Caring for adolescents and young adults with opioid use disorder

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December 9, 2019

Webinar Reminders

1. Everyone is muted.
   - Press *7 to **unmute and** *6 to re-**mute** yourself.
2. Remember to chat in questions!
3. Webinar is being recorded and will be sent out via email and posted to the program page.

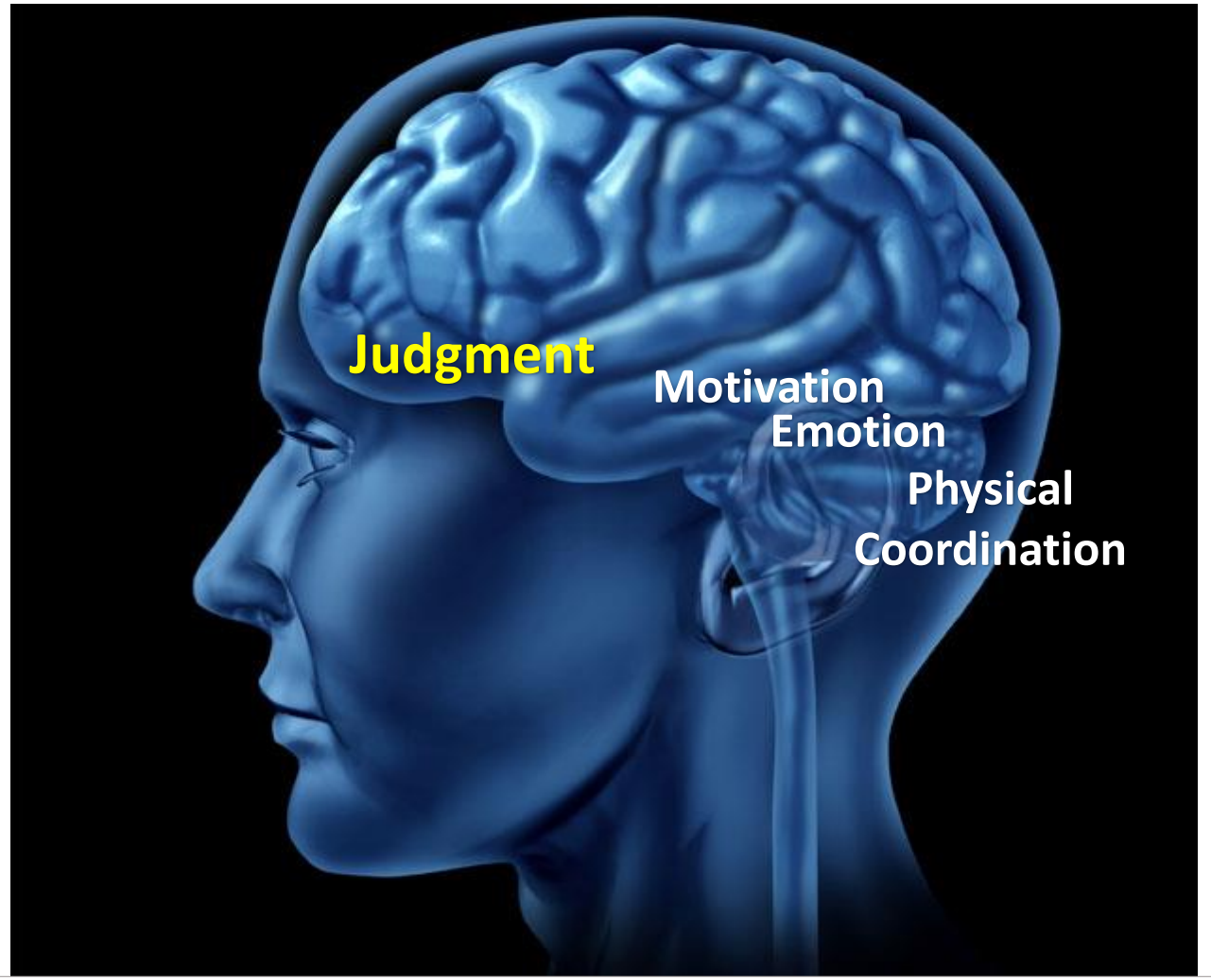
Outline

1. Review the epidemiology and risk factors for opioid use disorder

2. Discuss the efficacy and effectiveness of medication treatment in youth

3. Special considerations when caring for youth

Big Picture: Brain Develops Back to Front



Source: *S Levy. Children's Hospital Boston*

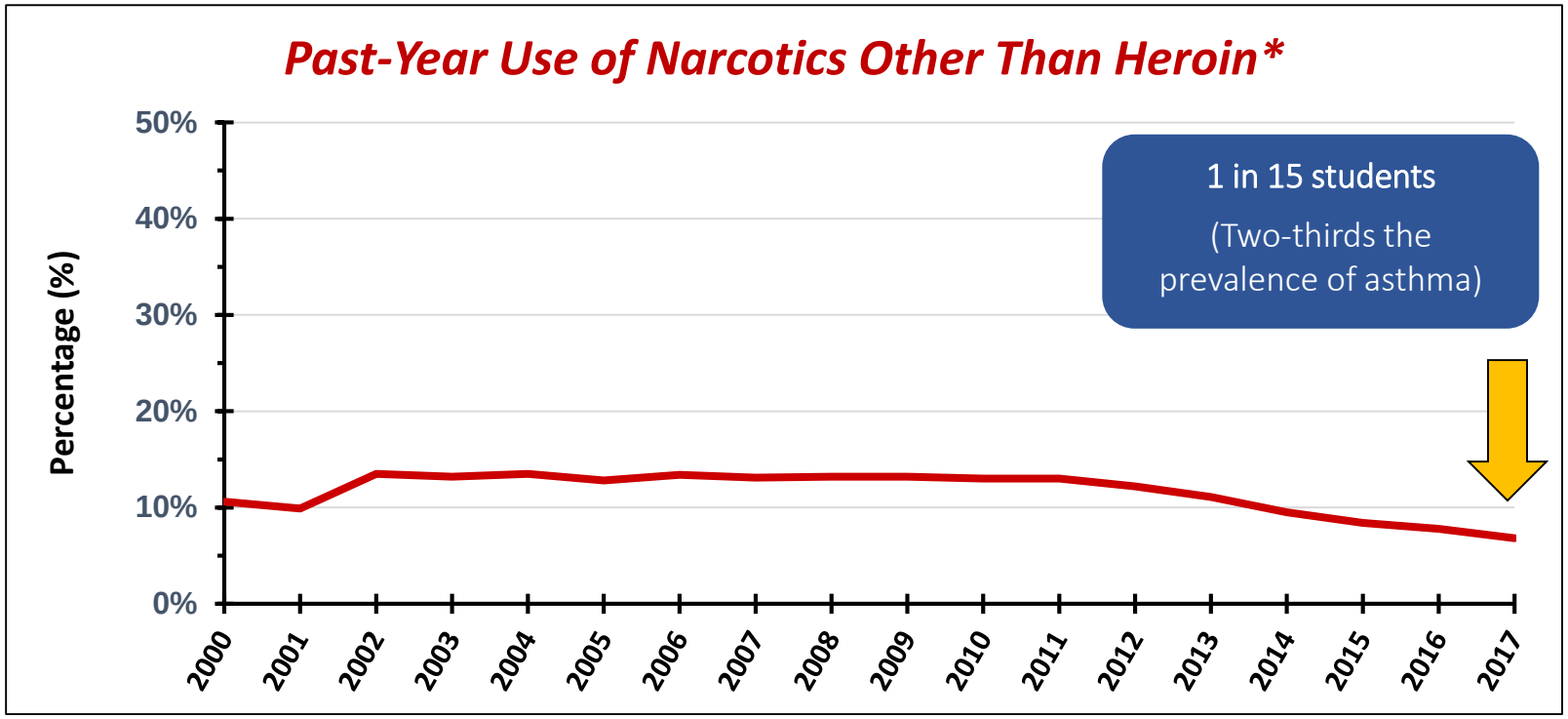
Adolescence and young adulthood is a key developmental period

- Transitional
- Decision making
- Identity exploration, search for self
- Increased autonomy

- However – this is also the time that youth take more risks, are impulsive…
- Significant opportunity to avoid effects of substance use

Why Youth Matter

2 in 3 individuals in opioid treatment report first use before **age 25**, and **1 in 3** report first use before **age 18**…

