THE CARLAT REPORT CHILD PSYCHIATRY

A CME Publication

Subscribe today! Call 866-348-9279

UNBIASED INFORMATION FOR CHILD PSYCHIATRISTS

Special Double Issue! Worth 2 CME credits!

Joshua D. Feder, MD
Editor-in-Chief

Volume 10 Issue 6 & 7
September/October 2019
www.thecarlatchildreport.com

IN THIS ISSUE

Substance Use in Children and Adolescents

Learning Objectives

After reading these articles, you should be able to:

1. Discuss management and prevention strategies to address suicide in teens.
2. Describe current treatments for opioid use disorder in adolescents and young adults.
3. Identify ways for clinicians to use tools such as motivational interviewing to discuss cannabis use with teens and young adults.
4. Summarize some of the current findings in the literature regarding psychiatric treatment for children and adolescents.

Growing Rate of Suicide in Teens: Assessment and Prevention

Clinicians treating children and adolescents regularly encounter patients with suicidal thoughts. And with rising rates of adolescent suicide and shrinking inpatient stays, we're seeing more of these suicidal kids in our offices. This article examines some of the novel risk factors and offers management and prevention strategies for you to consider utilizing in your clinical practice.

Highlights From This Issue

Suicide assessment and prevention deserves a thoughtful and organized approach and can be guided by semi-structured instruments.

There are well-laid-out approaches for child psychiatrists to manage opioid treatment within the child or teen's community.

Child psychiatrists can learn and use motivational interviewing to help patients across a range of substance use disorders.

Rising trends

Although suicide rates fell in the 1990s, they started rising in 2007. The rate of suicide and preferred method differs by age.

10–14 years old: Between 2007 and 2015, the suicide rate increased slightly in boys (from 2.3 to 2.5 per 100k) but tripled in girls (from 0.6 to 1.7 per 100k). While death by suffocation and firearms was almost equal in boys (48% each), 70% of girls died by suffocation (Hedegaard H et al, *NCHS Data Brief* 2018;309:1–8).

Continued on page 4

Q&A With the Expert

Outpatient Management of Opioid Addiction
Sandra Gomez-Luna, MD

Child, adolescent, and adult psychiatrist in Darien, CT. Medical Director of Parent Child Support Center, a subsidiary of Behavioral Health Care (BHcare)

Dr. Gomez-Luna has disclosed that she has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

CCPR: Tell us about your position and what you do.

Dr. Gomez-Luna: I directed a short-term adolescent residential program, where I saw a need for identifying and treating kids' co-occurring conditions. I did another fellowship in addiction psychiatry, then joined studies at Yale on tobacco use and electronic nicotine devices in adolescents. Now I'm back in a community setting, where I've created a community-based addiction program for adolescents called Today's Choices.

CCPR: Can you describe your typical patients?

Dr. Gomez-Luna: Most of our kids are referred to us after being suspended. We see kids with cannabis, alcohol use, and nicotine disorders, but also opioid use disorders and all the conditions that come along with that, including mood disorders, trauma, and personality disorders.

CCPR: How do you approach opioid use in general child psychiatric practice? It seems almost every kid has access to opioids from

Continued on page 2

Expert Interview – Outpatient Management of Opioid Addiction

Continued from page 1

somebody's surgical procedure, and when they can't find those opioids anymore, heroin's not hard to track down.

Dr. Gomez-Luna: Absolutely. Wisdom teeth procedures often the open door for that age group (Harbaugh C et al, *JAMA* 2018;320(5):504–506). Because of the rapid use and the reinforcement aspects of these substances, sometimes it's a little late when families find out. We try to catch those adolescents in the initial stages of using opioids to slow the process of severe addiction.

CCPR: What's your general strategy for catching substance use early on?

Dr. Gomez-Luna: We work with schools and primary care offices to identify children at risk for developing rapid addiction. We often get referrals after they are in trouble with schools and coaches, so we reach out a step before that, starting interventions in the community. It's hard to make a diagnosis because kids don't talk until they trust people. We want to catch kids when they're found with marijuana paraphernalia or using nicotine devices. We try to identify that they have tried opioids.

CCPR: What conditions make outpatient treatment of a child's opioid addiction a reasonable approach?

Dr. Gomez-Luna: It depends on the severity of the problem, the resources they have in the community, family support, and past history—a child who makes poor choices but has a good history of school and social development. For family and community support, we use the Adolescent Community Reinforcement Approach (A-CRA). SAMHSA revised the manual in 2016. We want kids who don't have severe addiction to opioids to remain in the community, going to school, and doing outside activities (Godley MD et al, *Drug Alcohol Depend* 2017;174:9–16).

CCPR: What are some of the treatment choices you'll opt for?

Dr. Gomez-Luna: We'll prescribe psychotropics, if necessary, and interventions—mostly oriented around cognitive behavioral therapy, but also employing dialectical behavioral therapy, and family and supportive interventions. We also collaborate with community therapists. It's important to work with adolescents with opioid use disorders who are pre-contemplating coming in. Their families bring them, and we use motivational interviewing (MI). *(Editor's note: For more information on MI, see the QA with Dr. D'Amico on page 7.)* We try to get them into a group in their community. For children who have higher symptomatology, we consider a hospital-based or a residential-based treatment.

CCPR: What about detox?

Dr. Gomez-Luna: We don't like the word "detox." We say that complete abstinence and recovery is possible and construct a team to support the child's temporary disconnect from the community, then reintegration when the child is ready. Often, children with substance use disorders feel outcast from their community, so it's beneficial to facilitate their transition to residential settings. Others want friends and families around, so it's hard to convince them to stay in residential. The days when detox was the only treatment used are hopefully in the past, but it is necessary sometimes.

CCPR: How do you structure the treatment?

Dr. Gomez-Luna: A-CRA requires individual, family, and community intervention, and a minimum of 2 visits a week. We want the kids to remain in their community, but it comes with a commitment. If you're driving, you need to drive twice. If you're taking public transportation, you need to do so twice a week. This is difficult. Families are busy and working, but they need to understand that close monitoring requires more than weekly prescription visits. We are creative, going into communities, providing services to families in their homes. Those who are homeless and living in insecure housing are harder to plan for.

CCPR: Child psychiatrists generally refer a child with an opioid problem to an IOP or a hospital, but what you're doing is kind of in between. The role of a solo child psychiatrist would include screening, coaxing a teen to tell us what's going on (or collaborating with teachers, coaches, or somebody whom the child will talk to), and MI. Do we have other roles, for instance medication or therapy, or are we better off referring to a more robust program?

