CARLY FRITSCH: My name is Carly Fritsch. I'm one of the social workers that works in the liver transplant program. You know, I think any of us who work directly with patients who struggle with addiction and a history of substance abuse understand how difficult and challenging that can be. When we add encephalopathy on top of it, it's an extra treat.

It can be disheartening to know and to learn about the lack of resources to support individuals who are dealing with this type of disease. And where I spend a lot of my time is working with folks who are working towards getting on the transplant list or are on the list or after transplant, and keeping them plugged into resources to support sobriety and recovery.

So today I'm hoping to give a brief review of substance use disorders, but particularly to focus on alcohol, to talk about treatment options, to talk about practical strategies for getting folks plugged into treatment, to talk about barriers to getting into treatment, and to talk about treatment outcomes and recovery.

I thought I'd start by sharing this definition of addiction from the American Society of Addiction Medicine. And they remind us that addiction is primary, chronic, and progressive, but most importantly, they remind us that addiction, like other chronic diseases, involves cycles of relapse and remission. So like liver disease, it's not one stop shopping. It's not something that goes away with one treatment. It's something that's going to require ongoing care, monitoring, adjustments over time. Really, it's a relapse prone disorder, and that's something that we can expect.

Addiction also impacts the whole person. You know, generally, by the time I'm meeting folks in transplant clinic, not only are they experiencing a medical impact of their disease, but oftentimes I'm hearing that there's been impact in other parts of their lives as well. Whether that's a history of DUI, for example, relationship difficulties, loss of jobs, things along those lines, we're really looking to get them plugged into recovery, or sometimes back into the recovery phase.

Just one other way to consider addiction-- the DSM, with the latest update, really changed how they think about substance use disorders. We used to hear about alcohol abuse versus alcohol dependence, and they've changed it with this latest update to really think about alcohol use disorders along a continuum.

And as you can see, you really only need to meet two of these criteria-- I won't read through all of them but they are in the slides-- to meet symptoms for an alcohol use disorder, and for it to be very appropriate for someone to recommend an individual who meets two or more of these criteria for a substance abuse assessment. Now, I don't share this with you to have you diagnose anybody or even to ruin any Friday night plans, but really just to let you know that it's very reasonable, if we have folks who have continued to drink, despite medical recommendation not to, or are experiencing any other of these criteria, to have them referred for a specialized assessment.

So once we're moving to the phase of, you know, we've identified someone who has either continued to drink despite being told not to, we have concerns, they meet some of these criteria, that's really where we want to start planting a seed, to encourage folks to think about getting some help. Oftentimes, the patients that I meet aren't necessarily ready to do this. And that's a struggle. Because sometimes we feel as though we're racing against the clock. We have people who are having climbing mouths, we want to get them plugged into treatment, so that they may be able to be eligible to be placed on our transplant list, yet they're not necessarily ready to take that step on their own.

So we really want to spend a lot of time planting a seed. You know, when you're ready to do this type of treatment, let me know. Have you thought about this? And oftentimes I'll hear, you know, either days, weeks, or months later, folks who kind of come around to the idea and are at least willing to give it a shot, even though oftentimes it's very obvious to me or to us as their medical team, shockingly, sometimes it's not obvious to the individuals that there's been a long relationship with alcohol that needs some treatment.

So what is recovery? What do we mean by that and what are we looking for? So recovery is much more than just abstinence from substances or from alcohol. It's something that's voluntary. And this is a gray area in transplant and with individuals with end stage liver disease who have stopped drinking, sometimes because they've developed such significant symptoms when they do drink that's a natural deterrent. And so we struggle, sometimes, to understand if our patients are voluntarily sober.

But to be fully recovered, folks are voluntarily continuing to avoid all substances. They're sober, of course. There's a focus on overall health and wellness, so not just their physical wellness, but psychological wellness as well.

