

# Treatment of Opioid Addiction in Adolescents and Young Adults

CSAT/CTN Webinar  
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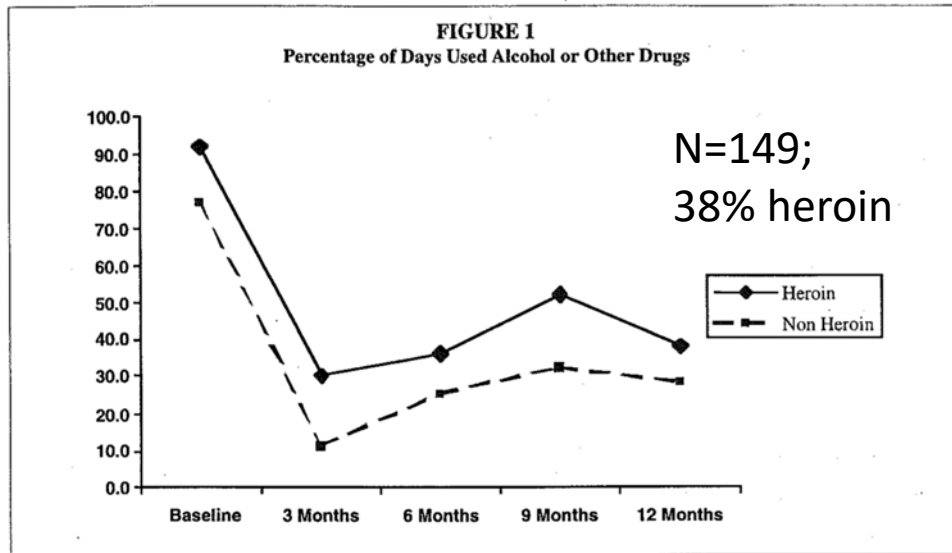
# What should we do with this case?

- 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?”)

