Tailoring Conversations and Treatment to Adolescents and Young Adults at Risk for Substance Use Disorders

Questions from Participants and Answers from the Presenter

Q: Cannabis is used to decrease the shakes and loss of appetite during chemo therapy. Why does that work?

A: Cannabis commonly increases appetite in the general population so it would make sense that it would do so as well for medical conditions that create poor appetite such as individuals undergoing chemotherapy. I am not familiar with any studies looking at less shakiness among individuals using cannabis while undergoing chemotherapy. Unfortunately, I am not familiar with the mechanism of action of chemotherapy drugs to be able to speak to the cause of shakiness; however, from an anxiety perspective, cannabis may either increase or decrease anxiety thereby making shakiness either worse or better. Sorry that I cannot be more helpful with this question.

Q: What screening tool do you recommend during the appointment?

A: I prefer to use a clinical interview to conduct a fuller assessment but that there are many screening tools available to identify substance use, depression, anxiety and trauma related risk to determine if a full assessment is needed. Here is a link to several of them: https://sbirt.webs.com/screening-tools-and-examples

Q: What % of the population is "energized" by opioids?

A: Excellent question! Unfortunately, nobody to date has done the research for a precise answer. Among those who develop an opioid use disorder, I would say it is much greater than 50% (best clinical guess 70-75%.) However, we could not truly get a truly accurate figure in the general population as there would be a subpopulation who have not been exposed to opioids who would be energized if they were. This would be a great research project for someone to take on.

Q: What best practices do you recommend for engaging young people in treatment, as well as supporting their loved ones/families in this process?

A: Here are some good resources:

- https://www.nctsn.org/resources/engaging-adolescents-treatment-tips-mental-health-professionals
- http://www.mcs.bc.ca/pdf/Concurrent_disorders_literature_review.pdf

Q: When you say you would avoid stimulants, does this include those with true ADHD? What are your thoughts about Ritalin and abuse later on?

A: Individuals with true ADHD (confirmed by psychological testing rather than a checklist or self-diagnosis) do not get a reinforcing response to stimulants. They tend to get calm and focused rather than high, and as such, do not find stimulants a desirable drug of abuse even if they may abuse other substances. So, it is not necessary to avoid these medications per se, unless there is a concern about selling or family members taking them.

Studies do show that individuals with ADHD are more likely to abuse substances. I am not aware of studies showing they are less likely to abuse stimulants, but I have seen this in my years of clinical practice.

I do not believe that a young person appropriately diagnosed with ADHD (ruling out anxiety, trauma, depression and other conditions that can impact focus and behavior) and treated with a medication such as Ritalin will be more likely to abuse substances later on. On the contrary, some research shows that kids with ADHD who are treated are less likely to engage in substance abuse.

Young people with inaccurate diagnoses of ADHD (especially if they have trauma or depression) may find prescribed stimulants inappropriately reinforcing and may abuse their medication. Any past abuse of a stimulant would be grounds for an alternative, non-stimulant treatment of ADHD.

And I would also screen for the effects of the stimulant: if Ritalin or Adderall is providing energy (most of us would be more productive if taking these medications,) this is a warning sign that the condition may not be true ADHD and I would consider alternatives to stimulant medications.

Q: Considering the health disparities in our country, the lack of mental health care access, how do we make a change/help our students/clients without resources?

A: The lack of resources continues to be a very real challenge. Without adequate mental health services in a given area, I would encourage providers in primary care and related fields to educate themselves to the best of their abilities and network with mental health and addiction providers in other areas (there are various listservs and Facebook groups among specialties). I would also encourage speaking out to those locally who have the power to affect change (legislators, hospital boards.) This is a complicated issue. Wishing you luck and forward movement on this area.

Q: Typically, how long does someone stay on MAT?

A: There is more than one opinion on this question, and some disagreement among specialists. The research is strong that less than 1 year of MAT is not effective long-term. However, at the other end of the spectrum, there are many Addiction specialists who see MAT (specifically ORT) as life-long. The data are conflicting on whether this is the best approach.

My personal opinion is a slow gradual taper of ORT while actively engaged in treatment for both substance abuse and underlying mental health. In my private practice, I have employed this method since 2003 with success. The average length of treatment varies with the starting dose of opioid replacement medication but appears to average 4-6 years.