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Improving Minors' Access to Treatment for Opioid Use Disorder: A Policy Analysis

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MPH 683: Integrated Learning Experience

August 7, 2023

Abstract

As the opioid epidemic continues to have devastating effects on our communities, medications to treat opioid use disorder (MOUDs) are severely underutilized especially for adolescents. Unlike adults, minors need parental approval before obtaining MOUDs presenting a key barrier to timely treatment. Being able to treat adolescents as soon as they are ready is critically important for people with OUD, and while cost and other barriers have been addressed in the literature, there is a paucity on how parental consent affects the accessibility of treatment. This paper aims to explore a potential policy in California that addresses the lack of access for adolescents. A health policy analysis format was used to compare and assess each policy option through a criteria of feasibility, effectiveness, relevance, and impact. Peer-reviewed articles and public health data was utilized for this analysis. After a comparison of two policy options, the more favorable option was a revision to California's minor consent laws to allow providers to confidentially treat addicted youth, 16 and older, with buprenorphine. This analysis showed how this policy will likely be more effective in narrowing the treatment gap among older adolescents. Recommendations, implications and potential limitations were also discussed.

Improving Minors' Access to Treatment for Opioid Use Disorder: A Policy Analysis

Despite the declaration of the opioid epidemic as a national public health emergency in 2017, communities continue to see devastating effects of opioids. According to the Centers for Disease Control & Prevention(CDC)(2023), the United States saw 80,411 opioid-related deaths in 2021, a significant increase compared to 47,600 deaths just four years prior. Additionally, 5.6 million people report having an opioid use disorder (OUD) in 2021 (Substance Abuse and Mental Health Services Administration, 2023a). Sadly, this crisis has reached adolescents with 2,037 overdose deaths in the age group (10-19 years old), a 94% rise from 2019 to 2020, followed by an additional 20% increase in the subsequent year (Tanz et al., 2022).

Here in California in 2021, we witnessed 7,175 opioid overdose deaths, which was a 400% increase from five years prior (California Overdose Surveillance Dashboard, 2022). Additionally, roughly 37,000 adolescents (12-17 years old) were diagnosed with OUD (Substance Abuse and Mental Health Services Administration, 2023b). Altogether, California ranked as the third highest state in OUD prevalence and overall opioid overdose rate (Substance Abuse and Mental Health Services Administration, 2023b). At the local level, San Francisco emerged as the county with the fifth highest rate of opioid overdose deaths, recording 435 deaths and a rate of 41.99 deaths per 100,000 in one year (California Overdose Surveillance Dashboard, 2022).

In California, the highest rates of opioid overdose deaths occurred in Native American/Alaska Native and Black communities with a crude rate of 45.32 and 36.11 per 100,000 residents respectively (California Overdose Surveillance Dashboard, 2022). In White communities the rate was 25.51. Additionally, Black and Native American individuals were also less likely to receive medication treatment than their White counterparts (Dunphy et al., 2022).

The national economic impact of the opioid crisis includes various factors such as healthcare and criminal justice costs, as well as the loss of productivity resulting from morbidity and mortality. In 2017 alone, these costs amounted to \$1.02 trillion (Florence et al., 2021). As the opioid epidemic worsened, the cost jumped to \$1.5 trillion in 2020 (The Joint Economic Committee, 2020).

Like adults, adolescents with OUD have effective medication treatments available that demonstrate improvements in abstinence from opioid use, and retention in recovery treatment programs (National Academies of Sciences, Engineering, and Medicine, 2019). Unfortunately, compared to their adult counterparts, they are significantly less likely to be treated with these medications (Mouro et al., 2022). Despite the availability of effective medication treatments for OUD, around 87% of people with the disorder remain untreated (Krawczyk et al., 2022). In the case of adolescents, the treatment gap is far worse and is estimated to be 98% untreated (Hadland et al., 2017).

Health policies can safeguard the health and well-being of individuals or communities, while ensuring equitable access to essential preventative and treatment services (Office of Disease Prevention and Health Promotion, n.d). This paper will assess a potential health policy for California that aims to improve OUD treatment access for struggling adolescents. I will thoroughly discuss the issue of OUD in youth, present previous policies directed at mending the treatment gap for adolescents, and analyze potential strategies to consider.

Methods

This paper utilizes a health policy analysis, a systematic and interdisciplinary approach that examines public policies in the healthcare field (CDC, 2022b; Walt et al., 2008). The primary objective is to identify the most suitable policy option through a comprehensive and structured evaluation process. By offering policymakers, stakeholders, and the public relevant information and recommendations, policy analysis serves as an effective strategy to promote well-informed decision-making (Walt et al., 2008).

To facilitate this process, I will employ Eugene Bardach's practical guide, known as Bardach's Eightfold Path, which consists of the following eight steps (Bardach, 2019):

1. Define the problem
2. Assemble the evidence
3. Construct the alternatives
4. Select the criteria
5. Project the outcomes
6. Confront the trade-offs
7. Decide
8. Tell your story

By following Bardach's Eightfold Path, the objective is to present a comprehensive and insightful health policy analysis for the California legislature. The evidence for this analysis is derived from public health data and peer-reviewed articles. To forecast potential outcomes for each policy option, a comparative evaluation utilizing a set of criteria that encompassed effectiveness, impact, relevance, and feasibility was conducted. Furthermore, a thorough examination of the tradeoffs associated with each identified policy option, enabled a well-informed decision to arrive at the most favorable policy option, which is subjected to further discussion.

Literature Review

Opioid Addiction in Adolescents

Overview of Opioids

Opioids encompass a range of compounds, spanning from illegal substances like heroin and street fentanyl to legitimately prescribed pain relievers like oxycodone, hydrocodone, morphine, and many more. They are highly addictive chemicals that attach to our brain's opioid receptors and release a surge of neurotransmitters like dopamine creating pleasurable and euphoric sensations which can reinforce desire to repeat use (Volkow et al., 2015; Azardfard et al., 2022). Opioids also have powerful

pain-relieving effects that can numb both physical and emotional pain. Over time, the brain builds a tolerance to the presence of opioids and individuals require higher doses of opioids to achieve the desired effect (Volkow et al., 2015). Once the brain becomes accustomed to the presence of opioids, the individual faces severe flu-like withdrawal symptoms, if they stop consuming opioids. When the person is unable to stop using opioids despite the negative consequences to their health and livelihood, they have developed OUD (American Psychiatric Association, 2014).