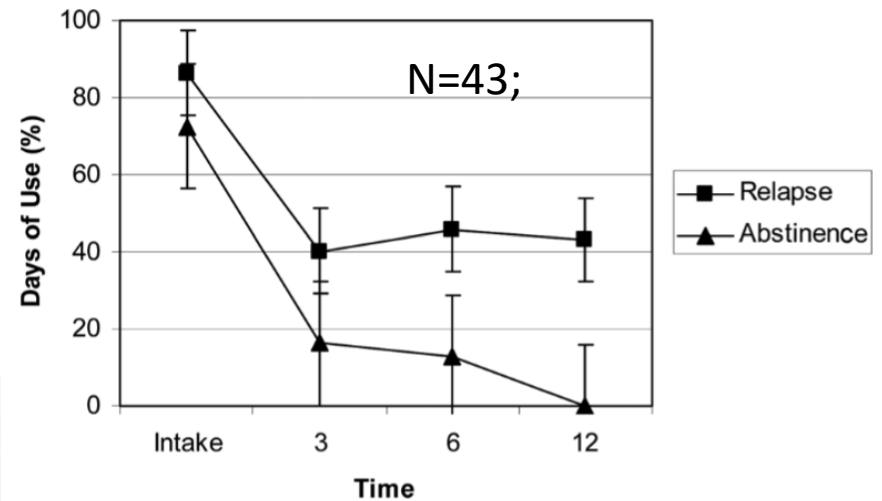
# Features of youth opioid treatment

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

# Residential treatment



Clemmey. *Psychoactive Drugs*. 2004

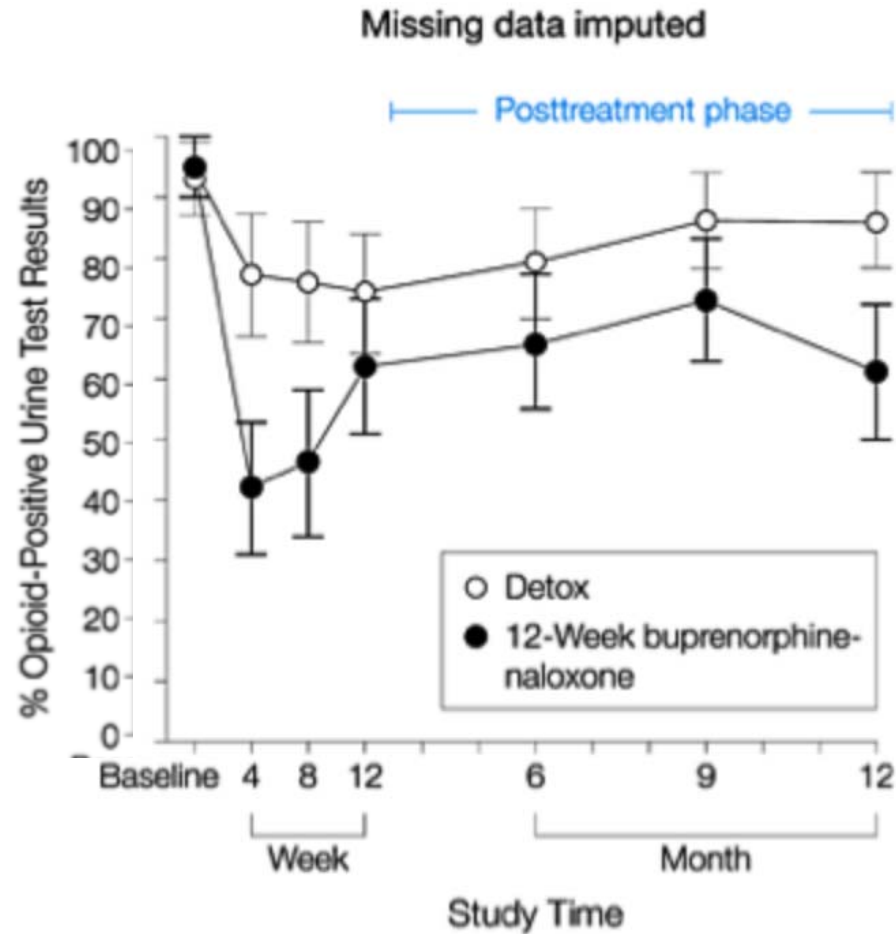


Branson. *J Child Adol Sub Abuse*. 2012

- Young adult (n=292) outcomes at 12 month: opioid dependent (25%) had 29% 90d abstinence (similar to opioid misuse and no opioid use). Opioid dependent had greater return to inpatient and greater utilization outpatient. (Schuman-Olivier. *DAD*. 2014)

# CTN Youth Buprenorphine Study

## Opioid Positive Urines: 12 weeks Bup vs Detox



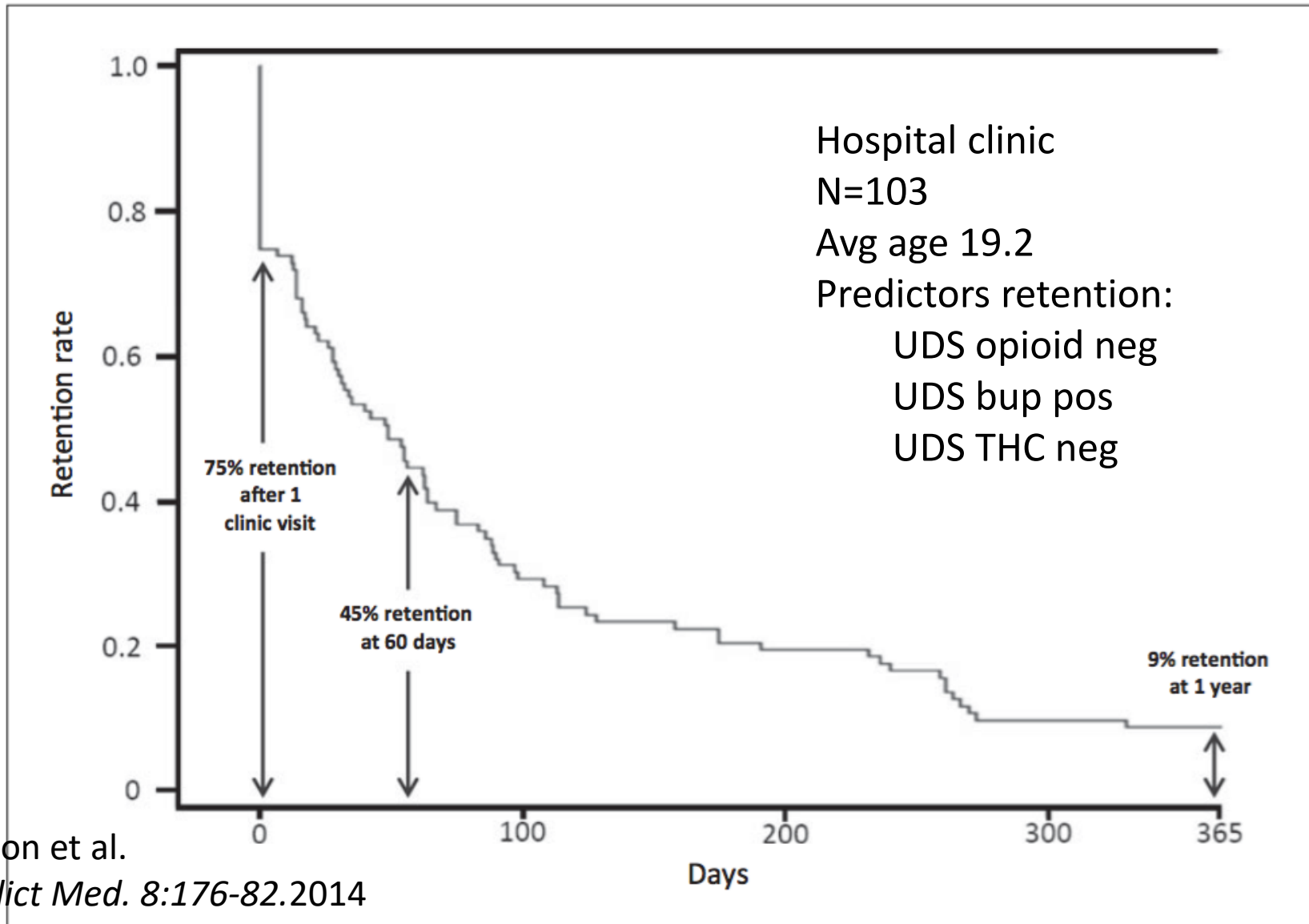
Woody et al JAMA. 2008.

