

'Population-Oriented' TRANSFORMATION of Army Behavioral Health's Preventive & Clinical Services



EveryOne Matters...

and we all do best in small groups,
where everyone looks out for each other...☺

COL RENE' J. ROBICHAUX
Chief, Dept. of Social Work
Brooke Army Medical Center

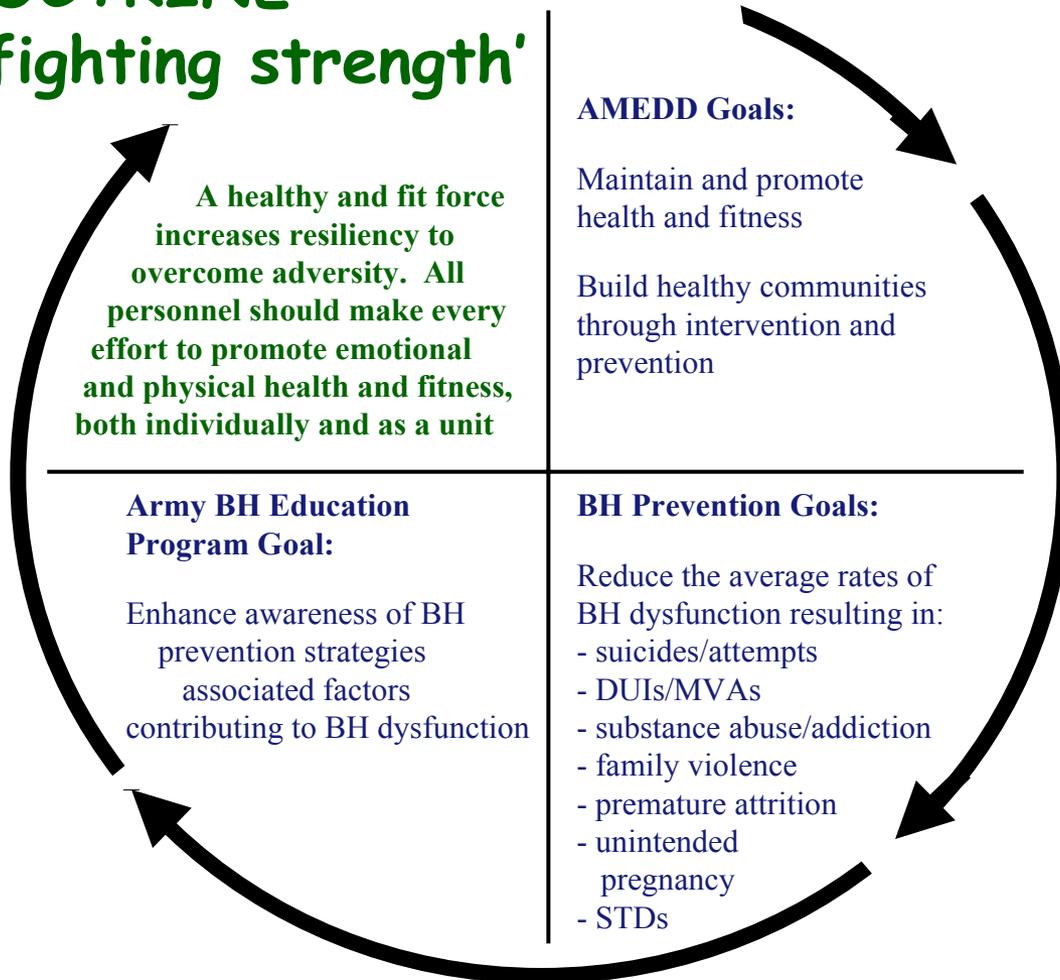
Tricare Region 11 Beh. Health Symposium

5 Dec 2002

Why do we have Behavioral Health practitioners in the Army?

The Army & Behavioral Health(BH)

AMEDD DOCTRINE 'conserve fighting strength'



Responsibility to Self & Community

- Social connections save & improve lives
- Taking care of each other is everyone's business & responsibility
- The key for BH prevention is:
 - early detection of behavioral dysfunction
 - proactive requests for help for self and others
 - followed by appropriate interventions and sustained follow-up

'Quality-of-Life'

- Exists on a continuum for each of us
- All persons experience the 'vicissitudes of life'(ie. problems) to some degree of severity at times
- Our resiliency is a function of our experience, competency & support

Coping and Problem-Solving

Coping and problem-solving are dependent on a combination of many factors:

- Extent, duration, & intensity of the problem
- Nature of the problem
- Number & type of co-occurring problems
- Resources available
- Presence/absence of a social support network
- Existential beliefs
- Developmental history
- Experience/maturity
- Cognitive capabilities
- Physical health

Why is BH in the Army important?

- Mortality
 - suicide completions (~ 40-60/yr.)
 - 2nd or 3rd most common cause for AD fatalities
 - domestic violence fatalities
 - (relatively small #, but major current issue of concern)
 - fatal MVAs from impulsivity/recklessness
 - leading cause of AD fatalities
 - substance abuse-related fatalities
 - MVAs while intoxicated
 - Overdoses
 - Cirrhosis
 - Lung cancer, etc.

Why is BH in the Army important?

- Morbidity

- Social/Domestic

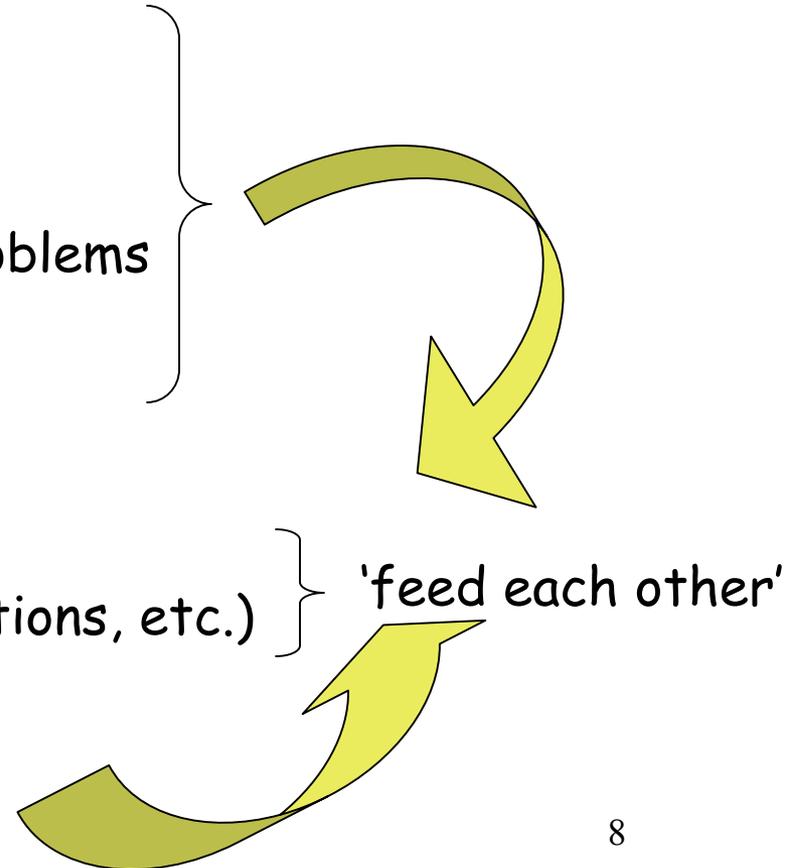
- Divorce
- Spousal/child abuse
- Financial problems
- Substance abuse-related problems
- STDs
- Unintended pregnancies

- Occupational

- Premature attrition
- Career dysfunction (< promotions, etc.)

- Legal

- UCMJ/civilian legal issues



What do we know about the
AD population 'at risk' for
BH dysfunction?

