ASAM American Society of Addiction Medicine

THE ASAM NATIONAL PRACTICE GUIDELINE FOR THE TREATMENT OF OPIOID USE DISORDER: 2020 FOCUSED UPDATE WEBINAR

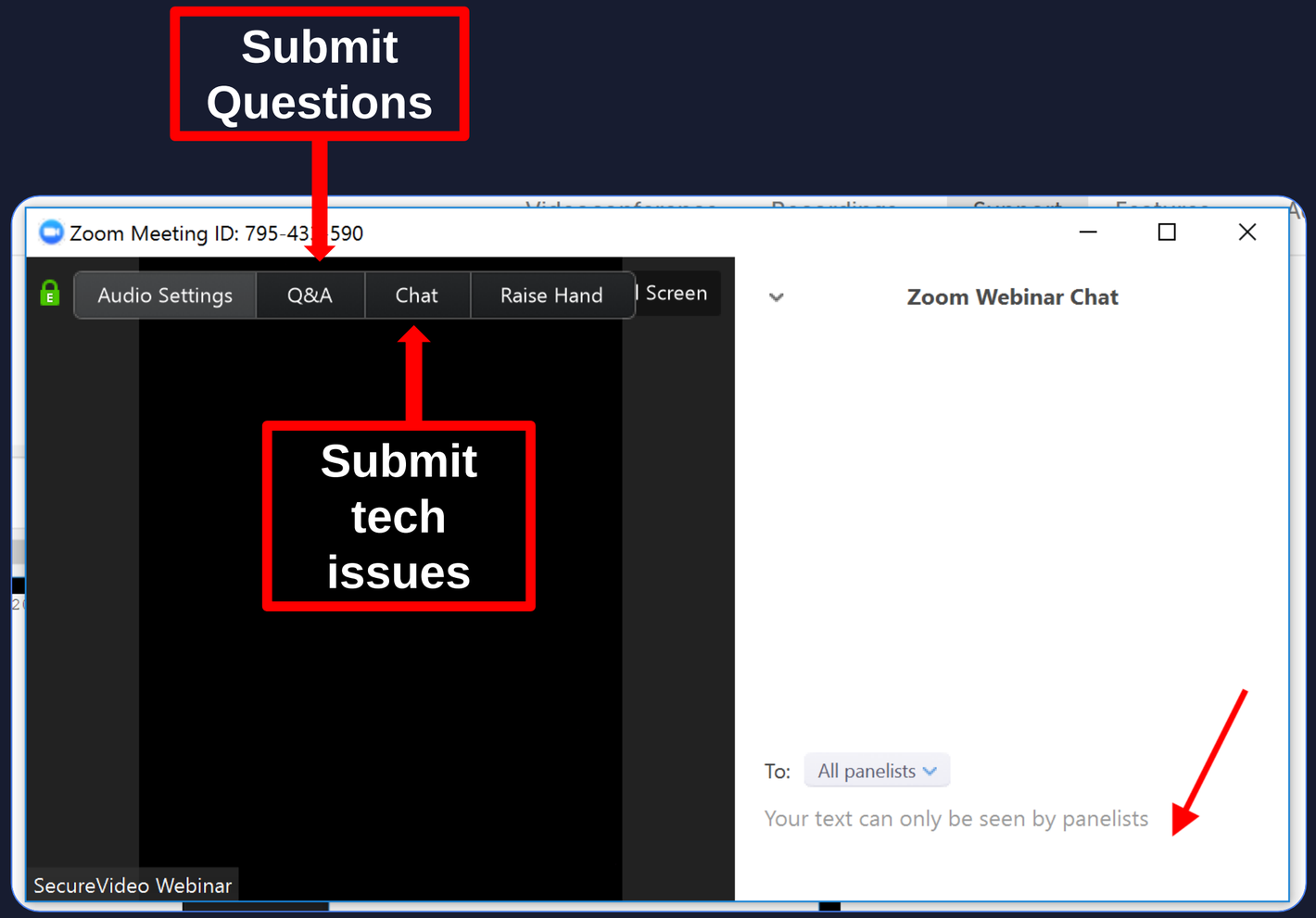
ADOLESCENTS AND YOUNG ADULTS

SCHEDULE

1:00 – 1:05 pm	Announcements ASAM STAFF
1:05 – 1:45 pm	Presentation DR. MARC FISHMAN
1:45 – 2:00 pm	Questions & Answers DR. MARC FISHMAN
2:00 pm	Concluding Remarks ASAM STAFF

ANNOUNCEMENTS

1. Information on obtaining your CME will be provided at the end of the webinar.
2. Attendee Audio: Mics are automatically set to mute.
3. Questions? Type questions into the Q&A box.
4. Technical Issues? Use the chat box feature to submit questions to your hosts.

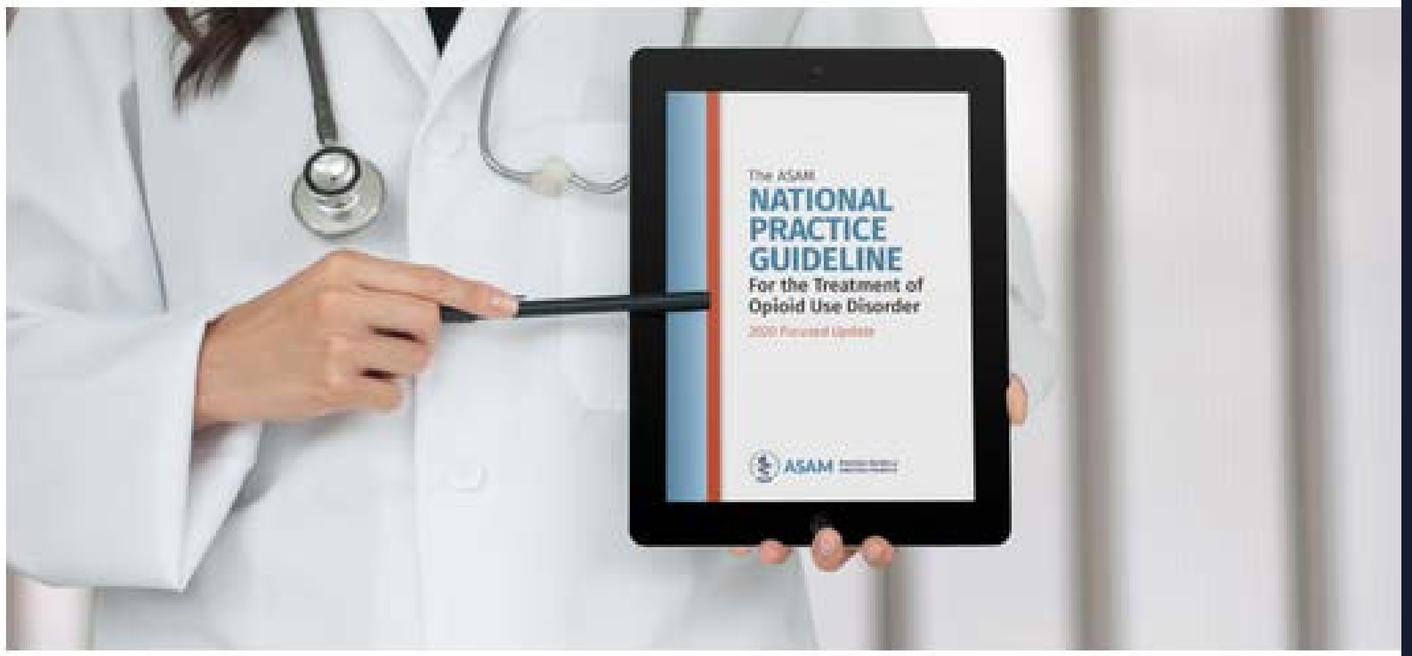


The ASAM National Practice Guideline 2020 Focused Update Webinar – Adolescents & Young Adults

★★★★★ 5 (1 vote)

Includes a Live Event on 09/24/2020 at 1:00 PM (EDT)

Overview | Speakers | Handouts | Credits & Disclosures | Contents (3)



HOW TO OBTAIN CME

1. Go to:
   https://elearning.asam.org/p/NPG2020_Webinar4
2. Go to *Contents* tab.
3. Complete:
   - ❑ CME Quiz
   - ❑ Evaluation
   - ❑ Credit and Certificate

PRESENTER

Marc Fishman, MD, DFASAM

- Marc Fishman, MD is a specialist in addiction psychiatry and addiction medicine. He is a member of the Department of Psychiatry at the Johns Hopkins University School of Medicine. He leads Maryland Treatment Centers, which offers programs for residential and outpatient treatment of drug-involved and dual-diagnosis adolescents and adults.

- He has written and lectured widely on a variety of topics including youth treatment, placement and treatment matching strategies, co-occurring disorders, and medication treatment for addiction. His research focus has been in treatment of opioid use disorders in youth.

- Dr. Fishman served as co-editor for the most recent editions of ASAM's Patient Placement Criteria, leading the adolescent section and served as the Chief Editor for the ASAM PPC Supplement on Pharmacotherapies for Alcohol Use Disorders. He is the Chair of the Adolescent Committee for ASAM, a Past President of the Maryland Society of Addiction Medicine, and a current member of its Board.

FINANCIAL DISCLOSURES

Alkermes Inc.

