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ISSUES IN IMPLEMENTING CAMPUS COMMUNITY MENTAL HEALTH PROGRAMS.

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THIS PAPER IS CONCERNED WITH FIVE ISSUES RELEVANT TO IMPLEMENTING A COMMUNITY-ORIENTED MENTAL HEALTH APPROACH IN A COLLEGE CAMPUS CONTEXT. THE ISSUES ARE--(1) THE CONFIDENTIALITY ISSUE, (2) INTRODUCTION OF CONSULTATIVE METHODS, (3) INVOLVING STUDENTS IN THE INFLUENCE PROCESS, (4) WAYS OF GAINING SUPPORT, AND (5) HEALTH PROMOTION. IT IS PROPOSED THAT THE LIMITS OF CONFIDENTIALITY BE STRETCHED, AND THAT IT BE REGARDED AS A GENERAL PRINCIPLE CONSIDERED SEPARATELY IN INDIVIDUAL SITUATIONS. CONSULTATIVE METHODS MUST INCREASINGLY BE UTILIZED, WITH CASE-CENTERED CONSULTATION BEING THE MOST LIKELY FORM. STUDENT INTEREST IN THE PROGRAM AND POSSIBLE ADMINISTRATIVE REACTIONS ARE DISCUSSED. LISTED AS WAYS OF GAINING SUPPORT ARE--(1) OUTSIDE CONSULTANTS, (2) ADVISORY BOARDS, (3) AVAILABLE THERAPY FOR FACULTY AND ADMINISTRATION, AND (4) MEETINGS WITH OTHER STUDENT PERSONNEL WORKERS. TO PROMOTE MENTAL HEALTH, BROAD PROGRAMS MUST BE DEVISED, AND RESEARCH FOCUSING UPON BROADLY RANGING ISSUES RELATED TO THE INSTITUTION MUST BE UNDERTAKEN. (PH)

ISSUES IN IMPLEMENTING CAMPUS COMMUNITY MENTAL HEALTH PROGRAMS

Thomas R. Brigante, Ph. D.

"You see things; and you say 'Why?' But I dream things that never were, and I say 'Why not?'"

....quoted from Back to Methuselah
in an address to the Irish Parliament
by Pres. John F. Kennedy

There are many issues which might be discussed relevant to implementing a community-oriented mental health approach in a college campus context. Issues selected for consideration in the present paper are regarded as especially salient in the earlier stages of transition from a more traditional program to a community approach. Although various campuses across the country have portions or bits of a community approach, there is no single campus known to this author or reported in the literature which simultaneously incorporates the range of cardinal features of a community approach. Within the next ten to twenty years, as community-oriented campus programs move ahead, we will have an opportunity to learn about issues which arise at later stages of development. Our present remarks will be concerned with a reevaluation of the confidentiality issue, introduction of consultative methods, involving students in the process of influencing decision makers, consideration of ways of mobilizing community support, and some aspects of health promotion.

THE ISSUE OF CONFIDENTIALITY

One of the knottiest problems to be faced in moving from a conventional campus program to a community-oriented program has to do with the management of confidentiality. Traditionally we tend to think of confidentiality as pertaining only to the relationship between the therapist and student. As a community-oriented program is developed, other kinds of confidential relationships spring up which may affect attitudes toward confidentiality in the therapist-student relationship. In a previous paper (Brigante, 1967), we have spoken about developing a broad spectrum of trusting relationships in a community program as the basis for the kind of collaboration which must occur if the program is to be successful.

Customarily, confidentiality between therapist and student has been considered the cornerstone of any mental health program if it is to have any meaning at all (Farnworth and Munter, 1961). On campuses where administrators have not understood the need for confidentiality, long and hard struggles have gone on in order to establish the prime importance of confidentiality between therapist and student if any program is to exist. In this kind of situation it is undoubtedly important that the need for confidentiality be firmly established if students are to experience any freedom in talking about their lives to mental health professionals. Students cannot be expected to talk confidentially to people whom they implicitly suspect of reporting details of their lives or behavior to administrative officers of the college. It is well known on various campuses that others in allied roles over a period of

time may come to respect and honor the need for mental health professionals to have this kind of relationship with students. If, however, the establishment of such relationships is accompanied by subtle derogation on the part of mental health professionals toward others who also work with students in that their relationships are not confidential and therefore less important, confidentiality itself may become a symbol of the discrimination which mental health professionals practice toward other student personnel workers.

