

Maryland BHIPP

*Youth and Substances: What's a
Primary Care Provider To Do?*

September 25th, 2020 12:30 – 1:30 PM

Mark Fishman, M.D.

MACS
Maryland Addiction Consultation Service



855-MD-BHIPP (632-4477)

www.mdbhipp.org

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Meet The Presenter



Mark Fishman, M.D.

Marc Fishman, MD, is an addiction psychiatrist, Medical Director of Maryland Treatment Centers, and a member of the Psychiatry faculty of the Johns Hopkins University School of Medicine. Dr Fishman leads Maryland Treatment Centers, a regional behavioral health care provider, which includes Mountain Manor Treatment Centers in Baltimore and Emmitsburg as well as several other inpatient and outpatient programs. In that role he has been involved in development and implementation of innovative programming in addiction and co-occurring disorder treatment. His clinical specialties include treatment of drug-involved and dual-diagnosis youth, opioid addiction in adolescents and adults, and addiction with co-occurring psychiatric disorders. His research work has focused on medication treatment for SUDs as well as, models of care and treatment outcomes in youth, in particular opioid addiction. He has been a president of the MD Society of Addiction Medicine, and is currently a member of its Board.



Who We Are – Maryland BHIPP



Offering support to pediatric primary care providers through free:

- Telephone consultation (855-MD-BHIPP)
- Resource & referral support
- Training & education
- Regionally specific social work co-location (Salisbury University and Morgan State University)
- Project ECHO®

Coming soon!

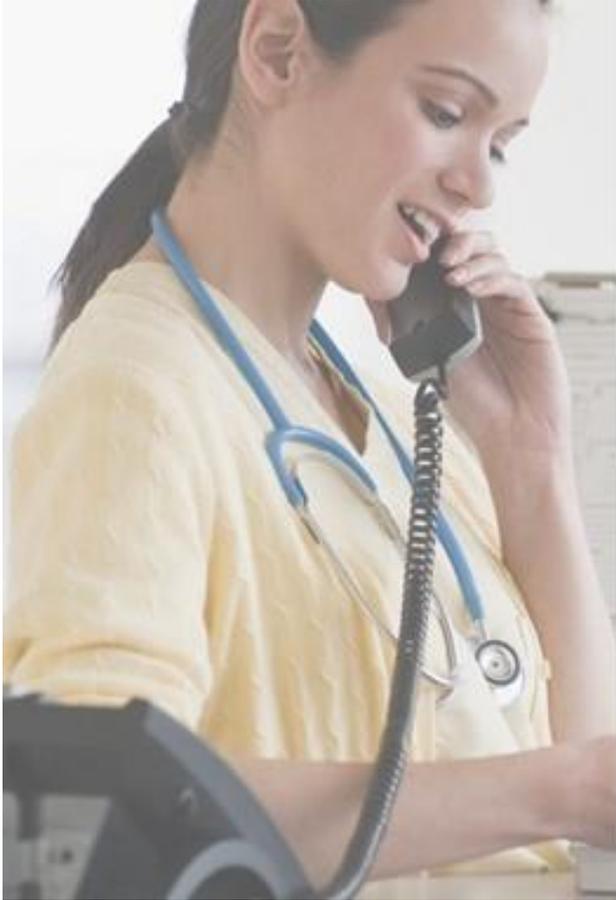
- Direct Telespsychiatry & Telecounseling Services
- Care coordination

Partners & Funding

- BHIPP is supported by funding from the **Maryland Department of Health, Behavioral Health Administration** and operates as a collaboration between the **University of Maryland School of Medicine**, the **Johns Hopkins University School of Medicine**, **Salisbury University** and **Morgan State University**.
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BHIPP is Available to Provide Support to PCPs During Coronavirus



BHIPP is open.

The BHIPP phone line remains open during this challenging time to support primary care clinicians in assessing and managing the mental health needs of their patients.

1-855-MD-BHIPP
(1-855-632-4477)

www.mdbhipp.org



Ways to Connect:

- Visit our COVID-19 Resource Page:
www.mdbhipp.org
- Sign up for our newsletter:
<https://mdbhipp.org/contact.html>
- Follow us on Facebook:
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Provides support to prescribers and their practices in addressing the needs of their patients with substance use disorders and chronic pain management.

All Services are FREE

- Phone consultation for clinical questions
- Education and training opportunities related to substance use disorders and chronic pain management
- Assistance with addiction and behavioral health resources and referrals
- Technical assistance to practices implementing or expanding office-based addiction treatment services
- MACS TeleECHO™ Clinics: collaborative medical education through didactic presentations and case-based learning

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Outline (Whirlwind overview)

- Scope of the problem: use patterns and vulnerability
- Cannabis: what's the fuss
- Clinical approaches: assessment, intervention, referral
- Opioids

Some things never change

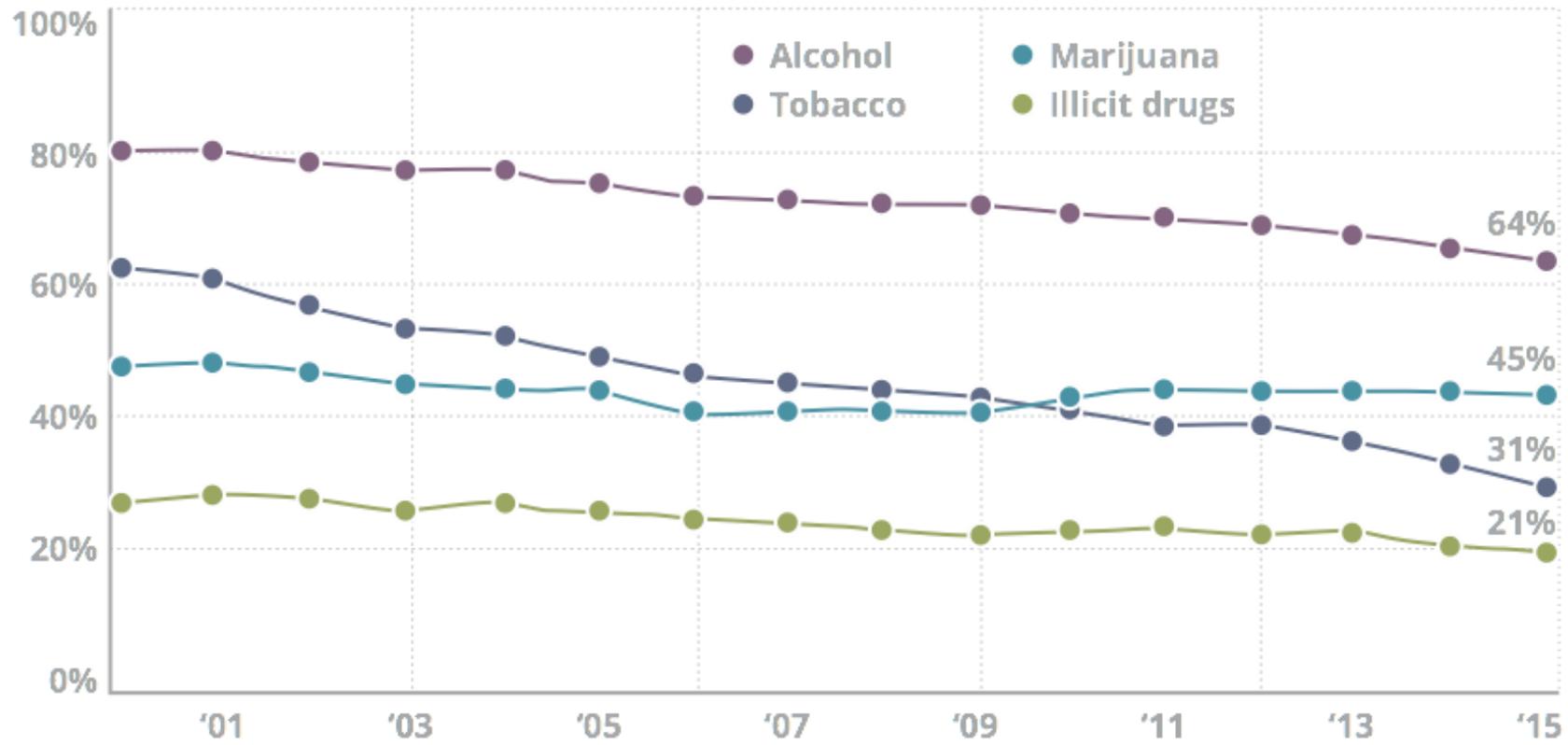
“We live in a decadent age.
Young people no longer respect their parents.
They are rude and impatient.
They frequent taverns and have no
self-respect.”

