Treatment of Opioid Addiction in Adolescents and Young Adults

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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

NSDUH, 2014
+ Difference between this estimate and the 2014 estimate is statistically significant at the .05 level.
Young adults highest prevalence for Heroin

Figure 13. Past Year Heroin Use among People Aged 12 or Older, by Age Group: Percentages, 2002-2014

NSDUH, 2014

+ Difference between this estimate and the 2014 estimate is statistically significant at the .05 level.
What should we do with this case?

• 18 M
• 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?”)
Features of youth opioid treatment

• Developmental barriers to treatment engagement
  – Invincibility
  – Immaturity
  – Motivation and treatment appeal
  – Salience of burdens of treatment
• Variable effectiveness of family leverage (or not)
• Pushback against sense of parental dependence and restriction
• Prominence of co-morbidity
Residential treatment

- Young adult (n=292) outcomes at 12 month: opioid dependent (25%) had 29% 90d abstinence, greater return to inpatient and greater outpatient utilization.

(Schuman-Olivier. DAD. 2014)
Pharmacotherapy Detoxification in adolescents

• Retention at 4 wk (n=36):
  Bupe (72%) vs clonidine (39%)

Marsch. Arch Gen Psych. 2005

Figure 1. Participant retention in detoxification treatment by medication condition.
CTN Youth Buprenorphine Study
Opioid Positive Urines: 12 weeks Bup vs Detox

Predictors of success
Secondary analyses CTN 10

• Predictors of retention: Early adherence to Rx, early opioid neg UDS, any medication treatment in the month prior, non-heroin use. Early adherence to psychosocial and use of sleep Rx sig initially but lost independent sig in multivariate (Warden Addictive Behaviors 2012)

• Predictors of abstinence: Early abstinence, additional non-study treatments, injection use, more severe medical /psychiatric problems (Subramaniam JAACAP 2011)
Youth bup OP longer term retention

Hospital clinic
N=103
Avg age 19.2
Predictors retention:
  UDS opioid neg
  UDS bup pos
  UDS THC neg

Matson et al.
*J Addict Med.* 8:176-82.2014
Retention bup treatment young adults vs older adults

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

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

Opioid Negative UDS (absent imputed as pos)

Overall \( p = .06 \)

\( * p < .05 \), individual time points

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

N=65; Avg age = 23 (range 19-26); SBX 77%, NTX 23%

Treatment Weeks
Youth bupe taper -- 56d vs 28d

43% UDS neg vs 9%
N=53

Some conclusions

• Medications feasible and effective (Bup better than no bup)
• Longer bup better than shorter bup
• Residential (with and without bupe) effective as a component of continuum
• XRNTX promising but adherence problematic
• Initial exploration of moderators/mediators
  – Early adherence and success
  – ? Other substances esp MJ
  – Concurrent psychiatric treatment
If only it were that easy

"We found this in your brain."
Emerging models of care
Elements of recommended treatment model

• Emphasis on ongoing engagement from detox to next levels of care (the revolving door should lead somewhere)
• Specialty care
• Longitudinal follow-up and management
• Integration of relapse prevention medication as standard of care
  – Buprenorphine
  – Extended release naltrexone
• Counseling and mutual help
• Co-occurring (dual diagnosis) treatment
Residential/ Inpatient Treatment

• Detoxification, withdrawal management
• Crisis stabilization
• Assurance of temporary abstinence
• Role induction for next step of treatment
  – Detox/residential stay is NOT at CURE
  – First battle in a long war
  – Engagement/transition into outpatient treatment
• Readmission booster for relapse
Continuing care

- Start weekly prescription supply for bupe, increase duration of Rx duration over time, used as contingency management
- Monthly injections for xr-ntx
- Expectation of counseling attendance
- Opioid-specific group
- Frequent urine monitoring
- Psychiatric treatment
Choice of medication: Bupe vs XR-NTX

- Patient preference
- Family preference
- Failure of other treatments, try something new
- Side effects, anxious anticipation
- Long acting duration of xr-ntx for poor treatment engagement and adherence
- Bupe intrinsically reinforcing
- More familiarity with bupe, pos and neg reputation
- Problems with acceptability of agonist pharmacotherapies
- More tools in the toolbox
Conceptual underpinnings

• Use as many effective tools as are available
• One size does not fit all: as many doors as possible
• A full continuum of care: multiple services with flexible responses
• Expectation of relapsing/remitting course
• Expectation of variable and shifting treatment readiness
• Recovery as a gradual process, not an overnight event -- expectation of incremental progress
Maintaining credibility in the real world: Medications, mischief, and monkey business

- Side effects
- Diversion
- Non-compliance
- Drop-out
- Inconsistency
- Other substances
What’s the active ingredient?

• Question:
  Which is better – medications or counseling or meetings?

• Answer:
  Yes
New directions
Tensions in emerging models

• Stagewise matching:
  – Contemplation/preparation vs action
  – Severity
• Intensity and structure vs reduction of burden and accessibility
• Treatment fatigue, early and less early
• Clear bright line on all intoxicants vs graduated tolerance of MJ/ETOH
• Parental involvement vs youth autonomy
Family Framework
Rationale

• Addressing family conflicts, which are often barriers both for the youth and the parents, usually leads to improvement
• Natural tensions over issues of independence, control, confidentiality, trust, autonomy etc, can usually be addressed and negotiated successfully
• Parents’ natural strengths in supporting their children can be used effectively in support of treatment and recovery
• While personal transformation is the responsibility of the youth, parents can have a particularly effective role in supporting adherence to professional treatment and its delivery, reinforcing behavioral change, and promoting the self-efficacy of their young adult child
Family Framework

• Family mobilization – “Medicine may help with the receptors, but you still have to parent this difficult young person”

• Both families and youth need a recipe for treatment, with role definitions, expectations, and responsibilities.

• Home delivery?
New directions:
Home based delivery of XRNTX

Figure 1. Graphic Representation of Course of Cases

- Patients (by order of enrollment)
- Months in Outpatient Treatment
- Inpt dose
- OP clinic dose
- Home dose
- Inpt
- Active
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?
A call to action
(and hypothetical miracle cures...)

[Image of a vintage diner with signs for 'Brains 25¢', 'Hamburger 25¢', and 'Donuts' with an arrow pointing right]