Community of Practice on Traumatic Brain Injury

Transcript Webinar 10: Substance Abuse and Coordinated Care
June 4th, 2014. 2:00-3:00 P.M. ET

>> Rebekah: HI, EVERYBODY.
THIS IS BECCA.
WELCOME TO TODAY’S TENTH MEETING
OF THE COMMUNITY OF PRACTICE ON
TRAUMATIC BRAIN INJURY.
THAT DOES MEAN WE ONLY HAVE TWO
MORE MEETINGS LEFT BEFORE THE
CLOSEOUT OF OUR COMMUNITY OF
PRACTICE, BUT I’M VERY EXCITED
TO HAVE THIS PRESENTATION TODAY
FOCUSING ON SUBSTANCE ABUSE AND
OTHER CO-OCcurring CONDITIONS
WITH TRAUMATIC BRAIN INJURY.
I’LL PASS THINGS TO REBECCA
WILMER TO COVER TIPS OF
TECHNOLOGY ON THE WEBINAR.
>> TWO OPTIONS FOR TODAY’S
AUDIO.
YOU CAN LISTEN TO THE SPEAKERS
OR CALL INTO OUR PHONE LINE AT
866-835-7973.

MUTE TO ELIMINATE ECHO.

PHONE LINES WILL BE OPENED AT THE END FOR Q&A.

TO JOIN IN IN THE DISCUSSION, CALL IN TO THE PHONE LINES.

YOU CAN ALSO RAISE YOUR HAND OR ENTER IN ANY QUESTIONS INTO THE CHAT BOX ON THE LEFT IF YOU ARE UNABLE TO CALL IN.

...

>> Presenter: GREAT, TANKS SO, THANKS SO MUCH, REBECCA.

OUR PRESENTER IS CHARLIE ALKARAZ (PHONETIC), A SOUTHERN ARIZONA NATIVE WHO WORKED IN THE ADDICTION FIELD IN SOUTHERN ARIZONA OVER A DECADE, WORKED TO INCREASE STANCE ABUSE TREATMENT SERVICES FOR AT-RISK MINORITY YOUTH AND FAMILIES AND HIS MOST RECENT ROLE AS CLINICAL DIRECTOR AT AN ADOLESCENT OUTPATIENT CLINIC, MR. ALCARAZ HAS DEVELOPED NETWORKS WITH VARIOUS
YOUTH SERVING COMMUNITY PARTNERS
INCLUDING SCHOOLS, YOUTH
SHELTERS, SOCIAL SERVICE
AGENCIES AND THE JUVENILE
JUSTICE SYSTEM.
IN ADDITION TO IMPROVING
TREATMENT SERVICES FOR AT-RISK
YOUTH, HE SERVED ON THE JUVENILE
COURT JUVENILE DETENTION
ALTERNATIVE AND DISPROPORTIONATE
MINORITY CONTACT AND THE JUVE
FILE DRUG COURT TEAM.
IN THESE ROLES, HE HAS ADVOCATED
FOR THE USE OF EVIDENCE-BASED
TREATMENT MODELS AS AN EFFECTIVE
AND NECESSARY STRATEGY FOR
REDUCING RECIDIVISM AND
DETAINMENT AMONG MINORITY YOUTH.
HE ALSO SERVED AS A POLICY VISOR
TO THE COUNCIL ON COMMISSION,
ADDITION AND TREATMENT WITH
REGARD TO YOUTH SUBSTANCE ABUSE
ISSUES UNDERCOLLUDING UNDERAGE
DRINKING AND SUBSTANCE DRUG USE.
I WOULD LIKE TO PASS THINGS TO
CHARLIE TO TALK TO US ABOUT ENGAGING SUBSTANCE ABUSE PARTNERS AND TRAUMATIC BRAIN INJURY.
CHARLEY, IT'S ALL YOURS.

>> THANK YOU ALL VERY MUCH FOR HAVING ME TODAY.

AS BECCA MENTIONED, I WORK IN TUCSON FOR PEMA PREVENTION PARTNERSHIP AND WE HAVE BEEN DOING TREATMENT TORE SERVICES FOR ADOLESCENTS FOR ABOUT THE PAST DECADE OR SO.

WE'LL DO A COUPLE OF THINGS TODAY DURING THE PRESENTATION. WE'RE GOING TO -- LET ME SEE, BECCA, I SEEMED TO HAVE LOST THE PRESENTATION HERE IN FRONT OF ME ON THE SCREEN.

>> Presenter: WE'RE WORKING ON PULLING IT BACK UP.

>> OWN OUR PRESENTATION TOORKSD WE'LL GO OVER BRIEF DEFINITIONS OF TRAUMATIC BRAIN INJURY.
I KNOW YOU HAVE BEEN WORKING FOR
A WHILE ON THIS TOPIC
I'LL FOCUS ON SUBSTANCE ABUSE AND TREATMENT DISORDERS SO WE CAN UNDERSTAND THE DIFFERENCE BETWEEN TRAUMATIC BRAIN INJURY AND SUBSTANCE ABUSE.
WE'LL DO RAE CAP ON SYMPTOMS OF TRAUMATIC BRAIN INJURY AND THIS IS SPECIFIC ON SUBSTANCE ABUSE AND CO-OCCURRING DISORDERS.
WE'LL TALK ABOUT THE FACTS OF SUBSTANCE ABUSE DISORDERS AND TRAUMATIC BRAIN INJURY, AND THEN A COUPLE OF THINGS WE'LL TALK ABOUT IS ESPERT OR SCREENING PREVENTION AND REFERRAL TO TREATMENT AND HOW THAT REFERS TO TRAINING PREVENTION AND THEN WE'LL TALK ABOUT THE SCREENING HERE AS OUR TREATMENT SERVICE.
ONE OF THE TOOLS WE FOUND TO BE HELPFUL.
LASTLY, WE'LL FINISH WITH BEST PRACTICE APPROACH FOR SERVING FOLKS WHO HAVE CO-OCCURRING AND
SUBSTANCE ABUSE DISORDERS AND
TRAUMATIC BRAIN INJURY.
SO THAT WILL FINISH OFF THE
PRESENTATION.
I SEE IT AGAIN.
LOOKS LIKE WE'RE READY.
WE'LL START WITH THE DEFINITIONS
OF TRAUMATIC BRAIN INJURY THAT I
FOUND THAT I THOUGHT WERE
INTERESTING.
THE FIRST ONE IS FROM THE
CENTERS FOR DISEASE CONTROL.
SAYS CRANIOCEREBRAL TRAUMA
ASSOCIATED WITH NEUROLOGICAL OR
NEUROPSYCHOLOGICAL
ABNORMALITIES, SKULL FRACTURE,
INTRAINIAL LEAGUES OR DEATH.
THE BRAIN INJURY ASSOCIATION OF
AMERICA DEFIANE T.B.I. AS
ALTERATION IN BRAIN FUNCTION OR
OTHER EVIDENCE OF BRAIN
PATHOLOGY, CAUSED BY AN EXTERNAL
FORCE.
SO THE CHANGE IN FUNCTION IS KEY
TO TRAUMATIC BRAIN INJURY.
As we look at the symptoms of traumatic brain injury, you all are probably quite familiar with these, we're seeing major symptoms associated with motor and sensory effects, fatigue, lethargy, sleep disturbances, cognitive problems, obviously having problems planning, following through, problem solving, problems with judgment, impaired concentration.

There are also the commotional effects including increases in aggression and irritability, there's also anxiety, difficulty regulating our emotions so it's oftentimes emotional outbursts will occur.

What I want to focus on is how similar these things may be to other things we see and specifically as we talk about substance abuse and co-occurring mental health disorders.
WHAT WE FIND IS A LOT OF THE
SYMPTOMS TEND TO OVERLAP WITH
PSYCHIATRIC DISORDERS AND ARE
MITS DIAGNOSED OR LACK OF
DIAGNOSIS OF TRAUMATIC BRAIN
INJURY AND HOW THOSE CONTRIBUTE
TO THE BEHAVIORS OF A PATIENT OR
CLIENT.
THIS OVERLAP IS SOMETHING I
WOULD WANT TO POINT TO AS FAR AS
A REASON WHY WE WOULD WANTED TO
SCREEN FOR TRAUMATIC BRAIN
INJURY AND FOR OTHER
PSYCHOLOGICAL DISORDERS AS WELL
AS SUBSTANCE ABUSE DISORDERS
BECAUSE OF THE OVERLAP.
SUBSTANCE ABUSE IS A RISK FOR
T.B.I.
WE'LL TALK ABOUT THAT
SPECIFICALLY.
THERE IS BETWEEN 33% AND 80% OF
HISTORIES OF PEOPLE WHO HAVE
SUBSTANCE ABUSE DISORDERS ALSO
HAVE -- I'M SORRY, OF TRAUMATIC
BRAIN INJURY, HAVE SUBSTANCE
MISUSE.
SO THAT'S A LARGE PERCENTAGE.
ALCOHOL IS THE ONE MOST COMMONLY
REPORTED.
ALCOHOL USED AT TIME OF
TRAUMATIC BRAIN INJURY IS ALSO
VERY COMMON.
THREE OUT OF FOUR T.B.I.
PATIENTS HAVE ALCOHOL IN THEIR
BLOOD UPON ADMISSION TO THE
HOSPITAL.
SO THIS IS A SIGNIFICANT FINDING
THAT TIES IN THE MISUSE OF
ALCOHOL AND DRUGS WITH THE
OCURRENCE OF TRAUMATIC BRAIN
INJURY.
WE ALSO SEE THAT ABOUT A THIRD
TO HALF OF THE FOLKS WHO ARE IN
THE HOSPITAL FOR TRAUMATIC BRAIN
INJURY ARE ACTUALLY INTOXICATED
AT THE TIME OF INJURY SO, NOT
ONLY DO THEY HAVE ALCOHOL IN
THEIR SYSTEM, BUT THEY HAVE
ENOUGH ALCOHOL TO THE POINT
WHERE THEY'RE INTOXICATED.
SO, AGAIN, THAT BEING A PRETTY SIGNIFICANT CONTRIBUTING FACTOR TO THE TRAUMATIC BRAIN INJURY.

