COCA Call: Impact of Deployment on the Health of Service Members and Their Families – Why Clinicians Should Ask

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Speakers:

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Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen only mode. During the question and answer session press star 1. Today's conference is being recorded so if you have any objections you may disconnect at this time.

I would now like to turn today's meeting over to LeShaundra Cordier, thank you, you may begin.

LeShaundra Cordier: Good afternoon, I'm LeShaundra Cordier representing the Clinician Outreach and Communication Activity, COCA with the emergency communication system at the Centers for Disease Control and Prevention, CDC. Welcome to today's COCA conference call, impact of deployment on the health of service members and their families, why clinicians should ask.

We are currently experiencing a fire alarm right now so I'm going to quickly breeze through my introduction and hope everyone can please forgive me.

During today's call you will hear presenters referring to slides in their PowerPoint presentation. The PowerPoint slide set is available on our http://emergency.cdc.gov/coca . Click on COCA calls and the slides that can be found by clicking today's date, September 21 2010.

In compliance with continuing education requirements, all presenters must disclose any financial or other relationships with the manufacturers of commercial products, suppliers of commercial services or commercial supporters as well as any unlabeled products or products under investigational use. Today's presentation will not include any discussion of unlabeled use of product or products under investigational use. There is no commercial support for this presentation.

Our moderator today is Dr. Marc Safran MD, MPA and Captain with the US Public Health Service. Dr. Safran is the longest serving psychiatrist at CDC and has led successful efforts to gain acceptance for mental health as part of CDC's mission and as a main stream part of public health.

A distinguished fellow of the American Psychiatric Association, a fellow of the American College of Preventative Medicine, a long term chair of the CDC mental health workgroup and a graduate of CDC's Epidemic Intelligence Service (EIS) training program, Captain Safran has worked to combat chronic and infectious disease and served in emergency response.

He's conducted research on psychological distress and persons with active duty military experience and has served as a mental health subject matter expert on several COCA conference calls. At this time please welcome our moderator, Dr. Marc Safran.

Marc Safran: Thank you LeShaundra. Today we're going to be talking about a very important topic, the impact of deployment on the health of service members and their families.

Before we move on to that though I want to thank Congressman Brian Baird for recommending that we give more attention to this topic. His support and suggestions have been valuable in helping us plan for today's program.

Today many Americans who have been or will be deployed receive care from civilian clinicians and emergency responders who may not know of their military or other international service on behalf of our country.

As you can see from my next slide, our first question for today is why clinicians should ask if a patient or family member has been or may be deployed. The reason that's an important question to include in a clinical history is that once that question is asked, a range of potential health issues that might not otherwise be considered may then come to attention.

The next slide provides examples of ways in which deployment may impact upon health. Three of the examples focused in blue are the examples that will be the focus of this conference call today: behavioral health issues, traumatic brain injury, and child and family issues.

But there are many other types of injuries that may occur during deployment which we won't have time to discuss today. And there are infectious diseases to which persons may be exposed when deployed overseas that clinicians back home wouldn't ordinarily suspect if they didn't know their patients had been overseas.

On deployments there may also be toxic exposures, nutritional changes, medication side effects and other medical problems. All of these are things

that clinicians might not consider if they didn't know deployment had been or was about to be a part of their patient's life.

So as we go to the next slide I'm going to stress that, in, summary if a clinician doesn't ask if a patient has been deployed or if a patient may be deployed then a lot may be missed.

That's especially true regarding the next three topics you'll be hearing about today. Our first speaker or our next speaker will be Dr. David Riggs. Dr. Riggs is executive director of the Center for Deployment Psychology and a research associate professor in the Department of Medical and Clinical Psychology at the Uniformed Services University of the Health Sciences.

Dr. Riggs will be presenting on behavioral health issues related to deployment. Dr. Riggs.

David Riggs: Thank you Marc. I'm just going to ask folks to skip past the slide that has my name on it and we'll talk about kind of where we're beginning. If we think about the last nine years that our country has been in two wars, one in Afghanistan, one in Iraq, about 2 million members of our armed services have deployed in the theater.

That in and of itself is a large number, but if we look at the family members that are impacted as well, including spouses, children, parents and a group that largely gets forgotten, siblings of those who are deploying, we're really talking about more than 10 million Americans who are directly or one step removed impacted by deployments.

The next slide shows that in this war, unlike some of our other recent wars, a good portion of those folks who are deploying into combat reflect our reserve component troops -- those in the National Guard and reserves -- who return

home throughout the country, often at a distance from DOD or VA health care facilities.

And therefore they will often turn to civilian and community providers for care. As will many of their family members and veterans who upon leaving the service return home to their communities.

So there are a good number of our service members and their families who will be seeking care from community providers, not necessarily familiar with the military and their experiences.

When we talk about the deployment cycle, illustrated on the next slide we used to talk about the idea that troops would ramp up during the pre-deployment phase, deploy and then upon returning home would typically exit the service and not go back again.

