weitzman institute

Translating Research into Practice on Alcohol and Polysubstance Use Disorders
by Educating the Interprofessional Primary Care Team

Alcohol Use in Adolescents

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Learning Objectives

At the end of this talk you will be able to:

- Identify at least three factors associated with higher-risk adolescent alcohol use.
- Apply basic principles of adolescent alcohol screening and brief intervention.

Why This Matters in Clinical Practice

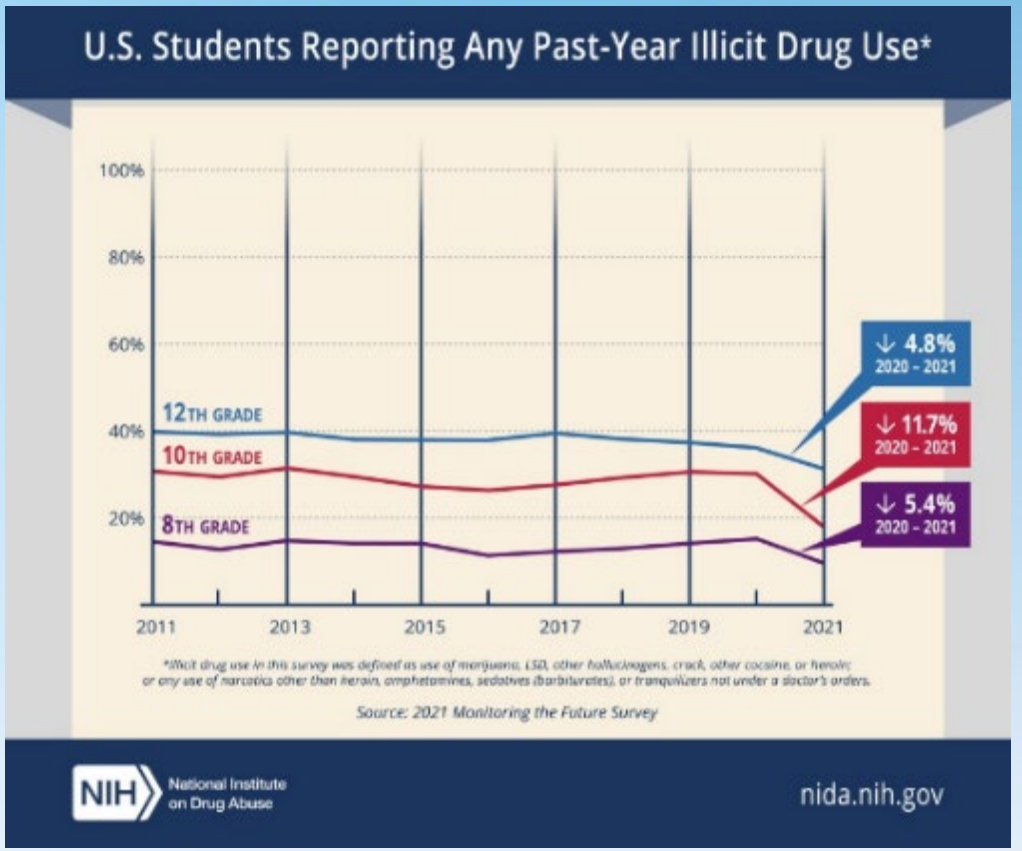
- Alcohol is the most used substance among U.S. teens
- Early use is associated with:
  - Higher risk of AUD (Alcohol Use Disorder)
  - Poor mental health outcomes
  - Injury, suicide, violence
- interdisciplinary impact—primary care, medical specialty, mental health, social work, and education are all impacted and all should play a role in addressing these issues.

The New Clinical Reality: Many Teens Don't' Drink, But Alcohol Still Matters

- Most adolescents are not drinking regularly
- Alcohol remains the most commonly used substance among youth
- Risk clusters in certain groups and context

Clinical focus: identify early use, binge use, co-occurring symptoms, family risk, safety risk, and escalation

The Majority of American Teens Do Not Drink Alcohol



12th graders 2025

Lifetime 48.6%
92.6% in 1981

Last 12 months 41%
87% in 1981

Last 30 days 22%
70.7% in 1981

Binge drinking 9%
41% in 1981

Zoom Poll 1:

- Which statement best reflects current adolescent alcohol use in the United States?
  - A. Most high school seniors drink alcohol monthly
  - B. Alcohol use has declined substantially, but a clinically important subgroup continues to experience significant risk
  - C. Cannabis has completely replaced alcohol as the primary adolescent substance concern
  - D. Because most adolescents do not drink, routine alcohol screening is no longer necessary

