

Serving Those Who Have Served: *Educational Needs of Health Care Providers Working with Military Members, Veterans, and their Families*

A Web Survey of Mental Health
and Primary Care Professionals

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DoD photo by Cherie Cullen



DoD photo by Cpl. Reece Lodder,
U.S. Marine Corps.



The September 11, 2001 terrorist attacks on the World Trade Center in New York City and the Pentagon set in motion the longest military conflicts in our nation's history. In a recent editorial in the *Journal of the American Medical Association*, Charles Hoge (2011) documents the toll the conflicts in Afghanistan and Iraq have taken on the mental and physical health of those who have served and their families. Many of those who have served are still in the active duty Armed Forces, National Guard, or Reserves, whereas others have completed their military service and are now veterans.

The men and women who have served in this conflict have family members who are concerned about their safety when they deploy. Family members also have concerns about the well-being and adjustment of their relatives when they return home. The stressful impact of these conflicts upon both those who have served and their families has been magnified by several factors, including the long duration of the conflict, the extensive use of the National Guard and Reserves, extended tours of duty, and multiple deployments.

Our nation has made a major commitment to address the physical and mental health needs of those who have served in Iraq and Afghanistan and their families. Two signature injuries of these conflicts are posttraumatic stress disorder (PTSD) and traumatic brain injury (TBI). An illustration of the nation's commitment to improving mental health care is that the Department of Veterans Affairs (VA) has added approximately 5000 new mental health professionals to its staff and mandated that all veterans treated for PTSD have access to treatments with the highest level of empirical support. The VA and the Department of Defense (DoD) have also implemented numerous screening, outreach, and treatment programs designed to serve those who have served and their families.

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However, Hoge (2011) notes that these efforts to identify those who need PTSD treatment and get them access to effective treatment have been only partially successful. Among the key barriers he identifies: ineligibility for services, reluctance to seek treatment at VA or DoD facilities, treatment dropout, and failure of treatment providers to understand key aspects of the military culture that influence both the clinical picture of PTSD and service members' willingness to seek treatment. Hoge argues that the DoD and VA alone cannot address these unmet service needs and that "meeting veterans where they are" is essential in both an existential and geographical sense. From an eligibility perspective, not all veterans are eligible for PTSD treatment services at VA health care facilities, and members of the National Guard and Reserves are generally not eligible for treatment at DoD facilities unless they are in active duty status. In addition, even if they are eligible for treatment, many individuals may not live near a DoD or VA hospital or outpatient facility. For family members of service members and veterans, access to services is more complex. Although the VA system is loosening restrictions about providing services to family members, priority is still given to veterans. Family members of active duty service members are eligible for coverage through TRICARE, a form of subsidized health care insurance for military dependents and retirees, but may not necessarily be seen in a military treatment facility. For all of these reasons, it is clear that many of those who have served and their families receive their health care from providers in the private sector—not from those in DoD or VA facilities.

Meeting veterans where they are is much more than providing access to nearby care. According to Hoge, it is also essential for treatment providers to understand aspects of military and combat culture that help those who have served feel understood by providers who are attempting to care for them. The military has a unique culture developed through rigorous training and maintained by a strong sense of membership in an elite group of well-trained professionals. Their experiences are difficult to understand by those who are not part of the profession. Hoge also describes how

important it is for treatment providers to understand how some behaviors and physical reactions that are considered symptoms in civilian life are actually adaptive in combat situations (e.g. being extremely vigilant in dangerous situations is adaptive, but it becomes the PTSD symptom of hypervigilance if it persists in non-dangerous situations). Thus, "meeting veterans where they are" requires that we understand their culture, their profession, and how their "work experiences" and culture have influenced their view of their problems, why they might be reluctant to seek treatment, and the clinical presentation of their symptoms.

Not all, and perhaps not even most, PTSD assessment and treatment is provided by mental health providers, so the role of primary care professionals in serving those who have served and their families is important. This is true in the DoD and VA health care delivery systems, but it is particularly true for those who are treated in the private sector. Therefore, it is important to include primary care as well as mental health providers in any efforts to expand access to assessment and treatment services. Primary care providers perform an important gate keeping function for the health care system and are well-positioned to screen for potential problems among those who have served and their family members. They also can make referrals to mental health providers with special expertise in PTSD treatment. Some mental health providers have this expertise, but many do not.

The VA has developed several initiatives designed to engage private sector primary care and mental health providers in the assessment and treatment of veterans, particularly those who reside in rural areas. However, it is unclear how many private sector providers are willing to collaborate in these initiatives or might be willing to participate if they were provided with information and training. Nor do we know much about the type of information and trainings providers want or need, or the ways in which they would prefer to receive the information. Such knowledge would be extremely useful to those developing educational and training materials and to those involved in these VA rural initiatives.

Overview of Project Methodology

This project was designed to gather information from a large, diverse group of primary care and mental health care providers who were predominately from the private sector. A web-based survey was designed and conducted by the Medical University of South Carolina (MUSC) with funding from the VA's Office of Rural Health through the VISN-6 Rural Health Initiative. The basic strategy was to obtain several lists of primary care and mental health professionals and send them an invitation to participate in a brief web survey (see Appendix A). The invitation included a description of what the survey was about, stated that no compensation was involved and that the survey would take approximately 10 minutes to complete, and provided a link at which the survey was located. The survey was constructed using the REDCap platform, and it included information about the following topics:

- Type of specialty and nature of practice
- Whether practice accepts TRICARE
- Prior or current service in the Armed Services, National Guard, or Reserves
- Prior training or employment at VAMC
- Percent of patient panel who are former or current members of Armed Forces
- Practices regarding screening of patients for current/former members of the Armed Forces and their families
- Opinions about quality of care provided by the DoD and VA
- Knowledge about eligibility requirements for veterans and Reservists to receive VA care and willingness to refer patients to the VA
- Extent to which providers thought they were knowledgeable about, and confident in, their ability to use best practice treatments for relevant conditions
- Providers' interest in training topics and modalities

In addition, providers were given the opportunity to provide open ended responses to questions about factors determining their use of educational materials and types of training resources that would be most helpful.

Survey Findings

Participation Rate: Of the 327 providers who accessed the survey, 97.6% (n=319) agreed to participate. There is no way to determine how many potential providers were informed about the study because numerous invitations were sent out by multiple organizations, so we cannot determine how many unique individuals received invitations. However, it is clear that the vast majority of those who visited the survey site agreed to participate.

Description of Provider Sample: As illustrated in TABLE 1, approximately two-thirds of providers were mental health professionals, and the remainder identified themselves as primary care providers or other professionals. Among mental health professionals, psychologists were the most prevalent group, followed by psychiatrists, and social workers/other mental health professionals. The most prevalent type of primary care specialty among providers was family medicine, followed by pediatrics and internal medicine.



“I moved to NC because my son called from Afghanistan, saying, ‘My guys have seen too much, please come down here.’ It is what I came here to do. I want to do it the best way.”

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Table 1 Overview of Provider sample

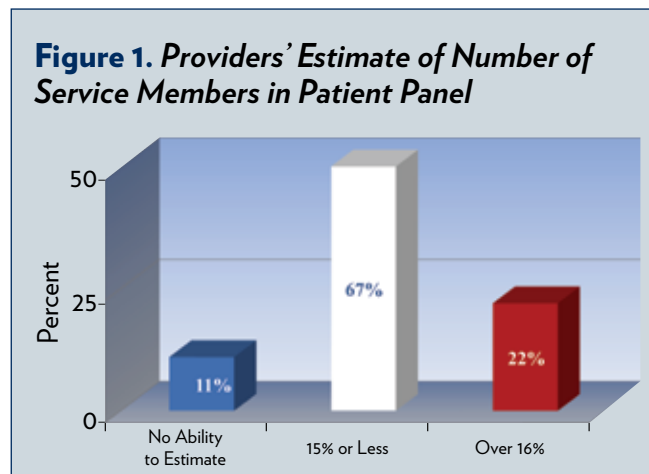
<i>Type of Provider</i>		
Mental Health Professional		67%
Psychologist	32%	
Psychiatrist	19%	
Social Worker/Other	16%	
Primary Care		27%
Family Medicine	17%	
Pediatrics	7%	
Internal Medicine	3%	
Other Professional		6%
<i>Type of Practice Setting</i>		
Private Practice		49%
Clinic Based		39%
Hospital		12%
<i>Rural Practice?</i>		
Yes		34%
No		60%
Not Sure		6%
<i>Ever Serve in the Armed Forces?</i>		
Yes		16%
No		84%
<i>Ever Trained in VA?</i>		
Yes		31%
No		69%

Among providers, almost half (48.1%) stated that the setting in which they worked was a private practice. Another 38% worked in a clinic-based practice, and 12% worked in a hospital setting. When asked whether they would describe their practice as rural, approximately one third of providers said yes (34%), 60% said no, and the remaining 6% were not sure. Over half (59%) of providers stated that their practice accepted TRICARE for reimbursement, and 28% said no. Interestingly, 13% of providers did not know whether their practice accepted TRICARE, suggesting a need for more education about this important reimbursement source.

