

Synopsis

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Congressional Military Mental Health Caucus Meeting

This special caucus held the second of its three planned public briefings today. Congressional caucuses allow Members and Senators to join forces in collecting information, garnering support, and crafting and passing legislation on areas of special interest to them. This particular caucus was only formally created this year, and has a high level of bipartisan support.

While May has been declared Mental Health Month, today was specifically Military Mental Health Day.

Opening Comments

Rep. Napolitano (D-CA) cited statistics that anywhere from one in three to one in five members of the military suffer from mental health issues. Whatever the exact number might be, it is important to address these problems immediately.

Government needs to better educate the public. All members of the mental health community must come together in those efforts.

In the military, about 10,000 service members a month are released to return home. They must have access to services and resources. The stigma must be removed from seeking care. The care provided must also be expanded.

Rep. Murphy (R-PA) stressed the importance of recognizing that stress is a normal reaction to being in combat. It is not the same as a psychological disorder.

PTSD is something different. This disorder occurs when the person continually relives the stressing events in their own mind, and is exacerbated when traumatic brain injuries also occur. Treatment is available and does work.

The word needs to be disseminated among the service members and veterans that they can be helped and healed.

Over the centuries, the weapons and modes of combat have changed. However, the people fighting the battles have not changed. We do have more resources available to help them today, though.

Veterans Affairs Perspective

House VA Committee chairman Rep. Filner(D-CA) observed that the mental health issues among OIF/OEF veterans is even more severe than for Vietnam veterans.

In terms of homelessness, the newer veterans become homeless far sooner after military separation than it has been for the Vietnam veterans.

Filner believes that more Vietnam veterans have been lost through suicide than were lost during the entire war.

Mental illness must be addressed. The stigma against seeking care does exist, and must be eliminated. Things are changing, but not fast enough. He has heard too many anecdotes of people being taunted for seeking care, and being told not to report problems otherwise they will not be allowed to go home.

Brain injuries are not being diagnosed sufficiently and accurately. As a result, they are being released from service without the right diagnosis. Once they are again civilians, they also tend not to come to the VA facilities to seek care.

Filner said that the VA reports half a million OIF/OEF veterans with war-related injuries, which is far, far lower than DoD's reported casualty rate. He called for some research into why that differential exists.

Filner also asked the military representatives why the Services do not provide any kind of decompression time for separating service members. He would like to see a twelve week program, while still on active duty, for these service members before they are allowed to return home. During this period, they should receive a competent, full, face-to-face psychological screening, as well as education and services for them and their family members.

The current questionnaires are simply not enough.

Filner stressed the importance of including the families in the separation process, in order to provide additional support and to encourage those who need it to seek treatment. During Filner's desired twelve week program, treatment could be started, education could be provided in a more leisurely setting, and decompression could start.

Filner's comments seemed to be focused largely upon members of the reserve components, as he repeatedly stressed that returning troops do not pay full attention to the TAPS program and do not answer questionnaires honestly because they simply want to get home.

The Member does have legislation pending to create such a program.

In closing, Filner emphasized that everyone who has engaged in combat comes out with some level of PTSD. It is a life-changing experience. Congress has given a lot of money to DoD and VA to address these issues, yet there are still shortages of resources around the country.

Vet Centers were created to give Vietnam veterans a "safe" place to go to receive mental health care. However, there is no similar type of place for today's OIF/OEF veterans. He suggested creating such a place, maybe even combined with a cyber-café type of setting. Telemedicine and other Internet resources do exist, and should be used more extensively.

Napolitano agreed with Filner's comments. She addressed the Pentagon representatives, saying that veterans tend to refuse to talk to anyone other than another veteran. They will not even talk to her staff, she claimed. These veterans want to receive care from "their own," and deserve it.

Marine Corps/Navy Psychological Health Programs

Captain Margaret McKeathern, MD, MC, Director, Deployment Health Directorate, USN

Captain McKeathern said that the Marine Corps and Navy programs are evidence-based and address the continuum of psychological health stresses and care.