Teens /Young Adult vs Older Adults

Decreased
-sedation

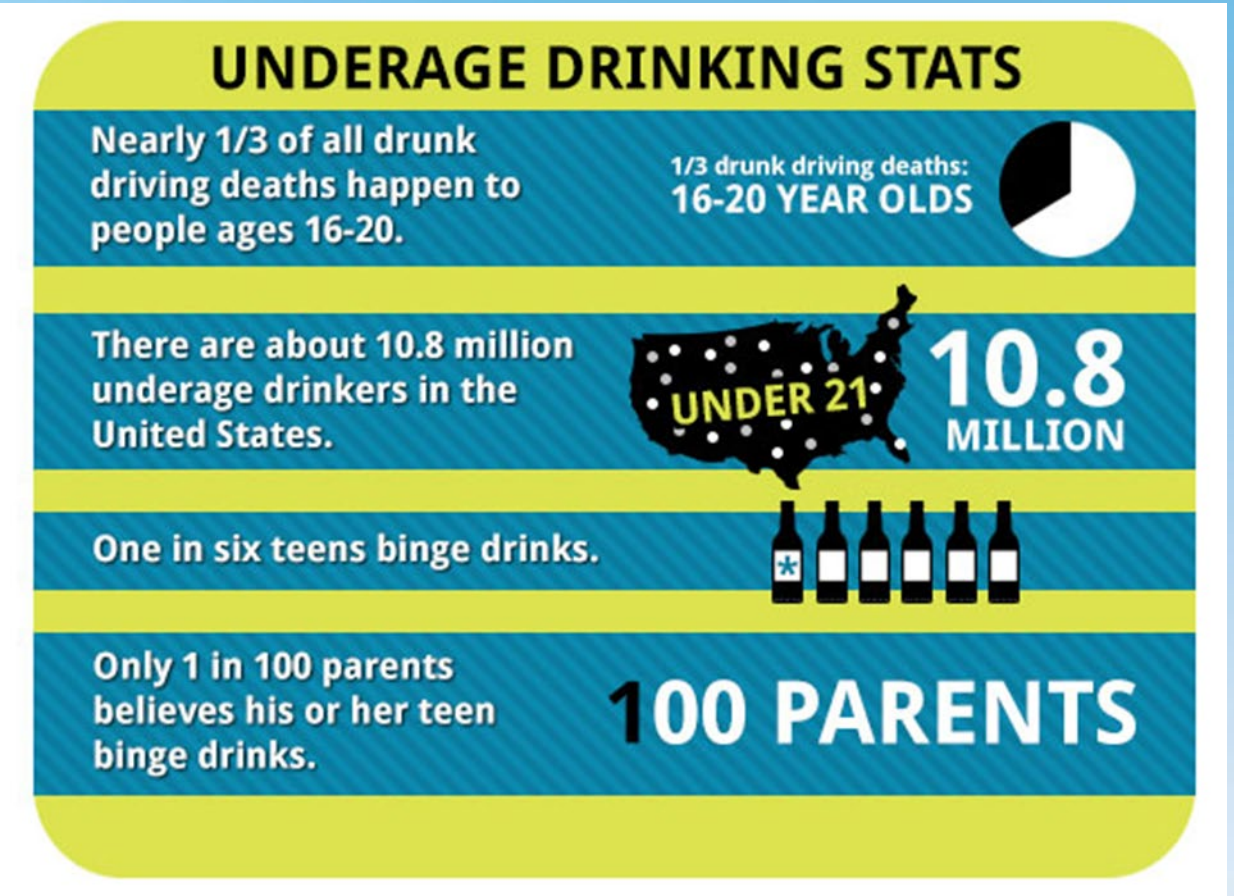
Decreased
-motor impairment

Decreased
-dysphoria with hangover

Increased
-social facilitation

Increased
-memory disruption

Silveri and Spear 1998;Markwiese et al. 1998; Schuckit 1995.



College students

-1,825 **die** alcohol-related unintentional injuries

-696,000 **assaulted** by another student who has been drinking.

-97,000 alcohol-related **sexual assault** or date rape

Newer Public Health Message: Alcohol and Cancer Risk

- Alcohol is a proven carcinogen.
- Risk is not limited to “severe alcoholism.”
- Adolescents and families often underestimate long-term health risk.

Clinical pearl: avoid scare tactics, but include cancer risk in honest anticipatory guidance.

