

Cross-System VA and Civilian Lessons and Opportunities

Session 6 – May 12, 2026

Amanda Rabinowitz, Ph.D

Daniel Klyce, Ph.D, ABPP

Disclosures

Amanda Rabinowitz, Ph.D.

- *Employed by:*
 - Sidney Kimmel Medical College of Thomas Jefferson University
 - Jefferson Moss Rehabilitation Research Institute, Jefferson Moss Magee Rehabilitation Hospital
- *Funding from:*
 - HHS/National Institute of Health (NIH) [Grant #s:1R43MH142076-01, 1UG3NS117844-01A1]
 - HHS/National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILRR) [Grant #s: 90DPTB0035, 90DPTB0019]
 - Department of Defense (DoD) [Grant #: W81XWH2210999]

Daniel Klyce, Ph.D., ABPP

- *Employed by:*
 - Central Virginia VA Health Care System
 - Virginia Commonwealth University – School of Medicine & Health System
 - Sheltering Arms Institute
- *Funding from:*
 - HHS / National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILRR) [Grant # 90DPTB0005]
 - DoD / TBI and Psychological Health Research Program (TBIPHRP) [Grant # W81XWH-22-S-TBIPH1]
 - VA Office of Research and Development (ORD) – Brain Health Coordinating Center (salary support)
- *Renumeration from:*
 - American Psychological Association Publishing
- *Disclaimer:*
 - The views expressed in this presentation are my own and do not necessarily reflect the position or policy of the VA or US government.

Session 6

Overview

Mental health care after TBI unfolds within **complex, highly variable civilian and VA systems.**

- Individuals' experiences differ markedly depending on:
 - Point of system entry
 - Identification of mental health needs
 - Availability and coordination of services over time
- This variability creates **multiple care pathways**, along with numerous opportunities for unmet need.

