

Opioids and Mental Health Concerns Workforce Competencies

Results from a Survey with
Subject Matter Experts



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Table of Contents

Introduction	Error! Bookmark not defined.
Methodology	4
Data Collection Tool	4
Target Population	4
Data Validation and Analysis	5
Results.....	6
Background Information of SMEs	6
Rating of Competencies	9
Basic Medical Rehabilitation Concept Competencies	9
Brain Injury and Co-morbidities Competencies	10
Screening and Assessments Competencies.....	13
Accommodations and Intervention Competencies	14
Resource Facilitation Competencies	16
Implications/Discussion/ Next Steps	17
Appendices	18
Appendix A: ACL Workforce Competencies and Emerging Practices SME Survey...	18
Appendix B: Tables.....	24
About TBI TARC.....	32

Introduction

The Opioid Use and Mental Health Concerns workgroup is a group of States funded by the Administration for Community Living (ACL) Traumatic Brain Injury State Partnership Program, focused on increasing awareness of behavioral health concerns in the brain injury community. The workgroup is comprised of two mentor states (Massachusetts and Virginia) and six partner states (Alabama, Kentucky, Maine, Maryland, North Carolina, and Ohio). Mentor States host workgroup calls and coordinate activities to advance the field in specific areas of focus; these calls serve as a forum for Partner State grantees to benefit from Mentor State grantee leadership, tools, and experience.

One of the activities of the workgroup was to develop workforce competencies and emerging practices for professional and paraprofessionals who serve individuals with a brain injury. These competencies and practices are intended to serve as a general guide to the essential knowledge, skills, and abilities necessary for serving individuals with a brain injury and co-occurring behavioral health disorders in a wide range of settings (such as prevention programs, community-based programs, facility-based treatment programs, primary care health delivery systems, emergency rooms, criminal justice systems, schools, or higher education institutions). These basic promising practices are not intended to encompass the full range of competencies related to working with individuals living with brain injury and who have or are at risk of co-occurring behavioral health disorders, but rather, they are to be broadly reflective of current research and practice in the field.

Staff from the Traumatic Brain Injury Technical Assistance and Resource Center (TBI TARC) assisted the Opioid Use and Mental Health Concerns workgroup with their work on the workforce competencies. The TBI TARC is a national center funded by the Administration for Community Living.

Methodology

The process of developing the workforce competencies and practices began by identifying useful and promising practices which would then be rated for their relevancy.

Data Collection Tool

A list of competencies and promising practices was collated by the Opioid Use and Mental Health Concerns Workgroup based on a review of literature and current field practices. These competencies included concepts from basic medical and rehabilitation knowledge, brain injury and comorbidities, screenings, assessments, accommodations, interventions, and resource facilitation.

Questions on the responder's background and the list of competencies was built into a questionnaire using SurveyMonkey. For each competency, subject matter experts were required to provide their assessment of the level of its relevance to the work of professionals serving the needs of individuals living with a brain injury and co-occurring behavioral health disorders on a scale of 1 to 7, with 1 being "Not Relevant" and 7 being "Highly Relevant". Experts were also asked to leave a comment with more information against any competency that was rated a 4 or less.

See Appendix A for a sample of the questionnaire that includes background questions and each competency.

Target Population

The questionnaire was sent to subject matter experts (SMEs) who comprised of professionals and paraprofessionals that work with individuals living with brain injury who are served by brain injury and behavioral health programs and systems. SMEs were identified by members of the workgroup and were sent email reminders. Data collection occurred between April 2021 and June 2021.

Data Validation and Analysis

Responses were exported into an Excel analytic spreadsheet and cleaned. Aggregate counts of the relevancy ratings were extracted from SurveyMonkey and used to create tables and graphs showing the ratings for each corresponding competency. Responses were checked to ensure that all values were valid and within allowable ranges. Missing responses for any competency were omitted from the final analysis.

Data quality standards were maintained throughout the importation, data cleaning and analysis processes by having one member of the team perform data cleaning and analysis and having another member of the team perform quality control procedures.

Results

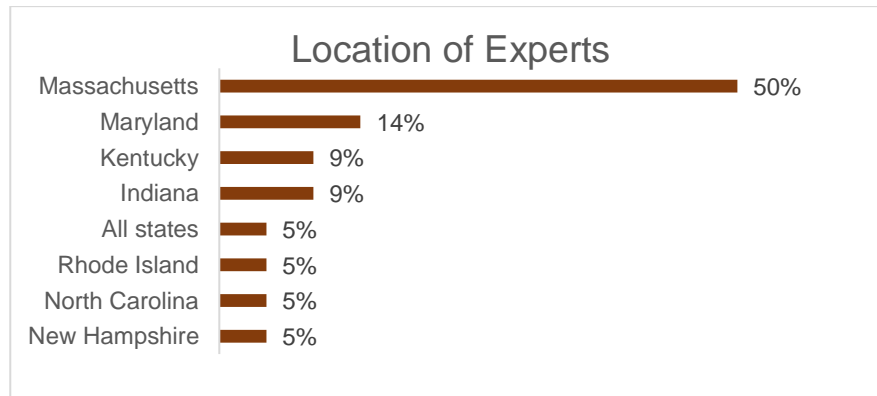
Twenty-two of 63 subject matter experts (SMEs) contacted responded to the questionnaire (36.5% response rate).

Background Information of SMEs

Exhibits 1 through 6 show the location of the SMEs, their work setting, and their focus areas. Appendix B contains more detailed data tables.

Fifty percent (11) of SMEs worked in Massachusetts, fourteen percent (3) worked in MD, 9% (2) each worked in Kentucky and Indiana, 5% (1) each worked in New Hampshire, North Carolina, and Rhode Island, while another 5% (1) worked across all states in the US (Exhibit 1).

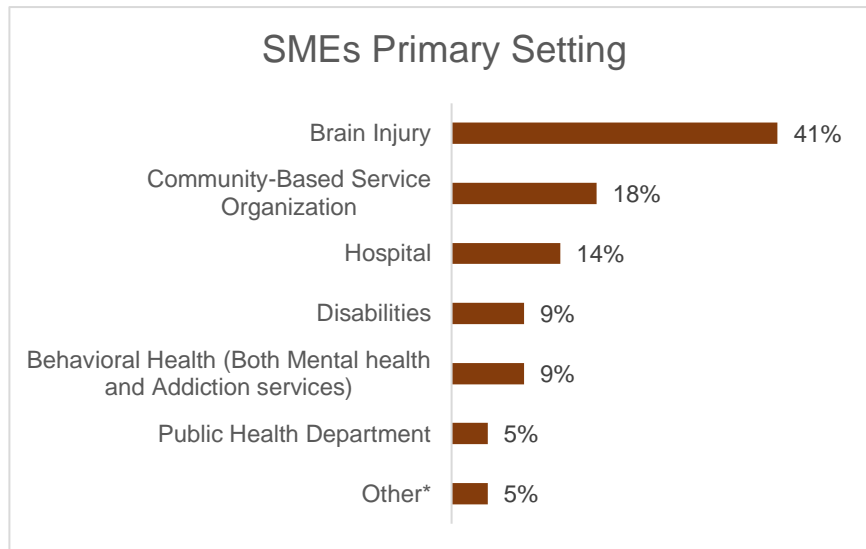
Exhibit 1. Location of Experts



Notes: Based on data from 22 responses

Forty-one percent (9) of SMEs worked in state/local brain injury organizations, 18% (4) worked in a community-based service organization, 14% (3) worked in a hospital setting, 9% (2) worked with individuals with disabilities, 9% (2) worked in behavioral health (both mental health and addiction services) and 5% (1) worked in a public health department (Exhibit 2). One SME was in a private practice setting.

