Approaches to Treatment of Youth with Opioid Addiction

Marc Fishman MD
Mountain Manor Treatment Center
Johns Hopkins University

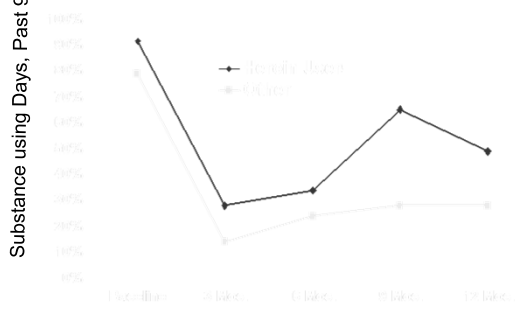
What should we do with this case?

- 17 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
- Buprenorphine treatment (monthly supply Rx x 4), took erratically, sold half
- Presents in crisis seeking detox ("Can I be out of here by Friday?")

Youth opioid users Clinical experience

- Higher severity and worse outcomes than non opioid using counterparts
- High rates of AMA from residential
- Low rates of continuing care in outpatient
- Relapse and drop out as the rule
- Alarming rates of overdose and death
- Lack of consensus and coherent approach
- Emergence of increasing "deep end" high severity, high chronicity population

ATM Baltimore Site
Heroin Users vs Others



Conceptual underpinnings
One set of tools (among many)

- 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
- Institutional affiliation promotes engagement
- 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

Elements of 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
- Co-occurring (dual diagnosis) treatment

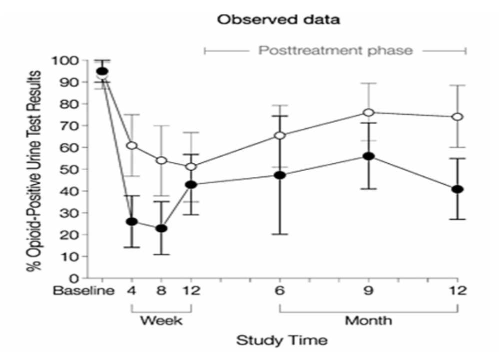
Journal of the American Medical Association, 2008

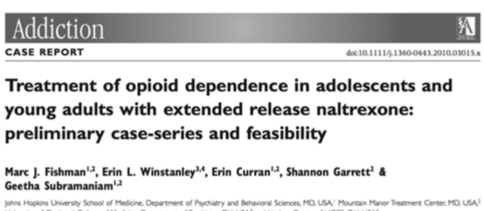

ORIGINAL CONTRIBUTION

Extended vs Short-term Buprenorphine-Naloxone for Treatment of Opioid-Addicted Youth

A Randomized Trial

CTN Youth Buprenorphine Study
Opioid Positive Urines: 12 weeks Bup vs Detox




Addiction
CASE REPORT
doi:10.1111/j.1360-0443.2010.03015.x

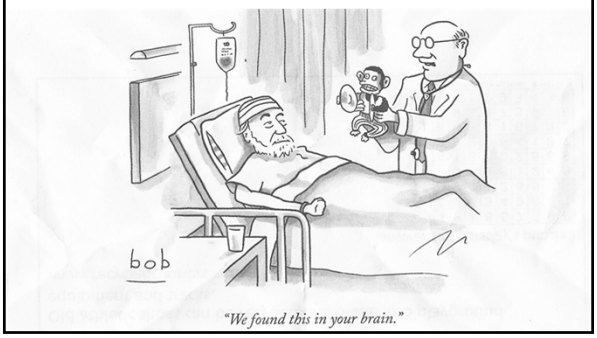
Treatment of opioid dependence in adolescents and young adults with extended release naltrexone: preliminary case-series and feasibility

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

If only it were that easy



Residential Admission: Detox

- 7d standardized detox protocol
  - Suboxone, max 12mg daily
  - First dose when symptomatic/in withdrawal
- During 7 d detox lay groundwork for next step of treatment
  - Detox/residential stay is NOT at CURE
  - first battle in a long war
  - Engage/transition into outpatient treatment

Detox Issues

- Asleep or awake?
- Aggressive symptom management
  - Diarrhea/constipation, aches & chills, anxiety, insomnia
- Where will they live after residential
- Verifying insurance coverage
  - Impacts both inpt/resid care & planning for aftercare

Buprenorphine induction method

- Residential detox using bupe taper
- Interruption of taper, switch to steady dose, or
- Completion of taper, later resume bupe
- Alternative induction as outpatient (minority)
- Outpatient maintenance

Ryan

- 19 M injection heroin, multiple treatments
- Does well during IOP, with structure of recovery house
- Typical pattern of relapse after high intensity treatment, after leaving structured environment
- Buprenorphine treatment for the first time gives him a link to continuing care and a bridge out of recovery house
- Abstinent 15 months, back home with parents, back at college

XR-NTX Induction

- Residential detox using bupe taper
- 7 day opioid washout by confinement
- NTX induction with 4 d oral dose titration
  - 6.25, 12.5, 25, 50 mg
- 1st dose injectable XR-NTX prior to residential discharge
- Outpatient maintenance

Brittany

- 15 yo WF
- 1 yr hx prescription opioids, recent progression to injection heroin, parents didn't know extent of dependence, shocked to discover a needle
- Parents compelled by idea of XR-NTX

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

Jennifer

- 17 yo from the suburbs, injection heroin x 2 years, 3rd episode detox
- Uses street bupe intermittently
- Strong parental and juvenile justice pressures, ambivalent about quitting
- "If I wake up & there is heroin & suboxone on the table -- I'll use heroin every time"
- Agrees to trial of XR-NTX

What's the active ingredient?

