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*Moderator:* We are just about at the top of the hour. We will give people a few more moments to get settled. We do have two presenters joining us today. We have Dr. Marc Rosen. He is the director of substance abuse at VA Connecticut, and director of clinical research for VISN 1 MIRECC. He is also an associate professor of psychiatry at Yale. Joining him, we have Dr. Sarah Meshberg-Cohen. She is a clinical psychologist at the VA Connecticut healthcare system, and an assistant clinical professor in the department of psychiatry, also at Yale School of Medicine. At this time, I would like to turn it over to Dr. Meshberg-Cohen.

*Sarah Meshberg-Cohen:* Thank you so much. Thank you all for the opportunity to talk to you today, about benefits counseling and therapeutic encounters after compensation and pension exams.

Today, due to the significant negative impact that mental illness has on social, occupational and financial wellbeing, veterans are eligible for VA disability compensation for mental health conditions that were either caused by or aggravated by their service in the military. The VA disability program differs from the Social Security/Disability system in that eligibility for VA disability is not based on income, or an inability to work.

One reason why people who receive VA disability payments may be underemployed is the perception that veterans who work will lose their disability benefits. In fact, service connected veterans rarely lose benefits because of working. Veterans who are rated anywhere from 10% to 100% can work full or part-time, with no limit as to how much they can earn, and still be eligible to receive their monthly benefits, even if they are at 100%.

Disability rating is based primarily upon the average impairment earning capacity, that is, upon the economic or industrial handicap that must be overcome by the average person. It is not from the individual success in overcoming it. A veteran is not supposed to be penalized for overcoming a handicap.

The reason why we are highlighting employment here when discussing service connected disability is because work is associated with so many different aspects of one’s overall life. Many of them are positive. In addition to the obvious beneficial financial benefits that we see, employment can also provide a sense of wellbeing. For many, it also provides a sense of belonging, a decreased social isolation and a sense of routine and goal directed activity. This could lead to improved self-esteem and a sense of achievement.

If someone has lost an arm for example, there is less question about disability or handicap. The difference with mental health issues, such as post-traumatic stress disorder, is that when someone is working, it might be indicative that their condition is not as disruptive as the loss of limb is. The Veterans’ Benefits Administration Office may decide that you cannot be that sick if you are working. There are times when someone is functioning so well in various areas of their life that the individual may not meet criteria for service connected disability. In these cases, obviously one’s ability to work is not the only reason for denying a claim. It might be one aspect of the entire evaluation process that goes into this decision of a denial.

On the other hand, the Veterans’ Benefits Administration may also decide you have a service connected condition and you can cope with it so well that you are able to work, but you still have the condition. They will approve you for some rating of service connection. In addition, they may determine that your condition upsets your family life, upsets your sleep and daytime functioning, but you are able to pull it together enough to be able to work. Even though you can work, your condition harms you in other ways. They can approve you for service connected related disability.

Before we move on with our presentation, we would like to take a quick poll here. At this time, we want you to indicate all of the roles that apply to you. You can select more than one, if more than one of these choices applies.

*Moderator:* Thank you Sarah. It looks like our options are clinical care, treat veterans applying for service connection, conduct C&P evaluations for service connection, conduct research or other. It looks like several of our attendees do wear multiple hats regarding this. It looks like the answers have stopped streaming in. You can review those really quick, if you would like to.

*Sarah Meshberg-Cohen:* Okay, great. With the multiple hats, I am right there with you guys. It sounds like, by looking at this, about 62.5% if I am looking right, provide clinical care to veterans. About 50% treat veterans applying for service connection. About 18.7% conduct C&P evaluations for service connection. We have about 31.2% who conduct research and about 18% who have other things. This seems like it is really relevant to the work the listeners are doing here. I am glad we are addressing this now.

Despite the many positive effects of disability payments, including decreased homelessness, less poverty and greater decrease in post-traumatic stress disorder symptoms among those who receive service connection as compared to those who are denied their claims, one concern is that veterans with psychiatric disabilities who receive disability payments are less likely to be employed, compared to those who are denied their benefits. Rosenheck and Colleagues, and Drew and Colleagues found that there is low employment, especially among those with higher disability ratings. At about 50% service connection, we see less employment as compared to those who are denied their claims for mental health issues.

