Responses to Mental Healthcare Demands in U.S. Higher Education

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Over the last decade diagnosed symptoms of mental health disorders have increased dramatically in youth and young adults in the U.S. “Rates of major depressive episodes in the last year increased 52% 2005–2017 (from 8.7% to 13.2%) among adolescents aged 12 to 17 and 63% 2009–2017 (from 8.1% to 13.2%) among young adults 18–25” (APA, 2019). Universities’ response rising mental healthcare demands from students is the product of competitive influences from university students with a mental illness, university employees, university administrators, healthcare workers, and government agencies.

The 2012 Association for University and College Counseling Center Directors Annual Survey reported that more than 95 percent of schools had increased concerns about students with psychological problems. Colleges uniformly recognize the problem, but the causes and the remedies are debated. Auerbach et al. (2016) report that “Mental disorders are common among college students, have onsets that mostly occur prior to college entry, in the case of pre-matriculation disorders are associated with college attrition, and are typically untreated.” Is it the responsibility of colleges to help their students, or should something be done much earlier?

Mental disorders can persist without attention, and may worsen without treatment. Dr Sherry Benton advises: “If the problem is more serious or has continued for several months, help from a therapist can be highly effective” (cited in Hess, 2018). Around half of the states either don’t require counseling for K-12 students or have a large counselor-to-student ratio. (ASCA, 2020). Students are developing mental disorders before they get to college; earlier treatment

might reduce the number of depressed college students and wait times to receive treatment in college might be shorter. One reporter found that "Constance Rodenbarger, a student at Indiana University, attempted suicide while waiting for an appointment at the campus counseling office" (Thielking, 2017). Waits of up to 3 weeks are not uncommon according to Thielking. Not much is known about the impact of wait times, but for every day of waiting, 1% of patients cancel their appointments (Dampier, 2018). Waits are attributable to the volume of patients, the number of care providers, and insurance plans. "If I'm an average patient with an insurance plan, I'm probably going to wait at least three weeks for an appointment," says professor Christopher R. Larrison (cited in Dampier, 2018).

Publicly funded universities apply some of their state support to their health services. After losing his son to a suicide related to mental illness, Virginia state senator Creigh Deeds said: "We cannot afford to wait for another crisis or tragedy. Too many lives have been lost, too many families changed forever" (cited in Szabo, 2019). The University of Virginia's 2018-2019 budget lists "total direct expenses" at $14,182,358 (University of Virginia, 2019), while the university's endowment is $9.5 billion (Smith, 2018). Public institutions need to spend much more on mental health services. Such spending has shown promising results. The California Mental Health Services Authority allots $8.7 million in public funding for California schools per year. 13% more students received treatment and over 300 students additional students graduated from the previous year (Lam, 2015).

Colleges and universities are planning for the increase in mental healthcare needs. The University of Virginia is investing $100 million to build a new student health center, so that it can be one of the leaders in student health and wellness research," said Dr. Christopher Holstege

(cited in Kelly, 2018) about UVA's new health center. According to Holly Chessman, a research fellow with the American Council on Education, "We know that poor mental health hinders student academic success." She adds "I think it's important that mental health and well-being be a campuswide priority, and it is for a lot of college presidents" (cited in Bauer-Wolf, 2019).

The Americans with Disabilities Act (ADA) states that no state or local entity shall discriminate based on physical or mental disability (ADATA, 2020). Colleges fall under this umbrella. Allegations of discrimiation in mental healthcare are controversial. What counts as equality when it comes to mental health care and evaluation? The American College Counseling association is "an Association for those persons in higher education to include colleges, universities, community and technical college settings, whose professional identity is counseling and whose purpose is fostering students' development" (ACCA, 2020). ACCA found that 62 percent of colleges offered suicide prevention programming; 20 percent had a dedicated staff member to provide case management for students (ACCA, 2013).

If by following ADA guidelines 100 percent of buildings are wheelchair accessible, how do we transfer such success to mental healthcare? Given limited funding, should programs such as suicide prevention be scrapped to make way for crisis counseling, for example? The Supreme Judicial Court of Massachusetts had interpretations for this. In 2009, MIT graduate student Han Duy Nguyen commited suicide on campus. His father sued MIT for wrongful death. The Supreme court found MIT not resposnible for Nguyens death, stating "Generally, there is no duty to prevent another from committing suicide. Under our case law, we do not owe others a duty to take action to rescue or protect them from conditions we have not created" (*Nguyen v. MIT,* 2018). However, the court stated that universities could be responsible in other situations: "With

