We will see how that impacts the young adult personal IOP combination program. Thus far, in the virtual format it has been quite successful. Bailey, did I miss anything?

>> JENNIFER: I think when you are saying it like that, I think we are all laughing at this because of how ambitious and fantastic it is that it happened and got pulled off in the middle of a worldwide public health emergency.

>> ARIANNA: I am proud of is too.

(Laughter)

>> JENNIFER: I just wanted to say that reflectively.

>> ARIANNA: Anything else I am missing or should we advance. I think we can advance. Let's talk about the nitty-gritty. How do we make determinations about which treatment track will be the best fit for someone? Often times, we get feedback when I only want to do the evening program. That is wonderful except you just had a really serious suicide attempt and you are not functioning in your classes or life and have no structure throughout the day. I genuinely do not think three day per week intervention that takes place during the evenings will be benefit to you. We came up with criteria that helps guide decision-making. Certainly, we take student preference into consideration as we are making recommendations. Our primary goal is going to be deliver the best clinical fit.

How do we break this down? Who is appropriate for which program? In the young adult PHP IOP, program, we have a list of basic criteria. If the student needs four or more of criteria, that is a good PHP referral. If they are 18 to 24 and benefit with the same age peer, and that part is really important to notice because we do have some people that fall into that age range that are actually in different stages of their own development and having the same age peer is not as much benefit. Maybe somebody falls into the age range but if already graduated from college, married, have a child and not in the same stage of life that the majority of students and other folks that fall into that each category. They are struggling with different issues and problems. We take into consideration even if they fall into the age range, is the same age peer element going to be benefit or hindrance in this case?

Are they experiencing suicidal ideation? Do they have plan but no intent? Are they safe to stay out of the hospital but really struggling with suicidal thought? Do they lack structure? Are they attending to activities of daily living? Are they able to structure their day to take care of basic needs? Maybe they are new to treatment and lack insight into some factors that might be contributing to symptoms. They will need intensive intervention to develop the insight. Be they lack support and very isolated. Wanting to make sure they have more intense level of support while here. Are they dealing with complex trauma? Do they lack basic emotional regulation skills?

We want to make sure we offer the rate dose of intervention when somebody is coming to treatment with these complex problems. Do they demonstrate significant impulsivity? One minute the mood is in a stable place but the next minute they are really upset about something and not sure how to cope and they behave in ways that are impulsive. Is the diagnosis unclear? It might be benefit to make sure this person is in treatment daily so we can observe symptoms over time and try to clarify that diagnosis alongside them.

With it benefit from slower pace? Or partial hospital intensive termination programs pace our education curriculum much differently than we do in the IOP only programs. Many times, when the person is struggling with more severe symptoms of anxiety or depression, their ability to concentrate and take in new information and learning is impaired. Developing intervention that goes at slower pace and breaks things down more specifically is really important for folks dealing with symptoms that are that severe. Maybe this person has complex medication issues that require monitoring. That would be another sign that partial is better fit for this person. If someone has four or more criteria, we will be looking at placing them in the partial hospital treatment track. Even if the schedule is inconvenient.

The schedule for young adult programs would meet Monday through Friday from 9:15 AM until 3 PM, with breaks built in or about the first five to seven sessions. Is that person moves to the intensive outreach, that schedule is by 15 a.m. until 12:30 PM. For about 12 to 15 sessions. The whole program you complete in about one month to six weeks. We understand that is a commitment which is why the collaboration on campus is so important to make sure we are able to access some accommodations for folks to get the care they need.

How do we make determination between the two remaining standalone intensive programs? Good referrals for the mood and substance use track, and for that track we don't only look at substance use if there are some other problematic habits that the person is struggling with, they may also benefit from that treatment track so we will consider them for placement there as well even if it's not a substance they struggle with. That same age range of 18 to 24 and benefit from being in treatment with the same aged peers. There primary mood disorder diagnosis. They have secondary substance use disorder diagnosis that does not require detox. They do not require the partial hospital level of care.

If all the criteria are met, we will place the person in that treatment track. For the mood disorder only IOP track, we are looking at primary mood disorder diagnosis and they do not require PHP. I should clarify that PHP is the appreciation for the partial hospital program and IOP is abbreviation for intensive outpatient program. I don't know if he specified before, that is jargon that I get used to saying and realize not everybody knows what those abbreviations mean. Have I missed anything? I think that is it.

>> JENNIFER: This is great amount of information of determination. The fantastic part about the programs at Harding is you all do such a great job of being very transparent with folks. It's not just like okay, Bailey, after you told me everything, you need to go to partial and this is when it starts. You guys are very intentional with this developmental group about saying based on this and this, this is why I think this would be helpful or useful for you. Keeping them informed and building in that psychoeducation piece. I think students even if they are surprised or thought it would be a different program, I think they respond well to it and very appreciative of it. I think it continues this motivation trajectory for them following through and doing what they need to do even if in the middle or beginning they might be frazzled like how am I going to do this? We work together to manage that. I just wanted to let the audience know this isn't a secret form that we are filling out. It's collaboration.

>> BAILEY: The only thing I wanted to mention is 24 is rigid. If we notice 25 or 26-year-old would benefit from being with other people going through the transitional phase, we would allow them in the program. Which is clinically try to decide and let them decide what would be better atmosphere for them.

>> ARIANNA: The last thing I will talk about right now, and then I will hand back over. Just to mention that we accept referrals from variety of spaces on and off campus including self-referral. You will see in the center we have PHP and IOP programming. Then you see all the different entities referring. We have developed processes to try to expedite and prioritize those situations where someone is in very acute need. We have pathways to expedite referrals, particularly from the emergency department or from the behavior health department. If the patient is seen in that space and it's determined this person symptoms have escalated and we don't think they need inpatient has position but more than what outpatient can provide. Here is the assessment that detail symptoms and needs, we will work to get that person started in treatment immediately providing we have space for them to begin treatment. We really have tried to carve out pathways to prioritize those in greatest need.

We also have developed and I think Jennifer will talk about this in one moment, pathway for students on campus to learn more about the program and make informed decisions about whether or not this will be the right move for them to make at this time prior to asking for commitment to start the program. We do a lot of work on the front-end to make sure this is something somebody thinks is feasible for them before we would take up the intake slot for the person because we have a lot of people waiting and they are coming at us from all sides. We want to make sure considering the linkage you have the information ahead of time so they can make the best decision for them. You will see a lot of the spaces that refer to us are internal to OSU, but we also accept referrals from community-based providers. We accept people that call on their own to say I want to enroll in your program.

We do our best to make sure everybody is getting service as quickly as possible. We are very sensitive to the fact that if you need partial or intensive services that your symptoms are quite distressing and we want to make sure we are not contributing to that distress by making you wait longer than you need to. Now I think we will turn it back over to someone else.

>> BAILEY: I think this is me. That was a good production of what orientation is. We have two orientations in our unit. One is held in our building for a lot of self-referrals or outside provider referrals. We have one in Duncan with Jennifer at CCS. As mentioned, the benefits are two old. When benefit is for us. We have so many people interested that we need to let people know what it looks like for we can assess them to decide whether or not they are interested. Two, it benefits the students coming to their turf and explaining what is in the benefits. We reviewed the benefits and that it's a lot Jennifer and clinicians shared with the students when they come to the orientation. Similar to Dr. Eshelman, our intake is very. We can come to the OSU campus until the patient's this is a free assessment. It's not committing to the program and spending money. You will learn how much money you will have to spend.

It allows the linkage to be smooth. As I said, it is collaborative. Jennifer, I know I'm out of touch since I moved partial but one or two of them will run it and clinicians from our team will run it. Ice to go and now it's typically people from IOP. I think I already talked a lot about this. This is held biweekly and even sometimes if we have students interested, they call us directly, if OSU orientation is more available than our orientation, we can send them to that one and get them into whichever one is more available.

The attendance is about five students but we have the cap of nine because for the staff year, the coordinators getting many more than that can be overwhelming with scheduling assessments. Do you have anything to say?

>> JENNIFER: I would just say the collaboration piece is really key for us. When they get too much overflow, we can accommodate OSU students and hours. Or one clinician at our center just like Dr. Eshelman was saying, in October and February we have found have been the trending months where CCS ends up meeting a lot. We reach our cap for orientation appointments. I will reach out to Bailey, Lauren, or another clinician and say is there any chance we can bump it to next week? I think that's where the flexibility and collaboration really come into play to try to get students in. I will say in our system if we have reached the cap on orientation, the people we have assessed if they studied partial or IOP, the staff will consider alternative referrals that might be able to get them in sooner. We will explain it's not 18 to Ä24 program and help the students which saying you can wait which may not be beneficial or do this.

That does come up from time to time. Not very often, but it does happen. We have ways to mitigate and manage that. It was in person but we moved orientation to Zoom and that has been good too. I think we weren't sure what would happen, but it has gone very smoothly even though I miss very much seeing my people in person.

The other nice thing of having orientation that is central to CCS is sometimes students reflect. They come into our office maybe have thoughts or expectations that they will be seen in our office. I think sometimes it helps when they get a recordation or referral for something like this, that it is here and helps with anxiety with transitioning here potentially.

>> BAILEY: Meeting the clinician they are working with can help bridge that gap too. Orientation, the goal I already mentioned is inform the patients of what they might be committing to and let them have some agency over that decision and if it's healthy. The format and Jennifer, I'm out of touch but when I was doing it, they would go in the lobby and we would pull them back and just introduce ourselves. Back in the day when I did it, there was court clinician teams and we could all go in introduce everyone and say you'll probably work with one of us and just review some attendance policies which they can be strict. Get the insurance information even provide information about what insurance looks like and what seeing the psychiatrist will look like. Often as we mentioned, getting into medical care might be one of the first time so we can sit down and give education about what the insurance would look like and what doing IOP would look like. We spent good amount of time Jennifer does more that talk about balancing academics with treatment. Everything OSU has worked hard to offer everyone interested in how they can help balance classes.

Again, we discussed insurance concerns. OSU does have opportunities to apply for financial aid to do these programs. Just creating the space to allow them to answer questions and sit there with them and create the time to introduce the topic.

>> JENNIFER: I think the fact that it is group style orientation really helps because one question one student may have, another student in the orientation might be thinking that isn't sure whether or not they should ask. It ends up being information that I think and efface the rest of the folks there for orientation as well. Some of the questions that come up are about academics or what is group therapy like? Or is the group going to be confidential? Maybe they have never done group therapy before. It's a lot of psychoeducation, giving them considerations. At the end of the day, we always tell people this is not a mandated program. We want you motivated to do it and identify it as being something you would find beneficial. At the end of the orientation, if the student chooses to move forward with the program, they can schedule assessments. The assessment is the free appointment with the clinician where they are determining partial or IOP in the start date. If the student says no, I don't want to schedule right now or let me think about it, it doesn't mean they are locked out of the program.

We reinforce and say you can follow up with the person who referred you, but if you change your mind, you can contact the PHP or IOP office and they will get you scheduled when you are ready.

>> BAILEY: This is something we use to hand out and I'm sure it's emailed now that we gave to all the people who attend. It is guidance on how to talk to the resources that exist on campus. A lot of times if we get students from inpatient, they are unaware of the resources that OSU offers. It's also great opportunity to inform them about what resources they have and how much support exists that they can lean into. Jennifer has written out an example letter for what you can send to professors. We let them know that we can send letters to professors saying this is medically necessary. A lot of this stuff is so new young adults. It's important to have the space to sit down and answer these questions and provide information about the resources that they have.

>> JENNIFER: We really develop this document after having time where we would talk about this at orientation. Again, going back to addressing at the developmental age, sometimes we need to spell out what would be helpful to say? Encouraging them to have self-advocacy skills as well. We will talk about this later, COVID-19 has been interesting. I have found in many ways professors on campus have been very accommodating. We have had a lot more accommodation with folks doing partial and IOP during things being remote and asynchronous which has been interesting. We give this to students to encourage them to consider. It does include financial resources as well. Those are financial resources that are internal to the OSU Wexner Medical Center in the hospital tribal system program. We talk about payment plans. This goes along with the departmental navigation of healthcare. Literacy is really important. I'm sure we will talk later this afternoon but there has been grant money from time to time that students are eligible for that have really benefited student seeking high level of care in this situation. This is an example of some of the resources.

The only other thing I wanted to say about the slide is if students have parents or family members that are involved in supportive of their involvement in treatment, I encourage them to share this document as well with parents. This is looking at the number of total attendances at orientation over the years. You see an increase steadily and upward trajectory of referrals over time. I think this can be attributed to a lot of things. I think staff at CCS have become more comfortable and familiar with the program and knowing and understanding and communicating the benefits to students. I don't know especially this year if maybe some increase has been feeling more accessible or more of an option because we have been virtual this year as well.

It may be reflective of some COVID-19 mental health increases we might be seeing. That is our total number of attendances at orientation. The next slide is the average attendance at the orientation. We have about 70% attendance rate at these appointments. We had more referrals than the slide indicates total. This is the attendance. You see over time as they get more information, what we have noticed is commitment to care tends to increase. If they get to orientation and part of that 69%, I think the last two years we have been between 80 and 85% of students that attend orientation and then go on to schedule assessments. They take the next steps. Which I think is really fantastic. Where are the referrals coming from internally? If you think back to that triangle in the different levels of care moving up and down, we have had fair number of students referred who were already established with ongoing services. You would be thinking about referrals coming from psychiatry appointments, referrals from ongoing appointments. They are already established with therapist or psychiatrist at CCS. At the client in collaboration and what treatment providers decide they need more and they have been referred. The care manager appointments are folks entering the system presenting with either chronic or acute concerns that we are assessing of needing higher level of care treatment from that appointment.

These are demographics of the folks referred to partial and IOP. You see the breakdown in terms of gender, but also race as well. We have fantastic representation of having commitment to diverse students, getting care and getting linked to what they need and diverse involvement. That has been really helpful and important. Referrals have become more diverse. We have had great conversation in orientation and within the team ensuring we are addressing issues of diversity, concerns that are coming up in terms of racial violence. We have worked as a team to ensure that the space where it's being addressed.

This is demographics and because is 18 to 24, sometimes 25 and 26, we see the graduate portion of the pie be smaller. That does not mean there are not more OSU student doing other partial or IOP. They may be trapped to the general program. You see for the last year, juniors and seniors being bigger portion of who we serve. I don't have thoughts specifically on why this would be or if COVID impacted this in terms of it being transitional from typical OSU experience to being remote and more isolated and disconnected things like that I kick it over to Bailey to talk about Harding outcomes.

>> BAILEY: I was lucky enough to stumble over this. We have all of our data from all the patients that have done our program. I wanted to look at the data because I really wanted to advocate for more in little programming. You will see this first one and 2020 gets shifty but we have 18 to 24-year-old in general from 2016 to 2020 has gone up significantly. The yellow is IOP including PHP. You will see that is also significantly risen. This is the general adult PHP in orange. The great is the evening IOP. You will see the young adults in the groups have slowly declined because of the space they take up in the little programming. This is specifically 18 to 24-year-olds that I did the data. Over here is total programming. Despite COVID we have increased the amount of people we have had in programming. Through 2019, you can see in the orange PHP, we do not lose any patients. Even though we did lose young adults the program remains stable which means there are adults and (Indiscernible). We didn't lose any in this program despite losing young adults. We just use the space with general adults that needed the programming. Here you see the groups keep growing. You will see the drop off here and we think that is COVID-19 related. During 2020 people were like we will rate waited out and little did we know that waiting it out would have been one year. I don't know if there are other thoughts?

>> ARIANNA: That is a good hypothesis and I'm not sure how to test it out but we did get quite a few referrals early on that when they learned we were operating in the telehealth format, they were like maybe I will wait. I prefer in person care. They opted to hold the referral until we were to come back in person. Little did we know more than one year later we would be continuing to operate in the telehealth format and have seen benefits to doing so which we will talk about as well. What I think is really compelling about this data that you compiled is looking at how creating specific treatment tracks for this population really did open up access not just for those young adults to feel comfortable to engage in treatment, but also open up access for people in the general adult population that also need this level of care but their spot was occupied by young adults previously. Now they have their own program and we have more space in the general to programs as well. It has been beneficial and lots of directions to create these pathways.

