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Psychiatry and Addictions Case Conference
UW Medicine | Psychiatry and Behavioral Sciences

TREATMENT OF OPIOID USE DISORDERS IN YOUTH

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Integrated Care Training Program
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project ECHO

GENERAL DISCLOSURES

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GENERAL DISCLOSURES

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SPEAKER DISCLOSURES

- Alkermes (maker of XR-NTX) – consultant, research grant
- US World Meds – (maker of lofexidine) – consultant
- The Drug Delivery Company (maker of investigational NTX implant) – consultant
- ASAM – consultant

PLANNER DISCLOSURES

The following series planners have no relevant conflicts of interest to disclose:

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TREATMENT OF YOUTH OUD OUTLINE

- Scope of the problem
- Prevention
- Overview of the research evidence so far
- Treatment:
  - Survey of current evidence
  - Emerging models of care
- New directions: Engaging families and home delivery
- Conclusions

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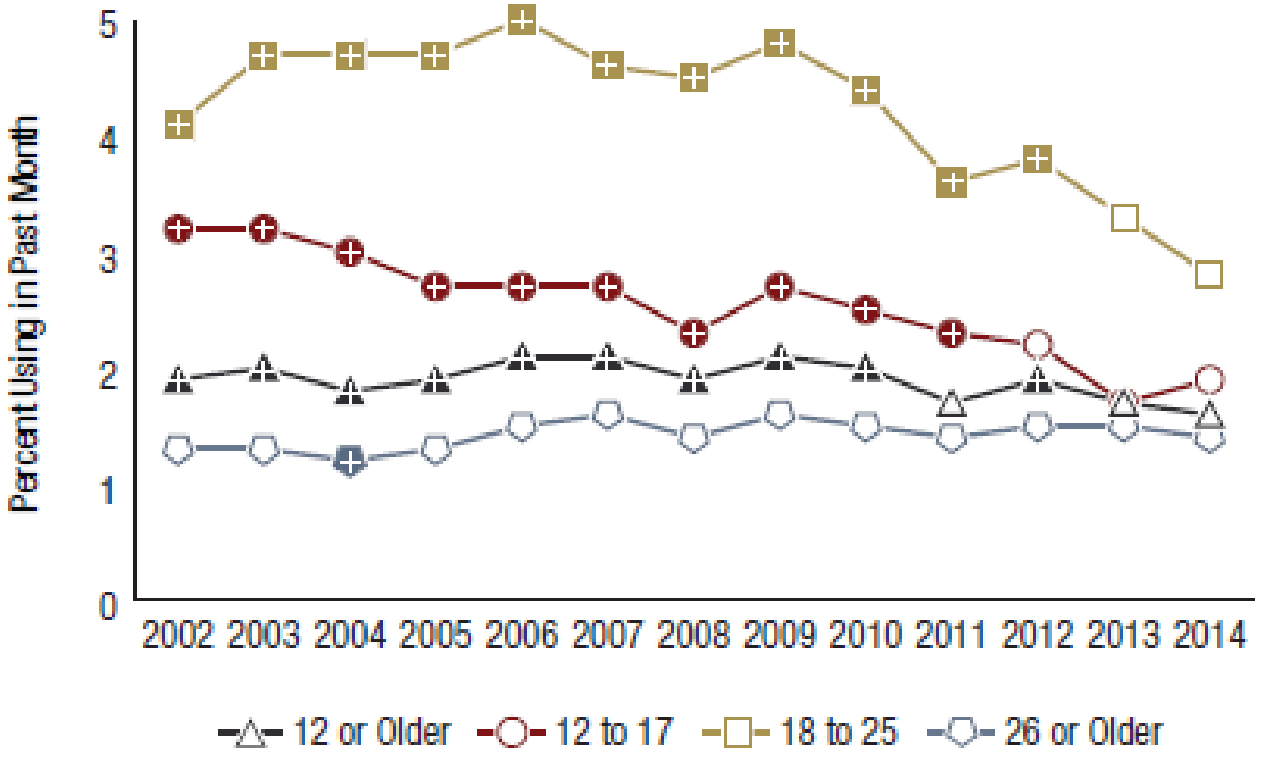
SCOPE OF THE PROBLEM

YOUNG ADULTS HIGHEST PREVALENCE NON-MEDICAL PRESCRIPTION OPIOIDS

Figure 6. Past Month Nonmedical Use of Pain Relievers among People Aged 12 or Older, by Age Group: Percentages, 2002-2014



+ Difference between this estimate and the 2014 estimate is statistically significant at the .05 level.

NSDUH, 2014

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HISTORICAL MISADVENTURES
WE'VE BEEN HERE BEFORE

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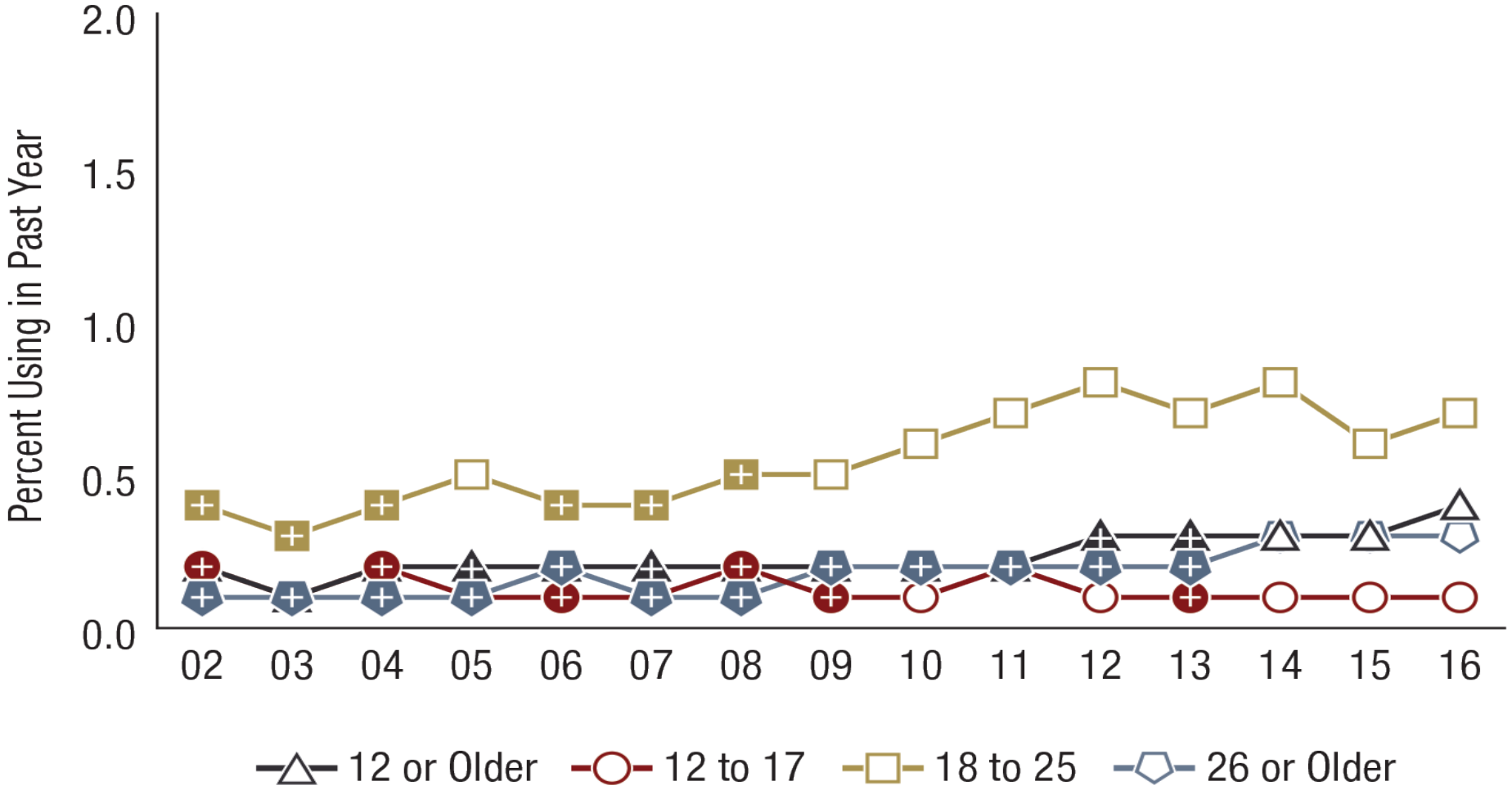
YOUNG ADULTS HIGHEST PREVALENCE HEROIN



+ Difference between this estimate and the 2016 estimate is statistically significant at the .05 level.

