



The Use of Telemental Health to Meet the Mental Health Needs of Women Using Department of Veterans Affairs Services

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ABSTRACT

Background: Women veterans are a growing segment of Department of Veterans Affairs (VA) users with distinct mental health needs and well-documented barriers to care. Telemental health holds much promise for reducing barriers to mental health care. We assessed VA stakeholders' perceptions of telemental health's appropriateness and potential to address the mental health needs of women veteran VA users.

Methods: We conducted semistructured qualitative interviews with 40 key leadership and clinical stakeholders at VA medical centers and associated outpatient clinics. Transcripts were summarized in a template of key domains developed based on the interview guide, and coded for topics relevant to women's mental health needs and telehealth services.

Results: Telemental health was perceived to increase access to mental health care, including same-gender care and access to providers with specialized training, especially for rural women and those with other limiting circumstances. Respondents saw women veterans as being particularly poised to benefit from telemental health, owing to responsibilities associated with childcare, spousal care, and elder caregiving. Interviewees expressed enthusiasm for telemental health's potential and were eager to expand services, including women-only mental health groups. Implementation challenges were also noted.

Conclusions: Overall, our stakeholders saw telemental health as a good fit for helping to address the perceived needs of women veterans, especially in addressing the geographical barriers experienced by rural women and those with a limited ability to travel. These findings can help to inform gender-tailored expansion of telemental health within and outside of the VA.

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Geographic barriers limit access to mental health care in areas that have a shortage of providers (Benavides-Vaello, Strode, & Sheeran, 2013; Dyck & Hardy, 2013; Hoge et al., 2004; Jameson & Blank, 2007). Telemental health, an application of clinical video telehealth that uses internet, software, or cellular platforms to support real-time videoconferencing between patients and providers across distances, has the potential to reduce geographic barriers to mental health care. It may improve access for rural patients and those with other restrictions on mobility, and improve access to providers with specialized expertise in specific conditions (Brownlee, Graham, Doucette, Hotson, & Halverson, 2010; Hassija & Gray, 2011; Hoolahan, Grosvenor, Kurtz, & Kelly, 2007). Telemental health can take the form of telepsychiatry, and both individual and group psychotherapy formats. (Deen, Godleski, & Fortney, 2012).

In noninferiority studies, telemental health has been found to be effective and equivalent to in-person care (Acierno et al., 2017; Hilty et al., 2013; Luxton et al., 2016; Richardson, Christopher Frueh, Grubaugh, Egede, & Elhai, 2009; Yuen et al., 2015). Outcome measures for treatment via telemental health have been shown to be at least equivalent to in-person care for posttraumatic stress disorder (PTSD; Backhaus et al., 2012; Frueh et al., 2007; Gros, Yoder, Tuerk, Lozano, & Acierno, 2011; Morland, Hynes, Mackintosh, Resick, & Chard, 2011; Morland et al., 2014; Tuerk, Yoder, Ruggiero, Gros, & Acierno, 2010; Ziemba et al., 2014), substance abuse (Benavides-Vaello et al., 2013; Hilty et al., 2013), depression (Hilty et al., 2013; Khatri, Marzali, Tchernikov, & Shepherd, 2014), and psychosis (Godleski, Darkins, & Peters, 2012; Sharp, Kobak, & Osman, 2011). Telemental health as a mode of care delivery is generally acceptable to patients (Dobkin et al., 2013; Godleski et al., 2012; Hilty et al., 2013; Kruse et al., 2017; Morland et al., 2013; Richardson et al., 2009), although there are some patient-related barriers, including concerns about privacy, and for some, unfamiliarity with and low use of technology (Wangelin, Szafranski, & Gros, 2016; Whealin, King, Shore, & Spira, 2017). Provider acceptability can also be a barrier (Brooks, Turvey, & Augusterfer, 2013; Jameson, Farmer, Head, Fortney, & Teal, 2011; Lindsay et al., 2015; Rees & Stone, 2005).