Dr. Gomez-Luna: Yes. Collaborate with schools, with therapists who have time to see the families and the children. Conduct MI so the child is ready for the treatment itself. Office-based treatment for opioid use disorder was conceived for clinicians treating fairly motivated people. You need other psychosocial interventions and work in close collaboration with the therapist, with families and schools as a very close collateral. The problem is that by the time the situation comes to us, we often have no choice but to refer.

CCPR: If we do have those pieces in place, what kinds of treatments or medications are helpful? What would child psychiatrists do to support this plan?

Dr. Gomez-Luna: Everything is extrapolated from the adult population. In Connecticut, the age of consent is 16, which coincides with the age

Continued on page 3

EDITORIAL INFORMATION

Publisher: **Daniel Carlat, MD**

Editor-in-Chief: **Joshua D. Feder, MD**

Deputy Editor: **Talia Puzantian, PharmD, BCPP,** professor at the Keck Graduate Institute School of Pharmacy in Claremont, CA.

Executive Editor: **Janice Jutras**

Editorial Contributor: **Pavan Madan, MD**

Founding Editor: **Caroline Fisher, MD, PhD,** training director and chief of child psychiatry at Samaritan Health Systems in Corvallis, OR.

Editorial Board:

Glen R. Elliott, MD, PhD, chief psychiatrist and medical director at the Children's Health Council in Palo Alto, CA.

Jonathan C. Gamze, MD, psychiatrist in private practice in Arlington Heights, IL.

Jennifer Harris, MD, lecturer in psychiatry at Harvard Medical School and in private practice in Arlington, MA.

Peter Parry, MBBS, consultant child & adolescent psychiatrist and senior lecturer at Flinders University in Adelaide, Australia.

Elizabeth Tien, MD, supervising psychiatrist at the Mental Health Service Corps in New York, NY.

All editorial content is peer reviewed by the editorial board. Dr. Carlat, Ms. Jutras, Dr. Elliott, Dr. Feder, Dr. Fisher, Dr. Gamze, Dr. Harris, Dr. Madan, Dr. Parry, Dr. Puzantian, and Dr. Tien have disclosed that they have no relevant financial or other interests in any commercial companies pertaining to this educational activity.

This CME/CE activity is intended for psychiatrists, psychiatric nurses, psychologists, and other health care professionals with an interest in the diagnosis and treatment of psychiatric disorders.

Mailing Information

The Carlat Child Psychiatry Report (ISSN 2473-4217) is published 6 times per year (Jan, March, May, July, Sept, Nov) by Carlat Publishing, LLC; 79 State Street, Newburyport, MA 01950. Periodicals Postage Paid at Newburyport, MA and at additional mailing offices.

POSTMASTER: Send address changes to *The Carlat Child Psychiatry Report*, P.O. Box 626, Newburyport, MA 01950

Expert Interview – Outpatient Management of Opioid Addiction

Continued from page 2

buprenorphine treatment starts. We're using buprenorphine in children for whom it's appropriate, and naltrexone as well as psychotropic interventions, such as antidepressants and mood stabilizers. For trauma, we do a mix of treatment for mood, impulsivity, and mood dysregulation. You have to specify in the consent that there is no approval yet for treatment of opioid use disorder in the adolescent population and no safety data, but buprenorphine has been proven to be effective and well tolerated in the adult population (Vicencio-Rosas E et al, *J Pain Research* 2018;11:549–559). Families have concerns about long-term treatment with partial agonists. I find in my practice that families favor naltrexone when they're ready for medication, because it is not an agonist or partial-agonist treatment.

CCPR: Once patients are on buprenorphine or Suboxone, what I'm hearing is they don't get off. It's like the old methadone clinics.

Dr. Gomez-Luna: Correct. I never prescribe buprenorphine alone, although others do. I use Suboxone (buprenorphine with naloxone). We educate females about trying to avoid pregnancy. This may make the decision easier to be on Suboxone versus just Subutex (buprenorphine). But methadone continues to be the gold standard in treatment of opioid use in pregnant women. Some families decide just to take Narcan (naloxone), and I work with them to be ready for more treatment. It's all good, because with Narcan, hopefully they can prevent a fatal overdose. Families struggling with suicidal teens can't predict what will happen, and that is very stressful. There's so little that these families can control. Narcan might mitigate their fear.

CCPR: So, if I understand you correctly, starting Suboxone is a big move. It's beginning a medication that has no clear endpoint. If we embark on office treatment of adolescents with opioid disorders, we need to have the other pieces in place before exploring treatment with buprenorphine/naloxone or naltrexone. Also, we should avoid using buprenorphine alone, and educate and provide Narcan to families, yes?

Dr. Gomez-Luna: Yes, that's right. There is a lot to consider before prescribing Suboxone.

"For most people with addiction, it takes several times for treatment to stick. We are very careful about using the word 'relapse.' Instead, we say 'reuse' or 'OK, so you used again.' Hopefully patients will reestablish trust in you once they're ready to attempt treatment again. We need to understand addiction in that sense."

Sandra Gomez-Luna, MD

CCPR: What about office drug testing? There was a study a number of years ago that said doing drug tests in your office was no better than asking adolescents about the specifics of their drug use.

Dr. Gomez-Luna: I don't agree. Point-of-care drug testing is part of our multi-component treatment. It gets tricky, especially for opioids like fentanyl, carfentanyl, other illicitly manufactured opioids, and Kratom, none of which are routinely detected with current immunoassay tests. Sometimes users don't know their heroin is tainted. So you need confirmation tests, and while you are waiting, use a mix of collateral information and your own understanding of the adolescent's use. Fentanyl is deadly, and people who use their usual amount of heroin may overdose. You have to understand the nuances of getting urine from an adolescent, especially when you're a psychiatrist treating trauma. Somebody's observing, but it's not always a direct observation.

CCPR: Besides drug testing, what other supervision do you talk with parents about?

Dr. Gomez-Luna: We recommend they try to preserve their child's functioning in the community. But often, what's done is undone when teens go to parties or stay overnight somewhere. We focus on reasonable but structured systems, so the adolescent is not immersed in the places and people that promote substance use. Sometimes that means the teen won't be going out for a while. That's part of the commitment. Some families stop drinking alcohol if it's triggering for their kids.

CCPR: What about end points in this approach?

Dr. Gomez-Luna: It all depends on the child and the return to functioning in the community. First comes a phase of safety and medical and psychiatric stabilization. As the child becomes able to function without consistent substance use, we refer the child to a lower level of care. Manualized treatment approaches like A-CRA have a commitment of 3 months, and that's not enough for the opioid use population. Since adolescents often can't see themselves 3 years in the future, we say "OK, let's commit for these 3 months." Then they do better as they continue to be abstinent from the substance.

CCPR: What's the long view for these patients?

