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An Integrated Approach to Mental Health Support for International Graduate Students: A Curriculum for Student Affairs Professionals

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An abstract of
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Abstract

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By Deborah Adenikinju

Background: International students constitute about 14% of the U.S graduate school enrollment. Research shows that in addition to typical stressors associated with college life, this student population faces stressors unique to their immigration and educational status. The culmination of different stressors can have an adverse impact on international students' mental health. Despite the increased stress and risk of mental health issues, international students are reported to have the lowest utilization rate of campus counseling services.

Purpose: The purpose of this special studies project is to create a three-part mental health curriculum for student affairs professionals to improve the provision of culturally appropriate mental health & wellbeing services for international students at the Rollins School of Public Health

Methods: A thorough review of literature on current approaches to mental health on college campuses and theories that better account for the unique experiences of international students was conducted. This review informed the selection of the Gatekeeper Training (GKT) model as the principal intervention strategy of the curriculum. The three parts of the curriculum are mental health awareness, cultural humility and compassion, and resource awareness. Didactic lectures, group discussions, and case studies will be the delivery techniques.

Discussion: This project addresses the gaps in literature on addressing international students' mental health, particularly those in graduate school. Additionally, this curriculum explores the role of compassion as a pathway for addressing reluctance and behavior maintenance in gatekeepers.

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CHAPTER 1: INTRODUCTION

Significance of the Health Problem

Mental health continues to be one of the most neglected areas of health despite the steady increase in the prevalence rates of mental health conditions globally (World Health Organization et al., 2020). The World Health Organization (WHO) defines mental health as "an integral and essential component of health" and "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively, and fruitfully, and is able to make a contribution to his or her community" (World Health Organization, 2018, paras. 1-2). Data shows a 38% increase in global burden and a 2.1% increase in total disability-adjusted life-years (DALYs) of mental health disorders and substance abuse between 1990 and 2010 (Atkinson et al., 2013). Although time trends between 1990 and 2016 show a continuous decrease in age-standardized rates of DALYs and deaths of all diseases (30.4% to 16.3%), there is an opposite trend in these rates for mental and addictive disorders (9.3% to 12.0%) (Rehm & Shield, 2019).

As stated by WHO (2018), "there is no health without mental health" (2018, "Key Facts" section). Indeed, mental health conditions can affect all aspects of life and are significant causes of illness and disability across the lifespan (World Health Organization, 2018). Mental disorders have varying causes and degrees of severity, ranging from mild, moderate, to severe impairment in the thought, behavior, and functioning of an individual (CDC | National Center for Health Statistics, 2022). In 2020, approximately one billion people were living with a mental health disorder, and it was estimated that every 40 seconds, a person dies by suicide (World Health Organization et al., 2020). Despite the impact and growing prevalence of mental health disorders, relatively few in need of mental health care have access to quality mental health

services globally (Wainberg et al., 2017; World Health Organization et al., 2020). As cited by Wainberg et al. (2017), some factors contributing to the current treatment gap include fragmented service delivery models, human resource shortages, stigma, and lack of research capacity for implementation and policy change.

Mental Health in the United States

According to the National Institute of Mental Health (NIMH), more than 50% of the United States (U.S) population will be diagnosed with a mental disorder in their lifetime, and one in five people will experience mental illness each year (52.9 million in 2020) (National Institute of Mental Health, 2022). Despite spending about 17.6%, (approx. US$2.5 trillion) of its gross domestic product on health (5% on mental health), the U.S. continues to rank low for mental health outcomes compared to other developed and many developing nations (Atkinson et al., 2013). Data from the 2018 National Ambulatory Medical Care Survey showed mental health as the primary diagnosis for 55.7 million physician office visits, and mental disorders, behavioral and neurodevelopmental as the primary diagnosis for 4.9 million emergency department visits (CDC | National Center for Health Statistics, 2022). Additional statistics on the leading causes of death in 2019 showed that suicide was the 10th leading cause of death in the U.S, 4th leading cause of death for individuals 35- 44 years of age, and the 2nd leading cause of death for individuals 10 – 34 years of age (CDC | National Center for Health Statistics, 2022).

Mental Health Among Graduate Students in the United States

Surveys assessing mental health at colleges and universities across the U.S indicate an increasing prevalence of student mental health needs (Wesley, 2019). The 2015 Annual Report from the Center for Collegiate Mental Health (2016) with contributing data from 139 college and university counseling centers, 100,736 mental health treatments, 770,000 appointments, and

2,770 clinicians showed an average increase of 30-40% of student visits to counseling centers from 2009 to 2015. Depression and anxiety were the two most common reasons for counseling visits (Wesley, 2019). The American College Health Association Annual National College Health Assessment (ACHA-NCHA) provides the most extensive and comprehensive data set on a vast spectrum of student health in the US (American College Health Association, 2018). Data from the ACHA-NCHA II Fall 2017 Reference Group consisting of 52 postsecondary institutions showed that approximately 60% of respondents reported "overwhelming anxiety" and about 40% reported depression affecting functioning over the past 12 months (2018, p. 14). Furthermore, research shows suicide as the second leading cause of death for students on U.S. college campuses. The data also reveals that 50% of undergraduates have contemplated suicide, and about 8% have attempted suicide each year (Servaty-Seib et al., 2016).

Over the years, there has been a growing outcry from students and organizations such as the Council for Graduate Studies (CGS) and The Jed Foundation (JED) for attention to the mental health condition of graduate students in the U.S (Evans et al., 2018; Forrester, 2021; Gewin, 2012). A study by Levecque et al. (2017) found that graduate students are twice as likely to have or develop a common psychiatric disorder when compared to the highly educated within the general population. A different study by Evans et al. compared graduate students to the general population and found that graduate students are six times more likely to experience anxiety and depression (2018).

The conditions of graduate studies differ from undergraduate studies as this time is focused more on in-depth on a specialized area with increased stress associated with finances, career planning and prospects, job market, graduate assistantship responsibilities, tense advisor-student relationships, and poor mentorship (Forrester, 2021; Levecque et al., 2017; Wyatt &

Oswalt, 2013). Data reveals a connection between the inability to maintain a healthy work-life balance and elevated levels of stress in graduate students (Wyatt & Oswalt, 2013). Furthermore, most social and cultural activities and mental health support on campuses typically target the undergraduate population (Gewin, 2012; Wyatt & Oswalt, 2013). The pervasive pressures of graduate study can lead to challenges and stressors related to work/life balance, unpredictable and unstructured academic processes, time-based demands, financial constraints, decreased productivity, burnout, illness, etc.; factors leading to emotional and mental exhaustion thus impacting a student's ability to learn and succeed in school (Evans et al., 2018; Levecque et al., 2017).

In 2019, CGS and JED undertook a project to address the growing body of evidence on the mental health challenges faced by graduate students and barriers to effective care (Council of Graduate Schools & The Jed Foundation, 2021). One of the ultimate goals of the project was to "provide a framework for individual and collective action to support the mental health and well-being of master's and doctoral students" (Council of Graduate Schools & The Jed Foundation, 2021, p. 15). The report identified two significant gaps in the assessment of previous studies on graduate student mental health and wellbeing. The first gap is the paucity of data on the mental health of master's students compared to Ph.D. students. Although master's students represent 74% of students enrolled in U.S graduate programs, much of the media coverage and literature focuses on the experience of Ph.D. students (Council of Graduate Schools & The Jed Foundation, 2021; Okahana et al., 2021). This myopic focus has resulted in the generalization of the experience of doctoral students to all graduate students, thus overlooking the unique experiences of master's students. The second cited gap in the literature is the scarcity of information on the experiences of graduate students with intersectional identities (Council of

Graduate Schools & The Jed Foundation, 2021). This report as well as other recent studies (Khanlou, 2019; National Academies of Sciences, 2021) have called for further study on this topic as identity groups within this student population varies widely and may shape individual experiences (Council of Graduate Schools & The Jed Foundation, 2021).

Mental Health Among International Graduate Students in the United States

According to the *Open Doors Report* from the Institute of International Education (2021), over one million international students from more than 200 countries were present in the U.S between 2019 and 2020. In addition to the typical stressors associated with college life, international students generally encounter additional challenges unique to their status (Anandavalli, 2019). Living and studying in a foreign country can impose various challenges such as separation from family, new responsibilities, linguistic, financial, academic, interpersonal, and intrapersonal concerns (Anandavalli, 2019). Existing literature also makes mention of other issues, including social isolation, discrimination, and safety/xenophobia (Levecque et al., 2017). The adaptation and adjustment process to a new environment, culture, language, and educational system can be overwhelming and adversely impact the experience of international students (Yi, 2019).

Recent studies have found that the challenges faced by this population can contribute to psychological distress, resulting in adverse mental health outcomes and the development of mental health issues such as anxiety, depression, and suicidal ideation (Servaty-Seib et al., 2016). Despite the increased susceptibility to mental health concerns due to increased stressors, data from several studies shows international students have one of the lowest campus counseling services utilization rates (Anandavalli, 2019). A study by Nilsson et al. (2004) revealed that only 2% of international students at a large university utilized counseling services. The same study

showed international students had the lowest utilization rates even when compared to domestic racial minorities on campus: Black/African Americans (15%), Hispanic Americans (5%), and Asian Americans (13%) (Nilsson et al., 2004).

International students constitute about 14% of the U.S. graduate school enrollment (Anandavalli, 2019). This student population is subject to the stressors commonly experienced by international students while also burdened with the added challenges of rigorous academic life. A paper commissioned by CGS on the mental health experience of international graduate students identified the following four leading concerns: language, social isolation, cultural adjustment, and neo-racism (Lee, 2021). Compared to undergraduate study, language barriers in graduate study can significantly impact academics due to a heavier emphasis on independent research (Lee, 2021; Okahana et al., 2021). Furthermore, fewer opportunities for social and cultural activities at this educational level can also lead to greater social isolation (Glass et al., 2014). Language barriers exacerbating difficulties related to academics and a sense of belonging could lead to severe consequences on the mental health of graduate international students (Lee, 2021). Another factor cited by Lee (2021) that is unique to the experience of international students at the graduate level, especially students from low-income countries, is the issue of treating these students as “cheap labor” on research projects. Graduate international students may experience differential treatment compared to their domestic counterparts regarding faculty expectations, hours, and pay (Cantwell & Lee, 2011; Cantwell et al., 2018; Lee, 2021).

One of the primary reasons commonly cited for the under-utilization of counseling services by international students at all educational levels is mental health counselors' multicultural competency(Anandavalli, 2019; Boafo-Arthur & Boafo-Arthur, 2016; Pendse & Inman, 2017). The limited cultural awareness and sensitivity amongst counselors due to lack of

formal training in working with this student population adversely impacts international students' utilization of mental health services on campus (Pendse & Inman, 2017). The positive correlation between international students' perception of their counselor's multicultural competency and their counseling experience is evidence of the importance and effectiveness of culturally informed and appropriate counseling (Pendse & Inman, 2017). Counselors who are perceived as culturally aware and sensitive are also perceived as more credible, attractive, and trustworthy by international students (Pendse & Inman, 2017).

Mental Health Among Students at Emory University

The 2017 National College Health Assessment (NCHA) conducted at Emory University found that stress, anxiety, and sleep difficulties were students' top three academic impediments. The assessment also showed an increased percentage of students experiencing "more than average stress" or "tremendous stress" in the past 12 months (62.3%) when compared to the 2014 Emory NCHA (59.8%). Respondents were also asked about treatment or diagnosis of mental health-related disorders or illnesses within the last 12 months. A similar increase was found in the diagnosis of anxiety, depression, panic attacks, attention deficit hyperactivity disorder (ADHD), and obsessive-compulsive disorder (OCD) between 2014 and 2017 (Emory NCHA 2017). The top three mental health disorders reported in the 2017 Emory NCHA were anxiety (20.1%), depression (14.8%), and panic attacks (9.1%). When compared to domestic students and specific subgroups (females, undergraduates, and graduate/professional students), international students were still less likely to consider seeking mental health support from a professional (See Table 1) (Amposta et al., 2018).

Table 1

Mental Health Help-Seeking intentions, 2017 Emory NCHA Respondents

Variable	Would consider help seeking % (n)	X^2	p-value
Biological Sex			
Female	87.0% (678)	14.900	<.001*
Male	77.6% (239)		
International Student			
Yes	71.4% (80)	15.692	<.001*
No	91.2% (834)		
Oxford Continuee			
Yes	84.3% (75)	.001	.976
No	91.8% (838)		
School Status			
Undergraduate	81.5% (437)	6.824	.033*
Graduate/Prof.	87.2% (470)		

*p<.05, thus representing significance across groups

Note. *From* "2017 Emory University National College Health Assessment Summary", by J. Williams, 2022, *Emory University Office of Health Promotion.*

Mental Health Among International Graduate Students at Emory University

International students make up 19% of the student population at Emory University. In the 2017 Emory NCHA, 25.9% of international graduate students reported no or less than average stress, 32.3% reported average stress, and 42% reported more than average or tremendous stress. The top three stressors included academics, career-related issues, and the death of a family member. When asked about mental health diagnoses, depression (12.9%), anxiety (6.4%), and insomnia (4.6%) ranked the highest, respectively (Williams, 2022a).

Williams conducted an additional assessment of the 2017 Emory NCHA focusing exclusively on international students at the Rollins School of Public Health (RSPH) (n=20). Compared to other information related to mental health and wellbeing (grief and loss, relationship difficulties, sleep difficulties, etc.), international students at RSPH were most interested in information on stress reduction (90%) (Williams, 2022b). Regarding stress levels

over the last 12 months, 25.0% of respondents reported no or less than average stress, 20% reported average stress, and 55% reported more than average or tremendous stress. This sample's top two experienced stressors were academics (50%) and career-related issues (45%). The reported utilization of mental health services is presented in Table 2 (Williams, 2022b).

Table 2

Utilization of Mental Health Services – RSPH International Students

Service	Utilized Service
Counselor/Therapist/Psychologist	35.0% (n=7)
Psychiatrist	10.0% (n=2)
Other Medical Provider	5.0% (n=2)
Minister/Priest/Rabbi/Other Clergy	0.0% (n=0)
University Health/Counseling	30.0% (n=6)

Note. From "2017 Emory University American College Health Association - National College Health Assessment Data Brief: RSPH International Students" by J. Williams, 2022, *Emory University Office of Health Promotion*

Problem Statement

Graduate international students in the U.S often experience significant challenges related to academics, finance, work-life balance, and adjustment (i.e., culture shock and transitional stress), placing them at high risk for mental health disorders (Anandavalli, 2019; Boafo-Arthur & Boafo-Arthur, 2016; Forrester, 2021; Levecque et al., 2017). The increasing number of international students in the U.S. and the upward trend in mental health diagnoses observed on college campuses among graduate students requires that university administrators pay attention and prioritize adequate and appropriate mental health support to this student population (American College Health Association, 2018; Evans et al., 2018; Levecque et al., 2017; Wesley, 2019).

As a general pattern, most of the literature on the mental health needs of international students focuses on the individual level. The pervasive individual-oriented approaches in existing literature place the primary focus on factors such as attitudes and beliefs towards counseling, demographic characteristics (e.g., age), and help-seeking behavior (Pendse & Inman, 2017). This narrow focus leads to individualization of responsibility and risk and largely ignores the influence of interpersonal and environmental-level factors. Although some studies do acknowledge the contribution of these other levels, there remains a scarcity of data targeting interpersonal and environmental level factors (Pendse & Inman, 2017). One area in which research and interventions expand past the individual-level factors on promoting the mental well-being of international students is the use of multicultural competency frameworks for mental health counselors on campus (Kim et al., 2019; Raymond Ting & Morse, 2016; The Steve Fund & The Jed Foundation, 2017). This approach moves beyond the level of the individual to some degree, but still largely neglects many factors affecting the mental health of international graduate students (Teegen & Conrad-Popova, 2021). National and local Emory data show persistent low utilization of mental health counseling among the international student (Amposta et al., 2018; Anandavalli, 2019; Nilsson et al., 2004; Williams, 2022a); thus, it is vital to explore alternative interventions at the interpersonal and environmental level that can support this student population.

Purpose Statement

Currently, literature on the mental health experience of international students is saturated with discussions on individual-level factors (e.g., help-seeking behavior), and the limited studies exploring interpersonal and environmental level factors are dominated by clinical-oriented perspectives to mental health. The under-utilization rate of counseling services among

international students underscores the need to explore other professionals within academic institutions that can contribute to the improvement of the mental health experiences of international students. Through this project, I am exploring a possible framework that emphasizes the engagement of student affairs professionals in providing timely and culturally appropriate support to promote the mental health experience and overall wellbeing of international students.

Goal: To create a three-part mental health curriculum for student affairs professionals to improve the provision of culturally appropriate mental health & wellbeing services for international students at the Rollins School of Public Health (herein, Rollins).

Aim 1: Assess current literature and best practices on mental health interventions to inform the development of mental health training for student affairs professionals at Rollins.

Aim 2: Increase student affairs professionals' knowledge & skills related to cultural sensitivity and humility

Aim 3: Improve referral to timely and appropriate resources by developing a network and resource map that increases awareness of resources and promotes collaboration.

Brief Overview

This thesis is divided into four parts. Chapter One has provided an overview of the topic of mental health among international graduate students, the significance of the health problem, the public health implications, and how this study aims to address the gap in current literature and practice. Chapter Two will provide a detailed literature review and critique of existing practices on the delivery of mental health services for university students as well as a close look at theoretical frameworks to understand the mental health experiences of international students. The chapter will also include more information about the role of cultural awareness and humility

in working with international students. Chapter Three will consist of a description of this project's methodology, approach, and rationale, and Chapter Four will present discussion, conclusion, and recommendations.

Definition of Terms

Graduate student: A student who has earned a bachelor's degree and is pursuing additional education to earn a master's or doctoral degree. (United States Department of State, n.d)

International graduate student: Students on an F-1 visa pursuing educational training in a master's or doctoral level (Anandavalli, 2019).

Mental health professional/counselor: Health care professionals with a master's or doctoral degree trained to evaluate a person's mental health and use therapeutic techniques for symptom reduction (National Alliance on Mental Health, n.d).

Student affairs professional: A staff member who creates an atmosphere and environment that promotes student development both personally and professionally outside the classroom (Killam & Degges-White, 2017).

Person of Color: A person who does not identify as European or of White descent (Anandavalli, 2019)

Multicultural competency: The awareness, knowledge, and skills needed to work with others who are culturally different from self in meaning (Pope et al., 2004).

CHAPTER 2: LITERATURE REVIEW

International students in the U.S come from diverse racial, religious, political, and socioeconomic backgrounds (Anandavalli, 2019). Research shows that international students face additional stressors compared to the general student population yet have the lowest utilization rate of counseling services on college campuses (Alharbi & Smith, 2018). This chapter provides an overview of current approaches to addressing mental health on college campuses. In addition, the chapter explores two theoretical frameworks to understand the mental health experience of international students and then the chapter closes with a discussion on the role of cultural humility in providing appropriate mental health support to international students.

Overview Of Current Approaches to Mental Health On College Campuses

Move Towards a Comprehensive Approach to Mental Health on College Campuses

College enrollment continues to rise, with numbers expected to reach close to 37 million by 2029. The vast number of young people enrolled in colleges and universities creates an opportunity for these institutions to serve as possible "safety nets" for students with mental health concerns (MacPhee et al., 2021). Promoting student mental health could ensure immediate and longer-term favorable outcomes (MacPhee et al., 2021). Conversely, it is clear that the consequences of unresolved mental health concerns among students can exceed difficulties with academic performance. There are many long-lasting impacts and broader societal implications for individuals with untreated mental health challenges including disability, social isolation, unemployment, and poverty (Center for Collegiate Mental Health, 2020).

The scale and range of mental health challenges on college campuses warrant a comprehensive approach to mental health promotion and the prevention of mental health illness. Rather than focusing on a single factor, a comprehensive approach addresses multiple

contributing factors such as risk factors, life skills, and healthcare access (The Jed Foundation, 2018). The Jed Foundation is one organization that strongly advocates for a comprehensive approach to promoting mental health and preventing suicide on college campuses.

JED Comprehensive Approach. The Jed Foundation (JED) is a nonprofit organization that consults with higher education institutions across the U.S to evaluate and support their mental health approaches, programs, policies, and services. JED consultation is particularly important as suicide rates increase. In fact, recent data show that suicide is the second leading cause of death among college students (Moskow et al., 2022; Schwartz, 2006; Turner et al., 2013).

In 2004, JED, alongside the Suicide Prevention Resource Center (SPRC), adapted the Air Force Suicide Prevention Program (AFSPP) developed by the U.S. Air Force in the 1990s to the college campus environment (MacPhee et al., 2021). In earlier trials during the 1990s, AFSPP showed promise with a 33% reduction in suicides rates in active-duty soldiers and a sustained reduction in suicide incidence rates 11 years after launching the program (Knox et al., 2010). The adaptation to the program, known as the JED Comprehensive Approach to Health Promotion and Suicide Prevention, is shown in Figure 1. The approach has seven strategic domains that address four major thematic areas: promotion of resilience and protective factors, encouragement of early intervention, access to clinical services, and the implementation of environmental safety to restrict access to lethal means (MacPhee et al., 2021; Suicide Prevention Resource Center, 2020). Colleges and universities can partner with Jed Foundation in implementing the Comprehensive Approach through the JED Campus Program, a four-year structured intervention. Participation in the JED Campus programs includes customized support for student and campus-level assessments and strategic plans to facilitate systems change- level changes to promote student

wellbeing (MacPhee et al., 2021). There are currently 336 colleges and universities participating in the JED Campus program. Colleges and universities that have completed JED Campus report supporting students' physical and emotional wellbeing by developing programs to enhance mindfulness, emotional regulation, and resilience (MacPhee et al., 2021).

Figure 1

JED's Comprehensive Approach to Mental Health Promotion and Suicide Prevention

Note. From JED'S ComprehensiveApproach to Mental Health Promotion and Suicide Prevention for Colleges and Universities, by The Jed Foundation, 2021

No-Wrong Door Approach. The "no-wrong-door" approach also underscores the comprehensive approach to mental health promotion in colleges and universities. This approach emphasizes the importance of creating a seamless process to access appropriate mental health services and care regardless of the entry point and allows for interdisciplinary behavioral intervention that promotes transparency, improves communications, and increases awareness about mental health resources and services among faculty, staff, and students (Wesley, 2019). Within this approach, information is shared across various channels and coordination of cross-campus responses to students' needs. Cross-campus responses may involve representatives from the office of student affairs, disability services, academic affairs, campus legal counsel, etc. (Higher Education Mental Health Alliance & Jed Foundation, 2012). This approach to mental health also breaks down the complexity and ambiguity that exists within mental health processes on campus. The availability of a clear and simplified flowchart has been shown to improve the referral process and guide individuals to the appropriate resources and action steps in response to different concerns (Wesley, 2019). The success of this approach, however, depends on relevant and ongoing training for individuals (i.e., faculty and staff), at each entry point, on how to assist students in accessing appropriate and timely mental health support and resources (Wesley, 2019).

Gatekeeper Training for Mental Health

The promotion of the "no wrong door" approach to care has led to increased attention to the role of gatekeepers within educational institutions. Generally, gatekeepers are individuals who have "face-to-face contact with large numbers of community members as part of their usual routine"(Burnette et al., 2015, p. 2). These individuals, including teachers, student leaders, coaches, clergy, and staff, occupy spaces that allow them to assist members of their communities (Aldrich et al., 2018). Gatekeeper training (GKT) programs have shown great potential in

addressing mental health concerns in various settings (Hawgood et al., 2021; Reiff et al., 2019). Although many GKT programs focus on suicide prevention, others address common mental health concerns, including anxiety and depression (S. K. Lipson et al., 2014). Two widely used gatekeeper training are Question, Persuade, Refer (QPR), and Mental Health First Aid (MHFA).

