# AMERICAN ACADEMY OF PEDIATRICS

Committee on Substance Abuse

# Indications for Management and Referral of Patients Involved in Substance Abuse

**ABSTRACT. This statement addresses the challenge of evaluating and managing the various stages of substance use by children and adolescents in the context of pediatric practice. Approaches are suggested that would assist the pediatrician in differentiating highly prevalent experimental and occasional use from more severe use with adverse consequences that affect emotional, behavioral, educational, or physical health. Comorbid psychiatric conditions are common and should be evaluated and treated simultaneously by child and adolescent mental health specialists. Guidelines for referral based on severity of involvement using established patient treatment-matching criteria are outlined. Pediatricians need to become familiar with treatment professionals and facilities in their communities and to ensure that treatment for adolescent patients is appropriate based on their developmental, psychosocial, medical, and mental health needs. The family should be encouraged to participate actively in the treatment process.**

ABBREVIATIONS. *DSM-IV, Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition; DSM-PC, Diagnostic and Statistical Manual for Primary Care Child and Adolescent Version.*

The stages of substance use leading to abuse and dependency were defined more than a decade ago (Table 1).[1] Since then, the American Academy of Pediatrics has published a number of related policy statements and has defined the role of the pediatrician in the management of substance abuse by children and adolescents.[2] One challenge that remains for the practitioner, however, is to determine the severity of the young person's drug involvement and then make a decision about continued office follow-up or referral for evaluation and possible treatment. If specialized treatment is needed, the practitioner should determine the most appropriate referral for that patient.

The early stages of substance abuse are often the most difficult to evaluate. Although experimentation with mood-altering chemicals, including nicotine, is common, it is important that the experimentation not be condoned or trivialized by adults. The first and only use of even the so-called gateway drugs (alcohol, marijuana, and inhalants) may result in tragic consequences as a result of unintentional injuries or even death. Often the early user is naive about the effects of a substance, is uninitiated in its use, and has no tolerance for the effects of the drug.

**TABLE 1.** Stages of Adolescent Substance Abuse*

| Stage | Description |
|---|---|
| 1 | Potential for abuse |
| | Decreased impulse control |
| | Need for immediate gratification |
| | Availability of tobacco, drugs, alcohol, inhalants |
| | Need for peer acceptance |
| 2 | Experimentation: learning the euphoria |
| | Use of inhalants, tobacco, marijuana, and alcohol with friends |
| | Few, if any, consequences |
| | May increase to regular weekend use |
| | Little change in behavior |
| 3 | Regular use: seeking the euphoria |
| | Use of other drugs, eg, stimulants, lysergic acid diethylamide (LSD), sedatives |
| | Behavioral changes and some consequences |
| | Increased frequency of use; use alone |
| | Buying or stealing drugs |
| 4 | Regular use: preoccupation with the "high" |
| | Daily use of drugs |
| | Loss of control |
| | Multiple consequences and risk-taking |
| | Estrangement from family and "straight" friends |
| 5 | Burnout: use of drugs to feel normal |
| | Use of multiple substances; cross-addiction |
| | Guilt, withdrawal, shame, remorse, depression |
| | Physical and mental deterioration |
| | Increased risk-taking, self-destructive behavior, or suicidal behavior |

* Adapted from Comerci.[1(pp58–59)]

For the young person who is experimenting with drugs (stage 2), the pediatrician can have an important role in the educational process for the patient and the family. If there have been no adverse consequences, brief counseling and in-office follow-up may be all that are needed. For the young person who has begun to experience adverse consequences of substance abuse, such as injuries associated with acute intoxication, trouble with the law, truancy, decline in school performance, or deterioration in physical or mental health, intervention is indicated.

Although confidentiality is the cornerstone of establishing a relationship with older children and adolescents, sometimes the behaviors of a young person are dangerous enough to justify and require a discussion with the parents. Depending on the circumstances, maintenance of confidentiality with the adolescent and the family may not be possible. A level of substance abuse associated with injuries, legal entanglements, failure in school, or deterioration of physical or mental health requires that family

The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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members be made aware of the dangers so that they can become involved in the therapeutic process.

