

March 11, 2026

TBI and Substance Misuse

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Director of SUD Services



“Unidentified traumatic brain injury is an unrecognized major source of social and vocational failure.”



A traumatic brain injury (TBI) is a brain injury caused by an external force that disrupts normal brain function, ranging from mild to severe and potentially leading to long-term disability or death.



Traumatic Brain Injury (TBI) is a common but often undiagnosed co-occurring condition with substance misuse disorders.



An overdose has the potential to cause serious and permanent brain damage, even if the person survives the initial medical crisis. The severity of the damage depends on the substance taken, the quantity, and the time elapsed before emergency intervention begins.



“One way to think about this would be that **an overdose is like a concussion**, where you have a traumatic brain injury to the brain ... if the person doesn't die, the brain recovers, but they may be, like with a concussion, **more susceptible to a future event**. And then there also may be **cumulative damage** that occurs.”

-Dr. Alex Walley

Associated Professor of Medicine, Boston University School of Medicine



Depending on the setting you work in, one-quarter to one-half of the people you serve will report a history of brain injury with some loss of consciousness.

Those who do report a history of brain injury will also have longer and more severe histories of substance misuse and co-occurring behavioral health issues.

75% of the people seeking services for concurrent mental health and substance misuse disorders are living with the effects of brain injury.

In most settings, the bottom line is that at least one out of five people presenting for treatment of a substance misuse disorder is also living with the effects of brain injury.



Because brain injury is often an invisible disability, it is easy to miss and to misunderstand.

People with TBI seeking services for substance misuse may experience subtle but significant changes in:

- Memory
- Attention
- Problem-solving
- Sensation
- Social behavior
- Self-regulation
- Making it difficult to remember appointments, understand expectations, follow through with tasks, and participate in group settings.



Who Should Be Screened for Brain Injury?

The answer is simple:
Everyone you serve.



When Should Screening Occur?

The timing of screening for brain injury will depend on the setting you work in and the clients you serve.



Recognizing and Accommodating Cognitive Impairments.

- Problems with Alertness (Fatigue).
- Problems with Attention.
- Problems with Processing Information.
- Problems with Memory.
- Problems with Executive Functioning.
- Problems with Communication.
- Difficulties with Self-Awareness.



Current SUD Treatment



Rehab Daily Schedule Example

Below is a sample of what one may expect during a day in one of our residential treatment centers:

- **7:00 a.m.** Breakfast
- **7:45 a.m.** Meditation
- **8:30 a.m.** Physical Wellness Training
- **10:00 a.m.** Behavioral Health Group
- **11:00 a.m.** Relapse Prevention Group
- **12:00 p.m.** Lunch and Reflection Time
- **1:00 p.m.** Nutrition and Wellness Group
- **2:00 p.m.** One-on-One Therapy
- **3:00 p.m.** Expressive Therapies in Recovery
- **4:00 p.m.** Therapeutic Community Group
- **5:00 p.m.** Dinner
- **6:30 p.m.** Recovery Meeting
- **7:30 p.m.** Clean & Sober Structured Activities/Recreation
- **10:00 p.m.** Lights Out



06/19/2023	06/20/2023	06/21/2023	06/22/2023	06/23/2023
Monday	Tuesday	Wednesday	Thursday	Friday
8:30-9:30 Check-In and Community Group	8:30-9:30 Check-In and Community Group	8:30-9:30 Check-In and Community Group	8:30-9:30 Check-In and Community Group	8:30-9:30 Check-In and Community Group
Bob	Wendy	Bob	Wendy	Wendy
9:30-10:30 Symptom Management	9:30-10:30 Relationship Skills	9:30-10:30 Understanding your Illness	9:30-10:30 Getting the Best Results from your Meds	9:30-10:30 Recognizing and responding to relapse
Carol	Bob	Wendy	Carol	Carol
10:45-12:00 Understanding Substance Use	10:45-12:00 Conflict Resolution	10:45-12:00 Relaxation and leisure skills	10:45-12:00 What is Recovery	10:45-12:00 Stress Management and Problem Solving
Wendy	Carol	Carol	Bob	Bob
12:00-1:00 Recovery Plan and Wrap up	12:00-1:00 Recovery Plan and Wrap up	12:00-1:00 Recovery Plan and Wrap up	12:00-1:00 Recovery Plan and Wrap up	12:00-1:00 Weekend Planning and Wrap up
Carol	Bob	Wendy	Carol	Wendy

Your part of this agreement is:

- Attend and participate in all group sessions
 - Attend and participate in all individual counseling sessions
 - Be actively involved in the development of your treatment plan.
 - Follow up on the objectives laid out in your treatment plan.
-
- Provide emergency contact information.
 - Keep honest and open communication.
 - Maintain confidentiality of other PHP and Elliot Hospital participants.



- Provide random drug/alcohol screens.
- Pay program fees, if applicable
- Personally call the program if you must be late or absent from the program.
- Follow all policies laid out in the PHP Participant Handbook.
- Take all prescribed medications as directed by the prescriber.
- Accept responsibility for your actions.
- To explore self-help support options while attending the PHP, attending a minimum of three (3) meetings per week.
- Safeguard any belongings that I bring into the program.



