1000 – 1661 Portage Avenue
Winnipeg, MB R3J 3T7
Tel: (204) 774-4344 Fax: (204) 774-0750
Toll Free (MB only) 1-877-774-4344
www.cpsm.mb.ca

MANITOBA OPIOID AGONIST THERAPY RECOMMENDED PRACTICE MANUAL

1.13 Recommendations for Adolescents & Opioid Agonist Therapy

GENERAL CONSIDERATIONS

The treatment of choice for adults with opioid use disorder (OUD) is opioid agonist therapy (OAT), ideally in combination with psychosocial interventions such as counseling, contingency management, and/or peer support.

Similarly, while the evidence for treating youth is less robust compared to adults[3], the general consensus among experienced providers is that OAT is *also effective* in adolescents*. **Those who meet criteria for OUD should be offered timely OAT induction**. Careful assessment is needed to assure the adolescent meets OUD criteria before prescribing[4] and, in some cases, consultation with experienced colleagues may be warranted. Despite the limited evidence for treating adolescents with OAT, the vast evidence demonstrating the risks of untreated OUD would far outweigh the risks of treatment[3].

Ideally, adolescents should be treated in OAT programs with case management capacity and wrap-around care supports, such as low-barrier counselling, harm-reduction interventions, and connection to primary and/or specialist care as needed. However, given the risks of untreated OUD, timely induction should be pursued even if this level of care is not readily available. Connection and collaboration with additional supports can be established once the patient is medically stable and able to participate in further psychosocial treatment planning.

*For the purpose of this manual, **Adolescence is defined as "the phase of life between childhood and adulthood, from ages 10 to 19. It is a unique stage of human development and an important time for laying the foundations of good health"**[1]. However, for healthcare purposes in Manitoba, and medicine in general, patients are considered and treated as adults by age 18. The authors also acknowledge that Adolescent & Youth Medicine is a subspecialty that focuses on the healthcare and well-being of patients who are between the *ages of 10 and 25 years*, and that this transitional period is a critical time for addiction medicine intervention[1,2].

SPECIFIC CONSIDERATIONS

Patients under the age of 18 who seek assessment and treatment for OUD represent a very small percentage of all patients on OAT. Inexperienced providers and providers who have never treated adolescents are strongly encouraged to reach out to experienced OAT colleagues for guidance as needed.

Occasionally, providers may also wish to obtain a second opinion from a colleague as to the appropriateness of OAT in an adolescent patient. However, seeking a second opinion should not delay induction and thereby potentially expose the patient to further preventable harms associated with OUD.

The approach to induction and dose titration for youth is similar to the approach for adults. Induction and titration recommendations for Buprenorphine/naloxone and Methadone are reviewed in those respective chapters. It is important to titrate the dose to therapeutic effect to establish a stable dose as soon as practically possible. This promotes the adolescent's ongoing engagement in care to optimize treatment retention and progress toward therapeutic goals.

Buprenorphine First-line Treatment

Due to its comparable effectiveness and enhanced safety and side-effect profile, buprenorphine/naloxone is the preferred first-line treatment for OUD. For the majority of patients with OUD, including adolescents, it should be used preferentially.

Consideration for methadone as an alternative agent may be appropriate if there is a contraindication to buprenorphine/naloxone, if there are intolerable side-effects on buprenorphine/naloxone, or if preferred by the patient. Treatment should not be withheld if the adolescent patient specifically requests methadone. If the patient has received adequate education about the benefits of buprenorphine, methadone is a reasonable second-line treatment option, but again, further consultation with an experienced colleague may be warranted.

Capacity to Consent

Like in other areas of medical care, it is important for the OAT prescriber to assess and document whether or not the **adolescent patient is capable of giving informed consent to treatment**.

It is also important to consider that adolescents may be dependent on their parent(s) or guardian(s) for medication coverage/financial support. Parental involvement may need to be explored if the patient requires access to medication coverage/funds to pay for OAT medications. An exception is youth with medication coverage through Non-Insured Health Benefits (NIHB), as parental involvement is not required to facilitate this coverage.

LOCKED BOXES & NIHB

For patients whose medications are covered by Non-Insured Health Benefits (NIHB), the cost of a lockbox may be covered once per patient, per lifetime (up to $35), for the safe storage of take-home doses of OAT. If indicated, this coverage extends to safe storage of other high-risk medications, including other opioids, benzodiazepines, stimulants, or sedating/psychoactive drugs, where a lockbox can improve safety for NIHB clients and communities.

Access to Care & Provincial Resources

Youth under 18 years of age *cannot* be assessed or treated for substance use disorders at the Rapid Access to Addiction Medicine (RAAM) clinic located at the Crisis Response Centre (CRC) in Winnipeg, due to a facility restriction (CRC does not see any patients under age 18).

However, there are no restrictions to youth being assessed and treated with OAT in the other RAAM clinics across Manitoba, including at the River Point Centre in Winnipeg.

