

Psychiatric Concerns in a College Population

During this session, the participant will identify the psychiatric illnesses prevalent in the college aged population; understand the challenges in treatment, and become familiar with basic psychiatric medications and algorithms.

TOPIC RELEVANCE

- In contrast to many health and medical issues, psychiatric illnesses are often already present or have peak incidence in the young adult population. This presents a challenge for Student Health Centers in that it often serves as both a vehicle for prevention and education, as well as treatment. There is much data to support the accurate diagnosis and initial treatment of psychiatric patients in order to impart effective strategies to decrease overall morbidity and improve prognosis.

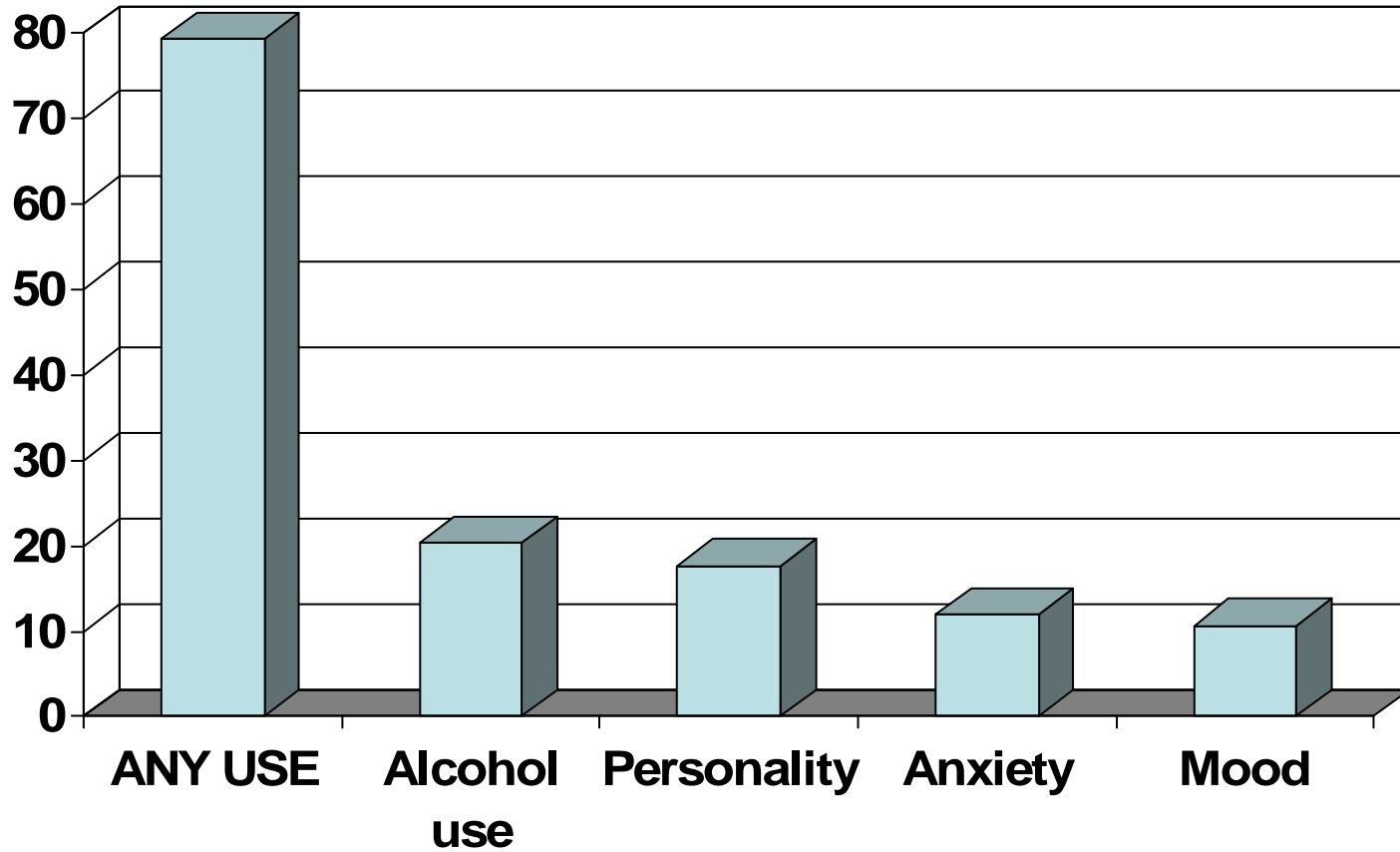
Prevalence

- Mental disorders are common in the United States and internationally. An estimated 26.2 percent of Americans ages 18 and older — about one in four adults — suffer from a diagnosable mental disorder in a given year.
- 2006 Nat'l Survey of Counseling Center Directors 92% believe increase students with severe psychological problems

