

# Treatment Challenges in Adolescent Drug Users

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## Trends in Drug Use

The problem of drug use amongst adolescents has become an increasingly apparent issue over the course of the last ten years. In order to tackle this problem it is necessary to be aware of the scale of drug use in this population. Since 1990 the Health Research Board (HRB) has produced yearly figures in relation to drug users presenting at treatment agencies. These figures allow service providers to examine trends and plan services more effectively. The HRB figures in relation to new treatment contacts over the years' 1990-1996 has shown a 330% increase (Health Research Board, 1997). This increase is felt to be a real increase in the problem of drug use in Ireland and particularly a real increase in the problem of opiate misuse in the Eastern Health Board area. Other interesting trends over this period are that the mean age of first opiate use has declined and that users are presenting to services earlier in their drug using career. Interestingly, since 1994 heroin users are more likely to be smoking (chasing) heroin rather than injecting. The 1996 figures for opiate use indicate that 65% of users between the ages of 15 and 19 years were smoking heroin. This has prompted professionals to speculate as to whether this route of opiate use has become somewhat socially acceptable.

## Ecstasy and Heroin Use

Another interesting finding in research carried out in the EHB establish a link between heroin smoking and Ecstasy use. We examined a cohort of heroin smokers and discovered firstly that the mean age of first heroin use was 16.9 years and that for one third of the cohort, the first time they smoked heroin was to come down off Ecstasy. At least half of the cohort had at some stage used heroin to come down off Ecstasy (Gervin, 1998). The average time from first use of heroin to daily use was 6 months and the mean time to first intravenous use was almost 3 years. This link between Ecstasy use and heroin smoking may have implications for the whole country given the widespread abuse of Ecstasy in Ireland. The combination of Ecstasy and heroin is being cleverly marketed by drug pushers who tell Ecstasy users that by smoking heroin they will appear relaxed and calm in front of parents who will not suspect Ecstasy use. They also state that smoking heroin is not as serious a problem as injecting however they neglect to mention the serious addictive properties of opiate drugs.

## Injecting Drug Use

The problem of injecting drug use has long been associated with the spread of blood borne viruses such as HIV and Hepatitis B and C. A study of 733 new attendees at the Drug Treatment Centre in Pearse Street between 1992 and 1997 showed an overall prevalence of Hepatitis C antibodies of 61.8% and a HIV prevalence of 1.2% (Smyth, 1998). The prevalence of Hepatitis C antibodies in those under the age of 18 was 53.2%. When an individual first injects it is usually not a planned event. They will generally inject as a result of peer pressure and initially share injecting equipment. Given the high prevalence of Hepatitis C, the first time an individual shares injecting equipment there is a greater than 50% chance of sharing with someone who is Hepatitis C positive. Although the overall prevalence of HIV is quite low there is no room for complacency as shown by a significant increase in the number of individuals who tested positive from certain areas of Dublin in 1999. The fact that the majority of these individuals were less than 23 years of age is doubly worrying, given that they were raised in an era when HIV information and education was available.

Therefore, treatment services, particularly in the EHB area were presented with a large group of opiate users who had started using heroin at an earlier age, who were presenting for treatment earlier and were smoking heroin. Also when they commenced injecting heroin many of them were coming into contact with Hepatitis C and HIV at an early stage in their injecting career. Available treatment services were based on adult models that had developed in the late 1980's and early 1990's as a harm reduction response to the problem of HIV. The programmes were too rigid to meet the needs of

adolescents and services providers own values came into play in that there was a feeling that because these individuals had not got an extensive history of opiate use then they should stop using as quickly as possible. Thus an over reliance on a rapid detoxification developed and there was not enough emphasis on personal development and life skills. Professional values shaped programmes and individuals devising these programmes did so without an adequate knowledge of adolescent development and needs. In order then to provide a service that meets the needs of the target group(adolescents) it is necessary to be aware of adolescent development and the differences that they present with compared to adults. Therefore I will spend some time on adolescent development, risk factors, protective factors and prevention before moving on to look at some characteristics of successful treatment programmes.

