SUD Treatment for People with Cognitive Challenges

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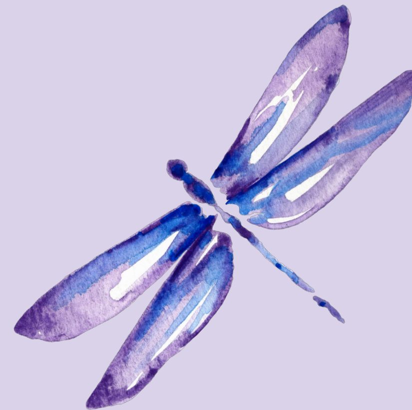
Introduction: Contextual Framework

1. Concept of Complexity
2. Cultural Competence
3. Person-Centered Treatment
4. Trauma-Informed Care



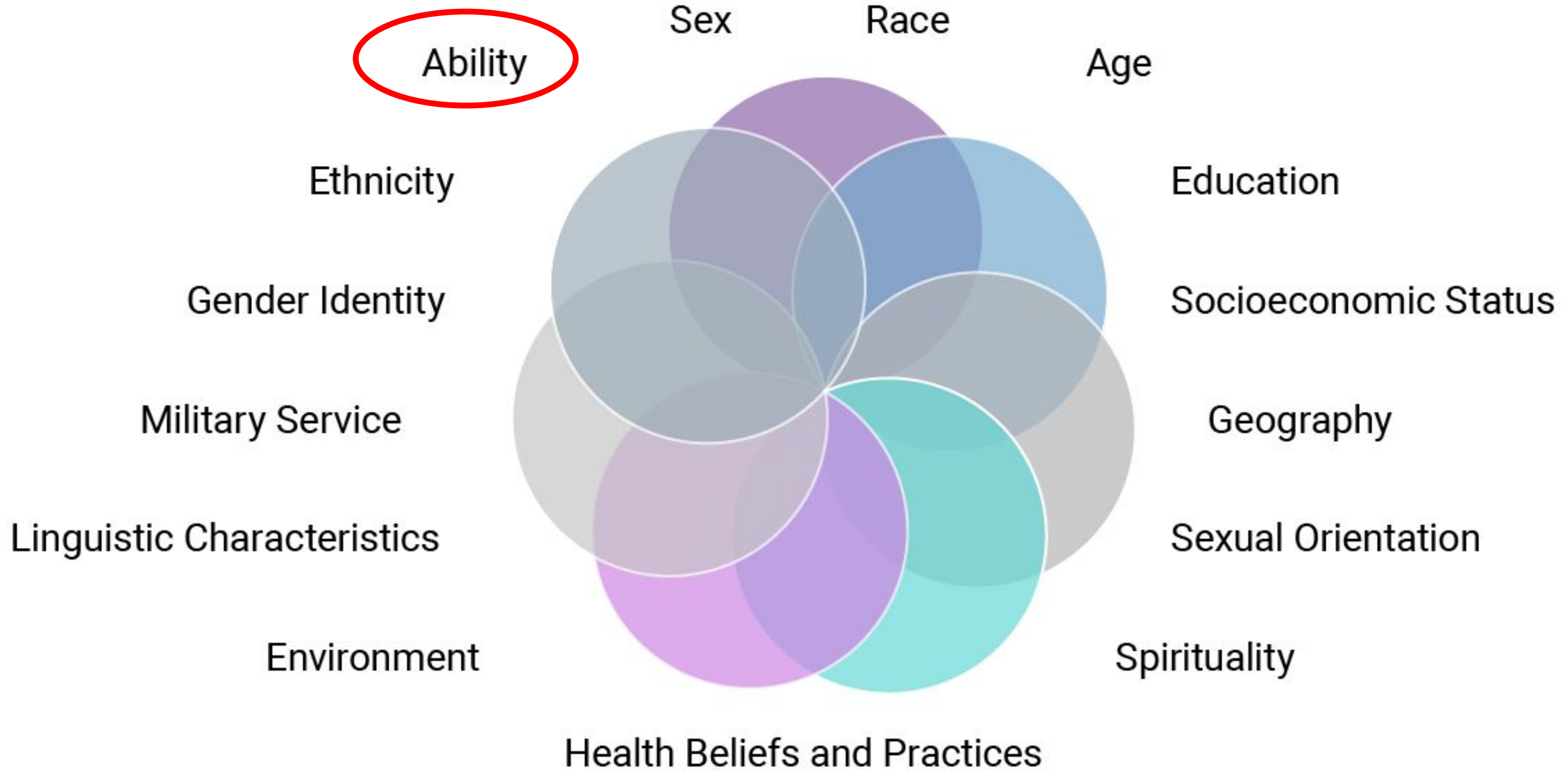
Co-Occurring Systems of Care

Christie A. Cline, MD, MBA, and Kenneth Minkoff, MD; Zia Partners:

“In real world behavioral health and health systems, ***individuals and families with multiple co-occurring needs are an expectation,*** **not an exception.**

Individuals and families not only have substance use and mental health issues, they frequently have medical issues, legal issues, trauma issues, housing issues, parenting issues, educational issues, vocational issues and cognitive/learning issues. In addition, these individuals and families are culturally and linguistically diverse. In short, ***these are people and families who are characterized by ‘complexity’, and they tend to have poorer outcomes and higher costs of care.***”

Cultural Competence, Cultural Identity & Intersectionality



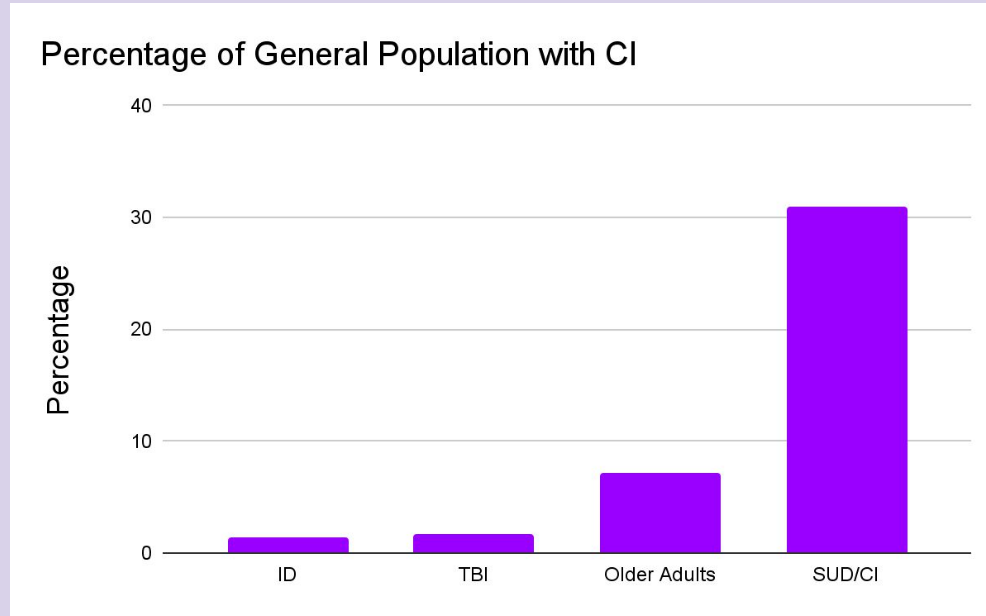
thinkculturalhealth.hhs.gov/education/behavioral-health

