The Kids Are (Not) Alright: A Multidisciplinary Approach to Care for Adolescents

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Abbreviations

AYA	Adolescents and Young Adults
HLOC	Higher Level of Care
IPV	Intimate Partner Violence
SUD	Substance Use Disorders
TIC	Trauma-Informed Care
WHO	World Health Organization

Learning Objectives

- Develop **frameworks to address complex psychosocial needs** and healthcare barriers for AYA with SUD
- Describe the **importance of confidentiality** with AYA, including its role in rapport building, legal contexts, situations where it is medically necessary to breach confidentiality
- Integrate available **interprofessional resources to optimize health services** for AYA with SUD
- Understand the direct **correlation between trauma and substance use**, and identify the importance of utilizing trauma informed care in clinical practice with adolescents

"The adolescent brain is often likened to a car with a fully functioning gas pedal (reward system) but weak brakes (prefrontal cortex)."

NIDA Principles of Adolescent Substance Use Disorder Treatment: A Research-Based Guide

Knowledge Review

The Kids Are (Not) Alright:
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Adolescents and Adolescence

- Why so scary?!
- What is adolescence? Definitions vary
  - "Puberty to Maturity"
  - Age 10 to 19 approximation (WHO)
  - Age 12 to 21+ (most academic AYA groups)
- Not large children or small adults!
- Period of rapid physical, cognitive, and psychosocial growth

References: National Research Council, 1999; Singh et al, 2019.
Image: Leish, 2020.

Adolescents and Adolescence

- Also: a period of vulnerability
- Brain systems in different stages of development
  - Areas of emotions and reward-seeking are fully developed
  - Circuits governing judgement and self-inhibition still forming
- Circuit imbalance = teenage behaviors!
  - More impulsive,
  - Seeking new sensations and experience
  - Easily swayed by peers and environments around them

References: National Research Council, 1999; Singh et al, 2019.

The Docs Are (Not) Alright

- Working with AYA can be challenging for clinicians
- Survey of 75 AYA primary care providers reported:
  - Time constraints
  - Challenges related to parental involvement
  - Lack of training on SUD screening
  - Perceived lack of effectiveness in using brief interventions
  - Unsure about referral to treatment
  - Limited options for treatment
- Hard to keep up with what's cool… On fleek? That's fire?

Reference: Palmer et al, 2019.

The Docs Are (Not) Alright

- Risk taking in adolescence is developmentally normal!
  - Ambivalence towards treatment (normal)
- Substance use may be… normal?
  - Abstention rate (12th grade):
    38% lifetime; **63%** past 30 days
- AYA Substance use not risk-free
- Clinicians have to wear a lot of hats
  - Often not in the job description!

Reference: Palmer et al, 2019; Miech et al, 2023. Image: Hunaidah, 2018.

Challenges for Clinicians

- Navigating patient confidentiality and time alone
- Managing relationships between AYA and caregivers
  - Parents, legal guardians, social welfare orgs, foster providers, etc.
- Feeling unprepared to monitor and manage all the things:
  - Substance use, physical activity, nutrition, mental health and more
- Adolescents seek out healthcare less frequently
- Clinicians have to do more in less time
  - Follow-up rates may be lower than other populations

Reference: Palmer et al, 2019.

The Multidisciplinary Approach

- Teamwork focus for AYA with any SUD
  - Physicians & medical providers
  - Social Workers
  - Pharmacists
  - Nurses
  - Therapists
  - Peer navigators
  - Trainees in all disciplines!

Image: Alouani, 2022.

The Multidisciplinary Approach

- Clinical care
  - New patient assessments and level of care determination
  - Counseling outside of therapy: SW, pharmacist
  - Follow-ups, linkage to resources
- Majority of visit is with patient alone
  - Caregivers heavily involved
- Monthly clinic-wide team meeting
- Distributed case management

AYA Consent and Confidentiality

- Disclaimer: We are not lawyers!
  - Laws and regulations vary by state/region
- Reminder: young adults (18+) are still adults
- Adolescents more likely to seek sensitive health care if:
  - They can provide their own consent
  - Feel confident medical care will be private
- May forego needed health care if unable to have privacy

References: Lehrer et al, 2007; Reddy et al, 2002.

AYA Consent and Confidentiality

- Scenario studied if no confidentiality
- Sexually active adolescent girls:
  - **59%** would stop using all reproductive health services
  - Delay screening and treatment for sexually transmitted infections
  - Discontinue specific services
- **99%** would remain sexually active
- Disclosing substance use
  - 39% to 47% with confidentiality statement (1997 RCT)

References: Reddy et al, 2002, Ford et al, 1997.

