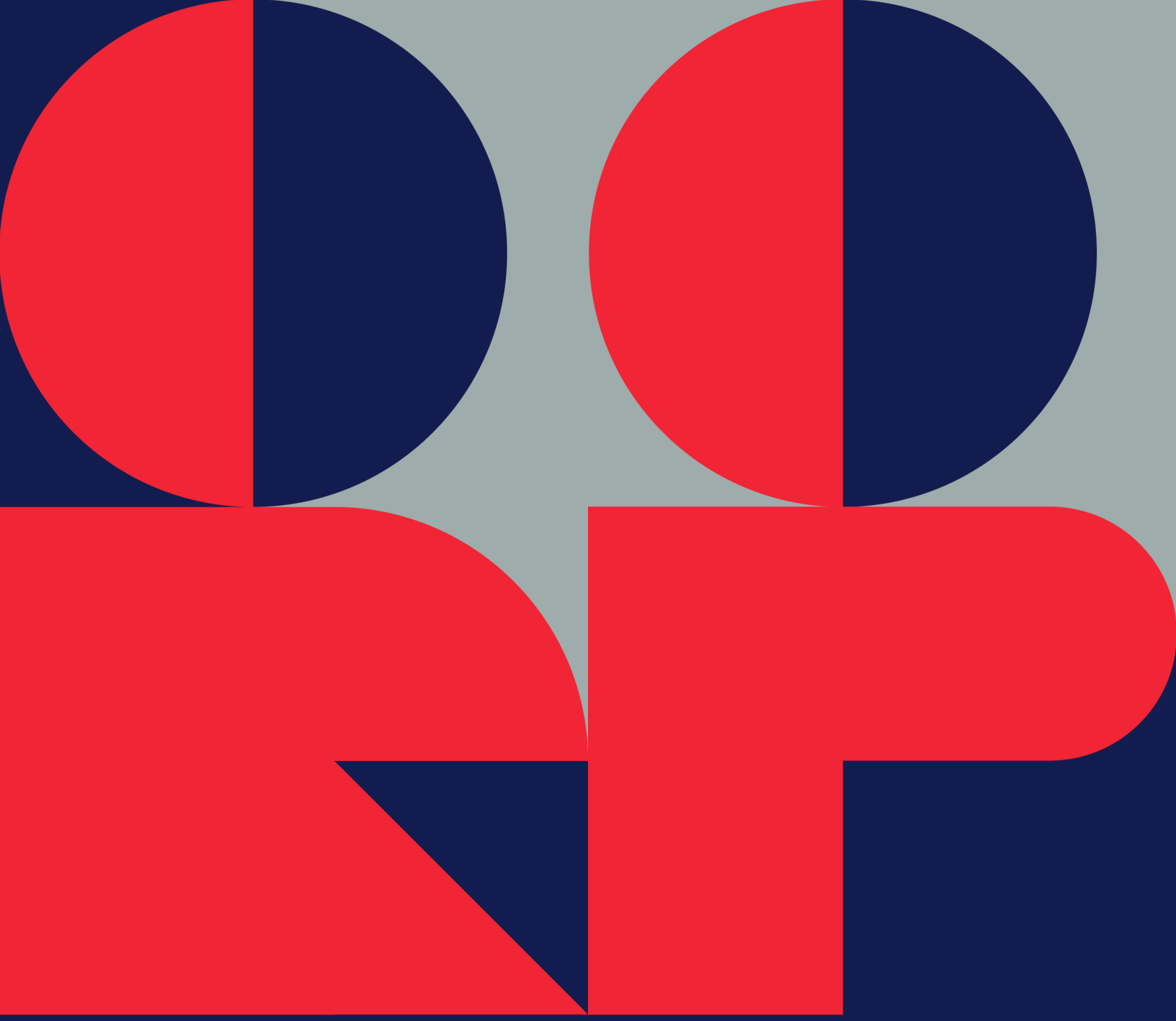

Crisis Co-Responder Program

Development Guide

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Foreword

We are living living in a time of unprecedented challenges and opportunities for higher education. Among the many issues that demand our attention and action, mental health stands out as one of the most pressing and complex. As college and university leaders, we have a moral and ethical obligation to provide optimal care and support for our students, especially those who are struggling with mental health crises.

However, the traditional models of crisis response on college campuses, which often involve law enforcement/public safety as the primary or sole responders, have proven to be limiting in addressing the diverse and evolving needs of our student population. These models can be inefficient, and even harmful, as they may exacerbate the trauma and stigma associated with mental health crises, and potentially escalate situations that could be resolved more peacefully and compassionately.

That is why we have embarked on a journey to reimagine how we can best serve and protect our students in times of distress and emergency. We have adopted the Co-Responder Mobile Crisis Team model, a collaborative approach that pairs trained mental health professionals with law enforcement/public safety officers to respond to mental health crises on campus. This model leverages the expertise and resources of both disciplines, while ensuring that the mental health needs and rights of the students are prioritized and respected.