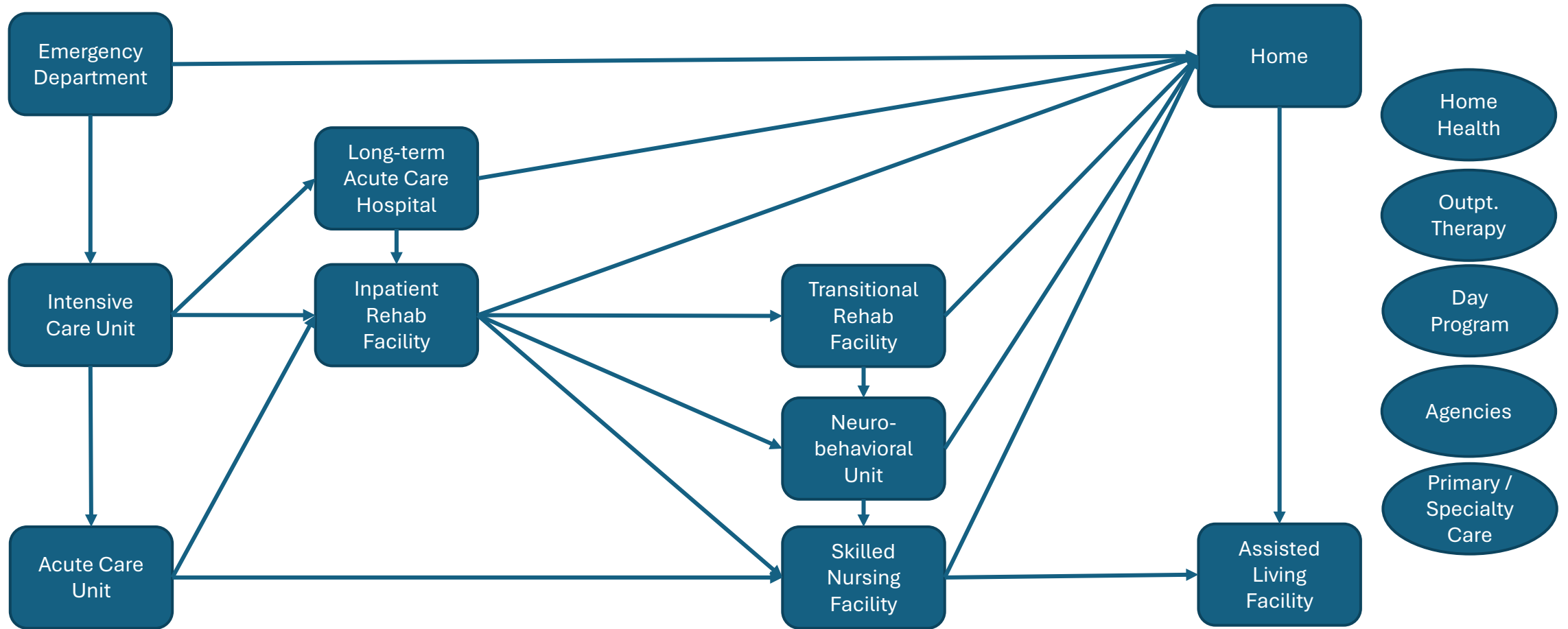
Session 6

Overview

To structure today's discussion:

- We use **four example pathways** reflecting common and divergent trajectories for individuals with post-TBI mental health needs.
- These pathways allow us to systematically examine:
 - System strengths
 - Gaps and challenges
 - Practical opportunities for improving implementation and outcomes across systems

Clinical Pathways



STAGES OF A CARE JOURNEY AFTER TBI

FOR MANY, THE JOURNEY IS NOT CONTINUOUS OR SMOOTH.

There can be bio-psycho-socio-ecological factors leading to:

- A missed or delayed diagnosis
- Difficulty accessing specialized care
- Loss of access to care over time

Some people who experience chronic symptoms will need long-term services and supports.

CLASSIFICATION

Assessment of the nature and severity of a TBI to inform diagnosis, prognosis, and treatment. Includes reassessment as a person's condition evolves.



