Substance Abuse Education & Intervention: Tips and Tools for Clinicians Working with Individuals with a History of Brain Injury

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Introduction

This manual is a companion piece to information provided via lecture and contained in power point presentations and training provided to professionals attending the Maryland Traumatic Brain Injury Partnership Implementation Project's trainings on the topic of brain injury and substance abuse. The materials are directed at several audiences. These include mental health and substance abuse professionals including certified addiction specialists working in community programs and in Maryland's detention centers. Another intended audience is brain injury professionals, especially those working in outpatient rehabilitation settings. For every audience, the goal is to increase awareness of brain injury and substance abuse as conditions that are often co-occurring and the impact these conditions have on recovery, from both substance use and brain injury. It's recommended the tools and strategies included in this manual are shared with consumers and integrated into program intake and policies.

Use of the Group

- BrainStorm with group members; What do you know about substance abuse, the brain and brain injury? How are they related?

- What do you want to know about substance abuse, the brain and brain injury?

- Make all activities interactive and age appropriate

The Quiz

(Can be done verbally or using paper & pen)

1. In 1998, the cost of alcohol abuse in the United States was estimated to be $184.6 billion. *True or False* (Gold 2005)

2. If there are alcoholics in your family tree, you are at risk for alcohol abuse, even if you were adopted and raised by nondrinkers. *True or False* (Gold 2005)

3. Addiction is: a) brain disease b) a moral failing

4. Alcohol use after brain injury may increase the risk of seizures. *True or False*

5. 5-10% of adults with a brain injury who never had a drinking problem before their injury, develop a problem with drinking after their injury *True or False*

Discussion Based on the “Quiz”

1. Review the correct answers (1-true, 2-true, 3-a, 4-true, 5-true)

2. Ask group members for other thoughts, knowledge and experiences regarding substance/alcohol use and abuse.

3. Provide group with “Messages to Share”.

4. Discuss the “Messages to Share”

Suggestions

1. The “Quiz” and “Messages to Share” can be done with a group or with one or two individuals

2. Any one of the messages can be explored in depth, with the facilitator sharing the research on a specific message or messages.

3. The group can digress at any time to discussion of the brain’s functioning and anatomy-relate that information to the impact of alcohol/substances on the brain

Messages to Share
Drinking After Brain Injury

Adapted from Ohio Valley Center for Brain Injury Prevention and Rehabilitation (1994). *User's Manual for Faster More Reliable Operation of a Brain after Injury*. Columbus, Ohio.

- People who use alcohol or drugs after TBI don't recover as fast as those who don't
- Any injury related problems in balance, walking or talking can be made worse by using alcohol or drugs
- People who have had a brain injury often say or do things without thinking first, a problem made worse by using alcohol or drugs
- Brain injuries cause problems with thinking, like concentration or memory, and alcohol or drugs makes these worse
- After a brain injury alcohol and other drugs have a more powerful effect
- People who have had a brain injury are more likely to have times when they feel sad or depressed and drinking or doing drugs makes this worse
- After a brain injury, drinking alcohol or other drugs can cause a seizure
- People who drink alcohol or use other drugs after a brain injury are more likely to have another brain injury

Screening Tools

- Cage Questionnaire

- Brief Michigan Alcoholism Screening Test (BMAST)

- AUDIT

These alcohol-screening tools have been evaluated and/or utilized by brain injury professionals and researchers. Based on their analyses the above tools are considered reliable and valid for use with individuals with a history of brain injury.

CAGE (Ewing 1984)

1. Have you ever felt you should **Cut down** in your drinking?

2. Have you ever felt **Annoyed** by someone criticizing your drinking?

3. Have you ever felt bad or **Guilty** about your drinking?

4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover? (**Eye opener)**

About the CAGE

1. Researchers at Mt. Sinai found the specificity of the CAGE of alcohol abuse both pre and post TBI to be high, 96% & 86% respectively. (2004)

2. CAGE is very easy to administer and sensitive with TBI population. (Fuller et. al. 1994)

3. CAGE's brevity allows for easy integration into intake interviews

4. Limitation of CAGE-lacks consumption questions needed to determine individuals with current versus lifetime of alcohol-related problems. (Bombardier & Davis)

Brief Michigan Alcohol Screening Test BMAST

(Selzer et.al)

1. Do you feel you are a normal drinker?

2. Do friends or relatives think you are a normal drinker?

3. Have you ever attended a meeting of Alcoholics Anonymous?

4. Have you ever lost friends or boy/girlfriends because of your drinking?

5. Have you ever gotten into trouble at work because of drinking?

6. Have you ever neglected your obligations, your family or your work for two or more days in a row because you were drinking?

