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Taking care of the sick Veteran – Mental health care within the Department of Veterans Affairs, USA

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Summary

The article describes the functioning of the system of mental health care for veterans in the U.S. on the example of the state of California. Two clinical cases illustrating the issue of mental health disorders in this population of patients have also been presented. Veterans as well as active duty soldiers and civilian employees of the military compose a group of patients suffering from mental health problems, requiring increased attention of clinicians not only in the U.S. but in all countries that are engaged in military missions.

Key words: veterans, psychiatric health care system, PTSD

Introduction

According to the official webpage of the United States Department of Veteran Affairs (www.va.gov) the system (referred to as the VA throughout this article) is the nation's largest integrated healthcare system. There are 1,700 facilities within the 50 states as well as Puerto Rico, Guam, American Samoa, Virgin Islands, and the Philippines [1]. These facilities include hospitals, clinics, counseling, cemetery, and benefits centers. The Mental Health component of VA health care has been a priority within the system. There is an additional focused interest on care for Posttraumatic Stress Disorder, Military Sexual Trauma, and suicide prevention. The major theme within VA Mental Health Departments is a focus on recovery which includes empowerment for the veterans to overcome their hardships. The goal is to have Veterans lead as fulfilling lives as possible [2].

Eligibility for care

A veteran is eligible for VA health benefits if he or she served in one of the branches of the military (Army, Navy, Air Force, Marines, and Coast Guard) with a discharge that was under honorable conditions. Further requirements for veterans who enlisted after 9/7/1980 include a minimum period of active service of 24 continuous

months. Veterans who qualify for service connection, disability payments for medical conditions sustained while during service, are eligible for tax free monthly payments depending on the level of their disability. This support is provided by the Veteran Benefits Administration, which is a separate operating entity from the Healthcare Administration. Obtaining service connection is a process that often takes months to years to complete. The process includes extensive medical, surgical, and, if necessary, psychiatric evaluations. Veterans who are fully disabled, i.e. 100% service connected, are eligible for several health care benefits in excess of those available to other vets, such as free medications, free transportation, complete payments for care at long term facilities, etc.

The VA Central California Health Care System

The VA Central California Health Care System (VA CCHCS) is located within the San Joaquin Valley with its main facility in Fresno, California. The hospital has an active emergency room, inpatient medicine and surgical service with an intensive care unit, as well as a 12 bed inpatient psychiatric unit. The department of mental health is made up of over 70 staff. They provide a variety of services to Veterans in the Central Valley. Sections of the department include the Acute Psychiatric Services, Substance Use Disorder program, Outpatient Mental Health, Peer Support Services, and Neuro-Psychology services.

The Acute Psychiatric Services is made up of Inpatient, Emergency, and Psychiatric Consultation and Liaison care. There is a 12 bed inpatient unit within the main hospital. The Average Daily census is 7-8 patients with an average length of stay between 4-5 days. The average number of admissions per month is 50. The emergency department has an average of 80 mental health patients per month that require assessment. Most of the patients present during the day time hours, but there is 24 hour coverage. Consultation liaison services are available to patients admitted to medicine and surgery. These consults are seen within 24 hours of requests, often within much less time. There are typically 20 consults per month.

The Substance Use Disorder Program provides care every weekday for veterans who require assistance with addictions. There are daily groups with services for dual diagnoses as well as addiction without co-occurring mental illness. There is a buprenorphine clinic as well. They provide consultation support and have open access to care. A veteran who is seeking treatment can start immediately in the assessment group that runs Monday through Friday. For those who are not willing to maintain sobriety but are interested in seeking education and options for starting treatment, they are encouraged to attend the Stepping Stones Group. The goal of this group is to encourage transition into a more structured abstinence based program. This group meets twice per week and there is no contractual commitment.

The Mental Health clinic is the largest component of the department. It has services to include Primary Care Integrative Health, Routine Outpatient Mental Health at the main facility as well as satellite clinics, Tele-mental Health, Intensive Case Management, Posttraumatic Stress Disorder Clinical Treatment Team, and Suicide Prevention.

There are also Clozaril and Decanoate clinics for psychotic patients who require closer monitoring and administration of special medications.

Primary Care Integrative Health is a team of mental health providers embedded within the primary care clinic. The group is made up of a psychiatrist, a psychologist, a nurse and two social workers. These staff are available to take direct referrals on a walk in basis from the primary providers. This eliminates the referral process and delay's with accessing mental health care. These patients typically have lower acuity concerns such as uncomplicated anxiety or depression. If symptoms are severe they are managed till they can be transitioned to the mental health clinic.

Some patients cannot come to the Fresno facility regularly because they live too far away. The VA Central California Healthcare System developed satellite clinics to provide routine outpatient care. These facilities are referred to as Community Based Outreach Clinics (CBOC). The clinics are located approximately 60-100 miles away from the main hospital. The Merced clinic is located in the North, Tulare clinic is in the South, and there is a newly built Oakhurst clinic in the Sierra Mountains near Yosemite National Park. Patients can elect to see mental health staff in these clinics or the psychiatrist via Telemedicine with the Tele-mental health program.

Patients with the most severe and chronic illnesses benefit from the efforts of the Mental Health Intensive Case Management program (MHICM). This is a team comprised of a nurse practitioner and two social workers. Patients eligible for this program have a history of at least three admissions or at least 30 total days of inpatient care within a twelve month period. They must be diagnosed with a chronic psychotic or bipolar illness. They are seen at their residences, taken to stores to purchase food, and driven to appointments. When in crisis and unstable they are brought to the facility for emergent care and assessment for possible admission.

The Posttraumatic Stress Disorder Clinical Team is relatively new within the department. This was created in a response to the increasing need for this type of treatment within the Veteran population. The team is made up of four psychologists and one psychiatrist. They provide individual and group treatments for veterans who cope with trauma from serving in combat. There are separate groups for the various types of combat veterans. For example, the Vietnam Veterans will have a different group compared to the Iraq and Afghanistan War Veterans.

Suicide awareness and prevention is a top priority within the VA Healthcare System. There is a specific team at all facilities to assist in monitoring suicide attempts, track high risks patients, and provide outreach for those in crisis. There are two Social Workers who provide this care at the Fresno VA. They will monitor a caseload of patients who have been determined to be at risk of attempting suicide. Peer support services are a new addition to the VA Healthcare system. The peer support program is driven by a recovery model of care. Peer support technicians are veterans and patients themselves who interact with patients on an equal level in order to encourage them engage in care for their illnesses. Neuro-psychology provides testing to help with diagnostic clarification, the predominant population served by this section is the elderly with testing for dementia.

CPRS

The VA invested \$4 Billion in health information technology in 1997. They developed the Computerized Patient Record System (CPRS). It is the Department of Veteran Affairs means of storing vast amounts of patient data, records, documents, imaging, laboratory results, etc. all within one integrative system. The system contains records of approximately 8.3 million patients. It provides an ease of viewing of patient records chronologically in time at any given facility, but also allows access to all the VA facilities that the patient has received care. This population is often a mobile one. It is of tremendous benefit to the provider to have full unrestricted access to past present and future care from any facility with any veteran. With the integration and development health information technology the VA saved \$7 billion from 1997 to 2007. The implementation of CPRS resulted in the elimination of duplicated tests and reduction in medical errors which accounted for 86% of the savings [3].

State of California involuntary confinement laws

California state law governs involuntary psychiatric admissions. Compared to other states (such as New York, for example, where two physicians can confine a patient to involuntary psychiatric treatment for up to 2 months without any court hearings). Psychiatrists in California may place a patient on what is called 5150 hold for up to 72 hours, and then extend the hold by filing a 5250 document for another 14 days [4]. The basis the must be substantiated to hold someone against their will include a danger to self, a danger to others, or grave disability. Grave disability is defined as an inability to seek food, clothing, or shelter due to a mental illness. When a patient is placed on 5250 hold, he or she has a right to a court hearing on the inpatient mental unit. The psychiatrist presents the case to a court officer, and then the patient is questioned in the presence of his or her patient rights advocate. If the court officer does not agree with the psychiatrist's rationale, then the patient is free to leave the hospital that same day. The patient is often discharged Against Medical Advice (AMA). A further hold, 5270, may extend the stay for an additional 30 days of involuntary care, this however is the extent of involuntary stays at the Fresno VA. Of note, patients may remain on the unit for treatment on a voluntary status without time limitations in the eyes of the law. After a 5250 or 5270 hold is supported for reasons of grave disability, the psychiatrist may then file a petition for guardianship with the patients county or residence. A subsequent formal court hearing in the County Superior Court determines whether to grant or decline the petition for conservatorship. If accepted, the patient is then sent to a long term locked care facility for continued psychiatric treatment. Following the de-institutionalization process, which in the US started in the early 1970s, there has been a drastic diminution of beds available in state hospitals which used to care for the most severely ill psychiatric patients [5].

Acute Services – Inpatient Psychiatric Care

The inpatient psychiatric unit cares for a variety of patients with chronic persistent mental illness, most commonly diagnosed with schizophrenia and schizoaffective

disorder. These patients have high rates of readmissions stemming from such psycho-social problems as poor medication compliance, poor housing situations, continued symptoms, and poor overall social supports. A large percentage of patients at any given time also suffer from co-morbid addictions, most common in the central valley being methamphetamine, alcohol, and cannabis. There is less use of cocaine, PCP, and other hallucinogens. Newer mind altering substances such as bath salts, which are not yet detected on our routine urine drug screens, are responsible for an unknown percentage of admissions.

When treating veterans one has to be vigilant for undiagnosed Post Traumatic Stress Disorder, and the co-morbid affective and anxiety disorders that are common to any general population. There is a significant amount of major depression, anxiety disorders, panic disorder, etc. Women veterans as well as younger age group veterans (under 30) are beginning to constitute a large percentage of patients at all VA's across the country [6,7]. This coincides with Iraq and Afghanistan conflict era service members returning home. In addition to all the above mentioned conditions, the younger veterans often struggle with unemployment, marital/family discord, homelessness and legal problems. Several VA programs seek to offer assistance to this at risk veteran group to ease their process of reintegration to the civilian society. Amongst these are the department of social work, homeless services, veterans justice outreach, and compensated work therapy.

Vignettes

To help illustrate how the system operates with specific patients we provide two clinical vignettes below. These are not based on any specific patient, however they contain components from our work with patients as a whole.

CASE 1

Patient A is a 56 year old male veteran 50 % service connected for psychosis not otherwise specified, with history of schizophrenia, paranoid type complicated by alcohol and methamphetamine use disorders. He has a history of chronic homelessness and legal problems (Driving Under Influence [of alcohol]). He has been followed by the Mental Health Intensive Case Management team (MHICM). He was brought in to the Emergency Room by the police overnight because of agitation and walking into traffic. On initial evaluation in the ER he was agitated with disorganized thought process and overt paranoia. He was disheveled with poor hygiene. He told the provider that the aliens are infiltrating Yosemite National Park via microwave beams projected from Half Dome. He insisted that this has caused the water in the park waterfalls to become radioactive and poisonous. Prior to admission he has made several phone calls to the Park Rangers alerting them of this alleged danger. He threatened to harm the Park Service because they were not heeding his warnings. A review of the CPRS records revealed that patient A has a long history of multiple presentations and subsequent psychiatric admissions to several of the west coast VA's including Los Angeles, San

Diego, New Mexico, Santa Fe, Phoenix, and Las Vegas. Three weeks prior to current episode patient received an injection of the long acting antipsychotic Invega-Sustenna at the Phoenix VA and he did not keep his follow up appointment.

The patient was medically cleared by the Emergency Room physician, with normal basic labs and physical examination. The urine toxicology screen was negative and urine alcohol level was 127 mg/dl. The patient was admitted on a 5150 hold for Danger to Others and Grave Disability. He was detoxified from alcohol following the CIWA protocol with thiamine, folic acid, and multivitamin supplementation. He received his regularly scheduled medications for hypertension, dyslipidemia and gout. He received the next injection of Invega-Sustenna. Emergency PRN medications were ordered during his inpatient stay however the patient did not necessitate any. He remained calm on the unit, was cooperative with medications and treatment. He was able to establish some minimal rapport with the treatment team. He however did continue to endorse a deeply held delusional system about the aliens and the poisoned waterfalls. Working in collaboration with the MHICM a decision was reached to recommend patient A to the Fresno County Public Guardian's Office for continuation of care in a locked facility under a conservatorship. A court appointed officer upheld the 5250 hold. A petition for conservatorship was submitted and a Fresno County Judge ordered the conservatorship. Patient was then sent to a long term facility for further stabilization and care once placement could be found.

CASE 2

24 year old male, former Marine, who has a history of four years of honorable service with two eight month deployments to Afghanistan presented to the emergency department for help with alcohol use. He noted that prior to serving in the military he did not drink much but after his first deployment he began to drink regularly. He did this to cope with recurrent thoughts about what he had seen while serving as an infantryman. He had been providing convoy security for supplies for most of his first tour. His convoys would be attacked by insurgents, on many occasions he was in fire fights. He saw friends get killed from improvised explosive devices (IED). His fellow Marines coped with these events by drinking when they returned home, he thought it was normal. There was no impairment in his ability to function at that time and he was re-deployed for a second tour six months later. He was again engaged in security operations and foot patrols. At times he would be fired upon and engaged in combat operations. He saw several fellow Marines die. After his return home he elected to leave the Marine Corps. He had fulfilled his four year obligation. Upon arriving at home his family noticed a significant difference in his behavior. He drank more, was angry, argumentative, and at times would lash out verbally with family. He attempted to find jobs but would only last a few weeks before being released for arguing or fighting with his superiors. He had a family history of alcoholism and they encouraged him to present for further care.

Upon presentation to the Emergency room he was medically screened with a physical exam, lab work to include CBC, Chemistries, liver function studies, urinalysis,

serum alcohol level and a urine drug screen. His serum alcohol level was 134 mg/dl. He stated his last drink was the night before. He admitted to drinking alcohol daily since his return home from serving in the military. When he tried to stop he noted withdrawal symptoms of anxiety, sweats, aches, tremors, and nausea. He explained that he turned to alcohol to cope with the traumatic events that he witnessed while deployed to Afghanistan. He witnessed multiple traumatic events but the hardest was watching one his friend's burn to death after an IED blast. His friend's vehicle caught on fire and he could not escape. He has recurrent thoughts of this event with nightmares that wake him at night. „The only thing that helps me sleep is alcohol.” Certain burning smells will cause him to re-experience the event. „It's like I am right back there again”. He has felt depressed at times but denied any prominent sustained neurovegetative symptoms, with the exception of impaired sleep. He denied any manic or psychotic symptoms. He denied any previous history of psychiatric evaluations or care. When asked about his post deployment screenings that check for psychological trauma (form DD 2796, including detailed questions e.g. regarding military service history, locations of operation, history of receiving medical help during deployment, symptoms during last month, traumas, major life stressors in the past month, exposure to dangerous substances, as well as use of alcohol) [8,9], he stated he did complete them truthfully, „I just wanted to get processed through and go home.” He agreed to admission for help with his alcohol use and to start further assessment and treatment of his anxiety/stressor related symptoms.

The patient was admitted and monitored for alcohol withdrawal. He required only a few doses of Ativan with CIWA-Ar assessments every four hours over three days. He was assessed further for mood symptoms the subsequent days when there was no alcohol in his system. He continued to endorse nightmares, flashbacks, hypervigilance, and periods where he would feel startled with loud noises. He was started on Sertraline 50mg per day as well as Prazosin 2mg at bed time. He participated in the ward activities and over time he was more comfortable and engaged with others. During his stay Prazosin was loaded to 5mg at bed time with an improvement in sleep and a decrease in nightmares. Zoloft was increased to 100mg per day without any notable side effects. He met with the addiction program staff and agreed to follow up daily in their program for assistance with his alcohol use. A referral was made to the Post-traumatic Stress Disorder Clinical Team with a plan that he would be screened and enrolled in their program once stable in his recovery process from alcohol use. He was then discharged to the addiction program for daily care and set up with a follow up outpatient psychiatrist appointment two days after discharge.

Concluding Remarks

Caring for the nation's veterans is a rewarding and challenging vocation in many respects. The veterans with mental health problems present a unique population of patients that need a varied and inter-disciplinary treatment plan approach. The VA provides a network of inpatient, outpatient and ancillary services to enable these men and women to maintain access to treatment and focus on long term recovery.

В артикуле представлен способ функционирования системы психиатрической опеки службы здравоохранения для ветеранов США, на примере штата Калифорния. Представлены также два описания клинических наблюдений, иллюстрируя проблемы нарушений психического здоровья этой популяции пациентов. Ветераны, также как и солдаты действующей армии и гражданские сотрудники военных частей, составляют группу пациентов, борющихся с нарушениями психического здоровья. Эта группа ветеранов требует все возрастающим вниманием клиницистов, не только в США, но и во всех странах, которые пребывают на различных военно-стабилизационных миссиях.

Ключевые слова: ветераны, система оздоровительной психиатрической опеки, посттравматический синдром

Behandlung des kranken Soldaten – System der psychiatrischen Gesundheitsbetreuung im Kriegsveteranenministerium der Vereinigten Staaten (Department of Veterans Affairs, USA)

Zusammenfassung

Im Artikel wurde die Funktionsweise des Systems der psychiatrischen Gesundheitsbetreuung für die USA – Veteranen auf dem Beispiel des Landes Kalifornien beschrieben. Es wurden auch zwei klinische Fälle beschrieben, die die Problematik der Störungen der psychischen Gesundheit unter dieser Population von Patienten veranschaulichen. Die Veteranen, auch die aktiven Soldaten und die zivilen Mitarbeiter der Armee bilden eine Gruppe der Patienten, die unter psychischen Störungen leiden. Diese Gruppe erfordert die Aufmerksamkeit der klinischen Ärzte nicht nur in den USA, sondern in allen Ländern, die sich in militärische Missionen/Friedensmissionen engagiert haben.

Schlüsselwörter: Veteranen, System der psychiatrischen Gesundheitsbetreuung, PTSD

Les services de santé adressés aux vétérans – le système des soins psychiatriques de Department of Veterans Affairs des Etats-Unis

Résumé

L'article présente le fonctionnement du système des soins médicaux adressés aux vétérans à Californie, aux Etats-Unis en décrivant comme illustration deux cas cliniques. Les vétérans ainsi que les soldats de l'armée active et les employeurs civils de l'armée constituent le groupe de patients souffrant des troubles mentaux et exigeant l'attention des cliniciens non seulement en Etats-Unis mais aussi dans tous les pays qui s'engagent dans les missions militaires.

Mots-clés : vétéran, systèmes des soins psychiatriques, PTSD

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