Substance Abuse Treatment in Traumatic Brain Injury Rehabilitation Programs

Many people recovering from traumatic brain injuries face the additional tasks required to recover from substance addiction. Research by Dr. John Corrigan et al. (1995) of Ohio State University found that 30-50 percent of people hospitalized with a traumatic brain injury (TBI) had a blood alcohol level of .10 at the time of their accident, which is above the legal limit in all states. This research also found that 66 percent of adolescents and adults admitted into TBI rehabilitation programs have a history of substance abuse.

The TBI Model Systems National database* also showed that 43 percent of people with a TBI had problem alcohol use and 29 percent had illicit drug use. Drug abuse problems have shown to worsen in two to five years after a person discharges from substance abuse rehabilitation services. It is not encouraging news that 10-20 percent of people with brain injuries develop substance abuse problems for the first time after their injury.

To treat people with substance use disorders (SUD), the National Institute on Drug Abuse (NIDA) recommends detoxification, medication (when appropriate), behavioral therapy and developing a formal relapse prevention plan.

A thorough assessment is a must

Appropriate assessment of the person entering treatment is required to develop an individualized plan of care. This assessment must include information from all available medical records. Details of the person’s history should be evaluated by an experienced professional who recognizes cultural sensitivity which, over time, helps to develop a complete picture of the person.

Mandatory details include age at first use of drugs and/or alcohol, a complete list of all drugs used over time, and consequences associated with their use. Any previous diagnosis of mood disorder (such as depression and social phobia) and a history of learning disabilities or attention deficit challenges in childhood can significantly affect how treatment is planned.

It is also important to know any history of substance abuse treatments and their experience in utilizing community supports such as Alcoholics Anonymous and Narcotics Anonymous.

Individuals recovering from both TBI and SUD encounter unique challenges that clinicians and case managers should be prepared for. Behavioral issues such as treatment refusal, verbal aggression, disinhibition and poor initiation can make traditional treatment unrealistic.

These behaviors, even for professionals, may be seen as “intentionally disruptive” when there are no visible signs of disability, and cognitive impairments are misinterpreted as resistance.

COMMUNITY PROGRAMS
Alcoholics Anonymous and Narcotics Anonymous

Both programs are similar in that they describe themselves as a “fellowship of men and women” who are trying to overcome and recover from abuse of alcohol and other substances. Both boast a global, multicultural membership with numbers reaching into the millions. And both use the principles of the 12-step program, founded in 1935 by Bill Wilson and Dr. Bob Smith in Akron, OH.

The programs are available to anyone who needs them at a low cost or free to those who can’t afford the program.

Participation in Alcoholics Anonymous is mandatory or highly encouraged in most contemporary substance use disorder recovery settings.

People who do recover have positive relationships with Alcoholics Anonymous and Narcotics Anonymous and have greater involvement with these organizations over time.

See www.aa.org and www.na.org for more information on these organizations.
Dependence vs. abuse
A person may be diagnosed as being either physiologically dependent (addiction) to substance(s) or as having abused substances.

Addiction is defined as a chronic progressive disease characterized by physical and psychological symptoms such as craving, compulsive use, loss of control, continued use despite consequence and chronic use.

Abuse is defined as a maladaptive pattern of alcohol use leading to clinically significant impairment or distress resulting in actions such as failure to fulfill major role obligations at work, school or home. This also includes alcohol use in situations in which it is physically hazardous and alcohol-related activities that result in legal problems.

Knowing whether a person meets the criteria for dependence or abuse is important in prescribing the appropriate level of care.

Levels of care in substance abuse treatment
Structured advancement programs within TBI and SUD treatment should have increasing levels of independence that support people with more abilities or who have demonstrated the necessary responsibilities of recovery. The first level of care takes the form of structured, supervised residences, which graduates to moderate support residences and ultimately semi-independent apartment settings or home.

Additionally, persons in a substance abuse treatment program may need a higher level of care or even residential placement when there are legal problems, chronic relapses, medical issues related to substance use or when there is any type of violence involved.

Dr. Corrigan has studied treatment of TBI and SUD and has identified the following components as best practices for substance abuse treatment programs:

The role of pain management and addictionist services
Many people recovering from brain injuries also suffer from pain disorders associated with their initial accident. Proper assessment and treatment of pain and differentiating pain complaints from addiction-related disorders is the role of an addictionist. Addictionology is a branch of medicine that is concerned with the prevention, detection, treatment and rehabilitation of persons with substance abuse disorders. Addictionists are board-certified in their state of practice and are capable of prescribing certain medications that can assist in a person’s recovery from active addiction.

