Mental Health Care For Iraq And Afghanistan War Veterans

Meeting combat-related mental health needs requires broad reform of services that looks beyond the Veterans Health Administration.

by M. Audrey Burnam, Lisa S. Meredith, Terri Tanielian, and Lisa H. Jaycox

ABSTRACT: Despite recent efforts to increase access to appropriate mental health care for veterans returning from conflicts in Iraq and Afghanistan, many challenges remain. These include veterans’ reluctance to seek care, insufficient mental health workforce capacity and competency in evidence-based practice, and inadequate systems support for improving care. These broad challenges must be addressed across the Veterans Health Administration, the Department of Defense, and community-based care. Policy reform will require federal leadership to engage health plans, professional organizations, states, and local communities in strategies to improve veterans’ access to high-quality services. [Health Affairs 28, no. 3 (2009): 771–782; 10.1377/hlthaff.28.3.771]

To date, approximately 1.7 million U.S. troops have been deployed in support of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). Nearly a third of the deployed have come from the National Guard and Military Reserves, representing the heaviest reliance on the reserve component for combat operations in recent years.¹ These volunteer troops face a number of unusual circumstances unique to the current conflicts, including more frequent and longer deployments with shorter rest periods in between. Exposure to the extreme stresses of this combat environment—including roadside bombs, improvised explosive devices (IEDs), suicide bombers, the handling of human remains, and human violence and death—increases risk for post-traumatic stress disorder (PTSD) and major depression.²

Although most service members return from Iraq and Afghanistan without physical injuries, many return with symptoms of PTSD or depression.³ Recent data from a RAND study estimated that 18.5 percent of returned troops (about 300,000 of OEF/OIF veterans) met criteria on a structured survey assessing probable PTSD or depression.⁴

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Many veterans who are afflicted with combat-related mental disorders after serving in OEF/OIF are not receiving mental health care. In the RAND study, only about half of those who met criteria for PTSD or depression had sought help from a provider in the past year, and of these, fewer than half received minimally adequate treatment (Exhibit 1). Not all of those who failed to receive care may have needed it—some cases will remit without treatment, and others might prefer not to use mental health services. Nonetheless, this gap is so substantial that it indicates a clear unmet need for treatment among OEF/OIF veterans.

In the wake of nationally publicized concerns over the care for wounded warriors, several task forces, working groups, and a presidential commission have intensified the focus on the care system for returning members of the armed forces. Heightened public attention and reports emanating from these work groups spurred Congress to greatly increase funding for both the Department of Defense (DoD) and the Veterans Health Administration (VHA). Since 2006, billions of dollars have been poured into DoD and VHA health care systems, with specific mandates for improving treatment for those wounded in the war. Specific allocations were also made for expanding mental health care and investing in more research on PTSD and traumatic brain injury (TBI). The DoD and VHA swiftly responded by creating new oversight committees, implementing new screening programs, hiring more mental health providers, and creating new infrastructure for addressing these issues. One of the key policy actions was the establishment of the Defense Center of Excellence (DCoE) for Psychological Health and Traumatic Brain Injury. Through this DCoE, the DoD and VHA are working collaboratively to address the important issues surrounding the prevention, recognition, and treat-

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EXHIBIT 1
Proportion Of OEF/OIF Veterans With Probable Mental Health Problems, By Receipt Of Care, 2008

<table>
<thead>
<tr>
<th>Mental Health Problem, No Treatment</th>
<th>8.8%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Problem, Any Treatment</td>
<td>4.1%</td>
</tr>
<tr>
<td>No Mental Health Problem</td>
<td>81.5%</td>
</tr>
<tr>
<td>Mental Health Problem, Minimally Adequate Treatment</td>
<td>5.6%</td>
</tr>
</tbody>
</table>


**NOTES:** A mental health problem is defined as meeting scoring criteria on a survey for probable diagnosis of post-traumatic stress disorder (PTSD) or depression. Minimally adequate treatment is defined as at least eight sessions averaging thirty minutes in duration for those reporting psychotherapy, and at least four visits with a doctor and staying on medication as long as the doctor recommended for those on medication during the prior year. OEF is Operation Enduring Freedom. OIF is Operation Iraqi Freedom.
ment of combat-related psychological and cognitive injuries.

Improving the quality of mental health benefits and services in the DoD and VHA is undoubtedly a key step in improving care for this population. However, they are only part of the systems of care needed to address the mental health problems of returning veterans. Improvements in access to and quality of community-based services outside of the DoD and VHA will also be very important.

