A Creative Approach to Managing Substance Abuse

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Editor's Note:

Alcohol and drug use are leading causes of morbidity and mortality in young people in the United States. To help address the problem, the American Academy of Pediatrics recommends that substance use guidance be incorporated into routine pediatric clinical care, and that patients with addictions be managed in collaboration with child and adolescent mental health practitioners or addiction specialists.

At Boston Children's Hospital, clinicians are doing just that. Sharon Levy, MD, MPH, Director of the hospital's Adolescent Substance Abuse Program and Steering Committee member for the Prescribers' Clinical Support System for both opioids and buprenorphine, recently spoke with Medscape about their unique, effective approach to managing young patients battling substance abuse. It all starts with location...

A Novel Model for Treating Substance Abuse

Introduction

Medscape: Can you give us some background on the adolescent substance abuse program at Boston Children's Hospital and your role in the program?

Dr. Levy: We have a unique program here at Boston Children's Hospital. I believe with fair certainty that it is the only substance abuse program for adolescents situated within a department of pediatrics. That's important, because we're not a rehab program. Physicians and other referrers feel comfortable sending kids to us whom you would never send to rehab. Parents and kids feel comfortable coming even when they don't have the most serious substance abuse disorders.

We see the full spectrum of kids, and about 10% of our kids don't have a substance use disorder. Often, those kids come in and the family is pretty sure they don't have a problem, but they want to be proactive and preventive. And so we offer them support and psychoeducation after their assessment. Of course, about one third to one quarter of the kids who come in have very serious substance abuse disorders. So it's a pretty unique setup where we're really treating just about everybody.

Medscape: What age range do you see, and how are your patients referred to you? By primary care providers? By parents?

Dr. Levy: There are lots of doors that lead into our program. In terms of age, patients have to start the program before they turn 22, and we've seen a couple of kids as young as 11. But we would certainly take any child, even younger if there is a question of substance use or abuse. At those younger ages, if there's a question of substance abuse, I think an evaluation would be appropriate. A lot of the kids who come in when they're 14 or 15 report that they started when they were 9 or 10 -- they'll have developed these disorders by the time they're in their middle adolescence.

The kids get here in a variety of ways. Often, their parents are concerned and want them to have an evaluation. They might present to a pediatrician's office, and then the pediatrician will recommend that they come here. A lot of mental health counselors in the greater Boston area are aware of our program, so they may send patients in. Sometimes parents find us on the Internet. Occasionally, a patient will be sent in by a school because they've had a problem related to use at school or they've been caught with drugs or paraphernalia on campus. Some of the local

schools have relationships with us. Sometimes a kid will be picked up by the police and will be sent in here by a probation officer. There are a lot of ways that you can get in.

Medscape: What types of substance abuse do you most commonly see?

Dr. Levy: The most common substances used by kids are marijuana and alcohol. I would say somewhere around two thirds of the kids we see will have problems with one of them. Most of the rest are opioid-dependent, many of whom will also have alcohol and marijuana problems. But it's often not just 1 substance.

Medscape: These are mostly recreational opioid users?

Dr. Levy: Yes; most kids we see are not using them for a specific medical condition. I haven't been in high school for a long time, but it seems like opioids are easily available, and a lot of kids are curious and trying them.

The heartbreak of opioids in particular is that they are so addictive, and a lot of the kids whom I see will tell me, "I knew I was addicted the first time I tried it." For some kids, it's that fast, and it's really important for people to understand that.

I often sit with parents and tell them that I think for some kids, and for some substances, addiction happens really quickly. Experimenting with opioids is a big mistake. But all adolescents make mistakes; they do crazy things all the time. Unfortunately for some kids, the consequences are high.

Should You Tell the Parents?

Medscape: How often are young patients willing to admit and address their potential addiction? And do they ever seek treatment without being pushed by a parent or clinician?

Dr. Levy: We do see treatment-seeking kids. The opioid-dependent kids are often treatment-seeking. They're an interesting group, because they'll often have marijuana and alcohol problems as well. They often come in asking for help to quit using opioids, but they may want to continue using other substances. So we'll get them on opioid replacement if we think that's indicated and they're interested. We'll try to get them to stop using the opioids right away, and then we'll work on the other substances. We tell them that it is very important to quit all substances for many reasons, including to protect their recovery from opioid addiction. We want them to agree to do counseling, and we take it from there.

