Recommendations to Strengthen Mental Health Services for Military Service Members, Veterans, and Their Families

The current conflicts in Iraq and Afghanistan are affecting the mental and emotional health of military personnel and their families. A large number of soldiers are returning from Iraq and Afghanistan who have significant mental health issues (Hoge, Auchterlonie, and Milliken, 2006 and Seal, Bertenthal, Miner, Sen, and Marmar, 2007). The capacity of the Department of Veterans Affairs (VA) to meet the mental health, housing, and vocational rehabilitation and employment needs of all veterans has been stretched significantly. A large number of individuals serving in the reserve components and National Guard are being deployed (Defense Science Board Task Force on Deployment of Members of the National Guard and Reserve in the Global War on Terrorism, 2007). Deployment is a stressful time for all families, but may be particularly difficult for families in the reserve components and National Guard. Children experience various emotional and behavioral problems when parents are deployed (American Psychological Association Presidential Task Force on Military Deployment Services for Youth, Families, and Service Members, 2007). Families of soldiers serving in the reserve components and National Guard are not well connected to traditional military family support structures, which help with the stresses of deployment (National Military Family Association, 2005).

Strengthening mental health prevention and early intervention services for soldiers currently serving in the military may reduce the demand placed upon the VA once these soldiers are discharged. Building partnerships between the federal, state, and local governments to expand service capacity may ensure veterans who have a significant mental health issue and need mental health treatment, permanent supportive housing, and/or vocational rehabilitation and employment services receive those services in a timely manner. Reducing eligibility and enrollment barriers may increase the number of veterans who receive needed mental health, housing, and vocational rehabilitation and employment services. Strengthening family support networks for families in the reserve components and National Guard may reduce the stress associated with deployment. The following recommendations are intended to promote these three goals.

Goal 1 – Strengthen Prevention and Early Intervention Services

The mental health issues that veterans experience often begin with exposure to traumatic events while deployed. Access to prevention and early intervention services while deployed is a critical part of building resilience and reducing the development of significant mental health issues after returning from deployment. However, there are a number of barriers to accessing prevention and early intervention services prior to deployment, while deployed and after deployment. These barriers include stigma, a lack of periodic mental health assessments, and

availability of specialized mental health providers (Department of Defense Task Force on Mental Health, 2007).

There is overwhelming evidence that stigma about mental illness exists in the military and is a barrier to seeking treatment. Military leaders need to provide a consistent message that building and maintaining resilience through early and assertive intervention is critical to the health of service members and their families and to force readiness. To accomplish this, the California Mental Health Planning Council supports the following recommendations developed by the Department of Defense Task Force on Mental Health (Department of Defense Task Force on Mental Health, 2007).

> ***Recommendation 1.1 – The Department of Defense should develop and implement a core curricula on psychological health as an integral part of all levels of leadership training***
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> ***Recommendation 1.2 – The Department of Defense should develop and implement Department of Defense-wide core curricula on psychological health for family members and market those materials to all family members***
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> ***Recommendation 1.3 – The Department of Defense should develop and implement a department-wide core curriculum to train all medical staff on recognizing and responding to service members and family members in distress***
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> ***Recommendation 1.4 – The Department of Defense should develop and implement a Department-wide core curriculum to train all mental health personnel on current and emerging clinical practice guidelines[1]***
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> ***Recommendation 1.5 - The Department of Defense should implement an anti-stigma public education campaign, using evidence-based techniques to provide factual information about mental illness***

The military currently offers military personnel and their family members' access to a number of mental health assessments. The military currently requires soldiers to receive a periodic health assessment. A periodic health assessment is an annual process that is intended to identify and treat physical and mental health concerns prior to deployment. However, this has not been fully implemented. Soldiers also receive a health assessment prior to deployment (pre-deployment health assessment) after deployment (post-deployment health assessment) and 90-180 days after returning from combat (post-deployment health reassessment). These health assessments offer soldiers an opportunity

[1] The core curriculum should address current and emerging clinical practices that are culturally and linguistically competent.

to self report mental health concerns that might require a more comprehensive assessment. Critics argue that soldiers are not likely to respond honestly on the pre-deployment and post-deployment health assessments because prior to deployment soldiers are anxious to deploy and post-deployment soldiers are anxious to see their families. Identifying possible mental health concerns might delay their deployment or their return home to see their families. Consequently, these assessments may not be identifying a number of soldiers who would benefit from early intervention services. A large percentage of the soldiers who are referred for a mental health issue following the post-deployment health assessment are not seen within 90 days (Hoge, Auchterlonie, and Millikin, 2006). To improve the identification of soldiers who may need mental health services and improve their access to specialty mental health services, the California Mental Health Planning Council supports the following recommendations developed by the Department of Defense Task Force on Mental Health (Department of Defense Task Force on Mental Health, 2007).

