Substance Use and Case Management
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Building better lives...one step at a time

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 ways to integrate substance abuse assessment into Case Managers initial assessments including using motivational interviewing techniques for assessments.
4. Understand the impact of substance use on patient care across different settings.
5. Learn from case examples how to manage complex SUD cases in different treatment settings and make appropriate referrals.

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**

**Acute Treatment Services- ATS**
- Inpatient “detox”
- Requires medical monitoring of withdrawal symptoms
- Actively using daily
- 5-7 days typical length of stay

**Transitional Support Services- TSS**
- Short-term residential safe and structured environment and support services
  - Transition from ATS to residential rehabilitation, outpatient or other aftercare.
- 2-4 week or more average length of stay

**Clinical Stabilization Services- CSS**
- Can be step down from detox
- Individuals may have post acute withdrawal symptoms
- May admit without need for detox first (non daily use, on MAT, stimulant use)
- Requires intensive clinical monitoring
- 2-4 weeks average length of stay

**Inpatient/Residential**

**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)

Types of Residential
- Clinically Managed Residential Treatment- may be less intense then CSS but clinically focused residential services that include group treatment and individual counseling
- Recovery homes- structured setting for people in recovery. Residents become part of a community and use community resources, including self-help groups and employment
- Social model programs- sober living setting, peer counseling, and case management. Residents provide each other with a culture of recovery, support, and role modeling. Residents are in the community (work, education, volunteer)
- Therapeutic communities- provide residential treatment in a very structured setting. Residents take an active role in their treatment, helping them to take responsibility and become positive role models
### Accessing Inpatient/Residential

**Acute Treatment Services - ATS**
- Typically individual calls ATS for bed availability
- May be asked to call back if no bed available or come in during a window of time

**Transitional Support Services - TSS**
- Referred by a publicly funded ATS or homeless shelter program
- Often slow turnover because of long waits to access longer term beds

**Clinical Stabilization Services - CSS**
- More challenging to access due to demand
- Can refer from community or as a step down/up from another program

**Residential**
- Some programs may have wait lists due to less frequent turnover and longer length of stay
- May need to check in for bed availability and to indicate continued need and interest

### Accessing Outpatient

**Intensive Outpatient/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

### Accessing Outpatient

**Intensive Outpatient/Partial Hospital Program**
- Typically call program and complete screening and attend a scheduled admission prior to starting group

**Outpatient Counseling**
- Call and attend scheduled admission assessment, some programs offer walk in access

**Medication Assisted Treatment**
- Differences depending on program/medication
- Multi-step process including clinical assessment, medical screening and assessment with a physician
- Some programs offer walk in admissions where all steps are completed in one visit, others schedule separate assessments
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

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
- Buprenorphine 2 mg
- Naloxone 0.5 mg

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

*Mono* buprenorphine sublingual form
- No abuse protection
- Sublingual
- 2 mg
- 8 mg

Buprenorphine Film
- Individually packaged
- Serial numbers on each
- Additional strengths
- Intended to decrease child exposure, prevent diversion, prevent morbidity

Naltrexone
- Opioid Receptor blocker
- Oral and monthly injectable forms
- Approved for both opioid and alcohol addiction
- For alcohol, naltrexone most effective medication available
- For opioid, 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 Masshealth plans, increasing commercial plans and funding from the Department of Public Health
- 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 for 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 of 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

Medication for the Treatment of Alcohol

- Aversives
  - Disulfiram
- Neuromodulators
  - Naltrexone
  - Acamprosate
  - Topiramate
Medication for the Treatment of Alcohol
Acamprosate (Campral)
- Impacts CNS activity
- Dose: 3X daily initiate after 7 days abstaining - don’t stop for relapse
- Toxicity
  - Headache, GI side effects common
  - Renal excretion, avoid with renal insufficiency
  - No liver monitoring

Naltrexone
- Opiate receptor antagonist - Thought to reduce craving
- Oral/dosing/IM dosing
- Toxicity/Contraindications
  - Nausea, fatigue, depression, abdominal pain, nausea joint pain
  - User toxicity noted at high doses (300 mg); no reports at approved dose ranges
  - Blocks opiate pain medications

Disulfiram (Antabuse)
- Alcohol sensitizing agent
- Causes: warmth, flushing, tachycardia, hypotension, nausea, vomiting, sweating, dizziness

