PTSD and TBI in the Military
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Consultant Clinical Psychologist/Neuropsychologist
The population

Background
-Predominantly young 18-30 male population doing a variety of combat and non-combat related jobs

Current conflicts
-Iraq and Afghanistan

Exercise and non-operational roles
PTSD in Military

Assumptions

Around 4% in both UK deployed and non-deployed populations – non deployed n = 5550; deployed n= 4722 (Hotopf et al., 2006)

Iraq veterans – 3.7% (Iverson et al., 2008)

Reality on the ground

Veterans - combat stress, NHS MH services
ABI in the Military

- TBI’s – Mild, Moderate and Severe
- RTA’s, Assaults, Gunshots, Parachute injuries, Training activities, Blast injuries – IED’s, Hypoxic
- Stroke, Dementia, MS
- Tumours
- Infections
TBI and the Military

Inpatient Services: DMRC Headley Court
Neuro rehab pathway

Military patient presents to MO/NHS with neurological symptoms

Patient’s neurological diagnosis confirmed

Patient referred to DMRC

Referral assessed within 48 hrs

OPD assessment

mTBI team

Neurologist

Discharge to MO with advice and rehabilitation plan

Admit NRU DMRC

POC: Dr Emer Mc Gilloway
DMRC-NEUROConsultant@mod.uk

Traumatic Brain Injury
Stroke
Cerebral infection
encephalitis
meningitis
Multiple Sclerosis
Parkinson’s disease
Cerebral Tumour

Neurologist

Discharge to MO with advice and rehabilitation plan

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NHS interface

- from referrals (acute)
- upon discharge from military - return to NHS services
- community brain injury rehabilitation teams
Centre for Neuro Rehabilitation

Traumatic Brain Injury
- Mild, Moderate, Severe
- Battle and Non Battle injuries

Other Neuro Conditions
- Stroke
- Brain Tumours
- Neuro medical conditions

Mild Traumatic Brain Injury
- MTBI/Concussion – from operational and non operational Injuries. Focus is on symptom education, strategy management and support.

Rehab Programmes
- Goal driven, Evidence Based Practice, following National Clinical Guidelines
- Treatment addresses impairments in cognitive, executive, communication, physical, psychosocial independent living vocational rehabilitation sessions (work trials)
- Evaluation of patients outcomes

IDT Working
- Occupational Therapy
- Speech and Language Therapy
- Physiotherapy
- Neuropsychology
- Exercise Rehabilitation
- Doctors and Nurses
- Social Work
- Administration

Outcomes
- 87% of patients return to independent living
- 80% Employable (part time 26%, full time 54%)
- Focus for 2014 / 15 is on Long term Vocational Outcomes MTBI / Neuro

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Neuro Rehab Group Pathways

Referral → Out-patient Clinic → Mild Traumatic Brain Injury Group (MTBI)

Admission & Assessment

Treatment Planning Meeting
Week 3

Non Return to work Stream
Blue Stream
Further rehabilitation required

Return to work Streams
Red Stream
Civilian Work
Green Stream
Military Work

All patients are followed up in the out-patient clinic 4 months post discharge
Pathway for Return to Work (Military)

**Green Stream**

MDT assessment highlights vocational need
TPM – **Green stream**

- Impairment / Activity based rehab (cognitive, executive, mood and behaviour, communication, physical skills)
- Functional Skills: Personal home / Self Occupation

Vocational Rehabilitation
Aim to identify appropriate Job Demands Analysis re current job role. May include vocational counselling, vocational assessment, work hardening.

Contact line manager to liaise re work performance pre injury

Team Evaluation of feasibility to undertake a return to work, to include Vocational meeting and worksite assessment.

- GRoW
  When no major barriers are identified or the Work Trial has been successful, Voc OT to refer to ROHT for GRoW programme.

