

North Carolina Institute of Medicine
Task Force on Behavioral Health Services for the Military and their Families
Friday, January 15, 2009
Meeting Summary

ATTENDEES

Task Force/Steering Committee Members: Senator William Purcell, Michael Watson, Linda Alcove, David Amos, Lionel Cartwright, David Cistola, Grayce Crockett, Carol Cullum, Debra Dihoff, Sandra Farmer, Israel Garcia, Bob Goodale, Robin Hurley, Lil Ingram, Representative Verla Insko, Mike Lancaster, Sara McEwen, Karen Stallings, John Wagnitz, Laura Yates, Peter Bernardini, Li Fang, John Harris, Flo Stein

Interested Persons: Worth Bolton, Holly Danford, Anne Doolen, Carol Graham, Sylvia Hammond, Joan Kaye, Jessica Meed, Col. Elspeth Ritchie, Tanya Roberts, Jeffrey Sonis, Susan Storti, Kristy Straits-Troster, Jim Swain, Doug Taggart, Kippie Tomkin

NCIOM Staff and Intern: Pam Silberman, Mark Holmes, Kimberly Alexander-Bratcher, Thalia Fuller, Lindsey Haynes, Paul Mandsager

WELCOME

The Honorable William Purcell, MD, Senator, North Carolina Senate, Co-Chair

Sen. Purcell welcomed members of the Task Force.

LESSENING THE INVISIBLE WOUNDS OF WAR: LESSONS LEARNED FROM ARMY SURVEILLANCE AND RESEARCH

Col. Elspeth Ritchie, MD MPH, Adult and Forensic Psychiatrist, Director, Behavioral Health Proponency, Office of the Army Surgeon General

In the years since September 11, 2001, there has been an increasing acceptance of the importance of behavioral health issues among military leadership. The conflicts in Iraq (Operation Iraqi Freedom – OIF) and Afghanistan (Operation Enduring Freedom – OEF) have been significantly different than past wars. Many soldiers have had extended and/or multiple deployments, battlefield stressors, and medical issues including supervising detainees. The Armed Forces are comprised entirely of volunteers who know they are going to war, have a large reserve component, and are both seasoned and fatigued. There is a wide range of reactions to all the stress. The rates of suicide and survival of formerly deadly injuries is increasing. Families experience some of those stresses and others related to adjustment, injury, or death.

There have been numerous efforts to improve and help support the behavioral health needs of the military. The Mental Health Advisory Teams studies include data on soldiers' mental health beginning in 2003. Periodic Health Assessments are conducted annually and Post Deployment Health Assessments and Reassessments are completed after every soldier returns from deployment. The main needs were increased access to care, services for family members, and combating stigma (making sure that people seeking help are not penalized). New initiatives focus on integrated services including telemedicine, enhancing resiliency, improving health surveillance, campaigns to reduce stigma, and updated clinical treatment guidelines for behavioral health issues.

The published Mental Health Advisory Teams' (MHAT) results have consistently shown mental health symptoms in soldiers involved in combat. The MHAT involves anonymous self report surveys focused on what the soldiers are currently experiencing. Results show higher rates of mental health and marital problems among those with multiple deployments. The National Guard

may be at increased risk for mental health symptoms because of the rapid reintegration into their communities after deployment. The reported issues correlate with the course of war – increasing during times of intense combat and decreasing with successful operations including the surge. The dwell time, or amount of time a soldier spends at home between deployments, is also significantly correlated with mental health issues – return to normal levels within 24 months and full recovery within 30 to 36 months. These results are especially important in North Carolina as nearly 20% of all soldiers deploy from the state. North Carolina has a critical role in helping these soldiers with both preparation for war and eventual return to community.

In 2008, the suicide rate for the Army exceeded the matched US population's suicide rate. In response, there have been suicide-specific screening and surveillance. The suicide rates among active duty military, reserve and National Guard are increasing. The rates are higher for those who have deployed than for those who have not. The annual and post-deployment screenings are not suicide screens, but new screening tools are being used. Although there is ample data, it has not translated into effective prevention. In major recent murder-suicides, many of the same themes emerged (recent deployment, unfaithful partner, violent crime, drugs, guns, and access to behavioral health care). The stigma associated with behavioral health varies among the military population – younger personnel are concerned about their peers and older personnel are concerned about the effects on their career and perceived ability to lead. Suicide rates seem to serve as an indicator of overall behavioral health needs.

A comprehensive approach to suicide prevention is needed to bring awareness, help identify high risk individuals and target the large military population. Past approaches have analyzed incident suicides, used clinical interventions, and trained the entire community to recognize and respond to risk factors. There are several training programs for peer support and training leaders to help identify soldiers in their command. The Army Suicide Prevention Campaign began in March 2009. It focuses on policy development, pilot programs for behavioral health treatment without automatic command notification, and stigma concerning behavioral health treatment. The multidimensional suicide prevention strategy includes assessment of suicide risk factors, identification of high risk individuals, and population-based strategies. Many service members experience desensitization to violence and pain. Evidence based practice suggests those with more involved symptoms need an average of 10 to 20 sessions, while most who seek treatment only have one clinical encounter.