But we have many troops these days who complete the circle and have been deployed multiple times, sometimes three, four, five times over the last nine years, often spending a great deal of time away from families and certainly being impacted in many ways over the course of those deployments.

I want to emphasize that the deployment cycle is stressful in different ways at different stages. And while I'm going to talk quite a bit about what happens during deployments to service members when they're in combat, there are stresses that happen to them and their families as they ramp up and prepare to deploy, in particular time that's away from family and long work hours that can add to stress levels.

And when they return from deployments and try both to reintegrate into their families and communities, but then also in many cases have to begin the

process anew and start preparing for the next deployment which may come sooner than any would like it to.

The next slide shows a diagram that we borrowed from Captain Koffman although I think it originates with Captain Nash, he's worked for a good deal of time with the Marine Corps and describes quite poignantly that the stressors involved in combat exposure are not simply the traumas that we hear about or read about.

But to exist in a combat deployed state is to exist for a prolonged period of time under intense stress. This might be months, six or seven months depending on the length of deployment, it might be over a year in the case of some deployments that last 12 to 15 months.

Interspersed within that existence of living under stress, which in and of itself can create medical and emotional problems, you have particular events like traumatic exposure or loss events where a buddy or a squad mate might be killed and there's grief that goes along with that.

People have also described kind of the wear and tear injuries associated with just the fatigue of being in a high stress environment, particularly one that not only is the work stressful but the environment is stressful. So working in temperatures upwards of 115 or 120 degrees in heavy body armor can certainly add wear and tear to both the body and the mind.

And then also moral injuries where the events that one experiences or witnesses can create a disruption in one's own sense of self and one's moral values.

Marc talked about the importance of asking whether somebody has been deployed and the next slide actually illustrates the importance not only of asking have they been deployed but where they've been deployed and when.

These data are actually gathered from what the Army calls their mental health advisory teams. Just as an aside the military is doing a better job this time around than in any previous war in tracking the emotional impact of combat deployments. And one of the things they've done is placed in the field their mental health advisory teams who have gone out into Iraq and Afghanistan, mental health professionals to survey the troops and evaluate how they're doing.

This slide on combat exposure simply illustrates that right now or as of last year when the MHAT VI was conducted the types of combat exposure or the amount of combat exposure happening in Afghanistan was higher than those happening in Iraq.

If you paid much attention to the newspapers we kind of know this is true as combat activities decreased in Iraq and increased in Afghanistan. This has a lasting effect illustrated in the next slide on the emotional well being of troops.

And if you see there that the mental health problems reported in OEF, which is Operation Enduring Freedom -- that's the activities in and around Afghanistan -- have increased over the last four years or so, whereas those in Iraq, Operation Iraqi Freedom, OIF, have decreased of late.

When one comes home there's a reintegration process that needs to occur and borrowing from some work of Chaplain John Morris who has worked at length with the Minnesota National Guard, we talk about five particular challenges faced by troops coming back.

The first one, overcoming a sense of alienation that "I've changed and you, the larger population, you won't really understand what I've been through or where I'm at right now."

A sense of having to move from what is a fairly simple life -- that is somebody tells you where to go and when to be there and what to do -- to a more complex life here in their home communities.

Replacing war with other forms of highs for excitement or feeling alive, we often see people come back and maybe drive too fast, get a bit of a rush that way or turn to substances and look for the high that way.

A movement beyond war to find meaning in life, again for many of our reserve component folks who go back to their normal daily jobs and sometimes have a hard time getting the same sense of meaning out of making a widget today as opposed to leading men into combat and bringing them back out alive.

Then finally along with those moral injuries, that sense of having to come to terms with what I've seen or done or experienced and how do I make peace with that. These reintegration steps are complicated by the development of emotional and physical injuries and the next slide illustrates data from a survey done by the Rand Corporation.

Finding that roughly 20% of the respondents had problems with either depression or PTSD, about 20% had apparent lasting effects from a traumatic brain injury and so there's significant overlap between those two things.

And then next slide just reinforces that idea that often problems overlap and present together so when you're working with people who have PTSD,

particularly chronic PTSD, you're going to see a lot of other things that go along with that.

And it's important for us as professionals to try and get as complete a picture as possible in order to best treat the complex problems that come forward when troops return from combat.

Next slide illustrates the link between PTSD and TBI, and there have been a lot of theoretical papers written about this. Charles Hoge, who is one of the primary epidemiologists surveying emotional distress after the current wars, has this study that shows that when you have somebody who's identified as experiencing head injury that includes loss of consciousness, the rate at which they are diagnosed with PTSD or depression is about four times greater than if they haven't had such an injury.

So there's apparently a link that suggests that traumatic brain injuries, at least those that result in a loss of consciousness may place people at risk for mental health problems or at least be markers that identify those at risk for mental health problems.

This is complicated by the large overlap in presentation and symptoms, the next slide shows that if you just look at the symptoms and complaints presented in cases of folks who have experienced mild traumatic brain injury that is repeated concussions, post traumatic stress disorder, chronic pain, substance use disorders and depression, the complaints and symptoms often overlap making the diagnostic process and particularly the differential diagnosis a very complicated thing.