Group Expectations:

1. Protect the confidentiality of all group members. What is said in group stays there.
2. One person speaks at a time – avoid crosstalk. Listen.... Even if you don't agree with the speaker.
3. Racial, ethnic, sexual or gender put-downs are not tolerated.
4. Physical abuse will result in being discharged from the program.
5. Please use the bathroom before group, during breaks or after the program.
6. Beverages are allowed in the group room, but food is not allowed.
7. Hats and hoods are not worn in group. Sunglasses are not to be worn unless medically approved and required. Cell phones are to be turned off.
8. Drug/alcohol-related clothing and jewelry are not allowed.
9. Relapses can happen. Talk about them so that you and others can learn from them.



What happens to a client that can not follow the group or residential expectations in traditional substance misuse treatment?



Given a verbal contract/written.
Removed from group.
Classified as defiant/difficult.
Misdiagnosed.(Antisocial/Personality
Disorder)
Asked to leave due to non-
compliance.



Clients and staff are likely to need some support to....





**Understand
the impact of
brain injury and
substance use**



**Remember
what to do and
when**



**Make
decisions and
set clear goals**



**Make plans
and problem-
solve**



**Get started
starting**



**Keep track
of goals and
evaluate
progress**

Recommendations for service delivery.

Programs geared to support individuals with concurrent disorders, including the impact of brain injury, will generally need to take a long-term perspective, anticipating that the course of intervention will take longer than for individuals with less complex difficulties.



Will require more individualized support and case management to achieve their goals.

The goals of case management will be largely determined by the client's stage of change with respect to their substance use, as well as their level of awareness of the difficulties that they are having as the result of their cognitive impairments.



Provider Guide for Intervention

Building Alliance

Setting Norms/Routines

Creating an Emotionally Safe Environment

Enhancing Motivation for Change

Clarification of Personal Goals

Building Discrepancy

Fishing for Change Talk

Preparation

Building a Schedule of Competing Activity

Building a Social Network/Supports

Setting Achievable Goals

Action

Skill Building

Specific Changes Strategies for Substance Use

Relapse Prevention

Managing Lapses

Building a Follow-up Plan

Key Considerations in Program Development:

Longer-term interventions and smaller caseloads may be required to adequately address clients' needs. Clients with brain injury present with greater symptom complexity and are likely to require longer periods of intervention along with more integrated aftercare supports.

Coordination with community partners will be needed. This will likely require actively reaching out to, and creating partnerships with, brain injury providers and other support agencies in the community.

Providers should recognize the elevated risks for impulsive behavior, including suicide, and regularly assess suicide risk.

Providers should be aware of these elevated risks of pain, seizure, endocrine, and neurodegenerative disorders and make referrals for assessment as required.

Adaptations for group therapy

Create a safe space

- Use name tags.
- Limit groups to five or six participants. Too many individuals in the room may serve as a distraction to those with cognitive impairments.

Promote engagement

- Make individualized attendance plans that include items such as transportation routes and departure times.
- Allow for the possibility of clients leaving sessions early and staff having individual follow-up sessions.

Use a consistent format

- Give time to settle in/brief mindfulness activity.
- Remind group members of important rules/guidelines.
- Provide a brief summary of the previous group.
- Outline the goal for the current session.
- Make the sessions interactive, and build in time for breaks.
- Provide a brief summary at the end.

Adaptation for Outreach Services

Many people living with cognitive impairment have difficulty identifying and seeking out services that would be beneficial.



Adaptation for Intake Services

To avoid barriers to care, a simplified intake process that includes support to attend the initial appointment minimizes the requirement for documentation and forms to be completed before the appointment and enables you to gather needed information.



Community Linkages

Given the prevalence of cognitive impairment due to TBI and other brain injuries, substance misuse disorder treatment programs should consider developing longstanding linkages with brain injury providers.



Considerations for Physical Space

Universal design principles should be used in the design of clinical programs, including appropriate accommodation for mobility limitations. Signage should clearly indicate program locations. Signage is also helpful for wayfinding, storage of items, and rules of program engagement. Physical cues to increase orientation, such as clocks and calendars, as well as daily program schedules, are also helpful to individuals who may have difficulty in tracking this information.



Education about Substance Use and Brain injury

For clients who are aware of the cognitive impact of their brain injury, it may be motivating to consider the brain health benefits associated with abstaining from or reducing substance use



Questions?



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Resources

Lemsky C. (2021, November) Traumatic Brain Injury and Substance Use Disorders: Making the Connections. SAMSHA TBI-SUD-Toolkit-FINAL-11.05.2021.pdf

Corrigan J, Adams R, Dams-O’Conner K (2021): At-risk substance use and substance use disorders. In: Zasler ND, Katz DI, Zafonte RD, editors. Brain Injury Medicine: Principles and Practice, 3rd ed. New York: Springer Publishing Company, LLC, 1241–1251.

Corrigan JD, Adams RS, Dams-O’Connor K. Chapter 81. At-Risk Substance Use and Substance Use Disorders. In: Zasler ND, Katz DI, Zafonte RD, editors. Brain Injury Medicine: Principles and Practice. Third Edition. New York: Springer Publishing Company, LLC; 2021. pp. 1241–51.



Introduction

Why is it important for peer specialists to have a working understanding of TBI and ABI?

- A history of TBI is often hidden (**especially if incurred in childhood/adolescence**) with behavioral health challenges (mental health and addiction)
- Recognizing possible signs and symptoms of brain injury in individuals encountered in services and in the community and knowing how to use simple supports to engage with those affected by brain injury can facilitate treatment initiation AND retention
- Because of the nature of the work and with people directly, peer specialists are in a unique position to assess where people are having struggles (memory, concentration, following directions) and can design and help implement practical strategies

Substance Abuse

Treatment in clients with TBI:

- First used at a younger age
- Have more severe SUD (worse use and more prior treatments)
- Have more co-occurring mental health problems
- Have poorer prognosis for successful treatment outcome (more so earlier the age at first TBI?)