31%

The prevalence of cognitive impairment in one study among participants who were seeking treatment for Substance Use Disorder (SUD). However, prevalence rates are not firmly established and range anywhere from **30-80%**. Rates can vary due to factors such as age, length and severity of use, substance(s) used, and age at onset of use.

How Does That Compare to the General Population?

- People with Intellectual Disability: 1%
- People living with long-term disability from TBI: 1.7%
- Older Adults (without Dementia) with Mild Cognitive Impairment: 1.8 - 7.2%



Cognitive “Impairment” or Cognitive “Challenges”?

Cognitive Impairment (CI) is a clinical term used in scientific literature related to:

- Medical conditions
- Psychological disorders
- Substance Use Disorders

Cognitive Challenges is a descriptive term that is:

- More inclusive
- Less diagnostic
- More functional

Poll:

Have you ever worked with an individual with a known CI, such as Intellectual Disability (ID) or Traumatic Brain Injury (TBI)?

a. Yes
b. No
c. I don’t know

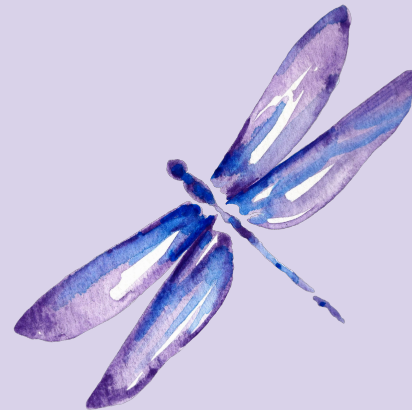
Poll:

Have you ever worked with someone who did not have a formal diagnosis, but who appeared to have challenges learning, understanding, remembering, or applying materials or information presented?

a. Yes
b. No
c. I don’t know

What is Cognitive Impairment?

And how does it impact treatment?



Cognitive Impairment includes:

- Intellectual/Developmental Disabilities (IDD)
- Traumatic Brain Injury (TBI)
- Acquired Brain Injury, such as brain damage resulting from Opioid overdose(s)
- Serious Mental Illness resulting in loss of cognitive functioning
- Serious Learning Disability
- Years of substance use resulting in loss of cognitive functioning
- Undiagnosed issues resulting in loss of cognitive functioning--would be referred to as Cognitive Challenges or Cognitive Differences.

CDC signs of Intellectual Disability

According to the CDC, individuals with ID may:

- find it hard to remember things
- have trouble understanding social rules
- have trouble seeing the results of their actions
- have trouble solving problems

https://www.cdc.gov/ncbddd/actearly/pdf/parents_pdfs/IntellectualDisability.pdf

CI Due to Traumatic Brain Injury (TBI)

TBIs can result in damage to any part of the brain, and can cause problems in several areas, including:

Cognitive Problems

- Memory
- Learning
- Reasoning
- Judgment
- Attention or concentration

Executive Functioning Problems

- Problem-solving
- Multitasking
- Organization
- Planning
- Decision-making
- Beginning or completing tasks

CI due to Serious Mental Illness

- Cognitive functioning is moderately to severely impaired in people with Schizophrenia
- CI is common, but often not recognized or documented in health/clinical settings
    - In one study, 60% of older adults with SMI exhibited CI, but it was only documented in 17% of their charts
- People with comorbid SMI and CI have higher healthcare costs
    - In another study, 61% of participants with SMI exhibited CI, which was correlated to higher healthcare costs over time

So what does all this mean?

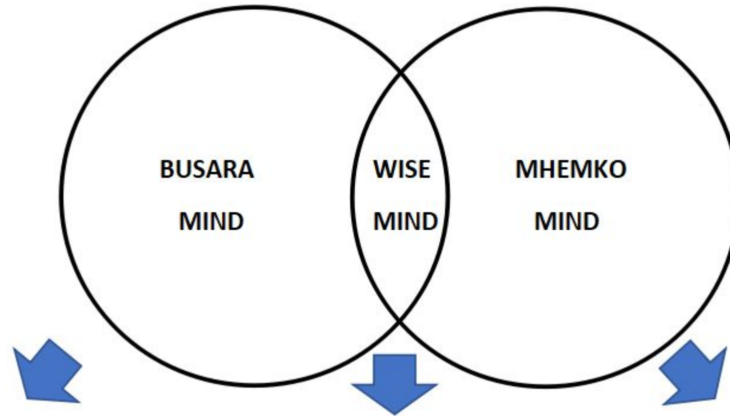
People with cognitive challenges often have problems with:

- learning,
- understanding,
- remembering and/or
- applying new information and skills.

“Handout” activity

Imagine it is your first day in group, and you are given the following handout to discuss...

Wise Mind: Hali ya Akili



Busara Mind is: **Cool** **Sababu** **Kazi-Umakini** **When in busara mind,** You are ruled by facts, jili, mantiki and vitendo. Maadili and feelings are not muhimu.	**Wise Mind is:** **The hekima within each person** **Seeing the value of both busara and mhemko** **Bringing left brain and right brain together** **The middle path**	**Mhemko Mind is:** **Hot** **Hisia-Tegemezi** **Mhemko-Umakini** **When in Mhemko mind,** You are ruled by your hisia, feelings, and inataka to do or say things. Facts, jili and mantiki are not muhimu.

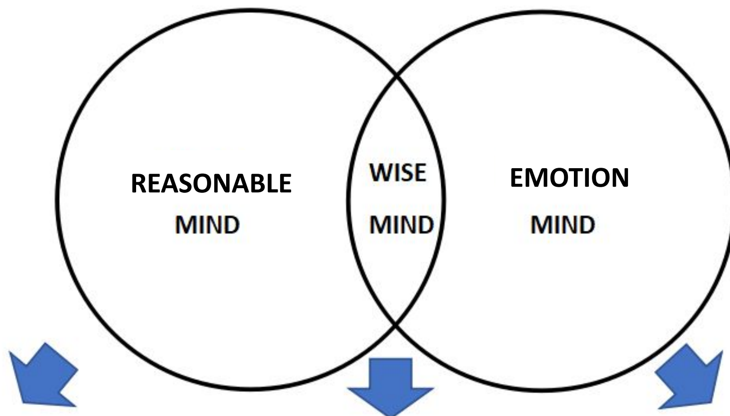
Based on a mindfulness handout from DBT Skills Training Handouts and Worksheets, Second Edition, by Marsha Linehan.

