Clinical Interventions for Individuals with Co-occurring TBI and Substance Abuse

Robert Walker, M.S.W., L.C.S.W.
Assistant Professor, University of Kentucky
Center on Drug and Alcohol Research

Thanks also to:

Colleen Ryall, Ed.D.

Kentucky Department of Mental Health and Mental Retardation Services, Brain Injury Branch

John D. Corrigan, Ph.D.

Department of Physical Medicine and Rehabilitation, Ohio State University

Outline - overview

- The service array that is generally going to be helpful for persons with TBI and SA
- A brief look at how assessment is used to guide interventions
- First things and how to initiate treatment approaches
- Tips on how to relate clinically to clients
- Specific techniques and tools

“Programs”

- Do not hold out hope for a wonderful, successful residential program that “really works.”
  - While there are residential programs that have some relatively immediate positive results, be cautious about this.
  - The chronicity of substance abuse problems and the long-term course of TBI suggest that we need more focus on long-term management of problems, not “treatment” as we usually think of it.
- The number of persons with TBI and substance abuse vastly exceeds the number of beds available.
- The very nature of most TBI problems suggests that the likelihood of positive outcomes from traditional treatment is unlikely.

Why not traditional treatment?

- Because most traditional SA programs use cognitive-behavioral approaches that assume a basically intact cognitive capability.
- Because traditional treatment still places a high premium on the will to change –
  - Called “stages of change” or
  - “Treatment readiness” or
  - “Treatment motivation”
- All of which are contingent on a reasonably intact capability to have goals and to decide to change goals.

So, what's needed?

- Services that take into account the co-occurring chronicity of both TBI and substance abuse.
- This is NOT to suggest having no expectations for change.
- It IS to guide providers to have realistic expectations for incremental change coupled with –
- Careful monitoring over time to examine how changes are sustained or how they may need "boosters."

Service array for persons with TBI and substance abuse

- Careful, ongoing assessment of functioning and needs.
- Linkage to a targeted case management service.
- Linkage to a clinical consultant.
- Intensive Outpatient or other day programs are greatly preferred over standard outpatient counseling.
- Residential may be helpful, but long term facilities are hard to find and always leave questions about how much of the program “stays” with the client.

Targeted case management services

- The traditional boundary between case management and clinical roles is problematic with TBI clients.
- What is often needed is combined skills and focus.
- The traditional substance abuse treatment philosophies may be problematic as well:
  - Waiting for expressed desire for change
  - Commitment to AA or NA as part of recovery plan
  - Avoidance of doing FOR clients versus WITH clients
  - Avoidance of enabling family members – yes and no in these cases

One other ‘first thing’

- **WHO** is your client?
  - This is critical with TBI and substance abuse cases.
  - Your “real” client maybe the caregiver.
  - Unlike traditional substance abuse treatment approaches, the focus on the caregiver may be primary.
  - Look for other family members – even those not in the home who might be able to participate in interventions – or at least some respite care.
  - The caregiver may need coping strategies and may benefit more from this than the client will benefit from substance abuse interventions.

The overall picture

- Overall, you will need a clear understanding of the neurobehavioral patterns of your client.
- This means:
  - Cognitive processing factors
  - Emotion processing factors
  - Behavioral factors
- Coupled with the environmental contribution to current levels of functioning