Resiliency, a soldier's inner strength to face fear and adversity during combat with courage, is another focus for the military population's behavioral health. Programs focus on changes in the deployment cycle, life cycle, soldier support, provider support, reintegration and reunion, specific behavioral health conditions, adventure and fitness. Battlemind is a corporate program that helps soldiers prepare for deployment. Warrior Adventure Quest is a high intensity adventure program that can be used to help reconstitute a unit after returning from deployment, engage new people in unit, or other training that focuses on demanding physical challenges rather than stress management. Reintegration into society and reconstitution with family members is a delicate process that may cause stress on both sides from changes in the soldier. This time is also a focus of training and support for military families.

Behavioral health care for this population has significant challenges. Using surveillance and many of the available technology and tools, including telehealth, there is a way ahead to fill the gaps and meet the needs of the military population in North Carolina.

DEPRESSION: AN ILLNESS YOU CAN'T SEE

Mrs. Carol Graham, Wife of Major General Mark A. Graham, US Army, Deputy Chief of Staff, G-3/5/7

Mrs. Graham discussed her family's personal losses. Major General and Mrs. Mark Graham tragically have lost both of their sons. Mrs. Graham quotes her husband saying, "My sons died fighting different battles." Her youngest son Kevin, a University of Kentucky senior Army ROTC scholarship cadet, was studying to be an Army doctor when he died by suicide on June 21, 2003. Kevin was being treated for depression but had stopped taking his medication. She described clearly missing the signs of his depression and the stigma associated with his suicide. Kevin had expressed to his parents "depression is an illness and not just a feeling." He said things like "guys are supposed to suck it up" and "my brain just doesn't work anymore."

The Graham's oldest son Jeffrey was a scholarship student that graduated from the University of Kentucky in May 2003 with a degree in civil engineering, and was commissioned a lieutenant in the US Army as an Armor officer. Although the Army offered Jeff a position in a non-deploying unit because of the death of his younger brother, Jeff said he needed to be with Soldiers and wanted to serve his country. Less than one year after losing Kevin, Jeff was killed while leading his platoon on a dismounted patrol in Khaldiya, Iraq. Jeff spotted an IED taped to a guardrail and warned his platoon moments before it exploded. Mrs. Graham described the difference in extended family and community responses to the two young men's deaths.

The Grahams believe sharing their story and continuing to serve in the military is their way to make sure the boys' legacy lives on. They work to prevent suicide within the military and across the nation. They deal with their losses one day at a time, but hope that other people can be helped through their openness. Mrs. Graham also shared stories about her daughter, Melanie, who had an extremely difficult time coping with the losses of her older brothers. She made the decision to channel her pain and loss by serving other people for the rest of her life. Last year, she graduated with a degree in nursing from Oklahoma University and is now a registered nurse in the Department of Neurology at Beth Israel Hospital in Boston, Massachusetts. The Graham family has become strong behavioral health advocates for the military and young people. They have worked tirelessly to raise awareness of the dangers of untreated depression and suicide prevention. The Grahams' complete story can be found in the new version of *Words Can Work When Talking About Depression* by BlakeWorks, Inc. (www.wordscanwork.com).

TAKING THE FIGHT TO THE ENEMY: EVIDENCE BASED SUBSTANCE ABUSE INTERVENTIONS FOR IRAQ AND AFGHANISTAN VETERANS AND THEIR FAMILIES

Susan Storti, PhD, RN, CARN-AP, Project Director, National Institute on Drug Abuse Blending Research and Practice

Dr. Storti presented information on behavioral health challenges affecting new veterans and their families, evidence based treatment for behavioral health conditions, and provided individual examples to help participants better understand the challenges individuals and their families face.

The behavioral health service delivery system needs to change to meet the differing challenges of the current conflict. For example, there are more women serving in combat consequently increasing the possibility of exposure to both sexual trauma and combat trauma. As service members return home, there are significant challenges associated with re-entry and adjustment to both family and work. Many returning military members have serious injuries and there is an

increased incidence of traumatic brain injury. Services should be better aligned to meet these challenges and decrease duplication.

From her work with more than 80 community based organizations, veterans and their families in Rhode Island, Dr. Storti helped form the *Veterans' Task Force of Rhode Island*. They began with key informant surveys and learned about services that were available to deployed families. Many of the participants volunteered to help with an initiative to develop the *Rhode Island Blueprint*, a strategic plan for the development of a system-wide response which focuses on veteran's issues. The planning group grew into a multidisciplinary military-civilian partnership. In Vermont, a group changed this model by dividing the committees into county areas because the state is very rural. The model may work for states like North Carolina too.

The veterans and their families identified several areas of concern. The emotional cycle of deployment and changes in the family structure may profoundly affect family members. These changes may cause additional conflicts with the military member who is returning home. Specific examples of these conflicts include: placing a loaded gun under the bed at night and fishing wire on the steps to protect his fiancé, flashbacks that can be misinterpreted by medical personnel, and older grandparents acting as caregivers to young children. Informal discussions included some women service members minimizing their combat experiences because their partner will not understand. Both military and family members may choose to deal with these additional stressors in many ways.

Substance abuse is a common method of coping with the stress associated with returning from deployment. Alcohol, narcotics, benzodiazepines, and marijuana are among the most common substances. While substances may seem to provide initial relief, the long term effects can be worse than the initial symptoms. A number of studies have reviewed substance use and other behavioral health disorders in the military. The Millennium Cohort Study included a large percentage of National Guard and Reservists. It showed that the youngest members were most at risk for all alcohol related outcomes. Those ages 18 to 24 were also more likely to have behavioral health diagnoses. Recently narcotic and opioid prescriptions have increased from 30% to 50%. Orthopedic injuries may originally be treated with opioids and progress to abuse. This is most common among older service members who are trying to maintain their level of activity.

Treatment for alcohol and other substance abuse can take many forms including both pharmaceutical and behavioral approaches. A combination of therapies is often needed to treat addiction. Pharmacotherapy can successfully treat addiction to alcohol (oral or injectable naltrexone), opioids (methadone, buprenorphine), and other drugs. Psychosocial interventions also can help individuals and groups with a number of behavioral health issues including addiction disorders. Behavioral couples therapy improves relationship functioning and reduces child distress. Cognitive behavioral coping skills training helps the individual gain control of their feelings and behavior. Community reinforcement approach encourages positive behaviors and may include group activities like Warrior Adventure Quest. Contingency management and motivational incentives are used in addition to therapy to reward small steps toward recovery. Motivational enhancement therapy focuses on encouraging change from the inside out. Twelve Step Facilitation is the approach used in Alcoholics Anonymous and Narcotics Anonymous that focuses on a brief structured and manual-driven approach to recovery. There is no type of therapy that works in a single visit. Most evidence based practices need between 10 and 20 sessions, but service members often only come for a single session. Cultural competency for the military is very important for providers and those seeking help.

TROOPS TO TEACHERS

Doug Taggart, Program Coordinator, NC Troops to Teachers / Military Liaison, Educator Recruitment and Development, NC Dept. of Public Instruction

Troops to Teachers is a federal program that assists qualifying service members, reservists, guard, and retirees become public school teachers. The program recruits teachers for schools serving low income families. It helps relieve teacher shortages in math, science, and special education. The program also helps military members transition into a second career by providing counseling to that goal. Stipends are offered for teacher education and licensing costs and bonus incentives are offered for being hired in high need schools. Most school districts in North Carolina either qualify as high need districts or have schools in them that qualify as high need schools.

To qualify for the Troops to Teachers program, a service member must have six years of military service or physical disability discharge from the military. Additionally, other service and education requirements apply for funding eligibility. More than 95% of the program participants in North Carolina become teachers through lateral entry. In order to qualify for the lateral entry program, the person must have a bachelor's degree and at least a 2.5 cumulative grade point average. The program also adds to the diversity of school staff in the state. Nationally, more than half of the program participants are from minority groups and more than 80% of them are male.

In North Carolina, 35 new teachers were hired through the Troops to Teachers program last year. Over 500 teachers have been added since 2003. Originally funding was paid to the school systems, generating more than \$3 million in federal funding between 1994 and 2001 for the state. Since 2002, the funding has been used for individual incentives totaling \$2.4 million. The teachers have real world experience, are mature, and are committed to the profession. Many find similarities in execution between the school system administration and their former military positions.

In addition to NC Troops to Teachers, Mr. Taggart also serves as the Military Liaison for the North Carolina Department of Public Instruction. In this role, he helps students transition between states, attends base realignment and closure meetings as his time allows, coordinates training activities with the Military Child Education Coalition (MCEC). The MCEC training sessions, entitled *Supporting Children of the National Guard and Reserve Institute*, were delivered in 2009 to New Hanover, Wake, and Mecklenburg public school systems to give staff information about how the military works and how it can affect students in the family.

Other related resources include school liaison officers that work for the active duty installations in North Carolina. The General Assembly supports four Regional Military Family Counselor positions that work directly in four NC school systems. Those systems are Craven, Cumberland, Onslow and Wayne counties.

TASK FORCE DISCUSSION

The Task Force discussed topics for more discussion and potential recommendations. In the area of workforce, the areas of interest included emergency department, pastors/chaplains/faith leaders, substance abuse providers not recognized by TRICARE, encouraging provider participation in TRICARE, and provider skills training specific to substance abuse and mental health issues. There was also discussion about the possibility of a needs assessment for substance abuses and mental health services and services for family members. Other topics were family members from prior wars, engaging community organizations, the effects of health reform, stigma associated with substance abuse and mental health services, outreach to service members and their families, expanding CARELINE back to 24 hours, and the Families At Ease call center.

The next meeting will be held Thursday February 18, 2010 at the NCIOM offices in Morrisville.