# Identifying the Needs of OEF/OIF Veterans with Traumatic Brain Injury (TBI) and Co-Occurring Behavioral Health Issues and Their Families

Lisa A. Brenner, PhD, ABPP (Rp), Bridget B. Matarazzo, PsyD, Jennifer H. Olson-Madden, PhD, & Gina M. Signoracci, PhD

VA VISN 19 Mental Illness Research, Education and Clinical Center (MIRECC), University of Colorado Anschutz Medical Campus, School of Medicine

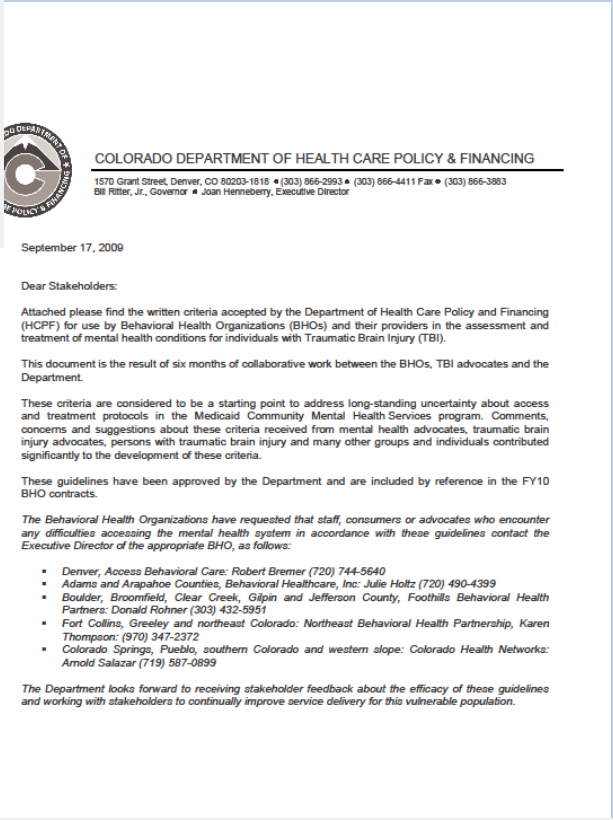
# Disclosure

This presentation is based on work supported, in part, by the Department of Veterans Affairs, but does not necessarily represent the views of the Department of Veterans Affairs or the United States Government.

# Systemic Factors: Climate and Macro-policy

The CO Needs and Resource Assessment indicated that a **majority of adult respondents (70% to 80%)** indicated that they needed mental health services related to their TBI.

**A significant barrier to accessing appropriate mental health services for individuals with TBI is funding**. Many individuals are not eligible for Medicaid dollars. Theoretically, individuals of low income who are not eligible for Medicaid would be eligible for indigent funds however, these funds are very limited. There are roughly 30,000 individuals being provided mental health services through indigent funds however, based on a recently completed 2009 CO Population in Need Study conducted by DBH there are approximately 71,000 individuals who have serious mental illness in CO.



COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

1570 Grant Street, Denver, CO 80203-1818 • (303) 866-2993 • (303) 866-4411 Fax • (303) 866-3883
Bill Ritter, Jr., Governor • Joan Henneberry, Executive Director

September 17, 2009

Dear Stakeholders:

Attached please find the written criteria accepted by the Department of Health Care Policy and Financing (HCPF) for use by Behavioral Health Organizations (BHOs) and their providers in the assessment and treatment of mental health conditions for individuals with Traumatic Brain Injury (TBI).

This document is the result of six months of collaborative work between the BHOs, TBI advocates and the Department.

These criteria are considered to be a starting point to address long-standing uncertainty about access and treatment protocols in the Medicaid Community Mental Health Services program. Comments, concerns and suggestions about these criteria received from mental health advocates, traumatic brain injury advocates, persons with traumatic brain injury and many other groups and individuals contributed significantly to the development of these criteria.

These guidelines have been approved by the Department and are included by reference in the FY10 BHO contracts.

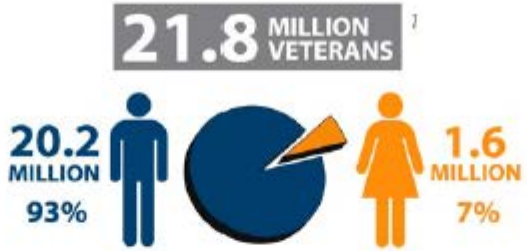
*The Behavioral Health Organizations have requested that staff, consumers or advocates who encounter any difficulties accessing the mental health system in accordance with these guidelines contact the Executive Director of the appropriate BHO, as follows:*

- *Denver, Access Behavioral Care: Robert Bremer (720) 744-5640*
- *Adams and Arapahoe Counties, Behavioral Healthcare, Inc: Julie Holtz (720) 490-4399*
- *Boulder, Broomfield, Clear Creek, Gilpin and Jefferson County, Foothills Behavioral Health Partners: Donald Rohner (303) 432-5951*
- *Fort Collins, Greeley and northeast Colorado: Northeast Behavioral Health Partnership, Karen Thompson: (970) 347-2372*
- *Colorado Springs, Pueblo, southern Colorado and western slope: Colorado Health Networks: Arnold Salazar (719) 587-0899*

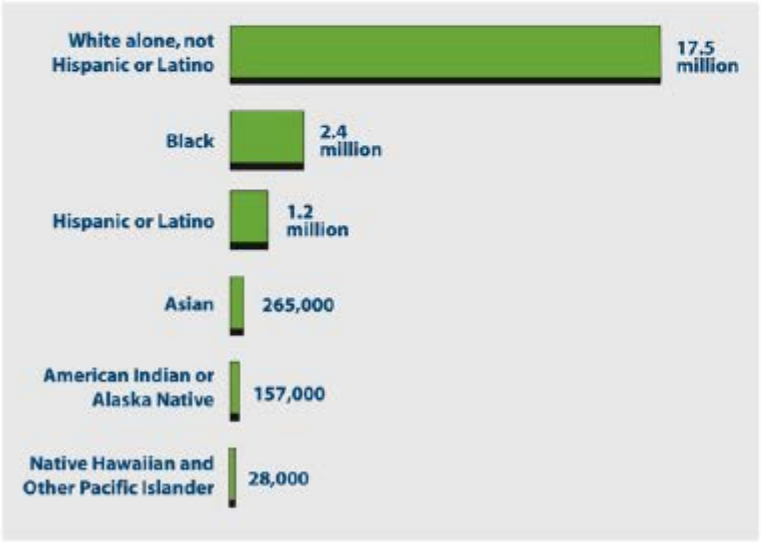
*The Department looks forward to receiving stakeholder feedback about the efficacy of these guidelines and working with stakeholders to continually improve service delivery for this vulnerable population.*

During 2007 and 2008 - CO Department of Health Care Policy and Finance that many **Behavioral Health Organizations and Community Mental Health Centers were not appropriately interpreting their Medicaid contract obligations in regard to treating individuals with TBI**.

