Talking to Clients about their Substance Use

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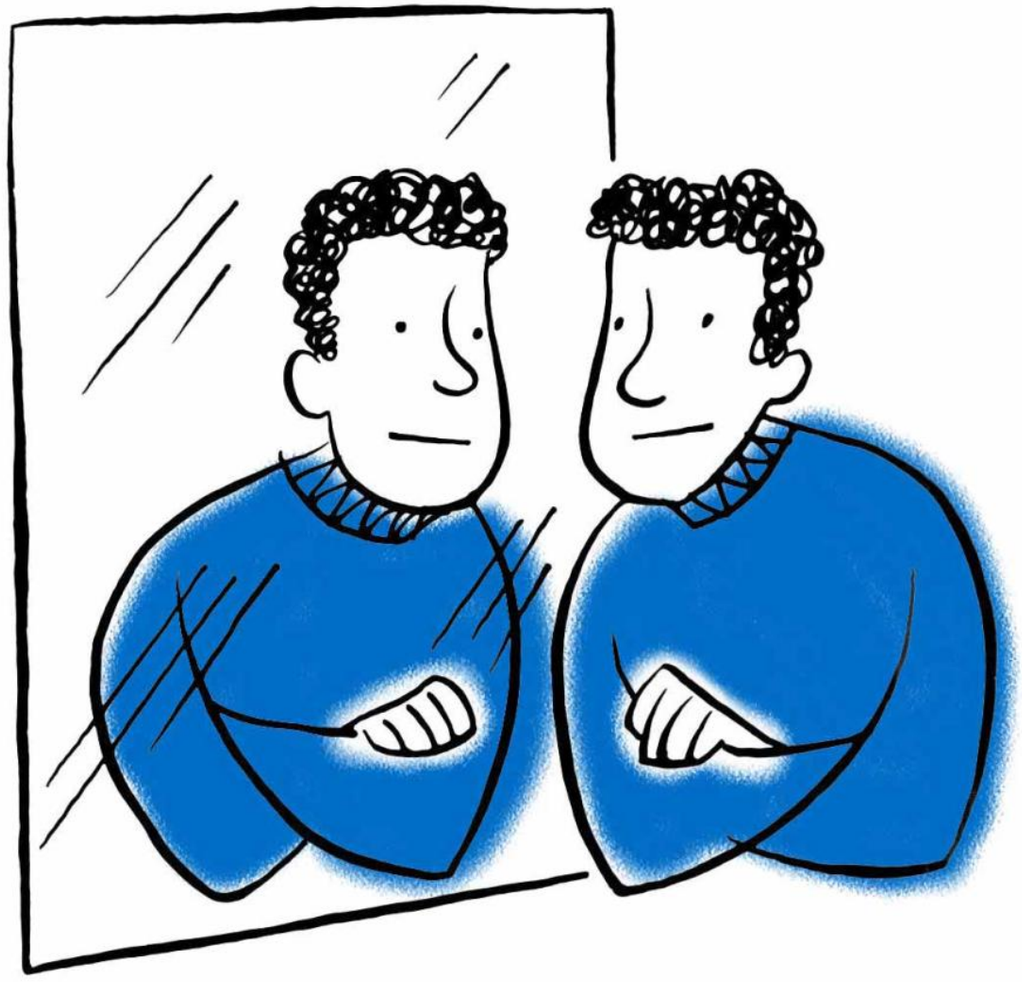
What ABI providers should know About Substance Use and Brain Injury

Toronto abi Network

CHIRS
Community Head injury
Resource services of Toronto

Evidence-based Intervention



From the literature… ABI-Specific Treatment Models

Fewer than 20 Studies

Five types of intervention

- Strategies for tx retention (Treatment Incentives/Barrier Reduction)
- Intensive case management
- Skills training
- Motivational Interviewing
- Peer Support
- Long-term residential programming

Ongoing Treatment Challenges

Engagement

Drop-outs

Empirically Supported Interventions

- Motivational Interviewing
- Cognitive Behavioural Strategies (Relapse Prevention)
- Behavioural Models (Community Reinforcement and Family Training)
- Case Management
- 12 Step (AA/NA)
- Pharmacotherapy
- Harm reduction
- Brief Treatment/FRAMES

M.I. is therapist guided and client centered

The counselor:

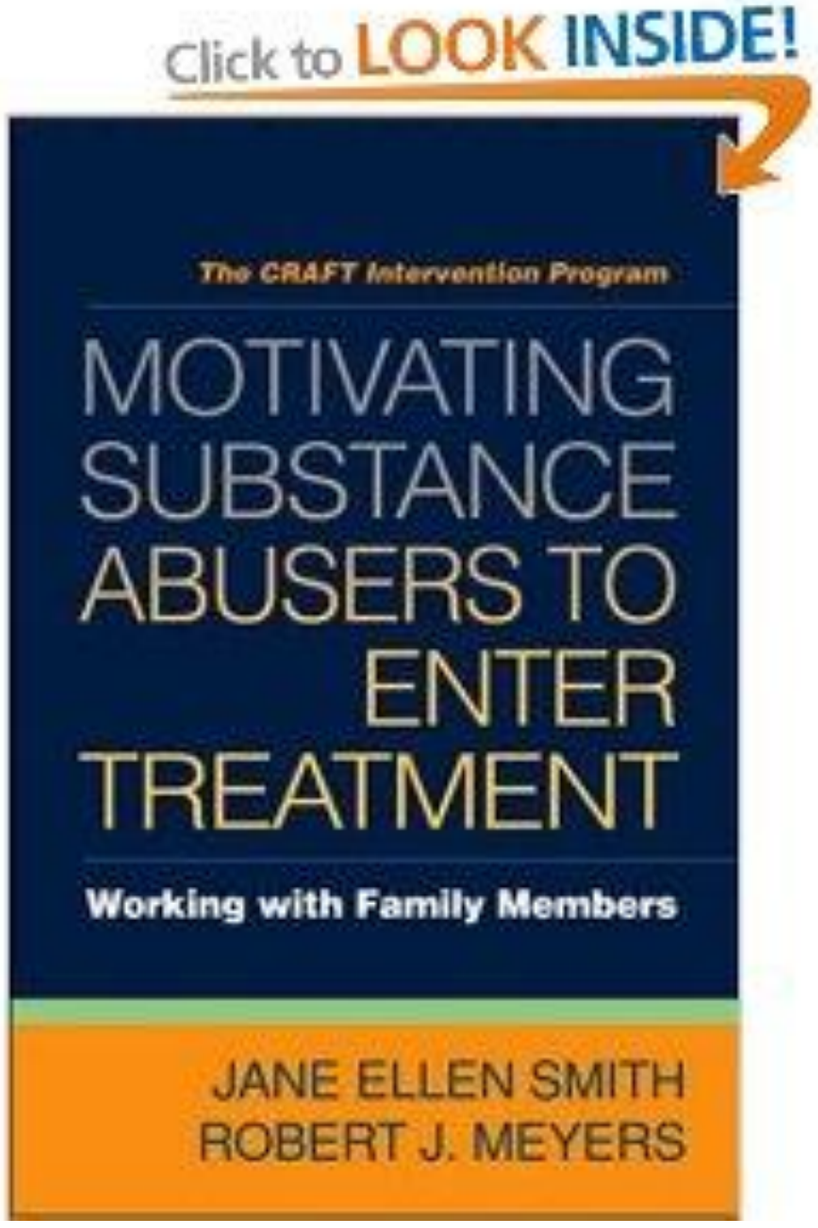
- Sets the agenda
- *Uses cognitive compensation strategies such as frequent summaries, repetition, and notes suited to the client's abilities*