One consequence of that probably is illustrated on the next slide, these are data collected from about 350 patients seen at a VA hospital who were diagnosed with traumatic brain injury, chronic pain and/or PTSD.

And what you see from the slide is that there's a significant overlap in diagnosis as well as presentation. Over 40% of the individuals in this sample were actually diagnosed with all three PTSD, TBI and chronic pain problems.

And the vast majority were identified as having at least two of those problems on board at the same time. Again this complicates treatment, but it makes it vitally important that as we strive to identify veterans and service members and the kinds of issues they're dealing with that we remember to ask questions about a variety of problems they may present with.

My final slide, just identifies as one of the things that is important is an awareness among primary care providers for these issues. We know for example that there is quite a bit of stigma associated with seeking mental health care among those in the military.

Something that's been recognized for a while and steps are being taken to reduce that stigma, for example the security clearance paperwork that used to require service members to report if they had sought mental health care, that question has been changed so that if the mental health care is related to their combat deployments they don't have to report that.

And that's a reflection of the concern among the service members that if they were to report mental health care that they would not be considered for security clearances or would allow them to move forward in their careers.

But that's only one piece, stigma still exists and despite the efforts that the military is making to reduce it, it means that soldiers and marines and airmen and sailors are much more likely to seek care through primary care providers.

They do this as part of their normal process within the military but it is also a place that they find to identify for care initially even working with community providers.

Because emotional problems and histories of TBI can contribute to or at least are related with a large number of physical complaints as well it's very likely that they'll report to primary care offices complaining about something other than the nightmares or flashbacks that might be associated with their PTSD.

And it's really important that folks ask questions to identify potentially those other problems that go along with and potentially complicate the treatment of the physical complaints that they have. So that wraps up my presentation Marc.

Marc Safran: Thank you very much Dr. Riggs and before we introduce the next presentation I just wanted to remind everyone that these are very detailed clinical problems that you'll be hearing about and certainly no one is expected to treat them alone.

And a lot of times just recognizing something because you asked about that, that might be enough to get you the information you need to make the referral that you need.

So didn't want anyone to feel alone on this. One reason people don't ask sometimes is because they're afraid of what they might find out if they do ask. A lot of help is available.

Our next speaker will be Dr. Vik Kapil who is the associate director for science in CDC's division of injury response. Dr. Kapil will be presenting on traumatic brain injury. Dr. Kapil.

Vik Kapil: Thank you very much Marc, it's my pleasure to be here this afternoon to provide an overview of traumatic brain injury in general and also with some specific focus on TBI among service members.

If we could start with the first slide which is entitled Traumatic Brain Injury, I'd like to start with just a brief overview. A traumatic brain injury or TBI is a bump, blow or jolt to the head or a penetrating head injury that disrupts the normal function of the brain.

A couple of important considerations here are that it doesn't necessarily have to be a direct impact to the head and that if even as we're well aware severe shaking or an overpressure wave for example from a blast may result in brain injury.

Fortunately most of these cases, particularly in those cases where the injury is relatively mild recover fully without treatment. However some people may actually develop longer lasting sequelae.

For clinicians, mutating this type of information regarding the course of the recovery and generally good prognosis is very important in the care of patients with mild TBI.

CDC has recently published its report on TBI in the United States which includes data from 2002 to 2006 and this is shown in the next slide which is entitled TBI in the United States.

You'll note that total there were approximately 1.7 million TBI associated deaths, hospitalizations and ED visits during that time period annually and that's in that triangle on the left.

This total breaks down to about 52,000 deaths, 275,000 hospitalizations and around - almost 1.4 million TBI related ED visits. It's also important to note that these data are underestimates of the overall incidents because they don't include care that's received in an ambulatory office setting or those people who actually sustain an injury but did not receive any care at all.

Overall if you look to the right, the circle you can see that falls are the leading cause of TBI in the united States and they're also the most common cause of TBI related ED visits and hospitalizations. The highest rates of falls in related TBI are seen in children under the age of four and also older adults over the age of 75.

Next slide shows you a little overview of signs and symptoms of TBI. Signs vary and symptoms vary greatly from patient to patient and also with the severity of the original injury.

Even patients with mild TBI may suffer from headache, nausea, vomiting, vision disturbance as well as some behavioral and cognitive complaints such as memory problems, irritability, difficulty concentrating and sleep disturbance.

As you will note many of these signs and symptoms commonly associated with TBI are relatively non-specific and could easily be attributed to a variety of other conditions or could result in overlap with other conditions.

TBI in the military is an important problem and may occur due to combat operations as well as non-combat related incidents. The next slide illustrates that about - approximately 1.6 million service members have been deployed to date in Iraq and Afghanistan, it may be a little more than that by now, of course that's a moving number.

And TBI has been labeled by some as the signature injury for these conflicts. Both the departments of defense and veterans affairs have devoted significant resources and effort towards improving the detection, the tracking and the management of the acute and longer term consequences of TBI among service members and veterans.