US World Meds

The Drug Delivery Company

Verily Life Sciences

National Institute on Drug Abuse

OBJECTIVES OF THE WEBINAR

- Summarize the guideline's **treatment recommendations** for adolescents and young adults with OUD and discuss how they should be used in practice.
- Identify the fundamental components of an OUD patient assessment and diagnosis for adolescents and young adults.
- Recognize the **unique needs and treatment recommendations** for adolescents and young adults with OUD.

The ASAM

NATIONAL PRACTICE GUIDELINE

For the Treatment of Opioid Use Disorder

2020 Focused Update

ASAM American Society of Addiction Medicine

PART 10
SPECIAL POPULATIONS:
ADOLESCENTS

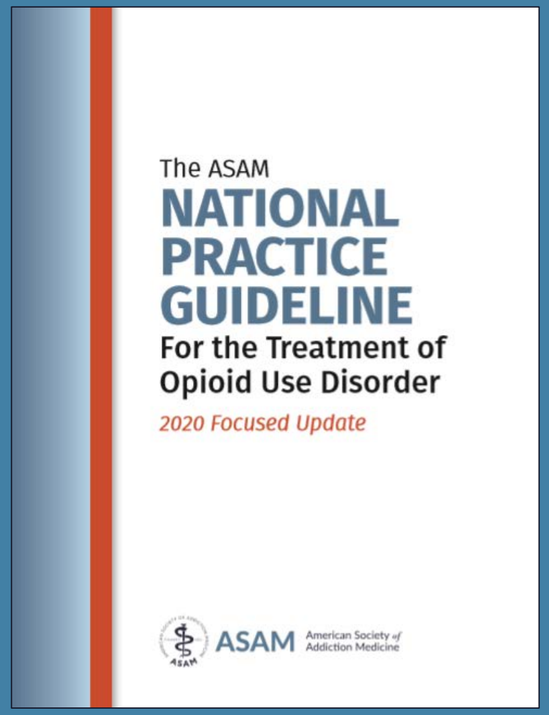
Treatment of Youth OUD Outline

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

Overview

- Opioid use disorder (OUD) is an advanced, malignant form of substance use disorder (SUD), usually beginning in **youth**
- Young adults are disproportionately affected by the opioid epidemic
- There is evidence and consensus for **medications in OUD** (MOUD) in youth, but dissemination is poor due to problems with capacity, misinformation, and prejudice
- Youth have **worse outcomes** than mature adults
- The development vulnerability in youth is prominent
- We need improved, developmentally-informed strategies that target engagement, retention and medication adherence
- Despite barriers, MOUD should be the **standard of care** in youth

Treatment Guidelines for Youth

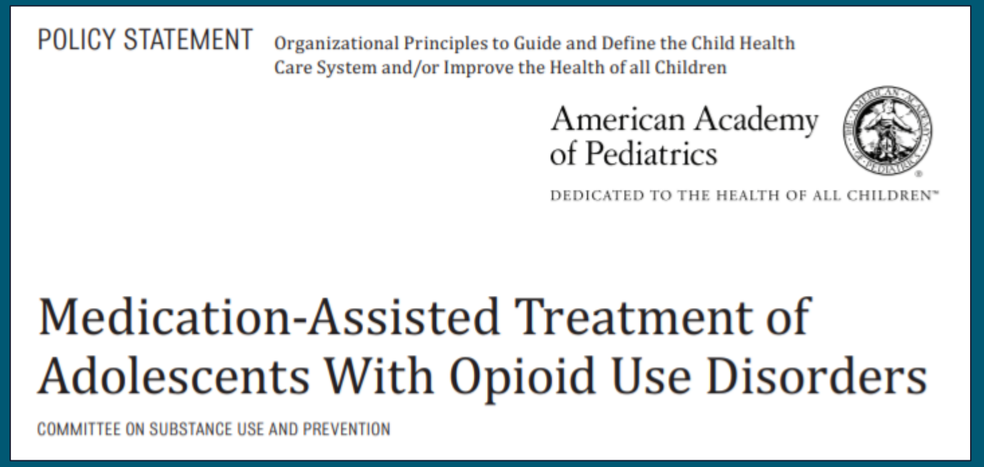


American Society of Addiction Medicine (2020)

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

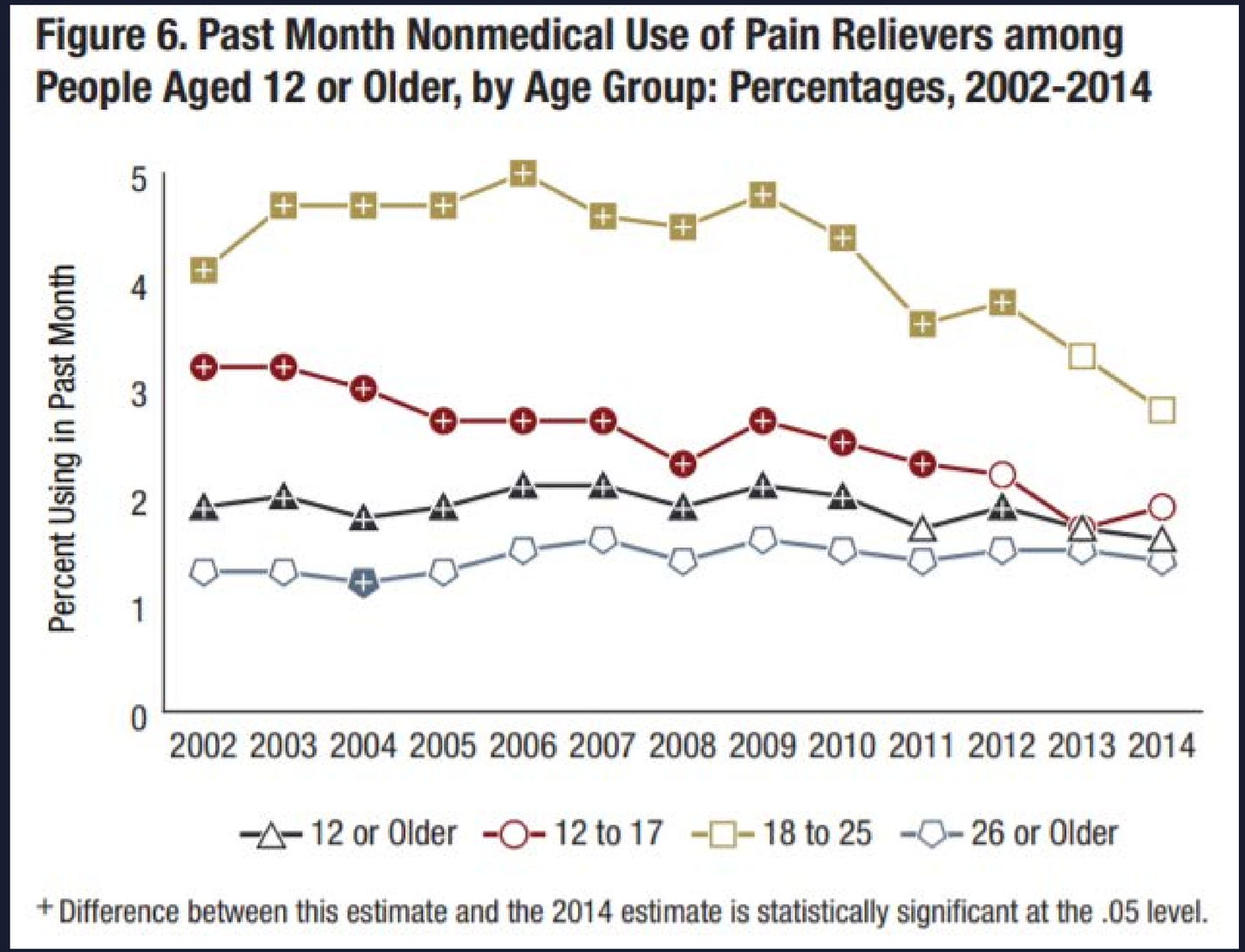
American Academy of Pediatrics (2016)

Encouraging pediatricians to consider offering medication-assisted treatment (MAT) or discussing referrals to other providers for this service.



