Substance abuse and harm minimisation in adolescents

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BACKGROUND
Adolescent substance use is prevalent among Australian school students. Although a degree of risk taking is a normal developmental task it can lead to serious consequences. For some it is a short lived risk taking experience. For others it is a flag for other life difficulties and a possible trajectory to addiction.

OBJECTIVE
This article outlines an approach to engaging with the adolescent to identify substance abuse and the context in which it occurs. The process outlined allows for identification of multiple concerns and opportunities to reduce harm.

DISCUSSION
The key to addressing adolescent substance use is engagement. This involves allowing for time with the adolescent alone and with a support person if they wish, discussing confidentiality issues and using a framework for obtaining a comprehensive psychosocial history. This enables identification of multiple concerns, comorbid conditions and opportunities to reduce harm.

Adolescence is a normal developmental stage in a person's life that often involves experimentation and risk taking. Adolescence is the time when many people first experience and experiment with drugs. Although a degree of risk taking is a normal developmental task it can lead to serious consequences. For some it is a short lived risk taking experience and for others a flag for other life difficulties and a possible trajectory to addiction.

The Australian Secondary Students Alcohol and Drug Survey (ASSAD) 2005 shows that by 17 years of age: over 90% of students have tried alcohol, 50% have smoked at least once and one-third have tried cannabis. The ASSAD 2005 also shows that all forms of substance use increase with age across adolescence.[1] For example, the proportion of students who had drunk alcohol in the previous week rose from 10% for students aged 12 years to 49% for students aged 17 years. The proportion of students who had smoked at least one cigarette in the previous week rose from 2% for those aged 12 years to 18% for those aged 17 years. The ASSAD has been running for over 21 years and an analysis of trends shows that the rate of current and committed smokers has decreased over the years as has the proportion of students who ha ever used cannabis or used cannabis in the past month.[1]

Substance abuse in adolescence may manifest in different ways:

- nonharmful experimentation
- harmful in the context of other difficulties
- development of addiction.

Protective factors, that is, factors that reduce the risk for substance abuse include:

- good family communication
- good family functioning
- connectedness to adults
- connectedness to school, and
- individual characteristics such as good verbal communication skills, easy temperament, problem solving skills, humour, empathy and spirituality.[2]

Children and adolescents of parents who have substance use disorders are more likely to develop a substance use disorder themselves.[3]

Assessment

Identification of drug abuse by the general practitioner is best undertaken by an approach that allows ongoing therapeutic relationship with the adolescent. This is what is referred to as 'engagement'. The following is a suggested assessment process that allows for the development of therapeutic engagement with the adolescent:

- allow the adolescent to see you on an individual basis or with a support person if that is their preference
- explain confidentiality and its limits. Confidentiality assurance has been shown to be an important factor as to whether an adolescence will disclose sensitive information to their physician.[4] Adolescent concerns regarding confidentiality can be a barrier to accessing health care[5]
- use a framework for gaining a psychosocial biopsy of the adolescent. The original term 'HEADSS', coined by Goldenring and Cohen,[6] is an acronym that stands for home, education and employment, activities, drugs, sexuality, suicide and depression. It starts with the least threatening areas and ends with the more sensitive areas for discussion. (The extra 'D' is often included to give depression a category in its own right, ie. 'HEADDSS'. Sometimes an extra 'E' is included for 'eating patterns' ie. 'HEEADDSS').

This framework is not only important for identification of substance use but also the context in which it may be occurring and helps identify comorbid issues that may need to be addressed and which underlie, or may be contributing to, the substance abuse. Identification and management of these identified issues leads to harm minimisation.

Additionally, use of a screening tool such as CRAFFT can be helpful in eliciting substance use history (*Table 1*).[7]

Table 1. CRAFFT

C	Have you ever ridden in a **car** driven by someone (including yourself) who was 'high' or had been using alcohol or drugs?
R	Do you ever use alcohol or drugs to **relax**, feel better about yourself, or to fit in?
A	Do you ever use alcohol or drugs while you are by yourself, **alone**?
F	Do you ever **forget** things you did while using alcohol or drugs?
F	Do your **family or friends** ever tell you that you should cut down on your drinking or drug use?
T	Have you ever gotten into **trouble** while you were using alcohol or drugs?

Management

Goal setting

In formulating a management plan it is important to explore what goals the young person has in mind as these may be quite different to what you or the parent may have in mind. The goals may be specific to the drug use or to a comorbid medical or nonmedical issue. Longer term goals may seem overwhelming to the adolescent so it is vital to establish goals that are:

- short term
- realistic, and
- achievable.

