

Dr. Stephen Taylor: Hello and welcome back, friends and colleagues, to another episode of ASAM Practice Pearls, a podcast from the American Society of Addiction Medicine. I'm your host, Dr. Steven Taylor.

I want to start off today's episode by talking about an experience I had as a young pre-medical college student working at Kings County Hospital in Brooklyn, when I was only 19 years old, at the K building, which was the outpatient addiction treatment building of Kings County Hospital. I had the opportunity to do the job of taking the intake information on all the folks who were coming in seeking treatment, very raw, right in off the street, many of them in active withdrawal and seeking help.

And I remember the experience of having people start telling me their story, even as I was simply getting demographic information, and almost to a person, people would say, "I wish I had gotten some help for this back when I was a young teenager," and "I had just started using some marijuana or drinking a little bit," or "just started experimenting with drugs when I was still a teenager. I really wish I had gotten some help then. Now, I've been doing this for a number of years, and it's going to be so much harder for me."

And I remember thinking about that experience as a young person and saying, you know what? We really need to be helping people long before they get to this point, when they're literally geriatric people in their thirties and forties who've been using drugs for a couple of decades already. We need to really try to address this from the time that they're teenagers and young adults, when this disease gets started.

So, that's what taught me that addiction is a disease of pediatric onset, a disease of adolescent onset, and probably more people than we realized wish that they had gotten some help from early on when they first got started with using drugs and having problems with drugs. And so, today's episode is really about someone who is helping to make that wish come true for other young folks who are experiencing substance use disorder at a very early age and trying to intervene with those folks at a young age.

So, we fast forward to today, and we've got nearly 90% of opioid overdose deaths in children that occur among teenagers. And in 2023, approximately 1.2% of adolescents age 12 to 17, which is not a small number. It comes to about 316,000 individuals that met the criteria for opioid use disorders, and yet, despite this prevalence, less than 5% of adolescents, 4.4% of adolescents, received any sort of substance use disorder treatment in the past year. Which means, of course, that the vast majority of youth with opioid use disorder are not receiving the care they need, and, specifically, less than 2% of adolescents with opioid use disorder ever receive any kind of MOUD.

Needless to say, we need many more doctors like my friend, an esteemed colleague, Johns Hopkins's own Dr. Marc Fishman, whom I am so happy to have with us on today's episode. Since we can't clone Dr. Fishman a few dozen times, which is what we really need to do, we'll do the next best thing, which is have him share some of his wisdom with us here on ASAM Practice Pearls to discuss how we can improve outcomes for youth with OUD who are in treatment. Mark, would you please say hello to our listeners?

Dr. Marc Fishman: Yeah. Hello and thank you, Steve, for that warm welcome. I love your introductory vignette and the story, thinking about early intervention as such a natural opportunity. And I know we're going to spend our time today talking about treatments, for the most part, of opioid use disorder in young people.

But I just want to riff with you for a second on this prevention message. I agree with you. It's become my tagline to say that addiction is a developmental problem with pediatric onset. I'm right with you there. We know that 90-95% of adults with substance use disorders initiated before the age of 18. It makes all the sense in the world in a chronic relapsing condition, like any chronic relapsing condition, to intervene early before the disorder has crystallized, before the disorder has progressed to its most advanced malignant form, as it goes on and accelerates through the life course. So, it makes total sense. And the message there is that young people who eventually initiate opioids don't do so in a vacuum. Most of them, the vast majority of them, have already had loss of control and trouble with pre-opioid, if you will, substances.

And for adolescents, what's that? It's nicotine, alcohol, and cannabis. And so, big message there is if we do a better job intervening early before opioid initiation, that, in itself, is opioid overdose death prevention. So, I think if we focus resources and attention and knowledge, that'd be helpful.

Dr. Stephen Taylor: First of all, you're a hundred percent correct. I could not agree more on that. And remember, there are three different types of prevention. There's primary prevention before anyone's ever started using this substance. There's secondary prevention, which is a lot of what we're talking about when we're providing treatment to adolescents with substance use disorder. All of that could be characterized as secondary prevention because the disease process has gotten started, but it really hasn't even had time enough to become an advanced disease process. And then, of course, tertiary prevention, in terms of things like naloxone and preventing other complications of the disease process. So yeah, we are, in fact, having a conversation about prevention.

