Medication Assisted Treatment

Opioid Use Disorder in Adolescents: Medications, Evidence-Based Practices, and Family Support

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Person Centered Treatment & MAT

Measuring stigma and bias professionals and/or the community may have related to Medication Assisted Treatment (MAT)

Questions for the Participants:

1. What biases have you observed related to MAT?
2. Do you have any personal biases related to MAT?

MAT Treatment: The Myths and Facts

MYTH #1: Patients are still dependent

FACT: Addiction is pathologic use of a substance and may or may not include physical dependence.

Physical dependence on a medication for treatment of a medical problem does not mean the person is engaging in pathologic use and other behaviors.

Adapted from NIDA Blending Initiative (NIDA-SAMHSA) 2007

MAT Treatment: The Myths and Facts pt 2

MYTH #2: MAT is simply a substitute for heroin or other opioids

FACT: MAT is a replacement medication; it is not simply a substitute

- MAT is a legally prescribed medication, not illegally obtained.
- MAT is medication that is a very safe route of administration.
- MAT allows the person to function normally.

Adapted from NIDA Blending Initiative (NIDA-SAMHSA) 2007

MAT Treatment: The Myths and Facts pt 3

MYTH #3: Providing medication alone is sufficient treatment for opioid use diagnosis.

FACT: MAT is an important treatment option. However, the complete treatment package must include other elements, as well.

- Combining pharmacotherapy with counseling and other ancillary services increases the likelihood of success.

Adapted from NIDA Blending Initiative (NIDA-SAMHSA) 2007

MAT Treatment: The Myths and Facts pt 4

MYTH #4: Patients are still getting high specific to MAT.

FACT: When taken sublingually, buprenorphine is slower acting, and does not provide the same "rush" as heroin. (Also, other methods of administration that are safe and effective)

- Buprenorphine has a ceiling effect resulting in lowered experience of the euphoria felt at higher doses.
- Methadone is orally taken within a treatment system of care.

Adapted from NIDA Blending Initiative (NIDA-SAMHSA) 2007

Person-Centered-Care

When you hear the phrase, person-centered care, what comes to mind?

Program Driven or Person Centered, that is the question?

- Business Model Bias (Does your program structure create barriers?)
- Care Coordination for Methadone
- Adolescent Considerations
- Three Federally Approved Medications for OUD Treatment
  - Methadone (Full Agonist)
  - Buprenorphine (Partial Agonist)
  - Naltrexone (Anti-Agonist)

Referrals, Connections, Planning & Support-

For treatment and Wrap-Around Services

Strengths of a CCBHC!

- Targeted Case Management
- Peer Support
- Coordination of Care Partnership Agreements
- SUD & MH outpatient services
- MAT
- ACT

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Amanda Hankins, CADC, CADC-S

Las Vegas Native

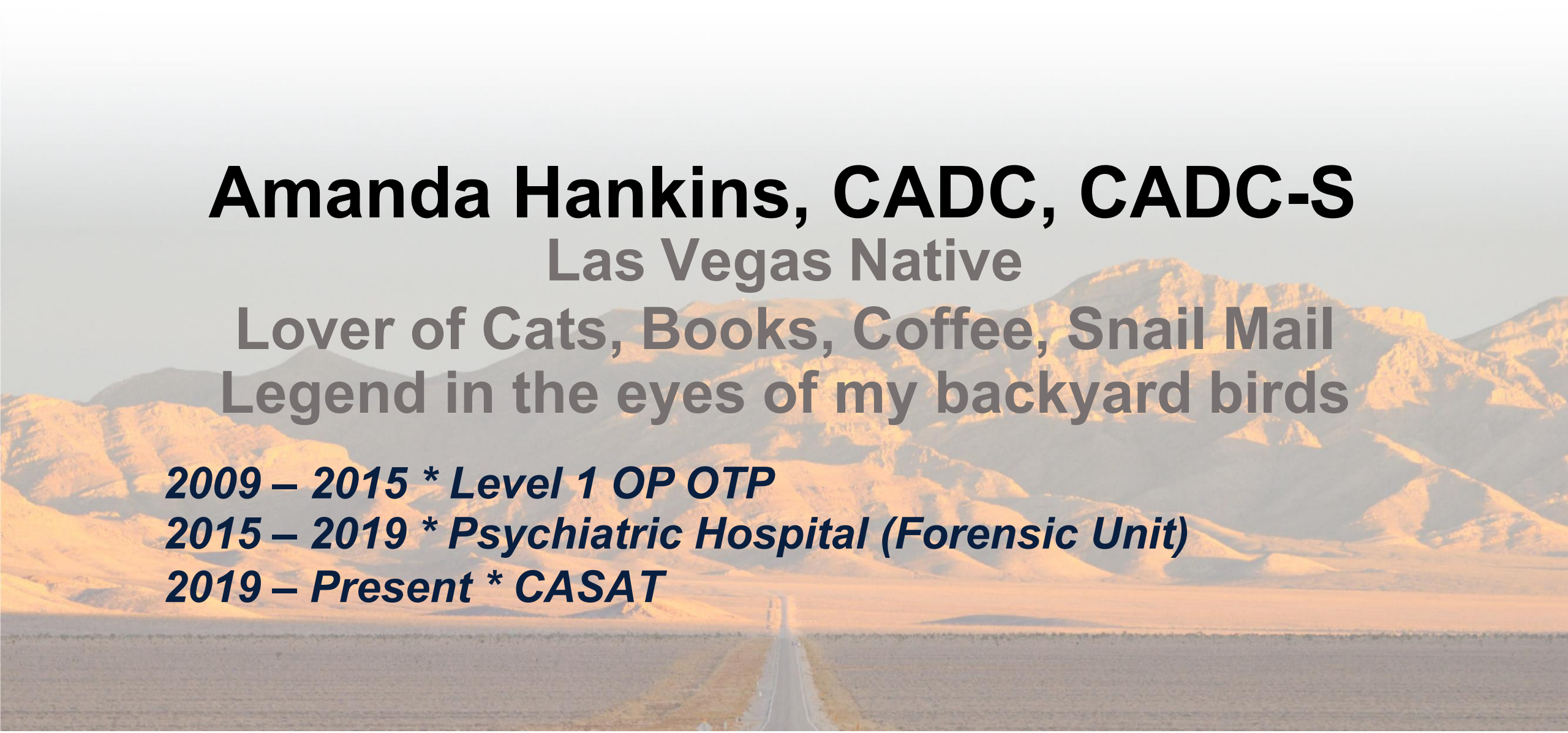
Lover of Cats, Books, Coffee, Snail Mail

Legend in the eyes of my backyard birds

2009 – 2015 * Level 1 OP OTP

2015 – 2019 * Psychiatric Hospital (Forensic Unit)

2019 – Present * CASAT



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Learning Objectives

*Identify and understand evidence-based medications used in the treatment of opioid use disorder, including their efficacy and current trends for the adolescent population.

*Analyze current trends and patterns in opioid use among adolescents, including factors contributing to risk for overdose, patterns of use, strategies for intervention and harm reduction tailored to this population.

*Develop effective communication strategies for engaging with families and loved ones of individuals struggling with opioid use disorder, including techniques for providing support and explaining treatment options.

Information from SAMHSA's TIP 63: Medications for Opioid Use Disorder

Substance Use Disorders are chronic, treatable illnesses.

Opioid Use Disorder (Moderate/Severe) requires continuing care for effective treatment, rather than an episodic, acute-care treatment approach.

According to the CDC **Chronic Diseases** are defined broadly as conditions that last 1 year or more and require **ongoing** medical attention or limit activities of daily living or both.

