

Pri o r i t i z i n g M e n t a l H e a l t h:
A C a m p u s I m p e r a t i v e

**Proposal For A Standing
Academic Senate Subcommittee
Addressing
Student Mental Health**

October 2003
U.C. Berkeley

Graduate Assembly Mental Health Task Force
ASUC Mental Health Task Force
GA Office of Academic Affairs

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□ INTRODUCTION

University and college campuses across the country are experiencing a profound increase in the incidence of student depression and mental illness. A recent poll revealed that 85% of colleges and universities are seeing an increase in mental health problems on their campuses [Gallagher, 2001]. Berkeley is no exception.

The Counseling and Psychological Services unit of University Health Services, which provides psychological and psychiatric care for Berkeley undergraduate and graduate students, has observed the following trends:

- Increased utilization of mental health services: Counseling & Psychological Services (CPS) has provided over 100,000 mental health consultations in the last ten years and reports a 300% increase in demand for psychiatric visits in recent years.
- Greater acuity and severity of student problems: In the past, students presented with relationship break-ups, identity concerns and difficulties with career decision-making. Today students are more likely to present with serious clinical depression, bipolar disorder, and psychosis, conditions that often require emergency services and hospitalization.
- Increasing proportion of graduate students seeking services at CPS: 43% of students seen at CPS are graduate students, though graduate students comprise only 30% of the campus population. Graduate students who seek services are likely to be only a small percentage of those who need help.
- Dearth of data on student suicide and suicide attempts: There are currently no data describing the incidence of suicide, attempted suicide, major depression, and bipolar disorder in Berkeley's student population. This lack of data impairs our ability to identify and address health problems as they arise.

Because depression can be a lethal disease, these statistics and trends are of grave concern. Rates of suicide in America are significant for college-aged individuals; according to some estimates, suicide is the third leading cause of death for Americans aged 18-24 [CDC, 2002].

Even more alarming, it has been reported that, in the 2002-2003 academic year, there were at least six student suicides at UC Berkeley. This figure, which represents a rate of suicide twice the national average for college-aged Americans, is an estimate based on anecdotal information. There are no detailed public statistics collected on student suicides or attempted suicides at U.C. Berkeley.

Clearly, the Berkeley campus requires a strategic plan for protecting student mental health.

In this document, we define mental health broadly, to include not only care and prevention of mental disorders, but also education of the community on issues related to emotional well being. According to Healthy People 2010 (a statement of national health objectives developed in part by the U.S. Department of Health and Human Services):

Mental health is sometimes thought of as simply the absence of a mental illness but is actually much broader. Mental health is a state of successful mental functioning, resulting in productive activities, fulfilling relationships, and the ability to adapt to change and cope with adversity. Mental health is indispensable to personal well-being, family and interpersonal relationships, and one's contribution to society.

To fulfill our mandate as a premiere public university, we must make education accessible to the state's population. This requires that the campus maintain the well-being of all students who join our institution, even those prone to depression and other mental conditions. If we do not support our graduate student researchers and instructors — and if we neglect to teach our undergraduate students about the importance of maintaining mental health — we compromise the excellence, intensity, and breadth of the Berkeley education.

A recent report [J. Affective Disorders, 2001] suggests that optimum treatment for depression requires the recognition of major depression in ourselves and the identification of symptoms and high-risk behaviors in others. It is time for this campus to begin implementing the educational programs, policy changes, and community building required to successfully treat and prevent depression and other mental conditions.

As an academic community focused on intellectual performance, we cannot afford to compromise or neglect the mental health of our students.

□ STATUS OF MENTAL HEALTH ON THE BERKELEY CAMPUS

- Data on student mental health:

Currently, there is little or no formal collection of data that can describe the state of student mental health. Tracking of suicides, student deaths, attempted suicides, and other mental health indicators must be implemented to identify campus concerns, inform priorities, and gauge the effectiveness of campus efforts to improve student mental health. The relationship between a student's social support and his/her academic performance should also be evaluated.

- Mental Health services:

Campus mental health services and resources are limited. This results in part from campus-wide budget cuts, which considerably limit the capacity of University Health Services. As of this year, there will be only two full-time staff psychiatry positions to serve a student community of 30,000. This is not adequate to meet the needs of students. Additionally, there are only 12 full time, permanent psychology staff members to serve the academic, personal, and crisis counseling needs of the entire student population. Unlike other campuses and communities, UC Berkeley's student led crisis hotline operates only during business hours and has an unfortunately low profile on campus.