And then there's this component of citizenship. And sometimes that's thought of as spirituality, but really, it doesn't have to be spirituality or religious based. It's kind of a sense of living with regard and respect for the people around you and for the environment around you. So oftentimes when we'll meet with folks in our clinics, we'll say to them, what are you doing to help stay clean and sober?

And they'll say, it's not a problem. I'm doing all the same things I did before, I just don't drink. I go to the same bars-- doesn't bother me. I hang out with the same people-- no problem. I offer drinks to the people who are coming over to my house on the weekends-- not a problem. But really, that's not what we're looking for. We're looking for more than that.

So how do we get there? How do we get folks plugged into substance use treatment? I'm going to go through each of these just quickly to explain what these different levels are. Inpatient treatment is very short term, and really, more specifically, it's medical withdrawal. That's not something that we see patients get plugged into much by the time they're coming to our clinic. Because oftentimes by the time people are getting referred to liver transplant, they've been sober for some period of time.

But any more it's not like we see on intervention television shows, unless people have significant resources to pay for long term inpatient stay, that's pretty uncommon. Really, it's kind of days long medical withdraw treatment, and that would always transition into some sort of outpatient treatment. If we hear a patient that says, yeah, I'm sober because six months ago I spent four days inpatient at Brighton Hospital and I didn't have to do anything after that, they've not followed through on something that was intended for them.

Residential is a great treatment option, but again, something that we don't frequently see anymore. It's more than 30 days, and a lot of the insurance companies don't really cover it any more. But on top of that, it would be difficult for any patient who is dealing with any medical symptoms to be in a residential treatment facility. They don't have any way to manage lactulose for patients, for example, or manage any symptoms that we're frequently hearing from our patients about.

On top of that, patients have to fulfill some sort of work requirement. So if we have folks who are needing paracenteses, if they're not able to do things at home, they're certainly not going to be able to, for example, be working on the farm at Dawn Farms, which is our residential treatment facility close to the hospital.

If folks were plugged into residential treatment, that would involve individual and group treatment, and of course, would also take folks away from their homes, their families, their jobs, which is another barrier, oftentimes, to folks being willing to follow through with residential treatment.

Outpatient and intensive outpatient is generally where we're looking to get our patients plugged in. That's generally where we find the most success. I'm going to spend a few slides talking about the vast differences in terms of the number of treatment sessions that are covered by the insurance companies, and really explaining that the treatment modalities vary quite a bit. So we could have two patients in one clinic who are getting vastly different treatments, despite having the same insurance. Likewise, if folks have different insurances, one may qualify for 20 sessions a year, one may qualify for 10. And so obviously, that provides a different type of treatment for folks.

Mutual aid groups I'm going to talk about. They are a great option, as is medication assisted treatment. All of these options are insurance driven, and really, ultimately, it's important to keep in mind that patients don't really get to decide which level of treatment they're getting plugged into. That's really driven by the insurance companies.

So if I have a patient who I want to help get plugged in to treatment, the first thing I'm asking them about is their insurance. And if there's somebody who has private insurance, who has a Medicare Advantage plan or a Medicaid HMO, I'm telling them to call the number on the back of their insurance card. More often than not, they're going to get hooked up with somebody who can give them an explanation of their benefits, but it's generally not somebody who knows a lot about substance use disorders.

It's not somebody who's knows anything about encephalopathy, or can help them navigate this system of understanding what type of treatment they might be looking for in order to be able to be eligible for transplant. These folks are going to be telling them, you know, what coverage they have, the number of sessions, the amount of the co-pay, and local referrals. And these coverage options vary greatly depending on the insurance.

When we have folks who have original Medicare-- that's pretty good coverage-- it's similar to their medical coverage. So you know, they have the same 20% co-pay that they would if they were seeing a medical physician. The biggest thing we need to keep in mind is that they have to go to a Medicare participating provider or facility. The best way to hook them up with that, we generally refer folks to samhsa.gov or the Michigan Mental Health Networker. Both of these are great options for getting folks plugged in who have straight Medicare.

