SUBI

SUBSTANCE USE/
BRAIN INJURY
BRIDGING PROJECT

Substance Use and Abuse and Brain Injury Where to Start?

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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

2009-2013

Substance use and Acquired Brain injury Research to Practice Network

camh
Centre for Addiction and Mental Health
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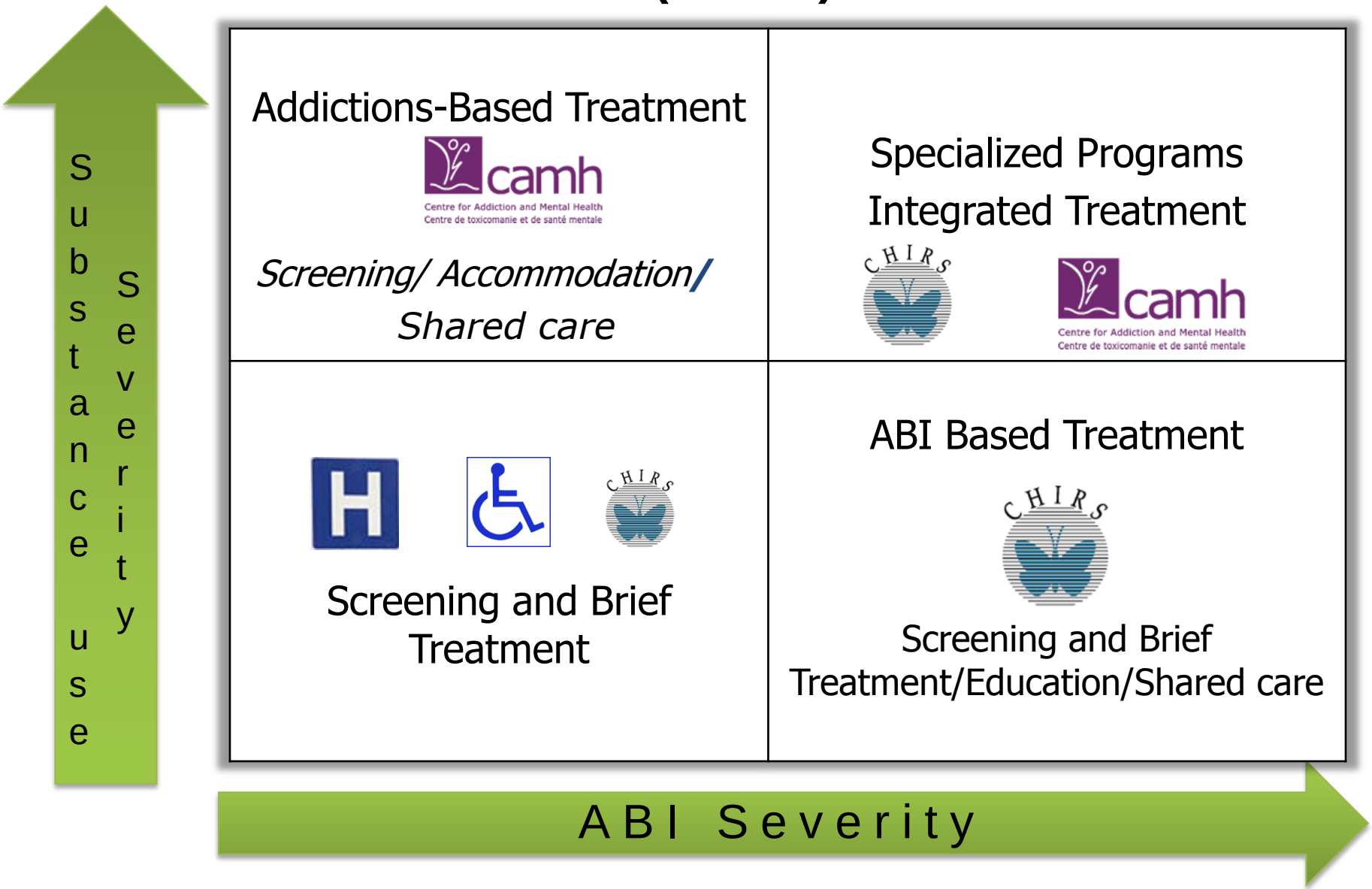
Ontario Neurotrauma Foundation
Fondation ontarienne de neurotraumatologie

CHIRS
Community Head Injury Resource Services

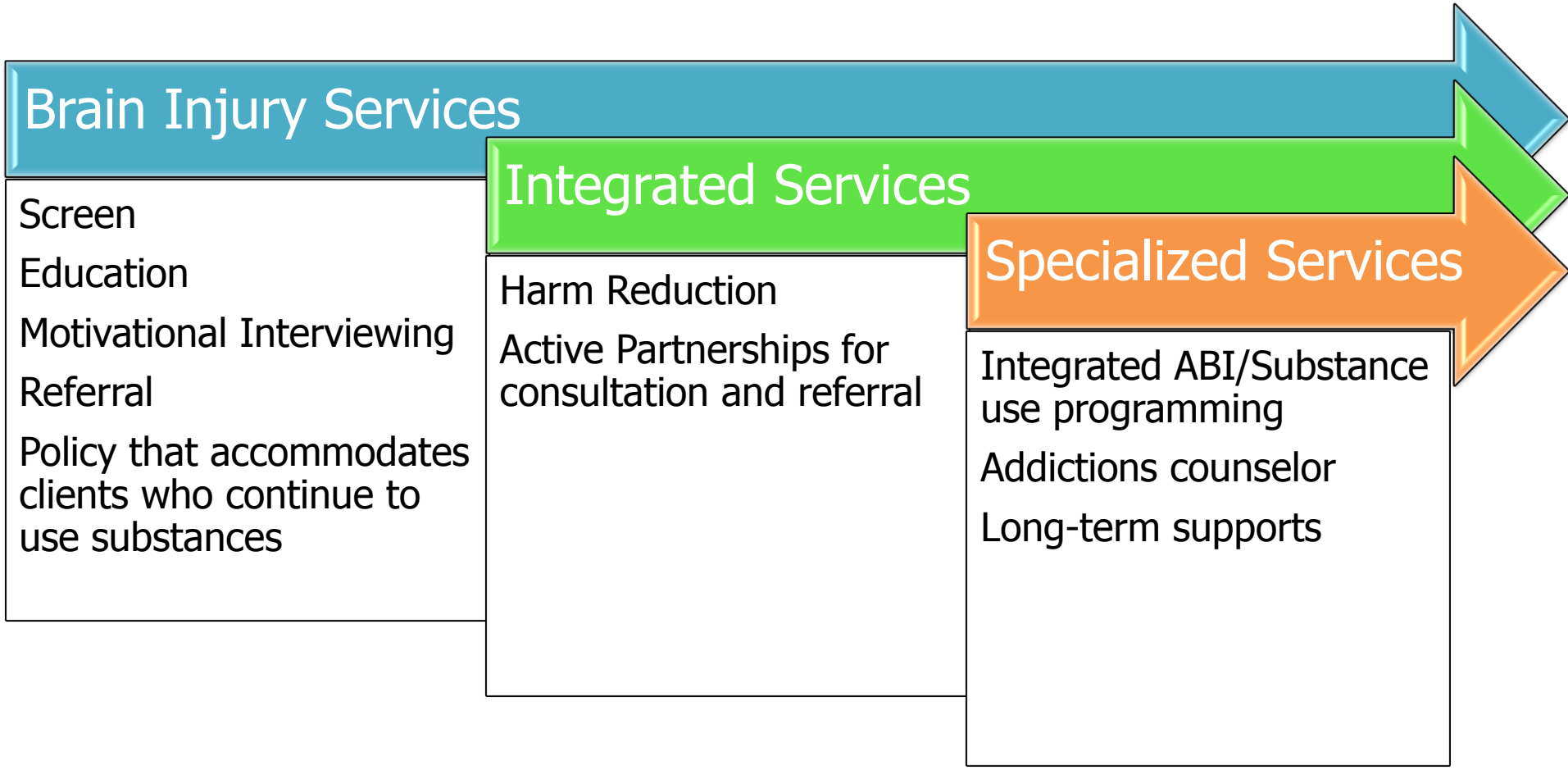
Where to get started?

