



PATIENT'S NAME _____

TODAY'S DATE _____

PRIMARY DR. _____

Rx

Psychiatric Medications & College Counseling

DOCTOR SIGNATURE _____

Authored By:

Josh E. Gunn, Ph.D.

Exec. Director of Counseling and Psychological Services
Kennesaw State University

Mary-Jeanne Raleigh, Ph.D. LPC, LMHC, NCC

Director of Counseling and Psychological Services
University of North Carolina, Pembroke

Vanessa Pomarico-Denino

MSN, FNP-BC, APRN, FAANP
Northeast Medical Group, Connecticut

Brian Van Brunt, Ed.D.

Executive Director
National Behavioral Intervention Team Association

TABLE OF CONTENTS

Introduction.....2

Who Should Be Referred?.....2

Where Should Students Be Referred?.....3

What Are Some of The Common Medications Prescribed?.....5

Should Parents, Family, or Partners Be Told?.....6

Final Thoughts.....6

References.....7

About the Authors.....8

INTRODUCTION

As increasing numbers of students with mental health conditions enroll in college, the use of psychiatric medications on college campuses has been on the rise in recent years (Kirsch, Doerfler, and Truong, 2015). This raises a number of questions for student affairs professionals. What students should be referred for prescription of psychiatric medication? What systems exist in counseling, health and combined wellness centers, and in off-campus community resources to prescribe needed medications for students? How should institutions help students who have prescriptions for such medications from their hometown

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medical providers manage their medications? Should individuals in supportive roles, such as parents and partners, be part of this discussion? What are the risks for colleges and universities that prescribe psychotropic drugs to students who might be suicidal? Are there limits on the medications that should be prescribed on campus?

Most of these questions are sources of ongoing debate among counselors, psychologists, social workers, and other mental health professionals. Complicating this debate is the lack of consistent evidence on the effectiveness of psychiatric medications, as well as insufficient explanations from the pharmacological and psychiatric industries as to how and why these medications work for some individuals and not for others. Regardless, campus practitioners tasked with supporting student success cannot afford inaction while discussion around these topics continues. With students’ ability to succeed academically and cope with everyday life on the line, it’s important to know that while many questions remain unanswered, we must use our best professional judgment to ensure students have a pathway to the psychiatric medications they need. This paper will help you hone your ability to determine when medication referrals may be needed.

WHO SHOULD BE REFERRED?

Understanding that all medications and referrals for medication are not the same is an excellent starting place. While this may seem obvious for those with clinical backgrounds, it may be less clear for a student affairs practitioner with little to no knowledge of mental health conditions and their treatment. A diagnosis doesn’t automatically mean that pharmacological treatment may be warranted. Further, two students diagnosed with the same condition and even experiencing the same symptoms may not necessarily require the same approach to a medication referral, since one may be using coping strategies to mitigate the symptoms of the condition that are as effective for that student as medication might be for the other. When considering whether a referral for medication may be useful, look at the level of disruption and impairment that symptoms seem to be causing in students’ lives. If they appear to be struggling, making a referral to a medical professional who can determine whether or not they may benefit from medication is always a good idea.

The most common medications prescribed are for anxiety and depression, the most frequently seen mental health disorders on college campuses (AUCCCD, 2014; Gallagher, 2014). Students struggling with anxiety may be referred for medications if they have brief but intense reactions to particular situations, such as upcoming air travel or a public speaking commitment. More pervasive symptoms, such as intense daily worry, persistent trauma reactions,

severe test anxiety, and debilitating panic attacks can lead students to avoid normal activities and would likely benefit from referral. Students with depression may be referred for mild but persistent sadness, occasional but severe sadness, or in either case, thoughts of suicide.

Other medication referrals commonly involve students who have difficulty focusing or paying attention to classroom lectures and assignments. This often leads to diagnoses of Attention Deficit/Hyperactivity Disorder (ADHD), which is typically treated with stimulant medications. However, reaching an accurate diagnosis of this condition tends to require intelligence and achievement testing, as well as medical testing to rule out physical causes of the attention problems. These tests can be very expensive and time-consuming, leading to delays in diagnoses, which in turn delay needed treatment and academic accommodations. On-campus medical professionals are less likely than their off-campus peers to prescribe stimulant-based ADHD medications because these are controlled substances that carry a risk of misuse and abuse, especially on college campuses, where the ability to focus on studies is paramount. Additionally, because of the high number of students diagnosed with ADHD and in need of medication, an on-campus provider with limited hours may restrict ADHD medication referrals to off-campus providers to avoid spending inordinate amounts of time on just those students with attention problems. These issues don't mean that campus practitioners should avoid making referrals to medication for students who seemingly struggle with attention deficits, but it is important to understand what students may experience once receiving a referral.

