Working Together to Understand and Address the Needs of Teens Who Use Substances

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DISCLOSURE OF FINANCIAL SUPPORT

- No External Support

FACULTY/PRESENTER DISCLOSURE

- Faculty: Drs. Karen Leslie and Jessica Empringham, Catherine Maser
- Relationships with financial sponsors:
  - Not applicable

INTROS

Who are you and where do you work?

What are YOUR learning goals for this session?

OBJECTIVES

By the end of this workshop participants will be able to:

1. Describe the developmental stages of adolescence and the interplay with substance use
2. Discuss aspects of substance use assessment and care that are unique to working with adolescents
3. Identify approaches to working with youth across health settings that can optimize health and wellbeing

POLL QUESTIONS

STORY

Denyse is an almost 16-year-old assigned female (she/her), who enjoys classic rock music and basketball, who comes to the emergency room with polysubstance use (vaping, cannabis use, daily alcohol use, intermittent use of cocaine and MDMA) and symptoms of alcohol withdrawal. Her parents arrive after being called by her friends and want to know what's going on with their daughter.

What next?

BREAKOUT GROUP DISCUSSION

- What aspect of this teen's presentation need further assessment?
- What considerations there might be for next steps/provision of care?

WHAT PRIOR WORK INFORMED THIS SESSION?

Patient scenario that prompted a formal review (M and M)

Review of Youth Withdrawal Management Project in 1997

- Our question: What withdrawal management services are currently available for youth <18 in the GTA and Ontario?

Modified survey from 1997 and approved as SickKids QI Project

- Two thirds of youth not able to access withdrawal
- One program with access to youth focused care

Emailed questionnaire to RAAM clinics, withdrawal management programs and youth agencies

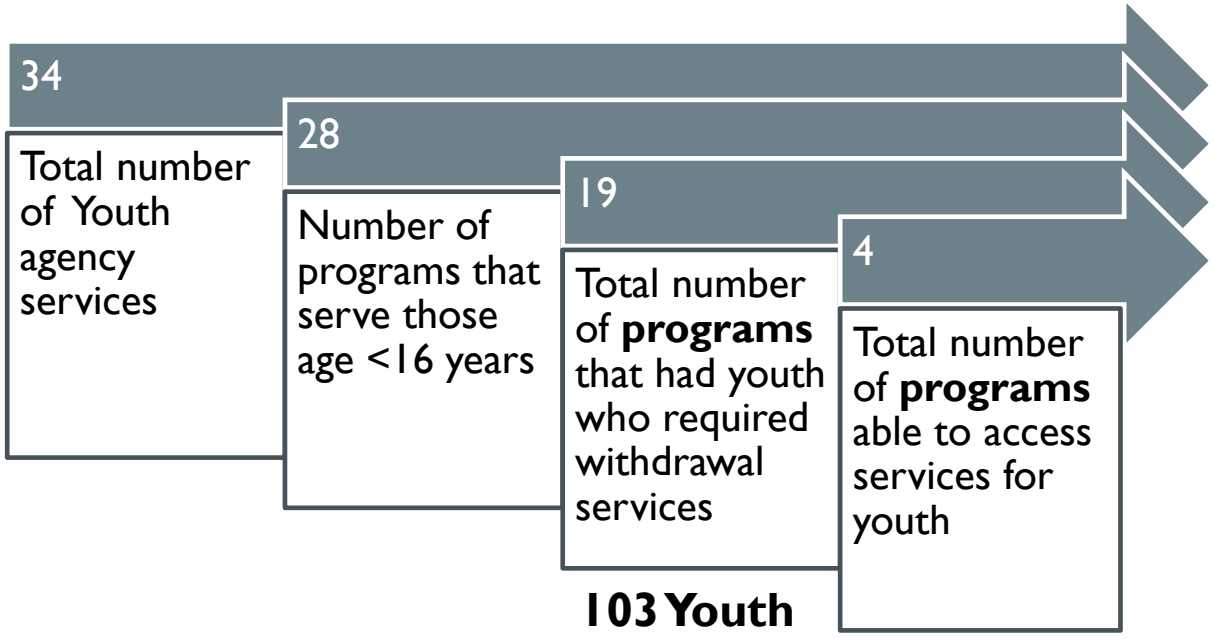
- Identifying services in the area and perceived need for these programs
- Identifying availability of youth-centered care
- Impact of covid

What has changed?

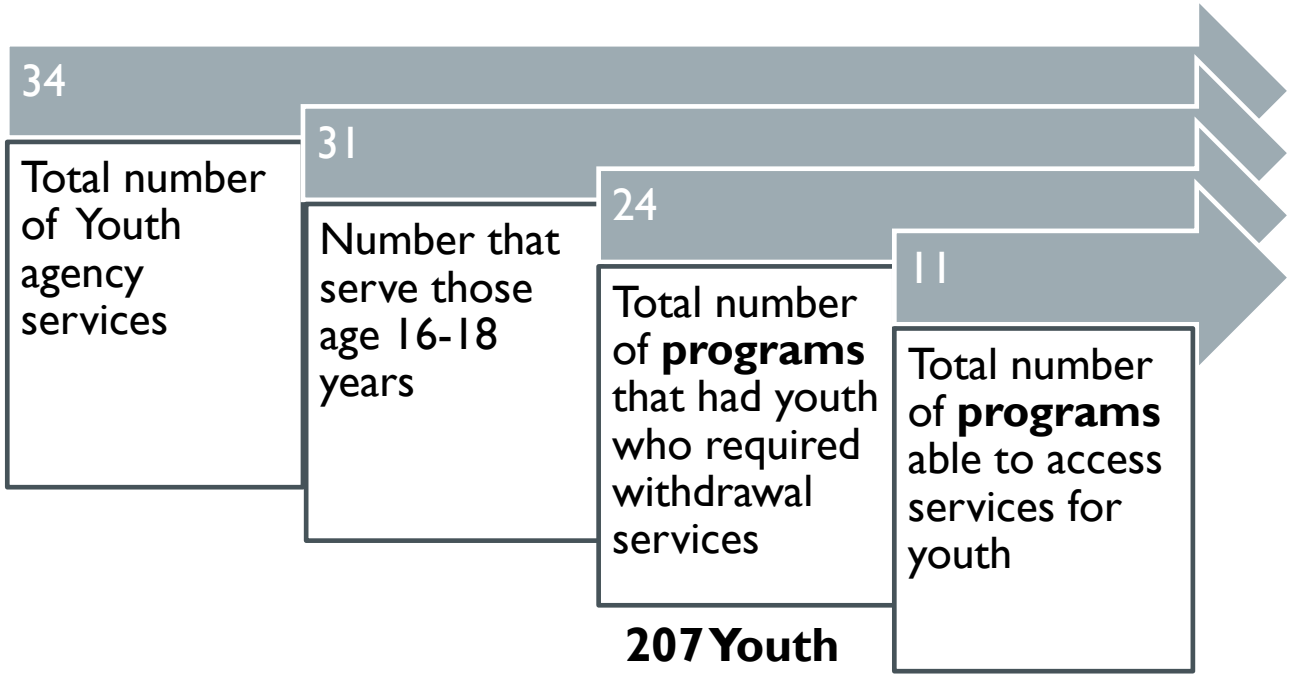
- New RAAM programs
- Increased focus on mental health and addiction medicine