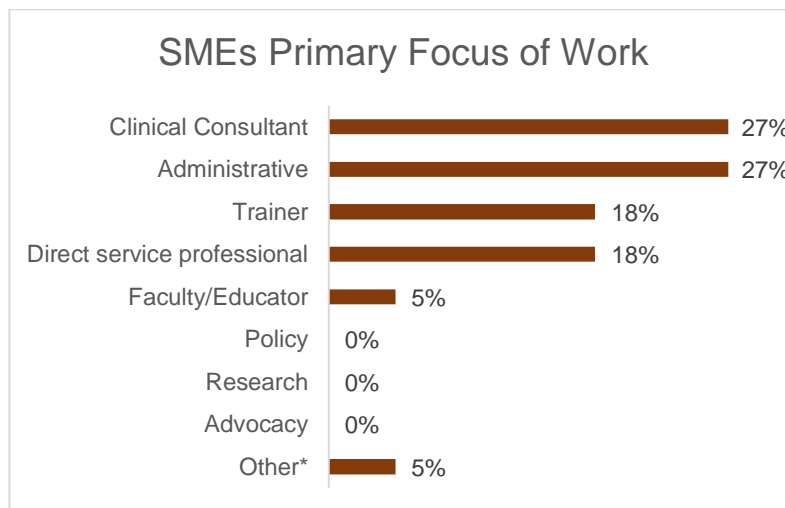
Exhibit 2. SMEs Primary Setting



Notes: Data based on 22 responses
"Other" primary setting is private practice.

Twenty-seven percent (6) of the SMEs had primary work focus as clinical consultants and administrative work. Trainers and direct service providers each accounted for 18% (4) of primary work focus while 5% (1) of SMEs were faculty members/educators (Exhibit 3). One SME described their primary focus as a combination of community-based case management, coordination of services, advocacy, and resource development. There were no SMEs with a primary focus on advocacy, research, or policy.

Exhibit 3. SMEs Primary Focus of Work



Notes: Data based on 22 responses
"Other" category is described as community-based case management; coordination of services; advocacy; and resource development

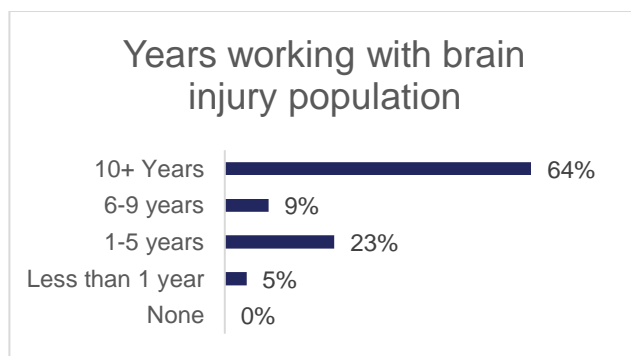
SMEs who responded had some experience working with individuals living with either a brain injury, a mental health disorder or a substance use disorder.

About 60% of SMEs had worked with populations with brain injury and populations with substance use disorder for ten years or more (64% and 59% respectively), while 68% of had worked with populations with mental health disorders for 10 years or more. 9% of SMEs had worked with populations with brain injury and populations with substance use disorder for 6-9 years, while 14% had worked with populations with mental health disorders for 6-9 years (Exhibits 4 through 6).

23%, 14% and 18% of SMEs had worked with brain injury populations, populations with mental health disorder and substance use disorder populations respectively for 1-5 years. About 5% of SMEs had only worked for less than a year with populations with brain injury and substance use disorders (Exhibits 4 through 6). SMEs with no experience working with populations with mental health disorders and substance use disorders accounted for 5% and 9% respectively.

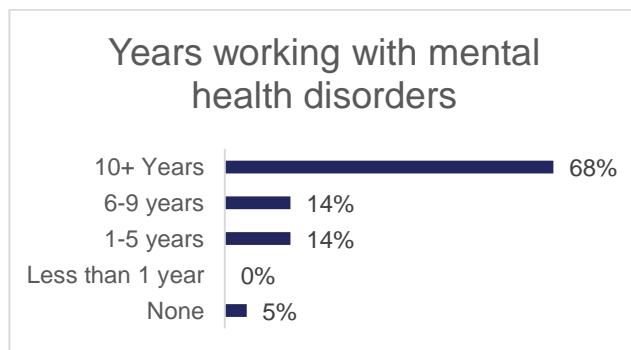
It is important to note that most respondents (about 60%) were well experienced in working with the populations of focus, and those that weren't had at least 1 year of experience working with the populations of focus.

Exhibit 4. Years Working with Brain Injury Population



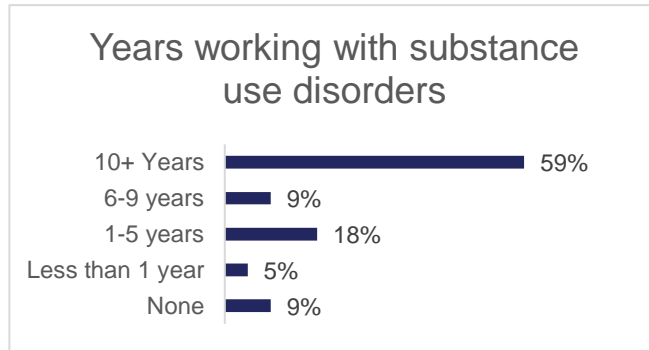
Notes: Data based on 22 responses

Exhibit 5. Years Working with Populations with Mental Health Disorders



Notes: Data based on 22 responses

Exhibit 6. Years Working with Populations with Substance Use Disorders



Notes: Data based on 22 responses

Rating of Competencies

Discussed below is how the SMEs rated the competencies within the five core concept areas: 1) basic medical and rehabilitation; 2) brain injury and comorbidities; 3) screening and assessments; 4) accommodations and interventions; and 4) resource facilitation.

