Insights and Innovations in Community Mental Health

The Erich Lindemann Memorial Lectures

organized and edited by
The Erich Lindemann Memorial Lecture Committee

hosted by William James College

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Foreward

The Erich Lindemann Memorial Lecture is a forum in which to address issues of community mental health, public health, and social policy. It is also a place to give a hearing to those working in these fields, and to encourage students and workers to pursue this perspective, even in times that do not emphasize the social and humane perspective. It's important that social and community psychiatry continue to be presented and encouraged to an audience increasingly unfamiliar with its origins and with Dr. Lindemann as a person. The lecturers and discussants have presented a wide range of clinical, policy, and historical topics that continue to have much to teach.

Here we make available lectures that were presented since 1988. They are still live issues that have not been solved or become less important. This teaches us the historical lesson that societal needs and problems are an existential part of the ongoing life of people, communities, and society. We adapt ways of coping with them that are more effective and more appropriate to changed circumstances—values, technology, and populations. The inisghts and suggested approaches are still appropriate and inspiring.

Another value of the Lectures is the process of addressing problems that they exemplify: A group agrees on the importance of an issue, seeks out those with experience, enthusiasm, and creativity, and brings them together to share their approaches and open themselves to cross-fertilization. This results in new ideas, approaches, and collaborations. It might be argued that this apparoach, characteristic of social psychiatry and community mental health, is more important for societal benefit than are specific new techniques.

We hope that readers will become interested, excited, and broadly educated.
For a listing of all the Erich Lindemann Memorial Lectures, please visit www.williamjames.edu/lindemann.

The Erich Lindemann Memorial Lecture Committee presents

THE THIRTY SECOND ANNUAL
ERICH LINDEMANN MEMORIAL LECTURE

Returning War Veterans: Challenges in Continuing Mental Health Care After Military and Civilian Trauma

Veterans returning from war carry emotional and brain injuries that are long-lasting and call for protracted care beyond crisis intervention. Post traumatic stress disorder, disruption of social ties, substance abuse, unemployment and homelessness are destructive and stubborn consequences of not only military but also civilian trauma—war, genocide, hurricanes, economic depression. Is our mental health system and our society—traditionally geared to acute care of acute problems—willing and able to provide this care? How can we enhance our military, veterans administration, and civilian mental health systems and our community support to deal with these prolonged mental health needs?

Speakers

Jaine L. Darwin, PsyD, Co-Chair, Strategic Outreach to Families of All Reservists (SOFAR); Clinical Instructor in Psychology, Harvard Medical School; Supervising Analyst, Massachusetts Institute for Psychoanalysis

Gary B. Kaplan, MD, Director, Mental Health Services, Veterans Administration Boston Healthcare System; Professor of Psychiatry, Boston University School of Medicine

Erin Daly, PhD, Director, Center for Returning Veterans, Veterans Administration Boston Healthcare System; Assistant Professor of Psychiatry, Boston University School of Medicine

Tom Kelley, BA, MS, Secretary, Massachusetts Department of Veterans Services

Barbara A. Leadholm, MS, MBA, Commissioner, Department of Mental Health, Commonwealth of Massachusetts

Moderator

David G. Satin, MD, DLFAPA, Assistant Clinical Professor of Psychiatry, Harvard Medical School, Chairman, Erich Lindemann Memorial Lecture Committee

June 5, 2009, 2:30 – 5:00 pm

Massachusetts School of Professional Psychology
221 Rivermoor Street, Boston, MA 02132

Introduction by David G. Satin, MD and Nicholas A. Covino, PsyD

David Satin:

Ladies and gentlemen, I want to welcome you to the 32nd Annual Erich Lindemann Memorial Lecture. This one is entitled "Returning War Veterans: Challenges in Continuing Mental Health Care after Military and Civilian Trauma."

Nicholas Covino:

Thank you, David. It's a pleasure for me to be here each year to welcome people to the Lindemann Lecture. They're always very creative, they're always very timely, and they're always in keeping with the spirit of somebody who was a significant force in the treatment of trauma in our country.

Most of the time following any war, countries want to repress what just happened. We tend to do that because of the horror of it. We tend to do that because we often don't know what to do in the wake of it. We tend to do that because we want to forget and go onto something new, and sadly we also don't know how to pay for and/or deliver the services that our soldiers and marines are in need of after they have finished their service. We do that all of the time, and we've done that with each war.

Absent is the presence, the constant presence of the VA system. So the VA system finds a way all of the time to bring services, but we know we've got a million and a half people coming back from this war, and it's very different. These are people who largely citizen soldiers. They did not think that they were going to go fight in a war. These are people who've been there for often two tours of duty. These are people that 90% of whom have been shot at, so it's very different even from the Vietnam era where people could be at the front and a lot of people could be at the back. Ninety percent of the people who've been through this war have seen action and they've been traumatized. A quarter of these people, or a little less, a fifth of these people, are going to be coming back with traumatic brain injury, about a third of these folks have Major Depression and Anxiety disorders. This is a serious piece of business that needs all of the help in the room, so for me it's very gratifying to see our supervisors in the room.

It's important and gratifying to see beginning mental health practitioners in the room. It's very gratifying for me to see folks coming from VA system, folks coming from the State system, folks coming from the private sector, to think together about how we going to meet the mental health needs of these folks. What I will do on behalf of this effort is to start a program here at MSPP for returning veterans.

Like our Lucero Latino Mental Health program, this Yellow Ribbon Committee and project will be a way of bringing language and culturally competent mental health providers back into training in mental health to serve this population. Because our

thought is, like the Hispanic population serving the Hispanic population, there's a culture that needs to be understood by a mental health provider best done by somebody whose been there. There's translation that needs to be done. We know how to do the mental health services because that's what we do here at MSPP. If you're an expert in this area, you want to help us with this effort, you know the culture, you've been there, or if you've been especially a mental health provider whose been there, I'd like to hear from you as we begin this in September. I applaud each of you for your efforts to sit and think about this very important mental health issue.

Gary B. Kaplan, MD

Director, Mental Health Services, Veterans Administration Boston Healthcare System; Professor of Psychiatry, Boston University School of Medicine

Introduction by David G. Satin, MD

Our first speakers are Gary Kaplan, MD, who is a graduate of Hahnemann and Tufts University Schools of Medicine, for medicine and psychiatry. He is a professor of Psychiatry, Pharmacology, and Psychology at the Boston University School of Medicine and Director of the Mental Health Service. He is also the Chief of the Psychiatric Service of the VA Boston Healthcare System. In 2000, he was awarded the Physician of the Year Award by the Disabled Veterans of Rhode Island. Also speaking with him is Erin Scott Daly, Graduate of Harvard and Temple Universities in Education and Psychology, Assistant Professor in the Department of Psychiatry, Boston University School of Medicine, Director of the Center for Returning Veterans and Coordinator of the Military Sexual Trauma Program of the VA Boston Healthcare System, a reviewer for the Journal of Traumatic Stress, and received the citation of the Boston Fire Department Commissioner for quote "fighting stress in the fire service." She is also a co-author of *Disaster Mental Health Workers: Responding to Ground Zero One Year Later,* and, *Assessing the Etiology of Co-occurring Substance Use and Post Traumatic Stress Disorder*.

Gary B. Kaplan, MD and Erin Daly, PhD

Thank you, Dr. Satin, for inviting me. Thank you all for your invitation today. It's really a pleasure for Dr. Daly and I to talk with you and our distinguished panel about the VA Boston healthcare system. We want to talk about the remarkable mental health services that we provide for a large number of veterans, and the overall care that we provide for veterans in our system and to help you know more about the VA. So my presentation's going be relatively brief. I'm going to be speaking about the VA system, introducing you to that and our mental health service, and then Dr. Daly will tell you specifically about the program we developed just four years ago, called The Center for Returning Vets for veterans returning from Iraq and Afghanistan and the mental health services that we provide. We'll try to do this in about twenty minutes so that we'll have about ten minutes to interact with you in the audience, to have you ask questions, and to get in a dialogue about VA services.

So, let me start with an overview about VA Boston. Actually, there's a lot that you may not know about the VA system. The VA Boston medical centers have changed dramatically in the last few years. What you may remember is that there were four

medical centers in the Boston area: VA Boston was once Jamaica Plan VA, West Roxbury VA across the street, Brockton VA twenty-three miles away, and Bedford VA to the north. In fact in 1999, VA Boston merged, and that means the West Roxbury, Brockton, and Jamaica Plain campuses merged into one system; one system of organization to provide medical, mental health care, substance use care, substance abuse treatment, surgical care, primary care, and nursing care under one umbrella, under one organization. So we've been together working as an organized system for the last ten years. There is no longer a West Roxbury VA distinct from the Jamaica Plain VA. We work as one system. Bedford VA is an independent VA north of us, not part of the VA Boston system.

We've been very fortunate in that we have a very large system of inpatient, residential, and outpatient mental health care for many veterans. Over all of VA Boston, for total care; medical, surgical, primary care, and mental health care, we provide care for about 65,000 veterans. For mental health services, we provide treatment for about 12,000 veterans a year, and we provide treatment in inpatient, residential, and outpatient settings. We have over forty different treatment programs in mental health available to these 65,000 veterans who need care, 12,000 of whom are actively engaged in care. We have a large inpatient program based at Brockton and we have 126 beds, 56 of those beds are acute psychiatry inpatient beds, 56 of those beds are longer term psychiatry beds, we have 14 detoxification beds for alcoholism. So that's a really enormous program of inpatient care. Pretty well integrated with that is a large residential system of care, so patients can move along in a continuum of care from acute inpatient care to residential care to step down into substance abuse residential or chronic or serious mental illness residential.

We have a new residential program for women with PTSD and substance abuse. These programs are all primarily based in Brockton, so we have about 150 residential beds where patients can then rebuild their lives and move along the continuum of care. They can move in multiple directions, up and down, based on their needs. If you start with an acutely ill, for example with severe PTSD and substance abuse relapse, they may be admitted to the VA Boston Brockton inpatient beds, and then after a relatively short length of stay may transition to a residential program where they'll get the skills that they need to make progress and live independently in their lives. Then patients with several weeks or several months in residential care can transition into other programs.

We also have a domiciliary program for patients who are homeless, with over 50 beds for homeless veterans. Then they can transition to community residential. We also have many different types of outpatient treatment. It's a very large system, and we try to individualize care for each veteran and their needs. We have large subspecialty outpatient care for 12,000 veterans, as I mentioned. Our main conditions that we treat include Schizophrenia, Posttraumatic Stress Disorder, substance-use disorders, and

other anxiety and affective disorders. We provide for 2,300 inpatients every year and we have a large commitment to homeless veterans. VA Secretary Shinseki has really made it one of his main goals is to eliminate homelessness amongst veterans, certainly amongst returning veterans. It's very sad for us to see returning veterans deteriorate and require inpatient care, become homeless, lose their families, lose their support in the community. So we have a very large commitment to prevent and treat homelessness.