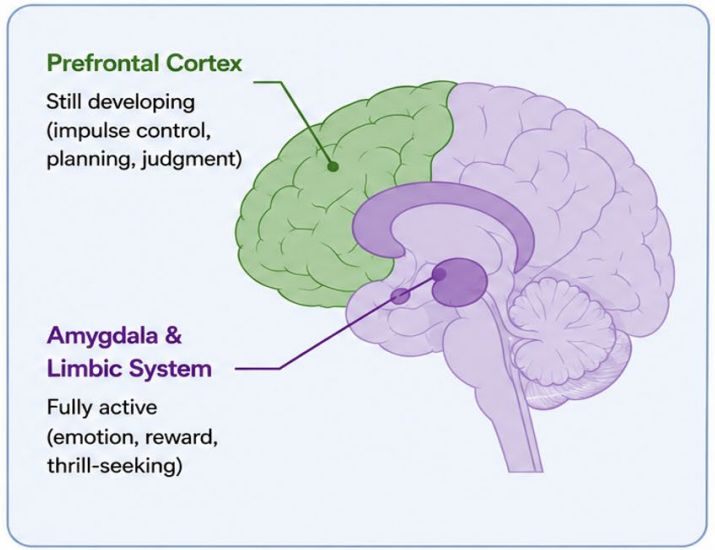
Adolescent Brain Development

The Adolescent Brain

Amygdala: fully active → strong emotions, thrill-seeking

Prefrontal Cortex: still developing → poor impulse control

Teens are highly sensitive to rewards, novelty, and risk

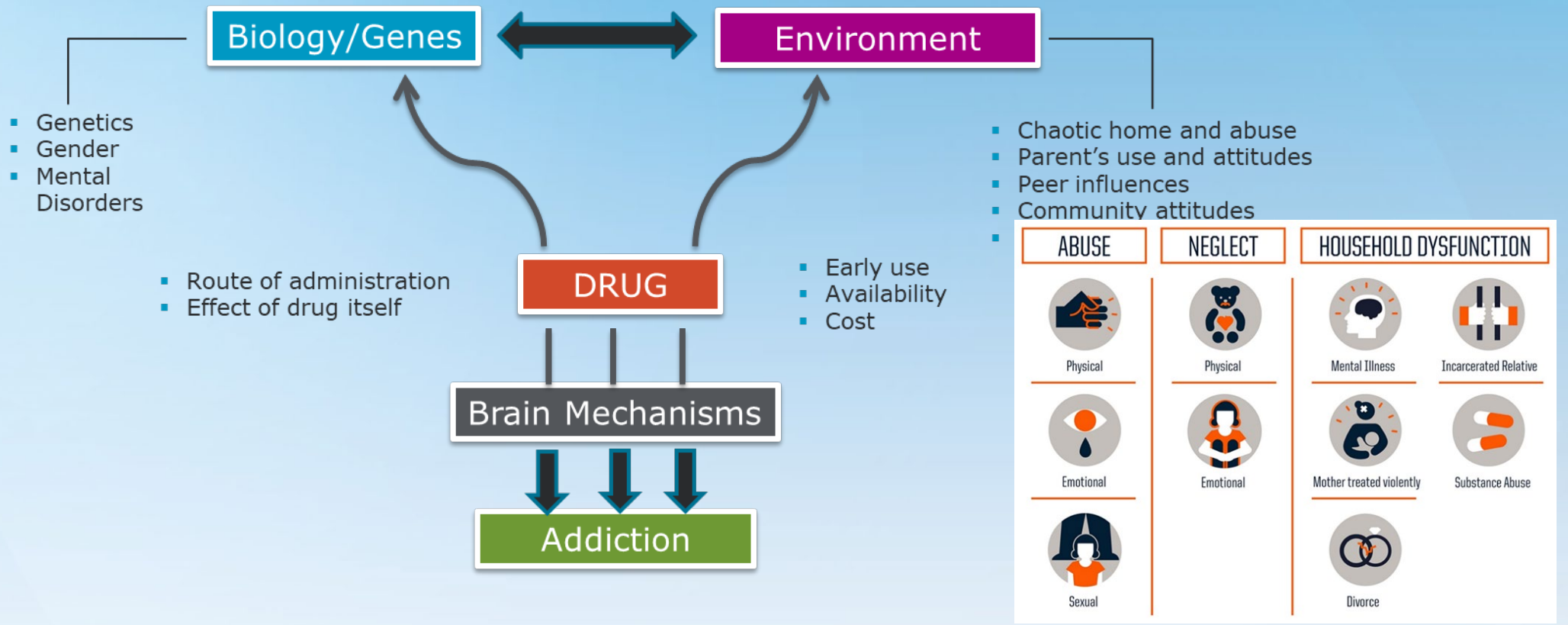


CLINICAL PEARL | Understand the brain first → teens feel more, seek more, and think less ahead. This is not defiance — it is development.