When Confidentiality is Discussed

- Overall: positive outcomes for AYA!
  - Presenting for care
  - Disclosing sensitive information
  - Returning for future care
  - Having positive perceptions of care
  - Feeling more actively involved

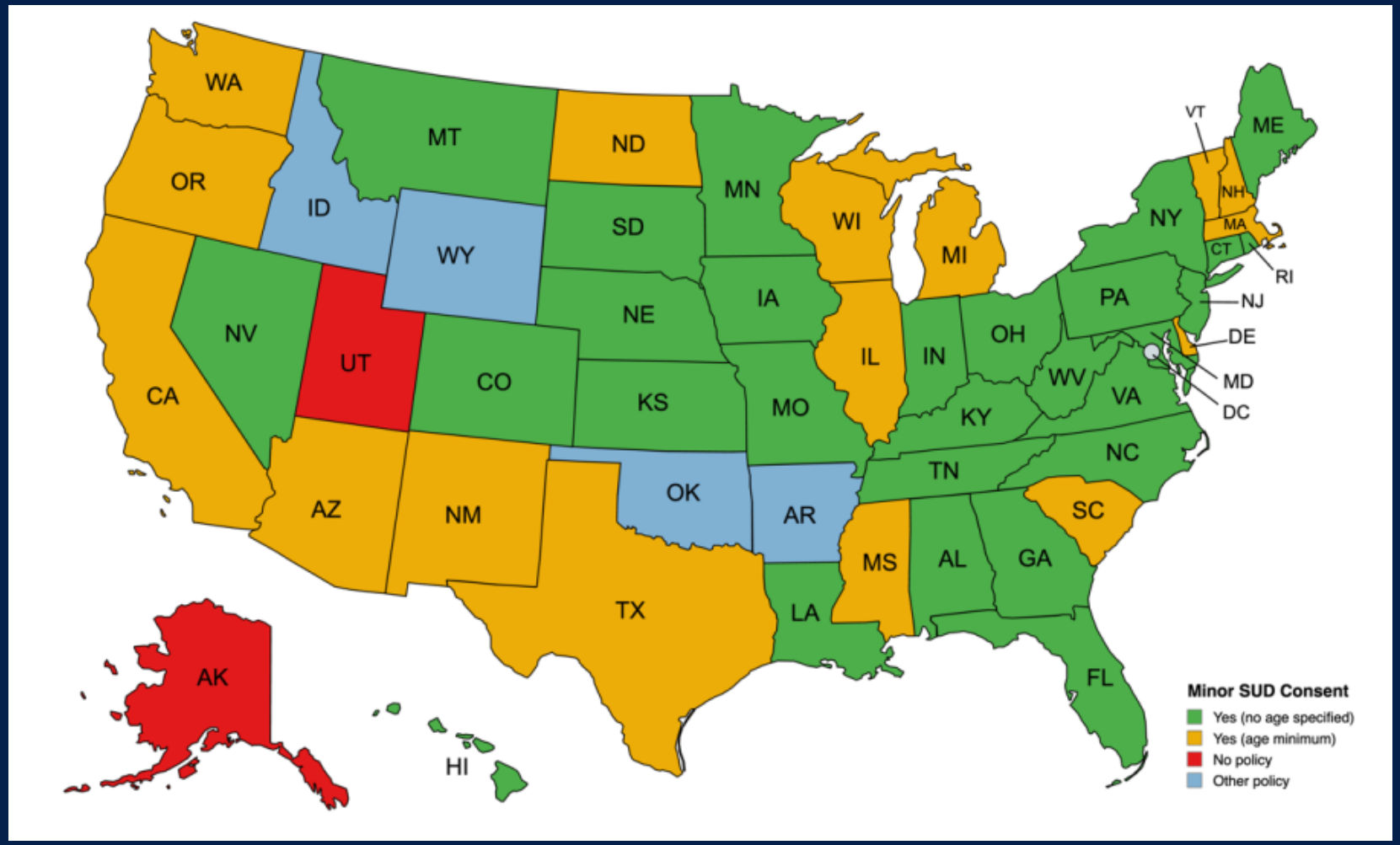
Reference: Ford et al, 1997. Image: Okun, 2023.