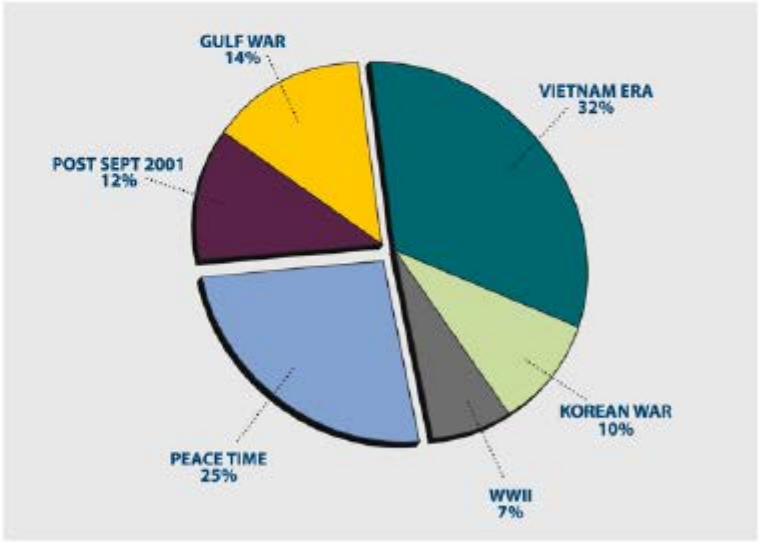
# Veterans today




## Race & Ethnicity [1]




## Service Era [2]

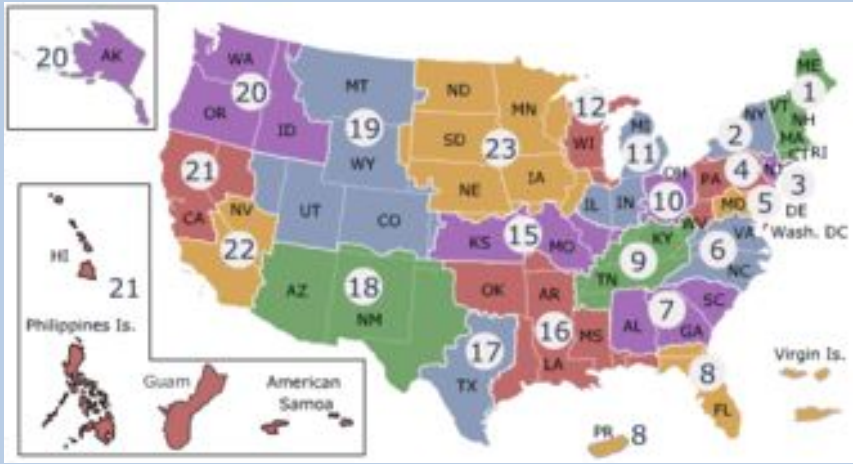



1. U.S. Census Bureau (2010). *American Community Survey.* Retrieved from http://www.census.gov/how/infographics/veterans.html.

2. U.S. Department of Veterans Affairs (2012). *VetPop 2007, Table 2L: Veterans by State, Period, Age Group, Gender, 2000-2036* as of 9/30/11; and Table 10L: *Veterans 2000-2036 by Gulf War Service, Age, Gender Period* as of 9/30/11.

# Why Veterans?

- Majority of Veterans seek care outside of VHA:
  - 22% males and 15% females currently receiving VA health care
  - Community based health care providers must be able to meet the specialized behavioral health needs of returning military personnel and Veterans
  - Specifically, clinicians need to be aware of the factors which may differentiate these clients from members of the general population.




US Government Accountability Office, 2010

# Combat

- According to a study by Hoge and colleagues (Hoge, Auchterloine, & Milliken, 2006), **65% of Soldiers who served in Iraq reported a history of combat experience**.

# Screening Results: n=3,973

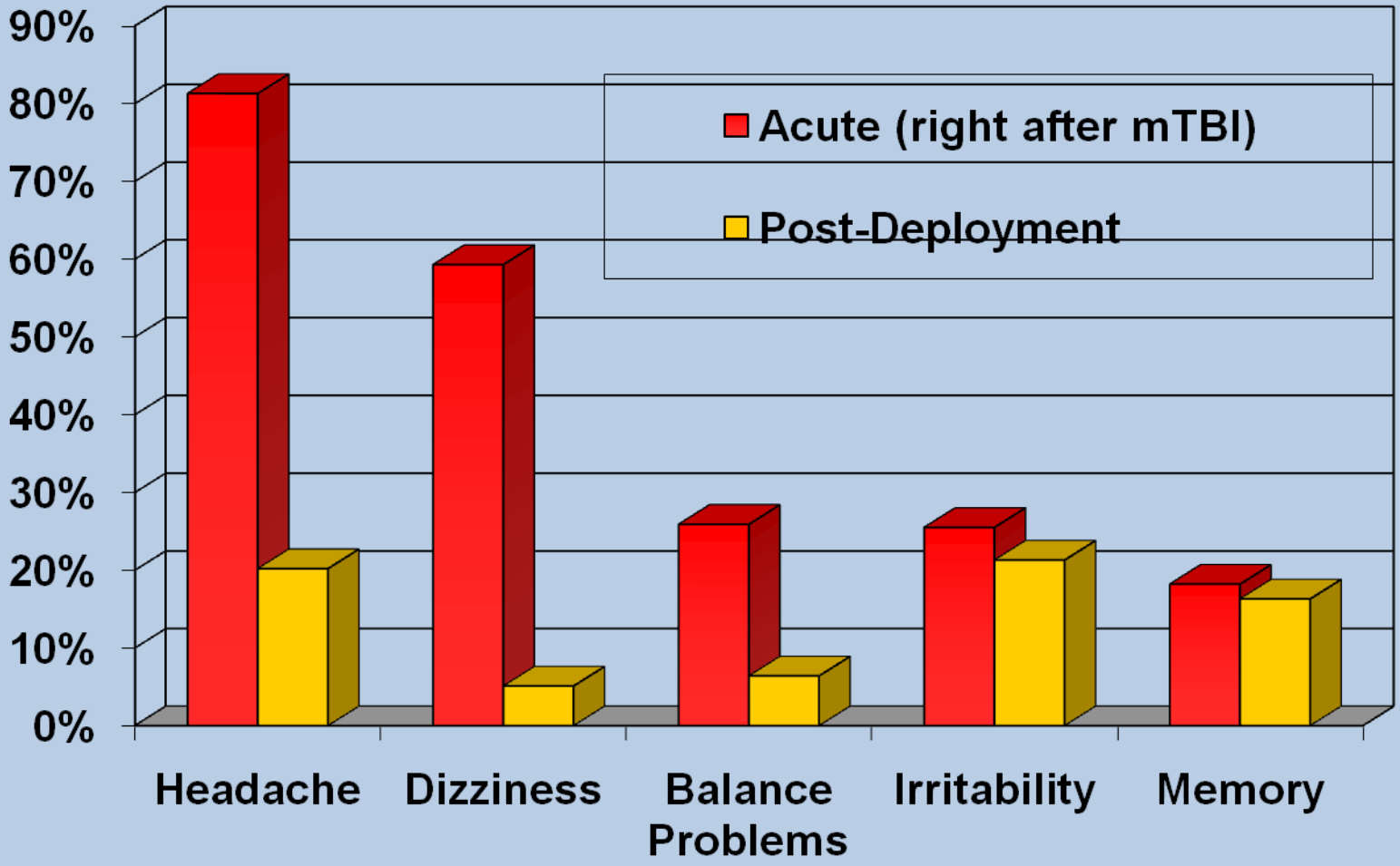
| **Injury Status** | N (%) |
|---|---|
| Injured with TBI | 907 (22.8) |
| Injured without TBI | 385 (9.7) |
| Not injured | 2,681 (67.5) |
| **Total Screened** | **3,973 (100)** |
| | |
| **Injury Characteristics for Soldiers with TBI‡** | |
| Dazed or confused only | 572 (63.1) |
| Had LOC* or could not remember the injury | 335 (36.9) |
| **Total with TBI** | **907 (100)** |