# Predictors of success

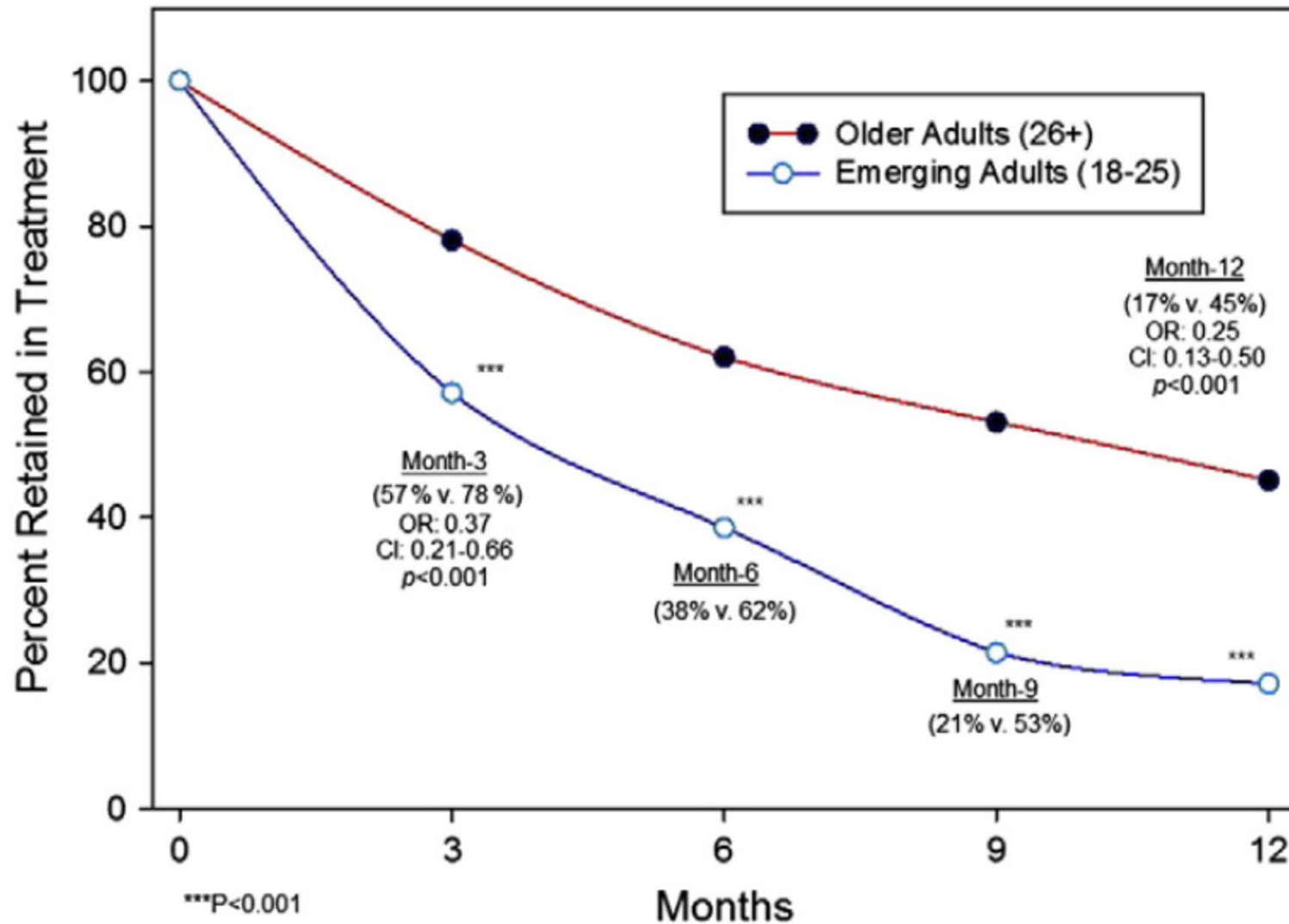
## Secondary analyses CTN 10

- 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



# 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