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Information from SAMHSA's TIP 63: Medications for Opioid Use Disorder pt 2

Principles for good care of chronic diseases according to the World Health Organization (WHO)

- Develop a treatment partnership with patients.
- Focus on patients' concerns and priorities.
- Support patient self-management of illness.

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Information from SAMHSA's TIP 63: Medications for Opioid Use Disorder pt 3

Principles for good care of chronic diseases according to the World Health Organization (WHO)

- Use the five A's at every visit (assess, advise, agree, assist and arrange).
- Organize proactive follow-up.
- Link patients to community resources/support.

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Information from SAMHSA's TIP 63: Medications for Opioid Use Disorder pt 4

Principles for good care of chronic diseases according to the World Health Organization (WHO)

- Work as a clinical team.
- Involve "expert patients," peer educators, and support staff in the health facility.
- Ensure continuity of care.

Important considerations:

There is no “one size fits all” approach to OUD treatment.

People with OUD deserve access to medication, SUD counseling, mental health treatment and recovery support services.

Negative attitudes from public and healthcare professionals can deter people from seeking treatment.

It’s important to use medical terms when discussing SUDs (ex. Positive UDS, not “clean” or “dirty” UDS)

People with OUD benefit from treatment with medication for varying lengths of time, including lifelong treatment.

What are the 3 FDA approved medications for Opioid Use Disorder?

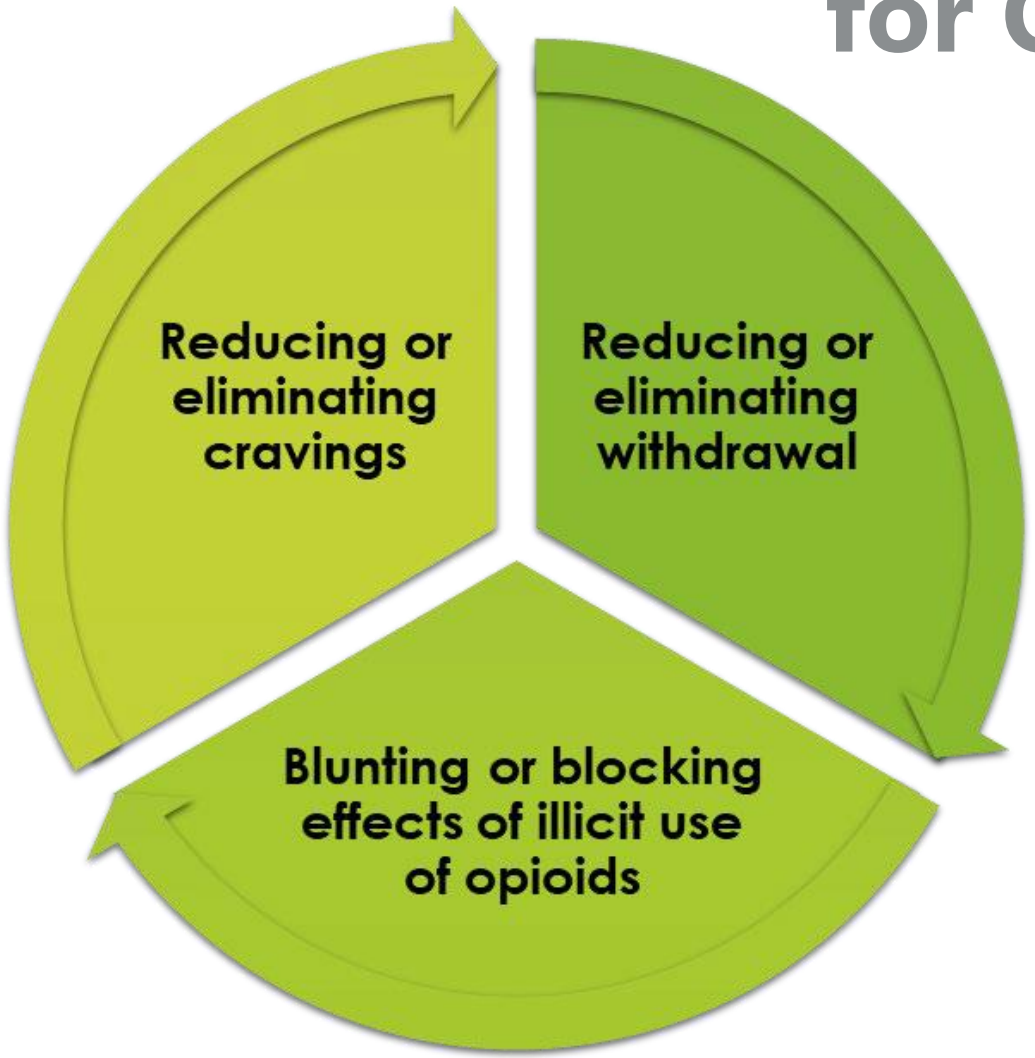
Medications for Opioid Use Disorder

Methadone

Buprenorphine

Naltrexone

Benefits of the 3 FDA approved medications for OUD



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According to NIDA (Natl. Institute on Drug Abuse)

Benefits of MOUD:

- *Reduce opioid use and OUD related symptoms*
- *Reduce risk of infectious disease transmission*
- *Reduce criminal behavior associated with drug use*
- *Increase likelihood of remaining in treatment*

Remaining in treatment associated with:

- *Lower risk of overdose mortality*
- *Reduced risk of HIV and communicable virus transmission*
- *Reduced criminal justice involvement*
- *Greater likelihood of employment*

Comparison of Medications for OUD

Prescribing considerations	Methadone	Naltrexone	Buprenorphine
Mechanism of action at mu-Opioid Receptor	Agonist	Antagonist	Partial Agonist
Phase of treatment	Medically supervised withdrawal, maintenance	Prevention of relapse to opioid misuse, following medically supervised withdrawal	Medically supervised withdrawal, maintenance
Route of administration	Oral	Oral, intramuscular extended-release	Sublingual, buccal, subdermal implant, subcutaneous extended release injection

Comparison of Medications for OUD pt 2

Prescribing considerations	Methadone	Naltrexone	Buprenorphine
Possible adverse effects	**Constipation**, hyperhidrosis, respiratory depression, sedation, QT prolongation, **sexual dysfunction**, severe hypotension including orthostatic hypotension and syncope, **misuse potential**, neonatal abstinence syndrome	**Nausea**, anxiety, **insomnia**, precipitated opioid withdrawal, hepatotoxicity, vulnerability to opioid overdose, **depression**, **suicidality**, muscle cramps, dizziness or syncope, somnolence or sedation, **anorexia**, decreased appetite or other appetite disorders Intramuscular: **Pain**, **swelling**, induration (including some cases requiring surgical intervention)	**Constipation**, nausea, precipitated opioid withdrawal, **excessive sweating**, **insomnia**, pain, peripheral edema, **respiratory depression (particularly combined with benzodiazepines or other CNS depressants),** misuse potential, neonatal abstinence syndrome Implant: Nerve damage during insertion/removal, accidental overdose or misuse if extruded, local migration or protrusion Subcutaneous Injection: **Injection site itching or pain**, death from intravenous injection

Comparison of Medications for OUD pt 3

Prescribing considerations	Methadone	Naltrexone	Buprenorphine
Regulations and availability	Schedule II; only available at federally certified OTPs and the acute inpatient hospital setting for OUD treatment	Not a scheduled medication; not included in OTP regulations; requires prescription; office-based treatment or specialty substance use treatment programs, including OTPs	Schedule III; no longer requires waiver to prescribe outside OTPs. Often available in Community OTP and other health care settings including doctors offices.

