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HOW THE PEDIATRIC WORKFORCE CAN ADDRESS THE OPIOID CRISIS

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COMMENT

An estimated 17 million people worldwide engage in heroin and nonmedical prescription opioid use, resulting in a public health emergency with enormous morbidity and mortality.¹ In parts of North America and Western Europe, overdose deaths have surpassed motor vehicle crash fatalities,^{2,3} and even the US presidential campaign has pivoted to addressing the opioid crisis as a national issue. Recognizing that youth commonly receive care from a pediatrician or general practitioner during adolescence and young adulthood – precisely when the incidence of opioid use disorder (OUD) sharply increases⁴ – the American Academy of Pediatrics released a policy statement this month calling for expanded access to medication-assisted treatment (MAT) for youth.⁵

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This marks the first time a major pediatric professional organization has supported extending MAT to youth. MAT, which adds pharmacotherapy to behavioral therapy, is evidence-based but greatly underutilized. Agonist pharmacotherapy with methadone or buprenorphine can be prescribed in primary care in the UK and other countries, as can buprenorphine in the USA.^{6,7} However, nearly 9 in 10 youth with addiction in the USA do not receive any treatment, and for those who do, treatment often does not include medication;⁸ care gaps are similarly concerning internationally.¹ Pediatricians who prescribe medications for OUD are exceedingly rare, and many general practitioners do not offer medications to adolescents.^{9,10} Yet when they intervene early, providers caring for youth have a unique opportunity to avert a life course trajectory of opioid addiction and its harms. Pediatric providers are therefore a vital but insufficiently mobilized component of the worldwide opioid response.

MAT should be more readily offered in pediatric primary care. Doing so helps youth and families avoid the stigma they may experience at specialized drug treatment centers. Many centers treat youth alongside adults of all ages, yet youth have unique physiological, neurocognitive, and psychosocial needs that necessitate developmentally appropriate services, ideally separate from older clients. Primary care-based services allow youth to receive family-centered care from a trusted provider in the same familiar setting where they receive the remainder of their medical care.

Though some pediatric providers may be hesitant to manage OUD in primary care, many already treat other conditions with behavioral underpinnings such as obesity, asthma, and attention deficit hyperactivity disorder. For primary care-based management of adolescent depression, a collaborative care approach combining antidepressant medications, counseling, and case management is highly efficacious.¹¹ Parallels to managing OUD are easily drawn, since office-based opioid treatment incorporates the same components and personnel.

Throughout, pediatric addiction medicine subspecialists – who comprise only a small portion of the workforce needed to treat the large number of youth with OUD – are well-poised to provide support to pediatric generalists. In 2015, Addiction Medicine became officially recognized by the American Board of Medical Specialties, thus expanding opportunities for fellowship training and board certification in the USA; addiction medicine remains a young or non-existent field in other countries. For geographically isolated practices, telemedicine allows pediatric addiction medicine subspecialists to support pediatric providers in rural regions, many of which have been disproportionately affected by the opioid crisis. Project ECHO is a distance-learning program that connects remote primary care providers with addiction subspecialists and offers mentorship for practitioners who may initially lack comfort offering MAT but who can assume a greater part of the treatment plan as they gain experience.¹²

Despite the tremendous promise of a pediatric addiction medicine subspecialty workforce, a large training gap currently looms; currently, only 1% of all US addiction medicine board diplomates are pediatricians. Pediatric training programs therefore have a responsibility to develop addiction medicine fellowships and promote the field. However, it is imperative that *all* pediatric providers – not only those pursuing subspecialty addiction training – learn to

prevent and treat addiction. Residency programs should develop specific training in MAT and offer robust clinical experiences in youth addiction medicine.

Addressing the opioid crisis will require innovative strategies, including some that should prompt dramatic rethinking of the role and training of pediatric generalists. With its neurobiologic, molecular, and genetic aspects, addiction is a distinctly medical condition that falls squarely into the set of common conditions in which pediatric providers should demonstrate competency. It is incumbent on providers who care for youth to do their part to address the opioid crisis before more young lives are tragically lost.

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