



Co-Occurring TBI and Mental Health Symptoms Toolkit: Development and Dissemination

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Data to Inform Guideline and Toolkit Development

- **TBI Expert Consensus Conference**

Consensus paper summarized themes reviewed and expert input regarding recommendations made for assessment and treatment guidelines

- **Focus Groups**

Qualitative and Quantitative data collected from providers to inform information to be included in toolkit

Consensus Conference



**TBI among OEF/OIF/OND Veterans Seeking Community Mental
Health Services:
A Consensus Conference Regarding Identification and Treatment**

October 24, 2011

Meeting Charge

It is necessary to increase the capacity of the non-VA community mental health system within the State of Colorado to provide a comprehensive and coordinated service delivery system for OEF/OIF/OND Veterans with TBI and co-occurring behavioral health issues.

To meet this objective, these expert panels have been convened to develop assessment and treatment guidelines.

After this meeting, consensus opinions will be synthesized and used to develop educational materials (e.g., TBI Toolkit) for dissemination within the non-VA community mental health system.

Participants

MIRECC project team

Director of the Colorado TBI Program

7 National experts in TBI Assessment

7 National experts in TBI Intervention

2 Colorado Community Mental Health Center experts

1 State leader in TBI

MIRECC support staff

Procedures

- Attendees discussed and revised the initial set of assumptions and questions regarding TBI assessment and intervention.
- Experts broke out into smaller work groups based on expertise/interest (e.g., TBI screening, assessment and evaluation or TBI intervention) to develop consensus responses to the questions.
- A final review of the responses was completed and group consensus was achieved in order to provide recommendations that are considered feasible in the current Colorado community mental health system.

Assumptions

Table 1. Consensus Conference Agreed Upon Assumptions

1	Veterans with TBI (mild, moderate and severe) are seeking treatment within the non-VA mental health system.
2	Although severity of TBI would be expected to impact functioning post-injury, outcomes are a complex interplay between pre- and post-injury factors. As such, potentially complicating factors (e.g., lifetime history of TBI, age at first injury, pre-morbid functioning, etc.) should be assessed.
3	The typical course of recovery of those with one mild TBI is a return to baseline functioning within weeks to months of the injury. Emerging research suggests that a history of multiple injuries may complicate the recovery process.
4	Inquiry regarding history of medical conditions that may impact functioning should be included in the mental health intake process. Conditions of interest include TBI (mild, moderate and severe).
5	Documentation of TBI history, regardless of the injury's impact on current functioning, is indicated.
6	If it is determined that an individual's history of TBI is clinically relevant, assessment and treatment is indicated.
7	Mental health therapists may or may not have a basic knowledge regarding TBI.

Key Questions for Expert Discussion

Table 2. Sample of Consensus Conference Agreed Upon Questions

Assessment

1. What measures (screening, assessment, evaluation) could appropriately be used by those whose primary training is in mental health? Could basic training be provided in this area and if so how?
2. What questions/tools should CMHCs add to their evaluation procedures to assess for functional impairment/symptoms in those who screen positive?

Treatment

1. Under what circumstances and how should an individual's TBI history be incorporated into treatment planning? Further, how can the consumer be an active part of this process?
2. Under what circumstances is specialized treatment indicated? And, when and to what degree is it appropriate for clinicians to change the content and format of evidence-based interventions?

Implementation

1. Once identified, how do we disseminate this to all systems/clinicians/others so that effective strategies can be utilized? (The goal is to optimize the number of available treatments AND accessibility of existing treatments)
2. What barriers/facilitators (e.g., individual [clinician], systems) may impact assessment and treatment planning? Intervention?

Assessment Guidelines

What steps should be included in the screening/assessment process?

Consensus Statement:

Information regarding Veteran status should be collected during the intake process and used to inform assessment. Such information might include:

- Whether or not the individual or one of their immediate family members served in the military
- The Veteran's combat and/or deployment history
- Military-related duties
- Amount of time in the military

What questions/tools should Centers add to their intake process to identify potential history of TBI and at what point should the screening occur?

Consensus Statement:

In terms of TBI history, several brief yes/no questions could be added to the intake process (i.e., medical history form, clinician intake form).

Questions should focus on injury history. One such question that could be added to facilities' medical history form is:

Have you ever been knocked out or unconscious following an accident or injury?

Olson-Madden, 2010



More comprehensively, recommended items for addition to the clinical interview conducted at intake are taken from the **Ohio State University Traumatic Brain Injury Identification Method (OSU TBI-ID) Short Form** and include:

1. In your lifetime, have you ever been hospitalized or treated in an emergency room following an injury to your head or neck? Think about any childhood injuries you remember or were told about.
2. In your lifetime, have you ever injured your head or neck in a car accident or from crashing some other moving vehicle like a bicycle, motorcycle or ATV?
3. In your lifetime, have you ever injured your head or neck in a fall or from being hit by something (for example, falling from a bike or horse, rollerblading, falling on ice, being hit by a rock)?; Have you ever injured your head or neck playing sports or on the playground?
4. In your lifetime, have you ever injured your head or neck in a fight, from being hit by someone, or from being shaken violently? Have you ever been shot in the head?
5. In your lifetime, have you ever been nearby when an explosion or a blast occurred? If you served in the military, think about any combat- or training related incidents.

(For further detail please see: <https://ckm.osu.edu/sitetool/sites/ohiovalleypublic/documents/OSUTBISF4-9-11Life.pdf>)

Should history of probable TBI identified via the intake process be documented in the individual's medical record and if so, how much information about the history of TBI should be documented?

Consensus Statement:

All information regarding history of TBI (responses to screening and evaluation measures) should be included in the individual's medical record.

If an individual responds “no” to all screening questions, information documented would be limited to these responses.

What questions/tools should Centers add to their evaluation procedures to assess for functional impairment/ symptoms in those who screen positive?

Consensus Statement:

There are many measures of impairment/symptoms for use among those with a history of **moderate to severe TBI**. A resource for such measures is the Center for Outcome Measurement in Brain Injury (COMBI):

www.tbims.org/combi/list.html

Resources for assessing functioning among those with **mild TBI** are more limited →



Under what circumstances and how should an individual who has been identified (via assessment) as having a positive history of TBI be further evaluated for potential impairment and/or disability and participation activities?

Consensus Statement:

Based on available resources, it is recommended that further evaluation occur if the client does not appear to be benefiting from treatment as offered (e.g., if treatment is not impacting functioning).

This might include: occupational/physical therapy,
neuropsychological evaluation

What measures (screening, assessment, evaluation) could appropriately be used by those whose primary training is in mental health?

Consensus Statement:

A brief training is all that is required →



Utilize observable behaviors to determine if more services or accommodations are necessary

Obtain collateral information from family/friends

How should screening, assessment, and/or evaluation feedback be provided to consumers and/or their families?

Consensus Statement:

Clinicians are encouraged to discuss the individual's history of TBI; however, in many cases the history will not warrant being the **focus** of feedback.

It may be helpful to discuss how the individual's history of TBI and sequelae **are impacting co-occurring problems** (e.g., psychiatric symptoms). Adopting a holistic approach that incorporates the potential impact of TBI is recommended.

It is also important to educate consumers regarding the benefits of preventing future TBIs. This may entail a discussion about reducing risky behaviors.

Intervention Guidelines

Under what circumstances and how should an individual's TBI history be incorporated into treatment planning?

Consensus Statement:

If identification of TBI is relevant to the proposed treatment or informs direct services or case conceptualization, and its recognition promotes an emphasis on functional recovery, then TBI should be incorporated.

*A diagnosis of TBI might not be as relevant as is the awareness of when and how to intervene (e.g., if impairment or behavior conflicts with current treatment)

How should clinicians incorporate screening, assessment, and/or evaluation results into their case conceptualization?

Consensus Statement:

Screening/assessment/evaluation results should be incorporated to the degree that they can be used productively (e.g., to specifically inform treatment goals and strategies, to build relevant functional outcomes into the treatment plan).

***Results should identify and promote positive functional outcomes rather than to solely identify deficits/impairments**



Under what circumstances can current best practices (e.g., CBT/SSRI for major depression) be utilized with none or only minor revisions?

Consensus Statement:

Clinicians should consider utilizing current evidence-based practices (EBP) among those with a history of TBI. However, modifications to treatment may be required, for example, if cognitive deficits interfere with the individual's ability to engage fully in the treatment.

VA/DoD Evidence Based Practice Clinical Practice Guideline for the Management of Concussion/mild Traumatic Brain Injury provides specific comments and guidance on the role of pharmacotherapies (as well as many other interventions) in the management of cognitive, emotional, and behavioral symptoms among persons with TBI.



Under what circumstances is specialized treatment (e.g., major changes to existing evidence-based practices [EBP] or EBP for those with a history of TBI) indicated?

Consensus Statement:

If indicated via the assessment process, specialized treatment may be considered appropriate.

However, if assessment results do not suggest that ongoing sequelae might interfere with a structured treatment approach, modifications to EBP are not indicated.

What modifications are recommended and not recommended?

Consensus Statement:

Strategies to augment EBPs could be wide-ranging, are likely contingent on the individual's level of functioning and available resources

Match treatment as best as possible to individual's needs!



Are there specific treatment strategies/technology or interventions that might improve outcomes?

Consensus Statement:

Regardless of TBI history, the aim of treatment is to optimize functioning and quality of life.

As such, strategies which accommodate for deficits/limitations are indicated.

The committee concurs that the same use of technology for “able-bodied” individuals is appropriate.

