The Role of Psychologists in the Care of Iraq and Afghanistan Veterans in Primary Care Settings

Shira Maguen
San Francisco VA Medical Center and University of California, San Francisco

Greg Cohen
San Francisco VA Medical Center

San Francisco VA Medical Center and University of California, San Francisco

Although military personnel serving in Iraq and Afghanistan are at high risk of developing mental health problems, many report significant barriers to care and few seek help. Integrated primary care is a comprehensive model of health care that aims to improve access to care and provides a framework to assess and meet the complex psychiatric needs of newly returning veterans by embedding mental health specialists within primary care. We describe the role of psychologists in a Department of Veterans Affairs (VA) integrated primary care clinic that serves veterans of Iraq and Afghanistan. Psychologists based in primary care can assist veterans with reintegration to civilian life by providing rapid mental health assessment, normalizing readjustment concerns, planning for veterans’ safety, implementing brief interventions within primary care, facilitating transition to additional mental health care, and informing veterans of other available psychosocial services. A case example demonstrating the psychologist’s role highlights the benefits of an integrated care model. Implications of employing this model include reduction of symptoms and impairment by reducing stigma and barriers to seeking mental health care, increased motivation to engage in treatment, and implementation of early interventions. This model may also be beneficial in the civilian health care sector with groups that are at high risk for mental health problems, yet experience barriers to care, particularly stigma.

Keywords: integrated care, veterans, mental health, post-traumatic stress disorder, health care

Military personnel serving in Afghanistan as part of Operation Enduring Freedom (OEF) and in Iraq as part of Operation Iraqi Freedom (OIF) or surrounding areas are at high risk of developing mental health problems, including post-traumatic stress disorder (PTSD), depression, and generalized anxiety disorders. Hoge and colleagues (2004, 2006) found that 16 to 19% of returning OIF military personnel and 11% of returning OEF military personnel met screening criteria for at least one of these disorders. Military
personnel returning from deployments to Iraq and Afghanistan are also at risk for alcohol abuse. Among OIF soldiers, 25% met screening criteria for problem alcohol use (Maguen et al., in press) and among OEF/OIF veterans enrolled in Department of Veterans Affairs (VA) health care, 33% screened positive for alcohol abuse, which was nearly three times the rate of those screening positive for PTSD (Erbes, Westermeyer, Engelahl, & Johnsen, 2007). Among OEF/OIF veterans seen at VA health care facilities, 37% received mental health diagnoses, with 62% of these meeting criteria for two or more mental health diagnoses (Seal, Metzler, Gima, Bertenthal, Maguen, & Marmar, 2009). Further complicating the diagnosis of mental health disorders, 12 to 15% of returning OEF/OIF military personnel reported a history and symptoms consistent with mild traumatic brain injury (TBI; Hoge et al., 2008; Schneiderman, Braver, & Kang, 2008). Many of the cardinal features of mild TBI, such as diminished attention and concentration, irritability, and insomnia, are also hallmark symptoms of PTSD and depression. Because combat-related TBI occurs in the context of other combat-related trauma and because TBI affects neuropsychological processes, it is commonly associated with comorbid PTSD, depression, and substance use disorders (Hoge et al., 2008; Schneiderman et al., 2008). A recent study found that 42% of those with TBI also had PTSD symptoms (Schwartz et al., 2007). Despite high rates of mental health problems, only a minority of veterans seek help (Hoge et al., 2006). Among those screening positive for a mental health disorder, only 23 to 40% received professional mental health care in the prior year (Hoge et al., 2004). Among OEF/OIF veterans with a mental health diagnosis who were already enrolled in the VA system, one third did not attend specialty mental health care in the first year of diagnosis (Seal et al., in press). In another sample of OEF/OIF veterans enrolled in VA care, of veterans screening positive for PTSD, just over half (56%) reported using mental health services; of those screening positive for problem drinking, only 18% had sought mental health services (Erbes et al., 2007).

