

# Adolescent Substance Use Disorder (SUD) – Medication Assisted Treatment (MAT) 101



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March 23, 2023

# WELCOME AND INTRODUCTION

HEALTH MANAGEMENT ASSOCIATES

# INTRODUCTION



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# AGENDA

The Neurobiology of Substance Use Disorder: A Chronic Disease

About Youth and Opioids and Stimulants

MAT and Youth

Considerations for Pregnant Teens

Youth Relevant Harm Reduction

Minor Consent Laws and Other Special Considerations

Next Steps

## LEARNING OBJECTIVES

- At the end of the webinar, participants will be able to:
  - Describe the basic neuroscience of addiction with particular emphasis on the role of dopamine
  - Explain why Substance Use Disorder (SUD) is a chronic medical condition
  - Compare relevant differences in brain development and function in adults and adolescents and how that predisposes adolescents to use substances
  - List three medications that are FDA approved for the treatment of OUD
  - List at least two constraints adolescents face in accessing MAT
  - List three important considerations for MAT use among pregnant and parenting teens
  - Describe three ways to make harm reduction more accessible to adolescents

# OPIOID RELATED DEATHS AMONG YOUTH INCREASING AT A RATE MORE RAPID THAN ADULT DEATHS

## Opioid-Related Overdose Deaths, 2018

	Total	Percent of Deaths	Rate per 100,000 population
10 to 14 yr old	1	0.0%	0.04
15 to 19 yr old	53	2.2%	2.08
20 to 24 yr old	176	7.2%	6.49
10 to 24 yr old	230	9.5%	
All ages	2428	100.0%	5.82

Source: California Department of Public Health - Injury and Violence Prevention using CDPH Center for Health Statistics and Informatics Vital Statistics - Multiple Cause of Death and California Comprehensive Death Files

## Opioid-Related Overdose Deaths, 2020 preliminary

	Total	Percent of Deaths	Rate per 100,000 population
10 to 14 yr old	12	0.2%	0.48
15 to 19 yr old	257	4.8%	10.14
20 to 24 yr old	580	10.8%	22.00
10 to 24 yr old	849	15.8%	
All ages	5563	100.0%	

Source: adapted from California Department of Public Health - Injury and Violence Prevention using CDPH Center for Health Statistics and Informatics Vital Statistics - Multiple Cause of Death and California Comprehensive Death Files

Source: <https://skylab.cdph.ca.gov/ODdash/>

# CHATTER FALL

Please respond to following prompt by typing into the chat box

*What is something you would like to know more about regarding the treatment of SUD in teens?*

Type your response and  
**don't click enter.**

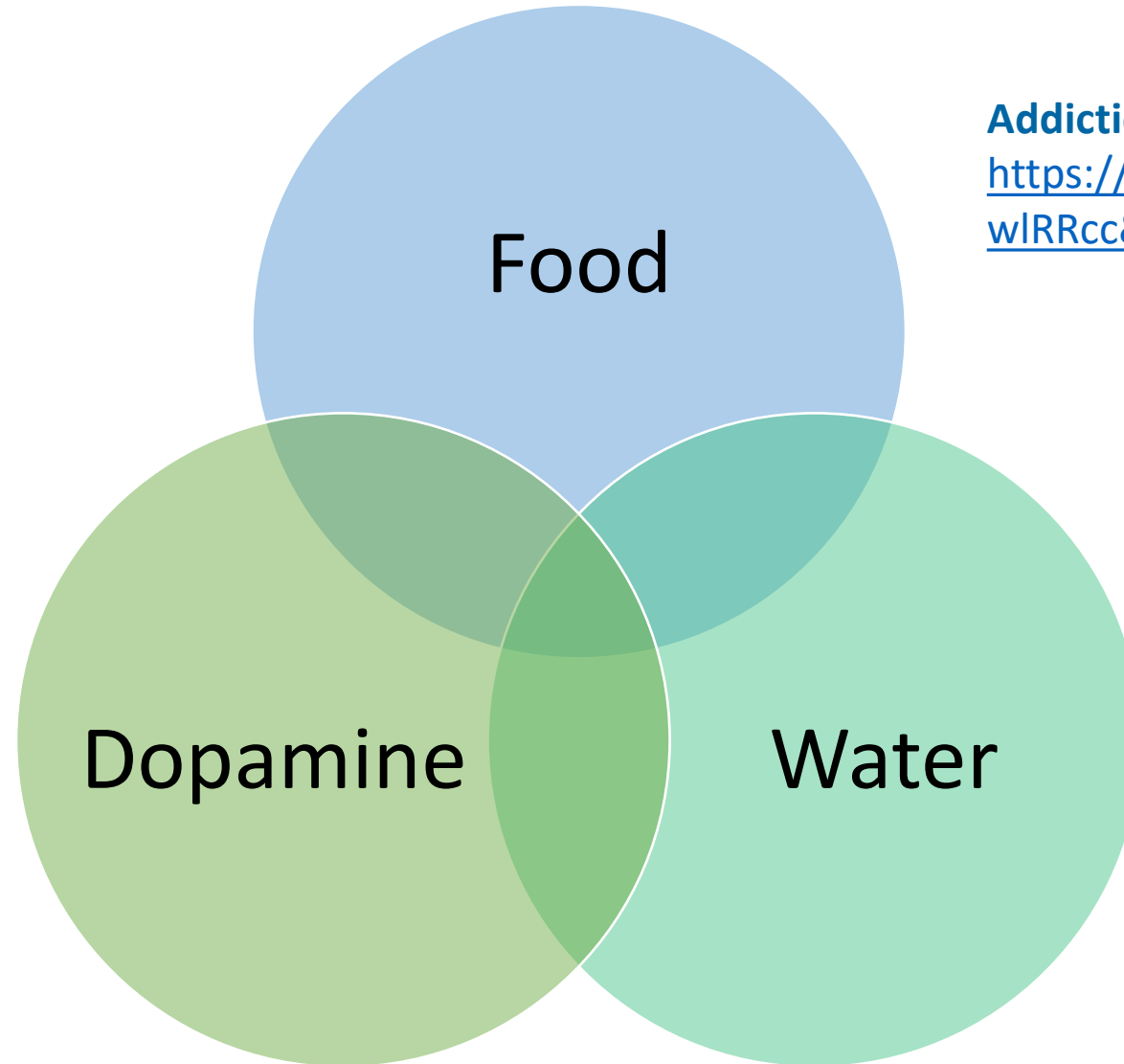


# NEUROBIOLOGY OF ADDICTION AND SUBSTANCE USE DISORDERS (SUD) AS A CHRONIC DISEASE

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# ■ BASIC MECHANISM OF HOW SUD AFFECTS THE BRAIN



**Addiction Neuroscience 101 Video:**  
<https://www.youtube.com/watch?v=bwZcPwIRcc&t=266s>

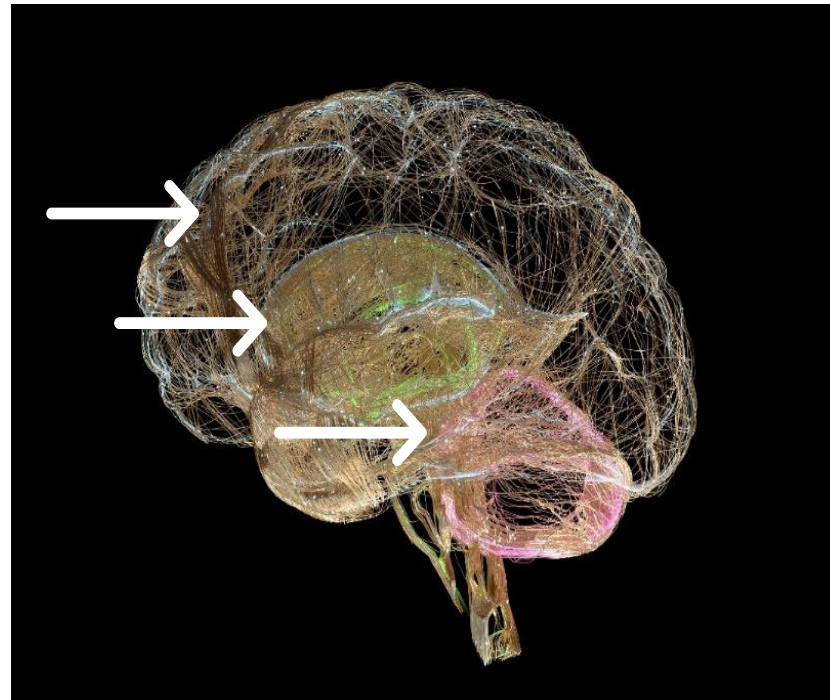
# HOW SUBSTANCES OF ABUSE AFFECT THE BRAIN

- All substances of abuse result in activation of the reward pathway
- The same pathway activated by naturally rewarding substances and events