Dr. Marc Fishman: Yeah. No, that's so true. The other thing that you mentioned is the problem with uptake of good treatment that is accessible for youth and is developmentally specific and, therefore, more effective for youth. And there's a bunch of reasons why that is.

You know, you quoted such a small number of young people. It's true for adolescents. It's also true for young adults in terms of what evidence-based, life-saving treatment access they get. And there's a bunch of reasons for that. There's misunderstandings and misconceptions about that. Should medications be second line only because we should only give medications to young people who fail first non-medication treatment?

Oh, my goodness! The evidence is so clear that, as it is throughout the lifespan, the standard of care for opioid use disorder are the medications for opioid use disorder that applies to adolescents and the young adults as well. Not everybody's gotten the memo, though, and we don't want to wait to fail first. What does it mean to fail an episode of care for OUD that could be fatal? So that's one reason.

Another reason is that young people tend not to be treatment presenting, and we can talk about that as we talk about what some of the barriers are, but they're invincible, or they don't want to think of themselves as having an illness, certainly not a chronic illness. That's the same in addictions as it's in juvenile diabetes or depression or other kinds of things that's developmentally normative.

There's also stigma and prejudice up against medicines and against young people, and there also aren't enough youth-welcoming or youth-expert providers to go around. Never mind cloning me, there's a lot of people we need to clone, including you. But to be able to push this out into primary care as one model, or to be able to think of specialty addiction treatment providers as being able to reach down in age group with developmentally specific methods.

Another barrier has been the FDA labeling, and this remains a sticky point. You and I know that most of what we do in all of medicine is off-label, but it's still a barrier. Buprenorphine, for example, sublingual buprenorphine labeled for 16 and up, extended-release naltrexone labeled for 18 and up, and extended-release buprenorphine labeled for adults without even a mention of age. For some people, that becomes a regulatory barrier or a payer barrier or a "I can't do that because it's not allowed," and it should be advocated for.

Dr. Stephen Taylor: Absolutely. So, once we've got a young person in treatment, which of course is no easy feat for all the reasons you discussed, what is it that makes adherence and retention so uniquely challenging in this population? And are they different from the challenges we see in adults?

Dr. Marc Fishman: Some are overlapping and similar, and others are different. Adherence is a problem with MOUD throughout the lifespan, and as good as the medicines are, our retention rates have lots of room for improvement. But it's worse in young adults and adolescents, and probably the reasons are the same kind of developmental vulnerabilities that get them in trouble in the first place. Whether it's impulsivity, whether it's the amplitude of emotional reactivity, as opposed to good, careful strategic planning in the future, which adolescents are immature at anyway, their frontal cortices are not fully developed, their executive inhibitory control is not fully mature. The sense of invincibility that I talked about, "I don't have an illness." "I don't want to take your stinking meds." "What's this all about?" "I'll be just fine." "Leave me alone." And "By the way, you can't tell me what to do. I'm all grown up." And "Mom, what do you know about it?" And "Dr. Fishman, what do you know about it?" And you know, the usual kinds of normative things, but you got to roll with that, and you got to make it work.

And that requires some developmentally targeted interventions where we take into account adolescent vulnerability, where, and you know this, you've got to use humor and you've got to build therapeutic alliance and you've got to be able to take the sass and lean into it because it's part of the interaction.

Another thing that I think is super helpful and is underdone in our field is an emphasis on family involvement. I'm a big fan, and you and I have talked about this, of thinking about

what are the ways that we can include families or the designated loved ones of our patients. And I'm particularly interested in this, and the research work I've done in the field has been focused mostly on young people, but I think it's relevant across the lifespan. No matter how old you are, there's somebody who loves you. And those people can be so supportive and so helpful, and we tend to think about them in a marginalized way that we can't talk about it, that we've got to strictly cleaved to confidentiality. But I think we can have our cake and eat it, too.