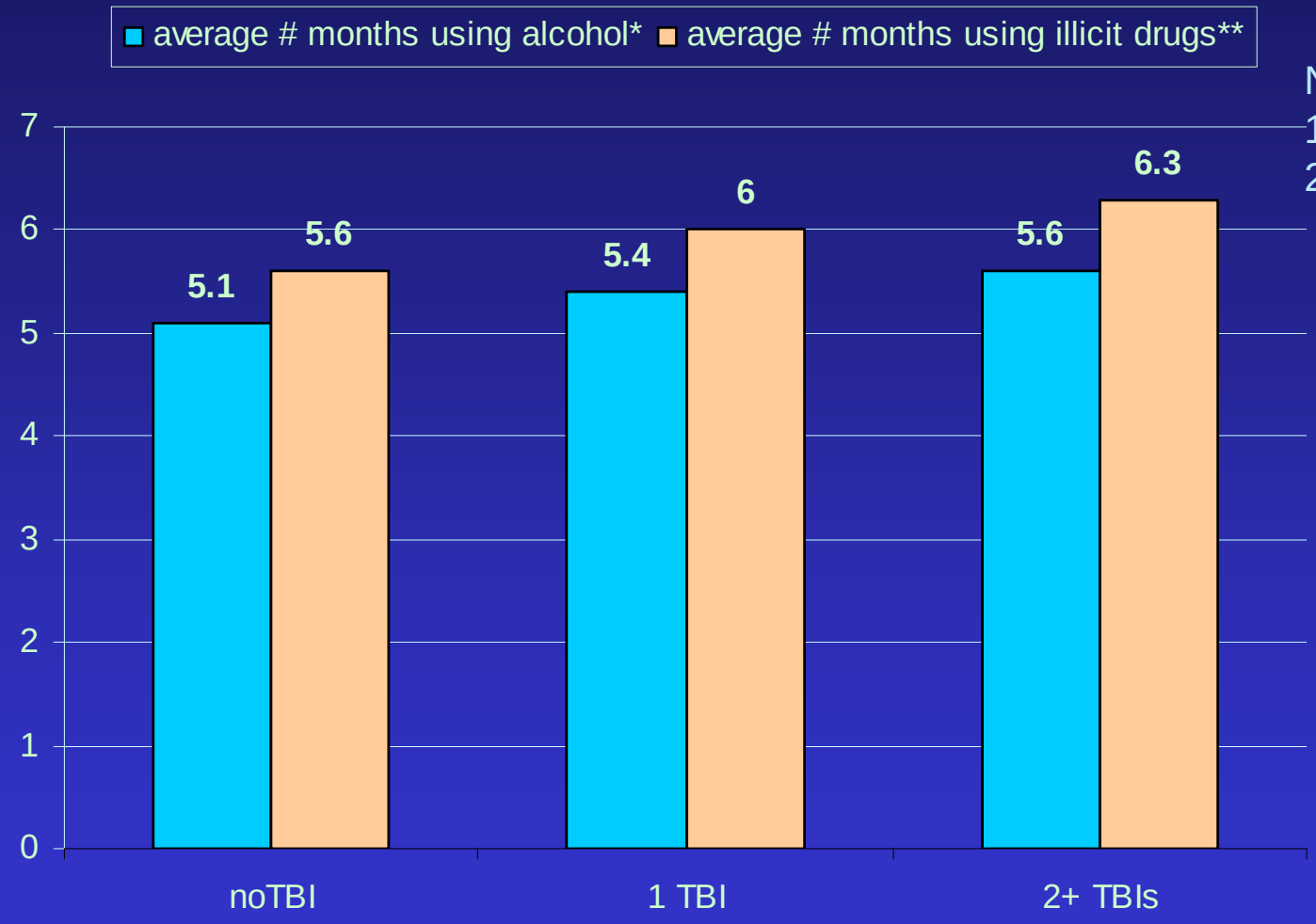
Ongoing assessment of functioning

- This involves close assessment of substance use patterns –
  - What substances?
  - What frequency?
  - How obtained?
  - What volume?
  - Where is it used?
  - What are the effects of the substance on behavior?
  - TBI number, severity and substance use associations

Drug use preferences

- The substances that are most likely to be abused by individuals with TBI are CNS depressants.
- Benzodiazepines, opiate analgesics, alcohol are the ones of greatest concern.
- In many cases, the benzos and opiates may be obtained “legitimately.”
- Clients should be assessed for conditions that are likely to suggest these medications.

Substance use patterns in the past 12 months among clients in substance abuse treatment: with and without TBI (n=7784)



No TBI n=5319
1 TBI n= 1541
2+ TBIs n= 924

*p<.01, **p<.001

(Walker, Cole, Logan, & Corrigan, 2007)