Adolescence is a critical period characterized by heightened vulnerability to experimentation and addictive behaviors (Hammond et al., 2014). During this developmental stage, teens exhibit underdeveloped cognitive control systems, making it challenging for them to resist temptations, while simultaneously experiencing a heightened reward system, driven by the desire to seek pleasurable experiences and gratification (Hammond et al., 2014). Teenagers also undergo significant identity changes, and experience greater social and academic pressure. Individuals often turn to substances in order to cope with these stressors (Sinha, 2008). Lastly, teens are striving for independence from parental figures and placing greater emphasis on peer interactions, which further shape their behavioral choices and substance use risk (Office of Population Affairs, n.d.).

Today, the majority of opioid addiction in adolescents starts with prescription opioid misuse (Muhuri et al., 2013). It is estimated one in seven adolescents reported prescription opioid misuse (CDC, 2022a), which is defined as using prescribed pain meds inappropriately such as taking a higher dose, or using someone else's prescription (CDC, 2021). One of the dangers of opioid misuse is that it puts individuals at high risk of developing OUD, with one statistic showing that those who engage in such misuse are at 19 times greater risk of transitioning to heroin use compared to individuals who did not misuse pain medications (Lankenau et al., 2012). This typical progression from prescription opioid misuse to more hazardous and illicit substances during adolescents underscores to target interventions during these years.

The ramifications of OUD in the adolescent population have severe and enduring impacts. Once individuals develop an opioid addiction, their focus and time become consumed by obtaining and using these substances. As a result, they often find themselves with less time to dedicate to academic pursuits, social interactions, and self-care activities (Azardfard et al., 2022). This susceptibility to prioritizing opioids frequently leads to financial difficulties, homelessness, legal troubles, and an array of health challenges in the future (National Alliance to End Homelessness, 2016; Ellis et al., 2020; Winkelman et al., 2018).

Adolescents with OUD not only face an elevated risk of fatal overdoses but also encounter significant health hazards, including the transmission of diseases such as hepatitis B and C, HIV, and bacterial endocarditis through intravenous drug use (CDC, 2021). Further, they are at an increased susceptibility to experiencing depression and suicidality (Azardfard et al., 2022; Haider et al., 2015). These consequences leave individuals with a 20-fold increase of dying early compared to people without OUD (National Academies of Sciences, Engineering, and Medicine et al., 2019).

Risk factors for opioid misuse and opioid addiction include comorbid mental illness, homelessness, and other substance use (Edlund et al., 2015; Marshall et al., 2019; Winkelman et al., 2018). For instance, adolescents diagnosed with depression are 1.5 times more likely to engage in such misuse (Edlund et al., 2015). Additionally, unhoused persons face higher rates of prescription opioid misuse, overdose deaths (Marshall et al., 2019), and lack of access to treatment (McLaughlin et al., 2021). Key protective factors that mitigate risk include positive relationships with family, friends, or the community, individuals with healthy coping skills, and cultural or religious beliefs that prioritize self-protection (Indian Health Service, n.d.). Additionally, the accessibility of healthcare services and openness to seek professional help are pivotal protective factors (Indian Health Service, n.d.).

OUD Medications Treatment for Teens

Since its FDA approval in 2003, buprenorphine has emerged as a vital treatment for adolescents aged 16 and older with OUD (Hadland et al., 2017). This medication has demonstrated considerable effectiveness in alleviating cravings, reducing opioid use, and enhancing retention in treatment services among adolescents, backed by high-quality clinical trials and observational studies (Hadland et al., 2018; Marsch et al., 2016; Marsche et al., 2005; Vo et al., 2016; Smyth et al., 2018; Woody et al., 2008). Its formulations include buprenorphine/naloxone, commonly known by the trade name Suboxone. Buprenorphine's mechanism of action involves partial attachment to opioid receptors in the brain, leading to partial activation that does not induce a euphoric high (Kumar & Saadabadi, 2023). By effectively preventing withdrawal symptoms and reducing cravings for opioids, the medication supports patients' recovery (Kumar & Saadabadi, 2023). Additionally, the literature emphasizes the importance of longer-term regimens for MOUDs, akin to medication treatments for chronic medical conditions like diabetes and hypertension (Becker et al., 2022; Smyth et al., 2018; Woody et al., 2008), but the precise duration of treatment in youth is unknown and requires further research.

According to interviews with adolescent participants, buprenorphine/naloxone was well tolerated citing the most significant advantages included its ability to treat OUD without requiring the painful process of withdrawal, and working "as advertised" helping many achieve remission from OUD (Moore et al., 2014). Other medications, including methadone and naltrexone, are occasionally used; however, they tend to be less effective, or have higher risks, and also lack FDA-approval for adolescents (Chang et al., 2018; Wakeman et al., 2020).

Medications for Opioid Use Disorder (MOUDs) have more successful treatment rates compared to behavioral interventions alone, such as counseling and intensive inpatient treatments, and is considered the gold-standard treatment for OUD (American Academy of Pediatrics, 2016; American Psychiatric Association, 2022). While behavioral inventions like counseling facilitate recovery for OUD and should be simultaneously offered with medication treatment, it is not required before starting

someone on MOUDs (American Psychiatric Association, 2022; American Academy of Pediatrics, 2016). Addiction-medicine providers are keenly aware that delays in treatment increase the risk of individuals changing their minds and forgoing treatment (Marchant et al., 2022). As untreated OUD heightens the risk of morbidity and mortality, it is crucial to address barriers that hinder adolescents from accessing timely treatment.

