Children's Hospital of Philadelphia
PolicyLab

Teens Need Access to Opioid Use Disorder Treatment, Too

Adolescent Health & Well-Being

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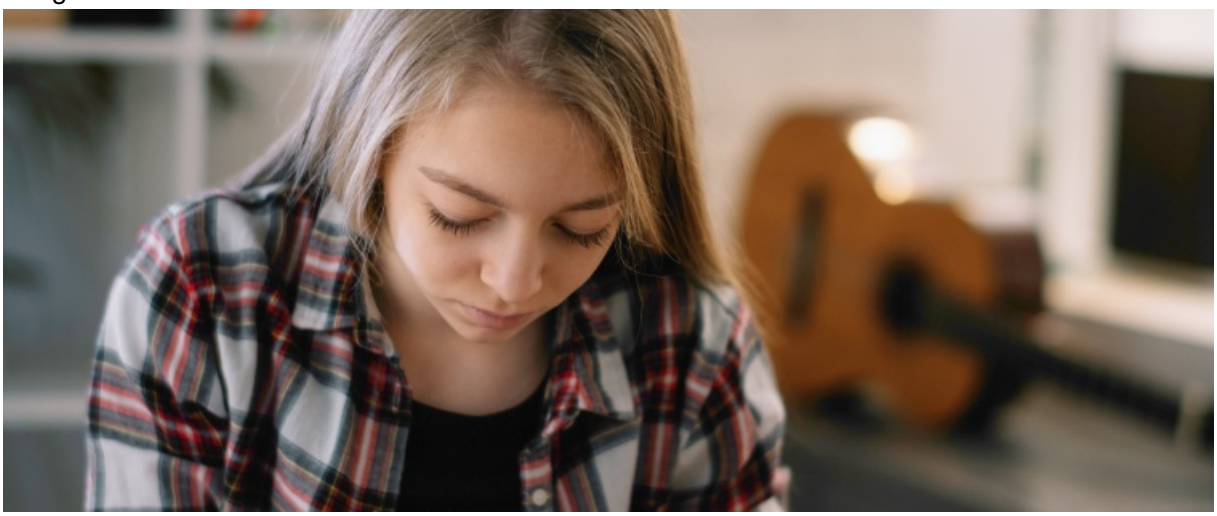

Editor's Note: This post is part of a series taking a family lens to substance use and substance use disorder through solutions that can support children, teens and caregivers. Through harm reduction measures, public policies, and connections between health care systems and community-based services, the authors offer tangible opportunities to address the substance use crisis impacting families in our community and across the country. PolicyLab developed the series in partnership with Children's Hospital of Philadelphia's Comprehensive Opioid Response and Education (CORE) Program.

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With the elimination of the X-Waiver, all providers who apply to prescribe Schedule II-V medications are required to complete eight hours of education on opioid or other substance use disorders (SUDs). But why do pediatricians need training on SUDs?

The answer is that addiction starts in childhood. According to The National Center on Addiction and Substance

Abuse (CASA), up to 9 of 10 people who meet criteria for SUD began smoking, drinking or using other substances before their 18th birthday. As people who care for and about teens, it is vital to understand the facts and shortcomings of opioid use disorder (OUD) treatment for adolescents so we can tackle the roots of this public health crisis.

What do we know about SUDs in adolescents and young adults?

The developing brain places adolescents at risk of SUDs because of inherent structural and functional changes during adolescence. The limbic system, the brain region responsible for emotion, develops earlier than the prefrontal cortex, which is responsible for executive control. From ages 13-25, our brains undergo “pruning.” Like wires in a circuit board, the connections within nerve pathways are reinforced to be more efficient the more they are used, while those used less frequently are disconnected. Consequently, emerging adults have brains pre-wired for reward-seeking behavior without higher-level control.