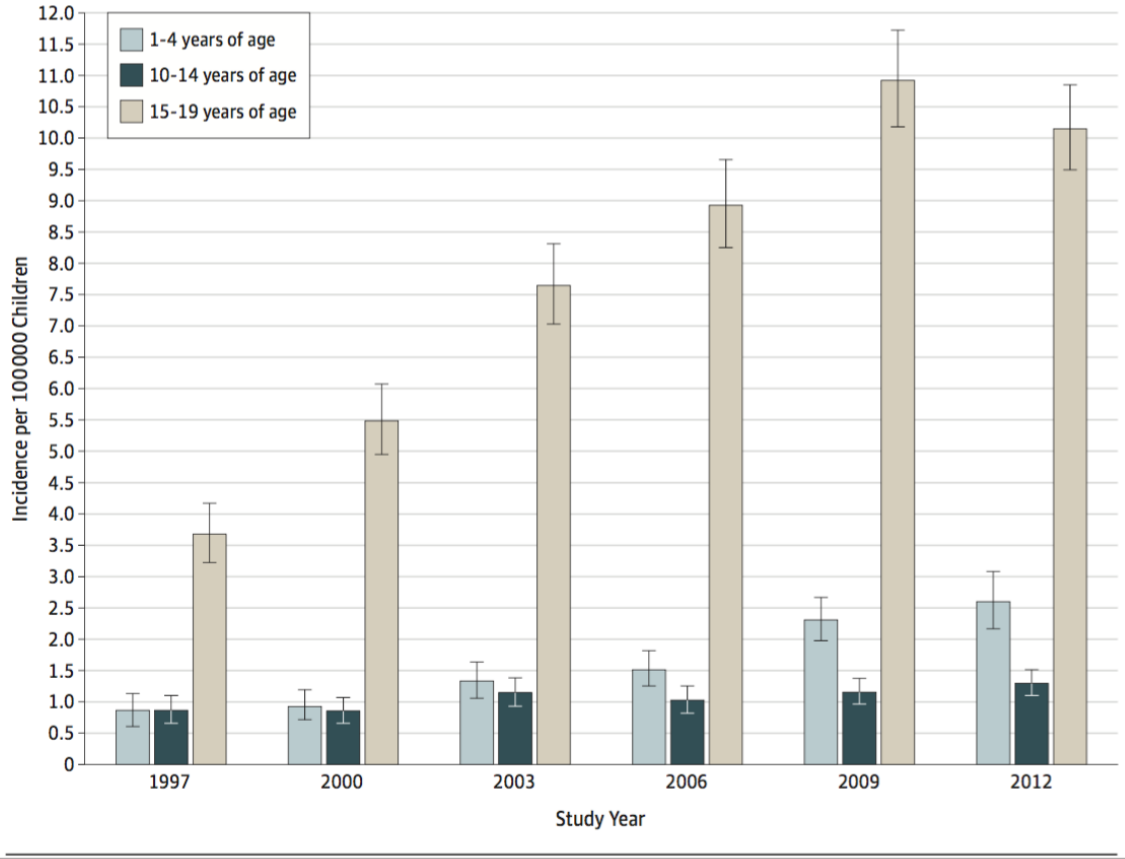


*Note: Only 0.7% of all 12th grade students reported past-year heroin use in 2017

Monitoring the Future, University of Michigan, 2018
Treatment Episode Data Set (TEDS): 2013. SAMHSA, 2015

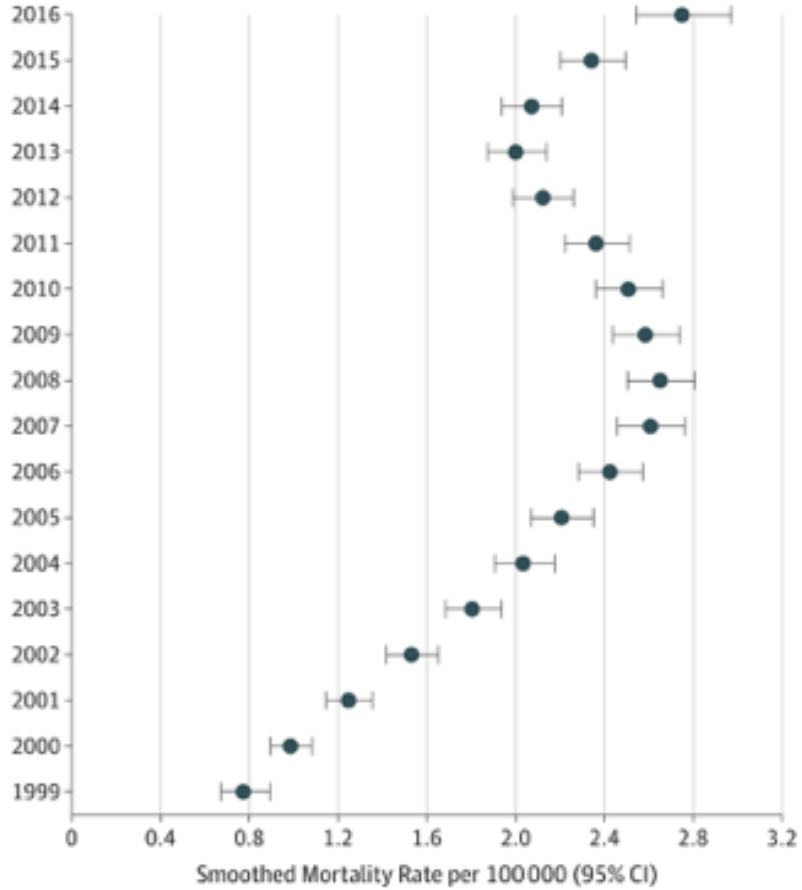
Hospitalizations for prescription opioid poisonings among youth increasing

Figure 1. Weighted National Estimates of Temporal Trends in Hospitalizations for Prescription Opioid Poisonings Stratified by Age Category



Gauthier et al. (2016) *JAMA Peds*

Opioid deaths increasing among adolescents



Between 1999 and 2016, overdose deaths rose among 15- to 19-year-olds:

95% for prescription opioids

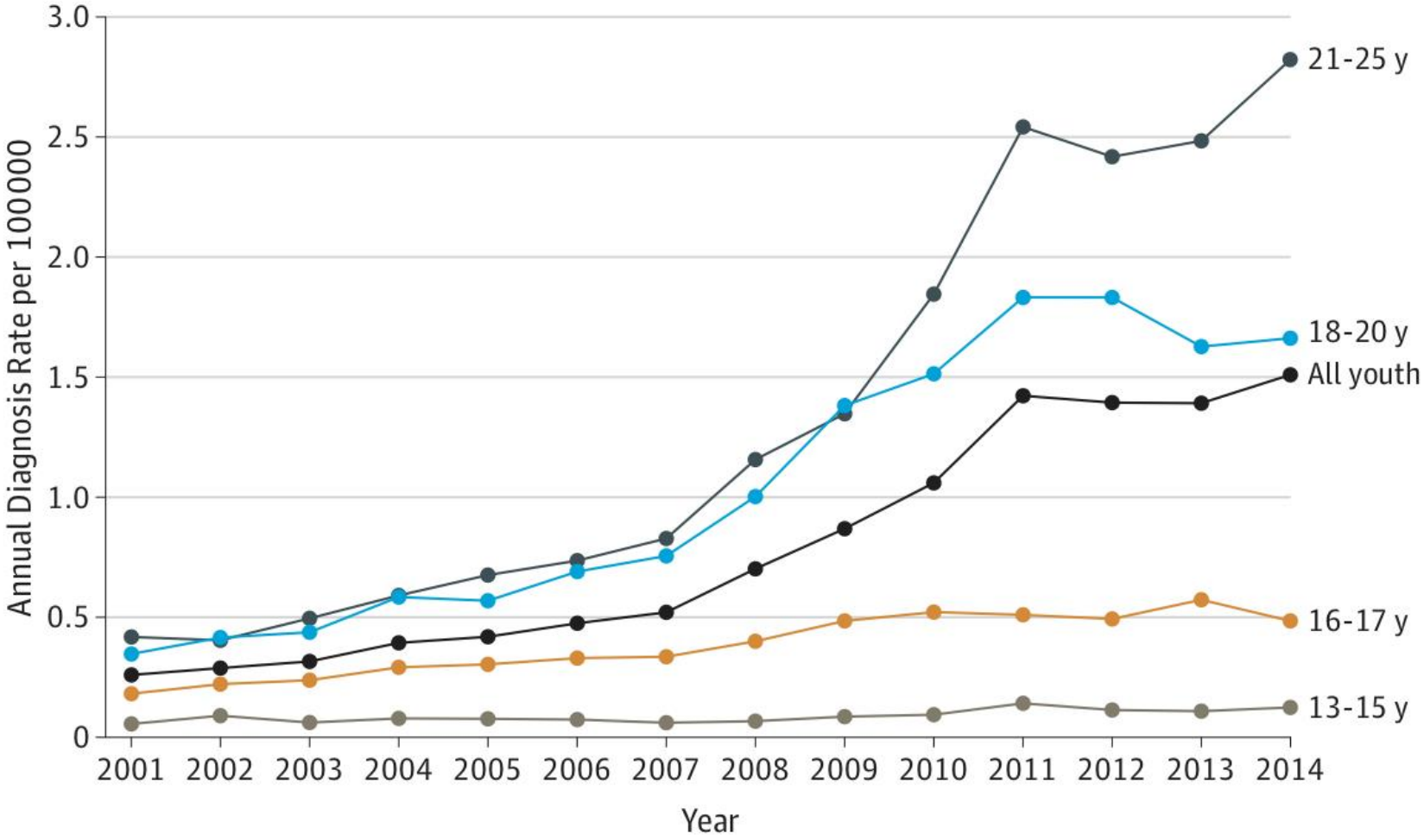
405% for heroin

2,925% for synthetic opioids (i.e., fentanyl)

US National Trends in Pediatric Deaths From Prescription and Illicit Opioids, 1999-2016

Gaither JR, et al. *JAMA Netw Open*. 2018;1(8):e186558

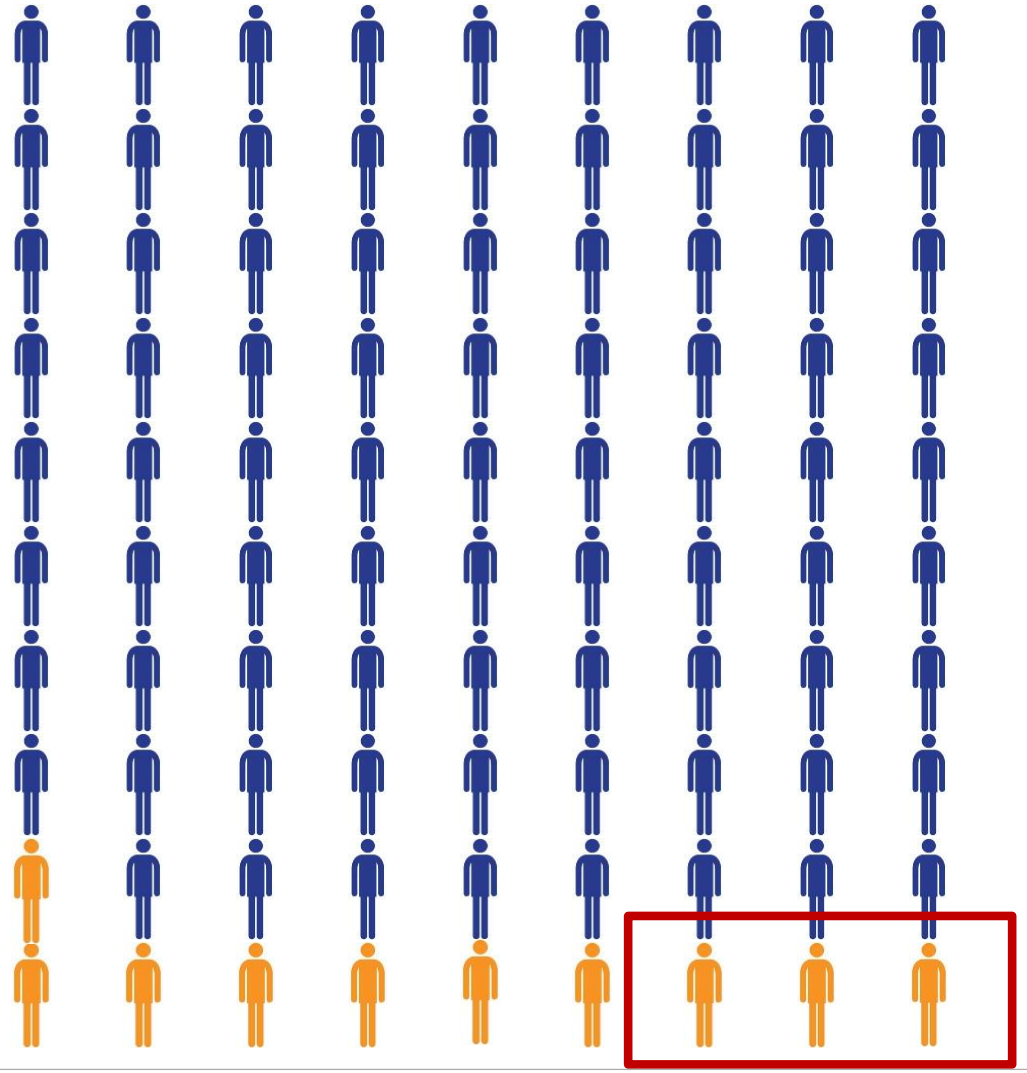
Diagnoses of OUD increasing among youth



Hadland SE, et al. (2017) *JAMA Pediatr*

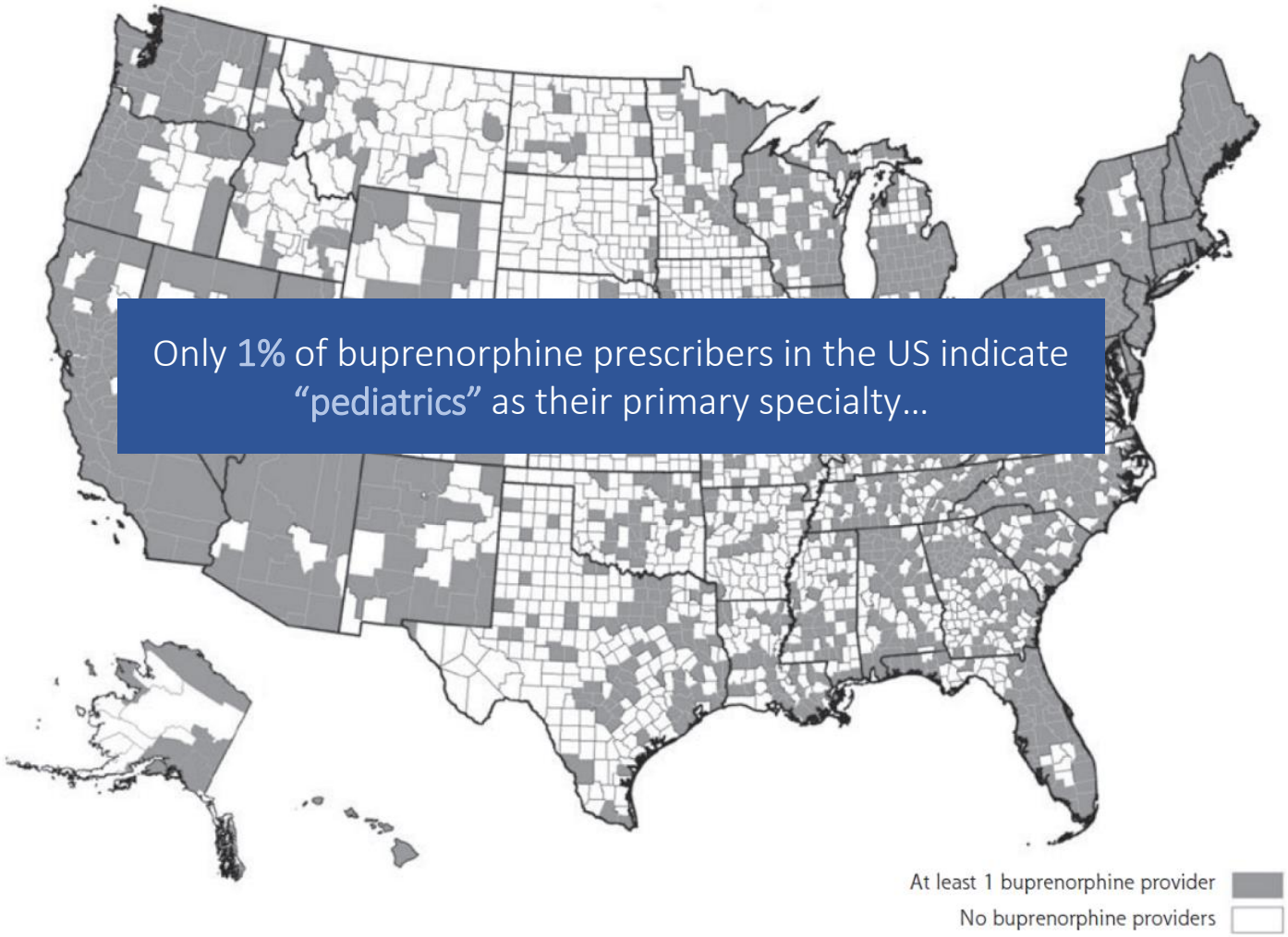
Are medications an option for youth?