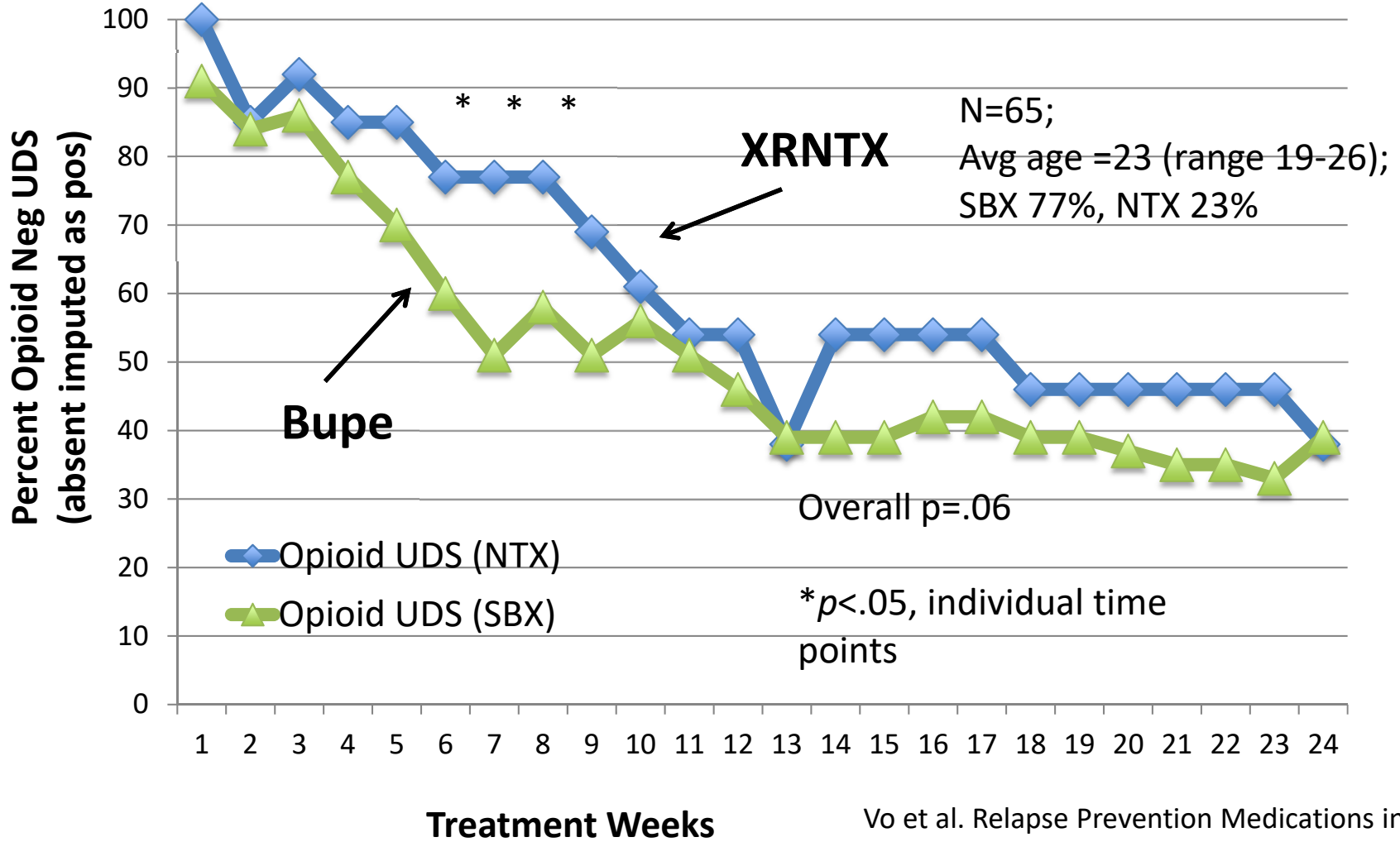
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- 20 youth received xr-ntx
- 16 initiated OP treatment
- 10 retained at 4 months
- 9 “good outcome”