- Work Trial
  A supported trial at work (2-12 weeks) facilitated by Headley Court Voc OT to identify and manage neuro related barriers to return to work

- Unable to return to work
  Move to red stream

Evaluation of Work Trial/workplace meeting

Out-patient review at 4 months

Successful
Unsuccessful
Vocational Rehabilitation
Aim to identify appropriate civilian career options. May include vocational counselling, vocational assessment at contract provider, work hardening, volunteering, work placements, job preparation skills (interviews, job searching, CV prep, work behaviours)

Outcome
• Action plan to access standard resettlement / work / study
• PRU engaged in action plan and needs of patient unable to access standard resettlement

Jobcentre plus – only accessible once discharged from military
• Disability Employment Advisor (DEA) will review need for schemes such as Access to work, Job introduction scheme, WORKSTEP, New Deal for Disabled People (NDDP) and Permitted work scheme

Alternative work preparation provider
• Via contract provider
• DEOT (Defence Employment and Opportunities Team)

College / retraining
• Local college
• Headway

Pathway for Return to Work (Civilian)

Red Stream
MDT assessment highlights vocational need
TPM – Red stream

• Impairment / activity based rehab (cognitive, executive, mood and behaviour, communication, physical skills)
• Functional Skills: Personal home / Self Occupation
• Discharge planning to home and for ongoing community rehab services

PRU Pathway
• Resettlement courses
• Admin/general support
• Supported by Career Transition Partnership

Out-patient review at 4 months
Pathway for Non-Return to Work

Blue Stream

MDT assessment – TPM – Blue stream

3 months +
Impairment / Activity based rehab
cognitive, executive, mood and behaviour, communication, physical skills

- Functional Skills:
  Personal home / Self Occupation

- Discharge planning to home and for ongoing community rehab services

Return home with community input
Liaison with social services / PCT/ charitable organisations regarding ongoing care & / or continued rehab

Transfer to another provider
- Contract Providers as per MOD contract
- JSP770 Chap 5 Para 1.05.4e(4)

If over achieving goals - move to red stream

Out-patient review at 4 months
US military experience:
14% of all patients admitted to WRAMC from Iraq had sustained mTBI. (Warden, 2006)

UK military experience: Estimated worse case scenario that 1.8% (n=462) of 26,000 recorded medical admissions from Iraq had sustained mTBI. This suggested the need for a service (Hodgetts unpublished 2007)

The treatment programme began in June 2008 at the Centre for Mental & Cognitive Health
Phase 1
weeks 0-3

Phase 2
weeks 3-12

Phase 3
weeks 12-14

Phase 4
ongoing

mTBI Card + Sheets + Monitoring

Tip Cards + Goal Setting + Telephone Support + Monitoring

Group Programme

Goal Setting + Telephone Support + Monitoring

The Filter Model
mTBI Clinical

Treatment approaches

- Education
- Process training
- Functional activities
- Strategy training
Outpatient services

Department of Community Mental Health (DCMH)

Psychiatrist

Psychologist

Community Psychiatric Nurses

14 in England and Scotland, 1 in N.I and 1 in Germany
On Discharge from DMRC

Military resources e.g. Personal recovery units, resettlement courses, Occupational Health.

Outside contracts: BIRT and QEF
How we differ from the NHS

- Lower threshold for admission
- No time limitation
- Greater intensity of treatment
- Military environment
- Client group
When do we see PTSD?

- Neuro-rehab unit - less frequently
- Previous PTSD
- Patients pre-occupation with event is more curious than fearful
- Acute stress reaction/ adjustment difficulties
When do we see PTSD?

- MTBI - more frequently than inpatient Neuro ward
- Complex presentations
- Cross-over of cognitive and mental health symptoms
- Adjustment difficulties
- Marked variability in presentation

- DCMH's -
  - Not usually in conjunction with TBI's
  - Sometimes more complex in presentation - dissociation and personality issues
Other salient factors

- Social stressors
- Coming out of military
- Compensation
- Stigma
- Misunderstanding of diagnosis
How do we treat it?

Trauma focussed CBT,
EMDR - not used with vestibular patients or with those that have significant difficulty with self soothing
relaxation,
mindfulness techniques,
anger management
groups
Issues to be mindful of...

PCS and PTSD?
- cross over of symptoms, with many symptoms commonly having a psychological aetiology (Hoge et al., 2008)

The potential damage of psycho-education
- becoming over-aware of cognitive symptoms
- mTBI implies potentially long-lasting symptoms

Potential return to work
- most are eager for this, some are not

Secondary gains
- poor effort
Take home messages

- Don't always assume that PTSD is going to be the best psychological diagnosis.
- Be mindful of psychological factors impacting cognition.
- Just because someone has psychological symptoms does not mean that there is no underlying organic damage.
- Don't get paralysed by the PTSD vs TBI debate.
- Individual formulations are key.
- An individually tailored eclectic approach can be helpful.