LASTLY, ON THE SLIDE, YOU WILL SEE THAT ABOUT 54% OF FOLKS WHO SUSTAIN A SECOND TRAUMATIC BRAIN INJURY ARE UNDER THE INFLUENCE OF ALCOHOL OR OTHER DRUGS.

SO, AGAIN, MORE THAN HALF OF THE FOLKS WHO GET A SECOND TRAUMATIC BRAIN INJURY, IT'S LIKELY IT'S RELATED TO SOME MISUSE OF ALCOHOL OR SUBSTANCES.

SO, AGAIN, A VERY SIGNIFICANT FINDING.

...

AS WE CONTINUE TO LEARN ABOUT STANCE ABUSE DISORDERS AND TRAUMATIC BRAIN INJURY, WE SEE TRAUMATIC BRAIN INJURY IS ACTUALLY COMMON AMONG FOLKS IN SUBSTANCE ABUSE DISORDERS TREATMENT.

SO BETWEEN 38% AND 63% OF PEOPLE IN TREATMENT FOR SUBSTANCE ABUSE
HAVE HAD A PRIOR TRAUMATIC BRAIN INJURY.

THE OTHER THING WE SEE IS THAT STANCE ABUSE DISORDERS -- THE OTHER THING WE KNOW IS SUBSTANCE ABUSE DISORDERS AND TRAUMATIC BRAIN INJURY, COMPOUND THE EFFECTS ON THE BRAIN.

AS THE BRAIN IS HEALING FROM TRAUMATIC BRAIN INJURY, THE USE OF SUBSTANCES INCLUDING ALCOHOL OFTEN INTERFERES WITH THE BRAIN'S ABILITY TO FULLY ACCOMMODATE OR MAKE THE ACCOMMODATIONS TO RECOVER FROM A TRAUMATIC BRAIN INJURY.

TRAUMATIC BRAIN INJURY IS ALSO ASSOCIATED WITH ABSTINENCE OR REDUCTION.

TYPICALLY AFTER TRAUMATIC BRAIN INJURY, THERE'S A PERIOD OF INTENSE CLINICAL MONITORING, SPECIFICALLY IN HOSPITALIZATION AND ALSO AS THEY CONTINUE CARE OUTSIDE THE HOSPITAL, SO
INCREASED MONITORING AND VINAL
LANCE WHICH TYPICALLY RESULTS IN
REDUCED SUBSTANCE ABUSE AFTER
THE BRAIN INJURY.

ALSO, THERE'S ADVICE TYPICALLY
FROM OUTPATIENT HEALTH CARE
PROVIDERS TO ABSTAIN FROM
SUBSTANCES AS WELL AS DECISIONS
FROM THE PATIENT TO MAKE CHANGES
AFTER THEIR LIFE IN THE BRAIN
INJURY.

... 

HOWEVER, WE ALSO KNOW THAT FOR
SOME PEOPLE THE REDUCTION IN USE
IS ONLY TEMPORARY.

THERE'S A MINORITY OF FOLKS WHO
BEGIN DRINKING AGAIN OR ACTUALLY
INCREASE THEIR ALCOHOL
CONSUMPTION IN THE FIRST YEAR
AFTER THE INJURY AND OFTENTIMES
THAT MAY BE RELATED TO INCREASED
SYMPTOMS ASSOCIATED WITH
DEPRESSION DUE TO THE CHANGES
THAT MAY HAVE HAPPENED AS A
RESULT OF THE BRAIN INJURY.
SO, AGAIN, IN ORDER TO
SELF-MEDICATE THESE FEELINGS OR
SENSES THAT MAY OCCUR, THEY ARE
TYPICALLY -- OR THEY MAY DRINK
MORE.
SUBSTANCE ABUSE BEFORE T.B.I. IS
A RISK FACTOR FOR HEAVY DRINKING
AFTERWARDS, SO THAT MAKES SENSE.
WE SEE ABOUT 50% OF TRAUMATIC
BRAIN INJURY SURVIVORS RETURN TO
PRE-INJURY USE PATTERNS WITHIN
THE FIRST YEAR.
SO, AGAIN, ABOUT HALF OF THEM
WILL RETURN TO THOSE PRE-BRAIN
INJURY DRINKING PATTERNS WITHIN
THE FIRST YEAR.
SO ALTHOUGH THERE'S THE INITIAL
MAYBE ABSTINENCE OR CESSATION OF
SUBSTANCE USE OR EVEN A DECREASE
IN THE FIRST YEAR, ABOUT HALF OF
THEM WILL GO BACK TO PRE-USE
PATTERNS.
SO A QUICK RECAP:
WHAT DO ALL THESE FACTS TELL US?
WHAT THEY TELL US, WHAT THEY
POINT TO IS THAT AT-RISK ALCOHOL AND SUBSTANCE ABUSE PLAYS A SIGNIFICANT ROLE AND IS A CONTRIBUTING FACTOR TO TRAUMATIC BRAIN INJURY.

NEARLY HALF OF ALL TRAUMA BEDS IN HOSPITALS ARE ACTUALLY OCCUPIED BY PATIENTS INJURED WHILE UNDER THE INFLUENCE OF ALCOHOL SO, AGAIN, THIS IS A SIGNIFICANT ISSUE, THE USE AND MISUSE OF ALCOHOL AND DRUGS IS SIGNIFICANTLY CONTRIBUTING TO TRAUMATIC BRAIN INJURY.

PATIENTS SEEKING TREATMENT IN THE E.R. ARE MORE LIKELY TO SELF-DISCLOSE ALCOHOL USE THAN IN PRIMARY CARE SETTINGS. SO HERE WE SEE AN OPPORTUNITY, AN OPPORTUNITY TO POSSIBLY IMPACT THE SUBSTANCE ABUSE DECISION MAKING THAT THE FOLKS THAT COME INTO THE E.R. HAVE IN THE FUTURE WHICH WILL LEAD US INTO THE NEXT STRATEGY THAT WE
WILL BE TALKING ABOUT.

THE OTHER THING THAT THIS TELLS
US THAT THE EFFORTS TO REDUCE
THE RISK FOR TRAUMATIC BRAIN
INJURY ARE NOT LIKELY TO BE
SUCCESSFUL IF WE'RE NOT
ADDRESSING THE UNDERLYING RISK
FACTORS WHICH, IN THIS CASE, IT
LOOKS LIKE ABOUT HALF OF THEM
ARE THERE AS A RESULT OF ALCOHOL
USE AND, SO, WE NEED TO ADDRESS
THOSE UNDERLYING RISKS FACTORS
OF SUBSTANCE ABUSE.

LASTLY ON THE SLIDE YOU WILL SEE
THAT ALTHOUGH WE SEE FOLKS WHO
PRESENT AT EMERGENCY ROOMS AND
TRAUMA BEDS WITH OBVIOUS
UNHEALTHY DRINKING HABITS, AS
FEW AS 15% ACTUALLY HAVE THEIR
RISKY BEHAVIORS ADDRESSED DURING
THEIR VISIT.

SO, AGAIN, LESS THAN 20% OF
FOLKS WILL HAVE SOME SORT OF
INTERVENTION THAT DIRECTLY
ADDRESSES THEIR SUBSTANCE-USING
BEHAVIORS THAT MAY HAVE LED TO THE OCCURRENCE OF A TRAUMATIC BRAIN INJURY.

... THE OTHER THING THAT WE KNOW IS THERE'S THIS IMMEDIACY BETWEEN THE EVENT BRINGING THEM TO CARE AND THE CONNECTION BETWEEN RISKY DRINKING AND INJURY.

SO THERE'S A SENSE OF URGENCY THAT CAN BE DEVELOPED IN THIS POLITICAL TIME.

IT CAN PREVENT A CRISIS THAT MOTIVATES A PERSON TO CHANGE THEIR DRINKING BEHAVIOR AND CREATES AN OPTIMUM TIME FOR EMERGENCY PERSONNEL TO INTERVENE.

SO WE HAVE AN OPPORTUNITY AT THE MOMENT WHEN SOMEONE IS ADMITTED INTO A HOSPITAL, INTO A TRAUMA CENTER, HAS SUFFERED A BRAIN INJURY OR OTHER INJURY THAT PUTS THEM AT MORE RISK OR MAKES IT MORE LIKELY THEY WILL SUSTAIN A
TRAUMATIC BRAIN INJURY IN THE FUTURE.

