Webinar: Substance Use Interventions for Adolescents and Transitional Age Youth

Questions from Participants and Answers from the Presenter

Q: Can pharmacotherapy be prescribed before a behavioral therapy approach? If yes, in what scenario?

A: Yes, there are a couple of considerations.

For patients with an opioid use disorder, medication treatment is protective against overdose (in adult populations it is the one intervention that has been shown to reduce overdose-related mortality). It is recommended to offer it first or in addition to behavioral treatment. For some patients, it may be the reason that they want to engage in care. Although it is optimal for patients to engage in behavioral treatment as well, we do not recommend making it a condition/requirement.

For alcohol use disorder, it can be appropriate to offer in addition to behavioral treatment. As mentioned in the webinar, only buprenorphine is approved for 16 years and older although naltrexone is used off-label for youth under 18 years of age for both opioid and alcohol use disorder.

Q: Can you speak to family involvement when families are the source of stress and triggers (e.g. abusive, neglectful families)? Is it recommended to then include other natural supports or "chosen" family?

A: Great question and this is common. I think that in those cases, it is important to expand the idea of "family" to include other natural supports for the patient. In addition, it can be important to think about ways to offer the family that may be the problem their own support.

Q: Does Medicaid pay for opioid treatment programs?

A: This varies from state to state: https://www.kff.org/other/state-indicator/medicaid-behavioral-health-services-methadone-for-medication-assisted-treatment-mat/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D#note-14

Q: Does an adolescent's confidentiality also include bullying/harassment?

A: This is an important question. In these cases, a provider would have to weigh the risks of breaking confidentiality. In general, that will include when there is concern for imminent harm to the patient. If there is not imminent risk but the provider feels like it would be important to involve family or other

supports, we would suggest working with the adolescent to identify someone else to involve, to help address the situation.

Q: Have you seen an increase in youth engaging in substances (alcohol, tobacco, and other drugs) during this pandemic?

A: Many studies/surveys have shown an increase in the intensity/frequency of substance use among adolescents and young adults since the beginning of the current pandemic. The occurrence of solitary use, often associated with poorer mental health outcomes, has also increased.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7368647/

Q: How can SUD prevention coalitions best support the expansion of SBIRT in communities, especially in rural/small schools?

A: SUD prevention coalitions can best support SBIRT expansion in a few ways depending on the expertise and capacity of the members: (1) helping with training of nurses or school counselors in SBIRT, (2) providing schools with the resources needed for referrals for students identified as needing treatment, and (3) providing education for parents and teachers about SUD in youth.

Q: How did Massachusetts handle the increased capacity needs that come along with requiring SBIRT? (If you identify a need, what did they do to make sure they had the resources to address the need that was identified?)

A: Unfortunately, there was no additional funding that came with the requirement to perform SBIRT in schools in Massachusetts. School staff was given specific SBIRT training, but no additional resources were provided and there was no additional funding for schools attached to the legislation. However, early reports on the first few years of the program suggest that most schools were able to handle positive screens internally (i.e. with their own psychologists, counselors, etc.).

Q: Is there a medication that helps with cannabis use disorder?

A: There are no FDA approved medications for treatment of cannabis use disorder. NAC has been shown to improve abstinence in adolescents in a small number of randomized controlled trials.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2826714/

https://pubmed.ncbi.nlm.nih.gov/22706327/

Q: Now that we know the Positive Childhood Experiences are protective factors, are you hearing about questions to ask adolescent maybe during MI to gauge a PCE score?

A: We personally do not have experience using PCE questions or scores. However, we found this reference which may be of interest and includes a 7-item PCE score:

“The PCEs score included 7 items asking respondents to report how often or how much as a child they: (1) felt able to talk to their family about feelings; (2) felt their family stood by them during difficult times; (3) enjoyed participating in community traditions; (4) felt a sense of belonging in high school (not including those who did not attend school or were home schooled); (5) felt supported by friends; (6) had at least 2 nonparent adults who took genuine interest in them; and (7) felt safe and protected by an adult in their home.”

Source: Bethell C, Jones J, Gombojav N, Linkenbach J, Sege R. Positive Childhood Experiences and Adult Mental and Relational Health in a Statewide Sample: Associations Across Adverse Childhood Experiences Levels. JAMA Pediatr. 2019;173(11):e193007. https://pubmed.ncbi.nlm.nih.gov/31498386/

Q: Please advise about effective, specialized interventions for adolescents, ages 12 to 16, or 12 to 18.

A: In general, we have a similar approach to these age groups. The behavioral interventions that we discussed, CBT, MET, CM, and DBT are all used in these age groups. Although they are effective, ensuring that co-occurring psychiatric disorders are screened for and addressed is also important.

For younger youth (under the age of 16) who have an alcohol and opioid use disorder and for who we might be considering medication treatment, it would be worth thinking about finding an addiction specialist to consult with. For those interested in learning more, the Providers Clinical Support Program, https://pcssnow.org/mentoring/, has a mentoring program to give support to providers treating SUD.

Q: Can you comment on the differences between the three screening tools and what factors would influence the decision to use one over the other?

A: All three screening tools (S2BI, BSTAD and CRAFFT) are effective and validated screening tools and are good options for substance use screening in primary care. S2BI is the shortest tool, and focuses on nicotine/tobacco, alcohol and cannabis. It can be an interesting option when time is limited or when working with a lower risk population group. BSTAD and CRAFFT are both two-part screening tools. BSTAD includes 3 initial questions (on nicotine/tobacco, alcohol and cannabis/other drugs), followed by more detailed questions on specific substances and frequency of use over the past month, 90 days and year. The CRAFFT includes 4 initial questions (alcohol, cannabis, other drugs and nicotine/tobacco) that are followed by 6 questions which can help assess the impacts of substance use on a young person's everyday life and functioning. While S2Bi has the advantage of being shorter, the BSTAD and CRAFFT can help with a more detailed assessment. The CRAFFT has the added advantage of including potential speaking points (in the second part) which can be part of an effective brief intervention.

Q: What about giving youth the data on how many are NOT using? Evidence shows that youth tend to think 'everyone's using'.

A: This is a great point. It is certainly helpful to be familiar with local/state specific data and be able to provide that information to youth. In fact, the proportion of youth who are abstinent from all substances during adolescence has been steadily increasing over the past thirty years.

https://pediatrics.aappublications.org/content/142/2/e20173498

Q: Why is methadone safer than opioids and is methadone addictive? Additionally, once someone is on methadone, are they meant to be weaned off?

A: Methadone is an opioid and a full agonist. When used to treat opioid use disorder (in the US) it must be dispensed from an opioid treatment program and is difficult for people under 18 years to access. Studies have consistently shown that individuals with OUD treated with methadone have

better outcomes related to mortality, quality of life, infectious complications of drug use, and retention in care than with no medication treatment.

People treated with methadone will develop a physical dependence, but if taken through an OTP, the risk of addiction is low. There is an increased overdose risk when taking methadone with other sedating medications so it is important for prescribers to be aware of that. We do not have the data to inform the optimal duration of treatment but want to at least wait until someone is stable. In youth, methadone is often prescribed with a medium to long term goal of gradually tapering and eventually stopping it, but it can also be prescribed long term as maintenance treatment.