Addressing the Needs of Returning Soldiers and their Families

State of Rhode Island

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Overview

The Vision

Since September 11, 2001, more than 3800 members of the Rhode Island National Guard have been deployed with more deployments expected. As research has demonstrated, our returning soldiers and their families will present new challenges for the health care system. It is clear that although services are available to meet these challenges, there are gaps in the service system. Our active duty personnel, veterans, and their families, who have given much sacrifice for our well being, now require our committed service to them.

We envision a system in which individuals, families, employers, academics, the Veteran's Affairs Medical Center, the Vet Center and other communities and service agencies work cooperatively toward the development of an easily accessible and knowledgeable system of care for veterans, returning soldiers, and their families. Through the development an *interagency coalition*, the State of Rhode Island will make strategic investments for individuals, families and communities most affected by the consequences of combat.

Principles for Success

- Veterans, soldiers, and/or families needing treatment and/or other interventions are identified early, effectively and efficiently.

- Veterans, soldiers, and/or families receive effective assessments and are referred to appropriate levels of care.

- A continuum of services, with supply corresponding to appropriate demand, is available and well managed.

- Assessment, treatment and support services are timely, appropriate and effectively delivered.

Scope of the Problem

Many Soldiers and Families Struggle with Deployment

Thousands of military families are coping with the dangers and sacrifices of deployments in Afghanistan and Iraq. Deployment can be a difficult time, for both the adults being deployed and the families they are leaving behind. Children face a host of special issues when one or both of their parents are deployed.

- Deployment and family separations have become the dominant aspects of 21st Century military service and military family life (Killebrew, 2004).

- A large proportion of the persons deployed in Iraq are members of the National Guard and military reservists. Unlike active-duty soldiers, these individuals are civilians who are not steeped in military culture; they reside in the community instead of on military bases; they did not volunteer for full-time service; and they did not expect to be serving in serving in a war zone. As a result, these individuals may suffer serious consequences including adverse reactions to the traumatic stress of war, and disruption of marriages, families and work life (Hoge et al., 2004).

- Families of deployed guardsmen and reservists face challenges beyond those of active-duty families. Guardsmen and reservists generally do not have the built-in support system that comes from living in or around a big military base with lots of other families in the same boat.

- The changing composition of today's military, especially the increase in married personnel and the influx of female service members, and active duty single parents, has created concerns about child care within the family (Drummet, Coleman & Cable, 2003).

- During separation, children often display minor to serious behavior problems, including anxiety, sleep disturbances, and an increase in physical ailments (Drummet, Coleman & Cable, 2003; Ursano & Norwood, 1996).

- When one parent is deployed, the remaining parent is likely to encounter separation strain, loneliness, role overload, role shifts, financial concerns, changes in community support, increased parenting demands and frustration with the military bureaucracy (Bennis, 2004; Vormbrock, 1993). This may progress to anger, anxiety, and depression (Fisher McNulty, 2005).

- Separation can create boundary ambiguity, a situation in which the family becomes unclear about which roles each member plays (Boss, 1980). Once resolved, family members assuming new responsibilities may be reluctant to relinquish them upon return of the soldier (Riggs, 1990).

- Divorce rates for all branches of the armed services have increased since 2004 with rates being significantly higher for military women than for men (Jowers & Cavallaro, 2005).

Many Returning Soldiers Struggle with Reunification with Family Members

Many armed forces veterans and their families struggle to re-socialize into relationships, parenting, education and civilian employment – especially after extended exposure to a combat environment. Available data on Iraq an/Afghan Veterans and the documented readjustment problems that have faced past generations of veterans and their families illustrate an alarming problem.

- Despite the best efforts of the military, VA and numerous other providers, statistics show that many veterans and their families struggle with mental illness, substance abuse, homelessness, family and employment problems after leaving the military.

- Homecoming and subsequent interpersonal functioning is often difficult for the returning soldier, especially if he/she was physically wounded during deployment. Younger families may be particularly less prepared to deal with the added stress of recovery, rehabilitation and/or adjustment to a chronic physical disability (National Center for Post-Traumatic Stress Disorder, 2004a).