NSDUH, 2016

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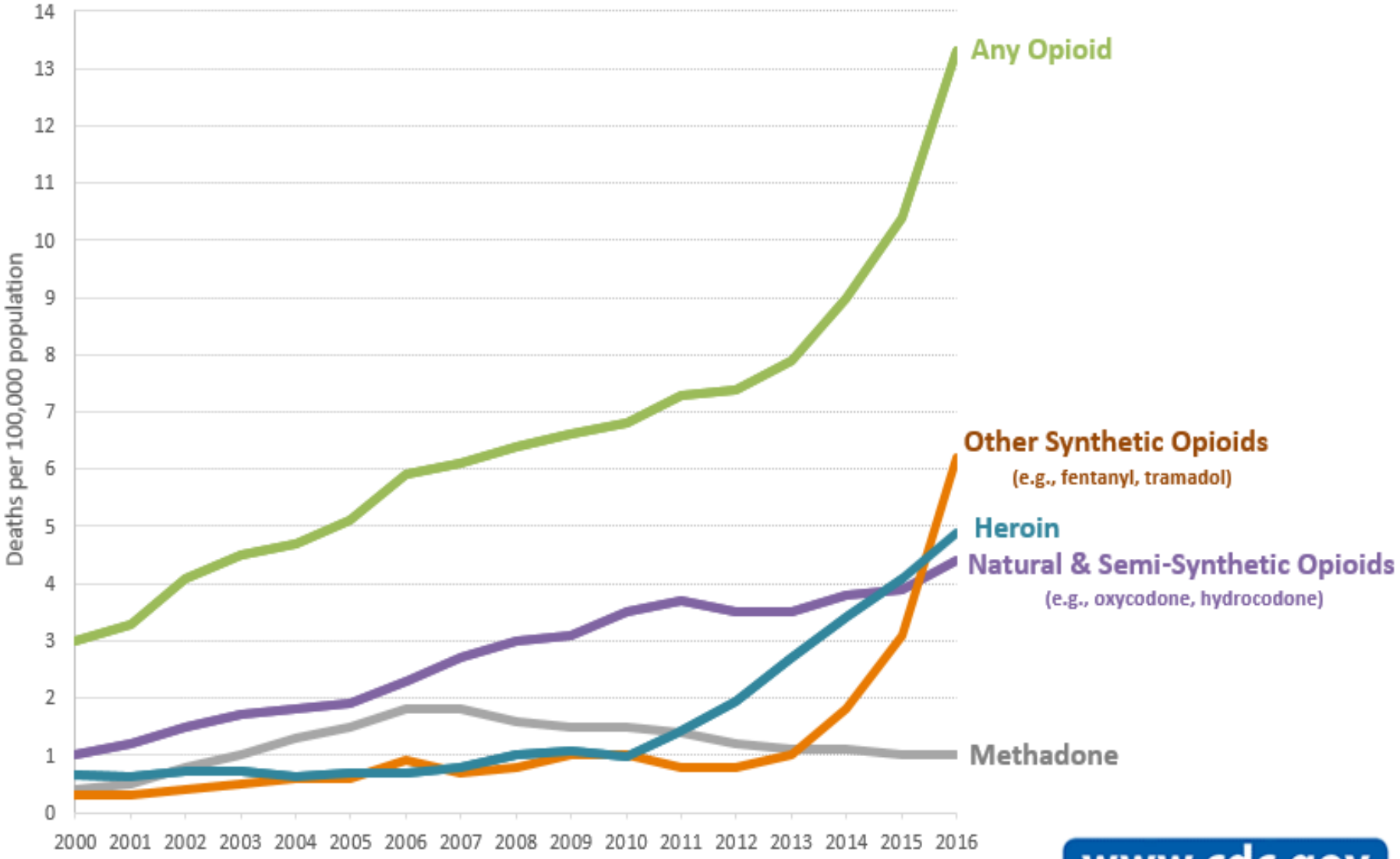
Overdose Deaths Involving Opioids, by Type of Opioid, United States, 2000-2016



SOURCE: CDC/NCHS, National Vital Statistics System, Mortality. CDC WONDER, Atlanta, GA: US Department of Health and Human Ser vices, CDC; 2017. https://wonder.cdc.gov/.

www.cdc.gov
Your Source for Credible Health Information

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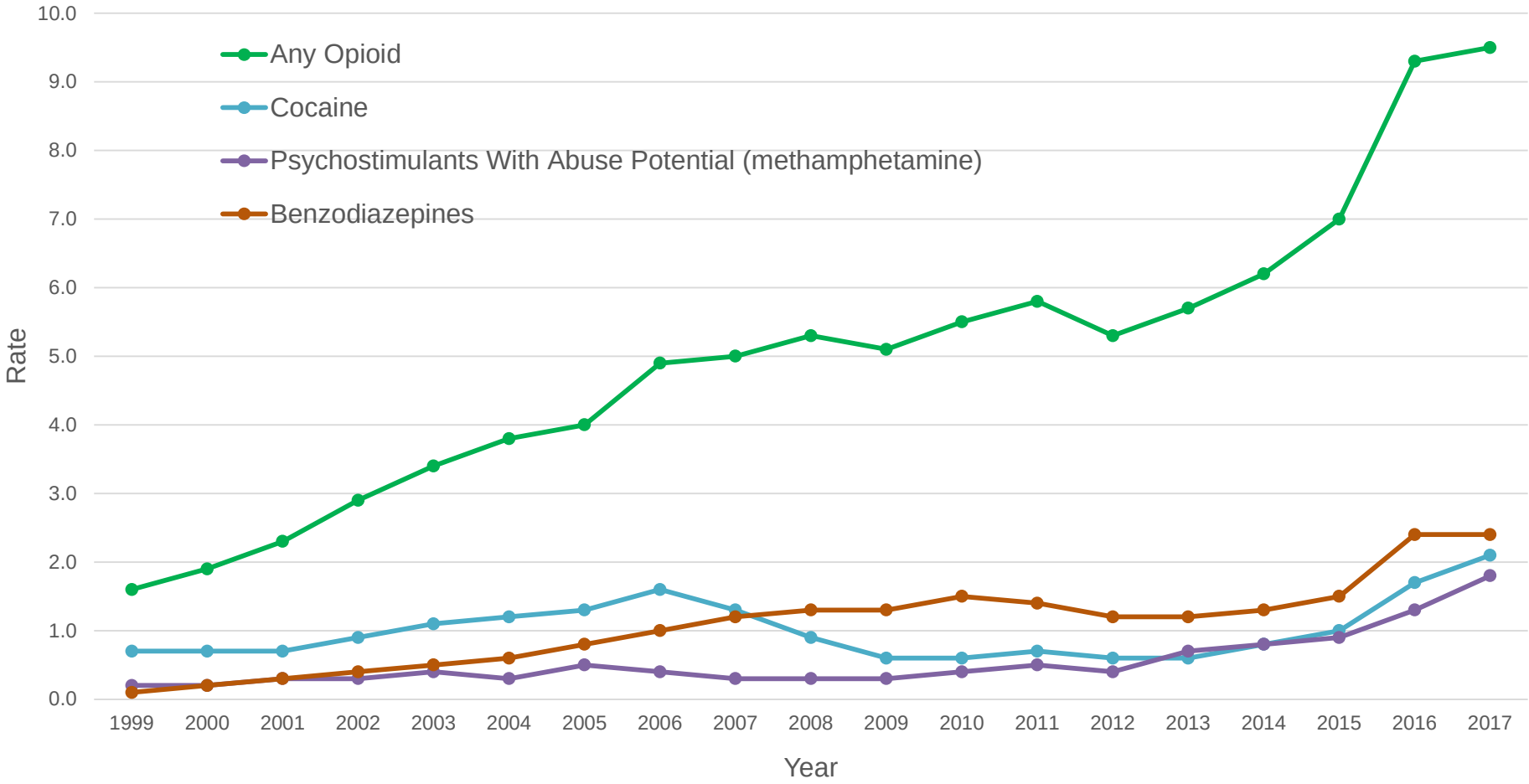
OVERDOSE DEATHS – TYPE OF DRUG