Think Break

Take a minute to try to figure out what the words on the handout mean.
Use the chat box to share your initial reaction (thoughts and feelings).

Moderator will share some responses.

Wise Mind: States of Mind



Reasonable Mind is:	Wise Mind is:	Emotion Mind is:
Cool Rational Task Focused **When in reasonable mind** you are ruled by facts, reason, logic and pragmatics. Values and feelings are not important.	**The wisdom within each person** **Seeing the value of both reason and emotion** **Bringing left brain and right brain together** **The middle path**	Hot Mood-dependent Emotion-focused **When in emotion mind** you are ruled by your moods, feelings, and urges to do or say things. Facts, reason, and logic are not important.

From DBT Skills Training Handouts and Worksheets, Second Edition, by Marsha M. Linehan. Copyright 2015 by Marsha M. Linehan.

Impact on Treatment

Cognitive challenges in individuals with SUD can have a negative impact on therapeutic “mechanisms of change”, including:

- Less treatment adherence or engagement
- Decreased insight
- Less readiness to change
- Increased denial of addiction
- Lower self-efficacy

Rapid Cognitive Screening of Patients with Substance Use Disorders .

Impact on Treatment, Continued

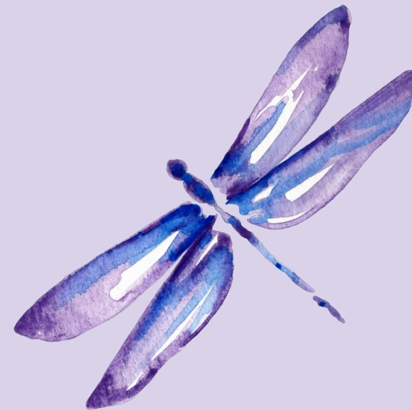
Which ultimately contribute to poorer treatment outcomes, including:

- Decreased treatment retention
- Less abstinence from substance(s) of abuse

Rapid Cognitive Screening of Patients with Substance Use Disorders

Functional presentation of CI in a treatment setting

Is it “behavior” or is it Cognitive Challenges?



A functional definition of SUD:

“If someone's use of a substance is causing problems, it's a problem.”

- Signs
  - Physical changes
  - Emotional changes
  - Behavioral changes
- Consequences
  - Physical/mental health
  - Relationships
  - Responsibilities
  - Unexpected problems (legal and otherwise).

How can the signs and consequences be different in a person with CI?

Living arrangements

- living with parents/family members
- living in a residence
- living in a supportive/independent apartment
- Unhoused

Employment status

- unemployed or on disability
- working in supportive employment
- working independently

Financial independence/responsibility

- cannot hold money; others pay bills
- has “allowance” but must submit receipts; others pay bills
- Independent use of spending money; signs checks
- Handles finances independently.

Looking at SUD criteria through the lens of CI

Criteria

1. Larger amts/longer time than desired
2. Unsuccessful attempts/desire to cut down/stop
3. Time getting/using/recovering
4. Cravings/urges
5. Negative impact work/home/school
6. Use despite relationship problems
7. Give up important activities
8. Use again & again/danger
9. Cont'd use despite physical/psych problems caused/worsened by use
10. Tolerance
11. Withdrawal

Impact of CI

- May not be able to accurately describe amount/frequency of use
- May not have the freedom/money to use as much or as long as they want
- May have to get creative in order to obtain substance
- May not be able to articulate cravings
- May not understand what an urge is
- May not have a job due to disability--is substance use adding to inability to work?
- May have limited relationships to start--how do you gauge impact of substance use?
- May not be able to articulate tolerance/withdrawal

Recognizing CI in a Clinical Setting is:

- Easy if you know the person has a diagnosis, such as ID or TBI;
- More difficult if you do not. However:

If you know what to look for there are signs that can be recognized.

An individual with CI may display:

- Limited comprehension
- Communication difficulties
  - receptive
  - expressive
- Shorter attention span
- Repetitive/stereotypic patterns of behavior
  - movements/actions
  - speech
  - topics
- Inability to interpret social cues
- Other social skills deficits.

Or challenges may present more subtly

Think about how the following issues might appear in a clinic setting:

- Literacy Issues
- Difficulty Processing Input
- “Behaviors” Stemming From Emotional Dysregulation.

Literacy Issues

- Difficulty reading and writing, or unable to read or write (Swahili "handout")
- May appear as:
  - Reluctance or refusal to participate
  - Joking or self-deprecation
  - Embarrassment
  - Inappropriate/one-word answers
  - "Manipulative" behavior to try to get out of assignments.

Difficulty Processing Input

- New information, emotions, experiences of others
- May appear as:
  - making jokes
  - “taking things the wrong way”
  - inappropriate emotional displays, such as laughing
  - repeating statements/questions
  - responding to material covered previously after counselor/group has moved on.

“Behavior” Issues

Unusual or unexpected behavior in individual and/or group settings

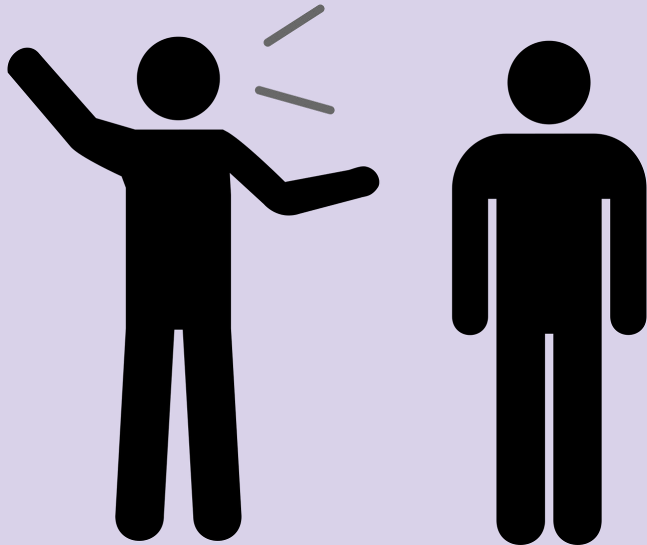
Possible causes:	**May appear as**:
Shorter attention span	Interrupting, changing subject, blurting out responses, standing up, pacing
Autism Spectrum	Repeating or mimicking others, rocking, poor eye contact, repetitive speech/movements, “extreme” reaction to certain stimuli
Boundary issues	Could see both extremes: refusing to stand or sit close to others, sitting/standing too close to others, touching others, extreme reaction to raised voices or proximity
Difficulty interpreting/ sending social cues	Unaware of own body language, unable to interpret others’ body language or nonverbal cues, literal/concrete interpretation of others’ spoken language, personalization

Developing a Modified Program:

Assessment and Treatment Planning for individuals with cognitive challenges

Starting off--Presenting problem

- Ask, “what brings you here today?” and you may get a long and complicated answer that has nothing to do with substance use--
- OR-- a one-word answer!



