What if they're not ready yet?

Practical approaches to substance use after brain injury

Carolyn Lemsky, Ph.D.,C.Psych



CHIRS
Community Head Injury Resource Services

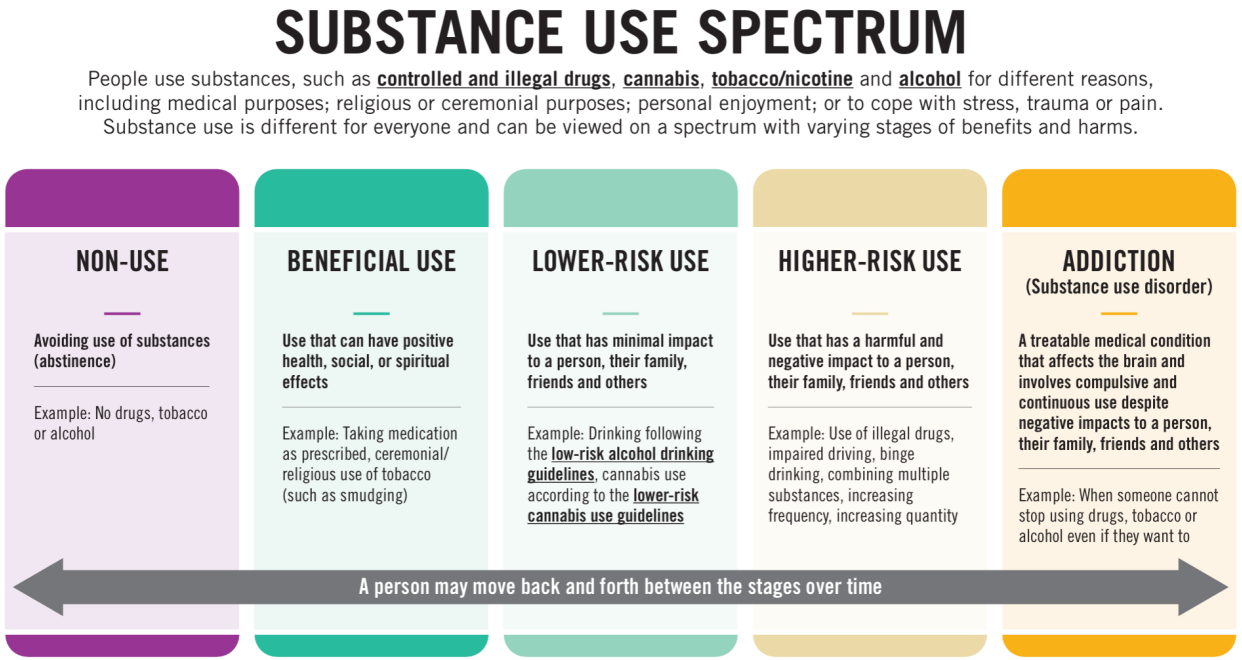
Disclosures

Dr. Lemsky received funding for this work by the Substance Abuse and Mental Health Administration, Mid-America Technology Transfer Center and the National Association of State Head Injury Administrators.

Earlier versions of this work were funded by the Ontario Neurotrauma Foundation

CHIRS
Community Head Injury Resource Services

What is Problematic Substance Use?



- Craving
- Use the Continues despite harms
- Loss of Control
- Compulsion

"Addiction is a treatable, chronic medical disease involving **complex interactions among brain circuits**, genetics, the environment, and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences."

SUBSTANCE USE SPECTRUM

People use substances, such as **controlled and illegal drugs**, **cannabis**, **tobacco/nicotine** and **alcohol** for different reasons, including medical purposes; religious or ceremonial purposes; personal enjoyment; or to cope with stress, trauma or pain. Substance use is different for everyone and can be viewed on a spectrum with varying stages of benefits and harms.

NON-USE

Avoiding use of substances (abstinence)

Example: No drugs, tobacco or alcohol

BENEFICIAL USE

Use that can have positive health, social, or spiritual effects

Example: Taking medication as prescribed, ceremonial/ religious use of tobacco (such as smudging)

LOWER-RISK USE

Use that has minimal impact to a person, their family, friends and others

Example: Drinking following the **low-risk alcohol drinking guidelines**, cannabis use according to the **lower-risk cannabis use guidelines**

HIGHER-RISK USE

Use that has a harmful and negative impact to a person, their family, friends and others

Example: Use of illegal drugs, impaired driving, binge drinking, combining multiple substances, increasing frequency, increasing quantity

ADDICTION
(Substance use disorder)

A treatable medical condition that affects the brain and involves compulsive and continuous use despite negative impacts to a person, their family, friends and others

Example: When someone cannot stop using drugs, tobacco or alcohol even if they want to

A person may move back and forth between the stages over time

I can’t stop now

I need it to… think, be creative, relax, cope with pain

Why stop?

It isn’t really a problem



Enhance mood
Escape (break)
Pain management
Mind expansion
Socialization



Missed appointments
Attending intoxicated
Falls
Impulsivity
Financial issues
Deteriorating relationships



Can I help him if he's using?

Am I getting the whole story?

What he's doing is dangerous.

He's in Denial.

Am I enabling use.



Canadian Centre on Substance Use and Addiction

Evidence. Engagement. Impact.

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Acquired Brain Injury and Substance Use Health

https://www.ccsa.ca/en/acquired-brain-injury-and-substance-use-health

The impact of ABI makes accessing and benefitting from treatment more difficult.

“Interventions that restore cognitive function and improve functional outcomes are therefore highly recommended for individuals with cooccurring ABI and SU/SUD (Nardo et al., 2022).”



Canadian Centre on Substance Use and Addiction

Evidence. Engagement. Impact.

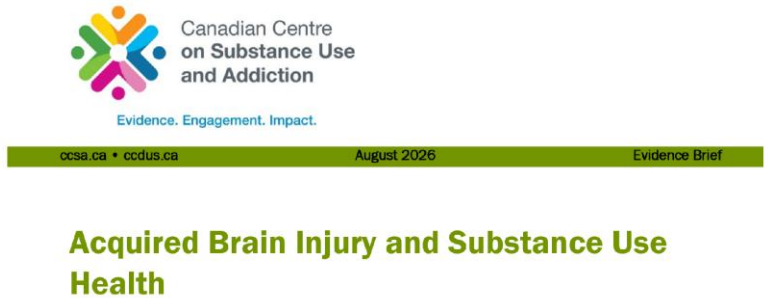
ccsa.ca • ccdus.ca August 2026 Evidence Brief

Acquired Brain Injury and Substance Use Health

Drug toxicity events

“In Canadian jurisdictions, individuals with a history of experiencing drug toxicity events were 19.5 times more likely to experience brain injury than their peers without such experiences (BC Centre for Disease Control, 2025). They are also at a significantly greater risk of adverse health outcomes (Vogler et al., 2014), including suicide rates that are three to four times higher than those of the general population (Simpson & Tate, 2007).”





The task is not simply to help people reduce substance use, but to help people build a life that offers more rewarding alternatives.

Miller, W. R., Meyers, R. J., & Hiller-Sturmhöfel, S. (1999). The community-reinforcement approach. *Alcohol Research & Health, 23*(2), 116–121.

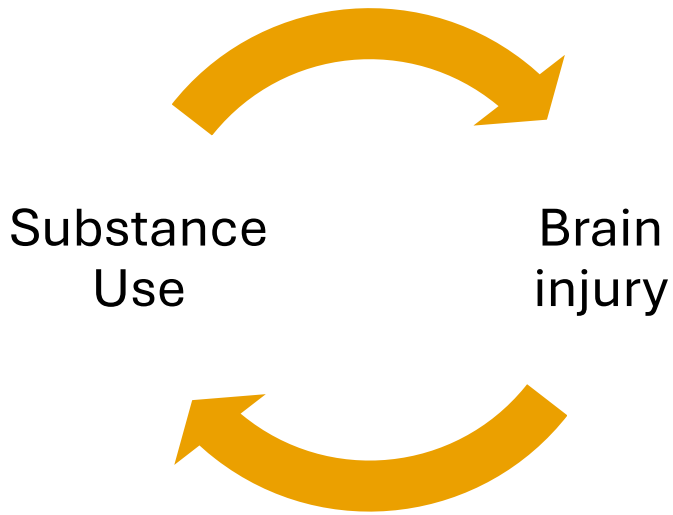
Substance use is a regular part of most rehabilitation professionals' practice.

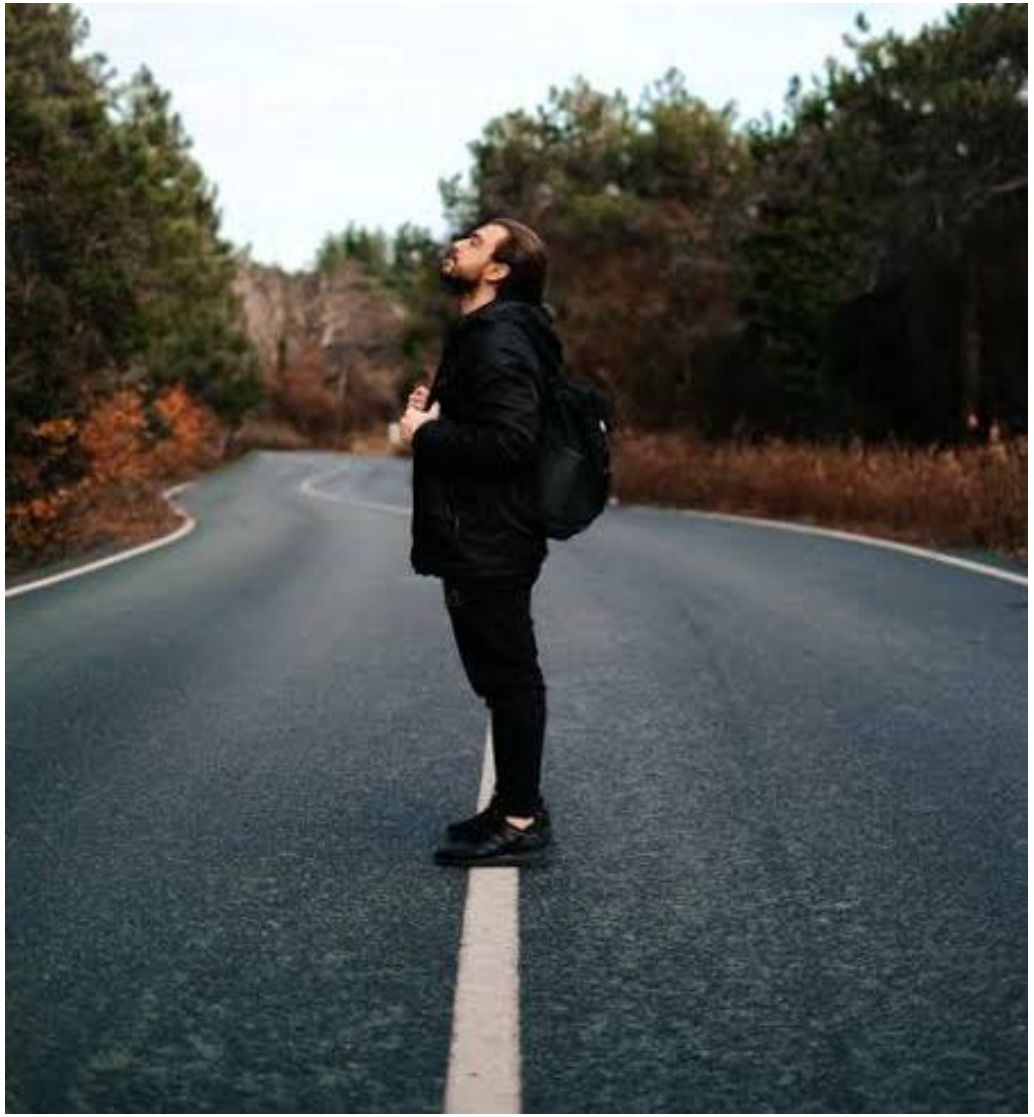
Common Co-Occurring condition

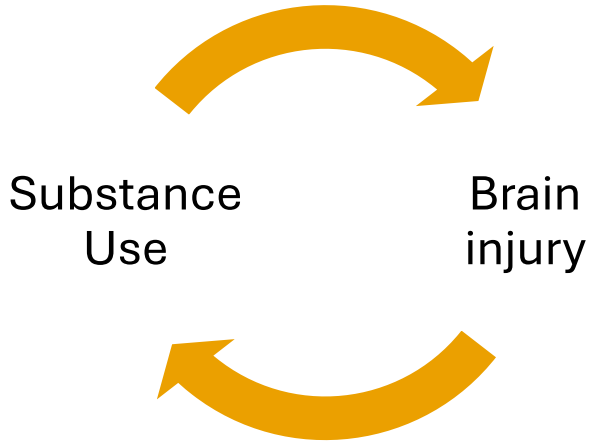
Unaddressed, outcomes are poorer

Dropout is higher

Lower threshold for harm



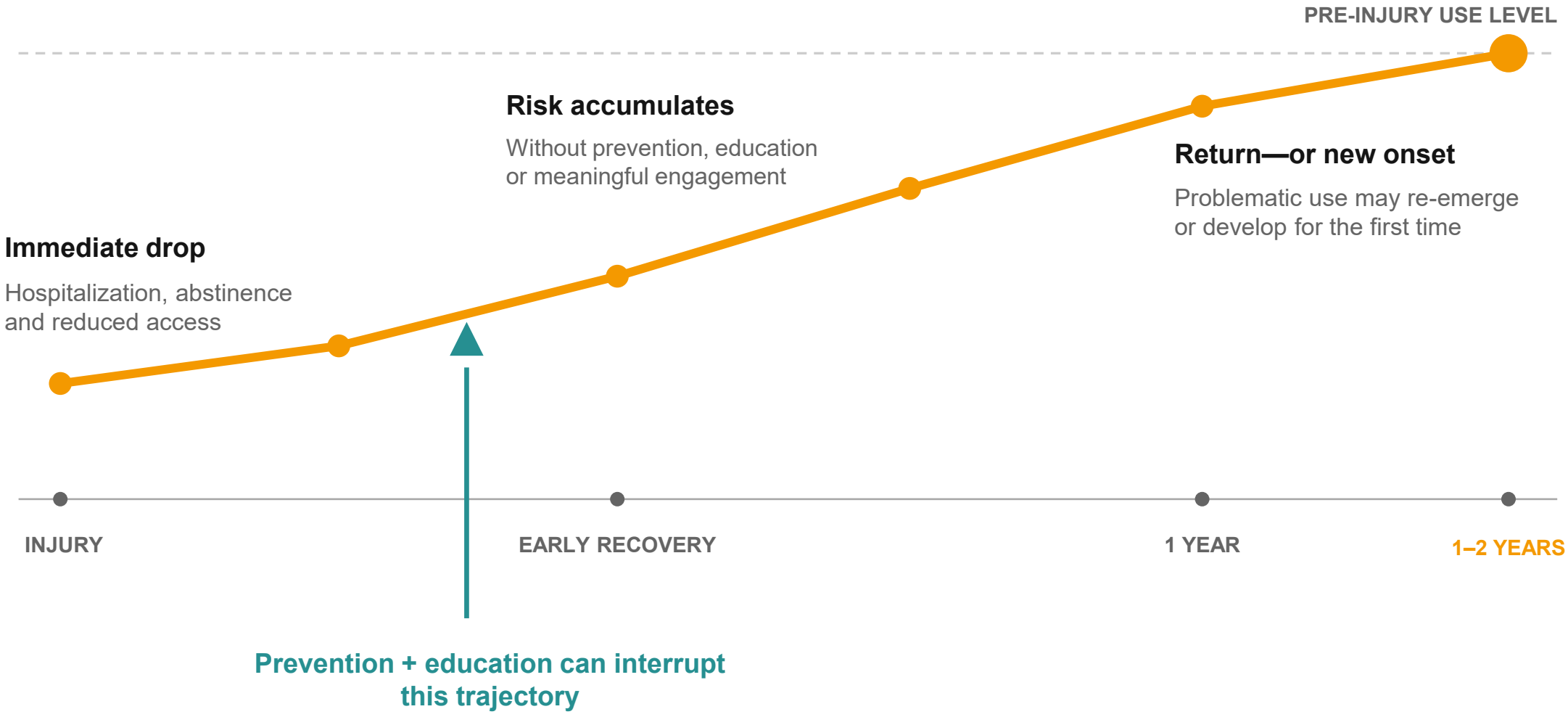




- Injury Risk
- Slowed Recovery
- Cognitive Impairments
- Emotional Regulation
- Social Participation

