Spectrum
HEALTH SYSTEMS

Comprehensive Approach to Addiction Treatment

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Building better lives…one step at a time

Company Overview

- Not-for profit organization
- Founded in 1969 in Massachusetts
- Leader in addiction treatment for 49 years
- 1,200 employees
- 5 states

- Behavioral Health Services Statewide Continuum: Inpatient/Outpatient/MAT/Peer Recovery Support
- New England Recovery Center™ (Private Pay & Commercial Insurance) Inpatient Detoxification & Inpatient Rehabilitation
- Adolescent Services (MA DYS Funded)Residential Programs
- Corrections Treatment (State DOC Contracts)In-Prison & Community Corrections




Spectrum's Continuum of Care

- Inpatient Services Westboro (coed)Weymouth (male)
  - Detoxification
  - Clinical Stabilization
  - Residential Treatment
- Outpatient Services
  - Medication-Assisted Treatment (Methadone, Vivitrol & Suboxone)
  - Intensive Outpatient Treatment (Worcester only)
  - Outpatient Counseling (substance use & mental health)
- Peer Recovery Support Centers (Worcester, Marlboro, Lawrence)
- Correctional Substance Use Treatment
  - Massachusetts, Georgia, Virginia, Tennessee
- Adolescent Services for at risk youth in Department of Youth Services

Outpatient Locations

- Framingham
- Haverhill
- Leominster
- Milford
- Millbury
- North Adams
- Pittsfield
- Saugus
- Southbridge
- Waltham
- Weymouth
- Worcester Lincoln St
- Worcester Merrick St.
- Worcester Pleasant St

Objectives of the Presentation

By participating in this presentation participants will:

1. Develop an understanding of the continuum of care for substance use disorders and how to access that continuum for treatment options
2. Understand Medication Assisted Treatment options and how to make a referral for the best fit
3. Learn the components of effective treatment to manage complex SUD cases in different treatment settings

How Do People Recover?

Natural Recovery

- Shift of desires and values
- Changes in social environment and role expectations
- Improved decision making
- Decreased risk taking

Supported Recovery

- Family interventions
- Legal/work sanctions
- Brief counseling interventions
- 12 step/self help involvement

Formal SUD treatment:

- Long term neuro-chemical changes
- Relapsing-remitting course
- Significant health and social consequences

Treatment goals:

- Shorten SUD course
- Reduce harm
- Achieve recovery
- Sustain recovery

Goals of Treatment

Behavioral Treatment

- Enhance motivation for change
- Improve skills for making change
- Relapse prevention/CBT:
  - Anticipate triggers and halt cycle of conditioned behaviors
  - Understand thoughts/feelings associated with use and develop safer alternatives
    - Healthy coping vs. Chemical coping
- Restructure social environment
- Encourage pro-social activities

Medication Assisted Treatment

- Stabilize neurochemical imbalances
  - Relieve symptoms of withdrawal
  - Decrease craving
- Prevent intoxication and overdose
- Facilitate neural repair/restructuring
- Improve engagement and retention in other addiction treatment modalities
  - Effective tools, not definitive cures
  - Designed to be used with other treatment modalities

Inpatient/Residential Levels of Care

Inpatient Detox

- Requires medical monitoring of withdrawal symptoms
- Actively using daily
- 5-7 days typical length of stay

Short term Stabilization

- Safe and structured environment and support services
- Transition from ATS to residential rehabilitation, outpatient or other aftercare.
- Individuals may have post acute withdrawal symptoms
- May admit without need for detox first (non daily use, on MAT, stimulant use)
- Length of stay varies based on state and program

Residential

- Often structured but level of structure depends on program
- Varied length of stay by program type/client need (1-3 mos, 6-9 mos, 1 year)

Outpatient

Intensive Outpatient/Day Treatment/Partial Hospital Program

- Frequency varies based on client need
- Often 3-3.5 hour groups offered 5 x/ week or less frequent- day or evening
- Depending on program type may include or be concurrent with mental health treatment
- 2-4 week typical length of stay

Outpatient Counseling

- Frequency varies based on need
- May be individual, group, family or a combination of all
- May include or be concurrent with mental health treatment

Medication Assisted Treatment

- Differences depending on program/medication
- Medication used as a tool to manage withdrawal and cravings
- Most effective when offered with outpatient counseling

Medication Treatment for Opioids

Methadone

- Long acting opioid- lasts 24+ hours
- Peak at 3-4 hours post dose
- Low doses relieve withdrawal
- Moderate doses reduce craving
- High doses block opioid drug effects
- Average *effective* maintenance dose 80-120 mg

Medication Treatment for Opioids

Methadone Benefits and challenges

- Observed medication administration
- Requires daily attendance and transportation
- Toxicology screening
- Monitoring for alcohol use and other substance use, legal, social problems
- Mandated behavioral treatment- encourages participation even when motivation is low
- Program structure therapeutic- structured schedule prepares for productive recovery schedule
- Must monitor for overdose risk particularly in combination with ongoing use and other medications

Medication Treatment for Opioids

Buprenorphine

- Opioid partial agonist
- Flexible, office-based treatment
- Integrated with other care- variation based on program
- Patients control dosing times (this is not always therapeutic)
- Can be used for maintenance or detoxification
- Mixed with naloxone to prevent IV abuse

Medication Treatment for Opioids

Buprenorphine Options

"Combo" sublingual form- *abuse prevention form*
- Bup 2mg/naloxone 0.5mg
- Bup 8mg/naloxone 2mg

Why add naloxone?
- Minimal absorption taken sublingual
- Full activity if crushed and injected- precipitate withdrawal
- Bitter taste

"Mono" buprenorphine sublingual form
- No abuse protection
  - 2mg
  - 8 mg
- Limited availability and utility
  - Pregnancy
  - Allergy

Buprenorphine Film
- Individually packaged
- Serial numbers on each
- Additional strengths
  - 12, 8, 4, 2 mg
- Intended to decrease child exposures, Prevent diversion, Prevent med exchanges

Medication Treatment for Opioids

Naltrexone

- Opioid Receptor blocker
- Oral and monthly injectable forms
- Approved for both opioid and alcohol addiction
- For alcohol, naltrexone most effective medication available
- For opioids, naltrexone approved but not direct comparable to agonist treatment
- Medication itself can be expensive
- Bloodwork needed as may be contraindicated with significant liver function problems

Choose Medication based on client current needs

All three types of MAT medications work in their own way, when reviewing the best patient match the answer may be more related to structure of the program