Inscription on Egyptian tomb circa 3000 BC

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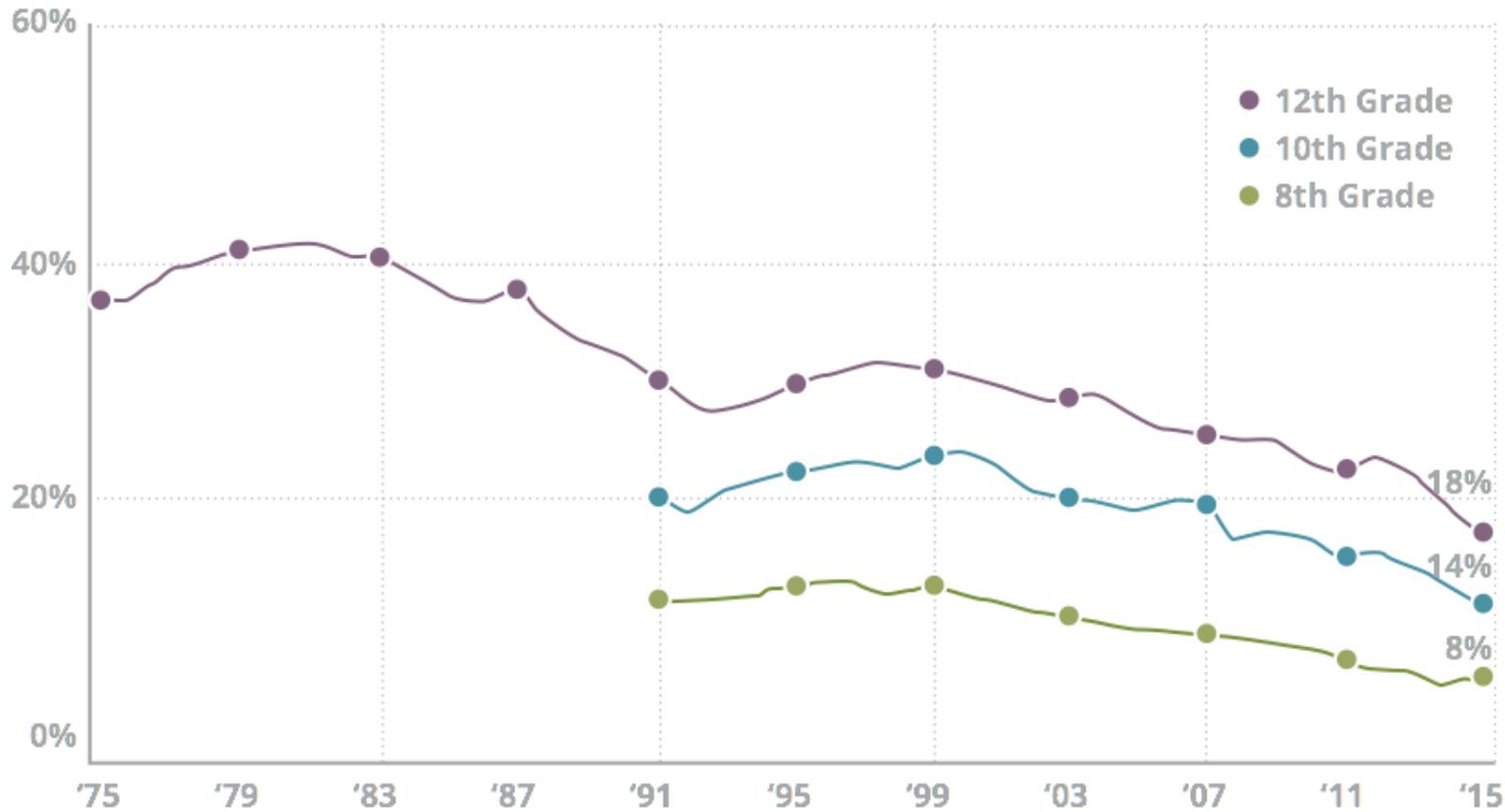