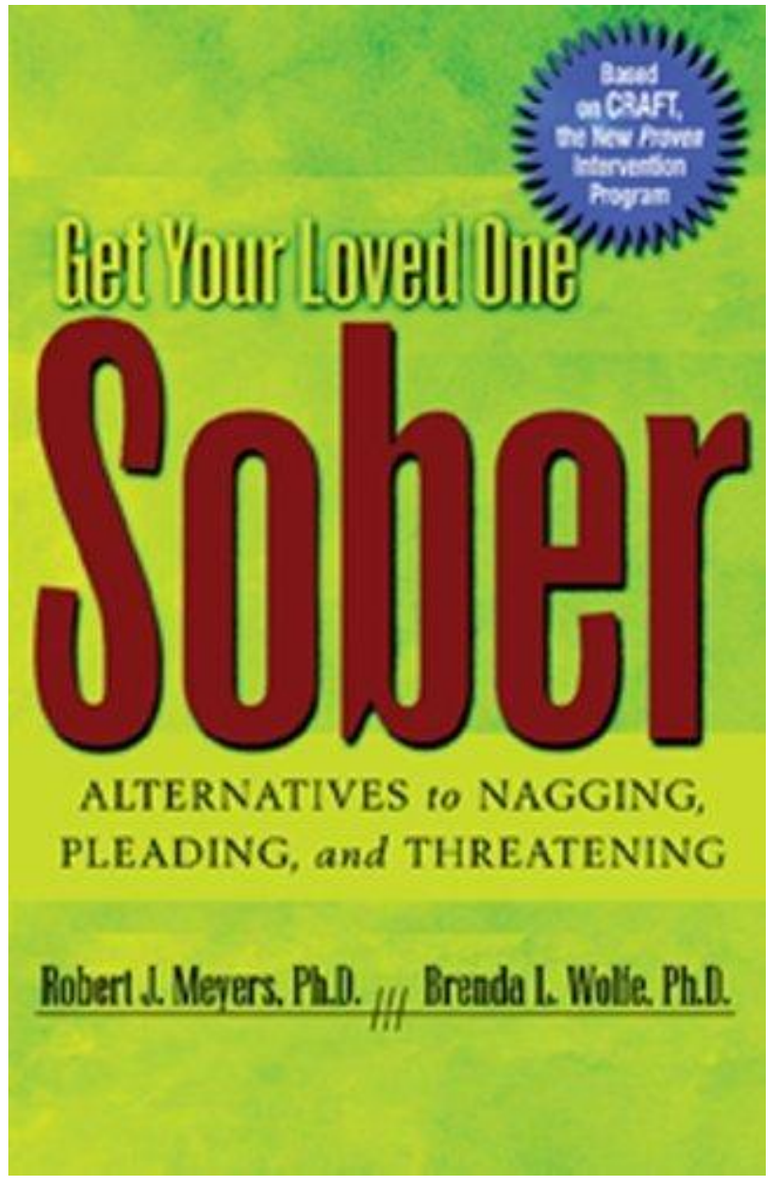
The Client:

- Fills in the content
- Sets the pace for change

C.R.A.F.T.

Community Reinforcement and Family Training





Community Reinforcement and Family Training (CRAFT)

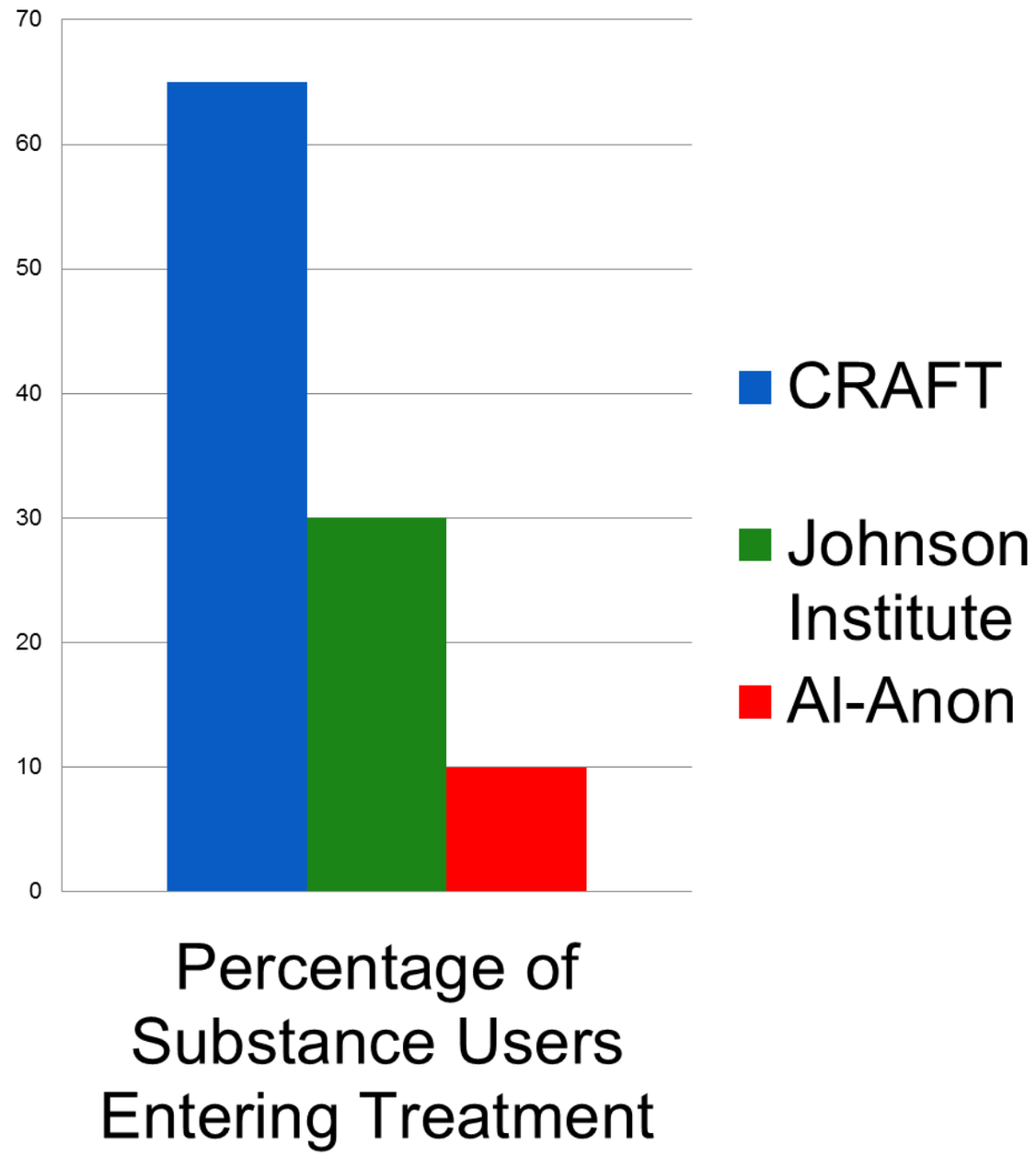
1. Motivational strategies
2. Functional analysis of the substance use behavior
3. Domestic violence precautions
4. Communication training
5. Positive reinforcement training
6. Discouragement of using behavior
7. Significant other self-reinforcement training
8. Suggestion of treatment to the Identified Patient

CRAFT

Evidence-based: Randomized control trials with alcohol, drugs, adults and youth

Based on behavioural principles

- Families learn to reinforce non-using behaviour
- Communication and problem-solving skills are emphasized
- Families are taught to attend to their own needs, increasing quality of life



Brief Treatment

F eedback: provide feedback on the patient's risk for alcohol problems
R esponsibility: highlight that the individual is responsible for change
A dvice: advise reduction or give explicit direction to change
M enu: provide a variety of options for change
E mpathy: emphasize a warm, reflective and understanding approach
S elf-efficacy: encourage optimism about changing behaviour

ABI-tested interventions

- Treatment incentives (Corrigan et al., 2005)
- Intensive case management (Bogner et al., 1997)
- Skills training (Vungkhanching et al., 2007)
- Motivational Interviewing (Cox et al., 2003)