Question, Persuade and Refer (QPR). The Question, Persuade and Refer (QPR) suicide prevention training is currently listed in the *Best Practices Registry for Suicide Prevention* and is registered in the SAMHSA's National Registry of Evidence-based Practices and Policies (NREPP) (Quinnett, 2013). The QPR training was created in 1995 by Paul Quinnett as an emergency mental health intervention. It was specifically designed to detect and respond to individuals exhibiting suicide warning signs. Since its development, the training has been used more broadly as a universal intervention to support individuals experiencing emotional distress (Quinnett, 2013).

It is crucial to note that QPR is not a suicide risk assessment training. Instead, QPR equips gatekeepers to clarify suicide warning signs, listen to concerns, and attempt to connect the individual to a mental health professional. The training can also be used as a behavioral action plan to guide a "willing or ambivalent suicidal person" to receive a referral to a mental health professional for evaluation and treatment (Quinnett, 2013, p. 6). QPR teaches gatekeepers – individuals strategically positioned to act– warning signs of a suicide crisis and how to respond promptly and effectively. Research indicates that QPR training increases knowledge of suicide, boosts confidence and comfort for intervention, and enhances gatekeeper skills such as persuasive communication and timely referral to the appropriate level of intervention (Aldrich et al., 2018; Quinnett, 2013). In addition to increased knowledge, QPR training also improves

attitude and self-efficacy in learners across populations. The skills learned through QPR training can be applied in various professional settings and for different age groups (Quinnett, 2013).

Currently, over 5,000,000 people have been trained worldwide. The QPR training uses adult learning methods and is taught for a minimum of one hour; with additional time added for role-playing and practice (Quinnett, 2013). The training is facilitated by certified instructors and can be delivered in person or through an online format. All instructors are required to master module content on "facts, theory, program delivery and required content, teaching methods, and answering audience questions" (Quinnett, 2013, p. 6). The key components covered in the QPR gatekeeper training are outlined in Table 3.

Table 3

Key Components in QPR Gatekeeper Training

• How to Question, Persuade and Refer someone who may be suicidal
• How to get help for yourself or learn more about preventing suicide
• The common causes of suicidal behavior
• The warning signs of suicide
• How to get help for someone in crisis

Note. Adapted from "QPR Gatekeeper Training for Suicide Prevention The Model, Theory and Research," by Quinnett, P., 2013

The outcome effects (safety, utility, effectiveness, etc.) of the QPR training have been assessed in diverse settings and with several target populations (Cerel et al., 2012; Isaac et al., 2009; Litteken & Sale, 2018). For example, post-test results from the Kentucky statewide QPR program revealed improved perceived knowledge of suicide and self-efficacy to intervene (Cerel et al., 2012). Evaluation of the QPR training with Veterans Health Administration employees in New York showed an increase in knowledge, and abilities to engage, identify and refer at-risk

veterans to appropriate resources and care (Matthieu et al., 2009). A longitudinal study by Litteken and Sale (2018) assessing the effectiveness of QPR revealed both short and long-term positive outcomes in self-efficacy, suicide prevention knowledge, and help-giving behaviors.

The utility and effectiveness of QPR have also been examined within school settings with similar results of increased knowledge, attitudes, and skills (Aldrich et al., 2018; Mitchell et al., 2013). In a national survey, college counseling center directors report that QPR (29%) is the most commonly used intervention for suicide prevention compared to other programs like Collaborative Assessment and Management of Suicidality (11%), Campus Connect (8%), and Mental Health First Aid (7%) (Gallagher, 2011). A study assessing the effectiveness of QPR at secondary schools in a rural community found that participating teachers and staff showed greater gains in attitude, knowledge, and beliefs regarding suicide and suicide prevention compared to the control groups (Tompkins et al., 2010). Results from a study by Cross et al. (2010) employing a pretest-posttest method to assess the impact of QPR on employees (faculty, staff, coaches, resident-assistants) at US universities found an increase in gatekeeper skills, including active listening, persuading to get help, and giving specific referrals. Aldrich et al. (2018) assessed the effectiveness of QPR in a small U.S campus using the theory of planned behavior. Findings showed significant improvement in attitudes, subjective norms, and perceived behavioral control. Results also showed that the QPR training effectively increases intentions – an individual's willingness to intervene with a suicidal person (Aldrich et al., 2018).

Although Cross et al. (2010) found similar results in the effectiveness of QPR in enhancing suicide-specific skills in gatekeepers in universities, the authors revealed that there was no change in observed general skills pre and post-training. Cross et al. (2010) argue that although the one-hour QPR training emphasizes the importance of sensitive communication and

clarifying questions, the training does not focus on teaching soft skills such as active listening and empathic reflections. Findings from this study align with suggestions from Wyman et al. (2008) for more comprehensive training that focuses on communication styles among gatekeepers.

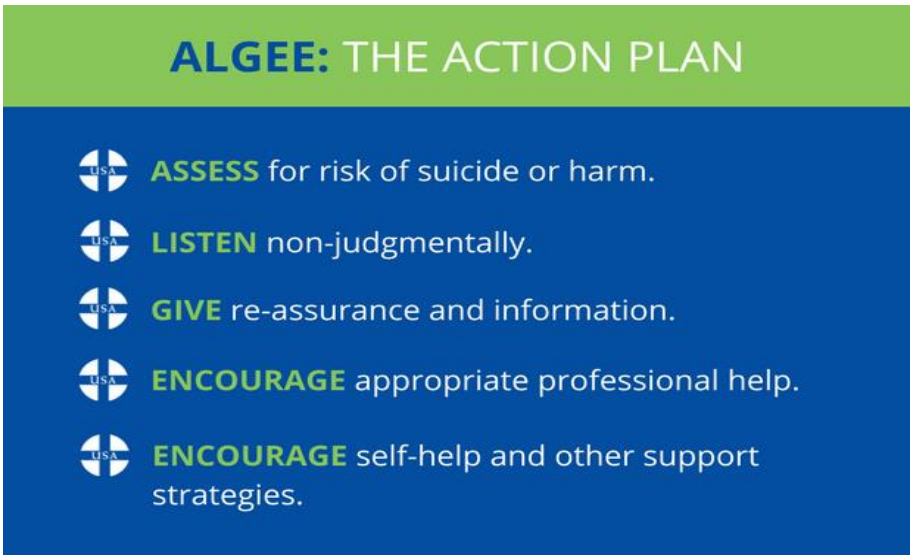
Mental Health First Aid. Another training that follows the gatekeeper model is the Mental Health First Aid (MHFA) training from the National Council for Mental Wellbeing. MHFA is an evidence-based education tool that teaches skills to help the public identify, understand, and respond to signs of a mental health problem or crisis. There are two available programs: Youth Mental First Aid (YMHFA) and Adult Mental Health First Aid (AMHFA) (National Council for Mental Wellbeing, n.d-b). YMHFA is catered towards adolescents (ages 12-18) and teaches individuals common mental health challenges for this population, typical adolescent development, and how to provide support in crisis and non-crisis situations (National Council for Mental Wellbeing, n.d-c). AMHFA teaches individuals how to support a person 18 years and older by providing training on recognizing signs of mental health or substance abuse, offering initial help, and referring to appropriate care. This program is designed for the unique culture and resources present on college and university campuses and aids with early detection and the lessening of severity and impact of mental health and addiction challenges (National Council for Mental Wellbeing, n.d-a).

Various methods are used in training, including simulations and role-play to demonstrate recognition and response to warning signs, assessment of a mental health crisis, and intervention selection and connection to appropriate care (National Council for Mental Wellbeing, n.d-b). MHFA training includes an eight-hour training, discussions, exercises, videos, MHFA handbook, MHFA Action Plan ALGEE (See Figure 2), practice scenarios, and a three-year certification.

Individuals interested in becoming MHFA instructors complete a five-day or three-day training providing in-depth instruction on curriculum facilitation, a final written exam, and a demonstration of ability to present to various audiences (National Council for Mental Wellbeing, n.d-b).

Figure 2

Mental Health First Aid ALGEE



Note. From "ALGEE In Action: Helping a Friend in Need" by E. Call, 2017, *National Council for Mental Wellbeing*

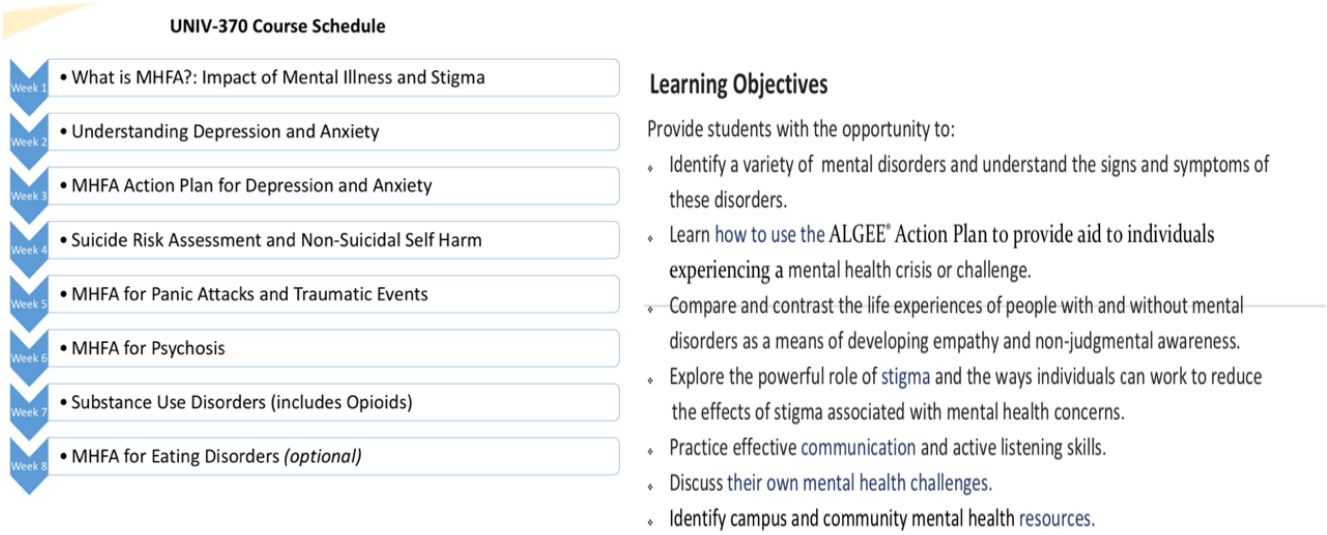
A meta-analysis conducted by Hadlaczky et al. (2014) to estimate the effect and potential of MHFA as a public mental health awareness strategy found that the training decreased negative attitudes and increased participants' knowledge of mental health and supportive behavior towards individuals with mental health concerns. MHFA has been adapted for various settings and shows promising results for diverse populations, including nursing students (Hung et al., 2019), Latinx and Asian American immigrant communities (Lee & Tokmic, 2019), Aboriginal and Torres Strait Islanders in Australia (Armstrong et al., 2018), UK medical students (Davies et

al., 2018), university administrative staff in Japan (Hashimoto et al., 2016) and community members in Vietnam (Minas et al., 2009).

Studies assessing MHFA on college campuses have investigated outcomes such as knowledge, stigmatizing attitudes, confidence, and intention have yielded positive results (Liang et al., 2021; Spiker & Hammer, 2019). Kennesaw State University, Kent State University, and Georgia State University are among the universities in the U.S that have made MHFA training available to students, faculty, and staff (Coles College News, 2018; Georgia State University; Kent State University). Although most universities follow the traditional format for MHFA training, George Mason University offers the training as a one-credit college course over seven weeks. Figure 3 shows the course schedule and learning objectives of the George Mason course (George Mason University, n.d).

Figure 3

George Mason University MHFA Course



Note. From "Mental Health First Aid (MHFA) Training for the College Curriculum:An Innovative Approach for Teaching Students About Mental Illnesses and Promoting Mental Health Well-Being", by George Mason University, n.d.

Despite the positive outcomes observed in participants of MHFA training in colleges and universities, Lipson et al. (2014) found mixed results in their study on the effect of MHFA on overall student communities. The study showed personal benefits to participants (resident assistants) but no increase in the utilization of mental health services among residents. The authors recommend further research to determine if this null effect is solely attributable to MHFA, the choice of gatekeeper, or, more broadly, the GKT programs (Lipson et al., 2014).

The Three R's. Colleges and universities across the U.S have implemented GKT programs based on three essential components: Recognize, Respond, Refer (RRR). RRR programs teach gatekeepers on college campuses how to ***R****ecognize* signs indicating that a student is in distress or experiencing mental health concerns, ***R****espond* appropriately based on signs present and type of relationship, and ***R****efer* to mental health support and services (Centre for Innovation in Campus Mental Health, n.d-a). Hellmans et al. speak on the applicability and importance of RRR programs by saying, "Instructors, staff, and peers could all use more training on how to have difficult conversations; how to recognize signs of mental illness and crisis; how to implement universal instructional design; and effective practices for supporting students from diverse backgrounds and experiences, particularly Black and Indigenous students." (2021, para 14) Arizona State University, Washington State University, and the Rollins School of Public Health at Emory University have GTK programs based on the RRR model.

The Arizona State University C3 Program. The C3 Program at Arizona State University aims to build a community of compassionate communication, and connection by training faculty and staff to identify and support the needs of students struggling with personal challenges that may hinder their success. The program is grounded in the Motivational Interviewing (MI), and the Screening, Brief Intervention and Referral to Treatment (SBIRT) models (Arizona State

University, n.d.). MI is recommended as an evidence-based approach with a "collaborative, goal-oriented communication style with particular attention to the language of change" (Miller & Rollnick, 2013, p.29). The model emphasizes interaction with a collaborative, evocative spirit that honors the client's autonomy. In the *C3 Program,* faculty and staff are taught to use MI to administer a brief screening to identify students engaged in high-risk behaviors and refer them to appropriate resources and treatment. The SBIRT model is used in the program to deliver early intervention and treatment to individuals with or at risk of developing substance abuse disorders. Through SBIRT, professionals can identify an issue, explore the potential for change, refer to appropriate resources, and support the use of treatment for those presenting signs of dependence.

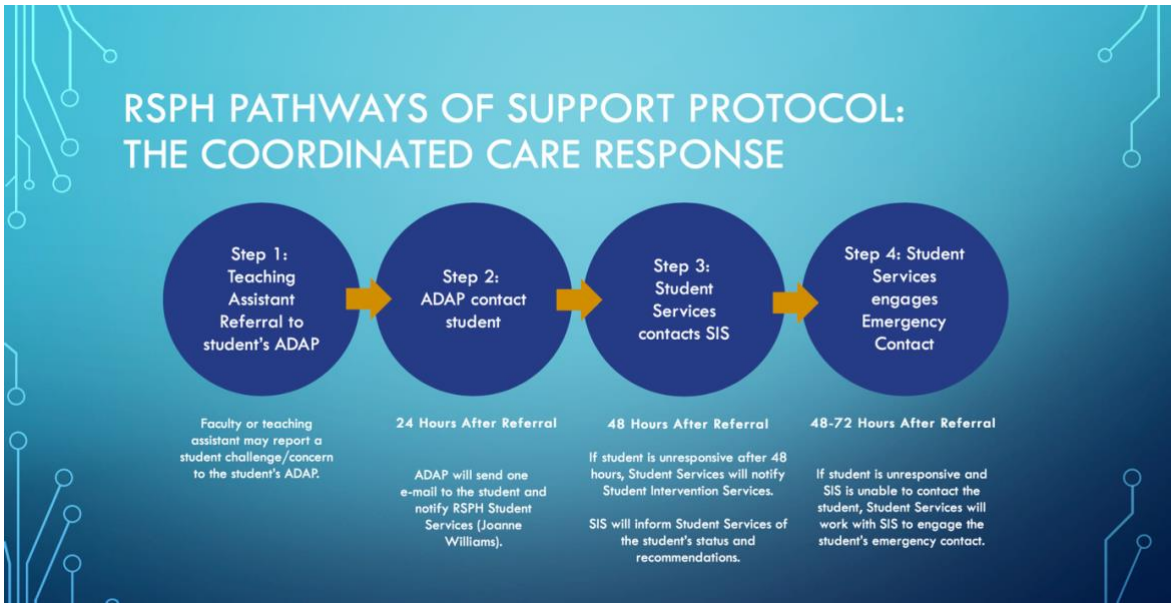
The WSU RRRR Model. Washington State University (WSU) adapted the RRR model to include an additional component on "Reporting". WSU's Recognize, Respond, Refer, Report (RRRR) model aims to support students in distress. WSU has a CARE team that handles all reports, identifies next steps, and determines the best way to connect students with resources. The following recommendations were provided for responding with compassion: listen sensitively and carefully, trust your gut, connect with campus resources, take care, stay safe and share what you know (Washington State University). See Appendix K for a visualization of the WSU guidance on helping students in distress using the RRRR model.

Rollins Coordinated Care Response Training. Another adaptation of the RRR model can be found at the Rollins School of Public Health (RSPH) at Emory University. The Coordinated Care Response Training provided to Teaching Assistants (TA) is based on a Recognize, Relate, Refer model. The training teaches TAs to recognize signs of student distress (i.e., academic, interpersonal, and behavior), relate based on whether the student is receptive, and refer students for care based on the first two steps. The training provides a pathway for support (See Figure 5)

and provides an overview of the roles of key individuals and offices. As part of the training, TAs go through case studies, discuss solutions to different student concerns using the RRR model, and identify appropriate referrals using the support protocol pathway. TAs are also provided with a student support toolkit with various student concerns and resources to guide the referral process.

Figure 5

RSPH Pathways of Support Protocol: The Coordinated Care Response



Note. From "Coordinated Care Response Training for RSPH Teaching Assistants, by J. Williams, 2022, *RSPH Office of Admission & Student Services*

Before finalizing this section, it is important to note that the RRR model is not specific to college settings and can be applied to train gatekeepers in other sectors. For example, the Brisbane South PHN in Australia created a RRR program to support general practitioners responding to domestic and family violence (Brisbane South PHN, 2022). The Recognize Respond, Refer program aims to improve overall system responsiveness and ultimately improve outcomes for individuals who experience domestic and family violence by bringing together

general practitioners and specialists in domestic and family services (DFV) services (Brisbane South PHN, 2022). Through the program, general practitioners can take a more defined role in a systemic response to domestic and family violence (Brisbane South PHN, 2022).

Peer Interventions to Mental Health

In addition to GKT programs, some colleges and universities have taken an additional step to integrate students into the strategic planning and outreach strategy for mental health support on campus. Student involvement can range from serving as volunteers to assisting with mental health education and training programs to participating in student-led mental health clubs and advisory boards that facilitate peer-to-peer and student-to-staff communication (Reetz et al., 2016). The integration of students into this process is also an opportunity for campus mental health services to receive feedback on services, identify student needs, and learn about treatment gaps while being held accountable for stated commitments to care (Wesley, 2019).

Leveraging student voices can take various forms on university and college campuses. *The Prevent@UWG Program* at the University of West Georgia uses peer mentors as an integral component of the school's mental health support and outreach effort (University of West Georgia, n.d). Through this program, students can co-facilitate and participate in mental health education programs and gatekeeper training and work with faculty and staff to implement campus outreach initiatives, increase mental health awareness, and promote suicide prevention. (University of West Georgia, n.d). Whereas at the University of Michigan, a student group housed under the office of Counseling and Psychological Services produces and edits a video series highlighting stories about how mental health affects the day-to-day lives of students (University of Michigan Counseling and Psychological Services, n.d.).

Organizations like *Active Minds*, not linked to a specific college or university, works to support mental health awareness and peer education for young adults ages 14-25. Currently, in over 600 campuses throughout all 50 U.S states, *Active Minds* reaches millions of students through awareness campaigns, advocacy, outreach, and more (Active Minds, n.d). The organization works through a student-to-student model and aims to leverage student involvement to increase mental health awareness and provide peer education to help prevent suicide and eliminate the stigma around mental health issues (Active Minds, n.d.). Through these student-led chapters, there are opportunities for students to collaborate with campus health and counseling services and to serve as mental health policy advocates (Wesley, 2019).

Triage Model

Although GKT programs and peer intervention models contribute to mental health promotion on college campuses, certain services can only be provided by trained mental health professionals. The triage model is one method colleges, and universities employ to address the demand for mental health services at college counseling centers (Wesley, 2019).

The triage model originated in emergency medicine to organize the needs of patients and efficiently deliver care to the most amount of people without losing the quality of services (Shaffer et al., 2017). This model was first applied to mental health in Australia in the 1990s and then in the United Kingdom (UK) in the early 2000s. The triage model in the UK was used to assess risk levels and identify the corresponding response type. For example, an "A" triage code means the case involves an emergency and requires an immediate referral, whereas a "D" code represents a moderate risk of harm and will receive a semi-urgent response within 72 hours (Monica Z. Osburn & Teffanie Grossman, 2019).

Based on the applications of the triage model to mental health, Rockland-Miller and Eells (2006) proposed a system for implementing this model on college campuses to screen and determine if care is emergent, urgent, or routine. The triage model is conducted at the point of entry (i.e., phone consultation, drop-in) and uses a problem-solving approach to assess and categorize mental health needs based on nature and severity to determine the appropriate level of care and treatment (Centre for Innovation in Campus Mental Health, n.d-b). Levels of care include same-day appointments, traditional counseling, single-session counseling, workshop, therapy groups, or facilitated referrals (Centre for Innovation in Campus Mental Health, n.d-b; University of Houston, n.d). For example, a student at high risk of harming themselves or others should receive immediate individual counseling or referral to an off-campus specialist based on institution policies. In contrast, a student with prior counseling sessions who does not pose an immediate threat to themselves, or others may be better served in group therapy with extra assignments to complete during personal time. Figure 6 shows an example of the triage model implemented at the University of North Texas. The process includes a call or in-person visit at the counseling center and an evaluation form students can use to describe their needs.

Figure 6

University of North Texas Triage Process

Name: _____ Student ID: _____ Phone Number: _____

Date: _____ Date of Birth: _____

To help us determine which type of consultation fits your needs, please read the levels and **circle number 1, 2, 3, or 4.** **Please mark only ONE Number**. *Return this to the receptionist when completed.*

O **1-** **Emergency Consultations** - I am concerned about my ability to keep myself safe. - I have a current plan to attempt suicide. - I have taken recent steps to end my life. - I may physically hurt someone else. - I have a strong desire to harm someone else. - I have been referred by the Dean of Students because I or they are concerned about my ability to keep myself safe. - I have recently been physically or sexually assaulted. - I am hearing voices or seeing things other people do not.	O **2-** **Urgent Consultations** - Someone close has recently received a serious diagnosis or died. - I have recently been discharged from a psychiatric hospital and need help finding follow-up care in the community. - I am in such emotional distress I have not been able to meet my daily responsibilities. - I have been referred by the Dean of Students to help me find follow-up care in the community.
O **3-** **Initial Consultations** - I am experiencing anxiety and/or stress. - I feel depressed and/or have low mood/energy. - I am concerned about my alcohol and/or drug use. - I am having difficulty adjusting to a recent change. - I am having relationship(s) problems. - I am unsure about something significant in my future. - I need to make a major decision and need feedback - I am dealing with a sudden loss	O **4- Single Session Consultation** - I have a specific emotional concern or question that can probably be resolved in a single appointment. - I need to make a major decision in the next 2-3 days. - I am concerned about someone else (a friend, roommate, etc.). - I am seeking a referral for medication or counseling elsewhere.