The next slide which is the pie chart is the slide from the armed forces health surveillance center. We see that the cumulative incidents of TBI of varying degrees of severity from 2000 to 2010 among all military service members.

During this time period almost 179,000 service members sustained a TBI with the vast majority, about 137,000 of those being classified as mild in terms of severity. It's important to note that these data represent those cases with the TBI related diagnosis confirmed and documented in the medical record.

Although a higher incidence has been reported in some studies of deployed personnel, those data are typically from survey results and have reported symptoms or history of TBI with all the associated challenges of recalling remote events and sorting out various symptoms which as I mentioned earlier may overlap with a number of other conditions.

There are a number of important causes of TBI among service members; the next slide reflects some of those. They include blast injury and blast injury may be primary blast injury due to the blast pressure wave itself. Could be secondary due to penetrating wounds from the blast event and tertiary in which the blast wave actually results in an individual being thrown against another object or against the ground.

In addition, penetrating wounds that are not related to blast events such as gunshot wounds could result in TBI, and like the rest of us, service members

are also at risk for non-combat injuries such as motor vehicle crashes, falls, assaults and even sports and recreational injuries.

Clinicians who care for active duty and returning service personnel face a number of challenges that they should keep in mind. The accuracy of the diagnosis is not always a given due to the prospect of overlapping signs and symptoms that I discussed earlier and Dr. Riggs also mentioned.

The history of injury may be remote and the presence of memory impairment or other cognitive impairment may also complicate obtaining a reliable history.

Just as we see in sports and similar circumstances, for a number of reasons personnel may downplay their signs and symptoms. Sometimes it has to do with a stigma that Dr. Riggs spoke about, sometimes because of their desire to return to duty as quickly as possible and to their units. So finally as clinicians we must always been very cautious and aware the risk of repetitive or recurrent TBI.

This includes a higher risk of subsequent TBI, delayed recovery among those people that have multiple TBI incidents over time and in addition they're also rare case reports, particularly in the sports literature of individuals who suffer catastrophic brain injury when they sustain a subsequent head impact or brain injury while they're still symptomatic from an earlier injury.

So in summary clinicians who care for active duty or returning service members should specifically ask patients about their service history and potential TBI including those that may not have been associated with the direct impact to the head such as a blast event. We also need to be alert for the possibility of a range of signs and symptoms which may be easily attributed to other conditions.

In addition to a good and thorough history in examination, the clinician should also maintain a high index of suspicion and be prepared to seek appropriate imaging, neuro psych assessments, and specialty consultation if TBI or its sequelae are suspected for that patient.

I'll stop there and turn it back over to Dr. Safran. Thank you.

Marc Safran: Thank you Dr. Kapil. Our next speaker will be Dr. Ruth Perou who is the child development studies team leader at CDC. Dr. Perou will be presenting on child and family issues. Dr. Perou.

Ruth Perou: Thank you Marc and thank you everyone for this opportunity. It has been mentioned previously when we're looking at the impact of deployment it's not limited to the service members themselves, but also includes their families.

An important thing to keep in mind when working with military families is being familiar and respectful of military culture. As you can see from my next slide when we talk about this if you want to honor a service member the best way to accomplish this is to honor and support their legacy, their children.

My next slide on military family demographics I want to again reiterate some of what you've been hearing earlier today of the impact of deployment and the numbers that we're dealing with.

We know that almost 2 million children are living in military families and that about 60% of these families have some family responsibility. And when you look at that breakdown, 43% of active duty military families have children.

And the largest percentage of children are between birth and five years of age with 41% of that rate and what you see here is this is a critical time period of development and with a lot of impact from the stresses of deployment.

Another important thing to keep in mind as Dr. Riggs mentioned earlier is that now we're also dealing with the larger component of the reserve being deployed. We see slightly different numbers for the reserve with them about 52% of their children are between the ages of 6 and 11 so you have a different rate of presentation in these families.

In looking at the impact of deployment on these families we also know that at least 19,000 children have had a parent wounded in action and over 2000 children have lost a parent in Iraq or Afghanistan. And please keep in mind that these numbers do not include the families of other federal and private entities that have been deployed.

In my next slide on the impact of deployment of families I want to talk to you a little bit more about what these families are going through. We know that military families in general experience high rates of stress and trauma, especially with moving around and being pulled away from their communities.

But in addition the impact of deployment on these families has an additional strain. We know that deployment of a primary care giver is perhaps one of the most stressful events for children and has an additional stress for the parent that's left behind. Actually a recent study looked at the wives of deployed soldiers and showed high rates of diagnosis of depression, anxiety, sleep disorders and acute stress reaction and adjustment disorders.

What we're also seeing in these families is that when those military servicemen return that they have been exposed to life changing stresses as has

been presented by the two earlier presenters showing a lot of mental health and stressful issues. And that reintegration also has additional stress on these families and it's disruptive to the civilian life and family function is affected by this combat exposure.