these considerations in mind, we conclude that a university has a special relationship with a student and a corresponding duty to take reasonable measures to prevent his or her suicide in the following circumstances … the university has a duty to take reasonable measures under the circumstances to protect the student from self-harm" (*Nguyen v. MIT,* 2018). Nguyen's case was mentioned in 2018, in a wrongful death lawsuit against Harvard. Luke Z. Tang commited suicide in 2015, and his family believes Harvard is responsible for Tang's death. Harvard used Nguyen's case as a defense stating "The SJC held that colleges do not have a 'generalized duty to prevent suicide.' Instead, the SJC held, colleges have a duty 'limited to initiating the university's suicide prevention protocol'" (*Tang v. Harvard,* 2018). In the still-ongoing suit, Judge Michael D. Ricciuti defended the court's decision not to dismiss the suit in 2019: "Harvard's argument to dismiss this case reduces Nguyen to a check-box, and that once a university checks one of three boxes — a protocol, or if there is none, clinical care, or if that is refused, reaching an emergency contact — its duty ends regardless of how well or poorly the university fulfills its duty" (Franklin, 2019).

In both of these cases, the University believed their respective students received adequate counseling: "Plaintiff's Complaint acknowledges that the defendants continued to make Harvard resources available to Tang, and repeatedly stated their recommendation and expectation that he remain in treatment even while visiting China over the summer, which Tang declined" (*Tang v Harvard,* 2018). If the students were given adequate counseling why were they driven to suicide? The answer may lie in the students' willingness to cooperate. Luke Tang stated that "he felt 'forced' to continue mental health counseling and explained his desire to decide for himself whether to continue counseling 'past the remaining two weeks of the semester'" (*Tang v*

Harvard, 2018). At MIT, Nguyen had denied having a mental health condition, telling a psychologist at MIT Health "that he did not know why he 'was referred here. My issues have nothing to do with [mental health].' During the intake meeting, Nguyen denied suicidal ideation" (*Nguyen v MIT,* 2018). Nguyen had received phycological help for depression before and during his time at MIT, but not with the school's health center. Nguyen "found MIT Mental Health to be 'useless,' that Barnes 'proceeded to turn me into a mental patient, and I was forced to discuss things that I really didn't want to'" (*Nguyen v MIT,* 2018). Both students felt forced to get counseling.

Organizations have endorsed candidates for their efforts on mental healthcare, such as Tim Kaine after his response to the Virginia Tech shooting in 2007 (Raftery, 2016). Like the ADA, mental healthcare has become a bipartisan issue (Craig, 2019). President Trump attributed mass shootings to mental illness. However, Trump opposed Medicaid funding that would have provided mental healthcare coverage to many Americans (Tankersley & Tackett, 2019). Presidential candidate Bernie Sanders has proposed a universal healthcare system, in which mental healthcare would be covered. President Obama's Affordable Care Act declared mental health services as an essential health benefit. Republican Tim Murphy and Democrat Eddie Bernice Johnson re-introduced a mental healthcare bill designed to help struggling Americans. As politics goes, it's impossible to determine the motives politicians have in their decisions. However, we can look at the effect these laws have had. Insurance payments for mental healthcare have historically been less than the payments for physical healthcare (Sipe et al., 2015). After legislation, access to mental healthcare resources have been less expensive. Recent

legislation, including Tim Murphy's bill, have been the result of mass-shootings (Sullivan, 2016).

Even after long wait times for appointments, students still sometimes need access to medication to help their symptoms. For out-of-state students, licensure requirements may complicate care (Title 21 USC, 2018). Federal law prohibits the prescription of controlled substances without an in-person intake meeting: "The term valid prescription means a prescription that is issued for a legitimate medical purpose in the usual course of professional practice by (i) a practitioner who has conducted at least 1 in-person medical evaluation of the patient" (Title 21 USC). Many doctors cannot prescribe or refill medications across state lines, compelling some students to find new temporary care providers. Because of long waiting times, some students get no help until they return to campus.

Some argue that medication should not be prescribed as often as it is. Dr. Steven Hollon of Vanderbilt University states: "at least half the folks who are being treated with antidepressants aren't benefiting from the active pharmacological effects of the drugs themselves but from a placebo effect" (Smith, 2012). Cognitive behavior therapy "is a common type of talk therapy (psychotherapy). You work with a mental health counselor (psychotherapist or therapist) in a structured way, attending a limited number of sessions" (Mayo Clinic, 2019). Instead of using drugs to alter brain chemistry, cognitive behavior therapy seeks to fix patient's methods of dealing with stress and emotions. cognitive behavior therapy is known to help anxiety, depression, and sleep disorders—all common issues plaguing students. Cognitive behavioral therapy has been evaluated against alternatives: "CBT showed higher response rates than the comparison conditions in 7 of these reviews and only one review reported that CBT had lower

response rates than comparison treatments. In general, the evidence-base of CBT is very strong" (Hoffman, 2012).