In this talk, we are going to be addressing how many veterans are impacted by service connection. We will be discussing some of the main reasons why veterans are applying for service connection, as well reasons why they might hold back from initially applying. The main thing we are going to focus on now in this talk is this impact on working, followed by a clinical trial of benefits counseling for veterans applying for service connection related to mental health issues. For now, I am going to discuss service connection for PTSD, due to the high percentage of veterans who are currently receiving or seeking service connection for post-traumatic stress disorder.

There has been a dramatic increase in PTSD beneficiaries over the past 15 years. Back in 1999, we had about 120,000 PTSD cases that were service connected. In 2004, there were about 216,000. In 2008, we saw about 346,000. By 2011, it was over half a million veterans who were service connected for PTSD. In 2012, which is not up there, we had about 572,600 that are service connected for PTSD. A lot of the new applications are not necessarily OEF-OIF veterans. A lot of them are veterans from prior service engagements. It is anticipated that at least half of OEF-OIF veterans are likely to apply for service connection at some point. We are going to see even more increases in connection.

At this point, we would like to discuss and ask you guys, those of you who work with veterans, to what extent you discuss the clinical impact of service connection claims with your veterans who are applying.

*Moderator:* Do not be shy ladies and gentlemen. This is an anonymous poll. Feel free to answer and answer honestly. It looks like people are starting to stream in their responses. We will give everybody a little bit more time to see if anybody else wants to reply. It looks like that might be it Sarah.

*Sarah Meshberg-Cohen:* Okay, great. From what I am seeing, it is about 18% of you that rarely discuss. Fifty-four percent usually discuss. About 27% of the listeners are always discussing. It looks like a lot of you are discussing the service connection with your veterans.

I am not sure about your experience, but in my clinical practice here at the VA, there certainly have been times where I have been working with a veteran doing therapy and we learn later on down the line, I might see them and in two weeks, we have another therapy session in one week. And I learn at that point,that they had a C&P evaluation. There are times where I do not even know that my veteran is seeking compensation and pension, or service connection.

Since I have been working with Dr. Rosen, I have been much more aware of how service connection can affect a veteran overall. I take multiple opportunities to discuss employment, but also identity and what it means for the veteran to be applying for service connection or receiving service connection. Obviously if they have not talked with me about it, what were some of the reasons they may have held back from discussing it with me before they went to their C&P evaluation? The majority do discuss it with me beforehand. It is interesting to see when I learn about it.

Sayers and Colleagues, whose research lab is in Minnesota, found some main reasons for why veterans report seeking disability compensation for PTSD. In addition to finding a lot of variability in the background of these veterans, many were not in mental health treatment at the time of their application. This is pretty concerning and something we are only going to have time to lightly address during this presentation. It is also something we are examining in one of our current clinical trials. Stay tuned. We are getting closer to completing those studies to hear more about it.

As far as the reasons for why we find that people are applying for service connection, most of the claimants are reporting that they are seeking disability compensation for symbolic reasons, especially for acknowledgement, validation and release from self-blame. Reasons having to do with improved finances are less frequently endorsed in research. They are also one of the main reasons. The sense of investment in obtaining a sense of self-acceptance or acceptance from others through disability status appears to vary by socio-demographic variables.

It is also important to mention that we also see a large amount of hesitancy from some of our veterans, particularly among those of our OEF-OIF veterans, when it comes to applying for service connection related to mental health issues. We have seen that job security and concerns about how service connection and/or treatment for mental health issues will affect their future employment and/or military status are at the top of their reasons for not seeking help or benefits.

Here are a couple of direct quotes from some of the veterans I have worked with. The first quote is from a veteran who is in the OEF-OIF study that we are doing, that is ongoing. They are randomized to either expert or no therapy sessions. This person, when I asked him what made him decide now to apply for service connection, said, “I was told I could never get a job in law enforcement. If I was service connected for PTSD, I would not be able to get the job.” This is the quote that he gave me, which is what you can read up there.

This individual held off for a while, until some of his buddies encouraged him to come in for help and to file a claim. That is what eventually brought him in, after six years of suffering from post-traumatic stress disorder. As we know, some people early on may show some symptoms. They may go into remission. It is not that people should be applying right away necessarily. Some should, but six years is quite a while to be suffering and holding off on getting help and filing a claim.