We have a large multi-disciplinary staff in VA Boston in mental health. We have 375 full-time equivalent staff disbursed throughout our three major medical center campuses and our community-based clinics. I have to say; the tragedy of course, is that there are two wars going on. The only thing you can say that is positive is that there has been a commitment at the Federal level to provide major expansion of mental health services for all veterans and for returning veterans. So in the last two years we've expanded our clinical staff by a third, which is enormous. So we have filled gaps in care and expanded care by 100 full-time equivalent staff.

Another thing to know about the VA healthcare system is that it's very academic. We have a very large training mission in psychology, social work, and psychiatry. We have major affiliations with Harvard Education School and Boston University School of Medicine. We have large training programs in psychiatry in psychology, as I mentioned. We have large research programs, many of you may know Dr. Keane, who's been an academic fixture in VA Boston, who as chief of research has developed a very active vibrant PTSD research program that has expanded tremendously.

As I mentioned, we have three major campuses; Brockton, Jamaica Plain, and West Roxbury. Basically, at West Roxbury we provide tertiary care, acute care for in medicine and surgery, and then we provide consult liaison care for the mental health needs of patients and medical surgical beds. In Jamaica Plain, we have a large, multi-specialty out-patient program with dozens and dozens of clinicians providing outpatient care at Jamaica Plain. At Brockton, we have a large outpatient program and inpatient and residential program, where we also serve veterans. We also serve veterans in many communities in Framingham, Worcester, and Lowell and have many community-based clinics. The organization of our mental health services is really based on pro-treatment needs of the veteran. So an individual with Schizophrenia will have of course different needs than someone with PTSD, and we provide treatment services in major areas like PTSD substance use disorders, serious mental illness and general mental health.

As I mentioned, we have two major academic affiliations, with Harvard and BU. We have a very large training mission with 32 psychiatry residents throughout VA Boston. We have twelve Boston University residents, we have VA BU fellows in addictions, Brigham VA fellows in psychosomatic medicine, we have a very large psychology training mission, with 19 interns and twelve post-doc physicians and many social work

internships. So our clinicians come not only to treat veterans, but they come to teach the next generation of professionals, much like many of you.

I'm going to transition to Dr. Daly's presentation. As mentioned, there's a very high risk of mental health problems in veterans returning from Afghanistan and Iraq. Two recent studies from the journal VA/MA showed that extensive mental health needs for these returning veterans in fact about a third of the veterans at some time in the period of the first two years post-employment have made use of mental health services, so we've needed to expand services, and Dr. Daly is going to talk about these veteran mental health services. In 2005 we created the Center for Returning Vets, which is an outreach program, a psycho-educational program and a treatment program for veterans and we also perform other missions, our teaching and our research mission. So I think that the main presentation you'll want to hear from is Dr. Daly and her description of mental health services for returning vets, thanks for your attention.

Erin Daly, PhD

Director, Center for Returning Veterans, Veterans Administration Healthcare System; Assistant Professor of Psychiatry, Boston University School of Medicine

My goal today is to describe some the unique challenges we face in serving returning veterans from the wars in Afghanistan (Operation Enduring Freedom/OEF) and Iraq (Operation Iraqi Freedom/OIF). Dr. Kaplan provided an excellent review of the broad ranging and multifaceted mental health programs available to all veterans within the VA Boston Healthcare System. Our goal in responding to the needs of returning veterans is not to create a parallel system of care. The VA provides extensive inpatient, residential, and outpatient specialty mental health programs that are accessible to all veterans and provide an excellent resource for many returning veterans. However, returning veterans face unique challenges, including the possibility of redeployments during the course of treatment, and significant demographic differences from previous war veterans. One of the VA's responses to these challenges was the creation of the Center for Returning Veterans. The Center for Returning Veterans (CRV) provides critical supplemental mental health services, outreach and education to VA staff about the needs of returning veterans, and outreach into the military and the community to educate returning veterans about what is available to them within the VA.

What are some of the challenges to engaging returning veterans in VA mental health care? There is research literature on the factors that may interfere with engagement in mental health treatment. These factors include personal factors or characteristics of the veteran that may make it difficult for him or her to seek care. In addition, there are institutional and structural factors that can impede treatment-seeking. For example, if

veterans are not aware of what is available to them or the procedure for enrolling in care is difficult, those in need may not seek care. Finally, veterans' concerns about the stigma of seeking mental health care may interfere with help-seeking.

How can we attempt to minimize some of these barriers to care? One of the key factors is outreach; that is, reaching into the community to let veterans know what is available to them so that we reduce institutional/structural barriers. In addition, when we outreach to non-help-seeking veterans, we talk in detail about the process of readjustment. Specifically, we discuss how difficult it can be to one day be in a combat zone, practicing skills that work very well in keeping you alive, and then the next day, to return to the civilian context and suddenly find that the skills that worked effectively in the combat zone, suddenly don't work very well. In fact, these skills may start to interfere in relationships and cause challenges in the workplace. This broad message has the benefit of both pulling in wider range of veterans, including those with milder symptoms for whom we may be able to prevent more significant pathology, and allowing those who are experience more significant difficulties to feel more comfortable in seeking care because their difficulties can be viewed on a continuum of normal responding. This is one way in which we try to reduce the stigma associated with returning veterans seeking mental health care.

Although many returning veterans are making it to the VA and approximately 42% have enrolled in VA healthcare thus far, not all of those in need are receiving mental health services. Therefore, we must ask how we can best facilitate the process for veterans to receive mental health evaluation and treatment when they register for VA services or are seen in primary care or other specialties. How can we help them to make a seamless transition from medical treatment to mental health treatment?

Two major VA initiatives have been designed to respond to this issue. One is the primary care behavioral health program in which mental health staff are integrated into primary care clinics. This is not a returning veteran-specific program, but returning veterans make great use of it. A veteran who comes into a primary care visit for an annual health maintenance visit or a sick visit may be identified by their primary care doctor as in need of mental health services. Integrated mental health staff are available in these clinics to meet immediately with veterans in need to normalize the seeking of mental health care, reduce stigma by providing care in a general medical setting, and prevent the possibility of a veteran being lost to follow-up.

The other initiative is the development of the Center for Returning Veterans (CRV). The CRV is co-located with the VA's returning veteran outreach staff that facilitate all returning veterans' entry into the VA system, and is intentionally not located in a mental health area. Therefore, the moment that a returning veteran is registered in the VA system, if he or she identifies a re-adjustment or mental health concern, an immediate

connection can be made to CRV mental health staff. If possible, these veterans are seen immediately, but if this is not possible they are scheduled for an appointment so that they leave the clinic in an effort to smooth that difficult transition from initiation of VA healthcare to mental health treatment.

The Center for Returning Veterans provides a broad range of services. Initially, we perform comprehensive assessments, to ascertain where returning veterans will be best served and to help them navigate our large mental health system (e.g. facilitating entry into a substance-abuse program). In addition, we provide brief treatment for returning veterans experiencing readjustment concerns, as well as other mild or short-term psychological disturbance. It is important to note that, for a recently returned veteran, it may not be immediately clear whether the veteran is suffering from Posttraumatic Stress Disorder that will become chronic or from an adjustment reaction that may resolve over time. Therefore, we collaborate closely with specialty mental health clinics in order to ensure appropriate transfer of care if needed.

In addition, the CRV provides ongoing psychotherapy for returning veterans who are not good candidates for transitioning to specialty mental health programs. One example is a veteran who is abusing alcohol or drugs but who is not currently acknowledging this behavior is problematic. This veteran would likely be unwilling to accept referral to a substance abuse treatment program. However, he or she may be willing to participate in treatment aimed at stress reduction. Due to the CRV's broad mission, treatment can appropriately be provided in this case for both stress and drug/alcohol abuse simultaneously. In addition, veterans with intense anxiety about stigma and being identified by others as having a mental health issue may be more comfortable seeking care in the CRV because of its location away from other mental health clinics.

The primary psychotherapeutic interventions that are employed in the CRV for veterans receiving brief treatment include psychoeducation (e.g. explaining the normal process of readjustment), motivational-enhancement interventions (e.g. assisting veterans in identifying what is not working in their lives and taking ownership over making life changes), and a wide range of empirically-based treatments, particularly brief cognitive-behavioral treatments (e.g. Cognitive Processing Therapy, Prolonged Exposure, CBT for anxiety and depressive disorders).

We have reviewed the challenges of engaging returning veterans in care, however, it is also important to note some of the unique characteristics of this population in order to best serve them clinically. Recent wars have seen increased numbers of women (within the VA, 12% of returning veterans are women) exposed to both combat trauma and, frequently, military sexual trauma. In addition, 58% of returning veterans are under 30.

Importantly, returning veterans are diverse, and vary in age with National Guard and Reservists typically older and regular active duty military veterans typically younger.

Another key co-occurring issue in returning veterans is traumatic brain injury (TBI). Compared to previous wars, returning OEF and OIF veterans are at approximately twice the risk TBI. This is the result of both the types of trauma exposures faced in the current wars and to the fact that recent veterans are surviving major injuries with greater frequency. One of the challenges in mental health treatment is symptom overlap between PTSD and TBI (e.g. memory issues, concentration difficulties, and sleep disturbance are common with both diagnoses).

It can be extremely difficult to determine whether a symptom is the result of TBI or PTSD. TBI can also impact treatment engagement and follow-through with treatment recommendations. It may be more difficult for a veteran with TBI to track appointments and treatment-related assignments; therefore, the mental health clinician may need to make frequent reminder calls and strategize with veterans on how to best manage memory and concentration-related difficulties. In addition, research has not yet answered the question of how to approach these diagnoses. For example, should these issues be treated consecutively or concurrently? Therefore, we currently make these decisions on a patient-by-patient basis, trying to identify the best approach for each individual veteran. We anticipate that research may reveal more over time but our goal is to maintain a patient-centered approach.

Another key issue is occurrence of multiple deployments for many recent veterans. Veterans may present for VA mental health treatment while still active duty through sharing agreements with the Department of Defense. In addition, Reservists and National Guard soldiers who have previously served in combat may present for mental health treatment while engaged in the military with the potential for redeployment. Treatment under these circumstances may lead to fitness for duty questions and the need to prepare veterans for future deployments, and may exacerbate concerns by veterans about the impact of mental health treatment on their ability to advance in their career. These are issues infrequently addressed previously in the VA.

