

SUBSTANCE RELATED DISORDERS IN CHILDREN AND ADOLESCENTS—IN BRIEF:

Differential Diagnosis & Comorbidities

- The primary differential diagnosis is establishing whether substance use or induced disorder exists for each substance and to what extent relevant comorbid conditions are present.
- *Comorbidity is the rule rather than the exception among adolescents with substance related disorders* (Aarons et al., 2001).

Virtually any psychiatric disorder may occur in association with substance use as a cause, an effect, or a correlate. Substance use disorders often occur with:

- Attention-Deficit/Hyperactivity Disorder
 - Oppositional Defiant Disorder (ODD)
 - Conduct Disorder (CD)
 - Depression
 - Anxiety Disorders
 - Post-Traumatic Stress Disorder
 - Specific Developmental Disorders (e.g., learning disabilities)
 - Bipolar Disorder
 - Psychotic Disorder
- The presence of ADHD, especially when accompanied by ODD or CD is associated with early onset of substance use.
 - 30–70 % of children and adolescents with Anxiety Disorders have a Depressive Disorder.
 - 15–25 % of children and adolescents with Anxiety Disorders meet criteria for ADHD.

Assessment & Treatment Recommendations in Primary Care Settings

(Substance Use Screening, Brief Intervention, and Referral to Treatment):

The Substance Abuse and Mental Health Services Administration (SAMHSA) recommends that universal screening for substance use, brief intervention, and/or referral to treatment (SBIRT) become a part of routine health care (Rockville, 2009), (See SBIRT algorithm, Appendix II).

Recommendations for Pediatricians by the American Academy of Pediatrics (AAP):

The AAP recommends that pediatricians:

- Become knowledgeable about all aspects of SBIRT through training program curricula or continuing medical education that provides current best practices training.
- Become knowledgeable about the spectrum of substance use and the patterns of nicotine, alcohol, and other drug use, particularly by the pediatric population in their practice area.
- Ensure appropriate confidentiality in care by becoming familiar and complying with state and federal regulations that govern health information privacy, including the confidential exchange of substance use and treatment information.

- Screen all adolescent patients for tobacco, alcohol, and other drug use with a formal, validated screening tool, such as the CRAFFT screen (see below), at every health supervision visit and appropriate acute care visits, and respond to screening results with the appropriate brief intervention.
- Augment interpersonal communication and patient care skills by becoming familiar with motivational interviewing techniques.
- Develop close working relationships with qualified and licensed professionals and programs that provide the range of substance use prevention and treatment services, including tobacco cessation, that are necessary for comprehensive patient care.
- Facilitate patient referrals through familiarity with the levels of treatment available in the area and application of the multidimensional assessment criteria to determine the intensity of services needed.
- Make referrals to adolescent appropriate treatment for youth with problematic use or a substance related disorder.
- Consider throughout the SBIRT process that psychiatric disorders can co-occur in adolescents who use psychoactive substances.
- Stay abreast of coding regulations, strategies, and updates to bill for tobacco, alcohol, and other drug use SBIRT services.
- Advocate that healthcare institutions and payment organizations provide mental health and substance use services across the pediatric/adolescent ages and developmental stages while ensuring parity, quality, and integration with primary care and other health services.

Substance Use Spectrum and Goals for Office Intervention

Stage	Description	Office Intervention Goals
Abstinence	The time before an individual has ever used drugs or alcohol (more than a few sips)	Prevent or delay initiation of substance use through positive reinforcement and patient/parent education
Experimentation	The first 1–2 times that a substance is used and the adolescent wants to know how intoxication from using a certain drug(s) feels	Promote patient strengths; encourage abstinence and cessation through brief, clear medical advice and educational counseling
Limited Use	Use together with friends in relatively low-risk situations and without related problems; typically, use occurs at predictable times such as on weekends	Promote patient strengths; further encourage cessation through brief, clear medical advice and educational counseling
Problematic Use	Use in a high-risk situation, such as when driving or babysitting; use associated with a problem such as a fight, arrest, or school suspension; or use for emotional regulation such as to relieve stress or depression	As stated above, plus initiate office visits or referral for brief intervention to enhance motivation to make behavioral changes; provide close patient follow-up; consider breaking confidentiality
Abuse Drug	Use associated with recurrent problems or that interferes with functioning, as defined in the <i>DSM-IV-TR</i> as ‘abuse’	Continue as stated above, plus enhance motivation to make behavioral changes by exploring ambivalence and triggering preparation for action; monitor closely for progression to alcohol and other drug addiction; refer for comprehensive assessment and treatment; consider breaking confidentiality

Screening:

- Screening an adolescent for substance use is designed to determine if the adolescent has used alcohol or other drugs in the previous 12 months and, if so, to delineate the associated level of risk and further intervention accordingly.