It may be beneficial to connect adolescents to **Youth Addiction Centralized Intake** (YACI) after OAT induction, as they may benefit from the additional supports/services available through YACI, or the **Youth Addictions Stabilization Unit** (YASU). It is important to note that there are unfortunately no OAT providers associated with YACI or YASU.

In general, publicly funded youth addiction and mental health services in Manitoba do not include OAT access. Community prescribers who are willing and comfortable treating youth on OAT are a valuable resource for adolescents with OUD. Effective collaboration between OAT prescribers and existing youth addiction and mental health services has the potential to optimize outcomes and fill gaps in care for vulnerable patients.

"Detox" NOT Recommended

It is not uncommon for young patients and their parents/guardians to request "detox" towards cessation of opioid use and abstinence-based treatment. In adults with OUD, withdrawal management or "detox" without transition to OAT and long-term treatment is specifically *not recommended* as it has been associated with increased morbidity, such as HIV transmission, and mortality secondary to overdose.

Likewise, "detox" towards abstinence is not recommended for adolescents with OUD due to the same substantial risk of serious harms. These potential harms include death by overdose given the lost tolerance created by an abstinence-based detoxification admission. However, home "detox" may be an alternative option for some individuals. Home "detox" is defined as a self-guided process of tapering a low to moderate dose of opioids, or abstinence from opioids over a predetermined period, outside of an established clinical or institutional setting. **It is important to consider that this approach has limited evidence and carries significant risk**[5].

If adolescents decline OAT despite the risks, a slow outpatient taper of opioids is a safer approach than admission to a hospital or residential detox setting. Please refer to Alternative Treatment Approaches for OUD for further considerations around home-based withdrawal management. Again, consultation with an experienced colleague may be warranted.

Parental Involvement

Overall, it can be beneficial for parents or guardians to receive education about OAT and to be involved in exploring solutions to potential barriers to treatment. Parental support can facilitate medication funding, transport, housing and/or other practical support that aligns with the treatment plan.

However, the adolescent's relationship with their parent(s) or guardian(s) may be non-existent, strained, or a source of instability and/or trauma. These issues can be complex and must be explored in a sensitive and culturally safe manner during the initial assessment.

Insisting on parental involvement or consent to treatment may be harmful in some cases and can cause the adolescent to disengage and become lost to care. OAT prescribers must use their professional judgement, on a case-by-case basis, to determine if seeking parental consent/involvement in treatment is prudent. Most importantly, if parental involvement is not possible or desirable for the adolescent, **treatment can still proceed if capacity to consent has been established and funding for medication is in place.**

Duty to Report

Suffering from OUD is not reportable. Nor is engaging in OAT care. However, when caring for patients under the age of 18, OAT providers can encounter issues/circumstances that may require reporting to the relevant authorities. Reporting requirements may differ by profession, and it is important for OAT team members to discuss these issues in a frank and collaborative manner.

The CPSM Standard of Practice for the Duty to Report Self, Colleagues, or Patients outlines the expectations, ethics, and legalities of reporting. This Standard came into effect in 2021 and all physicians holding a CPSM Certificate of Practice must comply. Physicians must also document all relevant information in the medical record, including a decision to report. The Standard highlights that honesty and compassion are fundamental to the patient-physician relationship. It encourages communication with patients around reporting duties and potential breaches as appropriate, to foster a trusting relationship between patient and provider[6]. Please see the Standard for more information about mandatory reporting with patients.

There may be times when a prescriber, after carefully considering all available information together with the treatment team, believes that reporting a particular issue will cause serious harm to the therapeutic alliance with a young patient. This harm may include damage to the therapeutic relationship, the patient disengaging from care, and potentially returning to

unregulated opioid use with the associated harms of relapse. In such situations, the physician must carefully weigh their duty to report against the real and/or perceived harms of making a report. Prescribers must document their rationale for the decision made, including the patient's response to this information in the medical record.

STANDARD OF PRACTICE: DUTY TO REPORT[6]

This Standard of Practice, specifically Part 3 Duty to Report the Medical Condition or Knowledge of Patient Information, emphasizes:

3.1. Registrants must comply with any duty to report the medical condition or knowledge of patient information as prescribed by Provincial and Federal Legislation (see Contextual Information and Resources for list of legislation).

3.2. Honesty and compassion are virtues fundamental to the patient-physician relationship. To ensure a trusting physician-patient relationship, registrants should communicate with their patients about their reporting duties and breach of confidentiality except in rare instances when notifying the patient is not appropriate, such as where the registrant is concerned about the safety of the patient or another person.

The Manitoba Government provides information on Reporting for Child Protection and Child Abuse, along with resources for services providers. Additionally, the *Contextual Information and Resources* in the above-mentioned Standard of Practice lists legislation that involves mandatory reporting, and outlines further considerations in reporting and patient/public safety.

References

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