Treatment is a process; it doesn't all happen on the first day. Kids who engage in the process do well. Some kids take years before they become completely sober -- but if we can get them to engage and stick with it, they can get there.

There are sometimes kids with alcohol or marijuana problems who come here on their own -- usually the older adolescents. Some kids really want to cut down or want to quit. But they tend to be lost to follow-up a little bit earlier. Even the opioid-dependent kids usually realize they have a problem; they want treatment, and they turn to their parents. Their parents will bring them here, which actually makes it a lot easier for me, because then everybody already knows. The story is out, and I can involve the parents right away.

It's my personal feeling that if there is an available parent, involving a parent will make treatment go better. Unfortunately, a lot of the kids who are treatment-seeking are not as able to follow through. When a parent is involved, it's more likely that the kid will follow through all the way. Occasionally, kids will come here and say, "I have an opioid problem. I really don't want Mom or Dad to know." And we'll work with them. Particularly for kids who are going to go on opioid replacement -- they're going to have all these appointments, need medications, and need to do drug testing. It's really hard for a 16-year-old to do that without a parent finding out about it, never mind helping.

Medscape: So you respect the patient's wishes, but you try to work toward the goal of disclosing it to the parents?

Dr. Levy: We consider involving the parent a treatment goal. It's like, "You don't want to tell your parents, fine. Let's get you started, and then we'll explore why you don't you want to tell your parents."

There are a variety of reasons why kids don't want parents to know. Occasionally, it's because a parent is somehow unavailable, or the parent might have their own addiction or mental health problems that are ongoing. When that's the case, we try to involve another responsible adult, such as a grandparent or uncle. And often we're very successful in doing that.

For the majority of kids, it's just that they feel embarrassed or ashamed or don't want to hurt their parents. I consider that completely understandable, and something that we can work with. I've helped kids tell their parents. Sometimes kids can't do it, but they get them to come to an appointment and we sit and we do it together. We practice how we are going to do it and the kids will often have words that are okay and not okay to use.

Usually by the time the parents are coming up to the clinic, they know that there is a problem. They may not know all the details, but they certainly suspect. So, breaking the news is really never as traumatic as the kids think it's going to be. But once we get the parents involved, they have a lot more support.

Medscape: How do you balance patient confidentiality with moral and legal obligations in cases of potential self-harm or harm to others?

Dr. Levy: We are mandated reporters. If we get from the history that there is domestic violence, abuse, or neglect of any kind, we wouldn't be able to keep that confidential.

We explain confidentiality to patients pretty carefully. We have a very brief orientation the first time the kids come in. We tell them who they are going to be speaking with and what they are going to be talking about. And we review our confidentiality policy, including the limits of confidentiality. We let them know that if we think that they are at significant risk of hurting themselves or others, we will release that information to their parents.

We also let them know that because we're a family-based program, we assume that if they're coming in with their parents, their parents know quite a lot already. We tell them that we will also release any diagnoses and all treatment recommendations. But what we can do for them is keep the details they discuss with us confidential. We never release the who, what, when, and where information to the parents. It's often not necessary for the parents to know all of those details in order to support their child and to be able to implement a treatment plan. We want the patients to really feel comfortable with our therapeutic alliance and know them talking to us is not a direct line to their parents.

Medscape: So, for example, you wouldn't reveal to parents that a child's best friend from down the street might be supplying the substances?

Dr. Levy: Exactly right, and parents don't really push us on that. My experience is that many programs won't talk to parents at all. Although this is a tightrope and it takes some experience in learning how to do it, parents are often very, very satisfied when we explain what we're going to do.

Medscape: Are you seeing any new trends in drug use among young patients? Have you seen anything in, say, the past decade that has changed significantly?

Dr. Levy: I'm probably not the right person to answer that question, because we're a referral clinic and we may not be seeing what's going on in the community. I can tell you the trend that I've seen -- and this is really more my instinct than based any kind of data -- is that I think there is a shifting in the types of opioids that kids will use.

I don't know how much you really want to get into names here, but when I first started seeing opioid-dependent patients -- when we first started offering opioid replacement in 2004 -- I would say that the majority of kids were starting with OxyContin® (oxycodone). I know that's been reformulated, and that's no longer the case. I think it's now other brand-name drugs that they're coming in with.

In the past couple of years, we've seen more and more kids whose first opioid of choice was Suboxone® (buprenorphine and naloxone), which is used for opioid replacement therapy. I prescribe a lot of Suboxone, but it's just a reminder to all of us who prescribe any of these medications that there is definitely potential for abuse and diversion.

