SUD Technical Assistance Webinar Series

VIRGINIA MEDICAID: 35—SUD TREATMENT FOR ADOLESCENTS
PAUL BRASLER, LCSW, CAIP
MARCH 22 & 24, 2022

Department of Medical Assistance Services
Welcome & Meeting Information

- WebEx participants are muted
- Please use the Q & A feature or the Chat feature if you have a question

- The focus of today’s presentation is practice-based – please Contact SUD@dmas.virginia.gov with technical or billing questions

- We do not offer CEUs for this webinar series
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The Virginia Department of Medical Assistance Services (DMAS) SUPPORT Act Grant projects are supported by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $4,997,093 with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government.
Naloxone Resources

- Get trained now on naloxone distribution
  - REVIVE! Online training provided by DBHDS every Wednesday
  - [https://getnaloxonenow.org/](https://getnaloxonenow.org/)
    - Register and enter your zip code to access free online training
- Medicaid provides naloxone to members at no cost and without prior authorization!
- Call your pharmacy before you go to pick it up!
- Getting naloxone via mail
  - Contact the Chris Atwood Foundation
    - [https://thecaf.acemlnb.com/lt.php?s=e522cf8b34e867e626ba19d229bbb1b0&i=96A94A1A422](https://thecaf.acemlnb.com/lt.php?s=e522cf8b34e867e626ba19d229bbb1b0&i=96A94A1A422)
    - Available only to Virginia residents, intramuscular administration
SUPPORT Act Grant Website
https://www.dmas.virginia.gov/#/artssupport
The grant team has been working closely with Montserrat Serra, DMAS Civil Rights Coordinator, to provide closed captioning for our webinars and stakeholder meetings.

We were now able to provide closed captioning through Hamilton Relay for all upcoming webinars.

The link for transcription can be found on the Winter Webinar schedule and will be sent in the chat.
Pre-Webinar Survey

In conjunction with the VCU Wright Center and the VCU Institute for Drug and Alcohol Studies, we are conducting a survey for research purposes in order to gain a better understanding of provider impressions and experiences of individuals with substance use disorders (SUDs), medication assisted treatment, and Medicaid. The information obtained will be used to assist in identifying potential barriers to treating these individuals.

If you haven't already, before the start of today’s webinar please use the link in the chat to access a brief (less than 5 minutes) electronic survey. https://redcap.vcu.edu/surveys/?s=C8HERT9N3P

• Your name and contact information will not be linked to your survey responses.
• Your decision to complete the survey is completely voluntary.
• When exiting this webinar, you will be directed to complete the survey again as a post-training assessment. Again, it will be your decision to complete the follow-up survey or not.
• You are able to complete one pre and post survey per each webinar topic you attend.
• Your completion of the pre-webinar survey will enter you into a drawing to win a $50 Amazon gift card as well as participation in the post-webinar survey will enter you into another $50 Amazon gift card drawing!

If you have any questions about the current study, please feel free to contact, Dr. Lori Keyser-Marcus at Lori.keysermarcus@vcuhealth.org or (804) 828-4164. Thank you for helping us with this effort!
Winter 2022 Webinars

- SUD Treatment for Adolescents: 3-22, 10 – 11 AM & 3-24, 1 – 2 PM
- ASAM Criteria Assessment Dimensions 5 & 6: 3-29, 10 – 11 AM & 3-31, 1 – 2 PM
Paul Brasler is the Behavioral Health Addictions Specialist with the SUPPORT Grant Team at DMAS. Prior to working for DMAS, Paul was the Head of Behavioral Health at Daily Planet Health Services, a Federally-Qualified Health Center in Richmond, Virginia. Paul also works in Emergency Departments conducting Psychiatric and Substance Use Disorder assessments, and in a small medical practice. He has worked in community mental health and in residential treatment settings. He is a national presenter for PESI, specializing in training for clinicians working with high risk clients. His first book, *High Risk Clients: Evidence-based Assessment & Clinical Tools to Recognize and Effectively Respond to Mental Health Crises* was published in 2019.
Two Important Things You Must Do Before Working With Any Client

I. **You must care!** You must like people in general regardless of their circumstances, behaviors or opinions of you

II. **Find something to like** in the person you are working with—connect with them on a human level
NO ONE sets out to become addicted to chemicals or behaviors
What Does “Adolescence” Mean?
Historical Perspective
Expanding “Adolescence”? 