7. Have you ever had delirium tremens (DTs), severe shaking heard voices, seen things that weren't there after heavy drinking?

8. Have you ever gone to anyone for help because of your drinking?

9. Have you ever been in a hospital because of your drinking?

10. Have you ever been arrested for drunk driving or driving after drinking?

Scoring the BMAST

Add up all the assigned points for each response below.

1. No =2 points
2 No=2 point
3 Yes=5 points
4. Yes=2 points
5. Yes=6 points
6. Yes=2 points
7. Yes=5 points
8. Yes=5 points
9 Yes=5 points
10 .Yes=2 points

Add up all the points:
3 or less points, nonalcoholic
4 or more points, suggestive of alcoholism
5 or more points, indicates alcoholism

About the BMAST

1. BMAST is very easy to administer and sensitive with TBI population. (Fuller et. al 1994)

2. BMAST is nearly as sensitive as the complete MAST, using a cutoff of three or more among individuals with TBI

3. Simple true or false format

4. Sensitive to less severe alcohol problems

5. Well researched

6. Limitations-long, some questions may be difficult to understand, and some questions may be offensive. (e.g. “ are you a normal drinker” Bombardier and Davis 2001)

Alcohol Use Disorders Identification Test AUDIT

The AUDIT is a ten item screening tool intended to "screen for excessive drinking and in particular to help practitioners identify people who would benefit from reducing or ceasing drinking". The AUDIT, developed by the World Health Organization includes the following"

- 3 items on alcohol consumption, e.g., *How often do you have a drink containing alcohol?*
- 4 items on alcohol-related life problems, e.g., *How often during the last year have you failed to do what was normally expected of you because of drinking?*
- 3 items on alcohol dependence symptoms e.g., *How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?*

Each of the ten items is scored 0-4 allowing for a maximum score of 40. Cutoff point of 8 is recommended all scoring 8 or more can be classified as at-risk for the harmful or hazardous effects of chronic alcohol use.

To download the user's manual and test for free go to: http://www.who.int/substance_abuse/publications/alcohol/en/index.html. Scroll down to **Brief Intervention for Hazardous and Harmful Drinking: A Manual for Use in Primary Care**

About the AUDIT
(Bombardier & Davis 2001)

1. Takes 2-3 minutes to administer, 1 minute to score

2. Identifies alcohol abuse, not just dependence

3. Sensitivity of the AUDIT is above 90%

4. Developed multi-nationally

5. Can be used to provide specific feedback regarding risk

6. Limitations-length, not used widely with individuals with TBI at this time, but is recommended by Bombardier and Davis for use with this population

7. The AUDIT has been translated into many languages including Spanish, Italian, French, German, and Chinese

Other screening tools used by brain injury practitioners and researchers include;

- *Substance Abuse Subtle Screening Inventory –3,* useful for screening for alcohol abuse and the drug sub scale may be useful for screening for drug abuse in individuals with TBI. (Ashman et. al 2004)
- *Addiction Severity Index-R,* (very long)
- *Quantity-Frequency-Variability Index,* Well researched self-report questionnaire. Provides quantitative measure of alcohol use. Researchers at the Medical College of Virginia use the QFVI.

How to Utilize Screenings

Depending on the agency, consumers served, and how the program is organized

1. At intake to program services

2. Individually as part of initial assessment early on in program

3. As part of a group activity

4. As part of ongoing individual counseling/therapy sessions

5. To be repeated as part of discharge preparations

Why Screening should be integrated into program for all participants

- Screening all will catch covert users and individuals at risk for developing problems with substance abuse
- Contrary to the belief among some clinicians that self-report of alcohol use is unreliable, the opposite is true, if you ask, people will tell (Bombardier and Davis)
- Those who are using or are suspected of using will not be stigmatized

Strategies for Human Service Professionals Working With Individuals with a History of Brain Injury
Modifying Substance Abuse Education and Treatment Interventions

- Review if available any neuropsychological or neuropsychiatric records, this will provide information on memory, processing and new learning capabilities. This is helpful in tailoring supports towards the individual's strengths and compensating for injury-imposed problems. For example, an individual who has difficulty retaining auditory information can have information conveyed in a written format.