Adolescents and Young Adults (15-24 year olds)



Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2017 on CDC WONDER Online Database, released December, 2018

PREVENTION

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PATHS TO YOUTH OUD

- The vast majority of youth who initiate opioids have problems with other substances first
- Most youth who are prescribed medical opioid analgesics do not use non-medically
- While some youth have been prescribed medical opioids before non-medical use, the majority initiate with non-medical

INTERVENTION FOR YOUTH SUBSTANCE USE IS **PREVENTION** FOR YOUTH OUD

- Addiction – a developmental disorder of pediatric onset
- Earlier onset associated with worse outcomes
- Earlier intervention more effective
- Opioid addiction as an advanced stage along a continuum of illness

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TREATMENT

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WHAT SHOULD WE DO WITH THIS CASE?

- 18 M
- Onset cannabis age 13
- Onset prescription opioids 15, progressing to daily use with withdrawal within 8 months
- Onset nasal heroin 16, injection heroin 6 months later
- 3 episodes residential tx, 2 AMA, 1 completed, but no continuing care
- Buprenorphine treatment (monthly supply Rx x 4), took erratically, sold half
- Presents in crisis seeking detox (“Can I be out of here by Friday?”)

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FEATURES OF YOUTH OPIOID TREATMENT

- Developmental barriers to treatment engagement
  - Invincibility
  - Immaturity
  - Motivation and treatment appeal
  - Less salience of consequences
  - Strong salience of burdens of treatment
- Variable effectiveness of family leverage
- Pushback against sense of parental dependence and restriction
- Prominence of co-morbidity

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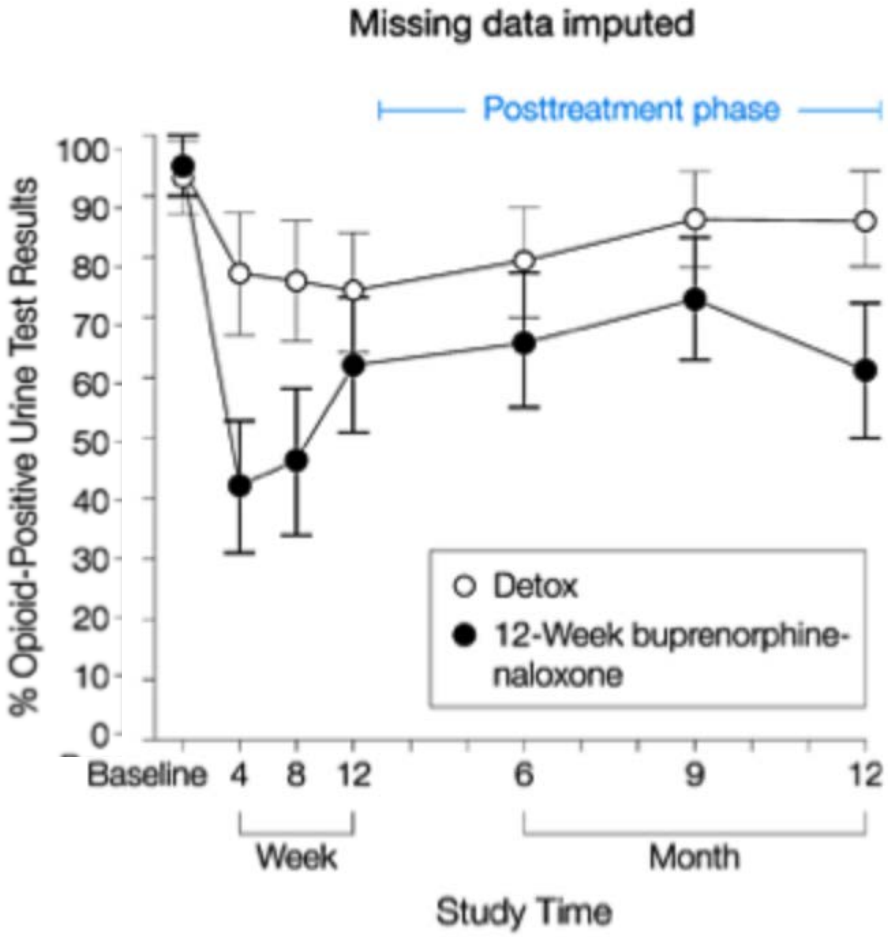
CTN YOUTH BUPRENORPHINE STUDY
OPIOID POSITIVE URINES: 12 WEEKS BUP VS DETOX



Woody et al JAMA. 2008.

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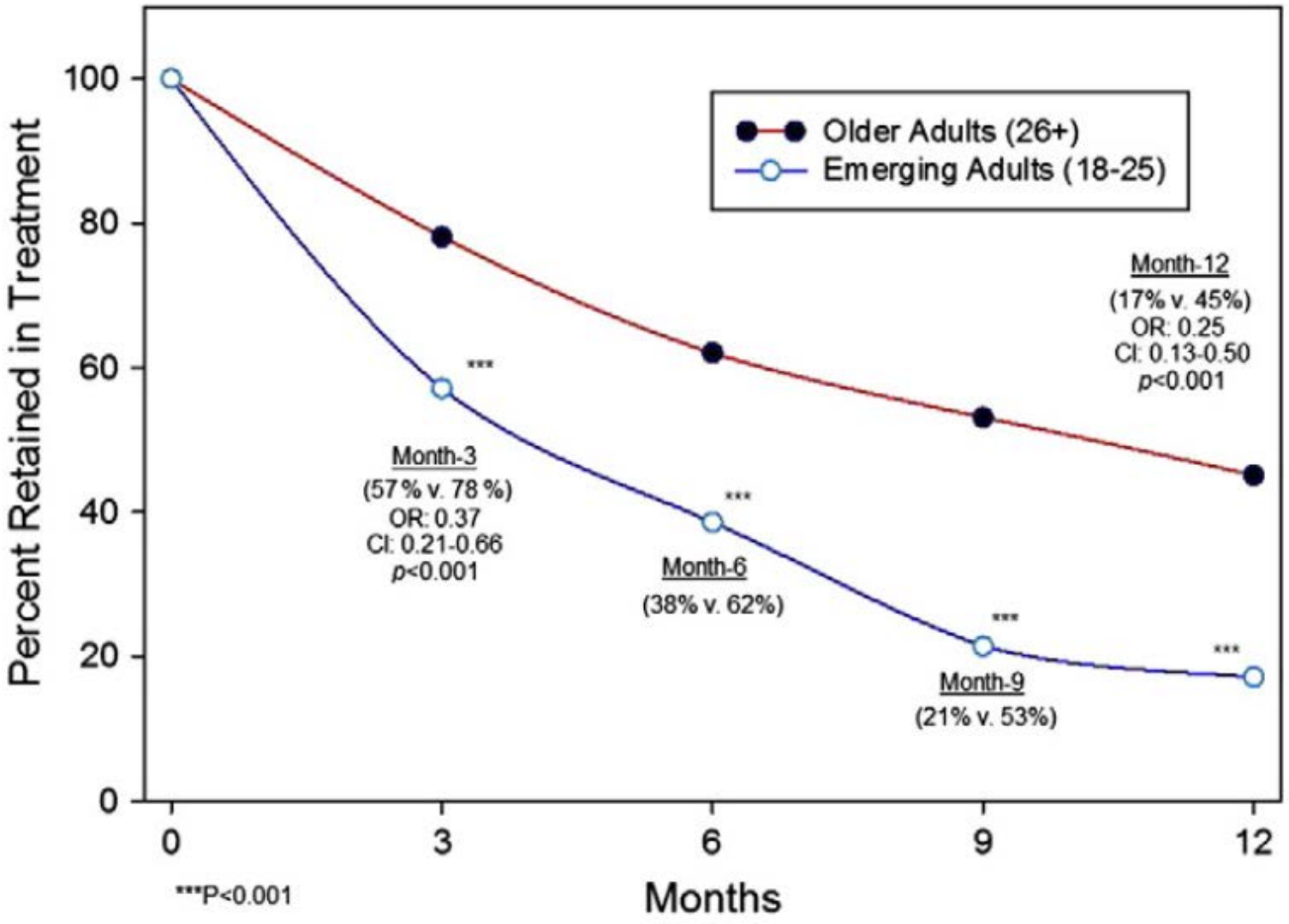
Retention bup treatment young adults vs older adults



