PRACTICAL PSYCHOPHARMACOLOGY

NIDA Targets Young Opioid Abusers

Less than 4% of high school seniors abused prescription opioids in the early 1990s. By 2002, between 8% and 10% of 12th graders were abusing prescription opioids.

The ominous numbers remain relentlessly high, translating into thousands of new users under the age of 18 each year.

To counter this alarming trend, officials at the National Institute of Drug Abuse are turning to child and adult psychiatrists, pediatricians, adolescent medicine specialists, family physicians, and internists to help them stem the tide of opioid abuse among adolescents and young adults.

A new initiative is underway to recruit office-based physicians to prescribe buprenorphine and coordinate counseling among vulnerable youth, according to Dr. Geetha Subramaniam, who unveiled the program at the NIDA's 8th annual "blending conference," which is aimed at showcasing strategies for applying research findings to clinical practice.

The core message behind the initiative is that research now justifies use of buprenorphine in opioid-dependent adolescents, who historically fell through the cracks in programs designed to treat opioid addiction in adults.

Buprenorphine is a partial opioid agonist currently approved by the Food and Drug Administration for treating opioid dependence in patients as young as age 16 years. It is marketed as both Subutex, which is buprenorphine alone, and Suboxone, which is a combination of buprenorphine/naloxone. Both are available as sublingual tablets.

"We now have very robust evidence that this is a viable treatment option…in combination with psychological counseling," Dr. Subramaniam said during an interview following the April meeting.

Early Intervention, Better Outcomes

Because extended treatment (up to 12 weeks) with buprenorphine keeps young patients in treatment longer, it has been shown to outperform short-term detoxification in terms of reducing positive urine screens for opioids as well as other drugs, including marijuana, cocaine, and intravenous drugs (including heroin), said Dr. Subramaniam, medical officer in NIDA's Bethesda, Md.–based Division of Clinical Neuroscience and Behavioral Research.

She and other experts expressed hope that by reaching young people with accessible, confidential, efficacious outpatient treatment, they can avert deeply entrenched drug abuse patterns with the potential of ruining lives.

"The idea is that medications can tremendously augment the effects of counseling and 12-Step involvement and treat these kids before they have accumulated the medical and psychosocial problems that are common complications of [years of] opioid use," said Dr. George Woody, professor of psychiatry and director of the clinical trials unit at the University of Pennsylvania Center for Studies of Addictions in Philadelphia.

Existing research on treatments for opioid-dependent youth is outdated and limited to uncontrolled trials evaluating methadone. While methadone is a very effective treatment for opioid dependence, it is of limited application for young people because it is available only through specialized clinics. Patients aged 16-18 years are eligible for this treatment option only after they have failed two prior treatments and only if they have the consent of a legal guardian.

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There is "robust evidence" that buprenorphine combined with counseling is a viable treatment option for opioid dependence, Dr. Geetha Subramaniam says.

Standard detoxification/rehabilitation programs that typically work with adults may admit youth, but the young people feel stigmatized being there.

In a pivotal 12-week trial directed by Dr. Woody, treatment retention was strikingly improved among 13- to 17-year-olds randomly assigned to receive counseling and either buprenorphine therapy or traditional detoxification (JAMA 2008;300:2003-11).

At the 3-month mark, just 16 of 78 (21%) subjects who underwent detoxification and counseling remained in treatment, compared with 52 of 74 (70%) assigned to a protocol combining buprenorphine and counseling.

Buprenorphine appears to reduce cravings long enough for young people to take advantage of psychosocial interventions and to begin to make earnest lifestyle changes.

Significant differences exist between youth who use the different opioid drug classes, Dr. Subramaniam pointed out.

For one thing, teens dependent on heroin may ironically come to the attention of medical providers earlier in the course of their addiction for reasons both chemical and practical.

Prescription opioids are long-acting drugs most often obtained though an informal distribution system originating in the family medicine cabinet, at grandma's house, or in a teen's own supply of pain medications leftover from a sports injury or dental work.

Users, she said, "Can fly under the radar," hiding their use and obtaining more drugs through friends, often for quite a period of time before their problem comes to light. Eventually, though, the drugs may become more difficult to obtain, and expensive to buy.

Users may eventually switch to heroin, a cheaper opioid, which may send them out onto the streets.

With heroin, "You have to keep feeding the addiction because it's very short-acting," generally requiring multiple dosing throughout the day. It also requires IV administration, which puts users at high risk for hepatitis C and HIV infections.

Significant differences exist, too, between abusers of any opioid and those youth who use marijuana and/or alcohol. Opioid users were more likely to be white, non-urban school drop-outs and were more likely than problem users of marijuana and/or alcohol to also have cocaine and/or sedative use disorders, and 3 or more non-opioid substance use disorders (Drug and Alcohol Depend. 2009;99:141-9).

Opioids' Added Risks

Dr. Subramaniam's recent analysis of data from 88 studies showed that the added risks of opioid use among marijuana and alcohol users were substantial. The opioid users had significantly more major clinical problems than those using marijuana and alcohol (5.1 vs. 3.4), and also demonstrated greater psychiatric comorbidity, victimization, and treatment utilization (Addiction 2010;105:686-98).

Clearly, young opioid users are a population in need, Dr. Subramaniam said.

Medication/counseling programs may help to meet that need, if office-based physicians are willing to go through the government-sponsored training program that enables them to prescribe buprenorphine and ensure that appropriate counseling is available.

In some cases, office-based physicians provide counseling themselves, she said. Others establish close collaborative relationships with neighboring counseling programs.

In either case, patients require "very close monitoring in the early days of treatment as one aims to find the most optimal dose of buprenorphine during the induction phase." Regular follow-up monitoring and counseling over the ensuing weeks and months is advised.

Family Support and Buy-In

As a child psychiatrist who specialized in addiction medicine before assuming her government post, Dr. Subramaniam has had years of hands-on clinical experience treating opioid-dependent youths with buprenorphine."I always recommended that a supportive adult monitor compliance," she said. "You need family support and buy-in."

Office-based physicians who become qualified to prescribe buprenorphine through the waiver program can provide the agent to patients as young as age 16 years.

"What if the adolescent is younger?"

Dr. Subramaniam noted that research supports use of the drug in children as young as 15, since that was the youngest patient recruited for the NIDA sponsored clinical trial, she said.

Direction and guidance for thorny clinical issues are currently available through no-cost mentoring by senior physicians experienced in using buprenorphine through a Physician Clinical Support System sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), noted Dr. Subramaniam. Information can be found at www.pcssmentor.org.

At NIDA, "We are trying to make a very concerted effort to provide training to clinicians and to educate them about why this is a good thing to do," she said.

Office-based physicians "can have a tremendous impact," echoed Dr. Woody.

"It's to everyone's advantage to become more familiar with this approach to addiction. The field is going in this direction."

Dr. Subramaniam reported having no conflicts of interest. Dr. Woody disclosed that he has received a consulting fee from Alkermes Pharmaceuticals Inc., and serves on the RADARS system scientific advisory board.

For more information about receiving a waiver to practice opioid addiction therapy, go to http://buprenorphine.samhsa.gov/waiver_qualifications. ■

By Betsy Bates. Share your thoughts at cpnews@elsevier.com.