RISK TRAJECTORY

Without prevention and education, risk rises toward pre-injury use





Risk Factors For Substance Use Disorders

- Biological and family vulnerability
- Trauma and chronic stress (ACEs)
- Mental health and coping difficulties
- Early substance use and ongoing exposure
- Social disconnection and substance-using networks
- Housing insecurity and social adversity

Protective factors: What can we strengthen?

- Connection and belonging
- Meaningful roles and rewarding activities
- Coping and emotional-regulation skills
- Hope and confidence in the ability to change
- Safe housing and practical stability
- Access to care and ongoing support



Cognitive impairment influences drinking outcome by altering therapeutic mechanisms of change

Marsha E Bates [1], Anthony P Pawlak, J Scott Tonigan, Jennifer F Buckman

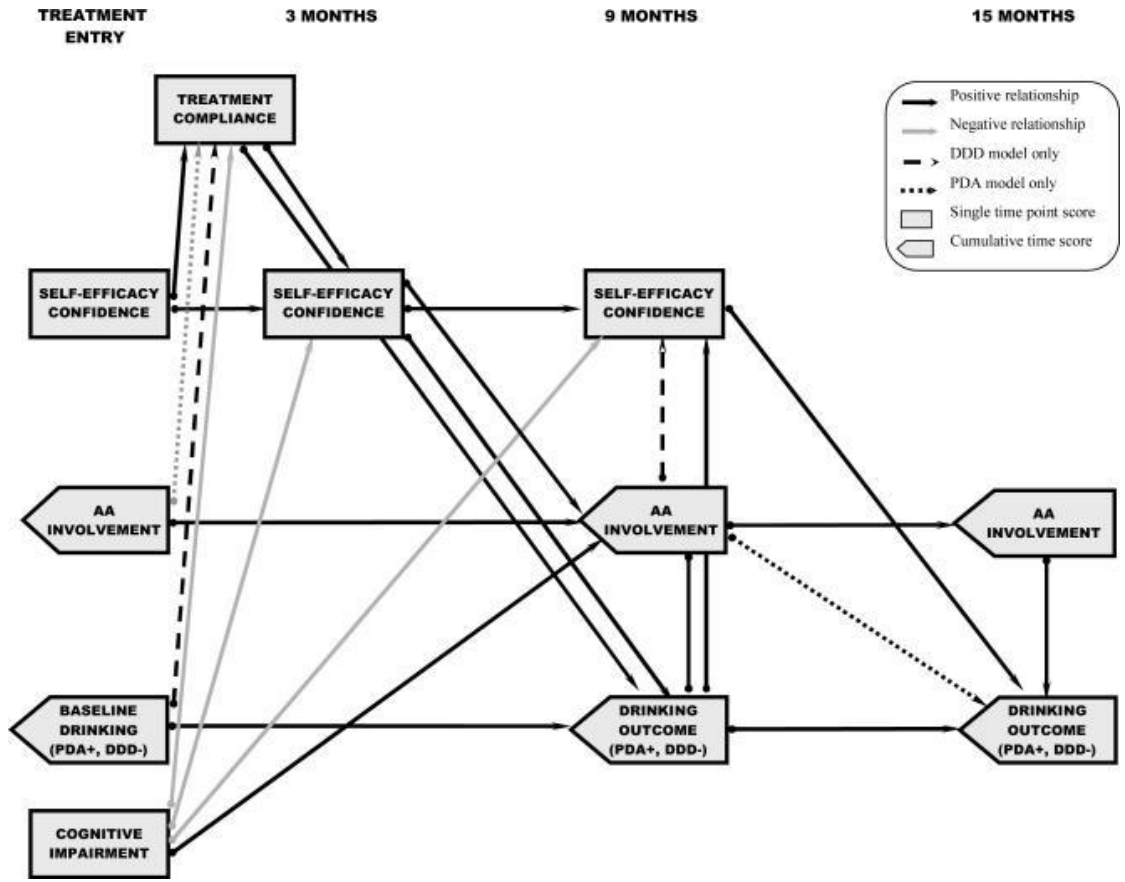
Affiliations + expand

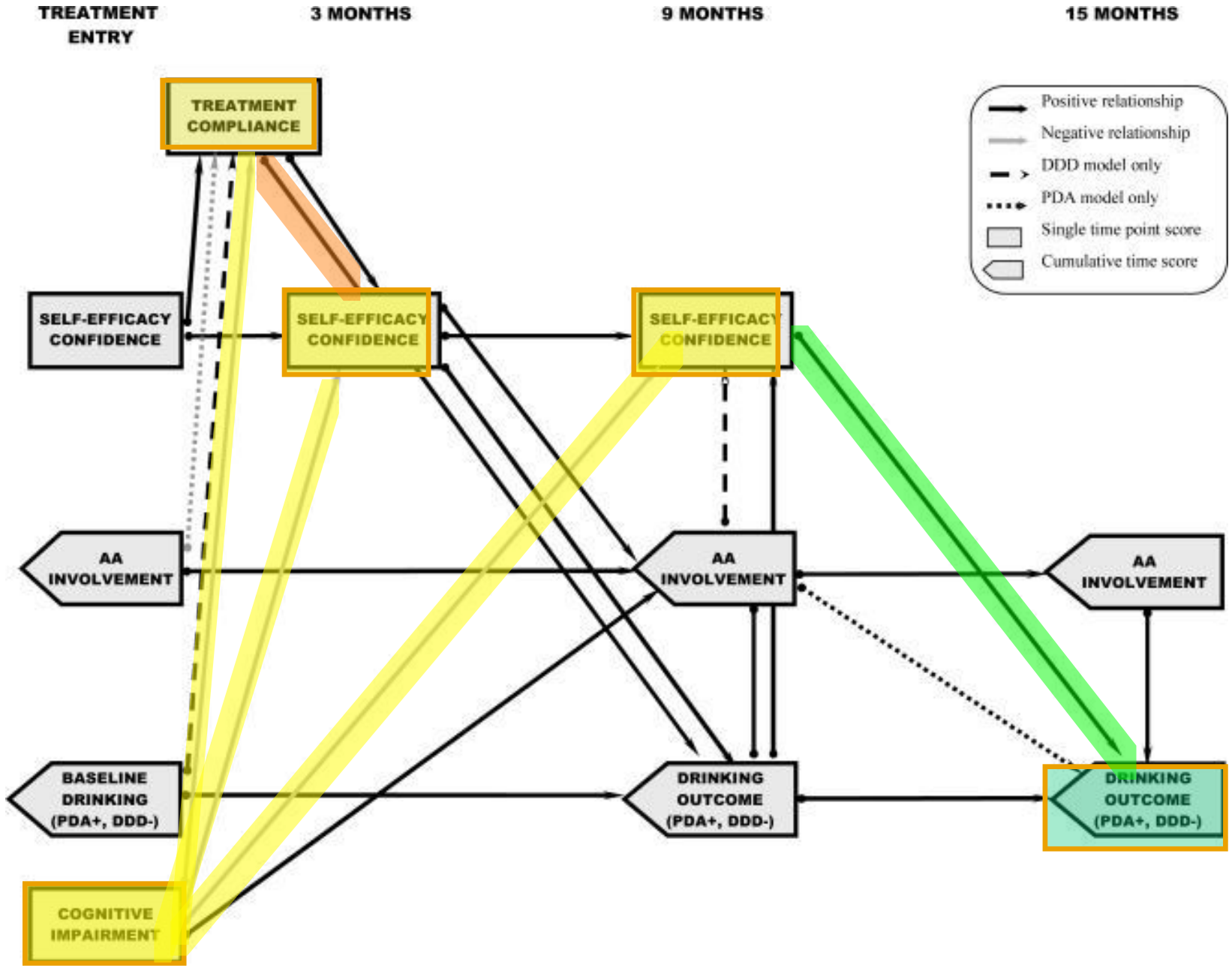
PMID: 16938062 PMCID: PMC2965453 DOI: 10.1037/0893-164X.20.3.241

Abstract

Serious neuropsychological impairments are seen in a minority of addiction treatment clients, and, theoretically, these impairments should undermine behavioral changes targeted by treatment; however, little evidence supports a direct influence of impairment on treatment response. To address this paradox, the authors used structural equation modeling and Project MATCH data (N=1,726) to examine direct, mediated, and moderated paths between cognitive impairment, therapeutic processes, and treatment outcome. Mediated relations were found, wherein impairment led to less treatment compliance, lower self-efficacy, and greater Alcoholics Anonymous Involvement, which, in turn, more proximally predicted drinking. Impairment further moderated the effect of self-efficacy, making it a poor predictor of drinking outcomes in impaired clients, thereby suggesting that impaired and unimpaired clients traverse different pathways to addiction recovery.

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TREATMENT ENTRY
3 MONTHS
9 MONTHS
15 MONTHS
TREATMENT COMPLIANCE
SELF-EFFICACY CONFIDENCE
SELF-EFFICACY CONFIDENCE
SELF-EFFICACY CONFIDENCE
AA INVOLVEMENT
AA INVOLVEMENT
AA INVOLVEMENT
BASELINE DRINKING (PDA+, DDD-)
DRINKING OUTCOME (PDA+, DDD-)
DRINKING OUTCOME (PDA+, DDD-)
COGNITIVE IMPAIRMENT
Positive relationship
Negative relationship
DDD model only
PDA model only
Single time point score
Cumulative time score

Outcomes from a modified treatment program

N=67 participants

N=33 screened positive for cognitive impairments

Program materials based on the Original SUBI manual

Collaborative treatment planning

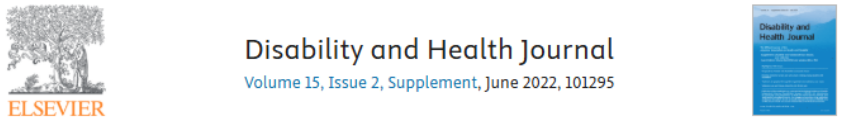
Skill rehearsal, clear goals, celebration of success

Posted calendars

Name tags

Cognitive compensation strategies

Specific supports to assist clients in meeting program expectations



Collings S, Allan J, Munro A. Improving treatment for people with cognitive impairment and substance misuse issues: Lessons from an inclusive residential treatment program pilot in Australia. Disabil Health J. 2022 Jun;15(2S):101295. doi: 10.1016/j.dhjo.2022.101295. Epub 2022 Mar 1. PMID: 35365421.

Treatment completion improved by a factor of 5 in people with cognitive impairment (prior to intervention 10% completed, with program changes 50% completed)

Critical elements

- Safe environment
- Structured routines
- Modified materials
- Strength-based programming
- Staff support

Re-Framing self-view

Learning to deal with emotions

Practical skills

University of Wollongong
Research Online

Faculty of Social Sciences - Papers (Archive) Faculty of Arts, Social Sciences & Humanities

January 2019

The process of change for people with cognitive impairment in a residential rehabilitation program for substance problems: A phenomenographical analysis

Julaine M. Allan
Lives Lived Well, julaine@uow.edu.au

Susan Collings

Alice Munro

Allan, J., Collings, S. & Munro, A. The process of change for people with cognitive impairment in a residential rehabilitation program for substance problems: a phenomenographical analysis. *Subst Abuse Treat Prev Policy* **14**, 13 (2019). https://doi.org/10.1186/s13011-019-0200-y

Best Practice

KITE – UHN Guidelines

https://kite-uhn.com/brain-injury/en/guidelines

Table 1
Knowledge, Innovation, Talent Everywhere Research Institute/university health Network guidelines summary

Recommendation	Evidence Level	Key Action
Screen & educate universally	B	Use setting-appropriate tools, referral as required
Concurrent integrated care	C	No exclusion; consult specialists in addiction, pain management.
Incentives & barriers reduction	B	Improve engagement with incentives for early treatment milestones, provide supports to engage in care
Prevention via MI/ education	C	Tailored after post-traumatic amnesia is cleared,verbal and written formats MI is recommended with environmental supports to accommodate cognitive and neurobehavioral impairments.

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Three key assumptions.

01

Ambivalence is a typical response to the prospect of change.