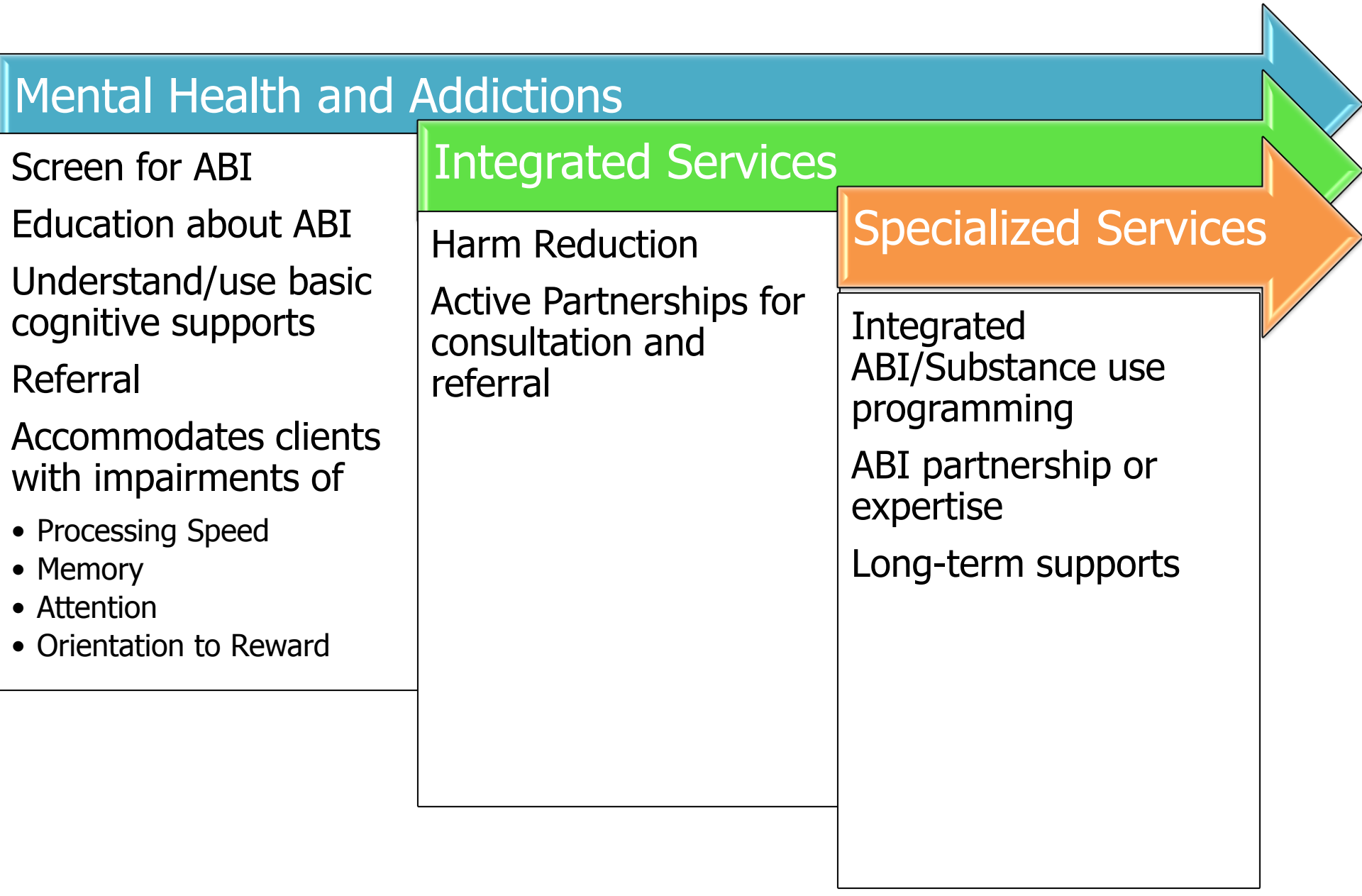
Provide an introduction to the skills mental health and addictions workers need to effectively support people with problematic substance use, mental health symptoms and brain injury

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



Modified from Kenneth Minkof, John Corrigan and others…


Brain Injury Services
Screen
Education
Motivational Interviewing
Referral
Policy that accommodates clients who continue to use substances
Integrated Services
Harm Reduction
Active Partnerships for consultation and referral
Specialized Services
Integrated ABI/Substance use programming
Addictions counselor
Long-term supports


Mental Health and Addictions
Screen for ABI
Education about ABI
Understand/use basic cognitive supports
Referral
Accommodates clients with impairments of
• Processing Speed
• Memory
• Attention
• Orientation to Reward
Integrated Services
Harm Reduction
Active Partnerships for consultation and referral
Specialized Services
Integrated ABI/Substance use programming
ABI partnership or expertise
Long-term supports

Mental Health and Addictions professionals should know how to…

- Screen for ABI
- Recognize the most common types of cognitive impairment
- Know basic strategies for cognitive compensation
- Assess level of awareness

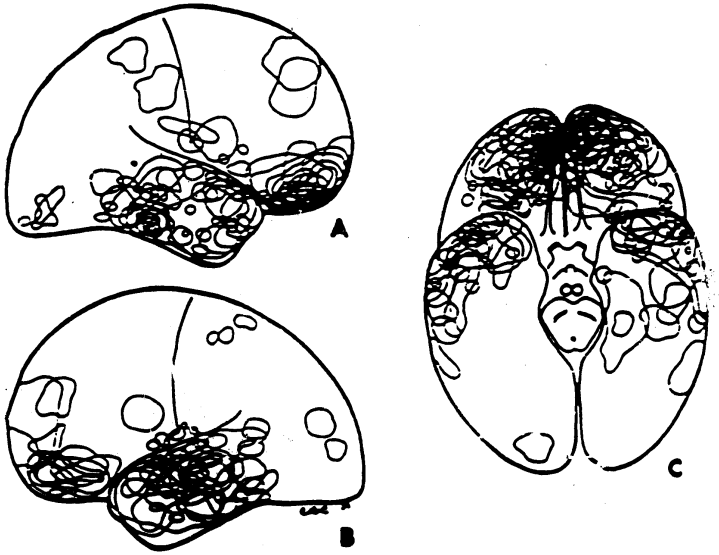
Overview

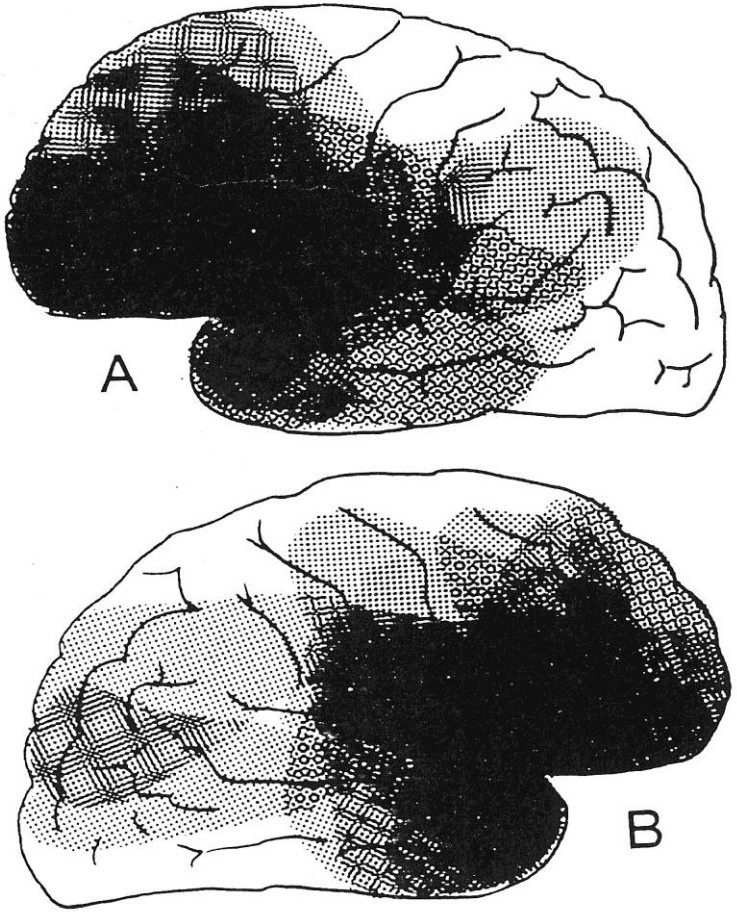
- Quick overview of the contribution of ABI to mental health and addictions
- How to Screen for ABI
- Basic Support Strategies for people with cognitive impairment
- Case examples to illustrate intervention planning and the four quadrant model of care
- Discussion of application

Red Flags

- Greater than typical difference between what a client does and what they seem able to do
- Tangential speech
- Poor social skills (history of impulsivity, aggression, poor social boundaries)
- Poor memory/inattention
- History of leaving treatment early because of ‘non-compliance’.

Series of 40 patients
(Courville, 1950)

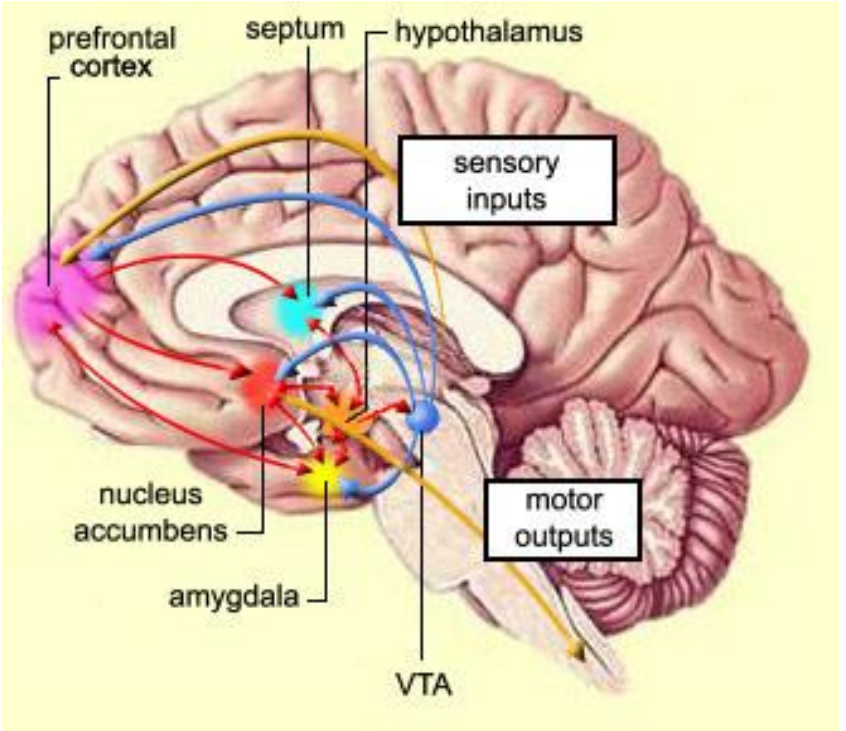




Series of 100 patients
(Bigler, 1984)

TBI's contribution to SUD

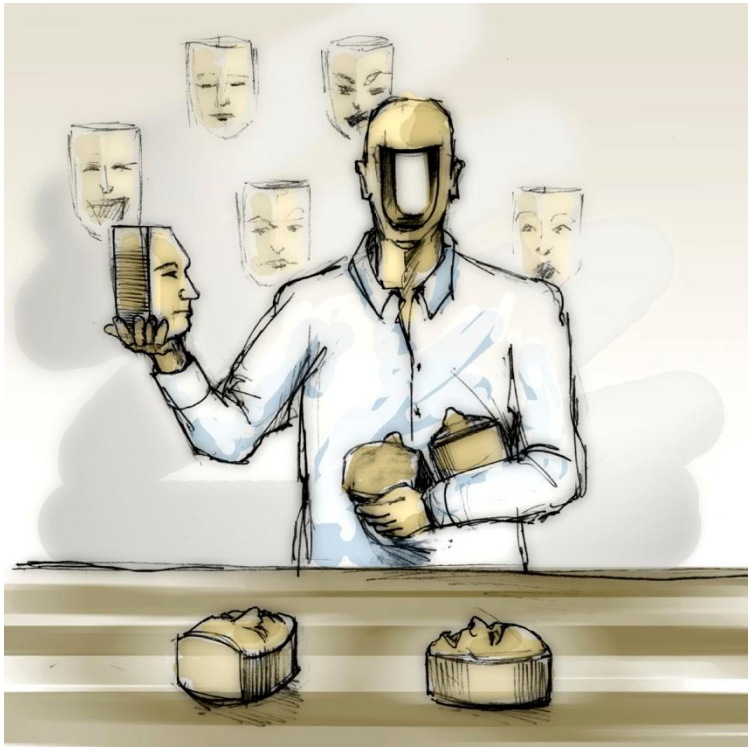
- Structural changes to the reward system
- Psycho-social changes
- Early Brain injury may alter the course of development, causing a pre-disposition to SUD



Executive Functioning Deficits May Mimic Psychiatric Disturbance

- Reduced response to emotional stimuli
  - Personality disorder
- Cognitive rigidity
  - Anger/frustration
- Deficits in ability to anticipate consequences
  - Impulsivity
- Poor Problem-solving/confabulation
  - Unusual beliefs (psychosis)

- About 1/3 of survivors of Moderate to severe ABI will have significant depression
- Anxiety & depression coexist in approx 60% TBI rehabilitation patients
- Increased likelihood of mood disorders with left dorsolateral frontal lesions and/or left basal ganglia lesions



Mood

Psychosis

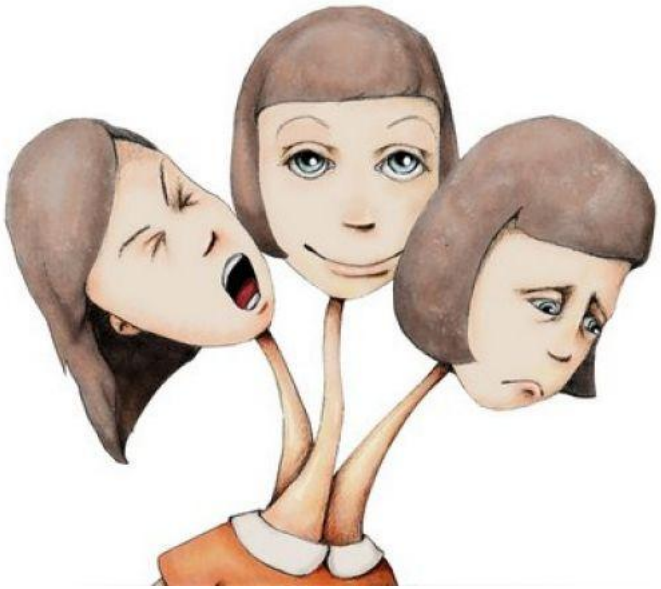
- Uncommon in ABI Survivors
- Schizophrenic like disorders are 2-3 times more common in patients with history of TBI
- Impaired self-awareness? (Arciniegas et al., 2003, Silver et al., 2001)

Risk factors for psychosis after ABI

- Left hemisphere injury
- More severe injuries
- Prior CNS injury
- Premorbid characteristics plus added brain trauma

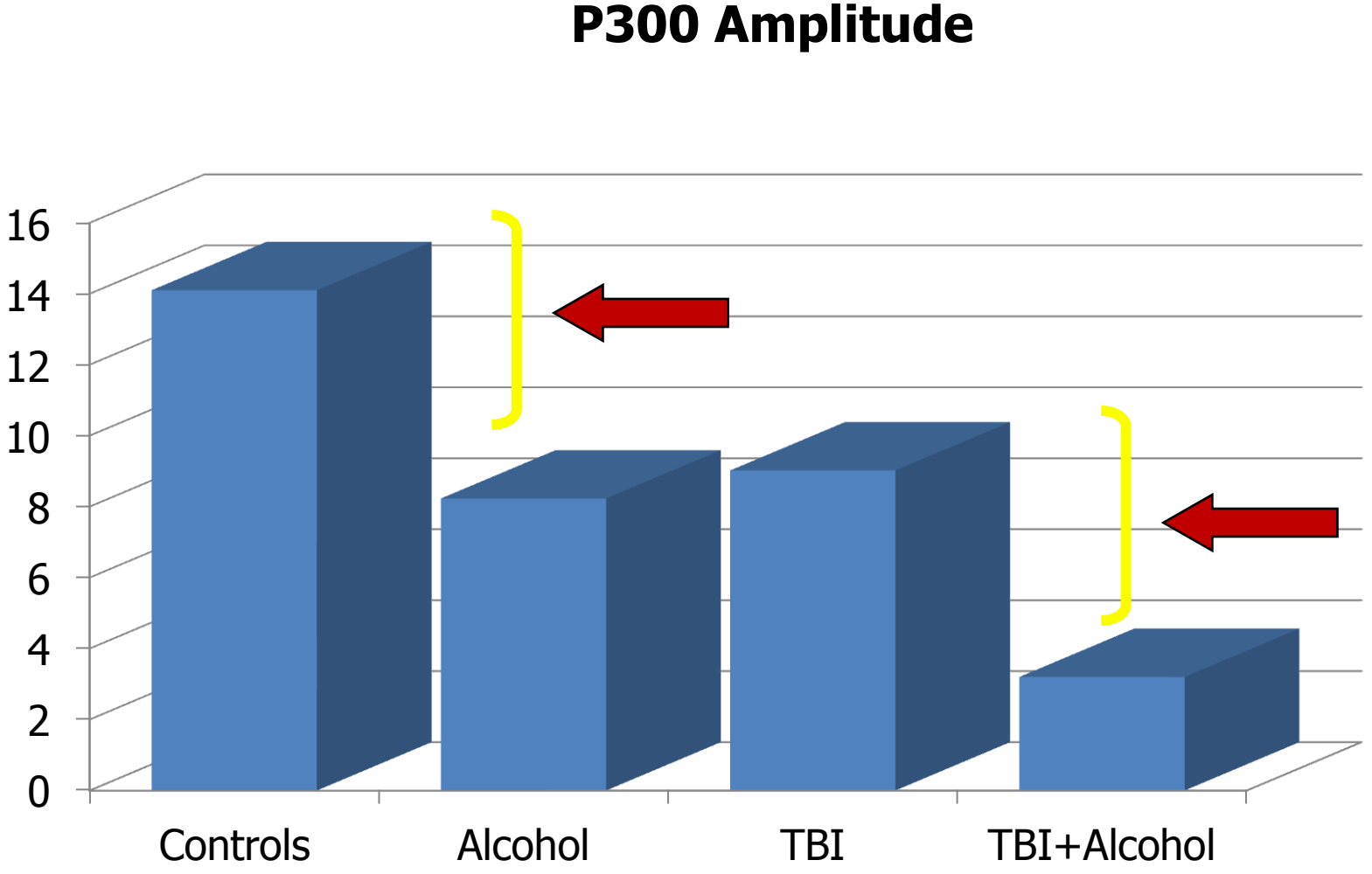
Personality Characteristics

- Lack of empathy
- Irritability
- Socially Inappropriate Language
- Impaired social judgment
- Inflated sense of self
- Impulsivity
- Reduced initiation



