SUD Technical Assistance Webinar Series

VIRGINIA MEDICAID: 6—
SUD & TRAUMA
PAUL BRASLER, LCSW
FEBRUARY 22 & 24, 2022

Department of Medical Assistance Services
Welcome & Meeting Information

- WebEx participants are muted
- Please use the Q & A feature or the Chat feature if you have a question
- The focus of today’s presentation is practice-based – please Contact SUD@dmas.virginia.gov with technical or billing questions
- We do not offer CEUs for this webinar series
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The Virginia Department of Medical Assistance Services (DMAS) SUPPORT Act Grant projects are supported by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $4,997,093 with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government.
Naloxone Resources

- Get trained now on naloxone distribution
  - REVIVE! Online training provided by DBHDS every Wednesday
  - [https://getnaloxonenow.org/](https://getnaloxonenow.org/)
    - Register and enter your zip code to access free online training

- Medicaid provides naloxone to members at no cost and without prior authorization!
- Call your pharmacy before you go to pick it up!

- Getting naloxone via mail
  - Contact the Chris Atwood Foundation
  - [https://thecaf.acemlnb.com/lt.php?s=e522cf8b34e867e626ba19d229bbb1b0&i=96A94A1A422](https://thecaf.acemlnb.com/lt.php?s=e522cf8b34e867e626ba19d229bbb1b0&i=96A94A1A422)
    - Available only to Virginia residents, intramuscular administration
SUPPORT Act Grant Website

https://www.dmas.virginia.gov/#/artssupport
The grant team has been working closely with Montserrat Serra, DMAS Civil Rights Coordinator, to provide closed captioning for our webinars and stakeholder meetings. We were now able to provide closed captioning through Hamilton Relay for all upcoming webinars. The link for transcription can be found on the Winter Webinar schedule and will be sent in the chat.
Pre-Webinar Survey

In conjunction with the VCU Wright Center and the VCU Institute for Drug and Alcohol Studies, we are conducting a survey for research purposes in order to gain a better understanding of provider impressions and experiences of individuals with substance use disorders (SUDs), medication assisted treatment, and Medicaid. The information obtained will be used to assist in identifying potential barriers to treating these individuals.

If you haven’t already, before the start of today’s webinar please use the link in the chat to access a brief (less than 5 minutes) electronic survey. [https://redcap.vcu.edu/surveys/?s=C8HERT9N3P](https://redcap.vcu.edu/surveys/?s=C8HERT9N3P)

- Your name and contact information will not be linked to your survey responses.
- Your decision to complete the survey is completely voluntary.
- When exiting this webinar, you will be directed to complete the survey again as a post-training assessment. Again, it will be your decision to complete the follow-up survey or not.
- You are able to complete one pre and post survey per each webinar topic you attend.
- Your completion of the pre-webinar survey will enter you into a drawing to win a $50 Amazon gift card as well as participation in the post-webinar survey will enter you into another $50 Amazon gift card drawing!

If you have any questions about the current study, please feel free to contact, Dr. Lori Keyser-Marcus at [Lori.keysermarcus@vcuhealth.org](mailto:Lori.keysermarcus@vcuhealth.org) or (804) 828-4164. Thank you for helping us with this effort!
Winter 2022 Webinars

- SUD & Trauma: 2-22, 10 – 11 AM & 2-24, 1 – 2 PM
- Co-occurring Disorders, Part 1: 3-1, 10 – 11 AM & 3-3, 1 – 2 PM
- Co-occurring Disorders, Part 2: 3-8, 10 – 11 AM & 3-10, 1 – 2 PM
- ASAM Criteria Assessment Dimension 4: 3-15, 10 – 11 AM & 3-17, 1 – 2 PM
- SUD Treatment for Adolescents: 3-22, 10 – 11 AM & 3-24, 1 – 2 PM
- ASAM Criteria Assessment Dimensions 5 & 6: 3-29, 10 – 11 AM & 3-31, 1 – 2 PM
Paul Brasler is the Behavioral Health Addictions Specialist with the SUPPORT Grant Team at DMAS. Prior to working for DMAS, Paul was the Head of Behavioral Health at Daily Planet Health Services, a Federally-Qualified Health Center in Richmond, Virginia. Paul also works in Emergency Departments conducting Psychiatric and Substance Use Disorder assessments, and in a small medical practice. He has worked in community mental health and in residential treatment settings. He is a national presenter for PESI, specializing in training for clinicians working with high risk clients. His first book, *High Risk Clients: Evidence-based Assessment & Clinical Tools to Recognize and Effectively Respond to Mental Health Crises* was published in 2019.
First Things First…

➢ Even the best assessment policy, process, tools or forms cannot replace an empathetic, trained provider.

