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Position paper

Medication for Adolescents and Young Adults With Opioid Use Disorder

The Society for Adolescent Health and Medicine

A B S T R A C T

Opioid-related morbidity and mortality have risen in many settings globally. It is critical that practitioners who work with adolescents and young adults (AYAs) provide timely, evidence-based treatment for opioid use disorder (OUD). Such treatment should include medications for opioid use disorder (MOUD), including buprenorphine, naltrexone, and methadone. Medication treatment is associated with reduced mortality, fewer relapses to opioid use, and enhanced recovery and retention in addiction care, among other positive health outcomes. Unfortunately, the vast majority of AYAs with OUD do not receive medication. The Society for Adolescent Health and Medicine recommends that AYAs be offered MOUD as a critical component of an integrated treatment approach. Barriers to receipt of medications are widespread; many are common to high-, middle-, and low-income countries alike, whereas others differ. Such barriers should be minimized to ensure equitable access to youth-friendly, affirming, and confidential addiction treatment that includes MOUD. Robust education on OUD and medication treatment should be provided to all practitioners who work with AYAs. Strategies to reduce stigma surrounding medication—and stigma experienced by individuals with substance use disorders more generally—should be widely implemented. A broad research agenda is proposed with the goal of expanding the evidence base for the use and delivery of MOUD for AYAs.

Positions of the Society for Adolescent Health and Medicine

1. 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.
2. Barriers to the receipt of medications for OUD need to be minimized.
3. Robust education on OUD treatment should be provided for all practitioners who work with AYAs.
4. Strategies to reduce stigma surrounding the use of medications for OUD among AYAs should be widely implemented.
5. Research efforts to expand the evidence base for the use and delivery of medications for OUD among AYAs should be supported.

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Statement of the Problem

Over the last two decades, opioid-related overdose mortality among AYAs has increased dramatically [1,2]. Although rising overdose mortality in North America has received much attention, mortality is substantially higher in low- and middle-income countries [2]. OUD commonly begins during adolescence and young adulthood [3] and compromises not only safety and well-being but also healthy development among AYAs [4].

Providing early, effective treatment for OUD is critical to preventing worsening addiction and the potential for lifelong harm. Evidence-based medications for OUD (MOUD) include buprenorphine, naltrexone, and methadone and are associated with reduced mortality, fewer relapses to opioid use, and enhanced recovery and retention in addiction care [5–13]. However, the majority of AYAs who need treatment for OUD do not receive it [14–17]. After receiving a diagnosis of OUD or experiencing overdose, most AYAs only receive behavioral health services if they receive any treatment at all, which places them at risk for overdose and worsening, severe addiction [6,18].

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This Position Paper advocates for improving receipt of MOUD among AYAs by addressing health systems barriers, workforce limitations, stigma, and research gaps. Throughout, the term MOUD (i.e., "medications for opioid use disorder") is used rather than the term "medication-assisted treatment," which implies that medications are an adjunct to OUD care, rather than a critical component of therapy. Although the focus of this article is on treatment, the utmost importance of prevention efforts should also be highlighted.

Methods

Positions were compiled after examining existing clinical guidelines, including those from (alphabetically) the American Academy of Pediatrics [4]; American Society of Addiction Medicine [19]; British Columbia Centre for Substance Use [16]; Indian Psychiatric Society [20]; New South Wales, Australia [15]; U.S. Substance Abuse and Mental Health Services Administration [21]; and World Health Organization [22]; as well as reviewing clinical trials and observational studies.

Positions and Recommendations

1. *All AYAs with OUD should be offered medication for OUD as a critical component of an integrated treatment approach that includes pharmacologic and nonpharmacologic strategies.*

Clinical trial and high-quality observational data strongly support the use of MOUD. Treatment with buprenorphine or methadone, which are opioid agonists, or with naltrexone, an opioid antagonist, is associated with fewer opioid cravings, withdrawal, and relapses, and enhanced recovery and retention in addiction care [5–13]. Furthermore, retention in buprenorphine or methadone treatment is associated with reduced mortality [5].