WE SEE THE LAST THING ON THE SLIDE IS A PATIENT’S OPENNESS TO DISCUSS ALCOHOL PROBLEMS DECREASES SIGNIFICANTLY AFTER A COUPLE OF DAYS. SO IT’S A SHORT WINDOW OF OPPORTUNITY THAT WE SEE HERE WHEN FOLKS ARE PRESENTING TO THE EMERGENCY ROOM THEY'RE ACTUALLY QUITE WILLING TO TALK ABOUT THE DRINKING BEHAVIORS INITIALLY BUT THE WINDOW IS SHORT SO WILL CLOSE WITHIN A COUPLE OF DAYS. SO WHAT DOES THAT MEAN FOR US? WE HAVE AN OPPORTUNITY TO PREVENT TRAUMATIC BRAIN INJURY IN THE FUTURE. THIS FIRST MODEL IS CALLED THE SBIRT MODEL, STANDS FOR SCREENING, BRIEF INTERVENTION. WE’LL TALK ABOUT THE SUBSTANCE ABUSE DISORDERS SPECIFICALLY BECAUSE IT SEEMS TO BE A VERY
SIGNIFICANT FACTOR CONTRIBUTING TO TRAUMATIC BRAIN INJURY.

SO THE SCREENING PORTION IS DESIGNED TO QUICKLY ASSESS THE SEVERITY OF SUBSTANCE ABUSE AND IDENTIFY APPROPRIATE INTERVENTIONS.

THE THEORY BEHIND SCREENING IS UNIVERSAL SCREENING.

WE MAKE NO ASSUMPTIONS OF WHO SHOULD BE SCREENED FOR SUBSTANCE ABUSE DISORDERS.

EVERYONE GETS TREATED EQUALLY AND WE SCREEN EVERYONE.

IF SOMEONE SCREENS POSITIVE FOR HAVING A SUBSTANCE ABUSE OR MISUSE ISSUE, WE WILL PROVIDE A BRIEF INTERVENTION.

SO THE BRIEF INTERVENTION IS DESIGNED TO CREATE AWARENESS OF THE SUBSTANCE ABUSE.

MOTIVATION IS ALSO DEVELOPED.

LASTLY DEPENDING ON THE RESULTS OR THE SCORES OF THE ASSESSMENT FOR SUBSTANCE ABUSE DISORDERS,
THERE’S THE OPPORTUNITY TO PROVIDE A REFERRAL TO TREATMENT. SO THEN REFERRALS TO TREATMENT ARE PROVIDED FOR FOLKS WHO MAY NEED MORE EXTENSIVE TREATMENT OR ACCESS TO SPECIALTY CARE. MAYBE SOMEONE WHO PRESENTS WITH SYMPTOMS OF A CO-OCCURRING DISORDER OR SOMEONE WHO PRESENTS WITH SUBSTANCE DEPENDENCE DISORDERS. THIS ENTIRE PROCESS FROM SCREENING, BRIEF INTERVENTION AND REFERRAL TO TREATMENT HAS BEEN BOILED DOWN TO A TIME OF ABOUT 15 MINUTES AND, SO, AGAIN, IT’S BEEN SEEN AS SOMETHING THAT’S BEEN QUITE EFFECTIVE ESPECIALLY IN EMERGENCY ROOM SETTINGS AND WE’LL TALK MORE ABOUT THE OUTCOMES THAT IT’S PRODUCED. 
...
BEFORE WE GET INTO THE DETAILS, I WANTED THE DO A QUICK POLL.
SO I'VE GOT A COUPLE OF QUESTIONS FOR YOU ALL.

THE FIRST ONE IS ABOUT HOW MANY OF YOU HAVE ACTUALLY HEARD OF THE SBIRT MODEL?

AND THE SECOND POLL IS ABOUT HOW CURRENTLY USES THE SBIRT MODEL TO ADDRESS T.B.I.

ALL RIGHT.

SO I'M GOING TO GIVE IT A MINUTE SO ALL THE RESULTS CAN COME IN.

SO LOOKS LIKE A MAJORITY OF YOU HAVE NOT HEARD ABOUT THE SBIRT MODEL.

ALMOST 50/50.

THAT'S GOOD.

THERE'S KNOWLEDGE ABOUT THE SBIRT MODEL.

WHAT I'M SEEING IN THE SECOND POLL QUESTION IS THAT NO ONE IS REALLY USING THE SBIRT MODEL TO ADDRESS TRAUMATIC BRAIN INJURY, WHICH IS SOMETHING THAT I SUSPECTED BUT I WASN'T SURE.

I THINK THE SBIRT MODEL IS
TRADITIONALLY RECOGNIZED AS A MODEL TO ADDRESS SUBSTANCE USING BEHAVIOR, BUT IF WE DON'T RECOGNIZE THE CONNECTION BETWEEN SUBSTANCE USING BEHAVIOR AND TRAUMATIC BRAIN INJURY, THEY'RE TYPICALLY NOT CORRELATED OR SEEN AS A SUPPORTING OR HELPFUL MODEL WITHIN THE CONTEXT OF TRAUMATIC BRAIN INJURY.

SO WE'LL TALK A LITTLE BIT MORE ABOUT SBIRT.

WE KNOW IT'S EFFECTIVE BECAUSE IT CAN CATCH ALCOHOL AND DRUG PROBLEMS BEFORE THEY DRAMATICALLY AFFECT A PERSON'S LIFE.

WITHIN THE CONTEXT OF OUR CONVERSATION, DRAMATICALLY AFFECTING A PERSON'S LIFE IN THIS CASE WOULD BE SUFFERING A TRAUMATIC BRAIN INJURY.

SO, AGAIN, IF WE'RE DOING UNIVERSAL SCREENING FOR ALL THE FOLKS WHO COME THROUGH THE
EMERGENCY ROOM OR TRAUMA ROOM DOORS, THERE'S A GREAT CHANCE WE CAN AGAIN CATCH THESE, ADDRESS THESE SUBSTANCE ABUSE DISORDERS BEFORE THEY TRANSLATE INTO TRAUMATIC BRAIN INJURY.

THE SECOND THING WE KNOW IS IT'S EFFECTIVE BECAUSE IT USES SIMPLE SCREENING AND BRIEF MOTIVATION TO AFFECT CHANGE.

SO WE'RE TALKING ABOUT A 15-MINUTE INTERVENTION THAT CAN HAVE DRAMATIC EFFECTS ON PEOPLE'S LIVES, BY REDUCING SUBSTANCE USING BEHAVIORS, IF WE REDUCE THE BEHAVIORS THEY'RE LESS LIKELY TO SUFFER TRAUMATIC BRAIN INJURY AS A RESULT OF THOSE.

LASTLY, SBIRT IS EFFECTIVE BECAUSE IT TAKES AWAY THE STIGMA ASSOCIATED WITH ALCOHOL AND DRUG TREATMENT BY NORMALIZING IT IN A HEALTHCARE SETTING.

WE'RE DOING UNIVERSALS
SCREENING, PROVIDING THE SERVICES IN HEALTHCARE SETTINGS IN EMERGENCY ROOMS, TRAUMA CARE AND PRIMARY CARE CENTERS SO THERE'S LESS STIGMA SURROUNDING THE TREATMENT OF ALCOHOL AND DRUG DISORDERS.

AS I MENTIONED BEFORE, SBIRT'S BEEN AROUND FOR QUITE SOME TIME NOW AND WE'RE FORTUNATE TO HAVE DOCUMENTED SUCCESS OF THE FACT THAT IT'S WORKING, SPECIFICALLY IN E.R. AND TRAUMA CENTERS, BRIEF INTERVENTION STORIES INDICATE THEY ARE MORE EFFECTIVE THAN NO COUNSELING WHICH MAKES SENSE, AND AS EFFECTIVE AS TRADITIONAL THERAPY IN ACHIEVING REDUCTIONS IN ALCOHOL CONSUMPTION.

WE SAW EARLIER ABOUT 50% OF THE FOLKS IN OUR TRAUMA BEDS ARE THERE BECAUSE THEY HAVE BEEN INTOXICATED AND HAVE SUFFERED SOME SORT OF INJURY.
AGAIN, IF WE CAN REDUCE LEVELS
OF INTOXICATION OR ALCOHOL
CONSUMPTION, WE’RE MORE LIKELY
TO PREVENT TRAUMATIC BRAIN
INJURIES AND OTHER INJURIES
WHICH TAKE UP THE VALUABLE
RESOURCES IN OUR TRAUMA CENTERS
AND E.R.s.
IT’S ALSO EFFECTIVE IN ACHIEVING
SUCCESSFUL REFERRALS AND
PARTICIPATION IN ALCOHOL AND
SUBSTANCE ABUSE PROGRAMS.
PEOPLE ARE GETTING BETTER
BECAUSE THEY’RE ENGAGING IN THE
OTHER SERVICES.
IT’S ALSO EFFECTIVE IN
REDUCTIONS IN DRINKING AND
DRIVING AND REMOVING TRAFFIC
VIOLATIONS.
SO DRINKING AND DRIVING ARE
OTHER ISSUES THAT CONTRIBUTE TO
TRAUMATIC BRAIN INJURY.
LASTLY, WHAT WE SEE IS THEY HAVE
BEEN SUCCESSFUL IN ACHIEVING
REDUCTIONS IN REPEAT INJURIES
AND INJURY HOSPITALIZATIONS.
SO THEN MANY OF THESE INJURIES
ARE ALSO INJURIES THAT
CONTRIBUTE OR RESULT IN
TRAUMATIC BRAIN INJURY.
IN ADDITION TO BEING EFFECTIVE,
SBIRT IS ALSO COST EFFECTIVE,
WHICH IS SOMETHING WE'VE ALL GOT
to consider.
WHAT WE SEE IS WITH DECREASES IN
UNHEALTHY DRINKING, WE ALSO SEE
THE SAME REDUCTIONS IN
HOSPITALIZATION AND HEALTH CARE
COSTS.
SO WHAT WE KNOW IS THERE'S BEEN
A SIGNIFICANT REDUCTION IN COSTS
IN RELATION TO EMERGENCY ROOM
RESOURCES.
IT'S EXPENSIVE TO PROVIDE THE
SERVICES SO IF WE REDUCE THE
FREQUENCY OF RETURN TO EMERGENCY
DEPARTMENTS THERE'S LESS
RESOURCES THAT HAVE TO BE
DEDICATED TO THOSE, SO WE SAVE
MONEY THERE.
A recent cost analysis of brief intervention in a primary care setting found a net cost savings of about $330 per intervention. So if we’re providing these services, we’re seeing fewer people through the emergency room, fewer people coming back to primary care because to have the exacerbation of their health issues, and, so, we’re seeing savings in those ways.

