Children's National-Pediatric Health Network

Navigating Complexities of Treating Opioid Use Disorder in Adolescents: Practical Strategies and Emerging Solutions

Sivabalaji Kaliamurthy, MD

February 12, 2025

Pediatric Health Network

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Notes About Today's Webinar

- All lines are muted throughout the presentation.
- Please use the Q&A to ask questions or make comments.
- We will be recording the session.
- Today's recording and materials will be posted to the PHN website following the presentation: https://pediatrichealthnetwork.org/
- **Save the date:** The next webinar in this series will be Wednesday, April 9 at noon.

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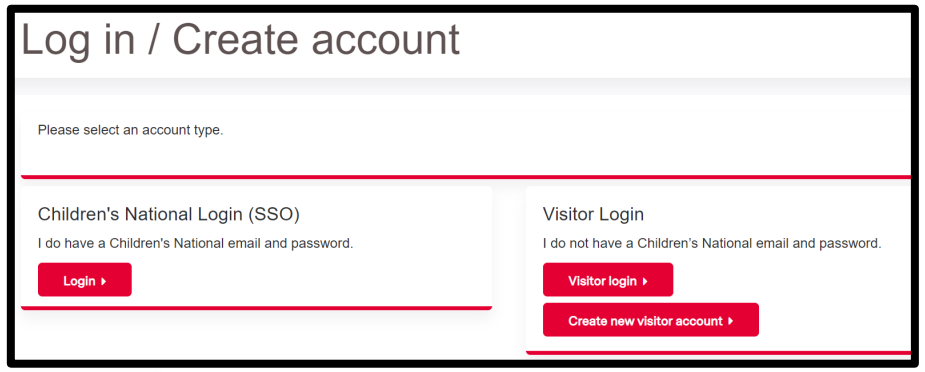

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Today's Speaker

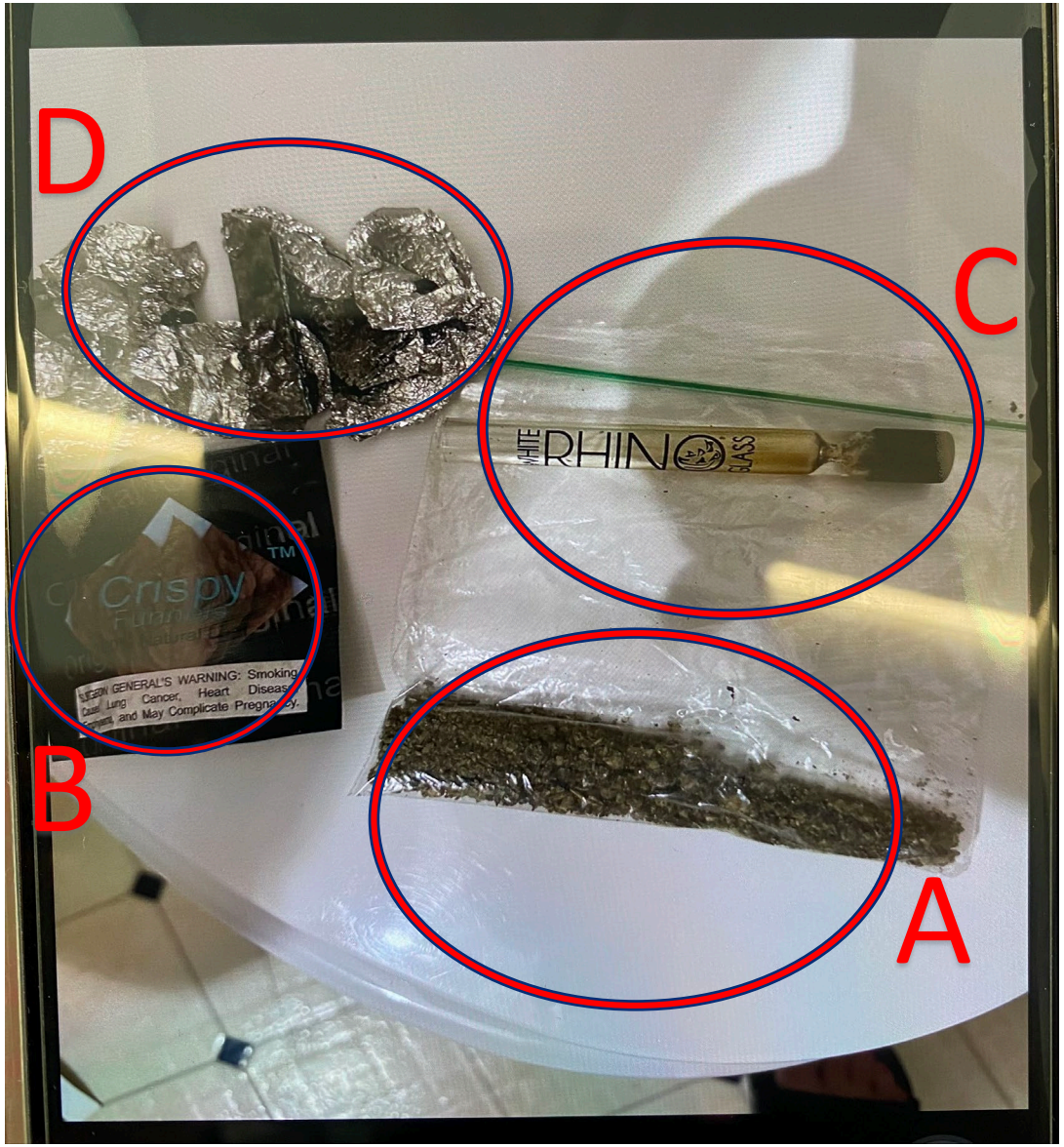
Sivabalaji Kaliamurthy, MD
Psychiatrist

Disclosures

- No financial disclosures.
- We will be discussing off label use of certain medications today.

Learning Objectives

1. Understand the Scope and Presentation of Pediatric Opioid Use Disorder
2. Implement Evidence-Based Screening and Diagnostic Practices
3. Initiate and Support Comprehensive Treatment Plans


D
C
B
A
WHITE RHINO GLASS
Crispy
GENERAL'S WARNING: Smoking
Cancer, Heart Disease
and May Complicate Pregnancy.

From: **Trends in Drug Overdose Deaths Among US Adolescents, January 2010 to June 2021**