Dr. Gomez-Luna: Recovery comes at different times. We are very careful about using the word "relapse." Instead, we say "reuse" or "OK, so you used again." We look for success everywhere. For example, I had a patient taking benzos and opioids. He was able to get onto Suboxone. For me, that was good enough, because using benzos and opioids is a recipe for a fatal overdose. For most people with addiction, it takes several times for treatment to stick. If you're establishing a relationship with teens, you become a resource, and they will hopefully reestablish trust in you once they're ready to attempt treatment again. Psychiatrists need to understand addiction in that sense.

CCPR: They have to be able to tolerate the uncertainties and the fact that some kids don't make it.

Dr. Gomez-Luna: Yes. The young adult population is at higher risk of developing significant conditions, and for attempting and completing suicide. MI is important, and you need the skills to sit tight when you are under pressure to fix things, having a tolerance for what you can't completely control. That's something we teach families. I find it difficult, and I was formally trained in MI to be able to immediately engage adolescents, collaborating with them and helping them to choose their goals. If you get that component, you will be much more adept in providing treatment—not just for opioid use disorders, but all substance use conditions in adolescents.

CCPR: Thank you for your time, Dr. Gomez-Luna.

Growing Rate of Suicide in Teens: Assessment and Prevention
Continued from page 1

15–19 years old: The suicide rate increased 31% for boys (from 10.8 to 14.2 per 100k) and more than doubled for girls (from 2.4 to 5.1 per 100k) between 2007 and 2015 (Curtin SC et al, *Morb Mortal Wkly Rep* 2017;66:816. doi:10.15585/mmwr.mm6630a6). As compared to boys, girls in this age group also died more commonly by suffocation (56% vs 40%) over firearms (22% vs 48%) and poisoning (13% vs 5%).

Suicide and social media

Although we don't know for sure what's behind the acute rise in suicide, one thing that has increased sharply since 2007 is teen use of social media and personal digital devices. Today, over 95% of American youth are connected to the internet, and 45% are online almost constantly (Pew Research Center, May 2018).

Use of social media may be especially problematic for children and teens. Unlike teen interactions at school, the time spent on social media can be potentially limitless—inviting endless possibilities for stressors, ranging from cyberbullying to relationship breakups, at all hours of the day.

Girls might be especially vulnerable. Compared to boys, girls use social media more frequently and are more likely to experience cyberbullying. Social media use and cyberbullying is more strongly connected with depression in girls than boys. Furthermore, girls with depression elicit more negative responses from peers on social media than depressed boys do (Luby J and Kertz S, *JAMA Netw Open* 2019;2(5):e193916).

Assessment of imminent risk

Suicide risk assessment through clinical interview and mental status examination is vital for any psychiatric interview. There are many ways to screen for imminent risk. While we all might have our usual styles, there is a lot to be learned from the structure of evidence-based approaches. For example, the Ask Suicide-Screening Questions (ASQ) Toolkit, published by the National Institute of Mental Health (NIMH), offers a simple four-question approach.

Other more extensive assessments such as the Columbia Suicide Severity Rating Scale (C-SSRS) cover details of suicidal and self-injurious behavior, activating events, treatment history, current clinical status (ie, such things as current hopelessness, agitation, and historical details such as abuse), and protective factors such as reasons for living and family support. The even more detailed CAMS Suicide Status Form–4 (SSF-4) has a detailed assessment process including rating pain, comparing reasons for living and dying, and mental status and treatment planning for initial, interim, and final session stages of care (see evidence-based screening approaches table below). Even if you choose not to use one of these assessments, the structure of their approaches can help to organize your thinking and care planning.

Ask Suicide-Screening Questions Toolkit Questionnaire

1. In the past few weeks, have you wished you were dead?
2. In the past few weeks, have you felt that you or your family would be better off if you were dead?
3. In the past week, have you been having thoughts about killing yourself?
4. Have you ever tried to kill yourself? (If yes, ask how and when.)
5. *If the patient answers yes to any of the above, ask: Are you having thoughts of killing yourself right now? If yes, please describe.

Source: National Institute of Mental Health (NIMH) (www.tinyurl.com/y68bmngf)

Assessment of chronic risk

Chronic risk refers to the ongoing likelihood of the patient making a future suicide attempt. The most important chronic risk factors include prior or family history of suicide, history of maltreatment, access to firearms or other lethal methods, chronic physical or mental health disorder, substance use, and certain demographic variables (male gender, lack/loss of social support).

It is also important to assess for and address biopsychosocial risk factors. Mental health and well-being of parents and siblings can significantly affect teens' depression and suicide risk. Treatment of maternal depression results in reduced externalization/internalization symptoms and reduced depression in children. I routinely recommend depression screening for children of mothers with depression and mothers of children with depression.

Watchful outpatient management

Patients assessed to be at imminent risk of self-harm are usually referred to an emergency room or inpatient psychiatric units. Others are referred to intensive outpatient programs.

In less acute cases, the Suicide Prevention Resource Center has a Safety Plan Template that is a good starting point for developing a safety plan (see www.sprc.org/effective-prevention/strategic-planning). This plan involves a collaborative process of listening with intent, helping patients discover their triggers and how to address them. The plan also provides resources for patient and/or family help,

Continued on page 8

Evidence-Based Approaches for Suicide Screening

Scale	Website	Notes
Ask Suicide-Screening Questions (ASQ) Toolkit	www.tinyurl.com/y3qu32px	Four screening questions that take 20 seconds to administer to identify youth at risk for suicide. Published by the National Institute of Mental Health (NIMH).
CAMS Suicide Status Form–4 (SSF-4) Initial Session	http://b.link/cams-status	Published by Collaborative Assessment and Management of Suicidality (CAMS). Based on the works of Schneidman, Beck, and Baumeister, assesses five critical risk factors on a scale of 1–5.[1]
Columbia-Suicide Severity Rating Scale (C-SSRS)	www.tinyurl.com/y4by9xd3	Three-page risk assessment version used in acute care settings to establish imminent risk of suicide.

[1]Jones DA, *Suicide Life Threat Behav* 2012;42(6):640–653

Q&A With the Expert

Assessing and Treating Cannabis Use Disorder

Gabriella Gobbi, MD, PhD

Professor, Department of Psychiatry, McGill University; Psychiatrist and Clinical Scientist at the McGill University Health Center

Dr. Gobbi has disclosed that she has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

CCPR: Tell us a little bit about your background.

Dr. Gobbi: I trained in medicine, psychiatry, and psychotherapy in Rome, Italy, then received a PhD in neuroscience, working in preclinical psychopharmacology. I now work in our mood disorder clinic and ER, and I direct our basic psychopharmacology lab (neurobiological psychiatry unit), including research on cannabis and the endocannabinoid system. I wear two hats: clinician and basic researcher.