At the bottom of the slide, we’ve also got a couple of examples. The first one is the Wisconsin SBIRT. The Wisconsin SBIRT sees a reduction in hospital costs, emergency room visit resulting in $1,000 per person screened. Significant dollars. $1,000 for every person who actually participates in the
SBIRT SCREENING PROCESS.
SO THAT'S A BIG SAVINGS IF YOU'RE SCREENING EVERYONE WHO COMES THROUGH.
THE TEXAS SBIRT ALSO SAW A NET SAVINGS OF ABOUT $3.81 IN EMERGENCY DEPARTMENT COSTS FOR EVERY DOLLAR INVESTED IN SCREENING.
SO, AGAIN, WE'RE SEEING SIGNIFICANT RETURN ON INVESTMENT HERE BASED ON DOING THESE UNIVERSAL SCREENINGS.
THEY ALSO SAW EMERGENCY ROOM -- EXCUSE ME -- A 5% REDUCTION IN CURRENT ALCOHOL-RELATED INJURIES.
SO, AGAIN, SIGNIFICANT REDUCTIONS IN ALCOHOL-RELATED INJURIES, MANY ASSOCIATED WITH TRAUMATIC BRAIN INJURY.
...
SO WE'RE GOING TO SWITCH GEARS A LITTLE BIT HERE IN THE LAST HALF OF THE PRESENTATION TO DISCUSS
ONE OF THE OPPOSITE HERE WHERE WE'RE ALSO SCREENING FOLKS IN SUBSTANCE ABUSE DISORDERS TREATMENT FOR BRAIN INJURY. AS YOU KNOW IN THE PREVIOUS SLIDES, BRAIN INJURY IS PREVALENT AMONG FOLKS WHO ARE IN SUBSTANCE ABUSE DISORDERS TREATMENT BECAUSE THE SUBSTANCE ABUSE DISORDERS HAVE RESULTED IN OFTENTIMES TRAUMATIC BRAIN INJURY AND OTHER INJURIES AS WELL. WE USE THE HELPS BRAIN INJURY SCREENING TOOL. IT'S BEEN HELPFUL FOR US TO UNDERSTAND OR GET AN INITIAL ASSESSMENT OF SCREENING OF WHETHER OR NOT THAT MAY BE AN ISSUE WITHIN TREATMENT AND SOMETHING WE MAY NEED TO MAKE REFERRALS FOR. IT WAS DEVELOPED BY SCARISBRIC IN 1981 AND IT'S A QUICK TOOL. WE'RE GOING TO REVIEW EACH OF
THE SCREENING DOMAINS QUICKLY SO YOU GET AN IDEA OF WHAT IT TOUCHES ON AND THEN WE’LL TALK ABOUT SCORING.

THE FIRST QUESTION IS HIT HEAD, HAVE YOU EVER BEEN HURT OR HIT YOUR HEAD.

WE WORK WITH ADOLESCENTS, SO WE SEE QUITE A BIT OF ACTIVITY THAT RESULTS OFTEN TIMES IN HEAD OR BRAIN INJURIES -- SKATEBOARDING, FOOTBALL, MIXED MARTIAL ARTS IS SOMETHING THAT SEEMS TO BE INCREASING IN POPULARITY, SO WE’RE ABLE TO PROBE FOR THESE THINGS, AGAIN, BASED ON THE CONTEXT OF THEIR LIFE.

WE ALSO HAVE SUPPLEMENTAL INFORMATION OR ASSESSMENT THAT WE USE TO CROSS-REFERENCE, INCLUDING WHEN THEY HAVE BEEN TO HOSPITALS OR EMERGENCY ROOMS, AND SO, WE MAY FOLLOW UP WITH THOSE.
THEY MAY NOT BE RELATED TO A HEAD INJURY BUT WE ALWAYS WANT TO BE SURE TO CONFIRM.

SO A VERY SIMPLE QUESTION FOR A YOUNG PERSON BEING SCREENED, HAVE YOU EVER HIT YOUR HEAD OR BEEN HIT ON THE HEAD?

THE E. IN HELP STANDS FOR EMERGENCY ROOM AND MEDICAL CARE.

SO THE QUESTION HERE IS WERE YOU EVER SEEN IN THE EMERGENCY ROOM HOSPITAL OR BY A DOCTOR BECAUSE OF AN INJURY TO YOUR HEAD?

SO, AGAIN, WE WANT TO CONSIDER PARAMEDICS CALLED TO THE SCENE AFTER HEAD INJURY OR IF ADDITIONAL MEDICAL ATTENTION WAS RECOMMENDED.

THIS MAY HAVE BEEN SOMETHING WHERE THEY WERE DENIED OR DECLINED TREATMENT SERVICES BASED ON LACK OF INSURANCE OR FINANCIAL CRISIS, BUT, AGAIN, WE WANT TO KNOW IF THERE WAS SOME SORT OF EMERGENCY ROOM CARE OR
IF IT WAS RECOMMENDED FOR THEM 
TO RECEIVE ADDITIONAL TREATMENT. 

THE L. IN HELP STANDS FOR LOSE 
CONSCIOUSNESS. 

SO THE QUESTION IS DID YOU EVER 
LOSE CONSCIOUSNESS OR EXPERIENCE 
A PERIOD OF BEING DAZED OR 
CONFUSED BECAUSE OF AN INJURY TO 
YOUR HEAD. 

SO, AGAIN, WE ALWAYS TRAIN OUR 
FOLKS TO KEEP IN MIND THAT 
LOSING CONSCIOUSNESS IS AN 
INDICATOR BUT NOT ALL THOSE WHO 
SUFFER A TRAUMATIC BRAIN INJURY 
WILL LOSE CONSCIOUSNESS. 

SO IT'S NOT A REQUIREMENT BUT AN 
INDICATOR. 

WE UNDERSTAND WITHIN OUR YOUNG 
FOLKS-POPULATION THAT THEY MAY 
NOT RECOGNIZED THE IDEA OF BEING 
DAZED AND USE ALTERNATIVE 
TERMINOLOGY. 

WE SEE ADOLESCENTS USE WORDS 
SUCH AS BEING "ROCKED" FOR BEING 
DAZED.
SO JUST PAYING ATTENTION TO THE TERMINOLOGY USED WITHIN WHATEVER POPULATION YOU SERVE IN YOUR SCREENING.

THE P. IN HELP STAND FOR PROBLEMS.

AGAIN, WE'RE LOOKING FOR ANY CHANGES OR PROBLEMS IN THE DAILY LIFE.

THE QUESTION IS DO YOU Experience any of these problems in your daily life since you hit your head?

WE'RE GOING TO GO THROUGH EACH OF THESE.

WE LIKE TO MAKE SURE WE'RE CONSIDERING MOTIVATIONAL INTERVIEWING, STRATEGIES AND USING WORDS SUCH AS CHANGES INSTEAD OF "PROBLEMS" BECAUSE IT'S A MORE FRIENDLY TERM.

WE LIKE TO USE OPEN-ENDED QUESTIONS FIRST, LIKE HAVE YOU EXPERIENCED ANY PROBLEMS OR CHANGES IN YOUR LIFE SINCE YOU
HIT YOUR HEAD AND THEN FOLLOW UP WITH PROBING QUESTIONS.

IT'S A SIMPLE SCREEN.

IT'S NOT COMPLICATED, SO IT'S ACTUALLY QUITE EASY TO ADMINISTER AND ADMINISTER IT UNIVERSALLY.

SO EVERY SINGLE PERSON, WE DON'T MAKE ANY ASSUMPTIONS.

THE LAST ONE, THE S. IS SICKNESS.

WE UNDERSTAND TRAUMATIC BRAIN INJURY CAN BE THE RESULT OF A SICKNESS OR INJURY THAT MAY HAVE CAUSED BRAIN SWELLING, NOT JUST THE EXTERNAL IMPACT OR FORCE APPLIED TO THE BRAIN.

THIS QUESTION, AGAIN, REMINDS US OF THAT.

AND THAT'S THE ENTIRE SCREENING TOOL.

IT ONLY TAKES A COUPLE OF MINUTES TO ADMINISTER, WHICH MAKES IT EASY.