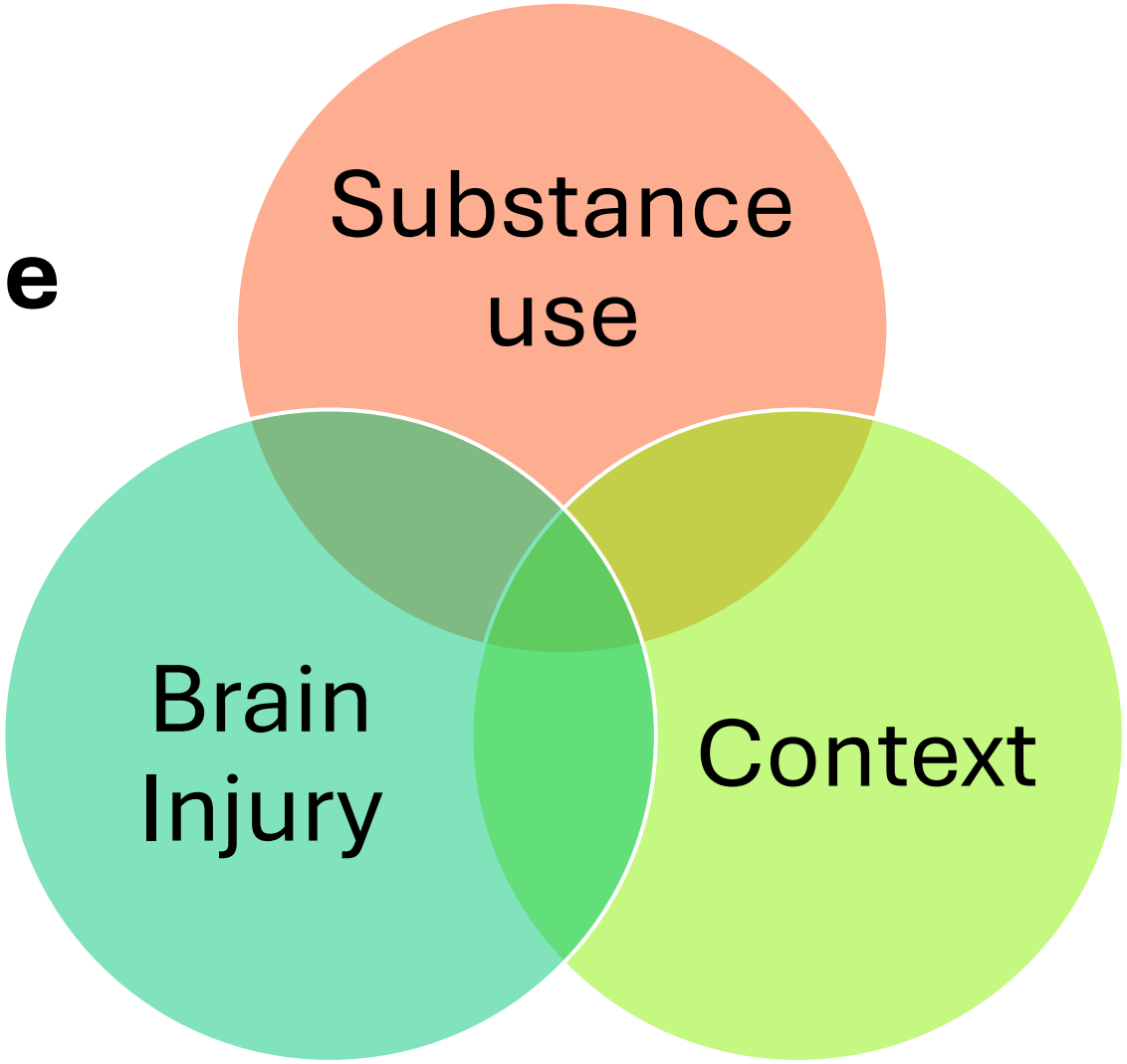
02

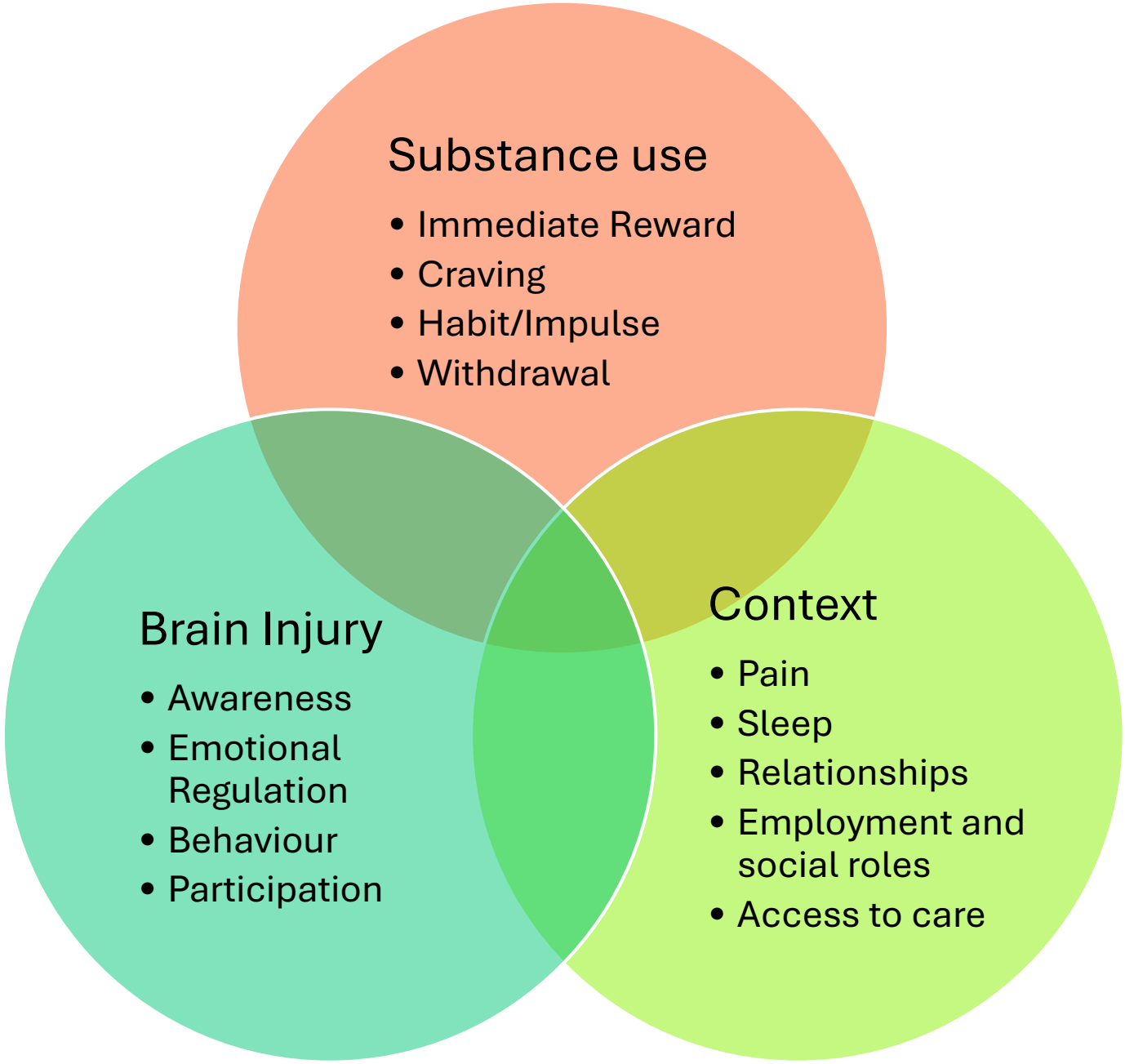
The effects of stigma are real.

03

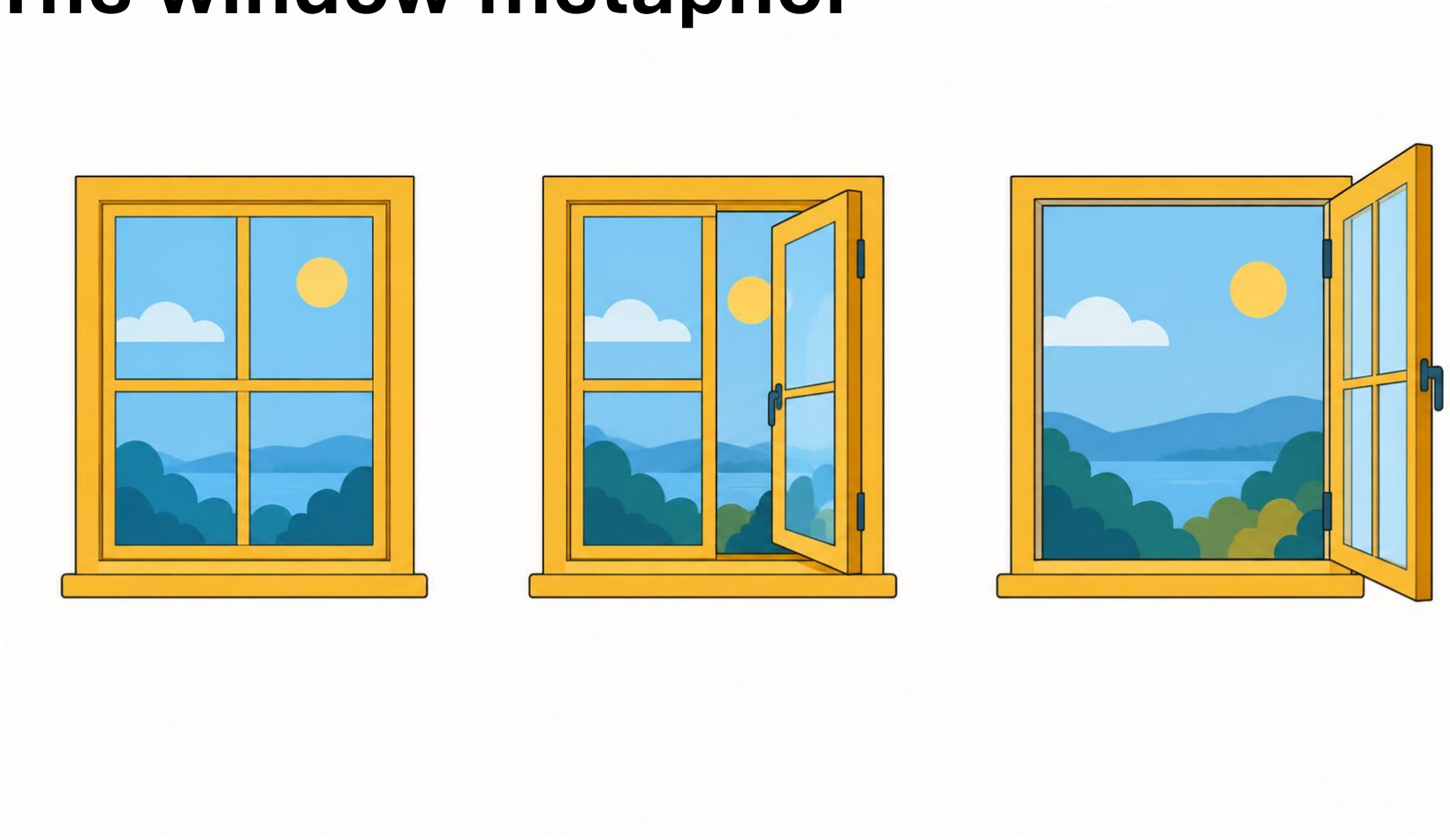
Change occurs when a person feels ready, willing and able.

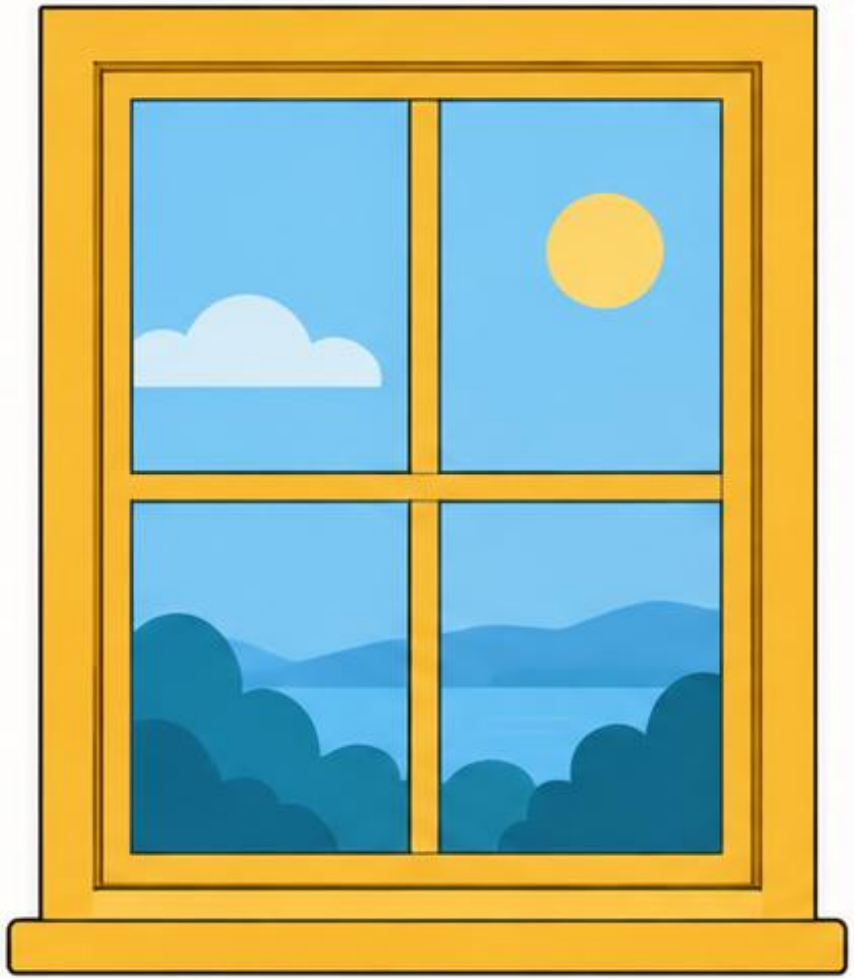
What we see as motivation is an interaction between the person and the environment.