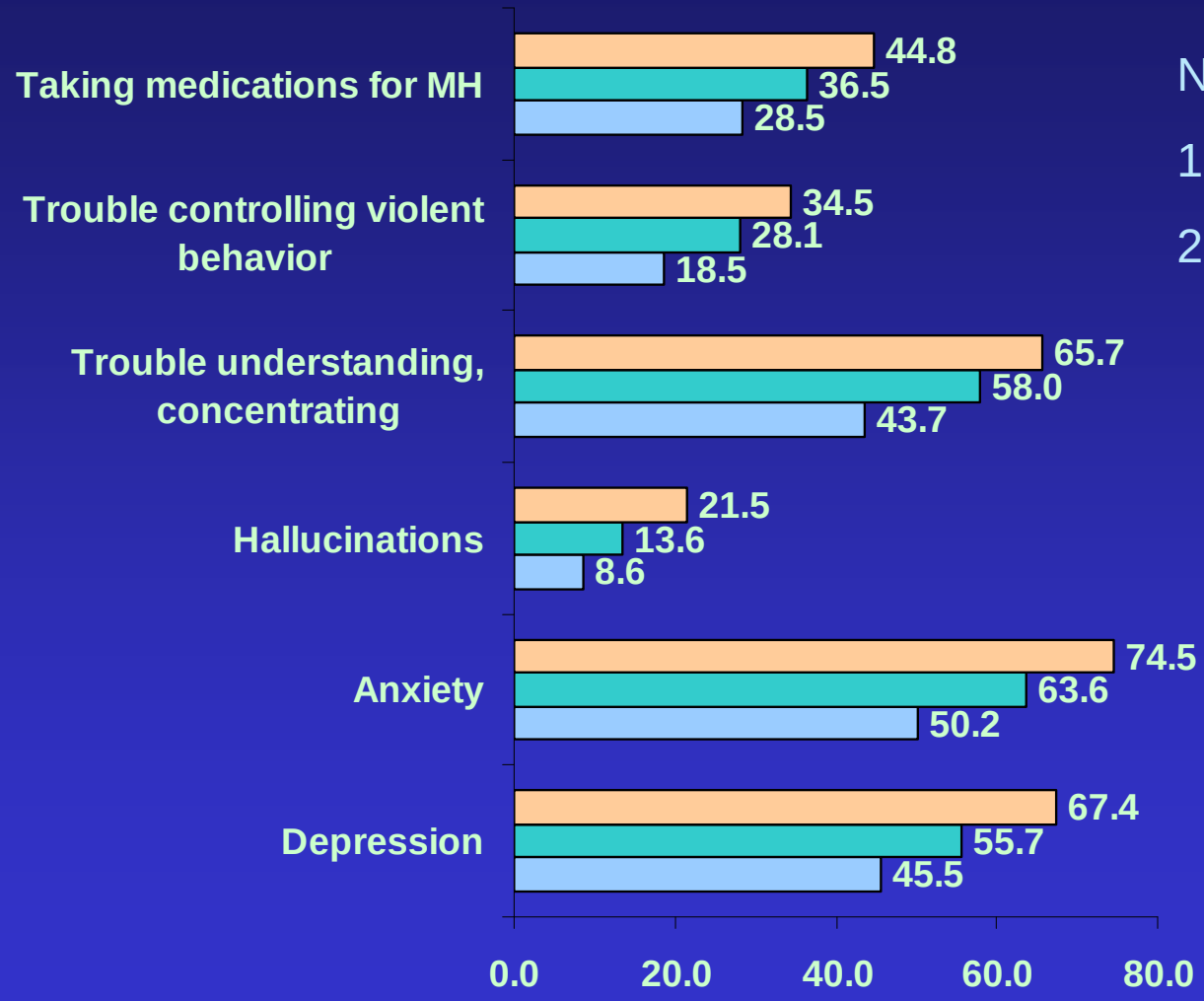
On-going assessment of functioning: Physical factors

- Sleep disturbance, sleep loss
- Chronic non-malignant pain
- Other medical conditions such as diabetes
- Capability limitations (perhaps related to injuries sustained along with the TBI)
- Coordination problems

Ongoing assessment of functioning

- This also means paying attention to mental health problems
  - Most commonly –
    - Depression
    - Anxiety
    - Difficulty concentrating, paying attention, remembering things
    - Hallucinations
    - Difficulty controlling violent behavior and thoughts
    - Overall impulsivity – cognitive and behavioral
  - Also, explore alexithymia
  - And working memory – human RAM

Percent of clients reporting mental health problems in the past 12 months among clients in substance abuse treatment: with and without TBI (n=7,784)