National attention on VHA and DoD mental health services has primarily emphasized treatment for PTSD; however, we include depression because it is similarly associated with combat experience, affects similar numbers of OEF/OIF returned troops, and more often than not co-occurs with PTSD. For this paper, we draw from our work as part of a recent RAND study, Invisible Wounds of War.

Systems Of Health Care For OEF/OIF Veterans

- **DoD.** The DoD’s military health system provides care for active-duty military and their family members, eligible military retirees and their families, as well as some reserve-component members and their families. The DoD delivers on-base services through military treatment facilities and clinics that prioritize services for active-duty military. These services are supplemented through contracts with civilian network providers that largely serve families and retirees. The TRICARE contractors function similarly to many private health insurance plans. National Guard and Reserve members who return from deployments have transitional benefits through TRICARE and then have the option to contribute to the cost of continuing TRICARE coverage. Participation in TRICARE Reserve Select has been low; most deactivated Guard and Reserve members return to civilian employment (74 percent) or retirement (20 percent).

- **VHA.** The VHA provides health care services to eligible veterans and some active-duty service members. It operates 877 hospitals and clinics and, within these, nearly 200 specialized outpatient and day treatment programs for PTSD, as well as inpatient units dedicated to PTSD. Care for depression within the VHA is delivered largely within the primary care outpatient setting.

All veterans with combat service after 11 November 1998 (including OEF/OIF veterans) are eligible to receive cost-free health care through the VHA for five years after separation for conditions that are potentially service connected; those who enroll during this initial five-year period retain eligibility after the five years elapse, although some may be charged copayments for non-service-connected care. The VHA uses an eight-level priority system (Exhibit 2) that gives highest priority to those with service-connected disabilities.

Access To Care

It is important to consider broad community capacity to meet the needs of OEF/OIF veterans, in addition to VHA and DoD services. As veterans become reintegrated into their home communities and local economies, it is likely that they
will seek their mental health care in conjunction with the rest of their care, through their employer-based health plans. Although some combat veterans (such as those who maintain military affiliation) will have access to community-based networks of practitioners through TRICARE, most deactivated Guard/Reserve or separated personnel will not be TRICARE beneficiaries. VHA services are an option for all combat veterans and had been accessed for any reason by 42 percent of OEF/OIF eligible veterans as of September 2008.\textsuperscript{12} Distance from VHA facilities and lower priority status are likely to deter many veterans.\textsuperscript{13} Additionally, reports from young OEF/OIF veterans suggest that some are uncomfortable with VHA facility environments because they perceive them to be oriented to treatment of older and more chronically ill patients.\textsuperscript{14} The VHA has been expanding its capacity to provide PTSD services; it is also responding to an increased demand for these services from earlier generations of Vietnam and Gulf War veterans. In 2005, later-generation veterans from the Persian Gulf conflicts (OEF/OIF) constituted only 3 percent (8,904) of patients receiving VHA specialty treatment for PTSD.\textsuperscript{15}

To address the mental health needs of returning combat veterans, two broad challenges must be met to close the gap between those with mental health needs and those receiving services: reluctance to seek care, and workforce capacity.

\textbf{Reluctance to seek care.} Surveys and focus groups repeatedly show that the

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\hline
\textbf{Priority level} & \textbf{Enrollment eligibility} \\
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1 & Service-connected disabilities rated 50% or more disabling \\
2 & Service-connected disabilities rated 30% or 40% disabling \\
3 & Former prisoners of war, recipients of the Purple Heart, service-connected disabilities rated 10% or 20% disabling, discharged from active duty for disability incurred or aggravated in the line of duty, special eligibility for a disability caused by treatment or vocational rehabilitation \\
4 & Receive aid and attendance, or housebound benefits, catastrophic disabilities unrelated to service \\
5 & Non-service-connected and noncompensable service-connected, rated 0% disabled, with annual income and net worth below the VA means test thresholds \\
6 & Meet specific criteria, such as having served in the World War I, environmental exposure under certain testing and occupation conditions, combat veterans serving after 11 November 1998 discharged from active duty during specified time periods \\
7 & Veterans with income or net worth above the VA national income threshold and income below the geographic income threshold who agree to pay copays \\
8 & Veterans with income above the geographic income threshold who agree to pay copays (enrollment is closed for some veterans in this category; see source for details) \\
\hline
\end{tabular}
\caption{Current Eligibility And Priorities For Veterans Affairs (VA) Health Services}
\end{table}