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/PDDAT/Tsag.html#Comparison

Assessment of Substance Use Disorders
Standardized screenings
- CAGE: 4 questions- easy to score
- AUDIT: 10 questions focused on frequency of alcohol use
- SBIRT: Screening, Brief Intervention and Referral to Treatment (SBIRT)
  - Longer and quick version
- National Institute of Health (NIDA) Quick Screen and NIDA-Modified Assist
  https://www.drugabuse.gov/sites/default/files/files/QuickScreen_Updated_2013%281%29
- Opioid Risk Tool for Self-Assessment
  https://www.drugabuse.gov/sites/default/files/files/OpioidRiskTool

Assessment of Substance Use Disorders

- Screening questions
  - What substances are used - ask each substance type directly (don’t assume the patient will disclose)
  - Frequency, Amount and Route of Use (oral, nasal, IV)
  - How long using/age of first use
  - Substance of Choice - and why?
  - Treatment history - was treatment helpful? What happened at discharge?
  - Family current and history of substance use
  - Current environment and substance use
    - Home
    - Friends

Motivational Interviewing Approach

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

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

Closed Questions
- Are you worried about your current situation?
- Have you noticed changes?
- Do you care about your health?

Open Questions
- What worries you most about your current situation?
- What changes have you noticed?
- Why do you care about your health?

Motivational Interviewing Techniques

Affirmations
- Statements and gestures that recognize strengths and acknowledge behaviors that lead in the direction of positive change
- Demonstrate that you value a person’s worth – “Thank you.” “You are working on your recovery”
- Be genuine and specific

Reflective Listening
Hypothesis testing; make guesses about what the speaker means - Statements rather than questions
- Repeat: restate using the same words
- Rephrase: use synonyms
- Paraphrase: infer meaning behind the words or emphasize emotional aspects

Summaries
- Transition or ending statements “Here is what I’ve heard so far… What did I miss?”
- Collect “change talk” statements “I am hearing you say you want to make some changes”
- Present bouquet of patient’s own reasons for change “We’ve gone over quite a bit. Let me make sure I am understanding…”
Motivational Interviewing Steps

**Step 1 Build Rapport**
- Ask about substance use - Ask permission

**Step 2 Pros and Cons**
- Pros- What do you like about use
- Cons- What are the downsides
- Summarize

**Step 3 Feedback & Information**
- Ask permission - I have some information on [X] use—would you mind if I shared it with you?
- Give information- We know that drinking / using can put you at risk for overdose or illness.
- Elicit reaction- What are your thoughts on that?

**Step 5 Action Plan**
- Create action plan- Ask client for ideas first
- Affirm ideas
- Ask permission
- Write down action plan
- Summary of action steps / ideas
- Seal the Deal
- Suggest other services that might be useful
- Make an "active referral"

**Readiness Ruler**

**Case Example**
Chris is a 33 year old male who was recently admitted for an overdose in the local hospital. He was brought to the ER from EMS after being found unresponsive in a parking lot at the library. He tested positive for opiates, cocaine and fentanyl. He reports 4 overdoses in the past 6 months, and 3 detox admissions, 2 that he left AMA from because he had a ride back to his friends house where he has been sleeping on the couch. He has tried Suboxone through a doctors office in the past but was not able to stop using. He works construction but has only been able to work small jobs intermittently due to use and chronic back pain.

Considerations:
- level of care
- bed availability
- payment options
- admission authentization considerations
- long term planning for sober housing
Case Example
Amanda is a 29-year-old woman who presents to the health center to initiate prenatal care. During the visit Amanda reveals that she has been actively using heroin for over a year with daily use and most recent use of this morning. She expresses concern for her pregnancy and states that she wants to stop but does not know how. She reports that she knows that she must and wants to know how to do that. She has a great deal of questions regarding her pregnancy and the effects on her unborn child. She reports that the father of the child is actively using and that she lives with him and believes that he will not support her in sobriety.

Considerations:
- Level of care
- Bed availability
- Payment options
- Admission authorization considerations
- Long term planning for sober housing

Case Example
Donna is a 56-year-old female admitted to rehab after suffering a fractured hip upon fall at home. Donna reports that she has been in long term sustained recovery from opioids using MAT through a local provider. She is on methadone and wants to continue with her current treatment protocol. Her provider requires attendance at counseling appointments to receive her medication.

Considerations:
- Funding capacity
- Barriers to access while in a rehab
- Potential solutions
- Current legislation and regulations impacting care

Case Example
Michael is a 65-year-old male admitted to a general medical surgical floor for cellulitis. Upon assessment nurse notes mild shaking and irritability. During screening patient reports drinking 4-5 mixed drinks per day for the past 15 years “with dinner”. Patient denies that it is a problem but reports on screening that he has had family and friends indicate that it is a problem and that it has interfered in his job performance at least 3 times in the last 6 months with resulting discipline. Patient is scheduled for discharge 24 hours after admission with good response to antibiotics.