Z. Schuman-Olivier et al. / Journal of Substance Abuse Treatment 47 (2014) 202–212

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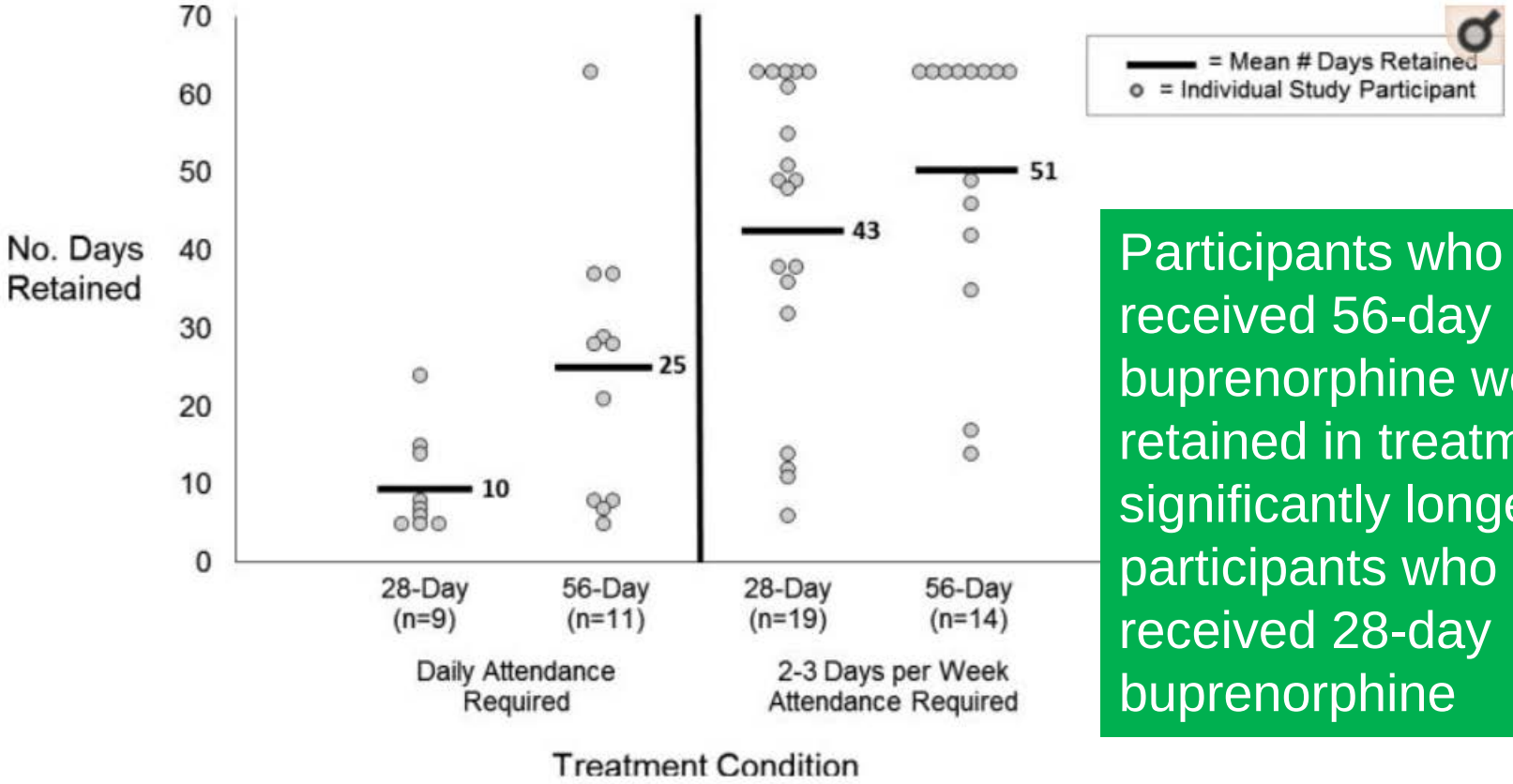
DURATION OF TREATMENT IMPACT OF TREATMENT DELIVERY



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

Marsch et al. (2016): Addiction: 111(8):1406-1415

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

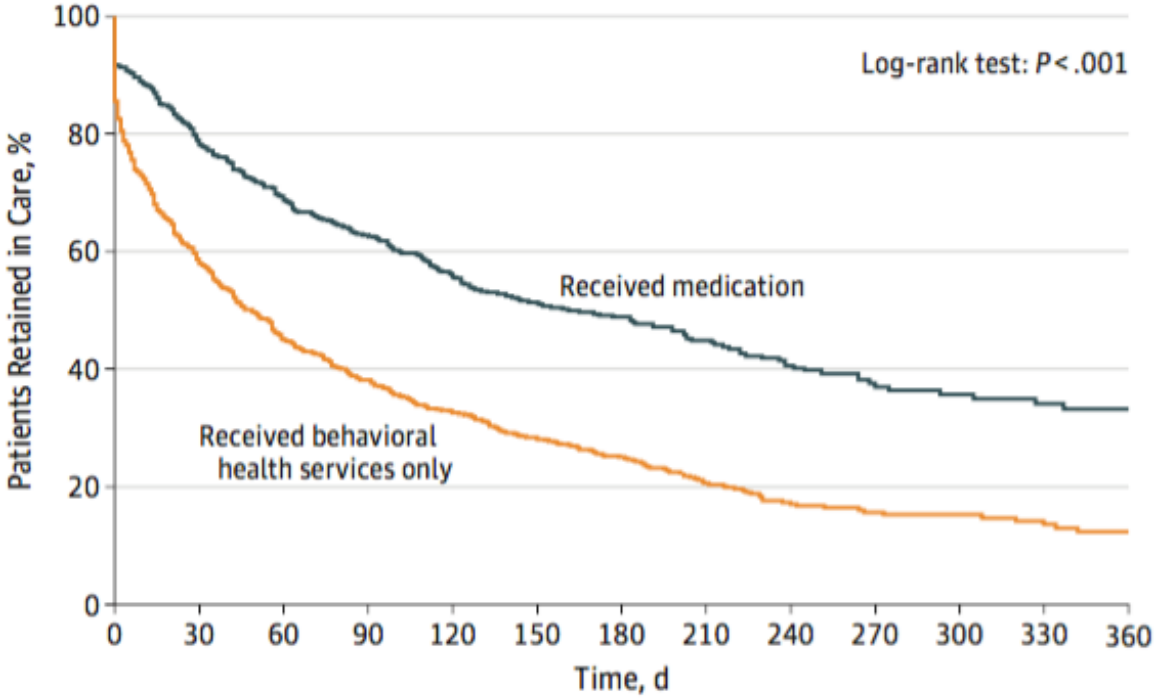
Marc J. Fishman[1,2], Erin L. Winstanley[3,4], Erin Curran[1,2], Shannon Garrett[2] & Geetha Subramaniam[1,2]

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]

- 20 youth received xr-ntx
- 16 initiated OP treatment
- 10 retained at 4 months
- 9 “good outcome”

MEDICATIONS PROMOTE RETENTION FOR YOUTH

- Medicaid claims datasets, 11 states, ages 13-22
- N = 4837 youths dx OUD (out of 2.4M, 0.2%)
- 76% received *any* treatment within 3 months of dx
- 52% received psychosocial services only
- 26% received any medication (5% for age <18 yrs).