- Social support:

A sense of community and support can greatly enhance individuals' mental health. However, many students in emotional distress do not know how to build social networks on campus. This may be particularly true of graduate students, who spend many hours engaged in individual research and less time in the classroom. The Administration, faculty, staff, and students must recognize of the importance of activities that promote social interaction and community engagement. In addition, we must foster student groups and organizations that provide social support.

- Partnership of faculty, students, staff:

The tone of academia is often set by members of the faculty; postdocs and students inevitably view their professors and advisors as role models. Therefore, members of the faculty have an important role to play in promoting healthy behaviors and opening communication about mental health. Many professors and lecturers are poorly equipped for assisting students in emotional distress. Staff and faculty need education on how to build a supportive academic climate and on how to recognize and respond to students in need.

- Integration of Mental Health and Academics:

Mental health is the cornerstone of a solid academic career. Academic policies and administrative procedures should enable students to meet academic challenges successfully, without damage to their health and well being. In addition, students' reluctance to acknowledge mental health problems (and their reluctance to seek help) must be considered when devising, implementing, and publicizing new policies.

□ CHARTER AND CHARGE OF THE COMMITTEE

CHARTER

The Committee on Student Mental Health, proposed as a standing sub-committee of the Academic Senate Student Affairs Committee (STA), would be charged with reviewing the policies, practices, and climate of the Berkeley campus to determine how adequately they support students' emotional and academic well being. The committee would make recommendations for campus-wide policies and policy changes to improve the emotional welfare of undergraduates, graduate students, and postdocs and to promote healthy behaviors and lifestyles throughout our academic community.

CHARGE

Issues addressed by the Committee on Student Mental Health might include:

Data Collection and Climate Assessment

- Develop or advocate for a data collection system to track deaths (due to suicide, accidents, etc) and withdrawals (due to mental health problems, etc) of students and postdoctoral fellows at Berkeley.
- Commission Berkeley-specific studies and review existing data on the rates of student depression, death, and mental illness.
- Encourage all departments to complete a self-review of internal academic climate (e.g. level of emotional support provided to students, degrees of competitiveness, collegiality, collaboration, etc).
- Incorporate questions about mental health, emotional support, and student well being into graduate students' exit surveys. If it doesn't already exist, implement a parallel questionnaire for postdoctoral fellows and for students who have dropped out or withdrawn from graduate studies at UC Berkeley.
- Encourage all departments to incorporate questions about mental health, emotional support, and student well being into undergraduate exit surveys.
- Evaluate the relationship between mental health and academic performance, using such metrics as publication record and GPA (to assess academic performance of graduate and undergraduate students, respectively), and incidence of depression as well as possible protective factors, such as degree of support from the community or family, level of education about mental disorders or disease, and access to medical care (to assess mental health).

Education

- Review existing materials (or develop new materials) for training faculty to recognize and assist emotionally distressed students. Implement mechanisms for distributing these materials to members of the faculty.
- Consider requiring new students to participate in a seminar or workshop on how to survive and thrive at UC Berkeley. For example, a segment might be inserted into existing “freshman” seminars and a workshop might be included in new graduate student orientations. Curriculum should be based on existing programs at other major research universities; topics relating to mental health might include symptoms of depression, recognition of mental disorders, how to seek and find help for oneself and for others.
- Review current training for Graduate Student Instructors and consider further training focused on recognition and assistance of emotionally distressed students. Graduate students, in their roles as graduate student instructors, are in an excellent position to identify mental health issues and fill critical gaps in outreach to the undergraduate population. As many graduate students have recently engaged in study at an undergraduate level, they may be more sensitive to the academic support needs of undergraduates.