JAMA. 2022;327(14):1398-1400. doi:10.1001/jama.2022.2847

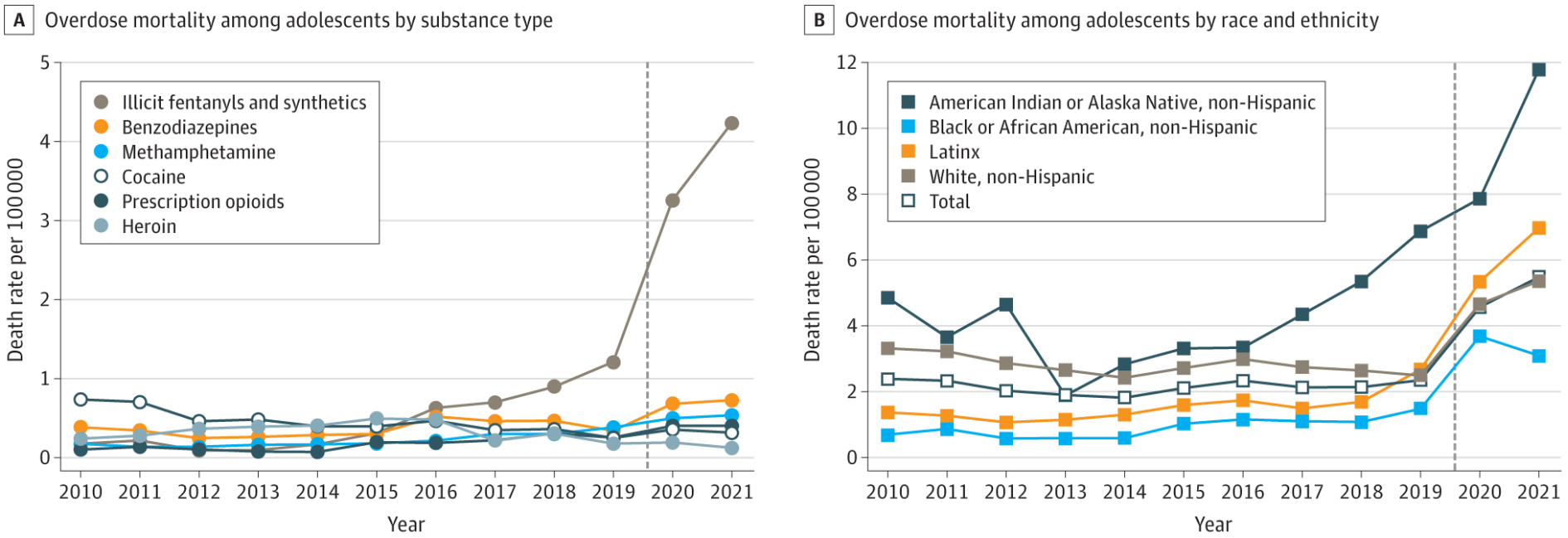


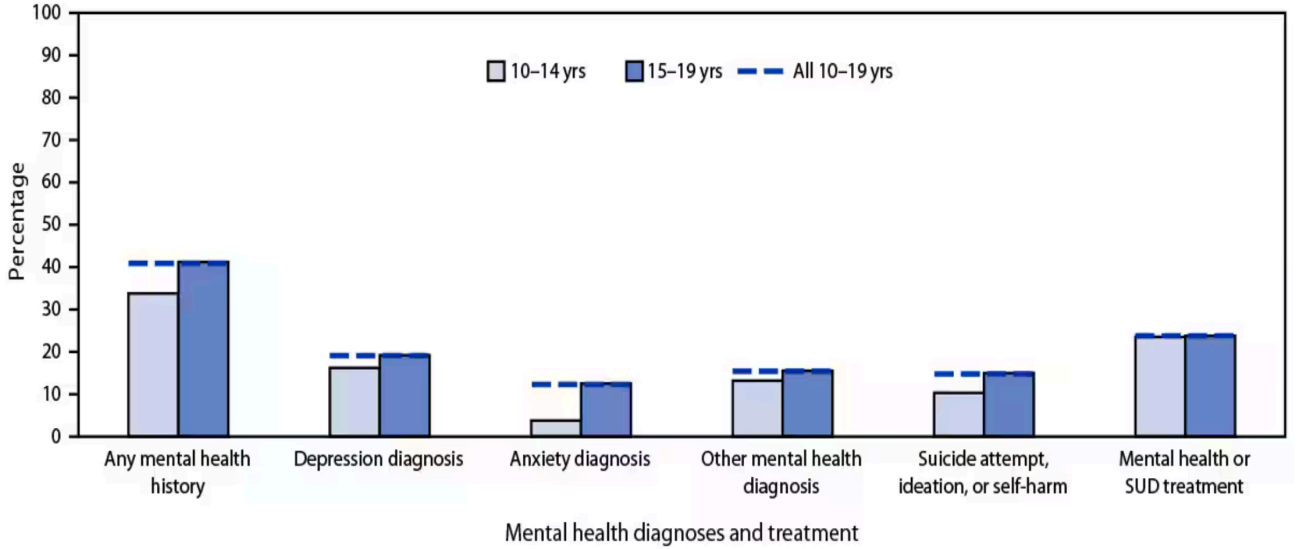
Figure Legend:

Adolescent Overdose Deaths, 2010-2021Drug overdose rates per 100 000 adolescents are shown by (A) substance involved and (B) race and ethnicity. The year 2021 refers to January to June 2021, and rates have been annualized. The vertical dashed lines delineate the prepandemic and pandemic periods of observed data.

Drug Overdose Deaths Among Persons Aged 10–19 Years — United States, July 2019–December 2021 *Tanz et al., (2022)*

- Approximately 84% of deaths involved illicitly manufactured fentanyl.
- Two thirds of decedents had a potential bystander present, although most provided no overdose response.
- 35% of adolescent decedents had documented opioid use history and 14.9% had previous overdose.
- Approximately 41% of decedents had a history of mental health conditions or treatment.

FIGURE 2. Mental health conditions and treatment history of drug overdose decedents aged 10–19 years (N = 1,871), overall and by age group — State Unintentional Drug Overdose Reporting System, 43 jurisdictions,* July 2019–December 2021†,§



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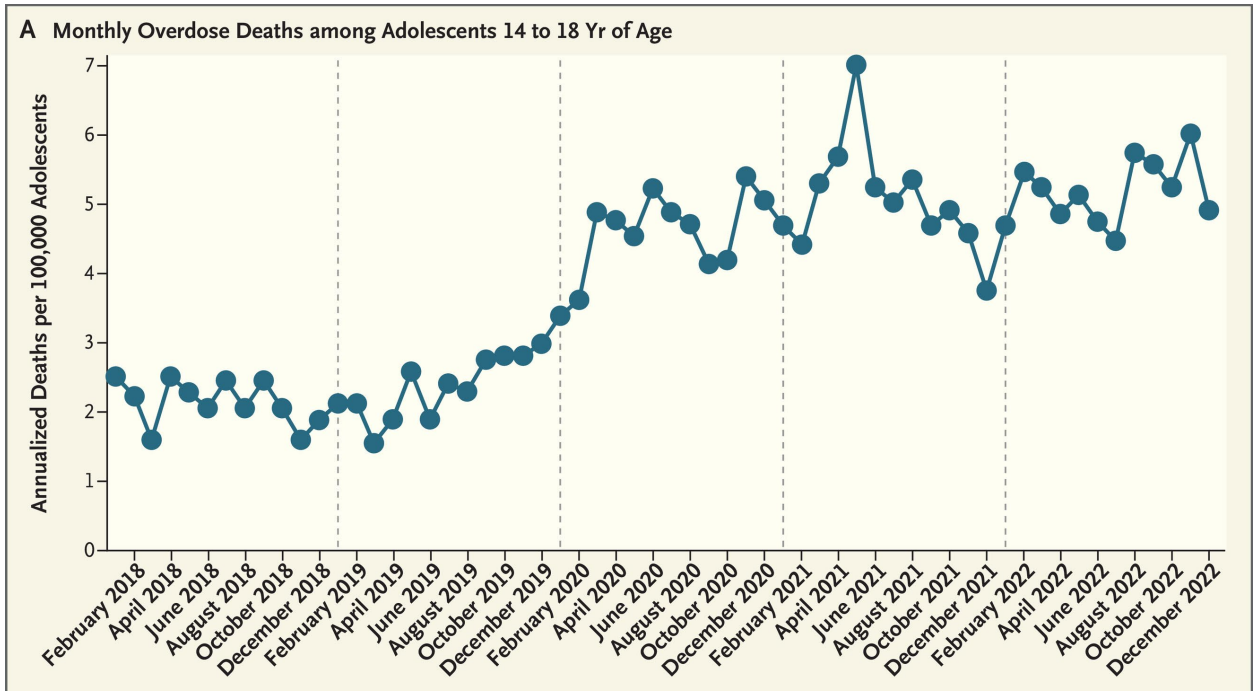
Trends in Adolescent Overdose: A Snapshot from 2021 Onwards

- Provisional data from the CDC WONDER data base shows that overdose rates in adolescents had a small decrease in 2023.

- *Does recent decline in overdoses impact adolescents?*



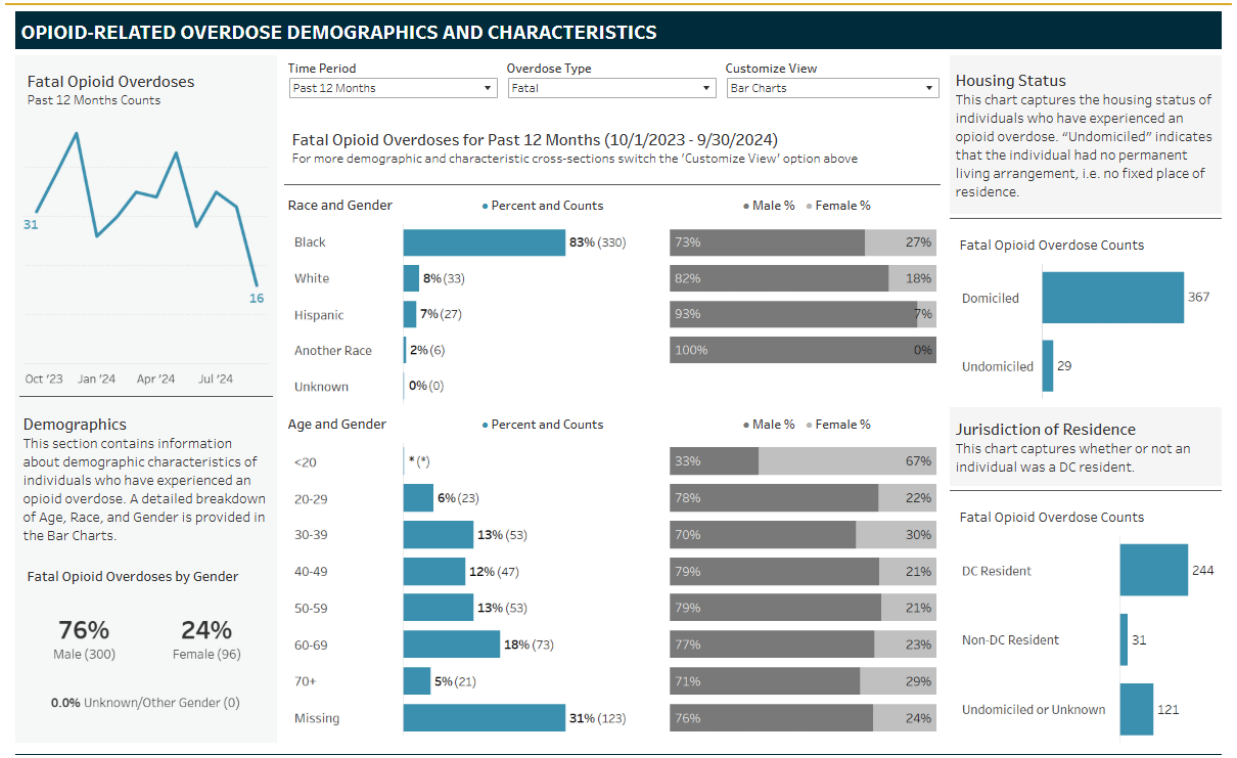
Friedman & Hadland (2024)