This manual is the product of our collective efforts to implement this innovative and promising model on our respective campuses. It is based on the experiences and insights from community-based programs such as CAHOOTS in Eugene, Oregon, as well as several institutions of higher education that have successfully adopted this model, such as Johns Hopkins University, University of Rochester, University of Pittsburgh, and University of Texas at Austin.

This manual is intended to serve as a guide and a resource for those who are interested in launching or enhancing their own Co-Responder Mobile Crisis Teams. It covers various aspects of the program development, implementation, assessment, and improvement process, drawing on the lessons learned and best practices from our own journeys. We recognize that each institution will have its own unique context, culture, and challenges, and we encourage you to adapt and modify the information and recommendations in this manual to suit your specific needs and goals.

As you embark on this transformative endeavor, we hope that this manual will be a valuable and reliable companion, providing you with practical and relevant information, as well as inspiration and encouragement. We believe that the Co-Responder Mobile Crisis Team model is not only feasible, but essential for creating a safer, more supportive, and more inclusive campus community for our students. We invite you to join us in this movement, and we look forward to learning from your experiences and insights as well.

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Acknowledgments

The successful launch of these ambitious programs stands as a testament to the expertise, dedication and collaborative spirit of numerous individuals within our respective teams, as well as the invaluable consultation provided by community organizations.

We extend our gratitude to those who consulted with us on this manual, without whom this endeavor would not have been possible.

Johns Hopkins University

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We are privileged to have such dedicated partners in our mission to support and enhance the well-being of our community.

Planning & Development

Thoughtful planning prior to implementation includes paying attention to your unique context and environment in order to gain support from key constituents, identifying program leaders, and developing a robust advisory committee. Other details that need to be considered include funding sources, relationships between clinicians and law enforcement, necessary training for both clinicians and law enforcement, marketing, and sources of consultation. Depending on your particular university, the need for a focus on clinician safety may be paramount. Find a detailed list of items to consider below.

Support of Campus, Local Community, and Campus Administration

I. Gaining support from campus administration and university community

   A. Identify key leaders whose support is necessary for successful implementation. These leaders may include (but are not limited to) students - especially particular organized student groups such as BIPOC student groups, LGBTQIA+ student groups, disability advocacy groups, student government, and mental health focused groups; upper administration including the college/university president; faculty; leaders in the counseling center and in the law enforcement departments of the university; offices supporting marginalized students, and/or any administrators overseeing potential sources of funding.

   B. Depending on the level of interest and support, proposals may benefit from statistics on current campus mental health crisis response, numbers of involuntary hospitalizations, student perception of mental health crisis support, increase of mental health calls on campus that law enforcement are responding to, etc.

   C. Make your program an institutional priority (e.g., Presidential initiative) or part of a strategic plan. This will make a significant difference in the efforts to socialize, promote, and infuse the campus culture with knowledge and support for this effort.

   D. Leverage the support of leadership and students committed to social justice issues.

II. Gaining support from your law enforcement partners
Mental health clinicians and law enforcement officers come to this work from different cultures and with different values and practices - though with a shared goal of keeping students safe. Work closely with law enforcement leadership in the initial planning and in ongoing administration of the program.

III. Gaining support from the local community
When the co-responders are also responding in neighboring communities, and not just on campus, the importance of socialization and attending to the existing town-gown relationship is paramount from the very beginning of planning through implementation and review.

IV. Sharing the advantages of having a collaborative crisis response program
As you develop your proposal, the following list - while not exhaustive - includes many of the advantages we and others have observed and experienced of a collaborative crisis response program:

   A. Dual educational opportunities for both police and mental health clinicians.

   B. Increased perceived and actual support for students on campus (particularly marginalized groups).

   C. Training opportunities for graduate students in mental health fields.

   D. Improved campus and community trust in mental health crisis response.

E. Reducing barriers to accessing care, especially for populations that have been historically underserved.

F. De-escalation of situations involving individuals with mental illness and decreased number of involuntary hospitalizations.

G. Decreased repeat encounters with law enforcement and an increased diversion from the criminal justice system.

H. Reduced use of force and violence.

I. Reduced trauma in law enforcement encounters for people who are having a mental health crisis (particularly those from communities/identities who historically have not had positive relationships with police).

J. Increased collaboration and better relationships with campus law enforcement, local community agencies, and hospitals.

K. Decreased stigma associated with mental illness through educating the campus community.

L. More proactive engagement with the community from counseling services and law enforcement.

M. Increased student satisfaction with available services.

Program Leadership

I. Structuring program leadership

A. Depending on the university's structure, the program leadership might include the Assistant Vice President (AVP) for Student Health, University Counseling Center (UCC) Director, UCC Clinical Director, or a Crisis Coordinator. Additionally, there could be co-leaders such as the head of your law enforcement or student affairs leadership. You need someone who will oversee the logistics of the program and someone who will provide supervision/consultation of the clinicians.

B. In a "co-responder" model, you should consider a jointly led program between your student mental health services and law enforcement. Co-leadership demonstrates this is a true partnership. Also consider who is funding the program and how that can impact implementation of the program.