What percentage of youth receives any treatment?



NSDUH, 2016

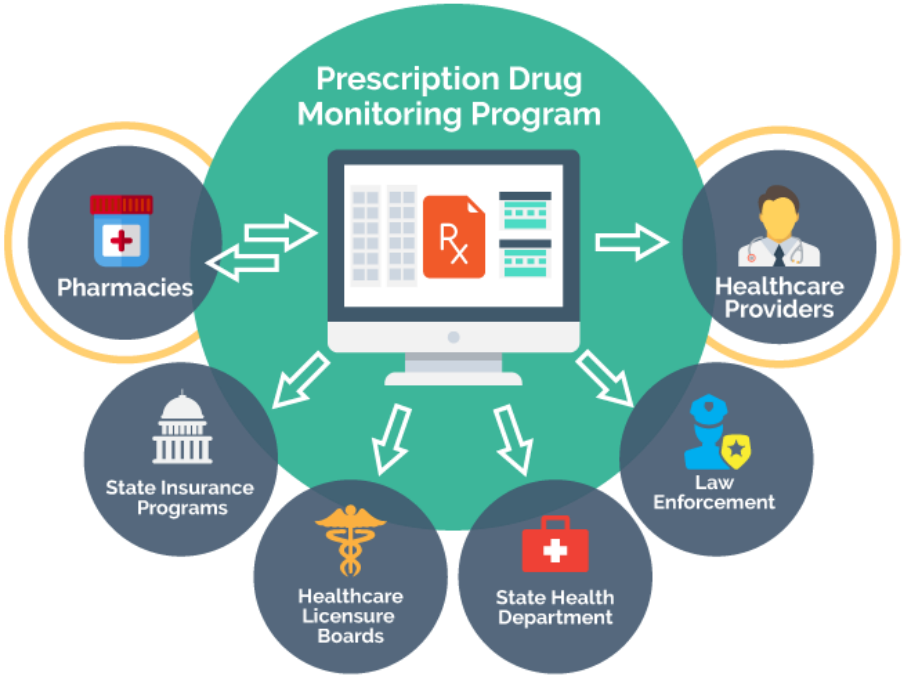
Shortage of Providers

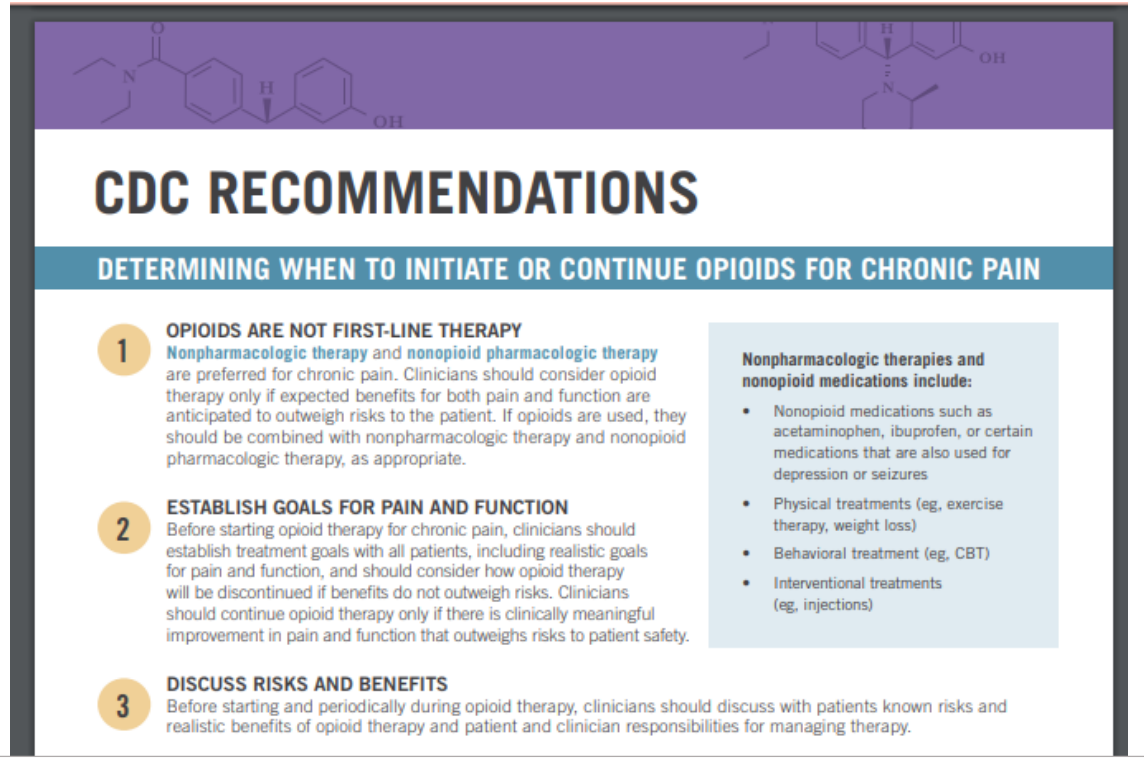


RA Rosenblatt et al. (2015) *Ann Fam Med*

Response to opioid overdose deaths

- Safer prescribing: CDC Guideline for Prescribing Opioids for Chronic Pain: https://www.cdc.gov/drugoverdose/prescribing/guideline.html
- Prescription Drug Monitoring Programs: https://www.cdc.gov/drugoverdose/pdmp/states.html





CDC RECOMMENDATIONS

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

1 OPIOIDS ARE NOT FIRST-LINE THERAPY

Nonpharmacologic therapy and **nonopioid pharmacologic therapy** are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

Nonpharmacologic therapies and nonopioid medications include:

- Nonopioid medications such as acetaminophen, ibuprofen, or certain medications that are also used for depression or seizures
- Physical treatments (eg, exercise therapy, weight loss)
- Behavioral treatment (eg, CBT)
- Interventional treatments (eg, injections)

