Tobacco, Alcohol, and Other Drugs: The Role of the Pediatrician in Prevention and Management of Substance Abuse

from the AAP Committee on Substance Abuse

The full text of this policy statement including references will appear in an upcoming issue of Pediatrics.

Pervasiveness of Drug Use

The pattern of substance abuse among teenagers has undergone significant change during the past 30 years. Prior to the late 1960s, the abuse of alcohol and other psychoactive drugs including tobacco was predominantly by adults. Beginning in the late 1960s and early 1970s, substance abuse became widespread among adolescents and more recently among preadolescents. In addition to alcohol and tobacco, opiates, cocaine, amphetamines, barbiturates, marijuana, hallucinogens, anabolic steroids, and prescription and nonprescription medications and inhalants (volatile substances) are used/abused by many teenagers and a growing number of pre-teens. The use of even drugs like tobacco in this age group represent a significant health threat and are associated with an increased likelihood of future use of marijuana and other illegal drugs.

Recent statistics show a steady increase from 1991 through 1996 in the use of drugs among students in 8th through 12th grade. Alcohol continues to be the most common substance of abuse used by young people. Nearly 80% of high school seniors report having used alcohol at some time in their lives. Binge drinking (consuming five or more drinks in a row, presumably to achieve intoxication) is alarmingly common with 90% of 8th graders, 25% of 10th graders, and 36% of seniors reporting having done so within the previous 2 weeks. Lifetime use of other drugs among high school seniors in 1996 was 45% for marijuana, 17% for inhalants, 7% for cocaine, 2% for heroin, and 15% for amphetamines. Even more alarming is the fact that marijuana use among 8th graders has increased 250% since 1991, from 10% to 25%.

Significantly, daily use of tobacco and marijuana among young people in school is at an epidemic level. Among 8th graders, one in ten smokes cigarettes and 1.5% use marijuana daily. One in six 10th graders smokes, and 3.5% use marijuana daily. Among high school seniors, nearly one in four smokes daily and 5% admit to daily use of marijuana. The “Monitoring the Future” study that yields these data reports only those in school; tobacco, alcohol, and other drug use is greater among the population that does not attend school. For example, it is estimated that 75% of 18-ear-olds who are not in school use tobacco. Rates of substance use also vary among ethnic groups and tend to be highest among whites, followed by Hispanics and then African-Americans.

Possible factors implicated in the increase in usage include a decrease in perceived risk, fewer school-based substance abuse programs, pervasive messages in the electronic and print media as well as advertisements that glamorize tobacco and alcohol, and the somewhat lenient pattern of parenting in the 1990s. The perception that the casual use of recreational drugs is not a significant concern is held by many adults as well, including a sizable number of pediatrics surveyed by the AAP in 1995. While the prevalence of drug use may vary from community to community, there is general agreement that use of tobacco and alcohol at an early age is a predictive factor for use of other drugs, use of a greater variety of drugs, and use of more potent agents. Furthermore, the onset of tobacco addiction occurs primarily among children. Most adults who smoke began to do so before the age of 19 years, at an average age of 12 1/2; most were regular smokers by the age of 14. Thus, it is critical for the pediatrician to be knowledgeable about smoking prevention and treatment measures.

Maximizing the Pediatric Evaluation

Appropriate interviewing techniques are critical in obtaining a comprehensive substance abuse history. Central to this is the issue of confidentiality and the most useful information will be obtained in an atmosphere of mutual trust and comfort. Pre-teens as well as teenagers should be interviewed privately during each office visit with the reassurance of confidentiality and a discussion of its limits. Even an apparently straightforward complaint such as headache or sore throat may be associated with an underlying substance abuse problem. Open-ended questions are usually the most nonthreatening and a concerned, nonjudgmental style of interviewing may encourage the development of an honest doctor-patient relationship. It may be helpful to begin with questions about the patient’s attitude toward use of tobacco, alcohol, and other drugs in his or her life or experiences with friends, home, school, and friends rather than probing personal beliefs or habits. This questioning may lead logically to inquiry about the patient’s experience with tobacco, alcohol, and other drugs. Many clinicians use structured interviews and questionnaires to determine a substance abuse history.