- Question:
  Which is better –
  medications or counseling or meetings?
- Answer:
  Yes

Encouraging MAR/MAT

- Battling myths and untruths
  - I will still have cravings
  - I will be "addicted to something else"
  - I hate needles
  - Suboxone makes you sick, I need subutex
  - NTX makes you sick
  - NTX puts you in withdrawal
  - You can die on NTX/XR-NTX

Continuing care

- Start daily administration 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

Features of youth treatment

- Family leverage
- Pushback against sense of parental dependence and restriction
- Salience of burdens of treatment
- Prominence of co-morbidity
- Family mobilization – “Medicine may help with the receptors, you still have to parent your difficult teenager”

Chloe

- 18 F onset injection heroin 16, occasional street suboxone
- Outpatient suboxone maintenance but would take it only intermittently when heroin unavailable
- Clarified goal: not ready to quit, suboxone stopped but MET continued
- 2 months later Rx restarted under mother’s supervision with new commitment --> 6 months abstinence

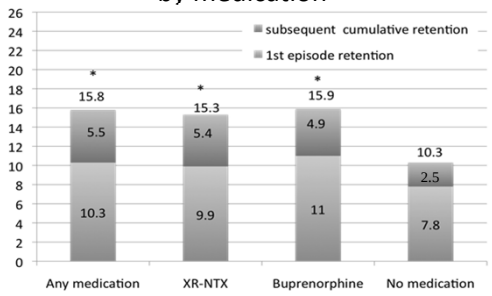
Matthew

- 19 M, 3 yr hx injection heroin
- 4 previous episodes detox, 2 previous episodes of failure with bupe outpt treatment
- Wants to try bupe again
- Parents make XR-NTX a condition of returning home

Greg

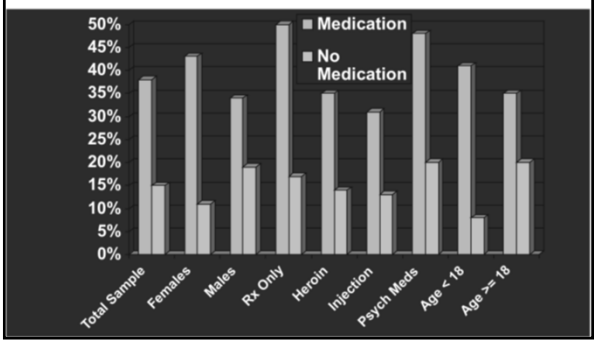
- 16 M prescription opioid dependence
- Residential detox, XR-NTX induction
- Abstinent x 3 months
- Family vacation, out of town, dose #4 delayed
- While at beach started deliberate plan to use, diverting few dollars at a time to prevent detection
- On return, told parents he was headed to treatment, went to get drugs instead, missed XR-NTX
- Relapse x 3 weeks
- Brief residential detox
- Restart XR-NTX with new level of parental involvement

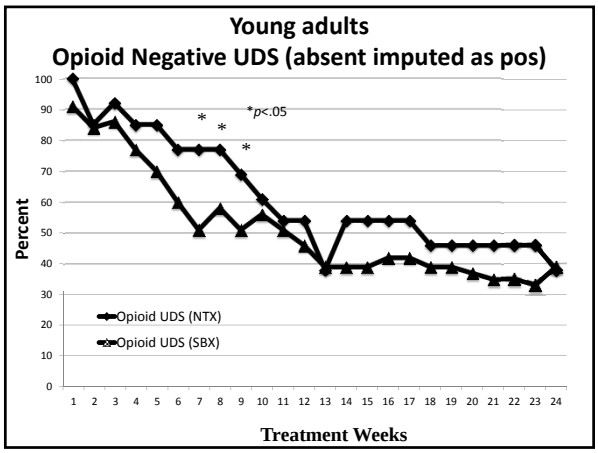
Cumulative retention over 26 weeks by medication



* = p < 0.01 compared to no medication

Additional Factors Medication vs. No Medication Cross-sectional retention at 26 weeks





Maintaining credibility in the real world: Medications, mischief, and monkey business

- Side effects
- Diversion
- Non-compliance
- Inconsistency
- Other substances
- Conflicting messages

Prepare for discrepancy and stigma

- How to talk to family
- How to talk to others in the 12 step fellowship
- How to shop for meetings and sponsors
- Don't ask, don't tell?

Sarah

- 18 F injection heroin, multiple failed treatments
- Inpatient treatment, recovery house, continuation suboxone
- Made connection to NA for the first time
- Abstinent x 6 months
- Told at NA meeting “not really clean” → stopped Rx
- Relapse
- 6 months later back on suboxone
- New stance towards Rx “don’t ask, don’t tell”
- 2 years abstinence

Additional adherence enhancements

- Long acting formulations
- Increased intensity / frequency of provider monitoring
- Increased coordination and communication between medical and counseling staff
- Role of concerned other in monitoring of adherence (eg network therapy)
- Supervised administration by caregiver or staff
- Prescriptions left for counselor to distribute
- Direct med administration up to daily

Psychiatric co-morbidity

- Co-occurring disorders nearly universal
- Concurrent psychiatric treatment essential

Future directions

- Increased family involvement and responsibility
- Assertive outreach
- Home delivery of XR-NTX
- Longer term residential support

A sprint or a marathon?

Early: I agree I was out of control with the dope, but I can still use a little oxy on the weekends.

Middle: I'm an opioid addict, not an alcoholic. I just need to stop using heroin (and pills). A few beers is fine.

Later: When I get drunk, I end up using heroin again. Maybe I need to stop drinking too. But taking a little xanax when I'm stressed is no big deal. And MJ isn't really a drug anyway…

(sigh)

We've come a long way…

But we have a long way to go.