

A Congressional Look at Postdeployment Behavioral Health Care

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As the 2 US senators from North Carolina, it is our job to support veterans and active-duty personnel as they work to keep our country safe. Because of the physical and psychological stresses of repeated deployments, it is critically important that we make significant strides to improve the behavioral health services available to these individuals and their families.

As the 2 US senators from North Carolina, it is our job to support our veterans and active-duty service members, who fight each day to keep our country safe. North Carolina is the most military-friendly state in the nation. Our state has the fourth-largest military footprint in the country, and 35% of North Carolinians serve in the military, have an immediate family member who serves, or are veterans [1].

As the US armed forces—the best in the world—work to defeat terrorists abroad, they are coping with the physical and psychological stresses of repeated deployments to Afghanistan and Iraq. While there are programs that provide behavioral health services for military service members, veterans, and their families, it is critically important that significant strides are made to improve these services across the country.

Traumatic Brain Injury (TBI) and Posttraumatic Stress Disorder (PTSD)

Detonation of improvised explosive devices (IEDs) by insurgents in Iraq and Afghanistan exposes troops to shocks that can cause concussions. The effect these shockwaves have on the brain and on the cognitive ability of the service member is difficult to detect by a postevent assessment. The severity of TBIs can be exacerbated if they are left undetected. In the early years of combat in Iraq, troops who experienced IED blasts and did not demonstrate a reduction in cognitive ability were back on patrol within minutes or hours. Many experienced multiple blasts and associated concussions.

The Department of Defense (DoD) continues to improve cognitive assessments and reporting procedures in theater (ie, during deployment). Although medical experts acknowledge the relationship between TBI and PTSD, the nexus is not fully understood. Congress authorized the DoD to increase the number of behavioral health professionals

at forward operating bases in Iraq and Afghanistan and has assigned such professionals to deploying units. The Army and the Marine Corps are also training medics and corpsmen to identify signs of cognitive and psychological stress. The DoD's health care network, TRICARE, has increased the number of behavioral health professionals in its provider base to meet the needs of military personnel and their families. However, progress has been slower in some parts of the country, especially rural areas.

Reducing the stigmatization associated with TBI and PTSD among military personnel is critical to minimizing the effects of these conditions on the individual, their unit, and their family. However, the military's cultural norms can sometimes make service members hesitant to seek appropriate care [2]. As a result, many service members continue to avoid reporting behavioral problems because they believe that reporting might harm their careers [3].

The Army and the Marine Corps established warrior transition units (WTUs) and wounded warrior regiments (WWRs) for service members who experienced traumatic physical and invisible (ie, emotional and psychological) wounds. These units provide a secure environment where service members can obtain outpatient treatment for their conditions, receive behavioral health counseling, and benefit from the camaraderie of the unit. There is a WTU at Fort Bragg and a WWR at Camp Lejeune. Both units have access to DoD behavioral health professionals; interaction with nonprofit organizations, for special assistance; and Veterans Affairs (VA) representatives, who assist the service members with their transition from active duty to veteran status. However, because of limitations in assessment and self-reporting mechanisms, not all service members with TBI or PTSD join a WTU or WWR. Accurate and timely in-theater reports of the behavioral and physical conditions of service members who have been injured or wounded should be incorporated into the individuals' medical records.

Electronically published April 21, 2011.

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0029-2559/2011/72107

Gaps in Care Across the DoD and the VA

While the DoD-VA interaction at military installations is essential for individuals leaving active service, uneven follow-through by the VA and veterans has caused gaps in delivery of care, a problem acknowledged not only by members of Congress, but also by the VA [4]. The VA is struggling to alleviate a backlog of disability claims; because of this, the VA is seeking solutions.

While effective treatment and counseling are fundamental for a service member or veteran with TBI or PTSD, gaining access to the proper blend of treatment can become a problem if the service member is relying on the VA for that care. In many cases, a veteran comes to the VA without a prior diagnosis from a DoD clinician and must undergo a medical evaluation to receive a diagnosis that determines whether the veteran is eligible for VA disability benefits. The average interval between a qualifying diagnosis and receipt of VA disability benefits is approximately 6 months. Furthermore, access to VA health care is not, in every case, allowed until a final disability determination is made, a decision that could take months or years.

The VA has received authorizations and appropriations from Congress to integrate behavioral health care, especially screening for TBI and PTSD, into VA primary care. The VA also has full-spectrum therapies to treat veterans with PTSD and to address the related behavioral health issues that emanate from this condition, including suicidal tendencies, substance abuse, and inability to function as a contributing member of the family, work environment, or community. Continual congressional oversight is needed to monitor progress.

Suicide Prevention and Substance Abuse Counseling

Suicide prevention and substance abuse are important aspects of behavioral health issues affecting military personnel, veterans, and their families. Suicides among service members have increased since 2003, when US forces began combat operations in Iraq. In 2009, the Army experienced its worst year for suicides among active-duty soldiers, with 162 cases [5]. That year also marked the highest annual suicide rate in the Marine Corps over at least the past decade [6].