The next one is taken from one of the veterans I work with. I facilitate an OEF-OIF combat group in the substance abuse forum. This is a quote from one of the guys in the group. He said, “I thought you could not get a federal job if you had service connection.” In actuality, you can earn a higher preference for some of the VA jobs. This was actually in one or two of our groups, that we talked about this and what it means to them. Some of the veterans in that group are actually now working at the VA.

In addition to the PTSD related avoidance that inhibits veterans from filing a PTSD related claim, there is a high value placed on emotional strength, mental toughness and the fear of negative consequences, in particular negative career consequences or being seen as unfit. These are reasons why we might here that people are not seeking mental health treatment, as well as what I have been seeing from some of the veterans who are holding off on filing disability claims related to mental health issues.

We know that many people wait years and years, even decades, before seeking professional help for mental health problems. It is not just unique to PTSD. It is not just unique to veterans. Due to some of the military culture around being a soldier, a Marine and being in the military service, we do see that this is a big deal for them, what it means for them to be applying for service connection.

Indeed, when I asked one of the VA employees here about his thoughts on service connection, he said, “I still do not want people to know that I am service connected, because they will think I am crazy.” He went on to say that his mother goes to Al-Anon meetings and sometimes he joins her. She makes mention of the fact that he is a veteran and that he is service connected. There is a lot of self-stigma that he has placed on his own self, and also how we talked about what it meant for him to be in some of those meetings and have her bring it up. I thought that was pretty interesting.

While examining the kinds of attitudes and perceptions that veterans who are applying for service connection have around work, a recent article that we published, which is based on some of the baseline data from the clinical trial Dr. Rosen will be discussing in a few minutes, found that not only did veterans endorse high levels of agreement with statements that working would lead to a loss of benefits, but the majority agreed that they would turn down a job offer if it entailed loss of disability payments. Furthermore, we found that veterans with substance abuse agreed more strongly that they would rather turn down a job offer than lose financial benefits.

This is on a zero to four ratings scale, from strongly disagree to strongly agree, with the statement, “I would rather turn down a job offer than lose financial benefits.” As you can see, the veterans’ responses show they strongly agree they would turn down a job offer rather than losing their financial benefits. Among those with substance use disorders, it was significantly stronger, their agreement.

Here are some of the conclusions that we are drawing from this outcome. It is enlightening that each veteran’s situation is unique. Evaluation of work vis-à-vis service connection varies with the likelihood of finding work, the type of work available to the veteran assuming he is at work, other illnesses and their current financial situation. I recently asked one of our veterans about his thoughts regarding our findings that those with substance abuse agreed more strongly that they would rather turn down a job offer than risk losing financial benefits. He said it made complete sense. His initial response, without any hesitation, was, “I would, because I have so much anxiety of new things and new people. If I were to lose my benefits, I would turn down a job offer.” He went on to explain that his bosses did not understand his anxiety, which makes it more difficult to feel that he can work.

This is a direct quote from a 100% service connected VA employee here. “Nobody has to be unemployed to get service connection. Excuse me, the service connection comes whether you are employed or not.” This is just some of the different ways of how our veterans are viewing their service connection when it comes to employability.

In the clinical trial we are currently conducting with OEF-OIF veterans who are seeking connection for PTSD, we are asking them questions about their beliefs about work and how it might affect their chance of getting benefits. Here is a true/false question that we posed. The statement is, “To get service connection, I have to be unemployed.” Among those who are already enrolled in this clinical trial, everyone answered false. What we do know is that the OEF-OIF veterans that we have surveyed so far knew that you could work and still receive service connection. Many veterans accurately see some connection between service connection and working.

As you saw two slides ago, in our current clinical trial all of the veterans, the OEF-OIF veterans, answered false to the statement, “To get service connection, I have to be unemployed.” On this slide, we are showing the results from the same ongoing study about veterans’ beliefs about service connection and working. You can see here that the statements were rated on a scale from one to five, on the following statements for how they believed it would affect their chance of getting benefits. One is much less likely to affect their chances and five is much more likely. Three would be having no effect. We have two as slightly less likely and four as slightly more likely.