Substance Use History

Information Requested:	**Try Using**:
Age of first use	significant life events as reference points, e.g. “while you were in school” vs. “after you finished school” and then narrow down to “middle school” or “high school” etc.
Amount and frequency, progression of use	pictures and weekly calendar to try to get “snapshots” in time (is this “minimizing” or inability to recall?)
Consequences	give examples of problems or negative consequences in different life areas to determine what the person has experienced
Names of other drugs used	ask them “what other things have you used that got you high?” and try to establish what it was; or may need to list different street names until they recognize the drug.

Mental health and medical history

- If person cannot recall information, may have to rely on referent and documentation submitted with referral packet for the following:
  - Diagnoses
  - Medications (past and current)
  - Treatment history (for substance use disorder, mental health and medical)
  - Names of current doctors, psychiatrist, therapist.

Mental status exam

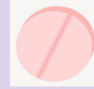
- Not always part of an admission assessment, but can provide useful information
- Proverb: Good indicator of the concreteness of the person's thought process
- Memory: Short and long term. Can use words and/or pictures for short-term recall
- Mood: Standard MSE forms have a wide range of moods/feelings to choose from. May need to be simplified. Be prepared to describe each mood. Can use feelings photographs to aid understanding.

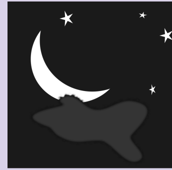
Mental health screening

- If you use an instrument like the Modified Mini Screen (MMS) you may need to adapt questions in several areas, including:
  - Vocabulary: “intensely anxious, frightened, uncomfortable, or uneasy”, “unwanted, distasteful, inappropriate, intrusive, or distressing”
  - References to time: “in the past two weeks”, “past month” or “past six months”
  - Amounts and/or frequency: “excessively”, “most of the time”, “repeatedly”.

Strategies for Assessing DSM V Criteria

1. Use Visual Aids:





Strategies for Assessing DSM V Criteria

2. Ask Questions to Assist Individuals to Remember or Describe

   a. "Did you ever try to stop? What happened?"
   b. "Did you ever try to think of a way to make sure you didn't use too much, like only buying one ___ at a time?"
   c. "How do you get your ___? Do you just go buy it or do you have to figure out how to get the money first, or do you have to get someone to buy it for you?"
   d. "Do you ever start thinking about ___ and then you can't stop thinking about it until you get some?"

Strategies for Assessing DSM V Criteria

3. Break Items Down to Their Smallest Components

   a. For social/interpersonal problems, ask one question at a time about losing friends, getting into arguments, SO breaking up with them, forgetting to do things with family or friends, etc.
   b. Get information in stages: find out what person enjoys doing, or used to like to do, then ask if they have been doing those activities less often, or what made them stop.
   c. For symptoms of withdrawal, ask “Do you ever wake up the next day feeling sick?” then name specific symptoms: headache, body aches, shakes, sweating, runny nose, trouble sleeping, etc.

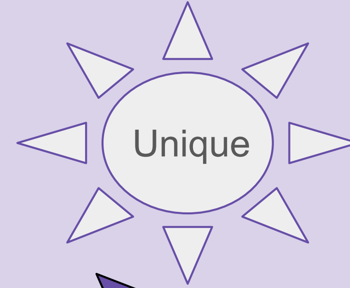
Strategies for completing psychosocials

- Try to get as much history as possible from referent, family, previous treatment providers, care givers, etc.
- Use what you have and ask questions to fill in the blanks, such as, “This says you went to ________ school. Tell me about that”
- Avoid using questions with yes or no answers, because person may just “yes” or “no” you--especially if they don’t really understand the question. Try open-ended questions and if person can't answer, offer 2 or 3 choices*
- Look for factors that may help motivate person to get/stay sober--important relationships, preferred staff, preferred activities, pets, hobbies, likes/dislikes
- Literacy, life skills and social/leisure questions are very important for individuals with CI, even if you usually skip them.

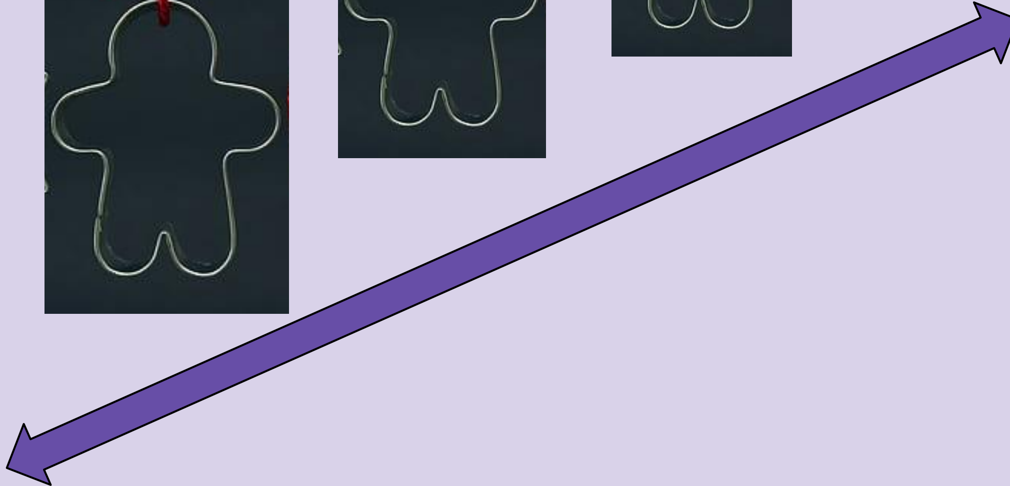
Practical considerations

- May need to have short sessions and complete 1 or 2 sections at a time
- Review referral packet for any history of trauma prior to starting psychosocial
- Be aware of changes in body language, speech, etc. that may indicate discomfort with a particular topic. Honor requests to skip a topic if person does not want to discuss. Can always return to it later or ask referent/collateral contact for more information.

Treatment Plans--cookie cutter or completely individualized?