Barriers to Treatment

There is a massive treatment gap among addicted adolescents, with national estimates of 98% left untreated (Hadland et al., 2017). To estimate the treatment gap for California youths, I pulled buprenorphine prescription data from California's Public Health Departments' overdose surveillance system, and SAMHSA's youth OUD rates. Counting 37,000 adolescents (12-17 years old) suffering from OUD in 2021 (SAMHSA, 2023) and 3,450 buprenorphine prescriptions for 10 to 19 year-olds in the same year (California Overdose Dashboard, 2023), an estimated treatment gap in the vicinity of 91% was calculated. However, since the surveillance system gave me a wider age range for buprenorphine prescriptions that included 18 and 19 years, who are more likely to receive treatment, the actual treatment gap in adolescents is likely much greater and reflects national estimates.

Youth face numerous barriers that contribute to this treatment gap; examining them through the socioecological model provides valuable insights into the complex dynamics affecting teens with OUD. At the individual level, addicted youth often internalize society's stigma surrounding substance use disorders leading to shame and disempowerment, and reduced treatment seeking (Harris & McElrath, 2012). A pervasive societal misconception around addiction is that the disease stems from lack of willpower or a moral failing (John Hopkins Medicine, n.d.). These beliefs perpetuate the misperception and bias of those struggling with opioid addiction as unworthy of assistance (John Hopkins Medicine, n.d.). Additionally, there are stigmatized beliefs of MOUDs and prevalent misperceptions that these treatments are "replacing one drug with another" and that people on these

medications are “still addicted,” rather than in recovery (Bagley et al., 2017). The stigma linked to MOUD might be more pronounced when recommending it to teenagers, as there is a prevalent viewpoint that these “medications must only be considered when all else fails,” a perspective that contradicts evidence-based recommendations (Bagley et al., 2017).

Confidentiality concerns at the interpersonal level pose another barrier. Many adolescents fear that seeking treatment for OUD will expose their struggles to their parents or other peers, leading to reluctance in seeking help (Wu et al., 2011; Lehrer et al., 2022). Some adolescents may face violence, neglect, or abandonment if their parents were to discover that they were behaving contrary to their parents' beliefs or values (Schantz, 2018). These confidentiality barriers among adolescents are abundant across other sensitive issues including mental health issues and sexual health issues, which have encouraged past public health officials to implement confidentiality and minor consent laws to increase treatment (Guttmacher Institute, 2022).

Another barrier includes the shortage of OUD-treating pediatric clinicians and treatment centers that further exacerbates the problem at the organizational and community levels (Lagisetty et al., 2019; Marchand et al., 2022; Pilarinos et al., 2022a). Nationally, about 30% of rural patients are more likely to have addiction treatments out of reach while this number is 2% from urban patients (Lagisetty et al., 2019). Additionally, only 1% of addiction medicine doctors are pediatricians (Hadland et al., 2016).

Lastly, policy level barriers for adolescents can significantly impact access to treatment. Today, every state requires minors to obtain parental consent before providers can prescribe MOUDs. This requirement can be a significant obstacle for many adolescents, particularly those who are unhoused or unable to disclose their substance use to their parents. As a result, some advocates are pushing for policy changes to address this specific barrier and improve access to treatment for vulnerable youth (Society of Adolescent Health and Medicine, 2021; Assemblymember Matt Haney, 2023). Additionally,

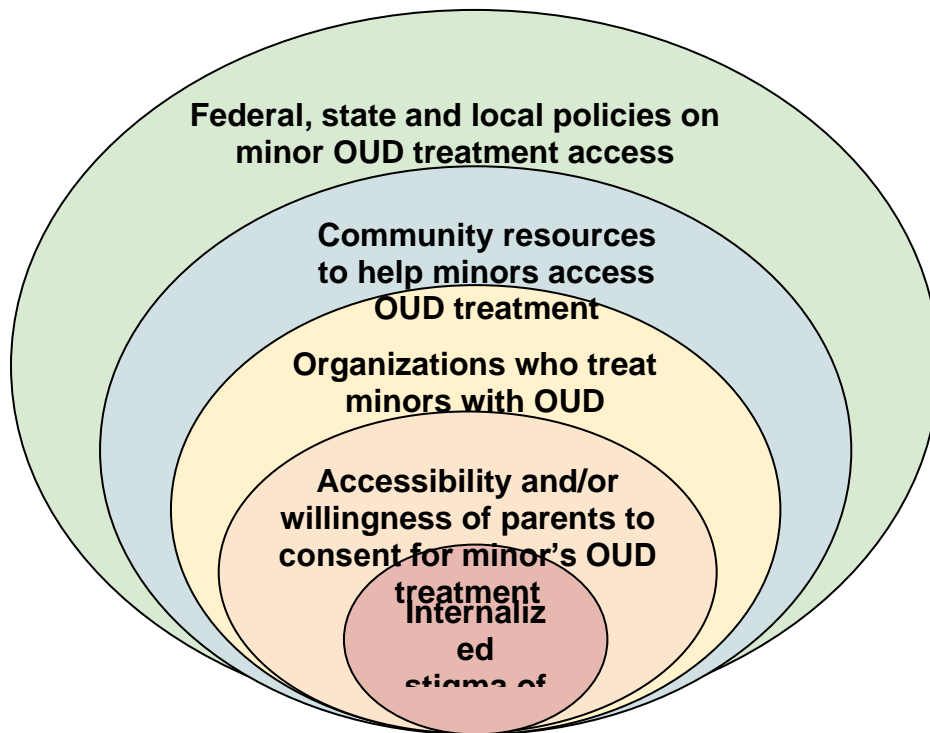
policies have influence on the affordability of OUD treatment for people with or without insurance coverage.

As I have discussed, the treatment gap among adolescents with OUD is a multifaceted issue influenced by barriers at various levels of the socioecological model. Stigma, confidentiality concerns, limited clinician availability, financial constraints, and parental consent requirements all contribute to hindering access to essential services. Addressing these barriers and implementing comprehensive policies that prioritize the needs of youth with OUD will be essential in closing the treatment gap and ensuring that all adolescents have access to effective and timely OUD treatment.

