

# Substance Use Disorders (SUD) and Addictions among Older Adults in Health Centers

Learning Collaborative (LC) 4: Treatment & Referral  
Part 2



# National Center for Equitable Care for Elders (NCECE)

[www.ece.hsdm.harvard.edu](http://www.ece.hsdm.harvard.edu)

**Who We Are-** Established in 2017, the National Center for Equitable Care for Elders (NCECE) is a training and technical assistance Center that provides innovative and culturally competent models of care, inter-professional training and educational resources to health care professionals providing care to older adults

**Our Mission** is to build strong, innovative and competent health care models by partnering with CHCs, PCAs and FQHCs to provide quality, and inclusive care for older adults



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# Health Center Resources Clearinghouse

- This comprehensive website provides easy access to a broad framework of resources, tools, and information developed by the National Cooperative Agreement (NCA) organizations, and additional partners soon! Check it out at [www.healthcenterinfo.org](http://www.healthcenterinfo.org).



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# Approach to Management of Substance Use Disorder

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Harvard Dental School  
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# Disclosures

- None!



# Objectives

- Review basic facts and definitions around addiction and team-based care
- Discuss alcohol use disorder and list management strategies
- Discuss opioid use disorder and list management strategies



## Addiction is a *disease*, not a moral failing

Substance use disorder is defined as a problematic pattern of substance use leading to clinically significant impairment or distress manifested by clinical criteria (DSM-V).

- Individuals with SUD continue to seek substances, despite harm
- Cravings
- They cannot stop



**Reducing Stigma** – approximately one in 10 people with SUD receive treatment, and stigma is most often the primary reason why people do not access treatment.  
*Our language matters.*



## What we say and how we say it makes a difference to our patients with substance use disorder.



### NON-STIGMATIZING LANGUAGE

- Person with a substance use disorder

- Substance use disorder or addiction
- Use, misuse
- Risky, unhealthy, or heavy use

- Person in recovery
- Abstinent
- Not drinking or taking drugs

- Treatment or medication for addiction
- Medication for Addiction Treatment
- Positive, negative (toxicology screen results)



### STIGMATIZING LANGUAGE

- Substance abuser or drug abuser
- Alcoholic
- Addict
- User
- Abuser
- Drunk
- Junkie

- Drug habit
- Abuse
- Problem

- Clean

- Substitution or replacement therapy
- Medication-Assisted Treatment
- Clean, dirty



## SUS at NWH – Team-based Care Model for Treating Addiction

- Ambulatory care: our mission is provide the best, evidence-based support for our patients with a goal of transitioning to long-term care – in partnership with primary care and community organizations
- Recurrent substance use ≠ Treatment Failure – many recovery pathways
- Like any complex disease such as diabetes or heart failure, SUD treatment requires an ongoing multidisciplinary approach:
  - Lifestyle modification
  - Behavioral and mental health support
  - Medication management
  - Peer/group support
  - Community engagement



## Case 1: patient BV with AUD

- AUD Hx:
  - First drink at 21 and heavier drinking started in her 30's, functional alcoholic was able to maintain her job in sales. Reported anxiety and self medication. Married at 37 no kids, switched job to real estate then school aid both allowed increased free time in afternoon would drink before her husband got home, hide bottles.
  - Concern escalated husband, family, pcp. Medical issues, weight gain, jaundice, increased LFTs.
  - DWI and "fender benders", pulled over 10 AM 2 flat tires.
  - Multiple programs and AA relapse shortly after each. Failed Naltrexone (nausea/fatigue), Disulfuram (non compliant).
- PMH-anxiety
- Social- Married no children, not currently employed



## BV referred by her PCP to SUS

- Started on acamprosate (Campral)
- Seen frequently by all team members
- Started SMART recovery groups
- 1 set back and used alcohol since SUS initiation
- Introduced to Boston Bulldogs full circle recovery program