You know, it's so intuitive in every other medical practice. Us, as providers of medical services, if somebody you care about is struggling with an illness, if somebody you love is having difficulty navigating the medical utilization system, you help them. If Granny can't take her pill, you figure it out with her. If somebody can't understand what the doctor is saying or doesn't know how to parse the advice, you go to the appointments with them and you ask questions and you take notes and you make a new appointment or help them get to the doctor. But not an addiction. An addiction: It's secret. It's shameful. It's embarrassing. It shouldn't be that way!

Dr. Stephen Taylor: I agree. And in fact, one of the things I learned in my fellowship was that I trained as a child and adolescent psychiatrist. I also did a fellowship in addiction psychiatry under another Mark, whom I respect immensely. Dr. Marc Galanter, who developed network therapy, and you have talked about network therapy. Can you share some of your thoughts on that, specifically in its utility, in terms of involving families?

Dr. Marc Fishman: No, that's exactly right. Marc is a great teacher and a contributor giant in the field. And everything we do rests on the shoulders of giants like him. And so, I have shamelessly stolen from him and people like that. But his great insight was that you can involve these concerns with significant others. Let the patient designate a family member, a spouse, a loved one, a close friend, and let's include them in the collaborative partnership to try to improve adherence.

And he did this primarily in adults. His first work was with disulfiram for alcohol use disorder, but he did it broadly and developed the case for the efficacy. And so, one of our ideas has been to incorporate that idea. And other people have also tried to incorporate conservative significant others and to incorporate those ideas by asking our young patients to do exactly that, designate a treatment significant other.

Often, it's a parent, but [it] can be anybody. And this is going to be a partner and we're going to coach that person and educate that person and we're going to focus our attention as an opener on medication adherence. Not because that's the only important treatment goal, but because it's a highly effective one, especially when we have high effect size medications, like we're lucky enough to have for opioid use disorder, and that's going to be where the preponderance of the variance is. Let's get you on medicines. Let's work on all sorts of comprehensive, multimodal treatment goals. But first, we've got to keep you alive. And first, we've got to get you to stop relapsing and get through all of this.

The other thing that I've learned, very compelling thinking about the role of the treatment, significant other, parent or otherwise, is that when parents and other family members come to us with a young person, and they're miserable and they don't know what to do, and they're up to their ears and alligators, they're in chaos. And they say they've tried everything, and they don't know what... They want to kick them out. They want to cut their head off. They've spent all this money on lawyers and whatever. And giving them a focus and a recipe that you can have an impact instead of all the heat and light and screaming and yelling. Focus on the medicine. Get the medicine in them. "Well, Dr. Fishman, can't you get him to clean his room?" Yeah, okay, maybe that's next Tuesday, but for now, let's get the medicine in them. And then, that's compelling once you can persuade them to the role of what it's like to parent a sick kid.

And it's mom 101, right? Everybody's had the experience of having a 5-year-old with an earache and a fever, who doesn't want to take the pink medicine. Now it's one thing to be able to take a five-year-old in a basket hold and squirt a syringe of medicine in their mouth. That's maybe different than a 200-pound 19-year-old who doesn't want to take the medicine. But the core concept is there. This is an irritable person who's not themselves. They don't know how to navigate the medical utilization service system. You're the mom, you're the dad, you're the aunt, you're the grandmother, you're the girlfriend, the boyfriend. Step up and help in a way that's productive. And people, I think, resonate with that.

Dr. Stephen Taylor: They really do. Here's another thing that I want to point out that I've experienced, and that I know you have, and I'd like to get your thoughts on it. The fun thing about working with adolescents, in particular with a substance use disorder, is that this is a population of folks who are going through tremendous development.

They're trying out all kinds of things, so they're incredibly inquisitive in many cases. And of course, ones who have gotten fairly far along the spectrum of substance use, many of them are incredibly imaginative, resourceful, highly intelligent, and that poses both a potential danger for them, in terms of how much they've gotten involved in substance use, but it also is a strength that we can take advantage of and help them to utilize in their own work towards recovery. Talk about that, if you have had experiences with that, which I know you have. For me, that's some of the most fun aspects of working specifically with adolescents with SUD.