Percent of US Adults Reporting Using Substances in Lifetime, 2000-2015

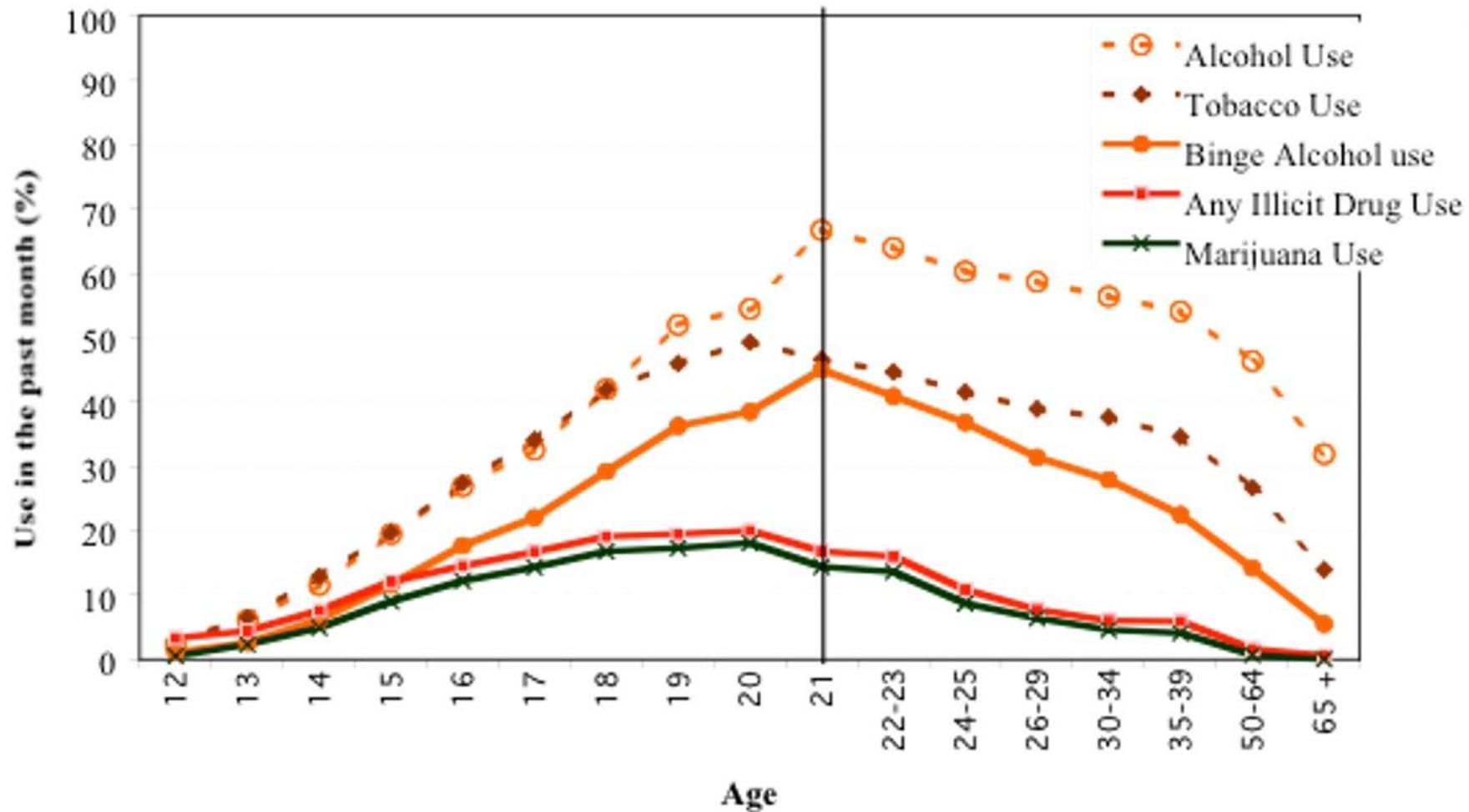




BINGE DRINKING (5+ Drinks) Past 2 Weeks



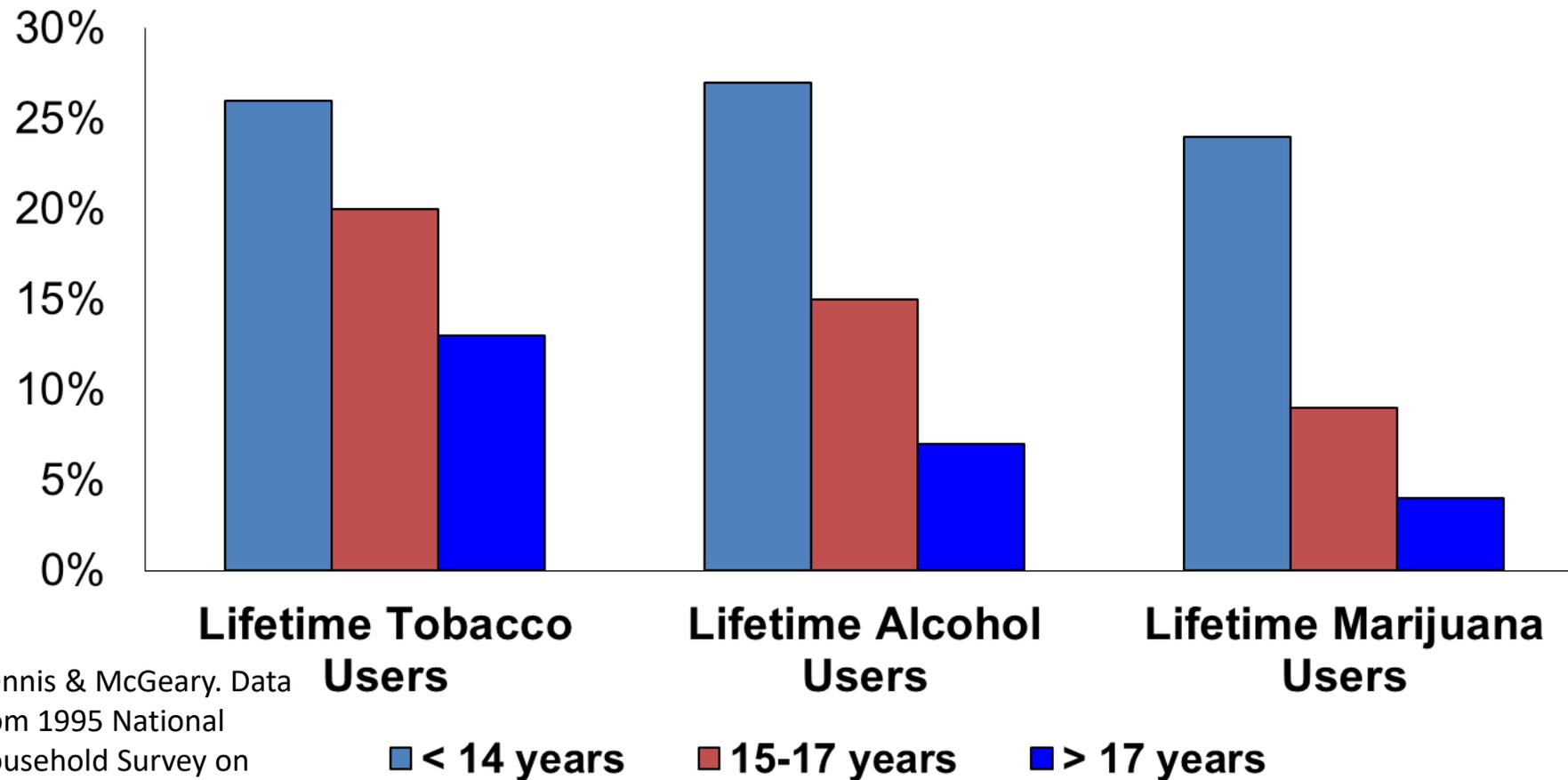
Relationship between Past Month Substance Use and Age



Source: Dennis (2002) and 1998 NHSDA.

Does Development Matter?

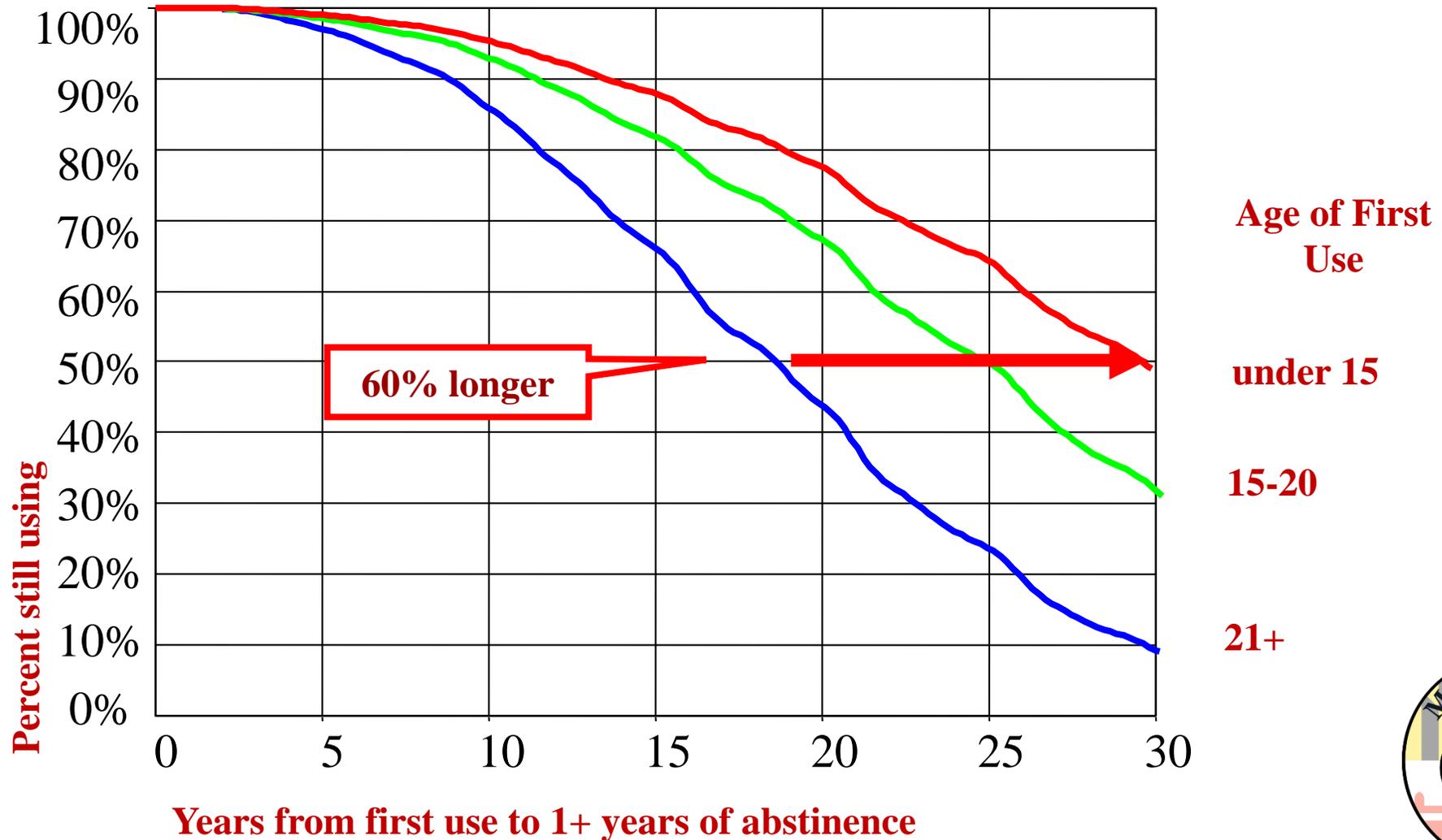
Probability of Having 1 or More Dependence Symptom(s) as an Adult Based on Age of First Use