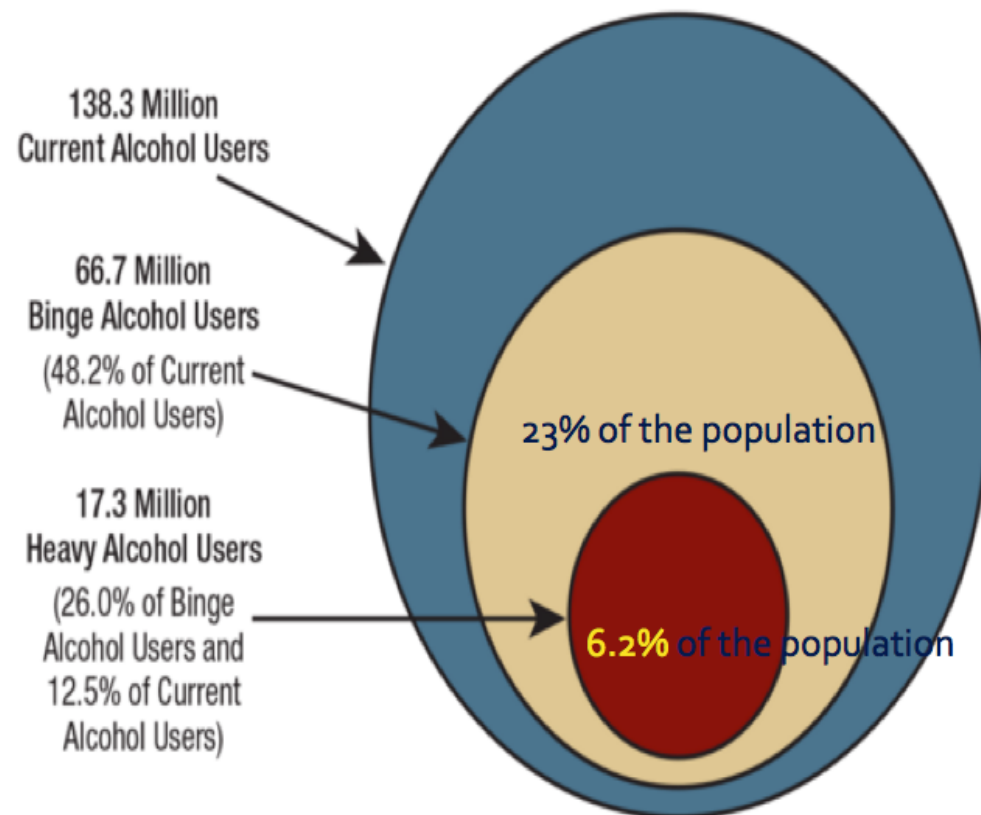
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# Alcohol Use Disorder (AUD)



## Prevalence of Alcohol Use Disorder

- Estimated 14-18 million alcohol-abusing or alcohol-dependent individuals in United States
- 20 % of the drinking population drinks 80% of the alcohol sold (NIAAA)
- In 2012 about 3.3 millions deaths, or 5.9 % of a global deaths, were attributable to alcohol consumption
- Prevalence similar to other chronic diseases such as asthma, diabetes, and depression
- 88,000 deaths per year in United States
- Causes many other health problems either directly or indirectly