Providers' Experience with the Armed Forces and VA.

In light of Hoge's comments about the importance of military culture, we thought that it was important to determine if providers had served in the Armed Forces and about whether they completed any of their professional training at the VA.

- Only one out of six (16%) providers stated that they had ever served in the Armed Forces including the Reserves or National Guard
- Approximately one third (33%) of the providers had completed some part of their training in a VA hospital
- Only one out of eight (12%) have ever been employed as a health professional in the VA system



These findings suggest that most providers in our survey had no direct military experience themselves. Also, most providers also lacked training or working experiences at the VA that could have provided them with information about veterans and military culture.

Knowledge of Members of Armed Forces, Veterans, and Family Members in Patient Panels.

Providers were asked what percentage of their patient panels was either a current or former member of the Armed Forces (see Figure 1).

- Approximately two-thirds said between 0-15%
- Just under 1 in 5 said between 16-50%
- 5% said over 50%
- 11% indicated that they had no ability to estimate

When asked the percentage of their panel who were family members of current or former members of the Armed Forces (see Figure 2).

- 31% said they had no ability to estimate
- 39% said 15% or less
- 27% said between 16-50%
- 3% said over 50%

Respondents were also asked if they regularly screened their patients to determine if they were a current or former member of the Armed Forces or a family member of such a person (see Figure 3).

- Almost half of providers (47%) said they did not screen
- 44% said they did screen
- 9% said it was not necessary to screen because they knew their patients quite well

From these responses, it is clear that systematic screening for military or veterans status was not the norm among these providers. Many did not know the proportion of their case loads who were either current or former members of the armed forces or family members of the same. This suggests that implementing some type of brief screening would improve recognition.

“I probably have a significant number of former service members that I’m unaware of.”

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Figure 2. Providers' Estimate of Number of Family Members in Patient Panel

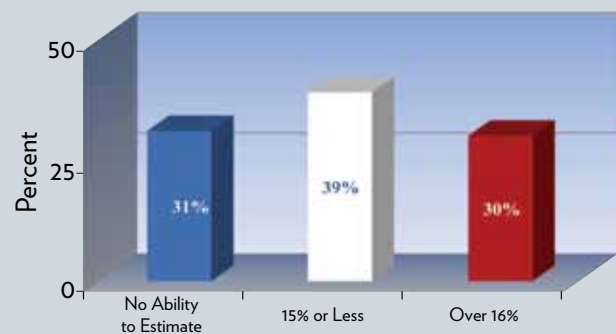
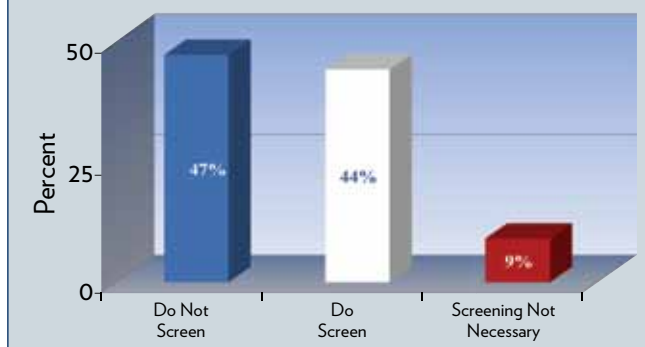


Figure 3. Providers' Screening for Military Experience



“I do what I do without any idea of what the DoD/VA team is up to. My role is second guessing and advising the patient what to ask for and what to watch out for.”

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Distance of Practice from Nearest VA and DoD Health Care Facility

One question of interest was whether providers’ practices were located near VA or DoD health care facilities. Although providers who are in close proximity to VA or DoD facilities still have a valuable role to play, those whose practices are more distant from VA or DoD facilities are better situated to serve those who lack ready access to a VA or DoD facility.

When asked how far away their practice was from the nearest VA medical facility:

- 3% said not sure
- 3% said over 2 hours
- 50% said between 30 minutes and 2 hours
- 44% said less than 30 minutes

When asked how far their practice was from the nearest DoD medical facility:

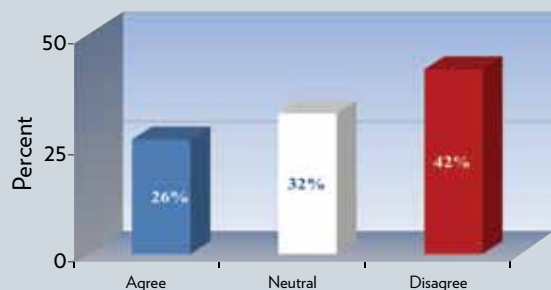
- 17% said not sure
- 27% said over 2 hours
- 49% said between 30 minutes and 2 hours
- 7% said less than 30 minutes

Two interesting findings emerge from these responses. First, VA facilities tend to be located closer to the practices of these providers than DoD facilities. Second, most of these providers indicate that their practices are more than thirty minutes away from VA or DoD health care facilities. This indicates that most of these providers were practicing in a location that was not adjacent to VA or DoD health care facilities.

Attitudes about VA and DoD Health Care Services:

It is reasonable to assume that providers have attitudes and opinions about VA and DoD health care systems and the quality of care delivered within these systems that influence their

Figure 4. VA healthcare system does an adequate job of meeting the medical and mental health needs of Veterans and returning Reservists (N=317)



willingness to collaborate with health care professionals within these systems. Likewise, such attitudes and opinions may also influence willingness to provide care. Therefore, the survey included several questions designed to measure relevant attitudes and opinions. The format of these questions involved presenting a series of statements and asking respondents to the extent to which they agreed with the statement.

The first statement was “The VA healthcare system does an adequate job meeting the medical and mental health needs of veterans and returning Reservists.” As illustrated in Figure 4, more than 4 out of 10 respondents did not agree that VA healthcare system meets these needs, and almost one-third of respondents were neutral in their assessment. Slightly more than one quarter of respondents agreed that VA is doing an adequate job meeting medical and mental health needs.

The second statement was “Active duty members of the Armed Forces receive adequate medical and mental health services from providers within the DoD health system.” As Figure 5 indicates, respondents had mixed opinions about the adequacy of care provided within the DoD system.

- Most were neutral and said that they neither agreed nor disagreed with the statement.
- Slightly more than one in four providers agreed that members of the Armed Forces received adequate care from the DoD.
- Over a third of the practitioners disagreed that adequate care was provided at DoD facilities.

The third statement assessed opinions about whether “VA health care system provides high quality medical and mental health care.” Figure 6 illustrates the responses to this statement.

- Approximately a third of providers were neutral in their assessment.
- Only one provider in five disagreed with the statement.

Another statement addressed whether “My concerns about the quality of service provided in VA facilities make me hesitant to refer eligible patients to VA for medical and mental health care services.” As Figure 7 indicates:

- Almost half of providers disagreed with this statement, indicating that they are not hesitant about making such referrals.
- About a third of providers had neutral opinions about this statement.
- Almost one in five providers agreed with the statement, indicating that their concerns about the quality of services at VA resulted in their reluctance to refer patients to the VA.

These findings have implications for potential outreach efforts by VA and DoD. First, many providers already have reasonably favorable attitudes about VA and DoD health care systems and the quality of medical and mental health care that these systems provide. Second, attitudes about VA care appear to be somewhat more favorable than those about DoD care. Third, the fairly large percentage of providers who had neutral responses indicates that there is a major “target of opportunity” for educational outreach about VA and DoD health care systems. Providers with neutral opinions are providers who can be converted to advocates if they are provided with more information.

Figure 5. Active duty members of the Armed Forces receive adequate medical and mental health care services from providers within the DoD health system (N=316)

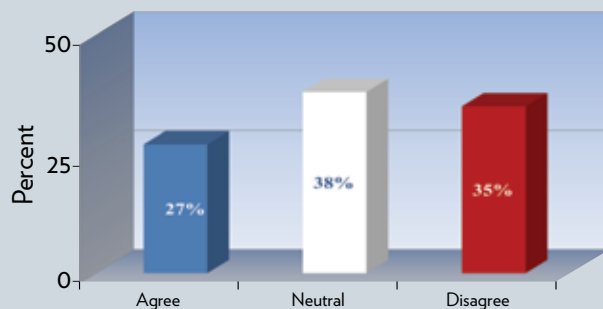


Figure 6. VA health care system provides high quality medical and mental health services (N=316)

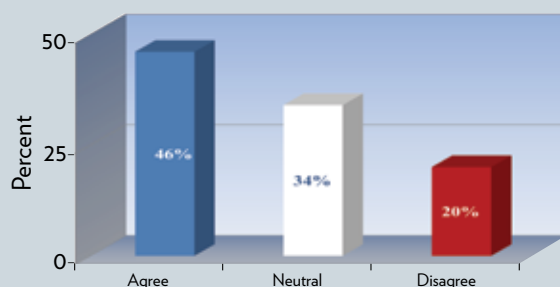
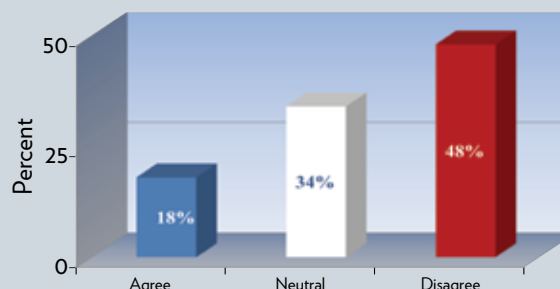