Hadland et al. JAMA Pediatrics 2018

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MOUD FOR ADOLESCENTS AND YOUNG ADULTS SUMMARY OF THE EVIDENCE

- Buprenorphine effective, though outcomes not as good as for older adults
- Longer is better; no evidence for time limitation
- XR-NTX promising, but little youth-specific research
- No signal for safety problems based on age
- MOUD first line; No evidence for fail-first

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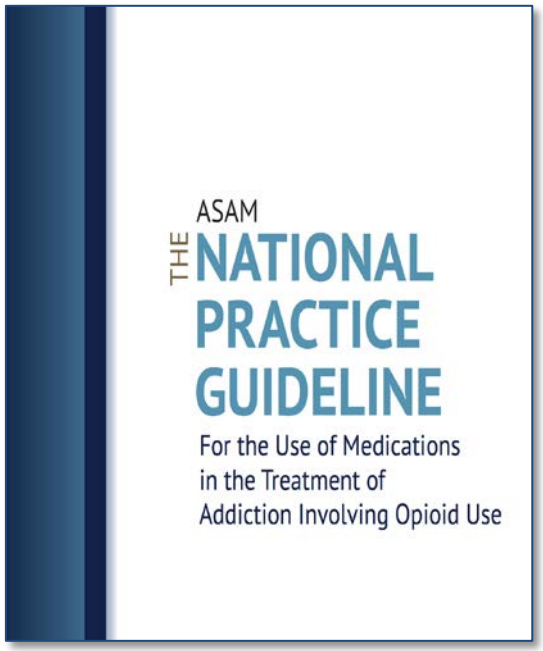
TREATMENT GUIDELINES FOR YOUTH

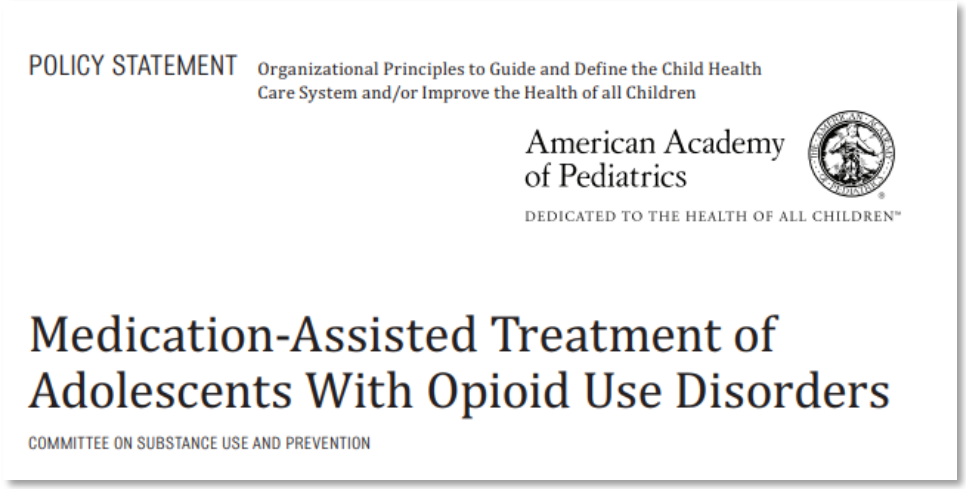


American Society of Addition Medicine (2015):

- 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


POLICY STATEMENT

Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Medication-Assisted Treatment of Adolescents With Opioid Use Disorders

COMMITTEE ON SUBSTANCE USE AND PREVENTION

Committee on Substance Use and Prevention Medication-assisted treatment of adolescents with opioid use disorders. *Pediatrics,* 2016;138(3):1893.
Kampman K & Jarvis M. *Journal of Addiction Medicine*, 2015;9(5):358-367.

IF ONLY IT WERE THAT EASY

"We found this in your brain."

LOW RECEIPT OF MOUD AFTER NON-FATAL OVERDOSE

1 in 3 young adults received medication for opioid use disorder in the 12 months after surviving an overdose

