Substance abuse by adolescents remains a major public health problem in the United States, and thus a common issue encountered by healthcare professionals caring for patients in this age group. Adolescence is by nature a period of challenges and transitions ideally leading to achievement of the goal to define “self” as a healthy and emancipated individual with a personal, vocational, and sexual identity. The primary developmental processes through which this goal is attained include behavioral experimentation, testing authority, rejection of parental values, and struggling for independence. Currently, in the United States, use of alcohol, tobacco, and other drugs poses a readily available, albeit unhealthy, means to use these developmental processes in fulfilling the goal. The use and abuse of substances is relatively common during the adolescent years, as are use-related consequences and disorders. It is important that behavioral experimentation with drugs and alcohol not be condoned, promoted, trivialized, or overlooked by adults, irrespective of whether they are parents, teachers, or healthcare professionals.

How is it that so much is known about substance abuse during the teen and young adult years? Although several information sources report on America’s drug use, three of these sources are more widely recognized because they have for years regularly quantified and monitored adolescent use trends: The National Survey on Drug Use and Health, the Youth Risk Behavior Surveillance System, and the Monitoring the Future (MTF) Survey [1–3]. The Substance Abuse and Mental Health Services Administration’s National Survey on Drug Use and Health is an annual survey of approximately 67,000 Americans aged ≥12 years that provides nationwide prevalence and incidence figures regarding illicit drug, alcohol, and tobacco use, abuse, and dependence. As part of the Centers for Disease Control and Prevention’s Youth Risk Behavior Surveillance System, the Youth Risk Behavior Survey collects data from students in grades 9–12 with regard to a wide variety of health-related risk behaviors, including substance abuse. Probably the best recognized of the three, the MTF survey has since 1975 been funded by the National Institute on Drug Abuse and conducted by University of Michigan investigators as an annual nationwide survey measuring drug, alcohol, and tobacco use, as well as related teen attitudes. More than 46,000 students in the 8th, 10th, and 12th grades participating from nearly 400 public and private schools comprised the nationally representative sample this past year.

The recently released 2010 MTF survey findings reported rising prevalence rates for marijuana use, ecstasy use, and the “ever” use of any illicit drug [3]. Over the past several years, the percentage of students reporting using any illicit drug other than marijuana has gradually declined until 2010, when no further decline was noted. In all, 17% of 12th graders reported having used any illicit drug other than marijuana in the previous 12 months and 25% reported “ever” having done so at any point in their lifetime. In addition, nearly 35% of high-school seniors reported having used marijuana at least once in the previous 12 months and 6% reported use on a daily basis.

Through these types of studies, it is now well known that all adolescents, regardless of demographic, racial or ethnic factors, and rural or urban location, are at risk for substance use and any of the associated problems. Males, as compared with females, have higher rates of illicit drug use and heavy alcohol use. African American teens consistently have significantly lower rates of drug use than do Hispanic youth who in turn have lower use rates than do white teens. College-bound adolescents are less likely to use illicit drugs, drink heavily, or smoke as compared with those who are not planning to enroll into a college. Use of alcohol and other drugs remains the leading cause of youth morbidity and mortality in the United States [1–5]. In addition to the generally increased susceptibility of adolescents to alcohol, tobacco, and other drug use, as well as related health risk-taking behaviors and injuries, research on the developing brain has substantiated that adolescents have a neurodevelopmental vulnerability for developing addictions. Age at first drug use is inversely correlated with lifetime incidence of developing a substance use disorder [6–8].

No patient population that includes adolescents is exempt from also including substance-abusing patients and their related issues. Providing excellent health care to adolescents involves practitioners mastering care aspects related to risk behaviors, including being prepared to identify and intervene on behalf of those youth under their care who are engaged in the problematic use of alcohol, tobacco, or other substances of abuse. Because the
adolescent age group of patients remains likely to seek care in their medical home, either for routine health supervision visits, school or sports physicals, or diverse healthcare issues, pediatric care providers have multiple opportunities to carry out their role in prevention, detection, and treatment of patients’ substance abuse. This is particularly pertinent in the current U.S. health economic context shown to disadvantage young adults as compared with adolescents in accessing health care [9,10].