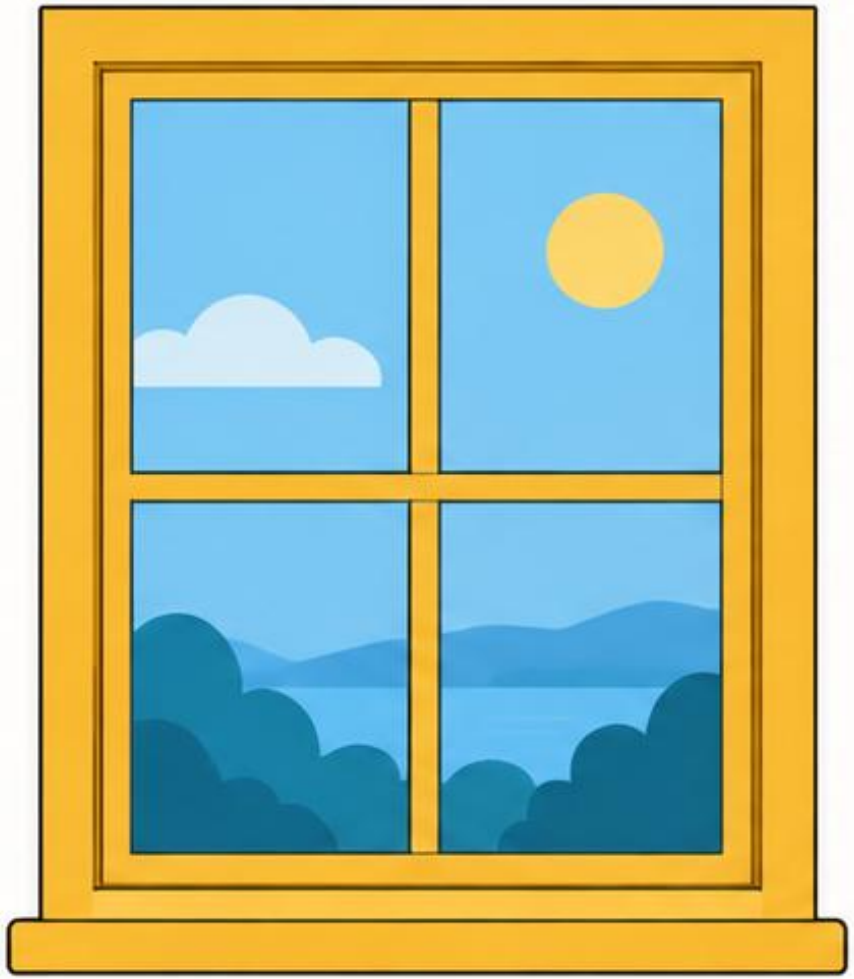

Substance use
• Immediate Reward
• Craving
• Habit/Impulse
• Withdrawal
Brain Injury
• Awareness
• Emotional Regulation
• Behaviour
• Participation
Context
• Pain
• Sleep
• Relationships
• Employment and social roles
• Access to care

The window metaphor





“This is not a problem.”
“Maybe it’s a problem, but I don’t see a reason to change.”
“I can’t do what you expect.”



Low self-efficacy

Threat

Low Autonomy

Stress/Distress

- Pain/Discomfort
- Shame

Impaired awareness



Supporting Discovery

Respectful curiosity

Demonstrating Concern Vs. Communicating blame

Affirming strengths Vs. focus on use or problems.

Exploring values and goals



Signs that the window is opening

Desire: “I wish things were different.”
Reasons: “I don’t want another fall.”
Ability: “I could to it when…”
Need: “I have to keep a job, friend, home…”
Experimentation: “Maybe I could try not using before therapy.”
Help-seeking: “Can you tell me what my options are?”



Responding to Readiness

Reflecting and amplify

Ask permission before providing suggestions/feedback

Supporting choice

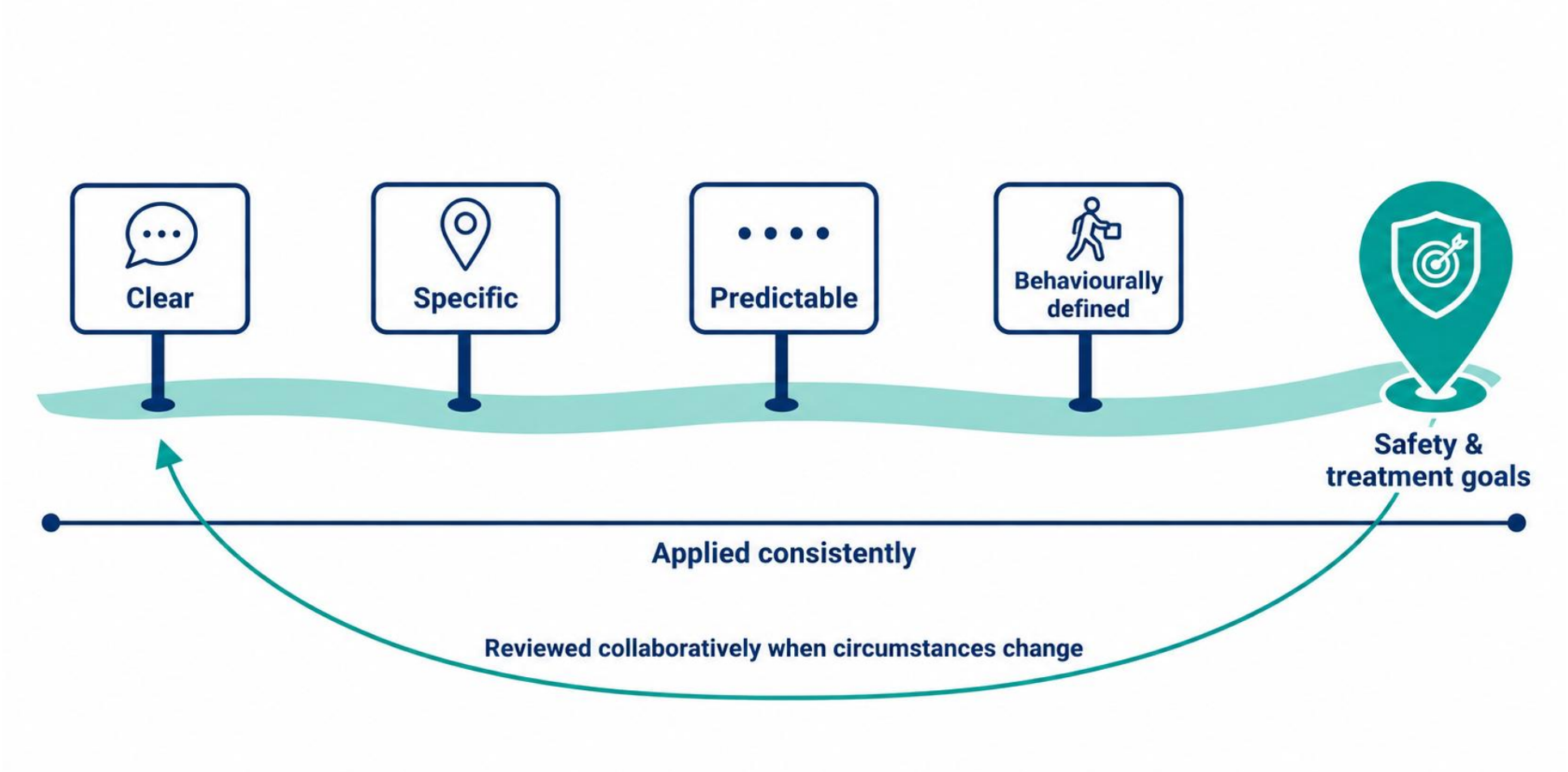
Dimensions relevant to readiness



We can respect autonomy without accepting preventable harms or danger



Boundary Setting



Boundary setting statements



Shared Goal

Name Shared Goal: “You came to rehab to work on (your goal).



Observable Concern

State the Concern: “Today you had trouble walking and focusing, and you let me know you had (substance) just before coming here.



Clear Limit

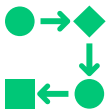
State the Boundary: “For safety we can’t continue today.”



Practical Alternative

State the Next Step: “I’ll call you later to make a plan for next time.”

- Reminder to avoid use.



Path back to care

Keep the relationship open: “This is a problem we can get around if we work together.”

A boundary keeps care safe—and keeps the door open

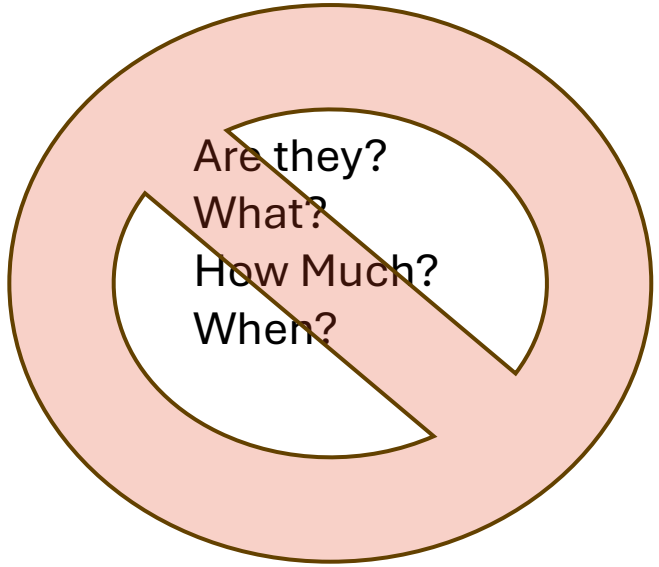
The difference is not firmness. It is purpose, predictability, and a path back.

BOUNDARY — supports safe participation		CONSEQUENCE — punishes or excludes
Defines conditions for safe care	versus	**Expresses disapproval and need for punishment**
Focuses on observable behaviour	versus	Focuses on character or diagnosis
Includes a path back into care	versus	**Excludes without a plan to return**
Is predictable and consistent	versus	Is improvised or reactive
Protects the person, team, and others	versus	Increases shame and disengagement
Is reviewed when circumstances change	versus	Is treated as permanent

A good boundary names the safe condition and shows how care can continue.

Don’t become an intoxication detective

- Focus on safety
- Behavioural Observations
  - “Your balance is off today…”
  - “You are falling asleep…”
  - “You seem more annoyed than usual…”
  - “Thinks are slow today…trouble focusing….”
- Respectful Curiosity…
  - I wonder if this has to do with use? When do you use last?
  - We don’t have to talk about this now, but I will ask to talk about it at a better time…
- With denials/lack of candid discussion…
  - I have a ‘theory” about what’s happening
  - What can we do about….balance, etc.



Observation Framework

- B – Baseline: What has changed from the client's usual presentation?
- A – Appearance and alertness: Are the more sleepy, agitated?
- S – Safety and function: Are they walking safely, is communication clear, can the client follow instructions and participate safely?
- E – Extra assessment or services: Is there a need for medical assessment, emergency response or a change in treatment plan.



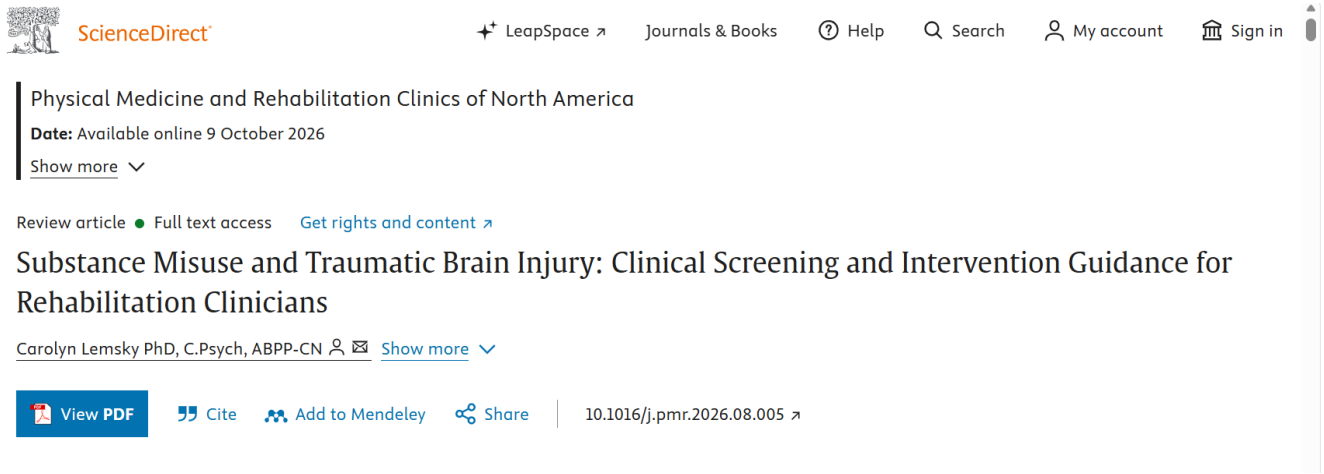
Signs of commitment to change

Commitment: “I must do this…”

