Chapter 11
Clinical Health Psychologists' Role in the COVID-19 Response in Veteran and Military Hospitals

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The coronavirus disease 2019 (COVID-19) pandemic produced psychosocial stressors across the globe. Stressors that include social isolation, financial loss, and the disruption of daily routines were detrimental to long-term mental health as well for all populations affected (Gruber et al., 2020). In particular, the pandemic drastically altered the quality of life for military personnel and veterans. Psychologists in every sector of society, including in veteran and military hospitals, were faced with medical, psychological, and social challenges for both themselves and their patients. In the wake of the COVID-19 pandemic, health psychologists were called upon to better understand individuals' responses to the pandemic's effects on their daily lives, the public's transmission-related behaviors, and the potential psychosocial and physical impact of COVID-19 on frontline health care workers (Arden & Chilcot, 2020; Castelnuovo et al., 2020; Kazak, 2020). Health psychologists can apply their expertise to COVID-19-related health behaviors, including resistance to vaccine recommendations, mask wearing, and social isolation. Further, health psychologists can conduct essential public health research related to public health communication, health disparities, and the prolonged effects of the COVID-19 pandemic (Freedland et al., 2020).

This chapter describes how clinical health psychologists, the Veteran's Health Administration (VHA), and military hospitals adapted to address mental health service delivery in the face of the unique challenges posed by the COVID-19 pandemic. The sections that follow will summarize the impact of COVID-19 on military service members, veterans, military hospital administration, and frontline workers. Further, this chapter will discuss health psychology's role in the VHA's response to

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service delivery, will outline the factors that contributed to enabling access to services, and discuss the factors that impeded this progress. Finally, this chapter will discuss recommendations and will review areas for future work for health psychologists in veteran and military hospitals in future pandemics.

1 Impact of COVID-19 on Military and Veterans

Providing mental health treatment is essential during any global disaster. Pandemics and natural disasters are known to increase rates of depression, post-traumatic stress disorder (PTSD), and substance use disorders (SUD) in civilian populations (Galea et al., 2020). Symptoms of depression, anxiety, and substance abuse increased substantially in the United States population during the early phases of the COVID-19 pandemic (Czeisler et al., 2020; Holingue et al., 2020a, b; Holman et al., 2020). Military and veteran populations, however, held pre-existing vulnerabilities before the pandemic, including higher rates of suicide, psychiatric disorders, physical health conditions, and psychosocial stressors relative to nonveterans (Bruce, 2010; Levine & Sher, 2021). Veterans, as a vulnerable population, are at a higher risk of poor health because they experience barriers to vital resources (e.g., social, economic, political, and environmental) and limitations due to illness or disability. Veterans frequently report elevated rates of adverse childhood experiences (Katon et al., 2015), intimate partner violence, and military sexual trauma (Gerber, 2019). Thus, researchers posited that COVID-19 would place veterans and military service members at a unique risk for long-term mental health effects, given their pre-existing psychological vulnerabilities (Gerber, 2020; Ramchand et al., 2020).

Individuals with pre-existing mental illness are more likely to suffer worsened distress in response to pandemics (Egede et al., 2020; Panchal et al., 2020). While there is a dearth of research on the effects of pandemics on military and veteran populations, military personnel in humanitarian disasters have been shown to experience increased depressive and trauma symptoms (Cunha et al., 2018; West & Morganstein, 2016). Given evidence that the effects of the pandemic can contribute to the development and exacerbation of mental health symptoms, psychologists and clinicians must be aware of the impact of COVID-19 on veteran and military populations (Gerber, 2020; Ramchand et al., 2020). Indeed, preliminary studies have shown that veterans reported increased levels of depression, anxiety, and loneliness after the start of the COVID-19 pandemic, relative to pre-COVID-19 (Wynn et al., 2020a, b).

An estimated 30.9%, 12.1%, and 13.8% of Vietnam, Gulf War, and post-9/11 veterans meet criteria for a diagnosis of PTSD, respectively (Kang et al., 2003; Kulka et al., 1990; Tanielian et al., 2008). Acute stress disorder (ASD) and PTSD are likely to develop or worsen in military personnel and veterans due to several costly COVID-19 stressors, including significant life disruption, threats to safety, erosion of social supports, deaths of loved ones, and loss of financial supports

(Bonanno et al., 2010; Marini et al., 2020). Experiencing symptoms of PTSD also places individuals at risk for substance abuse and suicidal ideation (Sareen, 2014). The COVID-19 pandemic may also increase suicide rates among veterans (Gunnel et al., 2020; Levine & Sher, 2021; Sher, 2020). Indeed, a 2020 report by the Wounded Warriors Project concluded that "lack of social connection (loneliness) along with co-occurring mental health conditions (PTSD, depression, suicidal ideation) exacerbates and magnifies the burden warriors experience during adverse events like COVID-19" (Wounded Warrior Project, 2020). Conversely, the COVID-19 pandemic led to a decrease in VA psychiatric emergency room visits, suggesting that many veterans may have postponed necessary mental health and substance use treatment (Mitchell & Fuehrlein, 2021).

Those with PTSD are also at increased risk of developing physical health problems including obesity and sleep disturbances (Kubansky et al., 2014). In a cross-sectional analysis report of COVID-19 patient demographics, infection, mortality, and case-fatality rates in the veteran population, researchers found that 59.7% were 65-or-more years old, 92.5% were men, 68.7% were white, and 14.2% were black. Veterans over the age of 65 comprised 52.1% of cases and 89.9% of deaths (Luo et al., 2021). Veteran COVID-19 mortality was also associated with increased strains on VHA hospital capacity (Bravata et al., 2021).

1.1 Caregiver and Provider Stress

In addition to military and veterans, caregivers of individuals with mental illness are also at increased risk for developing mental illness (Ramchand et al., 2014). The mental health needs of healthcare workers should also not be neglected (Zaka et al., 2020). At present, there is little research that addresses the mental health needs of health care workers (Gruber et al., 2020). Health care workers are burdened by the task of managing the needs of their COVID-19 patients while putting themselves and coworkers at increased risk for transmission of the virus. From studies of prior pandemics, health care workers may suffer social isolation due to being perceived as having higher risk of infection (Williams et al., 2011). During prior pandemics, health care workers with a history of mental illness were more likely to report experiencing symptom relapse (Lai et al., 2020; Lancee et al., 2008).

2 Veteran Health Administration's Response to Service Provision During COVID-19

The Veterans Health Administration (VHA) is the nation's largest integrated health care system, providing annual services to over six million veterans at 1286 sites and mental health care to 1.7 million veterans alone in 2019 (Connolly et al., 2020a, b;

Harpaz-Rotem & Hoff, 2020; VHA Support Service Center, 2020). The VHA's initial response to COVID-19's challenges was driven by three priorities: (1) to continue providing mental health care to millions of patients; (2) to prevent the spread of COVID-19 in medical centers while balancing patient and staff safety; and (3) to expand access to mental health care in high-risk locations and states under "stay at home" orders (Heyworth et al., 2020). The VHA and psychologists were primarily able to address these priorities by delivering virtual care to patients.

2.1 VHA's Expansion of Virtual Care

As the nation's largest integrated healthcare system, the VHA has been a pioneer in implementing and developing telemental health for decades prior to the COVID-19 pandemic (Adams et al., 2019; Darkins, 2014; Perrin et al., 2020). In 2019 alone, VHA providers delivered nearly 786,000 video telemental health encounters to more than 230,000 veterans (Rosen et al., 2020). Thus, the VHA was well-prepared to expand telemental health by the onset of COVID-19. The rapid transition to telehealth psychotherapy services was spurred following COVID-19 restrictions of nonurgent in-person appointments. To address this challenge, the VHA specifically directed in-person psychotherapy visits to transition to telehealth appointments (Heyworth et al., 2020). Five key avenues were critical in rapidly shifting the VHA's virtual care initiative: (1) providing training to both staff and patients; (2) growing the VHA's technology infrastructure; (3) providing consistent messaging to diverse stakeholders; (4) meeting the needs of high-risk patients; and (5) as necessary, expanding support of the private sector (Heyworth et al., 2020). The US Department of Defense (DoD) published the DoD COVID-19 *Practice Management Guidelines: Clinical Management of COVID-19* (Matos & Chung, 2020), and, within these guidelines, the Department of Psychiatry at the Uniformed Services University in the DoD developed a Mental Health and Well-Being toolkit to support patients and medical providers (Uniformed Services University and Defense Health Agency, 2020). The VHA increased telemental health service delivery, which subsequently decreased in-person appointments by 80% (Rosen et al., 2020). In just the first six weeks following the World Health Organization's (WHO) pandemic declaration (March 11, 2020–April 22, 2020), daily telemental health encounters grew 556%, while in-person psychotherapy appointments dropped by 81% (Connolly et al., 2020a, b).