Completely Person-centered



Not person-centered

Person-Centered Care Guidance for OASAS Certified Programs

Principles

- Person-centered treatment plans are developed **using an individual's own language to identify treatment goals**. Plans should reflect the individual's values, culture and beliefs;
- Person-centered treatment planning includes **working with individuals who may have treatment goals other than abstinence**. This includes reducing use and minimizing risk associated with substance use pattern;
- Individual goal setting should reflect shared decision making and informed choice. Every individual seeking services should be informed of the comprehensive array of available treatment options. **The individual should make an informed choice regarding medication and behavioral approaches to treatment**;
- The multidisciplinary treatment team maintains a professional role by informing treatment planning and assuming ultimate responsibility for the plan;
- **Person-centered treatment is evidence-based, strength-based and non-punitive.**

--using the individual's own language and consistent with values, culture, beliefs and goals

"Treatment planning begins at the first conversation with an individual about an addiction issue. It is important to support an individual's personal motivation to seek treatment and assure treatment planning remains non-judgmental and free from bias. Using a person's own words in identifying what elements of their use they find problematic and prioritization of their main goals helps to align the treatment plan to the person."

This can be difficult for individuals with CI

- Problems identified during intake and psychosocial assessments may be completely focused on others or external factors, e.g. “My house is telling me I can't get in trouble any more”, or “My boss says that I call out too much but I'm sick”, or “If I had a job I wouldn't drink as much.”
- Individual may lack insight into their problems
- Individual may not be able to identify or express wants, needs, values or beliefs

SO WHAT DO YOU DO?

Become a treatment planning detective

- Have to get creative
- Help individual identify parts of their substance use that are causing problems, by helping them connect the external factors to their own behavior, e.g. what boss is saying to them, what family/staff are saying, etc.
- May need to be more directive than with a typical individual to help the person connect the dots between substance use and negative consequences, and keep “drilling down” to identify the heart of the problem(s)
- This is where motivating factors identified during assessments come into play.

The ultimate treatment planning detective:

"The counselor is active in guiding, reframing, raising discrepancies, offering compassion and hope by taking what the person is saying and translating that to a plan of action that the person recognizes as their own."

This is what we do with all individuals; we just need to take it to a different level with people with cognitive challenges.

Goal planning: keep it simple, sweetie!

“Goal planning does not need to be complex, it should be straight forward and developed collaboratively alongside the client engaged in care. Goals answer the basic questions – What do you want? Objectives answer - How will you achieve that? What steps will you take? When will you take them? Who will help you?

An initial plan may consist of a single goal and one or two steps that the individual and the treatment team are taking to meet the goal.”

Person-centered care includes treatment plans that support the individual's own goals.

"People arrive in treatment for many different reasons, and present at various stages of change, with many different expectations, aspirations and theories about how they arrived at the place they are. They have different ideas of what successful treatment would look like for them, including the steps they believe will help them get there…

Person-centered care **includes a menu of treatment options**. Goals are always in the direction of **positive change** and may include: **improving** functioning, **increasing** emotional regulation, **building** social connectedness, **reducing or eliminating** substance use and individualized goal attainment (find employment, leave or find a relationship, complete degree, etc). A person-centered interview focuses on what the person is saying and their framing of the problems and potential solutions."

Recovery Supports

"Recovery Supports that provide peer to peer, recreation, social connectedness through a variety of options to a wide range of individuals are included in the plan."

Sober living skills, adult daily living skills and socialization skills are all an essential part of treatment planning for individuals with CI, and should be addressed in a way that meets the specific needs and interests of the individual.

Person-centered treatment is evidence-based, strength-based and non-punitive.

“Treating the chronic disease of addiction within stringent service requirements with limited/no individual choice can be detrimental to a person’s ability to recover. A warm, accepting and nonjudgmental response from the counselor and staff are expectations of a professional setting. Treatment for substance use disorder is no exception. All people, whether they have a substance use disorder or not, have a good idea of what weaknesses they have. It is empowering to identify strengths and even more empowering to reframe what looked like a weakness or failure as a strength.”

Example of a client statement:

"Everyone is mad at me. My family is mad at me and I keep getting in trouble. I try to talk to them but they don't understand me and when I ask them to explain what they are saying they change the subject or tell me not to worry about it. But I do."

How could you reframe that?

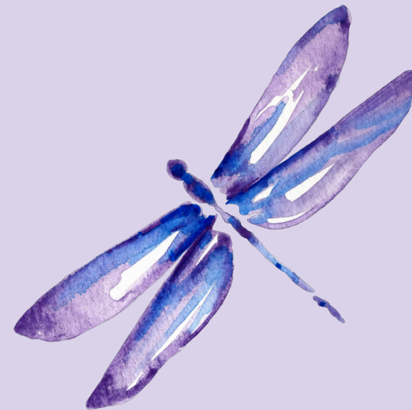
Example of reframed statement(s):

- You want to understand your family
- You want them to understand you
- You don't give up, even when you're frustrated
- You know when to walk away to cool off.

Questions

Developing a Modified Program:

Generalized Approaches



Welcoming a new individual with CI

- Anticipate being more directive/prescriptive than you would be with other individuals
- Rules and expectations need to be clearly stated and reinforced regularly
- If possible, review or create group rules with both words and images, and post them in group room(s)
- If an individual frequently “breaks” a rule, do not assume it is intentional or with malicious intent until you are certain they understand what the expectation/rule means and that they are capable of following it.

Expectations of traditional treatment settings

“Patient responsibilities”

Question:

What are the typical expectations of participants in traditional treatment settings as far as attendance, punctuality, participation, behavior, etc.?

Expectations or Hidden Assumptions

- Sit in individual or group session for 45 minutes, 1 hour, up to 4 hours
- Read and complete worksheets or homework
- Sit through, pay attention to and discuss movies
- Stay on topic while participating in group/individual sessions
- Identify and express feelings “appropriately”
- Display appropriate emotions and respond empathetically to others
- Grasp material at the same speed as the rest of the group
- Ask “appropriate” questions (e.g. on current topic).

Expectations for individual progress

- Therapeutic alliance may take longer to develop, so careful selection of primary counselor is essential, and it is important that the individual is not bounced around from primary counselor to primary counselor if at all possible
- Once trust is established, individual may show a strong preference for one staff member. Transference issues need to be addressed delicately
- Individual may not appear to be making progress; however, lack of progress should not be a reason to discharge patient. Expect that it will take a lot longer for individual to grasp concepts. Stay focused on strengths and small steps!

People with CI face challenges with:

- Learning
- Understanding
- Remembering and
- Applying (generalizing) new information or skills

So how do we modify a traditional treatment approach to help people with CI be more successful and overcome these challenges?

