NAATP NATIONAL 2023

NATIONAL ASSOCIATION OF ADDICTION TREATMENT PROVIDERS

Voice. Vision. Leadership.

Managing Increased Patient Acuity and Complexity from both a Clinical and Organizational Perspective

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Learning Objectives

1. Understand the shared neurobiology between ACEs/Trauma and SUD and how systems of care can utilize this information to develop care models that address the specific needs of acute and complex patients

2. Recognize the realities of clinician experiences when working with acute and complex patients and how effectively integrated care models can reduce compassion fatigue and empathetic distress

3. Understand The Interpersonal Theory of Suicide (Thomas Joiner) and how this research can be utilized with traditional Suicide Risk Assessment tools before, during and after a treatment episode.

4. Understand how to establish and maintain a system that creates a safe environment for patients and staff.

Let’s Meet Lina

Lina is a 23 y/o single woman who presents to our outpatient program as a referral following a recent hospitalization as the result of an overdose. At the time of the overdose, her tox was positive for opioids, benzodiazepines, and methamphetamine. She acknowledges using ¼ to ½ gram of heroin and/or meth IN/IV “several times per week.” She also obtains “pain pills and benzos” off the street and estimates that she uses 4-6 tabs of each “most days.” She does not know the doses of the pills and when asked what specific pills she takes, she responds with “anything and everything.”

Her medical records show that she has been in and out of the ED numerous times (12 times in the last 18 months) following overdoses and incidents of self-harm with cutting and SI. Her arms are covered with laceration scars, most well-healed and appearing to be predominately superficial. Along with the cuts are clear track marks and she has a tattoo over each wrist (a bloody rose on the right and a teddy bear on the left) covering numerous scars.

Let's Meet Lina (continued)

Medical Hx is significant for pelvic pain of unclear etiology and neg w/u.

In the hospital she was restarted on sertraline 50mg qDay.

She has a long history of depression and has been in and out of MH care and has been prescribed various SSRIs and SNRIs over the past 7 years since age 16. She also relates a significant trauma history consisting primarily of physical and emotional abuse from her parents who both suffer from addiction and depression.

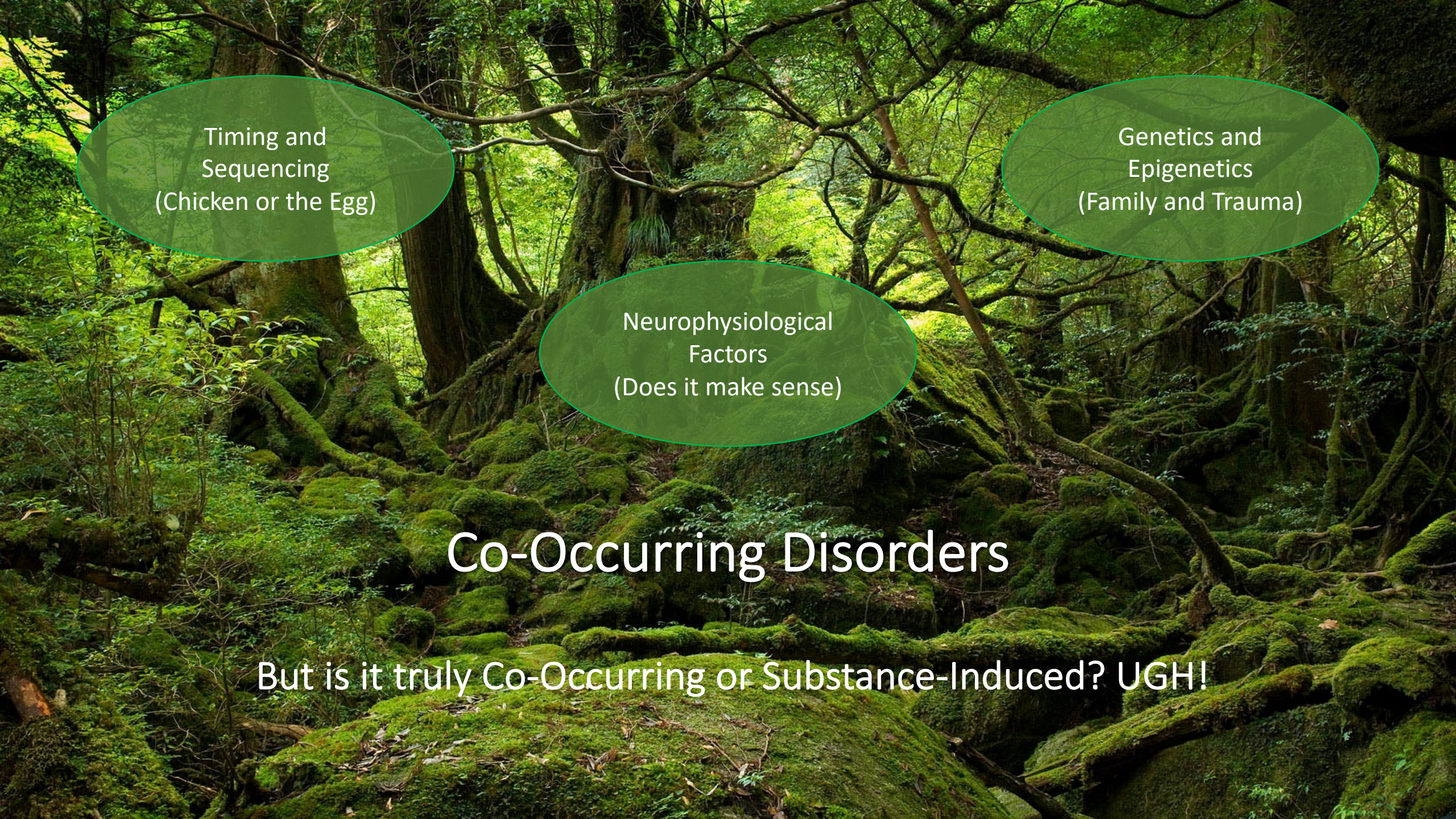
NOTE – after trust is established, we learn that there was also significant sexual abuse from ages 12-14 from an older maternal cousin.