- Individuals with a brain injury may benefit from attending 12-Step meetings with a "buddy" or staff member. (open meetings can be attended by those not participating in the program) That person can then review the highlights of the meeting with the individual to reinforce and process what was discussed.

- Individuals new to 12-Step programs are often encouraged to attend "90 meetings in 90 days." This schedule maybe too stimulating or fatiguing for an individual with a brain injury. Efforts should be made to tailor a meeting schedule to capitalize on the benefits of the meetings in terms of supporting sobriety and providing social interaction with each individual's ability to tolerate the demands of attending meetings.

- If an individual plans to share at a meeting, it can be helpful to review what they want to share and jot down their comments on an index card for reference. This is a helpful strategy for those who have injury related memory problems, or difficulty organizing their thoughts verbally.

- Dr. Frank Spardeo, a neuropsychologist who has worked in the field of substance abuse and brain injury for many years recommends the judicious use of drug testing. In his experience, some individuals will request random drug testing to keep themselves "honest". (NASHIA Webcast 2003)

Original Twelve Steps

1. We admitted we were powerless over alcohol; that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves and to another human being the exact nature of our wrongs.
6. We are entirely ready to have God remove all these defects of character.
7. Humbly asked God to remove our shortcomings.
8. Made a list of all persons we had harmed and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong, promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all of our affairs.

Version of the Twelve Steps of Alcoholics Anonymous for People With Traumatic Brain Injuries *by William Peterman, BS, CADAC*

1. Admit that if you drink or use drugs your life will be out of control. Admit that the use of alcohol and drugs after having a brain injury will make your life unmanageable.

2. You start to believe that someone can help you put your life in order. This someone could be God, an AA group, counselor, sponsor,etc.

3. You decide to get help from others or god. You open yourself up.

4. You make a complete list of the negative behaviors in your past and your current behavior problems. You also make a list of your positive behaviors.

5. Mett with someone you trust and discuss what you wrote in step 4.

6. Become ready to sincerely try to change your negative behaviors.

7. Ask God for the strength to be a responsible person with responsible behaviors.

8. Make a list of people your negative behaviors have affected. Be ready to apologize or make things right with them.

9. Contact these people. Apologize or make things right.

10. Continue to check yourself and your behaviors daily. Correct negative behaviors and improve them. If you hurt another person, apologize and make corrections.

11. Stop and think about how you are behaving several times each day. Are my behaviors positive? Am I being responsible? If not ask for help. Reward yourself when you are able to behave in a positive and responsible fashion.

If you try to work these steps you will start to feel much better about yourself. Now it's your turn to help others do the same. Helping others will make you feel even better. Continue to work these steps on a daily basis.

A Letter to Potential AA and NA Sponsor

By Ken McHenry, MEd

From the National Head Injury Foundation
Substance Abuse Task Force White Paper

Dear Sponsor:
As a twelve-stepper in AA or NA, you know fully well the horror chemical dependency thrusts into a person's life. Without concerted and persistent effort toward recovery, personal, family and social dimensions of life are deeply threatened and treacherously undermined. In the case of the person you are now sponsoring or are considering whether to sponsor, the addiction has been further compounded by a head injury which has to some degree, caused damage to the brain. Because of this damage, the very organ responsible for memory, language, reasoning, judgment, and behavior (among other skills and abilities) has been compromised. Consequently, problems have emerged that are a direct result of the trauma to the brain, and these problems now are inevitably overlapping and interacting with the individual's addictive nature.
At this stage in his or her recovery from the trauma, the individual with whom you are working has undoubtedly regained many of those diminished abilities. However, in all probability, there are lasting effects (sequelae, in medical terminology) that remain and that you may now be witnessing. These residual problems may be manifested in obvious or subtle ways, and an explanation of their nature may be helpful.

The purpose of this letter is to acquaint you with some of the more common cognitive (i.e., having to do with perceiving, organizing, interpreting, and acting on information) and emotional problems that head injured people face as a direct result of brain trauma. With a good medical recovery it is not at all unusual for these individuals to appear unimpaired unless one takes a close look and your work as a sponsor certainly will require close interaction.

These comments, then, are offered in a spirit of gratitude for your help to this person who must now come to grips with himself/herself on several levels. Who must now, en route to recovery from addiction, untangle a complex knot of problems including the changing of a pre-traumatic lifestyle while dealing with the confusion and psychological pain that recently shattered cognition brings.