1. Learning: Teaching Methods for People with CI

- Break down concepts or tasks into small pieces or steps. Once one piece is learned, build on it with new information. The more complex the concept, the smaller the pieces
- Use a “hands on” approach--information is concrete and observed. Role plays and behavior rehearsal are good examples. Practice makes perfect!
- Use visual aids, including pictures, icons, graphs, charts or symbols. This also includes facial expressions, body language and gestures
- Provide direct and immediate feedback. This helps the individual make a connection between cause and effect
- “Cover all bases”: use a combination of the above teaching methods in one activity. Pair small pieces of information with an icon or picture. Encourage active participation through game formats. Model desired behavior.

2. Check for and increase understanding

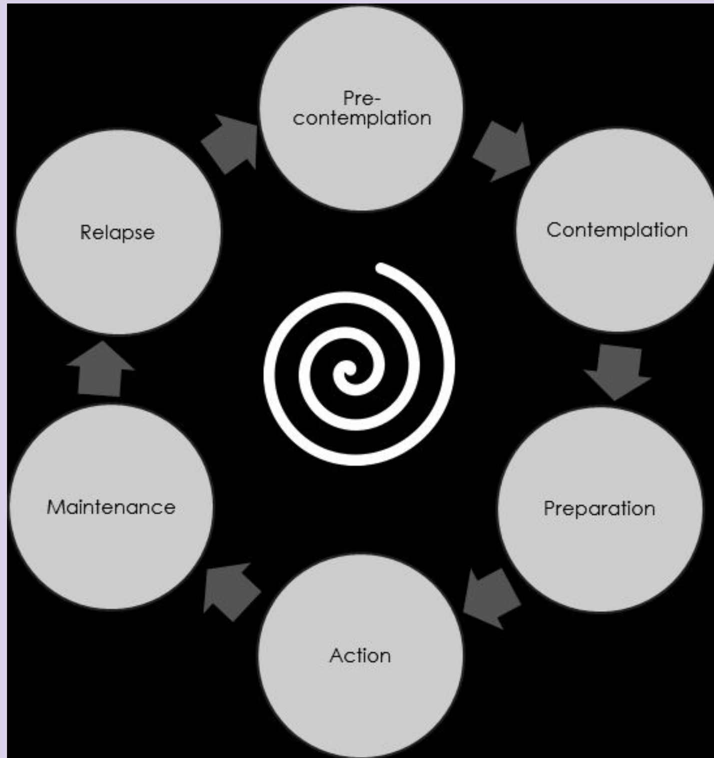
- Remember the Swahili handout? Be aware of vocabulary!
- Check frequently for understanding. Say, “so tell me what withdrawal is” or ask, “What do you think 'serenity' means in the Serenity Prayer?”
- Rephrase new or complex words with terms that are already familiar, e.g. “...that's called a trigger; something that makes you want to use.”
- Use examples, pictures or stories to reinforce understanding
- Be aware of the pace. New and/or complex concepts may require a slower pace with more frequent checks for understanding
- If using pre-made material, identify “chunks” and cover each chunk separately. Watch out for cognitive overload.

If someone does not understand:

You may see an increase in seemingly unrelated behavior:

- agitation/anger/frustration that may be blamed on something else
- becoming sleepy
- changing the subject
- becoming fidgety
- making jokes.

Example: The Transtheoretical Model



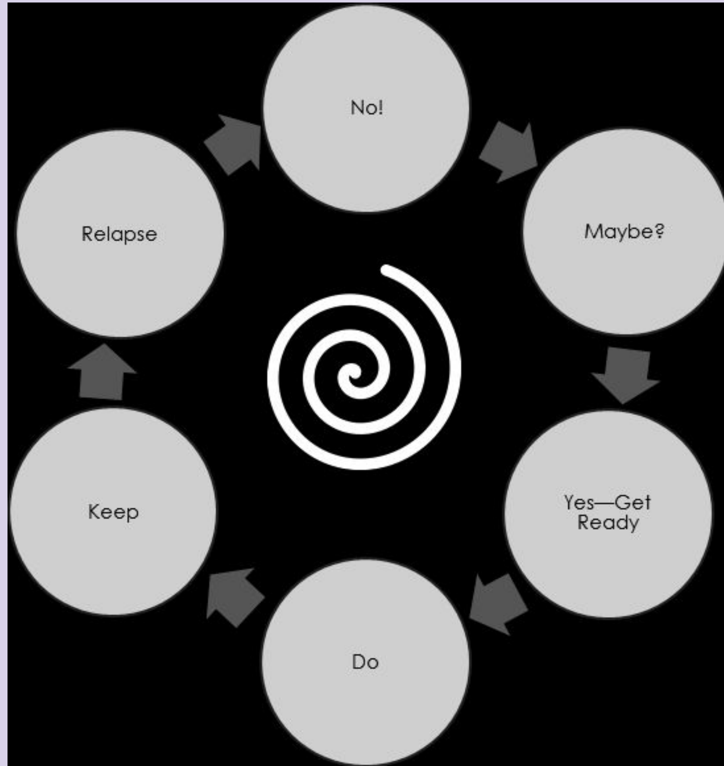
Known as “Stages of Change”

Individuals move through a series of five stages in the adoption of healthy behaviors or cessation of unhealthy ones.

Treatment is focused on helping the individual progress through the stages, “meeting” the individual where they are currently and moving forward.

Accepts that recurrence is a possible stage in the cycle, however progress is made in an upward spiral

Modified Stages of Change



1. No! Problem? What problem? I'm not thinking about the issue, and I'm not interested in even talking about it.

2. **Maybe?** I've started thinking about the issue. Maybe I do have a problem?

3. **Yes—Get Ready** OK, I do have a problem. What can I do about it? Where can I get help?

4. **Do** I'm in treatment and making changes in my attitudes and behaviors.

5. **Keep** I'm done with the first part of treatment and now I need to keep going to aftercare and/or my meetings and call my sponsor!

3. Remembering

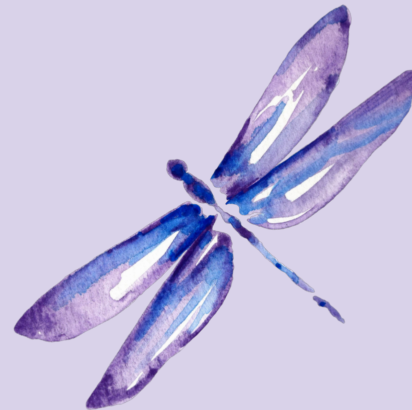
- Know your client: some individuals have better short-term memory than others. Refer to the mental status exam and intake packet for guidance about what to expect for each individual
- Repetition is the key to remembering--but it's boring to cover the same material over and over in the same way
- Mix it up! Review older material and introduce one new piece
- Use different teaching methods for the same information/skills: read/discuss, complete a worksheet, play a game using the information, do role plays, “what would you do?” scenarios, etc.
- Have one group member lead the discussion on a specific topic.