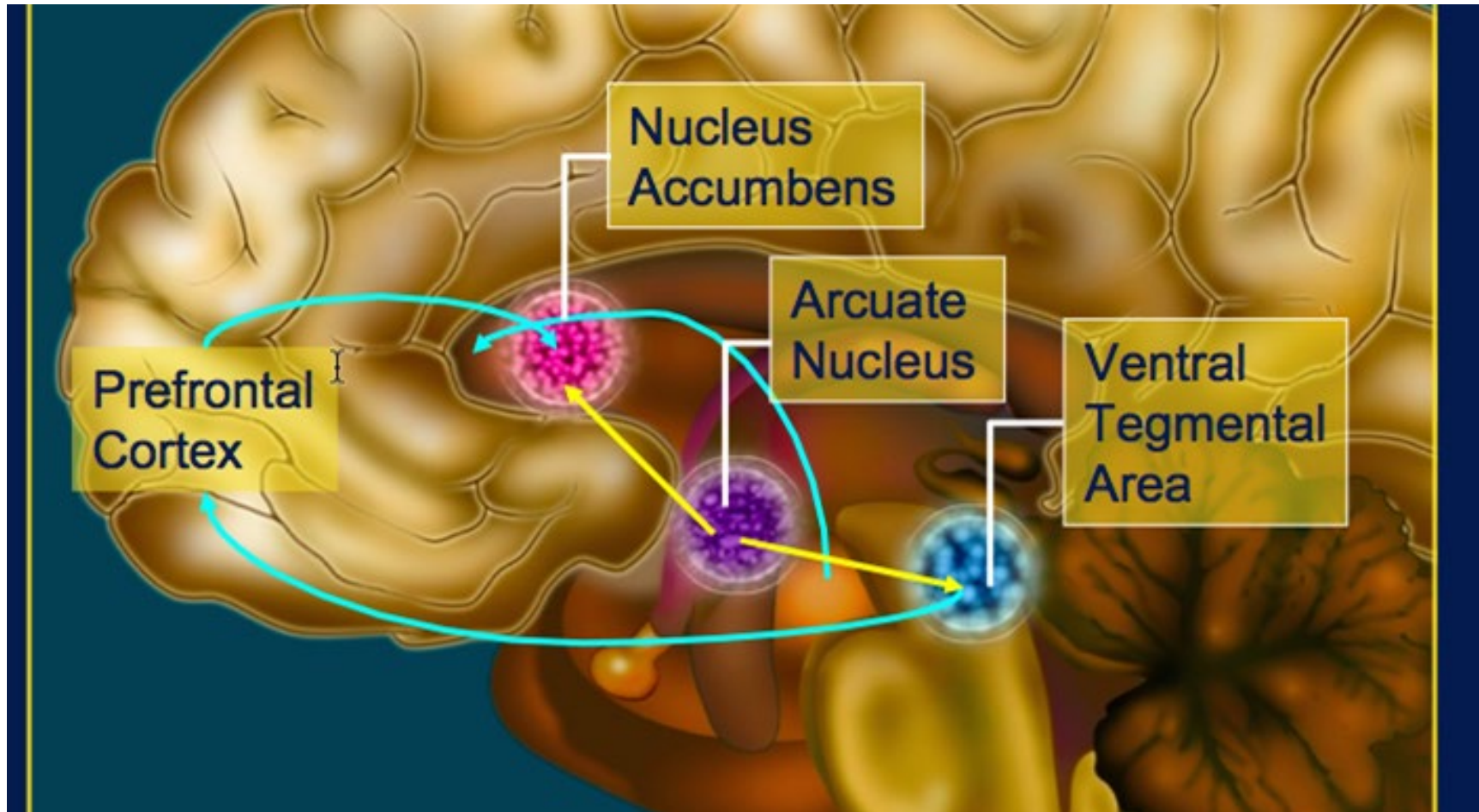


# When to Consider Pharmacotherapy for AUD

- Anti-craving medication → *standard of care* → Efficacy requires clinical continuity
- FDA-approved medications include:
  - Naltrexone (Revia 1994) / Long acting Naltrexone IM (Vivitrol 2006)
  - Acamprosate (Campral 2004)
  - Disulfiram (Antabuse 1949 )
- Off-label medications for AUD include:
  - Valproate
  - Topiramate
  - Gabapentin
  - Baclofen



## Alcohol Use Disorder is a Disease





## Acamprosate for AUD

- MOA: Stabilizes and re-balances inhibitory (GABA) and excitatory (Glutamate) and NMDA systems disrupted with chronic ETOH exposure
- Effects: Anticraving, reduced negative reinforcement (abstinence craving)
- Reduced protracted withdrawal: irritability, mood/anxiety, sleep dysregulation
- Renal metabolism; contraindicated if Crcl <30 or pregnant. Rec for those on opioids, liver disease, polypharmacy (no drug interactions).
- Effective in improving abstinence: 20 vs 10% abstinence rates 1yr out

(Kranzler and Gage 2008)