She has been referred to our program for assessment and treatment of both her SUD and mental health symptoms. It is noted that previous mental health providers stopped working with her because of missed appointments and recurrent no shows.

She is currently unemployed and living with a boyfriend who drinks and smokes marijuana daily.

What are we dealing with?

Conceptual Evolution To…



Co-Occurring Disorders

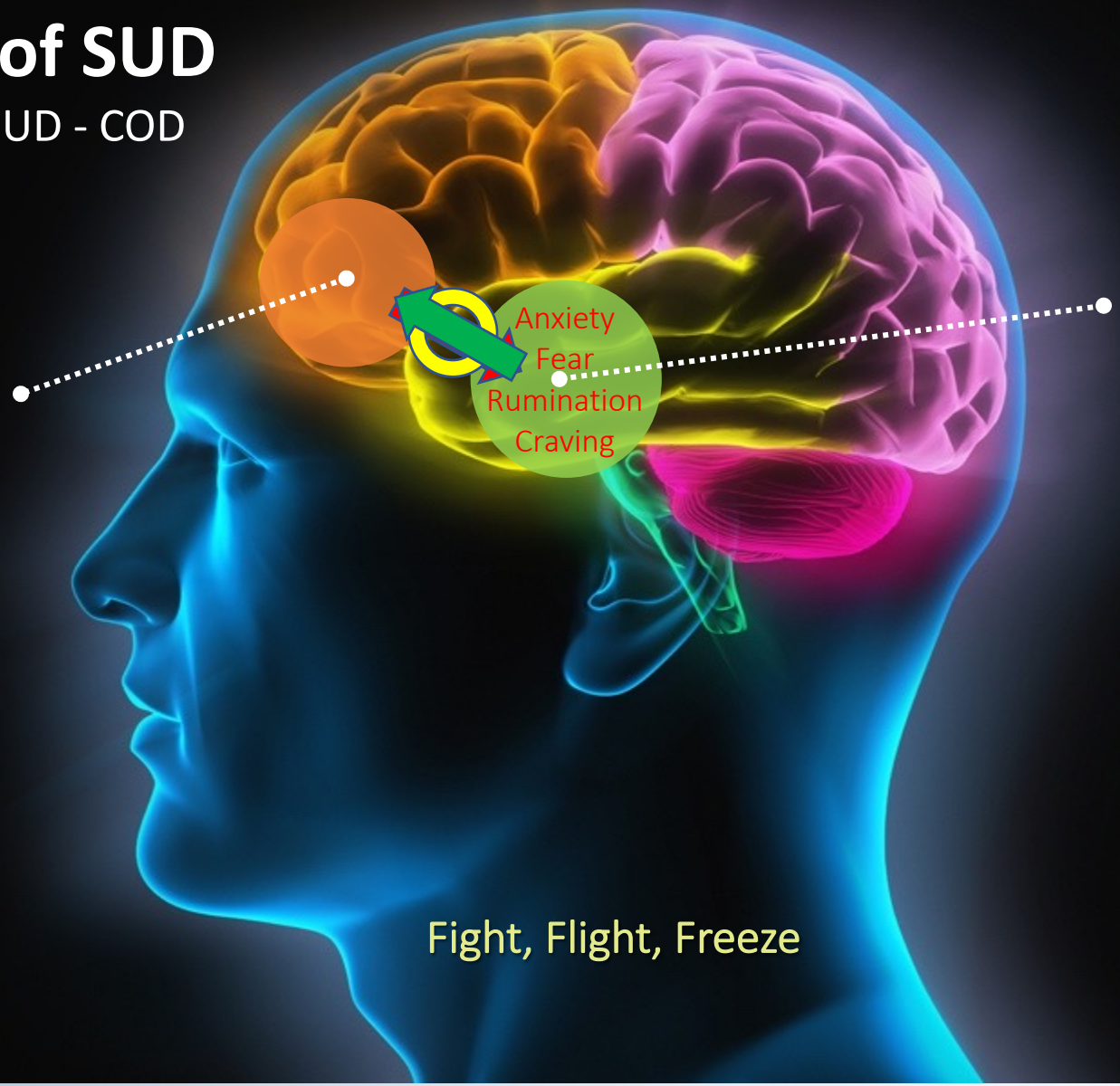
But is it truly Co-Occurring or Substance-Induced? UGH!