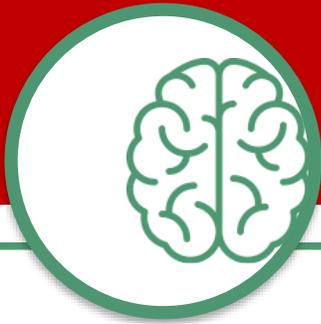


Dennis & McGeary. Data from 1995 National Household Survey on Drug Abuse



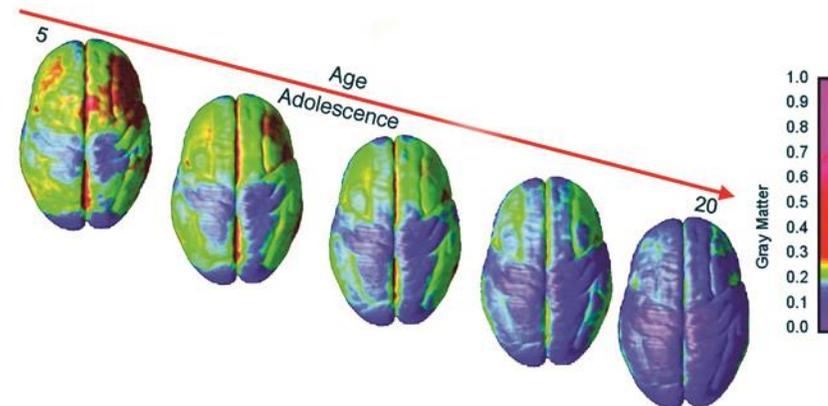
The Younger They Start, The Longer They Use





Adolescents Are Vulnerable

- Early substance use = high risk addiction
- Adolescent immaturity during critical development period = vulnerability
 - Impulsiveness and excitement seeking
 - Difficulty delaying gratification
 - Poor executive function and inhibitory control



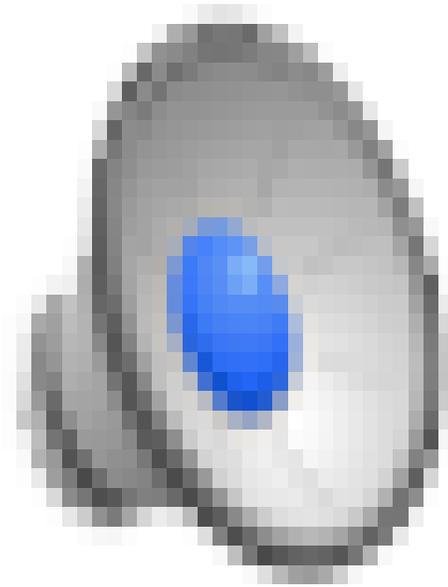
Executive Control

Stanford Marshmallow Experiment

- Important body of work by Walter Michel
- Intrinsic inhibitory control and capacity for postponement of gratification
- https://www.youtube.com/watch?v=QX_oy9614HQ



Marshmallow test



Executive Function: Interference and Impulse Inhibition

Name these colors:

Yellow

Green

Blue

Red

Antecedent Vulnerability: Emotional Dysregulation

- Common examples of difficulties preceding onset of substance use –
“my child has always had this trouble”
- Intersecting vulnerabilities
 - Impulsivity
 - Lability and moodiness
 - Over-reactivity and tantrums
 - Poor frustration tolerance
 - Irritability and anger