CCPR: What are your thoughts about the relationship between depression and cannabis use in adolescents and young adults?

Dr. Gobbi: The relationship is complex and goes two ways. About 50% of adolescents with depressive symptoms smoke cannabis, most likely for self-medication reasons, yet recreational cannabis can increase the risk of depression. In our recent meta-analysis, we looked at the association between adolescent cannabis consumption and depression in young adulthood and found an increased risk of about 40%. Some research says that young people who are depressed and smoke cannabis can develop treatment-resistant depression (Goldstein BI et al, *J Am Acad Child Adolesc Psychiatry* 2009;48(12):1182–1192). We also found a link between cannabis consumption in adolescents and suicidality, about a 50% increase (Gobbi G et al, *JAMA Psychiatry* 2019;76(4):426–434). So cannabis consumption may trigger depression, even in the absence of a premorbid depression or predisposition for depression.

CCPR: How does this inform our assessment of patients? What do you recommend for an everyday clinician to sort all this out?

Dr. Gobbi: Very often the symptoms of cannabis withdrawal and the symptoms of chronic cannabis consumption (or cannabis use disorder [CUD]) overlap with those found in depression. It is important for doctors to try to sort out the symptomatology of depression, but also to assess the patient's cannabis consumption—both past and current.

CCPR: What types of questions should we be asking?

Dr. Gobbi: Try to establish when cannabis use first started—at what age and under what circumstances. How often does the patient use cannabis: weekly, monthly, or every day? This is important since there are serious mental health consequences from both daily as well as weekly consumption of cannabis (Silins E et al, *Lancet Psychiatry* 2014;1(4):286–293). THC—the main component of cannabis—and its metabolites have a long half-life, up to 2 weeks. So, even if somebody smokes only once a week, the cannabis is still present in the body and in the brain (Huestis MA, *Handb Exp Pharmacol* 2005;(168):657–690). You'll also want to ask how much cannabis the patient consumes and what the concentration of THC is, if the patient knows.

CCPR: We've all heard that the THC concentration is higher now than it used to be.

Dr. Gobbi: Right. Over the last several years the concentration of THC has risen dramatically. One study in the US had it at 4% in 1995 and 12% in 2016 (ElSohly MA et al, *Biol Psychiatry* 2016;79(7):613–619). Recreational cannabis has been legal in Canada since October 2018; there, legal shops sell cannabis concentrations with 20%–30% of THC, which is a pharmacologically significant concentration. In the illegal market, THC concentrations in joints can range from 10% to 50%. The statistics we have are mostly from epidemiological studies done in the 1980s, 1990s, and early 2000s, and we worry what will happen to people who are smoking cannabis with today's higher THC concentrations.

CCPR: What about other types of cannabis?

Dr. Gobbi: Hashish, or butane hash oil—also called BHO, budder, crumble, dabs, earwax, errl, honeycomb, honey oil, live resin, oil, or wax—may have very concentrated THC, about 60%–70%. A new trend is also edible cannabis—cookies, candies, etc—that can contain up to 10 mg of THC per serving (Source: Health Canada).

CCPR: Besides how often and how much cannabis, what else we should be asking?

Dr. Gobbi: Find out why the patient is using it. Patients often report consuming cannabis to self-medicate their depression, anxiety, insomnia, or pain, and also for improving socialization skills. When patients with depression see a psychiatrist in a mood disorder clinic, they aren't making the connection that their depression could be caused by cannabis or that cannabis can worsen their depression.

CCPR: So, what do we do? Do we use motivational interviewing, or harm reduction, to try to get them to use just a little bit less?

Dr. Gobbi: After asking patients about their level of consumption of cannabis, the next step is to motivate and teach them about the possible consequences of cannabis. This can take a long time. Some patients accept this slowly through motivational therapy. Some agree to slowly decrease consumption of cannabis or stop completely, and other patients

Continued on page 6

Expert Interview – Assessing and Treating Cannabis Use Disorder

Continued from page 5

deny the problem. One of the complications of CUD is that patients underestimate the impact of cannabis consumption on mental health, so it's not always easy to motivate patients with depression to stop their cannabis use. However, motivational therapy is an evidence-based approach, as is cognitive behavioral therapy to stop the use of cannabis. *(Editor's note: For more about motivational therapy, see the Q&A with Dr. D'Amico on page 7.)*

CCPR: How do you assess if a patient has CUD? How do you recognize the symptoms of withdrawal?

Dr. Gobbi: The symptoms of cannabis withdrawal overlap with the symptoms of depression: namely mood changes, diminished appetite, irritability, and insomnia. Patients also can have headaches, loss of focus, sweating, chills, an increased feeling of depression and paranoia, as well as stomach problems. It is difficult for both the clinician and the patient to definitively say which symptoms come from depression and which come from cannabis withdrawal. Sometimes, by developing a close relationship with the patient, you can better understand the delineation. For example, if a patient on a stable antidepressant treatment starts suffering from insomnia, increased irritability, and sweating a week after stopping cannabis, these symptoms are more likely linked to cannabis withdrawal than depression. At this point, it is mandatory to motivate the patient to stop cannabis completely and use medications to relieve withdrawal symptoms.

"Patients often report consuming cannabis to self-medicate their depression, anxiety, insomnia, or pain, and also for improving socialization skills. When patients with depression see a psychiatrist in a mood disorder clinic, they aren't making the connection that their depression could be caused by cannabis and that cannabis can also worsen their depression."

Gabriella Gobbi, MD

CCPR: What do we do about people who continue to use weed?

Dr. Gobbi: There are no medications that are FDA labeled for treating CUD, but there are some medications that we use off-label. In our department, one of the most accepted treatments is the use of gabapentin. There are some clinical trials showing that gabapentin can treat CUD (Mason BJ et al, *Neuropsychopharmacology* 2012;37(7):1689–1698). There is also evidence for the use of lithium and valproic acid, as well as bupropion, venlafaxine, and buspirone (Lee DC, *Drug Alcohol Depend* 2019;194:500–517).

CCPR: Those are interesting choices. Some people use topiramate as an off-label approach. Do you ever consider that?

Dr. Gobbi: Yes, topiramate also has some evidence. And all the mood stabilizers can also help in CUD. As I mentioned, there can also be uses for gabapentin, lithium, and valproic acid. All these drugs are used off-label, and patients and families need to know this.

CCPR: Some people seem to get addicted to gabapentin. Have you seen that? Is that something we should be worried about?

Dr. Gobbi: No. We frequently use gabapentin here, and that hasn't been my experience. When people stop gabapentin, they may feel more anxious, but to the best of my knowledge, it is more a decrease in the medication (gabapentin) that was controlling the anxiety, not a real addiction.