Note. From "Triage and Clinic Flow Advanced Topics in College Counseling" by Monica Z. Osburn, & Teffanie Grossman, 2019, *American College Counseling Association*

Although there are several benefits to the effective implementation of the triage model, overreliance on this approach can result in wrongful placements and may lead to emergencies and future costs. Table 4 shows the benefits and limitations/risks of the triage model on college campuses.

Table 4

Strengths and Weakness of the Triage Model

Strengths/Benefits	Limitations/Risks
Increased availability in clinical slot times	Non-urgent (lower risk) students might face longer wait time before follow-up intake or counseling
Relieves pressure on administrative staff	Students miss out on full counseling
Increased efficiency for counselors	Waitlist after triage = increased attrition
Shorter wait time	Therapeutic alliance is difficult to establish during triage (less personal)
Helps screen out concerns inappropriate for counseling centers	Students have to tell their stories more than once
Increased information about student's presenting concerns	Discomfort and limited ability in making risk assessment in short amount of time
Direct students to more appropriate services	Overemphasis on access can lead to treatment shortage

Note. Adapted from "Triage and Clinic Flow Advanced Topics in College Counseling" by Monica Z. Osburn, & Teffanie Grossman, 2019, *American College Counseling Association*

Telehealth Services

Another approach colleges and universities employ to meet the demands for professional mental health services is Telehealth. Telehealth, in general, is the use of telecommunication technologies to provide care and facilitate client-patient interactions through synchronous and asynchronous methods (See Figure 7) (Substance Abuse and Mental Health Services Administration, 2021). It is important to note that telehealth is not a type of intervention but rather a mode of service delivery. Telehealth has been used in clinical settings for over 60 years to increase access to screening, assessments, treatment, medication management, crisis, and recovery support. The Quadruple Aim, a conceptual framework used to understand, measure, and optimize health system performance, organizes the benefits of telehealth into four main

categories: improved client experience, improved provider experience, improved population health, and decreased cost.

Figure 7

Synchronous and Asynchronous Application of Telehealth

	Timing	Application	Technology Options
Synchronous	Real-time interactive client and provider interactions.	Clinical assessments, ongoing care and treatment, and triage of emergency service needs (e.g., for clients with suicidal ideation).[10]	Telephone, video calls, and web-conferencing platforms.[11]
Asynchronous	Sharing of health information that is collected at one point in time and responded to or interpreted at a later time to direct the next steps of a client's treatment or care plan and complement synchronous treatment.[12] Methods can be interactive (i.e., the client actively sending information to the provider) or passive (i.e., client data transmitted to providers through portals, sensors, or peripherals).	Clinical assessments, symptom management, client education, and treatment reminders that complement synchronous client-provider interactions and inform updates to treatment plans through methods such as: • Store and forward (i.e., client uploads and transfers medical information, such as health histories, to identify or refine a treatment plan) • Remote client monitoring (i.e., collecting medical and health data in one location and transmitting to another) • mHealth (i.e., capture of health information by the client and transmission of the information to a provider through mobile applications, mobile devices, smartphones, tablets, or computers) • Client education (e.g., online psychoeducation sessions and workbooks)	Web-based portals (i.e., client portals), email messages, text messages, mobile applications, symptom management tracking, sensors, peripherals, client education modules, or electronic medical record data.[13-19]

Note. From "Treatment of opioid use disorder during COVID-19: Experiences of clinicians transitioning to telemedicine", by Uscher-Pines et al., 2020, *Journal of Substance Abuse Treatment, 118*

Telemental Health Services. Telemental health services (TMH), a subset of telehealth, is the use of telecommunication technologies to provide services, including screening and assessment, treatments (medication management & pharmacotherapy), case management, crisis services, behavioral therapy, and recovery supports (Substance Abuse and Mental Health Services Administration, 2021). Telecommunication technologies include email, text messages, chat tools, video conferencing, and telephone (Dart et al., 2016). This mode of delivery has been used for more than six decades and continues to evolve with the introduction of new technology (Hadler et al., 2021). The suitability of telehealth depends on various factors such as the client's

comfort with technology, the nature and complexity of condition and complexity, and the ease and preference of accessing in-person services (Substance Abuse and Mental Health Services Administration, 2021). While there is strong evidence for the application of TMH for some mental health services (i.e., screening and assessment), there is scarce evidence for the sole use of TMH in providing other services (Hyler et al., 2005). For example, the changing regulations associated with the use of Medication-Assisted Treatment (MAT) (combination of counseling and pharmacological medications) to treat Substance Use Disorders (SUD) have resulted in the support for a hybrid approach (in-person and telehealth) (Huskamp et al., 2018; Uscher-Pines et al., 2020). Likewise, the provision of some interventions requires the sole use of synchronous telehealth modalities in order to maintain intervention fidelity (Substance Abuse and Mental Health Services Administration, 2021).

The use of TMH has been explored by colleges and universities in meeting students' growing demands for mental health services (Hadler et al., 2021). Between 2016 and 2018, the number of U.S colleges providing TMH services increased from 10 to 59% (LeViness et al., 2018). Studies show that TMH can be used to treat mental health concerns such as depression, anxiety, stress, sleep, eating disorders, and alcohol use disorders in this population (Bolinski et al., 2020; Gipson et al., 2019; Harrer et al., 2019; Paschall et al., 2011).

Hadler et al. (2021) reviewed recent literature on students' experience and attitudes toward TMH and identified the following perceived advantages: the ability to overcome structural (waitlists, appointment times) and psychological barriers (stigma, lack of motivation to seek treatment), convenience, flexibility, applicability and usability of TMH services, continued use of services (i.e., psychoeducation and mindfulness video sessions), provision of opportunity to avoid the stigma of seeking help, and an increased sense of ownership over the pace of

intervention. TMH also shows promise as a cost-effective method to provide mental health support (Higher Education Mental Health Alliance, 2018). Vanderbilt University is one of many universities that uses the My Student Support Program (MySSP) to offer international students free, 24/7 counseling through phone and live chat with no appointment needed. In addition to real-time support, international students can also request an appointment in their preferred language, if available (Vanderbilt University, 2021).

Even though colleges note overall student satisfaction with TMH, the literature shows limitations and drawbacks of this approach (Hadler et al., 2021; Palacios et al., 2018). One commonly noted drawback is how TMH can exacerbate current health disparities as ethnic minority students have limited access to technology and the internet (Higher Education Mental Health Alliance, 2018; Wesley, 2019). Studies also show that students frequently report the inadequate customization – personalized care and interaction with providers - of TMH services to be a significant drawback (Lungu & Sun, 2016; Palacios et al., 2018). The perceived lack of connection to providers might be due to communication via telecommunication platforms (i.e., text messaging or online chatting) rather than in-person (Hadler et al., 2021). Other limitations of TMH include confidentiality and vulnerability to malpractice claims due to limited guidance on standards and practices (Higher Education Mental Health Alliance, 2018).

Theories in Addressing the Mental Health of International Students

While the approaches mentioned above show promise in addressing the mental health needs of the general student population, the increasing number of international students in the U.S. calls for greater attention to the association between culture and mental health. From 2006 to 2016, there was a 60% increase in international students pursuing post-secondary study in the U.S (Raymond Ting & Morse, 2016). Data also shows rapid growth in the countries of origin,

with an annual increase in international students originating from several countries, including Brazil (78%), Kuwait (24%), Nigeria (19%), and Mexico (15%). The recent and rapid growth of international students requires that further attention be paid to educational institutions' strategic planning and practices in creating an inclusive environment that promotes excellence for all students (Raymond Ting & Morse, 2016). Several models and frameworks have been explored to better understand the major factors contributing to the mental health experience of international students.

Berry's Theory of Acculturation

Existing literature has found challenges related to acculturation to be a primary source of stress that could adversely impact the experience of international students (Anandavalli, 2019). Much of the literature on acculturation is based on Berry's theory of acculturation (Anandavalli, 2019). Acculturation is defined as "the dual process of cultural and psychological change that takes place as a result of contact between two or more cultural groups and their individual members" (Berry, 2005, p. 698). Berry's theory focuses on five primary factors that determine the process of acculturation (Berry, 1997).

The first factor, nature of society, includes macrostructures and social institutions (i.e., universities and education policies). The second factor, nature of contact, reflects a broad range of status an individual might occupy in the new environment, including international student, immigrant, refugee, etc. The third factor is the social and demographic characteristics of the individual, and the fourth factor includes psychological characteristics (i.e., attachment style, personality, etc.) (Berry, 1997). The fifth factor, modes of acculturation, refers to strategies individuals use to explore, understand, and interact with a new environment and culture (See Table 5) (Berry, 1997). Berry classifies the modes of acculturation into two dimensions: cultural

maintenance and contact and participation (Berry, 1997). Cultural maintenance is the extent to which a person strives to maintain the culture of their origin country. Contact and participation is the extent to which a person chooses to integrate into the host culture (Berry, 1997). Table 5 shows how the four acculturation strategies, integration, assimilation, separation, and marginalization, fit within the two dimensions.

Table 5

Berry's Acculturation Strategies

Acculturation Strategy	Intent to maintain one's home culture	Intent to adopt the host culture
Integration	Yes	Yes
Assimilation	No	Yes
Separation	Yes	No
Marginalization	No	No

Note. Adapted from "Immigration, Acculturation, and Adaptation" by Berry.J.W, 1997, *Applied Psychology, 46(1), 5-34.*

Berry's theory offers a valuable theoretical framework to guide the exploration of variables contributing to international students' acculturative experience and how this ties into mental health challenges (Anandavalli, 2019). For example, English language proficiency has been found to be an indicator of an international student's acculturation status. Poor English skills contributed to increased difficulties with academics and building friendships with domestic students (Dao et al., 2007). These negative experiences have been shown to contribute to acculturative stress and increase symptoms of psychological distress (Anandavalli, 2019). For example, Ogunsanya et al. (2018) conducted a cross-sectional study assessing the relationship between perceived stress, acculturative stress, coping mechanisms, and health-related quality of life (HRQoL) among a cohort of international graduate students. The dependent variable,

HRQoL, spanned eight domains of health: general health perceptions, physical health, role (physical), bodily pain, vitality, social functioning, role (emotional), and mental health. Study findings revealed that perceived and acculturative stress significantly impacts the HRQoL of international students. Perceived and acculturative stress were strong predictors of mental health, and acculturative stress was a significant predictor of physical health. The authors posit that international students' unique position and exposure to multiple stressors contribute to acculturative stress, which inevitably negatively impacts their psychological well-being (Ogunsanya et al., 2018).

A significant limitation of Berry's theory of acculturation is its strong focus on the individual level components (i.e., psychological characteristics & demographics) and less on environmental factors (i.e., religion, ethnicity, culture, etc.). The individualistic approach limits the theory's applicability to international students from collectivistic cultures (He & Hutson, 2018; Li & Zizzi, 2018). For example, research has shown that international students often depend on monocultural and co-national friendships (friendships among people from the same nationality) to navigate a new culture (He & Hutson, 2018). Multicultural friendship (friendship with other international students) is also a popular source of support for international students (Li & Zizzi, 2018). Despite the impact of these types of support systems on international students' well-being, Berry's theory does not incorporate or recognize the role of these factors in influencing acculturation (Anandavalli, 2019). Another limitation of this model is that it does not provide practitioners with a multicultural framework that envisages the cultural strengths or preferred coping skills of these student populations (Yakunina et al., 2013). In addition to the individualistic approach of Berry's theory, there is also the critique that this framework is primarily positivist and naturalist. Berry describes the modes of acculturation as distinct,

exhaustive, and mutually exclusive (Anandavalli, 2019). On the contrary, research on the experience of international students shows that modes of acculturation typically vary depending on context (setting, demographic factors, etc.) (Ngo et al., 2018). Decades after Berry's theory of acculturation, there is still a scarcity of multicultural theories that provide counselors with a framework for exploring international students' cultural strengths to provide adequate and appropriate mental health support (Anandavalli, 2019).

Yosso's Theory of Community Cultural Wealth

Understanding the cultural capital and strengths of international students and not just the wide range of stressors contributing to acculturative and psychological distress is vital to comprehending the whole experience of this student population (Anandavalli, 2019). For example, while Berry's Theory of Acculturation has led researchers to view English language proficiency as a predictor of acculturative stress for international students (Benzie, 2010), an approach highlighting cultural strengths could demonstrate that multilingual skills can enhance international student's experience. Dewaele and van Oudenhoven (2009) found that those who display advanced multilingual skills scored significantly higher in openness to other cultures and cultural empathy compared to monolingual individuals.

Yosso's Theory of Community Cultural Wealth is one such theory that provides a framework for understanding cultural wealth. Research has shown that minority groups utilize their cultural capital to effectively maintain academic, physical, and financial well-being (Anandavalli, 2019). Although Yosso's Theory of Community Cultural Wealth was initially created to highlight the cultural capital of racial minorities in the U.S., the theory can also be used as a framework to explore and recognize the unique experience, strengths, and capital of international students. Yosso explored the experiences of Students of Color in U.S schools,

brought attention to the intersecting identities of students (gender, race, language), and highlighted their unique cultural assets. The six types of cultural wealth identified by Yosso are aspirational, social, familial, resistant, linguistic, and navigational (See Figure 8) (Yosso, 2005).

Figure 8

Yosso's Theory of Community Cultural Wealth

Note. Adapted from "Whose culture has capital? A critical race theory discussion of community cultural wealth" by Yosso, T.J, 2005, *Race Ethnicity and Education, 8(1), 69-91.*

The application of Yosso's Theory of Community Wealth presents a strengths-based approach to understanding the dynamic and diverse experiences of international students (Anandavalli, 2021). A strength-based approach will spotlight this student population's strengths, resourcefulness, and self-determination rather than their perceived limitations and deficiencies (Lillyman & Bennett, 2014; Pendse & Inman, 2017). He and Hutson (2018) conducted a mixed-methods study to explore the strengths of Chinese international students and found that despite linguistic challenges, these students displayed great 'aspiration capital' and were determined to complete their program requirements. The importance of recognizing these strengths is underscored by studies that show that silence due to linguistic barriers might be misinterpreted by faculty as signs of disinterest, disengagement, or lack of intelligence (Sato & Hodge, 2015; Yates & Nguyen, 2012). Various other studies have explored the social capital (Li & Zizzi, 2018), familial capital (He & Hutson, 2018), resistant capital (George Mwangi et al., 2019), linguistic capital (George Mwangi et al., 2019; Vasilopoulos, 2016), and navigational capital (Anandavalli, 2019) of international students.

Cultural Humility

The call for greater attention to the cultural strengths of international students has resulted in efforts to promote cultural awareness on college campuses. The role of culture in providing appropriate care is well established in literature and across different professional fields (Lekas et al., 2020). Several trainings have been designed to achieve "cultural competence" (Lekas et al., 2020). With origins in the medical field, cultural competence emphasizes how cultural differences can impact the provision of person-centered care and reduce health disparities (Lekas et al., 2020). Currently, many health-related jobs and associations, medical

schools, and government entities within the U.S. mandate cultural competency training for their staff (Kirmayer, 2012; Lekas et al., 2020).

Although cultural competency training provides tools and teaches skills to improve communication and establish effective relationships with patients, "cultural competence" has been labeled problematic. One reason for this pushback is that the term competence feeds into existing social stereotypes and reinforces the power imbalance between patients and providers (Kirmayer, 2012; Lekas et al., 2020; Shepherd, 2019; Tervalon & Murray-García, 1998). Lekas et al. (2020) reason that culture is evolving - changes to belief and value systems shift due to constant interaction with varying factors (persons, institutions, technology, socioeconomic, media, etc.). The claim of competency presents a static and totalizing view and contradicts the inherent mutability within cultures. Furthermore, this static view holds no room for intersectionality and the dynamic nature of individuals (race, class, gender, etc.) (Lekas et al., 2020).

In recent years, there has been a paradigm shift from cultural competency to cultural humility. Originating within the medical and nursing fields, cultural humility was first proposed to supplement cultural competency by Tervalon and Murray-García (1998). They defined cultural humility as "a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and non-paternalistic clinical and advocacy partnerships" (Gottlieb, 2021, p. 465). Tervalon and Murray-García (1998) argue for the importance of a cultural humility framework to aid physicians in acknowledging the intersections of multiple identities in their patients.

Authors Lekas, Pahl, and Lewis define cultural humility as an "orientation towards caring for one's patient that is based on: self-reflexivity and assessment, appreciation of patients'

expertise on the social and cultural context of their lives, openness to establishing power-balanced relationships with patients, and a lifelong dedication to learning" (Lekas et al., 2020, p. 2). Whereas competence implies mastery, humility emphasizes an intrapersonal and interpersonal approach to care. There is awareness of one's embeddedness in culture and reflection on beliefs, values, biases, and how that impacts communication and quality of care. Taking a shift from the content-orientation focus in cultural competence training, cultural humility training is process-oriented, fostering provider awareness, openness, and humility.

Various cultural humility frameworks have been proposed for different fields, including medicine, nursing, social work, psychology, research, etc. In 2012, Chang, Simon, and Dong introduced the QIAN 謙 (Humbleness) curriculum: "**Q**uestioning and critique, bi-directional cultural **I**mmersion, mutually **A**ctive-listening, and the flexibility of **N**egotiation.". The curriculum was geared towards the medical community and applied explicitly to Chinese immigrants. However, the authors stated that the concepts could be used across cultures to draw attention to power imbalances inherent within healthcare professions and the importance of accounting for patients' cultural factors (values, beliefs, etc.)(Gottlieb, 2021).

Within the field of social work, Ortega and Faller (2011) present a model of cultural humility mainly focusing on child welfare systems. The model has emphasized realistic and ongoing self-appraisal of biases and stereotypes, openness, and transcendence. The authors state that current cultural competence models exacerbated power imbalances by placing an overemphasis on shared group characteristics at the expense of unique individual differences, thus privileging workers' expertise over client culture (Ortega & Faller, 2011). The proposed model addresses this challenge by encouraging active engagement with clients, promoting an

inclusive environment, and discarding notions of cultural expertise among workers (Ortega & Faller, 2011).

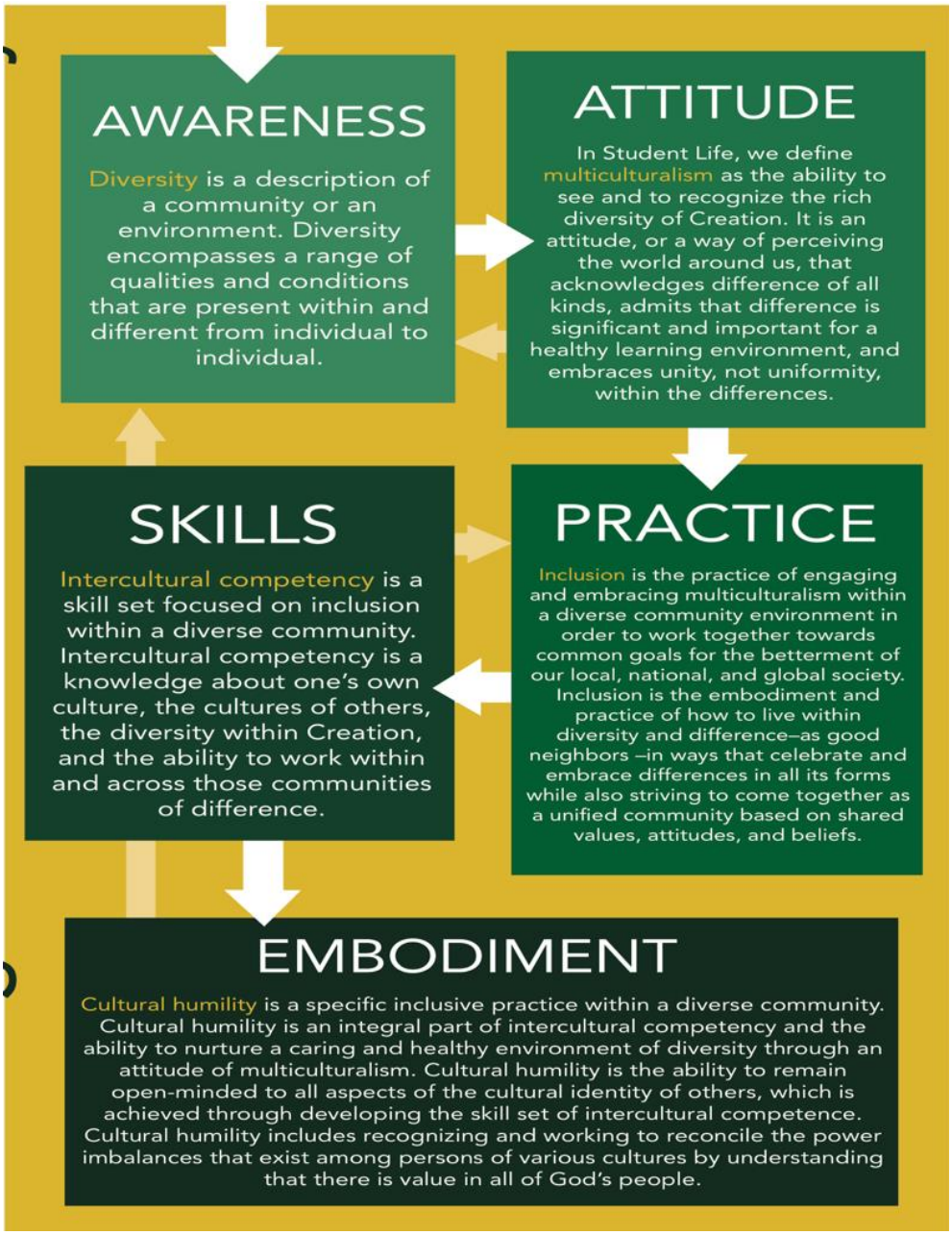
In 2013, the Cultural Humility Scale, the only quantitative measurement of cultural humility, was created and tested by Hook, Davis, Owen, Worthington, and Utsey (Hook et al., 2013). The scale aims to measure a client's perceptions of their therapists' cultural humility using a 12-item Likert scale. Based on the scale, therapists who rank high in cultural humility are defined as being other-oriented, open, and respectful of clients' beliefs, values, worldviews, experiences, and cultural backgrounds (Hook et al., 2013). Hook et al. (2013) conducted a study with college students to test the reliability and validity of the Cultural Humility Scale. Their results showed an association between therapists' cultural humility and the development of stronger working relationships and therapy outcomes in students. Data also indicated that students' perceptions of their therapists' cultural humility could lessen the effects of power imbalances and serve as a "buffer between therapist missteps (i.e., microaggressions) and therapy outcomes" (Hook et al., 2013, p. 354).

Cultural humility is very relevant to academic settings, especially concerning faculty. The existing power dynamic in a classroom and unconscious bias among faculty could perpetuate stereotypes that could be harmful to international students (Sharma & Clark, 2021). Many colleges and universities have established processes to institutionalize cultural competency standards. These processes are commonly housed and assessed under the Office of Diversity, Equity, and Inclusion (DEI) (Zhang et al., 2021). Kent State University (Sharma & Clark, 2021), Oregon State University (Oregon State University, n.d), Baylor University (Baylor University, n.d), University of San Francisco (University of San Francisco, n.d), and University of Washington/Tacoma (University of Washington | Tacoma, n.d) are some of the institutions with

webpages dedicated to information and resources on cultural humility. Figure 9 shows a guide developed by Baylor University Office of Diversity & Inclusion on developing cultural humility.

