

Overview of Traumatic Brain Injury (TBI) in the Military



Acknowledgements

This talk is based on the collaborative efforts of TBICoE and CDP

Learning Objectives

1. Differentiate between the types of brain injury that are most common in military populations.
2. Integrate methods of concussion assessment into clinical practice.
3. Choose appropriate interventions when working with individuals with traumatic brain injury.

What is Traumatic Brain Injury (TBI)?



Definition of TBI

A structural injury or physiological disruption of the brain due to an external force that results in *one or more* of the following symptoms:

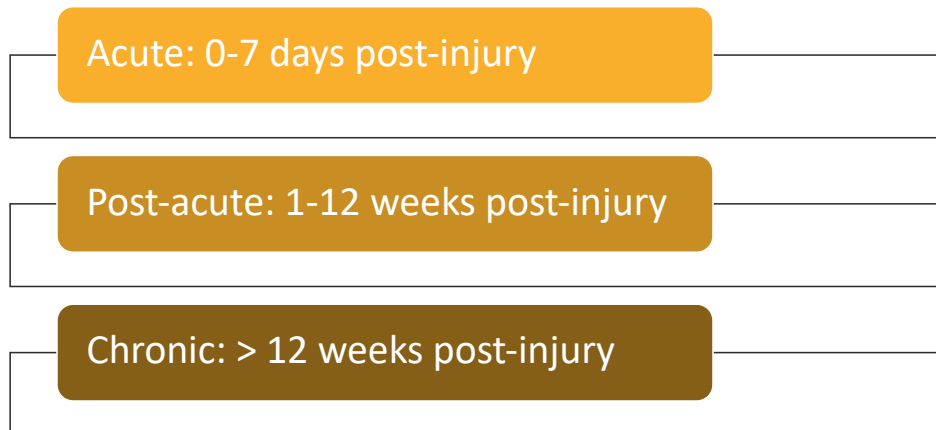
- Loss of or decreased consciousness for any period of time
- Loss of memory immediately before or after injury
- Alteration of mental state at time of injury
- Neurological deficits
- Intracranial lesion

The Management and Rehabilitation of Post-Acute Mild Traumatic Brain Injury Work Group (2021)



5

Definition of TBI

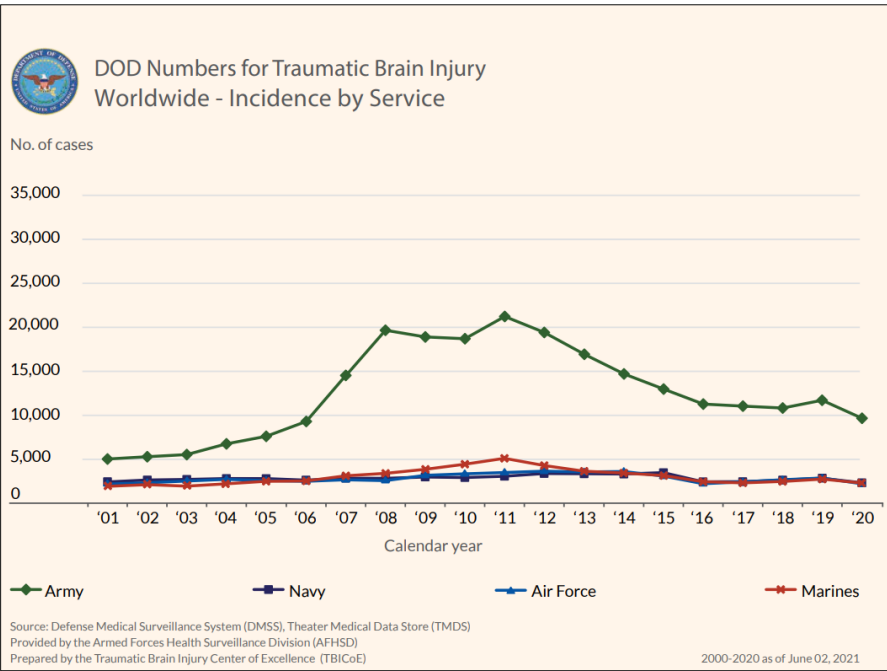


The Management and Rehabilitation of Post-Acute Mild Traumatic Brain Injury Work Group (2021)

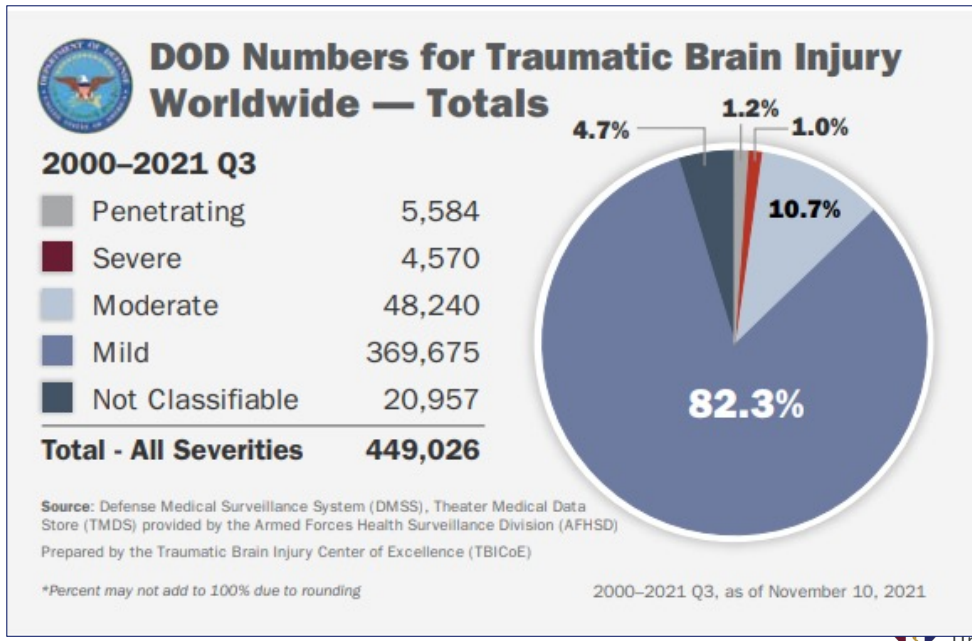


6

TBI Incidents by Branch of Service 2000 – 2020



All Armed Forces – TBI 2000 – 2021



Barriers to Identification and Intervention

“Participants ... perceived a lack of adequate expertise and training in the early identification and diagnosis of mTBI. As a result, participants reported their mTBIs were diagnosed and treated long after the point of injury, often years later.”

“Participants noted that the fast paced and demanding military environment, stigma associated with a history of mTBI, and the prioritization of returning to duty can be barriers to recognizing TBI.”

