



Substance Use Screening and Assessment in Campus Health Care

Tips for Clinical Professionals
Working with Young Adult Students

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About the Maryland Collaborative to Reduce College Drinking and Related Problems

The Maryland Collaborative to Reduce College Drinking and Related Problems began in 2012 with funding from the Maryland Department of Health. Its purpose is to bring together Maryland colleges and universities toward a shared goal—to reduce excessive drinking among college students, by creating environments that support student and community health, safety, and success. More information about the Maryland Collaborative can be found at www.marylandcollaborative.org.

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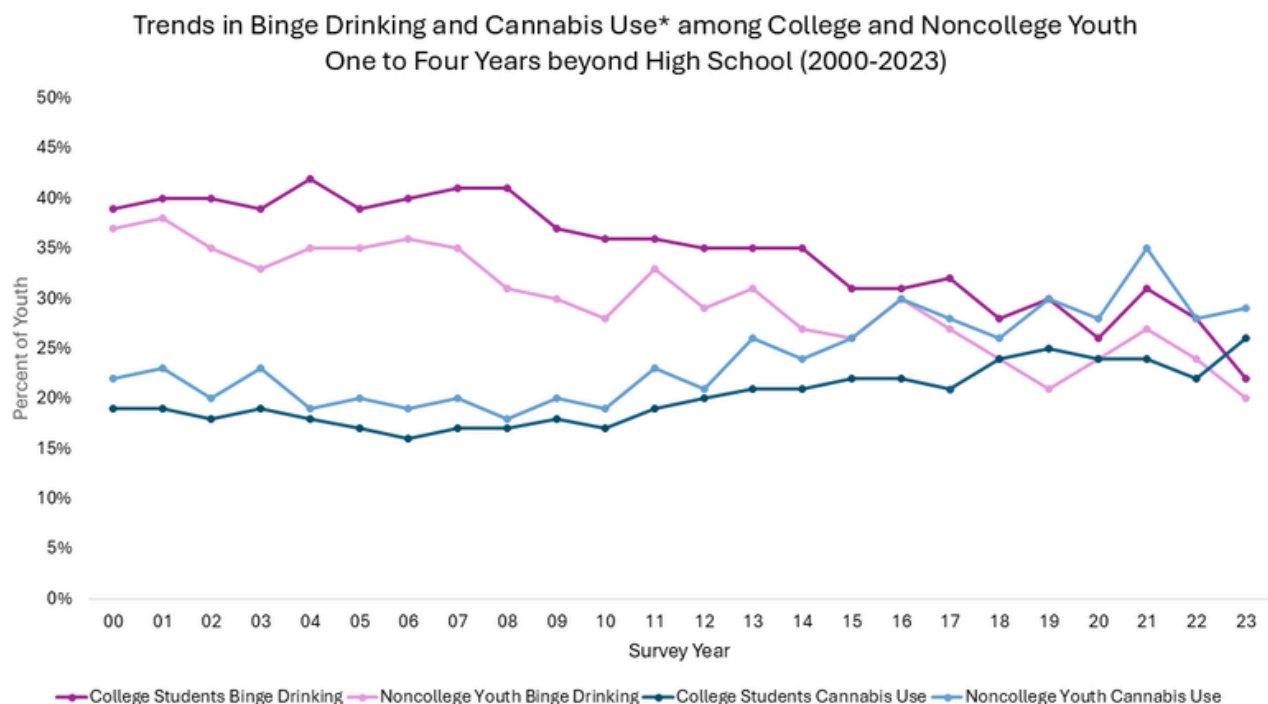


THE MARYLAND COLLABORATIVE
TO REDUCE COLLEGE DRINKING AND RELATED PROBLEMS

WHY DOES THIS GUIDANCE MATTER?