Figure 9

Baylor University Moving Towards Cultural Humility



Note. Taken from Developing Cultural Humility, by Baylor University, n.d. (https://www.baylor.edu/diversity/index.php?id=948078)

Summary

The literature review provided an overview and critique of five current approaches to mental health on college campuses: a comprehensive approach to mental health, gatekeeper training for mental health, peer interventions to mental health, the triage model, and telehealth services. Because these approaches focus primarily on the general student population, Berry's theory of acculturation and Yosso's theory of community cultural wealth were explored to gain more insight into the mental health experience of international students. Given the emphasis on culture in these theories, the role of cultural humility in providing mental health support to international students was assessed.

CHAPTER 3: METHODS

Chapter One introduced the thesis topic: how to improve the provision of mental health support to international graduate students and the project objectives. Chapter Two provided an overview and critique of exiting approaches to mental health on college campuses; explored Berry's Theory of Acculturation and Yosso's Community Wealth Theory as it relates to the experiences of international students; discussed the role of culture; and highlighted the gaps in current literature on mental health approaches for international students. This third chapter will provide information on this project's theoretical and conceptual framework, project design, and methodology.

Summary

Overall, the review of current approaches to mental health on college campuses and the exploration of Berry's Theory of Acculturation and Yosso's Theory of Community Cultural Wealth indicate that interventions to support international students should be comprehensive and leverage the roles of gatekeepers. Additionally, to create an effective intervention for this student population, it is critical that cultural humility training is accounted for and the utilization of non-clinical support services be considered. Based on the information reviewed, this mental health curriculum found in Appendix A will consist of trainings to increase mental health literacy, increase awareness of cultural humility, teach intercultural communication skills, and increase awareness of resources at Emory. This curriculum will also include a module on compassion; a concept that is not covered in the literature review but is relevant in supporting the international student population.

Overview of Program Models and Theory

Gatekeeper Training Model

The Gatekeeper model continues to increase in popularity as an approach to addressing access to mental health support for various settings and diverse populations (Lipson et al., 2014). This model equips individuals whose "roles place them naturally at strategic points of intersection between service deliverers and the public" with the knowledge and skills to recognize, intervene and refer individuals going through mental distress to appropriate resource (Bissonette, 1979, p. 294; Lipson et al., 2014). Given the low utilization rate of campus counseling services amongst international students, this model is appropriate because it targets individuals who are in more frequent contact with international students (vs. counselors in counseling offices) (Anandavalli, 2019).

The Three "R's" Model

The RRR model has been applied across various campuses in the U.S to support students experiencing mental health distress. Colleges and universities adapt this model in mental health and suicide prevention training program. The RRR model is used in conjunction with the gatekeeper model to train faculty, staff, teaching assistants, etc., to recognize, respond and refer students to campus resources (Centre for Innovation in Campus Mental Health, n.d-a). The three main parts of this curriculum map onto the RRR model very closely.

Table 6

RRR Model

RRR Model	Mental Health Component	Description
Recognize	Part 1	Mental health and suicide prevention training
Respond/Relate	Part 2	Cultural humility and Compassion training
Refer	Part 3	Resource awareness training

RAND Model of Gatekeeping

This curriculum follows RAND's conceptual model for gatekeeper interventions. Guided by the literature on gatekeeping and Social Cognitive Theory (SCT), RAND National Defense Research Institute developed a model for suicide prevention training (Burnette et al., 2015). The model shows the pathway between training and behavior and accounts for individual characteristics and social contexts that could hinder or facilitate the effectiveness of training and intervention behavior (Burnette et al., 2015). For this curriculum, the RAND's model was adapted to create an intended process of the gatekeeper intervention. The intended process incorporates the four main factors: knowledge, beliefs & attitudes, self-efficacy, and reluctance (Burnette et al., 2015). Figure 10 depicts the intended process and outlines how each key component of the curriculum (mental health, cultural humility, compassion, and resource awareness), aligns with the four factors in RAND's model and the process that leads to expected behaviors and overall curriculum goal.

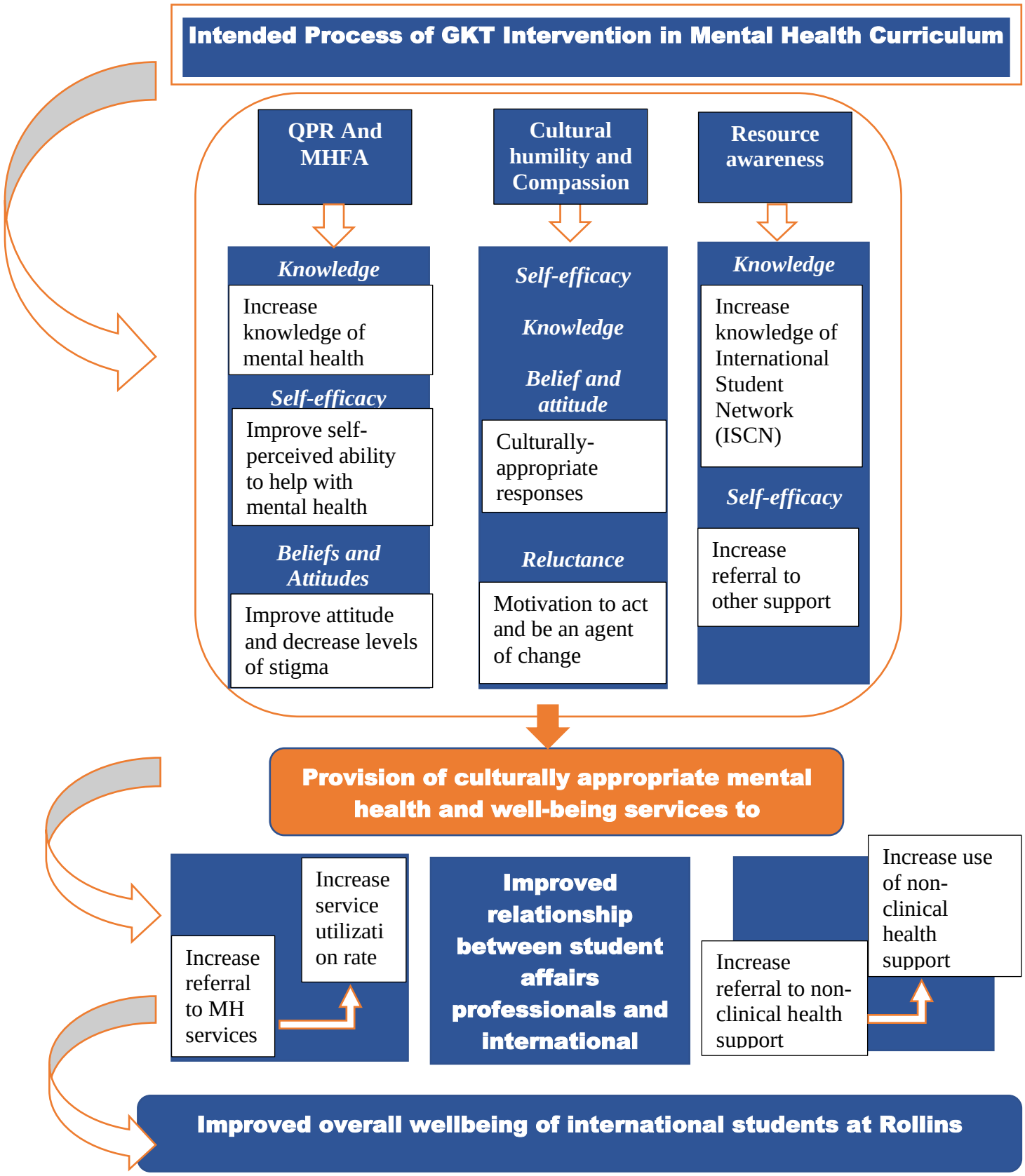
Social Cognitive Theory (SCT) was developed by Albert Bandura in 1986. SCT is one of the most comprehensive behavior theories (Rimer & Glanz, 2005) and has been applied in a variety of settings as the foundation for behavior change (Luszczynska & Schwarzer, 2020). The theory posits that learning a new behavior is influenced by a dynamic, ongoing relationship between personal and environmental factors (Burnette et al., 2015). The theory explores the reciprocal interaction between an individual and their environment – behavior is not simply a product of the environment and vice versa (Rimer & Glanz, 2005). Because SCT integrates concepts from different models of behavior change (behaviorist, emotional, cognitive), the model includes the following constructs: reciprocal determinism, behavioral capability, expectations, self-efficacy, observational learning (modeling and reinforcement (Rimer & Glanz, 2005). This

mental health curriculum will apply the behavioral capability and self-efficacy constructs of SCT as the basis for behavior change. Behavior capability pertains to the knowledge and skills needed to perform a given behavior and self-efficacy reflects a subjective estimate of one's ability to execute a behavior (Burnette et al., 2015) (Luszczynska & Schwarzer, 2020).

Conceptual Model of the Curriculum

Figure 10

Intended process of GKT intervention



Overview of the Conceptual Model

The pathway between the training provided through the mental health curriculum and the "intervention behavior" is outlined in Figure 1. In this model, several aspects of the program can be viewed: 1) the program components: QPR and MHFA trainings, cultural humility and compassion training and resource awareness tools and strategies; 2) the factors that influence the target groups decision to engage in desired behavior: knowledge, self-efficacy, reluctance, and beliefs and attitudes; 3) a pathway that shows the link between the desired behavior of student affairs professionals to improvement in three key areas: utilization of mental health services, the relationship between student affairs professionals and international students, and the use of non-clinical support services. The author purports that change in these areas would result in the improvement of the overall well-being of international students at Rollins.

1. Program Components

A brief description of the program components and several figures that describe how each part of the curriculum influences the four factors and contributes to the desired behavior are below:

Mental Health First Aid (MHFA)

The Mental Health First Aid (MHFA) training follows the gatekeeper model and thus aligns with the structure of this mental health curriculum. MHFA is incorporated into this mental health curriculum to increase the mental health literacy of student affairs professionals. The training consists of both asynchronous and synchronous components providing information on common mental health challenges for individuals 18 years and older. SAF will be trained in recognizing warning signs of a mental health crisis or substance abuse and how to provide appropriate care. Although the MHFA training is not tailored to the international student

population, the training does provide an overview of how culture impacts the presentation of psychological symptoms. SAF will learn how to use the ALGEE Action Plan.

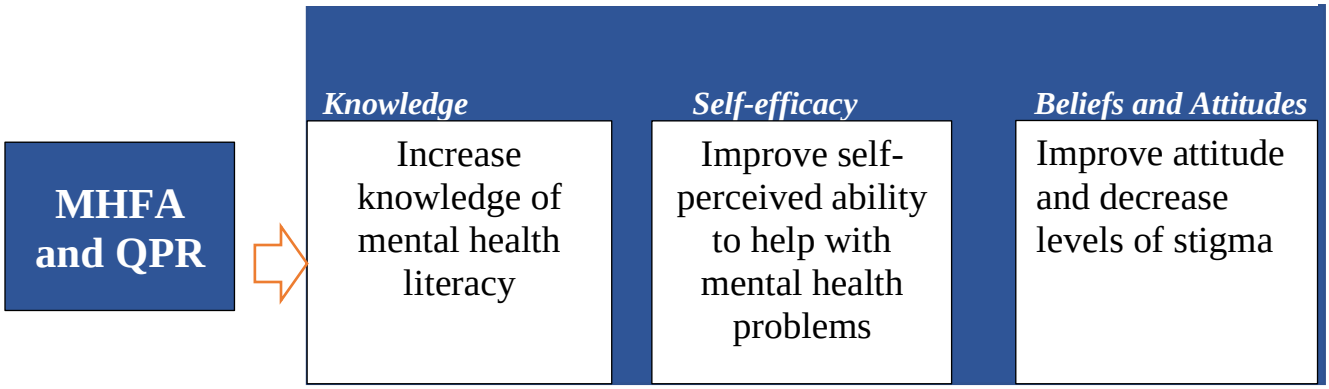
Question, Persuade and Refer (QPR)

Following the MHFA training providing general information on mental health, SAF will complete the Question, Persuade and Refer (QPR) training focusing on suicide prevention. The QPR training will equip SAF with the knowledge and skills to identify students going through a mental crisis and/or exhibiting suicide symptoms. While the MHFA provides some information on suicide, QPR will go in-depth with information on common causes and warning signs of suicide. The training will be facilitated by the Emory Office of Counseling and Psychological Services who will provide information on local services and also specific resources available at Emory.

Figure 11 shows how the MHFA and QPR training in the curriculum influences student affairs professionals' decisions and ability to act by changing knowledge, self-efficacy and beliefs and attitudes. The knowledge component refers to increased perceived and declarative knowledge of mental health disorders, warning signs of mental health crisis and suicide, and suicide prevention. The self-efficacy component refers to an improvement in student affairs professionals' perceived comfort and competence to identify and support an international student with mental health concerns. Beliefs and attitudes refer to an improvement in student affairs professionals' beliefs about mental health and suicide and the appropriateness of their intervention.

Figure 11

Mental Health Awareness



It is important to note that part one of the mental health curriculum is not tailored to the target population and does not address causes, or warning signs specific to international students. In the later parts of the curriculum, SAF will learn how to apply the knowledge and skills learned to address the needs of international students at Rollins.

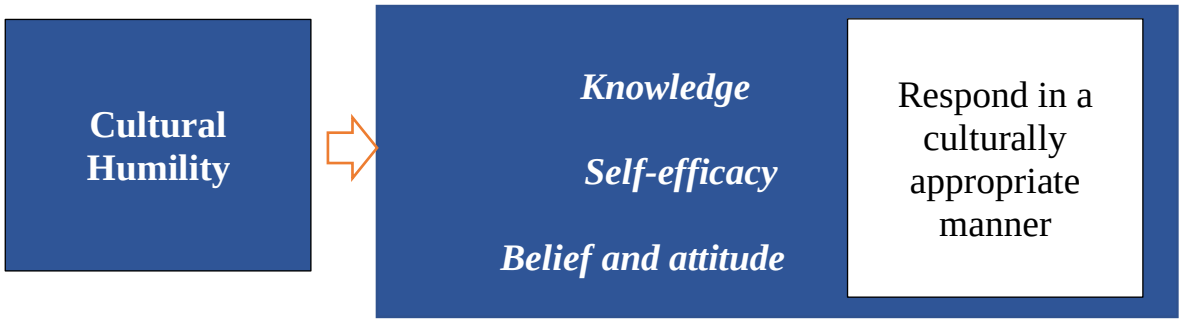
Cultural Humility

The Intercultural Development Inventory (IDI) is a "cross-culturally generalizable (i.e., international, and domestic diverse culture groups), valid and reliable measure of intercultural competence that does not contain cultural bias."(Intercultural Development Inventory, n.d, para. 4) The assessment tool measures the level of intercultural competence/sensitivity across a developmental continuum ranging from a monocultural mindset to an intercultural/global mindset (Hammer, 2011). In addition to measuring intercultural competence on the continuum, IDI also measures the capacity to observe cultural similarities and differences and modify behavior to cultural context. The assessment is in its third version and has been translated into multiple languages for select demographics and can be used by individuals, groups, and organizations (Hammer, 2011). Additional information on IDI can be found in Appendix J.

Figure 12 shows how the cultural humility training in the curriculum influences student affairs professionals' decisions and ability to act by changing knowledge, self-efficacy, and beliefs and attitudes. The knowledge component refers to increased perceived and declarative knowledge of culture and intercultural communication skills. The self-efficacy component refers to an improvement in student affairs professionals' perceived comfort and competence to interact with international students in a manner that is respectful and acknowledges their cultural backgrounds, beliefs, and perceptions. Beliefs and attitudes refer to a positive change in student affairs professionals' beliefs and attitudes about assumptions and the value of international students' cultural backgrounds.

Figure 12

Cultural Humiliy



2. Factors that Influence the Behavior of Target Group

It is important to note that individual characteristics and social context both affect how a change in these factors could influence intervention behavior. Individual characteristics are personal attributes that include both demographic and professional background such as age, sex, job role, education, prior mental health, cultural humility training, etc. The social context refers to the environment in which student affairs professionals are expected to act as gatekeepers. Social context includes organizational-level factors such as competing demands that limit the

ability to act, the culture and climate at the school including supervisor and coworkers' support of student affairs professional's role as gatekeepers. The individual characteristics and social context could modify the effect of the training covered in the mental health curriculum on the four factors. For example, individuals in certain job roles might have more time constraints which could impact their ability to complete training, impact the knowledge factor, and ultimately the intervention behavior.

Compassion

The last decade has seen a significant increase in empirical research on compassion in multidisciplinary and cross-disciplinary studies (Mascaro et al., 2020). Diverse methods and theoretical frameworks have been developed and employed to understand and measure the impact of compassion in different settings and with diverse populations (Mascaro et al., 2020). Of note is the role of compassion in fostering cooperation and unity in an increasingly interconnected society (Weng et al., 2015). There's a growing body of literature on how compassion mediation training can influence an individual's desire to relieve suffering and emotional response to caring through contemplative practices and cognitive restructuring (Pace et al., 2009).

For example, Weng et al. (2015) investigated the relationship between compassion and altruistic behavior and found that participants showed more altruistic helping of unknown victims after two weeks of compassion training. Taylor et al. (2018) explored the role of compassionate care in Board Certified Behavior Analysts (BCBAs) and their work with children with autism and their families. The authors describe the difference between the constructs of sympathy, empathy, and compassion in mental health. Taylor et al. (2018) argue that compassion differs from the other two constructs because it introduces an action component to an otherwise

emotional response. Lown et al. define compassion as "the recognition, empathic understanding of and emotional resonance with the concerns, pain, distress or suffering of others coupled with motivation and relational action to ameliorate these conditions (2014, p.3).

The compassion section of the curriculum will engage participants in dialogue about compassion and highlight the relationship with cultural humility. Figure 4 shows how the compassion training in the curriculum influences student affairs professionals' decisions and ability to act by serving as motivation. Through the training there is a change in student affairs professionals' perception of taking responsibility to support the mental health and well-being of international students. Notably, this mental health curriculum will also explore the role of compassion in addressing the reluctance factor in student affairs professionals

Figure 13

Compassion

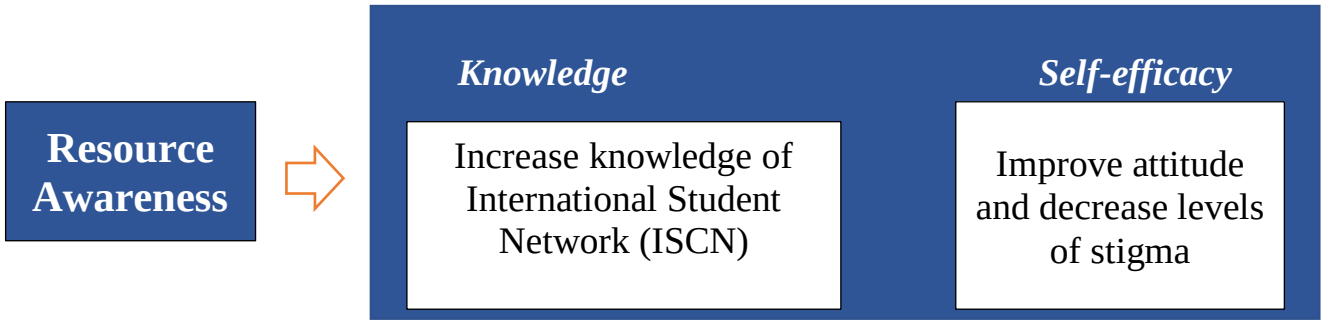
Resource Awareness

The resource awareness training will introduce the International Student Care Network (ISCN) and a corresponding flowchart. Participants would have access to the flowchart (see Appendix A) prior to the training and are encouraged to review the document and come ready to discuss. The Associate Director of Student Engagement will facilitate the training and provide further information on the offices included in the ISCN and the support services they provide. After the instructional session, participants will be presented with three different case studies.

After each case study, they will be divided into groups to discuss what the appropriate responses should be. Participants will then return to the bigger group where the facilitator will present the correct answer. At this time participants will have the opportunity to continue discussions on resources at Emory and how to utilize them to support international students.

Figure 14

Resource Awareness



Stakeholder Involvement

This project is a culmination of literature review and support from several mentors and collaborators. My thesis committee chair, Dr. Joanne McGriff, provided constructive feedback on the curriculum content regarding utility, value and alignment with the desired goals. Thesis committee member, Joanne Williams, provided access to reports from the 2017 Emory NCHA data on student mental health as well as a report on the mental health experience of international graduate students at Emory. She also helped identify relevant resources at Emory and established connections with other stakeholders for this project. Dr. David Addiss provided guidance on exploring the literature on compassion and applying different constructs to the curriculum. A brief description of other stakeholders that will be necessary to implement the curriculum can be found in Appendix B.

Project Setting

The mental health curriculum will be piloted at the Emory University Rollins School of Public Health (Rollins) located in Atlanta, Georgia. Rollins currently offers master's, doctoral and dual degree programs. Students are enrolled in one of six department programs and have the opportunity to choose from eleven certificate options. According to the school's 2021 student profile, the average student age is 25 with 81% of the student population being female and 26% as international students.

Rollins employees who manage student life and engagement are housed in the office of student services. With twenty full-time staff and three graduate assistants, the office of student services organizes events to promote student well-being at Rollins. The Global Peer Network (GPN) is one of many initiatives by the office to support the international student community. GPN is a program that aims to "promote cross-cultural relationships for all RSPH students and form a community for international students" (Rollins School of Public Health, n.d).

The mental health curriculum will be positioned under the Office of Student Services. The office will be responsible for recruitment, implementation of program activities, and evaluation. Relevant data on how the curriculum contributes to DEI goals will be reported to the Assistant Dean of Diversity, Equity, and Inclusion.

Target Population

Based on the recommendations of Lipson et al. (2014), the selection of the gatekeepers as participants was based on two main domains: mental health knowledge and gatekeeper ability. In this project, gatekeeper ability is based on position/role at Rollins and the accompanying level of contact with international students. Four main groups (of gatekeepers) were analyzed to determine the best program targets: Graduate Teaching Assistants (GTAs), upper-level

administration, faculty, and student affairs professionals. The analysis was based on the literature and factors within the Rollins setting (e.g organizational structure, school employees, job title, roles, and responsibilities, etc.)

Table 7

Selection of Gatekeeper

		Gatekeeper Ability	
		High	Low
Mental Health Knowledge	High	Graduate Teaching Assistants	Upper-level administration
	Low	**Student affairs professionals**	Faculty

Note. Adapted from "Gatekeeper training and access to mental health care at universities and colleges", by Lipson et al., 2014, *The Journal of adolescent health:official publication of the Society for Adolescent Medicine, 55(5), 612-619.*

Graduate Teaching Assistants (GTAs). GTAs are students enrolled in graduate school who are assigned instructional duties in a course (University of Georgia Graduate School, n.d). GTAs at Rollins rank high in both gatekeeper ability and mental health knowledge. These students have access to the QPR training through the Emory Office of Counseling and Psychological Services and MHFA training through student clubs such as Emory Mental Health Alliance. Despite the high gatekeeper ability of this group, there are limitations to selecting this group to participate in the program. The main issue has to do with the duration of engagement with students. GTAs at Rollins typically hold their positions for a semester with classes ranging from one to fourteen weeks. The limited time with students poses a challenge to engaging this group as primary gatekeepers to train.

Faculty. As professionals who specialize in a specific academic subject and aim to educate students, faculty face a similar challenge with the duration of their interaction with students. Typically, students are enrolled in a course for a semester (one to fourteen weeks), which is different than the college context where students sometimes have multiple classes with the same professor or when students operate on a trimester schedule with varying faculty contact. Although many faculty members extend their interactions/relationships with students after coursework is complete, there is generally less contact after classes end and thus decreased support. Additionally, faculty time limits due to research or service activities could make this group less optimal to train.

