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TACKLING YOUTH SUBSTANCE USE CHALLENGES DURING THE PANDEMIC

Webinar date: **June 16, 2021**
Presentation Slides and Recording: **https://ubccpd.ca/2021-06-16-tackling-youth-substance-use-challenges-during-pandemic**

Disclaimer: Information on COVID-19 is changing rapidly and much of the research is preliminary. Assessment and management protocols are suggestions only; they do not take the place of clinical judgement. Please check with your own health authorities and local medical health officers as policies and support for the suggested approaches to patient care may vary between regions.

This summary was prepared by Dr. Birinder Narang and not by the speakers.

Webinar Summary

Dr. Warshawski Presentation – SUD Development

- **Overview**
  - Surge in gonadal hormones trigger development of secondary sexual characteristics exert profound effects on brain structure and cognition
    - These changes predispose teens to approach, explore and take risks i.e. with drugs
    - Teenage brain is under construction and at high risk for substances to permanently influence neurodevelopment.
    - Prevention and early intervention critically important
- **Puberty & Socioemotional Control**
  - Diffuse temporal cortical changes
  - Puberty triggers non-linear decrease in grey matter with linear increase in white matter
  - Changes stabilize in early 20s
  - **Basil Ganglia** (motivation to pursue rewards, novel and intense situations)

        - Puberty brings marked decrease in volume secondary to pruning
        - Puberty associated with sensation seeking, immediate gratification and risk taking
    - **Amygdala** – emotional, anxiety, fear + depression
        - Puberty induces marked increase in volume + increased cortical connections
        - Increased influence on decision making, decreases in adulthood
    - **Prefrontal Cortex** – executive control, impulse and response inhibition, attention regulation, emotional regulation and planning
        - Independent of pubertal hormones
        - Develops in a slow, linear fashion
        - Not fully developed until mid-late twenties
- **Addiction Cycle**
    - Person ingests substance, flood of dopamine in the reward centre, once the drug is out of the system, they may:
        - Have downregulation of receptors
        - Have depletion if dopamine in synapses
        - Set stage for withdrawal
        - Can be exacerbated of stress neurotransmitters (i.e. from environmental factors or from withdrawal)
        - Can cause negative affect and push need to have drugs again
    - This cycle can happen over and over again
    - Developing brain is vulnerable
- **Cognitive Imbalance**
    - Puberty causes surge in socioemotional brain
    - Overwhelms slow non-hormonal, linear path of cognitive control
    - Adult reasoning is restored/gained once cognitive control and socioemotional control rebalances
- **Adolescence – Sensitive Period**
    - Many teens experiment with substances of abuse
    - 5-15% of teens who initiate substance use develop SUD
    - Each year of delay (13-21 years), drops risk of SUD by 4-5%
    - Preventing and/or delaying chronic drug use, and early intervention for problematic drug use is vital

Dr. Smith Presentation – Developing Resilience

- **Levels of Prevention**

- Tertiary Prevention
  - People who have identified at high risk, or early onset disorder (specialized)
- Secondary
  - Those who are high risk
- Primary
  - Universal to all youth

- **Preventing and Treating Childhood Mental Disorders:**
  - Recent Research Report on Effective Interventions
  - Had one section on substance use disorders:
    - In school-based substance abuse prevention programs:
      - Universal prevention (to all students)
        - 6 Randomized Controlled Trials proved effective
        - **Unplugged** program stood out for decreasing alcohol and cannabis use
      - Targeted Prevention
        - 4 Randomized Controlled Trials proved effective
        - **PreVenture** stood out for decreasing alcohol use
  - **Unplugged**
    - Multicomponent intervention, combination of resistance skills, parent training, child education, child social skills training & child/family communications skills training
    - 2 RCTs – EU study + Czech study
      - 12x45 mins lessons, trained teachers provided program
  - **Pre-Venture -** Targeted programs
    - 2-90 minute "workshops"
    - Strength based- CBT + Motivational Interviewing Skills
    - Understand how their personality style leads to certain emotional and behavioural reactions
    - Students grouped according to 4 personal profiles
      - Impulse Control
      - Sensation Seeking
      - Anxiety Sensitivity
      - Depression
    - Outcomes
        - Evidence based program, 8 RCTs, published JAMAm, AJCAP, Time
        - Upstream

            - Specific, Strength based and well received
            - Relatively low cost and resource investment
            - High yield outcome – approx. 40-50% dec in substance use across the board for at least 2 years (NNT 2)
            - “Inoculates” our youth
        - “Herd Immunity”
            - The 60% of students who don’t participate (not screened in), still demonstrated 30% reduction in substance use in peer group
            - Higher risk youth are using less, so the less at risk will also use less

