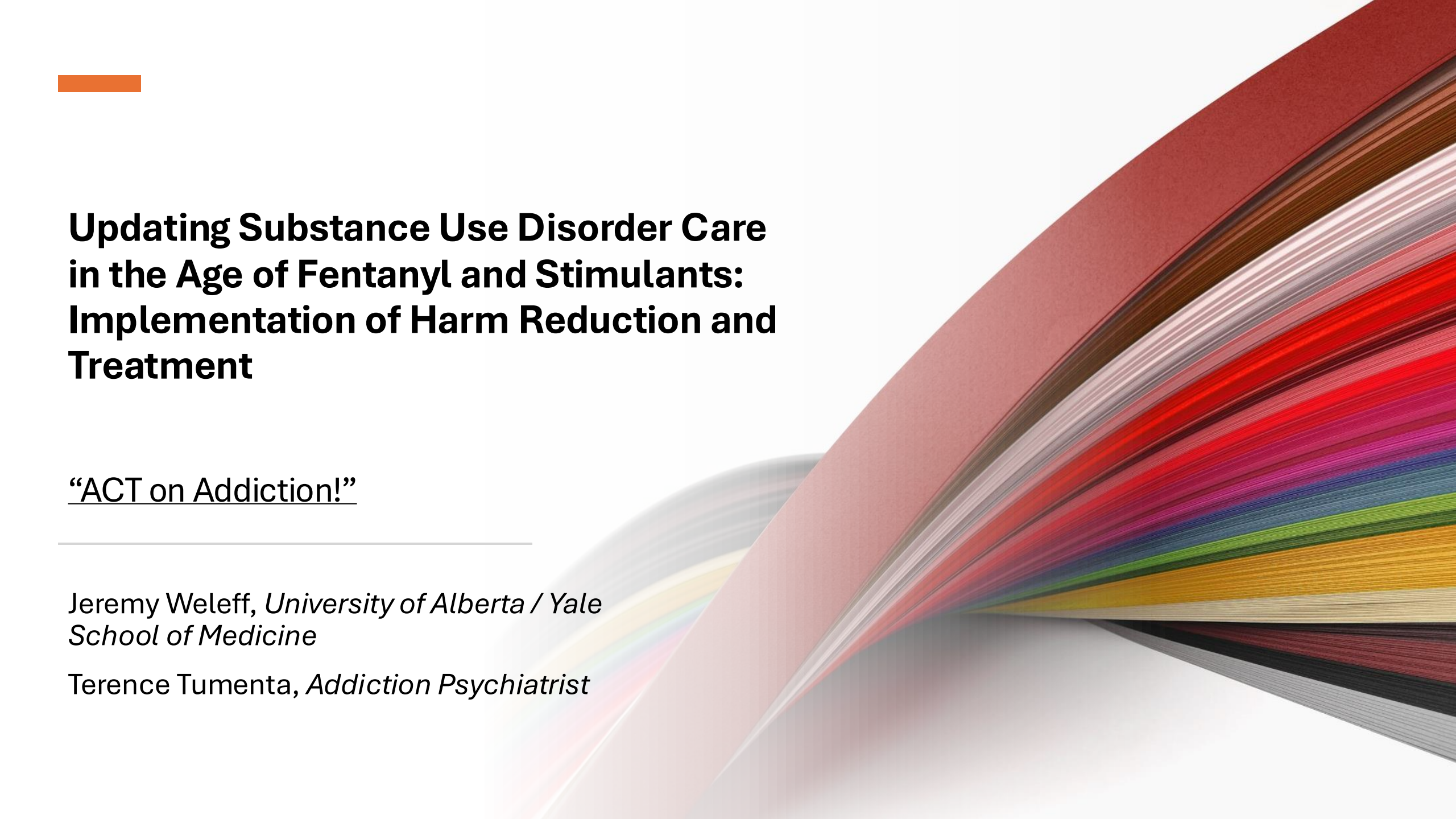
# Updating Substance Use Disorder Care in the Age of Fentanyl and Stimulants: Implementation of Harm Reduction and Treatment

"ACT on Addiction!"

Jeremy Weleff, *University of Alberta / Yale School of Medicine*

Terence Tumenta, *Addiction Psychiatrist*



# Hand in hand

# Psychiatry and Substance use disorders treatments are inseparable

- Substances impact the mind / brain
    - Substance-induced disorders and mood/trauma-induced substance use disorders
- Psychiatry “owns” these diagnoses in the DSM
- Co-treatment is imperative, standard of care, and therefore a minimum of “psychiatric care” *[high prev, better tmt outcomes, etc]*
- Suicide vs. Addiction-related overdoses *[blurry epidemiological data, treated very different by us]*

# Modern swing back towards institutionalization

- Across the USA From NYC → California

U.S. NEWS

## New California law aims to force people with mental illness or addiction to get help

SACRAMENTO, Calif. (AP) — More Californians with untreated mental illness and addiction issues could be detained against their will and forced into treatment under a new law signed by Gov. Gavin Newsom, a move to help overhaul the state's mental health system and address its growing homelessness crisis.

BY TRÂN NGUYỄN

Updated 10:21 AM MDT, October 10, 2023

# ACT History

## Alternative to Mental Hospital Treatment

I. Conceptual Model, Treatment Program, and Clinical Evaluation

Leonard I. Stein, MD, Mary Ann Test, PhD

- 1970s in Wisconsin ; post-deinstitutionalization ; offspring of social rehabilitation
  - **Community Integration and Support**
  - **Comprehensive and Person-Centered Care**
  - **Multidisciplinary and Collaborative Approach**

- **Recovery Oriented*** -- no real difference between SUD recovery and MH
- Responsible for the full care of the patient

# ACT Fidelity Metrics

- Fidelity important to prevent “generational / program drift”
- Structural component to have SUD-specialists on team + measure outcomes related to SUDs
- Philosophical alignment with addiction treatment / harm reduction as standard of care and recovery orientation
- Various forms of assessment tools through time… → TMACTS *(Tool for Measurement of ACT)*

Monroe-DeVita, M., Moser, L.L. & Teague, G.B. (2013). *The tool for measurement of assertive community treatment (TMACT).* In M. P. McGovern, G. J. McHugo, R. E. Drake, G. R. Bond, & M. R. Merrens. (Eds.), *Implementing evidence-based practices in behavioral health*. Center City, MN: Hazelden.

| Specialist Team (ST) Subscale | | | | | | |
|---|---|---|---|---|---|---|
| ST1 | CO-OCCURRING DISORDERS SPECIALIST ON TEAM: The team has at least one 1.0 FTE team member designated as a co-occurring disorders (COD) specialist who has at least a bachelor's degree and meets local standards for certification as a co-occurring specialist. Preferably this specialist has training or experience in integrated treatment for COD. | Less than 0.25 (actual or adjusted) FTE COD specialist with at least minimal qualifications OR criteria for a "2" rating met, except qualifications standards. | 0.25 - 0.49 (actual or adjusted) FTE COD specialist with at least minimal qualifications OR criteria for a "3" rating met, except qualifications standards. | 0.50 - 0.74 (actual or adjusted) FTE COD specialist with at least minimal qualifications OR criteria for a "4" rating met, except qualifications standards. | 0.75 - 0.99 (actual or adjusted) FTE COD specialist with at least minimal qualifications OR criteria for a "5" rating met, except qualifications standards. | At least 1.0 (actual or adjusted) FTE COD specialist with at least minimal qualifications. |

*^SUD specialist on team and their roles defined below (assessment, tracking, MI, modeling skills, cross-training, team meetings etc.)*

| ITEM | | RATINGS / ANCHORS | | | | |
|---|---|---|---|---|---|---|
| | | (1) | (2) | (3) | (4) | (5) |
| Specialist Team (ST) Subscale (cont.) | | | | | | |
| ST2 | ROLE OF CO-OCCURRING DISORDERS SPECIALIST IN TREATMENT: The co-occurring disorders (COD) specialist provides integrated treatment for COD to ACT clients who have a substance use problem. Core services include the following: (1) Conducting ongoing comprehensive substance use assessments that consider the relationship between substance use and mental health; (2) Assessing and tracking clients' stages of change readiness and stages of treatment; (3) Using outreach and motivational interviewing (MI) techniques; (4) Using cognitive behavioral approaches and relapse prevention; and (5) Applying treatment approaches consistent with clients' stage of change readiness. | The COD specialist provides 1 or fewer integrated treatment for co- occurring disorder services. | 2 integrated treatment for COD services are provided (3 are absent). | 3-4 integrated treatment for COD services are provided, (1 or 2 are absent) OR ALL 5 services are provided, with 3 or more services PARTIALLY provided. | ALL 5 integrated treatment for COD services are provided, but up to 2 services are only PARTIALLY provided. | ALL 5 integrated treatment for COD services are FULLY provided. |
| ST3 | ROLE OF CO-OCCURRING DISORDERS SPECIALIST WITHIN TEAM:The co-occurring disorders (COD) specialist is a key team member in the service planning for clients with COD. The COD specialist performs the following functions WITHIN THE TEAM: (1) Modeling skills and consultation; (2) Cross-training to other staff on the team to help them develop co-occurring disorder assessment and treatment skills; (3) Attending all daily team meetings; and (4) Attending the majority of treatment planning meetings for clients with COD. | The COD specialist does not perform any of the 4 functions within the team. | 1 function is performed within the team. | 2 functions are performed within the team. | 3 functions are performed within the team. | ALL 4 functions are performed within the team. |

| Evidence-Based Practices (EP) Subscale | | | | | | |
|---|---|---|---|---|---|---|
| EP1 | FULL RESPONSIBILITY FOR INTEGRATED TREATMENT FOR CO-OCCURRING DISORDERS: The team assumes responsibility for providing integrated treatment for co-occurring disorders (COD) services within the larger framework of integrated treatment for COD, where there is little need for clients to have to access such services outside of the team. Core services include systematic and integrated screening and assessment and interventions tailored to those in early stages of change readiness (e.g., outreach, motivational interviewing) and later stages of change readiness (e.g., CBT, relapse prevention). It is expected that the ACT COD specialist will assume the majority of responsibility for delivering integrated treatment for co-occurring disorders, but ideally other team members also provide some integrated treatment for co-occurring disorders services. Integrated treatment for co- occurring disorders reported here from the Excel spreadsheet should be reflected across other data sources (e.g., progress notes, treatment plans). | Less than 20% of clients in need of integrated treatment for COD are receiving them from the team. | 20 - 49% of clients in need of integrated treatment for COD are receiving them from the team. | 50 - 74% of clients in need of integrated treatment for COD are receiving them from the team. | 75 - 89% of clients in need of integrated treatment for COD are receiving them from the team. | 90% or more of clients in need of integrated treatment for COD are receiving them from the team. |

^*Full responsibility for Co-occurring disorders*

| | | | | | | |
|---|---|---|---|---|---|---|
| EP4 | INTEGRATED TREATMENT FOR CO-OCCURRING DISORDERS: The TEAM practices from a model aligning with integrated treatment for co-occurring disorders (COD) where the TEAM (1) considers interactions between mental illness and COD; (2) does not have absolute expectations of abstinence and supports harm reduction; (3) understands and applies stages of change readiness in treatment; (4) is skilled in motivational interviewing; and (5) follows cognitive-behavioral principles. | Criteria are not met. | Only 1 - 3 criteria are met. | 4 criteria met at least PARTIALLY (1 absent) OR 5 criteria met with 3 or more PARTIALLY met. | Team primarily operates from integrated treatment for COD, meeting all 5 criteria, with up to 2 PARTIALLY met. | Team is fully based in integrated treatment for COD principles, FULLY meeting all 5 criteria. |

^*Explicit about harm reduction philosophy*

# Despite these measures…

- Almost no research in the last 10 years on ACT-SUD issues ; surprising since we are about 10 years post-introduction of fentanyl in the drug supply and record levels of opioid-related deaths in USA

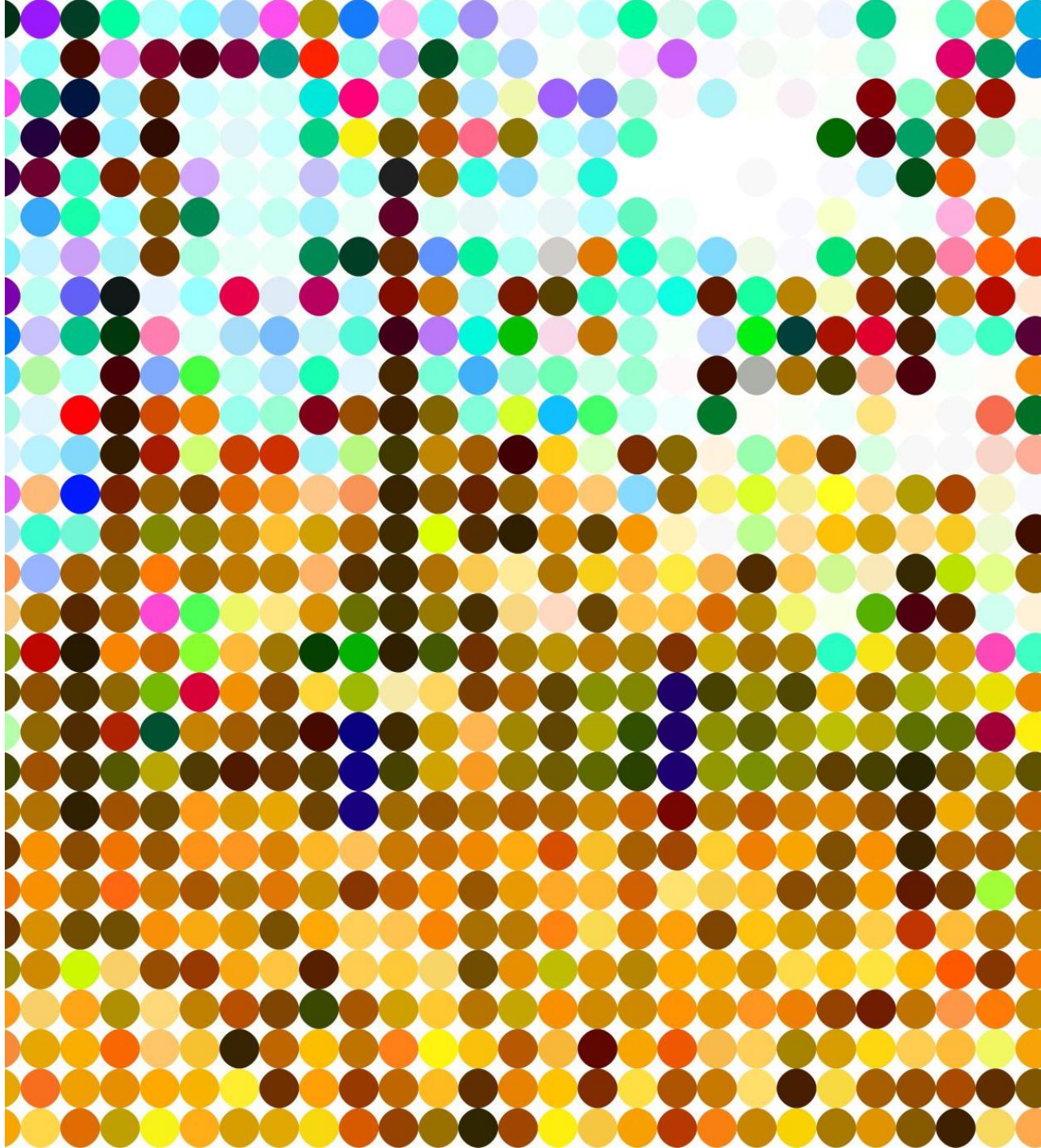
- Large attention to MH issues in the general medical/addiction setting

- **What do we do to improve SUD outcomes for our CMHC patients and how do we model this for teams?** *[feeling that something should be done.. but what?]*

