Returning to Work After Traumatic Brain Injury

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“No matter how much detail a person’s medical records indicate about their injury, the record is only a shadow, a small hint, at the human behind the injury.”
Why return to work?

- Personal (identity, social interaction and supports, normalcy)
- Generate income (increased medical costs, quality of life)
- Self-sufficiency (family burdens)
- Decrease in service demand (cost of TBI, amount utilizing benefits and welfare)
- Positive health effects both physical and mental
- Returning to work is strongly correlated with better quality of life
Cost of not returning to work

- Significant impact on the individual
- Significant impact on caregivers
- Financial consequences
- Health consequences
- Potential consequences of impeding maximum recovery potential
What does it mean when a RTW is successful?

- Return to work is often one of the main objectives in multi-disciplinary teams
- Employment is often used as an “end point” when measuring recovery and reintegration, and the effectiveness of therapeutic interventions
- Return to work = greatest measure of success of rehabilitation programs (Journal of Head Trauma and Rehabilitation)
- Decreased health related absences
Data is mixed

- An estimated 40% of persons with moderate to severe TBI maintain community-based employment
- 75% of survivors that return to work lose their job within 90 days
- Unsuccessful return in an estimated 35-71%
- Fewer than 5% are able to keep their jobs as long as one year
- So, we know some return to work and some don’t
<table>
<thead>
<tr>
<th>Factors Associated with Lower RTW</th>
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<tbody>
<tr>
<td>Post-traumatic stress</td>
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<tr>
<td>Lower levels of memory functioning</td>
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<td>Lower levels of executive functioning</td>
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<td>Reduced interpersonal/social skills</td>
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<td>Pre-existing mental health issues</td>
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<td>Lower pre-morbid levels of intelligence</td>
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<td>Poor work history prior to injury</td>
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<td>Pre-injury substance misuse</td>
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<td>Male</td>
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Strategies for Returning to Work

- The right time to return to work is difficult to predict
- Accurate prediction of a successful return to work is “not feasible”
- Early intervention: even if there is still rehabilitation to be completed, planning for a return to work is the best option
- Addressing mental health concerns, adjustment, social skills
- Treatment for substance use
- Neuropsychological and neurological evaluation and recommendations
- Securing transportation
Strategies for Returning to School

- Start slow and build
- Utilize disability support office
- Identify learning barriers through neuropsychological evaluation
- Vocational planning
- Assistive devices
- Examine financial and personal impact
Common Barriers

- Balance
- Hemiparesis, especially of the dominant side
- Mobility
- Fine motor function
- Memory impairments
- Fatigue
- Lack of compensatory strategies
- Mood dysregulation
- Attentional deficits
- Attitude/pessimism
- Personality/trait based concerns
Additional Barriers

- Substance use
- Location
- Options
- Lack of network
- Lack of work history/spotty work history
- Legal issues
- Employers
- Secondary gains
- Litigation
- Lack of support
Focus of Healthcare for Return to Work

- Identify outcome criteria for work and training goals
  - Include patient/client, family, specialists
- Identify important work skills the individual can currently:
  - Do independently
  - Do only with assistance
  - Cannot do
- Create plan to focus on work skills in order of importance and that are realistic
- Evaluate based on outcome criteria
Focus of Rehabilitation for Return to Work

- Occupational therapy for activities of daily living, compensatory techniques
- Physical therapy for function, pain relief, mobility
- Speech therapy
- Treatment of spasticity
- Identification of assistive devices
- Augmentative communication
- Transportation
What do patients and community providers say?

Patients say the most helpful is:
1. Support of family and friends
2. Support of providers (this also includes you)
3. Employers providing accommodations

Community providers say the most helpful is:
1. Motivation to work
2. Daily living skills (bathing, toiletry, getting dressed)
3. Awareness and openness
4. Being able to schedule
5. Stable personal life
Integration into Programs and Supports

- DHSS Brain Injury
- NAMI
- Substance use treatment
- Case management services
- Guardianship
- Social Security/Disability Determinations
- MOBIA
- Support groups
Vocational Rehabilitation Services

- VR services assist people with physical and/or mental disabilities find and/or maintain employment.
- Missouri VR is a division of Missouri Department of Elementary and Secondary Education.
- Offices serve every county in the state. (Two offices in Springfield, Kearney and Catalpa)
Vocational Rehabilitation History

