Contents

1. Project Title and Purpose

Project Title: Addressing Clinical Knowledge Gaps in Supporting Persons with Moderate-to-SevereTraumatic Brain Injury, Mental Illness and/or Addiction

Project Purpose (clearly indicate the Recommendation number and wording from the Clinical Practice Guideline):

This catalyst grant address implementation of the following recommendation:

S 1.2 – Education and training should be provided to healthcare professionals in drug and alcohol misuse programs in relation to traumatic brain injury, its sequelae, and effects on drug and alcohol use.

2. Project Description:

A. Methods:

The main objective of the current project was to increase access to addictions care for people living with brain injury who are also experiencing problematic substance useby providing appropriate training to mental health and addictions professionals. Project activities included the development and implementation of an 8-week, 14-hour, asynchronous training program for addictions and mental health providers, implementationof training opportunities for medical staff members and the launching of an online community of practice. Each of the online learning modules included questions for reflection, readings, and resources as well as activities to illustrate concepts.

Module 1: Background information

- *Introduction to ABI*
- *Introduction to Substance Use Disorders (SUD)*
- *Relationship between brain injury, substance use disorders and the social determinants of health*
- *Recognizing the impact of ABI*
- *The interaction between ABI and SUD.*

Module 2: Adapting treatment

- *Screening for ABI*
- *Adapting Motivational Interviewing*
- *A concurrent disorders approach to treatment of SUD*
- *An Introduction to pharmacological interventions*
- *Interventions for tobacco sue and opioids*

Module 3: Supporting clients with Cognitive Impairment

- *Introduction to cognitive impairment associated with ABI*
- *Introduction to self-management challenges after ABI*
- *Screening for and identifying cognitive impairment*
- *Cognitive compensation strategies for observed cognitive impairment*
- *Creating /providing environmental supports*

Module 4: Implementing services for individuals living with ABI

- *Creating accessible settings*
- *Outreach*
- *Modifications to intake processes*
- *Recommendations to promote client engagement in individual and group therapies*
- *Integration with community resources*

Training provided in ECHO for physicians and other professionals included the following:

1. Epidemiology of ABI and SUD
2. The link between SUD, Overdose and ABI
3. The presentation of ABI in addictions settings
4. Feasible adaptations to service delivery based on evidence-based practices in ABI and SUDsettings.
5. Model of case management that emphasizes the needed for less intensive, but longer lastingmodels of care which include the development of stable environmental supports

B. Data collection Tools:

i. Tools to measure Clinical process

N/A

ii. Tools to measure Clinical outcome

N/A

iii. Tools to measure Implementation process

Tools used to assess the training process are included in the appendices. These measures are adaptations to measures developed by the TEACH project and are fully owned by CAMH. Use is by permission of the TEACH project.

iv. Tools to measure Implementation outcome

Tools used to assess the post-course learning are included in the appendix. These measures are adaptations to measures developed by the TEACH project and are fully owned by CAMH. Use is by permission of the TEACH project. These are also included in Appendix 'A'.

C. Findings (process and outcome):

Course Satisfaction

These data will be updated when more information becomes available after the extended coursedeadline.

25 individuals registered for the course; 21 completed the required assignments, however, only 15 post course assessments were available at the time of this writing. Rankings were made on a scale of strongly disagree= 1 to Strongly agree = 5. Overall, attendees ranked the course quality as 4.5 and usefulness 4.0. Comments indicated that while course readings were regarded as useful, participants would have enjoyed a more interactive experience including more video-taped explanations and didactic materials. 75% (n= 9) of respondents ranked the amount of information provided in the course, and the level of complexity of material presented was "about right", 16.75% (n=2) described thecourse as "advanced" while 1 participant described the course as "basic" (8.3%).

Self-Rated changes in trainees

Highly statistically significant changes were observed in participants' self rankings (0 = low and 10 = high)regarding knowledge, skill, feasibility, importance and confidence in implementing interventions with clients who have a history of brain injury. The largest changes were observed in knowledge, skill and confidence. More detail is provided in Appendix 'B'.