Depression, anxiety, and suicidal thoughts and behaviors have been increasing among young persons in the US,¹ and college students in particular.² Although the reasons underlying the rise in mental health concerns are unclear, social media use,³ academic pressure,⁴ and loneliness^{5,6} are all potential contributors.⁷ On the positive side, increased awareness and lower stigma might be encouraging young people to seek care.⁸

A variety of common mental health issues affect young adults, including sleep disturbances, adjustment and identity issues, loneliness, and emotional regulation. Discerning what is a “normal” developmental issue from something that might require more careful attention is difficult for clinicians. Even subclinical issues can negatively impact academic success, relationships with peers and family members, and quality of life. **Substance use, including alcohol consumption and cannabis use, can affect mental health symptoms, as well as exacerbate or precipitate more serious mental health conditions.**^{9,10} For example, even low-frequency cannabis use is associated with an elevated risk for developing schizophrenia among adolescents and young adults.¹¹ Research clearly demonstrates that young adulthood is the peak developmental period for the onset of excessive drinking and other forms of substance use.^{12,13} Substance use is associated with several negative outcomes for college students including worsening academic performance, discontinuous enrollment, post-college unemployment, suicide risk, and mental health service utilization.¹⁴⁻¹⁸



Patrick, M. E., Miech, R. A., Johnston, L. D., & O'Malley, P. M. (2024). Monitoring the Future Panel Study annual report: National data on substance use among adults ages 19 to 65, 1976-2023. Monitoring the Future Monograph Series. Ann Arbor, MI: Institute for Social Research, University of Michigan. Available at: <https://monitoringthefuture.org/results/annual-reports/>

The use of substances other than cannabis has been declining among college students, but several substances are important to note for clinicians caring for college students. College students have a higher prevalence of excessive drinking than young adults who are not in college. Cannabis use has been rapidly increasing among young adults, regardless of college enrollment. Not shown here are trends in nonmedical use of prescription stimulants, which are used by a higher proportion of college students than same-aged persons not in college.¹⁹

WHO IS THIS GUIDANCE FOR?

This guidance document aims to assist a wide variety of clinical professionals in their ability to carefully assess how substance use might be related to the variety of presenting problems of young adult patients in the college context, and how to begin to address co-existing substance use.

Learning how to evaluate substance use, identify problematic substance use behaviors or disorders, and manage them is becoming an increasingly important part of a healthcare professional's responsibilities. Unfortunately, substance use topics are often underemphasized and the educational content and clinical experiences are often limited outside of specialty training.²⁰⁻²³ For those who have training, the multiple clinical topics that need to be addressed in clinical encounters might limit the time they have to discuss substance use. Yet, substance use can critically affect a students' overall health and well-being, making the identification and management of problematic substance use an essential skill for clinicians.

Healthcare professionals on college campuses, including licensed counselors, psychiatrists, primary clinicians, health promotion professionals, occupational therapists, etc., interact with students in different contexts. Learning how to assess, identify, and discuss problematic substance use aligns around the shared common goal of improving student health and well-being. Below are examples of how a few of these professionals' responsibilities might intersect with student substance use.

Psychiatrists Caring for Young Adults Attending College

Nearly half of students who receive mental healthcare are seeing a professional in their hometown.²⁴ Receipt of care from a distance risks losing the security of regular, close evaluations and medication adjustments from a psychiatric professional (who can be trained either as a medical doctor or as a nurse practitioner). Long distances from primary practitioners becomes particularly problematic when the stressors of college (e.g., changes in social supports, newfound independence, increased academic pressure) provoke an exacerbation of mental illness that would require careful management from a psychiatric provider.

College campus service providers should encourage students and their families to discuss care options before such situations arise. Psychiatrists who work on college campuses have an important role in diagnosing and treating mental health conditions on their campuses. Between 2007 and 2019, the proportion of students using of anti-depressants, mood stabilizers, and anti-anxiety medications roughly doubled, while the proportion using psychostimulants tripled.²⁵ Substance use can often result in symptoms (such as poor attention) that might be mistaken for other psychiatric illnesses (such as ADHD) or exacerbate symptoms of an actual comorbid mental illness (such as bipolar disorder, see Table 1).

Primary Care Clinicians Working in University Health Centers

Those working in campus primary care clinics have a variety of disciplinary trainings (medical doctor, nurse practitioner, physician assistant, etc.) and see a variety of health conditions among the students who use these services. There are several reasons why primary care clinicians play an integral role in assessing substance use behaviors. One is the frequency of these behaviors among students visiting college clinics. Data from a consortium of universities showed that mental health concerns were one of the top five most frequent diagnoses on student health center visits, and that among those mental health visits, nearly 20% were for problems related to drug or alcohol use.²⁶ Most mental illnesses have their onset by young adulthood,^{27,28} making the role of primary care clinicians indispensable in the recognition of mental health concerns, including substance use. Even when the primary concern is not directly related to substance use, it is still important to assess how substance use might play a role. For example, problems with sleep, sexual health, gastrointestinal concerns, or cardiovascular problems might all have a relationship to underlying substance use.