>> BAILEY: You probably saw earlier on the slides we kind of gained groups each year. If you build it, they will come. What we have learned is if you build it, they will come. All of these groups have filled up pretty immediately with the exception of the partial which we created during the pandemic. It's hard to say. We have maintained the caseload whereas the YIOP we created neatly filled up and it was at the brim for so long and that's why we created the evening because we couldn't keep up with the amount of people interested. Just like was said, the more space we create, not only do they take it, it allows space for people who have been on the waitlist for longer and young adult program, we have maximized it and it keeps coming.

>> ARIANNA: Need is there in one quick note to give context about why we are saying programs are full if there are people waiting. One of the things unique to partial hospital or intensive outpatient program is CMS put the centers for Medicare and Medicaid services put specific guidance on how many people can participate in one single group at each level of care. Just like when someone is waiting for beds in the hospital, there are only certain number of beds. The same restrictions are present for partial and IOP. For partial hospitalization program there can only be 10 participants per group. When we are talking out intensive outpatient programs, that number goes up to generous 12 without having to split into separate sections for the group. We really maximize without impacting quality or breaking CMS rules.

>> BAILEY: I wanted to shout out to leadership. They have worked hard to expand young adult programming and created transitional age floor to continue to support this neatly see. I just wanted to throw the shadow out there.

>> ARIANNA: We are back to me. This is probably my favorite slide because it talks about outcomes and we get to brag on ourselves. I am proud of the progress the patient's make in treatment in partial and intensive programs. What you see on this graph, these are outcomes. We administer tools called the basis 24 and it screens for symptoms. It's self-reporting survey that we give to every patient that comes to the program at the point of admission, treatment and discharge. We are trying to monitor progress and if we do our jobs well, we'll see symptoms decrease over time in our program. What you see on the graph is we are achieving that aim with our programs. Patients typically come to treatment and experiencing symptoms in this pink severe category.

Most patients experience moderate to severe symptoms across all of these different domains. We look at depression and functioning, interpersonal relationships. We look at self-harm, emotional liability, psychosis, substance use, and overall scores and aggregate of severity of symptoms. Patients are coming to the program in that severe category with most symptoms. You will see steady decrease over time from admission, at midpoint to discharge. What we really want to see his folks are in the mild to moderate category by the time they leave treatment. That is good indicator that outpatient treatment will be sufficient and right level of care for that person as their next step and I'm happy to report that is the outcome we see in our program.

The data looked at January through December 2020. We are looking at data during the midst of pandemic and in this format. I also looked at data that predates the pandemic when we were engaging in treatment in person. These outcomes are almost direct mirror. I'm really proud to report in spite of having to very quickly needing to pivot to new ways of offering care without a lot of leave time to plan, patients continue to get significantly better while in the program and able to transition back to outpatient care to continue to learn ways to manage symptoms and get support. I'm really happy this is where we are able to sit with outcomes. There is always room to look at where can we improve and can impact things more? But in general, where things sit with the severity of symptoms at discharge, that is in general where we want to see folks getting to self-harm indicate they are ready to transition back to outpatient.

>> JENNIFER: These are really impressive data. Thank you for sharing that. Shifting to the young adult program support team, this is another fantastic outcome. The collaboration has outcomes in terms of patient success and improvement and that's really important and valuable. Again, the work Harding has done has been fantastic. I think some of the support team work help keep students in treatment and going so they can experience some of these benefits. This was developed about one year or so into the young adult IOP existence.

One meeting I developed in order to have key stakeholders at the table every semester. Some or student advocacy, student health, myself, Morgan, clinicians from the intensive and partial programs. We meet every semester and it started off as what do you all do to really get better grasp on different roles that each office is playing and student success? Then talking about different barriers to treatment and academic success. Certainly, with coveted and remote the communication and relationships were so important within departments and roles changing processes. It's been really critical even before COVID-19 but such benefit that we have this established prior to something like this happening. We were able to share general trends that we were seeing in terms of IOP, mental health, enrollment, involvement, accessing different resources. One of the big outcomes I'm really proud of and I'm blanking because COVID status up one year. About two years ago we developed joint release of information with the blessing of legal student life and Wexner and shared the information that helps streamline communication.

Includes all of the offices on the young adult program support team. And little partial and IOP. Students can consent that we are able to share information to really help on the backend of things and coordinate resources or if I need to provide letters of support to disability services or Bailey needs to talk to Kim as student advocacy about grants, we are able to talk and communicate in surveying that student. There's problem-solving of individual cases. These updates about services during COVID has been really important.

I think the existence of having teams like this really helps cultivate understanding that mental health treatment is an invaluable part of the student's academic success plan. It's just as important for the student to have these academic supports try to maintain student identity as being an important part of mental health and well-being. Sometimes students do have to make difficult decisions about staying in or dropping out. If we can mitigate that to can be in their best interest and there are resources to have them drop some classes but still be participating in doing treatment, how can we work together to make those goals realized for the student at the same time and that has been really Certainly, important. I don't know if anyone wants to speak to the team at all from being at meetings?

>> ARIANNA: I think it's just really wonderful and refreshing to be part of team of individuals that really keep the best interest of students central. How can we serve them better and streamline operations as much as possible to make sure students get needs met? It's been wonderful to collaborate and work together in service of that mission. I just think everyone involved that has worked to build those relationships and maintain communication in both directions, kudos. This is the way it is supposed to work.

>> BAILEY: Just getting to meet everyone it has helped me understand as clinician it's hard to create mental space to think about students outside of your office. Meetings have kept me more centered and grounded what the student goes through outside the office and how I can be more in touch and guide them.

I think within one week she planned how to transition services to the online format. We didn't miss one day treatment or have any days that patients could not, or told anyone not to come. Was probably on Friday we were in person and the next Monday we were live. It's been amazing in ways we didn't expect and ways we did before. What something that surprised me is how many people were able to get this care because it was accessible. I Hyo doesn't have as much access to treatment and we have been able to reach those thoughts which is been really great. Thinking anecdotally, I had one patient who drove back to Cleveland on Friday and then they came to group that Monday continuing care and not have to disrupt them due to physical barriers. Other anecdotal things, I have noticed patients have been craving more socialization than they have been able to get in groups have found ways to do that. It is also reasons to get out of bed especially on breaks. I have noticed it's been really important. As Jennifer mentioned, there have been a lot of traumatic and painful things happening over the past year so having the space to talk about that Safeway's have been huge.

>> JENNIFER: A lot of folks on campus are probably aware and we have had some of these really challenging or traumatic difficult events, CCS will partner with the multicultural center on campus to have open dialogue and spaces. When it happens, because we have this relationship and communication, I will reach out to other clinicians and say let students know about this. There is this ongoing way we can support students who are in the program with resources still happening on campus around some of these really distressing and disturbing events, which has been really fantastic.

>> BAILEY: Greatly appreciate all the resources you are sending our way.

>> JENNIFER: And I get a lot of emails. And I think one thing that has happened a lot which is been really interesting and I'm glad we are having these conversations is students of color and underrepresented folks are coming to orientation and I'm sure you can speak to this, and coming into treatment and saying in talking about their identities and representation within the groups and with clinicians. I think it's been great that they have had that space that feels smaller and safer for all of that to connect and talk about those things. I don't know if anyone has anything else before he moved to questions?

>> ARIANNA: The only thing that I will mention as it relates to this pivot to telehealth, it has not all been roses and there are challenges that are inherent in operating and intensive group therapy program in the telehealth format. Some of the questions I get on regular basis and maybe these are some coming up in the Q&A is are we planning to continue to operate in the telehealth format once COVID-19 crisis abates? The short answer is I don't know. Some of this decision-making will hinge on legislation at the federal level about what is going to be allowable in a post-pandemic world. Prior to COVID-19 there were strict rules in place about physically where partial hospital and intensive services could be located and how they had to operate. We just don't know yet how or if those rules change in the post COVID world.

There certainly are tremendous and if it's for subset of patients to access care. As Bailey mention, for students that may not be located centrally on campus but this is home base. There can be great benefits. For folks participating in more rural areas that don't have as many resources, being able to offer these services have been wonderful benefit. I just don't know what the future holds in terms of telehealth for this level of programming. Stay tuned but no we are doing the best we can to be thoughtful on planning for contingencies. If we can continue to operate in the telehealth format, under what conditions will be best practice to do so? If we have the ability to maintain the telehealth program, we may do that, but we will develop set of criteria that under these conditions it makes sense for this person to participate in the virtual program versus the in-person program. I just wanted to throw that out there in case folks were curious about the future.

>> JENNIFER: I think we can turn it over to Morgan for questions.

Thank you for that presentation. I know I sit on the team and definitely have learned new things today. The first question and feel free to put your question department but the first comes from and Wilson. This was on the presentation on levels of care with the triangle. How do you measure it's very and what criteria to be used to assess what level of care is needed?

>> JENNIFER: Hopefully Arianna's piece spoke to that but generally we are looking at things like functioning. Especially for students, are you able to go to class and getting work done? For some students who go to partial, I have students say I have not opened my email and 30 days and have not been to class at all this semester. Versus some folks in IOP are saying and procrastinated more don't feel as motivated. The quality is not as good but I'm still managing. We are also looking at things like how chronic symptoms are. Has this been something you have struggled with for a long time? We need to think about dosing of treatment we give them. We may need to hit that hard to try to break up how significant those symptoms have been impacting the person for a long time. We are looking at things like safety. If the person is able to establish safety on their own on daily basis? Do they have other supports? Those are other things we consider and I hope that helps.

Shannon says students this may be insert later on in the day as well, but students learning to be honest and vulnerable can be good but wondering to what extent do you as clinicians or does the IOP group where other people can feel unsafe? She is thinking about the influence of social media and importance of projecting image of idealized life being vulnerable to others who are not in the same place or have not learned the skills can be nerve-racking. Is there tension to this?

>> BAILEY: Moving to some adult groups, and I think we doubled and divided it up into more groups. We have groups unhealthy relationship, trust and boundaries. We have groups on stigma and authenticity and disclosure. We talk about this in process group too. Absolutely, we are approaching this in talking about what vulnerability means and does not mean. We talk about how Laurel been judgment vulnerability (Indiscernible) and you see how they react and decide if you should tell them more. Great question and absolutely, I think it will be addressed more this afternoon. We have worked hard to develop specific curriculum that talks more about what healthy relationships look like and how to build them.

Barbara as thinking about the presentation from Dr. Eshelman, any scholarships for students that attend PHP education? Does the assurance program cover (Indiscernible)?

>> ARIANNA: Great question and Jennifer can speak more of what's available through student advocacy, but one of the things we really emphasize with all patients is the financial element. We try to give open feedback about what somebody can expect to pay out-of-pocket based on whatever their insurance coverages. If somebody's having hard time being able to afford whatever that out-of-pocket cost is, we will give them referrals to our financial service department here at the hospital to see if they qualify for hospital-based financial support to attend treatment. There are some hospital programs that will help pay somebody's co-pay if they fall within financial demographics. On the hospital side, we do what we can to make sure patients understand what the options are in terms of accessing financial support for this level of care. On the University side, Jennifer's work and stuff as well.

>> JENNIFER: I would just say it's a great question and we talked a lot at orientation about there being lots of different resources. Some insurances have a lot of coverage and folks find out at the time of assessment sometimes they are surprised like I don't have to pay anything. There are ranges. Sometimes there is higher level in between. I would say myself, Morgan and other care managers, Sean, Mandy, and other folks, we work hard to sometimes just sit and look at the resources like let's fill out this application for the hospital charitable system program together. That's one resource. Connectivity student advocacy centers to see if you qualify for these grant funding. Again, it's little tease coming this afternoon, Kim will be talking out the cares act money and other grant money available. I know we have been able to get great number of students to participate in treatment based on all of those resources which is great. In my world I would love to have scholarships but I think that is something we can look at in the future.

My last question comes from Lindsay who asks can you share how attendance requirements for -- sorry. Since showing up can be barriers for students from suffering from depression and anxiety?

>> ARIANNA: Went you give it a go and I will supplement.

>> BAILEY: Great question and something I think is one reason we have the attendance policy. They can miss three sessions. On the first we have conversations around what does your nighttime routine look like? When are you going to bed? Are you eating food? In my program, the partial program, the attendance is help regulate their body and help them get out of bed and stay out of bed and interact. It does take intentionality on problem solving in helping make intentional decisions to regulate their body. I guess that would be response.

>> ARIANNA: The reason that we have the attendance restrictions that we have or the attendance policy that we have is really to encourage students and patients to have access to the correct dose of treatment. If someone is only coming sometimes, it is equivalent to only taking half a dose of medication. We want to make sure but we offer will be effective. You can only have that effective treatment outcome if you are showing up to treatment.

That is the inspiration behind the attendance policy. It's also disruptive to the group dynamic if the patient is only coming every once in a while, dropping in. It's difficult for groups to gain cohesion if they are only coming sometimes. We want to balance and yes, of course life gets in the way you wake up and you are sick or have this prior appointment and it's hard to change. You have this exam does hard to change. We try to make flexibility inherent in the program. You can miss up to three sessions without it impacting care. Any more than that, there will be diminishing return. We don't want you to go through 4 to 6 weeks of treatment and still not be feeling any better because you only attended half the sessions. Yes, we acknowledge your symptoms are making it difficult for you to be consistent or get out of bed, or attend, and because it is hard doesn't mean that you cannot do it. Part of what we are doing is challenging that I can't statement. It's difficult, so let's plan. It's difficult to what support do you need? Helping people gain agency over their own decision-making even when symptoms are present. That's really the inspiration behind setting the standards. It's not to be overly restrictive. It's really helping people address symptoms most effectively.

>> JENNIFER: It becomes more information in more chance for intervention. I think we are at time. I appreciate everyone's time, patience and flexibility. We are heading into lunch and will me back at 1 PM. We have given you a lot to chew on. Pardon the pun. We will see back at 1 PM where we will dive into more of the micro intervention used to facilitate these fantastic outcomes that we have in the program. Thank you so much and hope you enjoy your lunch.

>> ARIANNA: Goodbye, everybody.

(Event is on lunch break and will reconvene at 1 PM Est. Captioner is on stand by)

(Captioner's Transitioning)

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>> JENNIFER:† All right.† Well, I am aware of the time.† I hope everyone had a good lunch.† Maybe enjoyed the sunshine outside.† I appreciate you all coming back.† Our next presenters will shift us a bit more to some of the micro practice specific interventions that are used in the young adult program.† Please join me in welcoming Claire Sutter, Lauren House, and Nate Gelinas from the young adult partial and IOP programs to share with us their presentation this afternoon.† Lauren, you can start sharing your screen.† Thank you.†

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>> LAUREN HOUSE:† Thanks, Jennifer.† Let me go ahead and share my screen and go ahead and get started.†

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>> CLAIRE SUTTER:† Lauren and I are set up on how we teach.† We're both vaccinated.† We are going to talk about treatment modalities, what we use here.† You are going to get a little education.† Kind of the way we teach our group and group therapy.†

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>> LAUREN HOUSE:† The example I like to give when I give†-- I have to give credit to Jennifer for this one.† During our orientations, the way Jennifer phrases what are†-- what are treatment interventions look like as a program?† She phrases it as tapas.† You get a bit of everything and choose what you like.† I like that example because we do teach a lot of different skills in this program.† It is really because of just that.† Not every skill is going to work for every person.† People are going to see I think these certain skills and interventions and tools work for me but not so much of the other ones.† We do throw a lot to our patients but do a good job of educating them.†

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>> CLAIRE SUTTER:† I like to call it the poo poo platter.† Jennifer mixed and that said tapa.† It's a tapa therapy treatment.†

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>> LAUREN HOUSE:† Goals for today.† We're tying to do a modality and treatment and interventions.† All of the concepts we introduce in the young adult IOP and PHP.† A couple of people went over that earlier.† Arianna described at.† Objectives for today.† Discussing the initiative for treatment specific to young adult populations.† We do have a lot of specific things that we teach young adults.† Only that demographic.† Distinguishing between group therapy and individual therapy as well as components of group therapy.† Why do we do group therapy?† Why is that helpful?† Understanding the treatment modalities used in the programming.† We're going to give you a little dose of some of the therapy practices we use.† Understanding who would benefit from treatment.† Understand working with barriers of treatment.† I'm going to cover a slide later talking about the various barriers that a lot of the students come to our program with.† Lastly, Nate is going to review a hypothetical study to showcase how we use our intervention and apply them in real time.†

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>> CLAIRE SUTTER:† Why group therapy?† A lot of research out there that compares group therapy to individual therapy.† A lot of benefit from doing group.† Here's a 2003 study of experimental and quasi experimental studies.† 72% of untreated controls.† Improvement with related to group compositions.† Type of group.† The setting or the environment set up in.