Implementation Guidelines



What barriers/facilitators (e.g., individual [clinician], systems) may assist in the implementation of screening procedures? Assessment procedures? Evaluation for impairment and/or disability and participation activities?

What barriers/facilitators (e.g., individual [clinician], systems) may impact the case conceptualization process?

What barriers/facilitators (e.g., individual [clinician], systems) may impact treatment planning? Intervention?

Consensus Statement: Barriers

Potential barriers were identified:

- Lack of available resources (e.g., time, funding)
- Clinician may not feel competent (e.g., lack of education) to treat clients with TBI
- Clinician may not feel comfortable treating clients with TBI
- Misinformation/myths about policy/payer sources and its implications for treating individuals with TBI may interfere with implementation

Consensus Statement: Facilitators

Potential facilitators were identified:

- **Expertise exists** within CMHCs regarding providing EBPs to a diverse population with wide-ranging impairments
- There are commonalities between **recovery and rehabilitation models**, highlighting current knowledge and application to a TBI population
- Others: Electronic medical records system, movement toward integrated health care, access to VA resources, and acceptance of multiple payer sources

Take Home Points

- Emphasis was placed on identifying facilitators and barriers to implementing these practices within the Colorado community-based mental health care system.
- Screening, Assessment, and Evaluation: Consensus was achieved regarding the types of questions that should be asked to assess for a history of TBI and related sequelae.
- Intervention: Consensus was achieved regarding how to utilize evidence-based practices with this population. Specific recommendations were made re: how to maximize functioning and reduce stigma.

Identification and Treatment of TBI and Co-occurring Psychiatric Symptoms Among OEF/OIF/OND Veterans Seeking Mental Health Services Within the State of Colorado: Establishing Consensus for Best Practices

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Expert Consensus Collaborators

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Abstract This paper highlights the results of a consensus meeting regarding best practices for the assessment and treatment of co-occurring traumatic brain injury (TBI) and mental health (MH) problems among Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn Veterans seeking care in non-Veterans Affairs Colorado community MH settings. Twenty individuals with expertise in TBI screening, assessment, and intervention, as well as the state MH system, convened to establish and review questions and assumptions regarding care for this Veteran population. Unanimous consensus regarding best practices was achieved. Recommendations for improving care for Veterans seeking care in community MH settings are provided.

Expert Consensus Collaborators and Conference Moderating Assistant are given in "Appendix".

The views in this paper are those of the authors and do not necessarily represent the official policy or position of the Department of Veterans Affairs or the United States Government. This material is the result of work supported with resources and the use of facilities at the Eastern Colorado Health Care System VA medical center.

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Keywords Traumatic brain injury · Mental health ·
Assessment · Intervention · Implementation

Background

According to the Centers for Disease Control (CDC 2011) 1.7 million Americans sustain a TBI annually. Regarding TBI within the state of Colorado, findings from the Colorado Traumatic Brain Injury Surveillance System (B. Gabelta, personal communication, 2009) suggest that on average there are 950 deaths, 5,000 hospitalizations and 23,000 emergency department (ED) visits annually. Approximately 100,000 Coloradans live with long-term disabilities as a result of TBI. A wide range of cognitive, physical and psychiatric impairments (Hibbard et al. 1998) are associated with TBI. In addition, military personnel serving in Iraq and Afghanistan are sustaining injuries while deployed (Terrio et al. 2009). Upon return to the United States, military personnel are also reporting psychiatric symptoms including those associated with post traumatic stress disorder (PTSD) and depression (Tanielian and Jaycox 2008). Returned Veterans are seeking medical and/or mental health care both within and outside of the Veterans Health Administration (VHA). Because of this, community-based, non-VHA providers require the knowledge and skills to meet the special needs of this cohort. As one means to help meet this need, the Department of Veterans Affairs has developed a new online Community Provider Toolkit aimed at delivering support, therapeutic tools, and resources to community providers treating Veterans for mental health concerns (available at www.mentalhealth.va.gov/communityproviders).

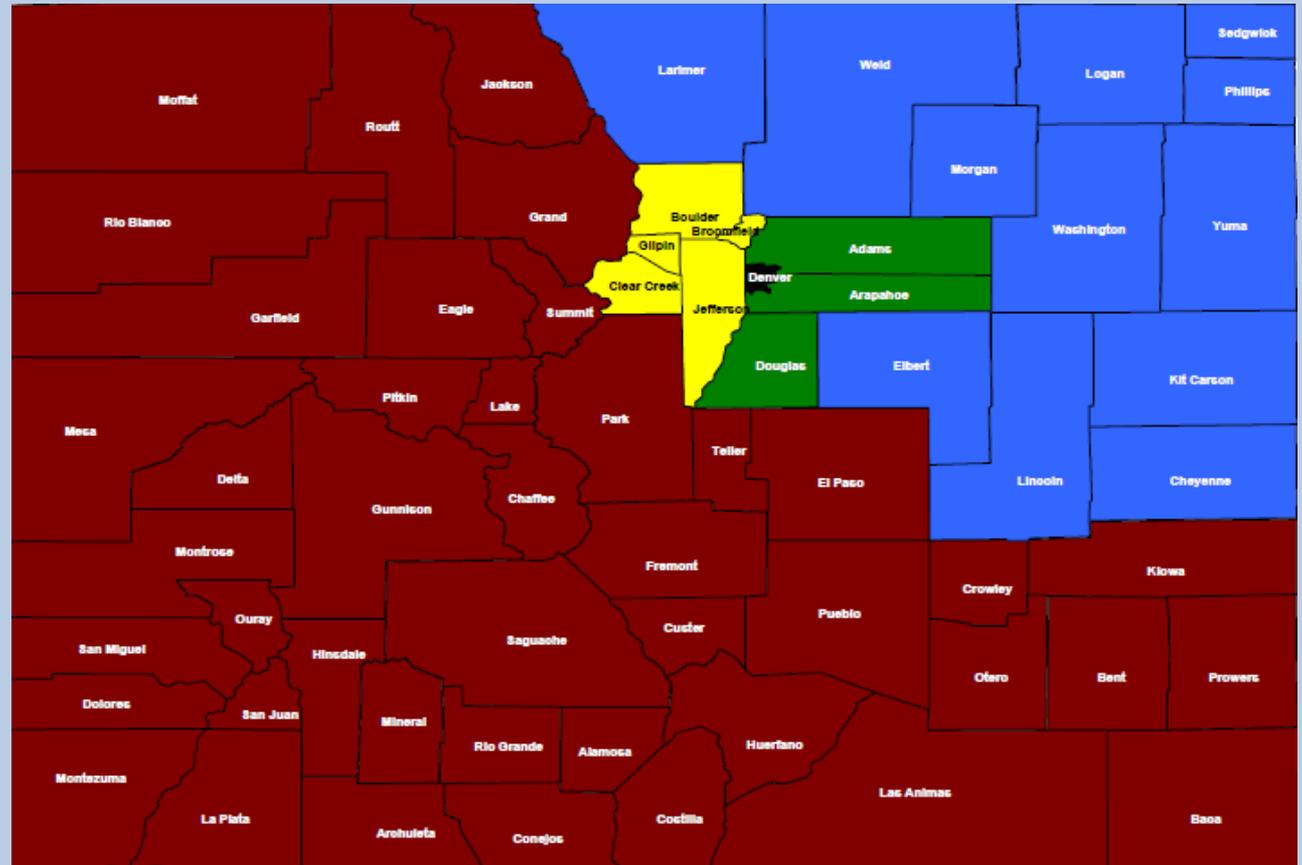
With regard to the community mental health care system in the State of Colorado, there are five Behavioral Health Organizations (BHOs) consisting of 17 Community Mental

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Focus Groups



What was the purpose?

- To collect information from administrators and providers working in community mental health regarding their experiences working with Veterans with a history of TBI and co-occurring mental health concerns
- Identify barriers and facilitators to providing this care
- Use this information to inform the development of the training and toolkit

What did we do?



Participants

- 6 Community Mental Health Centers (CMHCs) across the 5 BHO regions
- Three groups were recruited:
 - Providers
 - OEF/OIF Veterans with TBI history and co-occurring MH concerns
 - Family members/supports
- 44 providers from the 6 CMHCs attended the meetings
- 0 Veterans and 0 family members/supports attended
- Quantitative and qualitative data was collected

Participant Characteristics

- Predominantly female, broad age distribution
- Worked in MH for an average of 12 years
- Over half had never worked with an OEF/OIF Veteran
- 80% had worked with a client with TBI and co-occurring MH concerns

Measures

- Quantitative measures
 - Focus group questionnaire
 - Perceived Barriers to Seeking Mental Health Services: Modified Version
- Qualitative measures
 - Semi-structured interview

What did we find?

Quantitative

- Possible barriers identified
 - Not knowing where to get help
 - Costing too much money
 - Too embarrassing
 - May harm careers
 - Others might have less confidence in them

Topic 1: Experiences working with Veterans with co-occurring TBI and mental health concerns

- Very limited experience working with this population
- Belief that Veterans don't seek care in the community because of factors related to mental health stigma

“Oh I think it's about their own perceived stigma, and that macho thing. You know. They're soldiers...”

“I don't know if the, if it's just stigma associated with visiting a mental health center in general...which, in some of our small communities is a real factor.”