## Naltrexone PO

- MOA: Reduces positive reinforcement (reward craving); inhibitor at mu opioid receptor; modulates mesolimbic DA system in VTA and projections to NA
- Result: less euphorogenic/reinforcing effect of alcohol, suppressing endogenous opioids (beta endorphins) involved in reinforcing pleasurable effects of alcohol and possibly craving
- Liver metabolism: monitor LFTS
- Prevents a slip → prolonged relapse heavy drinking as seen in meta analysis 36% relapse rate to heavy drinking Srisurapanont M Cochrane Database 2005
- Combination of Naltrexone/counseling best results Anton et al "Project Combine" JAMA 2006
- IM vs PO Naltrexone



## Behavioral Strategies for BV

- **Motivational Interviewing (MI)**: Patient-centered counseling elicits behavior change by resolving ambivalence
- **Cognitive Behavioral Therapy (CBT)**: Identify risk, develop coping skills and new lifestyle behaviors builds sense of self efficacy
- **Community Reinforcement Approach (CRA)**: operant conditioning for SUD learned behavior
- **Contingency Management (CM)**: operant conditioning, contingencies/therapeutic purpose
- **Dialectical Behavior Therapy (DBT)**: behavioral treatment utilizing validation and motivational enhancement
- **Community Reinforcement & Family Training (CRAFT) and Behavioral Marital Therapy (BMT)**



# Community Engagement: What is SMART Recovery?

- *Self-Management and Recovery Training*
- On-line and in-person group support program that incorporates tools based on evidence-based addiction treatments, including Cognitive Behavioral Therapy and Motivational Interviewing
- 4-Point Program



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# Boston Bulldogs Running Club





# What is a Recovery Coach?

- Peer-to-peer positive support for individuals with SUD
- Has lived experience with AUD/SUD and is in recovery
- Is a partnership model
- Supports successful change
- Helps participant find resources (ex: detox, harm reduction, family support, 12-step/online meetings)
- Is open to all pathways to recovery
- Supports positive changes
- Helps avoid setbacks
- Helps with decision making
- Identifies recovery and life goals with participant (ex: education, work, relationships)



## A Recovery Coach is *not*:

- Clinical
- Primary treatment for AUD/SUD
- Diagnosing participants
- Addressing a participants past
- Working on trauma
- Addressing and/or treating mental health
- Sponsor
- Friend



## Options for Addiction Treatment?

- *Detox or Acute Treatment Services (ATS)*
  - stopping a substance + withdrawal management
  - average length of stay is 4-7 days - followed by:
- *Clinical Stabilization Services (CSS) Transitional Support Services (TSS)*
  - short-term residential for further stabilization – 24 hour support
  - average length of stay is 14-21 days
- *Dual Diagnosis Inpatient Programs*
  - addresses mental health & AUD/SUD
- *Intensive Outpatient Programs (IOP)*
  - Average length is 2-5 days per week & 2-8 hours per day
- *Medication Assisted Treatment (MAT)/Outpatient consultations*