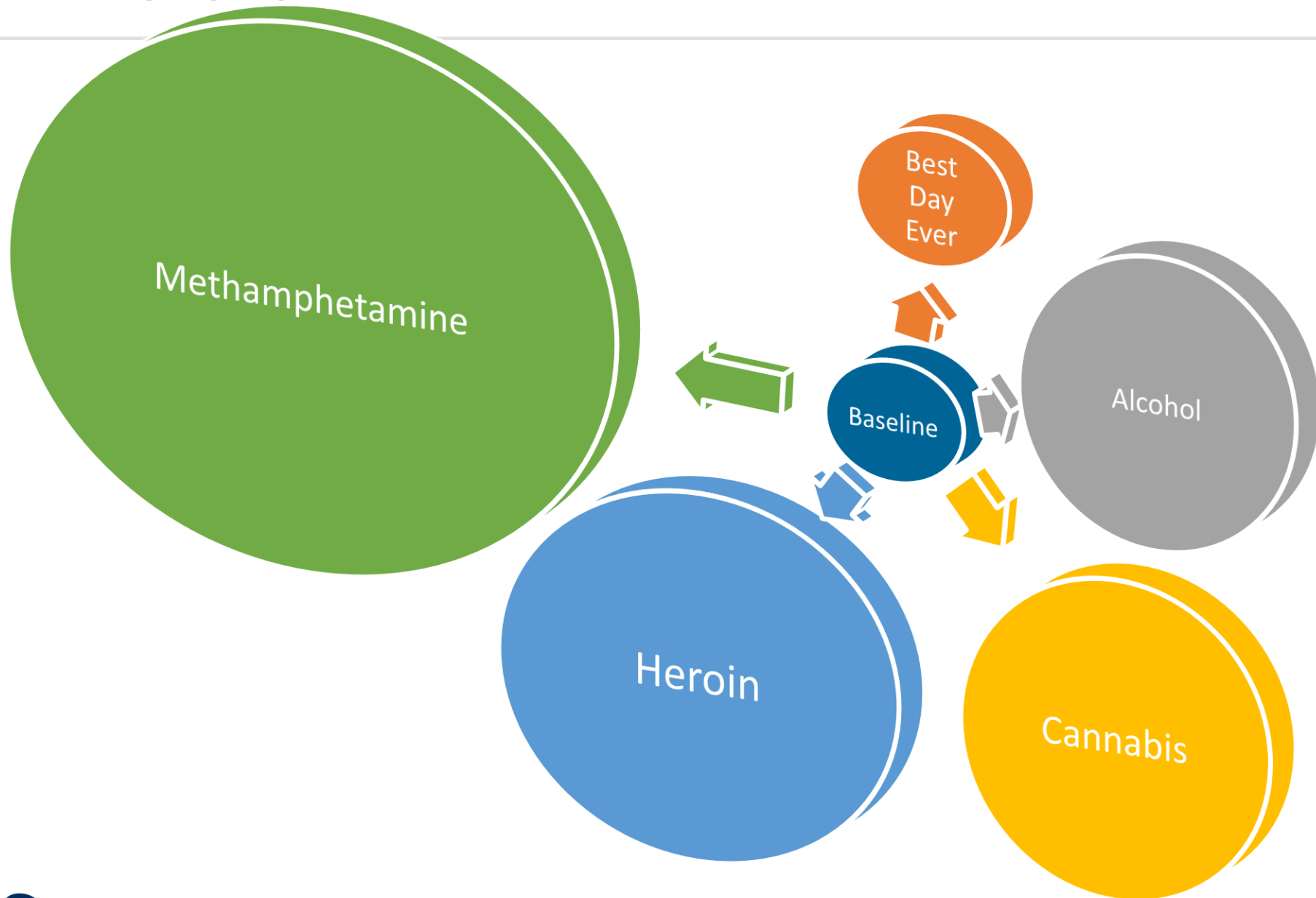
**Frontal Lobe**

**Nucleus Accumbens**

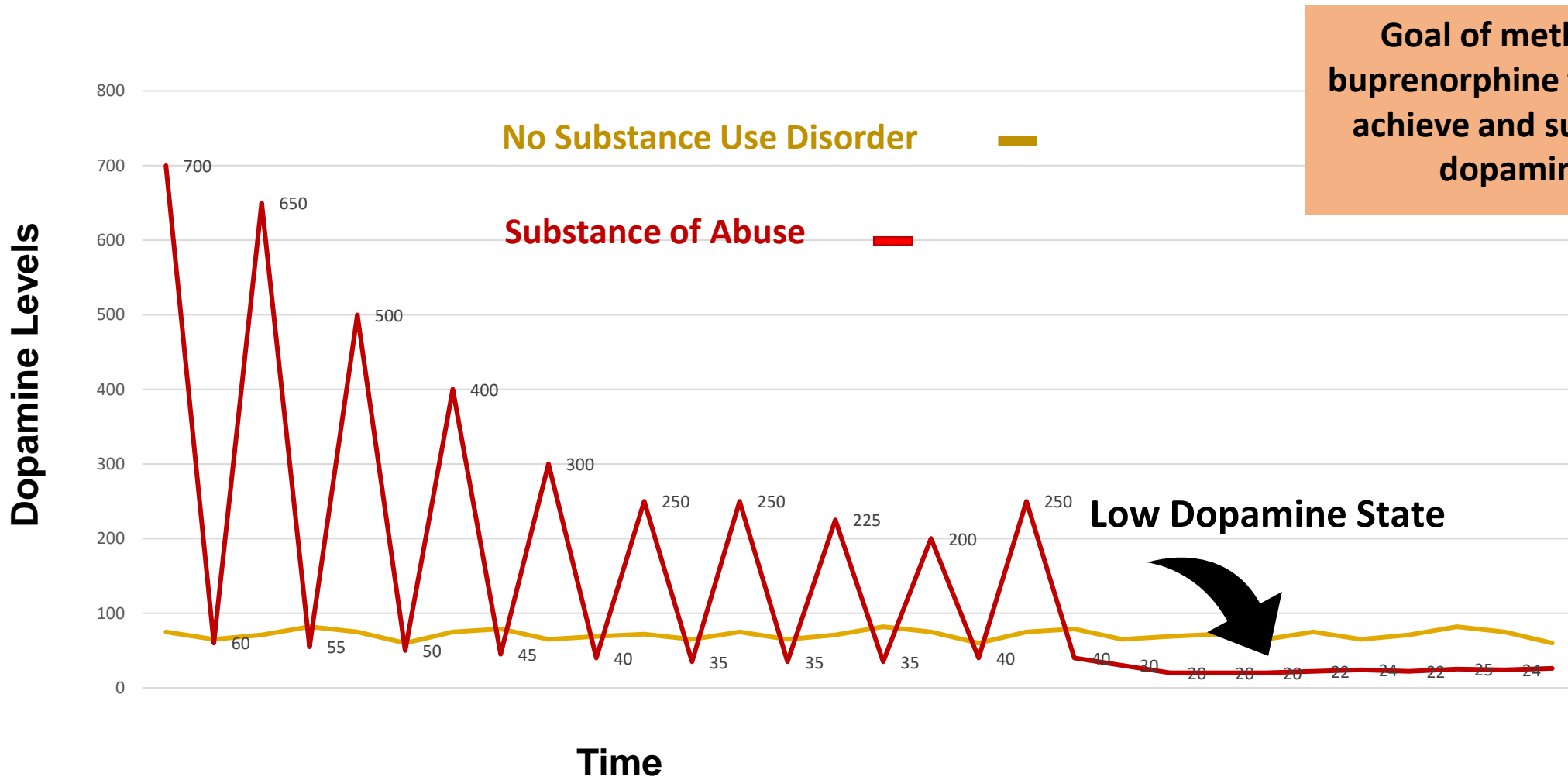
**Ventral Tegmental Area**



# DOPAMINE RESPONSE



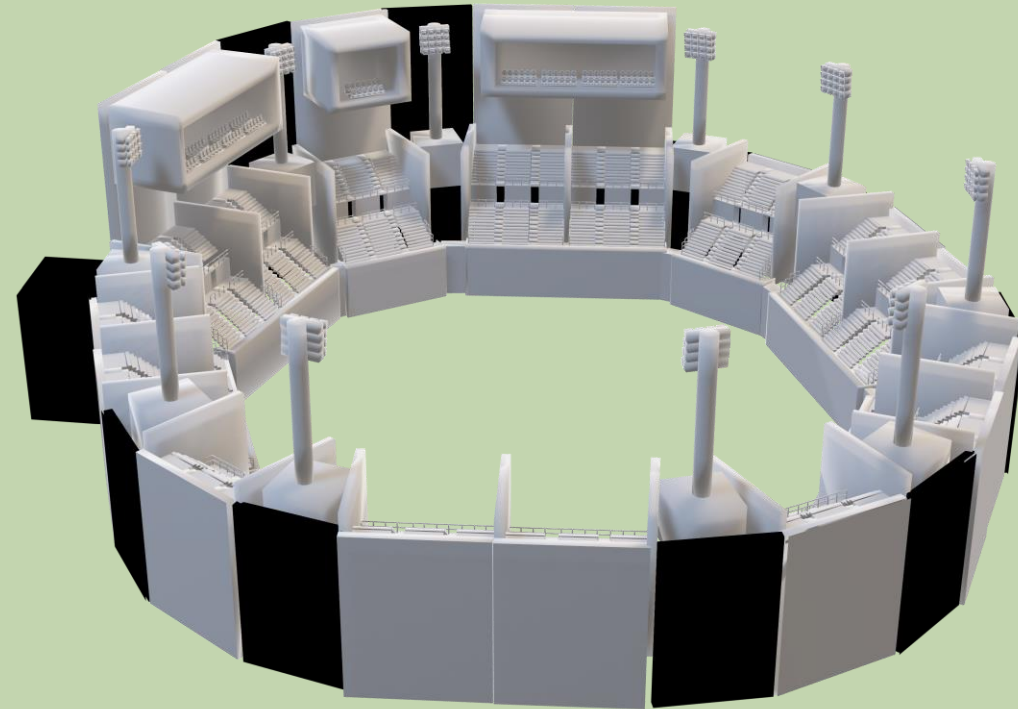
# BRAIN CHANGES WITH EPISODES OF SUBSTANCE USE



