

# student health SPECTRUM

Fall 2001, Leadership Forum

## Depression on College Campuses: A New Challenge for Student Health Services and Counseling Centers

by Stephen C. Caulfield  
Chairman

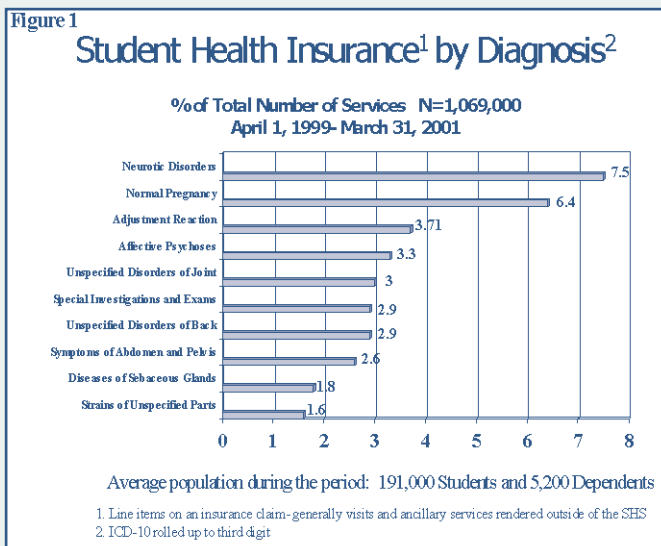
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The reported incidences of depression among college students is rising dramatically. This increase coupled with increased concerns about suicides among college students, is promoting new challenges for Student Health Services, Counseling Centers and Student Affairs Officers.

For example, this year's National Survey of Counseling Center Directors reported that 84 percent of respondents are concerned about the increase in students coming to college with "severe psychological illness".

A recent review of Chickering's insurance claims covering a 12 month period ending March 31, 2001 (over 1 million line items), found that 7.5% of these claims were for neurotic disorders (ICD-10 at 3rd digit), 3.7% for adjustment reaction, and 3.3% for affective psychoses. (See Fig. 1) Thus, 14.5 percent of clinical contacts outside the Student Health Center and Counseling Center were for psychological illness.



*Depression and other significant behavioral disorders are among the most frequent diagnoses among college students.*

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## Dr. Linda M. Ragosta Joins The Chickering Group

I am pleased to have the opportunity to introduce myself as a new member of The Chickering Group management team. I will be serving in the newly created position of Vice President for Institutional Relations, having joined Chickering after over 20 years in higher education. Most recently I served as Vice President for Student Affairs and also Vice President for Academic Affairs at Newbury College just outside of Boston. My background also includes positions in Student Affairs at Babson College and Bridgewater State College, both in Massachusetts. Having also taught graduate level courses in Counseling and supervising graduate interns in various areas of student affairs has given me an additional perspective on student life and all of its complexities. Throughout the years, it was evident that maintaining student health and wellness correlated directly with a student's ability to achieve his/her academic, social, and professional development potential.

Higher education's ability to positively influence the health and well being of students takes place on many levels. The direct approaches, through health services, health education, counseling, and health insurance are challenging, although well understood.

The more subtle challenge is to influence other components of the environment regarding the role of health and wellness in enabling students to maintain academic priorities. Toward that end, students must be provided with the information and tools they need to make health conscious choices as part of their social and emotional development. Incorporating this philosophy and practice into day-to-day student life better equips them to focus on achievement of their academic goals.

While I have considerable experience in this area, I will be calling on student affairs professionals and others in specialized areas of student affairs to identify the most pressing health issues and trends affecting college students and ways we can better assist you in addressing them.

I will also be working with philanthropic organizations to identify and develop partnerships to support health-related initiatives on college and university campuses. The Chickering Group has already undertaken a number of initiatives toward these ends. Foremost among them is the Annual Leadership Forum.

On October 25th and 26th, the Fifth Annual Leadership Forum, directed by Chairman Steve Caulfield, will provide college health leaders an opportunity to come together to share experiences and strategize ways to improve their practice to better serve the students at our nation's colleges and universities.

The prospect of continuing to work with my colleagues in student affairs to focus on health and wellness as a student development issue and its impact on retention and achievement of academic goals is very exciting. After working closely with The Chickering Group for well over 10 years, I believe it to be the best example of an organization whose goals for promoting student health and wellness are aligned with student development professionals in higher education. I am eager to work with you in this new capacity and I look forward to talking with you in the coming weeks regarding our common goals.

A handwritten signature in blue ink that reads "Linda".

Linda M. Ragosta, Ed. D.  
Vice President for Institutional Relations  
The Chickering Group

# HIPAA Preparation

by Gary Nicksa

Senior Vice President of Finance and Administration

As with many of you, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Administrative Simplification rules have become part of Chickering's life. Since August 2000, when the final rule on transactions and code sets was published, senior management and staff from the company's legal, information systems, operations, and finance departments have been engaged in understanding how the rules apply to the business of student health insurance brokerage and claims payment. With the help of Aetna, clients, and our vendors, we will be fully prepared to comply with not only the letter of law, but the spirit.