Advisory Committee

I. Building an advisory committee

A. The purpose of the advisory committee is to shape and support the formation of your crisis response program. Having an advisory committee helps foster community-wide buy-in, provides opportunity for constituents to inform the policies and protocols, and takes advantage of the vast expertise across the university. Feedback obtained during regular meetings helps inform decisions around hiring, programmatic processes, and design throughout each phase of project development. This includes developing assessment and evaluations tools.

B. What to consider when selecting members of an advisory committee:

1. Faculty – faculty who have experience in mental health and crisis response.
   a. Departments to consider are Public Health, Nursing, Medicine, Psychology, and Social Work.
2. Students – representation from various student groups who have historically been under-represented or not served well in mental health services (i.e., students with disabilities, LGBTQ students, students of color, international students, etc.).
3. Staff – key stakeholder offices such as identity and multicultural based offices, campus law enforcement, risk management/emergency services, counseling center, care and resource support, and residential life.
   a. Employee Assistance Program Representative or HR – if your team responds to faculty and staff community members who are in crisis.
4. Community organizations – local city crisis intervention teams, organizations that promote mental health advocacy for the homeless, LGBTQ communities, etc.
   a. Local police – crisis response and ability to do emergency petitions.

Funding

I. Securing funding is something that many will have to grapple with. For some universities, this will not be an issue and financial support will be abundant. For others, support of the idea/concept may be there but the funding less so. Some options include:

   A. Counseling center budgets and/or students affairs budgets.

   B. Campus law enforcement budgets.

   C. Relevant federal or state grants.

   D. Development/advancement/alumni offices may be able to identify potential donors.

   E. Funding from multiple offices. For example, one program utilizing graduate students draws funds from law enforcement (stipends and meal plans), Residential Life (housing) and the counseling center (administrative and clinical oversight).

II. Starting with a pilot program gives time to demonstrate that the program will be successful. A short-term, smaller financial commitment is less overwhelming than the thought of committing recurring money for a new program. Consider staffing the program less than 24/7, e.g., limited hours based on data showing higher call volume, or only on weekends to start.

Scope of Practice

I. Is your focus only on students? What about faculty/staff or community members who are on the university campus or surrounding area?

   A. Most programs to date are focused mainly on students. However some programs do respond to anyone in crisis within their designated area. In these cases you need to work out a “warm hand-off” of care for faculty/staff and community members.

B. If you only respond to students, how will they be identified in a crisis so as not to profile "who looks like a student" and "who looks like a community member?"

C. Many institutions have summer programs which enroll a large number of minors. Processes and contingency plans need to be put in place for how the team will interface (or not) with these programs.

II. What is your geographic scope?

A. University residence halls only.

B. University property.

C. Campus law enforcement may patrol areas that could include public and private property outside of the university campus proper.

D. Some programs do respond to private apartment buildings and residents where their students reside. If you choose to do so, it is advisable to have a standing agreement with those properties.

III. Scope of care

A. After initial triage and response, does the team do any follow-up case management? When and how are cases referred if there is need for more follow-up after the situation is stabilized?

B. Hours of operation - will your program be 24/7?

C. Most programs have looked at peak after hour times but do not provide 24-hour in-person coverage.

D. Will clinicians be on site the entire time or are there certain hours that they are "on-call" and able to respond to campus within X time-frame?

Relationships with First Responders

I. Collaborating with law enforcement to ensure success

A. Do you have a campus police department, public safety or both? If you have your own police department, you should review your process for involuntary hospitalizations. If you have public safety and don't have your own police department you may need to depend on local guidelines to manage involuntary hospitalizations. Some public safety departments are sworn peace officers and are able to manage involuntary hospitalizations. Working out roles and responsibilities when doing an involuntary hospitalization will help ensure a smoother process during a very difficult situation.

B. You also need to consider where your clinicians will "sit" while on duty. Are they embedded in your campus policy/security department, so they are dispatched in real time with security/police? Do they sit in another location, e.g., your counseling center?

C. If the team is dispatched through security, develop training and criteria for dispatchers for when the clinicians are "dispatched."

II. Developing relationships with first responders

A. The relationship between mental health providers and law enforcement is key to program success; failure to develop good relationships at the outset could jeopardize the program. As the relationship develops, trust is formed and that is especially important during crisis situations when adrenaline and anxiety are running high.

B. Relationships and trust building can be accomplished in a variety of different ways: ride-alongs, joint orientation and training (including Crisis Intervention Training and/or Citizens Police Academy if available), daily debriefings and check-ins, and team building activities.

C. Cultural differences

1. Respecting differences in perspective and values between clinicians and law enforcement is important to build strong relationships. They have different cultures, languages, and priorities. The more time spent together as you start the program, the better. For example, while both emphasize safety in crisis situations, clinicians may focus more on client autonomy while officers may focus more on managing the physical safety of the situation. Without attention to these different perspectives, distrust, misunderstandings, and tension can develop.

Training & Education

Included in the appendices are orientation and training schedules and on-boarding checklists.