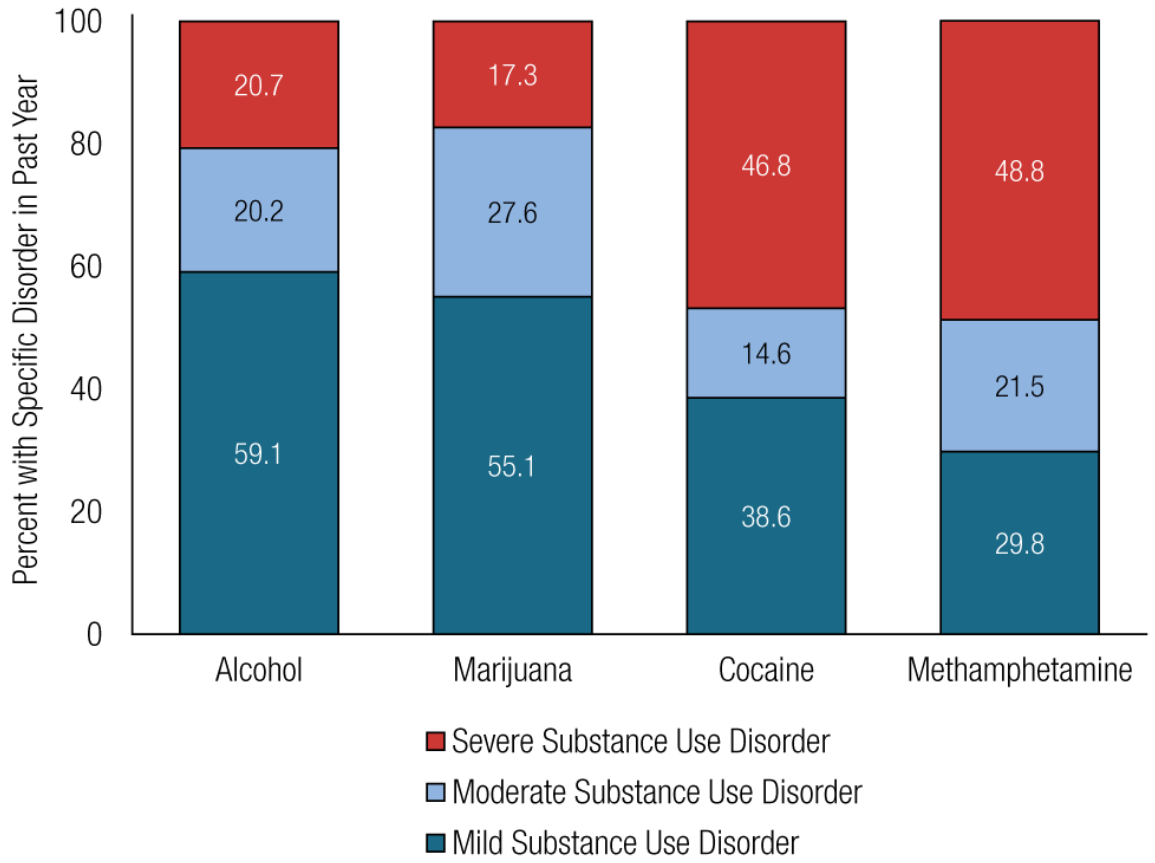
# Assertive Community Treatment and Co-Occurring Psychiatric Disorders

Terence Tumenta, MD; MPH

Addiction Psychiatrist



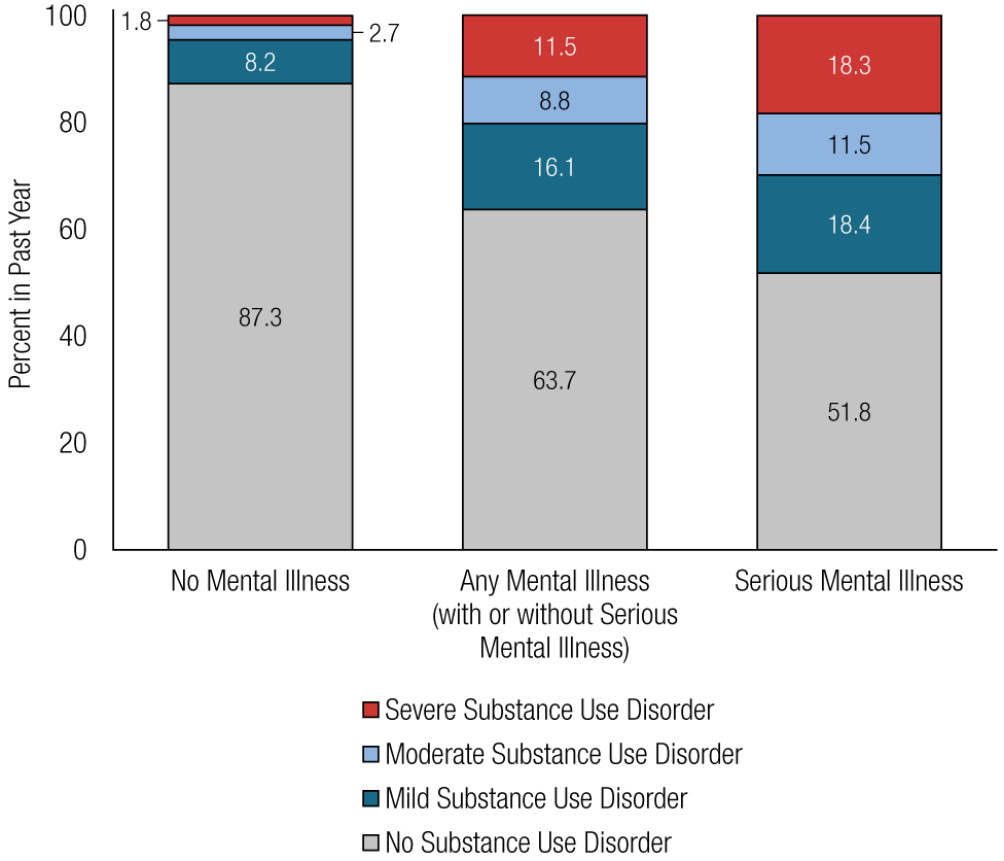
# Substance Use Disorder Severity Level for Specific Substances in the Past Year: Among People Aged 12 or Older with a Specific Substance Use Disorder; 2022




Note: The percentages may not add to 100 percent due to rounding.

Note: There are 11 criteria from the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition, that apply to these substances. People who meet two or three criteria are considered to have a "mild" disorder, those who meet four or five criteria are considered to have a "moderate" disorder, and those who meet six or more criteria are considered to have a "severe" disorder.

# Substance Use Disorder Severity Level in the Past Year: Among Adults Aged 18 or Older; by Past Year Mental Illness Status, 2022

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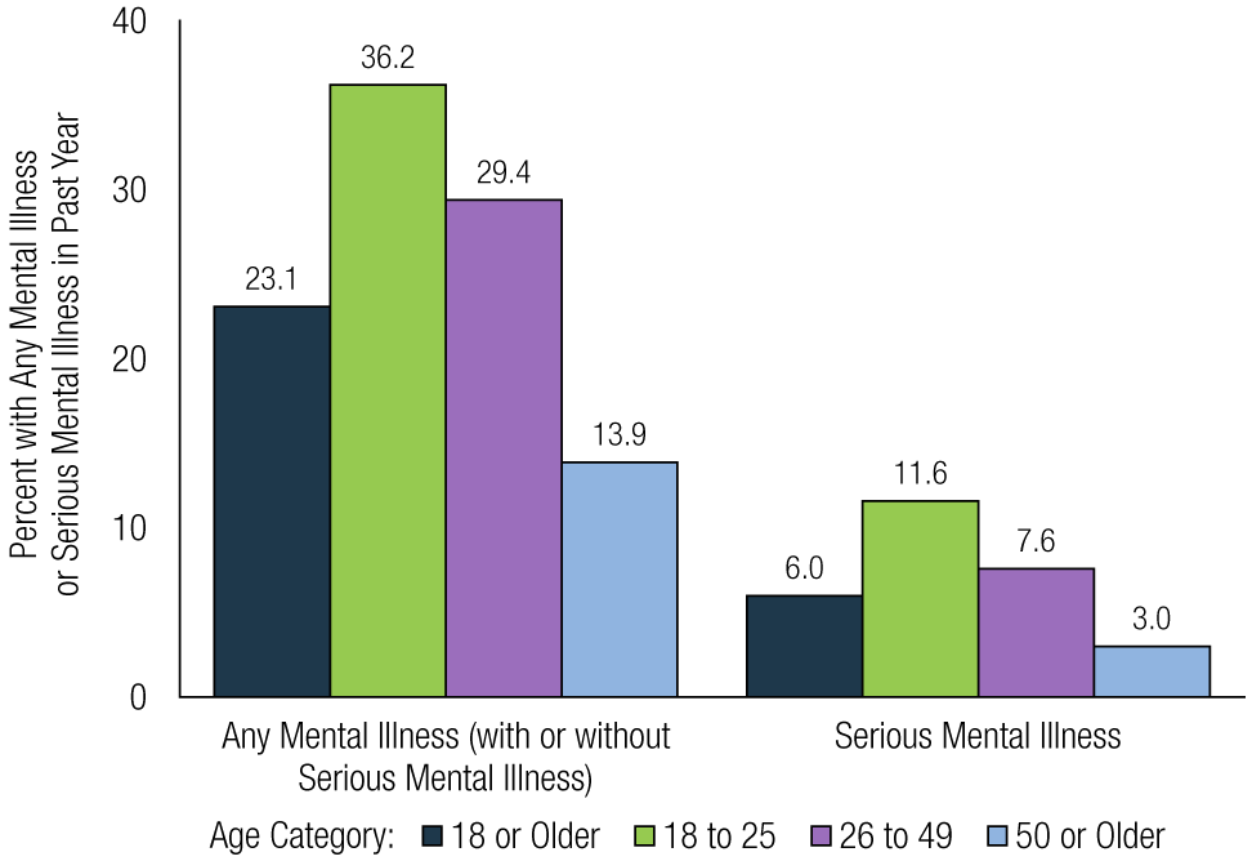
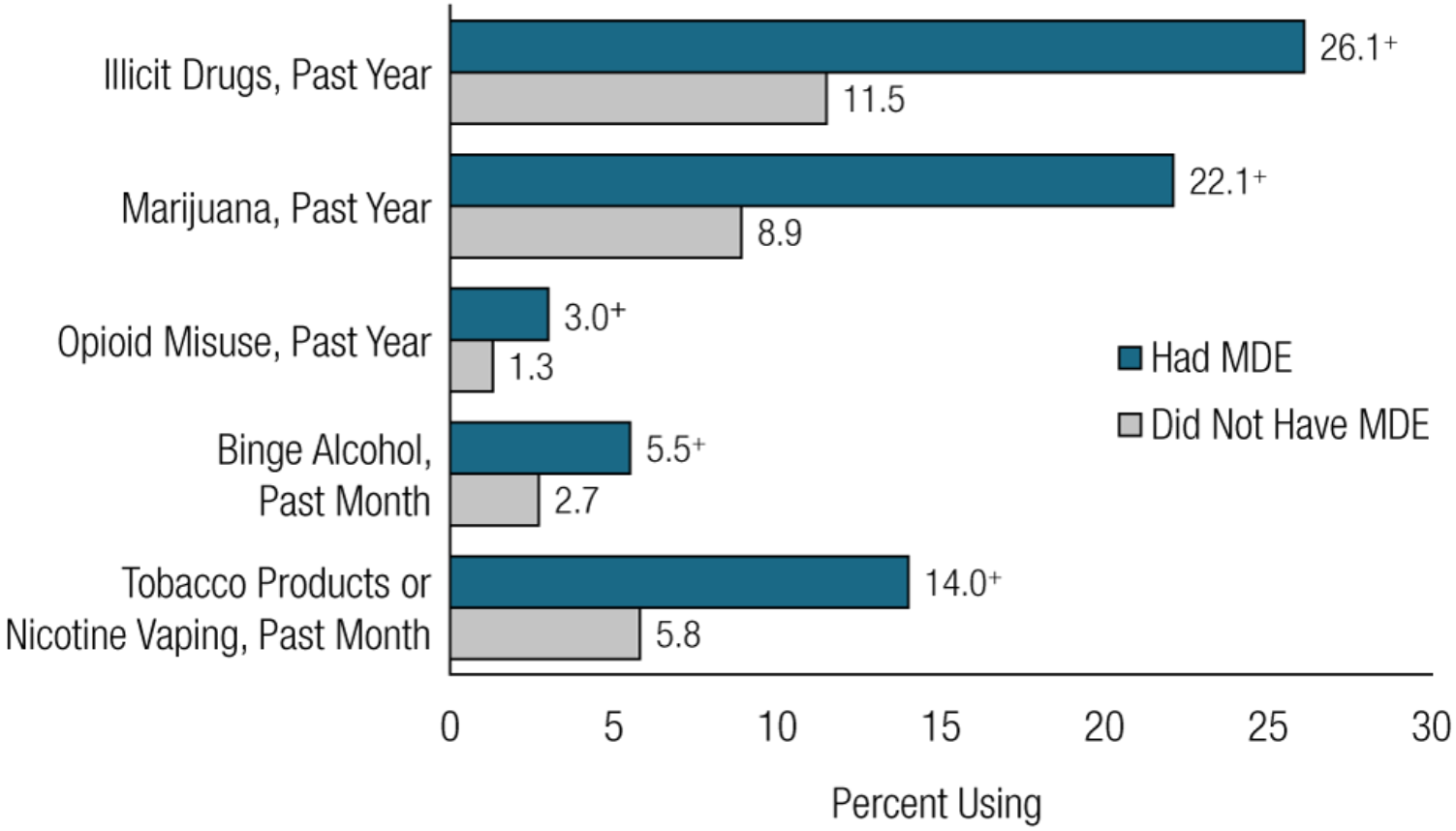
# Any Mental Illness or Serious Mental Illness in the Past Year: Among Adults Aged 18 or Older; 2022

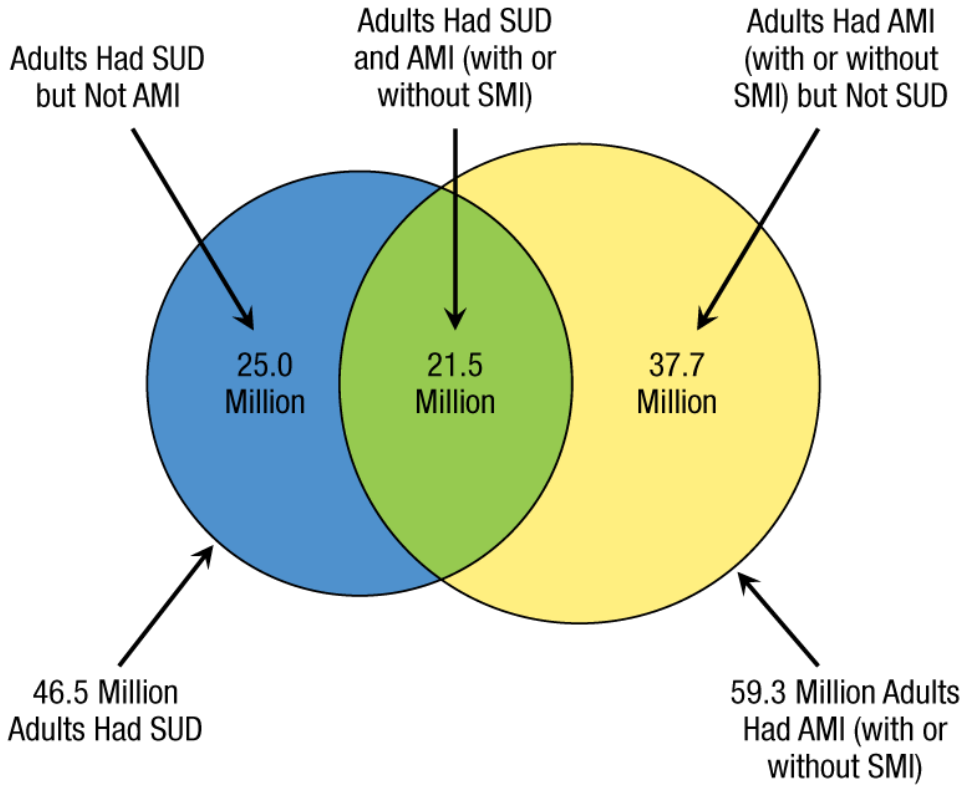


# Past Year or Past Month Substance Use: Among Adolescents Aged 12 to 17; by Past Year Major Depressive Episode (MDE) Status, 2022

