

SOCIAL PHILOSOPHY

COMPARATIVE ANALYSIS OF THE U.S. AND ARMENIAN VETERAN MENTAL HEALTH SERVICES

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Abstract: This article aims to present the analysis of systematic approaches to the treatment of PTSD and war-related mental health issues adopted in Armenia and to illuminate possible differences and similarities between the latter and the best practices implemented in the USA.

The analysis of the aforementioned mental health systems has been carried out based on three main axes: general treatment management, diagnosis and treatment planning, treatment and subsequent follow-up.

As a result, we have concluded that despite the absence of a regulatory framework of the Armenian mental health system and the lack of a well-thought-out organization of patient admission, therapy and follow-up procedure, the model in place has more similarities than differences with the U.S. system. In particular, the therapeutic modalities, the format of psychotherapy, and the clinical supervision of specialists implemented in the psychological centres across Armenia are in line with U.S. standards. Nevertheless, as the psychological assistance delivered to veterans is not regulated on a national level and as there is currently a significant lack of institutional and professional resources, the improvement of the efficiency and the quality of mental health services in Armenia remains an important challenge.

Keywords: veterans, PTSD treatment, psychotherapy, mental health, U.S. and Armenian experience.

Introduction

In recent years the world has witnessed many armed conflicts such as wars in Iraq, Lebanon, Nagorno-Karabakh (Artsakh), Ukraine etc. Along with physical destruction of infrastruc-

tures, losses of human lives and other apparent consequences, the effects of war include long-term psychological harm to people directly or indirectly involved in armed conflicts and even their family members.

In particular, people who have been exposed

to traumatic events, i.e. shocking, scary, or dangerous experiences (Coping with traumatic events, n.d.), may later develop PTSD (post-traumatic stress disorder), a specific syndrome from which, according to some estimates suffer around 354 million adult war survivors worldwide (Hoppen & Morina, 2019).

Previously called by different names such as “shell shock”, “battle fatigue”, and “war neurosis”, the term PTSD first appeared in 1980 in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) published by the American Psychiatric Association (Crocq & Crocq, 2000) and is actually a household name for the disorder that may develop after exposure to exceptionally threatening or horrifying events (Bisson, 2015) Pursuant to the Evaluation of the Department of Veterans Affairs Mental Health Services (2018) (hereinafter referred to as “Evaluation”) military-related traumatic events that may trigger PTSD include exposure to war, threatened or actual physical assault, threatened or actual sexual assault, being taken hostage, torture, incarceration as a prisoner of war, and motor vehicle accidents.

With some differences between the diagnostic criteria of DSM-5 and ICD-11, in order to diagnose PTSD, both classifications require exposure to the threatening, horrific event, followed by symptoms of intrusion (re-experiencing of the traumatic event(s) in the present day with emotions of fear or horror), avoidance (avoidance of traumatic reminders), alterations in arousal and reactivity (sense of a current threat manifested as hypervigilance and/or an exaggerated startle response) (Haravuori, Kiviruusu, Suomalainen, & Marttunen, 2016; Trauma-informed care in behavioural health services, 2014; Bisson, 2015).

As it can be inferred from the joint analysis of generally accepted symptoms of PTSD, if not treated properly, the latter may lead to significant psychological, social and physical complications and adaptation problems.

The use of psychological interventions, namely cognitive behavioural therapy (CBT), eye movement desensitization and reprocessing (EMDR), prolonged exposure (PE) and cognitive processing therapy (CPT), are regarded as effective treatments for PTSD by a range of authoritative sources such as the APA guidelines, VA/DoD guideline, NICE guideline (Megnin-Viggars, Mavranetzouli, Greenberg, Hajioff, &

Leach, 2019; Watkins, Sprang, & Rothbaum, 2018).

Research and systematic improvements in PTSD treatment approaches are of particular importance in countries that are periodically or have at least once been involved in an armed conflict. This is due to the fact that PTSD symptoms cause significant distress or impairment in social, occupational, or other important areas of functioning (VA/DoD clinical practice guideline for the management of posttraumatic stress disorder and acute stress disorder, 2017), which eventually affects the general working ability of these persons.

Moreover, PTSD among military personnel may create risks to the proper replenishment of the armed forces. In particular, mental disorders have been shown to be the most common reason for leaving military service, compared to hospitalization for any other disease category (Hoge et al., 2002; The occupational burden of mental disorders in the U.S. military: Psychiatric hospitalizations, involuntary separations, and disability, n.d.). This is why the mental health of military personnel and veterans should be a priority for state bodies.