To wrap up, let us briefly review some of the lessons learned thus far in work with returning veterans. It is of key importance to provide highly accessible mental health care in order to engage veterans at the moment that they feel ready to seek mental health treatment. Each additional step creates a greater barrier to treatment engagement. In addition, it is essential to provide early intervention in order to prevent long-term disability. Specifically, it is necessary to engage with veterans who are experiencing distress that may not meet full psychiatric diagnostic criteria (e.g. alcohol overuse, adjustment concerns) and those experiencing psychosocial stressors (e.g. marital conflict, child-rearing difficulties). Finally, it is important for the mental health care

system to be flexible. As a system, we need to be understanding that returning veterans may seek mental health care in multiple episodes in multiple settings, and that they may be open to treatment for one issue, but not another at a given time. Clearly, we still have much to learn and we must continue to work together to improve our knowledge. I'm excited to hear from some of the other presenters about what else is being done in different settings. Thank you.

David Satin:

Thank you for a quick and dense overview of the VA system. My understanding is there are many new, inventive and well-supported programs stimulated by this war and this influx of veterans. But our concern today is, how long will those resources, and how long will that focus of interest be available when there are more wars or there are more budget cuts, or there are other emphases by the government which supports the VA?

Tom Kelley, BA, MS

Secretary, Massachusetts Department of Veterans Services

Introduction by David G. Satin, MD

Our third speaker is Thomas G. Kelley, who had his education at the College of the Holy Cross and the Navy Officer Candidate and Post Graduate Schools. He spent thirty years in the United States Navy, rising to the rank of Captain as a U.S. Navy surface warfare officer, as Commander of Warships and Facilities and on staff duty. He was awarded the Medal of Honor and the Purple Heart during his service in the Vietnam War. He was Commissioner and is now Secretary of the Massachusetts Department of Veteran Services and served, interestingly, on the Massachusetts Interagency Council on Housing and Homelessness.Very appropriate for the occasion. Secretary Kelley…

Tom Kelley, BA, MS

Well good afternoon and thank you, Doctor. I don't have a power point presentation. I know that's going to really disappoint you but you're going to have to just look at me, I think. I'm anti-power point, to tell you the truth. I'd like to just clear up a couple of things before I get started, Dr. Daly mentioned two issues which I'd like to follow up on. Number 1 is the homeless veterans issue, and who in the community is able to take care of the needs of returning veterans. The good news here in Massachusetts is that we are unique in that every city in the Commonwealth has a local veteran's office, a municipal employee whose job is to take care of the men and women who are veterans in their community.

We have a financial assistance program, whereby the town can actually pay first and last month's rent for veterans to keep them from becoming homeless. If somebody loses their job or faces foreclosure, in many many cases the local community can take care of that veteran and his or her family. Then, we the state, reimburse the town 75 cents on the dollar down the road. The second item would be talking about supportive housing for veterans. The VA does have a program called VASH, VA Supportive Housing, which is a Section 8 voucher type of program, which includes case management for veterans with social issues. They have to be homeless, they have to be in danger of being homeless, they have to have a mental health issue or a substance-abuse issue, and the VA provides one case worker for every 35 clients. Right now we have actively about 200 of these vouchers have been issued over the last year, and I think we're getting about 200 more in the next year. So it's a great program, and it's under the purview of both the VA, HUD and local housing authorities here in the Commonwealth of Massachusetts.

So having said that, I'll tell you a little about what we're doing at the Massachusetts Department of Veteran Services. Barbara Leadholm and I are both agency heads within the Executive Office of Health and Human Services. So we work very closely together and of course with the folks at the Boston VA Healthcare system and the Bedford VA Healthcare system. Since 9/11 about 30, 000 men and women have completed their military service and come back home to Massachusetts. They're part of the nearly half a million veterans that we do have here in Massachusetts. Of that 30,000, about 20,000 have served in Iraq or Afghanistan, and a significant portion of them have served multiple tours over there.

What makes this war so different from some of the others and I know the previous speakers have addressed this to some extent, is that there is no real distinction between front lines and rear areas in Iraq and Afghanistan. Men and women are almost constantly exposed to the risk of violence from unexpected sources like improvised explosive devices. When they go out on a patrol or they leave the compound, there's always that danger. And some figures show and I think Dr. Kaplan mentioned it, that up to 90% of the troops in Iraq have actually seen a friend, fellow soldier, civilian, or an enemy seriously injured or killed. This is much higher than in previous conflicts.

I served in Vietnam, and I think the figures I recall seeing was only about 20% of the soldiers who served in Vietnam actually saw combat up close or violence up close, so this is a really significant statistic. It clearly adds to the stress that the soldiers are experiencing, the uncertainty of where next blast may come from. Moreover, according to a recent army study, multiple deployments really raises the risk of PTSD in service members, and with the all-volunteer force which we went to back in 1972, we're sending these same men and women overseas over and over and over again.

Now when a soldier comes home- I'm using the term soldier- I was a sailor and we probably have some marines in the room and airmen and coastguardsmen. "Soldiers" is easier, but it's generic. I'm talking about service men and women. When they come home, particularly from combat, they go through the process of readjustment, reintegration, back with their family, their workplace, their college campus, and with society in general. The contrast in the environment is stark, as Dr. Daly mentioned, the same support system which helped pull them through that year in a combat situation, could cause problems if not properly addressed when they come back home.

They enter a world which is hopefully full of love, caring, compassion, but even those qualities may seem strange to a soldier, to his or her family and friends because it's been absent for the last year. They've been in a survival mode for the last year. The fact remains that this integration process produces stress. We feel an obligation in the Department of Veterans' Services and everybody at the table here, to make sure to do our best to make sure the stress does not turn into a disorder. By the way, we need to

remember always that this same stress exists at least as much and equally upon members of the family of this soldier.

We heard mention of the RAND study before, I won't go into that, but one in five returning service members are reporting symptoms of PTSD. It's a large number, but what's more troubling is that this does not include those who are returning home and who are not reporting their symptoms and instead choose to suffer silently. As far as I know, those numbers of people are not included in that 20%. Researchers have found many treatment gaps exist for those with PTSD and depression, and only 53% of the service members with PTSD and depression sought help from a provider over the last year. And roughly half of those got at least minimally adequate treatment. Another issue in another RAND study talks about traumatic brain injury, and we heard how sometimes the lines are kind of murky between TBI and PTSD. Here in Massachusetts, the Mass Rehab Commission, which is another agency under Executive Office of Health and Human Services, has set up a Veterans Traumatic Brain Injury Consortium with some federal dollars. It's been in effect about two years now I think. And all the appropriate parties are at the table, the Brain Injury Association, SHIP, DPH, DMH, Veterans Services, National Guard- they are all part of it and it's an effective program. It's a learning process and very very helpful, and they just got a renewal of their grant within the last couple of months.

So what's being done to address the mental health issues? You've heard primarily the VA is really stepped up to the plate by pre-deployment training and briefings for soldiers and their families. The Guard is doing that. During deployment, family members have professional help available, both from military sources and from exceptional private sources such as SOFAR. Dr. Darwin's going to talk about that in a moment, which is a pro-bono mental health program for families of all reservists, another organization called Give an Hour, which is a nation-wide organization which does basically the same thing. It helps people give an hour or more to help families and servicemen and women. When the soldier's ready to come home, the families are gathered together to help them prepare for the sometimes traumatic experience of being reunited with your loved one.

When a unit of the Mass National Guard returns, there's a mental health assessment made by the VA through the Vet Center personnel. They have Vet Center's which are walk-in storefront operations around the state. There are half a dozen or so here in Massachusetts, and this is peer counseling, combat vet to combat vet. They feel very comfortable walking in and talking to these people. They might not feel as comfortable talking to an old fuddy duddy like me, but they do with a fellow young veteran. It's a one-to-one, face-to-face interview, over 5,000 interviews have been conducted in Massachusetts and New Hampshire in the last couple of years and about 60% of those

soldiers have requested follow-on counseling or treatment through the VA or through other providers.

At the Department of Veteran Services, a State agency, we started a program about a year ago to assist in this readjustment and reintegration process. In collaboration with Mass Dept of Public Health, we received some funding for the purpose of suicide prevention. It's incredibly unfortunate and the statistics are startling, but suicide rates in service members are higher now than ever before. You've probably read about that in the study, in the papers and in the literature. This past February, the Army reported that more soldiers had died by suicide in January than by combat overseas. According to DOD, between 1995 and 2007, there were 2200 suicides, 188 last year alone. And these only included active duty soldiers. In 2005, another study showed that veterans were more than twice as likely to commit suicide than than nonveterans. We established a program about a year and a half ago called SAVE, which is an acronym for Statewide Advocacy for Veterans' Empowerment. The team is comprised of recently returned Iraq and Afghan vets, some of whom have been wounded over there, as well as family members of veterans. With the help of federal, state agencies, local private, nonprofits, the team has become well-versed in the field of suicide prevention, understanding the signs and so forth.

Through peer support, outreach and advocacy, the team acts as a referral service. They're not clinicians, they're a referral service for veterans and their families and every agency that that our team refers people to, the team members have been through those agencies themselves so they can do it with a fair amount of credibility. "We've tried it, it worked for us, why don't you try it." Very effective, and these are all young, 25 to 30 year old young men and women. They're dealing with men and women who have been through what they've been through, which significantly does add to their credibility.

When formulating this program, we were fortunate enough to have the Mom and Dad of a young marine who after returning home from Iraq did not receive the services which he desperately needed, and he ultimately took his own life. Joyce and Kevin Lucey, helped us to determine what was needed so that other families and soldiers would not go through what they and their son Jeffrey had experienced. SAVE teams are on the road and around the state on a full time basis, they work with the local VSOs in every city and towns, with the VA, other state agencies and other health care providers. The Mass National Guard, as Commissioner Leadholm mentioned, has established a program called Yellow Ribbon or Operation Total Warrior. They have a fully staffed resource center out there in Wellesley, with mental health professionals and reps from various agencies and programs, and they take care of service members, veterans and their families, not just members of the Guard. They'll help anybody that walks in the door. We work hand in glove with the Guard on that.