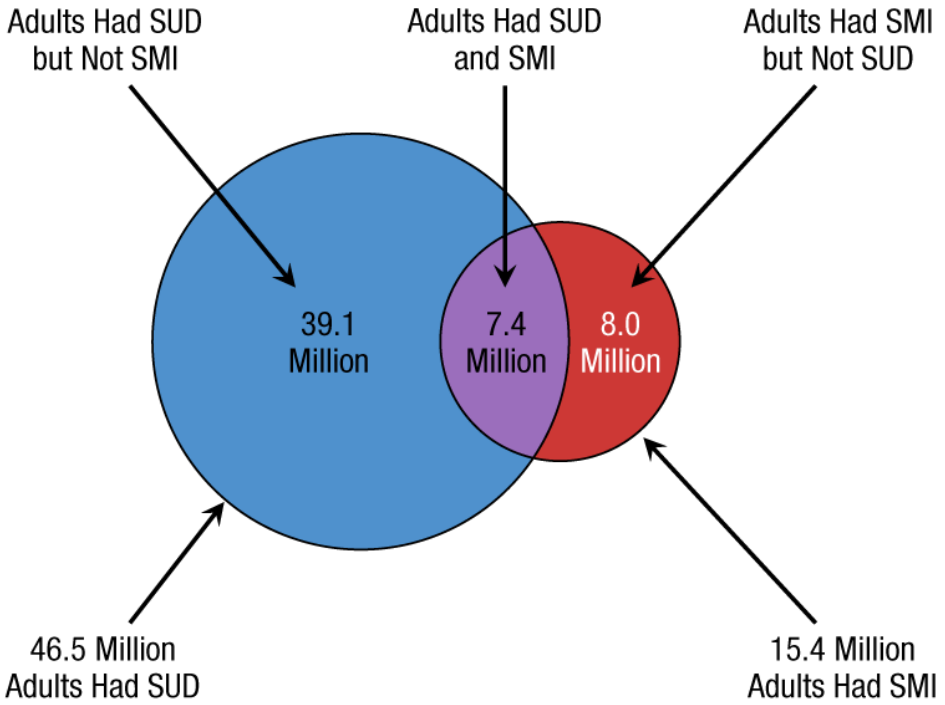



+ Difference between this estimate and the estimate for adolescents who did not have MDE is statistically significant at the .05 level.
Note: Adolescent respondents with unknown MDE data were excluded.

# Any Mental Illness (AMI), Serious Mental Illness (SMI), or Substance Use Disorder (SUD) in the Past Year: Among Adults Aged 18 or Older; 2022

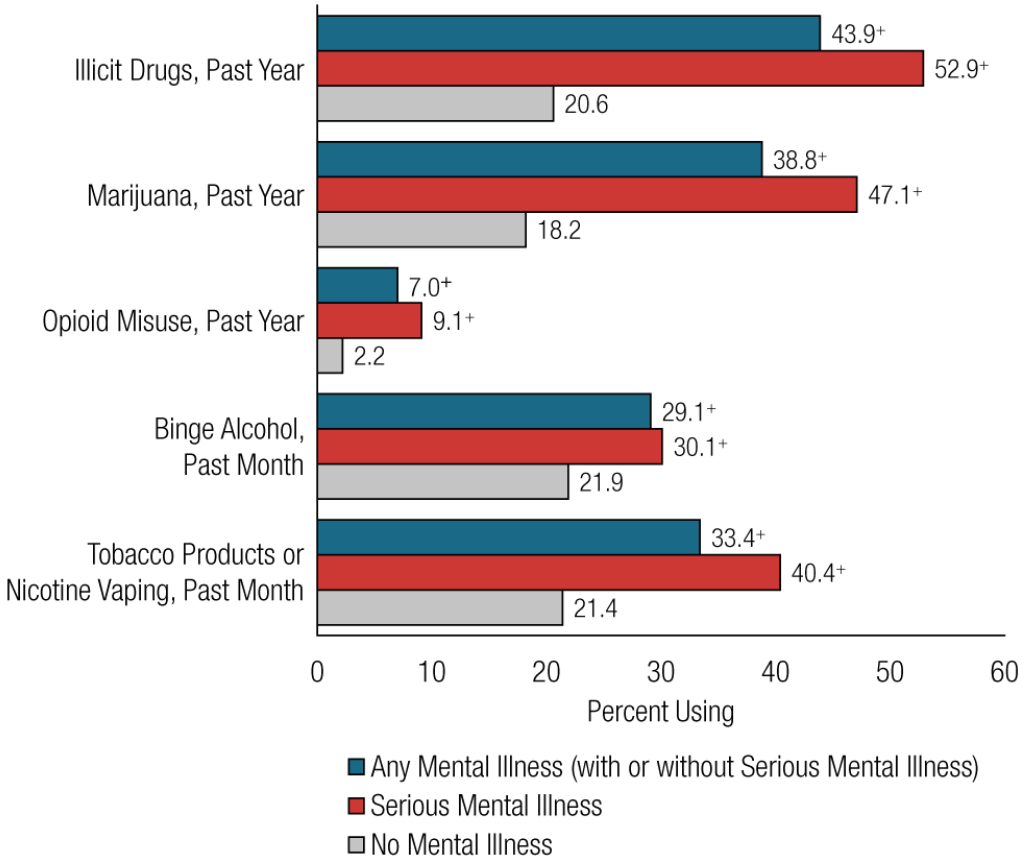



84.2 Million Adults Had Either SUD or AMI (with or without SMI)




54.4 Million Adults Had Either SUD or SMI

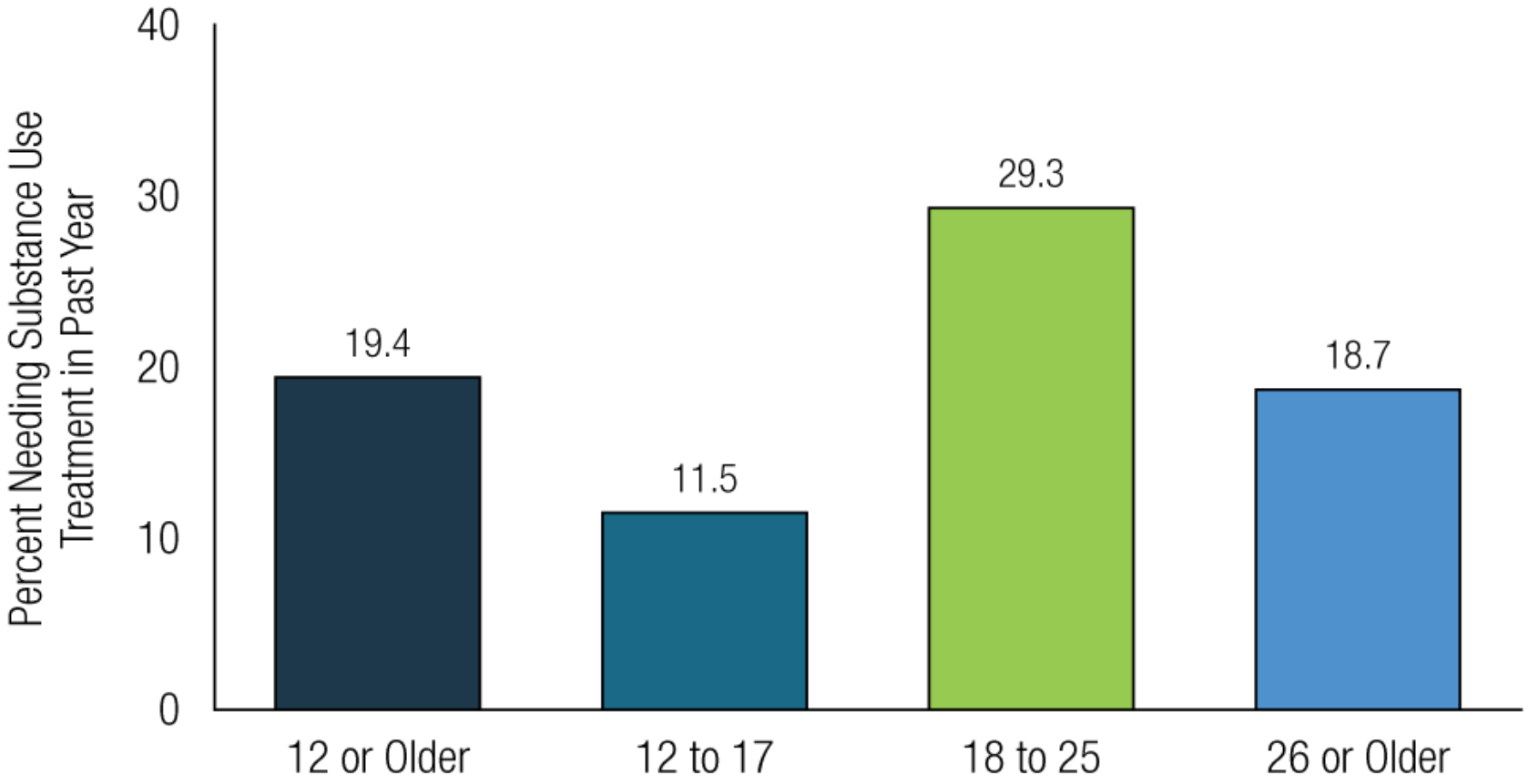
# Past Year or Past Month Substance Use: Among Adults Aged 18 or Older; by Past Year Mental Illness Status, 2022




+ Difference between this estimate and the estimate for adults aged 18 or older with no mental illness is statistically significant at the .05 level.

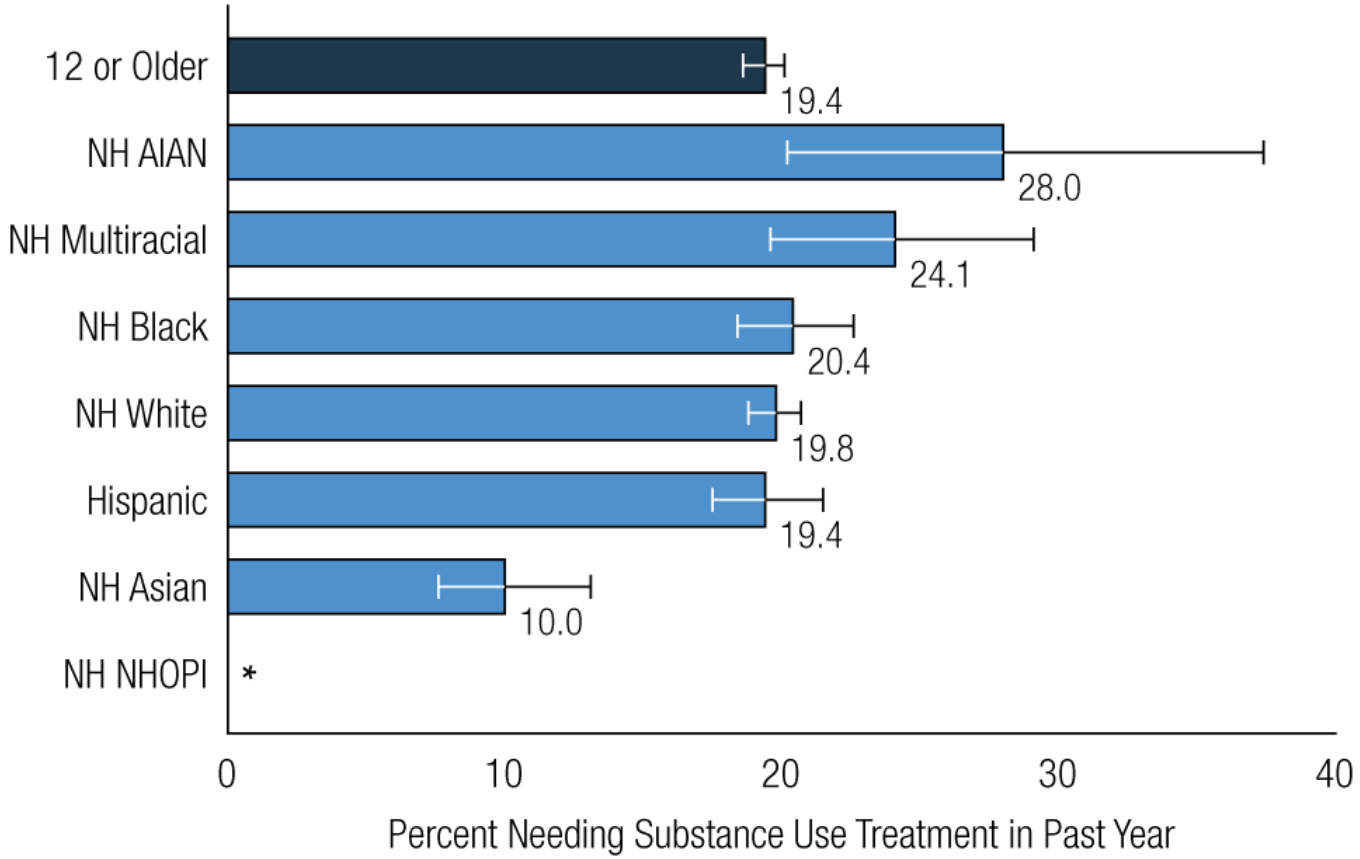
SAMHSA
Substance Abuse and Mental Health Services Administration

# Need for Substance Use Treatment in the Past Year: Among People Aged 12 or Older; 2022




Note: Need for Substance Use Treatment is defined as having a substance use disorder in the past year or receiving substance use treatment in the past year.

# Need for Substance Use Treatment in the Past Year: Among People Aged 12 or Older; by Race/Ethnicity, 2022



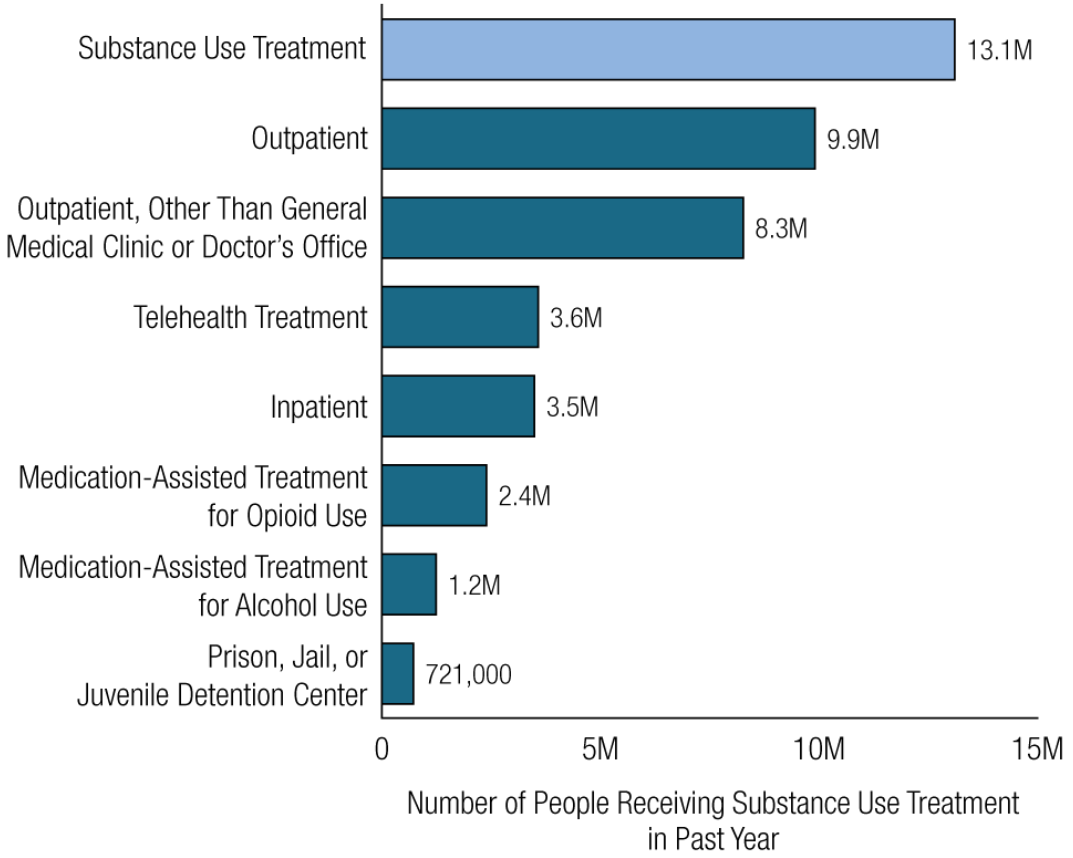

* Low precision; no estimate reported.