One of the biggest challenges that mental health care professionals face in providing post-deployment mental health services to OEF/OIF veterans is perceived stigma regarding mental health care. Among OEF/OIF military personnel screening positive for a mental health disorder, only 38 to 45% expressed interest in receiving help (Hoge et al., 2004). Additionally, those screening positive for a mental health disorder were twice as likely as those who did not meet screening criteria to report stigma and barriers to care for seeking mental health care (Hoge et al., 2004).

Although there are many individual-level barriers to mental health care, including common fears of being seen as weak (65%) and fears of adverse treatment from unit leadership (63%), there are also several system-level barriers to care that can be addressed within the context of the VA health care system that serves OEF/OIF veterans upon their return home. For example, among veterans screening positive for mental health diagnoses, most reported that not getting time off from work for treatment was a barrier to care (55%), nearly half reported that it would be difficult to schedule an appointment (45%), and one quarter reported that treatment would cost too much money (25%; Hoge et al., 2004).

The Case for Integrated Primary Care and Mental Health in Treatment of OEF/OIF Vets

Integrated primary care is one model that aims to reduce barriers to care and stigma among primary care and mental health consumers. It also attempts to lessen the physical and psychiatric burden of disease over time by facilitating mental health diagnosis as well as rapid, streamlined, and effective treatment. Integrated primary care refers to targeted, comprehensive health care services in which primary care providers (PCPs) work collaboratively with specialty providers such as psychologists, social workers, and/or psychiatric nurses. Integrated primary care targeting mental health problems was first developed to enhance treatment for depressed patients (e.g., Katon et al., 1996), and has been expanded for use in the detection and care of patients with PTSD, using the care management model (definition below; Engel et al., 2008). While the VA health care system’s computer-based clinical reminder system has improved mental health screening in primary care, a substantial number of veterans with mental health needs may go undiagnosed and untreated without more thorough assessment and targeted referral by a specialty mental health clinician. For example, in a study by Magruder and colleagues (2005), PTSD was undetected in over half (54%) of a prior cohort in standard primary care.

Within the VA, there are three main models of integrated primary care: (1) the co-located care model, which will be the focus of this article, embeds mental health specialists within a primary care clinic, (2) the care management model utilizes a care manager who tracks and reinforces patients’ adherence to treatment plans across mental health and primary care services, and (3) the blended model combines the first two approaches (Zeiss & Karlin, 2008). Early approaches to integrated primary care featured a consultation-liaison model (e.g., Katon & Gonzalez, 1994), while recent innovations include “stepped” models of care that systematically target and account for patient symptom severity (e.g., Katon et al., 1999; Unutzer et al., 2002; Zatzick et al., 2004). Although integrated primary care has been conceptualized in a variety of ways (e.g., Blount, 2003; Katon, Von Korff, Lin, & Simon, 2001; Zeiss & Karlin, 2008), and fidelity to the care management model has been most strongly associated with effectiveness and homogeneity of outcome (Gilbody, Bower, Fletcher, Richards, & Sutton, 2006), we review a range of models and generally refer to integrated care in a broad sense.

Primary care clinics serve as the main gateway to the VA Healthcare System; they function as a critical point of intervention for OEF/OIF veterans, given the significant proportion of mental health diagnoses that originate in primary care clinics (e.g., Seal et al., in press). Community studies have demonstrated that in addition to diagnosis, most patients receive mental health treatment in primary care, which is the “de facto” mental health care system (e.g., Regier et al., 1993; Wang et al., 2005). Indeed, most VA patients are treated for depression in primary care settings (Kilbourne et al., 2006). Whereas some evidence-based treatments for depression can be delivered by PCPs (e.g., first and second line antidepressant medications), evidence-based treatments for other mental health disorders, such as PTSD, are typically provided by mental health professionals. Integrated primary care is an ideal opportunity to initially engage veterans who are in need of mental health treatment and might otherwise be unwilling to see a mental
health specialist. Integrated primary care also may improve engagement in treatment by reducing the time from referral to treatment initiation and by reducing the stigma of receiving care in a specialty mental health setting. Specialty mental health providers located within an integrated primary care system can ensure that individuals who need further evaluation and treatment are identified, appropriately triaged, and receive care in a timely fashion. In some integrated primary care settings, brief interventions are provided in primary care over a limited number of sessions. In other integrated primary care settings, initial engagement is made, and follow-up care is provided in mental health clinics.