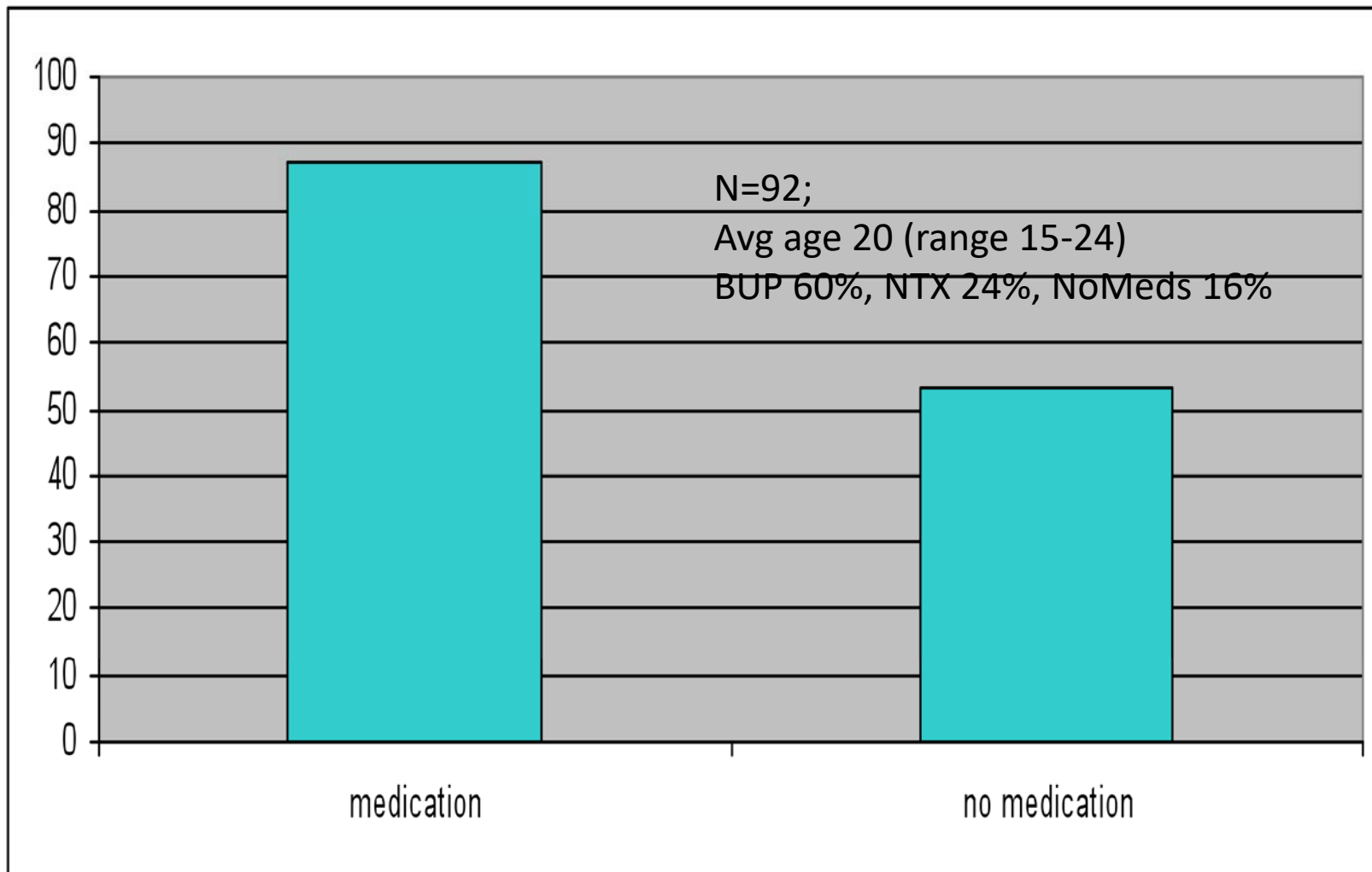
# Program #1: Young adults

## Opioid Negative UDS (absent imputed as pos)

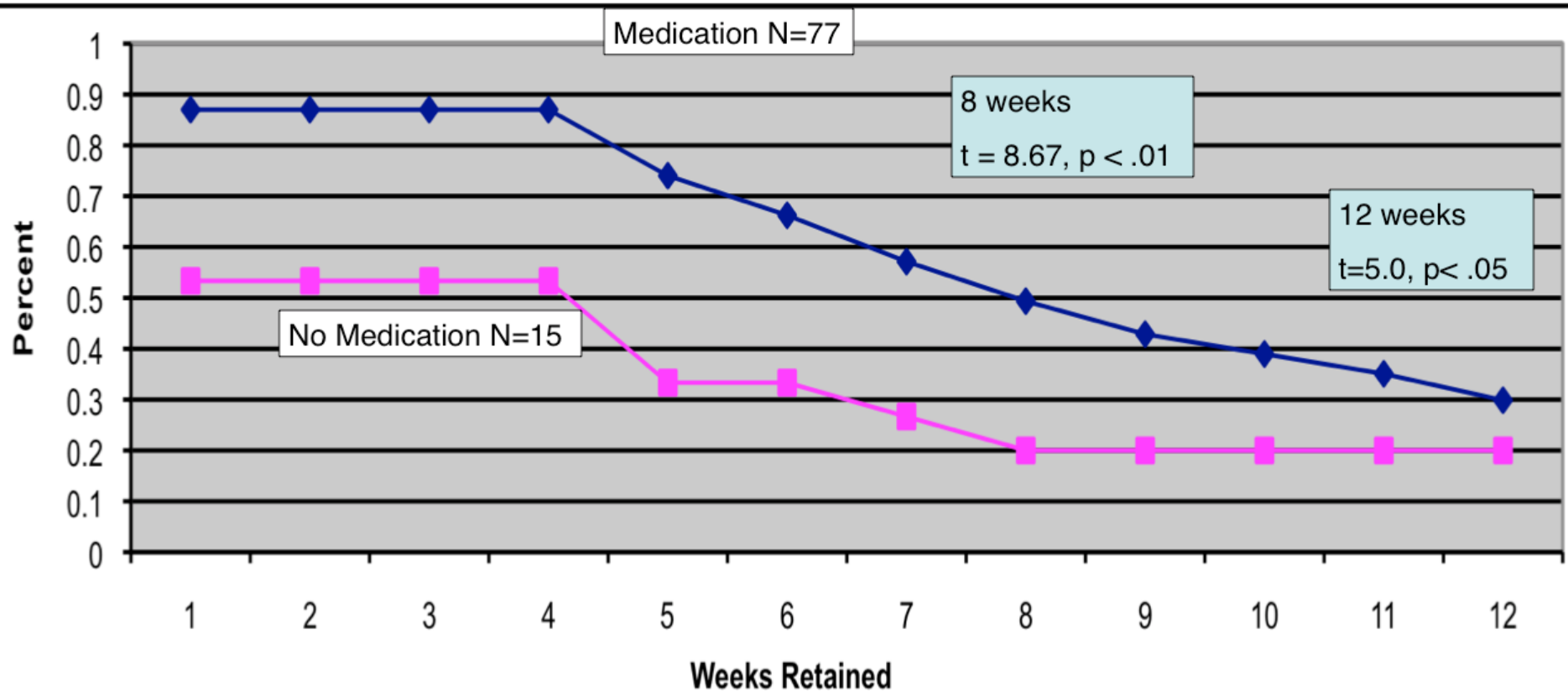


Vo et al. Relapse Prevention Medications in Community Treatment for Young Adults with Opioid Addiction. *Substance Abuse*. 2016