Source: Corrigan and Mysiw, "Substance Abuse Among Person's with Traumatic Brain Injury" Brain Injury Medicine, 2nd Edition 2012

Observations

“One way to think about this would be that **an overdose is like a concussion**, where you have a traumatic brain injury to the brain ... if the person doesn't die, the brain recovers, but they may be, like with a concussion, **more susceptible to a future event**. And then there also may be **cumulative damage** that occurs.”

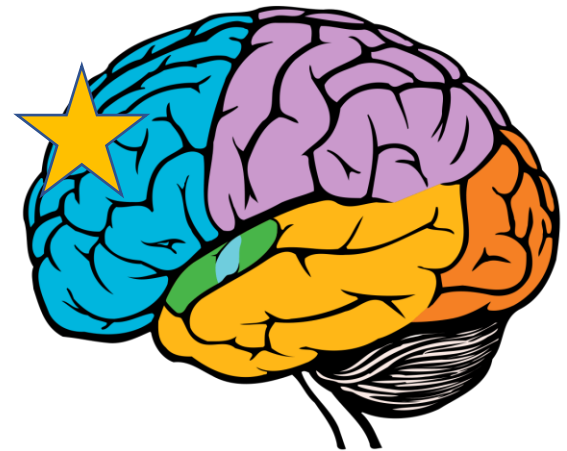
-Dr. Alex Walley

Associated Professor of Medicine, Boston University School of Medicine

Source: <https://www.npr.org/sections/health-shots/2017/04/13/523452905/what-doesnt-kill-you-can-maim-unexpected-injuries-from-opioids>

Brain Hypoxia

- The frontal lobe is highly susceptible to brain hypoxia (reduced oxygen)
- Frontal lobe damage leads to potential loss of executive functions which are often required to participate, engage and thrive in treatment
- As a result of frontal lobe damage, survivors of overdose may have issues with noncompliance, poor follow through or a lack of engagement
- Decreased ability to participate and engage in substance treatment puts these individuals at increased risk for relapse



TBI and Opioid Use

- Those who experience a serious traumatic injury such as TBI may be at greater risk of opioid misuse and unintentional death due to opioid poisoning due to long-term disability with multiple secondary health conditions frequently treated with opioids such as headache and orthopedic injury
- Challenges common post TBI including cognitive impairment, impulsivity and co-occurring mood disorders that may increase the risk of inadvertent overuse (e.g. forgetting when prescribed dose was last taken)

Source: Summary of Responses to RFO: People with Disabilities and Opioid Use Disorder, National Institute on Disability, Independent Living, and Rehabilitation Research retrieved on 8.1.18 <https://www.acl.gov/sites/default/files/news%202018-05/20180502NIDILRROpioidRFIFindings.pdf>

TBI and Opioid Use

- Currently, there are no opioid prescribing guidelines for individuals living with TBI
- Researchers from the TBI Model Systems found that individuals living with TBI are 11 times more likely to die of overdose than individuals who are not living with a TBI
- Between 70-80 percent of individuals with moderate to severe TBI are discharged from hospital and rehabilitation setting with a prescription for an opioid

Sources: *Hammond, F. M., Dams-O'Connor, K., Ketchum J et al (2018). Mortality secondary to accidental poisoning after inpatient rehabilitation for traumatic brain injury study: A NIDILRR Traumatic Brain Injury Model Systems Study. Manuscript in Preparation.*

Seal, K.H., Bertenthal, D. E., Byers, A. L., et al (2018). Traumatic Brain Injury and receipt of Prescription Opioid Therapy for Chronic Pain in Iraq and Afghanistan Veterans: Do Clinical Practice Guidelines Matter? The Journal of Pain, August; 19(8):931-934

Problematic Implication

- People with a history of brain injury, either traumatic or acquired, may have difficulty accessing services or remaining engaged in services due to barriers created by cognitive and/or behavioral weaknesses

Source: *John Corrigan Ph.D.*

Suggestions for Providers

- Look for neurologically based cognitive and behavioral barriers to treatment
- Adapt service provision to accommodate weaknesses
- Assist with the development of compensatory strategies
- Be cautious when making inferences about motivation based on observed behaviors

Source: John Corrigan Ph.D.

Messages to Share

12 Steps of Alcoholics Anonymous (AA) for a TBI

Source: Developed by William Peterman, BS, CADAD and reprinted with permission of the National Head Injury Foundation Substance Abuse Task Force White Paper, Southborough, MA: NHIF, 1988.

- Admit that if you drink and/or use drugs your life will be out of control and that the use of substances after having a TBI will make your life unmanageable
- You start to believe that someone can help you put your life in order — potentially God and AA/AN group, counselor, sponsors, etc.
- You decide to get help from others or God and open yourself up
- You will make a complete list of the negative behaviors in your past and current behavior problems, as well as a list of your positive behaviors
- Meet with someone you trust and discuss what you wrote above
- Become ready to sincerely try to change your negative behaviors
- Ask God for the strength to be a responsible person with responsible behaviors
- Make a list of people your negative behaviors have affected and be ready to apologize or make things right with them
- Contact these people to apologize or make things right
- Continue to check yourself and your behaviors daily to correct negative behaviors and improve them and apologize and make corrections if you hurt another person
- Stop and think how you are behaving several times a day to ask yourself if your behaviors positive and if you are being responsible
- If not, ask for help and 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 and help others with their steps