Other divisions of the VHA also quickly adapted to meet the unique needs of patients. Prior to COVID-19, the Cohen Veterans Network (CVN) was established to provide behavioral health care to veterans and their families. By late March 2020, CVN clinics converted more than 90% of their clinical services to telehealth (Shelton et al., 2020). The COVID-19 pandemic and stay-at-home orders put women veterans at a higher risk for interpersonal partner violence. As such, the VHA's existing Intimate Partner Violence Assistance Program (IPVAP) provided guidelines for screening and intervention through telehealth formats (Rossi et al.,

2020). In sum, not only was the VHA network prepared to manage the mental health of its broad veteran population, but also the unique needs of veteran subpopulations.

2.2 Telemental Health

Pre-pandemic teletherapy faced several barriers to its inception, including intrapsychic barriers (e.g., bias and low self-efficacy), environmental barriers (e.g., federal HIPAA security, Medicare regulations, state laws and regulations, and settings in which psychologists practice), and technical issues with clinicians or patients (Pierce et al., 2020). Nonetheless, the research shows great promise for the efficacy of virtual teletherapy. At least a decade of research supports the efficacy of psychological interventions delivered over the telephone, particularly in interventions targeting PTSD, depression, and anxiety (Varker et al., 2019). In several studies comparing teletherapy to traditional therapy, patients completed a higher number of sessions than those participating in face-to-face therapy (Hernandez-Tejada et al., 2014). In a systematic review, Turgoose et al. (2018) found that veterans with PTSD reported high levels of acceptability and satisfaction using teletherapy. Despite common misconceptions, evidence suggests that at least similar to strong therapeutic alliances can be established via telephone therapy (Irvine et al., 2020; Stiles-Shields et al., 2014). Telephone psychotherapy has also been shown to reduce suicidality (Rhee et al., 2005), as well as to successfully prevent relapse and improve health behaviors (Baker et al., 2018). Several treatment studies of veterans with PTSD found video teletherapy as effective as in-person psychotherapy (Acierno et al., 2016, 2017; Morland et al., 2010, 2014, 2015, 2019, 2020). Studies across a range of mental health conditions report high rates of patient satisfaction with video telemental health treatment (Campbell et al., 2015; Fletcher et al., 2018).

2.3 Adjustment to Teletherapy During COVID-19

Prior to the COVID-19 pandemic, psychologists working in Veterans Affairs medical centers performed 11.28% of their clinical work using telepsychology, which increased seven-fold to 80.65% during the pandemic (Pierce et al., 2020). The COVID-19 pandemic ameliorated much of psychologists' bias and barriers to teletherapy. During COVID-19, mental health practitioners reported positive experiences with telemental health that include treatment effectiveness, increased flexibility of services, lower threshold for contact, and a lack of travel time for delivering services (Feijt et al., 2020). In a recent review of clinicians' attitudes toward via videoconference telemental health, clinicians reported that video teletherapy was effective, they valued the improved access to care, they saved time and money, and experienced increased flexibility in their duties (Connolly et al., 2020a,

b). Furthermore, most psychotherapists identified having a positive attitude toward online therapy, suggesting they are likely to keep using online therapy in the future (Bekes & Doorn, 2020).

Patient agreeableness and openness to telehealth and teletherapy also improved after the start of COVID-19. Relative to other types of care (e.g., primary care, rehabilitation care, specialty care), mental health care had the greatest percentage and number of video-based encounters provided in VA outpatient settings (Ferguson et al., 2020). One study found that veterans with a previous PTSD clinical diagnosis were more likely to get tested for COVID-19, and were less likely to test positive, than veterans without PTSD, which may indicate increased social isolation among veterans with PTSD (Haderlein et al., 2020). Outcomes for veterans during the COVID-19 pandemic may be promoted by encouraging veterans to engage in positive but safe social contact and by using existing coping skills that aided their resilience during past stressors (Fiori, 2020). Cornwell et al. (2021) compared Primary Care-Mental Health Integration (PC-MHI) service utilization in the VHA system before and after COVID-19 was declared a national emergency. While PCMHI services initially saw drastic increases of phone and home telemental health encounters (147% and 645%, respectively), overall encounters decreased to 82% of pre-pandemic volumes with some sites experiencing continual declines. Such increases suggest more acceptability of virtual care, while declines may be attributed to sites with limited to no access to remote care (Cornwell et al., 2021).