Choose Medication based on client current needs

Naltrexone

- Effective with clients able to be 10-15 days without an opiate required to administer injection
- Intermittent user or stepping down from inpatient care or incarceration where the use was suspended in part due to their controlled environment
- Often this population does not need intensive therapy and may have a somewhat stable home environment that contributes to reinforcing recovery

Choose Medication based on client current needs

Buprenorphine

- Ceiling effect which allows the medication to be safer to prescribe out of a doctors office which reduces the need for daily visits and provides flexibility particularly for working individuals
- Individuals with significant use patterns may not have full relief from withdrawal
- The population who does best with this medication is able to manage prescriptions
- A stable safe environment to keep the medication is needed
- Reduced but not eliminated overdose risk

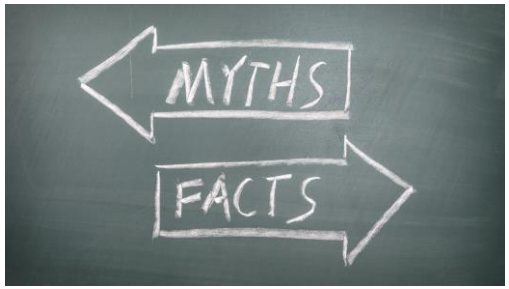
Choose Medication based on client current needs

Methadone

- The structure of the methadone program becomes part of the treatment
- Daily visits that provide medication to protect from withdrawal, connection with clinical staff and structured individual and group counseling.
- Individuals who have been unsuccessful at other treatments, who do not have solid recovery supports, and could benefit from close monitoring are appropriate
- More potent medication may be more appropriate for longer term high levels of use and high risk individuals
- Clients may earn take home medication over time to reduce the frequency of contact once clear evidence of recovery is shown over time
- Lower cost, widespread coverage by Medicaid plans, increasing commercial plans and state funding may be available
- There are some medication interactions and cardiac effects may limit use in some patients

Opiate Agonist Treatment Myths (Methadone)

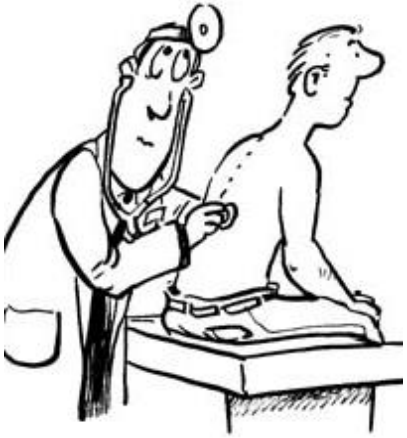
- If the patient is opioid tolerant, it does not make him/her "high"
  - It is not a substitute "addiction"
  - It WILL cause a "high" if the patient is not currently opioid tolerant (if not using, withdrawing)
- Patients are not (all) unproductive. Many work full time, take care fo their families, volunteer, and give back to the community
- Patients are not "trapped" in treatment
- It is **not** ok to continue to use drugs (opioids or other drugs) while in treatment
- Methadone on the streets that is being abused is RARELY from methadone programs



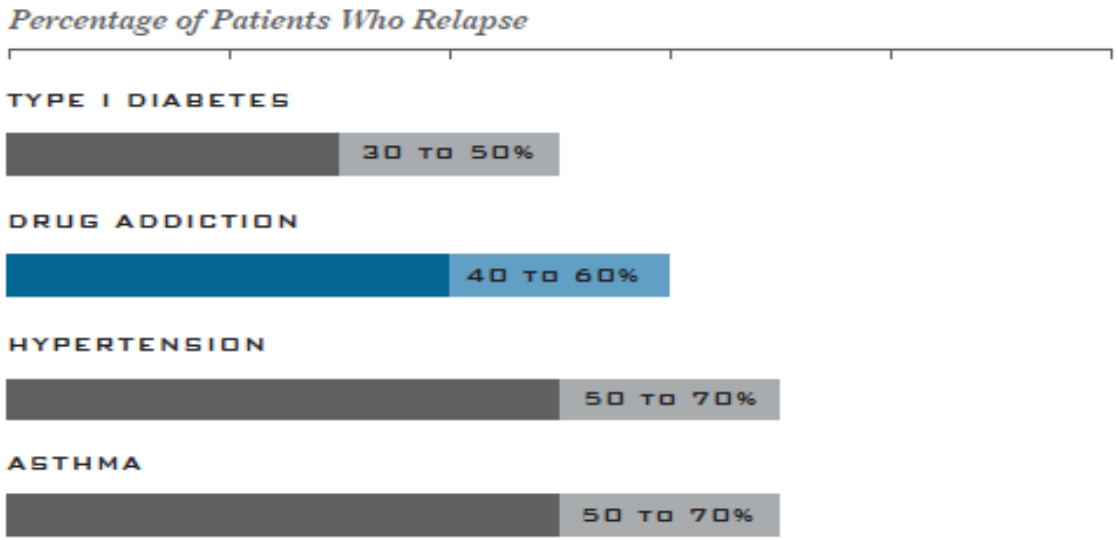
Determinants of Treatment Duration

- Duration and severity of drug use
- Mental health symptoms and conditions
- Medical
- Family history of addiction
- Few supports, responsibilities or job prospects
- Social environment where drug use is normative

Treating Addiction is not like treating a pneumonia…



- High-intensity short term treatments have limited impact without continuing care
- "cure" is not a realistic goal for most
- One treatment episode is rarely enough
- Detox is a transition not a treatment
- Providers sometimes feel discouraged about referring pts for SUD treatment. Sometimes it seems like it just isn't worth the effort. But relapse rates are really no different than other chronic diseases:



http://www.nida.nih.gov/PODAT/faqs.html#Comparison

Release from Prison—High Risk of Death

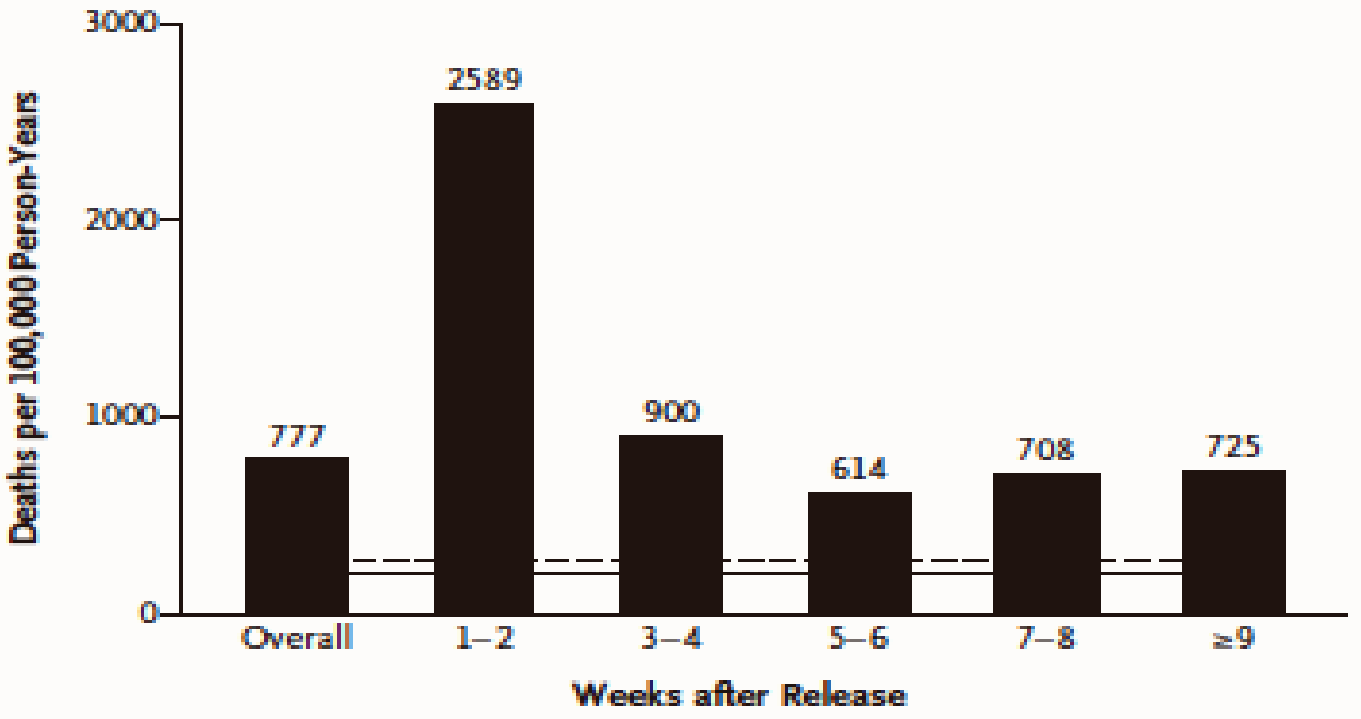


Figure 1. Mortality Rates among Former Inmates of the Washington State Department of Corrections during the Study Follow-up (Overall) and According to 2-Week Periods after Release from Prison.

Risk of Death Former Inmates
compared to general population

	Increased Relative Risk
Overall	3.5
Time since release: 0-2 weeks	12.7
Time since release: 3-4 weels	4.4
Time since release: ≥ 5 weeks	3.2
Drug overdose	12.2
Drug overdose first two weeks	***129***
Homicide	10.4
Liver disease	4.7
Suicide	3.4
Motor Vehicle Accident	3.4
Cardiovascular disease	2.1
Cancer	1.7

Binswanger NEJM 2007

Medication Initiation During Incarceration Saves Lives

- Green, TC et. al. 2018 JAMA Psychiatry
  - Rhode Island Dept. of Corrections
  - Every admission assessed for opioid use disorder and offered medications
  - Methadone, buprenorphine, or naltrexone started, able to continue on release
- Overdose deaths after release from incarceration reduced > 60%
- State-wide OD death rate reduced 12%

Consider All the Tools in the toolbox

Naltrexone vs. Buprenorphine

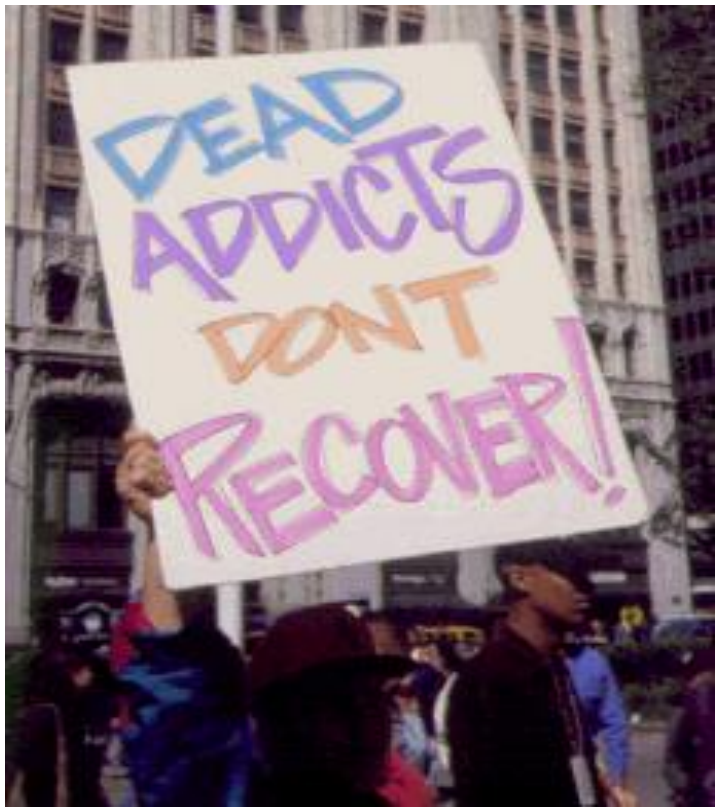
Lee JD et al. Lancet Jan 2018

- Patients recruited from opioid detox
- Detox protocols/time varied
- Outcome: Induction
  - ERINTX: 204/283 (72%)
    - More success if started later in treatment
  - BUP: 270/287 (94%)
- Outcomes <u>once successfully started</u>:
  - Retention/no relapse no difference (~40% at 24 weeks)

Why Opioid Maintenance?