Another study actually showed that the rates of child neglect and maltreatment are especially been elevated for military families with child neglect a two fold increase and maltreatment increasing and those are seen especially in young families.

In my next slide I'll talk a little bit more about the impact of deployment specific to children's health and well being. While there has been limited research in this area there are new current studies that are showing that children in military families experienced high rates of mental health trauma and related problems.

And that military life can be a source of psychological stress for children with multiple deployments, frequent moves and having a parent injured or die is a reality for many children in military families. We're seeing these - the impact of this stress reflected in changes in school performance, lashing out in anger, worrying, hiding emotions, disrespecting parents and authority figures and feeling a sense of loss and symptoms consistent with depression.

And a lot of children in all age groups actually report high levels of sadness. Other studies have shown - recent studies actually have shown that we can see depression in one in four children, academic problems occurring in one in five children and that 37% of children with deployed parents actually reported that they seriously worried about what could happen to the deployed caregiver.

Other issues that impact children-- We've also seen other health complaints, a recent study actually showed that adolescents of deployed families had higher heart rates and systolic blood pressure as well as symptoms of depression.

In my next slide which discusses the response of children to stress and separation, actually these are key questions that were generated by the American Academy of Child and Adolescent Psychiatry and what we're seeing here is that the impact of stress and separation naturally of disappointment is going to vary by child age and also by time of deployment.

So in infants what you might see a response to these receptions with decreased appetite and weight loss, in toddlers you'll see more temper tantrums and some sleep problems.

As in pre-schoolers you'll see their behaviors may regress such as toilet training, sleep and separation fears. And as children get older they may become more aware of these issues and aware of their parent's separation.

And so they'll show irritable behavior, aggression or whininess, may become regressed and fearful about their parent's safety. And in teenagers what you're going to see is probably more rebelliousness, irritable or more challenging of authority. And parents and clinicians have to be highly vigilant about high risk behaviors such as problems with the law, sexual acting out and drug and alcohol use.

My next slide I'll talk a little bit about protective factors. In actuality this goes along with understanding and knowledge and respect for the military culture. Most military families will rise to the occasion and resiliency plays a very important factor in their ability to cope and deal with deployment.

And families that feel that they're ready to deal with the deployment and they feel connected and supported by their social network are more likely to adapt better to deployment, adjusting to deployment pre during and post.

Family preparedness for deployment is critical, this is why it's important to discuss some of these issues as you're seeing these families. And actually the mental health status of the at-home parent can ameliorate the impacts and stressful events around deployment.

Other issues that can help families better deal with deployment and the impact of military life is if they accept and respect the military lifestyle, if they're optimistic and self reliant and are very flexible in dealing with changes.

In the following slide actually highlights some factors, some risk factors of families in dealing and adjusting to deployment. A family with a history of rigid coping styles or any kind of family dysfunction is going to have more challenges and perhaps events more mental health issues and behavioral issues as they're dealing with deployment.

Young families, especially those dealing with the first military separations are going to have more challenges in dealing with deployment. And families that have recently moved to a new duty station, families with a foreign born spouse or young children and families without any unit affiliation again these families are going to struggle.

And again going back to the need to feeling connected, at having a sense of support. And the next slide I want to talk a little bit more of what you can do as clinicians.

As has been mentioned throughout the presentation and as Marc mentioned the important thing is to develop an awareness of the presence of military children and families within your communities and practices.

As Dr. Riggs mentioned a substantial portion will be accessing healthcare and social services from the civilian healthcare system and so you're more likely to see these families.

It's also been mentioned before, consider screening children at check in to see if they are members of a military family because this will help you to better frame and be better prepared to deal with a lot of issues and some of the stresses and struggles that they're dealing with.

Develop knowledge about the culture of military. Again this deals with the respect in honoring these families and what they're struggling with. If you can establish that trust you can engage youth and families in a way that will allow them to share their concerns.

Continuing on the next slide of what you can do, children's health issues may be an entry point for family health. As you've seen with the data and some of the research is showing that the whole family is at additional risk for mental and behavioral health issues.

And so you should consider screening the non-deployed parent for psycho-social stressors and functional impairment.

Both in terms of ensuring that that individual receives the services and healthcare that they merit but also that their mental health and behavioral health has an impact on the whole family and those children.

And as Dr. Riggs mentioned there is a culture in the military of not seeking out and looking for mental health services so this may be a prime opportunity to really work with that family and discussing the service members' health issues.

And this could be your entry point to deal with those issues. Another key point here that we've seen is the importance of resilience and preparedness and that to monitor mental health pre during and post deployment actually I think Dr. Riggs may have mentioned this, the period of reintegration may be one of the most stressful periods for that family and service member as they're coming back together.

And so that's why it's important to consider all these issues at different times of deployment. And there are a variety of resources available and there's a list of these resources that are part of the slide sets and they will also be available on the Web. Both from the military and from some of our federal partners and some of our private partners that are doing a great deal of work in this area, including from the Substance Abuse and Mental Health Services Administration (SAMHSA), one of our federal partners and also from the American Academy of Pediatrics, the American Psychological Association and the American Academy of Child and Adolescent Psychiatry.