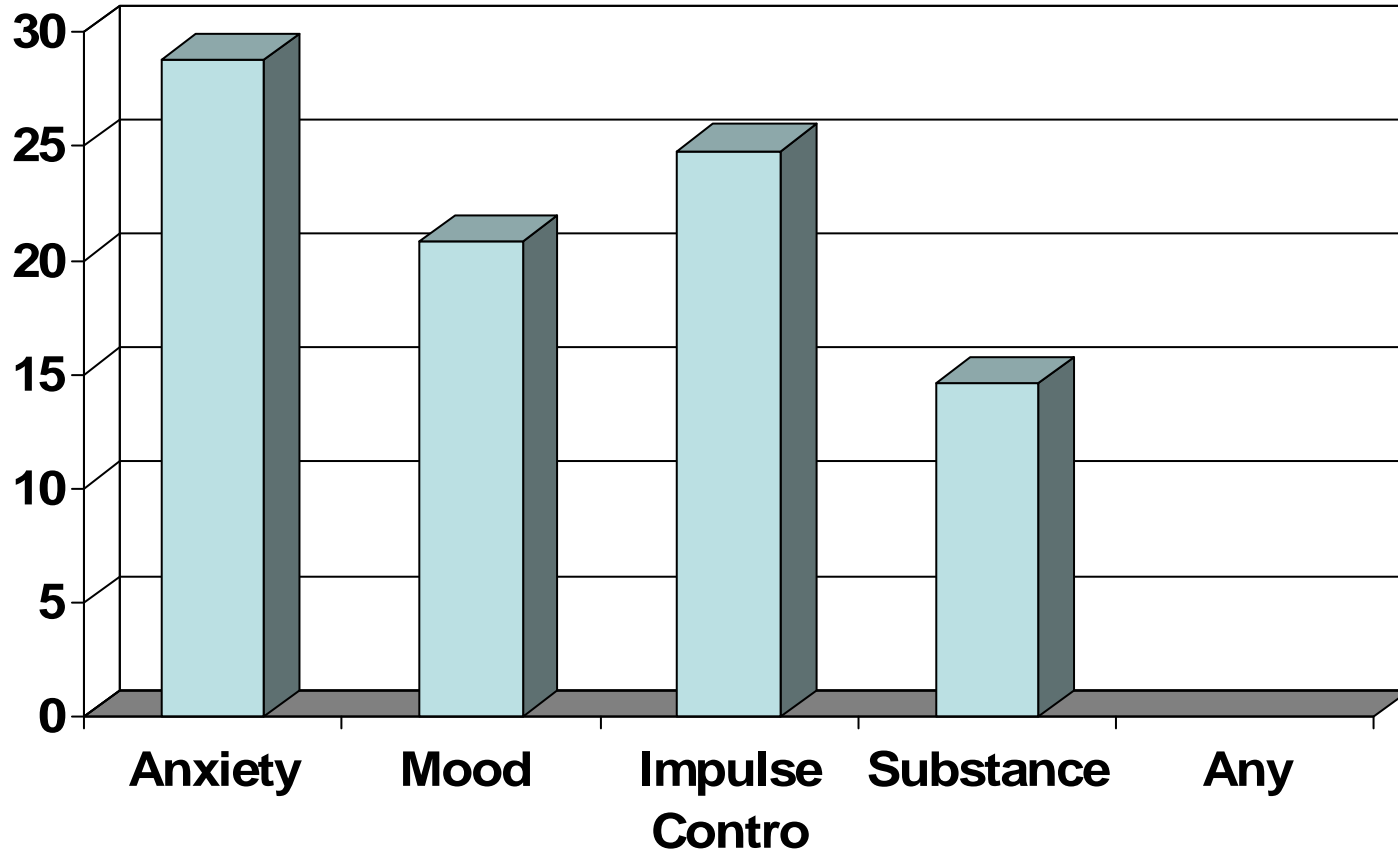
Prevalence

- One Sick Prognosis
- OP-ED in the Washington Times on January 7, 2009 in response to the Archives of General Psychiatry December 2008
- “I have had more than 300 students a year in my classes, and in the past five years I have had no more than two or three disruptive or even badly behaving ones. More than one percent of students’ severe psychological problems would surely reveal themselves in classes from time to time.”