- **80-90% relapse to drug use without it**
- **Increased treatment retention**
- **80% decreases in drug use, crime**
- **70% decrease all cause death rate**

NIH Consensus Statement
JAMA 1998



Relapse Events for Individuals with Opioid Use Disorders by Treatment Type

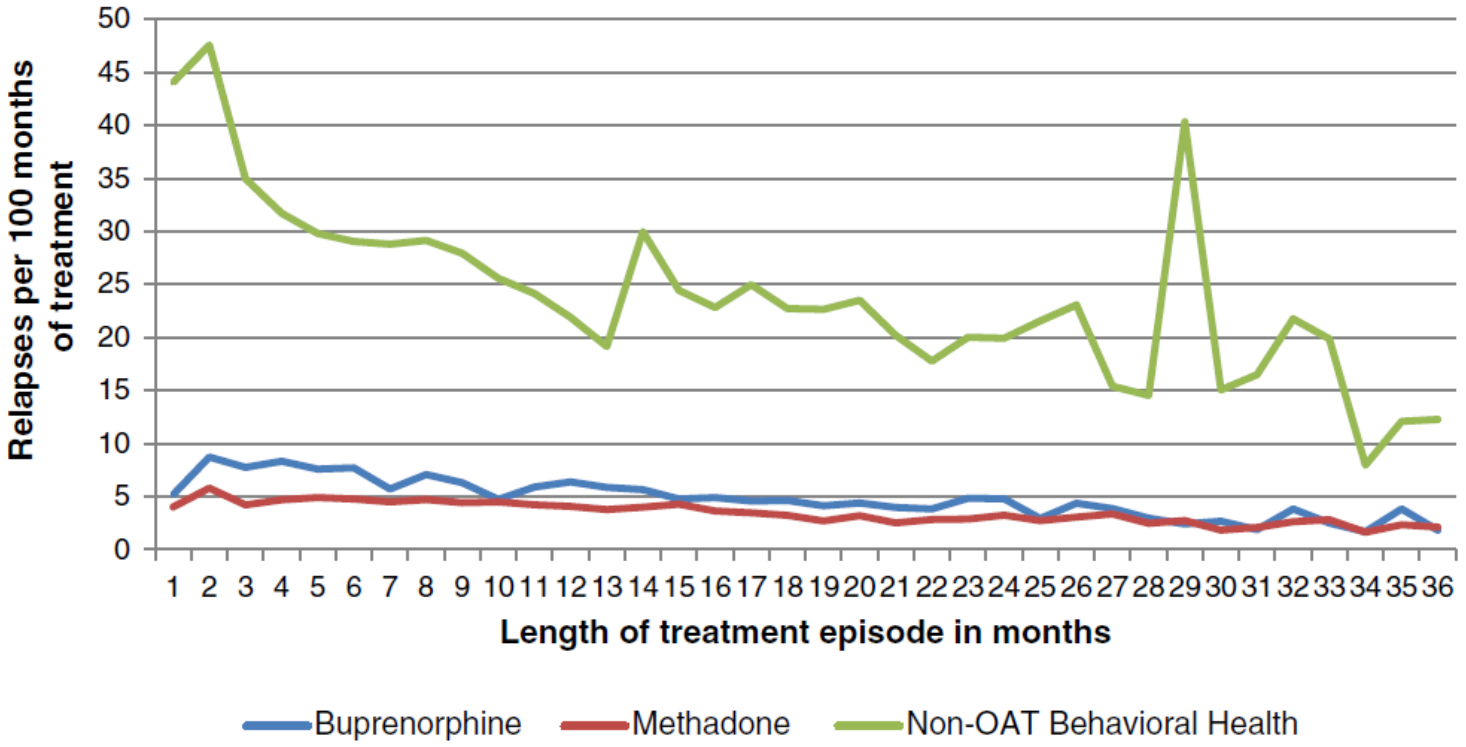


Figure 4. Clark, Robin E., et al. "Risk factors for relapse and higher costs among Medicaid members with opioid dependence or abuse: opioid agonists, comorbidities, and treatment history." Journal of substance abuse treatment 57 (2015): 75-80