> ***Recommendation 1.6 – Each service member should undergo an annual psychological needs assessment addressing cognition, psychological functioning, and overall psychological readiness. The assessment should be conducted in a setting that allows interpretation by a trained professional and prompt referral to a credentialed mental health provider, with a person to person handoff[2]***
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> ***Recommendation 1.7 – The Department of Defense should establish clear policies and procedures assuring privacy during all mental health assessments and have mental health professionals accessible at assessment locations***
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> ***Recommendation 1.8 – The items on the pre-deployment health assessment, post-deployment health assessment, and post-deployment health reassessment should be coordinated to ensure maximum reliability and validity***

The availability of specialized mental health providers is also a barrier to soldiers accessing mental health services when needed. The military offers mental health services through specialty clinics that are isolated. Stigma may prevent soldiers who need mental health care from seeking care from those clinics. Specialty mental health providers need to be available in more normalized settings. To make specialty mental health providers more widely available to soldiers prior to deployment, while deployed, and after deployment, the California Mental Health Planning Council supports the following recommendations of the Department of Defense Task Force on Mental Health (Department of Defense Task Force on Mental Health, 2007).

[2] These services may be provided by any qualified mental health professional such as licensed clinical social workers and marriage and family therapists.

Recommendation 1.9 – The military should embed mental health professionals as organic assets in line units or make consultative mental health professionals available to line units

Recommendation 1.10 – The military services should integrate mental health professionals into primary care setting

If soldiers receive better mental health treatment while in the military, fewer are likely to develop significant mental health issues after they separate from the military. However, a number of veterans will continue to need mental health services. Most veterans are eligible to receive mental health services from the Department of Veterans Affairs. However, there are a number of barriers veterans might experience that prevent them from receiving the mental health services they need. These barriers include discharge status and the capacity of the Department of Veterans Affairs health care system to respond to the mental health needs of all veterans.

Goal 2: Build Federal, State and Local Partnerships

The VA's capacity to meet the mental health, housing, and vocational rehabilitation and employment needs of veterans who have significant mental health issues and their family members has been stretched significantly. California's state and local governments also provide mental health, housing, and vocational rehabilitation and employment services and may serve veterans. Building partnerships between these federal, state, and local governments may expand the capacity to meet the service needs of veterans and their family members.

California's county mental health departments should be important partners in meeting the mental health service needs of veterans and their family members. One approach to building this partnership is for county mental health departments to ensure that veterans and veterans service agencies are included as stakeholders in Mental Health Services Act community planning processes. The MHSA requires county mental health departments to implement a community planning process to inform their development of MHSA three-year expenditure plans. The community planning process is expected to include involvement of clients who have a serious mental illness or serious emotional disturbance and the participation of stakeholders, particularly those from un-served and under-served populations. Veterans have not historically been considered stakeholders of California's public mental health system because they could have health insurance through the Department of Veterans Affairs. Recent experience indicates that some veterans are seeking mental health services from county mental health providers rather than the VA. Recent legislation has clarified that veterans are part of the target population that county

mental health departments serve (Chapter 221, 2005 and Chapter 618, 2006). For that reason, veterans should be involved in MHSA local planning processes.

> ***Recommendation 2.1 – The Mental Health Services Oversight and Accountability Commission and Department of Mental Health should explicitly identify veterans as stakeholders in the community planning process when it releases the county guidelines for the next three year expenditure plan.***

In addition to clarifying that veterans are part of the target population that county mental health departments serve, Chapter 221, 2005 required county mental health departments to refer veterans to the county veterans service officer for assistance accessing VA benefits. County veterans service officers are an important resource for veterans to navigate the complex VA benefits system. Chapter 221 has helped to promote a partnership between county mental health departments and veterans service officers. These partnerships should continue to be developed and strengthened.

> **Recommendation 2.2 – County mental health departments should develop and strengthen referral mechanisms to the county veterans service officer to ensure that veterans are able to access needed VA benefits, including mental health care.**

In addition to strengthening partnerships with the county veterans service officer, county mental health departments may build stronger partnerships with the VA Health Care Systems that serve veterans in California. Some veterans may not be able to access mental health services from the VA because of limited capacity or may not want to seek mental health services from the VA for reasons such as stigma or personal preference. For example, research has indicated that veterans living in rural areas do not have easy access to VA facilities and thus services (Wallace, Weeks, Wang, Lee, and Kazis, 2006). To build its capacity to better meet the mental health service needs of veterans in Western Montana, the Montana Health Care System contracted with the Western Montana Mental Health Center (Mental Health Weekly, 2007).

