Psychological Issues of War: Valuable Information Learned from Army Surveillance and Research

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A Brief History of Psychological Reactions to War

- World War I--"shell shock", over evacuation led to chronic psychiatric conditions
- World War II--ineffective pre-screening, "battle fatigue", lessons relearned, 3 hots and a cot
- The Korean War---initial high rates of psychiatric casualties, then dramatic decrease

  Principles of "PIES" (proximity, immediacy, expectancy, simplicity)
- Vietnam
  - Drug and alcohol use, misconduct
  - Post Traumatic Stress Disorder identified later
- Desert Storm/Shield
  - "Persian Gulf illnesses", medically unexplained physical symptoms
- Operations Other than War (OOTW)
  - Combat and Operational Stress Control, routine front line mental health treatment
- 9/11
  - "Therapy by walking around"
  - Increased acceptance by leadership over past eight years

Operation Enduring Freedom/ Operation Iraqi Freedom

- Numerous stressors
  - Multiple and extended deployments
  - Battlefield stressors
    - IEDs, ambushes, severe sleep deprivation, direct combat, etc.
  - Medical
    - Severely wounded Soldiers, injured children, detainees
- Changing sense of mission
- Strong support of American people for Soldiers
- Major Focus of senior Army Staff
- Numerous new programs developed to support Soldiers and Families

Recent Background

- Volunteer Army
  - Know they are going to war
  - Seasoned, fatigued
  - Large Reserve Component
  - Reserve, National Guard
- Mental Health Advisory Teams (MHATs)
  - MHAT I through V, 2003 through 2007
- DoD Mental Health Task Force
- Congress provides supplemental funds to DoD in Summer 07
  - 96 M to Army for “Psychological Health”
  - Defense Center of Excellence
- Elevated suicide rate
- Wounded Soldiers
- Effects on Families
  - Continuous deployments
  - Families of deceased
  - Families of wounded

Range of Deployment-Related Stress Reactions

- Mild to moderate
  - Combat Stress and Operational Stress Reactions (Acute)
  - Post-traumatic stress (PTS) or disorder (PTSD)
  - Symptoms such as irritability, bad dreams, sleeplessness
  - Family / Relationship / Behavioral difficulties
  - Alcohol abuse
  - “Compassion fatigue” or provider fatigue
  - Suicidal behaviors
- Moderate to severe
  - Increased risk taking behavior leading to accidents
  - Depression
  - Alcohol dependence
  - Completed suicides

PTSD Diagnostic Concept

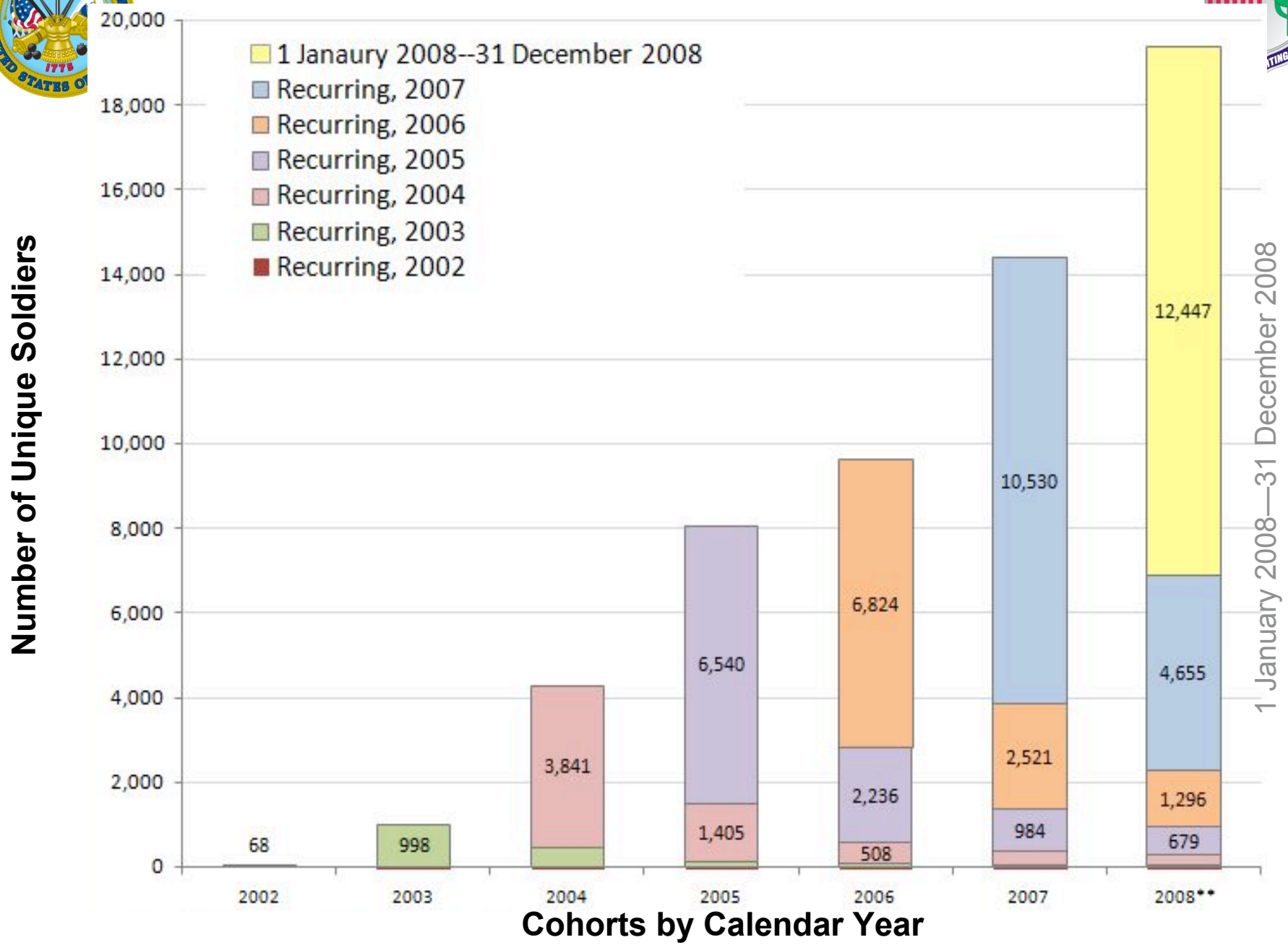
- Traumatic experience leads to:
  - Threat of death/serious injury
  - Intense fear, helplessness or horror
- Symptoms (3 main types)
  - Reexperiencing the trauma (flashbacks, intrusive thoughts)
  - Numbing & avoidance (social isolation)
  - Physiologic arousal ("fight or flight")
- Which may cause impairment in
  - Social or occupational functioning
- Persistence of symptoms

mTBI may be associated with PTSD, especially in the context of Blast or other weapons injury

Behavioral Health: Where We've Been

- Robust surveillance in theater and upon return
  - Mental Health Advisory Teams (MHATs)
  - Post Deployment Health Assessment and Re-Assessment
- Difficulties with access to care
- Stigma about mental health care despite:
  - Chain teach on PTSD and TBI with 900,000 Soldiers in 2007
  - Beyond the Front and Shoulder to Shoulder in 2009
- Increasing surveillance of PTSD and TBI
- Rising suicide rate (multiple reasons: fractured relationships, alcohol abuse).
- Services to help only partially integrated
  - Numerous helping agencies, including medical, behavioral health, chaplains, Family programs
- Close collaboration with DCoE (Defense Center of Excellence)

ARMY: PTSD Cases



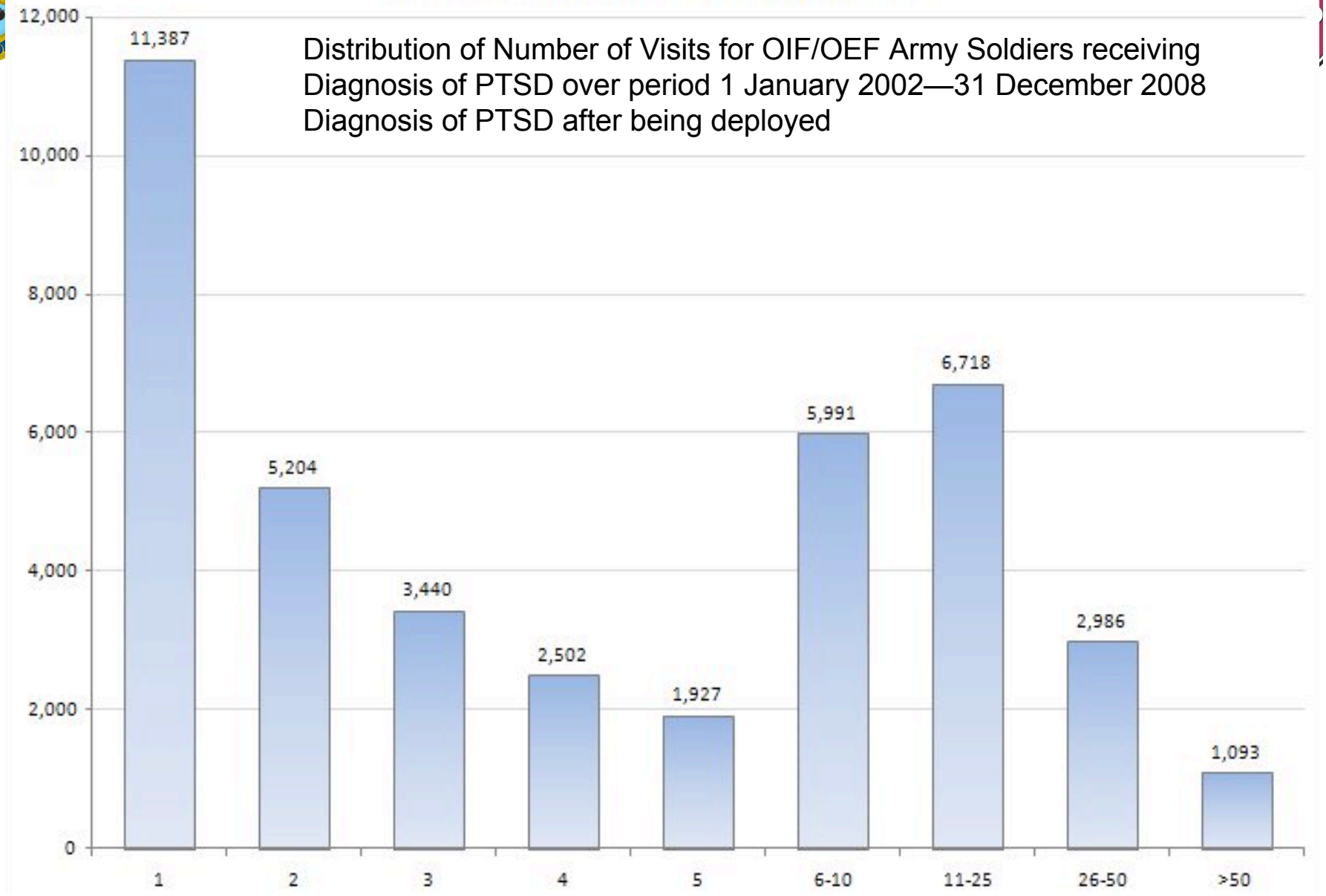
POC: Dr. Michael J. Carino, DASG-WT

Data Source: MDR (SADR, SIDR, TEDI, TEDNI) and CTS Roster

Earliest deployment of >30 days per Soldier was used

Data as of 13 August 2008 (there is data lag, especially for inpatient

ARMY: PTSD Follow-Up Care Rate



POC: Dr. Michael J. Carino, DASG-WT

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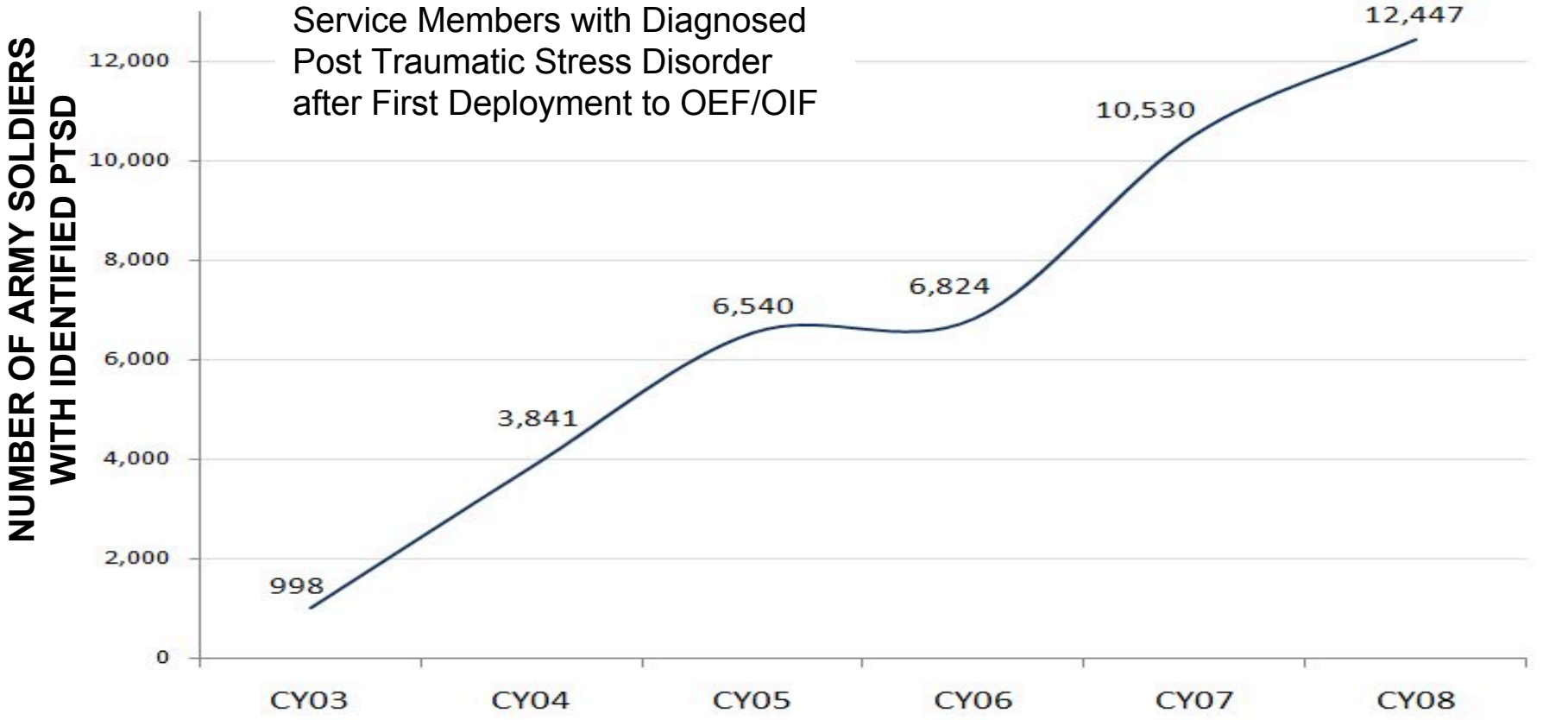
POST TRAUMATIC STRESS DISORDER

Number of Newly Identified Cases, Army OIF/OEF Soldiers

OIF & OEF JAN 05--31 DEC 08

	AC	ARNG	USAR	ARM
CY05	4,681	1,298	561	6,54
percent of new cases	72%	20%	9%	
CY06	5,117	1,144	563	6,82
percent of new cases	75%	17%	8%	
CY07	8,251	1,574	705	10,5
percent of new cases	78%	15%	7%	
CY08	9,795	1,772	880	12,4
percent of new cases	79%	14%	7%	
4 YR Cumulative	27,844	5,788	2,709	36,3
percent of new cases	77%	16%	7%	



We expect the number of new cases to be related to the number of exposed troops, the number of deployments and the overall exposure to combat. We would estimate that the number of Newly Identified PTSD Cases for CY09 to be similar to CY08 if deploy numbers are also similar.

- These are new cases of PTSD. New PTSD cases are identified using ICD-9 Code and represent unique SSN. The data is pulled from the Medical Data Repository (MDR) and represents both Direct Care and Purchased Care entries. Data is updated monthly.

- These are newly identified clinical cases presented to health system and diagnosed, not survey data (anonymous surveys). The diagnosis of PTSD is made subsequent to a Soldier's deployment for OIF/OEF and deployment information is acquired using the Contingency Tracking System (CTS), Defense Manpower Data Center (DMDC).

- Post-Traumatic Stress Disorder is a psychiatric disorder that may occur after exposure to trauma. Typical symptoms include hypervigilence, intrusive thoughts, flashbacks, numbness, avoidance, and nightmares.

- We have numerous education, identification, and treatment programs for PTSD, including Battlemind, PDHA, PDHRA, the chain-teach program, and Respect-mil.

- Based on survey data (Mental Health Advisory Teams I-V):
  - The more exposure to combat the higher the likelihood of developing of PTSD.
  - Multiple deployers have a higher likelihood of endorsing positive symptoms.