We keep all of our prescriptions small and get kids set up so that the parents -- when we have a good family system, which is most often the case -- hold and administer the medications. I don't think that you can prevent all diversion, but I think you can prevent a lot of it, and I think you can certainly shift the risk/benefit balance by doing that, at a minimum.

What Treatment Methods Work?

Medscape: What sort of treatment methods do you use, both in terms of pharmacotherapy and psychotherapy or counseling?

Dr. Levy: All of our recommendations are personalized, but they generally fall into a couple of categories. We recommend opioid replacement for opioid-dependent kids. For kids who don't want that -- and I have seen a couple of kids who said, "I got addicted to Suboxone and I don't really want treatment with that" -- we offer naltrexone. I personally think of it as second line, but we put both drugs out there for kids who are opioid-dependent and let them decide with their parents.

We occasionally use naltrexone for kids who are alcohol-dependent, although that's fairly rare, because I think alcohol dependence in kids looks different than alcohol dependence in adults. And I think less is known about naltrexone use in adolescents, but for some of the older kids, you have a more adult-appearing presentation. So that's mostly what we do in terms of pharmacotherapy.

The mainstay of treatment, of course, is counseling and support. We offer kids individual counseling, along with parental support. The counseling style we use will depend on where the kids are in their treatment, what their diagnoses are, and where we see them in their stage of treatment. In kids who come in because they were dragged in by Mom and Dad and don't want to be here, we'll try to get them to agree to some ground rules. If they really won't budge on quitting or cutting down, we'll try to agree on very basic ground rules: For example, there are no drugs or paraphernalia in your room or in your possession, and there is no driving. Just set some basic ground rules that hopefully everybody can agree to.

We then ask them to come back for counseling sessions; in fact, that has to be part of the agreement. And even the resistant kids will be able to do that. For those kids, we do motivational work. Often, they come in reacting to something. There have been some big fights at home, and it's not necessarily that they don't have ambivalence about their use, but something else is blocking it and we try and work through that.

It can be a process; it can take a long time. Sometimes parents get frustrated: "I've been coming here for 6 months, and I haven't seen too much of a change." As long as kids and families are willing to stick with us, we're certainly willing to stick with them. If a kid is not willing to agree to even basic ground rules, or engage in treatment at all, then parents may need to take a harder line. In our state, as in many others, parents may need to file an order with the police to help support their rules. It's always better to get kids to agree to come, but if they won't, a parent can't just stand by and allow the status quo.

Some kids come in and they've had a big problem, and they have decided that they are going to quit entirely, at least for a while, and so we'll do supportive counseling with them. We'll offer them drug testing to show the world that they can do this. We've done a lot of research on drug testing, and one of the things that we've learned is that one of the reasons that kids use less drugs when they're drug testing -- at least in this program -- is because they like getting negative drug test results and they like hearing from their parents, "Oh, that's great, I'm really glad that these are negative, I'm glad that you're not using."

We are able to incorporate that into some sort of positive contingencies. Depending on where they are, some kids really need some relapse prevention work. Some kids have been using drugs and alcohol since they were very young, and they use them to blunt their emotions or to relax, and so they don't necessarily have all of the skills that we would like them to have. They just don't have any idea how to relax without smoking marijuana. We'll teach them how to do breathing exercises, or whatever is going to work for them. I don't know whether these kids really take the breathing exercises home exactly as we do them, but we're trying to open their minds to think about what other ways you can relax and try and get them to try other things.

Some kids have a problem in their life, and they use marijuana to disassociate. For kids like that, we're going to really want them in counseling and working with a supportive person as they are making an attempt to cut down or to quit.

Medscape: How do you engage with the patient's parents throughout the management process?

Dr. Levy: We invite parents to have their own separate appointments to support them and answer their questions, because their job is critical and so difficult. We want them to set firm, logical limits, but we also want them to be careful not to polarize the situation. We want parents to not forget to tell their kids that they love them. Sometimes parents get very angry and may struggle with this. And in some cases, the situation just gets polarized, and then the parent gets angrier and angrier and they implement stricter and stricter discipline; at the same time as the discipline is getting very strict, the kid just starts to ignore everything, and a war breaks out in the house.