Among other factors, the probability of overcoming a mental disorder largely depends on the effectiveness of the psychological intervention. Implementation of an effective system of PTSD treatment requires addressing issues regarding treatment accessibility, proper diagnosis, treatment, and follow-up.

This study aims at analyzing the methodological approaches to the treatment of PTSD in the Armenian mental health system in comparison with the best practice implemented in the United States of America.

In order to accomplish this research objective, our study was divided into four different phases:

1. Creating a Questionnaire in order to evaluate the process of general treatment management, diagnosis and treatment of veterans.
2. Choosing the centres in Armenia focused on the treatment of veterans and collecting the data.
3. Research on the U.S. best practices of veterans' mental health treatment.
4. Comparative analysis.

So in order to examine the existing practice in Armenia, we have developed a questionnaire based on the main sections of the OEF/OIF/

OND Veterans' Access to Health Services Survey, presented in the framework of the Evaluation of the Department of Veterans Affairs Mental Health Services (2018). The questionnaire (31 questions) consisted of open and closed questions aimed at identifying specific information related to the following three areas:

1. General management of treatment/therapy.
2. Diagnosis and treatment/therapy planning.
3. Treatment/therapy and subsequent follow-up.

In the second stage, we have selected fifteen Psychological centres operating in Armenia and have sorted out eight of them that have a proven intensive track record of working with patients suffering from war-related PTSD (mostly veterans) since at least 2020. After selection, we conducted semi-structured interviews with the heads and specialists of the said psychological centres/departments based on the specially designed questionnaire.

As for the analysis of the U.S. best practices, which comprised the third step of our research, we have conducted thorough research of available scientific articles and publications (mainly on PubMed) regarding the aforementioned topics (general management of treatment/therapy, diagnosis and treatment/therapy planning, treatment/therapy and subsequent follow-up). Organizational issues pertaining to veterans' mental health care system were analyzed based on the information available on official governmental websites.

Research Overview: General Management of Treatment/Support

U.S. Department of Veterans Affairs (VA) is the second largest agency of the federal government on the basis of the number of employees and has three administrations – the Veterans Health Administration (VHA), the Veterans Benefits Administration, and the National Cemetery Administration. The VA is responsible for overseeing the U.S. largest integrated health care system, providing health care to approximately nine million veterans at 1243 different health care facilities (Greenstone et al., 2019) and offering education opportunities, rehabilitation services and various compensation to veterans and their family members. In particular, as we can find out on Department's webpage (PTSD Treatment Pro-

grams, 2007), VA offers specialized outpatient PTSD programs (SOPPs), where group or one-to-one outpatient treatment is offered. Outpatient mental health services are provided to veterans at VA medical centres (Evaluation of the department of veterans affairs mental health services, 2018).

Furthermore, the VA offers specialized intensive PTSD programs (SIPPs), which provide PTSD treatment services in an inpatient or residential setting. According to the "Guide to VA mental health services for Veterans & Families" (Sullivan et al., n.d.), in-patient care may be offered to veterans in need of intensive intervention, e.g. suicidal veterans or veterans suffering from very severe or life-threatening illness. Pursuant to the Evaluation, the inpatient program is most commonly located within a VA medical centre or a non-VHA community facility that has an agreement with the VHA.

For veterans with a diagnosis of severe and persistent mental illness or severe functional impairment, the U.S. Department of Veterans Affairs (VA) has developed mental health intensive case management (MHICM) program, which operates at VA facilities. MHICM program also is applicable for those with mental illness who are inadequately served by standard outpatient care, have high hospital usage, and are clinically appropriate for outpatient care. MHICM services are "delivered by an integrated, interdisciplinary team that serves as a "fixed point of clinical responsibility" with a focus on frequent contacts, flexibility, community orientation, integration with medical and mental health services provided at the VA system, and natural support systems, rehabilitation, and transition to self-care, independent living, and competitive employment where possible" (Mohamed, Neale, & Rosenheck, 2009). According to the Evaluation, the VA provides mental health care that is generally of comparable or superior quality to mental health care that is provided in the private and non-VA public sectors, but the accessibility and quality of mental health care services across the system vary by facility.

In Armenia, no standards are set for procedures covering psychological assistance in general and psychological rehabilitation for veterans in particular, which is primarily due to the lack of a specific legal framework and a well-thought-out approach and policy in the field of mental

health. And as a result, there is no state or umbrella professional institution that regulates and organizes the delivery of mental health services to veterans and other stakeholders.