Review of Academic Policies

- Consider implementing a suicide attempt reporting policy, which encourages faculty and staff to submit confidential reports to University Health Services whenever there is compelling evidence of a suicide attempt by a student. Similar policies have implemented at other major state universities and may have contributed to decreases in student suicide rates.
- Review the medical leave of absence policy: How often is it used for mental health? How accessible (well advertised) is this policy? Are students with mental health problems aware of their options when contemplating withdrawal?
- Develop guidelines for creating mental health-friendly academic policies, to be used by campus administrators and committee members.
- Encourage departments to communicate, so that support services or screening tools available to some faculty, staff, and students are shared with the rest of the campus.
- Assess campus awareness of existing policies: Are faculty and staff aware of procedures and policies applied in cases of a student with major depression? What about suicide attempts and student suicides?

Identifying and Rewarding Best Practices

- Given the California budget crisis (and resulting cuts to student health services), how can departments and individuals help students facing emotional distress? How much responsibility do departments have for supporting their graduate and undergraduate students?
- Best practices: Which departments currently offer superlative mental health services, mentoring, or support for their students? One example is the existence in some departments of confidential faculty counseling of graduate students with personal, career, or relationship problems.
- Awards: Recognize those individuals (including staff, faculty, coaches, resident advisors, and students) who contribute to the mental health of the U.C. Berkeley community.

Review of Mental Health Services Available on Campus

- Review the allocation of campus resources to UHS and CPS. Are current budget allocations adequate?
- Prevention: Are enough campus resources devoted to diagnosis, preventive care, and education about mental health? Or is UHS/CPS forced to focus on crisis intervention and emergency care?

□ PROPOSED COMMITTEE MEMBERSHIP

Faculty:

At the discretion of the Academic Senate

Academic Senate Staff:

At the discretion of the Academic Senate

Recommended Administrators:

Steve Lustig, Assistant Vice Chancellor of University Health Services

Harry LeGrande, Assistant Vice Chancellor, Residential & Student Service Programs

Christina Maslach, Vice Provost of Undergraduate Education

Mary Ann Mason, Dean of Graduate Division

Recommended CPS Staff:

Jeff Prince, PhD, Director of CPS

Susan Bell, PhD, Outreach Coordinator at CPS

Recommended Students:

2 Graduate Students (Graduate Assembly Appointees)

2+ Undergraduate Students (ASUC Appointees)

□ COMMITTEE RESULTS AND TIMELINE

We recommend that the STA Subcommittee on Student Mental Health be convened by February 2004. As the committee will be an augmented, standing subcommittee of the Academic Senate, its appointment is subject to approval of the Berkeley Academic Senate Divisional Council and the Committee on Committees (COMS). Approvals by these bodies should be secured by January 2004.

The recommendations and results of the proposed STA Subcommittee on Student Mental Health will depend on its membership and on the particular issues addressed.

However, the drafting and circulation of a report on student mental health (including recommendations, policy issues to be addressed, and a strategic plan for prioritizing mental health) would be extremely useful to the campus community. This report is to be completed by May 2004 and forwarded to the Chancellor, the Academic Senate Divisional Council, and all campus administrators for review.

In academic year 2003-2004, we propose that the Committee on Student Mental Health focus on data collection, university policy review, and faculty education. In future years, the committee should expand its focus to address graduate student instructor education, community building, and budget allocations to student services (particularly University Health Services). The committee's work on community building should be tied to concurrent efforts undertaken by the UC Berkeley faculty and administration (such as the Campus Community Initiative).

The STA Subcommittee on Student Mental Health will work closely with the recently convened UHS Advisory Committees on Student Mental Health. These committees, which are administered through CPS, will advise on faculty and student education, campus mental health needs, and university policy issues. The faculty chair of the STA Subcommittee on Student Mental Health would be invited to join the UHS Advisory Committees.

The ASUC and Graduate Assembly Mental Health Task Forces are a significant resource for the Committee on Student Mental Health, particularly for outreach to smaller student communities within the Berkeley campus. Because depression may disproportionately impact economically and/or socially disadvantaged groups (Am. J. Psychiatry, 2003), it is important for the Committee to liaise with the ASUC student groups and GA projects that provide targeted resources to women, international students, minorities, and student parents on the Berkeley campus.

□ APPENDIX

Journal of the American Medical Association
Mounting Student Depression Taxing Campus Mental Health Services
April 23/30, 2003

Nature
Reflections on the Death of A Young Scientist
395(823), 1998

New York *Times* Article:
In College and in Despair
October 26, 2003

San Francisco *Chronicle* Article:
Help for depression lacking, studies find
June 18, 2003

Mounting Student Depression Taxing Campus Mental Health Services

Rebecca Voelker

JAMA. 2003;289:2055-2056.