Treatment incentives

In the general population, early attendance predicts treatment success

Corrigan, Bogner, Lamb-Hart, Heinemann & Moore (2005):

Brief Motivational Interview

Reduction of barriers to attendance

Financial incentives

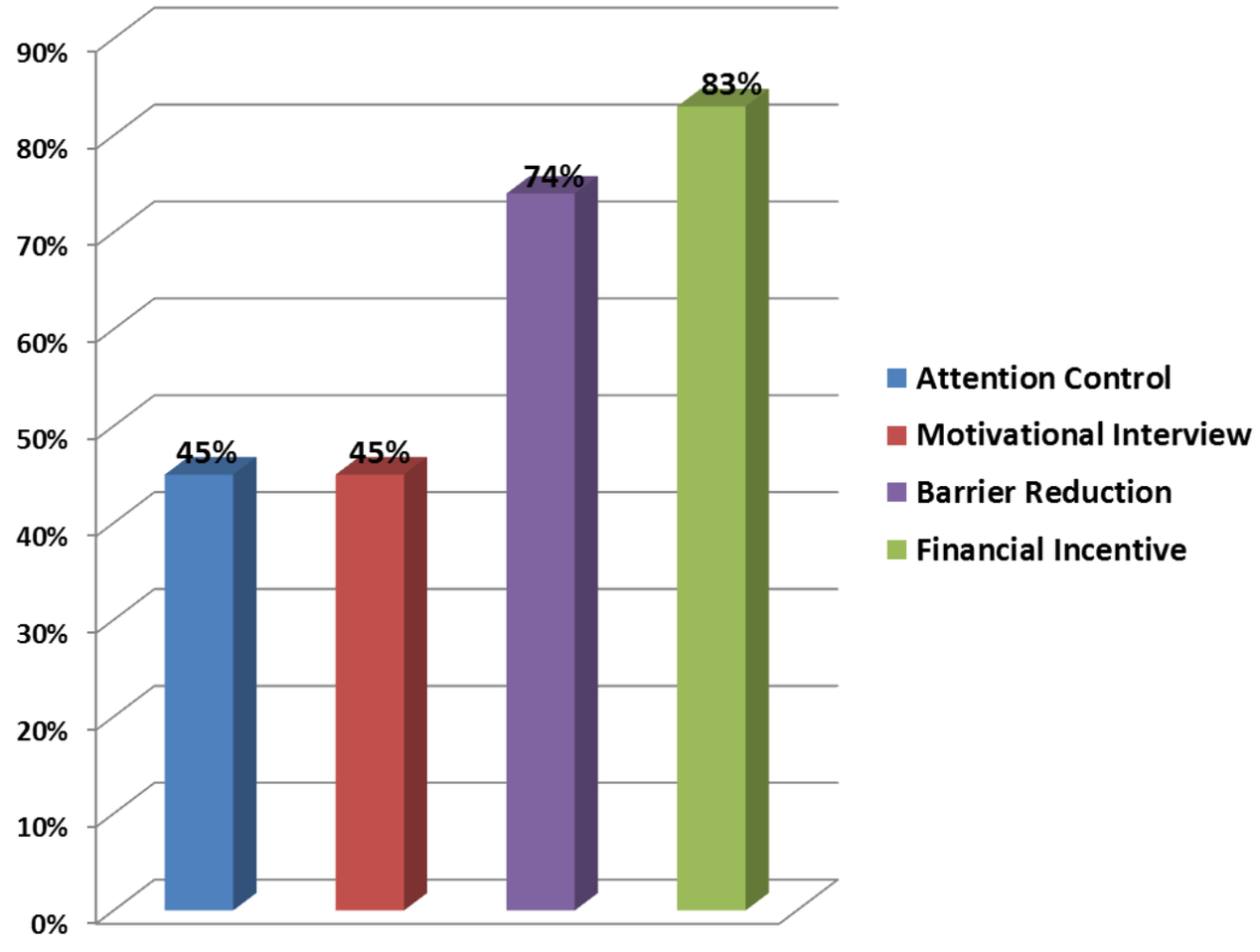
Attention control

Findings

N = 195 (138 men; 57 women)

Mean age = 36.6 (range = 18 to 72)

Mean time since injury = 8.0 years (range = 3 weeks to 55 years)



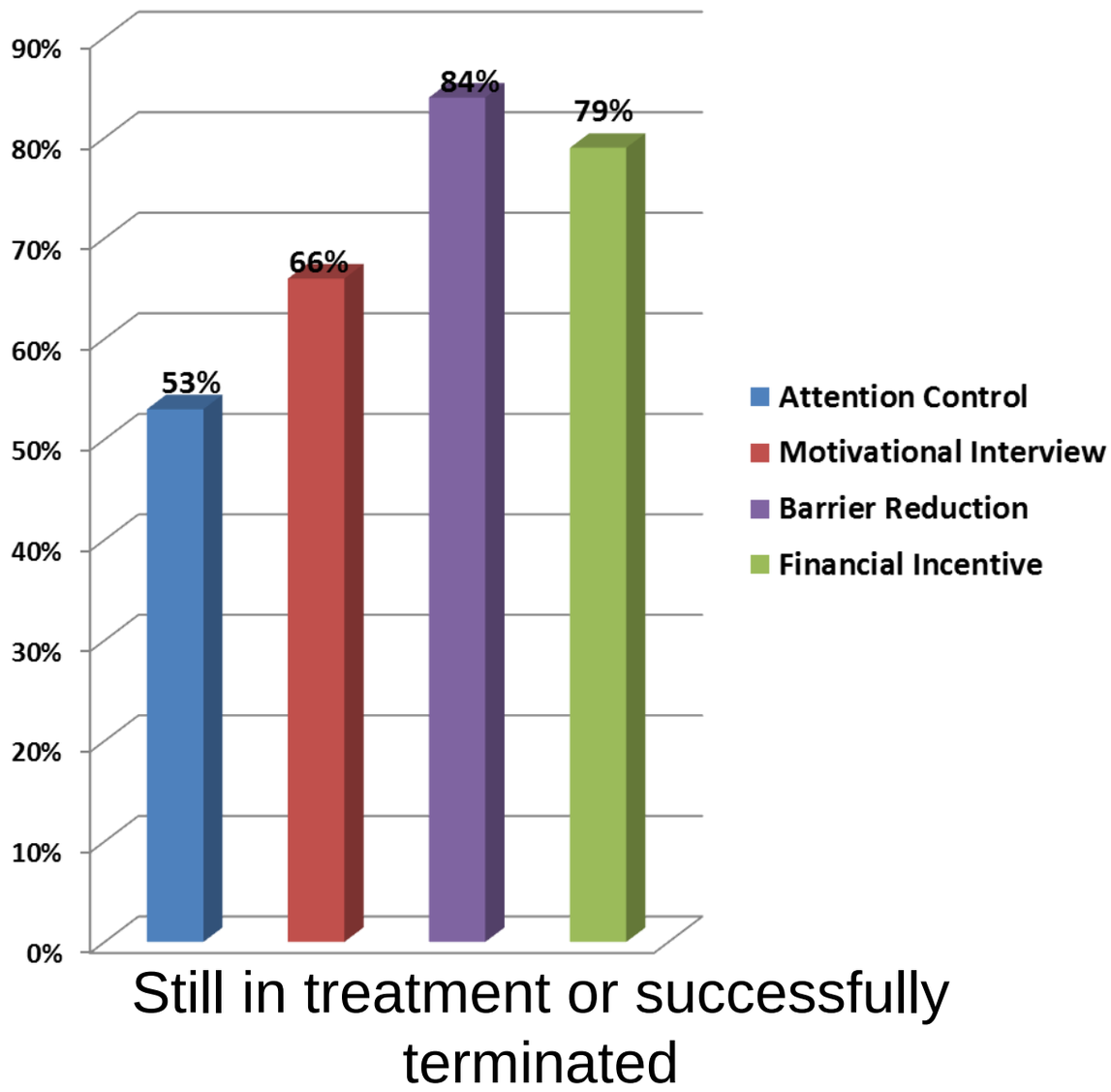
% Complete individual service plan in 30 days

Six month follow-up data

By six months, over 30% had terminated therapy

50% improvement over control for Barrier Reduction and Financial Incentives

Brief phone intervention makes a big difference



Why did these interventions work?