‡ TBI is defined by an alteration in consciousness, such as being dazed or confused, not remembering the injury event, and/or losing consciousness in the context of an injury

* LOC=loss of consciousness

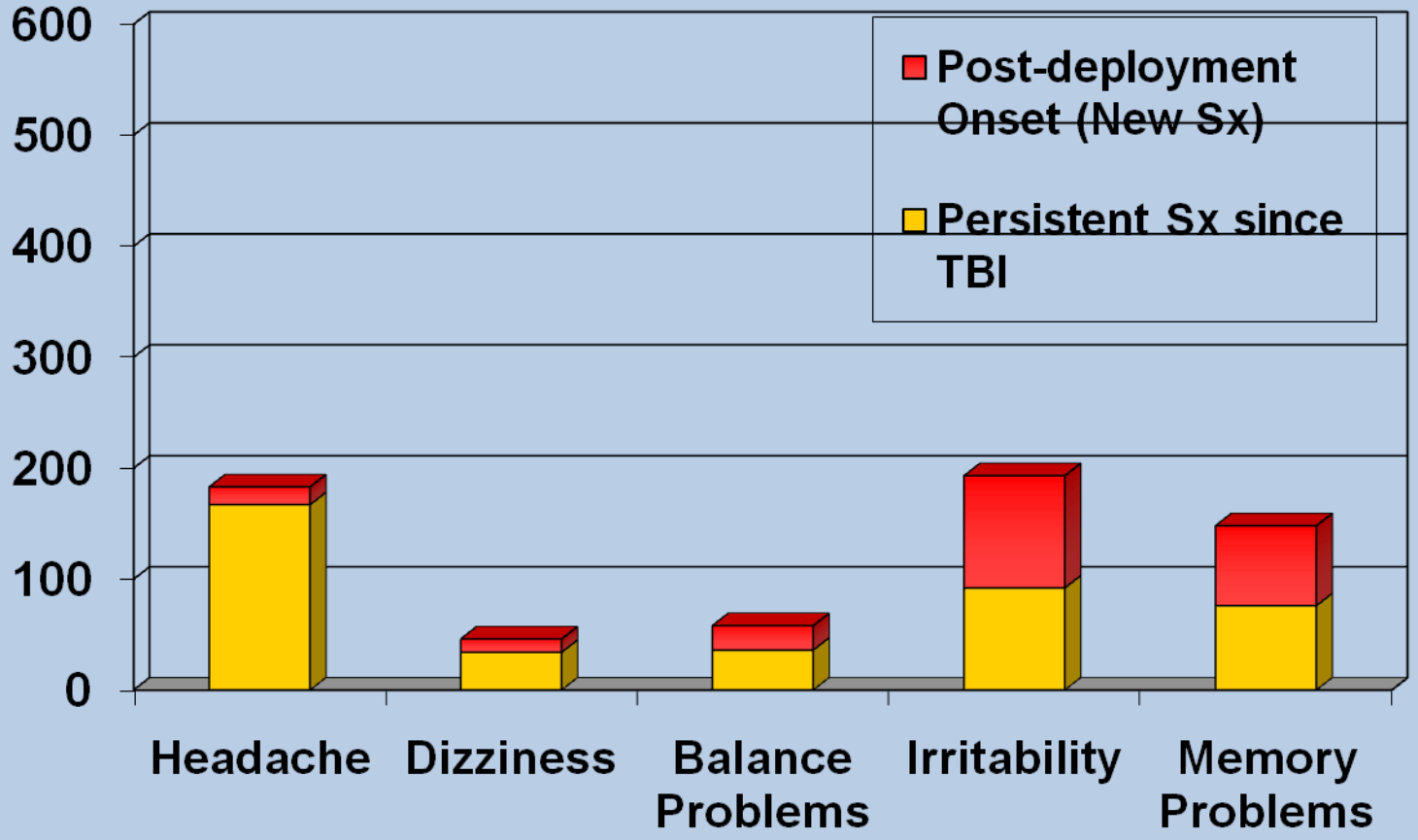
Terrio et al., 2009

# Ft. Carson:
# Post-Deployment Data (n = 907)




Terrio H, Brenner LA, Ivins B, Cho JM, Helmick K, Schwab K, et al. Traumatic brain injury screening: Preliminary findings regarding prevalence and sequelae in a US Army Brigade Combat Team. Journal of Head Trauma Rehabilitation. 2009; 24(1):14-23.