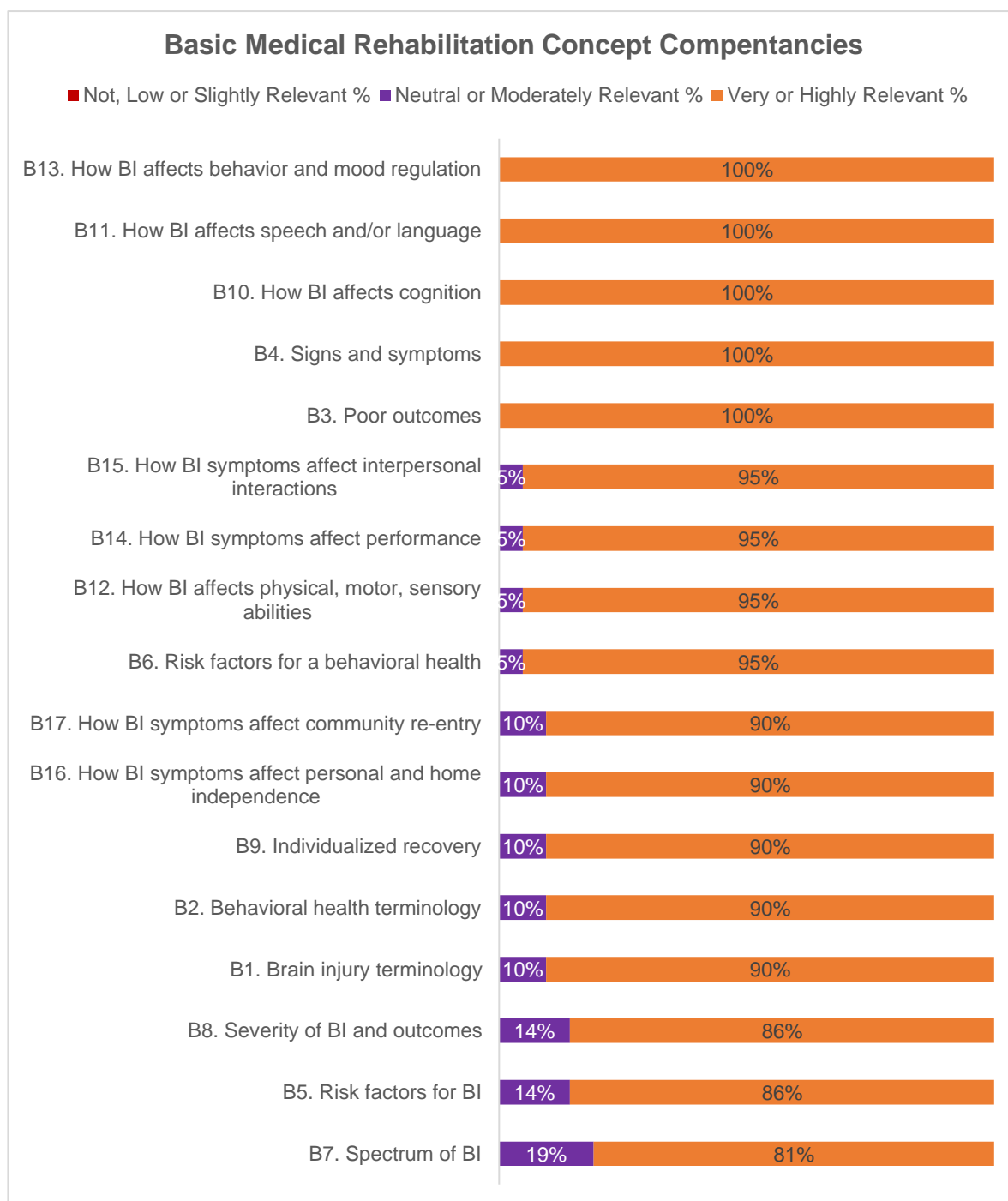
Basic Medical and Rehabilitation Competencies

The most rated competencies, with 100% (n=21) of responders rating them very or highly relevant, were: understanding of how brain injury affects behavior and/or mood regulation (awareness, adjustment, mood, interpersonal skills, etc.) (B13); understanding of how brain injury affects speech and/or language production and/or comprehension (B11); understanding of how brain injury affects cognition (memory, attention, executive skills, problem solving, processing speed, etc.) (B10); understanding of the factors that contribute to poor outcomes in persons living with a brain injury (B3); and understanding of the signs and symptoms of unhealthy substance use (B4) (Exhibit 7).

The least rated competency among basic medical rehabilitation concepts with 81% of responders who rated it very or highly relevant and 19% who rated it neutral or moderately relevant was knowledge of the severity spectrum of brain injury (mild to severe) (B7).

One SME was neutral to the competency related to understanding how symptoms of brain injury affect community re-entry (B17) but didn't leave any comments. No competencies in this section were rated not relevant, or as low or slightly relevant. See Exhibit 7 for more results on ratings below.

Exhibit 7. Basic Medical Rehabilitation Concepts Competencies



Notes: Data based on 21 responses

Brain Injury and Co-morbidities Competencies

Among the brain injury and co-morbidities competencies, understanding of the needs and challenges of individuals living with both a brain injury and co-occurring disorder(s) (C1) was rated as very or highly relevant by all the SMEs

Traumatic Brain Injury Technical Assistance and Resource Center

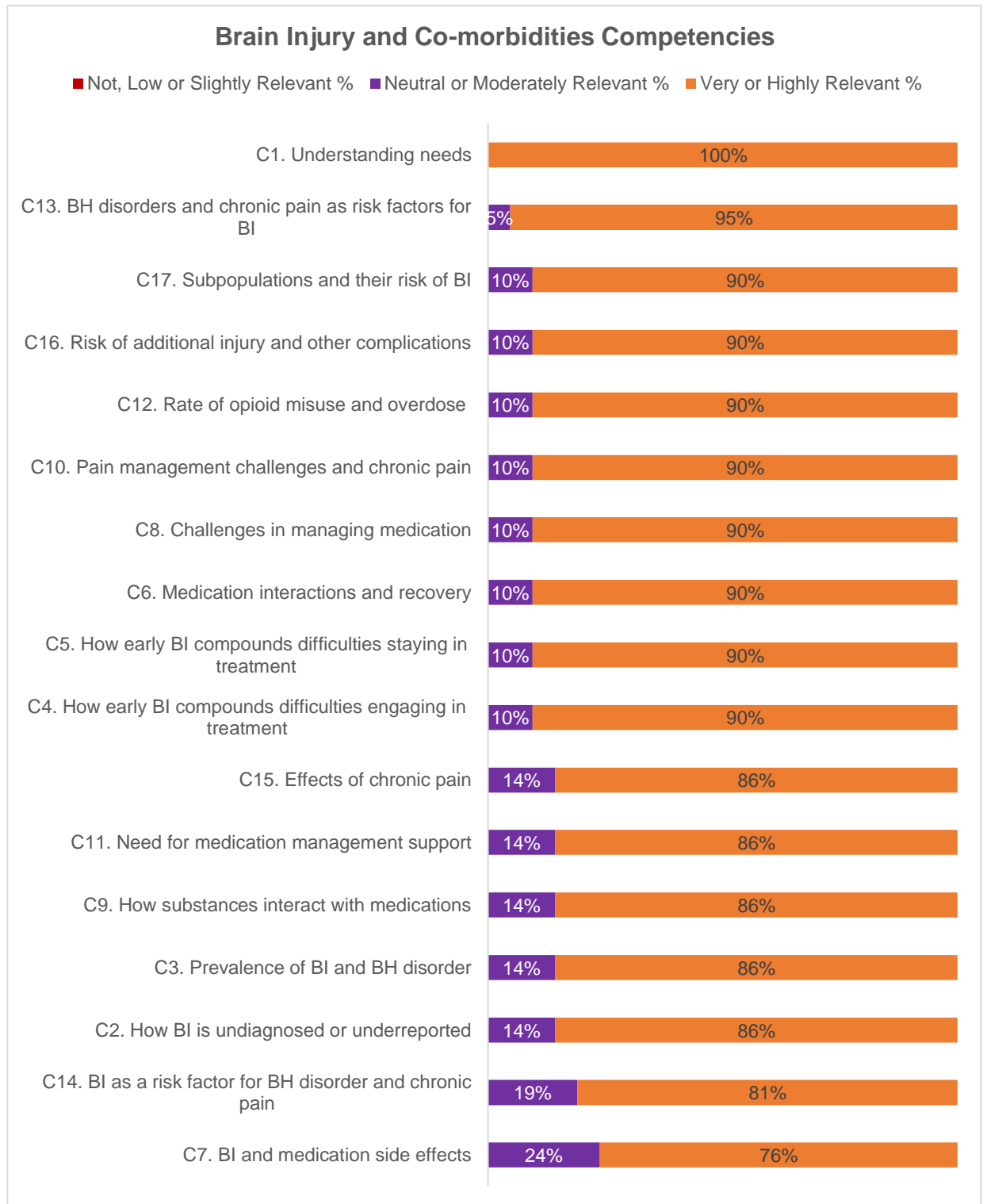
followed by understanding of how behavioral health disorders and chronic pain are risk factors for sustaining a brain injury which was rated as very or highly relevant by 95% (20) of experts (Exhibit 8).

76% (16) of responders rated the understanding of how brain injuries may increase risk of known medication side effects (C7) as very or highly relevant while 24% (5) rated it as neutral or moderately relevant making it the least endorsed competency in this section (Exhibit 8).

