Policy on Substance Use by Adolescent Patients

Latest Revision
2026

Abbreviations
AAPD: American Academy of Pediatric Dentistry.
Majr: Medical subject headings major topic.
SUD: Substance use disorder.
Tiab: Title and abstract.

Purpose
The American Academy of Pediatric Dentistry (**AAPD**) recognizes that substance use and substance use disorders (**SUD**) in adolescents are significant health burdens with societal and familial impacts in the United States. The persistence of substance use among adolescents obligates dental personnel to identify behaviors characteristic of active use, recognize clinical signs and symptoms of active use or withdrawal, modify dental treatment accordingly, and facilitate referral to medical providers or behavioral addiction specialists. This policy reviews the scope and the harmful effects of substance use in the adolescent population and the oral health care professional's role in addressing concerns regarding SUD in pediatric patients.

Methods
This policy, developed by the Council on Clinical Affairs and adopted in 2016,[1] was last revised in 2021.[2] This revision is based upon a review of current dental and medical literature, including a literature review through the PubMed/MEDLINE database using the terms: (*detection* [**Majr**] OR *substance abuse, intravenous* [Majr] OR *alcoholism* [Majr] OR *drug overdose* [Majr] OR *opiate overdose* [Majr] OR *alcohol-related disorders* [Majr] OR *substance withdrawal syndrome* [Majr] OR *marijuana abuse* [Majr] OR *underage drinking* [Majr]*)* OR *(adolescent substance abuse* [**Tiab**] OR *adolescent substance misuse* [Tiab] OR *adolescent substance use* [Tiab]) OR *(adolescent prescription drug use* [Tiab] OR *adolescent prescription drug abuse* [Tiab]) OR *(adolescent alcohol use* [Tiab] OR *adolescent alcohol abuse* [Tiab] OR *adolescent alcohol misuse* [Tiab]) OR *(electronic nicotine delivery systems* [Majr] OR *tobacco use* [Majr] OR *tobacco use disorder* [Majr] OR *tobacco smoking* [Majr] OR *smokers* [Majr]). The search resulted in 410 papers. When additional limitations (ie, humans, English, the last 5 years, birth through 18, 19+ years) were applied, 33 papers were identified and reviewed by abstract and title. Papers for review were chosen from this list and from the references within selected articles. Websites and documents from select health care and public policy organizations, as well as governmental agencies, also were reviewed.

Definitions
***Adolescence*:** "11 to 21 years of age and beyond, dividing the group into early (ages 11-14 years), middle (ages 15-17 years), and late (ages 18-21 years and beyond) adolescence."[3]
***Substance use disorder (SUD)*:** "a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problem".[4p545]

Background

Adolescent substance use is etiologically complex, arising from the cumulative and interacting influence of individual, family, peer, school, and community factors rather than any single cause. Physical, social, and behavioral changes that occur during the adolescent years can increase susceptibility to SUD.[5,6] The most consistently replicated predictors are at the family-level—particularly parental substance use, low parental monitoring, and family conflict—followed closely by peer association with substance users and individual-level vulnerabilities such as impulsivity, low self-esteem, and untreated mental health conditions.[7] Neurobiological development patterns, specifically the maturational lag between prefrontal cortical systems and subcortical reward circuitry, bias adolescents toward high-risk, high-reward decision-making.[8] The protective factors most strongly associated with avoidance of substance use include maternal education, parental monitoring, and household relational quality.[9] Peer-level factors constitute a well-supported secondary tier of protective variables, with social network composition and prevailing peer norms regarding substance use each exerting independent and measurable influence.[9] Individual-level protective factors—including self-regulatory capacity, emotional competence, high academic achievement, and internalized anti-drug attitudes—serve as proximal buffers against substance use risk, particularly when reinforced by supportive family and peer environments.[9]

Drug use at an early age is an important predictor of development of an SUD later in life.[10] The consequences of substance use impact not only the immediate health and safety of young people but also their long-term developmental trajectories. Repeated use of legal or illicit substances can seriously harm health, lead to disability, and prevent individuals from meeting important responsibilities at work, school, or home.[11]

Substances misused by adolescents include depressants, cannabinoids, hallucinogens, stimulants, and steroids.[12] According to the *Monitoring the Future Study*—a national longitudinal surveillance system tracking substance use trends—adolescent substance use rates have declined consistently over 4 decades for all surveyed substances except nicotine pouches.[13p20,21] Conversely, the number of adolescent deaths caused by SUD has risen.[14] Oral health care professionals will encounter adolescents who use substances, most commonly alcohol, cannabis, and nicotine.[13p22] Adolescent substance use presents unique clinical challenges due to rapidly evolving trends and shifting patterns of use. Familiarity with misused substances, their oral manifestations, and SUD treatment options enables oral health care professionals to support and care for patients with SUD.