This should not be a surprise





Cannabis

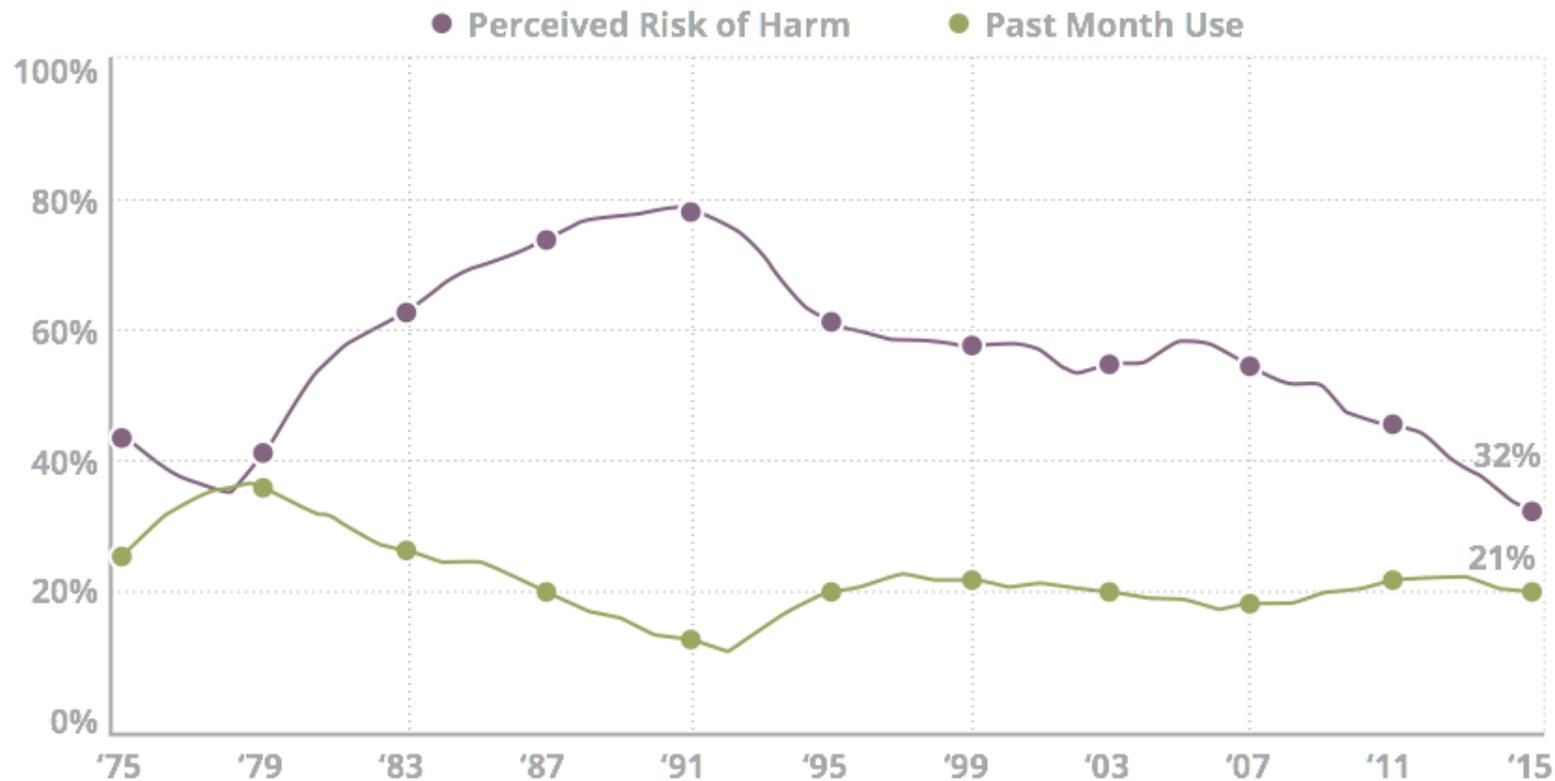


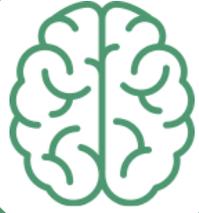
Why do we care about cannabis? What's all the fuss?

- Vulnerable populations: youth, psychiatric illness, other substance use disorders
- Acute consequences of intoxication, eg MVCs
- Psychiatric consequences of use
 - Depression/ anxiety
 - Psychosis
 - Cognitive impairment
- Progression to cannabis use disorders and other substance use disorders



Perceived Risk of Harm and Marijuana Use - US 12th Graders: 1975 - 2015



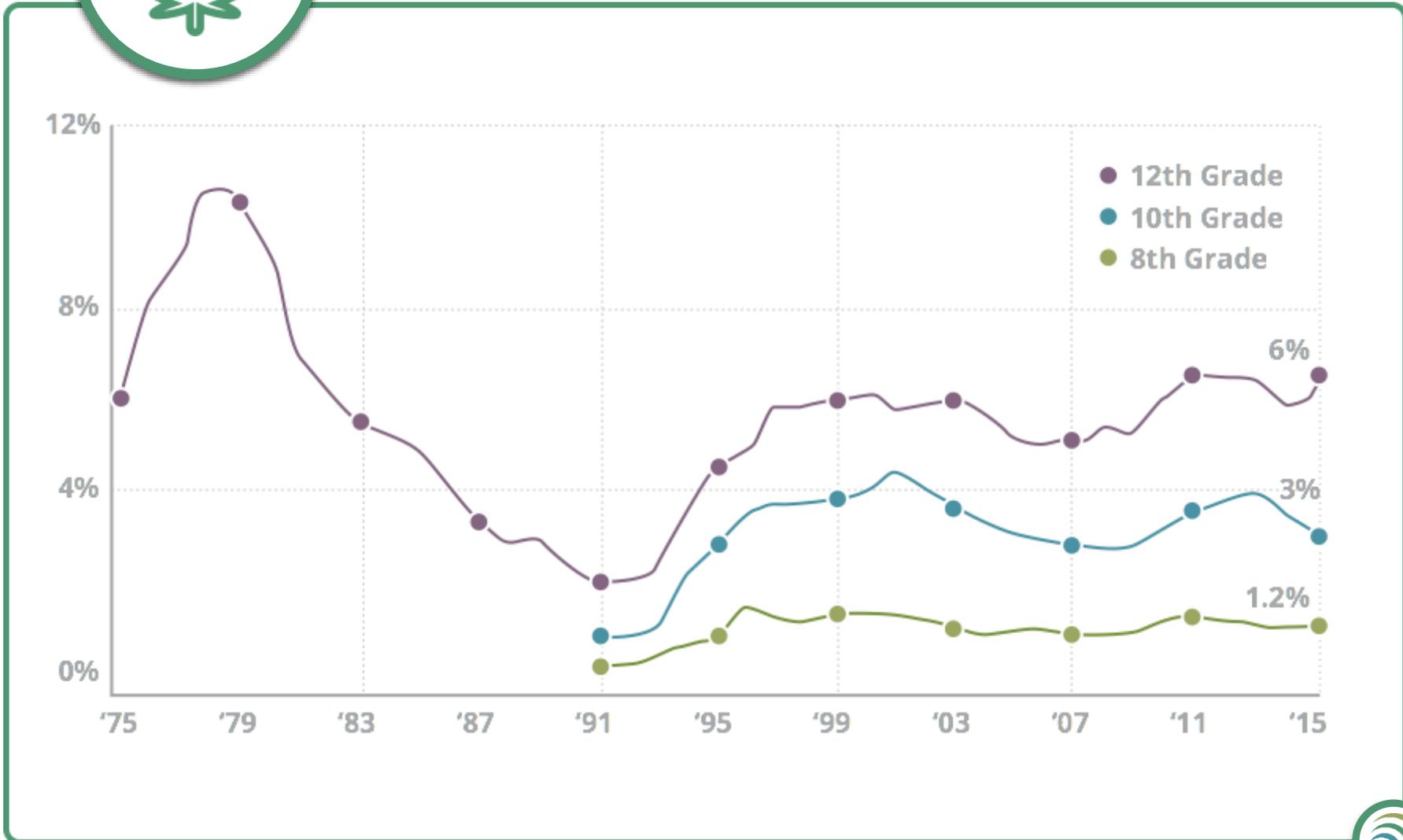


Our Culture





% WHO USE DAILY



Vulnerability in youth

Progression to addiction

- Conditional risk of use disorder in adolescents as high as 40%
- Daily use of MJ <age 17 associated with substantially increased risk of:
 - Persistent MJ Dependence (OR=18)
 - High school drop out (OR=3)
 - Use of other drugs (OR=8)
 - Suicide attempts (OR=7)

Pooled longitudinal studies. N =2537 to N=3765.

Silens et al. *Lancet Psychiatry*, 1,: 286 – 293, 2014S

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Messaging - Overcoming societal attitudes

- We have too easily been cast in the role of puritanical prohibitionists , but we are concerned with **problem use**
- MJ can be harmful and addictive (but not everyone gets harmed or addicted)
- Broader use leads to broader **problem** use through access and decreased perception of harm
- This is a huge problem for youth (and other vulnerable populations)
- How to respond to MJ as “medicine” or consumer good:
 - Medicalization (analogy: US prescription opioid epidemic)
 - Recreational commercialization (analogy: alcohol)

Can we establish credibility despite historic exaggeration?



Access: I scream, you scream, we all scream for...



Clinical approaches

Treatment Engagement and Stages of Change



- Progressive treatment engagement
- Relationship and therapeutic alliance
- Motivational enhancement

Motivational approaches

- Do you know other kids who have been in trouble...
- Do you know why I or your parents might think it's a problem...
- What are the pro's and con's for you...
- What would be evidence in your view that it's a problem...
- If you could stop anytime, would you be willing to see what it's like...
- Let's schedule you to come back and see how it's going...
- Will you go and see a specialist? Get another opinion?