Upper-level administration. This includes upper management within the university, including divisional leaders (enrollment, admission, finance), deans, and department chairs/directors. Although this group may have a high level of knowledge about mental health, staff in upper-level administration are often removed from student life and do not have many one-to-one interactions with students. Therefore, they would not be the ideal group to train as gatekeepers.

Student affairs professionals. Student affairs professionals are staff members who create an atmosphere and environment that promotes student development both personally and professionally outside the classroom (Killam & Degges-White, 2017). Student affairs professionals have a continuous relationship with students on various levels. This group of individuals provide support to students throughout their time at Rollins, thus allowing them to establish and build a relationship with students over time. Due to their unique positions and role, they have been selected as the primary target population for this curriculum.

More about Student Affairs Professionals for Gatekeeper Intervention in Universities

Student affairs professionals occupy a crucial position within colleges and universities due to their extensive contact and relationship with students, making them gatekeepers. Given the profession's commitment to developing "the whole person, "student affairs professionals can play a critical role in promoting graduate students' mental well-being (University of Nevada |Reno). Data from a 2019 survey conducted by American College Health Association (ACHA) showed that 24% of graduate students reported stress that negatively affected their academics, 41% reported feeling so depressed that it was difficult to function, and 63% reported overwhelming anxiety (Stebleton & Kaler, 2020). One set of researchers, Stebleton and Kaler (2020), argue that addressing this mental health issues is equally a moral and ethical responsibility of student affairs professionals (given their support function and unique position). Mental health support at this level does not require formal therapy or counseling skills but instead involves the practice of empathy, mental health literacy and the ability to refer to resources, and advocacy or facilitation of culture change within departments (Stebleton & Kaler, 2020).

Student affairs professionals can play an even more significant role in the case of international students. The contribution of student affairs professionals to supporting a diverse and inclusive environment can affirm the valuable cultural diversity international students bring and lead to a rich educational experience for this student population (Raymond Ting & Morse, 2016). The ability of student affairs professionals to provide appropriate support and effectively contribute to creating an inclusive environment requires awareness, knowledge, and skills related to culture (Cierra, 2004).

For the purpose of this mental health curriculum, the following offices have been selected as housing student affairs professionals who can address major areas of need and can support the mental well-being of international graduate students at Rollins:

1. **Rollins Office of Admission & Student Services**: Aims to promote a diverse and collaborative learning environment and offers programs and services to support academic and social support.
2. **Rollins Office of Enrollment Services**: Responsible for issues regarding student honor & conduct code, tuition & aid, and financial services.
3. **Assistant/Associate Directors of Academic Programs (ADAPs):** Academic advisors and first point of contact for department-specific questions, classes, etc.
4. **Office of Career Development (OCD):** Provides support to students in navigating public health opportunities by offering customized resources and partnerships.

Recruitment

Office of Student Services staff members will be responsible for recruiting student affairs staff members from the four identified offices to participate in the mental health curriculum. Office of Student Services staff members will hold an informational session for all interested staff members to provide further details on the components of the curriculum, time requirements, and expectations.

Pilot Testing

The Associate Director of Student Engagement and Program Coordinator will pilot the mental health curriculum in the fall of 2022. These staff members in conjunction with training facilitators will decide whether their individual sections will occur in person or online over zoom. In-person training will take place in an audio/video-compatible classroom at Rollins. The

Program Coordinator will be present to help with setup and coordinate with facilitators to participants with necessary materials. It is recommended that the pilot test has a cohort size of eight to ten participants. This sample size is ideal for program implementation, particularly, the administration and evaluation of training assessments. A scope, sequence and implementation plan is included in Appendix C. An example timeline for the pilot test is included in Appendix D and a proposed budget for the program is also included in Appendix E. Additional resources for implementation is shown in Appendix I.

Training Assessment

Participants will complete pre-and post-assessments as part of the training. First, the curriculum coordinator will work with the Cultural Humility and Intercultural Communication training facilitator to administer a pre-and post-training survey. Participants can provide a self-rating of their perceived knowledge of concepts before and after the training. Participants can also provide overall feedback on the format and content covered in training. Participants will also take a brief survey before and after the resource awareness training to assess knowledge acquisition. The assessment will ask questions about the International Student Care Network (ISCN). The program coordinator will be present for each training and conduct observations to be used for evaluation of curriculum content and overall program. Program goals and objectives can be found in Appendix F. A set of possible indicators for a process and outcomes evaluation of the full program is recommended in Appendix G. Appendix H shows some sample program assessesment tools.

Ethics and IRB considerations

No IRB proposal was submitted for this project. Based on Emory University's IRB guidelines, this special studies project does not need IRB review because it is not considered

research and does not involve any human subjects or clinical investigation. This project is for educational purposes only with the intent of being used to improve services for international students.

CHAPTER 4: DISCUSSION AND RECOMMENDATIONS

International graduate students are at a high risk of mental health concerns due to unique stressors related to their status and the additional challenges of rigorous graduate academic life. Stressors associated with language, finances, academics, and the adaptation and adjustment process to a new culture, to name a few, can lead to psychological distress and result in adverse mental health outcomes. This special studies project aims to improve the the provision of culturally appropriate mental health and well-being services for international students at Rollins. This goal was achieved through the creation of a three-part mental health curriculum for student affairs professionals that increases mental health literacy, increases knowledge and skills related to cultural sensitivity and humility, and increases awareness of resources available at Emory University. This final chapter discusses the mental health curriculum's strengths, limitations, and implications. Furthermore, recommendations are provided for future studies and improvements.

Curriculum Strengths and Limitations

Strengths

Organizational-level Intervention. A majority of the literature on mental health interventions for international students focuses on individual-level factors (Pendse & Inman, 2017). The literature is saturated with research on topics such as cultural adjustment/acculturation and the help-seeking behavior of international students. This limited focus on the “individual” in research contributes to an exaggerated and inaccurate representation of personal responsibility in addressing mental health concerns within this student population (Pendse & Inman, 2017). As recognized and recommended in the socio-ecological models, health outcomes should be framed as an interaction between individual, interpersonal, organizational, community, and policy fields (Castillo et al., 2019). This mental health

curriculum veers away from the overemphasis on individual-level factors and approaches student mental health needs from an organizational level. Meaning, student affairs professionals are trained as a means to improve the social "environment" that international students occupy. While, the mental health curriculum influences changes at the individual level for student affairs professionals (knowledge, self-efficacy, reluctance, and beliefs and attitudes), the goal is to create an inclusive and supportive environment for international students. The training of student affairs professionals to address the mental health needs of international students underscores the effect of the environment in improving mental health outcomes.

Link to Diversity, Equity, and Inclusion efforts. For nearly two years, the Rollins School of Public Health (RSPH) has increased its efforts to promote Diversity, Equity, and Inclusion (DEI). A notable step in this direction was the selection of a new Assistant Dean for Diversity, Equity, and Inclusion (Rollins School of Public Health, 2020). Given that international students tend to be an overlooked population on college campuses, it is important to acknowledge that the support of this student population is, in fact, an issue of equity and inclusion. The goal of this curriculum aligns with the school's current DEI's efforts to support a culture of inclusivity and ensure that the climate at Rollins is indeed equitable to all student groups. The inclusion of training on cultural humility and intercultural communication, and bias reporting in the ISCN referral pathway supports specific DEI efforts to address issues regarding implicit bias at Rollins.

Comprehensive Approach. The literature review covered in Chapter Two highlighted the need for a comprehensive approach to mental health promotion on college campuses. This curriculum integrates this approach by having Emory's first-ever International Student Care Network (ISCN). ISCN includes a network of stakeholders that span offices at Emory involved in supporting international students' academic, social, intellectual, and emotional needs. An

established network of stakeholders that specialize in key issues that influence international student mental health is valuable in helping individuals (international students, faculty, staff) navigate campus resources (Lee, 2021). In fact, the increased awareness of available resources at Emory could reduce an over-reliance on clinical services and promote the referral and use of non-clinical support services.

Limitations

Secondary Data Collection. One limitation of this project is that no primary data were collected for curriculum development. The literature review informed the selection process of gatekeepers and the selection of mental health training to include in the curriculum. Since no primary data was used in the development process, assumptions were made about the feasibility and acceptability of this curriculum. Assumptions are made on the availability of funds for curriculum implementation and maintenance, school buy-in, student affairs professionals' engagement, ownership, etc. A situational analysis would have provided the opportunity to collect information and engage with stakeholders to establish a clear and detailed picture of resources and possible challenges and barriers to curriculum implementation and success. This is particularly relevant because the majority of existing literature on the mental health experience of international students is focused on students from Asian countries (Pendse & Inman, 2017). The lack of diversity and appropriate representation in research leads to a danger of generalizing and normalizing the experience of one national group.

Generalizability of the Curriculum. Although the MHFA and QPR training are not context-specific, the trainings on cultural humility, compassion, and resource awareness are designed to be tailored to Emory University, potentially limiting generalizability. In addition, the selection of the target population is very specific to Rollins. Although the generalizability of the

curriculum to other schools within Emory and other colleges and universities might be unclear, the structure and key components of the curriculum can, at minimum, be used as a starting point for considerations of similar issues.

Implications

This mental health curriculum is the first of its kind. The curriculum is a unique combination of the strongest components of many curricula on mental health and cultural humility. The curriculum is developed to increase the mental health literacy of student affairs professionals while simultaneously providing tools to combat cultural assumptions and biases that could impact the provision of appropriate care. Furthermore, mental health training coupled with cultural humility and intercultural communication training provides tools to boost the individualization of support. Given the diverse and dynamic nature of the international student population, it is critical that support is not provided in a monolithic manner as this could reinforce stereotypes and cause harm. The utilization of gatekeeper skills (e.g., active listening) and intercultural communication skills allows for student affairs professionals to be sensitive to subtle differences that exist both within and between international students' groups. The skills taught in this curriculum will help student affairs professioanls to recognize the heterogeneity of international student experienes, honor multidimensional identities and celebrate uniqueness.

Moreover, no other existing mental health curriculum draws on the role of compassion as a pathway for change. Although compassion is linked to the practice of cultural humility, compassion is rarely discussed as an integral part of training for individuals working with international students. Compassion is integrated into the curriculum with the goal of achieving change at both the individual and organizational levels. This curriculum attempts to coalesce

evidence-based approaches to mental health and cultural humility while concurrently utilizing explanations for sustainable behavior change founded in the language of compassion.

Recommendations for Improvements and Future Studies

Program Implementation

According to the social cognitive theory, reinforcement serves a significant role in behavior change (Rimer & Glanz, 2005). Reinforcements affect the likelihood of adopting and maintaining a behavior. Currently, student affairs professionals' engagement and full participation are based solely on intrinsic motivation. Efforts should be made to explore reinforcements that student affairs professionals would value to encourage full participation and engagement with the program. Possible reinforcements could be incentives such as a small gift upon completing all modules, a certificate of completion, or the opportunity to speak about their experience to the school's DEI committee or a different school function.

Data for System-level Changes

To better understand system-level factors influencing program success, a post-training survey should be administered to student affairs professionals with open-ended questions to capture perceived structural and organizational barriers at Rollins. The survey should be anonymous and adminstered six and twelve months following the end of the final training. Possible barriers at the system level could lead to the underutilization of acquired knowledge and skills, which can lead to inefficiencies and negatively impact desired outcomes. For example, if student affairs professionals are experiencing time constraint issues due to too much work, this could limit their ability to thoroughly engage with international students that show signs of a mental health crisis. It is essential to recognize that the environment (or organizational climate)

impacts, not only international students, but also impacts student affairs professionals and their ability to act to support international students.

Inclusion of CBCT

It should be noted that the module on compassion is not meant to be a one-stop training for compassion. Learning compassion requires time and attention and a significant amount of individual work. The decision to include this section is to give student affairs professionals a chance to engage in dialogue to understand what compassion currently means to them and, importantly, foster community engagement on compassion at an organizational level. Although compassion is not typically seen as a science, there is growing evidence of the applicability and tangible skills that could be gained through engagement in compassion training.

The Cognitively-Based Compassion Training (CBCT) housed under the Emory University Center for Contemplative Science and Compassion-Based Ethics shows great promise and should be considered as an addition to the current curriculum module on compassion. CBCT is designed to strengthen and sustain compassion through targeted analytic reflections to understand one's relationship to self and others as well as training on attention stability and increased emotional awareness (Center for Contemplative Science and Compassion-Based Ethics n.d). The center currently collaborates with the Emory School of Medicine and offers CBCT twice annually to faculty and staff. CBCT training is also provided to nurses and other providers at the Emory Nell Hodgson Woodruff School of Nursing (Center for Contemplative Science and Compassion-Based Ethics n.d). Future studies should be done to examine the adaptation of CBCT to Rollins following pilot testing of the mental health curriculum.

Trauma-informed Training

In October 2020, the #EndSARS movement in Nigeria led to weeks of active protests and the unfortunate event at Lekki Toll Gate that resulted in protesters being injured and killed. This event had an adverse effect on citizens of the country, including international students from Nigeria. This occurrence, coupled with the impact of the COVID-19 pandemic (uncertainty about immigration law, loss of jobs, death of family), created an extremely difficult situation for students from the country. More recently, Russia's invasion of Ukraine has created a similarly difficult situation for international students from Ukraine (e.g., the uncertainty about the safety of family) is. Although some traumatic experiences are ongoing in some countries, other events are once-in-a-lifetime occurrences that may conjure more intense emotional responses and will likely impact the mental health of students from affected countries. Therefore, another recommendation is that trauma-informed training be included in the mental health curriculum to help student affairs professionals deal with these specific cases appropriately. Through this training, student affairs professionals can develop trauma-sensitive attitudes and be more in-tune with advocating and providing additional support to international students. The Center for Excellence in Teaching and Learning at Minnesota State University Mankato has developed an impressive collection of trauma-informed teaching resources that could be beneficial in the development of this additional module (Murn, n.d).

Conclusion

This mental health curriculum shows promise of positively impacting the mental health experience of international students at Rollins by increasing the mental health literacy of student affairs professionals, as primary gatekeepers, and promoting their cultural awareness/humility and practice of compassion. I hope that this curriculum also contributes to shifting the overall

culture/climate at Rollins to be more compassionate and supportive of international students and, by extension, minority students and the general student population

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APPENDICES

Appendix A: Curriculum and Facilitation Guide

The curriculum and facilitation guide begins on the **next page.**

A Mental Health Curriculum for Rollins Student Affairs Professionals

Created by Deborah Adenikinju

For Rollins School of Public health

A Mental Health Curriculum for Student Affairs Professionals

Created by: Deborah Adenikinju

For: Rollins School of Public Health (Rollins)

Introduction and Aim	This mental health curriculum is intended to provide training on the signs and symptoms of mental health, suicide, and substance use challenges that may impact adults. The curriculum also covers cultural humility, intercultural communication, and compassion concepts. Lastly, the curriculum will provide an overview of the International Student Care Network. The curriculum utilizes several teaching methods - didactic lectures, group discussions, and case studies – to facilitate various learning styles. The curriculum aims to increase the knowledge and skills of Student Affairs Professionals in the following areas: mental health, cultural humility, compassion, and resource awareness. The hope is that the knowledge and skill acquired will be applied to support international students at Rollins and promote their mental wellbeing.
Parts	This curriculum consists of an introduction and three training parts: A. Mental Health B. Cultural Humility and Compassion C. Resource Awareness
Target Audience	The intended audience for this curriculum is Student Affairs Professionals at the Rollins School of Public Health
Format	The curriculum includes both synchronous and asynchronous components.
Setting	The curriculum will be facilitated both in-person and over zoom. **In-person:** The ideal physical location for this curriculum should be a classroom or conference room large enough to accommodate all participants in a manner that facilitates discussion and presents no hierarchy (i.e., chairs arranged in a "U" shape or a circle. A PowerPoint projector and computer should be available for use. **Zoom:** Facilitation over zoom will require a stable internet connection.
Format and Time Frame	**Synchronous**: The synchronous components of the modules will range from 60-90 minutes. **Asynchronous**: The asynchronous components of the modules are self-paced, and participants are not required to complete this section in one sitting. Completion of asynchronous material will range from 10-to 120 minutes. All module components should be taught in the sequence laid out in this curriculum.

Introduction to Mental Health Curriculum

Goal: To improve the provision of culturally appropriate support to international students at Rollins.

Why You?: You occupy a position at Rollins that allows you to interact with international students, recognize when they might going through a mental health crisis, and provide support.

Overview: This curriculum will consist of three parts:

A. Mental Health
   a. Mental Health First Aid
   b. Question Persuade Refer (QPR) suicide prevention training

B. Cultural Humility & Compassion
   a. Cultural Humility
   b. Intercultural Communication
   c. Introduction to Compassion

C. Resource Awareness
   a. International Student Care Network

2. Organize your schedule
   - ❑ Treat the mental health curriculum as you would a required training. Make it a priority and be intentional about putting the dates and times of each training on your calendar. Attached is a timeline with training dates and times.

3. Attend ALL trainings in the curriculum
   - ❑ Do your best to not miss any trainings in the curriculum because each part provides specific knowledge and skills. If you must miss a training, please make sure to let the program coordinator know.
   - ❑ Eat prior to trainings so you're not distracted and have water in case you get thirsty.
   - ❑ Bring a pen/pencil, notebook, or preferred notetaking method.
   - ❑ Turn your phone off or put on silent to avoid distractions.

4. Importance of practice and regular reflection
   - ❑ Although the training will provide information and teach skills, practice is important. Be active and intentional about the application of knowledge and skills learned.
   - ❑ Practice journaling to understand your experience and reflect on areas of improvement.

Mental Health Curriculum – Part A Mental Health Awareness	
Time	8 – 9 hours
Materials	- Pre/Post MHFA survey (online) - MHFA Manual & certification - QPR booklet & certification
Format	Asynchronous Synchronous
Module Summary	Part 1 will give an overview of mental health and common disorders, risk factors for mental health or substance use-related crisis, and warning sign of suicide. This section will include information on the Mental Health First Aid action plan and the ALGEE method for responding to students in mental health crisis. Participants will also learn about how to QPR method for preventing suicide.
Goal	To educate participants on the unique risk factors and warning signs of mental health concerns in adults, warning signs of suicide, and how to respond.
Objective	By the end of this session, participants will be able to: - Recognize students at risk for mental health or substance use concerns - Recognize students at risk for suicide - Intervene with those at risk - Refer to appropriate mental health resource (general and school-specific)

Module 1: Adult Mental Health First Aid (MHFA)

The MHFA training will be administered through the Center for Leadership Disability at Georgia State University School of Public Health. The program coordinator should reach out to the training coordinator ideally three months before the start date to schedule a training the second week of the desired month.

Contact Information

Name: Natasha De Veauuse Brown, Ph.D., MPH

Title: Youth Mental Health First Aid Training Coordinator

Address: 75 Piedmont Avenue NE Suite 514 Atlanta, GA 30303

Email: **irene.daboin.dominguez@emory.edu**

Phone: 404-413-3602

Website: CLD Homepage - Center for Leadership in Disability (gsu.edu)

Hello Natasha,

I hope this email finds you well. I'm writing to schedule an Adult-MHFA training offered through the Center for Leadership Disability. Can you please provide available times for the next 2 to 3 months when trainings can be offered as well as a quote for the cost? We expect to have eight participants for the training. We look forward to hearing from you.

Kind Regards,
Office of Admissions and Student Services

Module 2: Question, Persuade, Refer (QPR)

The QPR training will be administered through the Office of Counseling and Psychological Services (CAPS). The program coordinator should reach out to the CAPS ideally three months before the start date to schedule a training the first week of the desired month.

Contact Information

Name: Irene Daboin Dominguez, Ph.D.

Title: Licensed Psychologist & Suicide Prevention Coordinator

Address: 1462 Clifton Road, Suite 235 Atlanta, GA 30322

Email: **irene.daboin.dominguez@emory.edu**

Phone: (404)727-7450

Website: **http://www.counseling.emory.edu/**

Hello Irene,

I hope this email finds you well. I'm reaching out to schedule QPR training administered by the Office of Counseling and Psychological Services (CAPS). Can you please provide available times for the next 2 to 3 months when training can be offered? We expect to have eight participants for the training. We look forward to hearing from you.

Kind Regards,
Office of Admissions and Student Services

Mental Health Curriculum – Part 2 Cultural Humility & Compassion	
Time	5 hours
Materials	- IDI Individual Profile Report - IDI Intercultural Development Plan - "Cultural Humility" PowerPoint slides - "Intercultural Communication" PowerPoint slides - Pre/post cultural humility training survey - Pre/post intercultural communication survey
Format	Asynchronous Synchronous
Module Summary	Participants will learn about cultural humility and practice intercultural communication skills. Participants will engage in dialogue on compassion as it relates to self and other, interconnectedness and being an agent of change. Lastly, participants will explore the relationship between cultural humility and compassion.
Goal	To educate participants on components of cultural humility, provide an overview of foundations to intercultural communication and explain the role of compassion in supporting international students.
Objective	By the end of this session, participants will be able to: - Describe culture, cultural humility, and intercultural communication - Practice D.I.V.E - Identify at least two common anxieties and sources of misunderstanding when communicating across cultures - Apply intercultural communication skills - Describe the basics of compassion - Explain the relationship between compassion practice and cultural humility

Module 3: Cultural Humility

The cultural humility training will be administered through the Office of International Student & Scholar Services (ISSS). The program coordinator should reach out to the Amber Cordell ideally three months before the start date to schedule a training for the first week of the desired month.

Contact Information

Name: Amber Cordell

Title: Associate Director, Programming and Support

Address: 1784 North Decatur Road, Suite 130, Atlanta, GA 30322

Email: amber.paige.cordell@emory.edu

Phone: 404-727-8604

Website: **https://isss.emory.edu**

Hello Amber,

I hope this email finds you well. I'm writing to schedule the cultural humility training offered through the ISSS. Can you please provide available times for the next 2 to 3 months when trainings can be offered? We expect to have eight participants for the training. We look forward to hearing from you.

Kind Regards,
Office of Student Services

Cultural Humility Survey

How would you rate your overall comprehension of cultural humility?

Session	Very Dissatisfied	Dissatisfied	Neither	Satisfied	Very Satisfied
Before the Workshop	❑	❑	❑	❑	❑
After the Workshop	❑	❑	❑	❑	❑

Please answer the following questions to the best of your ability: how do you identify with the following learning objectives

Statements	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
I deeply understand what culture is	❑	❑	❑	❑	❑
I deeply understand what is meant by cultural humility	❑	❑	❑	❑	❑
I know how interculturalists define intercultural competence	❑	❑	❑	❑	❑
I can articulate the difference between intercultural competence and cultural humility	❑	❑	❑	❑	❑
I can use the **D.I.V.E** method to be less judgmental, more curious and more open-minded	❑	❑	❑	❑	❑
I feel more confident in my ability to practice cultural humility in my work	❑	❑	❑	❑	❑
Through this study I was to gain more knowledge on cultural humility	❑	❑	❑	❑	❑

1. What were your greatest takeaways?
2. If you were to make any changes to this Study/Survey, what would they be?
3. Comments/suggestions?

Module 4: Intercultural Communication

The intercultural communication training will be administered through the Office of International Student & Scholar Services (ISSS). The program coordinator should reach out to the Amber Cordell ideally three months before the start date to schedule a training for the first week of the desired month.