With the mean answer for the statement, “The veteran is working for pay,” the mean response was 2.7, indicating no effect. They did not feel like that would affect his or her chances of getting benefits. Over here, we have the veteran who is not employed and not seeking work. The mean was 3.1, no effect. The next statement, “The veteran is having trouble at work,” was about 3.5, which is slightly more likely to affect. For “The veteran’s symptoms make it harder to work,” the average was about a 4.3, indicating they feel it is more likely to affect their chance of getting benefits.

With the current veterans applying for service connection, I have the opportunity to meet with many of the veterans within weeks of their initial C&P evaluation. I found during the clinical trial we are doing right now, that veterans report work is very important to them. Sometimes it is at the top of their list of values when we do a values based chart for it. In the recent paper we published using the clinical trial examining employment-focused intervention, among veterans from various eras; work was the second most important domain. It was immediately followed by family, leisure, religion and community. It was high up there in their lists of values. The fact that some veterans are concerned that work would lead to a loss of benefits is very worrisome, especially considering the value on work placed by veterans during baseline assessments that we have accumulated thus far.

In summary, veterans consider service connection in the context of their attitudes about their mental health conditions, employment/work, military service and finances. Applying for service connection impacts employment for some veterans here. At this time, I am going to turn the microphone over to Dr. Rosen.

*Marc I. Rosen:* Okay, thank you. Dr. Meshberg-Cohen has sort of walked you through the importance of work to veterans applying for service connection, and the extent to which they have complicated thoughts about it. We thought that this might be an opportunity, when someone is applying for service connection and they are thinking about the pros and cons of working, to reinforce their ability to work and perhaps counter the emphasis on their disability claim. It is also an opportunity to engage people in treatment, who may be newly prioritized for VA treatment.

What I am going to talk about now is the extent to which these attitudes about work are modifiable. If you counsel people who are applying for service connection about the relationship between their benefits and their work, are you able to actually engage more of them in work, or work related activities? Does counseling move veterans toward working and related activities?

Benefits counseling was developed for Social Security beneficiaries, people who get SSI or SSDI for a psychiatric condition. For SSI and SSDI, there really is a strong disincentive to work. There have been two studies, two data studies, of benefits counseling, both with Bob Drake’s substantial input. One involved eight hours of benefits counseling, in which people with SSI and SSDI who were interested in working, were encouraged to work and got counseling about the programs that the Social Security offers that allow people to work and at least temporarily keep their benefits.

In the Tremblay study, which was published in Psychiatric Services, people who got this counseling earned about $1,200 more per year than the control group. The other study is Bob Drake’s study, in the American Journal of Psychiatry. This was a large randomized control trial with people receiving SSI or SSDI for psychiatric conditions. Benefits counseling was bundled with a lot of other employment supports. One of the key supports was that the beneficiaries were told that they were going to suspend the review of the SSI and SSDI application for three years. That basically meant it was much more likely that participants would lose their benefits if they worked.

The rates of SSI and SSDI beneficiaries working without this kind of push are really low, or working for pay and coming off SSI or SSDI. With this bundled intervention including benefits counseling, there were about 15% more beneficiaries working than in the control group. It was a nice, positive study of supporting benefits counseling.

How does benefits counseling work to facilitate engagement? How does the therapy work to facilitate working? One part of the mechanism of action, which Dr. Meshberg has been talking about, it just explaining the relationship between work and service connection, explaining that there is a relatively low likelihood of losing benefits if one works, as well as explaining what the options are. Generally, with more thought about this, the hope is that veterans will consider working more favorably.

A related part of this counseling is just the discussion of the pros and cons of working, with a sort of motivational interviewing stance, again with the idea that with more discussion, this would facilitate working. The discussion is a broader discussion of the veteran’s goals. The thought is that a veteran who is applying for service connection is in some ways at a crossroad. They are saying, “I have a condition that may be making it more difficult for me to work.” That is the focus of the service connection evaluation. There is also the broader context of, “What am I going to be doing for the next years? How much money do I really want?” With a sort of broader consideration, the hope is that most veterans who are ambivalent about this would feel more strongly that work really would help them achieve their goals. There is also the idea that this is a time to engage veterans in VA treatment.

*Moderator:* Marc?

*Marc I. Rosen:* Yes.