Local Data

District of Columbia → Live.Long.DC

Maryland → MDH Interactive Dashboard

Virginia → Drug Overdose and Substance Use



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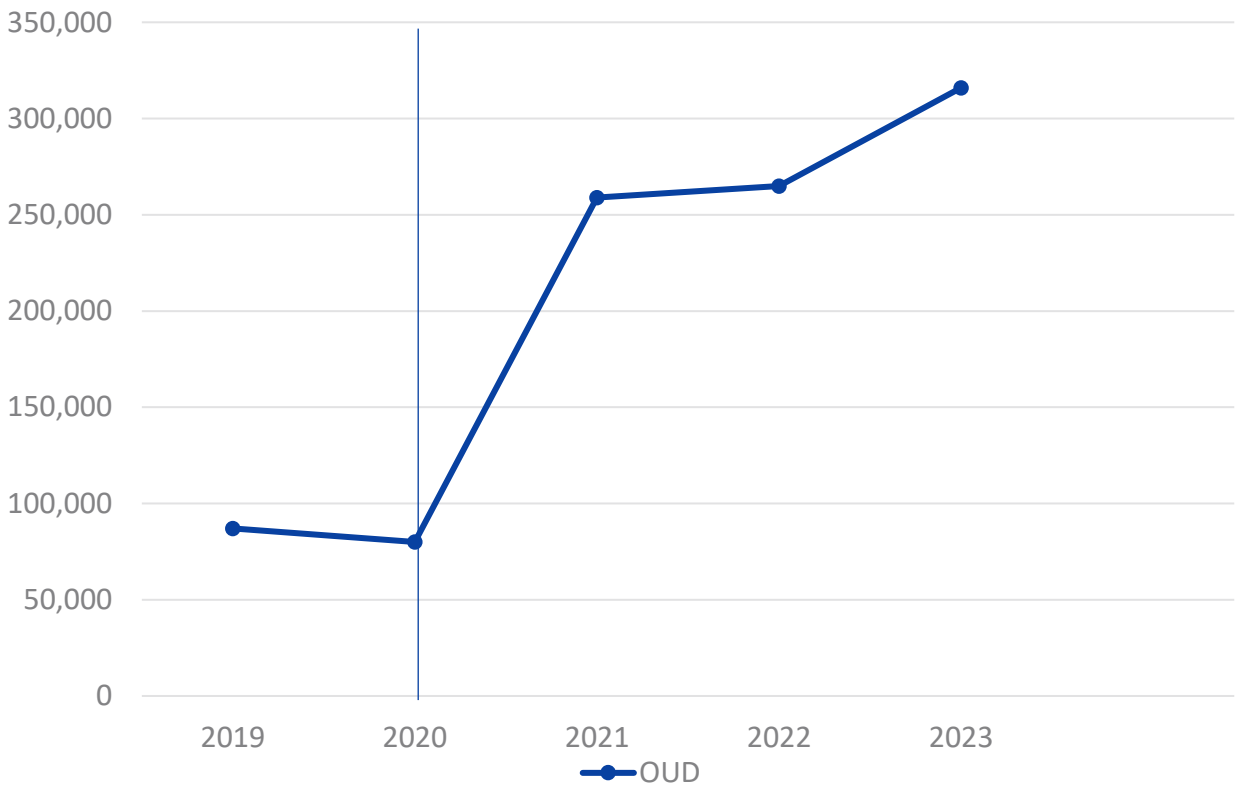
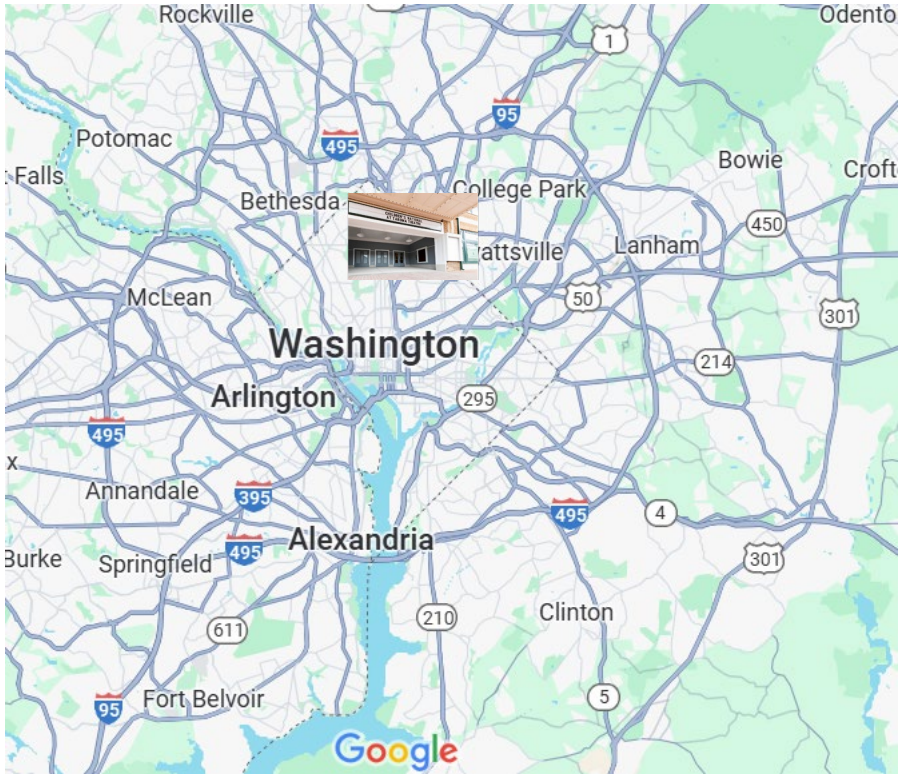
Past Year OUD Diagnosis in Adolescents Ages 12 to 17 Years *NSDUH*



Substance Abuse and Mental Health Services Administration. (2024). Key substance use and mental health indicators in the United States: Results from the 2023 National Survey on Drug Use and Health (HHS Publication No. PEP24-07-021, NSDUH Series H-59). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/report/2023-nsduh-annual-national-report

Brief Report on Outpatient Treatment of Adolescent Opioid Use Disorder *(Kaliamurthy et al., 2024)*



- Mean age at intake, 16.8 (1.0) yrs
- 65% of patients identified Race/Ethnicity as Hispanic/Latinx.
- Age at first use of opioids, 15.4 (1.2) yrs
- Smoking identified as preferred method.
- Age at first use of any substance. 13.2 (1.6) yrs
- High rates of co-occurring substance use disorder. (50% reported using psychedelics)
- All of them had family involvement. High acceptance of MOUD.
- Approximately 60% retention at three months.
- Low utilization of psychosocial services.

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Who is the at-risk adolescent?

Substance Use Patterns	• Hx of non-medical opioid use • Using multiple substances • History of overdose (strongest predictor of future overdose)
Psychiatric Comorbidities	• Depression, anxiety, PTSD, or other mood disorders • History of suicidal ideation or self-harm (intentional overdose often overlaps with unintentional overdose risk)
Social & Environmental Factors	• Parental or household substance use disorder (higher genetic and environmental risk) • Peers engaging in substance use (peer influence is a major factor in initiation and escalation) • Access to opioids (via prescriptions, friends, or street sources)
Medical & Behavioral Indicators	• Frequent ED visits or hospitalizations for intoxication • Recent release from juvenile detention, residential treatment, or hospitalization (periods of abstinence increase risk due to lower tolerance)

Patient and family Perspectives

" I have three other kids, if I take time off work to get him to treatment, the other kids will end up starving."

" We strap her down to a chair every night and make sure that we put the medicine under her tongue and wait 5 minutes before we let her go, it's the only way we can find peace"

" I am a proud man, I cannot stand to see my son begging on the streets. So, I give him money everyday to buy drugs."

" I lost 5 of my friends this year to overdoses. I don't want to die."

" I thought I got COVID the first time I experienced withdrawals, my friends later told me why I was feeling sick."

" I am afraid he is going to die from an overdose. I made him promise that he will only use at home and we have Narcan ready in case we need to use it."

" I was suspended from school for carrying Narcan, the teacher told me that I must be okay with my friends using drugs since I was carrying Narcan. "

"Thanks for getting our son back!"

"Once you go foil, you stay loyal"

"Can you lock him away"

" We came to this country hoping for a better future but we are now considering sending our child back since we are afraid they are going to die."

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Takeaways

#1 Adolescent overdose deaths continue to be a concern. Prevention efforts continue to lag.

#2 Be familiar with the local trend in your region.

#3 There are some static and dynamic risk factors to consider.

Learning Objectives

1. Understand the Scope and Presentation of Pediatric Opioid Use Disorder
2. Implement Evidence-Based Screening and Diagnostic Practices
3. Initiate and Support Comprehensive Treatment Plans

Implementing a Framework to Address SUD

Screening

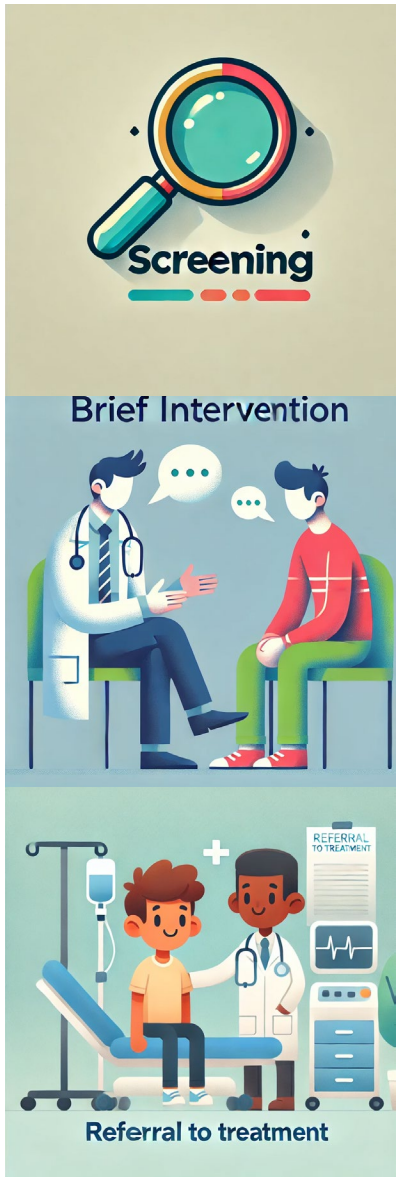
- Using a validated questionnaire to identify substance use.