Dr. Carl Christensen, associate professor of Psychiatry at Wayne State University in Detroit and medical director of Addiction Medicine at Detroit Medical Center, states that a competent addictionist keeps asking themselves if they have made the right diagnosis. They have to determine if it’s a true pain disorder, or if it’s malingering and “pseudo addiction,” in which a patient is prescribed drugs and sells them to others. Dr. Christensen shares several “red flags” of addiction for people who are reporting chronic pain.

Warning signs of addiction in patients presenting with chronic pain:
- Tobacco addiction
- Legal history (especially driving under the influence)
- Marijuana use
- Family history
- Non-prescribed/prescribed sedative use

According to Dr. Christensen, benzodiazepines are frequently prescribed with opiates with the purpose of decreasing anxiety as well as pain perception. However, there is a high risk of side effects when these two drug types are used in combination. Benzodiazepines may also paradoxically lower pain threshold and are highly addictive.

According to Dr. Christensen, drug testing is an extremely important part of substance abuse treatment for people with TBI and pain disorders. Clinicians must check for medications that have been prescribed and also for drugs that indicate abuse. Many powerful drugs like methadone and fentanyl do not show up on most drug screens. Everyone should be tested for their own safety.

Dr. Christensen also utilizes the Michigan Automated Prescription System (MAPS), which is a service that physicians use to check whether or not the patient has been receiving controlled substances from other providers. Anyone with a Drug Enforcement Agency number can enroll. This service is confidential and cannot be used for legal proceedings.

How to treat co-occurring chronic pain, substance addiction and TBI
The best practice is to avoid an emphasis on medication when helping people recover from addiction and traumatic brain injury. Dr. Christensen recommends avoiding short-acting opioids and is very careful when prescribing stimulants. He says that stimulants decrease pain in the short-term but during withdrawal will increase pain.

Sedatives and stimulants individually or in combination can be dangerous because they change behavior, are addictive and have side effects.
Detoxification  Physiological dependence that requires medical oversight to prevent seizures or serious health complications.

Inpatient Treatment  Residential treatment in a supervised, well-controlled environment to prevent impulsive relapse and provide very close supervision.

Residential Treatment  Typically a “safe house” where people in recovery share group responsibilities and are supported by peers.

Day Treatment  Individuals live independently in the community but attend facilitated groups, individual therapies and medical services eight hours a day in specialized treatment settings.

Intensive Outpatient Treatment  Individuals live independently in the community but attend facilitated groups, individual therapies and medical services four to eight hours a day in specialized treatment settings.

Outpatient Treatment  Individuals live independently in the community but attend facilitated groups, individual therapies and medical services one or more days a week in specialized treatment settings.

Additional elements of treatment

Dr. Corrigan recognized that negative outcomes have been largely due to the neurobehavioral consequences of TBI, which undermine a person’s ability to participate in conventional treatment. There are greater co-occurring psychiatric disorders that have not been properly recognized or treated for people with TBI. Those with TBI may also have less ability to sustain improvements without the support of external structure.

It is recommended that accommodations be made in treatment programs that take advantage of a person’s neurobehavioral strengths. Motivational counseling and the general avoidance of confrontation with patients seems to be effective in most cases. The diagnosis and treatment of any additional mood disorders or psychiatric problems should be a priority of treatment.

It is recommended that specialized case managers be assigned in cases with both TBI and SUD to frequently consult with additional professionals and coordinate care with all available community resources (Corrigan et al. 1995).

A person’s readiness to change

Readiness to change is a theoretical model of recovery developed by Prochaska and DiClemente (1984) and is used to identify the specific level of willingness and readiness a person has in the recovery process. A person’s readiness has been broken down into stages or levels.

Stages of Change

Pre-contemplation  Where a person does not think there is a problem with their use of drugs or alcohol.

Contemplation  A person becomes aware that they have a substance abuse problem but are unwilling, unable or not educated on how to take action.

Preparation  Where a person has taken steps to enter treatment or acquire information on how to quit.

Action  A person commits or enters treatment and follows through on treatment providers’ recommendations.

Maintenance  A period of successful recovery and participation in recovery-based activities with little or no additional monitoring.

Relapse  A potential level of change that can occur during any level but can be used as a landmark for learning instead of an opportunity to resume active addiction or to leave treatment. The importance of this model lies in the fact that a person cannot be “made to advance” in readiness—treatment focuses on helping a person at one level to achieve the next level through education, treatment, introduction to multiple supports and practice.