Confidential relationships of various sorts may exist throughout the campus not only between students and staff but between students and students. It therefore may be regarded as a presumptuous act on the part of the mental health professional to somehow cast his relationship with the student as being "special" in the sense that it is, by definition, more meaningful than the students' relationships with other persons in his life.

However, it may be possible to dispel the special aura associated with a confidential relationship, once confidentiality has come to be accepted as a valuable component in the development of a trusting relationship between the therapist and student or between faculty member and student. Confidentiality is in effect a way of legitimizing the possibility of developing a trusting relationship. In and of itself it does notensure that a trusting relationship will be developed. Many students are quite clear themselves about this distinction when they talk to mental health staff. Issues sometimes arise which require that the mental health staff member ask the student whether he may communicate with a dormitory resident regarding the student's presence at the center,

in order to clarify some aspects of the student's dormitory behavior. Although some students may react negatively to this because they do not wish their coming to the mental health center to be known, many feel no qualms about having others know that they are seeking professional help. Further, it is widely recognized within the society at large that receiving professional help can become a status symbol, and that many people openly brag about the fact that they do receive professional help.

Within the context of community-oriented programs, it is believed that the limits of confidentiality as conventionally defined need to be stretched. For example, where a therapist and dormitory resident need to communicate about a student and a trusting relationship exists between the student and therapist and between therapist and dormitory resident, it is possible for the therapist to ask the student's permission to discuss his situation with the resident in general terms. Another illustration may be given in order to illustrate the point. A student may habitually come in late to the dorm during week nights and is to be brought before the judiciary board in order to have some judgment made about action. In the process the dormitory head resident may become irritated with the student's habitual lateness and may know that because the student himself has indicated it that the student is seeking help at the mental health center. The resident may call the mental health center and ask for information. By providing an explanation to the dormitory resident about the meaning of the student's behavior the mental health staff may make it more likely in this circumstance that wise management of the student's rule breaking behavior will

be undertaken. The dormitory resident may have a sufficiently open mind to at least entertain the explanation being offered by the mental health professional, which might increase understanding and empathy with the student's behavior. This does not mean that explanations are needed in order to help students avoid facing things that they need to face and to avoid having realistic limits when they engage in antisocial behavior. However, it may help others to enlarge their perceptions of the student so he is perceived as something more than a rule breaker. If in such a situation there is no possibility for the mental health staff member to serve as an intermediary between student and dormitory head resident, then an opportunity has been lost to increase understanding.

It has sometimes happened that in our zeal to preserve our rights for confidential relationships with clients we have lost sight of the larger goals of mental health programs. It must constantly be kept in mind that an aura of suspicion and fear often surround the whole matter of seeking professional help for emotional difficulties. The principle of confidentiality, although necessary and important, may at times be seen as a manifestation of the fact that such issues and suspicions are justified. After all, in the long run we are trying to move toward a situation in which people do not feel the need to hide either the fact that they have emotional difficulties or that they are seeking professional help to alleviate these difficulties. It is not being advocated that they make a fetish of their difficulties. However, understanding on the part of others and acceptance of one's emotional difficulties without considering them to be a cause for shame can best be promoted if

we regard the presence of such difficulties as one of the realities of life. Approaches to the definition and implementation of the principle of confidentiality need to be viewed within this broader context. Sometimes the enactment of this general principle can be carried out with such rigidity that broader issues are ignored and, in specific instances, the welfare of individual clients is not served best. Confidentiality is a general principle which needs to be considered in the light of individual situations. It cannot be applied in a cut and dried manner across the board to all situations. If we are to serve the client's welfare best, this issue becomes more focal as we move toward the development of community programs.

USE OF CONSULTATIVE METHODS

If the mental health program is to move toward a more community-oriented approach, consultative methods must increasingly be utilized. Accomplishing this transition within a campus setting may be more complicated than within the context of a community program serving an urban or suburban community. In talking about consultation, I have in mind the four-fold model proposed by Caplan (1962). Without discussing the model in detail, let me just say that two of the methods of consultation involve working with an intermediary (dormitory resident, physician, chaplain, dean) about (a) a student or (b) a program. Two other methods involve working with these same intermediaries about a student or program, but in an effort to resolve issues in the intermediary which block his ability to help the student or to implement the program.