Beliefs about substance use, ceremonies that include substance use, and patterns of use may vary among those of different ethnic backgrounds, cultures, and sexual orientation. Psychosocial stresses contributing to use may include isolation or limited access to some youth that they are inadequate because of their social or cultural group, a sense of being out of the mainstream, awareness of a lack of educational and employment opportunities, knowledge of widespread poverty and violence in one’s community, and sociopolitical disenfranchisement.

Inquiry into age-appropriate psychosocial history, such as family and peer relationships, academic progress, nonacademic activities, behavior, acceptance of authority, degree of self-esteem, and ongoing episodes of inframandibular or extramandibular child abuse may reveal risk factors for future or present substance abuse. These issues should be a part of every history when a patient aged 8 or older is seen for health care.

It is estimated that one in five children grows up in a home in which there is someone who abuses alcohol or other drugs. Inquiry regarding the extent of tobacco, alcohol, or other drug use by peers and family should be a part of the routine history of every child who is seen in the pediatrician’s office. This questioning should be followed by an age-appropriate discussion of the possible consequences of such use with the child and his or her parent or guardian. If this discussion reveals a family history of chemical dependency, the pediatrician should feel comfortable addressing the issue and be able to make appropriate referrals for care.

Inquiry regarding other risk behaviors is also important in dealing with the issue of substance abuse. Research suggests the clustering of behaviors such as early and promiscuous sexual activity, membership in antisocial clubs and gangs, illegal use of firearms or drugs while riding in or driving a motor vehicle, and engaging in other illegal activities, and that those who engage in one risk behavior are more likely to engage in others.

Information should be obtained on the teenager’s use of specific drugs, including tobacco and alcohol; the extent of such use; settings in which the use occurs; and the degree of social, educational, and vocational disruption attributable to the drug use. Teenagers may display varying degrees of honesty when discussing their use of tobacco, alcohol, and other drugs. Use may be exaggerated or minimized, and the pediatrician may need to rely on other contextual clues such as mood, dress, and physical and behavioral symptoms (such as criminal activity or problems at home or school) to fully assess usage patterns.

Drug Testing

Laboratory investigation (drug testing) may be utilized when it is necessary to determine the cause of dysfunctional behavior and other changes in the teen’s physical appearance. A good example is a patient who has undergone some significant physical change (such as weight gain) that makes it important to differentiate between “screening” and “testing” for drugs of abuse. “Screening” is a technique used to evaluate broad populations, such as screening all athletes trying out for a school team. “Testing,” on the other hand, implies evaluation based on a clinical suspicion of use. Guidelines published by the American Academy of Pediatrics as well as issues of consent and confidentiality should be considered when deciding whether to utilize drug testing in the diagnosis and management of substance abuse. Upon obtaining urine for testing, it is critical that accidental and purposeful contamination, dilution, or substitution be avoided. Knowledge about the capability of the laboratory to identify specific substances and the accuracy and sensitivity of the procedures employed is necessary when such testing is being ordered.

Initially, a clinical history of substance abuse obviates the need for testing. In general, testing should be done only with the patient’s consent. Exceptions include situations in which the patient’s mental status or judgment is impaired, or when testing is a routine part of treatment and maintenance of abstinence.

Issues Involving Management and Prevention

The pre-teen or teenager who admits to repeated experimentation with the use of tobacco, alcohol, or other drugs requires careful evaluation to determine whether intervention and treatment are indicated. Any substance use by young pre-teens carries extraordinary risk because of the likelihood of progression to the use of additional and more dangerous substances and the impact of such use on physical, psychological, and emotional development.

Intervention is required for any patient in whom substance use is having an obvious effect upon academic, social, or vocational func-