Neurobiology of SUD

and Overlap Between SUD - COD and Trauma/ACEs

Prefrontal Cortex

Emotional control, delayed reward valuation, executive functioning, judgement, perspective



Limbic System

reward and motivation, memory, stress response, emotions

The Fight, Flight, or Freeze Response (FFF)

https://youtu.be/jEHwB1PG_-Q

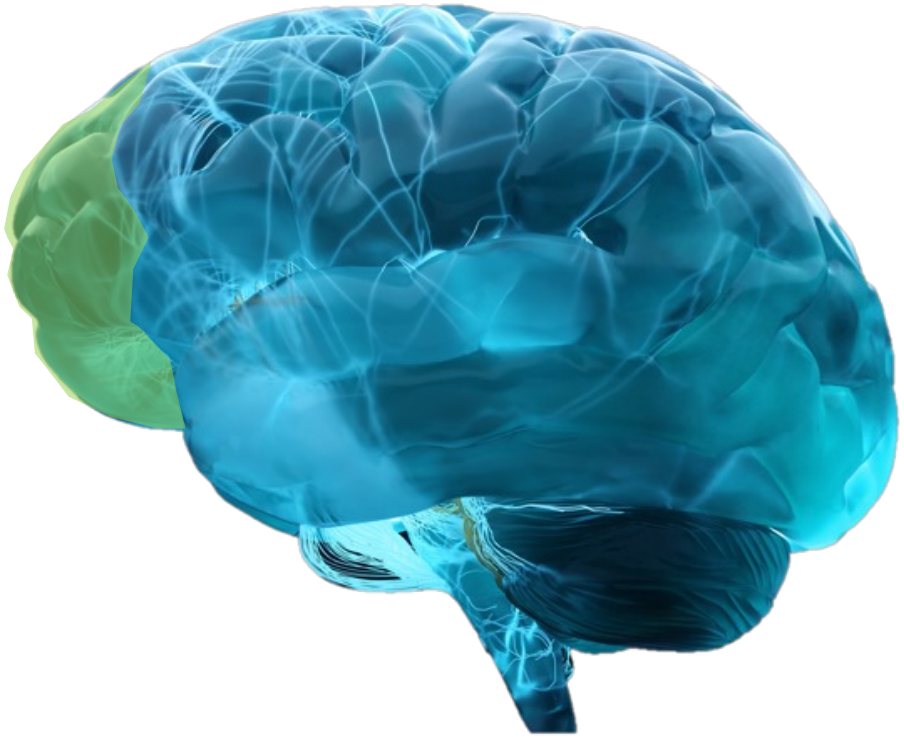
Source: *Author Braive - https://youtu.be/jEHwB1PG_-Q*

Signs of prefrontal cortex deficits

NON-CLINICAL TERMS

(what we all see lived out, stigmatizing):

- Inability to objectively assess oneself
- Poor judgment
- Inability to learn from experience
- Decreased attention span
- Becoming easily bored
- Argumentative
- Thin skinned
- Self-centered
- Disorganized



(We need to check our own reactions)

Follow up with Lina

Team Integration across SUD, MH, Medical, and Peer Specialist

Lina has continued to work with her SUD counselor, participating in weekly groups and individual sessions. She is also engaged in formal DBT and the cutting behaviors have gradually decreased in frequency (not gone).