➢ Prior to even thinking about doing an assessment, we need to agree:

  ➢ People are worthy of help, have the right to self-determination, and should be treated with respect and dignity.

  ➢ Our role is to walk with our clients; not live their lives for them, and to respect their choices, even when those choices are things we disagree about.

  ➢ No one sets out to become addicted to substances or behaviors.

  ➢ Recovery is possible and is defined by the client.
We want to use “Person-Centered language”

- Not “Addict,” but **Person who uses drugs** or **Person with a substance use/behavioral disorder**
- Not “Addiction,” but **Substance Use Disorder (SUD)**
- Not “Abuse,” but **Use**
- Not “Clean,” but **In Recovery** or **Testing Negative**
- Not “Dirty,” but **Testing Positive**
- Not “Relapse,” but **Return to Use**

At the same time, out of habit, I may inadvertently use some of these older words/terminology—and some of the sources I quote use older terms.

Be cognizant that some people may describe themselves as “alcoholics,” “junkies,” etc., or may refer to “clean time” as how long they have been in recovery (and we need to respect this).
### ASAM Criteria Assessment Dimensions

(Herron & Brennan, 2020, p. 174)

<table>
<thead>
<tr>
<th>Assessment Dimensions</th>
<th>Assessment &amp; Treatment Planning Focus</th>
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<tbody>
<tr>
<td>3. Emotional, behavioral, or cognitive conditions and complications</td>
<td>Assess and treat co-occurring diagnostic or sub-diagnostic mental health conditions or complications. Treatment provided within the level of care or through coordination of mental health services</td>
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<tr>
<td>4. Readiness to change</td>
<td>Assess stage of readiness to change. If not ready to commit to full recovery, engage into treatment using motivational enhancement strategies. If ready for recovery, consolidate and expand action for change</td>
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Bereavement (Not Trauma)

- **Grief:** The subjective feeling as a result of a loss
- **Mourning:** The process in which grief is resolved
- **Bereavement:** Being in a state of mourning
PHASES (NOT STAGES) OF GRIEF

- Shock and Denial (days & weeks)
  - Disbelief, numbness, protesting, yearning

- Acute anguish (weeks & months)
  - Somatic problems, emotional withdrawal, anger, guilt, preoccupation

- Loss of patterns of conduct (weeks & months)
  - Restlessness, agitation, aimlessness, unmotivated

- Resolution (months & years)
  - Resume old roles, acquire new roles, re-experience pleasure
“Attachment theory recognizes that human beings are interactional and constantly impacted by our relationships and the environment around us. When the fundamental ability to connect with others is damaged, it is not surprising that some seek external emotional support and regulation from a substance. As the use of substances increases, the individual’s ability to interact with others is further impaired, and the cycle of addiction is set in motion.” (Fletcher, Nutton & Brend, 2015, as cited by Morgan, 2019, p. 119)
Types of Attachment

- **Secure** attachment: The caregiver responds appropriately and timely to the child’s needs

- **Anxious-Ambivalent** attachment: The child’s emotional needs are not met appropriately and consistently

- **Anxious-Avoidant** attachment: Parent and child appear to be detached from one another

- **Disorganized/Unresolved** attachment
“An event in which a person witnesses or experiences a threat to his or her own life or physical safety or that of others and experiences fear, terror, or helplessness. The event may also cause dissociation, confusion, and a loss of a sense of safety. Traumatic events challenge an individual’s view of the world as a just, safe and predictable place.”

-American Psychological Association’s Dictionary of Psychology
Types of Trauma

- Verbal, physical or sexual abuse
- Emotional neglect or basic needs unmet (e.g., lack of food)
- Parental violence, separation or divorce
- Family member’s substance use
- Family member’s death, particularly a suicide or homicide
- Family member’s incarceration
- Medical issues
- Incarceration or long-term admission to a psychiatric facility
- Primary caretaker of a family member’s medical issues
- Natural or human-made disaster
- Unstable housing; homelessness
- Deployment into a combat zone; remote combat operations
- Political refugee
- Multiple relocations
- **WHAT ELSE…?**
Beginning in 1995, the ACEs studies examined the childhood experiences of over 17,000 individuals and their relationship with health outcomes in later life.