I. Training/education of campus responders

A. Training may be provided by the counseling center clinical services team, law enforcement and/or community-based organizations. Building relationships between law enforcement and clinicians should be considered throughout the training experiences, recognizing the significant importance of building rapport and alliance. Several key areas should be considered in the training of the team members, building upon their previous experience and training. These may include:

1. Risk assessment and safety planning.
2. De-escalation techniques.
3. Responding to sexual assault.
4. Symptom management and reduction.
5. Culturally responsive care.
6. Specific contextual and cultural factors to the university should be considered that may influence clinical presentation, interaction with mental health providers and interaction with law enforcement.
7. Trauma informed approaches to crisis work.
8. Law enforcement culture, including time shadowing the university police on regular shifts.
9. Campus resources, e.g., advising, accessibility resources, care teams, wellness resources, religious/spiritual resources, academic reports, and basic needs.
10. Community resources for mental health and sexual assault.

11. First Aid and CPR training.
12. Specific university-based policies and procedures.
13. Confidentiality and privacy.
14. Release of information practices.
15. Crisis notification guidelines.
16. Orientation to local hospital emergency departments.
17. Documentation guidelines.
18. Mandated reporting guidelines within the university and jurisdiction.
19. Voluntary vs involuntary hospitalizations.

Consultation

I. Utilizing consultation (both legal and clinical)

A. In the development stages there are a number of key agencies and organizations to consider consulting with depending on the scope and format of your program.

1. External Consultation

a. Clear understanding and agreements between your local city/county police department and your campus police and security department is critical. It will be important for your city/county police department to know the goals and scope of your program as well as have a clear understanding of roles if involuntary hospitalization is needed.

b. Informing local community leaders such as neighborhood association and elected officials will be key if your team responds to situations around your campus not owned by the university.

c. Many cities have launched community behavioral crisis units that are part of the local police department or are separate entities. These organizations may be great partners when developing training programs for your clinicians and campus policy/security. Also if your team is responding to behavioral health crises surrounding your campus but not on your campus proper, it is also important to establish jurisdiction. Some of the campus behavioral teams also respond to community members (non-affiliates) who are on campus or in the surrounding area therefore having a process for hand-off of care and resources is critical.

2. Internal Consultation of Stakeholders

a. An internal consulting team is also crucial as you work out your internal protocols and procedures such as General Counsel and Risk Management. For more complex cases you will need to consider how the team interfaces with other campus departments such as care teams, threat assessment teams, and how the team fits within university emergency response protocols.

Clinician Safety

I. Policies and practices to protect the safety of responding clinicians

A. There are several policies that you should consider when developing your program depending on the context of your university including:

1. Ensuring that law enforcement secure the scene prior to clinician engaging with the student.
2. Only respond to a crisis when there is no known weapon on the scene and no threats of violence. Maintain communication with law enforcement to ensure the scene is secure before engaging in clinical intervention.
3. Working with a student under the influence of drugs and/or alcohol should be considered thoughtfully - oftentimes an assessment and safety plan is not possible and medical treatment is necessary.
4. Some programs stipulate that clinicians should always co-respond with law enforcement to ensure safety; other programs allow for dispatch without law enforcement when certain criteria are met (e.g., no weapons present, no threats or acts of violence to others, no obvious intoxication).
5. Consider bullet proof vests for responding clinicians.

II. Uniforms for responding clinicians.

A. Having clothing that identifies the clinicians is important to both distinguish them from law enforcement and also provide an element of official status to their presence. Consider the cultural context and physical climate of your university in making selections. Some programs have found that outerwear and polo shirts are easily made into casual uniforms with the logo of the program. If concerns of privacy or HIPAA violations emerge, consider plain clothes for clinicians.

Marketing

I. Marketing to the campus community

A. There are several marketing strategies you can use to market the program to the campus community including: social media, word of mouth, campus email newsletters, orientation events, campus wide notifications, student newspaper articles, incorporating it into RA and student leader trainings, community-based journalists, general campus and community outreach, and publishing it on your website.

II. Responsibility for marketing efforts

A. Something else to consider is who will be responsible for marketing the program. Your university may have a central communications department and/or marketing department that would assist with marketing. It is important to have discussions with them during the early stages of program development to ensure they can assist with program implementation when ready.

Implementation

Now you're ready to implement your thoughtfully planned out program! Determining who will be your clinical staff and what hours they will be available is an important first step. Logistics such as dispatching, documentation, confidentiality guidelines and follow up/case management are all discussed in the following section. The Appendices include useful resources such as position descriptions.

Staffing Needs

I. Program staff

A. How many staff you need to successfully implement and sustain the program can vary. Some can run a program with one staff member and others with a team of 10.

B. The more staff you have, the more coverage you can provide. If your goal is to cover 4 days a week, 9 hours per day, then you might only need one full time mental health provider. If you want to cover shifts 24/7, then you need at least eight.

C. As you plan staffing, be sure to account for vacation, sick leave and holidays when planning for coverage. Can your staffing plan be successful if a clinician needs to be out for a length of time?

D. If you are only funded for one counselor and want 4, then let the data tell your story.

E. Consider the impact of adding a co-responder program on law enforcement staffing in consultation with your law enforcement partners.

II. Hours/shifts

A. When determining the coverage, consider the needs of your university, the scope of your practice, when crises happen and need to be addressed, and what staffing/funding will allow you to provide. Models include:

1. 24-hour coverage.
2. After hours model: Clinicians respond only when the counseling center is closed.
3. Daytime only coverage.