Figure 1.

Socioecological Model: OUD Treatment

Access for Minors



Policies Aimed to Increase Access to Treatment

Throughout the last few decades, various policies have been made by groups and individuals concerned about the low treatment rates among youths. In the next section, a discussion about minor consent laws and recent policies to enhance access to treatment will be presented.

Minor Consent and Confidentiality Laws

During the 1970s, the U.S. federal and state governments created minor consent and confidentiality laws that enabled adolescents to seek important services for sensitive issues like birth control, STD treatment, and mental health/substance use services (Guttmacher Institute, 2022). A large national study conducted shortly after these policies, revealed one in three teens would forgo seeking reproductive services because of worries around telling their parents (Klein et al., 1998). A more recent study showed that this number is one in two adolescents (Reddy et al., 2002). These studies proved that minor consent and confidentiality laws were crucial to connecting many teens to essential services.

While regulations for minor consent laws are generally decided by state governments, services provided by federally-funded clinics for minors will be protected in all states (SAMHSA, 2023c). Two pieces of legislature supported these protections. First, the Public Health Service Act in 1970, which established federally funded Title X clinics, focused on providing confidential and low-cost sexual and reproductive health services to vulnerable groups including minors (Hasstedt, 2018). For substance use service protections, Title 42 Part 2 of the Code of Federal Regulations was first promulgated in 1975 and prohibited disclosure of information about a minor's substance use disorder (SUD) treatment (excluding MOUDs) (SAMHSA, n.d.). These regulations do not apply to non federally-funded clinics; therefore, state governments have authority of whether a minor's confidentiality is protected in these clinics. In California, minor confidentiality laws grant adolescents privacy over abortion procedures, STD/HIV

treatments, birth control medications, and counseling services for mental health/substance use issues, but similar to all other states, exclude consent for MOUDs (National Center for Youth Law, 2019).

Parity Laws

During the 1990s, several states, including California, required private insurers to include mental health and SUD treatment coverage on par with coverage for physical ailments. They were referred to as "parity laws," and their purpose was to address the financial obstacles hindering the availability of mental health treatment. These laws were introduced during a time of heightened awareness of the importance of mental health and a boom in scientific advancements in the psychiatric and mental health fields (Barry et al., 2016). Each state had different variations of parity laws with some states only covering public employees, while others covered only severe or "biologically based" disorders (Barry et al., 2016). In 2008, Congress passed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act, which advanced mental health parity on a federal level (Barry et al., 2016). This law served as a foundation for subsequent progress in achieving parity through the Affordable Care Act (Barry et al., 2016). Additionally, the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 included parity provisions for the Children's Health Insurance Program (CHIP), extending parity protections to children and adolescents (Barry et al., 2016). Before these parity laws, those seeking mental health services would have to pay a coinsurance of 50%, compared to 20% of medical/surgical services (Barry et al., 2016).

While researchers generally agree that parity laws have contributed to improving the treatment gap, challenges persist regarding timely access to providers and substance use treatments (Drake et al., 2019). In general, if SUD is treated with medications, the provider would be a psychiatrist. There is a worsening national shortage of psychiatrists as many are aging into retirement (The National Council for Mental Wellbeing, 2017). In the United States, there are nine psychiatrists per 100,000 people, which is short of 15 per 100,000 to provide decent mental health care (Harrar, 2019). The shortage is even worse

in rural counties (Harrar, 2019). The lack of psychiatrists leads to longer wait times, inadequate care, overreliance on emergency departments, and poorer health outcomes (The National Council for Mental Wellbeing, 2017). Additionally, a study in 2010 estimated that 45% and 57% of psychiatrists did not accept private and public health insurance, respectively (Bishop et al., 2014). To enhance access to mental health treatment for youth, it is necessary to improve the enforcement of parity laws, increase the psychiatric workforce, promote telehealth services, and facilitate mental health insurance coverage.

Recent Policies

In 2017, former President Trump officially recognized the opioid epidemic as a Public Health Crisis and then proceeded to approve the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act. These actions helped increase MOUD treatment access by removing restrictions, such as, raising the limit for how patients each provider can have, expanded who could prescribe MOUDs by including different types of nurse practitioners and physicians assistants, and also mandated that state Medicaid plans provide coverage MOUDs (Drug Enforcement Administration, 2020; Musumeci & Tolbert, 2022).

Then in 2021, The American Rescue Plan was signed by President Biden which allocated \$1.5 billion to help states fund their own opioid response programs. This contribution enabled states to increase the quality and accessibility of community mental health services and substance use disorder treatment (FACT SHEET: Improving Access and Care for Youth Mental Health and Substance Use Conditions, 2021). Numerous additional grants were sanctioned by the Department of Health and Human Services and SAMHSA to enhance the accessibility of substance use and mental health services. A subset of these grants played a crucial role in enabling uninsured youth to access essential treatment (SAMHSA, 2022).

In 2018, the California Department of Health Care Services launched the California MAT Expansion Project to combat the increasing overdose deaths in the state. MAT stands for medication-

assisted treatment and is synonymous with MOUD. Comprising over 30 individual projects, this project aimed to enhance access to MOUDs for vulnerable groups like tribal and LGBTQ+ communities, increase the number of MOUD prescribers, facilitate telehealth prescribing, and distribute Narcan, an overdose reversal medication, widely across the state (California Department of Public Health, 2019). Among these initiatives, the Youth Opioid Response Project focused on aiding youth with OUD, aiming to improve prevention and treatment access. Another vital aspect was the Statewide Anti-Stigma Campaign. According to the California Department of Public Health (2019) funding for the California MAT Expansion Project came from various sources, including the State Opioid Response (SOR) III grant program, which comes from federal grants like The American Rescue Plan, California State General Funds, and Opioid Settlement Funds. Interestingly, the Opioid Settlement Funds were obtained through legal action against Janssen Pharmaceuticals and the "big three" distributors (McKesson, AmerisourceBergen, and Cardinal Health) for their involvement in the opioid epidemic (California Department of Public Health, 2019). The project has been ongoing and has achieved significant results to date, enrolling 152,000 new patients with OUD for MOUD treatment and distributing naloxone, which has contributed to 171,000 overdose reversals.