Accommodating Symptoms

Environmental strategies:

- Changing or modifying the environment to support and/or compensate for an injury imposed deficit
- Example: labeling kitchen cabinets and drawers

Internal Strategies (the strategy is “in your head”)

- Pausing every two sentences during a conversation
- *“I have to work the memory muscle by counting everything, like how many times I pedal when I am on a bike”*

- Actor George Clooney discussing the use of internal memory strategies in *The London Sunday Times* Oct. 23, 2005

Mild TBI/Concussion

Facts

- Defined as a period of altered mental state or a brief loss of consciousness (LOC) following a blow to the head
- 80-85% of all TBIs are mild
- Often is undiagnosed, misdiagnosed
- Family and individual are seldom followed by medical community or receives education in the ER

Common Symptoms

- May or may not lose consciousness
- Headaches
- Dizziness
- Slowed processing
- Forgetfulness
- Fatigue
- Sensitivity to noise and lights
- Altered sleep pattern

Accommodating Symptoms

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Reflective

Recommendations

***“What helps you
with ... ?”***

- Learning new material
- Remembering assignments
- Staying on track
- Figuring out how to do new things
- Making choices that keep you healthy and safe

Strategies

- Encourage use of rest and low activity periods, naps are encouraged
- Work on accepting coaching from others
- Work on generalizing strategies to new situations
- Alarms (on phone, watch, PDA) to move through the day

Strategies

- Use of a template for routine tasks, on the job, at home and in the community
- Use of ear plugs to increase attention and screen out distractions (Parente & Herman, 1996)
- Partitions/cubicles, at work and quiet space at home
- Model tasks — e.g., turning on a computer, accessing email, etc.

Strategies

- Red lined index card and red stickers: addresses visual neglect, attention and concentration
- Reading guide: addresses a number of visual problems including figure ground deficits, jerky eye movements (nystagmus) and impairment in the ability to smoothly move the eyes
- Non-slip mats (“dycem”) holds books, plates, bowls, paper, etc. in place if one hand/arm has no or limited functioning

Strategies

- Use of pictures for faces/names, basic information for step-by-step procedures (e.g. making coffee)
- Use of a timer to track breaks at work, the time minimum technique and allocated time to puzzle over a problem or vent a frustration
- Audio books or movies and keep the subtitles on (for processing content in the case of memory and comprehension problems *and* increase awareness of nonverbal cues/communication)

Accommodating Symptoms

Watch the two scenarios of Monica and Kathy getting out the door.

Not Helpful? <https://youtu.be/pPfiL4t9aoQ>

Helpful? <https://youtu.be/wu-YMK1ksys>

Source: *Accommodating the Symptoms of Traumatic Brain Injury* <http://about-tbi.org/accommodating-tbi.html> created by the Ohio Valley Center for Brain Injury Prevention and Rehabilitation at Ohio State University (all rights reserved).

One Family's Story

Mary Pat Collins

- Before
- During
- After-what are the strategies and supports that matter

Moderate TBI

- LOC can last from minutes to hours
- May have tissue damage, bleeding or fractures in skull
- Symptoms may include loss of recall of the event, confusion, and impaired verbal memory

Severe TBI

- LOC for 6 or more hours
- Long –Term disability is highly likely
- Behavior, social, and communication impairments may result

-
- 15-20% of TBIs are moderate to severe in nature
 - Documented loss of consciousness
 - Potential skull fractures
 - Significant period (days to weeks) of coma
 - Significant loss of information for a period of time post event
 - Significant and chronic thinking, physical and emotional changes

Resources

- Ohio Valley Center for Brain Injury Prevention and Rehabilitation, 614-293-3802, www.ohiovalley.org
- Brainline, www.brainline.org, website funded through the Defense and Veterans Brain Injury Center offers civilians, returning service members with brain injury, families and professionals a variety of information and resources regarding life after brain injury

Traumatic Brain Injury Is **Not...**

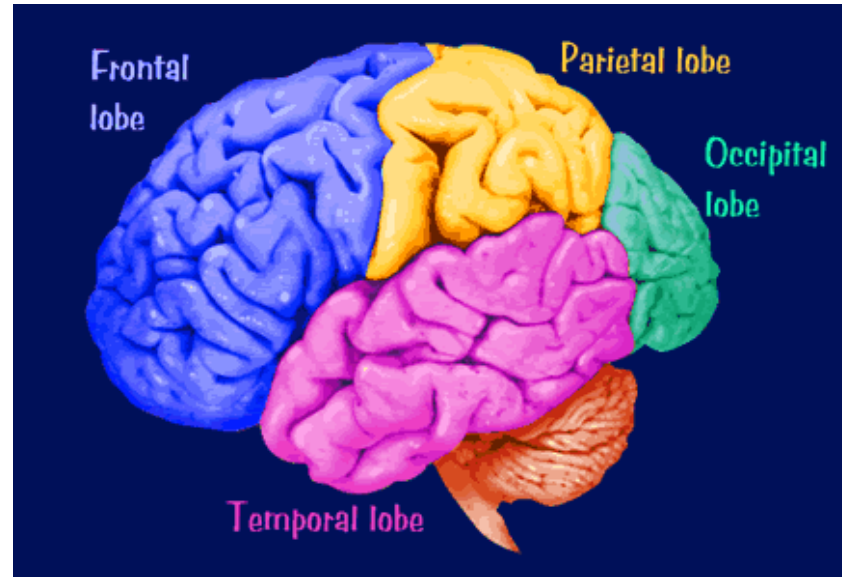
- a new onset of a mental disorder.
- just emotional stress.
- an acquired mental retardation.
- the effects of prolonged drug/alcohol abuse.
- a gradual change in cognitive function.

