Chapter 20

THE CONTINUUM OF CARE FOR NEW COMBAT VETERANS AND THEIR FAMILIES: A PUBLIC HEALTH APPROACH

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INTRODUCTION

On October 16, 2003, the US House of Representatives Committee on Veterans' Affairs held a hearing on healthcare for veterans, later published as *Handoff or Fumble? Do DoD and VA Provide Seamless Health Care Coverage to Transitioning Veterans?*[1] Testimony summarized developments to that date, including the push for systematic, standardized posttraumatic stress disorder (PTSD) screening and triage for all patients seen in Department of Defense (DoD) and Department of Veterans Affairs (VA) primary care and mental health settings; the release of the DoD/VA Clinical Practice Guideline for Management of Post-Traumatic Stress[2]; the placement of VA liaisons in major military medical treatment facilities (MTFs); the importance of coordination between medical personnel and chaplains in identifying and reaching out to veterans and their families; and the need for new information technologies capable of integrating best practices into DoD and VA computerized medical record systems.

A key observation made in this hearing was that

> the VA is the world leader in the care of post-traumatic stress disorder, but its clinical and research programs have primarily been directed towards veterans who suffer from chronic PTSD from Vietnam, Korea, and World War II. Starting with the first Gulf War and gaining momentum with [the attacks of] September 11 [2001 and] the conflicts in Afghanistan and Iraq, the VA is learning to tackle PTSD proactively.[2(p40)]

Furthermore, it was noted that

> real grunts see post-traumatic stress disorders, not as a reaction of a normal person exposed to a very abnormal situation, but rather, as a failure of training, of leadership, strength, or, perhaps, character. This is a stigma and it's the single greatest impediment to effective intervention and continuity of care.[2(p41)]

This observation was subsequently validated by Hoge et al in their seminal report, "Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care," that appeared in the *New England Journal of Medicine* in July 2004.[3] These considerations helped set the stage for the ongoing efforts to strengthen and integrate the continuum of care for combat veterans and their families across DoD, VA, state, and community settings described in this chapter.

A BRIEF OVERVIEW OF THE DEPARTMENT OF VETERANS AFFAIRS

Although the VA is well known nationally and internationally, it may still be helpful to provide a brief description of what the VA is and who it serves. The following information is primarily derived from the VA Web site, www.va.gov.[4] Established as a cabinet-level agency in 1989 succeeding the Veterans Administration, the department is responsible for providing federal benefits to veterans and their families. Its mission is inspired by the words of Abraham Lincoln's second inaugural address, delivered in the final days of the Civil War: "to care for him who shall have borne the battle and for his widow and his orphan." Headed by the Secretary of Veterans Affairs, the VA is the second largest of the 15 cabinet departments. The VA operates nationwide programs for healthcare (the Veterans Health Administration [VHA]), financial assistance (the Veterans Benefits Administration [VBA]), and burial benefits (the National Cemetery Administration). In fiscal year 2007, the VA's spending totaled over $80 billion, including $34.9 billion for healthcare and $41.5 billion for benefits.

Of the 24 million American veterans currently alive, nearly three quarters served during a war or an official period of conflict. About a quarter of the nation's population, approximately 74.5 million, are potentially eligible for VA benefits and services because they are either veterans, family members of veterans, or survivors of veterans. The VHA provided healthcare to almost 5.5 million people in 2006, a 29% increase since 2001. By the end of fiscal year 2006, 78% of all disabled and low-income veterans had enrolled for VA healthcare, and 65% of these had received care from the VA. The VA provides care at over 1,400 sites, including 155 VA medical centers, 872 community-based outpatient clinics, and 209 community-based Vet Centers. Expansion plans will bring the number of Vet Centers to 232. Facilities are located in all 50 states and in the District of Columbia, Puerto Rico, Guam, and the Philippines. VA services also extend over time: as of December 2007, VA was providing benefits to three children of Civil War veterans and 232 children and widows of Spanish–American War veterans. The VA also provides medical backup to DoD at times of national emergency or disaster.

The VA is the nation's largest provider of graduate medical education and a major contributor to medical and scientific research. Each year about 90,000 health professionals train in VA medical centers, and more than half of the physicians practicing in the United States received some part of their professional education through the VA. The quality of VA medical care significantly exceeds that of the Medicare fee-for-service program across a wide range of objective performance measures.[5]

Readjustment Counseling Service: The Vet Centers

The Readjustment Counseling Service (RCS), also known as the Vet Center system, plays a unique and pivotal role in the DoD/VA/state/community continuum of care. RCS was established by Congress in 1979 because of the recognition that many Vietnam veterans still struggled with readjustment problems years after that war's end.[6] Vet Centers are community-based and staffed by small multidisciplinary teams of dedicated providers, many of whom are combat veterans. Services are available to any veteran who served in the military in a combat theater or anywhere during a period of armed hostilities. Family members are also eligible for Vet Center services, such as support for the families of veterans coping with deployment-related stress and bereavement counseling services to surviving parents, spouses, children, and siblings of service members (including federally activated reserve and National Guard personnel) who die of any cause while on active duty.