## Legislative History

HIPAA Administrative Simplification rules are a work in process. In 1996, the law defined specific administrative tasks that, if improved, would contribute toward a more efficient and effective health care system. Congress wanted to "encourage the development of a health information system through the establishment of standards and requirements for the electronic transmission of certain health information." (HIPAA Subtitle F, Section 261). The law outlined a methodology for how the format and content of certain types of transactions should be standardized. The goal is to make information easier to exchange between health care providers and health plans (the insurers). As information would be easier to move, process, and access, Congress was compelled to include guidance on how health information should be secured and used in order to protect each individual's privacy.

## Status of the Rules

Administrative Simplification can be looked at in five parts. The current status of the rules for each part, according to the U.S. Department of Health and Human Services (HHS) web site (<http://aspe.hhs.gov/admn-simp>), is the following:

## Transaction and Code Set Standards

- Final rule published 8/17/00 to be implemented 10/16/02

## Unique Health Identifiers (for Providers, Employers, Health Plans, and Individuals)

- Notice of Proposed Rule Making (NPRM) for Provider and Employer ID's published 1998, Individual rule is on hold for now, no Health Plan for NPRM

## Security (protect information from unauthorized access, alteration, destruction or loss)

- NPRM published 8/12/98, final rule pending

## Privacy (control who is authorized to access information and with whom it will be shared)

- Final regulation published 12/28/00 to be implemented 4/14/03
- HHS First Guidance on Patient Privacy Protections, 7/6/01

## Enforcement (penalties for failure to comply with the rules)

- No NPRM published rules at this time

## Impact On Chickering

The Administrative Simplification law and rules apply to Providers, Health Plans, and Clearinghouses (entities that convert health data into the standard required by HIPAA). As a health insurance broker and third-party claims administrator, Chickering is not directly subject to the law. The company is however a Business Associate (a HIPAA defined term) of insurers and will, by contract, be required to comply with certain aspects of the security and privacy rules.

## Preparation Efforts

Chickering has developed a two pronged approach to working through the HIPAA Administrative Simplification rules.

Externally, we will be working very closely with Aetna's HIPAA Project Management Office to understand and define our Business Associate relationship.

Internally, a HIPAA Task Group was formed in February 2001 to gain an understanding of the law, review existing systems (gap analysis), assess potential compliance issues (risk analysis), develop a corporate education program, and facilitate privacy and security related process improvement discussions among departments and with vendors.

While rather daunting in scope, as a company used to working with many levels of federal and state regulation, we view the Administrative Simplification rules as a large, but not unique, compliance project.

As a practical matter, the Administrative Simplification rules will change what health information looks like, how it is communicated, and how it is worked with. HIPAA security and privacy standards will, in many ways, define best practices in the health care industry. While not everyone is a covered entity, it will make business sense for most organizations to develop systems that will speak the same (HIPAA) language.

Chickering has always treated student/customer and client/school information as strictly confidential. Improving our systems to incorporate the latest privacy and security standards is a logical next step in our evolution. In some cases we are ahead of the curve, e.g., our client service web site is encrypted for file transfer and compliance will be a simple matter of directing people to the right tools.

Conceptually, few people disagree with the basic goal of HIPAA Administrative Simplification. At Chickering, we believe that HIPAA standards will serve to focus and direct system development efforts, and will simply become part of an industry wide process improvement effort. The challenge will not be in wanting to comply with the rules, it will be in dealing with the many complexities involved in getting to "Administrative Simplification."●

In the

## SPOTLIGHT: Reaching Out to Students in Distress

by Timothy Marchell, Ph.D., MPH  
Cornell University

During recent years, colleges and universities across the country have experienced an increase in demand for mental health services. This increase is likely due to a combination of factors: potentially greater psycho-social stressors than those experienced by previous generations of students, growing comfort with utilization of mental health care, and more students arriving on campus with pre-existing conditions that are now manageable, in part because of medications. This increase in demand for services has taxed available resources significantly.

Despite the increased number of students who seek counseling services, many students in need of mental health care still do not self-refer for supportive services. This fact often becomes tragically apparent in the aftermath of suicides or other crises in which students seem to "fall through the cracks" of the institution's safety net.

### Institutional Response

For the past three years at Cornell University, we have been developing an innovative program to increase the likelihood that students will receive the services they need. This effort was initiated by our Director of Health Services, Janet Corson-Rikert, MD, a public-health minded pediatrician who helped establish a student assistance program during her tenure as director of the health center of Phillips Exeter Academy in New Hampshire.