YOUTH AGENCY: NEEDS ASSESSMENT

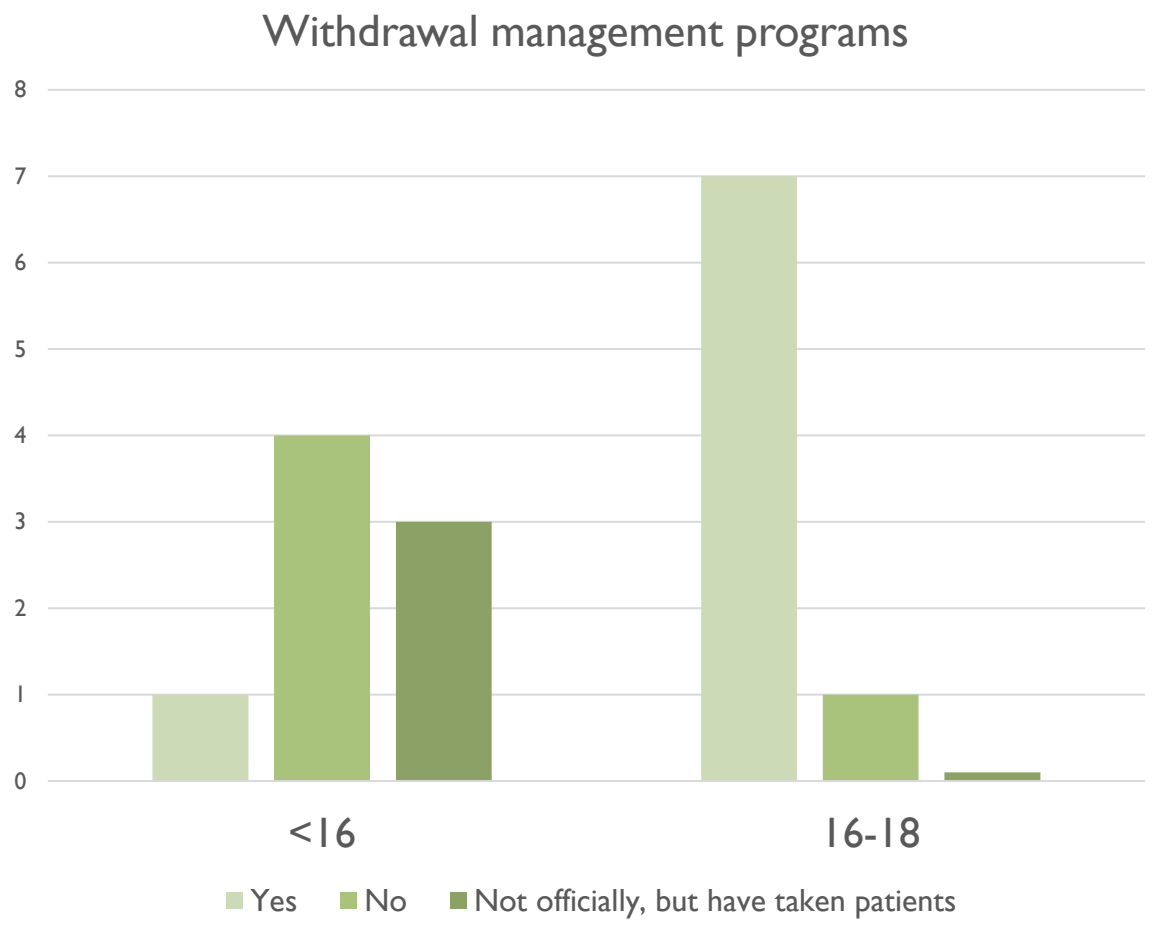
<16 years

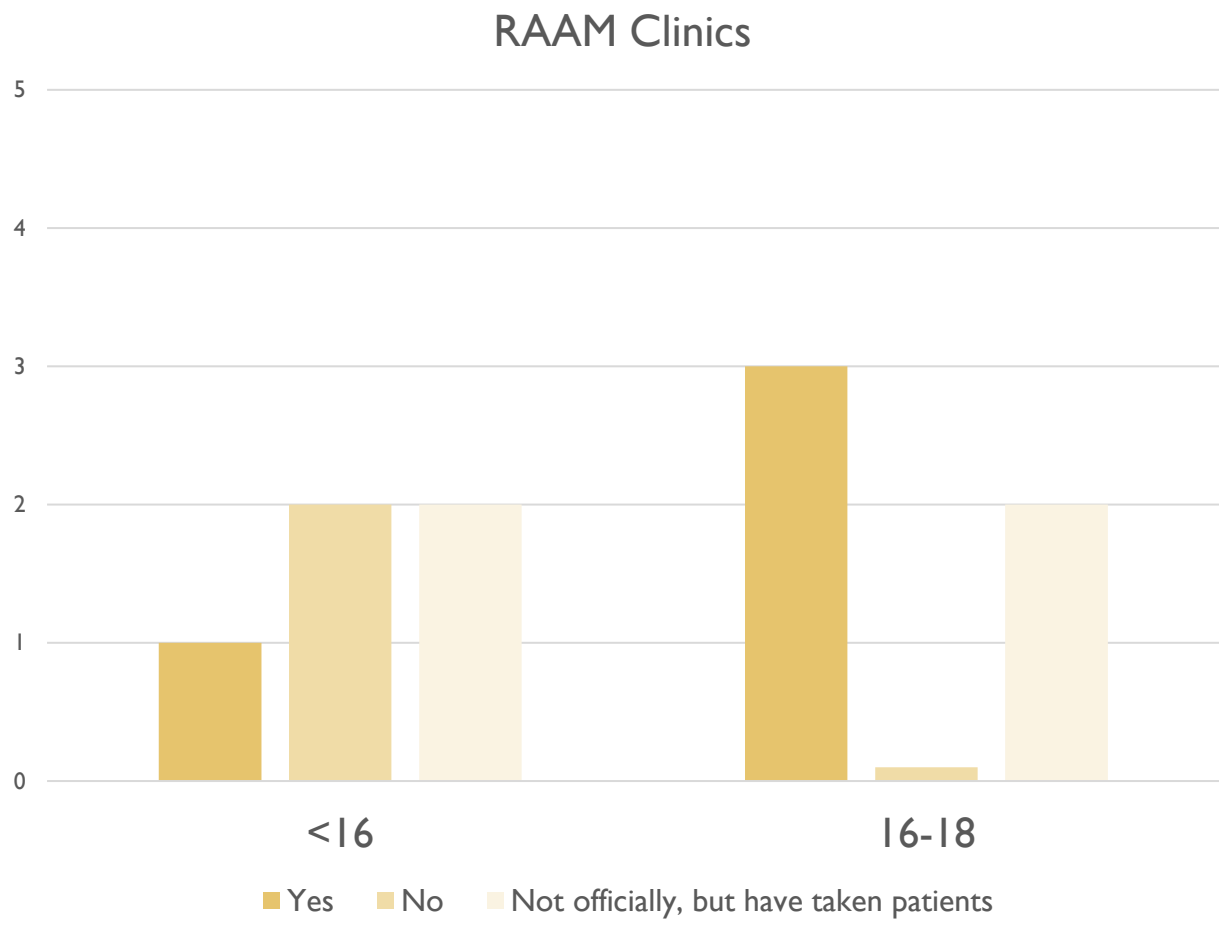


16-18 years

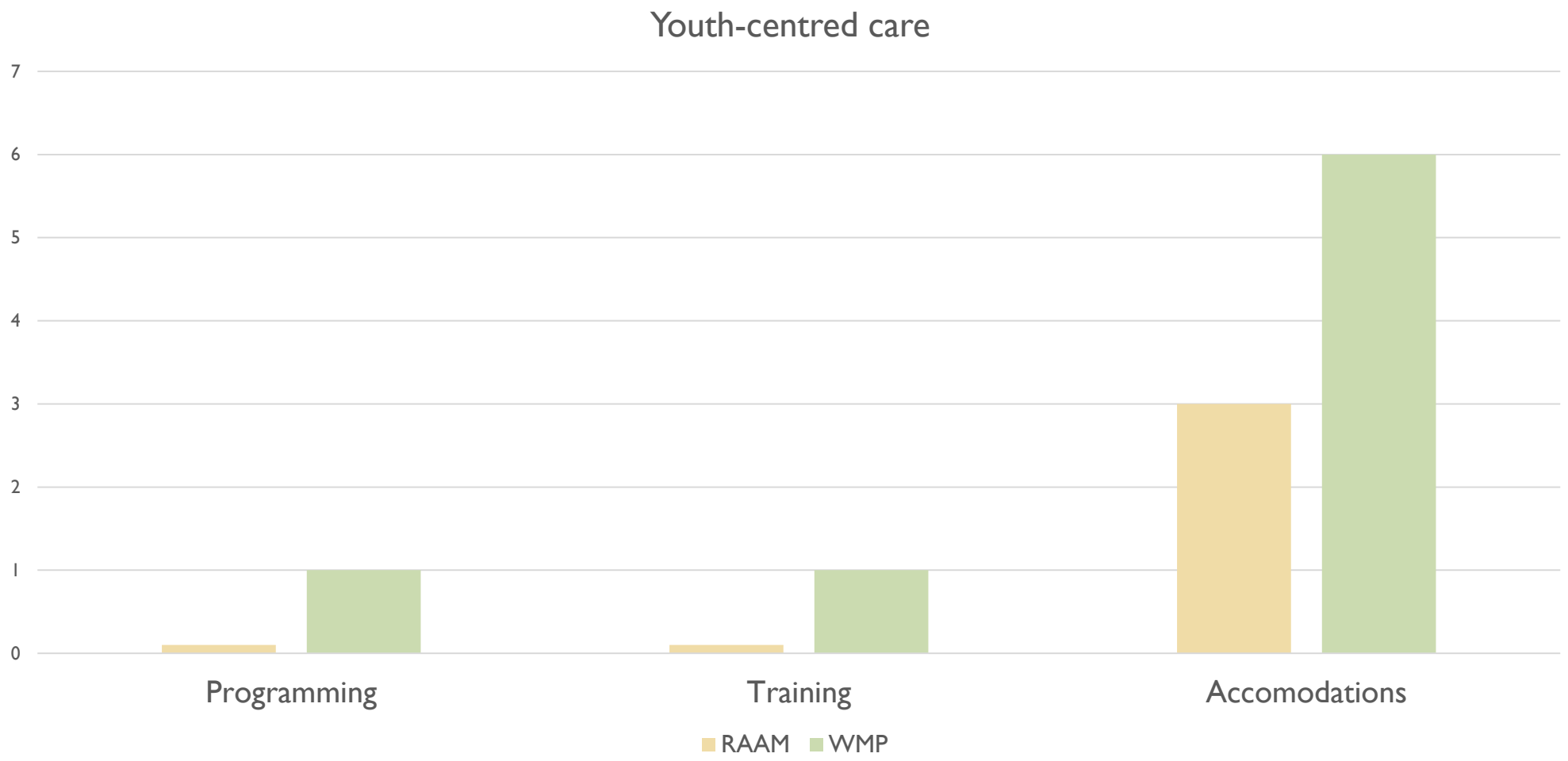


POPULATION SERVED BY AGE

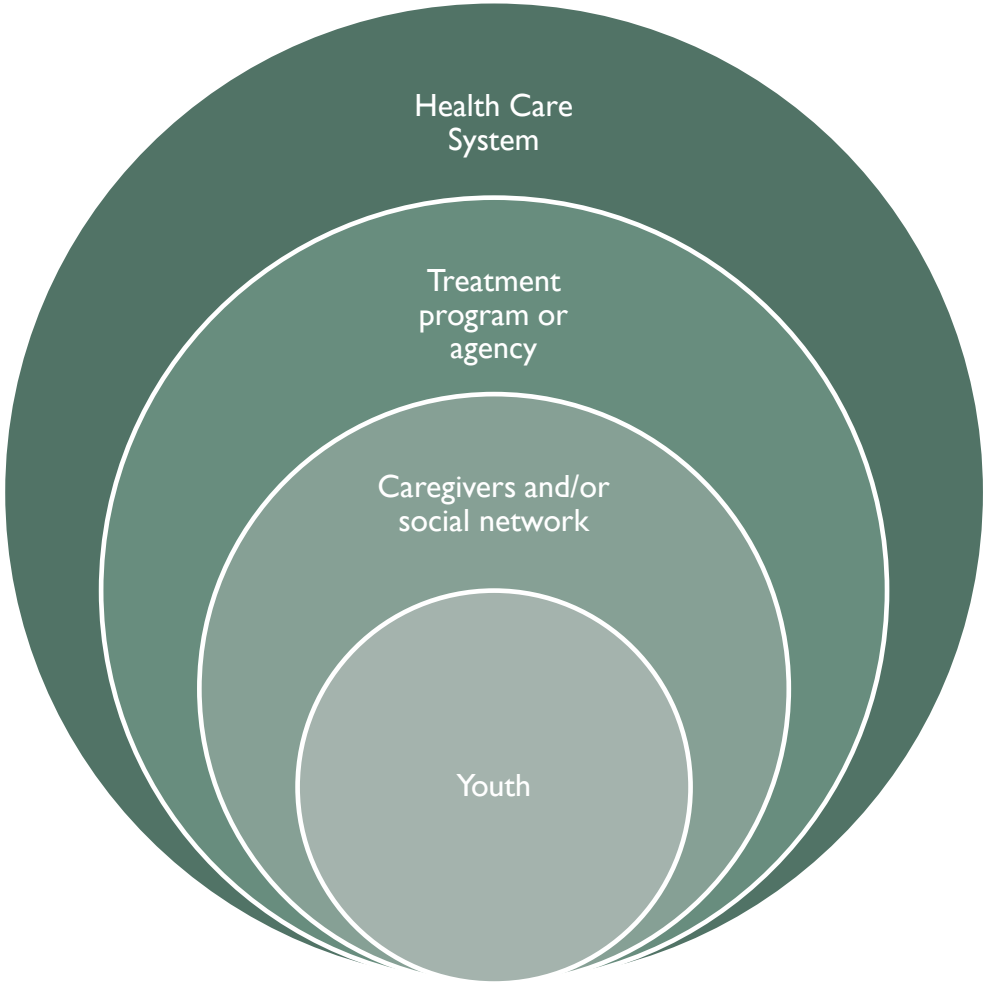




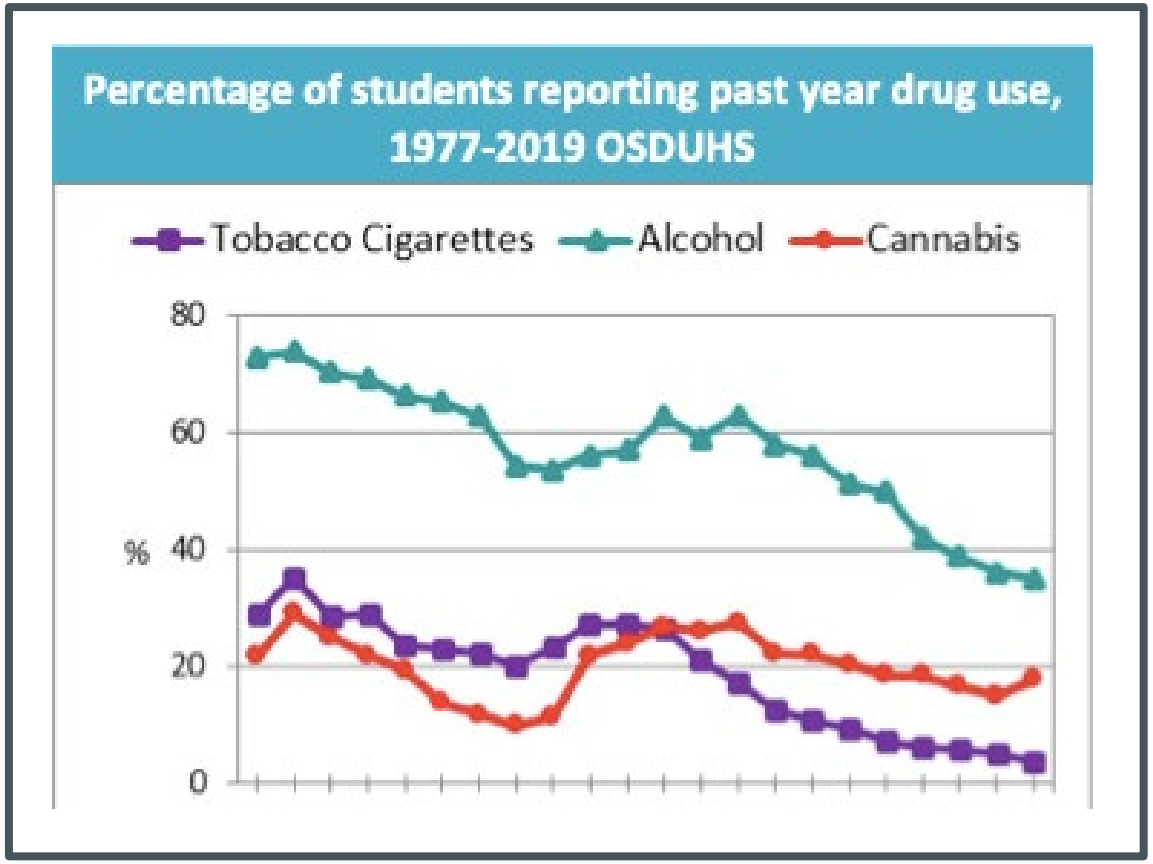
ACCESS TO YOUTH PROGRAMMING



SUBSTANCE USE DISORDER



ADOLESCENT SUBSTANCE USE IN ONTARIO YOUTH IN SCHOOLS



Alcohol

- Total 41.7% (66% of grade 12s)
- 1 in 7 screened positive for at risk alcohol use (AUDIT)

Non-medicinal use of opioids

- 1 in 10 high school students