Students who are experiencing rapid mood swings, reality perception problems, or hallucinations and/or delusions may have bipolar disorder, major depression with psychosis, drug addiction, or early symptoms of schizophrenia. All of these conditions have a higher prevalence of first occurrence under stress and onset during the age range commonly associated with the traditional-aged college student. On-campus medical staff may not prescribe medications for more complex conditions like these because, unlike medications for ADHD, many of the medications typically used to treat such conditions require blood tests beyond what most on-campus counseling and health centers can provide. Hence, an outside referral may be necessary. In addition, due to the scope of practice of primary care providers such as those employed by student health centers, these medications are typically prescribed by a psychiatrist or psychiatric advanced practice registered nurse, who are well-versed in the pharmacokinetics of this class of drugs as well as the nuances in prescribing medications for dual diagnoses in this disorder category.

WHERE SHOULD STUDENTS BE REFERRED?

Many models of clinical service delivery exist to meet the mental health needs of students across the country. These models are dependent on the level of fiscal support to an institution, the philosophy of the college or university with regards to student wellness and mental health, and the resources allocated to the counseling and/or health center to provide this kind of care to students.

Students often arrive at college with prescriptions for psychiatric medications from their primary care providers, who may be local or across the country. This can make tracking and monitoring the effectiveness of the medication difficult, as collaboration with off-campus providers is often much more challenging than with on-campus providers. This also creates some difficulty for student affairs professionals, as off-campus providers may be

more willing to prescribe medications that have a risk of being abused on campus. The high monetary value that some psychiatric drugs carry on college campuses is well known by providers, which is why most experienced and trained providers are hesitant to prescribe them liberally. While on-campus prescribing professionals are typically well attuned to drug-seeking behaviors and the risk of abuse of stimulant medications like Adderall and Ritalin, some off-campus providers may be less familiar with the realities of campus life and the practice of both sharing and even selling these medications. Thus, off-campus providers may be less likely to weigh those environmental factors as heavily when writing a prescription for a student.

This trend has been shifting recently, with state and federal drug laws and Drug Enforcement Administration rules actively addressing the problem of medication sharing, selling, and abuse. These include prohibiting medical professionals from prescribing more than 30 days' dosages at a time; requiring that patients stay current in their visits to their psychiatrist or APRN to refill prescriptions; and allowing only the patient to whom a psychiatric medication is prescribed to pick up the prescription from the prescribing provider.

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Another model involves combined health and counseling centers or standalone health centers that prescribe medication to students upon referral from the counseling or general medical staff. Students eligible for medications are typically referred for and may even be required to receive ongoing counseling, either on- or off-campus, to continue to be prescribed medication. Combined or standalone on-campus health centers may engage the services of a psychiatrist, physician, physician's assistant, or psychiatric nurse practitioner to prescribe these medications.

Less common are counseling centers that have invested in a staff member who can directly prescribe psychiatric medications to students who are diagnosed and open to medication options in their treatment. These staff members include psychiatric nurse practitioners, psychiatrists, or medical doctors who can prescribe medications. Each state regulates who has the ability to prescribe medication. In a few states, psychologists have successfully lobbied for limited access to prescription formularies for their patients.

Determining the best place to refer a student requires an understanding of the model employed at your institution, your counseling or health center's ability to serve students in a timely manner, and a variety of other factors. However, lacking sufficient knowledge of those factors should not be a deterrent to helping students. A referral to an on-campus counseling or medical professional may be just a rest stop on the way to the right provider and medication prescription, but it is movement in the right direction.

WHAT ARE SOME OF THE COMMON MEDICATIONS PRESCRIBED?

Anxiety: Clinical anxiety includes panic attacks, phobias, sleep disturbances, ruminating thoughts, heart palpitations, headaches, and chronic and intense worry that disrupt quality of life. Common medications prescribed for anxiety include Ativan (lorazepam), Xanax (alprazolam), Klonopin (clonazepam), Zoloft (sertraline), Luvox (fluvoxamine) and Paxil (paroxetine). Medications like Ativan, Xanax and Klonopin work quickly to address immediate symptoms, such as panic attacks or anxiety related to public speaking or air travel. There is an increased risk of developing tolerance to this class of drugs, and all students taking these medications should receive monthly follow-up and the medication plan should be re-evaluated after three or four months to determine whether or not continued use is warranted. Medications such as Zoloft, Luvox, and Paxil reach therapeutic serum levels (when the patient receives maximum benefit) in two weeks.