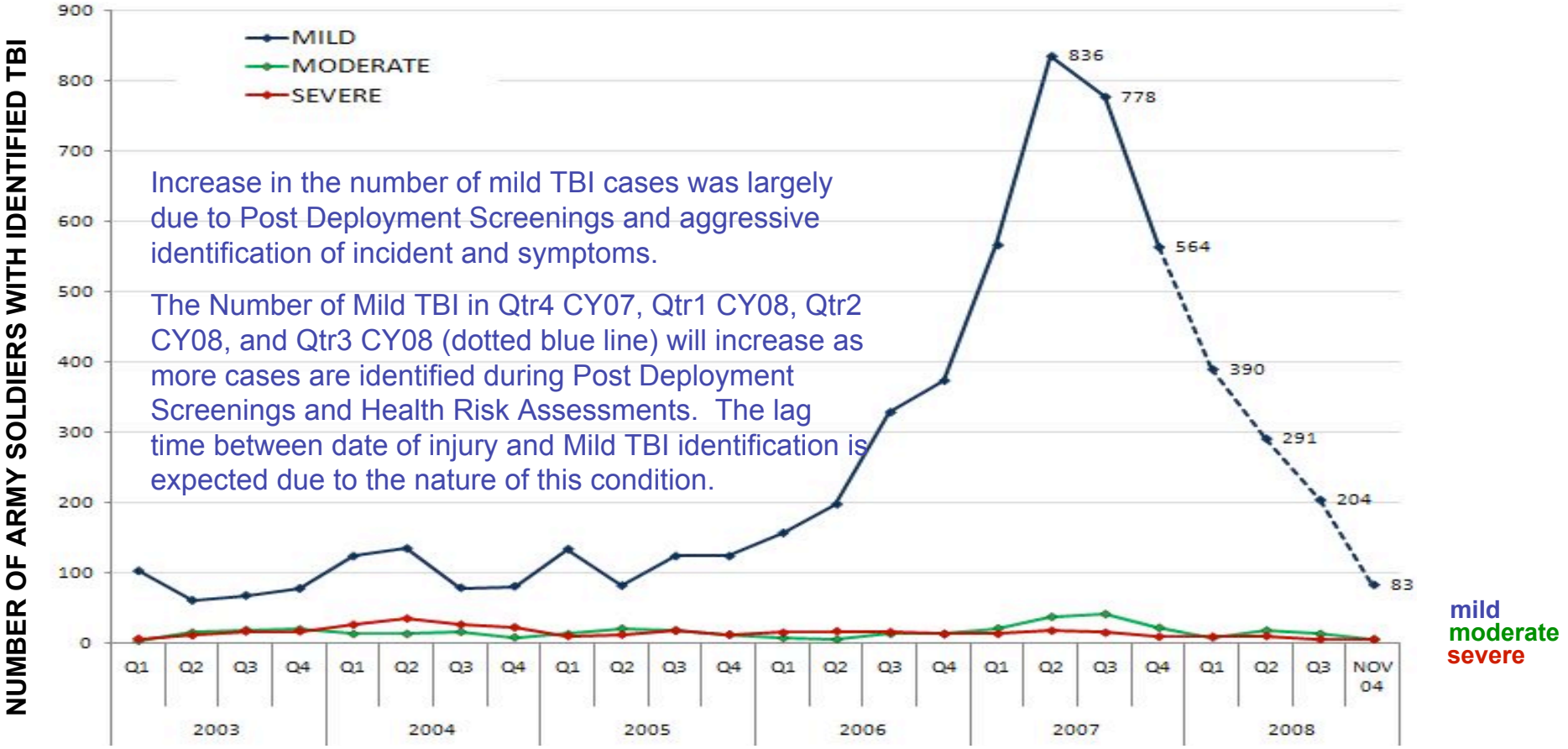
- We expect the number of new cases to be related to the number of exposed troops, the number of deployments and the overall exposure to combat. Therefore the number of new cases will likely be similar to the number of new cases identified in 2008 if the number of deployed Soldiers is similar in 2009 number. However, the unique battle environment for Afghanistan may cause an increase in the incidence of PTSD, relative to the number of Soldiers deployed in support of operations.

TRAUMATIC BRAIN INJURY

Trend for Army, OIF/OEF Soldiers

OIF & OEF OCT 2001--NOV 2008

	USA	ARNG	USAR	ARMY		
MILD	4995	823	231	6049	89.0%	MILD
	83%	14%	4%			
MODERATE	306	51	23	380	5.6%	MODERA
	81%	13%	8%			
SEVERE or PENETRATING	310	48	9	367	5.4%	SEVERI
	84%	13%	2%			
TOTAL	5611	922	263	6796		
	81%	13%	4%			



Increase in the number of mild TBI cases was largely due to Post Deployment Screenings and aggressive identification of incident and symptoms.

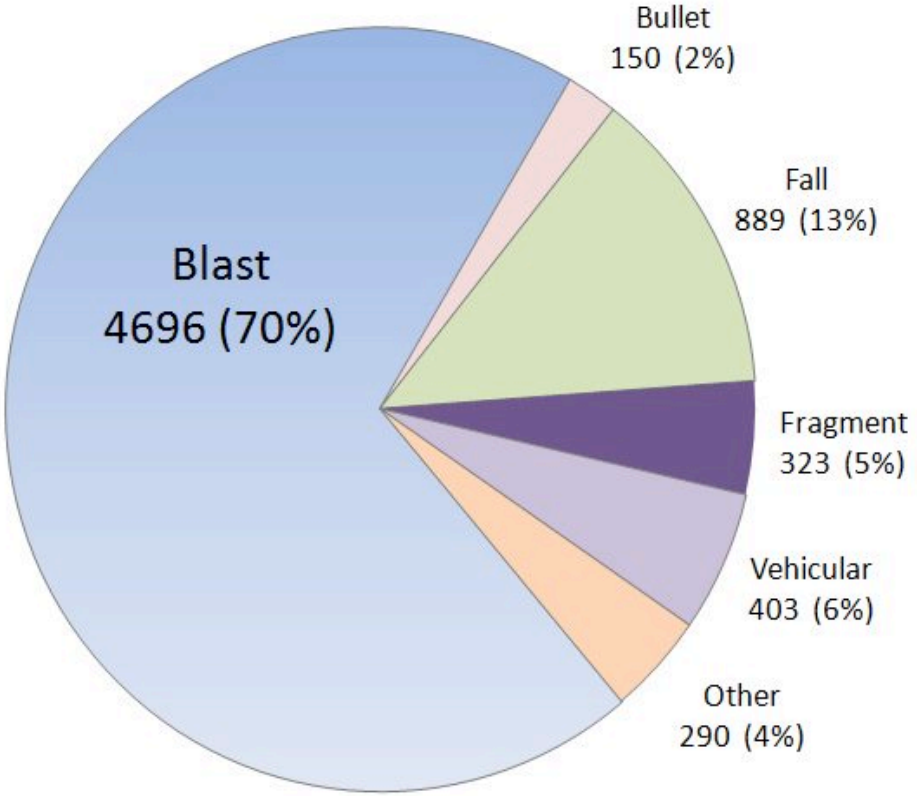
The Number of Mild TBI in Qtr4 CY07, Qtr1 CY08, Qtr2 CY08, and Qtr3 CY08 (dotted blue line) will increase as more cases are identified during Post Deployment Screenings and Health Risk Assessments. The lag time between date of injury and Mild TBI identification is expected due to the nature of this condition.

This slide depicts TBI of varying severity based on data from the Defense Veterans Brain Injury Center, November 2008. The Trend indicates variation in the number of Soldiers with Mild TBI and a decrease in the number of Soldiers with Severe TBI over time.

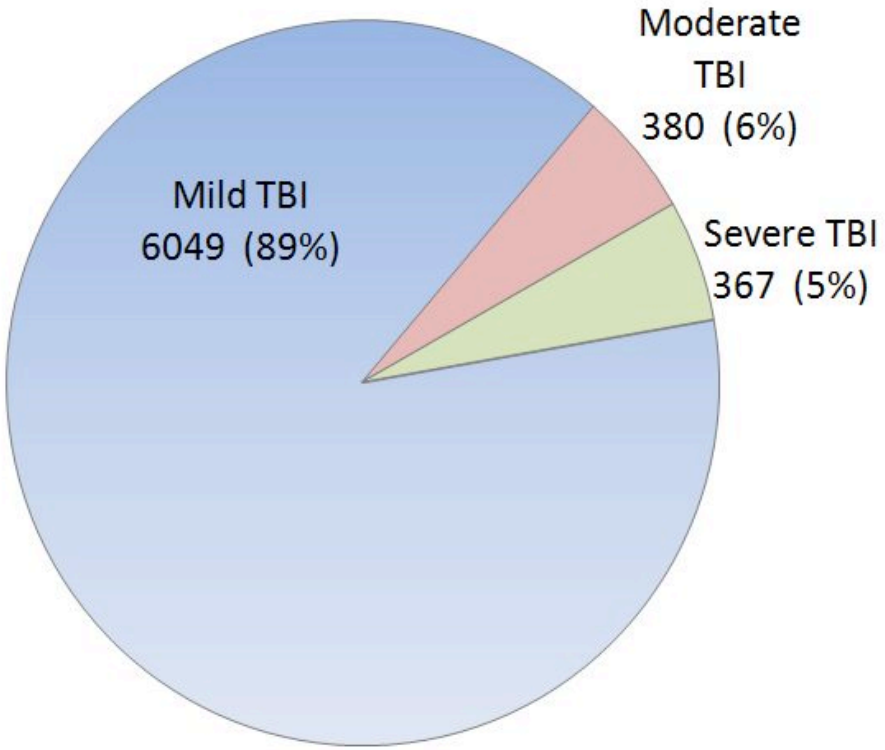
TRAUMATIC BRAIN INJURY

POC: Dr. Michael J. Carino, OTSG DVBIC Data November 2008

TBI PRIMARY INJURY MECHANISM
ARMY, OIF/OEF



TBI SEVERITY OF INJURY
ARMY, OIF/OEF



This slide depicts TBI of varying severity based on data from the Defense Veterans Brain Injury Center, November 2008. As of November 2008, there were 6,751 cases reported to DVBIC—most from IED/BLAST, and most were MILD. Data reflects only Army OIF/OEF.

Behavioral Health: Where We Are

- Evolving Comprehensive Behavioral Health Strategy
  - Comprehensive Soldier Fitness
  - Army's Campaign Plan for Health Promotion, Risk Reduction & Suicide Prevention (ACPHP)
  - Child and Adolescent Center of Excellence (Madigan)
- MHAT VI pending release; will emphasize returned focus on Operation Enduring Freedom (OEF)
- Army PH spend plan
  - The Army has implemented over 45 initiatives under the categories of access to care, resiliency, quality of care, and surveillance
  - Funding: $120M obligated in FY 08, expecting $145M obligations in FY09, POM funds FY10-15
- Improved access to care
  - 48% increase in behavioral health providers since 2007
  - Number of visits has more than doubled since 2003
- Stigma reduction
  - Battlemind lifecycle products fielded to TRADOC (Basic Battlemind)
- New policies to screen for PTSD and TBI
- Extensive unit and population-based research

Behavioral Health: Where We Are Going

- Mature Behavioral Health Strategy
  - Comprehensive Soldier Fitness
  - MEDCOM Behavioral Health Campaign Plan (BHCP)
  - Army's Campaign Plan for Health Promotion, Risk Reduction & Suicide Prevention (ACPHP)
- Continue to improve health surveillance as new issues arise
- Continue to improve access to care
  - Integrated behavioral health and primary care
  - Telemedicine implemented nationally and internationally
  - Revised force structure with increased behavioral health providers
- Reduce stigma
  - Defense Center of Excellence (DCoE) leading anti-stigma campaign: Real Warriors
- New treatments, research, and clinical guidelines for PTSD, TBI and pain management

Surveillance

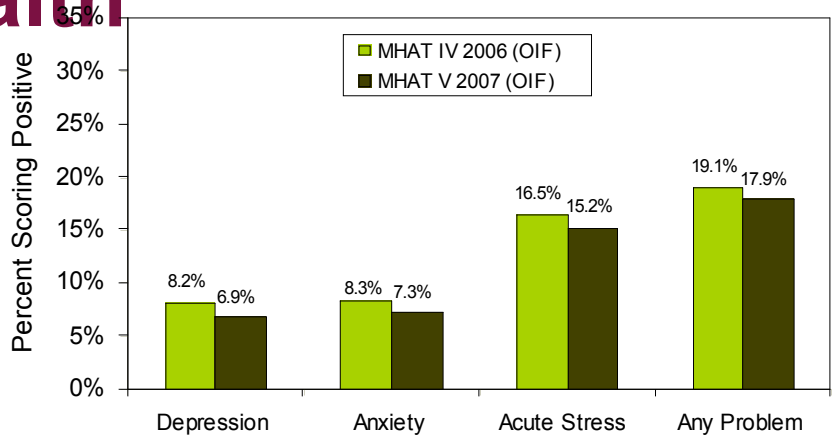
- Land Combat Study
  - Surveys of infantry Brigade Combat Teams throughout deployment cycle (n>30,000).
  - Anonymous with informed consent
- Post Deployment Health Assessment (PDHA) /Post Deployment Health Re-Assessment (PDHRA) (population-based)
  - Brief validated screening survey plus primary care interview
  - Not anonymous, linked to clinical care
- Health Care Utilization Data (population-based)
  - Military Treatment Facilities
  - VA Facilities
- Mental Health Advisory Teams
- Epidemiological Consultation Teams
- Suicide numbers and cases (Army/DoD Suicide Event Report)
- DoD Mental Health Task Force
- President's Commission on Wounded Warriors "Dole-Shalala Report"
- Rand Study: Invisible Wounds of War
- Suicide Analysis Cell

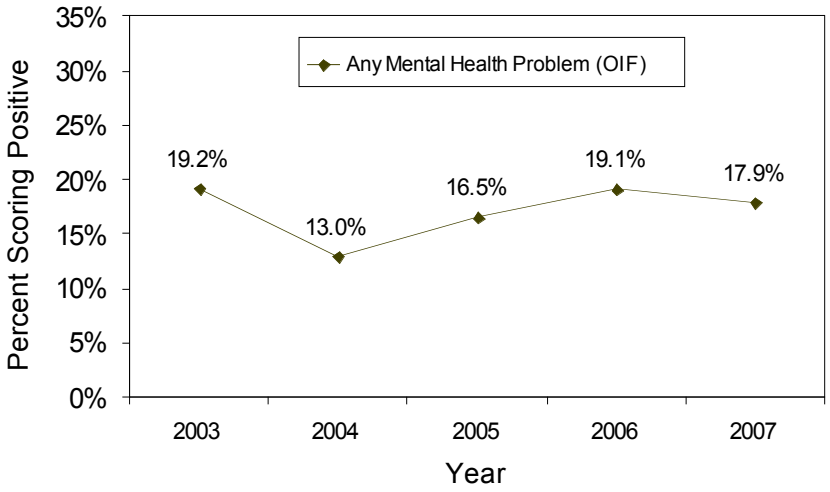
Mental Health Advisory Teams

- MHATs I through V have consistently shown that 14-20% of Soldiers from Brigade Combat Teams (BCTs) in Iraq are experiencing mental health symptoms
- MHAT I (data collection 2003)
  - First ever in theater assessment
  - Identified problems with distribution of behavioral health resources
- MHAT II (data collection 2004)
  - Mission confirmed that many of the recommended changes had been implemented
- MHAT III (data collection 2005)
  - Longer deployments and repeated deployments were associated with higher rates of mental health symptoms
- MHAT IV (data collection 2006)
  - First assessment of battlefield ethics attitudes / behaviors
  - Repeated deployments and longer deployments again confirmed to be associated with higher rates of mental health symptoms
- MHAT V (data collection 2007)
  - Included Afghanistan
  - See next slides

OIF Behavioral Health Status: Mental Health

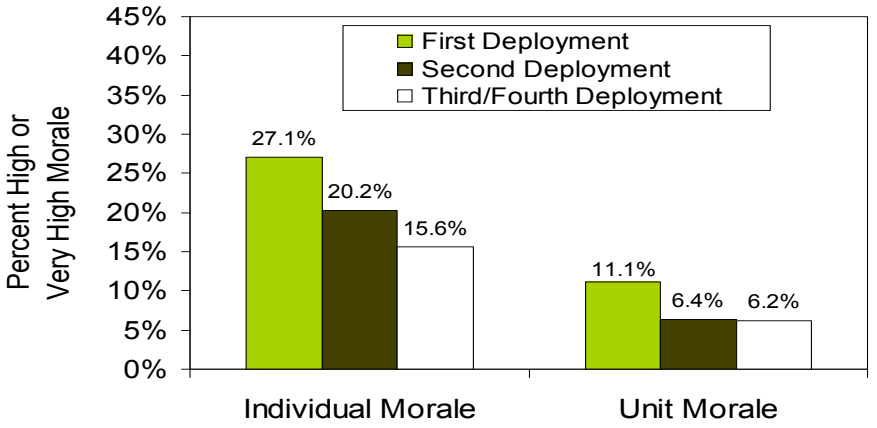
- Reports of mental health problems did not statistically differ from 2006 to 2007.
- Rates of mental health problems are comparable to every year except 2004.

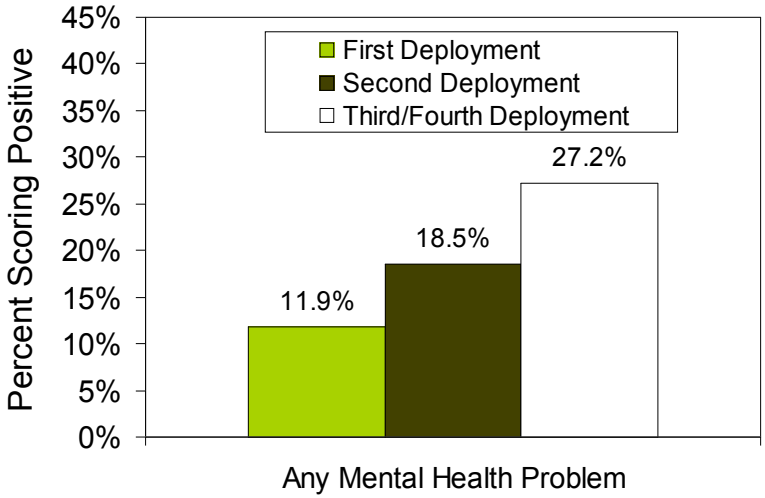




OIF Risk Factors: Multiple Deployments

- NCOs on either their second deployment to Iraq or their third/fourth deployment to Iraq report significantly lower morale than NCOs on their first deployment.
- Each deployment to Iraq puts NCOs at significantly more risk of reporting a mental health problem.