### **Adolescent Development**

Adolescence is a time of dramatic change and turmoil for the person involved. It is a time when the adolescent must develop autonomy from their parents and they come to rely on their peers for validation and direction. Adolescents assess themselves through the reaction of their peers and rejection by the peer group can be devastating. Thus acceptance by the peer group becomes the motivating factor for many behaviours. Physical changes are rapid and sexual relationships can be confusing. Cognitive changes also occur and the adolescent develops abstract thinking so that they begin to question ideas and values which their parents hold dear. Although they realise that others have their own thoughts and ideas they feel that everyone is as concerned about their behaviour as they are themselves. Risk taking also increases and may be related to hormonal levels, particularly testosterone. Long term consequences of behaviours and situations are not considered and this was one of the reasons why the 'doom and gloom' campaigns in relation to AIDS in the late 1980s had little impact on adolescents. To explain to an 18 year old that being positive for Hepatitis C may mean that in 15-20 years time they might develop liver problems has little impact.

Adolescence is a time when an individual must develop a sense of personal values, must become autonomous from parents, must develop sexual relationships, must consider education, a career and develop a philosophy for life. However, understanding adolescence and being sensitive to an individual's needs during this traumatic time allows health care professionals to make useful interventions particularly in the area of drug treatment.

### **Risk Factors**

During this time adolescents face considerable pressure from many different sources and the issue of drug use is simply another with which they must contend. Various risk factors are associated with increase in the likelihood of using drugs. These fall into four main groups, cognitive, personality, environmental and biological. Cognitively, the adolescent who has less negative attitudes about drugs and who is less aware of the negative consequences of drugs is more likely to abuse. It should, however, be noted that many people consider that experimentation with drugs is a normal part of development. Also, a survey among those under the age of 25 may well yield very different results compared to an older group if asked about substance use and the legalisation of certain illicit substances. Society in Ireland is undergoing considerable attitudinal change at present particularly among younger people and this should be recognised.

While there is no specific 'addictive personality', certain personality traits are associated with an increased risk of substance use. These include the adolescent who has low self esteem, low social confidence, low self confidence and poor assertiveness skills. In addition the adolescent who exhibits aggressive, impulsive behaviour, who is poor at developing interpersonal relationships and has a pessimistic view of life is at increased risk.

In the social or environmental sphere family influences are of great importance and parenting skills are vital. Inconsistent discipline, lack of praise for achievements, tolerant attitudes towards drug use and lack of maternal involvement are all associated with an increased risk. Parental substance use is important and one Dublin study examining a group of pregnant drug users identified that almost 50 % of patients had a family history of alcohol dependence. Poor academic performance also has negative consequences. By far the most important of the social influences are peer influences and peer pressure.

From a biological or genetic point of view a considerable amount of work is being carried out looking into this influence in substance abuse. The heritability of alcohol dependence has been demonstrated, particularly by the elegant adoption studies from Scandinavian countries, and is well established. Some American researchers feel that genetic influences are of prime importance and it may be that some genes determine a vulnerability for substance abuse but there is always interaction with the environment.

### **Protection and Prevention**

These risk factors seem endless but there are some protective factors. These include families where there is frank and open communication and the parents are emotionally supportive. An adolescent involved in organised school activities and has an importance place on academic achievement is also somewhat protected.

Before moving onto the area of treatment some mention should be made of the complex area of prevention. Such programmes should ensure that they target at risk groups and concentrate on areas such as developing communication and life skills, teaching stress management and assertiveness and work on life skills. These programmes are not the remit of any particular section of society and to be effective should involve schools, parents, communities and especially peer leaders given their extensive influence over adolescents.