Attendance early in treatment increases engagement

Rule-governed learning is easier for many individuals surviving brain injury and enabled engagement

Support to attend sessions enabled engagement

Evidence-Informed Practice

Motivational strategies and incentives to encourage participation in intervention

Behavioral/cognitive behavioral strategies

Development of behaviors incompatible with substance use (case management)

Harm reduction

8 principles for integrated treatment (Corrigan, 2012)

1. Goals are interwoven- not sequential or parallel

2. Treatment is holistic, addressing lifestyle not just substance use

3. Consumer and clinician collaborate to develop a mutually agreed upon treatment plan

4. Clinicians help consumers to develop awareness and optimism so that their motivation for recovery can be internalized

8 principles continued

5. Different services will be helpful at different points in recovery- staging, which must be incorporated into the overall treatment model

6. Treatment is longer-term

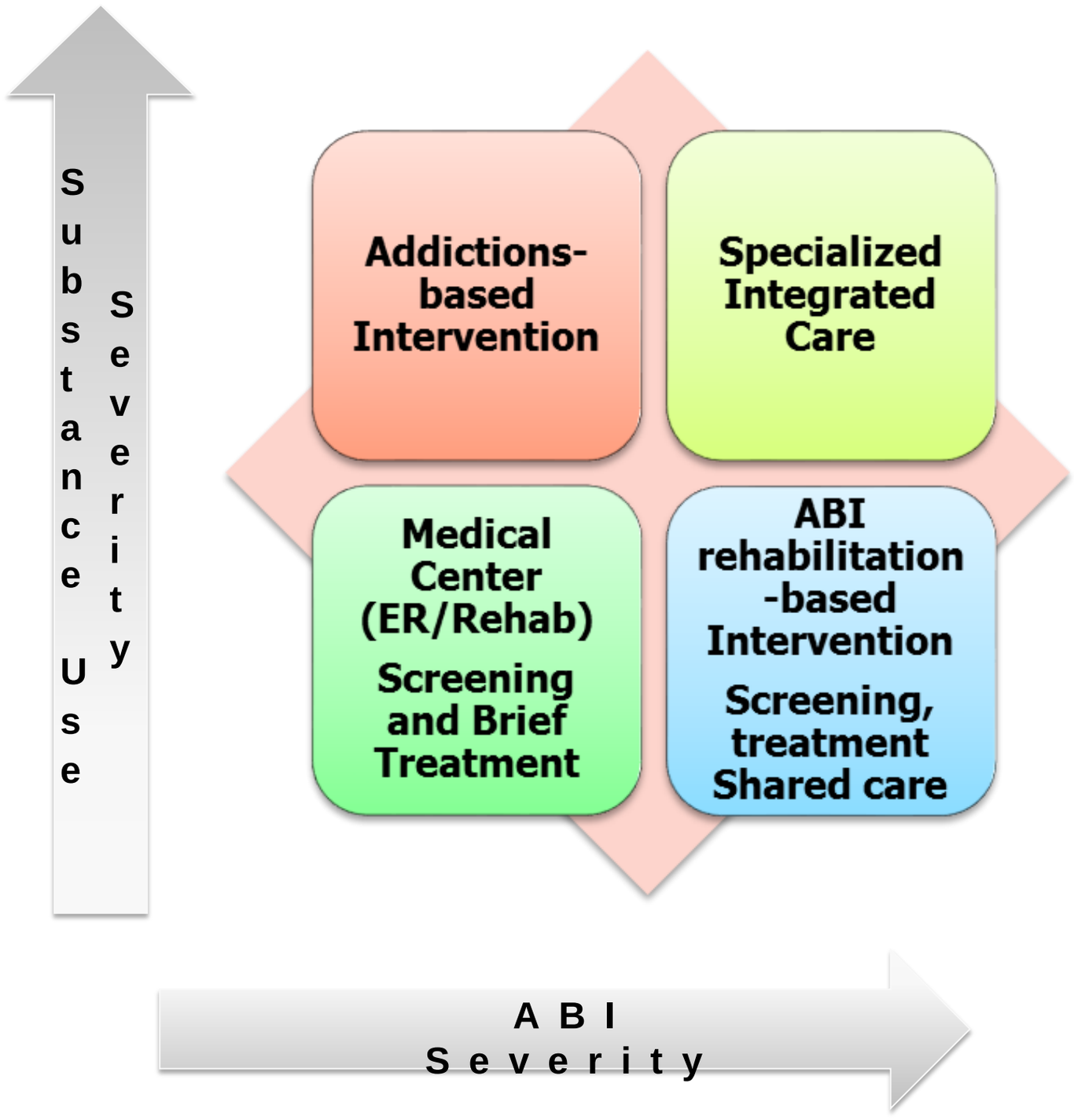
7. Key staff are cross-trained to work with both TBI and substance use disorders

8. Staff are more experienced and have smaller case loads

Factors that affect treatment recommendations

- Relative severity of the brain injury and the substance use disorder
- The client's current readiness to participate in treatment
- How well aware the individual is of the disabilities associated with their brain injury

Comprehensive, Continuous, Integrated System of Care (CCISC) Model



Continuum of services

Brain Injury Services

Screen

Education

Motivational Interviewing (Brief Intervention)