B. Clinician responsibility during the shifts may vary widely. Clinicians may carry a phone and respond as needed, they may be embedded with law enforcement for the entirety of their shift, or they may be assigned to the counseling center when not on calls.

C. Other duties may need to be assigned that both make use of their skill sets and allow them to be available to respond immediately to crises.

III. Recruitment challenges

Counseling centers across the country are already challenged to find sufficient qualified staff. Additionally, recruiting staff from diverse identity groups who are interested in crisis work and/or shift work for 24/7 programs can be an additional challenge. Some possible solutions include:

A. Recognize and advertise the unique nature of this position, e.g., the opportunity to engage in social justice focused work, to work out in the community rather than in an office, to focus on crisis work entirely.

B. Utilize a training model and hire graduate students (though this presents its own challenges in sufficient shift coverage due to class schedules and the need for hiring and training new clinicians every year).

C. Identify alternative advertising outlets from traditional counseling center sites.

D. Incentivize with other benefits, e.g., supervision for advanced licensure.

E. Pay clinicians at a higher rate because of the shift work or provide "incentive pay" (i.e., up to 10% more than other counseling center clinicians).

Responsibilities and Qualifications

I. Responsibilities/expectations of responding clinicians

A. Typical responsibilities include risk/safety assessment, de-escalation/containment, care/safety planning until the person can receive follow-up, linkage/referral to resources, and emergency petitions. Some teams also do consultation, training and community outreach.

B. Additional considerations:

1. Will clinicians accompany students to the hospital? Will they stay with them until admitted or released?
2. What level of follow-up care and case management will they perform and when is there a warm hand-off to other services?
3. Will your clinicians also work with students who present to the counseling center in crisis during regular business hours?
4. Will your clinicians offer consultation to other staff who are managing students in crisis?

II. Qualifications/credentials of responding clinicians

A. Responding clinicians may be licensed mental health providers at the master's or doctoral level, unlicensed clinicians, or clinicians in training working under the supervision of licensed providers. The decision among a licensed staff, unlicensed staff, or trainee model may be based on a number of factors including:

1. Do you have sufficient funding for licensed staff?
2. Have you had hiring challenges finding qualified licensed staff?
3. Do your licensure laws allow for university based mental health crisis responders to be unlicensed?
4. Do you have access to training programs in mental health?
5. Do you have licensed clinical staff (or can you hire licensed staff) willing and qualified to provide supervision to trainee clinicians?
6. Do you have an infrastructure for providing training and support for trainee clinicians?
7. How will students respond to trainee clinicians? How will your law enforcement partner?
8. How can you 'professionalize' trainee clinicians while also not misrepresenting them?

B. Hiring clinicians who represent a range of identities helps further lower the barriers to accessing care.

Dispatch Process

I. Dispatching responding clinicians

A. Most programs have their calls go through the security/campus police dispatch since they are already staffed for this function. Some campuses are tied into their local 911.

B. Calling law enforcement is a potential barrier for some people to reach out for help, so some campuses have created their own crisis access-line. In some cases that line is picked-up and triaged by their existing third-party vendor that is in use for after-hour service. Others have their on-call crisis clinician answering the line with a back-up back to security dispatch.

C. Some campuses have the Residential Life on-call and counseling center on-call staff trained to dispatch responding clinicians.

II. Workflow from dispatch to contact with the student in crisis

A. University law enforcement dispatch is the most common method of contact for corresponding teams. Generally, the minimum information obtained includes the nature of the crisis, name, location, and date of birth.

B. If the clinician is not already with law enforcement, they are typically picked up on the way to the scene. Clinicians can also respond in their own or program vehicles. At times, an officer may reach the scene first, and evaluate safety of the scene but ideally wait to intervene until the clinician arrives.

C. Some models that allow clinicians to respond in person without law enforcement also utilize other deployment methods in addition to university law enforcement dispatch. If the call comes through the counseling center, residential life or directly from community members, the same information as above is obtained. In addition, questions regarding the safety of the scene may be asked, e.g., “Is there a need for medical intervention?”, “Are there weapons involved?”, “Has the individual threatened violence to others?”, “Is there obvious intoxication?” Based on the responses to these questions, law enforcement may be called to accompany.

Documentation

Note: Examples of documentation forms can be found with the Appendices

I. Documenting deployments

A. Documentation of deployments is most often completed separately by law enforcement and clinicians within their usual systems. Depending on the electronic health record (EHR), counseling centers may need to determine how they will document information on students who are not active clients. Some programs have a separate tracking document for data collection purposes.

II. Managing students who are not clients

A. Documenting students who are not clients can be done similarly depending on your EHR by using a non-client note (if applicable).

III. Documentation of response to non-affiliates

A. Thought needs to be given to how to document responses to non-university members. Most schools make a non-client note in their EHR. Others keep the documentation separate.