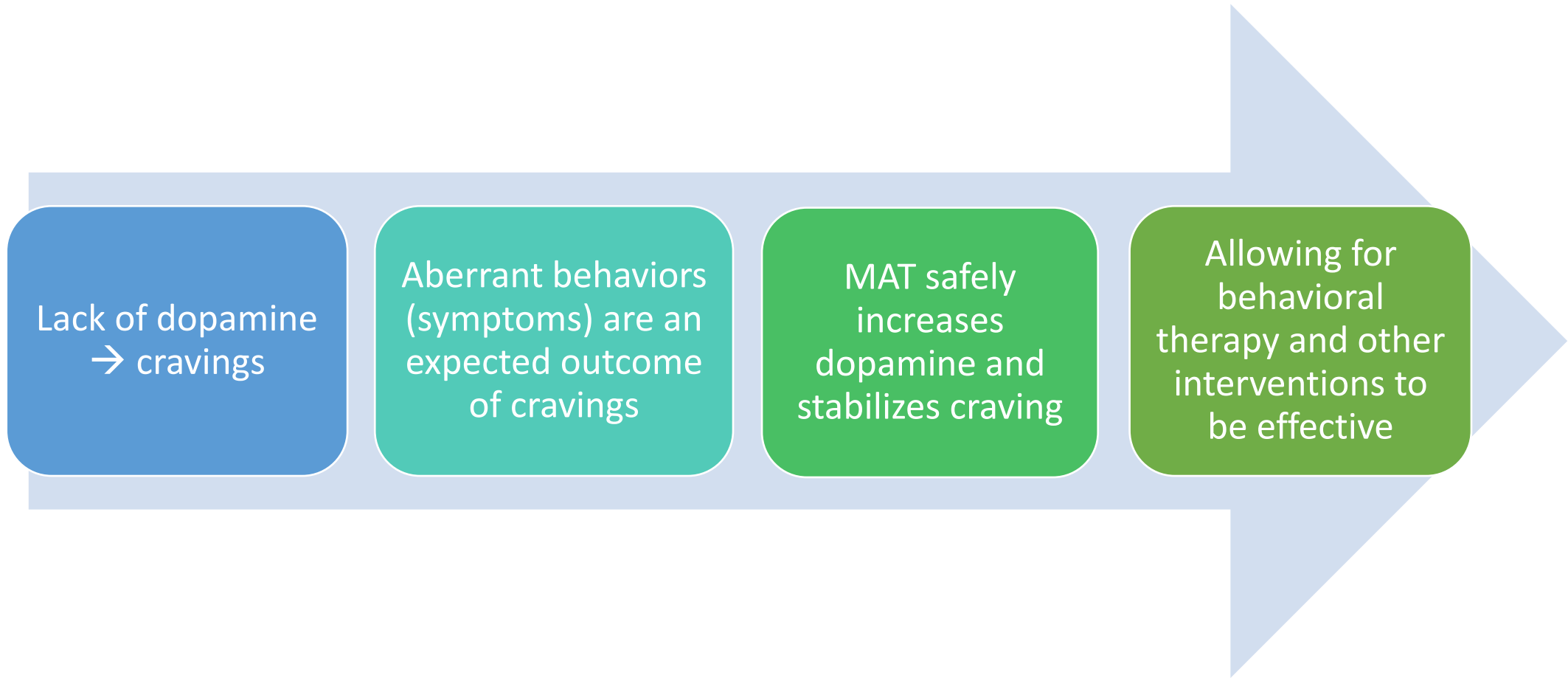
Goal of methadone and buprenorphine treatment is to achieve and sustain normal dopamine level.

# INTENSITY OF CRAVINGS

A direct, or indirect,  
force pulling  
someone towards a  
substance or  
behavior



# UNDERSTANDING ADDICTION TO INFORM TREATMENT



# DSM-5: DIAGNOSIS OF OUD

**TABLE 1** Summarized DSM-5 diagnostic categories and criteria for opioid use disorder

Category	Criteria
Impaired control	<ul style="list-style-type: none"><li>• Opioids used in larger amounts or for longer than intended</li><li>• Unsuccessful efforts or desire to cut back or control opioid use</li><li>• Excessive amount of time spent obtaining, using, or recovering from opioids</li><li>• Craving to use opioids</li></ul>
Social impairment	<ul style="list-style-type: none"><li>• Failure to fulfill major role obligations at work, school, or home as a result of recurrent opioid use</li><li>• Persistent or recurrent social or interpersonal problems that are exacerbated by opioids or continued use of opioids despite these problems</li><li>• Reduced or given up important social, occupational, or recreational activities because of opioid use</li></ul>
Risky use	<ul style="list-style-type: none"><li>• Opioid use in physically hazardous situations</li><li>• Continued opioid use despite knowledge of persistent physical or psychological problem that is likely caused by opioid use</li></ul>
Pharmacological properties	<ul style="list-style-type: none"><li>• Tolerance as demonstrated by increased amounts of opioids needed to achieve desired effect; diminished effect with continued use of the same amount</li><li>• Withdrawal as demonstrated by symptoms of opioid withdrawal syndrome; opioids taken to relieve or avoid withdrawal</li></ul>



# ADOLESCENT DEVELOPMENT AND THE PREDILECTION FOR SUBSTANCE USE DISORDER

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*“Substance use accounts for the vast majority of life-years lost due to disease, disability and premature death among those aged 15-24 and is arguably the most important modifiable health risk behavior impacting adolescents.”*

Levy S. Youth and the Opioid Epidemic. *Pediatrics*. 2019

# WHAT WE KNOW ABOUT TRENDS IN SUBSTANCE USE AMONG ADOLESCENTS

Individuals are most likely to begin using drugs during adolescence and young adulthood

- By the 12<sup>th</sup> grade, 70% of students have tried alcohol, half will have taken an illegal drug, 40% will have smoked a cigarette, AND 20% will have used a prescription drug for NONMEDICAL reasons (YRBS, 2019)

Fortunately, most adolescents who do experiment do NOT develop an addiction or other SUD

But, SUD among youth is part of other risky behaviors



# RISK FACTORS

- Adverse Childhood Events (ACE) predispose to SUD
  - 75% of those with OUD have history of ACEs (CTIPP, 2017)
  - Having >3 ACEs is associated with earlier onset use, greater prevalence IV drug use, greater overdose rate (Hughes et al, 2017)
  - Risk of SUD increases with number of ACEs (dose-response)
- 15.2% of people who start drinking by age 14 will eventually develop alcohol use disorder vs. 2.1 % of those WHO WAIT until they are 21 years or older (NIDA 2014)
- 25% of those who begin abusing Rx drugs at 13 years or YOUNGER develop a SUD some time in their lives (NSDUH, 2010)
- 13% of those with a SUD started using marijuana by the time they were 14 years (SAMHSA TEDS Report, 2014; Gray and Squeglia, 2018)

# WE CAN'T TREAT WHAT WE DON'T FIND: VALIDATED SCREENING TOOLS

- + Screening tools are validated for use in specific populations including youth
- + Screening for co-morbid conditions and suicide is also critical

General Population	Pregnant Women	Youth
<ul style="list-style-type: none"> <li>+ National Institute for Drug Addiction (NIDA) – Quick Screen</li> <li>+ Tobacco, Alcohol, Prescription, and other Substances (TAPS)</li> <li>+ AUDIT (Alcohol only)</li> <li>+ <i>Patient History Questionnaire (PHQ-9)</i></li> <li>+ <i>General Anxiety Disorder (GAD-7)</i></li> <li>+ <i>PTSD Checklist (PCL-5)</i></li> <li>+ <i>Columbia Suicide Severity Rating Scale (C-CCRS)</i></li> </ul>	<ul style="list-style-type: none"> <li>+ NIDA – Quick Screen*</li> <li>+ 4 P’s plus (license fee)</li> <li>+ Substance Use Risk Profile – Pregnancy (SURP)</li> <li>+ CRAFFT – for 12 -26 yo women (Car, Relax, Alone, Forget, Friend/Family, Trouble)</li> <li>+ <i>Perinatal Mood and Anxiety Disorder (PMAD) – Edinburgh, PHQ-9</i></li> </ul>	<ul style="list-style-type: none"> <li>+ Brief Screener for Alcohol, Tobacco and other Drugs (BSTAD) (12-17yo)</li> <li>+ Screening to Brief Intervention (S2BI) (12-17yo)</li> <li>+ Problem oriented screening instrument for Teens (POSIT)</li> <li>+ CRAFFT*</li> <li>+ <i>PHQ-9-adapted, Center for Epidemiologic Studies Depression Scale (CESDS)</i></li> </ul>

A man's face is the central focus, partially obscured by numerous blue sticky notes with white text. The notes contain various terms related to social and cultural concepts. The background is a solid blue color.