The Management and Rehabilitation of Post-Acute Mild Traumatic Brain Injury Work Group (2021)



9

TBIs and Deployment

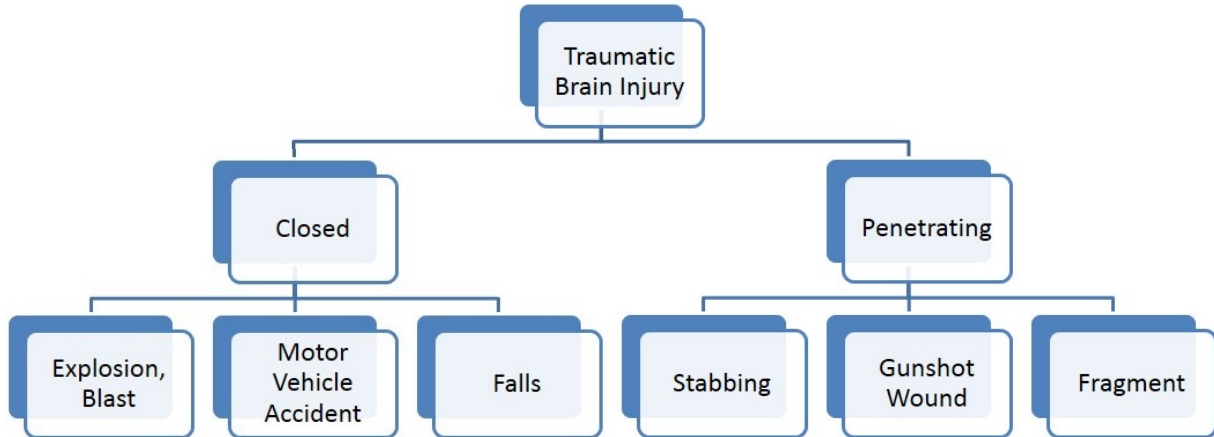
- Among SMs who sustained a TBI during deployment between 2001 and 2018:
 - TBI resulted in 123,677 lost duty days
 - 54% of SMs who sustained a concussion returned to duty
 - Blasts were the most common cause of TBI sustained in combat
 - SMs are also susceptible to non-combat TBIs

Dengler et al. (2021)

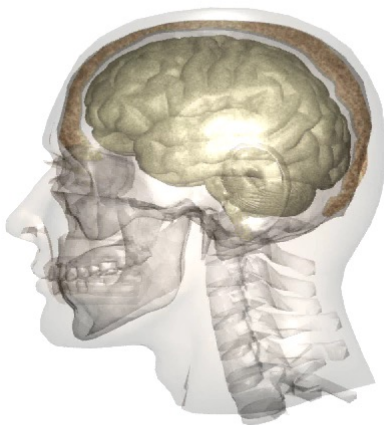


10

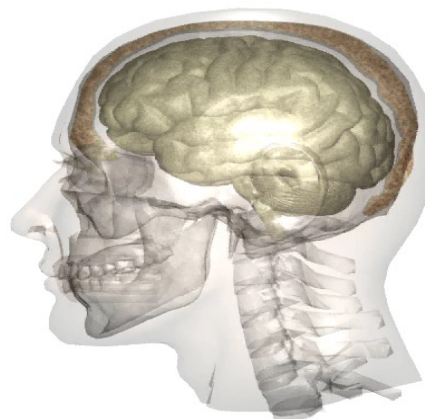
Mechanisms of Injury



Closed Brain Injury

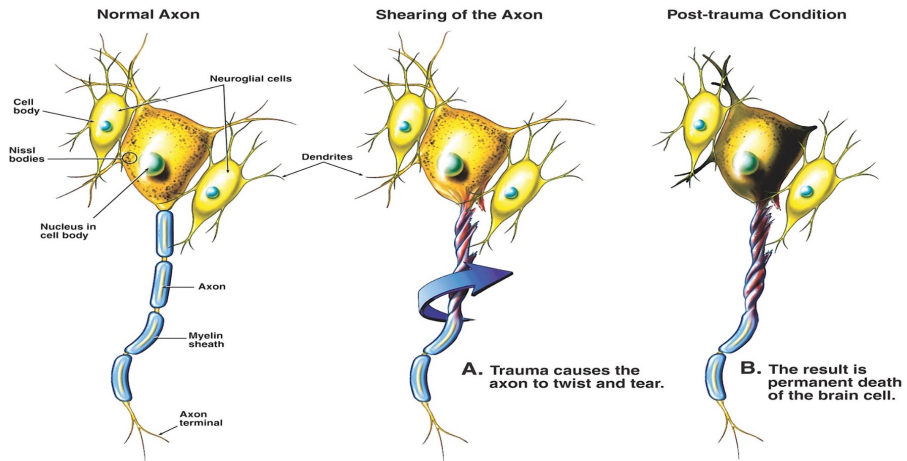


Contra Coup



Diffuse Axonal Injury

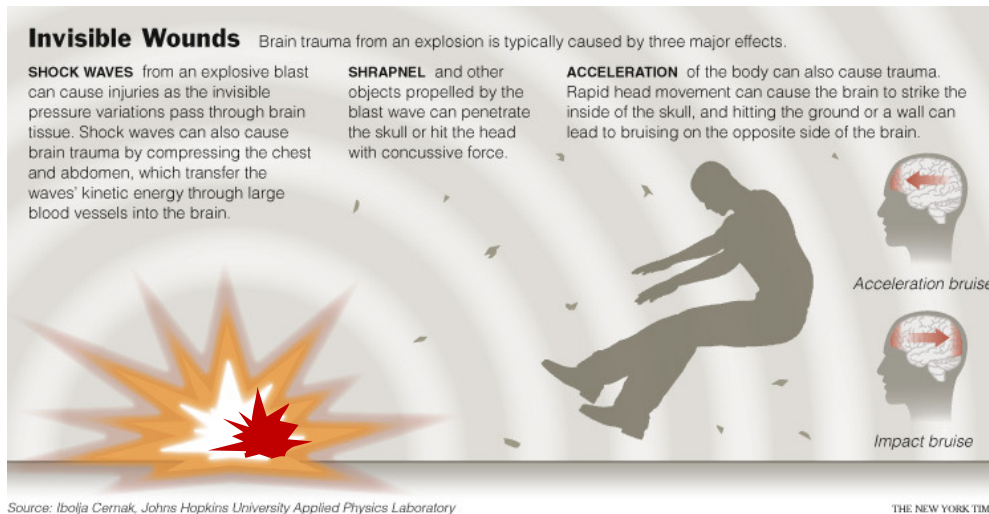
Diffuse Axonal Injury (DAI)



Blast Wave



Blast Injury Overview



Primary Blast Injury

- Enormous Over-Pressurization Wave:
 - Axonal damage
 - Changes in cell metabolism
- Primary Blast Injuries Examples:
 - Ear/Auditory/Vestibular
 - Lung
 - Abdomen

Other Blast-Related Injuries



Secondary Injuries

- Injuries caused by flying debris
- Lacerations and penetrating wounds



Tertiary Injuries

- Body displacement
- Bone fractures
- Amputations



Quaternary/Miscellaneous Injuries

- Complications from environmental conditions
- Smoke inhalation, burn injuries, displaced heavy objects

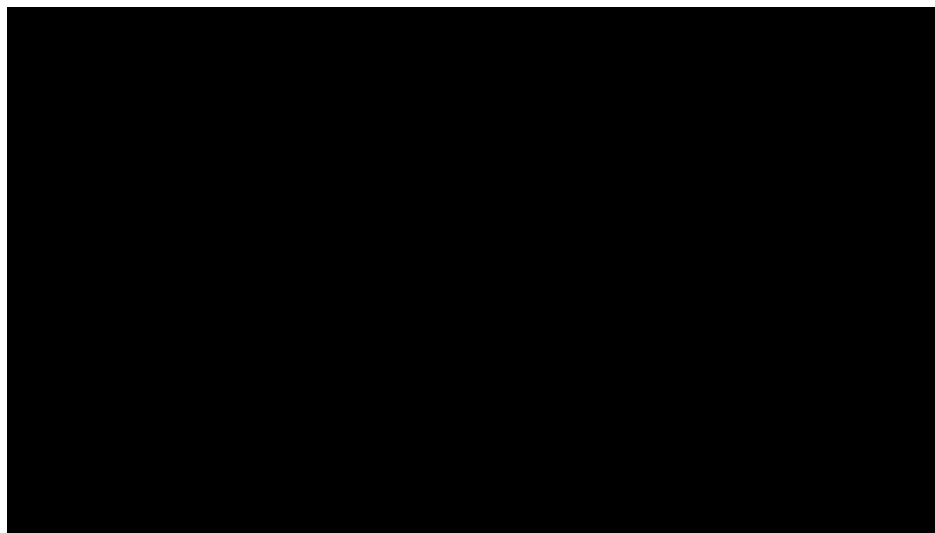
CDP



Uniformed
Services
University

17

Case Study: SFC Bradley Lee



<https://www.youtube.com/watch?v=soQMZyqWwQU>

CDP



Uniformed
Services
University

18



Neurocognitive Disorder due to TBI



Neurocognitive Disorder: DSM-5

A: Decline in one or more cognitive domains:

- Complex attention
- Executive functioning
- Learning and memory
- Language
- Perceptual-motor
- Social cognition
- The severity of cognitive deficits helps differentiate between *Major* and *Mild* Neurocognitive Disorder

Neurocognitive Disorder: DSM-5

- B: Capacity for independence in everyday activities
- The degree to which the neurocognitive deficits affect the individual's capacity for independent activities differentiates between *Major* and *Mild* Neurocognitive Disorder
- C: Deficits do not occur exclusively in the context of delirium
- D: Not better explained by another mental disorder

APA (2013)

Neurocognitive Disorder: DSM-5

Symptom Domain	Mild NCD	Major NCD
Cognitive Domain (Criteria A)	<i>Mild</i> decline in cognitive function, <i>moderate</i> impairment in cognitive performance	<i>Significant</i> decline in cognitive function, <i>substantial</i> impairment in cognitive performance
Capacity for Independence (Criteria B)	Cognitive decline <i>does not interfere</i> with independence though <i>patient may need to exert greater effort or receive accommodation</i> to manage complex tasks	Cognitive decline <i>interferes</i> with independence and patient <i>requires assistance</i> with complex tasks

APA (2013)

Neurocognitive Disorder due to TBI

A: Criteria met for Neurocognitive Disorder

B: Evidence of a TBI

C: The neurocognitive disorder presents immediately after the occurrence of the TBI or immediately after recovery of consciousness, and persists past the acute post-injury period

APA (2013)

Predisposing NCD Risk Factors

- Psychiatric conditions
- Personality traits
- Medical conditions
- Intelligence level
- Demographic characteristics
- Coping abilities



Assessing for TBI

TBI Assessment Domains

Severity	Glasgow Coma Score (GCS)	Alteration in consciousness (AOC)	Loss of consciousness (LOC)	Post traumatic amnesia (PTA)
Mild	13 – 15	≤ 24 hrs	0 – 30 min	≤ 24 hrs
Moderate	9 – 12	> 24 hrs	> 30 min < 24 hrs	> 24 hrs < 7 days
Severe	3 – 8	> 24 hrs	≥ 24 hrs	≥ 7 days

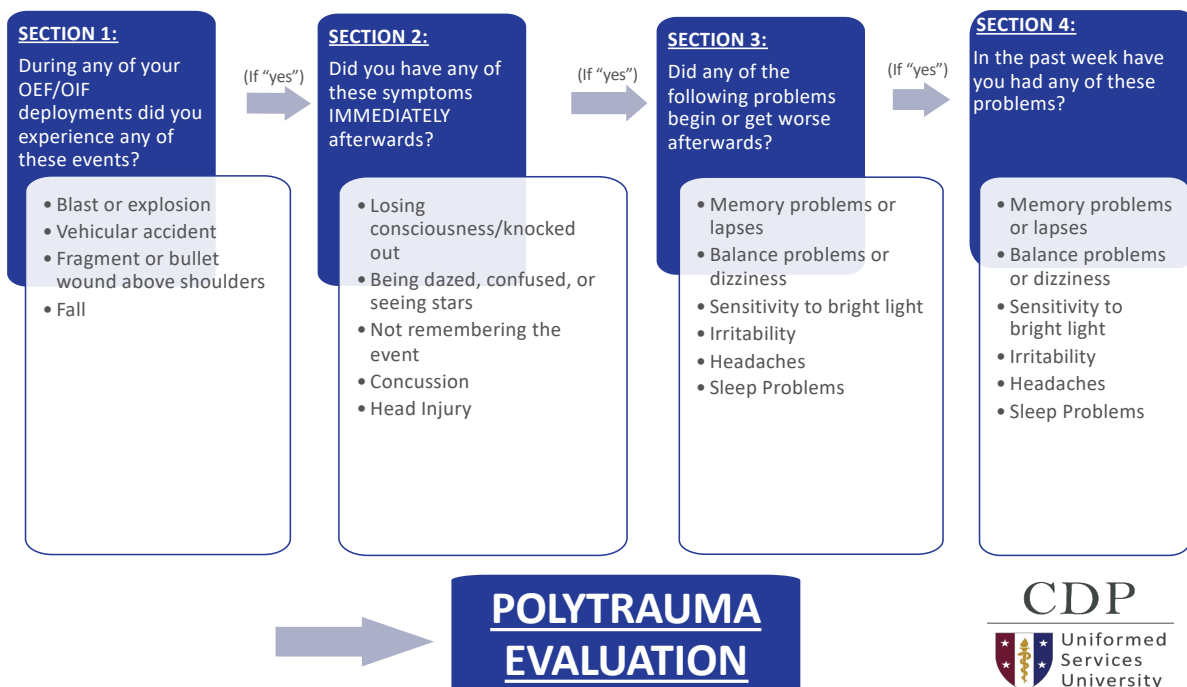
- Consider imaging results when determining level of severity
- Positive imaging = at least a moderate TBI rating
- GCS not as useful given complications of theater setting

Concussion Screening

- Military Acute Concussion Evaluation (MACE)
- Screening Protocols in Theater, Landstuhl, MTFs
- PDHA, PDHRA
- VA 4 Questions



VA “4 Questions”



Pre-Deployment Testing: ANAM



- Automated Neuropsychological Assessment Metrics (ANAM)
- Establishes baseline cognitive performance
- Controversial

Betthausen et al (2018); Roebuck-Spencer et al (2012)

Accurate Diagnostic Factors

- Screening checklists
- Records review
- COC input
- Family/patient interview
- Concussion history
- Potential missed & misdiagnoses issues



What are common changes following a concussion?

Executive Functioning



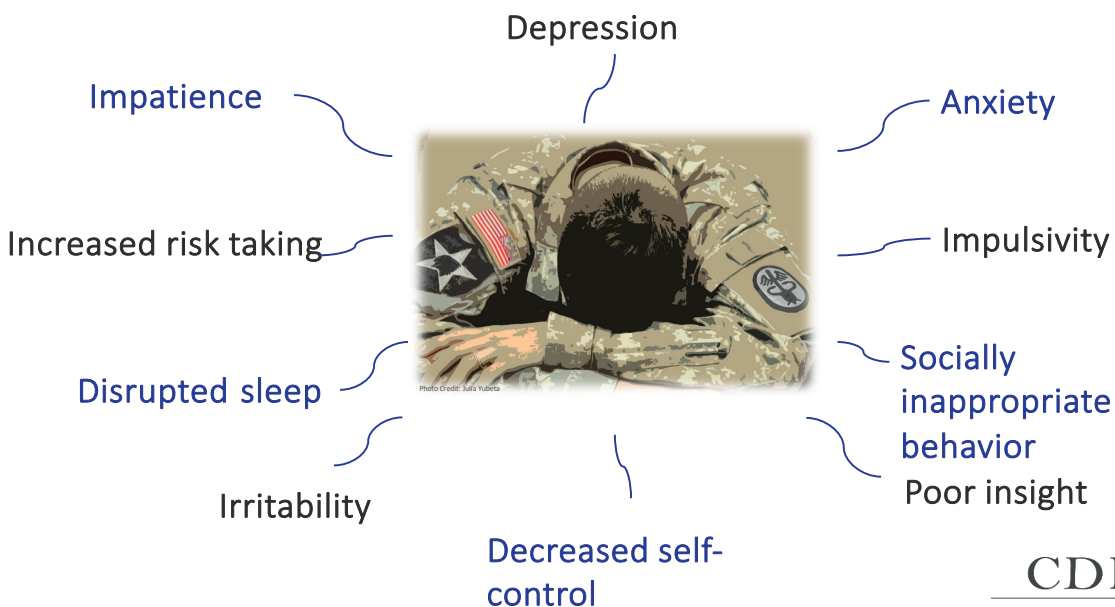
Decreased awareness of thinking changes in self