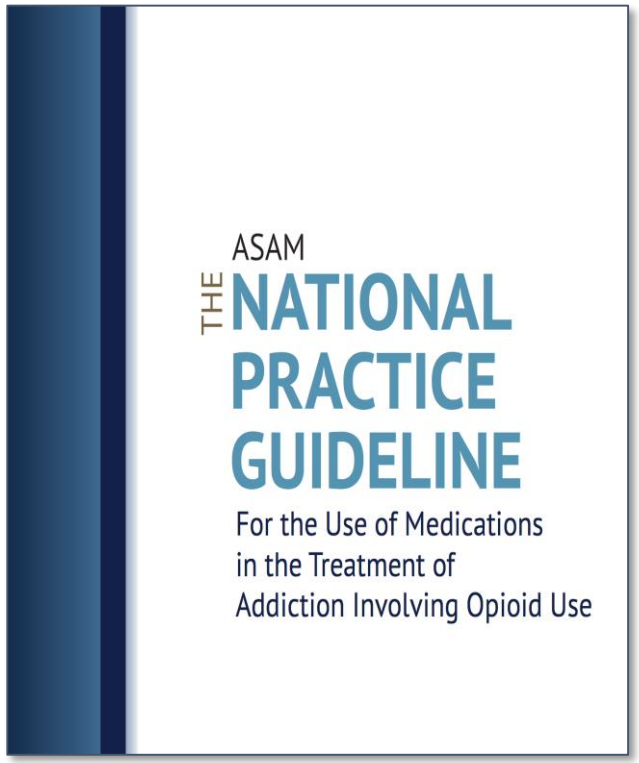
2 ESTABLISH GOALS FOR PAIN AND FUNCTION

Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

3 DISCUSS RISKS AND BENEFITS

Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

Medication for addiction treatment

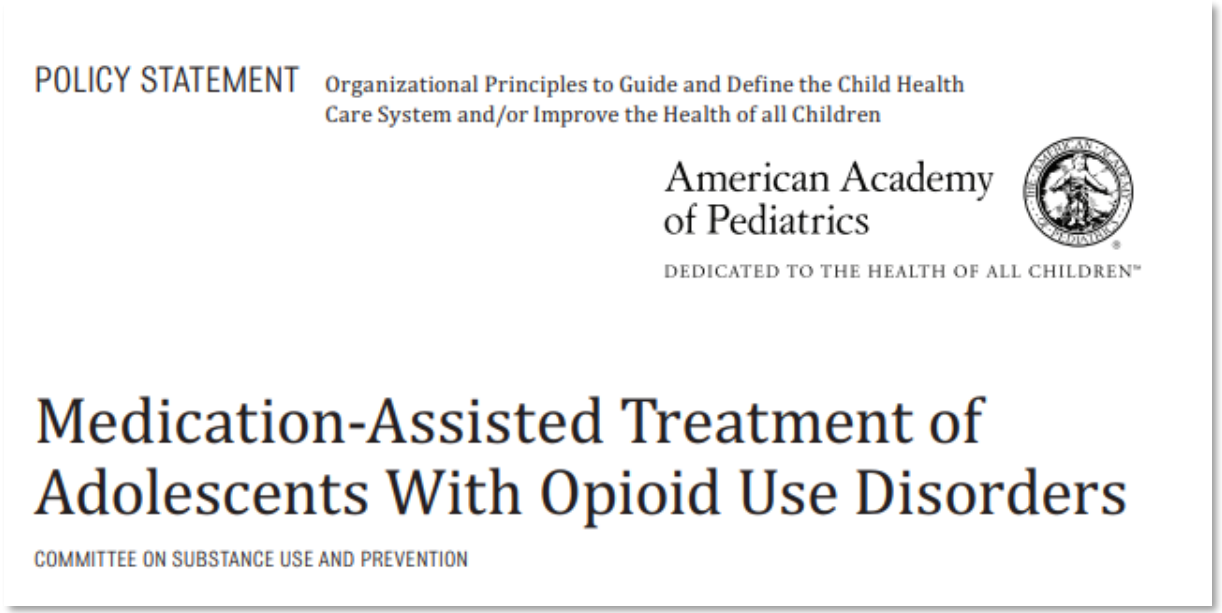


American Society of Addition Medicine (2015):

- Clinicians should consider treating adolescents using the full range of treatment options, including pharmacotherapy

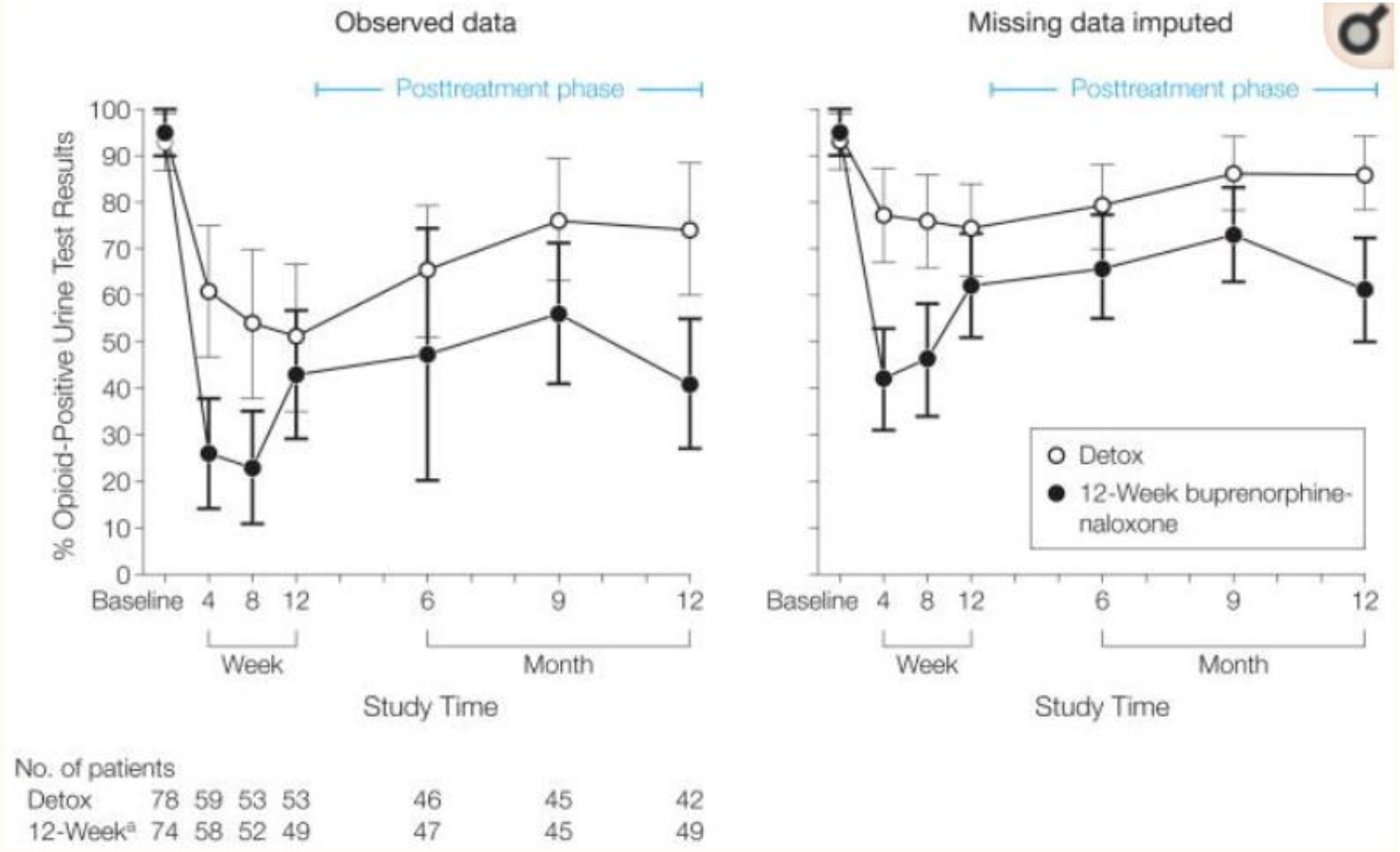
American Academy of Pediatrics (2016):

- Encouraging pediatricians to consider offering MAT or discussing referrals to other providers for this service



Committee on Substance Use and Prevention (2016) *Pediatrics*
Kampman K & Jarvis M. (2015) *Journal of Addiction Medicine*