Now, unfortunately, like a lot of things, the most vulnerable folks in the population are the ones who have the most confusing process to get plugged in. And oftentimes these are the folks who are the most limited financially, as well. Individuals who have straight Medicaid-- and this really could include folks who have Medicaid on a spend down or even folks who are uninsured-- they need to get plugged into their community mental health center for their county, wherever they live or wherever they obtain their insurance. So not necessarily where the doctor that they see is, but wherever their insurance is located, whatever address they used when they got their insurance.

I have a couple of the counties listed here, but really, it's as simple as Googling the county name and saying, CMH agency for that county. Now, some of these agencies will see folks directly. Some of them will refer out. Sometimes what they'll do is they'll do a phone intake, sometimes what they'll do is they'll schedule an appointment, and sometimes what they'll do, like the CMH that I worked at, there's just walk-in hours.

And so if the CMH I worked out had two intake social workers to do intakes, and an intake takes an hour, and if there are four people ahead of you in line, that means you're waiting at a minimum of two hours in the waiting room. Perhaps you've gotten a ride there, perhaps you don't have a car. And sometimes you may have to do that more than one day in a row to get plugged in. So it's certainly a challenge for folks to get plugged into treatment at CMH particularly.

On top of that, community mental health agencies, they don't have as much funding as they need to be able to treat as many patients as they would like to. And so they're also the folks who are going to be looking for individuals who are motivated to be there. If they have somebody who comes in and says, you know, I don't think I have a problem, but my doctor told me I should be here, they're going to say, you know, maybe I should schedule appointments with people who want to be here, who want to do this work and who are invested in their own outcomes. So motivation is another important thing that they're looking for at CMH.

Groups are common as well. So they may say, we can only see patients individually, once a month, but we can see them every week as a part of a group. So that's a common part of CMH treatment. Now, for individuals who don't have great insurance coverage, or who do and we still want to supplement it in any way, we are always recommending mutual aid groups for folks. This is a great predictor of short term abstinence, if folks are engaged in groups. They're great, they're free, they're available, they're everywhere.

In preparation for this talk, I plugged in the zip code to my grandmother's town in the upper peninsula of Crystal Falls, very small community. I said, if I lived in Crystal Falls and I could only go to meetings after work from 5:00 PM to 7:00 PM, I found at least four meetings throughout the course of the week where I could go. So really, we have hundreds in Washtenaw County, Grand Rapids area, Flint area, Midland, you know, there's lots of meetings to go to, and even in the most rural parts of the state.

I do encourage folks to shop around. You know, a lot of times folks will go to one meeting and say, I didn't like it. That's not uncommon. Just like anything else, it's good to shop around and find the right fit. There are groups for men, for women, LGBTQ, professionals, closed groups, open groups. So it's really something where they need to try it out and fit it on for size.

Another thing that I have folks mentioned to me is, well, I don't want to go there because the people who go to AA are going because they're court ordered to be there. You know, in that situation, we oftentimes remind folks, you're going for your own agenda. Doesn't matter why other people are going. And I may even try and draw on some similarities. You know, the individual there may be going because of an unwanted legal impact. You're going because of an unwanted medical impact. You both have unwanted impact. Maybe you'll get something out of this that you didn't expect.

The other thing that I'm always talking with folks about who are engaged in mutual aid groups are how their meetings are going and what they're doing. Because attendance isn't enough. We need to have some involvement.

So we want to know, who's your sponsor? What's your sponsor's name? How do you get along with your sponsor? Are you doing any speaking at the meetings? Are you participating in any of the service activities that they have? How's it going with these different groups? Because involvement is much better and takes it a step above simply attending but not participating.

There are currently three medications that are FDA approved for alcohol use disorders. The first is Antabuse, which effectively blocks the metabolism of alcohol and causes very unpleasant symptoms, thereby discouraging folks from drinking. They feel really bad when they drink.