AIAN = American Indian or Alaska Native; Black = Black or African American; Hispanic = Hispanic or Latino; NH = Not Hispanic or Latino; NHOPI = Native Hawaiian or Other Pacific Islander.

Note: Error bars were calculated as 99 percent confidence intervals. Wider error bars indicate less precise estimates. Large apparent differences between groups may not be statistically significant.

Note: Need for Substance Use Treatment is defined as having a substance use disorder in the past year or receiving substance use treatment in the past year.

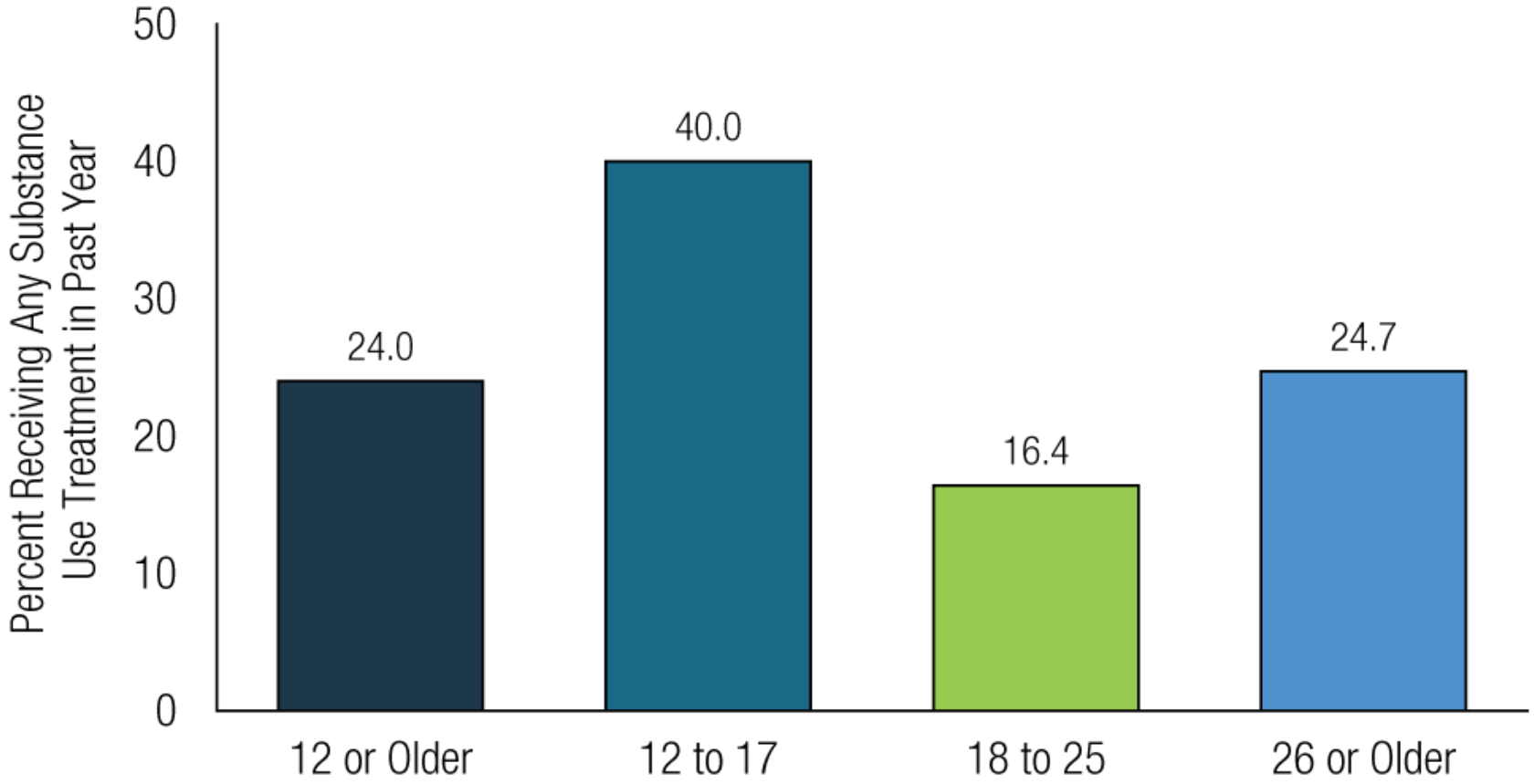
# Types and Locations of Substance Use Treatment in the Past Year: Among People Aged 12 or Older; 2022




Note: Types and locations where people received substance use treatment are not mutually exclusive because respondents could report that they received treatment in more than one setting in the past year. People who received outpatient substance use treatment other than in a general medical clinic or doctor's office also are included in the estimate for outpatient substance use treatment.

Note: Substance use treatment includes treatment for drug or alcohol use through inpatient treatment/counseling; outpatient treatment/counseling; medication-assisted treatment; telehealth treatment; or treatment received in a prison, jail, or juvenile detention center. People who received outpatient substance use treatment other than in a general medical clinic or doctor's office also are included in the estimate for outpatient substance use treatment.

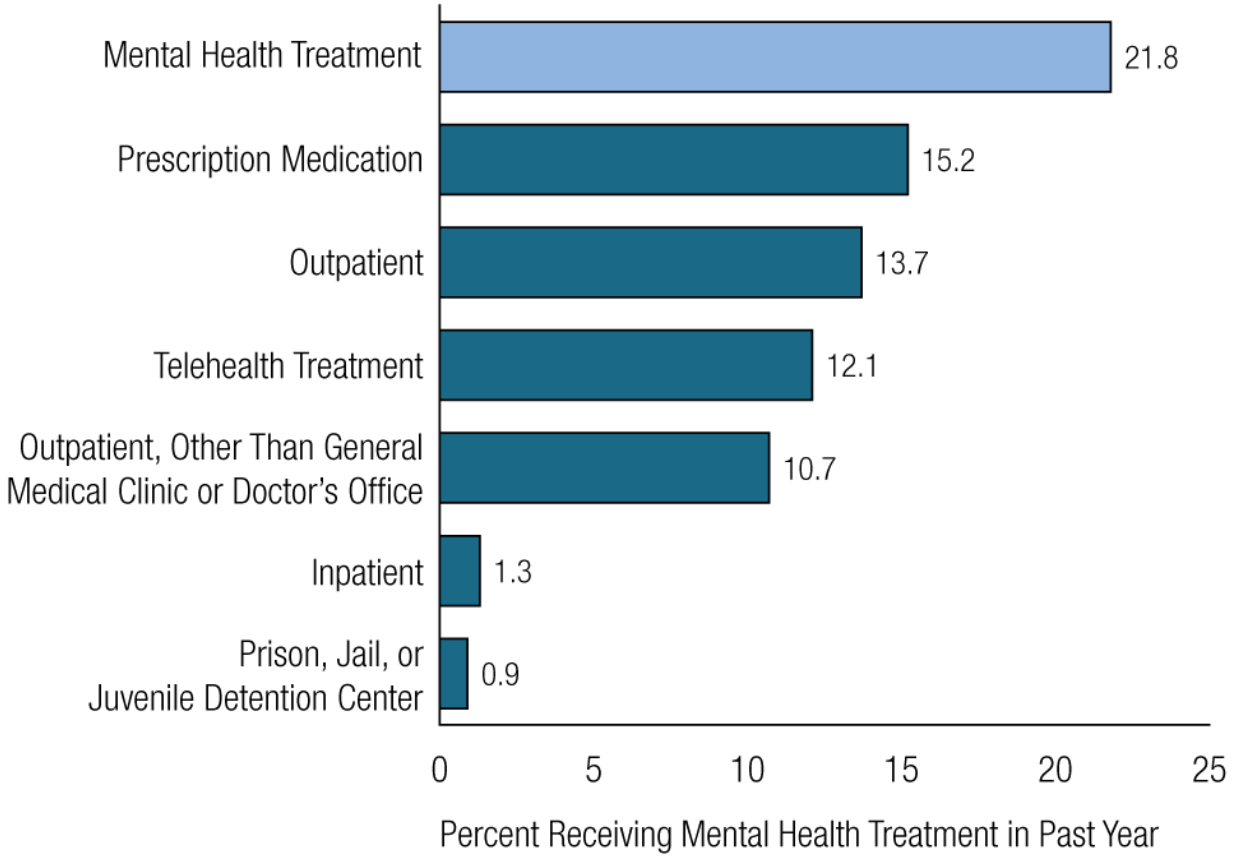
# Received Substance Use Treatment in the Past Year: Among People Aged 12 or Older Who Needed Substance Use Treatment in the Past Year; 2022




Note: Substance use treatment includes treatment for drug or alcohol use through inpatient treatment/counseling; outpatient treatment/counseling; medication-assisted treatment; telehealth treatment; or treatment received in a prison, jail, or juvenile detention center.

Note: Need for Substance Use Treatment is defined as having a substance use disorder in the past year or receiving substance use treatment in the past year.

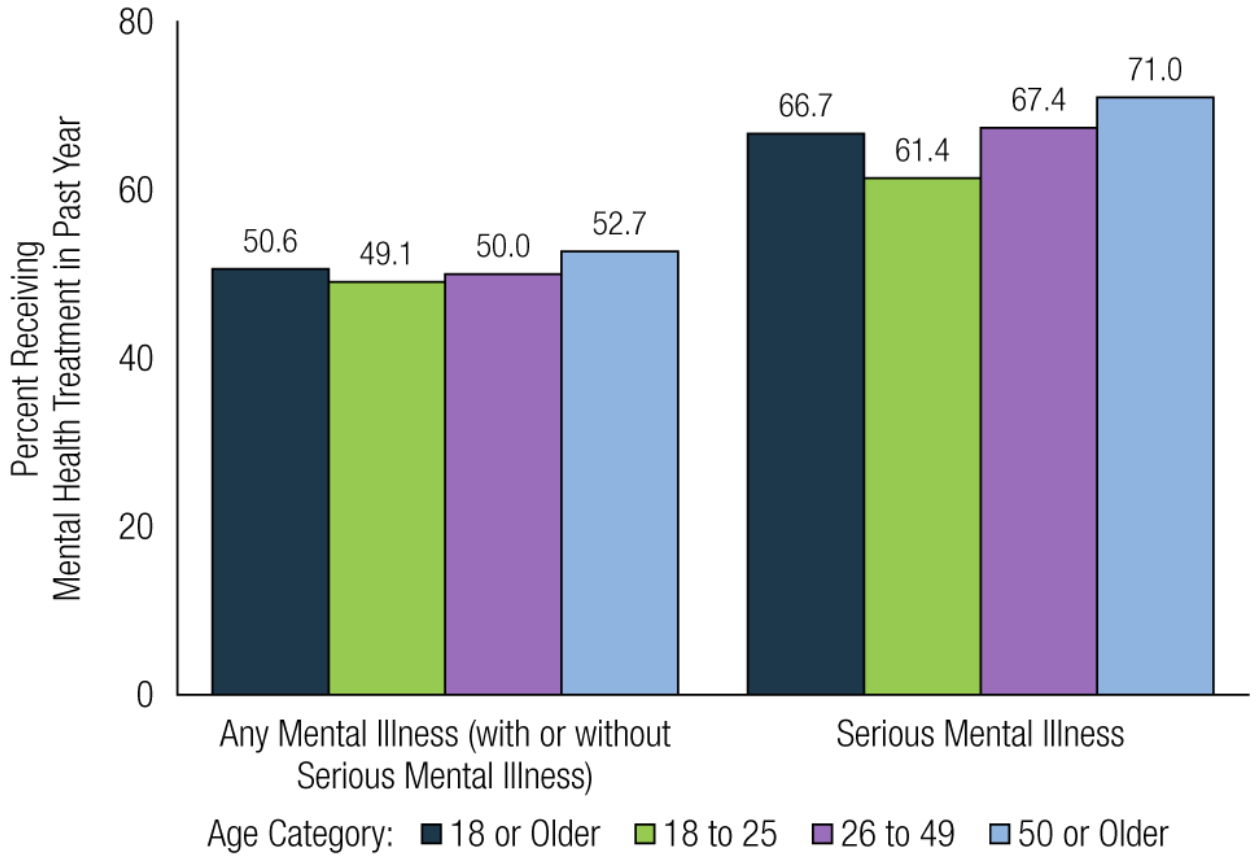
# Types and Locations of Mental Health Treatment Received in the Past Year: Among Adults Aged 18 or Older; 2022




Note: Types and locations where people received mental health treatment are not mutually exclusive because respondents could report that they received treatment in more than one setting in the past year.

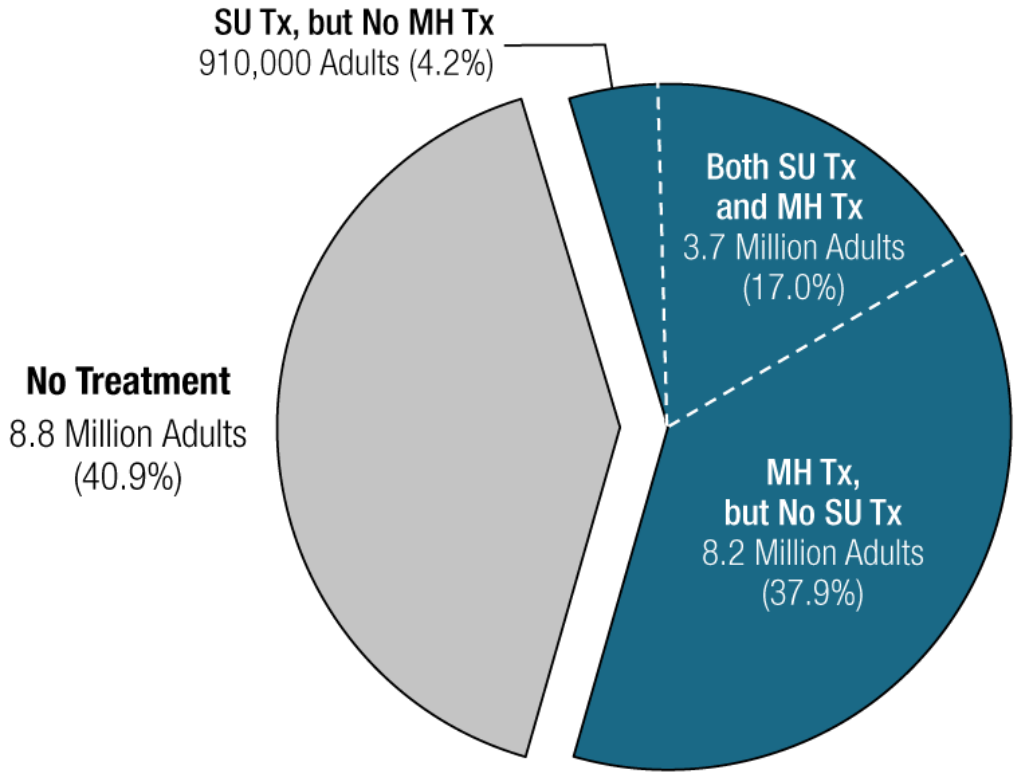
Note: Mental health treatment includes treatment/counseling received as an inpatient or as an outpatient; use of prescription medication to help with mental health; telehealth treatment; or treatment received in a prison, jail, or juvenile detention center. People who received outpatient mental health treatment in a location other than a general medical clinic or doctor's office also are included in the estimate for outpatient mental health treatment.