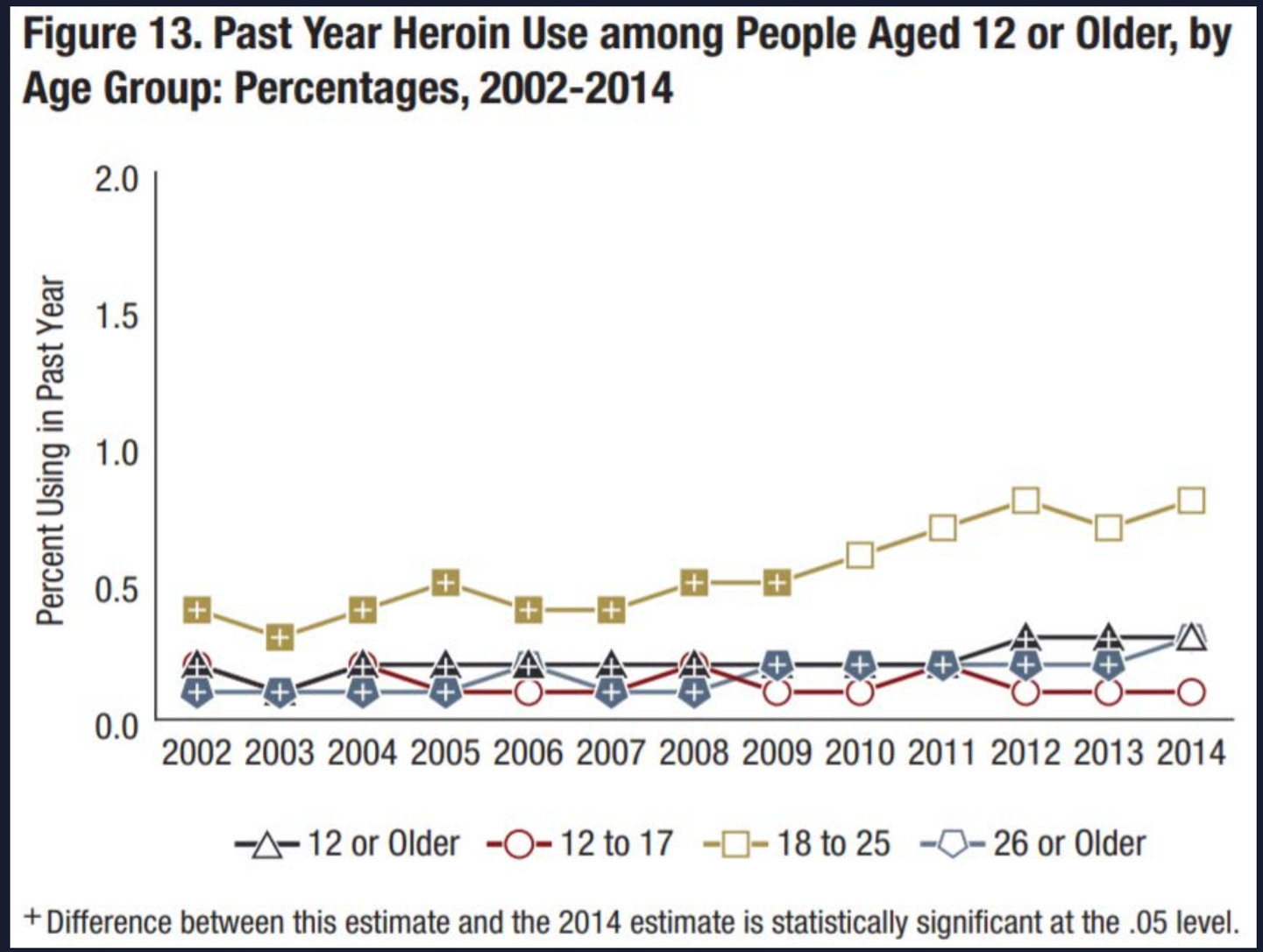
Scope of the Problem

Young adults have the highest prevalence of use of non-medical prescription opioids.



NSDUH, 2014

Young adults have the highest prevalence of use of heroin.



NSDUH, 2016

Prevention

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 had 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 is a developmental disorder of **pediatric onset**
- Earlier onset is associated with **worse outcomes**
- Earlier intervention is **more effective**
- Opioid addiction is an **advanced stage** along progression of illness

Treatment

Survey of current knowledge
Emerging models of care

What should we do with this case?

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

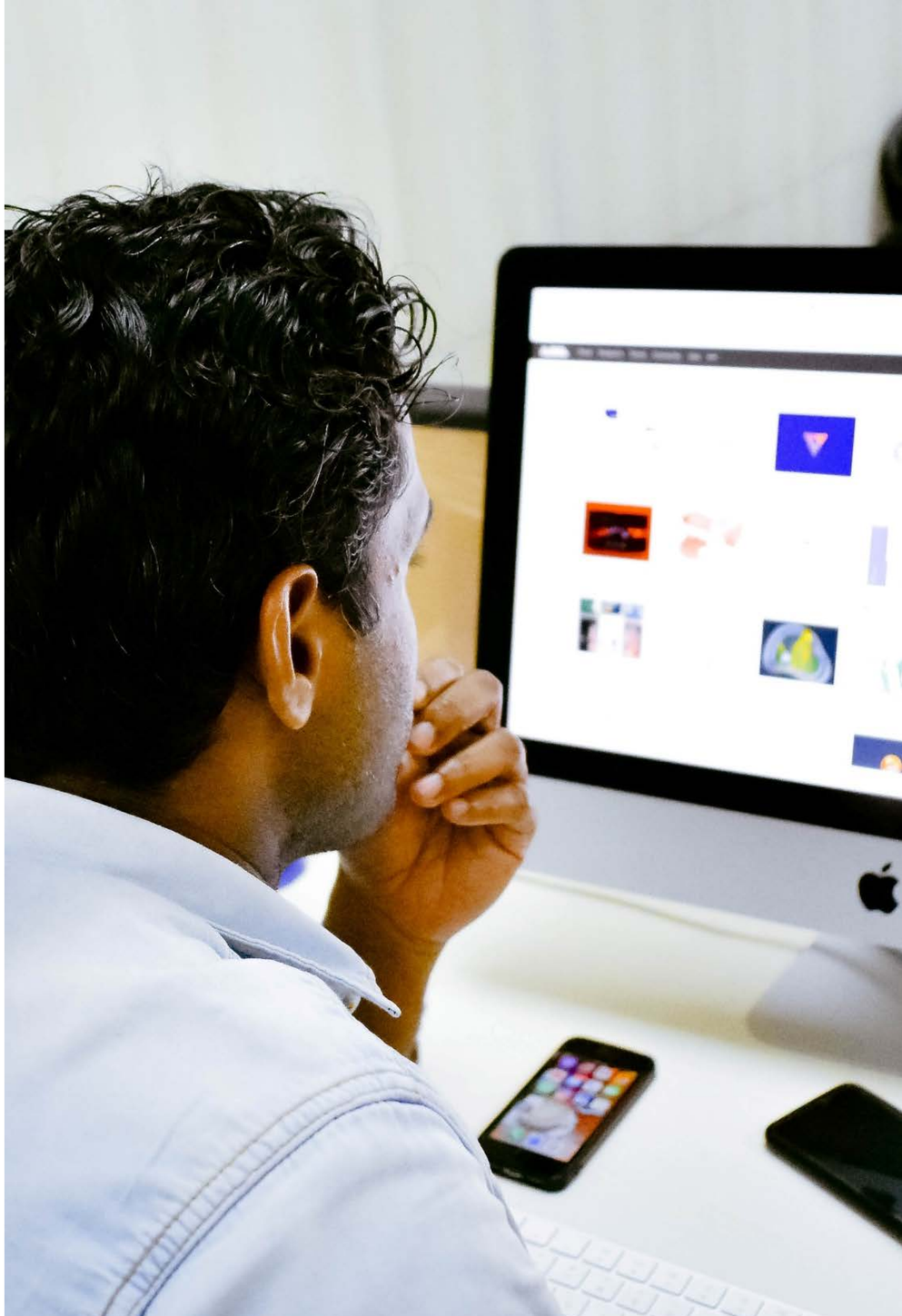
Features of Youth Opioid Treatment

- 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**

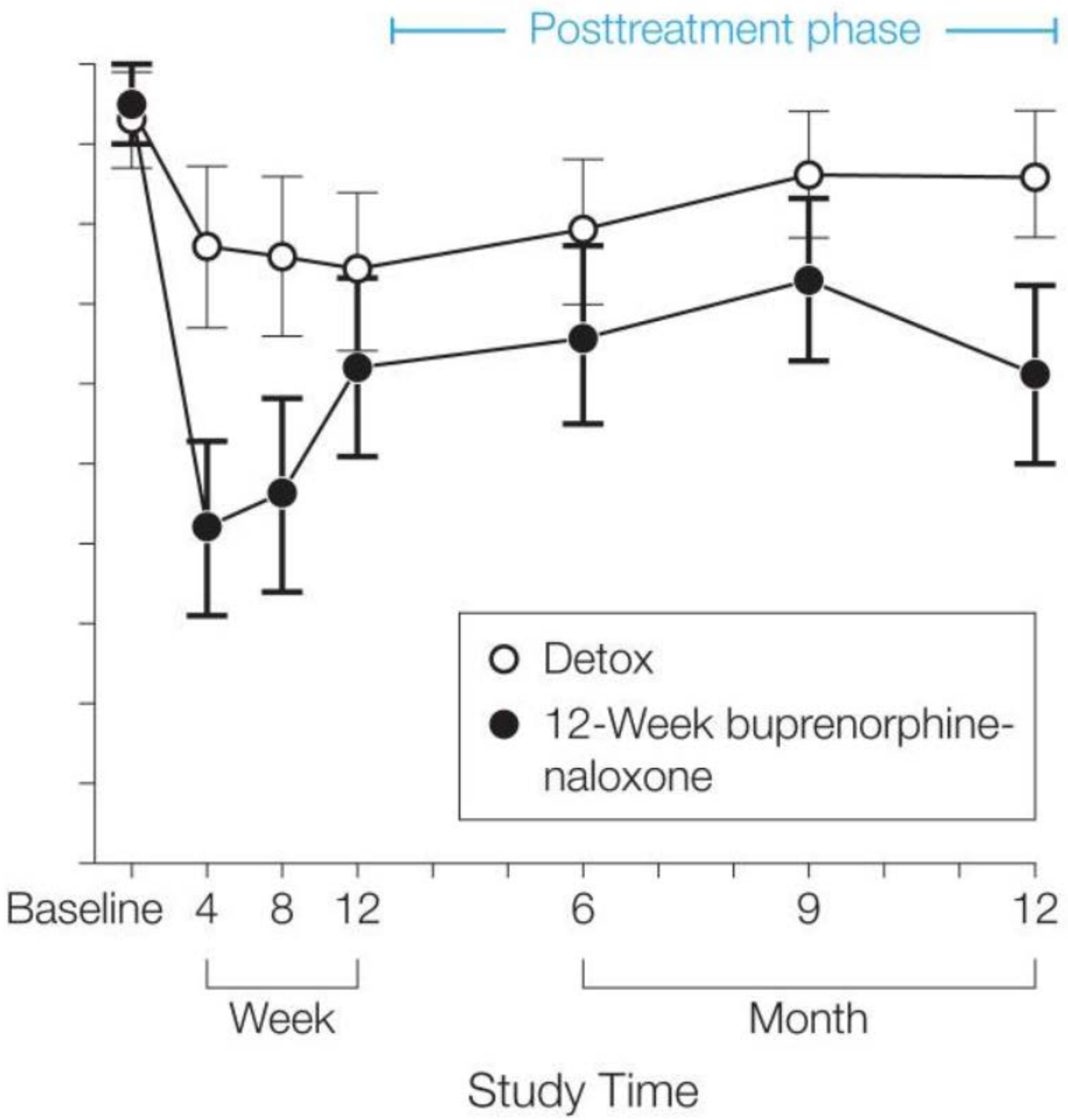
- Pushback against sense of parental dependence and restriction