BUT, AGAIN, WE RECOGNIZE THE
IMPORTANCE OF IDENTIFYING THAT AS A POSSIBLE ISSUE BECAUSE TRAUMATIC BRAIN INJURY DOES HAVE SOME SIGNIFICANT IMPACTS, AS YOU ALL KNOW, IN SOMEONE'S ABILITY TO PARTICIPATE IN A COGNITIVE BEHAVIORAL THERAPY MODEL. SO WE NEED TO KNOW IF THIS IS SOMETHING WE HAVE TO CONSIDER, IF WE NEED TO COORDINATE CARE. THE SCORING OF THE HELP SCREENING TOOL IS SIMPLE. THE HELP SCREENING IS CONSIDERED POSITIVE FOR POSSIBLE TRAUMATIC BRAIN INJURY WHEN THESE FOLLOWING THREE ITEMS ARE IDENTIFIED. AN EVENT THAT COULD HAVE CAUSED A BRAIN INJURY, A PERIOD OF LOSS OF CONSCIOUSNESS OR ALTERED CONSCIOUSNESS AFTER THE INJURY, OR ANOTHER INDICATOR THE INJURY WAS SEVERE -- SO THAT MIGHT BE THEY WENT TO THE EMERGENCY ROOM, THEY DID FEEL DAZED -- AND THE
LAST PIECE IS AND THE PRESENCE
OF TWO OR MORE CHRONIC PROBLEMS
LISTED IN THE "P." SECTION THAT
WERE NOT PRESENT BEFORE THE
INJURY.
SO, AGAIN, IT'S IMPORTANT TO
RECOGNIZE THESE ARE "ANDS," NOT
"ORS" THAT RESULT IN A POSSIBLE
T.B.I.
THIS DOESN'T MEAN THEY DO HAVE A
TRAUMATIC BRAIN INJURY.
THIS ISN'T A DIAGNOSIS OF
TRAUMATIC BRAIN INJURY.
BUT IF IT'S POSITIVE, IT RESULTS
IN THE POSSIBLE COORDINATION OF
CARE FOR SERVICES OR ADDITIONAL
ASSESSMENT RELATED TO THE BRAIN
INJURY.
...
SO SOME ADDITIONAL
CONSIDERATION, AGAIN, POSITIVE
SCREENING IS NOT SUFFICIENT TO
DIAGNOSE T.B.I., ACE JUST
MENTIONED.
SOME INDIVIDUALS COULD PRESENT
EXCEPTIONS TO THE SCREENING
RESULTS SUCH AS PEOPLE WHO HAVE
TRAUMATIC BRAIN INJURY-RELATED
PROBLEMS BUT ANSWERED NO TO SOME
QUESTIONS.
SO IT'S NOT 100% LIKE ANY OTHER
SCREENING TOOL WE KNOW.
ALSO IT'S IMPORTANT TO CONSIDER
THE POSITIVE RESPONSES WITHIN
THE CONTEXT OF A PERSON'S
SELF-PURPORT AND ALTERED
BEHAVIOR AND COGNITIVE
FUNCTIONS.
SO WE WANT TO MAKE SURE THAT
WE'RE LOOKING AT THE WHOLE
PICTURE.
IN TERMS OF TREATMENT
APPROACHES, WE LOOK AT SUBSTANCE
ABUSE TREATMENT FOR PEOPLE WHO
HAVE TRAUMATIC BRAIN INJURY OR
WHO HAVE SUFFERED TRAUMATIC
BRAIN INJURY.
THese ARE SOME OF THE EFFECTIVE
PRACTICES.
WE KNOW MOTIVATIONAL
INTERVIEWING STRATEGIES ARE VERY EFFECTIVE WITH THIS POPULATION.

WE ALSO UNDERSTAND THAT BARRIER REDUCTION IS CRITICAL, AGAIN, BECAUSE OF THE LIMITED PROBLEM-SOLVING PEOPLE MAY PRESENT, WITH IT’S IMPORTANT FOR US TO BE ABLE TO BARRIER REDUCE EARLY ON IN TREATMENT SERVICES.

FINANCIAL INCENTIVES, AGAIN, AN EVIDENCE-BASED TREATMENT SUPPORT MODEL WITHIN THE SUBSTANCE ABUSE FIELD BUT PROVIDING INCENTIVES FOR FOLLOWING THROUGH WITH TREATMENT SERVICES, RECOMMENDATIONS, WITH STRATEGIES.

IT’S SOMETHING THAT SEEMS TO WORK WITH THIS POPULATION BECAUSE THEY HAVE THE EXTERNAL REWARD.

WE’VE ALSO GOT THESE ASSESSMENT OF FUNCTIONAL UTILITY OF DRUG AND ALCOHOL USE SO AGAIN WE’RE SEEING WHAT PURPOSE DOES IT
SERVE WITHIN THEIR LIVES.

ALSO BUILDING, COPING, OTHER SKILLS, TRAINING, THOSE WILL BE CRITICAL FOR THEM.

PAROL PLAYS ARE ESSENTIAL BECAUSE IT GIVES THEM AN OPPORTUNITY TO PRACTICE THESE THINGS IN A SAFE ENVIRONMENT.

SO THESE ARE THE TREATMENT APPROACHES WE SEE AS BEING POSITIVE AND SUPPORTIVE AND HELPFUL FOR FOLKS WHO HAVE SUFFERED A TRAUMATIC BRAIN INJURY.

WE ALSO KNOW INTEGRATED APPROACHES ARE BEST SO WE WANT TO MAKE SURE WE’RE COORDINATING CARE WITH MED IS STAFF WHEN IT COMES TO TREATMENT OF FOLKS WITH SUBSTANCE ABUSE DISORDERS WHO ALSO SUFFERED A TRAUMATIC BRAIN INJURY.

IT’S IMPORTANT WE HAVE REGULAR COMMUNICATION, THAT WE’RE UNDERSTANDING WHAT EACH PERSON
IS DOING AND WHAT THEIR ROLE IS
WITHIN THIS PERSON'S RECOVERY.
WE ALSO WANT TO MAKE SURE WE
IDENTIFY AND UTILIZE UNIQUE
LEARNING STYLES.
SO WE WANT TO ASK AND OBSERVE
ABOUT ATTENTION SPANS.
WE WANT TO GET INPUT ABOUT
WRITTEN MATERIALS, AND USING
CONCRETE MATERIALS AND VISUAL
AIDS ARE ESSENTIAL IN TERMS OF
TREATMENT.
REPEAT, REVIEW, REHEARSE.
AGAIN, DEVELOPING THAT PATTERN,
DEVELOPING THE REHEARSAL,
PROVIDING OPPORTUNITIES TO
REPEAT THINGS, STRATEGIES IS
IMPORTANT FOR THIS POPULATION IN
TERMS OF TREATMENT FOR SUBSTANCE
ABUSE AND CO-OCCURRING MENTAL
HEALTH DISORDERS.
THese ARE POEM THINGS YOU KNOW,
ALREADY.
PROVIDING DIRECT FEEDBACK ABOUT
PEOPLE'S BEHAVIORS.
DON'T ASSUME THEY KNOW THEIR BEHAVIOR IS INAPPROPRIATE.

A TRAUMATIC BRAIN INJURY HAS SIGNIFICANT IMPACTS ON HOW PEOPLE PROCESS THINGS.

SO, THEN, TO PROVIDE THAT FEEDBACK IS IMPORTANT.

SO IN CONCLUSION, WE KNOW THAT TRAUMATIC BRAIN INJURY IS COMMON AMONG PEOPLE IN SUBSTANCE ABUSE DISORDERS TREATMENT.

WE ALSO KNOW THE SYMPTOMS OF TRAUMATIC BRAIN INJURY AND SUBSTANCE ABUSE DISORDERS AND OTHER PSYCHIATRIC DISORDERS ARE SIMILAR, SO IT'S VERY IMPORTANT THAT WE REALLY TUNE IN AND PAY ATTENTION TO EACH OF THOSE DIFFERENT SYMPTOMS AND LOOK AT PSYCHOLOGICAL TESTING, LOOK AT OTHER ASSESSMENTS TO MAKE SURE THAT WE UNDERSTAND WHAT'S REALLY GOING ON WITH EACH CLIENT AND NOT JUST ASSUME THAT THE SYMPTOMS ARE THE RESULT OF THE
TRAUMATIC BRAIN INJURY OR VICE VERSA.

WE ALSO KNOW THAT SBIRT CAN BE AN EFFECTIVE TRAUMATIC BRAIN INJURY PREVENTION STRATEGY. SO, AGAIN, THERE'S A LOT OF ALCOHOL-RELATED TRAUMATIC BRAIN INJURY, A LOT OF SUBSTANCE-RELATED TRAUMATIC BRAIN INJURY, SO IF WE CAN IDENTIFY THEM EARLY THROUGH IMPLEMENTATION OF AN SBIRT MODEL, WE CAN EFFECTIVELY PREVENT THEM FROM HAPPENING IN THE FUTURE.

SCREENING FOR TRAUMATIC BRAIN INJURY IS ESSENTIAL IN SUBSTANCE ABUSE TREATING SETTINGS. LASTLY, INTEGRATE THE APPROACH TO TREATMENT WITH MEDICAL STAFF, TREATMENT STAFF AND OTHERS AS WELL.