Topic 1: Experiences working with Veterans with co-occurring TBI and mental health concerns

- Identified a variety of presenting problems
 - MH symptoms and diagnoses- PTSD, substance use, anger, depression, sleep difficulty, anxiety and arousal
 - Psychosocial difficulties- homelessness, legal trouble, interpersonal problems, post-deployment re-integration and transition
 - Cognitive difficulties- taking more time to accomplish tasks, memory difficulties

Topic 1: Experiences working with Veterans with co-occurring TBI and mental health concerns

– Assessment

- General report that they do not use formal tools to evaluate TBI and/or MH symptoms
- Many felt that they were not capable of conducting formal TBI assessment

– Intervention

- Similar to work with other clients
- EBPs and solution-focused treatment
- Importance of family inclusion and peer support
- Unsure of how to modify treatment

Topic 2: Resources available to clinicians

- Barriers to accessing training and resources
 - Distance
 - Costs of registration and travel
 - Not having time to participate in training
- Self-initiated strategies for accessing information
 - Readings and online trainings relevant to this population
 - Refer to Veteran and TBI-focused services in the community

Topic 3: Perceived training needs

- Areas of interest- military culture and TBI
- Practical skills
- Web-based and/or in-person training

What were our conclusions?

- Limited experience with providing care to this population
- Belief that stigma prevents the cohort from engaging in care, despite the need for treatment
- Belief that screening and assessment is outside their scope of practice
- Desire for training related to TBI, co-occurring MH concerns and military culture

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Toolkit for Providers of Clients with Co-occurring TBI and Mental Health Symptoms



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The Homepage provides you with information about:

Why an On-line Toolkit?



Traumatic Brain Injury (TBI) is a significant public health concern. This toolkit provides mental health clinicians necessary information to address the needs of Veterans/Military Personnel with a history of TBI and co-occurring mental health conditions. Community mental health clinicians' input was integral in identifying areas of focus. This toolkit is designed to assist providers in identifying TBI and associated co-occurring problems and determining potential need for further evaluation and/or mental health treatment modification.

Homepage Continued:

The Purpose

The purpose of this toolkit is to offer providers working with Veterans who have a history TBI and mental health symptoms the following:

- Background information/Education
- Screening and Assessment Tools
- Interventions and Treatment Modification Suggestions
- Additional resources

This toolkit offers a useful starting point to increase the provision of TBI-related mental health services by community providers.

Structure of the Toolkit

Funding

This toolkit was developed as part of a collaborative project between the Veterans Integrated Service Network 19 Mental Illness Research, Education and Clinical Center (VISN 19 MIRECC) and the Colorado TBI Program at the Colorado Department of Human Services Division of Vocational Rehabilitation. The project is funded by the Health Resources and Services Administration (HRSA)

The Homepage also provides you with information about key definitions found throughout the toolkit

What is the difference between screening and assessment?

Definitions

Screening:

Screening refers to a "preliminary procedure, such as a test or examination, to detect the most characteristic sign or signs of a disorder that may require further investigation" (Myers, 2009). Screening helps providers identify who might have a history of TBI. A positive screen would suggest the potential need to conduct further assessment to make a determination regarding TBI history.

Assessment:

Assessment refers to "an evaluation or appraisal of a condition...based on the patient's subjective report of the symptoms and course of the illness or condition and the examiner's objective findings, including data obtained through laboratory tests, physical examination, medical history, and information reported by family members and other health care team members" (Myers, 2009). Assessment assists the provider in determining whether or not an individual has a history of TBI. Assessment of co-occurring mental health symptoms and other sequelae is a critical step in providing care to those who have a history of TBI.

Intervention:

Intervention is defined as "an act performed to prevent harm to a patient or to improve the mental, emotional, or physical function of a patient" (Myers, 2009). The interventions referenced in this toolkit are aimed at treating symptoms associated with TBI and common co-occurring mental health conditions.

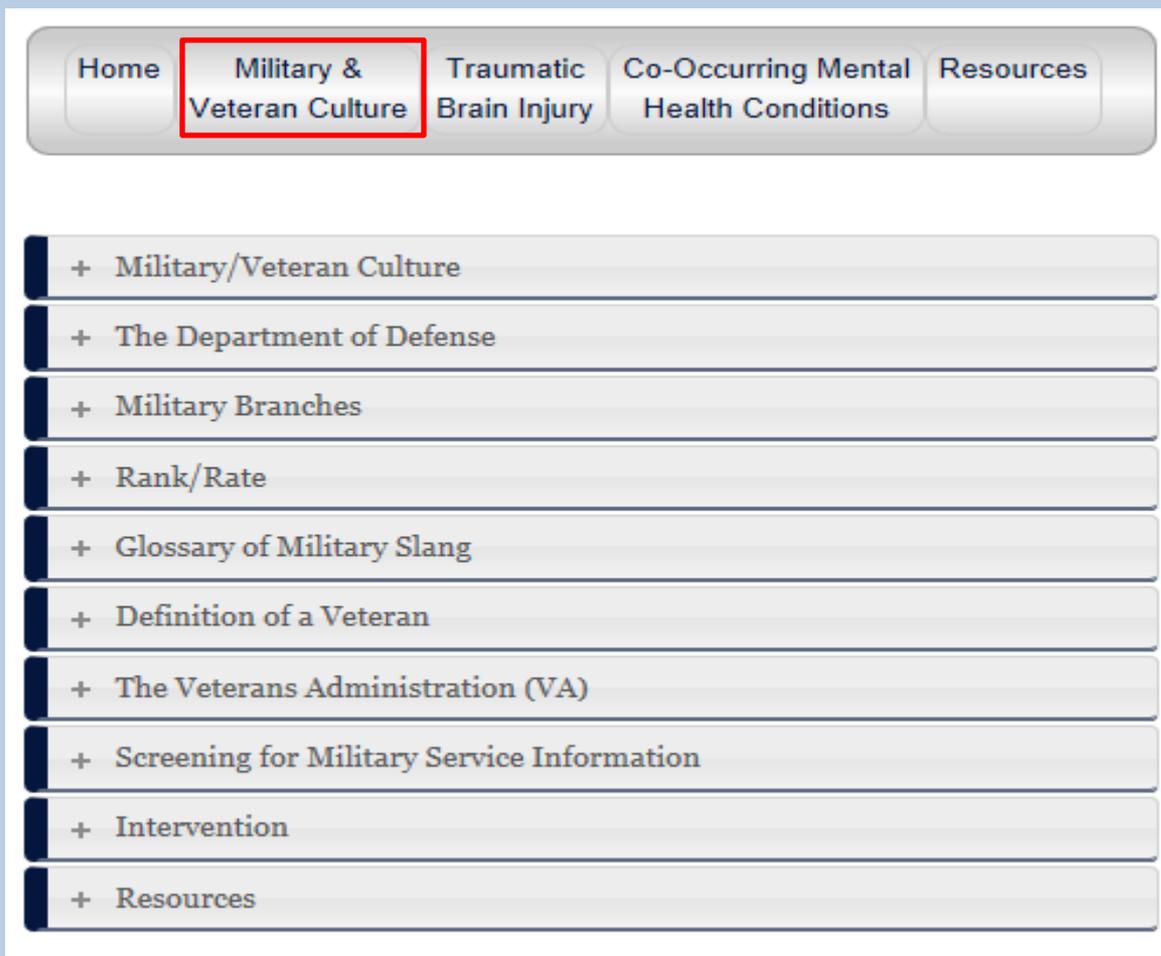
What kind of interventions will I find in the toolkit?

Site Navigation



- As described under the Structure section of the homepage, the toolkit is divided into 4 sections.
- Within each of the 4 sections you will find the following section headings:
 - Background
 - Screening
 - Assessment
 - Intervention
 - Resources

Viewing Information



The image shows a screenshot of a website's navigation menu. At the top, there is a horizontal bar with five buttons: 'Home', 'Military & Veteran Culture', 'Traumatic Brain Injury', 'Co-Occurring Mental Health Conditions', and 'Resources'. The 'Military & Veteran Culture' button is highlighted with a red rectangular border. Below this bar is a vertical list of ten items, each preceded by a plus sign (+) and a dark blue square icon. The items are: 'Military/Veteran Culture', 'The Department of Defense', 'Military Branches', 'Rank/Rate', 'Glossary of Military Slang', 'Definition of a Veteran', 'The Veterans Administration (VA)', 'Screening for Military Service Information', 'Intervention', and 'Resources'.

- + Military/Veteran Culture
- + The Department of Defense
- + Military Branches
- + Rank/Rate
- + Glossary of Military Slang
- + Definition of a Veteran
- + The Veterans Administration (VA)
- + Screening for Military Service Information
- + Intervention
- + Resources

Information found within this and all sections can be collapsed to view of all available information at-a-glance.

Home

Military &
Veteran Culture

Traumatic
Brain Injury

Co-Occurring Mental
Health Conditions

Resources

- Military/Veteran Culture

Understanding Military culture is an essential component to working with Veterans and Active Duty Personnel. This section offers introductory information regarding Military structure along with links to help civilian community providers better understand Military culture.

The nation which
forgets its
defenders will be
itself forgotten
~Calvin Coolidge

[Basics of the United States Military can also be found at this link.](#)

Simply click on the plus (+) symbol to expand the section and read more about each selected toolkit section. Click the minus (-) to close that section.

+ The Department of Defense

+ Military Branches

+ Rank/Rate

View desired information by expanding and collapsing the sections. Simply click on the + or - sign.

- Military/Veteran Culture

Understanding Military culture is an essential component to working with Veterans and Active Duty Personnel. This section offers introductory information regarding Military structure along with links to help civilian community providers better understand Military culture.

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Throughout the toolkit you will find links to helpful information. All links are colored **blue** so that they can be easily seen.