- Prominence of **co-morbidity**



CTN Youth Buprenorphine Study

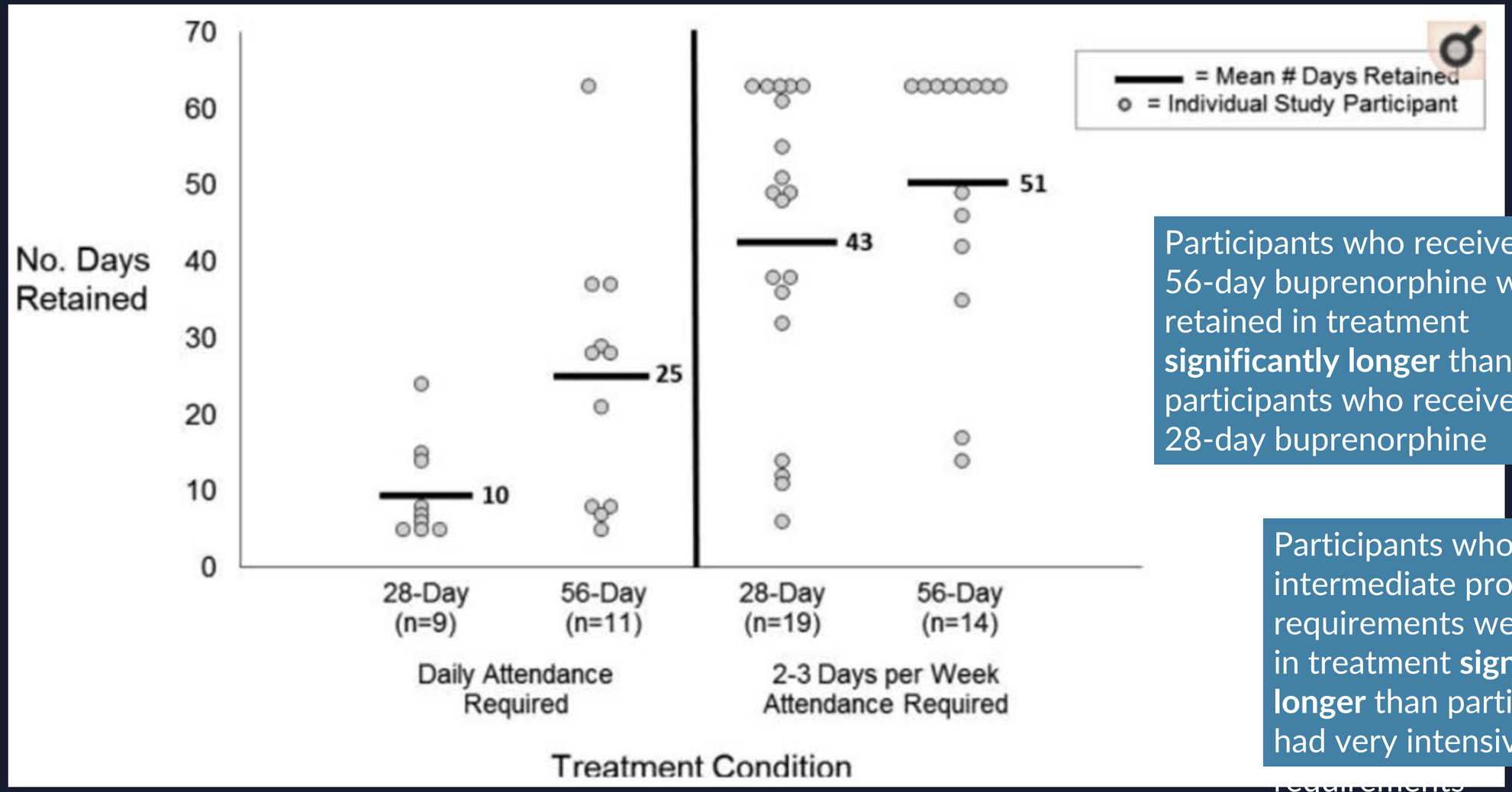
Opioid Positive Urines:
12 Weeks Buprenorphine vs. Detox



Woody et al JAMA 2008

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

Participants who had intermediate program requirements were retained in treatment **significantly longer** than participants who had very intensive program

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

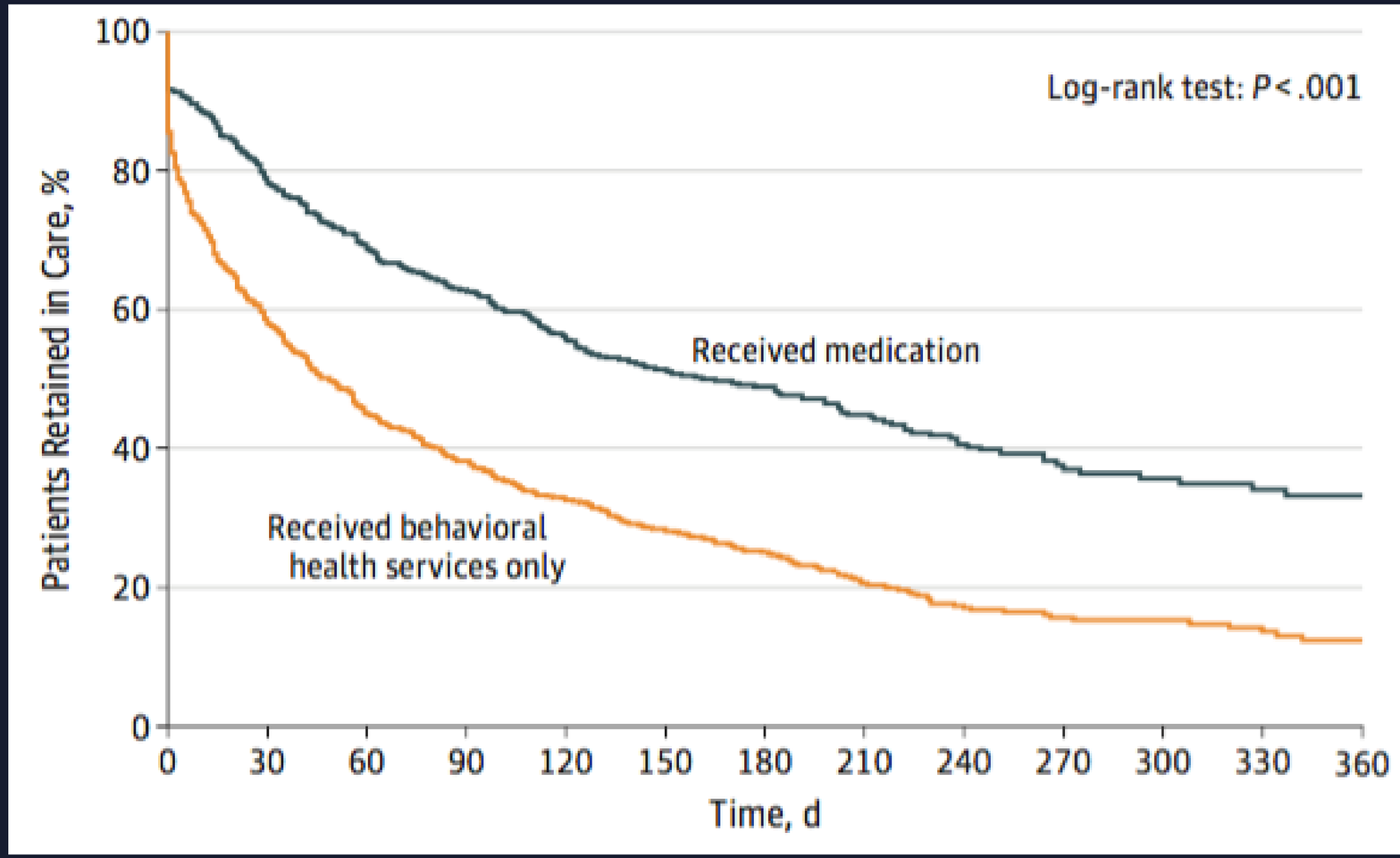
Marc J. Fishman[1,2], Erin L. Winstanley[3,4], Erin Curran[1,2], Shannon Garrett[2] & Geetha Subramaniam[1,2]