At follow-up office visits, the pediatrician has the opportunity to assess continued use or abuse. Families should be advised to set firm rules about their children's involvement with tobacco, alcohol, and other drugs, and the consequences for use should be defined so that all persons understand the expectations. Behavior by parents, teachers, other adults, and health care professionals that enables tobacco, alcohol, and other drug use (such as tolerating an adolescent's erratic behavior, decline in school performance, or association with known substance users) must be recognized and avoided. The pediatrician can become part of the chain of adults emphasizing the non-use message by providing clear and consistent information to parents and their children while maintaining a trusting and caring relationship. A nonjudgmental approach that emphasizes health risk is paramount.

Some adolescents are able to discontinue the use of alcohol and other drugs by making a personal commitment with little formal treatment and with the aid of self-help groups or family support only. Developmentally, most teenagers will stop abusing alcohol or other drugs by early adulthood. The goal should be not only to recommend treatment, but also to identify the consequences of a lifestyle of alcohol and other drug abuse and motivate the patient to seek the help needed to initiate and maintain recovery. This can be most difficult with the adolescent patient, and literature is emerging on the role of motivational interviewing to encourage change in the patient who is dependent on nicotine or other psychoactive drugs.[3,4] Physicians can enhance the motivational process in their patients by expressing their concerns and encouraging an evaluation or formal assessment. Successful recovery usually begins when the patient stops denying that substance abuse is the cause of the life consequences experienced. Active participation by the pediatrician can assist in breaking down the denial and facilitate entry into the recovery process.

The decision to refer more heavily involved children and adolescents (stages 3–5) is straightforward if their symptoms and signs are recognized as being caused by substance abuse or dependence. Deciding where to refer the identified adolescent in need of treatment often is more complicated. For admission, most treatment programs require a diagnosis of abuse or dependence based on the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*[5] (*DSM-IV*), (Tables 2 and 3). Some treatment programs or communities have education and prevention services available for those identified early. Although most primary care practitioners do not have a working knowledge of *DSM-IV* diagnoses, an understanding of "substance abuse" and "substance dependence" criteria can help decide who needs referral and where the person should be referred.[5] The *Diagnostic and Statistical Manual for Primary Care* (*DSM-PC*) *Child and Adolescent Version,* published by the American Academy of Pediatrics in 1996, also classifies substance use/abuse by adolescents.[6] Any adolescent meeting the *DSM-IV* criteria for abuse or dependence should be assessed by a professional experienced in adolescent chemical dependency. If the patient or family is unwilling to pursue evaluation in this phase of the drug use continuum, it may be a challenge to avoid an adversarial relationship as the pediatrician makes referral recommendations that clearly are indicated but not accepted by the patient or family. Although resistance and denial are intrinsic to the disease and are expected at this stage, it is important to make the best recommendation for the teenager and family while remaining available and supportive.

**TABLE 2.** *DSM-IV** Criteria for Substance Abuse[5]

1. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by 1 (or more) of the following, occurring within a 12-month period:
   a. recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (eg, repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household)
   b. recurrent substance use in situations in which it is physically hazardous (eg, driving an automobile or operating a machine when impaired by substance use)
   c. recurrent substance-related legal problems (eg, arrests for substance-related disorderly conduct)
   d. continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (eg, arguments with spouse about consequences of intoxication, physical fights)
2. The symptoms have never met the criteria for substance dependence for this class of substance.