Example of Linked Content (Basics of the United States Military)

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about careers

Job Search & Career Planning - Business & Finance - Media & Arts -

About.com > About Careers > US Military > Branches of the U.S. Armed Forces

U.S. Military 101

The "Basics" of the United States Military

By Rod Powers
US Military Expert

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Scott Olson/Getty Images News/Getty Images

Our present military organizational structure is a result of the National Security Act of 1947. This is the same act that created the United States Air Force, and restructured the "War Department" into the "Department of Defense."

The Department of Defense is headed by a civilian; the Secretary of Defense, who is appointed by the President of the United States. Under the Secretary of Defense, there are three

Military & Veteran Culture: Screening

– Screening for Military Service Information

Screening for history of military service and/or Veteran status is not something that may be commonly included in traditional community behavioral health intakes. Veterans may not volunteer this information to a clinician. Learning more about a Veteran's individual experiences may facilitate increased understanding of and treatment disposition for your client. We encourage you to ask all clients a few key questions regarding their military service. These questions could be incorporated into the intake process for new clients, or as part of screening processes already in place at your facility.

Screening for history of military service can be an essential component in understanding risk for traumatic brain injury, psychiatric difficulties, and other post-service issues.

Key Questions

Examples of key questions you may want to ask your client related to his or her military service might include:

- What branch of military service did you serve?
 - note that there may be more than one branch
- How many years (or months) of Active Duty Service did you have?
- How many years (or months) of Reserve Service did you have?
- What was your date of separation?
- In which service era did you serve?
 - note there may be more than one
 - [click to download a list of service eras](#) 
- Were you deployed? If yes, how many times were you deployed?
 - An explanation of deployment stressors experienced by service members during deployment, common challenges, and tips for working with Veterans who have been deployed - [click here to download](#) 
 - Additional information, assessment, and client handouts regarding deployment is available from the organization [After Deployment.org](#)
- Do you have a history of combat experience? If yes, how many combat tours have you served and where?
- Were you exposed to hand-to-hand combat?
 - Veterans and their family members may benefit from reading the Military Deployment Guide prepared by the US Department of Defense. The sections on post-deployment emotional let down, and combat and operational stress may be especially useful. [Download the PDF here](#) 
- Information regarding combat and operational [stress can also be downloaded here](#).

Mental Health Services

Deployment and Operational Experiences

WHAT IS DEPLOYMENT?

Military deployment is the movement of armed forces. Deployment includes any movement from a military personnel's home station to somewhere outside the continental U.S. and its territories. One example would be when a unit based in the U.S. is deployed to another country to enter into a combat zone, such as Iraq. Deployment is not restricted to combat; units can be deployed for other reasons such as humanitarian aid, evacuation of U.S. citizens, restoration of peace, or increased security.

Mobilization is when an individual or unit is sent somewhere within the continental U.S. or its territories. For example, a unit may have been mobilized to assist during the aftermath of Hurricane Katrina to a location in Louisiana from their base in Illinois. Mobilizations count as deployments under the USERRA Act.

Not all Veterans will deploy, some will have served one tour while some have served multiple, some will have been deployed to a theater of war while others have not.

DEPLOYMENTS CAN BE DIVERSE:

- Deployments may last up to 15 months. With the current conflicts, multiple deployments have become more common.
- Among war Veterans, significant differences exist between various eras, such as the WWII, Korean, Vietnam, and OIF/OEF/OND (Operation Iraqi Freedom/Operation Enduring Freedom/Operation Enduring Freedom) eras.
- Modern military units cycle through four deployment cycle phases as they prepare to deploy, perform their missions during deployment, and return and reintegrate with their homes and families.
 - o Preparation for deployment: A period of time when Service Members train with increasing focus and intensity for the upcoming deployment. Family members plan and prepare for the prolonged separation.
 - o Deployment (leaving): This is a brief period of intense readjustment of saying goodbye and beginning to adapt to the new normal of deployment.
 - o Sustainment while deployed: This is a relatively long phase, lasting from 7-13 months, while operational missions are performed and families cope with separation.
 - o Redeployment (returning): Like the deployment phase, redeployment (the official term for returning) is a brief but tumultuous transition phase between two very dissimilar worlds; it is a time of reintegrating, resettling, and trying to heal from psychological and physical injuries of many kinds.

Above is one example of tools found in this section.

Military & Veteran Culture: Intervention

Several tools available to facilitate culturally competent clinical practice.

- Intervention

Visit the Department of Veterans Affairs [Community Provider Toolkit](#): Working Together to Serve Veterans to participate in online "mini-clinics" for civilian clinicians. These educational, assessment, and treatment tools are geared to help support the rehabilitation and recovery of Veterans living with mental illness.

Mini-clinics for providers include the following topics:

- PTSD
- Suicide Prevention
- Serious Mental Illness
- Women Veterans
- Smoking & Tobacco Use
- Substance Use

Continuing Education and Training

- Earn CEs from the VA when you learn about military culture through online coursework:
 - National Center for PTSD - [Military Culture](#)
- The National Association of Social Workers offers a free online 5 course training module on working with military service members and families, [learn more here](#)
- Social workers may want to review the National Association of Social Workers Standards for Social Work Practice with [Service Members, Veterans, and Their Families](#) (2012), [download the PDF here](#) 
- Learn more about The American Psychological Association's efforts related to [service members, Veterans and their families](#).

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+ Resources

NATIONAL ASSOCIATION OF SOCIAL WORKERS

NASW Standards for
Social Work Practice with

Service
Members,
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Their Families

Traumatic Brain Injury

VA » Health Care » MIRECC/CoE » VISN 19 MIRECC » Toolkit for Providers of Clients with Co-occurring TBI and Mental Health Symptoms

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Toolkit for Providers of Clients with Co-occurring TBI and Mental Health Symptoms



Site Navigation:

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- + [TBI: Background Information](#)
- + [Traumatic Brain Injury \(TBI\) Sequelae and Symptoms](#)
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- + [Additional Helpful Information about Brain Injuries](#)

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City, Utah 84148
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801-582-1565 Ext. 2821

Traumatic Brain Injury: Continued

TBI: Background Information

Definition of TBI

The CDC (2014) defines TBI as "a bump, blow or jolt to the head or a penetrating head injury that disrupts the normal function of the brain. Not all blows or jolts to the head result in a TBI. **More information can be found at the CDC website on TBI.**"

The severity of a TBI may range from "mild," i.e., a brief change in mental status or consciousness to "severe," i.e., an extended period of unconsciousness or amnesia after the injury."

TBI severity is classified as mild, moderate or severe using criteria described in the table below. If a client meets criteria in more than one category of severity, the higher severity level is assigned.

TBI Severity Classification

CRITERIA	MILD	MODERATE	SEVERE
Structural imaging	Normal	Normal or abnormal	Normal or abnormal
Alteration of consciousness (AOC)*	a moment to 24 hours	>24 hours. Severity based on other criteria	Alteration of consciousness (AOC)*
Loss of Consciousness (LOC)	0-30 min	>30 min and <24 hours	>24 hours
Post-Traumatic Amnesia (PTA)	0-24 hours	>24 hours and <7 days	>7 days
Glasgow Coma Scale (GCS) (best available score in first 24 hours)	13-15	9-12	<9

Table adapted from Veterans Affairs (VA)/Department of Defense (DoD) Clinical Practice Guideline, as found in the Textbook of Traumatic Brain Injury, 2nd Ed. 2011, p. 5

* AOC must be immediately following the injury event. Symptoms may include: feeling dazed, confusion, difficulty thinking clearly or responding appropriately, and being unable to describe events immediately before or after the injury event.

The screenshot shows the CDC website page for Traumatic Brain Injury. The page is titled "Injury Prevention & Control: Traumatic Brain Injury". It features a navigation menu on the left with options like "Traumatic Brain Injury", "Get the Facts about TBI", "Concussion & Mild TBI", "Concussion in Sports", "Severe TBI", "Data & Statistics", "Potential Effects", "Reports & Fact Sheets", "Social & New Media", and "Heads Up to Concussion". The main content area includes a "CDC's Injury Center" section with social media links (Recommend, Tweet, Share) and a "Traumatic Brain Injury" section. The "Traumatic Brain Injury" section contains a definition of TBI, a paragraph about its severity, and a link to "More information can be found at the CDC website on TBI." (highlighted in a red box). Below this is a "HEADS UP" section for "FREE CONTINUING EDUCATION CONCUSSION TRAINING FOR MEDICAL PROVIDERS". The "Injury Center Topics" section lists various topics like "Savings Lives & Protecting People", "Home & Recreational Safety", "Motor Vehicle Safety", "Traumatic Brain Injury", "Injury Response", "Violence Prevention", "Data & Statistics (WISQARS)", "Funded Programs", "Communications", "Press Room", "Social Media", and "Publications". The "Research Activities" section includes a graph and a list of research topics like "Traumatic Brain Injuries Related to Sports and Recreation Activities Among Persons Aged ≤19 Years — United States, 2001–2009".

Consistent with the other sections, you will find background information and links to additional information and resources.

Traumatic Brain Injury: Screening

- TBI: Screening

Screening for TBI is the first step in gathering information regarding probable injury. The TBI-4 and the first five questions of the Ohio State University Traumatic Brain Injury Identification Method (OSU TBI-ID) are two examples of questions that can assist providers with screening.

A "yes" response to any of the questions is indicative of a probable TBI and warrants further assessment to confirm or deny previous injury. A positive response to question 2 is the most likely indicator of probable TBI when using the TBI-4.