Other Cognitive Challenges

- Learning & memory
- Attention
- Processing speed
- Communication



Emotional, Behavioral, and Social Changes



Impact of Changes

- Vocational and/or school failure
- Disrupted family and social relationships
- Increased financial burden on families and social service systems
- Chronic depression and/or anxiety



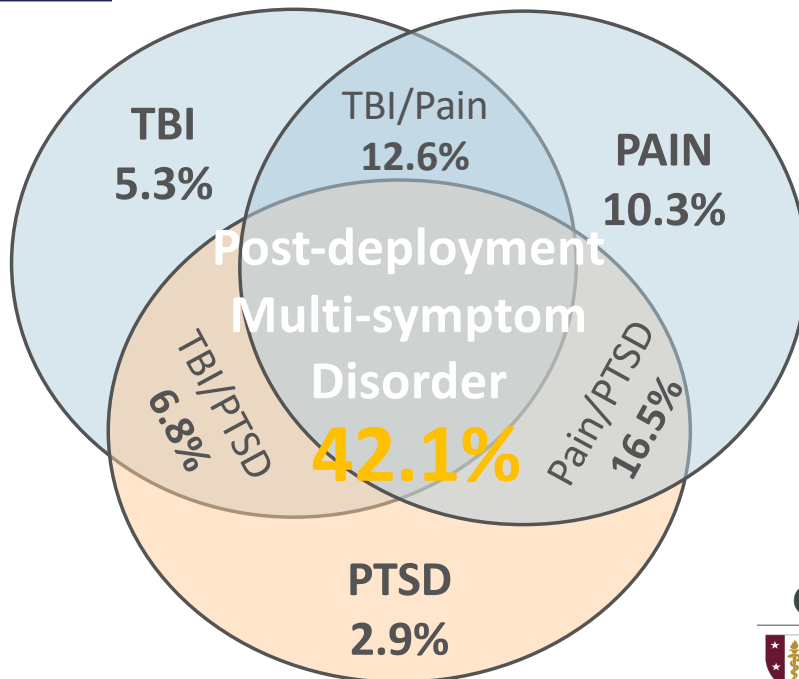
Common Comorbid Conditions

Comorbid Conditions & TBI Overview

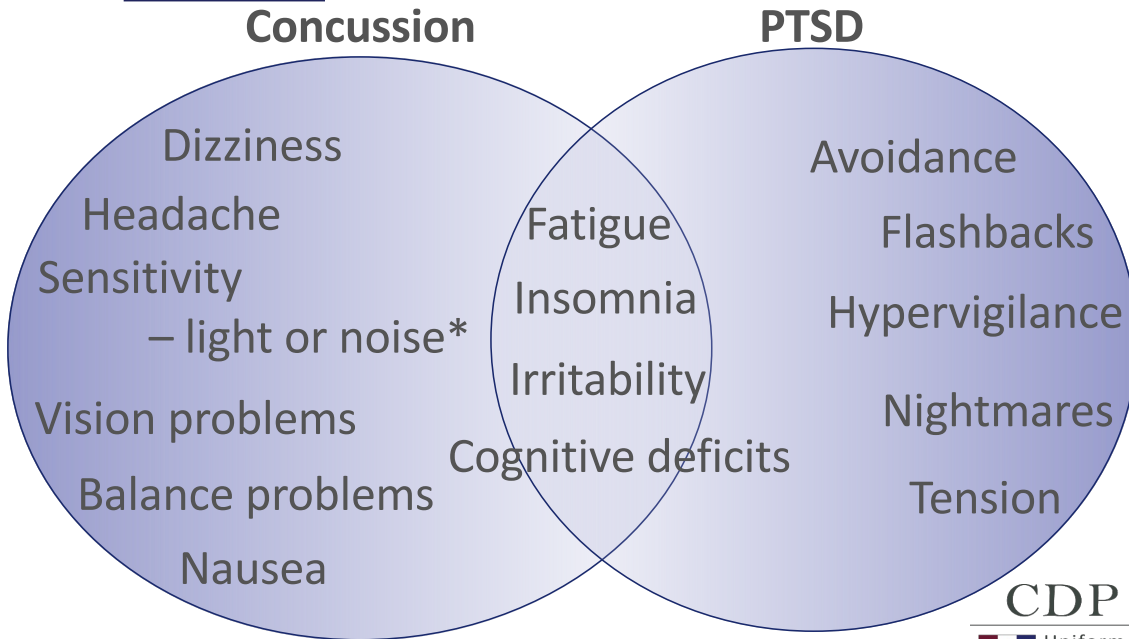
- Risk of psychiatric conditions increase with TBI
- Assessment difficulties due to similar symptoms
- Psychiatric conditions and cognitive compromise