Her use of benzodiazepines has decreased as she has learned coping skills from her DBT groups. Sertraline was increased to 100mg per day and she is on buprenorphine for her OUD.

While she continues to have emotional “storms” and crises, cutting behaviors are less than 1/mo and there have been no overdoses recent overdoses.

Most notably, she is consistently taking her meds and attending her appointments (will call if going to miss an appt and then reschedules her appt). She is also connecting with her peer recovery specialist.

Summary from the Clinician Perspective

1) Understanding the shared neurobiology between ACEs/Trauma, COD, and SUD can help maintain empathy and reduce compassion fatigue – Consider Attachment
2) Learn to recognize executive function deficits and FFF – need realistic expectations - ground yourself and the patient – create EXTERNAL prefrontal cortex
3) Always attend to your own reactions elicited by complex patients – you are human! Seek supervision
4) Seek collaboration across your system of care – team integration is crucial
5) Universally assess for SAFETY (patient, you, staff)
6) Attend to your needs – YOU MATTER TOO!

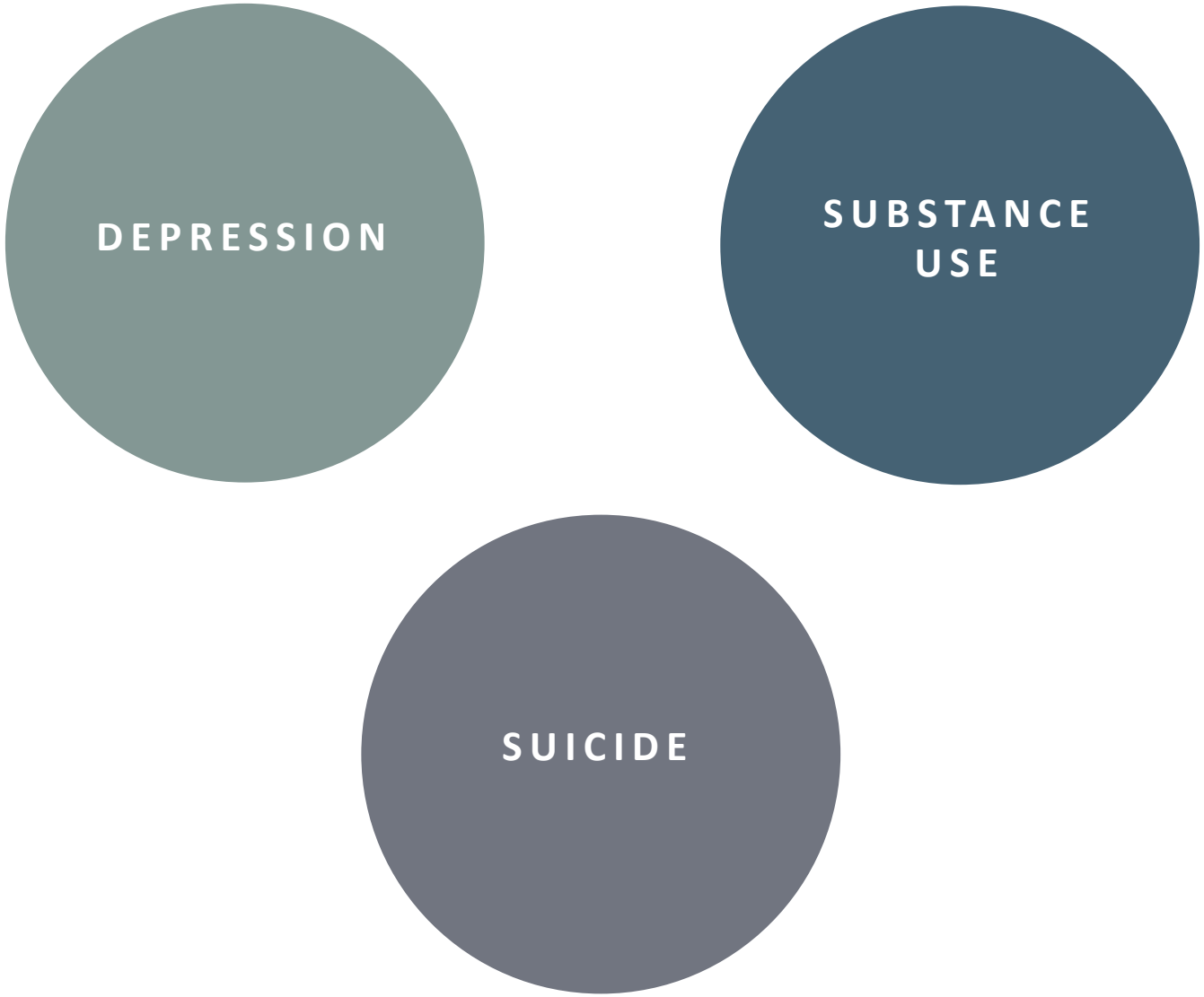
Patient Acuity and Complexity
Treatment Center/Organizational Impact