Frontal Lobe

- Initiation
- Problem solving
- Attention/Concentration
- Inhibition of behavior
- Planning/anticipation
- Self-monitoring
- Motor planning
- Personality/emotions
- Awareness of abilities/limitations
- Organization
- Judgment
- Mental flexibility
- Speaking (expressive language)

Parietal Lobe

- Sense of touch
- Differentiation :size, shape, color
- Spatial perception
- Visual perception



Occipital Lobe

- Vision

Cerebellum

- Balance
- Coordination
- Skilled motor activity

Temporal Lobe

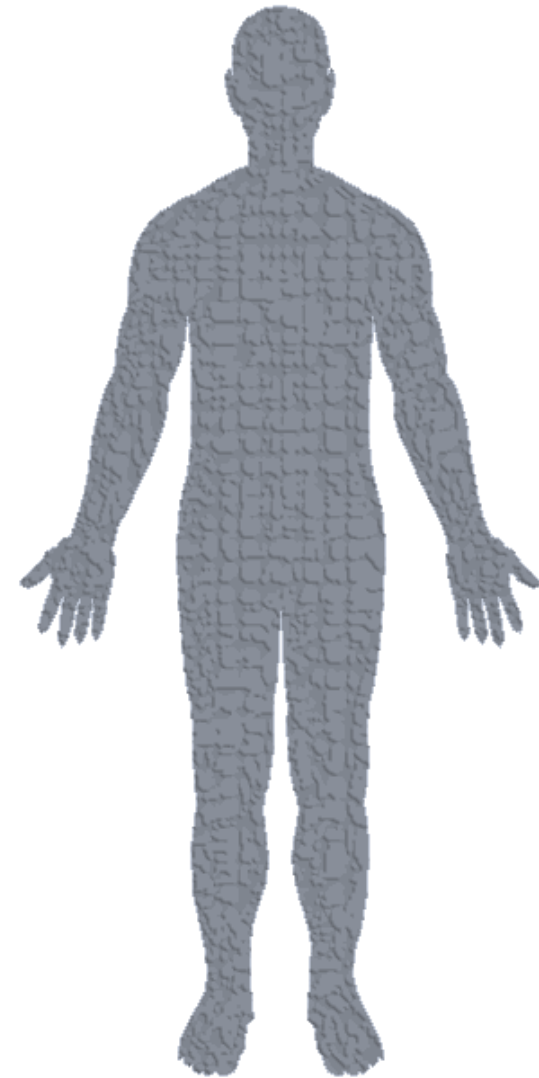
- Memory
- Hearing
- Understanding language (receptive language)
- Organization and sequencing

Brain Stem

- Breathing
- Heart rate
- Arousal/consciousness
- Sleep/wake functions
- Attention/concentration

Physical Changes

- Headaches
- Changes in sleep patterns
- Fatigue
- Seizures
- Mobility – full body or partial
- Speech impairment
- Hearing (i.e. partial loss)
- Vision (i.e. blurred, loss of, light sensitivity, “double vision”,)
- Taste/Smell
- Poor Balance
- Impaired coordination



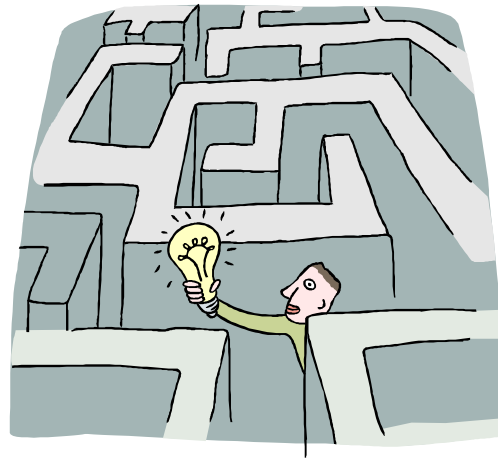
Thinking Changes in “Executive Functioning”

Difficulty
planning/setting goals

Problems being
organized

Difficulty being
flexible

Problems with
attention and
concentration



Difficulty problem solving

Difficulty prioritizing

Decreased awareness of thinking
changes in self

Emotional/Behavioral/Social Changes

Depression

Increased
impulsivity

Anxiety

Rebellious

Difficulty with
self -initiation

Impatience

Self-monitoring

Inability to get along
with others



Socially
inappropriate
behavior

Intolerant

Increased self-focus

Irritability/
agitation

Increased risk taking

Rapid loss of
emotional control
("short fuse")

Before-after
contrasts

An Individual With TBI...

- ✓ May be more difficult to engage.
- ✓ May show poorer follow-through on tasks.
- ✓ Likely to “not remember” prior discussions or routines.
- ✓ May have difficulty profiting from interventions provided.

- ✓ Is more likely to have difficulty adjusting to group living/shared responsibilities.
- ✓ May have greater behavioral control issues.
- ✓ May appear more confused, more inattentive and more fatigued than other residents.

Who is at risk?