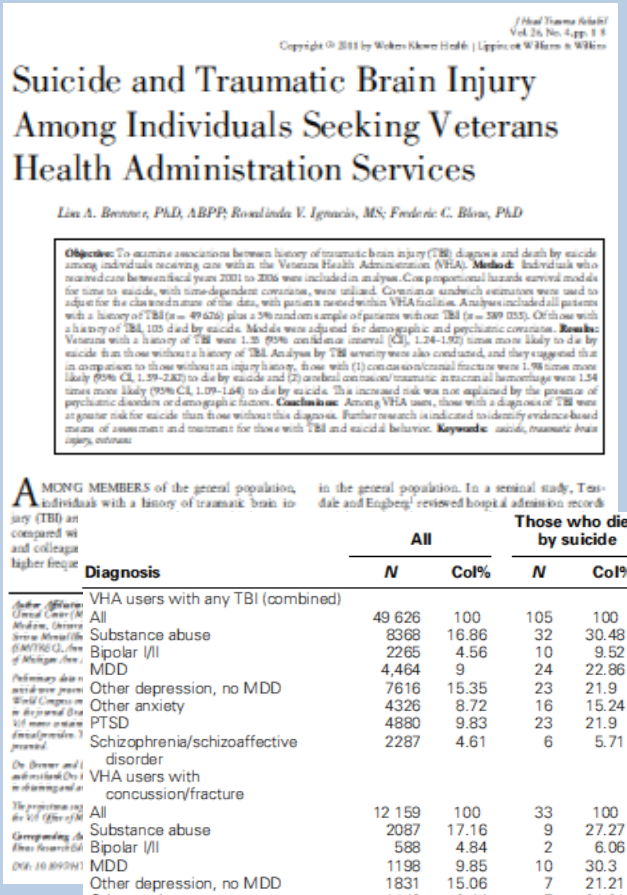
# Currently Symptomatic: Onset of Symptoms (n = 844)




Terrio H, Brenner LA, Ivins B, Cho JM, Helmick K, Schwab K, et al. Traumatic brain injury screening: Preliminary findings regarding prevalence and sequelae in a US Army Brigade Combat Team. Journal of Head Trauma Rehabilitation. 2009; 24(1):14-23.

# Suicide and Veterans

- 22 Veterans per day die by suicide
  - Kemp & Bossarte, 2012
- ~ 5 deaths from suicide/day among Veterans receiving care in VHA
  - VA Serious Mental Illness Treatment, Research and Evaluation Center
- More than 60% of suicides among utilizers of VHA services are among patients with a known diagnosis of a mental health condition
  - Serious Mental Illness Treatment Research and Education Center
- Veterans are more likely to use firearms as a means
  - National Violent Death Reporting System
- ~1000 attempts/month among Veterans receiving care in VHA as reported by suicide prevention coordinators
  - ~8 % repeat attempts with an average of 3 months follow-up
  - ~0.45% deaths from suicide in attempters with an average of 3 months follow-up
    - ~30% of recent suicides have a history of previous attempts
  - VA National Suicide Prevention Coordinator



Copyright © 2011 by Wolters Kluwer Health | Lippincott Williams & Wilkins

## Suicide and Traumatic Brain Injury Among Individuals Seeking Veterans Health Administration Services

Lisa A. Brenner, PhD, ABPP; Rosalinda V. Ignacio, MS; Frederic C. Blow, PhD

**Objective:** To examine associations between history of traumatic brain injury (TBI) diagnosis and death by suicide among individuals receiving care within the Veterans Health Administration (VHA). **Method:** Individuals who received care between fiscal years 2001 to 2006 were included in analyses. Cox proportional hazards survival models for time to suicide, with time-dependent covariates, were utilized. Covariance sandwich estimators were used to adjust for the clustered nature of the data, with patients nested within VHA facilities. Analyses included all patients with a history of TBI (n = 49 626) plus a 5% random sample of patients without TBI (n = 389 055). Of those with a history of TBI, 105 died by suicide. Models were adjusted for demographic and psychiatric covariates. **Results:** Veterans with a history of TBI were 1.35 (95% confidence interval (CI), 1.24–1.92) times more likely to die by suicide than those without a history of TBI. Analyses by TBI severity were also conducted, and they suggested that in comparison to those without an injury history, those with (1) concussion/cranial fracture were 1.98 times more likely (95% CI, 1.59–2.82) to die by suicide and (2) cerebral contusion/traumatic intracranial hemorrhage were 1.34 times more likely (95% CI, 1.09–1.64) to die by suicide. This increased risk was not explained by the presence of psychiatric disorders or demographic factors. **Conclusions:** Among VHA users, those with a diagnosis of TBI were at greater risk for suicide than those without this diagnosis. Further research is indicated to identify evidence-based means of assessment and treatment for those with TBI and suicidal behavior. **Keywords:** *suicide, traumatic brain injury, veterans*

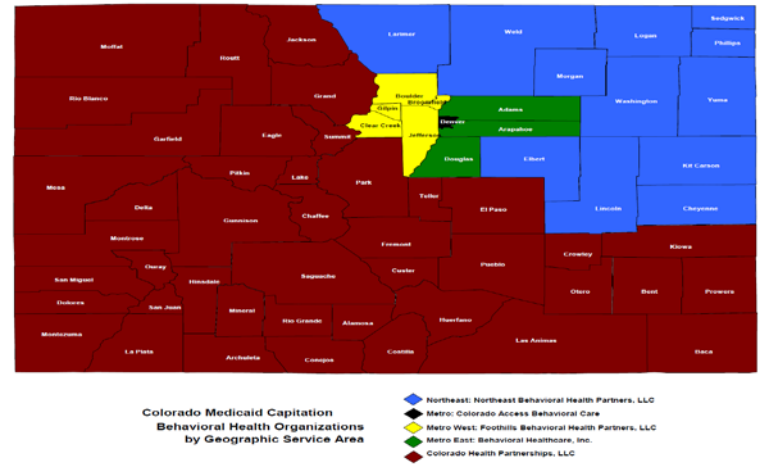
AMONG MEMBERS of the general population, individuals with a history of traumatic brain injury (TBI) are compared with and colleagues higher frequ in the general population. In a seminal study, Teasdale and Engberg[1] reviewed hospital admission records