### **Treatment Programmes**

Given all of the aforementioned it is not surprising that treatment of adolescent drug users is an extremely difficult area. Many treatment models have been employed however due to the fact they are largely based on adult programmes many of them do not meet the needs of this particular population. It is worth noting that any treatment is better than no treatment and in common with adult populations the best predictor of outcome is the length of time an individual can be retained in treatment. The best programmes involve skills training, family therapy and a good aftercare support. For the purposes of this paper I will concentrate on two programmes currently operating in the EHB area for opiate users. Fortune House in Ballyfermot runs an outpatient programme and Cuan Dara in Cherry Orchard hospital has a specific inpatient strand for adolescents. The staff involved in both units are worthy of particular praise in that they have demonstrated considerable skill and patience in developing their programmes. By being prepared to deal with adolescents in a different way and by listening to the needs of the adolescents themselves the staff have produced more effective approaches to this complex area.

### **Fortune House**

Fortune House opened in 1997 with a remit to provide a detoxification service to drug users from the community care area. Ballyfermot lies within this area and there was a well-recognised opiate problem among the youth of the area. Given this problem it was initially decided to provide a specific programme for adolescents from Ballyfermot. This programme was time limited with a structured reduction of methadone, group therapy, individual therapy and family therapy. Almost immediately it became apparent that despite the extent of the problem in Ballyfermot, not enough adolescents were presenting to sustain the programme. Therefore a decision was made to extend this service to those under 18 years from the whole of the community care area. Perhaps the reason for this was that not all adolescents using drugs see the need for treatment, many are enjoying the lifestyle of drug use and are not ready to abstain. Although initially a number of adolescents did complete the programme, they quickly relapsed and as time went on the numbers completing the entire programme decreased. In addition the behaviour of these adolescents proved very challenging and staff who had been experienced in dealing with adults found this behaviour unacceptable. Following this a number of staff meetings were held to re-evaluate the programme and determine a new direction.

These meetings allowed staff to re-examine their own approach and listen to the needs of the adolescents presenting to the service. As such a programme has developed which appears to be more successful in retaining the adolescents in treatment and achieving abstinence in certain cases. Dedicated time has been set aside for the programme with every afternoon in Fortune House solely for those under the age of 18 years (older are not considered eligible). This has remained so despite considerable pressure on the overall drugs

service particularly during the implementation of the new Methadone regulations. A more flexible approach has been adopted towards the dose of methadone and the rate of reduction and less emphasis placed on occasional 'dirty urines'. The involvement in the methadone programme may have allowed an adolescent to reduce their intake of heroin from 4 times per day to twice per week. Individual, group and family therapy continue but the programme has developed to incorporate other interventions.

An emphasis has now been placed on personal development and the development of life skills. Art therapy, communication skills, aromatherapy and head and neck massage have all been utilised at some stage. A simple behaviour programme has been instituted whereby good behaviour is rewarded by such things as social outings. Weekly multidisciplinary meetings occur to review progress and define goals. Aftercare support is available for those who successfully complete the programme and staff actively promote the move on to other forms of rehabilitation such as community employment initiatives. Difficult patients can have individual care plans instituted which has improved their outcomes. The result has been improved retention rates, more successful outcomes, an improvement in staff morale and a sense of ownership for the adolescent involved.

### **Cuan Dara**

The inpatient unit in Cuan Dara, Cherry Orchard Hospital has also undergone a similar process of change in relation to adolescents. The unit opened in 1995 to provide detoxification for opiate users from the whole of the EHB area and stabilisation for pregnant opiate addicts. The programme lasts for six weeks, the first two to three weeks on reducing medication and the remainder drug free. During their stay the patient is involved in individual counselling, group therapy and family involvement where appropriate. In parallel with other parts of the service since 1995 Cuan Dara has experienced a significant increase in the number of underage drug users requiring admission. Once again, given that the programme had been developed with an adult cohort in mind, staff found themselves ill equipped to deal with the needs and behaviour of a group of adolescents. Considerable staff time and energy was devoted to trying to meet the needs of this group and staff were not trained in adolescent models. As such the adult patients on the unit often felt neglected and there was an increase in the number of self discharges. The boundaries between staff and adolescents became blurred and arguments were frequent. The ward atmosphere deteriorated and at times the tension was palpable. Once again measures were put in place to cope with the special problems posed by adolescents.