Acamprosate, or Campral, we see more commonly. This is useful in folks who are already abstinent, and it curbs cravings for folks who are already abstinent. We see this sometimes more often in the liver population because it's renally clear. That makes it a little bit more preferable for our patients. Naltrexone is another one. It's also approved for opioid use disorder. It is different from Narcan, which is that emergency overdose medication. Naltrexone is something different. It was initially developed in a pill form.

It blocks the pleasure reward for alcohol, and they developed it later as a shot to have it longer acting. Initially, folks figured out that, hey, if I want to have the pleasure of alcohol return I can just stop taking the medication. You even hear of folks who would maybe, if they had somebody in their family watching them take that medication, if they coated it in nail polish it wouldn't work as effectively. So now that's available in a shot form which is longer acting.

These medications are typically recommended in conjunction with other forms of treatment, but they have been shown to be effective on their own. Some of that is attributed to a placebo effect, you know, that taking a pill just helps folks continue to avoid drinking. But they are shown to be effective, and I hear about them more and more. I'm going to talk a little bit more in a few slides about how the success rates vary quite a bit when we're looking at treatment outcomes for folks in recovery due to some various things to consider.

Specifically, when we're looking at getting folks plugged into treatment, the barriers that I'm often hearing on an individual level, you know, our ambivalence-- I'm sure all of us in the room who've asked folks about their interest in treatment have heard a lot of these statements. You know, I can't go. Who's going to pay? I'm not like those people. Resistance is expected and it's normal. We hear these almost every time I'm meeting with folks for the first time.

You know, what's not effective, we know from the research, is to use persuasion. What's not effective is to use shame or to use our reasons for encouraging folks to go. And that's another one of these areas that puts us in a bind in transplant, when we know that these folks have to be plugged into some sort of treatment in order to be eligible to be listed. And yet we need to somehow gain some of their intrinsic motivation for going. And so that can be a challenge.

It's better for us to show empathy to support self-efficacy, and to use change talk. I do a lot of education with folks, and I'm just very candid. You know, you're where you're at. I'm not here to talk you into doing anything that you don't want to do. But I can tell you that this is going to be something that is a requirement for transplant. I'm straightforward with folks about that. Whether that's persuasion or not, I'm not sure. But it feels better to be upfront with folks about the fact that that's going to be a barrier.

There are some very real systemic barriers that we come across that are very unfortunate and frustrating, not only for us as providers, but for patients and their family members. We see great discrepancies in terms of what insurance companies will offer to folks. Geographic availability varies quite a bit. You know, while there may be mutual aid groups available everywhere,

I've had patients in the UP where I'll jump on that SAMHSA or that Michigan Mental Health Networker and I will say, OK, I want to help this person get plugged into some treatment. And I'll find that there's not a clinic for 40 miles accepting new patients and accepting their insurance. And that's difficult for folks to A, have multiple medical appointments on top of it, B, are taking lactulose, C, may still be trying to work or may need to get their kids off the bus, things like that. So that's something that we certainly run into.

Limited funding, as I mentioned, particularly at community mental health agencies-- and then we see eligibility criteria vary quite a bit. And one of the things that we often see in this regard is sobriety time, where we'll occasionally hear from an agency, we have such a long wait list. We really don't have time to take in anybody who's more than a year sober at this point, or more than two years sober. And so that's something that we run up against. And it's unfortunate, because everybody would benefit from this type of treatment.

Now the research on the effectiveness of treatment varies widely. There are a few studies that look at recovery beyond a two year period. There is one that I'll mention in just a moment. Treatment success can be defined differently. You know, we're generally looking for abstinence, but some researchers have focused on looking at if folks are able to lower their risk or their amount of drinking, and if they're able to do some asymmetric drinking, by which we mean drinking without any negative consequences.

Conversely, we could think about how much of an imperfection constitutes a relapse or a slip. There there's been varying definitions over the years of alcoholism. We can think about problem drinkers or college aged binge drinkers. You know, do they qualify as a quote unquote "alcoholic" that we should be looking at in these studies?