Retention at 12 months

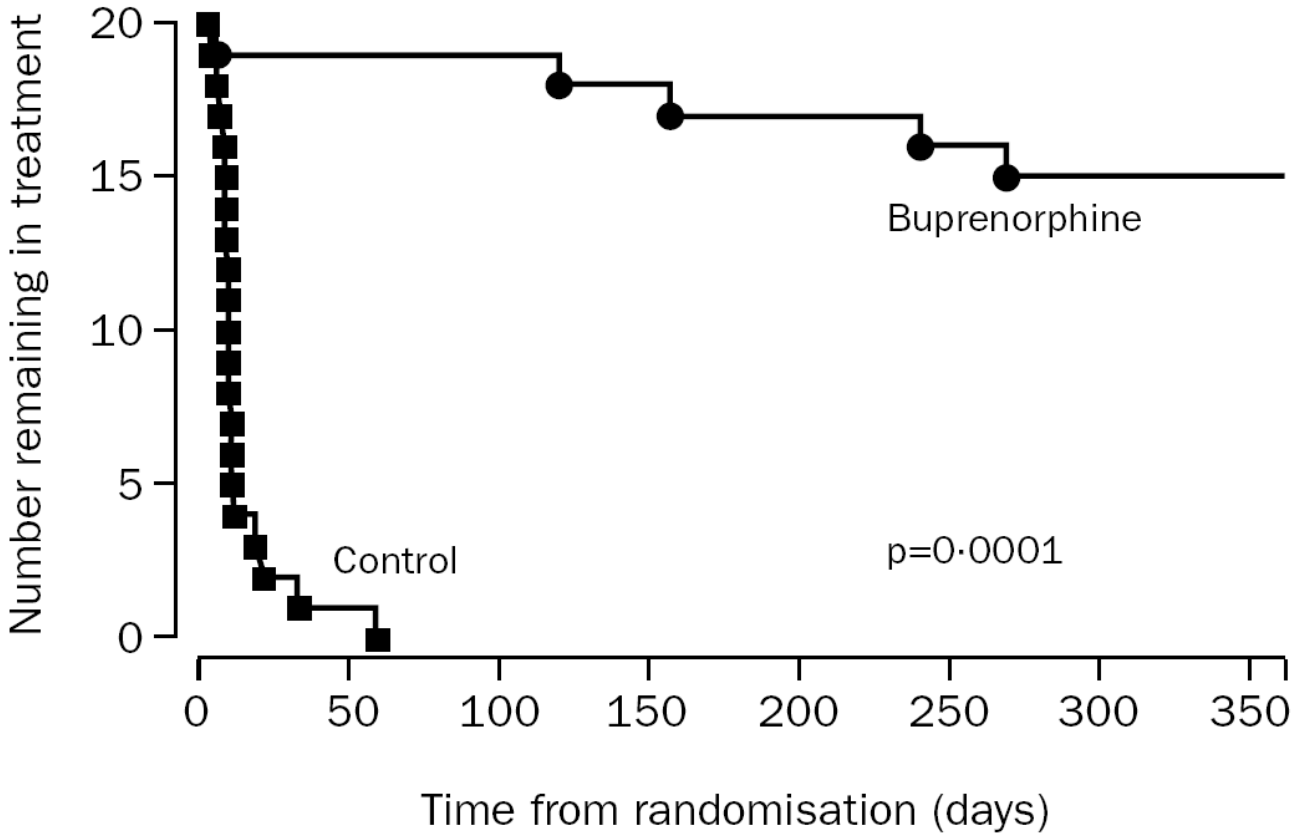
Methadone 52%

Buprenorphine 33%

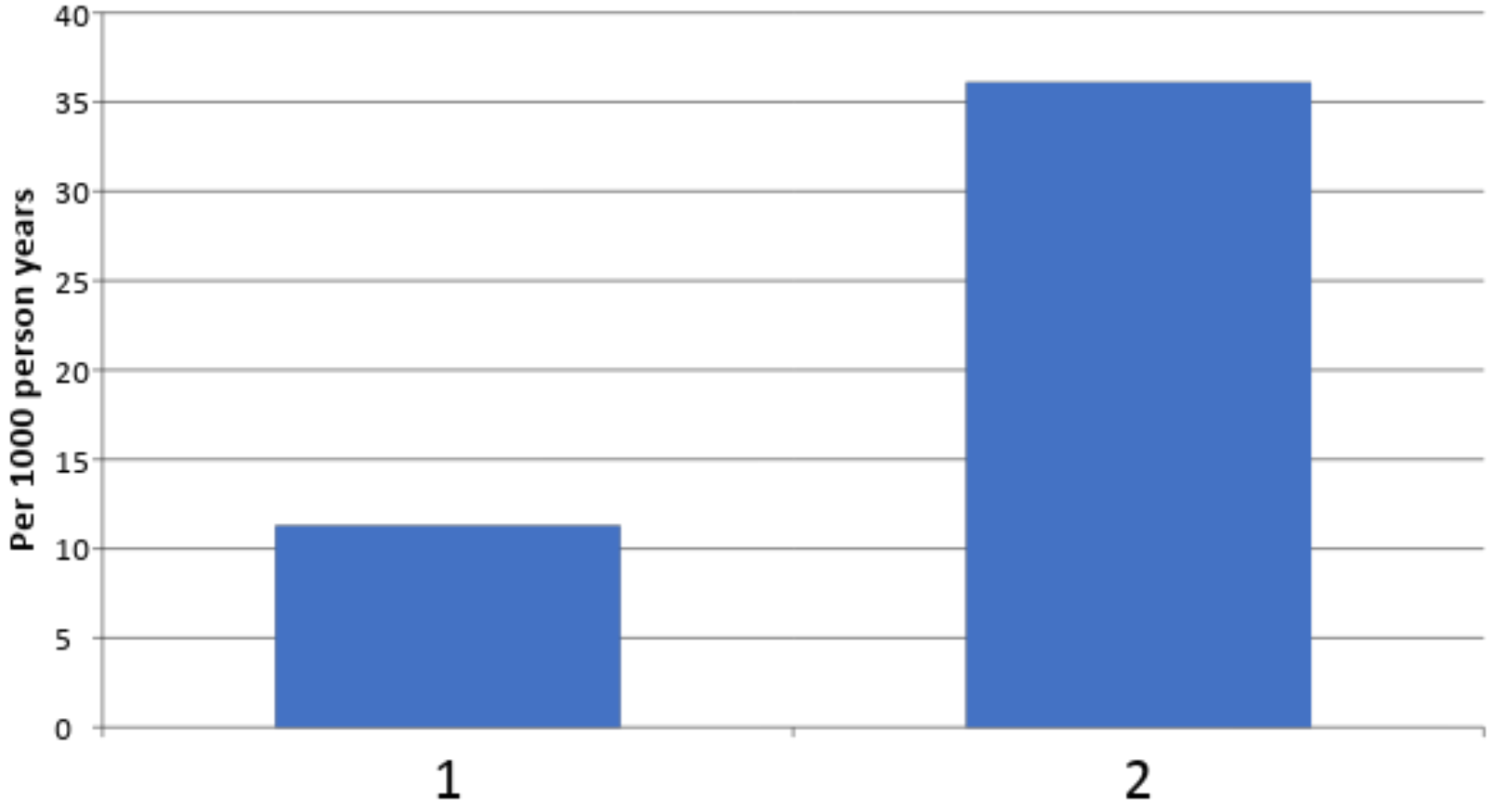
Non-OAT Tx 12%

Buprenorphine Maintenance vs. Detox

Kakko J et al. Lancet 2003

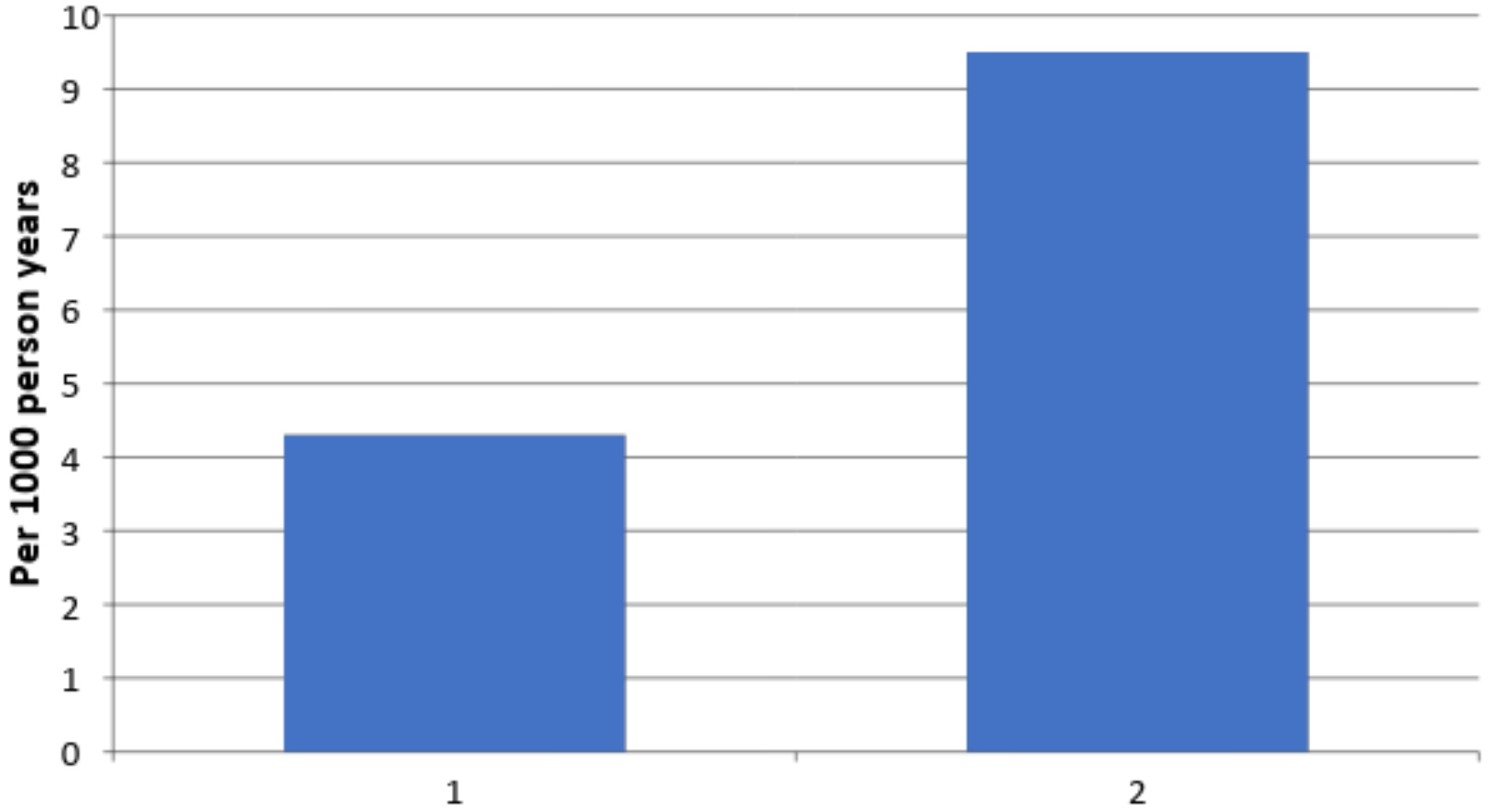


Mortality Risk in and out Methadone Treatment



Sordo, Luis, et al. "Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies." *bmj* 357 (2017): j1550.

Mortality Risk in and out Buprenorphine Treatment



Sordo, Luis, et al. "Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies." *bmj* 357 (2017): j1550.

Methadone And Buprenorphine Are Associated With Reduced Mortality After Nonfatal Opioid Overdose

RETROSPECTIVE COHORT, MASSACHUSETTS PUBLIC HEALTH DATASET, 2012-2014

17,568 opioid overdose survivors
with ambulance or hospital encounter

Only 3 in 10 receive MOUD*