Why Alcohol Effects Adolescents Differently

- Key areas impacted:
  - Prefrontal cortex → delaying development: **decision-making, impulse control**
  - Cingulate Gyrus → **Impaired error monitoring & decision-making→ riskier choices, poor impulse control**. **Reduced emotional regulation** → greater anxiety, depression, and aggression.
  - Less sedation and less perceived impairment can increase drinking risk.
  - More social reward and peer reinforcement.
  - More memory disruption and learning vulnerability.
  - Greater risk when alcohol is combined with sleep loss, depression, trauma, cannabis, ADHD, or impulsivity.
  - Alcohol disrupts development → greater long-term harm than in adults

Risk Factors for Use and Addiction



Red Flags in Clinical Settings

- Mood swings or irritability
- Declining academic performance
- Risky behaviors, e.g., unsafe sex, reckless driving
- Physical signs: sleep issues, fatigue, withdrawal symptoms
- Frequent injuries or ER visits

Tip: Alcohol use often co-occurs with other risk behaviors or mental health concerns.

Screening Tools for Primary Care & Behavioral Health

AAP Periodicity Schedule (year)

Psychosocial/behavioral assessment: **every well visit /** Depression screening: **annually 11–21y /** Alcohol/drug use assessment: **every visit 11–21y** and in any care setting (sick, ED, etc.)

- **CRAFFT 2.1** – Validated adolescent screening tool
- **CRAFFT 2.1 + N** – adds tobacco/nicotine questions
- **AUDIT-C** – For older adolescents
- **Screening opens the door to risk-matched response**:
  - Screening
  - Brief counseling/ motivational conversation
  - Referral to higher level of care when indicated

Note: CRAFFT can be self-administered or provider-led; use results to guide confidentiality, safety assessment, brief counseling, family involvement, and referral when needed.

CRAFFT

CAR • RELAX • ALONE • FORGET • FRIENDS • TROUBLE

2+ positive items → brief counseling, further assessment, and referral depending on severity/safety risk

During past 12 months did you

A. Drink any alcohol?
B. Smoke any marijuana or hashish?
C. Use anything else to get high?

If NO: Ask if you have ever ridden in a CAR driven by someone who was high or had been using drugs or alcohol?

IF YES – complete CRAFFT → → → →

CRAFFT is a mnemonic acronym of first letters of key words in the 6 screening questions. The questions should be asked exactly as written.

C Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?

R Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?

A Do you ever use alcohol or drugs while you are by yourself, or ALONE?

F Do you ever FORGET things you did while using alcohol or drugs?

F Do your family or FRIENDS ever tell you that you should cut down on your drinking or drug use?

T Have you ever gotten into TROUBLE while you were using alcohol or drugs?

Zoom Poll 2:

- A 16-year-old reports drinking at parties twice in the past month. The CRAFFT score is 2. There is no current intoxication, withdrawal, suicidal intent, or immediate safety concern. What is the best next step?
  - A. Reassure the adolescent because the use is infrequent
  - B. Immediately refer every adolescent with a CRAFFT score of 2 to residential treatment
  - C. Conduct a brief assessment, provide motivational counseling, evaluate safety and co-occurring concerns, and arrange follow-up
  - D. Inform the parent immediately without first discussing confidentiality with the adolescent

Brief Interventions: What to do After a Positive Screen

- **Motivational interviewing style**:
  - Elicit readiness and goals
  - Explore ambivalence
  - Normalize discussion without judgment
  - Give clear, brief medical advice
  - Involve family when appropriate and safe
  - Arrange follow-up or referral based on risk

Clinical Pearls for Effective Conversations

- Build trust → use confidentiality guidelines clearly
- Avoid scare tactics → use facts and developmentally appropriate language
- Start early (ages 9–11): normalize asking about substances
- Reinforce strengths and goals