Referral

Policy that accommodates clients who continue to use substances

ABI or Addictions –Based Shared Care

Harm Reduction

Active Partnerships for consultation and referral

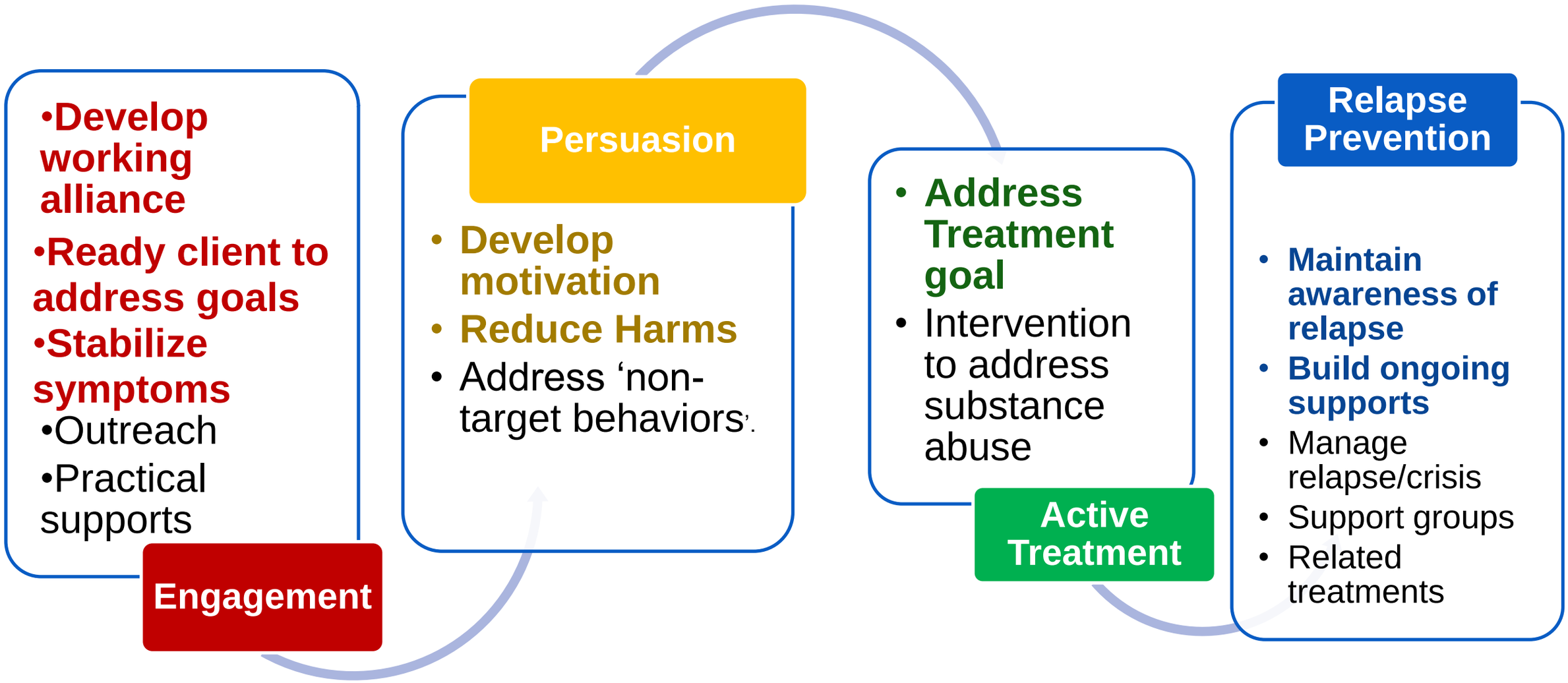
Specialized Services

Integrated ABI/ Substance use programming

Addictions counselor

Long-term supports

Phases of concurrent treatment



Why were referrals to addictions programs failing?

Failure to engage

- Cognitive and behavioural difficulties were interpreted as non-compliance/poor motivation.
- Clients who were *pre-contemplative* were referred to programs where a commitment to change was assumed.

What was missing from Addictions Programs?

Screening for Brain Injury

Strategies for recognizing and managing cognitive impairment

Willingness to adapt services for people living with neurocognitive impairment

What was missing from ABI programs?

- Screening for Substance Use
- Zero Tollerance rules precluded the development of a way to safely work with people who continue to use substances (harm reduction)
- limited understanding of the available addictions services
- Ways to encourage active participation in addictions care MI/Brief interventions
- Secondary Prevention

Problems in both service sectors

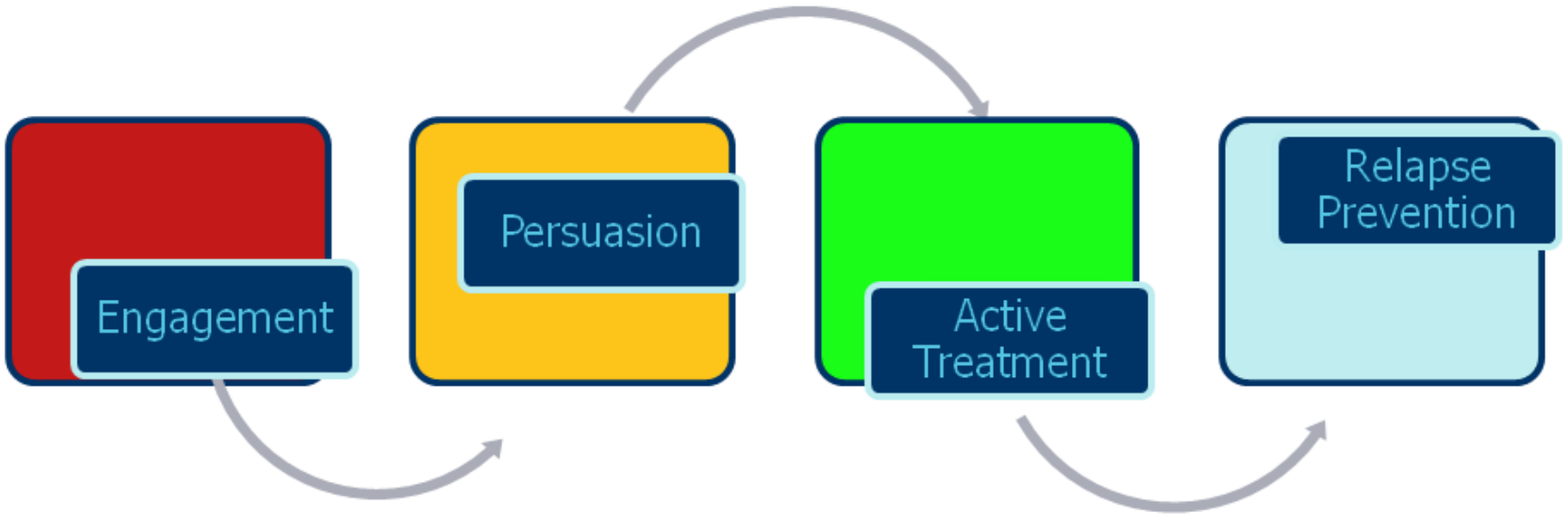
- Stigma
- Limited awareness of the problem
- Limited resources
- Institutional structures that limit the opportunity for community collaboration

Needs

Templates for intervention that are feasible within existing resources and are appropriate for the Ontario Health Context (urban, rural and remote)