**DSM-IV* indicates *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*.[5(pp182–183)]

**TABLE 3.** *DSM-IV** Criteria for Substance Dependence[5(p181)]

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by 3 (or more) of the following, occurring at any time in the same 12-month period:

1. tolerance, as defined by either of the following:
   a. a need for markedly increased amounts of the substance to achieve intoxication or desired effect
   b. markedly diminished effect with continued use of the same amount of the substance
2. withdrawal, as manifested by either of the following:
   a. the characteristic withdrawal syndrome for the substance
   b. the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms
3. the substance is often taken in larger amounts or over a longer period than was intended
4. there is a persistent desire or unsuccessful efforts to cut down or control substance use
5. a great deal of time is spent in activities necessary to obtain the substance (eg, visiting multiple doctors or driving long distances), use the substance (eg, chain-smoking), or recover from its effects
6. important social, occupational, or recreational activities are given up or reduced because of substance use
7. the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (eg, current cocaine use despite recognition of cocaine-induced depression or continued drinking despite recognition that an ulcer was made worse by alcohol consumption)

* *DSM-IV* indicates *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*.[5(p181)]

## DUAL DIAGNOSIS

Adolescents who manifest psychiatric diagnoses in addition to substance abuse raise additional diagnostic concerns.[7–10] Other psychiatric disorders, especially major depressive disorders and conduct disorder, have been demonstrated in adolescents who use tobacco, alcohol, and other drugs.[11] Although a high prevalence of comorbidity has been reported in adolescent substance abusers receiving inpatient treatment,[12–16] the number of adolescents who exhibit psychiatric symptoms because of the substance abuse disorder and the number who have a primary or coexisting psychiatric diagnosis is unclear. Miller and Fine[17] believe that methodological considerations, including the length of abstinence required before the diagnosis is made, the population sampled, and the perspective of the examiner, affect prevalence rates for psychiatric disorders in substance abusers and account for the variability. They see the prevalence rates for psychiatric disorders as being artificially elevated by the tendency to establish a diagnosis before some of the psychiatric symptomatology secondary to the substance use abates. Ideally, the patient in a stable condition should be observed for a minimum of 1 month after discontinuing drug use and before diagnosing a comorbid disorder or initiating treatment with a psychopharmacologic agent. In this era of very brief (or no) hospitalization, it may make sense to diagnose and prescribe medication sooner, especially if the disorder predates the substance use or if there is a family history of psychiatric disorder.

Awareness of the prevalence and manifestations of psychiatric diagnoses is essential for the quality treatment of adolescent substance abusers, and the clinician needs to know what kind of comorbid conditions are commonly seen. Large-scale population studies have not been conducted on children and adolescents, but the National Institute of Mental Health's Epidemiologic Catchment Area Study[18] attempted to estimate the true prevalence rates of alcohol abuse, other drug abuse disorders, and mental disorders in a community and institutional sample of more than 20 000 adults standardized to the US census. Of persons with alcohol disorders, 37% had another mental disorder, with the highest prevalence for affective, anxiety, and antisocial personality disorders. More than 50% of those with drug disorders other than alcohol use disorders had a comorbid mental disorder: 28% had anxiety disorders, 26% had affective disorders, 18% had antisocial personality disorder, and 7% had schizophrenia. The study[18] verified the widely held impression that comorbidity rates are much higher for patients in treatment and institutional settings than in the general population.

The diagnostic categories most likely to be encountered in the pediatrician's office are affective, anxiety, and disruptive behavior disorders. Pediatricians will best serve these patients if they:

1. Conduct a complete evaluation of each patient that includes a comprehensive psychosocial history and physical examination, as well as a mental status examination and an inquiry into other psychiatric symptomatology by using information obtained from collateral sources, such as parents or teachers;
2. Have a high index of suspicion for psychiatric comorbidity in adolescents whose conditions do not respond to treatment or who are presenting problems in treatment;
3. Individualize treatment to accommodate other psychiatric diagnoses; and
4. Have a working relationship with and know when to consult a mental health specialist. The close integration of mental health care and primary care are important; managed care arrangements that separate mental health and addiction services from primary care make this coordination more difficult.

## WHERE TO REFER PATIENTS

In addiction medicine, the concept of "patient-treatment matching" has become increasingly important in determining the appropriate level of care for the patient with a diagnosis of substance abuse or dependence.[19] Matching is based on a comprehensive biopsychosocial assessment of the patient and considers the history of current and past drug use, previous treatment, health consequences, comorbid psychiatric conditions, family and social issues, vocational-educational effects, experience with the justice system, motivation for treatment, and support systems available.