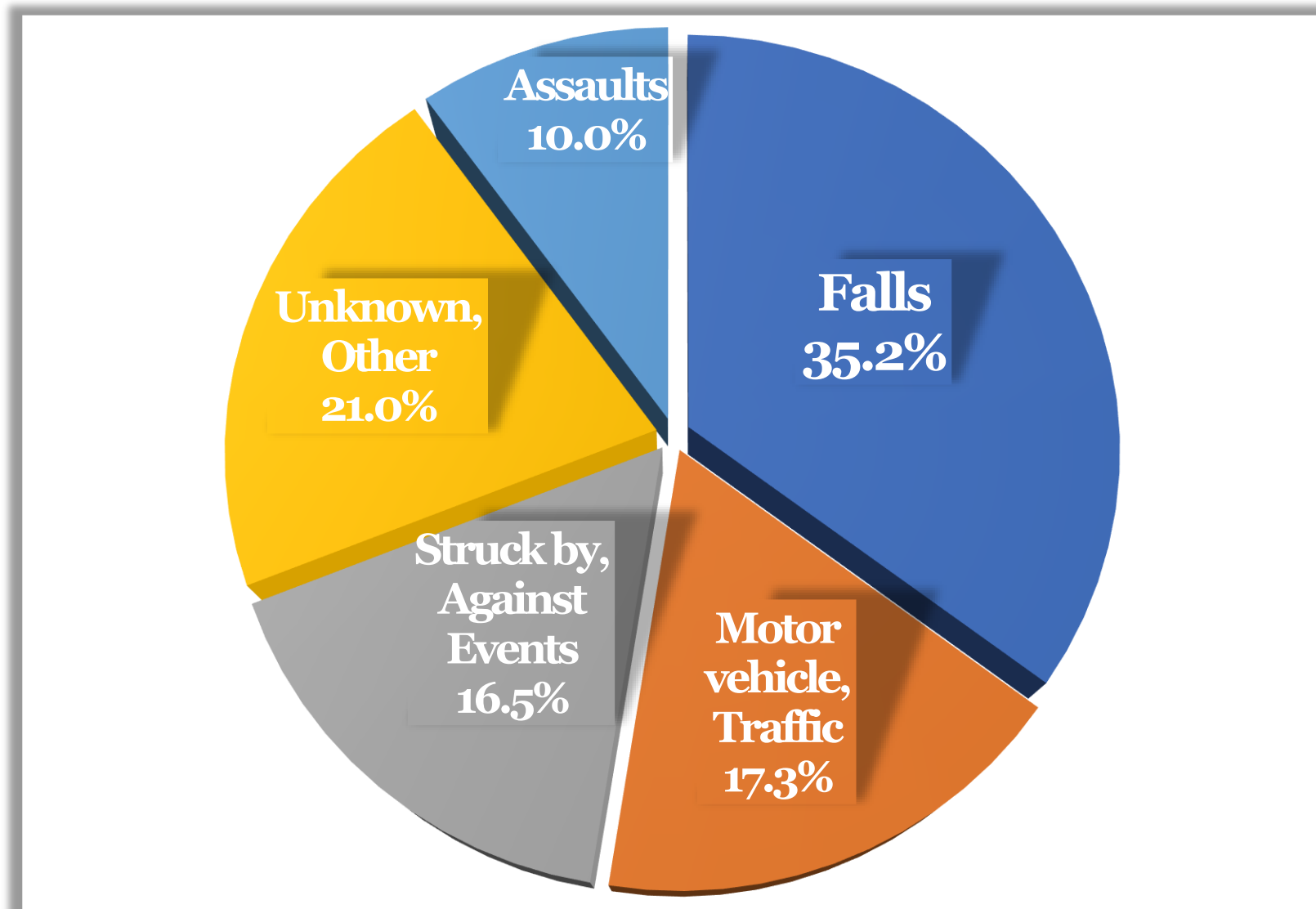
Estimated
1.7 million
injuries
annually¹

Ages most at risk:
0 to 4 years; 15
to 19 years; and
65 years and
older¹

Males have a
higher incident
rate (~75%) than
females.³

After the 1st TBI, the risk of a 2nd TBI is 3
times greater. After a 2nd TBI, the risk of a
third TBI is 8 times greater!

Leading Causes of TBI ^{1*}



*Based of CDC's annual estimates from 2002-2006

"Substance abuse is a risk factor for having a traumatic brain injury and traumatic brain injury is a risk factor for developing a substance abuse problem."

–John Corrigan⁹

Linking TBI and Substance Abuse (SA)^{8, 9}

- Approximately 50% of patients in acute rehab hospitals had a *history* of substance misuse or abuse according to a 2003 study.



- 1 in 5 adolescents and adults admitted to the hospital for treatment of TBI were *intoxicated at time of injury*
- One-Half of the individuals *receiving treatment for SA* report having a history of TBI

Linking TBI and Substance Abuse (SA)^{8, 9}

- Many with prior history of SA will *return to pre-injury levels of use* or greater
- In addition, up to 20% of those with TBI will abuse substances for the *FIRST time*.
- Substance use after TBI results in *poor recovery*



Effect of Substance Use and Abuse on TBI Recovery

- Substance use can hinder the healing process during early recovery
- Individual may have less motivation and/or social support to follow through with recovery efforts
- Substance use increases the risk of another TBI
- Increases effects of common deficits of TBI such as problems with coping, memory, coordination, mood regulation, problem solving, social skills, fatigue and sensitivity to stimulation
- Adds stress to family and support system

Difficulties with Treatment

- A brain injury may not be apparent: the “invisible disability”
- Participants with TBI may be unable to successfully participate in traditional and group setting programs
 - Inappropriate social skills may cause problems in a group
 - Deficits in initiation, self-awareness, and other executive functions can be perceived as uncooperative, disruptive, lazy, or noncompliant
 - General problems with cognitive functioning may prohibit understanding of program rules and materials



Q: How can I assist a client with a TBI in the SA treatment process?⁹

- 1) Acquire knowledge of TBI and provide information to everyone involved in client's treatment program.
- 2) Understand that treatment will be different. It may be longer and slower than usual.
- 3) Make modifications as necessary. For example,
 - Adjust environment to improve attentiveness
 - Simplify or eliminate reading materials.
 - Meet individually to review information from group session.
 - Allow longer time for assignments, etc.
- 4) Repetition, review, and rehearsal are important.