Depressants misused by adolescents include alcohol, opioids (both prescription and illicit), barbiturates, benzodiazepines, and inhalants. Past-year consumption of alcohol, current use, binge drinking, high-intensity drinking, and intoxication rates have reached historic lows over the past 30 years.[13p22] Opioid misuse among adolescents presents a more complex epidemiological picture characterized by declining prevalence but persistent mortality risks.[15] Adolescent overdose deaths more than doubled between 2019 and 2023, driven primarily by fentanyl.[16] Since 2019, 85% of adolescent and young adult overdose deaths have involved illicitly manufactured fentanyl.[17] These overdoses are largely accidental, occurring when adolescents unknowingly consume fentanyl-contaminated pills while seeking prescription opioids or other drugs.[17] The most common initial source of opioids among adolescents and young adults is from a friend or relative with a valid prescription.[18]

Cannabinoids and synthetic cannabinoids are the most frequently used illicit drug among adolescents.[19]2020 The landscape of cannabis consumption has evolved substantially, with increasing product potency and diversified consumption methods including vaping, dabbing, and edibles adding new complexities to prevention and intervention efforts.[19]2020 Notably, vaping has emerged as the predominant cannabinoid consumption method among adolescents, with the vast majority using flavored products.[20] Cannabis concentrates like wax, shatter, and oils are high-potency products associated with increased frequency of use, cannabis use disorder, anxiety, and acute adverse psychological reactions including paranoia, panic attacks, and psychotic episodes.[21]

Stimulants used by adolescents are, most commonly, nicotine products and prescription medications but also include caffeine and methamphetamine.[13p17,18] Although caffeine has historically been

underrepresented in adolescent drug use surveillance, chronic consumption can lead to dependence and health risks.[22] An emerging concern is nicotine pouch use, which increased significantly among high school students–between 2023 and 2024.[23] Use of nicotine pouches is readily concealable because they do not require expectoration of juice. Students primarily misuse prescription stimulants (eg, dextroamphetamine, methylphenidate) seeking academic enhancement despite lack of evidence for improved performance in those without attention-deficit/hyperactivity disorder (ADHD).[24] Illicit stimulant (eg, cocaine, methamphetamine) use remains rare among adolescents.[25]

Oral health care professionals will encounter both patients and parents/caregivers exhibiting signs of substance use. Clinical presentation of substance use is variable, based on both the substance and individual. Signs of substance use include behavioral changes, physical manifestations, and functional impairment across multiple life domains.[4p626] Behavioral changes may include poor impulse control, impaired decision-making, hostility, emotional instability, or hyperactivity.[4p626] Physical manifestations noted include slurred speech, staggering gait, hallucinations, disorientation, physical injuries and pupillary dilation/constriction.[26] Perioral and oral signs may include sores around the mouth, continual wetting or licking of lips, clenched teeth, bruxism, trismus, xerostomia, enamel chips or coronal fractures, neglected/poor oral hygiene, multiple cervical caries lesions, enamel erosion, gingivitis, gingival ulceration, periodontal disease, pale mucosa, leukoplakia, leukoedema, candidiasis, and intraoral burns.(Saini 2013; Partnership 2026) Individuals with SUD are at increased risk for caries, caries risk, oral and pharyngeal cancer and susceptibility to oral infections.[27]

Adolescent substance use frequently co-occurs with additional mental disorders.[28pxi,29] SUD often coexists with psychiatric conditions such as depression, anxiety disorders, attention-deficit hyperactivity disorder, oppositional defiant disorder, conduct disorder, bipolar disorder, posttraumatic stress disorder, bulimia nervosa, social phobia, and schizophrenia.[28pxi;30,31] Substance use may induce the deterioration, emergence, or reoccurrence of psychiatric disorders[4p551], or it may appear to reduce, mask, or enable an adolescent to cope with symptoms.[28p80,29,30] Oral health care professionals may experience difficulty differentiating between SUD and other mental health disorders. Taking care to distinguish between presentations attributable to substance use disorders and those consistent with primary mental health conditions can facilitate appropriate intervention.[28p80,30,31]

