

Roundtable Discussion

Mental Health Care for Returning Veterans: Maximizing Professional Resources

Veterans returning from combat in Iraq and Afghanistan endure a distinct group of stressors linked to long tours of duty and intense urban warfare that brings violence to a very personal level. In some cases, troops serve multiple tours in theater with relatively short respite between, leaving them and their families to endure the worries and difficulties of separation over long periods.

Added together, these stressful factors accompanying the five-year-plus engagements in Iraq and Afghanistan have produced a need for mental health services for troops and their families that is proving difficult to meet.

While the Defense and Veterans Affairs departments have undertaken innovative programs and are working to increase their ranks of mental health professionals, additional efforts are needed, especially since there is a shortage of such professionals nationwide and financial resources, though vastly increased, are not unlimited.

To examine how the federal and private sectors might further collaborate to expand the availability and range of mental health services available to returning veterans and their families, the nonprofit U.S. Medicine Institute for Health Studies convened a roundtable discussion involving representatives from federal agencies, congressional staff, professional associations, private-sector organizations and beneficiary groups.

Roundtable participants agreed that determining what constitutes success in treating such conditions as PTSD, depression, family estrangement and substance abuse remains elusive, and they urged additional research into best practices and development of evidence-based treatments, as well as use of new technologies.

Additional proposals that arose during the roundtable include:

- *Establishing a single joint transition office.* This VA/DoD office would assess initiatives across both agencies and promulgate them systemwide, as merited. It would serve as a “change agent” to help integrate research into clinical practice.

- *Establishing a multidisciplinary VA/DoD group that focuses on outcomes.* According to the Institute of Medicine, the only treatment documented as successful in addressing post-deployment mental health problems is exposure therapy, for PTSD. “We must look at outcomes, especially the ability to thrive in society.”

- *Dealing with the issue of security clearances.* Currently, those applying for security clearances are asked if they’ve ever sought mental health counseling. This is overly broad, roundtable participants said, and often deters military personnel from seeking assessment or counseling.

While this situation has been considered by a multi-agency group, resolution was not forthcoming for military personnel. One suggestion is

Discussion Highlights

- Service men and women generally are strong and resilient individuals. The Army’s Battle Mind program (www.battlemind.org) emphasizes this resiliency, training mental health professionals and troops to recognize that it is *normal* to be affected by the violence of war — and that those who experience symptoms should not be labeled “crazy.”

- Thirty-seven percent of veterans from Iraq and Afghanistan who have left military service have obtained health care from the VA. Of that number (nearly 300,000), 40 percent have a *possible* mental health diagnosis and require careful evaluation. “We must remember that symptoms don’t equal a disorder.”

- Outreach is essential — reaching out to veterans rather than waiting for them to seek help. “We have to overcome the stigma of being afraid to come into the system.”

- The attention being given returning veterans could help reduce the stigma that has been associated with mental health problems generally. However, stigma remains an issue, making educational campaigns for both the military and civilian communities imperative.

- Innovative strategies can help increase the availability of care. One approach suggested was to engage police psychologists, who also deal in issues of trauma. Give An Hour, a volunteer organization, asks participating psychologists to donate an hour of care each week for a year.

to allow each agency leeway to determine how clearances are approved.

- *Expanding the 90-day rotation program for physicians and dentists to include the Reserve Components and opening it to psychologists and social workers.* Limiting tour lengths for reservists would attract more mental health professionals into the reserves and would place professionals trained in the stresses of combat back into the civilian community once their rotations are over, enhancing access for veterans who seek care outside of DoD or VA.

There are drawbacks to this approach, however, since mental health professionals are embedded “far forward” with troops in theater. “If you plan to rotate them every year and then switch to 90 days, it takes four times more.”

- *Establishing a “de-boot camp” program for returning veterans.* This would be a 12-week decompression session for troops who return from deployment in Iraq and Afghanistan and their families. They would be screened and trained in life skills such as employment, financial issues, family interaction and the like.

There was concern among some roundtable participants that such a program would not be feasible, however, since most family members cannot leave work or school for three months. “It could actually increase stress for the family.”

Finding More Providers

There is increased demand nationwide for mental health providers, making it difficult for VA and DoD to secure the numbers and skill sets required, though both agencies are working to expand their ranks of such professionals. For example, VA

has added 3,800 since fiscal 2005, for a current total of nearly 17,000. DoD also is “ramping up” its supply of mental health providers — the Army currently is trying to add 275 — but in the past has seen the ratio of such providers to troops actually decline.

The supply problem is especially acute in rural areas, where the number of civilian mental health providers is low. Resentment can develop when federal programs (VA, in particular) offer higher pay and benefits than can be earned in the local community, drawing providers away and further limiting the care available to local residents.

Many mental health providers avoid the TriCare program, contending the paperwork is onerous and the reimbursement rate too low. Most have practices that already are full and do not need to take returning veterans and their families as patients. “We must increase capacity and have more synchronized efforts,” one participant urged. “Demand is up, and we will be overwhelmed if we don’t do it now.”

Some roundtable participants expressed concern that efforts to meet the demand for care by veterans from Iraq and Afghanistan could “squeeze” the care available to veterans of Korea and Vietnam.

Initiatives and Programs

A specially convened DoD Task Force on Mental Health in 2007 developed 95 recommendations which now are in various stages of implementation. Already accomplished has been the establishment of a Center of Excellence to enhance the quality of and access to mental health services. Additional steps being taken include creation of mental

health councils systemwide, increased accession and retention bonuses for mental health providers and a mental health provider locator service.

In the VA, mental health is being made part of the primary care team — “It’s easier to say you’re seeing your primary provider than a mental health provider” — and psychosocial rehabilitation is being emphasized.

Both VA and DoD say they are engaged in unprecedented cooperation and joint programs in trying to meet the mental health needs of returning veterans. And, in a nod to the tech generation, VA has worked with MTV to help reach out to veterans.

Participants in this roundtable: Brenda Bart-Knauer of TATRC; Cynthia Bascetta of GAO; Thomas Berger of Vietnam Veterans of America; Dan Blum of TATRC; William Cahill of TriWest Healthcare Alliance; René Campos of MOAA; Barbara Cohoon of the National Military Family Association; Mary Cooke of Johns Hopkins US Family Health Plan; Dolores Dunn of the House Veterans Affairs Committee; Diane Elmore of the American Psychological Association; Robert Heinsen of the National Institute of Mental Health; James Heywood of Patients Like Me; Polly Howard of Johns Hopkins US Family Health Plan; Bob Ireland of DoD; Joseph Kelley of DoD; Frank Maguire of TriWest Healthcare Alliance; Karen Malebranche of the Veterans Health Administration; Glen Peterson, police psychologist; Gale Pollock of the Army; Elspeth Ritchie of the Army; Barbara Romberg of Give An Hour; Sara Taber, social worker/writer; Charlotte Tsoucalas of TriWest Healthcare Alliance; Cathy Wiblemo of the House Veterans Affairs Committee; and Antonette Zeiss of the Veterans Health Administration.

The roundtable was moderated by Rick Erdtmann of the Board on Military and Veterans Health of the Institute of Medicine. USMI Managing Director is Nancy Tomich (www.usminstitute.org). The roundtable was sponsored by TriWest Healthcare Alliance.