Ann Arbor, Mich—The scenario is becoming all too common across college campuses today. Students face not only the time-honored ritual of leaving family and longtime friends, but a host of other pressures. New relationships can send students on an emotional roller coaster, while parents in the throes of divorce may add to the anxiety. The pressure to succeed academically perhaps has never been higher, and at the first sign of falling grades, even students who excelled in high school may wonder if they are really college material. And as college costs continue to climb, students approaching graduation with substantial loans to be repaid face the gloomiest job market in the past decade.

Against this backdrop, growing numbers of students are seeking help for depression and other psychiatric disorders. But student health services and campus counseling centers often have not kept pace with the increased demand for treatment.

At many student health centers, "the pattern still tends to be not to ask about family history, not to put this in a plural context, not to pursue what might be going on and get an early start on it," said John Greden, MD, executive director of the University of Michigan Depression Center and Rachel Upjohn professor of psychiatry and clinical neurosciences in the university's medical school.

That means thousands of students with depression go undiagnosed and untreated at a time when they face some of life's most important junctures.

Greden noted that the peak onset of symptoms in the general population occurs between the ages of 15 and 19 years. But for most students, a diagnosis will not be made until many years later. The average age at diagnosis for unipolar depression is 27 years and 21 years for bipolar disorder, according to the Depression and Bipolar Support Alliance, a national mood disorders advocacy group.

Because campus services can offer a crucial point of entry to diagnosis and treatment, officials at the University of Michigan recently hosted the inaugural "Depression on College Campuses" conference in March not only to boost awareness of the problem, but to discuss implementation of best practices in student mental health services.

"SCARY" STATISTICS

Several surveys conducted during the past decade suggest that the prevalence of depression among college students is growing, and that it eclipses the rate in the general public. Richard Kadison, MD, chief of the Mental Health Service at Harvard's University Health Services in Boston, Mass, offered what he called some "scary" statistics.

Citing a 2000 survey by the American College Health Association, Kadison said that within the last school year, 61% of college students reported feeling hopeless, 45% said they felt so depressed they could barely function, and 9% felt suicidal. The National Mental Health Association's College Student and Depression Pilot Initiative lists suicide as the second leading cause of death among college students.

Another survey by researchers at Kansas State University in Manhattan has shown that from 1988-1992 to 1996-2001, the proportion of students who came to its counseling center with depression increased from 21% to 41%. A 1999 survey by researchers at the University of California, Los Angeles, reported that 30% of college freshman felt overwhelmed by the transition to campus life, compared with only 16% in 1985. The US Surgeon General's report on mental health in 1999 indicated that about 20% of US adults will experience depression at some time in their lives.

In preparation for the conference, Todd Sevig, PhD, director of the University of Michigan Counseling and Psychological Services, examined 1992-2002 utilization data from counseling centers at the 11 universities that comprise the Big Ten Conference. "There has been roughly a 42% increase in the number of students seen at these counseling centers," he said.

Massachusetts Institute of Technology (MIT), in Boston, also has recorded an increase in the number of students seeking counseling. Kristine Girard, MD, chief of Mental Health Services, said that from 1995 to 2000, the proportion of the student body seeking counseling increased from 8% to 12%.

"That figure continues to rise at about 1% per year, and it taxes our services," said Girard.

BEST PRACTICES ON CAMPUS

At a time when public and private universities face worsening budget crises, how can campus mental health professionals expand existing programs or launch new ones to help their students face emotional crises? Kadison said it is a "no good deed goes unpunished" scenario.

"If we get the education out there, and get people to recognize that depression is very much a problem, where are we going to find the resources to take care of people?" he asked.

Recognizing that students with depression need immediate attention, Kadison said, Harvard has borrowed a triage system implemented nearby at the University of Massachusetts. Students who call Harvard's Mental Health Service often can get an appointment the same day.

"Getting students into care in a day or two is crucial," he said.

An even greater challenge is determining how much care individual students really need. Distinguishing developmental issues from clinical depression often is difficult at best, said Kadison. He noted that some individuals need a disproportionate amount of care.

