service use, and barriers to getting care, in hopes of improving preparedness for future disasters. Project Director Ronald Kessler, PhD, professor of health care policy at Harvard Medical School, Boston, Mass, and colleagues plan to interview about 3000 people, a representative sample of the 6.5 million adults affected by Katrina, every 6 months over the next 2 years. The researchers identified these individuals via random digit dialing of more than 100 000 residences nationwide, using lists from relief agencies, hotels, shelters, and other sources. Participants in the Hurricane Katrina Community Advisory Group include residents of the New Orleans metropolitan area and hurricane-affected areas of Alabama, Louisiana, and Mississippi.

Researchers conducted baseline interviews between January and March 2006, asking the same questions used in the Third National Comorbidity Survey Replication (NCS-R), a face-to-face household survey conducted between 2001 and 2003, also directed by Kessler. Availability of NCS-R data collected from 800 people in the same areas in 2003 allows comparisons of the same population before and after the hurricane, Kessler said. Results from the first wave of interviews are scheduled to be released in August in the *Bulletin of the World Health Organization* (http://www.who.int/bulletin/en/).

Researchers digitally recorded individuals' hurricane stories and will gather updates on how their lives progress as the study continues. More than 1000 oral histories are available at http://www.hurricanekatrina.med.harvard.edu. □

Experts Work to Prevent College Suicides

Lynne Lamberg

TORONTO—Feeling depressed after a friend's suicide, a college student voluntarily admitted himself to his university hospital's psychiatric unit. Within 2 days, the university barred him from campus and suspended him from school.

The student is now suing the institution, George Washington University in Washington, DC, claiming his suspension violated the Americans with Disabilities Act. The case received extensive press coverage, often critical of the university. In a March 13 editorial, the *Washington Post* said, "If the university wants to encourage ill students to seek timely treatment, this is a strange way to go about it."

Mandatory withdrawal policies for students deemed suicide risks appear to be on the rise at the nation's universities, said Paul Appelbaum, MD, a past president of the American Psychiatric Association (APA), at a symposium on campus suicides he chaired at APA's annual meeting here in May. College administrators worry about legal liability and adverse publicity that may follow a student suicide on campus, noted Appelbaum, professor of psychiatry and director of the division of psychiatry, law, and ethics at the Columbia University College of Physicians and Surgeons in New York City. Administrators also seek to avoid exposing other students to the disruption and stress that follow a campus suicide, and to minimize the likelihood of copycat suicides.

Yet mandatory leave takes students away from their friends, often their main support system, and may intensify feelings of failure, Appelbaum said. Some students may not find refuge at home; indeed, dysfunctional family relationships may contribute to distress. A mandatory leave policy also may discourage troubled students from seeking help (Appelbaum P. *Psychiatr Serv*. 2006;57:914-916).

Appelbaum and others discussed both practical tactics and ethical dilemmas in assessment and treatment of potentially suicidal college students. Speakers described a novel Web-based outreach program and a comprehensive mental health system now in place at one of the nation's premier universities.

A TRAGIC TOLL

An estimated 1100 suicides and 24 000 suicide attempts occur annually among US college students aged 18 to 24 years. About 10 million such students were enrolled in US colleges and universities in 2003—about one third of individuals in that age group living in the United States. The suicide rate on campus, estimated to be about 7.5 per 100 000 students, is about half that in nonstudents the same ages. Suicide is the third leading cause of death after unintentional injuries and homicides in persons aged 15 to 24 years in the United States, according to the Centers for Disease Control and Prevention. Because homicides occur less frequently in college students than in

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An estimated 1100 suicides and 24 000 suicide attempts occur annually among US college students aged 18 to 24 years. Colleges are grappling with how best to prevent suicides in this population.

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age-matched nonstudents, however, Appelbaum and others suggest suicides likely rank second only to unintentional injuries as a cause of death among college students.

About 10% of college undergraduates report having seriously considered suicide in the past year—"a staggering figure," Appelbaum said, and one that requires stepped-up educational and preventive efforts. About 1.5% of undergraduates report having made a suicide attempt.

College suicides often appear to be impulsive acts, Appelbaum said. About 1 in 5 suicides in college students occurs the same day as an acute life crisis, and 1 in 4 occurs within 2 weeks of such an event. These facts highlight the need for a rapid response to apparent distress.