THERE'S MY CONTACT INFORMATION. IF YOU HAVE ANY OTHER FOLLOW-UP QUESTIONS OR ANY OTHER
INFORMATION THAT YOU WOULD LIKE, FEEL FREE TO LET MY KNOW.
WE'VE DONE QUITE A BIT OF TRAINING IN THE SBIRT MODEL IN PRIMARY CARE AND EMERGENCY DEPARTMENTS AT PIMA PREVENTION PARTNERSHIP.
WE HAVE RESOURCES.
IF IT WOULD BE HELPFUL, LET ME KNOW.
THAT'S MY PRESENTATION.
HERE ARE REFERENCES ON THE LAST SLIDE THAT THEY'LL SEND OUT TO Y'ALL.
LIKE I SAID, LET ME KNOW IF THERE'S ANYTHING ELSE YOU NEED.
>> Presenter: GREAT, THANKS, CHARLIE.
THAT WAS AN INTERESTING AND SPOT-ON PRESENTATION.
GLAD TO HAVE YOU.
WE DID HAVE A QUESTION ABOUT THE REFERENCES AND THE DATA YOU CITED, SO WE WILL HAVE THESE UP AND AVAILABLE ON THE WEB SITE
SHORTLY AND YOU CAN CHECK THOSE OUT THERE.

CHARLIE WILL BE STICKING AROUND FOR A Q&A SESSION AT THE END, SO THANK YOU, CHARLIE.

NEXT, I WOULD LIKE TO PRESENT MAGGIE FERGUSON AND SCOTT LINDGREN FROM OUR IOWA TEAM AND THEY DEVELOPED A NEW TOOL IN COORDINATING CARE FOR ADOLESCENTS AND CHILDREN WHO HAVE SUSTAINED A TRAUMATIC BRAIN INJURY.

SO WITHOUT FURTHER ADIEU, I PASS IT TO MAGGIE AND SCOTT. THE FLOOR IS ALL YOURS.

>> SCOTT: THANKS TO EVERYBODY FOR INVITING US TO PRESENT ABOUT THE WORK THAT THE IOWA TEAM HAS BEEN DOING AS PART OF THE COMMUNITY OF PRACTICE.

I'M GOING TO SAY A FEW THINGS, FIRST, ABOUT WHY WE PUT TOGETHER WHAT WE DID, AND THEN MAGGIE'S GOING TO TELL YOU A LITTLE BIT
MORE ABOUT SOME OF THE RESOURCES
THAT WE'RE TRYING TO LINK
FAMILIES WITH AND ALSO GIVE YOU
A FEEL FOR HOW WE'RE PILOTING
THIS.
THIS IS STILL A WORK IN
PROGRESS, SO WE'RE NOT
PRESENTING A FINAL TOOL.
BUT AS YOU CAN SEE UP ON THE
SCREEN, I THINK -- I HOPE --
WHAT WE'RE CALLING A BRAIN CARE
GUIDE WHICH IS DESIGNED MOSTLY
FOR FAMILIES BUT ALSO FOR
SHARING INFORMATION AMONG
PROFESSIONALS OF VARIOUS
AGENCIES.
IT MIGHT BE INVOLVED WITH A
CHILD WHO HAS A MODERATE TO
SEVERE BRAIN INJURY.
I PROBABLY SHOULD SAY A LITTLE
BIT ABOUT WHY WE CREATED THE
TOOL.
THE REASONS FOR PUTTING THIS
TOGETHER REALLY GREW OUT OF A
SUMMIT ON PEDIATRIC BRAIN INJURY
THAT WE HELD ABOUT TWO YEARS AGO, NOW, IN IOWA, AND WE PUT TOGETHER A DIVERSE GROUP OF STAKEHOLDERS BUT IT WAS SMALL ENOUGH TO BE ABLE TO ACTUALLY HAVE SOME DISCUSSION, SO IT WASN'T JUST SOMEBODY LECTURING TO THE GROUP. AND WE HAD THE STAKEHOLDERS WHO WERE THERE TO RANK THE PRIORITY ISSUES, WHAT THEY SAY IN PEDIATRIC BRAIN INJURY, THAT WOULD REQUIRE SOME WORK TO MAKE THINGS BETTER FOR KIDS WITH BRAIN INJURIES, AND THE NUMBER ONE ISSUE THAT WAS IDENTIFIED ACROSS ALL THE DIFFERENT STAKEHOLDERS WAS THE CHALLENGE THAT FAMILIES FACE IN PULLING TOGETHER ALL THE RESOURCES THAT ARE NEEDED TO TREAT A BRAIN INJURY IN A CHILD. YOU KNOW, THERE WERE PROBLEMS WITH SHARING INFORMATION ACROSS DIFFERENT SERVICES AND PROGRAMS.
THERE WERE PROBLEMS FINDING OUT WHAT SERVICES MIGHT BE AVAILABLE, AND THERE WERE CERTAINLY PROBLEMS IN GETTING ACCESS TO ANY OF THE SERVICES THAT MIGHT BE CONSIDERED NEEDED. BECAUSE WE WANTED TO HAVE PREVENTION GUIDE OR EFFORT AS PART OF THE COMMUNITY OF PRACTICE, WE WANTED TO HAVE A PREVENTION THEME FOR WHAT WE ARE DOING, BUT IT'S NOT NECESSARILY PRIMARY PREVENTION. WE KNOW THAT EARLY AND APPROPRIATE CARE FOR BRAIN INJURY CERTAINLY CAN PREVENT MORE SERIOUS DISABILITIES FROM DEVELOPING IN THE FIRST PLACE AND EVEN IF THERE ARE ONGOING PROBLEMS, AT THE VERY LEAST, THIS KIND OF EARLY CARE AND APPROPRIATE CARE CAN REDUCE THE SEVERITY OR AVOID COMPLICATIONS OF A BRAIN INJURY. SO THAT WAS WHAT WE WANTED TO
FOCUS ON WAS MORE SECONDARY OR TERTIARY PREVENTION THEMES.
NOW, THE GOAL OF THIS TOOL IS TO PROVIDE INFORMATION ON SERVICES THAT A CHILD OR FAMILY MAY NEED AFTER A BRAIN INJURY, AND IT’S A PRETTY DIVERSE LIST, AS YOU WILL SEE, AS WE GET INTO IT.
THE GUIDE IS INTENDED TO BE COMPLETED AS EARLY AS POSSIBLE AFTER THE INJURY TO ENSURE THAT THE FAMILY IS AWARE OF SERVICES THEY MAY NEED AND ARE ENTITLED TO, AND THEN THE BACK PAGE OF THE GUIDE PROVIDES MORE EXPLANATIONS ABOUT TERMS THAT MAY BE CONFUSING TO PEOPLE, AS WELL AS SOME LINKS TO IMPORTANT SERVICES AND INFORMATION ACROSS THE STATE.
AND WE INTENDED THIS GUIDE TO BE COMPLETED BY ANY INDIVIDUAL WHO IS INVOLVED WITH SUPPORTING A FAMILY AFTER AN INJURY, SO COULD BE A SOCIAL WORKER, A NURSE OR A
PHYSICIAN OR A PSYCHOLOGIST OR A
THERAPIST OR AN EDUCATOR OR A
CASE MANAGER.
REALLY, ANYBODY WHO'S HELPING
THE FAMILY.
LET'S LOOK AT THE CARE GUIDE
ITSELF.
I THINK THAT'S WHAT YOU'VE GOT
UP ON YOUR SCREEN, SO YOU SHOULD
HAVE A COPY OF THIS, SO I'M NOT
GOING TO CALL YOUR ATTENTION TO
EVERYTHING ON HERE, BUT LET ME
AT LEAST FOCUS ON THE MAIN
AREAS.
AS YOU CAN SEE, WE RECOGNIZE
EVERY CHILD IS UNIQUE AND,
OBVIOUSLY, EVERY INJURY IS
UNIQUE, TOO.
SO THERE'S QUITE A WIDE RANGE OF
ITEMS THAT WE FOCUSED ON.
BUT BECAUSE WE WANTED TO FIT
THIS ON ONE PAGE, THERE'S REALLY
NOT A WHOLE LOT OF DETAIL ABOUT
ANY SINGLE ITEM.
SO WE HAVE ISSUES THAT CAN BE
IDENTIFIED AS AREAS THAT REQUIRE ATTENTION IN THE HEALTHCARE FIELD, IN THE THERAPY REHAB AREA, IN THE EDUCATIONAL SETTING, IN SCHOOLS, IN TERMS OF THINGS THAT MAY BE REQUIRED FOR SUPPORTING THE FAMILY, TRANSITION BETWEEN DIFFERENT PROGRAMS OR AT DIFFERENT AGES FOR KIDS WITH A BRAIN INJURY.

IF WE WANT TO PREVENT FUTURE INJURIES, CERTAINLY THESE KIDS ARE AT GREATER RISK FOR INJURIES IF THAT MIGHT COME ALONG, SO WE WANT THEM TO BE VERY CAREFUL AND TO FOCUS ON SOME THINGS THEY CAN DO TO BE MORE CAREFUL.

A LOT OF TIMES WE HAVE PROBLEMS WACK SEASES TO PARTICIPATING IN -- WE HAVE ACCESS TO PARTICIPATING IN THINGS PEOPLE DID BEFORE THE INJURY.

SO WE'RE CONCERNED ABOUT FUNDING SERVICES SOURCES AND COORDINATING CARE ACROSS
DIFFERENT TYPES OF SERVICES THAT MAY BE NEEDED FOR A CHILD AND TO HELP A FAMILY AS WELL.

