

**ENSURING BEHAVIORAL
HEALTHCARE CAPACITY
AND QUALITY
FOR SERVICEMEMBERS,
VETERANS AND MILITARY
FAMILIES**

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A great deal of attention has been paid in the past few years to the impact of war on behavioral health. Statistics now abound regarding the numbers of servicemembers who have deployed to OEF/OIF, the common visible and invisible wounds, and the high need (whether acknowledged by those in need or not) for behavioral health services. There appears to be widespread agreement that the capacity of our nation's behavioral health workforce must increase, and rapidly. Exactly how to go about increasing this capacity – in terms of both quantity and quality – is not as clear. This military behavioral health policy brief addresses the development of a high-capacity behavioral health workforce to care for our nation's servicemembers, veterans, and military families.

**IMPACT OF WAR ON
BEHAVIORAL HEALTH**

Our nation has been at war for over a decade, with more than 2.6 million American servicemembers having been deployed to Afghanistan or Iraq. Frequently cited statistics estimate that

one-third of all servicemembers will experience significant problems with combat stress, substance abuse, depression and/or suicide (DoD Task Force on Mental Health, 2007; Tanielian et al., 2008). Beyond the impact on those individuals, there are effects on the family members who send their loved ones off to war – and to whom the servicemembers return home. Many such family members experience significant socio-emotional challenges, even so-called “secondary PTSD”, and also require professional assistance (Chandra et al., 2010; Figley, 1998; Hall, 2008). Further, certain aspects of OEF/OIF, beyond the sheer number of those who have served, magnify the impact and exacerbate the stresses of war. These conditions include the extensive use of Reserve Component forces, repeated deployments of enlisted men and women, the absence of a combat “front,” constant exposure to threat, rapid return with little time for mental or emotional calibration, and lack of readiness in the civilian culture to understand and absorb veterans (Burnam et al., 2009; Castaneda et al., 2008; DoD Task Force on Mental Health, 2007; Erbes, 2009; Flynn & Hassan, 2010). For example, reservists deployed to Iraq or Afghanistan were later found to be twice as likely as active duty personnel to meet screening criteria for PTSD and depression, suggesting a marked need for mental health services among this subgroup (Castaneda et al., 2008; Schell & Marshall, 2008). This is not surprising, given the structure of their service itself: Reserve Component members return from deployment to

civilian jobs and communities, where there are often few supports – formal or informal – who understand their deployment experience and the major adjustment involved in returning to civilian life.

STRAINED TRADITIONAL SERVICE SYSTEMS AND THE CIVILIAN RESPONSE

Historically, living arrangements, schools, medical services, and other institutions serving the military and veterans have been separated and often isolated from civilian programs and services. While these insular systems of care may have been sufficient in previous generations, they are overloaded and no longer capable of independently meeting the needs of our wounded warriors and their families (Stahl, 2009). For example, a military installation in Hawaii was reported to have had one mental health officer for every 265 cases, whereas the official military standard is 1:50 (Pittsburgh Tribune Review, 2011). Similar examples are evident within the Department of Veterans Affairs, where recent research has borne out longstanding anecdotal scenarios of long delays in getting initial appointments, extended periods between appointments, and lengthy waiting room delays (National Council for Behavioral Healthcare, 2010; Schell & Tanielian, 2011). Clearly, not all servicemembers and veterans seeking care through the DoD or VA are currently able to find it, at least in a timely manner. Further, some veterans choose not to seek care through the VA, sometimes the result of logistical barriers, such as the lack of proximity to a healthcare facility or extended hours to accommodate a full-time work schedule, and other times due to perceptions of VA culture – that the VA is primarily

focused on older-generation and more severely disabled veterans (Schell & Tanielian, 2011).

Regardless of the reason, civilian providers are increasingly called to meet the behavioral healthcare needs of our nation's servicemembers, veterans and military families. Civilian education and training programs have historically not been oriented toward content crucial for work with military populations, and civilian providers often have minimal understanding of "military culture" (Hall, 2008; Tanielian et al., 2008). Without such background, civilians have difficulty in relating to the experience of veterans, and according to anecdotal evidence, are often less effective – at least at engaging new clients - than are uniformed providers. Many community mental health providers also fall short of recommended standards for treatment and care (Burnam et al., 2009; Castaneda et al., 2008; DoD Task Force on Mental Health, 2007; Erbes, 2009). Civilian behavioral healthcare providers may not realize the harm they are doing, or could do – not only by perpetuating beliefs about the inability of civilian providers to understand, or to help - but to the individual, family, community, and society by having someone continue to suffer from the invisible wounds of war long after the deployment has ended.

CURRENT RESPONSES TO INCREASING CAPACITY

Huge demand, strained service systems, and providers relatively unfamiliar with the specific needs of those they seek to serve point unequivocally to the need for expanded behavioral healthcare capacity. The Department of Defense Task Force on Mental

Health (2007) and RAND (Tanielian et al., 2008) provided clear and compelling arguments and recommendations for an expansion of our nation's behavioral healthcare workforce. Efforts appear to be mobilizing, both across the U.S. and across disciplines: at least four schools of social work and psychology offer degree-based programs specializing in military behavioral health (please see reference list); other degree-granting institutions offer focused electives; academic scholarship funding is available for students planning to pursue practice careers with military-related populations; and several academic institutions, governmental agencies and human services organizations offer continuing education courses for behavioral healthcare professionals on a variety of topics relevant to providing behavioral healthcare to servicemembers, veterans and military families. Moving a step beyond training, leaders in military social work have developed a set of guidelines for advanced practice in military social work (CSWE, 2010), and a similar document is being developed to guide behavioral healthcare practice with families impacted by military service (A. Hassan, personal communication, January 5, 2011).

What we do not know at this point is how effective are the various programs at increasing provider capacity, both in volume and in culturally-relevant, empirically-supported military behavioral health training. While recent activity in academia and in the service delivery sector suggests that the call for increased capacity has been heard, further attention needs to be directed towards understanding the impact, as well as the quality, of the response.

RECOMMENDATIONS

In light of previous literature that makes a clear case for expanding our nation's military-trained behavioral healthcare workforce, and the evidence of a mounting response, we suggest the following ways to maximize progress in this area:

- Behavioral healthcare provider training must include attention to the military as a culture, and integrate the latest empirically-supported methods of intervention.
- Providers of military behavioral health training would serve their students and their profession well by evaluating the impact of their training. Key outcomes for inclusion might include context-specific knowledge, trainee perceptions of influences on practice, and trainee characteristics, such as clinical self efficacy, in the context of working with a military population.
- Accrediting bodies might assess educational institutions offering degree programs in relation to newly-established military behavioral healthcare guidelines such as the Council on Social Work Education's *Advanced Practice Behaviors for Military Social Work Practice* (CSWE, 2010) or the forthcoming set of guidelines for practice with families impacted by military service (A. Hassan, personal communication, January 5, 2011). Additional guidelines, pertaining to specific areas of military behavioral healthcare practice, might need to be developed.
- Governmental entities at the national and state levels could ensure that relevant

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training is accessible to current behavioral healthcare professionals by working with the key professional associations, such as the American Psychological Association (APA), the National Association of Social Workers (NASW) and the Association for the Advancement of Marriage & Family Therapy (AAMFT), as well as with large provider groups (e.g., Give an Hour, Soldiers Project). Provision of funding support for workforce training, particularly among volunteer providers, could serve to enhance training availability and accessibility.

- Federal entities might also consider working with state licensing boards to mandate military culture continuing education courses for *all* behavioral healthcare providers. Such efforts are not uncommon when the relevant issues and populations are important and far-reaching; for example, the state of CA mandates that all Licensed Clinical Social Workers have one time and/or recurrent continuing education in domestic violence, law & ethics, and aging.

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