Certainly, we are in a virtual setting now and the diagnosis.† You know, it is really case by basis who would benefit most.† Some of the things we notice as clinicians working in group therapy is one-on-one with individuals, I think, can be very helpful.† Your role as a clinician in offering individual therapy is really to help connect dots.† We have that aspect here in group therapy.† The added component is you have peers that can relate to you.† There's something that is so powerful in†-- when we watch peers relate to each other that can really help with the healing process more than anything as clinicians can offer.† That's something we notice.† Hey, I'm struggling with this.† Someone can raise their hand.† They say, yeah, me, too.† That is going to be so healing for the patients we work with.† Also, just in general, an effective group program such as ours is gonna be able to serve a lot more people in a shorter timeframe without sacrificing the quality of care.† That's kind of the tapas we are talking about.

We are offering so many skills in such a short amount of time.† It's like getting a year of treatment in four weeks or 3†weeks.†

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>> LAUREN HOUSE:† Yeah.† I do think that we get a little bit of hesitation sometimes from patients from students about group therapy.† And not to say we try to sell it to them, but we really tell them give it a chance.† If you're in it for a week or two and you really think that it's just not for you, we'll talk about that then.† But give it a chance.† Very quickly on they start to realize the benefits of group therapy.† Especially with that age group where they're able to identify with each other, relate to each other, and just how exactly how healing that can be.† So we're gonna jump into some of the different†-- some of the different treatment modalities we use.† We're going to start by talking about CBT or cognitive behavioral therapy.

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>> CLAIRE SUTTER:† CBT, short for cognitive behavioral therapy, this is our bread and butter here.† If any of you out there are familiar with this, this has been around for a long time.† I think developed in the 60s.† Really is treatment goal, I guess.† Outpatient therapist use this as well.† This is effective for treating depression, anxiety, OCD, PTSD, lots of health disorders, and health diagnosis.† The kind of ideas we all have our views of the world.† Those views might not always be accurate.† Something cognitive behavioral therapy tends to do is challenge those views to improve overall mood.† We'll talk a little bit about what that looks like.† Certainly, in the case studies.† Another thing I want to say is we get a lot of the patients that come in and have already had this idea, this concept of my outpatient therapist tells me all the time to challenge my thoughts.† I don't get it because I don't feel better.

Here in therapy in our program we really go in depth of why this is helpful sand expectations that, yeah, you're not gonna feel better in the moment.† What we know is your brain changes over time.† That's how this therapy works is by over time.† By challenging your thoughts, you can improve overall mood.† Let's get CBT explanation.† What does it even look like?† CBT separates our symptoms.† As a society and a lot of our patients come in, they're like I feel like the world is ending or never going to move out of my parents' home or whatever it is.† It impacts their symptoms having these extreme catastrophic thought.† We don't think about what our symptoms look like.† CBT separates our symptoms in four different areas.†

Thoughts or cognitions.† These are your all the time thinking like it's a lovely day outside.† I'm never going to graduate.† These are thoughts that can be helpful and sometimes not helpful.† We have physical sensations.† These are how we feel that come with our body.† We can't have direct control over them.† That might be a headache.† I can't turn off and on a headache.† I'd have to take an ibuprofen.† Nausea.† If it's a heart attack, I feel my heart racing.† Behaviors is what we do or don't do when we're experiencing symptoms.† We say that they are a choice.† A lot of our behaviors with our symptoms can be either impulsive.† So it's like I'm really stressed.† I'm going to grab a donut which I did.† I'm really depressed so I'm going to isolate and stay in bed all day.† What we teach here is you have a choice and move towards positive behaviors.† A lot of what patients struggle with is emotions.†

Emotions is just the energy that kind of comes with our body, and they're never right or wrong and always valid.† Patients really struggle with this concept.† I think us as humans really struggle with this concept.† Your emotions, if you say something like I feel like the world is ending especially with this pandemic, that is actually a thought.† How do you feel when you think the world is ending?† Probably pretty anxious.† That emotion is valid if you truly believe that the world is ending.† Your emotions are trying to work for you.† We teach that they are survival mechanisms for us.† Even when they're unpleasant.† They are just trying to alert us to something.† That tends to really resonate with a lot of patients because they haven't had that kind of information before.† Maybe you guys out there haven't had that information before.† We spend a lot of time on this model in talking about it.† The last part of this model is all the arrows are drawn.† That just means everything is connected, and everything impacts something else.† Doesn't matter where you start.

If I have a headache, I'm probably gonna feel irritated.† The behavior I might engage in is going to drab ibuprofen.† The thought I might have with that is thank goodness that headache is gone.† If I start with a behavior of isolating all day, I might start to feel more depressed.† I might notice in my body that I feel, you know, maybe I have a heart racing, or I might develop a headache from isolating all day.† Thoughts I might have is like, you know, I can't do anything, or I'm too tired to do anything.† So then what we say as we draw all these arrows, they all connect to each other and draw this nice dotted line down here.† One side, we have more control over.† That's our thoughts.† I might not have control over the first thought that pops into my head.† We have a lot of weird thoughts.† We're humans.† I do have more control over where that thought takes me.† If I decide to engage with that thought, I decide to catastrophized.† Behaviors I have more control over.

Even if my body is telling me let's say all day, I'll have more intentional.† Maybe get outside for 15†minutes.† We're doing all this because it's going to impact your physical sensations and emotions.† On the other side, physical sensations and emotion, we accept them.† We accept them and not judge them and validate them.† So that was just a short hand version.† We go in depth with that with our patients for about 90†minutes.† Our group is that long.† We go in depth with that.† Another part of CBT is kind of teaching what we call the ABC theory.† Meaning we're gonna have a trigger.† We're going to have a thought about that trigger.† Depending on what that thought is, if it's more accurate or inaccurate, we're gonna have maybe our emotions and our physical sensations and behaviors are gonna be impacted.†

We talked about beliefs and the consequences of those beliefs and the results of those beliefs.† We also don't subscribe here†-- as far as changing our thoughts to improve mood, we are not trying to change them to be positive.† We don't really subscribe to positive†-- positive therapy or positive thinking because positive thinking might not always be accurate to reality either.† Certainly, positive thinking can be helpful for a lot of people.† I don't want to discredit that.† For some of the patients that come in and say, well, my parents tell me just be happy, or I just have to just do it.† That's not gonna be helpful.† So we kind of think more of in terms of what's more accurate to this situation?† Yes, you have a test on Friday.† Are you going to fail?† We don't know.† With some evidence that you might fail?† What's the evidence you haven't failed or not going to fail?†

Really, we go in depth.† That's kind of the last bullet point talks about the thought record.† It's how we challenge thought.† We really look for what's the evidence for this thought that you have that's maybe supporting it?† Oh, well, I failed every other test that I tested.† Okay.† Well, might be accurate that you're going to fail the test.† Typically, that's not true.† Then we look for evidence that maybe doesn't support that thought.† We try to come up with more balanced thinking.† Balanced thinking is what's going to impact and improve our mood.†

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>> LAUREN HOUSE:† The next thing we're gonna jump into and I'm going to cover is dialect Cal behavior therapy or DBT.† CBT focuses more on the thought side of things, challenging those thoughts.† DBT takes it into the direction of emotions including the behavior.† Primarily focuses on emotion regulation.† How can I manage a lot of those painful and difficult emotions so they don't start to negatively affect my relationships?† My job?† My educational functioning in school?† It was originally developed to treat borderline personality disorder and successful to treat a lot of different things like depression and anxiety, chronic suicidal ideation, PTSD, substance disorder, and other addictive disorders like eating disorders and those kinds of things.† When we talk about dialectics, what does word mean?† Dialectic is the end.

Dialectic looks at and.† It helps us to see there's more than one way to see a situation and solve a problem.† Like a middle ground.† The gray area.† One of the examples we hear this a lot is I can make a mistake and still be a good person.† I can have faults and still be lovable.† I can help others and help myself at the same time.† A lot of our patients get trapped in what we call all or nothing thinking or polarize thinking.† This helps combat that so we can look at that middle ground, that gray area and actually allows for some healing.† So with DBT, there are four skill sets.† Mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness.† I wish I had time to go through all of these.† To give you a really quick overview of this.

Mindfulness, practice of bringing your awareness to the present moment without judgment.† Mindfulness really incorporates things like grounding techniques to help patients who are struggling with anxiety.† Maybe they're spiraling.† We use that term thought spiral or mood spiral when they start here and circle, circle down and find themselves to get to a low place.† Mindfulness can help with that.† I'll give a couple of examples on the next slide.† Distress tolerance.† Skills to help manage intense emotions and endure stressful I vents.† When you're emotions are so intense that you aren't thinking clearly, you are maybe active impulsively, you feel you're in a crisis because of these intense, intense emotions.† Distress tolerance is a skill we use.† There's actually subset skills we introduce with distress tolerance.

Emotion regulation.† Again, skills to help recognize more clearly what you feel.† Then observe each emotion without getting overwhelmed by it.† How can I get in touch with my emotions so I can validate them so that I can try to evoke different behaviors and evoke different moods?† Lastly, interpersonal effectiveness.† This deals with relationships.† Skills to help beliefs and means.† Set healthy limits.† The art of setting healthy boundaries with people whether that's setting boundaries with someone in your relationship or setting a boundary with yourself.† Trying to protect your relationships, treating people with respect, and those kinds of things.† Typically, with DBT, again, this was formulated for borderline personality disorder.† One of the symptoms is this lack of interpersonal effectiveness.

Having rocky relationships.† These skills are really targeted towards that.† Then just some of the subset that I was talking about.† Some of the subset skills in DBT.† Mindfulness techniques.† There's a couple different ones.† The 5, 4, 3, 2, 1 exercise using all five of your senses.† What are five things you see?† What are four things you hear and so on.† This is a good grounded techniques when feeling painful emotions.† Paced breathing, progressive muscle relaxation.† This is where you tense muscle and release them.† Mindful eating is another example.† Opposite action.† We also call this opposite emotion action.† This is when you act in a way opposite of your mood or emotions might want you to do in order to discourage them from flourishing.† Some of the examples I give, when struggling with depression, one of the symptoms is social isolation.† I might start to withdraw this people especially my loved ones, my support system.†

Opposite action might be I'm gonna make plans with one of my friends.† Try to do the opposite of what I'm feeling to hopefully evoke better mood.† Another skill is healthy distraction.† Deliberately turning your mind away from a crisis until a healthy solution can be reached.† Healthy distraction is simply put distracting yourself.† It's very different from avoidance.† Avoidance is ignoring a problem.† Healthy distraction is saying, I'm going to focus on something else until a solution can be met or until a time can be reserved for me to focus on this issue.† Lastly, radical acceptance.† We're talking about unconditional total complete 100% acceptance of something.† This is like the acceptance things you cannot change.† If there's something going on in your life that truly you have no control over but it's triggering a lot of symptoms and triggering a lot of painful emotions for you, this is when you just can't change something.

Radical acceptance does not mean approval.† It just means I'm accepting this for what it is and continue on with my life and focus on the things I can't control.† In a nutshell, that's what these things are.†

†

>> CLAIRE SUTTER:† Then a third one is schema therapy.† We're going through this so fast.† It's like we're giving you guys all this information.† I understand it can be really overwhelming.† If you guys are overwhelmed, God, this is so much.† Think about what our patients go through.† They get a lot of information.† I wish we had time to delve into all of it.† Third modality is schema therapy.† Similar to CBT.† We are looking at your beliefs and ways that we can maybe challenge those beliefs.† It goes a little bit more in depth than that.† It's a way to kind of categorize your symptoms.† If I have five patients and all have depression, their depression is probably coming from different places.† Schema therapy helps you to identify the schema from which your symptoms are arising.

Schema is a persistent pattern of beliefs developed during childhood or adolescences and continues on through the life.† If you want an example, good example is the self-sacrifice schema.† If you grew up in a family where you had to take care of everyone else, you might develop a self-sacrifice schema which means you bring this belief with you to adulthood or young adulthood.† It's like I have to take care of everyone else and not my own needs which is going to give rise to an unhealthy symptoms or unpleasant symptoms.

†

>> LAUREN HOUSE:† One of the fun examples I'll like to share†-- Nate, you'll hear from in a little bit.† I think we might be the one.† He's the one who thought of this metaphor analogy.† Think about if you're holding a lemon.† You hold a lemon in front of you.† You put on blue tinted glasses.† What does the lemon look like?† Looks like a lime; right?† We look at schemas as, again, the glasses you see the world through.† If I put these glasses on, these are my experiences, core beliefs, things that happen to me, I'm going to have a distorted perception of reality.† Not necessarily saying I'm not based in reality.† Just my perception is different than the person next to me.

Claire and I are going to look at a situation differently because of how we were raised, our experience in life, our thoughts.† All those things.† Our perception tends to be distorted based on that.†

†

>> CLAIRE SUTTER:† That was an amazing analogy.† I'm going to steal that for my patients.†

†

>> LAUREN HOUSE:† All credit to Nate.

†

>> CLAIRE SUTTER:† I'm going to take credit for it so sorry.† I'm just kidding.† Another thing about schemas.† Everybody has them.† Not just people with a diagnosis have them.† I think that's important to emphasize.† I think a lot of our patients come in here and are like, I have this diagnosis.† Somehow, I'm different.† Really, a lot of these things that we talk about are all human.† We all come†-- we all have growing up some emotional needs that weren't met.† Whether or not your parents were the greatest parents in the world, sometimes, we have experiences that impact us and really color the way we see the world.† That's not good or bad.† It's just the glasses we wear.† Our job is to bring light to those glasses to move towards more healthy behaviors or what's gonna be the healthiest for us.†

And then how we work with schema therapy and schema interventions.† First of all, identifying what your schema is.† There's 18 schemas.† I wish we had time to go through all of them.† We do no.† First step is identify it.† Figure out where it came from and notice when it's happening.† For someone, again, with a self-sacrifice schema, they might see their friends struggling.† They may feel the need to help them.† Certainly, nothing wrong with helping your friend.† If it's coming at the expense of your own energy and maybe you didn't get to feed yourself that day or didn't get to study because you're constantly taking care of this friend, that's where maybe we need to start to learn to set boundaries.† One of the ways we kind of help facilitate engaging in more healthy behaviors is through a good parent letter.

It's the ideas like we're going to change the way we talk to ourselves or parent ourselves.† Basically, the concept is we have a lot of negative chatter going on.† How can I change that into a more compassionate talk?† Good parent letter kind of takes the idea of maybe you didn't learn everything growing up that you needed to or met.† Again, doesn't have to be from your parents or not.† How can I change those ideas through compassion?† We talk about, if you're being really hard on yourself because you're vulnerable and nervous about something, how can you be compassionate to that?† It makes sense why you want to take care of your friend.† You grew up in a household where you took care of your siblings.† Makes sense.

Also talks about setting limits.† If you're capable of taking care of yourself for this moment or spend time with your friend later, but let's also attend to your needs.† Again, we're not shaming ourselves.† We're moving towards self-compassion which is a huge component of treatment.† Then we also have a class†-- one of our core concepts that we teach is change theory which is just like how do I actually change?† We come into this program†-- patients come into this program I want things to be different.† We also need to understand how we change and our expectations for change.† So we use what's called change theory.† And the idea†-- there's a nice equation up there.† What that stands for is, if the pain of change is greater than the pain of staying the same, that†-- then you're not going to change.† There should be a slash there.†

There should be a slash instead of the equal sign.† The pain of your change, the pain of changes your ways and habits is greater than staying in those habits, then we're not going to change.† As soon as the pain of change is less than the pain of staying the same, we're going to change.† We're going to make some changes.† A lot of our patients come to this program because of that.† Because no longer what they're doing is working for them.† So they're ready to change.† Then we just talk about the cycle of change and†-- so there are stages of change that we go through.† We don't just make that change.† We talk about precontemplation which is I don't know what needs to be change in my life and have no intention of changing my behavior.