Treatment should generally include MOUD in combination with behavioral therapy, although AYAs who do not pursue behavioral therapy should not be denied MOUD [4,15,16,19–22]. MOUD may be most effective if provided as early as possible in the development of OUD to prevent worsening severity [4,6]. Because OUD carries high risk for mortality, MOUD should not be delayed while waiting to determine whether nonpharmacologic treatment alone is successful. Although buprenorphine, naltrexone, and methadone are not approved for use among adolescents aged <18 years in all countries, clinical guidelines nonetheless recommend the use for AYAs who meet criteria for OUD without age limitations [4,15,16,19–22].

Pharmacologic treatment is part of a broader care continuum extending from substance use prevention; screening, brief intervention, and referral to treatment; comprehensive addiction treatment with pharmacologic and nonpharmacologic components; overdose prevention and treatment, including use of naloxone; harm reduction; to long-term recovery support [4,16,19]. Ideally, these care continuum components are provided alongside other services, including primary care and mental health treatment, to optimize whole health. Ensuring this full spectrum of services requires that practitioners partner whenever possible with family members, other trusted adults in AYAs' lives, and other professionals (e.g., teachers, employers, faith leaders, community-based organizations, law enforcement, and criminal justice agencies) operating outside traditional medical settings (e.g., schools, places of employments, other community settings, and prisons/jails).

2. *Barriers to the receipt of MOUD need to be minimized.*

Worldwide, AYAs and their families encounter substantial barriers when seeking MOUD [23]. Among the most concerning barriers are U.S. policies specifically designed to limit medication access. Federal laws require that physicians complete 8 hours of training, and nurse practitioners and physician assistants complete 24 hours of training, before receiving a waiver (commonly known as the "X waiver") to prescribe buprenorphine. Federal policies also stipulate that adolescents aged <18 years must demonstrate two prior attempts at treatment that did not involve MOUD before being permitted to initiate methadone. Furthermore, methadone for OUD treatment can only be dispensed by a federally certified opioid treatment program, and availability of such programs that serve adolescents is exceedingly rare [6,18]. This is in contrast with Canada and some European countries (e.g., France, Germany, Norway, Luxembourg, Croatia, and Belgium), where opioid agonists can be provided by general office-based practitioners without such restrictions [24]. Similar to the U.S., other European countries have regulations on who can prescribe buprenorphine and methadone.

Other barriers worldwide include requirements for prior authorizations for buprenorphine and naltrexone, insufficient number of addiction treatment programs that offer MOUD to AYAs, lack of health insurance among AYAs, high copays for medications and clinical visits, and pervasive and persistent disparities in offered treatment and access to health care by race and ethnicity [25–27]. These striking disparities are linked to the complex intersection of historical injustices, culture, and policies [26,28].

MOUD provision is often hampered by the common misperception that AYAs should first have a trial of behavioral therapy that does not include pharmacotherapy, or worse, should not receive medications at all [29]. Such beliefs are in opposition to clinical practice guidelines and clinical trial data, highlighting that MOUD is associated with reduced mortality and improved treatment outcomes with or without counseling [4,15,16,19–22]. Some settings may lack confidential, youth-friendly medical and mental health services, and minors may not be allowed to consent to their own addiction treatment or use of MOUD. Even when AYAs do consent to their treatment, insurance claims that disclose their OUD diagnosis to a parent may threaten confidentiality. In some countries, certain MOUD formulations are not currently available (e.g., long-acting injectable naltrexone is not available for OUD treatment in Canada, and buprenorphine and methadone are not available in Russia).