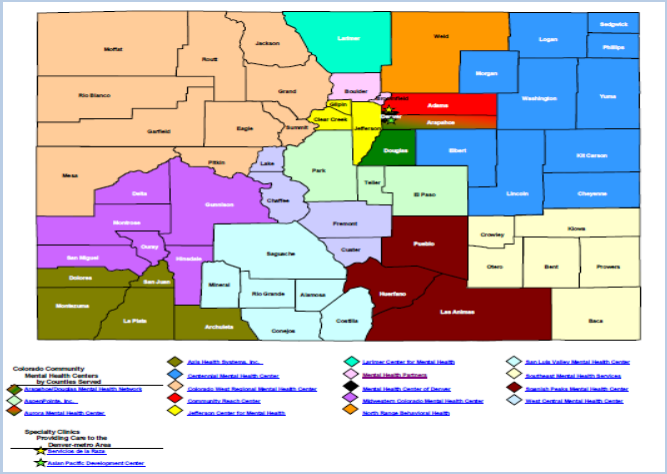
| Diagnosis | All N | All Col% | Those who died by suicide N | Those who died by suicide Col% | Those who did not die by suicide N | Those who did not die by suicide Col% | P |
|---|---|---|---|---|---|---|---|
| VHA users with any TBI (combined) | | | | | | | |
| All | 49 626 | 100 | 105 | 100 | 49 521 | 100 | |
| Substance abuse | 8368 | 16.86 | 32 | 30.48 | 8336 | 16.83 | .0002 |
| Bipolar I/II | 2265 | 4.56 | 10 | 9.52 | 2255 | 4.55 | .0292 |
| MDD | 4,464 | 9 | 24 | 22.86 | 4440 | 8.97 | <.0001 |
| Other depression, no MDD | 7616 | 15.35 | 23 | 21.9 | 7593 | 15.33 | .062 |
| Other anxiety | 4326 | 8.72 | 16 | 15.24 | 4310 | 8.7 | .0177 |
| PTSD | 4880 | 9.83 | 23 | 21.9 | 4857 | 9.81 | <.0001 |
| Schizophrenia/schizoaffective disorder | 2287 | 4.61 | 6 | 5.71 | 2281 | 4.61 | .4875 |
| VHA users with concussion/fracture | | | | | | | |
| All | 12 159 | 100 | 33 | 100 | 12 126 | 100 | |
| Substance abuse | 2087 | 17.16 | 9 | 27.27 | 2078 | 17.14 | .123 |
| Bipolar I/II | 588 | 4.84 | 2 | 6.06 | 586 | 4.83 | .6731 |
| MDD | 1198 | 9.85 | 10 | 30.3 | 1188 | 9.8 | .00092 |
| Other depression, no MDD | 1831 | 15.06 | 7 | 21.21 | 1824 | 15.04 | .3271 |
| Other anxiety | 1148 | 9.44 | 7 | 21.21 | 1141 | 9.41 | .0316 |
| PTSD | 1376 | 11.32 | 7 | 21.21 | 1369 | 11.29 | .0912 |
| Schizophrenia/schizoaffective disorder | 519 | 4.27 | 1 | 3.03 | 518 | 4.27 | .9999 |
| VHA users with cerebral contusion/traumatic intracranial hemorrhage | | | | | | | |
| All | 39 545 | 100 | 78 | 100 | 39 467 | 100 | |
| Substance abuse | 6728 | 17.01 | 25 | 32.05 | 6703 | 16.98 | .0004 |
| Bipolar I/II | 1802 | 4.56 | 8 | 10.26 | 1794 | 4.55 | .0256 |
| MDD | 3490 | 8.83 | 17 | 21.79 | 3473 | 8.8 | <.0001 |
| Other depression, no MDD | 6142 | 15.53 | 17 | 21.79 | 6125 | 15.52 | .1263 |
| Other anxiety | 3377 | 8.54 | 11 | 14.1 | 3366 | 8.53 | .0785 |
| PTSD | 3757 | 9.5 | 17 | 21.79 | 3740 | 9.48 | .0002 |
| Schizophrenia/schizoaffective disorder | 1869 | 4.73 | 5 | 6.41 | 1864 | 4.72 | .4199 |

# Purpose and Target Populations

To explore and **potentially 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 Operation Enduring Freedom (OEF)/Operation Iraq Freedom (OIF) Veterans and their families.

- OEF/OIF Veterans with a history of traumatic brain injury (TBI) and co-occurring behavioral health issues.
- Mental Health Providers
- Community and State Mental Health Leadership
- Behavioral Health Organizations

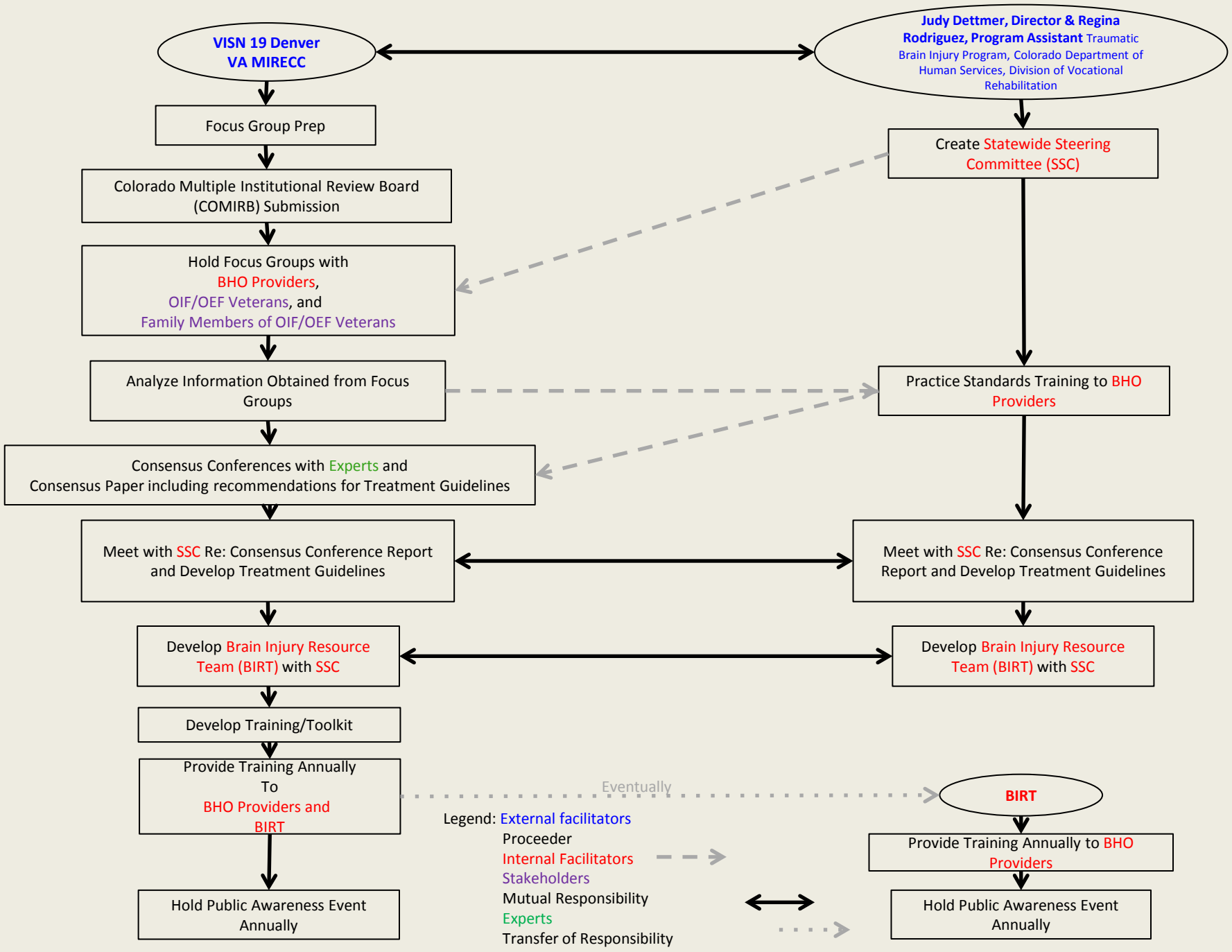


# Specific Aims

- Develop **assessment and treatment guidelines** to improve non-VA community mental health care for OEF/OIF Veterans with TBI and co-occurring behavioral health issues within the state of Colorado.
- Develop a **training and accompanying toolkit**, which may be used for annual educational training of mental health providers.