The human brain has specific sections that specialize in specific functions. If damage to any of these areas is severe enough, those functions, as well as higher level ones which they support, may be lastingly limited. Many of these regions of the brain interact to enable the performance of complex skills such as reading or remembering and following through on lengthy directions. Because the brain's functioning is so dependent on the interrelationship of parts, and because any of those parts may be hurt in a trauma, many sorts of problems can result. The more prominent and frequently occurring ones, discussed in cognitive and emotional areas, are as follows:

Cognitive:

1. **Attention**: This includes maintaining attention for normal periods of time and the ability to shift attention to different areas concentrating on one set of ideas. Also included here are difficulties screening out distractions (voices, noises, and visual things) in the environment, as well as suppressing one's own preoccupations while there is other work to be done.

   Suggestions: Settle for smaller amounts of quality time rather than attempting longer amounts which may prove too fatiguing to the sponsoree. Cue him when he seems stuck in prior topics (e.g., "We're talking about _____ now..."), or when he seems to have drifted away ("Tune back in now, okay"...). Gradually lengthen the time of expected attention and concentration as increasing abilities permit.

2. **Memory**: The most common type of deficit resulting from a brain injury is short tern memory. This appears as difficulty holding onto several pieces of information while also having to think through each item (e.g., cooking, while also staying mindful of the children's nearby play). Other common problems are remembering recent experiences and conversations. Fortunately, memory for pre-traumatic episodes is most often unimpaired by this tine in the person's medical recovery.

   Suggestions: Expect the person to use journals and date books and to review them frequently and independently to cue himself about past and future events. If such memory aids are necessary, consider this simply another component of the program to be worked. Do not shy from expecting self-responsibility. If the person is overloaded by doing two or more things simultaneously, encourage him to prioritize tasks and work out a time management schedule honoring that limitation.

2. **Language**:

Ability both to understand others and to express one's own ideas clearly are often affected. In both cases, a slower speed of processing language is at play. Also, delays in recalling the words needed to articulate a thought are common. When speaking, the head injured person may ramble and talk in a disorganized, circular kind of way, often failing to come to the point or himself losing it in the details of the conversation.

Suggestions: Encourage the person to ask questions and request clarification of information whenever needed to compensate for a slower rate of comprehension. For situations in which it is appropriate, encourage the head-injured person to ask speakers to slow down, to repeat points, and to explain ideas in different words. Support may be required to downplay feelings of embarrassment to do these meetings. As a speaker, the sponsoree may need cues to see the need for making his point more clearly, simply, or briefly; working out a system for your providing such cues that you both feel comfortable with might be useful. As a general rule, encourage him to take time to think about what he wants to say, to plan how to say it, and to be unrushed in finding the words he needs.

3. **Reasoning/Judgment**:

Basic skills such as cause-effect reasoning and/or the ability to make inferences are often reduced. Thinking may be excessively concrete, giving rise to confusion and misinterpretation of others' remarks
(E.g., "Come off your high horse"...). Similarly, problem solving skills are often marred by impulsive decision-making; difficulty in considering several solutions to problems; and in envisioning potential consequences of actions. Failure to note voice or facial cues of others that convey nonverbal messages also increases the chance of inappropriate remarks. Common too are related problems in inhibiting inappropriate behavior; determining what situations require what behavior; and reflecting on the propriety of what he has just said or done.
Suggestions: As an overall rule, do not avoid openly addressing the issues raised by the above-mentioned behaviors or misunderstandings. Apply the very same gentle but firm advice giving anyone working in a recovery program may require. It may be helpful to point out specific incidences as examples of behaviors that need to be avoided, or situations from which one can learn to "think first before saying or doing something." As you would with anyone looking to you for help, follow your good instincts to provide support in the amount, kind, and frequency that leads this particular person with this particular personality to the best levels of independence he can achieve.

4. **Executive Functions**: These refer to those abilities to initiate, organize, direct, monitor, and evaluate oneself. Self-insight is a crucial component. Owing to the very high level nature of these skills and to the vulnerability of the part of the brain responsible for their operation, they are frequently impaired in the person who as suffered a head trauma. As a result, even with other skills and abilities intact, the use of these executive functions in a directed, purposeful manner may be lacking, making the overall picture of brain operations rather like a full member, competent orchestra without a conductor to organize and lead their many mixing harmonies; or, like a ready and able work crew without a foreman to coordinate and direct their labor.