... SO I JUST WANTED TO GIVE YOU A SENSE OF WHY WE'RE PUTTING THESE TOGETHER AND TRYING TO LIST THOSE THINGS THAT WE THINK MAY BE ISSUES IN THE LONG RUN, AND I'M GOING TO TURN IT OVER TO MAGGIE AND LET HER TALK ABOUT THE SECOND PAGE AND GIVE YOU A LITTLE BIT OF A FEEL FOR HOW WE'RE PILOTING THIS TOOL RIGHT NOW.

SO MAGGIE, OVER TO YOU.

>> AS YOU CAN TELL ON THIS FIRST PAGE, OF COURSE, THERE'S A LOT OF INFORMATION THAT CAN BE CAPTURED AND WE HAD TO USE ANACHRONISMS IN MANY CASES AS WELL AS REFER TO SOME GENERAL CATEGORIES.

SO WE FELT THE NEED TO DEVELOP A TOOL FOR FAMILIES TO REFER TO
AND NOT ONLY EXPLAIN WHAT THE
ACRONYMS WERE BUT ALSO TO USE AS
A DIRECTORY TO POINT THEM TO
FURTHER RESOURCES AND
INFORMATION.
SO SOME OF THE RESOURCES, FOR
EXAMPLE, LIKE FAMILY NAVIGATION,
BRAIN INJURY SERVICES, HE MAKE
SURE PEOPLE CONNECTED TO THE
SERVICES SO WE PROVIDED THE
LINKS AND THAT'S A RESOURCE
THAT'S AVAILABLE.
WE DIDN'T WANT TO GET INTO
ANYTHING THAT WOULD BE TOO
REGIONALLY SPECIFIC OR GO BACK
TO -- OH, SORRY, I'M GETTING A
NOTE I NEED TO SPEAK LOUDER.
OKAY.
SO THE RESOURCES, AS I WAS
SAYING, ARE MORE GENERAL TO THE
STATE AND NOT REGIONALLY
SPECIFIC.
AGAIN, THE RESOURCES THAT ARE ON
THERE GO WITHIN THE DIFFERENT
DISCIPLINES, THE MEDICAL, THE
THERAPY, EXPLAINING WHAT THE ACRONYMS ARE.

THE TOOL CAN BE PREFERRED.

THE FAMILIES CAN TAKE IT WITH THEM.

IT'S PORTABLE SO THEY CAN COMMUNICATE WITH THE DIFFERENT SERVICES.

THESE ARE SUGGESTIONS I RECEIVED FROM MY THERAPIST AND THEY THOUGHT SOME SCHOOL THERAPY WOULD BE BENEFICIAL TO ME, FOR EXAMPLE, SO WE WANTED TO SHARE THE OTHER RESOURCES AND THEN ALSO COMMUNICATE WHAT SERVICES THE FAMILIES ARE RECEIVING CURRENTLY TO SHARE THAT INFORMATION ACROSS SETTINGS.

AS WE'RE PILOTING, WE ARE ABLE TO USE THE DIFFERENT AGENCIES AND SETTINGS THAT ARE COMMUNITIES OF PRACTICE TEAM MEMBERS BELONG TO, AND, SO, THEY WENT BACK AND THEY WERE GOING TO PILOT -- WE STARTED LAST MONTH
AND WE’RE GOING TO PILOT THROUGH
THIS MONTH AND WE SHOULD BE
COLLECTING SOME INFORMATION FROM
THEM IN JULY.
WE DID ASK THAT THEY BE ABLE TO
SUPPLY BACK TO US SOME COMPLETED
FORMS SO THAT WE HAVE AN IDEA OF
HOW THE TOOLS ACTUALLY ARE BEING
USED.
AS YOU CAN SEE FROM THE FIRST
PAGE, IT’S MORE OF THE CHECK
BOXES.
SO IT CAN REALLY BE OPEN TO
INTERPRETATION.
SO WE WANTED TO SEE EXACTLY HOW
PEOPLE WERE FILLING THIS OUT,
THE TYPE OF COMMENTS THEY WERE
USING AND WHAT AREAS WERE MOST
COMMONLY BEING FILLED OUT.
...
AS PART OF OUR FEEDBACK FROM THE
PILOT SITE, WE WANT TO FIND OUT
WHAT SETTING ARE YOU USING IT
IN, HOW MANY DID YOU USE IN YOUR
SITE, WE’RE ASKING IF THE
CLIENTS THAT THEY'RE SEEING OR
THE PATIENTS THAT THEY'RE
SEEING, IF THEY'VE REPORTED BACK
ACTUALLY FILLING OUT THE CARE
PLAN IN ANOTHER SETTING, AND
THEN ALSO ANY OTHER QUESTIONS OR
FEEDBACK THAT THEY HAD AS FAR AS
WHAT WAS USEFUL, HOW IT COULD BE
IMPROVED AND OTHER SUGGESTIONS
THAT THEY MIGHT HAVE RECEIVED
FROM THE PATIENTS AND CLIENTS,
AND THEN TO GET A FEEL FROM THE
PILOT SITES, IF THEY FELT IT WAS
USEFUL, THAT THEY WILL CONTINUE
USING THIS RESOURCE AS WELL.
I WOULD LIKE TO NOTE THAT WE DID
SHOW THIS TO OUR ADVISORY
COUNCIL ON BRAIN INJURIES IN THE
STATE.
THEY THOUGHT IT WAS GOOD.
THEY LIKED THE BREVITY AND HOW
IT WAS UNIVERSAL AND ARE GOING
TO BACK IT UP AS WELL WHEN WE
HAVE A FINAL FORM TO TRY TO
ENCOURAGE FOLKS TO CONTINUE TO
USE THE TOOL IN THE VARIOUS SETTINGS.

>> SCOTT: THE ONLY OTHER THING I WOULD ADD IS THAT WE'VE BEEN WORKING ON A TOOL FOR REALLY A GUIDE FOR CONCUSSION AND MILD INJURY AS WELL.

WE DIDN'T THINK THAT THE ISSUES WERE EXACTLY THE SAME AS WERE NEEDED FOR MORE SEVERE INJURIES.

SO THAT'S SOMETHING THAT'S IN PROCESS NOW.

>> MAGGIE: RIGHT, WE'RE WORKING ON THAT CURRENTLY AND WE SHOULD HAVE OUR NEXT -- WE'RE HOPING TO BE ABLE TO PILOT THAT AS WELL,

BUT WE MAY HAVE TO EXTEND THEIR COMMUNITY OF PRACTICE TEAM PAST THE SEPTEMBER DATE.

...

>> Presenter: GREAT!

THANKS SO MUCH!

I LOVE THE IDEA OF EXTENDING YOUR TEAM PAST THE COMMUNITY OF PRACTICE.
KEEP US POSTED ON HOW THAT GOES
AND WHAT KIND OF FORMAT YOU END
UP TAKING.
SO THOSE ARE OUR TWO
PRESENTATIONS FOR THE DAY.
WE HAVE ABOUT 15 MINUTES FOR
QUESTION AND ANSWER.
...
SO WE'LL OPEN UP THE PHONE LINES
MOMENTARILY, BUT FIRST I WANTED
TO GET TO HILLARY'S QUESTION
WHICH CAME IN IN THE BEGINNING.
THIS ONE'S FOR CHARLIE.
ESSENTIALLY, HILLARY IS ASKING
WHAT THE DIFFERENCE BETWEEN THE
T.B.I. POPULATION AND THE
REGULAR POPULATION IS AS FAR AS
SUBSTANCE USE.
SO HER QUESTION SAYS, "I'M
UNSURE OF THE SUBSTANCE USE
FREQUENCY OF THE GENERAL
POPULATION, WHAT PERCENT OF THE
ENTIRE POPULATION, INJURY OR
NOT, ARE UNDER THE INFLUENCE OF
ALCOHOL OR OTHER SUBSTANCES AT
ANY GIVEN TIME.”

SO I UNDERSTAND THAT WE PROBABLY WON’T HAVE A CUT AND DRY ANSWER TO THIS, BUT MAYBE CHARLIE CAN GIVE US YOUR THOUGHTS.


SO OVERALL, THERE'S 20% OF FOLKS WHO ARE BETWEEN EITHER RISKY
DRINKING AND THEN DEPENDENCE
WITH THE SMALLER PERCENTAGE
BEING THOSE WHO QUALIFY AS
ALCOHOL DEPENDENT AND THOSE ARE
ABOUT 5% OF THE STANDARD
POPULATION.
SO IT’S ASTONISHING THAT WHEN WE
THINK ABOUT THE FOLKS IN THE
EMERGENCY ROOM OR IN TRAUMA
CENTERS THAT ABOUT 50% OF THEM
ARE COMING IN UNDER THE
INFLUENCE SO, AGAIN, THAT’S A
REALLY HIGH PERCENTAGE.
>> Presenter: GREAT, CHARLIE.
IT IS KIND OF SHOCKING WHEN YOU
THINK ABOUT IT LIKE THAT.
I’D LIKE TO REMIND YOU, IF YOU
HAVE QUESTIONS, ENTER THEM INTO
THE CHAT POD ON THE LEFT-HAND
SIDE OF THE SCREEN.
I ALSO WANTED TO TELL YOU WE
HAVE THE TWO TOLLS FOR THE IOWA
TEAM AVAILABLE IN THE FILE SHARE
POD ON THE UPPER RIGHHAND SIDE
OF YOUR SCREEN.
SO THE FIRST ONE IS JUST A LETTER THAT WAS GOING TO THE PILOT SITES, I BELIEVE, THAT TALKS ABOUT THE GOALS OF THE PROJECT, AND THEN THE SECOND ONE IS THE TOOL ITSELF. SO YOU WILL BE ABLE TO DOWNLOAD THOSE AND CHECK THEM OUT AT YOUR LEISURE.