Ability: I can do this…

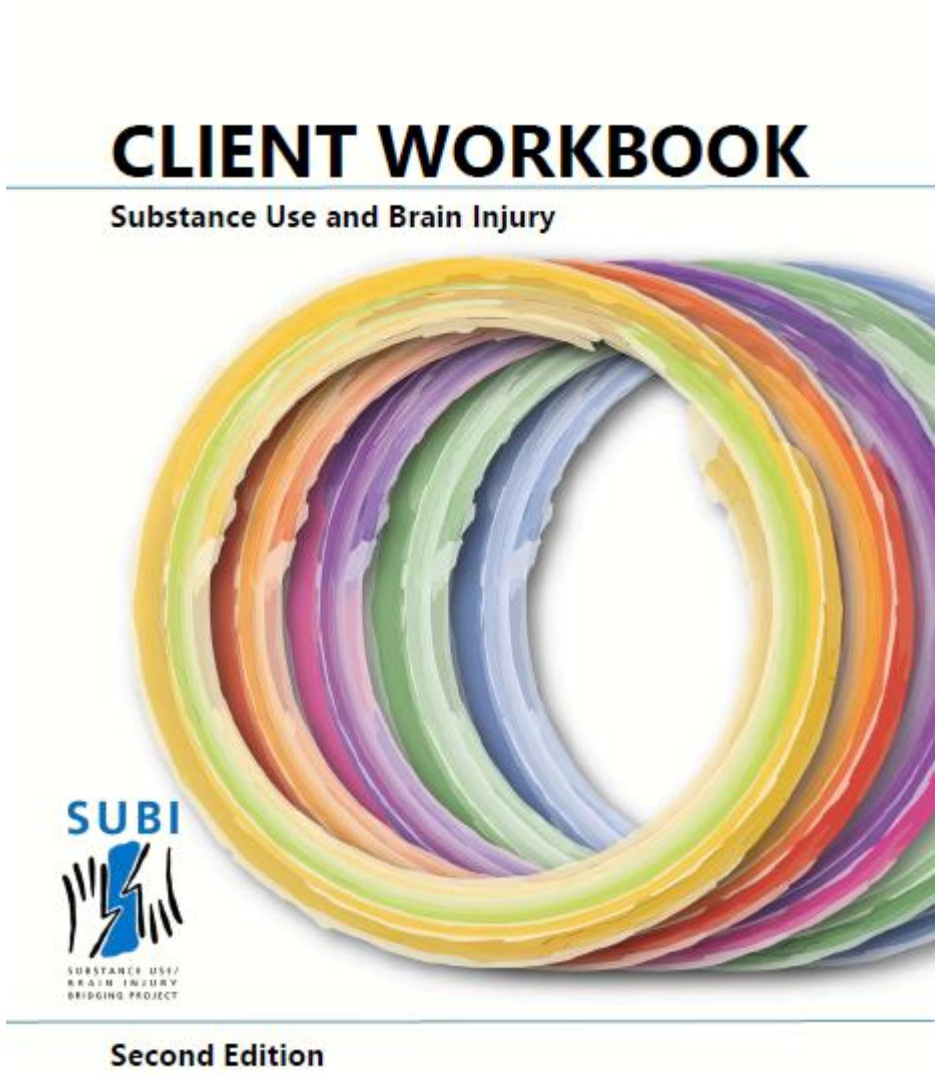
Trials: I have done this…

Screening for Substance Use Disorders

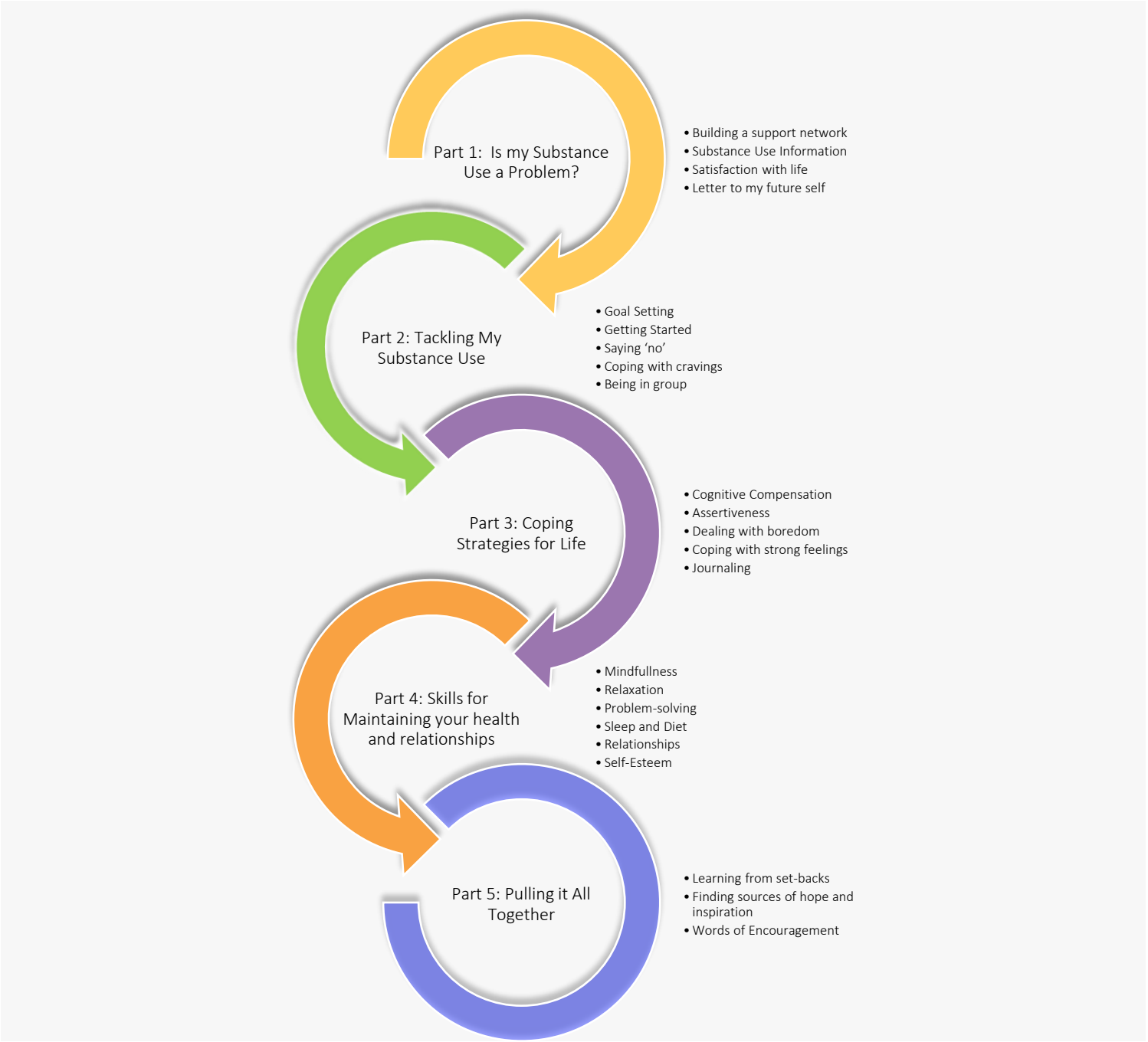


I talk with all of my clients about substance use, because it's important for brain health...

- People who use alcohol and other substances do not recover as well from their injuries.
- Alcohol and other substances can make problems with speech, balance and coordination worse.
- Using alcohol and other drugs increases the risk of re-injury.
- Using substances can make learning new skills more difficult.
- Alcohol and other drugs may have a greater effect after brain injury.
- Alcohol and other drugs may interfere with or be dangerous when taken in combination with prescribed drugs.
- Alcohol lowers the threshold for seizures.

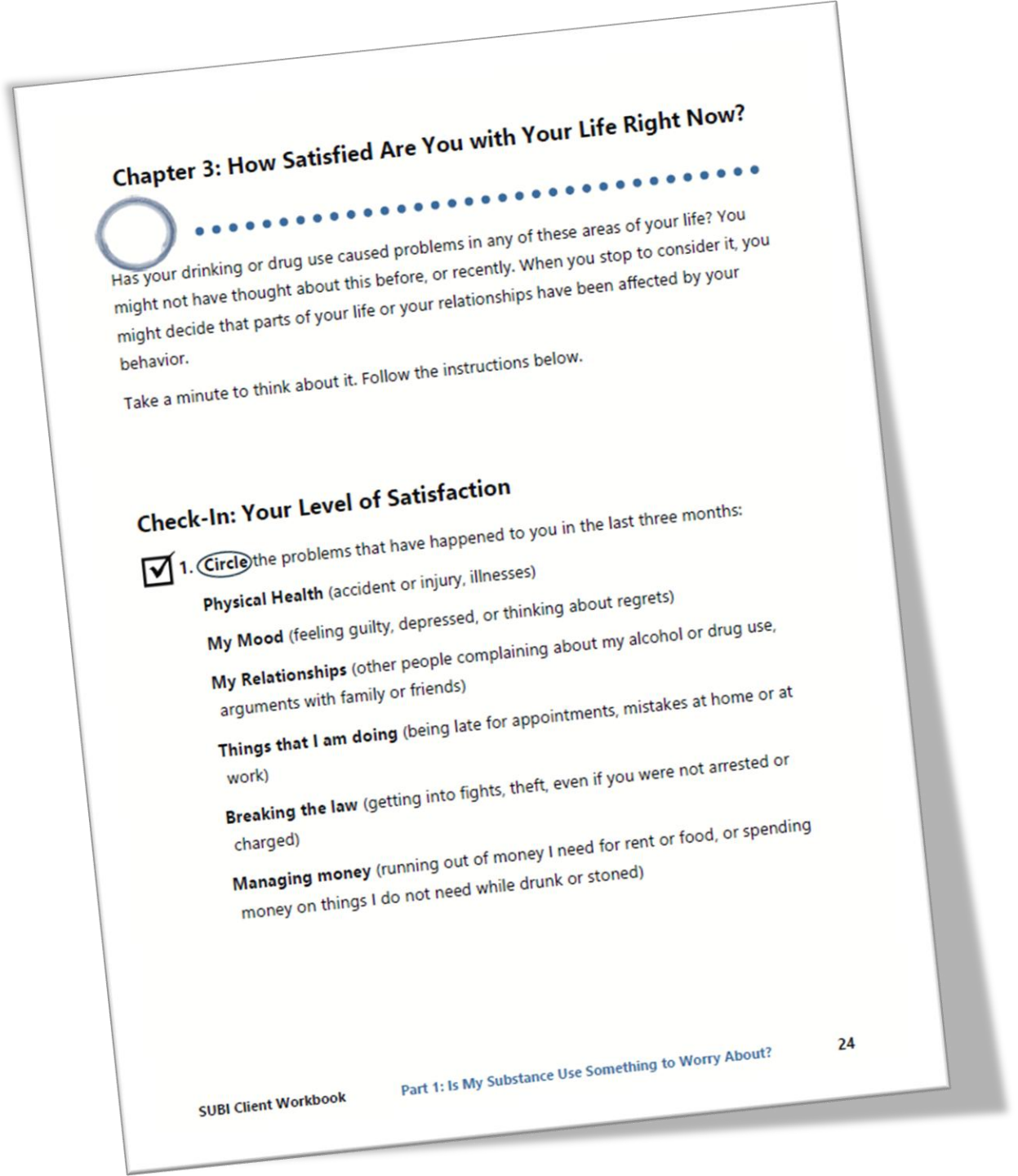


- Designed to illustrate adaptations of common practice in addictions for ABI
- A place to ‘get started’ for ABI-trained professionals
- MI focus now structured as a treatment program


Part 1: Is my Substance Use a Problem?
• Building a support network
• Substance Use Information
• Satisfaction with life
• Letter to my future self
Part 2: Tackling My Substance Use
• Goal Setting
• Getting Started
• Saying 'no'
• Coping with cravings
• Being in group
Part 3: Coping Strategies for Life
• Cognitive Compensation
• Assertiveness
• Dealing with boredom
• Coping with strong feelings
• Journaling
Part 4: Skills for Maintaining your health and relationships
• Mindfullness
• Relaxation
• Problem-solving
• Sleep and Diet
• Relationships
• Self-Esteem
Part 5: Pulling it All Together
• Learning from set-backs
• Finding sources of hope and inspiration
• Words of Encouragement

Part 1: Is my Substance Something to Worry About?

- Building a support network
- Substance Use Information
- Satisfaction with life
- Letter to my future self



Chapter 3: How Satisfied Are You with Your Life Right Now?

Has your drinking or drug use caused problems in any of these areas of your life? You might not have thought about this before, or recently. When you stop to consider it, you might decide that parts of your life or your relationships have been affected by your behavior.

Take a minute to think about it. Follow the instructions below.

Check-In: Your Level of Satisfaction

1. Circle the problems that have happened to you in the last three months:

Physical Health (accident or injury, illnesses)

My Mood (feeling guilty, depressed, or thinking about regrets)

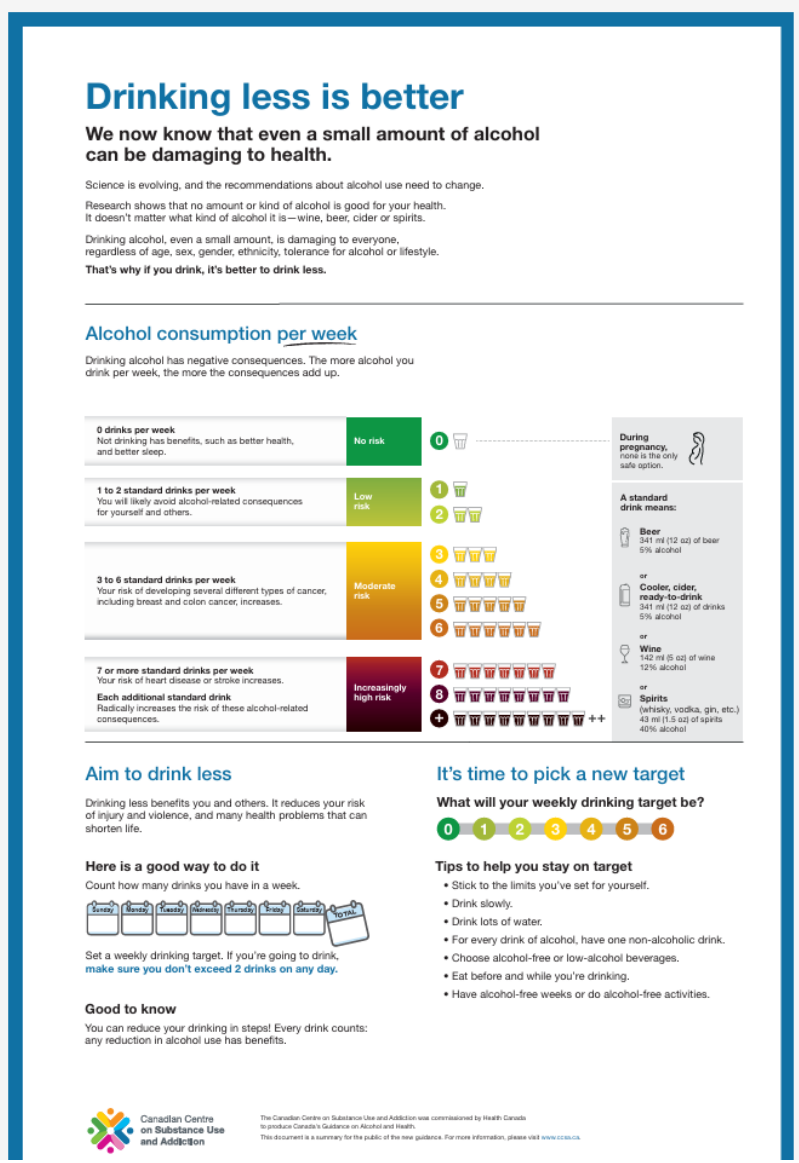
My Relationships (other people complaining about my alcohol or drug use, arguments with family or friends)

Things that I am doing (being late for appointments, mistakes at home or at work)

Breaking the law (getting into fights, theft, even if you were not arrested or charged)

Managing money (running out of money I need for rent or food, or spending money on things I do not need while drunk or stoned)

Be familiar with low-risk guidelines



Drinking less is better

We now know that even a small amount of alcohol can be damaging to health.

Science is evolving, and the recommendations about alcohol use need to change.

Research shows that no amount or kind of alcohol is good for your health.
It doesn't matter what kind of alcohol it is—wine, beer, cider or spirits.

Drinking alcohol, even a small amount, is damaging to everyone,
regardless of age, sex, gender, ethnicity, tolerance for alcohol or lifestyle.

That's why if you drink, it's better to drink less.

Alcohol consumption per week

Drinking alcohol has negative consequences. The more alcohol you drink per week, the more the consequences add up.

0 drinks per week
Not drinking has benefits, such as better health, and better sleep.
No risk

1 to 2 standard drinks per week
You will likely avoid alcohol-related consequences for yourself and others.
Low risk

3 to 6 standard drinks per week
Your risk of developing several different types of cancer, including breast and colon cancer, increases.
Moderate risk

7 or more standard drinks per week
Your risk of heart disease or stroke increases.