Brief Intervention

- Conversations to enhance motivation to delay or reduce substance use.

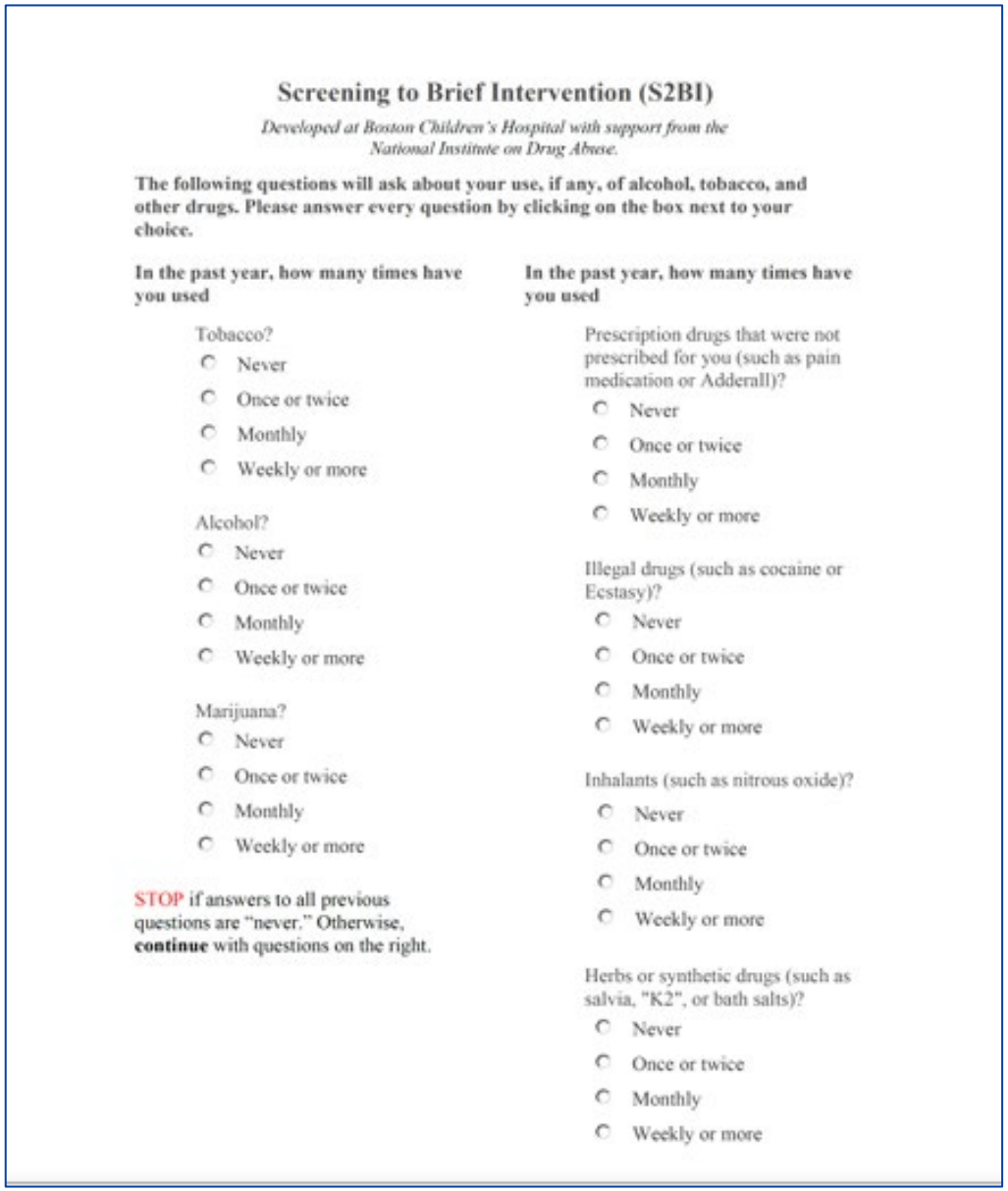
Referral to Treatment

- Further evaluation and services to address substance use and co-occurring disorders.



SCREENING

- Age to start? – Entry to middle school.
- Validated screeners. BSTAD & S2BI
- CRAFFT 2.1 + N – popular but not validated for screening purposes.
- There are no evidence-based screeners to identify kids at risk for overdose and kids struggling with opioid use disorder.



Screening to Brief Intervention (S2BI)

Developed at Boston Children's Hospital with support from the National Institute on Drug Abuse.

The following questions will ask about your use, if any, of alcohol, tobacco, and other drugs. Please answer every question by clicking on the box next to your choice.

In the past year, how many times have you used

Tobacco?
- Never
- Once or twice
- Monthly
- Weekly or more

Alcohol?
- Never
- Once or twice
- Monthly
- Weekly or more

Marijuana?
- Never
- Once or twice
- Monthly
- Weekly or more

STOP if answers to all previous questions are "never." Otherwise, **continue** with questions on the right.

In the past year, how many times have you used

Prescription drugs that were not prescribed for you (such as pain medication or Adderall)?
- Never
- Once or twice
- Monthly
- Weekly or more

Illegal drugs (such as cocaine or Ecstasy)?
- Never
- Once or twice
- Monthly
- Weekly or more

Inhalants (such as nitrous oxide)?
- Never
- Once or twice
- Monthly
- Weekly or more

Herbs or synthetic drugs (such as salvia, "K2", or bath salts)?
- Never
- Once or twice
- Monthly
- Weekly or more

Case Scenario – Presentation

- 15 yo female brought to your clinic by parents seeking help for her substance use.
- Smoking m-30 pills, up to 10/day for last 6 months. Previous cannabis use, nicotine use and alcohol use. Ambivalent about stopping.

Pill (Blue 30)

Percocet

Fentanyl* (O)
Para-fluorofentanyl (O)
Beta-hydroxyfentanyl (O)
Xylazine (A)
Caffeine (A)
Tramadol (O)
Phenacetin (A)
Acetylfentanyl (O)
Cocaine (S)
Levamisole (A)
Acrylfentanyl (O)

Starting material and/or byproducts in fentanyl(s) production: 4-ANPP, phenethyl-4-ANPP, Despropionyl para-fluorofentanyl
Norfentanyl (M)

Authentic oxycodone M30 tablets (top) vs. counterfeit oxycodone M30 tablets containing fentanyl (bottom).

Image Source: Department of Justice/Drug Enforcement Administration Drug Fact Sheet

Takeaways

#4 Ask/Screen: Studies have shown that this decreases stigma around seeking care for substance use related concerns.

#5 Using validated screeners can significantly improve detection of at-risk adolescents.

#6 DSM criteria are not age specific; patient must still meet criteria for SUD even if they are an adolescent.

#7 Be curious about the substance used, route of administration and source of finances.

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Confidentiality

- Federal law provides confidentiality to adolescents seeking help for substance use concerns.
- Privacy for screening and brief intervention is crucial.
- What if adolescent doesn't want help for substance use?
- What if adolescent is experimenting with cannabis use?
- THERE ARE NO GUIDELINES ON WHEN TO BREAK CONFIDENTIALITY.

"Our conversation will be confidential unless it involves issues related to your imminent safety"

Consent

Consent: State specific laws dictate minors' ability to consent to substance use disorder treatment without parental involvement. Different for mental health treatment.

District of Columbia: Minor of any age can consent for SUD treatment if provider deems that they have capacity.

Maryland: Minors have same capacity as adults to consent to treatment.

- (c-1) Capacity to refuse treatment. -- The capacity of a minor to consent to treatment for drug abuse or alcoholism under subsection (c)(1) or (2) of this section does not include the capacity to refuse treatment for drug abuse or alcoholism in an inpatient alcohol or drug abuse treatment program certified under Title 8 of this article for which a parent or guardian has given consent.

Virginia: Minors are granted the legal authority to consent to certain medical treatments without the need for parental approval. Specifically, subsection E of this statute states that a minor is deemed an adult for the purpose of consenting to:

1. Medical or health services needed in the case of outpatient care, treatment, or rehabilitation for substance abuse; (Parents can still access medical records)

Case Scenario – Work Up

Laboratory & Diagnostic Workup

Substance Screening

- **Urine drug screen (UDS)**: make sure the test specifically for fentanyl, this is not included under opioids in the standard screen.

Infectious Disease Screening

- **HIV & Hepatitis B/C**: IV drug use increases risk.
- **Tuberculosis (PPD or IGRA test)**: Higher risk due to social exposure.
- **Sexually Transmitted Infections (STIs)**: If there is a history of risky sexual behaviors.
- **Syphilis test**: VDRL/RPR screening.