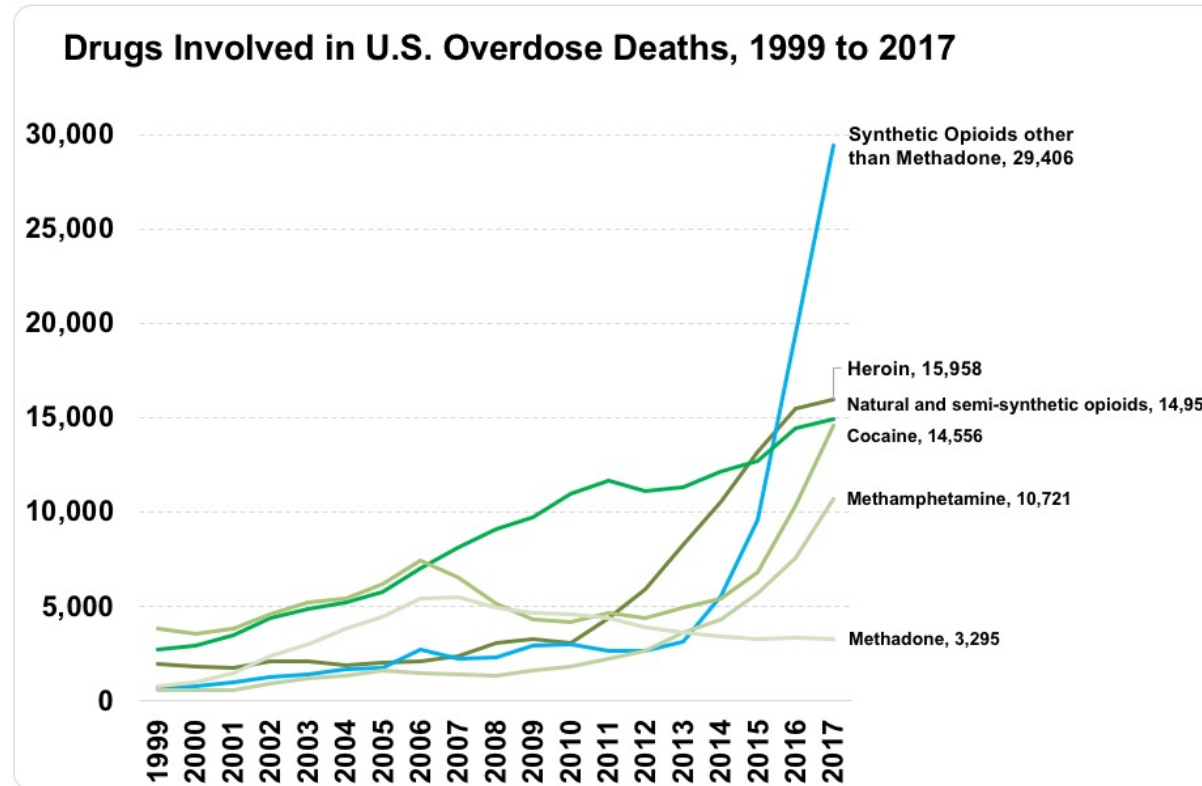


## Case 3: Bill

- Presented to ED June 4<sup>th</sup> with head injury and tongue laceration 48 hours after MVA related to opioid use
- 15+ year history polysubstance use (alcohol, intranasal heroin/fentanyl, cocaine)
- 2 opioid overdoses in 2018
- Lost his job as athletic director when overdosed at work in February
- First Naltrexone IM (Vivitrol) through MGH West End Clinic in April but did not return for the next injection, cravings after day 21 and relapsed
- Seen by SUS PA and RC in ED June 4th, requesting IM Naltrexone



# Opioid Use Disorder (OUD)





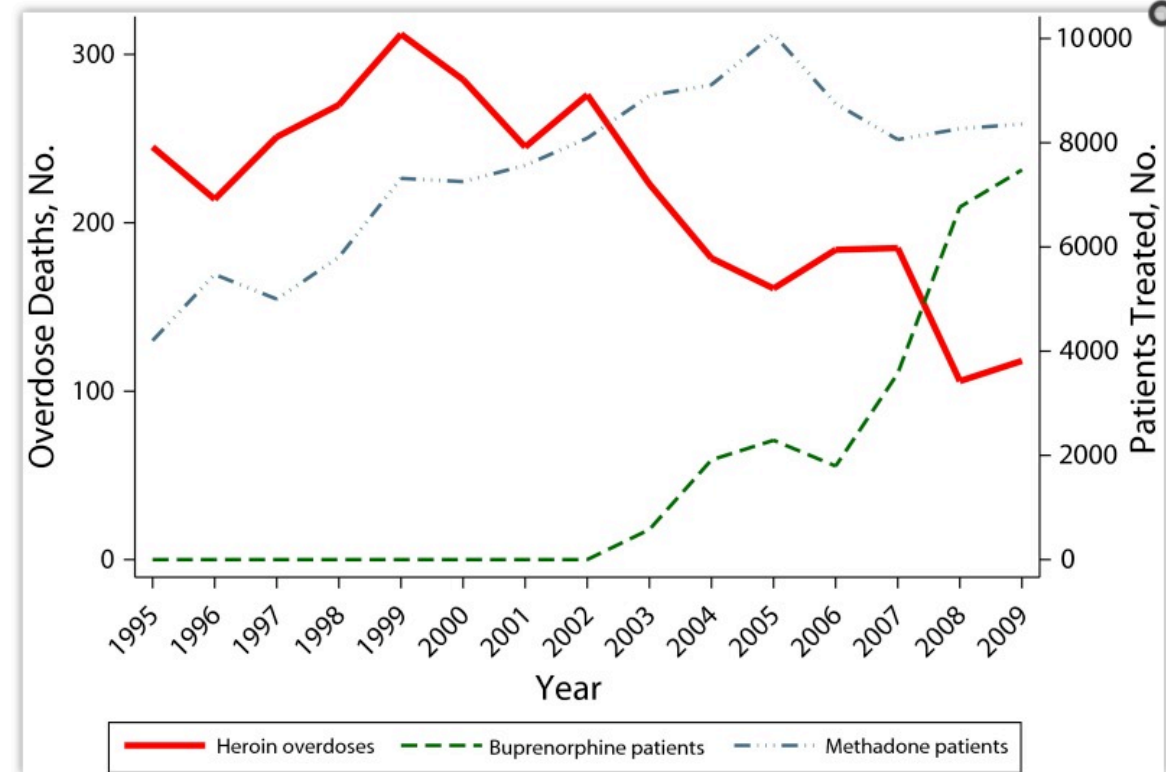
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# Medication Management for Opioid Use Disorder (OUD)