*Moderator:* I do apologize for interrupting you. Can you hold on just one second? We seem to be having an audio issue. I just want to go ahead and make sure we get that all squared away before you continue on.

*Marc I. Rosen:* Sure. Have I been talking to the Ether?

*Moderator:* It looks like it just went out a couple seconds ago. I will give you the heads up when to continue.

*Marc I. Rosen:* You will tell me when it is back on.

*Moderator:* Thank you so much.

*Marc I. Rosen:* Okay.

*Sarah Meshberg-Cohen:* It did not go off for me. I heard you.

*Marc I. Rosen:* I see.

*Moderator:* We are on the telephone together. Oh great, it is back on. All right. Sorry to interrupt. Continue on.

*Marc I. Rosen:* Thank you very much. That is the end of the talk. Just kidding. Everybody missed a really funny joke. You are not going to hear it again because I cannot repeat it.

Seriously, I was talking about how when veterans are applying for service connection, another aspect of benefits counseling is to try to engage veterans in mental health or if necessary, substance abuse treatment, that would facilitate working. By treating symptoms, a person would be more likely to work. This slide with the coin flip is because we are going to get into the clinical trial now.

We did a clinical trial, comparing veterans assigned to four sessions of benefits counseling to four sessions of VA orientation. The benefits counseling was 50 minutes each session, once a week for three weeks and then at three months or earlier if the person got their service connection decision earlier. The benefits counseling basically worked through the mechanisms that I just described. VA orientation was kind of a non-specific control for having a supportive person who encouraged you to come to the VA. At VA orientation, we had a walking tour of the VA campus. We had a movie about the VA and a little explanation of the history of the VA. It was intended to be pleasant and vaguely inviting. We did data assessments to look at how the intervention worked at zero, four, 12 and 24 weeks.

We enrolled veterans who were scheduled for a C&P exam with a psychiatrist or psychologist. We wanted people and required people that were not already receiving benefits for mental health conditions. We wanted people who were really at a decision point and not people who were more set in their opinions about this. We did not want people who had severe medical illnesses that precluded their working. We required them to have some difficulty working, which we assessed with the SF-36 question about saying that emotional difficulties made it more difficult to work in the preceding 28 days.

We approached 195 eligible people at the time of their C&P exams. Of the 195, we randomized 92 and then 84 completed a follow-up. This is not for everybody. There are people who come for a C&P exam, for whom work is not an issue. They are coming for a C&P exam because someone suggested they do it, but they have no trouble at work at all. There are people who are coming for C&P exams who are semi-retired. This is for the people for whom this is a decision point, for whom this is an active issue. There is some thought. “Where does work fit in?”

These are the demographics. The point of this slide is that there is a paper describing this clinical trial, that is in press in Psychiatric Services. All of these details are in that paper. As Sarah alluded to, there was a range of ages. Most of the veterans who enrolled in this study were not OEF-OIF. IT was about 29% in the benefits counseling group and 45% in the control group, with a range of psychiatric conditions. Most of the claims were for PTSD.

What happened after randomization? This slide shows the proportion of veterans who participated in their assigned treatments. The left hand column is the number of therapy sessions attended. Did the person attend zero, one or two? They were assigned to four sessions, but could attend fewer if they chose to. The therapy was completely voluntary. In the VA orientation group, three of the participants said, “No thanks.” A substantial number actually came for several sessions of VA orientation. I think that speaks to some willingness to be counseled among people applying for service connection.

In the benefits counseling group, the numbers were about the same. The vast majority of people attended two or more sessions. This also speaks to the control group being a reasonable control, in that it was not so boring or aversive that people did not come to it.

This is comparing the control groups in terms of pleasantness and some aspects of what it was like interacting with the therapist. In the left hand column, looking at non-specific aspects of counseling, these were rated by the participants on a one to seven scale, with one being not at all and seven being extremely. “Therapist spent time building rapport.” They thought the benefits counseling therapist spent a bit more time building rapport. This difference is statistically significant, the different between six and five. Basically, they thought that the therapists in both groups were reasonably pleasant about it.

In terms of the therapist demonstrating a desire to be helpful, that was almost identical in the two groups, six and 5.9. That was not statistically significantly different. It was a reasonably pleasant control condition, but somewhat less effort to build rapport. I think that is because the benefits counseling had the motivational interviewing emphasis. VA orientation was not as much of a feel your pain sort of thing. It was really more of a tour.