- Some families of returning soldiers may be at risk for domestic violence. A report from the Miles Foundation Hotline for Domestic-Violence in the Military notes that calls have jumped from 50 to more than 500 a month since the start of the war in Iraq (Tyre, 2004).

- The reunion with the children can be a challenge. Their feelings tend to depend on their age and understanding of why the soldier was gone. Babies younger than one may not know the soldier and cry when held. Toddlers may be slow to warm up. Pre-schoolers may feel guilty and scared of the separation. School age children may want a lot of attention. Teen-agers may be moody and may not appear to care.

- Soldiers reconnecting with family are coming from profound emotional experiences. The spouses also had these experiences, dealing with day-to-day issues by themselves, taking care of the children and gaining independence.

- Soldiers will want to reassert their role as a member of the family, taking back all the responsibilities they had before, which can lead to tension within the family structure (Logan, 1987).

Many Returning Soldiers Suffer From Psychological Trauma

Posttraumatic Stress Disorder (PTSD) was first brought to public attention by war veterans and there is, again, concern for and among this population. Numerous studies of war and combat trauma demonstrate a link between exposure and posttraumatic sequelae, including PTSD. Important factors for posttraumatic adjustment include individual and family history of mental health problems, the nature of combat, changes in combat experiences, other stress and trauma, physical injuries, and the social and political context to which combatants return.

- Once called "shell shock, "combat fatigue," or "battle fatigue," PTSD, is a psychiatric disorder that can occur following the experience or witnessing of life-threatening events such as military combat, natural disasters, terrorist incidents, serious accidents, or violent personal assaults.

- Soldiers diagnosed with PTSD often relive the experience through nightmares and flashbacks, have difficulty sleeping, and feel detached or estranged. In many cases, the symptoms worsen with time, leaving the victims at higher risk for alcohol and drug abuse, unemployment, homelessness and suicide (Tyre, 2004). The disorder has increasingly become to be understood as a psychobiological disorder, meaning that biological changes as well as psychological symptoms are often detected.

- According to a 2003 US Army study, 15-20% of US Iraq and Afghanistan veterans are showing symptoms of PTSD. Even though the VA has seen a tenfold increase in PTSD cases over the last year, nearly two-thirds of veterans who show symptoms do not seek treatment.

- Studies show that reservists and National Guard soldiers are particularly vulnerable to PTSD. In addition, female soldiers are more at risk for PTSD than male soldiers (i.e., about 20 to 25 percent of the women who served in the Vietnam War and the Gulf War developed PTSD; and psychologists are expecting figures to be at least as high for Iraq*)* (Spitz, 2004).

- Dr. William Winkenwerder, Assistant Secretary of Defense for Health Affairs, noted the effects of PTSD on returning soldiers in an interview with National Public Radio. He stated that while 15% of returning troops suffer from PTSD, only 3% admit to it upon initial re-entry. He suspects this discrepancy is due to the fear that if the soldiers report experiencing psychological stress, it would delay their return to their families (Montagne, 2005).

- According to the National Center for PTSD, the pairing of PTSD with alcohol and drug problems in veterans is not uncommon. Thus it is important to initiate preventive psychological and behavioral interventions to reduce drinking or prevent acceleration of alcohol consumption as a response to PTSD symptoms (National Center for Post-Traumatic Stress Disorder, 2004c).

- The long-term medical costs to the VA associated with chronic PTSD are staggering. These stem from the symptoms of PTSD itself, from mental health problems frequently associated with PTSD, from the increased medical morbidity associated with chronic PTSD, from the significantly higher medical care utilization among veterans with chronic PTSD, and from the cost of disability compensation to veterans with chronic PTSD.

Many Returning Soldiers May Require Mental and Behavioral Health Services

The nation's health care system for returning soldiers is facing a potential deluge of tens of thousands of men and women in uniform returning from Iraq with serious mental health problems brought on by the stress and carnage of war.