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Ongoing assessment of daily functioning

- Assess daily living habits
  - Sleep/wake cycle
  - Body care, clothing
  - Risk taking behaviors/habit
  - Diet habits
  - Social interaction – particularly in terms of exposure to substance use
  - Aggression
  - Applied concentration/application to tasks
- Willa Presmanes ADL scale may be helpful

Ongoing assessment of functioning

- What was the client's level of pre-injury functioning?
- Changes in assessed level of functioning post rehab – i.e., what is the "start point" for expectations of other interventions?
  - If the pre-injury functioning was low, with heavy substance use, then more environmental approaches are going to be critical.
  - The best scenario for interventions is with higher pre-injury functioning and only episodic substance abuse.

Ongoing assessment of needs

- This is largely a case management activity.
- Should be done in concert with clinical provider, if possible.
- Should include caregiver.
- Caregiver's substance use may need to be assessed as part of the intervention planning.

Ongoing assessment of needs

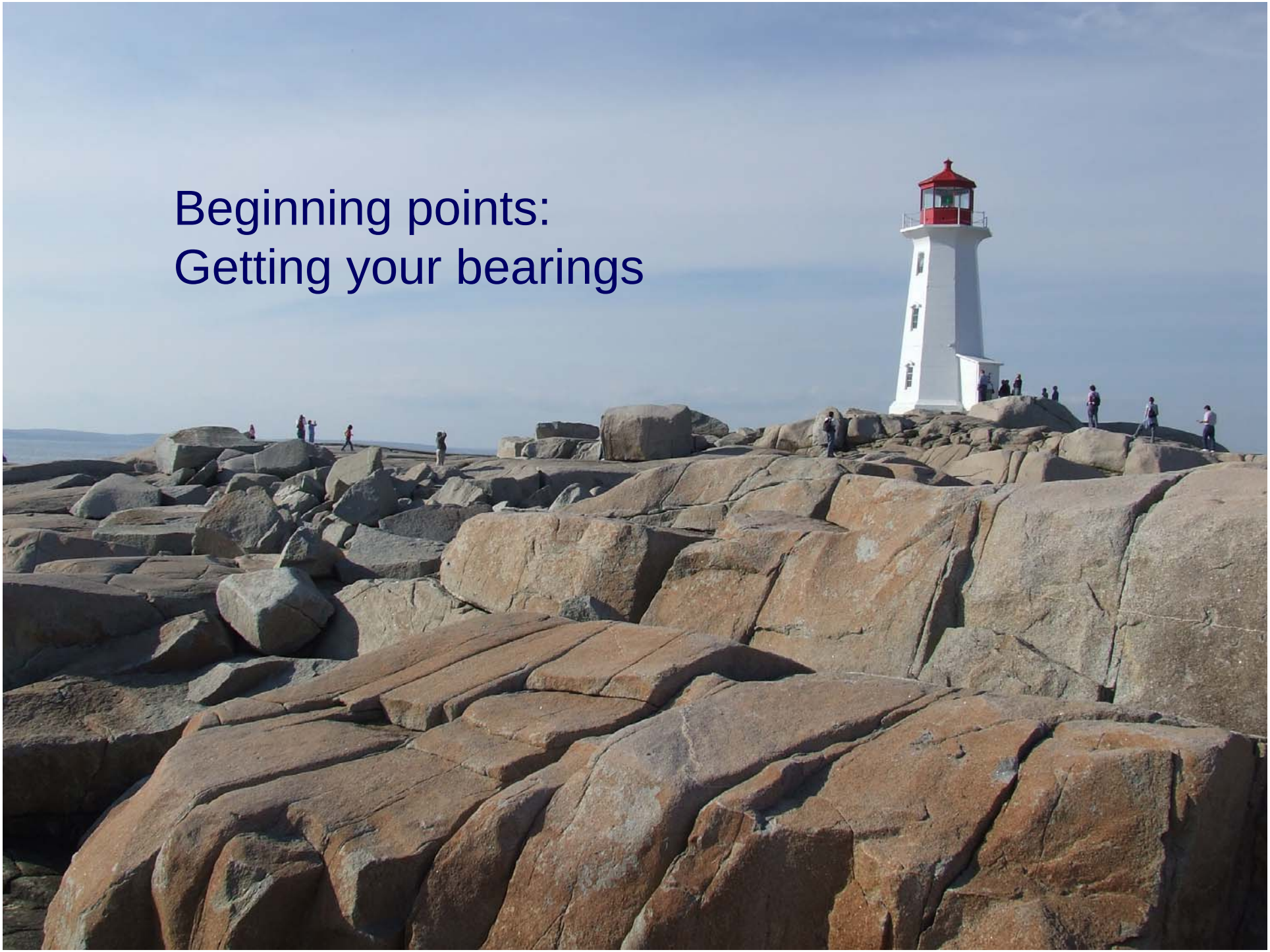
- Need for respite?
  - What kind of respite can be matched to this client?
- Need for self-help?
  - Try to recruit AA sponsor sympathetic to TBI or even one with TBI.
  - Look for 2years+ recovery
  - Get references
  - Contact PAR (Persons Advocating Recovery) for potential candidates
- Need for treatment of co-occurring disorders
  - Beware clinics that rely almost exclusively on neuroleptic or anticonvulsant ‘restraint’ medications