CCPR: What about direct medication treatment of underlying depression or anxiety disorders?

Dr. Gobbi: Current scientific evidence suggests that patients with comorbid depression and CUD should be treated with mood stabilizers (gabapentin, valproate, lithium) as well as antidepressants (bupropion, SSRIs, SNRIs), and there are several theories why this can help with CUD. Interestingly, a recent clinical study by D'Souza and colleagues found that fatty acid amide hydrolase (FAAH) inhibitor worked to treat the withdrawal symptoms and the mood symptoms, but also the craving for cannabis by stopping the breakdown of endocannabinoids in the brain (D'Souza DC et al, *Lancet Psychiatry* 2019;6(1):35–45).

CCPR: That's really interesting.

Dr. Gobbi: Yes, and very important. This study opens further avenues for the treatment of CUD. Also, synthetic THC (nabilone) may reduce cannabis withdrawal, but not cannabis consumption (Haney M et al, *Neuropsychopharmacology* 2013;38(8):1557–1565).

CCPR: Good to know. So many people ask about CBD. We certainly have a lot of people who are purchasing and using it, even though we might not think it's a great idea. What do you think about the safety of CBD?

Dr. Gobbi: CBD is worrisome for two reasons. First, people sometimes try CBD for bipolar disorder or depression rather than opting for a first-line treatment—so they bypass effective treatment. The other problem is that CBD's side effects include depression and suicidality as well as interactions with any drugs or medicines that the person is already taking (see www.tinyurl.com/y6zfpbj7).

CCPR: What about the idea that CBD can be a good alternative to cannabis, in the sense that it is less likely to lead to CUD?

Dr. Gobbi: Unfortunately, we don't have good clinical trials using CBD for CUD. Moreover, people often buy CBD on the open market that contains a percentage of THC. We would need randomized, double-blind clinical trials to really demonstrate that cannabidiol could be a good alternative to cannabis.

CCPR: Any final thoughts?

Dr. Gobbi: It is difficult for doctors and patients to recognize cannabis withdrawal. It is not like alcohol withdrawal where the patients experience clear symptoms such as tremors, headache, or vomiting in the 24 hours after

Continued on page 11

Q&A With the Expert

Motivational Interviewing With Teens About Weed

Elizabeth D'Amico, PhD

Senior Behavioral Scientist at RAND and member of the Motivational Interviewing Network of Trainers (MINT)

Dr. D'Amico has disclosed that she has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

With motivational interviewing (MI), people are more likely to accept and act when they feel ownership; MI is specifically helpful for teens, who are at an age where they do not want suggestions from others. We spoke with Dr. Elizabeth D'Amico, nationally recognized for her work developing, implementing, and evaluating interventions for adolescents, about the benefits of applying MI to marijuana use in teens.

CCPR: Tell us a little bit about your background.
Dr. D'Amico: My focus has been on community-based research, working with communities around prevention for alcohol and other drug use and risky sexual behavior. I work in middle schools, teen courts, homeless shelters, and primary care, and I do prevention work with urban Native American youth across California.
CCPR: Help us understand the scope of marijuana use in teens and how it impacts overall function.
Dr. D'Amico: Research is mixed. A recent study found cannabis use was not associated with structural brain differences in adulthood (Meier MH et al, *Drug Alcohol Depend* 2019;202:191–219). However, other work shows that teens who use cannabis frequently are more likely to do poorly on memory tests and higher-level problem solving and information processing (Morin JFG et al, *Am J Psychiatry* 2018;176(2):98–106).
CCPR: A lot of kids will say marijuana is pretty safe stuff because it's legal.
Dr. D'Amico: Cannabis has been marketed as medical, so people's views of it are different than alcohol. Most people would say "I would never drink and drive." But we hear teens say "Cannabis helps me focus and it's safe," yet we know that THC can alter their behavior.
CCPR: How do we advise psychiatrists given this set of circumstances?
Dr. D'Amico: Psychiatrists should screen for both cannabis and alcohol. Our large longitudinal study has shown that teens have more problems from marijuana than alcohol—academically, with mental health, and with delinquency (D'Amico EJ et al, *Addiction* 2016;111(10):1825–1835). In our primary care study, we found that rates of cannabis use disorder were three times as high as for alcohol use disorder (D'Amico EJ et al, *Pediatrics* 2016;138(6):e20161717).
CCPR: Do you have a recommended set of screening practices that make sense?
Dr. D'Amico: Yes. In our study we found that the CRAFFT best captured both alcohol and cannabis problem use and disorders. CRAFFT consists of 6 questions and is freely available at www.tinyurl.com/yxn8djnf (see part B). *(Editor's note: For more information on the CRAFFT screening tool, see www.thecarlatreport.com/CRAFFT.)*
CCPR: That's good to know. Before we get into specifics on applying MI, please give us your take on what it is.
Dr. D'Amico: MI is a collaborative approach. You work with teens to guide them to make a healthy choice, if they're ready. Not everybody's ready. We're not telling people "You need to stop," because when we do that, people typically react: "No way! I'm never going to stop!" MI is a guided approach to help people think through the pros and cons of using, how they balance that out, and whether it makes sense for them to make a change in their behavior.
CCPR: So, once we see that there is a problem, we ought to do MI?
Dr. D'Amico: Yes. There's an online training for providers that I developed with the National Institute of Drug Abuse (http://training.simmersion.com/). In this training, if a teen comes into your office reporting marijuana use, you as the provider try to use MI to determine the teen's level of use and what needs to be done. Busy providers don't have time to sit through an all-day training session. This is a way to learn MI efficiently, and you can get continuing education for it.
CCPR: What do teens think about MI?
Dr. D'Amico: In our primary care study, teens were coming in for a primary care appointment—a cold or a physical—but they were willing to talk about substance use. Many wanted to make changes, too. It helped them to talk about what it would mean, for their future and what they hoped to accomplish, if they continued using.
CCPR: Are there differences for psychiatrists? A lot of times the subject of substance use is already on the table because the teens' parents bring the kids to us to address it.
Dr. D'Amico: It's the same. Kids are using because maybe it helps them sleep, or they're getting pressure from friends. Maybe it's anxiety, and they feel it helps them. It's important to understand the good things they get

Continued on page 9

Growing Rate of Suicide in Teens: Assessment and Prevention
Continued from page 4

such as 24-hour hotlines for phone, text, or chat as well as suggestions for making the environment safe. When dealing with a patient in crisis, remember the acronym LEAP: Listen, Empathize, Agree, and Partner. No-suicide contracts are no longer recommended due to lack of supporting evidence for their effectiveness.