The Department of Veterans Affairs (VA) has invested in telemental health to improve access to mental health care (Tuerk et al., 2010). The VA is a national healthcare system with a significant proportion of rural or very rural patients (VHA Office of Rural Health, 2016). More than one-half of VA patients are seen at VA community outpatient clinics separate, and often distant, from VA medical centers (VAMCs; Department of Veterans Affairs, 2016a). In its original form, telemental health in VA has historically been used to connect patients at distant VA community outpatient clinics with VAMC-based mental health providers. Since 2010, this traditional “hub-and-spoke” model has been supplemented with the establishment of a nation-wide system connecting patients to mental health experts at VA locations partnered with leading academic medical centers, such as VA Boston with Harvard and VA Connecticut with Yale. VA–university partnerships build on the VA’s existing expertise by expanding capacity to connect veterans with leading experts for affective, psychotic, anxiety, and substance use disorder mental health diagnoses (Department of Veterans Affairs Telehealth Services, 2017).

Facilitating these innovations in telehealth delivery is the absence in VA of two common barriers to telehealth: state-based licensing of providers and third-party payment issues (Benavides-Vaello et al., 2013; Castro, Miller, & Nager, 2014). As

federal employees, VA providers have fewer barriers to providing services to patients across state lines (Department of Veterans Affairs, 2012), and are not limited by a payment system that may inhibit reimbursement for telehealth services. These structural advantages may have helped to foster the development of telehealth within VA. In fiscal year 2016, the VA provided more than 427,000 telemental health consultations to more than 133,000 veterans (Department of Veterans Affairs Telehealth Services, 2017).

The expansion of telemental health within and outside of the VA has increased the need to understand how telemental health may be tailored to better meet the mental health needs of different patient populations. Despite a growing body of evidence for the effectiveness of telemental health, less work has been done to better understand the applicability of telemental health for serving, for example, African American and Latino urban populations (George, Hamilton, & Baker, 2009; George, Hamilton, & Baker, 2012), incarcerated individuals (Deslich, Thistlethwaite, & Coustasse, 2013), and rural native peoples (Shore et al., 2008; Whealin et al., 2017). Among veterans, the use of telemental health has in the past been studied with all-male or predominantly male patient samples (Deitsch, Frueh, & Santos, 2000; Frueh et al., 2007; Greene et al., 2010; Morland et al., 2011; Morland et al., 2013, 2014; Tuerk et al., 2010; Ziemba et al., 2014).

Telemental health in women veterans has only recently begun to be studied (Morland et al., 2015). Women veterans are a numerical minority in VA (approximately 10%; Department of Veterans Affairs, 2016b) and their mental health needs may differ from those of their male counterparts (Department of Veterans Affairs Women’s Health Services, 2014). Overall, women veterans who use VA services carry a high mental health burden, and have high rates of trauma exposure including sexual harassment, abuse, and assault in the military (Department of Defense, 2017). Mental health conditions rank third in top categories of women veterans’ disease burden, impacting 45% of women veterans (compared with 31% of male veterans) in the VA (Department of Veterans Affairs Women’s Health Services, 2014).

Women veterans’ distinct mental health needs include conditions associated with reproductive life stages, such as premenstrual dysphoric disorder or postpartum depression, and access to providers familiar with the use of psychotropic medications during pregnancy and lactation. In addition, women may experience the same mental health diagnosis differently from men, calling for gender-specific expertise. Women veterans may also have mental health considerations that differ from those of male veterans and impact the delivery of their care. Mixed-gender care settings have been shown to be problematic for some women with trauma histories (Kehle-Forbes et al., 2017; Koblinsky, Schroeder, & Leslie, 2017), who may not be comfortable in large VA hospital settings where the majority of patients are male. In addition, many women veterans (28%) live in rural or very rural areas, with documented barriers to specialty care access (Cordasco, Mengeling, Yano, & Washington, 2016; Department of Veterans Affairs Women’s Health Services, 2014), including specialty mental health care.

Recent research available on women and telemental health is promising; it suggests that telemental health services can be effectively adapted to address women’s mental health needs (Azevedo, Weiss, Webb, Gimeno, & Cloitre, 2016; Gilmore et al., 2016; Koblinsky et al., 2017; Lehavot et al., 2017; Morland et al., 2015) and patient satisfaction is high (Polinski et al., 2016). However, given the ways in which women veterans’ mental

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