Contemplation is like I'm aware of the problem but I don't know if I want to change.† I have to weigh the pros and cons.† Preparation is I'm aware of the change.† What do I need to gather myself in order to make the change?† Action, you are changing.† You are doing.† Maintenance, you are maintaining that change and engaging in that habit.† Relapse is you're going to fall back into old patterns of behavior.† Then we draw this nice swirly thing in there.† What you can envision, your head is maybe a tornado spiralling up.† The idea is we're going to hit relapse when making a change especially if it's a hard change in our lives.† If it's I want to quit substance use, it's hard if I've been using substances for a long time to cope.† The idea is not†-- the idea is not to avoid relapse.† But, when and if it happens, it's not necessarily a step back.† You're not going right back to square one.† You're actually learning still about yourself and maybe it's like, oh, maybe I need to stay away from that trigger that I always go to.

Then you're moving back to the cycle of change.† Moves in an upward pattern.† Kind of the idea we're always moving forward.

†

>> LAUREN HOUSE:† Some of the other psychoeducation group or things we teach patients we're talking about communication and assertiveness.† That's going to become real handy in setting boundaries with others.† We do an entire group on radical acceptance.† Some I covered in DBT.† Healthy relationships and boundary setting.† I think this is crucial with the young adult population.† They're trying to gain independence.† They're forming relationships whether romantic, friendship, professional.† We teach them what is a healthy relationship look like and unhealthy?† How are some ways to set boundaries?† We talk about life balance and stress management.† Something that, unfortunately, young adults deal with constantly is all sorts of different stressors.

Decision-making. †What is a healthy decision?† Impulsivity?† Values?† Those kinds of things.† Anger management.† Talking about anger as a primary intense emotion and how we can manage that.† We've introduced a lot of different skills in the anxiety management group and talked about adequacy, self-compassion.† A lot of those things.†

†

>> CLAIRE SUTTER:† One last thing that kind of just say about the treatment that we do, I think a lot of people†-- especially if they're not familiar with therapy or what we do here, you might think therapists are just like we're going to validate you, and you're right.† Yeah, that professor was really mean, wasn't he?† We're not here to do that.† We are going to validate your emotions but also trying to move you towards how can you have a quality of life?† Sometimes, that means challenging you and taking accountability.† One thing we do talk about is how are you going to be accountable for yourself?† If I have a patient who is sleeping in because of their depressive symptoms which is completely understandable, I am also going to have expectations.

Three absences which is in your policies might mean that I'm gonna ask you to leave group until you're ready to challenge yourself to wake up and challenge yourself to get here on time.† We can†-- we are compassionate and flexible.† We are still holding people accountable for their behaviors.† Especially when it means it's going to lead them to a more fulfilling life.† Everyone with academics, you are struggling, yes.† And there are some expectations. †How can we meet those expectations?† How can we set those expectations in a kind way?† Avoidance or saying I'm constantly sleeping, that is a reality.† There are still expectations in life.† This's part of adulthood is taking accountability.† How are you going to change?† Setting boundaries especially with yourself and also setting boundaries and receiving boundaries.

Again, we have expectations here in group.† It's not that you can just come and show up whenever you want.† Expectation as you are here.† You are on camera.† If you are not, the†-- we are going to maybe mark an absence from you.† Again, we do this in a compassionate manner, but you have to be here to get treatment.† We're teaching our patients that there are expectations in the world.† You will have symptoms.† Let's find a way to manage our symptoms so we can meet those expectations.†

†

>> LAUREN HOUSE:† All right.† I'm going to try to go through harm reduction quickly.† I know we're running behind on time and give Nate on the case study.† The presentation that Jennifer, Arianna, and Bailey talked about, the first IOP young adult therapy group we started here was a substance group. .† Everyone dealing with the disorder and anxiety and the like.† Secondary is using it as a coping skill.† Most folks are using substances to cope with their symptoms.† I'm drinking because I feel socially anxious.† Or smoking weed to help my sleep.† I am not sleeping as much and not that much appetite so I'm using that to cope.†

Harm reduction is an intentional approach to substance use.† Different than the abstinence 12-step thing.† Why is this helpful?† Why do we do this in our program?† It gives the patients the opportunity to use the skills we teach them.† If you're smoking daily, why don't we cut back to 1 or 2†days a week?† When struggling the other days of the week, try to introduce the skills we're teaching you.† Leaves that window for opportunity for them to use the skills we're teaching them.† Often, substance use and other addictive behaviors are the number one coping skills.† When we go full abstinence, it takes away the coping skills and more likely to relapse.† Harm reduction can be beneficial for people but not everyone.† It's something we introduce that can be helpful for patients.† That's how we come from a frame of mind with the substance use piece.†

Lastly, I think†-- this is our last before turning it over to Nate.† Lastly, barriers of treatment.† Everybody in our program comes in with a couple different barriers to the program.† Sometimes none.† Couple different barriers we see a lot when folks are making the decision to do the program or not.† There's financial, academic, occupational.† The financial piece.† We collect benefits prior to a patient getting assessment.† We have an estimated out-of-pocket cost at the time of their assessment to be transparent.† Sometimes, it's pretty high for a lot of students.† We have a couple of different things we can introduce.† One, patient financial services through the medical center.† Then, if they are OSU student, there's an emergency financial assistance through student advocacy.† I know Kim Pachell will talk more about that a little bit.† Academic.† Again, they will talk about this on the panel later.† Student life services can provide for accommodations for classes.† If there's a time conflict for class, they can help with that.

OSU services can help with navigating the changes.† We're fortunately to be consistently collaborating with these departments with student life to help students.† Lastly, occupational.† Sometimes, folks are working full-time jobs.† They are really struggling.† We can provide letters to say, hey, they're in this program on these days and times.† Can you please medically excuse them?† Sometimes, we assist with FMLA paperwork.† We're helping them make the time and space in their life to do treatment.† We'll save questions for the very end.† Right now, we'll switch it over to Nate who is going to talk about hypothetical case study and how we apply all these interventions we've been talking at.†

†

>> NATE GELINAS:† Thanks, Lauren.† If you want to click, Lauren, it'll magically appear.† This case study is kind of a composite of different people through our group.† I'm going to call her Maya.† Typical though in the sense we're going to say she's coming through orientation through CCS.† Relationship problem with her boyfriend, difficulty functioning academically, and having a hard time talking to her parents on what is going on.† She doesn't want to worry them or disappointment then.† Particularly her mom.† All pretty typical.† She goes to the orientation and assessment.† She's put in this dual diagnosis group.† IOP for mood disorder and substance use because she's been helping cope with our symptoms.† That's developing with the problem.† Next slide.

Getting started.† Ambivalence comes up.† It comes up for Maya.† In orientation, it comes up again in the assessment.† Usually, you hear how big is the groups?† I don't like groups.† I would say I don't like groups either.† I don't know how I became a group leader.† We try to validate the anxiety and make space for it and encourage them to take a step.† What about my classes?† A lot of anxiety about that.† Like you've heard, we try to work with that to say there's probably options.† Let's give it a try and see what we can do.† The barriers that Lauren just talked about.† We might provide documentation.† We get started right away.† First couple days of treatment we do a treatment plan with them.† I want's a collaborative thing where they're really taking the lead and saying what do I want to work on in group?† That's important for me?† For Maya, it's emotional relation.† She has periods of numbness and falls apart and loses control of her emotions.† I'm starting to get a sense she minimizes her emotions. †She masks them and disassociates from them sometimes.† All of ways of coping.

You also get to get a little bit more concrete of relationships.† Even isolating.† She doesn't want to do that as much.† Chronically low self-esteem.† She would like to see that improve.† You get a sense of some of the stress of these recent relationship with her ex-boyfriend.† A lot of times people are coming in the group because stuff has been happening.† Your emotions are spiked because of the stressors.† I'd like to get a sense of that.† What are some of the things you're going to want to talk about that's important to you to process?† That's kind of on our radar.† Let's talk about this relationship.† She does want to cut back on the alcohol use.† With our group, it can be contemplation.† Might be a problem.† I'm ready to be sober.† We have a full spread that makes it challenging to have people in the group with different goals there.† We try to support and mobilize the group.

This is pretty typical where you just want to cut back.† Not ready to be sober but doesn't want to drink a lot.† She doesn't want to binge as much.† A lot of anxiety.† We don't process on the first day.† We wait on the second day and try to mobilize the group as much as possible to support her and let her know she's not the only one.† Okay to feel anxious.† She starts to kind of relax a little bit.† Usually, it's pretty amazing.† Usually, peers are just really supportive of each other.† You can go to the next slide.† She's going to gain insight.† We are going to want her to gain insight.† Usually happens through a mix of the curriculum.† We'll talk about a long list of thought distortion, list of schemas.† We explained what these distortions and schemas are.† You get a chance to say I do that.† That's me. †Sometimes, it's like alarming because how do you know I do that?†

You might also come out in process group where you might talk about your life.† We might start you're doing catastrophizing right now.† Or I can see this is your schema coming up.† I listed a few schemas here that this type of patient would have.† Abandonment.† Other people is going to leave me.† Emotion deprivation.† My emotional needs are never going to be met by other person.† Self-sacrifices.† Other's needs are more important than mine.† Those link together.† We are going to work to make her work with that.† Her beliefs about emotions are coming out quickly.† I don't want to†-- I'm not going to share my emotions because I don't want to burden others.† I need to be the strong one.† They are not important.† They are wrong.† She doesn't have that much trust in it.

Process group is not just theatrical.† It becomes a place where you get to test all this stuff out.† You say would you tell somebody else in the group that their emotions aren't important?† Why don't you just give it a try?† Stay with it.† Talk with us about this.† Let your emotions matter.† It's gaining insight.† Also getting some practice through being in this kind of group setting.† You can go to the next slide.† Next slide, Lauren.† Gaining skills.† Like Lauren and Claire was talking about.† A ton of skills these kids get thrown at them.† For Maya, most important are these three.† Assertiveness.† I think with the ex-boyfriend, with her mom.† It's going to come up where I need an assertiveness script and test out†-- can I communicate directly with this person in this situation?† The group encourages her through that process and challenges her to not avoid it but step into that.

The good parent letter that Claire was talking about is a super vulnerable exercise we push on people.† You write a letter to yourself being kind to yourself and feels awkward and weird and read it in front of the group.† Then what†-- amazingly, it's†-- people have†-- most of these kids have a good parent voice in them where they are able to be kind to themselves.† It just needs to be supported and practice it and get used to it.† That exercise usually ends up being pivotal for a lot of people.† For Maya†-- why did you drink?† Why did you smoke?† What was the purpose of it?† We can keep going.† I know we're running short on time.† Next slide.† These, especially, I'd say the first one.† If we can get a family session, it's really helpful.† In this case, we probably encourage Maya and her mom to come together in a three-way conversation where I would be facilitating or Lauren or Claire.

This three-way conversation where we're just trying to make it dialect Cal where they can listen to each other.† Usually, the parent needs to let go some of the control.† The kid†-- the young adult has to say I need to take more responsibility where they're trying to hear each other.† A chance to practice that assertiveness.† Almost always goes really well.† Academic fallout.† We have people hiding their laptops in their closets for weeks and weeks because they're avoiding the e-mail from their professors and hoping it goes away.† In this case, trying to push through that avoidance and reach out to advocacy and reach out to your professors.† If you need to file an incomplete, let's do that.† That may be is coming up.† Process group is the place where we're going to do a lot of this work.† Opposite action.† Get in the group.† Take up space in the group.

That's not a problem for everyone.† In this kind†-- with this kind of patient, she might need help to take up space.† If someone is overapologizing, they're always saying I'm sorry for everything, process group is important.† Stop it.† You're not doing anything wrong.† Mind reading.† Great to have a group where you can test out these things coming out of your head.† I feel like people don't like me.† We can say, group, what do you think?† Is that happening?† You get to challenge it and get a chance to stay presence.† I think I have another slide.†

Setbacks that come up for Maya.† Almost definitely is relapses.† She's going to have time where she slips on that goal.† Helpful to normalize and help her not to slip into shame.† Usually, the midpoint goes up and supported in the beginning and realize it's not a quick fix.† So you have a lower midpoint.† That's also a good lesson.† Progress is not linear.† Let's keep moving and get you to a better spot by the end.† Stuck point that come up where she gets stuck is like a carousel.† You get to see the same points come back around and see a pattern.† Last three on the next slide†-- the last few bullet points are just about discharge.† Trying to get aftercare set up for her.† Helping her leave the group make that transition back into her regular life without the group.† When we can, we haven't been doing virtually.† We usually offer refresher group once a month.† Anyone who's graduated from the programs can come back for support group and touch base with us on how things are going.†

I think that's all about the time we have.† I don't know if we have questions.†

†

>> JENNIFER:† Cool.† You guys did fantastic.† You can see why we have the data and outcomes and the positive feedback the students have given with all of these different tools.† I think, Lauren, Claire, and Nate, you did a great job of showing that ideally students are leaving with their own tool box.† They come in with their own unique concerns.† Through all the information shared, they come out with their own tool kit.† I think that that's what a lot of students feel that empowers them. †Right now, I'm mindful of the time.† We do have one question in the Q&A right now from Dr.†COPLEY.† Psychiatrist here at CCS.† Can we get a list of the schemas and the brief description?† My patients keep talking to me about them.† I want to support them which is great.†

†

>> LAUREN HOUSE:† That makes me feel so good that they're talking.† A lot of online resources.† We can send them to you, but there are some online.† If you schema therapy, a lot of online resources that can help with that and better explain.† With our slides and PowerPoints, a lot of us explaining thing.† Online resources would be more helpful.†

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>> JENNIFER:† Fantastic.† I can do it.† There you go.† Thank you, guys.† I don't have any other questions right now.† Obviously, if other folks have questions after today is over, feel free to e-mail me.† I can distribute questions or whatever.† I'm mindful of the time.† We are going to head to a short break.† Then we will be coming back at 2:00†o'clock joined by some fantastic folks from across campus to have a panel discussion about kind of these adjunctive ways we can help support students when entering this kind of treatment.†

†

[Break]

All right, everyone.† Welcome back from break.† I am so pleased to be joined from across campus as we will be moving into our panel discussion with folks from essential support across campus that interface with our students to help promote mental health as part of the academic success.† I'll be moderating our discussion.† I have a couple of questions that will lead our discussion.† As we are going through some of our questions, I'll be inviting our participants to answer and discuss.† If you have questions, please put that in the Q&A.† We will try and get to them in the end.† To kick us off, I will ask all of our panelist if they can provide an introduction of your unit or role at the university and how you interface with Ohio State students related to mental health concerns and treatment.†

†

>> ADAM CRAWFORD:† I can get started.†

†

>> JENNIFER:† Wonder, Adam.† Thank you.

†

>> ADAM CRAWFORD:† Hi.† Everyone.† My name is Adam Crawford.† I'm a student director with student life disability services.† How we intersect with this topic is we can help get students registered for our services.† Disability in higher education and context of communications is a broad term.† A lot of student don't realize they have a mental health condition like anxiety, PTSD, and anything of the things we are talking about today.† That qualifies for an disability and can get register for accommodation.† I can talk later on what that process looks like in detail.† We work one-on-one with students to figure out their disability or†-- create friction when it comes to their academic journey or time here at Ohio State and identify what accommodations we can set up to help eliminate that barrier.

Every student is different.† Mental health will manifest differently with different students.† Sometimes, it's†-- their mental health impacts their test taking or attendance in class.† We engage with them to figure out how we best can support them.†

†

>> KIMBERLY PACHELL:† I'm happy to go next.† My name is Kimberly Pachell.† I am the director of the student advocacy center here on campus.† Our office is committed to helping students navigate the complex structure that exist at Ohio State.† It can be academic issues, financial issues, mental health concerns, or other health concerns.† Anything that might impact their ability to progress towards their degree.† We work hard in helping them resolve the issues and empower them to overcome those obstacles and continue to move forward and with the end goal of earning their degree.† We really work hard and work very collaboratively with the number of the people on this call as well as numerous other offices to look for alternatives, help resolve issues that might arise.† Really creating that culture of care and bringing things full circle for the students to minimize the impact of hospitalization or enrollment in IOP might have for them.