For families with patients in outpatient programs, integrated CBT, DBT, mentalization, promotion of family resilience, family-based attachment therapy, and family CBT all show promise to address depression and suicide. While we recommend avoiding use of hypnotic medications and working to manage current medications to avoid interference with sleep, insomnia treatment via CBT-I (cognitive behavioral therapy for insomnia) can improve depression and lessen suicidal ideation (Brent D, *J Am Acad Child Adolesc Psychiatry* 2019;58(1):25–35).

While under your care, avoid prescribing medications that can be lethal in overdose, such as TCAs, benzos, and barbiturates. If you do, provide only a short supply at one time and ask pharmacists for blister packs when available.

Although restriction at home can be challenging, families need to take measures to make the environment as safe as possible (see Safety Plan Template link in earlier discussion). For example, make sure families are aware that commonly available objects (eg, extension cords, bedding, dog leashes) and anchor points (tree branches, beams, and closets) are often used for suicide by asphyxiation (Yau et al, *Inj Epidemiol* 2018;5(1):1). Although often considered only as a safety measure for young children, a useful protective measure is utilizing safes and lockboxes for prescriptions and OTC meds, and a locking cabinet for poisons, pesticides, cords, ropes, and knives.

Prevention

With teen suicide a chronic and growing concern, we need to focus on preventive strategies targeting vulnerable population at several levels, often in our roles consulting and collaborating beyond patient-focused appointments.

Family/home

We know that starting as early as possible is the best way to build resilience. Early intervention can be crucial. Parent training interventions like Positive Parenting Program (www.triplep.net/glo-en/home/) and Parent-Child Interaction Therapy (www.pcit.org/) improve parenting skills and reduce child maltreatment, thus reducing potential risk factors. Family-based interventions such as Familias Unidas, Family Check-Up, and the Family Bereavement Program also improve long-term outcomes on suicide (Brent DA, *J Am Acad Child Adolesc Psychiatry* 2019;58(1):25–35).

Limiting firearm access is critical. Whether your patient is at risk or not, always ask if there are firearms at home. Almost 30% of youth live in homes in which firearms are not stored safely, and of these, 40% of youth have easy access to such firearms. When firearms are kept locked, unloaded, and away from separately locked ammunition, children and teens are less likely to use them to harm not only themselves but others (Grossman DC et al, *JAMA* 2005;293(6):707–714). We strongly recommend that firearms be stored off-site or in firearm safes. If you want to ensure no access, ask the family to call law enforcement to remove the firearms from the house, and be sure to follow up with the family to check whether this has been done.

Hospitals

Emergency rooms can play an important role in suicide prevention. The ED-SAFE study showed that simple universal screening using the Patient Safety Screener-3 (see www.tinyurl.com/yxkehx42) and brief intervention led to lower suicide attempts at follow-up (Miller IW et al, *JAMA Psychiatry* 2017;74(6):563–570). Hospitals and correctional facilities should actively seek and restrict access to means and anchor points for hanging.

At the institutional scale, the Zero Suicide Initiative has had tremendous success across the UK and later in the US at Henry Ford Health System. The initiative's efforts showed that suicide rates drop significantly when healthcare institutions (hospitals, clinics, etc.) provide suicide risk training to all staff, have the option of a dual-diagnosis unit, use rating scales to help assess depression, ensure adequate dosing of antidepressants, counsel family involvement in treatment, teach emotional regulation and distress tolerance to teens, and routinely conduct multidisciplinary review whenever a suicide in care takes place. (The Zero Suicide Guidelines are available at www.tinyurl.com/y3drvssn.)

School/community

At the school level, one notable prevention program is the Good Behavior Game, a pro-social classroom behavior management tool that teachers implement in the classroom (www.tinyurl.com/y5qf6pny). The goals of using this tool include reducing disruptive, aggressive, and/or socially isolating behaviors—risk factors for future problems ranging from suicidal thoughts and behaviors to substance use. First graders who participated regularly in this game showed persistent reductions in substance use, antisocial behavior, and suicidal thoughts even 25 years later. Among preventive programs, this has the best return on investment (Kellam SG et al, *Addict Sci Clin Pract* 2011;6(1):73–84).

In the community, bridge barriers with phones can be lifesaving, particularly at places where people frequently leap to their deaths.

CCPR VERDICT:

Preventing and treating suicide in teens is an uphill battle with worsening trends. Astute clinicians need to stay abreast of all the resources available in their area as well as online to afford the best chance of survival for their patients. If possible, try to bring some of the abovementioned measures/initiatives in your practice, neighborhood, school, or healthcare facility. Lastly, don't go it alone. While it is always a good idea to have consultative relationships with colleagues to discuss difficult cases, in the matter of suicidality, it is extremely important to actively consult with other colleagues to better think through care plans and help ensure the best possible care in these hazardous circumstances.

Editor's note: The topic of suicide runs broad and deep. Cultural issues, the black box warning of 2004 (see CCPR, *Summer 2019), supervision of youths, and safety measures (www.tinyurl.com/y3o3nppa) are additional issues to consider.*

Expert Interview – Motivational Interviewing With Teens About Weed

Continued from page 7

from using and the not-so-good things. The good usually doesn't outweigh the not-so-good, and they can see that on their own. You might reflect back: "It's really fun for you to use and you love hanging out with your friends, and yet you've gotten in a lot of trouble with your parents and your grades are dropping." MI works well when someone is ambivalent about a behavior.

CCPR: When patients tell us they use marijuana to feel good and/or to fit in with friends, how do you apply MI?

Dr. D'Amico: Those are the main reasons we hear. For a teen who is very influenced by friends, you might ask: "How confident are you to not use around your friends on Friday, since you said you wanted to cut back on your use?" For others, it might be: "How confident are you to try other ways to get to sleep without using?" If they're ready to make a change, we discuss how they could make that happen.

CCPR: They often say they want to stop, but it's really hard.

Dr. D'Amico: Really hard. If teens can cut back to using once a week vs every day, I think that's a great outcome. They're still using, but it's probably not going to affect them as much. I go with what they think they can handle as a starting point.

CCPR: So, harm reduction is okay.

Dr. D'Amico: Right. Teens are not going to walk out of the office and never use cannabis again. That's not going to happen. But it's a good outcome if they avoid using before driving or they don't get in a car with someone who's using. Or maybe they stopped using during school hours, and they're getting their homework done. They might still use with their friends on a Friday—but overall, because they cut back, their consequences are significantly reduced in terms of academics, mental health, and physical health. You have to start somewhere.

"If teens can cut back to using once a week vs every day, I think that's a great outcome. They're still using, but it's probably not going to affect them as much. I go with what they think they can handle as a starting point."