- The **CRAFFT Screening Tool** is a validated, developmentally appropriate, brief, easy-to-use screen with good discriminative properties for determining high risk of substance related disorders in the adolescent age group treated in primary care (Knight et al., 2002).
- The clinician **should question all patients older than 9 years** about substance use and younger patients about any accidental use, in a nonjudgmental manner using the 2-step method of the CRAFFT Screening Tool.

Brief Intervention:

- In primary care pediatrics, the term “brief intervention” encompasses a spectrum of responses’ that includes:
 - Providing patients who report no substance use with brief positive feedback about their ability to make healthy choices.
 - Brief advice, medical education and psychoeducation when the screening process reveals alcohol or other drug use but the problem is relatively minor. Providers can also obtain a signed contract whenever appropriate.
 - Using a **Brief Negotiated Interview (BNI)** based on motivational techniques to encourage the desired behavior change or acceptance of a referral for treatment for adolescents who have had relatively minor consequences associated with their substance use.
 - Urgent intervention against patient’s wishes and breaking of confidentiality if the patient is in acute crisis.
- The clinicians performing a BNI in primary care should:
 - Summarize information from the assessment.
 - Repeat for emphasis any problems associated with substance use identified by the adolescent.
 - Ask the adolescent whether he or she would like to make changes in the future (e.g., “I understand that you really enjoy smoking marijuana with your friends. On the other hand, you were suspended from the basketball team after the coach caught you with marijuana, and you are worried that having a ‘record’ of marijuana use might be bad for your college applications. What are your plans regarding marijuana use in the future?”)
- In contrast to brief advice, a **BNI involves a negotiation that attempts to reduce substance use** and related risk behaviors by using the negative aspects of substance use as reported by the adolescent.
- Telling adolescents who are invested in their substance use to stop using substances can trigger resistance, whereas asking about their own plans might present an opportunity for positive feedback and to build rapport for further work (e.g., “It sounds as if you have already thought this through. I fully support your decision to quit using for now”).
- The **BNI is based on the principles of motivational interviewing**, which is a counseling approach in which a clinician encourages a patient to explore the effects (both positive and negative) in a non-judgmental way of his/her current behavior on personal interests or goals.
- These principles align well with established pediatric medical home practices of providing

confidential care and building a trusting relationship and rapport.

- Motivational-interviewing or BNI techniques are particularly useful for adolescents who have experienced problems associated with alcohol or drug use but remain ambivalent about continued use or have not yet considered the possibility of changing their behavior.
- **Steps of Brief Intervention depend upon the determined Level of Risk** (please refer to the flow chart at the end of each section in the Full Guideline for a snapshot of risk levels. Further treatment options are outlined in the Appendix II of the Full Guideline).

Referral to Treatment:

- For referral help, call Psych TLC: 501-320-7270 or 1-844-547-5688.
- Any adolescent who meets the DSM 5 or DSM-IV-TR (Transitional tool) criteria for substance related disorder should be assessed by a professional experienced with adolescent addiction.
- In accordance with the SBIRT algorithm, signs of acute danger or red flags for addiction usually indicate the need for referral to adolescent-specific specialty care.
- Decide where to refer an adolescent in need of treatment is often complicated by limited treatment availability and insurance-coverage complexities.
- In most cases, pediatricians refer adolescent patients to a mental health or addiction specialist to conduct a comprehensive biopsychosocial assessment and determine the appropriate level of care from the treatment spectrum, which ranges from outpatient substance abuse counseling to long-term residential treatment programs.

Relapse Prevention:

- The primary goal of the treatment of adolescents with SUDs is achieving and maintaining abstinence from substance use. While abstinence should remain the explicit, long-term goal of treatment, a realistic view recognizes relapse as a part of the recovery process.
- Relapse can be prevented, but because it often occurs, it should be anticipated as a potential part of the recovery process. Relapse should be viewed not as failure but as a learning opportunity.
- Ongoing assessment of substance use as discussed above in every visit is important.
- Periodic urine testing - toxicology, through the collection of bodily fluids or specimens, should be a routine part of follow-up of an adolescent with a substance use history.
- Relapse should be detected early and the same flowchart as discussed at length above needs to be followed.

Recommendation - Collaborative Care

- Primary Care clinicians should actively support children and adolescents who are referred to mental health for substance related symptoms. Consider sharing care with mental health professionals if possible.
- **The free Psych TLC service is available for:**
 - Consultation on psychiatric medication related issues including:

- Advice on diagnosis and initial management for your patient
 - Titration of psychiatric medications
 - Side effects of psychiatric medications
 - Combination of psychiatric medications with other medications
 - Referral and services consultation regarding children with mental health issues
- A licensed mental health professional (MHP) and a child and adolescent psychiatrist (CAP) are available via telephone to provide consultation and support to PCPs from 8am-5pm, M-F. Simply call **(844) 547-5688** or **(501) 320-7270** to contact the Psych TLC Call Center. One of our expert MHPs will obtain basic information from you about the child and then set up a convenient time for Peter S. Jensen, MD, or another child & adolescent psychiatrist to call you back, usually within 30 minutes to 2 hours.