Within the context of the traditional counseling center, the most likely form of consultation initially requested is case-centered consultation. If the co-professional wishes to make a referral to the counseling center, it is difficult for mental health staff to work within the framework of consultee-centered consultation and not accept the referral, but instead to work with the co-professional as an intermediary in assisting the client. A dean or faculty member may view his own professional responsibility as that of providing the student with a referral, rather than talking to the student himself. Any kind of administrative consultation can only occur when the counseling staff are regarded as having the kind of generalized

competence as social scientists which will lead them to be called on. Also, they must be regarded as sufficiently non-threatening so that administrators can seek and accept their help.

Although shifting to consultative methods may make a great deal of sense to mental health professionals, it may make much less sense to others. In a situation where mental health staff are scarce, any proposal that consultation methods be increasingly employed may be regarded as looking for more work when there is already too much to do. The mental health staff may be branded as having an excess of messianic zeal and desire to "save everyone." Where administrators have latent concerns about rising student use of mental health facilities, they may be irritated by proposals for community-oriented programs because such programs seem to add to already overburdened facilities. Also, they may have questions about the real need for this kind of an approach. One catastrophic maneuver in such a situation is to try to ram through the program in the face of these attitudes. Another fatal move is to argue that students as a group are much more emotionally unbalanced than administrators realize. Such an argument may cater to already exaggerated fears that administrators possess about the magnitude of emotional difficulties of students. A far more productive approach is to work toward establishing a clear-cut linkage between the college's aims as an educational enterprise and its mental health program. If the mental health staff can satisfactorily demonstrate that the quality of students and of the institution will be enhanced through fuller collaboration between mental health staff and the rest of the institution, major strides will have been taken.

College administrators are upset when any sizeable proportion of students commit academic suicide or drop out, especially if they are considered to have outstanding potential. Sometimes administrators have the notion that only the poorest students seek professional help from mental health staff. This perception can be counteracted by collecting statistics which reflect the real situation. In fact, the brightest and most sensitive students are seeking help in increasing numbers.

These general considerations imply that timing is an important factor in undertaking consultative programs as part of a total mental health effort. For a period of time, the mental health staff may simply need to demonstrate the usefulness of their efforts and the need for some kind of satisfactory mental health program before the argument for a community-oriented program and widespread use of consultative methods can be made effectively. The issue certainly is not one of availability of opportunities for consultation, especially within the residential campus setting. Dormitory head residents, student sponsors, deans, physicians, clergy, faculty members, admissions personnel, students on tutorial and work projects, might all benefit from consultative efforts. It may seem that it is more feasible to begin consultative efforts with groups who are more comfortable with accepting such help, such as student sponsors. Where administrative support is lacking for such beginnings, even these efforts may boomerang. Working with sponsors may have additional complications. Some sponsors may become so overinvolved as "helpers" that they do more harm than good by being excessively "hovery" in trying to help other students. It is especially easy for them to

live out their conflicts through helping efforts in closed dormitory situations. Working with sponsors in a consultative program immediately raises the issue of sponsor selection and the possibility of involving mental health personnel in choosing sponsors. It is clear that such involvement might eventually raise the efficacy of sponsors' helping efforts in that poor candidates could be more effectively screened out.

For some period of time it may be necessary to simply give effective case consultation whenever it is requested and to work in the area of establishing generalized trust within the campus community so that interchanges may become freer and the possibility can be entertained of broadening the consultation program. In one of our colleges, we have been successful in reaching this point but only after broad student, faculty, and administrative support had been mobilized. In weighing time perspectives about such issues, it might be mentioned that in order to achieve this level of trust, four and a half years were required. Now, an effective consultation program is being undertaken which offers consultation to the dean of students, dormitory head residents, student sponsors, and some faculty members. Periodic case centered consultations are also given to the college president and to the dean of faculty. As Caplan points out, as such program gains momentum, progress is often much more rapid than in the early phases. A "contagion" effect may occur and mental health staff may suddenly find more requests for consultation than they can meet. This is a good kind of problem, however.