The focus of the student assistance concept is to identify and reach out to students in distress. While we were concerned from the outset about all forms of student distress, we focused our initial

efforts on students with substance abuse problems. We knew from our survey research that one in ten Cornell students think that they might have an alcohol or other drug problem, yet the number of students seen in our counseling center for such problems is relatively small. Since substance abuse by its nature often involves ambivalence about or denial of the problem, it made sense to develop strategies for helping students with such issues.

### Conceptualization and Funding

In 1999, we received a corporate grant to develop our student assistance model. This grant provided funding for one of our counseling center staff to work part-time for a semester on developing the program. Following discussion with us about the concepts we were exploring, Chickering focused its annual Leadership Forum later that year on the topic of "Student Assistance Programs: Early Case Finding and Intervention." While the Forum's discussion revealed an array of strategies for preventing and treating mental health problems, comprehensive approaches to early case finding were lacking. Two of the primary barriers to the development of integrated approaches were the existence of "silos" or institutional structural barriers, and a lack of funding for program staff.

Following the Leadership Forum, we embarked on a program development strategy that entailed two main strands: 1) design of a comprehensive model, and 2) fundraising. Our first step was to submit a grant proposal for a student assistance program to the Department of Education's Fund for the Improvement of Secondary Education (FIPSE).

The preliminary proposal requested funding for a three-year program with two full-time staff to develop an integrated, campus-wide approach to identifying and reaching out to students with substance abuse problems. We were encouraged that the preliminary proposal received strong reviews and that we were invited to submit a final proposal.

Shortly before the FIPSE deadline, we experienced an unanticipated and rather synchronistic development on our campus. Independent of our efforts to conceptualize the student assistance program, a newly formed group called Professional Academic Advising Leaders (PAAL), made up of staff from counseling and academic advising offices across the university, sponsored a panel discussion for staff and faculty on how to assist students in distress. The discussion underscored the challenges of identifying students in need and coordinating care for them on our highly decentralized campus. The very fact that our groups had been unaware of each other's initiatives was emblematic of the silo problem we sought to overcome.

In addition to confirming the need for improved communication and coordination of services, the panel discussion also persuaded us that a program focusing on substance abuse would not sufficiently address the range of student problems encountered by most student service staff and faculty. One reason is that students with substance abuse problems often show non-specific signs of distress. Another is that many students experience other problems (e.g., eating disorders, cutting, depression) that by their nature may decrease the likelihood of a self-referral for help, despite signs of a problem that are evident to others.

One overriding theme was that many staff, faculty and peers are aware of students in distress, but do not know what to do or do not recognize the severity of the problem because they only see the impairment in one aspect of the student's functioning. Panelists identified needs for training in: 1) screening techniques, and 2) communication between staff and faculty regarding students about whom they are concerned.

Following the panel we met with the PAAL group to integrate our efforts and subsequently modified our FIPSE proposal to reflect a broader focus on students in distress. At the same time, we engaged our Vice President for Student and Academic Services and the university's development staff in discussions about the proposal. They were particularly enthusiastic that the model sought to bridge the work of the health center with departments across campus. Their interest led to discussions with prospective alumni donors, including a couple who offered to fund the program in the event that the federal funds were not granted. When we received word from FIPSE that we had not made the final cut, these alumni provided a gift of \$500,000 to establish the program over a three-year period.

### **Evolution of the Model**

Despite the major breakthrough in funding the program, we struggled for several months to formulate the model in a way that addressed the needs of the campus and could be easily comprehended. The members of the health center's student assistance program development team (medical, nursing, counseling and health promotion administrators) found it challenging to put into cogent terms the goals and functions of the program. "Conceptual drift" occurred between meetings and the term "student assistance program" took on different meanings to different people. As we talked with our colleagues around campus, we encountered many different hopes and needs that we attempted to incorporate into the design.

Gradually, a few key concepts emerged upon which we could all agree.

Staff, faculty and students who are not in formal helping roles are often the people who notice that a student is exhibiting signs of distress. We refer to these individuals as our "eyes and ears."

In addition to the health center's Counseling and Psychological Services (CAPS), professional staff members with varying levels of mental health experience provide an array of support services across campus. While some student services providers have limited experience, others are seasoned counselors.

With greater access to consultation from mental health professionals, many staff and faculty would be willing and able to provide more support for students in distress. The program should focus initially on supporting staff and faculty, and expand to address the needs of student leaders and peers as the program evolves.

Roles and responsibilities must be clearly defined so that the program staff focuses on providing consultation and training for faculty and staff, while the CAPS staff provides clinical services for students identified through the program.

Many students who are referred to CAPS could more appropriately be served by staff from other offices, such as academic advising, campus ministries, or our Gay, Lesbian, Bisexual, and Transgendered Resource Center.

Some colleges and major units (e.g., residence life) have systems in place for identifying and assisting students in need, while others have less well-developed procedures.

Student support services often operate in unintended silos due to limited opportunities for interdepartmental communication.

