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Closing the Medication-Assisted Treatment Gap for Youth With Opioid Use Disorder

Brendan Saloner, PhD, Kenneth A. Feder, BA, and Noa Krawczyk, BA

Department of Health Policy and Management, Johns Hopkins Bloomberg School of Public Health, The Johns Hopkins University, Baltimore, Maryland (Saloner); Department of Mental Health, Johns Hopkins Bloomberg School of Public Health, The Johns Hopkins University, Baltimore, Maryland (Saloner, Feder, Krawczyk)

In years past, an adolescent patient presenting to primary care with symptoms of opioid use disorder (OUD) would have been a highly rare event in most communities. With OUD and fatal overdoses rising among adolescents and young adults (termed *youth*) over the past 15 years, this scenario has unfortunately become more common. Fatal drug over-doses increased 3.5-fold for youth aged 15 to 24 years from 1999 to 2014.¹ Amidst this epidemic, relatively little is known about how primary care clinicians treat youth with OUD. Of particular interest is whether youth receive medication-assisted treatments (MATs), which have been shown to improve quality of life and reduce overdose risk.²

In this issue of *JAMA Pediatrics*, Hadland and colleagues³ examine trends in receipt of MAT in a cohort of privately insured youth aged 13 to 25 years diagnosed with an OUD. The study was conducted from 2001 to 2014, coinciding with the introduction of buprenorphine and long-acting naltrexone–MATs that can be prescribed by office-based physicians. The authors found that diagnosis of OUD surged among youth during this time.

Hadland and colleagues also found that, among youth with OUD, MAT use at first increased significantly, from 3.0% in 2002 to 31.8% in 2009, but then declined in subsequent years even as the prevalence of OUD among youth continued to rise. In adjusted analyses, being young or female or belonging to a racial or ethnic minority group were all associated with lower odds of receiving MAT. Most youth who received MAT were given buprenorphine (89.2%), but naltrexone was prescribed more commonly to females, younger individuals, and persons residing in more disadvantaged areas.

These findings suggest that provision of MAT is not keeping up with the growing need for these treatments among youth. Adolescents are especially unlikely to be treated with MAT, which may reflect the limited research that has been conducted about use of these medications among adolescents compared with adults. Still, the findings that MAT is being underutilized among adolescents are troubling, as research shows that teenagers who receive maintenance therapy with MAT have better treatment retention and are less likely to engage

Corresponding Author: Brendan Saloner, PhD, Department of Health Policy and Management, Johns Hopkins Bloomberg School of Public Health, The Johns Hopkins University, 624 N Broadway St, Hampton House, Office 344, Baltimore, MD 21205 (bsaloner@jhu.edu).

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in risk behaviors, such as drug injection.⁴ These findings highlight the importance of a 2016 recommendation from the American Academy of Pediatrics that pediatricians should consider offering MAT to adolescents with OUD, given that buprenorphine, in particular, has been shown to be effective among youth populations.⁵

Several barriers may contribute to the underutilization of MAT in office-based settings for youth. First, most pediatricians have limited training in addiction medicine. Second, prescribing buprenorphine requires a federal waiver that very few pediatricians have. Although prescribing naltrexone does not require a waiver, pediatricians may be unlikely to stock the medication or may be unfamiliar with its administration. Third, while buprenorphine is available in most commercial insurance plans, insurers often restrict access to MAT by placing drugs such as buprenorphine on the highest cost-sharing tier.⁶

If pediatricians are unable to administer MAT, they should at least be able to refer youth to MAT in specialty treatment, such as a methadone clinic. However, methadone is considerably harder for youth to access than for adults. Adolescents are legally restricted from receiving methadone treatment unless medication-free treatment has failed multiple times. Furthermore, few opioid treatment programs have staff and resources to provide targeted care to youth populations. Our own research found that only approximately 2% of all adolescents treated for heroin use disorder in specialty settings received any MAT, compared with 26% of adults.⁷

Misinformation and stigma about MAT are also pervasive and contribute to its underuse.⁸ The discourse surrounding “opioid substitution” has created a misconception among both patients and prescribers that medications simply “substitute one addiction for another” rather than treating the underlying disorder. In fact, these medications have been shown to lead to a host of positive outcomes in adults⁹ and could potentially also help advance goals that should be the target of youth recovery: completing school, obtaining employment, and maintaining healthy relationships with family and friends.

Changes in policy and clinical practice could help to increase utilization of MAT for youth struggling with an OUD. It is essential to build capacity in pediatric primary care so that more physicians have the knowledge and support to prescribe MAT. To achieve this goal, pediatricians should be included in initiatives to expand the office-based prescriber workforce. The 21st Century Cures Act of 2016 includes \$1 billion in federal aid to states over 2 years to increase MAT provision and build health care professional capacity.¹⁰ Broad-based initiatives to increase knowledge of addiction medicine and administration of MAT for adult primary care physicians through academic detailing and residency programs might also benefit pediatricians. However, curricula and training models should be tailored to the psychosocial needs of youth, for example, by addressing school and family needs in counseling.

Another important step is integration of primary and specialty care. Models that have shown promise for adult populations could be adapted for youth populations. This includes the “hub-and-spoke” model pioneered in Vermont.¹¹ In this model, office-based prescribers are linked to opioid treatment programs that provide buprenorphine induction for patients,

which requires more intensive care at initial stages of treatment. Particularly in communities hard-hit by the opioid epidemic, there may be sufficient need to develop a network of pediatric and family medicine practices in which physicians are trained in MAT and linked to opioid treatment programs able to provide special visiting times or dedicated counselors for youth populations.

Changes in clinical practice must also be supported by cultural change to reduce stigma toward MAT. There is a need for research on how physicians, patients, and families communicate about MAT and how youth-specific concerns about buprenorphine use could be addressed in office-based settings. It is troubling that MAT was less commonly used among females as well as youth from minority backgrounds, and further work is needed to understand the source of these discrepancies.

Finally, health insurance policy can better support access to MAT for youth. Federal policy, especially the Affordable Care Act, has expanded insurance coverage among youth through the extension of dependent coverage provision, as well as by making drug treatment an essential health benefit in Medicaid expansion and the exchanges.¹² Current legislation in the US Congress to repeal and replace the Affordable Care Act would represent a troubling departure from these policies, as they would result in more uninsured youth and weakened insurance protections. In addition, the federal Mental Health Parity and Addiction Equity Act has increased comprehensiveness of drug coverage in most insurance plans.⁶ As noted, however, tiering in insurance plans may continue to limit access to or duration of MAT. There is also a need to examine whether payment rates adequately support buprenorphine maintenance and care management, particularly for publicly insured youth. To allow comprehensive care, it is also essential that insurance programs pay for recovery services needed to complement medication, including counseling and recovery management.

Primary care physicians serving youth with OUD play an instrumental role in shaping the trajectory of these young people's adult lives. Expanding our knowledge base and evidence-based treatment to youth with OUD can avert needless loss of life, disability, incarceration, and unemployment. Public health researchers and practitioners should therefore continue to advocate for federal and state investments in access to substance use treatment and insurance coverage for vulnerable youth and their families. Although individual practice changes are important, comprehensive policy changes are needed to close the gap in evidence-based care for youth with OUD.

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