INVOLVING STUDENTS IN THE INFLUENCE PROCESS

When the mental health program begins to play a more central role on a college campus and students find the mental health services useful, a buildup of student sentiment in support of the mental health cause may occur. Various manifestations of this buildup of sentiment can be observed. As students begin to grumble because they have to wait in order to be seen for help, they also may surmise that the mental health program is understaffed. Above and beyond their personal needs for help, they may spot the fact that the college itself has a somewhat hypocritical attitude, if it professes to be student oriented and yet neglects the development of services attuned to the personal lives of students as they are intertwined with academic functioning. Students are especially sensitive to manifestations of hypocrisy within adults and within institutic al contexts during the college era. For students who have difficulties with their families, the hypocrisies they confront on the college campus may become especially burning issues to them because they are psychically linked to hypocritical attitudes manifested by their own parents. Some students may join together and form a campus mental health organization. Others may begin to write articles and letters in the student newspaper in which they take pot-shots at the administration. When such students combine articulate expression, accurate statements, and a confronting attitude in getting after administrators through the medium of the student newspaper, they can generate defensiveness along with some productive consequences.

In the course of building their "case" against the administration while serving as allies to the mental health staff, students may wish to involve mental health personnel in making direct statements about administrative policies which buttress their arguments. This places the mental health staff in a difficult position. They may appreciate the students' sympathies, and after a period of frustration with the resistances they have encountered in developing a program, may have their own axes to grind with regard to administrative policy decisions affecting the growth of the mental health program. Offers on the part of students to lend support through a campaign against the administration may be a vehicle for both the students and the mental health staff to act out their hostilities toward the administration. This is certainly a different circumstance than is involved in the therapist's relationship to a patient who, for example, threatens to leave treatment. The therapist may not agree with the patient's decision, but his own welfare and survival as a therapist does not rest upon the degree of support and agreement he has with each individual patient. In contrast, within an institutional context disagreements between mental health staff and the administration can be relatively more threatening to mental health staff and make it subjectively more difficult to chart a course based upon sound and mature judgment. Where both students and mental health staff see themselves as being controlled by institutional forces which they cannot affect, it is easy to become either resigned in attitude or diffusely hostile.

Consideration of this particular circumstance points to the wisdom of mental health staff members not having a one-sided view

of the institution's functioning. From the point of view of administrative arrangements, having access to institutional decision makers becomes centrally important, not simply as a way of affecting decisions, but also to gain further understanding of administrators' viewpoints and role complications. Administrators experience a wide range of pressures and forces which determine their decisions about budgets and priorities. Mental health staff members may not have enough contact with a college president, for example, to understand the forces which determine his attitudes about budgets and priorities. Similar considerations may be involved with regard to relationships between mental health staff and boards of trustees. Here again there may be a lack of mutual understanding of each other's attitudes. Opportunities for contact must be arranged if stereotypes on both sides are to be dispelled. On one side, the college president who sees the mental health program as a necessary evil and whose board members are unsympathetic toward his decision making priorities may be likely to become more defensive when irate students put him on the spot. He may be thinking of the time when there was no mental health program or when it was half the size that it is currently, and may regard mental health staff as somewhat self-righteous, self-pitying, and overdemanding.

WAYS OF GAINING SUPPORT

Several kinds of moves may be in order to take corrective action in such a situation. First, if there is a buildup of tension between mental health staff and college administration, it may be possible to propose that an outside consultant come in to evaluate the situation and make recommendations to the administration about its mental health program. Second, the mental health staff may ask for an advisory board of faculty and administrative personnel to help the mental health center establish policies and implement them. The more faculty members and administrators who become acquainted with mental health center's problems and viewpoints, the more likely it is that there will be reverberations throughout the college community to dispel stereotypes about the mental health program. In the course of such negotiations it may be possible to have either the consultant or the advisory board make a recommendation, if such is not already the case, that the director of the mental health staff report directly to the college president rather than to intermediaries. This will give him an opportunity for expressing his own viewpoint and understanding the college president's viewpoint more clearly. Third, if an outside consultant is effective in his initial contact with the college, it may be possible for him to be retained as a direct consultant to the college president on a periodic basis regarding the development of the center and other campus issues which he wishes to explore with an outsider. If such a consultant is able to provide real help to the college president on administrative and personnel matters, over time this

may enhance the possibility that mental health professionals are perceived in a different way than simply as specialists who work with disturbed students.