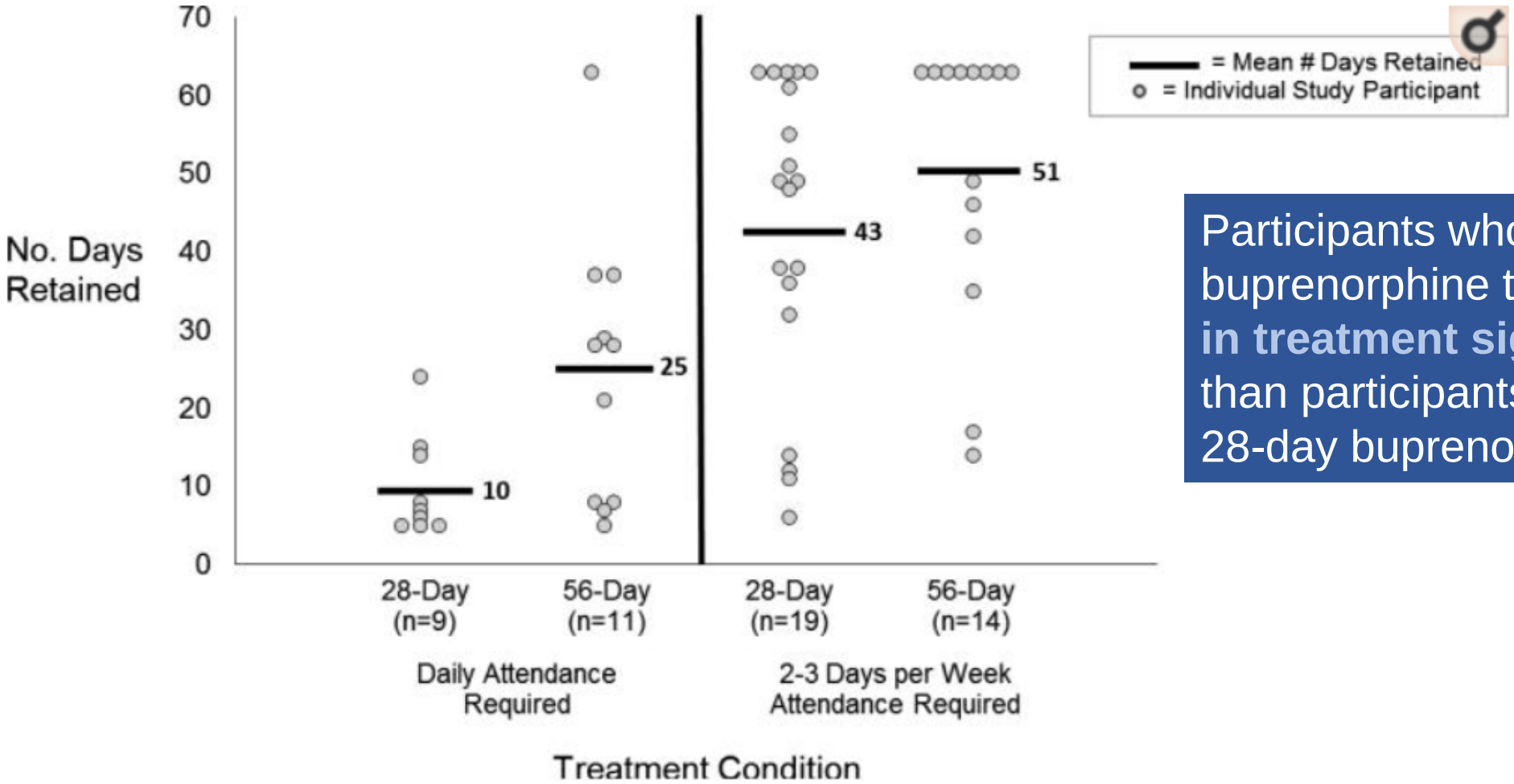
Evidence for using MAT for adolescents



- Improves treatment retention
- Contributes to lower relapse rates
- Decreases engagement in risky behaviors
- Increases abstinence

Minozzi et al. (2014) *Cochrane Database of Systematic Reviews*
Woody et al., (2008) *JAMA*

Treatment retention with buprenorphine



Participants who received a 56-day buprenorphine taper were **retained in treatment significantly longer** than participants who received a 28-day buprenorphine taper

Marsch et al. (2016) *Addiction*

Evidence for naltrexone in youth

Addiction
CASE REPORT
doi:10.1111/j.1360-0443.2010.03015.x

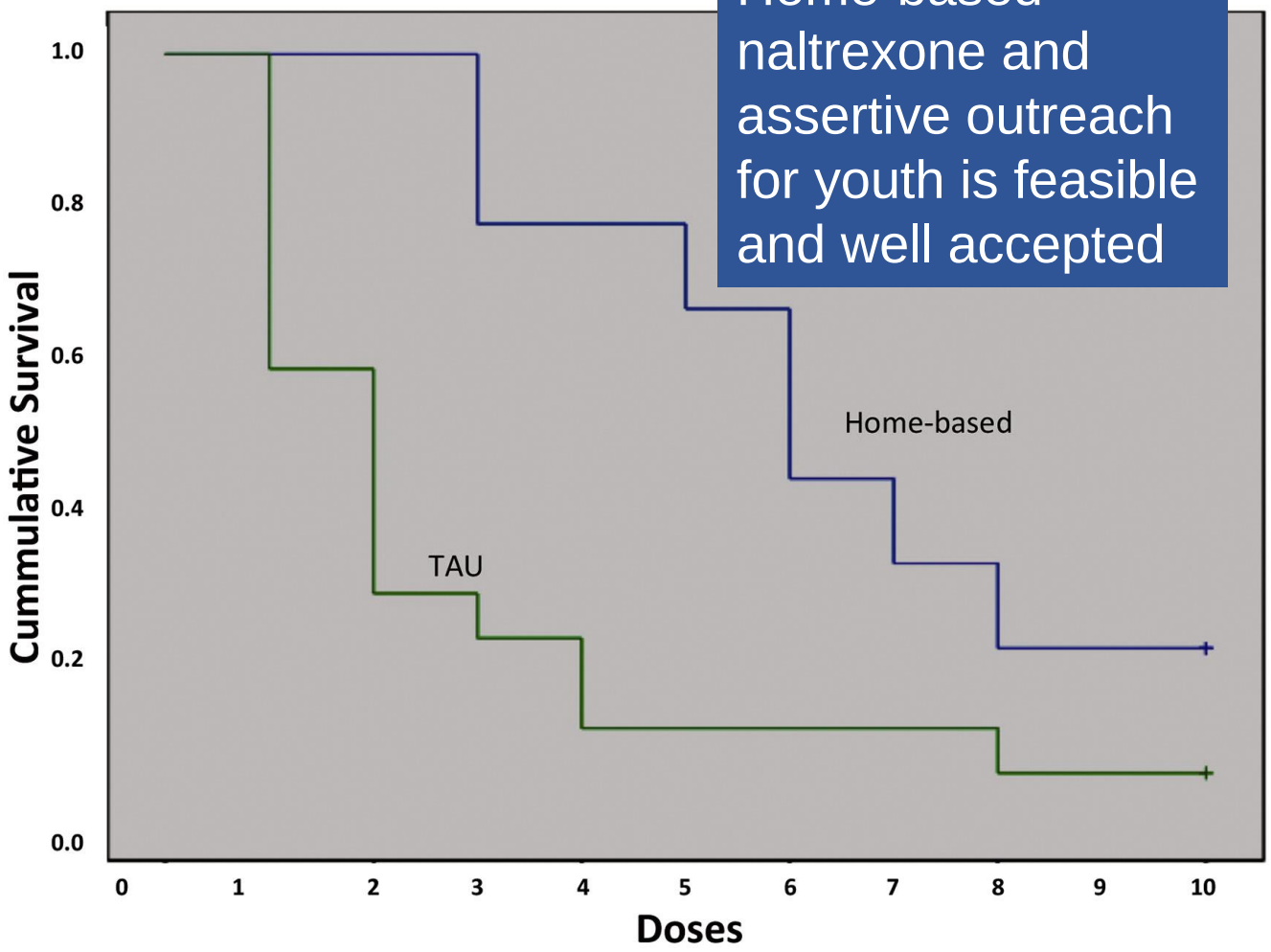
Treatment of opioid dependence in adolescents and young adults with extended release naltrexone: preliminary case-series and feasibility

Marc J. Fishman[1,2], Erin L. Winstanley[3,4], Erin Curran[1,2], Shannon Garrett[2] & Geetha Subramaniam[1,2]

Johns Hopkins University School of Medicine, Department of Psychiatry and Behavioral Sciences, MD, USA,[1] Mountain Manor Treatment Center, MD, USA,[2] University of Cincinnati College of Medicine, Department of Psychiatry, OH, USA[3] and Lindner Center of HOPE, OH, USA[4]