Dr. Marc Fishman: Yeah, it's such an amazing time in the lifespan. It's a time of endless open opportunity and unwritten pages of the future. And that's a lot of fun, and they're full of boundless energy. They've got millions of plans, and you can tap into what they're interested in. You've got to be interested in that and you've got to ask questions. You may not like their music, but you've got to care about their music and want them to teach you about it.

In fact, the strategy of saying, "teach me something," is very disarming and engaging, and I think works well as a technique. But to really respect the idea that this is an age of discovery. And if you can allow people and help them connect the dots between the things

that they really want and wish for, but the difficulties and impairments that have come from substances, even when they don't recognize it yet.

Dr. Stephen Taylor: So, let's get back to the whole issue of extended-release medications for OUD in this population in terms of safety, effectiveness, feasibility. How do these medicines work for young people? How do we utilize them to perhaps even improve adherence and retention and treatment for young folks?

Dr. Marc Fishman: Yeah, that's such a great question. The first thing that's important to help providers with is that there is plenty of evidence of safety for all of the MOUDs. So, we've looked at this most in sublingual buprenorphine, but we've got very good emerging evidence of extended-release naltrexone and new emerging evidence in extended-release buprenorphine.

And, of course, all medicines can have side effects, including Tylenol, right? But there's, luckily, no signal whatsoever of additional safety concerns or side effects conferred by chronological age. So, these medicines are safe. We don't have quite the efficacy knowledge base that we do from 70 years of evidence in adults, but we've got plenty of good evidence that they're effective.

Sublingual buprenorphine is probably [the] most widely used and has been the most easy in its uptake. But the long-acting injectables, those have lots of presumed adherence advantages, just as you say, and we've now been able to see that demonstrated in trials with adults. There have not been extended-release buprenorphine trials yet in adolescents, but we've got lots of experience using extended-release naltrexone. And in just the last year, very enthusiastic about extended-release buprenorphine as being an adherence enhancement.

We have tons and tons of evidence from other disorders like schizophrenia with the use of long-acting injectable antipsychotics, that's a slam dunk. And so, I think we're going to see as that evidence base is emerging, and confirm that we're going to see the same advantages in adolescence.

My colleague at Children's National, Dr. Sivabalaji Kaliyamurthy, presented with us at the national conference, whose case series that recently got published. Small, six cases, but that's how you start. I've got about 10 cases under my belt now with extended-release buprenorphine, and in each of them, I see that this medicine is a way of addressing the natural and developmentally normative ambivalence that we see with the need of having to take a daily medicine.

If you're in for a month, that's not forever. It's pretty good. And that amount of time gives you the ability to be engaging, to have a month of non-use. And if I'm lucky, we'll see, we've planned a multi-site randomized trial of sublingual buprenorphine versus extended-release buprenorphine in this specific target population, in adolescents with OUD. And we've gotten a preliminary green light from NIDA. But I'm very hopeful that next year [when] we talk again, I'll be able to tell you about our initial enrollment and how the trial is proceeding,

because we need that evidence base to be able to get the FDA labeling. We need that evidence base to persuade big systems that this is the right thing to do to get providers in. So, wish me luck there.

Dr. Stephen Taylor: Oh, definitely. Good luck with that. And I will be in touch in about a year or so to get follow-up on that. I'm actually very hopeful that that will come through.

You know, you mentioned Dr. Kaliamurthy, and I had the opportunity to co-present with him at an event that we had at my alma mater, actually, Howard University College of Medicine. And when we were talking about the overdose, a spike of young people from opioid overdoses in the DC area, which I know you are very intimately familiar with, but one of the things that he pointed out when he spoke, and I want to get your take on this.

Back when I was doing my fellowship under Dr. Marc Galanter, one of the things he said to me was, which was a reason why he didn't work so much with adolescents was because, you know, a lot of adolescents just didn't really feel like they had a lot of reasons why they needed to stop. They didn't see a lot of potential harm coming to them from the substance use they were engaged in, sort of the invincibility you referred to earlier.