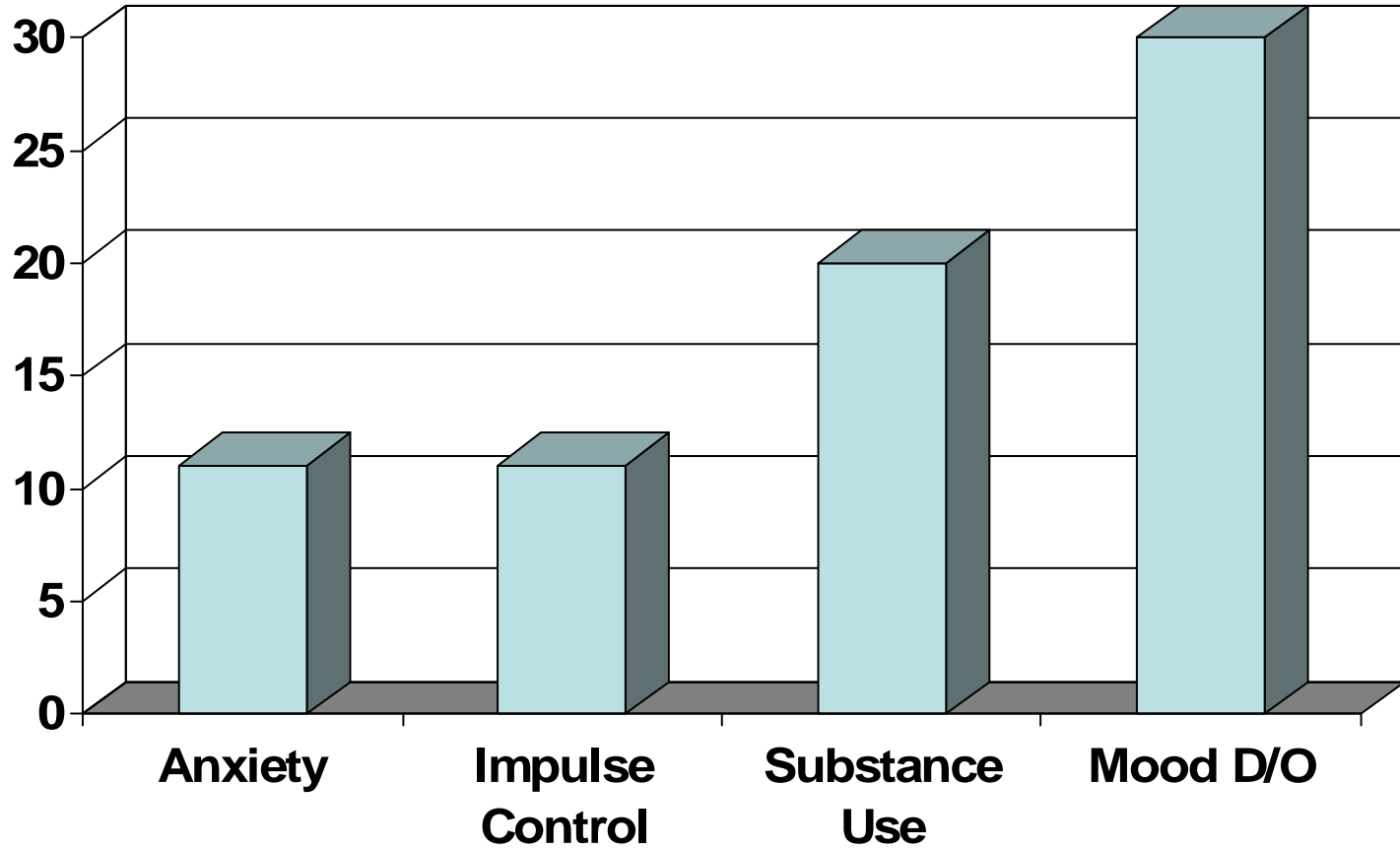
Prevalence: NESARC



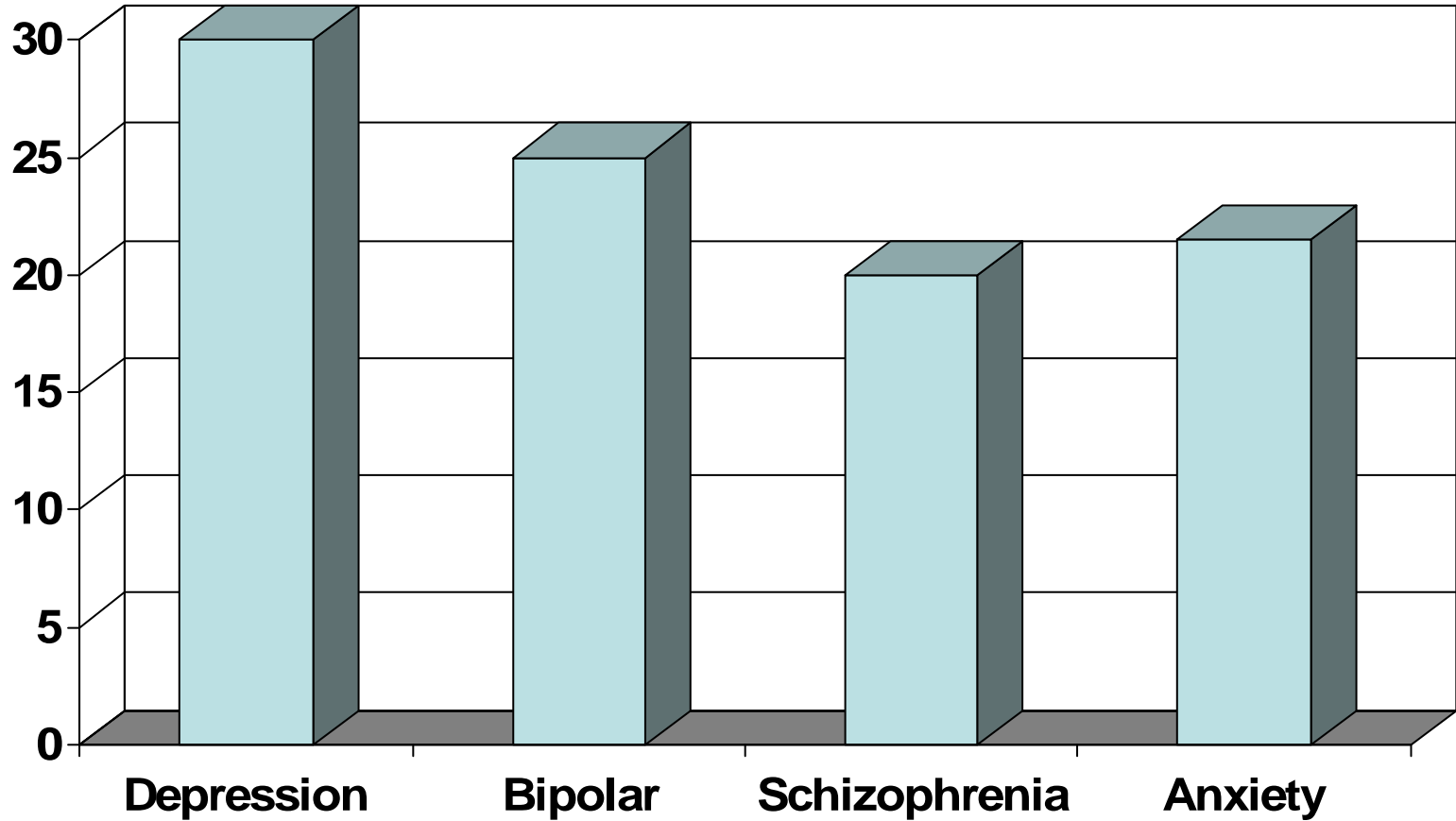
Lifetime Prevalence



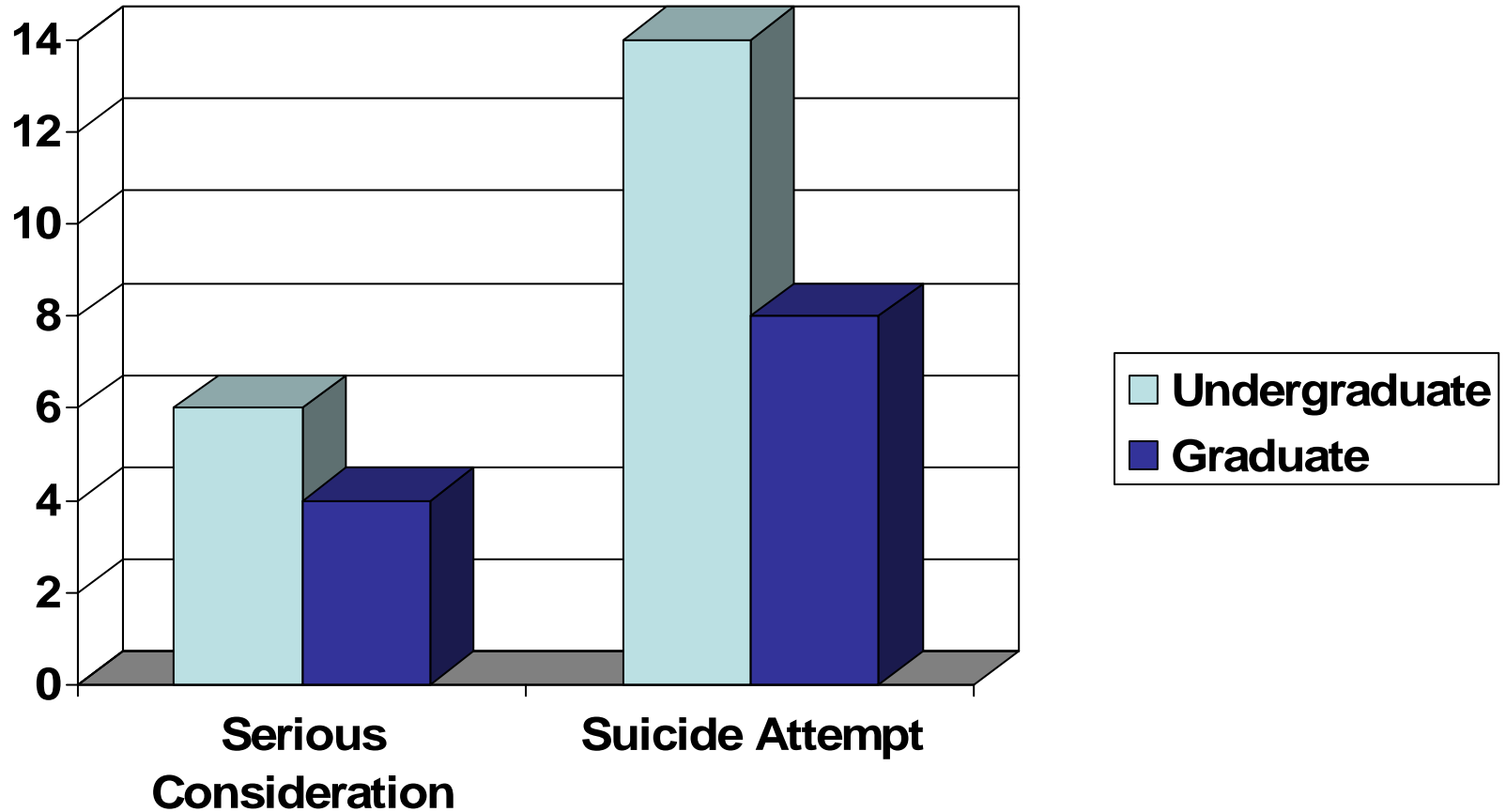
Age of Onset



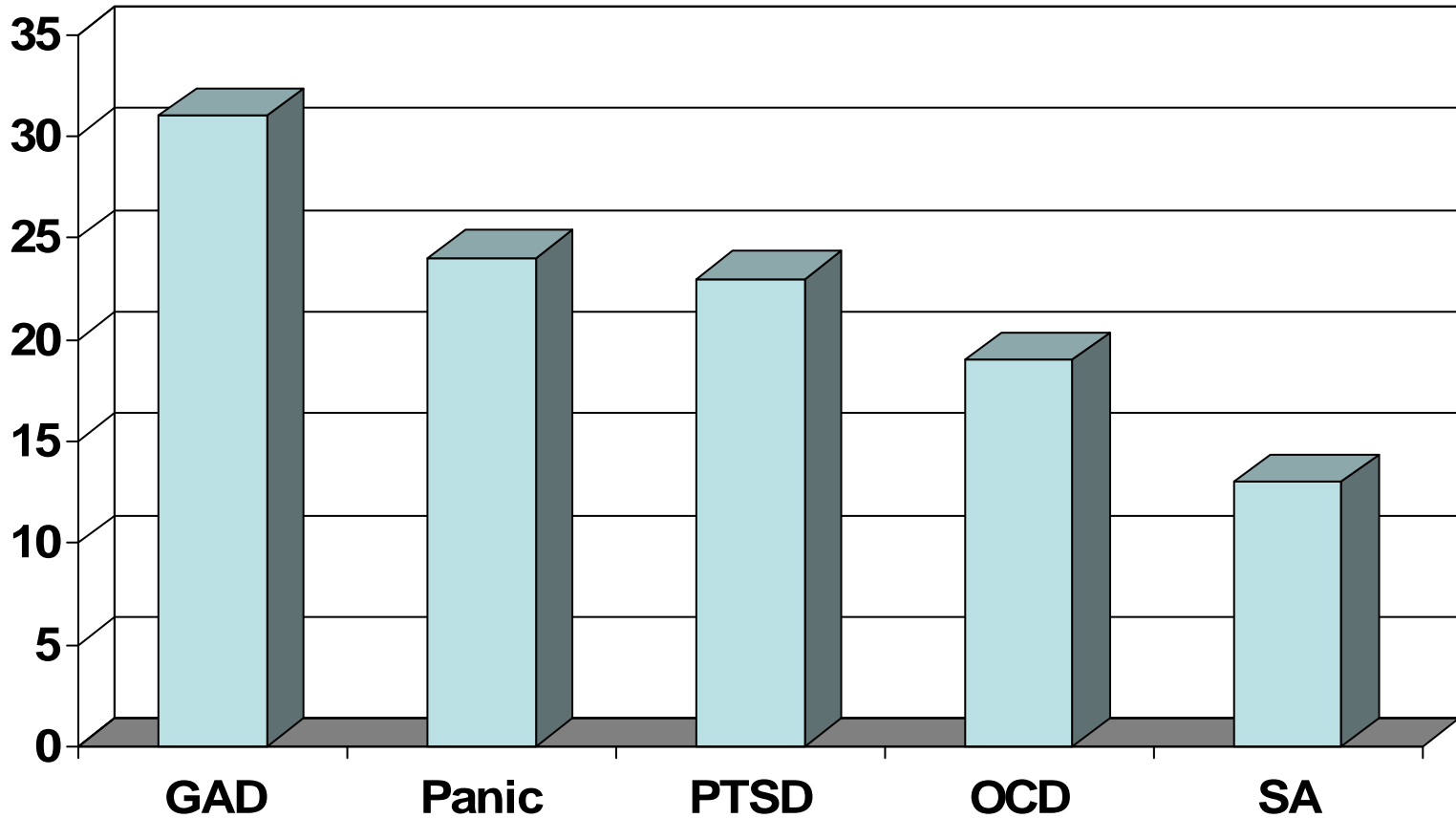
Age of Onset: Median Age



Suicide in College Students



Age of Onset: Anxiety Disorders



Eating Disorders: Anorexia

- Anorexia: pre-teen to early/middle adolescence
- 90% women
- UK database: 4/100,000
- European data 0.2-0.7% prevalence
- ED frequently preceded by anxiety disorders

