



Medication-Assisted Treatment of Adolescents With Opioid Use Disorders

COMMITTEE ON SUBSTANCE USE AND PREVENTION

Under Review

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Opioid use disorder is a leading cause of morbidity and mortality among US youth. Effective treatments, both medications and substance use disorder counseling, are available but underused, and access to developmentally appropriate treatment is severely restricted for adolescents and young adults. Resources to disseminate available therapies and to develop new treatments specifically for this age group are needed to save and improve lives of youth with opioid addiction.

abstract

FREE

BACKGROUND

With a renewed emphasis on treating pain directed by the US Department of Health and Human Services in 1992¹ and institutionalized by the Joint Commission on Accreditation of Hospitals in 2001,² combined with the development of potent oral opioid pain medications, exponential increases in the annual number of opioid prescriptions written by US physicians have occurred over the past 2 decades.³ Between 1991 and 2012, the rate of “nonmedical use” (ie, use without a prescription or more than prescribed) of opioid medication by adolescents (12–17 years of age) and young adults (18–25 years of age) more than doubled,^{4,5} and the rate of opioid use disorders, including heroin addiction, increased in parallel.⁶ The rate of fatal opioid overdose more than doubled between 2000 and 2013.⁷ In 2008, more than 16 000 people died of opioid pain reliever overdose.⁷ Other serious adverse health outcomes result from intravenous drug use and include endocarditis,⁸ abscesses,⁹ and infection with hepatitis C.¹⁰

Severe opioid use disorder is a chronic condition in which neurologic changes in the reward center of the brain are responsible for cravings and compulsive substance use.¹¹ The associated behavioral disruptions and change in functioning range from modest to severe; remarkably, some adolescents may continue to do well in school and in other areas of life despite severe opioid use disorder. The rate of spontaneous remission is low; however, patients can recover. Three medications are currently indicated for treating severe opioid use disorder: methadone,

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naltrexone, and buprenorphine. Methadone, a full opioid agonist with a long half-life that can ameliorate the cycle of intense euphoria followed by intense withdrawal associated with opioid use, has long been established as an effective treatment of opioid addiction, although federal regulations prohibit most methadone programs from admitting patients younger than 18 years. In 2000, the US Congress passed the Drug Addiction Treatment Act, which allows for physicians to complete 8 hours of training and apply for a waiver to prescribe buprenorphine, a partial opioid agonist, to treat opioid use disorders in general medical settings.¹² Naltrexone, an opioid antagonist with high affinity for the opioid receptor, has also proven to be an effective treatment of opioid addiction. Unlike opioid agonists, naltrexone has a very limited potential for misuse or diversion. The extended-release formulation may reduce patient adherence burden. Although there is not yet rigorous research support for efficacy in adolescents, growing experience and anecdotal reports support it as a promising practice. Naltrexone, which also reduces alcohol cravings, may be a good therapeutic option for adolescents and young adults with co-occurring alcohol use disorder, as well as those living in unstable or unsupervised housing.

In 2002, the US Food and Drug Administration approved the use of buprenorphine for patients 16 years and older.¹³ Buprenorphine is a partial opioid agonist with high affinity for the opioid receptor. Buprenorphine binding results in gentle stimulation of the opioid system, which, like methadone, can ameliorate the highs and lows associated with full agonists with short and moderate half-lives. An expansive body of research has shown the effectiveness of buprenorphine for treating adults with opioid use disorders,¹⁴ and

2 randomized controlled trials have examined the therapeutic efficacy of buprenorphine combined with substance use counseling in adolescents and young adults. Marsch et al¹⁵ found that adolescents 13 to 18 years of age who received 2 weeks of buprenorphine treatment were more likely to continue medical care compared with those who received clonidine for the same period of time. A trial conducted by Woody et al¹⁶ compared 2 detoxification regimens among adolescents and young adults 15 to 21 years of age. One group received 8 weeks of buprenorphine before tapering, and the second group received 2 weeks. Adolescents who received 8 weeks had lower rates of illicit opioid use while they were taking buprenorphine, and the differences quickly disappeared once the medication was discontinued. The findings led the authors to conclude that there is no obvious reason to stop medications in adolescent patients who are doing well on buprenorphine. Matson et al¹⁷ found that continued buprenorphine compliance is associated with an increase in treatment and can help adolescents achieve long-term sobriety. In general, youth have lower rates of treatment retention compared with adults,^{18–20} underscoring the need to deliver developmentally appropriate treatment to achieve best outcomes.

Buprenorphine has the potential for misuse and diversion because of its opioid agonist activity, although its “addiction potential” is thought to be much lower than that of full opioid agonists, such as oxycodone or heroin. Extensive experience with adults has established the evidence supporting the efficacy of buprenorphine, and although not as well studied among youth so far, research and clinical experience to date have not identified any age-specific safety concerns. Nonetheless, confusion, stigma, and limited resources severely restrict

access to buprenorphine for both adolescents and adults. Knudsen et al²¹ found that less than 50% of a nationally representative sample of 345 addiction treatment programs serving adolescents and adults offer patients medication for the treatment of opioid use disorders, and even among programs that do offer it, medication is significantly underutilized. The same study found that only 34% of opioid-dependent patients in treatment receive medication. By comparison, 70% of patients with mental health disorders in these same programs received medication. Policies, attitudes, and messages that serve to prevent patients from accessing a medication that can effectively treat a life-threatening condition may be harmful to adolescent health.

RECOMMENDATIONS

1. Opioid addiction is a chronic relapsing neurologic disorder. Although rates of spontaneous recovery are low, outcomes can be improved with medication-assisted treatment. The American Academy of Pediatrics (AAP) advocates for increasing resources to improve access to medication-assisted treatment of opioid-addicted adolescents and young adults. This recommendation includes both increasing resources for medication-assisted treatment within primary care and access to developmentally appropriate substance use disorder counseling in community settings. Pediatricians have access to an AAP-endorsed buprenorphine waiver course at www.aap.org/mat.
2. The AAP recommends that pediatricians consider offering medication-assisted treatment to their adolescent and young adult patients with severe opioid use disorders or discuss referrals to other providers for this service.

3. The AAP supports further research focus on developmentally appropriate treatment of substance use disorders in adolescents and young adults, including primary and secondary prevention, behavioral interventions, and medication treatment.

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ABBREVIATION

AAP: American Academy of Pediatrics

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