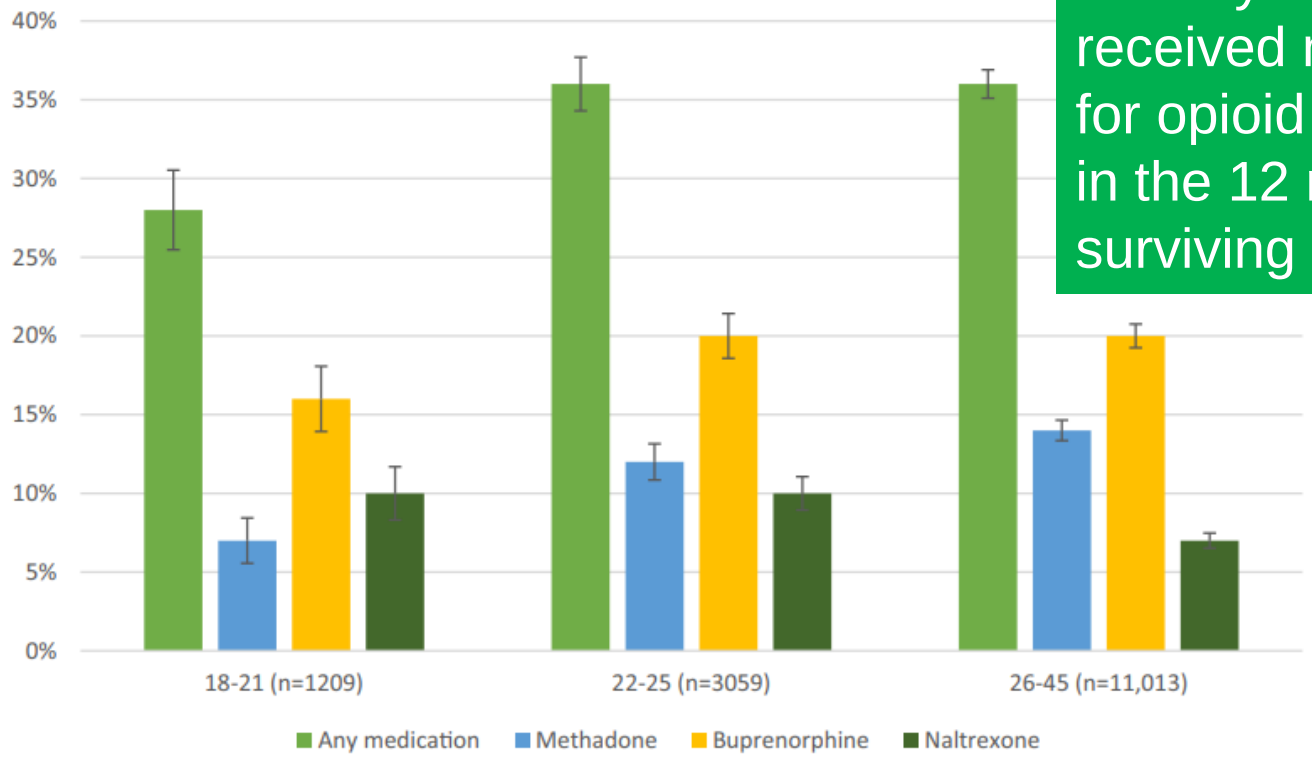
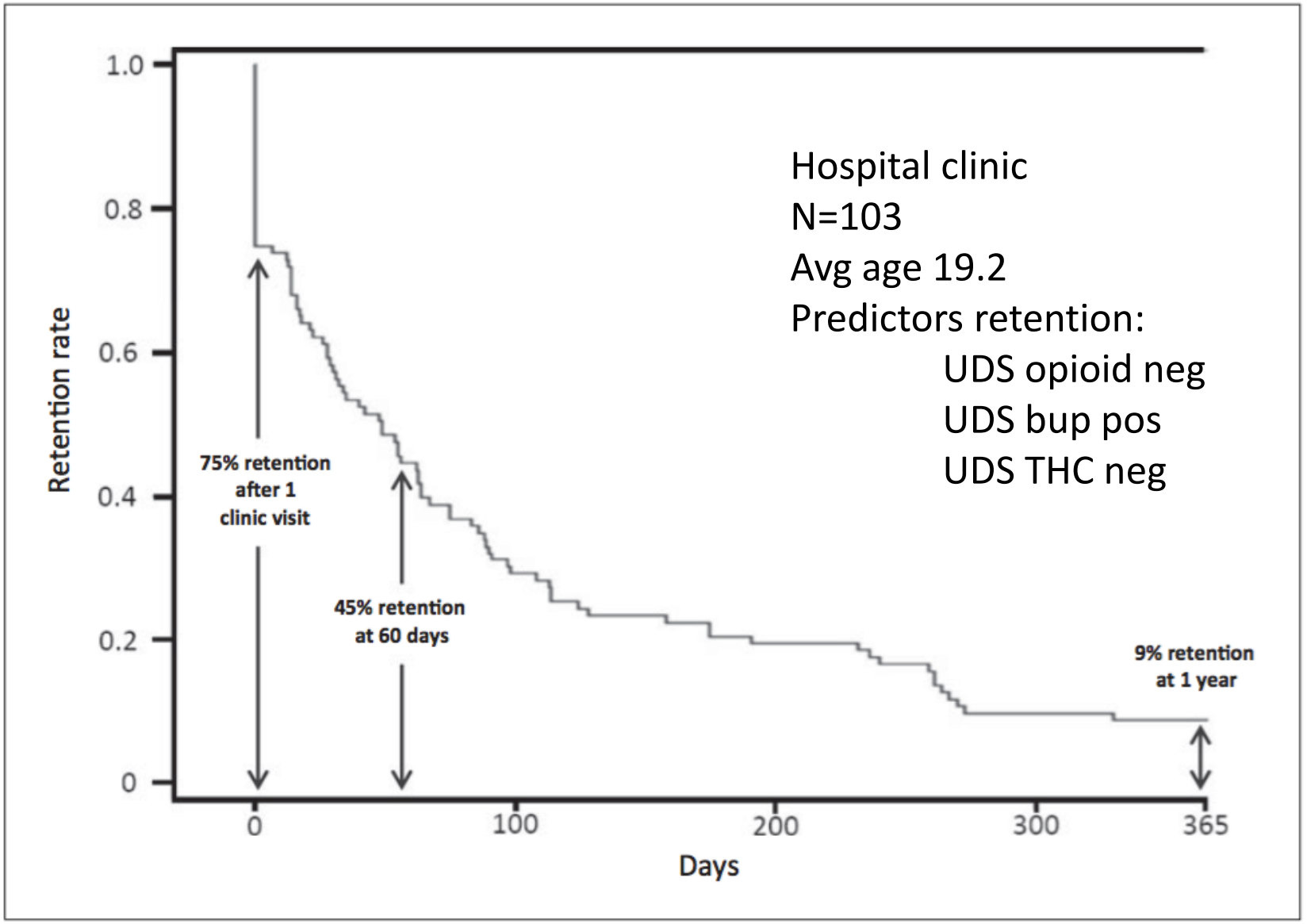


Figure 1. Receipt of medication treatment in the 12 months after a nonfatal overdose, stratified by age groups. Error bars represent 95% CI.*. *Individuals could have received more than one kind of medication type.

Bagley et al. (2019) Annals of Emergency Medicine.

YOUTH BUP OP LONGER TERM RETENTION



Matson et al.
*J Addict Med. 8:176-82.*2014

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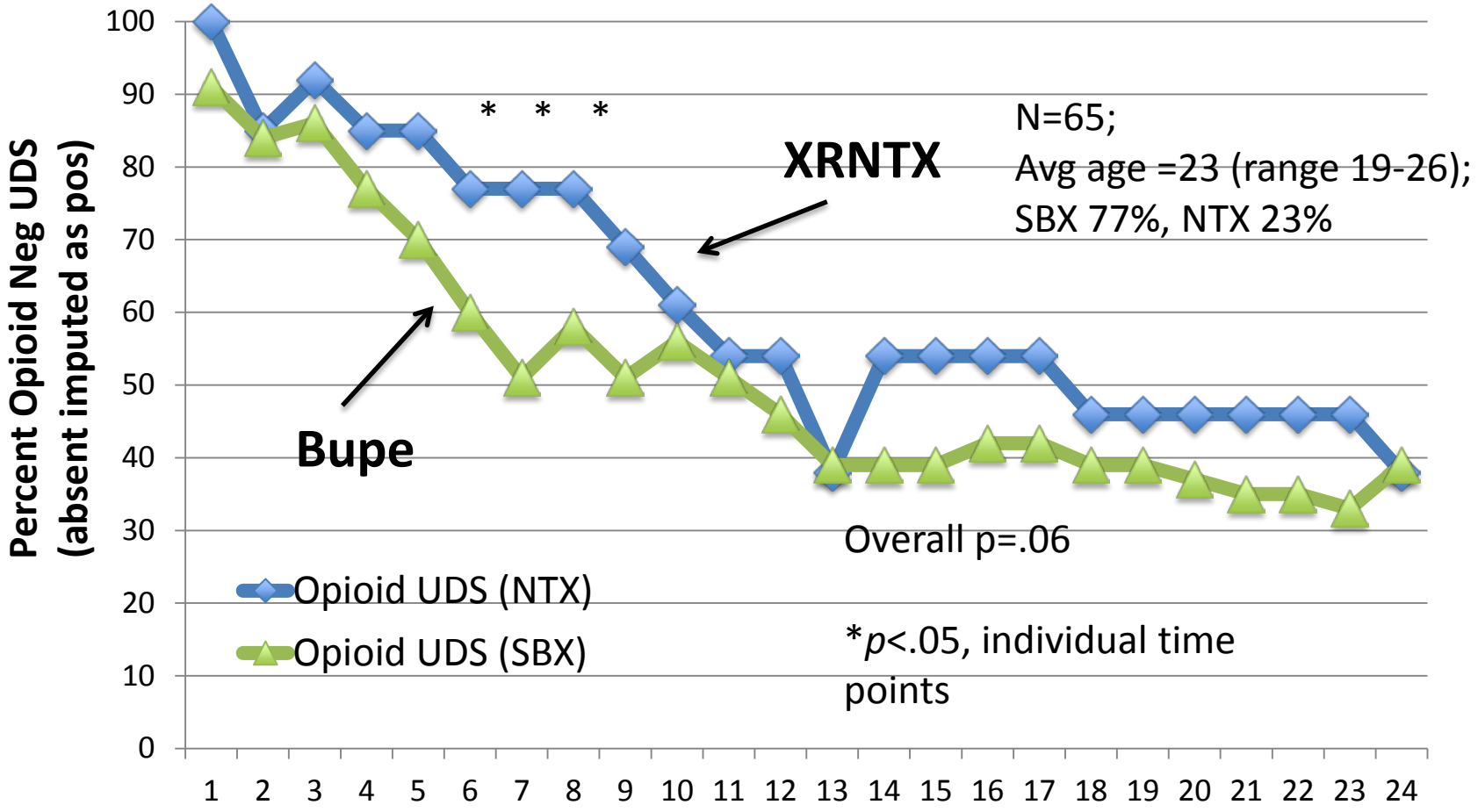
YOUNG ADULTS ENROLLED IN SPECIALTY IOP



Vo et al. Relapse Prevention Medications in Community Treatment for Young Adults with Opioid Addiction. *Substance Abuse.* 2016