Community support services, medical treatment facilities, and unit leadership are often housed at several locations on military installations, leading to ineffective approaches for suicide prevention [2]. Commanders need additional tools to detect and track unit-level suicide risk factors and identify individuals who are at high risk [2].

The DoD has not concluded that multiple deployments and limited dwell time are the main causes of military suicides. According to the Army, one-third of the active-duty soldiers who killed themselves in 2009 had no deployment history [7]. More research is needed to explore the influence of dwell time on suicide risk.

The DoD and medical professionals have expressed concern about the possible relationship between suicide and psychiatric medications prescribed for military service members [8]. Prescription drugs can help troops deal with the physical, psychological, and emotional wounds incurred on duty and with readjustment to life back home, but some medications can potentially have dangerous side effects. Additional research is needed to investigate this potential relationship and to identify medications that will reduce anxiety and depression without increasing the risk of suicide. We also must ensure that service members have proper physician supervision in theater and on returning from combat.

The Army and the Marine Corps have instituted leadership training and are using social media and peer involvement to educate troops on suicide risk factors and signs. This is a positive step.

In the past 3 years, Congress has appropriated funds for the VA to establish and maintain readjustment counseling centers, known as Vet Centers, in every state. North Carolina is fortunate to have 6 such facilities that focus on readjustment counseling for veterans with PTSD. These centers also offer postdeployment health screening for active-duty personnel who prefer not to seek assistance at a military treatment facility or at a civilian facility via the TRICARE network. In addition to Vet Centers, there are 4 medical centers, 4 VA outpatient clinics, and 8 community-based outpatient clinics in North Carolina that deliver on-site treatment for substance abuse and behavioral illness. These facilities may also contract with partner providers in the community.

VA Telehealth Initiatives

We are pleased that the VA is exploring ways to reach veterans who live in remote areas or are isolated because of physical or emotional reasons. The VA operates one of the largest tele-mental health programs in the world, with devices that connect veterans with practitioners. There are plans to establish real-time clinical videoconferencing systems to deliver services between VA medical centers and community-based outpatient clinics. Since 2008, tele-mental health programs have facilitated more than 45,000 video-based health encounters and more than 5,000 home tele-mental health encounters each year [9]. As the younger, technologically savvy generation of veterans becomes part of the VA's network, the potential for this particular approach to health care delivery will need to be expanded and refined.

Care and Resources for Families of Military Personnel

Because the needs of military families have become more complex, all volunteer spouse-led groups that are connected to each unit are now supported by a family-readiness officer, a family-assistance coordinator, or a family-readiness assistant. We have heard positive responses from military families about this. These staff are full-time employees who are

often retired military members and live in the local community. They serve as the coordinator for family readiness, linking and integrating resources available to family members. The Army and the Marine Corps have increased the number of these coordinators to meet the increased demand for their services.

Deployments can take a heavy toll on families [10]. The most vulnerable individuals are obviously children and adolescents [11]. Younger children may not comprehend why a parent must leave on deployment. Older children and adolescents are forced to cope with parental deployment during important social and emotional developmental stages in their lives [12]. Behavioral problems and difficulties with academic engagement worsen with increasing age among children coping with parental military deployments [13]. Additionally, girls tend to experience more difficulties during parental deployment than do boys [13]. More research must be completed to determine how behavioral health conditions such as TBI and PTSD among parents might impact their children and families [11].

Despite the implementation of programs across the defense and civilian sectors to support military families coping with deployments, assessment of the effectiveness of these programs is insufficient [11]. Congressional oversight is needed to determine whether existing programs are meeting the needs of military families. This will lead to effective policies geared toward helping military families cope with deployments. Additionally, more research focused on deployment and reintegration challenges among children is needed [11].

Conclusion

Our service members form the most resilient fighting force in the world. However, the prolonged wars, extended deployments, shorter dwell times, and high operational tempo have created a more stressful environment for service members and their families. The effects of invisible wounds are just beginning to emerge, and the long-term impacts of such wounds are unknown [14]. Service members need adequate time to recover and restore total fitness and balance, or psychological stressors will continue to negatively impact their behavioral health and the health of their families [2].

Increased research on military suicide, substance abuse, TBI, and PTSD is necessary to ensure that behavioral health programs meet the emerging needs of military service members, veterans, and their families. Nongovernmental organizations, commercial health care providers, and nonprofit veterans' advocacy groups also play an important role by facilitating effective grassroots solutions. We hope that professional and community organizations will increase their understanding of the unique challenges service members, veterans, and their families face in the realm of behavioral health. NCMJ

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Acknowledgments

Potential conflicts of interest. R.B. and K.H. have no relevant conflicts of interest.

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