# Mental Health Treatment Received in the Past Year: Among Adults Aged 18 or Older with Any Mental Illness or Serious Mental Illness in the Past Year; 2022




Note: Mental health treatment includes treatment/counseling received as an inpatient or as an outpatient; use of prescription medication to help with mental health; telehealth treatment; or treatment received in a prison, jail, or juvenile detention center.

# Receipt of Substance Use Treatment or Mental Health Treatment in the Past Year: Among Adults Aged 18 or Older with Past Year Substance Use Disorder and Any Mental Illness; 2022



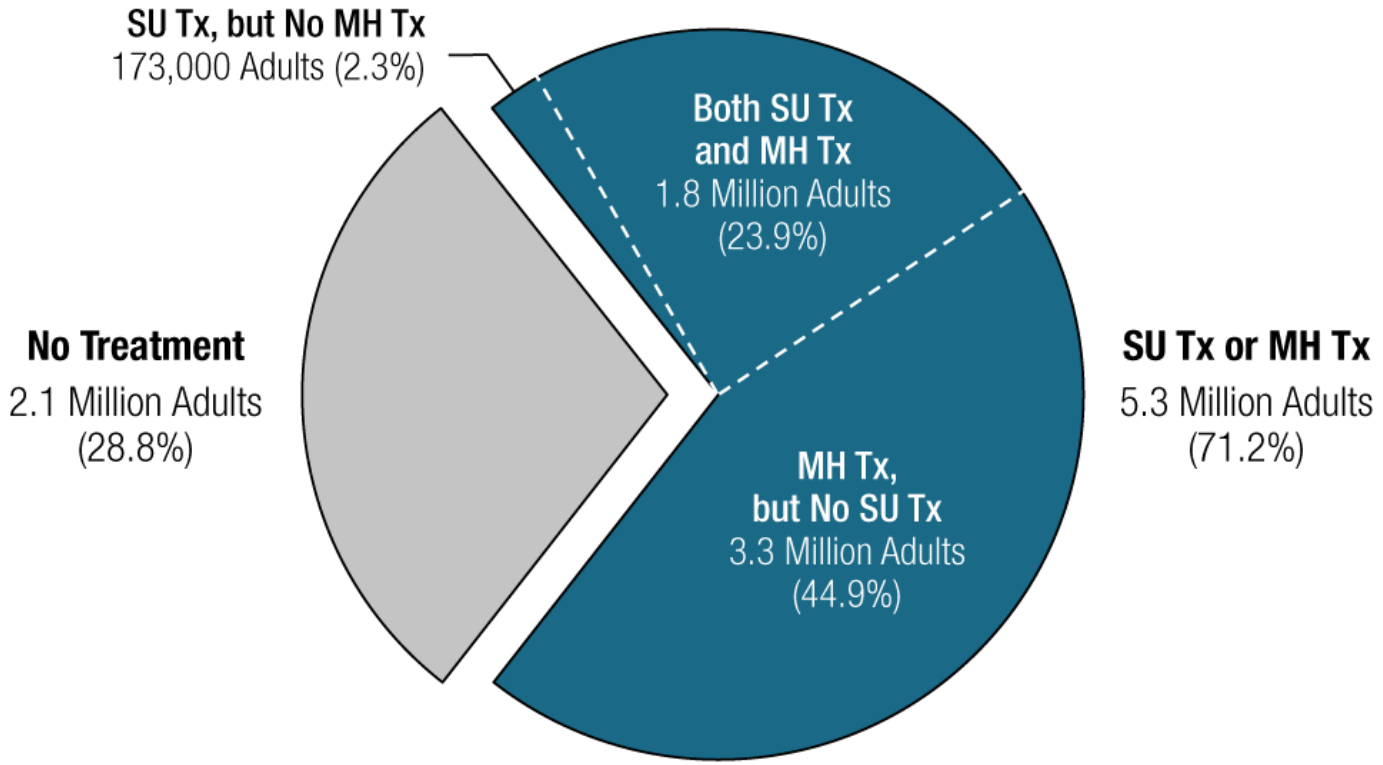

**21.5 Million Adults with a Substance Use Disorder and Any Mental Illness**

MH Tx = mental health treatment; SU Tx = substance use treatment.

Note: Substance use treatment includes treatment for drug or alcohol use through inpatient treatment/counseling; outpatient treatment/counseling; medication-assisted treatment; telehealth treatment; or treatment received in a prison, jail, or juvenile detention center.

Note: Mental health treatment includes treatment/counseling received as an inpatient or as an outpatient; use of prescription medication to help with mental health; telehealth treatment; or treatment received in a prison, jail, or juvenile detention center.

# Receipt of Substance Use Treatment or Mental Health Treatment in the Past Year: Among Adults Aged 18 or Older with Past Year Substance Use Disorder and Serious Mental Illness; 2022




**7.4 Million Adults with a Substance Use Disorder and Serious Mental Illness**

MH Tx = mental health treatment; SU Tx = substance use treatment.

Note: The percentages may not add to 100 percent due to rounding.

Note: Substance use treatment includes treatment for drug or alcohol use through inpatient treatment/counseling; outpatient treatment/counseling; medication-assisted treatment; telehealth treatment; or treatment received in a prison, jail, or juvenile detention center.

Note: Mental health treatment includes treatment/counseling received as an inpatient or as an outpatient; use of prescription medication to help with mental health; telehealth treatment; or treatment received in a prison, jail, or juvenile detention center.

# Who Does ACT Serve?

- Assertive community treatment is for people who experience the most severe and persistent symptoms of mental illness and who have frequent episodes of very severe symptoms that are difficult to manage.

- Because of the severe nature of their symptoms, individuals may have a lot of trouble simply taking care of their basic needs, protecting themselves, keeping safe and adequate housing, or staying employed.

# Who Does ACT Serve?

- People who receive ACT often have spent a lot of time in hospitals or living on the streets because of their illness.

- They also are often people who have a problem with drugs or alcohol or who have been in trouble with the police because of their illness.

# Integrated Treatment for Co-Occurring Disorders

- In providing a full range of services, inclusive of engagement and outreach, **ACT should be providing integrated treatment for co-occurring disorders.**

- **The Integrated Dual Disorder Treatment** (IDDT) model is an evidence-based practice that improves the quality of life for people with co-occurring severe mental illness and substance use disorders by combining substance abuse services with mental health services. It helps people address both disorders at the same time—in the same service organization by the same team of treatment providers.

https://case.edu/socialwork/centerforebp/practices/substance-abuse-mental-illness/integrated-dual-disorder-treatment

# IDDT

- Integrated Dual Disorder Treatment (IDDT) is:
  - multidisciplinary
  - combines pharmacological (medication), psychological, educational, and social interventions
- Goal = address the needs of clients and their family members.

- IDDT also promotes client and family involvement in service delivery, stable housing as a necessary condition for recovery, and employment as an expectation for many.

https://case.edu/socialwork/centerforebp/practices/substance-abuse-mental-illness/integrated-dual-disorder-treatment

# Core Components of IDDT

- Multidisciplinary Team
- Stage-Wise Interventions (stages of change, stages of treatment)
- Access to Comprehensive Services (e.g., residential, employment, etc.)
- Time-Unlimited Services
- Assertive Outreach
- Motivational Interventions
- Substance Abuse Counseling
- Group Treatment
- Family Psychoeducation
- Participation in Alcohol and Drug Self-Help Groups
- Pharmacological Treatment
- Interventions to Promote Health
- Secondary Interventions for Treatment of Non- Responders

https://case.edu/socialwork/centerforebp/practices/substance-abuse-mental-illness/integrated-dual-disorder-treatment

# Research Project

- **Title: A renewed focus on substance use disorder care for patients in assertive community treatment (ACT) teams: updating fidelity, evidence, and best practices for the opioid epidemic**

- **Short title:** ACT teams and addiction

- **Authors:**
  - Jeremy Weleff DO
  - Terence Tumenta MD, MPH
  - Lauren Wilseck DO, MPH
  - Walter S. Mathis MD

- **Here we summarize what is known about SUD care within ACT teams and discuss current best practices, which can also be translated for general psychiatry settings to improve care for those with co-occurring disorders.**

# Co-occurring OUD

- limited data regarding the prevalence of opioid use disorder and ACT involvement.

- ACT Teams have led to overall positive OUD outcomes, such as abstinence and shorter hospital stays associated with relapse

## Substance Use Disorders as a Critical Element for Decision-Making in Forensic Assertive Community Treatment: A Systematic Review

Thomas Marquant[1,2,3*] Meike Van Nuffel[4] Bernard Sabbe[1,5,6] Kris Goethals[1,5,6,7]

- two pathways, either from a care continuum or directly from prison.
- The severity of SUD at intake emerges as a critical element when deciding which pathway to choose.
- All studies offered integrated SUD treatment. These included evidence-based techniques like CBT, therapeutic communities, and Substance Abuse Management Module.
- Results on SUD outcomes were mixed:
  - 4 studies mentioned abstinence in 50–75%.
  - The severity of SUD tended to increase initially and then stabilize afterward.

https://www.frontiersin.org/journals/psychiatry/articles/10.3389/fpsyt.2021.777141/full

# A community outreach intervention to link individuals with opioid use disorders to medication-assisted treatment

Christy K. Scott [a], Michael L. Dennis [b], Christine E. Grella [c], Rachel Kurz [c], Jamie Sumpter [c], Lisa Nicholson [c], Rodney R. Funk [b]

- 1638/3308 (50%) outreach encounters were eligible and agreed to a linkage meeting.
- 890/972 (92%) of those who met with a linkage manager were linked to MAT.
- 765/890 (86%) of those who were linked to MAT showed to the MAT intake.
- Treatment entry was lower among homeless individuals and those with ED contact.
- 498/696 (72%) of those who received one dose were still in treatment 30 days later.

# Co-Occurring AUD

- ACT Teams have demonstrated benefits in AUD outcomes, such as reduced total alcohol consumed and reduced drinking days.

# Assertive Community Treatment For People With Alcohol Dependence: A Pilot Randomized Controlled Trial

Colin Drummond [1], Helen Gilburt [2 3], Tom Burns [4], Alex Copello [5], Michael Crawford [6], Ed Day [1], Paolo Deluca [1], Christine Godfrey [7], Steve Parrott [7], Abigail Rose [8], Julia Sinclair [9], Simon Coulton [10]

Affiliations + expand

PMID: 27940571 PMCID: PMC5378220 DOI: 10.1093/alcalc/agw091

- A total of 94 participants were randomized, 45 in ACT and 49 in TAU.
- Follow-up was achieved with 98 and 88%, respectively at 12 months.
- Those in ACT had:
  - better treatment engagement and were more often seen in their homes or local community than TAU participants.
  - a higher percentage of days abstinent.
  - less unplanned healthcare use than TAU.

# Treatment Resistant and Resistant to Treatment? Evaluation of 40 Alcohol Dependent Patients Admitted for Involuntary Treatment

Glenys Dore [1], Barbara Sinclair [2], Robin Murray [3]

Affiliations + expand

PMID: 26362017 DOI: 10.1093/alcalc/agv103

- Forty patients admitted to an inpatient IDAT program were prospectively followed up over 6 months using standardized questionnaires.
- Six months after discharge, 25% of patients were abstinent and living in the community and 17.5% had notably reduced alcohol use.
- A further 7.5% were abstinent due to involuntary hospitalization.
- Number of admissions and admission days reduced by 51 and 45% respectively for the 17 abstinent or improved community-based patients.
- 82% of this patient group were actively engaged with an Assertive Community Treatment (ACT) team.

# Hospitalisation of severely mentally ill patients with and without problematic substance use before and during Assertive Community Treatment: an observational cohort study

Hanne Clausen [1 2], Torleif Ruud [3 4], Sigrun Odden [5], Jūratė Šaltytė Benth [4 6], Kristin Sverdvik Heiervang [3], Hanne Kilen Stuen [5], Helen Killaspy [7], Robert E Drake [8], Anne Landheim [5 9]

Affiliations + expand

PMID: 27145937 PMCID: PMC4855443 DOI: 10.1186/s12888-016-0826-5

- A naturalistic observational study included 142 patients of 12 different ACT teams throughout Norway
- A total of 84 (59%) participants had problematic substance use upon enrolment into the ACT teams.
- In the 2 years after ACT enrolment, both participants with and without problematic substance use experienced a reduction in total inpatient days.
- Those with problematic substance use also had fewer involuntary inpatient days.

# Impact of assertive community treatment and client characteristics on criminal justice outcomes in dual disorder homeless individuals

Robert J Calsyn [1], Robert D Yonker, Matthew R Lemming, Gary A Morse, W Dean Klinkenberg

Affiliations + expand

PMID: 16575844 DOI: 10.1002/cbm.24

- Randomized controlled trial comparing standard treatment, assertive community treatment (ACT) , and integrated treatment (IT)
- Half the sample was arrested and a quarter was incarcerated during the two-year follow-up period.
- Neither the type nor the amount of mental health treatment received predicted subsequent criminal behavior.

# Treatment of alcohol dependence. Alcohol and homelessness: social point of view

Giovanni Alessandrini [1], Rosaria Ciccarelli [2], Gemma Battagliese [2], Federica Cereatti [2], Simona Gencarelli [3], Marisa Patrizia Messina [4], Mario Vitali [5], Francesca De Rosa [2], Roberta Ledda [2], Serena Mancini [2], Maria Luisa Attilia [2];
Interdisciplinary Study Group CRARL - SITAC - SIPaD - SITD - SIPDip

Collaborators, Affiliations + expand

PMID: 29912211 DOI: 10.1708/2925.29411

- Standard Case Management was able to improve housing stability, reduce drug use, and remove working barriers.
- The Assertive Community Treatment was able to improve housing stability and had a better efficacy for patients suffering from dual diagnosis.

# What happens when you embed a 0.2 FTE Addiction Psychiatrist in an ACT Team?

Academic Detailing for SUDs

# Day 1 – Plan / Do

1. **Stakeholder analysis**
   - Initial interviews with ACT team physician lead and Team Leader. Initial interviews with clinical staff and appointed substance use specialist on the team.

2. **Baseline SUD-specific data recording practices**
   - Review of current ACT-related data collection processes. Attempting to determine prevalence of specific SUDs of patients being seen on the team. Attempting to determine other SUD-related needs of current patients.

3. **Baseline SUD-related TMACTs assessment**
   - Following the TMACTs guide for SUD-related measures.

4. **Qualitative results of formal and informal clinical support by SUD specialist**
   - Discussions with team during meetings/curbsides etc. / during care coordination

1. **Stakeholder analysis**
    - Desire/need to pay attention to SUD-related issues amongst leaders. Team experienced multiple patient deaths in recent years related to ODs. Feeling of demoralization and not knowing what to do about SUDs / having long-term chronic patients who haven't "improved at all". Tensions about best practices in addiction (urine drug screening, etc).

2. **Baseline SUD-specific data recording practices**
    - Face sheet with formal diagnoses. Review of these and collecting in a single table. **Creating planned space for review of these patients and these diagnoses in Team Rounds with full team**.