Eating Disorders: Anorexia

- The mortality rate among people with anorexia has been estimated at 0.56 percent per year, or approximately 5.6 percent per decade, which is about 12 times higher than the annual death rate due to all causes of death among females ages 15-24 in the general population.
- Prognosis: 51 teenage onset have 27% continued ED and 50% “poor” psychosocial functioning
- Favorable prognosis: minimizing onset to treatment time and early age of onset

Eating Disorders: Bulimia

- Bulimia: Late adolescence to early adulthood
- Up to 1% women
- 9:1 female: male
- 20-30% college women
- Prognosis: 10 years
 - 50% full recovery
 - 33% partial
 - 10% still have symptoms

Alcohol and College Students

- Hasin 2003 shows hazard rate for onset of alcohol use disorders peaks at age 19 years and becomes much lower in the following years.
- One half of individuals with alcohol use disorders at age 19 years continue to have these disorders at age 25 years (Sher 1999, Rohde 2001)

Treatment Challenges

- College milieu and accessibility
- Individual
- Making a diagnosis
- Access
- Institutional factors

Treatment Challenges: Diagnosis

“In psychiatry, history is everything.”

ADD/ADHD

Bipolar

Psychosis

Depression

ED

Anxiety

Depression-Unipolar or Bipolar

- Lasting sad, anxious, or empty mood
- Feelings of hopelessness or pessimism
- Feelings of guilt, worthlessness, or helplessness
- Loss of interest or pleasure in activities once enjoyed, including sex
- Decreased energy, a feeling of fatigue or of being “slowed down”
- Difficulty concentrating, remembering, making decisions
- Restlessness or irritability
- Sleeping too much, or can’t sleep
- Change in appetite and/or unintended weight loss or gain
- Chronic pain or other persistent bodily symptoms that are not caused by physical illness or injury
- Thoughts of death or suicide, or suicide attempts
- A depressive episode is diagnosed if five or more of these symptoms last most of the day, nearly every day, for a period of 2 weeks or longer.

Bipolar-Mania

- Increased energy, activity, and restlessness
- Excessively “high,” overly good, euphoric mood
- Extreme irritability
- Racing thoughts and talking very fast, jumping from one idea to another
- Distractibility, can’t concentrate well
- Little sleep needed
- Unrealistic beliefs in one’s abilities and powers
- Poor judgment
- Spending sprees
- A lasting period of behavior that is different from usual
- Increased sexual drive
- Abuse of drugs, particularly cocaine, alcohol, and sleeping medications
- Provocative, intrusive, or aggressive behavior
- Denial that anything is wrong

ADD/ADHD

- ADHD, one of the most common mental disorders in children and adolescents, also affects an estimated 4.1 percent of adults, ages 18-44, in a given year.
- ADHD usually becomes evident in preschool or early elementary years. The median age of onset of ADHD is seven years, although the disorder can persist into adolescence and occasionally into adulthood.

ADD/ADHD: NIMH guidelines

- **How is ADHD diagnosed?**
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- Children mature at different rates and have different personalities, temperaments, and energy levels. Most children get distracted, act impulsively, and struggle to concentrate at one time or another. Sometimes, these normal factors may be mistaken for ADHD. ADHD symptoms usually appear early in life, often between the ages of 3 and 6, and because symptoms vary from person to person, the disorder can be hard to diagnose. Parents may first notice that their child loses interest in things sooner than other children, or seems constantly "out of control." Often, teachers notice the symptoms first, when a child has trouble following rules, or frequently "spaces out" in the classroom or on the playground.
- No single test can diagnose a child as having ADHD. Instead, a licensed health professional needs to gather information about the child, and his or her behavior and environment. A family may want to first talk with the child's pediatrician. Some pediatricians can assess the child themselves, but many will refer the family to a mental health specialist with experience in childhood mental disorders such as ADHD. The pediatrician or mental health specialist will first try to rule out other possibilities for the symptoms. For example, certain situations, events, or health conditions may cause temporary behaviors in a child that seem like ADHD.
- Between them, the referring pediatrician and specialist will determine if a child:
 - Is experiencing undetected seizures that could be associated with other medical conditions
 - Has a middle ear infection that is causing hearing problems
 - Has any undetected hearing or vision problems
 - Has any medical problems that affect thinking and behavior
 - Has any learning disabilities
 - Has anxiety or depression, or other psychiatric problems that might cause ADHD-like symptoms
 - Has been affected by a significant and sudden change, such as the death of a family member, a divorce, or parent's job loss.
- A specialist will also check school and medical records for clues, to see if the child's home or school settings appear unusually stressful or disrupted, and gather information from the child's parents and teachers. Coaches, babysitters, and other adults who know the child well also may be consulted.
- The specialist also will ask:
 - Are the behaviors excessive and long-term, and do they affect all aspects of the child's life?
 - Do they happen more often in this child compared with the child's peers?
 - Are the behaviors a continuous problem or a response to a temporary situation?
 - Do the behaviors occur in several settings or only in one place, such as the playground, classroom, or home?
- The specialist pays close attention to the child's behavior during different situations. Some situations are highly structured, some have less structure. Others would require the child to keep paying attention. Most children with ADHD are better able to control their behaviors in situations where they are getting individual attention and when they are free to focus on enjoyable activities. These types of situations are less important in the assessment. A child also may be evaluated to see how he or she acts in social situations, and may be given tests of intellectual ability and academic achievement to see if he or she has a learning disability.
- Finally, if after gathering all this information the child meets the criteria for ADHD, he or she will be diagnosed with the disorder.