Each additional standard drink
Radically increases the risk of these alcohol-related consequences.
Increasingly high risk

During pregnancy, none is the only safe option.

A standard drink means:

Beer
341 ml (12 oz) of beer
5% alcohol

or

Cooler, cider, ready-to-drink
341 ml (12 oz) of drinks
5% alcohol

or

Wine
142 ml (5 oz) of wine
12% alcohol

or

Spirits
(whisky, vodka, gin, etc.)
43 ml (1.5 oz) of spirits
40% alcohol

Aim to drink less

Drinking less benefits you and others. It reduces your risk of injury and violence, and many health problems that can shorten life.

Here is a good way to do it

Count how many drinks you have in a week.

Sunday Monday Tuesday Wednesday Thursday Friday Saturday TOTAL

Set a weekly drinking target. If you're going to drink, **make sure you don't exceed 2 drinks on any day.**

Good to know

You can reduce your drinking in steps! Every drink counts: any reduction in alcohol use has benefits.

It's time to pick a new target

What will your weekly drinking target be?

0 1 2 3 4 5 6

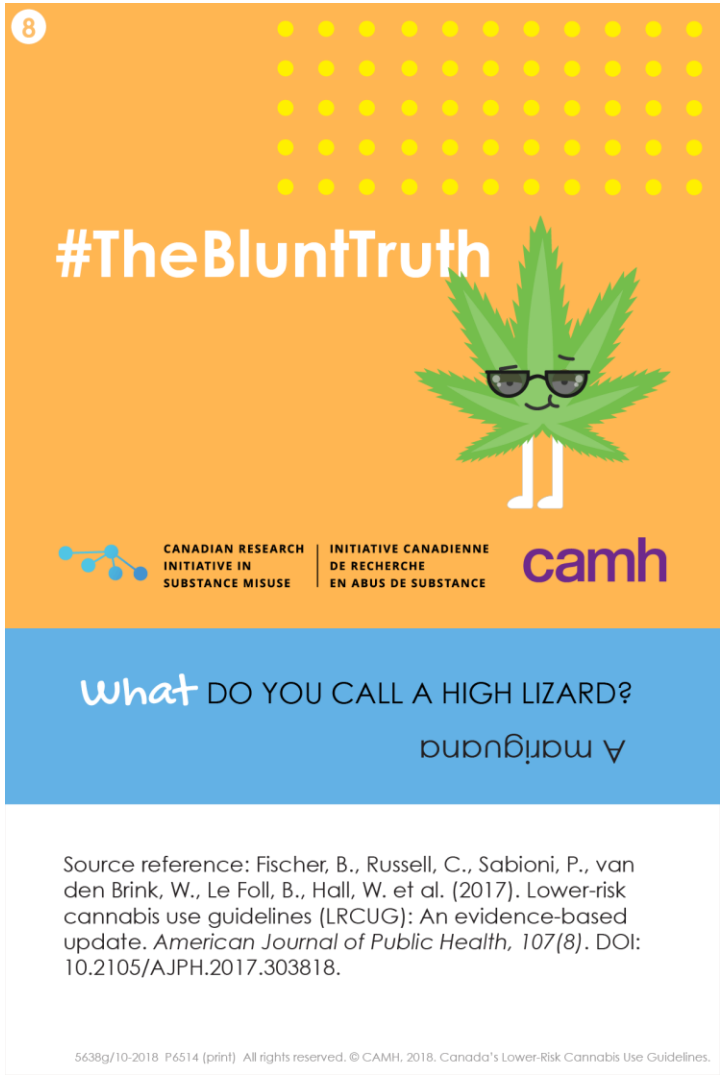
Tips to help you stay on target

- Stick to the limits you've set for yourself.
- Drink slowly.
- Drink lots of water.
- For every drink of alcohol, have one non-alcoholic drink.
- Choose alcohol-free or low-alcohol beverages.
- Eat before and while you're drinking.
- Have alcohol-free weeks or do alcohol-free activities.

Canadian Centre on Substance Use and Addiction

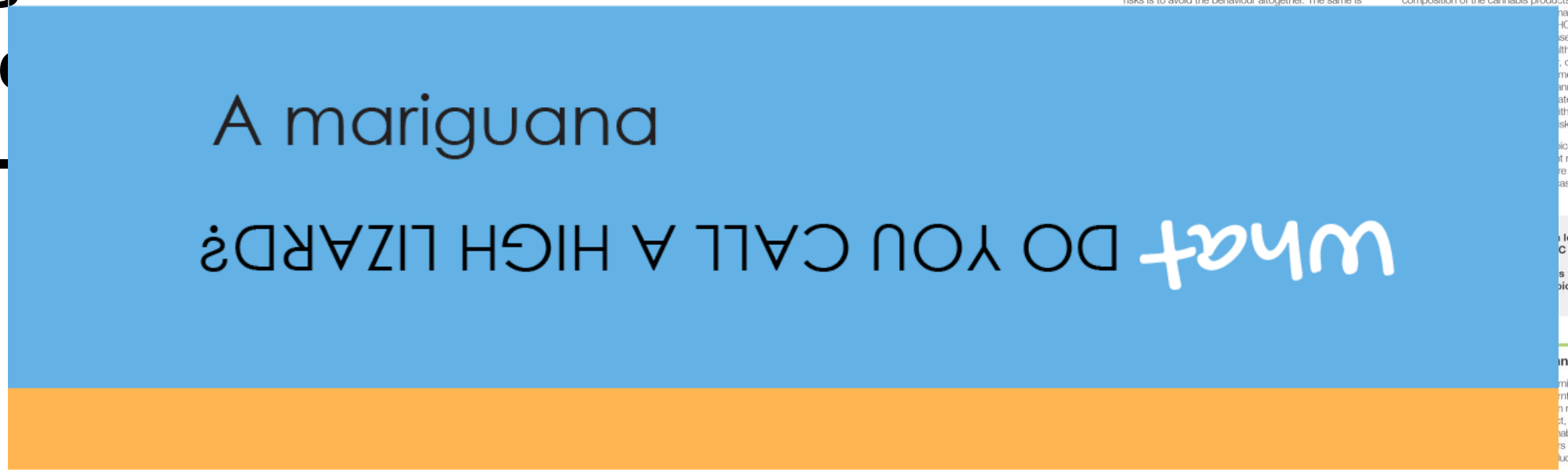
The Canadian Centre on Substance Use and Addiction was commissioned by Health Canada to produce Canada's Guidance on Alcohol and Health.
This document is a summary for the public of the new guidance. For more information, please visit www.ccsa.ca

https://www.camh.ca/en/health-info/guides-and-publications/lrcug-for-youth

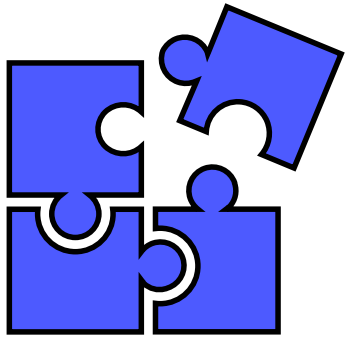




https://www.camh.ca/en/health-info/guides-and-publi
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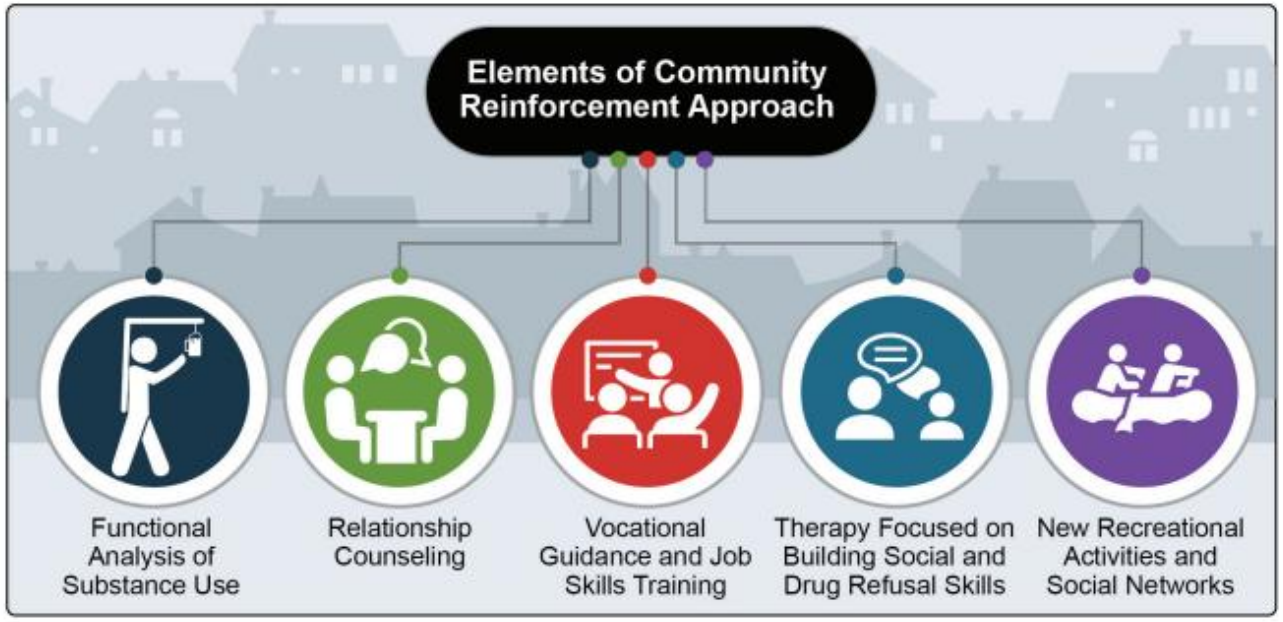


Matching Clients to care



Clinical need	Possible response
Information or curiosity	Education, brief intervention, harm reduction
Ambivalence	MI-informed counselling or follow-up
Medical or overdose risk, opioid use or medical question	RAAM (Addiction medicine) withdrawal assessment, medication support
Ready for structured change	Outpatient, intensive outpatient, or residential care if appropriate
Cognitive barriers	ABI-informed accommodations, case management, shared care
Family distress	Family support, CRAFT-informed education, safety planning

Program characteristics to consider



Concurrent disorders programs

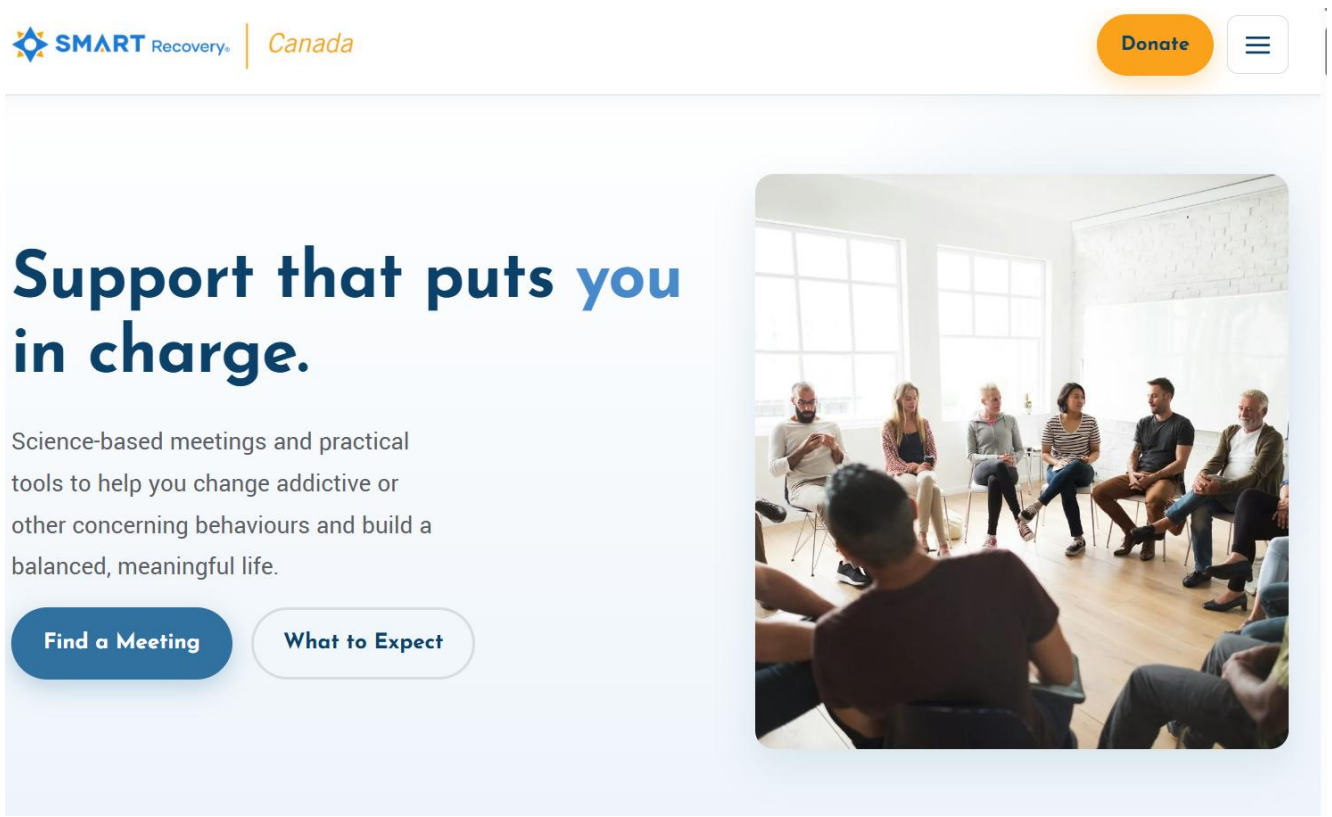
Holistic programming that includes productive activity

Community Reinforcement and Family Training (CRAFT) programs.