This assists with harm minimisation and allows the adolescent the opportunity to identify and achieve early success. Which of the drug related problems to address might be dictated by how motivated the adolescent is to engage in change. There is evidence that the more highly motivated a person is the more committed to treatment they are, and the more engaged with their counsellor.[8]

Motivational enhancement

Motivational interviewing allows further exploration of where the adolescent is at in their attitude to their drug use issue and also provides a framework for supporting them to move through the stages of change.[9]

Stages of change

Each of the stages of change requires a different therapeutic approach.

Precontemplation

Precontemplation is where the adolescent is not yet considering any change. They may be attending your service for another related or unrelated issue, or been brought in by their parent. At this stage it may be useful to explore what the adolescent understands about drugs, to acknowledge what they do know, and provide further information.

Contemplation

In the contemplation stage the adolescent shows an awareness of the problems relating to their drug use. At this stage they should be further encouraged and supported to fully explore the pros and cons of continuing their drug use. Advantages and disadvantages that mean something to them at this point in their life are much more likely to be useful motivators than more theoretical issues such as long term health problems.

Action

In the action stage the adolescent is actively attempting to cease their drug use. At this stage they should be supported with a specific treatment plan.

Maintenance

In the maintenance stage the adolescent continues on sustaining their changed drug use behaviour.

At any point in the stages of change there is a risk of relapsing to any of the earlier stages. The other point of note is that the adolescent may be in a different stage of change for different aspects of their substance abuse. For example, while the adolescent may be precontemplative to ceasing their opiate use, they may be contemplative or action oriented toward the use of clean needles and syringes.

Management of comorbid conditions

Young people with drug use often have comorbid problems such as depression, attention deficit hyperactivity disorder (ADHD), abuse, and homelessness. These issues are just as important to address and treat as they are often closely connected with drug use. Similarly there are resultant harms from drug use such as blood borne viruses, skin infections, violence and other trauma. In managing the complexities of the adolescent's substance use, referral to local youth, counselling or mental health services is to be encouraged.

Family involvement

While this article has focused on individual management of adolescent substance use there is also a place for a family approach. One such example is where there is parental smoking. A primarily family focused approach such as addressing the parents' use of tobacco has been shown to be of benefit to supporting the adolescent from using tobacco as well.[10] In families where there is parental substance abuse it would be important to address this as both children and adolescents are at risk of also developing substance abuse.[3] It has also been shown that parental factors can influence engagement of the adolescent with treatment. In one study, the higher the parental expectation for their child's educational attainment, or the more highly they rated their child's externalising behaviour, the more engaged the adolescent was with treatment.[11]

Conclusion

There is limited information available as to which other specific approaches to substance use treatment are helpful in adolescents, but what is documented is that it is helpful to be engaged in a treatment process. Generic adolescent approaches form a strong framework for identification and management as well as more specific approaches outlined (eg. CRAFFT, motivational interviewing). Within the process outlined for assessing and developing a plan for management for the adolescent's substance abuse a number of opportunities arise for addressing a wide range of drug and nondrug related issues, all of which may contribute to minimising harm for the adolescent.

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References

1. White V, Hayman J. A drink, a smoke, a joint: new stats on students' use. Of Substance 2007;522–4.
2. Resnick MD. Protective factors, resiliency, and healthy youth development. Adolesc Med 2000;11:157–63.
3. Biederman J, Faraone SV, Monuteaux MC, Feighner JA. Patterns of alcohol and drug use in adolescents can be predicted by parental substance use disorders. Pediatrics 2000;106:792–7.
4. Ford CA, Milstein SG, Halper-Flesher BL, Irwin CE. Influence of physician confidentiality assurances on adolescent's willingness to disclose information and seek future health care: a randomised controlled trial. JAMA 1997;278:1029–34.
5. Booth M, Bernard D, Quine S, et al. Access to health care amongst Australian adolescents: young peoples perspectives and their sociodemographic distribution. J Adolesc Health 2004;34:97–103.
6. Goldenring JM, Cohen E. Getting into adolescent HEADS. Contemp Pediatr 1988;7:75–90.
7. Knight JR, Sherritt L, Shrier LA, et al. Validity of the CRAFFT substance abuse screening test among adolescent clinic patients. Arch Pediatr Adolesc Med 2002;156:607–14.
8. Broome KM, Joe GW, Simpson DD. Engagement models for adolescents in DATOS -A. J Adolesc Res 2001;16:608–23.
9. Prochaska JO, DiClemente CC. Stages of change in the modification of problem behaviours. Prog Behav Modif 1992;28:183–218.
10. Thomas RE, Baker P, Lorenzetti D. Family based programmes for preventing smoking by children and adolescents. Cochrane Database of Systematic Reviews 2007; Issue 2.
11. Dakof GA, Tejeda M, Liddle HA. Predictors of engagement in adolescent drug abuse treatment. J Am Acad Child Adolesc Psychiatry 2001;40:274–81.

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