Patients in our care are more complicated

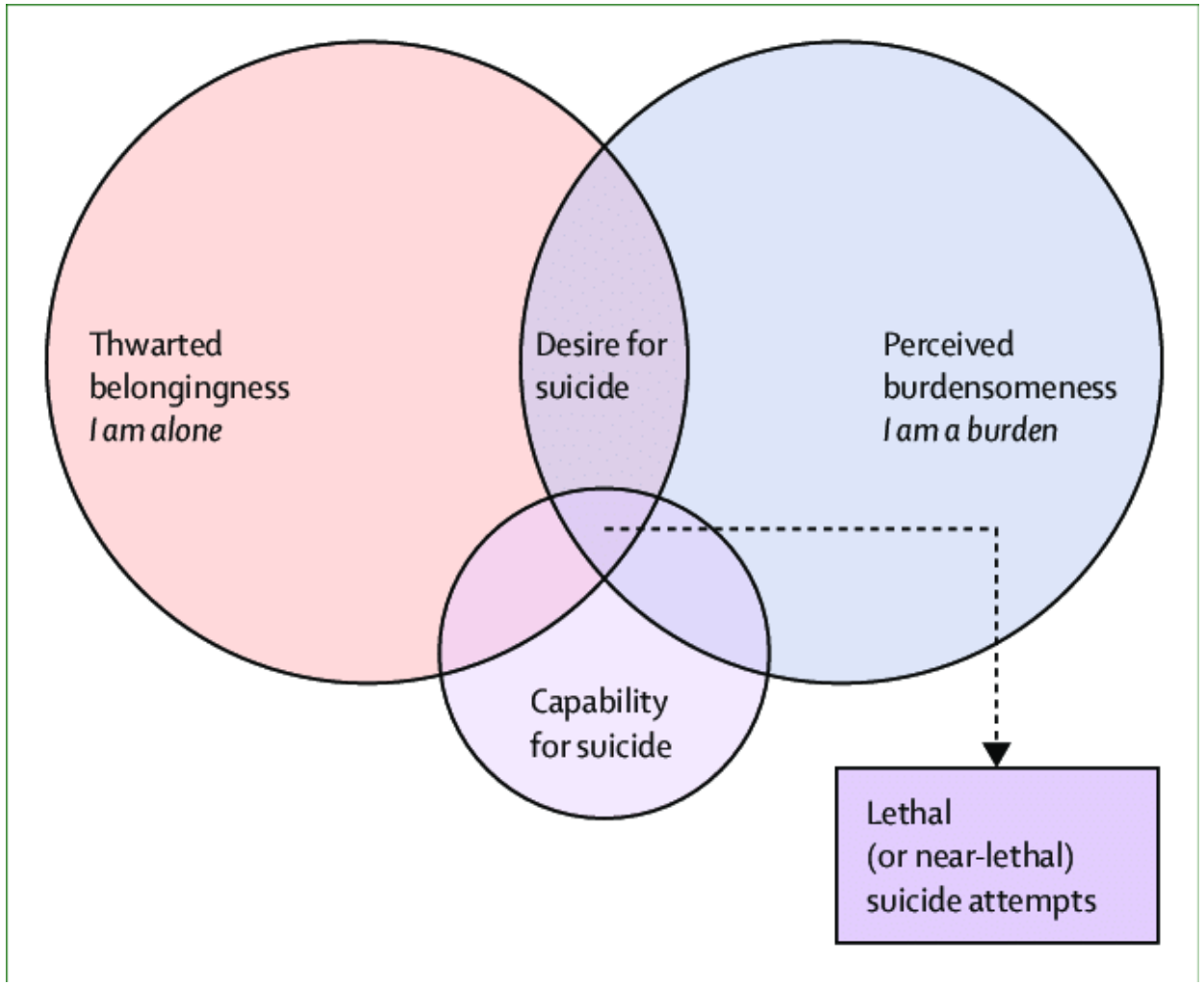
- Polysubstance
- Mental illness
- Families
- Physical deconditioning
- Milieu management
- Drug induced psychosis