Treatment program for substance use disorder

- 0.7%

Boak, A et. al., 2020

ADOLESCENT DEVELOPMENT

(Dotterweich, J., 2006)


Independence
Hallmark
Testing limits
Peer Group
Fitting in
Social skills
Body Image
Appearance
Weight
Identity
Sexual
Gender
Developmental tasks of adolescence

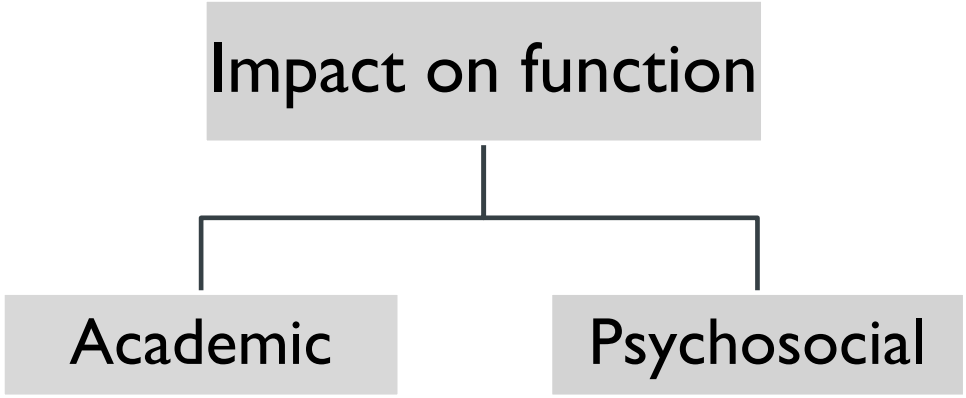
ADOLESCENT SUBSTANCE USE

Risks for developing Substance Use Disorder[3]

- Early onset of use
- Rapid progression through substance use
- Comorbid mental health conditions

Youth more vulnerable to idea they can quit on their own – don't need help, increased impulsivity[4,14]

- Polysubstance use
- Tend not to reveal withdrawal symptoms
- Less likely to seek treatment on own



ADOLESCENT SUBSTANCE USE

Environmental factors

- Adverse childhood events (ACE)[5]
  - Direct harm to child and indirect of environment – **OR of problematic drug use >7** if 4 or more ACEs
- **Access to substances[5]**
- Parental use[6]

Individual factors

- Comorbid conditions: ADHD, CD, LD, MDD anxiety disorders, eating disorders[6]
- Character traits: Extreme extroversion, affect dysregulation, cognitive impairment[6]
- Genetic factors

ADOLESCENT SUBSTANCE USE

- Variable course[8]
- Risks[9]
  - Greatest risk of death in age group: accident, homicide, suicide
  - Legal trouble, DUI
  - Victimization
  - Interference with brain development
- Function
  - Academic
  - Psychosocial

CAREGIVERS AND SOCIAL NETWORK

Involvement of caregivers

1. In negotiation and discussion with young person
2. Limits and boundaries of caregiver involvement directed by youth
3. May involve:
   - Housing support
   - Financial support
   - Emotional support
   - Safety planning