Additional Bloodwork

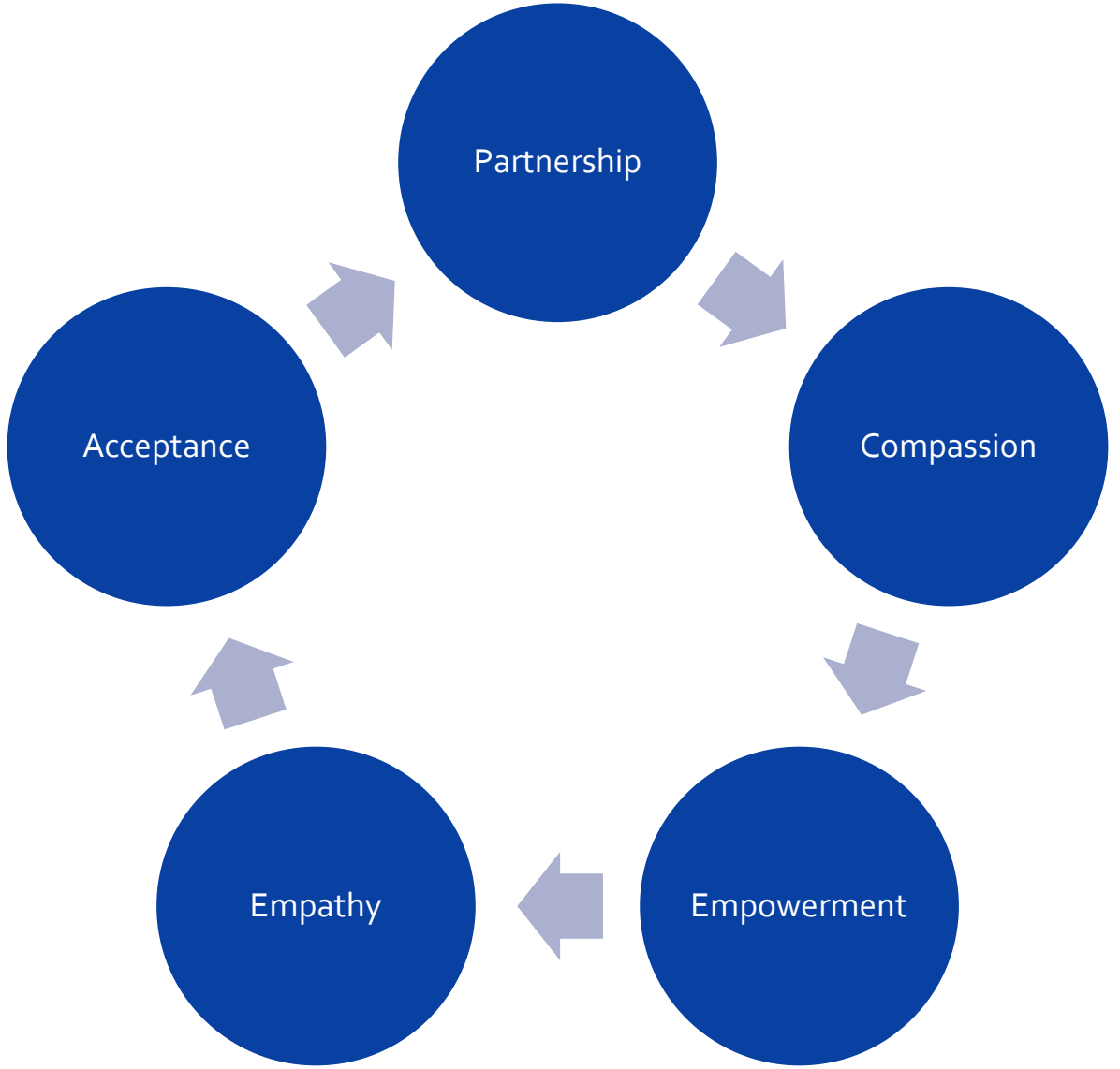
- **Complete Blood Count (CBC)**: Screen for infection, anemia.
- **Liver function tests (LFTs)**: Check for hepatitis, liver damage.
- **Electrolytes, BUN, creatinine**: Assess kidney function and hydration.
- **Creatine Kinase (CK)**: Evaluate for rhabdomyolysis (if prolonged immobilization from overdose).
- **Pregnancy test (if applicable)**: For adolescent females.

Brief Intervention

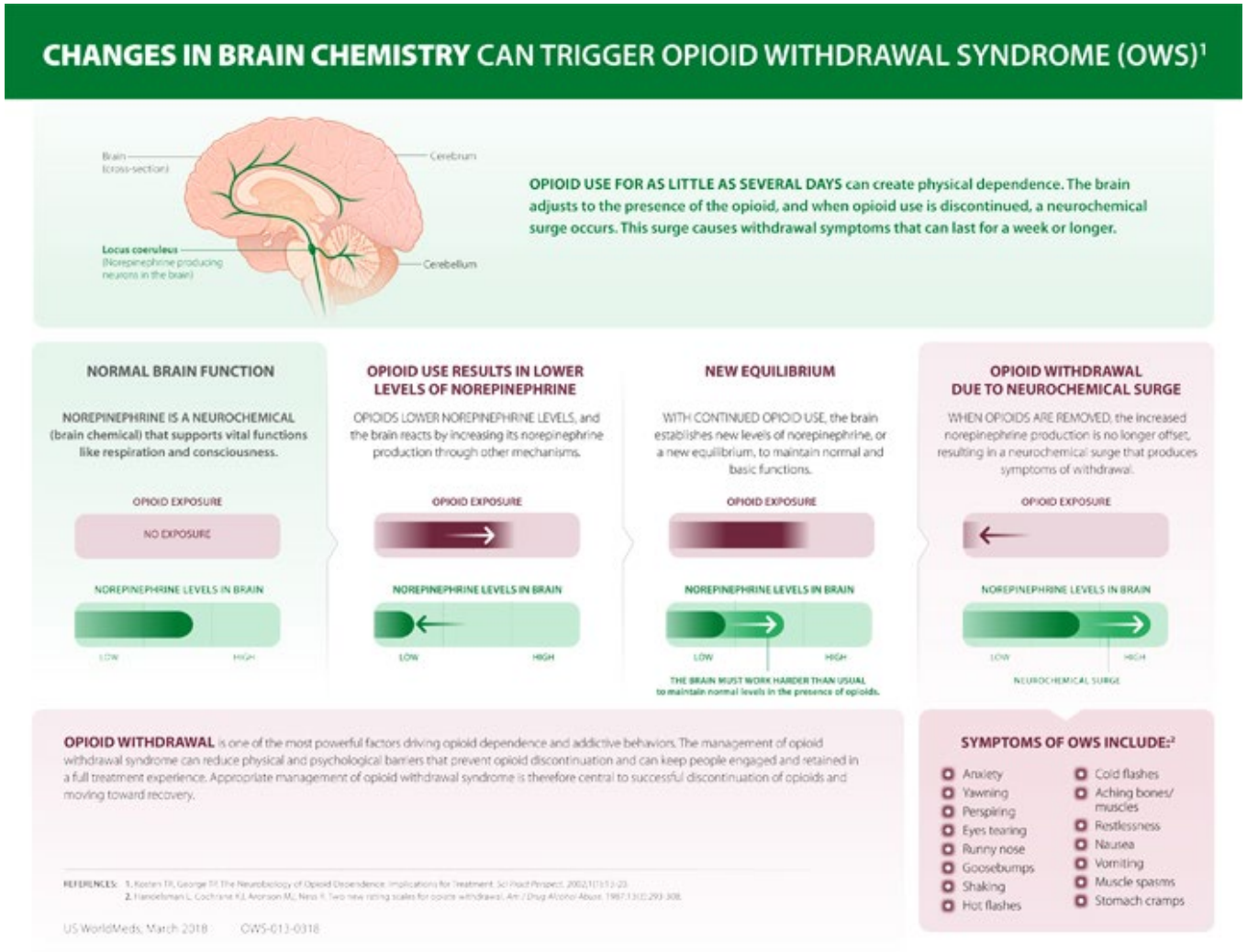
A conversation that encourages healthy choices to prevent, reduce or stop risky behaviors.

Encompasses

- Positive reinforcement
- Medically-based advice
- Brief motivational interventions
- Referral to treatment