> ***Recommendation 2.3 – The VA Health Care Systems operating in California (i.e., Central California, Loma Linda, Long Beach, Greater Los Angeles, Northern California, Palo Alto, and San Diego) should consider the option of contracting with county mental health departments within their service areas to provide mental health treatment to eligible veterans.***

> ***Recommendation 2.4 – The United States Congress should appropriate sufficient resources for the Veterans Health Administration to build the capacity to ensure eligible veterans are able to access the mental health services they need.***

Stronger partnerships between county mental health departments, community-based veterans services agencies and the VA Health Care Systems in California might increase access to permanent supportive housing for veterans who are homeless and have a significant mental health issue. Permanent supportive housing is an effective model for assisting homeless individuals, including homeless veterans, to make the transition from homelessness to independent living. A number of federal and state programs are available that provide permanent supportive housing to individuals who are homeless and have a serious mental illness. For example, the HUD-VA Supportive Housing program targets veterans who have a serious mental illness and or substance abuse disorder. The VA Health Care Systems refer homeless veterans to supportive housing under this program. Other organizations, including veteran's services agencies, offer veterans permanent supportive housing through other federal programs, such as the Department of Housing and Urban Development's Shelter Plus Care and Supportive Housing Program. Some veterans may also be accessing supportive housing through state funded programs, such as Proposition 1C supportive housing. Even with these programs, there is not enough permanent supportive housing for veterans living in California.

The Mental Health Services Act (MHSA) Housing Program provides funding for capital costs and operating subsidies to establish permanent supportive housing for persons with a serious mental illness who are homeless or at risk of homelessness and meet the criteria for Community Services and Supports (CSS) in their county of residence. Veterans who have a significant mental health issue and are homeless may meet the eligibility criteria for Community Services and Supports in their county. Veterans who are otherwise eligible for the MHSA Housing Program should be able to access this permanent supportive housing.

> ***Recommendation 2.5 – County mental health departments should establish mechanisms through which community-based veteran's service agencies may refer veterans who are homeless and have a serious mental illness to MHSA Supportive Housing Programs, consistent with provisions of the MHSA.***
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> ***Recommendation 2.6 – County mental health departments should establish mechanisms through which the United States Department of Veterans Affairs Homeless Coordinators may refer veterans who are homeless and have a serious mental illness to MHSA Supportive Housing Programs.***

Finally, building a partnership between the Veterans Benefits Administration and the California Department of Rehabilitation may strengthen the delivery of vocational rehabilitation and employment services for veterans who have a serious mental illness and other disabilities. The Vocational Rehabilitation and Employment services are coordinated through VBA regional offices. VBA

regional offices are located in the following California cities: Los Angeles, Oakland, and San Diego. The Vocational Rehabilitation and Employment Task Force recommended in its 2004 report that the regional offices develop partnerships with state Departments of Rehabilitation to improve the delivery of vocational rehabilitation and employment services. At that time, the Task Force recommended that the VBA establish a pilot program in Alabama (VA Vocational Rehabilitation and Employment Task Force, 2004).

> ***Recommendation 2.7 – The Veterans Benefits Administration should establish a partnership between the regional offices in Los Angeles, Oakland, and San Diego and the California Department of Rehabilitation to better provide vocational rehabilitation and employment services to veterans who have a serious mental illness and other disabilities.***

Goal 3: Reducing Eligibility and Enrollment Barriers

Some veterans who have significant mental health issues may not be able to access services through the VA because of eligibility and enrollment barriers. Veterans who have received a discharge under dishonorable conditions are not eligible for VA health benefits or vocational rehabilitation and employment services. The complexity of the enrollment priority groups the Veterans Health Administration uses may also be a barrier to enrollment for veterans who are eligible for health care benefits.

Veterans who are discharged from the military under dishonorable conditions are not eligible to receive health and vocational rehabilitation and employment services from the United States Department of Veterans Affairs. This includes some soldiers who have trauma-induced mental health issues, such as post-traumatic stress disorder and traumatic brain injury. Soldiers who have these mental health problems often exhibit behavior that leads to disciplinary action. Unfortunately, the behavior is the result of the trauma induced mental health issues developed while deployed. These soldiers should not be discharged under dishonorable conditions and should remain eligible to receive mental health and vocational rehabilitation and employment services from the United States Department of Veterans Affairs for conditions that were developed or exacerbated while deployed.

> ***Recommendation 3.1 – The Department of Defense should carefully assess a soldier's exposure to conditions potentially resulting in post-traumatic stress disorder, traumatic brain injury, or related diagnoses during administrative and disciplinary proceedings (Department of Defense Task Force on Mental Health, 2007).***

> ***Recommendation 3.2 – The Department of Defense should establish policies that prevent an individual from being discharged under***

dishonorable conditions when his/her misconduct is related to a mental health condition.