- Soldier’s Rehabilitation Act of 1918
- Modern medicine allowed more injured soldiers to survive and come home with significant disabilities, but they could not go back to their old jobs
- Public Vocational Act of 1920
- Vocational Rehabilitation paid to treat some physical disabilities and provide equipment
- 1965 Amendment included substance misuse and other mental health disorders
- 1973 Amendment mandated VR service people with significant physical and/or mental disabilities
Indications for Vocational Rehabilitation Referral

- Medically released
- Desire to return to work
- Mobility issues considered (rural area and transportation, vehicle modification, assistance with mobility device, public transportation availability, etc.)
- Additional surgeries
- Substance use and treatment
- 3-6 months post injury (focus on acute rehabilitation first)
Eligibility for Services

- A person must have an impairment causing a significant impediment to employment. The impairment must be permanent or ongoing.

- Three levels of impairment- impairment level indicates what types of services can be offered.

- A person will not be eligible if they have a disability when the disability is not causing an impediment to employment.
Services

- Assessment - testing, evaluation, referral, recommendations, job sampling
- Job Development
  - Client works with a community provider to assist with resume, interviews, job search, applications, advocacy, and maintenance
  - Job coaching provides on-the-job support for a limited period of time
Services cont...

- Tools - client must be “job ready” or need tools as part of a training program that VR is supporting
- Assistive Technology - hearing devices, vehicle modifications, wheelchairs, etc.
- Training - vocational and college education programs
- Dental - limited services
- Guidance and counseling
Specialized Services

- Mental Health
- Autism Spectrum
- Hard of Hearing
- Individual Placement and Support Model
- Traumatic Brain Injury
TBI Program

- Brain injury secondary to head injury, stroke, tumor, post-concussive, congenital, etc.
- Specialized services through Preferred Healthcare’s Brain Injury Program
- Differences in supports compared to other programs
- Pre-vocational supports, DHSS, DMH
Trial Work Assessment

- Patient/client meets with Vocational Rehabilitation counselor as well as assessor from community agency
- Employment history, goals, and barriers reviewed
- Patient participates in work at actual job sites or, if necessary, simulations
- Often this is the first time a patient/client faces their difficulties in the workplace
  - Denial as self-protection or anosognosia as organic lack of insight
  - Especially difficult to accept cognitive impairments
  - Many people become discouraged, angry, drop out of services
“They all had loved ones who had suffered brain injuries, spinal cord injuries, or both, but they soon found they all had another common denominator: none of them knew what to do once the hospital stay ended.”

Typical entry into Vocational Rehabilitation services is a few years after injury, and often the person’s life “is in shambles” (housing, transportation, employment, supports, family/caretaker fatigue, lack of SSI/SSDI, homelessness, mental health, victims of crime, manipulated, addiction).

One of the largest difficulties is when a return to employment has been done but later there are significant changes in the workplace or work tasks and “everything falls apart.”
About 40% of those hospitalized with a TBI had at least one unmet need for services one year after their injury. The most frequent unmet needs were:

- Improving memory and problem solving
- Managing stress and emotional upsets
- Controlling one’s temper
- Improving one’s job skills
What is the cost of service gaps?

Lifetime history of any TBI:
- Psychiatric inpatients - 68%
- Combat veterans - 67%
- SUD treatment - 65%
- Incarcerated - 60%
- Homeless - 53%
Case Studies

- Elderly female, s/p stroke, dementia, balance and mobility issues, immigrant, no high school education, relies on family for transportation, lives rurally
  - Participated in a trial work assessment: strengths identified, interest identified, work history utilized
  - Outcome: individual hired, able to keep benefits

- Young male, veteran, TBI, paraplegia, no transportation
  - Utilized existing employment, assisted with vehicle modification
  - Outcome: employment maintained, hours increased, transportation accessed
Case Studies cont...

- Middle-aged female, brain injury from MVA, memory and confusion, fatigue
- Utilized previous employment, accessed additional training
- Outcome: transitioned from part-time to full-time employment, no longer utilizing SSDI, increased income

- Middle-aged male, brain injury from exposure to chemicals, veteran, memory impairment, aphasia, anxiety, hearing impairment
- Utilized previous education, provided job coaching, hearing devices
- Outcome: successful full-time employment, no longer utilizing SSDI, increased income
References

- Journal of Head Trauma and Rehabilitation, October 1997 Special Issue
Contact Information

General
State of Missouri, Department of Elementary and Secondary Education, Adult Learning/Rehabilitation Services, Vocational Rehabilitation
https://dese.mo.gov/adult-learning-rehabilitation-services/vocational-rehabilitation

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