It is noteworthy that despite the fact that after the war that took place in 2020, the Armenian government undertook an unprecedented initiative to consolidate psychological centres and services across Armenia and create a consortium of organizations working with the military personnel and their families, no unified regulation of consortium's activity, nor a general structure, direction and methodology of work has been put in place. As a result, we get a methodologically wrong situation where each individual centre applied its own methodology of therapeutic and effectiveness assessment and understanding of the clinical needs of veterans.

Also, since the government's efforts were primarily directed at providing veterans with their first psychological aid in a short period of time (the program lasted 6 months), the organization of a unified veterans' mental health system has not been set out as a priority. In December 2021, the state program ended, but the need for psychological rehabilitation of veterans and their families has remained. Since then, this need has partly been covered by private psychological centres (most of which have been surveyed in the framework of this study) on a volunteer basis or based on the means received from international grants, which has not, however, proved to ensure the provision of an effective, systematic and sustainable rehabilitation service.

When addressing the issues related to the implementation of an effective mental health system, one of the first questions is the initiation of

mental health treatment. As some research has proven, awareness of mental health services for veterans is one of the main barriers that affect the decision to seek or not to seek help (Bovin et al., 2019). As it may be inferred from our findings, the vast majority of patients who have received mental health diagnoses in the U.S. are seen in primary care (Treatment for posttraumatic stress disorder in military and veteran populations: Initial assessment, n.d.). Therefore, general practitioners play gatekeeper roles and decide whom to refer for psychological therapies (Stavrou, Cape, & Barker, 2009). As stated in the Evaluation, eligible veterans enrolled to receive VHA health care can access mental health care services in outpatient, inpatient, and residential settings in several ways, such as by going to a VHA facility or a Vet Center on their own, by receiving their mental health services within the primary care setting, or entering the VHA health care system via emergency service departments, either at VHA facilities or at civilian hospitals.

In Armenia, psychological support is mainly provided by private psychological centres. Therefore, people in need of help (including veterans and their families) mostly find specialists and/or mental health services by themselves. This fact has also been confirmed by the results of our research (see Fig. 1), which suggests that the vast majority of veterans who applied to the surveyed centres for psychological help found their contacts through the internet and/or the media. In addition, as we may infer from the collected data, state/international institutions, as well as primary care physicians, referred veterans to psychosocial centres in only half of the centres.

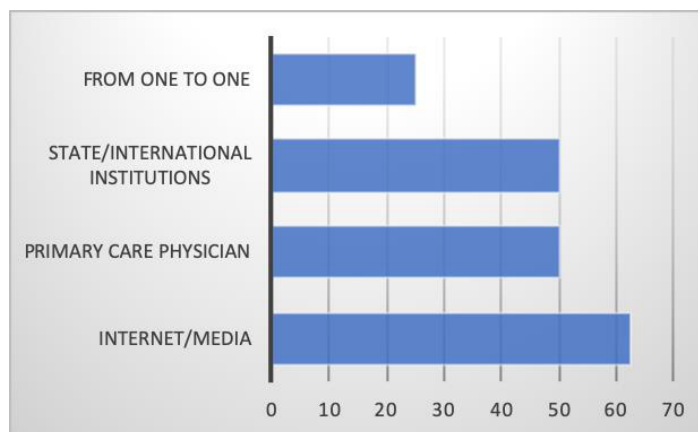


Figure 1. How Do Veterans Generally Learn about or Find Psychosocial Services in Armenia?

Any healthcare program or system requires detailed methodological regulatory standards and codes that define the scope, modalities, mechanisms, limits and ethical rules for services. The Veterans Health Administration (VHA) Handbook (2008), which defines the minimum clinical requirements for VHA Mental Health Services, acts as a fundamental document in U.S. practice. This VHA Handbook incorporates the new standard requirements for VHA Mental Health Services nationwide. It also specifies the services that must be provided at each Department of Veterans Affairs (VA) Medical Center and each Community-Based Outpatient Clinic (CBOC).

The VHA Handbook defines the responsibilities of different types of mental health providers, the principles of their collaboration and co-management, the principles of the Consensus Statement (National Consensus Statement on Mental Health Recovery, n.d.), the mechanisms of the services' implementation, the structure, management, reporting and monitoring of services, the inpatient and outpatient services system, the principles of care transitions, psychosocial rehabilitation and recovery services, etc.

As already noted, there is no general regulation of psychological services for veterans in Armenia. However, half of the surveyed centres claimed that they have internal regulations of services that include a general description of the main stages of work with veterans, methods for assessing their mental health, as well as temporal and technical features of the services provided. But it is obvious that this is not enough to provide a systematic approach to rehabilitation.