# “Detox” alone versus Medication Management

- Traditional “detoxification” or abstinence-based programs *alone* are ineffective and require active treatment after withdrawal management
- Medication management = treatment ≠ “replacement”



**Heroin overdose deaths and opioid agonist treatment: Baltimore, MD, 1995–2009.**

Schwartz RP *et al.* Opioid Agonist Treatments and Heroin Overdose Deaths in Baltimore, Maryland 1995-2009. *Am J Public Health* 2013; 103(5):917-922.

- Wakeman SE, Barnett ML. Primary Care and the Opioid-Overdose Crisis – Buprenorphine Myths and Realities. *NEJM* 2018; 379(1):1-4.  
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- Nielsen S, Larance B, Degenhardt L, Gowing L, Kehler C, Lintzeris N. Opioid agonist treatment for pharmaceutical opioid dependent people. *Cochrane Database Syst Rev.* 2016:CD011117.  
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	Methadone	Buprenorphine	Naltrexone
<b>Mu-opioid receptor activity</b>	Full agonist	Partial agonist	Full antagonist
<b>FDA-Approved Formulations</b>	Oral solution, dissolvable tablet	Transmucosal buprenorphine/naloxone (Suboxone, Bunavail, Zubsolv) Injectable buprenorphine (Probuphine, Sublocade)	Oral tablets, Extended-release IM injection (Vivitrol)
<b>Dosing</b>	Oral: 20-30 mg once daily; titrated up to 80-120 mg once daily as tolerated  <i>Caution with QTc prolongation, may increase LFTs; caution with overdose risk</i>	Transmucosal: 8-16 mg (or equivalent) once daily (or in divided doses) Probuphine (for patients maintained on $\leq 8$ mg/day): 1 dose (4 implants) for 6 months Sublocade (for patients maintained on $\leq 8$ mg/day): 300 mg subcutaneous injection monthly for 2 doses then 100 mg monthly	Oral: 25 mg on day 1 then 50 mg daily Vivitrol: 380 mg IM every 4 weeks
<b>Setting</b>	Licensed outpatient treatment program	Any medical setting; X waiver required	Any medical setting
<b>Additional benefits</b>	Use in co-morbid pain, high potency, high structure of delivery setting	Safety compared to methadone, use in co-morbid pain, dosing flexibility, less structured treatment setting; displaces opioid $\rightarrow$ precipitated withdrawal	Low diversion, not an opioid, compliance, no physical dependence, verifiable dosing, less stigma, less structured treatment setting



## Injectable extended-release naltrexone for opioid dependence: a double-blind, placebo-controlled, multicentre randomised trial