attitudes and beliefs of military service members and veterans inhibit them from seeking care for mental health problems. Military culture promotes pride in inner strength, self-reliance, toughness, and being able to “shake off” ailments or injuries. Service members and veterans report that they would be seen as weak in admitting to having mental health problems. Many worry that use of any formal mental health services will harm their careers, and such concerns are difficult to assuage, particularly for active-duty personnel, who are required to make this information known for their military medical records and, until recently, for security clearance. Skepticism about the value of treatment is also prominent in this population, including concerns about negative side effects of medications, that medications will be “pushed” on them, or that treatments will not be helpful or were tried and did not work.

**Workforce capacity.** Recent estimates suggest that there are about a half-million clinically trained mental health professionals in the country. Geographic disparity in the distribution of this workforce is a major, long-standing problem. Most specialists are concentrated in urban areas; many rural areas have none. And even in densely populated areas, regional disparities in availability of specialists are extreme; distribution of psychiatrists, for example, was found to be 8.2 per 100,000 population in the Mid-Atlantic region, compared to 53 per 100,000 in New England. Poor availability of mental health specialists in many parts of the country has been noted as an important barrier to obtaining mental health care for OIF/OEF veterans and their families. In addition, even in communities where mental health professionals are available, financial incentives may be inadequate to ensure access by OEF/OIF veterans. For example, some providers report that they will not accept TRICARE patients because of low reimbursement rates.

**Community initiatives.** In recognition of access barriers, many states have developed efforts to create connections across sectors of care or to create new community-based support resources from which combat veterans can seek care. Rhode Island formed a Veterans Task Force to address the state’s needs for veterans and their families. An outcome of that effort is a handbook containing information about postdeployment challenges and a resource listing. Washington State implemented a free PTSD counseling program and also trains teachers and school counselors about the potential needs of children and families of service members. In Colorado, poor availability of VHA mental health services in some rural areas has been addressed through cooperative agreements with the VHA and private funders to increase veterans’ access to confidential mental health services from community mental health centers throughout the state. Other states have gone so far as to create special programs for their Guard troops, in an effort to ensure that there are programs to fill the access gaps left by restricted VHA capacity. The New York State Office of Mental Health is partnering with the VHA to offer mental health screening as part of the New York National Guard Yellow Ribbon Reintegration Program. To date, there is no information on the extent to which the many and diverse state and local initiatives have increased access to mental health services for OEF/OIF veterans.
Gaps In The Quality Of Care

Policy and program initiatives to address the mental health needs of OEF/OIF veterans have largely focused on increasing access to care by extending eligibility or hiring more providers, yet there are also major quality gaps in mental health care. Unless these gaps are addressed, we risk increasing access to services that are not effective.

Evidence-based treatments. Evidence-based treatments for PTSD and depression include psychotherapy (cognitive and cognitive behavioral therapy for depression and PTSD; interpersonal therapy for depression; prolonged exposure therapy and eye-movement desensitization and reprocessing for PTSD); and medications (most commonly, selective serotonin reuptake inhibitors [SSRIs] for major depression and PTSD). Choice among treatments, or their combination, depends on patients’ preferences, severity of symptoms, and prior treatment response. For treatment of PTSD, however, there is stronger evidence for the effectiveness of psychotherapy than for medication. None of these treatments is highly expensive or complicated. They can be delivered on an outpatient basis, with few visits, and the acute phase of treatment typically lasts well under a year. Challenges to providing evidence-based practices include national workforce competency concerns, and limited implementation of systems that support improvements in the quality of care.

Workforce competency. A variety of mental health specialists can provide psychotherapy, including psychiatrists, clinical psychologists, counselors, clinical social workers, marriage and family therapists, and pastoral counselors, with vast differences across these professions in the duration and nature of their training. Psychiatrists are trained and licensed to deliver both psychopharmacology and psychotherapy (although training places less emphasis on the latter). Primary care physicians are an important complement to psychiatrists for psychopharmacology and have had a rapidly expanding role in prescribing SSRIs, although their practice teams do not typically include staff trained to deliver psychotherapy.