- NOTHING 'hard'
from our own data
- But we have some clues...

Consider our new Soldier "Inputs"

- Our current cohorts of DoD recruits arrive at IET with significant 'non-Army issue' developmental "baggage":
 - approx. 40% self-report having been raised in homes where they were physically &/or sexually abused &/or neglected*
 - > 40% come from 'non-traditional' homes without 2 consistent parenting figures**
 - ~ 20% of HS students had seriously considered attempting suicide during a 12 month period***
 - ~ 15% had made a suicide plan***
 - ~ 8% of HS students reported making a suicide attempt in the preceding 12 month period****
 - ~ 3% received medical attention for a suicide attempt in the 12 months***

* data from Naval Health Research Center-Report #95-26: Pre-enlistment Maltreatment Histories of US Navy Basic Trainees: Prevalence of Abusive Behavior"

** data from Zill & Robinson, "The Generation X", *American Demographics*, April 1995, pp. 24-33

*** data from Centers for Disease Control(CDC) Youth Risk Behavior Surveillance 1999

****data from National Strategy for Suicide Prevention, US Public Health Surgeon General, May 2001

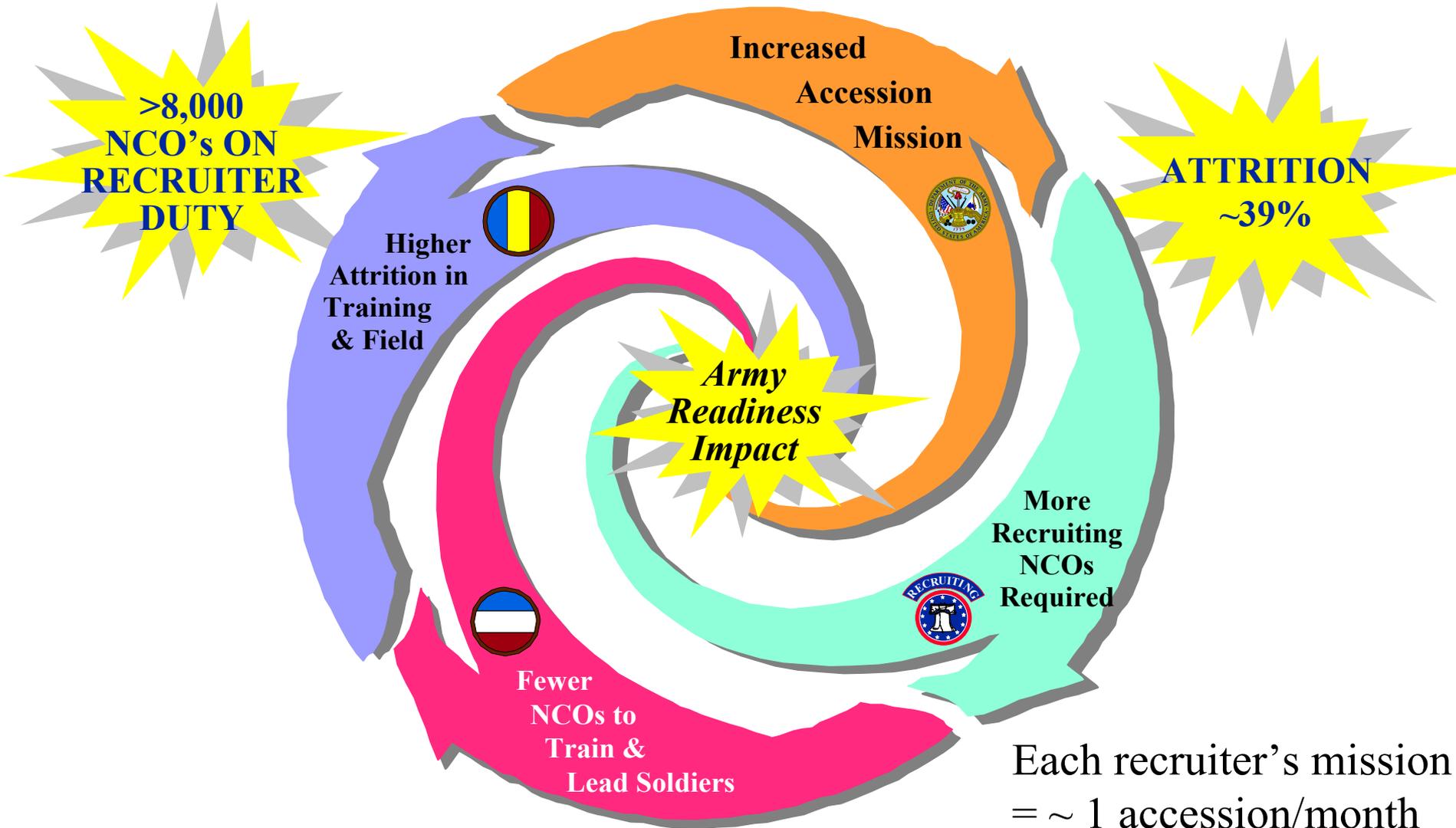
How does this developmental 'burden' play out in terms of issues important to the Army?

- ? association with:
 - premature **attrition**
 - **suicide** behaviors(completed & attempts)
 - **lost duty days** (not available for mission)
 - preventable **medical expense** (hospitalizations, clinic visits, etc.)
 - the '**human cost**' in suffering (lost lives, ruined careers, incarceration, etc.)

First Term Attrition:

- Annual attrition rate during first term enlistment (for period ending June 1999):
 - Training Base, 0 to 6 months service = ~16 percent.
 - 7-36 months service = ~7 percent annually
- Overall **attrition** in first term (0-36 months) = **~39%**
- Most common separation categories, 0-6 months:
 - Defective Enl, ILO CM, Misconduct, Homosexual Act, Personality Disorder, Physical (not disability), Hardship
 - Behavioral dysfunction accounts for > **40%** of all attrition
- Most common separation categories, 7-36 months:
 - Misconduct, ILO CM, Unsat Perform, Physical Disability, Pregnancy, Weight control, Personality Disorder
 - Behavioral dysfunction accounts for > **80%** of all attrition

The Attrition Spiral



Cumulative Rate of Leaving Service After First Hospitalization for Mental Disorder, Army AD, 1996 Cohort

No. (%) Who Left Service After Hospitalization for:

Time After 1st Hospitalization	Mental Disorders (n=2,519)	Other 15 Categories of Illness (n=23,653)
3 Months	805 (32%)	1,700 (7%) (range 5-15%)
6 Months	1,186 (47%)	3,202 (14%) (range 12-19%)
1 Year	1,537 (61%)	5,708 (24%) (range 22-29%)
2 Years	1,854 (74%)	9,462 (40%) (range 33-44%)

Data from WRAIR - Hoge, et al (Am J Psychiatry 2002; 159:1-8)

Rate of Leaving Military Service After One or More Outpatient Visits, Army

	Total Number of Patients Treated in 1997	Number (%) Who Left AD Service by End of 1998
Mental Disorders	24,603	11,846 (48%)
Other 15 Illness Categories	Range 2,200-142,252	Overall attrition=28% (range 25-39%)

Data from WRAIR - Hoge, et al (Am J Psychiatry 2002; 159:1-8)

Conclusions Regarding Mental Disorders: Major Threat to our Force

- Leading cause of medically-related premature attrition
- 2nd leading cause of hospitalizations (accounts for **15%** of all admissions) [#1 = pregnancy]
- Leading cause of hospital-related lost duty days (accounts for **30%** of total bed days)
- 4th leading cause of ambulatory care visits
 - > **7%** of AD population use known BH services annually
- Remarkably resistant to reduction in utilization
 - Rate of non-substance related admissions virtually unchanged over past decade
 - Reported rate of ambulatory visits rising faster than for any other medical-surgical disorder

Mental Disorders in the Military: Conclusions (Continued)

- Most common diagnoses:
 - adjustment disorders, alcohol/ substance related, mood disorders, personality disorders
- Higher incidence correlated with:
 - younger age, lower rank, lower educational status, shorter duration of service, being female and single (unclear which are independent risk factors)
- Higher incidence generally not correlated with:
 - race/ethnic status (except for Native Americans)

So what can we do about the BH dysfunction 'burden' affecting our soldiers?

