Complex Cases and Trust Building

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January 21, 2022

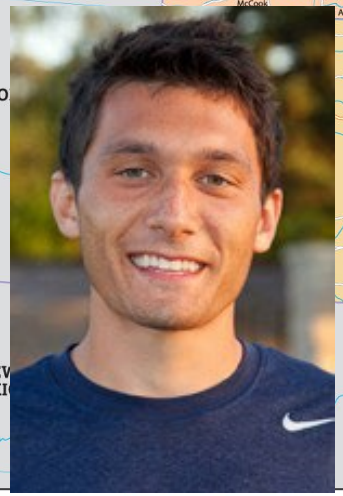
Disclosure

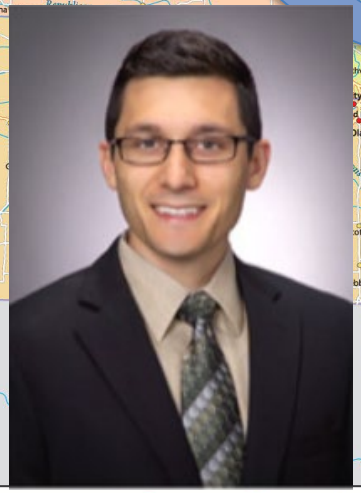
I, Cameron Risma, have no relevant financial or non-financial disclosures or conflicts of interest with the presented material in this presentation.

Objectives

- Describe at least 3 strategies for building trust in SUD treatment.
- Identify the value of establishing trust in SUD treatment
- Understand and implement strategies for managing complex SUD cases

About Me...





About Us…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Why Build Trust?

Why Build Trust?

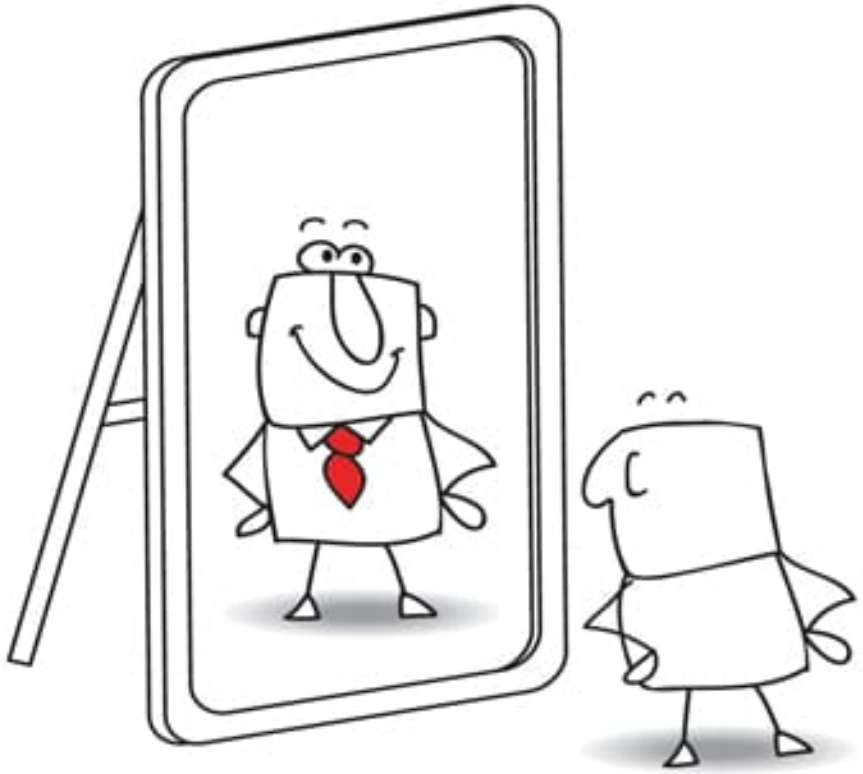
- Screening and assessments are only as good as the answers you get
- Accurate information crucial to appropriate referral and resource allocation

How many drinks containing alcohol did you have on a typical day when you were drinking in the past year?

1 or 2 drinks	**0**
3 or 4	+1
5 or 6	+2
7 to 9	+3
10 or more	+4

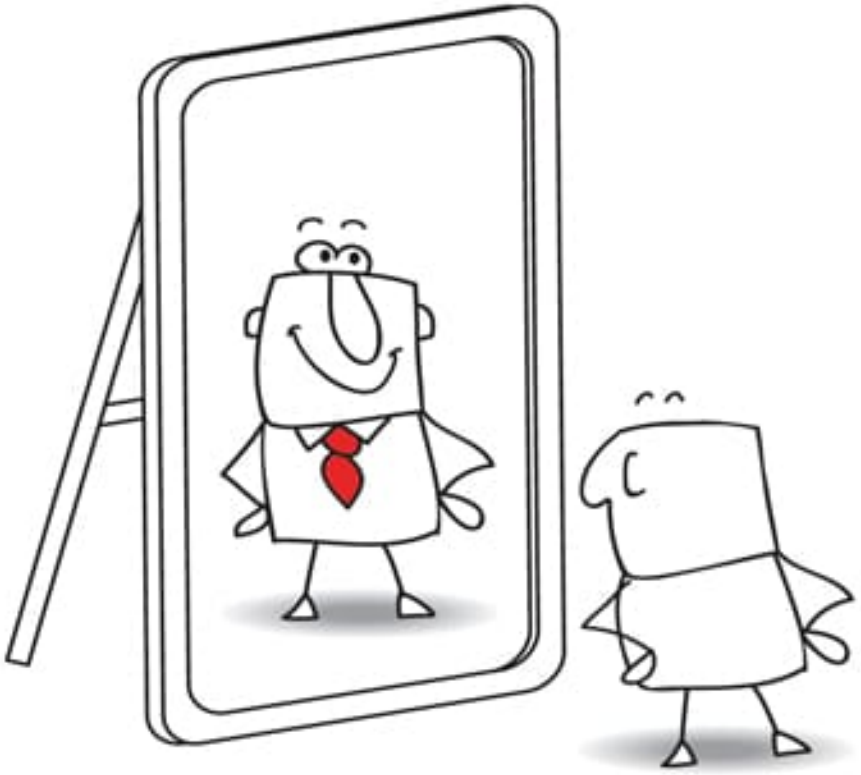
Building Trust: Strategies

- Be genuine
- Unconditional positive regard
- Empathy
- Loosen up!
- Mirroring
- Respect autonomy

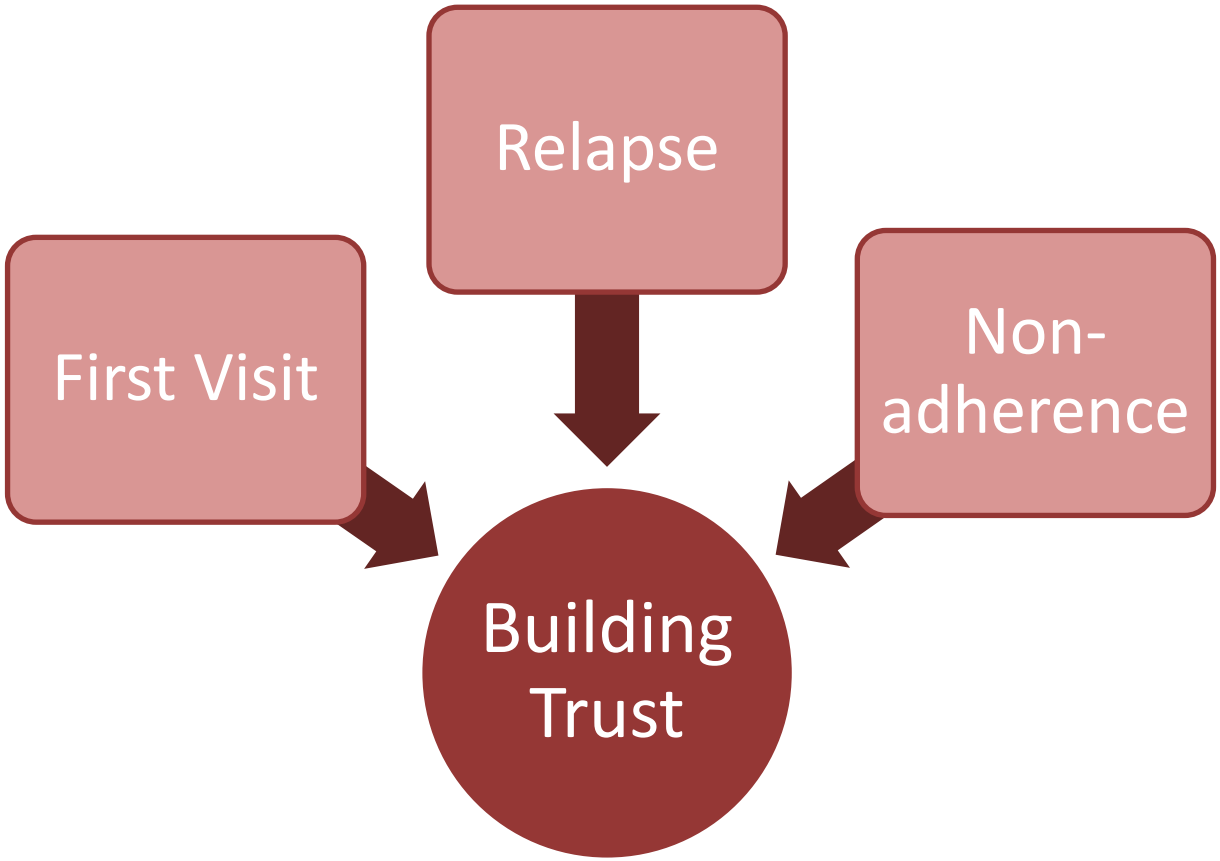


Building Trust: Strategies

- Let's learn from each other…
- What specific approaches do you use to help with trust building?

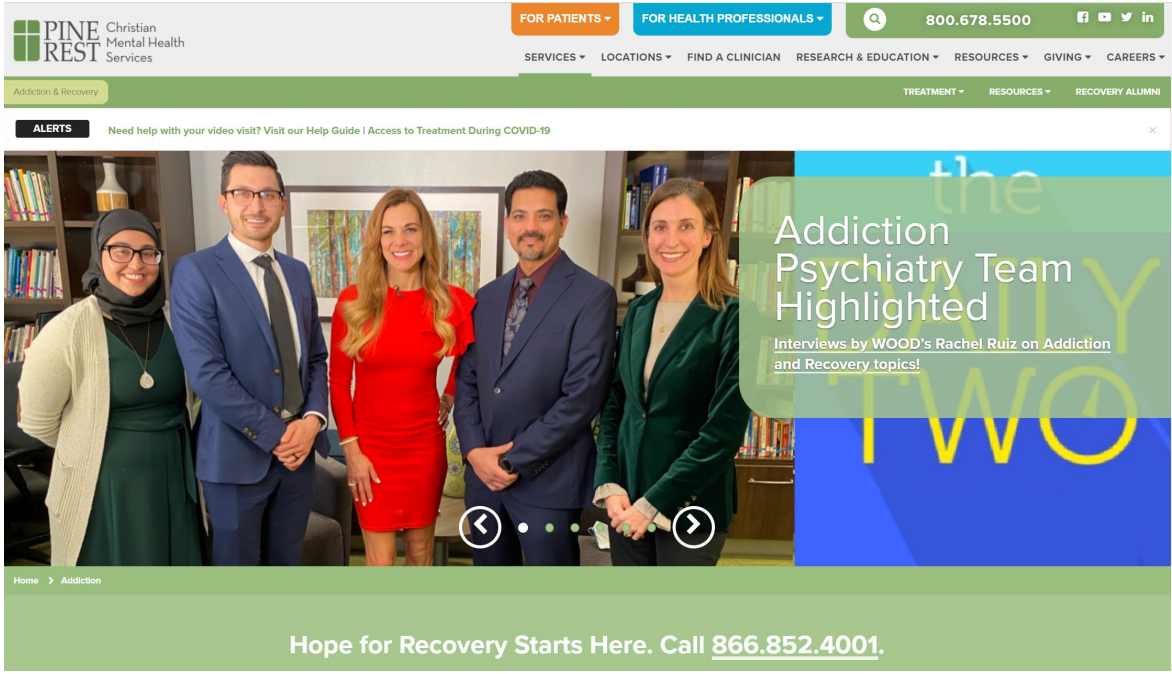


Building Trust



Building Trust: Prior to First Visit

- First impressions…
  - Website
  - Patient portal
  - Online reviews
  - Word of mouth
  - Phone call
  - Support staff



Building Trust: Prior to First Visit

- What are my attitudes toward substance use?
- What is my own experience (self or family) with substance use?
- What prejudices do I bring?
- What assumptions am I making?
- How am I wording questions?
- Whose goals will I prioritize?
- How will I respond?

Building Trust: First Visit

- First Visit
  - Set the frame
  - Non-judgmental
  - Drop your agenda
  - No finger wagging
  - Mind your face!
  - Accept ambivalence/resistance

Building Trust: First Visit

- Collaboration
  - Adaptability
  - Harm reduction?

- Evoke goals
  - *“Where would you like to be in 6 months?”*
  - *“What’s the best next step to get you there?”*

Alcohol: Harm Reduction

- Benefits in…
  - Injuries
  - Cardiac function
  - Blood pressure
  - Weight loss
  - Liver cirrhosis
  - Withdrawal risk
  - Psychiatric symptoms
  - Hospitalizations
  - Self-confidence
  - Quality of life
  - Stigma

Building Trust: First Visit

- SUD History
  - "*Everybody does everything, and that's okay.*"
  - Don't leave it to the end
  - Order matters
  - Overshoot
  - Give them a chance to brag
  - Build your street cred
  - Check your non-verbals

Building Trust: Relapses

- Expect it!
- Eliminate shaming messages
- Respond with genuine care
- Affirm help-seeking behaviors
- Explore triggers
- Evaluate need for higher level of care
- Build on recovery plan

Building Trust: Non-Adherence

- Avoid arguing!
- Roll with resistance
  - *"On one hand…on the other…"*
  - *"You're right …"*
- Support self-efficacy
  - *"What're you willing to do from here?"*
- Explore discrepancies
  - *"On one hand we're missing appointments, on the other you desperately want to get sober."*

Complex Cases

What makes a case complex?

Polysubstance use	Risky behaviors	CPS reports	Medical comorbidities
Chronic pain	Trauma	Severe psychiatric symptoms	Family dynamics
Chronic relapses	Non-adherence	Pregnancy	Post-op pain control
At-risk populations	Personality disorders	Homelessness	…?

Complex Cases

- Provider/team frustration
- Patient frustration
- Poor outcomes
- Frequent relapses + complications
- Non-adherence
- Poor engagement
- Worsening mental/physical health
- Job loss
- Family loss
- Legal issues

Case Management

- *"Health care and resource coordination to achieve stated goals"*
- Benefits:
  - Single point of contact
  - Health care advocate
  - Care coordination
  - Access to resources

Case Management

- May…
  - Reduce inpatient psychiatric hospitalizations
  - Improve QOL
  - Increase access to services (cost?)
  - Reduced alcohol/drug use

THE COLLABORATIVE CARE MODEL

Chronic Pain

Exhibit 1-1 Statistics on Substance Use and Chronic Pain in the United States

Category	Statistic
Chronic pain patients who may have addictive disorders	32% (Chelminski et al., 2005)
People ages 20 and older who report pain that lasted more than 3 months	56% (National Center for Health Statistics, 2006)
People experiencing disabling pain in the previous year	36% (Portenoy, Ugarte, Fuller, & Haas, 2004)
People ages 65 and older who experience pain that has lasted more than 12 months	57% (National Center for Health Statistics, 2006)
Civilian, noninstitutionalized U.S. residents ages 12 and older who report nonmedical use* of pain relievers in past year	5% (Substance Abuse and Mental Health Services Administration [SAMHSA], 2007)
People ages 12 and older who report that they initiated illegal drug use with pain relievers	19% (SAMHSA, 2008)
People with opioid addiction who report chronic pain	29–60% (Peles, Schreiber, Gordon, & Adelson, 2005; Potter, Shiffman, & Weiss, 2008; Rosenblum et al., 2003; Sheu et al., 2008)

**Nonmedical use* is use for purposes other than that for which the medication was prescribed.

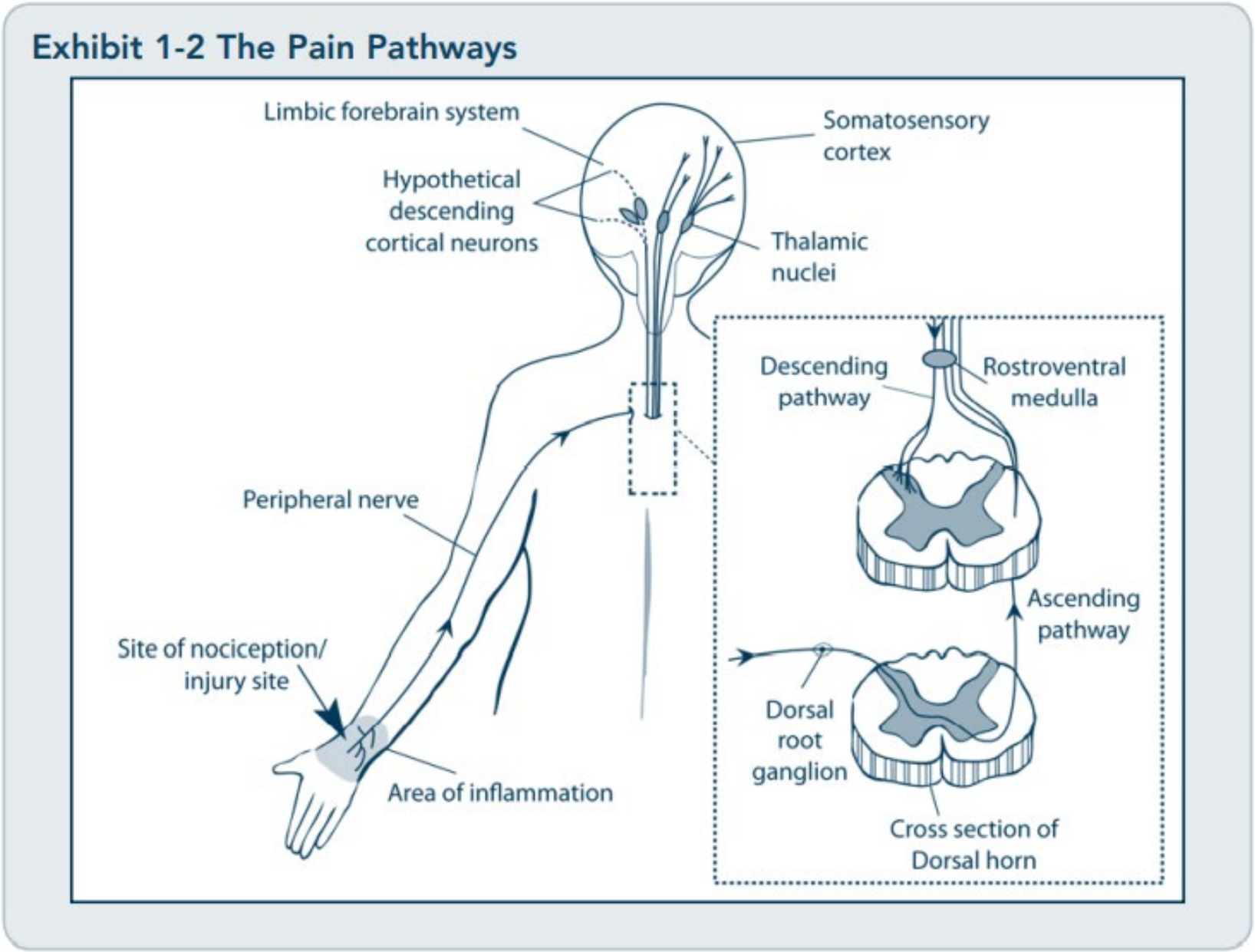
Chronic Pain

- Chronic Non-Cancer Pain (CNCP)
  - Acute, Intermittent, Chronic, Acute-on-Chronic
  - Neural sensitization + hyperalgesia
  - Allodynia

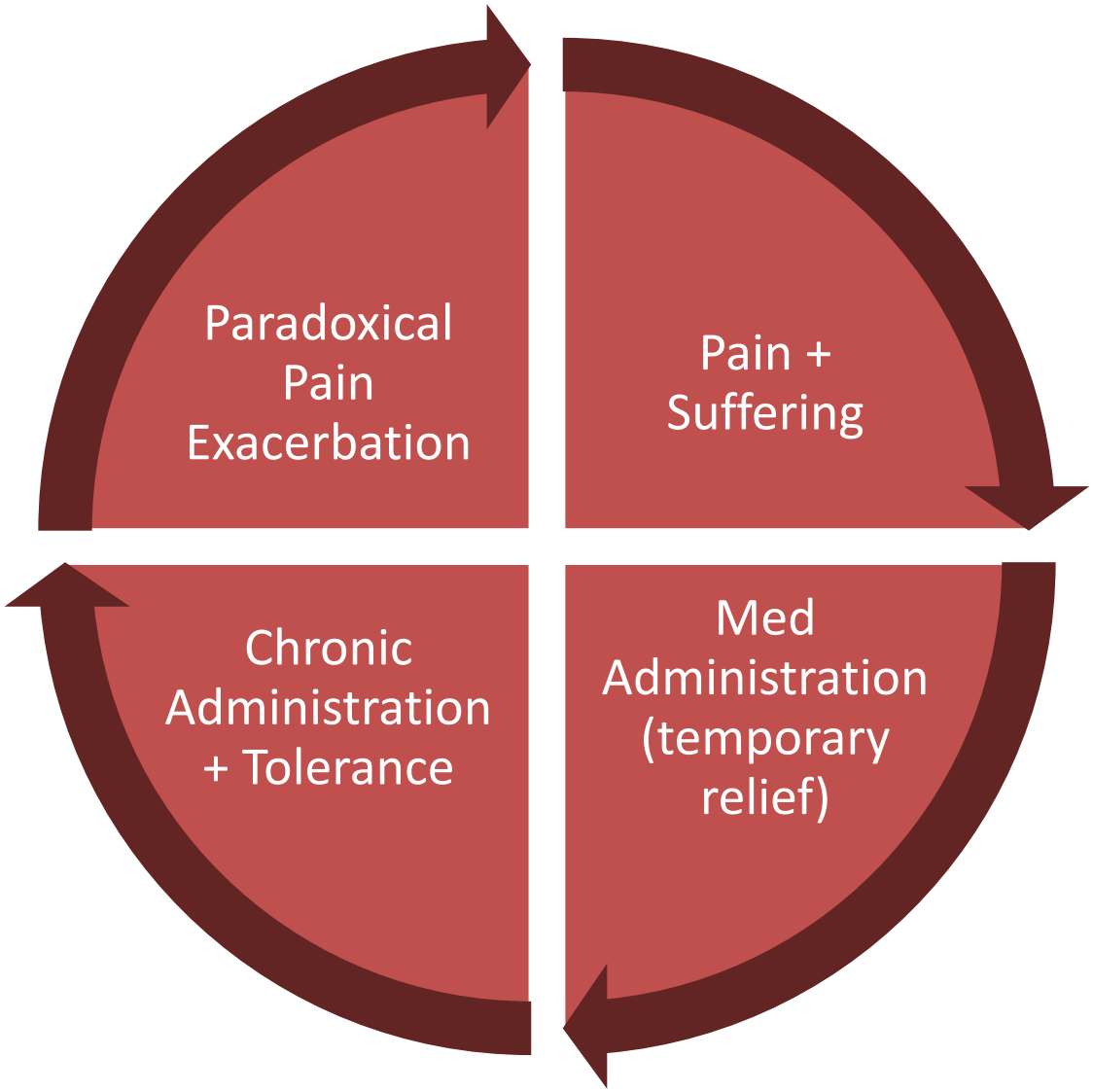
- Not all CNCP is bad!
  - Inhibitory/protective responses

- Goal: adaptive response to pain
  - Function + management. Not elimination

Opioid Induced Hyperalgesia



Chronic Pain + SUD



Chronic pain + Suffering

- Persistent pain → stress response → emotional suffering
  - Insomnia, depression, anxiety, substance use
  - Pain avoidance, activity avoidance, isolation
  - Chronic pain treatment less effective with uncontrolled depression/anxiety
- Pain Psychology

Chronic Pain Assessments

- Etiology of pain
- Pain coping
- Functional assessment
- Focus on opioids to exclusion of other modalities
- Comorbid psychiatric illness
- SUD History

Exhibit 2-14 SOAPP–R Questions

1. How often d you have mood swings?
2. How often h ve you felt a need for higher doses of medication to treat your pain?
3. How often h ve you felt impatient with your doctors?
4. How often h ve you felt that things are just too overwhelming that you can't handle them?
5. How often i there tension in the home?
6. How often h ve you counted pain pills to see how many are remaining?
7. How often h ve you been concerned that people will judge you for taking pain medication?
8. How often d you feel bored?
9. How often h ve you taken more pain medication than you were supposed to?
10. How often h ve you worried about being left alone?
11. How often h ve you felt a craving for medication?
12. How often h ve others expressed concern over your use of medication?
13. How often h ve any of your close friends had a problem with alcohol or drugs?
14. How often h ve others told you that you have a bad temper?
15. How often h ve you felt consumed by the need to get pain medication?
16. How often h ve you run out of pain medication early?
17. How often h ve others kept you from getting what you deserve?
18. How often, n your lifetime, have you had legal problems or been arrested?
19. How often h ve you attended an Alcoholics Anonymous or Narcotics Anonymous meeting?
20. How often h ve you been in an argument that was so out of control that someone got hurt?
21. How often h ve you been sexually abused?
22. How often h ve others suggested that you have a drug or alcohol problem?
23. How often h ve you had to borrow pain medications from your family or friends?
24. How often h ve you been treated for an alcohol or drug problem?

Chronic Pain + SUD Management

- Multidisciplinary team
  - PCP
  - Addiction Specialist
  - Pain Specialist
  - Pain Psychologist
  - Therapist
  - RN
  - Pharmacist
  - PT/OT

Mary Free Bed Rehabilitation Hospital

Mary Free Bed Rehabilitation Hospital
235 Wealthy St. NE
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Mary Free Bed at Cancer & Hematology Centers of West Michigan – East
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616.840.9697 – fax

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Norton Shores, MI 49444
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Mary Free Bed Holland
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Building D, Suite 150
Holland, MI 49424
616.294.4066 – phone
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Mary Free Bed Kalamazoo Southwest
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Kalamazoo, MI 49009
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Mary Free Bed Novi
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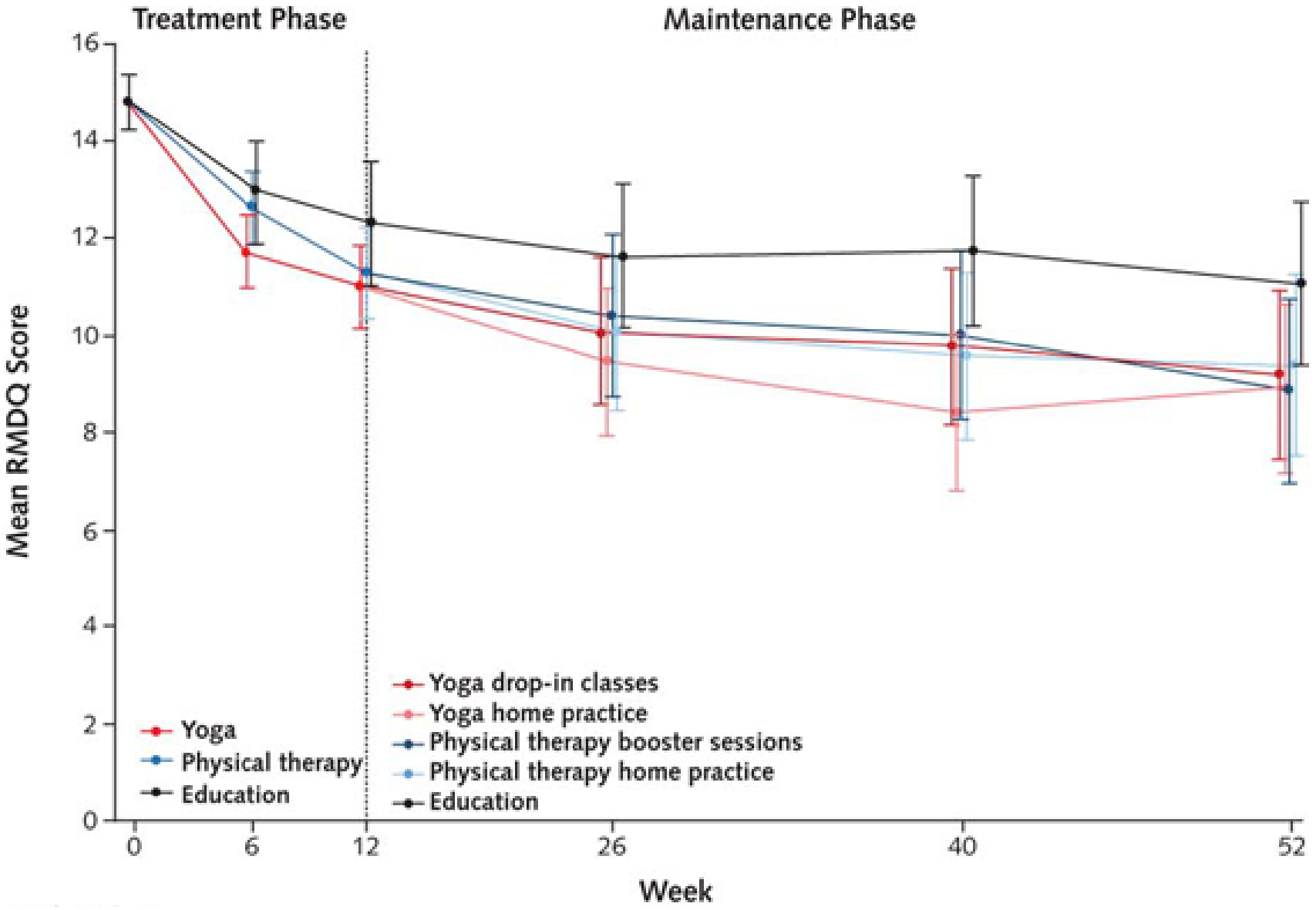
Novi, MI 48377
248.994.8596 – phone
248.994.8769 – fax

