

Collaborative Intervention: A Model for Coordinated Treatment of Mental Health Issues within a Combat Unit

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Disclaimer

The views expressed in this presentation are those of the presenter and do not necessarily reflect the official policy or position of the department of the Navy, Department of Defense, nor the U. S. Government

Objectives

- Participants will gain a detailed understanding of a collaborative model of treatment of mental health issues within a combat unit
- Participants will be able to differentiate the functions of Chaplains and Medical Officers with regards to treatment of mental health issues within combat units
- Participants will be able to state how Chaplains and Medical Officers can collaboratively treat combat stress injuries and PTSD through a structured model of intervention



**Why do we need a collaborative
model?**

The Need for a Collaborative Model

- The mental health implications from the global war on terror speak to the need for Chaplains and Medical Officers, considered by many to be the front-line defense in ground combat units, to provide a model of intervention that is both effective and efficient

The Need for a Collaborative Model

- Unit Chaplains and Medical Officers are well positioned by virtue of their position and relationship to their Marines and Soldiers to significantly prevent psychological injury and develop effective coping skills

The Need for a Collaborative Model

- An anonymous survey of 3,671 Marines and Soldiers 3-4 months following combat in Iraq or Afghanistan discovered the following (Hoge et al., 2004):
- Rates of post-traumatic stress disorder (PTSD), depression, and generalized anxiety disorder were approximately 16% as compared to a baseline figure of approximately 9%
- PTSD rates pre and post-deployment were 9.4 and 19% respectively
- Problematic alcohol behavior was approximately 12% pre-deployment as compared to 18-29% post-deployment
- 86% of Marines who had a serious emotional problem recognized it, but of that number, only 45% wanted help, and only 24% actually received help from a mental health provider

The Need for a Collaborative Model

- Less than half of the service members needing help actually sought it. The Department of Defense Task Force on Mental Health identified stigma or the shame and disgrace associated with seeking help for mental health or psychosocial problems as a “critical barrier to accessing needed psychological care” (p. 5)

The Need for a Collaborative Model

- When a service member is wounded physically or emotionally in combat, the costs of care and treatment continue even after the individual is separated or retired from military service
- Many, if not most veterans have limited financial means and therefore have little access to private treatment facilities, particularly those that may be more exclusive or costly
- In 2000, the percentage of the U.S. population with government insurance, including military health care, was only 24.7%. In 2006, this rose slightly to 27%

The Need for a Collaborative Model

- post-deployment mental health is about much more than PTSD
- Veterans that meet criteria for a diagnosable disorder actually tend to endorse a range of disorders, even several disorders at once
- In addition to combat-related PTSD, veterans may suffer from depression, alcohol/drug abuse (sometimes originating from methods used to fall or stay asleep), narcotic addiction (often beginning with use of prescription pain medication), and psychological consequences of traumatic brain injury (TBI)

The Need for a Collaborative Model

- Psychological health involves not only the detection and remediation of illness, but also the provision of effective preventive strategies
- Strategies to prevent other common problems, such as dental disease or orthopedic injuries, are well-developed
- “A similar capacity must be developed to prevent psychological dysfunction and enhance resilience to stress” (Department of Defense Task Force on Mental Health, 2007, p. 5)

The Need for a Collaborative Model

- Within present traditional roles, the Medical Officer's focus is on the treatment of physical disorders, while the Chaplain's focus is on spiritual issues or emotional concerns related to adjustment
- Between these two traditional foci there is a void -- the treatment of psychological or more severe emotional issues
 - This often results in the person being referred outside of the unit to a mental health department or facility for further assessment, evaluation, and treatment.

What a Collaborative Model Provides

- a Collaborative Intervention Model that will enable Medical Officers and Chaplains to work together to more effectively and efficiently treat significant psychological or emotional issues
- Inclusion of helping professionals from one's own unit, particularly the Chaplain, may assist with overcoming the shame associated with asking for or receiving help
- This model is most applicable to situations where the Chaplain has a strong background in counseling, psychology, and clinical mental health issues.