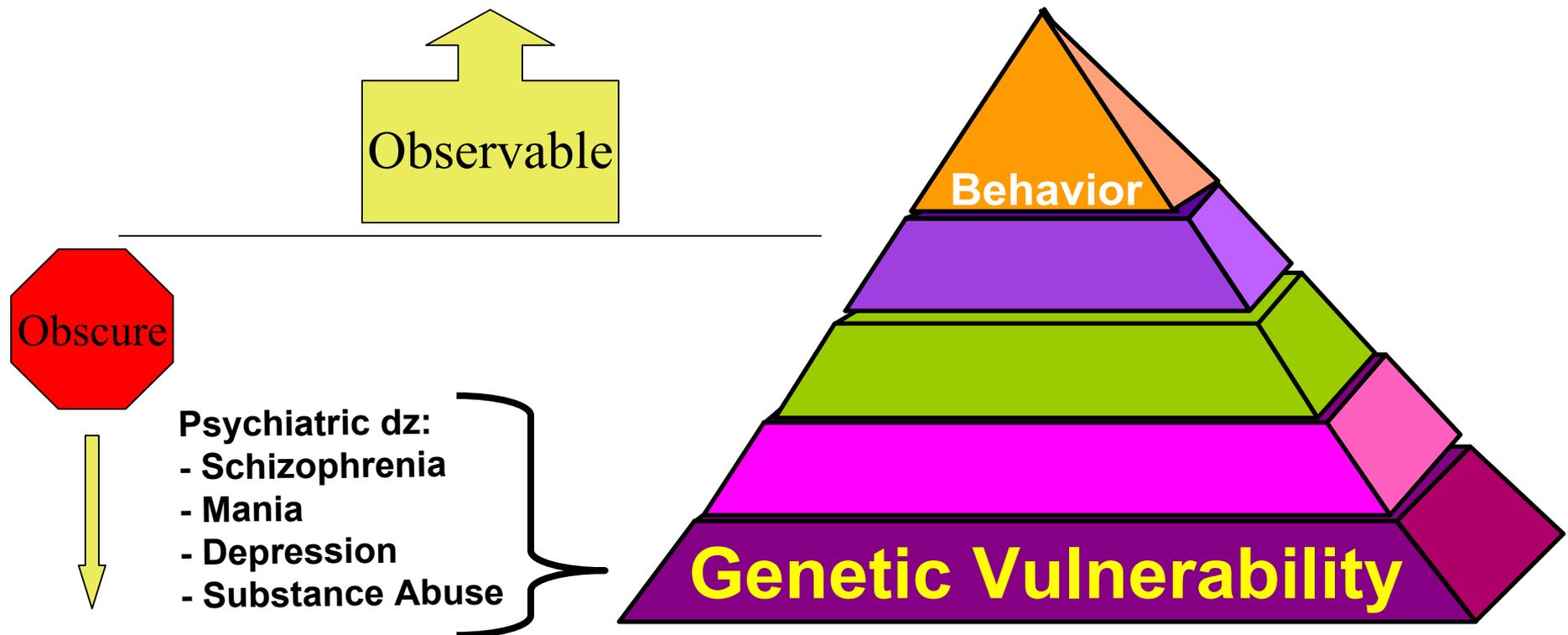
- 1st we have to understand why we are not currently successful...
 - Unknown population 'burden' of individuals predisposed to dysfunctional behaviors Army inherits from its civilian inductees
 - Reactive vs. Proactive
 - 'visibility' on dysfunctional behaviors occurs AFTER violations of UCMJ or worse...
 - Results in 'after the fact' treatment interventions & premature attrition of soldier or worse...

So how do soldiers develop BH dysfunction?

- Complex mix of:
 - genetic vulnerability
 - coupled with
 - past developmental history
 - projected into
 - current environment
 - and its
 - stressors
 - either constructively or destructively mediated by
 - coping strategies/skills...

A Model for Dysfunctional Behavior

- we all observe some of each other's behavior
- understanding of the underlying issues and events obscured
- our 'genetic loading' makes us more or less vulnerable to psychiatric dz.
 - upon induction currently unknown to medical system/line leadership
 - frequently unknown by vulnerable soldier, until dz or disorder emerges

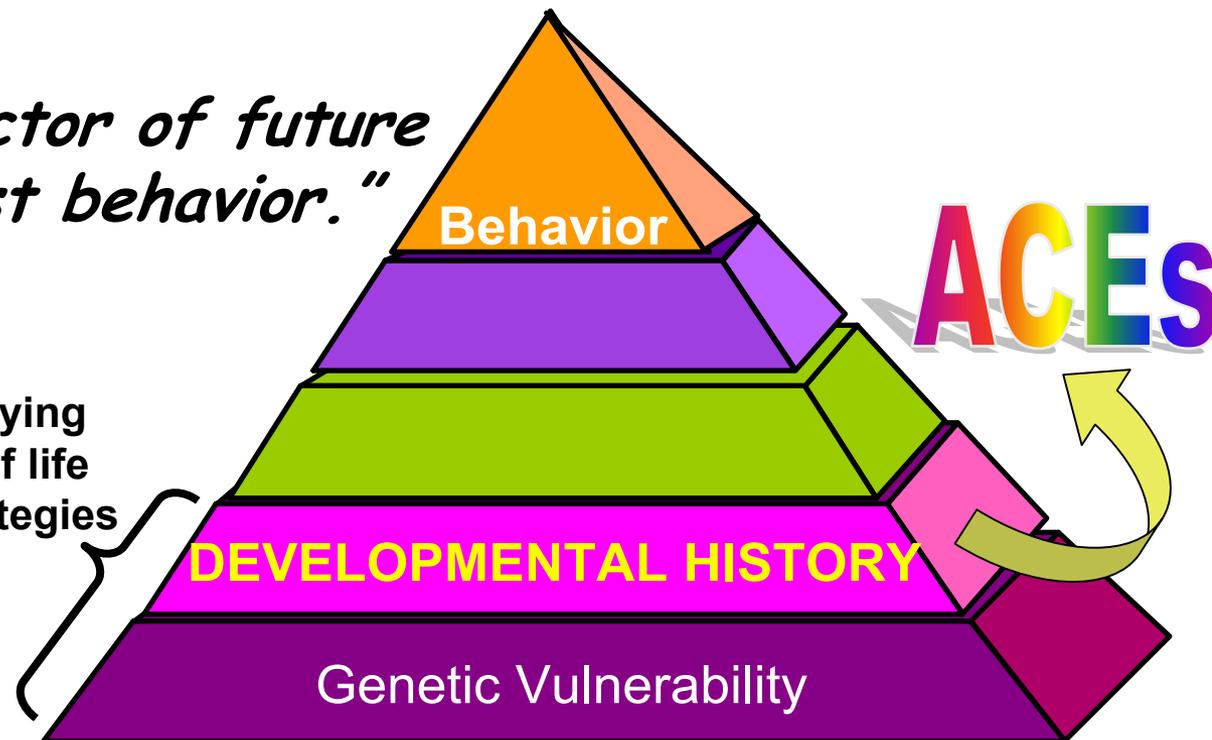


A Model for Dysfunctional Behavior(2)

- our developmental history also has significant impact on shaping behavior
- individuals that experience *adverse childhood experiences (ACEs *)* are much more likely to display dysfunctional adult behaviors
- exposures include: verbal/physical/sexual abuse, maternal abuse, household substance abuse/incarceration/mental illness

"The best predictor of future behavior is past behavior."