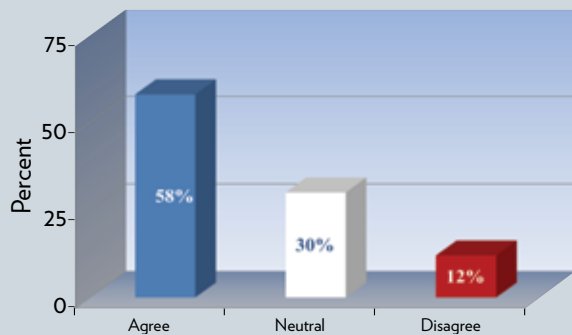
Figure 7. My concerns about the quality of service provided in VA facilities make me hesitant to refer eligible patients to the VA for medical or mental health care services (N=316)



Knowledge of Eligibility Requirements for VA Services, How to Make Referrals, Desire for More Information, and Referral Practices:

It is difficult for providers to make referrals to the VA health care system if they do not understand eligibility requirements to receive VA services. As inspection of Figure 8 indicates, practitioners were interested in increasing their knowledge about these eligibility requirements:

Figure 8. I would like to be more knowledgeable about the eligibility requirements for Veterans and Reservists to receive VA services (N=318)



- Over half of providers said they would like to be more knowledgeable about VA eligibility requirements.
- Just under one-third were neutral.
- Only 12% said they did not wish to become more knowledgeable.

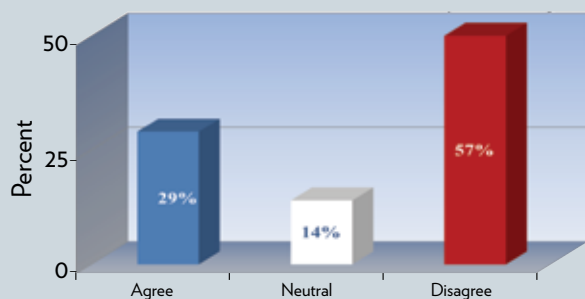
However as illustrated in Figure 9, most providers do not think they are knowledgeable about how to refer a Veteran for medical or mental health care at the VA:

- Fewer than one-third of providers said they were knowledgeable.
- Almost 6 out of 10 providers disagreed that they are knowledgeable.
- 14% were unsure.

Of the 93 providers who said they were knowledgeable about how to refer Veterans to the VA, over half (58%) said they sometimes made referrals to the VA. Only 13% said they never made referrals. Twenty-six percent said they made referrals often (13%) or very often (13%), and 3% said they were not sure about how frequently they made referrals.

Providers were asked the extent to which they agreed with the statement, “I am knowledgeable about support service in my community for family members of current and former members of the Armed Forces.”

Figure 9. I am knowledgeable about how to refer a Veteran for medical or mental health care services at the VA (N=317)



- Only 28% of providers agreed with this statement.
- Almost 6 out of 10 providers disagreed, indicating that they were not familiar with such community services.
- The remaining 15% neither agreed nor disagreed with the statement.

These findings indicate that many providers need increased education about VA eligibility requirements. Also, perhaps relatedly, many providers state that they do not refer all eligible patients to the VA. Finally, the majority of providers say that they are unfamiliar with support services for families, suggesting another potential educational need.

support services for families, suggesting another potential educational need.

Appropriateness of Screening for Stress of Being Part of a Military Family and of Applying Knowledge Gained in Civilian Treatment of PTSD and Depression when Treating Military Populations:

The vast majority (90%) of providers agreed that it is helpful to ask family members of current and former members of the Armed Forces about stressors related to being part of a military family. Only 1% disagreed, and 9% were neutral. This suggests that most providers think it is important to ask family members about these stressors.

Those who thought it was helpful to ask about military family stressors were asked how often they asked family members about such stressors.

- 23% said very often
- 27% said often
- 38% said sometimes
- 5% said never
- 7% were not sure

This indicates that only half of providers who think it is helpful to screen actually do so often or very often. An obvious question is why these providers do not screen, but the survey did not ask this follow-up question.

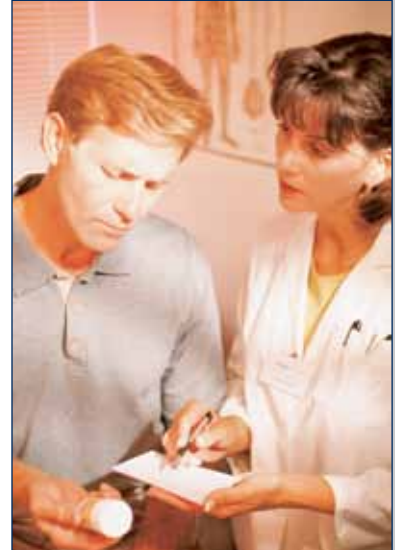
Another relevant question is whether providers think that knowledge and skills obtained by treating civilians can be applied to treating military populations. When asked whether they agreed that it was appropriate to apply knowledge about treating PTSD or depression in civilians to these treatment of these conditions in military populations:

- 62% said it was appropriate
- 13% said it was not appropriate
- 25% were neutral

These findings suggest that most providers believe that treatment expertise acquired in the civilian sector is applicable to treatment of conditions such as PTSD and depression among individuals from the military.

Knowledge About and Confidence In Best Practice Treatments for Conditions Among Current and Former Members of the Armed Forces.

Providing treatment services to current and former members of the Armed Forces is facilitated if providers are knowledgeable about best practice treatments and are confident in their ability to deliver them to current and former members of the Armed Forces. Therefore, the survey asked two questions about treatment of several conditions that are particularly relevant. The first set of questions asked providers how knowledgeable they were about the treatment of each condition. The second set of questions asked how confident they were



about treating each condition among current and former members of the Armed Forces.

Table 2 contains responses concerning knowledge about best practice treatments for these conditions. Major findings were:

- There were differences in knowledge of best practice treatment for different conditions.
- The conditions with the highest knowledge ratings were treatments for depression (61%), suicide (52%), and family stress and relationship problems (50%).
- Fewer than half of providers said they were knowledgeable about best practice treatments for PTSD (45%), substance abuse/dependence (42%), and TBI (24%).

Table 2 Knowledgeable About Best Practice Treatments for Relevant Conditions Among Current and Former Members of the Armed Forces

Knowledgeable About Best Practices In Treatment of:	Agree	Neutral	Disagree
PTSD	45%	17%	38%
TBI	24%	18%	58%
Depression	61%	20%	19%
Substance Abuse/Dependence	42%	21%	37%
Family Stress and Relationship Problems	50%	24%	26%
Suicide	52%	20%	28%

Table 3 provides information about the extent to which providers said they were confident in their ability to provide best practice treatments for these relevant conditions to current or former members of the Armed Services. As was the case for knowledge, providers were more likely to express confidence in their ability to use best practice treatments for some conditions than for others.

- Providers were most confident in their ability to treat depression, suicide, and family stress and relationship problems.
- Providers had less confidence in their ability to use best practice treatments for PTSD, substance abuse/dependence, and TBI.

Table 3 Confidence in Ability to Provide Best Practice Treatment for Relevant Conditions Among Current and Former Members of the Armed Forces

Confident in Ability to Deliver Best Practice Treatment for:	Agree	Neutral	Disagree
PTSD	41%	23%	46%
TBI	19%	22%	59%
Depression	64%	17%	19%
Substance Abuse/Dependence	39%	21%	40%
Family Stress and Relationship Problems	51%	24%	25%
Suicide	51%	20%	29%

PTSD and TBI have been described as the signature injuries of the current military conflicts, so it is noteworthy that providers were less knowledgeable about, and less confident in the use of, treatments for PTSD and TBI than for other conditions. This also suggests that an opportunity exists for increased education and training about treatments for these conditions. It may be that providers with greater knowledge about and confidence in their ability to provide treatment for major conditions affecting members of the Armed Services would be more likely to screen for past or current military status.

Topics Providers Would Like to Learn More About.

The next set of questions identified several topic areas and asked providers whether they would like to obtain more information. For each statement, respondents were asked if they agreed that they would like more information about the topic, if they disagreed, or if they were neutral. Providers' responses are summarized in Table 4. Major findings were:

- Over half of providers wanted more information about providing care to current or former members of the Armed Forces with legal troubles and to Veterans and Reservists with significant housing problems.
- Also, 8 out of 10 providers wanted more information about the medical and mental health problems of current and former members of the Armed Forces and their families.
- Almost three-fourths of providers wanted more information about the roles of women in the military and how that might impact their health.