4. Applying/generalizing

- State-dependent learning applies--individual may be able to use skills in the clinic setting but not be able to use them at home
- Individual may have NO sober socialization or leisure skills, which is why socialization/recreation activities are necessary
- Use teachable moments, both within group and with events that people share from outside of group
- Make role-plays as realistic as possible
- If rehearsing phone calls, use a phone
- Practice using 12-Step tools, including Steps, slogans, serenity prayer, etc.
- Remind individuals that this is why we practice over and over again!

Developing a Modified Program:

Adapting Evidence-Based Practices



Adapting Evidence-Based Practices (EBPs)

The following EBPs will be reviewed:

- Motivational Interviewing (MI)
- Cognitive-Behavioral Therapy (CBT)
- Dialectical Behavior Therapy (DBT)
- 12-Step Facilitation
- Mindfulness Based Interventions (MBIs)
- Trauma-informed care.

Principles of Motivational Interviewing (MI)

- Develop discrepancy
- Express empathy
- Amplify ambivalence
- Roll with resistance*
- Support self-efficacy

*In MI resistance is not considered a client problem, but an indicator of a counselor problem. It is a signal that the counselor’s approach is eliciting resistance.

Techniques of Motivational Interviewing

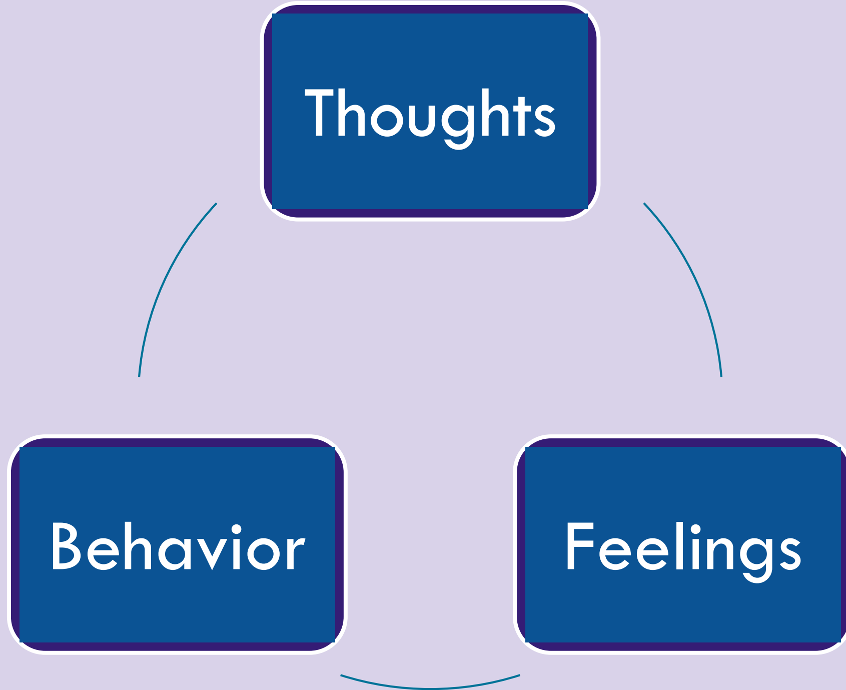
- Open-ended questions
  - "Tell me about a situation when you were able to make a difficult change?"
- Affirmations
  - "Even though you have to take two buses to get here, you have done a great job keeping your appointments."
- Reflections
  - "On one hand you'd like to use condoms, but you're concerned about how your partner might react."
- Summarizing
  - "It looks like you have a realistic exercise plan, have decided on a reasonable first step, and are ready to start tomorrow."

Adapting Motivational Interviewing

- Adapt to language level: Open ended questions are concrete and clear. Avoid “why” questions. Use short sentences and simple language. Start questions with a query word.
- Adjust to cognitive abilities: One question at a time. Help client verbalize feelings. Use both verbal and nonverbal affirmations. Summarize frequently and in between topics. Take small steps.
- Important characteristics of staff: trustworthiness, engagement, acceptance, empathy, and honesty.

https://www.ncbi.nlm.nih.gov/pubmed/24279780

Cognitive-Behavioral Therapy (CBT)



- It is common for individuals struggling with SUD to have destructive, negative thinking. These thoughts create painful feelings and often result in self-defeating or harmful behaviors, such as drinking and/or drugging. The consequences of these behaviors only reinforce the negative thoughts and feelings.
- Addressing harmful thought patterns helps individuals improve their ability to practice alternative ways of thinking, which can regulate distressing feelings and harmful behavior.

Pillars of CBT

- Time-Limited/Short-Term
- Functional Analysis
  - Assess high-risk situations
  - Provide insight into triggers to use substances
- Skills Training
  - Unlearn old habits associated with substance use
  - (Re)learn new, positive habits and healthier skills
- Cognitive distortions
  - Become aware of thought patterns that are not logical or rational
  - Dismiss automatic “negative thoughts” and replace with healthy ones.

Modified CBT Strategies--groups and individuals

- Longer time-frame for implementation; incorporated into long-term treatment
- Skills training through psychoeducational groups:
  - Addiction education, attitudes and behaviors, recovery tools, critical thinking, mindfulness, recurrence prevention, sober living skills, healthy relationships
- Anticipating likely problems and identifying/developing specific coping skills
- Exploring positive and negative consequences of continued use
- Teaching the concept of self-monitoring and “catching yourself” doing “old” behaviors (also see mindfulness)
- Identifying high risk situations and developing plans to avoid and/or cope with them
- Identifying, understanding and changing “stinking thinking”.

Modified CBT techniques for interactive groups

- **Group completion of worksheets**; assist with reading, spelling, writing as needed
- **Role playing:** coping skills, refusal skills, anger management, communication skills
- **Game formats:** bingo, jeopardy, card games, thumb balls, pull a topic from a bag
- **Use of icons, symbols and visual aids:** stages of change, addiction triangle, coping skills, identifying steps to relapse, identifying feelings, (also see Emotion Regulation skills in DBT)
- **Behavior rehearsal:** refusal skills, making phone calls, appropriate sharing in meetings
- **Drawing, coloring, illustrating key points and skills:** self-concept, defense mechanisms, coping skills, spirituality, feelings, etc.