Changes to 42 CFR Part 8 *(effective 4-2-24)*

- *Notable changes that patients will care about:*
  - More flexibility with take home medication access (methadone)
  - Use of Telehealth for initiation of buprenorphine
  - No longer have to have been using opioids for 1 year+
  - Under 18, no longer required to have two failed attempts at withdrawal management
  - Removes participation in counseling as a contingency for medication
    - Although it's still best practice and recommended

Opioid Overdose Reversal Medications

- *Safe and effective life-saving tools*
- *Play a critical role in a science-based approach to the overdose crisis*
- *Only living people can access tools like treatment for change*
- *Available overdose reversal medications*
  - Naloxone
    - Narcan, Kloxxado, Zimhi, ReVive
  - Nalmefene
    - Opvee

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How to use Naloxone - CDC

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What's the latest?

According to the Nevada Drug Overdose Surveillance Monthly report for June 2025

- *There were 965 total suspected drug-related overdose ED visits in Nevada*
- *Female = 39.9% and Male= 60.1%*
- *Highest percentage with 25.3% were aged 35-44*
- *Under 25 comprised 20%*
  - Age 0 – 10 = 5%
  - Age 11 – 14 = 2.2%
  - **Age 15 – 24 = 12.8%**

What's the latest?

According to the Nevada Drug Overdose Surveillance Monthly report for June 2025

- *There were 47 total suspected drug-related overdose ED visits for adolescents between the ages of 12 and 17, in Nevada*
- *Female = 61.7% and Male= 38.3%*
- *White – 51.1%*
- *Multiracial/Other – 19.1%*
- *Black – 12.8%*
- *Hispanic – 12.8%*
- *Asian – 2.1%*

What's the latest?

According to the National Institute on Drug Abuse (NIDA) and the "Monitoring the Future" annual survey of students in 8th, 10th and 12th grades. . .

- *The % of adolescents reporting they used any illicit substances in 2023 continued to hold steady below the pre-pandemic levels reported in 2020. However. . .*
- *2023 demonstrated a rise in overdose deaths among teens, largely attributed to fentanyl.*
- *Delaying the start of substance use among young people, even by one year, can decrease SU for the rest of their lives.*

What's the latest?

According to the National Institute on Drug Abuse (NIDA) and the "Monitoring the Future" annual survey of students in 8th, 10th and 12th grades. . .

- *After declining significantly during the COVID-19 pandemic, substance use among adolescents has continued to hold steady at lowered levels for the fourth year in a row.*
- *Abstainers are students with no use of alchol, marijuana, or nicotine by cigarettes or vaping. In 2024, levels of abstainers are at the highest recorded since the survey first started reporting this measure (1975-12th grade and 1991-10th and 8th grade)*
- *In 2024, marijuana use declined in all three grades for lifetime, past 12-month and past 30-day use, with statistically significant decrease amongst 12th graders. (Use in the past 12 months: 12th -26%, 10th -16%, 8th -7%)*
- *In 2024 use of nicotine pouches increased, doubling for 12th graders from 3% reporting any use in lifetime and use in the last 12 months to 6%.*

What's the latest?

According to the National Institute on Drug Abuse (NIDA) and the "Monitoring the Future" annual survey of students in 8th, 10th and 12th grades. . .

- *In 2024 Vaping Nicotine for all timeframes and each grade level decreased, however these rates remain high (Use in the last 12 months: 12th-21%, 10th-15%) For 12 and 10th graders this ranks third to alcohol and marijuana.*

What's the latest?

According to the National Institute on Drug Abuse (NIDA) and the "Monitoring the Future" annual survey of students in 8th, 10th and 12th grades. . .

- *There are noted implications of this survey related to efficacy of prevention efforts.*
- *Noncontinuation can and does change appreciably, and therefore, any comprehensive prevention strategy should include increasing cessation*
- *Early intervention in terms of turning initial experimental use into nonuse is not only a viable goal for prevention, but an important one.*

What's the latest?

According to the National Institute on Drug Abuse (NIDA) Center for Clinical Trials Network study (Woody et al., 2008)

- *Evaluated efficacy of continuing buprenorphine naloxone treatment for 12 weeks vs. providing only withdrawal management to youth ages 15 – 21 with OUD*
- *Outcomes for youth who received continued treatment with Medication experienced improved outcomes*
  - **Less opioid positive urine drug screens**
  - **Less opioid use**
  - **Less IV use**

What's the latest?

According to the National Institute on Drug Abuse (NIDA) and a study in the Journal of the American Academy of Child and Adolescent Psychiatry (Subramaniam et al., 2011)

- *Examined predictors of opioid abstinence in buprenorphine/naloxone assisted psychosocial treatment for OUD youth (15-21) n=152*
- *Youth presenting with previous 30-day IV drug use and more active medical/psychiatric problems were less likely to have an Opioid Positive UA on week 12.*
- *Youth with early treatment opioid abstinence (weeks 1 and 2) AND who received additional non-study related treatment during the study were less likely to have an Opioid Positive UA on week 12.*
- *Youth who did not complete treatment were more likely to have an Opioid Positive UA on week 12.*

What's the latest?

A systemic review of randomized controlled trials looked at the effects of buprenorphine on opioid cravings in comparison to other medications for OUD (Baxley et al., 2023)

- *This review was intended to look at buprenorphine vs. methadone / extended-release naltrexone(XR-NTX) at managing cravings for opioids.*
- *Evaluated studies that had been done and that had measured opioid cravings.*
- *Reviewed a total of 10 studies and found. . .*
  - **Bup/Nal associated with lower cravings than placebo**
  - **Lower doses of Bup = Higher Cravings**
  - **Compared to methadone and XR-NTX, Bup/Nal was linked to greater cravings**

What's the latest?

"Another tool for the tool box? I'll take it!": Feasibility and acceptability of mobile recovery outreach teams (MROT) for opioid overdose patients in the emergency room (Wagner et al., 2019)

- *ER staff strongly support mobile recovery outreach teams (MROT) providing outreach to overdose patients.*
- *MROTs have the potential to confer benefits to the hospital, staff and patients.*
- *Logistics issues should be considered prior to implementation.*
- *MROTs could help reduce stress and burnout among ER staff.*

What's the latest?

"Another tool for the tool box? I'll take it!": Feasibility and acceptability of mobile recovery outreach teams (MROT) for opioid overdose patients in the emergency room (Wagner et al., 2019)

Results:

- *92% strongly agreed they were supportive of the program in their hospital*
- *84% strongly agreed they were enthusiastic*
- *72% strongly agreed the program is very much needed*
- *76% strongly agreed the MROT program is good for patients in the ER*
- *64% strongly agreed the MROT program would result in improvements for opioid overdose patients presenting in the ER*

What's the latest?

Emergency department-based peer support for opioid use disorder: Emergent functions and forms(McGuire et al., 2019)

Core Functions

1. *Integration of peers into the Emergency Department*
2. *Identifying and linking PWOUD with peer recovery support*
3. *Connecting PWOUDs to MAT and other recovery services*

What's the latest?