63% retained in treatment for at least 4 months

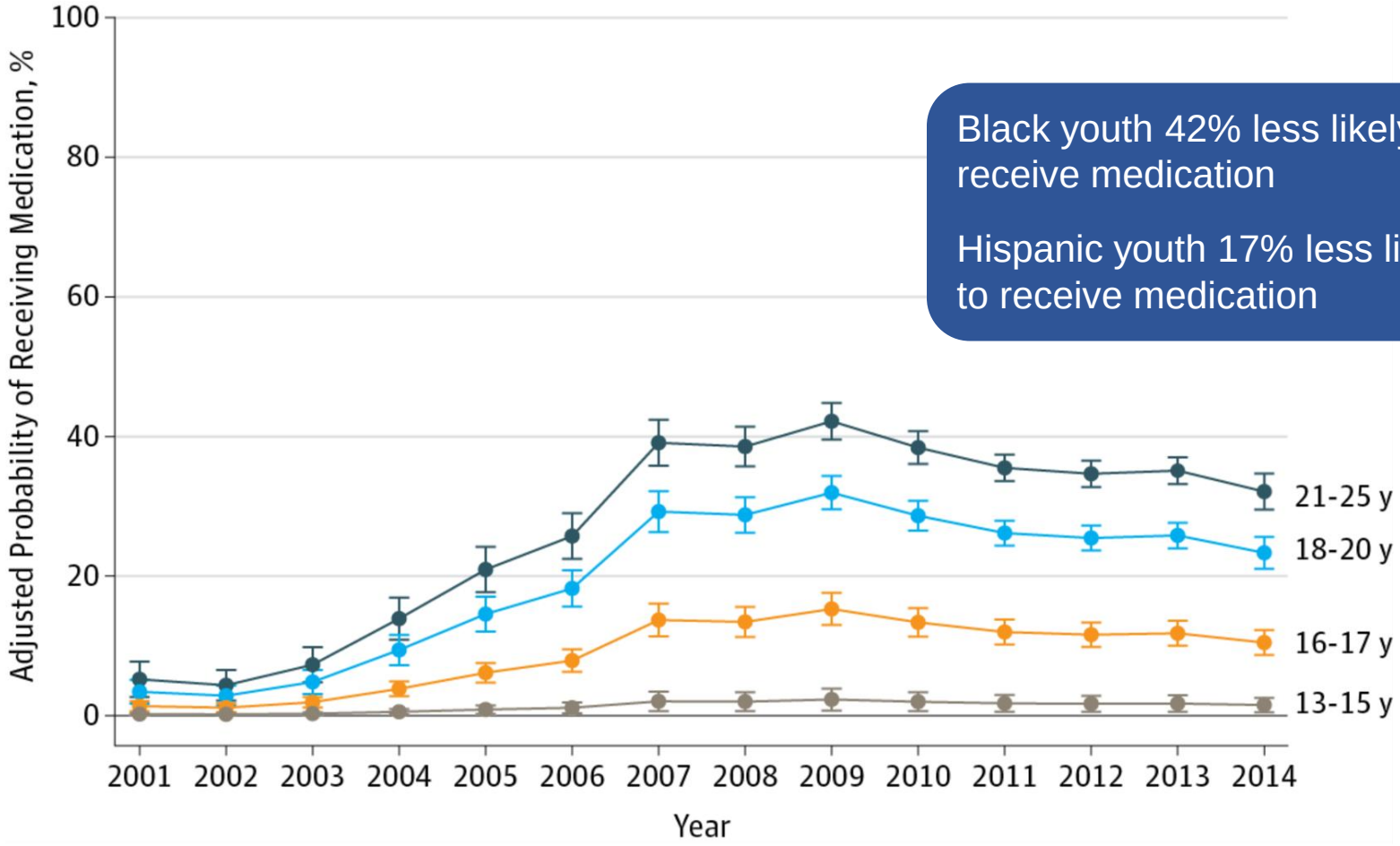
Home-based naltrexone and assertive outreach for youth is feasible and well accepted



Vo et al. (2018) *J Subst Abuse Treat*
Fishman et al. (2010) *Addiction*

Receipt of buprenorphine and naltrexone

From 2000 to 2014 **only 1 in 4** youth diagnosed with OUD received medication (buprenorphine or naltrexone) within 6 months of diagnosis



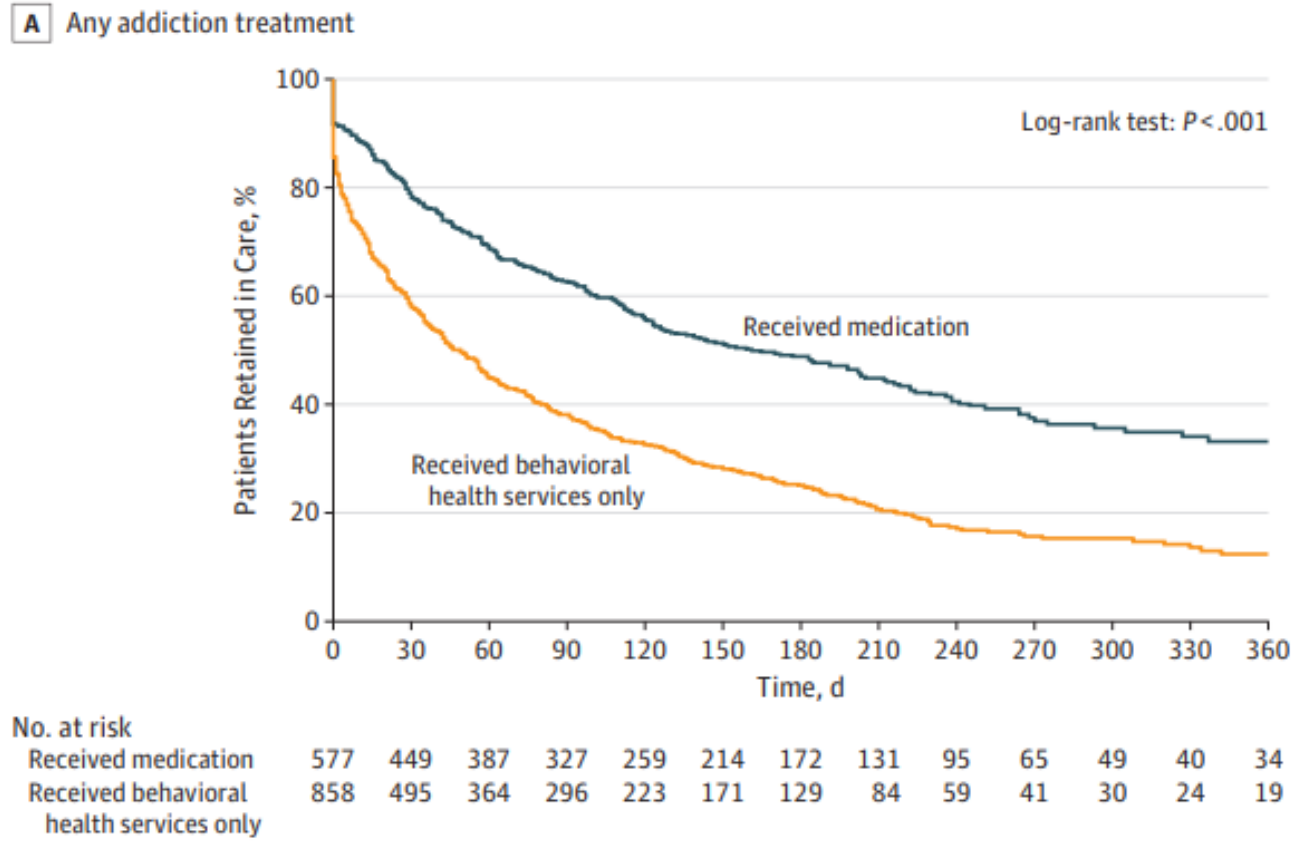
Black youth 42% less likely to receive medication

Hispanic youth 17% less likely to receive medication

Hadland SE, et al. (2017) *JAMA Pediatr*

Retention in medication treatment

Figure. Retention in Care According to Timely Receipt of Opioid Use Disorder Medication Within 3 Months of Diagnosis Among Youths