The Association for University and College Counseling Center Directors (AUCCCD) is "an international organization comprised of colleges and universities from the United States and its territories … . AUCCCD works to be the higher education leaders for collegiate mental health" (AUCCCD, 2020). The AUCCCD releases a yearly survey of information collected about college counseling centers. Of 571 centers surveyed, 545 (95.4 percent) were in the U.S. (AUCCCD Annual Survey, 2018). Because questions have varied year to year, comparisons are difficult. In 2015, 73.1 percent of schools reported growing mental health needs; 1.4 percent reported declining needs. In 2016, 57.1 percent of schools had growing needs; 0.8% had declining needs.

In 2015. 71.67 percent of surveyed students said mental health counseling improved their academic performance; in 2018, only 58.3 of clients said counseling improved it. The mean amount of talk therapy sessions for clients was 5.53 in 2015 and 5.09 in 2018. Mean students served in 2015 was 12.06 percent of the student body and 11.8 percent in 2018. The mean percentage of the student body served decreases as schools get larger for both 2015 and 2018. In 3 years the sessions per client decreased slightly but reported academic improvement has decreased drastically.

In 2015, 34.6 percent of centers had active waitlists. The waitlisted is utilized from mean 8 weeks per year to mean 23 weeks per year, with no clear trend. In 2018, 33.7 percent of schools had students on waitlist. The waitlisted is implemented from mean 8 weeks per year to mean 38 weeks per year, trending with waitlists being used more in smaller schools. However,

larger schools had on average more students per wait list (range 13.8 to 145.2 students). The amount of schools with active waitlists remains largely unchanged, but larger schools are experiencing much more volume of students in need.

For all schools surveyed in 2018 the mean time until the first appointment was 6.5 days (range 4.5-10.2 days), but there was no trend on maximum time waiting (range 14 to 55 days). However, after the first triage appointment the maximum wait increased to range (14-103) while the mean wait time remained largely the same (8.6). These numbers go up significantly when a client is on the waitlist. There is mean 17.7 days until the first appointment, with range (21-90) days maximum. In 2017 the mean wait time was 6.6 days (range 3.5 - 10 days). Those on waitlists had mean 17.3 days of waiting (range 5 - 47.7 days). 14.2% average of first appointments were considered crisis appointments, trending higher per bigger school. If a student were to be suicidal during a crisis appointment, long wait times could prevent that student from receiving help in time.

Long wait times, funding constraints, and efficacy are few of the many issues in college mental healthcare. Are colleges responsible for protecting their students? Massachusetts says only special cases are the school's responsibility, such as clear suicidal intentions. In the cases of Han Duy Nguyen and Luke Tang, there is a link where both colleges failed. I believe that the lack of effectiveness of counseling was the root problem. In court and email transcripts it is clear that the administration and academic staff cared for their students' wellbeing (*Tang v Harvard,* 2018). The sessions, after multiple meetings, failed to make the students feel comfortable. As seen in the AUCCCD survey, the effectiveness of counseling is decreasing. It's unfair to place blame on the counselors for seemingly failing. As patient volume and waitlist times increase,

counselors need to do their best to accommodate everyone. And this may mean sub-par sessions with clients. What happens to clients who are triaged as low-priority and develop worse symptoms as they wait for an appointment? The system exists as a positive feedback loop. In 2018 An average of 1 full time employee staff was responsible for 1411 students, while both staff and trainers were 1 per 103 (AUCCCD Annual Survey, 2018). This figure also does not account for staff who are allowed to prescribe drugs to patients. Even if staff are allowed to prescribe drugs, the law prohibits them from doing across state lines. This is especially problematic for college students who don't reside permanently near their college.

In the data provided by the AUCCCD Annual Surveys, many means were consistent (first appointment, weeks waitlist is utilized, mean student body served, etc.) but many categories had concerning outliers. Students may be fine with 6 day appointment wait times, but what about the students who are pushing 100 days on the waitlist? There are many accounts of students feeling uncomfortable during counseling, and the mean sessions per client remains mostly steady. I believe this is because as volume increases, quality and availability of counseling decreases.

The government has been enacting policy to help mental healthcare, but most of these bills have been reactions to tragedy. With the amount of mentally ill students rising, mental healthcare should be a priority. Instead of trying to only prevent shootings, the government should aim to improve general wellbeing. This could be accomplished by spending more on universities and healthcare in general. Small changes in legislation could make a huge positive impact on Americans, such as allowing prescriptions to be sent across state lines. There must also be improved infrastructure outside of colleges and universities so students can get help when

they're not at school. Transferring to different clinics should not be such a hurdle, and wait times need to be reduced.

As universities increase their spending on mental healthcare resources, they need to also anticipate the far future. Schools like Virginia have done so by building a new student health complex to help future generations of students. The remedy to the mental healthcare crisis is multifaceted. There needs to be more infrastructure for students, more training for counselors, and more funding for universities.

There is hope still for the remediation of the mental healthcare crisis in the United States education system. The majority of that hope lies in increased funding to universities and public health institutions. If there are more professionals available to treat patients, there will be shorter wait times, higher quality sessions, and hopefully less people in need.

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