"It's Gonna be a Lifeline": Findings From Focus Group Research to Investigate What People Who Use Opioids Want From Peer-Based Postoverdose Interventions in the Emergency Department (Wagner et al., 2020)

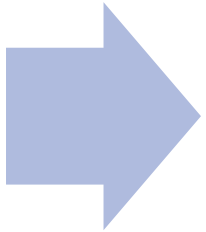
Nine Focus Groups with 30 people who use opioids

Perceived Benefits:

- *Advocacy and support*
- *Model of hope and encouragement*
- *Fill key gaps in service*

Finding Information and Resources

Part of your job is staying up to date with recent and relevant information



The Digital World makes access to information easy (check sources)

Finding Information and Resources

nvopioidcoe.org

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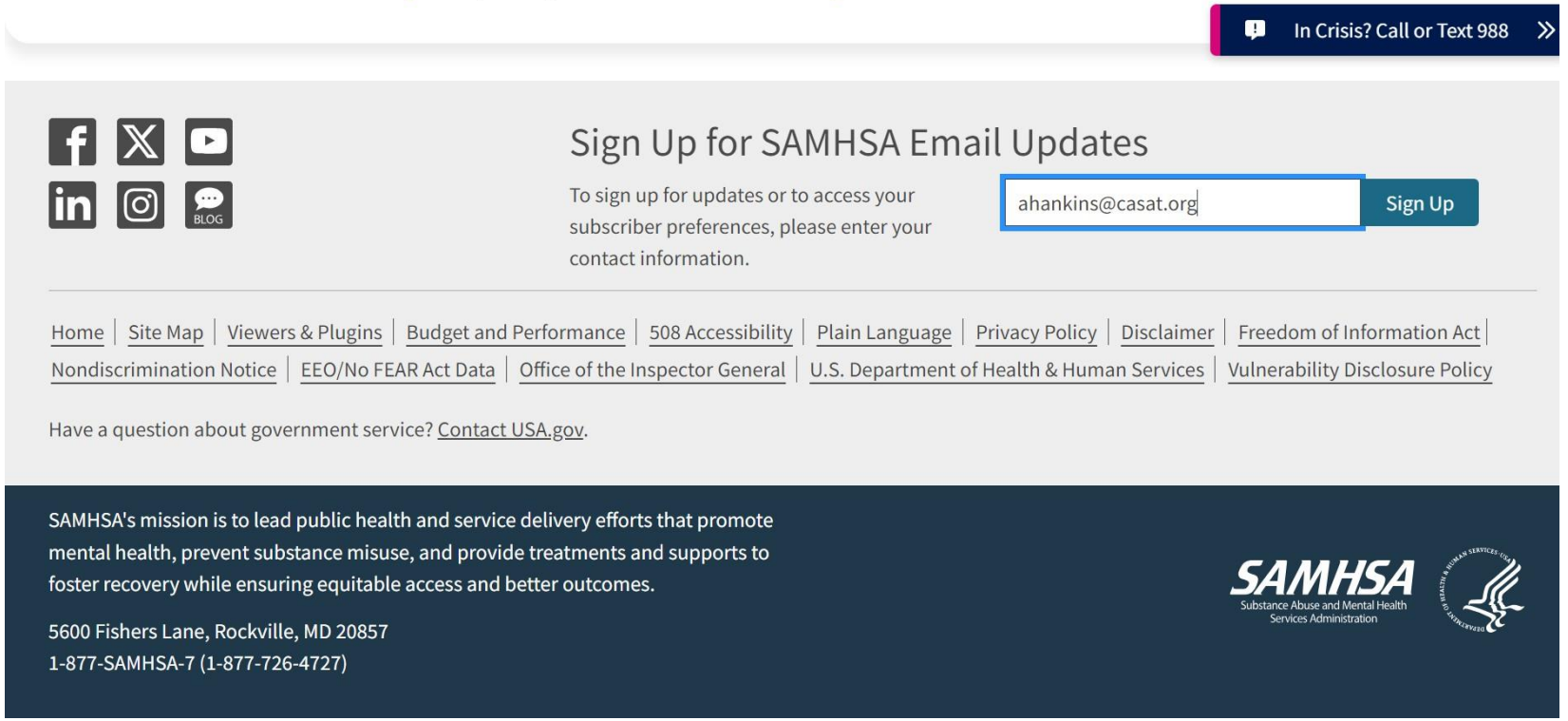
Finding Information and Resources

samhsa.gov



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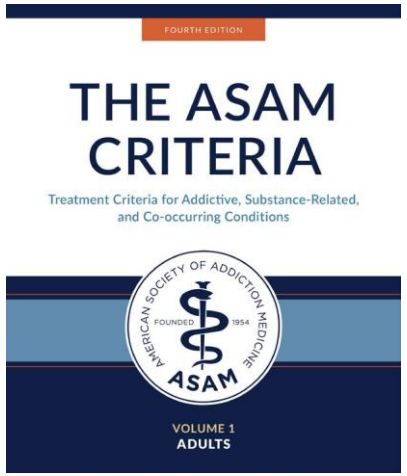
Finding Information and Resources pt 2

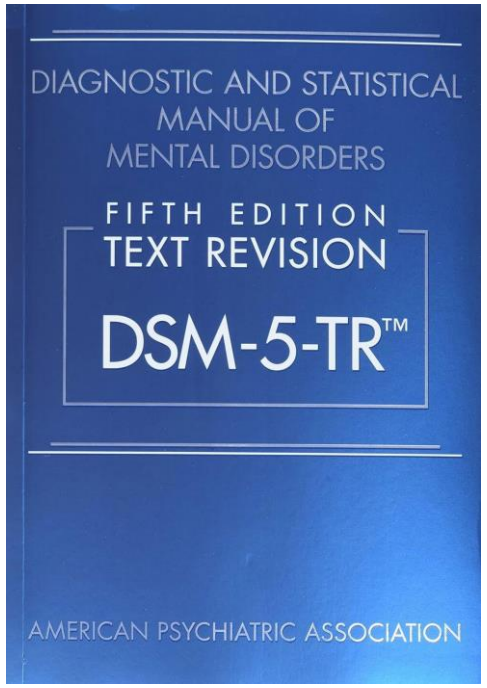
https://www.naadac.org/

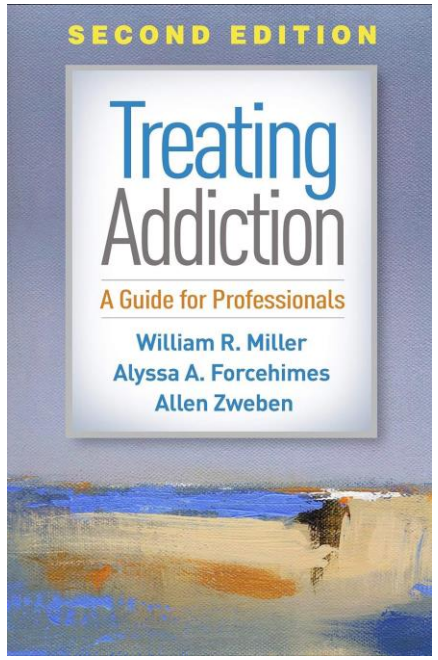
https://attcnetwork.org/

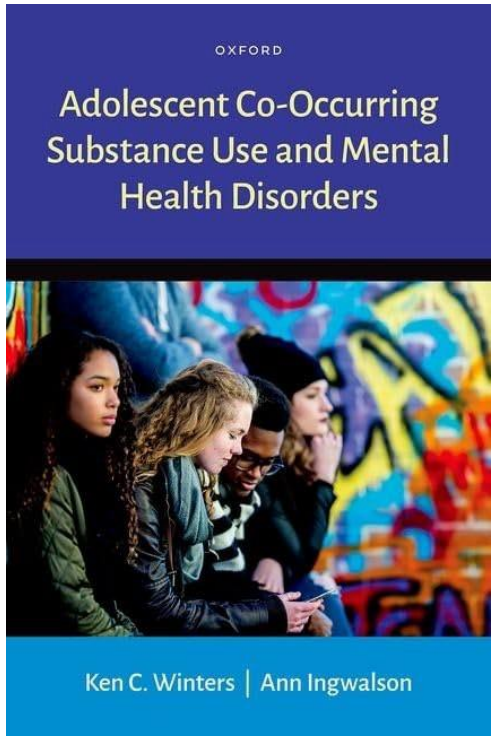
https://attcnetwork.org/center/pacific-southwest-attc/

