



TOWARD A VETERAN-CENTRIC VIEW ON COMMUNITY (RE)INTEGRATION

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INTRODUCTION

Research on postdeployment health is critical to inform the development and dissemination of health services for Veterans. Since September 11, 2001, more than 2.2 million men and women have served in Operation Iraqi Freedom (OIF), Operation Enduring Freedom (OEF), and Operation New Dawn (OND) [1]. In contrast with prior conflicts, servicemembers experienced more repeat tours, greater perceived level of danger due to the continuous risk of unconventional means of warfare, and diverse military cultures serving together [2]. The effects of these circumstances on Veterans' lives over time are not clear; however, as early as 2007, Resnik and Allen observed that a significant number were at risk of poor community reintegration upon returning home from deployment [3]. Following a comprehensive review of the literature, this guest editorial provides a synopsis of the current state of research related to community "(re)integration" in OIF/OEF/OND servicemembers and Veterans that can serve to advance the science. It includes discussion of advances in defining and measuring community (re)integration, stakeholder response, and emerging needs.

THE CHALLENGES

Approximately 44 percent of returning servicemembers and Veterans reported a range of difficulties readjusting to postdeployment status [1]. "Coming home" is an immersive experience, involving all realms of life and influencing health and well-being [4]. Many servicemembers and Veterans encounter the interrelated and simultaneous tasks of processing combat experiences while reentering a civilian life that has changed in their absence. Difficulty with community reintegration is associated with worse overall mental health [5]. Comorbid mental health disorders such as post-traumatic stress disorder (PTSD), anxiety, depression, and alcohol and substance abuse that resulted from or were exacerbated by combat exposure have been reported [2]. Increased rates of suicide

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and a changing face of homeless Veterans have been noted in recent literature [6–7]. Resuming predeployment life roles can be especially challenging for servicemembers and Veterans who sustained physical injury, an unfortunate reality in this cohort where traumatic brain injury (TBI) and motor vehicle accidents are common [8]. The disability associated with physical and psychological injury is far reaching, affecting self-care, employment, education, relationships, marriages, finances, home, and civic and community life [8–10]. The reality that issues can exist in isolation or in combination further complicates the transition back home and increases the likelihood that no two experiences are identical.

DEFINING (RE)INTEGRATION

The terms community "integration" and community "reintegration" are frequently used interchangeably in the literature, even within the same article. For over 30 years, health service providers and researchers have attempted to define these terms [11]. Though usually in reference to rehabilitation outcomes, elements of each are relevant and applicable when discussing the transition from deployment to "home." Community integration has been described as participation in life roles [10] and the return of individuals to their age-, sex-, and culturally appropriate role functions [3]. Community reintegration has been used to describe a return to participation in life roles following discharge from an institution where one was separated from normal community living and then returns to life in a community. It has also been used to describe repatriation from a foreign county [10]. Reistetter and Abreu described reintegration as an

adaptation process that is multidimensional, dynamic, personal, and culturally bound [12].

The ultimate goal of any rehabilitation effort is to help those who have been injured adjust to life in the community [11]. While rehabilitation may not seem immediately relevant to those without physical injury, adjustment to life in their community is a reasonable goal for all who are transitioning postdeployment. Whereas the Department of Defense does not have a uniform definition of reintegration, its postdeployment programs emphasize areas including relationships, employment or schooling, access to benefits, health-care, and housing; in other words, domains relevant to full participation in community life [5]. Though variance in definition exists, the consensus of the articles included in this review of the literature reveals that similar to the goals of TBI rehabilitation, servicemembers and Veterans who have successfully (re)integrated postdeployment are productive participants at home, their place of work or school, and within their community [13]. Recognizing that successful (re)integration has a subjective component, this definition of community (re)integration will be used for the purposes of this guest editorial. The inconsistency in use of the terms integration and reintegration reflects the literature and is reported as the authors intended in the sections that follow.

MEASURING (RE)INTEGRATION

In addition to variance in defining successful community (re)integration, differences are noted in its measurement in both Veteran and non-Veteran populations [10]. Determining the extent and nature of disability faced is critical in developing interventions that best meet the needs of the servicemembers and Veterans who return from conflict [10,14]. Yet, gaps in measurement complicate this task. To date, no gold standard exists to assess community (re)integration in this population [10]. Though measurement tools exist, they differ in conceptual basis, the vantage point of analysis (subjective vs objective), target population (those with neurological disorders, Veteran, etc.), ease of use or burden, indication (clinical or research), constructs measured, and psychometric validation. The difficulty in measurement is compounded by the fact that not all wounds are physically visible in this group, and psychological injuries may also interfere with the ser-

vicemembers' and Veterans' experience upon returning home.

The International Classification of Functioning, Disability and Health (ICF) is a systematic and universal framework used to describe the full range of human functioning and possible effects of various health conditions. It can be applied to all people, regardless of disability [15], and is frequently used as a framework for outcomes measurement. In addition, several population-specific instruments have been developed to measure aspects of community reintegration for people with a history of stroke, spinal cord injury, or TBI. Examples of this are the Community Integration Measure, the Craig Handicap Assessment and Reporting Technique, and the Community Integration Questionnaire, which are further described elsewhere [10–12]. Until recently, no tools were designed specifically for use with OIF/OEF/OND Veterans. In 2007, the lack of a brief, psychometrically sound measure of reintegration postdeployment was suggested as a factor contributing to a lack of research on the reintegration issues faced by servicemembers and their families [16]. Department of Veterans Affairs (VA) researchers similarly identified this need and responded.

Using the ICF to understand problems faced by OIF/OEF Veterans, Resnik and Allen reported many similarities in the issues faced by those with and without polytraumatic injuries [3]. They found that none of the available measures comprehensively addressed the specific needs identified by OIF/OEF Veterans, prompting development of the Community Reintegration for Service Members (CRIS), a tool designed to specifically incorporate issues relevant to injured servicemembers [10]. The CRIS has been validated for use in person and via telephone [8] and has a computer-adapted version [14]. Sayer et al. reported that most reintegration measures are intended for those with neurological disorders and might not be relevant to those without physical handicaps or specialized rehabilitation needs, prompting the development of the Military to Civilian Questionnaire [5]. This tool was designed to assess specific community reintegration problems faced by OIF/OEF combat Veterans and may be useful in research protocols. Additional outcomes research and validation for use in clinical settings is needed [5].

Though the science of measuring community (re)integration in OIF/OEF/OND Veterans is advancing, questions about the best timing for measurement and most appropriate tool remain unanswered. A review

by Reistetter and Abreu indicated that following a TBI, community integration does not begin to stabilize until at least 1 yr postinjury, and it is quite possible that stabilization postdeployment requires some time for servicemembers and Veterans as well [12]. They also suggested that researchers need to consider community integration outcomes of interest when deciding which measure to use [12]. Missing from either of the aforementioned, more Veteran-specific, measurement tools is the subjective voice of the servicemember and Veteran. By capturing this perspective, researchers, clinicians, and policymakers can have an enhanced understanding of the environmental barriers and facilitators influencing the resumption of desired community roles.

STAKEHOLDER RESPONSE

All branches of the military have programs dedicated to providing assistance to servicemembers and Veterans with combat-related injuries or illnesses resulting from their involvement in the OIF/OEF/OND conflicts [17]. Helping this cohort of Veterans to adjust and return to full participation in community life roles is also a VA research priority [8,10]. Since September 2001, the VA has responded to the needs of returning servicemembers and Veterans in several ways. For example, in 2008, the State of the Art (SOTA) conference on TBI convened and sought to advance knowledge gaps and determine relevant research questions to advance the understanding and treatment of TBI via several topical foci, including community integration for those with TBI [18]. The National Center for PTSD is dedicated to research and education on trauma and PTSD, working to assure that the latest research findings help those exposed to trauma [19]. The VA Health Services Research and Development Service (HSR&D) Polytrauma/Blast-Related Injury (PT/BRI) Quality Enhancement Research Initiative (QUERI) promotes the successful rehabilitation, psychological adjustment, and community reintegration for individuals with PT/BRIs through implementation activities [20]. Gaps identified by this QUERI included the lack of documentation of the clinical challenges and needs of patients with polytrauma and their families. The SOTA conference on outcome measures in rehabilitation convened in January 2010 to address

the clinical complexity and long-term nature of injuries faced by this cohort of Veterans [21]. A Working Group on Community Reintegration identified concerns and dimensions of community reintegration that could or should be measured, provided suggestions to improve measurement, made suggestions for future research focused on outcome measures for community integration efforts, and made policy recommendations to facilitate this area of research within the VA [10].

Research is being conducted to identify the treatment needs and address barriers to (re)integration faced by OIF/OEF/OND Veterans who are receiving care at the VA and beyond. A recent search of HSR&D research studies and implementation projects using the search term “community reintegration” revealed 28 unique projects funded from 2007 to 2016 [22]. Of the 28 projects, 25 were specific to OIF/OEF/OND Veterans. Further describing the projects, 15 utilized mixed or qualitative methods while 10 were quantitatively focused. How these and other efforts translate into practice and policy on many of these important issues remains to be seen.

EMERGING NEEDS

Findings to date suggest that Veterans are interested in information and interventions to help their readjustment to community life [23]. The use of technology has been suggested as one way to facilitate communication via email, chat rooms, bulletin boards, and instant messaging [2]. Hinojosa and Hinojosa highlighted the significance of military friendships in dealing with the challenges of deployment and suggest that they may serve an important role in postdeployment reintegration [24]. Connections with others and choosing to have a positive attitude have also been reported as methods utilized in an attempt to resolve issues faced upon return home [4]. Despite efforts by Federal and state governments to implement programs that address reintegration difficulties and promote community (re)integration postdeployment, evaluation of the effectiveness of these programs is lacking [23,25–26]. The need for concentrated efforts to advance the science of measurement of community reintegration is recognized [10]. The identification of the critical elements of participation for specific groups of Veterans

has been recommended by the 2012 Working Group on Community Reintegration.