Some veterans who are eligible to enroll in the Department of Veterans Affairs health care system may not because of the complexity of the enrollment priority groups. The Veterans Health Administration assigns eligible veterans to one of a number of enrollment priority groups based upon a complex set of criteria. These priority groups are used to help the Veterans Health Administration manage the provision of health and mental health services. For example, President Bush recently issued an Executive Order making some veterans who meet certain income thresholds ineligible to enroll in the VA Health Care System and receive health benefits. The complexity of these priority groups appears to be a barrier to enrolling in the Veterans Health Administration and accessing needed services.

Recommendation 3.3 – The Veterans Health Administration should revise its enrollment priority groups and processes based upon the principle that veterans should be able to enroll and access services quickly and efficiently.

Some veterans who receive disability compensation for a serious mental illness do not qualify for state funded supportive housing through the Department of Housing and Community Development's supportive housing program. To be eligible for supportive housing through HCD, an individual must be homeless or at risk of homelessness. An individual is not considered at risk of homelessness when he has income in excess of 30% of the greater of state median income or area median income. An individual who receives disability compensation with a 100% disability rating would not qualify for supportive housing in any county in California.

Recommendation 3.4. – The California Department of Housing and Community Development should modify its definition for supportive housing programs of "at risk of homelessness" to include individuals, including veterans, whose income does not exceed 50% of the greater of state median income or area median income.

Goal 4 – Strengthen Family Support Networks for Families of Veterans, Reserve and National Guard Service Members

The family members of soldiers who are deployed to combat situations experience significant stress during all phases of a soldier's deployment. Some children exhibit emotional and behavioral problems. Some soldiers return from deployment with a significant mental health issues, such as post-traumatic stress disorder, depression and anxiety. These changes in behavior are part of the stresses associated with deployment.

Resilience is an important factor in a family's ability to cope with the stresses associated with a loved one who is deployed. Family readiness is considered to be a key factor in resilience. Family members of the individuals serving in the reserve components and National Guard are often isolated from the traditional military family support structure (National Military Family Association, 2005).

In California, the Department of Mental Health funds organizations that support and advocate for families who have children and other family members with a serious emotional disturbance or serious mental illness. The Department might fund these organizations to build family support networks for veteran and military families in the reserve components and National Guard.

Recommendation 4.1 – The Department of Mental Health should work with the family support organizations it funds to connect family members of veterans and reserve and National Guard service members with existing family support networks.

References

American Psychological Association Presidential Task Force on Military Deployment Services for Youth, Families, and Service Members, *Psychological Needs of U.S. Military Service Members and Their Families: A Preliminary Report*, February 2007.

Defense Science Board Task Force on Deployment of Members of the National Guard and Reserve in the Global War on Terrorism, September 2007

Department of Defense Task Force on Mental Health, *An Achievable Vision: Report of the Department of Defense Task Force on Mental Health*, Falls Church, VA Defense Health Board, June 2007.

Hoge, Charles W, MD; Auchterlonie, Jennifer L, MS; and Milliken, Charles S, MD, "Mental Health Problems, Use of Mental Health Services, and Attrition From Military Service After Returning From Deployment to Iraq and Afghanistan," *Journal of the American Medical Association,* 295 (9): 1023-1032, 2006.

Seal, Karen H. MD, MPH; Bertenthal, Daniel, MPH; Miner, Christian R., PhD; Sen, Saunak, PhD; Marmar, Charles, MD, "Bringing the War Back Home: Mental Health Disorder Among 103,788 US Veterans Returning from Iraq and Afghanistan Seen at Department of Veterans Affairs Facilities," *Archives of Internal Medicine*, 167 (5): 476-482, 2007

Mental Health Weekly, "CMHCs partner with local VA systems to address MH needs of veterans", 17(21), Wiley Periodicals, Inc, May 28, 2007.

National Military Family Association, *Cycles of Deployment: An Analysis of Survey Responses From April Through September 2005*, 2005.

VA Vocational Rehabilitation and Employment Task Force, *Report to the Secretary of Veterans Affairs: The Vocational Rehabilitation and Employment Program for the 21st Century Veterans,* March 2004.

Wallace, Amy E., MD, MPH; Weeks, William B, MD, MBA; Wang, Stanley, MS; Austin, Lee F, PhD; and Lewis, Kazis E., Sc,D, "Rural and Urban Disparities in Health-Related Quality of Life Among Veterans with Psychiatric Disorders," *Psychiatric Services*, 57(6): 851-856, June 2006.