It also depends on where the kids and parents are when they come in. Some parents have very liberal attitudes toward alcohol and drug use in their kids, and then they come in and, lo and behold, their kid has a serious marijuana problem. They're smoking 3 times a day, and suddenly the parent realizes that marijuana use is not so benign -- that's also hard for parents to negotiate.

We also offer group therapy. I have to say the one issue with group therapy is that there is always the risk for or the concern about contagion. If I have a kid who really wants to quit smoking marijuana, and I put him in with some kids who don't want to stop, but they were told they have to go to this group meeting, is that going to be good for my kid or not? Which way is the group dynamic going to go?

Once they do go in, there is a curriculum for kids and there is a curriculum for parents that run simultaneously in a different room; they're kind of parallel curricula. So, for example, kids will work on communication strategies, which include how to talk to your parents. And the parents will work on communication strategies, including how to listen to your kids.

We offer separate groups for kids who are opioid-dependent and for kids who are non-opioid-dependent. But often the parents will do a mixed group -- all the parents in one group.

We also offer our continuing care group, for kids who have been in the program for a while and have had a very strong recovery. That group meets less frequently, only twice a month instead of weekly. It's a slightly less structured curriculum. We like to offer those kids a chance to do some leadership -- for example, we try to find opportunities for them to speak at events. Some kids are shy and they don't want that, but they want to stay in group for the support.

So, there is a whole package. We also have psychiatrists as part of our multidisciplinary team. They see kids with co -occurring mental health disorders and prescribe medications, so they get everything in one place. We have a resource specialist who connects families with outside resources, so if we want somebody to see an outside counselor, or if somebody needs a higher level of care for a period of time, our team can facilitate those connections. I'm trained in developmental pediatrics and so are my colleagues, and if kids are struggling with school and need some help accessing resources, we can help them with that as well.

Medscape: Can you go into a bit more detail about your collaborative care model, which has proven very effective?

Dr. Levy: I think that the multidisciplinary team is really critical. One of the things that I think is really special about our program is that there's an entire multidisciplinary team in 1 center, consisting of about 15 people -- pediatricians, psychiatrists, social workers, volunteers in training, administrative support people, and so on. We round every week for 2 to 2.5 hours. We present all of our new patients so that everybody can meet our new patients -- of course, the patients aren't there -- but we present them and talk about treatments, suggestions, and treatment approaches, which can be just as important as the actual recommendation.

We also review; we have approximately 150 patients in treatment at any given time. Anybody who is treating a patient but feeling like their treatment isn't going well will bring the patient up to the team. All of the kids in the drug testing program, their drug tests will be read by one of the physicians before the multidisciplinary rounds. But as you may know, a lot of drug test results that are returned to the laboratory are inconclusive. The drug test may be dilute; or perhaps the child is skipping the drug test and we don't know why; or there is marijuana on the test, but is this representing ongoing use or is this just a prolonged excretion? Or there is a very low level of alcohol -- does that really represent alcohol use?

Having the multidisciplinary team there when we read the drug test, there will be a note that says this week's sample was dilute. And the counselor who was working with the kid can say, "You know, I really think the kid is doing well. Let's just watch for now; let's not make an intervention." In another case, the team will say, this kid has missed 3 drug tests in a row, and the administrator will say that Mom just called me and they've been away this month, so they couldn't do testing. Another kid will have a very low level of alcohol, and the physician who just saw them will say, I'm really worried about her -- she didn't look good the last time she came in, and Mom noticed that there was some money missing. That kid will get called in.

So you can see how rich the case reading is when you're doing it in the context of a multidisciplinary team that is working with these kids and families.

Medscape: How can clinicians implement some of your approaches to better manage their young addicted patients, assuming that they don't have access to a center offering similar services? And how can they better facilitate collaborative care?

Dr. Levy: We do a lot of things that are unique and special, but I think that there are lots of things that people can do.

For starters, one of the most important things I really learned over the 10 or 15 years that we've been running this program is that the most important things is engagement. Getting kids and families to come back and stick with it -- to keep going, even if it feels like the process is very slow. There are times where it's discouraging, because you don't know where it's going; just keep going, because over time people get better.

I think coordination of care is really critical, as is everybody talking together, everybody agreeing on the recommendations, and everybody putting together what they notice. Two heads are definitely better than one, and if you're working by yourself and not in a large coordinated program, pick up the phone and call the other people who

are working with the kid. It's a time investment, it's intense to take care of these kids, but I am convinced that speaking with the other treaters who may be seeing the kid and the family is a critical component.

References

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