The program addresses five domains:

- Access to care
- Quality of care
- Surveillance and screening
- Warrior performance enhancement, with resiliency training and stigma reduction
- Transition and care coordination across the DoD, VA and civilian network

They also have the FOCUS program (Families Over Coming Under Stress). This program builds resiliency among the families dealing with repeated deployments. The program is available at bases around the country, including among the Marine Corps Wounded Warrior Regiment.

A great deal of information on Navy programs is available on line.

Air Force Mental Health Programs

Colonel John Forbes, MD, Deputy Director of Psychological Health, Air Force Medical Support Agency (AFMSA), USAF

Colonel Forbes talked about how the Air Force prevents and deals with PTSD among Airmen.

Of course, combat exposure is the biggest predictor of PTSD. The Air Force has created a pyramid model to build and sustain resiliency. The top tier consists of high risk deployers, who are tracked and receive targeted training. Forbes observed that the Air Force envisions a program similar to the twelve week program proposed by Filner.

That would be the Deployment Transition Center (DTC) pilot program standing up this summer. It is a two day program with relaxation, reintegration and training. There is no actual treatment provided during this period. All Airmen leaving the theater of operations will go through this program.

The DTC does not cover people such as medics and those piloting remote aircraft. However, the Air Force is creating a similar program to address their needs.

The Air Force has seen a slight increase in its suicide rate. This month, the entire Air Force will have a half-day stand down to address preventable deaths, particularly those due to

suicide and automobile accidents. All Airmen will break into small unit groups to discuss these issues.

The Air Force has also increased the amount of behavioral health provided in primary care. At this point, 50% of all behavioral health disorders are treated through primary care. Providing this care with no separate mental health chart or appointment eliminates any stigma associated with seeking such care. For minor problems the initial findings show good results.

Family support programs recognize that families are an important part of the overall puzzle. They are looking the provision of targeted programs for specific populations (e.g., young children or teens) and the provision of leisure programs to help them relax. The Air Force is looking closely at how the wars are affecting the families, and how their resources can best be used.

Traditionally, Airmen did not deploy for long periods of time. As a result, they did not have the appropriate support programs in place. Today, the Air Force is deploying differently so they are working hard to identify the needs and address them.

Social networks are being used to get the word out to younger Airmen and families. They are creating a spousal inventory to identify what their experiences actually are, in order to better identify what their needs might be.

Initiatives on the family support side include family life consultants. They can meet the families off-site (such as at a restaurant or coffee shop) to provide counseling in a less-threatening and stigma-removed setting.

More deployment support is being provided to Airmen and their families both during and after the deployment.

Key family members are being identified to disseminate information to other families throughout the process.

The Air Force is also enhancing the support available to families with special stressors, such as children with special needs. When an Airman in such a family is deployed, the family stress level increases even more, and the Airman is also under additional stress. The additional support provided to these families goes to both help at home and relieve some of the anxiety of the deployed family member.

Napolitano commented that she has been told by unit leaders in the field that deployed service members actually report more stress resulting from "dear John" letters and other relationship problems at home than from being deployed in and of itself.

Army Behavioral Health Program

Major General Patricia Horoho, Deputy Surgeon General, Chief, Army Nurse Corps, Army Medical Department (AMEDD), USA

General Horoho spoke about the Army's comprehensive behavioral health system of care. This includes everything from providing more support far forward on the battlefield all the way back to caring for the families, especially children, left at home. The program also includes follow-on care after the deployment.

As dwell time lengthens between deployments the Soldiers have a greater chance to re-

integrate into their families and readjust to being at home.

Virtual behavior health allows the Army to surge the provision of these services to places where greater need might be, such as when a unit returns home. This also allows Soldiers a choice between meeting with a counselor face to face or through a webcam.

The Army has also instituted a policy of requiring 100% of deploying and returning troops to receive a face to face psychological briefing. This helps eliminate the stigma, since everyone is doing it. It also allows for better identification of individuals with higher stressor risks, including financial and family situations.