Treatment Challenges: Diagnosis and Prescription Overuse

- ADHD prevalence 3%-8% school age children
- Dawson (1999) 10% students on meds
- Angold (2000)
 - 3.4% met criteria but 7.3% received prescription
- Kube (2002) 43% met criteria for a final diagnosis

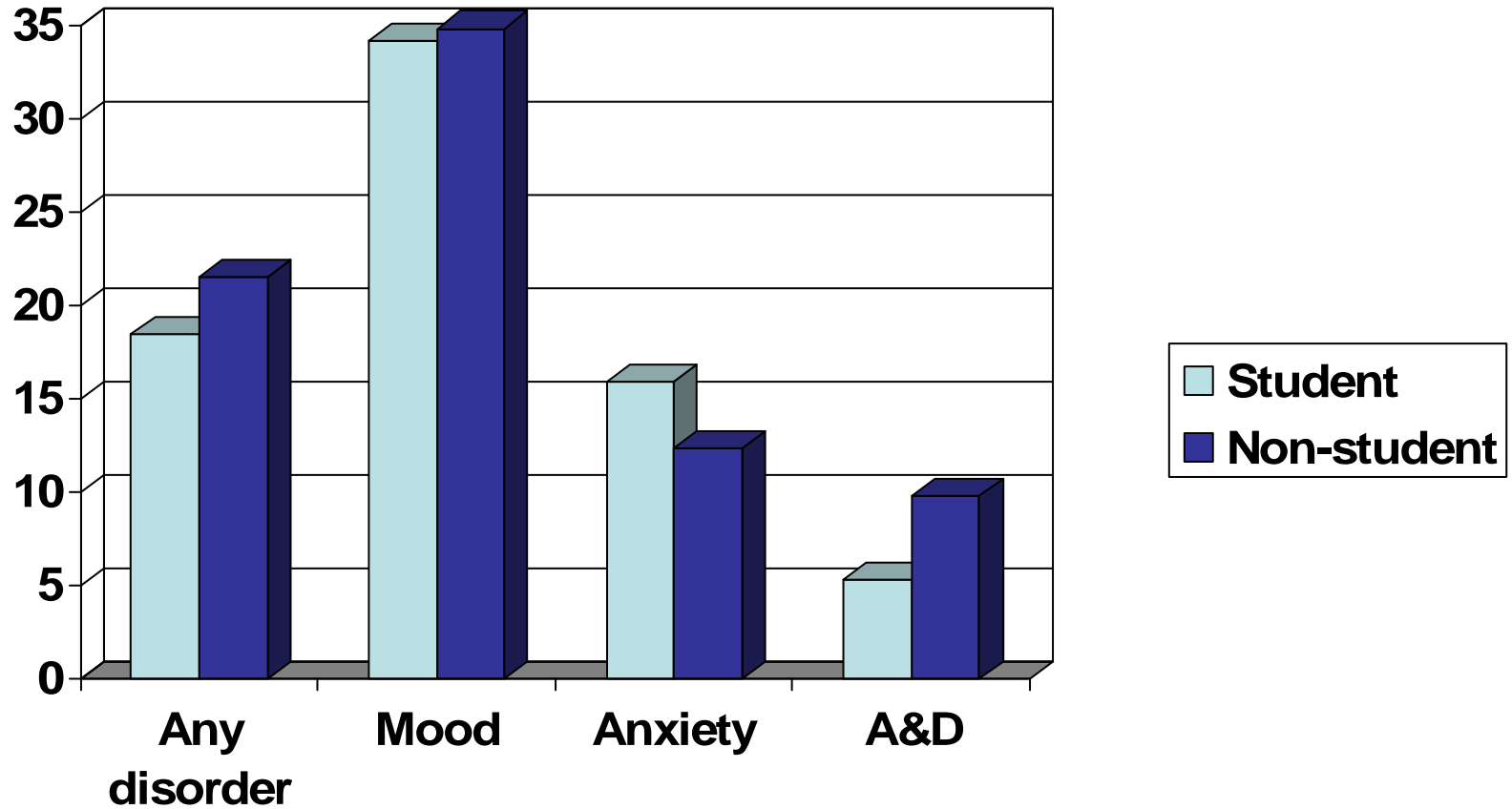
Alcohol use in College Students

- Higher rates of sexual assault
- Vehicle usage
 - 13% drove
 - 23% rode with intoxicated driver
- 25% acknowledged alcohol as a problem
- Fraternity and sorority membership increased the risk in freshman
- 48% drink to get drunk

Alcohol use in College Students

- Binge drinking defined as >5 for men and >4 for women
- 44% reported binge drinking
- Associated with missing class, falling behind in schoolwork, less studying and lower grades
- More likely to have legal involvement and engage in unprotected sexual activity