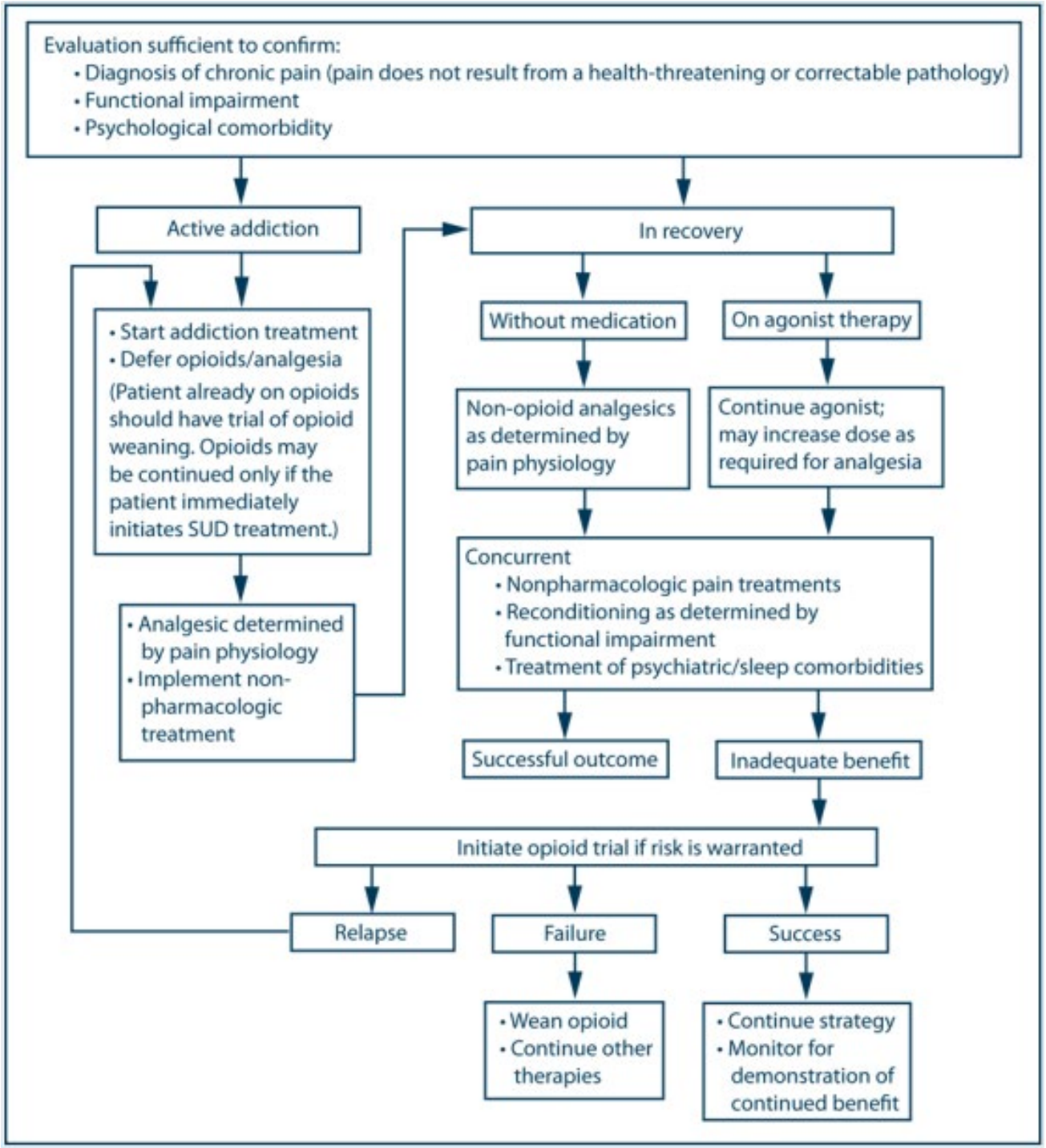
Mary Free Bed Rehabilitation – Troy
1845 Livernois Road
Troy, MI 48083
248.362.2150 – phone
248.362.1702 – fax

Pain Rehab Center

Chronic Pain + SUD Management

- SUD Treatment
- Recovery-supportive analgesia
- Alternative modalities
  - Therapeutic exercise
  - CBT
  - CAM
  - PT/OT
- Cautious use of opioids


Treatment Phase
Maintenance Phase
Mean RMDQ Score
16
14
12
10
8
6
4
2
0
0
6
12
26
40
52
Week
Yoga
Physical therapy
Education
Yoga drop-in classes
Yoga home practice
Physical therapy booster sessions
Physical therapy home practice
Education


Evaluation sufficient to confirm:
• Diagnosis of chronic pain (pain does not result from a health-threatening or correctable pathology)
• Functional impairment
• Psychological comorbidity
Active addiction
In recovery
• Start addiction treatment
• Defer opioids/analgesia
(Patient already on opioids should have trial of opioid weaning. Opioids may be continued only if the patient immediately initiates SUD treatment.)
• Analgesic determined by pain physiology
• Implement non-pharmacologic treatment
Without medication
On agonist therapy
Non-opioid analgesics as determined by pain physiology
Continue agonist; may increase dose as required for analgesia
Concurrent
• Nonpharmacologic pain treatments
• Reconditioning as determined by functional impairment
• Treatment of psychiatric/sleep comorbidities
Successful outcome
Inadequate benefit
Initiate opioid trial if risk is warranted
Relapse
Failure
Success
• Wean opioid
• Continue other therapies
• Continue strategy
• Monitor for demonstration of continued benefit