There are two significant challenges, I think I'll wrap it up by saying. Number 1, the multiple deployments that our soldiers are facing. Clearly, they add to the stress and compound the severity of it all. Just last night I was up at Salem State College, and I spoke with a gentleman who's an elementary school principal with a Ph.D in education. He's also a Sergeant in the Mass National Guard, has spent two tours in Iraq at counseling centers and with the troops. He spoke of one battalion, not a Mass National Guard Battalion but an Army Battalion that he worked with, which was on its third deployment to Iraq in which 60 per cent of the soldiers in that battalion had become or were in the process of getting a divorce. The same sergeant spoke of roughly 300 soldiers whom he had dealt with, who were close enough to suicide that they had a weapon at the ready. Now these are active duty men and women who have the services right there available to them at their fingertips, and 300 were ready to commit suicide. It's appalling to think of that, and to see how many don't have anybody to turn to and that's where we all come into it. This gentleman I spoke to last night, he served in the same counseling center over there in Iraq at which a soldier just a couple of weeks ago killed two of the counselors. You read about that in the paper. He was in that same center, he knew those two gentlemen who were killed;

The last thought I'd like to leave with you has already been mentioned by everybody, and that's the well-known stigma attached to mental illness and to seeking treatment. It's there and it's real. The army is becoming more aware of it due to some high ranking generals acknowledging their own PTSD. One high ranking general has had two sons die, one in combat and one by suicide while a cadet at West Point. We still have a long way to go though. Here in Massachusetts I know a police officer who came home from Iraq, sought and received treatment for his PTSD and promptly had his weapon taken away from him and put to work shuffling papers. His department has basically written him off. He doesn't even feel like a cop anymore. We know of National Guard members and police officers here in Massachusetts also who travel across the state to receive counseling and mental health treatment and who pay for it out of their own pockets because they don't want their fellow officers or their bosses to found out. This is clearly keeping people from seeking the help that they obviously need. We need to encourage our soldiers and our veterans to come forward and to ask for help if it's needed, and the bravest thing they can do is to ask. So we need to seek out these men and women who are coming home. Let them know that what we in Massachusetts have in place to assist them. So I thank you and I hope we can collectively come to grips with the challenges facing us. Thank you very much.

David Satin:

Thank you Secretary Kelley. We have to remember that veterans once were civilians and after their service become civilians again. And so we have to look to them as a part of the community who needs an integrated set of services, and I think Veteran Services have followed uh that population for a longer period of time after their return to civilian life, longer than anybody else.

Barbara A. Leadholm, MS, MBA

Commissioner, Department of Mental Health, Commonwealth of Massachusetts

Introduction by David G. Satin, MD

I want to next introduce Barbara Leadholm. Commissioner Leadholm is a psychiatric nurse clinician, who received her education from Boston College and Business Administration education from Boston University. She has worked on the line as a psychiatric nurse clinician in a community mental health center and has been Vice President of Magellan Health Services in a mental health managed care corporation, integrating health plans and public sector programs. She is now Commissioner of the Massachusetts Department of Mental Health. Commissioner.

Barbara A. Leadholm, MS, MBA

It is a pleasure to be here today and I would really like to focus my conversation much more on some of the policy and the issues related to how we do or do not work together very well. It became very clear to the Governor, the Lieutenant Governor, and the Legislature that we have returning veterans or folks in service and we are not necessarily prepared to think about how veterans services are received through the VA system, how services are received through the state system and the Federal overlay, and how we could approach all these services together. So what we embarked on is a number of different approaches, some of which I know Secretary Kelley will talk about as well. I want to present a quick overview of what we did as a "Policy Academy," and then I am going to talk about a specific program.

As we began to hear from legislators and the Governor and Lieutenant Governor's task force where they are sorting through all the various needs and hearing directly from returning veterans, from families and from advocates who have for a long time been concerned about how people access services. So we applied, on behalf of the Commonwealth through the Executive Office of Health and Human Services to be what we call a "Policy Academy," and we attended a three-day work meeting of sorts that included the Departments of Public Health, Mental Health, the Secretary of Veterans' Services, National Guard representation, UMass Worcester, because of their particular interest, the Massachusetts Rehabilitation Commission, as well as the SHIP program- which really looks at head injury under the Department of Public Health. We all attended a Substance Abuse and Mental Health Services Administration (SAMHSA) sponsored "Policy Academy" for three days where we tried to think about how the Commonwealth of Massachusetts would begin to cross the agency agendas if you will, as well as how we could begin to think about connecting with veterans' services through the VA system.

That occurred a year ago, and we developed a plan, which Secretary Kelley will talk about, through the Legislature and the Lieutenant Governor in terms of prioritizing how the Commonwealth is going to approach this issue.

As Mental Health Commissioner, there are things that are especially important to me. We have problems with stigma in the general public, imagine what stigma is like when you are facing someone who is viewing him or herself much more as a protector of this country, fighting in a war that is very complicated in terms of not only who they are and what they are and what they are trying to do, but it just puts on a layer of complexity. Add to it, as Dr. Daly mentioned, people who are returning more than one time in terms of their tour of duty. Add to that, people are coming back in one piece in many respects, I mean technology is allowing people to survive; if you look at previous wars, you would not have as many survivors, and yet, now we are really talking much more directly about the emotional scars and the trauma and our preparedness to really address those issues. So I think from my standpoint, it really speaks to this larger discussion which we would all like to have with you, which is our cross-team work that is only just beginning and I think it is interesting that we are here as a panel.

I have never met these folks and yet we talk about the VA system, it is clearly here in Boston, it is part of the state, and yet the connections are not strong in the way that you would really like them to be if you are thinking about how you would design a service system that is really intervening early, obviously able to provide many services, and yet we are not really organized in that way. So very quickly, I am going to speak about a kind of specialized program, but I thought to go a little bit more into depth because other people are going to be talking about the other parts of their system.

One of the issues for me concerns those folks who are not going to show up in the VA, they are not going to show up in our community mental health system, but people who are going to show up through their interactions with the police. And so, we really see that there is a problem in terms of police being the front-line responders, first responders for many people who have mental illness. That is the issue for us in terms of access to services. They may be homeless, have economic dislocation, or co-occurring disorders as Dr. Daly mentioned. One of the things that is very important to us is that again, at least one in five veterans returning from Iraq and Afghanistan will potentially develop Posttraumatic Stress Disorder, other trauma related disorders, substance abuse, or addiction. Now that is a pretty high number from my standpoint. And then obviously, once you have co-occurring issues of mental health and substance abuse. We are most concerned, that they are more likely to be involved in the criminal justice system.

It is a national understanding that there are particular things we can do, the specialized mental health and drug courts and jail diversion programs. So this is just thinking about anyone with mental illness or anyone who might have a co-occurring

condition. These are national efforts that we understand are very important in terms of addressing the issue. So in terms of when you think about what can you do, for the Department of Mental Health jail diversion is an important model that we consider for early intervention in terms of preventing an individual from going the criminal route, when in fact we know it is mental illness or some related issue that is a result of the behavior that has gotten them into the system and it is our responsibility to think about that. This outlines how one would consider a diversion model. I have a number of slides which illustrate the basic concept of diversion from the jail system. And then the treatment model which shows what we are using for veterans.

We are actually modifying a traditional jail diversion program and we are creating a specific model with the University of Massachusetts Medical School that will target veterans who potentially could be diverted from the criminal system, and we are looking at how we integrate evidence-based practices of mental health and substance use treatment. Many of you I think are familiar with assertive community treatment, a much more active engagement in the community as well as vocational support. And critical to this, as any of you in the mental health field know, we are talking a lot about peer counseling or peer support. How do we really bring together people who have the shared experience to feel that empathy and support in a stronger way. There is a MISSION Treatment Manual that we are changing to incorporate evidence-based trauma-informed care through consultation with the VA National Center for PTSD. Materials will be modified and pilot tested in the first year of the project to really establish this model for veterans along with ongoing service delivery. Materials will be available for wider distribution through the State of Massachusetts.

I talked about jail diversion and what we want to do is decrease or completely bypass for individuals with mental illness involvement in the criminal justice system. This includes diversion from arrest (no charges or charges dropped), diversion from lock up post-arrest, diversion from incarceration, and use of specialized courts. I am using a graphic representation of the community which shows that once you are being booked, the jail support, the re-entry, and then the correction- so that is a visual of the system of the courts of appeal.

We currently have jail diversion programs and have been very successful in terms of diverting folks from jail and working with the police. A little bit more on numbers, a slide on DMH Jail Diversion Data. We have just started collecting data in terms of the effectiveness of working with our police and the two Jail Diversion Programs I just mentioned. You would look at the total in terms of working with the police and you can see the number of diversions or those individuals who were actually diverted; and the number of arrests or those individuals who we were not able to divert and they were arrested which is a much smaller numbers.

We were able, through a SAMHSA grant, to have an opportunity to look at how we would modify the diversion program. The issue is, how does one maintain someone's independence and sobriety through a systems integration approach as well as the fact that this model is really based on working with homeless veterans and we are now modifying it to include the broader spectrum of folks who might be experiencing Post Traumatic Stress Disorder, depression and other psychiatric illnesses?

UMass is partnering with DMH, we are consulting with the VA National Center for PTSD and then what we are saying is, how would you modify a generic program that is diverting folks, specifically looking at people with co-occurring conditions, specifically Posttraumatic Stress Disorder, what would you need to do differently? How would you really target your interventions to address the trauma and the psychiatric condition? We have five goals. In years one and two, we are starting by bringing together a statewide advisory committee in which we are including state criminal justice, mental health department, public health, Medicaid, and rehabilitation agencies, the VA will be at the table with us, the National Guard and veterans organizations. Obviously, families and other interested people have a great interest in figuring out how could we really plan together and organize ourselves in a different way. Then, I keep referencing this MISSION service intervention. It is really a validated treatment and training approach, in which we are modifying it to accommodate the goals of this study.

Years three to five, we are going to be piloting this in Worcester. We will be adding one or two additional sites, and then we are going to evaluate the model in terms of those who actually go through with the MISSION program and we will compare these individuals with 150 additional folks who will not be going through the MISSION program, but will be receiving services as anyone else in the jail diversion program. So we are hopeful that we can see and demonstrate not only the cost effectiveness of jail diversion, but really the outcomes in terms of the individual and the family.

In terms of our support for this, we are allowing staff resources and project management working with UMass and the VA. The rationale for taking this approach in time was to assure that the resources are there for the services rather than the design model, and how you get cross agencies working together? How do you really develop trauma-sensitive, veteran-focused treatment and really allow folks to think about expanding the resources in terms of treatment availability? What you need to know about veterans if you are going to be offering services to them?

For myself, getting involved in the planning related to veterans there is a culture that you are not even aware of. I will tell you when we went to the "Policy Academy," we were all told we needed to come in suits because the military was there, and they are. It was a very formal three-day meeting. I mean you would not show up in jeans, you would not show up in business casual. I think acknowledgement of the culture that you are

beginning to engage in and I think as treaters, if we are thinking about early intervention, one needs to put him or herself in the shoes of people who have committed their lives to being in the service, and many folks have been there for many years, as well as the National Guard.