   Suggestions: If impairments in executive functioning are apparent in the person you sponsor, it may well become especially important for you to assume a role of guiding some of these operations within the context in which you work together. To an extent, you would do this anyway; it is a large part of sponsorship. For a head-injured person, however, the need for such help may be deeper and more substantial. Your skills as a conductor or foreman, may be particularly required. A little more firmly offered advice in decision-making, for example…or better perhaps, encouragement to make one's own sound decisions with you available to monitor, affirm, give feedback, and gently correct when necessary. As noted earlier, in most cases it would be perfectly okay to talk openly about the need for your help in this regard because of the limitations imposed by the head injury. But be careful not to foster unnecessary dependence. Increased well being through healthy, clear-minded independence is always, as you know, the ultimate goal.

6. **Emotional**: There is an array of emotional problems typically related to head injury. These include irritability, poor frustration tolerance, dependence on others, insensitivity, lack of awareness of one's impact on others, and heightened emotionality. There may be tendencies toward overreaction to stressful situations, some paranoia, depression, withdrawal, or denial of problems. No single head injured person evidences all of these problems, of course, and most would show only subtle signs of some of these psychosocial difficulties. These are mentioned, however, to familiarize you with some of the emotional problems that often accompany brain trauma, and to alert you to their similarity to those characteristics of many persons with histories of substance abuse.

   Suggestions: In your sponsoring of a head injured person who may exhibit some of the above problems, the art of playing issues straight is recommended. Your sponsoree should know what problems you see impeding his progress toward greater recovery. Since his well being is the goal, your responsibility is as it would be with any other such partnership.
   Tactful but clear identification of problems, complete with acceptance of them as risks to continued sobriety or clean time which will necessitate work, is an appropriate attitude to adopt. Whether these sorts of problems are attributable to an addictive personality, or to the head injury, or to both, open, honest

acknowledgement of the work to be done and the support needed to do it is what recovery is all about. The sponsorship concept, moreover, is a very plausible means of addressing those sorts of problems.

Please also be aware that there are three main avenues of assistance further available to you:

1. If the head-injured person with whom you work has received treatment from a center specializing in rehabilitation of victims of brain trauma, do not hesitate to contact the treating staff to ask advice. They may be aware of approaches or strategies that work well with your individual.

2. Materials on head injury and chemical dependency may be obtained from the Brain Injury Association of America, 1608 Spry Hill Rd. Suite 110, Vienna VA 22180

You are one of the main supports of the recovering chemically dependent, head injured person. You deserve great thanks. The comments of this letter are not meant to frighten or dissuade you from sponsorship, but rather to provide you with basic information with which to enhance your preparedness and diffuse any unnecessary anxieties you may feel. Trust yourself in your work; your status as a twelve stepper speaks well for your patience, intelligence, and straightforwardness. The recovering head injured person receiving your help is fortunate to have you in his comer.

Kurt Vonnegut wrote that, "Detours are dancing lessons from God." You understand chemical dependency and recovery. Confronting a major life obstacle, you have learned to dance. Your sponsorship of the head-injured person with whom you are beginning involvement represents help for someone whose life has been shattered in a particularly devastating way, whose detour is indeed formidable. May your help in teaching that person to dance be gratifying and blessed, and an occasion for joy and learning for you both.

Sincerely,

The members of the Task Force on Chemical Dependency
The National Head Injury Foundation (now called the Brain Injury Association of America)

The Massachusetts Statewide Head Injury Program
Residential Substance Abuse Treatment

Change Plan Worksheet

The changes I want to make are:

The most important reasons why I want to make these changes are:

The steps I plan to take in making these changes are:

The ways other people can help me are:
List the person's name and the way they can help:

I will know that my plan is working if:

Some things that could interfere with my plan are:

Personal Emergency Plan: Lapse

Reminder Sheet

A slip is a major crisis in recovery. Returning to sobriety will require an all-out effort. Here are some things that can be done.

If I experience a lapse:

1. I will get rid of the alcohol or drugs and get away from the setting where I lapsed.

2. I will realize that one drink or even one day of drinking or drug use does not have to result in a full-blown relapse.

3. I will not give in to feelings of guilt or blame because I know these feelings will pass in time.

4. I will call for help from someone else.

5. At my next session, I will examine this lapse with my counselor. I will discuss the events prior to my use and identify the triggers and my reaction to them.

6. I will explore with my counselor, what I expected the alcohol or drug to change or provide for me. I will set up a plan so that I will be able to cope with a similar situation in the future.