Elizabeth D'Amico, PhD

CCPR: What about parents' expectations that their teen will stop altogether?

Dr. D'Amico: Let them know it depends on whether the teen is using to such an extent that maybe there's a need for more intensive treatment. Brief MI interventions are for teens who are at risk, maybe starting to use more regularly, to catch them and help them change their use.

CCPR: How do you decide when somebody needs a referral for treatment?

Dr. D'Amico: Every teen is different. If a teen is using every day, not going to school, having a lot of problems, that person needs more than a 15-minute intervention. What was fascinating in our research is that teens who came in with more negative consequences from marijuana benefited more from the brief intervention than teens in usual care. But when we had teens come in who weren't experiencing a lot of consequences from marijuana, they actually did better in usual care. We think this is because with MI, the focus is on whether or not you're ready to make a change, and if teens are not experiencing a lot of consequences, they may not be ready to make a change in their use.

CCPR: What is "usual care"?

Continued on page 10

Five Principles of Motivational Interviewing

Principle	Elements	Example
Express Empathy	• Express empathy toward teen to help build rapport • Use reflective listening	"It sounds like you're frustrated with people you love telling you to stop smoking."
Develop Discrepancy	• Raise awareness of teen's current behavior • Help them to identify differences between goals/values and current behavior • Encourage teen to come up with ways to adjust behaviors to align with stated values and goals	"I hear you that you enjoy smoking, and yet you are worried that your little sister will start too. What do you think are some ways to prevent that from happening?"
Avoid Arguing or Confrontation	• Reframe statements • Acknowledge ambivalence	"I hear you that you are not ready to change your smoking behavior. What do you think would be helpful if and when you are ready to make a change?"
Support Self-Efficacy	• Explore past successes in other problem areas and apply to present situation • Provide strategies and resources that can help assist teen with change • Affirm that teen is able to choose and carry out personal change	"You were able to get in shape to make the soccer team. This is kind of the same. If it's OK with you, I can share some ideas that have worked for other people that might help and we can also think about other ideas together. You can do this."
Support Autonomy	• Reinforce that agency—the power for change—lies within the teen vs counselor, teachers, or parents • Listen as teen develops an action list of steps to change behavior	"You have some really great ideas about how to make some changes. We can continue to talk together as you figure out how you want to do it."

Source: Miller WR, Rollnick S. *Motivational Interviewing: Helping People Change.* 3rd ed. New York: Guilford Press; 2012.

Research Updates IN PSYCHIATRY

SUICIDE

Update: Is Watching 13 Reasons Why *Bad for Teens?*

REVIEW OF: Niederkrotenthaler T et al, *JAMA Psychiatry* 2019. doi: 10.1001/jamapsychiatry.2019.0922

Several studies have examined whether Netflix's *13 Reasons Why* is good or bad for teens. Results have been mixed. In the *CCPR* March/April 2019 issue, we reported a study finding that most suicidal ideation decreased after watching the first season of the series (Zimmerman A et al, *J Am Acad Child Adolesc Psychiatry* 2018;57(8):610–613). But other findings include increases in suicide-related hospitalizations and self-harm. Now a new article has been published looking at actual suicide data.

Investigators examined CDC-collected suicide data before and after the show's release in April 2017. Monthly data across 19 years (1999–2017) was used to estimate expected suicide counts. Twitter and Instagram posts, a proxy for viewership data, estimated that social media attention from the show was highest in April 2017 and trivial after June 2017. As such, only these 3 months following the show's release were explored. Suicide counts and methods were compared across these age groups: 10–19 years, 20–29 years, and 30 years or older.

Among the show's target audience (ages 10–19), suicide counts were about 15% higher than expected in the 3 months following the series premiere. No excess suicide mortality was found in other age groups. Excess suicides were higher among girls versus boys (22% vs 12%). The 27% increase in hanging suicide was particularly high compared to other methods (such as cutting, which was the method used in the show).

Study strengths include analysis of suicide counts instead of proxies (eg, hospitalizations, symptoms, and attitudes), suicide methods, and various age groups. The time series analysis also accounted for trends, temporal fluctuations, and seasonal fluctuations in suicides. Because this is an observational study at a population level, it is unknown whether those who committed suicide watched the series. Netflix also added content warnings to the show in May 2017. It is unknown what effect, if any, this has had on results.

CCPR TAKE

Since the first season, the show has shifted its tone from authentic teen experience to a mashup of who-done-it mystery and #MeToo shoutouts. While this show may promote dialogue about teen depression and suicide and about help-seeking behaviors, we must ask: At what cost? This study identifies an association between release of *13 Reasons Why* and an increase in youth suicides. The timing, age specificity, and gender specificity of the associations, at least for the first season, is consistent with potential suicide contagion by media. This study suggests an association, not causation. Nonetheless, it highlights the importance that media portrayals of suicide follow best practices to reduce possible unintended consequences. It also suggests caution may be warranted with exposing vulnerable teens to certain kinds of media.

—Kristen Gardner, PharmD. Dr. Gardner has disclosed that she has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

To learn more, listen to our 8/12/19 podcast, *"Is Watching* 13 Reasons Why *Bad for Teens?"* Search for "Carlat" on your podcast store.

Expert Interview – Motivational Interviewing With Teens About Weed

Continued from page 9

Dr. D'Amico: In our study, we gave teens a brochure with information about marijuana, alcohol, and other drugs, plus several websites and numbers to get more information.

CCPR: So, if you have somebody who comes in who has more bad things happening, MI makes sense. Otherwise you might do some psychoeducation with the teen, and that actually might be more effective.

Dr. D'Amico: Right. You can frame it as building the teen's self-efficacy for the future: "If you were having problems, what would you do?" You could talk about strategies to recognize when problems are developing so the teen knows when change is needed.

CCPR: What's the time frame for MI when you're working on harm reduction with a patient who is using to some degree?

Dr. D'Amico: We did one-time 15-minute brief interventions. Teens who were experiencing more consequences often reduced their use and consequences one year later (D'Amico EJ et al, *Pediatrics* 2019;144(2):e20183014). But if you check in with them in a few months and find they didn't make changes, ask: Why not? Are they ready to make changes now? How might they do that? Work on their coping skills. We ask patients how motivated they are to change their use, and how confident they are to change. Really motivated teens who aren't confident will need skills training; teens who aren't motivated to change, but are confident they could, require a different conversation.

CCPR: Sometimes it's almost as if they don't have the will or the ability to make the changes that we're talking about.