We know it's a reality that most students will encounter a health issue or other kinds of crisis during a student.† We want that to have the most minimal impact.† We want to do our best to minimize the disruption of the academic by helping them and make contact with instructors, work out resolutions and exceptions that might be necessary for them to move forward.†

†

>> CAROLINE WAGNER: I'll say hi.† I'm Caroline Wagner.† I'm a faculty member at the public affairs.† I had the pleasure of serving at the task force of suicide and mental health.† I'll talk a little bit about that today.†

†

>> CAROLINE OMOLESKY:† My name is Caroline Omolesky.† I work at the international of office affairs.† On my team, we work with incoming international students.† We have sort of two teams.† One that focuses on immigration advising and one that focuses more on programming.† Really on both of those sides, we end up coming into contact with students who we realize may need some mental health treatment or services.† On the immigration side, often students will come to us needing to drop classes often because they're having some health issues or personal issues going on in their life.† So we help them navigate what their options are from an immigration standpoint whether or not they can remain in the U.S. legally and pursue that.† Very often, there's a referral to CCS as part of that process.† We're also contacted all the time by social workers who may be working with the students navigating their situation.

We work with students in leadership groups or events we offer†-- when we get to know students, we also just come across students who we realize need extra support and doing referrals that way.† International students definitely are a population that we are referring quite often to counseling and consultation service.†

†

>> SHEILA WESTENDORF:† I can go next if you'd like.† Hi, everyone.† I'm Sheila Westendorf from the medical director in student Wilce services.† As you can guess, we interact with students for many health concerns diagnosing and treating and referring to many of you.† Our leading diagnosis are mental health concerns, anxiety, and depression even though many people think it's other things like colds, etcetera.† We were really lucky to get an embedded case manager last year, Morgan Blumenfeld.† She works closely with our providers.† COVID struck right as she started our position at our center.† We're going to be working really after I get back from vacation here.† What we're going to start doing in the fall and normalizing everything.†

†

>> MORGAN BLUMENFELD:† That's a good segue into my introduction.† I'm Morgan Blumenfeld.† I'm the counseling consultation service embedded manager.† I interface with the students and referrals from the medical staff at Wilce student health services.†

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>> JENNIFER:† Thank you, all, for being here.† We have a lot of very different offices represented and kind of all the different kind of moving parts involved in this process in many ways.† Next I'm hoping folks†-- share and you feel comfortable.† Can share barriers from your perspective and your role in your unit that you have seen students experience in terms of accessing mental health treatment in particular higher levels of care.† Things like intensive outpatient or hospitalizations.† Things like that.†

†

>> CAROLINE WAGNER:† I can talk a little bit about faculty.† Faculty members are often have an opportunity to interface with students who are in distress.† Many times, faculty don't know the resources on campus that are available for students.† It's not something that we're given in a briefing or given a lot of information about.† So many times we'll see problems and not really know how to help.† Part of the role that the implementation team took on was finding a way to better inform faculty and offer greater opportunities for training.† One of the things I took away from the implementation team activities is that culture of care means that each person on campus should have someone that they can talk to who has been trained to listen.

So I learned that train to listen side of things also from the implementation team because I thought, well, I'm a compassionate person.† I'd be happy to listen to someone's troubles.† In fact, it's not just to listen to someone's troubles.† It's learning how to listen and not just listen how to listen but respond appropriately.† There are different trainings.† We've encouraged the faculty at our college, Glen College, to take the trainings and COGNITO training in order to learn how to listen to students who might be in distress.† We created small cards.† Business size cards to pass out to faculty and student services.† Then it's easy for a faculty member.† Sometimes, in a faculty situation where you're teaching or advising you meet a student that needs help.† How do you tell them how to find help?† Many times, students don't want a faculty member to take note of the problem.† The little cards gave us the opportunity to slip somebody a little card and say here are some resources you might want to think about without being too dramatic about it.†

Those were some of the things that we put in place to try to make faculty more comfortable with the culture of care concept and with the tools they might need to put it in practice.†

†

>> KIMBERLY PACHELL:† I'd be happy to talk really echoing about what Lauren and Claire were talking about.† The most common barriers that we see on our side are financial.† We†-- students don't have access to medication because they can't afford it or access to treatment because they can't afford the co-pays.† I know that there's been a long awaited talk about our mental health cares emergency funding which I can talk about a little bit later.† That is a topic that has come up over and over again for many, many years.† I think one of the other things that they eluded to was the academic concerns.† Students feeling like they might have to choose between receiving treatment or staying in school and not able to see that there can sometimes be a middle ground of working with instructors and being able to do that.

The flip side of that taking time away from school to focus on your mental health is critical.† That is a delicate and gentle balance we have in the discussions with students.† We don't want their academic performance to be compromised as a result of the mental health. †We do know what oftentimes they're coming to us class in four weeks or not able to focus and perform at the level they might otherwise been able to perform at.† So it's real important for us to all to work together to support them and almost to keep pushing in one direction.† That's where our support team has been really vital in us to being able to talk to one another and really help the student get to the best decision for their particular†-- their particular situation.†

I think one of the other things we see on the academic side is that navigating the academic†-- or the university processes can be cumbersome and overwhelming.† Students often delay taking care of things like dropping classes or submitting a petition.† That can have a lot of rippling effects for them whether it be their GPA suffers or financial impact.† Various things like that.† Again, us all being on the same page, us being able to support the students†-- student in ways that can help facilitate those things and move those along a little faster, knowing that we're there to hold their hand has been really critical.†

†

>> CAROLINE OMOLESKY:† I can talk a little bit about for international students.† I think there are definitely some barriers there.† When I say international students, I mean students who are entering the U.S. on a student visa type.† We have a little over 6,000 of them at Ohio State.† I think some of the biggest barriers we see are, first of all, understanding how the U.S. health care system works.† It's hard even I think for us as people who have grown up here.† It's very, very different.† A lot of our students are coming from and may not understand when do I go see my primary care physician if they have one?† When do I go to the emergency room?† What is covered on any insurance?† That kind of thing.† I think a lot of confusion there.

Also some immigration restrictions and requirements of students want to do things like take time off from school.† If a student needs to withdraw from classes because of mental health or other reasons that's going to have implications for their legal status in the country.† There's quite a lot of paperwork involved in getting approved for doing that withdrawal to allow them to actually stay in the U.S. while not taking classes.† That†-- if not a barrier, certainly a burden on the students.† I think we also see the stigma of seeking mental health treatment.† Definitely coming up with our population, a lot of students are not comfortable sharing with their families what's going on or aren't comfortable sharing with anyone what's going on.† We are told often by the counselors we work with CCF international students don't come to them until they're in crisis.

That is something we have tried to do a lot of outreach on.† Seek help while†-- when you need it before things get really bad.† Another thing that we hear from students is that they may not feel comfortable going to counseling in English.† They like to have someone who speaks their native language often.† Not always but that's helpful.† Aren't always a lot of options depending where the student is from.† I think that's another barrier we see.† Right now, with a lot of the students return to their home country during the COVID crisis, they don't have the option using the telehealth services.† That has been a direct barrier.† I think also just the fact†-- lastly, we're such a large university.† There are students who may be don't meet up with the right sort of trusted adult who can guide them to the right resources.

Just because there are so many students and aren't always enough staff to develop that close relationship with them, they may not happen to find someone who can guide them to the right place.† If they're not part of one of our leadership groups or don't get to know them personally in that way and don't feel comfortable coming to us.† I think being in such a huge school sometimes, unfortunately, can slip through the cracks.† Those are the things that I would highlight.†

†

>> ADAM CRAWFORD:† Yeah.† I think I would echo a lot of what has been said by my fellow panelists.† Maybe with that an added layer of thinking about disability and sort of receiving academic accommodations.† As I mentioned earlier, a lot of students don't realize they would qualify to get connected with disability services to receive that academic support related to needing a higher level of caring.† We really rely†-- we do our best to get the word out there.† We also really rely on the campus partners many of whom on the panel or listening right now to help educate students and refer students our way.† I think certainly stigma is a huge problem as well.† Of course, mental health itself has a†-- students can struggle with stigma there.† In my anecdotal experience, oftentimes, I'll interact with students somewhat comfortable and accept their status of being with someone with a mental health condition, but they don't have a disability.† They'll tell you.† They don't feel comfortable saying I'm disabled or a student with disability.† There's that sort of cognitive barrier of not wanting to associate with our office because of the internalized stigma of what it might mean if I say I have a disability?†

We try to help talk students through that.† What societal messages have maybe sort of seeped in as you grew up†-- what do you think it means to have a disability?† We help educate them how it's a natural aspect of human diversity and doesn't mean you're not a good student.† It doesn't mean you're not qualified to be here at Ohio State.† We try to dispel some of those myths.† Our campus partners are also really great at doing that as well.† I think also I see students who are concerned about confidentiality.† They may not bring things up with professors or may not get connected to our office.† They're afraid everyone is going to know exactly what is going on with me medically and my diagnoses and traumas.† Everything is going to be shared with everybody.† I think the more we can let students know about sort of the right to confidentiality.† For example, when connected to disability services and they're approved for accommodations and faculties are notified.

It's the students information to share if they want to.† We can also just say the student's in a treatment program.† A required treatment program.† This is what we need to do to help figure out if the student can stay in this class given ABC conflict or student needs extended time on tests.† You don't get to know the medical reason why.† We respect the confidentiality there.†

†

>> SHEILA WESTENDORF:† I can speak from a provider perspective if you'd like.† At student health, we're all trained at primary care.† We're not psychiatrist.† We have over the past years increasingly seen complex cases.† It has been difficult at times to, one, assess the true risk of the student; two, to get them the care that we think they need.† This would be more students with perhaps mood disorders, depression, and pushing us out of our comfort zone of treatment and having to bridge until we can get them to a psychiatrist or seen by a psychiatrist and/or counseling at times.† We've worked hard this past year now that we have Morgan with us.† We†-- I think we've made some gains in that respect.† I think we have ways to go and make sure our students get what they need sometimes.†

Of course, we also probably†-- we get asked to do paperwork a lot for disability services and other accommodations.† That doesn't†-- that typically isn't too problematic for us.†

†

>> MORGAN BLUMENFELD:† Really the only thing I would add to that is some barriers that I've seen recently have been one about insurance.† Is there going to be a record of kind of the mental health treatment that I'm getting especially if it's a higher level of care.† Does that now mean my parents know about my mental health concerns if they are going through their parent's insurance as well as the cost that can†-- we've been talking about throughout the day.† Some other things I think are myths that people or students on campus have about how long it takes to get connected to services and what different services mean about their mental stability and as a person as well?† What it means if I need a higher level of care?† Last thing from a low standpoint when we have people with mental health medical diagnosis, which are we prioritizing first, and can we meet the needs of both through a higher level of care?†

†

>> CAROLINE WAGNER:† Stopping the stigma or trying to address the stigma is something we discuss quite actively the implementation task force as well.† I know there are a number of campuses to address this stigma.† From a faculty standpoint, we have been able to normalize mental health and bring it up.† We have a statement on the syllabi first day of class address the fact you may have mental health concern during this semester and many ways you can seek help for that.† For me, as a faculty member, that's been a great help to have that syllabus statement now in the syllabi.† Also, it's opened up an opportunity for me to just talk about my own mental health experience and the access that I've had to services in the past.†

I felt that that was a good kind of beginning point for faculty.† Then in addition over this last year, just†-- I've done this myself.† That is beginning of each class I'd take a mental health moment with my students.† I do a little breathing exercise with them to center ourselves in the moment and just come to some kind of moments of calm as we get into learning.† I thought some of these different activities at the university level, at the task force level, and individually we can all address breaking the stigma around asking for help with mental health concerns.†

†

>> ADAM CRAWFORD:† I'd really like to echo what Dr.†Wagner just said.† In my experience, I know I talked a little bit about internal stigma.† Certainly, perceived or anticipating external stigma or discrimination can be a huge deterrent for seeking treatment or accommodations.† The more the faculty can do some of the things that Dr.†Wagner talked about like talk about their own experiences or naming or normalizing mental health in the classroom or normalizing being registered to disability services or inviting students to share.† Even some good literature out there that talks about how students with disabilities very rationally make sort of pro/con decisions.† Cost benefit decisions.† They analyze every class and every faculty member.

Is the benefit of accommodations going to be worth it to the potential sort of negative biases my professor might have against me?† They might treat me differently, etcetera, etcetera.† That might happen. †Students weigh that every time they're in class.† The more we can normalize it on a personal level is critical.†

†

>> JENNIFER:† I think on that point, too, it goes back to the idea that we have speaking to my naming there's a young adult, IOP, and PHP, hopefully take some stigma out of it as a lot of the clinicians have said.† Or I say to clients a lot, if you were the only OSU students who's ever been stabilized with a mental health concern, I would not have that job.† That's all I do.† Certainly, that doesn't take that†-- it's still challenging and still things to navigate that hopefully it takes some of the staying and anxiety of feeling alone and helpfulness in that experience.†

Sounds like we're all on the same page about a lot of the barriers and some of the specifics for each of our units.† I'm wondering if we can shift now to, you know, some successes; right?† If you all can share ways your unit has work with other offices on this panel or on campus or with OSU Harding, IOP, partial what have you to try problem solve and navigate some of these barriers.† I think about the most concrete thing I can come up with is we have this support team and this collaborative information now that really takes a lot of extra efforts and work to navigate some of our students that are working with us.† I'd like to open it up and hear examples from you all.†

†

>> CAROLINE WAGNER:† One of the things we did at the Glen College†-- actually, this started even before the president mental health task force got underway.† We had a tragedy with one of the students at Glen College.† We had a wellness committee.† What we did was take the wellness committee and expanded it to also include mental health.† Then we did a mental health survey of students just to ask them†-- anonymous survey to ask them about their own mental health and wellness.† That was an eye opener to us.† One of the things that came out of that survey was a feeling on a number of students parts they had also experienced discrimination.

We were surprised by that. †We didn't expect that.† That actually caused our mental health and wellness committee to expand our remit to include the sense of addressing the problem that some students may be feeling isolated from full student experience.† So we began to put together workshops and working groups of students and faculty and staff so that we could have students come and talk about any kinds of issues that they had and feelings that they weren't being heard perhaps or their concerns weren't getting full attention.† So that's been a great mover and shaker for us.† In addition, a graduate student group got organized to address these issues on their own.† They are now focusing a lot on inclusion and diversity issues.† Also, healing.† Racial healing issues as well.†

We found that it expanded from what we started off with.† It's expanded really out of kind of a bottom up issues that came from the students themselves and has been quite directed by them.† The administration at our college has been quite responsive to hearing from students and their experiences.†

†

>> CAROLINE OMOLESKY:† I think for us at OIA, when I think of a success, I think of when the communication was smooth and when the different offices involved all understand each other's processes and requirements and are able to support the student without sort of burdening the student too much with all the administrative processes that they have to go through.† I know†-- unfortunately, on the immigration side, there's just a lot that the student has to do and show in order to satisfy the government requirements.† The more that we can support the student in that process, especially if they are hospitalized, really tricky for them to running around campus obviously gathering all the signatures and documents they need.† I'm always grateful when working with a counselor or a social worker willing to take an extra minute for a student to get all the boxes checked for them.†

Also, when everything happens in a timely manner because often we are right up against a deadline of having to approve it before the end of a term or things like that.† I can think of a lot of situations where students just were really grateful there were people willing to take an extra moment to help them get all the paperwork done they needed.†

†

>> KIMBERLY PACHELL:† I would echo that as well, Caroline.† I know that we regularly work with the folks whether it be the hospital emergency department or Harding social workers or our police†-- OSU police, Columbus police, who might be called for a well check that wraparound care whether it be in the moment or as crisis continues for the student has been critical.† I think one of the great benefits we've been able to have especially as we've all come together as a group is that soft pass off for the student.† It's like I have a friend.† I have a friend in this office.† I can get you right to them.† Or you pick up the phone and say, hey, can I send them over?† I'd like to think that builds trust and confidence in the student as well to be able to know that they'll be well cared for once they get to that next stop.† If they have to move themselves around campus.† We know that's not always possible and try to minimize and eliminate some of those burdens for them when able to do so.