To better respond to the needs of the newest generation of US combat veterans, Congress authorized RCS to hire and train 100 veterans of Operation Enduring Freedom (OEF) or Operation Iraqi Freedom (OIF) as global war on terror (GWOT) outreach workers. These counselors provide briefings on readjustment and VA services to active and reserve component service members after deployment and help enroll new veterans in RCS and VA programs once they become eligible for services. Their shared military experience promotes rapport between GWOT outreach workers and their fellow OEF/OIF veterans, which helps greatly to reduce the stigma associated with discussing postdeployment problems.

Vet Centers seek to increase the resilience of new combat veterans and their families through early intervention. The ultimate aim of these efforts is to prevent the development of more chronic postwar problems including occupational, marital/family, social, financial, or psychological problems. There is never a fee or co-pay for RCS services, and veterans do not have to be enrolled in VA healthcare to access them. Following a tradition of providing "help without hassles," Vet Centers are designed to decrease the stigma that veterans and their families often associate with talking about deployment-related issues in traditional healthcare settings by providing a veteran- and family-centered approach emphasizing access and understanding. These characteristics of RCS have recently been featured (and sensitively portrayed) in Gary Trudeau's *Doonesbury* cartoon series, which depicts the readjustment struggles of a newly returned OIF veteran as he works with his Vet Center counselor (himself a Vietnam veteran).[7]

In addition to psychological counseling for combat-related trauma, RCS services include community outreach, case management and referral, supportive social services, and counseling for veterans who were sexually assaulted or harassed while on active duty. Vet Centers play an important role in connecting veterans with appropriate VA services. Since the first Vet Center opened, more than 2 million veterans have been served. Each year, RCS serves more than 130,000 veterans and provides more than 1 million visits to veterans and family members.[4] From the beginning of the conflicts in Afghanistan and Iraq through the second quarter of fiscal year 2007, Vet Centers had contact with over 227,000 OEF/OIF veterans (this represents over one quarter of discharged OEF/OIF veterans to date). Over 54,000 of these new veterans presented directly to Vet Centers, and the remainder have been contacted at Post-Deployment Health Re-Assessment (PDHRA) programs and through outreach efforts conducted primarily at active duty and reserve component demobilization sites.

Seamless Transition, Care Management, and Social Work

In August 2003, to ensure that returning OEF and OIF combat veterans have timely access to VA care following discharge from military service, then-VA Secretary for Veterans Affairs Anthony Principi and Dr Michael J Kussman, deputy chief in the Office for Patient Care Services, undertook an unprecedented shift in VA policy. Dr Kussman, a retired Army general who had previously commanded Walter Reed Army Medical Center (WRAMC), arranged for VA social workers to work side-by-side with Army medical staff to facilitate the seamless transition of wounded veterans to VA medical care.[8] From the beginning of OIF, the VBA had stationed VA benefits counselors in DoD MTFs to inform wounded service members about VA services and help them begin the claims process. These benefits counselors could not, however, enroll service members for VA healthcare or transfer them to VA facilities. A new clinical system was needed that would involve VHA staff with the clinical experience needed to triage new veterans to the right level and location of care. In Dr Kussman's words: "We just cut through the paperwork and got this going."[8(p17)]

Within a month, a VA social worker from the Washington, DC, VA medical center was detailed to the new VA Seamless Transition Office at WRAMC. In rounding with the Army treatment teams, she and the VA social workers who took up the same efforts at Brooke, Eisenhower, and Madigan Army medical centers overcame the lack of a common computer record system (or even a shared set of paper forms) to develop innovative

ways to help new veterans access needed VA services. One of their findings was that when a veteran was to be discharged from the MTF into care at a VA facility, it was often difficult to identify the person at the receiving facility responsible for ensuring follow-up. Within weeks, VA established a list of seamless transition points of contact for administrative issues and seamless transition care managers (usually social workers) for clinical issues at every VA medical facility and VBA regional office nationwide. Seamless transition workers at each VA medical center subsequently enlarged their scope of service to become the point of contact for all new combat veterans presenting to the VA. The success and value of this effort led the VA to develop what is intended to stand as a permanent policy[8(p19)] on DoD/VA care coordination. In January 2005, the VA established the Office of Seamless Transition to assist in working with the DoD on strengthening transition efforts.

These transition efforts have continued to expand. The VA now has social workers and benefits counselors attached to 11 MTFs and the newly created "Center for the Intrepid" rehabilitation facility in San Antonio, Texas. The US Army surgeon general assigned an Army Medical Department soldier to each of the four VA polytrauma rehabilitation centers in March 2005 to assist all active duty service members and their families with transition issues. The VA has posted Army Wounded Warrior (AW2) soldier–family management specialists to VA medical centers across the nation. The VA also detailed a certified rehabilitation registered nurse to WRAMC to assist in the transition of soldiers to VA care. In 2006 the VA established a polytrauma call center operating 24 hours a day, 7 days a week, to help seriously injured service members and their families connect with needed care and benefits. The VA has formed a partnership with the National Guard Bureau that provides for 54 transition assistance advisors, one stationed in each state and territory, to assist with transition issues among National Guard members. The VA is working with the Army Manpower and Reserve Affairs program on the Army Physical Disability Evaluation System improvement initiative. These and other efforts, including a 2007 VA conference, "Evolving Paradigms: Providing Health Care to Transitioning Combat Veterans," attended by 250 DoD and 1,000 VA participants, have further extended the integration of healthcare services and benefits provided by the DoD and VA.