I think that that's all for that. The next few set of slides are just talking about the resources and you can look through those slides. And then finally the last slide after my name actually has some of the literature that shows different reactions from children at the time of deployment. Thank you.

Marc Safran: Thank you Dr. Perou. And thanks to the entire COCA team. Every topic we've discussed today is a huge topic that could have in and of itself been the subject of a full week of training or more and still not have covered

everything. So I thank my fellow presenters for packing as much information as they did into so little time.

Before we move to questions and answers, I just want to remind everyone that we've covered the importance of why clinicians should ask if a patient or family member has been or may be deployed.

Another issue to think about is how this gets reflected in the medical record because often times someone may tell you as the clinicians all of this valuable important information or at least some information that's important. And if the next person [clinician] seeing them doesn't have a record of it then that may be lost and the person [patient] may not come forward and share it again.

So that's a whole other issue; But at this point I would imagine there are probably a lot of questions that people have. We're going to try to cover as many of them as we can in the next few minutes. And I'm going to ask the operator to open the line for questions now, any questions that we don't cover now you'll be hearing at the end about how you can send those questions to us by email.

Thank you again to everyone who helped to make today's call possible. And now do we have the first question?

Coordinator: Yes thank you, and if you would like to ask a question press star 1, ensure your phone is unmuted and record your name clearly and loudly when prompted.

Your name is required to introduce your question and once again that was star 1. And I do have a question from (Arthur Winston), your line is open. (Arthur) your line is open.

(Arthur Winston): Yes, my question was why is it - does the doc instead of asking what's wrong they look and see where we fit in a book instead of you know trying to diagnose this with some type of PTSD or some type of issue.

It seems like they're not looking to see what's really wrong with the veteran, they're looking to see how they can label it.

Marc Safran: People looking to see how to label instead of really looking at the whole person, is that the question?

(Arthur Winston): Yes sir.

Marc Safran: Okay, Dr. Riggs would you like to handle that first?

David Riggs: I can certainly try and I would say that it is a problem if all that a doctor is trying to do or any care provider is trying to do is to label, then that's potentially a major problem. It's rare for any of these difficulties that people might have adjusting to exist in isolation and so a label doesn't capture all the issues that may be going on.

It's also the case that a lot of the experiences that veterans have while they're deployed and as they come home and work to reintegrate may not be pathological. And we don't want to over diagnose. If we look at the data that's available the vast majority of veterans will come back from their combat experiences and adjust well.

But that doesn't mean that they won't have some difficulties here and there, and we don't want to leap to the conclusion that they have PTSD or any number of other diagnosable problems just because they're having a little difficulty here and there. So I think the answer is two fold, one that we don't

want to minimize problems that people may be having by attaching a label and assuming that tells us the whole story.

And we also don't want to attach that label too quickly and over-pathologize what is a difficult transition process but not a pathological one.

Marc Safran: Thank you Dr. Riggs. And so I think we all can agree that we have to emphasize that we're always talking about people and not diagnoses. Do we have another question?

Coordinator: Yes, the next question comes from Dr. (Jennifer Rand), your line is open.

(Jennifer Aurand): I work for a community mental health center in Freeport and what I've been trying to do for months is work and get a contact with a local veteran's department with someone who can contract or make some decisions because our guys have to travel really to the state of Wisconsin to get their comprehensive treatment.

So what this essentially means is that these guys who are in pain or suffering or have some mental health problems, flashbacks, what have you, they have to get into a car with a bunch of other guys and drive for a long period of time, go to a VA out of state.

Stay there all day long, get every single service under the sun at which winds up including some oh boy, like telepsychiatry which the feedback although I understand we have limited resources, they don't really appreciate staring at a screen after what they've been through.

They want to sit in front of a person and then travel all the way back. If they come to a center like ours VA doesn't pay for it so my question is after that

long caveat, what is your advice to an agency like mine so we can help these folks as quickly and as painlessly as possible in our community?

Marc Safran: Thank you, that was a valuable comment, and so you highlighted basically the barrier that distances the care of some of your clients and your patients.

(Jennifer Aurand): Yeah.

Marc Safran: And so unfortunately we don't have - none of our presenters actually work for the VA but what we can do is I'll let - before I let Dr. Riggs try to address this one as well let me say that what we can do is if you send us an email comment using the directions that we've given after the call and if you basically just say what you just said, remind us that you were the person who just brought this up on the call we can forward this to the - basically to the VA.

And note that we got this request and comment on the call and we can ask that they respond. But Dr. Riggs do you have a suggestion right now?

David Riggs: Well the easy answer to that would be no. But I'm not sure that's the satisfying answer. I think it's fairly well recognized by both the VA and the Department of Defense that one barrier among others that limits the ability for veterans and service members or even family members to get access to care is living a distance from the facilities where that care is available through the VA or DOD systems.