3. **Baseline SUD-related TMACTs assessment**
    - [following slides]

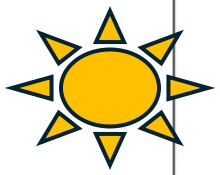
4. **Qualitative results of formal and informal clinical support by SUD specialist**
    - Many questions about SUD medications and harm reduction. Plenty of confusion about these specifics medications and what may be helpful for conditions like stimulant use disorders. Knowledge gaps about which clients would need naloxone.

| Specialist Team (ST) Subscale | | | | | | |
|---|---|---|---|---|---|---|
| ST1 | CO-OCCURRING DISORDERS SPECIALIST ON TEAM: The team has at least one 1.0 FTE team member designated as a co-occurring disorders (COD) specialist who has at least a bachelor's degree and meets local standards for certification as a co-occurring specialist. Preferably this specialist has training or experience in integrated treatment for COD. | Less than 0.25 (actual or adjusted) FTE COD specialist with at least minimal qualifications OR criteria for a "2" rating met, except qualifications standards. | 0.25 - 0.49 (actual or adjusted) FTE COD specialist with at least minimal qualifications OR criteria for a "3" rating met, except qualifications standards. | 0.50 - 0.74 (actual or adjusted) FTE COD specialist with at least minimal qualifications OR criteria for a "4" rating met, except qualifications standards. | 0.75 - 0.99 (actual or adjusted) FTE COD specialist with at least minimal qualifications OR criteria for a "5" rating met, except qualifications standards. | At least 1.0 (actual or adjusted) FTE COD specialist with at least minimal qualifications. |

*^SUD specialist on team and their roles defined below (assessment, tracking, MI, modeling skills, cross-training, team meetings etc.)*

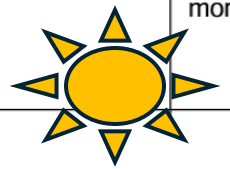
| ITEM | | RATINGS / ANCHORS | | | | |
|---|---|---|---|---|---|---|
| | | (1) | (2) | (3) | (4) | (5) |
| Specialist Team (ST) Subscale (cont.) | | | | | | |
| ST2 | ROLE OF CO-OCCURRING DISORDERS SPECIALIST IN TREATMENT: The co-occurring disorders (COD) specialist provides integrated treatment for COD to ACT clients who have a substance use problem. Core services include the following: (1) Conducting ongoing comprehensive substance use assessments that consider the relationship between substance use and mental health; (2) Assessing and tracking clients' stages of change readiness and stages of treatment; (3) Using outreach and motivational interviewing (MI) techniques; (4) Using cognitive behavioral approaches and relapse prevention; and (5) Applying treatment approaches consistent with clients' stage of change readiness. | The COD specialist provides 1 or fewer integrated treatment for co- occurring disorder services. | 2 integrated treatment for COD services are provided (3 are absent). | 3-4 integrated treatment for COD services are provided, (1 or 2 are absent) OR ALL 5 services are provided, with 3 or more services PARTIALLY provided. | ALL 5 integrated treatment for COD services are provided, but up to 2 services are only PARTIALLY provided. | ALL 5 integrated treatment for COD services are FULLY provided. |
| ST3 | ROLE OF CO-OCCURRING DISORDERS SPECIALIST WITHIN TEAM:The co-occurring disorders (COD) specialist is a key team member in the service planning for clients with COD. The COD specialist performs the following functions WITHIN THE TEAM: (1) Modeling skills and consultation; (2) Cross-training to other staff on the team to help them develop co-occurring disorder assessment and treatment skills; (3) Attending all daily team meetings; and (4) Attending the majority of treatment planning meetings for clients with COD. | The COD specialist does not perform any of the 4 functions within the team. | 1 function is performed within the team. | 2 functions are performed within the team. | 3 functions are performed within the team. | ALL 4 functions are performed within the team. |

| Evidence-Based Practices (EP) Subscale | | | | | | |
|---|---|---|---|---|---|---|
| EP1 | FULL RESPONSIBILITY FOR INTEGRATED TREATMENT FOR CO-OCCURRING DISORDERS: The team assumes responsibility for providing integrated treatment for co-occurring disorders (COD) services within the larger framework of integrated treatment for COD, where there is little need for clients to have to access such services outside of the team. Core services include systematic and integrated screening and assessment and interventions tailored to those in early stages of change readiness (e.g., outreach, motivational interviewing) and later stages of change readiness (e.g., CBT, relapse prevention). It is expected that the ACT COD specialist will assume the majority of responsibility for delivering integrated treatment for co-occurring disorders, but ideally other team members also provide some integrated treatment for co-occurring disorders services. Integrated treatment for co- occurring disorders reported here from the Excel spreadsheet should be reflected across other data sources (e.g., progress notes, treatment plans). | Less than 20% of clients in need of integrated treatment for COD are receiving them from the team. | 20 - 49% of clients in need of integrated treatment for COD are receiving them from the team. | 50 - 74% of clients in need of integrated treatment for COD are receiving them from the team. | 75 - 89% of clients in need of integrated treatment for COD are receiving them from the team. | 90% or more of clients in need of integrated treatment for COD are receiving them from the team. |



^*Full responsibility for Co-occurring disorders (didn't have this % at start of program but was estimate)*

| | | | | | | |
|---|---|---|---|---|---|---|
| EP4 | INTEGRATED TREATMENT FOR CO-OCCURRING DISORDERS: The TEAM practices from a model aligning with integrated treatment for co-occurring disorders (COD) where the TEAM (1) considers interactions between mental illness and COD; (2) does not have absolute expectations of abstinence and supports harm reduction; (3) understands and applies stages of change readiness in treatment; (4) is skilled in motivational interviewing; and (5) follows cognitive-behavioral principles. | Criteria are not met. | Only 1 - 3 criteria are met. | 4 criteria met at least PARTIALLY (1 absent) OR 5 criteria met with 3 or more PARTIALLY met. | Team primarily operates from integrated treatment for COD, meeting all 5 criteria, with up to 2 PARTIALLY met. | Team is fully based in integrated treatment for COD principles, FULLY meeting all 5 criteria. |



^*Explicit about harm reduction philosophy/abstinence*

# Initial demographics/assessment

**MAT and ACT Summary - 37 Clients**

**<u>ACT Team Demographics</u>**

Avg Age = 50.68 ; StD = 12.63 ; Range = (29-74)

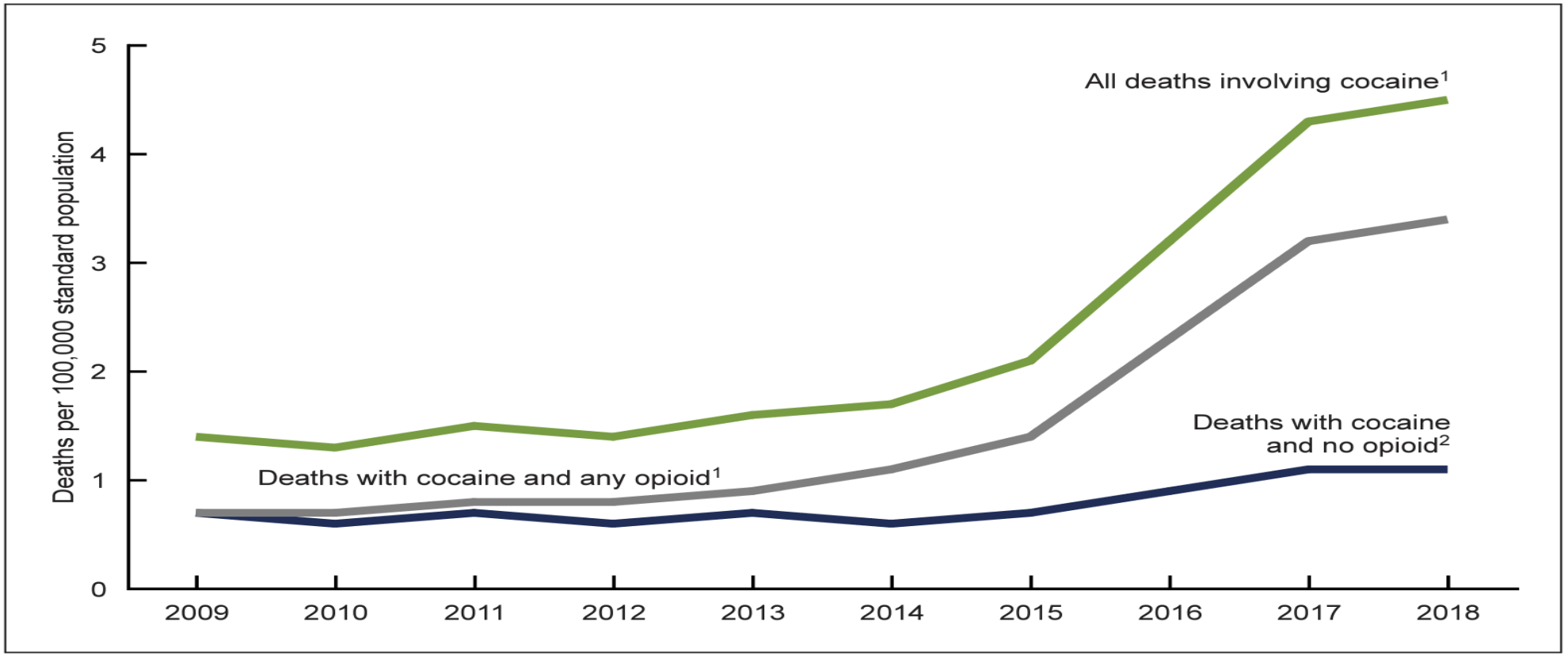
Sex/gender = 32% female (12), 65% male (24), 1% trans (1)

Race/ethnicity = 57% Black (21), 32% White (12), 11% Hispanic/Latinx (4)

| | | |
|---|---|---|
| **Patients with at least 1 SUD diagnosis =** | **92%** | ***SUDs are the norm rather than the exception**** |
| **Tobacco use disorder** | 65% | Lower than expected? |
| **Alcohol use disorder** | 32% | |
| **THC/heavy use/ or cannabis use disorder** | 41% | Almost half with cannabis |
| **OUD** | 5% | Relatively low but increasing* |
| **Stimulant (cocaine/crack/meth)** | 43% | ***Almost half with stimulant use disorder**** |
| **Other risky/ unknown street drugs (Pills, "everything", etc)** | 8% | |

## From 2014 through 2018, the rate of drug overdose deaths involving cocaine with opioids increased at a faster pace than the rate of cocaine deaths without opioids.

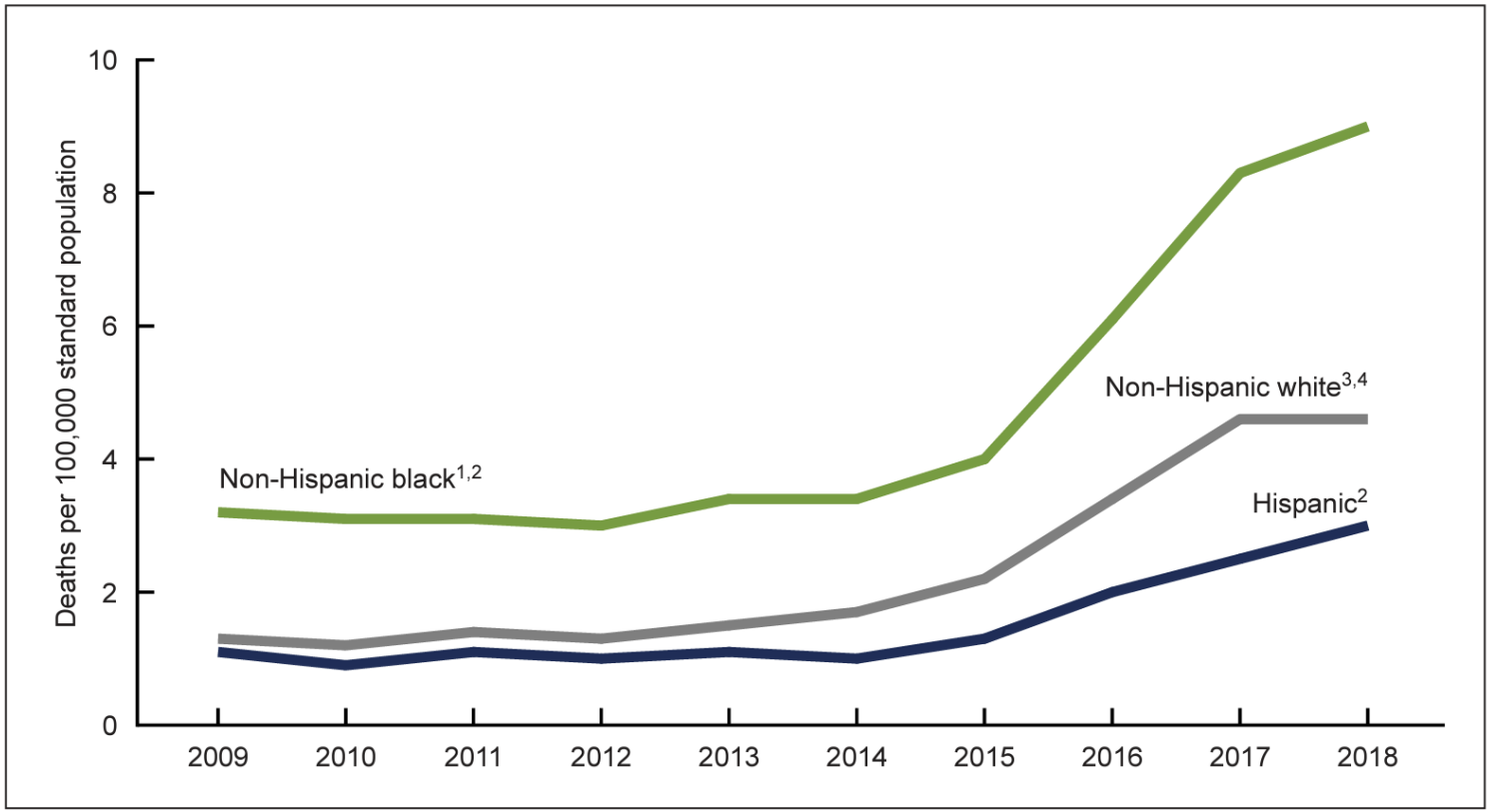
Figure 4. Age-adjusted rates of drug overdose deaths involving cocaine, by concurrent involvement of opioids: United States, 2009–2018




https://www.cdc.gov/nchs/data/databriefs/dbtable4-pdf.

> The rate for the non-Hispanic Black population (9.0) was nearly twice that for the non-Hispanic White (4.6) and three times that for the Hispanic (3.0) populations.

Figure 3. Age-adjusted rates of drug overdose deaths involving cocaine, by race and Hispanic origin: United States, 2009–2018




https://www.cdc.gov/nchs/data/databriefs/dbtable3-pdf.

**Fentanyl is increasingly contaminating stimulant drugs.**
**Have some racial/ethnic groups been more affected than others?**

Using death certificate data, we compared 2007-2019 trends in overdose mortality by:

- Race/ethnicity
- Drug type
- U.S. state

↑ 575%

in *cocaine*/opioid mortality in Black people, vs.

↑ 184%

in white people.

This disparity was largest in eastern states.

↑ 16,200%

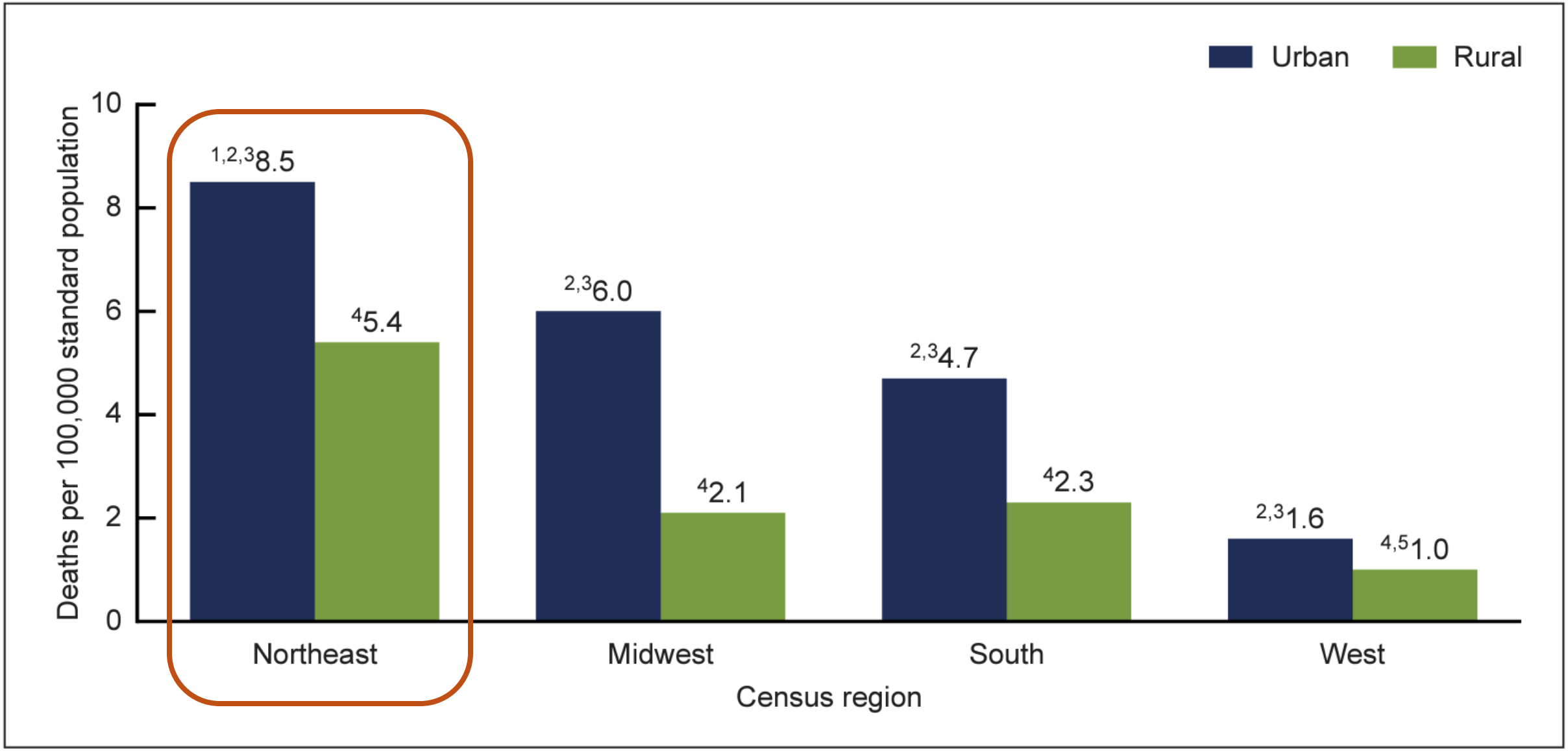
in *methamphetamine* and other stimulant /opioid mortality in Black people, vs.