Three competencies were rated neutral by 1 SME. The responder noted that though basic awareness of the importance of some competencies were important such as understanding of how substances interact with medications (C9) and understanding of the need medication management support for individuals living with a brain injury (C11), staff should always refer to medical professionals with expertise in substance use disorder (SUD) and medication concerns. Another SME noted that in relation to understanding how subpopulations are at a higher risk for sustaining brain injuries (C17), subpopulations aren't always identified yet should be treated in the same respect as all others with co-occurring traumatic brain injury and SUD.

No competencies in this section were rated not relevant, or as low or slightly relevant. See Exhibit 8 below for more results on ratings.

Exhibit 8. Brain Injury and Co-morbidities Competencies



Notes: Data based on 21 responses

Screening and Assessments Competencies

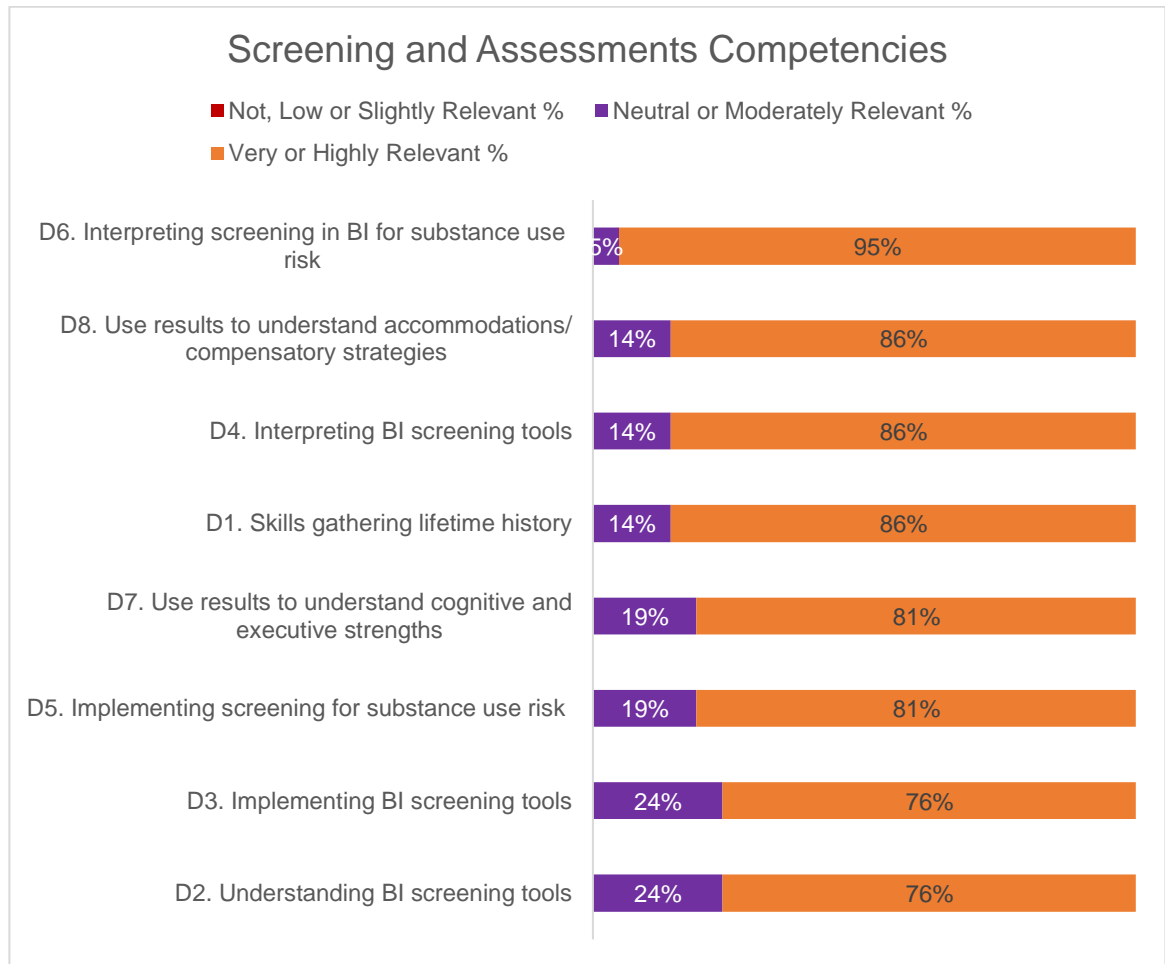
Skills in interpreting the screening of individuals with brain injuries for substance use risk (D6) was the most rated competency with 95% (20) of SMEs rating it as very or highly relevant while 5% (1) rated it neutral or moderately relevant (Exhibit 9).

The least rated competencies were understanding of how brain injury screening tools assist in the identification of persons living with brain injury (D2), and skills in implementing brain injury screening tools (D3) respectively with 76% (16) of responders who rated them as very or highly relevant while 24% (5) rated them as neutral or moderately relevant.

A responder who rated the competency D7 as neutral (the ability to use results from cognitive screening and/or neuropsychological assessments for understanding a person's cognitive and executive strengths) noted that service providers (e.g., community-based workers) should not be expected to interpret results but rather utilize a trained professional (e.g., neuropsychologist) to interpret results and utilize recommendations.

No competencies in this section were rated not relevant, or as low or slightly relevant. See Exhibit 9 below for more results on ratings.

Exhibit 9. Screening and Assessments Competencies



Notes: Data based on 21 responses

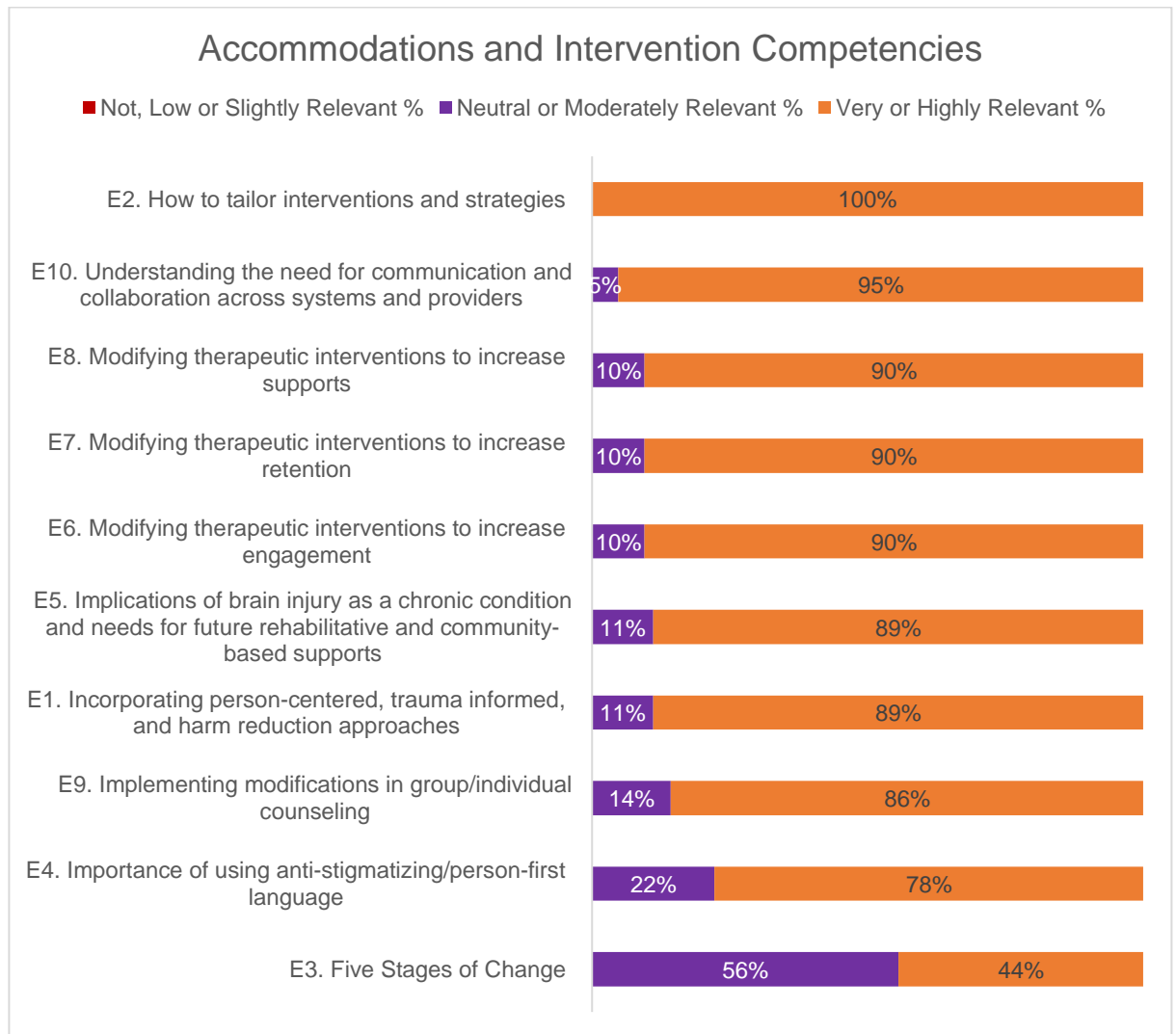
Accommodations and Interventions Competencies