Contact Information

Name: Amber Cordell

Title: Associate Director, Programming and Support

Address: 1784 North Decatur Road, Suite 130, Atlanta, GA 30322

Email: amber.paige.cordell@emory.edu

Phone: 404-727-8604

Website: https://isss.emory.edu

Hello Amber,

I hope this email finds you well. I'm writing to schedule the intercultural communication training offered through the ISSS. Can you please provide available times for the next 2 to 3 months when trainings can be offered? We expect to have eight participants for the training. We look forward to hearing from you.

Kind Regards,
Office of Student Services

Intercultural Communication Survey

How would you rate your overall comprehension of intercultural communication?

Session	Very Dissatisfied	Dissatisfied	Neither	Satisfied	Very Satisfied
Before the Workshop	❑	❑	❑	❑	❑
After the Workshop	❑	❑	❑	❑	❑

Please answer the following questions to the best of your ability: how do you identify with the following learning objectives

Statements	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
I know what culture is	❑	❑	❑	❑	❑
I know what intercultural communication means	❑	❑	❑	❑	❑
I know what cultural humility represents	❑	❑	❑	❑	❑
I know how interculturalists define intercultural competence	❑	❑	❑	❑	❑
I can name sources of anxiety and misunderstandings across cultures	❑	❑	❑	❑	❑
I can list non-verbal sources of miscommunication	❑	❑	❑	❑	❑
I can name some cultural value differences	❑	❑	❑	❑	❑
I can articulate what does and doesn't help English language learners	❑	❑	❑	❑	❑
I feel more confident about my intercultural communication skills	❑	❑	❑	❑	❑
Through this study I gained more knowledge on intercultural communication	❑	❑	❑	❑	❑

1. What were your greatest takeaways?

2. If you were to make any changes to this Study/Survey, what would they be?

3. Comments/suggestions?

Module 5: Introduction to Compassion

The introduction to compassion training will be facilitated by instructors from Compassionate Atlanta. The program coordinator should reach out to Leanne Rubenstein at Compassionate Atlanta ideally three months before the start date to schedule and prepare for the training.

Contact Information

Name: Leanne Rubenstein

Title: Co-director

Address: P.O Box 311408 Atlanta, GA 31131

Email: leanne@compassionateatl.org

Phone: 404-247-1663

Website: **https://compassionateatl.org**

Hello Leanne,

I hope this email finds you well. I'm writing to schedule the compassion training offered through the Compassionate Atlanta. Can you please provide available times for the next 2 to 3 months when trainings can be offered? We expect to have eight participants for the training. We look forward to hearing from you.

Kind Regards,
Office of Student Services

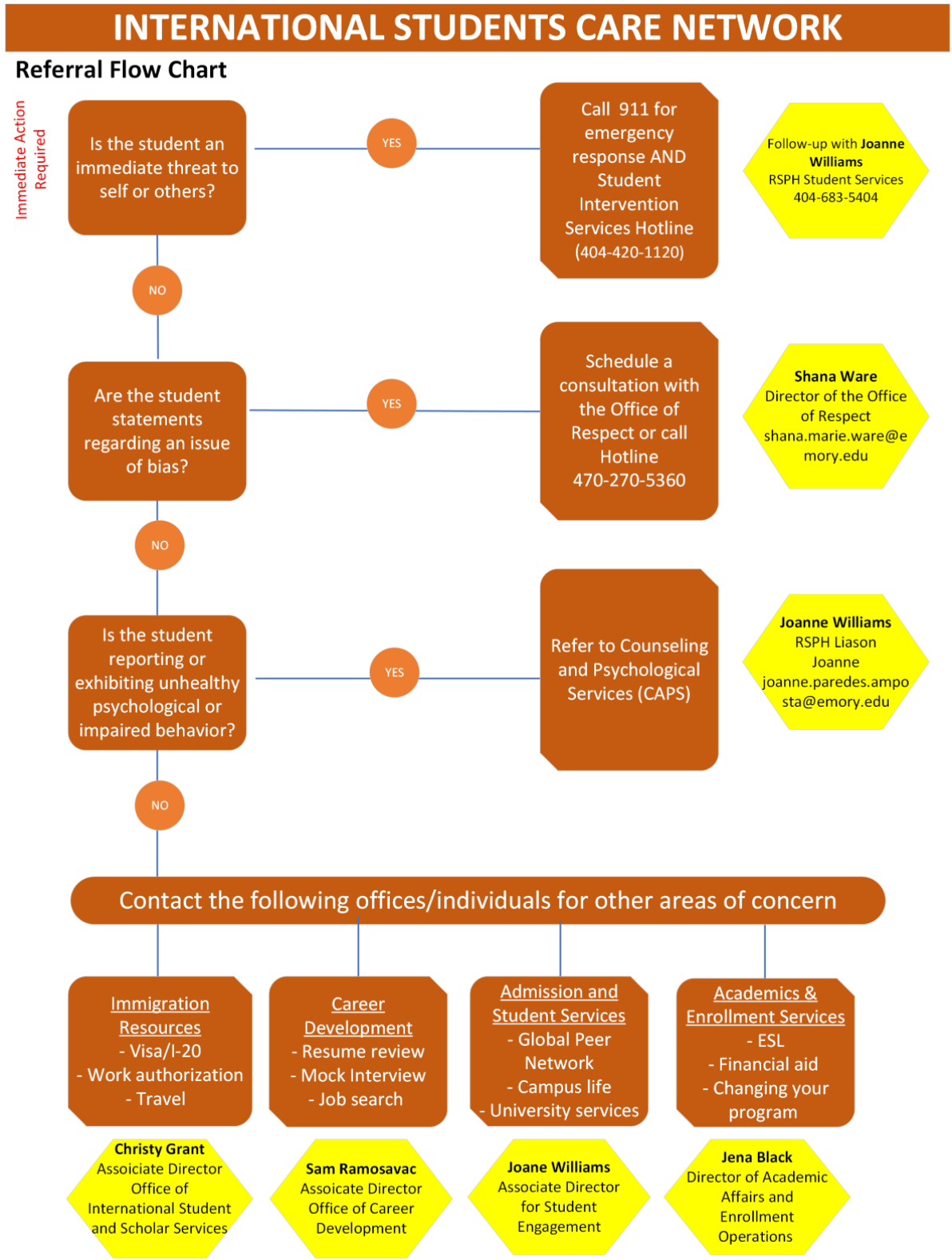
Mental Health Curriculum – Part C Resource Awareness	
Time	90 minutes
Materials	- Laptop - Pre/Post resource awareness training survey - "Resource Awareness" PowerPoint Slides - ISCN Flowchart - ISCN Tracking Sheet
Format	Synchronous
Module Summary	Part 3 will give an overview of the International Student Care Network (ISCN) Key messages surrounding support services provided by members of ISCN.
Goal	To educate participants on ISCN and support services available to international students at Rollins.
Objective	By the end of this session, participants will be able to: - Describe how ISCN works. - Apply the ISCN referral flowchart. - Identify university resources available to international students

Module 6: Resource Awareness

Resource Awareness Pre-Survey

Resource Awareness Pre-Test			
1. If an International Student has concerns regarding their I-20, what office should they contact?			
A. Student Services	B. Career Development	**C. Immigration Resources**	D. Academic and Enrollment Services
2. An International Student is facing multiple issues of bias, what office should seek consultation with?			
A. I.S. and Scholar Services	**B. Respect**	C. Academic Affairs	D. CAPS
3. What is NOT typically handled by the Office of Student Services?			
A. Job Search	B. Campus Life	C. University Services	D. Global Peer Network
4. If a student is an immediate threat to themselves and/or others, who should be called?			
A. Office of Respect and Academic Affairs	B. 911 and Immigration Resources	**C. Student Intervention Services and 911** D.	E. Career Development and Enrollment Services
5. The office of Career Development is a place for students to practice mock interviews, True or False?			
A. True		B. False	
6. If an international student wants to change their program, should they contact Academic Affairs and Enrollment Operations, or Office of International Student and Scholar Services?			
A. Academic Affairs and Enrollment Operations		B. Office of International Student and Scholar Services	
7. Student Services is the best place to contact for Financial Aid questions, True or False?			
A. True		**B. False**	
8. An International Student is exhibiting impaired behavior, what office should be contacted?			
_____			

International Student Care Network (ISCN) Referral Flowchart



Resource Awareness Presentation

Office of Respect

Who are we?

Our mission is to work with key stakeholders to eradicate sexual assault, sexual harassment, stalking, and intimate partner violence to create a safer, healthier campus where all students can learn, grow, and thrive. This occurs through education, bystander intervention training, crisis intervention, advocacy, policy development, and supportive peer networks.

What we offer

- offer 24-hour support resources for Emory students impacted by interpersonal violence.
- assist with safety planning
- provide legal and medical accompaniment
- offer academic assistance.

Where can you find us?

check **respect.emory.edu** for office updates.
Our social media handles:
Instagram: office_of_respect
Facebook: Emory University
The Office of Respect
Twitter: @RespectWell

Counseling and Psychological Services (CAPS)

Who we are?

CAPS provides individual, group, and couples counseling; stress management classes; and community outreach to provide support for students and assist them in negotiating emotional and interpersonal difficulties as they matriculate through Emory University.

What we offer

- Provide clinical services
- Workshops on managing stress & anxiety during COVID-19, managing loneliness, prepare for procrastination, anxiety toolkit
- support groups (e.g., international student support, Black graduate student support

Where can you find us?

More information about how to participate in these services can be found here: bit.ly/emorycaps
Go social with
Instagram page: **emorycaps**

International Student and Scholar Services Office

Who we are?

International Student and Scholar Services (ISSS) serves Emory's global community which includes international students, scholars, and hosting departments through immigration advisement, intercultural competency and leadership training, and educational and social events. ISSS aspires to be a comprehensive resource for Emory University's diverse international community through advocacy, collaboration, education, and immigration expertise.

What we offer

- Immigration Documents
- Travel
- Visa/I-20

Academic and Enrollment Services

Who are we?

The Office of Academic and Enrollment services processes student enrollment and class registration and provides resources to support and promote students during their development.

What we offer

- Financial Services
- Admitted Student Portal
- English Language Support for Multilingual Learners
- Student Organizations

Office of Admission and Student Services

Who we are?
Student

What we offer
- Global Peer Network
- Campus life
- University services

Case study 1

Case Study 1:
Mental Health Concerns

A 1st-year international student schedules an appointment with you and during the meeting mentions that they miss home. When you inquire about how they're doing they mention the following:

"I just thought it would be different. No one here likes me, and I always feel like an outsider even in the classroom. I know my English is not good, but I really try my best to be better, but people still avoid me and say hurtful things about me and my country. The other day in class, my professor asked for a volunteer to lead the class in the next week's discussion. I raised my hand, but the professor laughed and asked if I should be raising my hand since my English was so poor. I approached my professor after class to ask why they said that, but they responded by saying it's not their fault I'm in America and can't speak good English and maybe I should have stayed in my country. I've not been able to return to that class. Every time I'm on campus, my heart starts racing because I'm so afraid to see the professor. I'm barely sleeping and have lost 10 pounds. I am sad all the time but don't know how to tell my parents because they'll be disappointed that I'm missing class. I feel like I don't belong here, but I also know I won't be accepted back home for failing. I want to make the pain go away – I don't want to feel anything anymore"

1

What do you do next?

Solutions:

1. Make sure to not interrupt the student while they're speaking and practice active listening.
2. Acknowledge the student's feelings and thank them for sharing this experience with you.
3. Notify Student Intervention Services (404-430-1120) and Joanne Williams (4040-683-5404) immediately to initiate a coordinated response.
4. Ask if the student is familiar with CAPS and willing to speak with a counselor
   - A. If yes, recommend that they reach out.
   - B. If no, let them know you'll be connecting them to Joanne Williams, liaison to CAPS
5. Email or print out the student toolkit that provides information on further mental health resources including TimelyCare
   - Inform the student about Global Peer Network and share the document for "Belonging" resources for international students.
6. Ask the student if they're comfortable with you sharing the details of the incident with Joanne Williams to determine appropriate next steps.

2

Case Study 2

Case Study 2:
Immigration

A 2nd year international student has scheduled an appointment with you to discuss plans for post-graduation. During the session, the student mentions the following:

> "Hello [Staff Name], I have been feeling overwhelmed about my plans after graduation.

"Hello [Staff Name], I have been feeling overwhelmed about my plans after graduation. I am eager to begin the interview process with prospective employers, but I am unsure what part-time positions I am allowed to have under my immigration status. I am also considering volunteering with a nonprofit I have worked closely with during my time at Rollins and I believe there might be an opportunity for employment with them. I have friends and family members telling me what to do and there's so much conflicting information online. I do not want to do anything that might jeopardize my status.

3

What do you do next?

Solutions:

1. Practice empathy while listening to the student, taking care not to offer immigration advice.
2. Ask the student to contact their ISSS Advisor to clarify up-to-date work requirements and ensure that the student is compliant with their visa status. .
3. After the student contacts ISSS, you can advise the student to reach out to Sam Ramosevac in the Office of Career Development to assist with locating part-time positions.
4. Email or print out the student toolkit that provides information on further mental health resources including TimelyCare

4

Case Study 3

Case Study 3:
Financial Hardship

An international student you're supporting writes to you to say they are going through a hard time.

"Hello [Staff Name],

I'm going through a hard time and not sure who else to turn to. You've been there for me in the past and I'm hoping you can assist me. My mother informed me last week that there was a fire in our neighborhood that destroyed many businesses, ours included. My family are struggling to make ends meet and the savings put away for my education must be used to handle things at home. My family will no longer be able to support me financially. Although I have a scholarship, it only covers my tuition. My rent is due in two weeks, and I have no means of paying it. I also have no money to get groceries and other necessities. I have been applying to jobs nonstop but yet to hear back from anyone. My roommates are requesting money for utilities, and I don't know how to tell them about my situation. I fear that they might take me off the lease. I don't know if I should consider moving back home.

What do you do next?

Solutions:

1. Listen attentively and empathize with the student on their situation.
2. Inform the student that you will connect with university officials to ensure they receive appropriate support..
3. Refer the student to Sam Ramosevac at the Office of Career Development to help with job application.
4. Contact Joanne Williams to inform her of student hardship.
5. Contact Jena Black at the Office of Student Enrollment Services to explore financial support options.
6. Share the international student financial hardship document for immediate support.

Resource Awareness Post-Survey

Resource Awareness Post-Test

1. **If an International Student has concerns regarding their I-20, what office should they contact?**

A. Student Services
B. Career Development
C. Immigration Resources
D. Academic and Enrollment Services

2. **An International Student is facing multiple issues of bias, what office should seek consultation with?**

A. I.S. and Scholar Services
B. Respect
C. Academic Affairs
D. CAPS

3. **What is NOT typically handled by the Office of Student Services?**

A. Job Search
B. Campus Life
C. University Services
D. Global Peer Network

4. **If a student is an immediate threat to themselves and/or others, who should be called?**

A. Office of Respect and Academic Affairs
B. 911 and Immigration Resources
C. Student Intervention Services and 911
D. Career Development and Enrollment Services
F.

5. **The office of Career Development is a place for students to practice mock interviews, True or False?**

A. True
B. False

6. **If an international student wants to change their program, should they contact Academic Affairs and Enrollment Operations, or Office of International Student and Scholar Services?**

A. Academic Affairs and Enrollment Operations
B. Office of International Student and Scholar Services

7. **Student Services is the best place to contact for Financial Aid questions, True or False?**

A. True
B. False

8. **An International Student is exhibiting impaired behavior, what office should be contacted?**

9. What does CAPS stand for?

_____

10. An International Student has a question about securing employment, what two offices should they contact?

11.

_____

12. What did you like best about the course?

_____

13. What did you like least about the course?

_____

14. What else would you have wanted to cover in the curriculum?

_____

15. Do you feel more knowledgeable about the issues International Students face regarding higher education?

A. Yes A. No

16. Would you recommend this course to any other faculty here at Rollins?

A. Yes B. No

Appendix B: Stakeholders for Curriculum Implementation and Management

Any staff members at the Office of Career Development, the Office of Admission and Student Services, the Office of Academics and Enrollment Services, the Office Admission and Student Services, and ADAPs will be encouraged to participate in the program. The RSPH Associate Director of the Office of Student Services will oversee the curriculum implementation activities. The associate director will work with the program coordinator, on data collection and analysis. The program coordinator will be responsible for creating the timeline, summarizing the training dates and times, and relaying this information to participants. In addition to this, the program coordinator will be in charge of communication and administrative tasks that ensure all participants are well informed and updated about the trainings.

First, instructors from the Center for Leadership in Disability School of Public Health at Georgia State University will lead Mental Health First Aid (MHFA) training. Next, the Emory Office of Counseling and Psychological Services will facilitate Question Persuade Refer (QPR) Training. Following the completion of QPR training, the Associate Director of Programming and Support at the office of International Student and Scholar Services (ISSS) will conduct the cultural humility training and subsequently the intercultural communication training. To incorporate a distinctive component of the curriculum, Compassionate Atlanta will facilitate a discussion on compassion. Lastly, participants will complete the resource awareness training, led by the Associate Director of the Office of Student Services. Finally, participants will complete program surveys that will be used for the program evaluation. All training facilitators will participate in the program evaluation. Table 1 provides an overview of all stakeholders and their roles in the implementation, evaluation, and maintenance of the program.

Table 8

Overview of Stakeholders and Roles

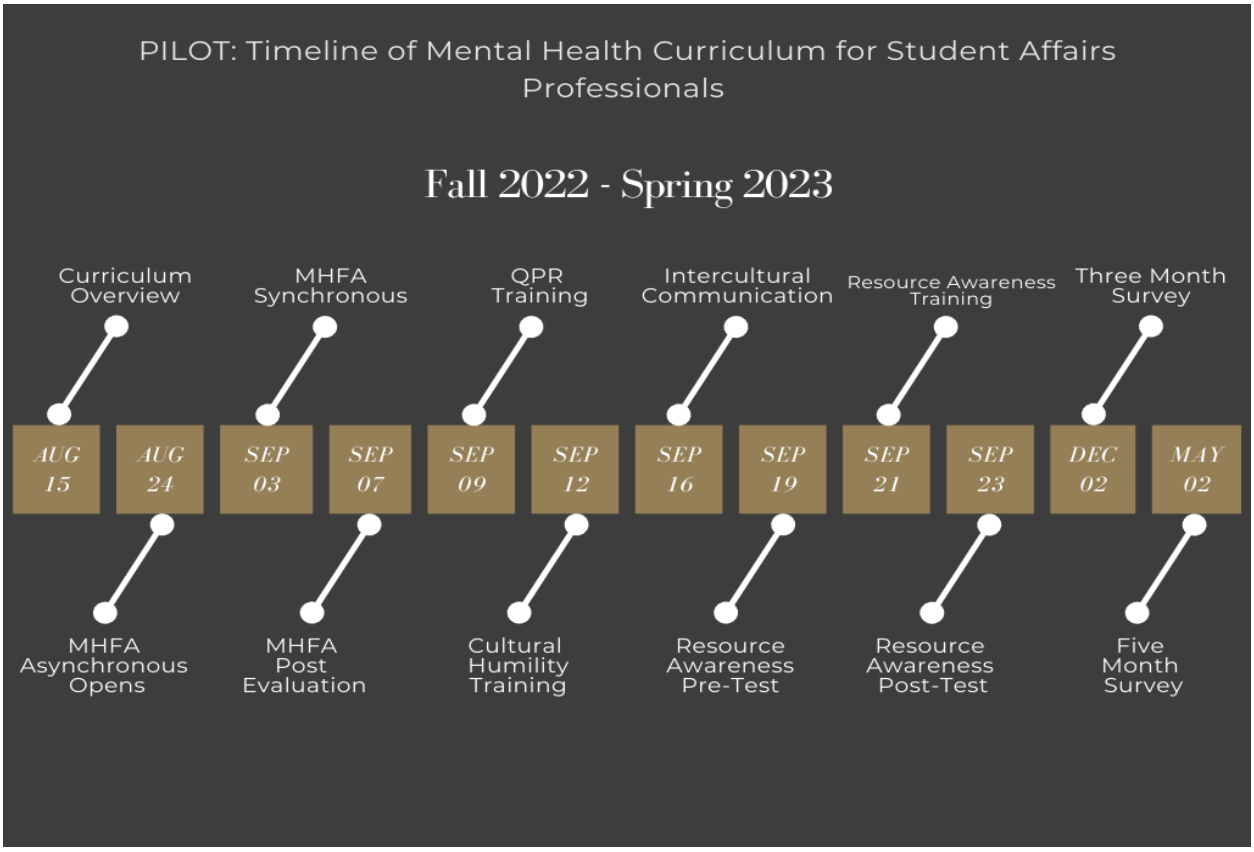
Personnel	Description	Role
RSPH Assistant/Associate Director of Academic Programs (ADAPs)	ADAPs that are interested in completing the mental health curriculum	• Participate in the mental health curriculum. • Participate in the cultural humility training • Participate in the compassion training • Complete program surveys
Office of Career Development	Staff members at OCD that are interested in completing the mental health curriculum	• Participate in the mental health curriculum. • Participate in the cultural humility training • Participate in the compassion training • Complete program surveys
RSPH Office of Student Services	Staff members within the Office of Admission and Student Services interested in completing the mental health curriculum	• Participate in the mental health curriculum. • Participate in the cultural humility training • Participate in the compassion training • Complete program surveys
RSPH Office of Enrollment Services	Staff members within the Office of Academics and Enrollment Services interested in completing the mental health curriculum	• Participate in the mental health curriculum. • Participate in the cultural humility training • Participate in the compassion training • Complete program surveys
RSPH Associate Director, Office of Student Services	Staff member at the Office Admission and Student Services who handles trainings and events on student engagement and wellbeing	• Facilitate resource awareness training. • Manage mental health curriculum activities

		• Responsible for data collection and analysis.
Program Coordinator	Graduate Assistant (GA) with the Office of Student Services	• Assist with data collection and analysis. • Responsible for communication and administrative tasks. • Create timeline and summary of training dates and times
RSPH Associate Director, Programming and Support International Student & Scholar Services (ISSS)	Staff from International Student and Scholar Services responsible for cultural humility and intercultural communication training.	• Facilitate cultural humility training • Facilitate intercultural communication • Present and participate in program evaluation
Emory Office of Counseling and Psychological Services (CAPS)	CAPS staff member responsible for Question Persuade Refer (QPR) Training	• Facilitate QPR training • Send QPR certification
Center for Leadership in Disability School of Public Health Georgia State University	Mental Health First Aid (MHFA) training coordinator and instructors from Georgia State University	• Facilitate MHFA Training • Present and participate in program evaluation
Compassionate Atlanta	Staff from Compassionate Atlanta providing education around compassion and organizational culture and structure.	• Facilitate introductory session for compassion

Appendix C: Scope, Sequence, and Implementation Plan

Parts	Module	Description	Evaluation Plan
Introduction		Introduction to Curriculum: Alignment of Goals and Values Individual Action Plan	KWL Chart
A	1	Mental Health Training with Student Affairs Professionals: **MHFA**	Pre & post assessment
	2	Mental Health Training with Student Affairs Professionals: **QPR**	Post assessment
B	3	Pilot Cultural Humility and Compassion Training with Student Affairs Professionals	Post assessment
	4	Pilot Intercultural Communication Training with Student Affairs Professionals	Post assessment
	5	Pilot Compassion Training with Student Affairs Professionals	Post assessment
C	6	Pilot Resource Awareness Training with Student Affairs Professionals	Pre and post assessment

Appendix D: Example Timeline



Appendix E: Proposed Budget

Budget Expense Table					
Staffing Expenses					
Position		**Salary**		**Budget Percentage**	**Explanation**
Graduate Assistant (Program coordinator)		$2500.00		82%	*A graduate assistant will be necessary to coordinate and facilitate the program activities*
Training Expenses - Individual Expenses					
Item	**Number of Person**	**Per Person Cost**	**Total Cost**	**Budget Percentage**	**Explanation**
Mental Health First Aid Training (MHFA)	8	$30.00	$240.00	8%	*A cost of $30 per trainee covers access to the MHFA manual, instructor-led session, and certification.*
IDI Assessment	8	$8.00	$64.00	2%	*A fee of $8 to take the IDI assessment and individual report. Payment will be processed through the office of International Student & Scholars Services (*
Training Expenses - Administrative					
Personnel		**Fee**		**Budget Percentage**	**Explanation**
IDI Debrief Specialist		$150.00		5%	*In using the standard education-based price, the IDI Debrief paid $150 for a one-to-one IDI report debrief and facilitation of cultural humility and intercultural communication.*
Miscellaneous Expenses					
Item	**Number of Units**	**Per Unit Cost**	**Total Cost**	**Budget Percentage**	**Explanation**
Training Meals (MHFA)	8	$10.00	$80.00	2.5%	*Purchase meals for all cohort participants. An average cost of $10.00,*
Printing Materials	100	$.10	$10.00	0.5%	*Printing at 10¢ per piece, approximately 100 sheets for a total cost of $10*
Budget Summary					
Expense Account		Overall Cost		Budget Percentage	*Total Budget Expense*
Staffing		$2500.00		82%	**$3,034.00**
Training - Individual		$304.00		10%	
Training - Administrative		$150.00		5%	
Miscellaneous		$80.00		3%	

Appendix F: Program Goals and Objectives

The proposed objectives for the mental health training component of the curriculum is based on the examination of previous studies implementing the Mental Health First Aid (MHFA) and Question Persuade Refer (QPR) training. The metrics associated with each objective is based on the domains evaluated to assess the effectiveness of MHFA and QPR. These domains include knowledge, self-efficacy, confidence, and attitudes (Aldrich et al., 2018). The objectives for cultural humility and compassion training and resource awareness training are based on a review of previous interventions with the goal of promoting cultural humility and increasing resource awareness.