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 extended release naltrexone
- 16 youth initiated outpatient treatment
- 10 youth retained at 4 months
- 9 youth “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 years)



Hadland et al. JAMA Pediatrics 2018

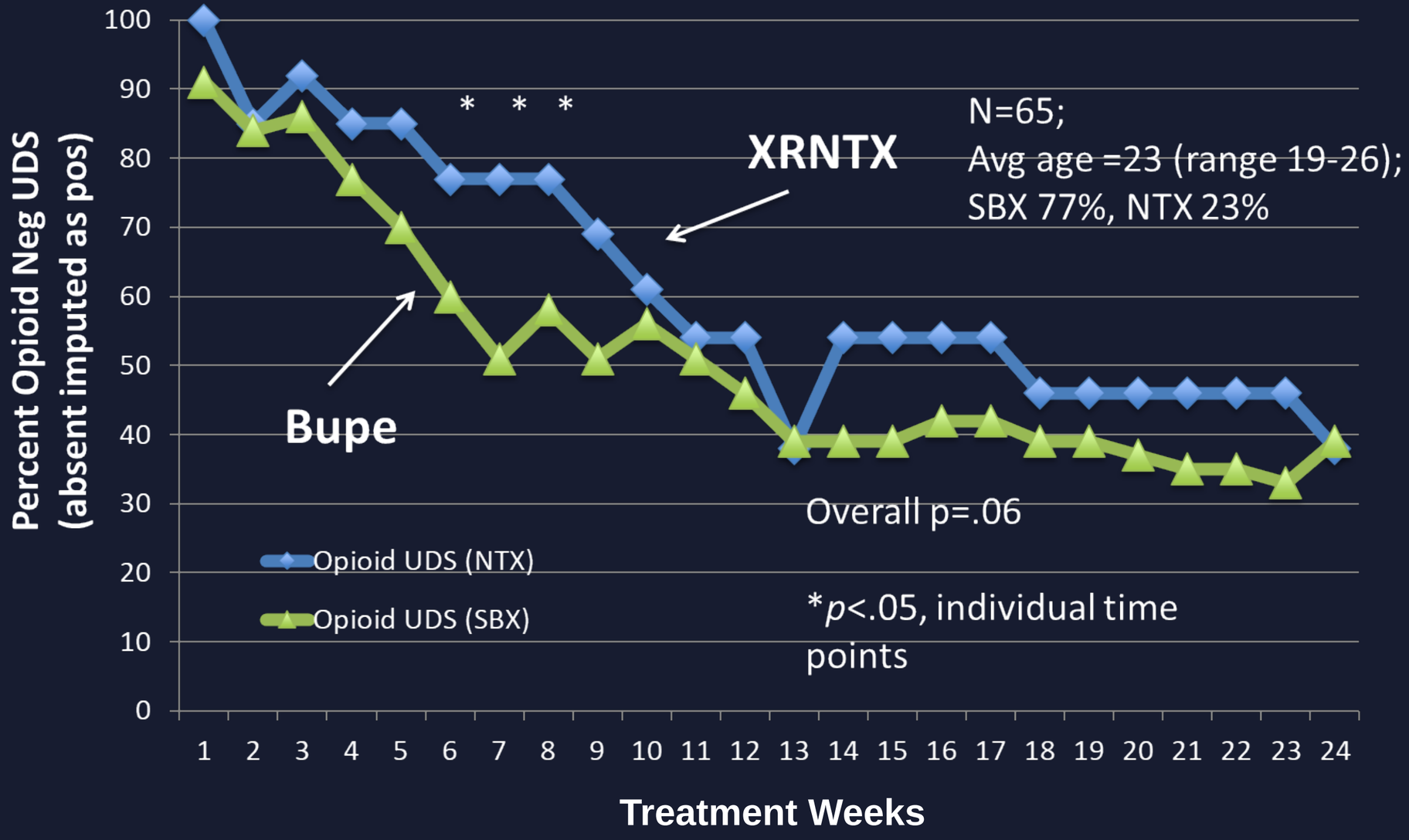
MOUD for Adolescents and Young Adults

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

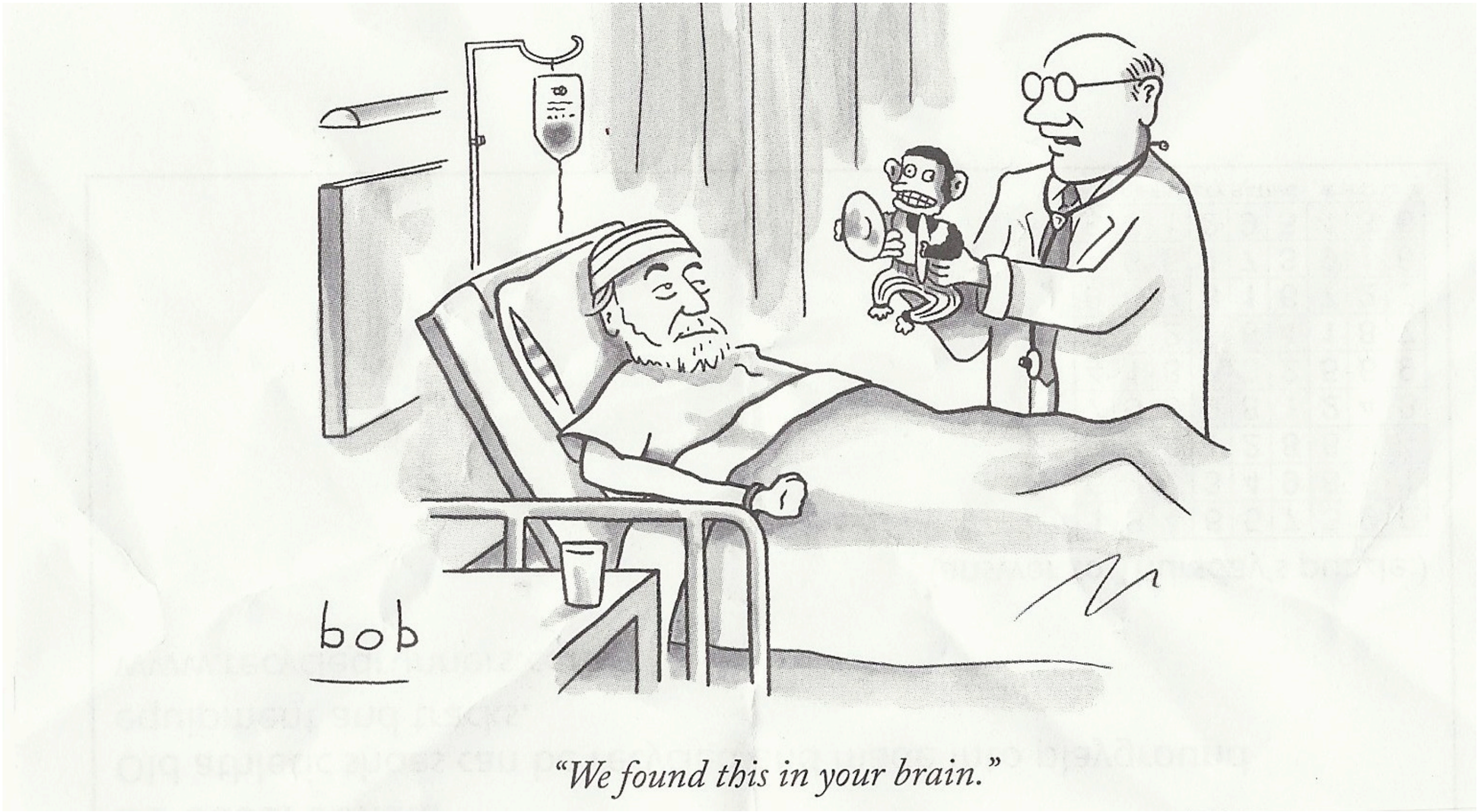
Young Adults

Enrolled in Specialty Intensive Outpatient (IOP)