I think one of the things that I found fascinating is that one of the people we work very closely with is Major David Hencke who is the Chief of Deployment Cycle Support for the Massachusetts National Guard in Wellesley. They have set up a pre- and post-welcoming center for folks who are going to and from deployment, and it is really a fascinating experience in terms of how the National Guard has its own culture as well as the various armed forces in terms of their cultures. Add that overlay as I said earlier to think about accessing mental health services and to think about approaching early intervention for families or for the service people. It really just adds a layer of complexity that I am not sure we as mental health clinicians or people in the field of mental health and substance use really think enough about in terms of how one would need to modify our approaches and really what sensitivity needs to be brought to the table. So we are actually at this point developing this model in which we can work with the district courts. The court process is really looking at how we identify the veterans in need of treatment and then we will be recruiting people for the services in the fall as well as I said really bringing in the peers who will support the veterans.

In conclusion, I think it is a unique population- one in which we as mental health professionals or people working with people with co-occurring conditions, we have tremendous skills and understanding of human behavior to bring to the conversation and to the planning and to the actual interventions. On the other hand, I think we have to be cognizant of the unique needs of veterans and their families and the particular experiences they are living through in terms of these two most recent wars. I also think it is very important that we think about the criminal justice system and how we work with the police, how we work with communities, how we address some of the other re-entry issues that are much more social, much more community-based. Secretary Kelley will be talking about that.

Jail diversion really aims at addressing how we can really bring hope to the intervening and really avoiding the criminal system and bringing resources to bear to ensure that we do that. Obviously the goal is to achieve a life of quality, independence, and stability. The rates of suicide, depression, and Posttraumatic Stress Disorder are incredibly alarming. The Rand Report that has begun to talk about prevalence costs and evidence-based practice and the role that we all need to assume is very compelling, and I think this kind of forum is a wonderful opportunity to really begin the dialogue and look more carefully together because frankly, there is a role for everybody here.

The issue is really how do we cross our various interests and come together to support the service folks who are in critical roles and yet having a very difficult time, readjusting. That being said, any of the literature I have read and I certainly would defer to Drs. Kaplan and Daly to talk more about the statistics, is that most people come back able to integrate well into their communities with basic supports with an acknowledgement that they will re-enter their family lives, their community lives, their jobs very successfully. Those who cannot are really the challenge to all of us and I look forward to those conversations with you. Thank you.

Jaine L. Darwin, PsyD

Co-Chair, Strategic Outreach to Families of All Reservists (SOFAR); Clinical Instructor in Psychology, Harvard Medical School; Supervising Analyst, Massachusetts Institute for Psychoanalysis

Introduction by David G. Satin, MD

Our final speaker is Jaine Darwin, who is an alumna of this August Institution. She received her Doctorate in Psychology from MSPP, the Massachusetts School of Professional Psychology. She has a certificate in psychoanalysis and is a supervising analyst and a member of the Curriculum Committee and a teacher at the Massachusetts Institute for Psychoanalysis. She's a Clinical Instructor in Psychology at the Harvard Medical School. She's a clinical supervisor in the Victims of Violence program at the Cambridge Hospital, and is co-chairman of SOFAR, Strategic Outreach to Families of All Reservists. In the past, she was a psychologist at a community mental health agency, and at present has a private practice of psychoanalysis and psychotherapy. In 2008, she received awards from the Massachusetts Institute for Psychoanalysis and the International Federation for Psychoanalytic Education. She is a liaison to Division 19 Military Psychology of the American Psychological Association, and her publications include *Wounded Warriors: Citizen Soldiers Changed Forever*, and "PTSD: It's Symptoms, How Family and Friends Can Help Veterans," in the publication, *War's Returning Wounded, Injured and Ill*. Dr. Darwin…

Jaine L. Darwin, PsyD

Hi. SOFAR is a pro-bono mental health project that provides services to extended family of reserve and guard, beginning at deployment, and continuing through reunion and reintegration which gets longer and longer and longer. I'm honored to be a member of a panel of people so committed to caring for our veterans and their family members. We are lucky to live in Massachusetts, a Commonwealth that offers exemplary services to veterans, with support and guidance from Governor Patrick, Lieutenant Governor Murray, and Secretary of Veteran Services Kelley. As I've often said, when a soldier deploys, the whole family serves. When a soldier returns, the whole family is impacted. Veterans and their families continue to be challenged by the aftermath of this service. As community mental health professionals, our support is needed to augment the services provided by the Commonwealth and Veteran's Administration. Why might that be?

Veterans return home to spouses, partners and fiancés, and to children. They also return home to parents, siblings, grandparents, grandchildren, aunts, uncles, nieces, nephews, and cousins. While the VA offers top-notch services to our veterans, they're not

mandated to treat what is identified as "the collaterals." May I present the collaterals for your view. All the loved ones listed above, yet the loved ones are mandated by love and caring to help each veteran make the transition to civilian life and to work together to adjust to the new normal, lives change by both the separation and reunion, and whatever problems might result from repeated deployments and repeated exposure to combat. Some of this is repetitious because I thought I was speaking first, but I'm doing clean up.

Nationally, 1.7 million soldiers have deployed multiple times since the beginning of the wars in Afghanistan and Iraq. If you do the math, you can envision how many family members have been conscripted for this effort to help their soldiers readjust. Between 35% and 50% of troops return with transient but diagnosable mental health conditions: anxiety; depression; sleep problems. What is it like to cope with a family member who cannot tolerate the flurry of a crowded supermarket, or to sit at a table in a restaurant unless his or her back is to the wall, who has panic attacks in a traffic jam for fear of enemy attack? What is it like to have a loved one startle at any loud noise or refuse to attend his or her own welcome home party?

These are normal parts of a transition when someone has served in harm's way and possesses a nervous system stilled attuned to scanning for danger. What is it like to live with someone who suffers from Posttraumatic Stress Disorder? The veteran might alternate between periods of hyper-arousal and periods of blunt affect, of flatness and non-responsiveness. He or she may be moody, quick to anger or withdrawn. The veteran might isolate or increase the use of alcohol, prescription, and recreational drugs. Picture a teenage girl who has waited sixteen months for the return of her big brother, who rebuffs her, won't talk with her, and won't share in any of their old routines for which she yearned. Picture a wife who longed to sleep alongside her husband and is awakened each night by his screaming and thrashing in his sleep, as he is repeatedly taken back to the war zone in his dreams.

And what about the veteran who suffers from Traumatic Brain Injury? The veteran might have problems at work or not be trusted to provide childcare because of impaired judgment. Imagine waiting for the return of a co-parent for 16 months and finding your spouse unable to resume that role at present. Even if a veteran will return unscathed, renegotiating roles will challenge the reconstituted family. Wives have learned to manage finances, husbands have learned to cook and to braid their daughter's hair. A son who has defended his country does not want a curfew when he returns home or to be told to clean his room. Babies have become toddlers, latency-aged children have grown, and preteens have become sullen adolescents who want tattoos or to borrow the car. Grandparents may have grown the infirm or even passed away during the deployment. Intimate relationships that were held together by Skype, by videocam, cell phone and email must now transition from virtual to actual. And as we've all pointed out, this is a

very unique war because of the new communications, the war is in the living room and the living room is in the war. Children might need to be returned to their own beds as it is not unusual for many kids to ease the pain of separation by ending up in the bed of the parent who remains at home. Husbands and wives have to get reacquainted before they can rekindle their sexual intimacy.

We as professionals have a moral obligation to serve those who have served us. The special commission to study and investigate the hidden wounds of war in Massachusetts service members was charged with examining the mental health effects of war upon Massachusetts members and identifying best practices. The report of the commission that was just submitted this past January strongly encouraged the Governor to call upon members of Massachusetts mental health provider community to volunteer their time and expertise to assist returning service members. They went on to say "the participation of the mental health community is a vital part of a community-based effort to provide service members and their families with the support they need. The Commission further recommends that the Commonwealth of Massachusetts' Legislature and Governor's Advisory Council and Veterans' Services announce a formal partnership with the State and Give and Hour and So Far to provide- to coordinate the providers' community volunteer efforts. Such a partnership would serve to highlight these resources for service members and their families. The Commission applauds the work of both programs, which provide confidential counseling services outside the traditional military community. Both programs provide counseling to non-dependents of a service member, a service that the Department of Defense and the VA do not automatically provide.

SOFAR has been providing service to extended family members of the National Guard and other military reservists since 2005, and we learned several things quickly. For this community, as you have heard everybody say, mental health is stigmatized. We would have to reach out to this community if they were going to make use of our services. While many benefit from psychotherapy, more could benefit from psychoeducational interventions that build resilience and educate them about the challenges they're facing. Many family members are so busy surviving that thriving really becomes aspirational. Many family members do meet in various grassroots groups, and we try regularly to meet with them in any setting in which we can access them- Family Readiness, which is the system by which the military supports family members while they are deployed; groups run by veterans' agencies in each town; Blue Star Mothers, a group consisting of mothers of children who have served or are serving. In these venues, we can help them voice their worries and assure them how normal these worries are. These groups provide us with the opportunity to help families understand the universality of what they are experiencing.

One of the biggest problems that confronts families is isolation. Alone in their communities without the cohesion of a military base or even of a town, where many have

served, a family may not understand how many others suffer the same challenges and worries. During deployment, they all fear the knock on the door from the casualty officer, announcing the death of their soldier. When their soldiers have transitioned to being veterans, they're often not aware of how many households in addition to theirs where people wake up every morning and kind of eyeball the vet and wonder, is this going to be one of his or her difficult days, or one of the days where things go smoothly?

Tomorrow SOFAR volunteers will attend the Family Readiness Group meeting of the 325th Transportation Unit, which is a reserve unit. They have just mobilized for their third deployment. Three deployments will total forty-five months of separation since 2003; forty-five months of emotional and perhaps financial hardship. We worked with them for 2005 and 2006, welcoming them back in August 2006, and now we reunite with them again as their soldier prepares to be in harm's way for another 12 months, and they begin their jobs as single parents, as worried mothers and fathers, to raise children once again the only children in their school with a deployed parent. They know the worry of service and have twice withstood the rigors of reunion and reintegration. They will have much to teach us about what helps them withstand these rigors. What builds resilience? How have they changed as the number of deployments mount up?

We know that repeated deployments and repeated exposure to combat increases a soldier's vulnerability to PTSD, but there is a new study out in October 2008 that now says the mental health problems of spouses of soldiers who fight in Afghanistan and Iraq are actually comparable to the rate of mental health problems of the soldiers. These problems do not disappear when a soldier returns home. In tomorrow's meeting and in our meetings for groups of family members and veterans, we provide education about the bumpy road of reunion and reintegration. Helping them anticipate the affective dysregulation that occurs when a soldier moves from an asymmetrical battlefield, where danger lurks everywhere, to the home front, where the external world and the internal alert system are out of sync. We can talk about problems in relationships that come with long separations. We can begin to teach them when they should be concerned enough about their vets to seek professional services.