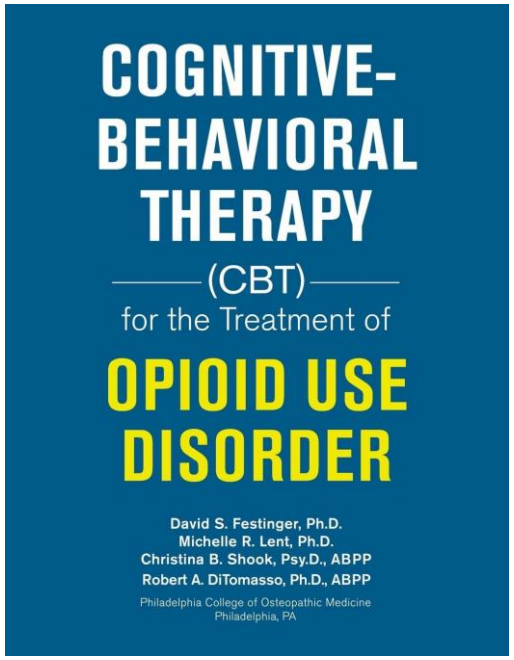
Books for the Addiction Professional











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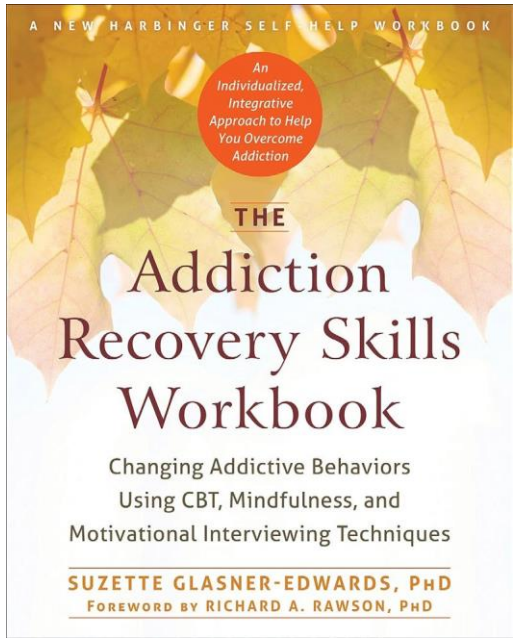
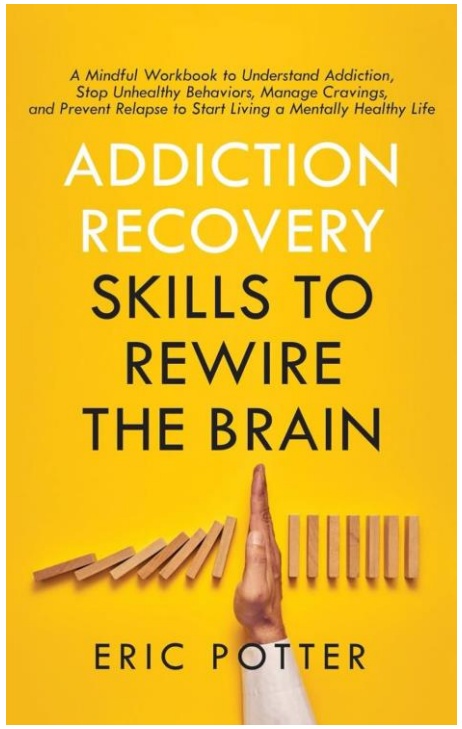
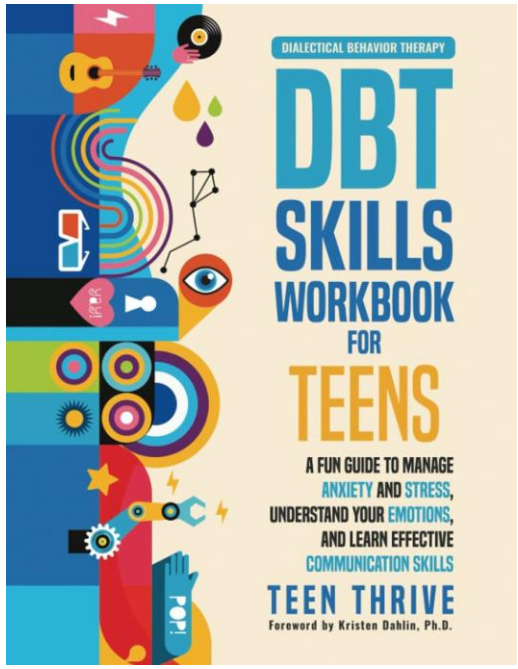
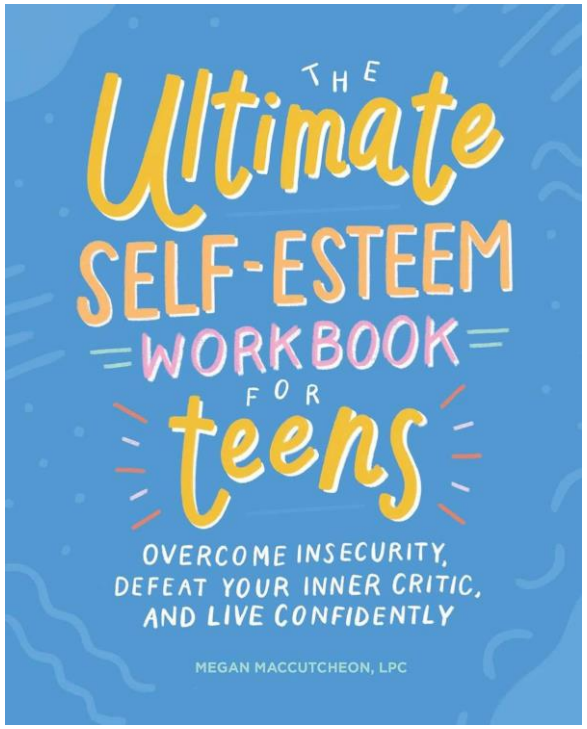
Books to recommend to Youth









