News

Reaching Students Who Don't Report Depression

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SAN FRANCISCO -- Among the greatest frustrations of campus mental health professionals is that those who need help the most may never seek out services that are available. “If you talk to college counseling directors about those on their campuses who have committed suicide, most of them never entered their centers," said Henry Chung, to many nods here, at a session at the annual meeting of the American College Health Association.

Chung, assistant vice president for student health at New York University, was reviewing data showing that large majorities of college students showing signs of depression -- even signs serious enough to suggest that they may be prone to suicide -- never seek counseling help of any kind. At the meeting here, he presented the results of a large experiment with screening for depression those students who seek treatment in campus health clinics that offer primary care.

The theory behind the **National College Depression Partnership** -- which is based at NYU and currently involves a total of 20 colleges and universities, large and small, from all over the country -- is that students who would never go to a counseling center do seek primary medical care, creating an opening to identify those who need mental health care that they are missing. The partnership involves creating procedures for screening and for a more engaged and persistent case management system to follow up with those identified as needing care.

Results of an initial pilot program and a larger project with all 20 institutions are so encouraging that the program is now seeking to expand to involve many more colleges.

In the last nine months, the colleges screened more than 100,000 students seeking primary care and identified more than 2,000 who had depression or other serious mental health conditions for which they were not seeking treatment. Based on follow-up results, more than 90 percent of those with clinical depression or conditions that "severely impaired" their functioning were in formal treatment programs within four weeks of the first screening, and almost half of them reported "normal or near normal" functioning being restored after only 12 weeks of treatment. Those results represent significant gains over typical rates.

Colleges that have used the system are also finding that they are reaching populations that for a variety of reasons were not seeking mental health care. Minority students, many of whom avoid counseling centers, were well represented in this program, he said. Chung noted emerging concerns that Asian American students are particularly vulnerable to having problems for which they won't seek treatment. Gender is also a factor. Chung said that one participating college that he didn't identify had noticed that 80 percent of those seeking treatment at the counseling center were female, leaving officials there concerned that they were missing male students who needed care. This system had the particular impact, at that college, of identifying more male students who needed care, and who are now receiving it.

And in another result that may be of particular interest to counseling centers, Chung said that several colleges involved in the study had found that the data showing the number of students needing help had led administrators to agree to increase budgets -- even in these tight times. "Centers can and need to show how ill their students are and how they can help," said Chung.

Michael C. Klein, a clinical psychologist at NYU, said that the research suggests that a different focus is needed so that counseling centers can have the maximum possible impact. "There is so much pressure being put on counseling centers to see more and more students, but you are never going to see every student, and you are not going to get enough staff to do so," so it's essential that better

tools be identified to get the right students into the center, and enough staff for the real population in need (which exceeds those currently being seen).

Chung's presentation stressed two key and interrelated parts of the program -- the initial screening and the case management.

The screening is done using the **Patient Health Questionnaire, commonly called the PHQ-9,** which asks various questions that can indicate mental health disorders by inquiring whether those answering have experienced certain conditions (little interest in activities, feeling down, feeling tired, little appetite or overeating, etc.) during the past two weeks and whether any such conditions were frequent or rare. This results in a score, helping in diagnosis and in monitoring any improvements. The first two questions are just worked into routine questions a patient would receive when seeking primary care.

Then if appropriate, other questions are asked at that time or in a follow-up call from a case worker.

Eleanor Davidson, director of health services at Case Western Reserve University, one of the institutions involved in the program, said that it was important for health centers to have protocols in place for how much of the questionnaire to go through at the first meeting. If someone comes in complaining of flu symptoms and turns out to have a temperature of 102, "we're not going to do all nine questions," she said. "We're not going to drag you through a full depression screening if you are feeling terrible."

But she noted that many of the initial symptoms that students report make the full questionnaire immediately relevant. She said that some of the most frequent complaints by students seeking an initial evaluation concern feeling tired all the time, backaches and headaches, and other ailments that "are a complete mystery to the student" and yet may relate to mental health issues.

Davidson said that when a full questionnaire is given, she immediately shares the results with the student and starts a conversation with him or her.

Klein said that this is where the case worker comes into play. In many cases, the primary care center will suggest that a patient see someone in the counseling center "and we have all of these people who say 'I won't go to the counseling center, but I'll come back and talk to you.' " So the case worker, who has the goal of getting the person in counseling, will arrange a second meeting at the health center and continue meeting until the patient can be persuaded to see a counselor. "This is about meeting the students where they are, and a hand-off over time," he said.

For all of the modern societal knowledge about mental health -- compared to what was known in previous generations -- the stigma of depression and mental health difficulties remains strong among students, many of whom assume that some bad feelings they are experiencing will naturally go away, he said. "This is about creating a bridge to counseling," he said.

The case workers are generally social workers, nurses, or nurse practitioners -- not the people who will provide the actual counseling, but people who can work with both the primary care and counseling parts of the equation. And who can pester.

Chung stressed that the case workers monitor treatment until the counselor and all health professionals involved believe that monitoring isn't needed. Otherwise, he said, the gains from using screening to identify those who need treatment will be easily lost.

“If you think about the lessons of Virginia Tech, we can’t allow any student to drop out [of treatment]," he said. "That sounds awfully Big Brother. If a student doesn’t come back, we use case managers and they call, and they call again and they pester, and they try to ask some questions on the phone and talk about getting care." Many of those students are eventually seeking treatment, he said. They aren't making progress as quickly as those who are better within 12 weeks, but they are receiving outreach regularly. "That's the safety net we are creating."

— **Scott Jaschik**