Contingency Management


Elements of Community Reinforcement Approach
Functional Analysis of Substance Use
Relationship Counseling
Vocational Guidance and Job Skills Training
Therapy Focused on Building Social and Drug Refusal Skills
New Recreational Activities and Social Networks

Peer Support



Risks

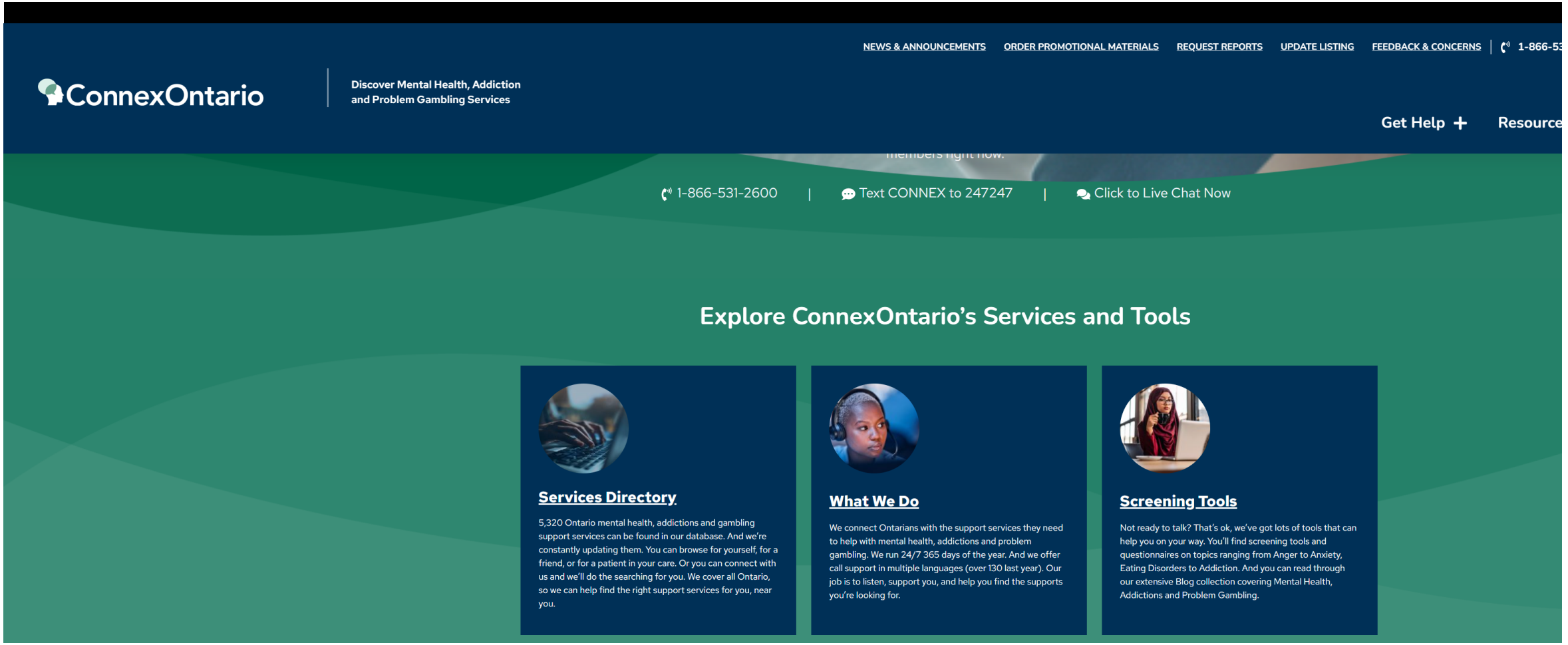
- May be cognitively overwhelming.
- The feeling of being triggered may over-ride the messages.
- Often a place to meet people who continued to use substances

Benefits

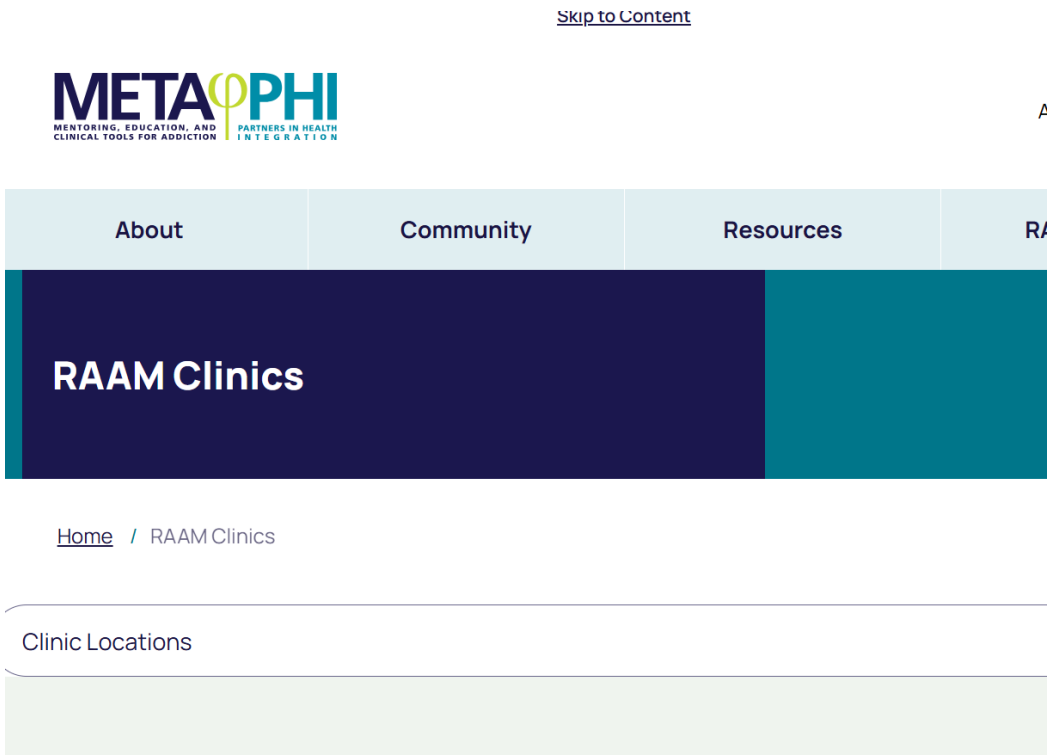
- Long-term support in the community
- Safe social opportunities

Options

- Smart Recovery/AA/NA
- Connect with current member
- Use Workbook to introduce group work
- Go online with your client



Finding addictions services



Addiction Services in Toronto

https://www.metaphi.ca/raam-clinics/

nearly 100 funded

Service hours, access vary

Harm Reduction

Service Referrals

Counselling

Addiction Medicine

Ontario addiction care pathways

Match the access point and level of support to the person's clinical needs.

LEVEL OF CARE	TARGET POPULATION / INDICATORS	PRIMARY SERVICES	ACCESS
LOW-BARRIER / WALK-IN **RAAM clinics**	Immediate, low-threshold help for alcohol, opioid or stimulant concerns	Rapid medical assessment; short-term pharmacotherapy; brief counselling	Walk-in or self-referral; no physician referral in most settings
CENTRALIZED ASSESSMENT **MAARS (CAMH)**	Comprehensive diagnostic evaluation and matching to specialized treatment	In-depth addiction assessment; recommendations; placement into residential or outpatient care	Self-referral via Access CAMH: 416-535-8501, press 2
INTENSIVE OUTPATIENT **IOP / Matrix Model**	Stimulant or multi-substance use requiring structured, non-confrontational therapy	16-week program: CBT, early recovery, relapse prevention, family education and screening	Courts, probation, primary care, mental health services or self-application
WITHDRAWAL MANAGEMENT **Detox / stabilization**	Acute physical withdrawal requiring safe substance clearance and stabilization	Medical or non-medical monitoring; stabilization; direct discharge planning	Direct intake, self-referral, emergency or clinical referral
RESIDENTIAL / BED-BASED **Treatment & recovery**	High-severity addiction or unstable living environments with limited community support	24/7 structured living; peer support; individual/group counselling; cultural integration	Formal application via assessment centres or regional health authorities

24/7 NAVIGATION

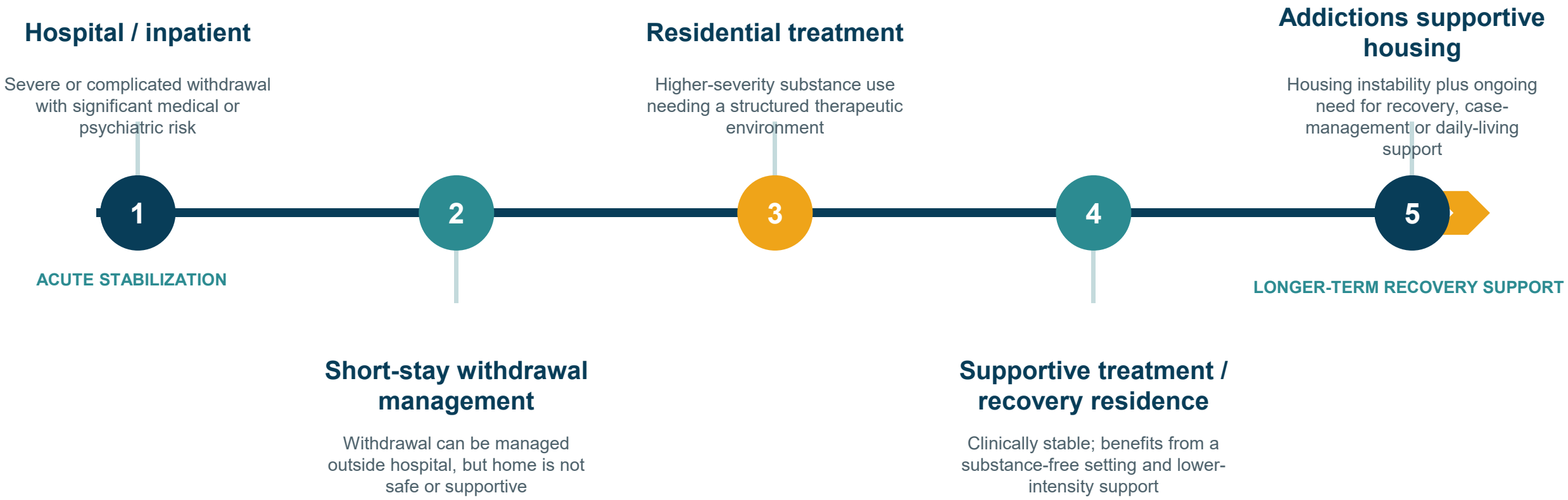
ConnexOntario

Free, confidential regional information, service matching and warm transfers for individuals, families and providers.

Call 1-866-531-2600
Text CONNEX to 247247

Continuum of Bed-based programs

Choose the setting by clinical risk, housing stability and the intensity of support needed.



Sources: ConnexOntario; CAMH; Lakeridge Health; Addictions & Mental Health Ontario; CCSA

Support the transition to addictions care



ASK PERMISSION



OFFER A SMALL MENU



EXPLAIN IN CONCRETE DETAIL WHAT WILL HAPPEN



CONFIRM THE ABILITY TO ADAPT CARE FOR ABI



CALL OR BOOK ASSESSMENT WITH THE CLIENT



SHARE AN ACCOMMODATION PROFILE WITH CONSENT



PLAN FOR FIRST CONTACT.



FOLLOW-UP AND PLAN FOR DISCHARGE

When ABI-Ready addiction programs are not available

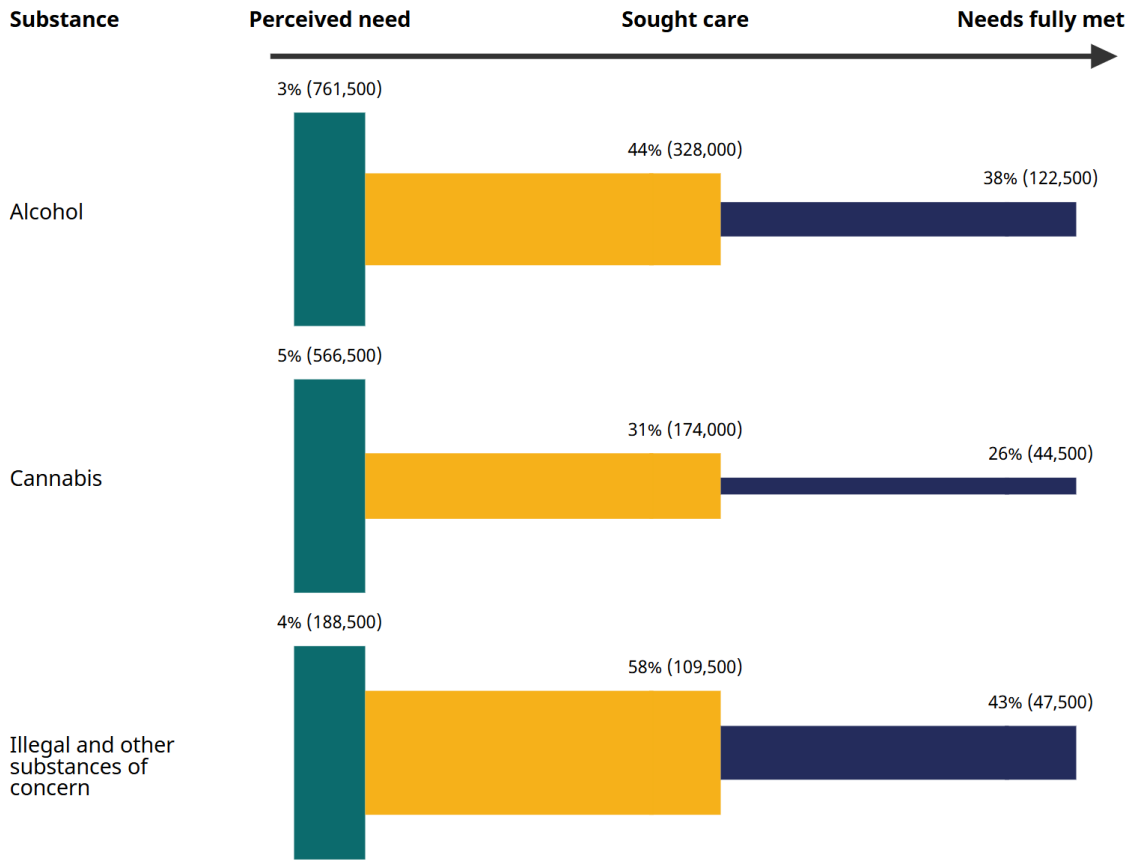
BUILD a Partnership

ABI provider brings	Addictions provider brings
Cognitive and functional formulation	Substance-use assessment and intervention
Accommodation planning	Withdrawal, overdose, craving, medication expertise
Rehabilitation goals	Harm reduction and recovery supports
Environmental supports	Addictions treatment planning
Community participation strategies	Substance-specific risk management

Need for substance use treatment

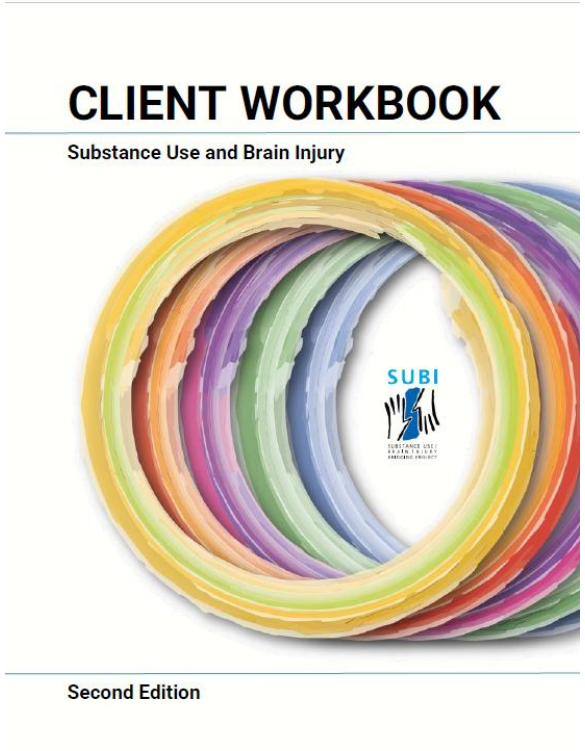
The following presents the percent (and number of people) who reported that they needed professional care related to their use of substances. “Sought care” is the percentage of those who needed care who looked for it, and “needs fully met” reflects the percentage of people who found care and received all that they needed.