OIF Stigma and Barriers to Care

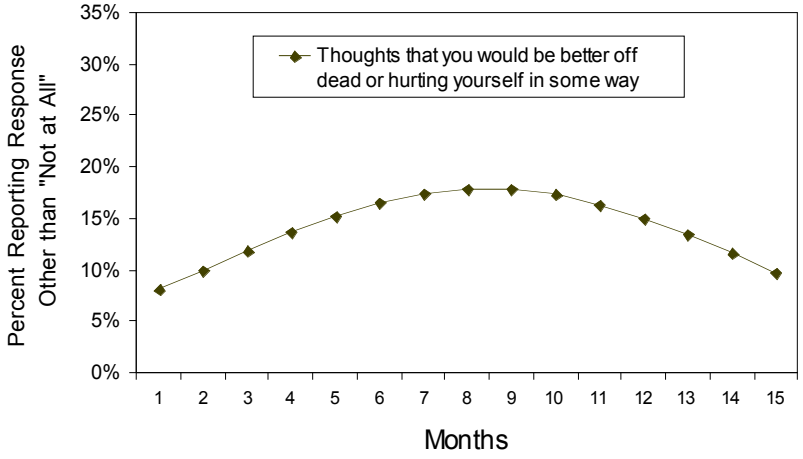
Factors that affect your decision to receive mental health services	Percent Agree or Strongly Agree: MHAT IV (OIF) 2006	Percent Agree or Strongly Agree: MHAT V (OIF) 2007	p-value
It would be too embarrassing.	36.6%	32.0%	0.04
It would harm my career.	33.9%	29.1%	0.02
Members of my unit might have less confidence in me.	51.1%	44.8%	0.00
My unit membership might treat me differently.	57.8%	52.1%	0.00
My leaders would blame me for the problem.	43.0%	38.5%	NS
I would be seen as weak.	53.2%	49.8%	NS

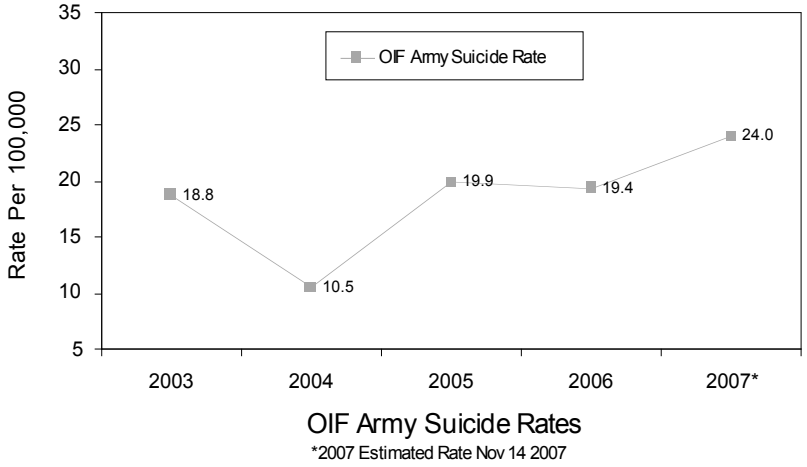
- Soldiers who screened positive for mental health problems reported significantly lower stigma about receiving care in 2007 than in 2006.
- Soldiers report higher barriers to care (not shown). The increase is likely due to the high percentage of Soldiers way from the main Forward Operating Bases (FOBs).

NS=Not significant

OIF Risk Factors: Months Deployed (cont.)

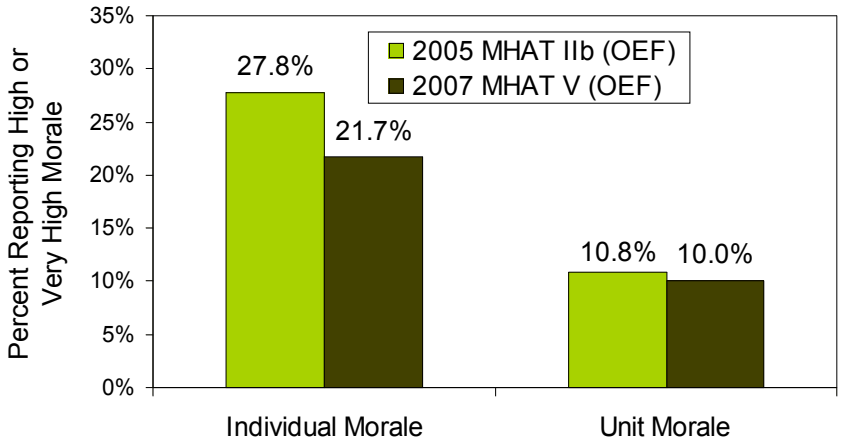
- The risk for reports of suicide ideation increase mid-deployment.
- Suicide rates continue to be elevated relative to historic rate of 12.36 per 100,000. Many suicides involve failed relationships.

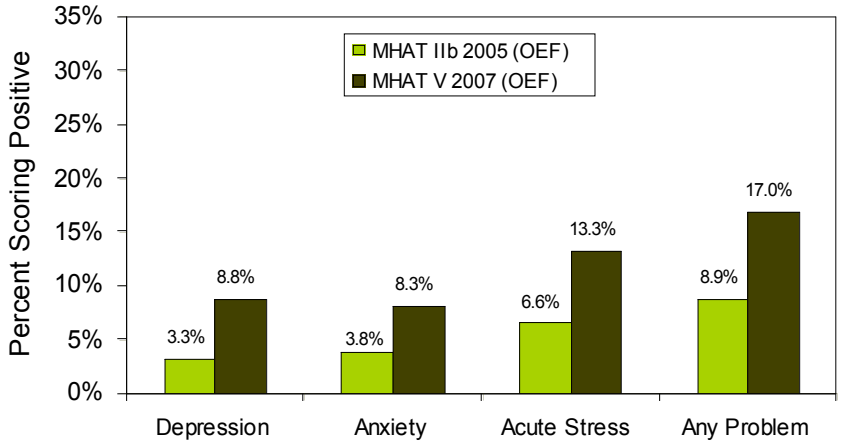




OEF Behavioral Health Status

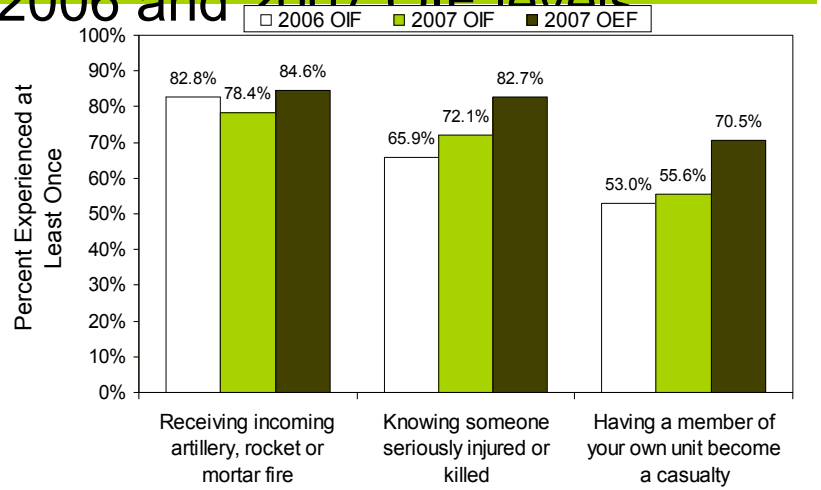
- Soldiers' reports of individual morale are significantly lower than in 2005. OEF rates in 2007 are similar to OIF 2007 rates (page 12).
- Soldiers' reports of mental health problems are significantly higher than in 2005. OEF rates in 2007 are similar to OIF 2007 rates (page 13).
- OEF Soldiers in BCTs (n=282) report higher levels of mental health problems than OIF Soldiers (not shown).





OEF Risk Factors: Combat Experiences

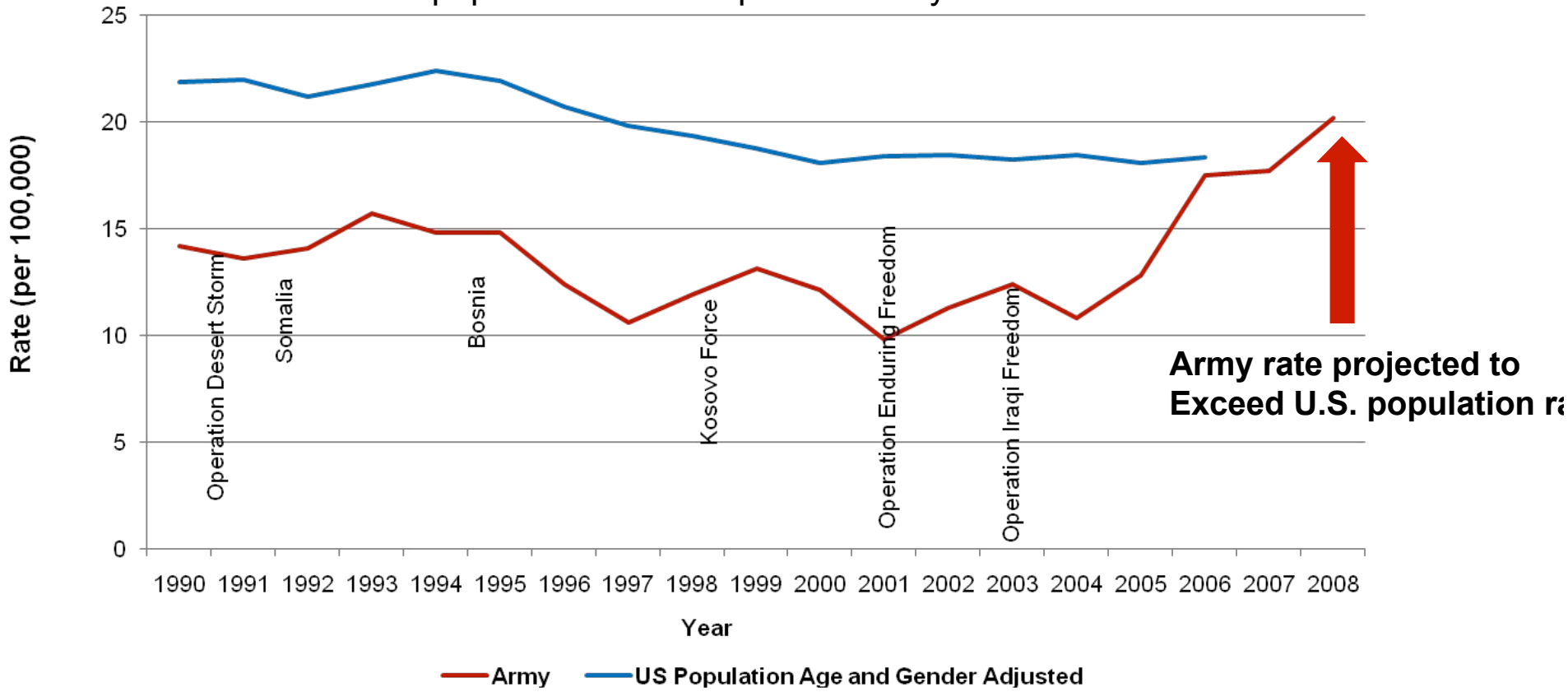
- A number of combat experiences significantly changed from 2005 to 2007.
- MHAT V OEF Soldiers in BCTs (n=282) reported levels of combat equal to or higher than 2006 and 2007 OIF levels.



Combat Experiences	Percent MHAT IIB (OEF) 2005	Percent MHAT V (OEF) 2007
Significant Increases		
Being attacked or ambushed.	43.3%	53.0%
Being wounded/injured.	5.1%	11.4%
Being directly responsible for the death of an enemy combatant.	9.0%	14.0%
Had a close call, dud landed near you.	14.7%	20.6%
Significant Decreases		
Seeing destroyed homes and villages.	61.2%	46.5%
Disarming civilians	33.7%	20.3%
Clearing/searching homes or buildings.	42.7%	26.1%
Clearing/searching caves or bunkers.	34.6%	23.6%
Seeing ill/injured women or children who you were unable to help.	43.9%	30.0%

Suicide Rates from 1990-2008

- Historically, the US Army rate has been lower than the US population rate
- Both populations experienced a downward trend from the mid-90's to 2001
- From 2001 to 2006, the US population rate was steady at 1x/100k while the Army rate doubled from 10 to 20/100k
- The U.S. population was age adjusted to the Army population by excluding those under 15 years of age and over 60 years of age, as well as adjusting the gender and age distribution within the population to a comparable Army distribution.

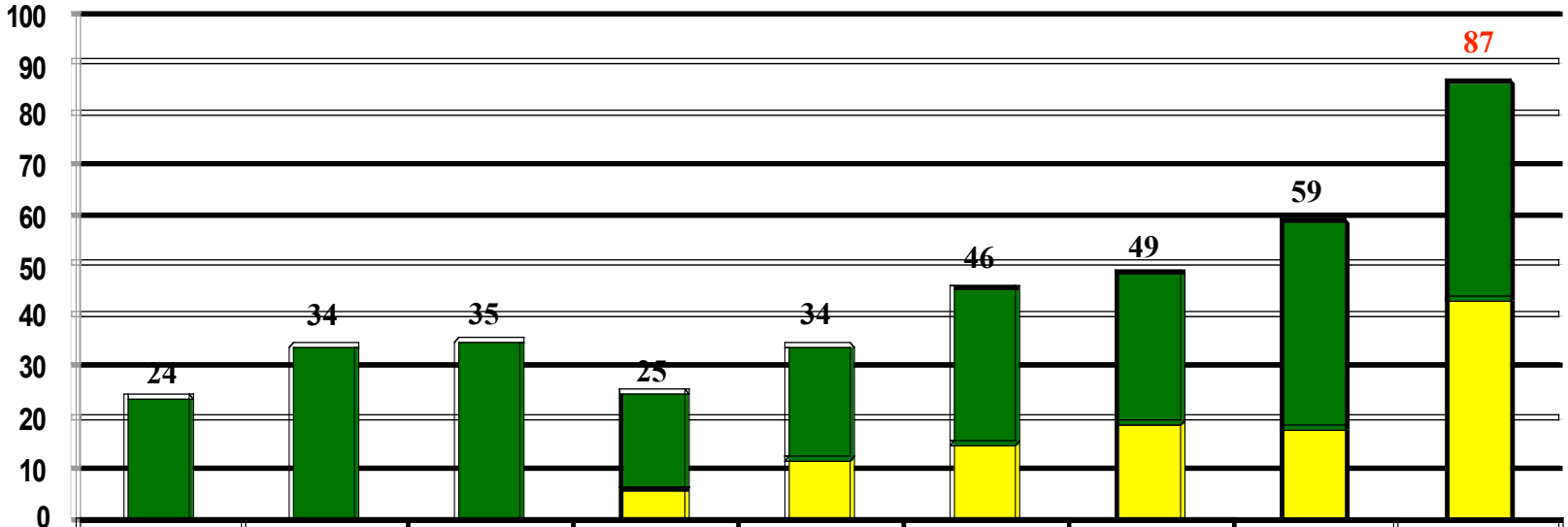


SOURCE: CDC/NCHS, National Vital Statistics System (civilian data). G1 (Army data)

Comparable civilian rates were only available from 1990-2006

Calendar Year

Active Duty Suicides Comparison 01 Jan – 15 Jun (CY01 – CY09)



	CY01	CY02	CY03	CY04	CY05	CY06	CY07	CY08	CY09
Confirmed	24	34	35	19	22	31	30	41	44
Pending	0	0	0	6	12	15	19	18	43

- Data include Active Duty: Active Army (includes Cadets), USAR, ARNG
- Source: DCIPS and AFME

Note: Year-to-Date "Pending" Data not available for CY01 - CY03

Screening and Surveillance
Annual and Post Deployment Screens

- The Department of Defense has mandated annual and post-deployment screening for suicidality.
  - Periodic Health Assessment (PHA): Conducted annually
  - Post-deployment Health Assessment (PDHA): Conducted within 30 days of service members returning from deployment
  - Post-deployment Health Re-assessment (PDHRA): Conducted within 3-6 months for service members returning from deployment
- Screening is based on an interview with a behavioral health care provider using a standardized interview guide. Service members at risk will received immediate intervention or a mental health referral.

Screening and Surveillance

The DoD Suicide Event Report

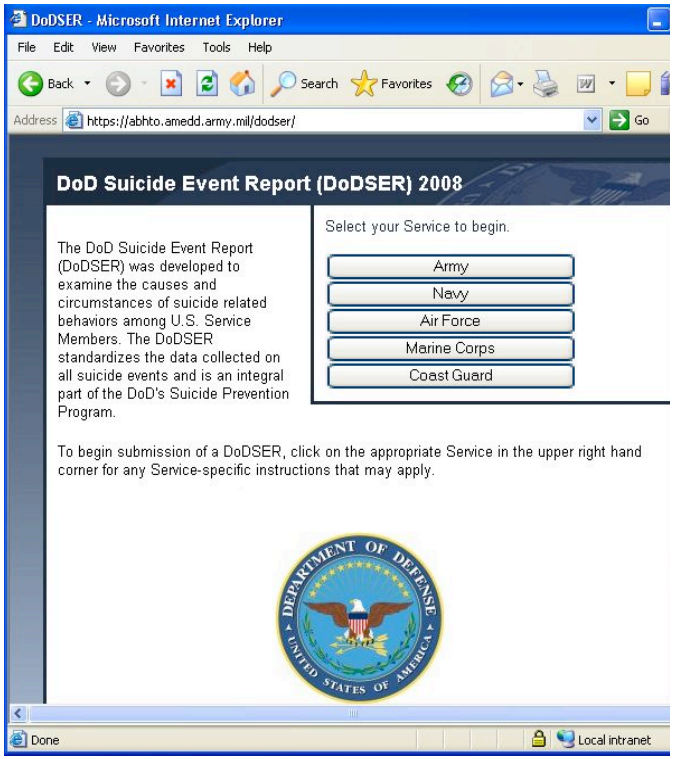
- The Department of Defense implemented the DoD Suicide Event Report (DoDSER) based on the Army Suicide Event Report (ASER), which was validated by the U.S. Army Medical Research and Materiel Command.
- DoDSERs are submitted for suicide behaviors that result in death, hospitalization or evacuation from theater.
- Data collected from standardized records

(e.g., medical records, CID).