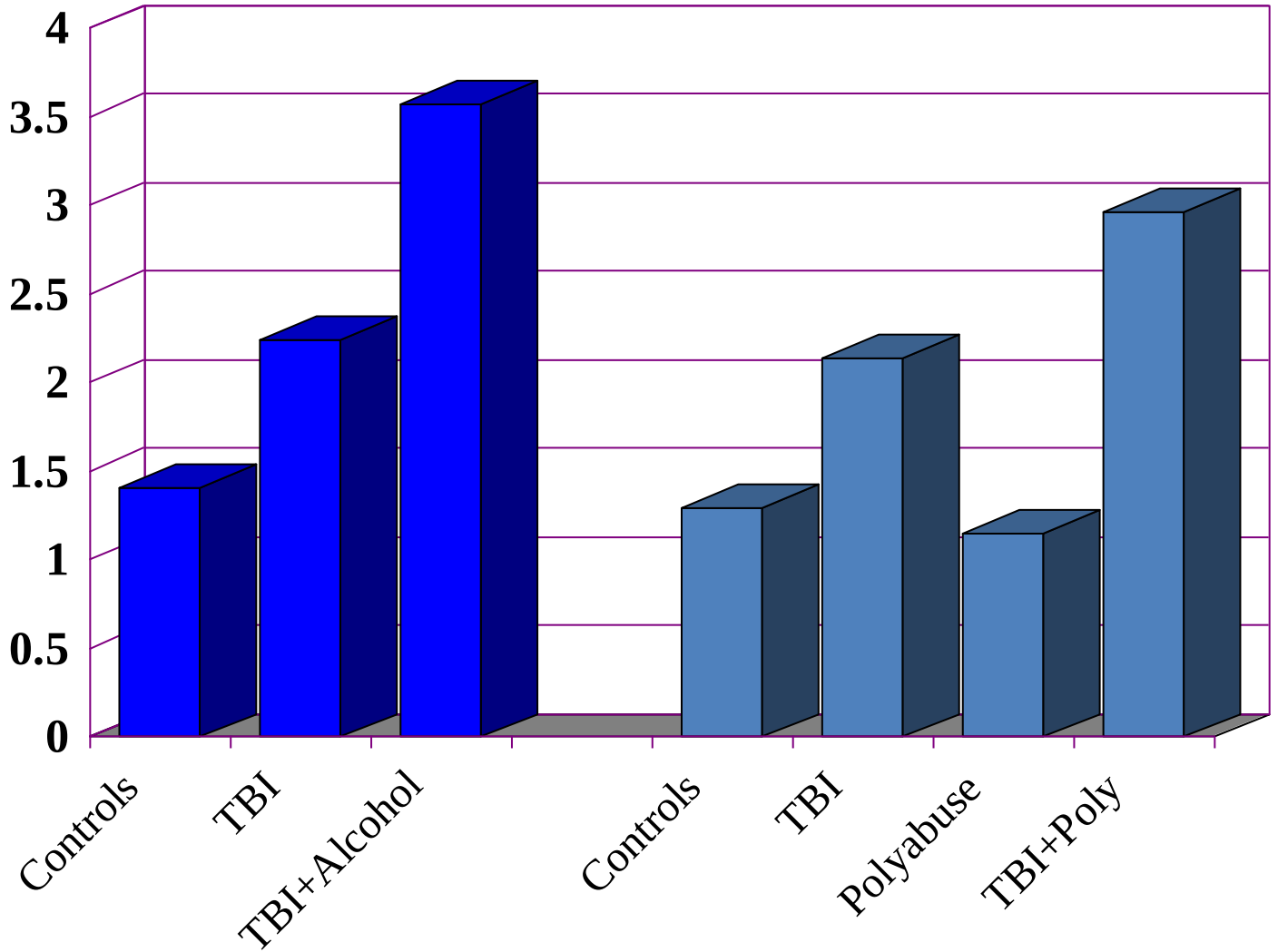
Increased risk of having a diagnosis of personality disorder and organic personality disorder after brain injury

Event Related Evoked Potentials
[from Baguley, et al., 1997]



Ventricle to Brain Ratio

Bigler, et al., 1996 Barker, et al., 1999



Lifetime Episodes of Treatment for substance use

	No TBI	TBI No LOC	LOC<5min	LOC > 5 min
	Mean	**Mean**	**Mean**	**Mean**
Alcohol*	.61	.38	2.10	1.25
Drug	.83	1.38	2.10	.92

Summary

Substance use and ABI are additive in their impact on the brain and cognitive functioning

People with brain injury are at risk for repeated episodes of care for their addictions.

Changes in the reward system, cognitive and psycho-social changes may account for worse outcomes and increase complexity.

Screening for Brain Injury

Trauma

Behavioural Effect

Impact

T-B-I SCREENING

Name: _____

Date: _____ Date of Birth: _____

Traumatic Brain Injury, or TBI, is "… an insult to the brain caused by an external force that results in an altered state of consciousness and one or more impairments of brain functioning. Effects may be temporary or permanent." (CDC)

Use these questions to help a person recall injuries that may have involved an impact to the head or neck.

T

TRAUMA: An injury that includes a blow to the head, the head having impact with another object (e.g., the ground, a windshield), or substantial shaking without impact.

	YES	NO
Have you ever been knocked out following an accident, an assault, or any other injury?		
Have you ever been injured … in a car or bike accident?		
… from being hit by something?		
… in a fight?		
… playing sports?		
… by a family member?		
… while serving in the military?		
… being near an explosion?		
Have you ever been treated in an emergency room, or hospitalized following an injury?		
Were you ever injured and should have received medical attention but didn't?		

With the identification of a possible trauma, next evaluate whether any of the injuries caused an altered state of consciousness.

For each injury, determine if the person was hit in the head, near an explosion, or if the head could have been shaken violently. If so, was the person dazed or confused, have a period of memory lapse, or actually knocked out or unconscious?

B

BEHAVIORAL EFFECT IMMEDIATELY: An altered state of consciousness evident in confusion, impaired memory for events around the injury, or loss of consciousness.

Incident	Age at time	*Were you dazed or confused (D/C), have a lapse in memory (Mem), or actually knocked out (KO)?*	If knocked out, how long?	*Were you treated in the ER, hospitalized, or admitted to a rehabilitation facility?*
		CIRCLE ONE		CIRCLE ONE
		D/C Mem KO		ER Hosp Rehab
		D/C Mem KO		ER Hosp Rehab
		D/C Mem KO		ER Hosp Rehab
		D/C Mem KO		ER Hosp Rehab
		D/C Mem KO		ER Hosp Rehab

I

IMPACT ON EVERYDAY FUNCTION: Following the injury, new onset or exacerbation of symptoms (e.g., headaches, dizziness, fatigue, depression) or function (e.g., attention, memory, employment, relationships).

After any of your injuries did any of these persist *for more than several weeks*?	YES	NO
Headaches		
Dizziness or balance problems		
Tiredness or fatigue		
Problems paying attention or concentrating		
Being sensitive to bright lights or loud noises		
In the months after any of your injuries did you:	YES	NO
Have new problems at work or school, or lose a job?		
Notice changes in your relationships with your family *(wife, husband, parents, friends)*?		
Have trouble remembering things or solving problems?		
Feel depressed or anxious more than before the injury?		
Have trouble controlling your temper?		

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Trauma

- Have you ever been knocked out or lost consciousness?
  - Where/When and for how long.
  - Did you get treatment?
  - How long did it take you to feel like yourself again?
- Always ask if there are other injuries.

Other Causes of Brain Injury

- Hospitalizations/serious illnesses
  - Heart attack
  - Stroke
- Chemical Exposure
- Chronic Substance Use

Behavioural Impact (immediate)

- Dazed
- Confused
- Memory lapse
- Knocked out (LOC)

Impact on Everday Functioning

- Do you notice any problems with thinking, learning or memory?
  - If so…what…
  - How do they affect you day to day….
    - At home
    - On the job
    - With relationships/family
    - Recreation

How to Judge Injury Severity

MILDER	Loss of consciousness of 30 minutes or less	Temporary effects	Having several TBIs with any loss of consciousness may show cumulative effects (e.g., though each of the TBIs are mild, their combined effect may be like a moderate or severe TBI).
		Some individuals will have a less severe TBI, but experience greater effects because of an interaction between the TBI and other neurologic compromises.	TBIs requiring hospitalization are generally more severe than those requiring ER care (however, hospitalization can be for injuries other than the TBI).
	Effects that persist	TBIs that have more effects on everyday functioning are more severe.	TBIs requiring rehabilitation are generally more severe than those requiring hospitalization only (however, rehabilitation can be for injuries other than TBI).
MORE SEVERE	Having no recall of a day or more ***after*** the injury	More severe TBI will be associated with greater cognitive, behavioral, and emotional problems. Often, the problem is regulating one's thinking, actions, or emotions.	May not report significant effects because they are not able to recognize changes in their ability to function because of an "unawareness" of deficits, (a specific kind of cognitive impairment that can result from TBI).

