

# A Decade of Observations from within the U.S. College Mental Health Psychiatry Listservs

Vivien Chan<sup>1\*</sup>, Edwin Feliciano<sup>2</sup> and Todd Mitchell<sup>3</sup>

<sup>1</sup>Student Health Center, University of California Irvine, California, USA

<sup>2</sup>Student Health Service, University of California Santa Barbara, California, USA

<sup>3</sup>Psychiatry Tang Center, University of California Berkeley, California, USA

\*Corresponding author: Vivien Chan, Chief of Psychiatry Service, Student Health Center, University of California Irvine, 501 Student Health, Irvine, California 92679-5200, USA, Tel: (949) 824-5304; Fax: (949) 824-0323; E-mail: [vchan1@uci.edu](mailto:vchan1@uci.edu)

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## Abstract

The American Psychiatric Association listserv, American Academy of Child and Adolescent Psychiatry's TAY-CSMH Committee listserv, and the University of Pennsylvania-sponsored College Psychiatry Listserv often reflect themes of psychiatric practice in college and university settings, conceptually a niche specialty. This commentary, written by chiefs of psychiatry within the University of California system, reflects on persistent themes discussed in the past decade on the listserv that include culture of practice, service models, leadership, staffing ratios, administration, transition of care, referrals and clinical challenges which are reflective of general practice concerns.

**Keywords:** College student; Mental health; Psychiatry; Leadership; Administration; Ratios

## Introduction

We have had the privilege to be part of college mental health at one of our nation's largest public university systems. Recognizing the importance of psychiatric conditions in the college age population, the American Psychiatric Association (APA) formed a listserv since 2005 which has continued to this day for its task force on College Mental Health. The APA's commitment to this patient care sector recognizes the need for practice, policy, and research leadership by and from its members for transitional aged youth and emerging adults. The active listserv has been a useful forum for practitioners embedded in college and university settings to exchange such information. Additionally, the American Academy of Child and Adolescent Psychiatry has a recognized Transitional Age Youth College Student Mental Health Committee with listserv, and the University of Pennsylvania also hosts a college mental health listserv where similar topics are discussed. The U Penn listserv does not require APA membership. An interesting phenomenon on the listservs has been the cyclic repetition of certain thematic questions and issues, especially when a psychiatrist newly joins the community. The following represents a list of topics about which psychiatrists in leadership roles are often asked to provide expertise. We think the list mirrors practice issues facing our profession at-large.

## Culture of College Mental Health

When attending the American College Health Association's annual meeting, it is often repeated, "If you've seen one university health system, you've seen one university health system." This speaks to the tremendous heterogeneity of investment in mental health from one campus community to another. Campus administrators, from junior colleges to research universities, did not enter their jobs expecting to be facile with psychoeducation. What works in one setting is highly influenced by the current administration, institutional culture, budget funding, and a local understanding of how student, staff and faculty mental health impacts daily productivity. In our opinion, healthy, progressive institutions have a responsibility to invest in appropriate, comprehensive, high quality mental health services for its people.

As psychiatrists, we have trained and learned our craft in formal academic settings, often tertiary-care hospitals. When health care is delivered in an educational setting, though, the culture and expectations change. In educational systems, "best practices" are often rooted in guiding principles set forth as ideals rather than being based on clinical practice guidelines (e.g. Institute of Medicine criteria) [1-4]. This exemplifies ways psychiatrists can be misunderstood within these systems, by using words familiar to us in clinical psychiatry cultures that unwittingly have very different meanings in non-psychiatric, non-clinical systems.

College mental health also shares its service delivery with deep roots originating in the counseling psychology field. Psychiatrists used to working with clinical psychology colleagues in academic medical centers or in clinical practice may be unfamiliar with this specialty within professional psychology [5] and its differences from the more familiar specialty of clinical psychology [6]. In some locations, the practical differences may be negligible, and in others the differences are vast. Many therapists who work exclusively in higher education have experience exclusively with college students. They may lack significant, longitudinal clinical experiences with acute outpatient, inpatient, community mental health, dual diagnosis, and other complex clinical presentations.

## Models of Service Provision

World-wide, the demand for mental health services outstrips the supply of services. This unfortunate phenomenon is evident across the United States, including within the college healthcare environment. Workforce issues arise, from limited provider panels in provider networks offered to faculty and staff by healthcare insurers [7] to the challenges of recruiting and retaining high quality medical specialists for students. In the majority of surveyed places [8], counseling or therapeutic services provided by counseling facilities are offered on a limited basis (average 4-6 sessions) because the service may be held to an expectation to serve all students. Sophisticated programs invested in delivering evidence-based psychotherapies (EBPs) are confronted by the reality that EBPs usually require greater than "average 5" sessions. Even with EBPs, there exists what Dr. Insel [9] has described as a "quality chasm" in the training and

delivery of EBPs. Campuses vary greatly, too, in defining “counseling” versus “psychotherapy.”

Former National Institute of Mental Health Director Thomas Insel’s blog dated July 14, 2015 <http://www.nimh.nih.gov/about/director/2015/quality-counts.shtml> describes the “quality chasm” regarding evidence based psychosocial therapies, Weissman et al. [10] noted that in 2006, 90% of psychiatry programs were in compliance of CBT training and 67% of PsyD programs did not require a didactic or supervision in an evidenced-based [psycho]therapy. That blog also introduces the now-National Academies of Sciences (then-Institute of Medicine’s) report Psychosocial Interventions for Mental and Substance Use Disorders: A Framework for Establishing Evidence-Based Standards [11].

Paraprofessionals and care extenders are often employed to stretch services and to reserve psychiatrists for the “sickest” patients. (Exchanges on this topic are very common on the listserv.) This trade-off means that thorough assessment, early detection, and prevention by an expert medical professional may be postponed until pathology has been more longstanding, more injurious, and/or more difficult to treat effectively. It also reinforces the stigma surrounding psychiatry.

The counseling model often found in counseling services on campuses nationwide aims to distinguish itself from a community mental health model, from a medical model, and from a purely clinical model. This primarily developmental approach retains 50-60% of time in “direct” clinical service and devotes 40-50% time to activities such as outreach and programming for its therapists [12]. Given that approximately 10% of the student body (and nonexistent national data on faculty and staff) use counseling services [8], counseling facilities exhort outreach and programming activities, ostensibly to reach the remaining “90%”. Counseling models explicitly eschew community mental health models by intending to focus on preventive efforts to those who remain well. While public health prevention is admirable, comprehensive clinical models can also seamlessly offer health education to the masses in more efficient ways (i.e. informed by top-level clinicians but delivered by paraprofessionals or peers; e-curriculums).

A multidisciplinary team in a campus setting may also be quite a different entity than what psychiatrists have previously come to expect. A university system of care shares features with other systems of care but also retains unique qualities. *A Primer for Working in Campus Mental Health: A System of Care* reviews the SAMHSA System of Care model and demonstrates how the campus structure is also a system of care, offering psychiatric intervention vignettes for each system component [13].

For example, county-based community mental health care (e.g., assertive case treatment) relies on teams to deliver unified services. These comprehensive care teams are led clinically by psychiatrists and include essential members: diagnosis-specific or topical specialists (e.g. rehabilitation, occupational, vocational), nurses, case managers, psychologists, social workers, and therapists. Hospitals, as well, function effectively by utilizing multidisciplinary and specialty-floor teams. In contrast, based on listserv postings, educational settings appear to be “reinventing the wheel” of multidisciplinary care. The multiple disciplines involved can feel like temporarily unified coalitions, instead of a cohesive care team. Many campuses have formed useful behavioral conduct intervention teams to help them deal with high-risk students. While these are a type of “multidisciplinary” group, the aim of these teams is not to deliver comprehensive services, but to assist the campus in risk management.

### Staffing

Whether psychiatrists report to other psychiatrists, primary care physicians, health administrators, psychologists (clinical or counseling), or therapists, many listserv posts discuss the energies spent in psychoeducation

about psychiatry’s role and reducing stigma. For the lone psychiatrist working in a campus setting, or the pioneer psychiatrist to a campus, reasonable workload and practice scope expectations are often explored. Dual role issues are routinely reviewed. Those psychiatrists reporting to medical specialists often face repeated requests to justify the pace of psychiatric work critical to the therapeutic relationship and combating the stigma which devalues “just” talk therapy. Here, our field has done itself a disservice due to the “quality chasm.” Similarly, an erroneous ideal of “meds only” psychiatric practice has gained popularity among many non-psychiatric clinicians and administrators, suggesting that rapid, focal psychopharmacological interventions are an acceptable, even preferable, alternative to comprehensive psychiatric assessment and treatment planning developed through careful therapeutic engagement. These failures to understand the rudiments of psychiatric practice consequently threaten to undermine the breadth, quality, and effectiveness of the services psychiatrists are capable of providing. Further, pressures persist to deliver clinical services in lieu of thoughtful, efficient service delivery models, devaluing the strategic planning leadership that psychiatrists can provide.

Those within psychiatric leadership are often asked, “How many psychiatrists are enough?” Discussions about caseloads panels, frequency of appointments, complexity of care and staffing ratios then ensue. Another oft-quoted, but in our opinion dreadfully outdated, guideline seen on the listserv suggests that one psychiatrist is adequate psychiatric coverage for a population of 10,000 (the mythical 1:10,000 ratio). Many wiser than us have attempted to explain the problem of estimating workforce [14,15]. Instead, we offer this discussion.