In addition to these observations, we also noted confusion about the meaning of the term "student assistance program." Some interpreted this name to mean that students would deliver the service; others understood it to mean financial aid. In our search for a more user-friendly name, we drew upon our assumption that a primary aim of the program is to facilitate, coordinate, and enhance the work of the many service providers already supporting students. We viewed these staff as our partners in an undefined network that we envisioned. In order to underscore the collective and integrated nature of the initiative, we chose a new name: University Counseling and Advising Network (U-CAN). This new name has helped "brand" the program and is quickly becoming part of the lexicon of student service providers and senior administrators on campus.

### **Mission**

With two staff members in place and a new name, we next developed a program brochure to articulate the mission, goals, and services of the U-CAN. The text and illustration in the brochure have provided a framework within which our strategies and services have continued to evolve.

The mission reads as follows:

"The University Counseling and Advising Network's (U-CAN) mission is to develop a comprehensive consultation, advisory and referral network which will identify and reach out effectively to students in distress, particularly to students who are unlikely to seek help for their problems through existing counseling and support services.

This network will bring together representatives of departments and divisions currently involved in student support services in order to facilitate the effective use of those services. The aim of the network is to reach students who may be isolated within the decentralized Cornell University system, and/or whose problems, by their very nature, increase the

(continued from page 5)

likelihood that they will not seek help for their distress.”

(See the U-CAN illustration at the right.) In the center is a student in distress, surrounded by the tier of "eyes and ears" who may be likely to detect a problem. These individuals are in turn surrounded by the U-CAN Network Partner (NP) offices that reside in each of the major departments or divisions of the university. The U-CAN staff members have established relationships with individuals in each of these offices. The role of the NP's is to serve as the liaison between the department/division and the U-CAN staff. The meaning of "liaison" varies between offices and is evolving as the program becomes more established.

The program brochure also describes the two primary goals and four basic services of the U-CAN:

**Goals**

**1) To increase the identification of students in distress.**

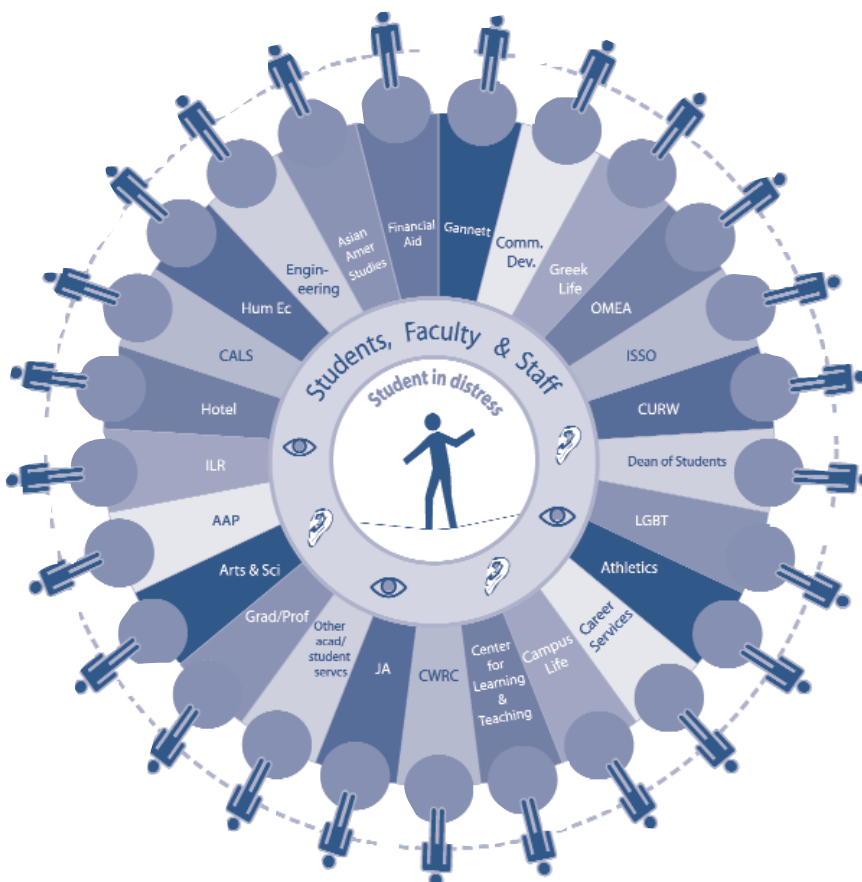
By increasing faculty, staff and student awareness of signs of stress among students.

By enhancing the effectiveness of existing systems and practices within and between departments and divisions for identification of students in distress.

**2) To connect students in distress with the appropriate level of services.**

By increasing the number of faculty, staff and students prepared to reach out to students in distress.

By partnering with student support services throughout the university to provide consultation, referral, and (occasionally) case management for students in distress.