In specific contexts, such as in criminal justice settings, MOUD access is often highly limited or specific medications (e.g., long-acting injectable naltrexone) are preferred over others (e.g., buprenorphine or methadone), thus preventing AYAs from being offered the full range of evidence-based medications [30]. Individuals involved with criminal justice systems are at high risk of death; the prevalence of OUD is high among incarcerated individuals, and overdose mortality within 2 weeks of release is 129 times higher than in the general population [31]. Yet, exceedingly few incarcerated individuals receive OUD treatment [32]. The full continuum of care should

be provided to AYAs in criminal justice settings [31,32]. Indeed, alternatives to incarceration should be sought for nonviolent drug-related offenses involving AYAs [30]. Although addiction is frequently viewed as a moral failing, it is more accurately considered a medical condition; as such, AYAs with OUD should receive treatment and recovery support, rather than punishment [30,31].

Many geographical regions—particularly rural areas and those with a higher percentage of indigenous people—lack sufficient practitioners with competency treating OUD. Given low insurance reimbursement for addiction treatment services, few financial incentives draw new practitioners into the OUD treatment workforce. Finally, stigma—both against people who use substances, as well as against MOUD use itself—prevents many AYAs from accessing care and receiving evidence-based treatment [33], which is discussed in depth below. Low- and middle-income countries experience many or all these same barriers to MOUD and other unique barriers [23]. Access to health care generally and addiction treatment specifically may be limited. The cost of MOUD, even if available, may be prohibitive.

Given the exceptionally high mortality of OUD, these myriad systemic and access barriers to MOUD place AYAs at great risk [5]. Historically, when such barriers have been removed, the number of individuals receiving MOUD has increased, and overdose mortality has improved. A compelling real-world example is that of France, which in 1995 began allowing physicians to prescribe buprenorphine without special training or licensure. Within 4 years, the number of individuals of all ages receiving buprenorphine increased more than threefold and overdose deaths decreased by nearly 80% [23].

Prescribing barriers such as the buprenorphine waiver requirement in the U.S. should be eliminated, as should guidelines and policies requiring that AYAs attempt a trial of behavioral treatment alone before providing MOUD [4,15,16,19–22]. Policies that result in preference of one medication over another should be abolished, allowing AYAs equal access to buprenorphine, naltrexone, and methadone [19,34]. The decision to choose one medication over another should be made by AYAs, their family members, and clinicians, rather than by restrictive policies.

Addiction services should be confidential, welcoming, and culturally sensitive, similar to other AYA services in which sensitivity and affirmation are critical to providing excellent care (e.g., reproductive health care, mental health care, care of lesbian/gay/bisexual/transgender/queer/questioning youth). AYAs should be allowed to consent for their own addiction treatment, including MOUD, although it should be noted that treatment is more likely to be effective with the involvement of a parent or other trusted adult [4]. Reimbursement for addiction treatment should have parity with that of other medical conditions.

3. *Robust education on OUD treatment should be provided for all practitioners who work with AYAs.*

A clear treatment gap exists whereby most individuals with OUD do not receive evidence-based treatment; this gap is even greater for AYAs [4,6,14,18]. Practitioners who have both addiction medicine expertise and competency treating AYAs are relatively rare. In the U.S., the country with the largest addiction medicine workforce, of all physicians who have completed buprenorphine waiver training, only 2% are pediatricians (personal communication, American Academy of Addiction Psychiatry, 2019). Although this Position Paper recommends that the buprenorphine waiver requirement be eliminated, while it exists, it is critical that physicians, nurse practitioners, and physician assistants who work with AYAs receive training to immediately expand the workforce.

More broadly, however, practitioners from all disciplines who work with AYAs—including physicians, nurse practitioners, physician assistants, pharmacists, nurses, social workers, and psychologists—should receive stronger training in the management of OUD. Such training should include a focus on MOUD as part of comprehensive treatment. More than this, however, training should foster the development of skills beyond simply prescribing, including but not limited to screening, diagnosis, behavioral interventions, management of comorbid mental health conditions, and involving and supporting family members. By fostering competency in addiction among interdisciplinary practitioners, the AYA-focused workforce can ensure there is no “wrong door” through which AYAs can enter to receive OUD treatment. To ensure a continued workforce pipeline of practitioners comfortable treating AYAs, professional training programs also must begin to educate their learners on addiction.