Table 4 Providers' Interest in Obtaining Information About Relevant Topics

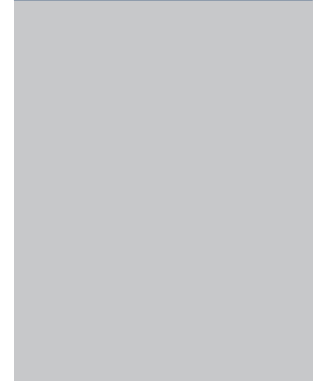
Interested in More Information About:	Agree	Neutral	Disagree
Roles women fulfill in the military and possible impact of these roles on women's health	72%	16%	12%
Providing care to current or former members of the Armed Forces who have gotten in trouble with the law	56%	20%	24%
Providing care to Veterans and returning Reservists who are homeless or who have significant housing problems	55%	21%	24%
Medical and mental health problems of current and former members of the Armed Forces and their families	79%	15%	6%

These findings indicate that most providers are interested in learning more about all of these topics. It is also noteworthy that very few providers state that they are not interested in learning about them. This suggests that providing information about each is likely to be received positively by providers.

When asked to respond to the statement, "Because of the demands on my time, learning about the health needs of veterans, service members, and their families is not a priority for me":

- Only 20% agreed with this statement.
- 29% were neutral
- 51% disagreed, indicating that they were open to learning more.

These findings indicate that even busy providers will make the time to learn more about the pressing problems of service members.



“Literally, I cannot afford financially to be away from my office for sick days, vacations, or extended holidays, let alone for training or other purposes.”

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Training Methods and Resources Identified by Providers as Being Most Useful for Increasing Knowledge.

Any training must consider not only the content of training that should be provided but also the way to provide information that would be most useful to providers. Therefore, the survey identified a number of potential training resources and asked providers which resources would be most useful in increasing their own knowledge about medical and mental health problems experienced by current and former members of the Armed Forces. Responses are compiled in Table 5. The most popular resources were:

- Web-based training courses
- Conferences or workshops
- One page informational handouts

The following resources were viewed as helpful by fewer providers:

- Telephone consultation with experts
- Pocket cards with symptoms
- Tri-fold brochures
- Teleconference (e.g., Skype) consultation with expert

Table 5 Which of the following types of resources would be most useful for increasing your own knowledge about medical and mental health problems experienced by current and former members of the armed forces? Identify all that apply

Educational Resource	Percent
Web-based training courses	63%
Conferences or workshops	62%
One page informational handouts	51%
Telephone consultation with expert	37%
Pocket cards listing symptoms or phone numbers	37%
Trifold brochures	34%
Teleconference (e.g., Skype consultation with expert)	21%
Other	5%

Most Important Factors in Determining Whether Providers Will Use Informational or Training Resource

Understanding factors related to training resource use is also important because it provides insights into the reasons providers do and do not avail themselves of training offerings. As detailed in Table 6, providers said the most important factors were:

- Convenience (e.g., distance from home, ease of access, flexibility of scheduling)
- Cost
- Ability to obtain CME or CE credits

Other factors were identified as important by fewer providers:

- Time away from practice
- Ability to get more referrals
- Receiving credentials for completing training

Based on these responses, it is clear that Web-based training courses have much to offer, particularly if they can be offered at low cost and provide CME or CE credits. They are convenient, do not require time away from one’s practice, can be provided at low or no cost, and can give CME and CE credits.



Table 6 What are the most important factors in determining whether you will use an informational or training resource? Identify all that apply

Factor	Percent
Convenience (e.g., distance from home, ease of access, flexible scheduling)	84%
Cost	68%
Ability to obtain CME or CE credits	65%
Time away from practice	46%
Ability to get more referrals of service members, veterans, Reservists, and their families	22%
Receive credential (e.g., certificate or accreditation) for completing training	20%
Other	3%



Comparisons of Rural and Non-Rural Providers.

One of the major objectives of the project was to identify characteristics, opinions, training needs, and training preferences of providers practicing in rural areas. We assumed that there would be many similarities between providers whether they practiced in rural areas or not, but we also know that there are particular challenges associated with practicing in rural areas. Therefore, we divided the sample into two groups based on rural vs non-rural practice location. For the purpose of the following analyses, 18 providers who were not sure whether their practice was rural were excluded, resulting in two groups: a) rural (n=107), and b) non-rural (n=188) providers. Next, we conducted a series of Chi Square analyses to determine if there were significant differences between the Rural (R) and Non-Rural (NR) groups with respect to their survey responses. Based on these analyses, we will focus on the survey responses that were significantly different between the two groups, but we will also describe the responses that were not significantly different.

- Providers in the R group were significantly more likely than those in the NR group to be primary care professionals (53% vs 14%) but less likely to be mental health professionals (44% vs 83%) Other professionals did not differ across the two groups (3% vs 3%).
- Type of practice differed significantly. Providers in the R group were more likely than those in the NR group to practice in clinics (51% vs 32%) and less likely to practice in hospitals (7% vs 15%) and private practice settings (42% vs 53%).
- Providers in the R group were more likely than those in the NR group to accept Tricare (73% vs 50%).
- There were no significant differences between the R and NR groups with respect to having served in the Armed Forces (20% vs 15%) or having done training in the VA (26% vs 35%). However, providers in the R group were significantly less likely than those in the NR group to have been a VA employee (6% vs 15%) and to have served on the clinical staff at the VA (4% vs 11%).
- There were no significant differences between the R and NR groups with respect to their estimates of the percentage of current or former members of the Armed Forces in their practice.
- When asked to estimate the percentage of family members of current or former members of the Armed Forces in their practice, there were significant differences between the R and NR groups. A larger percentage of the R group than the NR group estimated that under 50% of their patient load were family members (74% vs 62%), but a smaller percentage said they had no ability to estimate (24% vs 35%).
- A significantly smaller proportion of the R group than the NR group said they routinely screened their patients for military, veterans, and family member status (37% vs 47%).
- Not surprisingly, the nearest VA health care facility was significantly farther away from providers in the R group than in the NR group. For example, 57% of providers in the NR group said the nearest facility was less than 30 minutes away vs only 20% of providers in the R group.
- DoD health care facilities were also significantly more likely to be farther away from R group members than from NR groups. For example, 37% of the R group said the nearest such facility was more than 2 hours away in contrast to only 23% of the NR group.

- There were no significant differences between the two groups in attitudes about whether the VA and DoD meets mental health and medical needs, whether the VA provides high quality medical and mental health services, whether the provider wanted more information about eligibility for VA services, concerns making them hesitant to make a referral to the VA, knowing how to refer patients to the VA for services, and how frequently they made such referrals to the VA.
- There was no significant difference between R and NR group members with respect to how helpful they thought it was to ask family members about stressors related to being part of a military family, and how frequently they asked family members about military stress.

With respect to how knowledgeable they were about best practice treatments, there were few significant differences between rural and non-rural providers (see Table 7).

- Rural providers were more likely than non-rural providers to disagree that they were knowledgeable about best practice treatments for depression (26% vs 16%), substance abuse/dependence (26% vs 15%), and suicide (37% vs 24%).
- There were no significant differences among rural and non-rural providers in professed knowledge about best practice treatment of PTSD, TBI, and family stress and relationship problems.

Table 7 Knowledge About Best Practice Treatments for Conditions Among Current and Former Members of the Armed Forces: Rural vs. Non-Rural Providers

Knowledge About Best Practices in Treatment of:	Agree	Neutral	Disagree
PTSD^{NS}			
Rural	55%	33%	12%
Non-Rural	63%	23%	14%
TBI^{NS}			
Rural	19%	17%	64%
Non-Rural	27%	17%	56%
Depression*			
Rural	60%	14%	26%
Non-Rural	63%	21%	16%
Substance Abuse/Dependence*			
Rural	62%	12%	26%
Non-Rural	63%	21%	16%
Family Stress & Relationship Problems^{NS}			
Rural	47%	26%	28%
Non-Rural	54%	21%	25%
Suicide*			
Rural	43%	20%	37%
Non-Rural	59%	17%	24%

* Significant Difference, ^{NS} Not Significant

Table 8 Confidence in Ability to Provide Best Practice Treatment for Relevant Conditions Among Current and Former Members of the Armed Forces: Rural vs. Non-Rural Providers

Confidence in Ability to Provide Best Practices in Treatment of:	Agree	Neutral	Disagree
PTSD*			
Rural	34%	20%	46%
Non-Rural	51%	14%	35%
TBI^{NS}			
Rural	15%	21%	64%
Non-Rural	22%	22%	56%
Depression*			
Rural	62%	12%	26%
Non-Rural	67%	18%	15%
Substance Abuse/Dependence^{NS}			
Rural	40%	23%	37%
Non-Rural	39%	18%	43%
Family Stress & Relationship Problems^{NS}			
Rural	49%	23%	29%
Non-Rural	53%	23%	24%
Suicide*			
Rural	43%	20%	37%
Non-Rural	58%	18%	24%

* Significant Difference, ^{NS} Not Significant



With respect to confidence in ability to provide best practice treatments, rural and non-rural providers were significantly different on some treatments but not on others (see Table 8).