University Counseling Center

Licensed counselors who often meet with patients in the context of therapy sessions might notice that a variety of mental health symptoms, such as sleep problems, social anxiety, or adjustment issues, can be related to substance use in complex ways. For example, a first-year student with social anxiety, difficulty making friends, and loneliness might try to ‘blend in’ and make connections by going out to party and drink heavily. Such a student is vulnerable to peer influences, even when those influences do not promote their academic goals or are not consistent with their substance use or socialization habits prior to college. Evaluating the student’s complex motivations, discussing their substance use, and identifying healthier behaviors all fall in the purview of counselors.



Other Campus Health Specialists

Colleges and universities have expanded their health support services to include health promotion specialists that assist students with improving their physical, sexual, and mental health. Substance use has important relationships to each of those domains of health and providing educational materials and personalized guidance to students aligns closely with the goal of health promotion.

WHAT CAN HEALTHCARE PROFESSIONALS DO?

While considerable clinical expertise goes into managing substance use disorders and there are now established fellowships and board certifications, many clinicians can learn the essential skills necessary to assess, recognize, discuss, and begin to manage basic substance use concerns faced by college students. The following pages include several tips that are meant to help a licensed healthcare professional who works for a clinic or health promoting organization at a college or university evaluate and possibly sharpen their own practice in the context of their professional responsibilities. The approach outlined is consistent with the Screening, Brief Intervention, and Referral to Treatment (SBIRT) approach, which has demonstrated benefit for treating a wide variety of substance use disorders in various populations, including adolescents.^{29,30} Not all professionals have the expertise to treat substance use disorders, but a basic assessment and—if warranted—a referral to specialty treatment can be a life-changing intervention.



Tip 1.

Take a Thorough Substance Use History

The process by which students enroll in care at a campus clinic varies across institutions, but it usually takes the broader form of an expression of interest, the confirmation of administrative eligibility, a short triage evaluation to determine clinical appropriateness for various services, intake questionnaires, a clinical intake, and a comprehensive evaluation (perhaps from a therapist, a psychiatrist, or both). After this initial process, students continue with routine follow up appointments as clinically needed and permitted by the model of care.

Some intake processes might not assess substance use as thoroughly as clinicians might think. For example, the Counseling Center Assessment of Psychological Symptoms (CCAPS), one of the most common intake questionnaires in campus mental health clinics, has 62- and 34-item versions. The 34-item version has four questions about alcohol only (omitting other substances such as cannabis or nonmedical use of prescription stimulants), and the 62-item only adds two questions about substance use—one about alcohol use and another about ‘drugs.’ Highlighting this limited assessment of non-alcoholic substances by a standardized, commonly used intake questionnaire is a helpful reminder to clinicians that substance use should be a part of their clinical evaluation. Adding additional questions or evaluations to the intake process about substance use might help identify problematic substance use earlier and more reliably.

In the clinical evaluation itself, there are three key dimensions of initially assessing substance use—type, frequency, and context. If a person is using a substance frequently, then more information can be gathered related to when the substance use was initiated and diagnostic criteria for addiction. Modeled off an approach backed by expert consensus for assessing cannabis use, clinicians can start with the three questions listed below that will be familiar to most of them.³¹

1. ***“Have you ever used X?”, if Yes, then***
2. ***“When did you last use X?”, if in the past 30 days, then***
3. ***“In the past month, on how many days have you used X?”***

Quantifying and qualifying cannabis use can be particularly tricky and deserves special attention given its rise in use. Cannabis use has a variety of formulations, including edibles, pills, smoked compounds (joints, blunts, bong, vapes), infused drinks, lotion-type products applied to the skin, tinctures, and oils and concentrates (e.g., wax, shatter) that can be vaped or inhaled (dabbing). These concentrates are typically much higher potency.³² If cannabis use is ongoing, clinicians are encouraged to quantify use. When possible, quantify the daily amount of THC (the primary psychoactive ingredient) in milligrams.^{31,33} When unable to quantify THC consumption, clinicians can resort to less precise units, such as the number of hits, joints, or cartridges.