RECOGNITION

Awareness of the signs and symptoms of TBI, and the identification of an individual who needs care following a brain injury.



ACUTE CARE

Medical interventions to stabilize a person's health condition after a TBI, and to mitigate ongoing damage resulting from a TBI.

FOLLOW-UP

Continued engagement with the care system to identify and address ongoing and emerging needs, including provision of community-based support services.



REHABILITATION

Interventions aimed at improving a person's physical, cognitive, and psychosocial functions and quality of life after a TBI.



RECOVERY AND REINTEGRATION

Recovery of function to the greatest extent possible, including return to family, community, work, or school.



CHRONIC CONDITIONS

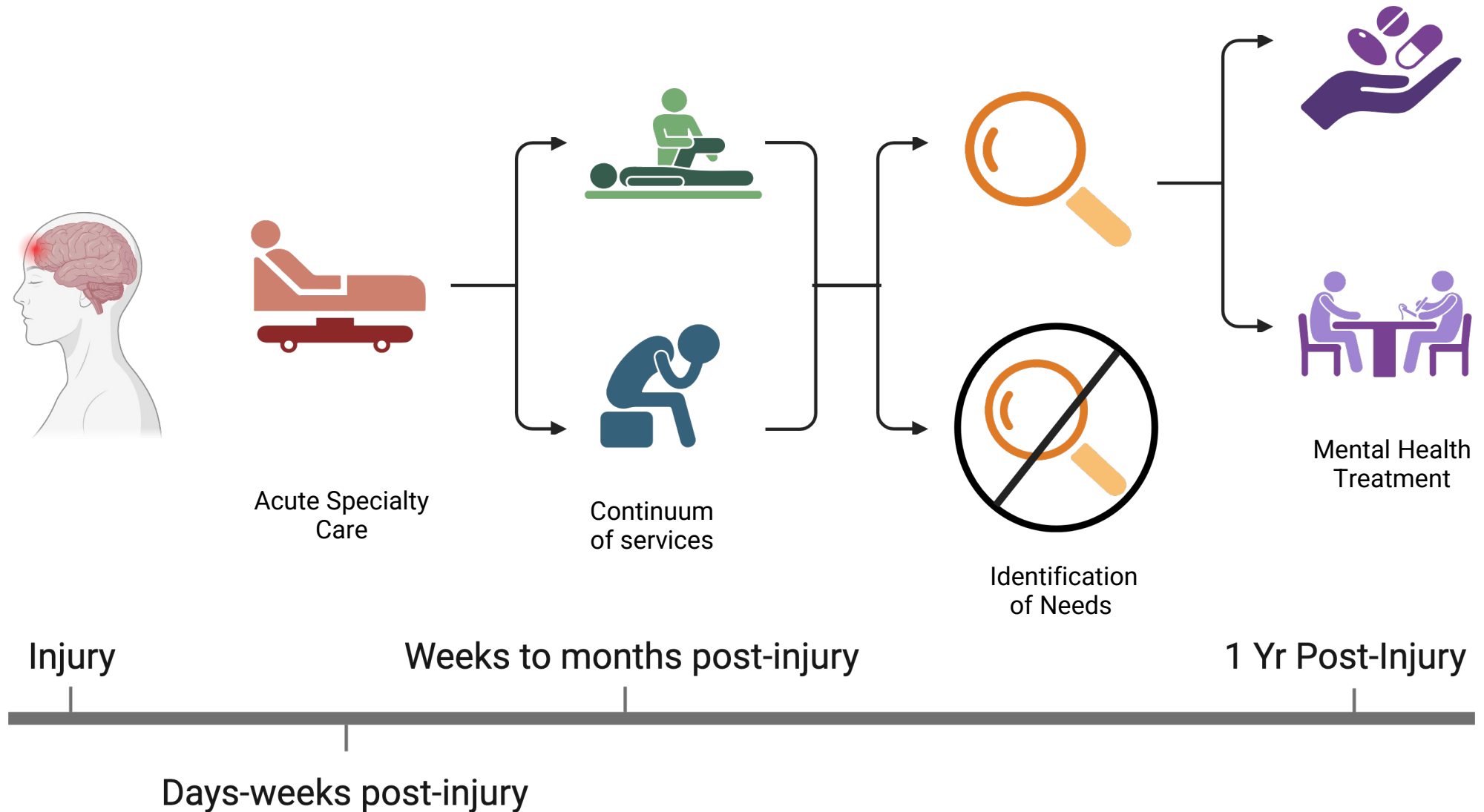
IF RE-INJURED...