Minor Consent for SUD Treatment

- Most states (28) allow minors to consent for SUD treatment
- Some (16) specify a minimum age of consent (range 12 to 16)
- Others (4) have more restrictive policies
  - Arkansas: “sufficient intelligence to appreciate the consequences”
  - Idaho: Optional parent notification if under 16
  - Oklahoma: emergency cases only
  - Wyoming: Nicotine/tobacco only (12+)
- No explicit policy in 2 states
- Laws do not always reflect best practices

References: Sharko, 2022; Weisleder, 2007.

Minor Consent for SUD Treatment



Reference: Sharko, 2022.

Minor Consent for SUD Treatment

- 2007 study of legislative choices:
  - Inconsistent age selections
- Colorado legislator on prior age limit:

"We probably pulled that number out of thin air."

References: Sharko, 2022; Weisleder, 2007. Image: Nthebolang, 2022.

Confidential Care: Legal Background

- In general…
  - If a minor is legally able to provide consent for health care
  - Then the clinician is obligated to maintain confidentiality for the issues being discussed

Image: Sierra, 2023.

Confidential Care

- SUD treatment as opportunity for other confidential services
- STI screening, testing, treatment
  - Minors allowed to consent for this in every state
- Contraception (including emergency contraception)
  - 27 states (and DC) allow minor consent
  - 19 states allow only certain categories of people younger than 18 to consent to contraceptive services
  - 4 states have no explicit policy or relevant case law
- Other counseling, condom distribution

Reference: Guttmacher Institute, 2023.

Limits of Confidentiality

- Mandated reporting: **safety** concerns
  - Suicidal ideation
  - Homicidal ideation (duty to warn)
  - Child abuse or maltreatment
- Safety and substance use?
  - Case-by-case and patient-specific
  - Degree of harms from substance use (overdose?)
  - Benefits of confidentiality for treatment versus harms of using
  - Social contexts (home environment, gang involvement, etc.)

Belitz & Bailey, 2009.

Confidentiality & 42 CFR

- Title 42 of Code of Federal Regulations (CFR) Part 2
  - Confidentiality of Substance Use Disorder Patient Records
- Part 2 programs are **federally assisted programs**
  - Prohibited from disclosing any identifying information of a patient with/prior SUD unless written consent
- Degree of consent needed varies based on program
- Many AYA programs are embedded within larger system
  - Degree of confidentiality may vary

One Approach to Confidentiality

- Inform your AYA patient and caregivers about confidentiality
  - Prior to one-on-one discussion
  - Discuss intention
  - Address limits
- Utilize EMR features to limit sharing (“sensitive notes”)
- Notes as education to others!
  - “This note contains history regarding substance use assessment and treatment and has additional confidentiality protections. Information contained here should not be disclosed outside of substance use medical care unless there is a specific need to break confidentiality.”

Reference: Ford et al, 1997.

Confidentiality Recap

- Know your state / region!
  - Laws vary regarding minor consent
- If minors able to consent,
  then that care is confidential
- Talk to patient + caregivers about
  confidentiality and limitations
- When in doubt,
  do the right thing for the patient

Image: Preciado, 2023.

Trauma-Informed Care (TIC)

- Disclaimer: Discussions around trauma and its impact, may provoke difficult or charged responses
- Please practice self-care, in whatever form that may be
- Addiction medicine-specific guide: 2023 SAMHSA
  - Great reference for all populations we may see
- Language variations you may see
  - Trauma-informed care (TIC)
  - Trauma-informed approach (TIA)
  - Adverse childhood events (ACEs)

Reference: SAMHSA, 2023.

TIC for SUD Treatment

- Individual trauma:
  - Results from an event, series of events, or set of circumstances
  - Experienced as physically or emotionally harmful OR life-threatening
  - Has lasting adverse effects on functioning AND / OR mental, physical, social, emotional, or spiritual well-being
- Various types of individual trauma
  - Events: Victim of crime, natural disasters, school violence
  - Interpersonal: Physical abuse, sexual abuse, neglect, IPV

Reference: CSAT, 2014.

TIC for SUD Treatment

- Collective trauma:
  - Cultural, historical, political and/or economic trauma
  - Impacts individuals and communities across generations
- Includes institutional barriers and social determinants of health
  - Racism
  - Food insecurity
  - Unsafe housing
  - Access to medical care (SUD treatment)

Reference: CSAT, 2014.