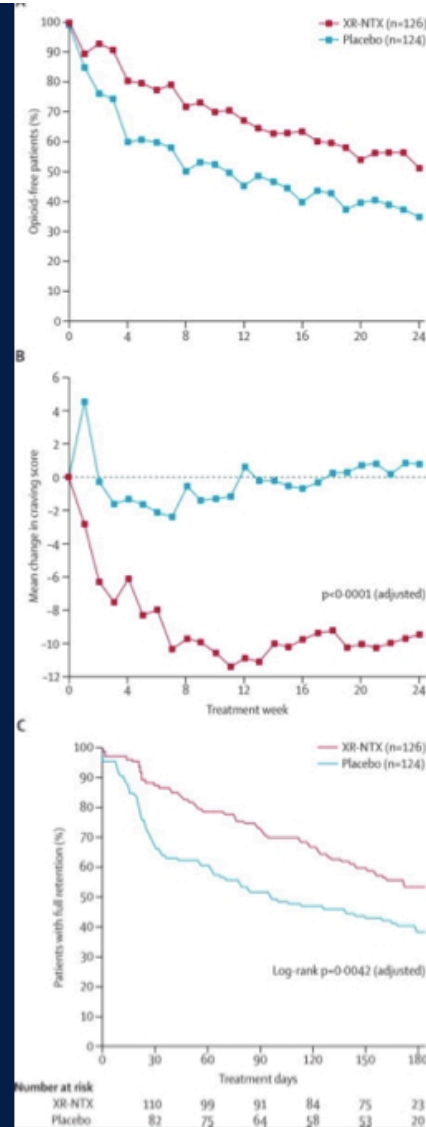
*Evgeny Krupitsky, Edward V Nunes, Walter Ling, Ari Illigeruma, David R Gastfriend, Bernard L Silverman*

### Summary

**Background** Opioid dependence is associated with low rates of treatment-seeking, poor adherence to treatment, frequent relapse, and major societal consequences. We aimed to assess the efficacy, safety, and patient-reported outcomes of an injectable, once monthly extended-release formulation of the opioid antagonist naltrexone (XR-NTX) for treatment of patients with opioid dependence after detoxification.

**Methods** We did a double-blind, placebo-controlled, randomised, 24-week trial of patients with opioid dependence disorder. Patients aged 18 years or over who had 30 days or less of inpatient detoxification and 7 days or more off all opioids were enrolled at 13 clinical sites in Russia. We randomly assigned patients (1:1) to either 380 mg XR-NTX or placebo by an interactive voice response system, stratified by site and gender in a centralised, permuted-block method. Participants also received 12 biweekly counselling sessions. Participants, investigators, staff, and the sponsor were masked to treatment allocation. The primary endpoint was the response profile for confirmed abstinence during weeks 5–24, assessed by urine drug tests and self report of non-use. Secondary endpoints were self-reported opioid-free days, opioid craving scores, number of days of retention, and relapse to physiological opioid dependence. Analyses were by intention to treat. This trial is registered at ClinicalTrials.gov, NCT00678418.

