Stigma and help-seeking in emerging adult college students

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Outline of presentation

1. Introduction (~5 min)
2. Conceptual framework (~5 min)
3. Epidemiological data (~10 min)
4. Intervention research (~10 min)
5. Next steps for current interventions (~5 min)
6. New approaches for a new generation (~5 min)

1. Introduction (~5 min)

College mental health: *missed opportunity*

- Most disorders have first onset by age 24 (Kessler et al, 2005 Arch Gen Psych)

- Mental disorders account for half of burden of disease in late adolescent age group (Michaud et al, 2006 Pop Health Metrics)

- College setting is uniquely poised to have an impact (vast web of interconnected resources)

- Yet…most students with disorders do not receive treatment (Blanco et al, 2008 Arch Gen Psych), and evidence to guide "public health" approaches is limited

Objectives of this presentation

- Review what we know about help-seeking and service use (epidemiological and intervention research) in this population

- Propose ideas for next steps in practice and research
  - Preview of conclusions: we need to go beyond traditional focus on stigma and education

2. Conceptual framework (~5 min)

Many models of help-seeking

- Health Belief Model: emphasizes knowledge, attitudes (e.g., stigma), beliefs about treatment (Rosenstock, 1966 Milbank Quarterly)

- Andersen Behavioral Model: also highlights social structural factors, such as financial factors and availability of providers (Andersen, 1995 J Health Soc Behav)

- Network Episode Model: also emphasizes informal social networks (Pescosolido and Boyer, 1996 The Sociology of Mental Illness)

Economic perspective

- Positive (descriptive) framework:
  - Consumers use services when marginal benefit (net value) exceeds monetary price
  - In context of college campuses, price is often close to zero, so decision hinges on nonmonetary benefits (improvement in health) versus costs (time, possible shame or embarrassment)
- Normative (prescriptive) framework:
  - Socially "optimal" situation is when services are used when benefits exceed costs and not consumed when the reverse is true.

3. Epidemiological data: prevalence and correlates of help-seeking (~10 min)

Prevalence of service use

- 2001-2002 NESARC data, people ages 19-25:
  - Among those with past-year mental disorder:
    - College students: 18% received treatment
    - Same-aged, non-college: 21% received treatment
  - Breaking down college student data further:
    - 34% received treatment, among those with mood disorder
    - 16% among those with anxiety disorder
    - 5% among those with alcohol or drug disorder

- Source: Blanco et al, 2008 Arch Gen Psych

Prevalence (cont'd)

- More recent data consistent with NESARC findings
- 2006 National Research Consortium study
  - 70 campuses and 26,000 survey respondents
  - Fewer than half of students with past-year suicidal ideation received any professional help
  - Source: Drum, Brownson, et al, 2009 Prof Psych: Res and Practice.

Prevalence (cont'd)

- Healthy Minds Study:
  - 2007-2009 pooled samples (26 campuses, 13,000 students)
  - Among students with apparent mental health problem (depression, anxiety, suicidal ideation, or self-injury), 36% received professional treatment in past year
  - This included 11% psychiatric medication only, 11% psychotherapy/counseling only, and 14% both
  - Large variations in treatment prevalence across campuses (20-58%)
  - Source: Eisenberg et al, 2011 J Nerv Ment Dis.

Prevalence (cont'd)

- Help and support from non-professional sources, particularly peers, is common
- Among students with mental health, 67% received counseling or support from friends, 52% from family (Eisenberg et al, 2011 JNMD)
- Among students with suicidal ideation, 54% told someone about this (most commonly peers) (Drum, Brownson, et al, 2009 Prof Psych: Res Prac)
- 25% of students' Facebook profiles at one institution displayed DSM depressive symptoms (Moreno et al, 2011 Dep & Anx)

Prevalence (cont'd)

- Service use higher among women: 39%, versus 30% among men
- Differences by race/ethnicity:
  - 40% among white students
  - 28% among Hispanic students
  - 26% among black students
  - 15% among Asian students
- Source: Eisenberg et al, 2011 JNMD

Correlates (barriers/facilitators)

- Many studies focus on stigma
- Healthy Minds data:
  - *Personal stigma* significantly correlated w/ lower service use, but *perceived public stigma* not correlated
  - Average level of perceived stigma higher than personal stigma
  - Personal stigma higher among: men, Asians, lower SES
  - Source: Eisenberg et al, 2009 Med Care Res Rev

Correlates (cont'd)

- Other significant correlates in Healthy Minds data:
  - Perceived need for help
  - Beliefs about effectiveness of treatment
  - Having close friends or family who have used treatment
  - Residential setting: students living on campus are more likely to use psychotherapy/counseling, but less likely to use psychiatric medication
  - Source: Eisenberg et al, 2011 JNMD