## Program # 2: Adolescents, Young Adults Initiation

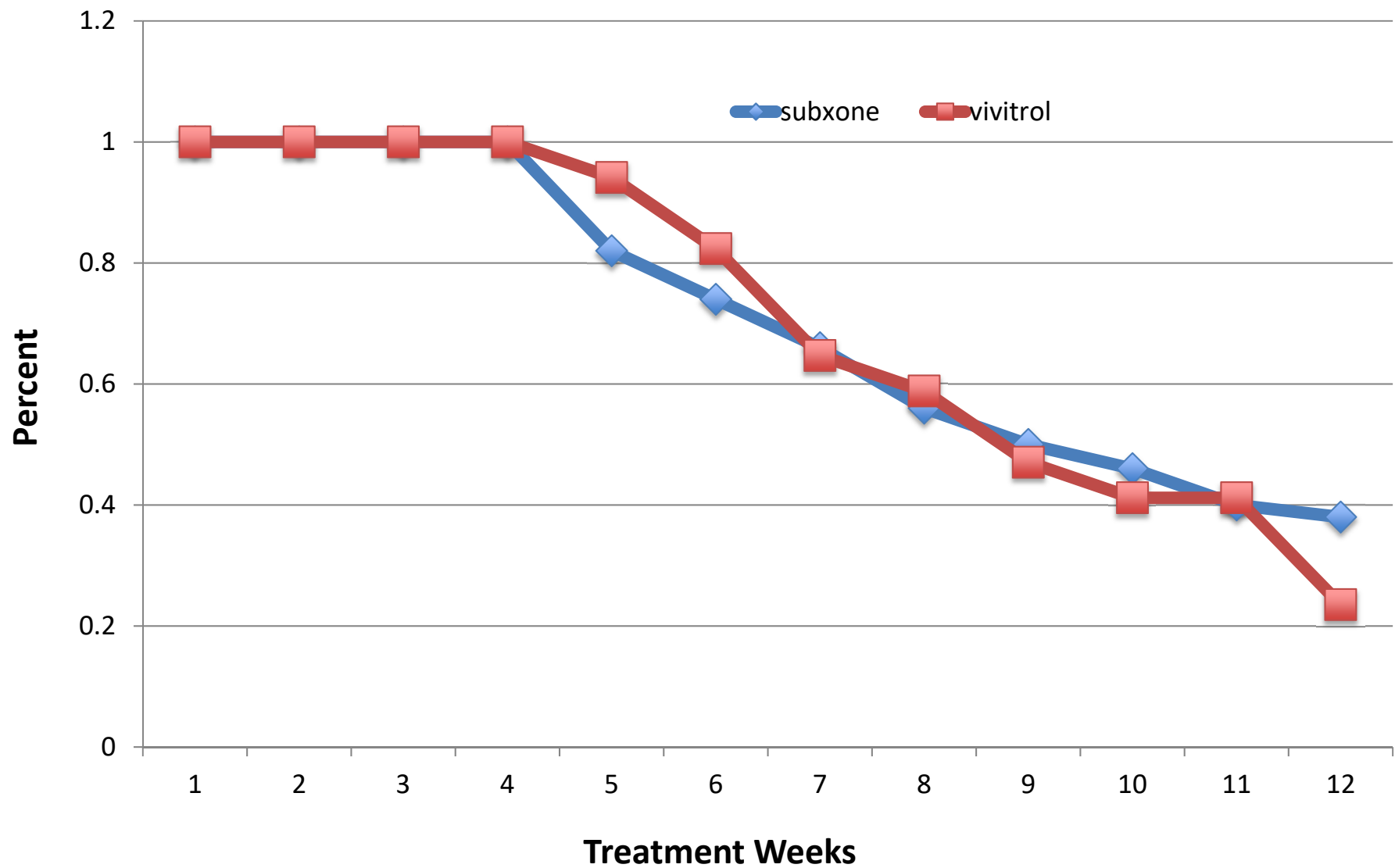


# Program # 2: Adolescents, Young Adults Retention: Medication vs no medication

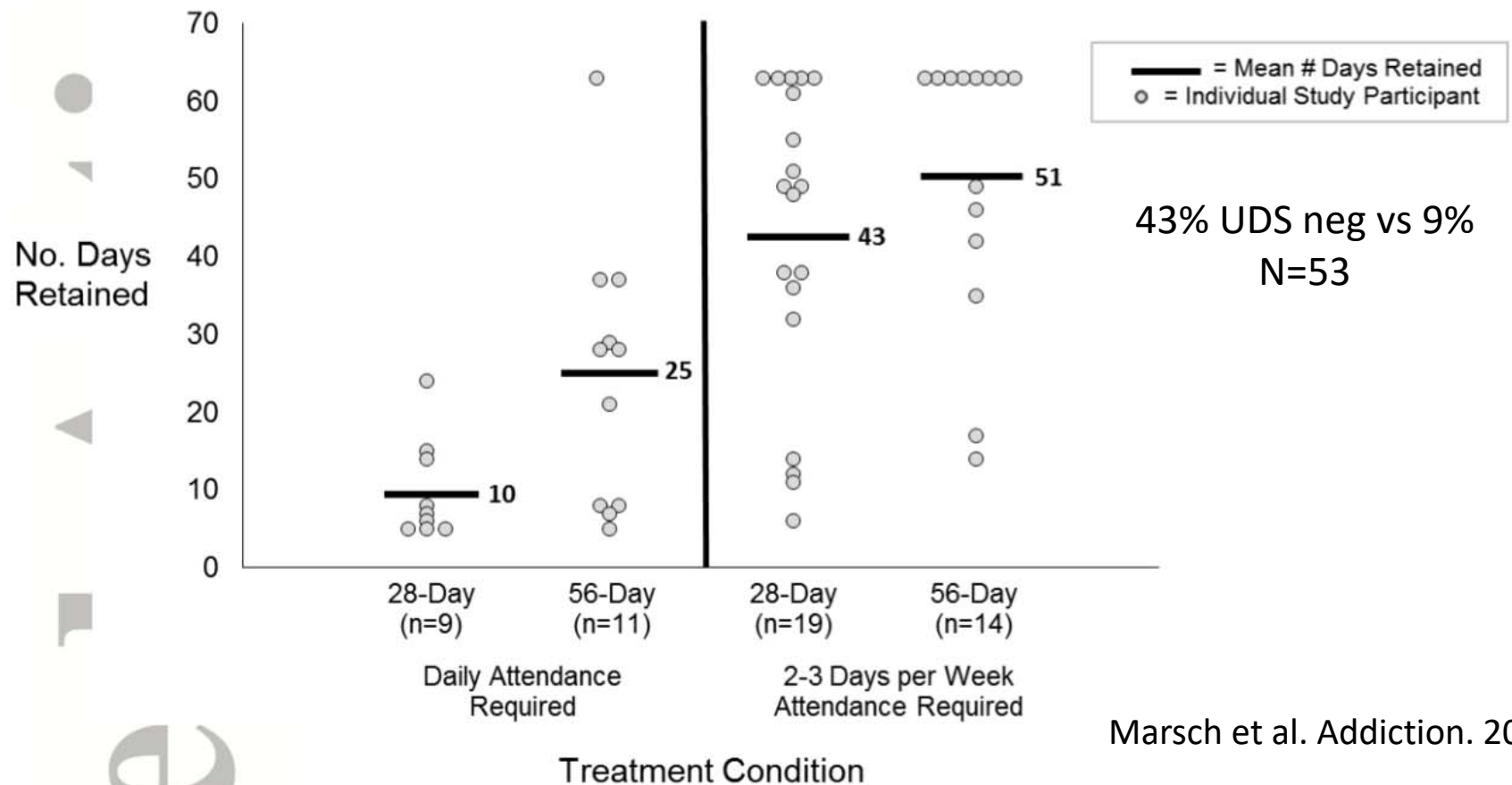


# Program # 2: Adolescents, Young Adults

## Retention: XRNTX vs Bup



# Youth bup taper -- 56d vs 28d



Marsch et al. Addiction. 2016

**Figure 2. Mean Percent of Urine Screens Documented as Opioid Negative by Buprenorphine Treatment Condition Before and After Changes in Attendance Requirement**

# Some conclusions

- Medications feasible and effective (Bupe better than no bupe)
- Longer bupe better than shorter bupe
- Residential (with and without bupe) effective as a component of continuum
- XRNTX promising
- Initial exploration of moderators/mediators
  - Early adherence and success
  - ? Other substances esp MJ
  - Concurrent psychiatric treatment

# 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 psychosocial treatment with relapse prevention medication *as standard of care*
  - Buprenorphine
  - Extended release naltrexone
- Co-occurring (dual diagnosis) treatment



# 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

- 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.

# 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

# Questions to move the field forward

- Optimal models of delivery
  - Psychosocial platforms
  - Dose, intensity, duration
  - Extra ingredients
  - Role of other substances
- Improving adherence to bupe and xrntx
- Treatment matching:
  - Severity (earlier vs later, heroin vs Rx only), Motivation, Age, Gender
  - Sequencing and branch points
- Additional supports
  - Family
  - Residential support
  - Assertive outreach
- Linkage to broader patient touchpoints:
  - General healthcare: ED, primary care, hospital
  - Juvenile/criminal justice

If only it were that easy



*"We found this in your brain."*