- Army DoDSERs due w/in 60–days.
- Objective, detailed, and standardized information

collected:

- Comprehensive data (method, location, fatality)
  - Extensive risk factor data
    - Dispositional or personal
    - Historical or developmental
    - Contextual or situational
    - Clinical or symptom factors



Common BH EPICON Themes

Theme	Ft Leonard Wood 2001 (suicide)	Ft Bragg 2002 (homicide)	Ft Riley 2005 (suicide)	Ft Hood 2006 (suicide)	Ft Campbell 2008 (suicide)	Ft Carson 2009 (homicide)
INDIVIDUAL RISK FACTORS						
Deployment: length, multiple, unpredictability		X	X	X	X	
Family Separation - Relationship Stress - Lack of Support						X
Increased violence against persons including spouse/family		X	X	X	X	X
Increased use of alcohol and drugs, and related offenses		X	X	X	X	X
Previous gestures/attempts/BH contact	X	X	X	X	X	X
Manipulating - Malingering	X		X		X	X
Legal and Financial Issues		X	X	X	X	X
History of misconduct						X
SYSTEMS ISSUES						
Stigma: personal, peer, leadership, career		X	X	X	X	X
Poor Service Delivery for dependents		X	X	X		
Transition, Reintegration (One size fits all)		X	X	X	X	X
Problems wit BH Services, FAP, ASAP	X	X	X	X	X	X
Lack standardized screening, tracking, intervention, data collection	X	X	X	X	X	X
Leadership Management/climate	X	X	X	X	X	X

Source: EPICON published reports

Stigma

• Four types of stigma generally seen: career, leadership, peer-to-peer, and personal

• Stigma was reported differently across rank groups; lower enlisted were more concerned about peer and self-perceptions, senior enlisted were most concerned about their career and perceived leadership abilities

Career	Leadership	Peer-to-Peer	Personal
On permanent record, effects future promotion and employment	Some old school, senior NCOs, and early promoted NCOs create/maintain stigma	Peer stigma is the worst	Weak, isolated, embarrassed
End career, lose retirement	More stigma for senior enlisted, others think they can't lead, fear of effecting retirement	More stigma if never deployed	Profile makes them feel worthless
Lose security clearance	Many squad/platoon leaders don't support	Treated differently, Ridiculed	Pride/Denial
"Boarded out" rather than rehabilitated	Treated differently; doubt 'warrior' abilities; ridicule those with a profile	Gossiped about/Perceived faking	Don't want to be viewed as a "bad" soldier

Resiliency Programs

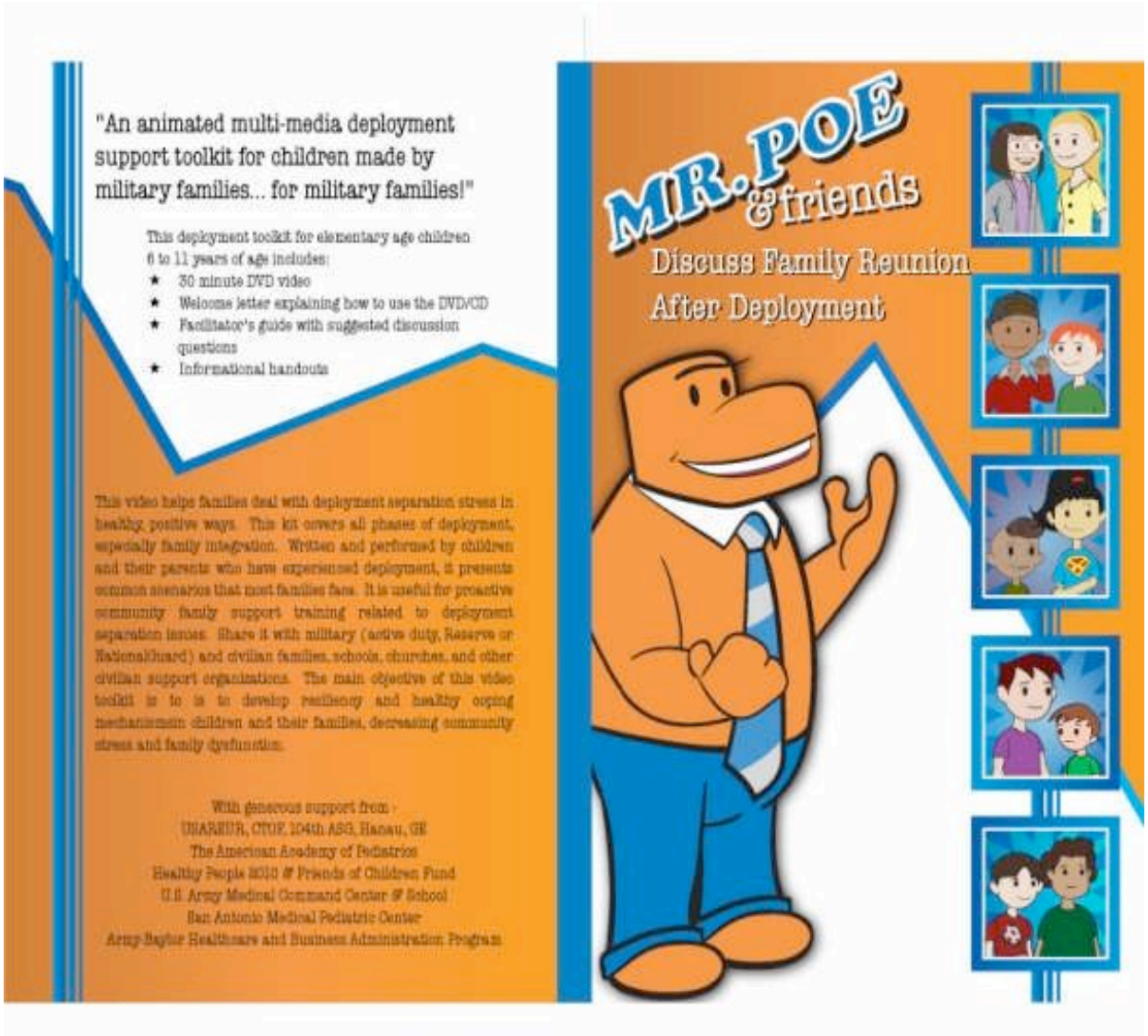
- **Battlemind**
  - The US Army psychological resiliency building program. This term describes the Soldier's inner strength to face fear and adversity during combat, with courage and speaks to resiliency skills that are developed to survive. It represents a range of training modules and tools under three categories: Deployment Cycle, Life Cycle and Soldier Support.
- **Suicide Prevention**
- **Provider Resiliency Training**
- **Reunion and Reintegration**
  - Deployment Cycle Support is in process of being upgraded.
- **Other Programs in Development**
  - New resiliency programs are being funded under congressional TBI/PH supplemental dollars
- **Warrior Adventure Quest**

Battlemind Training System: Web Page

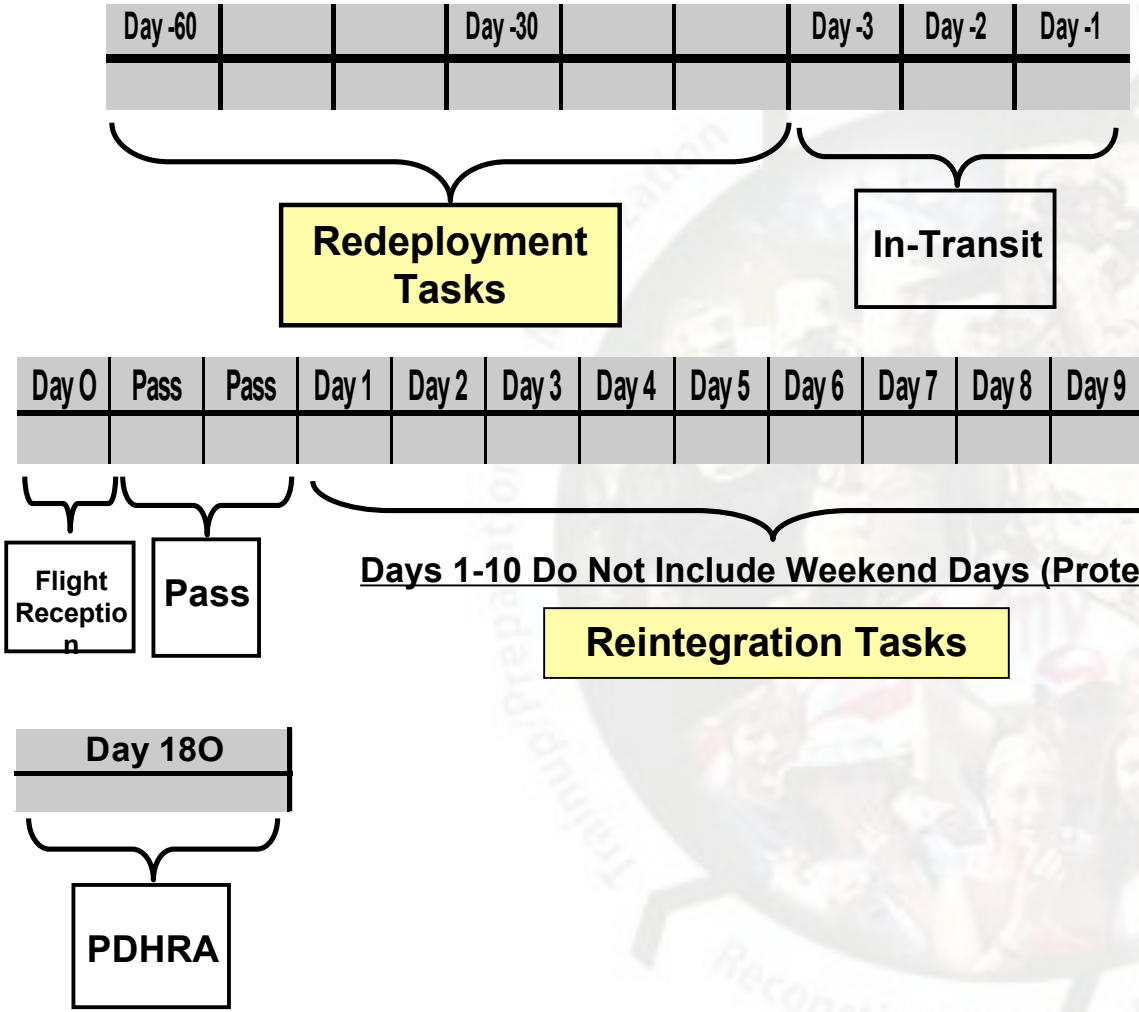
www.battlemind.army.mil

Military Youth Coping with Separation: When Family Members Deploy

Mr. Poe and Friends Discuss Reunion after Deployment



Updates in Decompression/Reintegration



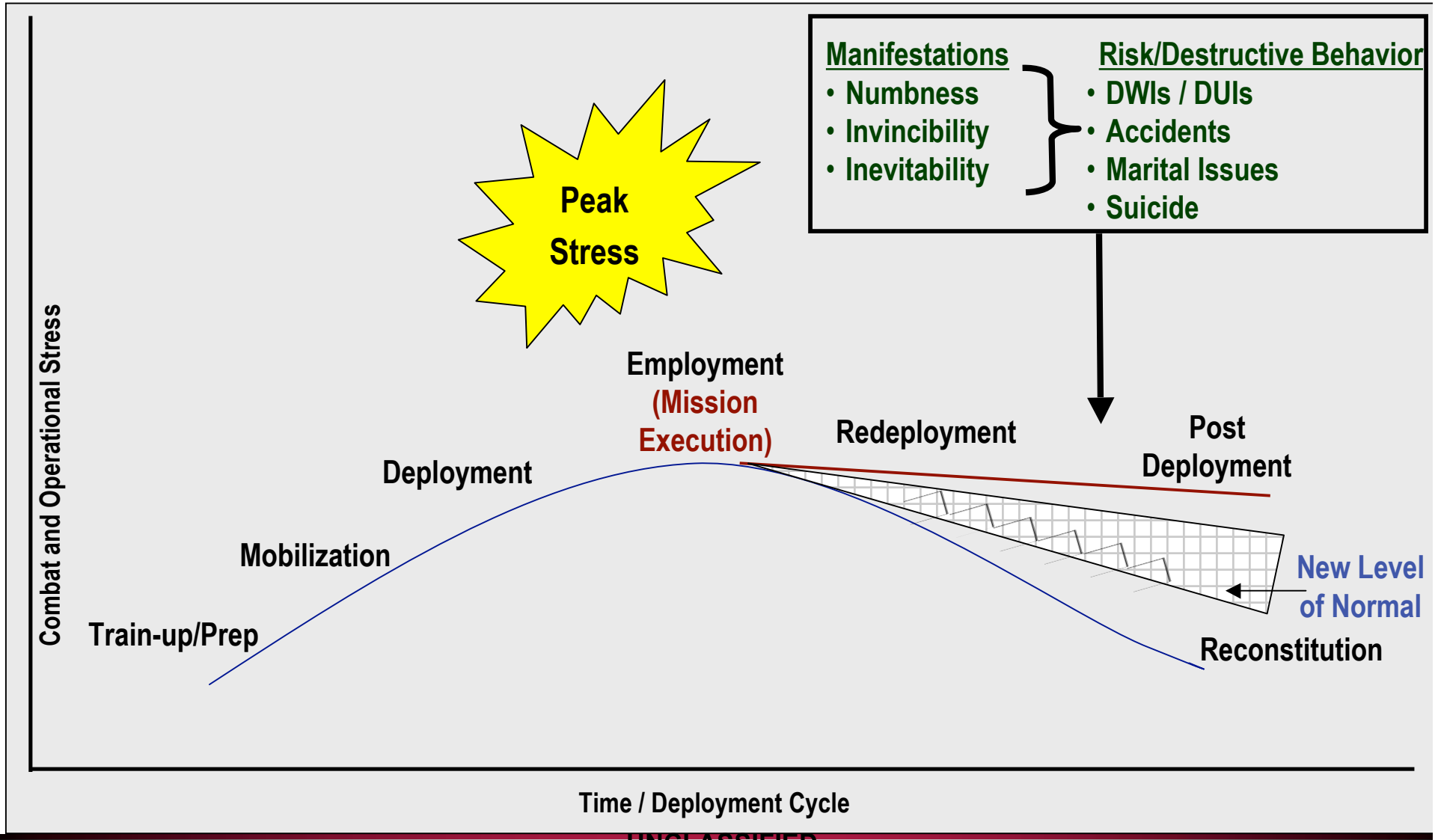
Key Components

- Commander's program
- Structured decompression / reintegration
- Mental health risk stratification program prior to departure from theater
- Active tracking and monitoring which involves coordination b/w BCT/Div and the local AMEDD resources.
- Tailored to both active component and reserve

WARRIOR ADVENTURE QUEST

- WAQ utilizes high risk/extreme sports in coordination with a debriefing tool to provide Soldier/Leader/Unit mitigation and coping skills that can address unresolved transition issues and build unit cohesion and moral, contributing to combat readiness.
- WAQ is NOT specific to reintegration, it is a training tool that can be incorporated across the ARFORGEN cycle.

Reintegration and Reconstitution



Unit Resiliency Fundamentals

Horizontal Bonding: Trust

Vertical Bonding: Trust

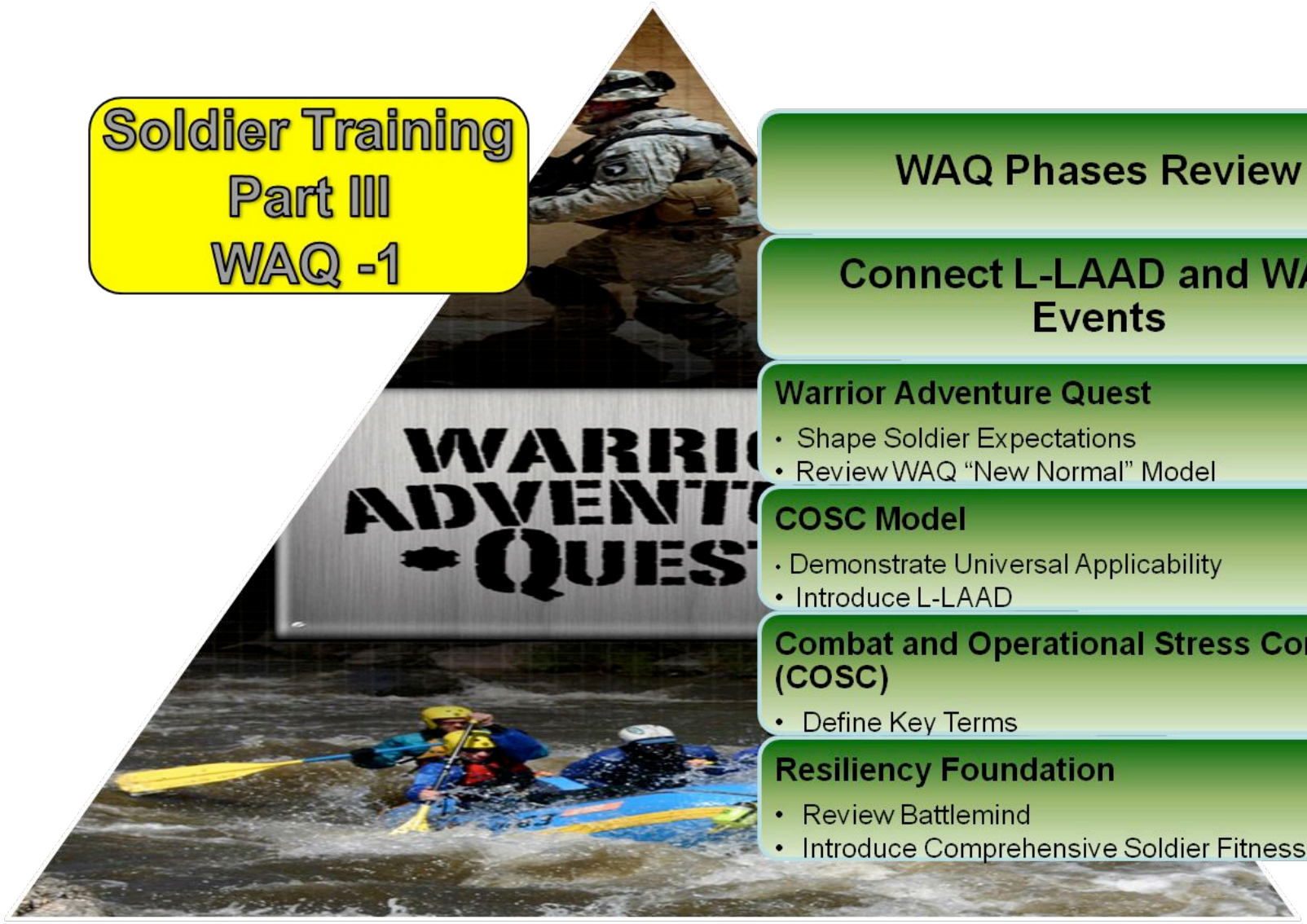
Esprit de Corps: Sense of

Unit Cohesion: Binding force which combines 3 previous concepts

Copyright 2002 From Black Hawk Down, Columbia TriStar Home Entertainment

- FM 6-22.5, COSC Guide, Leaders and Warriors (DRAFT, FEB 09)

Soldier Training Part III WAQ -1



WAQ Phases Review

Connect L-LAAD and WAQ Events

Warrior Adventure Quest
- Shape Soldier Expectations
- Review WAQ "New Normal" Model

COSC Model
- Demonstrate Universal Applicability
- Introduce L-LAAD

Combat and Operational Stress Control (COSC)
- Define Key Terms

Resiliency Foundation
- Review Battlemind
- Introduce Comprehensive Soldier Fitness