Depression: Although this is one of the most prevalent mental health issues, often thought of as the “common cold” of mental health, the presentation of the illness is multifaceted. Symptoms may include overwhelming sadness, anger, emotional disturbances, changes in sleep patterns to either little or extensive amounts of sleep, preoccupation with negative self-talk, and rumination. Commonly prescribed depression medications include serotonin-selective reuptake inhibitors (SSRIs) and serotonin-norepinephrine reuptake inhibitors (SNRIs) with a 60–70 percent response rate. These drugs include Prozac (fluoxetine), Celexa (citalopram), Lexapro (escitalopram), Paxil (paroxetine), and Zoloft (sertraline). These medications do not cause physiologic dependency problems and are also approved for the treatment of generalized anxiety disorder. It typically takes two weeks for patients to receive the maximum benefit of these medications. Patients who take SSRIs or SNRIs should be gradually weaned off these medications to avoid withdrawal symptoms. The abrupt discontinuation of this class of medications can lead to such symptoms on the first day without the medication.

Bipolar Disorder/Schizophrenia: Although there are several different ways bipolar disorder and schizophrenia can appear in individuals, the core symptoms include a high degree of cognitive disorganization, poor hygiene, loose connections to reality, bizarre behavioral presentation, delusions, hallucinations and, as the conditions progress, extended periods of low quality of life. Common medications include: Zyprexa (olanzapine), Seroquel (quetiapine), Risperdal (risperidone), Abilify (aripiprazole), Geodon (ziprasidone), and Clozaril (clozapine). Lamictal (lamotrigine) is a commonly prescribed first-line medication for bipolar disorder. Depakote (valproic acid) and benzodiazepines (such as clonazepam) are also used to treat acute mania from bipolar disorder. These medications can have more serious side effects and can take four to six weeks to take full effect.

ADHD: The diagnosis of Attention Deficit/Hyperactivity Disorder has increased drastically in the last decade. Symptoms include inattention to daily activities and non-interesting material, with hyper focus on highly visual and engaging material. Both ends of the attention spectrum include an overall lack of concentration, detail retention, and general recall. Common medications include: Adderall (amphetamine), Dexedrine (dextroamphetamine sulfate), Ritalin (methylphenidate), Strattera (atomoxetine) or Wellbutrin (bupropion). Adderall, Dexedrine, and Ritalin are stimulant medications and typically work quickly for patients. These medications also carry with them a higher risk of abuse. Medications like Strattera can take between one and four weeks to have an effect.

SHOULD PARENTS, FAMILY, OR PARTNERS BE TOLD?

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One of the most pressing concerns for student affairs administrators, aside from the misuse of prescription medication for suicide attempts, is that parents, spouses, or other family members might come forward after learning that their loved one has been prescribed a psychiatric medication without their knowledge or consent. While it is well understood that students who are over the age of 18 are able to make their own medical treatment decisions without parental permission, the idea of a college providing psychiatric medications to students raises concerns for many administrators given today’s highly litigious culture. Additionally, notifying a parent about prescribing psychiatric medication would not reach the necessary threshold to breach doctor-patient privilege, which could also lead to legal troubles for the prescriber and institution.

While there are certainly risks associated with prescribing psychiatric medications on campus, having clinical staff such as counselors, psychologists, and social workers treat significant mental health disorders such as major depression, bipolar disorder, and schizophrenia without medication also poses risks. The bigger cause for concern should be a student receiving less than the standard of care established for these types of diagnoses. Offering less than the ethical and expected standard of care can increase the risk for a malpractice lawsuit. Imagine the highly suicidal student being treated by outpatient therapy alone and then completing a suicide attempt. It would be reasonable for parents to ask why a medication or medication referral was not offered to the student. There is also a risk of clinicians working with un-medicated bipolar students, as they can also pose a threat for violence and unpredictable behavior when manic.

Ideally, clinical staff should seek appropriate support from family members and/or trusted individuals in a student-patient’s life, provided that they have permission to do so and that no contraindications exist to doing so. This is most significant when the severity of a mental health condition rises to the level of needing medication. For many of our traditional-aged college students, the group of support individuals includes parents. While there are some outlier cases where parental involvement would harm the client or be detrimental to care, these cases are few and far between.

FINAL THOUGHTS

The research is clear in supporting the use of medications for certain conditions, and a combination of counseling and medications leads to faster improvement in many cases. Thus, it’s vital that colleges and universities provide adequate resources to ensure that students have access to needed psychotherapeutic and psychopharmacological treatments. Offering students access to good care has not only been shown to improve academic performance and graduation rates, but can also prevent students from engaging in self-harming behavior and harm to others, as well as reduce the likelihood of litigation.

However, we must also explore the needs of special populations such as those with histories of drug abuse, which can complicate medication options in therapy. Online and distance students have a legal right to access your institution’s support services, so it is important to explore ways to address the gap between on-campus support options and the options available to remote students.

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As veterans continue enrolling in college at increasing rates, it’s also important that institutions be prepared for the issues with which they may present. Although only a small percentage of veterans suffer from clinically significant post-trauma stress disorder, higher numbers struggle with traumatic brain injury. Medication options and treatment

for PTSD and TBI can be new areas of practice for on-campus prescribing staff. In addition, it’s important to be aware that veterans may experience depression, military sexual trauma, and alcoholism or other substance abuse on top of PTSD and TBI, possibly requiring different medication and treatment options than a campus provider may be equipped to offer.