Integrated primary care is a viable framework to meet the complex psychiatric needs of OEF/OIF veterans. Integrated primary care for depression is well studied and validated across settings and populations (Gilbody et al., 2006), with evidence of long-term advantages in symptom reduction (Wells et al., 2004), and decreases in unmet needs for care among African Americans and Latinos (Wells et al., 2004), groups typically underserved in mental health care. Integrated primary care is efficacious for depressed adults in VA primary care (Hedrick et al., 2003) and is preferred by patients (Dietrich et al., 2004; Katon et al., 1996; Unutzer et al., 2002). Integrated primary care for depression is also superior to less intensive models of augmented primary care such as enhanced decision support (Dobscha et al., 2006), enhanced referral care (Bartels et al., 2004), and consult-liaison care within the VA (Hedrick et al., 2003). Although there are few studies of integrated care for PTSD, this approach appears efficacious in acute post-trauma care among civilians (Zatzick et al., 2004) and feasible in military primary care settings (Engel et al., 2008). Finally, integrated primary care is viable at a systems level (Felker et al., 2006) and has shown evidence of greater cost-effectiveness compared to usual primary care (Blount et al., 2007; Katon & Seeleg, 2008).

The Integrated Primary Care Model as a Solution

The OEF/OIF Integrated Care Clinic (ICC) is based on a “one stop shop” model developed at the Seattle VA Medical Center and modified for use at the San Francisco VA Medical Center: when an OEF/OIF veteran arrives for a primary care appointment, he/she is seen consecutively by a number of co-located providers, including a PCP, a psychologist, and a social worker. Veterans are told that partners and family members are welcome to accompany them to the clinic visits. A flowchart of the veteran’s movement through the ICC can be found in Figure 1.

Following orientation to primary care and administration of several brief screening instruments by a nurse (e.g., PTSD, depression, alcohol use, and traumatic brain injury), the veteran attending an ICC appointment will engage in a thorough primary care visit. Next, every veteran presenting in the ICC will meet with a mental health professional, one of several psychologists who are called post-deployment specialists (PDS). We chose the name PDS in order to emphasize the importance of evaluating and caring for a broad spectrum of post-deployment concerns, even in those who do not meet mental health diagnoses, and to reduce stigma involving seeking psychological care. The PDS will speak to the veteran about any mental health areas of concern and assess for mental health symptoms, including PTSD, depression, alcohol and drug use, functional impairment (e.g., relationship problems, employment difficulties), and safety (e.g., firearms in home, suicidal/homicidal behavior, domestic violence, etc.). The veteran also is oriented to mental health services available for OEF/OIF veterans, including a comprehensive mental health evaluation, skill-based groups focused on stabilization and readjustment (e.g., stress management, anger management, substance abuse harm reduction, etc.), individual therapy (e.g., evidence-based treatments (EBTs) for PTSD—cognitive processing therapy and prolonged exposure therapy, and depression—cognitive behavioral therapy and acceptance and commitment therapy), family therapy (i.e., couples or family therapy), medication management, and groups for maintenance of gains.

The functioning of the ICC as a whole depends on the strength and functioning of its individual parts (see Figure 1). As a result, each part of the system closely collaborates and communicates with all others. Prior to meeting with a veteran, the psychologist will check-in with the PCP and the primary care nurse who has completed basic screening for mental health problems. Before the veteran meets with the social worker, the psychologist will pass along any important information as well.

The Psychologist’s Role

The goal of the meeting with a psychologist is multifaceted. First, we wish to send a message that mental health screening and evaluation is a normal part of each check-up, similar to taking vital signs. Second, we hope to normalize many of the adjustment concerns that the veteran is experiencing. Third, we provide education about the course of symptoms, diagnosis, and healing. Fourth, our goal is to implement brief interventions within primary care as appropriate. Fifth, if more comprehensive mental health treatment is needed, the PDS facilitates transition to ongoing specialty mental health services. Sixth, we want to make veterans aware of all of the programs that are available to help them determine whether these programs can be of assistance now or at some point in the future. At the end of the mental health portion of the ICC visit, if the veteran screens positive for any mental health condition and requires further care, a clear plan for follow-up is established. We elaborate on each of these goals in more detail below, outlining each aspect of the appointment in the order it is presented to the veteran.

We begin by orienting the veteran to the PDS’s role within the ICC and providing an overview of our session. This is a critical component of the meeting, as it is an important opportunity to reduce stigma and normalize mental health screening, which we refer to as post-deployment concerns. It is also the chance to convey that while we will be interviewing the veteran, our meeting is a collaborative process.

The next phase of the meeting consists of a more thorough evaluation of the mental health concerns for which the veteran has screened positive (PTSD, depression, alcohol). In this respect, clinicians can either utilize open-ended interviews assessing symptoms, or established measures such as the PTSD Checklist (PCL; Weathers, Litz, Herman, Huska, & Keane, 1993), Patient Health Questionnaire for Depression (PHQ-9; Kroenke, Spitzer & Williams, 2001), and the Alcohol Use Disorders Identification Test (AUDIT; Babor, Higgins-Biddle, Saunders, & Monteiro, 2001). Within the context of integrated primary care, mental health symptoms can be considered on a spectrum rather than simply evalu-
ating whether a particular veteran meets DSM–IV criteria for a specific disorder. For example, some veterans may struggle with a few debilitating PTSD symptoms, despite not formally meeting diagnostic criteria for PTSD; treatments may be just as effective for these individuals. Additionally, it is important to evaluate functional impairment (e.g., legal, financial, relationships, etc.), and adjustment in general. Regarding conceptualization of adjustment issues, we have found a handout developed at the VA Boston Healthcare System extremely helpful (see Table 1).

To structure the one hour mental health appointment, we follow a mental health template that was developed by our ICC team at the San Francisco VA Medical Center and captures several important areas for evaluation (see Table 2). In addition to mental health symptoms, assessing risk is a priority. We begin by evaluating suicide risk, including history of suicidal ideation/attempts and present suicidal ideation. If current suicidal ideation is endorsed, the PDS will conduct a thorough examination of risk and protective factors, all of which are carefully reviewed and docu-

Figure 1. Integrated Primary Care Clinic: Flowchart of patient movement and clinic structure.
Safety
- Being constantly alert for dangerous situations
- Seeing anything unexpected or out of place as a possible explosive device
- Watching people and looking for escape routes

Trust and the enemy
- Being suspicious and seeing everyone as a potential enemy
- Being uncomfortable and alert around strangers or crowds
- Checking people for trustworthiness

Mission orientation
- Focusing only on a single task and not wasting time on unimportant things
- High use of energy and resources while on a mission
- Exhaustion and withdrawal when the mission is done

Decision making
- Chain of command determines who makes decisions
- Little questioning or discussion
- Deciding and acting without hesitation

Response tactics
- Act first, think later, and be ready to respond with force when necessary
- Avoid planning, be ready to react
- Be prepared and have things in place

Predictability and intelligence
- Be unpredictable, vary routes and behaviors
- Do not let others know what you are thinking
- Avoid talking or giving out information that could be used against you

Emotional control
- Control emotions to enhance performance
- Numb emotions, others may see them as weakness
- Have anger readily available to respond with

Talking about the war
- People will ask you stupid questions, prepare your answers well
- It may be very difficult to talk to people who were not there
- People may not want to hear about the details, don’t be surprised
- Learning who to talk to and when is important

Table 1
Adjustment Issues in OEF/OIF Veterans: War Zone Skills That May Interfere With Readjustment

<table>
<thead>
<tr>
<th>Skill</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety</td>
<td>Being constantly alert for dangerous situations</td>
</tr>
<tr>
<td></td>
<td>Seeing anything unexpected or out of place as a possible explosive device</td>
</tr>
<tr>
<td></td>
<td>Watching people and looking for escape routes</td>
</tr>
<tr>
<td>Trust and the enemy</td>
<td>Being suspicious and seeing everyone as a potential enemy</td>
</tr>
<tr>
<td></td>
<td>Being uncomfortable and alert around strangers or crowds</td>
</tr>
<tr>
<td></td>
<td>Checking people for trustworthiness</td>
</tr>
<tr>
<td>Mission orientation</td>
<td>Focusing only on a single task and not wasting time on unimportant things</td>
</tr>
<tr>
<td></td>
<td>High use of energy and resources while on a mission</td>
</tr>
<tr>
<td></td>
<td>Exhaustion and withdrawal when the mission is done</td>
</tr>
<tr>
<td>Decision making</td>
<td>Chain of command determines who makes decisions</td>
</tr>
<tr>
<td></td>
<td>Little questioning or discussion</td>
</tr>
<tr>
<td></td>
<td>Deciding and acting without hesitation</td>
</tr>
<tr>
<td>Response tactics</td>
<td>Act first, think later, and be ready to respond with force when necessary</td>
</tr>
<tr>
<td></td>
<td>Avoid planning, be ready to react</td>
</tr>
<tr>
<td></td>
<td>Be prepared and have things in place</td>
</tr>
<tr>
<td>Predictability and intelligence</td>
<td>Be unpredictable, vary routes and behaviors</td>
</tr>
<tr>
<td></td>
<td>Do not let others know what you are thinking</td>
</tr>
<tr>
<td></td>
<td>Avoid talking or giving out information that could be used against you</td>
</tr>
<tr>
<td>Emotional control</td>
<td>Control emotions to enhance performance</td>
</tr>
<tr>
<td></td>
<td>Numb emotions, others may see them as weakness</td>
</tr>
<tr>
<td></td>
<td>Have anger readily available to respond with</td>
</tr>
<tr>
<td>Talking about the war</td>
<td>People will ask you stupid questions, prepare your answers well</td>
</tr>
<tr>
<td></td>
<td>It may be very difficult to talk to people who were not there</td>
</tr>
<tr>
<td></td>
<td>People may not want to hear about the details, don’t be surprised</td>
</tr>
<tr>
<td></td>
<td>Learning who to talk to and when is important</td>
</tr>
</tbody>
</table>

Note. Developed by James Munroe, Boston VA Healthcare System.
treatments can be helpful. We have found that the presence of a partner can help tremendously in the veteran’s engagement and follow-through with these treatments, especially if couples or family therapy is recommended as a prevention strategy prior to the development of chronic symptoms.

The next phase of the meeting consists of a brief intervention, if appropriate. For many veterans, psychoeducation is a powerful intervention, normalizing symptoms and underscoring the fact that they are not alone in their struggles. Motivational interviewing (MI), a direct yet collaborative approach that elicits behavior change by helping patients to explore and resolve ambivalence, is another important intervention during this phase. This is especially salient given two critical issues: high levels of stigma and other barriers to care and high rates of alcohol use among veterans, even in those who do not have other mental health problems. Providers can explicitly assess barriers to care within the MI framework, including the veteran’s likelihood of following through with treatment. Assumptions about treatment and beliefs about emotional expression should be identified and challenged if necessary, in order to increase the likelihood of follow-through with care.

Alcohol consumption may be seen by veterans as a normative part of military life, and subsequently, they may be reluctant to see this behavior as problematic or out of the ordinary. Providing information about drinking norms is often helpful, as is assessing a veteran’s motivation to change problematic drinking behavior, and providing brief counseling. The interaction between alcohol abuse and mood/anxiety disorders is important to highlight, as is the impact of other substance abuse, including abuse of prescription drugs.