3 Post-pandemic Challenges and Future Directions for Health Psychologists in Military and Veteran Hospitals

Heyworth et al. (2020) reported several lessons learned from the VHA's expansion of virtual health in the initial months of the COVID-19 pandemic. First, clinicians' ability to conduct services across state lines was critical to the VHA's ability to marshal a national provision of telehealth services. Therefore, health psychologists and VHA administration should aim to promote service delivery across state lines in future pandemics to enhance military personnel and veterans' access and acceptability of services. Second, staff and patients displayed variable openness toward the adoption of telehealth, with many veterans opting to receive telehealth services by phone than by video-to-home methods. While the reasons for such are unknown, future research should aim to find the most ideal balance of in-person and virtual service delivery for patients. Third, many areas of the U.S. still have underdeveloped technological infrastructures. Thus, health psychologists and VHA administration should collaborate to expand internet and cellular access to military and veteran populations in rural or remote areas of the country to also provide access to telemental health in the future. Fourth, payment for clinical services was found to be both an incentive and barrier to virtual health care. Prior to COVID-19, the VHA was compensated three times more for video-to-home services than phone-only

services, leading the VA to incentivize video-to-home services regardless of phone visits being both more accessible and preferred by patients. Health psychologists should advocate for the VHA to evaluate existing payment policies in order to balance the use of video and phone service delivery. Fifth, mental healthcare experienced the largest increase in video-to-home telehealth services relative to other specialties (e.g., primary care). Health psychologists may wish to further study the reasons for such differences, including patient preferences and clinicians' requirements for visual observation of their patients. Sixth, the adoption of a learning health organizational model was significant toward expanding the rapid transition to telehealth (Heyworth et al., 2020). The learning health model ensured that VHA hospitals could implement and monitor telehealth service delivery to provide continual improvement of services.

3.1 Maintaining Frontline Providers' Well-being

The relationship between provider and patient well-being is bidirectional. In future public health crises, health psychologists may prevent strain on military and veteran health care systems by promoting more self-awareness and self-care in their respective patient populations (Arora & Grey, 2020). Likewise, frontline responders who maintain basic self-care are likely to perform their best, while maintaining clear, concise, and consistent communication between team members, patients, and their families will facilitate the best outcomes. Thus, it is essential the frontline providers' mental and physical health are maintained during public health crises. Maintaining self-care and crisis communication are key elements to guide military mental healthcare provision (Wynn et al., 2020a, b). Interventions to improve frontline health care workers' mental health should initially target basic human needs, including promoting rest and health safety, followed by targeting more advanced psychological needs and other adaptive interventions (e.g., communication, problem-solving, and general coping skills; Zaka et al., 2020). Researchers have presented several basic guidelines for upkeeping medical provider well-being, some of which include connecting to a sense of unified purpose, recognizing burnout in self and others, focusing on what can be controlled, and accepting what cannot be controlled (Wynn et al., 2020a, b). For mental health providers, recommendations include providing proactive support to frontline workers (medical and support staff), tailoring support as much as possible, and facilitating additional mental health care for individuals in high need. Other approaches to maintaining health care workers' mental health include working with military and veteran hospitals to create supportive environments, developing systems for monitoring mental health concerns, increasing access to resources for reducing daily life stress, and assessing training needs of pandemic health care workers (Gruber et al., 2020).

3.2 Implementing and Improving Teletherapy Technology

Health psychologists may facilitate technological mental health treatment in veterans by increasing veterans' access to technology, promoting technology literacy, increasing patient buy-in, and familiarizing themselves with such tools (Gould & Hantke, 2020; Gould et al., 2020). Considering that many adults access the internet with smartphones, mental health apps may be beneficial for military serving members and veterans, and the U.S. Department of Veterans' Affairs already provides a library of free mental health apps (https://www.mobile.va.gov/; Torous & Keshavan, 2020). Though there is limited evidence for the efficacy and effectiveness of mental health apps (Marshall et al., 2020a, b), the VA provides at least one app to treat PTSD and has been the primary research base for the efficacy of mental health apps to treat PTSD (Kuhn et al., 2017; Owen et al., 2018).

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