↑ 3,200%

in white people.

Authors: Townsend, T., Kline, D., (joint first authors), Rivera-Aguirre, A., Bunting, A.M., Mauro, P.M., Marshall, B.D.L., Martins, S., Cerdá, M.

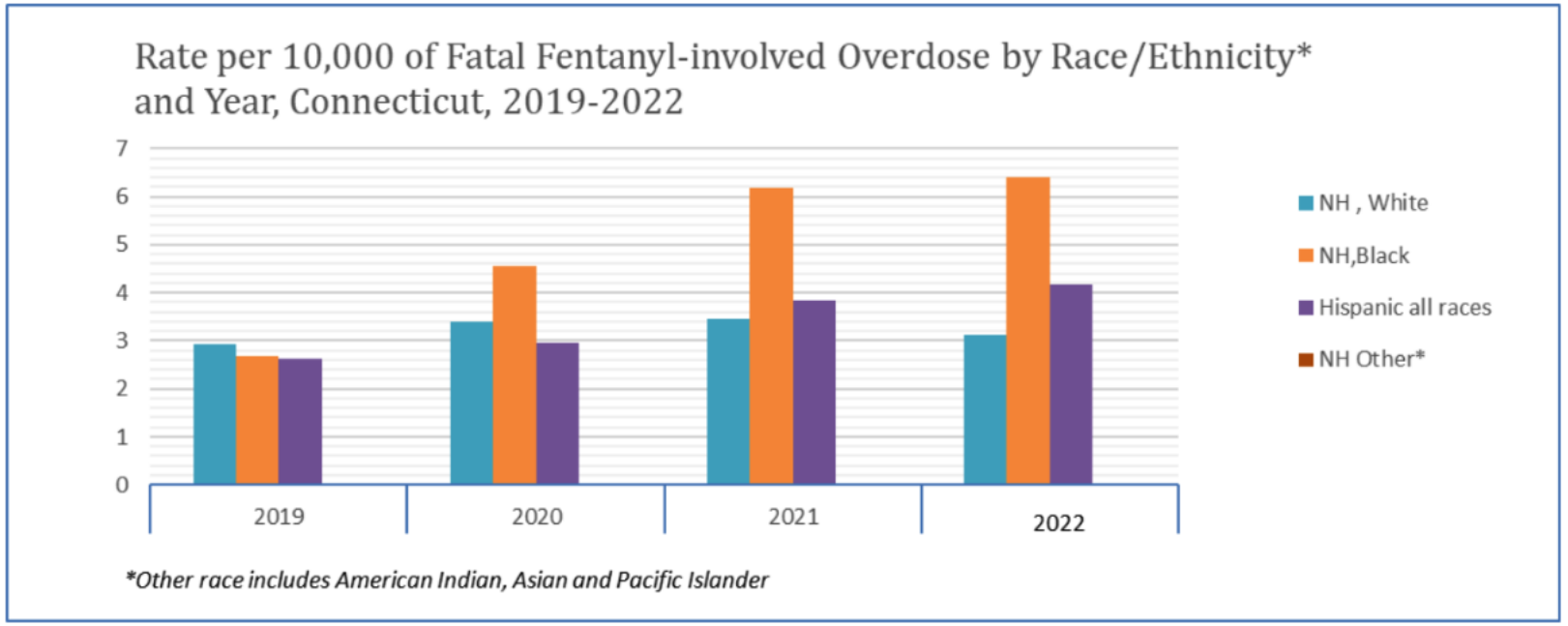
Figure 5. Age-adjusted rates of drug overdose deaths involving cocaine, by urbanicity and census region: United States, 2018

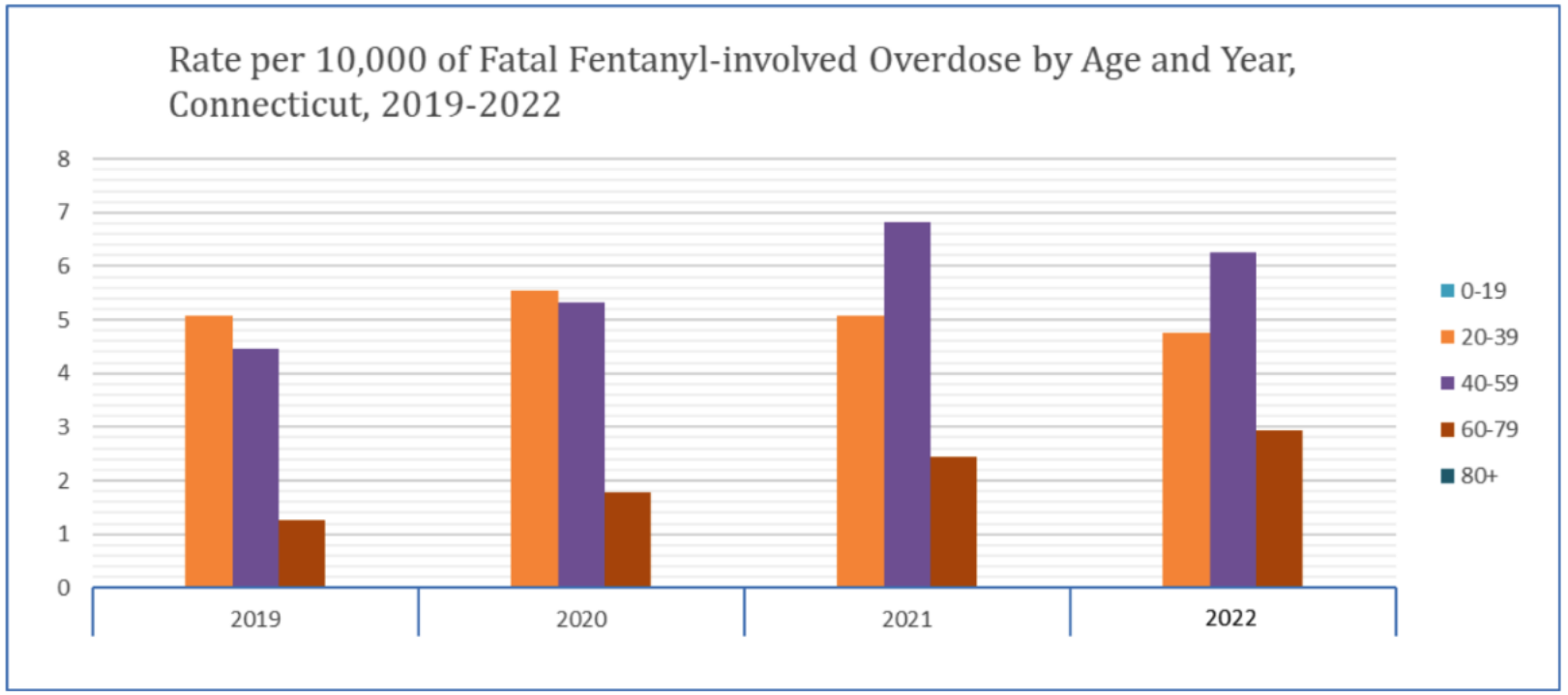




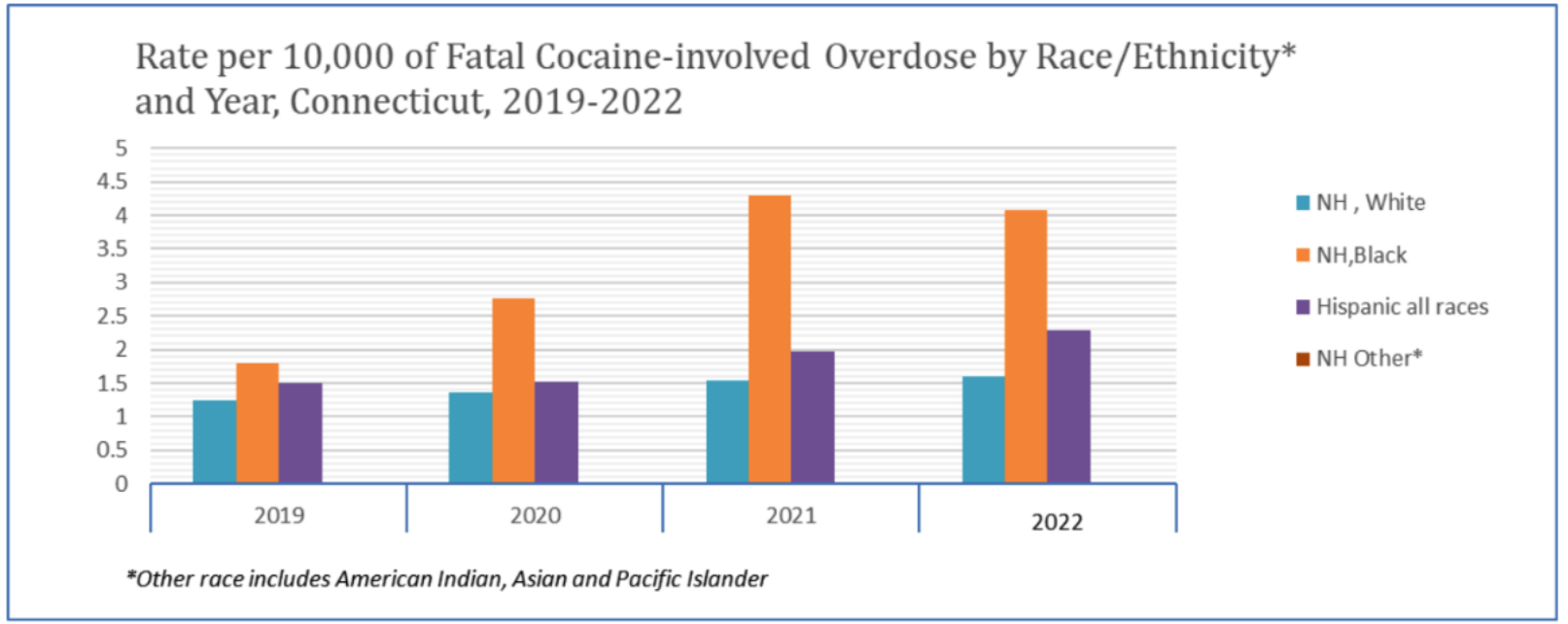

https://www.cdc.gov/nchs/data/databriefs/dbtables-pdf.

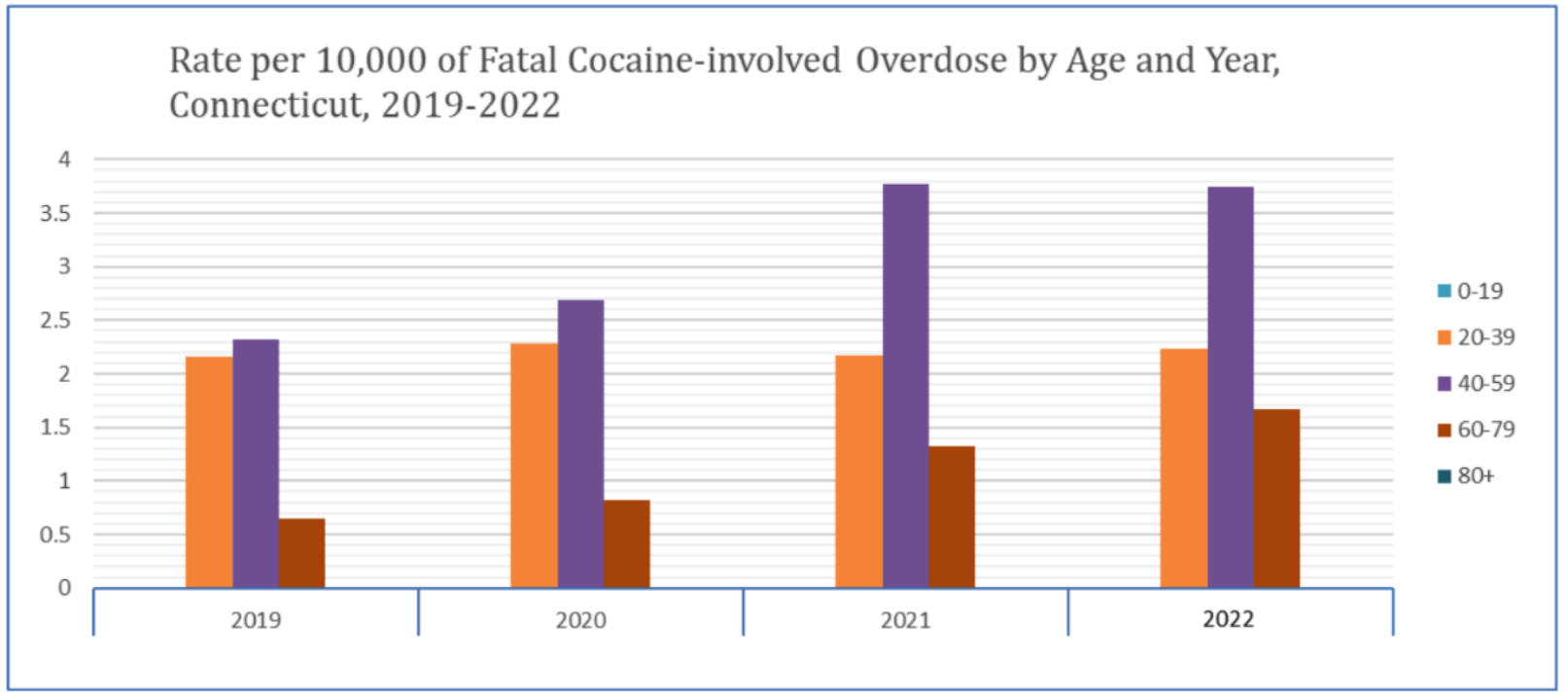
# Conn


Rate per 10,000 of Fatal Fentanyl-involved Overdose by Race/Ethnicity* and Year, Connecticut, 2019-2022
7
6
5
4
3
2
1
0
2019
2020
2021
2022
NH , White
NH,Black
Hispanic all races
NH Other*
*Other race includes American Indian, Asian and Pacific Islander


Rate per 10,000 of Fatal Fentanyl-involved Overdose by Age and Year, Connecticut, 2019-2022
8
7
6
5
4
3
2
1
0
2019
2020
2021
2022
0-19
20-39
40-59
60-79
80+

# Conn


Rate per 10,000 of Fatal Cocaine-involved Overdose by Race/Ethnicity* and Year, Connecticut, 2019-2022
5
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
2019
2020
2021
2022
NH , White
NH,Black
Hispanic all races
NH Other*
*Other race includes American Indian, Asian and Pacific Islander


Rate per 10,000 of Fatal Cocaine-involved Overdose by Age and Year, Connecticut, 2019-2022
4
3.5
3
2.5
2
1.5
1
0.5
0
2019
2020
2021
2022
0-19
20-39
40-59
60-79
80+

# In other words: these are the exact people that these numbers are referring to

**Stimulant Use Disorder Breakdown**

16 patients on the team*

Avg Age = 48.31 ; StD = 12.27 ; Range = (29-67)

Sex/gender = 25% female (4), 69% male (11), 6% trans (1)

Race/ethnicity = 69% Black (11), 19% White (3), 13% Hispanic/Latinx (2)

| | | |
|---|---|---|
| **MAT Referred** | **7** | |
| | 44% | 44% of all ACT Clients with a stimulant use disorder were referred to MAT Clinic between July-Dec 2023 |
| **Intervention** | | |
| | 100% | 100% of these patients were started on new medications for SUD and referred to start contingency management |

# Fentanyl positivity!
# Urine drug screenings on file

- **Of the 16 patients with stimulant use disorder patients:**
  - **37.5% with urine on file in last year**-- Only 6 with urines in Quest over the last year.
  - 83.3% with confirmed cocaine -- 5/6 with cocaine(confirmed) positive.