A helpful article describes four main “physician supply forecasting” approaches which we summarize here [16]. (Caveat: payor model influences ratios. A fee-for-service model is generally better-staffed, while HMO models often push their ratios to unsustainable limits). The supply or trend model makes per capita projections based on the current total pool of providers. This model assumes that the current supply is adequate. Different companies have generated ratios wildly varying from 1:5,128 (GMENAC) to 1:10,000 [17,18]. The demand based approach examines current utilizations of services and then makes forecasts on the future. This model assumes current usage of services is satisfactory and ignores underutilization. Again, ratios vary widely, offering 1:6,289 to 1:25,641 [17]. The need based approach estimates disease prevalence and the time required for care, sometimes measured in full time equivalents (FTEs) [13,18]. One article based in year 2010 projects that we will need 487% more psychiatrists for the future [19]. The last approach described is benchmarking which compares similar profile health systems to one another. For example, the Veterans Health Administration recently suggested a minimum of 1.22 FTE outpatient psychiatrists per 1,000 mental health patients [20]. In the same document, it comments that “the number of patients treated on a single psychiatrist’s panel would almost always be less than 820”, and allows for flexibility depending on the members of the multidisciplinary clinical team. Another VA report [21] maps productivity and workload expectations, that an outpatient psychiatrist is expected to have 6 hours of patient care in an 8 hour day and interestingly defines labor mapping of clinical time. Whatever the method used, local market forces, service quality and clinical effectiveness expectations, caseload complexities, and patient satisfaction goals also affect projection scenarios. Our review of the literature, extrapolated for application to our university-based system, suggests a minimum ratio of 1:6,250 within our system, and we suggest that 1 psychiatrist be available for full-time clinical work when there are 6 full time clinical therapy service providers.

### Transition of Care Issues / Referral Networks

One of the most useful and rewarding aspects of the listserv has been its role in making continuity of care linkages, especially when students are

leaving one region of the country to go to another. This, truly, creates a community of colleagues.

### Clinical Conundrums: ADHD, Eating Disorders, Substance Use Disorders

The diagnoses listed pose challenges to psychiatrists in general, as well as other medical and lay personnel. It seems that every few months, a question on at least one of these diagnoses surfaces. Through the listserv, practice pointers and policies are shared. The unsatisfying answer is that, at this time in our scientific technology, there are no quick diagnostic “tests” for ADHD and no easy recovery pathways from Eating and Substance Use Disorders. We must rely on our bedside manner, clinical expertise, and medical tools to promote recovery. These are also areas where longitudinal continuity of care is paramount. It is possible that a new conceptualization of ADHD as we know it will emerge [22,23]. However, college students self-endorse symptoms of ADHD at a higher rate (7.5% [24], 7.4% [25], 7.8% [26]) than expected compared the general population. The art of evaluating functional impairments is challenging when our young adult patient is reciting DSM-based symptom criteria to us in the context of potential secondary gain (the pursuit of stimulant medication) [27].

Here too, are where stigma problems persist. From overly-permissive attitudes about alcohol and other drug use (i.e. “Kids will be kids”/“College students will party”) and eating (“It’s just the ‘freshman 15 [lbs]”), sometimes the germinal stages of these serious disorders evoke powerful, polarizing reactions from the public, and even, medical staff. This is where psychiatric leadership is required not just for patient care, but to manage and address transference/counter transference issues within the staff and in the community environment.

### Transitional Age Youth/Emerging Adults as a Niche

More recently, listserv posts have discussed specific clinical and ethical dilemmas which have at their themes issues of autonomy and beneficence. Even though an institute of higher education views its students as autonomous adults, developmentally, many arriving students (even those in nontraditional routes) are still working through late adolescent struggles of identity and self agency. On the listserv, psychiatrists regularly consult and offer opinions on topics ranging from “emotional support animals versus pets” to managing safety for the complex, highly impaired student. In each of these situations, psychiatrists review the medical evidence, examine the specific developmental needs of the individual patient, balance the need for autonomy with duties to consult/collaborate/protect while hoping to facilitate growth and recovery.

### Conclusions

The field of college mental health remains a challenging psychiatric leadership frontier. Modeling clinical excellence for treatment-naïve patients can be rewarding, as is working in a community which values and respects mental health services. Psychiatrists who practice within the campus system or in the private/public sector can benefit from being literate about their unique campus communities [13]. However, sustained leadership is still required. Particularly, when issues surface repeatedly in the listserv, we know that significant hurdles persist. So far, 0.8% of mental health programs on college campuses are directed by psychiatrists [12], yet our unique skill set may be exactly the prescription: the renaissance psychiatrist who combines multidisciplinary leadership, policy development, politics, and staff management along with best-practice-standard clinical care can find fellowship within the available professional listservs.

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