Post-Deployment Disorders

Sample =
340 OEF/OIF
veterans at
Boston VA

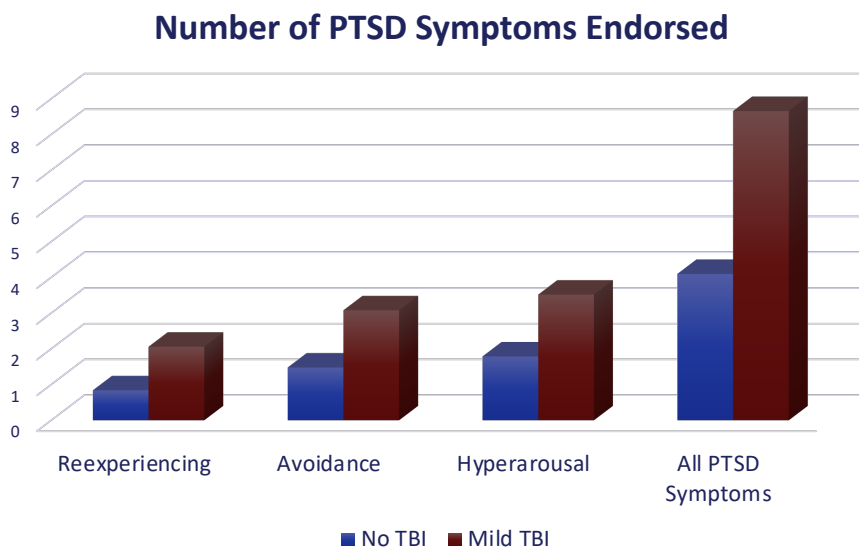


Concussion and PTSD Overlap

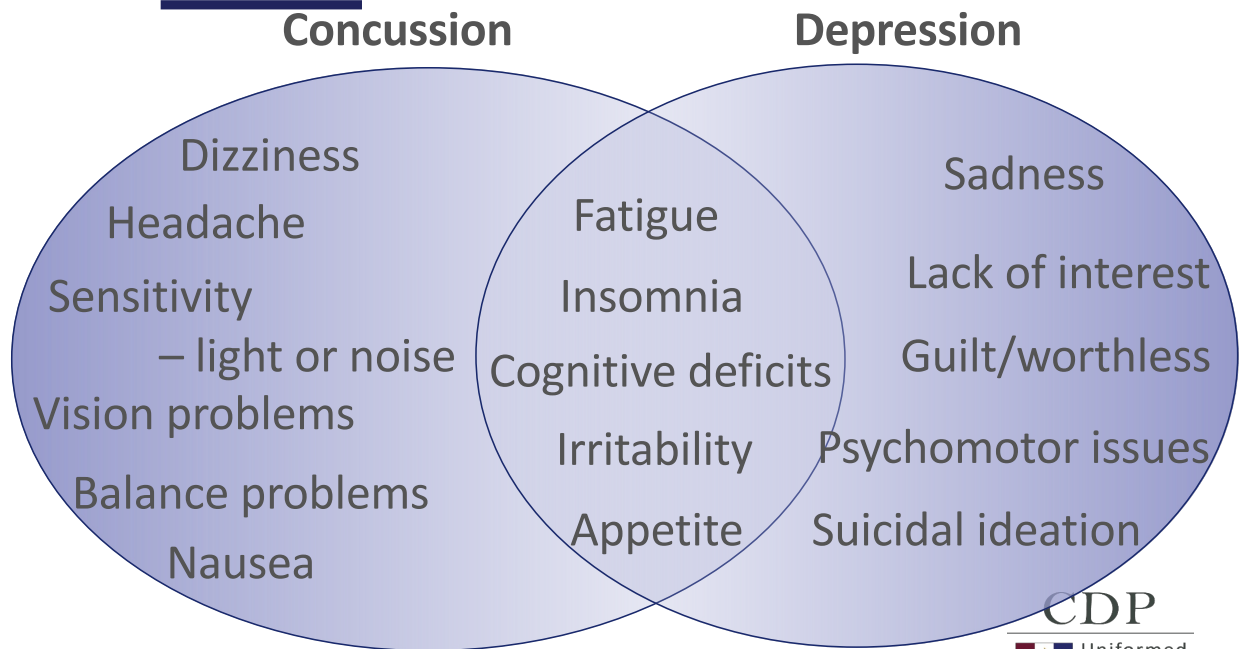


* Some PTSD patients startle to noises so sensitivity to noises could fall under PTSD as well.

Concussion and Comorbid PTSD in OEF/OIF Veterans



Concussion and Depression Overlap



Concussion and Comorbid AUD in OEF/OIF Veterans

- Veterans with concussion are more likely to misuse alcohol than those without
- Younger patients are at the highest risk
- Comorbid PTSD is likely a mediating factor
- Statistics related to women should be interpreted cautiously

TBI and Sleep

- In a study of soldiers with combat-related TBI:
 - 97.4% had a sleep complaint (e.g., poor sleep quality, sleep fragmentation)
 - 55.2% met DSM-IV criteria for insomnia
- There is **not** a direct correlation between severity of TBI and severity of insomnia
- Sleep disruption may persist for months or years post-injury
- In TBI, sleep disturbances may cause harmful consequences on attention/memory function and/or exacerbate comorbid symptoms
 - May prolong concussion recovery
 - May lead to longer hospital stays

Collen et al (2012), Grima et al (2017), Mahmood et al (2004), Montgomery et al (20222), Mosti et al (2019), Mathias & Alvar (2012)

Concussion and Suicide Risk in OEF/OIF/OND Veterans

- Veterans with history of concussion are almost **4x** more likely to attempt suicide
- History of multiple TBIs increases the likelihood of suicidal ideation
- Elevated suicide risk may be mediated by comorbid conditions/symptoms:
 - PTSD
 - Anger
 - Depression
 - Substance abuse
 - Poor sleep



DeBeer et al (2017), Fonda et al (2017), Shura et al (2019), Stanley et al (2017)



Patient Preferences for Intervention

“Participants described including family members in treatment/therapy as important and beneficial.”

“Participants expressed frustration with prescription medications and perceived them as an overused quick fix.”

“Participants want providers to use individualized treatment approaches, maintain an open dialogue, and participate in shared decision making.”

Best Practices for Providers

1. Recruit resilience
2. Cultivate therapeutic alliance
3. Acknowledge complexities
4. Build a team
5. Focus on function
6. Promote realistic expectations for recovery

Case Example: SFC Lee



How can we deliver best practices to SFC Lee?

1. Recruit resilience
2. Cultivate therapeutic alliance
3. Acknowledge complexities
4. Build a team
5. Focus on function
6. Promote realistic expectations for recovery

Concussion Brain Injury Clinical Course

- Full recovery (vast majority)
 - Rapid recovery (days to weeks) with minimal intervention
 - Longer recovery (3 months – 12+ months)
- Persisting symptoms (“miserable minority”)
 - Recovery takes years
 - Sometimes referred to as post-concussive syndrome (PCS) but controversial and not in DSM-5

Lange et al (2013); Dell'Acqua et al (2017); Barker-Collo et al (2016); Staab & Powell (2019)

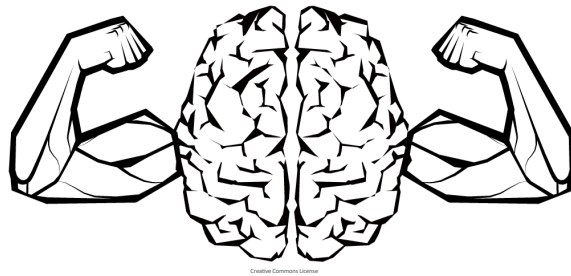
Complications with Clinical Course

- Second impact syndrome (repeated concussion before full recovery)
- Multiple concussions (>2) over time → more morbidity and slower recovery
- “Invisible Injury”
 - Can adversely impact interpersonal relationships
 - Symptoms can be missed due to more apparent physical injuries
 - Comorbid emotional distress

Factors Affecting Clinical Course

There are many factors that impact the clinical course of concussion, but.....

We **CAN** promote recovery



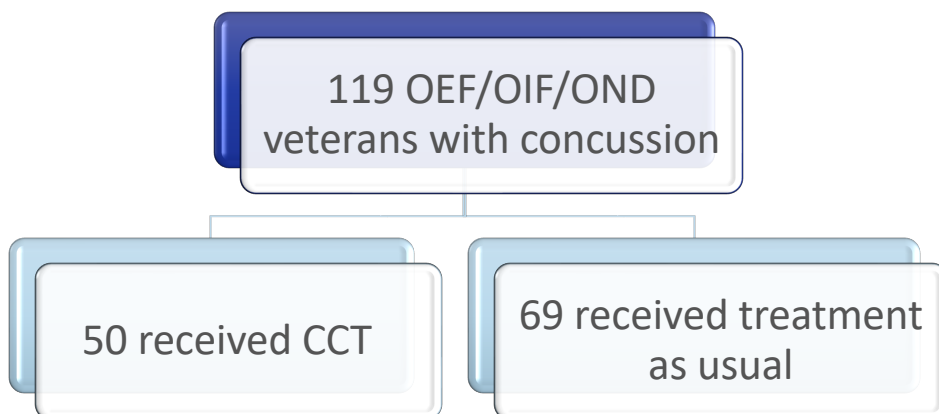
Concussion Education

- Early intervention with TBI education and positive expectations have a direct effect on recovery
 - Patients, families, providers, military command, employers
 - Reduces patient and family anxiety
- Prevent re-injury while recovering
- Address specific symptoms (e.g., headaches, sleep problems, anger) with strategies or referrals