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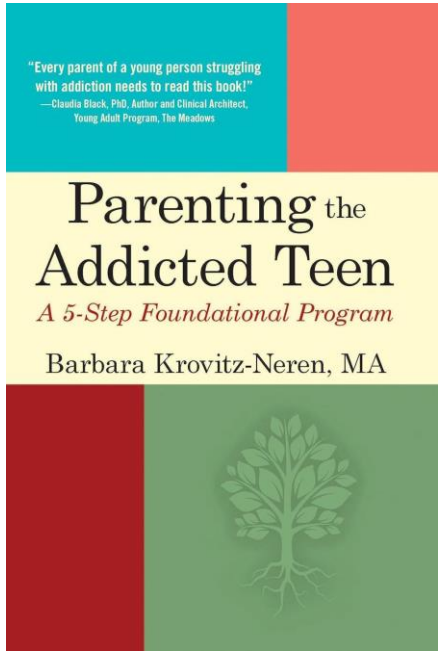
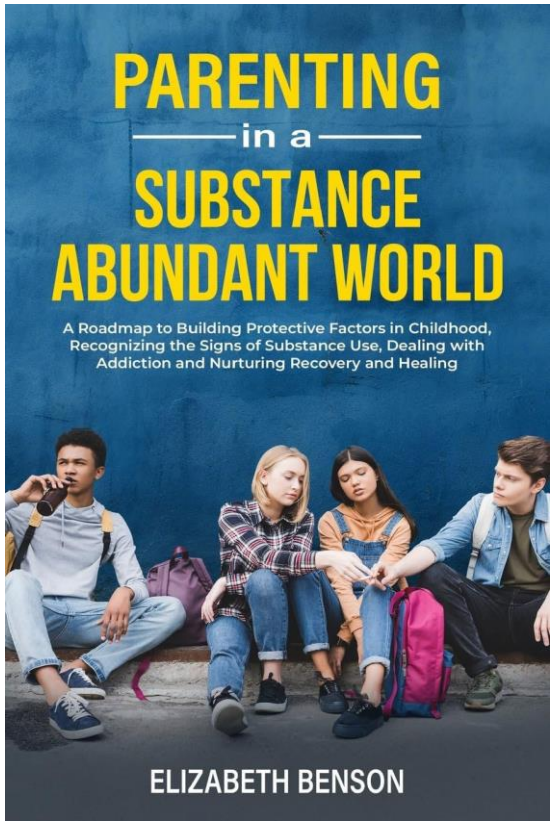
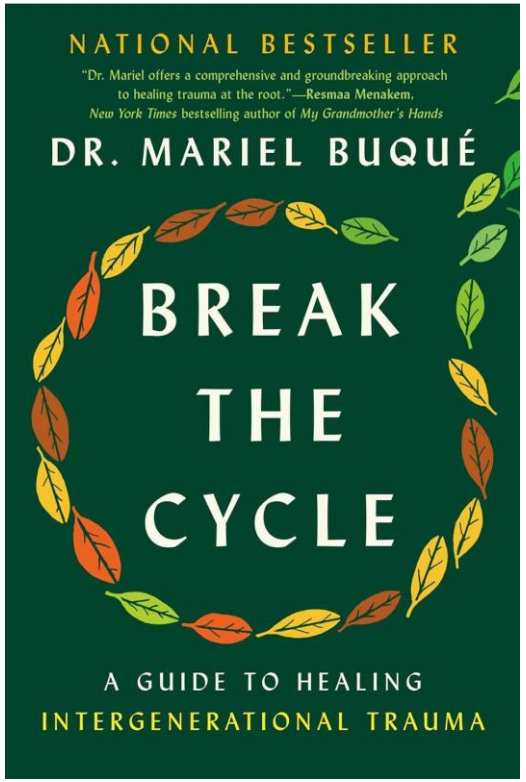
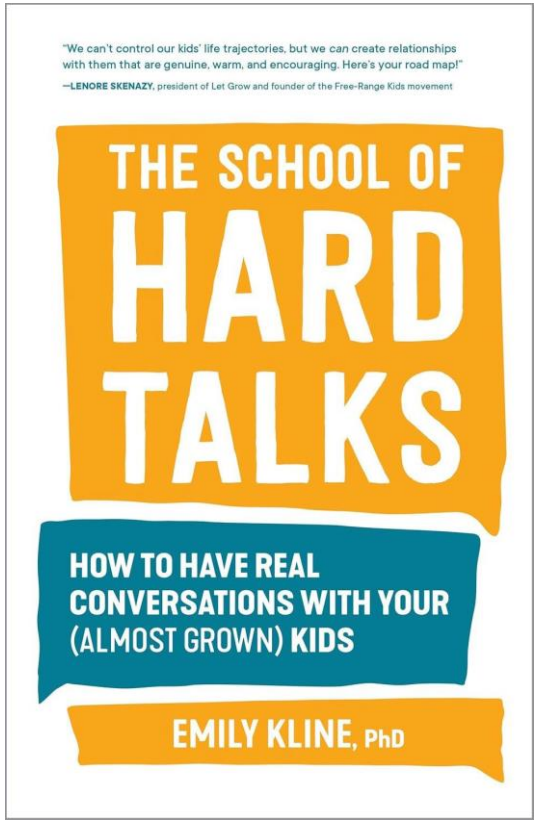
Books to recommend to parents









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Recovery Related Podcasts

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Questions. . .

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Communicating with Compassion

Practical Techniques for Supporting Individuals & Families through Treatment Conversations.

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Trauma-Informed Communication

Trauma is both a Risk Factor for & Consequence of OUD.

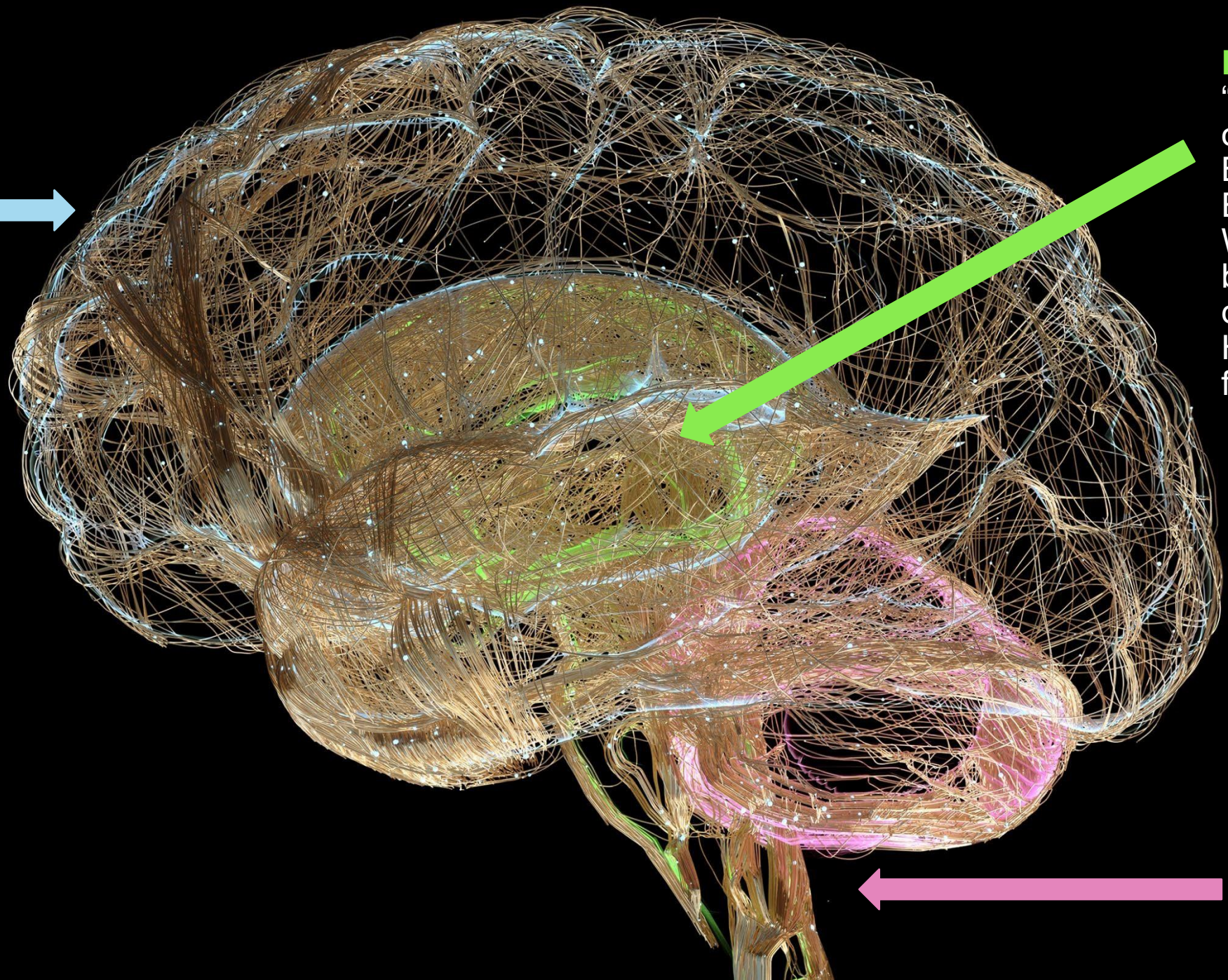
- Before OUD: Trauma can increase likelihood of risky substance use.
- After OUD: Substance use can lead to unstable housing, exploitation, criminalization, etc.…which can create or compound trauma.