These families are both optimistic and stoical. They may show a tolerance for a veteran's behavior because they are relieved the vet is home, they hope the behavior will stop over time, and because they feel they must be self-reliant. By providing the families with information, we try to train them to be guardians of their veterans; the first line of defense to identify veterans at risk. You've heard the great risk from suicide. There are a thousand veteran suicide attempts a month and 18 completed suicides each month. We teach them that a vet with nightmares may be normal, one who never sleeps is not. A vet who may want to avoid crowded places is normal but one who doesn't want to leave his or her room is not. A vet who sleeps with a gun is a vet headed for trouble. A vet who

drinks to excess every night is at risk; a vet who is having flashbacks is at risk. We urge them to seek professional help for their veterans when he or she shows symptoms of PTSD and TBI; when the veteran drinks more than usual for longer periods of time; when the veteran overuses or abuses prescription or over-the-counter medications; when the veteran shows any signs of violent or explosive behavior, both verbal and physical; when the veteran commits any act of domestic abuse. This is a growing problem, because domestic violence by vets is really often an offshoot of impulsivity and increased aggression because of PTSD, and it really calls for the re-education of the domestic violence community to understand that anger management, the treatment choice previously, is not the treatment choice for these soldiers. When the veteran shows any behavior that may be harmful to the veteran or to anyone else, these may include reckless driving, playing with guns and impaired judgment; most of all, when the veteran is unaware of changes in his or her behavior; and the veteran threatens suicide. We must also reach out to other professional groups or agencies where a family or a veteran might present themselves, without making the provider aware of the link between their problems and their status as a family member of a recently returned vet. These include schools, where children's misbehavior may be warning signs of stress at home, health facilities, where they present because stress often causes physical problems like headaches, stomach aches and insomnia, and the legal system, as the Commissioner has alluded to.

We have already published the SOFAR guide for helping children and youth cope with the deployment and return of a parent of the National Guard and other military reserves. This can be downloaded from the SOFAR webpage. With the support of the Governor's Office, this is to be distributed electronically to every school in Massachusetts. The book is written to education teachers, school nurses, pediatricians and parents about the developmental challenges children face at different ages in dealing with the deployment and return of a parent. We are just beginning to work on a SOFAR guide to help couples and families cope with relationship problems related to the deployment and return of a soldier, because as Secretary Kelley alluded, when you talk about suicide, one of the major causes for suicidal ideation is problem in relationships. In the current epidemic, it is of the major causes. We are in the process of actually attempting to work with one of the major managed care companies to design a workshop for primary care physicians to identify veterans and family members who are suffering from psychological problems following their service in combat and their return. We must develop a safe way for gatekeepers to pick out our high risk vets and our high risk families and direct them to individual health services to reduce the number of suicide and suicide attempts, and to help the families who are having trouble with reintegration.

Untreated post-traumatic stress lives on in the next generation and the toll goes well beyond the lifespan of the veteran.

Many of us have talked today about services available to veterans and their families, but we also have to highlight what everybody has alluded to which is an equally great problem: how to encourage vets and their families to access the available services. One of the greatest impediments to service is the stigma still attached to using mental health services. The most recent Rand report, *Mental Health Care for Iraqi and Afghanistan War Veterans*, which just came out this month says "Surveys and focus groups repeatedly show that the attitudes and beliefs of military service members and veterans inhibit them from seeking care for mental health problems." Military culture promotes pride and inner strength, self-reliance, and being able to shake off ailments or injuries. Service members and veterans report they would be seen as weak if they were to admit to have mental health problems. There's also a skepticism about the value of treatment, and that's prominent in this population, including concerns about negative side-effects of medications, that medications will be pushed on them, and that treatments would not be helpful or were tried and did not work.

Some of the concerns are practical ones: will my military career be negatively impacted if I undergo psychological treatment? Will my security clearance for my civilian job be jeopardized? Many of our Reserve Component soldiers are police and firemen in civilian life- they are asked about fitness for duty. Last May, Secretary of Defense Gates changed military policy about the security clearance questionnaire. Question 21, I do not know the number of any other question, but I do know Question 21-it asks if you have undergone mental health counseling. Our militaries are now allowed to answer 'no' to that question if the counseling is related to service in combat zones. This for me illustrates the tension in the military between wanting to care for their personnel and still being skittish about mental health.

It's a little like "Don't ask, don't tell" policy for those with the invisible wounds of war. Unfortunately, many reservists, distrusting the confidentiality of any mental health system, don't want their family members to receive counseling either. One of the advantages of community partners like SOFAR is that we can guarantee complete confidentiality because we don't charge and we don't bill insurance and this assures no paper trail. Volunteers in private practice can offer anonymity; it may not exist in the waiting room of an agency devoted to treating veterans. Ideally, I'd like to see us all work to make our services an integrated part of health care where treatment of the mind is no more unusual than treatment of the body. And how do we do this?

We get out there as much as possible to show soldiers, veterans, and family members that we are user-friendly. That we'll speak to them in a language they understand so we can help make their own problems understandable. The Real Warriors

Campaign is an initiative launched by the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, to promote the processes in building resilience, facilitating oibtaining services and supporting reintegration of returning service members, veterans and their families. Their tagline is "Real Warriors, Real Battles, Real Strength." High ranking military officers who have used counseling services after returning from combat have been encouraged to speak out. Fort Campbell in Kentucky ceased all activities and held a twenty-four hour stand-down on May 27 to educate the soldiers on the base about suicide prevention. Secretary Kelley has talked about the same initiative in Massachusetts, which is literally a mobile outreach team that does pick up and delivery for suicidal vets. They do a stellar job.

We need to be there to speak up, to step up and to step in when we see veterans and families at risk. I urge all mental health providers in this audience to volunteer their time. That may mean contributing an hour a week of pro-bono therapy. It may mean educating teachers about the mental health stresses of children and veterans. It may mean raising the consciousness of health care providers to the need for services for those of you who are working in integrated health care settings. I think we all have to continue to work together, veteran services, VAs, vet centers, Department of Mental Health, Department of Education, Department of Public Health, The Department of Health and Hospitals, the Office of the Attorney-General. In return for our veterans' services and conduct, we must launch our own effort to combat the invisible wounds of war to serve veterans and their families. Thank you.

David Satin:

Thank you Jaine. It's very interesting to have this as the ending presentation about what's done by the civilian population to help the former veterans who are former military people who are now back in the community, and how they can provide services differently than the institutional providers. I'd like to hear more about how this got organized and where they feel they fit amongst all of the institutional providers.

Discussion

David Satin:

We now have an opportunity to talk, as well as hear from the panel members, to talk to one another about what questions and what responses have come to their minds in talking with one another. We would like to hear from the audience about people, not just who are asking questions to have answers from the panel, but to have people express their own opinions, their own experiences, their own efforts in dealing with the chronic effects of trauma in military personnel and in civilian personnel. A request for the panel, so that we can accurately know who said what, would you hold this when you say it and give your name so we know who is who. It's time to go!

Gary Kaplan:

Go! I'm Gary Kaplan. I'm impressed actually by the breadth and depth of services through the Commonwealth, through the VA and federal agencies, and through the community in response to these set of wars, and to the mental health burdens that this set of warriors bring home with them and to their families. One of the things that is remarkable today, I think for you as a mental health community have helped bring us all together, different agencies who've been really scrambling very intensively for several years now to respond to this war and understand the mental health burdens that these veterans bring home.

We've all been scrambling incredibly to create services, to eliminate gaps in services, to do psychoeducation, to do outreach for these veterans, and to try to link together. I think we are just starting to link together services the massive needs that some of these veterans have; vocational needs, substance abuse disorders, mental health needs, physical needs, medical needs, needs of families and partners, and needs of the children of these affected veterans.

One thing that is clear is the massive set of mental health needs that these veterans have. There's been a very intense and clear and positive response by all these agencies. I think the hardest part of the course is building an integrated system across agencies for entire domains of services for any given veteran within our mental system or our system VA Boston. These veterans may need many services. They will have primary care needs, they'll have specialty needs, they may have physical injuries, they may have multiple mental health needs, substance abuse disorders, domestic violence problems, multiple diagnosis, including ones we haven't talked about. First episode of psychosis, bipolar disorder, some serious mental illness, and problems with homelessness, for example. So we're trying to coordinate care for very many complicated needs for many of these veterans with a high mental illness burden.

I think now we're trying to get to the point where we can actually collaborate across agencies because each program has its own types of specialization and expertise. It becomes an opportunity at this point with veterans returning that we can do more together, so I think it's thanks to you and this community brings us together as leaders of important community, state and federal agencies to actually work together, so…do you want to?

Jaine Darwin:

Thank you. Jaine Darwin, Co-Director of SOFAR: I would just like to say one of the things that is unique about our volunteers and to allude to some comments at the beginning. We teach cultural competence, and we have a lot of good psychotherapists, and one of the things that has been appealing to people about our program is that we have some very skilled psychotherapists. Most of our therapists have ten or fifteen years of experience. What we do is make sure they understand military culture, because what the families say to us is they don't want to have to train their therapist. One of the things we are trying to do is just that, get the word out. We've got a training package that we're able to use.

I think that it's interesting if we watch things catch up, because Secretary Kelley is certainly one of SOFAR's best friends and we've worked very closely with the state program. I think I got the nicest compliment in my life yesterday. We were meeting with Major Hankey from the Yellow Ribbon Program, and I said something, he looked at me and he said, "Are you military?" Which was quite a strange question to be asked, but I did take that as a compliment. We really had come to understand. It's reassuring to hear that people are now starting to do what we really started asking them to do in 2004, which was to get everybody together at the same table. Because if we don't have coordination then there's no reason to have duplication, but we need certain kinds of duplication because we have to serve. We have to serve food to everybody in many different forms.

Barbara Leadholm:

Thank you. My name is Barbara Leadholm, the Commissioner of the Department of Mental Health. What I have found fascinating is the expertise at the table, and the willingness of all of u to work together and I, too, want to thank you for bringing us here. I would like to focus my comment on two things: the personal cost to society, to families, and indiviuals is one that I think we in the mental health community don't talk about enough. The fact is that early intervention and treatmetn are critical to the success of well-functioning families, resilient children, and healthy families. I would really like to look to all of you: first I applaud your efforts to be interested in this topic and bring us together, and secondly, not only to talk about what each of us can do, but also how we

can contribute to the larger issues, and when we don't do something, the secondary costs, whether it is the broken families, the abuse, the neglect, and then the future for all of us. So you as people in the mental health community, I really look forward to your questions, comments, and solutions as we all sit her prepared to look where we can strengthen our efforts and really suport each other. Thank you.