4. *Strategies to reduce stigma surrounding the use of MOUD among AYAs should be widely implemented.*

Stigma against people living with addiction is rampant and detrimental [33]. Such stigma is commonplace in health care settings and prevents individuals from seeking needed help. There is additional stigma faced by people on MOUD, who may receive messaging from their own families and communities that being on an opioid agonist such as buprenorphine or methadone is simply “replacing one addiction with another,” or that someone on MOUD is “not really in recovery.” As the hallmark of OUD is ongoing use of opioids despite experiencing negative consequences, such statements are inappropriate because MOUD helps people with OUD reduce or eliminate the negative consequences of their substance use. Nonetheless, the stigma surrounding MOUD is even further amplified for AYAs, who may receive such deleterious messaging from trusted and otherwise well-meaning adults in their lives [29]. As a chronic medical condition, OUD often requires long-term treatment with MOUD. Although the optimal length of treatment for AYAs has not been thoroughly studied, in older adults, longer periods of MOUD receipt are associated with reduced mortality [5].

Given the respect that health care practitioners often have in their communities, they should partner with public health and other community officials to support messaging and education in support of MOUD and of people living with OUD. To battle stigma in their own clinical practices, practitioners should ensure youth-friendly, trauma-informed, culturally sensitive, and judgment-free treatment spaces to promote treatment seeking among AYAs. They should use appropriate language to describe MOUD, such as “pharmacotherapy” or “medications” rather than “replacement therapy.” “Medication-assisted treatment” is also an outdated term that is counterproductive to normalizing the use of pharmacotherapy [29]; such terminology is not used for other chronic medical conditions (e.g., insulin use in diabetes mellitus is simply referred to as “treatment,” rather than “medication-assisted treatment”), and should be avoided in OUD treatment. It is critical that practitioners help AYAs,

families, and other trusted adults understand the rationale for pharmacotherapy to battle these common stigmatizing statements [29,33].

Practitioners should also use person-first language. For example, they should describe AYAs with OUD as "a person with an opioid use disorder," rather than an "addict," a harmful term commonplace in the lay public. Similarly, practitioners should avoid the term "substance abuser" and "substance abuse" in spoken and written communication, as these terms are associated with stigma in health care settings [33,35]. Indeed, the term "substance abuse" has been removed from the latest edition of the *DSM-5*.

5. *Research efforts to expand the evidence base for the use and delivery of MOUD among AYAs should be supported.*

Despite clinical guidelines [4,15,16,19–21], clinical trial data [7,8,10–13], and high-quality observational studies [5,6] that support the use of MOUD in AYAs, much remains unknown [34]. Key questions that should drive a research agenda include (but are not limited to):

- What is the efficacy, effectiveness, and cost-effectiveness of each MOUD in the treatment of AYAs?
- What are the best practices to incorporate AYA and family preferences into medication choice?
- What is the optimal duration of treatment with MOUD, and does this vary by medication?
- What are the most effective models of MOUD delivery in different settings, including primary care and tertiary care (including pediatric hospital settings), and what are alternative modes of delivery (e.g., telemedicine, mobile clinics, and other community-based services)?
- What are strategies to incentivize practitioners who work with AYAs to more routinely offer MOUD?

Answering these and other related questions are central to improving care for AYAs with OUD.

Summary

Mortality among AYAs from OUD is rising, and expanding access to MOUD is a central strategy to confronting this critical problem. The urgency of achieving the goals in this Position Paper cannot be overstated. Practitioners caring for AYAs have a unique opportunity to provide developmentally appropriate treatment that includes MOUD and are well positioned to confront the challenge of improving the health and well-being of youth with OUD. Many practitioners already manage other complex conditions with biological and behavioral components. Perhaps no other workforce is better poised to address the complexities of OUD and ensure that addiction is treated early in the life course to avert decades of potential harm.

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