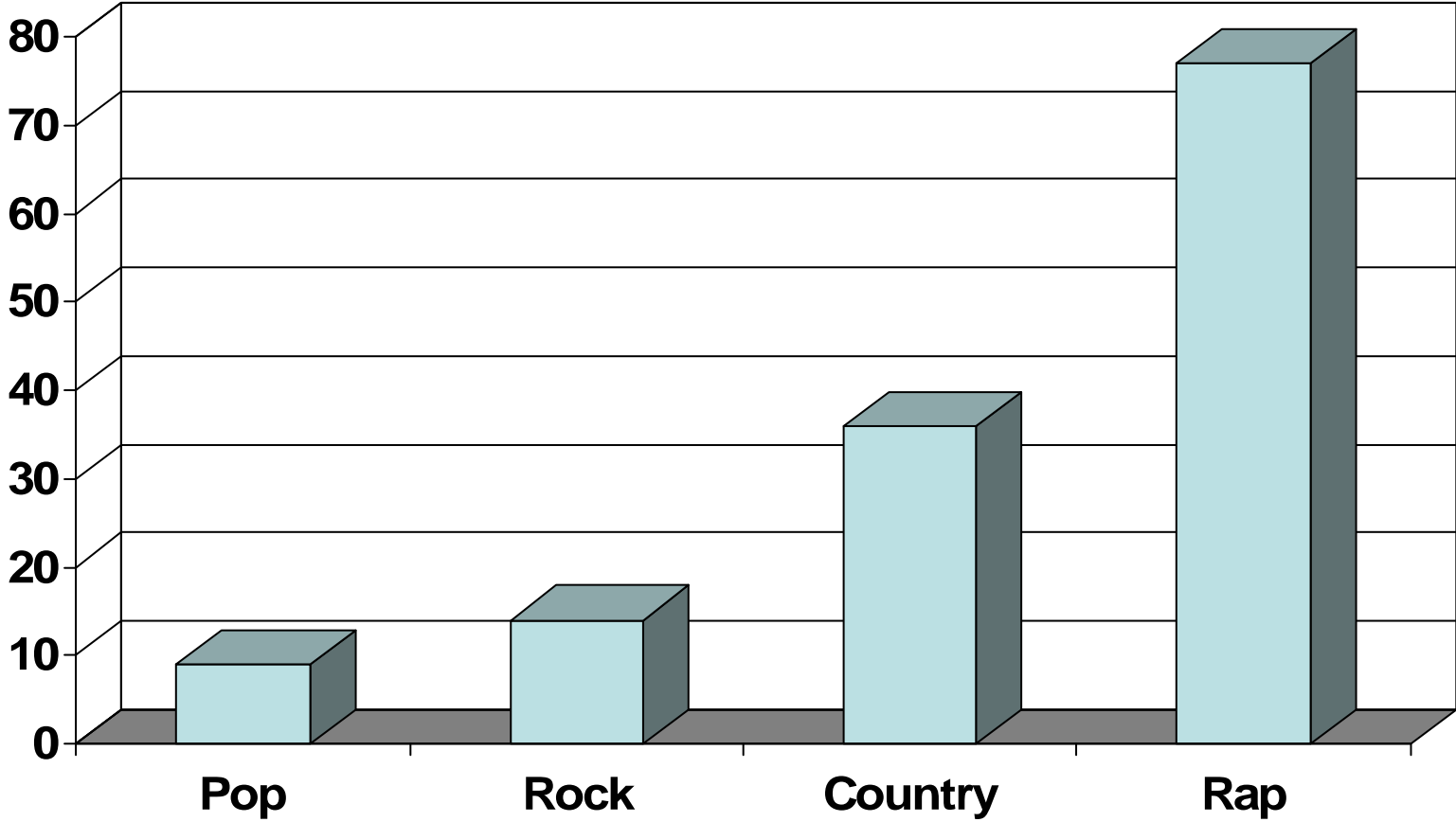
Mental Health Treatment



Treatment Challenges

- 2001-2002 Nat'l Epidemiologic Survey of Alcohol...
- 20% Alcohol use disorder (abuse/dependence)
- 18% Personality disorders
- Less likely to have drug use than peers
- Less likely to receive treatment than peers

Treatment Challenges: The Milieu



Treatment Challenges: Drug Use

- “Adolescence is the stage during development that the brain is more susceptible to the deleterious effects of repeated drug use.”
- Alcohol and tobacco use in teens confer a greater risk of other substance use later in life

Treatment Challenges: Student

- Stigma of seeking psychiatric care
- Prescription from “home” doctor
- Immaturity
- Alcohol/drug access
- Diversion
- Lack of family awareness of status of student and recognition of “problem”

Treatment Challenges: Student

- About half drink before entering college
- Membership in Greek system
- Belief that friends drink, Drink to “fit in”,
Low cost, Attending a high binge drinking college
- Highest rate associated with living off campus or in Greek housing

Treatment Challenges: Institution

- CAS revealed variation in binge drinking 1%-76%
- Higher in NE and Northcentral
- Lowest in Western
- Residential setting, low price, high density of alcohol outlets
- “Wet environment”

Treatment Challenges: Institutions

- Residential vs. Non residential
- Counseling Centers with trained personnel
- Specialized training for academic faculty
- Chronic VS. acute treatment provision
- Training for housing/residential advisors
- Health/fitness center education
- Competing or conflicting administrative policies

Treatment Challenges: Access

- Mental health professionals:
 - Psychiatrists, psychologists, social workers, A/D specialists
- General practice/IM/Peds/Family medicine
- ER facilities
- Screenings
- Coordination with other entities within a university—housing, wellness, academic deans, etc

Treatment Challenges: Provider

- Non-specialist vs. specialist
- Lack of ER appointments or assessment issues
- Inadequate resources for assistance with diagnosis (psychological testing, labs, etc.)
- HIPPA/confidentiality
- Corroborative information
- Treatment contract for controlled substances
- Lack of support for psychotherapeutic frame

Prescription Overuse and Diversion

- 1993= 3 million prescriptions
- 1996=10 million prescriptions
- Stimulants (MPH) rank in top 10 most frequently stolen
- DEA reports equal to morphine
- Wilens (2006) report immediate release MPH most often diverted (83%) and misused (75%)

ED: Treatment Challenges

- Medical complications
- Lack of multidisciplinary team
- Reluctance to seek help
- Chronic illness
- Medication response
- Psychotherapy
- Family involvement

Psychiatric Medications and Algorithms

- Bipolar Disorder
- Depression
- Schizophrenia
- Anxiety
- ED
- Alcohol and Drug

NIMH-Funded Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD)

- STEP-BD is the largest, federally-funded treatment study ever conducted for bipolar disorder.
- It is a long-term outpatient study that enrolled 4,360 participants from 22 sites over seven years (1998 to 2005).
- Evaluated q 3-6 months up to 5 years

STEP-BD conclusions

Bipolar is a highly recurring, chronic illness,
predominated by depressive episodes

Recurrence is related to residual symptoms
and other psychiatric comorbidities

Family involvement beneficial

Antidepressants not helpful for depressive
episodes

Sequence Treatment Alternatives to Relieve Depression STAR*D

- An overall assessment of the nation's largest real-world study of treatment-resistant depression suggests that a patient with persistent depression can get well after trying several treatment strategies, but his or her odds of beating the depression diminish as additional treatment strategies are needed.