Principles of Adolescent AUD Treatment

1. **Identify & Triage:** SBIRT; withdrawal risk; match level of care
2. **Whole-Person Plan:** co-occurring MH/SUD, sleep, school, SDoH
3. **Evidence-Based Treatments:** MI/CBT/CM; family therapies (MDFT/FFT)
4. **Medication adjuncts, select cases:** Off label naltrexone most commonly considered; specialist-guided and paired with behavioral/family treatment
5. **Safety:** alcohol poisoning, no driving, polysubstance risk, crisis plan
6. **Engagement & Access:** rapid starts, flexible scheduling/telehealth, navigation
7. **Recovery Supports:** community programs, peer/mentor, pro-social activities
8. **Monitor & Adjust:** ≥3 months active care + ongoing check-ins (Utox respectfully), measurement-based tweaks, plan for relapse/return

Medication Treatment: Where it Fits in Adolescents

1. **Behavioral and family-based treatment remain the foundation.**
2. **Medication may be considered off-label for select adolescents with moderate/severe AUD, relapse risk, strong cravings, or repeated failed lower-intensity care.**
3. **Consider naltrexone most often; acamprosate/disulfiram only selectively.**
4. **Check consent, liver status, pregnancy risk, opioid exposure, adherence, and family monitoring.**
5. **Medication is not a substitute for safety planning, family work, and co-occurring care.**

Co-Occurring Conditions

- Alcohol rarely presents alone:
  - **Depression/Anxiety**
  - **ADHD/Impulsivity**
  - **Trauma / PTSD**
  - **Eating disorder symptoms**
  - **Sleep problems**
  - **Family conflict**
  - **School decline**
  - **Suicidality/self-harm**
  - **Cannabis/nicotine/polysubstance use**

Clinical pearl: alcohol use changes the safety assessment, especially when there is depression, trauma, intoxication, impulsivity, driving risk, or access to lethal means.

Zoom Poll 3:

- Which statement about medication treatment for adolescent AUD is most accurate?
  - A. Medication should replace family-based and behavioral treatment when cravings are present
  - B. No medication can ever be considered because none is specifically FDA-approved for adolescent AUD
  - C. Medication may be considered off-label in selected adolescents, most commonly naltrexone, as an adjunct to behavioral, family, safety, and co-occurring-disorder treatment
  - D. Disulfiram should generally be the first medication used in adolescents

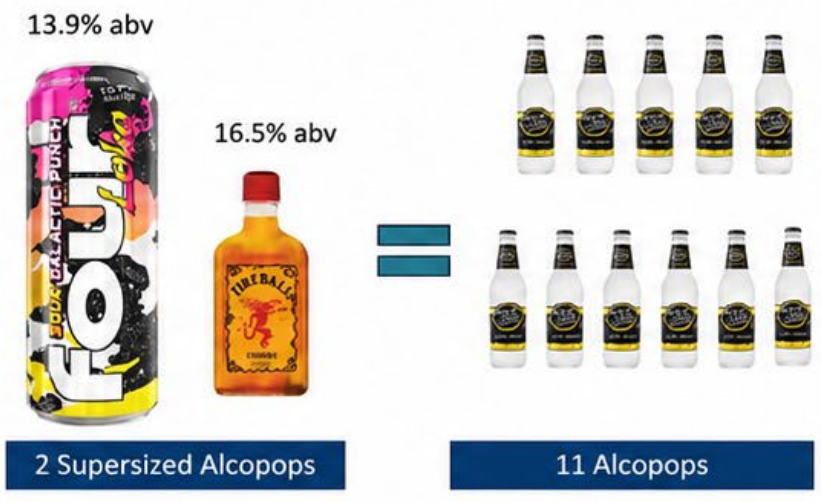
Prevention Strategies for Providers

- **Anticipatory guidance** (e.g., Bright Futures)
- Educate parents on safe storage & communication
- Advocate for community programs, school-based interventions
- Empower youth with coping skills and engagement opportunities

What Youth Are Seeing Now

1 Sweet, flavored, and youth-appealing products

2 High alcohol content in small packages



2 Supersized Alcopops = 11 Alcopops

One supersized alcopop can contain as much alcohol as **~5 to 6** standard alcopops.

3 Co-branding and crossover marketing

73.6% of underage drinkers reported flavored alcoholic beverage use in the past month.

Summary & Takeaways

- Adolescent alcohol use is **common**, but **not inevitable**
- **Routine screening helps identify risk early; brief, nonjudgemental counseling and follow-up can support safer choices and appropriate referral**
- Brain development science supports prevention urgency
- Providers across disciplines can collaborate to prevent and treat alcohol misuse

Community and Clinical Resources

- **SAMHSA Treatment Locator**
- **NIAAA Clinician's Guide**
- Local adolescent behavioral health services
- Telehealth options for rural or underserved areas

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