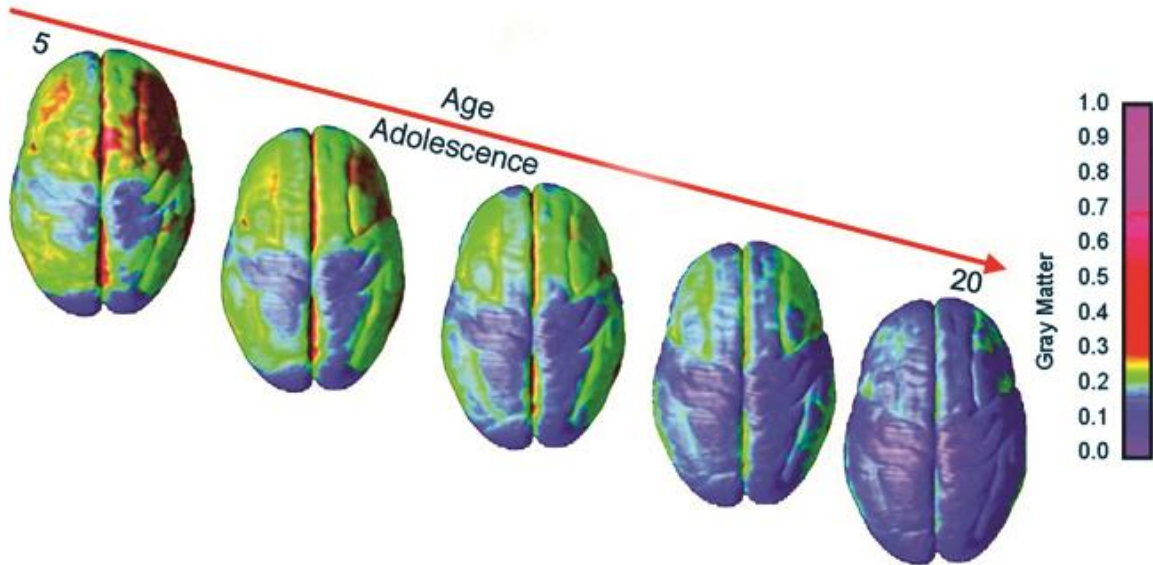
DEFINITIONS AND LEVEL  
SETTING

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# DEFINITIONS AND LEVEL-SETTING: THERE ARE MEANINGFUL DIFFERENCE IN THE POPULATIONS

	Ages in years	General Developmental Considerations	Practical and Legal Considerations
Adolescence	12 thru 17 years:	Moving to independence Ethics and Self-direction	Future Interests - Cognitive development Physical Changes Sexuality
• Early adolescence	10* thru 13	<ul style="list-style-type: none"> <li>Physical changes – worries about being normal</li> <li>Mood swings</li> <li>Limit testing</li> <li>Sense of invulnerability</li> <li>Close relationships gain importance (searching outside of family)</li> </ul>	<ul style="list-style-type: none"> <li>Familial Context                             <ul style="list-style-type: none"> <li>Financial dependent</li> <li>Health coverage dependent</li> <li>Emotional evolution</li> </ul> </li> <li>Must be enrolled in school</li> <li>Minor Consent laws in some states (unable to consent for treatment with MAT)</li> <li><i>Emancipation is the exception not the rule</i></li> </ul>
• Mid-Adolescence	15 thru 16	<ul style="list-style-type: none"> <li>Strong peer attachment</li> <li>Concerns about appearance and sexual appeal</li> <li>Interest in ideals, role models, moral reasoning</li> <li>Asserting independence → deeper conflicts</li> <li>Risk-taking</li> </ul>	
• Late Adolescence	17 thru 18	<ul style="list-style-type: none"> <li>Mainly independent decision-making</li> <li>Ability to delay gratification</li> <li>Defining realistic adult role in society and family</li> <li>Capable of insight, self-regulation of self-esteem</li> <li>Realization of vulnerability and limitations</li> </ul>	
Emerging Adults	18 thru 25	Do I have a role and place in this world?	Legal age for most decision-making

# ADOLESCENT BRAIN DEVELOPMENT: ALL GAS AND NO BRAKES

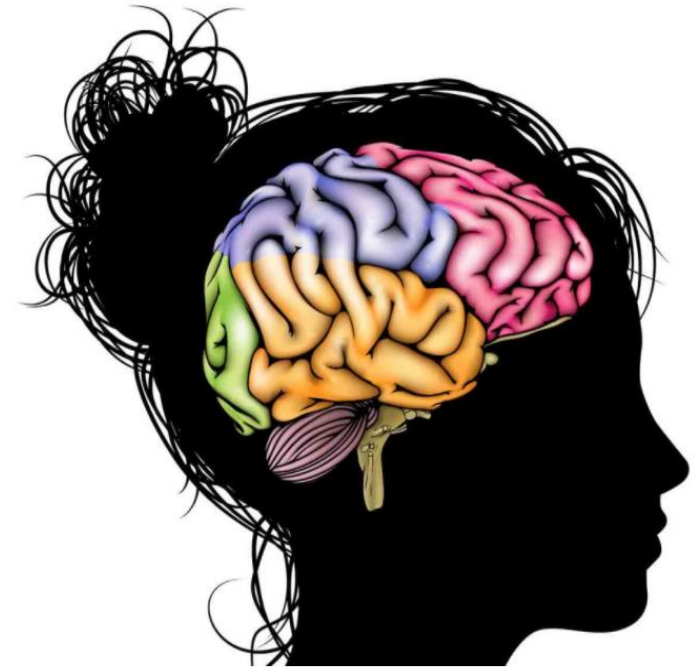


- Mid-brain areas are highly active during adolescence
  - Reward, motivation, moods/emotions, addiction
  - Dopamine-mediated (largely)
- Pre-frontal cortex develops much later (20s-30s)
- Brain in transition is “pruning” to develop greater efficiency and specificity (resilience)
- Pubertal hormones are implicated in development of areas of the brain that drive risk-taking

Copyright (2004) National Academy of Sciences, USA Gogtay et al (2004). P Nat Acad Sci. 101(21):8174-8179

## ■ MORE ON THE ADOLESCENT BRAIN: SO, WHAT DOES THAT MEAN?

- Adolescents are more likely to:
  - Act on impulse
  - Misread or misinterpret social cues
  - Get into accidents
  - Engage in risky behaviors (binging)
- Adolescents are less likely to:
  - Think before they act
  - Pause to consider consequences
  - Change their dangerous or inappropriate behaviors
  - Realize that their rapid performance is impaired
  - Perceive risk