Despite tremendous federal and state policy efforts that improved MOUD access for youth, barriers stemming from the lack of confidentiality and parental consent requirements have not yet been addressed. While teens with accessible and supportive parents have a better chance at receiving MOUDs thanks to these policies, many teens continue to have significant barriers impeding their access to treatment. In the following sections, I will compare potential policies that could make MOUDs more accessible to many struggling teens.

Alternatives

Policy 1: Providers are authorized to confidentially prescribe buprenorphine and its combinations to adolescents, 16 years old and up, without prior parental consent.

Rationale: The opioid epidemic is a pressing public health crisis that demands urgent interventions to improve treatment access, especially for minors. Unfortunately, minors encounter significant barriers due to the need for parental consent and the lack of confidentiality in OUD treatment, which can lead to treatment delays and prevent them from seeking professional help, thereby increasing the risk of overdoses and ongoing opioid use. Given that buprenorphine and its variations are FDA-approved and considered the gold-standard for treating OUD in individuals aged 16 and older (American Psychiatric Association, 2022), it becomes crucial to address these barriers effectively. Therefore, Policy 1 proposes revising California's minor consent laws to allow older minors access to buprenorphine while ensuring their confidentiality is protected.

Policy 2: Status Quo

According to today's minor consent laws in California, minors are allowed to receive outpatient mental health and substance use treatments without consent from their parents or guardians, excluding medication treatment (National Center for Youth Law, 2019). This policy option prevents teens from accessing MOUDs without their parent's knowledge, which may prevent some teens from hiding their addiction from their parents. Having parent's knowledgeable about their child's health issues can give parents a greater opportunity to help them. Additionally, California may have sufficient progress underway from existing statewide programs like the California MAT Expansion Act.

Criteria

Effectiveness and Impact

The effectiveness and impact of a policy are determined by how well it achieves its intended goals and the influence it has on the health and well-being of the population. In the context of Policy 1 and 2, effectiveness can be evaluated by assessing how likely each policy will improve the treatment gap among adolescents. Additionally, the National Survey on Drug Use and Health by SAMHSA, collects annual data on mental health issues and treatment utilization from over 70,000 individuals in each state,

and can be a valuable resource for measuring effectiveness (SAMHSA, 2023a). The impact of these policies is reflected in the changes they bring about in the health, livelihood, and overall well-being of individuals and communities. Furthermore, the impact of these policies can extend beyond the affected individuals and into broader communities.

Relevance and Feasibility

To make informed decisions between policy options, it is essential to thoroughly assess their relevance and feasibility. Relevance evaluation focuses on how well each policy aligns with the health needs and perspectives of the community and policymakers. On the other hand, feasibility examination involves considering multiple aspects that determine the policy's viability. This includes assessing its financial feasibility, to ensure it can be adequately funded, as well as gauging its public feasibility by considering whether the public will support it through voting. Additionally, political feasibility is crucial, as it entails evaluating the level of support the policy receives from politicians.

Projected Outcomes

Effectiveness and Impact- Policy 1

Policy 1 proposes granting providers the authority to prescribe buprenorphine to older adolescents seeking professional help. While there are no specific studies measuring the number of adolescents who are obstructed by parental consent barriers, existing research indicates that around a quarter of adolescents with OUD, avoid seeking help due to confidentiality concerns (Wu et al., 2011). Moreover, studies on teen birth control accessibility have found that approximately a third to half of adolescents would forego these services if parental consent were required (Klein et al., 1998; Reddy et al., 2002). Considering these findings, a general range of 25-50% of adolescents with OUD are likely negatively impacted by the parental consent barrier. Using the National Survey on Drug Use and Health data, which estimates 37,000 adolescents with OUD in California, we can extrapolate that roughly 9,250 to 18,500 of these adolescents lack access to treatment due to the parental consent requirement and

could directly gain access to treatment with enacting Policy 1. It's essential to note that this estimate does not include unhoused adolescents with OUD, whose number is unknown and who typically lack access to parents.

Drawing parallels with current minor consent laws, which already allow minors to obtain confidential consent for certain medical and preventative treatments like birth control pills and STI medications, positive outcomes have been observed. Since the implementation of these laws in the 1970s, teen birth rates have declined. Although the exact extent of these laws' contributions to the decline remains unclear, experts in the field have attributed part of the success to the protection of confidentiality—a crucial aspect of these laws (American Academy of Pediatrics, 2022; Fuentes et al., 2018). The American Academy of Pediatrics (AAP) emphasizes the significance of confidentiality in medical care, asserting that "everyone – including teenagers -- deserves the right to confidential medical care that best supports their own needs and is informed by their physician's expertise" (AAP, 2022). Applying this principle to the treatment of adolescents with OUD is essential for promoting their health and ensuring access to necessary healthcare services.

Policy 1 is expected to have a significant and positive impact by improving access to treatment for teenagers with OUD. The implementation of this policy will enable these adolescents to receive the necessary treatment and support during their recovery, which in turn will open up better opportunities for them to rebuild their lives. For example, they will have the chance to complete their education and plan for their future careers.

A compelling illustration of this impact can be presented with the following case of a young teacher who is in recovery from OUD and currently undergoing maintenance treatment with buprenorphine/naloxone (McClurg, 2023). Despite her efforts to explain to her parents that MOUDs are not meant to induce a high, they remained unsupportive. Thankfully, she was 18 years old when she sought help, which allowed her to access treatment independently without needing her parents'

permission. She believes that had she required their permission, she may have overdosed by now. This real-life example demonstrates that individuals who receive timely treatment for OUD can successfully move forward in their careers, even in the absence of familial support.