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Practical Treatment Approaches

- 95% is just showing up



Comorbidities

- **Medical**
 - Sexual risk behaviors and STI's, pregnancy prevention
 - Smoking (tobacco or marijuana): reactive airway disease
 - Injury
- **Mental Health**
 - Depression and anxiety
 - Safe adherence to stimulant Rx for ADHD



Communication and Disclosure

- “This is your private treatment, stays between us unless I’m concerned about your health and safety. I can’t help if I don’t know the whole story”
- “Let’s bring in your parents – do it together, I’ll run interference, they’ll find out anyway, better coming from you.”
- Medical decision making about risk and urgency (imminent harm vs postponement for further discussion)
- Getting to yes



Talking to parents

- Recognize this is tricky territory
- Families come in all shapes and sizes
- Family history can be instructive
- Education-only school programs are largely ineffective, it's parental attitude and influence that matters
- Some parents will minimize impairment = over-permissive
- Some parents will be alarmist = punitive, over-intrusive



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Model How to Talk With Your Kids



- Have the conversation(s)
- When parents speak to kids before they leave for college, it works
- Don't be surprised that "they don't get it..."
- Pick your battles



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Not In My House

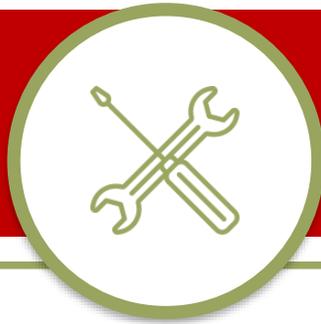


- Address the supply:
 - Monitor and secure medications
 - Dispose of medications no longer in use
 - Coordinate with peers, friends' parents, grandparents
- Parental Use? (tricky territory)
 - “Not that this applies to you, but some families may use substances socially...”
 - Remind them that kids are mimics



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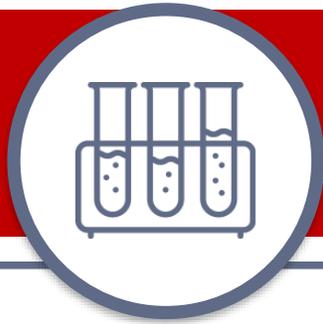
Follow-Up Monitoring

- Reflect on improvement or progression

“How’s it been going since last visit? Any thoughts about what we talked about?”

- “How many times have you _____ since then?”
- “Did you try to stop or cut down?”
- “How can we get help from your parents/family?”





Urine Drug Test (UDT)

- Normalize as part of routine testing
- Recognize it is an inflection point
- Medicalizes the conversation
- Practice your narrative around it





Consider This

- HCPs (esp primary care) have *enormous* impact on patients and families
- Set a clear standard:
 - Any intoxicant use is unhealthy for adolescents.
- On the other hand... marathon not a sprint
- Encourage waiting - every delay is impactful
- Normative experimentation among young adults, but easy to lose control
- Longitudinal follow-up holds up a mirror of dynamic change, positive and negative





Referral

- Know your “cut point” for referral – markers of severity
- Learn your local resources, develop your network of specialists and programs
- Assess quality
- If you can’t find great, go for good, or even OK
- Promote reciprocal communication with referral
- Reassure – easy for youth and families to jump to worst case scenario, simple evaluation is first step

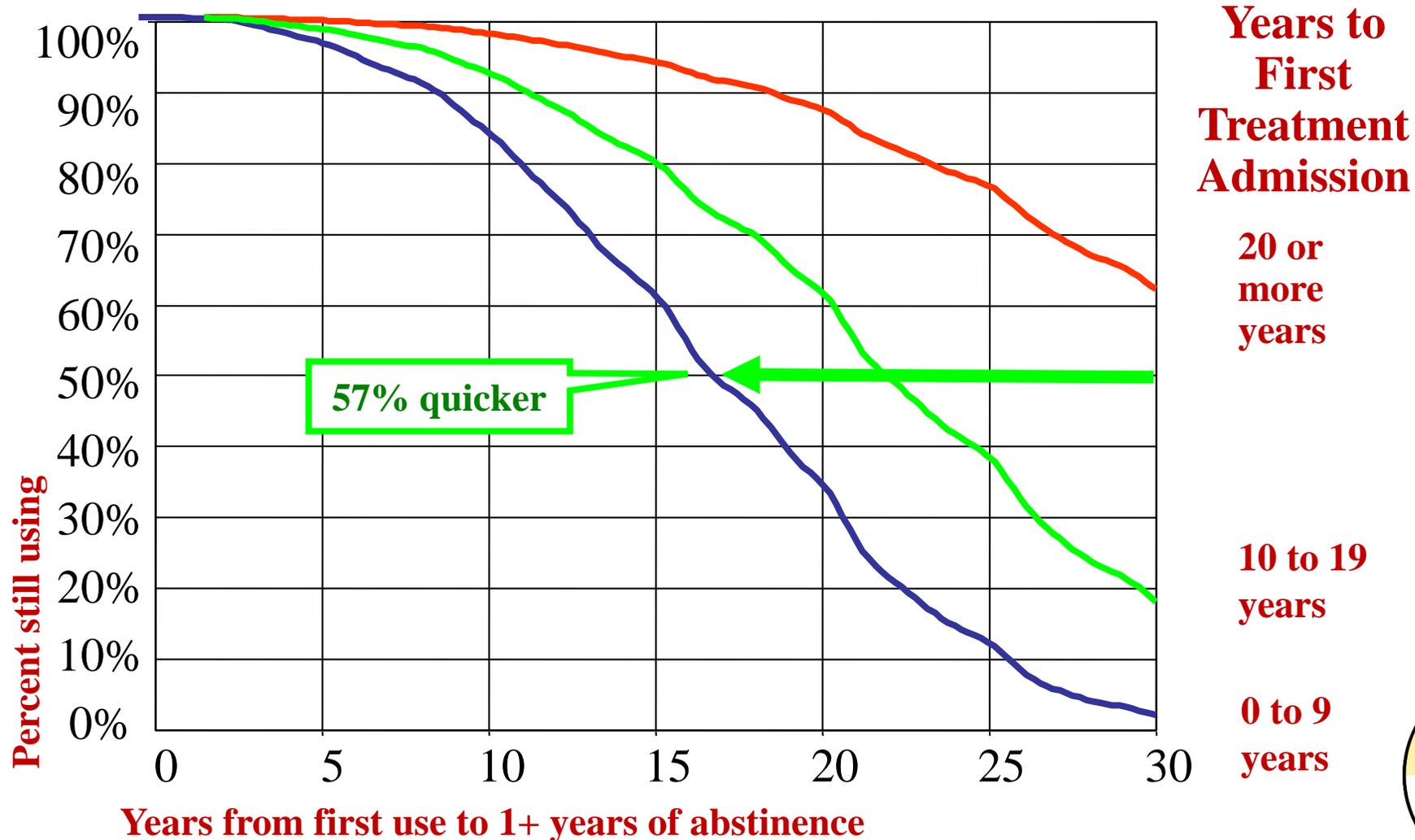


Talking Through the Referral

- Use the motivational moment
- Explore potential barriers
- Normalize anxiety and ambivalence
- Address patient's resistance to seeking help
- Convey urgency to families for high severity
- Administer a “warm hand-off”
- If patient refuses:
“Will you at least come back to talk with me?”



The Sooner we Intervene, The Quicker they get better...