Collaborative Intervention Model

- ***DOES PATIENT PRESENT WITH A MENTAL HEALTH OR EMOTIONAL ISSUE?***
 - YES – Is patient a threat to self or others?
 - NO – Treat physical or spiritual issues as appropriate

Collaborative Intervention Model

- ***IS THE PATIENT A THREAT TO SELF OR OTHERS?***
 - YES – Refer to hospital or psychiatrist for further evaluation
 - Outcomes: return to full duty, place on limited duty, medical separation
 - NO – Conduct mental status exam and assessment

Collaborative Intervention Model

- **MENTAL STATUS EXAM and ASSESSMENT**
 - Refer as appropriate
 - ***DOES THE PATIENT MEET CRITERIA FOR MEDICATION?***
 - YES - Prescribe as appropriate
 - NO – Refer to Chaplain

Collaborative Intervention Model

- ***IS FURTHER COUNSELING WARRANTED OR DESIRED?***
 - YES – Refer to mental health professional
 - YES – Refer to Chaplain
 - NO – Follow-up as appropriate to address medication and other pertinent issues

References

- American College of Physicians: Achieving a high performance health care system with universal access: What the United States can learn from other countries, Retrieved December 30, 2007 from www.annuals.org/cgi/content/full/0000605-200801010-00196v1, 2007.
- Butcher JN, Mineka S, Hooley JM: Abnormal Psychology (12th ed.). Boston, Allyn and Bacon, 2004.
- Cohen RJ, Swerdlik ME: Psychological Testing and Assessment (6th ed.), New York, NY, McGraw-Hill, 2005.
- Department of Defense Task Force on Mental Health: An achievable vision. Report of the Department of Defense Task Force on Mental Health, Fall Church, VA, Defense Health Board, 2007.
- Foa EB, Meadows EA: Psychosocial treatments for posttraumatic stress disorder: A critical review, Ann Review of Psychology, 48, 1997, 449-480.

References

- Hoge CW, Castro C, Messer SC, McGurk D, Cotting DI, Koffman RL: Combat duty in Iraq and Afghanistan: mental health problems and barriers to care, *N Engl J Med*, 2004, 351, 13-22.
- Howard, MD: Escaping the pain: examining the use of sexually compulsive behavior to avoid the traumatic memories of combat, *Sex Addiction and Compulsivity*, 14, 2007, 77-94.
- Kudler H: The need for psychodynamic principles in outreach to new combat veterans and their families, *J Am Academy Psychoanalysis Dynamic Psychiatry*, 35(1), 2007, 39-50.
- Multinational Force – Iraq and Office of the Surgeon General, U.S. Army Medical Command: Mental Health Advisory Team (MHAT-IV), 2006, Operation Iraqi Freedom 04-06.
- Office of the Surgeon Multinational Force – Iraq and Office of the Surgeon General, U.S. Army Medical Command: Mental Health Advisory Team (MHAT-III), 2005, Operation Iraqi Freedom 04-06.

References

- Reeves RR, Parker JD, Konkle-Parker DJ: War-related mental health problems of today's veterans, *J Psychosoc Nurs Ment Health Services*, 43(7), 2005, 18-28.
- Russ MJ, Kashdan T, Pollack S, Bajmakovic-Kacila S: Assessment of suicide risk 24 hours after psychiatric hospital admission, *Psychiatric Serv*, 50 (11), 1999, 1491-1493.
- Ruzek JL, Curran E, Friedman MJ, Gusman FD, Southwick SM, Swales P, Walser, RD, Watson, PJ, Whealin, J: Treatment of the returning Iraq War veteran in Iraq War clinician guide 2nd ed., pp. 33-45, White River Junction, VT., National Center for Posttraumatic Stress Disorder, Department of Veterans Affairs, 2004.
- Veterans Health Affairs Office of Public Health and Environmental Hazards: Analysis of VA Healthcare Utilization among US Southwest Asian War Veterans: Operation Iraqi Freedom, Operation Enduring Freedom, 2006, in Department of Defense Task Force on Mental Health: An achievable vision. Report of the Department of Defense Task Force on Mental Health, Fall Church, VA, Defense Health Board, 2007.



Questions?