And treatment is highly variable, and that includes wide differences in terms of clinician effectiveness. So I can tell you that when I went to grad school, I started in September, and by October I was providing substance abuse treatment services to individuals at Community Mental Health here in Michigan. And I can promise you, I was not as effective as the clinician down the hall who'd been doing it for 20 years. I know I had some supervision. You know, the treatment that I could provide was not nearly as effective as someone else who had experience. Treatment modalities vary quite a bit, too. Right now what we see a lot of is cognitive behavioral therapy or motivational interviewing, but folks have different styles that they use.

It's helpful to think-- and this kind of helps us refill our empathy cup, I think, in terms of thinking about individuals who experience addiction. It's helpful to consider addiction alongside of other chronic diseases, like diabetes, hypertension, and asthma. Relapse is common and similar across these diseases. In my next slide, you'll see that adherence is similar as well.

And so it can be helpful to think about treating a relapse as we would a flare with some of those other conditions, as a trigger, essentially, to adjust our treatment plan. I think one of the major differences that I see when I think about addiction in comparison to these other chronic diseases would be thinking about stigma that folks may experience if they're diagnosed with addiction as opposed to asthma, let's say. And also, the impact on the whole person, potentially, I think, could be more prevalent in addiction.

I heard a talk recently where the physician kind of encouraged us to think about if we had a patient who came into the hospital because they'd mismanaged their insulin with their diabetes. You know, we might see to that person, oh, come on, we've got to figure this out. We got to figure out the right way to get your insulin managed. You've got to do this. You've got to be really good about this.

If someone came in with a relapse, you know, would we have the same approach? Or might we think, ugh, this person is an addict. It's hopeless. And you know, that's one of the challenges of working with addiction. And I've certainly been guilty of sighing at times and losing track of my empathy. But it is helpful to think about addiction along side of these other chronic conditions.

Short term relapse rate-- so this is data from treatment centers that were reported to the national institution on drug abuse and the National Institute of Alcohol Abuse and Addiction. Following treatment-- and this is regardless of the therapeutic model-- 40% to 60% of folks return to alcohol or drug use in the first year. And of those folks, 60% of those who return to use will have multiple periods of abstinence and use within that first year.

So again, this just reiterates that it is a relapsing disease. It's something that's cyclical. We can expect that. That's not a personal failure on behalf of the patients. It's something that we can expect over the course of the disease.

Some things affiliated with short term abstinence-- participation and formal treatment, certainly, and longer time in treatment, affiliation with 12-step programs-- and that's both during and after completion of formal treatment-- a commitment to total abstinence-- makes sense-- and then something to lose can motivate change oftentimes for folks. If we have folks who may lose their job or may go to jail if they fail a drug screen, certainly that's going to be a motivator, at least in terms of their short term abstinence.

And then whenever there is social support that have attitudes which support recovery-- so when there's spouses or significant others, family members who are supportive of an individual making these behavior changes, making these changes in their routine, they're supportive of their individual loved one being gone, maybe after dinner for AA or getting up early and going to AA, that's better than when we hear the spouse who says, I don't think he has a problem. I don't think she has a problem. You know, she drank a few cocktails after work, very stressful, works for the unions, it was very difficult. It's better if we have spouses that we can get on board as well, and help educate and help them to understand some of the risks that are affiliated with addiction.

Long term relapse rates-- one of the best long term studies we have to look at was funded by the Center on Substance Abuse Treatment. It was called The Pathway to Long-term Abstinence study. This was looking at all substance use and not just alcohol use. But they found that 50% had one or more clean periods of one year or longer, and that 28% of individuals had clean periods of three years or longer before a slip or a relapse, which reminds us that relapse takes place over the course of the disease. It's not something where if we have somebody who's sober for a year, we don't have to do any more maintenance of that disease. It's chronic, it's lifelong, and we can expect that it's going to need monitoring and treatment over a long period of time.