By increasing the number of youth in recovery through improved access to treatment, this policy is expected to yield positive outcomes for communities. Some of these benefits include reduced incidents of bloodborne illnesses and mental health issues, decreased homelessness, and a decline in criminal activities related to OUD. By addressing these issues, communities in California will likely experience an overall improvement in public health and safety.

Furthermore, the successful implementation of this policy in California could serve as a model for other states seeking to enhance treatment accessibility for adolescents.

Relevance and Feasibility- Policy 1

Policy 1 is highly relevant in the current legislative climate in California. This is evident from the significant increase in the number of bills addressing aspects of the opioid crisis, which has risen to 45 bills in the current legislative bill cycle, compared to just seven bills in 2015 (California Legislative Information, 2023). This shows that policymakers are actively addressing the opioid crisis and are willing to take action. Furthermore, the frequent coverage of health impacts related to the opioid crisis in local and national news articles highlights the importance of this issue for the public. The passage of recent policies like the California MAT Expansion Plan and the bipartisan-supported SUPPORT Act also indicates a consensus and growing momentum for policies aimed at improving youths' access to MOUD.

Additionally, there is evidence of a growing awareness about mental health issues, especially for adolescents who struggled during the COVID-19 pandemic (Nealon, 2021). This societal awareness creates an opportune moment to introduce a policy that addresses mental health concerns. These developments collectively provide compelling evidence that Policy 1 aligns with the culture and policy landscape, making it highly relevant and timely for implementation.

The political feasibility and public acceptance of this policy may be a challenging area for Policy 1. To my knowledge, there are no other states that have Policy 1 in place. However, there are other governments which have similar policies in place including New Zealand, British Columbia, and the United Kingdom (British Columbia Centre on Substance Use, 2018; Ministry of Health, 2014; National Institute for Health and Care Excellence, 2007). All three governments have MOUD guidelines that allow providers to confidentially treat minors 16 and older with OUD with MOUD. Considering all three countries have outperformed the United States in overall health rankings according to The Commonwealth standards (The Commonwealth Fund, 2021), their health policies may hold valuable insights and potential solutions for our country. Additionally, state assemblymember Matt Haney of has introduced a bill (AB 816) that closely aligns with Policy 1, indicating a growing recognition and perhaps, feasibility of addressing adolescent confidentiality concerns in accessing MOUD (California State Assembly Democratic Caucus, 2023). The support of the American Academy of Pediatrics California Chapter further signifies the relevance and importance of Policy 1 (California State Assembly Democratic Caucus, 2023).

On the other hand, there was limited public support for a California Senator who wanted to support a bill that enabled 15 and older minors to consent to all vaccines (Aguilera, 2022). This proposal was shut down due to concerns about parental right infringement. This failure could indicate that Policy 1 is not yet feasible.

Effectiveness and Impact- Policy 2

The potential impact of Policy 2 can be gauged by examining the success of existing policies that are currently in progress. For instance, consider the California MAT Expansion program, which has facilitated access to MOUD for 152,000 new patients with OUD (California Public Health Department, 2019). Additionally, the ongoing Youth Opioid Response project focuses on improving MOUD access for teenagers (California Public Health Department, 2019). Although these projects likely have helped many

minors access MOUD, the exact numbers remain unknown, making it difficult to ascertain the full effectiveness and impact of Policy 2

Another crucial aspect to consider in assessing the impact of Policy 2 is its influence on parents. Unlike Policy 1, Policy 2 is more likely to protect parents' rights, specifically their right to have a say in their child's medical decisions. By restricting MOUD for adolescents with OUD, this policy necessitates that adolescents seek their parents' consent, effectively involving parents in the decision-making process. However, it is unlikely that this approach will encourage more adolescents to disclose their addiction to their parents if they are not doing so already.

Relevance and Feasibility- Policy 2

The relevance of Policy 2 can be evaluated through several key factors. Firstly, the opioid epidemic was driven in part by the over-prescribing of opioid pain medications (Hirsch, 2017), which has likely contributed to a distrust in medicine and healthcare. There is evidence of growing mistrust of the healthcare system and medical providers (Khullar, 2018), which may impede the public's support for Policy 1, which advocates for pharmaceutical interventions.

Furthermore, Policy 2 does not impose immediate costs. However, future costs due to the ongoing morbidity and mortality of the OUD in teens may perpetuate substantial costs in the future.

Another crucial aspect to consider in assessing the relevance and feasibility of Policy 2 is recent legislative attempts. As mentioned previously, Senator Scott Weiner's proposal in California sought to grant adolescents the ability to consent to all vaccines, including the COVID-19 vaccine, but faced resistance from parental rights groups (Aguilera, 2022). This failure underscores the challenges involved in implementing policies that offer minors confidential access to medical treatments.

Taking these factors into account, Policy 2 may have better feasibility compared to Policy 1. It avoids conflicts with parental rights groups, promotes reduced reliance on healthcare providers, and entails fewer immediate costs.

Trade-offs

Potential positive outcomes of Policy 1 include the downstream effects of fewer adolescents suffering from OUD. The burden of OUD can consume an individual's life, with time and money spent obtaining opioids and avoiding withdrawals. Once freed from this burden, adolescents may redirect their time and resources towards more productive activities, such as education or work. Since OUD increases the risk of dropping out of school (Tice et al., 2017), it is likely that Policy 1 could improve high school retention rates, academic performance, and college admission rates. In addition, fewer people buying opioids from illegal drug markets could lead to a reduction in crime rates. Lastly, buprenorphine, even long-term use (180 days), was associated with financial savings as compared to no treatment (Samples et al., 2020). This is because of the relative reductions in ER visits, inpatient stays, overdose events, and opioid prescriptions (Samples et al., 2020)

While Policy 1 has the potential to improve outcomes for adolescents with OUD, there are also associated risks that need to be addressed. One concern is the potential for MOUD abuse and misuse. Although relatively rare, MOUDs have been misused by people with and without a prescription for MOUD, often to relieve cravings and withdrawal symptoms or physical pain (Han et al., 2021). With more adolescents having access to buprenorphine, there is a possibility of a rise in diversion and higher rates of misuse.

