Letters

Increased Rates of Mental Health Service Utilization by U.S. College Students

TO THE EDITOR: The recent article by Lipson and colleagues (1) documents increased utilization of mental health services by U.S. college students in outpatient, inpatient, and emergency settings. The authors propose that this increase may be due to a combination of increased prevalence of mental illness and decreased stigma, specifically that decreased personal stigma may contribute to increased help seeking. This important article highlights the growing demand and need for mental health services on college campuses. We have several comments about these findings.

First, the increased rate of suicide in the 15- to 24-year-old age group over this same period suggests that the increased rate of mental illness, rather than stigma, may play a larger role in students' accessing more mental health services (2). Additional research could explore the impact of increased mental illness in the context of perceived stigma concerning service utilization.

Second, the data regarding stigma and help seeking are complicated. Although the authors cite that personal stigma, and not perceived stigma from others, is associated with treatment seeking among college students, other studies have concluded the opposite to be true (3). Specifically, other studies have shown that perceived stigma but not personal stigma was strongly related on college campuses to help-seeking behavior (4). Understanding the role of different kinds of stigma in help seeking warrants further investigation.

In addition, given that this broad study surveyed 196 college campuses across the country, the data do not account for regional variation in perceived stigma. A repeated finding has been that perceived stigma is a greater barrier to help seeking in rural areas than in urban areas, and this finding may therefore vary across U.S. campuses (5).

One possibility that was not discussed is whether increased severity of mental illness may contribute to an increase in both help seeking and suicide rate. Data we gathered from an inpatient psychiatric facility in a college town in the southeastern United States lend some credence to this notion. For persons ages 18–24, the number of unique patients admitted and total hospital admissions increased from 2007 to 2017 (see online supplement). For students specifically seen at the university student health psychiatry service over the past 5 years, the number of psychiatric hospitalizations has nearly tripled while the total student enrollment has increased by only 11.5% (see online supplement).

We agree with Lipson and colleagues that among college students, service use is rising, prevalence of psychiatric diagnoses is rising, and the suicide rate is rising. Clearly, there is a need for increased availability of high-quality mental health services on college campuses. We also agree that both increased rates of mental health problems and decreased stigma could contribute to increased service utilization. However, additional research is needed to prove any causal relationship between illness prevalence, illness severity, perceived stigma, and help seeking. Such research could shed light on the significance of each of these factors and lead to better understanding of how severity of mental illness and different kinds of stigma factor into service utilization.

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Michael Shapiro, M.D.
Marcia Morris, M.D.
Andres Pumariega, M.D.

Department of Psychiatry, University of Florida, Gainesville (all authors); Student Health Care Center Psychiatry, Counseling and Wellness Center, University of Florida, Gainesville (Morris). Send correspondence to Dr. Shapiro (mshapiro@ufl.edu).

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The Policy Debate on Medicaid's IMD Exclusion Rule (Continued)

TO THE EDITOR: I am writing in response to the policy debate on Medicaid's Institutions for Mental Diseases (IMD)

Exclusion Rule debated in the January issue of *Psychiatric Services* (1, 2). I applaud the authors for taking on this important topic and would like to add to the debate. The real solution to these issues cannot be found solely through IMD beds but rather through the development of a full continuum of care that combines inpatient, outpatient, and crisis options in proportion to the actual needs of the community in which they aspire to serve. I support an IMD waiver as an interim step to create a clear pathway to evolving community-based crisis service continua throughout the nation with the understanding that sole reliance on larger hospitals is *not* the answer in the long run.

The call for better access to acute mental health services is a result of crowded emergency departments, a lack of ability to connect to care, law enforcement frequently serving as a mental health response team, and jail census escalation over the past several years. Unfortunately, crisis services that incorporate a no-wrong-door approach to accepting all referrals are rare, but resources are now publicly available to pave the path. The CrisisNow.com Web site of the National Association of State Mental Health Program Directors includes the National Action Alliance for Suicide Prevention's clearly defined exceptional crisis practice standards, and resources on the site help quantify the needs of any community. As the Centers for Medicare and Medicaid Services (CMS) communication noted, "States participating in the SMI/SED demonstration opportunity will also be expected to commit to taking particular actions to improve community-based mental health care" (3). Mary C. Mayhew, deputy administrator and director for CMS, stated that "CMS strongly encourages states to include in their application a thorough assessment of current availability of mental health services throughout the state, particularly crisis stabilization services" (4).

RI International commends CMS on the expectation that states will improve their capacity to track the availability of inpatient and crisis stabilization beds, helping connect individuals in need with an appropriate level of care as soon as possible—an expectation that aligns fully with the Substance Abuse and Mental Health Services Administration's current comprehensive psychiatric crisis bed registry development program. Real-time data exchange is available and offers significant advantages over traditional bed registries that periodically self-report into a Web portal. Use of standardized, evidence-based, and publicly available patient assessment tools such as the Level of Care Utilization System or the Child and Adolescent Service Intensity Instrument will generate data that can drive referral pathways and system design based on the needs of individuals in each community.

I hope that CMS expects the use of actual admission and discharge data to provide insight into available real-time capacity. Creating a fit between clinical need and services naturally lowers costs significantly. Creating a responsive system will also ensure that the model built during the waiver period is self-sustaining as a lower-cost crisis alternative to traditional care that better aligns with the assessed need of the population experiencing a crisis.

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David W. Covington, LPC, M.B.A.

RI International, Phoenix. Send correspondence to Mr. Covington (david.covington@riinternational.com).

Dr. Covington is the chief executive officer and president of RI International, is an owner of Behavioral Health Link, and leads the Crisis Now and Zero Suicide Healthcare international initiatives.

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Open Dialogue: The Evidence and Further Research

TO THE EDITOR: We are grateful for and energized by Freeman et al.'s (1) and Mueser's (2) attention to Open Dialogue (OD) research. The point of the Freeman et al. review, that OD outcome literature has a "very low quality of evidence," is well taken, with some exceptions. Multiple studies (3) report that it reliably cut rates of chronicity and disability in schizophrenia by half and was highly cost-effective compared with geographic and historic control groups. As Freeman et al.'s review notes, blind evaluation, improved controls, and correction of math errors are essential for future research, but whether such increased rigor would have changed important real-world results, such as disability status, is unknown. I expect that Freeman et al.'s statement that "no strong conclusions . . . about the efficacy of OD can be drawn from the current available evidence" will inspire Freeman et al. when they implement and analyze ODDESSI (Open Dialogue: Development and Evaluation of a Social Network Intervention for Severe Mental Illness).

Mueser's opinion that the "data on Open Dialogue are insufficient to warrant calls for further research" does not follow from his summary of the Freeman et al. review. Incomplete implementation or methodology is not evidence of weak treatment effect. Government-level support may be necessary to assess such a comprehensive model with