STA Subcommittee on Student Mental Health

"Most counseling services find that 10% or 20% of students use 60% or 70% of the resources," he noted. Girard agreed, noting that, increasingly, students who seek mental health services at MIT require ongoing, continuous care.

"We're seeing growing numbers of students who need psychiatric hospitalization and growing numbers of medical leaves for reasons of mental health," she said.

Because resources are scarce, campus mental health professionals walk a fine line in determining whether to emphasize prevention or dedicate funds for intensive care for students with the greatest need.

Kadison, for example, questioned whether treatment sessions should be limited, and asked how universities can find alternatives to community resources that are drying up because of shrinking budgets. This can mean using creative strategies to help students get needed treatment; Kadison noted that sometimes he meets pharmaceutical representatives at an off-campus coffee shop. "They're not allowed on university property, so [by leaving the campus] I can get prescription samples and drop them off at the pharmacy so students can use them."

SCREENING TOOL

MIT contacts all incoming freshmen before they arrive on campus with information about campus medical services and a questionnaire about their own personal health, including a mental health history, said Girard. The practice is an effective screening tool, and it "normalizes" mental health issues for students by placing them in the overall context of general health, she noted.

Improving communication among campus departments is another key to optimal student care, said Rachel Glick, MD, former director of the University of Michigan's Psychiatric Emergency Services and now associate dean for student programs and clinical associate professor of psychiatry at the university's medical school. Universities "are very complex places with lots of different 'silos' where people can get help, but we don't talk to each other," she noted.

At the University of Michigan, students can block the release of personal information, including family contact information, explained Glick. If a student who has prohibited the release of that information comes to the hospital with a psychiatric emergency, physicians may have no way to determine if a previous psychiatric diagnosis has been made, or if the student is receiving treatment away from the campus.

Sharing information in a way that preserves confidentiality is essential, said Glick.

"As an institute of higher education, we need to figure out ways to be part of the same team so we can share information between the emergency room and the counseling service, between the registrar's office and the emergency room," she noted. "That will really improve the services we provide for individual students."

Preventing Campus Suicide

Researchers from the Big Ten Conference and the US Department of Education have estimated that nearly 1100 suicides occur on college campuses each year. The Jed Foundation, a nonprofit group formed by the parents of a 20-year-old university student who committed suicide, and the National Mental Health Association offer the following checklist for universities to help safeguard against student suicides.

- Is a screening program in place; are on-site mental health services available?
- Is transitional support available for families of incoming students who already have been diagnosed as having a mental illness?
- Have faculty, staff, coaches, clergy, and student or resident advisors received training to identify suicidal behaviors?
- Are students educated to identify their own at-risk behaviors and those of their fellow students?
- Are campus health care providers trained to handle suicidal clients? If not, is training available?
- Have working relationships been established with community mental health providers to ensure appropriate, off-site referrals?
- Is a crisis management plan in place if a suicide or other traumatic event occurs on campus?

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Reflections on the death of a young scientist

Nature 395, 823 (1998)

The tragic suicide of an outstanding graduate student at Harvard University poses troubling questions about academic priorities. But it also reinforces deeper concerns about the contemporary culture of research.

There is always something slightly humbling about human tragedy. Such is the case with the suicide two months ago of a fifth-year graduate student, Jason Altom, at Harvard University. It is impossible to speculate on the full range of factors that led an apparently outstanding and respected student, outwardly stable and well-liked by his fellow students, to decide to take his own life. What does prompt comment, however, is the fact that Altom left a detailed note describing the pressures to which he felt subject, and suggesting how some of these might have been avoided in different circumstances (see [page 826](#)).

The contents of the note, extracts of which have been published in the *Harvard Crimson*, allude to a situation with which all graduate students will be familiar. One is the constant pressure to succeed, with eyes fixed on a sometimes distant, often daunting and always challenging goal. A second is the intense relationship, which can be either supportive or destructive, with a single supervisor — a relationship that some Harvard students joke tends to last longer than most marriages.

Both pressures can be exacerbated by a lack of the financial means and social networks that might otherwise allow their more extreme impacts to be softened. Further problems are created by the system of 'indentured servitude' at some institutions, under which graduates are used to meet teaching and other commitments, and end up feeling that they are being treated as a source of cheap labour.