Theoretical orientations and standards of practice across these specialties are highly diverse, with little cross-disciplinary fertilization. Training of mental health specialists does not sufficiently emphasize evidence-based treatments or quality improvement (QI) approaches to practice. Trainees are often unprepared for the modern health care environment, in which there are expectations that care should be consistent with best-practice clinical guidelines and coordinated with other specialists or the “medical home.” Additionally, the content of psychotherapy is not easily monitored, so it is difficult to know how far routine practice deviates from evidence-based clinical guidelines. Furthermore, training and experience specific to combat-related mental health problems, and understanding of military culture and experience, are rare among community-based practitioners. Best-practice treatment guidelines for PTSD and depression are available, but standard practices for training clinicians in best practices and ensuring that they
meet core competencies do not exist.\textsuperscript{30}

Given this context, veterans face challenges in locating providers who use best practices to treat depression and PTSD. Health care organizations providing mental health services, including employer-based health plans, the VHA, and TRICARE, all draw upon a diverse practitioner workforce for whom licensing credentials do not ensure competencies required to appropriately assess and provide evidence-based treatment for combat-related mental disorders. In recognition of this problem, the DoD and VHA have begun developing and implementing programs to train clinicians in the use of evidence-based guidelines.\textsuperscript{31}

- **Systems support for QI.** The extent to which QI programs are being implemented in the community to address priorities for mental health problems faced by OEF/OIF veterans and whether these activities result in meaningful improvements in care are largely unknown. Although some specific efforts are under way, quality-assessment and decision-support tools are not readily or widely available to address the needs of this population.\textsuperscript{32} Further, unlike the maturing field of QI for depression in primary care settings and the emerging field of QI for panic disorder, little is known about improving care for PTSD.\textsuperscript{33}

QI system support is most apparent within the VHA, which developed an infrastructure to manage quality using systemwide performance measurement based on administrative data and patient satisfaction data. This performance-monitoring program led to improved preventive primary, chronic disease, and palliative care.\textsuperscript{34} Although the VHA routinely reports performance using measure sets that cover seven clinical areas (including PTSD care), no information is available from this system on the clinical quality or outcomes of PTSD services.\textsuperscript{35}

The VHA has also undertaken the Mental Health Quality Enhancement Research Initiative (MH-QUERI), which supports ongoing QI programs to improve outcomes for patients and improve the delivery of clinical services for mental health.\textsuperscript{36} MH-QUERI uses a collaborative care model for major depression with emphasis on joint care by primary care providers and mental health specialists, with support from a depression care manager. The collaborative care model, which has been shown to improve outcomes of depression treatment in a cost-effective manner, is a promising approach for the VHA but has yet to be widely implemented.\textsuperscript{37} Studies of QI efforts have found that patient care in the VHA is better relative to community-based care.\textsuperscript{38}

**Conclusions And Recommendations**

Many efforts to identify and treat PTSD and depression among veterans are underway. The large influx of funding to the DoD and VHA as well as the creation of the DCoE for Psychological Health and TBI represent historic opportunities to bring high-quality programs to service members and veterans. Increased investment in research, staff, training, and programs has been swift. Yet although great strides have been made, many challenges remain.
Recent research has suggested that the prevalence of PTSD and depression is high and may continue to rise as the current conflicts continue. If left untreated or undertreated, these problems could lead to other negative consequences, such as other mental and physical conditions, family/relationship problems, lower productivity, premature mortality, suicide, and homelessness. These conditions thus potentially place a high economic toll on society.39

Effective treatments for PTSD and depression exist, yet they are not being provided systematically to most affected veterans because of significant challenges that extend beyond the DoD and VHA service systems to the broader communities in which veterans reside, and to the private employer-based or public systems upon which they rely for health care. Above, we highlighted key challenges: veterans’ perceptions of the negative consequences of seeking care; inadequate availability of mental health professionals in many parts of the country; diverse and often competing mental health specialties and training approaches that inadequately prepare many practitioners to deliver evidence-based treatments for combat-related disorders or to understand military experience; and limited dissemination and implementation of QI strategies in mental health care settings. Surmounting these challenges will require federal, state, and local leadership.

There are no reported data or analyses to help the nation or specific regions and communities assess veterans’ needs for services by geographic area, and to plan for and coordinate service delivery across community-based, TRICARE, and VHA resources. Such analyses could inform specific recommendations for targeting resources. In spite of this limitation, we propose several general directions for moving forward.