I'm not a policy person; I certainly don't speak from the perspective of making or developing policy. I do know that there are attempts in place to include telemedicine with its pros and cons to try and make as available as possible the care that's needed. In terms of your specific question of how a particular agency that might be able to provide that care in a home community for our veterans might do that in coordination with and reimbursed by the VA

I have no answer at all. I mean I just don't know the process whereby that would happen.

Marc Safran: One of the reasons it's really valuable that you brought this up today is because what I found is that sometimes in these large systems that we work in, in public health, sometimes there are things that get - well you all know a lot of times things get missed or there are ways we can do things better that we don't all figure out.

But by sharing comments and ideas like this sometimes it will help to move for changes in the system. Again we can't speak for the VA because they're not here, but certainly - this is valuable for us to be aware of this problem and we will share your concerns with the VA after the call.

(Jennifer Aurand): Thank you.

Marc Safran: Thank you, and do we have another question?

Coordinator: Yes, the next question comes from (Katherine Hubbard), your line is open.

(Katherine Hubbard): Thank you very much. I'm a registered nurse, I'm also the former spouse of a retired Navy pilot, I have three children. We went through many, many, many deployments together.

We live in - this is really a follow up to the previous call, but if there would be some way that in more parts of the country there would be TriCare providers, Delta Dental providers, once you leave the military and you go to a place that is not concentrated at a military base it's very difficult to seek care even with a retired card.

Because there aren't providers, also the military doesn't issue like a healthcare ID card as well as they make it also difficult to get a copy of the previous military healthcare record. And I appreciate you taking my call.

Marc Safran: Thank you, thank you for raising that point and this is -- I think we're making a list right now of important points that we need to raise with our sister agencies. And we do - we are working across the government to try to improve mental health and reduce mental health disparities and particularly for persons who served in active duty.

So we will definitely bring these suggestions forward and again feel free also when you're - when you send those emails at the end to include comments like this and we'll pass them on to the appropriate people or organizations that need to see them. Thank you Dr. Riggs, did you have anything else?

David Riggs: The only thing that I would add, in addition to what I do professionally I'm the son of a career Army officer and my parents since my father retired have dealt with many of those same issues that the caller described.

The availability of TriCare providers is not limited solely by anything on the government side, it - you know it requires individual providers or groups to apply for and become TriCare providers.

And so one thing folks can do is encourage their colleagues to enter into that process and recognize that part of this is the - you know the support that we as providers can offer to our service members and veterans and their families as they deal with the lives that they've elected to lead and are off fighting our wars for us. So part of this is encouraging our colleagues to take that step as well.

Marc Safran: And it's crucial that if, I mean we know that we've made this commitment to provide TriCare, to provide care for persons who have served our country on active duty. And it's essential that we make sure that there is care available to back that commitment that we've made as a country. So I would support that as well. Do we have other comments and questions?

Coordinator: And the next question comes from (Barbara Knope), your line is open.

(Barbara Knope): As it would be I am a TriCare provider in southern Indiana and I have really enjoyed listening to the previous comments. My question was going to be how I as a TriCare provider get the word out that I have my services available because there seems to be a disparity there as well. People not knowing that services are available to treat TBI and PTSD.

Marc Safran: That's another really good comment. I've actually raised the question at times of - there used to - it seems there used to be a listing that used to list all of the TriCare providers and anyone could just access it.

I don't know if that still exists any more, at least I've not been able to find it when I've looked for it. Does anyone, Dr. Riggs do you know if that still exists?

David Riggs: I don't know one way or the other. One thing I might suggest to the caller, each of the states through the state National Guard office is designated to have on their roles a director of psychological health reviewed at DPH.

I don't - I'm sure that at any given moment in time not all 50 states have those people on board but I know that a good number of them do. And part - one role for that person is to identify referrals throughout their state that could be offered to guardsmen and women and their families who are seeking care.

Not just psychological care, although that's what their label is but so that they're aware of what the referral resources are in their state. And I know that reserve troops have been encouraged to access or to contact the DPH if they're in need of care as well.

So I know that in several states the DPH would be one way of getting your name associated with and therefore available when people ar seeking a referral for services.

(Barbara Knope): Thank you.

Coordinator: And our next question comes from (Grace Rhodes), your line is open.

(Grace Rhodes): Yes, I wanted to make an announcement that given our dot com is an association of licensed social workers throughout the United States that donate their time for veterans and family.

I wanted to be sure that that was out there, not to take away from any other providers, but there's just a greater need. Second part of my question is that I was wondering if they're doing any studies of doing on scene intervention right on the battlefield. And if that is so has that been productive? Thank you very much for the time.

Marc Safran: Thank you, and Dr. Riggs I'll let you address this question as well.

David Riggs: There are mental health providers who are deployed with our troops who are providing services very far forward in some cases and certainly in theater in most cases. As to the impact of those services, I can only speak anecdotally, I don't know of any numbers that have been presented or published.