Confidentiality

I. Managing issues of confidentiality with campus staff/faculty

A. Your campus law enforcement and counseling center likely have different policies around sharing of information regarding student contact with other campus partners. Depending on the documentation and reporting structure, it is best to clarify who will share what with whom from the start. Many universities have an expectation that campus law enforcement will share information with other student affairs offices but that counseling will not. Law enforcement may learn of confidential clinical information during a call, but in order to protect a student's confidentiality and sense of safety, documentation of details should be limited. Releases of information should be secured as needed for post-crisis communication. Ideally, clinicians are the primary contact as needed for any hospital communication in the event of an emergency room or inpatient stay.

Case Management

I. This type of work can provide further access to students who would possibly never seek mental health services in a traditional way due to stigma and barriers to care. Case management is a crucial bridge to that care.

A. A number of campus teams provide next day initial follow-up/case management. Working through a warm hand-off to case managers within the counseling center or in other departments, to other clinicians within-in the counseling center, or to community resources is key especially if a safety plan has been put in place. It's important to be mindful of delays in follow-up due to schedules/shifts of clinicians.

B. Releases of information and/or consent forms that include information sharing guidelines need to be developed to use when clinical information needs to be shared outside of the counseling center.

C. Similarly, agreements should be made on what case information is entered into your case management system if case managers outside of the counseling center have access.

D. Potential follow-up/case management, considering timeliness of case management follow up because of shift-work impacting call back times.

Other Important Considerations

I. Have a plan for interpretation services when working with students who may demonstrate a language barrier.

Program Review and Evaluation

Proposals to create and implement a co-responder crisis response program and to justify its continued existence can rely heavily on program evaluation data. Reviewing the outcomes of your program is essential for ongoing quality improvement, securing continued and additional funding, and to ensure you are meeting your goals. The Appendices include some specific data collection measures.

Program Evaluation

I. Evaluating program utilization and effectiveness

A. Tracking utilization data and administering satisfaction surveys are a few ways to demonstrate that the program is reaching its goals and/or determining which way it may need to pivot. Here are some different methods that you can utilize for program evaluation:

1. Baseline Data: documenting the response to mental health-related calls, including reason(s) for calls, demographics, frequency of encounters, type of intervention, clinical disposition, and outcome. This baseline data will be used as a comparison point to assess progress.
2. Database: utilizing a centralized database to house data collected by law enforcement and mental health providers. Such a database would ensure collaboration among the units responsible for supporting the members that it is intended to serve.
3. Interventions: tracking interventions used with students experiencing emotional distress or mental health crises. Data will be entered during, and/or immediately following responses as clinically indicated and appropriate.
4. Post-intervention review: an evaluation of response during team debriefing sessions occurring after each intervention. Data entry fields could include perceptions of response appropriateness, intervention effectiveness, potential areas for improvement, and an open-ended field for notes.
5. Case Management: tracking follow-up contacts and case management efforts.
6. Communication and Reporting Results: data visualization dashboards and quarterly reports to stakeholders.

II. Evaluation measures

A. There are a variety of ways to measure the success of your program. Feedback gathering can include websites, secure messaging within electronic health records, Qualtrics surveys, and phone numbers. Below are a few to consider:

1. Internal tracking tools - this can be as simple as an Excel spreadsheet documenting important information from each of the co-responses. Examples of what you can track include:
   a. Number of hospitalizations pre and post program implementation.
   b. Voluntary vs involuntary hospitalizations pre and post implementation.
   c. Demographics of students accessing crisis care pre and post program implementation.

d. Pre and post survey measures on target variables (e.g., perceptions of mental health crisis support on campus, perception of campus law enforcement, law enforcement sense of being supported when responding to mental health crises).

e. Client satisfaction surveys post interventions. Sending out well timed surveys is important - wait too long and clients are less likely to respond, send it too early and they may still be in crisis/in the hospital and unable to respond.

III. Research

A. Co-response programs are underrepresented in the literature. Your co-response program can be used to contribute to research by developing best practices for a co-response program or developing response models for dual crisis response interventions.

Appendices

NOTE: Assigning percentages for each major category depending on the structure of the position is optional

Mobile Crisis Response

- Creates a warm and welcoming clinical environment where clients feel supported and respected during times of crisis and as they pursue their personal, academic, and professional goals.
- Provides on-site, in-person, rapid response to students, staff, faculty, and neighbors who present with behavioral health concerns and/or crisis (this may vary depending on scope of your team).
- Conducts in-depth mental health assessments, determines the level of risk to the individual and/or others, noting contributing environmental, medical, psychiatric, and/or interpersonal factors.
- Works closely with Public Safety/Police in the field to intervene in response to calls received through security/police dispatch or other points of access, e.g., special access line, residential life on-call, etc. As needed, consults Security/Police lead, clinical team leaders, and colleagues to determine appropriate intervention(s).
- Provides referrals to appropriate internal resources for faculty and staff, and community resources to non-affiliates.
- Arranges transportation from campus security or local law enforcement partners to emergency and crisis facilities, when appropriate.
- In consultation with supervisor or lead clinician, issues emergency petitions when a higher level of care is clinically indicated, and the individual in crisis is unwilling to enter a higher level of care on a voluntary basis.
- Accompanies clients in need of hospitalization to the emergency room or community facility, provides collateral information to hospital/facility staff, and confirms disposition of case.
- Provides or secures emotional and resource support for bystanders and others impacted by critical incidents, including family, roommates, friends, other first responders, and the community at large.
- Communicates and collaborates with student health and other campus resources to facilitate continuity of care for students and learners in crisis.
- Participates in on-call schedules and overnight mobile crisis response (will vary depending on your structure).