In March 2007, the Secretary of Veterans Affairs authorized a number of additional positions at VA medical centers and outpatient clinics to provide expanded support for OEF/OIF veterans and their families. Each VA medical center has a full-time nurse or social worker who serves as an OEF/OIF program manager. These program managers are the primary coordinators for VA liaisons stationed at MTFs. They work with, and manage the activities of, the VA facility case managers and points of contact to assure seamless transition for all OEF/OIF service members and veterans. Program managers oversee facility outreach efforts including PDHRA events to OEF/OIF veterans including National Guard and reserve members. They work closely with VBA regional offices to track claims, and they also assign case managers for all severely injured or ill OEF/OIF veterans and others who may need or want case management.

Additionally, 100 transition patient advocates have been strategically distributed throughout the 21 veteran integrated service networks to function as ombudsmen for severely injured or ill OEF/OIF veterans and their families as they exit the military and enter the VA. The transition patient advocate, assigned to these service members while they are still at the MTF, arranges for the patients and their families to meet (virtually) with the treatment team at the receiving VA medical center and assists them with transition to the new medical center (escorting them when needed) and into the VA benefits system.[9] These programs are now organized under VA's Care Management and Social Work Service.

Much of the success of this integration is built upon VHA Directive 2002-049.[10] Enacted September 11, 2002, it ensured that hospital care, medical services, and nursing-home care were made available to recent combat veterans for 2 years beginning on the date of the veteran's discharge from military service. In January 2008, the period of service was extended to 5 years. During this 5-year period, these veterans are accorded high priority for VA care and are never charged a fee or co-pay for treatment of any illness that, in the clinician's opinion, is attributable to military service. Veterans are encouraged to begin the application process for any appropriate service connection so that military-related medical problems can be identified and rated for VA care to continue after the initial 5 years have elapsed. The provisions of VHA Directive 2002-049 ensure that recently discharged service members have expedited and unambiguous access to VA services.

In October 2007, the VA and DoD partnered to establish the Joint VA/DoD Federal Recovery Coordination Program to further integrate medical and nonmedical care and services. This program will focus on recovery, rehabilitation, and community reintegration to extend the close care coordination between the DoD and VA and across the lifetime continuum of care for severely injured service members, veterans, and their families.

SERVICES FOR VETERANS OF AFGHANISTAN AND IRAQ

As of February 2008, the DoD reported that 837,458 OEF/OIF veterans had become eligible for VA services. The VA tracks their care through its Environmental Epidemiology Service.[11] Of these new veterans, 39% (324,846) have already registered with the VHA for medical services (notably, the total number of OEF/OIF veterans who have presented for VA healthcare at the time of this writing represents only about 6% of the VA's current caseload).

Among the OEF/OIF veterans who have presented to VA medical facilities, the three most common health problems are (1) musculoskeletal injuries (including serious wounds and injuries but primarily joint and back problems commonly associated with deployment to the rocky terrains of Afghanistan and Iraq); (2) mental health problems; and (3) symptoms, signs, and ill-defined conditions. This third category is a diagnostic placeholder that designates a condition still in the process of evaluation.

Mental health issues reported by OEF/OIF veterans who have so far presented for VA care are represented in Table 20-1 (note that these numbers reflect only OEF/OIF veterans who have presented to VA medical centers and registered for care through the VHA). Over 11,000 other OEF/OIF veterans with a possible diagnosis of PTSD have presented to Vet Centers but not to VA medical facilities. It must be emphasized that the table lists provisional diagnoses. In many cases, the categories simply represent the results of positive screens for mental health diagnoses. Although positive screens are strongly suggestive of a diagnosis, they are not the same as a diagnosis. The VA has developed a "pop-up" clinical reminder within its computerized medical record[12] that prompts clinicians to screen OEF/OIF veterans for a number of mental health problems including PTSD, major depression, alcohol abuse or dependence, and traumatic brain injury. The range and number of mental health diagnoses can be expected to shift over time as clinical evaluations progress.

Diagnoses may also shift as some health issues improve and others develop. The Walter Reed Army Institute of Research (WRAIR) has reported that the majority of soldiers diagnosed with PTSD or depression at 7 months postdeployment did not meet criteria for either condition during the first month after deployment.[13] Given the stigma associated with mental health problems in general, and with postdeployment mental health problems in particular,[3] veterans with such problems may be hesitant to discuss them when they first present for care. Over time, as a clinician–patient trust develops and family or social pressure to seek help mounts, veterans and their family members may become more willing to report such problems. Kang and Hyams[14] have shown that although the rate at which medical problems are reported among OEF/OIF veterans in the VA is fairly constant, the rate at which mental health problems are reported increases with time.

The VA findings summarized in Table 20-1 demonstrate the broad range of mental health diagnoses to consider, including about as many cases of mood disorder and substance abuse or dependence as of PTSD. A similar ratio was observed in New York City in the wake of the September 11, 2001, attack on the World Trade Center.[15] Hoge et al[3] noted a significant increase in major depression and generalized anxiety disorder, as well as in PTSD, among recently deployed soldiers and marines. Postdeployment mental health cannot be about just PTSD anymore.