Dr. D'Amico: Kids will say "Yeah, this is affecting me, but I really like using pot." That's where you can step in and reflect this ambivalence. You could also say "Well, if it's OK with you, can I share some strategies other teens have tried?" You might suggest that they try to only use on the weekend or hang around other teens that don't use. Some of them are going to need treatment, and this brief intervention won't work. But for most teens at risk, it's a perfect approach to get them to think about their behavior.

CCPR: Does the training address this?

Dr. D'Amico: In the training, if you pick the wrong things to say to the patient, he will completely shut down and not tell you anything, just like what might happen in an actual appointment. It's based on real-life situations.

CCPR: Thank you for your time, Dr. D'Amico.

CME Post-Test

To earn CME or CE credit, you must read the articles and log on to www.TheCarlatReport.com to take the post-test. You must answer 75% of the questions correctly to earn credit. You will be given 2 attempts to pass the test. Tests must be completed within a year from each issue's publication date. As a subscriber to *CCPR,* you already have a username and password to log onto www.TheCarlatChildReport.com. To obtain your username and password, please email info@thecarlatreport.com or call 978-499-0583.

The Carlat CME Institute is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. Carlat CME Institute is also approved by the American Psychological Association to sponsor continuing education for psychologists. Carlat CME Institute maintains responsibility for this program and its content. Carlat CME Institute designates this enduring material educational activity for a maximum of two (2) *AMA PRA Category 1 Credits™* or 2 CE credits for psychologists. Physicians or psychologists should claim credit commensurate only with the extent of their participation in the activity. *Below are the questions for this month's CME/CE post-test. This page is intended as a study guide. Please complete the test online at www.TheCarlatChildReport.com. Note: Learning Objectives are listed on page 1.*

1. Between 2007 and 2015, the suicide rate in girls ages 10–14 years _____. (LO #1)

   [ ] a. Remained the same
   [ ] b. Increased slightly
   [ ] c. Doubled
   [ ] d. Tripled

2 According to Dr. Gobbi, a 2019 study found an association between adolescent cannabis consumption and a 10% increased risk of depression in young adulthood. (LO #3)

   [ ] a. True
   [ ] b. False

3. Which of the following is true about buprenorphine for use in treating opioid use disorder in adolescents and adult patients? (LO #2)

   [ ] a. Buprenorphine is FDA approved in both adolescents and adults for treating opioid use disorder
   [ ] b. Buprenorphine is not FDA approved for either adolescents or adults for treating opioid use disorder
   [ ] c. Although buprenorphine is not yet FDA approved in adolescents, multiple studies have established its safety for use in adolescents
   [ ] d. Buprenorphine is FDA approved only in adults for treating opioid use disorder but is often used off-label for adolescents

4. According to a 2019 study, no excess suicide mortality was found in any age groups in the 3 months following the series premiere of the Netflix series *13 Reasons Why.* (LO #4)

   [ ] a. True
   [ ] b. False

5. One of the four questions in the Ask Suicide-Screening Questions (ASQ) Toolkit Questionnaire includes: (LO #1)

   [ ] a. Do you have any religious beliefs that would stop you from acting on suicidal thoughts?
   [ ] b. Have any of your friends or people in your peer group attempted suicide?
   [ ] c. In the past few weeks, have you felt that you or your family would be better off if you were dead?
   [ ] d. Do you have a family history of suicide?

6. The Adolescent Community Reinforcement Approach (A-CRA) for substance use supports the model of children and adolescents remaining in the community and participating in activities while attending a minimum of 2 appointments a week. (LO #2)

   [ ] a. True
   [ ] b. False

7. Which of the following programs is used as a behavior management strategy in school-age children as a preventive approach to suicidal thoughts and behaviors? (LO #1)

   [ ] a. Positive Parenting Program
   [ ] b. Good Behavior Game
   [ ] c. Family Check-Up
   [ ] d. Parent-Child Interaction Therapy

8. According to Dr. D'Amico, a recent study indicates that teens who use cannabis frequently are more likely to _____ than those who don't use cannabis. (LO #3)

   [ ] a. Complete fewer years of education
   [ ] b. Drive impaired
   [ ] c. Do poorly on memory tests and higher-level problem solving
   [ ] d. Use other drugs like cocaine, MDMA, or heroin

Expert Interview – Assessing and Treating Cannabis Use Disorder

Continued from page 6

the last drink. Clinicians need to remember that patients in cannabis withdrawal have "softer" symptoms, such as increased irritability, depression, headache, sweating, and loss of appetite, which can appear 1 or 2 weeks after the last joint. Often neither patients nor doctors make this connection. I want to emphasize that, although it is not so easy to evaluate, if clinicians are more aware of cannabis withdrawal, there is a better chance that they will be able to recognize and clarify how to proceed with patients.

CCPR: Thank you for your time, Dr. Gobbi.

THE CARLAT REPORT
CHILD PSYCHIATRY
P.O. Box 626
Newburyport, MA 01950

This Issue:
Substance Use
Sep/Oct 2019

Next Issue:
Autism
Nov/Dec 2019

Your subscription expires:

Renew or extend online at
www.thecarlatreport.com
or by check using the order form below.

Note From the Editor-in-Chief

Welcome to the fall issue of the *Carlat Child Psychiatry Report*. This issue will help you assess and manage substance use disorders in teens. It features interviews with cutting-edge people: Dr. Sandra Gomez-Luna on the outpatient management of opiate use; Dr. Gabriella Gobbi on the impact of cannabis, its interaction with depression, and the conundrum of cannabis withdrawal; and Dr. Elizabeth D'Amico on the efficacy, training, and implementation of outpatient motivational interviewing for substance use with teens. The issue also discusses assessment, treatment planning, and prevention for children and teens at risk for suicide, with a follow-up on the problematic impact of the television series *13 Reasons Why*. In addition, we hope you're enjoying the podcast episodes I've recorded with my clinical colleague Mara Goverman (search for Carlat on your podcast store). We've posted episodes on *13 Reasons Why* and school refusal. We aspire to be the "Click and Clack" of child and adolescent mental health: clear and also really fun to listen to! Our job at Carlat is to offer accurate and useful content, and I welcome your feedback. Feel free to email me; it's always good to hear from you.

Regards,
Josh Feder, MD
jfeder@thecarlatreport.com

❑ Yes! I would like to subscribe to *The Carlat Child Psychiatry Report* for $129 for one year. I may cancel my subscription at any time for a full refund if not completely satisfied.

❑ Enclosed is my check made payable to *Carlat Publishing LLC*

Please charge my
❑ Visa ❑ MasterCard ❑ Amex

Card # Exp. Date

Signature

Name

Address

City State Zip

Phone / Email (required)

Please mail payment to:
The Carlat Child Psychiatry Report,
P.O. Box 626, Newburyport, MA 01950
Call toll-free 866-348-9279 or fax to 978-499-2278