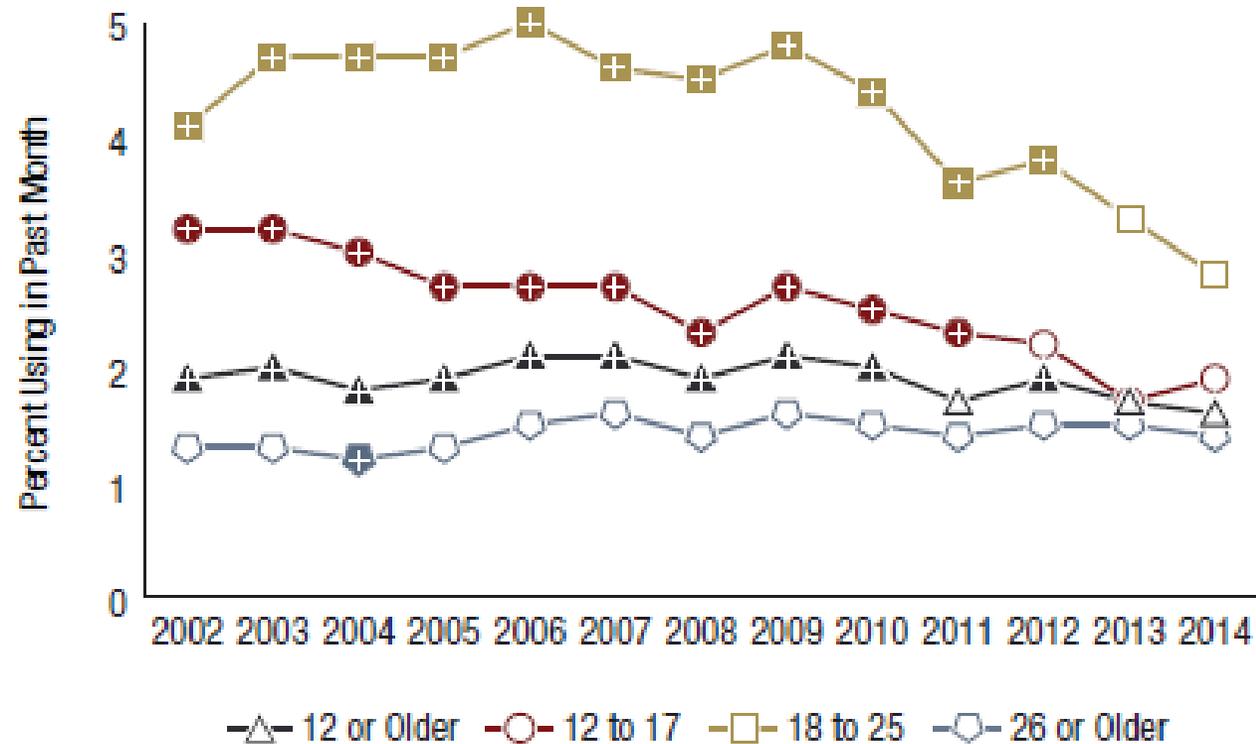


Opioids



Young adults highest prevalence Non-medical prescription opioids

Figure 6. Past Month Nonmedical Use of Pain Relievers among People Aged 12 or Older, by Age Group: Percentages, 2002-2014

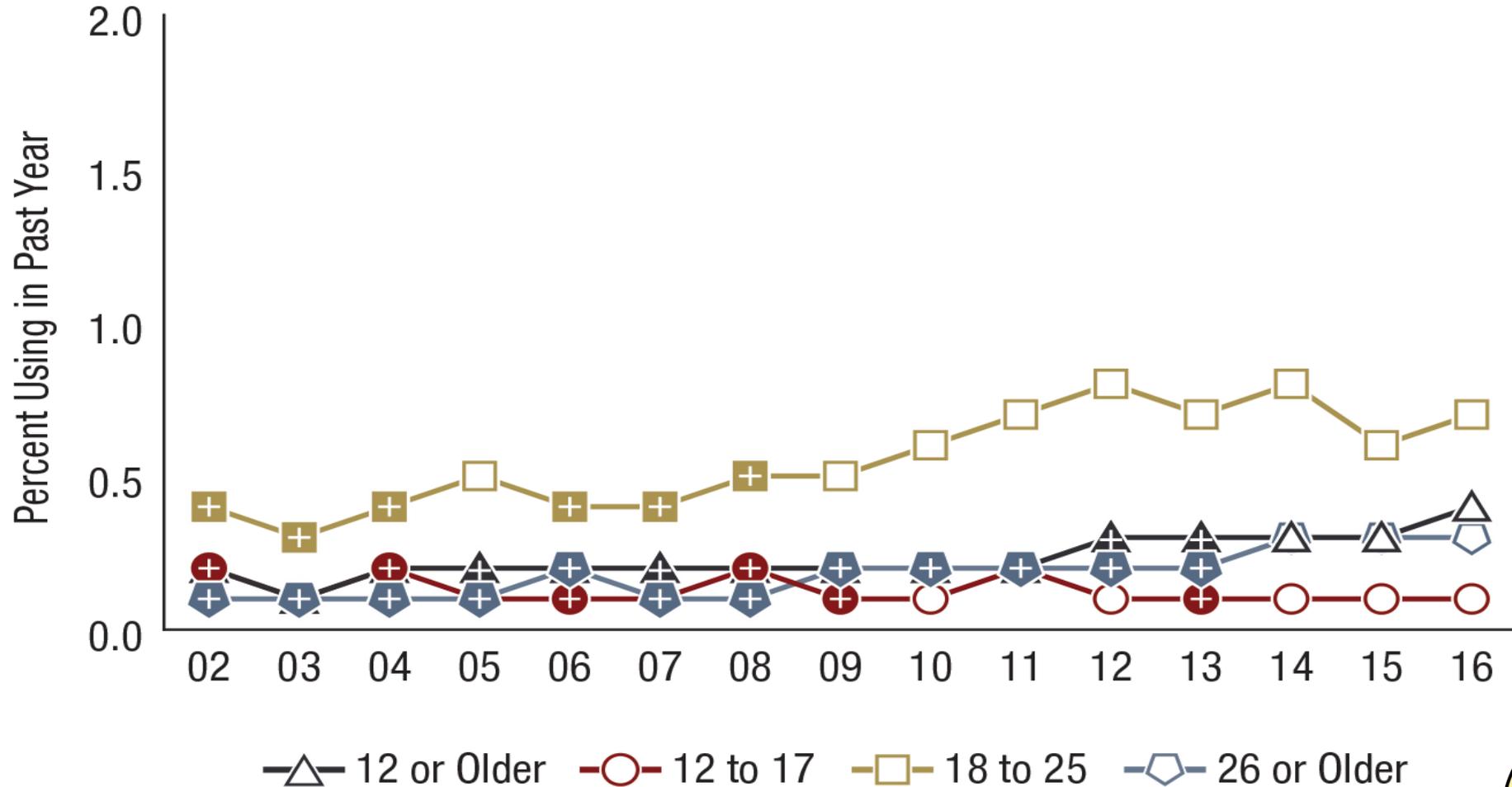


+ Difference between this estimate and the 2014 estimate is statistically significant at the .05 level.



Young adults highest prevalence

Heroin



+ Difference between this estimate and the 2016 estimate is statistically significant at the .05 level.



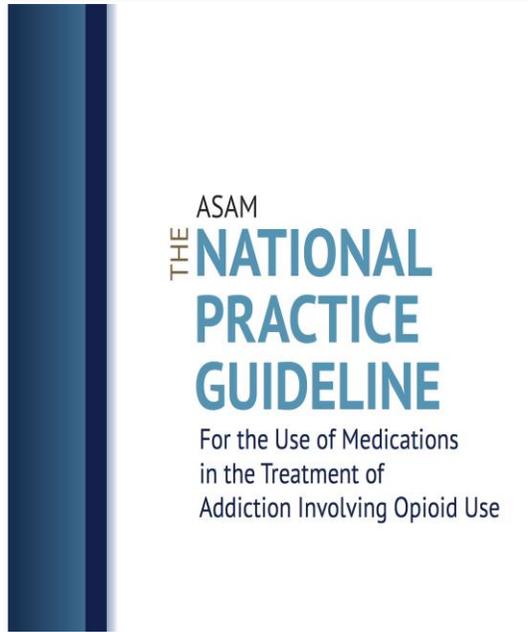
Paths to youth OUD

- The vast majority of youth who initiate opioids have problems with other substances first
- Most youth who are prescribed medical opioid analgesics do not use non-medically
- While some youth have been prescribed medical opioids before non-medical use, the majority initiate with non-medical

Intervention for youth substance use is Prevention for youth OUD

- Addiction – a developmental disorder of pediatric onset
- Earlier onset associated with worse outcomes
- Earlier intervention better outcomes
- Opioid addiction as an advanced stage along a continuum of illness

Treatment guidelines for youth



American Society of Addiction Medicine (2015, 2020):

- Clinicians should consider treating adolescents using the full range of treatment options, including pharmacotherapy

American Academy of Pediatrics (2016):

- Encouraging pediatricians to consider offering MAT or discussing referrals to other providers for this service

POLICY STATEMENT Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

American Academy
of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™

Medication-Assisted Treatment of Adolescents With Opioid Use Disorders

COMMITTEE ON SUBSTANCE USE AND PREVENTION

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Committee on Substance Use and Prevention Medication-assisted treatment of adolescents with opioid use disorders. *Pediatrics*, 2016;138(3):1893.
Kampman K & Jarvis M. *Journal of Addiction Medicine*, 2015;9(5):358-367.