TABLE 20-1

PROVISIONAL MENTAL HEALTH DIAGNOSES AMONG OEF/OIF VETERANS PRESENTING FOR VA MEDICAL CARE

Diagnosis	Number
Posttraumatic stress disorder	67,525*
Acute reaction to stress	4,070
Nondependent abuse of drugs†	54,415
Depressive disorder	45,155
Affective psychoses	25,399
Neurotic disorders‡	35,605
Alcohol dependence	11,245
Drug dependence	5,062

*21% of total
†Excessive tobacco use accounts for a large portion of those identified as involved in nondependent abuse of drugs.
‡This category includes a number of anxiety disorders such as generalized anxiety disorder and panic disorder.
OEF: Operation Enduring Freedom
OIF: Operation Iraqi Freedom
VA: Department of Veterans Affairs

NEW PROGRAMS FOR COMBAT VETERANS AND THEIR FAMILIES

As noted above, Hoge and colleagues at WRAIR demonstrated that the stigma associated with reporting postdeployment mental health problems may be the single greatest obstacle to accessing care.[3] Their 2004 study reported findings from over 3,600 active duty soldiers and marines 3 to 4 months after their return from service in Afghanistan or Iraq. For example, they found that when asked whether they had concerns about their decision to receive mental healthcare, 65% of these combat veterans were concerned that "I would be seen as weak," 63% were concerned that "my leadership might treat me differently," and 59% were concerned that "members of my unit might have less confidence in me."[3]

The Joint Conference on Postdeployment Mental Health

Hoge and colleagues' 2004 findings[3] and strong interagency desire to optimize mental healthcare across the DoD/VA continuum inspired plans for a joint DoD/VA conference on postdeployment mental health. Held in Alexandria, Virginia, on March 8–10, 2005, this conference was cochaired by Colonel Elspeth Ritchie, psychiatry consultant to the Army surgeon general, and Harold Kudler, MD, then cochair of the VA Under Secretary for Health's Special Committee on PTSD. Among the over 50 participants were the assistant secretary of defense for health affairs; the deputy secretary for veterans affairs; the surgeons general of the Army, Navy, and Air Force; mental health experts from across the DoD and VA; other representatives of Army, Navy, Marine Corps, Air Force, Coast Guard, National Guard, and reserve forces; and leading researchers and health systems planners from across the DoD and VA. Given the composition of its membership and the agenda set, the meeting might have been expected to result in the definition of a medical model for assessing and treating PTSD, depression, substance abuse, and other mental health diagnoses. Instead, the participants concluded this historic conference by defining a public health model for deployment mental health that has set the tone for DoD/VA efforts ever since.

The Public Health Model for Deployment Mental Health

The public health model sprang from the observation that most warfighters or veterans will not develop a mental illness, but that all warfighters or veterans and their families face important readjustment issues. These problems in living may be painful and at times disabling, but they are, nonetheless, normal responses to extreme stress rather than medical illnesses. Within the public health model, the focus is less on making diagnoses than on helping individuals and families retain or regain a healthy balance despite the multiple stressors associated with the deployment cycle. This approach incorporates the recovery model and other principles of the President's New Freedom Commission on Mental Health,[16] including the importance of fostering resiliency and independence.

The term "recovery" is generally associated with the reduction or remission of symptoms and signs specific to a given disease. Recovery also refers to the process by which people become progressively more able to live, learn, work, love, and fulfill a valuable and satisfying role within their families and their communities despite an ongoing medical problem. Thus, "recovery" may not be the same thing as "cure." As Parsons has shown,[17] disease is a biomedical process, but illness is largely a social process in which a person who has a disease accepts the sick role and its implicit and explicit limitations. Not everyone who has a disease lives within the sick role; there is a difference between having a significant problem (even a significant medical problem) and being disabled. Even when the signs and symptoms of disease are clearly disabling, recovery can be understood as the ability to live a fulfilling and productive life despite medical limitations. Recovery might also be understood as a life in which hope succeeds in sustaining the individual and the family even when medical efforts have failed.

"Resilience" refers to the qualities of an individual, a family, or a community that enable it to cope and rebound despite extreme stress. Resilience likely has psychological, biological, and social underpinnings with a different configuration in every person, family, and society. Resilient people retain or regain a sense of mastery, competence, and hope in response to adversity. Jerome Frank, who served as an Army psychiatrist during World War II, and went on to study how people cope with and recover from illness and stress in diverse cultures,[18] suggested that the restoration of morale was the common element in all successful forms of therapy.[19]

A public health model, while medically informed, is quite different than a traditional medical model. It coordinates the efforts of traditional medical programs but also extends into nonmedical settings. In a public health model based on recovery and resilience, the question is less "How do you feel?" than "How are you doing?" New combat veterans usually experience

the first question as insensitive and difficult to answer. The latter question places the focus on function and readjustment and will, therefore, engage the veteran in a more useful conversation.[20]

Hoge et als' findings,[3] and the VA utilization statistics provided above, demonstrate that it is not sufficient to announce that effective mental health treatment exists within the DoD and VA. Although many will appreciate the offer of care, only a minority will access it; the stigma associated with needing help is simply too powerful. The public health model circumvents the stigma associated with traditional mental health services by reaching directly into primary care settings and into the larger community. The primary care clinic is the de facto mental health system for a significant portion of the population. In times of trouble, people trust their primary care providers more than any other authority in their community.[21] Web sites and public service announcements help get the word out, but for the message to take hold and access to be maximized, it is necessary to partner with allies in the greater community. Among the most important of these is the veteran's family, because family members often decide when and where the veteran will seek help. Furthermore, resilient, supportive families significantly increase the resiliency of their members.[22,23]