- Some Pentagon experts predict that the number of returning soldiers eventually requiring mental health treatment could exceed 100,000 (Shane, 2004). PTSD is only one of several possible psychological outcomes following trauma. It is important to remember that substance abuse, depression, generalized anxiety disorder, and adjustment disorders have also been associated with traumatic exposure, fear of capture, injury, and death, as well as exposure to debilitated conditions of prisoners of war and dead bodies (Ursano & Norwood, 1996).

- A recent GAO report (February 2005) found that officials at six of seven Veterans Affairs medical facilities surveyed said they "may not be able to meet" increased demand for treatment of PTSD. Officers who served in Iraq say the unrelenting tension of the counterinsurgency will produce that demand (Shane, 2004).

- The GAO Report further states that if returning military personnel do not have access to PTSD services, the chance may be missed for early identification and treatment to lessen the severity of the symptoms and improve the quality of life of those returning from combat (Shane, 2004).

- A survey published by the Army Surgeon General noted there is approximately one behavioral health provider for every 900 soldiers. This could explain why only 27 percent of soldiers who screened positive for depression, anxiety, or traumatic stress said they had received any services from a mental health provider during their deployment (Daw Holloway, 2004).

- A longitudinal study of Gulf War Vets suggests that the prevalence of PTSD increases during the first two years after the soldier's return (Wolfe, Erickson, Sharkansky, King, & King, 1999).

- Returning soldiers are at a higher risk for attempted suicides and need to be monitored closely. In 2003, the suicide rate among Army troops in Iraq was 15.6 per 100,000 soldiers, an increase from 11.9 per 100,000 soldiers (Bennis, 2004).

- The effects of sexual assault occurring within a military unit. These experiences can lead to a heightened sense of apprehension and vulnerability because the victim must continue to live and work closely with the perpetrators (Friedman, 2005; Murdoch et al., 2003). Victims are often silenced by peer pressure, unreceptive leaders, or the fear of jeopardizing their careers (Friedman, 2005). Sexual assault is extremely common in women veterans (Fisher McNulty, 2005; Murdoch & Nichol, 1995). They are at high risk for developing PTSD (Baker, Boat, Grinvalsky, & Geracioti, 1998; Valentiner, Foa, Riggs, & Gershuny, 1996) major depressive episodes (Hankin et al., 1999) and anxiety disorders (Burman et al., 1988). They are also more likely to attempt suicide (Davidson, Hughes, George, & Blazer, 1996) and abuse drugs and alcohol (Burman et al., 1988).

- The unprecedented numbers of women serving in combat roles and situations. The women in the military today are younger, more ethnically divers, and have fewer socioeconomic resources (Stern et al., 2000; Sorensen & Field, 1994). Although there is several researchers have studied the health effects of the stressors of environments on military women (Bell & Roth, 1998; Norwood & Ursano, 1997; Murphy, Browne, Mather, Scheele, & Hymas, 1997), there is relatively little data regarding gender differences as it relates to how they experience environmental stressors and the implications that this may have on their physiological and psychological health.

Many Returning Soldiers May Require Long-Term Comprehensive Health Care

Since the beginning of the Iraq war in 2003, more than 12,000 soldiers have been seriously wounded suffering head and limb injuries caused by blast and shrapnel wounds. Soldiers who would have died in previous wars are coming home with traumatic brain injuries or as amputees (Bryant, 2005). These wounded soldiers will return to civilian life with serious wounds, disfiguring scars, or amputated limbs and will face greater challenges today obtaining assistance and finding opportunities that would enable them to provide for themselves and their families.

- US troops injured in Iraq have required limb amputations at twice the rate of past wars, and as many as 20 percent have suffered head and neck injuries that may require a lifetime of care (Bennis, 2004; Mishra, 2004).

- Depending upon the severity and location of the wound, it may take weeks from the time of a soldier's initial traumatic amputation to the final healing of the wound before it is ready for a prosthetic (Boivin, 2004).