# Identifying the Needs of OEF/OIF Veterans and Their Families: TBI and Co-Occurring Behavioral Health Issues



# Data to Inform Guideline and Toolkit Development

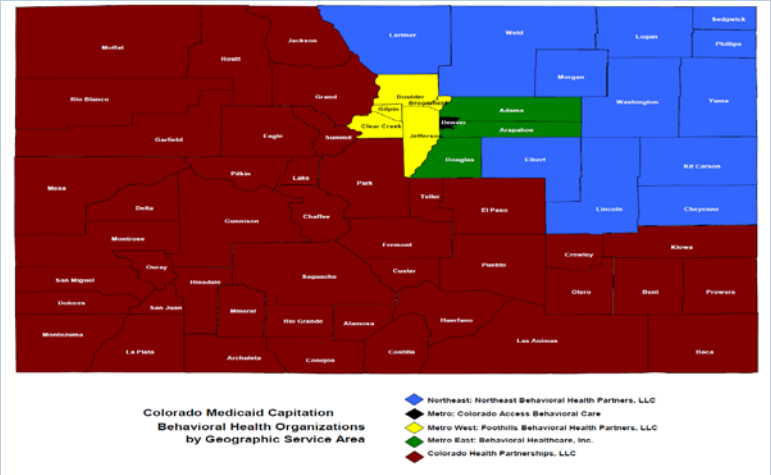
- **Focus Groups**
  - Qualitative and Quantitative

- **TBI Expert Consensus Conference**

  Consensus paper will be created to summarize themes reviewed and expert input regarding recommendations made for assessment and treatment guidelines

- **Statewide Steering Committee (SSC) Meetings**
  - Consultation with the SSC will result in recommendations tailored to be utilized by non-VA community mental health systems providing care to Veterans.

Focus groups with Behavioral Health Organization (BHO) providers, OEF/OIF Veterans, and family members of OEF/OIF Veterans were conducted in 5 regions throughout the state of Colorado




•Six focus groups were conducted with a total sample of 44 Behavioral Health Organization (BHO) providers.

•Provider participants completed a demographic form and the Perceived Barriers to Mental Health Treatment: Modified Version questionnaire (Hoge et al., 2004). Responses to the questionnaire regarding barriers to receiving mental health care were scored on a five-point scale with 1 = Strongly disagree and 5 = Strongly agree.

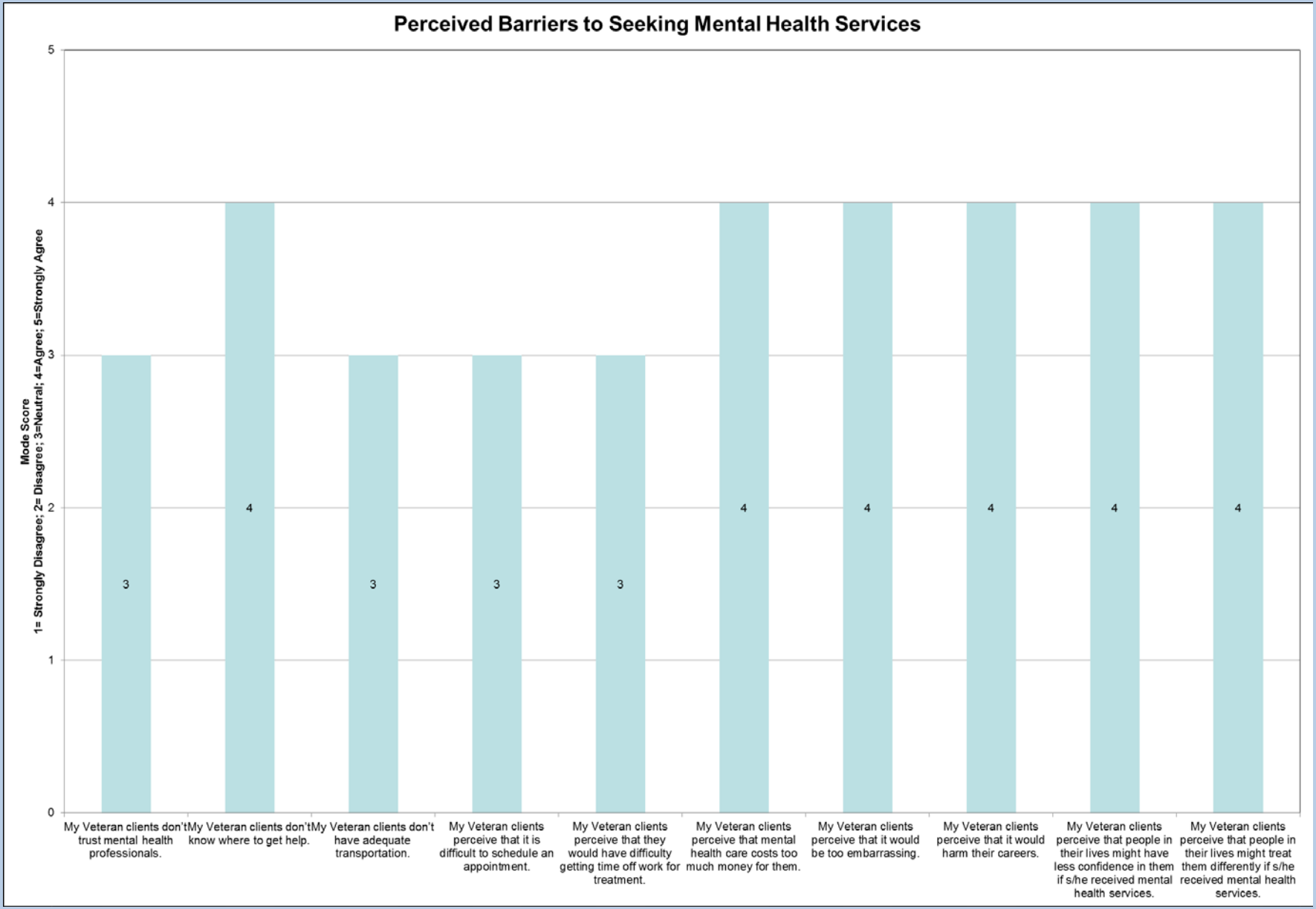
•Focus groups were transcribed and themes were identified.