Underlying Mechanism for Withdrawal



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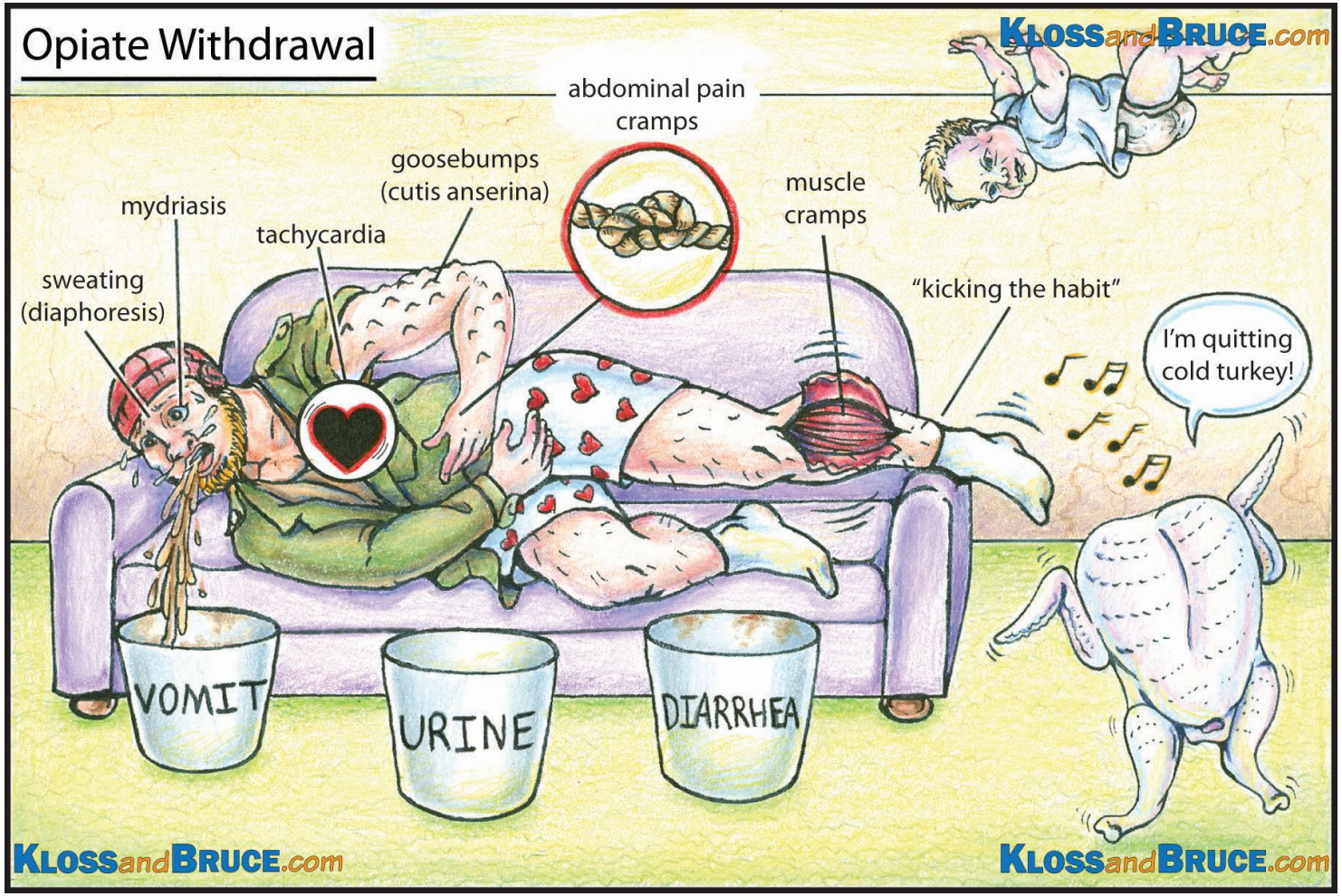
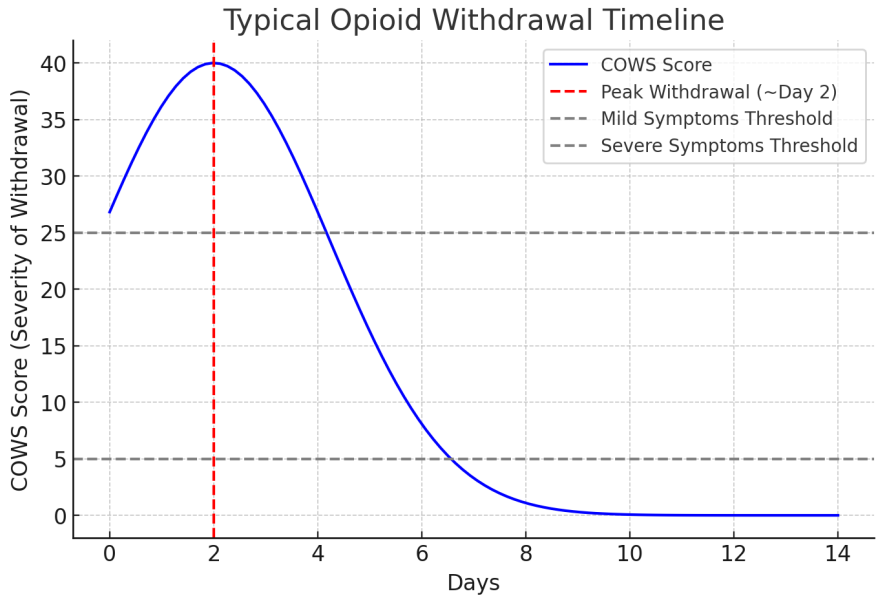
Typical Opioid Withdrawal Symptoms



Opioid Withdrawal Management

- Clinical Opioid Withdrawal Scales (COWS)
- Subjective Opioid Withdrawal Scales (SOWS)



Patient's Name:_____ Date and Time ___/___/___:_____

Reason for this assessment:_____

Resting Pulse Rate: _____beats/minute *Measured after patient is sitting or lying for one minute* 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120	**GI Upset**: *over last 1/2 hour* 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of diarrhea or vomiting
Sweating: *over past 1/2 hour not accounted for by room temperature or patient activity.* 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face	**Tremor** *observation of outstretched hands* 0 no tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching
Restlessness *Observation during assessment* 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 unable to sit still for more than a few seconds	**Yawning** *Observation during assessment* 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute
Pupil size 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible	**Anxiety or Irritability** 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable or anxious 4 patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort	**Gooseflesh skin** 0 skin is smooth 3 piloerrection of skin can be felt or hairs standing up on arms 5 prominent piloerrection
Runny nose or tearing *Not accounted for by cold symptoms or allergies* 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks	Total Score _____ The total score is the sum of all 11 items Initials of person completing assessment: _____

Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal

This version may be copied and used clinically.

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Symptomatic Management

- Clonidine – suppresses activity at locus coeruleus to decrease release of norepinephrine.

- Use other PRNS judiciously depending on the setting and provider assessment of patient/family to self administer if needed.

Adjunct Medications for Withdrawal Symptom Management

Drug	Dose	Targeted Opioid Withdrawal Symptoms
Clonidine* *Obtain BP before each dose and hold for SBP < 90 mmHg & DBP < 60 mmHg	Taper Option: 0.2 mg P.O. Q6H x 4 days 0.1 mg P.O. Q6H x 2 days 0.05 mg Q12H x 1 day PRN Option: Clonidine 0.1 mg P.O. Q4H PRN COWS > 10; Clonidine Not to Exceed 1.2 mg/24 hour period	Agitation, sympathetic overdrive
Loperamide	4 mg P.O. x1, then 2 mg Q6H PRN	Diarrhea
Dicyclomine	20 mg P.O. Q6H PRN	Abdominal Cramps
Ondansetron	8 mg P.O. Q6H PRN	Nausea
Prochlorperazine	10 mg PO Q6H PRN	Nausea
Ibuprofen	400 mg P.O. Q6H PRN	Myalgia
Trazodone	50 mg P.O. QHS PRN	Insomnia
Acetaminophen	650 mg P.O Q6H PRN	Myalgia
Hydroxyzine	25 mg P.O. Q6H PRN	Anxiety
Thiamine	100 mg P.O. Daily	N/A
Multivitamin	1 tablet P.O. Daily	N/A
Folic Acid	1 mg P.O. Daily	N/A

Medications for Opioid Use Disorder (MOUD) - Adolescents

Methadone

Buprenorphine

Naltrexone

Methadone

Efficacy and Retention: Adolescents on methadone had higher treatment retention rates compared to those on buprenorphine or non-opioid symptomatic treatment. For example, one study reported a 43% retention rate at 1 year.

Challenges and Accessibility: Methadone treatment for adolescents is highly restricted, requiring parental consent, documented prior treatment failures, and administration at a federally certified Opioid Treatment Program (OTP).

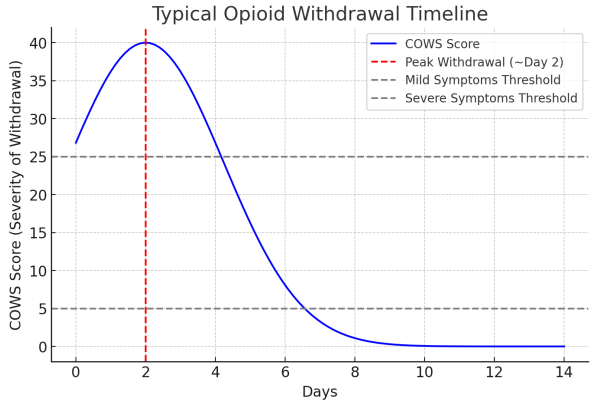
Potential Risks: Methadone carries risks of respiratory depression and QT prolongation, necessitating careful dose monitoring.

Buprenorphine

Efficacy and Retention: Only FDA-approved medication for adolescents (ages 16+), with studies showing superior treatment retention and reduced opioid use compared to detoxification-based approaches.