SOURCE: KQED.org



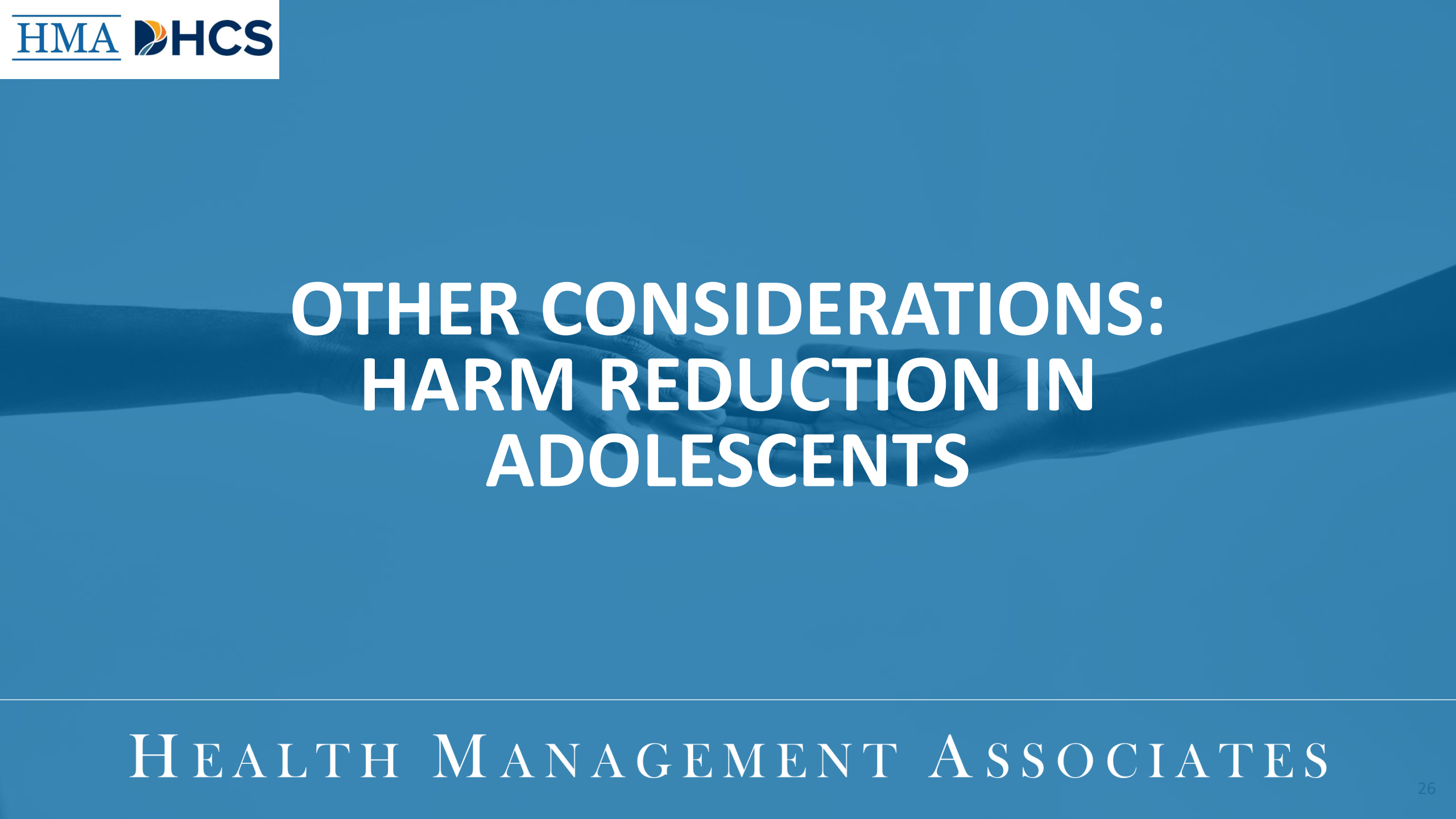
# ■ PROMISING LONGITUDINAL RESEARCH ON THE ADOLESCENT BRAIN



## Adolescent Brain Cognitive Development

*Teen Brains. Today's Science. Brighter Future.*

- The Adolescent Brain Cognitive development (ABCD) study Collaborative Research on Addiction at NIH (CRAN) - Longitudinal study of 10,000 youth from 10 -38 years across 21 sites (began in 2015)
- National Consortium on Alcohol and Neurodevelopment in Adolescence (NCANDA)-following over 800 youth across 5 sites for 10 years
- Understand the developmental trajectories and how those area affected by biopsychosocial, environmental and genetic factors, as well as exposure to substances; understand the impact of changing state and local policies on youth drug use and related health and development



# OTHER CONSIDERATIONS: HARM REDUCTION IN ADOLESCENTS

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# OBSTACLES TO EFFECTIVE HARM REDUCTION FOR YOUNG ADULT USERS

Stigma and Denial

Fear of law enforcement

Lack of Youth-friendly services

Disconnection from networks traditionally reached by harm reduction services

Lack of knowledge about safer injecting practices, harm reduction and HIV programs in their communities

# KEY STRATEGIES FOR EFFECTIVE HARM REDUCTION FOR YOUNG ADULTS



This Photo by Unknown Author is licensed under [CC BY-NC-ND](https://creativecommons.org/licenses/by-nc-nd/4.0/)

- ***Must be contextually relevant and responsive***
- Distribution of harm reduction materials and education using social networks and digital media.
- Venue-based interventions (distribution of harm reduction materials in clubs, bars, music events in which youth prescription opioid use may occur) should be considered.
- Peer-based naloxone training and distribution, and drug user-led programs to provide safer injection education are two examples of effective drug user “intravention”.
- Can the US embrace “differentiated normalization?”



### WHAT DOES THIS MEAN?

# Go Slow

If you use drugs, take action to prevent overdose. When you take a drug, start with a very small amount to test the strength. Don't slam it. You can always take more, but you can never take less. If you inject drugs, inject a little bit first and wait 20 seconds to see how strong it is. If it feels off, consider not using it or using less than planned. Be sure someone with you has naloxone.

If you use heroin, pills or even other drugs in Maryland, there's a good chance you're using fentanyl. Fentanyl has caused a huge spike in overdose deaths. Fentanyl acts FAST. Be careful.

<https://www.goslow.org/>

HARM REDUCTION TIPS

## Don't become a statistic.

Take action to protect yourself from overdose.



**1. CARRY NALOXONE.**  
Naloxone is available at all pharmacies in Maryland.



**2. GO SLOW.**  
Start with a very small amount to test the strength.



**3. NEVER USE ALONE.**  
Use with someone and **take turns** in case one of you needs naloxone.

# GO SLOW



**Fentanyl is here. Have a plan.**

# I NALOXONE OVERVIEW: HARM REDUCTION

Mu opioid antagonist used for opioid overdose (OD) reversal

Shorter half-life & more rapid onset of action than naltrexone

High affinity, competitive binding & displaces full agonists

Intranasal or intramuscular by bystander

Opioids have longer half-life than naloxone

May require more than one dose

Parental consent required (considered psychotropic medication)

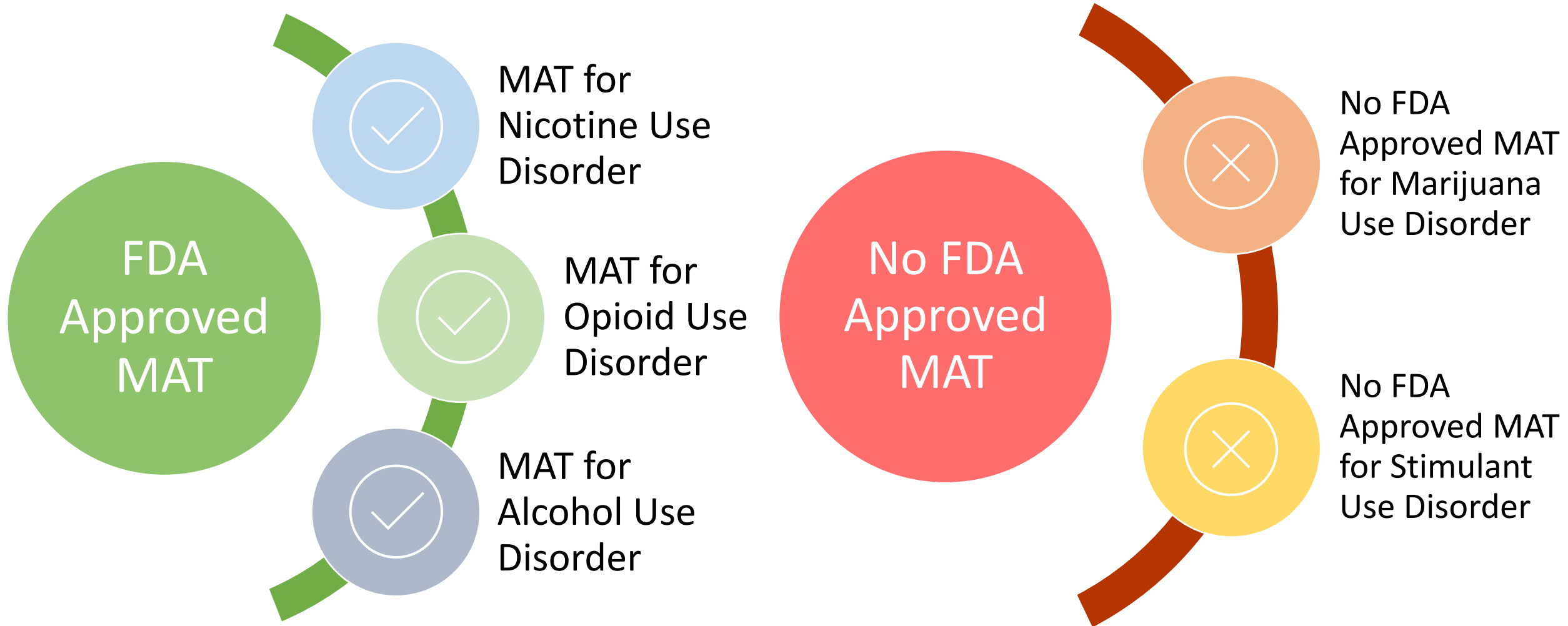
CA Assembly Bill 2760- Naloxone prescribing

- >90mg Morphine Milliequivalents
- Opioids + benzodiazepines
- Increased risk of OD: History of OD or SUD
- Minor consent challenges

# MEDICATIONS FOR ADDICTION TREATMENT AND YOUTH

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# FDA APPROVED MEDICATIONS FOR SUD





Treatment of adolescents with OUD with MAT is recommended by:

- American Society of Addiction Medicine
- American Academy of Pediatrics
- Society for Adolescent Health and Medicine
  - *“All adolescents and young adults (AYAs) with opioid use disorder (OUD) should be offered medication for OUD as a critical component of an integrated treatment approach that includes pharmacologic and nonpharmacologic strategies.”*

# WHY IS MAT FOR OUD IMPORTANT?

## Treat Withdrawal: Prevent Overdose

Symptoms include  
Muscle pain, dilated pupils, nausea, diarrhea, abdominal cramping, piloerection

- Lasts 3-7 days
- Using methadone or buprenorphine is recommended over abrupt cessation due to risk of relapse, overdose (OD) & death

## Address Dopamine Depletion

Reward/motivation pathway

- Depletion persists for months-years after people stop using
- Treated with methadone or buprenorphine

## Treat OUD

Abstinence based treatment results in 85% relapse within 1 year vs. 40-60% on MAT

## Achieve Results

Increases retention in treatment

Decreases

- opioid use
- cravings
- overdose
- complications IVDU and other risky behaviors
- criminal behavior

## I FDA APPROVED MAT FOR OUD

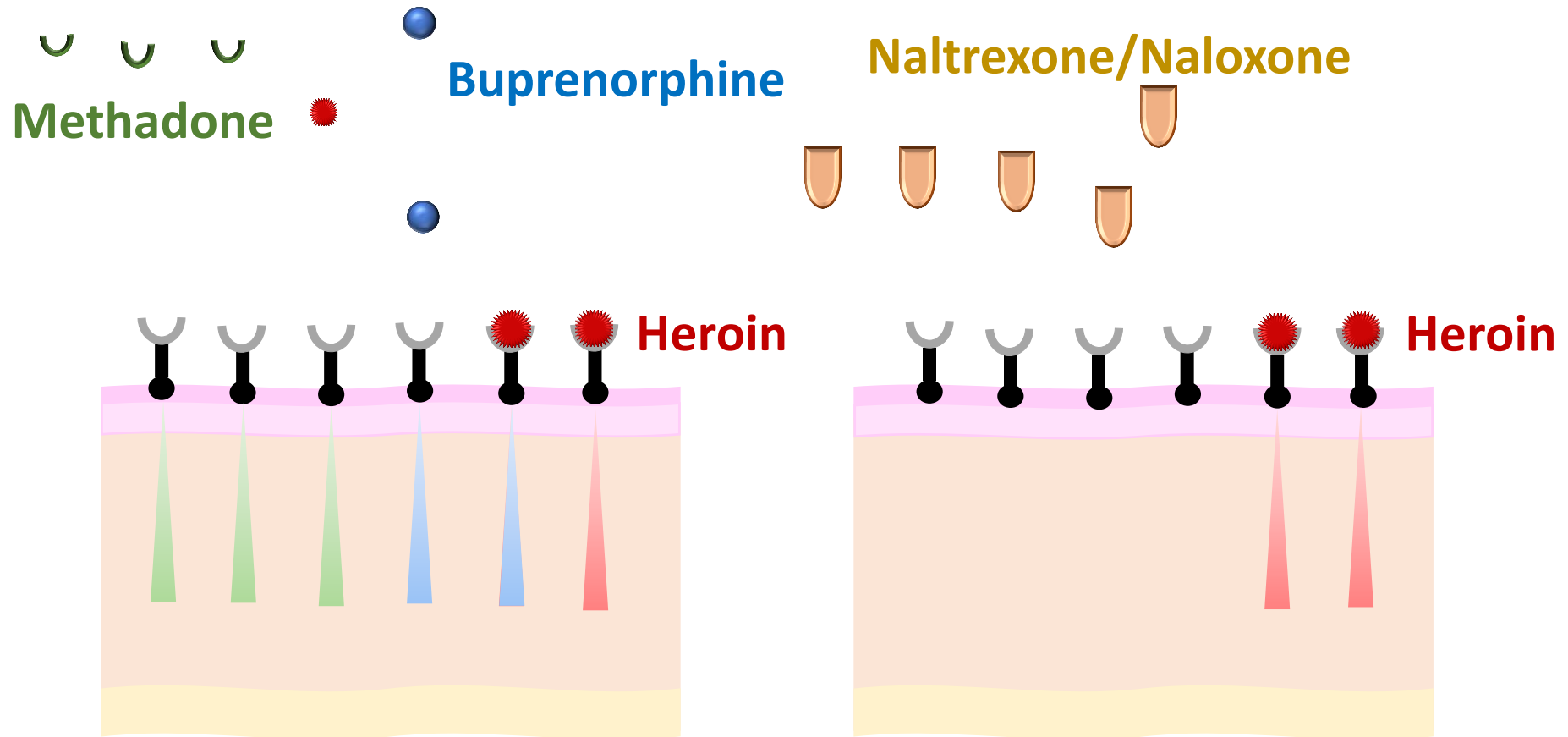
### Agonist Treatment:

- Methadone- approved for cough in 1940s, for OUD 1972
- Buprenorphine- approved in 1981 for pain; oral approved for OUD 2002, patch, implants & injection later

### Antagonist Treatment:

- Naltrexone- oral approved 1984; injectable 2006 AUD, 2010 OUD

# HOW DO THESE MEDICATIONS WORK?



Agonist Treatment

Antagonist Treatment

**Agonist turns on the receptor**  
**Antagonist blocks receptor from turning on**

# METHADONE: GENERAL FEDERAL REGULATIONS



Highly monitored  
in a Narcotics or  
Opioid Treatment  
Program setting  
(NTP/OTP)

Once patient is stable  
and after 6 weeks,  
can be given take-  
home doses \*



Use in minors  
requires parental/guardian  
consent  
and historically required  
“two documented  
unsuccessful attempts at  
short term detoxification  
or drug free treatment”\*\*



Delivered initially  
via observed  
dosing

Many  
requirements for  
treating patients\*



\*\*Removed in Proposed  
Rule [https://public-  
inspection.federalregister.gov/  
2022-27193.pdf](https://public-inspection.federalregister.gov/2022-27193.pdf)

*\*Changes in Omnibus Bill 12.29.22, 18 months for HHS to implement and in Proposed Rule*

## ■ METHADONE: WHAT AND FOR WHOM?

- Mu opioid agonist without a “ceiling effect”
- Reaching a therapeutic dose (60-120mg) takes time
  - <60 mg/d is not therapeutic
  - Increased frequency and daily dose required during pregnancy
- Several significant drug-drug interactions
- Illegal to write prescription for methadone to treat OUD unless:
  - Narcotic Treatment Program (NTP)
  - Hospital
  - Covering a gap of  $\leq 3$  days



Patients with a more severe OUD

Patients who would benefit from the services available in an OTP environment

Patients who were not reached treatment goals with other MOUD

# ■ BUPRENORPHINE: GENERAL REGULATIONS

DEA X-Waiver updates

<https://www.deadiversion.usdoj.gov/pubs/docs/index.html>

X-waiver no longer required

Use standard DEA number for buprenorphine prescriptions

No cap on number of people treated with buprenorphine



# I BUPRENORPHINE: WHAT AND FOR WHOM?

- Partial Mu opioid agonist with ceiling effect
  - Available alone or in combination w/naloxone
  - Combination formulation averts diversion
  - Different formulations (SL and buccal pill/film, injectable)
- Greater binding affinity than most full agonists
  - Start buprenorphine when client in moderate withdrawal (to avoid causing precipitated withdrawal)
- Many ways to do initiation (protocols needed)
  - Typical dose is 16-24 mg/d
  - Dosing adjustments required during pregnancy
- Fewer drug-drug interactions than methadone
- **Use in minors requires parental/guardian consent (all settings) and two prior detox attempts (at least, in NTPs)**

Opioid use disorder or withdrawal

Patient wants agonist treatment



# ■ NALTREXONE: GENERAL REGULATIONS



No Federal regulations inhibit the use

Not all BH clinics have RN to give injections



Multiple formulations:

- Pills at 25mg and 50 mg (50-100 mg for AUD)
- Long acting injectable 380mg (28-30 days)

# NALTREXONE: WHAT AND FOR WHOM?

- Mu opioid antagonist with high, competitive binding affinity
- Does NOT treat withdrawal or underlying dopamine depletion
- Client must be opioid free 5-7 days before starting
- More readily accepted in criminal justice and “abstinence-only” communities
- Evidence of decreased mortality is limited\*
- **Legal interpretation considers this a psychotropic medication - requires parental consent**

\*Source: Larochelle, et al. Medication for opioid use disorder after nonfatal opioid overdose and association with mortality. A cohort study. *Annals of Internal Medicine*. 169:3 (2018) 137-45.