Exhibit 10 shows the results of ratings of accommodations and interventions competencies. The most rated competencies with a rating of very or highly relevant from all responders was the understanding of how-to tailor interventions and strategies to the needs of individuals with brain injury (E2). The least rated competency in this category was understanding of the Five Stages of Change (precontemplation, contemplation, preparation, action, and maintenance) and application of them to determine readiness for change in individuals with brain injury (E3) which was rated as very or highly relevant by 44% (4) of responders and as neutral or moderately relevant by 56% (5) of responders.

Competencies E6, E7, E8, and E9 which relate to skills in modifying therapeutic interventions were rated neutral by 10% of responders. One SME expressed that these competencies should be focused on direct treatment providers and another SME noted that trained professionals and that individuals who are not treatment providers should only need to have a basic or general competency of therapeutic interventions especially for E6 through E8.

No competencies in this section were rated not relevant, or as low or slightly relevant. See Exhibit 10 below for more results on ratings.

Exhibit 10. Accommodations and Intervention Competencies



Notes: Data form E1-E5 based on 9 responses while data from E6-E10 are based on 21 responses due to an error with the survey distribution.

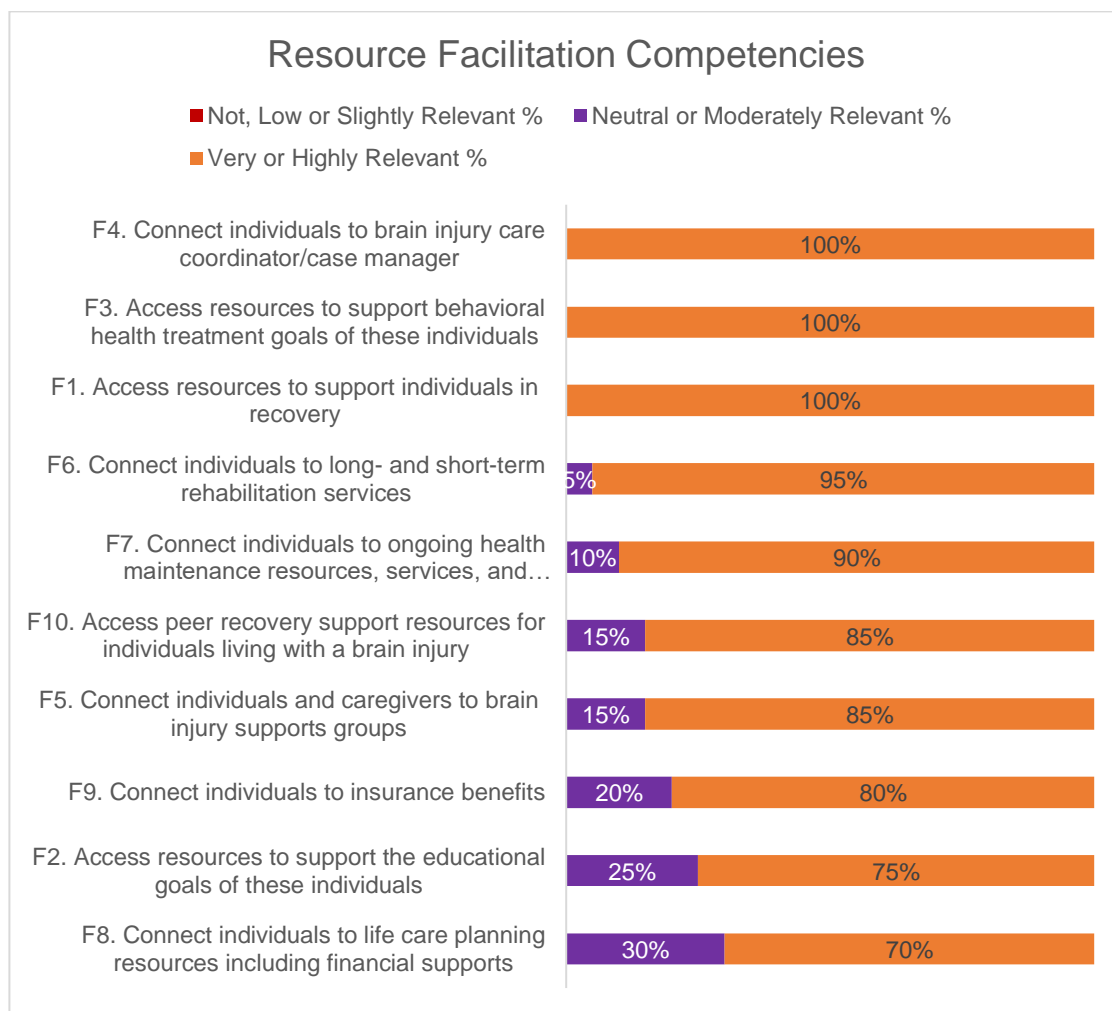
Resource Facilitation Competencies

Exhibit 11 shows the results of ratings of resource facilitation competencies. The most rated competencies with a rating of very or highly relevant from all responders were ability to access appropriate resources to support individuals in recovery (F1); ability to access appropriate resources to support behavioral health treatment goals of these individuals (F3); and ability to connect individuals to brain injury care coordinator/case manager (F4).

The least rated competency was the ability to connect individuals with a brain injury to life care planning resources including financial supports (F8) which was rated as very or highly relevant by 70% (14) of responders and neutral or moderately relevant by 30% (6) of responders.

No competencies in this section were rated not relevant, or as low or slightly relevant. See Exhibit 11 below for more results on ratings.

Exhibit 11. Resource Facilitation Competencies



Notes: Data based on 20 responses

Summary: Implications, Discussion, and Next Steps

It is important to note the competencies developed are intended to serve as a general guide to the essential knowledge, skills, and abilities necessary for professionals serving individuals with a brain injury and co-occurring behavioral health disorders.

Subject matter experts who responded to the survey were from diverse backgrounds and work settings with varying degrees of experience in the field. Though the sample size was quite small, about 60% of the SMEs had over ten years of experience working with the most relevant populations of focus.

Worthy of note is that none of the competencies and promising practices were rated as not relevant, or as low or slightly relevant in any category. This emphasizes the importance of possessing the knowledge, skills and abilities highlighted in the proposed list of competencies when serving populations with brain injury, a mental health disorder and/or a substance use disorder.