There is no reason to believe that the situation at Harvard, despite a hot-house culture in which many ambitious graduate students willingly participate, is significantly different from that at other leading research universities. And the chemistry department, which had already been engaged in debates about mitigating such pressures, has been prompted by Altom's death to take immediate action, such as requiring every second-year student to set up a three-member pre-thesis advisory panel, and making psychological counselling services readily available.

Such moves can only be welcomed. But they inevitably raise the question, prompted by genuine concern rather than reflex recrimination, of why it took the death of an outstanding student to prompt the department into action. According to one recent PhD student, proposals for improved student oversight had been submitted by a graduate student committee three years ago, but stalled when faculty members were unable to agree on its implementation. Yet, she points out, this happened at a time when the faculty was able to conceive and start construction of a new building, renovate existing laboratories and hire new faculty.

It is impossible to pass judgement without knowing the full circumstances. But such situations raise a key issue that lies behind a broad swathe of current concerns, from scientific misconduct to the plight of contract research staff: is a culture of achievement, fanned by an increasingly competitive job market and tight competition for research grants, now in danger of driving out the culture of mutual support from which both science and its protagonists have gained so much in the past?

Nature © Macmillan Publishers Ltd 1998

In College and in Despair

By **SABRINA TAVERNISE**

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October 26, 2003

Stephen Bohler had just joined the swimming team. He was doing well in French and Italian. He was so excited to be in college that when he first arrived at New York University, he climbed the seven flights of stairs to his dormitory room, as if to feel the firm reality of his achievement under his feet.

Two weeks ago Stephen, an N.Y.U. freshman who grew up in Dayton, Ohio, fell from the 10th floor of Bobst Library to his death in what appeared to be a suicide. His family, stunned, was left to wonder.

"It's sort of inconceivable that he was depressed," said his mother, Carolyn Bohler. Still, she added, "you never know deeply what is inside someone."

For days Mrs. Bohler, who moved to Irvine, Calif., this summer, has had to wrestle with the question of what she did not or could not know about her child. She does not fault N.Y.U. She had the e-mail address of her son's diving coach. She knew the name of his dormitory floor leader. There is even a chance that her son's death was not suicide, but a tragic mistake that occurred under the influence of drugs.

But she has, in the most painful way, come to appreciate the gulf that can open when a child goes to college. It is a gulf that many parents — those with children at N.Y.U., where three students appear to have leapt to their deaths in recent weeks, and those with children at other colleges — have wondered about in recent days.

In that reflecting, they have encountered what, for great numbers of parents, is an arresting fact — that the gulf is sometimes legally enforced. Laws make much of a student's college life secret. Without permission from students, colleges are barred from releasing everything from grades to medical records. Laws keep them from reaching out to parents, even when a child is in pain and feels at sea, unless the young person allows it.

"It's tricky because the kid is an adult, said Dr. David A. Brent, a professor of psychiatry at the University of Pittsburgh School of Medicine. "If the child doesn't want them to contact the parent, then you're in a very difficult situation. It highlights the stress on colleges to be 'in loco parentis,' to the child, even though they might not want to be."

The federal law that governs most privacy on college campuses is called the Family Educational Rights and Privacy Act. The law was passed in 1974, and its original purpose was to give students the right to examine their university records, which were sometimes kept from them by

administrators. But it also prohibited colleges from releasing information about the students without permission, and that meant often leaving parents in the dark, too.

Though nearly 30 years old, the law has changed little over time. But it still has the power to surprise, and unnerve.

"It's really frightening," said Nancy Paetzold, a New Jersey anesthesiologist, whose son, Jeremy April, 18, took his own life several years ago. "You pay \$35,000 and you can't even get to find out what your kid went to student health for. Somehow there has to be feedback. They're your kids and you don't get a second chance."

Occasionally the privacy issue reverberates in major ways on college campuses. The family of a Massachusetts Institute of Technology student, Elizabeth Shin, is suing the institute over its failure to contact them after their daughter threatened to kill herself, or even after she tried and failed.

She eventually did commit suicide, and the suit, filed in January 2002, accuses M.I.T. of breach of contract, medical malpractice and negligence on the part of its psychiatrists, residence hall advisers and the campus police. M.I.T. responded that it was not responsible for Ms. Shin's death. The case is awaiting trial.