The Four R's of TIC

- **Realize** the widespread impact of trauma and understands potential paths for recovery;
- **Recognize** the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
- **Respond** by fully integrating knowledge about trauma into policies, procedures, and practices; and
- **Resist** re-traumatization (actively practice this)

Reference: SAMHSA, 2014.

Think Outside the Box

Trauma may go unrecognized by us and by our patients!

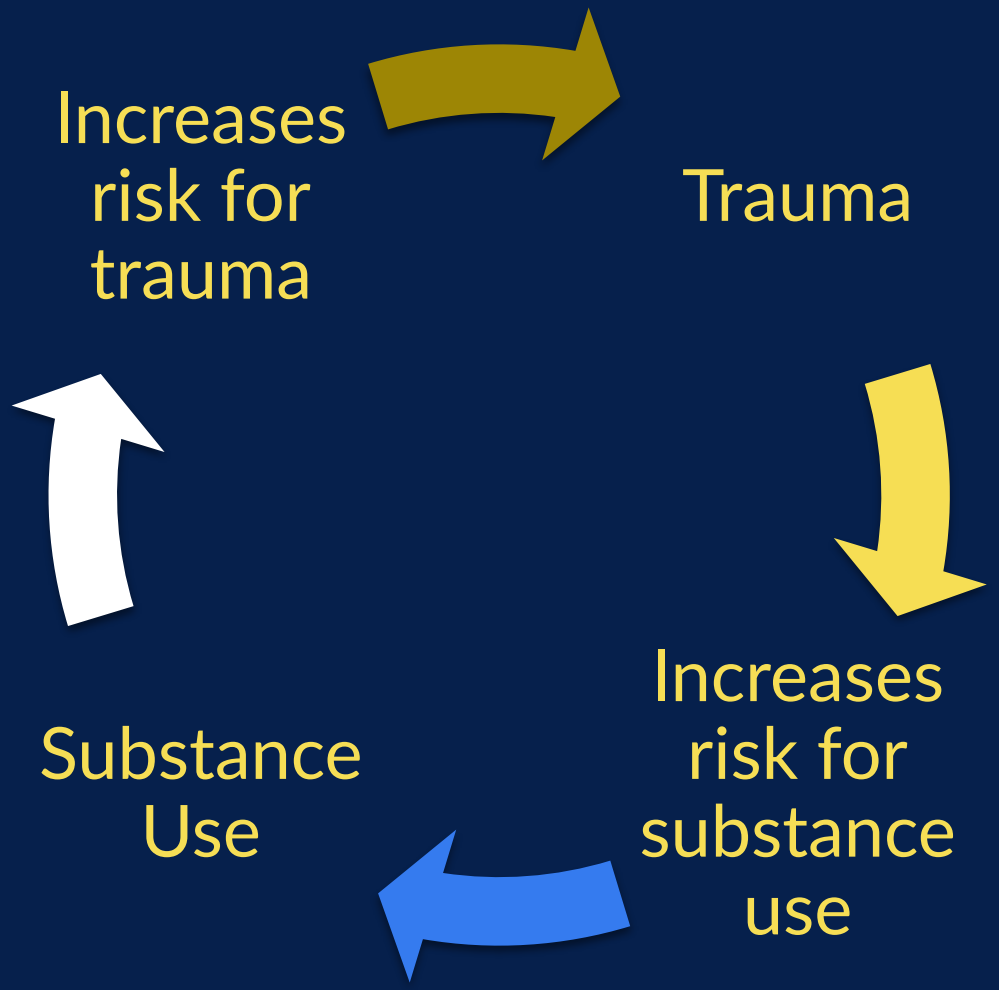
- CPS / foster care involvement
- Racism and racial inequities
- Poverty & unmet basic needs
- Housing instability
  - Frequent relocation: changing schools, homes, caregivers
- Death, incarceration, or loss of a resilient adult relative or mentor
- Unsafe community / violence
- Social media (cyber) bullying
- Witnessing IPV / abuse
- Trafficking, coercion, exploitation
- Medical trauma
- High performance pressures
  - Academic and/or athletic
- Spiritual or religious abuse

Reference: CSAT, 2014.

Relating Trauma & Substance Use

- Trauma is a risk factor for substance use
  - Substances often used to cope with systemic response associated with triggers, memories, etc.

