Adolescent and Young Adult Medication Assisted Recovery (MAR)

The purpose of this guideline is to help clinicians consider MAR options for adolescent and young adult patients with opioid use disorder (OUD).

Opioid overdose deaths have increased 500% among 15- to 24-year-olds since 1999. Overdose deaths among this age group increased by as much as 30% annually since 1999.

Among youth who suffer a non-fatal overdose, only 2% receive pharmacotherapy within 30 days of overdosing, 29% only receive behavioral health counseling, and more than 70% receive no treatment at all. This is despite the American Academy of Pediatrics supports the use of MAR in pediatric patients.

MAR[1] is the use of evidence-based FDA approved medications (e.g., methadone, buprenorphine, naltrexone, disulfiram, acamprosate) by individuals with a substance use disorder (SUD) to support their recovery. Currently buprenorphine is the only FDA approved medication for pediatric patients 16 years of age and older. However, buprenorphine has been used off label in patients younger than 16 and naltrexone has been used off label in patients less than 18 years of age.

IDHS/SUPR recognizes that individuals who identify in recovery and take medications to manage their SUD *are* in recovery.

- Clinicians should consider the use of validated screening tools in their pediatric wellness visits. Tools that may be used are the CRAFFT, Substances and Choice Scale (SACS), and Measurements in Addiction for Triage and Evaluation for Young People (MATE-Y)
- Using the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (DSM V) criteria, patients who have a moderate to severe OUD should consider MAR as a treatment option.
- Clinicians should be familiar and use non-stigmatizing language.
- Patients should be encouraged to talk with their family about their substance use and harm reduction interventions such as the use of Naloxone to reverse an opioid overdose. However, this should not be forced or a condition of treatment, MAR should not be withheld if the patient chooses not to disclose.
- At the initial visit, the clinician should review with the patient expectations of treatment including drug screening and frequency of appointments. Clinician may also wish to obtain a medication agreement. Special consideration should be made for adolescent or young adult patients who are in school and flexibility with appointments including virtual appointments should be an option.
- Clinicians should also take this opportunity to ensure the patient is up to date on vaccines and obtain labs for HIV, RPR, CBC, CMP, Pregnancy Test, Hepatitis C, and Hep B antibodies.
- For patients who wish to proceed with MAR buprenorphine induction:
    - Patient should be in moderate withdrawal
        - This is usually achieved by patient not using for 12-36 hours
        - It should be clearly explained to patient that if they do not abstain, they will have significant withdrawal symptoms and not feel well

    - Start with buprenorphine 4mg repeat dose after 1 hour if withdrawal symptoms continue
    - Typical dosing is 8-24mg per day
    - Split dosing to twice per day seems to offer better symptom control for some patients.
- Prescribe or provide Naloxone and educate the patient on Naloxone to reduce the risk of a fatal overdose. It is important patient understands that if they are to lapse or relapse that they are at risk of overdose and the reason why. They should also be instructed, if they are going to use, to never use alone. People who use opioids alone are at higher risk of fatal overdose.
- Offer wrap around services where available. Please note while having behavioral support and therapy is optimum it is not a requirement to begin MAR therapy. Medications for OUD decrease opioid mortality and all cause mortality even for those who do not engage in counseling

1. Anne E. Casey Foundation, Kids Count Data Center
2. U.S. Department of Health and Human Services (DHS) Substance Abuse and Mental Health Services Administration (SAMHSA), National Surveys on Drug Use and Health
3. SAMHSA, Overdose Death Rates
4. National Institutes of Health National Institute on Drug Abuse, Monitoring the Future Study
5. Official Journal of the American Academy of Pediatrics, Prescription Opioids in Adolescence and Future Opioid Misuse
6. COMMITTEE ON SUBSTANCE USE AND PREVENTION; Medication-Assisted Treatment of Adolescents With Opioid Use Disorders. *Pediatrics* September 2016; 138 (3): e20161893. 10.1542/peds.2016-1893
7. Krausz M, Westenberg JN, Tsang V, Suen J, Ignaszewski MJ, Mathew N, Azar P, Cabanis M, Elsner J, Vogel M, Spijkerman R, Orsolini L, Vo D, Moore E, Moe J, Strasser J, Köck P, Marian C, Dürsteler KM, Backmund M, Röhrig J, Post M, Haltmayer H, Wladika W, Trabi T, Muller C, Rechberger G, Teesson M, Farrell M, Christie G, Merry S, Mamdouh M, Alinsky R, Levy S, Fishman M, Rosenthal R, Jang K, Choi F. Towards an International Consensus on the Prevention, Treatment, and Management of High-Risk Substance Use and Overdose among Youth. *Medicina*. 2022; 58(4):539. https://doi.org/10.3390/medicina58040539