Brief interventions, such as EBTs for PTSD provided by a mental health professional either in primary care or a specialty mental health clinic, not only ameliorate mental health symptoms, but also have been shown to improve perceived physical health (e.g., Galovski, Monson, Bruce, & Resick, 2009). This is not surprising given the strong association between mental health disorders, such as PTSD, and perceived physical health (see Schnurr & Jankowski, 1999, for review), and has important implications for the treatment of both veterans and civilians.

At the end of the session, the post-deployment specialist leaves the veteran with a business card containing nonmental health language and contact information for our team of specialists. We also leave the veteran with a clear follow-up plan. For veterans who are not interested in initiating mental health treatment at that time, we brainstorm about when they would initiate treatment and arrange to follow up with them by phone as needed. Concerning high-risk patients who refuse mental health treatment, the OEF/OIF combat case manager plays an important role, continuing contact with them and providing support and encouragement. The MI process can explicitly assess barriers to care within the MI framework, including the veteran’s likelihood of following through with treatment. Assumptions about treatment and beliefs about emotional expression should be identified and challenged if necessary, in order to increase the likelihood of follow-through with care.

When meeting with the PDS, Mr. S was open about the barriers to seeking help for his mental health symptoms, expressing a belief that he was coping fine on his own and that seeking mental health treatment would not be effective. Upon further evaluation, the veteran endorsed multiple traumatic events, including two that were most prominent in his intrusive thoughts and nightmares. He described one event during which his unit was ambushed and multiple soldiers were killed, one of whom was his closest friend in Iraq. During this incident, Mr. S sustained a mild head injury and multiple injuries to his shoulder and back. A second incident involved an Iraqi child who, while holding a weapon, approached a group of soldiers; the veteran reported killing the young boy. Mr. S reported that children were a big trigger for him; when he saw children, they reminded him of the child that he killed.

Mr. S met criteria for PTSD, and he endorsed consuming more than three alcoholic beverages on a daily basis, openly stating that he drank to help with sleep, reduction of pain, and memories of his war experiences. Because his pain was a direct result of his injury and therefore tied to one of his worst traumatic events, pain was a trauma cue for him on an ongoing basis and was closely tied to the severity of his PTSD symptoms. The same was true for his TBI symptoms; Mr. S endorsed frequent headaches, which were also a trigger for his PTSD symptoms, increasing his war memories and vigilance, decreasing his ability to concentrate, and consequently interfering with his functioning in college classes.

When asked about risk issues, Mr. S denied suicidal ideation, but stated that anger was a problem and that often when drinking, he would become involved in physical fights that were triggered by negative comments about U.S. involvement in the current conflict. Additionally, although he denied being physically abusive toward his romantic partner, Mr. S reported that their relationship was unstable due to his worsening PTSD-related withdrawal, isolation, and emotional numbness. His girlfriend was supportive, yet she had recently told the veteran that she was not willing to continue in the relationship unless he sought help. Seeking help was a frequent source of argument because Mr. S perceived that reaching out to professionals meant acknowledging his own weakness. Related to his relationship, Mr. S also shared that the couple recently had a conversation about marriage and children. Mr. S reported being elusive during this conversation, which his partner perceived as rejection; she asked the veteran if he had been unfaithful. Mr. S disclosed during our session that he had never been unfaithful but did not believe that he deserved to be married or have children because of what he had done while in Iraq; however, he did not feel comfortable sharing the truth with his partner.

The next part of the session was spent educating Mr. S about the variety of adjustment difficulties that veterans face as they return from deployments. The PDS also spoke to the veteran about several observed symptoms, including re-experiencing, avoidance,
emotional numbing, and arousal symptoms, and provided education about the importance of treating these symptoms with evidence-based care before they became more chronic. The PDS also engaged in brief motivational interviewing with the veteran regarding his alcohol use, providing some norms about the average amount of alcohol consumed by a typical male his age, as well as highlighting some of the dangers of continuing to drink at his current level. The PDS evaluated the veteran’s motivation to change this behavior, and Mr. S was able to reflect on some of the potential negative aspects of drinking, including lack of inhibition related to his anger as well as inciting verbal fights with his partner. He also shared that he noticed that it was harder to concentrate in school following days of heavy drinking. The PDS and Mr. S also spoke about the pros and cons of engaging in long-term care related to the mental health symptoms that he experienced. The PDS recommended that Mr. S receive a comprehensive evaluation of the symptoms that he described and highlighted the benefits of treating these symptoms before they became ongoing and disrupted his relationship and school functioning even further. The PDS provided several handouts, some of which were specifically about relationships and the returning war veteran, and encouraged him to share these with his partner who was not able to attend the appointment.

After informing the veteran about the various forms of treatment available to OEF/OIF veterans, he agreed to engage in a more comprehensive mental health evaluation as well as to consider speaking with his partner about counseling for some of the adjustment issues that the PDS assured him many returning veterans face, especially when they are at a loss about how to explain to a loved one their experiences or reactions to being back in the civilian world. The veteran explicitly stated that he was not open to taking medications or being in groups, but would agree to an evaluation and consider treatment recommendations, with the goal of improving his relationship and school performance. He was left with a clear understanding of the next steps as well as with contact information of the PDS in case he had any follow-up questions prior to his scheduled mental health evaluation.

Mr. S ultimately was able to engage in a thorough mental health evaluation. After a brief cognitive behavioral therapy stabilization treatment, targeting harm reduction for drinking and anger management, he was able to begin EBT for PTSD and experienced a significant reduction in his PTSD symptoms over the course of treatment. Although Mr. S was not in formal couple’s therapy, he agreed to come in for a few sessions with his partner. These sessions were focused on education about the impact of deployment and related symptoms on relationships, and allowed the veteran to disclose some of his fears about committing to marriage with his partner. His ability to stay connected to mental health treatment was enhanced by an ongoing discussion of barriers to care. His care also required ongoing consultation with his primary care physician due to the prescription and management of pain medication as well as the association of his pain and PTSD symptoms. His PCP was also updated on his alcohol intake, and this information was used to monitor the veteran’s liver function as well as to engage him in discussions about the importance of reducing intake. Consequently, the veteran received a consistent message from members of his treatment team regarding the health risks of his alcohol use. The veteran’s care also involved ongoing communication with neurology about mild TBI symptoms, especially management of his headaches. The combat case manager also continued to be involved, helping the veteran address his financial issues and secure stable housing.

Conclusions

Given the multiple individual and system-level barriers to care among newly returning OEF/OIF veterans, we present a multidisciplinary, integrated model of care aimed at prevention and early intervention that strives to increase mental health care engagement before symptoms become chronic and progressively disabling. We describe specific ways in which psychologists can be involved within such an integrated primary care clinic, including practical information about how to structure a preliminary evaluation and an example of the ICC mental health template.

Given the comprehensive nature of the ICC model and the intensity of resources required, it may be difficult to implement in some settings. For clinics unable to devote the time and staffing, less intensive models in which licensed mental health specialists serve as behavioral health consultants, may be effective in augmenting triage and/or providing brief or ongoing treatment of those with moderate to severe mental health concerns. In this case, brief screening instruments can be implemented by nurses or PCPs, and those screening positive could be referred to a consultant in primary care (e.g., Robinson & Reiter, 2007).

Comprehensive treatment of Mr. S and other veterans like him requires a multidisciplinary team approach, beginning in the ICC and continuing once the veteran has established ongoing care. By meeting the veteran in a primary care setting, normalizing adjustment reactions, addressing barriers to care early and often, and maintaining an integrated care model, psychologists can provide OEF/OIF veterans with the most comprehensive and targeted care as they adjust back to civilian life.

References