Treat Comorbidities

- Use evidence-based practices to assess and treat comorbidities
- Resolving comorbidities leads to global improvement
- Effective treatment of comorbidities may reduce suicide risk
- Do not delay treatment

Compensatory Cognitive Training (CCT) for Veterans



- 10-week group-based cognitive training
- CCT led to improvements in attention, learning, and executive functioning
- Manual available at www.cogsmart.com

Summary of CCT Curriculum by Session

Session	Major concepts	Examples of strategies taught	Class activities	Home exercise
1	Course intro and TBI psychoeducation	Creating a "home" for important items	Day planner use	Finding a home for the day planner
2	Managing physical symptoms associated with mTBI	Strategies for dealing with sleep problems	Progressive muscle relaxation	Practice progressive muscle relaxation 2 times
3	Organization and prospective memory, part I	Time management	Scheduling	Practice using the calendar
4	Organization and prospective memory, part II	Weekly planning session	Enter it into the calendar	Follow through with planning session
5	Attention and concentration	Paying attention during conversations	Practicing paying attention during conversations	Active listening once a day
6	Learning and memory, part I	Internal memory strategies	Practice chunking	Practice using a strategy everyday
7	Learning and memory, part II	Overlearning	Scheduling strategies in planner	Practice using a strategy everyday
8	Planning and goal setting	Goal setting	Planning out an important goal	Practice planning out a goal
9	Problem-solving and cognitive flexibility	Self-monitoring	6-step problem-solving method	Practice problem-solving with 2 life goals
10	Skill integration and review	Review	How to maintain skills	Provided with additional TBI-related resources

CDP



Uniformed
Services
University

55

Veterans' In-Home Program (VIP)

- Focused on everyday challenges
- Veteran identifies targets for treatment
- Solicits family involvement
- Combination of home visits and telephone counseling



Photo by Rob McKeivine, FMVRC Public Affairs. <https://www.flickr.com/photos/familymen/403025620>

CDP



Uniformed
Services
University

56

VIP Phases of Treatment

- Phase I: Assessment
- Phase II: Develop action plan
- Phase III: Generalization of skills and closure

Up to 8 contacts in total

Examples of Action Plan Items

Examples of problems	Examples of interventions
Losing keys, leading to lateness and family frustration	Create “control center” near front door with keys and other necessities
Irritability while driving	Teach relaxation skills and practice before driving; play soothing music in car
Overstimulation by normal household noise	Family education; establish “quiet zone” in the home; refer for audiology assessment
Limited social engagement/activity	Behavioral activation (ex: increased physical activity); increase social contacts; refer to support group

Intervention for Concussion: Take Home Points

- Assess current symptoms and functioning
- Provide realistic psychoeducation
- Develop patient-driven treatment goals
- Include family and home environment when possible
- Treat comorbid conditions with evidence-based interventions
- Refer for other services as needed



A Head for the Future

A Head for the Future — A TBICoE Initiative

A HEAD FOR THE FUTURE

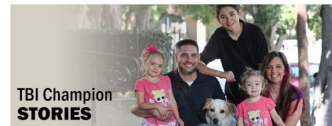
A Head for the Future provides resources to help the military community prevent, recognize and recover from traumatic brain injury. Learn about TBI, download fact sheets, and [read the stories](#) and [watch the videos](#) of service members and veterans who recognized TBI symptoms and got help.

TBI Champion Stories

TBI Champion Videos



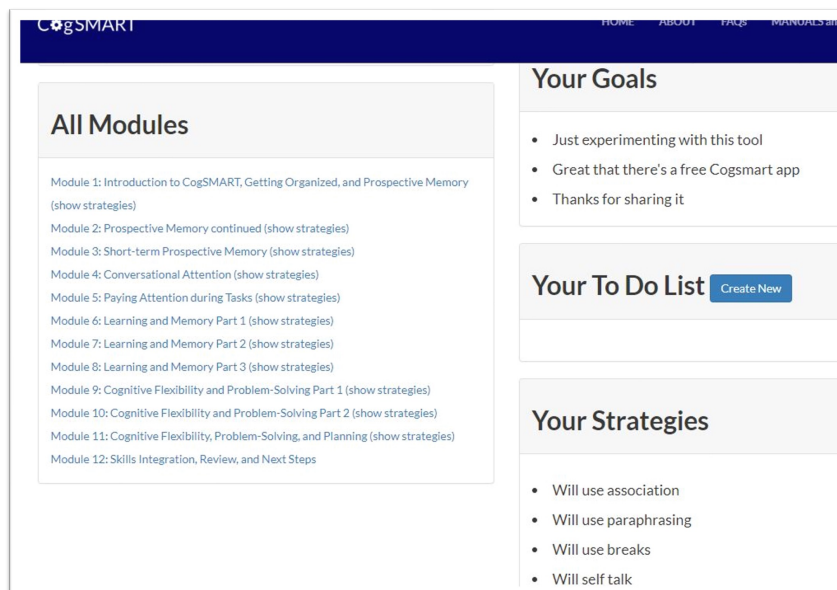
TBI Champion Stories



Check out stories of service members and veterans who experienced traumatic brain injuries and got help. Caregivers also share their stories of support and advocacy, tips and resources. Many of our TBI Champions are highlighted in [video stories](#) that you can check out and subscribe to on our [YouTube channel!](#)



CogSMART Interactive Program

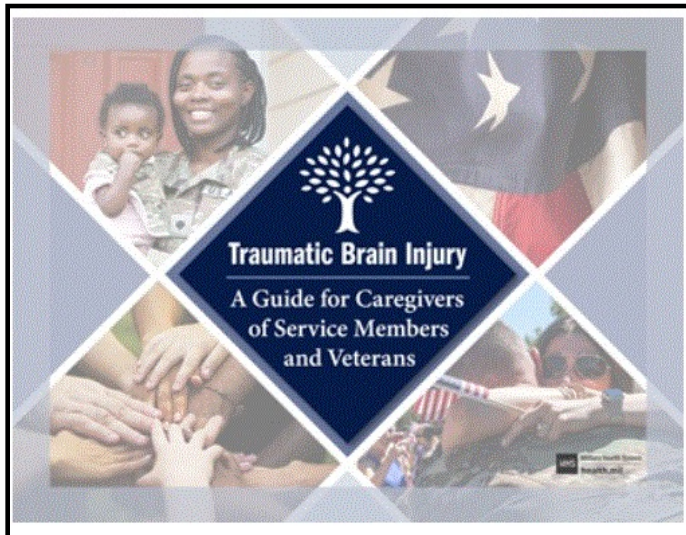


The screenshot shows the CogSMART website interface. At the top, there is a navigation bar with 'HOME', 'ABOUT', 'FAQS', and 'CONTACT US'. The main content area is divided into three sections:

- All Modules:** A list of 12 modules, each with a 'show strategies' link. The modules cover topics from introduction to skills integration.
- Your Goals:** A section with a list of three goals: 'Just experimenting with this tool', 'Great that there's a free Cogsmart app', and 'Thanks for sharing it'.
- Your To Do List:** A section with a 'Create New' button.
- Your Strategies:** A section with a list of four strategies: 'Will use association', 'Will use paraphrasing', 'Will use breaks', and 'Will self talk'.