Other allies include DoD and VA chaplains, DoD's family support programs for active and reserve component members, military medical boards, VBA, local health providers (including TRICARE providers), community mental health centers, public schools, local colleges (where many new combat veterans study), employers, local congregations, military unit associations, and veterans' service organizations. Military OneSource, a telephone and Web-based service available free of charge to service members and their families through a contract with DoD,[24] is a confidential and highly accessible outreach tool, but its service is most effective in coordination with the full range of public health resources available to veterans.

The highly successful Vet Center program was founded on public health principles and serves as a model for current efforts. RCS was specifically engineered to meet the needs of those Vietnam veterans who had reservations about seeking care at VA medical centers. RCS Vet Centers are neither hospitals nor mental health centers; they are community-based "storefront" operations. As its name clearly implies, RCS is about readjustment, not about mental illness. RCS freely involves family members and encourages them to share their concerns and express their own needs. RCS has proven effective in overcoming the stigma that kept many combat veterans from presenting to military or VA medical centers. Current public health efforts to reach a new generation of combat veterans and their families build upon the success of the RCS model.

Because the needs of OEF/OIF veterans and their families change over time (as does their access to different services), the public health approach requires a progressively engaging, phase-appropriate integration of services across the DoD/VA continuum. This program must (*a*) be driven by the needs of the veterans and their families rather than by existing organizational structures and processes; (*b*) meet prospective users where they live rather than wait for them to find their way to the right mix of services; and (*c*) better articulate the transition between DoD and VA. Shared computerized medical record systems, and standardized, longitudinal follow-up of mutually agreed upon baseline assessment measures may in time significantly strengthen the DoD/VA continuum of care. There is also an opportunity to optimize the interplay between the DoD medical board and the VBA service connection processes to accelerate the rate at which new veterans and their families can access the constellation of services designed to meet their needs.

Post-Deployment Health Re-Assessment: A New Level of Service Integration

In recognition that physical health, mental health, or other readjustment problems may not be immediately apparent or may take time to develop,[3] DoD developed the PDHRA as a follow-up to the postdeployment health assessment performed at the time of return from a contingency operation. PDHRA is performed 3 to 6 months postdeployment to ensure timely outreach, education, training, screening, assessment, triage, treatment, and follow-up. This intervention incorporates a nonpathologizing public health approach framed within a global health initiative.

Screening utilizes a standardized tool, the DD Form 2900. Service members fill out the self-report section of the form within the context of a special education and training session, focused on common deployment-related health concerns, that provides information on the range of responses and benefits available to meet their needs. Each service member's responses are reviewed with a healthcare provider to clarify issues, gather any needed clinical information, and ensure appropriate connection to services ranging from community-based support and preclinical counseling to referral for treatment in primary care, mental healthcare, other specialty care, or rehabilitative care as appropriate.

PDHRA is medically informed to effectively identify clinical problems and facilitate access to care, but, in

line with the public health model, the intervention emphasizes readjustment opportunities rather than pathology and disability. Vet Center and VA Seamless Transition staff and veterans' benefits counselors are on hand at PDHRA events to assist service members entering veteran status. To improve access to mental healthcare, military and VA medical systems are both in the process of increasing its integration into primary care settings. Efforts are underway to allow sharing of DD Form 2900 findings between DoD and VA clinicians to assure continuity of care across systems.

Battlemind Training

Hoge and colleagues[3] demonstrated that the stigma surrounding postdeployment readjustment stress is a significant barrier to new combat veterans receiving appropriate care. To get around this stigma, Hoge and his team at WRAIR developed and tested a new outreach approach to engage OEF/OIF combat veterans: Battlemind training.[25] Battlemind training has now been incorporated into the PDHRA intervention for the Army. (The US Marine Corps' Warrior Transition Program[26] addresses similar issues but is adapted to meet the unique needs of marines.)

"Battlemind" is an acronym for:

Buddies vs withdrawal
Accountability vs control
Targeted vs inappropriate aggression
Tactical awareness vs hypervigilance
Lethally armed vs unarmed
Emotional control vs anger or detachment
Mission and operational security vs secretiveness
Individual responsibility vs guilt
Nondefensive (combat) driving vs aggressive driving
Discipline and ordering vs conflict

Each element of Battlemind training speaks to an important aspect of postdeployment readjustment, and each is illustrated and explained in the video presentation (viewable at https://www.battlemind.army.mil/) that forms the centerpiece of training. Consonant with the public health model, Battlemind emphasizes resiliency rather than pathology, and engages service members through training rather than direct offers of treatment. Further interventions up to and including appropriate clinical assessment and treatment are more likely to be accepted if this initial outreach is accepted.