Nonmedical use of prescription stimulants is another common issue among college students.³⁴ A clinician wanting to understand a patient's nonmedical use of prescription stimulants might ask about number and doses of the pills they use, the chemical compound (a mixed-amphetamine salt versus a methylphenidate), and formulation (immediate release versus extended release). When a student is requesting a prescription for a stimulant, checking a prescription drug monitoring program can identify whether they have been obtaining prescriptions from other clinicians recently.

A clinician needs to build trust to obtain an accurate substance use history. One component of trust is approaching with empathy and avoiding judgmental attitudes or looks. This is not the same as condoning problematic substance use. When assessing substance use behaviors, clinicians can gather the information neutrally. Another component of trust is routinely going over confidentiality protections at the start of the clinical encounter.

For students who are not actively using but have used substances in the past, clinicians can still identify and discuss problematic use that occurred in the past to understand a student's possible risk factors for future use. For those who have never had problematic use, clinicians can invite discussion in future clinical encounters with a statement like, "It sounds like you have not had problems with substance use in the past, however, given how substance use can affect physical and mental health, I want you to know that you can always ask questions or discuss substance use in our visits."



Tip 2.

Understand The Motives Behind Substance Use

What role does substance use play in a patient's life? Knowing the answer helps a clinician guide a therapeutic approach to changing patterns of substance use. Sometimes, a thorough examination of motivations for substance use can uncover undertreated or unrecognized psychiatric symptoms or stressors. For example, some students might use alcohol or cannabis in social settings to help alleviate sleep latency or social anxiety. Open-ended questions that can elicit this information stem from Motivational Interviewing (MI) techniques that rely on empathy and understanding of the patient's goals and experiences.³⁵ Example questions include:

“How does your substance use affect you?”

“What particular feeling or effect are you trying to achieve?”

“Where do you typically use?”

“With whom do you typically use?”

Some students use substances to relieve stress, treating substance use like a ‘coping strategy.’ Establishing healthy coping strategies is an important developmental task for young adults. Professionals might be able to work with young adults to identify a range of ways to cope with normal stressors and list benefits and disadvantages to each. Substance use is usually viewed as a maladaptive coping strategy given that it tends to avoid unpleasant internal experiences in the short-term rather than address the root causes and this can worsen substance use and mental health outcomes.³⁶

Understanding motivations for substance use can catalyze psychoeducational interventions and steer the clinician to recommend subsequent targeted interventions. For example, the primary reason many students use prescription stimulants nonmedically is to improve academic performance.³⁷ However, research has suggested that the nonmedical use of prescription stimulants does not translate to improved academic performance.³⁸ Furthermore, providing students with psychoeducation on the lack of evidence for academic benefit from prescription stimulants has been shown to decrease nonmedical use.³⁹ If a student is concerned about their academic performance, discussing improved study habits and referring them to academic support services might decrease the pressure students feel when cramming for finals after a semester of poor study habits.

Tip 3.

Be Transparent About Ways That Substance Use Conflicts With Treatment Goals

Identifying the discrepancies between patient goals and their substance use behaviors is a key part of the MI approach. Addressing the discrepancy in a non-judgmental way that empathizes with the patient's context requires a strong clinician-patient relationship.³⁵ It is a clinician's responsibility to use their judgment and be transparent with our scientific knowledge about how a patient's behavior might lead to outcomes that do not align with their values or goals. A clinician must also know their patient's goals and be sensitive enough to know when and how to highlight these discrepancies.

An empathy-based approach can sometimes be misinterpreted to mean that clinicians ought to unquestioningly support their patients' choices. Every patient has nuances in their experience that require careful, sensitive discussion. Sometimes substance use is clearly limiting treatment progress. For example, a patient with Major Depressive Disorder who is struggling with motivation and attention and wants to improve their GPA might make limited progress with antidepressant treatment if they are also using cannabis daily.



Examples of questions that might identify discrepancies, if present, include:

“What do you notice about your mood in the days after you drink heavily?”

“How has your use of Adderall purchased from your friend at the end of the semester affected your study habits throughout the term?” “How has it affected your grades?”