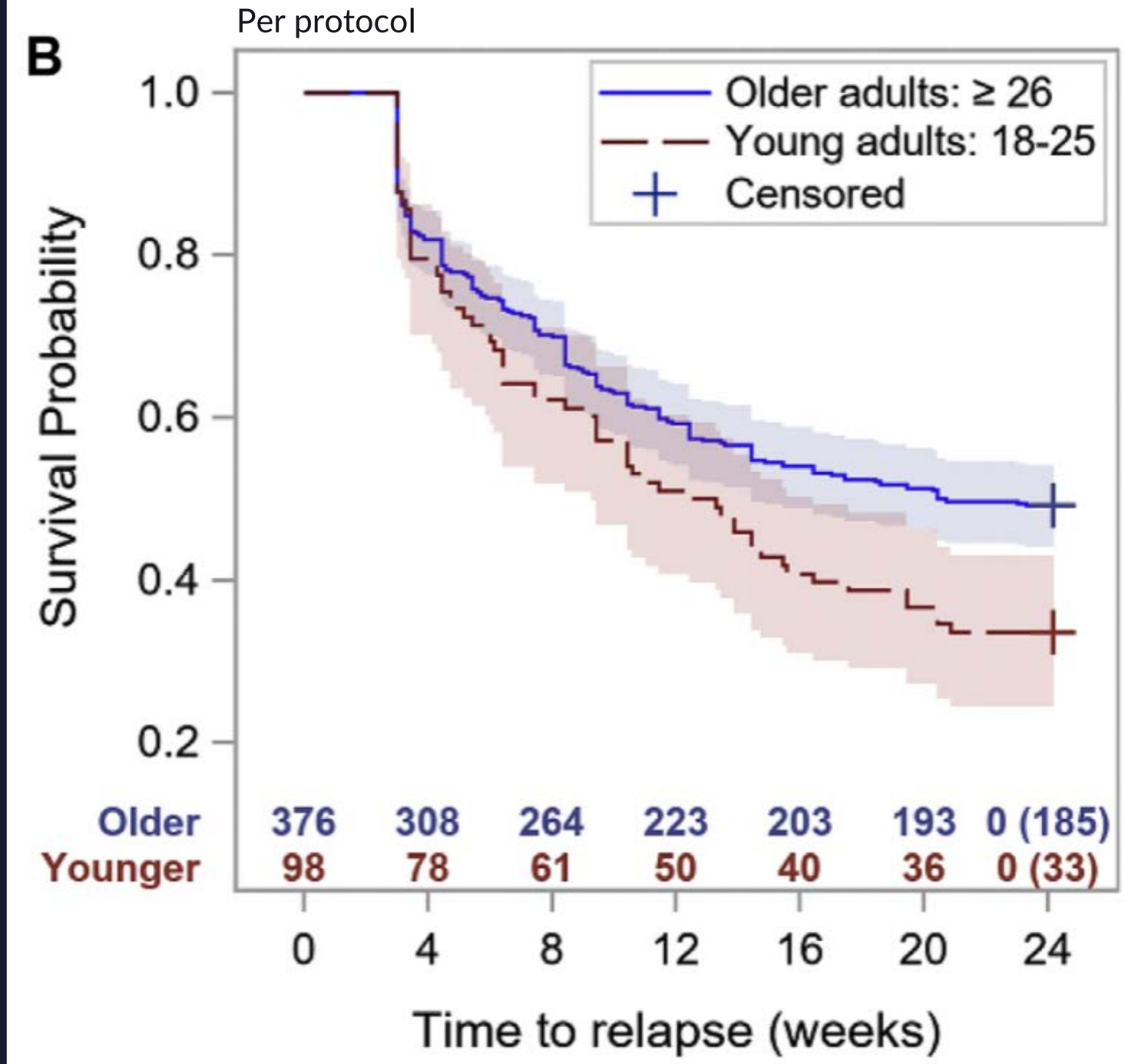
Vo et al. Relapse Prevention Medications in Community Treatment for Young Adults with Opioid Addiction. *Substance Abuse*. 2016

If only it were that easy



"We found this in your brain."

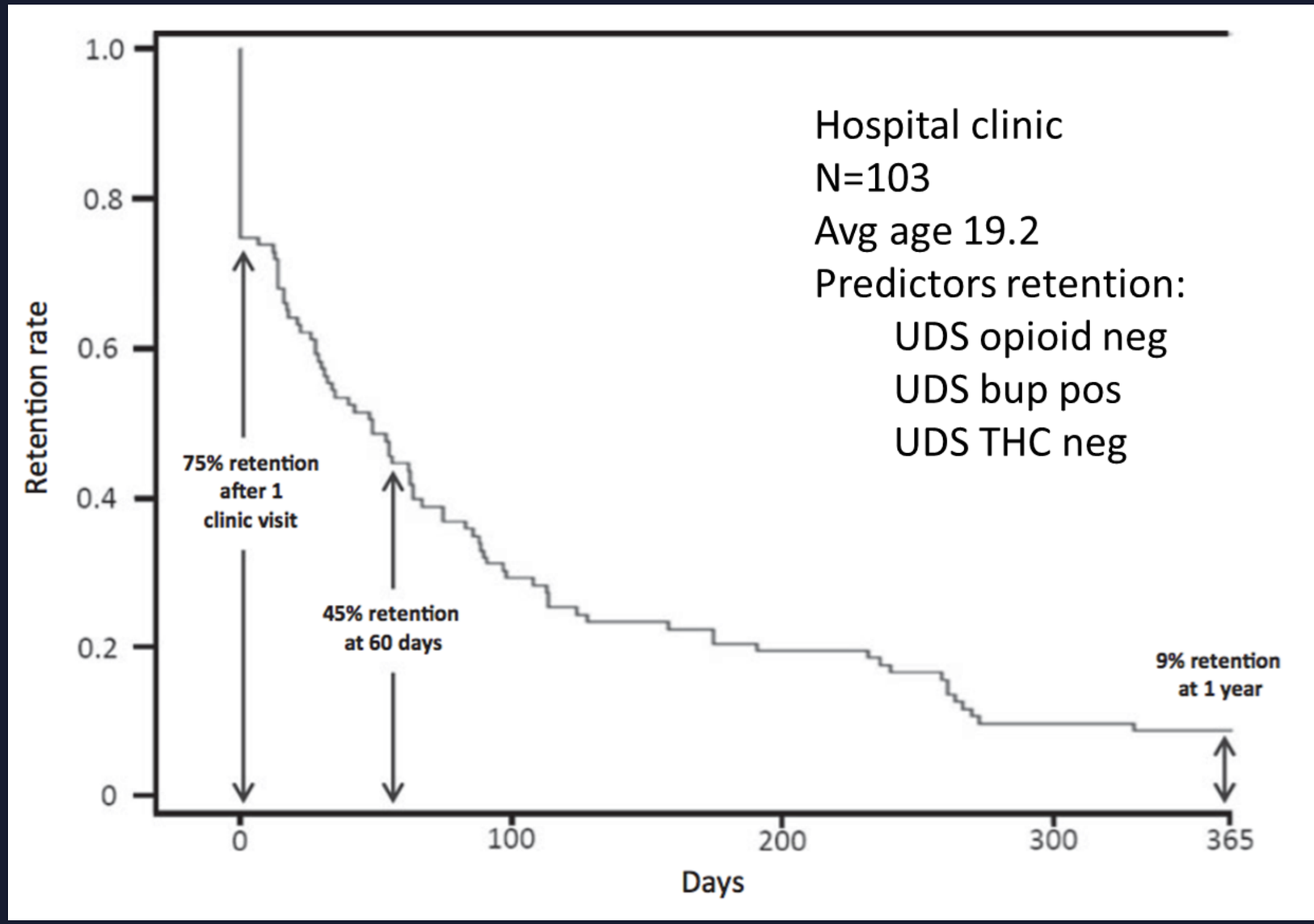
Young adults have worse outcomes vs. older adults: XBOT Secondary Analysis



Fishman M et al. J Adol Health 2020. In press.

Per protocol

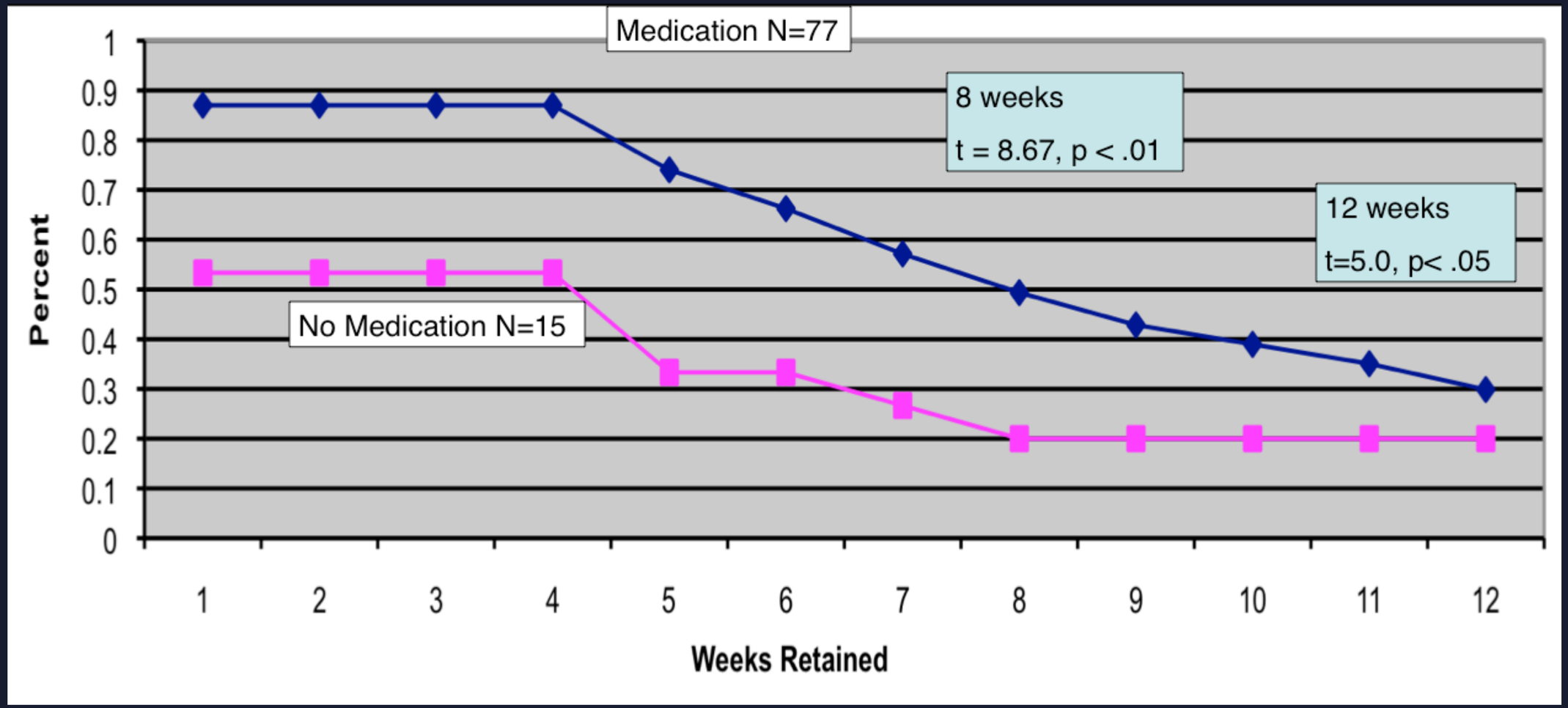
Youth Bup OP Longer Term Retention



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

Adolescents and Young Adults Referred to Co-Located IOP Linkage and Retention:

Medication (bup or xr ntx) vs. no medication, naturalistic treatment



MOUD feasible for youth in real world
But poor adherence in community treatment

- Treatment received in acute residential followed by multiple community providers, youth 15-21, N=288
  - XRNTX 28%, Bup 33%, No meds 39%

- Over 6 months following residential discharge **low rates of MOUD** use:
  - XRNTX: mean doses 1.3
    - 41% 1st OP dose
    - 12% 3rd OP dose
    - 2% 6th OP dose
  - Bup: mean days 57

- Retention in treatment and currently receiving MOUD **higher for the bup group** than XR-NTX or no medication at 6 months

- Self-reported opioid **use lower for XR-NTX group** than bup and no meds at 3 and 6 months

- Meeting OUD criteria **lower for XR-NTX** no meds at 3 and 6 months, and then bup at 3 months

New Directions

Increased emphasis on MOUD

Engaging families and assertive treatment

Primary care delivery

Primary Emphasis on MOUD

- High effect sizes
- Prevention of **overdose and death**
- Reduces barriers
- Familiar and easy to **conceptualize**

MAJOR REVISION

Psychosocial treatment is recommended in the treatment of adolescents with opioid use disorder. A patient's decision to decline psychosocial treatment or the absence of available psychosocial treatment should **not preclude or delay pharmacological treatment** of opioid use disorder, with appropriate medication management.

Motivational interviewing or enhancement can be used to encourage patients to engage in psychosocial treatment services appropriate for addressing their individual needs.

Rationale:

- The risk benefit balance of pharmacological treatment without concurrent psychosocial treatment should be carefully considered and discussed with the patient and her or his parent or guardian as appropriate.
- A requirement for psychosocial treatment can present barriers to access to treatment for some patients and is not consistent with the evidence base.

Example of Innovative Intervention

Youth Opioid Recovery Support

Assertive Outreach

+

Family Involvement

+

Medication Home Delivery

+

Incentives for Medication

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**

Poster Child?

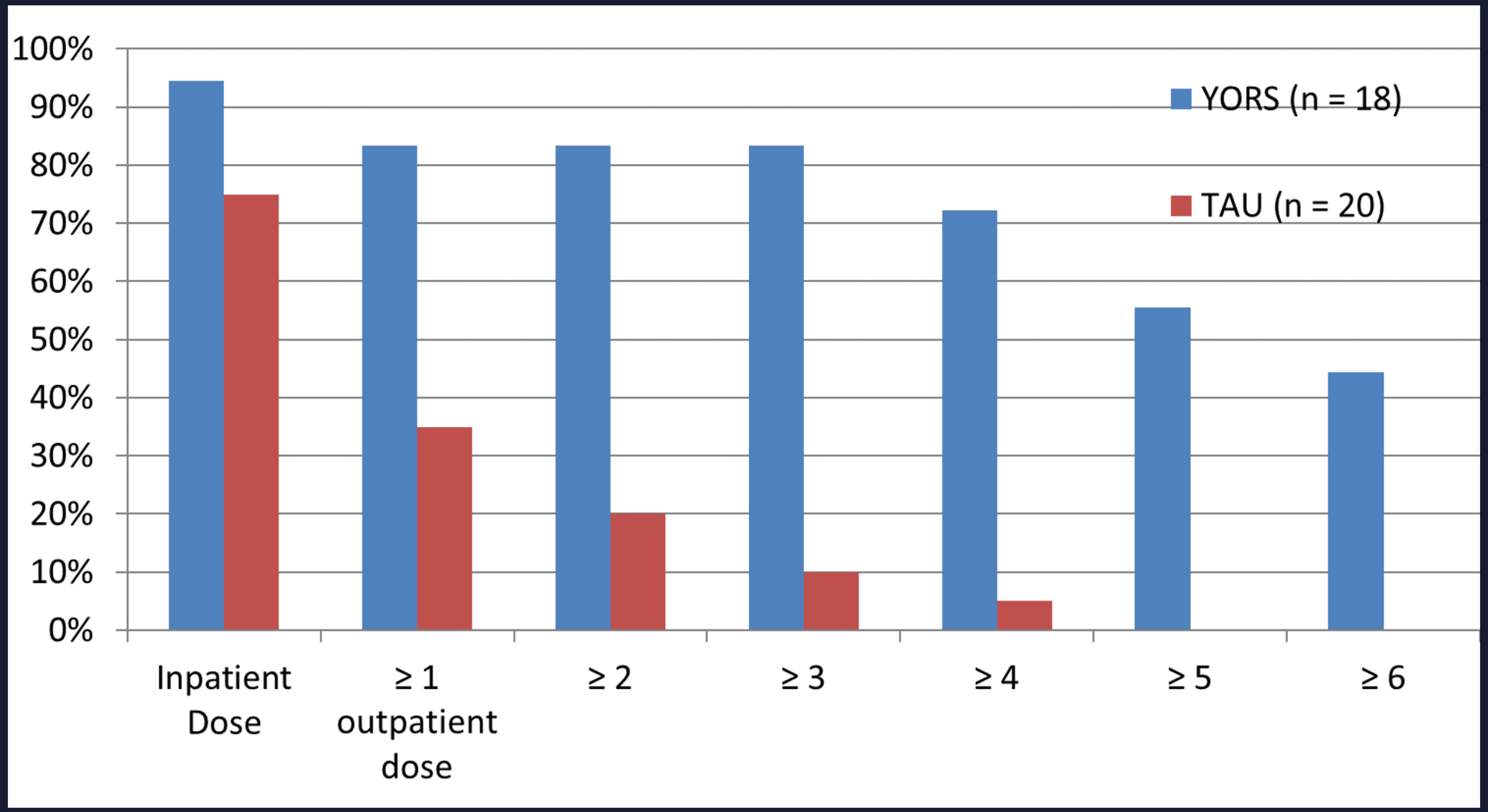
- 21-year-old male **injecting heroin**
- 5 inpatient detox admissions over **1.5 years**, each time got first dose of extended release naltrexone but never came back from 2nd dose
- Lives with GM, team shows up with dose, he says no thank you, she says no not an option, done deal, **gets 6 doses**