But when I spoke with Dr. Kaliamurthy, and on hearing his presentation, he'd actually worked with a lot of adolescents who had already seen more than one of their friends die from overdoses. These kids have already experienced serious losses from substance use. It's not some abstract notion to them. What are your thoughts on that in terms of how it can perhaps help motivate young people to stay in treatment, particularly for this illness?

Dr. Marc Fishman: I think both things are true, that on the one hand, adolescents, because they don't have as many road miles on them and have not experienced as many cumulative consequences, are often, to a large extent, still in a positive reinforcement ascendant phase, meaning they're still getting lots of euphoric pleasure.

They're still, if you will, in the "I'm enjoying partying. What are you bothering me for?" kind of phase of addiction before they had gotten to negative reinforcement, in which relief from distress is the predominant reinforcement phase, as it is for so many of decades-long adult users. So, I think that is true in general. It's certainly true of cannabis, which by the way, "Isn't a drug anyway. So really, what are you bothering me for?" So, that's the thing we've got to struggle with, that ambivalence of motivation, feeling like maybe I got in trouble today, but tomorrow feeling like, "Well, I'm still having fun." But it's also true that with opioids, the harms and the accrual of consequences are much accelerated compared, perhaps, to some other substances.

So, if you do have a friend or know someone who's suffered a non-fatal overdose, or, God forbid, a fatal overdose, that's irrefutable evidence of harm. And if you've had withdrawal, which is so much more prominent in opioids than perhaps in some other substances, that's irrefutable evidence of some degree of harm.

So, when working with an opioid use disorder population, adolescent can make some currency with their personal experience of difficulties, and they may, instead of being exclusively pre-contemplative or even pre pre-contemplative, they may have already made some kind of work across the stages of change to being contemplative and thinking about the role of these kinds of impairments and harms.

And I think it is an opportunity to engage. It is an opportunity to be able to talk to them about significant potential losses or even actual losses that have salience to them, which is important what matters to them.

Dr. Stephen Taylor: That's absolutely right. And speaking of what matters to them, obviously, adolescents tend to be in school of some sort, in many cases, not all cases. How can you engage community schools to help coordinate care for young folks with OUD?

Dr. Marc Fishman: It's so important. We've seen this all over the place now. Some of the adolescents that we treat are in school. Some have dropped out. Many of them are somewhere in between, "I go on Tuesdays, but I don't go on Thursdays. I haven't gone much this past semester, but I used to be really into it." And all of those things are potential pathways to trying to think about what is the role of school or the appropriate role of school?

Many schools are acutely aware of the problem or detected—I mean, they may not know what's going on, but if they do know that there have been multiple kids using opioids or other high severity substances, or God forbid, overdoses, they tend to be aware. Some have very good resources, like school counselors, even in school, substance use programs. Most, on the other hand, don't know where to turn and need guidance. And so, when I'm able to find resources that I can mold, that can be very helpful. It's critical, in treating these youngsters, to think about how to get them back into a school.

Now, school's not for everybody, and so there may be some kids who say, "Listen, it's more important for me that I work," especially older adolescents. And "Sure, I'll get my GED, but what I really need to do is get a job." All right, well, let's support what their goals are. But trying to reintegrate most kids back into school is developmentally appropriate and helpful. And that's a piece of work. Sometimes, the schools will see drug use exclusively as a disciplinary problem. Sometimes, homeschooling or virtual education [can act] as a bridge back in. Anyway, you're so right to point it out as a very important aspect of thinking about a young person's whole life, because, as in all addiction treatments, it's certainly about trying to transition to non-use of substances. But it's so much more than just the substances, in thinking about the various aspects of improving function across different functional domains.

Dr. Stephen Taylor: Absolutely. So, I want to get to this issue of assertive approach to youth MOUD treatment. You've talked about an assertive approach. Can you unpack what that means in practice, and if there's any more nuance to that whole issue of what does assertive engagement look like day-to-day with young people with OUD?