Suicide in the Army

- Suicide rates are increasing in all components of the US Army, across all age groups, and in both male and female Soldiers
- PDHA/PDHRA does not serve as an optimal way to identify and intervene
  - Need to develop tools for suicide risk assessment
  - Improve suicide assessment training for providers
- The suicide rate among Soldiers who have deployed to OIF/OEF is higher than for Soldiers who have never deployed.
- A comprehensive approach to suicide prevention is required which includes identification and treatment of high risk individuals as well as risk mitigation efforts in the Army population

Risk Factors for Suicide in Army Personnel

- Major Psychiatric Illness Not a Significant Contributor
  - Adjustment disorders, substance abuse common
- Relationships
- Legal/Occupational Problems
- Substance Abuse
- Pain/Disability
- Weapons
  - 70% with firearm
- Recent Trends
  - Older, higher rank, more females

Army Suicides: 2001 through 31 JULY 2009

	2001-2009†		Overall ARMY‡	
NUMBER OF SUICIDES	817			
	N	%		
MALE	774	94.7	86.0	***
FEMALE	43	5.3	14.0	
AVERAGE AGE	28		25	***
Aged 18-25	365	44.7	43.2	
Aged 25-35	287	35.1	38.4	
Aged 36-60	165	20.2	18.4	
RACE-ETHNICITY				
Caucasian/White	615	75.3	74.6	*
African American	104	12.7	15.7	
Hispanic and Other	98	12.0	9.7	
MARITAL STATUS				
SINGLE	365	44.7	39.1	***
MARRIED	423	51.8	53.4	
DIV/SEP/WIDOWED	29	3.5	7.5	

† Through 31 July 2009; ‡ Based on 2008 figures; * p<.05;** p<.01; ***p<.001

Prepared by: USACHPPM BSHOP

Source: ABHIDE

Estimated Rate of Suicide by Army Functional Group, 2004-2009

Functional Group	# Suicides (N=508)	% of Suicides	Population 2004-July 2009	Estimated Rate per 100,000*	99% Confidence Limits
OVERALL	***508***	***100***	***2,831,568***	***18.1***	***18.07-18.13***
Maneuver, Fire & Effects	267	52.6	1,226,517	21.8	21.75-21.86
Force Sustainment	118	23.2	708,260	16.7	16.65-16.75
Operations Support	70	13.8	559,224	12.5	12.46-12.54
Special Branches	36	7.1	212,933	16.9	16.81-16.99
Other	17	3.3	106,574	16.0	15.87-16.13

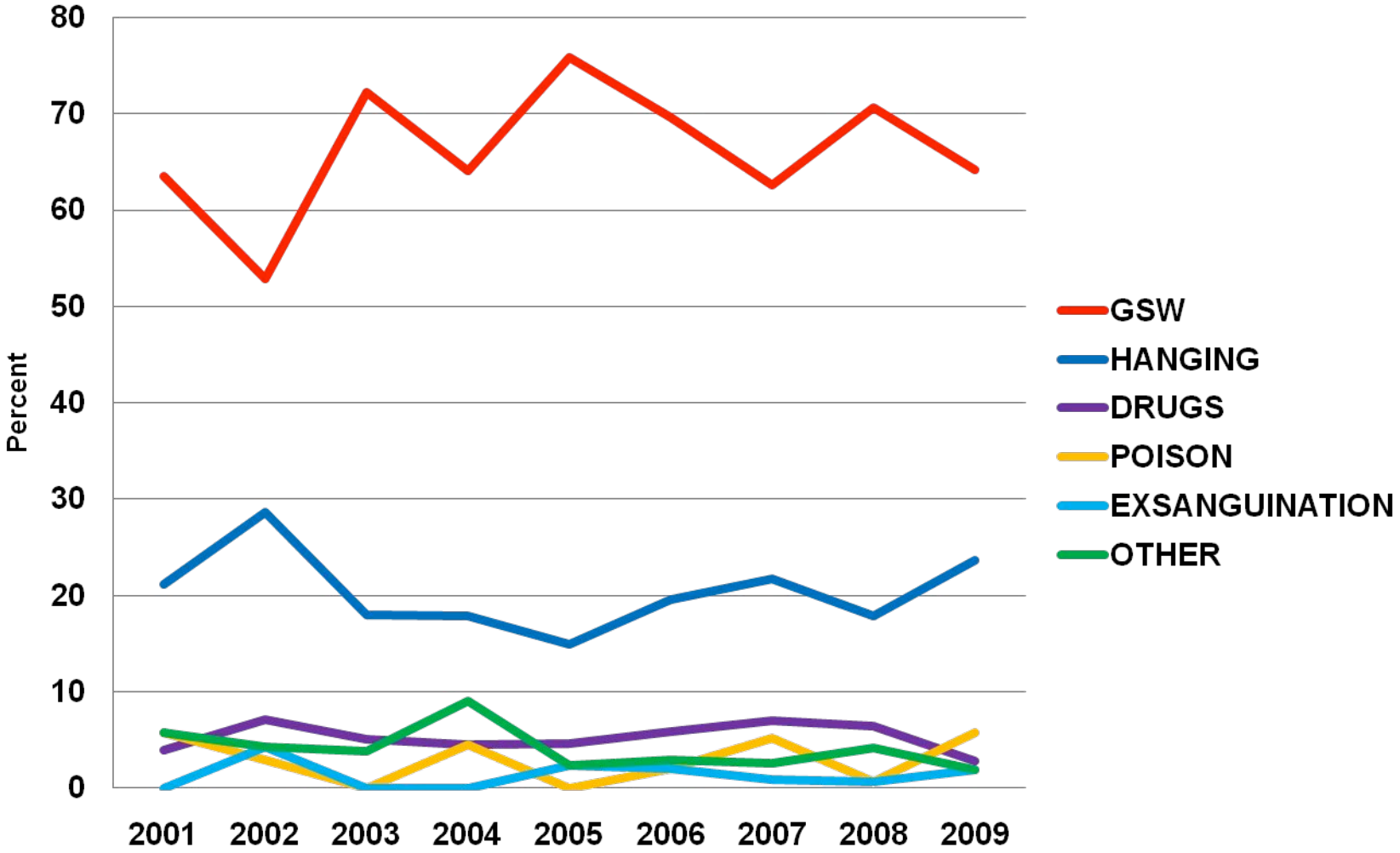
* Based on number of individuals, not person-years;