Another potential risk is associated with adolescents who rely on their medication and are susceptible to the fluctuations of the pharmaceutical companies, such as shortages or pricing spikes. For example, the 2023 Adderall shortage affected many individuals with ADHD who rely on this medication (Swetlitz, 2023). Similarly, and potentially more serious, individuals with OUD who depend on MOUD could be at risk of relapse if they experience medication shortages. Therefore, a plan must be developed to protect individuals from such disruptions.

Lastly, another potential risk of Policy 1 is associated with controversy between minor consent laws and parental rights. In 2022, California state senator Scott Weiner introduced a policy that allowed 15 year olds in California to consent for vaccines. Senator Weiner and his legislative team claimed to have received bomb threats and harassment from some parental rights groups and members of the public (Aguilera, 2022). It is possible that proponents for Policy 1 may receive a similar response from parental rights groups and other citizens who oppose this policy. While perhaps vaccines are more controversial than MOUDs, health care professionals and law-makers should be aware of this possible backlash.

Recommendations

After a comprehensive evaluation of the two policies, I strongly advocate for the implementation of Policy 1 over the status quo. Policy 1 revises California's minor consent laws to include the provision of buprenorphine to treat OUD in adolescents 16 and older. This change will secure older minors with prompt and confidential access to gold-standard OUD treatment. Policy 1 would also empower healthcare providers to treat young patients who seek their help, eliminating the need to turn them away for not having parental consent.

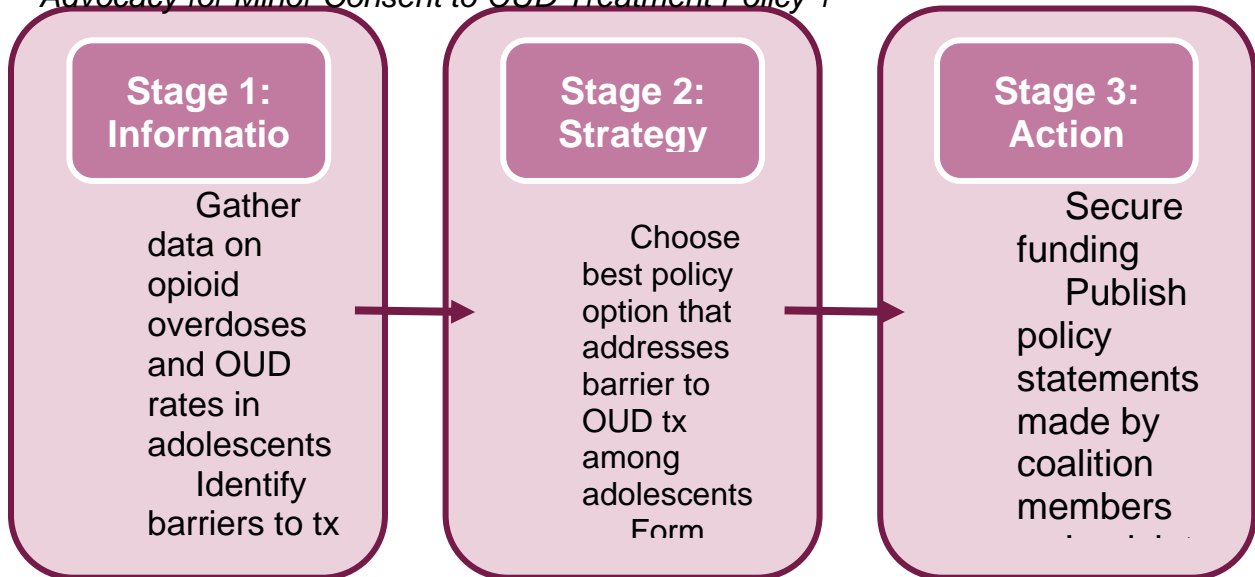
Our recommendation is supported by the Society of Adolescent Health and Medicine, a leading professional organization conducting research and advocacy for adolescent health. In their 2021 position statement, they state that addiction services for adolescents and young adults should be confidential, welcoming, and culturally-sensitive, similar to other critical healthcare services (Society of Adolescent Health and Medicine, 2021). Moreover, governments of New Zealand, British Columbia, and the United Kingdom have already implemented OUD treatment guidelines similar to Policy 1.

Health policy advocacy will be an essential strategy for promoting the revision of minor consent laws and OUD treatment guidelines. The health advocacy framework proposed by Christoffel (2000) will serve as a guide. This model visualizes policy advocacy as an assembly line process, incorporating various

products, people, and processes essential to successfully advocating for a policy. The three steps include information, strategy and action. Figure 2. Illustrates the progression of the three stages for this policy.

Figure 2:

Advocacy for Minor Consent to OUD Treatment Policy 1



The first stage focuses on information collection and the creation of a comprehensive document to organize this data. This paper can serve as the product of this first stage. The second stage involves crafting strategic solutions to address the issue at hand, in this case, the formulation of this current policy. To effectively implement this policy, coalitions should be established, ideally composed of members of professional organizations of those closest to the issue, which in this case is pediatric providers, OUD treatment centers, and people with OUD.

To ensure that treatment for minors suffering from OUD is effectively free, given their lack of income, various funding options should be explored. A potential source could be the American Rescue Plan of 2021, which allocated \$420 million to the Certified Community Behavioral Health Clinics expansion grant program. This fund is designed to enhance the quality and accessibility of community mental health services and substance use disorder treatment (FACT SHEET: Improving Access and Care for Youth Mental Health and Substance Use Conditions, 2021). Other potential sources include grants

approved by the Department of Health and Human Services and SAMHSA for improving access to substance use and mental health services. These grants have previously facilitated uninsured youth in gaining access to critical treatment (SAMHSA, 2022).