Lifetime History of TBI Corrigan, Bogner & Holloman (2012)

- More serious injuries or younger age at 1st injury associated with slower speed of information processing and greater cognitive complaints.
- Addictions more severe for those 1st injured before age 11.
- Uniqueness of early childhood TBI observed for persons with substance use disorders replicated in a sample of prisoners.

Consider the timing

- More recent ABI is associated with more attention, learning and memory problems
- Childhood TBI is associated with poor social development/skills, attention deficit and substance use disorders in adolescence.
- TBI in early adolescence my arrest social development and result in addiction

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Memory problems

There are many ways that a client's memory problems can interfere with progress in treatment. The most common problems are remembering new information, recent even and things to be done in the future. Each of these cognitive tasks involves new learning.

There may be times when you are surprised how well a client can remember, for exampl a comment that made them angry, but how little she or can remember about sessions or goals or actions they've agreed to take. That because memory is a very complicated and different types of memory involve different functions of the brain. However, unlike wha you may have seen in movies, it is extremely rare for people living with ABI to forget the own identity. Most of the time, they can recall their lives before injury quite well.

MEMORY PROBLEM	EXAMPLES	WHAT TO DO
1. PROBLEMS RECALLING INFORMATION/EVENTS BETWEEN SESSIONS	Clara can't answer an open-ended question like, *Do you remember what we talked about last week?* Sam doesn't bring up an issue in his session unless his provider prompts him to.	Give the client a clue to get a memory started. *Last week you told me about your trip to Ottawa and we discussed some of the issues you had. Do you remember?* *Have you made any notes about important events this week? Your worker said something about a party?*
2. PROBLEMS REMEMBERING TO DO SOMETHING	Connie doesn't complete homework even though she seems very interested in trying new strategies. Alex misses appointments even when you give him an appointment card. Brady regularly leaves things in your office. Jim forgets to bring his notebook to sessions.	The hardest thing for someone with ABI to remember is something that is to be done in the future. Treat failures as memory failures rather than a lack of motivation. Sometimes a routine will help. For example, you may ask the client to do something at the same time each day or put an object in the same place each time it is used. Matching tasks with activities that regularly take place can act as a cue. For example, reviewing therapy notes after dinner, or practice relaxation after setting your alarm clock. Consult with the rehabilitation team and use that tear to prompt the client.

MEMORY PROBLEM	EXAMPLES	WHAT TO DO
		Problem-solve with the client directly. *Alex, what can we do to help you to remember your appointments? Is there someone to remind you? How could you remind yourself.* *It's the end of our session Brady. I'll give you a few moments to pack up your things.* *Jim, can you leave a note to remember your therapy notebook? Perhaps you can leave it by the door on the night before your appointment.*
3. PROBLEMS WITH SELECTIVE MEMORY It is easier to learn information when it is organized and fits in with information that you already have. This is important to realize when you're trying to teach someone something. Find a way to make it memorable by using an example associated with the client's history. Information that has a strong emotion associated with it, like anger or fear, is more accessible than information that has less emotional impact. The same is true for information that is very interesting or holds the promise of a reward. Because these effects are magnified in clients with memory loss, it can be very important to relate information to what the client finds interesting. Realize that they often have little control over the type of information that they recall best.	Ben always seems to focus on things that make him upset or angry. He rarely brings up good things. Alan is interested in music and can remember everything about his favourite band. When it comes to what you talk about, he always seems to draw a blank.	*Ben, I think you need some extra help remembering what does work. It's to easy to remember the bad stuff. Maybe you and your worker could make a point of writing down some of the things that were successful next week.* *Alan, maybe we could capitalize on your interest in bands. Is there a song that you can think of that will remind you to think before you act?*
4. PROBLEMS WITH CONFABULATION When memory is poor and the client's attention, concentration and reasoning abilities are affected, he or she may fill in the blanks with information that seems sensible. They may even have difficulty distinguishing thoughts about events from the events themselves.	Joe often seems to be making up stories about seeing friends that you know he hasn't seen in a while. Donna re-tells very elaborate discussions she's had with her mother when you know she can't remember that much detail about most events. Ryan always has a reasonable explanation about why something has happened but his workers often tell me that what he has said isn't true.	Confabulation is not intentional. When in doubt, it is usually more productive to treat misinformation as a confabulation rather than an intentional lie. Avoid open-ended questions with clients who are known to confabulate. When you're treating clients who confabulate, include others who can provide correct information. Try not to repeat confabulated information. Just provide the correct information. Prevent confabulation by opening discussions with information. *I understand that you went to visit your family with weekend.* *You visited your family this weekend. Perhaps Sandy* (rehab worker) *has more information about the details.*

What's in the Provider Manual?

Page 43 - Screening for cognitive impairment

Page 51 – Cognitive Impairments and ABI

What does slow processing look like?

- Missing the middle of the message
- Overstimulated, dazed or tired in busy environments
- Long pauses in conversation
- Difficulty recognizing a change in topic

What does inattention look like?

- Tangential speech
- Behaviour that appears impulsive
- Distractability
- Difficulty remembering information

What does poor memory look like?

- Variable capacity to remember information and procedures
  - Declarative (conscious memory)
  - Procedural memory (learning by doing)
  - Prospective memory (initiating a planned behaviour)
  - Memory for faces
  - Visual vs. Verbal
  - Recall Vs. Recognition

Learn how a client compensates

- Would it be okay if you showed me how you make an entry into your date book?
- How would you remember to look for it?
- If you want to remember to bring something with you, what do you do?

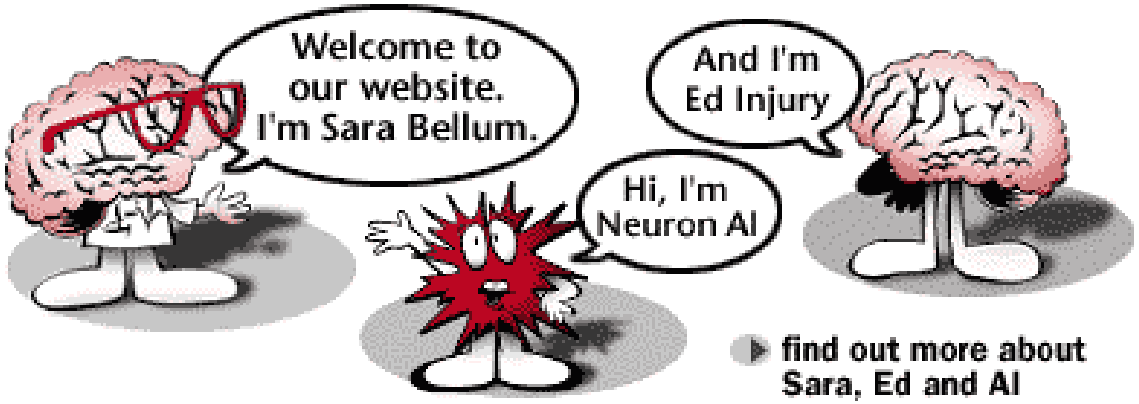
Listen for…

- A client who says they use a date book, but doesn’t carry it with them.
- Asks others to remind him/her
- Realistic way to record and then retrieve a note or appointment.

How much is too much after a brain injury?

Substance use in any amount can have bad effects after brain injury

Prevention



http://ohiovalley.org/informationeducation/materials/programmer/recovery/

Points to Consider

- Injured brains respond differently to substances.
- People with injured brains have a disadvantage in benefitting from treatment.
- The effects of substances have different implications (balance, slurred speech, disinhibilition).
- Psychosocial changes.

Prevention Messages

- Makes problems with walking and talking worse
- Limits recovery from brain injury
- Increases risk for seizures
- Interacts with prescribed medication
- Makes problems with depression worse

Prevention Messages

- Makes problems with saying or doing without thinking worse
- Makes problems with thinking, concentration and memory worse
- More powerful effect of substances

Helping Clients Compensate

- Slow down the message (sentences *not* paragraphs)
- Organize information
- Provide repetition
- Use visual cues
- Use routines

Live on my own

Vision

OWN APARTMENT

Job - Helping role

School Girlfriend

> Going Nuts

Need to Be Stable —

> Stop Outbursts

Management

~~#~~ Home management

- Cook
- Cleans
- Organized / Dry [illegible]

+ Cut Grass
- Take care Plants

Initiating → I POD + Supports

Timer

Organizing → Meta Cognitive Strategies

- Goal - (Specific / Measurable)
- Plan - Use organizational Strategy
- Do Implement
- Review

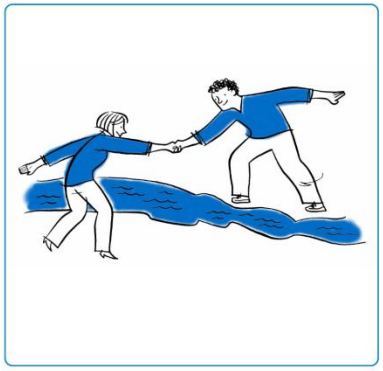
Use Timer to Recognize / Cope ☐ Distraction.