Case management functions: wraparound

- Brokering services on behalf of clients and family members, which may include:
  - Tracking down clinicians with positive attitude toward clients with TBI
  - Finding primary care providers who will work with patients with TBI
  - Assisting with SSI applications
  - Working with caregivers and clients to develop structure around daily living habits
  - Assisting with other social services and wrap-around services – dental, pain management, sleep disorder treatment etc.

Clinical approaches: Caveats

- First, the evidence to support the use of any particular treatment approach is very limited.
- Second, having TBI and substance abuse problems is not a diagnostic class – there is vast diversity within these two co-occurring disorders.
- Third, the sample size for narrowly defined clinical “types” of TBI/SA will be small, thus limiting the likelihood in the near future of controlled clinical trials of any intervention.
- **THUS, the recommended approaches in this presentation are NOT supported by direct clinical evidence.**
- **The approaches are based on a wide range of research, but they are not distinct evidence-based practices.**


Beginning points:
Getting your bearings

Beginning the Engagement Process

- The very first steps in initiating treatment should be guided by what the clinician has learned in the assessment process.
- If neurobehavioral functioning is only mildly disturbed, then motivational approaches may be a likely starting point.
- However, if functioning is at concrete levels, a more guided process may be necessary.

How much client buy-in is necessary?

- **Not a lot.**
- **If you can find any area in which clients can see a need for self-improvement, then work can begin.**
- **It does not HAVE to be a commitment to work on substance use right away.**
- **Partial engagement in treatment is the norm and sometimes that partial is very thin.**
- **Some clients never fully grasp the scope of their problems as we would like them to *but they still can make progress*.**

Some helpful hints – regardless of approach

Focus on one or two issues per session – Don't make it too complicated.

Do counseling where there is limited background noise or other people talking.

Ask simple, short questions.

Use open-ended questions - NOT questions that can be answered with "yes" or "no" responses

Keep the sessions short – if necessary, consider more sessions, but for shorter amounts of time (2 half sessions per week instead of 1 hour-long session).

Focusing on one or two issues per session

- **Some clients with brain injuries may need time to process ideas and to work them through with multiple examples.**
- **Going over it, re-working it, and then coming back to it again may be very helpful.**
- **Remind yourself – this is old hat information to the clinician, but it is brand new information to clients.**
- **Pace it – break it into workable pieces.**

Focusing on one or two issues per session

- **Use scenarios or brief stories to illustrate points and to reinforce the central issue of the session.**
- **At the beginning of the session state the issue for the session.**
  - **Then work on it**
  - **and end the session with a repeat of the issue followed by –**
- **Having the person restate the issue and his/her plan for putting suggestions into practice.**

Provide counseling in a quiet place

- **Background** noise or other voices can be very distracting to some clients with brain injuries, who may be unable to screen out distractions.
- The person's hearing may function like a crystal microphone, picking up everything as if it were foreground information to be processed and attended to.
- Counseling in group settings may be difficult if the practice of one person speaking at a time is not reinforced.

Ask simple questions

- **Example of what NOT to do:**
  - **Clinician:**

    “How are things at home now that your wife is working more hours and your mother is helping out with the child care? Are things settling down for you now – your anxiety doing better?”