Adolescence

- Chronologically age 13 – 18
- Still dependent on their parent(s) financially (and in other ways)
- Some adolescents transition quicker into adulthood than others

Transitional Age Youth

- Chronologically age 19 – 26
- Have a “foot in adolescence and a foot in the adult world”
- TAY who develop SUD in adolescence may experience delays in cognitive and emotional growth
Adolescent Neurological Development

- The human brain does not fully develop until the age of 23 to 25, specifically the prefrontal cortex, which controls executive functioning and decision-making.
- The more primitive areas of the brain develop earlier, so there is a time when the cravings and emotions related to drugs are strong, but ways to regulate these impulses have yet to develop.
- The hippocampus (learning and short-term memory) is smaller in adolescents who begin drinking at an earlier age.
- Emotional growth is also stunted.
Adolescent Risk

“It is estimated that between 5% and 15% of clients will meet the formal criteria for a SUD during adolescence. Two major factors that increase the risk of a SUD are:

1. Early onset of drug use
2. A preexisting behavioral or mental disorder, such as attention deficit hyperactivity disorder (ADHD), conduct disorder, [oppositional defiant disorder], or trauma”

(Herron & Brennan, 2020, p. 602)
Adolescent Risk

Peer factors: “Youth who associate with peers who use drugs are far more likely to use drugs than those who do not associate with peers who use drugs”

Family factors: Children whose parents have SUD are at increased risk to develop a SUD of their own

“Parenting factors: Increased drug use during adolescence is associated with families that lack closeness or affection, lack effective discipline, lack supervision, have excessive or weak parental control, and have inconsistent parenting. Parental antisocial behavior history is relevant in offspring SUD liability” (Herron & Brennan, 2020, p. 603 – 604)
“The adolescent brain places an oversized emphasis on the value of rewards with little real recognition of risk. And the way it learns to negotiate risk behavior is a critical part of how addiction is learned” (Szalavitz, 2016, p. 158)
Keys to Working with Teens

- Be respectful
- Expect respect
- Be authentic: Practice "genuineness"
- Know something about their world; if you are not sure, get them to teach you
- Limit the amount of "advice" or "parenting" that you do
- Expect to structure the therapeutic time
Monitoring the Future Survey

- A long-term study of the drug use habits of American 8th, 10th and 12th graders by the National Institute on Drug Abuse
- The study started in 1975 and changes yearly to reflect the previous year’s trends
- 32,260 students (75% of a typical sample size) from 319 public and private schools were surveyed from February though June 2021; the schools varied among region and socio-economic levels
- The survey is a questionnaire format (which changes slightly from year-to-year) administered during a class period (60% of respondents were in virtual school)
Significant declines were seen in 2021 from 2020 with alcohol, tobacco, cannabis and other substances—the biggest one-year decline since the start of MTF

- **Alcohol**: 46.5% of 12th graders reported using alcohol in the past year
- **Marijuana**: 30.5% of 12th graders reported using marijuana in the past year
- **Vaping nicotine**: 26.6% of 12th graders reported vaping nicotine in the past year
- **Other illicit drugs**: 7.2% of 12th graders reported using any illicit drug (other than marijuana) in the past year
Adolescents: Initiating Substance Use

- Adolescents start using by experimenting with cigarettes, alcohol or cannabis, [sometimes inhalants] usually in social settings.

- “A large body of research has shown that early initiation of substance use is associated with higher levels of use later as well as negative outcomes such as violent and delinquent behavior, poor physical health, and mental health problems” (Herron & Brennan 2020, p. 582)
Adolescents: Initiating Substance Use

“Neurodevelopment of brain regions associated with motivation and impulsivity, which primarily occurs during adolescence and young adulthood, suggests that treatment engagement and prognosis, and strategies to optimize treatment of OUD, may differ in youth compared with their adult counterparts” (Chang, 2018, p. 143)
Screening for Adolescents

The CRAFFFT Interview (version 2.1)—available at https://craft.org

“For the past 12 months:"
1. Have you ever ridden in a Car driven by someone, including yourself, who was high or had been using alcohol or drugs?
2. Do you ever use alcohol or drugs to Relax, feel better about yourself, or fit in?
3. Do you ever use alcohol or drugs while you are by yourself. Alone?
4. Do you ever Forget things you did while using alcohol or drugs?
5. Had your Family or Friends tell you that you should cut down on your drinking or drug use?
6. Gotten into Trouble while you were using alcohol or drugs?
Substance Use Assessment

A. **Substances** used (including tobacco, alcohol and caffeine) [“Tell me about your drug use”]

B. **Last use** (for each drug) [“When did you last use?”]

C. **Current drug** use [“What is your drug use like during an average week?”]

D. **Routes** of use (for each substance)

E. **Durations** of use (for each substance) [“How long have you been using?”]

F. **Amounts** of use (for each substance) [“How much do you use?”]
Substance Use Assessment

G. **Tolerance** (having to use more of a chemical to get the same reaction as before)

H. **Withdrawal** symptoms

I. **Overdose** history

J. **Impact** on education, relationships, health, legal problems

K. **Past treatment**; periods of sobriety or recovery

L. **Motivation** for treatment

M. **Family history** of substance use
ASAM Criteria Assessment
Dimensions & Adolescents

Dimension 1: Severe withdrawal (and corresponding management) is seen less often in adolescents, the exception being increased numbers of adolescents presenting with opioid withdrawal syndrome.

Dimension 2: While medical needs are not as common among adolescents, a medical examination should not be overlooked.

“"The need for contraception and other medical prevention and treatment services related to sexual behaviors in adolescents involved with drugs cannot be overemphasized" (Herron & Brennan, 2020, p. 608)
Dimension 3: Issues that should be taken into consideration:

- Previously diagnosed psychiatric illnesses
- High rates of depressive disorders, typically characterized by irritability, moodiness, over reactivity, and anxiety, rather than sadness
- Subsyndromal symptoms such as mood lability or anger issues
- The nonspecific features of immature or impaired executive functioning including impulsiveness, explosiveness, poor affective self-regulation, or poor strategic planning
Cognitive functioning and problems such as borderline intellectual functioning, fetal alcohol effects, assorted attentional deficits, or learning disorders

Complications of substance use

Behavioral issues

Adolescent learning in normal adolescent development as well as in those with the delayed development and immaturity that often accompanies drug use and co-occurring psychiatric disorders

Cannabis-induced or cannabis-exacerbated psychosis
ASAM Criteria Assessment  
Dimensions & Adolescents

- **Dimension 4**: Where is the adolescent (and their family) in terms of motivation to make changes?
- **Dimension 5**: What is the likelihood of resumption or continued substance use
- **Dimension 6**: “For adolescents, the most important features of the recovery environment generally involve family and peers” (Herron & Brennan, 2020, p. 609)
Providing treatment to adolescents is more than duplicating adult SUD treatment
ASAM Recommendations

“In general, for a given degree of severity or functional impairment, adolescents require more intensive treatment than adults”

(Mee-Lee et al., 2013)
“In general, adolescents with fewer supports, less resiliency, and lower levels of baseline functioning may need a higher intensity of services and longer lengths of service at all levels of care than do those with the benefits conferred by economic advantage”

(Herron & Brennan, 2020, p. 608)
ASAM Recommendations

- Treatment should be separate from adults
- “Strategies to engage adolescents, channel their energy, hold their attention, and retain them in treatment are especially critical” (Mee-Lee et al., 108)
- “Treatment must address the nuances of adolescent experience, including cognitive, emotional, physical, psychological, social, and moral development, in addition to involvement with alcohol and other drugs” (Mee-Lee et al., 108)
Treating Adolescents: Consent

“There is a general consensus that at around the age of 14 years, adolescents have the cognitive ability to understand informed consent” (Herron & Brennan, 2015, p. 623)

Some states require providers to obtain parental consent, while others allow adolescents to be treated without such consent.

Some additional factors to consider when determining whether the adolescent can consent (in addition to age):

- Adolescent's maturity
- Family situation; living situation
- Severity of the adolescent’s SUD
- Type of treatment to be provided
- Clinician’s liability for refusing to provide treatment (in some cases) or providing treatment (in other cases)
“Family involvement in adolescent addiction treatment has been shown to improve outcomes”
(Smyth et al., 2018), p. 9
When working with a family, the family (not individual members) is the client

- **Homeostasis**: “The tendency of any system to try to maintain itself in a state of equilibrium and balance” (Hull & Mather, 2005 as cited in Boyle et al, 2009)
  - In some family systems, the drive toward maintaining homeostasis may be stronger than the system’s desire for healing

- **Boundaries**: The separation people place between themselves as individuals, families and groups

- **Open or closed systems**: flexibility

- **Rules**: Reflect values; may be spoken or unspoken
Family Therapy Operationalized

- Family therapy is often used in conjunction with individual therapy.

- Multi-family group therapy is also sometimes used, during which several families (adults and adolescents), attend group therapy sessions with other families.
  - This is often a component of Partial Hospitalization programs, Intensive Outpatient programs or Drug Treatment Courts (Juvenile).

- Participation in AA, NA, Al-Anon, etc., can also be encouraged.
Types of Family Therapy

- Structural/Strategic Family Therapy
- Bowen Family Systems Therapy
- Multidimensional Family Therapy
- Multisystemic Therapy
- Community Reinforcement and Family Training (CRAFT)
Structural/Strategic Family Therapy

- Treatment works to identify the role that SUD plays in the family while the counselor guides change in the family structure

- Key interventions:
  - Supporting system strengths
  - Relabeling (normalizing)
  - Problem tracking (journaling/observations between sessions)
  - Stress management skills
  - Discussion and mutual decision-making
  - Role-plays & manipulating space
  - Communication skills training
Community Reinforcement & Family Training (CRAFT)

- CRAFT recognizes that the person with SUD in the family may be unaware of their SUD and its impact on the family, OR may be ambivalent about making changes, particularly about deciding to enter treatment.
- CRAFT utilizes many of the assumptions and practices of Motivational Interviewing.
- The initial focus of CRAFT is with the IA’s family members.
- Even if the IA chooses not to engage in treatment, the changes within the family system will benefit all members of the family.
CRAFT Components

(Meyers et al., 1999, p. 295 – 296)

1. Raising awareness of negative consequences caused by the person with SUD’s drug use and possible benefits of treatment
2. Learning specific strategies for preventing dangerous situations
3. Contingency management training to reinforce non-using behaviors and to [change] drug use
4. Social skills training to improve relationship communication and problem-solving skills
5. Planning of activities that interfere and compete with drug use
6. Practicing strategies to interfere with actual and potential drug use
7. Preparing to initiate treatment when the person with SUD appears ready, and supporting them once treatment begins
Adolescents & Medication for Opioid Use Disorder
“Of the approximately 37,000 physicians trained and waivered to prescribe buprenorphine nationwide, approximately 1% are pediatricians” (Levy et al., 2018, p. 1)
“Only 2.4% of adolescents in treatment for heroin addiction received medication-assisted treatment, as compared with 26.3% of adults” (Chang et al, 2018, p. 144)
Pharmacotherapy for Opioid Use Disorder

- Methadone and Buprenorphine (the active ingredient in Suboxone) are both opioids—human-made chemicals that are like opiates (medicines made from opium)
- Methadone was approved for opioid use disorder treatment in the 1970's and Buprenorphine in 2002
  - Used for opiate withdrawal management in inpatient settings and maintenance treatment in outpatient settings
  - Given by a licensed provider and administered in oral form (an injectable form of buprenorphine is available)
- Behavioral health treatment is an important part of MAT, but clients should not be forced to receive counseling to be able to receive pharmacotherapy
Methadone & Buprenorphine Therapies