“At the end of the semester, you shared with me that you bought Adderall from a friend to get through finals even though you felt bad doing so. Looking back, I’m wondering what you feel could have gone differently, to potentially prevent that outcome?”

“In our time working together, you’ve talked about how you enjoy using cannabis on the weekends, while alone in your room. At the same time, I’ve also heard how important it is to you to build friendships, and that it’s a goal of yours. How do you feel like these two things might relate to each other, if at all?”



These questions might not be right for every professional, nor might they be effective for every student. Each clinician can identify ways to adapt similar questions that are aligned with their practice style to reflect students’ goals and juxtapose them against problematic substance use behaviors.

Tip 4. Substance Use Can Affect Prescribing Decisions

Substance use can affect prescribing decisions in at least two ways: 1) by informing selection of new medications and 2) by interacting with already prescribed medications. Substance use can inform medication selection by pulling a clinician's decision towards a substance use treatment goal or by pushing a clinician away from prescribing a specific medication due to substance use risk. As an example of influencing a decision towards a substance use treatment goal (a pull), a clinician who is treating a patient with major depressive disorder and heavy cigarette smoking (with a desire to quit) might use bupropion instead of an SSRI as bupropion is also indicated for smoking cessation. As an example of substance use influencing a decision away from a certain treatment due to risk (a push), a clinician who is treating someone with ADHD who has frequently nonmedically used prescription stimulants might prioritize the prescription of a non-stimulant.

Substance use can also interact with prescribed medications, which makes initial and ongoing substance use evaluations important whenever a medication is being prescribed. Medication interactions occur in two main categories: pharmacodynamic interactions and pharmacokinetic interactions.

Interactions between Substances and Psychiatric Medications

Pharmacodynamic interaction: Alcohol and SSRI use can amplify alcohol's sedative and intoxicating effects

Pharmacokinetic interaction: CBD use can increase the blood levels of escitalopram



Pharmacodynamic interactions occur between compounds that have “similar or opposite pharmacological effects,” often at the site of the receptors they are targeting.⁴⁰ For example, simultaneous use of alcohol with benzodiazepines or selective serotonin reuptake inhibitor (SSRI) anti-depressants can amplify alcohol’s sedative and intoxicating effects.^{41,42}

Pharmacokinetic interactions occur because of how one compound influences the “absorption, distribution, metabolic, or excretion” of another.^{40,43} These interactions often occur in the liver’s cytochrome P450 enzyme system, which metabolizes a significant portion of drugs. For example, cannabidiol (CBD) is known to inhibit enzymes responsible for the metabolism of common SSRIs citalopram and escitalopram, which might lead to variable treatment and adverse effects.⁴⁴

In addition to a search of the scientific literature, drug interaction databases (such as Micromedex) and the U.S. Food and Drug Administration (FDA) website can be helpful tools for understanding possible interactions between psychiatric medications and substances. Clinicians should be transparent in their prescribing decisions and share information about potential interactions with patients.

Tip 5. Stay Informed On Cannabis

A recent trends analysis shows that cannabis is the only substance whose use is increasing among young adults,³⁴ while the use of most other common substances, including alcohol, is stable or declining. No doubt trends in substance use will continue to change over time, however, given its prevalence of use—cannabis is an important substance for clinicians to understand.

Understanding the effects of cannabis use requires attention to its components. The primary psychoactive component in cannabis is Δ -9-tetrahydrocannabinol, which is commonly known as THC.^{45,46} THC levels have risen dramatically and can range from 15-90%, as compared with the 3-5% THC in previous decades. Cannabidiol—usually known as CBD—is not known to have significant psychoactive properties.⁴⁶ CBD has effects on brain receptors that oppose THC, meaning that the impact of these substances might be different when used together compared with the use of either individually.⁴⁵

The US Food and Drug Administration (FDA) has approved versions of each compound for specific medical indications. The synthetic versions of THC (Dronabinol and Nabilone) are approved by the FDA for nausea and vomiting caused by chemotherapy that does not respond to other treatments.^{19,47} Cannabidiol (CBD) is sold in a purified drug form to treat specific seizure disorders.⁴⁸ Based on a comparison with the National Academy of Sciences review, there is little evidence for many of the qualifying conditions approved by state medical cannabis laws.⁴⁹