Another important consequence of the unregulated mental health services system is that half of the organizations surveyed do not have any limitations on veterans' comorbid disorders. This means that in half of the cases, all veterans, regardless of their mental, neurological and somatic status, are admitted into treatment/psychotherapy without proper evaluation conducted by specialized professionals.

The VHA Handbook also does not mention any restrictions for the provision of psychological services to veterans with comorbid disorders in the U.S.; however, this issue is covered by the presence of a variety of narrowly targeted health programs with a well-functioning referral system

designed for veterans. Obviously, this is not the case in Armenia.

Nevertheless, half of the surveyed Armenian organizations noted as a limitation the presence of severe neurological disease, cognitive impairment or brain injury, as well as substance addiction and mental retardation.

There is a strict distinction between psychological problems/services and psychiatric disorders/treatment in Armenia. Thus, 7 out of 8 organizations provide only outpatient services, and only one organization has an inpatient service, but it does not provide psychiatric treatment. Most veterans with psychiatric disorders (psychosis, bipolar disorder, etc.) receive pharmacological treatment either in a special military psychiatric unit or in civilian psychiatric clinics. It needs to be emphasized that in these clinics, psychosocial services are secondary and generally not carried out at the proper level.

In contrast, in the U.S., both psychiatric and psychological inpatient treatments are well-integrated into the unified Mental Health Treatment Programs, which ensures more flexibility and effectiveness in the provision of mental health services.

Diagnosis and Treatment Planning

Concerning the diagnostic evaluation process, it should be noted that in the U.S., the assessment of PTSD may include both initial screenings used for the identification of exposure to a stressor (DSM-5, Criterion A) among a large number of people and the eventual revelation of people at-risk for PTSD, which is typically conducted in primary care clinics and a more advanced assessment conducted with the aim of establishing a clinical diagnosis (Lancaster, Teeeters, Gros, & Back, 2016). VA policy requires that all new patients seen in the VA health system be screened for PTSD. In addition, patients in primary care are rescreened annually unless there is a clinical need for more frequent assessment (Evaluation of the department of veterans affairs mental health services, 2018).

As we can learn from the U.S. Department of Veterans Affairs (VA) website (How is PTSD assessed?, n.d.), "good assessment of PTSD can be done without the use of any special equip-

ment”, nevertheless it may be inferred that PTSD assessment is generally conducted by using two types of measures – structured interview, where the interviewer asks a set of prepared questions, and self-report questionnaire, which represents a set of questions handed to the interviewee to answer. Clinician-Administered PTSD Scale (CAPS) and Structured Clinical Interview for DSM-5 (SCID-5) are examples of widely used structured interviews. A common example of a self-report questionnaire is the PTSD Checklist for DSM-5 (PCL-5) which is a 20-item self-report measure that assesses the presence and severity of PTSD symptoms and can also be used in order to monitor the treatment progress (Using the PTSD checklist for DSM-5 (PCL-5), n.d.).

The VA/DoD guideline suggests that the PTSD diagnosis can be made on the basis of a clinical interview or a structured diagnostic interview (CAPS, SCID-5 and PSSI-I (Posttraumatic Stress Disorder Symptom Scale Interview for DSM-5)).

This study has revealed that for diagnostic purposes, the psychological centres operating in Armenia use methods of clinical interview, psychological testing and psychiatric assessment. In particular, five centres claim to implement PCL-

5 and CAPS, and another one uses Hamilton Clinical Anxiety and Depression Questionnaires. Despite the fact that these tools are comparable to the U.S. diagnostic standards, however, based on the fact that the marked questionnaires and structured clinical interviews are not adapted and not standardized for the Armenian population, their reliability is doubtful.

In addition, although all of the surveyed organizations noted the presence of a psychiatric evaluation in the process of diagnosing veterans, most of them (6 out of 8) stated that their patients are not always referred to a psychiatrist for evaluation. It turns out that the decision to conduct a psychiatric assessment is made by the psychologists based on their observations and experience, which, given the fact that psychologists often are poorly prepared in the field of clinical psychology and psychiatry, is not always justified.

One of the important components of treatment planning after diagnosis is the choice of the type of therapy: monotherapy or combined therapy (psycho and pharmacotherapy). As shown in Figure 2, half of the surveyed centres rarely offer combined therapy (only in cases where there are obvious mental disorders), and 37% of organizations often offer combined therapy (more than 50% of cases).

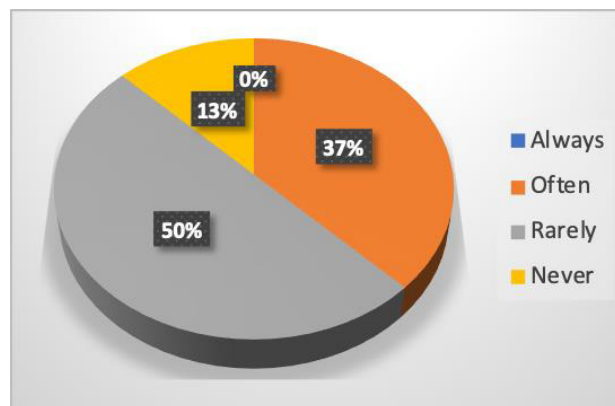


Figure 2. How often is Combined Therapy Offered in Armenia (Pharmacotherapy and Psychotherapy)?

In the U.S., combined therapy is a very common form of intervention for veterans, particularly in the treatment of PTSD, depression and anxiety disorders. And in cases of serious mental disorders and substance use disorders, the combination of psycho and pharmacotherapy is mandatory (VHA Handbook, 2008).

However, as Simiola, Neilson, Thompson,

and Cook's (2015) review showed, when informed of PTSD treatment options and offered a choice, most people prefer psychotherapy over medication, but data from the VA showed that a larger proportion of patients with PTSD are treated with medication than psychotherapy (Spoont, Murdoch, Hodges, & Nugent, 2010). A possible explanation offered by Harik (2018) is

that providers are not adequately eliciting or con-

sidering patients' treatment preferences.

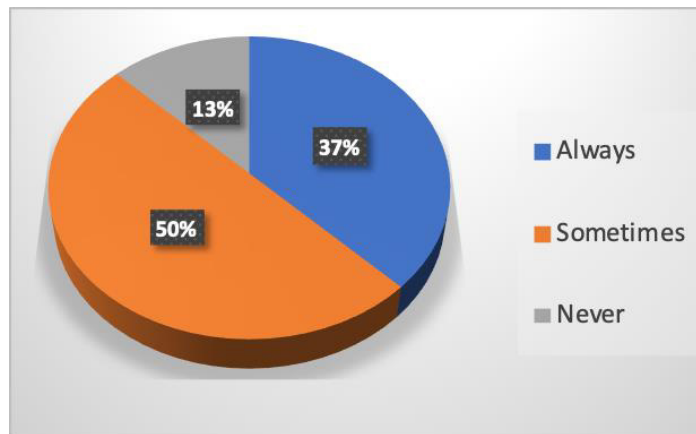


Figure 3. Veterans' Engagement in Shared Decision-Making on Their Treatment in Armenia.

Thus, another important issue in therapy planning is the involvement of veterans in the decision-making process regarding their treatment. As the VHA Handbook states, the treatment plan needs to be developed with input from the patient, and when the veteran consents, appropriate family members (VHA Handbook, 2008).

So far, no published studies have systematically assessed the extent to which shared decision-making is used in PTSD treatment. However, patients randomized to receive a shared decision-making protocol (Mott et al., 2014) or a decision aid (Watts et al., 2015) have demonstrated superior outcomes relative to usual care (Harik, 2018).

Only three out of eight surveyed psychological centres in Armenia practice shared decision-making, and four organizations - only in some cases (Fig. 3.). This means that there may be violations of the rights of veterans, in particular in obtaining informed consent for treatment. Also, the passive position of veterans in making decisions about their treatment can be an inhibitory factor in the progress of treatment.

Treatment/Psychotherapy and Follow-Up

One of the initial steps before starting the therapy sessions is the choice of a specific psychological intervention. In the U.S., trauma-focused CBT therapies incorporating exposure techniques, namely Prolonged Exposure (PE), Cognitive

Processing Therapy (CPT), Eye Movement Desensitization and Reprocessing (EMDR), are considered to be the most effective approaches to dealing with PTSD (Paintain & Cassidy, 2018). The Evaluation emphasizes the importance of ongoing monitoring of patient care during the treatment period in order to manage treatment delivery and assess the effectiveness of care, which is indispensable for the advancement of health care quality. For this reason, the VA collects data on the delivery of evidence-based psychotherapy using electronic clinical progress templates incorporated into veterans' health records. In the clinical progress templates, providers can document a patient's symptom changes over the course of treatment. These data are useful for studies examining the impact of treatment on health status and other patient outcomes. In order to check the effectiveness of psychotherapy for patients, clinicians generally state to administer self-report scales (such as the PCL) during the patient's treatment period; others evaluate the treatment progress by qualitatively assessing both the severity of symptoms and the social and occupational functioning of patients for example by noting that the patient's relationships have become more stable or that there is a decrease in symptoms etc. (Evaluation of the department of veterans affairs mental health services, 2018).

As shown in Figure 4, in the surveyed Armenian centres, the most common type of psychotherapeutic intervention for veterans is CBT/CPT (all centres), EMDR (5 of the surveyed entities),

Brainspotting and group therapy (4 of the surveyed entities). Client-centred therapy, art therapy and prolonged exposure are practised less often.

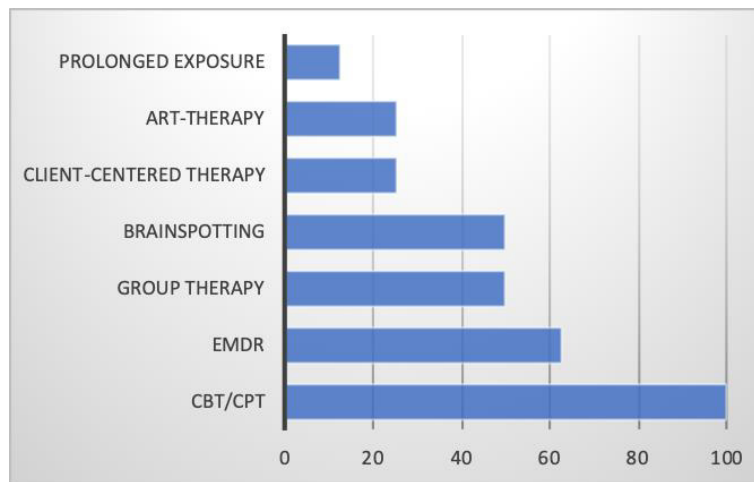


Figure 4. Psychological Interventions Offered to the Patients with War-Related Trauma in Armenia.

Clearly, there is a big similarity between the U.S. and Armenia in the choice of front-line PTSD therapies, with the exception of Prolonged Exposure, offered to veterans in only one Armenian organization we interviewed.

Although trauma-focused psychotherapies are widely accepted as first-line treatment for PTSD, some authors show concerns that are focusing on trauma can destabilize the patients with PTSD and even increase the risk of treatment dropout compared to other forms of treatment (Edwards-Stewart et al., 2021). Moreover, even though the recommended trauma-focused therapies, such as CPT and PE, have been proved to be effective, nonresponse rates are high, and many patients continue to have symptoms (Steenkam, Litz, Hoge, & Marmar, 2015).

Some studies suggest that non-trauma-focused psychotherapies for PTSD may be as effective as trauma-focused approaches (Yager, 2018) and that the supporting evidence in support of the superiority of trauma-focused treatments is proven to be weak (Wampold et al., 2010). For instance, the results of a clinical trial aimed to compare the non-trauma-focused practice of Transcendental Meditation (TM) with prolonged exposure therapy (PE) demonstrated that TM was significantly non-inferior to PE on change in CAPS score from baseline to 3-month post-test (Nidich et al., 2018).

As the research shows, for the patients who prefer non-trauma-focused therapies, the follow-

ing therapies are considered to have the most empirical support: present-centred therapy (PCT), interpersonal psychotherapy (IPT) and acceptance and commitment therapy (ACT) (Shea, Krupnick, Belsher, & Schnurr, 2020). There are also patients for whom psychotherapy alone is not preferred or fails to produce expected results, in which case pharmacotherapy is recommended as a first-line approach for treating PTSD (Reisman, 2016).

Interestingly, all the organizations interviewed in Armenia stated that they offer veterans not only trauma-focused therapy but also person-oriented long-term interventions. The list of such therapies is quite diverse and differs from the one usually found in the recommendations adopted in the U.S.: existential and client-centred therapies (in seven centres), interpersonal therapy, gestalt therapy, art-therapy, etc.

Another important issue is the possibility of the use of video-teleconferencing (VTC) psychotherapy, and even though we lack any statistical data on the prevalence of its use in the framework of PTSD treatment for veterans, the Guide to VA mental health services for Veterans & Families offers the possibility of mental health care to veterans through VTC. The VA/DoD guideline encourages VTC interventions in the following cases: in-person interventions are not feasible due to various patient access barriers, the patient would benefit from more frequent contact than is feasible with face-to-face sessions, or the

patient declines in-person treatment. According to the Evaluation, the actual use of telemedicine across the VA is highly variable and does not seem to be regulated by directed strategic approaches.

In Armenia, seven out of eight surveyed centres provide treatment using VTC, which makes the service accessible for veterans outside big cities. However, the effectiveness of VTC therapy with veterans in Armenia has not been evaluated.

The involvement of the family is another interesting methodological aspect of veterans' treatment. As a possible decision-making party, family members must be encouraged to participate in inpatient treatment planning and discharge planning to the fullest extent possible (with the veteran's consent). Also, VA medical centres in the frames of general mental health services must provide family education when it is associated with benefits to the veterans, as well as render psychosocial rehab services, including family psychoeducation and education, training and consultation regarding the recovery transformation. In cases of veterans' substance use disorders and traumatic brain injury, couples counselling and family therapy/consultations are offered (VHA handbook, 2008).

In Armenia, only two surveyed centres out of eight offer more or less systematic services to

veterans' family members. This includes family counselling and psychoeducation/training on mental health disorders. However, as the interviews showed, these services do not have any common standard, and the inclusion of family members in these processes is not regulated at all.

As for clinical supervision, in the U.S., the requirement for clinical supervision for mental health specialists is included in the State licensure laws, which require postgraduate clinical supervision experience for psychologists, social workers, and professional mental health counselors in order to obtain/maintain the license. This requirement is in line with the APA Guidelines for Clinical Supervision in Health Service Psychology (2014). Therefore, newly hired recent graduates in these professions work under the supervision of a licensed clinician while completing full licensure requirements (VHA directive 1027, 2019).

Despite the fact that in Armenia, the process of supervision of specialists is not regulated, and there is no licensing system which requires any kind of clinical supervision for specialists, in all eight organizations, psychotherapists work with veterans under supervision/intervention. There are several types/formats of supervision practice in these organizations (see Fig. 5).

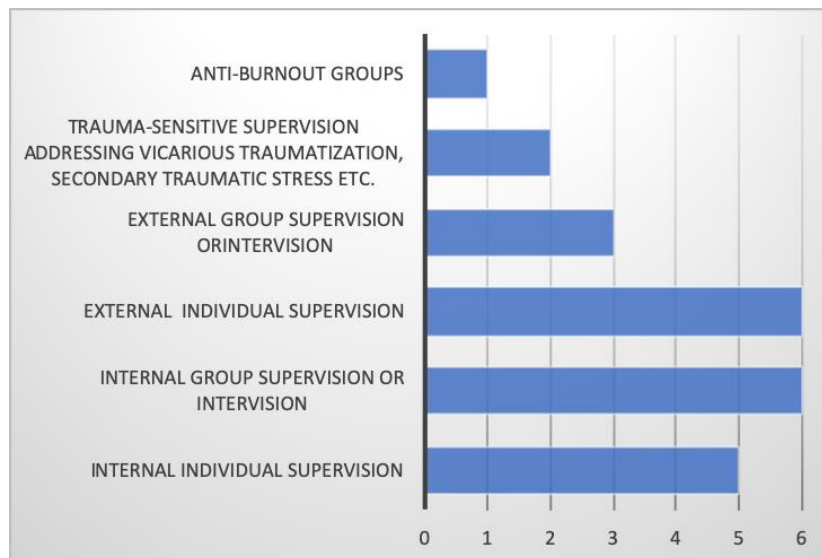


Figure 5. The types of Clinical Supervisions Provided to Psychotherapists Working with Veterans in Armenia.

The most commonly practised formats of supervision are internal group and individual supervision, as well as individual external supervision. However, it is noteworthy that in Armenia, there is no system of licensing/certification of clinical supervisors. Therefore internal supervisions are carried out by more experienced specialists, and external supervisions are provided by licensed supervisors from the U.S., Europe and Russia.

As to the follow-up procedures, we were unable to find any theoretical or statistical data on its implementation in the U.S. mental health system. Nevertheless, the VHA handbook on Uniform mental health service in VA medical centres and clinics (2015) provides some methodological directives, pursuant to which when discharged from inpatient or residential care settings, veterans must be given appointments for follow-up at

the time of discharge and receive follow-up mental health evaluations within 1 week of discharge. The handbook strongly recommends the provision of follow-up within 48 hours of discharge. When necessary, because of the distance of the veteran's home from the facility where the veteran receives follow-up care or other relevant factors, the 1-week follow-up may be by telephone. In all cases, it is stated that veterans must be seen for face-to-face evaluations within 2 weeks of discharge. When veterans refuse these evaluations, the refusal must be documented. When veterans miss scheduled appointments, there must be follow-up and documentation in the clinical records (VHA handbook, 2008).

In Armenia, only one out of eight organizations conduct follow-ups after veterans' treatment termination. Half of the organizations implement follow-up in some cases (Fig. 6).

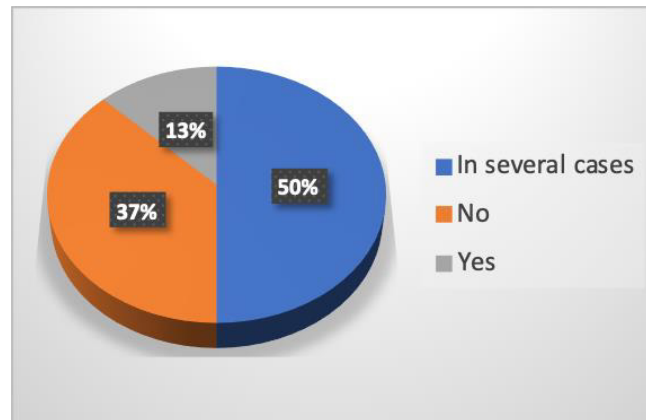


Figure 6. Are Veterans Followed-Up in Armenia after the End of Treatment?

The follow-up is usually conducted by the psychotherapist (only in one centre this is done by the social worker) and mostly by telephone or

face-to-face meeting, which corresponds to the American experience (Fig. 7).

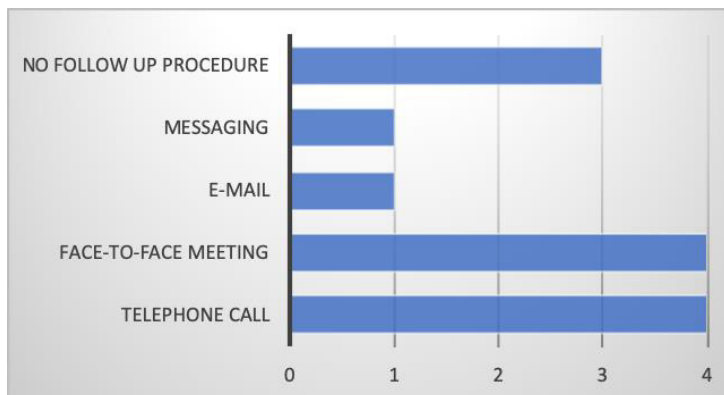


Figure 7. Veterans' Treatment Follow-Up Methods in Armenia.

In organizations that conduct follow-up, in most cases, it is done irregularly, without a standardized frequency and any documentation procedures referring to the follow-up process, results or refusal.

In case of a negative follow-up, when a deterioration in a veteran's mental state is detected, he is basically redirected to another mental health provider. This is likely due to the limited financial and professional resources of the organizations that are unable to re-include the veteran in the treatment process and not because of the individual's specific health condition.

Conclusion

Comparative analysis of the U.S. and Armenian systems of veterans' psychological assistance made it possible to conclude that the most serious problem of the Armenian system is of methodological nature - the lack of state standards and a regulated structure of mental health services. In the U.S. system, absolutely all aspects and stages of the procedure for providing psychological assistance are strictly regulated by the relevant official documents and directives, thanks to which the interdisciplinary and multi-level structure of psychological support works as efficiently as possible and ensures quality control of the services provided.

Despite the fact that after the Nagorno-Karabakh war of 2020, for the first time, the Armenian government initiated a six-month program to provide unified psychological assistance to veterans, these efforts cannot be sufficient since a comprehensive concept of mental health and services in this area for veterans has not been developed, the program lasted for only couple of months, and the organizations involved in the work had different methodological and regulatory backgrounds. This has been proven by the fact that the need for psychological rehabilitation of veterans and their families remained vital, and the service rejection rate during the first months was quite high. Most veterans are forced to seek quality psychological services on their own through the internet and media and often receive incompetent treatment, in particular, in complex comorbid cases.

On the other hand, the methodology of veterans' psychological assessment/diagnosis and

psychotherapy is generally comparable between the two systems, which indicates that Armenian specialists are trying to meet international professional standards. This is also evidenced by the presence of clinical supervision (individual and group) in all surveyed organizations. However, the lack of a unified approach and licensing system, as well as an acute lack of research on the effectiveness of various diagnostic methods, therapy and clinical supervision for the Armenian population, do not make it possible to correctly assess the situation.

Nevertheless, it may be inferred from the presented analysis that the psychological support system of veterans in Armenia is at an early stage of development and needs an institutional and state approach, which will allow integrating the rich individual experience of individual centres and specialists into a single coherent system of psychological assistance.

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