Managed care dictates treatment options in chemical dependency and mental health as rigorously as for medical and surgical treatments, and the primary care physician is routinely required to approve referrals for substance abuse and mental health treatment. Firm guidelines are being established that determine the level of care and length of treatment, and inpatient treatment is no longer the norm for the initial referral. More commonly, the patient must be unsuccessful at outpatient treatment before being recommended for inpatient treatment. The presence of a comorbid psychiatric condition may necessitate an earlier inpatient admission.

The American Society of Addiction Medicine has published *Patient Placement Criteria* that define levels of adult and adolescent treatment.[20] Adolescent levels include early intervention, outpatient treatment, and medically monitored or managed inpatient care. Placement is based on 6 dimensions that include acute intoxication/withdrawal potential, previous medical conditions and complications, emotional/behavioral conditions and complications, treatment acceptance/resistance, relapse/continued use potential, and recovery environment (Table 4). The publication also includes parameters for continued stay and discharge from the various levels of treatment.

A more comprehensive and detailed description of the continuum of adolescent treatment options based on multiple client assessment criteria has been published by the Center for Substance Abuse Treatment.[21] The treatment levels include more intensive outpatient options, as well as long-term residential psychosocial care (therapeutic communities), half-

**TABLE 4.** Adolescent Criteria: Crosswalk of Levels 0.5 Through IV*

| Criteria Dimensions | Levels of Service | | | | |
|---|---|---|---|---|---|
| | Level 0.5 Early Intervention | Level I Outpatient Treatment | Level II Intensive Outpatient Treatment | Level III Medically Monitored Intensive Inpatient Treatment | Level IV Medically Managed Intensive Inpatient Treatment |
| Dimension I: acute intoxication and/or withdrawal potential | No withdrawal risk | No withdrawal risk | Manifests no overt symptoms of withdrawal risk | Risk of withdrawal syndrome is present but manageable in Level III | Severe withdrawal risk |
| Dimension 2: biomedical conditions and complications | None or very stable | None or very stable | None or, if present, does not distract from addiction treatment; manageable at Level II | Require Medical monitoring but not intensive treatment | Requires 24-hour medical and nursing care |
| Dimension 3: emotional/ behavioral conditions and complications | None or very stable | None or manageable in an outpatient structured environment | Mild severity, with the potential to distract from recovery efforts | Moderate severity; requires a 24-hour structured setting | Severe problems require 24-hour psychiatric care, with concomitant addiction treatment |
| Dimension 4: treatment acceptance/resistance | Willing to understand how current use may affect personal goals | Willing to cooperate but needs motivating and monitoring strategies | Resistance high enough to require structured program but not so high as to render outpatient treatment ineffective | Resistance high despite negative consequences; needs intensive motivating strategies in a 24-hour structured setting | Problems in this dimension do not qualify patient for level IV treatment |
| Dimension 5: relapse/ continued use potential | Needs understanding of, or skills to change, current use patterns | Able to maintain abstinence and recovery goals with minimal support | Intensification of addiction symptoms; high likelihood of relapse without close monitoring and support | Unable to control use despite active participation in less intensive care; needs 24-hour structure | Problems in this dimension do not qualify patient for level IV treatment |
| Dimension 6: recovery environment | Social support system or significant others increase risk of personal conflict about alcohol/ other drug use | Supportive recovery environment and/or patient has skills to cope | Environment unsupportive but, with structure or support, patient can cope | Environment dangerous for recovery, necessitating removal from the environment; logistical impediments to outpatient treatment | Problems in this dimension do not qualify patient for level IV treatment |

* This overview of the adolescent admission criteria is an approximate summary to illustrate the principal concepts and structure of the criteria.
From the American Society of Addiction Medicine.[20(p131)]

way houses, and group home living arrangements for seriously involved adolescents.