**U-CAN: University Counseling & Advising Network**

●: Network Partner Office (NP);(In colleges, academic advising and COESP)  
 People Symbol: Representative of NP Office  
 Students, Faculty and Staff: Eyes and ears across the campus

**Services**

**1) Training:** U-CAN staff members provide and coordinate training modules to faculty, staff and student leaders within colleges, divisions, and student organizations to enhance their student support skills, and to assist them in identifying and reaching out to students in distress.

**2) Student-Centered Consultation:** U-CAN staff members provide consultation to student services staff for guidance in the management of difficult cases. Upon request, U-CAN staff will facilitate referral to Counseling and Psychological Services (CAPS) or other appropriate university or community-based services.

**3) Program-Centered Consultation:** U-CAN staff members provide consultation to colleges, divisions, and student service organizations to improve existing early intervention systems within each college for students in distress. U-CAN staff members work with departments across campus to develop practices and protocols that enable student service providers to enhance the existing safety net for students.

**4) Network Forum:** U-CAN staff members organize and facilitate an ongoing forum for student services professionals to foster better communication and coordination of services for students in distress.

The forum also provides discussion of topics including: signs and symptoms of students in distress, depression, suicidality, cultural diversity, eating disorders, alcohol and other drug abuse.

### Staffing

We hired the U-CAN staff for their experience in both direct service and program development. Sharon Mier, Psy.D., serves as the U-CAN Counselor-Manager and Lynn Gerstein, CSW, is the program's Counselor-Trainer. As their titles indicate, both provide consultations and have somewhat different emphases in their administrative duties. Their offices are situated in the Health Promotion department of our health center, though they also work closely with our counseling and medical staff. The relationship with our counselors is particularly important because of the overlap between the functions of CAPS and U-CAN. The U-CAN staff attends weekly CAPS meetings to ensure effective communication about consultation and case management. CAPS continues to provide consultation and outreach services, but these have been expanded considerably through the U-CAN. Another reason for close coordination with CAPS is the need to ensure that the cases generated by the U-CAN can be served in a timely manner. We are aware that the impact on CAPS' caseload will be two-way: on one hand, we seek to help student services staff handle (or refer to other campus or community services) appropriate cases that they would otherwise refer to CAPS. On the other hand, we will also generate an increased number of students who are in need of CAPS services.

### Evaluation

During the early phase of program development, we hired a faculty member and graduate student to serve as part-time evaluation specialists for the project. Incorporating evaluation from the outset served to clarify our thinking about what we wanted to achieve and has enabled us to provide feedback about our progress to our funders.

The evaluation specialists recommended focusing initially on formative measures designed to assess whether we are achieving our implementation objectives (i.e., the extent to which we are performing the services outlined above) and intermediate outcome measure (e.g., changes in knowledge and attitudes among participants in trainings). Development of final outcome measures will be more complicated and is being deferred until the current phase of program implementation is completed.

### Lessons Learned

When we initially conceived the U-CAN, we envisioned beginning the Network by bringing together all of our partners for an initial series of meetings to explore how the Network could best serve the members. In discussing this option with several of them, we heard a clear message that some were skeptical of attempts to overcome the vast decentralization of Cornell with large gatherings of staff. They had seen it tried and fail in the past. We also heard that many people did not want to add yet another meeting to their schedules until the program was more established. **Their message was clear:** *get out there and start doing it rather than bringing people together to talk about what we are going to do.*

Heeding the feedback of our colleagues, we chose instead to grow the Network from the ground up. This meant identifying offices and departments with whom we would establish pilot projects for the first year of the program. While we still plan to assemble the Network for periodic gatherings, we are not at this point holding the monthly meetings we anticipated. Instead, the U-CAN staff is working closely with particular offices to build the base of the Network. For example, they are working with certain colleges' advising offices to develop procedures for faculty and staff to share information about students who appear to be in distress. In one college, U-CAN staff members are attending academic advisor meetings on a regular basis to provide consultations.

Across colleges the U-CAN staff is conducting trainings for our "eyes and ears" including teaching assistants and secretaries across colleges. In addition, pilot projects adapted to differing organizational needs are being established with our athletics department, residence life staff, and graduate school.

These pilot projects proved invaluable in the wake of the recent terrorist bombings. With a large number of students from New York metropolitan area, Cornell was particularly shaken by the events. As our Dean of Students effectively coordinated a comprehensive response by campus staff and faculty, the connections of the U-CAN staff enabled them to provide timely support to several departments and offices. This crisis has accelerated the development of the program by creating an acute need for the U-CAN's services.