That relationship building that we've all done and continue to do not only amongst the offices but with the faculty and department level and advising level, etcetera, has been critical to ensure best service to the students.†

†

>> MORGAN BLUMENFELD:† One thing that I'm a part of as well as a couple of the provider is called the eating concerns consultation team which is joint team between CCS student health services and student wellness.† I think that's been a really good opportunity to really help in discuss and further consult on our cases that are shared between different departments which is something that's been really helpful in my position.† I also know student health services we have health advocates which has been really nice to offer to students who might have difficulties either with a language barrier or people who have never really have to make their own health appointments before and having that advocate in the room with them if they choose to do so can really courage some of those barriers as well.†

†

>> JENNIFER:† I would say I think one thing that I think, you know, OSU being such a huge place with so many different resources, I will often sit with a student in my office and maybe make a treatment or recommendation and just feels very overwhelming or impossible to them; right?† Even if I've given my clinical rationale, they're like, yes, that is happening for me.† I would need that.† But that just feels it can never happen; right?† Then being able to sit down with them and say, here's our next steps to try and making that possible and being able to make some phone calls to disability services about setting up accommodations.† And calling Kim's office to get financial stuff work done.† Then contacting Caroline and saying, hey, this person thinks they're going to get sent home if they try to approach us.† Can you try to take some of that misunderstanding out and walk the students next through the next step of the paperwork and visa process; right?†

It very quickly becomes a reality for the person to be able to access what they need.† Rather than being overwhelmed, leaving my office, and never returning and not seeking care.†

†

>> KIMBERLY PACHELL:† I think the other part of that, too, Jen, is the fact that we are all communicating with one another and able to do that helps keeps everybody on the same page.† If they don't end up showing up at our office like we planned, we can have that discussion so, in your next treatment session, you can go over that again and that gentle reminder.† Again, trying to help encourage them and keep the flow moving if you will for them.† Again, I worry a lot in the work that we all do about that rippling affect of waiting, you know?† Because, if you get into far beyond†-- I haven't been to class in three weeks.† Okay.† Well, three days was one thing.† Three weeks is another thing.† Now, what do we do?† Our options change the longer that goes on.†

I like that we've all been able to in many, many cases help to coordinate that care and ensure that we can keep the students moving forward on task, help them get from A to B to C to D, and, again, minimizing that impact overall.†

†

>> ADAM CRAWFORD:† Yeah.† I would echo what Kim said.† As far as the timeliness and being able to work proactively if at all possible.† It's not always possible.† When our office is involved in trying to set up formal accommodations related to students has the program they have to attend and conflicts with a class meeting, a lot more options on the table when we say the student is going to be missing next 4 to 6†weeks as opposed to be saying I have been made aware that the students have missed 4 to 6†weeks.† Now, what do we do?† That's where we seen the most success is when we know about it in advance and collaborating with each other and able to collaborate with faculty where the students not have their academic interrupted.

That may not be possible for all classes.† There are some classes that engagement is essential.† Then we talk about plan A, B, C.† We look at incompletes or possibly make the in-person work at another time.† We like to explore all the possible options.† That not being retroactive, not being reactive can be helpful.†

†

>> CAROLINE WAGNER:† One of the things the implementation team supported was helping to stand up the peer access line where we had students that were trained to point to some of these resources.† That's also been a great help to faculty because we can sit†-- remind students that access to information about help is really available in just a phone call away on a peer access line.† Students were very instrumental in getting that underway and enthusiastic on making that work.† It turned out to be a great way for that bridging function that you've been talking about.† A way to bridge from faculty to students to remind them about the peer access line with the phone number.

So that students could call and seek help should they need it.†

†

>> KIMBERLY PACHELL:† One of the†-- if I can chime in here with the mental health emergency funding.† That has been a huge success for students.† It's been short lived.† We've got our first 50 thousand dollars at the end of autumn semester.† We were able to help 45 students in the span of a month which was great.† We were able to award up to $3,000 for any student who was enrolled in just one-credit hour.† We had the absolute amazing fortune of getting a second round of funding which we just opened up this Monday the tenth for another $100,000.† Applications are coming in fast and furious.† They are for approved mental health expenses.

IOP, PHP programs, co-pays for therapy sessions, insurance, medications, transportation to and from those medical appointments, and even child care so students can access treatment if that's necessary.† You can check out the information to that on our website.† It's advocacy.osu.edu which I can drop in the chat for you.† It's under the mental health emergency system.† We have different funds.† This is federal health cares funding.† The federal government did the time for us so we don't have a lot of flexibility, but we have options like international education or some of the other college offices to be able to support students in different ways.† We've gotten creative.† Like, we can't pay for that, but we can pay your rent and maybe you can redirect your funds towards whatever that other need might be.† That's been a huge resource.†

As you're hearing from students that they're having basic needs issues meeting their basic needs or not seeking treatment because they can't afford it, we encourage you to talk to one of us because there are options out there and want to work to help them find that.† It's going to be a success for everybody.† A win-win.† We want to be sure we're doing our part to make sure they get what they need.†

†

>> JENNIFER:† Thank you for sharing that, Kim.† I think that's really important and highlights OSU is a huge institution with a lot of rules, regulations, processes.† If we can communicate and do some creative problem solving, a lot of things become more possible for a lot of our students.† Not everything; right?† But having these signs of communication, I can better understand what Kim can do on her side of the house or Caroline do on her side of the house or Dr.†Wagner in her course.† Having those discussions and communications is really invaluable.†

I am aware of the time. †I guess, my last question†-- we have one question in the chat.† It's just to throw out to folks if†-- within your department, offices, roles, if you have future considerations or ideas that your unit maybe has had around different policies or procedures or resource that can be implemented to improve access to care.

†

>> ADAM CRAWFORD:† I'm happy to jump in.† I'm excited.† This is sort of in the pipeline for fall and some of my fellow panelist know about this.† That we at disability services working on more sort of a spectrum model of accommodations related to attendance, flexibility, deadline, flexibility make-up work.† Historically, we sort of had a one size fits all model.† At least on paper.† When it did work, we had to manually adjust.† You're in an intensive hospital program or hospitalized in four weeks.† I guess, you can't make up those hours.† We're going to formalize that and lay out the spectrum similar to earlier when talking about the layers of need.† If you are not in a hospitalization program but just have occasional acute episodes, we have our sort of intermittent flexibility where, if you miss the exam, you can make it up in a couple of days.

If you have†-- if it's more you're going to be missing for several weeks through participation one of the programs, we're rolling out something we're tentatively calling a remain-in-class plan where can we put a plan where you don't have to drop a class and have a more formal structure to it.† We've done those things in the past but done it ad hoc and give a name to it and guidance to the professors.† We also have something we want to talk up more.† It's been available.† We think maybe more students would benefit from it if they need it existed.† We have something called full-time status with reduced course load.† Which means, if the level of severity of your condition or level of treatment you need means you cannot reasonably take a full-time course load†-- proportionally and equitably taking nine credits feels full-time to you we can set it up you are treated as greatest possible as a full-time student.† You can receive internal scholarships that require you to be full-time.

You can still be treasurer or do things and not lose on any of the opportunities.† There are limitations there.† Federal government and Pell Grants and other things are outside of our control.† There are some things inside of our control.† We're excited to sort of formalized some of that.†

†

>> CAROLINE WAGNER:† One obstacle we came across in the implementation task force is students who do have to drop out for different reasons similar to what Adam and Kim were talking about for mental health concerns and treatment find it hard to reenroll when they have outstanding student loans that have been in place and need to be paid back.† So that led to a discussion of how we might address that.† That's way beyond my pay grade or remit.† It is certainly something that I think we still need a discussion about because it did appear that, for some students, that was a true obstacle for them in reenrolling at the university after a crisis.† Something to think about going forward.†

†

>> KIMBERLY PACHELL:† When I think on the same lines as Dr.†Wagner, students forced to withdrawal due to medical circumstances of any kind of personal circumstances of any kind, the federal government gave us the flexibility of recalculating the aid they received for that term.† Based on the effective date of withdrawal, they can be in that potential that owe money because they took the time out.† That's unfortunate.† And trying to find ways to help them overcome that and return to school sooner rather than, hey, you have to pay us back $7,000 before you can reenroll.† Doesn't feel good when they really did the right thing and took the advice all of us had offered them to be able to do that.

Are there some institutional dollars that can help?† Are there other options?† Can the federal government be pried in any way?† Like you, it's well above our pay grade.† It's something we've been talking about for years.† That would be really helpful.† It just creates an awful stumble block hard to overcome.†

†

>> MORGAN BLUMENFELD:† I think for the services, there are a couple things we have planned for the upcoming year.† One lecture series or psychoeducation series for the providers to learn about mental health in treatments or psychiatry end of things even though they're not psychiatrist.† We do see a majority of mental health concerns coming through our doors as the appointment type or particular need.† Then the other piece which I'm hopeful to talk to or hearing about here soon is I would really like to have a joint conversation about what is Wilce student health services role?† We are not a psychiatry team.

One is to link Wilce back and hopefully that's to come.†

†

>> KIMBERLY PACHELL:† That's great.† I think one of the other things that we've been looking at within student life that we're still working through some of the details of that and before COVID hit but is kind of this idea of a care manager but in a different way.† We need to come up with a different title for it.† Somebody who would be able to help them coordinate, you know, the petition process, the moving out of the residence hall process which our office does for student who is are referred to us or make contact with us directly.† For example, the police may inform us that somebody has been hospitalized and reach out to the students.† It's difficult to follow-up with the student.† We heard you were hospitalize.† We want to help you get on track to get the resource you need.† They may or may not call us back.

If not, they could fall off the radar.† We don't want that to happen.† We want a person who can help us with those.† There's a couple hundred of those per year.† Just kind of generally speaking.† Really can use kind of a more consistent, let's check in with them 2 or 3 times.† Let's make sure we're checking with them on their grades and see if they were successful.† If not, what are the options?† Hopefully, as we move back in person and financial situations change a little bit, that can be something we are able to bring back to the table.† Again, just wanting to ensure the student's success.†

†

>> JENNIFER:† I think†-- Caroline, did you have one more thing?†

†

>> CAROLINE OMOLESKY:† Yeah.† Just real quick.† One of the things is being supportive of the families that contact us.† I think that's a challenge we are concerned about the FERPA regulations rightly so.† Really, really important to do whatever we can do support the parents and brothers and sisters who reach out to us who maybe our connection with the students now if they are not able to connect with us directly.† That's, I think, a challenge we especially have on the international student side because a lot of language barriers and that kind of thing.† I know the most successful outcomes we've had sometimes have been when families have been involved and have been really supportive of those students and communication lines have been opened.† I think it would be great to find ways to formalize that a little bit.†

†

>> JENNIFER:† Awesome.† I really appreciate all of the panelist time.† I'm hoping this inspires other folks in the department who are in the audience if you haven't already start thinking creatively about the things in your unit in your role maybe you can do to support students.† We did have one question.† I'll try and get to it quickly before we go to break.† Olivia Bear had said, I think another side of accepting disability may come from feeling like you're taking away support from those who need it more.† Would you say you've seen this thought process with some students?† I would say absolutely.† I think we many, many students that will come in and say, are you sure I really need that?† Am I taking somebody's spot who really needs X, Y, Z?† So I think a lot of that is folks who aren't doing so well sometimes get habituated to that.

They can sometimes minimize their concerns.† I think that's certainly something we can do to challenge stigma.† Thank you for that question in bringing that up, Olivia.† I'm mindful of the time.† We were supposed to break at 2:50 before our 3:00†o'clock speaker.† I give us until 3:05.† If we can reconvene at 3:05.† We will be joined for a student testimonial which I'm grateful for.† We'll see you in just a bit.

†

>> JENNIFER: Hello, everyone. I welcome us back. We are in the home stretch of a very enriching day. To start off some final elements of the afternoon, I am so pleased and honored to introduce Stephen, who is a recent spring 2021 graduate of Ohio State University graduate school. He will be sharing his story and experience in the intensive outpatient program at OSU. He will be guided by Lauren, clinician who was with us earlier in the afternoon. Please join me in welcoming them.

>> LAUREN: Thank you. I am Lauren and will be helping facilitate this student testimonial with Stephen who is a former patient of mine.

>> STEPHEN: Can you hear me? Hello, everyone. I wanted to start and say thank you for having me. I know a lot of you on this call, Lauren, Dr. Sharma work with you and really appreciate all the support you have given me. I've been nostalgic with graduation. I'm literally in my car celebrating with my boyfriend. He just graduated law school today as well. Very joyous moment and I'm happy to come here and share my story with you all.

>> LAUREN: Thank you. That's really exciting with your boyfriend graduating. Thank you for making time today to do this testimonial. First question I have I want to leave open-ended. Tell me about your background. What was the process of getting connected with the young adult IOP program? What was that like and how did you get connected with us?

>> STEPHEN: I never heard of the young adult or IOP or partial hospitalization before. The only group setting I had done before was CCS group success not access. I was there for a few weeks and didn't vibe with the group. I had always been worrisome or avoided some group settings. I have been with my psychologist, Avalon, for six years which I was referred through CCS provider database. That was helpful to help me find her. She's been helpful through this time. What eventually got me to IOP was I had been struggling with suicidal thoughts after a few life events that had put me in that position. After consistently being in the I knew my mental health was worsening and my psychologist could see that as well.

She suggested the program and had heard good things about that beforehand. Referral was helpful in getting me started. I did the orientation that you will do and I think it was myself and you sitting in the room talking about it just thinking what were my goals and some things I was facing in that moment. Substance use has been something I've struggled with and specifically cannabis use. I know that was something I have gotten a hold of since going through IOP and support from people at CRC. I love the support. I have set goals and went to the orientation and we decided IOP would be the best time for me to do that. I had done it at the end of the semester from December until the beginning of spring semester in that break allowed me the right amount of time to invest in myself for that.

>> LAUREN: What was going on in your life at the time with symptoms, stressors and circumstances? What was going on that your therapist thought it would be a good idea to do high level of care like IOP?

>> STEPHEN: I think this first time when I came into IOP in this beautiful part is I did it twice and enjoyed it both times and learned a lot both times. The first time was my relationship. Likely I'm still celebrating with my partner today and we are about to head out to Los Angeles together. One of the big things that put me in the mindset was us separating and just not really feeling or knowing where my path was following that. There was a lot of codependency issues. I think IOP and schema has helped me understand how to frame these things.

The relationship piece, I had been working a lot of jobs and really burn myself out in a lot of these areas. Was at Ohio State for undergrad and if you think of the typical involved kid, I did everything under the sun to try to keep myself busy do not think about these issues that I knew were sitting there on the back burner. I definitely hit the wall where I knew I needed to slow down and processed some of the things that I had going on.

Another thing is I had family issues as well. I grew up Catholic school 16 years and with my gay identity, that has affected how I have developed formulated my opinions and siblings and in-laws were not so nice about those things. Navigating that with the relationship pieces and the school. As you know, I was present of graduate students. I was heavily involved in kept myself busy and enjoyed doing these things.

I think at the detriment of myself and I think IOP was time for me to slow down and think about some things that I want to do and improve and find connections. I think that's one of the biggest things I have found is a lot of these pieces are interconnected for different strings of thinking. IOP has helped me connect these and realize where I want to go and not feel like I'm allowing my life to dictate where I'm going and have more decision in what I'm doing.

>> LAUREN: You mentioned facing discrimination or judgment for your sexual orientation identifying as gay. Was there any stigma related to mental health or any barriers in general that may be slow you down in coming to IOP? Was there anything you faced prior to coming here?

>> STEPHEN: I realized I still have stigmas I need to detach from healthcare and mental health care and substance use care as well. I think I was always someone very high functioning. I know a lot of folks with generalized anxiety and depression can be there but not as many think are as high functioning as I am. I think me being able to succeed and never hit the rock bottom piece, there is close to it but never to the point where I felt the consequences were enough for me to really have to stop and think about it until I hit the suicidal thoughts. That is really what brought me in. I think it's important now that I really want to be a champion because I think that helps the stigma and via come here and talk about it and have been very open on social media and finding support from folks here at Ohio State when doing that.

Our chief wellness officer, tweet and comment of this is how you take care of yourself and take time. Those small things really mean a lot. Some of those things are what allowed me to go back the second time because I knew I needed a lot of help and after having gone through the program, it was -- I didn't want to come back because I felt like I done it and I can tell you I got more out the second time for my first.