Confidentiality

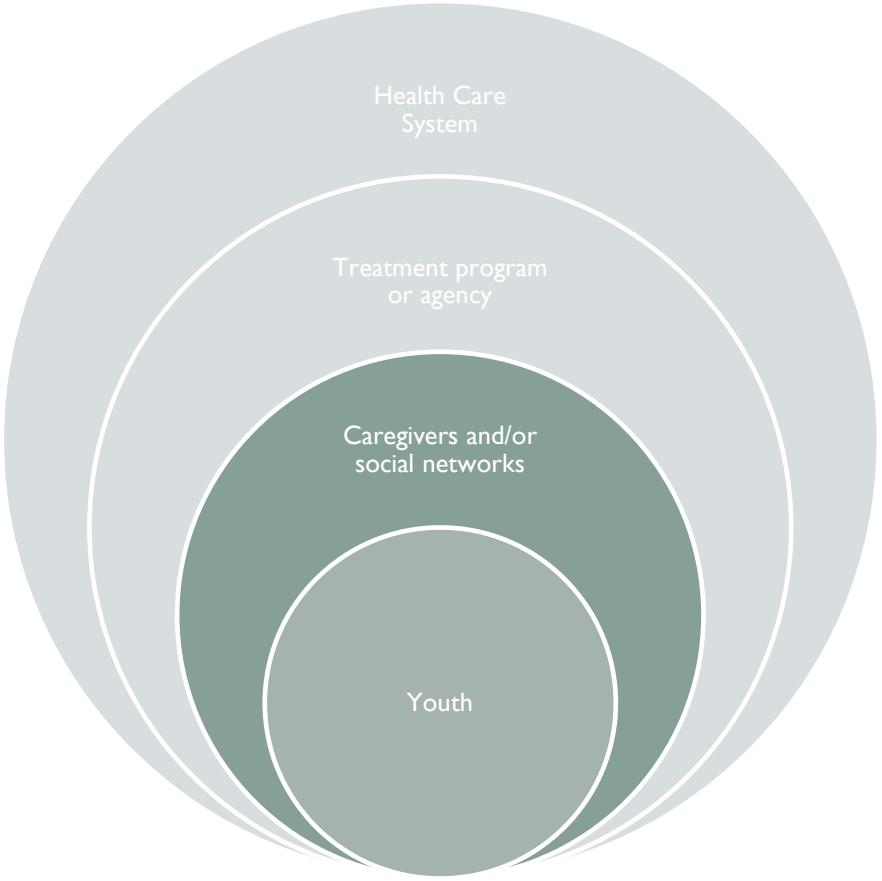
- Essential for youth treatment to build trust
- Boundaries of confidentiality
  - Suspect child abuse
  - Concern regarding plan to hurt self or another person
  - Ministry of transportation

Consent for treatment

- No age minimum for consent for treatment in Ontario
- All persons can consent to treatment if they are presumed to be capable

FAMILY BASED APPROACH*

- Parents, siblings and/or caregivers engaged in treatment[11]
  - Improvement in therapeutic alliance and attendance[12]
  - Positive relationships
  - Parental monitoring
  - Self regulation and behavioral management
- Characteristics of a successful program[13]
  - Informative
  - Boundaries and rules – consequence follow through
  - Dependent on age



Max is 14-year-old birth assigned male who identifies as non-binary and uses they/them pronouns, who enjoys Fortnight and being with their friends. They present to a clinic/office with multiple physical and mental health needs, including a chronic cough, symptoms of depression and anxiety and polysubstance use. They do not have a primary care provider and share that they have recently been 'kicked out' of their home. Max is somewhat vague when asked about where they have been staying and mentions an older 'friend' who allows teens to 'crash' at his place

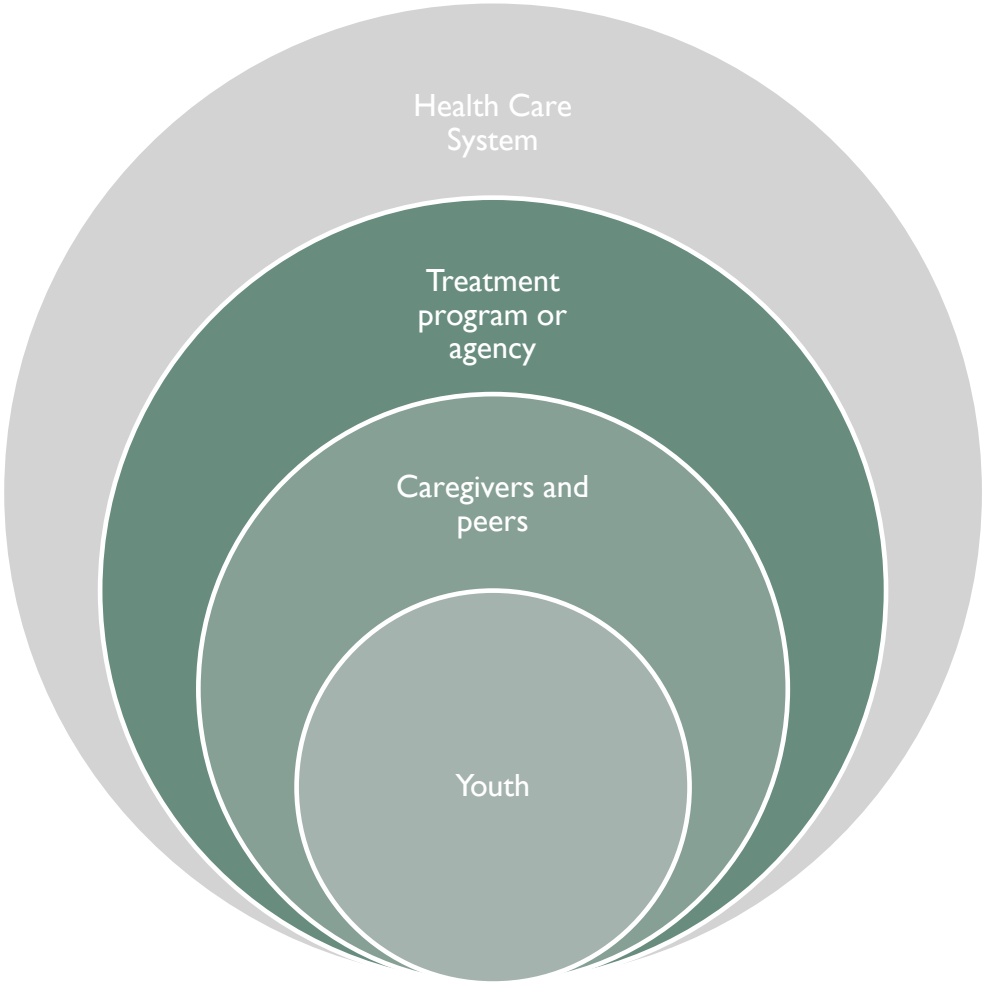
What next?

Image by al17 on Freepik

BREAKOUT GROUP DISCUSSION

- What aspect of this teen's presentation need further assessment?
- What considerations there might be for next steps/provision of care?