How might trauma affect how someone responds to authority or care?

- May appear distrustful, avoidant, defensive, or even aggressive.

Trauma, Emotional Arousal, & the Brain

- Traumatic events can elicit an acute stress response, leading to emotional arousal and heightened physiological responses (e.g., fight, flight, freeze, fawn).
- When people are in an emotionally aroused state, it can be difficult for their brain to absorb information.
- If you know someone has recently endured a traumatic event, such as an overdose, they may still be experiencing an acute stress response.



Prefrontal Cortex:
Complex planning and anticipation;
Sense of time and context;
Inhibition of inappropriate actions;
Empathic understanding

Limbic Region:
"Mammalian Brain" or "Emotional Brain"
Basic drives & Emotion
What is "good or bad"/ "safety or danger"
Helps us bond and form relationships

Brainstem:
"Reptilian Brain"
Fight-Flight-Freeze
Controls states of arousal: hungry/satiated, sexual desire/satisfaction, asleep/awake

Trauma, Emotional Arousal, & the Brain

- Trauma can dysregulate the nervous system, especially when a person is under stress
- Triggers for stress could be going through a clinical intake, going through detox, or even just having a family meeting.
  - *Fight*: May challenge or lash out at others, like staff or family.
  - *Flight*: May skip appointments or leave treatment prematurely.
  - *Freeze*: May seem withdrawn or unresponsive.
  - *Fawn*: May overcompensate, agree with everything, then disengage later.

Meeting them where they're at!

- Not physically speaking, but
  Cognitively and Emotionally
- We, as the experts, can often time see the bigger picture more quickly and more clearly than those we are trying to help.
- Important not to rush the process of getting the individuals we are trying to help from point A to point B.

Meeting them where they're at!

- *Assess the emotional state of the person(s) you are providing services to.*
  - Are they in visible distress?
    - If yes, you'll likely want to hold off on providing any new information.
    - Rather, you may find verbal de-escalation to be an appropriate intervention.
  - Are they receptive to engaging in any type of conversation?
    - If no, you'll likely want to hold off on providing any new information.
    - Rather, you'll want to focus on building trust and rapport.
      - Building trust and rapport is MORE important than making sure they know about resources.
      - **Your relationship is a RESOURCE**. There will be time to provide treatment resources & education once trust and rapport have been developed.
  - Are they receptive to learning about your services and community resources?
    - There is a chance someone is not in distress, is willing to have a conversation, but is NOT interested in resources.
    - What do you do? **Build trust & rapport!**

Trust & Rapport Building

What are ways you can build trust and rapport?

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Trust & Rapport Building

EMPATHY & VALIDATION

Trust & Rapport Building

PERSON-CENTERED LANGUAGE!

- Avoid stigmatizing terms
  - like “addict,” “junkie,” or “abuser.”
- Use respectful, person-first language:
  - “A person with opioid use disorder” or “problematic opioid use.”
- Language impacts engagement and trust
  - Model the kind of respect and empathy you want the person to feel

Trust & Rapport Building

Some more ways to build trust and rapport:

- Active listening
  - Listen closely to what the person is telling you.
  - Convey through body language, summary phrases, and empathic statements that you are listening.
- Not to pushing YOUR agenda…even though you have a good one ;)
- Utilize PEERS!
  - Peer Support Specialists
  - Family-to-Family Peer Support

Peer Support

Peer Support Services in Crisis Care – SAMHSA Advisory June 2022

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Peer support workers demonstrate that recovery is possible and act as an advocate for the individual.

Inclusion of peer support workers on your team can help improve outcomes, such as:

- Reducing trauma and agitation
- Increasing trust
- Reducing hospitalizations and emergency department usage
- Reducing recurrence of symptoms
- Decreasing recidivism.

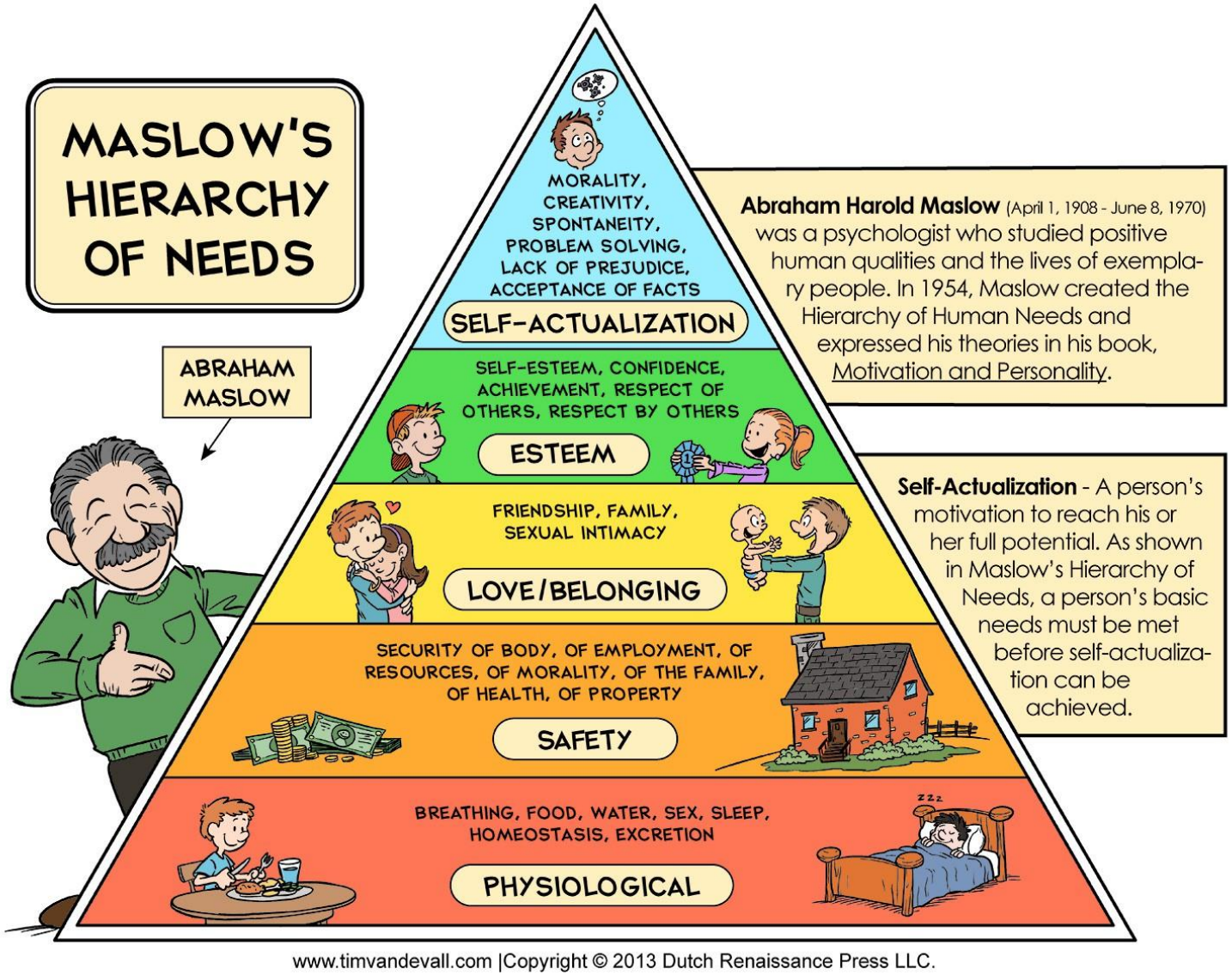
Providing Immediate Resources & Care

- Developing a thorough list of community resources is important.
  - This list should also have resources that are not OUD specific, such as social service or health service related resources:

    Housing, food, employment, transportation, clothing, primary care, etc…
- The list should be a "living" document, meaning that it evolves and is updated regularly to reflect the most current community services.
  - How often do you think your team should be reviewing and updating your resource list(s)?