While getting physical exams, participants were asked 10 questions focused on three broad categories:

▸ Abuse (physical, emotional, sexual)
▸ Neglect (physical, emotional)
▸ Household Dysfunction (mental illness, incarcerated relative, mother treated violently, substance abuse, divorce)

This was groundbreaking in its focus on childhood trauma as a health indicator—specifically the role that a high ACEs score indicated a marked increase in later negative health outcomes, including substance use disorder.
Think of Trauma as Physical and/or Emotional Wounds or Injuries

(Marich, 2012)

- Wounds come in all shapes and sizes
- Open wounds are visible
- Closed wounds are not
- Wounds are caused by many things
- Wounds affect individuals differently
- Wounds heal from the inside-out
- Wounds usually happen fairly quickly, but take a long time to heal
Think of Trauma as Physical and/or Emotional Wounds or Injuries
(Marich, 2012)

- Before wounds can begin to heal internally, steps must be taken to stop the initial bleeding
- Failure to receive proper treatment complicates the healing process
- Wounds can leave a variety of scars (some are permanent, some temporary; some hurt, etc.)
- The skin around a healed scar is tougher than regular skin
- No two people wound in the same way, even if they suffer the same injury
Another Way of Thinking About Trauma (Friesen et al, 2016)

**TYPE A TRAUMA**
- An **absence** of what a person needs:
  - Safety
  - Stability
  - Love & Nurture
  - Belonging
  - Understanding
  - Healthy boundaries

**TYPE B TRAUMA**
- **Presence** of something bad:
  - Physical abuse
  - Sexual abuse, assault, rape
  - Abandonment
  - Torture
  - Witnessing someone else being abused or killed
Type A + Type B = Severe Trauma

- People who experience a Type B trauma who also experienced a Type A trauma are more likely to develop lasting trauma symptoms, including PTSD.
- People who experience a Type B trauma who did not experience a Type A trauma are less likely to develop lasting trauma symptoms.
- People who experience Type A trauma who do not experience Type B trauma are typically unaware that they have experienced Type A trauma.
The Costs of Misdiagnosis & Trauma

- Wasted time and resources on unnecessary treatment
- Use of ineffective medications and treatment practices
- Attempts at treatment could further traumatize the individual
- Stigmatization of the individual by labeling them with a chronic illness
- Delays in treating trauma can lead to the development of Posttraumatic Stress Disorder later in life
Case Study: Dee

Dee is a 28-year-old female who states that she has bipolar disorder and feels out of control. She has never heard the term “manic episode” before but admits that “I get like that when I smoke cocaine,” which she used last night. She is prescribed Prozac and Xanax by her psychiatrist. Dee describes her symptoms as “being happy one minute and sad or angry the next.” Dee also states, “I have an anger management problem!” She receives disability payments for her bipolar disorder. Further discussion reveals that she was molested for much of her childhood by her step-father. When she reported this to her mother, her mother beat her and threw her out of the home.
Common Trauma Mis-Diagnoses

- Bipolar Disorders
- Anxiety Disorders
- Depressive Disorders
- Psychotic Disorders
- Personality Disorders (any of them)
- Somatization Disorders
- Sleep Disorders
- Attention Deficit Hyperactivity Disorder
- Conduct Disorder or Oppositional-Defiant Disorder
- Intermittent Explosive Disorder
- Substance Use Disorders

...ANYTHING ELSE?
Post Traumatic Stress Disorder & Acute Stress Disorder: Diagnostic Features

- The primary difference between PTSD and ASD is the length of time in which symptoms are present:
  - ASD can be diagnosed 3 – 30 days following a traumatic event
  - PTSD can be diagnosed 30 days or more from the traumatic event
- Most people who experience a trauma will not develop either ASD or PTSD
  - Likewise, many people who are diagnosed with ASD do not progress to PTSD
- As we saw in the first section, the connection between trauma and SUD is substantial
PTSD & ASD Diagnostic Features
(SAMSHA, 2020, p. 86)

- **Intrusive, persistent re-experiences of the trauma**, including recurrent dreams or nightmares, flashbacks, and distressing memories

- **Persistent avoidance** of people, places, objects, and events that remind the person of the trauma or otherwise trigger distressing memories, thoughts, feelings, and physiological reactions

- **Negative alterations in cognitions and mood**, such as memory loss (particularly regarding details surrounding the event), self-blame, guilt, hopelessness, social withdrawal, and an inability to experience positive emotions

- **Marked alterations in arousal and reactivity**, such as experiencing sleeplessness or feeling “jumpy,” “on edge,” easily startled, irritable, angry, or unable to concentrate
Primary Care PTSD Screen: (Prins, et al., 2003)

“Have you ever had an experience in your life that was so frightening, horrible, or upsetting that you:

- Had nightmares about it or thought about it when you didn’t want to?
- Tried hard not to think about it or went out of your way to avoid situations that remind you of it?
- Were constantly on guard, watchful, or easily startled?
- Felt numb or detached from others, activities, or your surroundings?”
Trauma Assessment

Abuse Screening:

► “Where do you live and who do you live with?”
► “What are your relationships like with each person living in your home?”
► “Do you feel safe at home?”
► “Have the police ever responded to a call at your home, if so, when was the last time this happened?”
► “Who is the one person in your life whom you feel you can count on the most? (It’s okay to say you don’t know or ‘no one’ if that is the case)”
Our Response to Trauma: Levels of Safety
Levels of Safety

**Social Engagement:** We turn to others for help. What is the individual’s support system? What happened in the past when the person tried to elicit help from those around them?