If a client answers "no" to all of the questions, no further assessment is needed.

Traumatic Brain Injury-4 (TBI-4)

1. Have you ever been hospitalized or treated in an emergency room following a head or neck injury? (Yes/No)
2. Have you ever been knocked out or unconscious following an accident or injury? (Yes/No)
3. Have you ever injured your head or neck in a car accident or from some other moving vehicle accident? (Yes/No)
4. Have you ever injured your head or neck in a fight or fall? (Yes/No)

Brenner et al., 2013

Ohio State University Traumatic Brain Injury Identification Method (OSU TBI-ID)

The first five questions from the Ohio State University Traumatic Brain Injury Identification Method (OSU TBI-ID) (Corrigan and Bogner, 2007;



Wexner Medical Center

Bogner and Corrigan, 2009) are listed below:

1. In your lifetime, have you ever been hospitalized or treated in an emergency room following an injury to your head or neck? Think about any childhood injuries you remember or were told about. (Yes/No)
2. In your lifetime, have you ever injured your head or neck in a car accident or from crashing some other moving vehicle like a bicycle, motorcycle, or ATV? (Yes/No)
3. In your lifetime, have you ever injured your head or neck in a fall or from being hit by something (for example, falling from a bike or horse, rollerblading, falling on ice, being hit by a rock?) Have you ever injured your head or neck playing sports or on the playground? (Yes/No)
4. In your lifetime, have you ever injured your head or neck in a fight, from being hit by someone, or from being shaken violently? Have you ever been shot in the head? (Yes/No)
5. In your lifetime, have you ever been nearby when an explosion or a blast occurred? If you served in the military, think about any combat-or training-related incidents. (Yes/No)

If an individual responds yes to any of these questions, further assessment can be completed using the rest of the OSU TBI-ID.

[Download the OSU TBI-ID and view an instructional video from The Ohio Valley Center for Brain Injury Prevention and Rehabilitation.](#)

References

- Corrigan, J. D., & Bogner, J. A. (2007). Initial reliability and validity of the OSU TBI Identification Method. *Journal of Head Trauma Rehabilitation, 22*(6), 318–329.
- Bogner, J. A., & Corrigan, J. D. (2009). Reliability and validity of the OSU TBI identification method with prisoners. *Journal of Head Trauma Rehabilitation, 24*(6), 279–291.

Traumatic Brain Injury: Assessment

- TBI: Assessment

Diagnosis of TBI and its associated comorbid symptoms and disorders present unique challenges to reliably making a diagnosis of TBI. As such, no screening instruments available can reliably make the diagnosis. Instead, full assessment should be implemented when screening results indicate probable TBI. It should be noted that assessment via brain imaging is not useful in detecting history of mTBI. As such, structured clinical interview is considered the gold standard assessment approach for diagnosing TBI. Assessment using a structured clinical interview will help to clarify the nature of the injury, confirm injury events, determine if a TBI was sustained, and if so, the severity of injury. The Ohio Valley Center for Brain Injury Prevention and Rehabilitation offers training regarding assessment of TBI history and related symptoms using the gold-standard Ohio State University TBI Identification Method (OSU TBI-ID). Although structured interview relies on verbal history which may be difficult to obtain, this approach provides a means for clinicians to elicit and obtain as much detailed injury history as possible in order to make a diagnosis.

TBI Assessment Tools

After information regarding TBI history has been gathered and a history of probable injury or injuries has been confirmed to establish diagnosis, it can be helpful to assess if and how symptoms associated with TBI may be impacting the client's life. Several tools are available to facilitate this process.

The screenshot displays the OSU TBI-ID website. The top navigation bar includes links for HOME, ABOUT US, PROGRAMS & RESEARCH, INFORMATION & EDUCATION, MODEL SYSTEMS, OSU TBI-ID, and RESOURCES. The main content area features a large banner for the "Traumatic Brain Injury Identification Method" with the subtitle "A Tool for Health Care and Social Service Professionals". The banner includes the Ohio State University logo and the Wexner Medical Center logo. Below the banner, the text reads "Ohio Valley Center for Brain Injury Prevention and Rehabilitation, Department of Physical Medicine and Rehabilitation, The Ohio State University". The footer contains contact information for the Ohio Valley Center for Brain Injury Prevention and Rehabilitation, including the address (2115 Dodd Hall, 480 Medical Center Drive, Columbus, OH 43210-1245), phone (614-293-3802), TTY (614-293-3802), and fax (614-293-8886). It also includes a "BEST HOSPITALS" award logo and a copyright notice for The Ohio State's Wexner Medical Center.

Traumatic Brain Injury: Assessment Continued

Symptoms

Neuro-behavioral Symptom Inventory (NSI)

The NSI (Cicerone & Kalmar, 1995) is a 22-item self-report measure of post-concussive (PC) symptoms that commonly occur after mild TBI, including affective, somatic, sensory and cognitive complaints. It can be used as part of a larger assessment battery.

Reference

Cicerone, K. D., & Kalmar, K. (1995). Persistent postconcussion syndrome: The structure of subjective complaints after mild traumatic brain injury. *Journal of Head Trauma Rehabilitation*, 10, 1–17.

Functioning

Craig Handicap Assessment and Reporting Technique (CHART)

The CHART (Whiteneck et al., 1992) is a 32-item interview based assessment which was developed to measure the degree to which impairments and disabilities result in handicaps years after initial rehabilitation. It can be used for individuals with a history of moderate to severe TBI. The CHART assesses functioning in six domains:

1. Cognitive Independence — the ability to “orient”;
2. Physical Independence — the ability to sustain a customarily effective independent existence;
3. Mobility — the ability to move about effectively in surroundings;
4. Occupation — ability to occupy time in the manner customary to that person's sex, age, and culture;
5. Social Integration — the ability to participate in and maintain customary social relationships; and
6. Economic Self-Sufficiency — the ability to sustain customary socioeconomic activity and independence.

In addition to the 32-item measure, a short form comprised of 19 questions is also available. The [measure can be accessed here](#).

Reference

Whiteneck, G.G., Charlifue, S.W., Frankel, M.H., Gardner, B.P., Gerhart, K.A., Krishnan, K.R., Menter, R.R., Nuseibeh, I., Short, D.J., et al. (1992). Mortality, morbidity, and psychosocial outcomes of persons spinal cord injured more than 20 years ago. *Paraplegia*,30(9), 617-30

Other tools include:

- World Health Organization Quality of Life (WHOQOL)
- Daily Living Activities (DLA-20)
- Participation Assessment with Recombined Tools-Objective (PART-O)

Traumatic Brain Injury: Intervention

- TBI: Intervention

Clinical Practice Guidelines

The following provide links to clinical practice guidelines for mild TBI and persistent symptoms. These guidelines offer information and direction to providers managing clients' recovery from mTBI:

- VA and DoD worked together to create the Clinical Practice Guidelines for mTBI to facilitate consistent and beneficial treatment. [Download the guidelines](#) 
- The Ontario Neurotrauma Foundation also created Guidelines for Concussion/Mild TBI and Persistent Symptoms, which include information about the treatment of persistent symptoms. [Download the guidelines](#).

VA » Health Care » VA/DoD Clinical Practice Guidelines » Clinical Practice Guidelines » Management of Concussion-mild Traumatic Brain Injury (mTBI) (2009)

VA/DoD Clinical Practice Guidelines

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 - Stroke Rehabilitation
 - Womens Health
- More Health Care

Management of Concussion-mild Traumatic Brain Injury (mTBI) (2009)

FDA Warning/Regulatory Alert

Note from the OQSV Evidence-Based Practice: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released since completion of the CPG.

Recommendation Against Continued Use: March 28, 2012 – Citalopram Hydrobromide (CELEXA®): new changes have been made to the citalopram product label, specifically: ECG and/or electrolyte monitoring should be performed in patients prescribed citalopram who have relative contraindications to citalopram use, such as in those with comorbid conditions predisposing a risk of QT prolongation; Previous label recommendations that "contraindicated" citalopram use in patients with congenital QT syndrome because of the risk for QT prolongation have been changed to less stringent terminology of "not recommended" to recognize patients with this condition who could benefit from citalopram or who cannot tolerate other alternatives; The maximum dose of citalopram remains at 20mg/day for patients greater than the age of 60 years; Citalopram should be discontinued in patients with QTc measurements persistently above 500ms.

[Link to Citalopram Notice](#)

VA/DoD Clinical Practice Guideline

Management of Concussion/Mild Traumatic Brain Injury

VA/DoD Evidence Based Practice

The guideline describes the critical decision points in the Management of Concussion/mild Traumatic Brain Injury (mTBI) and provides clear and comprehensive evidence based recommendations incorporating current information and practices for practitioners throughout the DoD and VA Health Care systems. The guideline is intended to improve patient outcomes and local management of patients with concussion/mTBI.

Disclaimer: This Clinical Practice Guideline is intended for use only as a tool to assist a clinician/healthcare professional and should not be used to replace clinical judgment.