- **Vernon, BC, SD #22 – Year 1 Results**
    - 3 high schools involved, 2 were controls, saw ~40% reduction in substance use and high-risk behaviours (i.e. getting intoxicated)
    - Testimonials
        - More goal oriented, less panic, focused on what is more important
        - Spontaneous testimonials (3-4 years after the program)
- **Call to Action**
    - “It is as improper to withhold an effective preventive intervention as it would be to withhold an effective therapeutic intervention”

Dr. Broker Presentation – Screening Tools/Resources

- **Pathways BC**
    - Addiction medicine provided demonstrated
    - Care Pathways/Algorithms demonstrated
    - PSP Pathway on Child and Youth Mental Health also reviewed
    - Please refer to resources section in this doc for instructions on how to login to Pathways BC

Dr. Saari Presentation – Screening Brief Intervention & Referral to Treatment

- **SBIRT**
    - Evidence based approach for identifying problematic substance use and reducing associated harms
- **Goals of SBIRT**
    - In the time you have with patient, to try and screen them and some type of counselling/advice to those who are using or considering use

    - Reduce unsafe behaviour patterns
    - Enhance connections to service providers
- Screening**, Brief Intervention (BI),** Referral Treatment
    - Use motivational interviewing techniques to increase a person's awareness of substance use and encourage changes in behaviour
    - The Key to successful BI is to extract a single, measurable, behavioural change from the broad process of recovery that will allow the youth to experience a small incremental success
- **FRAMES – Components of BI**
    - **F**eedback - regarding personal risk or impairment
    - **R**esponsibility – Emphasis on personal responsibility for change
    - **A**dvice – Clear advice to change
    - **M**enu – change options
    - **E**mpathy – Therapist empathy
    - **S**elf-efficacy – Encouragement of optimism about the potential to change
- **Applying BI**
    - Non-Users
        - Validate healthy choices
        - Reinforce information on personal choices, continuing brain development and healthy coping skills
    - Using with minor impairment
        - Offer education about risk
        - Suggest harm reduction ideas
    - Using with major impairment
        - Discuss referral to treatment options
        - Naloxone Kit
        - Safe supply testing
    - Apply the stages of change model
- **When do you refer for treatment?**
    - Personal Decision depends on comfort level
- **Why Do Youth Use?**
    - 67% Wanted to have fun
    - 32% Wanted to try it/experiment
    - 32% Friends were doing it
    - 24% Because of stress
    - 20% Down/depressed
        - And others, could be more than one reason as well.

- **Running Head Start Technique**
  - Purpose: to gain access to change talk by hearing motivations for maintaining status quo, provides insight into co-morbidities
  - What do/don't you like about marijuana?
    - What does it do for you physically that you like/don't like?
    - Emotionally/psychologically
    - Socially?
  - Could be part of the diagnostic pathway as well

Dr. Steve Mathias – Presentation on Foundry BC

- **Foundry Vision**
  - Our vision is to transform access to health and social services for youth and families
  - We aim to make BC the bets place in the world for young people to grow up
- **Foundry Mission**
  - To support youth in living a good life
- **Foundry BC**
  - Currently, Foundry offers young people age 12-24, resources, services and supports through youth service centres foundry virtual and foundrybc.ca
  - Centres are co-designed with family members and youth
  - Range in size from 5-8000 sq. ft.
  - Exist in 11 communities so far
- **5 Core Services**
  - Peer Support
  - Physical Health
  - Mental Health
  - Substance Use Support
  - Social Services
- **Foundry BC App**
  - Available for iOS/Android
  - Various resources, and access peer support/counselling without a
- 21,000 unique youths with 100,238 visits and 136,553 services accessed from May 2018-Jan 2021
- Age at registration 58% are from 19-24 years old, hoping to get younger teenagers through the door
- High rates of young people coming in using wide array of substances

- Marijuana, Tobacco and Alcohol at top of the list, seeing methamphetamine and opiate use as well

Question & Answers

Q: Can you speak to Bill22, proposed amendment to MHA, give physicians power to have youth detained in stabilization facility against their will? What are the implications are for youth engagement/harm reduction?

A: We must differentiate involuntary stabilization from mandated care. Bill 22 is meant to facilitate brief, involuntary, pause in a dangerous pattern of drug use, i.e. a youth opiate use. A youth that presents with an overdose has a 5-10% chance of dying in the next year. They likely have damaged capacity, from chronic drug use, or anoxia associated with overdose or from acute withdrawal. This is coupled to high incidence of suicidality, intellectual disability, and depression.

Involuntary stabilization is to introduce a pause, to reconnect with services, assess for concomitant mental health conditions, and offer treatment (not mandate treatment). They are then offered harm reduction.