Resources Specific

- **OhioValley.org**
 - Downloadable materials for consumers, family members, and professionals
- **Support Groups**
 - braininjurynetwork.org
- **SAMHSA.gov**
 - Substance Abuse and Mental Health Services Administration

General Resources

Centers of Disease Control

www.cdc.gov/traumaticbraininjury

Brain Injury Association of America

www.biausa.org

BrainLine.org

BrainInjuryEducation.org

University of Missouri TBI Guide

Lash and Associates Publishing

www.lapublishing.com

TraumaticBrainInjuryAtoZ.org

www.tbiGuide.com

Alabama Resources

UAB Model System

www.uab.edu/tbi

Alabama Head Injury Foundation

www.AHIF.org

Alabama Department of Rehabilitation Services

www.rehab.alabama.gov/tbi

Mapping Access to Program Services

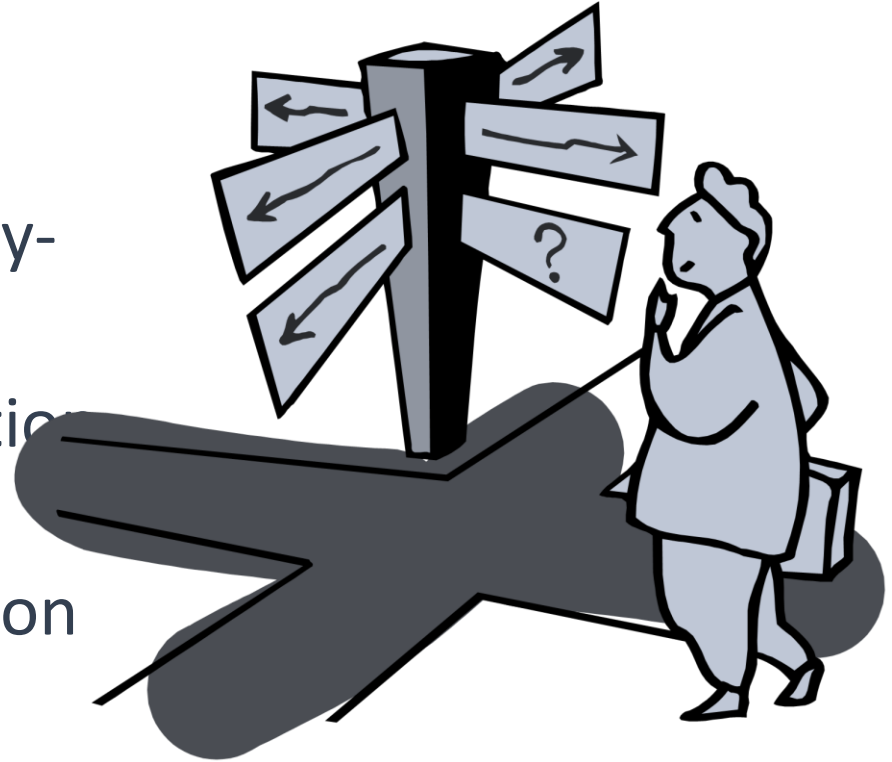
www.rehab.alabama.gov/maps

Alabama Disabilities Advocacy Program

www.adap.net

Core TBI Service System

- Alabama Head Injury Foundation
- Interactive Community-Based Model
- Vocational Rehabilitation Service
- Children's Rehabilitation Service



Alabama Head Injury Foundation (AHIF)

...a state-wide non-profit with the mission to improve the quality of life for people who have survived traumatic brain injuries and for their families.

AHIF helps access available resources and provides services and programs which meet the unique needs of individuals with traumatic brain injury (TBI) as well as spinal cord injury (SCI) in certain programs.

Programs include:

Resource Coordination, Respite Care, Housing Assistance, Information and Referral, Camp Program, Recreation Program, Advocacy, Recreational Support Groups, Car Seats for Kids, Neurobehavior Clinic

***For more information about AHIF, call 205-823-3818 or 800-433-8002, or email
AHIF1@bellsouth.net.***

Interactive Community-Based Model (ICBM)

A program within the Alabama Department of Rehabilitation Services

...an interactive, criterion-based program designed to address employability, independence and community reintegration for individuals with TBI.

To qualify the individual must:

- be less than 2 years post-injury, which was a result of external force neurotrauma
- not be appropriate for traditional vocational rehabilitation services at the time of referral
- be able to benefit from a cognitive and behavioral rehabilitation program

Services may include:

Counseling and Guidance, Cognitive Remediation,
Education, Individual and Family Support,
Management, Behavioral Program Development

Case

TBI

For more information about ICBM, call 205-290-4590 or 888-879-4706, or email maria.crowley@rehab.alabama.gov.

Children's Rehabilitation Service (CRS)

A division within the Alabama Department of Rehabilitation Services

...to assist children and youth in transition from hospital to home, to school, and to the community.

Eligibility:

Any child or adolescent younger than 21 years of age who is a resident of Alabama and has a special health care need.