- Substance use is a risk factor for trauma
  - Direct link between increase in high-risk behaviors due to substance use
  - Link stronger in AYA

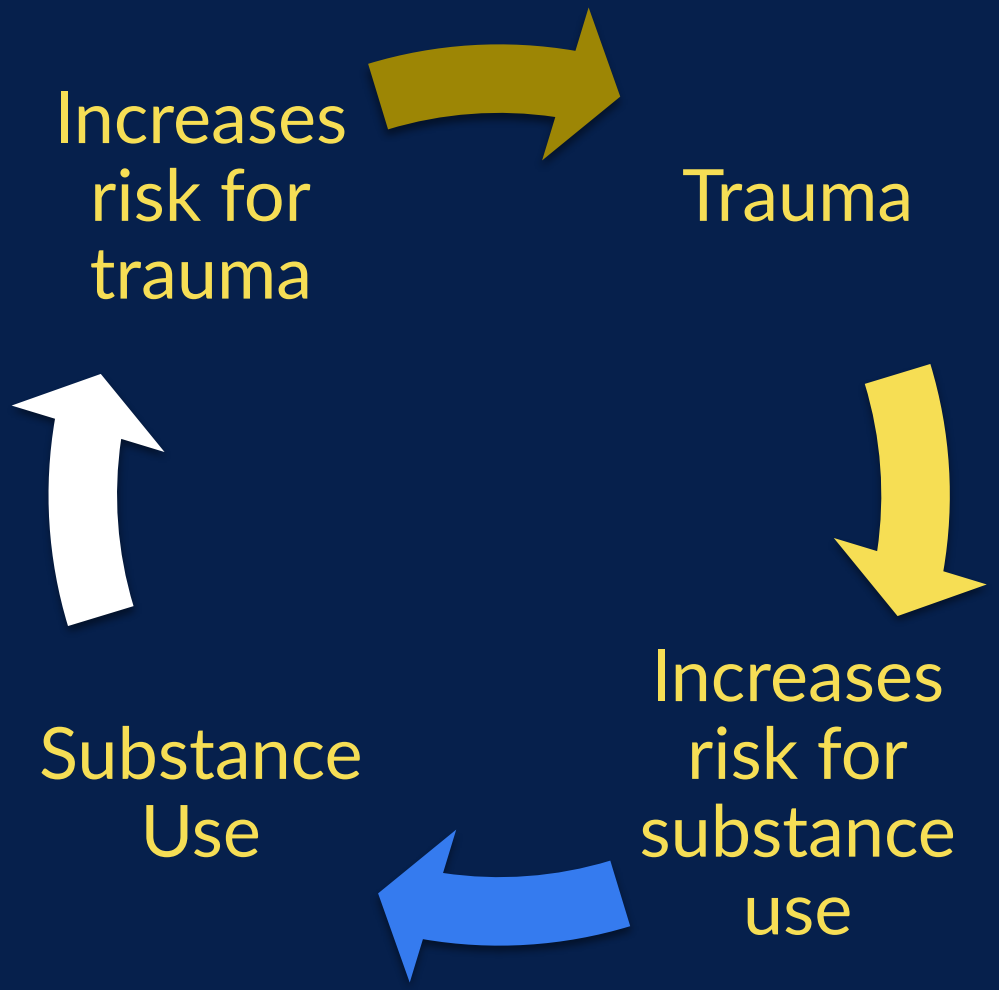


Reference: SAMHSA, 2023.

Relating Trauma & Substance Use

- Individuals with 3+ traumatic childhood experiences have increased rates of alcohol and drug use

- Individuals in substance use treatment:
  - ~75% report hx of abuse and trauma
  - ~12-34% are diagnosed with PTSD



Reference: SAMHSA, 2023.

Consider This

- Factor in TIC when assessing, diagnosing, and treatment planning
- Consider:
  - Genetic pre-disposition & family histories
  - Acute stresses in utero
  - Generational trauma
  - Learned behaviors and secondhand exposure

Reference: SAMHSA, 2023. Image: Cottonbro Studio, 2020.

TIC Tips: Practical Takeaways

- Use compassion & assume positive intent
- Be aware of personal space & ask permission
- Comfort with silence (motivational interviewing practice too)
- Be transparent, consistent, and predictable
  - Flow of visit, clinic room(s), timing, policies for running late, etc.
- Discuss confidentiality up front - no surprises!
- Be a part of their support system
- Give **voice & choice**: involve patient in treatment planning

Reference: Ott et al.