Successful addiction treatment usually involves more than one level of care during a long recovery process. The treatment may involve outpatient or inpatient care in the beginning with continued care at a level appropriate for the patient's recovery process. Most chemically dependent patients in treatment consider themselves "recovering" rather than "recovered" and are involved in sequential treatment levels that usually include a formal structured program, attendance at 12-step self-help groups (eg, Alcoholics Anonymous, Narcotics Anonymous), and continued self-recovery work. Relapse is an expected part of recovery and can be viewed as a learning opportunity that is important to the process rather than a failure. If relapse occurs, pediatricians once again can have an important supportive role or initiate further referral if additional formal treatment is required. By collaborating with a counselor or addiction specialist, as well as the insurance company, the school, and the family, the pediatrician can make a meaningful contribution to the recovery process.

## CRITERIA FOR THE SELECTION OF A SUBSTANCE ABUSE TREATMENT PROGRAM

Appropriate substance abuse treatment facilities for children and adolescents must have staff with adequate experience in dealing with these age groups. The following criteria may be useful in evaluating an inpatient or outpatient adolescent substance abuse treatment program.

1. The program views drug and alcohol abuse as a primary disease rather than a symptom.
2. The program includes a comprehensive evaluation of the patient and appropriately manages or refers for treatment any associated medical, emotional, or behavioral problems identified in the initial assessment.
3. The program adheres to an abstinence philosophy. Any use is abuse. Drug use is a chronic disease, and a drug-free environment is essential. Tobacco use ideally should be prohibited, or nicotine cessation treatment should at least be part of the overall treatment plan.
4. There is a low ratio of patients to staff. Treatment professionals should be knowledgeable in the treatment of chemical dependency and adolescent behavior and development.
5. Professionally led support groups and self-help groups are integral parts of the program.
6. Adolescent groups are separate from the adult groups if both are treated at the same facility.
7. The entire family is involved in treatment. The program relates to parents and patients with compassion and concern with the goal of reunification of the family whenever possible.
8. Follow-up and continuing care are integral parts of the program.
9. As progress is made in the program, patients have an opportunity to continue academic and vocational education and are assisted in restructuring family, school, and social life.
10. The program administration discusses costs and financial arrangements for inpatient and outpatient care and facilitates communication with managed care organizations.
11. The program is as close to home as possible to facilitate family involvement, even though separation of the adolescent from the family may be indicated initially.

## RECOMMENDATIONS FOR PEDIATRICIANS

1. Pediatricians need to become familiar with the patterns of adolescent nicotine, alcohol, and drug use and the stages of substance abuse. Knowledge of the *DSM-IV* and *DSM-PC* criteria for diagnosis is useful for differentiating experimental use from problem use.
2. A thorough psychosocial and medical assessment of the patient is essential before making a referral for evaluation or treatment. Familiarity with the levels of treatment available and the multidimensional assessment criteria used to determine the intensity of services required can assist the pediatrician to make an appropriate referral.
3. Substance abuse is a potentially fatal disease. Use to the point at which school, activities, home, or work is affected represents symptomatic substance abuse and usually warrants parental involvement and a comprehensive interview and assessment.
4. Awareness of the high prevalence of psychiatric disorders among adolescents who abuse or are dependent on psychoactive substances will affect the decision as to where to refer the adolescent. If the pediatrician suspects a comorbid psychiatric diagnosis and needs assistance in determining appropriate treatment, psychiatric consultation should be obtained.
5. As advocates for adolescents and families requiring substance abuse treatment, pediatricians have the opportunity and obligation to become familiar with professionals and programs in their communities that provide education, prevention, and treatment services, including smoking cessation. A close working relationship facilitates referrals and communication.
6. Pediatricians also can advocate with local managed care organizations to provide quality mental health and substance abuse services that are appropriate for specific ages and developmental stages and that are integrated with primary care. Knowledge of the criteria for selecting an adolescent treatment program and the American Society of Addiction Medicine *Patient Placement Criteria* form the basis for these advocacy efforts.
7. Pediatricians must be familiar with state and federal regulations governing confidential exchange of information about substance abuse treatment. These are available from the state alcohol and substance abuse treatment regulatory agencies.

COMMITTEE ON SUBSTANCE ABUSE, 1999–2000
Edward A. Jacobs, MD, Chairperson
Stuart M. Copperman, MD
Alain Joffe, MD

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