- Rural providers were more likely than non-rural providers to disagree that they were confident in their ability to treat PTSD (46% vs 35%), and they were less likely to agree that they were confident in their ability to use best practice treatments for PTSD (34% vs 15%).
- Rural providers were more likely than non-rural providers to disagree that they were confident in their ability to treat depression (26% vs 15%).
- Rural providers were less likely than non-rural providers to agree that they were confident in their ability to use best practice treatments for suicide (43% vs 58%).
- There were no significant differences between rural and non-rural providers in their confidence with respect to treatment of TBI, substance abuse/dependence, or family stress or relationship problems.

With respect to providers' interest in obtaining information about relevant topics, rural and non-rural providers did not differ significantly on interest in women's roles in the military, providing care to veterans and Reservists with legal problems, or learning more about the medical and mental health problems of Armed Forces members, veterans and family members. However, rural providers were more interested than non-rural providers in learning more about providing care to homeless veterans and Reservists (65% vs 49%).

There were no significant differences between rural and non-rural providers' views as to which types of educational resources they thought would be most useful.

In summary, rural and non-rural providers were similar in most respects, but some significant differences were noted. One relevant difference was that the provider mix included a higher percentage of primary care as opposed to mental health in rural areas, with the converse being true in non-rural areas. More providers accepted TRICARE in rural areas. Fewer rural providers screened patients for active duty military, veteran, and family member status. Rural providers' practices were more distant from the nearest VA and DoD health care facilities. Rural providers were less familiar with some forms of treatment and expressed less confidence in the use of best practice treatments for PTSD, depression, and suicide. Interestingly, there were no significant differences in the topics rural and non-rural providers were interested in learning about or in the types of learning resources they preferred. Therefore, it appears that rural providers have many of the same opinions and educational needs as their counterparts in non-rural areas, although there is clearly a rationale for tailoring some training materials to accommodate special needs and concerns of those in rural areas.

MUSC-VISN-6 Rural Health Professionals Survey

As a part of the survey, providers were asked to respond to five open-ended questions. Although there was no requirement to complete the open-ended questions, providers had the opportunity to comment on each of the questions. Several modal themes emerged and those themes are reported in this section. A more detailed report of the modal themes for each of the open-ended questions containing a selection of providers' comments can be found in Appendix B of this report.

Open-Ended Questions:



#1 What would motivate you to spend your time and energy learning about the medical or mental health needs of current and former members of the Armed Forces and their families?

This open-ended question had the greatest number of responses. Four major themes emerged.

The first theme suggested that a significant number of providers were not aware that many of their patients are current or former members of the Armed Services or their family members. Therefore, providers do not perceive a need for specialized training in this area. However, there was very little in the responses suggesting that providers make an attempt to screen their patients to determine whether or not their patients are/were in the Armed Services or are family members.

The second theme indicated that the providers' negative perceptions of TRICARE were directly related to their lack of motivation to learn about the health or mental health needs of military members and their families. Negative perceptions centered on perceived low reimbursement rates, past and current difficulties working with TRICARE and/or the DoD, and a perceived lack of collegiality when working with TRICARE and/or the DoD. A few of the providers surveyed suggested the lack of acceptance of Licensed Professional Counselor (LPC) credentials by TRICARE as a deterrent to their motivation to learn more.

The third theme centered on availability, content, and delivery of training. Comments from many providers highlighted the need to minimize hours that require them to be out of their offices. It was interesting however, that many of the providers surveyed who offered comments on potential training appeared to assume an in-person type model of training as the only format for a learning experience.

A fourth theme indicated a motivation to learn more about the health and mental health needs of current/former members of the Armed Forces and their families was based purely on a desire to better serve this population. A sense of patriotism and service to country on the part of the providers was revealed in the responses.



#2 What concerns, if any, do you have about the quality of medical and mental health care services provided within the DoD healthcare system?

This question drew many responses from the providers surveyed saying they did not have direct knowledge about the DoD healthcare system and that their opinions came from news reports or second-hand reports from their patients. Providers indicated that many of their opinions that were influenced by news reports or anecdotal reports were fairly negative.

Of those providers surveyed who expressed a more direct knowledge of the DoD healthcare system, the major theme that emerged was a belief that the DoD system is currently unable to meet the needs of military members or their families, including Reservists. In addition, many expressed concerns that future needs will also go unmet.

In addition to the general concern about a system that is unable to meet demands, other concerns expressed provided more specific information. These concerns focused on the lack of continuity of care, lack of easy access to care without encountering "red tape," and issues of confidentiality.



3 What concerns, if any, do you have about the quality of medical and mental health care services provided within the VA healthcare system?

Many providers surveyed indicated that their views of the VA healthcare system were quite similar to their views of the DoD healthcare system. The most frequently expressed concern was that the system was overloaded and, therefore, unable to meet the clinical need. Several of the comments from the providers were lengthy but focused on problems with access, bureaucracy, distance, poor services for women, uninterested physicians, and the lack of communication and/or collegiality with community providers. Providers that we surveyed reported a broad range of responses regarding the quality of VA services reflecting what may be significant variability in their experience with local VA facilities and providers. This suggests that different VA's are successful in engaging community providers to significantly different degrees. There were some comments expressed by providers regarding concerns about adequate health and mental health care availability in the future.



#4 What barriers, if any, do you see in your community with respect to accessing health care services for current and former members of the Armed Forces and their families?

Providers reported several barriers to current and former members of the Armed Forces and their families in terms of accessing health care services. Distance to VA or DoD hospitals/clinics; lack of transportation; and travel time necessary to receive services were frequently cited. They express concern that VA's bureaucracy and lack of willingness to engage community providers as partners are barriers to effective care. Providers surveyed also highlighted specific negative effects these barriers had on members of Armed Services and their families.

Many of the providers cited issues with TRICARE in response to this question. Finding providers who accept TRICARE, difficulties being paneled with TRICARE, and perceived low reimbursement rates, were all frequently cited by providers. These barriers were mentioned as especially significant for those needing mental health services. The bureaucracy of TRICARE in general was also listed as a barrier.

Providers did offer some advice on how to reduce barriers. Some examples and suggestions were pragmatic such as having more flexible hours/evening hours at VAs. Other suggestions called for the VA to develop better outreach and to provide information to communities/providers about available services.



5 If a new, on-line information resource were created addressing medical and behavioral concerns among current and former members of the Armed Forces and their families, what topics would be most helpful to you?

Not surprisingly, the most frequently cited topics by were PTSD, TBI, depression, substance abuse, suicide, anger management, and domestic violence. As one provider said, "any of them that relate to mental health treatment."

It should be noted that when the providers were referring to information about available treatments, they were consistent in requesting information on those topics be "evidence-based," coming from "the latest research," and those involving "best practices."

Respondents also indicated that information on issues experienced by military families would be helpful. Many providers also indicated, either directly or indirectly, the need for information on understanding the military culture. Providers expressed a need for information about the military (DoD) and VA treatment options for their patients, as well as information on community resources that might augment other forms of healthcare Armed Forces members or their families are currently using.

Conclusions and Recommendations

1. The survey should be replicated with a national sample of providers to determine if findings generalize.

2. Providers lack, but need, information about VA and DoD healthcare systems, eligibility requirements, and referral procedures. The data indicate that information on how to become a TRICARE provider and how to work with TRICARE to maximize service and expedite processes is greatly needed.

3. Many providers stated that they had no basis for knowing how many of their current or potential patients are members of the Armed Forces, Veterans, or family members. Therefore, the data indicate the need for the DoD and VA to share information with community providers regarding the numbers of Service Members/Veterans and family members (including Active and Reserve Component Members) who fall in within the providers' local areas. Sites such as <http://www.unc.edu/cssp/datacenter/> already exist and are free and in the public domain. This site includes access to geospatial maps of these populations which could easily inform providers of the potential numbers of military/veterans who may be in their current patient groups or potential patient groups.

4. Fewer than half of the providers said that they regularly screened for military involvement. This was especially true of rural providers. Based on the survey data, providers should be encouraged to include at least one screening question to be asked of every patient: "Have you or someone close to you served in the Armed Forces?" Training in efficient and sensitive ways to screen patients about their military service experience is needed for providers.

5. Given the relatively low percentage of providers with military experiences, provider training should focus on improving their understanding of military culture. Available training on deployment stress and related mental health issues should be widely disseminated to rural providers, professional associations and organizations, community groups, and other public domains. The website, www.abconnect.com/citizensoldier, is a good example of an educational site that includes and focuses on military culture topics.

6. Providers indicated that information on community programs that provide additional, non-medical support for members of the Armed Forces and their families was needed. Military OneSource <http://www.militaryonesource.mil> and <http://afterdeployment.org/> are examples of where needed information can be found. Including informational sites in any outreach efforts to rural providers would appear to be in order, given their lack of proximity to VA and DoD health care facilities.