Significantly greater than average

Source: ABHIDE

Prepared by: USACHPPM BSHOP

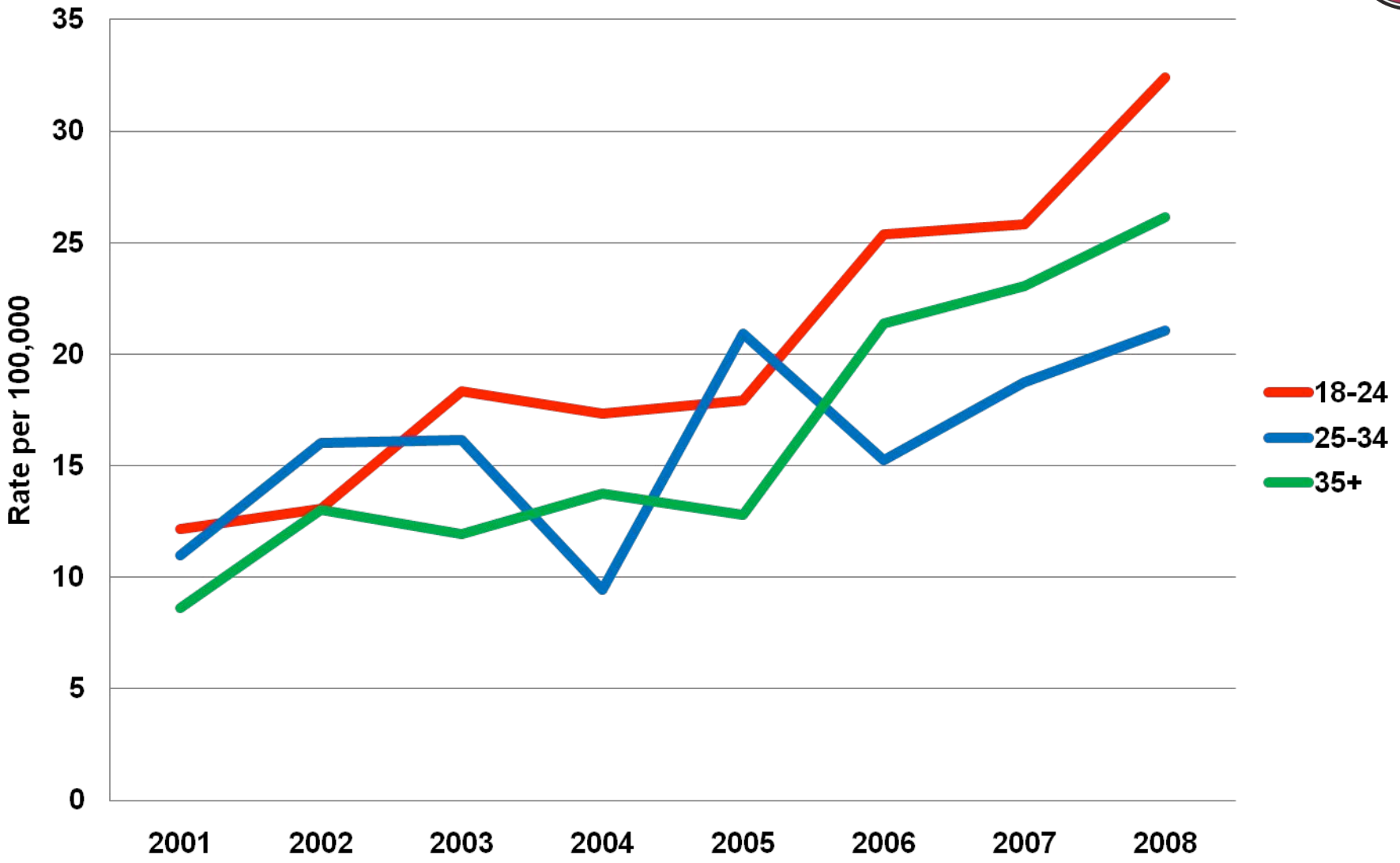
US ARMY Suicides: Method of Death



Source: ABHIDE

Prepared by: USACHPPM BSHOP

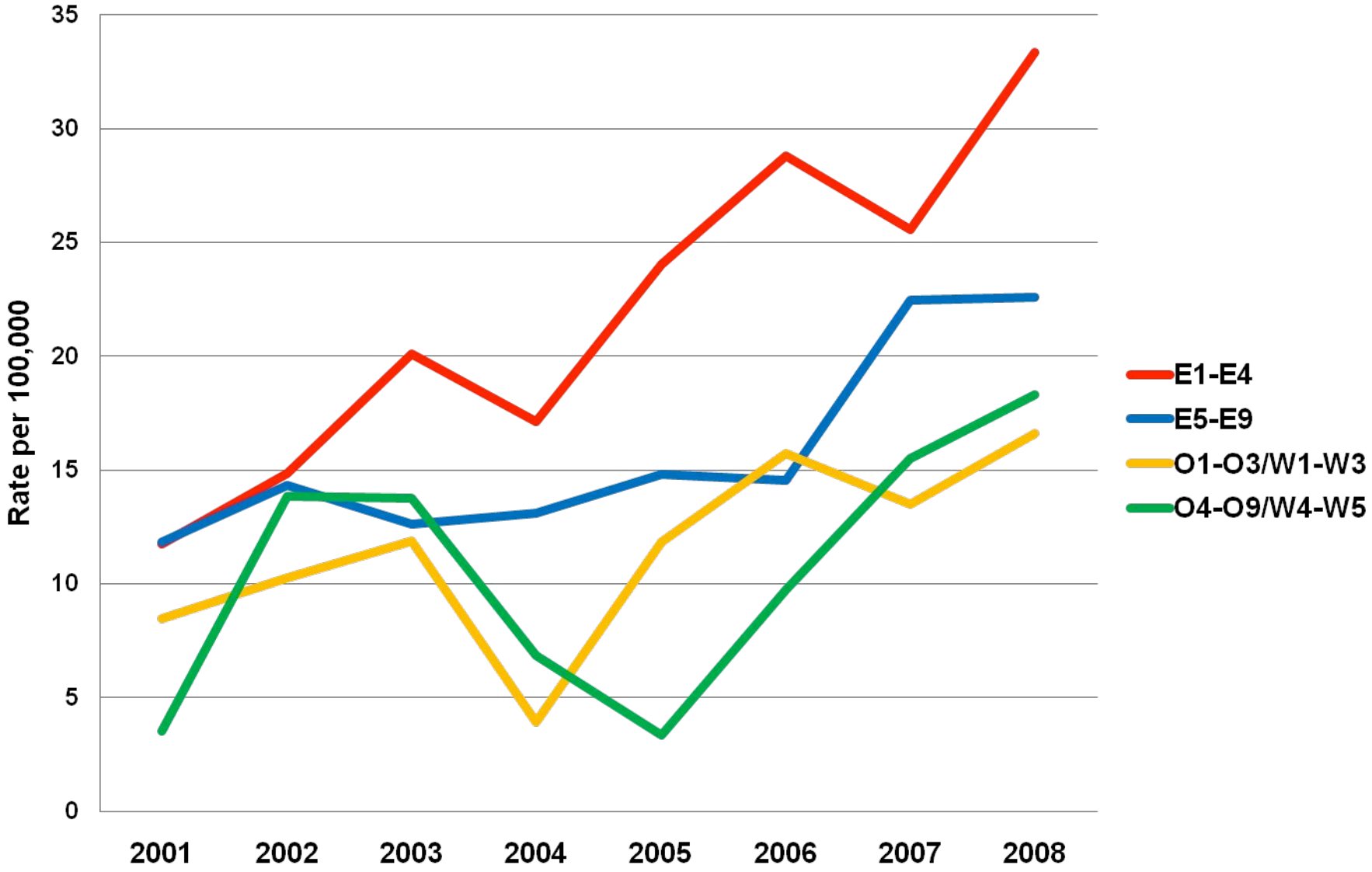
ARMY Suicide Rate Trends, by Age Group



Source: ABHIDE

Prepared by: USACHPPM BSHOP

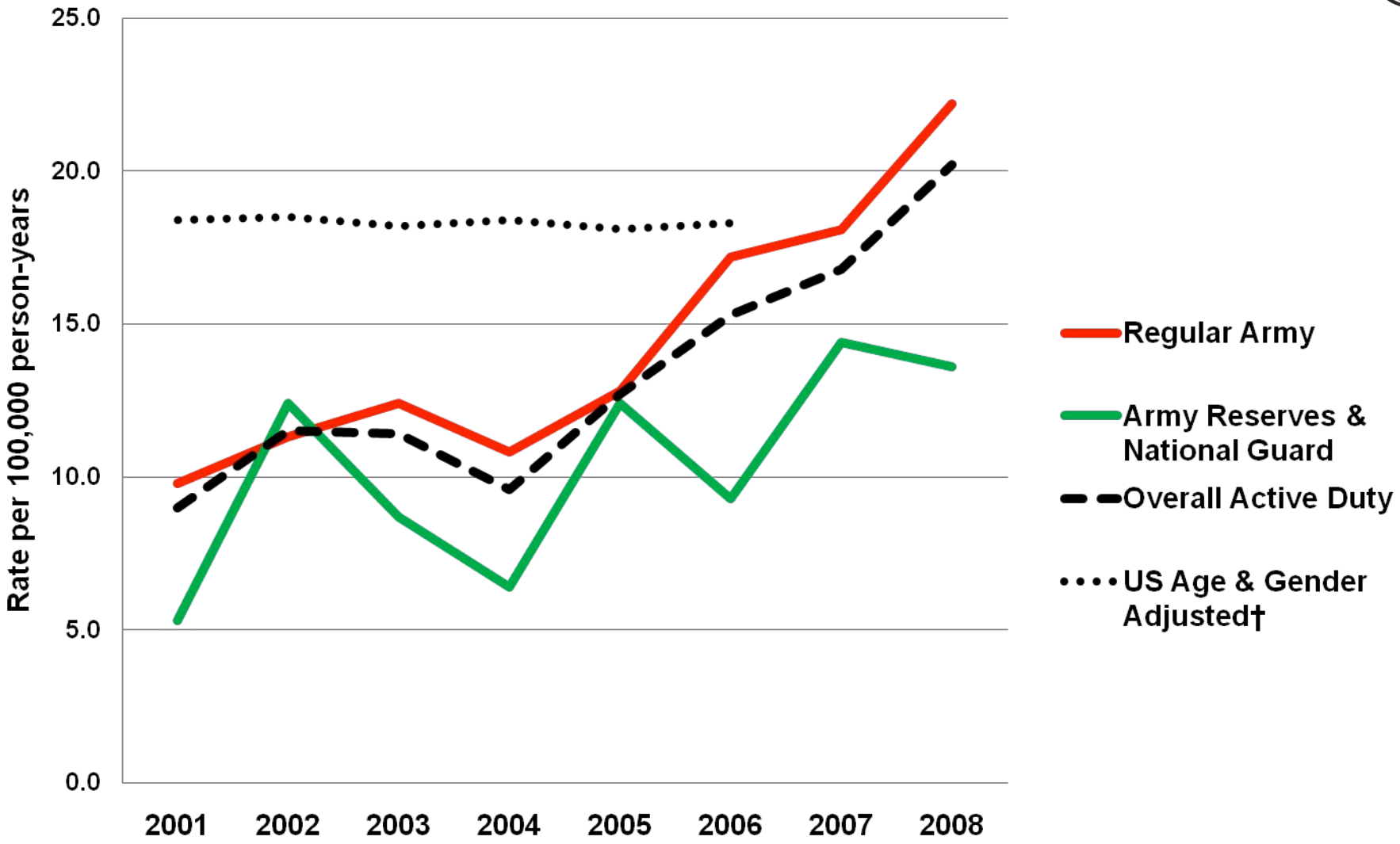
Army Suicide Rate Trends, by Rank



Source: ABHIDE

Prepared by: USACHPPM BSHOP

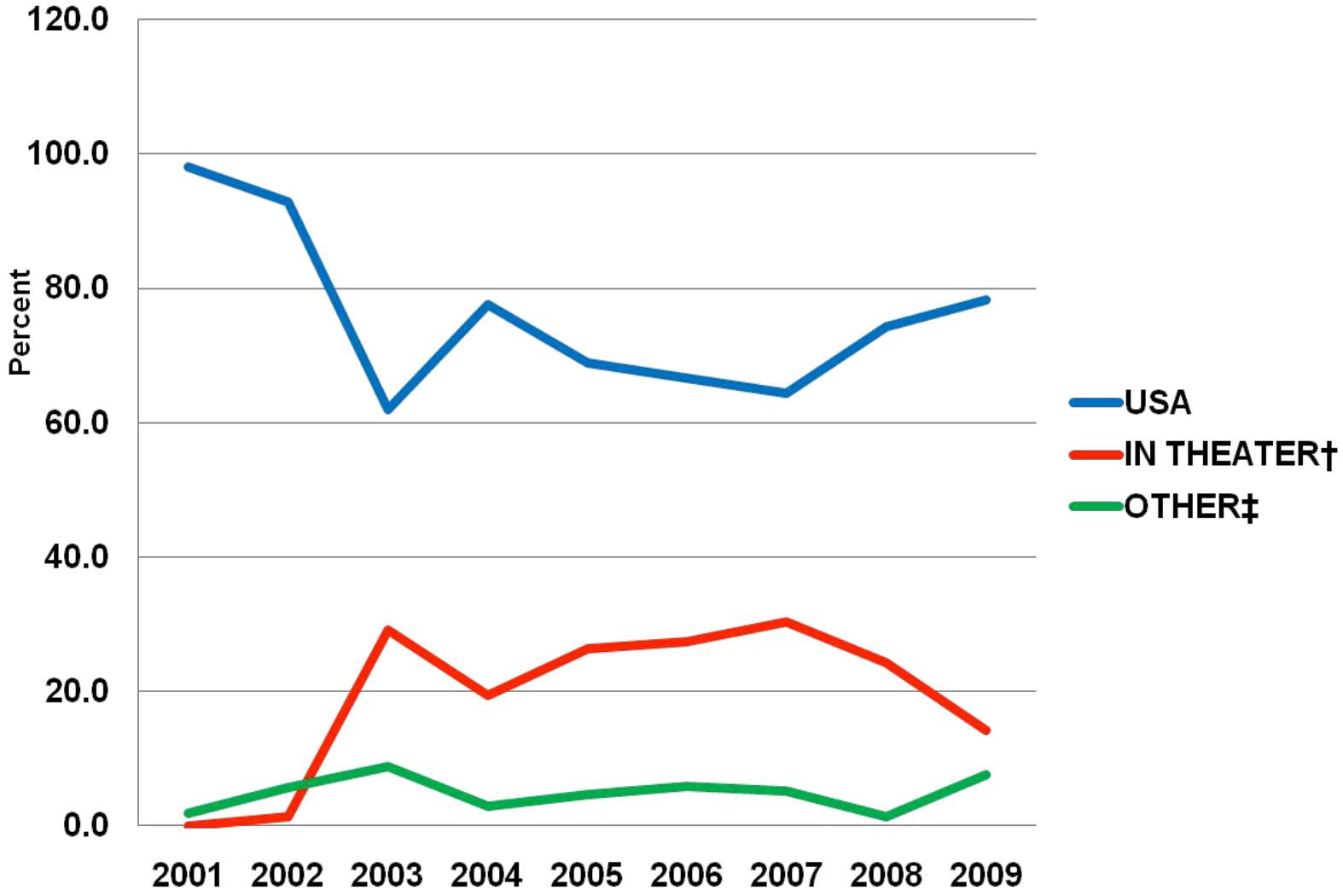
ARMY Suicide Rate Trends, by Component



Source: ABHIDE; Not Available for 2009

Prepared by: USACHPPM BSHOP

US Army Suicides by Place of Death, 2001-2009

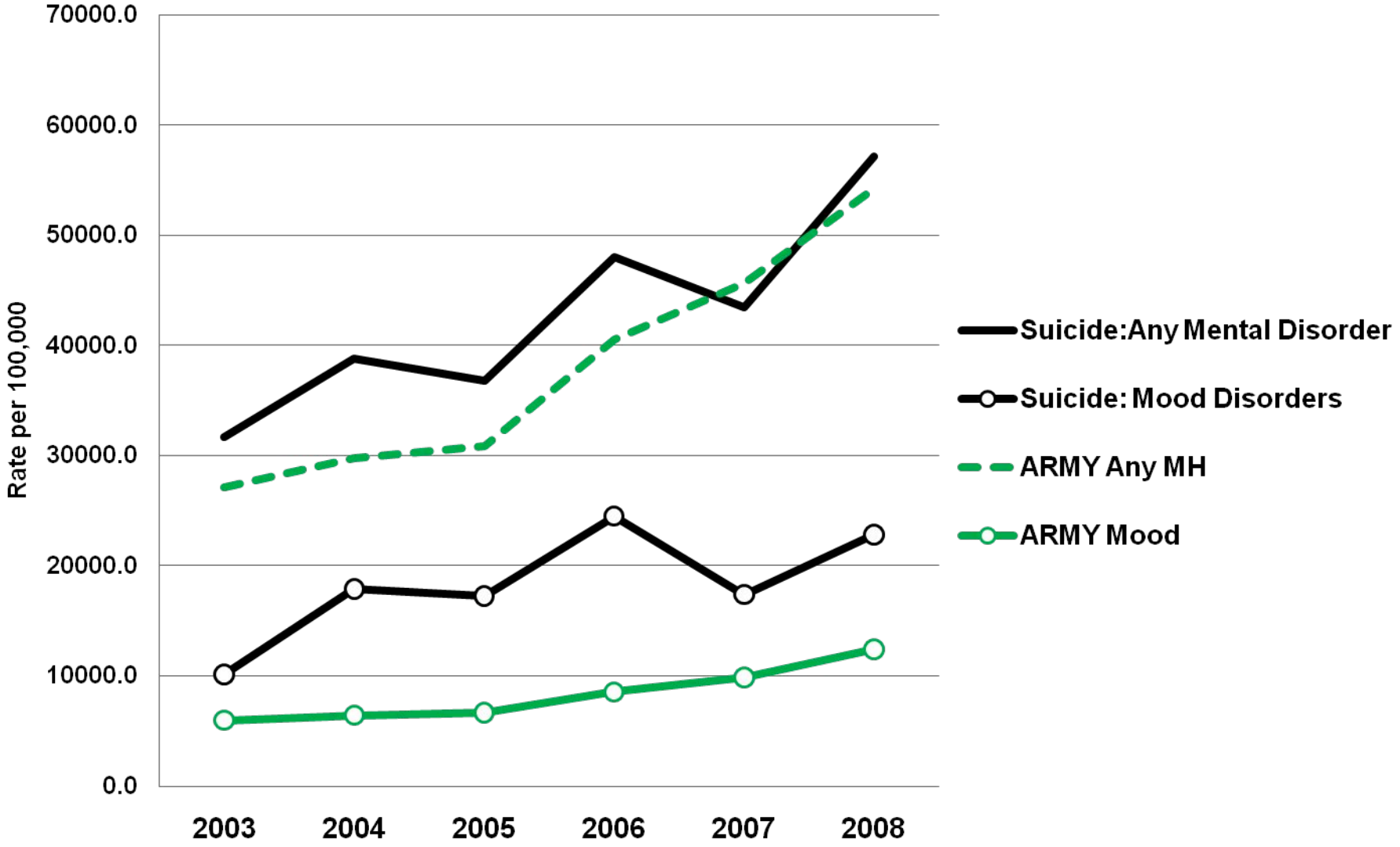


Source: G-1 and AFHSC

‡ OEF/OIF

‡ Africa, Cyprus, Germany, Kosovo, South Korea, Cuba, Italy, Belgium, Djibouti, Mexico, Poland, Thailand, Uzbekistan

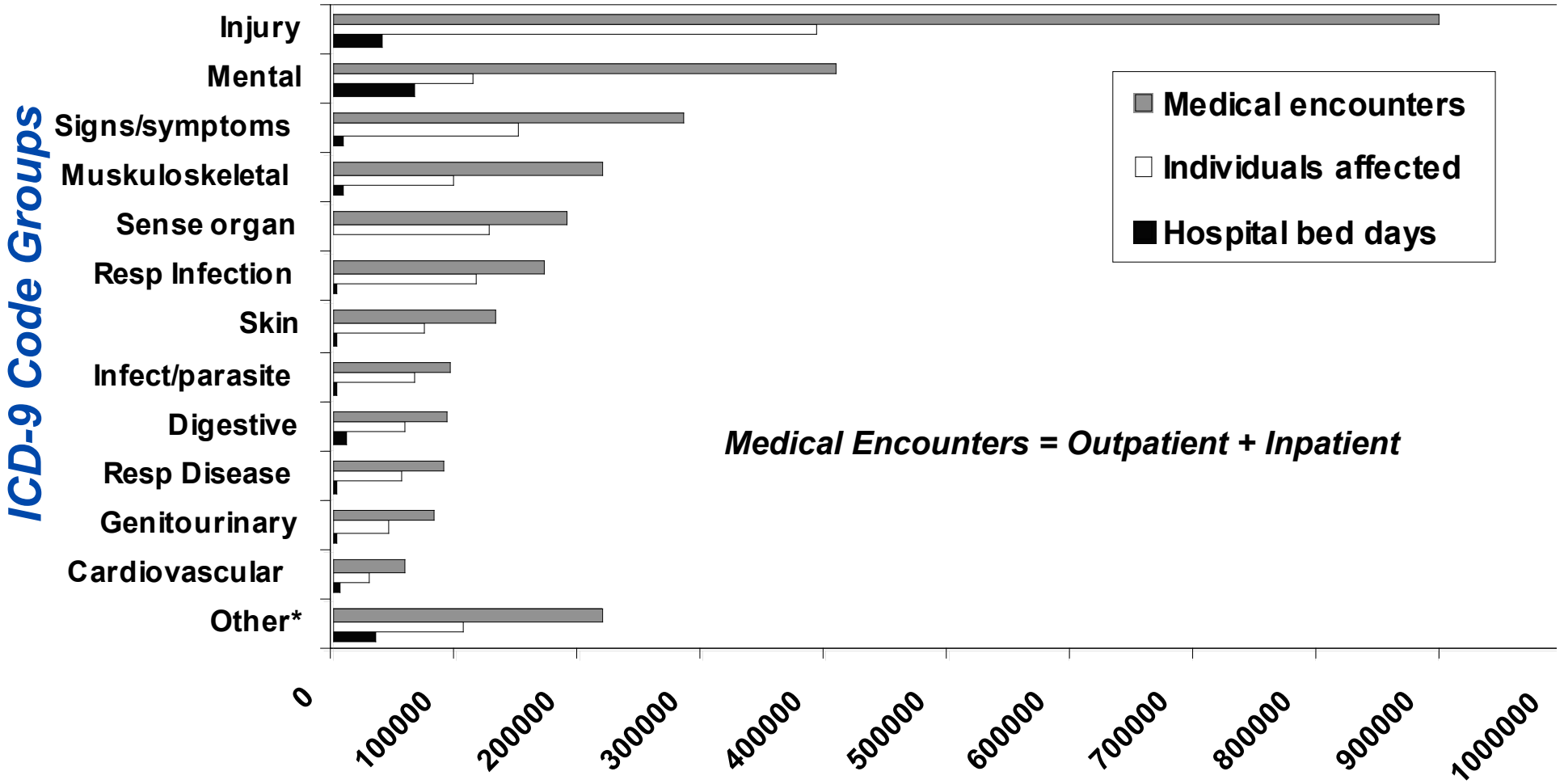
US Army Suicides: Mental Health Trends, 2001-2008



Prepared by: USACHPPM BSHOP

Source: ABHIDE & DMED

Burden of Injuries and Diseases
U.S. Army active duty, 2007



Medical Encounters/ Individuals Affected

**Includes all ICD-9 codes groups with less than 50,000 medical encounters*

Prepared by: USACHPPM BSHOP

Source: Defense Medical Surveillance System, Jul08

Past Suicide Mitigation Approaches

- Analysis of Incident Suicides
  - DOD Suicide Event Report (DODSER)
  - Epidemiologic Consultations (EPICONS)
- Clinical interventions to identify and treat high risk individuals
  - PDHA/PDHRA Screening
  - Respect.mil training for providers
- Training Soldiers, Leaders and Family Members to recognize and respond
  - ASSIST
  - ACE
  - Battlemind
  - Beyond the Front
  - Stand-Down Training

Suicide Awareness Training

- State-of-the-art universal suicide prevention effort involving a multidisciplinary approach.
- The Army's suicide awareness and training efforts represent several components
  - An educational program based on the "ACE" acronym that provides Soldiers behavioral-based training to help a fellow Soldier in need
  - An interactive training video entitled, "Beyond the Front" in which Soldiers experience firsthand the impact their actions can have when assisting a Soldier who is suicidal. All Soldiers received this training Feb-March 2009.
  - "Shoulder to Shoulder" chain teach March to July 2009.
- New Army Suicide Prevention Task Force
- Pending DoD Suicide Prevention Task Force

Changing Our Perspective of Suicide

"The Army's charter is more about holistically improving the physical, mental, and spiritual health of our Soldiers and their families than solely focusing on suicide prevention. If we do the first, we are convinced that the second will happen."

GEN Peter W. Chiarelli, VCSA, 29 March 2009

Army vice chief addresses suicide rate across Army

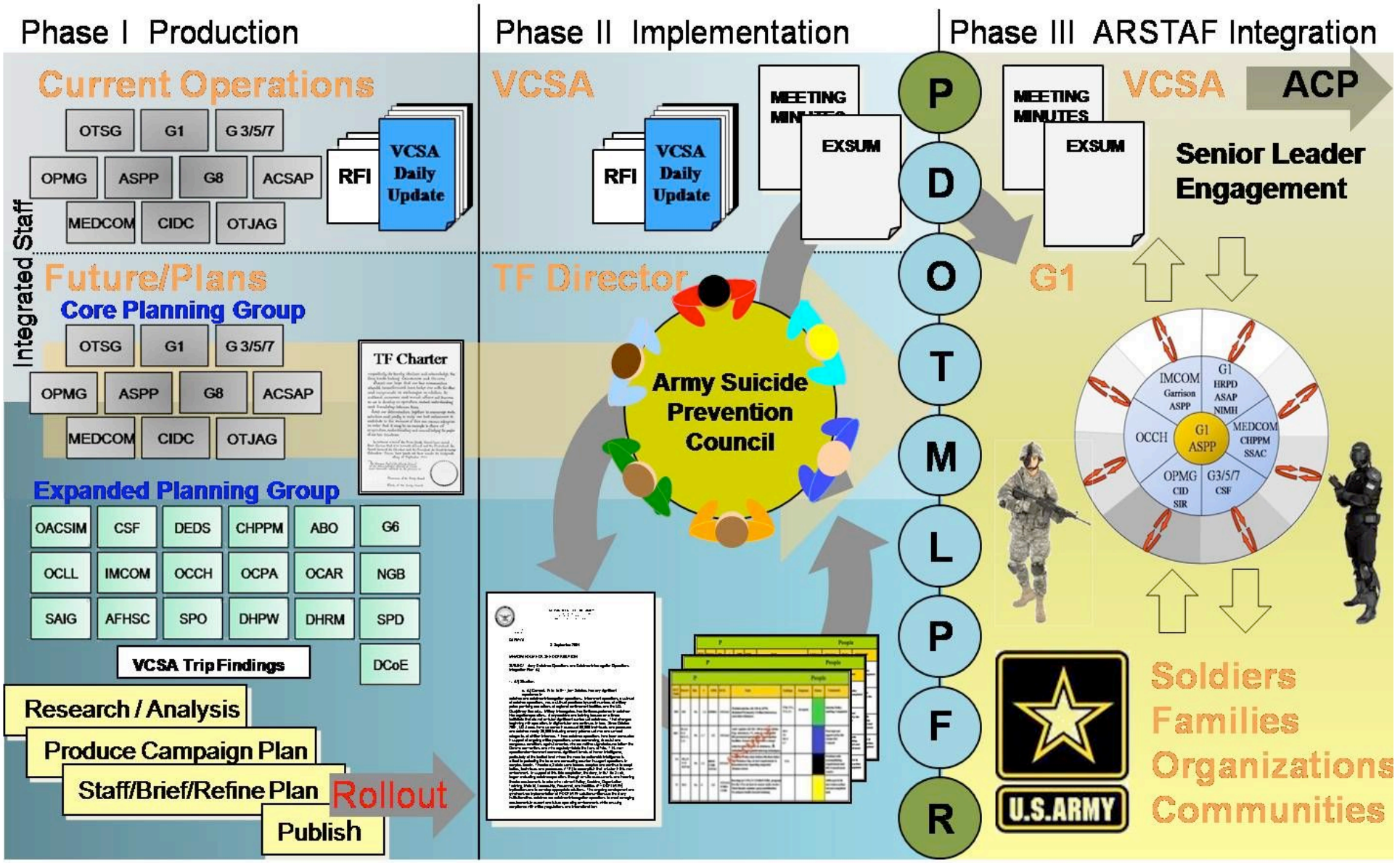
Mar 31

By **Eve Meinhardt**

Photo credit ***Eve Meinhardt***

Gen. Peter W. Chiarelli, Army vice chief of staff, speaks at Fort Bragg, N.C., March 25, during his visit to look at the implementation of suicide prevention training and best practices.

Army Suicide Prevention Campaign



Suicide Risk Assessment

Behavioral health care providers and key unit members play an active role in the management and treatment of suicidal Soldiers.

- Improve suicide assessment and evaluation (primary care, behavioral health clinic, VA).
  - Establish best clinical practices and standards of care
  - Train behavioral health and medical care providers at all levels
  - Conduct routine reviews and audits to ensure compliance
- Improve engagement and retention in behavioral health care employing motivational interviewing techniques.
- Involve close family members and friends where ever possible.
- Inform and educate unit leaders as appropriate.
- Enhanced focus on postvention efforts (maintain vigilance post crisis), including cases of completed suicides.

Evidence-Based Treatments

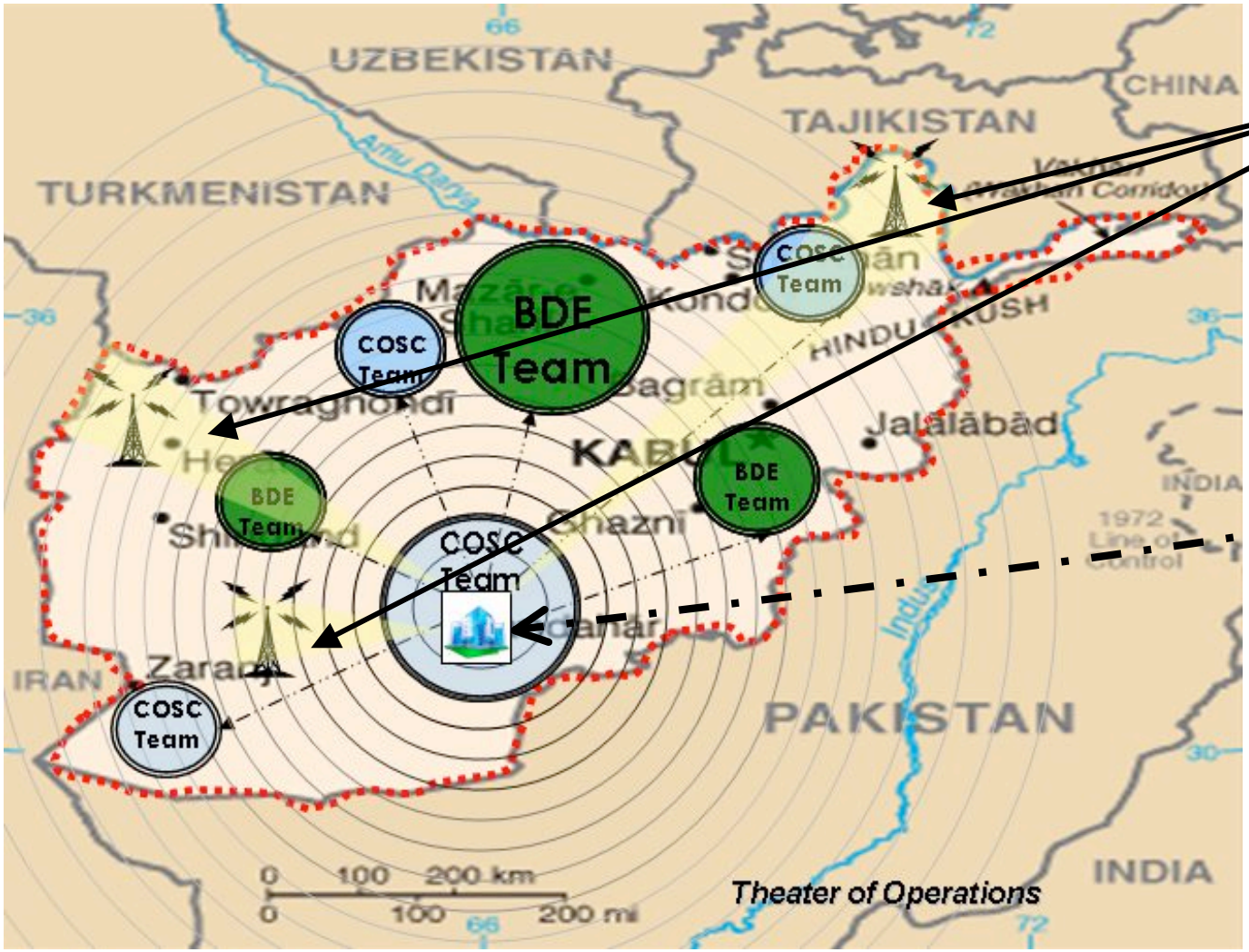
Adapt evidence-based treatments for suicidality among Soldiers.

- Two generally accepted psychotherapeutic approaches for treating suicidal patients:
  - Cognitive behavioral therapy (based on social learning theory that focuses on changing distorted beliefs and cognitions about self and the world).
  - Dialectical behavioral therapy (a cognitive behavioral approach that includes social skills and problem solving).
- Treat the underlying behavioral health disorder.

Population-Based Strategies for Suicide Mitigation

- *The best evidence-based suicide mitigation strategies are optimal identification of high-risk groups and treatment of suicidal individuals*
- "Gatekeeper" strategies, which identify high risk individuals, may decrease suicides if identification leads to appropriate clinical management or reduction of stress
- Recent literature suggests interventions which decrease risk-factors in the population may impact suicide rates
- Current Army suicide mitigation programs focus on identification/treatment of high risk individuals, not groups.
- Incorporating strategies to mitigate risk-factors in the general Army population and among specific high risk groups may decrease risk for suicide in the population

PH Telehealth in the Operational Environment



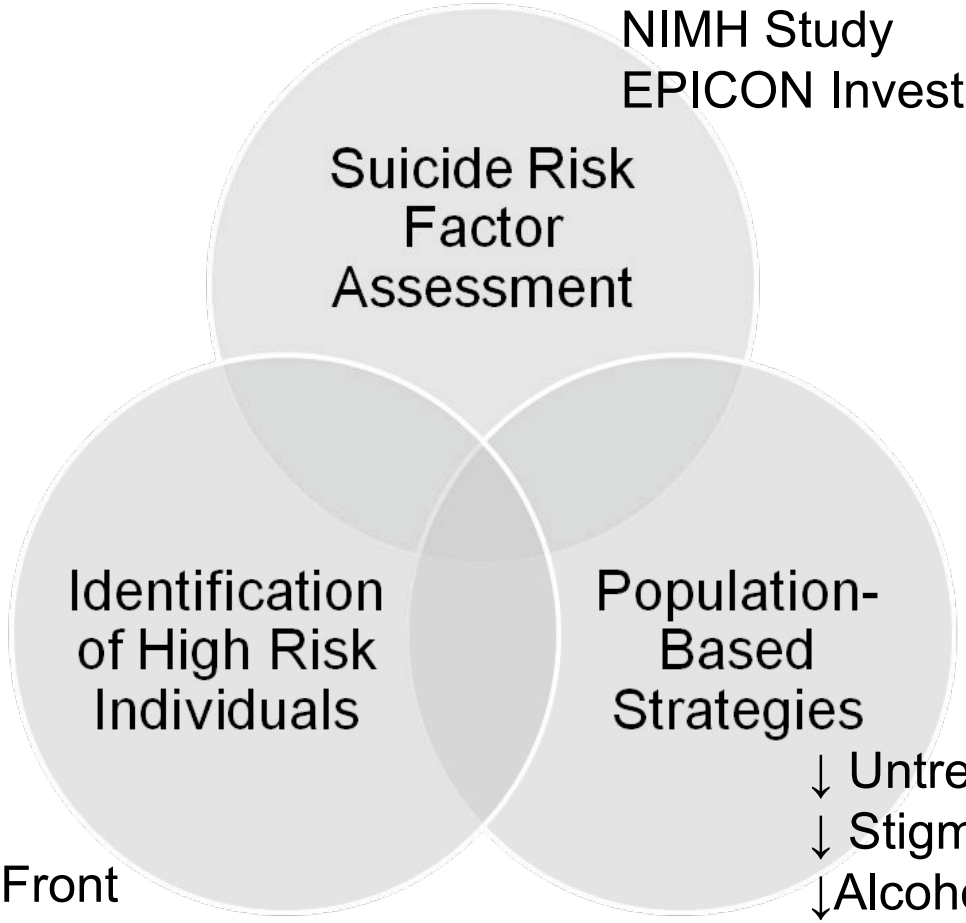
Dispersed / Remote Locations

LEGEND

- Telehealth connection
- Telehealth Site
- COSC HQ / Tele BH Team
- Theater of Operation
- Lines of Communication

Multi-dimensional Suicide Prevention Strategy

Strategic Analysis Cell
NIMH Study
EPICON Investigations

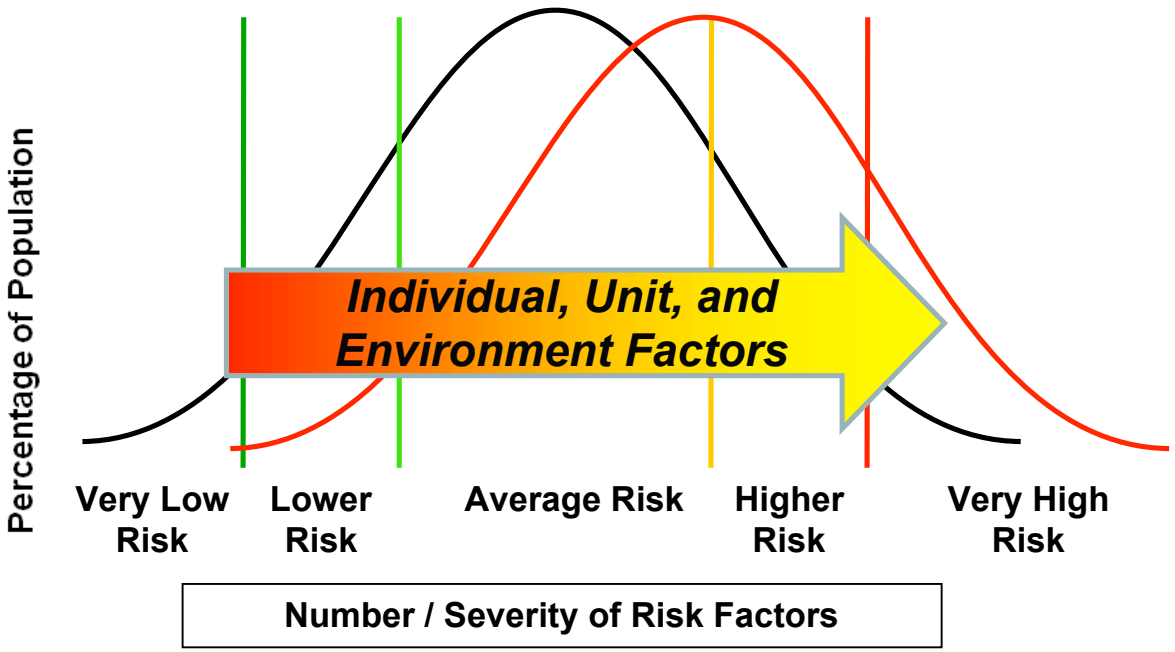


Treatment
ACE
ASSIST
Beyond the Front
Battlemind
Respect.mil

↓ Untreated/Undertreated BH
↓ Stigma to Seeking Care
↓Alcohol/Drug abuse
↓ Relationship/Family Problem
↓ Legal/Financial Issues
↑ Resilience

Causal Factors

- **Multiple individual, unit, and community factors appear to have converged to shift the population risk to the right**
- **This would put more Soldiers in the Very High Risk category making clustering more likely**



Facts

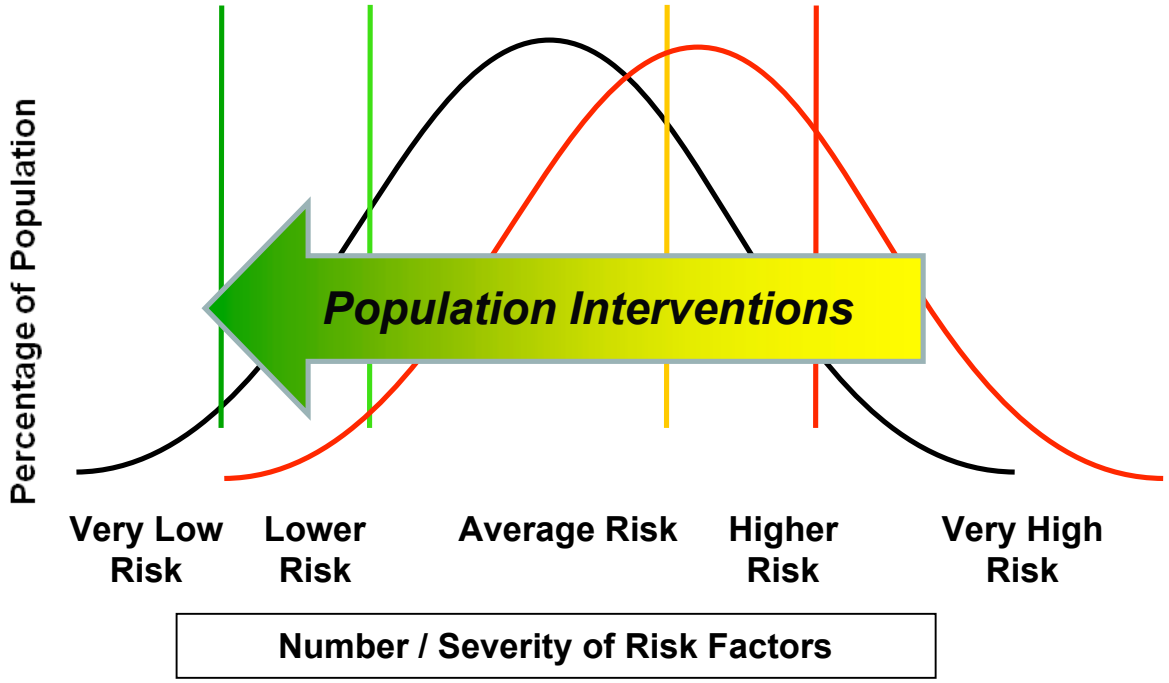
Individual
- Criminality/Misconduct
- Alcohol / Drugs
- BH Issues (untreated/under-treated)

Unit
- Turnover
- Leadership (Stigma)
- Training / Skills

Environment
- Turbulence
- Family Stress / Deployment
- Community
- Stigma

Factors to Consider

- **While it is important to identify and help individual Soldiers, the biggest impact will come from programs that shift the overall population risk back to the left**
- **Effective medical treatment can prevent individuals from increasing in risk or decrease their risk, but it cannot shift overall population risk very much**



Army Campaign Plan:

- Health Promotion, Risk Reduction, and Suicide Prevention
- Increase Resiliency
- Decrease Alcohol/Drug Abuse
- Decrease Untreated/Undertreated BH
- Decrease Stigma to Seeking Care
- Decrease Relationship/Family Problems
- Decrease Legal/Financial Issues

Installation:

- Reintegration (Plus)
  - Mobile Behavioral Health Teams
  - Mental Toughness Training
  - Resiliency Training
  - Military Family Life Consultants
  - Decompression Reintegration
  - Warrior Adventure Quest
- Consistent Stigma Reduction themes

Continuing Challenges and Way Ahead

Continuing Challenges

- **Array of services**
- **Stigma**
- **Increasing number of Soldiers with mTBI and PTSD**
- **Shortage of Providers**
- **Remote locations**
- **High OPTEMO**
- **Public Perceptions**
- **Suicide rate**
- **Lack of providers who accept TRICARE**
- **Provider fatigue**
- **Warrior Transition Office Soldiers**
- **Reintegration**
- **Guard/Reserve Soldiers**
- **Pain Control**

Way Ahead

- **Integration of services**
- **Policy changes, education**
- **Integration with primary care, other portals of care**
- **Grow number of providers**
- **Tele-Behavioral Health**
- **Optimal Reintegration**
- **Strategic communication**
- **Re-engineered suicide prevention**
- **Actively recruit providers to TRICARE**
- **Provider resiliency training**
- **Mental health organic in WTUs**
- **Enhanced reintegration strategies**
- **Mental health organic in Guard/Reserve**
- **Updated Clinical Practice Guidelines in Pain**

UNIVERSITY OF PRISHTINA
THE REPUBLIC OF KOSOVO

Ferid Agani MD, PhD
Mytaher Haskuka Phd; Bajram Maxhuni MD

CORRELATION OF SUICIDAL THOUGHTS, PTSD, EMOTIONAL DISTRESS AND DEPRESSION

NATO "Wounds of War" Conference
18 – 21 October, 2006
Südkämten Austria

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INTRODUCTION

- APARTHEID
- CHRONIC PSYCHOSOCIAL STRES
- WAR RELATED TRAUMA'S
- ANXIETY, EMOTIONAL DISTRESS, POST-TRAUMATIC STRESS DISORDER (PTSD)

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HARD RECOVERY

- 15% IN EXTREME POVERTY
- 40% UNEMPLOYED
- MORE THAN 2000 MISSING PERSONS

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TRANSITION

- COMPLEX POLITICAL SITUATION
- SLOW ECONOMIC DEVELOPMENT
- RAPID CULTURAL TRANSITION

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SUICIDES

- GROWING TREND
  - 1961: 1.2 / 100.000
  - 1977: 1.6
  - 1981: 2.2
  - 2005: 2.93
  - 2008: 3.96

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RESEARCH

- CDC, ATLANTA, USA
  - OCTOBER 1999
  - MAY 2000
- PTSD PREVALENCE [17.1%*, 25%**]

[*JAMA (2000). 284:569-577]
[** JTS (2003). 16: 4. 351-60]

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AIM

- COMPARATIVE FOLLOW UP STUDY
- 15 YEARS AND OLDER
- BIOLOGICAL AND PSYCHOSOCIAL CONTEXT OF SUICIDES
- PREVALENCE OF SUICIDAL THOUGHTS

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OBJECTIVE

- REPRESENTATIVE SAMPLE
- VULNERABLE GROUPS
- CORRELATION
- DEMOGRAPHIC, SOCIAL, MIGRATION, AND CLINICAL (ANXIETY, DEPRESSION, PTSD) CHARCTERISTICS

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MATERIAL

- POPULATION STUDY
- 1219 CITIZENS IN THE WHOLE TERRITORY OF KOSOVO 15 YEARS AND OLDER (1161 VALID QUESTIONNAIRES)

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METHODOLOGY

- RANDOM TWO-STAGE CLUSTER SAMPLING METHODOLOGY ALREADY USED IN THE EARLIER TWO CDC STUDIES
- A TOTAL OF 30 CLUSTERS WITH AT LEAST 40 ADULTS FOR 95% CONFIDENCE INTERVAL

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INSTRUMENTS

- GHQ-28: NON SPECIFIC PSYCHIATRIC MORBIDITY
- HTQ: TRAUMATIC EVENTS – PTSD
- MOS -20: SOCIAL FUNCTIONING AND PSYCHIATRIC MORBIDITY
- HSCL-25: EMOTIONAL DISTRES (ANXIETY) AND DEPRESSION

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DATA ANALYSES

- MICROSOFT OFFICE EXCEL 2003
- SPSS 12 STATISTICAL PACKAGE
- “ANOVA” ANALYSES: $P<0.05$ STATISTICALLY SIGNIFICANT
- FREQUENCIES

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DATA ANALYSES (2)

- CROSSTABS
- COMPARE MEANS
- MULTIVARIATE ANALYSES – GENERAL LINEAR MODEL

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RESULTS – DEMOGRAPHY

Characteristic	Number	Proportion (%)
Ethnicity		
Albanian	1,037	83.9
Serb	78	6.7
Turk	5	0.4
Bosnian	3	0.3
Roma, Ashkalia, Egyptian (RAE)	38	3.3
Location		
Rural	620	53.4
Urban	541	46.6
Sex		
Female	705	60.7
Male	456	39.3
Age group		
15 – 34 years	569	49.0
35-54 years	344	29.6
55-64 years	103	8.9
> 64 years	145	12.5
Region		
Prishtina	413	35.6
Mitrovica	159	13.7
Gjakova	39	3.4
Peja	92	7.9
Prizren	264	22.7
Gjilan	116	10.0
Ferizaj	78	6.7
TOTAL	1,161	100.0