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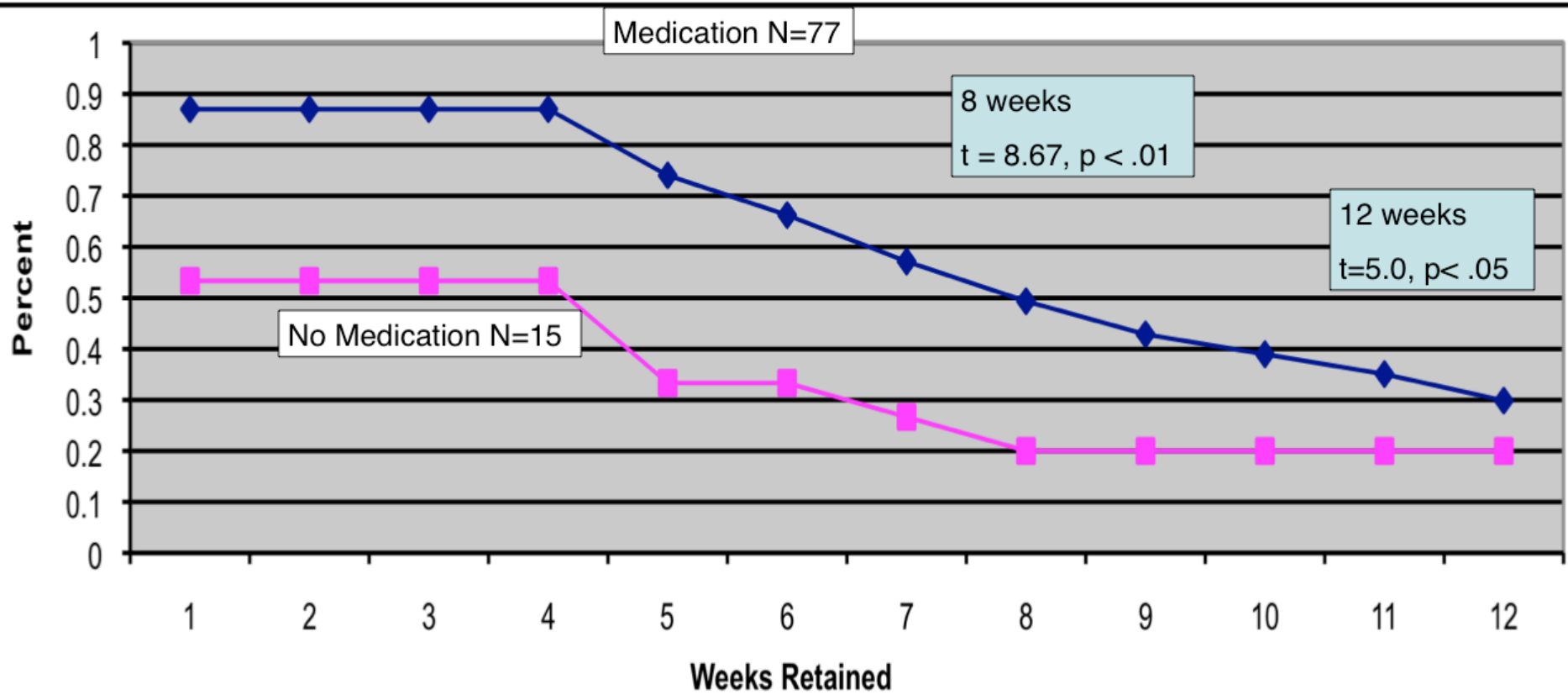
Adolescents and young adults referred to co-located IOP Linkage and retention: Medication (bup or xrntx) vs no medication, naturalistic treatment



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Adolescents and young adults

Referred from residential to multiple community providers

- Treatment received in acute residential (n=288)
  - XRNTX 28%, Bup 33%, No meds 39%
- Over 6 months following residential discharge low rates of MOUD use:
  - XRNTX: mean doses 1.8
    - 70% 1st dose
    - 17% 3rd dose
    - 7% 6th dose
  - Bup: mean days 57
- Leaving residential treatment on bup significantly associated with receiving MOUD at 3-mo compared to leaving on XR-NTX or no medications.
  - At 6-month follow-up, retention in treatment higher for the bup group than the no medication but not for the XR-NTX group..
- Self-reported opioid use was significantly lower for the XR-NTX group than the other two groups at 3 and 6 mo.
- Opioid positive tests were significantly lower for XR-NTX than the other two groups at 3 mo but not 6 mo

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NEW DIRECTIONS

Engaging families
and assertive treatment

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YORS
Youth opioid recovery services

- Family engagement
- Assertive outreach
- Home delivery of relapse prevention medications
- Contingency management: incentives for receipt of medication doses

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ASSERTIVE TREATMENT

- Well established for treatment of chronic illness in hard-to-reach populations in which medication adherence is a major barrier
  - TB, HIV, schizophrenia (ACT)

FAMILY ENGAGEMENT: HISTORICAL BARRIERS

- Normative pushback against sense of parental dependence and restriction
- Clinicians: lack of training, competence, comfort
- Focus on internal transformation
- Preoccupying focus on “enabling”
- Over-rigid concern with confidentiality

RATIONALE

- Both families and youth need a recipe for treatment, with role definitions, expectations, and responsibilities
- Families have core competence and natural leverage
- Encouragement of emerging youth autonomy and self-efficacy is compatible with empowerment of families
- Family mobilization – “Medicine may help with the receptors, persuasion may help with the motivation, but you still have to parent this difficult young person”

FAMILY FRAMEWORK ELEMENTS

- Family education
- 3-way treatment plan, collaboration, and contract: youth, family, program
- How will family know about attendance and treatment progress?
- How will family help support attendance and treatment progress?
- How will family help support medications?
- What is the back up or rescue plan if there is trouble?

PRINCIPLES OF FAMILY NEGOTIATION
THE ART OF THE DEAL

- Pick your battles
- Know your leverage
- You gotta give to get
- You have more juice than you realize
- Keep your eyes on the prize

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ASSERTIVE OUTREACH

- Whatever it takes to make contact

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HOME DELIVERY

- Meet them where they are (literally)!

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POSTER CHILD?

- 21 M injection heroin, 5 inpatient detox admissions over 1.5 years, each time got 1st dose XRNTX but never came back for 2nd dose
- Lives with GM, team shows up with dose, he says no thank you, she says no not an option, done deal, gets 6 doses

HOME DELIVERY
(AND FLEXIBLE VARIATIONS ON THE THEME)

- Homes (many flavors)
- Recovery residences
- Other provider's residential detox program
- Hospital bedroom of partner during visiting
- Restroom at McDonalds, KFC, Taco Bell
- Abandoned building

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PILOT RCT

- Ages 18-26
- Recruitment through index episode of acute residential treatment, with detox
- Randomization to YORS vs TAU
- 6 months duration
- N = 38