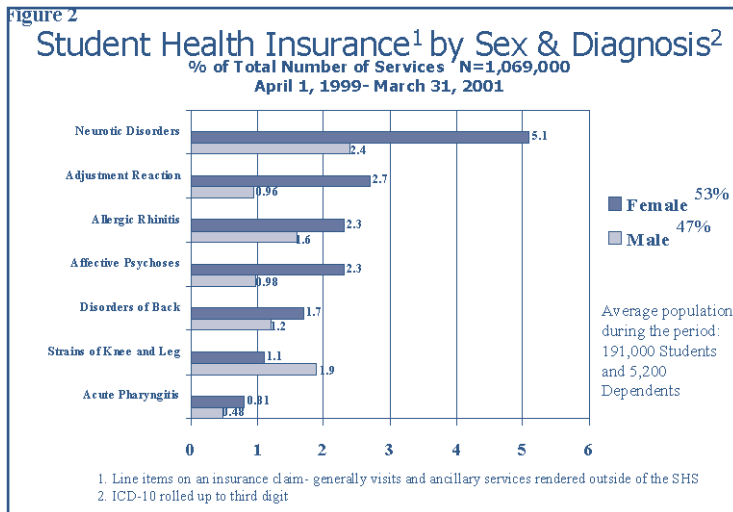
We are encouraged that we are on track with our original vision of increasing support for students in distress. Our model continues to take shape and adapt to the varied needs of the institution and the rapidly changing societal context of our work. As we move forward, support for our effort among our colleagues on campus continues to grow. By developing strategies that respond to the unique needs of both individuals and organizations within the institution, the U-CAN is becoming integrated into the fabric of the services the university provides. ■

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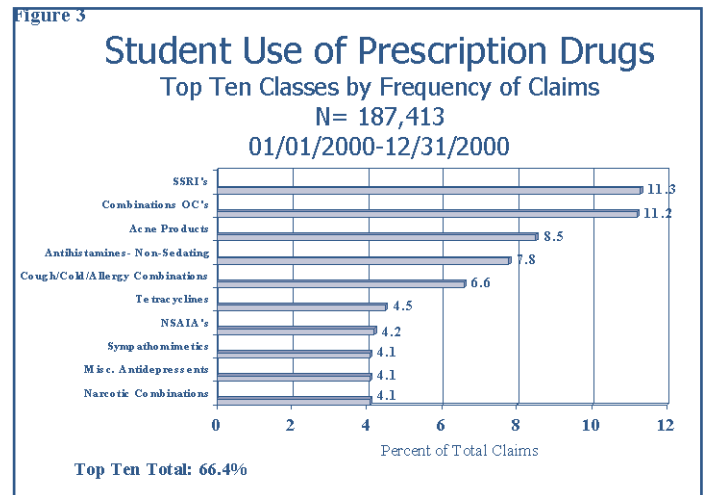
When these data were sorted by gender, these diagnoses were observed more than twice as frequently among women. (See Fig. 2)

Reviewing claims for prescriptions paid during the calendar year 2000, the most frequently prescribed class of drug was the antidepressant SSRI's at 11.3 percent of the total. (See Fig. 3)

Last Spring, at Chickering's request, a Student Health Service reviewed a small, random sample of all medical charts with a diagnosis code of adjustment reaction or depression. Seventy percent of these students had been previously diagnosed by a clinician outside the Student Health Service. One third of the total sample were continuing on previously prescribed psychotropic drugs (again prescribed by non-Student Health Service clinicians) and an additional 10% had previously been treated pharmacologically.



*The SSRI class of antidepressants tops the list of drugs prescribed for college students.*



*The frequency of behavioral diagnoses is twice as great for women.*

Of interest, although the majority of patients seen had been previously diagnosed and half of these were on active psycho-pharmacological treatment, 90% were referred to counseling or encouraged to continue counseling. About one third of these were referred to a psychiatrist. Said another way, for those students who came to college with a diagnosis and treatment plan in place, the Student Health Services, in reviewing these cases, overwhelmingly recommended continuing care. What is not known from this small study is what is happening to those students who came to college with a diagnosis of depression and a treatment plan for SSRI's, but who do not use the Student Health Services or Counseling Services.

Recent high profile incidents of suicide and murder-suicide on several campuses have resulted in substantially increased attention to depression, stress and other mental illness among college students, particularly in those affected institutions.

A provost's committee at Harvard met during 1999 and issued a comprehensive report last year. Its recommendations focused on student needs, access to care and counseling. The complexity of this university, and the natural barriers among academic programs, student life, residence life, student health and counseling were noted. (See *Spectrum*, Fall 1999 for a more general discussion on these issues, and Dr. Marchell's article in this issue, for a specific solution.)

More recently, MIT formed a task force to make recommendations on how to help students with emotional problems after six student suicides in three years. As with the Harvard report, MIT will be emphasizing improved access with longer hours of clinic times, increased staff for residence life and a Web site that helps students understand available resources.

The apparent increase in the incidence of depression is not limited to college students. The Wall Street Journal in a major feature article this June, reported, "In a typical office of 20 people, chances are that four will suffer from a mental illness. Depression (is) one of the most common."