GOAL: Improve provision of culturally appropriate mental health and wellbeing services for international students at Rollins.	
SHORT-TERM OBJECTIVES	Mental Health Training: • Increased knowledge of mental health disorders/illnesses and suicide prevention. • Increased recognition of mental health crisis/disorders? • Decreased stigmatizing attitudes about mental health issues.
	Cultural Humility and Compassion Training: • Increased knowledge of cultural humility. • Increased knowledge of intercultural communication • Increased knowledge of the role of compassion in supporting International Students.
	Resource Awareness Training: • Increased knowledge of International Student Care Network (ISCN)
INTERMEDIATE-TERM OBJECTIVES	Mental Health Training: • Increase referral to the Office of Counseling and Psychological Services (CAPS) • Increased confidence in providing support.
	Cultural Humility and Compassion Training: • Demonstrated proficiency of intercultural communication skills. • Increased practice of self-compassion and reflexivity among student affair professionals.
	Resource Awareness Training: • Increased referral to ISCN offices.
LONG-TERM OBJECTIVES	• Sustained implementation of mental health curriculum. • Fewer reports of negative mental health symptoms among international students at Rollins. • Increased use of mental health services by International Students • Increased use of non-mental health support services/resources by international students. • Promotion of supportive climate at Rollins.

Appendix G: Process and Outcome Evaluation

PROCESS EVALUATION			
Component	**Process Evaluation Questions**	**Indicators**	**Data Source**
Fidelity	To what extent was the mental health training implemented as planned?	Observation	Observation Cultural humility training checklist
	To what extent was the cultural humility training implemented as planned?	Observation	Observation Cultural humility training checklist
	To what extent was the Intercultural communication training implemented as planned?	Observation	Observation Intercultural communication training checklist
	To what extent was the compassion training implemented as planned?	Observation	Observation Compassion training checklist
	To what extent was the resource awareness training implemented as planned?	Observation	Observation Resource awareness training checklist
Dose (Delivered & Received)	To what extent were all the parts of the curriculum provided to participants?	Free-response questions 5-point Likert scale	Record of facilitators completing training
	How did SAF react to aspects of the mental health training?	Free-response questions 5-point Likert scale	Cultural humility survey Post-program survey
	How did SAF react to aspects of the cultural humility training?	Free-response questions 5-point Likert scale	Intercultural communication survey Post-program survey

	How did SAF react to aspects of the compassion training?	Free-response questions 5-point Likert scale	Resource awareness survey Post-program survey
	How did SAF react to aspects of the resource awareness training?	Free-response questions Observation 5-point Likert scale	Resource awareness survey Post-program survey
Reach	What was the demographics of SAP participating in training?	# of SAF who completed mental health training	Curriculum Pre-survey
	What proportion of SAF participated in mental health training?	# of SAF who completed mental health training	Attendance list
	What proportion of SAF participated cultural humility training?	# of SAF who completed cultural humility training	Attendance list
	What proportion of SAF participated in Intercultural communication training?	# of SAF who completed intercultural communication training	Attendance list
	What proportion of SAF participated resource awareness training?	# of SAF who completed resource awareness training	Attendance list
	What proportion of SAF completed every training in the mental health curriculum?	# of SAF who completed mental health curriculum training	Post-program survey
Recruitment	What recruitment procedures were used?	Recruitment plan section	Mental Health curriculum
	What are barriers to participation in training?	Free-response questions	Curriculum post-survey
Context	What environmental, social, capacity factors may serve as facilitators or barriers to implementation of curriculum?	Free-response questions	Facilitator post-survey
	What environmental, social, capacity factors may serve as facilitators or barriers to curriculum outcomes?	Free-response questions	6-month survey

OUTCOME EVALUATION			
Component	**Evaluation Questions**	**Indicators**	**Data Source**
Short Term Outcomes	How has SAP increased their knowledge of mental health and suicide prevention?	% correct on items assessing knowledge	Pre and Post MHFA training survey
	How has SAP increased their recognition of mental health disorders' symptoms and warning signs of crisis/suicide?	# correct answers during roleplay	Observation (roleplay)
	How have SAP decreased their stigmatizing attitudes about mental health?	Likert scale agreement about stigma	Curriculum pre & post survey
	How has SAP increased their knowledge of cultural humility?	5-point Likert scale agreement about knowledge	Post cultural humility survey
	How has SAP increased their knowledge of intercultural communication?	5-point Likert scale agreement about knowledge	Post intercultural communication survey
	How has SAP increased their knowledge of the basics of compassion?	5-point Likert scale agreement about knowledge	Post compassion training survey
	How has SAP increased their knowledge of resources at Emory?	% correct on items assessing knowledge	Pre and Post resource awareness survey
	To what extent have international students been referred to CAPS?	# of international students referred to CAPS by SAP	Referral tracking sheet
	To what extent does SAP feel more confident about supporting international students?	Point scale rated to confidence/self-efficacy	Curriculum pre & post-survey

Intermediate Term Outcomes	To what extent do SAP practice intercultural communication skills?	# of SAP reporting use of intercultural communication skills	Survey (3 & 6 months)
	To what extent do SAP practice self-compassion and reflexivity exercises?	# of SAP reporting practice of self-compassion & reflexivity exercises	Survey (3 & 6 months)
	To what extent have international students been referred to ISCN?	# of international students referred to ISCN by SAP	Referral tracking sheet
	How long has the mental health curriculum been implemented at Rollins?	# of times mental health curriculum was implemented.	Curriculum tracking sheet.
Long Term Outcomes	To what extent are international students experiencing fewer negative mental health symptoms?	# of international students experiencing negative mental health symptoms	Surveillance Data (NCHA) Aggregate clinician data (CAPS)
	To what extent are international students reporting increased use of mental health resources?	# of international students reporting use of mental health services	Surveillance Data (NCHA)
	To what extent are international students reporting increased use of non-mental health resources?	# of international students reporting use of non-mental health support services/resources.	Annual survey (international students) Student engagement data ("The Hub")
	To what extent do international students perceive the climate at Rollins to be supportive?	# of international students reporting a supportive climate at Rollins.	Annual survey (international students)

Appendix H: Program Assessment Tools

Mental Health Curriculum Interest Form

Mental Health Curriculum Interest Form

1. Name:
2. Email:
3. Please select all that apply: How would you identify yourself? ?
    - ❑ White
    - ❑ Black/ African American
    - ❑ Asian/ Pacific Islander
    - ❑ Hispanic/ Latino
    - ❑ American Indian/ Alaskan
    - ❑ Biracial/ Multiracial
    - ❑ Other
4. What is your employment status?
    - ❑ Full-time
    - ❑ Part-time
    - ❑ Other
5. Select your role at Rollins:
    - ❑ ADAP
    - ❑ Office of career development staff
    - ❑ Office of student services staff
    - ❑ Office of academic & enrollment services staff
6. Are you interested in completing the mental health curriculum training?
    - ❑ Yes
    - ❑ No
7. What part are you most interested in?
    - ❑ Mental Health Awareness
    - ❑ Cultural Humility & Compassion
    - ❑ Resource Awareness

KWL Chart

KWL Chart			
Component	What I **K**now	What I **W**ant to Know	What I **L**earned
Responding to a student experiencing mental health crisis			
Suicide warning signs & prevention			
Cultural humility			
Intercultural communication			
Compassion			
Student support services at Emory			

Post-Curriculum Survey

Mental Health Curriculum Post-Program Survey

Thank you for participating in the Mental Health Curriculum training. I truly value your opinions and hope that you can complete this survey with the knowledge you have gotten so far. There are no correct answers so please feel comfortable to be express your views. The following survey should take approximately 5-10 minutes to complete.
Thank you for your time! Please reach out to me at dadenik@emory.edu if you have any further questions or suggestions.

Please provide the month and last two digit of the year of your birthday. This will be used as your participant ID (e.g., month/year = 04/97).

_____ / _____

1. Please select all that apply: How would you identify yourself?

❑ White
❑ Black or African American
❑ Hispanic or Latino/a
❑ Asian or Pacific Islander
❑ American Indian or Alaskan
❑ Biracial or Multiracial
❑ Other

2. Select your role at Rollins?

❑ ADAP
❑ Office of career development staff
❑ Office of student services staff
❑ Office of academics & enrollment staff

3. What is your employment status?

❑ Full-time
❑ Part-time
❑ Other

4. Please rate your level of satisfaction for the five lessons of the Mental Health Curriculum:

Lesson	Very Dissatisfied	Dissatisfied	Neither	Satisfied	Very Satisfied
Lesson 1: Mental Health: MHFA	❑	❑	❑	❑	❑
Lesson 2: Mental Health: QPR	❑	❑	❑	❑	❑
Lesson 3: Cultural Humility	❑	❑	❑	❑	❑
Lesson 4: Intercultural Communication	❑	❑	❑	❑	❑
Lesson 5: Resource Awareness	❑	❑	❑	❑	❑

5. What were your greatest takeaways?

_____
_____
_____
_____

6. If you were to make any changes to this Study/Survey, what would they be?

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_____
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7. Comments/suggestions?

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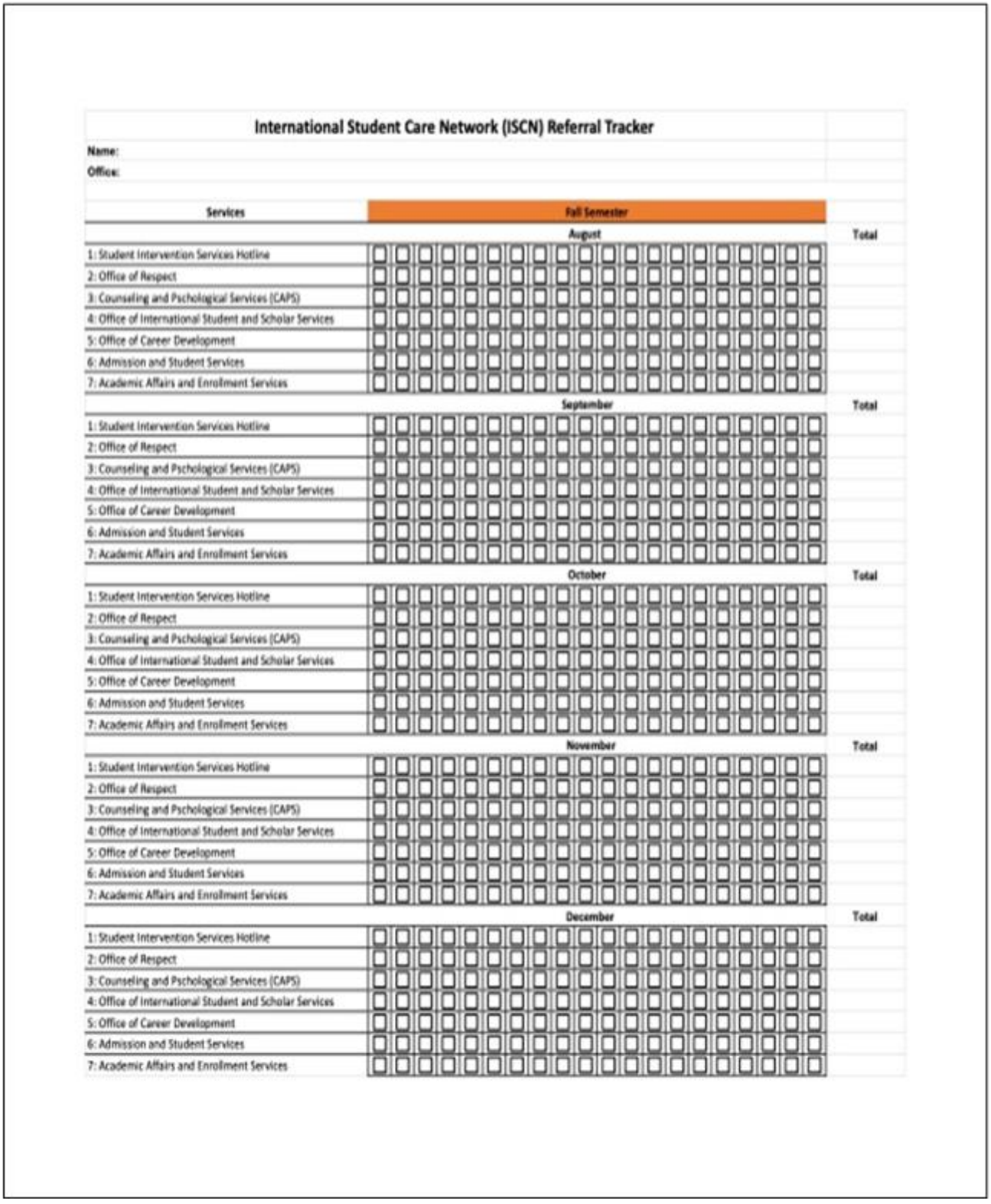
Referral Tracking Sheet: Fall



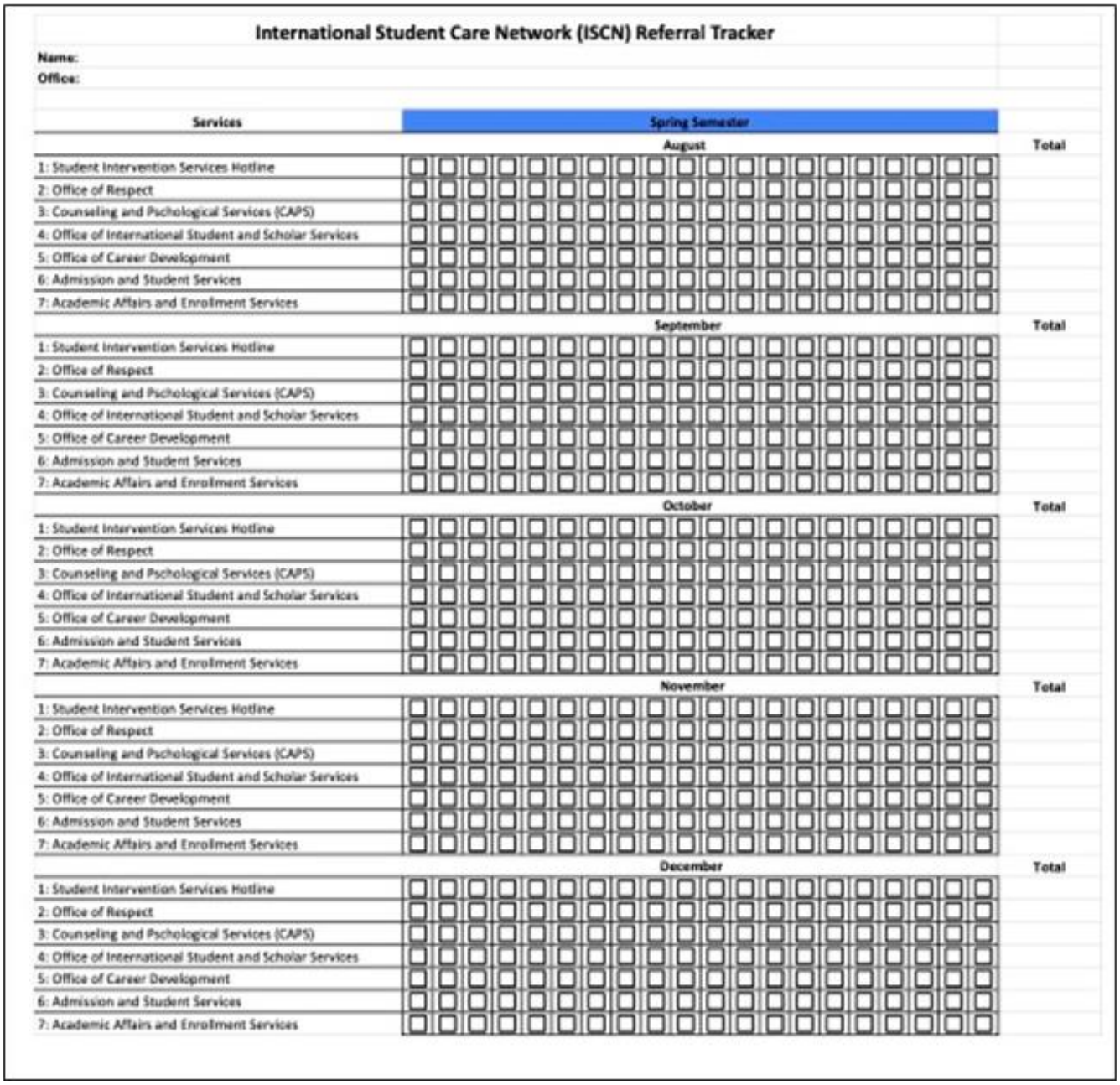
International Student Care Network (ISCN) Referral Tracker

Name:

Office:

Services	Fall Semester	
	August	Total
1: Student Intervention Services Hotline	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	
2: Office of Respect	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	
3: Counseling and Pschological Services (CAPS)	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	
4: Office of International Student and Scholar Services	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	
5: Office of Career Development	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	
6: Admission and Student Services	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	
7: Academic Affairs and Enrollment Services	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	
	September	Total
1: Student Intervention Services Hotline	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	
2: Office of Respect	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	
3: Counseling and Pschological Services (CAPS)	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	
4: Office of International Student and Scholar Services	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	
5: Office of Career Development	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	
6: Admission and Student Services	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	
7: Academic Affairs and Enrollment Services	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	
	October	Total
1: Student Intervention Services Hotline	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	
2: Office of Respect	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	
3: Counseling and Pschological Services (CAPS)	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	
4: Office of International Student and Scholar Services	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	
5: Office of Career Development	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	
6: Admission and Student Services	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	
7: Academic Affairs and Enrollment Services	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	
	November	Total
1: Student Intervention Services Hotline	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	
2: Office of Respect	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	
3: Counseling and Pschological Services (CAPS)	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	
4: Office of International Student and Scholar Services	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	
5: Office of Career Development	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	
6: Admission and Student Services	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	
7: Academic Affairs and Enrollment Services	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	
	December	Total
1: Student Intervention Services Hotline	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	
2: Office of Respect	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	
3: Counseling and Pschological Services (CAPS)	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	
4: Office of International Student and Scholar Services	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	
5: Office of Career Development	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	
6: Admission and Student Services	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	
7: Academic Affairs and Enrollment Services	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	

Referral Tracking Sheet: Spring



International Student Care Network (ISCN) Referral Tracker

Name:

Office:

Services	Spring Semester	
	August	Total
1: Student Intervention Services Hotline	☐ ☐	
2: Office of Respect	☐ ☐	
3: Counseling and Pschological Services (CAPS)	☐ ☐	
4: Office of International Student and Scholar Services	☐ ☐	
5: Office of Career Development	☐ ☐	
6: Admission and Student Services	☐ ☐	
7: Academic Affairs and Enrollment Services	☐ ☐	
	September	Total
1: Student Intervention Services Hotline	☐ ☐	
2: Office of Respect	☐ ☐	
3: Counseling and Pschological Services (CAPS)	☐ ☐	
4: Office of International Student and Scholar Services	☐ ☐	
5: Office of Career Development	☐ ☐	
6: Admission and Student Services	☐ ☐	
7: Academic Affairs and Enrollment Services	☐ ☐	
	October	Total
1: Student Intervention Services Hotline	☐ ☐	
2: Office of Respect	☐ ☐	
3: Counseling and Pschological Services (CAPS)	☐ ☐	
4: Office of International Student and Scholar Services	☐ ☐	
5: Office of Career Development	☐ ☐	
6: Admission and Student Services	☐ ☐	
7: Academic Affairs and Enrollment Services	☐ ☐	
	November	Total
1: Student Intervention Services Hotline	☐ ☐	
2: Office of Respect	☐ ☐	
3: Counseling and Pschological Services (CAPS)	☐ ☐	
4: Office of International Student and Scholar Services	☐ ☐	
5: Office of Career Development	☐ ☐	
6: Admission and Student Services	☐ ☐	
7: Academic Affairs and Enrollment Services	☐ ☐	
	December	Total
1: Student Intervention Services Hotline	☐ ☐	
2: Office of Respect	☐ ☐	
3: Counseling and Pschological Services (CAPS)	☐ ☐	
4: Office of International Student and Scholar Services	☐ ☐	
5: Office of Career Development	☐ ☐	
6: Admission and Student Services	☐ ☐	
7: Academic Affairs and Enrollment Services	☐ ☐	

Appendix I: Additional Program Resources

RSPH Support Toolkit

RSPH STUDENT SUPPORT TOOLKIT

[redacted]

TOPIC	RESOURCE
Finding a Mental Health Resource List	Students can access a comprehensive list of mental health resources at Emory and Rollins on the RSPH Student Services Canvas Page Graduate and Professional Student Resources at Emory University may also be found here.
Accessibility	To obtain an accommodation letter for your accessibility needs, you can e-mail accessibility@emory.edu or visit their website here. Additionally, you may contact RSPH Accessibility Liaison: Jena Black, Director of Enrollment Services and Academic Affairs, at jena.black@emory.edu
Academic Support/Tutoring	Rollins provides free quantitative (BIOS and EPI) and writing tutors through the RSPH Academic Resource Center. Information about how to schedule individual appointments and attend drop-in hours here. Additionally, you may contact rspharc@emory.edu
Belonging and Community Justice/ Identity Spaces	The Center for Belonging and Community Justice helps students find a sense of belonging and supports them in making change in their communities. ·Center for Women ·Office of LGBT Life ·Office of Racial and Cultural Engagement (RACE) BCJ also oversees the Identity Spaces Project, which includes the Asian Student Center, the Center for Women, Centro Latinx, Emory Black Student Union, and LGBT Life.
Bias-Related Incidents	If you or someone you know have experienced bias, please contact Joanne Williams, Associate Director of Student Engagement, at jampost@emory.edu. Additionally, students may contact Bias Support Services at Emory University to submit a report and/or obtain resources for advocacy and support. Click here for more information.
COVID-19 Support for Students	Information about COVID-19 for students is available on the Emory Forward Website. If you are experiencing symptoms or have been exposed to COVID-19, please contact rollinsstudentsupport@emory.edu. COVID-19 testing is also available on-demand to all Emory students for free. You can schedule a test here.
CAPS Therapy Appointments and TimelyCare	Counseling and Psychological Services (CAPS) allows students up to 8 sessions per academic year. Schedule an appointment here. Additionally, if you are unable to get an appointment - Emory University has contracted with TimelyCare to provide 24/7 mental health support. This support includes 12 counseling sessions for Emory students per year, and 24/7 access and emotional support with their Talk Now Program.