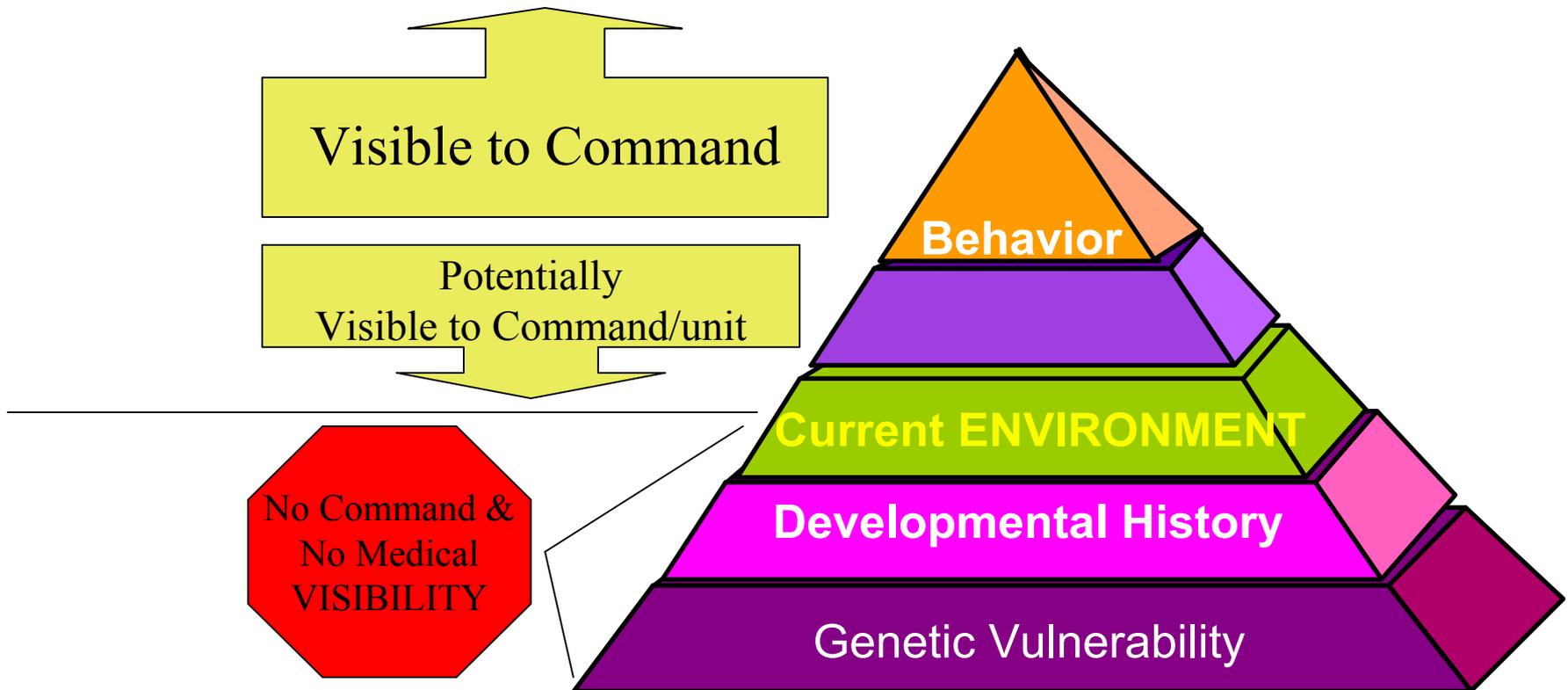
Resulting in varying degrees/types of life coping skills/strategies



- *Felitti, Anda, et al, Am J PM, 1998: 14(4);
- *Dietz, et al, JAMA, 1999: 282; 1359-1364
- *Hillis, et al, Pediatrics, 2000, 106(1)
- *Dube, et al, JAMA, 2001: 286, 3089-3096

A Model for Dysfunctional Behavior(3)

- current ENVIRONMENT influences behavior:
 - supportive vs. non-supportive
- this includes one's work, recreational, and home environments
- Army's first opportunity to positively impact behavior



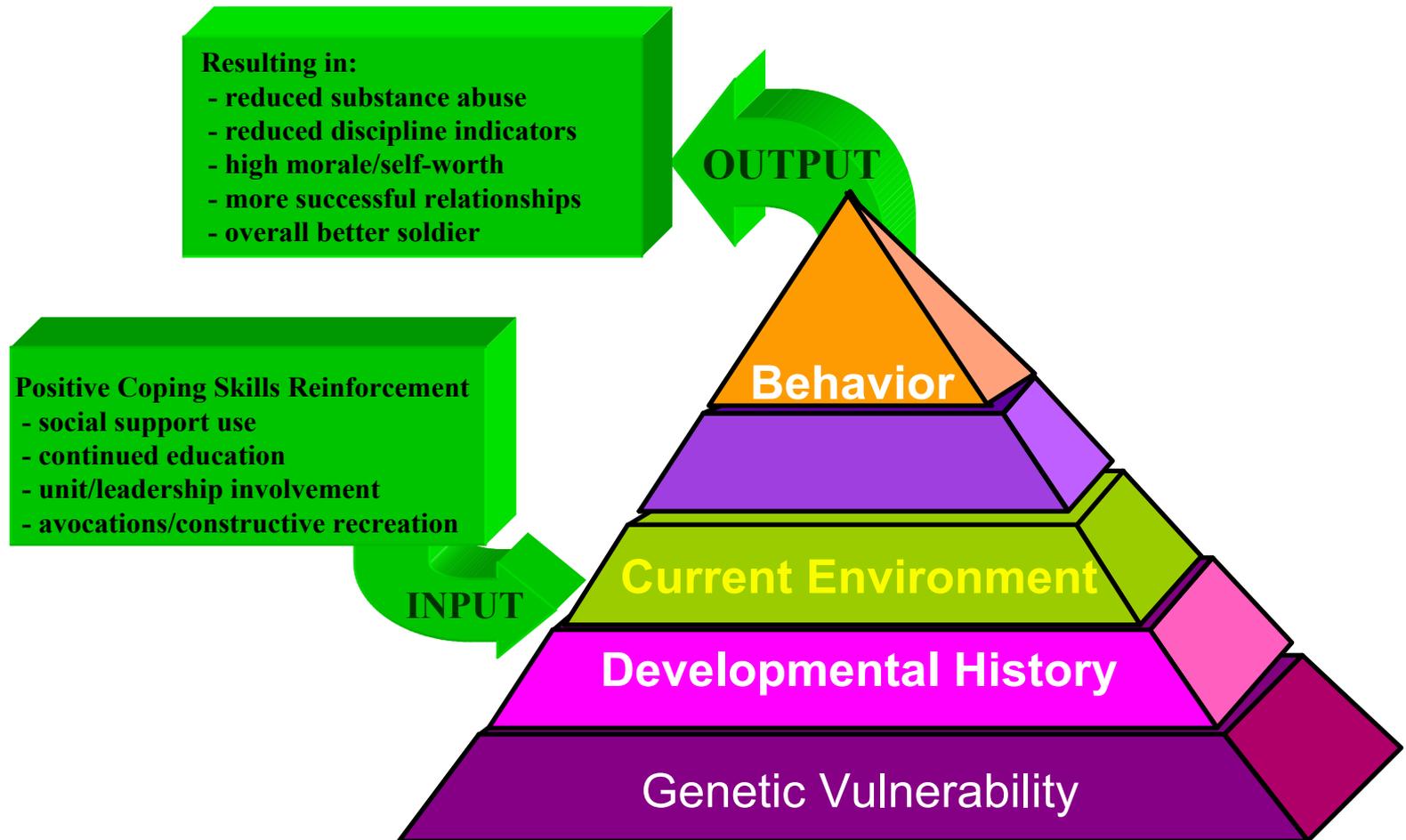
Support makes a **BIG** difference

Good support lets folks know help is there, they're heard, and they can make it.