This was sort of interesting. These are ratings of the extent to which the therapist made value judgments. Although the ratings are low, they are closer to one than seven; they are higher in the benefits counseling than the orientation. That is significant. There was some extent to which people who were asked to review their work situation felt that the therapist was conveying a value judgment about working. The ratings of feeling pressured were minimal and did not differ between the groups. There was some sense that the therapist was trying to steer them to work, but not feeling pressured by it. There was equal attendance at the two types of counseling.

Benefits counseling was effective at convincing more veterans to attend treatment. This column, the Y-axis, represents the proportion of people who attended any mental health or substance abuse treatment in the weeks after randomization. The column on the left is about 19% and for benefits counseling it is about 25%. The pre/post change, pre-counseling to post, was significantly different. Benefits counseling was associated with attending more treatment.

Was benefits counseling associated with working more? That was really the goal. Our primary outcome, our priority, was actually the number of days in the last 28 engaged in any work activity. For veterans for whom work was not a goal, we would encourage them to go to classes or do volunteer work. It was trying to encourage work and work related activities. For days in any work related activity, this is the benefits counseling group. At baseline, they were engaged in an average of 8.3 days of these sorts of activities in the last 28. This increased somewhat over time. It increased more in the benefits counseling group than in the VA orientation group, but not significantly more. The P-value right here is 0.1. It is not statistically significant, but it is a pretty large effect size. For days worked for pay, this was statistically significant at 0.01 and a pretty good effect size.

People spent hardly any days in vocational rehabilitation. Somewhat surprisingly, this was significant in the opposite direction. How did this come about, that the veterans spent more days working for pay with benefits counseling? Was it that the veterans who were working worked more? Were there veterans who were not working for pay, who were encouraged to do so? It looks like it was veterans who were not working for pay who were encouraged to do so. The Y-axis here is the proportion of veterans who were working for pay. The X-axis is time. You have about 50% of the veterans who had worked for pay in the preceding 28 days and that did not change over time. The proportion working kind of goes up, from 0.4 to 0.6. That other finding about more days working for pay was driven by people who were not working, who went on to work in the benefits counseling group.

To summarize the study results, most veterans who were randomized in this study attended two or more sessions of the counseling. There was a general receptiveness to extra counseling. The benefits counseling was associated with significantly more days worked, but significantly fewer days in vocational rehabilitation, which really had minimal effect since it did not impact many veterans. Veterans assigned to benefits counseling had more weeks using any kind of behavioral services after randomization, compared to the control group.

In terms of how or why this would work, I think there are two take-homes. One is that I think there were veterans for whom this was a sort of open question, who with a nudge and some encourage, sought paid work. We did look at whether their attitudes about work changed, whether they came to believe that they could work and still get service connection. Attitudes about that did not really change over time. I think the main factor was the nudge. That is my qualitative impression.

There are some caveats. This is a reasonably small clinical trial. It is single site. Benefits counseling is somewhat bundled intervention. There is encouragement to work. There is facilitation of engagement in treatment. There is discussion of attitudes about work and service connection. It could have been any combination of those things that was responsible for the impact. The impact on work and time spent was self-reported, which is how these studies are done. It would have been nice to have pay receipts and such. I think the main take-home is that with a nudge, that more veterans who are applying for service connection were engaged in work for pay, with focused counseling than with those without.

I would like to ask a poll question here. To what extent are you going to discuss the clinical impact of service connection with veterans who are applying? We tried to make the case here that addressing these issues actually has some therapeutic benefit. We have been motivational interviewing about it. We have not tried to assert. We have tried to present both sides of it and hope that you agree with us.

*Moderator:* Thank you Dr. Rosen. It looks like we have a little bit of a shy crowd at this moment. Just under 50% responded. Just take a moment and click your response. We would love to get a little more feedback.

*Marc I. Rosen:* There were a few who rarely or never discussed this last time. Either they have changed their minds or they just do not want to click now.

*Moderator:* It looks like we have a pretty good indication, if you want to review it really quickly.