- Head, face and neck injuries are not uncommon in combat environments and are increasing due to survivable injuries from the use of Kevlar helmets and body armor (Helling & McKinlay, 2005; Okie, 2005). While body armor helps save soldiers' lives, it can't prevent their brains from absorbing the force of a concussive blast or a bullet deflected off a helmet. (Larabee, 2005)

- Soldiers in both Iraq and Afghanistan are at risk for blast injuries from improvised explosive devices (IEDs), rocket-propelled grenades and land mines. It has been estimated that over 50% of all combat injuries are blast injuries (Brian Injury Association of American, 2005)

- Brain injuries add a new element of difficulty to casualty assessment, because the injuries are challenging to diagnose and difficult to differentiate from symptoms of other injuries, such as the symptoms of psychological stress. Brain injuries can exert themselves in physical, cognitive or emotional symptoms, and left untreated they can pose significant hurdles to recovery.

- According to the National Institute of Neurological Disorders, symptoms of a TBI can be mild, moderate, or severe depending on the extent of the damage to the brain. Approximately half of severely head-injured patients will need surgery to remove or repair ruptured blood vessels or bruised brain tissue (McCraken, 2005).

- The uncertainties of life after discharge for the remarkable large number of amputees and other wounded combatants (Gawande, 2004). These injuries may have long-term effects on the veterans' quality of like, marital adjustment, vocational opportunities, self-image, marital adjustment, vocational opportunities, self-image, future outlook, and mental health (Murdoch et al., 2003). Often when injured soldiers attempt to transition back to civilian life with their new physical disability, they are met with a multitude of obstacles. This is a major issue for these veterans (Bennis, 2004).

There Are Many Barriers to Accessing Services

Navigating the myriad of service providers and bureaucracy can be a frustrating and time consuming process that far too many veterans and their families give up on. Ongoing mental and behavioral health services to assist returning veterans and families transition to civilian life are often hard to access and under-resourced –especially after separation from the military.

- One of the most often identified barriers to accessing is stigma. Soldiers express concern about disclosing psychiatric difficulties to military mental health professionals (Friedman, 2005; Hoge et al., 2004) and that they will be viewed or treated differently by peers or leaders if they are known to be receiving mental health treatment (Hoge et al., 2004).

- Returning soldiers and families fear breach of confidentiality leading to reprisal by the military if they access services.

- Appointments are often made during work hours and individuals are unable to get time off work (Hoge et al., 2004).

- Lack of available and accessible transportation to travel to the location where care is available (Hoge et al., 2004).

- Returning veterans and families are often unaware of what resources are available and how to access them.

- There are a limited number of providers having expertise with working with returning soldiers and family members. Soldiers often feel that civilians do not and cannot understand the stressors experienced by them (Hoge et al., 2004).

- There is a limited availability of services and/or providers who have expertise working with children of deployed soldiers.

- There is a limited availability of services and/or providers who have expertise in working with parents of deployed soldiers.

- There is a limited availability of services and/or providers who have expertise in working with culturally diverse service members and families.

Addressing the Challenge

In the United States, we have learned so much from both our previous experiences of war, and from veterans of the Vietnam War. As a society we have learned not to confuse "the war with the warrior" (Friedman, 2005); we now recognize post-traumatic stress disorder as a diagnosable disorder; and we have developed new treatments, changing the landscape of hope. However we must prepare for some unprecedented challenges presented by our newest veterans.

Many gaps exist in our understanding of the full psychosocial impact of combat. The recent U.S. military operations in Iraq and Afghanistan have involved the first sustained ground combat since the Vietnam war. Recent data from the VA reveals that approximately 244,054 veterans of active duty in Iraq and Afghanistan have become eligible for VA benefits and that 20 percent of these new veterans have received health care at a VA facility since returning home.

Prior research has demonstrated that mental health disorders are a leading source of occupational morbidity and reason for transition out of military service for active-duty military personnel, with as many as one third of enlisted soldiers having difficulty in their first term of enlistment, most often due to mental, psychosocial, and behavioral problems. There is a need to improve the process by which the earliest possible identification and treatment of post traumatic readjustment problems is initiated and sustained.

The Vision

We envision a system in which individuals, families, employers, academics, the Veteran's Affairs Medical Center, the Vet Center and other communities and service agencies work cooperatively toward the development of an easily accessible and knowledgeable system of care for veterans, returning soldiers, and their families. Through the development an *interagency coalition*, the State of Rhode Island will make strategic investments for individuals, families and communities most affected by the consequences of combat.