Schools commonly focus on problems of adjustment to school by freshmen, but suicide rates among undergraduates are highest among seniors, Appelbaum said. They are even higher among graduate students, most of whom live off campus and get relatively little attention from college mental health services. More students with psychiatric disorders attend college today than in the past, Appelbaum said, a reflection of successful treatment of young children who might not otherwise have been on a college track.

In a 2005 survey, 366 college counseling center directors reported that 25% of students visiting their centers already were taking psychiatric medication, up from 20% in 2003 and 9% in 1994. Directors said nearly 43% of their clients have severe psychological problems and nearly 9% have impairment so serious that they cannot stay in school or can do so only with extensive psychological or psychiatric help. Fewer than 60% of the schools surveyed offer psychiatric services on campus, and 80% of directors said they need more psychiatric consulting hours (http://www.iacsinc.org/2005%20National%20Survey.pdf).

Similar surveys over the years consistently show that fewer than 20% of students who died by suicide were current or former counseling center clients. "The majority of those at risk for suicidal behavior do not seek help, at least not on campus," Appelbaum said. Some students may view themselves as stressed, rather than depressed, and not realize treatment is available, he noted. Some may use alcohol or drugs to blunt their pain.

REACHING OUT

A novel Web-based outreach program aims to find high-risk students and encourage them to get into treatment. The program was developed by the American Foundation for Suicide Prevention (AFSP) in collaboration with Emory University, in Atlanta, and the University of North Carolina (UNC), Chapel Hill. It underwent pilot testing for 6 semesters at Emory and for 3 at UNC between 2002 and 2005. Its use continues at both sites.

Students receive an invitation via campus e-mail to visit a secure Web site, register using a unique identifier and password, and complete an online screening questionnaire, explained Ann Haas, PhD, AFSP research director. The questionnaire, keyed to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*'s diagnostic criteria for major depressive disorder and based on the well-validated Patient Health Questionnaire, takes about 10 minutes to complete. It asks students to tell how frequently they experience little interest or pleasure in daily activities, feeling hopeless, trouble sleeping, and other common symptoms of depression, and to rate their level of difficulty functioning with these symptoms.

Other questions target suicidal ideation; prior suicide attempts; affective states associated with suicide, such as rage, desperation, and loss of control; use of alcohol and drugs; symptoms of eating disorders; and current psychiatric treatment or use of psychiatric medications. Students with scores above a defined threshold receive a prompt, detailed response from an experienced clinician, inviting them to a face-to-face meeting. However, students may continue to interact anonymously with the clinician via the Web site, where the clinician may address their concerns about privacy, confidentiality, or other reasons for not seeking treatment.

In the pilot test, 14 500 students at the two universities were invited to take part in the screening. For every 1000 invited, about 80 completed the questionnaire, 20 engaged in online dialogues, and about 10 entered treatment, Haas said. The majority of those completing the questionnaire had significant mental health problems. Few reported currently receiving psychotherapy or taking psychotropic medications. Clinicians said they thought most of those who sought treatment would not have done so without the program.

"The dialogue feature is absolutely critical to fostering a therapeutic relationship and resolving barriers to treatment," Haas said. Being able to consult the clinician outside the regular counseling center also was a plus.

Campus focus groups suggest the screening project reinforces a view of the university as a caring community, Haas said, even among students who did not seek help. Her group plans to offer the program soon at other universities, and to graduate students and resident physicians.

FOSTERING A CARING COMMUNITY

Harvard University, in Cambridge, Mass, uses a wide array of strategies and programs to promote student mental and physical health. These include "therapeutic breaks" that include shoulder and back massages during final examination weeks; workshops on consequences of sleep deprivation, stress management, respectful relationships, and responsible drinking; and health fairs offering self-administered screening tests for depression, anxiety, and other problems, said Paul Barreira, MD, director of behavioral health and academic counseling at Harvard University Health Services.