- **Many people with brain injuries would answer the previous question with "yes"**
  - **or "no" for several reasons.**
    - ***It's too much information to process;***
    - ***It ended with a close-ended question; and***
    - ***The person may be unable to follow*** **what the intent of the question is and be confused about the "expected" answer:**
      - **Is the topic *anxiety* or greater *financial security* or *how mother and wife are working out*?**
      - **Plus – if working memory is impaired, then a sentence of more than about 10 words is lost.**

Ask simple questions

- Example of *the right way* to ask the question*:*
- Clinician: “How is it with your wife working?”
  - Next question: “How do you like her work hours?”
  - Next question: “How helpful is your mother right now?”
  - Next question: “How nervous or worried are you now?”
  - Next question: “What is making you nervous?”
  - Next question: “What can we do to change that?”

Use open-ended questions

- Open-ended questions take more thinking to ask, AND more thought to respond –
- Therefore, they also *challenge* the brain a bit more and that is a good exercise for injured brains.
- Look at the difference:
  - Close-ended: “Have you been doing more work on your anger this week?”
  - Open-ended: “How did you deal with anger this week?”

Use open-ended questions

- **When you ask open-ended questions, it causes people to think.**
- **And the act of thinking is rehabilitating.**
- **Exercising “thinking muscles” in the frontal cortex is much like exercising arm or leg muscles – the more they are used, the stronger they become.**
- **Close-ended questions demand nothing of the brain and therefore they do nothing to stimulate growth and development.**

Use brief sessions

- Having to focus can be very tiring to people with TBI.
- They may be unable to focus for much more than 30-40 minutes.
- Once concentration is broken, progress comes to a halt, and further efforts may be counter productive.
- More sessions with shorter times is a better plan
- 20-30 minute sessions may be ideal – OR give multiple breaks if sessions must be longer.
- If the client is in a day program – use frequent breaks

Another Tip: Role of confrontation in substance abuse treatment

- **Use confrontation very cautiously around people with brain injuries.**
- **They may misunderstand the tone of voice or the body language used – even when the confrontation is directed to others-**
- **Clients may react with hostility, bewilderment or confusion in reaction to the emotional tone of the confrontation.**

Sample intervention aids: Some considerations

- **Memory aids**
- **Recovery books**
- **Flash cards – visual cues**

Sample intervention aids: Some considerations

- **Individually tailored memory aids can help prompt the person to remember key relapse prevention plans.**
  - **Temporary tattoos may be useful, for example.**
    - **They can be ordered at relatively low cost and can be used in group settings as part of the "joining" process.**
    - **The tattoos may include treatment or recovery oriented messages, mottos, or images.**
- **Recovery books or memory books with key contacts and important guidelines for behavior in bulleted format.**
- **Flash cards and other visual cues and signals for group and individual work**

Memory aids

- Once again, before using these, consider the overall neurobehavioral context of the client
- What was pre-injury functioning like?
- What specific deficits in memoral process have been observed?
- What are the client's most robust cues for memory?

Memory aids

- Make use of telephone case management contacts – reminders to clients about appointment, going to day programs, “just checking in.”
- Give clients calendars with key events marked in bold letters – circled days, etc.
- Put your contact info in plastic cover so it can endure abuse – makes it harder to lose.
- Try to schedule services and events on a routine – for example, if you plan to see the client 3x per week – make it the same MWF or MWTh – keep it routine.

Minders

- ***"Minders"*** **are for people who "forget" to remember.**
- **May include not remembering to work on their recovery or mental health treatment.**
- **Minders may include poster size message boards.**
- **Clinicians can make a poster *with a person* during a session and give it to him/her to take home and put up in her/his room.**

Other Minders

- **Minders may also include smaller cards that can be posted in the bathroom, in the kitchen, and in the car or other places.**
- **Use with magnets**
- **The cards can include individualized cautions or instructions such as the samples on the next couple of slides.**

Recovery Books

- Buy an inexpensive chapbook and you and he client make entries in during sessions.
- Use tabs for key sections with “dos and don’ts” – a quick reference.
- If you have access to wrap-around funds, purchase $5.00 or $10.00 gift cards to use as incentives for doing work in the book.