Areas that would benefit from further investigation include an exploration of the subjective experience and varying needs of several cohorts. This includes, but is not limited to, those with nontraditional family structures [1], those whose identification or help-seeking is limited by stigma [25], and those from racial and ethnic minority backgrounds who may face additional difficulties with (re)integration [5,27]. Further, exploration of the variance in experience between Active Duty and National Guard/Reserve Veterans [5,28–29], between returning male and female servicemembers [5,28,30], and assessment of the community (re)integration needs of those Veterans who are not patients in rehabilitation settings [5] is also recommended.

Identifying the most effective vocational and family support approaches is viewed as critical to successful community integration [13]. Additionally, as far as we are aware, an assessment of the attitudes and experiences of key supporters in the Veteran's life remains a void. Much research is being focused on those who receive services from within the VA system of care, while less is known about the Veterans who seek care outside of VA facilities [31]. This is important because a recent article by Sayer et al. reported that approximately 56 percent of OIF/OEF/OND Veterans were not enrolled in the VA and that of those enrolled, 40 percent were not classified as combat Veterans [23]. An additional concern is that many of the problems reported to date are out of the realm of traditional medical practice. As a result, Sayer et al. cautioned that mental health practitioners may be overwhelmed by the demand for services [23]. Finley et al. suggested that primary care clinicians may play an important link in the identification of those who may be experiencing difficulties upon return from deployment and are not currently receiving care within the VA system of care [31]. The experience of each of these cohorts has either not been studied extensively, has been identified as potentially benefitting from future study, or is in areas where past research is varied or inconclusive.

A NEW PERSPECTIVE

As noted, research on postdeployment health is critical to inform the development and dissemination

of health services. The 2010 SOTA conference on outcome measures in rehabilitation recognized the need to identify and understand factors affecting the outcome of rehabilitation interventions. Work by Sayer et al. identified the need for more in-depth study of the complications faced by returning Veterans and their preferences for interventions [23]. Despite the availability of medical treatments and rehabilitation to address the physical causalities of conflict, basic knowledge of the personal and socially meaningful outcomes of those with complications and their families is still lacking [32]. Just as disability occurs within a social context and is best understood as the interplay between the individual and his or her environment [14], the transition of (re)integration is likely best understood by considering these overlapping contexts as well. Wands reported that a noteworthy void in the research is the exploration of the Veteran's subjective experience with reintegration, including the strategies used to successfully navigate the transition from the battlefield to home [4]. Explanatory models (e.g., the social and cultural construction of illness in contrast with the medical understanding of disease) have been used to ensure the provision of patient-centered care in a variety of health-related contexts [33] and would be useful to expand understanding of the subjective experience of servicemember and Veteran (re)integration as well.

While randomized controlled trials of community (re)integration intervention are needed to demonstrate personal and system outcomes, the successes and failures of rehabilitation interventions are not fully understood through quantitative means alone [21]. Similarly, while quantitative measures capture the extent of disability or struggle associated with (re)integration, they are limited in the capacity to identify solutions or ways to best meet the needs of those experiencing difficulties in their postdeployment roles. A social ecological model of health [34], uniting the Veteran's behaviors and interactions with his or her sociocultural and physical environments, would help to deepen the understanding of the postdeployment experience and facilitate the development of innovative strategies and solutions. Acknowledging how differences in sex, age, culture, and experience influence the transition and engaging participants in developing meaningful solutions to

problems [35] are critical in advancing the science of (re)integration.

In an October 2013 newsletter, David Atkins, Director of VA HSR&D, wrote, "A big challenge for research and health care systems is to develop and test effective programs that can either promote a healthy culture or improve a dysfunctional one." He recognized the numerous ways that health services research and the contributions to HSR&D and QUERI projects made by anthropologists expand our understanding of health-care culture and culture change by illuminating aspects that may serve to either facilitate or impede efforts to improve care [36]. Qualitative and mixed methods programs of research provide multiple means to identify barriers and facilitators to community (re)integration, provide feedback on feasibility and acceptability during program development, and evaluate the effectiveness of programs that may already be in place. Additionally, this type of research can assist clinicians in the development of new therapies and provide a living example, which can be used by VA operations to influence policy makers. The results of the recent search of HSR&D-funded research studies and implementation projects suggests that support exists for qualitative and mixed methods programs of research within the VA. The VA Working Group on Community Reintegration recognized that successful community reintegration will be dependent on bridging the gaps between the alienation felt by returning Veterans and community expectations. Mixed research methodologies offer a vehicle to reduce this disjuncture [10].

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