- **Need for confidentiality.** Both DoD policy changes and educational efforts are needed to change attitudes toward mental health care. As the DoD continues to promote a culture of psychological health, it must also continue to reduce fears of negative career consequences that result from disclosure requirements. Recent changes to the security clearance procedures for those who have sought mental health services to deal with combat-related PTSD address this issue in part.40 But policies that require disclosure and command reporting of mental health care remain. To remove these barriers further, service members could be permitted to voluntarily seek and receive mental health care under the same level of confidentiality that is extended to civilians. The DoD must continue to determine the readiness of its forces, which is a rationale for current requirements for reporting mental health service use, but these determinations could be informed by other, potentially more useful, means that rely more directly on functioning and performance assessment.

- **Consumer education about treatment choices.** Enhanced national education and outreach efforts could enable service members, veterans, and their families to become informed consumers of mental health services and active participants in the decisions regarding their care. Some campaigns to raise awareness and provide information about treatment are under way through the VHA; however, Vet Cen-
ters, individual states (for example, the National Guard’s “Beyond the Yellow Ribbon”), the DoD (for example, Military OneSource, Battlemind, Landing Gear, and OSCAR), and additional community-based education and outreach could build on and reinforce existing efforts.41

- **Workforce policy.** Many mental health policy recommendations have already been put forward to address the alarming national workforce crisis in behavioral health—both the insufficient numbers of mental health treatment professionals to meet demand in many parts of the country, and an existing specialty workforce that is poorly prepared to provide high-quality mental health care. This crisis affects every system of mental health care, predates the growing mental health needs of the OEF/OIF population, and is the backdrop against which the VHA and the DoD are trying to increase the capacity of their mental health specialty staff and services. The recent Substance Abuse and Mental Health Services Administration (SAMSHA) action plan for behavioral health workforce development proposes seven broad strategic goals to address this crisis, including “implement systematic recruitment and retention strategies at the federal, state, and local levels” and “increase the relevance, effectiveness, and accessibility of training and education.”42 Others have put forward proposals for reform in graduate education to close the “training gap that leaves graduate students, working professionals, and other direct care providers inadequately prepared for practice in the current health care environment.”43

- **Training and certification.** Progress toward these goals may resolve the behavioral health workforce crisis over the long run, but immediate and focused efforts are also needed in the short run. Many communities have worked to develop local solutions to fill in the gaps for their OEF/OIF veterans. A broader national effort could assist local communities by making training and certification in treatment of combat-related mental health problems widely available to the existing community-based workforce and to primary care physicians and their clinical support staff. A formal certification program could provide incentives and set standards for training. A public awareness campaign could simultaneously educate OEF/OIF veterans and their families and direct them to certified practitioners, and TRICARE could establish preferences for certified practitioners in its behavioral health networks.

- **QI needs.** System-level QI efforts are also needed to support routine practice in the care of mental disorders for OEF/OIF veterans. Although QI has demonstrated effectiveness, it is not effective all of the time.44 Nevertheless, QI has great potential to reduce variability in the processes and outcomes of mental health care, improve the practice of guideline-concordant care, and improve outcomes for those who receive care. QI programs that set external performance goals, use financial incentives, and provide performance feedback are likely to help motivate change among individual clinicians and improve care over time.45 The VHA has made progress toward implementing and demonstrating the effectiveness of QI approaches in care for depression, and it is poised to make similar progress in care for PTSD. Greater chal-
Challenges exist in developing successful and sustainable QI approaches for typical community-based practices, where the infrastructure needed to support QI efforts is not established. Health plans such as TRICARE could play a key role by monitoring and providing feedback to practitioners, along with setting performance goals and designing performance incentives.

**Technical assistance to the states.** One final effort could make a difference for OEF/OIF veterans: provision of technical assistance, training, and evaluation resources to assist the numerous state and local efforts that are under way to reach out to and fill gaps in care for veterans. Such an effort should be focused on addressing gaps in access to and quality of mental health care. This could include assistance for building mental health capacity and workforce competency within existing programs for veterans such as storefront Vet Centers, “Beyond the Yellow Ribbon” programs, and other state initiatives.

Although the challenges are significant, many lessons have already been learned about how to care for the mental health problems of returning veterans. We know about treatments that work, about ways to remove barriers to care and engage informed consumers in decision making, about behavioral health workforce training and development, and about system-level support to promote and sustain high-quality mental health care. An investment made in applying those lessons will benefit our veterans, to whom we are indebted for their service and sacrifice, and will yield social benefits by helping a generation of young adults achieve productive lives.

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**NOTES**


27. IOM, “Increasing Workforce Capacity.”


29. L. Bickman, “Why Don’t We Have Effective Mental Health Services?” *Administration and Policy in Mental Health*.