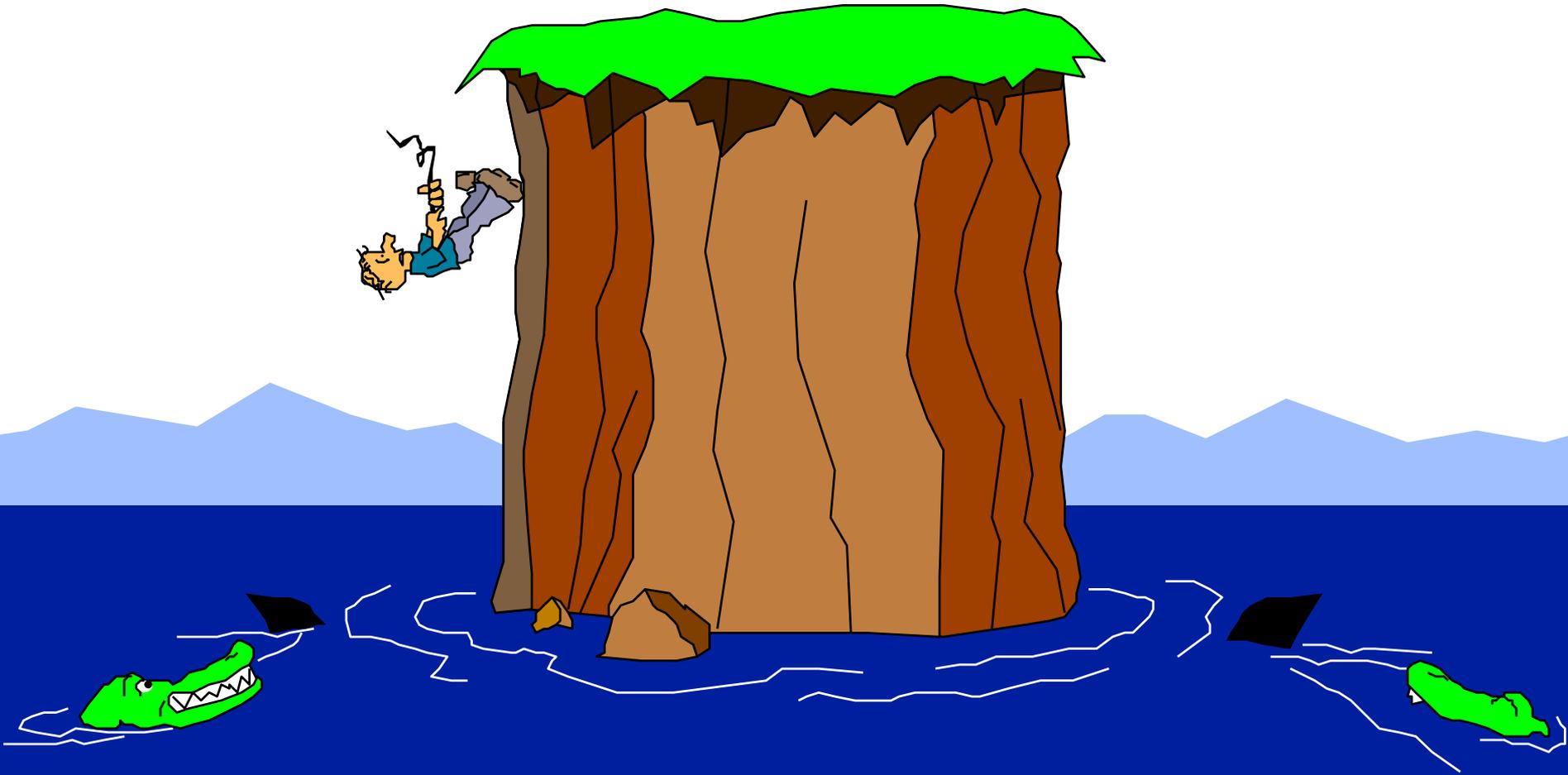
A Model for Dysfunctional Behavior(4)

- Supportive work environments can have a positive impact on behavior IF:
 - Leadership sincerely cares about their soldiers
 - Visibility on the soldier's environment & worries is sought/available



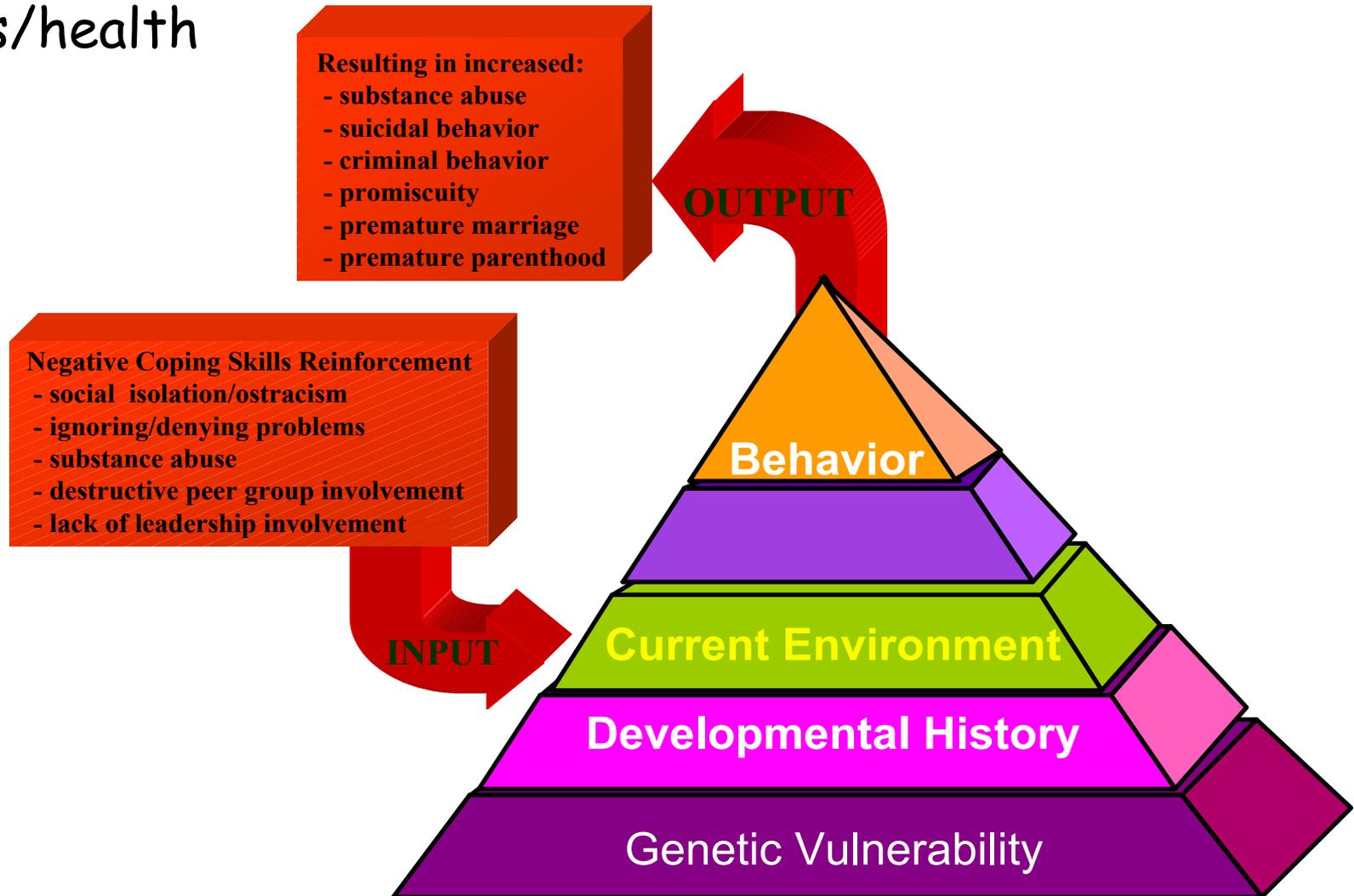
Support makes a big difference

‘Isolated’ soldiers can feel they’re alone, that no one is listening, and that they can’t make it (leads to attrition & sometimes suicide).



