TOOL

Caring for Youth with Substance Use Disorders

How to Engage Youth with Substance Use Disorder (SUD)

There are unique challenges faced by young people who use drugs. Adolescents and young adults are experiencing fast-growing rates of opioid overdose and hospitalization, yet have the lowest rates of access to treatment. A landmark randomized controlled study demonstrated that emergency departments (EDs) are uniquely positioned to reverse these trends and provide a lifeline to young people facing addiction.

According to the National Institute for Drug Abuse, substance use during adolescence can result in negative consequences including involvement with the criminal justice system, poor school performance, and health and mental health issues.[1] This document serves as guidance for acute treatment providers seeking to screen, identify and treat youth with substance use disorder, and also addresses consent considerations.

SCREENING

The American Academy of Pediatrics recommends routine screening at all primary care visits.[2] You can consider routine screening in other care settings, such as in the ED. Two quick screening tools that have been validated in adolescents are Screening to Brief Intervention (S2BI) and Brief Screener for Tobacco, Alcohol and Other Drugs (BSTAD). S2BI and BSTAD can be self-administered or provider-administered and can be completed in less than 2 minutes. Both tools have information to guide the provider to recommended responses and next steps.

Implementing screening can help identify youth at risk, normalize conversations around use and promote healthy behaviors and help-seeking from medical providers throughout life. Patients can be screened based on risk by ED staff/providers or given self-assessments to be taken while waiting.

Validated Screening Tools

Screening to Brief Intervention (S2BI)

- In the past year, how many times have you used tobacco?
- In the past year, how many times have you used alcohol?
- In the past year, how many times have you used marijuana?
- In the past year, how many times have you used prescription drugs (pain medicine or adderall) that were not prescribed to you?
- In the past year, how many times have you used illegal drugs (cocaine, ecstasy)?
- In the past year, how many times have you used inhalants (nitrous oxide)?
- In the past year, how many times have you used herbs or synthetic drugs (salvia, K2, bath salts)?

Brief Screener for Tobacco, Alcohol and Other Drugs (BSTAD)
BSTAD is similar to S2BI but asks instead, in the past year, how many days did you use a particular substance?

Note: S2BI and BSTAD can screen negative if patients are not using alcohol, tobacco or marijuana. Be sure to ask specifically about the use of pills and other substances if you have a high index of suspicion.

IDENTIFYING WITHDRAWAL

If a young person presents to you with any of the following symptoms, they could be in withdrawal and be a candidate for medication for addiction treatment (MAT).

Signs & Symptoms of Opioid Withdrawal

Objective Signs:

- Tachycardia
- Diaphoresis
- Restlessness and/or agitation
- Dilated pupils
- Rhinorrhea or lacrimation
- Vomiting, diarrhea
- Yawning
- Piloerection ("goose flesh" or "goose bumps")

Subjective Symptoms:

Patient reports feeling "bad" due to:

- Nausea
- Stomach/abdominal cramps
- Body aches
- Achy bones/joints
- Restlessness
- Hot and cold
- Runny nose

If your patient is exhibiting these symptoms, ask about opioid use and potential withdrawal. Patients often refer to this symptom constellation as being "sick." If their symptoms are from opioid withdrawal, you can treat them, stop the withdrawal, and start them on the path to recovery.

Onset of Symptoms and Precipitated Withdrawal

Onset of Withdrawal Symptoms:

- ≥ 12 hours after short acting opioid (some may experience symptoms as early as 8 hours after use)
- ≥ 24 hours after long acting opioid
- ≥ 48 hours (can be > 72 hours) after methadone

Precipitated Withdrawal:

- Sudden onset of severe opioid withdrawal after the administration of a medication that displaces opioids from the mu receptor (e.g. naloxone or buprenorphine)
- Usually time-limited and resolves with supportive care

TREATMENT

Medication for Addiction Treatment (MAT) reduces mortality for opioid use disorder (OUD) by preventing withdrawal, controlling cravings, and increasing compliance with treatment.[3,4,5] Treatment should be focused on safe, low-barrier, effective care. MAT is considered best practice for treating OUD during pregnancy (buprenorphine or methadone are both safe options).[6]

Overall, guidelines for youth patients are the same as those for adult patients. For treatment guidelines, see Buprenorphine Hospital Quick Start.

Substance Use Treatment Consultation Hotlines

California Substance Use Line: (844) 326-2626

Free, expert, confidential, 24/7 phone consultation for substance use evaluation and management, including guidance on medications for opioid use disorder. Available to any health care provider in California.

National Clinician Consultation Center: (855) 300-3595

Free, confidential, clinician-to-clinician phone consultation on evidence-based substance use evaluation and management. Available Monday - Friday, 6 AM - 5 PM PT to any provider in need of specialty addiction medicine consultation. Voicemail is open 24 hours a day, 7 days a week.