Four Representative Pathways

	High-level Specialty Care	Low/no Specialty Care
Early Mental Health Needs	<i>Pathway 1</i>	<i>Pathway 3</i>
Later/enduring Mental Health Needs	<i>Pathway 2</i>	<i>Pathway 4</i>

Pathway 1: Specialty Care + Early Mental Health Needs



Pathway 1

VA Example

- Moderate TBI with polytrauma; inpatient polytrauma rehab → outpatient care
- Early anxiety/sleep problems; mental health embedded in rehab
- Caregiver involved from inpatient phase

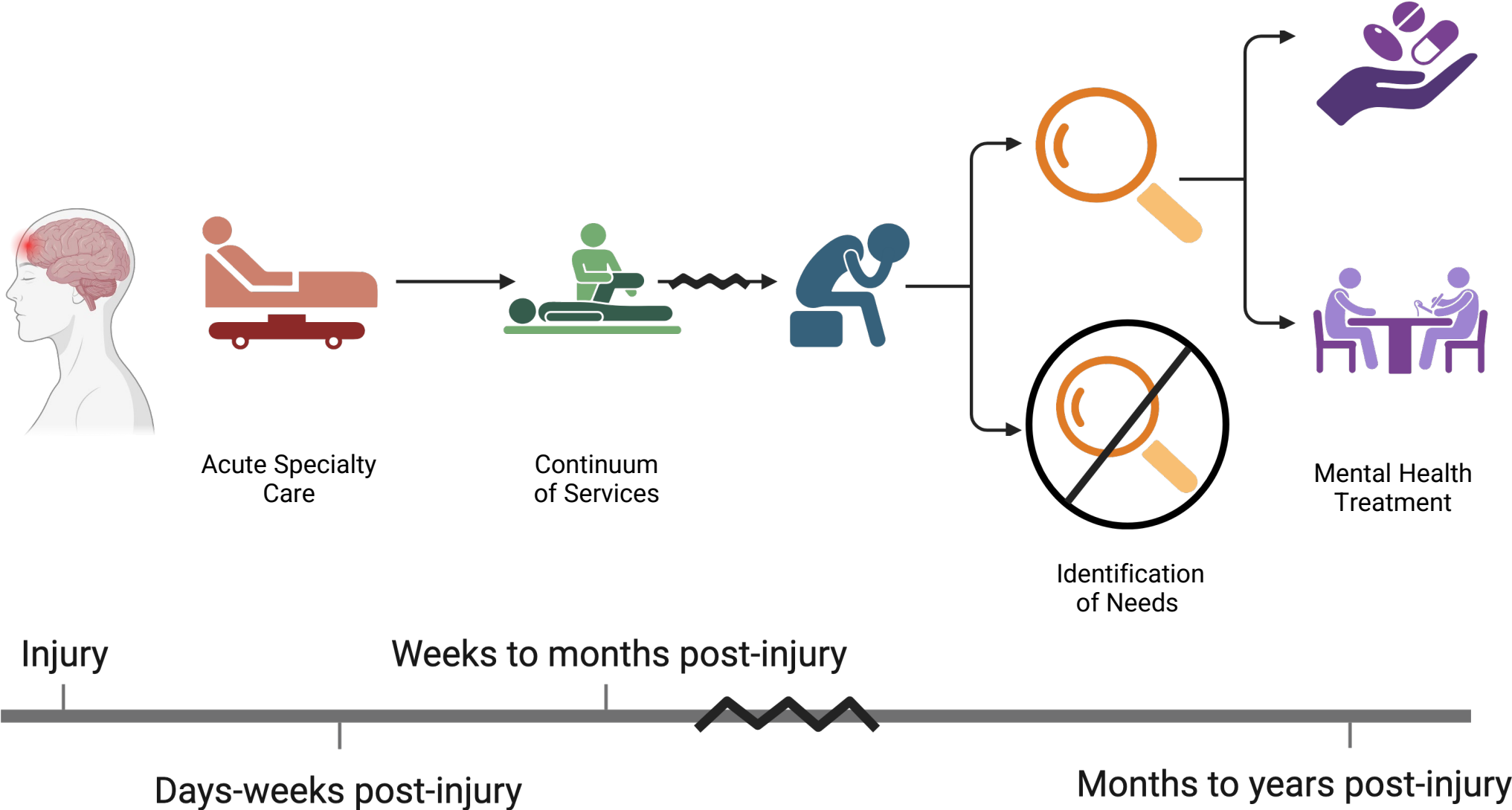
Civilian Example

- Moderate–severe TBI from MVC; inpatient rehab hospital
- No prior MH history; early mood and adjustment symptoms
- Integrated neuropsychology/psychiatry in rehab setting

“I just asked for help and then they assigned [Therapist Name] to me. I was discharged from [Rehab Hospital]. So when I left [Rehab Hospital] I had resources there.”

“At one point in time, I was up to like 17 different types of prescription pills. And I was telling the different providers I was seeing that this isn't helping. And it felt like I was like yelling at a wall... And I'm being told that the providers will talk to each other about making a plan and they never do.”

Pathway 2: Specialty Care + Late/Enduring Mental Health Needs



Pathway 2

VA Example

- Moderate TBI; completed polytrauma rehab years earlier
- Depression and irritability emerge later amid life stressors
- Re-engages VA MH through prior specialty connections