Clinical Practice Guidelines under wrap and development when Bill 22 was introduced. Another problem is that legal provisions were too weak. Green party said that and refused to pass that until legal safeguards were improved.

Evidence suggests that people who use drugs are hesitant to call for help if judicial system is activated, however, that is not the case in BC for involuntary stabilization. The youth that have gone through this are appreciative because they understood how at risk there were. Healthcare professionals must be trauma informed and conduct involuntary stabilization in a warm manner.

Q: Any government funding available to help administer prevention programs in schools and communities?

A: The government has made available a Mental Health and Schools program. Funding for Education around social and emotional learning for mental health and substance use costs $50,000 per school district for a 3-year program. Foundry is working with some provincial work with PreVenture, to help work together with school districts.

Q: Please discuss stimulant use (Rx + street), with regards to online learning environment, struggles with attention.

A: Cocaine has always been most popular. Students can try cocaine a few times and are okay, however, some will become dependent on it and keep using. Cocaine has a short high, so youth can get into using crystal meth, which is cheaper and lasts longer but does not have as good of a high as cocaine. There are lots of prescription stimulants that are on the street. Often youth do not take the correct dose and will

use what it makes to make them feel good. Talking to them about why they are using as much as they are. Some youth are doing well with Zoom learning. Others have a lot of trouble, are struggling, and have required psychostimulant prescription. Look at harm reduction measures, blistering, daily dispense, urine drug screen, etc. to help youth do it safely, in addition to adults.

Q: What is working well, anything you are excited about?

A: Concurrent disorders, is a term that is becoming more known. Trying to do more upstream work in prevention and education. Healthcare can often be reactive, trying to focus on more outpatient services. This year there has been an update to the online addictions course, through BCCSU.

Q: What efforts are being made for cultural safety for Indigenous youth, and for those who are homeless?

A: This subject is top of mind right now, especially with recent graves that have been found in the Kamloops residential school. With Foundry North Shore, we are trying to work with the First Nations. Trying to find out what it will take to make it comfortable for youth by placing artwork/signs in first nations languages, creating safe spaces, including spiritually safe spaces, involving elders, and more. It has been historically traumatizing to access mental health and substance use services. About 13% of people coming to Foundry identified as Indigenous, so foundry will continue to work on how to get trained for Indigenous Cultural Safety. Foundry has created an Indigenous Wellness Team, goal to make strategy to help support Indigenous youth. Two of the next eight centres will be opened by Indigenous organizations.

First Nations Health Authority website has a lot of resources that can be accessed.

For homeless populations, a new team was created in Island Health, a Youth Tier 5 team has been created in hotels and on streets to help with safe supply, to do mental health check ins.

Q: Any new online telemedicine availability services for detox/OAT management for youth?

A: 24/7 addictions line telephone service, in resources document. The RACE line is not 24/7 and requires PHN and DOB of patient. Methadone and Suboxone training is available through the BC Centre of Substance Use.

Q: Best methods and tools to help parents to understand the dangers of cannabis use in youth?

A: No quick solution for this but requires conversations with parents. Important to describe the differences in brains response in youth & adults. Also important to emphasize how delaying the start of substance use in children is protective against developing substance dependence/substance use disorder.

Q: What can we be done to tackle long wait lists? What resources can be made available to community & family members?

A: Need to expand services, need to build out peer support. A lot of time patients are placed on waitlists they do not need to be on, so need more integration and navigation resources.

Q: Any resources to help guide us as Family Physicians or Specialists at a community level, to help screen & manage youth with substance use disorders?

A: See attached resources for more information on Here to Help and Family Smart resources that can provide a parent or youth in residence. There are a lot of patient resources in Pathways. www.drugcocktails.ca is also a great resource that looks for the risk of interactions for starting psychiatric medications in someone who is using substances. Practice Support Program has also created a module on youth substance use.

Q: Can we use Plan G in youth? Same medications in use?

A: Yes, can sign for youth, to get psychiatric medications covered, some ADHD medications are not covered. Can use gabapentin and other medications in youth, the BCCSU course. Kadian, Methadone etc. can be used in youth.

Resources

- **Summary of resources from presentations:** https://ubccpd.ca/media/841/download

Thanks to the speakers on the video:

- **Dr. Hayley Broker**, Family Physician at Foundry North Shore
- **Dr. Steve Mathias**, Child and Adolescent Psychiatrist and Addiction Specialist, Executive Director of Foundry
- **Dr. Carol-Ann Saari**, Medical Lead and Division Head, Child and Adolescent Psychiatry, VIHA
- **Dr. Tom Warshawski**, Pediatrician, Medical Director for Child and Youth Health, IHA
- **Dr. David Smith**, Child & Adolescent Psychiatrist & Addiction Specialist and Medical Director for C&A Psychiatry, IHA