WORKING WITH YOUTH WITH SUBSTANCE USE DISORDERS



KEY ASPECTS ABOUT WORKING WITH YOUTH

Rapport

- Preferred names and pronouns
- Friendly – not friends!
- Spending time with youth alone

Communication

- Bi-directional communication
- Honesty
- Developmentally appropriate language

Trust

- Confidentiality
- Consent

Screening

- SSHADDESS assessment
- QYIT screen
- CRAFFT

SSHADDESS ASSESSMENT

- **S** - Strengths
- **S** - School
- **H** - Home
- **A** - Activities
- **D** – Diet
- **D** - Drugs
- **E** - Emotions
- S – Sexuality and Gender
- S – Safety (+Spirituality)

SCREENING FOR TRAFFICKING

Quick Youth Indicators of Trafficking (QYIT)

1. It is not uncommon for young people to stay in work situations that are risky or even dangerous, simply because they have no other options. Have you ever worked, or done other things, in a place that made you feel scared or unsafe?

2. Sometimes people are prevented from leaving an unfair or unsafe work situation by their employers. Have you ever been afraid to leave or quit a work situation due to fears of violence or threats of harm to yourself or your family?

3. Sometimes young people who are homeless or who have difficulties with their families have very few options to survive or fulfill their basic needs, such as food and shelter. Have you ever received anything in exchange for sex (e.g.: a place to stay, gifts, or food)?

4. Sometimes employers don't want people to know about the kind of work they have young employees doing. To protect themselves, they ask their employees to lie about the kind of work they are involved in. Have you ever worked for someone who asked you to lie while speaking to others about the work you do?

Answering yes to 1 or more questions **86.7% sensitive** and **76.5% specific**

TREATMENT PROGRAM

What is important to youth[10]?

- Confidentiality
- Trauma-informed care
- Harm reduction options
- Opportunity to build relationships
- Multidisciplinary care
- Safe space – youth friendly environment
- Disposition planning

Practical options for change

1. Best attempt to have same staff following youth
2. Create safe space for youth
   - Single room or room with other youth
   - Youth activities, LGBTQ+
   - Individual therapy rather than adult group
3. Multidisciplinary care
4. Life skills based groups
5. Follow up planning with youth considerations

CHILD PROTECTION SERVICES

When should you call?

1. If you have **reasonable grounds** to suspect that a child < 16 years of age is in need of protection
    1. You **can** contact if they are age 16-17, although this is **voluntary**
2. Concern regarding labour and/or sex trafficking
3. Sexual activity outside of legal consent
    1. Legal age of consent for sexual activity is 16 years
    2. Close in age exception
        1. 12-13 year olds can consent if partner is < 2 years older
        2. 14-15 year olds can consent if partner <5 years older
        3. **Does not apply to relationship of trust or authority**

LOTUS HEALTH

Lotus Health: and advocacy program for children and youth who have experienced or are experiencing sexual exploitation

- Survivor centered, trauma informed, harm reduction and developmentally sensitive
- Run by child abuse and neglect (SCAN) team at SickKids

Email: lotus.health@sickkids.ca

Phone: 436 226 3579

Lotus Health
A Program for Children and Youth

*only for patients within the GTA

PSYCHOTHERAPY

Cognitive behavioural therapy[14] – can be successful standalone psychotherapy

- Development of self regulation and coping skills
- Trauma focused
- Parent can attend parallel sessions

Dialectical Behaviourual Therapy

- Has been shown to reduce severity of AUD and SUD

Motivational interviewing and motivational enhancement – generally in combination

- Encourages youth to engage in treatment
- Especially helpful in acute settings[9]

Mindfulness based cognitive therapy – to be used in combination[13]

- Accepting rather than avoiding or denying feelings
- Generally engagement is good

DISPOSITION PLANNING

Accessibility

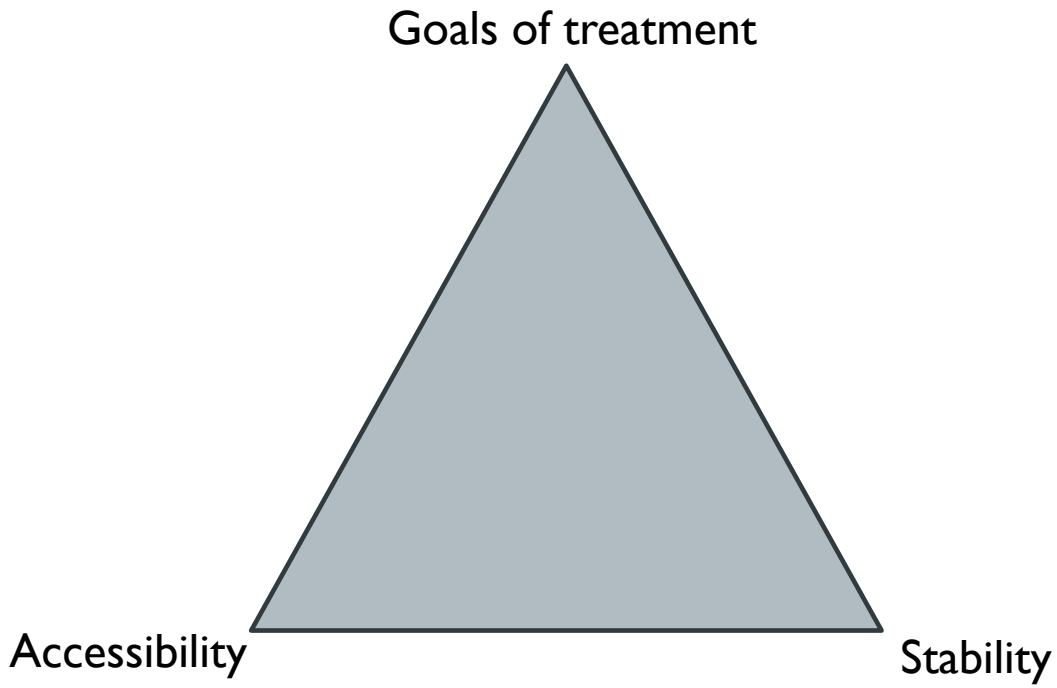
- Transportation
- Geographical location
- Link with primary care and local resources
- Resources to support virtual care access