Dialectical Behavior Therapy (DBT)

- Dialectical Behavior Therapy (DBT) is a specific form of CBT, intended to be a long-term process to address multiple and/or complex difficulties
- Originally developed to address borderline personality disorder and chronically suicidal individuals
- DBT focuses on building emotion regulation skills, building interpersonal effectiveness, developing mindfulness, and increasing distress tolerance and response in difficult situations
- It is also very effective for impulsivity, suicidality, and extreme emotional experiences that may interfere with one's ability to function
- One drawback: Marsha Linehan's original work is very complex and uses vocabulary that can be challenging.

Emotion Regulation Skills System

- The *Emotion Regulation Skills System for Cognitively Challenged Clients* is a therapeutic approach to learning basic DBT skills that has been tailored specifically for individuals with learning differences. It was developed by Julie F. Brown
- Many individuals struggle with impulsivity, interpersonal difficulties, and poor distress tolerance due to their cognitive challenges, as well as their drug use
- Some of the skills taught in this curriculum are “clear picture,” which is similar to mindfulness; safety planning; and “new-me activities”, which help individuals find appropriate sober activities to focus, feel better, serve as a distraction during stressful times and/or to have fun
- Through this curriculum, individuals learn how to better manage strong emotions, think before reacting, and build better lives through thoughtful action.
- For more information see the website, which includes an extensive e-learning platform, at www.skillssystem.com.

12-Step Facilitation

- An active engagement strategy designed to increase the likelihood of a person with SUD becoming affiliated with and actively involved in 12-step self-help groups.
- Three key concepts of the original model:
    1. Acceptance—that drug addiction is a chronic, progressive disease;
    2. Surrender—giving oneself over to a Higher Power, accepting the fellowship and support of other recovering addicts and following the 12 steps;
    3. Active involvement in 12-step meetings and related activities.
- Today, attendance at self-help meetings is often suggested, but cannot be mandated in most states (unless by the Criminal Justice system).

Making the Abstract Concrete

The Steps, slogans and literature are abstract and use difficult vocabulary. Here are some suggestions:

- Illustrated twelve steps
- Serenity Prayer flowchart
- How do you “use” a slogan?
- Slogan hangman
- Hazelden’s Keep it Simple series step workbooks
- Step 3: I made a decision illustration
- “Translating” AA written materials
- Practicing how to share in meetings
- Processing AA/NA meetings.

Mindfulness-Based Interventions (MBIs)

While mindfulness is an important component of DBT, which was initially developed to address self-harming behavior and Borderline Personality Disorder, several Mindfulness-Based Interventions (MBIs) have been developed to address mental health issues such as stress and depression. More recently, MBIs have also been shown to be effective as a treatment for Substance Use Disorders. Approaches include:

- Mindfulness Based Stress Reduction (MBSR)
- Mindfulness Based Cognitive Therapy (MBCT)
- Mindfulness Based Relapse Prevention (MBRP)
- Mindfulness-Oriented Recovery Enhancement (MORE).

Adapting mindfulness practices

- Keep it simple. Kabat-Zinn's definition of mindfulness, "paying attention in a particular way: on purpose, in the present moment, and nonjudgmentally", provides many groups' worth of material!
- Teach mindfulness meditation practice in small increments. Start with just a few minutes, with or without a brief body scan
- Use concrete examples, such as the raisin exercise from MBRP, listening and observation exercises, 5 senses countdown, even the game "I Spy"
- Challenge group members to a "mindful break" and see who can bring back the most details from their break
- Incorporate mindfulness into other groups, whenever possible.

Trauma-Informed Care and Why We Need it

NYS OASAS website states: “Trauma-informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives.”

According to the Substance Abuse and Mental Health Services Administration (SAMHSA):

- 75 percent of women and men in substance abuse treatment report histories of abuse and trauma.
- 97 percent of homeless women with mental illness report severe physical or sexual abuse.
- 12-34 percent of individuals in substance abuse treatment have PTSD.
- About one-third of people exposed to trauma develop PTSD. Men report higher incidences of trauma, but women are more likely to develop PTSD.

https://chronicleofsocialchange.org/child-trauma-2/when-trauma-slips-into-addiction/32462

Trauma in people with Cognitive Challenges

- One research study showed the prevalence of PTSD among people with CI was 10%--at the top of the range (5-10%) for the general population
- Another study showed the percentage of PTSD among people with SUD was 36.6%, and the percentage with trauma exposure was 97.4%.
- If you add ACEs (Adverse Childhood Experiences), the number of people with CI and SUD who have experienced trauma is virtually 100%.

Trauma Informed Care is essential for people with SUD and CI

- People with CI and trauma may not understand the connection between trauma and substance use
- People with CI and trauma may not be able to identify, verbalize or process their feelings related to the trauma, so it is important for those individuals to receive treatment in an environment that is physically and emotionally safe
- People with CI and trauma need help to understand what triggers are and to identify trauma triggers
- People with CI may not have much choice or control in other areas of their lives, so it is important to provide opportunities to exercise both.

Trauma-informed vs. Trauma-specific:

According to the National Trauma Consortium, addressing trauma in SUD treatment involves both “trauma-informed” and “trauma-specific” approaches.

- **Trauma-informed** systems and services take into account knowledge about trauma—its impact, interpersonal dynamics, and paths to recovery—and incorporate this knowledge thoroughly in all aspects of service delivery.
- The primary goals of **trauma-specific** services are more focused: to address directly the impact of trauma on people’s lives and to facilitate trauma recovery and healing.
- Ideally, SUD treatment programs will create trauma-informed environments, provide services that are sensitive and responsive to the unique needs of trauma survivors, and offer trauma-specific interventions.

Lessons learned about trauma-specific care

- Thorough training in the program or curriculum (e.g. Seeking Safety) is recommended.
- As with other EBPs, material may need to be presented in smaller “chunks” and at a slower pace with more review and checks for understanding.
- Individuals may need to develop skills in emotion regulation and distress tolerance prior to starting a trauma-specific program
- Seek assistance from trauma experts: according to the National Trauma Consortium, developers of 5 trauma-specific curricula are willing to assist with questions, adaptations and consultation.

Questions

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Mindfulness Resources

Mindfulness-Based Stress Reduction: Full Catastrophe Living: Using the Wisdom of Your Body and Mind to Face Stress, Pain, and Illness **Jon Kabat-Zinn, Thich Nhat Hanh**

Mindfulness-Based Cognitive Therapy: Segal, Williams, & Teasdale, 2002; Williams, Teasdale, Segal, & Kabat-Zinn, 2007

Mindfulness-Based Relapse Prevention: Bowen, Sarah; Chawla, Neha; Marlatt, G. Alan

Mindfulness-Oriented Recovery Enhancement: Eric Garland, Ph.D., LCSW
https://drericgarland.com/m-o-r-e/