

Teens with opioid use disorder may benefit from medication treatment

September 11 2019



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Although the effectiveness of medications to treat adults with opioid use

disorder has been well established, there has been little research about how—or even if—such treatment works in adolescents.

Now, a new review of the literature suggests that, in addition to adults, adolescents with severe [opioid](#) use disorder can be treated with one of three medications: [methadone](#), buprenorphine (Subutex/Suboxone) or extended-release naltrexone (Vivitrol). The study was published in the latest issue of the *Journal of Studies on Alcohol and Drugs*.

"In 2017, 900 adolescents started misusing opioid pain relievers each day," the authors write. In addition to abusing [prescription medication](#), some of these teens "initiate heroin use because of its ready availability, lower cost, and strong potency."

"Adolescents with severe opioid use disorder may benefit from a medication as part of a larger comprehensive treatment plan," says lead author Deepa R. Camenga, M.D., M.H.S., of the Yale School of Medicine. Further, "parents should try to consult with an addiction psychiatry or medicine specialist to see if there are additional treatments that may benefit their child."

In their research, Camenga and colleagues searched the scientific literature for investigations of the effects of medication in the treatment of opioid use disorder in adolescents. They identified 14 reports, published between 1973 and 2018. The number of adolescents in each study ranged from just a handful to several hundred.

Overall, the researchers report that the dangers of untreated opioid use disorder "far outweigh the risks" of treatment with methadone, buprenorphine, or naltrexone. However, few adolescents receive such therapy: Only about 2 to 5 percent of adolescents with an opioid use disorder receive treatment with one of these medications, compared with 12 to 26 percent of adults.

In general, methadone, buprenorphine and extended-release naltrexone improved the number of adolescents who remained in treatment, decreased opioid use, and led to more abstinence. But, the authors say, "research is still needed to understand the optimal treatment duration and how to retain adolescents in treatment."

The medications do have their challenges. For methadone, the authors say, the use of these medications needs to be closely monitored due to known side effects with high doses, including slow breathing and sedation, as well as heart rhythm problems. Further, methadone needs to be administered by a federally certified opioid treatment program, which can cause difficulty for adolescents who don't have transportation to such locations. Also, adolescents must receive special dispensation to receive it, and there is the risk that methadone itself can be abused.

Unlike methadone, buprenorphine can be administered on an outpatient basis. However, teens may need the oversight of an adult to help ensure the medication is taken properly and not misused.

For naltrexone, one challenge to treatment is that patients have to go through detoxification before starting treatment. Also, naltrexone may increase the risk of opioid overdose if a patient begins using opioids again once the medication wears off. Nonetheless, extended-release naltrexone is given by injection once a month and doesn't require the frequent visits of methadone or the oversight of buprenorphine.

However, there is a very limited number of health care professionals who treat teens with opioid use disorder. "There is a great need to improve adolescents' access to medications for the treatment of OUD and to increase workforce capacity to care for these adolescents," the authors conclude.

In a commentary that accompanies the review, a group of researchers led

by Rachel Gonzales-Castaneda, Ph.D., M.P.H., of UCLA, writes that, because relapse occurs in more than half of the adolescents treated for opioid use disorder with standard approaches, alternatives such a treatment with medication may need to be considered. However, they add that researchers lack information on how medical treatment may interact with other mental or physical disorders, or their treatments, and that much more research is needed that addresses the needs of the [adolescent](#) population with opioid disorder.

In a second commentary, Noel Vest, Ph.D., of the Stanford University School of Medicine, and Keith N. Humphreys, Ph.D., of the Veterans Affairs Palo Alto Health Care System in California, sound a cautious tone about the use of medication to treat [opioid use disorder](#) in adolescents.

Specifically, they write that teens treated with methadone "may end up taking the [medication](#) for half a century or more" and that the risks of such lengthy treatment are unknown. Further, they suggest that the treatment retention noted in the review does not necessarily equate to patients refraining from drugs or alcohol.

Last, diagnosing an adolescent poses complications. *"t can be challenging to determine whether 16-year-olds are truly dependent on Vicodin if they have been frequenting parties in which they are among many teenagers who consume the drug," Vest and Humphreys write.*

More information: Deepa R. Camenga et al, Medications for Maintenance Treatment of Opioid Use Disorder in Adolescents: A Narrative Review and Assessment of Clinical Benefits and Potential Risks, *Journal of Studies on Alcohol and Drugs* (2019). [DOI: 10.15288/jsad.2019.80.393](#)

Provided by Journal of Studies on Alcohol and Drugs

Citation: Teens with opioid use disorder may benefit from medication treatment (2019, September 11) retrieved 9 April 2024 from <https://medicalxpress.com/news/2019-09-teens-opioid-disorder-benefit-medication.html>

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