Case Management and Clinical Activities

- Provides ongoing case management and follow-up to clients to facilitate stabilization and transition to counseling, psychiatry, or other appropriate university and/or community resources.
- Consults and collaborates with campus partners including case management and support, student affairs staff, and other relevant resources.
- Provides clinical assessment of learners and recommendations to relevant student affairs offices in accordance with university policies for leave of absences.
- With supplementary training, provides assessment and consultation as part of the Student Threat Assessment Team process.

Collaborative and Other Activities

- Participates in ride alongs with campus safety/police to develop relationships with officers and community members, and to maintain knowledge of service areas.
- Maintains collaborative relationships with campus police officers and participates in joint trainings, meetings, and team-building activities.
- Participates in multi-disciplinary clinical and administrative teams, including case consultation, peer chart reviews, committees.
- Remains abreast of current literature and research on community and student behavioral health and evidenced-based intervention strategies.
- Facilitates outreach and educational activities including resource fairs, community meetings, and training to university faculty, staff and students.
- Contributes to professional development of Student Health and Wellness staff through provision of didactic training, consultation, and seminars.
- Other duties as assigned.

Education Requirements:

- Minimum of a master's degree in counseling, psychology or social work from an accredited institution.
- Must be licensed as a mental health provider in X State or license-eligible (licensed as a mental health provider in another state, licensed in X State within 6-months). Independent licensure strongly preferred (LCSW-C or LCPC).

Experience Requirements:

- Minimum two years' clinical experience delivering mental healthcare in a setting in which both trauma-informed care and crisis assessment were required.
- Demonstrated knowledge and experience in behavioral health crisis intervention services, including assessment, stabilization skills, and related case management responsibilities including accessing additional resources within an institution or community.
- Training and experience working with individuals from traditionally underserved identities – including but not limited to "first generation", disabilities, LGBTQIA+, BIPOC, Latinx, and international learner populations.

Special Knowledge, Skills, or Abilities:

- Demonstrated commitment to providing culturally responsive care in clinical work and professional activities.
- Experience in a university/higher education setting preferred.
- Language skills in X (depends on your community) preferred.
- Excellent interpersonal, listening, verbal and written communication skills.
- Demonstrated ability to work collaboratively with teammates, campus partners and community groups.
- Proven ability to relate effectively to a wide variety of people of various ages and backgrounds, student developmental needs, nationality, culture, faith/religion, language difference, ability differences, sexual orientation, gender identity or

expression.

- Understanding and appreciation of local communities and culture.
- Knowledge of DSM-V diagnosis and familiarity with full range of treatment options and mental health service delivery systems.
- Familiarity with research on mental health needs of college students, including suicide prevention and trauma informed care.
- Knowledge of local-area community mental health resources.

Graduate Assistants/Counselor in Residence (CIR)

- Job duties and functions may be similar to the full time clinicians as listed above.

  Required qualifications:

  › Current graduate student in good standing.

  › Demonstrated understanding of crisis management, mental health and wellness.

  › Experience working with communities who have experienced forms of oppression, e.g., people of color, LGBTQ+ communities, low-income, religious minorities, people with disabilities, etc.

  › Ability to respond to the complex nature of student mental health needs in a timely manner.

  › Availability for evening and overnight shift and weekend work; occasional daytime hours will be needed for training, department meetings, and weekly meetings with supervisory staff.

  Preferred qualifications:

  › Master's degree in a mental health related field.

  › Experience working in higher education and/or with college students around crisis, mental health and wellness.

  › Experience in helping college students exhibit help-seeking behaviors, and disseminating knowledge of campus mental health resources.

  › Experience working with people in crisis (e.g., suicide hotline, peer counselors).

  › Experience working with sexual assault survivors.

  › Experience with case management.

  › Experience working with law enforcement agencies.

  › Familiarity with civil rights laws including Title IX, federal and state laws and policies.

- Program purpose, goals, and distinctions from traditional counseling services.
- Working in higher education.
- Specific crisis intervention skills, emphasizing de-escalation and effective risk management.
- Communication strategies and conflict resolution for high-stress situations.
- Cultural/identity factors and trauma-informed considerations to mental health crisis response.
- Campus familiarity including residence halls, key buildings, and navigation logistics.
- Safety measures and equipment proficiency.
- Student privacy considerations in relation to safety/risk concerns.
- State-specific mental health commitment laws and duty to warn.
- Public Safety or Police Department orientation, structure, and dispatch process.
- Collaborative training for relationship building between clinicians and law enforcement.
- Procedural steps in co-response calls with officers.
- Welfare check components and essential information gathering.
- Criteria for escalating a call or consulting a clinical supervisor.
- Knowledge of external community resources and services.
- Voluntary transportation criteria and meeting unique ability needs.
- Documentation unique to co-response calls.
- Referrals and care coordination with internal and external programs and services.
- Postvention survey distribution and data collection methods.