Frequently Asked Questions

Are there weight-based dosing recommendations for buprenorphine?
No.

Are there age restrictions in prescribing buprenorphine?
Buprenorphine is approved for those over the age of 16. Buprenorphine has been widely used off label for patients under the age of 16 .

How do I determine appropriate dosing?
Dosing of medications is related to current symptoms and substance use history. See CA Bridge treatment protocols for more guidance.

Should I prescribe naloxone?
Yes, co-prescribing or dispensing naloxone is critical and life-saving. See the CA Bridge Guide to Naloxone Distribution for guidance on accessing free naloxone through the Department of Health Care Services.

FINDING MAT AT A NEARBY HOSPITAL AND LINKING TO ONGOING TREATMENT

Local EDs can partner with you to initiate MAT. Your Substance Use Navigator (SUN) can help you determine if the patient could benefit from connecting with your local ED. Your SUN knows the local resources and can connect patients to services and treatment. Office staff can call your SUN directly while the patient is in the office to start this outreach.

Your local SUN:
Hospital name:
SUN contact information:

MOTIVATIONAL INTERVIEWING TO ENCOURAGE TREATMENT

Most patients using substances have some idea of the risks and negative health consequences. Here are some tips for talking to a patient who may be ready to receive treatment:

1. Assess if they understand the risks associated with substance use.
2. Ask for their thoughts and interest in treatment.
3. Use Motivational Interviewing techniques to determine what motivates the patient.
4. Provide normative feedback, advice and facilitate goal setting.
5. Ask if their parents know about the substance use and ask permission to discuss the use with them.

CONSENT AND DISCLOSURE

A minor 12 years of age or older may consent to medical care and counseling related to the diagnosis and treatment of a drug- or alcohol-related problem. Parental consent is required for a minor's participation in MAT. For more guidance, including references for the below information, please see this guide from the National Youth Law Center.

Frequently Asked Questions

Is parental consent required for treatment of withdrawal in an ED and a hospital?
A minor 12 years old or older may seek drug treatment without parental consent (although, parents must be given the opportunity to participate in treatment, unless the provider deems it inappropriate and documents this). However, Family Code Section 6929(e) does not authorize a minor to receive replacement narcotic abuse treatment (such as methadone, levo-alpha-acetylmethadol (LAAM) or buprenorphine) without parental consent.

When is a minor considered emancipated in terms of consent for medication treatment?
The provider can make the determination of self-sufficiency based on age (15 or older), living apart from parents, and managing their own finances, regardless of income source. A pregnant minor is **not** legally authorized to consent to care unrelated to the pregnancy. The law doesn't specify the treatment type, but the care they can consent to would be treatment that a pregnant person would usually require, like prenatal care.

What documentation of consent is needed?
The documentation burden for patients started on medication in the ED or the hospital is the same as for adults. Providers should also collect documentation indicating emancipation status, if applicable. Providers should always obtain a minor's written authorization for disclosure of health information.

When does a minor need to consent to share health information regarding substance use with parents?
Providers should always attempt to obtain a minor's written authorization for disclosure of health information. However, where parents have sought drug treatment for a minor and the minor receives care, the physician must disclose the medical information to the parents upon their request, even where the minor objects.[7]

In emergent circumstances, is consent from the patient or parent(s) needed to provide medical intervention?
Treatment of a medical emergency may be provided without consent where the provider reasonably believes that a medical procedure should be undertaken immediately and that there is insufficient time to obtain the consent of the patient or of a person authorized to consent for the patient. The law implies consent in these circumstances on the theory that if the patient were able, or if a qualified legal representative were present, the consent would be given. This exception applies to minors as well as to adult patients. The location of the patient is not relevant to the determination of whether the patient has a medical emergency.

What about a youth whose parents are divorced? Do both parents need to consent to treatment?
If both parents agree on the proposed medical care of the minor, then the provider should have both parents sign the applicable consent forms. If parents disagree, then obtain a copy of the custody order to determine which parent has the authority to make health care decisions for the minor and include the custody order in the minor's medical record. If one parent has sole legal custody, then that parent has the authority to make healthcare decisions for the minor. If parents have joint legal custody, either parent has the authority to make healthcare decisions for the minor (unless the court has specified in the custody order that consent of both parents is required). If parents have joint legal custody and disagree, then they should obtain a court order resolving the dispute before medical care is provided, if the procedure can be delayed without jeopardizing the minor's health. If the delay might harm the minor, the provider and hospital may decide that medical care should be provided, even though one parent objects. Thoroughly document the rationale for such a decision in the minor's medical record. Access to a minor's medical records, to which the parent is otherwise entitled, may not be denied to a parent solely because the parent is not the custodial parent.[8]

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California Youth Opioid Response

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