Further efforts are needed to revise these proposed competencies.

Appendices

Appendix A: ACL Workforce Competencies and Emerging Practices SME Survey

(Section A) Subject Matter Expert Background

1. Please describe your professional title.
2. In what state do you work in?
3. What is your primary setting?
 - Community-Based Service Organization
 - Advocacy Organization
 - State/Local Agency – Brain Injury
 - State/Local Agency – Behavioral Health (Both Mental health and Addiction services)
 - State/Local Agency – Public Health Department
 - State/Local Agency – Aging
 - State/Local Agency – Disabilities
 - State/Local Agency – Mental Health
 - State/Local Agency – Addiction Services
 - University
 - Hospital
 - Other (please specify)
4. What is the primary focus of your work?
 - Advocacy
 - Direct service professional
 - Administrative
 - Research
 - Policy
 - Trainer
 - Faculty/Educator
 - Clinical Consultant
 - Other (please specify)

5. Number of years working with populations with brain injuries
 - None
 - Less than 1 year
 - 1-5 years
 - 6-9 years
 - 10+ Years

6. Number of years working with populations with mental health disorders
 - None
 - Less than 1 year
 - 1-5 years
 - 6-9 years
 - 10+ Years

7. Number of years working with populations with substance use disorders
 - None
 - Less than 1 year
 - 1-5 years
 - 6-9 years
 - 10+ Years

(Section B) BASIC MEDICAL AND REHABILITATIVE CONCEPTS

The following competencies relate to basic medical and rehabilitative concepts for individuals living with a brain injury and co-occurring behavioral health disorders (substance use and/or mental health concerns). Review the competencies on the subsequent pages of this survey. For each competency, please provide your assessment of the level of its relevance to the work of professionals serving the needs of individuals living with a brain injury and co-occurring behavioral health disorders on a scale of 1 to 7, with 1 being "Not Relevant" and 7 being "Highly Relevant":

1. Knowledge of common medical and/or rehabilitation terminology pertaining to brain injury
2. Knowledge of common medical and/or rehabilitation terminology pertaining to behavioral health
3. Understanding of the factors that contribute to poor outcomes in persons living with a brain injury
4. Understanding of the signs and symptoms of unhealthy substance use
5. Understanding of the risk factors for sustaining a brain injury
6. Understanding of the risk factors for developing a behavior health condition -after a brain injury
7. Knowledge of the severity spectrum of brain injury (mild to severe)
8. Understanding of the relationship between the severity categorization of initial brain injury and outcomes.
9. Understanding of the individualized nature of recovery from brain injury based on risk and protective factors.
10. Understanding of how brain injury affects **cognition** (memory, attention, executive skills, problem solving, processing speed, etc.)

11. Understanding of how brain injury affects **speech and/or language** production and/or comprehension.
12. Understanding of how brain injury affects **physical and/or motor and/or sensory abilities** (strength, endurance, range of motion, vision, perception, hearing, balance, etc.)
13. Understanding of how brain injury affects **behavior and/or mood regulation** (awareness, adjustment, mood, interpersonal skills, etc.)
14. Understanding of how symptoms of brain injury (fatigue, reduced auditory comprehension, impaired attention, impaired memory, decreased executive skills, and more) can affect **performance**.
15. Understanding of how symptoms of brain injury (fatigue, reduced auditory comprehension, impaired attention, impaired memory, decreased executive skills, and more) can affect **interpersonal interactions**.
16. Understanding of how symptoms of brain injury (fatigue, reduced auditory comprehension, impaired attention, impaired memory, decreased executive skills, and more) can affect **personal and home independence**.
17. Understanding of how symptoms of brain injury (fatigue, reduced auditory comprehension, impaired attention, impaired memory, decreased executive skills, and more) can affect **community re-entry**.

(Section C) BRAIN INJURY AND CO-MORBIDITIES

The following competencies relate to brain injury and co-morbidities for individuals living with a brain injury and co-occurring behavioral health disorders (substance use and/or mental health concerns). Review the competencies on the subsequent pages of this survey. For each competency, please provide your assessment of the level of its relevance to the work of professionals serving the needs of individuals living with a brain injury and co-occurring behavioral health disorders on a scale of 1 to 7, with 1 being "Not Relevant" and 7 being "Highly Relevant":

1. Understanding of the needs and challenges of individuals living with both a brain injury and co-occurring disorder(s)
2. Understanding of the ways brain injury can be undiagnosed or underreported in traditional behavior health treatment settings
3. Understanding of the prevalence of persons living with a brain injury and with co-occurring behavioral health disorder(s)
4. Understanding of how brain injuries sustained early in life (childhood) may contribute or compound **difficulties engaging in** brain injury and/or behavioral health treatment in adulthood
5. Understanding of how brain injuries sustained early in life (childhood) may contribute or compound **difficulties staying in** brain injury and/or behavioral health treatment in adulthood
6. Understanding mismanaged and/or medication interactions for individuals with co-occurring brain injury and behavioral health conditions could make for a longer recovery process or continued visits with no progress.
7. Understanding of how brain injuries may increase risk of known medication side effects

8. Understanding of how individuals living with a brain injury may encounter challenges in managing their medication
9. Understanding of how substances interact with medications
10. Understanding pain management challenges and the effects of chronic pain in individuals with brain injury and behavioral health conditions
11. Understanding of the need medication management support for individuals living with a brain injury
12. Understanding of occurrence/rate of opioid misuse and overdose in individuals living with brain injury.
13. Understanding of how behavioral health disorders and chronic pain are risk factors for sustaining a brain injury
14. Understanding of how brain injuries are a risk factor for developing behavioral health disorders and chronic pain
15. Understanding of the effects that chronic pain can have in people living with brain injury and/or behavioral health conditions and their pain management challenges
16. Understanding of how co-occurring brain injury and unhealthy substance use impact the risk of additional injury and other complications.
17. Understanding how subpopulations such as domestic violence/intimate partner violence, criminal justice, veterans, rural, older adult populations are at higher risk for sustaining brain injuries

(Section D) SCREENING AND ASSESSMENTS

The following competencies relate to screening and assessments for individuals living with a brain injury and co-occurring behavioral health disorders (substance use and/or mental health concerns). Review the competencies on the subsequent pages of this survey. For each competency, please provide your assessment of the level of its relevance to the work of professionals serving the needs of individuals living with a brain injury and co-occurring behavioral health disorders on a scale of 1 to 7, with 1 being “Not Relevant” and 7 being “Highly Relevant”:

1. Skills in gathering lifetime history of brain injury exposure to inform overall medical history at intake and use of that information in the provision of adaptive services throughout service completion.
2. Understanding of how brain injury screening tools assist in the identification of persons living with brain injury
3. Skills in implementing brain injury screening tools
4. Skills in interpreting brain injury screening tools
5. Skills in implementing screening for substance use risk (i.e., Screening, Brief Intervention and Referral to Treatment (SBIRT))
6. Skills in interpreting the screening of individuals with brain injuries for substance use risk
7. Ability to use results from cognitive screening and/or neuropsychological assessments for understanding **a person’s cognitive and executive strengths**

8. Ability to use results from cognitive screening and/or neuropsychological assessments for understanding **areas that will require accommodations/compensatory strategies**

(Section E) ACCOMMODATIONS AND INTERVENTIONS

The following competencies relate to accommodations, resources and interventions for individuals living with a brain injury and co-occurring behavioral health disorders (substance use and/or mental health concerns). Review the competencies on the subsequent pages of this survey. For each competency, please provide your assessment of the level of its relevance to the work of professionals serving the needs of individuals living with a brain injury and co-occurring behavioral health disorders on a scale of 1 to 7, with 1 being “Not Relevant” and 7 being “Highly Relevant”:

1. Skills incorporating person-centered, trauma informed, and harm reduction approaches when working with individuals living with a brain injury
2. Understanding of how-to tailor interventions and strategies to the needs of individuals with brain injury
3. Understanding of the Five Stages of Change (precontemplation, contemplation, preparation, action, and maintenance) and application of them to determine readiness for change in individuals with brain injury
4. Understanding of the importance of using anti-stigmatizing/person-first language to foster an environment of dignity, respect and hope
5. Understanding of the implications of brain injury as a chronic condition, including aging with brain injury, and individuals’ potential needs for future rehabilitative and community-based supports.
6. Skills in modifying therapeutic interventions (motivational interviewing, cognitive behavior therapy, and other Behavior Interventions, etc.) **to increase engagement** throughout treatment for individuals with brain injury
7. Skills in modifying therapeutic interventions (motivational interviewing, cognitive behavior therapy, and other Behavior Interventions, etc.) **to increase retention** throughout treatment for individuals with brain injury.
8. Skills in modifying therapeutic interventions (motivational interviewing, cognitive behavior therapy, and other Behavior Interventions, etc.) **to increase formal and informal supports** throughout treatment for individuals with brain injury.
9. Skills in implementing modification and/or considerations for those with brain injuries participating in group and/or individual counseling.
10. Understanding of the need for close communications and collaborations across systems and providers within the teams delivering services for individuals with brain injury.

(Section F) RESOURCE FACILITATION

The following competencies relate to resource facilitation for individuals living with a brain injury and co-occurring behavioral health disorders (substance Traumatic Brain Injury Technical Assistance and Resource Center

use and/or mental health concerns). Review the competencies on the subsequent pages of this survey. For each competency, please provide your assessment of the level of its relevance to the work of professionals serving the needs of individuals living with a brain injury and co-occurring behavioral health disorders on a scale of 1 to 7, with 1 being “Not Relevant” and 7 being “Highly Relevant”:

1. Ability to access appropriate resources to support individuals in recovery
2. Ability to access appropriate resources to support the educational goals of these individuals
3. Ability to access appropriate resources to support behavioral health treatment goals of these individuals
4. Ability to connect individuals to brain injury care coordinator/case manager
5. Ability to connect individuals and caregivers to brain injury supports groups
6. Ability to connect individuals to long- and short-term rehabilitation services.
7. Ability to connect individuals with a brain injury to ongoing health maintenance resources, services, and information
8. Ability to connect individuals with a brain injury to life care planning resources including financial supports.
9. Ability to connect individuals with a brain injury to insurance benefits
10. Ability to access peer recovery support resources for individuals living with a brain injury

CLOSING

1. Is there anything else you would us to know?

Thank you for your responses! Someone from the Opioids and Mental Health Concerns Workgroup will follow up with aggregate results and next steps.

Appendix B: Tables

Background Tables

Table 1. Location of Experts

State	N	%
Indiana	2	9.1%
Kentucky	2	9.1%
Maryland	3	13.6%
Massachusetts	11	50.0%
New Hampshire	1	4.5%
North Carolina	1	4.5%
Rhode Island	1	4.5%
All states	1	4.5%
TOTAL	22	100%

Table 2. SMEs Primary Setting

Primary setting	N	%
Community-Based Service Organization	4	18.2%
Advocacy Organization	0	0%
Brain Injury	9	40.9%
Behavioral Health (Both Mental health and Addiction services)	2	9.1%
Public Health Department	1	4.5%
Aging	0	0%
Disabilities	2	9.1%
Mental Health	0	0%
Addiction Services	0	0%
University	0	0%
Hospital	3	13.6%
Other*	1	4.5%
TOTAL	22	100%

Table 3. SMEs Primary Focus of Work

Primary focus of work	N	%
Advocacy	0	0%
Direct service professional	4	18.2%
Administrative	6	27.3%
Research	0	0%
Policy	0	0%
Trainer	4	18.2%
Faculty/Educator	1	4.5%
Clinical Consultant	6	27.3%
Other*	1	4.5%
TOTAL	22	100%

Table 4. Years working with Brain Injury Population

Working with brain injury population	N	%
None	0	0%
Less than 1 year	1	5%
1-5 years	5	23%
6-9 years	2	9%
10+ Years	14	64%
TOTAL	22	100%

Table 5. Years working with populations with mental health disorders

Working with populations with mental health disorders	N	%
None	1	5%
Less than 1 year	0	0%
1-5 years	3	14%
6-9 years	3	14%
10+ Years	15	68%
TOTAL	22	100%

Table 6. Duration working with substance use disorders

Working with substance use disorders	N	%
None	2	9%
Less than 1 year	1	5%
1-5 years	4	18%
6-9 years	2	9%
10+ Years	13	59%
TOTAL	22	100%



Background Tables

Table 7. Basic Medical Rehabilitation Concepts Competencies

	1 – Not Relevant		2 – Low relevance		3 – Slightly relevant		4 – Neutral		5 – Moderately relevant		6 – Very relevant		7 – Highly Relevant	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
B1. Brain injury terminology	0	0%	0	0%	0	0%	0	0%	2	9.5%	10	47.6%	9	42.9%
B2. Behavioral health terminology	0	0%	0	0%	0	0%	0	0%	2	9.5%	9	42.9%	10	47.6%
B3. Poor outcomes	0	0%	0	0%	0	0%	0	0%	0	0%	5	23.8%	16	76.2%
B4. Signs and symptoms	0	0%	0	0%	0	0%	0	0%	0	0%	4	19.0%	17	81.0%
B5. Risk factors for BI	0	0%	0	0%	0	0%	0	0%	3	14%	6	28.6%	12	57.1%
B6. Risk factors for a behavioral health	0	0%	0	0%	0	0%	0	0%	1	5%	4	19.0%	16	76.2%
B7. Spectrum of BI	0	0%	0	0%	0	0%	0	0%	4	19%	3	14.3%	14	66.7%
B8. Severity of BI and outcomes	0	0%	0	0%	0	0%	0	0%	3	14%	6	28.6%	12	57.1%
B9. Individualized recovery	0	0%	0	0%	0	0%	0	0%	2	10%	5	23.8%	14	66.7%
B10. How BI affects cognition	0	0%	0	0%	0	0%	0	0%	0	0%	4	19.0%	17	81.0%
B11. How BI affects speech and/or language	0	0%	0	0%	0	0%	0	0%	0	0%	7	33.3%	14	66.7%
B12. How BI affects physical, motor, sensory abilities	0	0%	0	0%	0	0%	0	0%	1	5%	5	23.8%	15	71.4%
B13. How BI affects behavior and mood regulation	0	0%	0	0%	0	0%	0	0%	0	0%	3	14.3%	18	85.7%
B14. How BI symptoms affect performance	0	0%	0	0%	0	0%	0	0%	1	5%	4	19.0%	16	76.2%
B15. How BI symptoms affect interpersonal interactions	0	0%	0	0%	0	0%	0	0%	1	5%	4	19.0%	16	76.2%
B16. How BI symptoms affect personal and home independence	0	0%	0	0%	0	0%	0	0%	2	10%	5	23.8%	14	66.7%
B17. How BI symptoms affect community re-entry	0	0%	0	0%	0	0%	1	5%	1	5%	3	14.3%	16	76.2%