In terms of the effects of cannabis, many clinicians are aware that even low-frequency cannabis use is associated with elevated risk of developing schizophrenia among adolescents and young adults.¹¹ Clinicians are often less aware that cannabis use is associated with increased risk for depression, anxiety, and suicidality in young adults.⁵⁰ A large, retrospective analysis of longitudinal data also shows that cannabis use disorder increases the risk for developing depression and bipolar disorder.⁵¹ Further relationships between cannabis, alcohol, and psychiatric symptoms or conditions are described in Table 1. Unfortunately, research shows that some students might use cannabis and switch off of their FDA-approved medication based on their misperception that cannabis helps their mental health condition.⁵²

Tip 6.

Use And Interpret Urine-Toxicology Screens With Care

Urine toxicology screens can be useful to validate information gathered by a clinical interview about substance use but can sometimes be damaging to a therapeutic relationship by conveying to a student that the clinician believes they are lying. When indicated, the clinician should explain their rationale for getting additional toxicology testing in the therapeutic encounter, rather than letting clinical staff inform the student that they are being asked to submit a urine sample. Some clinic policies require urine toxicology testing for students who are receiving controlled substances (such as prescription stimulants to treat ADHD).⁵³ This use of urine toxicology testing has not been studied. It is important to be familiar with the common urine toxicology tests your laboratory offers and to think critically about when additional tests that are not often included on standard toxicology screens (e.g., a fentanyl test) might be warranted.

Urine toxicology tests should also be interpreted with caution. Some false positive errors on urine toxicology tests include sertraline showing up as a positive benzodiazepine test,⁵⁴ bupropion showing up as a positive amphetamine test,⁵⁵ and diphenhydramine showing up as a positive phencyclidine or methadone test.⁵⁶⁻⁵⁸ False

positives are especially common with immunoassay tests that yield quicker results.⁵⁹ Positive test results should be discussed with the patient before making conclusions. Conventional timelines for detecting substance use might also depend on patterns of use. For example, while a single instance of cannabis use typically will no longer be detectable on toxicology testing after 72 hours, chronic use can be detected up to 30 days after the last use due to the storing of THC in adipose tissue.⁵⁸



Table 1: Evidence regarding the Relationship between Specific Mental Disorders and Alcohol and Cannabis Use

Clinical Topic	Alcohol Use	Cannabis Use
Mood Disorders	Alcohol use disorder is strongly associated with major depressive disorder. ¹⁰ For those who do not have major depressive disorder, alcohol use disorder appears to be associated with later development of major depressive disorder, providing some evidence for a causal link. ⁶⁰ For those with major depressive disorder, problematic alcohol use leads to worse depression outcomes, including risk of death and suicide. ⁶¹ Alcohol use among those with bipolar disorder is associated with increased risk for relapse of depression. ⁶²	Cannabis use likely worsens psychiatric symptoms among patients with mood disorders. One longitudinal study showed that persons with major depressive disorder and cannabis use had an increased risk for depression symptoms including worse sleep, anhedonia, and change in body weight, but no difference in suicidality, functionality, or quality of life. ⁶³ Another longitudinal study found that cannabis use worsened depression symptoms. ⁹ A systematic review concluded that cannabis use was linked to worse clinical outcomes for persons with bipolar disorder. ⁶⁴
Anxiety Disorders	Alcohol use disorder is strongly associated with anxiety disorders, ¹⁰ and the two appear to have a bidirectional relationship in which worse anxiety can cause worse alcohol use and vice versa. ⁶⁵⁻⁶⁷ Alcohol dependence is associated with persistent anxiety disorder symptoms. ⁶⁸	A longitudinal study found that cannabis use worsened anxiety symptoms. ⁹ Some patients are particularly vulnerable to feeling increased anxiety or paranoia with cannabis use.
ADHD	Patients with Attention-deficit/Hyperactivity Disorder (ADHD) might have deficits with sustained attention or executive function (which includes decision-making, impulse control, and working memory). Binge drinking is also associated with deficits in sustained attention, even after alcohol is fully metabolized. ⁶⁹	Individuals with ADHD are more likely to have cannabis use disorder, than those without ADHD. ⁷⁰ There is a lack of research on the role of cannabis in the clinical course of ADHD, ⁷¹ however, use of THC-containing products impairs attention. ⁴⁵