over 12 months of follow-up

*Medication for Opioid Use Disorder

Mortality at 12 months:
4.7 deaths / 100 person-yrs

Association of MOUD* with mortality:

Methadone	↓ 53%
Buprenorphine	↓ 37%
Naltrexone**	↔

** *limited by small sample*

Larochelle et al. *Annals of Internal Medicine*. 2018.

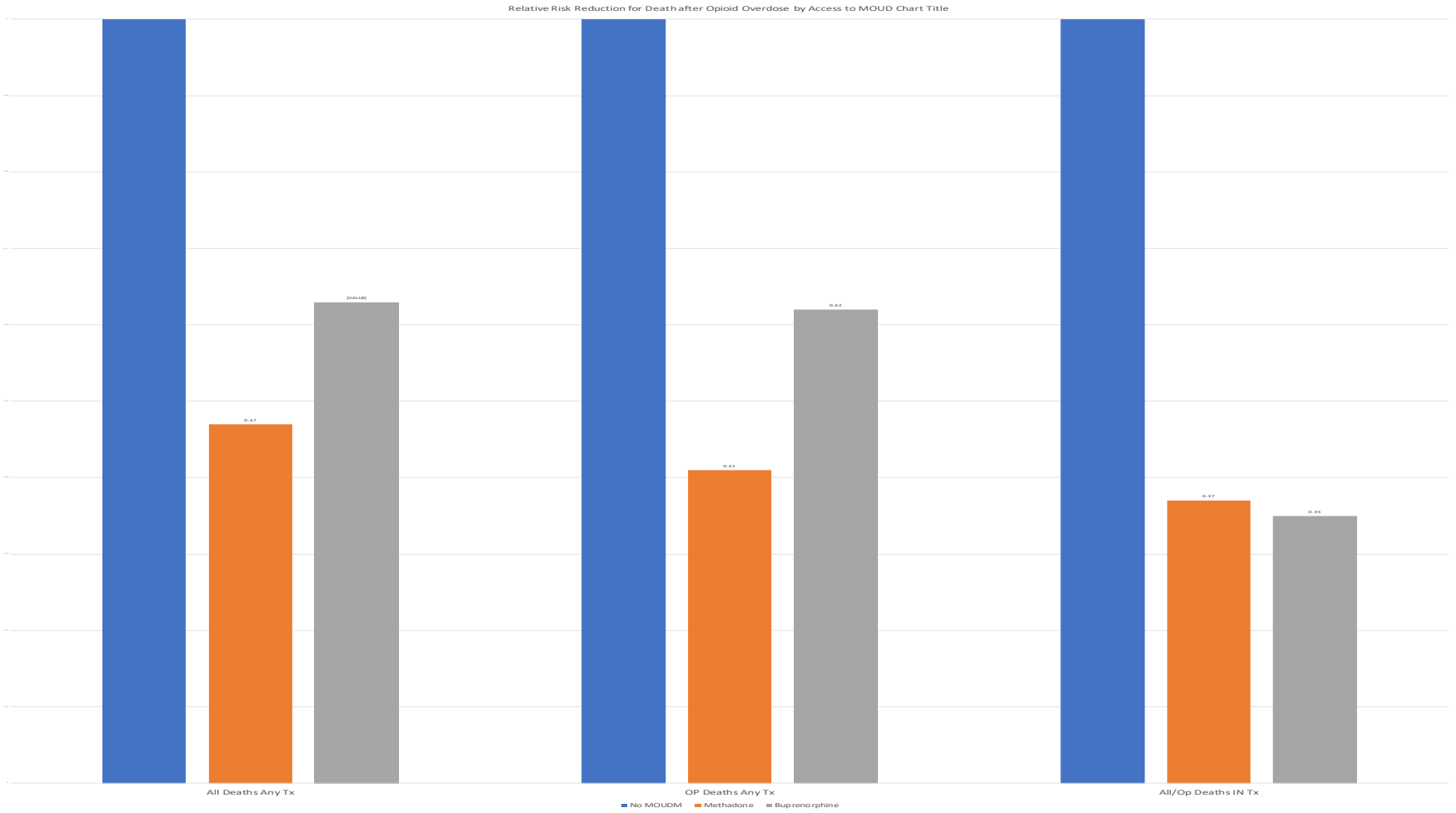
Boston Medical Center

Grayken Center for Addiction
Boston Medical Center

CARE

Boston University School of Medicine

Full Cohort (*n* = 17 568)	MOUDs in the 12 Months After Index Nonfatal Opioid Overdose‡				
	No MOUDs (*n* = 12 295)	Enrollment in MMT (*n* = 1416)	Buprenorphine (*n* = 2228)	Naltrexone (*n* = 772)	Multiple MOUDs (*n* = 857)



LaRochelle 2018 Ann Int Med

Missed Opportunities

Any approved medication is (much) better than no medication…
AND no one medication is the best for all patients or at all times.