Goals of treatment

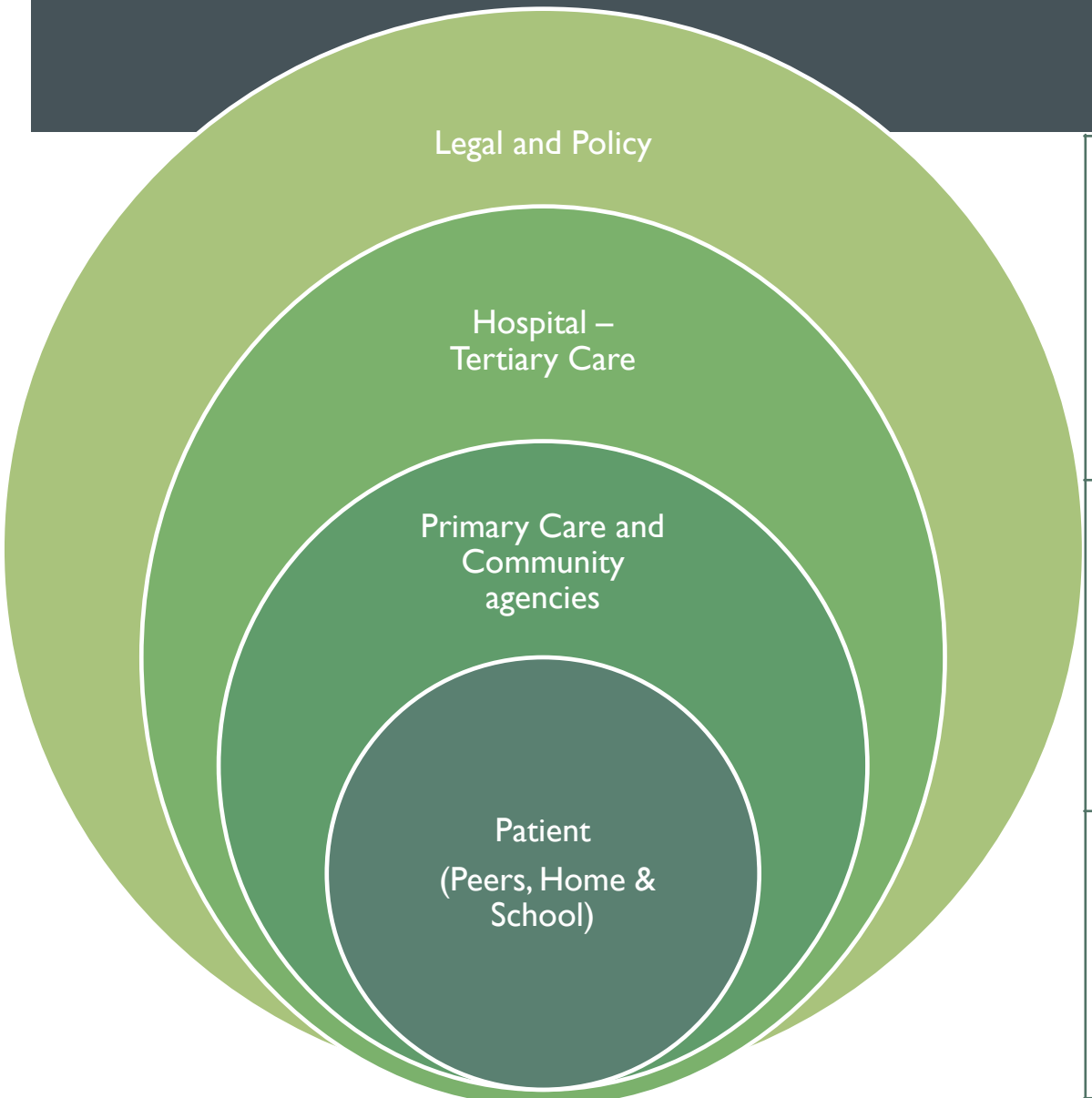
- Harm reduction option
- Trauma informed
- Youth oriented
- Medical options

Stability

- Finances
- Housing
- Follow up planning – Youth agencies
- Comorbidities



NAVIGATING THE INTERSECTION OF SYSTEMS



LEGAL and HEALTH CARE RELATED POLICY	LEGAL IMPLICATIONS OF SUBSTANCE USE CONSENT AND CAPACITY MENTAL HEALTH INVOLUNTARY STATUS HEALTH CARE CONSENT LEGALIZATION (ALCOHOL,CANNABIS..)
TERTIARY CARE	RESOURCE ALLOCATION SPECIALITY SERVICES AVAILABILITY - ADDICTION MEDICINE - CHILD AND ADOLESCENT PSYCHIATRY - PEDIATRICS/ADOLESCENT MEDICINE - ALLIED SERVICES
PRIMARY CARE and COMMUNITY AGENCIES	ACCESS TO PROVIDERS TRANSITIONS TO/FROM TERTIARY CARE CENTRES TRANSITIONS TO/FROM SERVICES

Jenny (she/her) is 14-year-old birth assigned female, who enjoys game nights and the guitar. Her Mom brings her to your clinic/office with concerns regarding substances. Jenny's Mom would like her to have a 'drug test' as she found a vape in Jenny's bedroom and is concerned about her vaping and believes that she is using other substances.

What next?

KEY POINTS

1. Adolescent developmental stage interacts with substance use disorders. These stages should be considered when working with teens to provide developmentally appropriate care.
2. Co-ordinated and collaborative care across different sectors is key to improve health outcomes for teens with substance use
3. Confidentiality and youth-centred care promotes trust and rapport building and enhances engagement in treatment

POST PRESENTATION EVALUATION

Thank you!

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