# Focus Group: Provider Demographics

| Provider Demographics - %/(n) | |
|---|---|
| **Gender** | (n = 45) |
| Male | 24.4% /(11) |
| Female | 68.9%/(31) |
| Missing | 6.7%/(3) |
| **Age-Range** | (n = 45) |
| 22-34 | 20.0% /(9) |
| 35-44 | 22.2%/(10) |
| 45-54 | 28.9% /(13) |
| 55-64 | 28.9%/(13) |
| **Degree Level** | (n = 45) |
| None | 2.2% /(1) |
| Bachelors | 8.9%/(4) |
| Masters | 66.7%/(30) |
| Trainee | 2.2%/(1) |
| Doctoral | 17.8%/(8) |
| Unknown | 2.2%/(1) |
| **Number of Years Working in Mental Health** | |
| Mean | 12.5 |
| Range | 0.04-41 |

| Patient Demographics - %/(n) | |
|---|---|
| **How many patients with TBI & co-occurring MH Concerns?** | |
| 0 | 20.0%/(9) |
| 1-10 | 42.2% /(19) |
| 11-20 | 11.1%/(5) |
| 21-50 | 13.3%/(6) |
| 51 and more | 6.7%/(3) |
| Missing | 6.7%/(3) |
| **If you have patients with TBI &MH, how many OEF/OIF vets?** | |
| 0 | 51.1%/(23) |
| 1-5 | 22.2%/(10) |
| 6 and more | 8.9%/(4) |
| Missing | 17.8%/(8) |
| **How many OEF/OIF Vets have you treated?** | |
| 0 | 55.6%/(25) |
| 1-10 | 20.0%/(9) |
| 11-50 | 8.9%/(4) |
| 50 and more | 8.9%/(4) |
| Missing | 6.7%/(3) |
| **How many family member of OEF/OIF Vets have you treated?** | |
| 0 | 64.4%/(29) |
| 1-11 | 11.1%/(5) |
| 11 and more | 11.1%(/5) |
| Missing | 13.3%/(6) |
| **Referred any OEF/OIF vets to VA for care?*** | |
| No | 66.7% /(30) |
| Yes | 33.3% /(15) |

* Examples listed: crisis, benefits, and PTSD


Perceived Barriers to Seeking Mental Health Services
Mode Score
1= Strongly Disagree; 2= Disagree; 3=Neutral; 4=Agree; 5=Strongly Agree
0
1
2
3
4
5
3
4
3
3
3
4
4
4
4
4
My Veteran clients don't trust mental health professionals.
My Veteran clients don't know where to get help.
My Veteran clients don't have adequate transportation.
My Veteran clients perceive that it is difficult to schedule an appointment.
My Veteran clients perceive that they would have difficulty getting time off work for treatment.
My Veteran clients perceive that mental health care costs too much money for them.
My Veteran clients perceive that it would be too embarrassing.
My Veteran clients perceive that it would harm their careers.
My Veteran clients perceive that people in their lives might have less confidence in them if s/he received mental health services.
My Veteran clients perceive that people in their lives might treat them differently if s/he received mental health services.

# Preliminary Results: Focus Group Themes

- There was great variability in providers' knowledge regarding how to provide care for Veterans.
  - Common concerns included not knowing how to access or navigate VA services, funding issues, and limited resources.

- Competence regarding Veteran/military culture widely varied.
  - Cultural knowledge appeared to be based solely on theoretical knowledge or on personal experience for others.
  - Proximity or access to military and Veteran resources also appeared to play a role.

- Providers appeared to have a general sense as to problems and/or diagnoses experienced by Veterans who served in combat (e.g., "PTSD," "substance abuse," "homelessness," "anger," and "readjustment issues").

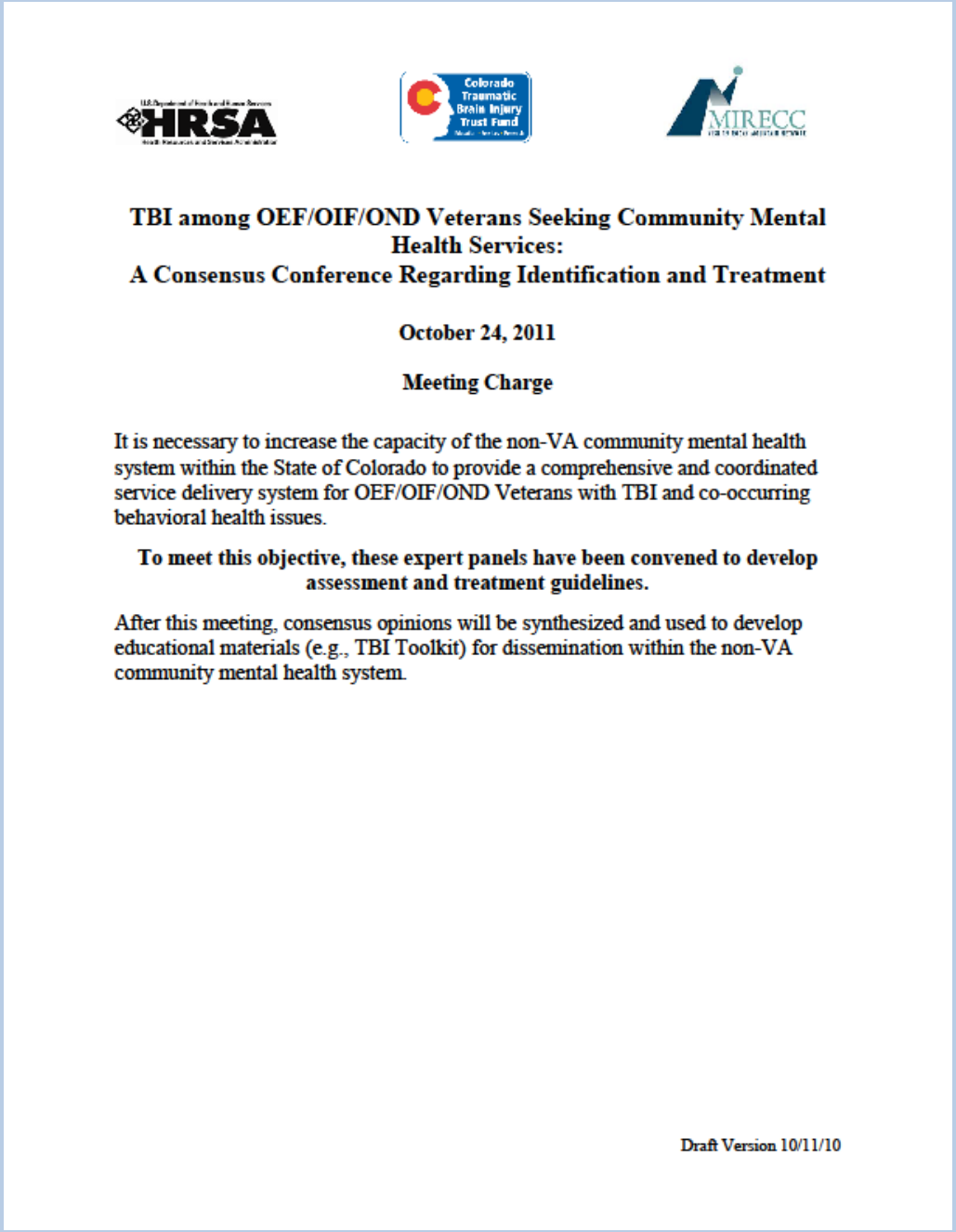
# Preliminary Results: Focus Group Themes