- Date of intervention
- Call dispatch, arrival, and end times
- Police or other identifying report number
- Caller information
  - Name, relationship to person of concern, phone number
- Person of concerns demographics
  - Name, pronouns, date of birth, student ID number or social security number (if applicable), phone number, address
- Location of the person of concern
  - Residence hall, apartment, off campus, community location, etc.
- Other first responders on site
  - Fire Department, Emergency Medical Services, SWAT, etc.
- Summary of the presenting crisis/reason for co-response
- Safety assessment details for person of concern
  - Self-harm, suicide risk, homicide risk, psychosis
  - Other risk factors
    - Access to weapons, substance abuse, recent attempts
  - Supportive/protective factors
  - Safety plan (if indicated)
- Cultural considerations
- Mental status examination
  - Indicate if unable to participate due to acute psychosis or intoxication
- Crisis interventions
  - De-escalation, rapport building, supportive listening, psychoeducation, etc.
- Disposition including recommendations, referrals, or transports
  - Return to the community, crisis walk-in center, emergency room
  - Transported by police, paramedics, or crisis clinicians
- Identify if a release of information was completed for care coordination
- Any planned communication with person of concern after the initial crisis call
  - Scheduled phone check-in, counseling appointment, hospital discharge summary of recommendations

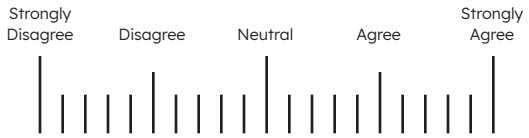
Self-Reported Demographics

1. What year are you in school?
    - First Year Undergraduate
    - Second Year Undergraduate
    - Third Year Undergraduate
    - Fourth Year Undergraduate
    - Fifth Year/Plus Undergraduate
    - Graduate Student
    - Doctoral Student
    - Prefer not to disclose
2. Which of the following best describes your gender identity? (You may select multiple answers)
    - Female
    - Male
    - Non-Binary
    - Genderfluid
    - Genderqueer
    - Two-spirit
    - Prefer not to disclose
    - I do not identify with any above
3. Which of the following best describes your racial/ethnic background? (You may select multiple answers)
    - Asian
    - American Indian or Alaskan Native
    - Black or African American
    - Hispanic or Latino
    - Native Hawaiian or Other Pacific Islander
    - White
    - A race/ethnicity not listed here
    - Race/Ethnicity Unknown
    - Prefer not to disclose
4. Do you identify as part of the LGBTQIA+ community?
    - Yes
    - No
    - Prefer not to disclose
5. Do you reside in on-campus student housing?
    - Yes
    - No
    - Prefer not to disclose

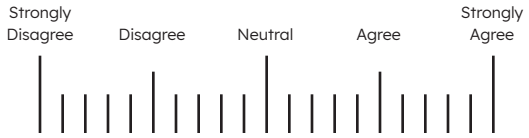
Self-Reported Satisfaction and Experience

Likert Scale Scoring

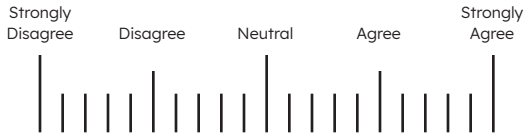
[Program Name] clinicians worked to ensure my safety during our interaction(s).



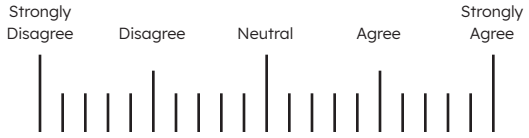
[Program Name] clinicians treated me with respect during our interaction(s).



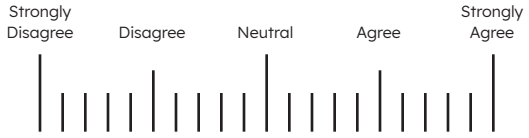
[Program Name] co-responding with **[Police Department Name]** is a beneficial service for members of the **[Name of Area or School]** community.



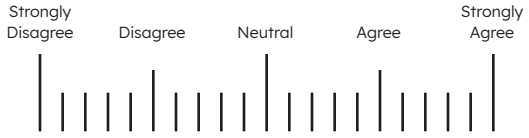
I felt safe during my interaction(s) with **[Police Department Name]** officers.



[Police Department Name] officers treated me with respect during our interaction(s).



How comfortable would you be re-engaging with **[Police Department Name]** in the future?



Additional Feedback

How would you classify your feedback? (choose all that apply)

- Compliment
- Complaint
- Suggestion

Please share any feedback regarding your experience(s) in the space provided below:

Do you grant permission for [Program Name] to use your anonymous feedback in program evaluation measures and data reports? This is entirely optional, and personal information will be de-identified. **Yes** **No**

This survey is anonymous; however, you may request to be contacted for a follow-up discussion about your experience. Would you like to be contacted? **Yes** **No**

You indicated that you would like to be contacted regarding your experience. Please provide us with your contact information in the space provided below: