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Improving Veteran Engagement With Mental Health Care

The VA is intent on reducing and preventing veteran deaths by suicide. Most veteran who die by suicide, however, did not get treatment from the VHA, emphasizing the need for improved outreach to those veterans who are not part of the VA health care system.

I will begin by reviewing some reasons why veterans do not go to the VHA or to other mental health treatment centers and how we can change that. I am well aware that the health care providers at the DoD and VHA—including myself—feel overwhelmed by the influx of patients already at their doorstep. Thus, many providers are ambivalent about bringing in more patients when timely access remains a challenge. However, it is critical to engage patients in care to try to improve their lives and, hopefully, bring down the suicide rate.

Another critical issue then is hiring additional clinical providers and administrative staff. More providers are essential for timely patient care. If phones are not answered and patients cannot make appointments, they become frustrated and give up, especially if they already are ambivalent about seeking treatment.

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MENTAL HEALTH SERVICE EXPERIENCES

Active-duty service members' experience of the mental health service ranges from helpful to humiliating. Why is this? The helpful part is easy. The military has hundreds of finely trained professional mental health care providers who try their best to help the soldiers, marines, airmen, and sailors recover from the stress of combat or from providing humanitarian assistance. They use up-to-date therapeutic techniques and medication.

At the humiliating end of the spectrum, many service members are sent to behavioral health for "clearance" before they are administratively separated, ie, discharged without benefits. The separation may be for a variety of administrative discharges, such as a personality disorder; other mental health or medical disorders; or less than honorable discharges. The labels of the discharge vary in the different services, but the disappointment remains.

If the service member is enrolled in a drug and alcohol program (eg, the Army Substance Alcohol Program), the standard is total abstinence. If a service member fails to achieve abstinence, he or she may be discharged without benefits. The denial of benefits is controversial but is still the standard. I recommend a harm reduction model, eg, less drinking or drug use, which may be more achievable in many cases.

The waiting room of a military mental health or behavioral health clinic usually is occupied with service members who are facing a variety of discharges from the military (considered "losers"). Sitting in a crowded waiting room, sometimes for hours, can be humiliating.

To be clear, the clinic experience is not always humiliating. At many Wounded Warrior clinics, the environment is more welcoming. For example, at the National Intrepid Center of Excellence and other specialty clinics, the atmosphere is much more therapeutic.

Significantly, the negative feelings from the routine military clinics often translate into reluctance to go to a mental health clinic at the VHA or elsewhere. To reduce the stigma, the military has switched from using the term *mental* health to *behavioral* health, but a name change does not really change the stigma.

Ending the Stigma

To reduce the stigma, DoD has deployed many public service announcements (PSAs). These often have positive messages, such as: It is a sign of strength to accept help; Being mentally injured is like having a broken leg; I am a 3-star general, I have PTSD, and I got help—you can too. Unfortunately, these messages do not resonate

with many service members: They have seen many of their friends discharged after seeking mental health services (although that may not have been the actual reason for their discharge). Hoping for a promotion may lead to avoidance of care out of fear that treatment will lead to being passed over for promotion.

Reluctance

When service members come to the VA, it is often with a defeatist attitude. "My wife said I need to come, or she will divorce me." "I cannot concentrate in school, and I am failing classes." "My girlfriend threw me out, and I have no place to live." There is an initial interview with a mental health provider—often after a long waiting period. Often the veteran does not return for a follow-up.

Unquestionably, psychiatric and psychological treatments benefit service members—but the treatments also have drawbacks. Psychiatric medications, although potentially helpful often cause weight gain and sexual adverse effects. Trauma-based therapies deliberately force service members to reexperience the trauma. Reliving the traumatic experience is inherently painful. Additionally, there may be practical concerns, such as getting to the clinic, traffic, and parking.

SOLUTIONS

So how do we engage the veteran? There are several well-established practices. I am a big supporter of all veteran outreach. The veteran service organizations (VSOs) are well established but traditionally appeal to older veterans. However, VSOs are working to reach younger veterans in the context of outreach or sporting activities. Peer outreach also works well with veterans in or out of the VA system connecting with their fellow veterans. I favor engaging veterans through baseball games, kayaking, picnics, and other athletic/social activities. These are nonthreatening ways to engage the veteran and his or her family. Using animals, especially dogs and horses, also is a good way to connect.

Clinical Strategies

When I treat veterans who are ambivalent—which the younger ones usually are—I ask where they live, then when or where did they serve, and what was their military occupational specialty. In other words, I ask them about their strengths.

Besides the standard depression and PTSD symptoms, I ask about sexual health, knowing that it often is a major concern. I describe the wide range of PTSD treatments, using the "3 buckets" model to describe them. The 3 buckets are psychiatric medication, talking therapies, and everything else. The last bucket includes exercise, yoga, meditation, animal-assisted therapies, and others, such as transcranial magnetic stimulation and stellate ganglion block.

Veterans often are more comfortable with the last bucket, as it allows them more options. With this knowledge the service members have more tools, so they feel less helpless and more in charge of their health care.

CONCLUSION

There are many reasons why service members do not seek mental health care. Stigma is one that is often cited. Also, they often associate mental health treatment with humiliation. We have a duty to change that paradigm. ●

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