

Subject: Studies in the News: (May 6, 2010) **Special Issue on Veterans**



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VETERANS

“Community Integration: Current Issues in Cognitive and Vocational Rehabilitation for Individuals with ABI.” By Paul Wehman and others, Virginia Commonwealth University. IN: *Journal of Rehabilitation, Research & Development*, vol.46, no. 6 (2009) pp. 909-918

[“In this article, we examine cognitive and vocational rehabilitation and the issues related to minority veterans with acquired brain injury (ABI). As more service members are returning from conflict, ways to help them repair their lives, not only physically but also socially and economically, are increasingly needed. The challenges of ABI are multifactorial; that is, the problems are not just cognitive or emotional but spill over into community living and vocational issues. Individuals from racial/ethnic minority backgrounds often face even more difficulties. Therefore, we review the nature of cognitive and vocational rehabilitation and suggest areas for additional research.”

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Related article: “Integrating Peer Support Initiatives in a Large Healthcare Organization.” (August 2008)

Full text at:

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“Description of Outpatient Utilization and Costs in Group of Veterans with Traumatic Brain Injury.” By Beeta Y. Homaifar, Department of Veteran’s Affairs, Denver, Colorado, and others. IN: *Journal of Rehabilitation Research & Development*, vol. 46, no. 8 (2009) pp. 1003-1010.

[“In an attempt to increase understanding regarding the nonacute healthcare needs of *veterans* with *traumatic brain injury* (TBI), we examined the outpatient utilization and cost patterns of 72 patients with TBI who were at least 4 years postinjury. We selected participants from a clinical database of *veterans* receiving care at a western Department of *Veterans* Affairs (VA) medical center. We extracted data from national utilization databases maintained by the VA and examined data from primary care and internal medicine, psychiatry and substance use, rehabilitation, and other services (e.g., ancillary, diagnostic, prosthetic, dental, nursing home, and home care). We extracted data for fiscal years 2002 to 2007. In addition to descriptive statistics, we modeled visits per year as a function of time since *injury*. The data show that this sample of patients with TBI consistently used a wide array of outpatient services over time with considerable variation in cost. Further study regarding economic aspects of care for patients with TBI is warranted.”]

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“A New Disability of Rehabilitation Counselors: Iraq War Veterans with Traumatic Brain Injury and Post-Traumatic Stress Disorder.” By Hillary S. Burke and others, San Diego State University. IN: *Journal of Rehabilitation*, vol. 75, no. 3 (July-September 2009) pp. 5-14.

[“*Traumatic brain injury* (TBI) and post-*traumatic* stress disorder (PTSD) are considered the “signature” *injuries* of military personnel serving in the Iraq war. An alarming number of returning *veterans* are incurring a combination of these two disabilities. TBI and PTSD combined presents an array of challenges for injured persons that are experienced differently by those separately affected by TBI or PTSD. Hence, the combination of TBI and PTSD presents a new disability classification for the rehabilitation counseling profession. There is an acute need to develop and facilitate specialized care and rehabilitative services for *veterans* impacted by this nascent disability. We highlight neurobiological, behavioral, and physiological characteristics associated with combat-incurred TBI/PTSD *injuries*. Additionally, we offer recommendations for rehabilitation counseling professionals and researchers to consider in response to our review of the current system of *veteran* care, common barriers to rehabilitation and societal re-integration, and available resources for military personnel impacted by TBI and PTSD.”]

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Related article: “Naturalistic Comparison of Models of Programmatic Interventions for Combat-Related Post Traumatic Stress Disorder.” (December 2008)

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PTSD in Iraq War Veterans: Implications for Primary Care. By Annabel Prins and others, U.S. Department of Veterans Affairs. (The Department, Washington, D.C.) 2010. pp. 1-4

[“During and after the Iraq War, primary care providers may notice changes in their patient population. There may be an increased number of veterans or active duty military personnel returning from the war. There also may be increased contact with family members of active duty personnel, including family members who have lost a loved one

in the war or family members of individuals missing in action (MIA) or taken prisoner of war (POW). In addition, there may be increased distress in veterans of other wars, conflicts, and peacekeeping missions. All of these patients may be experiencing symptoms of posttraumatic stress disorder (PTSD):

Veterans and active duty military personnel may have witnessed or participated in frightening and upsetting aspects of combat.

Veterans and active duty military personnel may have experienced military-related sexual trauma during their service.

Family members may suffer traumatic stress by hearing about frightening or upsetting events that happened to loved ones, or from the loss or fears of loss related to family members missing or deceased.

Other veterans may be reminded of frightening and upsetting experiences from past wars, which can exacerbate traumatic stress responses.

These types of stress reactions often lead people to increase their medical utilization.

Because far fewer people experiencing traumatic stress reactions seek mental health services, primary care providers are the health professionals with whom individuals with PTSD are most likely to come into contact.”]

Full text at:

<http://www.ptsd.va.gov/professional/pages/ptsd-iraq-vets-primary-care.asp>

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Related article: “Utilization of Primary Care by Veterans with Psychiatric Illness in the National Department of Veterans Affairs Health Care system.” (November 2008)

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Related article: “Flashback: Post-traumatic Stress Disorder.” (2007)

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=31585625&site=ehost-live>

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The Returning Veteran of the Iraq War: Background Issues and Assessment Guidelines. By Brett Litz and Susan Orsillo, United State Department of Veterans Affairs. (The Department, Washington, D.C.) 2010. pp. 1-5.

[“The psychological, social, and psychiatric toll of war can be immediate, acute, and chronic. These time intervals reflect periods of adaptation to severe war-zone stressors that are framed by different individual, contextual, and cultural features (and unique

additional demands), which are important to appreciate whenever a veteran of war presents clinically.

The immediate interval refers to psychological reactions and functional impairment that occur in the war-zone during battle or while exposed to other severe stressors during the war. The immediate response to severe stressors in the war-zone has had many different labels over many centuries (e.g., combat fatigue); the label combat stress reaction is used most often currently. However, this is somewhat a misnomer. As we discuss below, direct combat exposure is not the only source of severe stress in a war-zone such as Iraq. The term war-zone stress reaction carries more meaning and is less stigmatizing to soldiers who have difficulties as a result of experiences other than direct life-threat from combat. Generally, we also want to underscore to clinicians that being fired upon is only one of the many different severe stressors of the war-zone.”]

Full text at:

<http://www.ptsd.va.gov/professional/pages/vets-iraq-war-guidelines.asp>

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Related article: “Early Intervention for Trauma: Where are we and where do we need to go? A Commentary.” (December 2008)

Full text at:

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“A Roadmap for Rehabilitation Counseling to Serve Military Veterans with Disabilities.” By Michael P. Frain, Florida Atlantic University, and others. IN: Journal of Rehabilitation, vol. 76, no. 1 (2010) pp. 13-21.

[“Providing rehabilitation services to military veterans with disabilities presents unique and rewarding challenges for rehabilitation professionals. The need for these services has grown tremendously with the wars in Afghanistan and Iraq. The rehabilitation field needs a roadmap for understanding how its strengths can uniquely serve military veterans most appropriately. The paper outlines a five-pronged approach that will benefit outcomes for veterans with disabilities through: (1) infusing veterans’ issues into rehabilitation training; (2) focusing on distinct employment needs for veterans; (3) using self-management techniques to manage secondary disabilities; (4) using a Family Resiliency Model to address the holistic needs of veterans and their families; and (5) the call for rehabilitation to develop researchers that focus on veterans’ issues.” **NOTE: For an electronic copy of this article, please contact the California State Library.**]

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Related article: “A Predictive Screening Index for Posttraumatic Stress Disorder and Depression Following Traumatic Injury.” (December 2008)

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=pdh&AN=ccp-76-6-923&site=ehost-live>

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S. 1963: Caregivers and Veterans Omnibus Health Services Act of 2009. 111th Congress, 2009-2010. Summary. By the Congressional Research Service. April 21, 2010.

[“A bill to amend title 38, United States Code, to provide assistance to caregivers of veterans, to improve the provision of health care to veterans, and for other purposes.”]

Full text at:

<http://www.govtrack.us/congress/bill.xpd?bill=s111-1963&tab=summary>

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“Treatment Receipt by Veterans after PTSD Diagnosis in PTSD, Mental Health, or General Medical Clinics.” By Michelle R. Spont and others, Department of Veteran Affairs Medical Center, Minneapolis. IN: *Psychiatric Services*, vol. 61, no. 1 (January 2010) pp. 58-63.

[“Despite the high prevalence of posttraumatic stress disorder (PTSD) among veterans treated at Department of Veterans Affairs (VA) facilities, rates of initiation of mental health treatment and persistence in treatment are unknown. This study examined outpatient treatment participation among veterans with a recent PTSD diagnosis and treatment differences according to the VA sector in which they received the diagnosis (PTSD specialty treatment program, general mental health clinic, and general medical clinic). *Methods:* Administrative data for 20,284 veterans who had received a diagnosis of PTSD at VA facilities were analyzed to determine rates of treatment initiation (any psychotropic prescription, an antidepressant prescription, behavioral counseling, and either a prescription or counseling) and maintenance of pharmacotherapy (at least four 30-day supplies), and counseling (at least eight visits) for the six months after diagnosis. *Results:* Approximately two-thirds of the sample initiated treatment: 50% received a psychotropic medication and 39% received some counseling; 64% received either medication or counseling. About half of those given medication (54%) received at least a four-month supply, and 24% of those given counseling had at least eight sessions. Overall, 33% received minimally adequate treatment. Initiation, type, and duration varied by treatment sector: receipt of a diagnosis in a PTSD specialty program or a mental health clinic conferred small but significant benefits over receipt in a general medical clinic. *Conclusions:* Greater availability of mental health specialty services, particularly PTSD services, may be needed to ensure that veterans receive minimally adequate treatment after a PTSD diagnosis.” **NOTE: For an electronic copy of this article, please contact the California State Library.]**

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Trends and Risk Factors for Mental Health Diagnoses among Iraq and Afghanistan Veterans Using Department of Veterans Affairs Health Care: 2002-2008. By Karen Seal, San Francisco VA Medical Center, and others. IN: *American Journal of Public Health*, vol. 99, no. 9 (September 2009) pp. 1651-1658.

[“Objectives. We sought to investigate longitudinal trends and risk factors for mental health diagnoses among Iraq and Afghanistan veterans. Methods. We determined the prevalence and predictors of mental health diagnoses among 289328 Iraq and Afghanistan veterans entering Veterans Affairs (VA) health care from 2002 to 2008 using national VA data. Results. Of 289328 Iraq and Afghanistan veterans, 106726 (36.9%) received mental health diagnoses; 62929 (21.8%) were diagnosed with posttraumatic stress disorder (PTSD) and 50432 (17.4%) with depression. Adjusted 2-year prevalence rates of PTSD increased 4 to 7 times after the invasion of Iraq. Active duty veterans younger than 25 years had higher rates of PTSD and alcohol and drug use disorder diagnoses compared with active duty veterans older than 40 years (adjusted relative risk=2.0 and 4.9, respectively). Women were at higher risk for depression than were men, but men had over twice the risk for drug use disorders. Greater combat exposure was associated with higher risk for PTSD. Conclusions. Mental health diagnoses increased substantially after the start of the Iraq War among specific subgroups of returned veterans entering VA health care. Early targeted interventions may prevent chronic mental illness.” **NOTE: For an electronic copy of this article, please contact the California State Library.**]

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“VA Intensive Mental Health Case Management in Urban and Rural Areas: Veteran Characteristics and Service Delivery.” By Somaia Mohamed and others, Department of Psychiatry, Yale University. IN: *Psychiatric Services*, vol. 60, no. 7 (July 2009) pp. 914-921.

[“The availability of mental health services in rural areas— particularly intensive services such as assertive community treatment (ACT)—have been of increasing concern and were the focus of this study. In recent decades the U.S. Department of Veterans Affairs (VA) has developed a national network of ACT-like programs called mental health intensive case management (MHICM), which have served veterans from diverse locations across the country, including urban and rural areas. *Methods:* This study used rural-urban commuting area codes and national VA administrative data to compare characteristics of veterans and patterns of MHICM service delivery among veterans with mental illness living in large urban, large rural, small rural and isolated rural communities. *Results:* Among veterans enrolled in MHICM from FY 2000 to FY 2005 (N=5,221), 84% (N=4,373) resided in urban areas, 8% (N=421) in large cities, 6% (N=291) in small rural towns, and 3% (N=136) in isolated rural areas. MHICM participants who lived in rural areas had clinical problems broadly similar to those in urban areas, although more rural veterans were unemployed, disabled, received VA disability compensation, and had a payee or fiduciary. MHICM clients in smaller or isolated rural areas received slightly less frequent and less intensive contacts and less recovery-oriented services than those in large urban locations. *Conclusions:* These data

highlight the need for intensive case management services in rural areas and note some challenges in providing them at the intensity and frequency observed in urban areas where travel distances and times are shorter.” **NOTE: For an electronic copy of this article, please contact the California State Library.]**

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Veteran’s Health Administration: Community-Based Outpatient Clinics. By Sidath Viranga Panangala, Specialist in Veterans Policy and Bryce H.P.Mendez. Congressional Research Service, No. 7-5700. (The Service, Washington, D.C.) 17 p.

[“In the early 1990s, the Veterans Health Administration (VHA)—one of the three administrations to provide outpatient primary care, especially for veterans who had to travel long distances to receive care at VA facilities. To facilitate access to primary care closer to where veterans reside, VHA began implementing a system for approving and establishing Community-Based Outpatient Clinics (CBOCs).

A CBOC is a fixed health care site that is geographically distinct or separate from its parent VA medical facility. A CBOC can be either VA-owned and VA-staffed or contracted to Healthcare Management Organizations (HMO). Regardless of how it is administered, a CBOC must have the necessary professional medical staff, access to diagnostic testing and treatment capability, and the referral arrangements needed to ensure continuity of health care for current or eligible veteran patients. VA policies require all CBOCs to be operated in a manner that provides veterans with consistent, safe, high-quality health care. CBOCs are managed at the Veterans Integrated Service Network (VISN) level, and planning and development of a new CBOC is based on the VA’s need, available resources, local market circumstances, and veteran preference.

In FY2010, VA expects to have a total of 833 operational CBOCs throughout the United States and its territories to serve over 2.8 million veteran patients. In addition to primary care, CBOCs provide mental health services, management of acute and chronic medical conditions, and pharmacy benefits, among other services. It should be noted that the type of medical services available at a CBOC can vary from clinic to clinic. This report provides an overview of VA’s rationale in establishing CBOCs, describes how they are managed and administered, discusses medical services provided at CBOCs, and summarizes what is known about the quality and cost of providing care in CBOCs compared to primary care clinics at VA Medical Centers. Lastly, it describes the process for developing a new CBOC. This report will be updated if events warrant.”]

Full text at:

http://assets.opencrs.com/rpts/R41044_20100128.pdf

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