ABOUT THE CPG	GUIDELINE LINKS
<p>The guideline is formatted as three algorithms, with annotations:</p> <ul style="list-style-type: none">• Algorithm A<ul style="list-style-type: none">- Initial Presentation• Algorithm B<ul style="list-style-type: none">- Management of Symptoms• Algorithm C<ul style="list-style-type: none">- Follow-up of Persistent Symptoms	<ul style="list-style-type: none">mTBI Full Guideline (2009) mTBI Summary (2009) mTBI Pocket Card (2009) View the Guideline Online

QUICK LINKS

- Hospital Locator
 - Zip Code
 - Go
- Health Programs
- Protect Your Health
- A-Z Health Topics

Veterans Crisis Line
1-800-273-8255 PRESS 1

Traumatic Brain Injury: Intervention Continued

Strategies to Facilitate EBP

There are currently no widely established evidence-based practices (EBPs) focused on TBI. Those with a history of mTBI may benefit from any number of EBPs and may or may not require modifications to treatment delivery. Those with a history of moderate to severe TBI are most likely to require modifications to treatment delivery. For information regarding recommendations in this regard, please see Olson-Madden, Brenner, Matarazzo, Signoracci, and Expert Consensus Collaborators (2013).

Below are examples of several challenges clinicians often face when providing EBPs to individuals with a history of TBI. Specific strategies are provided with each question. Please also see Signoracci, Matarazzo, Bahraini (2012).

Question: Do you ever notice your client having a difficult time learning or remembering information they hear?

- **Strategy:** Slow pace of conversation
 - **Function:** Facilitate learning and memory for individuals who may become overwhelmed with auditory information
 - **Example:** N/A

References

Olson-Madden, J., Brenner, L., Matarazzo, B., & Signoracci, G. (2013). Identification and treatment of TBI and co-occurring psychiatric symptoms among OEF/OIF/OND veterans seeking mental health services within the state of Colorado: Establishing consensus for best practices. *Community Mental Health Journal*, 49(2), 220-229.

Signoracci, G.M., Matarazzo, B.B., Bahraini, N.H. (2012). Traumatic Brain Injury and Suicide: Contributing Factors, Risk Assessment and Safety Planning. In J. Lavigne & J. Kemp (Eds.), *Frontiers in suicide prevention and risk research, treatment and prevention*. Hauppauge, NY: Nova Science Publishers, Inc.

Visit the toolkit to access other
available tools!

Co-occurring TBI and Mental Health Symptoms

The screenshot shows the U.S. Department of Veterans Affairs website. At the top left is the VA logo and the text "U.S. Department of Veterans Affairs". To the right are social media icons and a search bar. Below the header is a navigation menu with links: Health, Benefits, Burials & Memorials, About VA, Resources, Media Room, Locations, and Contact Us. The main content area features a breadcrumb trail: "VA » Health Care » MIRECC/CoE » VISN 19 MIRECC » Toolkit for Providers of Clients with Co-occurring TBI and Mental Health Symptoms". The title "MIRECC/CoE" is prominently displayed. Below the title is a "QUICK LINKS" section with buttons for "Hospital Locator", "Health Programs", "Protect Your Health", and "A-Z Health Topics". The "Hospital Locator" button includes a "Zip Code" input field and a "Go" button. Below the quick links are logos for "Veterans Crisis Line" (1-800-273-8255 PRESS 1) and "My healthvet" (My Health, My Care: 24/7 Access to VA). The main content area is titled "Toolkit for Providers of Clients with Co-occurring TBI and Mental Health Symptoms" and features a large image of a red rock landscape. Below the image is a "Site Navigation" section with buttons for "Home", "Military & Veteran Culture", "Traumatic Brain Injury", "Co-Occurring Mental Health Conditions" (highlighted with a red box), and "Resources". Below the navigation buttons is a list of topics: "Co-Occurring Mental Health Disorders", "Substance Misuse/Abuse", "Depression", and "Posttraumatic Stress Disorder (PTSD)". On the right side, there is a "VISN 19 MIRECC Menu" with links for "Home", "Research", "Education", "Clinical", "Fellowships", "About Us", "Staff", and "Send a Message". Below the menu is a "Join for Announcements" button with a MIRECC logo. At the bottom right is a "CONTACT" section with the address: "VISN 19 MIRECC - Denver, 1055 Clermont Street, Denver, CO 80220, VA Eastern Colorado Health Care System, 303-399-8020 Ext. 5275".

U.S. Department of Veterans Affairs

VA » Health Care » MIRECC/CoE » VISN 19 MIRECC » Toolkit for Providers of Clients with Co-occurring TBI and Mental Health Symptoms

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My healthvet
My Health, My Care: 24/7 Access to VA

Toolkit for Providers of Clients with Co-occurring TBI and Mental Health Symptoms

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Co-occurring TBI and Mental Health Symptoms: Substance Abuse

Background Information

Problems with drinking or substance use may occur in response to stress or in combination with PTSD, depression, or other mental health and medical conditions. Pre-injury alcohol and drug abuse increases the risk for sustaining TBI (Vassallo et al., 2007). Additionally, clients with a history of substance abuse often have worse outcomes after sustaining a TBI (Corrigan, Rust, & Lamb-Hart, 1995). Substance use disorders typically decrease after an initial TBI, but there is usually an increase in substance use approximately two to three years after the TBI (Kreutzer, Marwitz & Witol, 1995). Substance use poses an increased risk for future TBIs.

It is essential for providers to routinely assess substance use in the ongoing management of individuals who sustained a TBI. The video "Substance Use and Traumatic Brain Injury Risk Reduction and Prevention" may be helpful for you and your client to view together in practice. The video provides education on how substance use can influence a person with TBI, the risks associated with substance use after a TBI, and how to reduce risk from sustaining future injuries. This video was designed to open dialogue with clients on the topic of substance use.



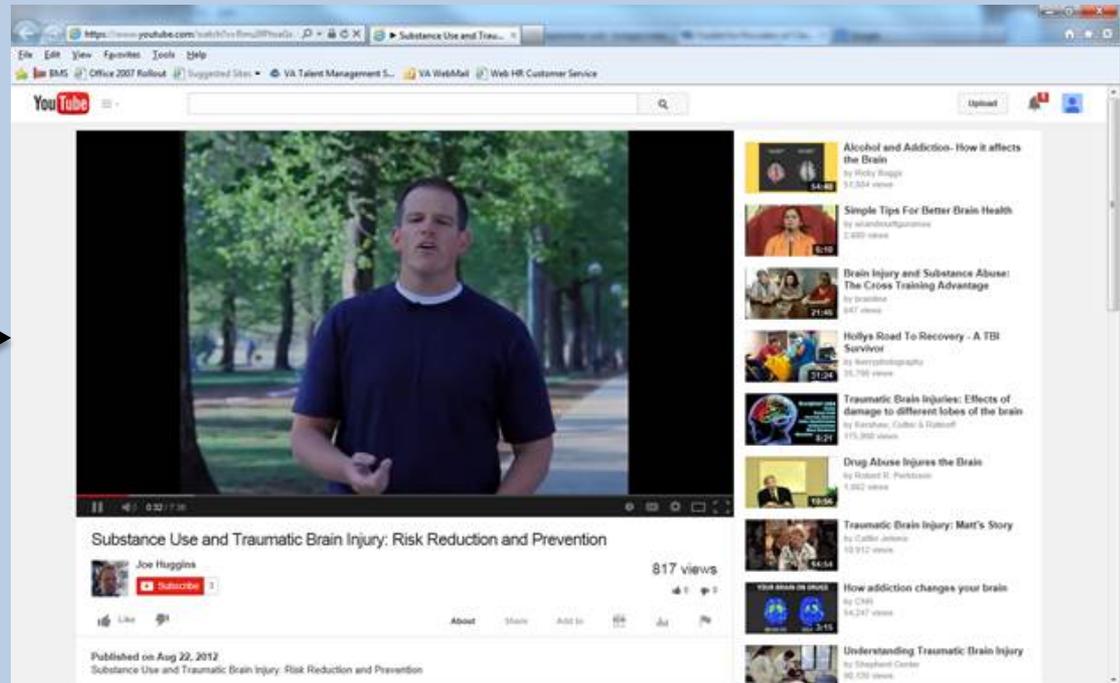
 BrainLine provides [more information about substance use and TBI at their website.](#)

The Ohio Valley Center for Brain Injury Prevention and Rehabilitation (OVC) also provides useful [information about working with individuals with TBI and substance use disorders.](#)



Wexner Medical Center

Another relevant article is [Substance Use and Mild Traumatic Brain Injury Risk Reduction and Prevention: A Novel Model for Treatment](#) co-authored by Jennifer Olson-Madden.



Co-occurring TBI and Mental Health Symptoms: Substance Abuse Screening

AUDIT-C (brief Alcohol Screening Questionnaire for Unhealthy Alcohol Use)

The AUDIT-C is a 3-item alcohol screen that can help identify persons who are hazardous drinkers or have active alcohol use disorders (including alcohol abuse or dependence). It does not include drug use.

AUDIT-C

Q1: How often did you have a drink containing alcohol in the past year?

Answer	Points
Never	0
Monthly or less	1
Two to four times a month	2
Two to three times a week	3
Four or more times a week	4

Q2: How many drinks did you have on a typical day when you were drinking in the past year?