AT THIS TIME, I'M GOING TO OPEN UP THE PHONE LINES. I ASK THAT IF YOU ARE ON YOUR COMPUTER, YOUR PLEASE MUTE YOUR COMPUTER SPEAKERS. IF YOU'RE IN AN AREA WITH A LOT OF BACKGROUND NOISE ON THE PHONE, PLEASE ALSO MUTE YOUR PHONE WHILE YOU'RE NOT SPEAKING SO WE CAN AVOID SOME BACKGROUND NOISE.

SO WITH THAT I'M OPENING THE PHONE LINES. GREAT.

SO YOU CAN FEEL FREE TO CHIME IN.
I see Mark is entering a question right now.

Charlie, I wanted to ask you if you've seen any correlation with traumatic brain injury, substance abuse and suicide in your work, and if there's anything you're doing to incorporate suicide screening?

>> Yeah, we actually do some suicide screening again at the university with all our clients, because it is something that's prevalent, actually, within the substance use field.

Again, there's oftentimes, in fact with a population that we serve, which is justice involved adolescents, we with see 40 to 60% come in presenting with co-occurring disorders, a lot of that being A.D.H.D., depression. So the suicide risk is something that's important.

In terms of it's correlation
WITH THE TRAUMATIC BRAIN INJURY,
I DIDN'T GET A CHANCE TO LOOK
INTO THAT, BUT, AGAIN, WITH A
SUBSTANCE ABUSE, AGAIN, THE
EFFECTS OF THE SUBSTANCE USE
TYPICALLY OR OFTENTIMES CAUSING
DEPRESSIVE EFFECTS AND ALSO
INHIBITING OUR ABILITY TO REALLY
PROCESS AND PROBLEM SOLVE,
MAKING IT INCREASINGLY LIKELY
THAT THEY WILL TURN TO SUICIDE
OR THE THOUGHTS OF SUICIDE AS A
SOLUTION AND, SO, IT IS
DEFINITELY SOMETHING THAT IS OF
CONCERN AND THAT I ADVOCATE FOR
AND I THINK IT'S IMPORTANT THAT
WE SCREEN, AGAIN, UNIVERSALLY
FOR SUICIDE IDEATION BECAUSE,
AGAIN, IT'S ONE OF THOSE THINGS
WHERE YOU CAN'T SEE IT AND, SO,
IT'S BETTER TO JUST NOT MAKE
ASSUMPTIONS AND DO THE
SCREENINGS UNIVERSALLY FOR
FOLKS.
...

...
Presenter: GREAT, THANK YOU, CHARLIE.

MARK ASKED YOU HOW WAS THE 1,000 SAVINGS FROM SBIRT FIGURED?
AND HE ALSO WISHES YOU WARM WISHES FROM MINNESOTA.

>> CHARLIE:  THANK YOU, VERY MUCH, MARK.
SO THE $1,000 SAVINGS IN THE SBIRT AGAIN WAS RELATE TO REDUCED USE OF EMERGENCY ROOM SERVICES, OF TRAUMA SERVICES BASED ON REDUCED FREQUENCY OF VISITS, SO THEY HAD LESS FOLKS RETURNING TO THE EMERGENCY ROOM AS A RESULT OF ALCOHOL-RELATED INJURIES AND, SO, THEY DIDN'T HAVE TO DEDICATE AS MANY OF THEIR RESOURCES, THOSE VERY HIGH-INTENSIVE, VERY COSTLY RESOURCES TO THAT SPECIFIC SERVICE ANYMORE AND, SO, THAT'S WHERE THEY REALIZED THEIR SAVINGS.

>> Presenter: GREAT, THANK
YOU!
SO SINCE NOBODY ELSE IS CHIMING
IN, YOU GUYS ARE USUALLY A
LITTLE MORE CHATTY THAN THIS,
COME IN AND ASK YOUR QUESTIONS.
I'LL HAVE MAGGIE AND -- I'LL ASK
MAGGIE AND SCOTT WHAT ARE THEIR
PLANS FOR EVALUATION OF THE
PROJECT AND IF THEY'RE PLANNING
ON INCORPORATING ANYTHING
SPECIFIC TO SUICIDE OR SUBSTANCE
ABUSE INTO THEIR TOOL.
...
>> MAGGIE: RIGHT NOW, WE
HAVEN'T GOTTEN TO THAT PART OF
DISCUSSING FURTHER EVALUATION.
WE TALKED ABOUT, YOU KNOW, THE
FEEDBACK SURVEY THAT WE'RE DOING
WITH THE PILOT SITES, BUT OTHER
THAN MOVING FORWARD, WE HAVEN'T
DWIGHT GOTTEN TO THAT PART IN
THE PROCESS.
AND THEN WHAT WAS THE SECOND
PART OF YOUR QUESTION?
OH, THE SUICIDE AND SUBSTANCE
ABUSE.

THAT WAS NOT A PART OF OUR
CONVERSATION.

WE INCLUDED RESOURCES FOR FOLKS
AROUND BEHAVIORAL HEALTH ON THE
TOOL BUT DIDN'T GET INTO THAT
PARTicular AREA.

>> YEAH.

THIS IS SCOTT.

I THINK WHAT MAGGIE SAID IS
RIGHT.

WE DIDN'T GO INTO THAT LEVEL OF
DETAIL IN TERMS OF THE MENTAL
HEALTH/BEHAVIORAL HEALTH NEEDS
BECAUSE IT WASN'T REALLY SO MUCH
AN ASSESSMENT OF WHERE THE CHILD
WAS AT, BUT IT WAS WHAT THEY
NEEDED, AND I THINK IT'S
SOMETHING, YOU KNOW, DEPENDING
ON WHAT WE GOT FROM THE PILOT
AND SOME OF THE THOUGHTS TODAY,
YOU KNOW, WE MAY DECIDE THAT
THERE IS SOME IMPORTANCE IN
INCLUDING THAT IN THIS MIX.

>> MAGGIE: I ALSO WOULD SHARE
IF PEOPLE DOWNLOAD THE RESOURCE FOR THE PILOT PROGRAM, THE LETTER THAT WE SENT OUT, THERE IS A LINK TO WHERE YOU CAN FIND THIS TOOL ON OUR WEB SITE AND ALSO MY CONTACT INFORMATION, IF PEOPLE HAVE QUESTIONS OR WANT TO SHARE ANY FEEDBACK WITH ME DIRECTLY.

>> Presenter: THANKS, AND WE CAN ALWAYS GET A CONVERSATION AROUND THIS TOPIC STARTED ON THE LIST SERVE, TOO, IF YOU LIKE. I KNOW THERE'S A COUPLE OTHER TEAMS IN THE COMMUNITY OF PRACTICE WHO ALSO FOCUS ON SUBSTANCE ABUSE OR EVEN SUICIDE, NAMELY NEW YORK AND NORTH DAKOTA. DO YOU FOLKS HAVE ANY THOUGHTS ABOUT THE WAY THAT YOU'RE APPROACHING THESE TOPIC AREAS AND CO-OCCURRING CONDITIONS, OR IF ANY OTHER TEAM WANTS TO CHIME IN, PLEASE FEEL FREE, TOO.
EVERYBODY WANTS TO BE QUIET TODAY.

WELL, SINCE NO ONE'S TALKING TOO MUCH, I HOPE YOU CONTINUE TO THINK ABOUT THE CO-OCCURRING CONDITIONS AND HOW YOU CAN INCORPORATE SBIRT AND THE HELPS TOOL AND THINK ABOUT COORDINATING CARE IN YOUR OWN STATE A TO INCORPORATE SUBSTANCE ABUSE TREATMENT AS WELL AS SUICIDE PREVENTION.

IF YOU HAVE ANY THOUGHTS ON THIS, PLEASE FEEL FREE TO EMAIL THE LIST SERVE OR SEND ME A MESSAGE, AND WE CAN TALK ABOUT THIS FURTHER.

ON THE SCREEN IN FRONT OF YOU, THERE'S A LINK TO A BRIEF SURVEY WHICH HELPS US FIND OUT WHAT YOU THOUGHT ABOUT THIS WEBINAR, WHAT WE THOUGHT WE SHOULD DO IN FUTURE WEBINARS AND GENERAL
COMMENTS AND FEEDBACKS.
FEEL FREE TO FILL THAT OUT AT
YOUR OWN LEISURE.
THE ARCHIVE WILL BE POSTED ON
THE CHILDREN'S SAFETY NETWORK
SHORTLY AND THE PDF OF THE SLIDE
AND THE TRANSCRIPT OF THE CLOSED
CAPTIONER'S.
WITHOUT FURTHER ADIEU, WE'LL
CALL THE TENTH MEETING OF THE
COMMUNITY OF PRACTICE TO A
CLOSE, AND LET ME KNOW IF YOU
HAVE ANY QUESTIONS AND KEEP UP
YOUR GREAT WORK.
THANKS SO MUCH, EVERYONE.
>> THE MEETING IS NOW OVER.
ALL THE PARTICIPANTS HAVE BEEN
DISCONNECTED.