For students with problems, the university offers multiple portals of entry to help, Barreira said. A student hampered by procrastination, for example, may seek advice on better learning strategies at the

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campus counseling center, staffed mainly by psychologists who provide such help, along with general counseling. A study counselor who suspects that anxiety or depression is contributing to the student's difficulty may refer the individual to the mental health service, staffed by psychiatrists and others who treat psychiatric disorders and also provide general college counseling. A student may ask a residential wellness tutor for advice on eating better, and the tutor may steer the student to a specialist in eating disorders. Dormitory-based peer counselors, who meet weekly with supervisors, also offer aid, usually in the evenings and on weekends.

More than 90% of referrals to the campus counseling center come from residential staff members trained to recognize depression symptoms, Barreira said. These individuals, usually graduate students in professional schools or junior faculty who also work as academic advisors, live in the dormitories, providing an adult presence there.

Because impulsive behavior is a key concern, each of the psychiatrists, psychologists, and social workers at the mental health service keeps open slots every day for urgent care or triage visits, Barreira said. This strategy enables clinicians to make an immediate connection with troubled students, he noted.

Harvard does not mandate treatment nor require students who have been hospitalized to leave, Barreira said. "We prefer to work with the student and often the family to determine what action is in the best interest of the student," he said. "The student needs to own the decision."

FUTURE DIRECTIONS

As recently as 3 or 4 decades ago, colleges and staff served in loco parentis, noted Barbara Stanley, PhD, director of the suicide intervention center at New York State Psychiatric Institute, in New York City, and symposium co-chair. Today, the Family Educational Rights and Privacy Act transfers parental rights affecting education records to the student when he or she reaches the age of 18 years or attends a school beyond the high school level (http://www.ed.gov/policy/gen/guid/fpco/ferpa/index.html). The usual medical record privacy protections also apply to students, she noted. Students need to give permission for parents to be informed about their problems or medical care.

Colleges and universities need a best practices model for dealing with suicidal students, Stanley said, with clear policies for adequately and fully informing students about the limits of confidentiality and possible consequences of revealing suicidal thoughts. Ideally, the institution would promote help-seeking behavior, she said, and provide genuine options for help on and off campus.

"The least controversial thing a university can do often is the least discussed and least pursued option," concurred Appelbaum. "It's providing adequate mental health services." ☐

For More Information

American Foundation for Suicide Prevention: http://www.afsp.org

ULifeline: http://www.ulifeline.org

Jed Foundation: http://jedfoundation.org

Rape at US Colleges Often Fueled by Alcohol

Thomas B. Cole, MD, MPH

A CHANGE IN WISCONSIN STATE LAW long sought by activists seeking stronger legal sanctions against alcohol-related sexual assaults will help make assailants who use alcohol to facilitate rape accountable for their actions. The law, which took effect in June 2006, allows prosecutors to argue that a woman may have been incapable of consenting to sex while she was under the influence of alcohol, an argument already permitted for intoxication by other drugs used far less commonly to facilitate rape. A person convicted of rape under the new law faces a fine of $100 000 and a prison term of up to 25 years. Rape prevention advocates in Wisconsin, the 50th state to enact such a law, say the change acknowledges that rapists often use alcohol to justify their actions.

The Wisconsin law was designed to protect women at risk of sexual assault by acquaintances at social gatherings where alcohol is served, a ubiquitous set of circumstances on or near college campuses. According to a 2003 US Department of Justice (DOJ) report (available at http://www.cops.usdoj.gov/mime/open.pdf?Item=269), rape is the most common violent crime at US universities. The incidence of rape is estimated to be 35 per 1000 female college students per year in the United States, although less than 5% of these rapes are reported to police. Women may decline to report rape for a variety of reasons, including shame, fear of social isolation from the assailant's friends, and self-reproach for drinking with the assailant before the rape.

Ninety percent of college women who are raped know their assailants, according to the DOJ report. Most rapes occur in social situations, such as at a party or studying together in a dormitory room, and about half of perpetrators and rape survivors are drinking alcohol at the time of the assault, according to a National Institute on Alcohol Abuse and Alcoholism (NIAAA) review of recent studies of alcohol and sexual assault (available at http://pubs.niaaa.nih.gov/publications/arh25-1/43-51.htm). Henry Wechsler, PhD, of the Harvard School of Public Health, in Boston, who has conducted studies of alcohol use by college students, says that most nonconsensual sex is fueled by alcohol. "Alcohol is the number 1 rape drug," says Wechsler.

The NIAAA review says that a typical sexual assault among college

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