Education and training was begun for all grades of staff and this was largely provided by an addiction counsellor with experience in working with adolescents seconded onto the unit. The assessment procedure and preparation process for adolescents referred to the unit was improved and tightened up considerably. A decision was reached to develop a dedicated programme for the underage group and a specific number of beds were set aside for the group (five out of the complement of seventeen). Boundaries between the staff and patients were once again established and staff learned to detach themselves somewhat from the traumas and trials the adolescent presented with as a matter of course.

Adolescent participants on the programme were given responsibilities for certain tasks such as organising the daily visit to the shop. In addition the family involvement was strengthened and often planned with the referral agency prior to admission. This specific approach to the adolescents resulted in staff becoming more aware of the dynamics and needs of the group. Tension on the unit subsided considerably and the adult patients once again perceived that their issues were dealt with. Retention rates increased and more patients both adolescent and adults completed their detoxification successfully.

### **Methadone Maintenance**

One other treatment option should be discussed and that is methadone maintenance for those under the age of 18 years. Methadone maintenance has been validated time and time again as a valid and effective intervention in the treatment of heroin addiction (Payne, 1997). Objections are mainly of a philosophical nature and are put forward by groups concerned solely with abstinence as the only intervention. Many patients have had significant improvements in their health and quality of life as a result of being commenced on a

methadone maintenance programme. However there has always been a reluctance about placing an adolescent on a maintenance programme.

The adolescent may not have had a particularly long history of heroin addiction and may be 'only' smoking heroin. The insistence on detoxification or discontinuation of treatment often results in a return to illicit drug use. When the individual once again presents for treatment they have been involved in heroin use for longer, may have progressed to injecting drug use and may have contracted one of the blood borne viruses such as Hepatitis C or HIV. In common with many adults some adolescents may not be ready to detoxify and surely a preferred option would be to retain the individual in treatment by the provision of a methadone maintenance programme.

### **Responding to Adolescent Drug Use**

The problem of adolescent drug use is a growing one and we will be presented with an increasingly large group of these patients over the coming years. In order to effectively cope with the problem a number of steps have to be put in place. One of the most important issues to be addressed is the adequate training of all staff in the areas of adolescent development and needs. Staff must be aware of the dangers of bringing their own values towards adolescent drug use into their interactions with the under 18 years age group. Prevention, education and treatment programmes all need to be re-evaluated and tailored to fit the target group.

Prevention programmes need to identify the risk factors involved in the progression to problem drug use and work on them. Thus life skills, communication skills, assertiveness skills and personal development all need to become integral parts of programmes working on prevention in adolescents. Education programmes need to be delivered in a non-judgemental fashion and avoid concentrating on a 'doom and gloom' scenario. They must target the at risk groups and involve schools, parents and communities. Peer leaders should be targeted given the influence that we are aware they have in the adolescent group.

Treatment programmes must be flexible, broad based and interesting to attract the adolescent into services. In some ways treatment services are in competition with drug pushers in the community. Once engaged every effort should be made to retain the patient in treatment as this has been shown to have the best long term outcome. The programmes must meet the needs of the adolescent and not the professionals. Success is more likely with skills training, family involvement and aftercare support. In certain cases methadone maintenance may be the only option.

Adolescents can be a frustrating and difficult group of patients to provide services for. However the work can be rewarding and any intervention provided is gratefully accepted once the adolescent perceives their needs being met and that the staff approaching the problem are prepared to listen and respond appropriately. Staff and programmes must be prepared to anticipate trends and respond effectively to the changes in our society. Agencies must work together in dealing with the problem of adolescent drug abuse as treatment services alone will not be sufficient to combat the myriad issues involved with this group of individuals.