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.

855-MD-BHIPP (632-4477)
www.mdbhipp.org
855-337-MACS (6227)
www.MarylandMACS.org
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.
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
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.

This program is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $433,296 with approximately 20% financed by non-governmental sources. The contents of this presentation are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS or the U.S. Government. For more information, visit www.hrsa.gov.
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:


➢ Sign up for our newsletter: https://mdbhipp.org/contact.html

➢ Follow us on Facebook: https://www.facebook.com/MDBHIPP/

➢ Follow us on Twitter: https://twitter.com/MDBHIPP
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

1-855-337-MACS (6227) • www.marylandMACS.org
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
Percent of US 12th Graders Reporting Using Substances in Lifetime, 2000-2015

Monitoring the Future Survey 2015
BINGE DRINKING (5+ Drinks) Past 2 Weeks

Monitoring the Future Survey 2015
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

![Graph showing the percentage of people still using drugs over time after their first use, with different lines for different age groups. The graph indicates that the younger a person starts using drugs, the longer they are likely to continue using.

Source: Dennis et al., 2005]
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

• 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

Monitoring the Future Survey 2015
Our Culture
Monitoring the Future Survey 2015
• 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
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?
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
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

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2701098/
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
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
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
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…

Source: Dennis et al., 2005
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

NSDUH, 2014
Young adults highest prevalence
Heroin

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

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

NSDUH, 2016
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
American Academy of Pediatrics (2016): • Encouraging pediatricians to consider offering MAT or discussing referrals to other providers for this service.

American Society of Addiction Medicine (2015, 2020): • Clinicians should consider treating adolescents using the full range of treatment options, including pharmacotherapy.

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
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.”
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?