Like college students, the observed incidence of depression in the workplace appears to be rising rapidly, so much so that even Behavioral Health Specialists are surprised.

Several explanations are offered for the increase in reported incidence of depression both among students and employed populations.

The U.S. sales of the SSRI class of antidepressants has risen 800% since 1990 (although the most significant growth was in the first half of the decade).<sup>1</sup> The use of these medication has enabled individuals with depression (and also with obsessive-compulsive disorder) to function at higher levels, qualifying them for acceptance at colleges and enabling them to perform at acceptable levels.

The availability of an effective treatment (the combination of medications and psychotherapy has been proven most effective) has led to an increased willingness among clinicians to make a diagnosis of depression. This increased use of clinical depression as a diagnosis may not always be appropriate. Some Student Health Service directors have suggested the diagnoses may simply be used to support the treatment (and the insurance claim) rather than the more traditional order of diagnosis determining treatment. They further suggest that this practice, particularly by family practitioners, internists, and pediatricians, may result in an overuse of the diagnosis of depression.

The availability of an effective treatment for vague somatic complaints for patients of primary care physicians may have further contributed to the increased use of the diagnosis of depression by physicians without specialty training in psychiatry or psychology. (It should be noted that SSRI class of antidepressants has been effective for somatization disorder, for irritable bowel syndrome, and for pain.)

The enactment of the Americans with Disability Act and the Mental Health Parity Laws, as well as a general decline in society's aversion to mental illness, particularly depression, may have contributed to both the increased frequency of the diagnosis and the willingness of patients to disclose their diagnosis.

The explosive growth of Direct to Consumer (DTC) advertising of SSRI's may have both exposed untreated disease and, perhaps, created unwarranted patient demand for treatment of social anxiety disorder, situational stress and/or mild transient depression. However, direct to consumer advertising was only part of the marketing strategy. Physicians have been aggressively courted by the pharmaceutical companies.

Whatever the explanation, Student Health Services and Counseling Centers are currently facing increased demands for care. Insurers (both Parental and College-Sponsored plans) are facing increasing medical and prescription drug benefit costs which get passed through as higher premiums. And academic programs, student affairs, residence life and other aspects of the campus community are increasingly concerned not only about stress and suicide, but more generally about academic performances and retention.

The terrorist attacks of September 11th have added a new and significant source of anxiety and concern which will undoubtedly play out in diverse ways on campus life.

What are the challenges and questions we continue to have ahead of us? In speaking with several SHS Directors, counseling directors and behavioral health professionals, four areas were identified as primary.

What is the responsibility of the University for students with clinical depression and/or other significant emotional problems?

What are the organizational issues to ensure reasonable access, coordination of care and efficient use of resources?

If additional resources are required, what financing mechanisms are fair and equitable: University funds, Student Health Funds, Insurance, or Self-pay?

Are more programs required to meet these newly identified needs? What are they and how should they be organized, staffed, and financed?

This, of course, is not an exhaustive list, but it represents significant challenges for most Colleges and Universities.

We suggest no answers here, but will elaborate somewhat on each of these four questions?

**What is the responsibility of the University,** and, by extension, the Student Health Services and Counseling Services for individuals with known morbidity, which may adversely affect their academic performance?

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If one expands the definition of morbidity beyond depression to include individuals with serious asthma, brittle diabetes, or Crohn's disease, some consensus emerges. Medically, the University should be able to help arrange the medical management of the student locally; be available to help manage acute episodes; and to guide and counsel other aspects of the University community on the accommodations, which may be required for successful academic performance.

Where there is a broader range of opinion, at least medically, is the degree to which SHS should review all students with a current diagnosis and ongoing treatment. One SHS Director said emphatically, "I disagree that the University has a "responsibility" for students with chronic or recurring diagnosis including depression. The student (and their parents) have the responsibility for both maintaining appropriate treatment and for seeking accommodation."

Another SHS Director said, "We cannot possibly provide all the clinical care our population needs. Our primary business is higher education, not to be a comprehensive medical center."

And another said, "I see no value in questioning a diagnosis or treatment, if the student is comfortable with it and functioning adequately."

On the other hand, some counseling center directors and many behavioral health experts are concerned with the potential for over diagnosing depression and over prescribing SSRI's. "These are not drugs without side effects and to require a young person to carry with them the label of depression for transient situational symptoms is both wrong and costly," said one SHS Director.

However the University and its Student Health Services and Counseling Center defines its role, it should be clearly stated and well understood by both staff and students.

• **Organizational Issues.** The relationship between Student Health Services and Counseling Centers follows a spectrum from those fully integrated programs, all the way to totally separate programs. The middle of the spectrum is occupied by "coordinated" programs, which may share space, staff, systems and/or information.

We do not advocate a particular structural model, but we do note that recent work by special committees at both Harvard and MIT have stressed that the needs of the students must come first.