Dr. Marc Fishman: Yeah, so that's been a cornerstone of some of the work we've done in developing our approaches. We've been working in Maryland for the past decade or so, developing, testing, and refining an intervention we call the Youth Opioid Recovery Support Intervention, or YORS for short. Family involvement, as we spoke about, is a key component, but another one is assertive outreach and assertive engagement.

Again, assertive interventions have been around for chronic remitting, relapsing illnesses in target populations that have chaos and adherence problems. For example, assertive community treatment acts in schizophrenia or observed therapies in HIV and tuberculosis, where health workers go out and give people their medicine.

So, the idea is, we're not waiting for ambivalent patient populations to come to us when they're ready. We are out there chasing them relentlessly. We call ourselves "the used car salesman of recovery." And we're just in your face, and we're texting and we're calling and we're Facebook messaging and we're Instagramming, you know, whatever it is. And with the families, too.

So, one of the things that's a lot of fun is for our patients in this YORS intervention, we establish group text chats that include the young patient and their designated concern significant other as a kind of instant monitoring communication, catch them being good report on progress, but also, "Wait, you missed your appointments." We want everybody to know transparently, are you a little overdue for your dose? Or wait, what about that last urine result? Or that kind of stuff. And then everybody's just normalized about the rules of engagement and communication.

And I've got to say, I'm old, but the young folks on my team have taught me an immense amount about how much therapeutic content you can pack into a text, and you get a lot of power from that, and it's the way that adolescents communicate anyway. They're not taking your phone calls, they're not showing up for Zooms, they're not coming to appointments, but you can at least get 140 characters in.

Dr. Stephen Taylor: Oh yeah. Text is the way to go. I learned that as well, working with young folks. That is really awesome. What else would you like for our listeners to take away from this discussion about improving OUD treatment outcomes for young people?

Dr. Marc Fishman: I would just say, I know that not everybody wants to be an 'adolescentologist,' and that's fine. But on the other hand, we need to build systems that can access young adults and adolescents, that can be welcoming to them.

And that means enabling settings that are already youth-welcoming, whether that's family practice or pediatric practices or juvenile justice settings or school-based settings, wherever the kids already are. What's the technology that we can export to get OUD treatment specificity there, but also in specialty settings where OUD treatment is done, but adolescents have not traditionally been welcoming. How can we stretch to welcome adolescents there? Thinking particularly about a medication-forward approach. I'm not saying it's the only tool. I'm not saying that we don't want multi-component holistic

treatment with multiple treatment goals. Of course we do. But what we've learned across the lifespan, and for adolescents, too, is that medication forward is the way to go.

That's the thin edge of the way or the tip of the spear, or whatever the metaphor is, but the idea that we're starting there, and we build alliance from there, we build recovery capital from there, we build engagement from there, and not everybody knows that. People say, "So what do you mean? Do I have to be on this medicine for the rest of my life?" No, I never said that. But before we talk about getting you off the medicine, let's have a conversation about getting you on the medicine and stabilize things. And if you give me a year, that's a good start. Where did I get that? I don't know. It's more than a day and less than a lifetime. But it's at least enough time, I think, to achieve a significant amount of stabilization.

Dr. Stephen Taylor: Yeah, absolutely. I remember saying to more than a few adolescents, the rest of your life, as young as you are, that is such a long time. Why are we even trying to contemplate that?

Dr. Marc Fishman: Why have that conversation now, right? If I can get you to next Tuesday, it'll be a win.

Dr. Stephen Taylor: Exactly. Listen, I can't thank you enough, Dr. Marc Fisherman, for sharing your wisdom and your insights with us. And, of course, thank you to all of our listeners for joining us for another episode of ASAM Practice Pearls. You heard from the best, you've heard from Dr. Marc Fishman, his remarkable insights on improving treatment outcomes for adolescents with OUD.

For more information on treating young people with OUD, check out the recording of Dr. Fishman's session from ASAM's 56th Annual conference, Improving Outcomes for Youth OUD Treatment, which inspired today's episode.

Remember to subscribe and share this episode with colleagues who may find this information helpful. We'd also love to hear from you. What topics are you interested in? Email us at education@asam.org. Thanks for listening, and we'll see you next time on ASAM Practice Pearls.