These reward pathways can be reinforced when affected by addictive substances, which is especially relevant to opioids because its euphoric effects strongly cue positive reward pathways while withdrawal symptoms significantly impact negative reinforcement pathways. This neurobiology is a large part of why SUDs and other behavioral health diagnoses emerge in adolescence. The average age for initiating opioid use is 16 years old. Opioid use may also be preceded by other adolescent substance use.

What are the trends in diagnosis and treatment of OUD in adolescents?

According to the 2021 National Survey on Drug Use and Health, approximately 1% of 12-17 year olds in the United States have OUD. There are evidence-based treatments that are effective in adolescents and young adults, and their use is endorsed by professional organizations including the American Academy of Pediatrics (AAP) and Society for Adolescent Health in Medicine (SAHM). The AAP recommends Screening, Behavioral Intervention and Referral to Treatment (SBIRT) for adolescents. SBIRT has been recommended for widespread use as an approach for any providers who care for adolescents, from the primary care setting to the emergency room.

Psychotherapies are effective, and there is a particular role for family-based therapy to reinforce support systems for young people with SUDs. Medications are part of the standard of care for adults with OUD, and their use for adolescents and young adults is highly effective to initiate recovery and prevent relapse. The three main medications for OUD (MOUD) are buprenorphine/naloxone, naltrexone and methadone. Due to age limitations, methadone is unavailable for treatment of adolescent OUD, limiting adolescents to two medication options. MOUD alone is associated with decreased risk of death from OUD, which is why use of medications is explicitly supported by the AAP and SAHM.

Narcan (naloxone) reduces risk of death from opioid overdose and increasing access to it works as harm reduction even if opioid use continues. Laws expanding access to naloxone have been shown to NOT increase rates of drug use. Therefore, increasing naloxone’s availability is a priority intervention for expansion—there are many examples of schools and youth programs distributing Narcan—that should be assessed for further investment.

How available is OUD treatment to adolescents?

Access for adolescents is limited in terms of treatment settings and availability of MOUD prescribers. When using the ATLAS treatment finder to search for OUD treatment for patients 12-18 years old, only four outpatient programs are available in Philadelphia. Even if an adolescent does find a supportive facility, more than half of those facilities in the country do not offer MOUD based on age. Recently released research demonstrated that of the 45% of residential treatment facilities that treat patients less than 18 years old, only 24.4% offer buprenorphine as a part of treatment.

A recent study looking at prescription registries found that from 2015-2020, the rate of buprenorphine dispensed to youth decreased 25% and the proportion of youth to whom buprenorphine was dispensed decreased 45%. Pediatricians accounted for less than 2% of all prescriptions dispensed.

In Pennsylvania, licensing requirements for drug and alcohol treatment facilities are stated very broadly. As a result, pediatricians, and the leaders of the institutions in which they practice, often worry they cannot provide AAP-recommended care without special licensing and thus forgo providing this care. This also impedes care for other SUDs, such as cannabis and nicotine use disorder.

What policy actions can we take to improve access to and success of SUD treatment in adolescents and young adults?

Per the AAP, SUD screening and treatment, including MOUD, should be integrated into routine primary care; we are in the process of operationalizing this here at Children's Hospital of Philadelphia. But there is more that we can do as policymakers, health care institutions, advocates and health care providers:

1. Expand knowledge, access, and affordability of naloxone (Narcan) among youth and families with adolescents to prevent morbidity and mortality, especially now that Narcan will be available over-the-counter
2. Encourage collaboration between local/state governments and pediatric hospitals to provide access to MOUD. Consider limiting age-based restriction to access of different levels of care, including medications, to build on the more robust systems that exist for adults
3. Design innovative models to broaden access to SUD care and meet adolescents where they are, such as through school-based programs that can support and connect youth to treatment for OUD
4. Advocate for insurance coverage of supportive family services for outpatient treatment, including peer support programs and Certified Family Recovery Specialists

As we manage the mental health of youth in the post-COVID world, we must ensure that adolescents with OUD and all SUDs receive the clinical and policy support that they deserve in this unique, vulnerable time in their development.

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