Providing Immediate Resources & Care

- Assess their most immediate needs, so you can offer the most relevant set resources..
  - Again, these resources may also be non-treatment, such housing.



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Providing Immediate Resources & Care

- Make sure the resource list includes details such as:
  - Location(s),
  - Hours of operation,
  - Costs & accepted insurance types,
  - Treatment type (MOUD, abstinence, faith-based, etc.), and
  - Any other notes that would be helpful for a potential new client to know.

KNOW YOUR RESOURCES!

The better acquainted you are with your resource list, the more helpful guidance you can provide!

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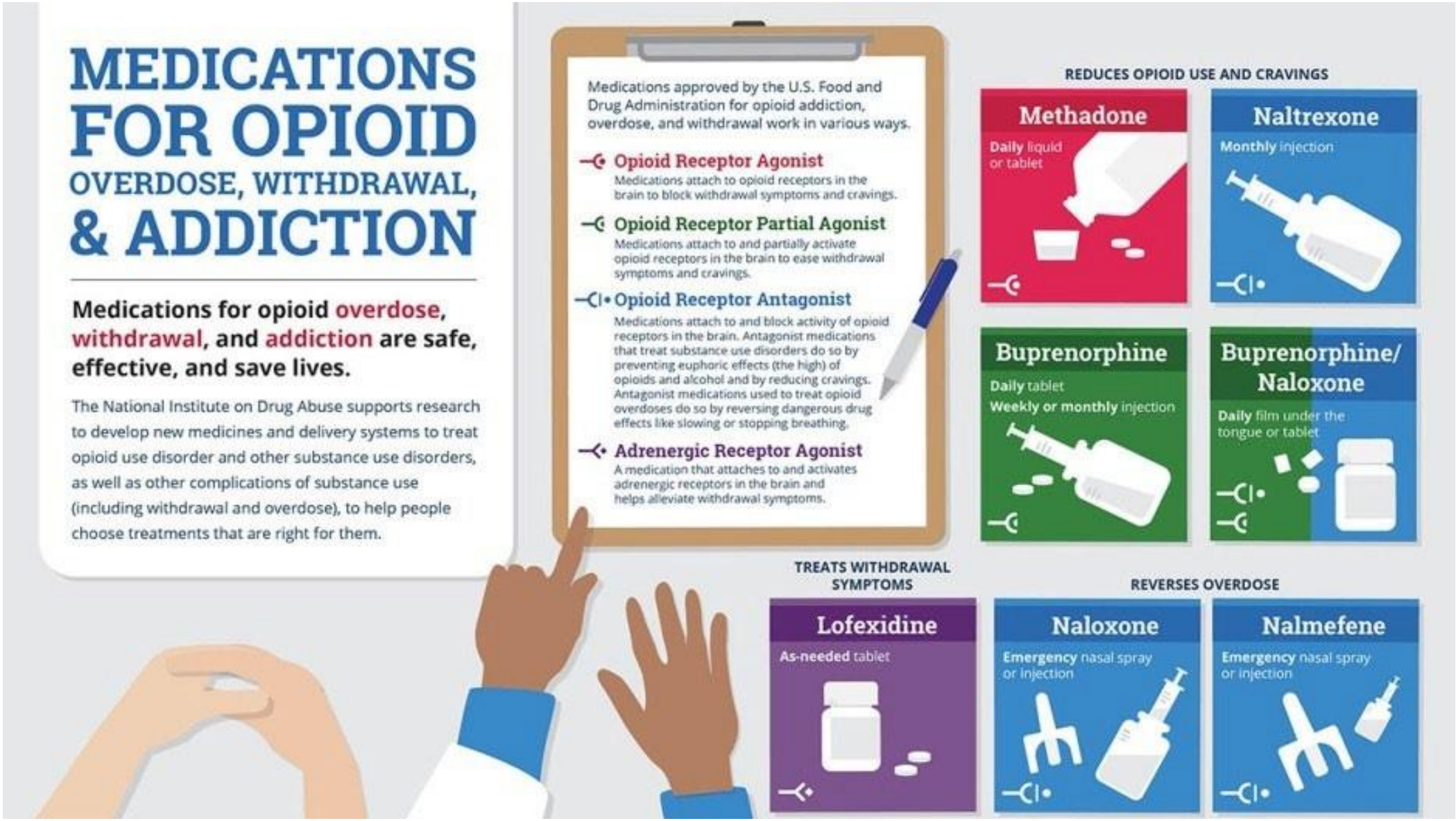
Psychoeducation to Clients & Family

- Taking all the information you know about opioid trends, treatment, MOUDs, Harm Reduction, etc., and breaking it down into easy to understand information.
  - Pamphlets and info graphs can be useful!



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https://nvopioidresponse.org/resources/families-friends/

What You Need to Know About Treatment and Recovery

There is hope. Recovery is possible.

Addiction Is A Disease

Opioids are highly addictive, and they change how the brain works. Anyone can become addicted, even when opioids are prescribed by a doctor and taken as directed. In fact, millions of people in the United States suffer from opioid addiction.

Signs of Opioid Addiction

A major warning sign of addiction is if a person keeps using opioids even though taking them has caused problems—like trouble keeping a job, relationship turmoil, or run-ins with law enforcement. Other signs can include:[1]

Opioid Use Disorder

Sometimes referred to as "**opioid addiction**," opioid use disorder is a chronic and relapsing disease that affects the body and brain. It can cause difficulties with tasks at work, school, or home, and can affect someone's ability to maintain healthy relationships. It can even lead to overdose and death.

- **Trying to stop or cut down on drug use, but not being able to.**
- **Taking one drug to get over the effects of another.**
- **Stealing drugs or money to pay for drugs.**
- **Using drugs because of being angry or upset with other people.**
- **Being scared at the thought of running out of drugs.**
- **Overdosing on drugs.**

[1] findtreatment.gov/content/understanding-addiction/addiction-can-affect-anyone

To learn more about opioid misuse, go to **cdc.gov/RxAwareness.**

CDC

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https://nvopioidresponse.org/resources/families-friends/

Psychoeducation to Clients & Family

Keep it Collaborative and Trauma-Informed!

- Avoid lecturing & invite dialogue: “What have you heard about treatment?” or “What’s been your experience so far?”
- Be sensitive to shame: never imply they should already “know better”
- Reinforce autonomy: “Here’s some info, please take what’s helpful to you.”

Engage with Cultural Humility

Engage with cultural humility.

- Learning about different cultures (especially those prevalent in our area) and building cultural competence is good, and…
- Know the difference between cultural competence and cultural humility! ☺

Engage with Cultural Humility

Cultural humility involves:

- Recognizing the complexity of identities within any one particular culture.
- Commitment to life-long learning of cultures rather than an achieved state of "competence."
- Practice of life-long reflection and openness to recognizing one's own biases and limitations.
- Platinum Rule: Treat others as ***they*** would want to be treated.
  - How is providing person-centered care similar to engaging with cultural humility?

Motivational Interviewing

Utilization of Motivational Interviewing Techniques

- Learning how to use motivational enhancement approaches or strategies can assist a person in making meaningful life changes by addressing ambivalence about changing behaviors.

Summary

- Trauma-informed approach
- Rapport building through Empathy & Validation
- Resource Expert
- Psychoeducation – Myth Busters!
- Cultural Humility – Platinum Rule
- Motivational Interviewing

Thank You!

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