Audience Member:

This is for Dr.s Daly and Kaplan. I'm just curious coming from a primarily substance abuse perspective at this time. I know you said you have multidisciplinary staff and several outpatient and inpatient programs that cater to all sorts of needs. What I'm curious about is if you have any specialty dual-diagnosis programs that really attack it at once? I've found that it's quite difficult to address them separately, as I'm sure many of you have. Since confidential care really is priority and necessary in addressing suicide in terms of mental health issues along with the substance abuse that usually follows. I'm just curious how you've addressed that in mostly the inpatient if you have dual diagnosis detox beds, which are very hard to come by across the state. Also I'm wondering about outpatient follow-up for people that do residential treatment, as it is very difficult to have a normal life if it's straight from residential right back to society.

Erin Daly:

Absolutely, you raise an incredibly important point, and one that I think the VA is starting to have real strong recognition of the importance of integrated care. You're asking specifically about dual diagnosis, inpatient detox beds. They're not officially labeled that way. We certainly see multiple diagnoses in all of our inpatient beds. There is a strong move in all of our outpatient programs to develop practitioners who are specialist across programs. We've hired both, actually nationally across the VA this has been mandated, but particularly in Boston we have just hired a psychologist to work, one at Brockton and one at the Jamaica Plain campus, specializing in coordinated PTSD and substance-abuse treatment.

Those psychologists won't only be the care providers, obviously they will provide a certain amount of direct care, but the idea is to provide widespread education throughout our system about how to approach these veterans in terms of dealing with all of their needs. This may mean at times still sequential care. There may be times where we think that's most clinically appropriate. We are trying to ensure that there aren't any closed doors. I don't want to go through the substance abuse program so, you can't get care. We want folks who are ready for care for various issues to get the care that they need, so there absolutely is a move in that direction and we've made great strides in terms of trying to integrate care but as you point out, I think it's an ongoing challenge.

Gary Kaplan:

To add to that, I think the VA has played a seminal role in the innovation and development of evidence-based treatments for both PTSD, for substance use and for the co morbid disorders. So as many people may know, Dr. Kerry Kean was part of the development and dissemination of prolonged exposure therapy. Dr. Patty Resik at the Women's Division of National Center for PTSD developed and is actively involved in dissemination across the country of cognitive processing therapy. We have Dr. Lisa Nadjavic who set up another evidence-based treatment program seeking safety which deals with the co-morbid PTSD and substance use disorders. So we're very engaged in the development and dissemination of these therapies, and people like Dr. Daly are really in the crosshair seeing the veterans and employing these types of evidence-based therapy in very flexible ways; motivational interviewing, cognitive behavioral therapies, case management, referring to a psychiatrist for psychopharm for the severe depression. Ultimately, where the rubber meets the road, you have to not throw out the handbook but adopt the handbook and we're getting skilled at that.

Audience Member:

Well I just want to thank the panel for coming today. As a Marine Corps Veteran and a future psychologist who's training here at MSPP, I think it's crucially important to talk about these issues. The crucial question I have is for Dr. Daly, I'm very interested to know what the specific access that the Department of Defense has to Veterans' mental health charts? Then a broader question to the panel is, it's great that we're talking about cultural competence and if there is an understanding of the different cultures between the military branches, as a marine I know that there is a specific culture that I'm familiar with.

Erin Daly:

I'm going to take on the tough question that you ask. One of the great strides that we've made is there are efforts to allow VA health care to access DOD records with the idea that we want to provide seamless transitions in mental health care. So for the military folks who have received mental health treatment while serving, we want to be able to take a look and see what sort of treatment they've received as they move their way into the VA. One of the components of that is a bi-directional system of access. So the move is toward allowing DOD and VA to share health care records. There are obviously strong benefits to that and some obvious downsides to it. At this point it's if you're active duty, or if you could potentially be redeployed, the DOD has access those returning records, and so we absolutely let our returning veterans know about that as a limit to their confidentiality when they come through our door, and we keep handy other resources, other places they may choose to seek care if that's something that they're very

uncomfortable about, so it's one of the more difficult issues that we deal with. I think there are strong benefits to some of that shared access to records but obviously you know we need to be understanding of the down side as well. There was another question you had about cultural competence?

Jaine Darwin:

I think for any of us who were not in the military it is a different culture and I wasn't kidding when I said I learned very quickly that while Secretary Kelley, who is a decorated hero, can get away with calling them all soldiers, the rest of us can't! And marines do not like to be called soldiers. I think it sounds like a funny thing, but it really is a way of being respectful, and being respectful of somebody else's culture, and you don't go into somebody else's house and insist that you live by your rules.

So we think it's terribly important for people to be aware of the language, for people to be aware of what the stresses are. Then it's fine to say, "Well I can't understand why you can't get your husband to go to the VA." Well of course we understand why you can't get your husband to go to the VA. Not because the VA services aren't excellent, but because we understand all the hesitancy, stigma, and all the issues involved. When we started out, we were going to be a volunteer pro-bono therapy program. We were going to give away therapy that's what we knew how to do, our program has evolved into a great deal more because it became clear that was not culturally competent treatment, that in order to really treat people that you had to meet them where they were.

So as people see us, as people eyeball us, it's only then that they start to develop enough trust to ask us about things. The other piece is to having to modify one's model. I was telling this story before, I can not tell you how many wives bring their husbands in to see us, to treat soldiers and vets, partly because I think people with complex PTSD are not well served in private offices. They really need access to multimodal treatments and systems. The wife comes in and says, "Tell him he has PTSD." And we listen for a while and very often we say it is highly likely that he has PTSD. That's all she wanted to know. She wanted her reality testing established. And then she said O.K., and off she goes, because the distinction she's interested in is that he just being badly behaved or does he have a problem? If he has a problem, she's ready to cope with it. If he's badly behaved, she wants to hit him in the head.

Audience Member:

Well, first I'm here on a lost and found mission, this pen was found at my seat. It's a Gershon Psychological Associates pen. I very much want to shake your hand. I very much appreciate your serving our country. I'm wearing several hats. First of all, I'm absolutely thrilled that I'm here. The hat I'm wearing is the Medical Director of the Community Mental Health Center that Erich Lindemann Founded in Wellesley,

Massachusetts. Hal Cohen is there as the chief psychologist who's on the staff of MSPP and we have trained probably hundreds of MSPP post docs, which I'm very proud to say some of you are in this room.

As a physician I'm very concerned about a particular aspect of something that was not mentioned on the panel. First of all, I thought the panel was a phenomenal sales person type of panel. I am going to volunteer as soon as I leave this. I'm not sure which one I'm going to call, I may call my good friend Barbara Lindholm, but the other three of you could very well receive my call. Something that hasn't been brought up, I am very concerned that if you take a human being and you redeploy them, with 90% of the time they are out of, doesn't matter they are all you know experiencing danger and violence, 90% of the time. You then redeploy them for two to three years. Are we causing a particular brain illness in human beings that's called iatrogenic brain traumatic disorder?

Are we exposing human beings to repetitive violence and dangers so their cortisol levels ruin a particular part of their brain called the amygdala. Are we then not surprised that 50% of the human beings then come back with a brain disorder that we may have precipitated by putting them in the throws of this repetitive trauma? I know all the neurobiological research of children, who I see as a child and adolescent psychiatrist, who are exposed to family trauma on a repetitive basis, they frequently have a very high percentage of PTSD. Are we doing the same thing with adults? If so, I don't know what to say about it, I never thought about it before until today. It's a very serious situation. I know we don't have a draft. Therefore, the population of people serving at times may be at a different socioeconomic, educational level that we're taking into the armed forces. Are there any longitudinal studies that show us the populations we're taking are more vulnerable perhaps to some of the exposure to trauma, which I don't know. So I just throw it out as a very serious thought that I have, and I'm not sure what if anything can be done with it, but it certainly concerns me as a human being and as a physician.

Jaine Darwin:

I can say two things which are, yes, we all know that people who have had prior exposure to posttraumatic stress are more vulnerable, we know that people who grow up in lower socioeconomic levels may have been more stressed, and we also know that a lot of people fighting in this war are children of Vietnam War vets who had untreated PTSD. That I think we potentially are not doing good things to our soldiers, but one of the things that motivated us to start our program was both having learned very carefully that there was a difference between government policy and the troops, and however one feels about government policy, the troops still deserve our support, which was something we hadn't gotten right in Vietnam.

What we decided was we needed to do something, so this was our contribution. I think we're talking about political issues, I think we're talking about civilian policy makers and the Department of Defense and I think the military understands us now and is really in what is a serious bind. They were not prepared for what they were getting into and they have been playing catch up. That one thing I have learned again over time is that the military are very committed to protecting their soldiers. But there is a problem because the military does not ask "why?" the military asks "how?" And there has been a person power shortage all along, and it has left people having multiple deployments when they probably ought not to have. It has left people, 12,000 of our troops go into battle medicated by the military with anti-anxiety and anti-depressant drugs, so we know that these things are happening, but it's a difficult problem in how one says we are here and we're going to treat what we have, and those of you who certainly may feel strongly and want to do things to intervene to protest policies that you feel are neither safe nor helpful.

Gary Kaplan:

Just as a brief comment to that, the neuroscience side of PTSD wasn't the focus of this panel, but I can say I'm a neuroscientist and psychiatrist, and I have a federally-funded research pre-clinical and clinical program. I'm interested in PTSD and fear conditioning and substance-abuse, and there are many researchers at VA Boston and throughout Boston who are very engaged understanding the effects of the stressful environment on the brain, looking at conditioned fear responses and looking at the result in hypersensitivity and hyperactivity of the amygdala, which produces hyper vigilance, dissociation, flashbacks, and the impairments of prefrontal cortical extinction. Additionally, it impacts the control of this hyper vigilance and inability to monitor impulses and manage behaviors as a result of prefrontal cortical inhibitions which occur in PTSD. So we could spend a few days talking about the neuroscience of PTSD, and there are many people interested and certainly very many at VA Boston. That's a whole other part, maybe that would be a whole other day's seminar about the brain changes and the effects of a stressful environment on the brain.

Audience Member:

Hi there, my question is mostly for Professor Leadholm, and it's about the diversion program. Today is the first time I've heard about that, and because we do a diversion program for youth, for first offences with drug and alcohol problems, I'm kind of wondering about how you determine eligibility? Is it a first-offender sort of program, whether you've measured reoffending after participation in the diversion program, and how you're training law enforcement about this because I don't know that our police department is aware of it?