Participants were asked to indicate the likelihood of relevant clinical activities in the six months post- training. 86% indicated that they would describe the relationship of ABI history to a client's presentation, 73.3% indicated that they would be applying a model of SUD care for people with ABI, 86%reported the ability to identify and use the basics of cognitive accommodation and 66.7% felt that they would be able to design an intervention for individuals living with brain injury.

Barriers to implementation of skills learned were also assessed. Program resources including funding,the amount of time available for individual clients and the need for more practice were cited by morethan 50% pf respondents as barriers to implementation. 93% of respondents indicated that having support of peers would enable their implementation, suggesting that the community of practice will play an important role in implementation.

D. Summary:

Problematic substance use is widely understood to be both a risk factor for brain injury as well as an outcome of brain injury. Despite the undeniable link between brain injury and substance use disorders,many addictions and mental health providers do not screen for brain injury. Even

when a history of brain injury is documented, mental health and addictions providers often lack the training to recognize and appropriately accommodate neurocognitive and neurobehavioural challenges.

The current project developed and implemented a training for professionals working in addictions and mental health settings. Training included webinar and case presentations as well as an asynchronous online training offered over 8 weeks. The initial offering attracted 25 registrants with mental health andaddictions backgrounds. Only the initial course assessment, completed by 15 of the 25 participants was available at the time of this writing. Satisfaction rankings were made on a scale of strongly disagree= 1 to Strongly agree = 5. Overall, attendees ranked the course quality as 4.5 and usefulness 4.0.

Comments indicated that while course readings were regarded as useful, participants would have enjoyed a more interactive experience including more video-taped explanations and didactic materials.
Pre-and post-course self-assessments were also conducted. Participants were asked to rate themselveson a ten-point scale (0 = low and 10 = high) regarding knowledge, skill, feasibility, importance, and confidence in implementing interventions with clients who have a history of brain injury. Initial findings indicate highly statistically significant changes as the result of course participation. The largest changes were observed in knowledge, skill, and confidence. More detail is provided in appendix 'B'.

Participants were asked to indicate the likelihood of relevant clinical activities in the six months post- training. 86% indicated that they would describe the relationship of ABI history to a client's presentation, 73.3% indicated that they would be applying a model of SUD care for people with ABI, 86%reported the ability to identify and use the basics of cognitive accommodation and 66.7% felt that they would be able to design an intervention for individuals living with brain injury.

Finally, barriers to implementation of skills learned were also assessed. Program resources including funding, the amount of time available for individual clients and the need for more practice were cited by more than 50% pf respondents as barriers to implementation. 93% of respondents indicated that havingsupport of peers would enable their implementation, suggesting that the community of practice will play an important role in implementation.

E. Lessons Learned:

The initial implementation of the course indicated that the course content is appropriate. The group ofparticipants was small and future administrations of the course will be needed to verify the findings from this project. Based on the comments provided by participants, the most dramatic change in addictions and mental health providers was their willingness to consider that

difficulties with intervention compliance, follow-through and behaviour may be related to neurological disability rather than a lack of motivation to participate in care. Training participants were also willing and able to learn accommodations for counselling settings. These were considered necessary, appropriate, and feasible for service delivery. Building treatment models that emphasize environmental supports were readily accepted as necessary but considered more difficult and costly to implement. They expressed a willingness to partner with community-based programs that can provide environmental supportssuch as programming that directly competes with substance use behaviour. Many individuals with histories of brain injury who enter addictions care do not have direct access to brain injury providers.

Many mental health and addictions providers are not familiar with brain injury support services in their local jurisdictions. Success in reducing barriers to care should include a mechanism for connecting localservice providers.

3. Recommendations for next steps to support full sustainable implementation: (for your organization, for future implementation projects, for policy, for system organization)

A brief presentation that introduces the material contained in the course will be made available to braininjury organizations in order to encourage participation in the course, an introduction to the brain injuryservices that are available in the jurisdiction, and to invite collaboration.

The online course will be amended to increase opportunities for interactive learning, and will include participation in the community of practice.

4. What has been done to ensure Sustainability:

The course will be run through CAMH with trained facilitators. A course fee will ensure sustainabilityand support ongoing modification as required. Applications for additional funding for course development is currently underway. We continue to seek funding to further refine the course and develop adjunct training materials such as a toolbox, and additional video demonstrations.

If you want more information about this Project, please contact:

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