>> LAUREN: That is good transition and another question I have for you is what was your experience like in the young adult program? The first time, second time in the difference between the two times, what was your overall experience like?

>> STEPHEN: The first time I did a lot of learning. I deftly had strong understanding of CBT. I had been in therapy for 8+ years so I had understanding of how these worked. I think the framing of some of the lessons that you put together really helps connect the dots to some of these issues in my own head. I think in the first round I was skeptical of that group. Aspect, especially walking in the first two or three days. If you like very extroverted and I was still like I don't know about this.

I think as soon as you start opening up, it's amazing just the aspect of IOP that I file other people in the small group alone, let alone the 60,000 students on campus experiencing the same things you are, it's really comforting and sense of community. I can tell you, there are a lot of people I met through IOP that I am still very close with Amy meet up with. We saw in group together and that peace is the most exciting piece; getting to help each other, being a grad student in some of the understood in that space when we had kids ever 19, 21 when I was 23 and 24. I found value in helping them as well.

It helps me be more grateful and experience gratitude more often hearing their experiences. I would be remiss to say I think we grew closer after IOP after one of our IOP members that went through our program with us had actually passed away due to drug overdose through COVID. That hit us all in the last IOP group that we finished and it was three months later this happen. The group of us went to the funeral and I think we all remember talking about this could have been any of us. One slip up 's and some of these things could happen. Remembering his presence and what we learned together is really important. I still take his experience with me every day because I know what he said in those spaces in know who he was. I think that community peace is so invaluable.

As a piece of IOP. I think that is really what is the core let alone lesson plan and feeling cognitively and emotionally expressing some of those things in those spaces is really this feeling that there are other students and peers experiencing these things and this is part of life. It's natural and you are supposed to go through struggle. I think that's another thing I have realized with stigma is I want people who know what struggle is to be in the spaces of power in spaces where I can see others and they talk about that and open with that. Being in the space of leadership at Ohio State, and I would love to see more.

I think a lot of folks have done that will and Dr. Wagner has done amazing things but for everywhere, just promoting this culture of care of mental health. I think it's really uplifting some of these folks in the work being done. It's about listening to the students as well and trying to connect them to these resources. I didn't hear about IOP through academics and school. I think you do great job but professors and faculty, you know when someone is not doing well and you can see it just with them walking out of the classroom and not being engaged. Just having certain professors that would ask me and see how I'm doing; you can go a long way. All of that connected to the community group aspect of IOP is what brought home some of the support and help me grow.

>> LAUREN: You bring up a good point at the end, having involvement in professors. That can be so substantial and can actually be really impactful. One of the questions I had for you is how did you feel supported by was you academically while you were in treatment?

>> STEPHEN: I had great folks like Glenn, Sammy was amazing, doctor Hallahan met with me often as well. On my professors are very empathetic. Because I been hooked up with student life disability services, Adam Crawford was my specialist and he helped me through a lot of things. Knowing that I could just go to someone and not have to think about these procedural things, I knew a lot of them because I engage with them every day through CGS. Knowing I could go to Adam in one of the biggest hardest things I was going through IOP was retroactive in my academics were in really rough shape and I got put on probation as well. He really helped me get through some of those times where I felt so overwhelmed that I couldn't process the things that I did know that I needed to do. Disability services was amazing. Towards the end of my career and I wish you would've done earlier is utilized the center.

Jackie over there was great academic coach and kept me on top of things.

Again, I knew the supports were there for me and the other one being the CRC. I met weekly if not monthly with some of these folks. I had a lot of support from student life and academically for my department which was great. I know that level of support is not present in any unit department. I know is someone who is still connected to the University that a lot of students don't know about these resources that I know about. That's why it's something like just promoting these resources and letting students know they are there. I took advantage of the student life advocacy fund for mental health and got a solid chunk payback and that was really helpful. I think that above all, some of these basic need resources are things I hope we can continue and not just be something we leave in the pandemic. These are expenses that students cannot meet all the time. I think it's really important to utilize some of the services and resources that we know of.

I think in relation to this conference and what we have talked about on the wider scale is this culture at Ohio State. Sometimes that is not always felt across the board. I think especially at higher levels, being able to stop and think about some of these things I know for myself it was very hard to go through a lot of these things personally while also going through life of present graduate students. It was a very lucky opportunity but there were definitely situations where I feel like I wasn't we seen as my whole person and I was just President of the graduate students. Folks didn't necessarily understand that I had the substance abuse disorder and needed help with my disability struggling in academics.

I think part of that is the nature we are in the pandemic and we are always go, go, go, need to get the next thing figure it out and support folks. Just the time to breathe and ask the individual people you're working with that you see meetings and you have your agenda set up and will go through the whole thing. It's like let's just breathe and see how each other is doing.

I think there are moments where I felt pitted against folks when I needed personal help in my development as a student. Ultimately, that's what I charge faculty and staff and demonstrators to do; I love the motto diverse what is right for the student and then make it work for Ohio State. Truly, those of us that feel like we have it together and show we have it together, it was struggling and it was great struggle and I learned a lot, I think there's always improvement in terms of having sense of compassion for every student.

>> LAUREN: Absolutely. I had no idea that Adam was the one helping you with disability services. That's fantastic. He and I have been working together. That's one of the things I always give you credit for and still give you credit for; or utilizing the resources. Resources available to you and really asking about what resources were available and trying to see what we could help you with and maintaining those helpful relationships throughout. I think that's really hard for a lot of students to access those resources even when they know they are available. It's difficult for them to say going to try to get all my ducks in a route and email my advisor and reach out to disability services. Sometimes it's really hard. You kept pushing through that and I give you credit. What have things been like since IOP? How have things been going and what have you been working on?

>> STEPHEN: I have continued to do a lot of the support I just talked about. I did just graduate on Sunday and I'm starting to try to shift some of the more community support. As I said, I do plan once I find a job, living to Los Angeles with my partner. Really excited for this new beginning and really shift. It pulls my heart sometimes because of how ingrained it is for me to be involved in staying in the community and no I will do that in some way but just for this next year or two I need to go inward and focus on myself. I think IOP really helped me realize some of those things that I already knew that I wanted to work on, but just lifted some of the barriers and walls I had put in front of myself. Really excited to figure these things out more so for myself what does it look like?

I have always struggled between her reduction versus more AA model. I still think I am exploring that and how that works for my life, especially given the research area I want to do. It has just made me more confident in myself and taking these issues forward. I will always be willing to speak about these things because so many people I know are struggling and folks still don't talk about it. That's why I think it's important for us to continue to have conferences like this in resources.

>> LAUREN: Absolutely. Before we wrap up, I wanted to ask what is one thing you would tell student struggling with mental health? Maybe debating on coming to IOP or PHP at Harding, what is something you would tell them based on your experience?

>> STEPHEN: I would say go for it. I know it sounds like a lot can be overwhelming 15 or 12 hours per week to come in every day, especially not when it was COVID. It is a struggle but helps teach you routines when you are so deep in depression or anxiety that you cannot do those things those routines at the IOP really help you get back up. The accountability from the group and knowing you had to check-in every day and say how are you feeling and what your score is and what your substance use was in all these different things and just live up to actions, it makes you think about your actions more. Just telling the students that there are others out there like you and you are not the only one struggling and this will only help you be better and prepare you better be able to help you find success in academics in your personal life even for short amount of times. Let yourself invest in yourself because you deserve it.

>> LAUREN: Let yourself invest in yourself. I love that. That is good advice. Thank you so much for coming to this conference today. I am so proud of you. I really consider myself lucky and honored to have been therapist not once but twice. Not that we enjoy having somebody come back to the program but we have the opportunity to help for the second time in they trust enough for that, I know Nate and I felt privileged that you trusted us and had that report to come back. I just want to say how proud I am of you and I cannot wait to see where life takes you next.

>> STEPHEN: Thank you. I finally feel like I can internalize that. This graduation week has done a lot for me and being able to do that. I went to thank you again because you have helped me so much more in pushed me in ways I needed to be pushed. You and everyone else on the conference that have helped throughout the past three and seven years altogether have been amazing. I thank you all of you as well.

>> JENNIFER: Thank you. I appreciate everything is shared and I think your story illustrates for the rest of the audience. I counted and I know you mentioned six different offices. The capacity for all of these different intersections have and one person in their success in their mental health journey is really important. All of us here play the part in that. Taking effort to mention that office or make that phone call or send the email to the student with that information is really important. I really appreciate you being here today and participating and offering your unique story and journey. Thank you so much.

>> STEPHEN: Thank you. I'm going to go grab food now.

>> JENNIFER: Congratulations.

>> LAUREN: Thank you, goodbye.

>> JENNIFER: Tough act to follow. The final presenters will be speaking on the progress on the suicide mental health task force implementation. Please join me in welcoming Dr. Ryan, board-certified child and adolescent forensic psychologist. And professor and vice chair of clinical services of the Department of psychiatry at Ohio State University and Dr. Sharma, directive student life counseling consultation service.

>> DR. SHARMA: Thank you and welcome. We are coming to the end of our conference and it has been a lot of screen time but also want to add my thank you demon and everything he shared. In this last presentation, what we are going to do is talk about both the original task force and work of the implementation committee in some specific highlights. Also, just things in general with regards to support services in different initiatives and programs that exist and have been created some before and after that are there to support students as they move forward. Carlos of struggles may be. Some of these things were touched on by the student who just spoke, and the different ways faculty, staff and fellow students can be supportive. It will really be not just about the culture of care we hope to establish on the campus, but how we continue to have that moving forward. Dr. Ryan will get us started. Let me share this PowerPoint. I can advance.

>> DR. RYAN: Thank you very much for inviting me to talk. I wanted to start out by giving you all some context for how the department of psychiatry and Harding hospital developed broader partnerships with the greater University to really help students who might be struggling with mental health conditions.

April 2018, President Michael Drake convened the OSU suicide and mental health task force. He charged us with a number things. One, this was in the wake of two tragic events, suicides from the garages. Within 72 hours of the second one, he convened this mental health task force. He wanted to find out what OSU does well in the area of suicide prevention and mental health. She wanted us to find out what we can do better in these areas. What practices we could implement to support the OSU community and make recommendations of areas of improvement.

Very importantly, provide the rationale for recommendations. There were a number of challenges with respect to this charge. One was the time constraint he wanted for us to have reports and make recommendations by the end of the academic year which we were not able to do. I think you will see why because of the work put into it. Another challenge is how do we define mental health?

There are varieties of definitions. Then the complexity and mess of volume of information on suicide. The volume of evidence-based research on suicide. Also, the danger of conflating suicide with mental health access. Just a few backs. Suicide is the second leading cause of death in the 10 to 34-year-old population. Some people are not aware there are twice as many suicides in the United States as homicides probably because the media tends to focus on homicides. There are at least twice as many suicides. One of the difficulties with studying and difficulty with suicide prevention is that completed suicide is what we call low base rate behavior. It certainly does not seem that way when there are two within the period of 72 hours, or when you know of people who have taken their own lives. It is a behavior that is very difficult to study and understand prevention because of that.

This is a statistic which varies from year to year, 13.4 suicides per 100,000 and that is a typo come up per 100,000 at the population of large. That goes up and down depending on the year. The latest data I have seen 2019 in Ohio, the rate is 15.1 per 100,000 of the population. The important point is college students, there are many protective factors for college students. Suicide at lower rates than the general population for their age. And the age-adjusted suicide rates the United States have increased by 28% from 1999 to 2016.

Less than half of college students experiencing mental health crisis seek help. This is really important and one of the areas we are really striving to make a dent in. The last point is important. Almost 80% of students who do go on to suicide do not present for campus counseling or mental health services. They do not reach out and ask for mental health services and there are variety of reasons for that. Fear of stigma and negative consequences. 6% of undergraduates and 4% of graduate students in four your colleges have seriously considered attempting suicide in the past year. About half did not tell anyone.

Here is the composition of the task force membership. Doctor Gaston who is now the president North of state was cochair of the task force with me. We really wanted to, and we did end up having a large student representation which was very important. Four out of the 11 members were students. We had other individuals from a variety of departments, colleges. We wanted to get wide representation.

One of the important areas was even though there was great deal of expertise in terms of the committee, we also wanted to reach out to other subject matter experts. These were service providers who had expertise in this area including student health, resident life. We also had Dr. Sharma from CCS and really wanted to get their perspectives of where things were working well and where we can make improvements.

We have some real expertise in terms of research on suicide here. Two of the people we brought in were John and Jeff, who are from Nationwide Children's Hospital. They were involved in the research on the increase suicides after the Netflix show 13 reasons why. We recently recruited but this was after the task force, doctor Brian, who is a nationally known expert on suicide, trying to understand more not only suicide prevention, but also crisis planning and what seems to work in that area.

Then we had foundation representative and (Indiscernible), associate vice president for student mental health New York University, which is where I was an undergraduate. The reason why we asked for her to advise the task force is because NYU has a library which is an architectural masterpiece but has open crosswalks. There were a number of suicides in that library. We really wanted to know what kinds of interventions are most helpful? We will talk about the importance of reducing access to lethal means and how that was affect give. We recommended in the task force for the garages. That was also very helpful.

Then we had students who provided really wonderful suggestions. They were very engaged. We had some of the students present in person but many presented virtually. USG created a feedback tool so that any student could provide feedback to the task force.

These were the recommendations and I'm going to focus on enhancing resources. We recommended that we needed to advance and sustained culture of care with very specific recommendations as to how that can be initiated, sustained, enhanced and standardized screening procedures for CCS and other areas and doors students may access for mental health care so that we were all basically speaking the same language, especially when it came to screening procedures. Enhanced resources which I will talk more about. Communication of support and mental health promotion. It's really important -- and this of course feeds into the culture of care that we really communicate on a regular basis not only when there is crisis in the University community, but how much we support students and their health. Expansion of digital delivery and support mechanisms, members of the task force and Dr. Sharma, we went to Cooperstown and met with Apple and started the process of designing an app which students could access. One of the recurrent themes we kept hearing and seeing when we were looking at the webpage and the services that OSU offered was there was tremendous amount of services for students that are offered. It was really difficult to know how to access the services. We wanted to develop something that would be easier for students to navigate and then explore campus environments to advance additional safety measures.

I'm going to talk about the department of psychiatry and behavior health at Harding Hospital. Some of this you have heard in great detail so I'm not going to go over this in detail. Going to talk about psychiatric emergency service which is where I do my clinical work. IOP in partial hospitalization for young adults which you have had a very thorough presentation on already. Something we have just developed which we call (Indiscernible) which is behavioral health immediate care clinic which is in Harding Hospital. Our ambulatory clinic and STAR would you already heard about. And then inpatient hospitalization.

On sight emergency services, our psychiatry team is what we call a consult team. If someone struggles with suicidal thoughts and need to come into the emergency department for whatever reason due to the severity or whatever, to evaluate the severity and what level of care is needed, they come in through the emergency department and we are consulted by the emergency medicine physician. Then the patient is moved over to our service embedded in the emergency department. The patient and student or whoever it is number evaluated by what we call consult clinician. That might be a licensed clinical social worker. It could be nurse practitioner. In the evenings, it might be physicians. Particularly at night.

Every patient is discussed with the attending psychiatrist physician. From 7 AM until 9 PM, they are also individually seen face-to-face in the emergency department. Collateral information is often critical to deciding what is the best level of treatment. That could be a roommate, family member. Then the person is linked with the appropriate service. We have been so appreciative that we have been able to get appointments with CCS typically within one day. BHIC is there but we haven't had to utilize because of students have been able to get hooked up with CCS for appointments. They might go to IOP or the partial hospital program. We have been able to secure spots very quickly. It may be that inpatient hospitalization is indicated within the last year we have opened a unit which used to be our adolescent unit but the adolescent unit has moved over to Nationwide Children's since the opening of their behavior health Pavilion.

The fourth floor is now a young adult hospital unit. What the goal is in these are young adults, is for if indicated, pretty rapid hospitalization. Used to have a service called calm which was observation unit were people might stay 24 to 72 hours. In many respects, patients are discharged within 72 hours from this inpatient unit and have more intensive treatment. There are other outside services we can recommend. For example, rehab services.