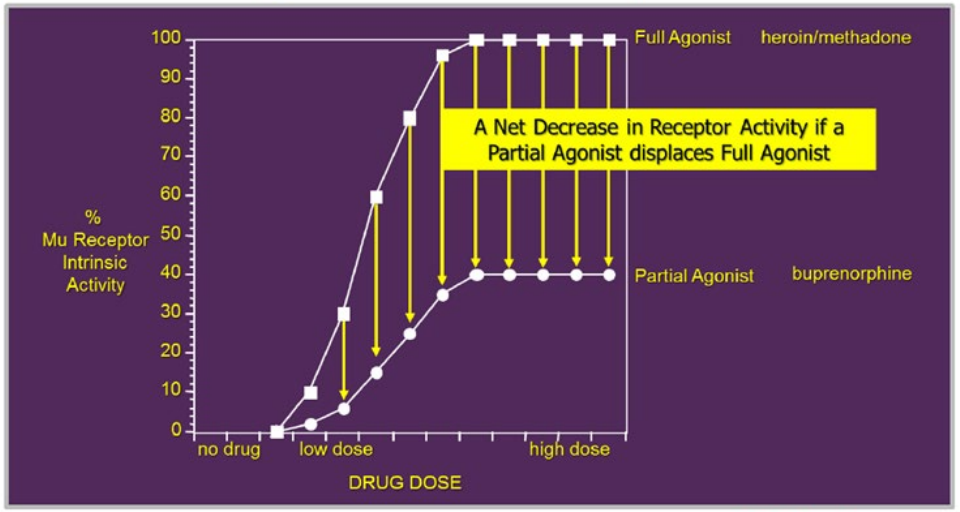
Advantages Over Methadone: Buprenorphine has a lower risk of respiratory depression and overdose compared to full agonists like methadone. It can be prescribed in office-based settings, reducing the need for daily clinic visits and improving accessibility.

PK/PD: Onset of action in approx. 30 to 60 minutes maximum. Peak clinical effect at 1 to 4 hours. Duration of effect is dose dependent. Last up to 24 hours and longer at doses more than 16 mg.



Pharmacology of Full vs. Partial Mu Opioid Receptor Agonists

- Buprenorphine can precipitate opiate withdrawal if it displaces a full agonist from mu receptors



PCSS MAT TRAINING PROVIDERS' CLINICAL SUPPORT SYSTEM For Medication Assisted Treatment

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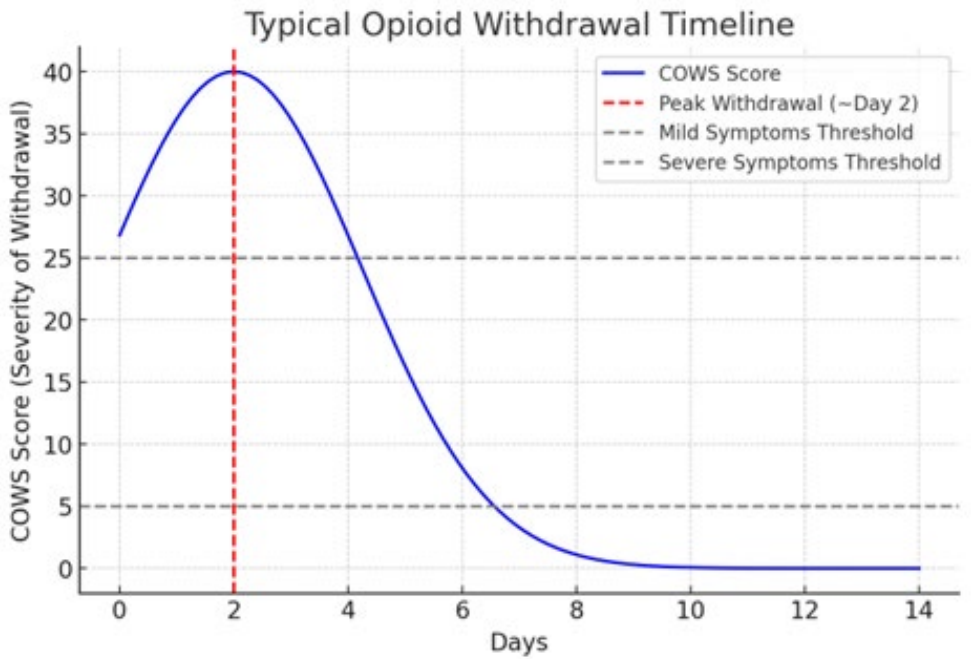
Naltrexone

Efficacy and Retention: Extended-release naltrexone (XR-naltrexone) is effective in preventing relapse once detoxification is completed, but induction can be challenging.

Advantages has no risk of misuse or diversion, making it an attractive option for adolescents and families concerned about medication misuse.

Challenges and Risks - Requires full detoxification before initiation, which can be a significant barrier to adherence and initiation of treatment. Risk of overdose increases if an individual relapses after discontinuing naltrexone due to lowered opioid tolerance.



MOUD Injectables (Not FDA-approved in patients younger than 18)

Naltrexone XR

- A case series of adolescents receiving XR-naltrexone showed a 63% retention rate at 4 months, indicating feasibility.

Buprenorphine XR

- Available in two formulations. (Sublocade® and Brixadi®)
- Insurance barriers often make it challenging to access for patients younger than 18.

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The Use of Extended-Release Buprenorphine in the Treatment of Adolescent Opioid Use Disorder *(Neptune & Kaliamurthy, 2025)*

- Used as last resort in our population.
- Well tolerated.
- No adverse effects noted so far. (One patient with sleep apnea, considering BUP to be a contributor).
- XR Naltrexone vs XR Buprenorphine

Table 1. Summary of Extended-Release Buprenorphine Cases

	Age	Sex	Race/Ethnicity	Opioid Type	Method of Use	XR-BUP and number of monthly doses received	Side effects or complications	Opioid abstinence for > 2 months at time of chart abstraction	Notes: Other psychiatric diagnoses, reason for XR-BUP initiation, treatment summary, ongoing substance use
1	15	M	Other, Hispanic	Fentanyl	Smoking	Sublocade® 300 mg x3 doses, Sublocade® 100 mg x5 doses	Constipation	Yes	Other psychiatric dx: unspecified anxiety disorder, cannabis use disorder. XR-BUP initiated due to poor medication adherence with sublingual buprenorphine-naloxone and ongoing fentanyl use. Received Sublocade® 300 mg x3 doses due to continued fentanyl use. Remains in treatment. Reports ongoing cannabis use.
2	16	F	Other, Hispanic	Fentanyl	Smoking	Sublocade® 300 mg x2 doses, Sublocade® 100 mg x1 dose	Constipation; opioid withdrawal 24 days after first Sublocade® dose	Yes	Other psychiatric dx: PTSD, MDD, cannabis use disorder. XR-BUP initiated due to poor medication adherence with sublingual buprenorphine-naloxone and ongoing fentanyl use. Experienced opioid withdrawal 24 days after first Sublocade® injection and required supplemental sublingual buprenorphine-naloxone until the second Sublocade® dose. Remains in treatment. Denies current substance use.
3	16	F	Caucasian	Fentanyl	Snorting & smoking	Brixadi® 96 mg x3 doses	Headache; unspecified body pain; injection site pain	Yes	Other psychiatric dx: MDD, GAD, SAD, self-injurious behavior, cannabis use disorder. XR-BUP initiated due to difficulty with sublingual buprenorphine-naloxone adherence (parents giving medication to patient while patient was asleep). Remains in treatment. Reports ongoing cannabis use.
4	17	F	Other, Hispanic	Fentanyl	Snorting & smoking	Sublocade® 300 mg x2 doses, Sublocade® 100 mg x3 doses	None reported	Yes	Other psychiatric dx: cannabis use disorder, nicotine use disorder, prolonged grief disorder. Initially treated with oral naltrexone (insurance denied XR naltrexone) and later sublingual buprenorphine-naloxone. XR-BUP initiated due to poor medication adherence with sublingual buprenorphine-naloxone. Remains in treatment. Reports ongoing cannabis and nicotine use.
5	17	F	Other, Hispanic	Fentanyl	Oral ingestion & smoking	Sublocade® 300 mg x2 doses, Sublocade® 100 mg x8 doses	None reported	Yes	Other psychiatric dx: depression, anxiety cannabis use disorder, nicotine use disorder, hallucinogen use disorder, PTSD. XR-BUP initiated while in residential treatment. Received first 3 doses of Sublocade® at a residential facility or IOP. Remains in treatment. Reports ongoing cannabis, alcohol, and nicotine use.
6	17	M	Other, Hispanic	Fentanyl	Snorting & smoking	Sublocade® 300 mg x2 doses	Vomiting (with question of small hematemesis); opioid withdrawal 2 to 3 weeks after first Sublocade® dose	No	Other psychiatric dx: self-reported depression and anxiety, unspecified psychosis presumed substance induced, cannabis use disorder. XR-BUP initiated due to poor medication adherence with sublingual buprenorphine-naloxone and ongoing fentanyl use. Unable to achieve the period of opioid abstinence required for naltrexone initiation. Experienced opioid withdrawal 2 to 3 weeks after first Sublocade® dose but did not report this to providers until his follow-up visit for his next dose. Remains in treatment. Reports ongoing fentanyl, cannabis and bath salt use.