Barbara Leadholm:

If you're talking specifically about the pilot in UMass in Worcester, it's just beginning. So in terms of the approach for this diversion program, we are specifically working with a statewide advisory committee as I mentioned earlier. We will be specifically working with the court establishing anetwork, and we are talking about veterans of any age, so anyone potentially who has either service historically, and we are not obviously just concerned about Iraq and Afghanistan. So any veteran, and then really taking a look at how we might intervene in a different way. Now the other programs that I was about about, those are in a few communities, standard programs and they depend on us again regardless of age, we are diverting, but typically you are probably talking late teenagers and in terms of our involvement with the police.

Audience Member:

And for any offence? It doesn't matter what it is, whether it's larceny or arson?

Barbara Leadholm:

There is a whole risk assessment and obviously the court would not just walk away. I would say, that it depends on the assessment of the person as well as what the court would determine in terms of their safety in the community and the ability of holding someone. So, potentially anyone, but of course the court would have to agree.

Audience Member:

My client base is Section 35, drug and alcohol-use people. Most of them that have PTSD seem to fall within age ranges that are almost like recipes of who's going to get PTSD and who isn't. What I've found is that a lot of the younger people have less than honorable discharges and at this point in time, unless something changed recently, are ineligible for any veteran services because of the gradation of their discharge. Is that going to change?

Jaine Darwin:

Can I say something. You know there was a scandal at Fort Carson that was highlighted by Daniel Throgen on NPR about people being diagnosed with personality disorders and then being discharged from the military. I don't think any of us are in a position to tell you that that is going on or not. It probably is going on in some places. That really is what the problem has been. The other problem has been as the military has needed more and more personnel, they have reduced the bottom threshold of who they will accept. So they indeed are accepting people who turn out needing more structure in their life and you put them in the military and they thrive. It really gives them something they haven't had before. Some of them you put them in the military and they continue to

have the same difficulties that they had before they were in the military, so I think you're asking a government policy question. It really is out of our area of expertise.

Erin Daly:

I was about to say just about the same thing. We can't serve dishonorable discharges; we can serve some other-than-honorable discharges. It's a decision that's made at a regional level. Certainly we see people through the appellate process as they're appealing negative discharges so we can treat them while that is worked out. As Jaine said, a lot of that is public policy and beyond that it's federal policy.

Audience Member:

I was just wondering how the vet centers sort of play into the system and if the issues of confidentiality are also relevant when some of them are trying to go through it.

Erin Daly:

Absolutely, I'm not sure of folks' familiarity with the VA verses the vet centers. The vet centers are largely community based. They start as readjustment counseling, largely staffed by veterans themselves, although not exclusively. The idea being to make a more comfortable environment for folks to come back and receive counseling, they don't provide psychopharmacology services, so it's purely counseling services. In terms of some of the confidentiality issues, they're documentation requirements are different from the VA hospital. So we are a hospital setting, have different sets of mandates that oversee our care, and electronic medical record and those sorts of things that lead to better integration with the DOD system which as I said can be terrific in terms of integrating care when that's desired from the move from the military to the VA. The Vet centers because they are somewhat separate are on paper documentation. Those issues related to confidentiality are less pressing. I can't say for a fact that they're never accessible, but they're much more difficult to access.

Audience Member:

Hi, this question is for Dr. Darwin. With the growing number of women in the military, another cohort that's got to be growing is army husbands. Has any research been done on how their needs differ from an army wife?

Jaine Darwin:

There is very little research that has been done on the family members, it's just starting to come out. Remember there are family members who are spouses of active duty military verses family members of reserve and guard. Because if you're an active duty or a family member of an active duty military person, more than likely you're on a base and you're surrounded by other people who are sharing your experience. If you're

reserve or guard, you're in your community where often you will be the only person around whose got a spouse who's serving. I think that I can tell you that anecdotally, it's a little like what happens when somebody becomes Mr. Mom, that I think socially it's a bit awkward for them. Sometimes it's quite challenging, but I think that any resilient family can rise to the occasion, but we have very little data on families and one of the things we're looking forward to is seeing more data on the stress on families.

Erin Daly:

I'd also point out that a lot of the veterans we see where the mother is deployed often the father is deployed at another time, it's you know both parents are military, so that also presents a unique set of challenges.

Audience Member:

Hi, my name is Josephine McNeal and I am not a mental health professional, but I was drawn here because I am the a developer of affordable housing, and we have developed affordable housing for various population including homeless women, single parents and victims of domestic violence. I have been thinking that given what's going on in the sense of our returning soldiers, I must confess when I was really thinking of housing in terms of soldiers who return with physical disability, and then I've been thinking a little more. I've just been fascinated and wondering how organizations like ours could be involved and whether we would have the capabilities when I hear you talking about the various issues. I always anticipated we would have professionals associated with this but, do you see a model of a group home. Do you see serving people in individual units? What have you seen and what do you think would be the best way to serve the population?

Gary Kaplan:

I think Secretary Kelley actually addressed some of that issue. He works in great partnerships with the VA around homelessness issues, so I think we have a large homelessness prevention program. For example, we have what's called grant per diem beds, 350 grant per diem beds around Eastern Massachusetts for homeless veterans, trying to help them transition from maybe more acute care to a stable environment, a sober environment, to help them regain their vocational abilities and help them search for housing. So I think anything that we do with community partnerships and our homelessness program. Our homelessness coordinator, her name's Karen Guthrie, is a social worker who oversees this very large homelessness program. I'm interested in partnerships in the community. We work with homeless shelters, the New England Center near Causeway Street in downtown Boston. We work in Worcester, there's a veterans shelter where we serve many veterans. We have a domiciliary for homeless

veterans, we have a lot of different programs, partnerships. We have these HUD VASH vouchers for writing Section 8 housing for veterans, so I think we go at it from all different directions, and any community partnerships. We have many in Boston and Worcester especially we would welcome.

I think one of the main themes we've been talking about is the issue serving these veterans in maybe traditional ways with individual one-to-one counseling will probably not work for many veterans because they have so many needs like homelessness, domestic violence, substance-use disorders, medical problems, financial needs, and vocational needs. That the best thing I think we can all do as individual providers as the community, is partner together to really serve these veterans, because they're going to have multiple levels and multiple layers of needs.

David Satin:

May I insert a question? I've mentioned a number of times that these are very creative, new and highly recognized highly publicized programs. How long will they last? These are mostly new and for acute needs. What happens when there is another war? What happens when the recession gets large enough that they have to cut funding? What happens when the interest turns to domestic violence or turns to child development problems or something else? How long are this going to go on and how much of this is going to be an acute response to a current issue? And where are the resources going to come from?

Jaine Darwin:

I think that we have been saying since 2005 that we are faced with a public health crisis, and that this is not going to go away. We all know that intergenerational transmission of trauma will live on, and that some of what we are seeing today is a result of untreated trauma from the Vietnam War. When you look at homelessness, one third of all homeless in America are veterans, from many wars, and I think if anything I have come to learn as I watch this, is how little attention we paid to the mental health in veterans after World War II. How unspoken that was. The story I was told by my then 88 year old father was when he had been shot in World War II. I knew he had been shot but I had never asked him to describe it to me. That there was a way in which the family joked about it, there was a lot of kidding about what went on.

The other thing I discovered, I was on a panel a couple of weeks ago, and Ken Burns was talking about his documentary about World War II and was telling a story about hearing from the family who had always been told "In the Battle of the Bulge, their father hid out in a farm house drinking wine." I had this "ah ha" moment, because Ken then goes on to talk about what horrendous things this father had really seen, that I know the story of my father drinking brandy in France, and five other people in the room had

parents who had been drinking something in some farmhouse somewhere, and it suddenly became aware. They became aware, that was the World War II cover story, that this was the "Don't ask me." and it's very easy not to ask. So I think David's point is well taken. When we met with Veteran Service organizations around looking for money, what they said to us was ultimately they would like the government to take responsibility because the shelf life of any volunteer project, is limited. I think you're going to talk about what kind of lifelong commitment the VA can make and will make.

Barbara Leadholm:

Well, obviously the fiscal realities are facing all of us. I do think this is underscoring for me the improtance of us showing the effectiveness of treatment and the effectiveness of early intervention. I don't want to talk about research per se, but I want to underscore the importance of us getting our facts straight in terms of studies that treatmetn works and really educating people about that. Because I do think that is some fo the battle, it is not just that we are always at the bottom of the barrel here, I do not think we have always been as successful in terms of talking about the effectiveness and talking about the indirect costs of not treating folks. I would not have been in this job if I did not have more of an optimistic view that this fight that we are all facing and certainly, specifically for veterans, that we need to come armed with facts, and then the heavy lobbying can support the various initiatives that we are trying to support.

Gary Kaplan:

For the federal perspective, these wars aren't going away for many years as we know, so these wars will be in the public eye for some time to come. I think sustained funding of the VA will continue but of course, because of the financial crisis we're in it will not be as good as it's been. So I think budgets already for 2010 will be different because of our problems within the federal budget. But there is a sustained commitment to veterans across the board- in this community you can see it today. Veterans are a very powerful and important constituency now more than ever before, so I think veterans and veteran service organizations and the community will continue to promote for the mental health needs of these veterans and I think efforts will be sustained for many years to come, how well will be the question.

Audience Member:

I'm the veteran service officer for the town of Bedford. We have a 60 person homeless shelter, and it's filled. The problem of homelessness is becoming more and more current in every community, everybody's looking for help. I am a war veteran of Vietnam. I spent 31 years in the military and as a sworn defender, I will tell you one of the ways we got men out of the service laws, we sent them to mental health. And some of

those problems right now are continuing. Luckily I didn't have to go; I was the one that sent people there. But in order to get better that was one of the things that happened. And it is still continuing to happen. I see almost all the time now that as a veteran service officer, a person is to come in and talk about the mental health issues.

Along with the doctor here, I don't know what effect it's going to have on continuing to send our young people back and forth over there for two or three four times. The mental problems that they're going have, and I see all the time, talking to a lot of the young folks. At one time I had 700 people working for me, and the mental health problems that they had, we just couldn't afford. We couldn't have a young man that's 19 20 years old working on continuing health care plan. How do we get rid of him? Send him to mental health. So we're going to have to be aware.

David Satin:

This could go on for a while. I think one of the takeaway messages that I get again is that war is bad for your mental health, and repeated deployments for several months is bad. I remember in World War II people were deployed for the duration until the war was over, which was four five years for some of them. So I think the ultimate preventive mental health intervention is not to have wars. Settle things some other way, or else we have to clean up the mess that war has caused, not only acutely but for years to come, when this becomes embedded in people's psyches. I want to thank you all for coming, and for sharing a concern and interest in this topic and hope that you will keep your eyes open for the 33rd Erich Annual Lindemann Memorial Lecture in the spring of 2010. If you'd like to stay for some more discussion among yourselves as well as with the speakers, please do.