Remembering → I POD + Support

Structure your interaction

- Remove distractions
- Develop a ‘settling in ritual’
- Write out an agenda
- Goal, Plan, Do, Review

SUBI Client Workbook



Client Workbook

- Designed to illustrate adaptations of common practice in addictions for ABI
- A place to 'get started' for ABI-trained professionals

Free Download: WWW. SUBI.ca

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Recommended for clients who are ready to begin making a change

Can be used to structure inpatient intervention or outpatient intervention

Provides ‘homework’ that can be reviewed between sessions by workers/family/ client

Chapter 1
Getting ready for change

Clearly stated goal

Goals

- To learn that the good things associated with substance use may come quick and easy, but they don't last long
- To learn that the problems that come from using drugs or alcohol last a long time

Information

The first step in your recovery is to understand why you use drugs or alcohol and your reasons for wanting to make a change

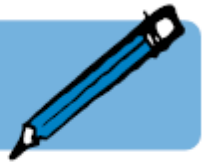
Self-assessment

Support discussion with client

Check any or all of these short-term benefits of drinking or drug use that apply to you:

- ❑ Instant gratification (feeling good right away)
- ❑ Helps me get to sleep
- ❑ Helps me deal with pain
- ❑ Helps me deal with stress
- ❑ Puts off having to deal with something that I don't want to think about
- ❑ Makes me numb (helps me to stop having feelings)
- ❑ Gives me something to do when I feel lonely

Worksheet, Chapter 1
Getting ready for change



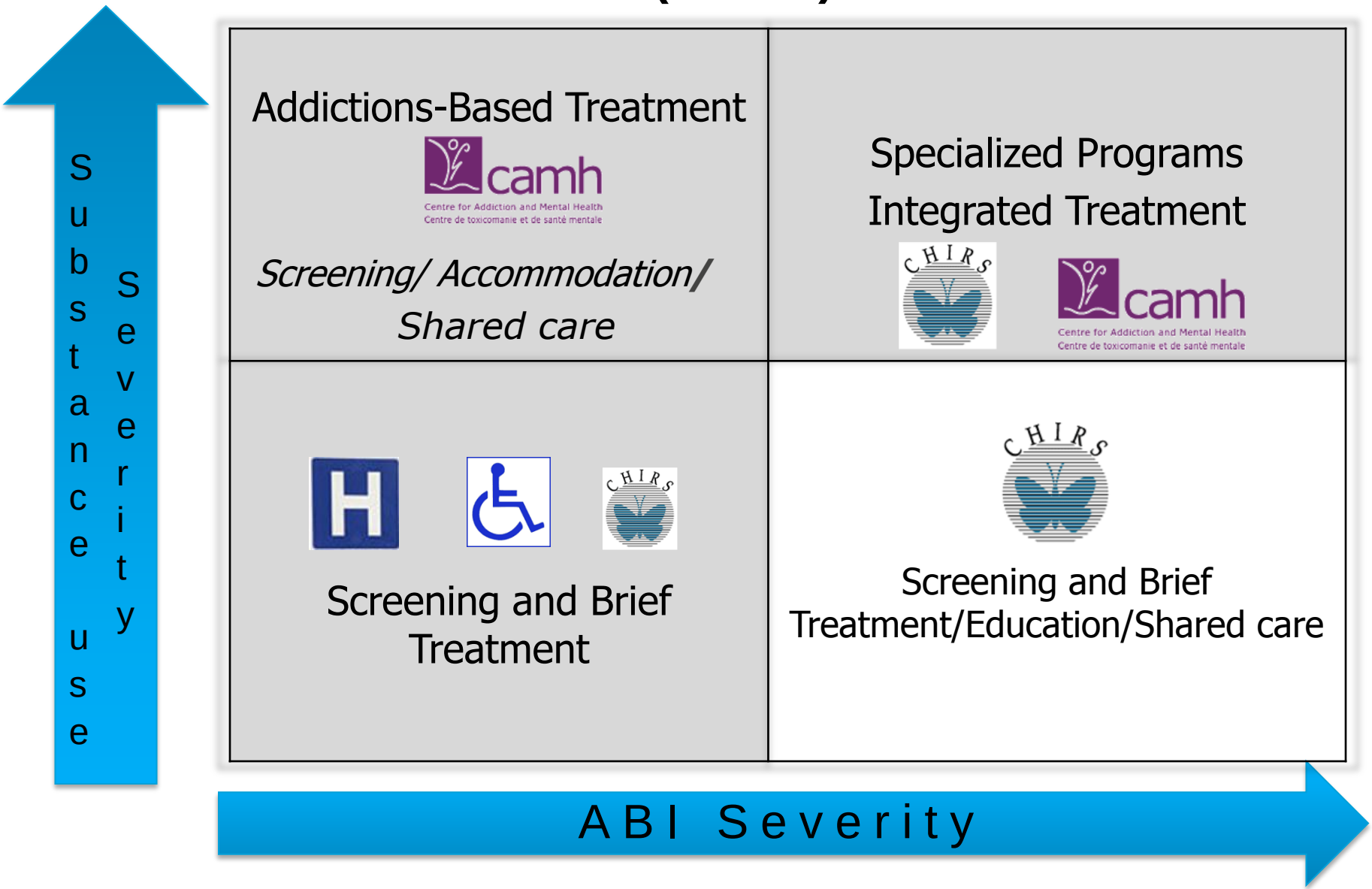
Now that you've had a chance to examine some of the pros and cons of your drinking or drug use, you might find it helpful to complete this chart. You may want to come back to it from time to time as you learn more about yourself.

Drinking or drug use

What's good about it	What's not good about it

Written record that is to be completed *with* the client

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



Modified from Kenneth Minkof, John Corrigan and others…

Alan
Needs Education /Harm reduction

- ABI at age 23
- Some underage drinking in High school
- Drinks 1 to 3 standard drinks, once or twice per months at Social events only.
- Occasional beer with meals
- Family are social drinkers
- Two charges of sexual assault.

Behavioural Assessment

- Impulsive/Dysexecutive
- Behaviour when intoxicated has led to a variety of difficulties owing to impulsivity
- Client sees drinking an ‘adult right’.
- Neither client nor family endorsed abstinence as a goal.

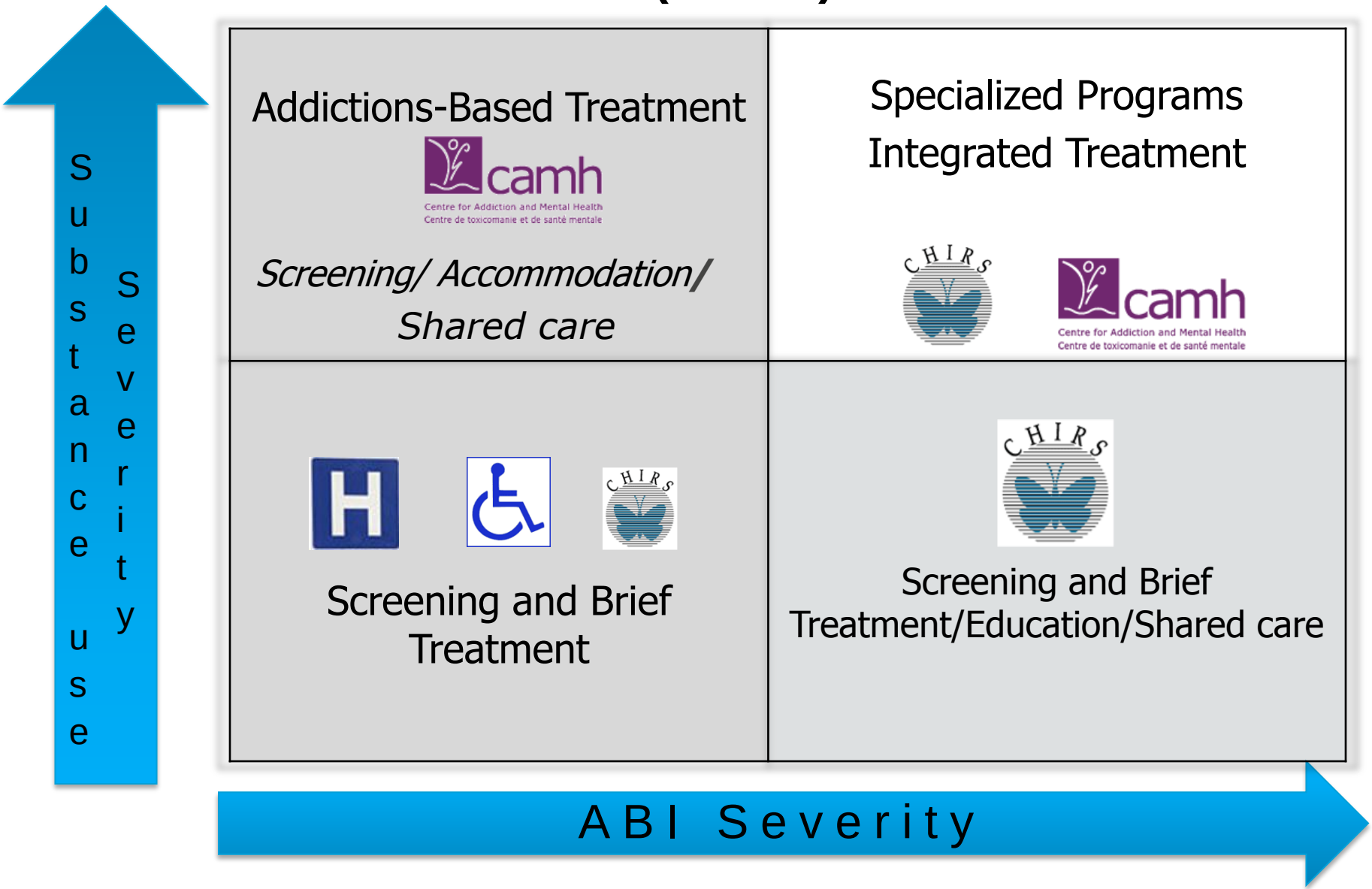
Intervention Plan

- Education
- Harm Reduction
  - No alcohol in public
  - No alcohol when guests are in the house
  - No more than two beers in a day
  - Only at home with support from a specific friend and/or family.