Increased Costs

Increased Risk - Before, During & After Treatment


DEPRESSION
SUBSTANCE USE
SUICIDE

Interpersonal theory of Suicide, Thomas Joiner, Phd



Why People Die by Suicide, Thomas Joiner

- Burdensomeness
- Failed Belongingness
- Impulsivity
- Childhood Abuse
- Lethal Self-Injury
- Genetic Impact

Burdensomeness and Belongingness

- Human Needs
- Feeling Effective or Competent
- “Perceived” Burdensomeness
- Lack of belongingness

Lethal Self-Injury

Most Basic Instinct = Self Preservation

- Fearlessness
- Provocative Experiences
- Pain Tolerant
- Knowledge of Self-Injury
- Habituate to the Behaviors
- *Reduced fear of provocative experiences =*
- *Capability for lethal self-injury*

Impulsivity as a Factor in Suicide

- Daredevil Behaviors?
- Reckless Driving?
- Theft of Material items?
- Spend Impulsively?
- Injured in Accidents?
- Lower levels of Serotonin Metabolites
- Serotonin-System Problems
- Theory of "Spur of the Moment" Suicide
- Primal humiliation

Risk Factors

- Prior Suicide Attempt
- Family History of Suicide
  - Shame, Legacy, Grief
- Trauma
- Substance Use Disorder
  - Alcohol
  - Drugs
- Mood Disorders

Risk Factors

- Relationship Disruption
- Job or Financial Loss
- Feeling like a burden
- Failed Belongingness
- Lack of social supports (lonely)
- Impulsivity – 15 minute
- Aggression / Anger
- Lethal Self-Injury
- Social Contagion
- Humiliation

Protective Factors

Most Basic Instinct = Self Preservation

- Resilience
- Optimism
- Employment
- Family Support
- Supportive Spouse
- Children
- Religious or Spiritual Belief

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

Posner, Brent, Lucas, Gould, Stanley, Brown, Fisher, Zelazny, Burke, Oquendo, & Mann

RISK ASSESSMENT

Instructions: Check all risk and protective factors that apply. To be completed following the patient interview, review of medical record(s) and/or consultation with family members and/or other professionals.

Past 3 Months	Suicidal and Self-Injurious Behavior	Lifetime
☐	Actual suicide attempt ☐ Lifetime	☐
☐	Interrupted attempt ☐ Lifetime	☐
☐	Aborted or Self-Interrupted attempt ☐ Lifetime	☐
☐	Other preparatory acts to kill self ☐ Lifetime	☐
☐	Self-injurious behavior ***without*** suicidal intent	☐

Suicidal Ideation Check Most Severe in Past Month	
☐	Wish to be dead
☐	Suicidal thoughts
☐	Suicidal thoughts with method (but without specific plan or intent to act)
☐	Suicidal intent (without specific plan)
☐	Suicidal intent with specific plan

Activating Events (Recent)	
☐	Recent loss(es) or other significant negative event(s) (legal, financial, relationship, etc.)
Describe:	
☐	Pending incarceration or homelessness
☐	Current or pending isolation or feeling alone

Treatment History	
☐	Previous psychiatric diagnoses and treatments
☐	Hopeless or dissatisfied with treatment
☐	Non-compliant with treatment
☐	Not receiving treatment

Other Risk Factors	
☐	
☐	
☐	

Clinical Status (Recent)	
☐	Hopelessness
☐	Major depressive episode
☐	Mixed affective episode (e.g. Bipolar)
☐	Command hallucinations to hurt self
☐	Highly impulsive behavior
☐	Substance abuse or dependence
☐	Agitation or severe anxiety
☐	Perceived burden on family or others
☐	Chronic physical pain or other acute medical problem (HIV/AIDS, COPD, cancer, etc.)
☐	Homicidal ideation
☐	Aggressive behavior towards others
☐	Method for suicide available (gun, pills, etc.)
☐	Refuses or feels unable to agree to safety plan
☐	Sexual abuse (lifetime)
☐	Family history of suicide (lifetime)