Considerations:
- Assessment of history of complicated detox
- Level of discomfort
- Stage of readiness
- Appropriate levels of care
- Family and social supports
Case Example
James is a 28 year old Caucasian male who presented at the emergency room complaining of back pain. James does have a history of injury secondary to a car accident in 2006. James reported that the pain was recently exacerbated by shoveling. He states that Motrin is not helping and that he has taken nothing else. Upon interview, the nurse noted that James gave some inconsistent answers to questions and seemed somewhat disoriented. Upon checking the PMP it was noted that James had received 51 different prescriptions of pain medications from 50 different doctors over the last year.

Considerations:
• readiness for treatment
• acute risk
• social determinants of health including housing availability, food availability, family and social support system.
• level of care options

Case Example
Julia is a 17 year old Hispanic female whose mother brought her into the ER after noticing her behavior seemed off, and she was difficult to awaken. She tested her with a home kit and tested positive for opiates and marijuana. Julia reports she drinks and parties with her friends occasionally but “its not a big deal”. She has been missing school and work, and items have gone missing from the house. Recently her mother found a needle in her room that Julia said was a friends.

Considerations:
• current use
• readiness for treatment
• acute risk
• level of care options
• current environment

Impact of substance use across settings
• Can be difficult to assess in brief, discreet assessment periods
• Complicates admission and discharge planning
• MAT, while effective tools can create regulatory barriers to continuing in certain settings and for discharge and step down care
• Particularly challenging with several stakeholders like residential program, and MAT/OTP provider
• Opiate Treatment Programs are one the most highly regulated settings of care: adding extra steps and layers to the transfer process (i.e. OTP “home” clinic needs to transfer care)
Impact of substance use across settings

- Insurance coverage issues
  - Most services covered by Medicaid
  - Many are not covered by Medicare
  - Commercial coverage will vary and require potentially high copays/co-insurance and/or prior authorization barriers
  - Uninsured can access many programs with funding in part form the Department of Public Health
  - For non methadone MAT- may be high copays for medication and no coverage for uninsured

- Chapter 258 in Massachusetts- Effective 10/1/15
  - Requires all payers to cover cost of ATS without authorization and up to 14 days combined detox and step down care (CSS or other residential)
  - Plans cannot require prior auth for substance use disorder services including early intervention services, outpatient services, residential and inpatient services

Current trends

- Novel psychoactive drugs mimic the effects of common substances
  - Opioids- fentanyl, carfentanyl
  - Stimulants
  - Hallucinogens- mephedrone, 3-MMC, MDPV, bath salts
  - Cannabinoids- K2/spice, drd-oil
  - Dissociatives
  - Negative effects range from psychosis, anxiety, agitation to increased heart rate and cardiac problems and seizures
  - Long term impact still unknown, addiction, withdrawal and prolonged psychosis
  - Beginning to see methamphetamine in parts of Massachusetts, may not require detox but can access residential treatment or CSS
  - Recent increase in cocaine laced with fentanyl! (not just opiate users at risk)

- Current trends
  - Synthetic drugs are increasingly available online and on the street.
  - Often inexpensive, accessible and attractive
  - New substances are being developed and disseminated constantly, making it difficult to track use and the impact and wide variation of effects.
  - Several different marketing names so that both the user and treating providers may not know what the user is consuming. Contamination is possible and high risk.
  - Traffickers manufacturing fentanyl purchase the key ingredient from China, which is unregulated and are cheaper and easier to distribute resulting in higher profits
  - May not appear on a drug screen
Further Learning
For further learning on this topic please review: Case Management Society of America- Opioid Use Disorder Case Management Guide 2018

For additional live training in Motivational Interviewing
Spectrum Health Systems Education, Training and Consultation - contact Romas Buivydas, PhD, LMHC romas.Buivydas@spectrumhealthsystems.org

CMSA online training: http://www.cmsa.org/mi-learning/

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/IAT/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

Overview of Programs & Services
- 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 abuse & mental health)

Overview of Programs & Services
- Outpatient Locations
  - Framingham
  - Haverhill
  - Leominster
  - Milford
  - Milbury
  - North Adams
  - Pittsfield
  - Saugus
  - Southbridge
  - Walpole
  - Weymouth
  - Worcester Lincoln
  - St.
  - Worcester Merrick
  - St.

Overview of Programs & Services
- Spectrum’s Continuum of Care
- Outpatient Locations
  - Framingham
  - Haverhill
  - Leominster
  - Milford
  - Milbury
  - North Adams
  - Pittsfield
  - Saugus
  - Southbridge
  - Walpole
  - Weymouth
  - Worcester Lincoln
  - St.
  - Worcester Merrick
  - St.