Oral health care professionals are credible sources of health information who have enduring relationships with their patients and are skilled in providing patient advice and utilizing behavior modification techniques such as motivational interviewing.[32] The strong, direct link between substance use and oral pathology[33] provides a natural entry point for practitioners to help patients identify the link between their behaviors and their health outcomes. Dentists can identify clinical manifestations of substance use, present brief interventions, and provide referrals to medical providers or behavioral health or addiction specialists.[34] Screening, Brief Intervention and Referral to Treatment (SBIRT)[35] and Car, Relax, Alone, Forget, Family/Friends, Trouble (CRAFFT)[36] are useful validated tools for this process. Oral health care professionals may assist the patient and family in finding treatment facilities, self-help groups, and community resources to address substance use specific to adolescents.[37,38] When substance use is suspected or confirmed, an empathetic, non-judgmental style of discussion facilitates a trusting patient-doctor relationship.[39] Asking open-ended questions may garner more information as they tend to be less threatening to the patient.[39] Involvement of the parent and other authorities in accordance with state laws is imperative when substance use places the adolescent patient or others in a high-risk or life-threatening situation.[40] The patient should receive notification when disclosure of confidential information will occur and be provided an opportunity to join the conversation.[40]

When providing treatment to a patient with suspected substance use, modifications to the administration or prescription of sedatives, anxiolytics, local anesthetics and analgesics may help to avoid unfavorable drug interactions or a relapse of an SUD. Knowledge of the patient's risk factors for active substance use, past SUD, current medications, and family history of SUDs is critical when recommending or prescribing medications, particularly those with abuse potential.[37,41] Prescription drug monitoring programs (PDMPs) have been implemented in most states and have been effective in reducing the number

of prescriptions and opiates available for misuse by adolescents.[42,43] When management of mild to moderate pain is necessary, non-opioid analgesics (eg, acetaminophen, nonsteroidal anti-inflammatory drugs [NSAIDS]) are considered first-line agents.[44] If prescription medication with abuse potential is indicated for severe pain, closely monitoring the patient, reducing length of time between visits for refills, prescribing smaller amounts of liquid medications or fewer pills, and educating both patients and caregivers/parents about proper use and potential risks of prescription medications, including the risk of sharing them with others can help decrease risk for misuse or diversion.[41]

Policy statement

Substance use is a public health problem.[11] Advocacy for SUD prevention and interventions across health care disciplines is critical to mitigate the devastating effects of substance use. To this end, AAPD supports

- collaboration between medical and dental providers to address SUD in the pediatric population.
- legislation and public policies that have demonstrated success in reducing the prevalence of SUD among adolescents.
- educational campaigns and programs that raise awareness of the dangers of substance use.
- comprehensive third-party payor coverage for addiction medicine.
- adherence to evidence-based analgesic recommendations in pediatric populations in order to minimize potential for nonmedical prescription medication use.
- additional research to determine safe and effective non-addictive treatment modalities for acute pain.

The AAPD recognizes providing dental care to patients with SUD requires awareness of clinical manifestations and may necessitate implementation of alternative treatment approaches. Therefore, the AAPD encourages oral health care professionals to

- gain knowledge of SUD and associated behavioral, physiological, and cognitive effects in adolescents.
- use a specific adolescent medical history documenting past and current substance use and previous treatments for SUD.
- recognize behaviors, clinical signs, and symptoms of adolescent substance use.
- provide brief interventions to educate the adolescent patient and family regarding the risks of substance use.
- provide brief interventions for encouragement, support, and positive reinforcement for avoiding substance use.
- provide referrals to primary care providers or behavioral health or addiction specialists for assessment and/or treatment of adolescents with suspected or confirmed SUD.
- be familiar with community resources, such as self-help groups and treatment facilities, specific to adolescents with SUD.
- be aware of drug interactions to avoid adverse responses when administering medications (eg, local anesthetics with vasoconstrictors, nitrous oxide, sedatives) to a patient having an SUD.
- consider SUD susceptibility when prescribing pain medications with potential for nonmedical use and dependency.
- respect patient confidentiality in accordance with state and federal laws.

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