MOUD for Adolescents and Young Adults

Summary of the Evidence

- Buprenorphine **effective**, though outcomes not as good as for older adults
- Longer is better; no evidence for time limitation
- XR-NTX promising, but little youth-specific research
- No signal for **safety problems** based on age
- MOUD first line; No evidence for fail-first



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Recommendations

Youth OUD treatment

- Youth SUD providers should prioritize OUD treatment including use of MOUD
- Youth serving medical providers should identify OUD cases and treat with MOUD
- Typical upstream touchpoints should trigger assertive treatment outreach –
 - OD, ED, medical hospitalization, psychiatric hosp, criminal/juvenile justice
- Innovative approaches to improve engagement and retention for high-severity, high-chronicity patients

Primary emphasis on MOUD

- High effect sizes
- Prevention of OD and death
- Reduces barriers
- Familiar and easy to conceptualize

Example of Innovative Intervention

Youth Opioid Recovery Support



Assertive
Outreach



Family
Involvement



Medication
Home Delivery



Incentives for
Medication



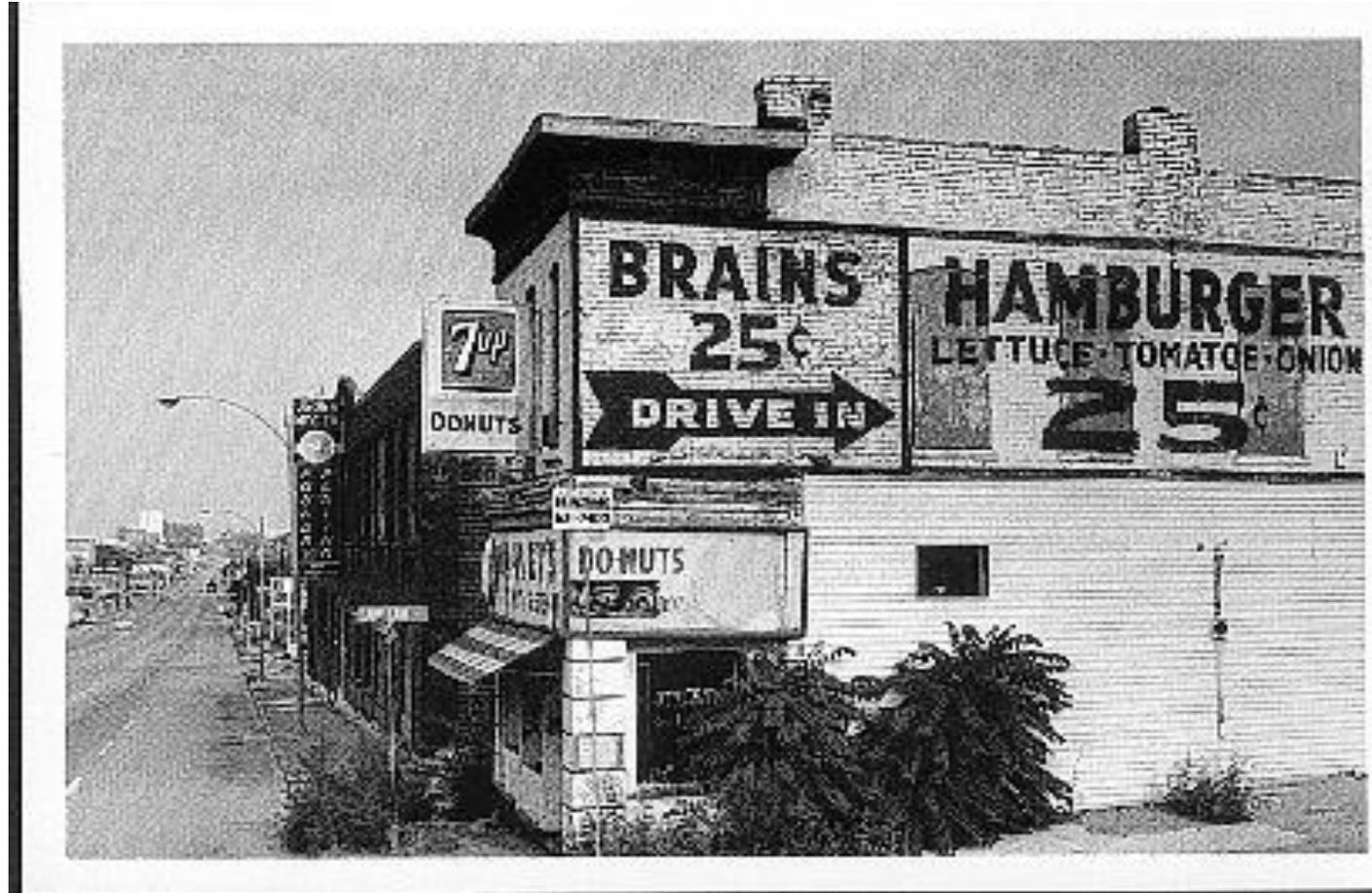
Conclusions

- Youth have developmental vulnerability to SUD with associated severe impairment
- Youth treatment should be developmentally-informed and address special needs
- We need to be clear and firm in our prevention messaging
- Relapse prevention medications have a role for OUD
- Youth SUD treatment is effective
- Recovery Happens!!

A call to action

- We are at a crossroads
- We have an existing and emerging toolbox but an alarmingly low level of adoption and utilization
- Therapeutic optimism remains one of our best tools!
- We are saving lives but we need to do better

Hypothetical Miracle Cures





Case #1



- 15 YO girl, parents describe social withdrawal, explosiveness, change in peer group, and academic decline; no knowledge of SU
- She acknowledges not feeling herself. Preoccupying worries, irritable, concentration decline, sleep disturbance
- Volunteers she has experimented with marijuana and beer; denies recent use
- Further exploration reveals ongoing weekend marijuana use; she acknowledges depression but believes the substances are “no big deal.”





Case #2



- 16 YO female, brought in by parents
- She's lost interest, grades declining, mom concerned about depression
- Stormy, on/off relationship with boyfriend who is substance abuser; she is ambivalent about sex, wants to discuss contraception; reluctantly agrees she has been drinking with him and his friends, has tried some pills
- She has started going to parties, smoking marijuana, taking more pills; admits to using opioids and benzos "not that much."





Case #3

- 20 YO male college soccer player
- Regular cannabis, binge drinking
- Struck in the face, required rhinoplasty, controlled pain with opioids
- During time away from sports, he fell in with deviant peers, escalated use non-medically, diverted to friends
- Prescription opioids cut-off, street supply, then switched to heroin
- Went to rehab, returned last month, ambivalent about continuing specialty care



Thank you!

Questions?

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