Implications/Discussion

Enhancing treatment accessibility for minors with OUD has hopeful benefits for improving public health outcomes among youth in California. By addressing OUD in minors, we can expect healthier communities marked by a reduction in adverse health consequences linked to OUD, such as blood-borne infections, ongoing addiction, and overdoses. Ultimately, as adolescents stick with treatment it will free up time that was previously required for obtaining and using opioids to do other things, such as pursuing their passions, accomplishing in school, developing meaningful relationships. Long-term, early intervention can lead to better health outcomes in adulthood, reduced chronic health issues, and improved overall well-being, contributing to healthier communities in the long-run.

In addition to the health benefits, bolstering treatment rates for minors with OUD can have significant societal advantages. It has the potential to alleviate the substantial financial burden placed on the healthcare system by the opioid epidemic and mitigate productivity losses due to morbidity and mortality. Successful implementation of this policy in California could serve as a model for other states, helping to combat the youth opioid crisis nationwide. However, it is essential to consider some limitations associated with the proposed policy.

As this policy will likely lead to more people reliant on buprenorphine, making them more vulnerable to the pharmaceutical industry's disruptions, there must be a plan in place to protect individuals from shortages and pricing spikes. Additionally, this policy may cause tension among parents who perceive it as encroaching on their rights. To address this concern, California could consider adopting phrasing used in OUD guidelines from New Zealand and British Columbia (see Table 1 below).

These guidelines advise healthcare providers to encourage adolescents with accessible parents to share their OUD issues, as close social support can significantly facilitate the recovery process.

<p>TABLE 1. <i>Minor’s OUD treatment Guidelines from New Zealand, United Kingdom, and British Columbia</i></p>	
New Zealand	Healthcare providers should not deny access to MOUDs solely based on age. If a young person can understand the reasons, process, and risks associated with medication treatment and agrees to undergo the treatment, they don't need parental or guardian consent. However, for clients under 18 years old, providers should still seek parental or guardian support if possible and appropriate (Ministry of Health, 2014, p. 10).
United Kingdom	Individuals who are 16 years old or older have the right to decide on their own treatment (NHS, 2022). Healthcare staff must ensure confidentiality for clients in treatment. It is encouraged to discuss whether younger clients should involve family or their guardians (National Institute of Care Excellence, 2007).
British Columbia	Healthcare staff should know that not all young people have positive family relationships. Therefore, those under 19 do not need parental consent for treatment of OUD. If they understand the treatment and its consequences, parental permission isn't required (British Columbia Centre on Substance Use, 2018).

Another notable limitation of this policy is its failure to fully address the treatment gap, which affects adolescents who are not impacted by issues of confidentiality and parental consent. This category of adolescents includes those who do not desire treatment for OUD, hold stigmatized beliefs about MOUDs, reside in areas lacking OUD treatment centers/providers, or lack adequate knowledge

about the benefits of MOUDs. Addressing the treatment gap for these individuals remains a considerable challenge that also needs to be addressed.

To ensure the success of our policy, there must be comprehensive improvements in areas of education, research, stigma-reduction, and the expansion of mental health providers. Starting with education, a priority should be placed on providing mental health and SUD education to middle and high school students, as well as parents. The education can raise awareness and dispel misconceptions surrounding OUD and its available treatments. In conjunction with education, further research is paramount to advance understanding of OUD treatment in youth, specifically studies exploring the optimal duration of treatment for adolescents. Moreover, the shortage of OUD treatment providers can be addressed through several strategies. First, promoting the use of telehealth services in underserved areas can extend treatment reach and accessibility. Second, supporting full-practice authority for nurse practitioners, who often are in the frontlines of the opioid epidemic, can help increase the availability of care. Finally, incentivizing medical and nursing students to pursue careers in substance use and mental health fields can bolster the workforce in these critical areas.

Conclusion

This policy analysis examines the issue of OUD among adolescents and highlights a hopeful health policy that addresses the immense treatment gaps among minors. As minor confidential consent has proven to be a valuable tool that effectively improves access to sensitive yet necessary services, expanding this strategy to encompass older teens with OUD would likely enhance treatment rates. At the same time, we must keep in mind the limitations and additional interventions needed to facilitate this policy and to fully close the treatment gap among youth with OUD, including stigma reduction strategies, expanding OUD treatment providers, and educating the public. As we collectively seek solutions to combat the opioid crisis, a policy that eliminates the parental consent requirement has hopeful prospects of being an effective, feasible, and impactful strategy.

Appendix

Capstone Course Competency Table

Competency Chosen From Foundational & Concentration Competency List (to be completed at the beginning of the semester)	Specific Portion of Paper and/or Poster Creation & Presentation Synthesizing Competency (to be completed at the end of the semester)	Confirmed by Faculty Y/N
#19 Communicate audience-appropriate public health content, both in writing and through oral presentation	All sections of my ILEX paper communicate public health content, in this case opioid use disorder among adolescents, to a public health student and faculty audience. Each section in my oral powerpoint presentation will communicate the same points to a live audience.	
Health Policy Leadership #2, Synthesize evidence from literature review and/or databases to write a policy paper for a specific audience, identifying a problem and proposing alternative approaches to meet health needs in underserved communities.	In the ILEX paper, the literature review and policy analysis sections propose a policy option as well as comparing it to an alternative. The problem that was identified was the treatment gap among adolescents with opioid addiction.	
NP Core Competencies "advocates for ethical policies that promote access, equity, quality, and cost" (The National Organization of Nurse Practitioner Faculties, 2013)	The recommendation and implications sections in my ILEX paper are the strongest areas where I advocate for a policy that promotes increased access to treatment to a vulnerable and underserved group. These sections also address cost and quality benefits to the proposed policy.	
NP Core Competencies "collaborates with interprofessional colleagues about advocacy and policy issues at the local, state, and national related to reducing	My oral presentation focuses on advocating for a state health policy for a mental health issue. The presentation recommends actions for individuals and national organizations to take. I will be presenting this to public health students and faculty from different specialties	

<p>health disparities and improving clinical outcomes for populations with mental health problems and psychiatric disorders” (The National Organization of Nurse Practitioner Faculties, 2013).</p>	<p>thereby collaborating with interprofessional colleagues.</p>	
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