Other measures are in order which also may help to dispel stereotypes and to raise the general health level of the community. Mental health staff members need to take the initiative in making arrangements to provide personal therapy for faculty members, administrative personnel, and their families wherever needed. Faculty members and administrators who have been effectively helped by mental health professionals or whose families have been helped are certainly more likely to be sympathetic to the aims of the mental health program. They are also more likely to be able to make effective contributions in working with students. The director of the mental health program will need to take the initiative to ensure either that faculty insurance covers private psychotherapy or that the college consider providing direct services to faculty members and their families on campus. Both patterns are possible and viable.

It is also important that the director of the mental health staff initiate meetings between his staff and other student personnel workers to discuss policy issues and matters of mutual concern. Sometimes joint planning efforts to meet issues arising with students can emerge from such sessions. In recent years on our campuses, for example, we have planned programs to meet the LSD issue and discuss changes in sexual mores. Although the programs themselves have not been overwhelmingly successful thus far, perhaps one of the best things that has come out of the meetings

has been the buildup of trust and confidence stemming from mutual planning efforts by the student personnel workers and mental health staff involved.

HEALTH PROMOTION

In a prior paper (Brigante, 1967, op. cit.) it was indicated that members of the mental health program must not take a one-sided position. Neither must they avoid the realities of major psychopathology where it exists nor should they dwell merely on psychopathology and ignore health. The viewpoints of mental health staff can be warped if they work only with the most disturbed students on the campus. In addition this limits the contribution they are able to make to the campus community. Programs need to be devised which address themselves to broad sectors of the campus community. For example, transition programs from high school to college during the freshman year in the first semester involving use of group methods might be one way in which mental health staff can have contact with a wider range of students. Sometimes mental health staff will be asked to volunteer in self-study projects that members of a college are undertaking. In one such instance, for example, a student-faculty committee was investigating student morale. The director of the mental health staff was called in to help design the study and participate in its execution. As a result he was able to meet with a large group of students in the college who were a cross section of the campus rather than simply students who had come to the center for help. Programs with gifted students are another excellent way in which the mental health center can become involved with a different group of students than might ordinarily be contacted.

In this connection we need to consider the stance to be taken by mental health staff toward reading and study habits courses,

as well as toward conducting vocational counseling with students. If the mental health staff define their roles as providing help to students in coping with the college experience, then they cannot ignore the needs of students to develop adequate coping techniques. Whether or not the mental health service itself may be able to provide all of these services directly, it certainly needs to take steps to ensure that such services are available to the students.

Mental health staff also need to become knowledgeable about dormitory regulations and even about such matters as dormitory construction. Within residential campuses dormitory regulations are certainly an important dimension of students' outlooks about the college as an institution. Mental health staff need to spend a portion of their time participating in discussions about dormitory regulations whenever they are invited to do so. With regard to dormitory and building construction, mental health staff need to become more knowledgeable about the relationship between physical arrangements and social interaction. Mental hospital designers have known for some years that such arrangements are quite important in terms of their effects upon the therapeutic process. Wherever possible, mental health staff may look for ways of sitting in on discussions regarding dormitory construction, or may suggest that outside social science consultants might be uniquely useful in evaluating plans before such buildings are built. Certainly mental health staff cannot expect themselves to be knowledgeable in all of these areas. However, they should understand the ways in which social scientists can make contributions to campus life (Kates and

Wohlwill, 1966) and should make arrangements for administrative decision makers to have appropriate consultation when it can be useful.

In time available for research, some portion of research undertaken should be focused upon broadly ranging issues which are related to the life of the institution itself. Attitudes of students, faculty members, and administrators can be fed back to the administrative decision makers as the basis for policy decisions. Research efforts by mental health staff can be invaluable in providing data to policy makers. Many mental health centers do no research at all, and others focus entirely on research which has no direct relationship to the life of the institution. When staff time is limited and there is a shortage of personnel, it is believed that administrators do have a right to question the use of research time when the questions being studied make no direct or indirect contribution to improving the functioning of the institution itself. In any case it may well be possible to select questions for study which have both basic and applied implications.

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