Battlemind training is designed to be highly acceptable to new combat veterans. Its key message is that combat skills and battle mindset sustained the warfighter's survival in the war zone. Battlemind is defined as the service member's inner strength to face fear and adversity in combat with courage. If, on returning home, service members find that they still "sleep with one eye open," are constantly on alert for signs of danger, and respond reflexively with aggression, this is evidence that they have adapted to the war zone. This explanation is quite different than telling new combat veterans that they may be expressing symptoms of a mental disorder such as PTSD. The clear implication is a positive one: if you were able to adapt to life in a war zone, you should be able to adapt again to life at home. In short, Battlemind training tells new combat veterans that their responses are the normal responses of good warfighters, but it also stresses that Battlemind may be hazardous to social and behavioral health on the home front if it is not transitioned: in other words, "don't try this at home." Battlemind training has been expanded to include spouse Battlemind training for both predeployment and postdeployment use. During 2006, qualified instructors from WRAIR trained all Vet Center staff members in Battlemind principles.

Extending and Strengthening the Continuum of Care

As this review demonstrates, DoD and VA have worked steadily since the start of operations in Afghanistan and Iraq to mesh the gears of their respective agencies through the development of joint clinical practice guidelines, the Joint VA/DoD Federal Recovery Coordination Program, PDHRA, and Battlemind training to extend and enhance the continuum of care for OEF/OIF veterans and their families. These steps can be understood as practical applications of a public health model particularly suited to this newest generation of combat veterans.

In 2005 the VA implemented a new program founded on these same principles, which was subsequently named Services for Returning Veterans-Mental Health (SeRV-MH). Rather than diagnosing specific disorders or limiting services to highly specialized interventions for PTSD, depression, or substance abuse, the goals of SeRV-MH are engagement, health promotion, recovery, and rehabilitation. Triage to primary care, general mental health services, and subspecialty services are available through SeRV-MH teams. SeRV-MH teams actively engage other VHA, VBA, and Vet Center programs; DoD active duty and reserve components; and other federal, state, and community agencies and programs in support of new combat veterans and their families.

Although outreach was initially identified as a core

SeRV-MH function, that role is, as noted above, the purview of Vet Centers, so SeRV-MH outreach is carried out in collaboration with Vet Center initiatives. SeRV-MH teams are distinguished by their unique "in-reach" function, which includes services in primary care settings designed to enhance access to behavioral health services while reducing the stigma that veterans and their families often associate with formal mental health settings. SeRV-MH staff members also support facility polytrauma services, including those for veterans with traumatic brain injury. Service delivery innovations to meet the needs of returning veterans who go to work or school include the establishment of weekend and evening SeRV-MH clinic hours.

SeRV-MH teams are agents of change within the various programs, promoting a view of mental health as an essential part of overall health and function. They help other VA clinical, administrative, and support staff to become aware of the special characteristics of OEF/OIF veterans and their families and develop new methods of intervention. They embody and disseminate the public health model. More than 80 SeRV-MH teams are now distributed across the nation (at least one per state), and nationally coordinated training (developed by a multidisciplinary DoD/VA team) is being rolled out. This training includes information on the Army Battlemind approach and education on topics not addressed in more traditional curricula on war stress disorders, such as improving closeness among family members and addressing traumatic grief.

The VA has also launched a Mental Illness Research, Education, and Clinic Center (MIRECC) dedicated to postdeployment mental health.[27] MIRECCs were established by Congress in 1997 as translational research centers. Ten MIRECCs exist nationwide and each is dedicated to a specific area of mental illness, such as schizophrenia, substance abuse, or dementia. Their stated mission is

> to generate new knowledge about the causes and treatments of mental disorders, apply new findings to model clinical programs, and widely disseminate new findings through education to improve the quality of veterans' lives and their daily functioning in their recovering from mental illness.[28]

The postdeployment MIRECC works with clinicians and researchers across the DoD/VA continuum to identify, develop, and disseminate best clinical practices in the service of new combat veterans and their families. Some of this work stems from MIRECC laboratory, health services, and epidemiological research, while other efforts apply and test new clinical models and educate other health workers, the general public, and OEF/OIF veterans and their families.

BEYOND THE DEPARTMENT OF DEFENSE/VETERANS AFFAIRS CONTINUUM

Ideally, the postdeployment readjustment and mental health problems of OEF/OIF veterans would be identified and addressed somewhere within the DoD/VA continuum of care, but this may not be a realistic expectation. Hoge et al[29] conducted a population-based descriptive study of all soldiers and marines who returned from deployment to OEF (n = 16,318), OIF (n = 222,620), and other locations (n = 64,967) between May 1, 2003, and April 30, 2004. They found that the prevalence of reporting a mental health problem was 19.1% among service members returning from Iraq, 11.3% after returning from Afghanistan, and 8.5% (close to the base rate in the military) after returning from other locations ($P < 0.001$). Although 35% of all OIF veterans accessed mental health services at least once within a year after their return home, 60% of those who screened positive for PTSD, major depression, or generalized anxiety (substance abuse was not addressed in this study) failed to present for any mental health service. These DoD findings closely parallel those in the VA that (as noted above) show that, as of February 2008, only 39% of all OEF/OIF veterans eligible for VA care have come to the VA for health services. Where are the other 61% of OEF/OIF veterans, and what are their mental health needs?