  - 33.3% did not include fentanyl testing on drug screen -- 2/6 did not have fentanyl screening.
    - **50% of those screened for fentanyl were positive** -- 2/4 that were screened for fentanyl (confirmed) positive.
      - **100% of these are MAT clinic referrals (and tested positive after MAT date)**

- ^*Another process improvement target for another time*

# Diagnostic Clarification

| | | |
|---|---|---|
| **new SUD dx on review** | **22%** | **22% got new SUD diagnosis on team review** |
| **refined a clunky dx or had no dx and now has at least 1** | 14% | *(these are examples where a non-specific diagnoses such as "other psychoactive substance use" gets turned into a real diagnosis)* |

# MAT Referrals

| | | |
|---|---|---|
| **Referred** | **7** | |
| | Almost 20% | Almost 20% of ACT clients referred to MAT Clinic (these were ones that the team felt patient may engage but there were others that weren't ready to take referral) |
| **Seen** | | |
| | 29% | 29% of these referrals were seen in MAT Clinic (patients mostly later refused after appt was scheduled) |
| **Intervention** | | |
| | 100% | 100% of these patients were started on new medications for SUD and referred to start contingency management (CM) |

*There are 2 additional patients here on the ACT Team that have their primary physician as a MAT doctor (not included in referred above or in intervention group)*

*^Numbers now higher with influx of ACT clients – at least 3-4 either co-managed or referred, etc*

# Additional Interventions

- Presence in Team Meetings twice a week *(mini-teaching episodes etc)*
- Referrals to MAT / curbsides for patients unable to access other treatments *(direct consultation of guideline/evidence-based treatments, etc.)* / or simply co-treatment in ACT
- Attend patient SUD-groups to talk about MAT Clinic and do Naloxone trainings/videos

# Day 2 – Study/Act
# Naloxone Needs—initial Fall investigation*

| Naloxone need | 20 | These are all patients with OUD/stimulant use disorder/or other risky unknown street substances use |
|---|---|---|
| **Percentage of team that need naloxone*** | 54% | Over 50% of ACT team needs regular access to naloxone* |
| **Total received naloxone at initial eval** | 100% | Of the 16/20 patients that were either not admitted/were locatable/didn't refuse – we met 100% naloxone coverage by Oct/Nov 2023 |

"Naloxone Coverage" construct

# PDSA – naloxone coverage

| | Total Narcan Need (changes each cycle because of new pts, deaths and/or transfers) | Final Viable Pts (pts connected with, not admitted etc.) | Coverage Achieved | Pts needed/ accepted new Narcan for any reason (lost, used, etc) | Pt didn't need Narcan* (still had from previous cycle) | % needed new narcan at start of new cycle | Notes |
|---|---|---|---|---|---|---|---|
| **Fall— Oct/Nov** | 20 | 16 | 100% | | | | 100% naloxone coverage by Oct/Nov 2023 |
| **Winter—Jan/Feb** | 18 | 12 | 100% | 11/12 | 1/12 | 91.7% | 2 deaths, 1 new pt, many admitted pts who will be DC'd with Naloxone* |
| ***Spring— April/May*** | *PENDING* | *PENDING* | *PENDING* | *PENDING* | *PENDING* | *PENDING* | *PENDING* |

# Naloxone Coverage Highlights

- **This is Easy to do!**
  - Maintain list of eligible patients that can be updated *[almost literally just me with a clipboard]*
  - Team engagement ; “we did everything we could” ; evidence-based

- **High Naloxone Need! High refill rate***
  - 11/12 pts (91.7%) accepted and received new naloxone ~3mo after first given (lost, stolen, used, any reason, etc).
  - 1/12 had naloxone from initial and didn’t need new naloxone

- **Winter Cycle Findings**
  - **2 patients died of cocaine/fentanyl related overdoses on the team**
    - Both with naloxone ; one also had it at housing location but died outside of home w/ no intervention

# Broad policy statements – Zero Overdose

- Not just for medications ; but remembering that medications for OUD are very good ; (and naltrexone for AUD has a better NNT than statins etc)
- But access to Contingency Management and StUD care is very low*

- VA Efforts – annual documentation requirements

## Academic Detailing Services - Opioid Overdose Education & Naloxone Distribution (OEND)

The VA OEND Program aims to reduce harm and risk of life-threatening opioid-related overdose and deaths among Veterans. Key components of the OEND program include education and training regarding opioid overdose prevention, recognition of opioid overdose, opioid overdose rescue response, and issuing naloxone kits. VA Academic Detailing Service has worked with the Office of Mental Health and Suicide Prevention (OMHSP) to produce patient education brochures for overdose prevention, overdose recognition, and instructional guides for the naloxone products.

| | Mechanism of Action | Effect on mortality |
|---|---|---|
| **Buprenorphine** | Partial agonist | ↓ 50% |
| **Methadone** | Full agonist | ↓ 50% |
| **Naltrexone** | Antagonist | ↔ |

# Parallels to Suicide

- **Suicide Care (Zero Suicide, etc. )**
  - Standardized Screening at routine interval
  - Standardized Documentation of Suicide Assessment
  - Risk Scoring / Risk Determination
  - Action Taken and other Evidence-based interventions (hospitalization, treatment, etc)

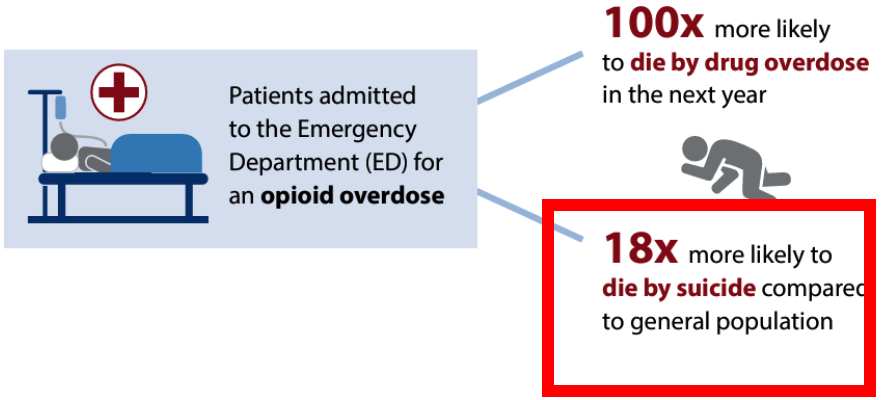
- Our practices would not stand if we didn't approach suicide care in a rigorous way
  - Given its extreme deadliness, why do we allow for a lower standard for addiction-related overdoses? Only because we are not "liable" in the same sense as suicide?

**Figure 2. Non-fatal overdose is associated with an increased risk of future overdose.[15]**

Among patients who died of an overdose,
**1 in 6 had a non-fatal overdose in the year prior.**

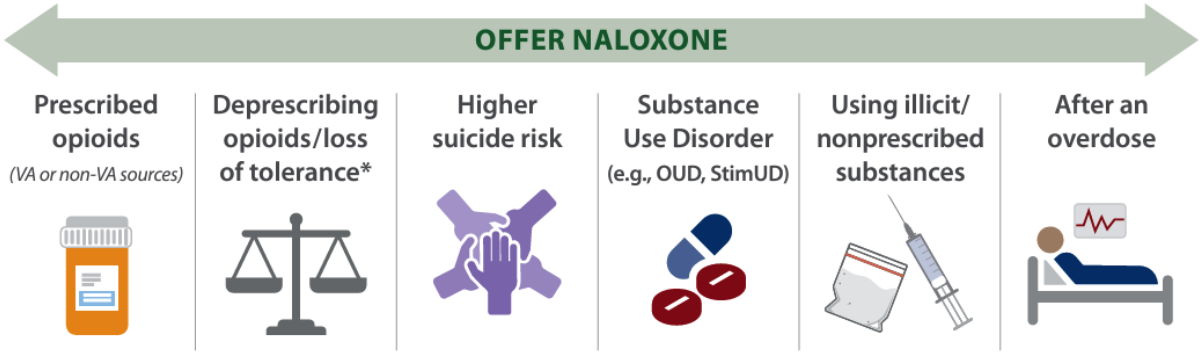
Naloxone can be an added safety measure to prevent death when opioids are involved in an overdose.

**Figure 3. Opioid overdose survivors not only have a higher risk of overdose but also suicide.[16]**



## Who is at risk for an overdose?

**Figure 7. Offer naloxone to at-risk Veterans in these groups.**[21,24,25]




*Includes Veterans undergoing an opioid taper or who have loss of tolerance from not taking an opioid for several days, e.g., hospitalization or incarceration.

## Using dashboards to find at-risk Veterans

**Table 1. Dashboards can help identify Veterans who could benefit from naloxone.**[26]

| Properties | Dashboard tool* | | |
|---|---|---|---|
| | STORM | ADS tools | OSI |
| Updated daily | ✓ | ✓ | Quarterly |
| Identifies proactive risk mitigation strategies (informed consent, PDMP check, urine drug test (UDT), naloxone) | ✓ | ✓ | Only UDT for patients on LTOT |
| Provides detailed patient information about key risk factors | ✓ | ✓ | |
| Facilitates review required prior to initiating opioid therapy | ✓ | | |
| Includes one-year risk of overdose or suicide for any Veteran, including those not currently prescribed opioids | ✓ | | |
| Provides the official public facing opioid prescribing metrics | | | ✓ |

# Within the culture:

**AUTOMATED EXTERNAL DEFIBRILLATOR (AED) CABINET NALOXONE PROGRAM**

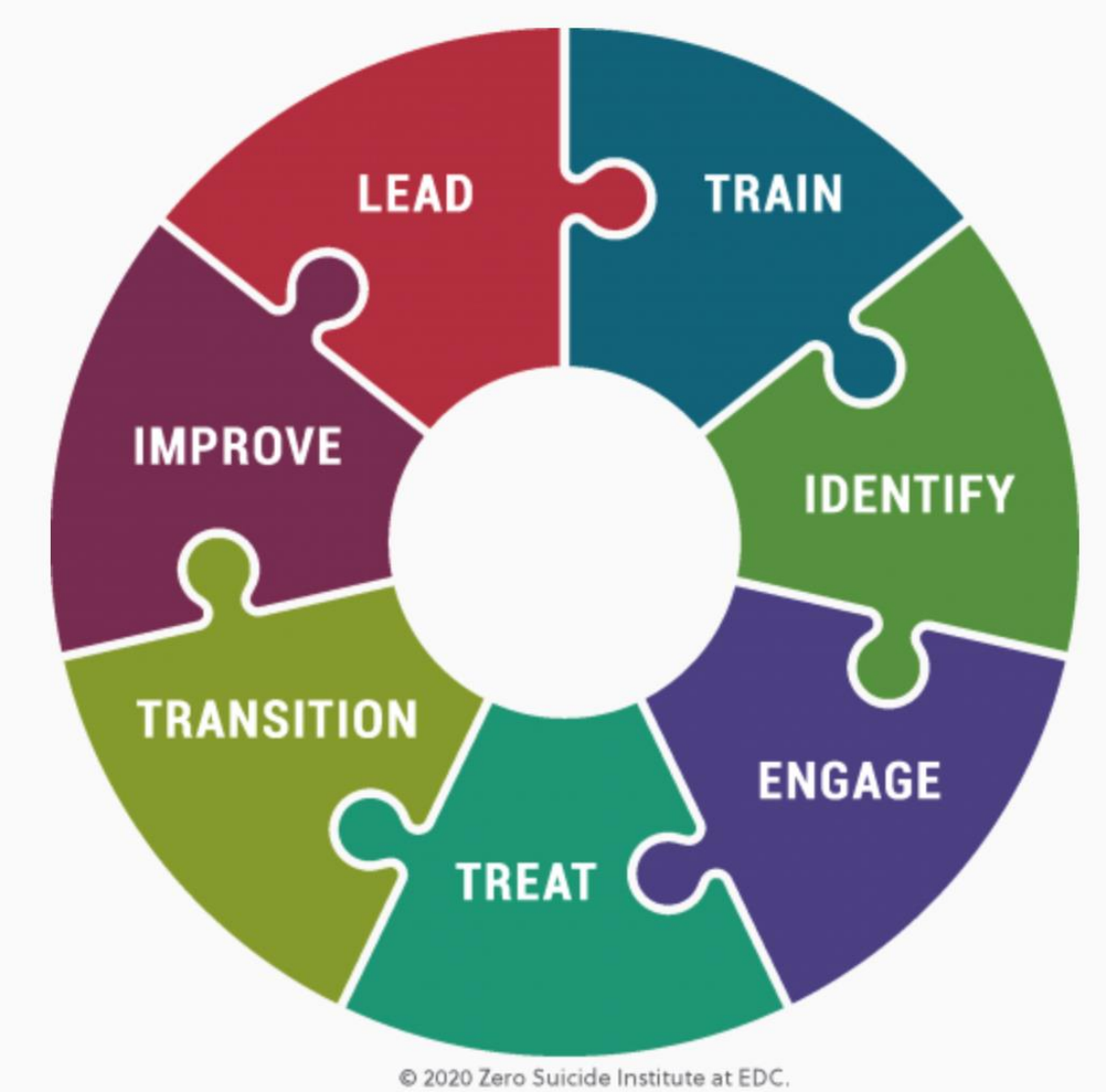
| | |
|---|---|
| Key Message ONE | Select AED cabinets in high-risk areas now contain nasal naloxone, making this lifesaving medication easier to access in the event of an opioid overdose. |
| Key Message TWO | First responders to an opioid overdose can act quickly with lifesaving nasal naloxone found in select AED cabinets. |
| Key Message THREE | We've established processes to make sure that our nasal naloxone-equipped AEDs meet standards set by The Joint Commission. |

- Embedding naloxone training within CPR etc.

# The Future

- Just like Zero Suicide = Zero Overdose Policy
- We can imagine a world where there are zero addiction-related overdoses and aim for that with the application of evidence-based practices into routine care

*(and by treating addiction as seriously as suicide)*



# Harm Reduction = Risk Reduction = “Treatment”

- **Should remember we should just simply call it Tertiary Prevention ; Forget the politics around “Harm Reduction”** *(even openly embraced by Trump’s Surgeon General)*

- Guideline Driven / Evidence-based strategies to reduce unwanted outcomes
  - Syringe Programs
  - Naloxone
  - When manualized in RCTs, harm reduction infused interventions has shown evidence to reduce drug use (most studies explicitly in those who are experiencing homelessness) *(note: curb drug use in general)*

- Even the VA can implement syringe programs/ safer use programs and has national support

# Ideas / Workshopping:

- Impact on fentanyl / OD related deaths on teams
- Treatment of stimulant induced psychosis / psychotic symptoms
- Using buprenorphine or long-acting injectable buprenorphine
- Reaching ZERO OVERDOSE on your teams

Questions?