Further, access and clarity about "where to go for what" have been emphasized as attributes of a student centered approach.

Anecdotally, too many stories exist about organizational structures which are driven largely by differences between the medical model and the psychological model, differences between a training mission and a service mission, and other issues, (i.e., funding sources) which are professional and territorial rather than service and quality orientated.

As with the mission, the organizational model used by a school should be well understood by all and, whatever the model, access, services and quality should govern.

• **Resources and Financing.** What resources will be required and how should financing be organized? Almost without regard to how narrowly defined the University's responsibility for providing direct care and counseling, or care coordination for students with behavioral diagnoses is, the recent increase in demand almost always requires the commitment of new resources. Counseling Centers report that in the past five years about 21 percent had a gain in staff, while 8 percent lost staff. <sup>2</sup> Almost without exception, both counseling centers and Student Health Services are experiencing both an increase in demand for clinical services as well as a demand for outreach and collaborative programs.

"This issue is huge," said one SHS Director, "it will tax all existing resources and require some new ones. But from where will these come?"

The choices are the same four that have financed Student Health and Counseling for years: University Funds, Specific Fees, Insurance, and Self-Pay.

Again we offer no recommendation, but do note that the University's philosophy about its role, and the professional value judgements it holds about what care is discretionary, can influence financing decisions. As a general rule, accommodation and access costs are born by the whole tuition base. (The retrofitting of campuses to create barrier-free access to comply with ADA was not charged to disabled students alone). Whether these costs are buried in the tuition or are raised through other fees or surcharges, everyone pays equally.

## News Release

October, 2001

The Chickering Group, has announced that they are eliminating the standard clause in student health insurance policies that excludes "expenses incurred for injuries or sickness from declared or undeclared war or any act thereof." Company officials moved quickly to respond to concerns expressed by higher education leaders and coordinated this change with Aetna; carrier for insurance plans provided by The Chickering Group. The Chickering Group is the first student health insurance company to take this action. ■

Conversely, many universities believe more intensive, psychoanalytically-oriented psychotherapy is discretionary and should be paid for by the patients or their insurance. Some Universities offer a limited number of psychological counseling services with no self-pay; after six or eight visits, the students may continue if clinically necessary for another six or eight visits at a below-market fee. Any care beyond this, then, is referred to the community at market rates. (It should be noted that this kind of graduated behavioral health benefit has existed for more than thirty years in some employer-sponsored plans and is now almost the universal approach of Employee Assistance Program (EAP's)).

• **New programs.** Four categories of "new" activities or programs for students are now being reported in colleges and universities. Screening risk appraisal and case finding; stress management, and risk reduction; new treatment modalities including cognitive behavioral therapy (CBT) and access, including residence-based groups; and Internet or Intranet resources for information and support. Programs for faculty and staff are also being added, building on training programs for residence life staff that have help sensitize staff to signs and symptoms of troubled students.

While labeled as "new", and many are, conceptually these interventions have their origins in the development of therapeutic communities in the 1950's and in the community mental health centers of the 1960's and '70's.

As one SHS Director commented, "I see the newer modalities (structured treatment, CBT, and short-term therapy) becoming more appropriate given the current constraints in financing, and resource availability. There is some resistances to moving in this direction because it threatens the old model. This is not a conflict between the medical model and the psychological model, it is a tension between the psycho-dynamic and cognitive approaches." The challenge then, is to overcome these resistances to make the right programs available for students.

Again, we avoid recommending specific programs, but rather focus on a programmatic balance of adequate resources for individuals in distress and interventions that reduce the "toxicity" of the environment. The campus which supports, restores, and promotes emotional health should be the goal. ■

### End Notes:

1. IMS Health, Wall Street Journal, June 13, 2001
2. National Survey of Counseling College Directors, 2000, International Association of Counseling Services, Inc.



*Aetna has a new look.*

**A**s Aetna works to retool its processes and procedures to rebuild the “new” Aetna, their logo has also changed to embody the principles of the new company. The logo's clean, classic look reflects Aetna's reputation as a leading benefits company that will continue to provide quality services to its members. It conveys a corporation that is efficient, friendly and member focused.

Aetna's new logo and announcement was provided by General Manager for Student Plans, Mark Jardin.

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### **Special thanks to**

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If you would like to see a topic covered or would like to be a contributing writer, please contact Marketing Communications Manager, Christine Murray, by telephone at (617) 245-2000 or by fax at (617) 225-2140.

### **Where to See Chickering Next?**

**MACHA** (Mid-Atlantic Health Association)  
**October 26-28, 2001**

**NECHA/NYSCHA** (New England and New York Student Health Association)  
**November 1-3, 2001**

**MACHA** (Mid-America Health Association)  
**November 7-9, 2001**

**CGS** (Council of Graduate Students)  
**December 5-8, 2001**

**SCHA** (Southern College Health Association)  
**March 21-23, 2002**