Awareness raising/Advocacy

Training/skill building for both ABI and Addictions providers

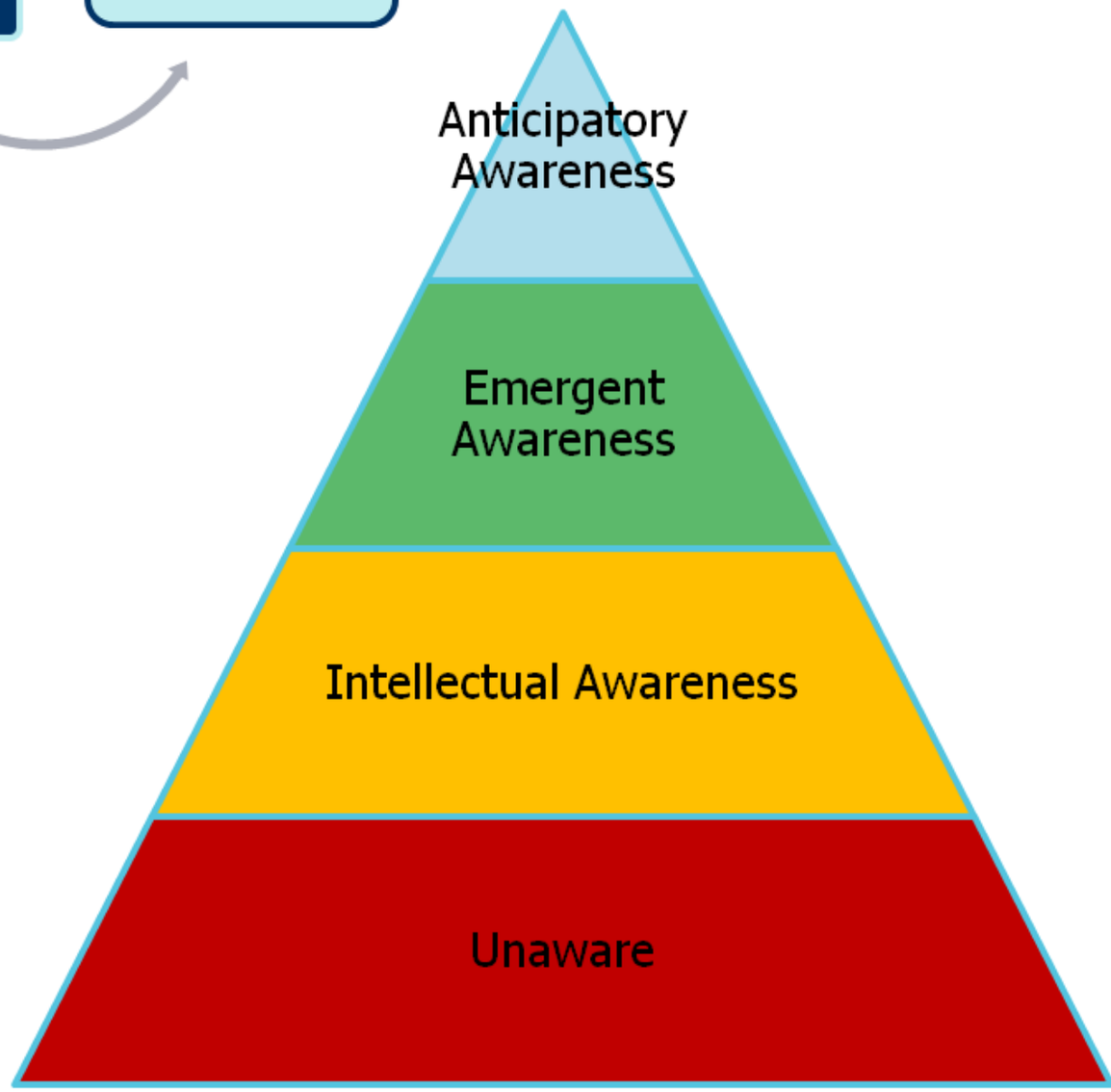


Collaborative Interventions

- Client-centered/collaborative goal setting
- Motivational Interviewing
- Supported trials
- Client education
- Cognitive/behavioural interventions
- Cognitive compensation

Environmental Supports

- Supervision/structured activity
- Trustee/Legal system
- Reduce exposure to substance
- Support to reduce harms/attend treatment
- Family intervention/education



Current Program Structure

4-session assessment with treatment incentive

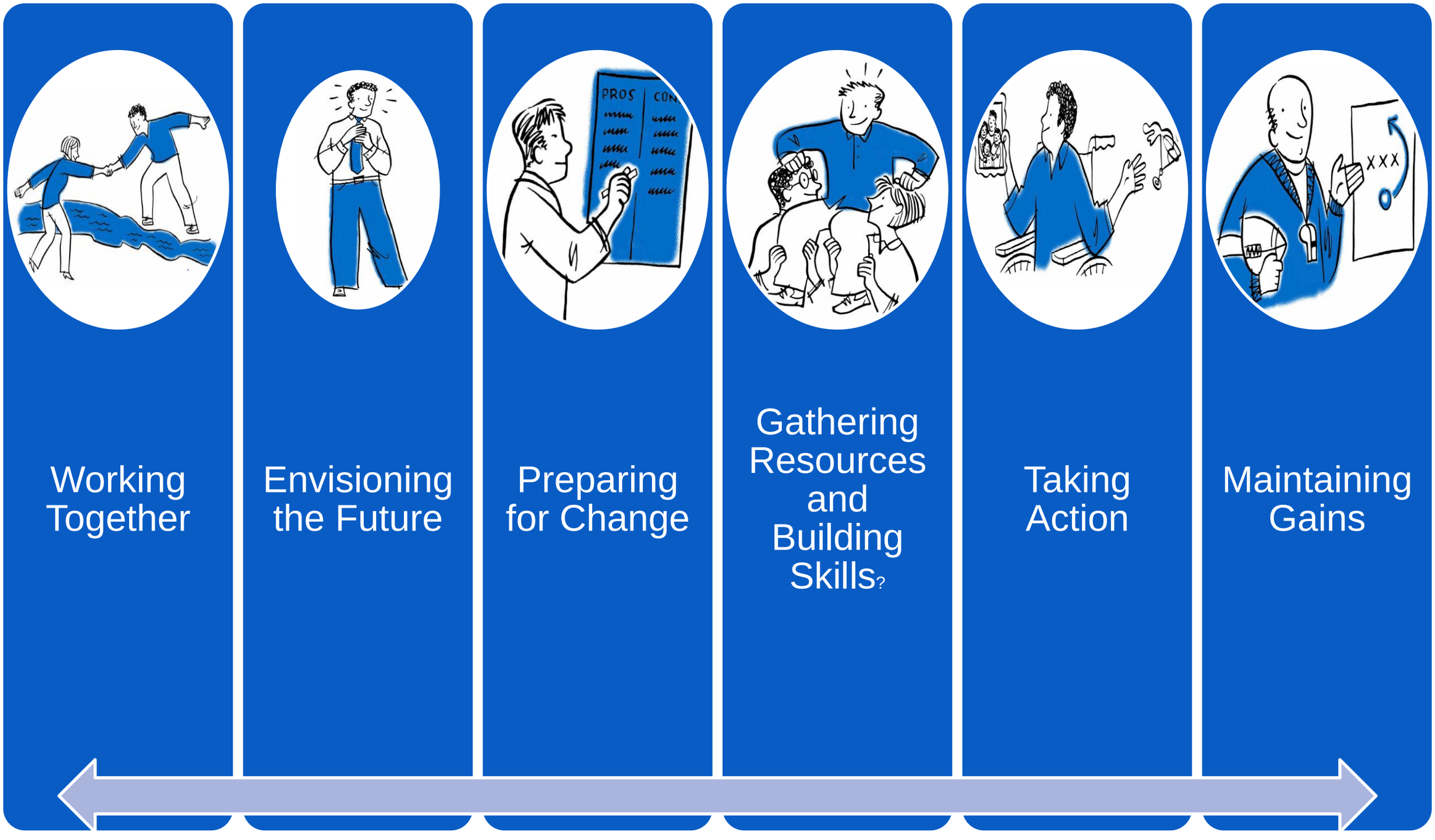
Groups

MI Based group
(pre-contemplative - contemplative)
16-week Psycho-educational Group
(Preparation/Action)
After Care/ CHIRS AA

Intensive Case Management

Integrated Clinical Care

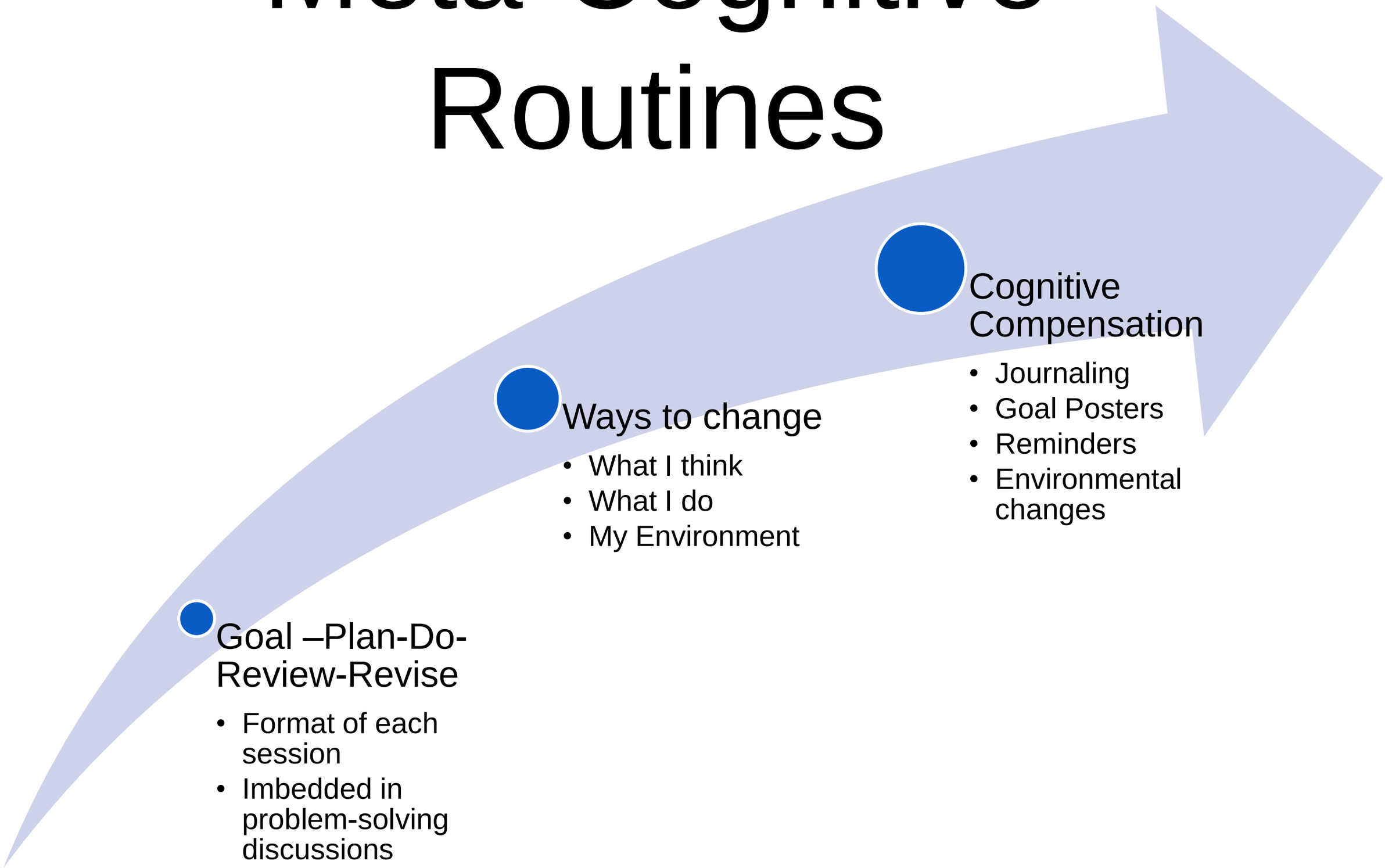
Each phase of the intervention helps answer different questions