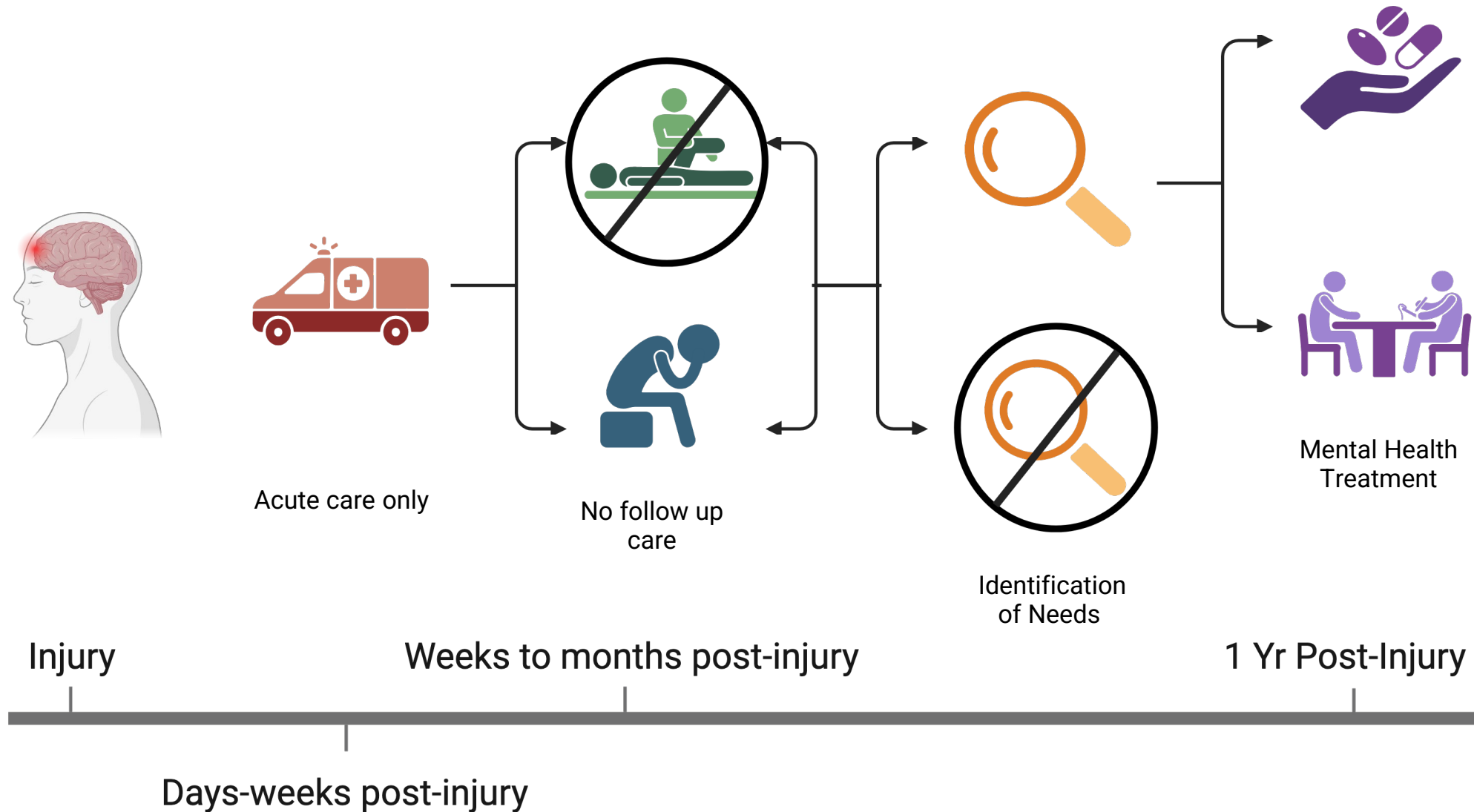
Civilian Example

- Moderate TBI; early inpatient/outpatient rehab
- Anxiety and emotional dysregulation emerge years post-injury
- Difficulty finding brain injury-informed MH providers

“I just heard about the head injury program. I had ended up like messing up in school. And I was like, maybe I need some help with this... But it had just been kind of word of mouth about the program, although I suppose I actually learned about it a long time ago when I first had my injury and then I had kind of forgotten about it.”

“I wouldn’t say [providers] are mean or anything, just, I noticed that people that have been specifically for brain injury are a lot more patient... It feels like they’re trying to think about all the things that I could be confused about and they want to make sure that those things are not confusing for me.”

Pathway 3: No Specialty Care + Early Mental Health Needs



Pathway 3

VA Example

- Mild TBI; ED visit and primary care follow-up
- Prior positive MH treatment experience
- Managed through Primary Care-Mental Health Integration