But the Shin case already has resonated at M.I.T., which has begun new suicide prevention programs. Faculty members and dormitory leaders are now trained and instructed to alert their supervisors when they see signs of depression in students. Alan Siegel, a psychologist who heads M.I.T.'s counseling center, said the program tried to include parents, whenever possible. Dr. Siegel said, "Part of the treatment plan is to engage the family. We make it clear to the student that is how you get better."

But the presence of relatives, sometimes a source of a young person's problems, is not always helpful. Lydia Conklin, a Harvard sophomore who was hospitalized with depression last year, said she was dismayed when her parents — alerted by her friends, not by the university — showed up on campus unannounced.

"I knew they weren't allowed to tell my parents," Ms. Conklin said, referring to the university. "I'm glad they have that policy. When my parents found out, I was still in a really bad situation. I would have told them eventually. But I didn't want to see them then."

Some parents agree that involving parents can drive a student away from seeking help. "We've all been that age and we know that there were parts of our lives we didn't want our parents to know about," said Helen Featherstone, associate professor of education at Michigan State University and a mother of three. "You really want to be careful not to have policies that will discourage kids who are seeking help."

But privacy, other parents said, should not take precedence over safety. Inez Okrent, whose son David, a Harvard junior, committed suicide five years ago, said that although she told her son's floor leader that he was depressed and asked that she be alerted if he seemed worse, no one bothered to keep her informed. She said she learned of David's death when an organ donor organization called her home.

"It's a tough one, it really is," said Ms. Okrent, who speaks to college students about the warning signs of suicide "The students really want to be adult. They don't want to confide. But a person suffering from depression cannot monitor themselves."

In recent years, colleges have shifted on the privacy issue, said Peter Lake, the professor of law at Stetson University in Florida and co-author of "The Rights and Responsibilities of the Modern University" (Carolina Academic Press, 1991). Colleges are opting more often for safety than for privacy, he said.

One catalyst for that shift was a ruling last year by the United States Supreme Court in a case involving the release of information by Gonzaga University in Spokane, Wash., about a sexual assault allegation against a student teacher. The court ruled that universities that violate the 1974 privacy law by divulging information about students will be liable only for administrative fines, not large personal settlements. "The privacy right issue really has been a bone of contention," Mr. Lake said, "but people are now putting more emphasis on health and safety."

The tilt toward safety is playing out at the University of Michigan, where counselors ask students who come for help to consider signing a form, which is not required, that would allow parents to be contacted. The counselors explain that families often aid the healing process.

"If a student says, 'I'm going to jump,' we will err on the side of protecting them, rather than respecting their confidentiality," said Cheryl King, director of the Child and Adolescent Depression Program, at the University of Michigan Depression Center. "We will take that risk, whether or not we have permission."

Privacy issues are being discussed at a time when student suicide rates are rising. A study of more than 13,000 Kansas State University students treated at the university counseling center from 1989 to 2001 showed a doubling of the percentage of students who suffered from depression at some point during their college years, to 41 percent, as did the percentage of students described as suicidal, to 9 percent.

A study of college students on Big 10 campuses from 1980 to 1990 found that the overall suicide rate was 7.5 per 100,000 per year, about half the rate for nonstudents in the same age group. "The children, they don't want to be a trouble, they don't want to hurt their parents," Ms. Okrent said. "But little do they know how they ultimately destroy their parents."

Help for depression lacking, studies find

14 million Americans suffer major episode annually, doctors say

Katherine Seligman, Chronicle Staff Writer

Wednesday, June 18, 2003

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URL: <http://www.sfgate.com/cgi-bin/article.cgi?file=/chronicle/archive/2003/06/18/MN74890.DTL>

As many as 14 million American adults a year have episodes of major depression, costing employers billions of dollars in lost productivity, but the majority of sufferers don't get adequate treatment, according to a series of studies published today in the Journal of the American Medical Association.

"This puts to rest the criticism that the high numbers (of people with depression) are overestimated," said Dr. Ronald Kessler of Harvard Medical School, lead author of a two-year study that used new clinical definitions to measure depression on 9,090 adults around the country. "There are a whole lot of capital D depressed people out there in the population."