EMERGENCY PLAN

If and when I feel like picking-up or I am in a high-risk situation:

- I will leave the place or change the situation.
- I will put off the decision to drink or drug for 15 minutes.
- I will challenge my thoughts about using. Do I really need a drink or a hit? My true needs are for food, water, shelter, health and friendship.
- I will think of something unrelated to drinking/drugging.
- I will remind myself of my success in staying clean/sober to this point.
- I will call my list of emergency number:

	Name	Phone Number
1.	_____	
2.	_____	
3.	_____	
4.	_____	
5.	_____	

Good Luck! Riding out this crisis will strengthen your recovery!

STAYING CLEAN
STAYING SOBER

One way to cope with the thoughts about using alcohol and other drugs is to remind yourself of the benefits of not using. Think about the unpleasant consequences of using and the reasons and the situations that make it hard for you to stay clean or sober. Use this sheet to make a list of the 5 or 10 reminders in each category. Fold it up and keep it with you. Read this sheet whenever you start to have thoughts about using.

Positive benefits of not using:

_____

_____

_____

_____

Unpleasant effects or consequences of using:

_____

_____

_____

_____

Reasons and high-risk situations that make it hard for me to stay clean or sober:

_____

_____

_____

Level of my personal commitment to remain drug-free or sober:

None 1 2 3 4 5 6 7 8 9 10 High

Change Plan Worksheet, Personal Emergency Plan: Lapse, Emergency Plan, and the Stay Clean and Sober Worksheet are handouts from the June 2003 *TBI and Substance Abuse* Webcast presentation sponsored by the National Association of State Head Injury Administrators, the Maternal and Child Health Bureau of the Health Resources and Services Administration and the U.S. Department of Health and Human Services. John Corrigan Ph.D, Frank Sparadeo Ph.D and Robert Ferris, LSW, presenters.

Handouts and Worksheets for use with Individuals and Groups

- The “Readiness Ruler” and “What I Want From Treatment” are both products of the Center on Alcoholism, Substance Abuse and Addictions at the University of Mexico. (CASAA) The “Readiness Ruler” can be used as a starting point to educate individuals on a variety of drugs and their side effects. Another CASAA product, “Reasons for Drinking” also lends itself to group discussions. These products and many others can be accessed at www.casaa.umn.edu/intro.asp. *
- The Alcohol Abstinence Self-Efficacy Scale breaks down items into categories of specific alcohol use triggers. The Scale was developed by Carlo DiClemente at the University of Maryland, Baltimore County and can be downloaded at http://www.umbc.edu/psyc/habits/SE-A.htm *
- 12 Steps modified for individuals with brain injury (attached)
- “Letter to a Sponsor”, this sample letter to a sponsor of an individual with a brain injury involved in a 12-Step program details the impact of brain injury on functioning and provides some suggestions for supports and strategies. The letter should be modified for each individual. (attached)
- Change Plan Worksheet, developed by the Massachusetts Statewide Head Injury Program. (attached)
- The Ohio Valley Center for Brain Injury Prevention and Rehabilitation, www.ohiovalley.org has information on brain injury and substance abuse that can be utilized by professionals. Also see their www.SynapShots.org.
- The Alcohol and Drug Abuse Institute at the University of Washington in Seattle, http://lib.adai.washington.edu/instruments/. Has information regarding assessment instruments and guides for use.
- Brain Injury Association of America www.biausa.org-see the BIAA website or call for additional information about brain injury and the consequences of brain injury including substance abuse.

* Instruments are currently being utilized by Pathways Inc. Brain Injury Recovery & Employment Services, Hollywood Maryland. Debra Fulton-Clark, Director

References

TBI and Substance Abuse (June 2003) Webcast presentation sponsored by the National Association of State Head Injury Administrators, the Maternal and Child Health Bureau of the Health Resources and Services Administration and the U.S. Department of Health and Human Services. John Corrigan Ph.D, Frank Sparadeo Ph.D and Robert Ferris, LSW.

Bombardier C., Davis, C. (2001). Screening for Alcohol Problems Among Persons with TBI. *Brain Injury Source.* Fall 16-19.

TBI Consumer Report #6: Coping with Substance Abuse After TBI. A publication of the Research and Training Center on Community Integration of Individuals with Traumatic Brain Injury. Department of Rehabilitation Medicine, the Mount Sinai School of Medicine, New York City
http://www.mssm.edu/tbicentral/resources/publications/.

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