Services may include:

Information and Referral, Care Coordination, Treatment, Transportation Assistance, Community Education and Support, Evaluation and Assessment, Family Education

***For more information about CRS, Services,
call 1-800-441-7607 (TTY 1-800-499-1816) or contact the CRS office in your area.
www.rehab.alabama.gov***

Vocational Rehabilitation Service (VRS)

A division within the Alabama Department of Rehabilitation Services

...provides services to eligible individuals with disabilities to improve opportunities for employment

To be eligible the individual must:

- Have a physical or mental disability that inhibits obtaining or maintaining employment
- Require vocational rehabilitation services in order to get or keep a job

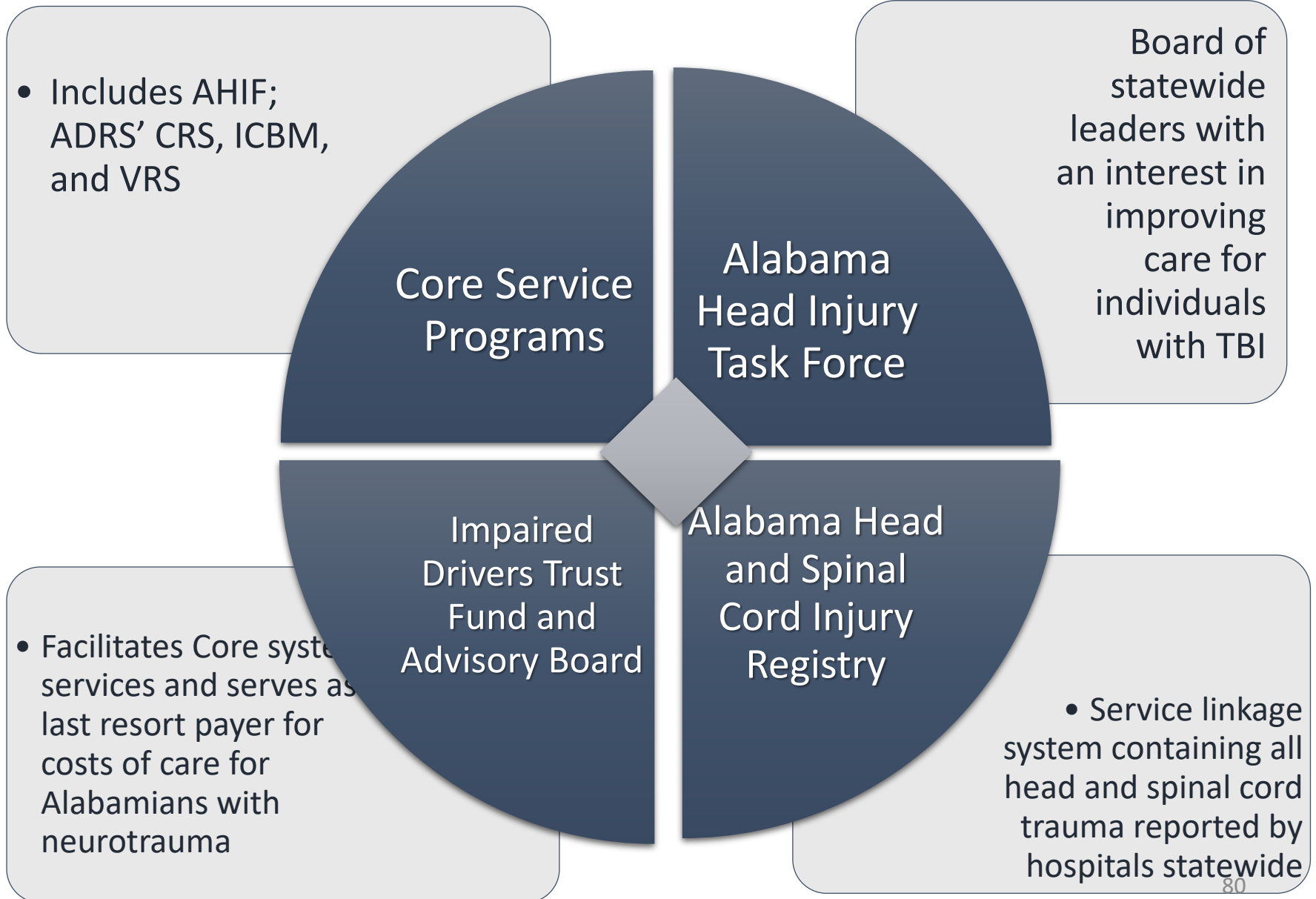
*Eligibility is presumed for recipients of SSI or SSDI who intend to achieve an employment outcome.

Services may include:

Counseling and Guidance, Evaluation, Training Services, Job Placement, Assistive Technology, Supported Employment, Postemployment Services

***For more information about VRS,
call 1-800-441-7607 (TTY 1-800-499-1816) or contact the VRS office in your area,
www.rehab.alabama.gov***

Alabama Statewide TBI Core System



Core System Contacts

Maria Crowley

State Head Injury Coordinator

205-290-4590 or 888-879-4706

maria.crowley@rehab.alabama.gov

www.rehab.alabama.gov/tbi

Alabama Head Injury Foundation

205-823-3818 or 800-433-8002

ahif1@bellsouth.net

www.ahif.org



Supported in part by ALH21MC06738 from the Department of Health and Human Services Health Resources and Services Administration, Maternal and Child Health Bureau. The contents are the sole responsibility of the authors and do not necessarily represent the official views of DHHS.

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