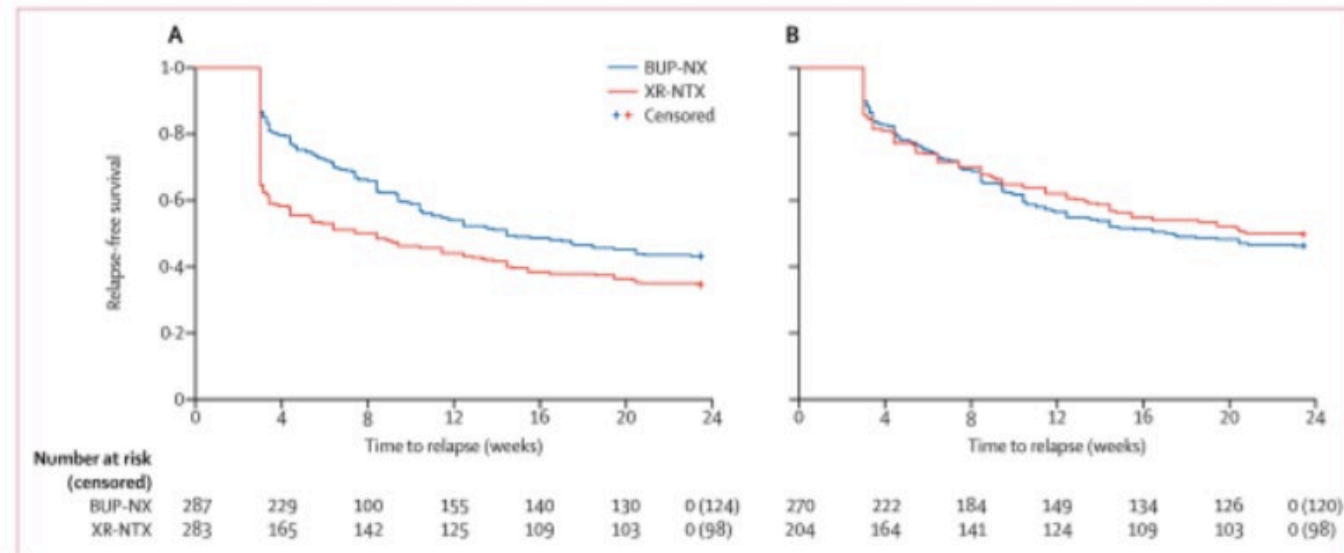
**Findings** Between July 3, 2008, and Oct 5, 2009, 250 patients were randomly assigned to XR-NTX (n=126) or placebo (n=124). The median proportion of weeks of confirmed abstinence was 90.0% (95% CI 69.9–92.4) in the XR-NTX group compared with 35.0% (11.4–63.8) in the placebo group (p=0.0002). Patients in the XR-NTX group self-reported a median of 99.2% (range 89.1–99.4) opioid-free days compared with 60.4% (46.2–94.0) for the placebo group (p=0.0004). The mean change in craving was -10.1 (95% CI -12.3 to -7.8) in the XR-NTX group compared with 0.7 (-3.1 to 4.4) in the placebo group (p<0.0001). Median retention was over 168 days in the XR-NTX group compared with 96 days (95% CI 63–165) in the placebo group (p=0.0042). Naloxone challenge confirmed relapse to physiological opioid dependence in 17 patients in the placebo group compared with one in the XR-NTX group (p<0.0001). XR-NTX was well tolerated. Two patients in each group discontinued owing to adverse events. No XR-NTX-treated patients died, overdosed, or discontinued owing to severe adverse events.





## Comparison study IM Naltrexone vs. Buprenorphine

- Comparative analysis of IM Naltrexone (XRT-NX) vs Suboxone (Bupe-NX) for opioid relapse prevention in a multicenter, open label, RCT.
- Compared large (570) Intention to treat study population in terms of opioid relapse free survival.
- Results: Higher relapse rate in XRT-NX (65%) vs Bupe-NX (57%).
- Note that early relapse 2/2 induction failure in XRT-NX responsible; once inducted relapse and overdose rate similar



Lee JD *et al.* Comparative effectiveness of extended-release naltrexone versus buprenorphine-naloxone for opioid relapse prevention (X:BOT): a multicentre, open-label, randomised controlled trial. *Lancet* 2018.



## Case 3: Bill

- Transferred from ED to St. Elizabeth's inpatient program
- On day 10 after last opioid use presented to SUS for IM naltrexone
- Engaged with St. Elizabeth's IOP



## To Consult SUS

- Call: 617-243-6062
- NWH, Blue 401, 2000 Washington Street, Newton
- Email: [abarreveld@partners.org](mailto:abarreveld@partners.org) or [carmstrong@partners.org](mailto:carmstrong@partners.org) for any consults or questions or to alert us regarding urgent referrals
- Outpatient Epic Referral: NWH Substance Use Services
- [www.nwh.org/sus](http://www.nwh.org/sus)

Ambulatory referral to NWH Substance Use Services

Class: Internal Ref. Internal Referral

Referral: Priority: [Red icon] [Search icon] Within 3 days (urgent) Within 2 weeks Within 1 month Elective

To provider: [Search icon] [Location icon] Provider Search

To prov spec: Internal Medicine [Search icon]

Patient Type: New Patient Re-Consult

Reason for Referral: OUD: Opioid Use Disorder AUD: Alcohol Use Disorder Other

Additional information helpful for referral: [Text area]



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Questions?