Facilitator's role

Building Alliance	Enhancing Motivation for Change	Preparation	Action	Relapse prevention
Setting Norms/ routines	Goal explora-tion	Meaningful Engagement	Skill Building	Managing Lapses
Creating Safety	Feed-back	Building a social network/supports	Change strategies	Building a follow-up plan
	Fishing for Change Talk	Setting achievable goals		

Meta-Cognitive Routines



A peek at SUBI group

Mindfulness

Check-In:

Substance of Concern

Last Use

Amount

Tracking our Progress

H- YMCA- how are you enjoying it?

A- Increasing activity- Ctech, and Thursday outings.

I- Budgeting, and exploring the gym in your area

T- reduction in smoking- regrouping

Tracking our progress

C- establishing a routine

P- Budget

What we heard you say

C said that you don’t need to be who you were pre-injury. “ you don’t need to (attempt to re-create) the vibrancy of life pre-injury by being intoxicated.

A identified that it is difficult for her to be the real A. with her friends right now, as they knew A pre-injury, when partying was a way of relating. A also shared that she feels like she is growing up in many ways.

Summary

We identified that responses will have more success if we plan ahead.

We talked about the “rituals” involved in addictive behaviour, and the importance of interrupting the chain of events/ritual

A, H, and I had the opportunity to problem solve around their triggering events

What we heard you say

T agreed to try using a prompt this evening in his phone to remind him of his coping strategy.

I agreed to set up a time to tour the YMCA with Roby- as a potential way to cope with boredom on a Saturday afternoon.

Goals of this session

- Review our challenging situations
- Learn to set an intention in a difficult situation
- Practice our response in challenging situations

Triggers

Common Triggers

Emotions: Happiness

Anger

Stress

Guilt

Sadness

Triggers

Common Triggers

Physiological Feelings/Sensations:

Pain

Hunger

Smells

Sounds

Withdrawal

Triggers

Common Triggers

People/Places/Things:

Old street or neighbourhood

Old Friend

Money

Situations eg. Celebration/Holiday

Songs

How to Cope?

Think of your substance use as a behavioural pattern or habit, which you can change.

First let’s think of scenarios where the unhelpful thinking happens.

” Someone once asked me how I hold my head up so high after all I’ve been through. I said, it’s because no matter what, I am a survivor. Not a victim.”

—Patricia Buckley

Triggering Situation: Saturday afternoon and my sister just dropped me off from shopping.

Plan: Set up a gym membership with support from my sister.

Unhelpful Thoughts: What can I do now? I've worked hard all week on my goals.

Challenging statement: I can go to the gym

A

Triggering Situation: Out with friends for dinner

Plan: Choose to spend time with friends who understand me, in a coffee house.

Unhelpful Thoughts: Everyone else is doing it. I’m allowed.

Challenging Statement: I am an adult, I know that this is not good for me.

H

Triggering Situation: Going to bank machine to check my account

Plan: Enter a message into iphone to prompt me not to go to the bank

Unhelpful Thinking: No Money – I feel bad about not having any money. Money – Just one time won’t hurt.

Challenging Statement: I don’t need substance, I can go to the gym instead

Journal

What message did you hear?

Be kind to yourself

STAY SAFE

Sample of Topics Addressed

Triggers and coping

Dealing with boredom

Refusal skills

Case example I.

- Bartender with history of poly substance use.
- Assaulted at age 44 resulting in severe injury.
- Substance of concern Alcohol and Marijuana.
- Admitted to SUBI group 8 years post injury.

Cognitive

Mild cognitive slowing

Mild to moderate memory impairment

Reduced problem-solving (limited response to contingencies)

Reduced complex attention (multi-tasking)

Reduced initiation

Harms associated with substance use

- Drank to intoxication most days, drinking during the day if he had funds to do so.

- Risky behaviour while drinking (walking into street intoxicated)

- Depressed mood

- Unable to maintain his home

- Family Conflict

- Money easily triggered use

Engagement – 1 Year

- •Assessment with incentive
- •Harm reduction group
- •1:1 community visits 2x week
- •Weekly schedule

Persuasion 8 months

- SUBI intensive

Active Treatment 2 years

- Gardening co-op
- Crossing Guard Job
- Doggy Daycare

Relapse Prevention - Ongoing

- Maintain awareness of relapse
- AA CHIRS
- AA community

Harm Reduction

Cognitive Compensation

Motivational Interviewing

Behavioural Intervention

Skills Training

Meaningful engagement

Relapse Prevention

Outcome

Drinking episodes reduced to less than weekly, and less intake (2-4 beers)

Triggers continued to be a friend with whom he drinks.

Marijuana use reduced to 2-3 time per month

Relationship with sister improved

Mood and initiation improved

Moved to a supported setting

Outcome Measures

Behavior Symptom and Identification Scale-32 (BASIS -32)
Eisen (1996)