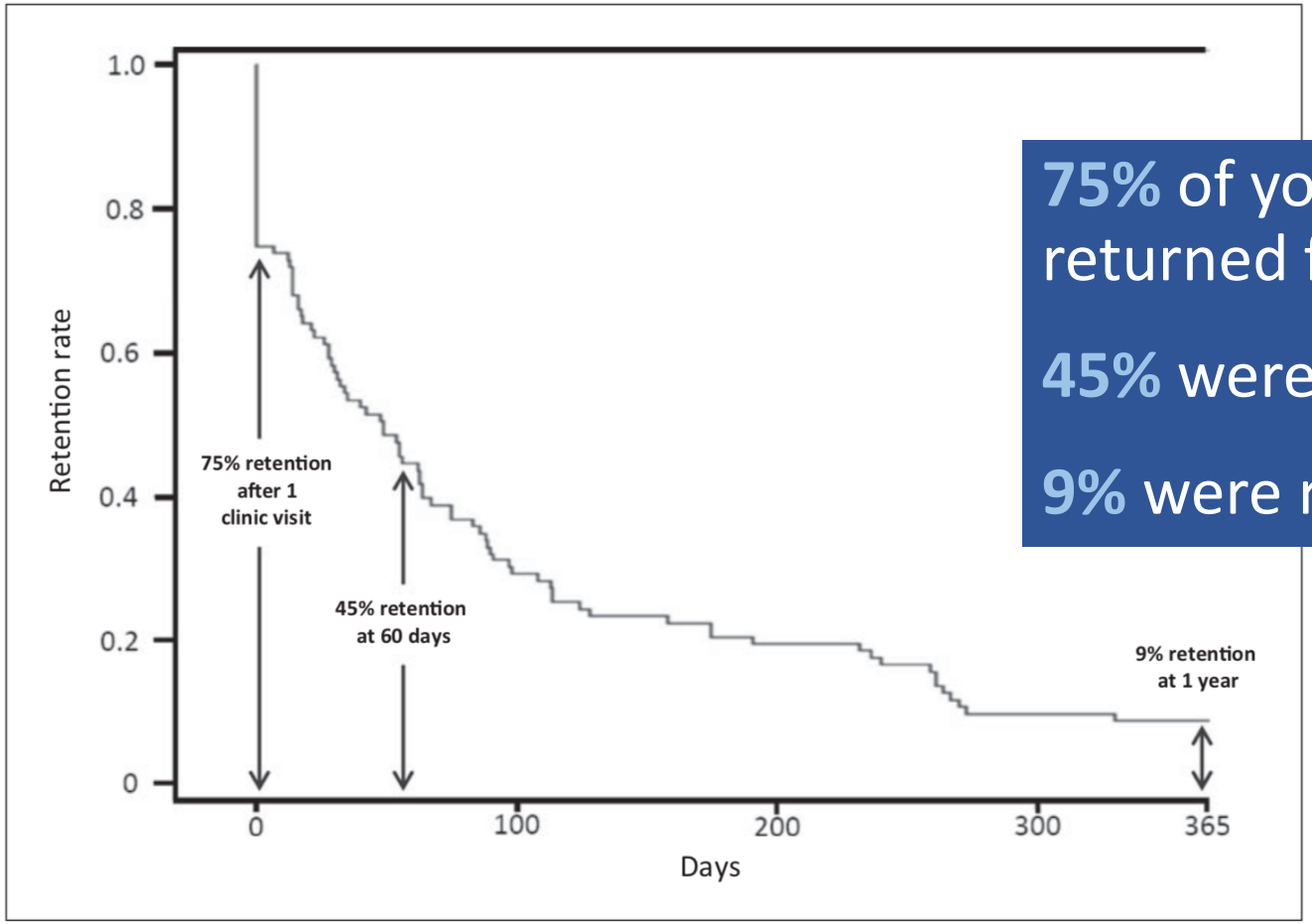


Only **4.7% of adolescents younger than 18 years** and **26.9% of young adults 18+** received timely OUD medications

Medications independently associated with **lower attrition from treatment** compared to behavioral health services alone

Hadland et al. (2018) *JAMA Pediatr*

Retention is hard



75% of youth (15-25 y/o) returned for a second visit

45% were retained at 60 days

9% were retained at 1 year

FIGURE 1. Retention rate over time of opioid-dependent adolescents and young adults receiving outpatient buprenorphine/naloxone therapy (N = 103).

Matson et al. (2014) *J Addict Med*

Retention is hard

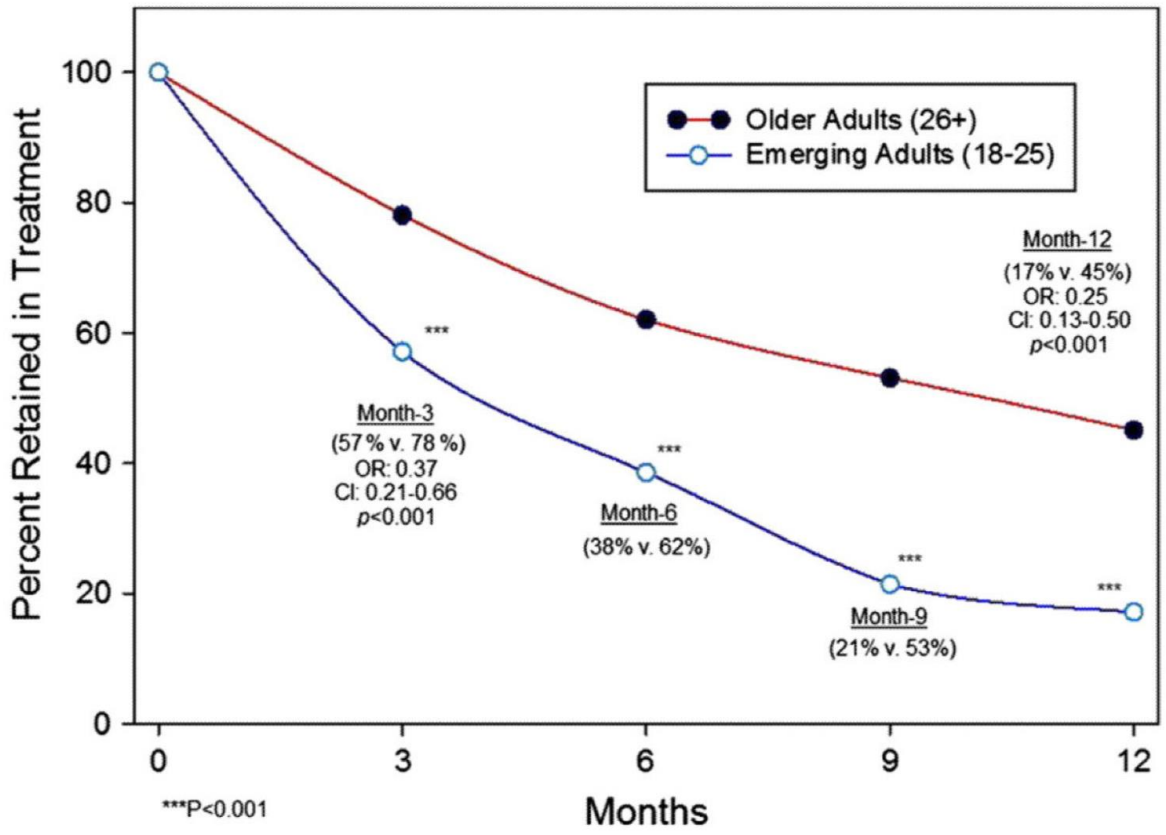


Fig. 2.
Retention over time during 12 months of collaborative care buprenorphine treatment.

Emerging adults remained in treatment at a lower rate at 3 months **(56% versus 78%)** and 12 months **(17% versus 45%)** than older adults

They were more likely to **test positive** for **illicit opioids**, **relapse**, or **drop out of treatment**

Schuman-Olivier et al. (2014) *J Subst Abuse Treat*

Deciding buprenorphine versus naltrexone

No perfect algorithm and not enough data to inform our decisions so….

- Patient (and family) choice
- Experiences with medications in the past
- Probably try buprenorphine with more severe patients

What is different about treating youth?

- Ambivalence regarding treatment
- Early in trajectory of addiction and harms
- Co-occurring mental health disorders
- Often have never received medications for addiction treatment before
- May still be learning how to navigate the health system for themselves
- Family
- Confidentiality

Implications for Care

- Flexible: hours, different kinds of substances
- Focus on short-term
- Need for integrated behavioral health
- Capacity to address needs other than related to substance use
- Family-based

Our model: CATALYST

Patients served: adolescents and young adults through age 25 who use substances

Combination of OBAT, specialty care, and integrated behavioral health

Team: social workers, nurses, recovery coaches, primary care providers, psychiatrist, recovery support navigator, and program manager

Offer medical management, therapy, recovery support, case management, primary care, HCV treatment and whatever else they need

What we have learned

- Texting helps
- Transportation a real barrier, we use Uber Health
- Challenges in addressing substance use other than opioids and alcohol
- Engagement of the family is hard…we are working on addressing that next

THANK YOU

Questions?

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Your feedback is needed!

- Please complete our 2-question poll in the chat box
- If you have any additional comments or suggestions, please fill out our post-session evaluation: https://www.tfaforms.com/4775736
- We value your feedback and will use it to help design future ATSH webinars.

Upcoming ATSH Webinars

- **MAT for Everybody: The Fundamentals of Providing Compassionate Care in the Primary Care Setting** Katie Bell, RN, ATSH Coach and Consultant, will lead this webinar on December 11, 2019, 12 - 1pm. The webinar is geared toward those who want to learn more about opioid use disorder, using medications for addiction treatment, etc. **Note:** Any staff member from your clinic can register, they do not need to be part of your MAT core team. Register here