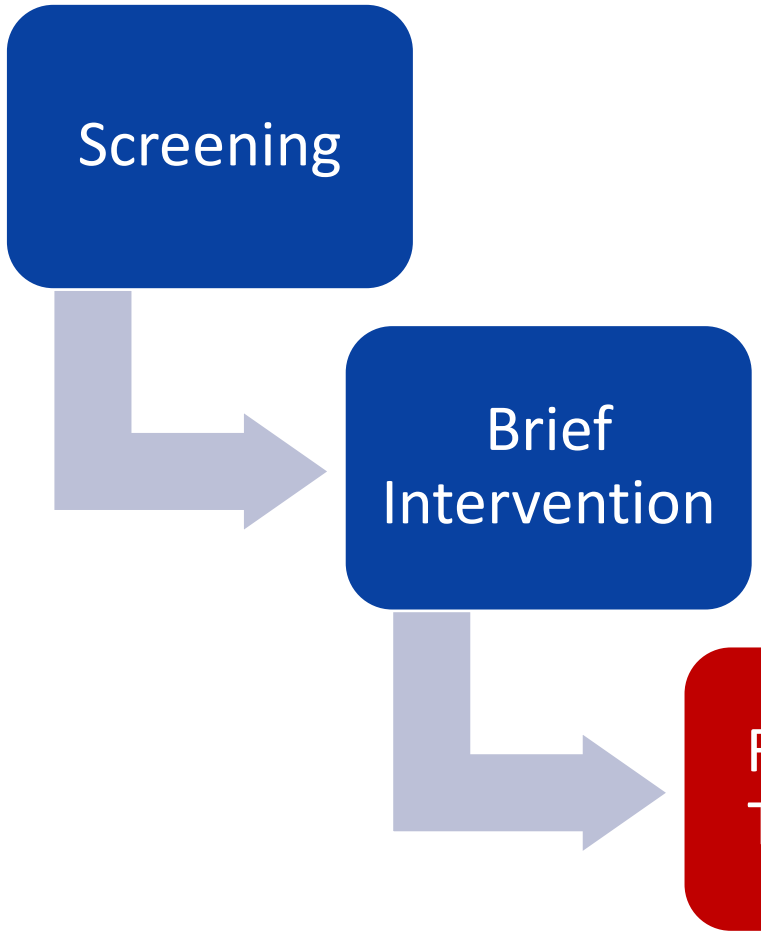
Nasal Naloxone

- Prescription is for family/communities. (Fire extinguisher).
- Opioid overdose education must accompany naloxone prescription. (Unresponsive, Slow breathing, Lack of breathing, Blue lips/fingertips)
- Adolescents younger than 18 can carry Naloxone on their person in only some school districts. Consider writing a Doctor's note if you have a high-risk adolescent and are in a school district that doesn't allow adolescents to carry. (* Many overdoses happen during school hours but outside school campus)

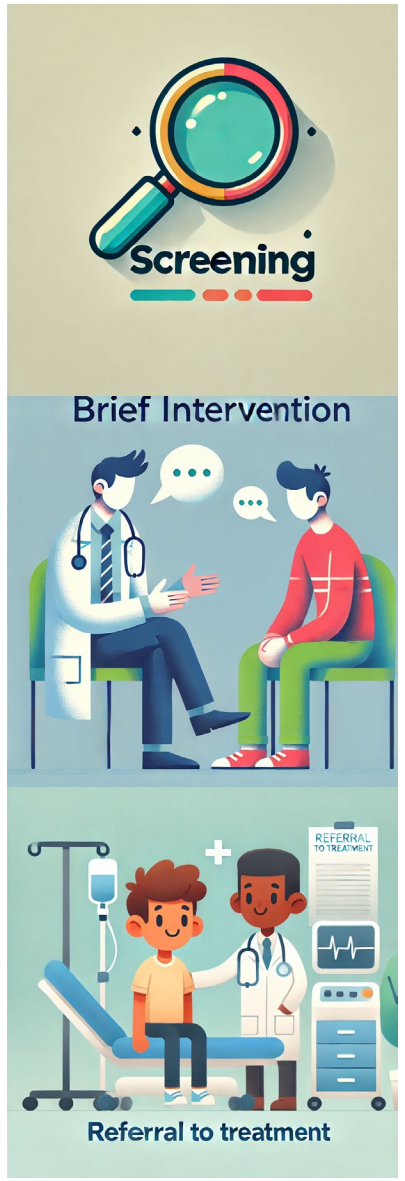
Case Scenario – Next Steps

- Safety assessment – break confidentiality.
- Brief Intervention – set small goals.
- Consider initiating medications for opioid use disorder.
- **Prescribe nasal naloxone.**
- Referral to treatment.

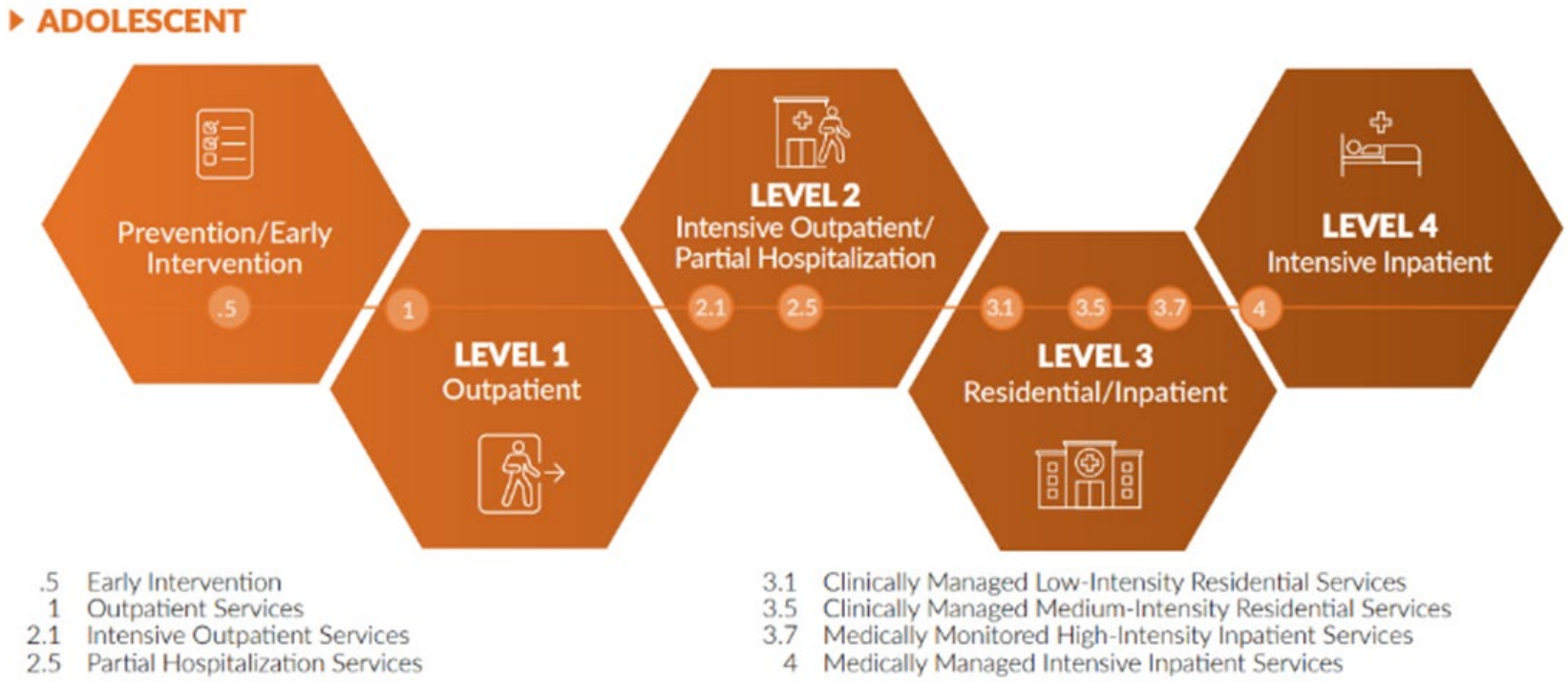
Implementing a Framework to Address SUD



- Referral rates are low despite implementation of SBIRT



Level of Care



Children's National Addiction Program

- ASAM Level 1 Outpatient Program within the Department of Psychiatry.
- Location: Children's National Takoma ROC, 6833 4th Street NW, Washington, DC, 20012.
- Open 5 days a week.
  - Attending Psychiatrist – Dr. Kaliamurthy
  - Nurse Practitioner – Ms. Jean Fletcher
- Appointments: **Family to call 202-729-3300** and follow options for psychiatry intake. Please make sure family marks **"Addiction"** on intake. New appointment will be scheduled within days once this step is completed.
- Projects underway to be effective in engaging and retaining adolescents in care.

Challenges in Treatment

Increasing access to medications for opioid use disorder (MOUD)

- Less than one third of youth (13 to 22 yrs) received timely addiction treatment after an opioid overdose. Only 1 in 54 youth received evidenced based pharmacotherapy. *Alinsky et al., (2020)*
- Between 0 to 5% of adolescents younger than 18 with OUD received MOUD. *Mauro et al., (2022), Teranella et al., (2023) & Hadland et al., (2018)*

What next once you initiate MOUD?

- How long do adolescents stay in care? Are there differences between MOUD? Methadone > Buprenorphine and Naltrexone in pre fentanyl era. Hadland et al., (2018)

Resource Limitation

- Only one in four residential addiction-treatment facilities for adolescents offer buprenorphine. *King et al., (2023)*

Takeaways

#8 Addiction is a CHRONIC disease with childhood onset.

#9 Retention in treatment is the best indicator of outcome.

#10 Medications for addiction treatment > No medications

#11 Treat co-occurring mental health illness (integrated treatment > sequential treatment)

#12 Always prescribe Nasal Naloxone and educate patients and parents on how to use it.

Resources

#YouthRecoveryHub

- Children's National Addiction Program Web Page
- American Academy of Pediatrics – Substance Use and Prevention Tool Kit
- Stanford Safety First Curriculum – A comprehensive, harm-reduction based, drug intervention curriculum.
- SAMHSA – Buprenorphine quick start guide.
- ASAM – Buprenorphine home start guide

Pediatric Health Network

Children's National

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    1. Ensure you complete all the steps to claim CE
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    4. **The texting option has a time limit of less than1 hr after the event has started, then the website link will have to be used.**
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Thank You!

Question & Answer

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