RESULTS – SOCIAL FACTORS

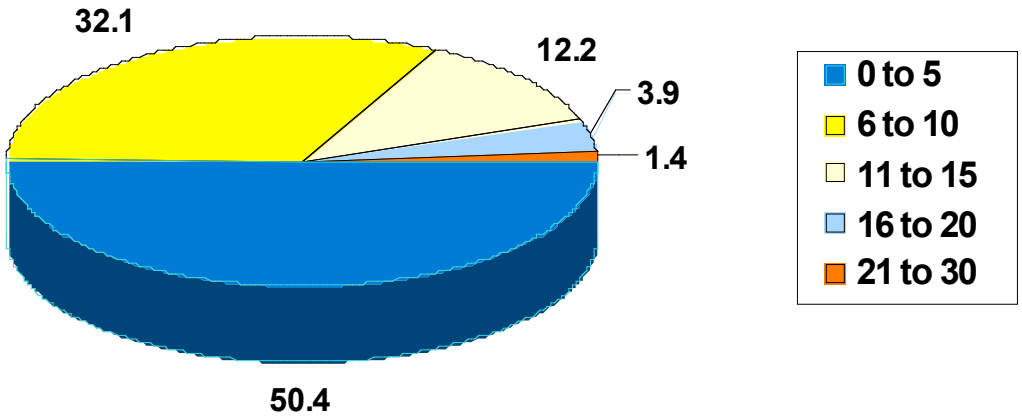
Characteristic	Number	Proportion (%)
Education		
Less than primary	167	14.4
Primary	476	41.0
Secondary	412	35.5
University	106	9.1
Marital status		
Married	708	61.0
Single	380	32.7
Widowed	38	5.9
Divorced	5	0.4
Employment		
Yes	180	15.5
No	981	84.5
TOTAL	1,161	100.0

RESULTS – MIGRATION

Characteristic	Number	Proportion (%)
Become Refugee		
Yes	531	45.7
No	630	54.3
Displaced within Kosovo		
Yes	539	46.0
No	622	54.0
Country went as a refugee		
Macedonia	191	16.5
Albania	212	18.3
Montenegro	27	2.3
Other	101	8.7
Refugee duration outside Kosovo		
0 – 7 days	18	1.6
7 – 30 days	31	2.7
More than 30 days	482	41.5
Displacement duration within Kosovo		
0 – 7 days	132	11.4
7 – 30 days	86	7.4
More than 30 days	321	27.6
Displaced currently		
Yes	95	8.2
No	1066	91.8
Since Sept. 1999, have you moved at all		
Yes	234	20.2
No	927	79.8
If Yes form another country to Kosovo		
Yes	117	10.1
No	117	10.1
Within Kosovo		
Yes	117	10.1
No	117	10.1
From rural to city (>10.000)		
Yes	115	9.9
No	1,046	

RESULTS – TRAUMATIC EVENTS

Trauma events Number	Experienced



RESULTS – MENTAL HEALTH

Mental Health Status (Score Range)	
GHQ -28 (1-7 for all subscales)	**Mean (SE)**
Somatic symptoms	2.58 (0.07)
Anxiety and insomnia	2.80 (0.07)
Social dysfunction	1.54 (0.06)
Symptoms of severe depression	1.17 (0.06)
TOTAL (0 -28)	7.91 (0.20)
MOS-20 (0-100 for all subscales)	**Mean (SE)**
General health perception	49.94 (0.76)
Mental health status	55.48 (0.66)
Bodily pain	63.47 (0.96)
Physical functioning status	72.68 (0.98)
Social functioning	47.15 (1.40)
Role functioning	51.27 (0.81)
HTQ Symptoms	**% (SE)**
Total PTSD prevalence %	22.05 (0.01)
HSCL-25 Symptoms	**% (SE)**
Total Depression prevalence (1.1 -25) %	41.76 (0.01)
Total Emotional Distress prevalence (1.0 -25) %	43.10 (0.01)

MENTAL HEALTH (3)

- VULNERABLE CATEGORIES
  - UNEMPLOYED
  - PREVIOUSLY MENTALLY ILL
  - THOSE WHO EXPERENCED RAPE & MULTIPLE TRAUMATIC EVENTS
  - KILLED FAMILY MEMBER OR A FRIEND DURING THE WAR

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RESULTS – SOCIAL FUNCTIONING

- LOWER SOCIAL FUNCTIONING
- VULNERABLE GROUPS
  - LIVING IN RURAL REGIONS
  - MALES
  - ELDERLY

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RESULTS – SOCIAL FUNCTIONING

- VULNERABLE GROUPS (CONT.)
  - DISPLACED MORE THAN 30 DAYS
  - PREVIOUSLY MENTALLY ILL
  - THOSE WHO EXPERIENCED RAPE &
  - MULTIPLE TRAUMATIC EVENTS

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PTSD, DEPRESSION, EMOTIONAL DISTRESS

- PTSD PREVALENCE – 22%
- LOW DROP; 2000 STUDY: 25.0%
- 41.76% PREVALENCE OF DEPRESSION
- 43.1% PREVALENCE OF ANXIETY
- IN ACCORDANCE WITH CLINICAL ESTIMATIONS

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VULNERABLE GROUPS

- ALBANIAN COMMUNITY
- LIVING IN RURAL AREAS
- UNEMPLOYED
- PREVIOUSLY MENTALLY ILL
- THOSE WHO EXPERIENCED RAPE &
- MULTIPLE TRAUMATIC EVENTS

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SUICIDAL THOUGHTS

GHQ -28 (D2, D3, D4, D6 dhe D7)	
Keni ndjenjen se jeta është plotësisht e pavlerë	**%**
Jo	56.5
Jo më shumë se zakonisht	19.1
Pak më shumë se zakonisht	18.0
Shumë më tepër se zakonisht	6.3
Keni përshtypjen se nuk ia vlenë të jetohet	**%**
Jo	63.3
Jo më shumë se zakonisht	16.3
Pak më shumë se zakonisht	14.3
Shumë më tepër se zakonisht	6.2
Keni menduar për mundësinë që ta vrisni vetën	**%**
Jo	88.6
Jo më shumë se zakonisht	5.8
Pak më shumë se zakonisht	3.7
Shumë më tepër se zakonisht	1.8
Keni dëshiruar të jeni i/e vdekur dhe larg të gjithave	**%**
Jo	78.5
Jo më shumë se zakonisht	10.6
Pak më shumë se zakonisht	7.4
Shumë më tepër se zakonisht	3.5
Ju vjen vazhdimisht ndërmend idea që t'ia merrni jetën vetes?	**%**
Jo	83.6
Jo më shumë se zakonisht	9.5
Pak më shumë se zakonisht	5.8
Shumë më tepër se zakonisht	1.0
HSCL-25 (pyetja 20)	
Keni mendime për t'i dhënë fund jetës suaj	**%**
Aspak	88.0
Pak	6.9
Mjaft	2.7
Shumë	2.4

CORRELATION WITH DEMOGRAPHIC & TRAUMA VARIABLES

GHQ-28			
VARIABLA	**Mesatarja (1 – 4)***	**Devijimi Standard**	**"p" Vlera**
Përkatësia kombëtare			
Shqiptar	1.40	0.57	
Serb	1.36	0.42	0.786
Tjerë	1.37	0.48	
TOTAL	1.39	0.56	
Vendbanimi			
Rural	1.46	0.60	0.000
Urban	1.32	0.49	
Gjinia			
Femër	1.39	0.54	0.883
Mashkull	1.39	0.58	
Grup -mosha			
15 - 34 vjeçar	1.41	0.59	
35 - 54 vjeçar	1.41	0.58	
55 - 64 vjeçar	1.33	0.43	0.422
> 64 vjeçar	1.35	0.46	
Regjioni			
Prishtinë	1.40	0.59	
Mitrovicë	1.27	0.45	
Gjakovë	2.08	0.60	
Pejë	1.41	0.59	0.000
Prizren	1.39	0.55	
Gjilan	1.36	0.46	
Ferizaj	1.33	0.47	
Arsimimi			
Më pak se sh.fillor	1.40	0.50	
Fillor	1.41	0.55	0.730
Sh. e mesme	1.39	0.61	
Universitet	1.34	0.48	
Statusi martesor			
Martuar	1.39	0.56	
Shkurorzuar	1.57	0.85	0.902
I/e ve	1.40	0.47	
Jo i/e martuar	1.40	0.57	
Anëtarë të familjes apo shok të vrarë			
Po	1.60	0.53	0.000
Jo	1.36	0.71	
Numri i ngjarjeve traumatike			
0 - 5	1.29	0.44	
6 - 10	1.46	0.59	
11 - 15	1.54	0.68	0.000
16 - 20	1.70	0.85	
21 - 30	1.51	0.60	

AVERAGE OF PREOCCUPATION WITH SUICIDAL THOUGHTS ACCORDING TO CATEGORIES IN GHQ-28, HSCL-25 & MOS-20

GHQ-28 (0-28)		
Kategoritë	**Mesatarja (1 – 4)**	**Vlera "p"**
0 – 5 (morbiditeti jospecifik psikiatrik nuk është prezent)	1.32	
6 – 11 (është prezent morbiditeti jospecifik psikiatrik i moderuar)	1.33	0.000
≤ 12 (është prezent morbiditeti jospecifik psikiatrik substancial)	1.89	
HSCL-25		
Kategoritë	**Mesatarja (1 – 4)**	**Vlera "p"**
>1.75 (është prezent depresioni)	1.71	
<1.75 (nuk është prezent depresioni)	1.16	0.000
>1.75 (është prezent distresi emocional)	1.70	
<1.75 (nuk është prezent distresi emocional)	1.17	0.000
MOS-20		
Kategoritë	**Mesatarja (1 – 4)**	**Vlera "p"**
<52 (shëndeti mendor – janë prezente çrregullimet psikiatrike)	1.60	
>52 (shëndeti mendor - nuk janë prezente çrregullimet psikiatrike)	1.26	0.000
<72 (funksionimi social i dobët)	1.63	
>72 (funksio nimi social i mirë)	1.42	0.000

SUICIDAL THOUGHTS (GHQ – 28 & HSCL – 25)

- 6% HAVE A FEELING THAT IS WORTHELSS LIVING
- 1.8% THOUGHT TO KILL THEMSELVES
- 3.5% WISH TO BE DEAD

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SUICIDAL THOUGHTS (2)

- 1% HAS SUICIDE RUMINATIONS
- 2.4% THOUGHT ABOUT SUICIDE AS OPTION FOR SOLUTION OF PROBLEMS

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SUICIDAL THOUGHTS (3)

- NO DIFFERENCES ON ETHNIC OR GENDER BASES
- VULNERABLE GROUPS
  - PEOPLE IN RURAL AREAS
  - YOUTH
  - KILLED FAMILY MEMBER
  - MULTIPLE TRAUMATIC EXPERIENCES

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SUICIDAL THOUGHTS (4)

- VULNERABLE GROUPS (CONT.):
  - HIGH NONSPECIFIC PSYCHIATRIC MORBIDITY
  - DEPRESSION
  - EMOTIONAL DISTRESS
  - LOW SOCIAL FUNCTIONING

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CONCLUSIONS

- LONG TERM IMPACT OF A WAR TRAUMA
- MULTIGENERATIONAL EFFECT
- HIGH CO – MORBIDITY OF PTSD, EMOTIONAL DISTRESS AND DEPRESSION

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CONCLUSIONS

- PREOCCUPATION WITH SUICIDAL THOUGHTS WAS SIGNIFICANTLY HIGHER IN PERSONS WITH PTSD, EMOTIONAL DISTRESS, AND/OR DEPRESSION

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CONCLUSIONS

- STATISTICALLY SIGNIFICANT CORRELATION WITH:
  - PEOPLE IN RURAL AREAS
  - YOUTH
  - KILLED FAMILY MEMBER
  - MULTIPLE TRAUMATIC EXPERIENCES

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JU FALEMINDERIT!

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NATO Advanced Research Worksho
WOUNDS OF WAR II
October 18 - 21, Carinthia, Austria
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PSYCHOLOGICAL SCREENING
PROCEDURE FOR RELOCATED
SOLDIERS OF THE AUSTRIAN
ARMED FORCES

Centre For Operations Preparation (COP)

- Department of Austrian Joint Forces Command
- International PfP-Training & Education Centre
- Implementation of Personnel Administration, Logistics & Welfare during PSO
- Dispatch, Repatriation & Rotation of approx. 5000 Soldiers per Year, from 4 Contingents and 10 Military Observer Missions abroad

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Psychology Section / COP

- 2 Military Psychologists
- Psychological Preparation and Pre-Mission Training
- Psychological Care-giving for PSO-Personnel and Relatives during all Phases of Deployment
- Psychological Screening Procedure for relocated Soldiers
- Anonymous After-Deployment-Questionnaire
- Psychological Interview with Homecomers

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Topics of the Psychological Interview 1

- Personal Data / Number of Months & Deployments
- Function / Pers. Resume / Prolonged Impairments
- Occurence of Critical Incidents Onsite or at Home
- In Case of CI -> Homecomer-Check-List (HCL)

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Homecomer-Check-List (HCL)

- Based on German Version of SCL-90-R (Derogatis, 1994)
- 32 Items of Symptoms related to 8 Scales (Somatisation, Depression, Anxiety, Obsessive-Compulsive, Phobic Anxiety, Paranoid Ideation, Aggression, Psychoticism)
- Comparison of Standard Grp (403) vs. Occasion Grp (100)
- Onset of Symptoms: 50% Standard vs. 89% Occasion Grp
- Number of Symptoms: 3.8 Standard vs. 6.9 Occasion Grp
- Intensity of Symptoms: 1.1 Standard vs. 1.3 Occasion Grp

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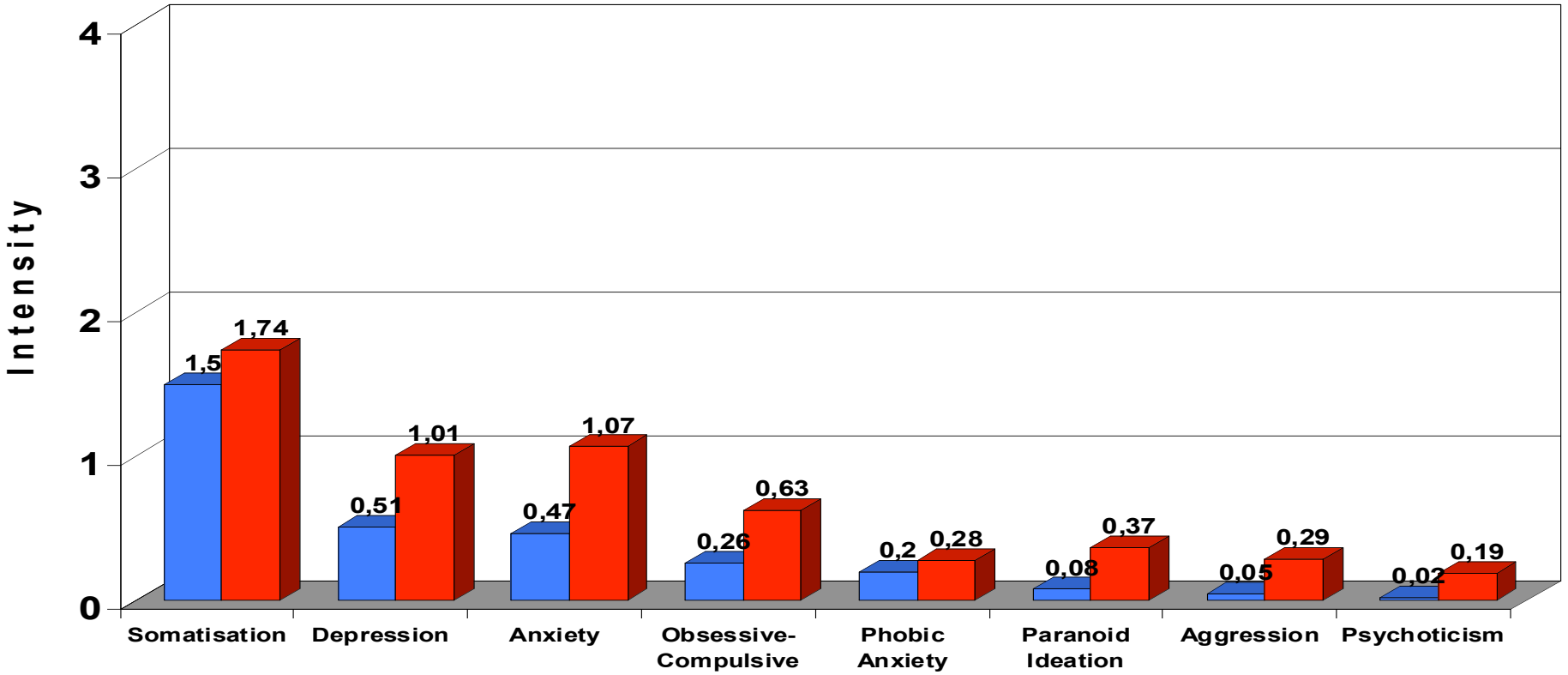
Average Prevalence of Symptoms (HCL)



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Topics of the Psychological Interview 2

- Personal Data / Number of Months & Deployments
- Function / Pers. Resume / Prolonged Impairments
- Occurence of Critical Incidents Onsite or at Home
- In Case of CI -> Homecomer-Check-List (HCL)
- Experiences with Separation from Home
- Future Prospects of Duty resp. Civilian Job at Home
- Preparation & Sensitization for Homecoming

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The Psychological Screening Procedure

- Interview approx. 3 to 5 Minutes per Candidate
- Detailed Exploration and Psychological Support
- 4 Contingents with 8 Rotations per Year
- Approximately 40 to 120 Homecomers per Day
- Additional Military Psychologists from AJFC
- Detailed Psychological Debriefing for MilObs
- Psychological Follow Up Care-Giving

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Clinical Psychological Trauma-Centre

- 2 Clinical & Health Psychologists (CISM, Cognitive & Behavioral Therapy, EMDR)
- For Professional Soldiers, Members of Militia and Deployed Civilian Personnel
- Part of Regional Military Medical Center
- Cooperation with Psychiatric Hospital
- Treatment of Internal & External Clients

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Thank you
for your Attention!