Patient and Family Resources



<https://health.mil/Military-Health-Topics/Centers-of-Excellence/Traumatic-Brain-Injury-Center-of-Excellence/Patient-and-Family-Resources>



63

Provider Resources

Concussion Symptom Management Provider Resources

- Cognitive Rehabilitation
- Sleep Disturbances
- Neuroimaging
- Headaches
- Head Injury and Dizziness

DOD Clinical Recommendation February 2019	
Cognitive Rehabilitation for Service Members and Veterans Following Mild to Moderate Traumatic Brain Injury	
<p>Introduction</p> <p>More than 330,000 service members sustained a traumatic brain injury (TBI) between 2000 and third quarter 2015. Most recommendations (R) were developed as mild traumatic brain injury (MTBI) also known as concussion. Headaches is the most common symptom reported following a concussion.^{1,2,3,4} In a study of Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans, 78 percent reported and headache headaches (PH) occurring within 30 days of sustaining a concussion.</p> <p>Introduction</p> <p>These recommendations were developed to provide comprehensive guidance for health care providers (HCP) based on current evidence from the "International Classification of Headache Disorders" (ICHD-3) as well as current research and expert testimony. This CR provides updated state-of-the-science information with an emphasis on non-pharmacologic, as well as pharmacologic, treatment of PH. This CR provides best practices and provides clinical guidance for primary care managers (PCM) in military and non-military settings for the assessment, diagnosis and treatment of PH.</p> <p>Background</p> <p>This CR, companion clinical support tool (CST) and patient fact sheet were created following a review of currently published literature and expert testimony from the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCO) in collaboration with clinical subject matter experts representing the academic, research and practice sectors, the DOD Armed Forces and the VA. Recommendations from the DOD and VA are provided in the "Recommendations" section. The DOD and VA are the lead agencies for the DOD and VA. Recommendations from the DOD and VA are provided in the "Recommendations" section. The DOD and VA are the lead agencies for the DOD and VA. Recommendations from the DOD and VA are provided in the "Recommendations" section.</p> <p>Summary</p> <p>This CR is in accordance with DOD policy. However, service-specific requirements regarding concussion or the management of PH may vary, and provider judgment and operational requirements supersede any of these recommendations for an individual patient.</p>	
1	1.1. Return to Productivity: Duty, Employment, Volunteering and School
1.2	1.2. Considerations for Military Service Members
2	2. Interventions and Strategies to Address Cognitive Dysfunction
2.1	2.1. Attentional Difficulties
2.2	2.2. Memory and New Learning Difficulties
2.3	2.3. Executive Dysfunction and Compensation Integrated Treatment
2.4	2.4. Cognitive Compensation (COP)
2.5	2.5. Use of Technology
2.6	2.6. Neuroimaging and Clinical Reality
2.7	2.7. Use of Employment Cognitive Rehabilitation
3	3. Culture of Rehabilitation for Patients with Cognitive Challenges: Taxonomy of Cognitive Rehabilitation
3.1	3.1. Treatment Plans
3.2	3.2. Frequency, Intensity, Length, Duration and Timing of Interventions
3.3	3.3. Modality of Treatment: Computer Mediated and Live Therapy
3.4	3.4. Manualized Treatments
3.5	3.5. Individualized Rehabilitation of Cognitive Dysfunction
3.6	3.6. Addressing Comorbidities
3.7	3.7. Considerations for Patients with Comorbid Reading in Cognitive Rehabilitation
3.8	3.8. Monitoring and Managing Treatment Effects
3.9	3.9. Patient Assessment and Follow-up Options
37	References

DOD Clinical Recommendation February 2016	
Management of Headache Following Concussion/ Mild Traumatic Brain Injury: Guidance for Primary Care Management in Deployed and Non-Deployed Settings	
<p>Introduction</p> <p>More than 330,000 service members sustained a traumatic brain injury (TBI) between 2000 and third quarter 2015. Most recommendations (R) were developed as mild traumatic brain injury (MTBI) also known as concussion. Headaches is the most common symptom reported following a concussion.^{1,2,3,4} In a study of Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans, 78 percent reported and headache headaches (PH) occurring within 30 days of sustaining a concussion.</p> <p>Introduction</p> <p>These recommendations were developed to provide comprehensive guidance for health care providers (HCP) based on current evidence from the "International Classification of Headache Disorders" (ICHD-3) as well as current research and expert testimony. This CR provides updated state-of-the-science information with an emphasis on non-pharmacologic, as well as pharmacologic, treatment of PH. This CR provides best practices and provides clinical guidance for primary care managers (PCM) in military and non-military settings for the assessment, diagnosis and treatment of PH.</p> <p>Background</p> <p>This CR, companion clinical support tool (CST) and patient fact sheet were created following a review of currently published literature and expert testimony from the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCO) in collaboration with clinical subject matter experts representing the academic, research and practice sectors, the DOD Armed Forces and the VA. Recommendations from the DOD and VA are provided in the "Recommendations" section. The DOD and VA are the lead agencies for the DOD and VA. Recommendations from the DOD and VA are provided in the "Recommendations" section.</p> <p>Summary</p> <p>This CR is in accordance with DOD policy. However, service-specific requirements regarding concussion or the management of PH may vary, and provider judgment and operational requirements supersede any of these recommendations for an individual patient.</p>	
1	1.1. Return to Productivity: Duty, Employment, Volunteering and School
1.2	1.2. Considerations for Military Service Members
2	2. Interventions and Strategies to Address Cognitive Dysfunction
2.1	2.1. Attentional Difficulties
2.2	2.2. Memory and New Learning Difficulties
2.3	2.3. Executive Dysfunction and Compensation Integrated Treatment
2.4	2.4. Cognitive Compensation (COP)
2.5	2.5. Use of Technology
2.6	2.6. Neuroimaging and Clinical Reality
2.7	2.7. Use of Employment Cognitive Rehabilitation
3	3. Culture of Rehabilitation for Patients with Cognitive Challenges: Taxonomy of Cognitive Rehabilitation
3.1	3.1. Treatment Plans
3.2	3.2. Frequency, Intensity, Length, Duration and Timing of Interventions
3.3	3.3. Modality of Treatment: Computer Mediated and Live Therapy
3.4	3.4. Manualized Treatments
3.5	3.5. Individualized Rehabilitation of Cognitive Dysfunction
3.6	3.6. Addressing Comorbidities
3.7	3.7. Considerations for Patients with Comorbid Reading in Cognitive Rehabilitation
3.8	3.8. Monitoring and Managing Treatment Effects
3.9	3.9. Patient Assessment and Follow-up Options
37	References