Answer	Points
None, I do not drink	0
1 or 2	0
3 or 4	1
5 or 6	2
7 to 9	3
10 or more	4

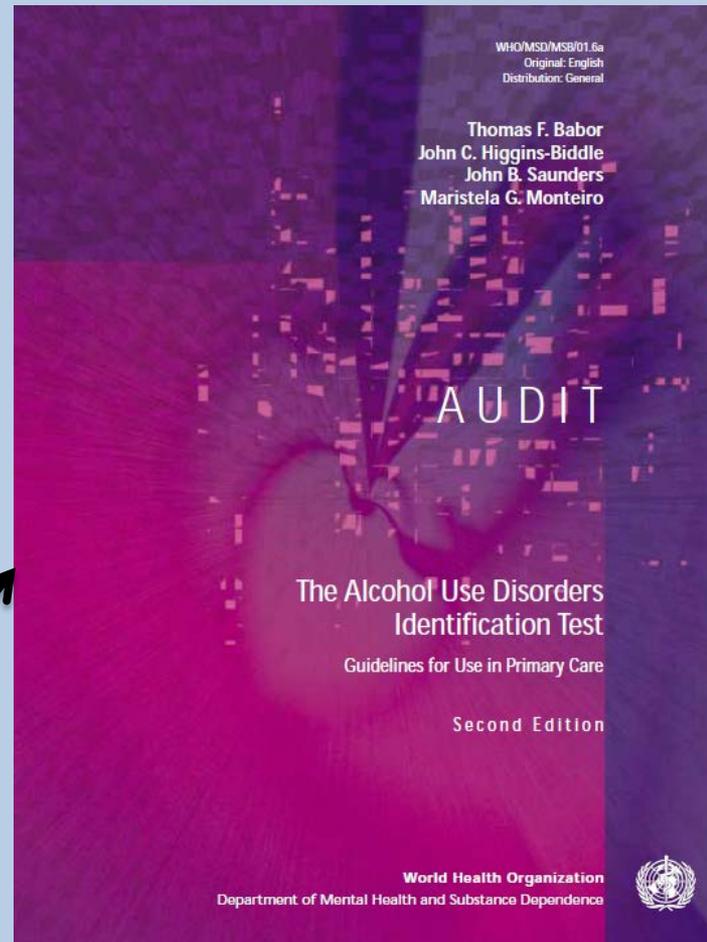
Q3: How often did you have six or more drinks on one occasion in the past year?

Answer	Points
Never	0
Less than monthly	1
Monthly	2
Weekly	3
Daily or almost daily	4

The AUDIT-C is scored on a scale of 0-12 (scores of 0 reflect no alcohol use). In men, a score of 4 or more is considered positive; in women, a score of 3 or more is considered positive. Generally, the higher the AUDIT-C score, the more likely it is that the patient's drinking is affecting his/her health and safety.

The Alcohol Use Disorders Identification Test is a publication of the World Health Organization, © 1990

Visit the toolkit to access other available tools!



Co-occurring TBI and Mental Health Symptoms: Substance Abuse Assessment

Information is provided to guide access to measures (i.e., purchase vs. download).

Assessment

**Diagnostic Assessment:
Comprehensive Addiction and Psychological Evaluation (CAAPE)**

CAAPE is a comprehensive tool that can be used for diagnostic purposes as part of a routine clinical intake when both substance use disorders and mental health disorders need to be considered. It takes approximately 35-50 minutes to complete the evaluation.

CAAPE is a copyrighted instrument. [For purchase information, visit Evince Clinical Assessments](#)

**Symptom Severity Assessment:
The Brief Addiction Monitor (BAM)**

The BAM is a 17-item assessment that can be administered by a clinician or completed as a self-administered questionnaire for clients involved in outpatient substance abuse programs. It includes both symptom level outcomes as well as functional outcomes.

[Download the BAM here](#) 📄

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Intervention

Interventions for substance misuse/abuse should be symptom-focused and evidence based in concurrence with current practice guidelines.

The [VA/DoD Clinical Practice Guidelines on Substance Use Disorders](#) can be found at their website along with the [full guideline](#) 📄 and a [pocket guide](#) 📄.

Download from SAMHSA the  **SAMHSA**
Substance Abuse and Mental Health Services Administration

[Substance Abuse Treatment Advisory: Treating Clients with Traumatic Brain Injury](#) 📄

Tools for intervention are also provided!



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1-800-273-8255 PRESS 1



My Health, My Care: 24/7 Access to VA

Toolkit for Providers of Clients with Co-occurring TBI and Mental Health Symptoms



Site Navigation:

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Background, Screening, Assessment, and Intervention information can also be found for:

- Depression
- Posttraumatic Stress Disorder (PTSD)

Resources

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Toolkit for Providers of Clients with Co-occurring TBI and Mental Health Symptoms



Site Navigation:

Home Military & Veteran Culture Traumatic Brain Injury Co-Occurring Mental Health Conditions **Resources**

- Resources



This page contains a variety of resources for Veterans, Family, Friends and Caregivers. There are also additional resources for Providers.

Simply click on the plus (+) symbol to expand the section and read more about each selected toolkit section. Click the minus (-) to close that section.

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- Resources



This page contains a variety of resources for Veterans, Family, Friends and Caregivers. There are also additional resources for Providers.

Simply click on the plus (+) symbol to expand the section and read more about each selected toolkit section. Click the minus (-) to close that section.

[+ For Veterans](#)[+ For Family & Friends](#)[+ For Providers](#)

Resources: Veterans

Resources

For Veterans

Further information about TBI and services that may be available to Veterans with a history of TBI are found in the links below.

Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE)

The mission of the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) is to improve the lives of our nation's service members, families and veterans by advancing excellence in psychological health and traumatic brain injury prevention and care.



The DCOE provides general information regarding **TBI/concussion and psychological health conditions** commonly affecting the Nation's military communities, service members and families.



afterdeployment.t2.health.mil

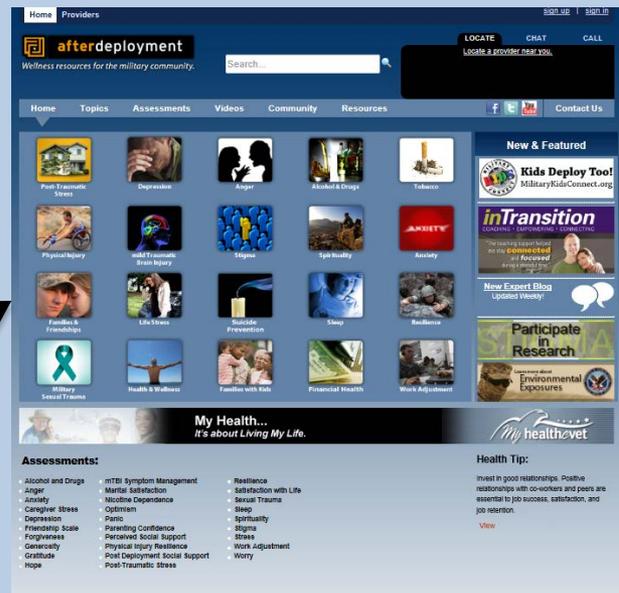
afterdeployment.t2.health.mil is a wellness resource for the military community. Our mission is to help service members, their families, and veterans overcome common adjustment problems following a deployment.

afterdeployment.t2.health.mil provides **information regarding Mild TBI commonly seen post-deployment.**

Brain Injury Association of America



The mission of Brain Injury Association of America is to advance brain injury prevention, research, treatment and education and to improve the quality of life for all individuals impacted by brain injury. Through advocacy, we bring help, hope and healing to millions of individuals living with brain injury, their families and the professionals who serve



Home Providers

afterdeployment
Wellness resources for the military community.

LOCATE CHAT CALL
Locate a provider near you.

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New & Featured

- Kids Deploy Too! MilitaryKidsConnect.org
- inTransition
- New Expert Blog Updated Weekly!
- Participate in Research

My Health... It's about Living My Life.

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- Forgiveness
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- Gratitude
- Hope
- mTBI Symptom Management
- Marital Satisfaction
- Nicotine Dependence
- Optimism
- Parenting Confidence
- Perceived Social Support
- Physical Injury Resilience
- Post Deployment Social Support
- Post-Traumatic Stress
- Resilience
- Satisfaction with Life
- Sexual Trauma
- Sleep
- Spirituality
- Stigma
- Stress
- Work Adjustment
- Worry

Health Tip:
Invest in good relationships. Positive relationships with co-workers and peers are essential to job success, satisfaction, and job retention.



BRAIN INJURY ASSOCIATION OF AMERICA

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NATIONAL Brain Injury Information Center (for Brain Injury Information Only) 1.800.444.4442

THE VOICE OF PROGRESS HEALTH CARE

Welcome to the Brain Injury Association of America

Brain injury is not an event or an outcome. It is the start of a misdiagnosed, misunderstood, under-funded neurological disease. Individuals who sustain brain injuries must have timely access to expert trauma care, specialized rehabilitation, lifelong disease management and individualized services and supports in order to live healthy, independent and satisfying lives.

The mission of the Brain Injury Association of America (BIAA) is to advance brain injury prevention, research, treatment and education and to improve the quality of life for all people affected by brain injury. We are dedicated to increasing access to quality health care and raising awareness and understanding of brain injury. With a network of state affiliates, local chapters and support groups, we are the voice of brain injury.

BOWLING FOR BRAIN INJURY

Bowling for Brain Injury is the signature fundraising and awareness event for the Brain Injury Association of America and its affiliates. Events are scheduled in Indiana, Virginia, California, New York, Nebraska, and Missouri. Money raised through Bowling for Brain Injury is used to assist those living with brain injury, their families and caregivers.

Why Get Involved?

DONATE & SUPPORT

WE'D LIKE TO THANK OUR SPONSORS...

CNS CENTRE FOR NEURO SKILLS

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Find Your Brain Injury Lawyer Here

TBI Rehabilitation Guidelines

FIND HELP HERE

Brain Injury Preferred Attorneys

BRAIN INJURY WARNING SIGNS

Resources: Family & Friends

— For Family & Friends

Family and other social support plays a major role in obtaining a successful outcome for those who have experienced a brain injury (Veterans Health Initiative, 2010). Ongoing sequelae from TBI, however, can have a significant impact on the social support network. For example, up to 47% of caregivers of persons with a history of TBI experience depression (Gillen et al., 1998). Below is a list of resources that can help support family, friends and caregivers of individuals who have experienced a TBI.