Clinical Component of SUD Treatment

"Medication-Assisted Treatment (MAT) is the use of medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders. Research shows that a combination of medication and therapy can successfully treat these disorders, and for some people struggling with addiction, MAT can help sustain recovery-

-Substance Abuse and Mental Health Services Administration

Clinical Component of SUD Treatment

Types of Behavioral Treatment

- Individual counseling
  - Motivational Interviewing
  - Cognitive Behavioral Therapy and Relapse prevention coping skills
- Group counseling
- Contingency Management
- Mental health and dual diagnosis treatment
  - Included in counseling
  - Psychiatric assessment and medication management

Motivational Interviewing

Client-centered * Goal-directed (behavior change) *Helps resolve ambivalence

A collaborative conversation style for strengthening a person's own motivation and commitment for change

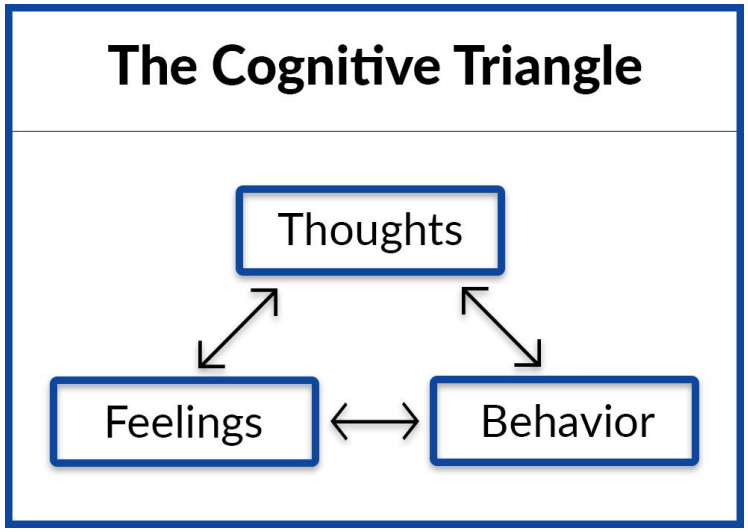
- Open Ended vs Closed Questions
- Affirmations- Statements and gestures that recognize strengths and acknowledge behaviors that lead in the direction of positive change and demonstrate that you value a person's
- Reflective Listening- Hypothesis-testing; make guesses about what the speaker means- Statements rather than questions-Repeat, Rephrase, Paraphrase
- Summaries-Transition or ending statements and Collect "change talk" statements

Motivational Interviewing

Readiness Ruler

- On a scale of 1-10 how ready are you to make a change in your drinking, drug use, substance use?
- Why not a lower number?
- Why would it take to move it to a higher number?

Cognitive Behavioral Therapy



Cognitive-behavioral therapy teaches individuals in treatment to recognize and stop negative patterns of thinking and behavior. For instance, cognitive-behavioral therapy might help a person be aware of the stressors, situations, and feelings that lead to substance use so that the person can avoid them or act differently when they occur

Cognitive Behavioral Therapy

Seven main areas of vulnerability that contributes to the patient's risk of alcohol and other substance misuse (Beck, Wright, Newman, & Liese, 1993)

1. ***High-risk situations***, both external (e.g., people, places, and things) and internal (e.g., problematic mood states).
2. ***Dysfunctional beliefs*** about drugs, oneself, and "relationship" with drugs.
3. ***Automatic thoughts*** increase arousal and intention to drink and/or use.
4. **Physiological *cravings and urges*** to use alcohol and other drugs.
5. ***"Permission-giving beliefs"*** that patients hold to "justify" their drug use.
6. ***Rituals*** and general behavioral strategies linked to the using of substances.
7. ***Adverse reactions*** to a *lapse or relapse* that lead to a vicious cycle.

Cognitive Behavioral Therapy

CBT Skills

- Learning how to *delay and distract* in response to
- Identifying dysfunctional ways of thinking
- Developing refusal skills
- Learning how to solve problems directly and effectively without use
- Understand the “pros and cons” of using vs recovery
- Practicing the behaviors and attitudes of self-respect vs negative self image that contribute to use
- Utilizing healthy social support
- Making lifestyle changes that support recovery and self-efficacy

Group Counseling

Individuals consistently say that their group counseling is what made all the difference in their recovery

Clinical Benefits of Group Counseling

- Skill building
- Positive peer support
- Feedback that can identify cognitive distortions
- Reduces isolation
- Sharing of real life examples and learn from others
- Healthy relationship building
- Provides hope and encouragement

Program Benefits

- Cost effective- one provider can treat many
- Provides structure and clear clinical content

Group Counseling

Types of Groups

- Relapse Prevention and Recovery Skills
- CBT
- Support groups
- Population Specific
  - Dual diagnosis with mental health (can be diagnosis specific- i.e anxiety)
  - Co- occurring trauma
  - Phase or individual stage specific- based on length of treatment or recovery
  - Gender specific

Contingency Management

Contingency management, rooted in behavioral psychology is designed to provide incentives to reinforce positive behaviors

These behaviors in addiction treatment can include

- Remaining abstinent from substance use
- Attendance at treatment sessions
- Meeting treatment plan goals
- Completing pro social or healthy activities

Contingency Management

Using contingency management to improve outcomes

- Offer incentives for positive behavior (behavior=incentive)
- These can be immediate or intermittent (raffle, drawing)

Types of incentives

- Gift cards, transportation
- Privileges in the program
- Recognitions

Dual Diagnosis treatment

According to SAMHSA's 2014 National Survey on Drug Use and Health (NSDUH) (PDF | 3.4 MB) an estimated 43.6 million (18.1%) Americans ages 18 and up experienced some form of mental illness. In the past year, 20.2 million adults (8.4%) had a substance use disorder. Of these, 7.9 million people had both a mental disorder and substance use disorder, also known as co-occurring mental health and substance use

Individuals with co-occurring disorders are best treated in integrated settings where both mental health symptoms and addiction are treated within one program

Integration denotes "those relationships among mental health and substance abuse providers in which the contributions of the professionals in both fields are moved into a single treatment setting and treatment regimen" www.samhsa.gov/reports/congress2002/index.html

