

The use of buprenorphine for the treatment of opioid addiction in adolescents has not been systematically studied. It is known, however, that patients younger than 18 years of age, with relatively short addiction histories, are at particularly high risk for serious complications of addiction (e.g., overdose deaths, suicide, HIV, other infectious diseases). Many experts in the field of opioid addiction treatment believe that buprenorphine should be the treatment of choice for adolescent patients with short addiction histories.

Additionally, buprenorphine may be an appropriate treatment option for adolescent patients who have histories of opioid abuse and addiction and multiple relapses but who are not currently dependent on opioids. Buprenorphine may be preferred to methadone for the treatment of opioid addiction in adolescents because of the relative ease of withdrawal from buprenorphine treatment. Because adolescents often present with short histories of drug use, detoxification with buprenorphine, followed by drug-free or naltrexone treatment, should be attempted first before proceeding to opioid maintenance.

Naltrexone may be a valuable therapeutic adjunct after detoxification. Naltrexone has no abuse potential and may help to prevent relapse by blocking the effects of opioids if the patient relapses to opioid use. Naltrexone has been a valuable therapeutic adjunct in some opioid-abusing populations, particularly youth and other opioid users early in the course of addiction. Naltrexone is most likely to be effective for patients with strong support systems that include one or more individuals willing to observe, supervise, or administer the naltrexone on a daily basis. In those adolescent patients in whom detoxification is followed by relapse, buprenorphine maintenance may then be the appropriate alternative.

The treatment of patients younger than 18 years of age can be complicated due to psychosocial considerations, the involvement of family members, and State laws concerning consent and reporting requirements for minors. Ancillary counseling and social services are important to support cooperation and follow through with the treatment regimen.

Parental Consent

Parental consent is a critical issue for physicians who treat adolescents addicted to opioids. In general, adult patients with “decisional capacity” have the unquestioned right to decide which treatments they will accept or refuse, even if refusal might result in death. The situation for adolescents is somewhat different, however. Adolescents do not have the legal status of adults unless they are legally “emancipated minors.”

Adolescents' rights to consent to or to refuse medical treatment differ from those of adults. Rules differ from State to State regarding whether an adolescent may obtain substance use disorder treatment without parental consent. Some State statutes governing consent and parental notification specify consideration of a number of fact-based variables, including the adolescent's age and stage of cognitive, emotional, and social development, as well as issues concerning payment for treatment and rules for emancipated minors.

More than one-half of the States permit individuals younger than 18 years of age to consent to substance use disorder treatment without parental consent. In States that do require parental

consent, providers may admit adolescents to treatment when parental consent is obtained. In States requiring parental notification, treatment may be provided to an adolescent when the adolescent is willing to have the program communicate with a parent.



tip Histories of neglect or abuse may be revealed during the care of adolescent patients, and physicians must be aware of reporting requirements in their State. Mandatory child abuse reporting takes precedence over Federal addiction treatment confidentiality regulations, according to Title 42, Part 2 of the Code of Federal Relations (42 C.F.R. Part 2).

Additional difficulties may arise when adolescents requesting treatment refuse to permit notification of a parent or guardian. With one very limited exception, the Federal confidentiality regulations prohibit physicians (or their designees) from communicating substance abuse treatment information to any third parties, including parents, without patient consent.

The sole exception allows a “program director” (i.e., treating physician) to communicate “facts relevant to reducing a threat to the life or physical well-being of the applicant or any other individual to the minor's parent, guardian, or other person authorized under State law to act in the minor's behalf,” when the program director believes that the adolescent, because of extreme youth or mental or physical condition, lacks the capacity to decide rationally whether to consent to the notification of his or her parent or guardian (42 C.F.R. Part 2, Subpart B, Section 2.14d 2001).

The program director must believe the disclosure to a parent or guardian is necessary to cope with a substantial threat to the life or physical well-being of the adolescent applicant or someone else. In some cases, communication with State child protection agencies or judicial authorities may be an acceptable alternative, or the required course of action, if the physician believes neglect or abuse has already occurred.

Treatment Setting

The more intensive a proposed treatment is, the more risk a program assumes in admitting adolescents without parental consent. Outpatient programs may have a better justification for admitting adolescents without parental consent than do intensive outpatient or residential programs.

Summary

Buprenorphine can be a useful option for the treatment of adolescents who have opioid addiction problems. The treatment of addiction in adolescents is complicated by a number of medical, legal, and ethical considerations, however. Physicians intending to treat addiction in adolescents should be thoroughly familiar with the laws in their State regarding parental consent. Physicians who do not specialize in the treatment of opioid addiction or adolescent medicine should strongly consider consulting with, or referring adolescent addiction patients to, such specialists.

Additionally, State child protection agencies can be a valuable resource when determining the proper disposition for adolescent patients.

See Reference: <http://www.suboxoneassistedtreatment.org/48.html>