Chronic Pain + SUD Management

- Treatment Agreements
- Appointment Frequency
- Therapy
- ROI for other providers
- Prescription Supply + Monitoring
- UDS
- Documentation

Trauma + SUD


PTSD
Other Stressor Disorder
Depressive Disorder
Normative Reactions
Acute Stress Disorder
No Reaction
Anxiety Disorder
Substance Use Disorder
Trauma Event(s)

Trauma + SUD

- 50% of those with h/o trauma meet criteria for AUD
- 59% of those with PTSD develop a SUD
  - Active SUD correlated with more severe PTSD symptoms
- Men with h/o trauma → cocaine
- Women with h/o trauma → heroin

Principles of Trauma-Informed Care

SAFETY

TRUST

PEER SUPPORT

COLLABORATION

EMPOWERMENT

CULTURAL SENSITIVITY

Trauma + SUD

- *Goal: orient policies, procedures, and staff training to create supportive/safe environment for people with h/o trauma*

- Emotional, behavioral, spiritual, physical impacts
- Recognize (mal)adaptive changes in people with h/o trauma
  - Resilience vs pathology
- Beware replicating trauma dynamics
  - Loss of control, trapped, powerless

Trauma Informed Care

Trauma Informed Care (TIC) recognizes that traumatic experiences ***terrify, overwhelm and violate*** the individual. TIC is a commitment not to repeat these experiences and, in whatever way possible, to **restore a sense of safety, power and worth**.

The Foundations of Trauma Informed Care

Commitment to Trauma Awareness

Understanding the Impact of Historical Trauma and Oppression

Agencies Demonstrate Trauma Informed Care with Policies, Procedures and Practices that:

Create Safe Context through:

- Physical safety
- Trustworthiness
- Clear and consistent boundaries
- Transparency
- Predictability
- Choice

Restore Power through:

- Choice
- Empowerment
- Strengths perspective
- Skill building

Build Self-Worth through:

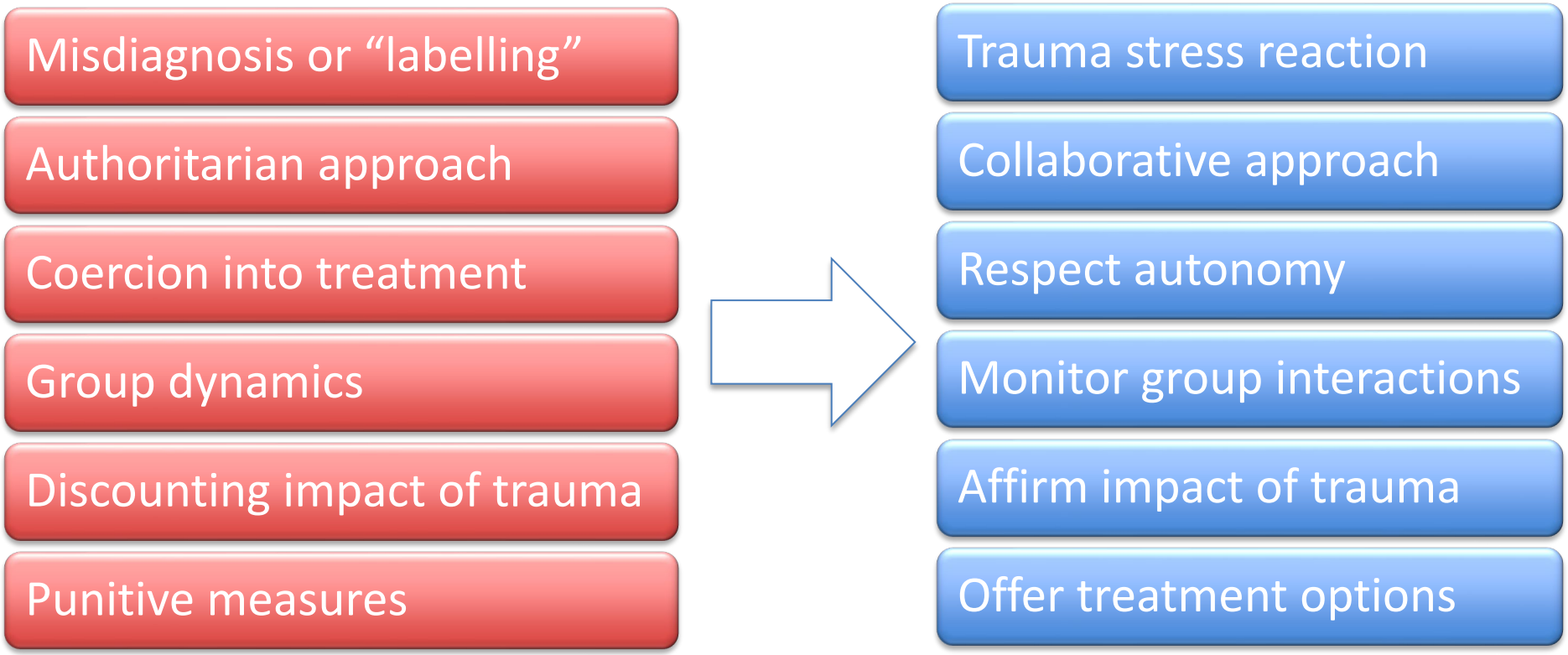
- Relationship
- Respect
- Compassion
- Acceptance and Nonjudgment
- Mutuality
- Collaboration