Principles for Success

- Veterans, soldiers, and/or families needing treatment and/or other interventions are identified early, effectively and efficiently.
- Veterans, soldiers, and/or families receive effective assessments and are referred to appropriate levels of care.
- A continuum of services, with supply corresponding to appropriate demand, is available and well managed.
- Assessment, treatment and support services are timely, appropriate and effectively delivered.

The following five priority areas will help us achieve our vision:

- **Establish an Interagency Coalition for the care of returning soldiers and their families to provide leadership to expand the role and capacity of communities to effectively address their needs.**
  - Maximize and align existing resources for addressing diverse needs; and
  - Develop unified strategies to drive changes in the behavioral health care system.

- **Develop accessible systems of services for Veterans and their families that:**
  - Are culturally responsive and focus on the whole person and family; and
  - Include the treatment and rehabilitation services known to be most effective.

- **Build strong communities for military families through**
  - Formal relationships among local public, non-profit and business groups, organizations, professional organizations, state and local governmental entities, military community leaders, and other key stakeholders that support and sustain military families;
  - Informal relationships among military families and non-military families, and military;

- **Expand screening, assessment and referral activities through:**
  - Develop a peer community of support that is accessible to veterans and their families;
  - Strategic partnerships with Veterans Administration Medical Center, the Vet Center, Rhode Island National Guard, criminal justice system, first responders, the educational system, mental health and substance abuse professionals, health care providers, community-based organizations, professional associations, local, state, regional, and governmental entities, and other key stakeholders;
  - Cross-training initiatives for human service agencies' staffs, community based providers, public safety professionals, and individuals in related disciplines to enhance screening, assessment, and referral skills; and
  - Effective and efficient identification of veterans and/or their families within primary care systems, school systems, state agencies, and other community and employment settings needing intervention and/or treatment services.

- **Increase knowledge about available resources to assist veterans and their families through:**
  - A resource guide identifying local, state, regional, and national services;
  - Communication that enhances knowledge exchange between the Veterans Administration Medical Center, the Vet Center, Rhode Island National Guard, employers, criminal justice system, first responders, the educational system mental health and substance abuse professionals, health care providers, community-based organizations, professional associations, local, state, regional and governmental entities, and other key stakeholders;
  - Educational programs for Veterans and family members on how to access services and insurance benefits; and
  - A peer to peer community of support that is accessible to veterans and their families.

- **Develop a multi-pronged community effort to address stigma through:**
  - Coordination of community efforts with governmental and private services that provide services to returning veterans and their families;
  - Community outreach, support and educational programs for veterans, families, parents and grandparents that address issues of privacy and confidentiality; and
  - Community outreach and educational programs for teachers, communities of faith, courts, the judiciary and the legal system that are designed to help all stakeholders better understand the issues that veterans and their family members face.

The Implementation Plan

A great deal of research support early identification and intervention as a means of reducing myriad of health and mental health problems (Hoel, 1998; Taylor, Adelman, & Howard, 2000). Additionally it is clear that collaborations and partnerships are essential in effective health promotion and service delivery in the context of limited financial and human resources (Anderson, Guthrie, & Schirle, 2002; Rubin, 1998). As we are challenged to find new ways to promote efficient service delivery, many endorse the development of partnership building strategies.

KEY ISSUE 1

Establish an Interagency Coalition for the care of returning soldiers and their families to provide leadership to expand the role and capacity of communities to effectively address their needs.

Recommendation A: Maximize and align existing resources for addressing diverse needs.

Strategies:

1. Identify of all key stakeholders to assist in implementing the recommendations contained in this report.

2. Develop specific plans and timelines for implementing the recommendations and strategies contained in this report.

3. Gather broad public input to identify specific needs of returning veterans and their families.

Recommendation B: Develop unified strategies to drive changes in the behavioral health care system.

Strategies:

1. Generate recommendations for improving state-level operations, reducing duplication of effort and facilitating communication

2. Work with existing government organizations to assess the current administrative practices and propose changes to support interagency collaboration.