Examples of Flash Cards

- If you are doing a group or in individual sessions, flash cards that target key decisional factors or that make a point can be useful.
- The cards should be big enough to be a “sign” but small enough to keep beside the clinician’s chair.
- Even other clients can be keepers of the cards and flash them when the moment is right.

Sample picture cards for use in treatment

On impulsive action – not thinking first – not checking things out

So, here goes John.

How's he doing?

What does he NEED to do first?

What's the fall-back plan?

Tell me - What's YOUR SAFETY NET?

Remember – THINK first

STOP, LISTEN to others, then THINK about it!

Then – take action

On relapse prevention ……

What are **your** triggers?

- Name them

Analog Scales

- Some assessment tools can actually be employed *during treatment* to help people identify their feelings and thoughts.
- For example, flash cards with **visual analog scales** work very well and bring discussion down to concrete terms very quickly.
- *Visual analogs* can facilitate problem recognition and definition.
  - This can include the use of visual analog scales for measuring problems and for "scoring" recovery-oriented responses to treatment. (I.e., holding up score cards for responses).
- Let's look at some examples. Don't be limited by these – you can create more of them for your practice.

Visual Analog Scale - Anger

How **Angry** I am right now……

Not at all angry

Ready to explode

1 2 3 4 5 6 7 8 9 10

Visual Analog Scale - Depression

How DOWN I am right now……

Not at all Depressed

Really Depressed

1 2 3 4 5 6 7 8 9 10

Visual Analog Scale – Anxious - Nervous

How Nervous I am right now….

Not at all Nervous

Really Nervous

1 2 3 4 5 6 7 8 9 10

Visual Analog Scale - Relapse

How **close** I am right now to **relapse**……

Not at all close

Really close

1 2 3 4 5 6 7 8 9 10

Other Clinical Approaches

- **Abstinence or recovery coaching – a new treatment role for clinicians**
- **It does not use standard "counseling" approaches – there is little exploration with this approach.**
- **It is a matter of teaching, correcting, monitoring, providing feedback, and showing how.**

Recovery Coaching

- **In substance abuse – the clinician becomes a "recovery coach" or "abstinence coach"**
- **In mental health – the clinician becomes the "recovery coach", "wellness coach", or "team manager/trainer" who gets everything together to make treatment happen and to help clients manage their illness**

Recovery Coaching

- This involves informing the client that you are his/her “recovery coach.” – Make it a job and task descriptor.
- This re-defines the statement “What are we going to work on today?”
- Here are example statements from the recovery coach:
  - Let’s practice how to talk with your mother
  - Let’s go over how you look for work
  - Let’s try a couple of ways to handle teasing
  - What happened in your last AA meeting? Let’s go over it.