- Methadone and Suboxone act as opioid agonists: They keep the client from experiencing opioid withdrawal symptoms (also called “dope sickness”) and block the euphoric effects should the client use heroin or another opioid, thus discouraging the client from continuing use.
- Neither of these chemicals, when used as prescribed, will get the client high.
- However, methadone and buprenorphine are the most-regulated medicines in the U.S. when used for treating SUD.
- Both chemicals allow the brain to heal from opioid use and provide opportunities for the client to address the underlying causes of their SUD.
Methadone

- Chemically unlike heroin or morphine, but works as an agonist for both
  - Also used to treat chronic pain
  - “Methadone has the strongest evidence base of any opioid addiction treatment” (Andraka-Christou, 2020, p. 52)

- Delivered in liquid or pill form in Opioid Treatment Programs (OTPs), sometimes called Methadone Clinics

- Long-term effects: 24 – 36 hours
  - This allows the client to work, attend school, parent, and engage in pro-social activities as opposed to purchasing, using and recovering from illicit opioid use
  - Responsible for some opioid overdose deaths, since Methadone accumulates in tissues before binding to plasma proteins
  - Withdrawal develops slowly and is prolonged when compared to morphine or heroin
Buprenorphine

- An **opioid agonist** in low doses and an **antagonist** in high doses, often combined with Naloxone: Suboxone®
  - In this formulation, should the patient try to inject or insufflate the drug (instead of taking it orally), they will go into withdrawal symptoms (but people have found ways around this) (Kavanaugh & McLean, 2020)
  - Suboxone is delivered in a buccal film or pill
  - Less respiratory depression than Methadone
  - Has a “ceiling effect” (at 32 mg) which makes overdose less likely—except when mixed with alcohol
  - In 2017, the Food and Drug Administration approved Sublocade®, an injectable form of buprenorphine
Naltrexone & Naloxone

These medications have antagonistic properties; they will cause an opioid user to go into withdrawal (Naloxone) if administered while the person is using opioids or will block the effects of opioids (Naltrexone)

- **Naltrexone** (Vivitrol®) is a deterrent, and is used to prevent relapse by limiting cravings
  - Also blocks the euphoric effects of opioids, cocaine, and alcohol
  - Time-release injectable versions and implant versions are available

- **Naloxone** (Narcan®) is injected or used intra-nasally to reverse an opiate overdose
Adolescents & Buprenorphine-Naloxone

“Youth with OUD have been treated with a range of maximum buprenorphine doses (2 – 32 mg per day). At induction, the dose should ideally be escalated gradually until there are no longer signs of withdrawal or craving. As with adults, titration pace and total dose should be based on patient severity, amount of illicit opioid used (tolerance), and clinical response” (Borodovsky et al., 2018, p. 11)
Buprenorphine-Naloxone & Tapering

“Recent randomized controlled trial found that longer duration (i.e., 56 days) of buprenorphine/naloxone was more effective in preventing relapse among youth compared with a shorter duration (i.e., 28 days) of therapy” (Chang et al., 2018, p. 143)

“Drawing on findings from the adult population, the Prescription Opioid Addiction Treatment Study (POATS) demonstrated that tapering off buprenorphine/naloxone OAT, even after 12 weeks of buprenorphine-naloxone treatment, was associated with a 90% relapse rate following taper, regardless of the receipt of ongoing counseling” (Chang et al., p. 144)
“Based on the strong evidence in the adult population and available evidence to date among youth, combined with its superior safety profile compared to methadone, first-line MOUD for youth should be buprenorphine-naloxone, with methadone as an alternative treatment option when buprenorphine-naloxone cannot be used, such as with challenging inductions or ongoing cravings on maxima doses of buprenorphine/naloxone” (Chang et al., p.143)

“While methadone can be prescribed to youth under the age of 18, the United States Code of Federal Regulations requires documentation that the patient has failed two previous drug-free or withdrawal management attempts and written consent from a parent or guardian” (Chang, p. 144)
Post-Webinar Survey

Here is the link to the Post-Webinar Survey. It should take you less than 5 minutes to complete:
https://redcap.vcu.edu/surveys/?s=W4P4ANWYK7

- Your name and contact information will not be linked to your survey responses.
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