The JAMA studies call for clearer treatment goals and better training of physicians, who themselves suffer a disproportionately high death rate from suicide. Together, they underscore both the serious toll that depression takes and the fact that while much is known about how to relieve symptoms, scientists still have a long way to go in figuring why the illness is so widespread.

"What is perhaps most remarkable about depression is there has been far more success in treating this illness than in understanding it," says a commentary accompanying the studies, written by Dr. Thomas Insel and Dr. Dennis Charney, both with the National Institute of Mental Health. Dr. Kessler and his colleagues found that 6.6 percent of adults in America had major depression in a year and that 16.2 percent -- or about one in six people -- were likely to have major episodes in their lifetimes. The rates did not differ based on where people lived but varied for men and women and by income level.

Women were 56 percent more likely than men to have depression over a lifetime according to the study, and students, homemakers, people never married and those living in poverty had the highest rates over a 12-month period.

IMPACT SEEN AS MAJOR

And the illness had substantial impact on their lives. Most people who reported depression in a given year said they noticed at least moderate impairment in some of their roles in life. Subjects with major depression in the past year reported being unable to work or carry out other normal activities for an average of 35 days.

Even so, most didn't get enough treatment, the study concluded. The good news, Kessler said, is that more treatments are available, and many more people are seeking them than 10 years ago, when a third got care. But today, while about 57 percent get some treatment, only 21 percent of the people with depression in the previous year got treatment that met minimum standards established by the federal Agency for Health Care Policy and Research.

Research has shown that a combination of medication and psychotherapy is effective in treating most cases of depression, Kessler said, but there is no one-size-fits-all treatment. Some people get inadequate doses of medication or they stop taking the pills or drop out of therapy as soon as they start to feel better. Some use unproven treatments such as Internet support groups and herbal supplements, he said.

Public awareness campaigns -- like one by the National Institute of Mental Health on men and depression -- have lessened the stigma of having the illness.

But many people don't get treatment because they still worry about disclosing they have depression.

Kessler's study, which was funded by the National Institute for Mental Health, other government agencies and the Robert Wood Johnson Foundation, used a newer definition for depression than most earlier studies, one that is included in the latest psychiatric Diagnostic and Statistical Manual and requires a finding of "clinically significant distress or impairment."

Untreated, depression causes not only suffering but also results in an estimated \$44 billion a year in lost productivity and work absences, according to another study. Depressed workers reported 5.6 hours a week in health-related lost productive time, as opposed to 1.5 hours for other workers.

ELI LILLY FUNDS STUDY

Most of the cost to employers -- about 81 percent -- is "invisible," the study says. It is explained by reduced work performance. While workers may show up to the office, they can't perform their best. The study, whose lead authors are doctors at the AdvancePCS Center for Work and Health in Maryland, received funding from Eli Lilly & Co.

Many depressed workers reported physical symptoms, including pain, weakness and fatigue (49 percent), sensory or nerve impairment (40 percent) and ringing ears or a feeling of "head fullness" (38 percent). Less than a third reported getting prescription drugs from doctors in the past year for depression or anxiety, according to this study.

Doctors are among a group highly vulnerable to depression, according to another of the JAMA articles. Doctors face lower death rates from cancer and heart disease than the general population but a greater risk from suicide.

"During the decades when physicians led the nation by heeding their own prevention advice to patients regarding smoking, they neglected to seek help for depression themselves and to diagnose it in their patients," says the article, a "consensus statement" by doctors in a suicide prevention forum.

About a third of doctors don't even have a regular source of health care, it says. Their use of mental health services also appears low, but there is little information on how many seek help. Medical students said barriers to treatment were lack of time or confidentiality, stigma, cost and fear of documentation on academic records.

In order to ensure doctors get treatment, "the culture of medicine" that gives mental health a low priority must change, the article concludes.

TREATMENT OF DEPRESSION OFTEN INADEQUATE

Only 21 percent of people treated for depression in the past year received adequate care, a new study says. Some signs of depression:

- Persistently sad, anxious or "empty mood"
- Feelings of hopelessness, helplessness, worthlessness
- Loss of interest or pleasure in hobbies and activities
- Decreased energy or fatigue, being "slowed down"

Sources: Journal of the American Medical Association; National Institute of Mental Health

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