<p>Sleep</p>	<p>While there is minimal data on whether alcohol affects sleep among persons with major depressive disorder or other psychiatric illnesses differently than among those without psychiatric disorders,⁷² a core feature of many psychiatric disorders is poor sleep. Alcohol is known to negatively affect sleep, which can result in a compounding of sleep—a key element in a patient’s quality of life. Patients with major depressive disorder have significant sleep impairment.⁷² Some people use alcohol to fall asleep more quickly, but it is important to note that it is associated with poorer overall sleep quality.^{73,74} Long-term alcohol use can lead to an opposite effect and actually delay sleep onset.⁷⁵</p>	<p>Cannabis is commonly thought to help with sleep. Yet, the evidence suggests cannabis can improve sleep only in select populations and can be harmful to other populations. The relationship between cannabis and sleep is complicated by the fact that cannabis withdrawal is associated with sleep disturbances. A meta-analysis shows that cannabinoids can confer a small magnitude improvement in sleep in persons with chronic pain.⁷⁶ A meta-analysis of the impact of cannabis products on persons with sleep disorders was inconclusive due to poor-quality data.⁷⁷ A meta-analysis of FDA-approved cannabis derivatives using randomized controlled trials did not find that those products negatively affect sleep among patients with a range of conditions (though primarily seizure disorders).⁷⁸ Importantly, one longitudinal study examined patients with major depressive disorder and found that those who used cannabis had an increased prevalence of sleep symptoms (hypersomnia and insomnia).⁶³</p>
<p>Other Cognitive Problems</p>	<p>Binge drinking is associated with deficits in decision-making and inhibition among adolescents and young adults, though the relationship might be bi-directional.¹²</p>	<p>Cannabis use clearly has negative effects on cognition among the general population, though some studies suggest these effects are reversible with abstinence. Two meta-analyses show that cannabis use is associated with small global cognitive deficits that appear to normalize after several days of abstinence.^{79,80} Importantly, a meta-analysis of longitudinal studies found that cannabis use among young persons was associated with a 2-point decrease in Intelligence Quotient (IQ).⁸¹</p>
<p>Other Psychiatric Problems</p>		<p><i>Eating disorders</i> A meta-analysis showed moderate evidence that CBD can decrease appetite, which complicates achieving treatment goals for patients with eating disorders.⁷⁸ Note that THC might have a different effect on appetite than CBD does.</p> <p><i>Psychosis</i> Cannabis has a clear association with onset of schizophrenia.^{82,83} While this association is not fully understood, the current evidence gives a strong reason to avoid cannabis among persons at risk for schizophrenia (prior psychotic symptoms or a family history of schizophrenia spectrum disorders).</p>

WHAT CAN HEALTHCARE PROFESSIONALS DO?

What If A Student Is Concerned About Confidentiality?

Remind patients that their clinical care on campus, including for substance use, is confidential except in rare circumstances. A student who is aware that their actions are breaking university, state, or federal regulations might hesitate to participate in care and be honest about critical clinical information if they have misperceptions about the confidentiality of student records. If you are unsure about federal or institutional confidentiality protections, your clinical or campus leadership should be consulted.

What If A Student Asks About Campus Rules For Substance Use?

Many institutions have campus drug and alcohol policies. Staying informed of their content and knowing how students can access these policies can position you to ensure your patients are informed of possible institutional consequences of their actions. Similarly, understanding federal and state laws about substance use will allow you to inform students of possible legal consequences of their actions. For example, some clinicians inform patients that it is illegal to sell, trade, or give away controlled substances when writing a prescription for stimulants. Be aware of situations in which state regulations (such as the legalization of recreational use of cannabis) might not align with institutional regulations (such as prohibiting the use of cannabis on campus).

What If I Don't Know The Answer To A Question The Student Asks About Their Substance Use? Where Can Clinicians Get Reliable Information About Substance Use?

The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) has a website dedicated to supporting practitioners that offers tools, training, and technical assistance.⁸⁴ Professional associations like the American Psychiatric Association or the American Society on Addiction Medicine offer multiple continuing education courses on substance use, many of which are free, through their online learning center. Many clinically-focused professional conferences also offer additional education on clinical practice related to substance use assessment and interventions.

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