STAR*D

- 25% suffer a chronic course
- 75% recurrent course
- Significant treatment resistance
- Anxious features in 46%
 - Older, unemployed, less educated, suicidal, greater severity, greater comorbidity
 - Atypical or melancholic
 - Substantial treatment attrition

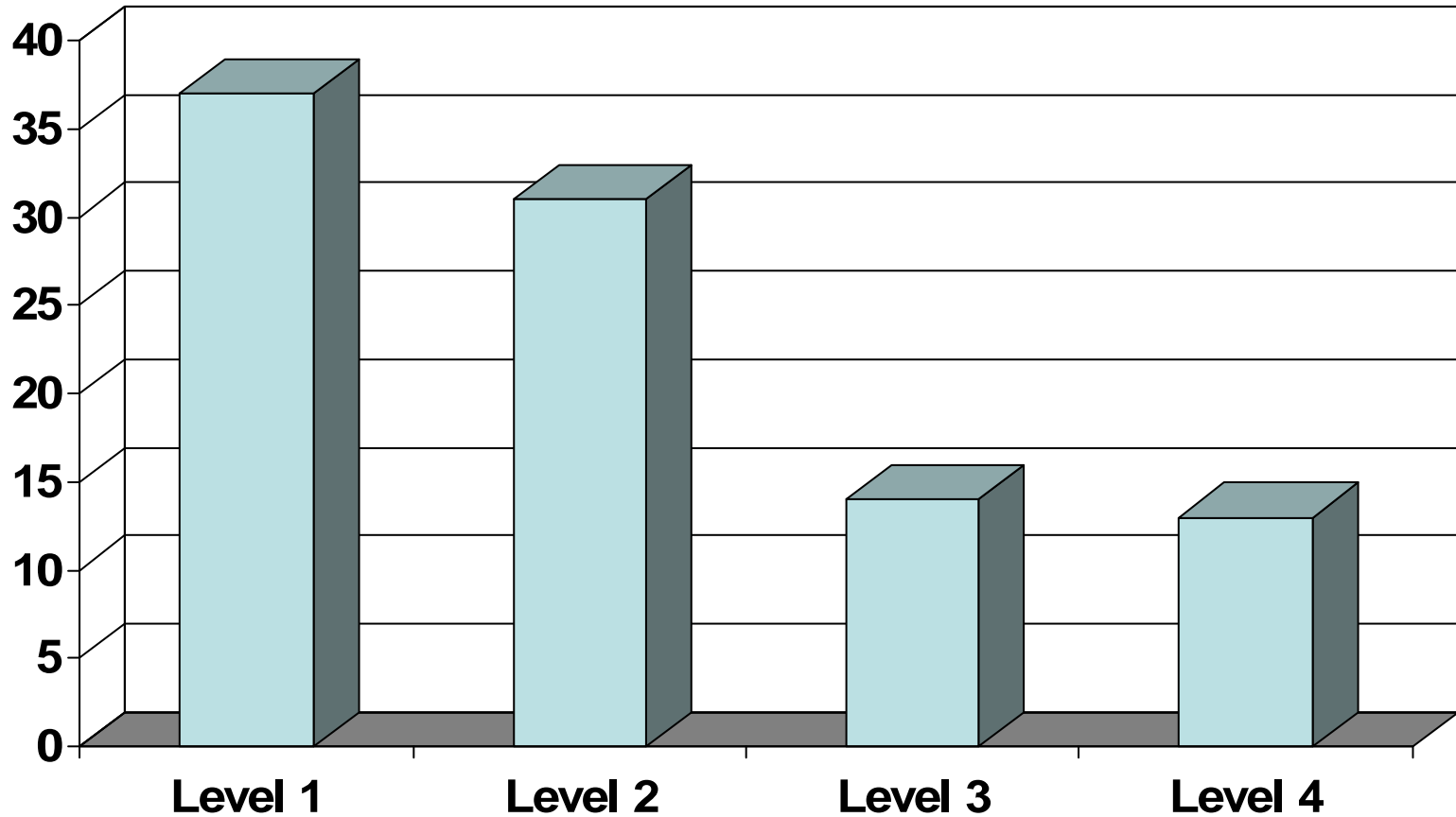
STAR*D

- the study enrolled 4,041 outpatients, ages 18-75 years
- Level 1: Citalopram x 12-14 weeks
- Level 2: SWITCH: Bupropion, Venlafaxine or Sertraline
- Level 2: ADD ON: Bupropion, Buspar or CBT

STAR*D con't

- Level 3: Switch to Mirtazapine or Nortriptyline
- Level 3: Add on Lithium or T3
- Level 4: D/C all meds
 - Mirtazapine and Venlafaxine
 - MAOI

STAR*D: Remission Rates



STAR*D

- Remission until 8 weeks or longer
- 4 weeks at maximally tolerated dose
- 37% remitted with initial treatment
- Realistic treatment expectations
- Anticipate non-compliance

CATIE

- A new study analyzing the economic implications of the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) concludes that the older (first generation) antipsychotic medication perphenazine was less expensive and no less effective than the newer (second generation) medications used in the trial during initial treatment, suggesting that older antipsychotics still have a role in treating schizophrenia. The study, published in the *American Journal of Psychiatry* on December 1, 2006, was funded by the National Institutes of Health's National Institute of Mental Health (NIMH).

CATIE

- Patients were randomly assigned to receive one of the five medications. The patients started on olanzapine were less likely to be hospitalized for a psychotic relapse and tended to stay on the medication longer than patients taking other medications. However, patients on olanzapine also experienced substantially more weight gain and metabolic changes associated with an increased risk of diabetes than those participants taking the other drugs.
- Contrary to expectations, movement side effects (rigidity, stiff movements, tremor, and muscle restlessness) primarily associated with the older medications were not seen more frequently with perphenazine than with the newer drugs

Treatment: Anxiety

- Specific Diagnosis
- Antidepressants: Tricyclic/SSRI/SNRI
- Buspar
- Anxiolytics
- AED's
- Antihistamines/B blockers/antipsychotics
- psychotherapy

Treatment: ED

- Specific type of ED
- Treat in team approach
- Antidepressants
- AED's
- Anxiolytics
- Antipsychotics

Treatment: ADD

- Stimulants
- SSRI or other antidepressants
- Strattera
- Treatment contract
- Clonidine

Treatment: Drug and Alcohol

- Specialized treatment
- Abstinence
- Detering medications: antabuse, naltrexone, acamprosate, etc.
- High emphasis on “being in recovery”
- Identify comorbidities

One Sick Prognosis

- OP ed
- “Those of us who have dealt with young people in colleges and universities for decades know that two of the most important values to teach students are
 - 1) the avoidance of dependency and
 - 2) the assumption of responsibility”