New analysis of HM data

BARRIERS:	stigma high	tx not helpful	no perceived need	%
Group 1	X	X	X	2%
Group 2	X	X		2%
Group 3	X		X	2%
Group 4	X			2%
Group 5		X	X	12%
Group 6		X		16%
Group 7			X	23%
Group 8				42%

Sample: 2007-2009 Healthy Minds, students with apparent depression, anxiety, or suicidal ideation, and no treatment (N=1,263)

New analysis (cont'd)

- In groups 7 and 8, most commonly endorsed reasons for not receiving treatment:
  - "I prefer to deal with these issues on my own" (55%)
  - "I don't have time" (51%)
  - "stress is normal in college/graduate school" (51%)
  - "I question how serious my needs are" (47%).

4. Intervention research (~10 min)

Current practice

- No systematic data, but our impression is that most four-year institutions have some kind of help-seeking intervention

- Large variation in approaches across institutions

- Three main categories:
  - Stigma reduction and education campaigns
  - Screening and linkage
  - Gatekeeper training

Stigma reduction and education

- Often run by campus counseling or health service centers ("outreach" programs)

- Variety of approaches to connect with students (speakers, performances, flyers and newsletters, stickers, banners, slogans, logos, etc.)

- Student organizations also lead these efforts (particularly through Active Minds, www.activeminds.org, with over 300 campus chapters)

- Very few, if any, published evaluations

Screening and linkage

- Many programs use online screening
- American Foundation for Suicide Prevention: Interactive Screening Project (ISP)
  - Web-based screen to identify students with higher risk
  - Students receive personalized note from counselor, and have opportunity to correspond about their situation and options for help
  - Linkage often successful when students engage with intervention, but many do not engage (e.g., 8% completed initial screen)
  - Source: Haas et al, 2008 J Am Coll Health

Screening (cont'd)

- Triage by health and counseling centers is important, given steady increases in demand for services
  - Phone triage system has been helpful at many campuses (Rockland-Miller and Eells, 2006 J Coll Stud Psychotherapy)
- Screening through primary care is also promising
  - College Breakthrough Series – Depression (CBS-D), also known as National College Depression Partnership (Chung et al, 2011 J Am Coll Health)

Gatekeeper Training

- Many programs in use, at hundreds of campuses:
  - Question, Persuade, Refer (QPR)
  - safeTALK
  - At-Risk (by Kognito, Inc.)
  - Campus Connect (developed at Syracuse)
  - Mental Health First Aid (MHFA)
- Decent evidence on effectiveness with respect to trainees' self-perceived knowledge and skills, but virtually no evidence on real impacts on communities

5. Next steps for current interventions (~5 min)

Next steps for current interventions

- Main approaches (anti-stigma/education, screening and linkage, and gatekeeper training) have shown promise, and are likely to be complementary

- Evidence too limited to say one approach is best

- Main priority should be to improve evidence base

Improving evidence base

- Evaluations can be initiated not just by researchers, but also by practitioners (internal evaluations)

- Research designs should include phased-in, if not randomized, comparisons, with pre- and post-outcome measures

- Practitioners need time and incentives to participate in research process

- Networks bridging research/practice are needed

More specific priorities

- Stigma/education campaigns
  - Evaluations need credible counterfactual (control)
  - Outcomes should include not only attitudes, but behaviors (help-seeking) and well-being
- Screening and linkage
  - How to engage students (incorporate in curriculum?)
  - Continue developing primary care approaches
- Gatekeeper training
  - Compare programs (optimal intensity?)
  - Who are best gatekeepers?

6. New approaches for a new generation (~5 min)

Moving beyond traditional barriers

- Large proportion of untreated students appear to have positive attitudes and beliefs about treatment

- For these students, maybe only a nudge is needed?

- Parallels with other health behaviors for which attitudes and knowledge appear inconsistent with behaviors?
  - Diet
  - Exercise

Possible directions

- Time preferences and procrastination
  - Behaviors involve upfront costs, with expectation of benefits in the future
  - Do people procrastinate mental health care?
- Effective approaches to diet/exercise typically include self-monitoring plus other self-regulation technique (e.g., feedback on performance, specific goal setting, review of goals)
  - Parallels in mental health context?

Possible directions (cont'd)

- Default or status quo bias (inertia)
  - Opt-out emotional wellness check-ups?
  - Screening generates automatic opt-out appointment?
- Insights from cognitive psychology
  - Having a mental image of an activity, based on experience, makes the activity seem much more likely to happen
  - Suggests that the biggest hurdle may be the first time seeking help for mental health
  - Ways to simulate that experience beforehand?