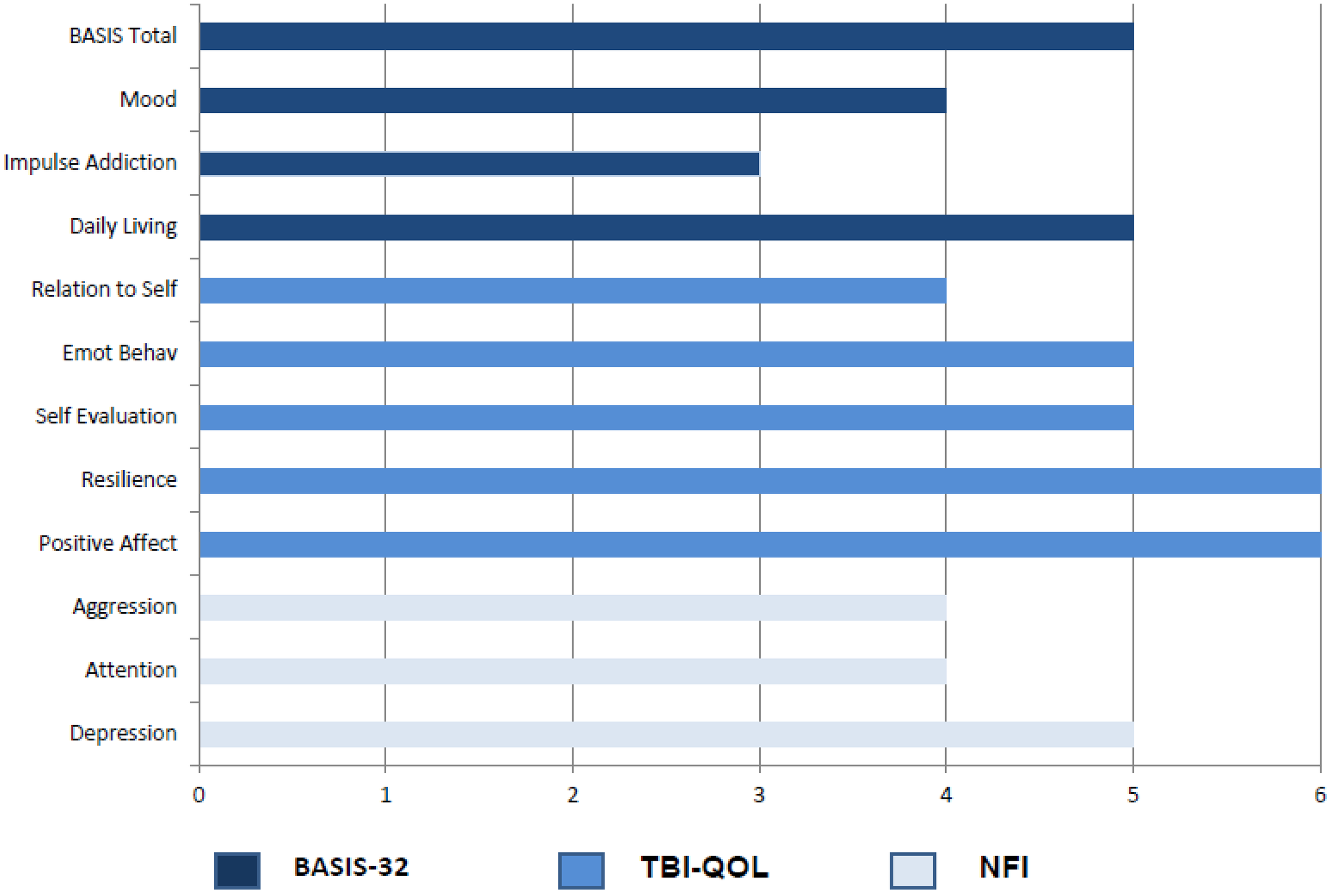
TBI Quality of Life V 1.0 (TBI-QOL)
Tulsky, 2010 based on NeuroQOL Cella, Lai, Nowinski et al (2012).

Neurobehavioral Functioning Inventory (NFI)
Kreutzer, Seel and Marwitz (1999)

Timeline Followback Interview (Sobell and Sobell, 1992)

Goal Attainment Scaling (Turner-Stokes, 2009)

Clients Demonstrating Clinically Relevant Change



Measures	Pre-Treatment Mean(SD)	Post-Treatment Mean (SD)	t	*p*
TBI-QOL				
• Satisfaction with Roles	29.33 (7.50)	33.50 (6.92)	-0.91	0.41
• Emot./Beh. Dyscontrol	33.00 (10.71)	38.67 (8.14)	-3.01	0.03*
• Self-Evaluation	31.67 (6.59)	37.00 (8.72)	-2.70	0.04*
• Positive Affect	30.67 (7.87)	36.50 (8.41)	-5.13	0.00*
• Resilience	23.50 (5.47)	26.33 (5.09)	-2.43	0.06*
Total	**148.17 (21.56)**	**172.00 (29.24)**	**-3.80**	**0.01***
BASIS-32				
• Relation to Self	1.74 (0.70)	1.26 (0.80)	2.71	0.04*
• Daily Living	2.02 (0.83)	1.29 (1.04)	4.13	0.01*
• Depression/Anxiety	1.56 (0.65)	1.00 (0.69)	1.89	0.12
• Impulsive/Addiction	0.94 (0.90)	1.11 (0.59)	-0.66	0.54
• Psychosis	0.54 (0.53)	0.58 (0.56)	-0.25	0.81
Total	**1.42 (0.67)**	**1.03 (0.60)**	**5.32**	**0.00***
NFI				
• Depression	34.00 (8.02)	34.33 (7.03)	-0.06	0.96
• Somatic	24.00 (6.36)	20.50 (5.65)	0.92	0.40
•Attention	47.00 (12.21)	47.83 (8.65)	-0.11	0.92
•Communication	21.50 (3.33)	20.50 (5.65)	0.33	0.76
•Aggression	17.67 (3.32)	15.67 (4.63)	0.81	0.45
Total	**18.17 (5.95)**	**14.33 (3.08)**	**1.26**	**0.26**
***Statically significant at *p* ≤.05**				

Preliminary Findings

Mood and psychiatric symptoms are clinically improved from intake to completion of psycho-educational group.

Neurocognitive symptom reports remain stable.

Substance use is reduced early in treatment, with continued reduction through the follow-up period for 80% of participants.

Case management goals and Harm reduction goals are met.

Conclusions

- Psycho-educational and group interventions are necessary but not sufficient to see changes in substance use.
- Positive affect seemed to precede improvements in self-management and substance use
- Interventions will take longer—models of service need to be designed to accommodate this
- CAMH/CHIRS partnership was a marriage. Supports ensured evidence-based practice, community-informed service design and has the promise for increased service integration

Context

Research indicates that the consumption of alcohol or non-prescription drugs is may be particularly harmful for individuals who have sustained a brain injury.

CHIRS discourages non-prescribed Drug and Alcohol use…continued usage is not the criterion for termination of support.

…harm reduction framework offers a viable treatment alternative

…diminish the impact of stigma suffered by substance users which may be compounded by the stigma resulting from living with a disability.

Definition

The International Harm Reduction Association (2002) describes harm reduction as:

Policies and programs which attempt primarily to reduce the adverse health, social and economic consequences of mood altering substances to individual drug users, their families and communities, without requiring decrease in drug use.

Principles

Mental illness and addiction are public health concerns, not criminal justice or moral issues.

Improving quality of life of the individual, the community and society at large is the primary criteria for measuring the success of interventions and policies.

There are many severe and lasting harms and dangers associated with untreated mental illness and drug use.

Choice is essential for recovery.

Socio-economic and biological factors influence people’s vulnerability to mental illness and addiction.

Policy

Clients at CHIRS are not required to abstain from using drugs or alcohol to receive support, but because of the immediate risks to clients, CHIRS does not permit use of drugs or alcohol on any of the CHIRS sites.

CHIRS adheres to Harm-Reduction principles.

As part of introducing CHIRS services, clients will be informed about the policy for non-use at CHIRS activities and the Harm-Reduction philosophy CHIRS employs.

IF a client who is participating in a CHIRS- supported activity in the community consumes alcohol or drugs, staff will respond according to the guidelines included in individual service plans, behavioural programs, or program guidelines.

Procedures

Screening for substance use at intake and during the course of care as required.

Staff members will be trained with management of substance-related episodes including recognizing intoxication and specific support procedures

General Guideline

Have a private conversation

Create a safety plan

Assist client to leave program and get home safely

Consult with supervisor

When a client is suspected (but not confirmed) to be intoxicated, a plan that considers safety, dignity and relationship may be developed in consultation with the supervisor on call.

Recommendations:

Review CHIRS policy and Counsel the client with regard to the risks they may expereince with substance use.

Specialized Referral

Development of a harm reduction programme.

Clients are asked not to keep intoxicating substances in their units (for the safety of other clients).

Breaches are managed on a case by case basis, with discharge considered if risks to other clients persist.

CHIRS doesn’t perform searches but would comply with legally authorized searches

Substances found will be destroyed

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CHIRS

camh
Centre for Addiction and Mental Health
Centre de toxicomanie et de santé mentale

Ontario Neurotrauma Foundation
Fondation ontarienne de neurotraumatologie

Toronto Acquired Brain Injury Network