*Marc I. Rosen:* Okay. It looks like the majority, going forward; everyone is going to at least sometimes discuss the clinical impact of service connection claims with veterans who are applying. Clearly, we have not gotten into the other side of this, which is that it is a delicate issue to bring up. There is a question of how you bring this up. We did this in the context of a clinical trial. Dr. Meshberg was discussing how she has integrated it into her practice. I really look forward to the questions and feedback, as well as expertise of participants around how you address these issues.

I would like to thank the people who allowed us to do this study. There are many. Bob Rosenheck, as so often happens, had the idea or at least steered us to Bob Drake and his group’s idea. It was really a team of people who allowed us to get this study done. This was a rehab R&D grant that funded it. Other grants contributed in various ways to particular data presented. This is our group’s website. As I mentioned, the clinical trial is going to be available online. Materials from the study, including a counseling manual, are available at this website. Thanks very much for your time and attention.

*Moderator:* Thank you to both of you for that great presentation. I know that a lot of our participants joined us after the top of the hour. We do want you to be able to interact with our presenters. Please use the Q&A box located in the lower right hand corner of your screen, to submit any questions or comments you have for them at this time. We do have a pending question here. Do you know what percent of veterans are already in VA care at the time they apply for service connection, versus what percent come for care after they receive their service connection?

*Marc I. Rosen:* I will take that one. That is a great question. I do not know the answer. In this study, I think it was in the range of 30% who had services in the preceding six months. It went somewhat higher. You have the two-column table we showed, where I think it was 19% versus 25% went for some treatment afterward. The rates beforehand were in that range. They were in the 20% range of people who had treatment before.

There is a lot of controversy about the issue of timing of when veterans are in treatment and when they apply for service connection. Brian Marx has published about that. I think Nina Sayers’s group has a paper about that. The Office of Inspector General described veterans who appeared to engage in treatment around the time they applied for service connection, and then stopped treatment after they got it. Those appear to have been isolated cases. With the majority, there is no real trend or change in the proportion toward dropping out of treatment after getting service connection. I think overall, it goes in the other direction. It is a good question. There is a lot of complicated data out there that does not tell a clear story.

*Moderator:* Thank you for that reply. The person who submitted the question has a follow-up comment. The service connection rating may affect their priority level to receive care, and if they are eligible to receive the counseling.

*Marc I. Rosen:* In terms of the clinical trial, the counseling was offered as part of a research study. The veterans were all availed of benefits counseling or VA orientation as part of the study, before they got or were denied service connection. The questioner’s implication is right. Basically getting service connection facilitates getting treatment. I think the weight of the data is that there is more engagement in treatment after getting service connection.

*Moderator:* Thank you for that reply. For our attendees, I am going to put up our feedback form at this time. I do request that you provide us your feedback. It is helpful for the presenters and it is also helpful for the cyberseminar program. We have the opportunity to take your opinions into consideration when we are choosing which sessions to host. I just want to give Drs. Rosen and Meshberg-Cohen the opportunity to give any concluding comments. Marc, would you like to go first.

*Marc I. Rosen:* Sure. I think the takeaway is that counseling veterans who apply for service connection about how that impacts with the rest of their treatment goals and life plans is potentially very valuable.

*Moderator:* Thank you. Dr. Meshberg-Cohen, do you have any concluding comments you would like to make?

*Sarah Meshberg-Cohen:* Yes. I agree. I think having service connection related to mental health issues affects the veteran in many different ways. Employment is definitely huge and has a lot of value for many of the veterans. Even based on the question that we received, getting treatment has its own barriers that we have seen. A lot of people have obstacles for that. If we can help people who are service connected for mental health issues feel better about getting treatment for it, that would be awesome too. They can work in treatment and help them overall improve their quality of life. That would be great. Thank you.

*Moderator:* Great. I would also like to thank each of you for lending your expertise to this field, on this very important topic. I would also like to thank our attendees for joining us today. I am going to leave this feedback survey up for a little while. Feel free to take your time submitting your responses. Once again, thank you to both of you for presenting for us. As I mentioned to our attendees, we did record this presentation. You will receive a follow-up email next week with a link leading to the recording. Feel free to pass that along to any of your colleagues, or veterans that may be interested in this subject. With that, this does conclude today’s HSR&D cyberseminar. Have a wonderful day everyone.