Finally, in a world where silos are all too common, we must make mention of the need for increased communication and information sharing among higher education counseling and health providers.

About one third of students who seek counseling on their college campus were already taking psychiatric medication when they arrived on campus. Thus, there is a clear need for counseling, health, and combined centers to be in constant communication about students who are being prescribed psychiatric medications. An interdisciplinary and interdepartmental approach to caring for this population is essential.

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ABOUT THE AUTHORS



Brian Van Brunt, Ed.D., is the Senior Executive Vice President for Professional Program Development with The NCHERM Group, LLC. He is a past-president of the American College Counseling Association (ACCA), the 2014–2015, President of NaBITA, and currently its Executive Director. He also serves as Managing Editor of *The Journal of Campus Behavioral Intervention (J-BIT)*, *The Journal of Campus Title IX Compliance and Best Practices (Campus IX)*, and *Student Affairs eNews (SAeN)*. He has a doctoral degree in counseling supervision and education from the University of Sarasota/Argosy and a master's degree in counseling and psychological services from Salem State University. He has served as the director of counseling at New England College and Western Kentucky University. He is the author of several books, including *Harm to Others: The Assessment and Treatment of Dangerousness*, *Ending Campus Violence: New Approaches in Prevention*, and *A Faculty Guide to Addressing Disruptive and Dangerous Behavior in the Classroom*. He recently developed the Structured Interview for Violence Risk Assessment (SIVRA-35), a starting place for law enforcement, clinical staff, and administrators to conduct a more standardized, research-based violence risk assessment with individuals determined to be at an increased risk.



Josh E. Gunn, Ph.D., is the Executive Director of Counseling and Psychological Services at Kennesaw State University, where he oversees the counseling centers for two separate campuses. He is a licensed psychologist and Past-President of the American College Counseling Association. He also serves on the Advisory Board of NaBITA, the National Behavioral Intervention Team Association, and is a frequent conference presenter on a myriad of issues related to campus mental health, college student development, psychological testing, and training and supervision. In addition, he serves on the Editorial Board of *The Journal of Campus Behavioral Intervention (J-BIT)*, NaBITA's flagship, peer-reviewed academic journal.



Vanessa Pomarico-Denino, MSN, APRN, FNP-BC, FAANP is employed by Northeast Medical Group as a nurse practitioner, where she specializes in internal medicine, with a special interest in women's health and transgender healthcare. She is also the interim director of the Family Nurse Practitioner track at Southern Connecticut State University's Department of Nursing; a courtesy faculty and guest lecturer for the Yale University and Fairfield University Schools of Nursing, as well as for the Quinnipiac University and University of Bridgeport Physician Assistant Programs. The recipient of the 2014 American Association of Nurse Practitioners Excellence Award and 2015 recipient of the Nightingale Award for nursing excellence, she is also the co-author of two textbooks, and a contributing author of *Focus on Adult Health Nursing*. She co-owns NP Business Consultants, LLC., and is the immediate past-president of the Connecticut Advanced Practice Registered Nurse Society.



Mary-Jeanne Raleigh, Ph.D., LPC, LMHC, NCC, is the Director of Counseling and Psychological Services at the University of North Carolina, Pembroke. She previously served as Director of Counseling Services at St. Mary's College of Maryland. With nearly 30 years of experience in counseling, she has led college counseling centers for more than 20 years. Raleigh has also served in other areas of student affairs and worked in private practice. She has taught at Antioch University, Johns Hopkins University, and New England College. She is a Past-President of the American College Counseling Association, she sits on the Council for the Advancement of Standards in Higher Education's Board of Directors. She is the recipient of the American College Counseling Association's Presidential Honor and Outstanding Professional Leadership Award.

ABOUT NaBITA



NaBITA, the National Behavioral Intervention Team Association, is an organization dedicated to the support and professional development of campus Behavioral Intervention Team members. NaBITA is committed to providing education, resources and support to professionals in schools and in the workplace who endeavor every day to make their campuses and workplaces safer through caring prevention and inter-

vention. For more information, please visit www.nabita.org.

ABOUT ACCA



The American College Counseling Association is made up of diverse mental health professionals from the fields of counseling, psychology, and social work. Our common theme is working within higher education settings. ACCA strives to support and enhance the practice of college counseling, to promote ethical and responsible professional practice, to promote communication and exchange among college counselors across service areas and institutional set-

tings, to encourage cooperation with other organizations related to higher education and college student development, and to provide leadership and advocacy for the profession of counseling in higher education. The American College Counseling Association is a division of the American Counseling Association.