VA Caregiver Support Program



The VA Caregiver website declares "VA values your commitment as a partner in our pledge to care for those who have "borne the battle," and we have several support and service options designed with you in mind. The programs are available both in and out of your home to help you care for the Veteran you love and for yourself."

The VA Family Caregivers Guide to TBI.

Defense and Veterans Brain Injury Center (DVBIC) Family & Friends

From their website "Family members and friends play an important role in the care and rehabilitation of individuals with traumatic brain injuries (TBIs). Most people who have sustained a TBI recover significantly in the first few months following injury. In fact, more than 85 percent of people with a concussion, also known as a mild TBI, recover completely within weeks to months with minimal intervention."



Family members and care givers may request support from **DVBIC's TBI Recovery Support Program**

See the DVBIC video "Caring for a Loved One After a Military TBI: One Wife's Perspective".



I'm Caring for a Veteran with Traumatic Brain Injury (TBI)

What Do I Need to Know?

VA Caregiver Support

Some Facts

What is Traumatic Brain Injury?
Traumatic brain injury (TBI) happens when something hits the head hard or makes it move quickly. Injuries may be due to blasts in combat, or as a result of motor vehicle accidents, falls, falling or flying objects, or assaults. TBI is called "mild" and may also be referred to as a concussion, when there is a brief change in awareness or consciousness at the time the injury occurs. It is called "moderate" or "severe" when there is a longer period of unconsciousness or amnesia, which means memory loss. The initial injury does not necessarily predict what long-term symptoms an individual may have.

Treatment may include: rehabilitation therapies, exercise and other activities, medication, education and support.

Physical and Mental Changes to Expect

There are some common physical and thinking changes that can occur with TBI depending on the type and severity of the injury. Some symptoms may be present immediately, while others may appear later. The Veteran's symptoms and course of recovery may differ from others with a similar type of injury. One individual may recover with little remaining problems, while others experience symptoms that can last for days, weeks, or sometimes longer. In general, recovery from TBI is slower for older individuals, and for those who have had a previous brain injury. For individuals with a more severe TBI, there may be lasting changes to or problems with physical, emotional or cognitive thinking functioning.

Physical changes may include: problems with vision, weakness and coordination, as well as headaches, dizziness, fatigue, pain, and sleep disturbances.

Thinking changes may include: memory and learning problems, decreased concentration, problems with judgment, and slower thinking.

Emotional issues may include: irritability, problems managing anger or frustration, depression, anxiety, adjustment difficulties, and problems with social functioning.

What Does This Mean for Me?

Family Caregivers play an important role in recovery. In fact, many people who work with TBI patients believe that having a Family Caregiver is one of the most important aids to recovery. You can offer support, encouragement and guidance to your injured family member, and help ensure the treatment plan established by the medical professionals caring for the Veteran is followed.

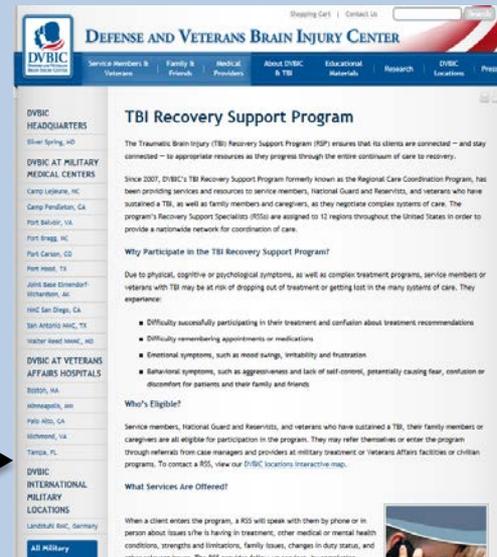
At times, you may feel overwhelmed, angry or scared. You may also feel alone, or feel worn out by caregiving responsibilities. These reactions are normal and typically come and go. If you feel like there is just too much to deal with, seek help either by confiding in a friend, participating in a support group or consulting a professional mental health practitioner.

Download PDF

www.va.gov/caregiver

U.S. Department of Veterans Affairs

And many more!



DEFENSE AND VETERANS BRAIN INJURY CENTER

TBI Recovery Support Program

The Traumatic Brain Injury (TBI) Recovery Support Program (RSP) ensures that its clients are connected – and stay connected – to appropriate resources as they progress through the entire continuum of care to recovery.

Since 2007, DVBIC's TBI Recovery Support Program formerly known as the Regional Care Coordination Program, has been providing services and resources to service members, National Guard and Reservists, and veterans who have sustained a TBI, as well as family members and caregivers, as they negotiate complex systems of care. The program's Recovery Support Specialists (RSS) are assigned to 12 regions throughout the United States in order to provide a nationwide network for coordination of care.

Why Participate in the TBI Recovery Support Program?

Due to physical, cognitive or psychological symptoms, as well as complex treatment programs, service members or veterans with TBI may be at risk of dropping out of treatment or getting lost in the many systems of care. They experience:

- Difficulty successfully participating in their treatment and confusion about treatment recommendations
- Difficulty remembering appointments or medications
- Emotional symptoms, such as mood swings, irritability and frustration
- Behavioral symptoms, such as aggressiveness and lack of self-control, potentially causing fear, confusion or discomfort for partners and their family and friends

Who's Eligible?

Service members, National Guard and Reservists, and veterans who have sustained a TBI, their family members or caregivers are all eligible for participation in the program. They may refer themselves or enter the program through referrals from case managers and providers at military treatment or Veterans Affairs facilities or civilian programs. To contact a RSS, view our DVBIC locations interactive map.

What Services Are Offered?

When a client enters the program, a RSS will speak with them by phone or in person about issues s/he is having in treatment, other medical or mental health conditions, strengths and limitations, family issues, changes in duty status, and other relevant issues. The RSS provides follow-up services, by completing

Resources: Providers

— For Providers

The links below provide additional information about TBI, Veterans services, and general information about how to work with individuals with a history of TBI.

Brain Injury Alliance of Colorado

The Brain Injury Alliance Colorado produces a valuable [Resource Directory](#)



Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE)

The mission of the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) is to improve the lives of our nation's service members, families and veterans by advancing excellence in psychological health and traumatic brain injury prevention and care.



The DCOE provides general information regarding [TBI/concussion and psychological health conditions](#) commonly affecting the Nation's military communities, service members and families.

afterdeployment.t2.health.mil

afterdeployment.t2.health.mil is a wellness resource for the military community. Our



mission is to help service members, their families, and veterans overcome common adjustment problems following a deployment.

afterdeployment.t2.health.mil provides [information regarding Mild TBI commonly seen post-deployment.](#)

Center for Disease Control and Prevention: Injury Prevention & Control: Traumatic Brain Injury



The CDC provides a toolkit for physicians called "[Heads Up: Brain Injury in Your Practice](#)" that is a valuable resource.

Ohio Valley Center for Brain Injury Prevention and Rehabilitation

The Ohio Valley Center for Brain Injury Prevention and Rehabilitation provides [information for community providers working with individuals with a history of TBI.](#)



Wexner Medical Center

Telehealth and Technology Web Resource Locator For TBI Case Managers



Case management resources for those working with Veterans with a history of TBI.

VISN 19 MIRECC

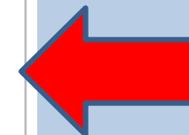
Information for professionals from the VISN 19 MIRECC whose mission is to study suicide with the goal of reducing suicidal ideation and behaviors in the Veteran population. Towards this end, the work of the VISN 19 MIRECC is focused on promising clinical interventions, as well as the cognitive and neurobiological underpinnings of suicidal thoughts and behaviors that may lead to innovative prevention strategies.



National Center for Telehealth and Technology: Provider Resilience App



Download the free App "[Provider Resilience](#)" created by the [National Center for Telehealth and Technology](#). Provider Resilience gives health care providers tools to guard against burnout and compassion fatigue as they help service members, Veterans and their families.



In addition to the other tools, be sure to visit the VISN 19 MIRECC!

VISN 19 MIRECC



U.S. Department of Veterans Affairs

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Updated: 3 April 2014

FEATURED CLINICIAN RESOURCE

Conceptualizing Suicide Risk in TBI: A Supplemental Handbook

Conceptualizing Suicide Risk in TBI
This handbook presents an overview of Traumatic Brain Injury (TBI), a kind of "TBI-The Basics" course. The handbook then explores the relationship between TBI and suicide risk, and the relationship between executive dysfunction and suicide risk. Presented in an easy to digest manner for our very busy clinician. This a must have for clinicians.

A New Handbook 

by VISN 19 MIRECC

Download your copy now 

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VA Salt Lake City Health Care System
801-582-1685 Ext. 2821

Suicide Prevention | TBI Resources | Other Resources

Suicide Prevention

VISN 19 MIRECC Menu

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- Research
- Education
- Clinical
- National Consult Service
- Resources for Clinicians
- SDV Nomenclature
- Assessment Tools
- Fellowships
- About Us



Using QR Codes and Your Smartphone to View the VISN 19 MIRECC Website



Requirements:

1. Smartphone with a camera
2. QR scanning software (available as a free download - just look at your phone's marketplace)



1 Scan QR Code **2** Open Website