Patients with a high degree of motivation (dopamine)

Patients who did not reach treatment goals with methadone or buprenorphine

Can be useful as “back-up” after discontinuation of methadone or buprenorphine

## WHAT WE KNOW ABOUT ACCESS TO MAT IN ADOLESCENTS

- Few published longitudinal studies about MAT for adolescents (pre-2018 data): Treatment outcomes are not as good as for adults, BUT:
  - Most viewed MAT as detoxification or short-term treatment
  - Often used subtherapeutic doses (<8 mg)
- The most current National Survey on Drug Use and Health indicates that only 8.3% of the ~1,000,000 youth 12-17 years who needed treatment for AUD or SUD actually received it
  - Less than 2.4% of adolescents and emerging adults (vs. 26.3% of adults) in treatment for heroin use and 4% of those in treatment for prescription drug use (vs. 12% of adults) received MAT
  - Black and Hispanic youth are less likely to receive treatment than white youth
- Retrospective cohort study (2001 – 2014) revealed about 26% of those diagnosed with OUD received MAT (the use of MAT increased 10-fold from 2002 to 2009, then dropped from 2009-2014 despite rise in diagnoses of OUD)
  - Females, Black and Hispanic patients and those <16 years were less likely to receive MAT
- Anecdotal evidence that MAT abuse potential is higher in adolescents
- There are significant logistical issues: parental consent, requirements for treatment failures, transportation, inadequate access

Source: <https://www.hhs.gov/about/news/2023/01/04/samhsa-announces-national-survey-drug-use-health-results-detailing-mental-illness-substance-use-levels-2021.html>

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# WHAT WE KNOW ABOUT EFFECTIVENESS OF MAT AND OTHER SUD TREATMENT IN ADOLESCENCE

- Need to acknowledge differences in youth and adults
  - Different neurodevelopmental concerns (puberty, cognitive skills, sense of self, social landscape)
  - Different addiction trajectory (more polysubstance, substitution and binging than adults) → need to consider different treatment outcomes
- Studies have likely not been reporting outcomes across all substance types
- American Academy of Pediatrics released a policy statement in 2016 calling for the **accessibility and use of pharmacotherapy for the youth with OUD**



American Academy of Pediatrics Committee on Substance Use and Prevention. Medication-assisted treatment of adolescents with opioid use disorders. *Pediatrics*. 2016;138(3):e20161893

[Article can be accessed here](#)

- Engagement in treatment significantly higher with MAT
- Median retention in care among youths who received timely MAT is much greater than for those receiving only behavioral health
  - Buprenorphine 123 days
  - Naltrexone 150 days
  - Methadone 324 days
  - Behavioral health only 64 days

# ADOLESCENTS AND MAT: “EVIDENCE” AND CONSIDERATIONS

MEDICATION	LEVEL OF EVIDENCE (mostly for adults)	CONSIDERATIONS
Methadone	High	<ul style="list-style-type: none"> <li>• <b>Limited access under 18 years</b></li> <li>• <b>Requires parental consent and two prior detox treatment failures</b></li> <li>• Same heavy regulations/requirements</li> <li>• Overdose potential exists in teens as in adults (mixing with other sedatives)</li> </ul>
Buprenorphine	High	<ul style="list-style-type: none"> <li>• <b>Approved for use in <math>\geq 16</math> years</b></li> <li>• <b>Requires parental consent (all settings) and two prior detox treatment attempts (at least, in NTPs)</b></li> <li>• Can be prescribed in primary care office</li> <li>• No evidence for limiting duration of treatment</li> <li>• Proven safety</li> <li>• Adjunct psycho-social treatment is encouraged</li> <li>• Recent revised guidelines facilitate obtaining X-waiver</li> </ul>
XR-Naltrexone	Moderate-high	<ul style="list-style-type: none"> <li>• <b>Use in pediatric patients with Autism and Crohn’s disease with good safety profile</b></li> <li>• Extended release is well-tolerated and increased adherence</li> </ul>

## I MORE...

- **Behavioral Health treatment is a vital adjunct**
- Motivational Interviewing or Enhancement approaches should be used
  - MI/MET are brief evidence-based (meaning well researched), treatments used to draw out change talk and strengthen one's motivation for change.
  - Motivational Enhancement Therapy (MET) consists of an initial assessment battery session, followed by two to four individual treatment sessions with a therapist using MI principles and techniques.
- Five Principles of Motivational Interviewing
  - Express empathy through reflective listening.
  - Develop discrepancy between clients' goals or values and their current behavior.
  - Avoid argument and direct confrontation.
  - Adjust to client resistance rather than opposing it directly.
  - Support self-efficacy and optimism.
- **Family Engagement Framework**-ALL involved with an adolescent with SUD need a recipe to proceed

# PERINATAL SUD, MAT AND OTHER CONSIDERATIONS

*In this presentation, the terms mother, maternal, she or her may be used in reference to the birthing person. Although there are few teen births to non-CIS gender youth, we recognize that not all birthing people identify as mothers or women and believe all birthing people are equally deserving of care that helps them attain their full potential and live authentic, healthy lives.*

## I ABOUT PREGNANT TEENS AND SUD

- The teen pregnancy rate in the United States continues to decline (from 1988-2018), but the overall rate (17.4/1000 youth 15-19 yo) is significantly above other developed countries
- Teens who become pregnant report more substance use prior to the pregnancy than non-pregnant teens
- Pregnant teens in SUD treatment have higher rates of methamphetamine use (16.9% vs 8.4%) and marijuana use (72.9% vs. 70.2%) and less alcohol use (45.7% vs. 58.5%) than non-pregnant teens
- Pregnant women, including teens, are less likely to use opioids for pain control during pregnancy than non-pregnant women, but the reported rate (31.89%) underscores the need for screening in the population

SOURCES: Martin, Natl Vital Stat Rep. 2019; Salas-Wright NSDUH, 2019; SAMHSA, TEDS Report 2013; St. Marie, Pain Manag Nurs, 2020





# I MAT DURING PREGNANCY

- Detoxification during pregnancy results in higher risk of relapse (59-90%), overdose, death
- Methadone and Buprenorphine are the standard of care
  - Safe for use during pregnancy
  - MAT tapering during pregnancy or immediate post-partum period is contraindicated
  - Doses may need to be adjusted upward during pregnancy
- MAT should not be considered replacement therapy
  - For persons with OUD, it treats the dysregulation that defines OUD as a chronic disease
  - Pain management in the peripartum period for women with OUD or on MAT should be coordinated with the medical team

MAT	OD Deaths	Retention in Treatment	Pregnancy Outcomes	NAS
Detox/Withdrawal	Red	Red	Red	Green
Methadone	Green	Green	Light Green	Yellow
Buprenorphine (Mono)	Light Green	Light Green	Green	Yellow
Buprenorphine /Naloxone	Light Green	Light Green	Green	Yellow
Naltrexone	Yellow	Yellow	Yellow	Green

The background of the slide is a dark, semi-transparent image of a woman with long hair, seen in profile, breastfeeding a baby. The image is centered and serves as the backdrop for the main title.

# WHAT ABOUT BREASTFEEDING, SUD AND MAT?

# | BENEFITS OF BREASTFEEDING: MOM'S SECOND GREATEST GIFT

## GENERAL BENEFITS

- Reduced respiratory infections and otitis media
- Reduced gastrointestinal infections
- Lowered risk of sudden infant death syndrome
- Protection against allergic disease
- Reduced risk of Celiac disease, inflammatory bowel disease
- Lower incidence of obesity, diabetes (types 1 and 2)
- Better neurodevelopmental outcomes

## BENEFITS TO WOMEN AND IN PERINATAL SUD

- Reduced risk of breast and ovarian cancer
- Improved maternal-infant bonding
- Reduced risk of child abuse
- Breastfed infants less likely to require pharmacological intervention for NAS
- Reduced symptoms of NAS
- Shorter length of stay for NAS
- Shorter duration of pharmacologic treatment when needed for NAS