Some of the top reasons for relapse that they found were exposure to triggers, stressful events or situations, urges, cravings, desires to use, or individuals just saying, I felt like I could handle it. I thought I had it under control. And I'm going to talk more about triggers in just another slide or two.

I personally find it really helpful to think about relapse as a process rather than relapse as an event. So if we think about relapse as just the moment somebody grabs ahold of a drink and swallows, we don't know what time we would have had to intervene. But really, what we can do and what we do in the substance abuse treatment community, is think about relapse as a process. So it's the time of stress, changes, exposure to trigger-- this maybe over the course of days or months leading up to the moment that the individual took the drink and swallowed-- that's helpful for us to think about really where we can make an impact and help individuals to intervene.

Most common triggers for relapse are interpersonal conflict, social pressures, environmental factors. You know, if we ever have folks who are going through a divorce, have lost a loved one, have lost a job, have significant changes in their life in some way, that's where we really want to hone in on those folks, even if they've been sober five years, 10 years. You know, how are you doing with your recovery? This must be really stressful. How is it impacting that? Are you still going to your meetings? Does your sponsor know what's going on with you? Maybe you want to touch base with some of your supports again. Have you thought about getting back into therapy as you navigate this stressful event?

As I note down below, oftentimes-- and I've heard this and seen this so much when I've sat in on public AA meetings-- folks are very surprised by the fact that they relapsed. You don't hear folks who are saying, I knew for a long period of time that I might-- no, it's usually folks who say, I was totally blind to those stressors that were impacting on me so much until I had already picked up the drink and it was too late.

I don't know that I have time to talk about Kerry Patterson's research on the willpower trap. I guess I'll say spoiler alert to rely on willpower as a trap.

Now despite all of this information that I've just given you about this being a relapse prone disease, there certainly is a lot of hope when we're working with individuals with addiction. That's certainly something that I really enjoy, working with folks who are looking for transplant. There's a lot of hope for the room in our conversations. And that's true in addiction as well. And so I remind myself to be encouraged with patients, to encourage them as they make progress. Each day of sobriety is a real success.

Some strategies for you all as you're meeting with patients, and you know, I know that as a social worker I certainly have a lot more time and opportunity to gather some of this information from folks. But for providers in the room, if you do have the opportunity to elicit on your own a substance use history, open up that conversation with patients about understanding, about how often do you drink? How old were you when you started to drink? Have you had periods of sobriety in the past followed by periods of relapse? What was drinking like in your home when you were younger? Things along these lines.

Providing education on damage to the diseased liver is really helpful for folks to hear, just in very concrete black and white terms the effect of ongoing drinking on their medical well-being. Including it in the problem list if you feel that's appropriate-- so that will be your cue to spend just a moment or two on it during each visit. Accepting a patient's level of readiness-- this is one of the things that I find the most difficult to do. Like I said, a lot of times we can see so clearly how much someone needs help, but we find it's more effective if we can wait for individuals to have this intrinsic motivation to pursue treatment.

Following up with patients about treatment and, as I said, discussing life stressors-- if you have an individual who sits down who's going through a lot, you hear their spouse has been hospitalized, things along those lines, bringing that back to how does that impact potentially their recovery. Random toxicology screens can be a really useful data point to monitor sobriety or use. And then always monitoring our own personal bias and judgment.

You know, again, as social workers I think we get a lot of opportunity for this. I don't know how often my multi-disciplinary colleagues get the opportunity to sit and think about the ways in which they may have personal feelings about this bias stigma. My colleague and I actually got the opportunity to go to two talks this week, and that's just this week. We get opportunities to do this all the time on top of supervision. So whatever we can do to monitor our own personal bias and judgment can be really helpful.

With that in mind, I hope some of this information was helpful. I encourage you to just think about how you're planting the seed with your patients who are coming in for treatment.