**Flight:** We try to run away from the threat. What if the person in crisis cannot get away?

**Fight:** We engage the threat. What if we cannot overcome the threat?
Levels of Safety

**Fawn:** “Triggered when a person responds to a threat by trying to be pleasing or helpful to appease and forestall an attacker” (Walker, 2014, p. 13)

**Freeze/Fold:** Collapse
Freeze/Fold Response & SUD

A state of shock, numbing, immobility, de-personalization

► Children and disempowered adults are unable to fight or physically escape more powerful perpetrators

► “Holding very still,” “pretending to be asleep,” “not breathing,” or “body going slack” can reduce or ward off a perpetrator’s behavior

► The freeze response elicits a dissociative state, creating analgesia and loss of memory
  ▶ Substances can help a person enter, or maintain this state, and create the sense that this state is “normal” long after the initial trauma
  ▶ Substances further help people avoid feelings (good & bad) to the point that the client does not wish to feel anything
SUD & Trauma Disorders

“The high comorbidity of posttraumatic stress disorder (PTSD) and substance use disorders (SUDs) indicates that persons presenting to treatment for either PTSD or SUDs should be screened for both”

“Both civilian and combat veteran populations have a more complicated clinical course and worse treatment outcomes with comorbid PTSD and SUDs than with SUDs alone”

“It has been estimated that between 39% and 90% of the population have been exposed to a traumatic event. Of those who experience a traumatic event, only 10% to 20% will develop PTSD”

(Herron & Brennan, 2020, p. 537)
The Three-Stage Consensus Model of Trauma Treatment

1. **Stabilization**
2. Working through the trauma
3. Reintegration/reconnection with society

- Clinicians often jump into *Stage Two* without ensuring that the patient has some stabilization strategies in place. It is up to the client to decide when to move beyond *Stage One*.
STAGE ONE: Safety & Skill Building

- Building the **Relationship**
- Personal and **Interpersonal Safety** Established
- Psychoeducation:
  - Impact of trauma on the brain
  - How traumatic memory gets stored differently
  - Fight, Flight, Freeze and Fold
  - Flashbacks
  - Internal Locus of Control Shift
  - Dissociation
  - Link between PTSD and Substance Use Disorders
- Skill Building/Practice
Coping Skills & Affect Regulation Strategies

- **Breathing Exercises**
  - Belly breathing (in through the nose, out through the mouth)
- **Pressure Points**
- **Yoga**
- **Guided Visual Imagery** (safe place)
- **Music and sound therapies**
- **Art therapy** (and play therapy for children)
- **Taste and smell** (gum/candy or aromatherapy)
- **Blended sense exercises** (including journaling)
STAGE TWO: Working Through the Trauma

There are many ways to address trauma in therapy, some of which include:

- Eye-Movement Desensitization & Reprocessing
- Trauma-Focused Cognitive Behavioral Therapy
- Experiential Therapies
- Psychedelic Treatments are rapidly entering the mainstream as they demonstrate very good results:
  - Ketamine infusion
  - MDMA
  - Psilocybin
Treating Co-occurring SUD Trauma Disorders

- “PTSD assessment should be conducted after a patient has emerged from acute alcohol or drug intoxication and withdrawal” (Herron & Brennan, 2020, p. 538)
- Group settings may be overwhelming to clients with anxiety and/or trauma disorders
- CBT approaches have proven successful in treating anxiety disorders and SUD
- Medical approaches should address potential abuse of medications, particularly benzodiazepines and drug-drug interactions
Treating Co-occurring SUD Trauma Disorders

- In the case of trauma-related disorders, trauma-informed care is essential throughout all phases of treatment.

- Traumatic memories are often a trigger for the client to use, so establishing safety is imperative...

- ...but trauma and SUD can be treated concurrently.

- One option is Seeking Safety: “A 25-session, present-focused, manualized treatment that provides psychoeducation, teaches coping skills, and helps clients gain more control over their lives” (Herron & Brennan, 2020, p. 539)
What Can We Do As a System?

- Assume that each person coming into your clinic has a history of trauma
- This means that every person who works for your agency or practice needs to have a basic understanding of trauma and how it manifests (i.e., Show them this training!)
- Be attentive to people as they come to the clinic: Greet them warmly
- Assess your physical spaces: Are they inviting? How easy is it for people to move around? Are areas well-lit, clean, and reasonably quiet?
Post-Webinar Survey

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https://redcap.vcu.edu/surveys/?s=W4P4ANWYK7

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