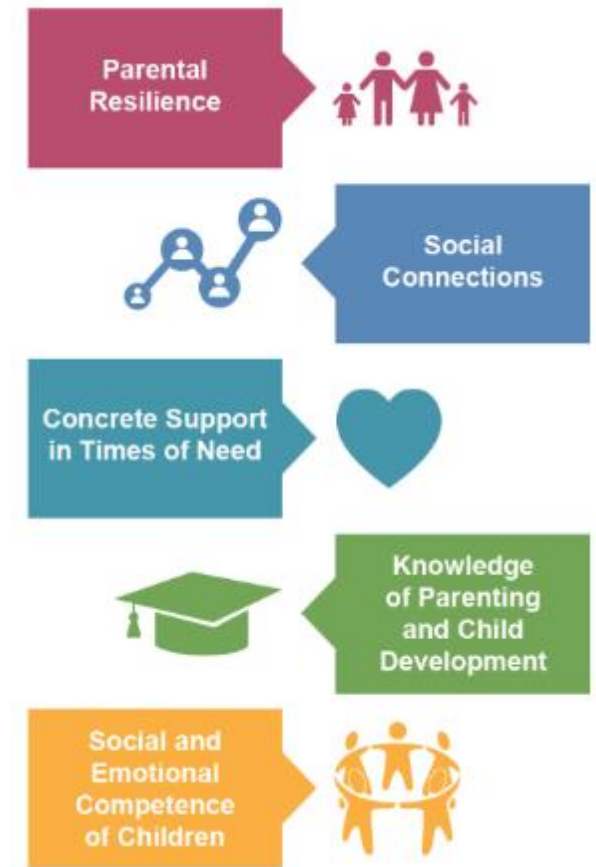
# FACTORS RELEVANT TO BREASTFEEDING DECISIONS: SHARED MEDICAL DECISION-MAKING

Relevant Factors	Specific Conditions	
<b>Medical Contraindications</b>	<p><b>Mother</b></p> <ul style="list-style-type: none"> <li>• Communicable diseases</li> <li>• Some psychotropic medications</li> </ul>	<p><b>Infant</b></p> <ul style="list-style-type: none"> <li>• Genetic conditions affecting metabolism</li> <li>• Mechanical (e.g., neurologic, severe cleft lip and palate)</li> </ul>
<b>Maternal conditions: Expressed milk only (avoid close contact)</b>	<ul style="list-style-type: none"> <li>• Communicable through close contact (respiratory)</li> </ul>	
<b>Maternal Conditions: Pump and Dump</b>	<ul style="list-style-type: none"> <li>• Communicable through bloodborne contact</li> </ul>	
<b>Special situations: Tailored recommendations</b>	<ul style="list-style-type: none"> <li>• Women with SUD NOT stable in treatment</li> <li>• Heavy alcohol consumption or AUD</li> <li>• Cannabis use (controversial)</li> </ul>	

**MOUD is NOT a contraindication to breastfeeding**  
**Women don't want to hurt their babies**

# SUPPORTIVE STRATEGIES AND POST-DISCHARGE CARE FOR PREGNANT MOMS

- Find or build stable, experienced recovery program opportunities for teen moms
  - Address and support basic parenting
  - Use trauma informed approaches for teens
  - Growth, skills development to address stigma and build confidence
- Formulate (shared) prenatal care plan that addresses all phases of pregnancy and breastfeeding (on MOUD)
- Ensure health services for mom (including ongoing MOUD and therapy)
- Medical and neuro-developmental monitoring for Baby
  - Monitoring for additional symptoms
  - Basic health care supervision for infants
- Protective Factors for Parenting



Picture from Children's Home Society, Concept from Center for the Study of Social Policy.

# HAVING A PLAN OF SAFE CARE IS VITAL – EVEN FOR TEEN MOMS

*The ideal Plan of Safe Care addresses mom's and baby's needs, is multidisciplinary, shared and reinforced*



# SPECIAL ISSUES FOR CONSENT TO ADDICTION TREATMENT FOR YOUTH

HEALTH MANAGEMENT ASSOCIATES

# MINOR CONSENT LAWS

- + The state of CA allows minors **over 12 years of age** to consent for the following services without parental consent:
  - **Drug or alcohol abuse treatment**
  - Outpatient mental health services/shelter services
  - Prevention, diagnosis and treatment of STIs
  - Diagnosis and treatment of other communicable diseases
  - Intimate partner violence
  - HIV/AIDS prevention, testing, and treatment
- + The state of CA allows minors of **any age** to consent for the following services without parental consent:
  - Prevention and treatment of pregnancy
  - Sexual assault services, and medical care for rape\*
  - Contraception including abortion
- + Minors **may not:**
  - + **Consent to “Replacement narcotic abuse treatment”**
  - + Refuse medical care and counseling for a drug or alcohol related problem **when** the minor’s parent consents to that treatment



SOURCE : Unsplash

Source: 1) 2018 National Center for Youth Law, revised: Nov. 2018. Available at [www.teenhealthlaw.org](http://www.teenhealthlaw.org); 2) <http://publichealth.lacounty.gov/dhsp/Providers/toolkit2.pdf>



# CONSENT FOR MINORS TO USE MEDICATIONS FOR ADDICTION TREATMENT

“Psychotropic Medications or psychotropic drugs are those medications prescribed to affect the central nervous system to treat psychiatric disorders or illnesses. They may include, but are not limited to, anxiolytic agents, antidepressants, mood stabilizers, antipsychotic medications, anti-Parkinson agents, hypnotics, medications for dementia, and psychostimulants.” – *CA Welfare and Institutions Code 369.5(d)*

Source: [https://leginfo.legislature.ca.gov/faces/codes\\_displaySection.xhtml?sectionNum=369.5.&lawCode=WIC](https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=369.5.&lawCode=WIC)

# MINORS HAVE RESTRICTED ACCESS TO MEDICATIONS FOR ADDICTION TREATMENT



- The CA Departments of Health Care and Social Services consider buprenorphine, methadone and naltrexone to be psychotropic medications
- Consequently, most minors must have their parent's or legal guardian's consent to be treated with MAT
- Consent for MAT for children/youth in foster care depends on custody status
  - For minors in temporary foster care, or who have not yet removed from parental custody:
    - Consent of the parent/guardian is still required to begin treatment
    - Consent may be given by the social worker only after notice has been given to the parent/guardian. If the parent/guardian objects, psychotropic medications require order of the court.
  - For minors, who are dependents and have been removed from the home, consent may be obtained from either:
    - The social worker, if the court has authorized the social worker to consent for care
    - The Court, based, only on the written recommendations from a health care provider
    - The parent/guardian, only if there is a specific court order delegating that authority to the parent

Source: NCYL. FAQ about Minor Consent for SUD Services in California.

<https://teenhealthlaw.org/wp-content/uploads/2020/12/SUDTreatmentMinorConsent-FAQ-Fam6929Chart-12-2020.pdf>

# MINOR CONSENT LAWS: PRIVACY AND RELEASE OF INFORMATION

- + When a state law allows minors to give consent for their own drug or alcohol abuse treatment, federal law generally prohibits providers from disclosing any information related to that treatment without the minor's written consent
- + Consequently, with limited exceptions, the privacy, access and confidentiality laws protecting others in SUD treatment apply to adolescents who have applied for and are receiving SUD treatment
  - + HIPAA:
    - + Passed in mid-1990s, updates in 2009 and 2013
    - + Defines “covered entities” and “business associates”
    - + “General” rule which healthcare operates to ensure data privacy/security
  - + 42 CFR part 2:
    - + Enacted in early 1970s (No “HIPAA” at that time)
    - + Ensure individuals seeking treatment for SUD would not be retaliated against



Source: <https://www.hhs.gov/about/news/2019/08/22/hhs-42-cfr-part-2-proposed-rule-fact-sheet.html>

# SHARING INFORMATION ABOUT ADOLESCENTS IN SUD TREATMENT

- In general, the teen's consent is required to disclose information that would identify this individual in SUD treatment
  - Information required on a valid consent form is the same as for adults (nine criteria for 42 CFR part 2)
  - That includes parents, teachers, and law enforcement (even with a routine subpoena signed by a judge)
  - EXCEPTION: When the **parent/guardian** seeks care for a drug- or alcohol-related problem of a minor (CA Family code section 6929)
- Consent is even required to disclose information about SUD treatment of youth in the Juvenile Justice System (JJS)
  - Rules about the length of time consent is valid for youth in JJS depend on:
    - "Substantial Change in Status"
    - Whether juvenile is receiving treatment in lieu of prosecution

# SUMMARY

HEALTH MANAGEMENT ASSOCIATES

There is a huge need for OUD (and all SUD) services for adolescents (NB. Many are now seeking out fentanyl by choice)

Adolescent brain development predisposes them to risky behaviors including substance use

Medications for Addiction Treatment / Medications for Opioid Use Disorder (MAT/MOUD) should be made available to all adolescents who need it, including pregnant teens

Adolescents can legally consent to most treatment for SUD, but MAY NOT consent to treatment with “replacement narcotic abuse treatment” (i.e., buprenorphine or methadone) and must have “two detox treatment failures” to qualify for methadone until Final Rule released

We can create a continuum of youth-specific and relevant services for this population that consider:

- Different use patterns and practices among adolescents
- Treatment and harm reduction approaches that exploit effective use of social media, venues when they use and peer-delivered messages



# CHATTERFALL

**Think about an adolescent you know who has struggled with addiction.**

**Reflecting on what you have heard so far today, has your thinking about their behavior related to SUD or treatment changed?**

If yes, please type a brief sentence about how your thinking may have changed.





**TIME FOR A POLL...**

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HEALTH MANAGEMENT ASSOCIATES



# POLL

**Do you know a young person who has received MAT for OUD?**

- A. Yes
- B. No

**If you answered yes in the previous poll, from your perspective, is/was this treatment helpful for them?**

- A. Yes
- B. No
- C. N/A (I do not know a youth who has received MAT for OUD)



# QUESTIONS?

HEALTH MANAGEMENT ASSOCIATES

## **I POLLING QUESTIONS**

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**1. Overall, today's webinar was:**

- A. Very useful**
- B. Somewhat useful**
- C. Not very useful**
- D. Not useful at all**

**2. The material presented today was:**

- A. At the right level**
- B. Too basic**
- C. Too detailed**

THANK YOU

HEALTH MANAGEMENT ASSOCIATES

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