But anecdotally there are certainly cases of individuals treated successfully while in theater, returned to their units and completing their tour successfully while they're there.

Marc Safran: Thank you.

LeShaundra Cordier: Operator, we have time for one more question.

Marc Safran: Okay, do we have the last question?

Man: I'm here.

Marc Safran: Yes, a question?

Man: Yes, do you hear me?

Marc Safran: Oh yes, we can hear you now sir.

Man: Yes, I'm a veteran and psychiatrist in Orange County. Actually I have a family with older children, teenage and even in the 20s and mother totally compensating and mom is in denial, refused care while the father, military member is going to be deployed.

So that's one thing, now does the government organize that each school obligatory have a list of all children from military families then not only the list of children from military families but did the children have to screen and assess?

We can divide kids into different groups of for example kids of families for example in the Navy or Air Force or never in active combat should have less to worry. And kids from family members who are in active combat the stress

is very different. Does the government organize; I think it doesn't take much time and resources to do that. I don't think it's done yet so there's no real support other than us talking, that's my question.

Marc Safran: That's a question and a suggestion, correct?

Man: Yes.

Marc Safran: Okay, do we - really quickly do we have either Dr. Perou or Dr. Riggs, would either of you like to respond to that?

Ruth Perou: This is Dr. Perou. If I understand correctly, I think what you're acknowledging is the importance to identify that different military families are going through different stressors. And if we can organize and have that kind of information that that would be most useful for clinicians is that correct?

Man: Yes. I think the school can make a list very easy, just ask the kids how many in the class have parents deployed. Just one question, the kids will raise their hand and later on the teacher would talk to them, just a few minutes.

You know what kind of - what department, where the parents are, are they in active combat or supportive out in the ships in the Navy out far away from the battlefield. The choice is very different for those children, I do see them. I don't see the government organized that yet, I think it's not difficult. It's very easy to do. All schools and officials will be very, very willing to cooperate.

Ruth Perou: Yes, and that's a very good point and a very good question. And that we have to handle this each individual family or each individual community will have different challenges. And actually in the list of resources there are actually resources available for schools and communities and how to deal with these issues.

Man: The schools frequently have meetings with all parents, they can make just another day to meet with parents of military families who's one of the parents is out. The school can organize just one more day to screen out and from that, that leads to further planning and meetings to support the families.

Marc Safran: So you'd like to see the schools really be more proactive and really come out there and start with a plan and try to move forward in a more...

Man: Yes, I think we should do this, (unintelligible) has to be made and screening has to be made and assessed and follow up with children's response at school, their grades, are they stable, are they going down, then we have proactive much earlier to help the families.

Ruth Perou: Okay, I think what we can do is go back to those resources of schools and who are working with communities and make sure that this comment gets back to them on how these tools would be much more useful for clinicians and that they're better organized. So thank you for that comment.

Marc Safran: Thank you. And I think really one of the things that we've heard throughout the Q&A section of this program today is that there are a lot of - there's a lot of concern about needs that still need to be met.

And there are a lot of suggestions for ways in which things can be done better. So what we'll do is we'll take the suggestions that we receive from this call and we will share them and pass them forward.

And we will also keep them in mind whenever we're asked for recommendations on, you know, ideas for how to move forward, because this is so important.

Actually I wish we had time for more questions but I believe we're out of time right now. I want to thank everyone who made suggestions and asked questions; and I want to thank everyone who presented and thank all the people who made today's presentation and today's conference call possible.

So thank you all. And this is just a huge public health problem, and so much more needs to be done! So let's all keep working on this. Thank you. And let me turn it back to LeShaundra because she's got some information she needs to give everyone regarding continuing education, asking of questions and other information you may need.

So thank you all again. Thank you LeShaundra.

LeShaundra Cordier: Thank you. On behalf of COCA I'd like to thank everyone for joining us today with a special thank you to our presenters, Dr. Safran, Dr. Riggs, Dr. Kapil and Dr. Perou.

If you have any additional questions for today's presenters, please email us at coca@cdc.gov , indicate the presenter's name in the subject line of your email.

We will ensure that your questions are forwarded to them for a response. Again that email address is coca@cdc.gov . The recording of this call and the transcript will be posted to the COCA Website at http://emergency.cdc.gov/coca/calls/2010/callinfo_092110.asp within the next few days.

Those who participated in today's COCA conference call and would like to receive continuing education credit should complete the online evaluation. Continuing education credits and contact hours for COCA conference calls are

issued online through the TCE online CDC training and continuing education online system.

For more information on how to receive offered continuing education and contact hours visit http://emergency.cdc.gov/coca/continuingeducation.asp . To receive information about upcoming COCA calls to subscribe to COCA, please send an email to coca@cdc.gov and write subscribe in the subject line.

We are hoping to also offer continuing education credits specific to mental health professionals for the archived version of this call. More information about that will be available on our Website. We'd like to thank you all again for being a part of today's COCA conference call and have a great day.

Coordinator: This concludes today's conference, thank you for participating, you may disconnect at this time.

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