A Model for Dysfunctional Behavior(5)

Conversely, failure to reinforce or develop positive life coping skills may result in behaviors not conducive to the individual's readiness/health

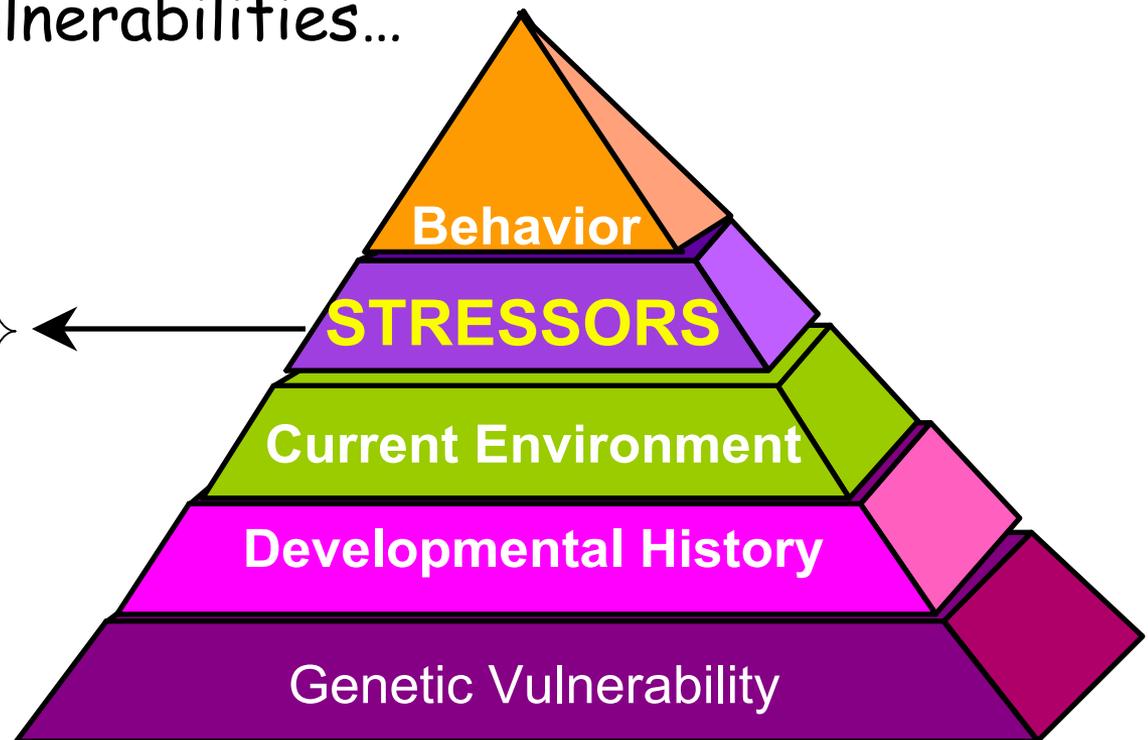


A Model for Dysfunctional Behavior⁽⁶⁾

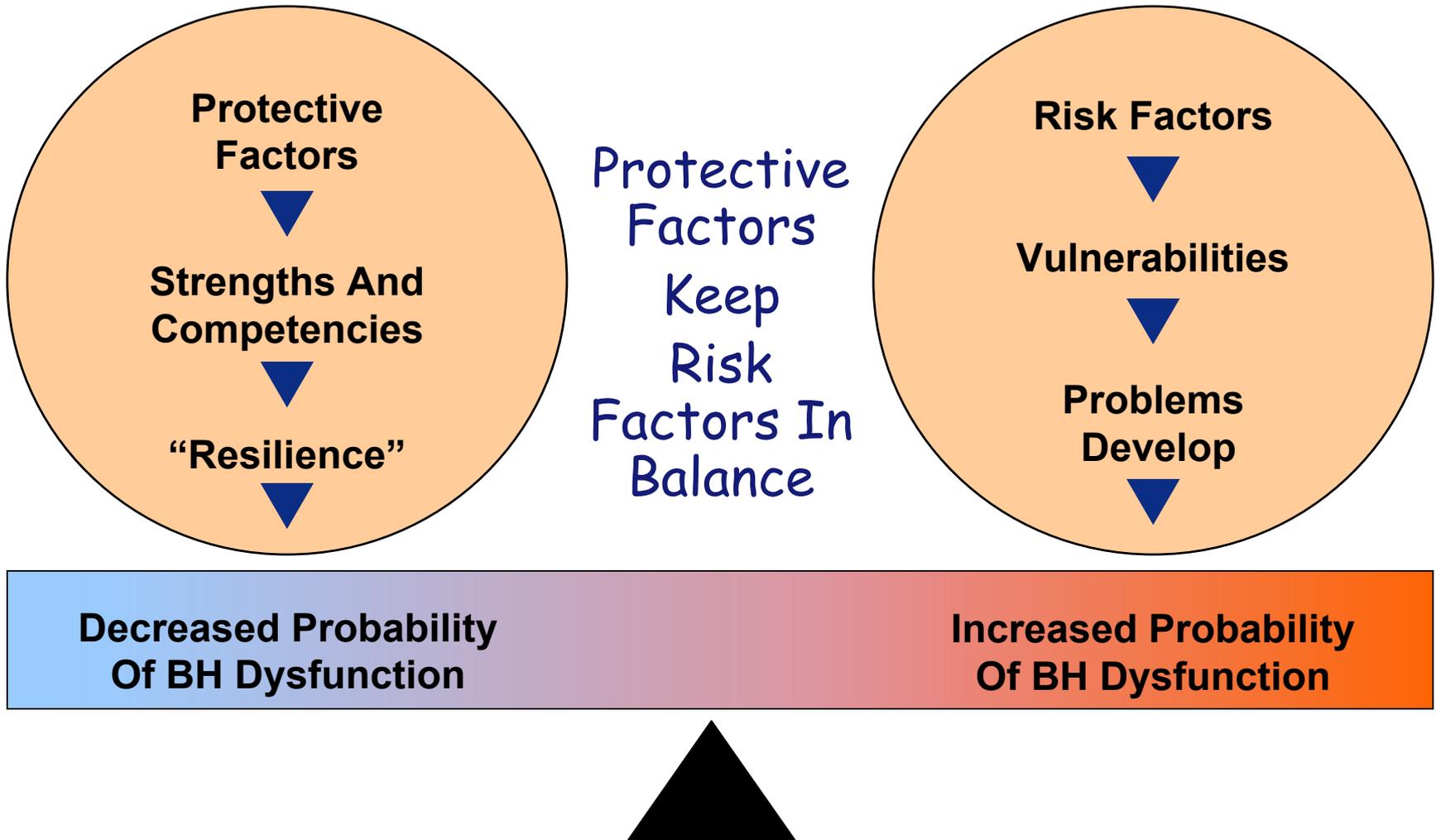
STRESSORS can serve as precursors or even the "trigger" for dysfunctional behavior(s) depending on:

- supportive vs. non-supportive nature of current *environment*, coupled with
- prior *ACE* - loading, juxtaposed with
- individual's *genetic* vulnerabilities...