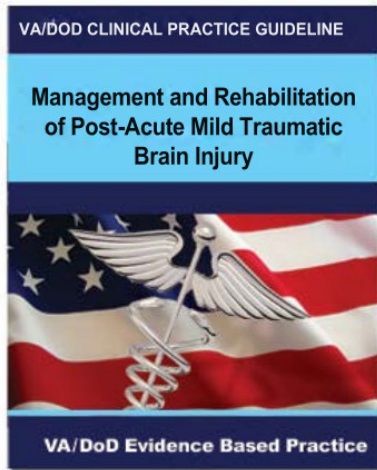
DOD Clinical Recommendation June 2020	
Management of Sleep Disturbances Following Concussion/MTBI: Guidance for Primary Care Management in Deployed and Non-Deployed Settings	
<p>Introduction</p> <p>Headaches and sleep disturbances are commonly associated with concussion or mild traumatic brain injury (MTBI) in the acute, sub-acute, and chronic recovery stages. The prevalence of sleep disorders is higher among individuals with TBI compared to the general population.¹ The most common sleep disorders associated with TBI include insomnia, excessive daytime sleepiness (EDS), circadian rhythm sleep-wake disorder (CRSWD), restless leg syndrome (RLS), and parasomnia.² Disturbances in sleeping regarding the prevalence of shift work disorder (SMD) and shiftwork sleep syndrome (SSS) in TBI have been documented in individuals with neurotrauma.³ These sleep disturbances may also represent the primary complaint and cause of TBI symptoms.</p> <p>Introduction</p> <p>These recommendations were developed to provide comprehensive guidance for health care providers (HCP) based on current evidence from the "International Classification of Sleep Disorders" (ICSD-3) as well as current research and expert testimony. This CR provides updated state-of-the-science information with an emphasis on non-pharmacologic, as well as pharmacologic, treatment of sleep disturbances. This CR provides best practices and provides clinical guidance for primary care managers (PCM) in military and non-military settings for the assessment, diagnosis and treatment of sleep disturbances.</p> <p>Background</p> <p>This CR, companion clinical support tool (CST) and patient fact sheet were created following a review of currently published literature and expert testimony from the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCO) in collaboration with clinical subject matter experts representing the academic, research and practice sectors, the DOD Armed Forces and the VA. Recommendations from the DOD and VA are provided in the "Recommendations" section. The DOD and VA are the lead agencies for the DOD and VA. Recommendations from the DOD and VA are provided in the "Recommendations" section.</p> <p>Summary</p> <p>This CR is in accordance with DOD policy. However, service-specific requirements regarding concussion or the management of sleep disturbances may vary, and provider judgment and operational requirements supersede any of these recommendations for an individual patient.</p>	
1	1.1. Return to Productivity: Duty, Employment, Volunteering and School
1.2	1.2. Considerations for Military Service Members
2	2. Interventions and Strategies to Address Cognitive Dysfunction
2.1	2.1. Attentional Difficulties
2.2	2.2. Memory and New Learning Difficulties
2.3	2.3. Executive Dysfunction and Compensation Integrated Treatment
2.4	2.4. Cognitive Compensation (COP)
2.5	2.5. Use of Technology
2.6	2.6. Neuroimaging and Clinical Reality
2.7	2.7. Use of Employment Cognitive Rehabilitation
3	3. Culture of Rehabilitation for Patients with Cognitive Challenges: Taxonomy of Cognitive Rehabilitation
3.1	3.1. Treatment Plans
3.2	3.2. Frequency, Intensity, Length, Duration and Timing of Interventions
3.3	3.3. Modality of Treatment: Computer Mediated and Live Therapy
3.4	3.4. Manualized Treatments
3.5	3.5. Individualized Rehabilitation of Cognitive Dysfunction
3.6	3.6. Addressing Comorbidities
3.7	3.7. Considerations for Patients with Comorbid Reading in Cognitive Rehabilitation
3.8	3.8. Monitoring and Managing Treatment Effects
3.9	3.9. Patient Assessment and Follow-up Options
37	References

<https://health.mil/Military-Health-Topics/Centers-of-Excellence/Traumatic-Brain-Injury-Center-of-Excellence/Provider-Resources>



64

mTBI Clinical Practice Guidelines



VA/DoD Clinical Practice Guideline for Management and Rehabilitation of Post-Acute Mild Traumatic Brain Injury

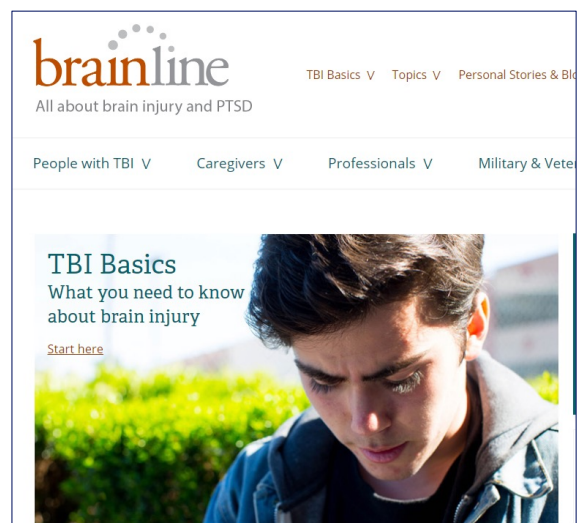
www.healthquality.va.gov



65

BrainLine.org

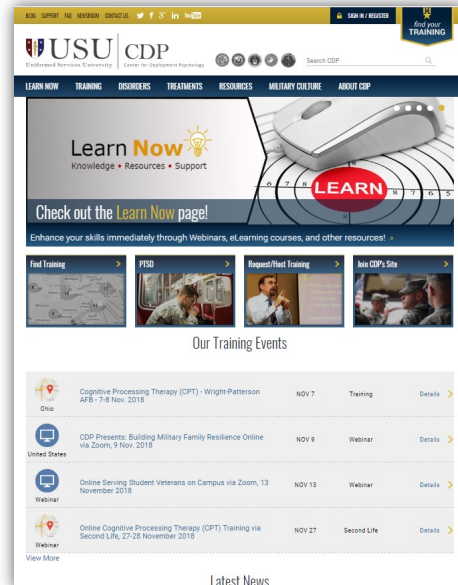
“BrainLine is a national multimedia project offering authoritative information and support to anyone whose life has been affected by brain injury or PTSD: people with brain injuries, their family and friends, and the professionals who work with them.”



66

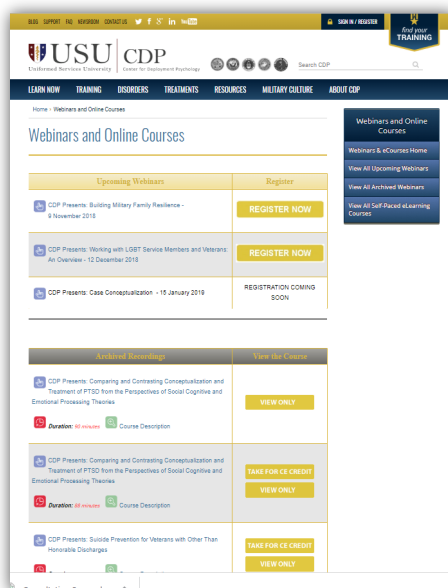
deploymentpsych.org

- Descriptions and schedules of upcoming training events
- Blog updated daily with a range of relevant content
- Articles by subject matter experts related to deployment psychology, including PTSD, suicide prevention, depression, and insomnia
- Other resources and information for behavioral health providers
- Links to CDP's Facebook page and Twitter feed



67

Other Learning Opportunities



- CDP Presents - Monthly Webinar Series
 - Live and archived
 - CEs free for live, small fee for on-demand CEs
 - View archived webinars free for no CEs
- On-demand Courses
 - Military Culture
 - Deployment Cycle
 - Intro to PE and CPT
 - ...and more!



68

Provider Support

CDP's "Provider Portal" is exclusively for individuals trained by CDP in evidence-based psychotherapies (e.g., CPT, PE, and CBT-I)

- Consultation resources
- Printable fact sheets, manuals, handouts, and other materials
- FAQs and 1:1 interaction with answers from SMEs
- Videos, webinars, and other multimedia training aids



Participants in CDP's evidence-based training will automatically receive an email instructing them how to activate their username and access the "Provider Portal" section at Deploymentpsych.org.



69

Center for Deployment Psychology

Uniformed Services University of the Health Sciences
4301 Jones Bridge Road, Bethesda, MD 20814-4799

Contact Us

Email: cdp-ggg@usuhs.edu

Website: deploymentpsych.org

Facebook:

<http://www.facebook.com/DeploymentPsych>

Twitter: @DeploymentPsych



70