7. Providers are more knowledgeable about, and are more confident in their ability to provide, Best Practice treatments for depression, suicide, and family stress than they are about and for TBI, PTSD, and substance abuse/dependence. This indicates a need for more training materials about how to identify, assess, and treat TBI, PTSD, and substance abuse/dependence. Rural providers may particularly benefit from such materials. In rural areas, mental health expertise may be more scarce, so greater awareness of military issues is even more important for primary practitioners.

8. Web-based courses as a training resource for providers have much to offer because they are convenient, reduce provider's time away from their practices, can be provided at low cost, and can be easily and centrally modified when updates and/or changes become available.

9. While VA has already made significant progress in developing telemental health bridges to rural communities, in order to address remaining training/access disparities between rural and non-rural providers indicated by this survey, further augmentation of tele-mental health training partnerships between DoD, VA, and community rural providers should be considered. Such a partnership could allow rural providers to receive training and case consultation from experts within DoD or VA settings and would not require significant technological upgrades for providers. Direct care for patients in community settings might also be possible, if confidentiality issues can be satisfactorily overcome.

10. Finally, data from this survey indicate that perceptions of some providers are consistent with the perceptions of many of their patients, the media, and even DoD and VA that much still needs to be done to improve the access, availability, timeliness, and frequency of care

within DoD and VA healthcare systems. DoD and VA have clearly made great strides in transforming the quality of care provided to those who have served yet survey responses indicate that perceptions among community providers, rural and non-rural, may lag behind these significant enhancements. These perceptions remain problematic whether they are true, false, or only partially true. If the perceptions are false or only partially true, there is clearly a need for DoD and VA to continue efforts to spread the word about the progress made among community providers and clearly map for them steps by which Service Members, Veterans and their family members can successfully enter the DoD/VA continuum of care. To the extent that at least some of these perceptions are true (or true for only some regions), this means that there are still gaps in meeting the current and future needs of members of the Armed Forces, Veterans, or their families. In any case, the information gathered in this survey about community providers' perceptions is extremely valuable because it instructs us about where there is still work to be done in correcting misperceptions, improving quality of care, or both.

Useful Web Resources

We have compiled a list of useful web resources in Table 9. These sites provide a broad range of information and training of the type that providers state they would like to receive. Many of these sites have already been mentioned or described, but we would like to highlight a few that may be particularly useful. The first set of sites provides national-level information.

- The VA National Center for PTSD site provides an enormous amount of material about a variety of topics that is relevant for providers, for veterans, and for families. This information includes training materials for providers.
- The VA Website contains valuable information about the VA, eligibility requirements for health care and other services, and location of VA facilities.
- The VA Office of Rural Health site provides information particularly relevant for providers in rural settings, including information about particular concerns of veterans and families in rural settings.

Table 9 Useful Web Resources

<i>Resources</i>
CPT Web: http://cpt.musc.edu
Military One Source: https://www.militaryonesource.mil
Defense Centers of Excellence: http://afterdeployment.org/
TRICARE: http://www.tricare.mil/
VA Website: http://www.va.gov
Vet Center Finder: http://www.va.gov/directory/guide/vetcenter_flash.asp
VA National Center for PTSD: http://www.ptsd.va.gov/
VA Office of Rural Health: http://www.ruralhealth.va.gov/
VISN 6 Mental Illness, Research, Education and Clinical Center: http://www.mirecc.va.gov/visn6/
VA/DoD Clinical Practice Guidelines for the Management of Traumatic Stress: http://www.healthquality.va.gov/Post_Traumatic_Stress_Disorder_PTSD.asp
Painting A Moving Train (free, accredited training on Deployment Mental Health for Community Providers developed by a joint DoD/VA/State and Community Team): http://www.aheconnect.com/citizensoldier
International Society for Traumatic Stress Studies: http://www.istss.org
Substance Abuse and Mental Health Services Administration: http://www.samhsa.gov/MilitaryFamilies/
VA Crisis Line (1-800-273-8255): http://www.veteranscrisisline.net/

- The VA/DOD Clinical Practice Guidelines for Management of PTSD site provides a comprehensive review of the strength of evidence supporting major treatments for PTSD.
- The Defense Centers of Excellence site has a wide variety of useful material for service members, families, and health professionals with emphasis on evidence-based practices.

- The Painting a Moving Train site, developed by a joint DOD/VA/State and Community team, provides free training on deployment mental health.
- The International Society for Traumatic Stress Studies (ISTSS) site includes background information on PTSD and related disorders as well as information about training opportunities.

The National Crime Victims Research and Treatment Center has developed a number of free web-based courses designed to provide training to mental health professionals. These include:

CPTWeb (<http://cpt.musc.edu>) is a multi-media web-based training for mental health providers seeking to learn Cognitive Processing Therapy (CPT) for PTSD. This course is designed to teach clinicians about using CPT with military populations and teaches all of the components of CPT using concise explanations, video demonstrations, and clinical scripts. Learners completing *CPTWeb* receive 9 hours of continuing education credit free of charge. The development of this program was funded by the US Navy Bureau of Medicine and Surgery.

TF-CBTWeb (www.musc.edu/tfcbt) is a web-based training course designed for therapists on delivering Trauma-Focused Cognitive-Behavioral Therapy. This program has been very successfully disseminated (over 100,000 registered learners from 111 countries). The course has ten modules that follow the components of TF-CBT and learners who complete this course receive 10 hours of continuing education credit free of charge.

CTGWeb (www.musc.edu/ctg) is a follow-up training course to *TF-CBTWeb* and teaches therapists how to apply TF-CBT to cases of child traumatic grief after the loss of a loved one. Each module is structured similarly to those of *TF-CBTWeb* and is modular and multimedia.

TF-CBTConsult provides online, automated clinical consultation to therapists using TF-CBT. Users can enter a question or set of keywords to view a long list of commonly asked consultation questions concerning TF-CBT. Answer pages contain concise text answers, video explanations by the TF-CBT developers, video dialogues between TF-CBT experts concerning clinical issues, and video clinical demonstrations. *TF-CBTConsult* is available only to learners who have completed *TF-CBTWeb*.



Reference

Hoge, C. (2011). Interventions for War-related Posttraumatic Stress Disorder: Meeting Veterans Where They Are. *JAMA*; 306(5), pp. 549-551.

APPENDIX A

Participating Programs and Agencies

Professional Associations:

Connecticut Psychiatric Society
www.ctpsych.org

North Carolina Psychiatric Association
<http://www.ncpsychiatry.org>

Pennsylvania Psychiatric Society
www.papsych.org

Psychiatric Society of Virginia, Inc.
www.psva.org

North Carolina Psychological Association
www.ncpsychology.org

National Association of Social Workers, Maryland Chapter
<http://www.nasw-md.org/>

State Agencies:

North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services
<http://www.ncdhhs.gov/mhddsas/>

North Carolina Department of Health and Human Services
<http://www.ncdhhs.gov>

North Carolina Office of Rural Health and Community Care
www.ncdhhs.gov/orhcc/

National Association of Community Health Centers
<http://www.nachc.org>

Community Care of North Carolina (CCNC)
<http://www.communitycarenc.org>

APPENDIX B

MUSC-VISN-6 Rural Health Professionals Survey

Open-Ended Questions:



#1 What would motivate you to spend your time and energy learning about the medical or mental health needs of current and former members of the Armed Forces and their families?

The first grouping of responses suggested that a significant number of providers were not aware that many of their patients may be current or former members of the Armed Services or their families. Therefore, providers do not perceive the need for specialized training. Illustrative comments include:

- If we had a greater presence in our patient panel of current and former members of the Armed Forces and their families.
- Having a larger percentage of veterans of recent conflicts referred to my practice.
- If my practice had a greater number of patients in this population.
- If I were to receive more referrals for this population.

However, little in the responses suggests that providers make an attempt to screen their patients to determine whether they are/were in the Armed Services or are family members. Several providers acknowledged they have not been screening their patients regarding military status: “I think the first step would be determining how many of my patients are current or former members of the Armed Forces. I probably have a significant number of former members that I’m unaware of,” and, “They are a population of patients that is more common than I probably realize.”

The second theme among responses indicated that the providers’ negative experiences with and perceptions of TRICARE were directly related to their lack of motivation to learn about the health needs of military members and their families. Responses centered on perceived low reimbursement rates, past and current difficulties working

with TRICARE and/or DoD, and a perceived lack of collegiality when working with TRICARE and/or DoD. A few survey providers noted that the lack of acceptance of LPC credentials by TRICARE decreased their motivation to learn more:

- If TRICARE would reimburse better that would motivate me to be a provider and therefore motivate me to seek up-to-date information on children/family issues of military families.
- I have made numerous attempts (via phone) to have someone contact our organization to learn about TRICARE and what can be done to become a provider under the umbrella. We have been unsuccessful in securing a call back.
- We need adequate resources for TRICARE military families especially psychological services, and we need adequate reimbursement from TRICARE for the services we provide to children of military families.
- My 18 physician group would consider doing more work with TRICARE if the reimbursement were enhanced. We are the only TRICARE providers in a 30 mile radius, but I do not know if we will continue to participate at the currently inadequate reimbursement rates.
- If you accepted the LPC credential, I would be very interested in working with vets.
- Less bureaucracy in reimbursement, authorization, etc. Having easy and accessible professionals to reach out to us.
- If I felt I were part of a “team” managing a patient, I would want to know what the team knows. As it is, DoD/VA team apparently is doing something. I do what I do without any idea of what they are up to. My role is frequently second guessing and advising the patient what to ask for and what to watch out for.
- Just becoming invited to utilize the resources (not being locked out because we are not DoD).