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

Per protocol

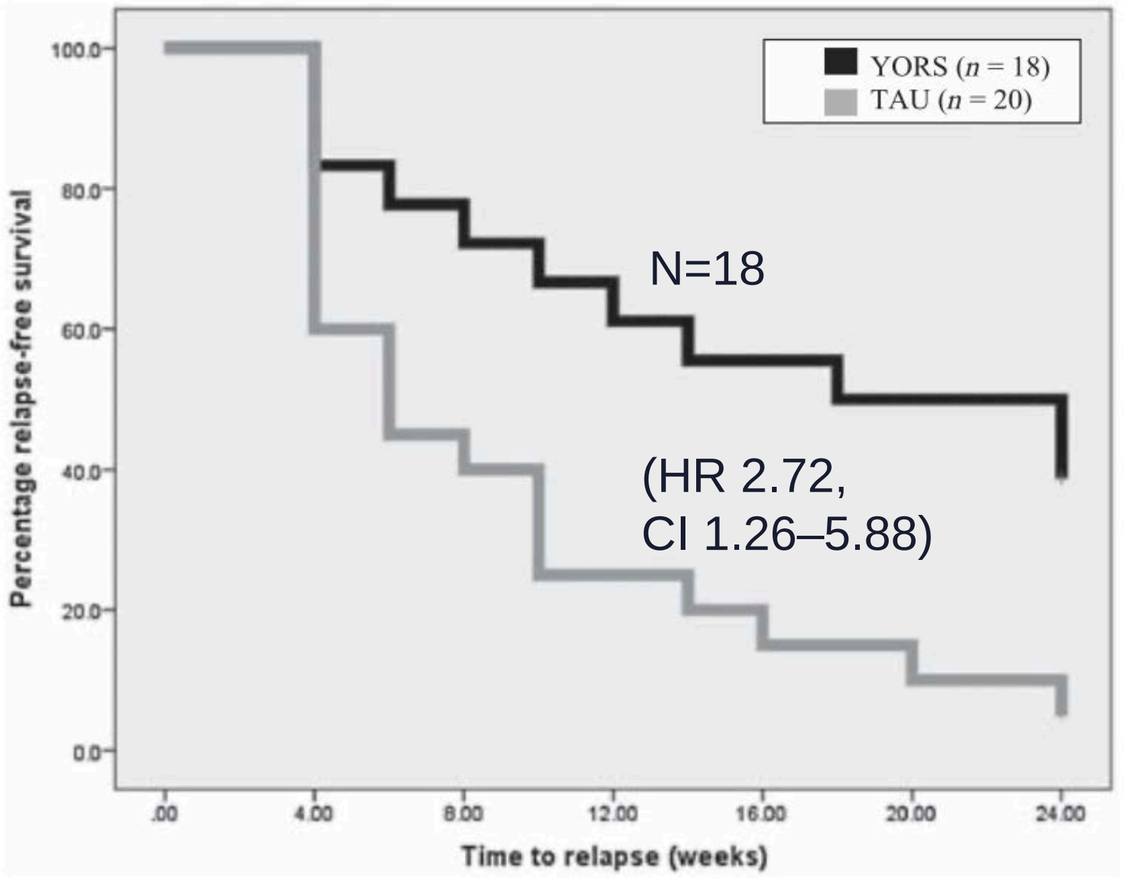
Receipt of Cumulative XR-NTX Doses

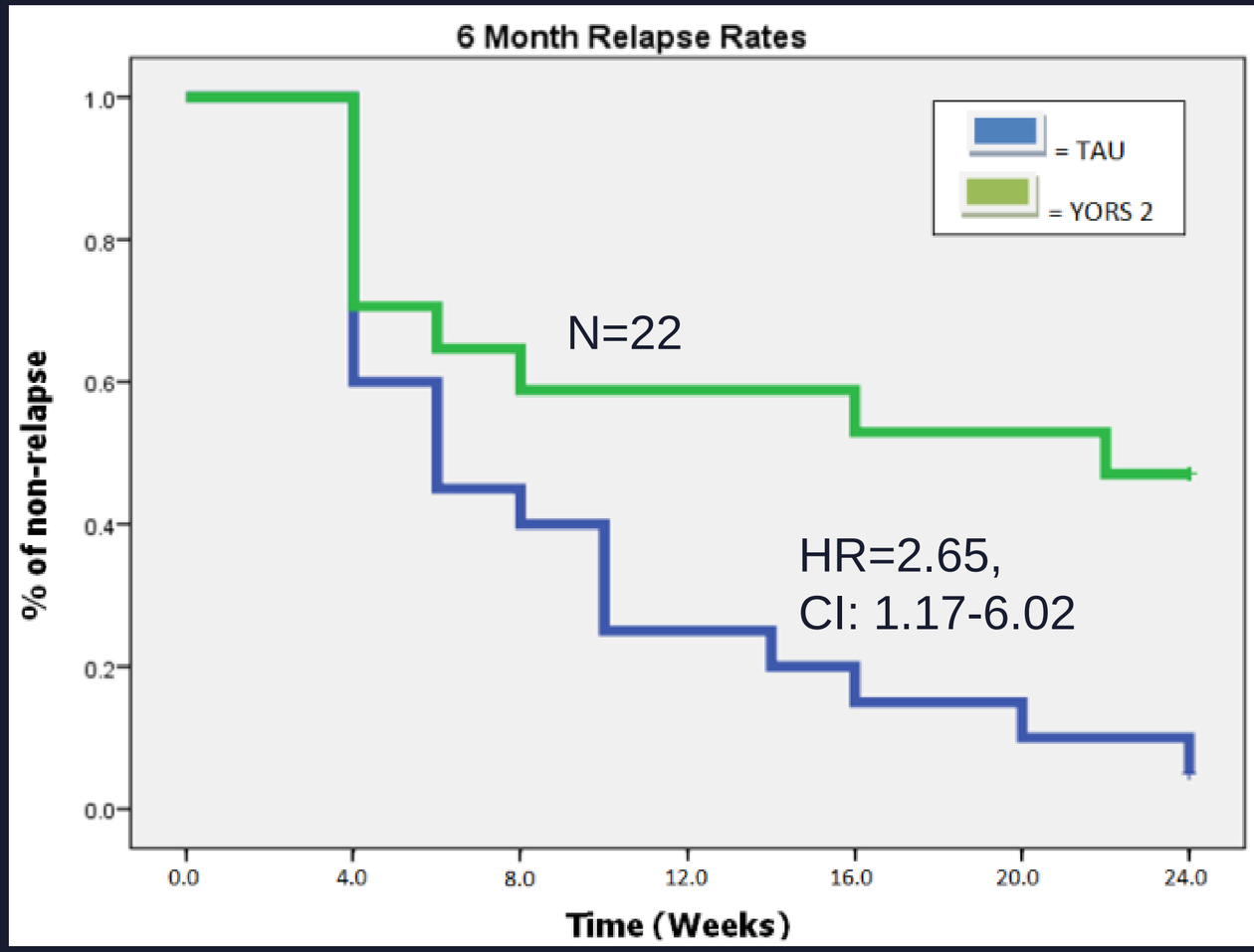


Fishman M, et al. *Addiction.* In press. 2020.

Per protocol

YORS Outcomes: Opioid Relapse-Free Survival





Fishman M, et al. *Addiction.* In press. 2020.
Wenzel K, et al. *JSAT*. Under revision. 2020.

Example of Innovative Intervention
Primary Care Delivery, Hub and Spoke

- MOUD in youth serving primary care (**spokes**)
- Consultation and support from regional special center (**hub**)

Levy S, et al. A Novel Approach to Treating Adolescents with Opioid Use Disorder in Pediatric Primary Care. *Substance Abuse.* 2018

Conclusions

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!**

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 hospital, criminal/juvenile justice

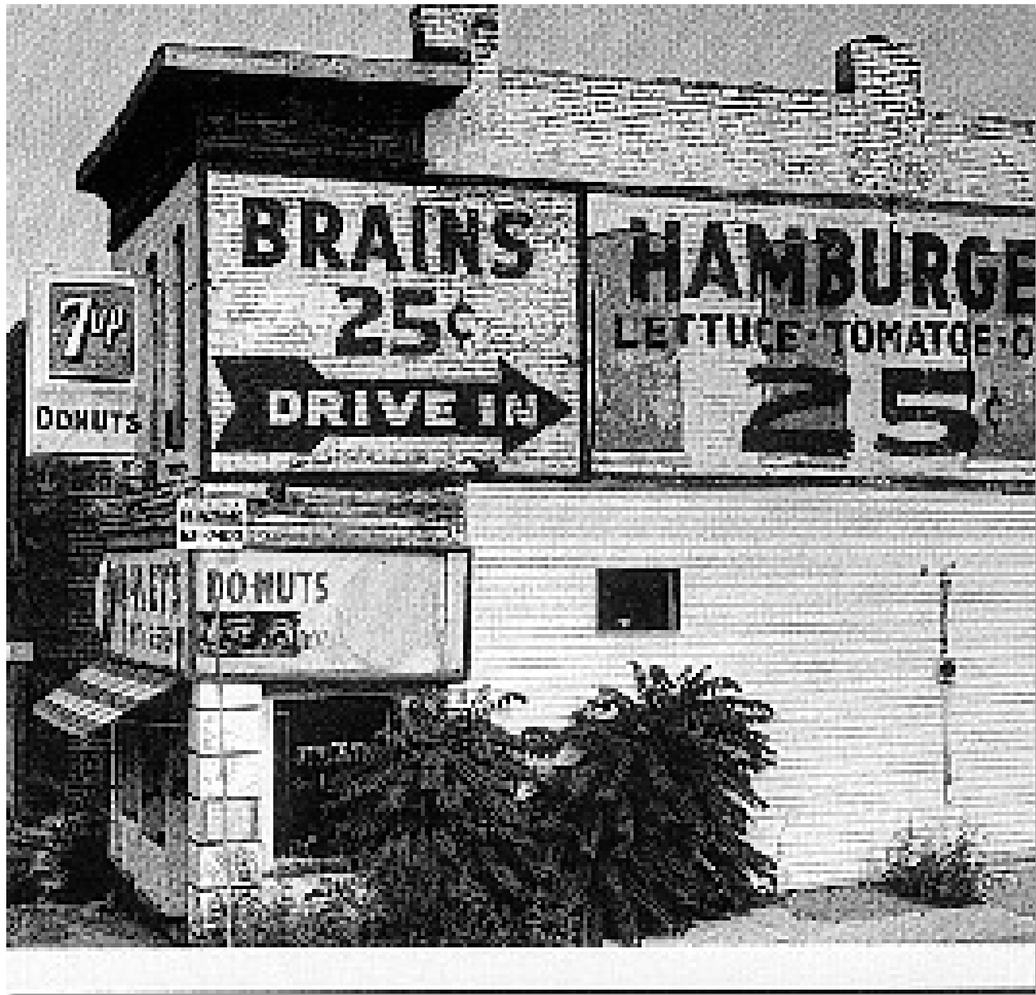
Recommendations
Not-So-Low Hanging Fruit

- Development of innovative approaches needed to **improve engagement and retention**, especially 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
- ASAM guidelines, emerging research and clinical consensus support **aggressive treatment of youth** with OUD including MOUD
- Therapeutic optimism remains one of our best tools!
- We are saving lives, **but we need to do better**
- If not now, then when?

Hypothetical miracle cures?



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AUDIENCE Q & A

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THANK YOU.