Another parallel exists between this information and the findings of the National Vietnam Veterans Readjustment Study,[30] which found that only 20% of Vietnam veterans who fulfilled diagnostic criteria for PTSD at the time of the study (conducted in the late 1980s) had ever gone to the VA for mental healthcare.[30(p228)] The same study found that 62% of all Vietnam veterans with PTSD had sought mental healthcare somewhere at some point in time. In other words, among Vietnam veterans with PTSD at the time of the study who ever sought mental healthcare, only 32% came to the VA for that care, while 68% went elsewhere for care.

These findings suggest that a "silent majority" of OEF/OIF veterans with postdeployment readjustment or mental health issues may not seek help within the DoD/VA continuum of care. Stigma may be the key reason for this. But if a silent majority does exist, several important questions face DoD and VA planners and clinicians:

- Who among these veterans should be reached?
- What are the best ways to reach them?

- At what point should they be reached?
- What interventions would be most appropriate once they have been reached?
- What about their families?

Work with the families is particularly important because the level of postdeployment social support received by combat veterans strongly predicts their resilience.[22,23] In addition, if new combat veterans are going to get needed help, family members will likely be instrumental in their getting it. Finally, families have needs of their own that, if left unmet, could have serious consequences for the families and their communities. To reach new combat veterans and their families, it is necessary for the DoD and VA to look beyond their own continuum of care towards partnerships at the state and community levels.

State and Community Partnerships

The DoD and VA realize a number of advantages in partnering at the state and community levels. Such partnerships enhance access for service members, veterans, and family members who are concerned about seeking help within the DoD/VA continuum. Partnerships may also enhance the quality of services new combat veterans and their family members receive in the community through joint training and improved interagency cooperation.

Because National Guard programs are organized at the state level, it makes sense for DoD and VA to develop state-level partnerships. Furthermore, each state has its own veterans' service program. Veterans' service officers in each county or region of the state work with veterans and their families to connect them with federal, state, and local programs that significantly improve their access to care, benefits, and reliable information. Finally, partnerships among the DoD, VA, states, and local communities help build new systems of interagency communication and coordination that may serve well at times of local or regional disaster. A number of DoD, VA, state, and community partnerships already exist in areas such as upstate New York, Washington state, Ohio, North Carolina, Virginia, Alabama, Vermont, and Rhode Island. Because each state has a different array of military bases, reserve units, VA facilities, and veteran populations, each faces unique challenges and opportunities.

One recent example of the DoD, VA, state, and community partnership was introduced on February 12, 2007, when the VA announced a national roll out of a partnership with state veterans' service officers through the National Association of State Directors of Veterans Affairs. This program links VA staff based at 10 DoD MTFs around the country with state veterans' service officers in all 50 states. The program helps identify injured military members who are being transferred to VA care so that state veterans' officers can more efficiently identify, locate, and link them and their family members to appropriate state benefits and services.[31]

Partnerships can and should extend well beyond the traditional scope of mental health and substance abuse services to include local primary care providers, pediatricians, ministers and congregations, teachers and school guidance counselors, campus-based veterans' benefits specialists, veterans' service organizations, mental health associations and advocacy organizations, employers and supervisors, law enforcement agents, judges, and others in order to make diverse members of the community more aware of the problems faced by OEF/OIF veterans and their families and of the resources available to assist them.

These partnerships often begin with a state-level summit meeting of potential partners including state-based DoD and VA elements. These conferences generally open with a presentation of the "boots on the ground" experiences of new combat veterans and the deployment cycle experiences of their families. The presence of top leadership, including the governor, the state secretary for health and human services, the adjutant general of the state National Guard, senior leadership from state-based DoD military programs and medical facilities, and VA network leadership, provides a strong and positive message to participants about the importance of the effort and the will of each respective partner to pursue it.

Representatives to the summit meeting exchange key information about their respective agencies' assets and goals to identify strategic partnerships in service for new combat veterans and their families. Attendees work to articulate an integrated continuum of care that emphasizes access, quality, effectiveness, efficiency, and compassion. Services are centered on service members or veterans and their families. Principles of resilience, prevention, and recovery are emphasized. Attendees agree to work together to optimize access to information, support, and, when necessary, clinical services across systems as part of a balanced public health approach. The product envisioned is a network of informational, supportive, clinical, and administrative services through which citizens of the state will have ready access to postdeployment readjustment assistance. The DoD, VA, state, and community partnership may begin with a single high-profile meeting as described above, but if the process is to be successful, it must be sustained. This calls for ongoing meetings of working subgroups, continued support within

each partnering entity, and a clear and practical joint plan with scheduled deliverables and clear lines of responsibility.

Key Elements Replicable in Every State

Some states are home to major military bases embedded within strong military-friendly communities. In such settings, postdeployment issues are often well recognized by local leaders, health professionals, teachers, guidance counselors, school principals, and local clergy. Many community support mechanisms may already be in place. Other states have few, if any, major bases, but have large numbers of reserve or National Guard members. Because these citizen soldiers tend to be scattered across communities (and relatively invisible within them), local leaders, health professionals, school personnel, and religious leaders may be less aware of deployment-related issues and less knowledgeable about how to access resources once a need is identified. Nonetheless, there are certain core elements of the DoD, VA, state, and community partnerships that can be successfully replicated in every community and state.