- *Relationship discord
- *Financial challenges
- *Legal/UCMJ charges
- *Career problems
- *Addictions
- *Injuries
- *Illness



Achieving a Balance



"ACEs" & Behavioral Health

How Do Adverse Childhood Experiences-ACEs Affect Dysfunctional Behaviors Years Later?

Adverse
Childhood
Experiences



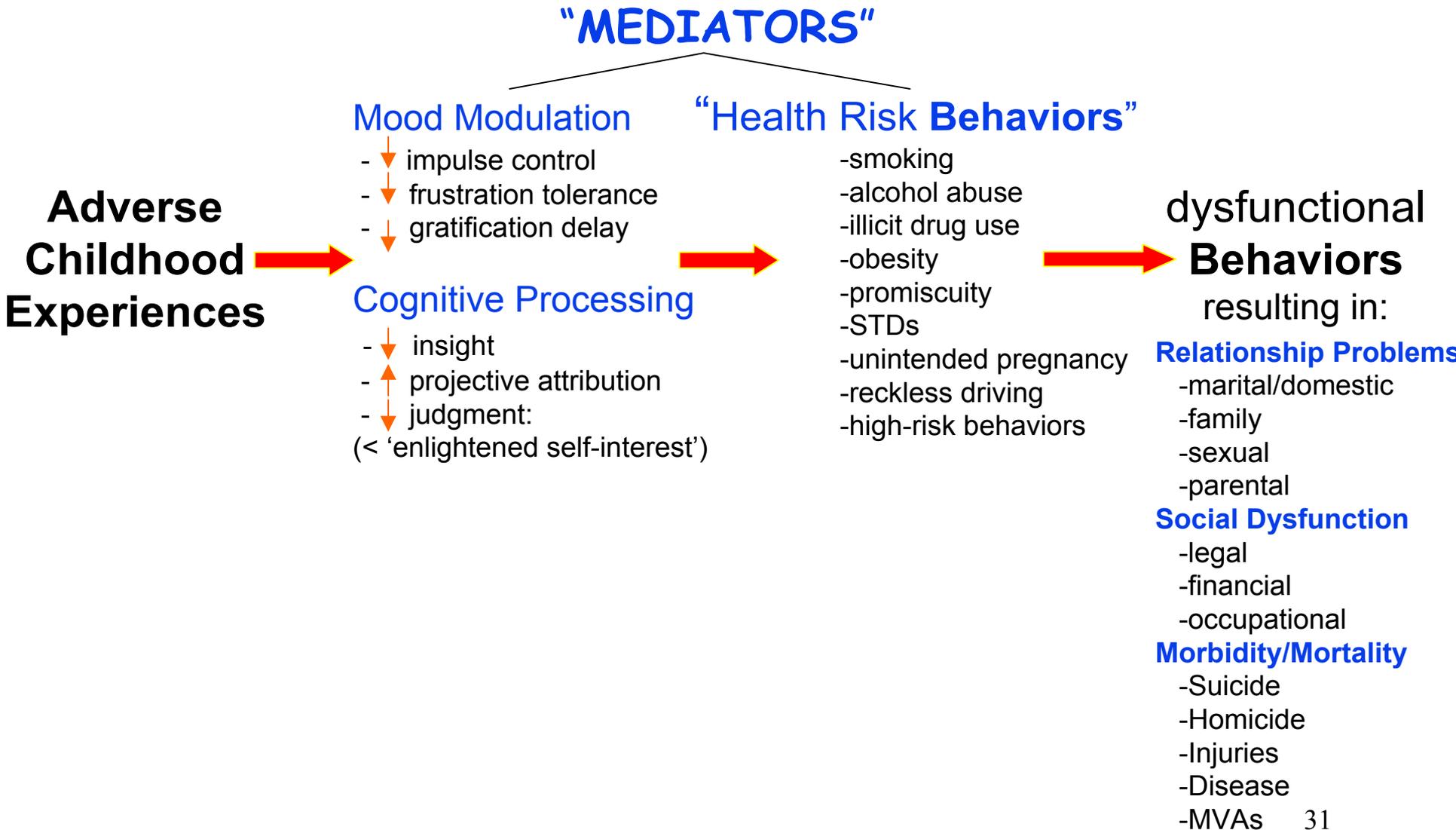
Dysfunctional
Behaviors

"ACEs" & Behavioral Health

How Are The Effects of ACEs
On Dysfunctional Behaviors Mediated?



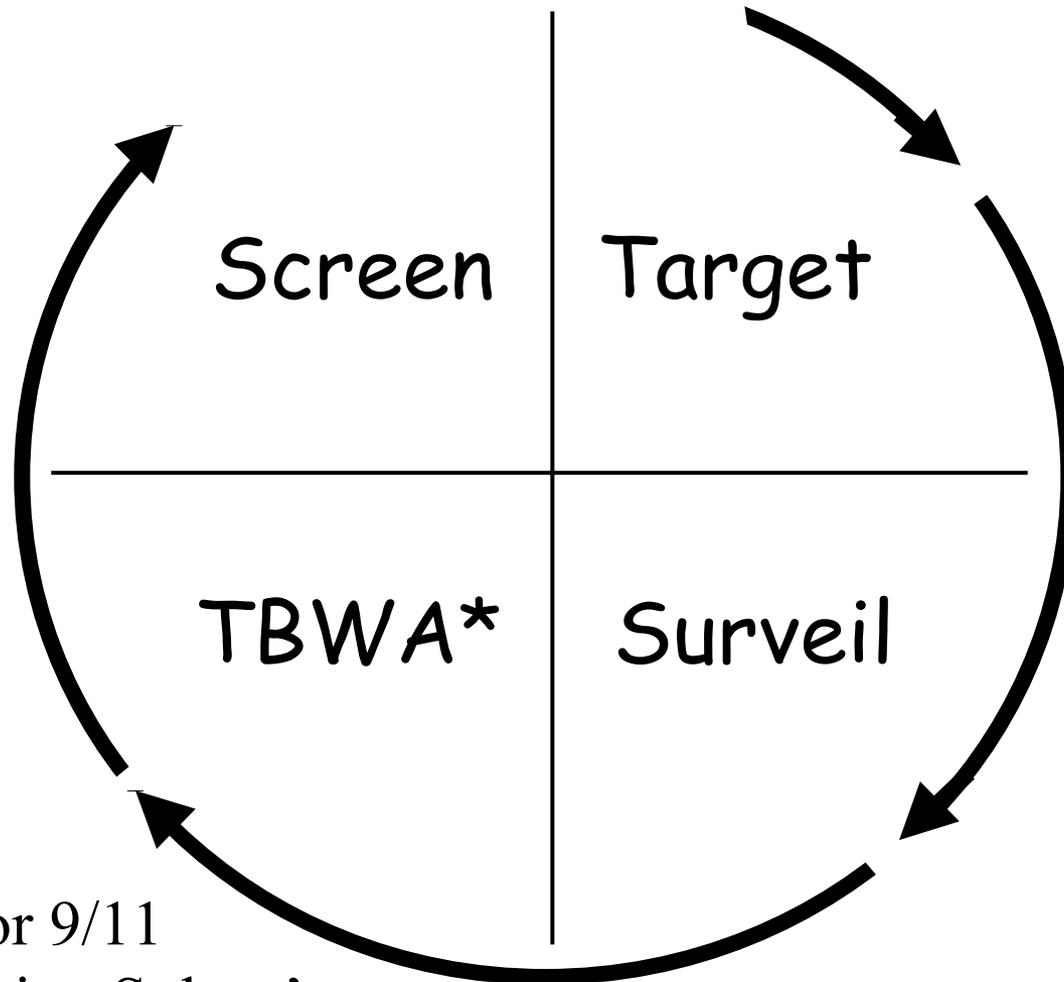
-Mediators & Behaviors in Proposed Causal Chain-



So how do we Transform BH?