Notes: Data based on 21 responses

Table 8. Brain Injury and Co-morbidities Competencies

	1 – Not Relevant		2 – Low relevance		3 – Slightly relevant		4 – Neutral		5 – Moderately relevant		6 – Very relevant		7 – Highly Relevant	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
C1. Understanding needs	0	0%	0	0%	0	0%	0	0%	0	0.0%	6	28.6%	15	71.4%
C2. How BI is undiagnosed or underreported	0	0%	0	0%	0	0%	0	0%	3	14.3%	6	28.6%	12	57.1%
C3. Prevalence of BI and BH disorder	0	0%	0	0%	0	0%	0	0%	3	14%	6	28.6%	12	57.1%
C4. How early BI compounds difficulties engaging in treatment	0	0%	0	0%	0	0%	0	0%	2	10%	10	47.6%	9	42.9%
C5. How early BI compounds difficulties staying in treatment	0	0%	0	0%	0	0%	0	0%	2	10%	9	42.9%	10	47.6%
C6. Medication interactions and recovery	0	0%	0	0%	0	0%	0	0%	2	10%	5	23.8%	14	66.7%
C7. BI and medication side effects	0	0%	0	0%	0	0%	0	0%	5	24%	7	33.3%	9	42.9%
C8. Challenges in managing medication	0	0%	0	0%	0	0%	0	0%	2	10%	5	23.8%	14	66.7%
C9. How substances interact with medications	0	0%	0	0%	0	0%	1	5%	2	10%	8	38.1%	10	47.6%
C10. Pain management challenges and chronic pain	0	0%	0	0%	0	0%	0	0%	2	10%	7	33.3%	12	57.1%
C11. Need for medication management support	0	0%	0	0%	0	0%	1	5%	2	10%	7	33.3%	11	52.4%
C12. Rate of opioid misuse and overdose	0	0%	0	0%	0	0%	0	0%	2	10%	10	47.6%	9	42.9%
C13. BH disorders and chronic pain as risk factors for BI	0	0%	0	0%	0	0%	0	0%	1	5%	9	42.9%	11	52.4%
C14. BI as a risk factor for BH disorder and chronic pain	0	0%	0	0%	0	0%	0	0%	4	19%	7	33.3%	10	47.6%
C15. Effects of chronic pain	0	0%	0	0%	0	0%	0	0%	3	14%	8	38.1%	10	47.6%
C16. Risk of additional injury and other complications	0	0%	0	0%	0	0%	0	0%	2	10%	8	38.1%	11	52.4%
C17. Subpopulations and their risk of BI	0	0%	0	0%	0	0%	1	5%	1	5%	7	33.3%	12	57.1%

Notes: Data based on 21 responses

Table 9. Screening and Assessments Competencies

	1 – Not Relevant		2 – Low relevance		3 – Slightly relevant		4 – Neutral		5 – Moderately relevant		6 – Very relevant		7 – Highly Relevant	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
D1. Skills gathering lifetime history	0	0%	0	0%	0	0%	0	0%	3	14.3%	3	14.3%	15	71.4%
D2. Understanding BI screening tools	0	0%	0	0%	0	0%	0	0%	5	23.8%	5	23.8%	11	52.4%
D3. Implementing BI screening tools	0	0%	0	0%	0	0%	0	0%	5	24%	5	23.8%	11	52.4%
D4. Interpreting BI screening tools	0	0%	0	0%	0	0%	0	0%	3	14%	5	23.8%	13	61.9%
D5. Implementing screening for substance use risk	0	0%	0	0%	0	0%	0	0%	4	19%	6	28.6%	11	52.4%
D6. Interpreting screening in BI for substance use risk	0	0%	0	0%	0	0%	0	0%	1	5%	7	33.3%	13	61.9%
D7. Use results to understand cognitive and executive strengths	0	0%	0	0%	0	0%	1	5%	3	14%	3	14.3%	14	66.7%
D8. Use results to understand accommodations/ compensatory strategies	0	0%	0	0%	0	0%	1	5%	2	10%	2	9.5%	16	76.2%

Notes: Data based on 21 responses

Table 10. Accommodations and Intervention Competencies

	1 – Not Relevant		2 – Low relevance		3 – Slightly relevant		4 – Neutral		5 – Moderately relevant		6 – Very relevant		7 – Highly Relevant	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
E1. Incorporating person-centered, trauma informed, and harm reduction approaches	0	0%	0	0%	0	0%	0	0%	1	11%	2	22.2%	6	66.7%
E2. How to tailor interventions and strategies	0	0%	0	0%	0	0%	0	0%	0	0%	1	11.1%	8	88.9%
E3. Five Stages of Change	0	0%	0	0%	0	0%	0	0%	5	56%	0	0.0%	4	44.4%
E4. Importance of using anti-stigmatizing/person-first language	0	0%	0	0%	0	0%	0	0%	2	22%	2	22.2%	5	55.6%
E5. Implications of brain injury as a chronic condition and needs for future rehabilitative and community-based supports	0	0%	0	0%	0	0%	0	0%	1	11%	2	22.2%	6	66.7%
E6. Modifying therapeutic interventions to increase engagement	0	0%	0	0%	0	0%	2	10%	0	0%	2	9.5%	17	81.0%
E7. Modifying therapeutic interventions to increase retention	0	0%	0	0%	0	0%	2	10%	0	0%	2	9.5%	17	81.0%
E8. Modifying therapeutic interventions to increase supports	0	0%	0	0%	0	0%	2	10%	0	0%	4	19.0%	15	71.4%
E9. Implementing modifications in group/individual counseling	0	0%	0	0%	0	0%	1	5%	2	10%	6	28.6%	12	57.1%
E10. Understanding the need for communication and collaboration across systems and providers	0	0%	0	0%	0	0%	0	0%	1	5%	7	33.3%	13	61.9%

Notes: Data form E1-E5 based on 9 responses while data from E6-E10 are based on 21 responses due to an error with the survey distribution.

Table 11. Resource Facilitation Competencies

	1 – Not Relevant		2 – Low relevance		3 – Slightly relevant		4 – Neutral		5 – Moderately relevant		6 – Very relevant		7 – Highly Relevant	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
F1. Access resources to support individuals in recovery	0	0%	0	0%	0	0%	0	0%	0	0.0%	5	25%	15	75.0%
F2. Access resources to support the educational goals of these individuals	0	0%	0	0%	0	0%	0	0%	5	25.0%	3	15%	12	60.0%
F3. Access resources to support behavioral health treatment goals of these individuals	0	0%	0	0%	0	0%	0	0%	0	0.0%	5	25%	15	75.0%
F4. Connect individuals to brain injury care coordinator/case manager	0	0%	0	0%	0	0%	0	0%	0	0.0%	6	30%	14	70.0%
F5. Connect individuals and caregivers to brain injury supports groups	0	0%	0	0%	0	0%	0	0%	3	15.0%	10	50%	7	35.0%
F6. Connect individuals to long- and short-term rehabilitation services	0	0%	0	0%	0	0%	0	0%	1	5.0%	8	40%	11	55.0%
F7. Connect individuals to ongoing health maintenance resources, services, and information	0	0%	0	0%	0	0%	1	5%	1	5.0%	6	30%	12	60.0%
F8. Connect individuals to life care planning resources including financial supports	0	0%	0	0%	0	0%	0	0%	6	30.0%	5	25%	9	45.0%
F9. Connect individuals to insurance benefits	0	0%	0	0%	0	0%	1	5%	3	15.0%	6	30%	10	50.0%
F10. Access peer recovery support resources for individuals living with a brain injury	0	0%	0	0%	0	0%	0	0%	3	15.0%	8	40%	9	45.0%

Notes: Data based on 20 responses

About TBI TARC

The Traumatic Brain Injury Technical Assistance and Resources Center (TBI TARC) is an initiative from the Administration for Community Living that helps TBI State Partnership Program grantees promote access to integrated, coordinated services and supports for people who have sustained a TBI, their families, and their caregivers. The Center also provides a variety of resources to non-grantee states, people affected by brain injury, policymakers, and providers.