KEY ISSUE 2

Develop accessible systems of services for Veterans and their families.

Recommendation A: Develop culturally responsive services that focus on the whole person and family.

Recommendation B: Utilize treatment and rehabilitation services known to be most effective.

Strategies:

1. Increase expertise and training in evidence-based/best practices across systems and services.

Implementation Plan

1. Based on agreed upon outcomes and best practices, develop at training plan in evidence-based techniques and best practices leveraging the training resources of various state and federal agencies.

2. Cross-train human service agencies′ staffs, providers′ workforces and individuals in related disciplines to enhance treatment skills for fidelity to established evidence-based methods.

KEY ISSUE 3

Building Strong Communities for Military Families

Recommendation A: Develop formal relationships among local public, non-profit and business groups, organizations, professional organizations, state and local governmental entities, military community leaders, and other key stakeholders that support and sustain military families.

Strategies:

1. Coordinate with the department of labor and training, academic institutions, and the business community to identify and/or provide job training, educational services, and opportunities for career development for returning veterans and/or military spouses.

2. Develop a working relationship between local and state educational systems, community organizations, and military community leaders to address the unique needs of military children.

Recommendation B: Develop informal relationships among military families and non-military families, and military.

KEY ISSUE 4

Expand screening, assessment and referral activities

Recommendation A: Develop a peer community of support that is accessible to veterans and their families;

Recommendation B: Create strategic partnerships with Veterans Administration Medical Center, the Vet Center, Rhode Island National Guard, criminal justice system, first responders, the educational system, mental health and substance abuse professionals, health care providers, community-based organizations, professional associations, local, state, regional, and governmental entities, and other key stakeholders.

Recommendation C: Develop cross-training initiatives for human service agencies' staffs, community based providers, public safety professionals, and individuals in related disciplines to enhance screening, assessment, and referral skills.

Strategies:

1. Conduct statewide training for appropriate levels of social service agencies (including case workers) on how deployment can adversely affects families

Recommendation D: Facilitate effective and efficient identification of veterans and/or their families within primary care systems, school systems, state agencies, and other community and employment settings needing intervention and/or treatment services.

KEY ISSUE 5

Increase knowledge about available resources to assist veterans and their families.

Recommendation A: Develop a resource guide identifying local, state, regional, and national services.

Recommendation B: Create communication mechanisms that enhances knowledge exchange between the Veterans Administration Medical Center, the Vet Center, Rhode Island National Guard, criminal justice system, first responders, the educational system mental health and substance abuse professionals, health care providers, community-based organizations, professional associations, local, state, regional and governmental entities, and other key stakeholders.

Recommendation C: Develop educational programs for Veterans and family members on how to access services and insurance benefits.

Recommendation D: Create a peer-to-peer community of support that is accessible to veterans and their families.

KEY ISSUE 6

Initiate a statewide public awareness campaign to address stigma utilizing a multi-pronged community approach.

Recommendation A: Coordinate community efforts with governmental and private services that provide services to returning veterans and their families.

Recommendation B: Develop community outreach, support and educational programs for veterans, families, parents and grandparents that address issues of privacy and confidentiality.

Strategies:

1. Implement a statewide educational program for veterans, families, parents and grandparents that address issues of privacy and confidentiality.

2. Implement a statewide outreach and educational campaign to help assist all stakeholders better understand the issues that veterans and their family members face, dispel the myths and stigmas surrounding getting help, learn about local providers that can provide relevant assistance, and connect those in need with immediate support from others who have been through, or are going through, the stress of deployment and the post-war transition from military to civilian life.

3. Encourage spokespersons/leaders/family members among the National Guard, the Vet Center, Veterans Organizations, local health care, businesses, etc. to speak at school events, to local community organizations and other public forums to increase awareness.

4. Develop culturally appropriate media campaigns that are tailored to respond to local needs and challenge social norms.

Recommendation C: Develop community outreach and educational programs for teachers, communities of faith, courts, public safety professionals, the judiciary and the legal system that are designed to help all stakeholders better understand the issues that veterans and their family members face.

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