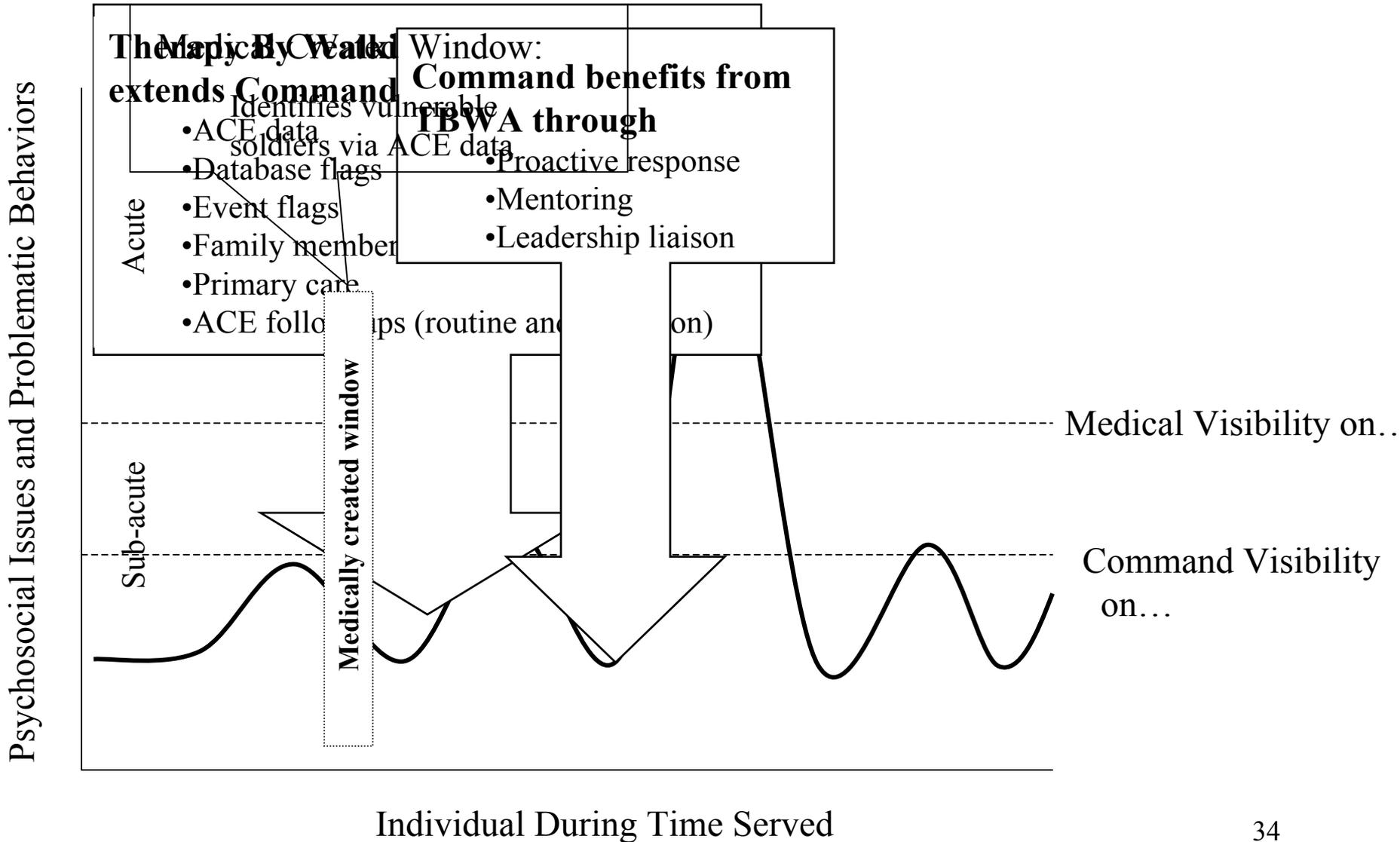
- "Screen in" ACE-burdened recruits
- Target remedial life skills training
- Surveillance of population using databases
- Targeted early intervention for 'at risk'
- Adopt battalion chaplain model for using 'preventive' BH assets:
 - 'therapy by walking around'(TBWA*)

Strategy to Maximize the Army's Behavioral Health capabilities



*Developed for 9/11
PNT – ‘Operation Solace’

'Vissitudes'(ups & downs) in a Soldier's Life



So what are the Challenges to
implementing a 'transformed'
Population-oriented BH Strategy ?

Challenges we face in Army BH

- 'Stovepiped' clinical/preventive services & funding
- No consensus on standards of care
- No information system to support BH 'continuity of care'
- Reactive rather than proactive services
- Stigmatized by soldiers & culture
- Ignorance about the baseline BH status of our soldiers when they are inducted
- Potential for personal & mission-related trauma NOT visible &/or predictable

Current Behavioral Health(BH) Services Model...

Sub-Optimal BH Services Through:

- ***Poorly integrated agencies & organizations***
 - with unstated objectives
 - minimal use of electronic technology
 - fragmented/dual-agency BH program organization/leadership/funding
- ***Poorly defined standards of care***
 - minimal accountability for product
 - no standardization of reports
 - minimal use of metrics for outcome
- ***Delivering poor continuity of care***
 - gives priority to tertiary care interventions
 - loose linkage of professional training to missions
 - pathology model: diagnose & dispose

The BH Services Model, we would like to have...

-truly optimal BH Services Through:

- ***Integrated BH agencies/organizations/funding***
 - clearly stated objectives
 - leverages advances in electronic technology
 - coordinated & military-responsive BH program leadership & funding
- ***Defined standards of care***
 - accountable for product
 - standardization of reports
 - uses metrics for outcome
- ***Delivering continuity of care***
 - priority to prevention of behavioral dysfunction
 - close linkage of professional training to missions
 - developmental model: proactively building on our Soldiers' strengths via unit-based TBWA

Army Behavioral Health Prevention Model



INDIVIDUAL
READINESS

Forward deploy BH assets

Normal Life Stressor

PREVENT

- Identifying "High Risk" Soldiers
- Caring and Proactive Leaders
- Encouraging Help Seeking Behavior
- Positive Life Coping Skills
- TBWA @ unit level

Awareness Training

Vigilance

Referral

Life Crisis

INTERVENE

- Unit Awareness and Vigilance
- Integrated & Synchronized Unit and Community-wide support Agencies
- Assured Problem Resolution
- TBWA @ unit level

Outpatient Care

Inpatient Care

Follow on Care

Dangerous Ideation

SECURE

- Safeguard
- Psychiatric Treatment
- Psychiatric Assessment

Dangerous Behaviors

Postvention

**Morbidity
Attrition/
DEATH**

Continuity of Care
Informed by data - BHAVRS

C

ommunity and individual capacity

A

wareness of protective and modifiable risk factors

R

esilience, health promotion, and early help-seeking

E

ngagement of peers, supervisors and leaders

Thanks for your interest 😊

?

s