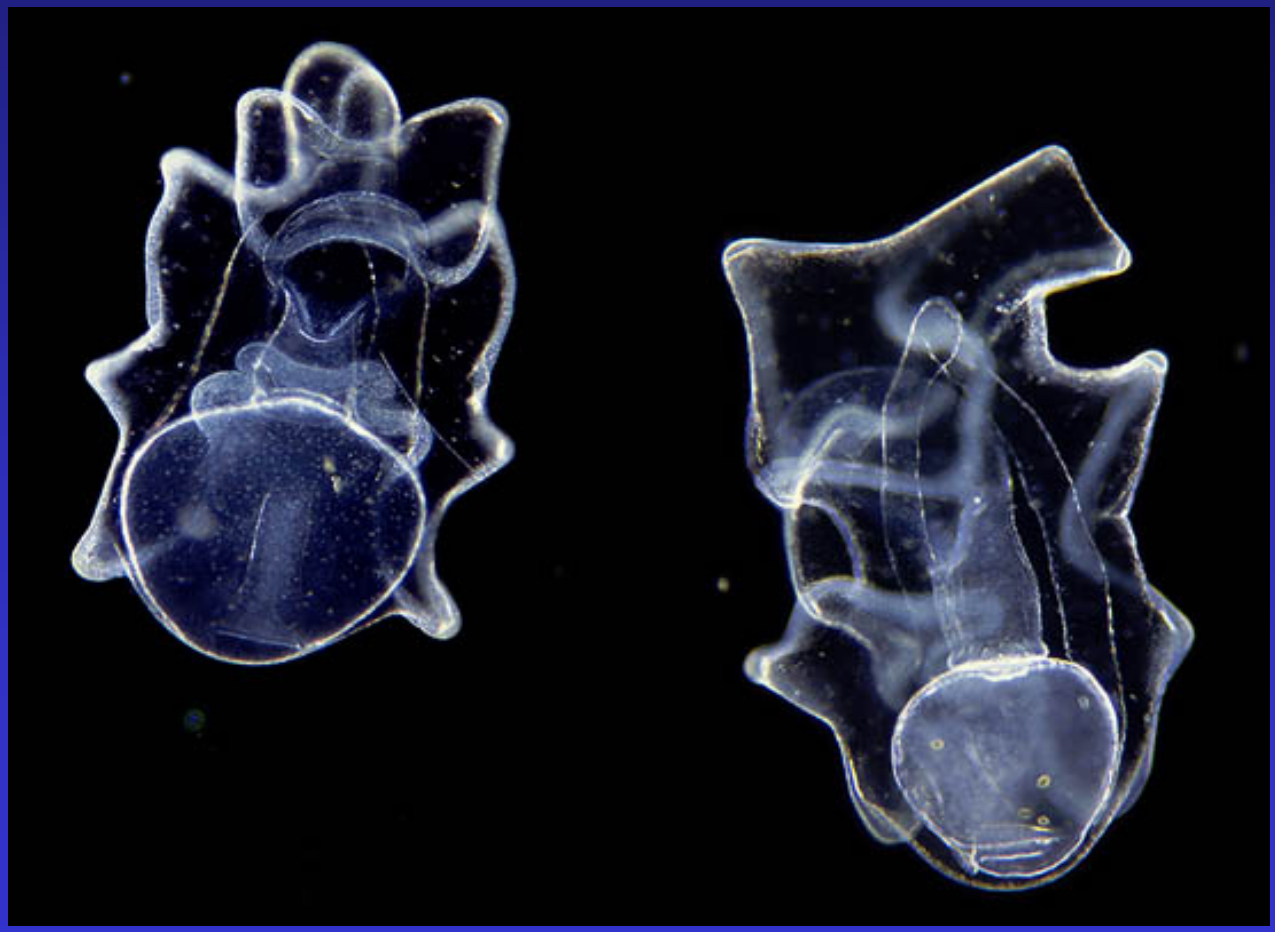
Summary of Clinical Approaches

- **Keep it simple and repetitive.**
- **Break it into small bits.**
- **Use visual aids to help make your point.**
- **Send items home with clients.**
  - **Give them mementos,**
  - **recovery books,**
  - **exercises that are simple and easy, but that repeat a theme from treatment.**

Don’t be a jellyfish – stick to clear-cut, focused and specific points in your coaching work.

Schmoozing it along with TBI clients is a recipe for disaster for both of you.

Also, avoid sending anyone with TBI to a substance abuse program that is a one-size-fits-all model



Lastly,

- Remind yourself that most substance abuse problems are chronic, long-term conditions that require MANAGEMENT OF SYMPTOMS, NOT CURE.
- TBI and substance abuse will continue to work synergistically over time, so careful case management is critical to avoid both more injuries and worsening substance abuse.
- View each client as a long-term commitment with services getting more intense or less so as conditions warrant.
- Beware programs or providers that advertise remarkable success. If its success “unbelievable”, it probably is unbelievable.

Case Management Best Practices

- URAC certification (nationally recognized accreditation for case management)
- Certification requirements for case managers (CCM, CDMS, CRRN, CRC, or COHN)
- Medical Director and/or physician consultation availability
- Model: Quality care and rehabilitation at reduced cost, with the ultimate goal of restoring human dignity, self esteem, and optimum health to individuals
- HIPAA Compliance
- Consumer Rights and Protection Policies (including disclosure, consent, and dispute resolution)
- Quality Assurance Program
- Supervisory oversight of each case
- Continuing Education Program
- Ability to provide on site case management as needed
- Advanced IT Program (capability of HIPAA Security compliance, database customization, ad hoc reporting, remote accessibility, and electronic data transfer)
- Reliable and valid return on investment reporting (including cost of program vs. cost savings, detailed description of savings, and outcome reporting)