The American Academy of Pediatrics guidelines for the general and mental health care of children and adolescents recommend that pediatric practitioners routinely include prevention, screening, and evaluation of youth regarding substance use as well as institute office-based intervention and referral for those with risk behaviors or problematic use and possible addiction [11–13]. Other respected professional guidelines, such as the American Medical Association Guidelines for Adolescent Preventive Services and the American Academy of Pediatrics Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents [14,15], provide similar recommendations. The Substance Abuse and Mental Health Services Administration is currently focusing on an ambitious program to decrease the effect of alcohol and other drug use on health and healthcare cost burden through educating health professionals about substance abuse screening, brief intervention, and referral to treatment (SBIRT), and changing related practice behaviors [16,17]. Despite the development of evidence-based practice guidelines and well-known recommendations, such as those reported previously, physicians have been shown to be reluctant to incorporate these recommendations into practice [18]. Among the barriers identified are time constraints; prioritized coexisting medical issues; inadequate reimbursement; possible patient or parent alienation; inadequate treatment resources or access; and inadequate training, confidence, or experience [19,20]. Research has shown that different types of training interventions and reinforcement can increase clinician-perceived self-efficacy to screen and counsel adolescents for risky behaviors [21].

The practice of pediatrics continues to undergo an important and dramatic transformation as forces have converged to move intervention with and treatment of adolescent substance abuse and other mental health diagnoses increasingly into the general pediatric outpatient practice setting from the exclusive domain of subspecialist care. The advent of workforce shortages of pediatric mental healthcare providers, the limited availability of adolescent substance abuse treatment programs, and the complexities of related insurance coverage are important contributors [12,22]. Not only does the practitioner’s role include referral to mental health care and being supportive of substance-using adolescent patients and their parents throughout and after treatment, but ever increasingly it includes serving as the frontline treatment provider, a role which many feel unprepared to assume and training programs are scrambling to ensure is adequately taught [13,23]. Adolescent patient care related to substance use includes the crucial family-centered medical home skills of providing confidential longitudinal care and knowing how and when to include the parent(s), as well as empowering parents with the realization that their own involvement with their adolescents is a powerful deterrent to substance use as well as predictor of treatment success [24–26]. Being able to discuss the epidemiology and local trends in adolescent substance use, recognize potential consequences of alcohol and drug use, provide confidential care while ensuring patient safety, use effective office-based SBIRT, guide parent–child interactions and manage conflicts concerning substance use, engage in collaborative care, and use laboratory testing for drug use detection are all a part of the complex care standards coming into play for the office setting [13,23].

The role of drug testing remains controversial among patients, parents, and practitioners alike. Levy et al reported little consensus among adolescent healthcare providers about indications for urine drug testing in the office and how to proceed with a positive test result [27]. More than 50% of pediatricians and family physicians reported that they would share positive results with parents, which is consistent with ensuring patient safety while engaging both the patient and their parents in the treatment process. General pediatricians, in comparison with adolescent medicine providers and family physicians, were the least likely to assess and treat adolescents with positive drug test in their own offices and most likely to make a mental health referral.

In this volume of the Journal of Adolescent Health, Levy et al [28] eclipse this controversy by describing drug testing as an adjuvant to outpatient adolescent substance abuse treatment and exploring the program’s acceptability to adolescent patients. The bold and innovative treatment program includes a structured drug testing protocol requiring parental notification of results. Built on the pediatric medical home’s inherently strong practitioner–patient trust relationship and confidential rapport, the program embedded parental involvement to serve as the key support modality determining and enforcing test results–related consequences and rewards. Responsibility shifting by the parent functioned to role-model core values and reinforce corrective behaviors, and potentially served as a cost-containment mechanism. Drug testing was not a deterrent to treatment acceptability for this highly motivated patient (and parent) population.

The authors’ focus on patients’ acceptability of their treatment program begs the broader question of acceptability of adolescent substance abuse prevention and treatment in the primary care practitioner’s office. Questions must be answered about the acceptability of the current cost burden from adolescent substance abuse, of insufficient treatment options, of inadequate financing of routine SBIRT practices and treatment in outpatient and inpatient adolescent care settings, and of general pediatric practitioners becoming the mainstay of adolescent substance abuse treatment. What is our medical community and our national “community” willing to accept and what are we motivated to change? Patients and their families, those providing their care as well as those financing it, must be prepared for mental health care to become a significant part of general pediatric practice in the near future.

Janet F. Williams, M.D.
Division of General Pediatrics
Department of Pediatrics
University of Texas Health Science Center
San Antonio, Texas

References