Harm reduction in the context of the TBI

- Compensation for impulsivity
  - Feedback from trusted others
  - Support/supervision from trusted others
- Compensation for memory Impairment
  - Reminders/repetition

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



Modified from Kenneth Minkof, John Corrigan and others…

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 (Cont'd)

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.

More principles

- Treatment strategies should consider that an individual's response to reward may be altered.
  - Treatment incentives are often useful
- Case management should strongly consider environmental supports
  - Activities that directly compete with substance use and enhance social roles should be emphasized

Each phase of the intervention will try to help you to answer different questions.

Working Together

- What is SUBI and how can it help?
- What are my rights and responsibilities?

Envisioning the Future

- What do I want for my life?
- How does my substance fit-in with my vision for the future?
- How do I set realistic goals?

Preparing for Change

- Formulating goals for change
- Clarifying my reasons for change

Gathering Resources and Building Skills

- How do I fill my time?
- Who can support me?
- What do I do when I'm sad, lonely, frustrated or angry?

Taking Action

- How do I prevent problem situations?
- What do I do if a problem occurs?
- How do I get around the problems caused by my brain injury?

Maintaining Gains

- What will help me maintain the gains I have made?
- What is the plan for the long run?

Richard

- Brain Injury at age 24
- Began using marijuana at age 14
- Drank heavily at social events to help with shyness
- Intoxicated at the time of injury
- When he has marijuana, smokes daily, several times per day
- Monthly episodes of drinking

Neurocognitive issues

- Moderate to severe memory impairment
- Aware of memory impairment unaware of social reasoning difficulties
- Reduced initiation
- Occasional drinking episodes, but without restraint

Richard

- No desire to change marijuana use
- Limited desire to stop alcohol use

Harms associated with use

- Falls when intoxicated
- Increase psychiatric symptoms related to substance use
- Marijuana seems to increase depressed mood and social isolation
- Misspending money

Richard's goals

- Live independently
- Have friends/girl friend
- Work with his hands
- Travel

How substance interferes

- Spends too much money on marijuana
- Doesn’t do much when high
- Isolates self when high
- Goes to bar to meet women, but has had several bad falls on the way home

Intervention plan

- Harm reduction
  - Desire to Travel
    - Work on budgeting to save for a trip and *reduce cash available for purchase of marijuana*
  - Desire to meet people/work with hands
    - Develop a schedule of activities with cues *which directly competes with the time available to use*
  - Coping strategies for feeling lonley
    - Planning events with friends

Adam

- History of poly substance abuse beginning at age 16
- Hockey player with many concussions
- MVA with severe injury age 23
- Neuro-syphilis age 25
- Prescribed medical marijuana
- Currently uses methamphetamine

Adam

Daily use of marijuana

Some alcohol use in family

History of trauma

No family in town, lives in supported housing

Methamphetamine 3-5 times per week—when I feel tired and unable to initiate

Feels triggered by being surrounded by people who use meth

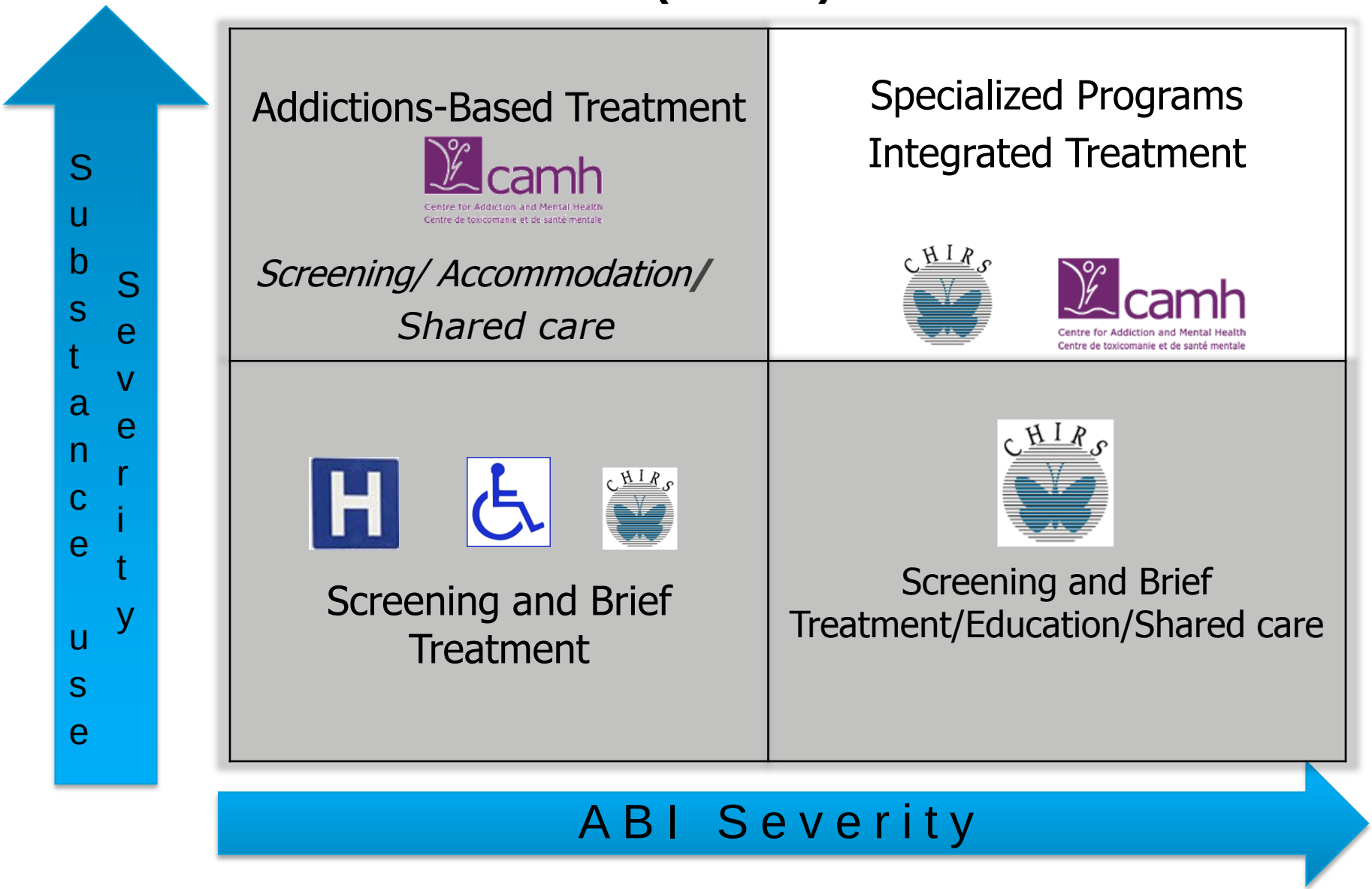
Cognitive issues

- Mild to moderate memory impairment
- Slowed cognitive processing
- Mild word-finding impairment
- Mildly perseverative
- Mildly to moderately reduced problem-solving

Assessment Findings

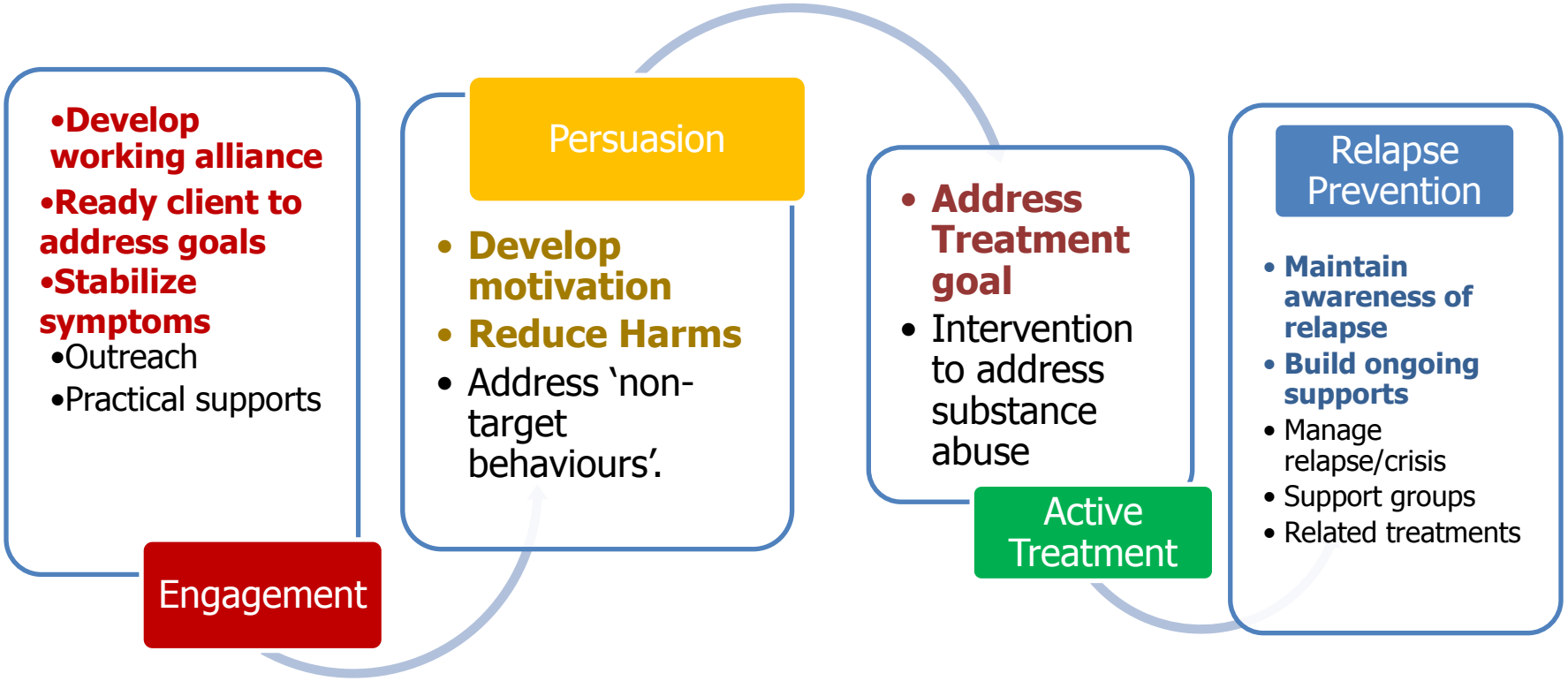
- Physical addiction
- Poly-substance abuse
- Depressed/anxious mood
- Hopeless
- Hostile toward providers

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



Modified from Kenneth Minkof, John Corrigan and others…

Phases of concurrent treatment



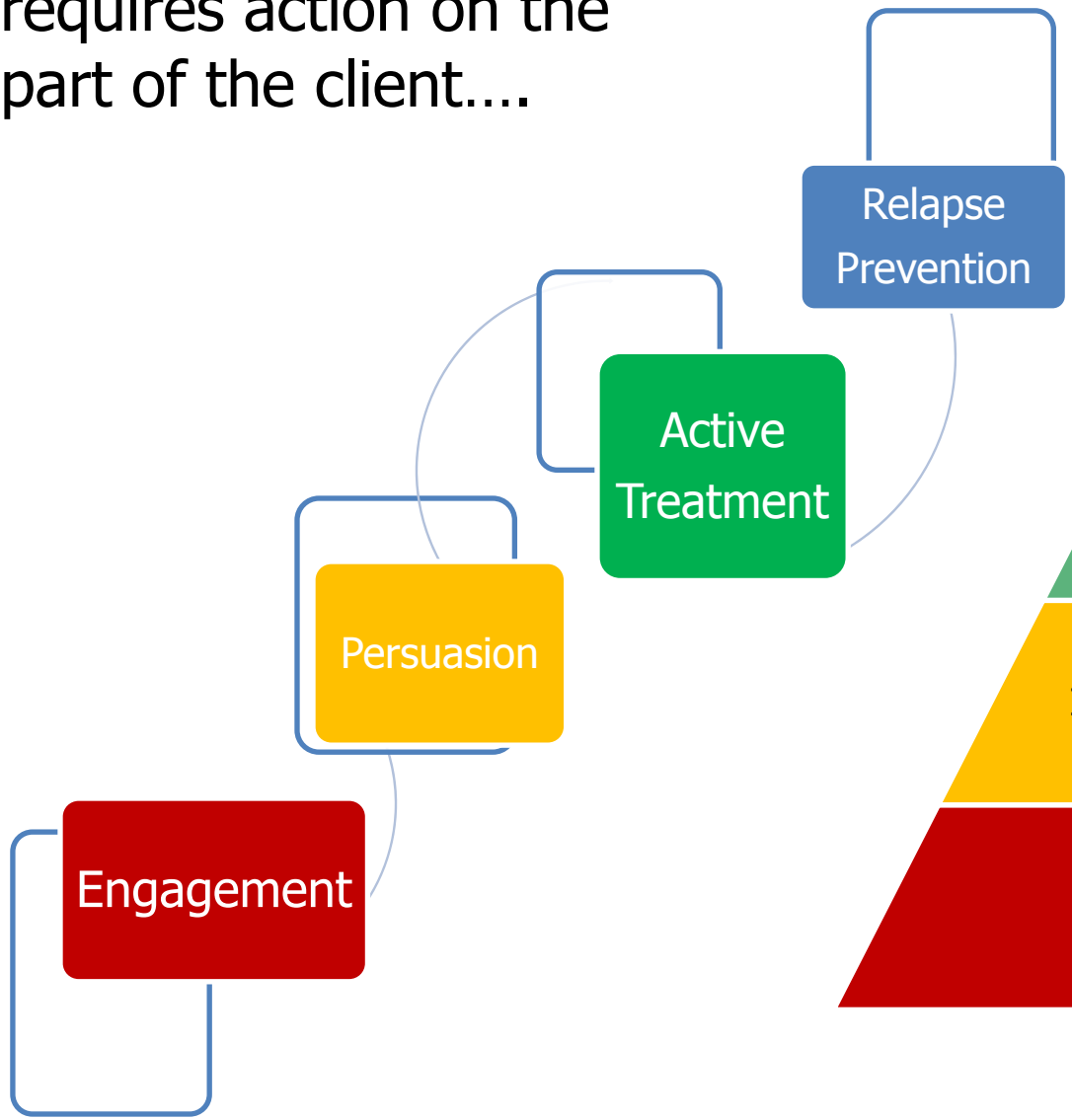
Engagement 10 months

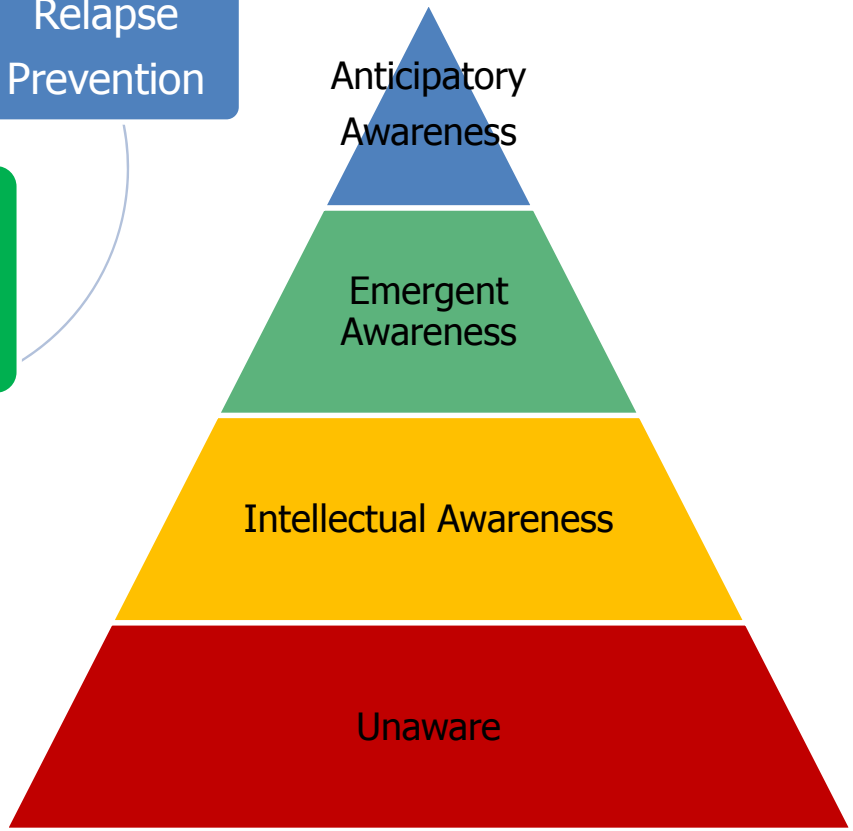
- Develop confidence in the relationships
- Learn about harms associated with substance use
- Understand risks and benefits of use for the purpose of reducing harms.
- Formulate life goals and instill optimism

Harm reduction

- Money is a trigger
  - Develop budgeting plan
- People at housing a trigger
  - Develop a schedule of competing activity
- Meth is used to address lethargy and inertia.
  - Consider prescribed medications

When the intervention requires action on the part of the client….





What does integrated treatment look like?

Developing a Strategy

Using incentives to support engagement

What is possible?

Systems Issues

Because of the relatively small size of the ABI service sector, addictions and mental health services need to accommodate people living with ABI

Settings serving people without stable housing or environmental supports need support strategies.