Relapse Prevention

Relapse prevention planning, developed by Marlatt and Gordon (1985), is a systematic approach to help a person who has achieved some abstinence providing prophylactic treatment and planning to prevent return to active addiction. This process typically takes place in the Action or Maintenance levels in the Stages of Change. Relapse prevention teaches the person how to:

• Recognize and avoid triggers and high-risk situations
• Pre-plan and rehearse coping strategies for stress and peer influences
• Nullify myths about drug use and relapse
• Develop strong support systems
• Acquire a balanced lifestyle

When utilized in the treatment for those who are living in residential treatment programs, this process requires constant vigilance and attention from the treatment team. It also begins the life-long effort by the person in recovery to be successful in the long term.
Process of treatment with relapse prevention
Simple things that could lead to a relapse could be additional discretionary income, spending too much time on the Internet, playing video games or using the cellphone in a way that detracts from recovery-based activities or working. The following is the process of treatment when a person has relapsed:
- Identify high-risk situations, enhance coping skills and increase self-efficacy
- Eliminate myths regarding drug and alcohol effects through education
- Management of lapses – restructuring clients’ perceptions of relapse process
- Balance lifestyle – develop positive addictions, stimulus control and avoidance techniques. Development of relapse roadmaps.

Motivational interviewing
Motivational interviewing (MI) is the evidenced-based counseling style developed by William Miller and Steve Rollnick (1991) that allows the therapist to respect the external motivators for a person’s entry into counseling. This style utilizes a person’s “readiness to change” as a model for goal setting and direction. The goals of therapy are: to educate, to create a therapeutic relationship and to reach the next stage of change towards recovery.

Motivational interviewing is a semi-directive, client-centered counseling style for eliciting behavior change by helping clients explore and resolve ambivalence. It utilizes an understanding of a person’s current readiness to change to guide treatment.

It allows the therapist to express empathy, show discrepancies between the person’s behavior and their values and to absorb the patient’s resistance to treatment. The therapist will then be non-confrontational, and support the person who is striving to achieve self-efficacy.

Vocational training
Dr. Corrigan and his colleagues found that people with both TBI and SUD are less likely to have gainful employment. They also found that people who terminate their treatment services before plan of care objectives are met had less success maintaining their alcohol and drug abstinence, were less likely to be working and reported less overall life satisfaction.

The integration of vocational retraining into the rehabilitation program is essential.

Working is an ongoing educational process in coping skill development and utilization. Working provides a balanced lifestyle—it can be a positive addiction. Working improves self-efficacy, teaches higher level social skills, promotes self-esteem and has built-in motivational incentives.

Lynn Brouwers, CBIST, director of Program Development and Vocational Therapy at Rainbow Rehabilitation Centers, says that in today’s economy, finding employment can be difficult for people with disabling conditions. A vocational specialist is often needed to engage the individual in developing a personalized vocational plan that will result in meaningful work and participation. Best outcomes are achieved when the person with the dual diagnosis is supported by a rehabilitation team, including a qualified SUD therapist, and has opportunities for vocational training or work trials. While performing real work, which has a wage as a built-in motivational incentive, the team can promote positive coping skills.

Brouwers states that evaluating the outcomes of rehabilitation activities requires measuring whether the person served meaningfully improved their lives, especially with regard to community and vocational participation, which are strongly linked to perceived quality of life. Most people feel that their life has quality when it includes meaningful relationships and a purpose.

Professional staff:
Substance abuse counselors and specialized case managers
The front line of providers treating the person in recovery are mental health therapists. These social workers, counselors and psychologists must provide proven therapy techniques within the treatment program to assist with the person’s recovery.

Best practices indicate that these professionals should acquire specialty certifications, such as Certified Advanced Addictions Counselor (CAADC) and Certified Brain Injury Specialist (CBIS), to provide better service for the individuals in recovery. Therapists with these sub-specialties are more apt to be trained in and utilize empirically based treatment models in therapy, such as motivational interviewing and cognitive behavior therapy.

Strong programs that value their employees and support an environment of quality care, relationship development and trust, are better able to assist persons in recovery. Low staff turnover is a feature of high quality rehabilitation programs. Also, when rehabilitation staff respects the patients in the program, the support necessary for success is provided.
Putting it all together
When considering treatment for your client, a family member or yourself, remember that people can and do recover from substance dependence, form healthier relationships and return to work. The provider you choose may give treatment recommendations that seem difficult for the person in recovery to understand and accept at first, but experience and research has shown the efforts are well worth the reward.

References:


