



DMHMRSAS Office of Substance Abuse Services
Guidance Bulletin No. 2005-02
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Title: Special Treatment Needs of Individuals with Co-Occurring Substance Use Disorders and Traumatic Brain Injuries

[] **Advisory (Evidence-Based Practice)**

[X] **Guidance on Statutory/Regulatory Requirements**

RECIPIENTS:

- Executive Directors and SA Services Managers of Community Services Boards (CSBs), Administrative Policy Boards (APBs), Behavioral Health Authorities (BHAs), and Local Government Departments (LGDs) with Policy Advisory CSBs
- Directors of Licensed SA Programs
- Chair of the Virginia Association of Community Services Boards (VACSB) Substance Abuse Services Council
- Director of the Brain Injury Association of Virginia (BIAV)
- Director of the Virginia Office for Protection and Advocacy (VOPA)
- Director of the Virginia Department of Rehabilitative Services (DRS) Brain Injury and Spinal Cord Injury Services (BI/SCIS) Unit

PURPOSE:

To help clinicians in substance abuse treatment programs address the special treatment needs of individuals with co-occurring substance use disorders (SUDs) and traumatic brain injuries. To assure that individuals with traumatic brain injuries or other similar impairments have full and equal participation in any program operated, funded or licensed by DMHMRSAS.

BACKGROUND:

Traumatic brain injuries (TBIs) are injuries to the head arising from blunt or penetrating trauma or from acceleration-deceleration forces. TBIs are associated with decreased level of consciousness, amnesia, neurologic or neuropsychologic abnormalities, skull fracture, diagnosed intracranial lesions, and death.¹ TBIs may cause problems with cognition (concentration, memory, judgment, and mood); movement abilities (strength, coordination, and balance); sensation (tactile sensation and

¹ Thurman DJ, Snieczek JE, Johnson D, Greenspan A, Smith SM. (1994). Guidelines for surveillance of central nervous system injury. Centers for Disease Control and Prevention. In National Association of State Head Injury Administrators, Traumatic brain injury facts: An overview. Retrieved March 24, 2005 from <http://www.nashia.org/pdocfiles/tbioverviewfactsheetrsa.pdf>

special senses such as vision); and emotion (instability and impulsivity).² Patients with TBI who are admitted for acute rehabilitation may show a high association with unemployment, living alone, engaging in criminal activity, and having low subjective well being.³ The leading causes of TBIs are vehicle crashes, violent assaults, and falls. Alcohol is major contributor to the occurrence of TBI-related injuries; it is involved in at least 50% of all motor vehicle accidents and nearly 75% of violent assaults.⁴ An estimated 15% of persons who sustain a mild brain injury continue to experience negative consequences one year after injury.⁵ At least 5.3 million Americans—2% of the U.S. population—currently live with disabilities resulting from TBI.⁶

TBI and Substance Use Disorders: As many as two-thirds of adolescents and adults hospitalized for TBI have evidence of pre-injury substance use disorders.⁷ One-quarter to one-third of persons hospitalized with TBI has a blood alcohol level of 0.10, but there are minimal data on other drug screens.⁸ Cognitive and emotional impairments caused by TBI present unique problems when addressing co-existing substance use disorders.^{9, 10, 11, 12} ***People with physical and cognitive disabilities are more likely to have a substance use disorder and less likely to get effective treatment for it than those without such a coexisting disability.***¹³ In the 1980's and 1990's, the rehabilitation staff at the Ohio State University Hospital Physical Medicine and Rehabilitation program recognized the extent of the relationship between TBI and substance use disorders. They found that there was a shortage of addictions counselors prepared to work with persons with TBI, or able to identify TBI as a unique complication for treatment; that lack of substance abuse treatment

² Thurman D, Alverson C, Dunn K, Guerrero J, Sniezek J. (1999). Traumatic brain injury in the United States: A public health perspective. *Journal of Head Trauma and Rehabilitation*, 14(6):602-15. In CDC fact sheet: TBI: Outcomes and Consequences. Retrieved March 24, 2005 from

<http://www.cdc.gov/node.do/id/0900f3ec8000dbdc/aspectId/A0400027>

³ Corrigan, JD. (March 2002). Identifying desired outcomes in treatment and rehabilitation: Community based treatment of substance abuse following traumatic brain injury. In E. Wolkstein, ed. Second National Conference on Substance Abuse and Coexisting Disabilities: Facilitating Employment for a Hidden Population. Dayton, Ohio: RRTC on Drugs and Disability, Wright State University Dayton, Ohio.

⁴ TBI Network, Agency Profile-History. Retrieved February 17, 2005 from

<http://www.tbnetwork.org/profile/history.html>.

⁵ Guerrero J, Thurman DJ, Sniezek JE. Emergency department visits associated with traumatic brain injury: United States, 1995-1996. *Brain injury 2000*; 14(2): 181-6. In CDC fact sheet: TBI: Outcomes and Consequences. Retrieved March 24, 2005 from <http://www.cdc.gov/node.do/id/0900f3ec8000dbdc/aspectId/A0400027>.

⁶ Thurman et al. *op cit.*, 1999.

⁷ Corrigan JD. (1995). Substance abuse as a mediating factor in outcome from traumatic brain injury. *Archives of Physical Medicine and Rehabilitation*, 76(4): 302-9.

⁸ Corrigan *op cit.*, March 2002.

⁹ Corrigan JD and Lamb-Hart, L. (June 4, 2003). Emotional issues associated with TBI. *Substance abuse and brain injury*. http://www.birf.info/artman/publish/article_32.shtml.

¹⁰ Langley MJ. (1991). Preventing post-injury alcohol-related problems: A behavioral approach. *Work worth doing: Advances in brain injury rehabilitation*. BT McMahon and LR Shaw. Orlando, FL, Paul M. Deutsch Press, Inc.

¹¹ Center for Substance Abuse Treatment (1998). Substance use disorder treatment for people with physical and cognitive disabilities. *Treatment Improvement Protocol (TIP) Series*. Washington, DC, US Government Printing Office. Number 29.

¹² Corrigan JD, Bogner JA., et al. (1999). Substance abuse and brain injury. *Rehabilitation of the Adult and Child with Traumatic Brain Injury*. 3rd Edition. M. Rosenthal, ER Griffith, JD Miller and J Kreutzer, eds. Philadelphia, PA. FA Davis Co.

¹³ CSAT-TIP 29, *op.cit.*, 1998.

was one of the most serious gaps in services for survivors of brain injury; and that poor medical, social and vocational outcomes resulted in TBI survivors that returned to substance use.¹⁴

STRATEGIES AND GUIDING PRINCIPLES:

The TBI Network: The TBI Network (www.tbnetwork.org/profile/philosophy.html) has developed a resource and service coordination model for individuals with TBI. Staff educate consumers and families about substance use disorders and TBI, and provide individualized planning and care through collaboration of professionals with expertise in brain injury, substance abuse, vocational rehabilitation, case management, community outreach, counseling and family dynamics. To assure appropriate treatment, staff consult with professionals of other agencies to assist them in understanding the unique problems of individual consumers, particularly the cognitive and emotional changes resulting from brain damage. All services provided by the agency are based on the following **six guiding principles**:

1. Persons will be eligible for involvement with the program regardless of their current attitudes or beliefs regarding alcohol or other drugs.
2. Involvement with clients is holistic, i.e., all problems of community integration must be addressed, not just those thought to be directly related to substance abuse or traumatic brain injury.
3. The client and family are the decision-makers regarding goals and objectives and staff are information providers and facilitators.
4. Attitudes, beliefs and skills acquired in a person's home community are more likely to be sustained in that community than attitudes, beliefs, and skills learned elsewhere that require generalization.
5. Client, family, and service providers are a team whose efforts need to be actively coordinated.
6. When facilitated through case-specific consultation, the expertise of local service providers is extremely applicable to the problems of substance abuse following traumatic brain injury.

In 1994, the TBI Network also produced "Whatever it Takes" (WIT), a list of **ten strategies** for addressing the complex needs and fragmented services experienced by persons who have sustained a TBI:

1. No two individuals with acquired brain injury are alike.
2. Skills are more likely to generalize when taught in the environment where they will be used.
3. Environments are easier to change than people.
4. Community integration should be holistic.

¹⁴ TBI Network, Agency Profile-History. Retrieved February 17, 2005 from <http://www.tbnetwork.org/profile/history.html>.

5. Life is a "place and train" venture.
6. Natural supports last longer than professionals.
7. Interventions must not do more harm than good.
8. Service delivery systems present many of the barriers to community integration.
9. Respect for the individual is paramount.
10. Needs of individuals with brain injuries last a lifetime; so should their resources.

The Brain Injury Association of America (BIAA): The BIAA was founded in 1980 by a group of individuals who wanted to improve the quality of life for their family members who had sustained brain injuries. It now encompasses a national network of more than 40 chartered state affiliates and hundreds of local chapters and support groups. The mission of the BIAA is to create a better future through brain injury prevention, research, education and advocacy. The BIAA envisions a world where all preventable brain injuries are prevented, all unpreventable brain injuries are minimized and all individuals who have experienced brain injury maximize their quality of life.

The BIAA has adopted the following **guiding principles**:¹⁵

1. Value and respect the dignity and worth of all people in a true spirit of inclusion.
2. Support individual choices.
3. People with brain injury should have opportunities to be full participating members of their community.
4. Recognize and support the needs of individual's families and their circle(s) of support.
5. Provide rapid, relevant and accessible information.
6. Promote excellence, quality and best practice in all fields.
7. Support prevention opportunities through research, education and public awareness.
8. Address complex and controversial thorny issues.
9. Promote progressive public policy.
10. Respond to issues with integrity and courage.

EVIDENCE-BASED PRACTICE & TREATMENT GUIDELINES:

Screening for Traumatic Brain Injury (TBI) and Identifying Persons in Need of More

Comprehensive Assessment For TBI.¹⁶ Screening and assessment to determine if trauma or injury to the brain has occurred is important because TBI sometimes causes behavior changes or unusual responses that may interfere with addictions treatment. Identifying trauma helps determine the cause of confusion, impulsiveness and forgetfulness. Loss of consciousness can indicate a very significant injury, but multiple mild injuries, such as fights, can have additive effects over time

¹⁵ Guiding Principles adopted at the Brain Injury Association of America's Board of Directors meeting on February 7, 1999; Reaffirmed 2001. http://www.biausa.org/Pages/guiding_principles.html.

¹⁶ Ohio Valley Center for Brain Injury Prevention and Rehabilitation Website, <http://www.ohiovalley.org/abuse/tbiscrn.html>

without significant loss of consciousness.¹⁷ Such changes, even short in duration, indicate that the injury has resulted in changes in cognitive functioning. Significant life changes may not be attributed to the injury until properly identified, so it is important to examine the quality of life since the trauma, and look at its long-term effects. Role alterations with family members, difficulties getting or keeping a job, and emotional changes may be reported.

- **Routinely ask about trauma and any visible scars or marks:**

- Injuries following a blow to the head?
- Hospitalizations or treatment in an emergency room following an injury?
- Major surgeries, broken bones, illnesses, strokes, heart attacks?
- Loss of consciousness following an accident or injury? (If so, how long?)
- Injury due to a fight?
- Injury by a spouse or family member?

- **Since the trauma:** Ask, “Since the trauma...”

- Getting stuck on one thought and cannot switch to something else, even when trying?
- Difficulty starting new things?
- Doing things impulsively?
- Saying things should not have said, or “putting a foot in the mouth?”
- Noticing changes in any of the following since the injury?

- | | |
|----------------------------|--|
| - Irritability; | - Problem solving; |
| - Impulse control; | - Time management; |
| - Social skills; | - Memory loss; |
| - Attention/concentration; | - Sensitivity to bright lights or noise; |
| - Judgment; | - Walking or balance; |
| - Confusion; | - Speech; |
| - Emotional lability; | |

- **Impact of the Trauma:**

- Problems keeping a job or job loss?
- Changes in relationships with family or friends?
- Changes pointed out by family or friends?
- Treatment by a psychiatrist or psychologist?

¹⁷ Ohio Valley Center for Brain Injury Prevention and Rehabilitation Website, <http://www.ohiovalley.org/abuse/tbiscrn.html>.

- Medications for seizures?
- Probation, parole or pending charges?
- Headaches, dizziness, vision problems or fatigue?

Suggestions for Substance Abuse Treatment Providers Working with Persons who Have Limitations in Cognitive Abilities.¹⁸

(Note: These techniques also apply to individuals without cognitive disorders.)

- **Determine the individual's unique communication and learning styles.**
 - Ask how well the person reads and writes; or evaluate via samples.
 - Evaluate whether the individual is able to comprehend both written and spoken language.
 - If someone is not able to speak (or speak easily), inquire as to alternate methods of expression (e.g., writing or gestures).
 - Ask about and observe a person's attention span; be attuned to whether attention seems to change in busy versus quiet environments.
 - Ask about and observe a person's capacity for new learning; inquire as to strengths and weaknesses or seek consultation to determine optimum approaches.
- **Assist the individual to compensate for a unique learning style.**
 - Modify written material to make it concise and to the point.
 - Paraphrase concepts, use concrete examples, incorporate visual aids, or otherwise present an idea in more than one way.
 - If it helps, allow the individual to take notes or at least write down key points for later review and recall.
 - Encourage the use of a calendar or planner; if the treatment program includes a daily schedule, make sure a "pocket version" is kept for easy reference.
 - Make sure homework assignments are written down.
 - After group sessions, meet individually to review main points.
 - Provide assistance with homework or worksheets; allow more time and take into account reading or writing abilities.
 - Enlist family, friends or other service providers to reinforce goals.
 - Do not take for granted that something learned in one situation will be generalized to another.
 - Repeat, review, rehearse, repeat, review, rehearse.

¹⁸ Ohio Valley Center for Brain Injury Prevention and Rehabilitation Website,
<http://www.ohiovalley.org/abuse/Suggestions.html>

- **Provide direct feedback regarding inappropriate behaviors.**
 - Let a person know a behavior is inappropriate; do not assume the individual knows and is choosing to do so anyway.
 - Provide straightforward feedback about when and where behaviors are appropriate. Redirect tangential or excessive speech, including a predetermined method of signals for use in groups.

- **Use caution when making inferences about motivation based on observed behaviors.**
 - Do not presume that non-compliance arises from lack of motivation or resistance; check it out.
 - Be aware that unawareness of deficits can arise as a result of specific damage to the brain and may not always be due to denial.
 - Confrontation shuts down thinking and elicits rigidity; roll with resistance.
 - Do not just discharge for non-compliance; follow-up and find out why someone has no-showed or otherwise not followed through.

Road to Rehabilitation Brochure Series: Series of eight brochures that offer a layman's guide to the rehabilitation process for families and individuals with brain injury. *Several of these may be particularly useful when adapting addiction treatment services to accommodate individuals with TBI.*¹⁹

- **Part One**-Pathways to Comfort: Dealing with Pain and Brain Injury;
- **Part Two**-Highways to Healing: Post Traumatic Headaches and Brain Injury;
- **Part Three**-Guideposts to Recognition: Cognition, Memory and Brain Injury;
- **Part Four**-Navigating the Curves: Behavior Change and Brain Injury;
- **Part Five**-Crossing the Communication Bridge: Speech, Language and Brain Injury;
- **Part Six**-Mapping the Way: Drug Therapy and Brain Injury;
- **Part Seven**-Traveling Toward Relief: Dealing with Spasticity and Brain Injury;
- **Part Eight**-Journey Toward Understanding: Concussion and Mild Brain Injury.

¹⁹ Brain Injury Association of America (BIAA): www.biausa.org/Pages/road_to_rehab.html.

POLICY:

Compliance with all applicable laws, regulations and policies is a community services board (CSB) requirement of the annual *Community Services Performance Contract* with the Department, and a requirement of all licensed programs per 12 VAC 35-105-150 (*Rules and Regulations for the Licensing of Providers of Mental Health, Mental Retardation and Substance Abuse Services*).

The requirements include, but are not limited to, compliance with the following laws, regulations or policies regarding disabilities:

- **Nondiscrimination under state grants and programs (§ 51.5-40):** “No otherwise qualified person with a disability shall, on the basis of disability, be excluded from participation in, denied the benefits of, or be subjected to discrimination under any program or activity receiving state financial assistance or under any program or activity conducted by or on behalf of any state agency.” The *Virginia Office for Protection and Advocacy (VOPA)* has been charged with promulgating regulations necessary to implement this section. These regulations must be consistent with regulations imposed by the federal Rehabilitation Act of 1973, as amended, and the federal Americans with Disabilities Act of 1990.
- **"The Virginians With Disabilities Act." (§ 51.5-1):** It is the policy of the Commonwealth to encourage and enable persons with disabilities to participate fully and equally in the social and economic life of the Commonwealth and to engage in remunerative employment. To these ends, the General Assembly directs state agencies to provide, in a comprehensive and coordinated manner that makes the best use of available resources, those services necessary to assure equal opportunity to persons with disabilities in the Commonwealth. Virginia DMHMRSAS is one of several state agencies that must comply with this act.
- **Case management requirements: (§ 37.1-194):** CSBs shall, to the extent practicable, develop and maintain linkages with other community and state agencies and facilities that are needed to assure that their consumers are able to access the treatment, training, rehabilitative, and habilitative mental health, mental retardation, and substance abuse services and supports identified in their individualized services plans.
- **Human Rights: (§ 37.1-84.1):** The Department is responsible for assuring the protection of the rights of consumers in facilities and programs operated, funded and licensed by DMHMRSAS. **Each consumer has the right to:**
 - Retain his/her legal rights as provided by state and federal law;
 - Receive prompt evaluation and treatment or training about which he/she is informed insofar as he/she is capable of understanding;
 - Be treated with dignity as a human being and be free from abuse and neglect;
 - Not be the subject of experimental or investigational research without prior written and informed consent or that of his/her legally authorized representative;

- Be afforded the opportunity to have access to consultation with a private physician at his/her own expense;
- Be treated under the least restrictive conditions consistent with his/her condition and not be subjected to unnecessary physical restraint or isolation;
- Be allowed to send and receive sealed letter mail;
- Have access to his/her medical and mental records and be assured of their confidentiality;
- Have the right to an impartial review of violations of the rights assured under section 37.1-84.1 and the right to access legal counsel; and
- Be afforded the appropriate opportunities... to participate in the development and implementation of his/her individualized service plan.

RESOURCES IN VIRGINIA:

1. Virginia Department of Rehabilitative Services(DRS) Brain Injury and Spinal Cord Injury Services (BI/SCIS) Unit:

The BI/SCIS field staff often serve as the initial point of contact for DRS staff and consumers who need resource or referral information about brain injury and spinal cord injury in general, as well as information about specific agency services for persons with neurotrauma. The DRS provides, or administers a variety of services as follows:

- **Brain Injury Direct Services Fund**, provides short-term specialized services to help people in their recovery from brain injury. Funds are typically used to provide services that help individuals live more independently, or to purchase equipment, assistive technology or other goods when no other funding is available. Funds may not be used for inpatient medical rehabilitation or residential services. Individuals must be at least one year post-injury and meet other specific criteria to be considered for funding.
- **Woodrow Wilson Rehabilitation Center's (WWRC) Brain Injury Services Program and Spinal Cord Injury Services**, provides:
 - Counseling/guidance (including neuropsychological assessment);
 - Cognitive rehabilitation services;
 - Driver evaluation/training;
 - Independent living/community re-entry skills;
 - Occupational/physical/recreational/speech and language therapy;
 - Peer support;
 - Rehabilitation engineering (e.g., wheelchair seating/assessment);
 - Follow-up clinical services;
 - Vocational evaluation/training/counseling; and
 - Specialized case management services.

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- **Community Rehabilitation Case Management Services Program**, offers case management services to individuals with central nervous system and other severe functional disabilities, including brain and spinal cord injury. Case managers assist individuals in identifying needs and coordinating resources to increase independent living and community integration.
- **Personal Assistance Services**, provide personal assistance to individuals with brain injury who are ineligible for attendant care services available through other sources. Services may include, but are not limited to, assistance in getting in/out of bed, dressing, bathing, meal preparation and housework. Priority is given to individuals residing in, or at risk of placement in, a nursing facility.
- **Vocational Rehabilitation Services**, offer employment-related assistance to persons with disabilities, through local field offices across Virginia. Applicants must meet eligibility criteria to qualify for services. Eligible individuals are assisted in the development of employment goals and services needed to achieve them. An Individualized Plan for Employment (IPE) is developed jointly with the individual. Services include, but are not limited to:
 - Help in determining employment goals;
 - Counseling and guidance;
 - Vocational training; and
 - Job seeking and job placement services.
- **Virginia Central Registry for Brain Injury and Spinal Cord Injury**, maintains a record of hospital reports of all persons treated for brain or spinal cord injury, and provides these individuals with information about available services, including vocational rehabilitation services available through VRS.
- **Commonwealth Neurotrauma Initiative Trust Fund**, disperses funds to Virginia-based organizations, institutions and researchers through a competitive grant application process.

CONTACT INFORMATION:

Contact your local DRS office or call the DRS BI/SCIS unit
at **1-800-552-5019** or **1-800-464-9950 (TTY)**.

2. Centers for Independent Living (CIL):

Centers for Independent Living (CILs) are non-profit organizations that are funded with state, federal, local and private dollars. There are sixteen CILs and two satellite CILs located throughout Virginia. CILs provide services that promote the leadership, empowerment, independence, and productivity of people with disabilities. Services and advocacy for local communities and individuals with disabilities include:

- Information and referral;
- Peer counseling;
- Independent living skills training; and
- Individual and systems change advocacy (disability awareness, technical assistance for accessibility and legal issues, and general information).

CONTACT INFORMATION:

Contact the Virginia Department of Rehabilitative Services at
1-800-552-5019 or 1-800-464-9950 (TTY).

Or go to <http://vadrs.org/cbs/cils.htm> for information about the nearest CIL.

3. Virginia Commonwealth University (VCU) Traumatic Brain Injury Model System:

The faculty and staff of the Department of Physical Medicine and Rehabilitation (DPMR) and colleagues in the VCU Health System work together to improve the lives of, and provides comprehensive, coordinated inpatient and outpatient care for, persons with TBI. The system, which achieved federal designation as a model system of care in 1987, includes emergency medical services, early intensive and acute medical care, comprehensive rehabilitation services, and long-term rehabilitation follow-up. Its research programs focus on improving care and quality of life for people with brain injury and their families, by studying the benefits of family support and education, identification and treatment of depression, and the effectiveness of early rehabilitation.

CONTACT INFORMATION:

Virginia Commonwealth University

Box 980542, Richmond, VA 23298-0542

Phone: (804) 828-3704 Toll free phone: (866) 296-6904 Fax: (804) 828-2378

URL: <http://www.tbi.pmr.vcu.edu/>

4. The Virginia Office for Protection and Advocacy (VOPA):

VOPA provides help with disability-related problems, helps people with disabilities obtain services and treatment, and provides advocacy services and/or legal representation. VOPA assists eligible individuals when they have problems with counselors or case managers, mediates disagreements about services, provides information on additional resources, and represents clients who are denied services or provided inappropriate services.

VOPA services are provided through the following programs:

- **Virginians with Disabilities Act Program (VDA)**, to assist individuals who may have experienced illegal discrimination on the basis of disability;
- **Developmental Disabilities Program (DD)**, to provide legal and advocacy services to assist children and adults with severe, lifelong disabilities who require special care, housing, treatment, and services and who have been abused, neglected, or discriminated against due to their disability;
- **Protection and Advocacy for Individuals with Mental Illness Program (PAIMI)**, to provide legal and advocacy services for people with mental illness who live in a hospital or other facility providing care and treatment for their illness. This service protects the right to obtain appropriate services, make complaints about services or treatment, ask questions of anyone who is supposed to provide services or treatment, be safe from harm, make decisions about services received, keep records private, and have a written plan in place before leaving a mental health facility.
- **Client Assistance Program (CAP)**, to explain and protect the rights of and benefits to persons who are clients of or applicants for services provided by the Department of Rehabilitative Services, Department for the Blind and Vision Impaired, Centers for Independent Living, or programs funded under the Rehabilitation Act of 1973, as amended.
- **Assistive Technology Program (AT)**, to assist individuals with disabilities seeking access to assistive technology devices and services, with emphasis on obtaining funding from vocational rehabilitation and special education providers, and Medicaid or Medicare. Assistive technology is any device, adaptive equipment, or service that enables people with disabilities to accomplish a task that would otherwise not be possible.
- **Protection and Advocacy of Individual Rights Program (PAIR)**, to expand VOPA services to individuals with disabilities in the community who are not eligible for other advocacy programs.
- **Protection and Advocacy for Beneficiaries of Social Security Program (PABSS)**, to provide assistance and representation to Social Security beneficiaries with disabilities who have experienced employment discrimination based on disability, who have been inappropriately

denied Medicaid (1619b status) benefits, and who are at-risk of losing their job or unable to take a job due to a loss or denial of Medicaid benefits.

- **Traumatic Brain Injury Program (TBI)**, to improve access to comprehensive, high quality services for individuals with, and to reduce the incidence of discrimination against, individuals with TBI.

CONTACT INFORMATION:

Virginia Office for Protection and Advocacy
1910 Byrd Avenue, Suite 5, Richmond, Virginia 23230
Phone: (804) 225-2042 (Voice/TTY)
Toll free in Virginia: (800) 552-3692 (Voice/TTY)
Email: generalvopa@vopa.state.va.us
URL: <http://www.vopa.state.va.us/>

FOR ADDITIONAL INFORMATION:

1. **Brain Injury Association of America (BIAA):** www.biausa.org

The BIAA offers a clearinghouse of community service information and resources, legislative advocacy, prevention awareness, educational programs, promotion of research. Refer to:

Family Helpline: The BIAA Family Hotline receives approximately 15,000 calls each year from individuals with TBI, family members and providers seeking assistance, education and support (M-F, 9 am-5pm). **1-800-444-6443**

2. **Brain Injury Resource Center (BIRC):** www.headinjury.com

The BIRC is a clearinghouse operated by the Head Injury Hotline in Seattle, Washington. The BIRC has provided “difficult to find information for individuals with TBI since 1985.” The BIRC multidisciplinary team of consultants trained in traumatic brain injury includes individuals with TBI, family members, learning specialists, nurses, paraprofessionals, lawyers, neuropsychologists, and physicians specializing in emergency medicine and neurology. (206-621-8558).

3. **Department of Health and Human Services (DHHS), Health Resources and Services Administration (HRSA), Maternal and Child Health (MCH) Bureau:**

Two HRSA initiatives include:

- **National Association of State Head Injury Administrators (NASHIA):** NASHIA, which provides assistance in promoting partnerships and building systems to meet the needs of individuals and their families. (www.nashia.org)
- **Traumatic Brain Injury Technical Assistance Center (TBITAC):** TBITAC provides assistance in the planning and development of effective programs that improve access to health and other services for individuals with TBI and their families. (www.tbitac.org)

4. National Association of Protection and Advocacy Systems (NAPAS): www.napas.org

NAPAS is a voluntary national membership association for the nationwide network of congressionally mandated, legally based disability rights agencies, including Protection and Advocacy Systems (P&As) and Client Assisted Programs (CAPs). It promotes self-determination, choice, and equality of opportunity and full participation of individuals with disabilities.

5. National Center for the Dissemination of Disability Research (NCDDR):

Two TCDDR initiatives include:

- **Model Spinal Cord Injury Systems (MSCIS):** Model SCI Centers across the United States work together to demonstrate improved care, maintain a national database, participate in independent and collaborative research, and provide continuing education relating to spinal cord injury. Eighteen projects are located in 16 states, including Virginia (Virginia Commonwealth University Regional Spinal Cord Injury System). (<http://www.ncddr.org/rpp/hf/hfdw/mscis/>)
- **Traumatic Brain Injury National Data Center (TBINDC):** The TBINDC is the coordinating center for research and dissemination efforts of the Traumatic Brain Injury Model Systems (TBIMS), which conduct innovative research and provide “model” care to individuals who experience TBI. Sixteen comprehensive systems of care are located in 14 states, including Virginia (Virginia Commonwealth University Traumatic Brain Injury Model System) (www.tbindc.org)

6. National Injury Prevention Foundation (NIPF) Think First! Program: www.thinkfirst.org

The NIPF provides public education to target children and teens, a high risk age group for devastating brain and spinal cord injuries from motor vehicle crashes, falls, sports and recreation activities and violence. The Think First! Program educates young people about personal vulnerability and risk-taking.

**7. National Institute on Disability and Rehabilitation Research (NIDRR)
Regional Disability and Business Technical Assistance Centers (DBTACs):**

www.adata.org/dbtac.html

The NIDRR operates ten regional centers (DBTACs) that provide information, training, technical assistance, and materials dissemination related to employers, individuals with disabilities, and other entities with responsibilities under the Americans with Disabilities Act (ADA), as well as other related disability legislation which may impact their rights or responsibilities, such as the Rehabilitation Act, the Family Medical Leave Act, and the Workforce Investment Act.

(Note: Virginia is served by the Region 3 Mid-Atlantic DBTAC—www.adainfo.org).

8. National Rehabilitation Information Center for Independence (NARIC): www.naric.com

The NARIC Instant Disability Research Center provides access to a collection of resource directories and databases with > 70,000 resources covering a wide range of disability and rehabilitation issues. The NARIC Knowledgebase contains > 2,800 agencies, organizations and databases. REHABDATA is an extensive database of disability and rehabilitation literature. The NIDRR Program Directory lists 400 disability and rehabilitation research projects across the country. Other resources include newsletters and free monthly email updates.

9. National Resource Center for Traumatic Brain Injury (NRCTBI):

www.neuro.pmr.vcu.edu

The NRCTBI provides relevant, practical information for professionals, individuals with brain injury, and family members. The Virginia Commonwealth University (VCU) Neuropsychology and Rehabilitation Psychology Division, the VCU Department of Physical Medicine and Rehabilitation, and the VCU Medical Center host the site as a part of the VCU TBI Model System.

OTHER REFERENCES:

- ***Axis I Psychopathology in Individuals with Traumatic Brain Injury.* Hibbard MR, Uysal S, Kepler K, Bogdany J and Silver J. Department of Rehabilitation Medicine, The Mount Sinai Medical Center, New York, New York 10029, USA.**

Assessment of the incidence, comorbidity and patterns of resolution of DSM-IV mood, anxiety and substance use disorders in individuals with TBI, using the Structured Clinical Interview for DSM-IV Diagnoses (SCID). Emphasis on the need for proactive psychiatric assessment and timely interventions in individuals with TBI.

- ***Heads Up: Facts for Physicians About Mild Traumatic Brain Injury (MTBI).*** Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control (NCIPC). <http://www.cdc.gov/doc.do/id/0900f3ec80017575>.

The role of physicians and other health care providers in helping to reduce the occurrence of TBI; focus on prevention, early identification and clinical management approaches.

- ***More than Accommodation: Overcoming Barriers to Effective Treatment of Persons with Both Cognitive Disabilities and Chemical Dependency.*** Annand, Jerry. Nightwing Publishing, 800-514-4045, www.nightwingpublishing.com.

A multidisciplinary treatment model for persons with cognitive disabilities and chemical dependency, innovative programs for non-mainstream consumers in a variety of agencies.

- ***Rehabilitation of Persons with Traumatic Brain Injury.*** NIH Consensus Statement 1998 Oct 26-28; 16(1): 1-41. (http://consensus.nih.gov/cons/109/109_intro.htm)

Results of the NIH Consensus Development Conference on Rehabilitation of Persons with TBI. Explores the scientific basis for common therapeutic interventions for the cognitive and behavioral sequelae of TBI, and common models of comprehensive, coordinated, multidisciplinary rehabilitation for people with TBI. Expands the narrow focus of medical restoration approaches, and instead emphasizes the importance of creating enabling conditions and improving access to rehabilitation services in order to optimize outcomes.

- ***Substance Use Disorder Treatment for People with Physical and Cognitive Disabilities, Treatment Improvement Protocol (TIP) Series 29.*** Moore D, Editor. Substance Abuse and Mental Health Services Administration. DHHS Publication No. (SMA) 98-3249, 1998. <http://ncadi.samhsa.gov/govpubs/BKD288/>

Guidelines for addressing the needs of adults in addictions treatment who have a coexisting physical or cognitive disability, with a focus on the legal and ethical responsibilities of providers to make treatment for these individuals as effective as possible. Review of requirements for compliance with the Americans with Disabilities Act (ADA), including issues related to equal access, removal of physical and attitudinal barriers, and accommodations for meaningful participation in treatment.

- ***Traumatic Brain Injury—Fact Sheet.*** Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control (NCIPC). <http://www.cdc.gov/doc.do/id/0900f3ec8016dc26>.

General Fact Sheet about Traumatic Brain Injury, including information about statistics, CDC activities, and prevention.

TERMINOLOGY:²⁰

Accommodation: Reducing barriers to equal participation, not giving special preferences. It is always a good idea to ask a client who has a disability if there are any accommodations he/she may need for successful treatment. Appropriate accommodation of a person with a disability fosters cooperation at the same time it enriches diversity.

Attitudinal Barriers: Attitudes about "disability" influence the ways nondisabled people react to people with disabilities, which can affect the latter's treatment outcomes. The stereotypes and expectations of others also influence the ways people think about their own disabilities. *Attitudinal barriers lead to discriminatory policies, practices and procedures, and present barriers to treatment of people with co-occurring substance use disorders and disabilities.* They result in people with disabilities being screened out or denied accommodation for his/her disability. Staff training is key to overcoming attitudinal barriers.

Cognitive Impairments: Disruptions of thinking skills, such as inattention, memory problems, perceptual problems, disruptions in communication, spatial disorientation, problems with sequencing (the ability to follow a set of steps in order to accomplish a task), misperception of time, and perseveration (constant repetition of meaningless or inappropriate words or phrases).

Disability: Diseases, disorders, and injuries, whether congenital or acquired, can have various effects on organs and body systems, and cause impairments, such as impaired cognitive ability, paralysis, blindness, or muscular dysfunction. Impairments cause disabilities, which limit an individual's ability to function in various areas of life, such as learning, reading, and mobility.

Handicap: "A condition or barrier imposed by society, the environment or one's own self. Handicap is synonymous with barrier and not a synonym for disability. Some people prefer inaccessible or not accessible to describe social and environmental barriers. Handicap can be used when citing laws and situations, but it should not be used to describe a disability."

Nondisabled: "Appropriate term for people without disabilities. Normal, healthy, or whole are inappropriate because they imply that people who are disabled are not these things."

"People-First" Language: When referring to people with disabilities, it is good etiquette to say "the person with the brain-injury" instead of the "brain injured person," and "the person with a disability" instead of the "disabled person." *Disabilities describe not who people are, but rather what condition they have.*

²⁰ SAMHSA-CSAT, TIP #29: Substance use disorder treatment for people with physical and cognitive disabilities.

DMHMRSAS OFFICE OF SUBSTANCE ABUSE SERVICES

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FOR MORE INFORMATION, PLEASE CONTACT:

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