The first element is effective outreach. One basic mechanism is development of a governor's letter to new combat veterans and their families. Because each state director of veterans' services receives a list of the names and mailing addresses of every OEF/OIF veteran living within the state, it is possible for the governor's office to reach out to every affected household. The North Carolina Governor's Focus on Returning Combat Veterans and Their Families recommended in its final report[32] that such a letter be sent to all service members and their families, thanking them on behalf of the entire state. The letter also invites recipients to make use of local resources as they readjust. In North Carolina, the letter provides a toll-free telephone number that combat veterans or family members can call for information and guidance to appropriate resources. As a key step toward enhancing resilience, the governor can conclude the letter by recognizing the strength, skills, and willingness to sacrifice demonstrated by veterans and their families.

The toll-free number used in North Carolina is an application of a preexisting "care line" system established by the state Department of Health and Human Services. It is staffed by information-and-referral specialists trained about a wide variety of human service programs across the state.[33] Care line services are provided in English and in Spanish and as a TTY (text telephone) service for the hearing-impaired (an important consideration among combat veterans). Until recently, these specialists did not routinely inquire whether a caller was a service member, a veteran, or someone calling about a service member or a veteran or in relation to postdeployment issues. These specialists have now undergone training on deployment mental health issues and have begun applying a simple algorithm when fielding calls. They ask about the caller's service in Iraq or Afghanistan, military branch, current military status (active duty or reserve component), date separated from service, date of return from last deployment, and zip code or county of residence.

With this information in hand, a range of services can quickly be identified and located in proximity to the caller's residence. The list of potential access points resides on an electronic database of over 10,000 agencies and programs across the state. The referral specialist can identify the caller's local Vet Center (and its GWOT outreach worker if one exists); the county veterans' services officer; the seamless transition case manager at the local VA medical center; any service-appropriate family program (such as the Guard Family Readiness Group); and the nearest regional VBA. The specialist can also put the caller in touch with Military OneSource or TRICARE services as appropriate to the caller's needs. This information can also be obtained at the care line Web site (http://www.nccareline.org).

Joint training efforts are required to build strong bridges between the DoD, VA, state, and community programs. These should include leaders and clinicians working in local mental health, primary care, and family support programs, as well as professional organizations and other state and community groups. Area Health Education Centers (AHECs), developed by Congress in 1971 to recruit, train, and retain a health professions workforce committed to underserved populations,[34] exist in almost every state. AHECs can play an important role in disseminating best practices and developing a common language and approach among federal, state, and community systems.

One strategy that can be employed with relative ease is to develop an AHEC educational program based on Battlemind training. Trainers can be recruited from local DoD and VA sites. Battlemind training videos and supporting materials are available in the public domain. Although Battlemind is an Army program and the Warrior Transition Program is a Marine Corps program, both incorporate principles that speak to universal issues of the deployment cycle and can be adapted to different audiences while still respecting distinct cultural differences among the military branches.

Local PDHRA events also offer important opportunities for the DoD, VA, state, and community cooperation. DoD and VA staffs routinely meet with local military units (and often with their family members)

during PDHRA. State and community representatives could be invited to attend to help reinforce transition back to the community and inform service members and their families about readjustment resources such as medical, vocational, and benefits programs. At the same time, participating state and community representatives have the opportunity to learn more about the challenges faced by new combat veterans and their families, which can then inform further efforts on their behalf. Partnerships should coordinate DoD, VA, state, and community efforts with those of local providers who contract with TRICARE and Military OneSource to assure full and ready access to well-trained clinicians for service members, new veterans, and their families. AHECs can disseminate needed clinical training and can also provide information about working with TRICARE (which could lead to more providers choosing to become TRICARE providers).

Many service members, veterans, and family members prefer to bring readjustment issues to their chaplain or local religious leader rather than to a medical provider. DoD, VA, state, and community partnerships offer a unique opportunity for interchange between military and VA chaplains and local clergy and their faith communities. These partnerships can substantially increase social support for returning combat veterans and their families. Clinical pastoral education programs are ideally suited to develop outreach and educational activities that promote readjustment, resilience, and recovery. Again, Army Battlemind training and the Marine Corps Warrior Transition Program can provide core content for instruction that can be adapted for specific faith communities. The strategies and tactics presented here are not meant to serve as an exhaustive list but rather as a jumping-off point for new ideas. It is essential that each community explore and develop partnerships specific to its own unique needs and assets.

SUMMARY

The VA has long-standing readjustment services stemming from Vietnam-era initiatives such as the Vet Center program; however, new programs have arisen in response to studies finding these efforts inadequate. The DoD and VA have established joint efforts built on a public health model, including partnerships with state and community resources. These partnerships are designed to enhance support and outreach, improve referral systems, reduce stigma, and promote better health outcomes for new combat veterans and their families. The goals of all these programs are to provide a seamless continuum of care that will support increased resilience, decreased military attrition, and decreased disability, as well as increased satisfaction among consumers and providers. Experience to date indicates that these ambitious goals are attainable. The ultimate goal is to transform the postdeployment health system: there should be no wrong door to which OEF/OIF veterans or their families can come for help. The DoD and VA have made significant progress in providing seamless healthcare coverage to transitioning veterans and their families since the start of military operations in Afghanistan and Iraq. The public health model and the DoD, VA, state, and community partnerships help mark the path for future progress.

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