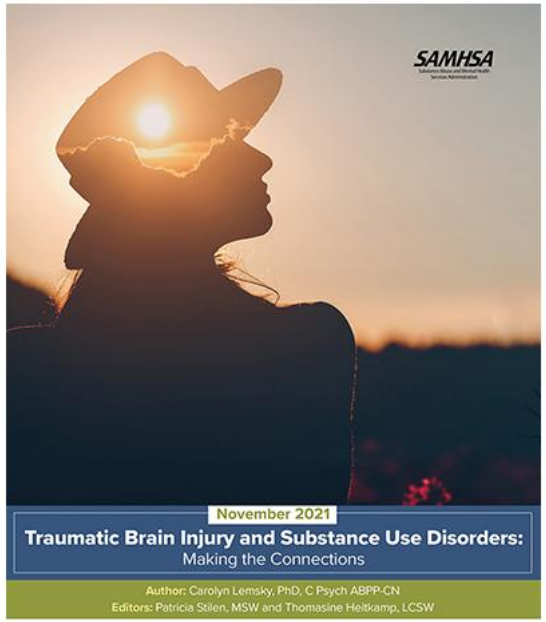
Figure 7: Care cascade for substance use treatment, by substance, among people who used the substance in the past 12 months



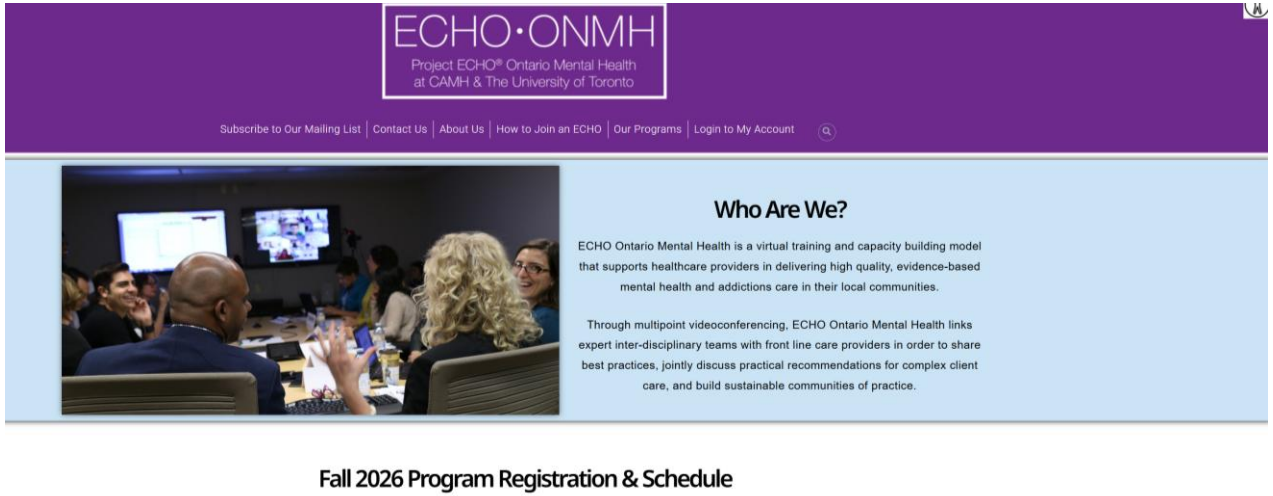
https://health-infobase.canada.ca/substance-use/reports/csus/

Mid-America (HHS Region 7)
ATTC Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration





https://attcnetwork.org/centers/mid-america-attc/traumatic-brain-injury-sud-series



CAMH Addictions Medicine and Psychosocial Interventions



Online Brain Injury Training | OBIA & Brock University

Canada's Leading Brain Injury Professional Training Programs

Developed in partnership between the **Ontario Brain Injury Association** and Brock University, OBIA's certificate training programs provide advanced, faculty-led education for professionals working with individuals living with acquired brain injuries.



Our programs are delivered LIVE ONLINE and led by university faculty, offering:

- Teaching by subject-matter experts
- Real-time instruction and discussion
- Immediate answers to questions
- Live, facilitated case analysis
- Interactive, responsive professional education

More than 10,000 professionals have completed OBIA's certificate training programs.

For over 35 years, OBIA has developed and delivered brain injury education and training and is recognized as a leader in the field.

Presented by the Ontario Brain Injury Association and formally recognized by Brock University, each program concludes with participants receiving a **non-credit Professional Certificate from Brock University** upon successful completion.

Your next moves

Six practical actions to build into routine care

CHECK AS YOU GO

- [ ] **Screen routinely and respectfully.**

  Make screening a standard, nonjudgmental part of care.

- [ ] **Define safe-participation boundaries.**

  Be clear about expectations, risks, and supports.

- [ ] **Ask about goals before substance use.**

  Start with what the person wants to achieve.

- [ ] **Know your local addiction partners.**

  Build referral relationships before they are needed.

- [ ] **Focus on what you observe.**

  Discuss changes and concerns—not assumptions.

- [ ] **Build team capacity.**

  Consider ECHO, OBIA, Motivational Interviewing and cross training.

Acknowledgements

Neurobehavioural Intervention Team CHIRS, current members and Alumni.

CAMH partners Tim Godden and Peter Selby

National Association of State Head Injury Administrators: Judy Dettmer and Maria Crowley

CHIRS
Community Head Injury Resource Services

Mid-America (HHS Region 7)
ATTC Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

Mountain Plains ATTC (HHS Region 8)
ATTC Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration



NASHIA

Phased care: what changes at each stage

Phase	Goal	Substance-use focus	Rehabilitation team
Acute injury	Safety + early identification	Assess withdrawal Support safe detox Screen substance use	Screen and educate post PTA Provide written guidance related to substance use MI-informed discussion with brain-health focus
Engagement	Alliance + motivation	Prevent immediate harm Explain health impacts Use motivational strategies	Communicate without judgment Monitor risks Coordinate care/ Consult with addictions medicine
Preparation	Clear goals + readiness	Connect with addiction services Enable direct entry to care	Address access barriers Coordinate referrals Build support and hope
Directed care	A realistic change plan	Start the treatment plan Use medication, behavioral, or peer supports Build community resources	Address stigma Align rehabilitation and addiction goals Support meaningful engagement
Maintenance	Sustain change	Maintain gains Build substance-free routines and relationships	Strengthen self-image Support transitions Plan for stress points

Table 3
Phased care

Phase	Goals	Substance Use–Related Tasks	Role of the Rehabilitation Team
Acute brain injury	For providers: • Client safety. • Screening and identification.	• Assess for withdrawal. • Safe detoxification. • Screening for substance use.	Screening at onset and follow-up (post PTA). Brain health and substance use education. • Provide written information. • MI-informed discussion. • Brief goal setting.
Engagement: Before a client expresses a goal for changing substance use and/or when hospitalization has interrupted substance use.	• Client safety. • Building therapeutic alliance. • Establishing norms and routines to facilitate intervention. • Enhancing motivation for change.	• Prevent immediate harms related to substance use. • Education regarding the health impact of substance use. • MI • Consider environmental interventions. ◦ Reduce cues to substance use. ◦ Consider behavioral intervention (eg CRAFT).	• Support with nonjudgmental communication. • Brain health and substance use education. • Be aware of signs of use. • Consult/partner with addictions providers. • Support attendance and participation in programming. • Use MI to enhance motivation for change. • Monitor and address pain management, mental health, and cognitive concerns. • Develop guidelines for safe participation in rehabilitation activity.
Preparation Initiated when a client is expressing a desire to make a change in substance use	• Clarification of goals for change. • Identification of strengths and barriers for change. • Facilitate access to addictions care.	• Shared care with addictions services. • Facilitate entry into direct substance use care.	• Consult with addictions providers. • Identify and address potential barriers to participation in addictions care, ◦ Skills required for group participation ◦ Cognitive compensation strategies • Assess client strengths and resources. • Facilitate identification and involvement of family and other supports—including external providers. • Identify sources of inspiration and hope.

(*continued on next page*)

Client Introduction to Model of Intervention



Working Together

- What is SUBI and how can it help?
- What are my rights and responsibilities?



Envisioning the Future

- What do I want for my life?
- How does my substance fit in with my vision for the future
- How do I set realistic goals?



Preparing for Change

- Formulating goals for change
- Clarifying my reasons for change



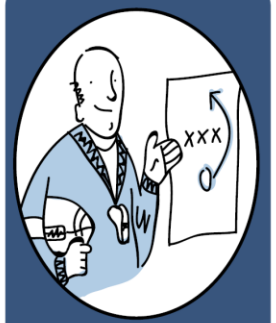
Gathering Resources and Building Skills

- How do I fill my time?
- Who can support me?
- What do I do when I'm sad, lonely, frustrated or angry?



Taking Action

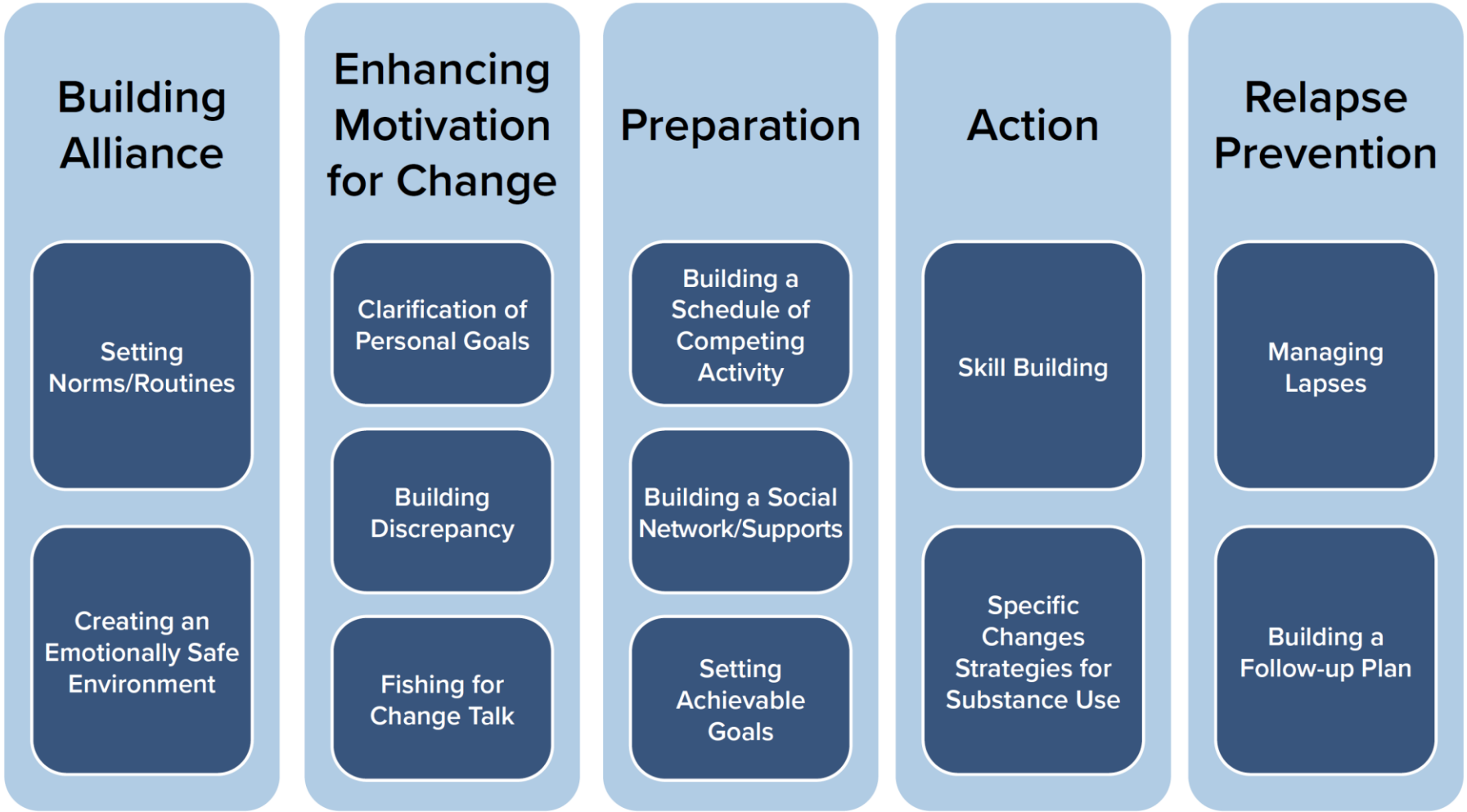
- How do I prevent problem situations?
- What do I do if a problem occurs?
- How do I get around the problems caused by my brain injury?



Maintaining Gains

- What will help me maintain the gains I have made?
- What is the plan for the long run?

Provider Guide for Intervention



Key Evidence-Based

Interventions with RTC/Meta-analyses	ABI Specific Evidence	Notes
Brief Intervention (FRAMES)	Prevention/Education (e.g. Bogner et al., 2021)	Multi-media key SBIRT - Booster sessions Brain Health/Health focus
Incentives Contingency Management	**(Corrigan et al., 2005)**	**Incentive to attend supported engagement**
Motivational Interviewing	**Small controlled studies Cox, et al., 2003)**	**Increase structure repetition**
Community Reinforcement and Family Training (CRAFT)	**Intensive case management (Bogner et al, 1997) Skills training (Vungkhanching et al., 2007)**	**Elements of CRAFT, but not full model**
Harm Reduction	?	
Pharmacotherapy	Limited RTCs,	