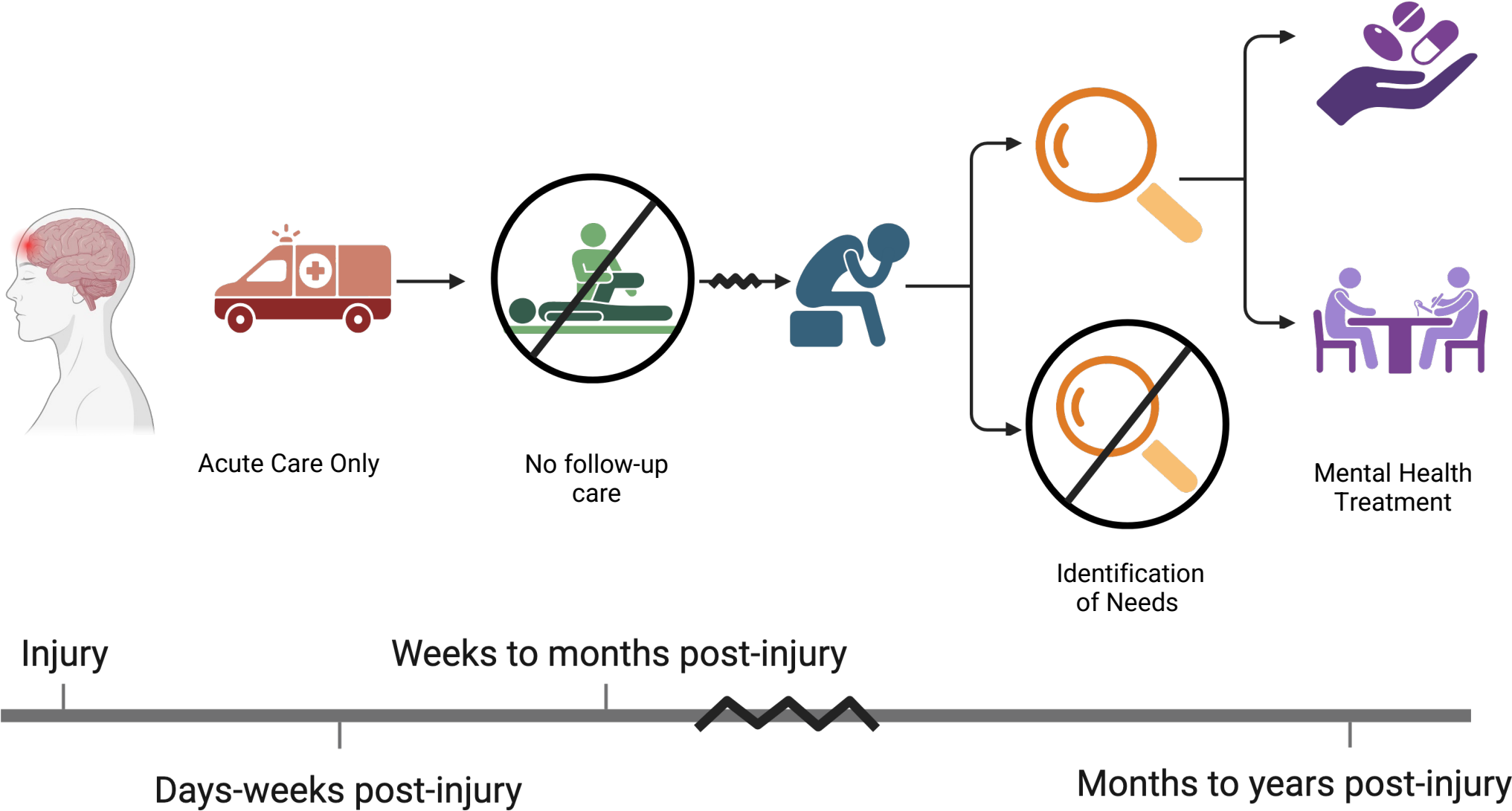
Civilian Example

- Mild sports-related TBI; no specialty follow-up
- History of anxiety; self-refers to community therapist
- Brain injury role may be under-recognized

“I was doing mental health counseling before I had the brain injury, so I knew how to get help. But it does help to know where to go and jump back into it when you need it.”

“I know what it’s like to be wait-listed, and then also depending on how many preferences you have, sort of narrows down the list of therapists you can speak to.”

Pathway 4: No Specialty Care + Late/Enduring Mental Health Needs



Pathway 4

VA Example

- Mild TBI; primary care–based follow-up only
- Later depression and cognitive fatigue
- Standard MH care without TBI framing

Civilian Example

- Mild TBI; fragmented care over time
- Persistent anxiety and sleep problems years later
- General MH treatment with limited brain injury expertise

“I happened to be able to get counseling from a neuropsychologist. That was great. If I knew that someone specialized in head injury and whatever else, I would certainly gravitate towards them.”

“My mom tried calling a couple of people and then there were insurance problems. So she just gave up.”

Key Challenges

Fragmented systems of care

Limited awareness / expertise in civilian settings

Different screening / referral expectations

High comorbidity burden without unified practices

Insurance and access barriers (civilian sector)

Data silos and outcome monitoring gaps

Cultural and stigma-related barriers

Key Opportunities

Expand interoperability and shared care pathways

Develop unified TBI+MH screening protocols

Broad access to integrated/collaborative care models

Share training and competency development across systems

Improve navigation and care management

Leverage telehealth and virtual MH-TBI integration

Adopt a learning health system model across sectors

Big Picture Takeaways



Balancing the strengths vs. the gaps in Civilian and VA care

VA has structured, integrated, protocol-driven system for MH and TBI

Civilian systems may leverage community service and innovate locally



Mental health needs, social support, self-management strategies

Factors influencing MH may be addressed through a variety of TBI-informed health care services and/or rehabilitation teams

Integrating process for MH screening, referral, and treatment are key



Need for coordinated and proactive care

Minimize “information loss” between systems and levels of care

Support to navigate and engage with care is key