TIC Tips: Practical Takeaways

- AYA are the expert: allow them to guide the conversation
- Maintain a non-judgmental environment and space
  - Be curious, not confrontational about use & life circumstances
- Reduce stigma, use person-first language
  - “Prepare your script”
- Include harm reduction: Learn about local resources
  - Naloxone, fentanyl test strips, needle exchange programs, etc.
- Remember that recovery is not linear!

Reference: Ott et al.

TIC Tips: Practical Takeaways

- The Invisible Suitcase
- Every person carries an invisible suitcase with them
- It contains:
  - Beliefs about their self
  - Beliefs about past and present caregivers
  - Beliefs about the world
- Viewed through the lens of trauma(s) they have experienced

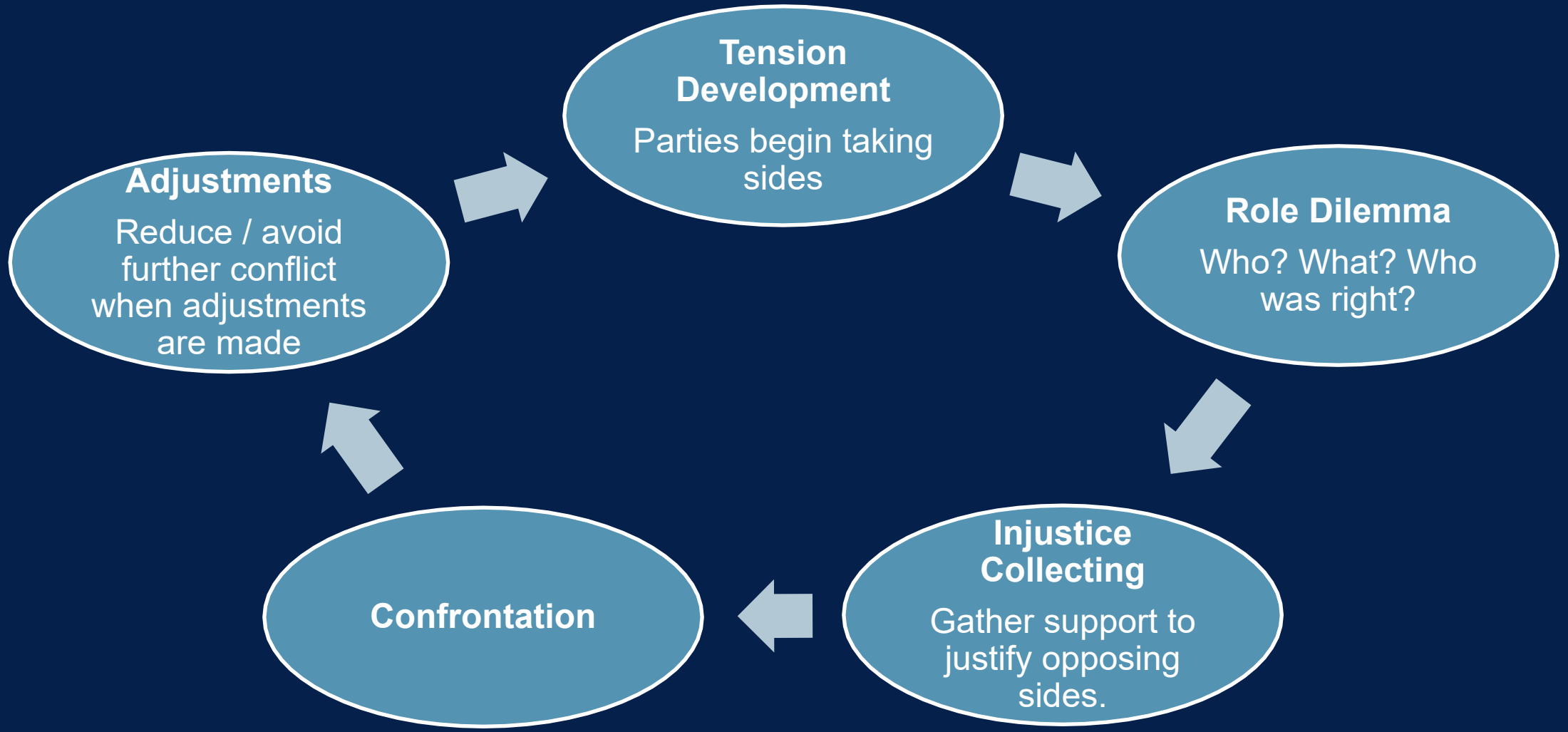
Reference: NCTSN, 2008.