Dual Diagnosis treatment

Integration Types

- One clinician provides all needed services; or one agency provides all services including MAT, substance use counseling, mental health counseling and psychopharmacology as appropriate
- Two or more clinicians work together to provide needed services, or multiple agencies formally work together
- Clinical team receives consultation
- Clinician coordinates care across all needed services

Dual Diagnosis treatment

Treating the whole person- by treating both addiction and mental health symptoms

- The cycle of addiction and withdrawal/relapse can mimic an cause mental symptoms of depression and anxiety
- Significant mental health symptoms can lead individuals to seek drugs and medications to manage or mask symptoms
- By treating both mental health and addiction we are treating both the symptoms, but also the triggers that promote relapse for both addiction and mental health disorders

Dual Diagnosis treatment

Psychiatric Medication Management and Addiction

- Some medications have addictive potential or may be stimulating, sedating or cause euphoric effects that can complicate existing addictive disorders
- Treating providers must balance between these effects and the therapeutic benefits

Prescribers must monitor

- Medication compliance
- Abuse and addiction potential
- Interactions between medications that may compound effect or increase risk (i.e. methadone and benzodiazepines)
- Current addiction and use patterns
- Current psychiatric symptoms

This is best done in an integrated setting with a multidisciplinary approach

Case Study- 55 yr male- Background

- 55 year old man, PTSD, bipolar, hx multiple psych hospitalizations and suicide attempts
- Using opioids since age 13
- Hospitalized: manic, suicidal, using coke and opioids, in active withdrawal
- Stabilized, new psych meds including mood stabilizers, started on buprenorphine
- Ready for discharge—nowhere to go

Case Study- 55 yr male- Initial plan

- Needs to ensure enough of a prescription to bridge to anew providers 2-4 week supply
- May need residential program but many restrict medications, travel, access to appointments
- Bup and Psych programs require (up to) weekly office visits
- Step down to IOP with ongoing psychopharm care while waiting for community intake
- Placed in sober home that allows medications, work and appointments (and the IOP!)
- Phone call to me directly asking if Spectrum could provide buprenorphine and/or psych care

Case Study- 55 yr male- Outcomes

- Part time job
- Connected to psychiatry provider, adherence to psych meds, improved mental health
- Adherence to probation
- Full participation in buprenorphine treamtent
- Opioid free
- Contact with family, especially teenage kids
- Rare cocaine use, self report to probation and program, received additional support

Case Study- 55 yr male- 1 year later

- Increased depression, suicidal ideation
- Hospitalizations x 2 for safety, med adjustment, returned to house
- Continued bup, opioid free
- Relapse to daily cocaine use, not allowed to return to house, lost job
- Suicide attempt, hospitalized. Referred again to sober living

Case Study- 55 yr male- post relapse

- Faith-based house
- Buprenorphine not allowed—rapidly tapered from buprenorphine, discharged to house with withdrawal and cravings
- House intolerant of mental health challenges
- Relapse to cocaine AND opioid use, crisis
- Readmitted to hospital, temporary bup treatment only, referred to another house that wont accept bup treatment and is far from his psych providers

Case Study- 55 yr male- post relapse

- He returns calls from his clinician at Spectrum.
- He is discharged to the shelter, with psych meds but without buprenorphine
- Brought in for urgent appointment, wet, cold, using drugs by IV, phone with dead battery and no minutes
- ”Can I use the phone?”—was supposed to have interview with residential program (that doesn’t allow buprenorphine)

Case Study- 55 yr male- next treatment

- Admitted to Spectrum ATS (Detox)
- Spectrum provides transportation via Uber
- Stabilized on methadone, offered to continue with bup or methadone treatment outpatient
- Goes from ATS to CSS
- From CSS, goes to residential, continues on methadone HOWEVER…
- Goes to residential program our area—methadone continued, no psych care

Case Study: 35 yr male- Background

- Opioid use starting age 17
- Daily opioid use in early 20's
- IV drug use since age 30, Hep C +
- 3 inpatient detox admits, 2 incarcerations for < 1 year each for crime related to "stealing and dealing to support my habit"
- Drug free 1-6 months after each episode
- Using heroin/fentanyl daily, admitted to detox for opioids after arrest, release on bail, on probation and court date pending

Case Study: 35 yr male- Initial plan

- Completes detox, transfers to CSS
- Requests methadone treatment—has suspended sentence, if violates probation will be incarcerated for 1 year
- Last dose methadone one week ago, last opioid use two weeks ago
- Still with obvious withdrawal signs
- Admitted to methadone, returns home, connects with methadone program (OTP)

Case Study: 35 yr male- post incarceration

- Medicates with OTP for 4 weeks, then AWOL
- Returns 3 weeks later, reports incarceration
- Allowed to detox from 70 mg methadone with only clonidine 0.1 mg 3 times per day
- Released yesterday, used, overdosed, reversed with intranasal naloxone
- “I haven’t slept in almost a month”
- Obvious persistent withdrawal, reamitted and restarted on methadone

Case Study: 35 yr male- next steps

- Medicates with OTP for 6 months
- Misses 1-2 doses per month, 1/3 of tox screens show + opiates (2/3 negative)
- Does not engage with clinician, rare group attendance, frequently cancels individual sessions
- Referred for clinical case review, possible discharge for non-compliance

Case Study: 35 yr male- clinical review

- Says tx is working
- using 1-2 times/mo
- working long hours, medicates at 0530, 90+ minute commute each way in company truck
- 10-12 hr days, 6 days/wk during busy times
- Unable to make it in for clinical appointments

- Is the treatment working?
- Do we discharge for non-compliance?

Case Study: 35 yr male- 2nd incarceration

- Medicates in OTP for 12 months, then AWOL
- Returns one year later, reports incarceration on probation violation, tox positive for opioids
- Had been still using 2-3 times per month
- Allowed to detox from 100 mg in jail
- “I was vomiting and hallucinating, they had to put me in isolation”
- Released 6 weeks ago—went two weeks no use, relapsed
- Overdose x 2, once intubated in ICU

Case Study: 35 yr male- next steps?

- Using fentanyl 2-3 gms IV daily
- ”I need help, I can’t do this on my own”
- On probation, doesn’t want methadone again
- “It worked for me, but I can’t detox like that again, I thought I was going to die”
- Could go back to his old job, but had trouble with program requirements, daily attendance
- Probation mandating IM naltrexone treatment, will violate probation if he doesn’t start that med ASAP

Contact Us

Inpatient Services

Outpatient Services

New England Recovery Center

Jeffrey Baxter, MD Chief Medical Officer

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