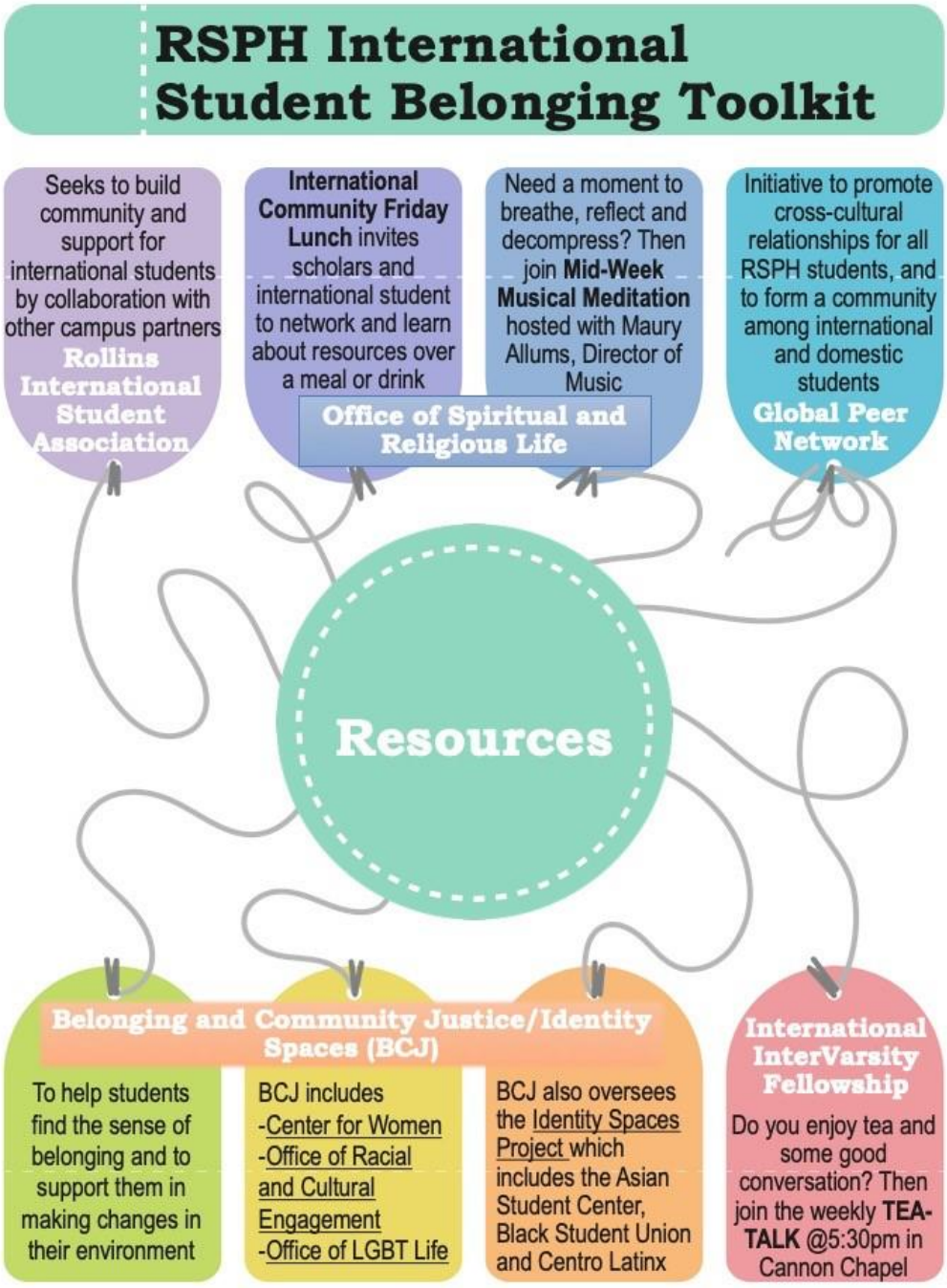
TOPIC	RESOURCE
CAPS Workshops, Skills Groups, and Toolkits	In addition to individual therapy, CAPS also has a variety of additional services, such as workshops, skills groups, and toolkits that do not require insurance. You can find more information here.
Crisis and Case Management	Student Case Management and Intervention Services assists students and their families on an ongoing basis and in times of crisis to meet academic, medical, financial, and social challenges. Click here for more information or call their 24/7 hotline at 404-430-1120.
Expecting Parents or Pregnancy Accommodations	If you are expecting, please contact Joanne Williams, RSPH Deputy Title IX Coordinator, at jampost@emory.edu.
Financial Support	If you are experiencing financial difficulties related to personal expenses or tuition, please contact RSPH Enrollment Services at rsphenrollmentservices@emory.edu.
Food or Housing Security	If you or someone you know is experiencing food or housing insecurity, you may contact Student Intervention Services at 404-430-1120 or complete a Student of Concern Form. You will be connected with a case manager who will confidentially work with you to get you access to the resources that you need.
Nutrition	Student Health Services offers students up to 14 free sessions with a registered dietician to meet their nutrition goals. You can sign up for an appointment through the Patient Portal.
Technological Support/ Access	If you are in need of a laptop and are seeking to purchase one at a discount, you can visit here. They provide next-day shipping.
Title IX (Sexual Harassment or Gender-Based Discrimination)	If you might have experienced sexual harassment or gender-based discrimination, please contact Joanne Williams, RSPH Deputy Title IX Coordinator, at jampost@emory.edu. Please note that she is a mandatory reporter. If you prefer to speak with someone confidentially, please contact an Advocate at the Emory University Office of Respect by e-mailing respect@emory.edu or calling their 24/7 Advocate Hotline at 470-270-5360.
Recreation and Wellness	Emory Rec and Wellness is open for graduate students; please visit this website for more information.

EMORY | ROLLINS SCHOOL OF PUBLIC HEALTH

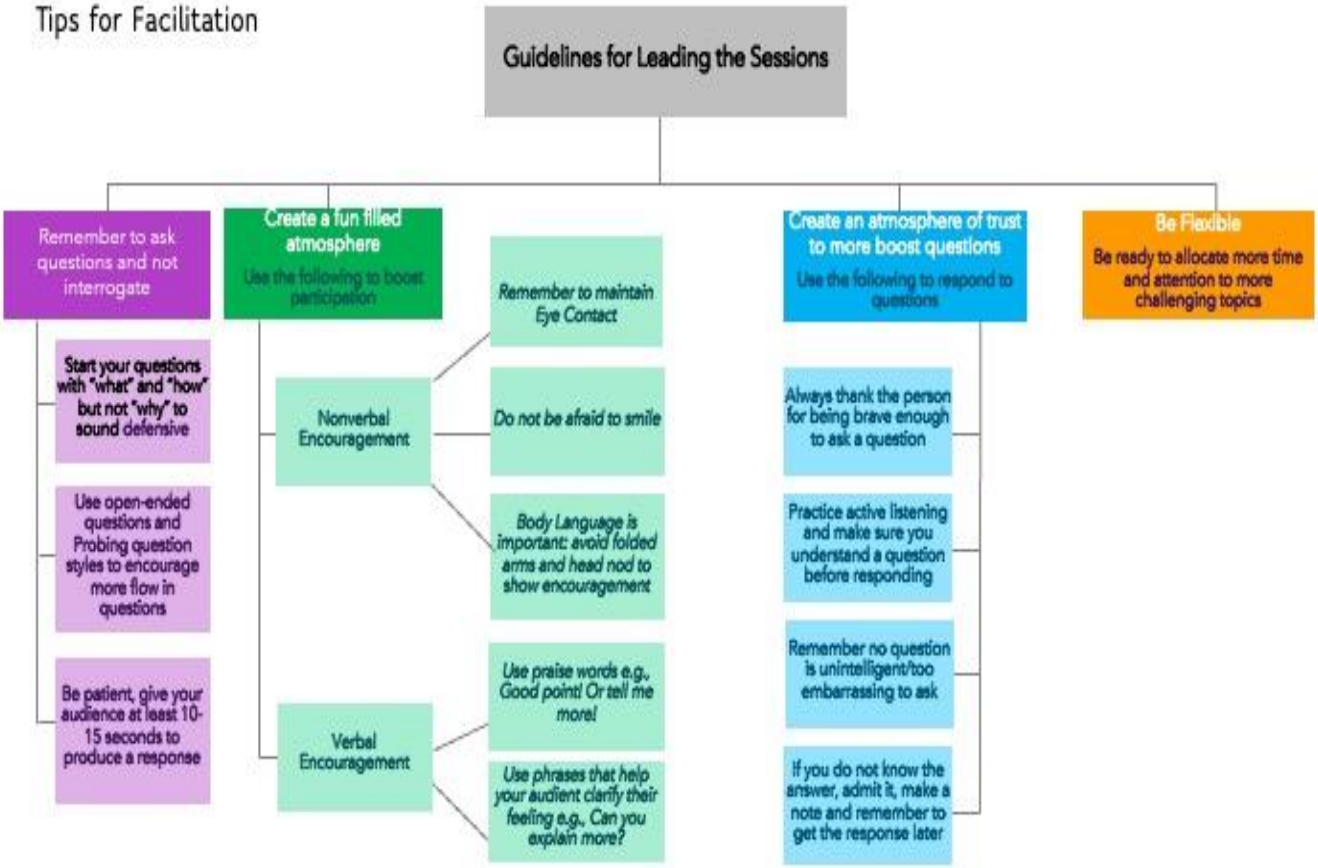
Help Us Help You

RSPH Student Engagement

RSPH International Student Belonging Toolkit



Tips for Facilitation



Appendix J: Intercultural Development Inventory (IDI)

The IDI assessment is grounded in Bennet's Developmental Model of Intercultural Sensitivity and its three main areas: integration, cultural disengagement, and minimization (Bennett, 2004; Bennett & Bennett, 1993). The integration stage focuses on creating an intercultural identity. The cultural disengagement stage reflects the degree to which the respondent is experiencing a sense of alienation from their cultural community. Lastly, Minimization is viewed as the ethnocentric stage (Hammer, 2011).

IDI consists of a 50-item questionnaire and five open-ended questions to provide context on the respondent's experiences around cultural differences. The total assessment can be completed in 15-20 minutes (Hammer, 2011). Once completed, a graphic profile is generated with the respondent's overall position on the developmental continuum. A monocultural mindset uses one's cultural perspective to perceive cultural differences. In contrast, an intercultural mindset allows for a shift in cultural perspective and the adaptation of behavior to cultural context (Hammer, 2011). Figure 2 shows a summary of the orientations on the intercultural developmental continuum.

Figure 15

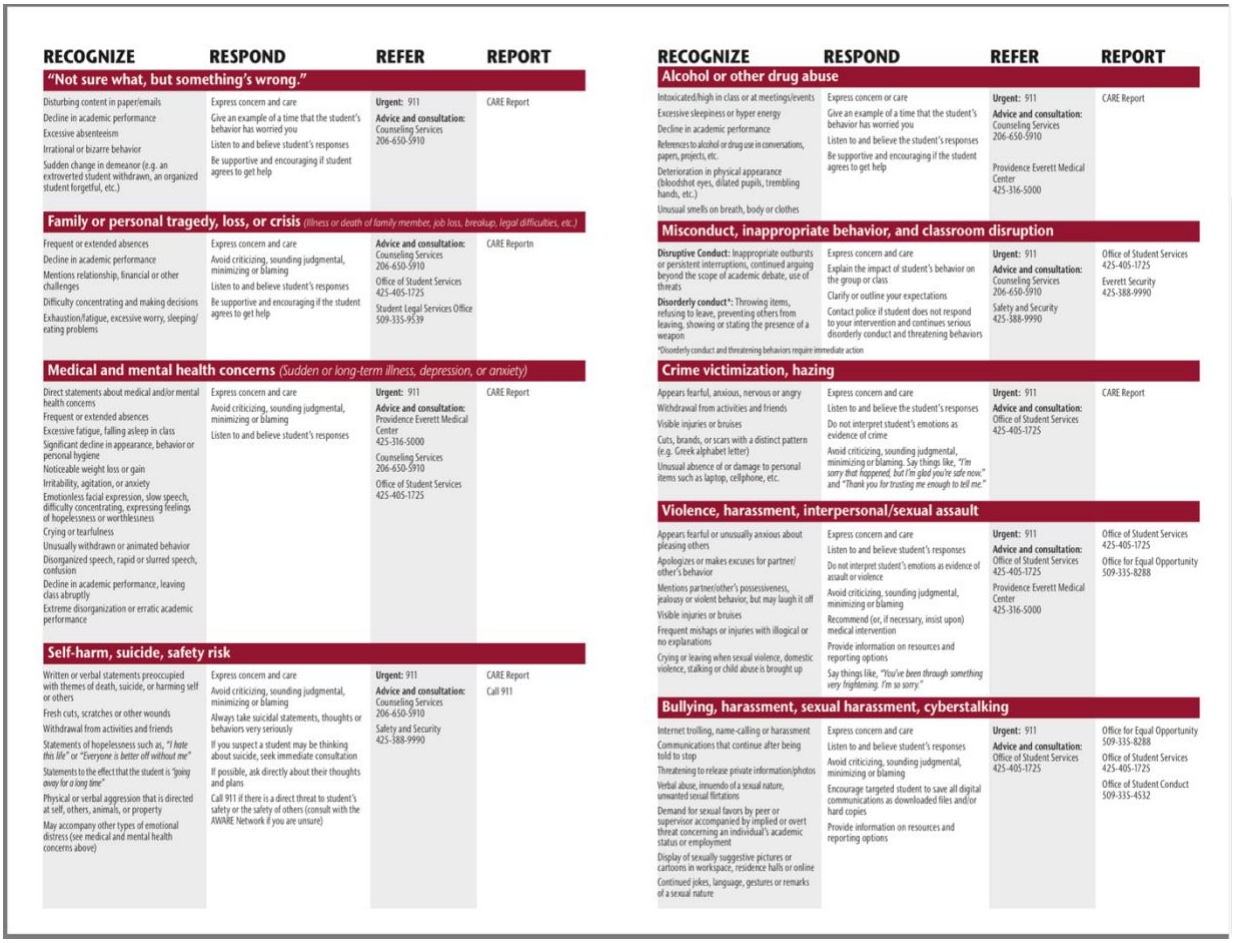
Summary of IDI developmental continuum orientations

Denial	An orientation that likely recognizes more observable cultural differences (e.g., food) but, may not notice deeper cultural differences (e.g., conflict resolution styles), and may avoid or withdraw from cultural differences.
Polarization	A judgmental orientation that views cultural differences in terms of "us" and "them". This can take the form of:
Defense	An uncritical view toward one's own cultural values and practices and an overly critical view toward other cultural values and practices.
Reversal	An overly critical orientation toward one's own cultural values and practices and an uncritical view toward other cultural values and practices.
Minimization	An orientation that highlights cultural commonality and universal values and principles that may also mask deeper recognition and appreciation of cultural differences.
Acceptance	An orientation that recognizes and appreciates patterns of cultural difference and commonality in one's own and other cultures.
Adaptation	An orientation that is capable of shifting cultural perspective and changing behavior in culturally appropriate and authentic ways.
Cultural Disengagement	A sense of disconnection or detachment from a primary cultural group.

Note. From "Additional cross-cultural validity testing of the Intercultural Development Inventory", by M.R Hammer, 2011, *International Journal of Intercultural Relations, 35(4), 474-487.*

Hammer (2011) assessed the validity of IDI version three with a sample of 4,762 participants from 11districts across different countries (United States, Austria, Brazil, Germany, Hong Kong, Italy, Japan, Costa Rica, and Ecuador). The sample consisted of high school and university students, members of a local church in the U.S, and managers from various countries working in non-governmental organizations. Results from this study suggest strong support for the cross-cultural reliability, validity, and generalizability of IDV v3 measures and the inclusion of the orientations, overall Developmental Orientation (DO), and Perceived orientation (PO) (Hammer, 2011).

Appendix K: Washington State University Recognize Respond Refer Report Model



RECOGNIZE	RESPOND	REFER	REPORT
"Not sure what, but something's wrong."			
Disturbing content in paper/emails Decline in academic performance Excessive absenteeism Irrational or bizarre behavior Sudden change in demeanor (e.g. an extroverted student withdrawn, an organized student forgetful, etc.)	Express concern and care Give an example of a time that the student's behavior has worried you Listen to and believe student's responses Be supportive and encouraging if student agrees to get help	**Urgent:** 911 **Advice and consultation:** Counseling Services 206-650-5910	CARE Report
Family or personal tragedy, loss, or crisis *(Illness or death of family member, job loss, breakup, legal difficulties, etc.)*			
Frequent or extended absences Decline in academic performance Mentions relationship, financial or other challenges Difficulty concentrating and making decisions Exhaustion/fatigue, excessive worry, sleeping/eating problems	Express concern and care Avoid criticizing, sounding judgmental, minimizing or blaming Listen to and believe student's responses Be supportive and encouraging if the student agrees to get help	**Advice and consultation:** Counseling Services 206-650-5910 Office of Student Services 425-405-1725 Student Legal Services Office 509-335-9539	CARE Reportn
Medical and mental health concerns *(Sudden or long-term illness, depression, or anxiety)*			
Direct statements about medical and/or mental health concerns Frequent or extended absences Excessive fatigue, falling asleep in class Significant decline in appearance, behavior or personal hygiene Noticeable weight loss or gain Irritability, agitation, or anxiety Emotionless facial expression, slow speech, difficulty concentrating, expressing feelings of hopelessness or worthlessness Crying or tearfulness Unusually withdrawn or animated behavior Disorganized speech, rapid or slurred speech, confusion Decline in academic performance, leaving class abruptly Extreme disorganization or erratic academic performance	Express concern and care Avoid criticizing, sounding judgmental, minimizing or blaming Listen to and believe student's responses	**Urgent:** 911 **Advice and consultation:** Providence Everett Medical Center 425-316-5000 Counseling Services 206-650-5910 Office of Student Services 425-405-1725	CARE Report
Self-harm, suicide, safety risk			
Written or verbal statements preoccupied with themes of death, suicide, or harming self or others Fresh cuts, scratches or other wounds Withdrawal from activities and friends Statements of hopelessness such as, *"I hate this life"* or *"Everyone is better off without me"* Statements to the effect that the student is *"going away for a long time"* Physical or verbal aggression that is directed at self, others, animals, or property May accompany other types of emotional distress (see medical and mental health concerns above)	Express concern and care Avoid criticizing, sounding judgmental, minimizing or blaming Always take suicidal statements, thoughts or behaviors very seriously If you suspect a student may be thinking about suicide, seek immediate consultation If possible, ask directly about their thoughts and plans Call 911 if there is a direct threat to student's safety or the safety of others (consult with the AWARE Network if you are unsure)	**Urgent:** 911 **Advice and consultation:** Counseling Services 206-650-5910 Safety and Security 425-388-9990	CARE Report Call 911

RECOGNIZE	RESPOND	REFER	REPORT
Alcohol or other drug abuse			
Intoxicated/high in class or at meetings/events Excessive sleepiness or hyper energy Decline in academic performance References to alcohol or drug use in conversations, papers, projects, etc. Deterioration in physical appearance (bloodshot eyes, dilated pupils, trembling hands, etc.) Unusual smells on breath, body or clothes	Express concern or care Give an example of a time that the student's behavior has worried you Listen to and believe the student's responses Be supportive and encouraging if the student agrees to get help	**Urgent:** 911 **Advice and consultation:** Counseling Services 206-650-5910 Providence Everett Medical Center 425-316-5000	CARE Report
Misconduct, inappropriate behavior, and classroom disruption			
Disruptive Conduct: Inappropriate outbursts or persistent interruptions, continued arguing beyond the scope of academic debate, use of threats **Disorderly conduct*:** Throwing items, refusing to leave, preventing others from leaving, showing or stating the presence of a weapon *Disorderly conduct and threatening behaviors require immediate action	Express concern and care Explain the impact of student's behavior on the group or class Clarify or outline your expectations Contact police if student does not respond to your intervention and continues serious disorderly conduct and threatening behaviors	**Urgent:** 911 **Advice and consultation:** Counseling Services 206-650-5910 Safety and Security 425-388-9990	Office of Student Services 425-405-1725 Everett Security 425-388-9990
Crime victimization, hazing			
Appears fearful, anxious, nervous or angry Withdrawal from activities and friends Visible injuries or bruises Cuts, brands, or scars with a distinct pattern (e.g. Greek alphabet letter) Unusual absence of or damage to personal items such as laptop, cellphone, etc.	Express concern and care Listen to and believe the student's responses Do not interpret student's emotions as evidence of crime Avoid criticizing, sounding judgmental, minimizing or blaming. Say things like, *"I'm sorry that happened, but I'm glad you're safe now."* and *"Thank you for trusting me enough to tell me."*	**Urgent:** 911 **Advice and consultation:** Office of Student Services 425-405-1725	CARE Report
Violence, harassment, interpersonal/sexual assault			
Appears fearful or unusually anxious about pleasing others Apologizes or makes excuses for partner/other's behavior Mentions partner/other's possessiveness, jealousy or violent behavior, but may laugh it off Visible injuries or bruises Frequent mishaps or injuries with illogical or no explanations Crying or leaving when sexual violence, domestic violence, stalking or child abuse is brought up	Express concern and care Listen to and believe student's responses Do not interpret student's emotions as evidence of assault or violence Avoid criticizing, sounding judgmental, minimizing or blaming Recommend (or, if necessary, insist upon) medical intervention Provide information on resources and reporting options Say things like, *"You've been through something very frightening. I'm so sorry."*	**Urgent:** 911 **Advice and consultation:** Office of Student Services 425-405-1725 Providence Everett Medical Center 425-316-5000	Office of Student Services 425-405-1725 Office for Equal Opportunity 509-335-8288
Bullying, harassment, sexual harassment, cyberstalking			
Internet trolling, name-calling or harassment Communications that continue after being told to stop Threatening to release private information/photos Verbal abuse, innuendo of a sexual nature, unwanted sexual flirtations Demand for sexual favors by peer or supervisor accompanied by implied or overt threat concerning an individual's academic status or employment Display of sexually suggestive pictures or cartoons in workspace, residence halls or online Continued jokes, language, gestures or remarks of a sexual nature	Express concern and care Listen to and believe student's responses Avoid criticizing, sounding judgmental, minimizing or blaming Encourage targeted student to save all digital communications as downloaded files and/or hard copies Provide information on resources and reporting options	**Urgent:** 911 **Advice and consultation:** Office of Student Services 425-405-1725	Office for Equal Opportunity 509-335-8288 Office of Student Services 425-405-1725 Office of Student Conduct 509-335-4532

Note. From "HELPING STUDENTS IN DISTRESS Recognize. Respond. Refer. Report" by Washington State University, n.d., *Division of Student Affairs.*