The families are also included in the reintegration process, especially the children. The Army is testing pilot programs to especially address the needs of the children. For example, some of these programs bring behavioral health programs to the public schools the children attend.

Soldiers are retained at the duty station to go through the phased reintegration program with their families. No one is released for the 30 day block leave until that program is complete. Individuals identified as being high risk then have a nurse case manager who now knows the Soldier and who continues to check in during the 30 days and thereafter.

The Army has learned that problems do not tend to show up until 90 to 120 days after the return home.

They have also determined that Soldiers are self-medicating with alcohol rather than seeking care. Thus, the Army has a pilot program allowing confidential self-referring for alcohol abuse problems. This way, the Soldier can seek care while avoiding stigma and having to reveal these problems to commanders.

Another key initiative is to build resiliency in all Soldiers, starting from the moment they enlist. Soldiers and their families go on line to self-assess their global resiliency levels. If there are areas with gaps, the on line tool moves them towards other resources to receive additional help and training.

Horoho said that the entire nation is changing its attitudes towards mental health as a result of these long wars. A large proportion of those who have served are in the Reserve and National Guard. They are returning home with these new attitudes, and disseminating them throughout their communities.

Discussion

Napolitano asked what the Services are doing to ensure that seeking care does not affect future careers. Horoho assured the Member that medical records are not seen by commissioning boards making promotion determinations.

Kristy Kaufmann (military family advocate) expressed appreciation for the focus upon including the families. Building resiliency “is great, but everyone hits the wall sometime.” She worries that important policy changes are not being made at the operational level. For example, the family support groups led by family volunteers are antiquated. These volunteers are exhausted; they are dealing with spousal deployments and caring for their own families, and really no longer have the internal resources needed to care for other families.

Kaufmann also brought up the issue of spouses committing suicide. Stigma also affects the spouses, and they are worried about seeking care for fear that it will reflect badly upon the service member's career.

She called for better resourcing of the family resource groups (FRGs). They need to be staffed with trained, paid people. Horoho assured her that the Army does recognize these problems, and is working on it. When the Army moved to the BCT model some resources were lost. In addition, she admitted that the FRG does not work in today's environment as well as it did before 9/11. Additional medical resources are being provided to the BCTs for this reason.

However, more than anything, Horoho stressed the importance of increasing the dwell time between deployments.

Kaufmann also stressed the importance of better and more funding for the FRGs. They can no longer operate based on the proceeds of bake sales.

Horoho told an audience member that the Army is implementing a pilot program in several locations that includes initial assessments at the primary care level with specially trained primary care providers. Those identified as being at risk are automatically sent for additional care, which is a new approach.

She added that General Hamm's "coming out" that he was having trouble went a very long way towards eliminating stigma.

The other Service representatives agreed that stigma is a huge part of the overall issue, and overcoming it is crucial to overall success. One way is to get service members to talk to each other, which normalizes any issues an individual might be dealing with. If others in the unit have the same problems, then it becomes more "normal" to seek care for it.

Forbes noted that word is getting out about non-medical counseling options, as well. This has the advantage of removing the idea that mental health problems are a disease.

The Army has over 3700 mental health providers, which is actually over the authorization. They did get an increase in their authorizations, and are working on filling those billets as well. They are using incentives and bonuses to recruit these professionals. Horoho observed that they are in competition with the private sector, and are examining all available avenues to bring on additional providers. For example, the Army is training more specialized nurse practitioners to increase the number of psychiatric counselors.

The other Services reported similar efforts to ensure that they have enough providers, and that they are in the right places.

Prompted by Napolitano, Horoho and Forbes briefly described how virtual reality programs are being used in treating traumatic brain injuries (TBI).

Napolitano told the Service representatives that she wants them to be sure to work with and educate local veteran service organizations on the resources available. Those organizations should be included as part of the overall mental health effort.