Protective Factors (Recent)	
☐	Identifies reasons for living
☐	Responsibility to family or others; living with family
☐	Supportive social network or family
☐	Fear of death or dying due to pain and suffering
☐	Belief that suicide is immoral; high spirituality
☐	Engaged in work or school

Other Protective Factors	
☐	
☐	
☐	

Suicide Risk Assessment

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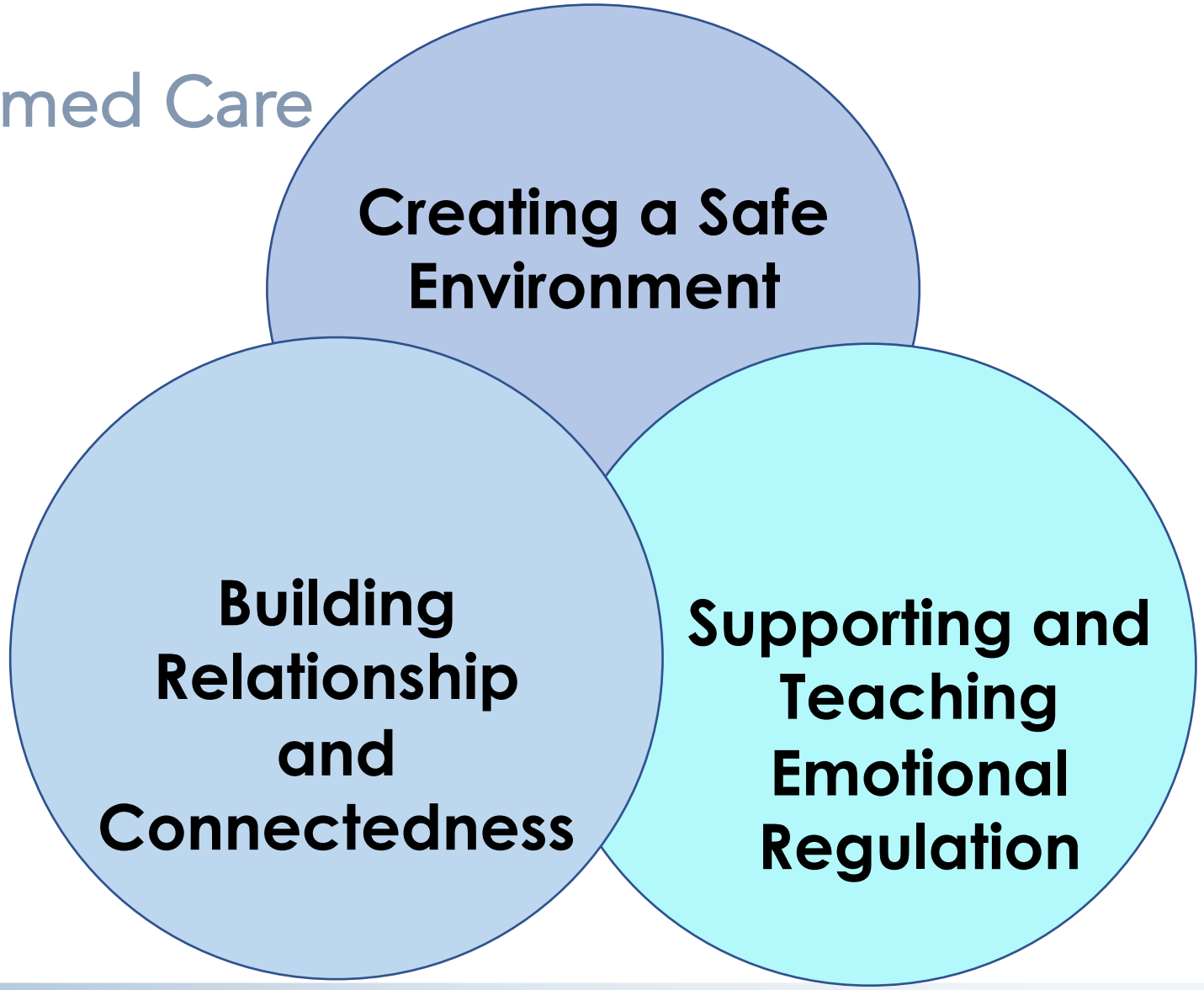
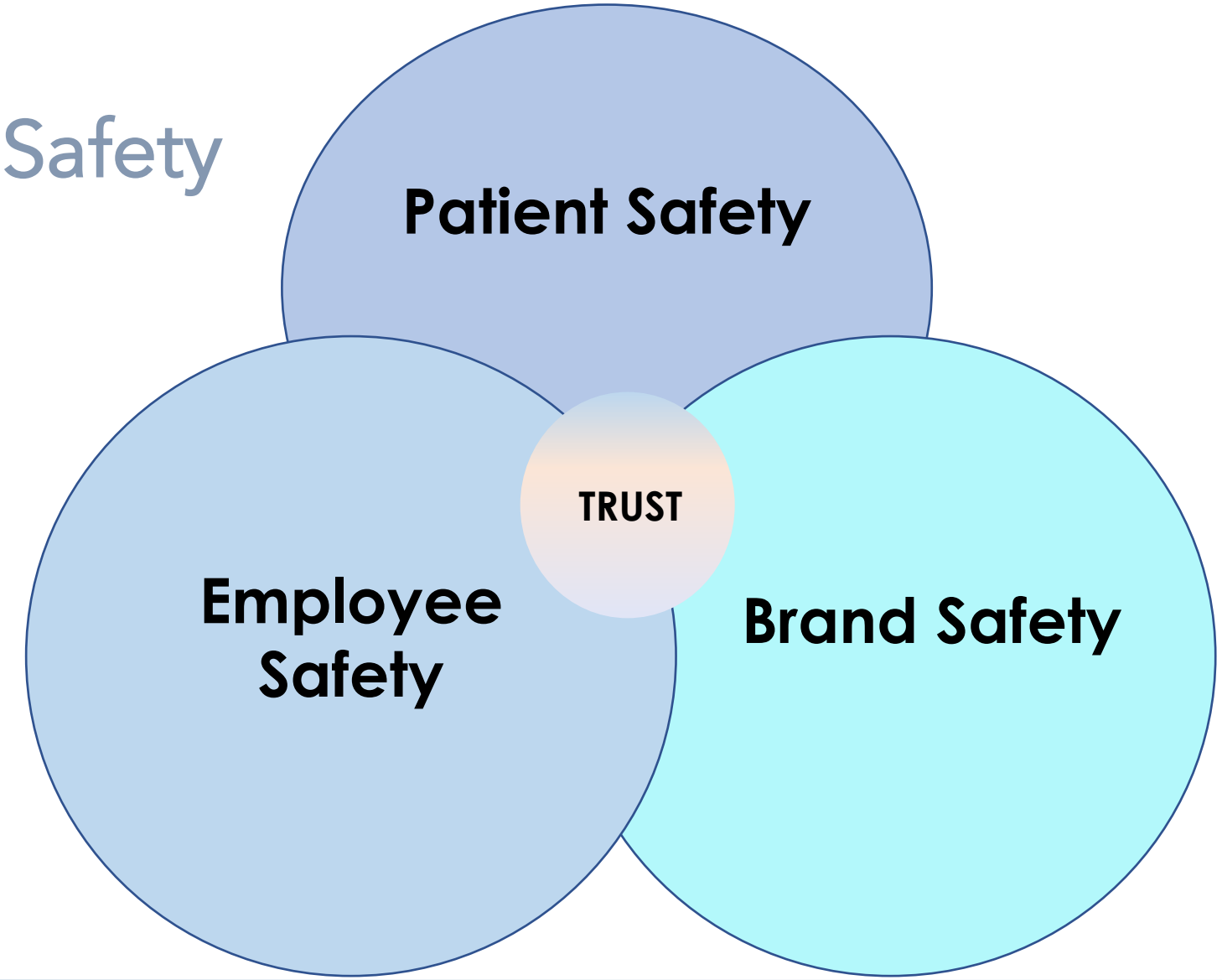
Trauma Informed Care



Culture of Safety



Solid Operational Practices

- Confront Stigma & Fear
- Review exclusionary criteria on a regular basis
- Understand Multiple Attempts
- Provide Training on Mental Health for staff and families
- Observe credentialing for clinicians
- Monitor Staffing Ratios
  - Wireless devices (Visible Hands)
  - Door alarms
  - Hours for Clinical team
- Presence of Psychiatry AND Internal Med Docs
- 24 Hour Goals – Admissions & Discharge
- Invite payers into discussion

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Questions and Discussion

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Thank you for attending

Upcoming Events:

2:45 - 3:15 Coffee & Networking Break in Exhibit Hall

3:15 - 4:15 Workshops

- 1st Annual Member to Member Forum: Workforce Reports from the Field
- Measuring and Implementing Integrated Substance Use and Mental Health Services
- Tobacco and the SUD Patient

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