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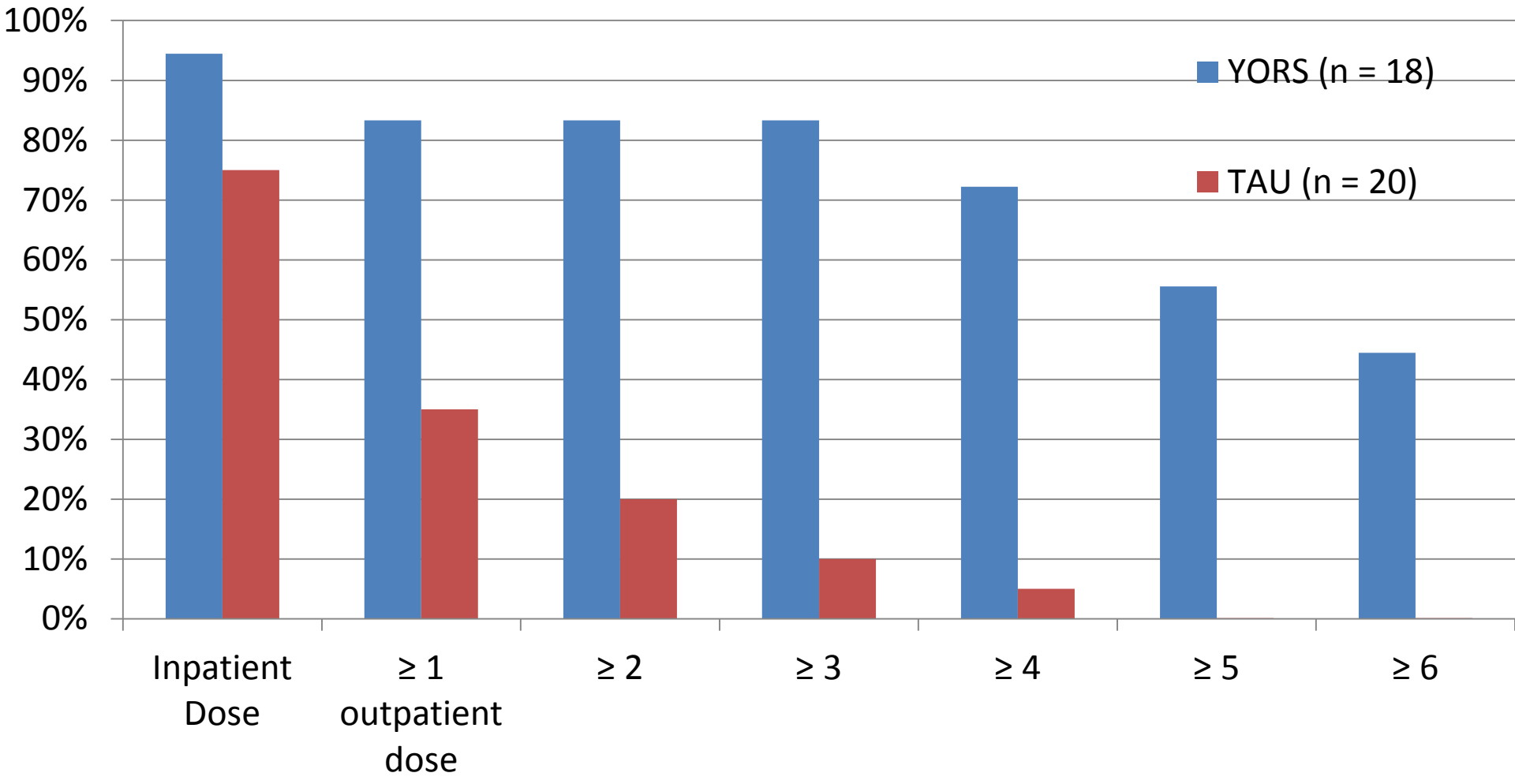
RECEIPT OF CUMULATIVE XR-NTX DOSES



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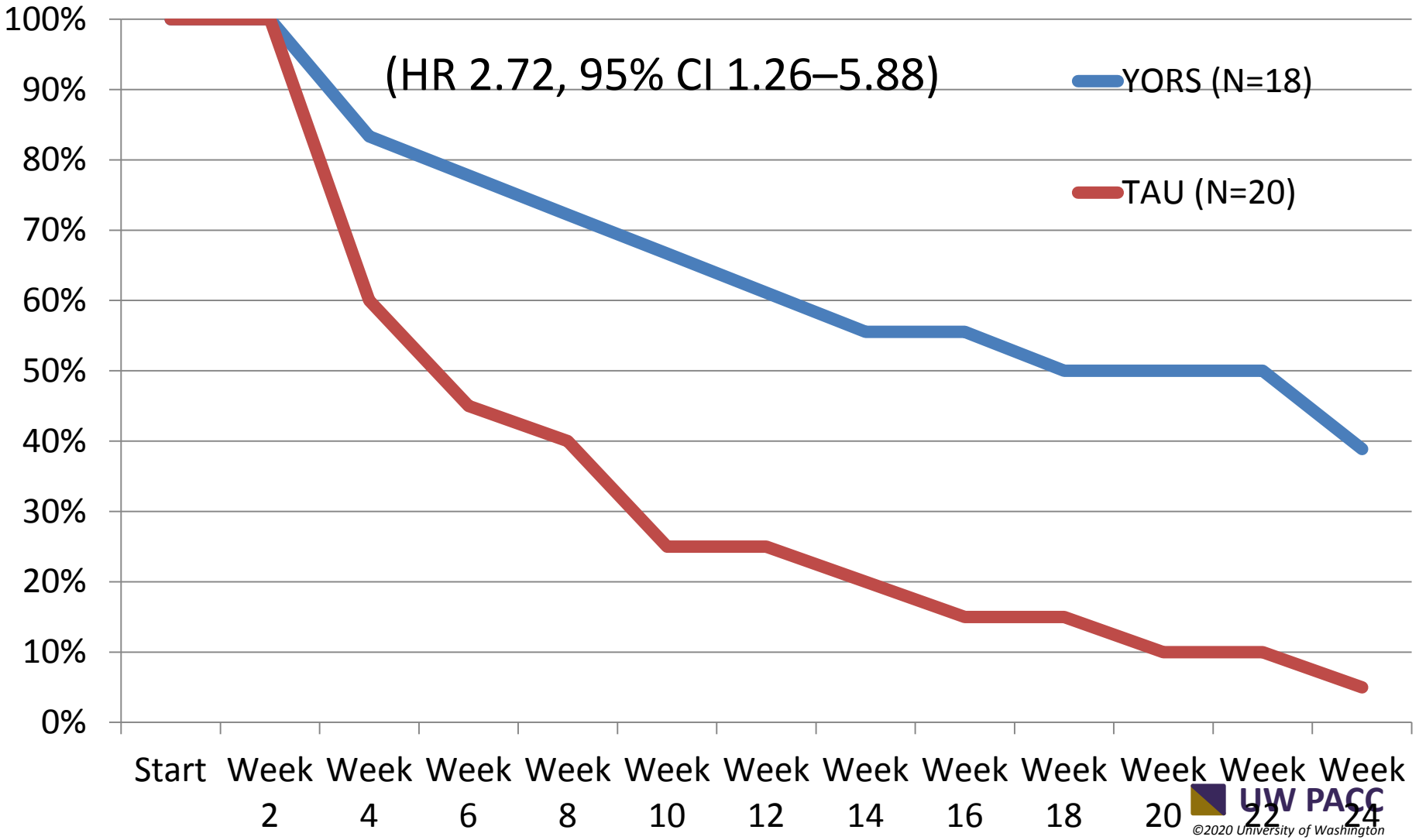
OPIOID NON-RELAPSE SURVIVAL



CONCLUSIONS

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CONCLUSIONS
OPIOID ADDICTION TREATMENT FOR YOUTH

- Early intervention to prevent progression
- Specialty treatment for opioid addiction
- Developmentally-informed treatment
- Longitudinal treatment
- **Incorporate relapse prevention medications**
- Integrate into comprehensive continuum
- Involve families
- More treatment!

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WHAT'S THE ACTIVE INGREDIENT?

- Question:

  Which is better –

  medication or counseling or family intervention?

- Answer:

  Yes

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RECOMMENDATIONS
LOW HANGING FRUIT

- Youth SUD providers should prioritize OUD treatment including use of MOUD
- Youth serving medical providers should identify OUD cases and treat with MOUD
- Typical upstream touchpoints should trigger assertive treatment outreach – OD, ED, medical hospitalization, psychiatric hosp

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RECOMMENDATIONS
NOT-SO-LOW HANGING FRUIT

- Development of innovative approaches needed to improve engagement and retention, esp for high-severity, high-chronicity patients

A CALL TO ACTION

- We are at a crossroads
- We have an existing and emerging toolbox but an alarmingly low level of adoption and utilization
- Therapeutic optimism remains one of our best tools!
- We are saving lives but we need to do better

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A CALL TO ACTION

(AND HYPOTHETICAL MIRACLE CURES…)