You have gotten a very thorough talk on the IOP impartial programs. Just to summarize, we have really increased since 2017, error capacity for IOP treatment. They are biweekly orientation on site at CCS. There is information able to be provided regarding financial concerns and student advocacy. One thing I have found when I'm down in the emergency department is students are very worried about what's going to happen with classes. We encourage students to get in touch with their professors while they are in the emergency department. That has worked out really well.

At least the situations I have been aware of they have felt very supportive and that has relieved a lot of anxiety in terms of yes, there's a test but get your health taking care of and we will worry about that at another time. The quarterly stakeholder group and I think as Arianna pointed out, the number of individuals from OSU participating in this program has tripled. BHIC which is this immediate care clinic was initiated last year to close some of the gaps in the continuum of care because we know patients are at highest risk for harming themselves and rehospitalization in those first 30 days. We really wanted to see people linked within 10 days of discharge from the hospital. That was one of the populations we wanted to target. As well as people seen in the emergency department who really don't need to be hospitalized, but it might take a while for them to get linked with outpatient appointments. This is particularly true with people seen in the ambulatory care clinic where there are waiting lists.

BHIC clinic has a therapist, nurse practitioner and psychiatrist. We plan on hiring an additional therapist and case manager. When we do that, we are hoping to offer walk in appointments. That is not available yet. Then there is ambulatory on psychiatry. You know about star. They achieved this grant that included the support for the case manager in therapist and able to increase their equivalent because of the increased demand. 10% of the volume in our ambulatory clinic at Harding and (Indiscernible) is OSU students.

Sometimes inpatient hospital is Asian is needed as I mentioned before, for more severely ill individuals who cannot be safely managed in outpatient. We moved it to the fourth floor for the young adult patients where we can focus on rapid treatment stabilization and link them with services that they need so they are not remaining in the hospital any longer than they need to be. If there is lag or delay before the first appointment whether that will be outpatient at CCS, or if it's going to be with our ambulatory clinic or IOP or partial we will see them in this clinic that I mentioned earlier. That was made to the implementation team which Dr. Sharma will talk about.

>> DR. SHARMA: The task force report was released in September 2018. In November 2018, the implementation team was convened and membership received discharge from President Drake which was there were 20 specific recommendations from the task force. Short and midterm recommendations, and put them into action. I will touch on some of that as well. You will see this group had representation of staff, faculty and students similar to the original task force. There was some crossover. (Indiscernible) Were the two crossover folks who served on both groups. There was some continuity in that regard. It was to really look at the specific short and midterm recommendations and take recommendations and put them into action. Let me touch upon not just those things but different things that have been occurring on campus since the work of the task force and some even predate the task force that get to have this culture of care is there to support students and has been as well as continue to support students moving forward.

We talk about multimodal services, I think historically one of the ships we have tried to make his going from place of if the student has health concerns, they need individual counseling and go to CCS period and that is the only option. Really what we have done it will talk about multimodal sources is look at what is the student's unique mental health need at this point in time and what service exists on the campus or off campus that can assist that student with that mental health? What you have is it's broken into mild moderate and severe and in terms of what is the level of distress and concern at the time.

I'm not going to read everything you look at the different support services available both within the office of student life and other places across campus. Learning Center was mentioned by the student the spoke earlier today. We have the drop-in workshops available through CCS Monday through Friday. There something every day of the week during the academic semester. I want to highlight the let's talk program which is not therapy but this past year we made that virtual and it was available every day Monday through Friday students could connect with a clinician from CCS. Problem-solving in nature or maybe I don't know if I need therapy but I want to talk to someone to figure out what's going on. Maybe something has happened and them having reactions and what to talk about it like racial violence, unrest. Just because you are having reactions doesn't mean you need therapy but make benefit from talking to somebody about it.

I will talk about the powerline we get moderate and that's for somebody may need treatment. We have the triage process. Also, there are four different locations on the campus where students can receive care. CCS is one, Harding outpatient clinic is one. Psychological service center and couple and family clinic. There are four different places students can receive outpatient treatment on campus, as well as when you move into severe, the emergency department, Wexner Medical Center and a lot of programs you learned about today. The IOP and PHP program available.

Anytime the department is closed the students can call the main number, pushed two and get patched into live counselors will get reports through the encrypted website of that call was students by 8 AM the next business day and we can reach out as well. What this highlight is there is supports to students in crisis on campus with the emergency department available 24 hours per day either in person or on the phone.

One of the big growths that have happened with CCS is expansion of the embedded counsel program. At this time, we have embedded counselors serving 13 different colleges and programs on campus. These are CCS clinicians dedicated to particular academic college or department. Morgan was highlighted today as someone who was with student help service or office of disability or office of diversity and inclusion. Residence on North campus, these are other areas with dedicated embedded counselors. The folks who do this with academic college really learn and focus with learning from students from that area or college and learning the culture of the college. Number of professional schools who have dedicated person and I think professional students in the school really take ownership.

This is our person or therapist. The clinician really learning that culture and academic culture really helps them in terms of providing treatment. This is a good example of something that works because the student regarding mental health says is not as severe as it used to be because they have an awesome in that college or area and they work with students in that area. We talk about the 1980s in this would not be successful because students don't want to be seen walking into the office that everyone knew the therapist was in. Today, we have students who are okay with that. Mentioned at the outset the students who are presenting, 60% have received treatment in the past.

There much more therapy friendly and that has allowed this type of program to be successful in terms of not just decrease stigma but increasing student access. Today has been all about the collaboration between Wexner Medical Center and student life support areas. You have heard a lot about that some not going to talk about the IOP and PHP program. Some things I will highlight, the stakeholder groups. This is mean quarterly, semester Lee and has treatment providers from the medical center and Harding two providers within student life and support folks who will fit together on quarterly or semester and just discuss new initiatives, programs, what are you seeing and what are we saying?

We are connecting and working on things together for the betterment in terms of how we can support students. This past year lot has been about the pandemic and providing support through virtual means. Telehealth, meetings and how you were doing that with working and not? Just as things continue to evolve, having that connection has been a will benefit. The other thing I would highlight with this is when student is taken to the hospital for inpatient, we have a good communication that occurs between folks at the hospital and Harding and CCS and care managers.

We can have care managers when available connect with the students while the student is in inpatient schedule visits with the care manager upon discharge. Doing that and having that connection while the student is still inpatient has led to students showing for that care manager equipment after they leave the hospital, 85 to 90% of the time which is a fantastic show rate after one leaves the hospital. This is important because it helps the student get reconnected campus. Questions they have. What I say to faculty are the folks who live on my floor while been gone? How can you help me with this?

Research indicates that unfortunately there is spike in suicide attempts one week and up to 30 days post discharge. Getting the person connected with support services after they leave the hospital is really important. This collaboration is really helped to be successful to keep students connected to the right resources after they leave the inpatient stay.

This was a student initiative. Two students who met with the task force and propose this to the task force. The PAL access line. PAL, students named. We had committee that had student staff and faculty that put this together and it went live less than one year after the task force report was released. It remains to this day. (Indiscernible) As I mentioned earlier when CCS is close, students can come and talk to live counselors and that is intentional so if there are calls to the panel line, that's more significant were serious or concerning they could do live transcript to the counselor who will be more trained to assist with the student in distress.

This is something that was student-driven with students that wanted to have this happen. This is something put together and took a lot of work to make it happen and provide support mechanisms. Also thinking about the culture of care adjusting faculty and staff students being able to support fellow students. The reach program suicide expansion. The director is Darcy and director is Laura Lewis. That has been referenced today. It's the suicide prevention awareness and training program developed here at Ohio State by the members of the SPP. From 2019 to current, 3700 people have gone through the reach training. That is in addition to the thousands who have gone through the reach training before 2019.

This is students, faculty and staff. Expansions of the task force and implementation is included the coordinator for the program and additional graduate assistants. That is allowed for more reach training is to occur. The online -- excuse me, the gatekeeper program, ISP, interactive screening program, has continued even though we have been in the pandemic, that has continued to operate for graduate students and veterans.

This is the way in which students are contacted and can complete the questionnaire survey. It goes through this portal back and forth to members of the suicide prevention program. If the person struggles with thoughts of suicide, they can communicate and then connect to resources. From 2020 to 2021, over 8000 students have gone through the interactive screening program. What is really helpful about the interactive screening program is it can identify students who may be struggling and no one knows the student is struggling because they haven't reached out for assistance or no one has contacted them or checked in. That is what this can do. It can be really helpful to identify students who need support in that way. With the shift in pandemic the program has developed what they call reach out. This is an online suicide education program that has been developed and live in has been over the last year. It's Trenton 75-minute program online and over 1000 students, faculty and staff have attended. The people who are reach trainers have become reach out educators. To get everyone back on campus that continues to happen, the reach training back in person will eventually be more like it has been.

This is something anyone, students, faculty, staff can attend. It gives you information about resources on campus and signs and symptoms to look for, language and what to say. That is where people struggle. If the top with someone where there's concern or they might be having thoughts of suicide, we don't want you to respond with silence. This training will teach you and give you the right questions, things to say and be aware of the resources on campus.

Some academic pursuits that have been helpful in this regard. The mental health at OSU conference is held in August 2019 and spearheaded by faculty members at the college of engineering. That conference was held on the campus and everyone was invited and it was learning about what the mental health resources are on campus and how to support students and how we can work together. That happen in August and a number of us that are here today presented and that was helpful. Faculty network, Dr. Wagner was very involved with this. This was wait for faculty to get connected and learn about programs and resources about supporting students and mental health support for students.

The next is perhaps the most significant, there withdrawal reenrollment process. For undergrads. If it's up to 10 weeks in the student withdraws, it is standardized. After 10 weeks, each college for undergrads basically have their own process. Students were frustrated and complained. What has been developed is a standardized form and standardized process for all undergrads need to withdraw post 10 weeks. Personal reasons, personal crisis, mental health crisis, medical reasons, whatever it is.

This process has been approved. This coming fall it will be piloted also not just the form and its use, but for the form to be reviewed in centralized ways. It will not matter what college, students will be supported and treated in the same way and streamlines. This will also be applicable for retroactive when the student is doing retroactive withdrawal in that way. This is really helpful that will be helpful to students moving forward in that way. This is something students had concerns about and wanted to see changes me. The mind strong course is run through the college of nursing and students can take this for credit. It's course that can help with overall well-being and development of resilience. This is an academic course students can take that can improve mental health and well-being. The reference was anyone could add to the syllabi and for faculty I hope you have done that.

Wants faculty member as it to the syllabi one time, it will be there every semester moving forward. That's about mental health resources on campus. Any faculty member can add that. This is what we have called the 911 folder. This is downloadable and printable. There are two versions. One can be posted in the room or classroom and the other one when printed becomes a folder so someone could keep it on their desk.

Members of the task force really overhaul this because it was too text heavy. It has signs and symptoms to look for but also resources available on campus. You can print inhabit as a folder to keep it on your desk or post on the classroom wall or office wall. This is something anyone can access. In the past we have had hundreds and thousands of copies printed but now it's downloadable of the website and anyone can print. It's updated and made with information both in terms of guidance for things to look for in ways to address things with students you are concerned about who are struggling and you want to look at rest supporting them in that way.

There is a website that's up. It is suicide and mental health dot OSU.edu. Spelled out. We wanted to stay away from Clement. I think you can figure out why. A lot of things that have covered the resources and updates. I don't know that we have done updates on website over the last year but they are listed on the website task force membership the full report from the original task force is on there as well.

This focuses on how you can keep culture of care moving forward. The next steps you can do, being here with commitment on your part and we appreciate that. Supporting the culture of care is taking information and making it part of your day-to-day work with students. Looking at different ways you can check in with students. Different ways you can break mental health stigma down. Supporting students and talk about mental health. The more you talk about that, the same way we talk about medical health, the better it is for everybody.

That is the win-win. If we truly wish to have this sustainable in moving forward culture of care on the campus, it's that everyone, staff, faculty and students can look at different ways in which they could be supportive of students. Stay up-to-date about supportive services on campus and how those adjust and shift over time. The mind strong course is available in the syllabus statement is available for anyone to add to their syllabi as well. Let me pause there.

>> JENNIFER: I do not see any questions in the Q&A box. I can give folks a moment if anyone has anything. Thank you for reviewing that. I know we have lots of names here and folks have been here since inception of the task force and folks who have arrived working on campus recently or in the midst of all that.

If anyone has questions, you can throw that in the Q&A box. As I said before, I'm sure it's been a lot of information and hopefully now you have names and contacts if other questions come up you need consultation around these items. Please, reach out to folks who have presented with us today. I see one. Doctor gives of student health said a resource that was very useful for students was the (Indiscernible). Will that be coming back?

>> DR. RYAN: There are no plans to bring the calm unit back. However, the length of stay on the young adult unit is the shortest length of stay in hospital. If a person is admitted to the inpatient unit and only needs to be there for two days or one day, or three days, they end up being discharged. Plus, the level of therapy is more intense than what would have been given in the unit which is more of observation rather than treatment unit.

>> JENNIFER: Thank you for that, Dr. Ryan. If we don't have any more questions for Dr. Ryan or Dr. Sharma, thank you again for sharing the work you have done together with the implementation and test scores. I will be moving to closing us out for the day. Again, thank you to folks who had attended today. I think we have been above 100 attorneys for the entirety of the date which is fantastic and I'm glad to see that. It was emailed to all registrants; this will be recorded.

The training will eventually make its way to student life counseling website next week. We have a page specifically for the young adult PHP and IOP support team. It will be there. I encourage you if you have new hires, other folks in the unit that you think would benefit from watching this, please feel free to encourage them to watch it.

I also do want to take one moment to extend a lot of gratitude and appreciation for folks who helped make today possible. The planning and implementation at CCS, (Indiscernible), Mary, Stephanie, Amy and big shout outs to Morgan who I could not have done today without at all. I also want to say all the folks over at the young adult program have been very gracious in giving with their time. They do so much work to treat students and have given a lot of time and energy into today, particularly Lauren, thank you so much. And all participants and presenters. I know it's been a very challenging year plus for all of us.

It is credit to have passionate you are about student mental health for you to join today. I really appreciate that. Ohio State energy partners, their grant funding of today's event so this is where this all began 18 months ago. I'm very grateful for their funding that may today happen. Certainly, the arts and sciences tech folks and Captioner's as well.

For those who stayed until the end you get to know the goodies or swag, if you can have that at conference that's virtual. We are happy to be randomly selecting 25 units or departments that were represented at today's attendees so that we can gift you guys a book that we think will further your knowledge, awareness, maybe looking into some topics on college, mental health and behavior health concerns and risks as we are talking about students who might need higher level of care for treatment.

You will be selected and it will be sent to you via mail. That is one thing coming your way. Everybody who is present today will be receiving this beautiful magnet, which highlights some student life offices that were discussed today that have been very supportive and instrumental of helping students to get to higher levels of care. All the contact information is on there. CCS is on there as well as Ohio State Harding Hospital IOP PHP program contact information.

Take of how many emails we have gotten in the last year, so hopefully having this magnet will be a quick reference to all of you. If you have students in front of you student emailing you saying I want to do this program, do you know how to do XYZ? You will hopefully have this available to you. That will be coming your way as well. We really hope you are leaving us today with encouragement, momentum and energy you can take into your unit. Think about different ways you can implement culture of care within your environment to support students.

The last thing I'll say is you will see a feedback survey pop up following the end of my comments that we would really appreciate request that you complete so that presenters, planners, myself can have feedback on what was helpful or maybe you want more of we did other programming? Please, complete that.

For those folks who have requested CEU or CME certificates, we are able to provide those for the hours folks attended today. You will receive those electronically to the email to which you have registered. If you have further questions about that, you can reach out to me directly. I will put my email address in the chat box. If you have further questions or follow-up from today. Thank you for your time and attention and hope you have a restful weekend.

>> DR. SHARMA: Let me add one more thing before we conclude. That is a huge thank you to Jennifer Lange who started this process, obtain this grant and was the lead in obtaining the grant in planning the conference today and today does not happen without her work. Thank you to Jennifer for all of her work to make today go off very seamlessly. Even through technology difficulties. I was hoping we wouldn't have any but even with that, she never got rattled even when the keynote kept dropping out and kept it moving steady through. Thank you from everyone.

>> JENNIFER: Thank you. Have a restful weekend.

(End of transcript)