- Providers suggested a number of reasons why Veterans may not seek community mental health care, including concerns about having less anonymity in smaller communities and perceptions that care interferes with the “warrior” persona.
- Some providers believed Veterans may not seek VA care because they are “unable to be helped by VA.”
- Perceived barriers to receiving care in general included Veterans having greater difficulties than non-Veterans.
- With regard to TBI knowledge, many providers expressed the belief that TBI can only be diagnosed and treated by a medical doctor (e.g., “TBI is out of my purview”), though they identified specific symptoms consistent with history TBI (e.g., “cognitive and emotional problems”).

# Preliminary Results: Focus Group Themes

- Providers' expressed needs and desires for training  varied across region and setting (e.g., rural or urban), as did their preference for training modality ("intensive and in-person workshop" or " brief, web-based presentation").
  - Many described a need for "practical tools" for working with this vulnerable population.

# 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.

Draft Version 10/11/10

# Participants

In attendance were the members of the MIRECC project team, the Director of the Colorado TBI Program, 7 national experts in TBI assessment, 7 national experts in TBI intervention, Colorado CMHC experts , a state leader in TBI and MIRECC support staff.

# Procedures

- Prior to the one-day meeting, MIRECC Investigators drafted and provided participants with selected literature and assumptions and questions regarding TBI assessment and intervention.

- At the consensus meeting, attendees were reminded that the primary focus of the one-day meeting was to reach consensus regarding answers to questions about TBI assessment and treatment that would be posed to them.

- Attendees discussed and revised the initial set of assumptions and questions.

- Experts then worked together in smaller break-out 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. |

**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?<br>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?<br>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)<br>2. What barriers/facilitators (e.g., individual [clinician], systems) may impact assessment and treatment planning? Intervention? |

# Results

- 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**

Jennifer H. Olson-Madden · Lisa A. Brenner · Bridget B. Matarazzo · Gina M. Signoracci · Expert Consensus Collaborators

Received: 27 June 2012 / Accepted: 21 December 2012
© Springer Science+Business Media New York 2013

**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 Assistance 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.

J. H. Olson-Madden (✉) · L. A. Brenner · B. B. Matarazzo · G. M. Signoracci
Veterans Integrated Service Network (VISN) 19, Mental Illness Research, Education, and Clinical Center (MIRECC), 1055 Clermont Street, Denver, CO 80220, USA
e-mail: jennifer.olson-madden@va.gov

J. H. Olson-Madden · B. B. Matarazzo · G. M. Signoracci
Department of Psychiatry, School of Medicine, University of Colorado Anschutz Medical Campus, Denver, CO, USA

L. A. Brenner
Departments of Psychiatry, Neurology, and Physical Medicine and Rehabilitation, School of Medicine, University of Colorado Anschutz Medical Campus, Denver, CO, USA

Published online: 17 January 2013

**Keywords** Trau… Assessment · Inte…

**Background**

According to the … 1.7 million Americ… within the state o… Traumatic Brain I… personal communi… are 950 deaths, 5,0… department (ED) … Coloradans live wi… A wide range of o… ments (Hibbard et… addition, military p… are sustaining inju… Upon return to the… reporting psychiat… with post traumati… (Tanielian and Jay… medical and/or me… the Veterans Healt… community-based, … edge and skills to m… one means to help … Affairs has develo… Toolkit aimed at … resources to com… mental health con… gov/communitypc…

With regard to t… in the State of Co… Organizations (BH…

Treatment Guidelines

*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?*

Consensus Statement: If identification of TBI is relevant to the proposed treatment and/or informs direct services, and its recognition promotes an emphasis on functional recovery, then its detection would be an important component of treatment planning. However, it is important to be careful to avoid "locking" the individual into the diagnosis, lest it become an obstacle to improvement. Notably, a diagnosis of TBI may not be as relevant as is the awareness of when and how to intervene (e.g., if behavior conflicts with current treatment, if clarification of functional impairment can facilitate accessing additional resources). Clinicians may consider aspects of TBI history which may be relevant to case conceptualization including proximity of time since injury, age at injury, specific symptom presentation, changes in "sense of self," etc. as those aspects may inform individualized treatment strategies and goals.

Providers must determine aspects of treatment that are beneficial and appropriate for the individual while also maintaining a collaborative treatment relationship. Indeed, the TBI survivor and/or the individual's supports should be considered essential aspects of treatment planning. For example, collaborative educational goal setting is indicated and represents an appreciation for individual/family involvement in treatment planning.

*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 may also be facilitative in establishing and maintaining accurate assumptions regarding the individual's sense of self and recovery. Results from screening/assessment/evaluation should be utilized to identify and promote positive psychiatric and functional outcomes, rather than to solely identify deficits/impairments. Having a clear understanding of findings and implications therein may result in a more culturally competent conceptualization of the individual and his/her needs.

*Under what circumstances can current best practices (e.g., Cognitive Behavioral Therapy (CBT)/Selective Serotonin Reuptake Inhibitor (SSRI) for major depression) be utilized with none or only minor revisions?*

# Next Steps

- Recommendations regarding best practices will be disseminated throughout the community-based mental health care system in Colorado.
  - These will be used to inform the development of a toolkit and training for community mental health center providers.
    - The toolkit will contain resources such as TBI assessment tools and information regarding treatment best practices.
- MIRECC staff will train champions in CMHCs who will then train their staff in order to enhance the services provided to Veterans with a history of TBI who seek mental health care outside of VHA.

# Next Steps

This statewide initiative may not only improve quality and access to non-VA community mental health care for persons with TBI and co-occurring behavioral health issues within Colorado, but also serve as a model for implementation across the country.

THANK YOU

lisa.brenner@va.gov
jennifer.olson-madden@va.gov
bridget.matarazzo@va.gov
gina.signoracci@va.gov

www.mirecc.va.gov/visn19

Use Your Smartphone to Visit the VISN 19 MIRECC Website