The third type of response focused on aspects of potential training activities. Respondents commented on training content, availability, and assessability. Many providers highlighted the need to minimize time out of the office:

- Convenient affordable training.
- High quality, information dense (i.e., effective use of time in learning), and not requiring a lot of time away from my practice.
- Literarily I cannot afford financially to be away from my office for sick days, vacations, or extended holiday, let alone for training or other purposes.
- I would be interested in this if I could be part of a group that met face-to-face for continuing ed/peer supervision and if it did not involve a lot of paperwork/certification in addition to my current credentials for payment or collection of fees.
- E-mail containing web links to further information, conferences, etc.
- CEU's, time, location.
- Location of training, cost of training, referrals, resources available.
- Ease of availability at a reasonable cost or fee.
- In order to take time away from my practice to get training for providing services to a relatively specialized population, I will have to know that when I return to my office, this training is going to pay.

A fourth theme among responses revealed a motivation to learn more about the health and mental health needs of current/former members of the Armed Forces and their families that was based purely on a desire to serve this population better. A sense of patriotism and service to country was evident in the responses.

- Willingness to help that population.
- Their need. I am very interested in helping those who have put themselves in harm's way to defend our freedom.
- Serving more of these patients.
- Concern for the well being of men and women who have sacrificed for their country and concern for the well being of their families.
- Whatever I can do to assist them and their families, I am honored to do so.
- Sense of responsibility, as a fellow citizen. That's it.

- My desire to see this population re-integrate into society with the least amount of trauma to themselves and/or family members. I would be willing to attend trainings in order to learn how to conduct effective intake assessments in order to link members to the best (and most adequate) community resources.
- I am a trauma specialist who moved to NC because my son called from Afghanistan, saying, 'My guys have seen too much, please come down here.' It is what I came here to do. I want to do it the best way.



#2 What concerns, if any, do you have about the quality of medical and mental health care services provided within DoD healthcare system?

Many providers said they did not have direct knowledge about the DoD healthcare system and that their opinions came from news reports or second-hand reports from their patients. Many of their opinions were influenced by negative news reports or anecdotal reports. For example:

- Reports from patients and families as well as media indicate many limitations and problems.
- Nothing that hasn't been reported by the New York Times or agreed to by the VA and DoD.
- I will willingly admit that the press is my main source of information regarding health care for the military. It is certainly my impression that our current resources are not sufficient.
- I only know what I hear through the media (60 Minutes, etc.), which seems to lean towards insufficient (lack of access rather than lack of quality) mental health services.
- They are based mostly on what I hear from others, and from some family members, but include: long waiting lists, feeling like the system is way too cumbersome and that services can't be accessed, concerns about confidentiality; lack of access to appointment times that coordinate with work and school demands; inability to access specialists (e.g., can see a therapist but they may not specialize in working with kids, working with domestic violence, etc.).

Of those respondents who expressed a more direct knowledge of the DoD healthcare system, the major theme that emerged was a belief that the DoD system is currently unable to meet the needs of military members or their families, including Reservists. In addition, many expressed worry that future needs will also go unmet. While frequently praising the DoD providers, providers expressed concern that the system, as a whole, is inadequate to meet the needs.

- I think the quality of care is in many ways excellent but there aren't enough resources to meet the current mental health need of the military and their families.
- Lack of treatment providers and long waiting lists.
- Access to services. Particularly for Reservists.
- There is a huge demand. The demand is not going to abate any time soon. Rather, I believe it will certainly increase.
- Routine complaints by patients and internal reports from the military hospital that they are overwhelmed and cannot keep up with the incoming.
- My concerns have less to do with the quality of the care than with the quantity available and with the need to have non-DoD connected services for those unwilling to access DoD affiliated services.
- I believe the DoD healthcare system provides good care but cannot handle the volume. Our military active duty psychologists set up a local PTSD group, but then the psychologists were sent to Afghanistan. Continuity of care falls apart. The psychologists I have met are good at their jobs but often are limited to twenty minute sessions due to volume of patients. The most recent military psychologist just was rotated and re-referred her caseload to our clinic. We gladly support and admire their efforts but suspicion, paranoia, and resistance to trust are an integral part of the PTSD process and keeps being triggered by the switching of professionals who are helping these troops.

In addition to the general concern about an overburdened system, other comments expressed more specific concerns. These focused on the lack of continuity of care, “red tape,” and issues of confidentiality.

- Clients have expressed that it's difficult to navigate the red tape involved.
- Too many deployments, not enough continuity of care.
- Docs discourage active duty people from discussing mental health concerns.
- I am concerned about the amount of medications that are prescribed vs. behavioral interventions.
- Too many hoops for significantly mentally ill people to jump through.
- Lack of confidentiality of mental health records, stigma, or penalty for mental health/substance abuse issues.
- Rapid turnover of personnel so there is often insufficient consistency; unavailability of providers in certain specialty areas; patient concerns with confidentiality and the possible impact of disclosure on military status.
- The DoD healthcare system is very difficult to use from the perspective of practicing outside of the system—we do not receive any communication from the providers within the DoD if we are concurrently caring for an individual within the system; makes continuity of care very difficult, dangerous for the patient.
- DoD is doing an admirable job. Recent influx of Iraq war population, new policies that require proactive screenings for mental health problems, and their general processing role (admit and discharge exams) has resulted in systemic overload for DoD/VA systems. Given this, I am encouraged to see the State Psychological Association take a pro-active role in promoting community involvement (add capacity/competency in non-military service system).



3 What concerns, if any, do you have about the quality of medical and mental health care services provided within the VA healthcare system?

Many providers indicated that their views of the VA healthcare system were quite similar to their views of the DoD healthcare system. The most frequently expressed concern was that the system was overloaded and, therefore, unable to meet the clinical need. This theme is captured

in the following comments that also describe how the perceived lack of adequate services by the VA affects community providers.

- The available services are not sufficient. Vets have to wait unacceptably long periods of time to receive services, and those of us in the community who lack adequate training with this population are left to struggle through as best we can. The counties are often called upon to provide services to vets who are otherwise insured and should be able to get treatment through the VA, but there are too many barriers and not enough providers.
- It is grossly inadequate. I constantly have to use my time and resources to help patients that are not getting their needs met through the VA system.

Just as respondents pointed out what they perceived to be problems with the DoD healthcare system, they also highlighted specific problems they perceive within the VA system. Several comments were lengthy but focused on problems with access, bureaucracy, distance, poor services for women, disinterested or unmotivated physicians, and the lack of communication and/or collegiality with community providers. Each of these problem areas was reported by a significant number of providers.

- The wait times to schedule regular appointments are distant sometimes, and many of their rules—e.g., for missed appointments, late appointments, reimbursements—are very rigid and bureaucracy-driven, rather than patient-oriented.
- Our “local” VA hospital is 3 ½ hours away one way. Most vets cannot afford the gas. The clinics that are available locally do not provide PTSD or TBI retraining. One clinic 90 minutes away has a Vietnam group but does not allow OIF or OEF or Gulf War vets and does not take women.
- Poor services for women especially.
- I know some excellent providers who work in the VA system. The problems I hear about are related to extremely heavy caseloads, waits for appointment, lack of support services, untreated substance abuse problems.

- Patients have reported their dissatisfaction to me, especially about lack of personal concern for them, especially by psychiatrists who spend little time with them and are uninterested in details of their experiences, and who make little personal contact. Patients are especially put off by mental health professionals who take notes on a computer screen while speaking with them, often making no eye contact.
- The VA “system” is a black hole. Impossible to get any information out about medical care issues. I see vets who travel to the VA several times a year for prescriptions. They presumably have a doc at the VA. I write prescriptions. They change the prescriptions. Never a letter, copy of their notes, labs....nothing. I give patients information to carry---never an acknowledgement. I cannot imagine that connecting with Behavioral Health professionals will be any easier.

Variability between VA facilities and providers was also noted.

- There is a high degree of variability among individual practitioners within the VA and quality of service depends on which provider the person gets. Some people I would highly recommend, and others I would just as soon avoid altogether.
- I have a bit more familiarity with the VA system, and I feel rather certain that the accessibility and quality are very uneven from one location and/or facility to another. My impression is that, nationwide, the services available through the VA system range from the very best available anywhere to the very worst available anywhere.

There were also comments expressing concerns about the availability of health and mental health care in the future.