Image Credit: Trauma Informed Oregon, 2014

Trauma + SUD: Safety

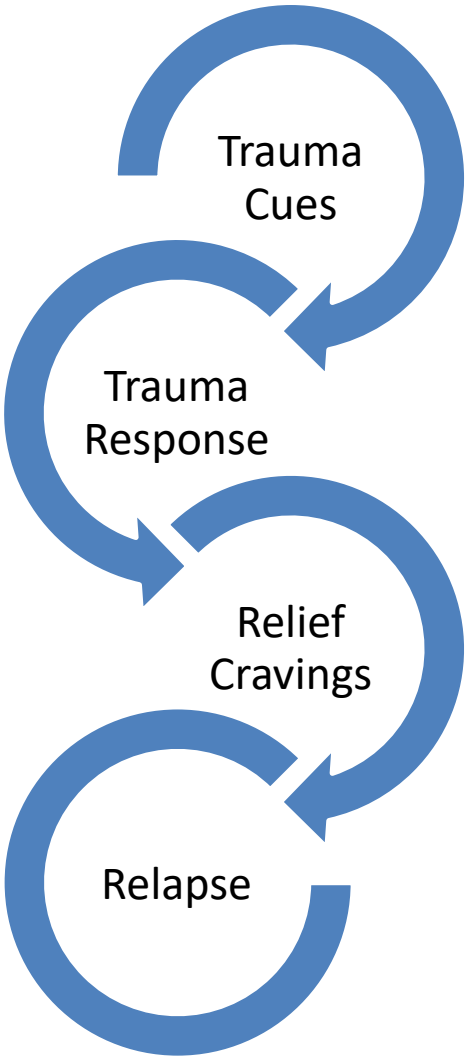
- Safety…
  - From symptoms
  - In the environment
  - From recurrent trauma
- Mind your space
  - Lighting, noises, room arrangements, etc

Clinic Retraumatization



Trauma + SUD

- Trauma often precedes SUD
  - SUD may develop as consequence of trauma
  - Recovery maintenance less likely without trauma recovery



Trauma + SUD: Management

- Screen everybody!
  - ACE
- Thorough assessments
  - Prepare several grounding exercises
- Build trust and resilience
- Medication management
- Referrals/Resources
  - Group/individual therapy, EMDR, peer support
  - Residential trauma recovery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Case Discussion

Case 1

35 y/o male with h/o polysubstance use (alcohol, heroin, meth, cannabis, BZD, bupropion, quetiapine) and hypoxic-ischemic brain injury (fentanyl OD) presenting for aftercare following discharge from inpatient psych. Divorced, lost custody of kids. Currently living at sober living facility. Smoking 1-3 g cannabis daily, scared sober living will find out. Slow, slurred speech, delayed responses. Meds as below. Demanding more stimulant for depression.

- Seroquel 300 mg nighty
- Neurontin 600 mg TID
- Wellbutrin XL 450 mg daily
- Depakote ER 1500 mg nightly
- Effexor XR 150 mg daily
- Suboxone 8-2 mg BID + 4-1 mg nightly
- Modafinil 100 mg daily

Case 1

- What are your concerns?
- How do confront his possible intoxication during the appointment without damaging rapport?
- What are your next steps?

Case 1

Returns to next appointment. Relapse on heroin/meth, discharged from SLF. Admits to detox facility. Still appears high when completely detoxed. Discharged to another SLF. Chronic pain exacerbation without Suboxone. Received small opioid prescription at the ED, “woke the beast.” Requesting to go back on Suboxone due to chronic pain.

Case 1

- How do you build trust while declining his repeated requests?
- What referrals are appropriate?

Case 2

43 y/o married, employed, Caucasian female. Lives with husband and 2 daughters (11, 7). H/o MDD, GAD, PTSD, Cannabis Use Disorder, Sedative Use Disorder (Xanax). Currently on Effexor, Wellbutrin, Buspar, Vistaril. Husband is volatile, manipulative, controlling. No physical/sexual abuse.

- Daughters hide and pack bags when dad yells
- Preplanned meeting location
- EMDR therapy
- Minimal peer support

Case 2

Substance use

- Cannabis: dabbing THC daily for relief from “mental exhaustion.”
  - High while caring for girls (no driving)
  - Wants to stop but can’t
- Xanax: h/o daily use in 2016, “really proud” about cessation
  - “Didn’t realize how much it was hindering me.”

Case 2

- How would you build trust and explore safety issues?
- How would you build on strengths, emphasize resilience, and work on reducing cannabis use?
- What kind of referrals/resources would she benefit from?
- CPS?

Case 3

37 y/o single, unemployed, Caucasian female with h/o polysubstance use (opioids, cannabis, tobacco, cocaine, alcohol, inhalants). H/o physical/sexual abuse. Parental rights terminated to all 3 kids. Current boyfriend very controlling and manipulative. Therapist requests transfer of doctor for stability purposes.

- Distrustful, guarded, demanding Xanax
- Accusatory of poor clinical decision making

Case 3

Returns with accusations of unsupportive practice, not sending medications to pharmacy. Requesting higher doses of Suboxone. Crisis phone calls on weekends. Left boyfriend, living in hotel. Multiple relapses. Requesting early refills.

- UDS + amph, meth, MDMA, cocaine, Bup, THC, benzo
- Never had clean UDS

Case 3

- What concerns do you have?
- How do you build trust with her?
- How do you set boundaries in treatment while maintaining her trust?
- What referrals are appropriate?

Case 4

- 62 y/o married, unemployed, female with h/o alcohol use disorder. Medical history of fibromyalgia, IBS, migraines. On disability due to chronic pain. Presented with repeated alcohol relapses triggered by physical pain. Drinking ½ gallon liquor daily. Pain limits daily functioning (dressing, bathing, cleaning, etc). No longer leaving the house due to pain. *“I don’t know why I keep doing this to myself!”*

Case 4

- How could you respond to repeated relapses in a way that builds trust?
- Other than recommending detox, what other referrals/resources might she need?

Case 4

Completes detox. New (safe) medication for chronic pain and alcohol use disorder. Wants even more definitive treatment for chronic pain to reduce risk of relapse. Radical acceptance is repugnant. *“If you knew anything about my religion you would understand.”*

Case 4

- How do you explore radical acceptance of pain without alienating her worldview?
- What are some approaches to exploring possible referral to pain rehab program?


Let’s collaborate!

Resources

Case Presentations from the Addiction Academy

Facilitating Entry into Treatment

TIP 54: Managing Chronic Pain in Adults With or in Recovery from Substance Use Disorders

TIP 57: Trauma-Informed Care in Behavioral Health Services

Integrating a Trauma-Informed Approach into Substance Use Disorder Treatment