Family Feud: Recovery Edition

- Understanding family dynamics is vital to navigating a young person's substance use and recovery
- Balance patient autonomy and wishes of caregiver/parent
- Incongruence happens: unrealistic expectations of caregiver
  - Poor understanding of family genetic predisposition
  - Cognitive distortions of severity of substance use
  - Treatment discussion: bringing caregivers back to reality
- Identifying clear boundaries of treatment of **the patient**
  - Have resources / outlets available to provide necessary supports

Reference: SAMHSA, 2019.

Managing Conflict



Reference: Robinson, 1978.

Focusing on Family

- Identify who the patient considers family
- Understanding the importance of therapeutic interventions when working with families
- Utilize non-blaming, solution focused, collaborative approach
- Focus on harm reduction rather than abstinence
- Broadening the perception of success
- Highlight the value of family relationships and how they impact recovery

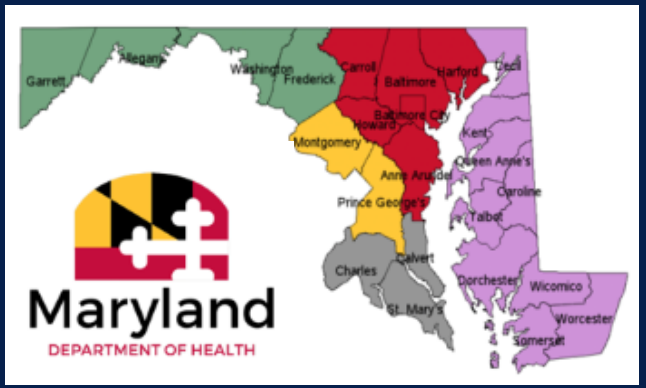
Reference: SAMHSA 2019.

Engaging Stakeholders

- Who are they? Who can they be?
- Child protective services
- Juvenile intervention / detention centers (JIC / JDC)
  - Specialty court dockets
  - Empower Court & Recovery Court [Central Ohio]
- Schools & school districts
- School-based health programs
- Youth drop-in centers, homeless shelters
  - STAR House [Central Ohio]

Engaging Stakeholders

- Community Treatment Providers
  - Buckeye Ranch & Maryhaven [Central Ohio]
- Community initiatives & school campaigns
- State / Regional / County Departments
  - Departments of Health (Mental Health, Addiction)
  - County Alcohol, Drug Addiction and Mental Health (ADAMH) [Ohio]
- Legislators & policy creators



Images: Ohio DMHAS; Maryland, 2021.

Strategies for Engagement

Outreach

- Peer support
- Training
- Partnerships: formal & informal
- Marketing Materials
- Face-to-face
- Attending conferences ☺

Education

- Share with stakeholders what your program does, services, etc.

Leverage Technology

- Use the EHR to make referrals and treatment communication efficient

Meet Expectations

- Transparency: set clear goals and expectations
- Consistency
- Streamline communications & updates

Praises and Pitfalls

Praises

- Mitigating barriers to care
- Faster engagement in care
- Learning opportunities / enhancing clinical skills and interventions
- Building rapport/ strengthening connections
- Obtaining information that reinforces initiatives

Pitfalls

- Limited understanding of adolescent substance use
- Limitations/continued gap in levels of care needed.
- Demand exceeding availability / staffing
  - If you build it, they will come… but maybe not right away!
- Proving program value

Transition to Adult Care & Services

- Challenging area without clear guidelines for AYA with SUD
- Highly dependent on available regional resources
  - Adult SUD services far outnumber AYA services in all states
  - Choice overload
- Added challenges when SUD is not in remission
  - Most HLOC programs operate outside of medical home network
  - Disjointed treatment episodes
- Key to success: creating continuity of care

Reference: AAP et al, 2011. Passetti 2016.

Patient Barriers

- Anxiety / fear of the unknown
  - New health care system, clinic locations, and adult-focused teams
- Finding an appropriate provider (choice overload)
- Limited availability of adult specialty clinicians
  - Paradoxical, right?
- Inadequate preparation and support from AYA clinicians
  - “How-to” guidebook?
- Absence of caregivers or mentors in adult model of care
- Multiple services to transition (e.g. primary care)

Reference: AAP et al, 2011.

Patient Barriers

- System difficulties
  - Transfer of medical records between systems
  - Hand-off between providers
- Logistical concerns
  - Making an appointment
  - Locating the new clinic, phone numbers, EMR setup, parking, etc.
  - Adequate insurance coverage, submitting paperwork
- Loss of built-in safeguards towards cost of care
  - Incentive programs, pharmacy support

Reference: AAP et al, 2011.