- I am concerned about the future quality and availability of services for veterans because of current federal budget issues and being involved in various conflicts over the last decade. This, in combination with rising health costs makes me concerned that there will be even more pressure to reduce costs and limit services. Since many effective treatments for ‘mental’ health issues are long

term, I am concerned that like what has happened with most private insurance companies there will be a push to limit the duration that those services will be provided.

Some survey providers also included specific suggestions to improve services or other aspects of the VA system.

- I also believe that our outreach to current and former members of the Armed Forces would be more successful if mental health providers were required to learn basic information about military training and structure (ranks, branches, MOS, etc.), U.S. military history, combat (including major operations or battles of specific wars), and typical impact of combat on the family. This would convey the respect that these men and women deserve.



#4 What barriers, if any, do you see in your community with respect to accessing health care services for current and former members of the Armed Forces and their families?

Several barriers to accessing health care services were noted. Distance to VA or DoD hospitals/clinics, lack of transportation, and travel time necessary to receive services were frequently cited. Survey providers also highlighted specific negative effects these barriers had on Armed Services members and their families:

- Nearest VA is one hour away.
- Distance is a problem, as some don't have reliable transportation.
- Our community is rural with few resources. The nearest VA is two hours away.
- Distance from the nearest VA facility as well as community resources such as transportation to/from the VA.
- We service individuals across 34 counties and many are 2 to 3 hours away from the nearest facility. With limited transportation, they often don't get the care they need.

- Our area is very rural, so distance is a barrier. While our VA has expanded, the closest location is still 30-40 minutes away, and many people lack transportation or they cannot get all the services they need at that location.
- Transportation from outlying rural areas where many of the military persons/families actually live and the difficulty in getting services consistently.

Many of the survey providers cited issues with TRICARE. Locating providers who accept TRICARE, difficulties being paneled, perceived low reimbursement rates and burdensome bureaucracy were all frequently cited by survey providers. These barriers were mentioned as especially significant for those needing mental health services:

- Not all practices accept TRICARE.
- For TRICARE Prime members, restricted access due to PPO insurance panel.
- Lack of TRICARE approval for care.
- TRICARE reimbursement is too low, thus it's not widely accepted.
- TRICARE's abysmal rate of reimbursement for psychologists. At best I break even, and sometimes I lose hundreds of dollars/day seeing TRICARE family members.
- As far as the availability of psychologists in the community, specifically, I don't think there are very many TRICARE-authorized providers around. As for me personally, I will accept TRICARE Standard reimbursement, but I literally can't afford to accept the low rates offered by the HMO-like TRICARE plans.
- I have had a very difficult time finding mental health counselors for children who accept TRICARE. This is the greatest barrier. Almost none in our area accepts TRICARE.
- TRICARE reimbursements are notoriously poor for mental health services, which severely limits their access to good mental health care and discourages practitioners from treating military personnel (including retired), informing themselves about

the needs of this population, and accepting them as patients. Insurance is a tremendous obstacle!

- Too much bureaucracy in reimbursement, authorization, referral, etc.
- TRICARE is very unsupportive of using insurance to see out-of-network providers.
- The bureaucracy of TRICARE. I asked for information about becoming paneled with them and never heard anything. This was a red flag for me as to the responsiveness of TRICARE, so I did not pursue the matter.

Providers also identified additional systemic barriers to care for members of the Armed Services and their families:

- No coordination between state systems of care and the local VA facilities.
- The Veterans Affairs Officer is uninformed about needs and treatment available.
- Losing jobs during active duty status for Reservists and then not having TRICARE insurance long enough. The insurance lasts 6 months and the problems surface shortly after in many circumstances, and they are unable to access services and aren't well informed about VA benefits.

Several respondents offered advice on how to reduce barriers. Some suggestions were pragmatic, such as having more flexible hours/evening hours at VAs. Others called for the VA to develop better outreach and to publicize available services:

- After hours services (clinic) to accommodate working patients, and more therapists and prescribers in mental health—especially with substance abuse.
- If joining a military panel was made easy and had some kind of incentive, i.e., “fair compensation,” trainings, information, referrals, I believe it would benefit everyone!
- I would personally refer more if I had more information about how to refer.
- More marketing and public announcements identifying potential resources would inform veterans and their families about treatment/service options.



5 If a new, on-line information resource were created addressing medical and behavioral concerns among current and former members of the Armed Forces and their families, what topics would be most helpful to you?

Of the open-ended questions, this one had the most uniformity in terms of responses. Specifically, and perhaps not surprisingly, the most frequently cited topics included PTSD, TBI, depression, substance abuse, suicide, anger management, and domestic violence. As one provider said, “any of them that relate to mental health treatment.” Some providers added that they would also like information on “how their symptoms might differ from the symptomatology of the general population,” and “differences that have been found in the Armed Forces population versus other populations in terms of assessment/intervention in areas such as depression, PTSD/trauma, family conflict, etc.” It should be noted that when the providers were referring to information about available treatments, they were consistent in requesting that information be “evidence-based,” drawn from “the latest research,” and “best practices.”

In addition to information/training about common behavioral health issues (e.g., PTSD, TBI, depression, etc.), some providers also indicated that information on issues experienced by military families would be helpful:

- Stress on military families. Deployments, before, during, and after. Frequent disruption of life given re-assignments of duty stations.
- Transitioning home. Issues for families post-deployment. Issues for families upon homecoming.

Providers also indicated, either directly or indirectly, the need for information on understanding the military culture:

- Best practices, military cultural competency.
- I run a psychiatry residency and I would be interested in materials I could use to teach residents about care of service members and veterans.
- Understanding of stressors unique to military families and service personnel.

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- The majority of my staff has never served. Thus they need everything from understanding the culture, major stressors, and how to individualize treatments.

One addition topic that many respondents suggested would be helpful to them was how to obtain information about the military (DoD) and VA treatment options for their patients efficiently. Similarly, the providers also requested more information on community resources that might augment other forms of healthcare Armed Forces members or their families are currently using:

- Mental health resource list specific to my geographic area.
- How to negotiate chain of command when advocating for individual service members and their families. What additional resources might be available for soldiers trying to get through the Warrior Transition Unit. What to do when you learn about unfair practices.
- Also need a one-stop simple to use site to advise civilian providers of the available federal programs to address various problems that service members, their families, and Veterans face in their everyday lives (for examples, there is not Legal Aid service for Veterans needing assistance). A similar one-stop site (preferable 'live, knowledgeable human being') available to those in federal governmental service who don't keep up with programs in the civilian world.
- More on community based government/city council's support in providing service outside of the medical/mental health basic services, e.g., support groups, centers, rehab services, employment training, etc.

National Crime Victims Research and Treatment Center

The National Crime Victims Research and Treatment Center (NCVC), established in 1977, is a division of the Department of Psychiatry and Behavioral Sciences at the Medical University of South Carolina. The faculty and staff of the NCVC have been devoted to achieving a better understanding of the impact of criminal victimization on adults, children, and their families. As the NCVC has grown, so has its mission. Its research focus, professional education efforts, and clinical services have expanded to address psychological responses to virtually all types of traumatic events, including disasters, combat, and accidental injuries. In addition to traditional methods of scientific dissemination, NCVC faculty also share their expertise through public policy consultation to the DVA, the DoD, and other national and international organizations. The NCVC has earned considerable recognition for the scope of its mission, research excellence, and high quality clinical services. Information about the NCVC and its clinical and research programs has appeared in major national print and news outlets, including all broadcast network morning and evening news programs, C-Span, CNBC, and CNN. NCVC faculty members have provided invited testimony to U.S. Senate and House of Representative Committees and served as Committee Members for the Institute of Medicine. Learn more about the NCVC here: www.musc.edu/ncvc.

The NCVC is also a leader in the use of technology for the dissemination of training in evidence-based mental health therapies for those affected by traumatic stress. The NCVC currently offers several self-directed, multi-media, Web-based training courses for mental health providers. Other Web-based resources, including training courses for victim advocates and self-help resources for disaster victims, are being developed. Current training courses include:

- **CPTWeb** (<http://www.musc.edu/cpt>) is a multi-media web-based training for mental health providers seeking to learn Cognitive Processing Therapy (CPT) for PTSD. This course is designed to teach clinicians to implement CPT with military populations and teaches all of the components of CPT using concise explanations, video demonstrations, and sample clinical scripts. Course completers receive 9 hours of continuing education credit free of charge.
- **TFCBTWeb** (www.musc.edu/tfcbt) is a web-based training course designed to teach therapists the components and methods of Trauma-Focused Cognitive-Behavioral Therapy for child and adolescent trauma victims and their families. The course has 10 modules that follow the components of TF-CBT, and learners who complete this course receive 10 hours of continuing education credit free of charge.
- **CTGWeb** (www.musc.edu/ctg) is a follow-up training course to TF-CBTWeb and teaches therapists how to supplement TF-CBT in cases of child traumatic grief after the loss of a loved one. Six hours of free continuing education credit are available.
- **TFCBTConsult** (www.musc.edu/tfcbtconsult) provides online clinical consultation to therapists using TF-CBT. Like CTGWeb, TFCBTConsult is available only to learners who have completed TFCBTWeb.

