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Mental Health Issues and Service Access in West Virginia Veterans of Recent Conflicts:

National Guard/Reserve Status and Rurality

Written Testimony
of
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Before the

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Hearing on VA Outreach to Members of the National Guard and Reserves

July 23, 2008

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Chairman Akaka, Ranking Member Burr, and Members of the Senate Committee on Veterans' Affairs: Thank you for the honor and the opportunity to provide the following testimony.

I am Joseph R. Scotti, Ph.D., a West Virginia licensed clinical psychologist and a professor of psychology at West Virginia University (Morgantown, WV), where I have been employed for the past 18 years. I have conducted service, teaching, and research in the area of posttraumatic stress disorder (PTSD) in a wide-range of populations (e.g., children, college students, adults) that have experienced a variety of traumatic stressors (e.g., combat, motor vehicle accidents, sexual assault, technological/industrial accidents). I have worked with combat Veterans of various eras (WW II, Korea, Vietnam, Desert Storm, and the current conflicts) since 1989 in various capacities, including over 12 years of consultation services (involving assessment, diagnosis, and treatment) at the Morgantown Vet Center (a Center that has distinguished itself as "Best Vet Center in the Nation" for multiple years) and the Louis A. Johnson VAMC (Clarksburg, WV), and through clinical services offered within the Department of Psychology at West Virginia University. I have multiple publications in journals and books, and dozens of conference presentations on PTSD in general, and combat veterans in particular. Presently, I am conducting

research with my colleagues on Veterans of recent conflicts, and am collaborating with the West Virginia National Guard Family Assistance Center to provide services to military service personnel and their families.

This testimony is provided to summarize key findings from a survey research study conducted by my colleagues and myself with Veterans from West Virginia who have been deployed in various areas of the Middle East as part of Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and related military operations.

The testimony shall show that for military personnel from the State of West Virginia:

1. Those who served as members of the National Guard and Reserves experienced exposure to combat and related war zone stressors at a level equal to that of Active Duty personnel.

(a) Those Veterans from Rural Counties of West Virginia experienced greater combat exposure than those from Urban West Virginia Counties.

2. Those Veterans who served as members of the National Guard and Reserves are experiencing a greater negative impact on psychological and daily functioning than are Active Duty personnel.

(a) Those Veterans from Rural Counties of West Virginia are experiencing a greater negative impact than those from Urban West Virginia Counties.

(b) The negative impact extends beyond the Veterans themselves and includes significant others and children.

3. Awareness of a wide range of services and supports to address the negative impact on the psychological and daily functioning of Veterans is generally high (80% to 90%).

(a) Utilization of services and supports varies by level, but typically, one-third to one-half or more of veterans in need are not utilizing professional or VA-related services.

(b) Only about one-half of Veterans report that a service they have utilized was "helpful" to them.

Background

This survey research study was conducted by the Veterans Work Group at West Virginia University (Project Coordinators: Virginia Majewski, Ph.D., School of Social Work, and Joseph R. Scotti, Ph.D., Department of Psychology; Key Contributing Members: Hilda R. Heady, M.S.W., Associate Vice President for Rural Health, and Roy Tunick, Ph.D., Department of Counseling and Rehabilitation Counseling). The survey was requested and funded by the West Virginia State Legislature Select Interim Committee on Veterans' Issues (Co-Chairs: Delegates Barbara E. Fleischauer and Richard J. Iaquinta, and Senator Jon B. Hunter) in response to that Committee's concerns regarding the need for and access to mental and physical health services among West Virginia's military personnel (particularly the National Guard and Reserves) who were returning from OEF/OIF and related deployments.

The survey study was funded in October of 2007, conducted during November 2007 to April 2008, and the resulting data have since been in various stages of analysis. The survey was an intentionally brief 108 questions in order to maximize response rate. The focus was on demographics, deployment experiences, the impact of those deployment experiences (in terms of symptoms of PTSD and depression, and changes in various areas of basic functioning), and awareness and use of a wide range of services. The staff of the WV State Division of Veterans Affairs mailed the survey to 6,400 WV Veterans from their mailing list of Veterans who had applied for the WV State Bonus ($600) for having served overseas. Approximately 1,000 surveys were undeliverable; approximately 1,100 completed surveys have been returned (a 20% response rate: 1,100/5,400). This testimony is based on 848 surveys presently entered into the survey database and which represent those Veterans who have served in the present conflicts of interest.

It is well established that there is an association between exposure to combat and other war zone stressors and the occurrence of mental health problems such as PTSD, depression, and substance abuse. Such research has almost exclusively been conducted with military Veterans who had enlisted or were drafted directly to active duty, and primarily with Veterans who were indentified through VA patient roles. The present military conflicts (i.e., beginning with Operations Desert Shield and Desert Storm to OEF and OIF) are unique in the inclusion of members of the National Guard in military conflicts outside the borders of the United States. Given the differences in the intensity, regularity, and type of training between active military and National Guard units, the impact of combat and related war zone stressors on members of the National Guard who have served in the conflicts overseas is a relative unknown. Thus, a portion of this testimony is dedicated to establishing the differential impact of war zone stressors on members of the National Guard, as compared to Active Duty personnel. Further, the Veterans in this survey were not accessed through VA patient roles, but rather through the WV State Division of Veterans Affairs. Thus, the information presented here represents both Veterans who have and have not sought VA services.

Survey Research Findings

General Demographics and Combat Exposure

Overall, the 848 persons (9% Female) in the study averaged 38 years of age (20-64 years) and were primarily white (96%, as reflects the demographics of WV). They came from all 55 counties in WV, with 57% reporting service in the National Guard or Reserves and all currently residing in WV. Of the 43% reporting Active Duty service, 56% were still out-of-state and primarily at a military base. Furthermore, of the 621 personnel residing in WV, 48% resided in the 13 urban counties of the State; 52% in the other 42 rural counties. All respondents indicated at least a high school degree and 30% reported some college. Active Duty personnel were younger, on average, than members of the Guard/Reserves (35 vs. 40 years), and were somewhat more ethnically/racially diverse (93% vs. 97% white). (We note an overwhelmingly positive response to this survey, with 87% or respondents reporting that the survey was "Worth the Time to Do.")

All respondents had been deployed at least once to the Persian Gulf Region since 1990 (97% since the year 2000) in--or in support of--various operations: Iraq (71%), Afghanistan (16%), the Persian Gulf Region (32%; e.g., Kuwait, Oman, Qatar, Saudi Arabia, Turkey), KFOR/SFOR (the

Kosovo Force/Stabilization Force in the Balkans region; 14%), and Operations Desert Shield/ Desert Storm (10%). Prior duty in Operation Restore Hope (Somalia, 1%) and Vietnam (2%), among other conflicts and operations, was additionally reported. Multiple duty stations and or deployments were reported by 43% of the respondents.

All branches of military service were represented; however, members of the Guard/Reserves were more likely to be in the Army (78%) than were Active Duty personnel (48%), and were more likely to report Combat Support Duty (70% vs. 60%) and less likely to report direct Combat Duty (43% vs.52%).

The Combat Exposure Scale (CES) was utilized to quantify the level of exposure to combat and war zone stressors, including engagement in patrols and dangerous duties; firing rounds at enemy forces; seeing someone hit by rounds or explosive devices; and the percentage of unit personnel who were wounded, killed, or missing. The CES score can be quantified as indicating Light, Light-Moderate, Moderate, Moderate-Heavy, and Heavy levels of combat exposure. The average score for both Guard/Reserve and Active Duty personnel was in the Moderate range; however, over 20% of Guard/Reserve and Active Duty personnel experienced Moderate-Heavy to Heavy levels of combat exposure.

Urban-Rural Differences. Veterans from Rural Counties of WV differed from those residing in Urban Counties in several ways. Rural Veterans were: (a) more likely than Urban Veterans to have been in the Army (83% vs. 60%), (b) to report Combat Duty (71% vs. 39%), and, (c) to report more exposure to a Moderate Level of combat (based on the Combat Exposure Scale; 33% vs. 23%) and less exposure to a Light Level of combat (16% vs. 28%).

Impact on Mental Health

Commonly used and well-validated self-report measures of PTSD and depression symptoms were utilized (PTSD Checklist, Center for Epidemiological Studies-Depression Scale) to evaluate the possible impact of combat exposure on the respondents.

[Symptoms of PTSD include reexperiencing the traumatic event, such as nightmares and intrusive thoughts; avoiding reminders of the event, including people, places, and activities; and hyperarousal, which includes exaggerated startle response, irritability, sleep disturbance, and concentration problems. Symptoms of depression include prolonged sadness, low self-worth, sleep and appetite disturbances, self-blame, and suicidal ideation.]

Using the recommended cut-off scores for these two measures (greater than 43 on the PTSD Checklist and greater than 15 on the CES-Depression Scale), 35% of the Veterans had scores suggesting clinical levels of PTSD, and 43% had scores suggesting clinical levels of Depression. Given the high concordance of depression with PTSD (a correlation of .85 in this study), Veterans were classified as having PTSD and/or Depression (PTSD/Depression Group: 47% of the respondents) or as not meeting criteria for either (Other Veterans Group: 53%).

[NOTE: It should not be assumed that the Other Veterans Group was free of mental health problems. The Other Veterans did not meet criteria for PTSD or Depression, but may well exhibit

other anxiety disorders, substance use/abuse problems, sleep disturbances, and a range of sub-clinical symptoms. Further, we did not directly evaluate Traumatic Brain Injury in this study.]

By point of comparison, the 35% rate of PTSD in the present study is similar to the 31% lifetime rate for PTSD reported in the National Vietnam Veterans Recovery Study (NVVRS). Further, the recent Rand Corporation Report (The Invisible Wounds of War, 2008) summarizes some 22 prior studies of OIF/OEF Veterans, giving a typical range of 5-15% for the occurrence of PTSD, but with some studies reporting rates as high as 30%. As if often seen in the trauma literature, rates vary by assessment measure and criteria, sample characteristics, and time since event, among other factors.

In this case, we note that members of the Guard/Reserves were more likely than Active Duty personnel to meet the criteria for PTSD/Depression (51% vs. 40%), despite having similar demographic backgrounds and combat experiences. This result may reflect the impact of pre-deployment preparation and training, support of families during deployment, and post-deployment debriefing and support resources.

Urban-Rural Differences. One characteristic that is related to mental health outcome in this study is whether the Veteran lived in an Urban or Rural County (a factor not investigated in the research summarized in the Rand Report). Veterans residing in West Virginia (primarily Guard and Reserves) were more likely to meet criteria for PTSD/Depression if they lived in a Rural County (58%) versus an Urban County (44%). Note, however, that county of origin may be a proxy for multiple other variables, including that persons in rural counties may have a lower income, lower employment levels, lower quality of education, dispersed support systems, greater transportation problems (roads, gas prices, reliable vehicles, and public services), and general availability and access to mental and physical health agencies and other support services.

Suicide Risk

Due to growing concerns about the increased rates of suicide among OIF/OEF Veterans, we reviewed the data for three factors that have been shown to be associated with increased suicide risk: high levels of symptoms of depression and PTSD, and high levels of combat exposure (Rand Corporation, 2008). In this sample, 8% of the Veterans had scores consistent with this "risk profile," suggesting high risk for suicide.

Impact on Daily Functioning and Family

We asked participating Veterans to report both how they currently were functioning in daily life, and how their level of functioning had changed from prior to their most recent deployment. Overall, veterans did not differ in their reported level of functioning by their type of service (Guard/Reserves vs. Active Duty), and time since last deployment was not related to impact (i.e., functioning did not improve over time).

As would be expected, Veterans with PTSD/Depression reported greater declines in pre- to post-deployment functioning on a 10-point scale (1 = extremely poor, 10 = extremely good), averaging less than a 1-point decline in rated functioning for Other Veterans, and averaging over a 3-point decline for those with PTSD Depression in the areas of: (a) Physical Health (-1.4 vs.

-3.7), (b) Mental Health (-0.8 vs. -4.1), (c) Family Relationships (-0.6 vs. -3.8), (d) Social Support (-0.2 vs. -2.5), and, (e) the Behavior and Academic Progress of Children (-0.2 vs. -1.5). Further, when rating overall current functioning, 60% of Veterans with PTSD/Depression rated at least one area of functioning (Work/School, Military Duties, Home/Family, Social/Friends) as Poor or Extremely Poor, as compared to only 7% of Other Veterans. It is critical to note here that the impact of PTSD/Depression goes beyond the mental and physical health of the Veteran; it also negatively impacts significant others, children, friends, and work.

Urban-Rural Differences. Those Veterans residing in Rural Counties were differentially impacted as compared to the Urban cohort. First, Rural versus Urban Veterans reported a more negative impact on Mental Health (-3.0 vs. -2.1) and Family Relationships (-2.7 vs. -1.8). Second, 43% of Rural Veterans rated at least one area of functioning (Work/School, Military Duties, Home/Family, Social/Friends) as Poor or Extremely Poor, as compared to 25% of Urban Veterans. Finally, and most telling, only 7% of both Urban and Rural Veterans without PTSD/Depression rated at least one area of functioning as Poor or Extremely Poor, as compared to 48% of Urban Veterans with PTSD/Depression. Over two-thirds (69%) of Rural Veterans with PTSD/Depression rated at least one area of functioning as Poor or Extremely Poor.

Service Awareness and Utilization

The above statistics establish that, as a group, members of the West Virginia National Guard and Reserves who served in the recent conflicts are experiencing a differentially greater mental health impact than Active Duty Veterans from West Virginia. Furthermore, Veterans residing in the Rural Counties of West Virginia are experiencing both a greater mental health impact and greater declines in functioning. It is then important to know if either Guard/Reserve Veterans or Veterans from Rural Counties are differentially aware of and seeking services.

To address this issue, the survey included a series of questions asking whether the Veterans were aware of a wide range of support and service options, whether they had used those services and support, and whether the services and supports had been helpful or not. The intentional brevity of the survey only allowed the respondents to indicate use of a service, such as a VAMC. They were not able to indicate the specific services accessed, such as the medical, psychiatric, or benefits services at a VAMC. Further, use of a service could have been by phone, mail, or in person. Thus, these results only indicate some contact with a service, not the method of contact, specific aspect of the service utilized, nor the duration of service utilization. With these caveats, the general findings are next presented.

Awareness of Services. Overall, West Virginia Veterans reported being aware of the availability of a wide-range of services and supports at each of five levels: (a) 92% reported the availability of Informal Supports (e.g., family, friends, other veterans), (b) 87% reported the availability of Formal Supports (e.g., Veterans organizations and other support groups), (c) 84% reported the availability of Emergency Medical Services (e.g., crisis line, emergency room), (d) 91% indicated being aware that services from Mental Health Professionals were available (e.g., clergy, counselors, psychologists, social workers, etc.), and, (e) 88% were aware that they could receive services from Center-Based Facilities (e.g., VAMC, Vet Center, community mental health center). These rates of awareness of availability did not differ by type of duty (Guard/Reserves vs. Active Duty). Urban Veterans without PTSD/Depression were somewhat more aware of the

availability of Emergency Medical Services than were Rural Veterans with PTSD/Depression (89% vs. 79%).

Use of Services. It would appear that awareness of services is quite high, although there is some room for improvement. Whether those services have been utilized or not is the next question. Regardless of status, 72% of Veterans in the survey reported use of Informal Supports. Use of Formal Supports (53% overall) was more likely to be reported by Veterans with PTSD/ Depression (62%) than Other Veterans (44%), as was the use of Emergency Medical Services (29% vs. 43%; 36% overall). Mental Health Professionals (62% overall) were used by 54% of Other Veterans and 70% of those with PTSD/Depression. Within the variety of Mental Health Professionals, Veterans with PTSD/Depression who lived in Rural Counties were the most likely group to use physician services (67%). Services at Center-Based Facilities (54% utilization, overall; including Vet Centers and VAMCs) were used more by Veterans with PTSD/Depression (65%) than Other Veterans (43%); within this set of services, hardly any use of community mental health centers was reported (5%).

Overall, the utilization of a wide range of supports and services is rather high, although clearly one-third or more of Veterans who are potentially in need of services are not accessing them. Further, the focus here is on a limited set of mental health issues, and not physical health and other areas of concern (including TBI and substance use/abuse). Nationally, about 39% of Veterans have at least one contact with the VA system. The overall 37% utilization rate for Vet Centers and 58% for VAMCs by West Virginia Veterans is apparently higher than the national figures, and is likely due to the density of services in West Virginia, with coverage by four different VISNs (4, 5, 6, 9) and including four VAMCs, eight Vet Centers, and multiple CBOCs and contract clinics in the most rural counties. The utilization rate reported here may also be higher due to the very broad definition of "service use" in this survey.

Helpfulness of Supports and Services. Overall, 65% of the respondents indicated that use of Informal Supports was helpful to them; 53% indicated that services of Mental Health Professionals were helpful. Formal Supports were helpful to 45% overall, but more so to Veterans with PTSD/Depression (50%) than Other Veterans (39%). Emergency Medical Services were helpful to 32% of the respondents who used them (36% of Veterans with PTSD/Depression, 26% of Other Veterans). Finally, while 45% found the Center-Based Facilities to be helpful, again Veterans with PTSD/Depression (52%) found the services more helpful than did Other Veterans (36%). Although we cannot determine from this survey if Veterans were seeking or receiving those services most appropriate to their individual situations, it is disheartening to see that less than half of Veterans (including those with mental health issues and declines in functioning) are reporting the receipt of helpful services.

Conclusions and Concerns

The prior sections support the initial statements concerning the: (a) high level of combat exposure experienced by members of the West Virginia National Guard and Reserves, with higher exposure by Rural than Urban Veterans; (b) greater negative impact on the psychological and daily functioning (of Veterans and their significant others and children) experienced by members of the National Guard and Reserves, with greater negative impact on Rural as compared to Urban Veterans; and, (c) apparent under-utilization of various levels of support and

services, and the much less than complete satisfaction with the "helpfulness" of those services, despite generally high rates of awareness of service availability among Veterans.

These findings point to significant concerns regarding the provision of adequate services to all Veterans, but especially members of the National Guard and Reserves, and those from rural areas of Our Nation. These findings, coupled with the fact that the respondents in WV seek out individuals in their informal helping systems first, and given that there are multiple levels of services and supports that Veterans utilize, we need not depend solely on the VA and DoD for the provision of those services and supports. Further, as the need for services goes well beyond Veteran themselves, but includes their children and immediate and extended families, the need for a wide range of family support services is evident-this being an area well beyond typical VA services. In West Virginia, for example, the Council of Churches has developed CARE-Net, a grassroots network of houses of worship and their local communities to provide support, services, and referrals to Veterans and their families. Further, the West Virginia National Guard Family Assistance Center is consulting with other States (such as Minnesota) about the development of a full circle of programs and supports that run from pre-deployment, during deployment, and following deployment. Although the Guard is now mandated to provide homecoming and follow-up programs, States are left to develop and fund those programs.

In West Virginia, we are also collaborating with the VA, AHEC (Area Health Education Centers), and the Citizen-Soldier Program to bring to our State a model program for disseminating information, providing continuing education to community providers, and linking agencies. These sorts of efforts are arising at all levels due to the overwhelming need to support and serve Veterans and their families, and to reintegrate Veterans back into their families and communities. It is recognized that the VA and DoD need not-and perhaps should not be expected to-do it all, even if such were possible. We recognize that it takes a community-not an agency-to welcome a Veteran home.

In our work, we have thus formulated a number of questions that will need to be addressed, including:

1. How will we network the multiple levels of service, from informal/grassroots groups to state programs and facilities to federal programs and facilities?

2. How will we identify and follow Veterans over years to decades, from initial return from deployment to resolution of identified problems?

3. How will we identify and follow those Veterans in most immediate need and those at greatest risk for suicide?

4. How will we ensure that all Veterans have equal access to services, including rural and minority Veterans, those who have been other than honorably discharged, and those who commonly do not seek treatment or experience significant barriers to service access?

5. How will we ensure that Veterans are able to return-as soon as possible-to a productive life?

6. How will we ensure that the Families of Veterans receive the support and services that they need at all stages of their Veteran's deployment?

7. How will we ensure adequate funding for services and related research?

8. How can we do our best, as a Nation, to fully honor the commitments and sacrifices of Veterans and their Families?

Recommendations

In response to these data, the above questions and concerns, and our personal experiences working with Veterans, families, communities, agencies, and committed professionals, we have formulated three key recommendations.

I. Fully fund and support homecoming programs to enable the National Guard to adequately prepare their personnel and families for upcoming deployment; provide support and services during deployment; and offer support, services and referrals post-deployment (such as at the required 30-, 60-, 90-, and 180-day reunions).

II. Support and fund the dissemination and evaluation of best practices in a broad array of areas, including: (a) group and individual treatment of combat-related PTSD (and comorbid depression, substance abuse, family violence, etc.); (b) identification of suicide risk and provision of related risk reduction services, (c) reintegration to community, work, and educational settings; and (d) child and family support and therapy services. Such dissemination should occur with a range of professionals (e.g., clergy, social workers, psychologists, vocational counselors, physicians and other primary care professionals, psychiatrists, teachers), and in a range of settings (e.g., from private mental and physical health practitioners; to local grade schools, technical schools, and colleges; houses of worship; community mental health centers; community health centers, hospitals, and rural health clinics; to state agencies, military units, and AHECs; to federal agencies, such as Vet Centers, CBOCs, and VAMCs).

III. Support and fund the linking of local, state, and federal agencies in a coordinated effort of overlapping lay, volunteer, paraprofessional, and professional services and resources in order to meet the tremendous mental health, physical health, and quality of life needs of our Military Personnel.

Respectfully Submitted,

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