Transition to Adult Care: Tips

- Start the conversation early
  - Prioritize treatment goals
  - Look for a “natural” transition point
- Don’t rush to transition
  - Avoid pushing out patients
- Unified team approach
  - Set boundaries when needed
- Network in the community!

Reference: AAP et al, 2011. Image: Garzón, 2021.

Case Discussions

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Case 1: Access to Care

- 17-year-old female, admitted to a pediatric hospital
- Reports a 6-month history of benzodiazepine use
  - 24 mg/day alprazolam at peak use 1 month ago
  - Also reports prior occasional use of cocaine and ketamine
- Has been cutting back step-wise, independently
- Admitted due to friend witnessing 2 seizures in patient
  - Experiencing agitation, skin crawling, tachycardia, insomnia at time of adolescent addiction medicine consultation
- Started on long-acting benzodiazepine taper & stabilized

Case 1: Access to Care

- Seen in addiction medicine clinic for follow-up
- Reports adherence to benzodiazepine taper
- However, having increased cravings and anxiety
  - Using cocaine and ketamine more frequently to cope
  - Has started using illicitly-supplied oxycodone
- Clinic recommends and patient agrees to start SSRI and she is scheduled with addiction-specific therapist
- Patient meets criteria for residential level of care
- **No treatment centers will accept with benzodiazepine taper**

Case 1: Access to Care

- Consider the next steps in developing a treatment plan. Who are the stakeholders to consider?
- How would you create a treatment plan for this patient when she requires a HLOC that is not available?
- What factors should be considered in creating a team approach to her care?

Case 1: Access to Care

- When may it be appropriate to break patient confidentiality and inform caregivers of her substance use?
- How might you approach a patient request for selective confidentiality, such as only informing one parent?

Case 1: Continued

- Over several follow-up visits, the patient discloses that she has been abused by her dealer
  - Dealer hit her with car, physical abuse
- Additionally, she has virtually no social connection or peers

- Consider how trauma informed care could be utilized to formulate treatment for this patient?

Case 2: Competing Priorities

- 16-year-old male, seen in addiction medicine clinic
- Caregivers found a nicotine vape in his bedroom
  - Caregivers want him to stop using nicotine / vaping immediately
  - As a result, patient is grounded at home
- During confidential interview, he discloses cannabis use
- Caregivers are not aware of any cannabis use
  - Concerned about consequence, such as forced residential
- Reasons for ongoing use include relief of stress and anxiety
- Does not feel ready to stop use

Case 2: Competing Priorities

- How might you navigate this situation where the caregivers and the young person have competing (incompatible?) goals and priorities?
- What scripts could you use if caregivers demand to know about substance use, either from the confidential interview or from a urine screen?
- Is residential treatment a realistic option? How might you discuss this with caregivers?

Case 3: Surprise!

- 15-year-old teenage presents with parents to your adolescent addiction medicine clinic
- Referred by parents for substance-related school suspension
  - Was caught with a vape in his backpack per scheduling call
- After being roomed, clinic staff informs the providers that the patient's chief complaint is **"I don't know why I'm here."**
  - Your clinic is housed within a pediatrics clinic building without specific signage stating there is an addiction medicine clinic
- They found out about clinic visit from parents this morning…

Case 3: Surprise!

- How do you navigate the situation where parents bring an adolescent to an appointment for substance use concerns without telling them about it prior to the appointment?

- How does this impact the team's ability to build rapport?

Case 3: Surprise!

- After navigating introducing the clinical team and purpose of the visit to the patient, the visit goes on
- Confidential discussion:
  - Patient reveals he uses cannabis intermittently
  - Primarily vapes when he can get it from a friend
  - He has tried benzodiazepines before, most recently a week ago
  - Parents do not know about cannabis or benzo use

Case 3: Surprise!

- The patient is hesitant to provide a urine sample for a drug screen at the visit today because he is afraid, we will tell his parents. How would you navigate this conversation with him?

Panel Review and Q & A

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Summary

- There is no one-size-fits-all approach to AYA
- A flexible team-based approach can address many of the psychosocial needs of AYA with SUD
- Confidentiality is crucial to developing rapport and understanding the needs of AYA
- Trauma and substance use are related and often cyclical, and TIC can help navigate and address these challenges

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