

# State Defense Force Monograph Series



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## Spring 2012, Homeland Security - Support for the National Guard and the State

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## FOREWORD

The articles in this issue vary across a wide range of functions that help to define the State Defense Force mission to support the National Guard mission in support of homeland security.

The legal article on the status of the militia examines how the militia should fit into the total military forces of our nation, including the relationship between the National Guard (NG) and the State Defense Force (SDF).

The article on examining the modern deployed reserve force mental health support needs deals with the problem returning veterans have with posttraumatic stress disorder (PTSD), how the SDF can offer some form of support to the NG in determining the existence of PTSD, a potential program to obtain treatment for these veterans and the potential for improvement through the new drug court program.

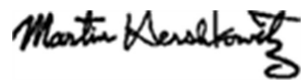
There is an article that describes a simulated surge medical event in joint with the SDF, a school of nursing, a Medical Reserve Corps unit and several other agencies.

Another article describes performing mental health screening while conducting military health clinics in low income Hispanic communities.

There is an article discussing tactical combat casualty care training for SDF medical units.

Another article discusses the value of the SDF and provides guidance to the state on the components of a SDF unit and the process for establishing one.

The last article presents the results of a survey of SDF units across the country in terms of their structure and homeland security mission, with detailed tables of their responses.



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**RESERVE FORCE TRIALS, TRAUMA AND TRANSITIONS:  
EXAMINING THE MODERN DEPLOYED RESERVE FORCE  
MENTAL HEALTH SUPPORT NEEDS  
(EMERGENT ROLES FOR THE STATE DEFENSE FORCE)**

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**ABSTRACT**

*In an address to the graduating class of the Michigan Military Academy, 19 June 1879, General William Tecumseh Sherman stated "I've seen cities and homes in ashes. I've seen thousands of men lying on the ground, their dead faces looking up at the skies. I tell you, **war is Hell!**" (Brown, 1933). He referred to the hell of combat and what is now referred to collateral damage. But there are two kinds of hell; that hell experienced by the Reserve Force warrior and his or her family during the deployment cycle and that hell they experience after deployment when the Reserve Force veteran seeks treatment for the symptoms of traumatic brain injury (TBI) and/or posttraumatic stress disorder (PTSD). The problems and possible solutions are explored herein.*

**INTRODUCTORY THOUGHT**

It is generally thought that Posttraumatic Stress Disorder, "... an anxiety disorder that some people get after experiencing a dangerous event. . . ," occurs at or somewhat after that traumatic event (UMASS Medical School, n.d.; National Center for PTSD, 2012), yet does it? The National Center for PTSD suggests that only some will develop PTSD following the event, depending on:

- How intense the trauma was or how long it lasted.
- If you lost someone you were close to or were hurt.
- How close you were to the event.
- How strong your reaction was.
- How much help and support you got after the event.

Consider, not for research ad infinitum but for incorporation during examination and diagnosis, the possibility that the seeds for potential PTSD are sown during the emotional upheaval that may attend pre-deployment that jointly faces the warrior and family, and perhaps

even more so for the part-time soldier who does not have familial comfort of the Active Force warrior.

## **THE HELL OF DEPLOYMENT**

### **From the Militia to the Reserve Force**

The American settler, later citizen always knew that protection of the homeland was the responsibility of the local militia. From the very first muster of 1636 through the French and Indian War of 1756, the Revolution of 1775, the Whiskey Rebellion of 1794, the Mexican War of 1847, the Civil War of 1861 and even all the way to global war on terrorism (GWOT) and Hurricane Katrina the “citizen soldier” in the local militia responded to the call (National Guard Bureau, n.d.; Sergeant, 1896).

In the 17<sup>th</sup> and 18<sup>th</sup> centuries, the era of small armies and limited warfare, members of the militia unit knew each other. They served in homogeneous home town companies. When they left their families they had each other for mutual support. When they returned home they worked together nurtured by their tightknit communities to restore their homes and properties to normal life. Their experience was shared in every sense of the word, in both their civil and military spheres of camaraderie.

The 19<sup>th</sup> century saw the first mass citizen mobilizations since Roman Republican times initiated by Napoleon. Armies swelled to monstrous size often absorbing both individuals and local volunteer militias into their unfamiliar and anonymous ranks. By the Civil War the only connectivity was that the soldier typically came from the same state. The earlier relationship no longer existed. Still, like Cincinnatus (Lucius Quinctius Cincinnatus, 2012), they left their “plow and farm” behind, returning after the crisis.

Today’s militia, the National Guard, is central to the Department of Defense (DOD) strategy to deter war, and combat terrorism by providing “operational capabilities and strategic depth to meet the nation’s defense requirements ...” (Department of Defense Office of Reserve Affairs, 2008; Adjutants General, 2011). The DOD Office of Reserve Affairs (2008) made this clear in its statement:

“... the Reserve components have been used in different ways and at unprecedented levels, most significantly after September 11, 2001, and the onset of the global war on terrorism. The demands of the persistent conflicts of the past seven years have been high—beyond the ability of the Active component to meet alone. The Reserve components have been relied on heavily to fill operational requirements—comprising close to 40 percent of forces in theater at the height of the mobilization. The role of the Reserves in the total force changed fundamentally.”

Twenty-first Century U.S. expeditionary troops in all anti-terror theaters were typically comprised of about 28% Reserve Force (RF) personnel including erstwhile militia (NG) and other reservists [from Table 1, below (Committee Staff, 2010, Table 2.1)]. This heavy reliance on citizen soldiers resulted in repetitious and prolonged deployment (Korb & Segal, 2011).

**Table 1: Service Members Deployed by Component as of April 30, 2009**

	Army	Navy	Air Force	Marine Corps	Coast Guard	TOTAL
<b>Active component</b>	582,733	320,140	269,220	209,175	3,539	1,384,807
<b>National Guard</b>	239,336	N/A	65,295	N/A	N/A	304,631
<b>Reserves</b>	125,595	33,891	38,056	37,602	228	235,372
<b>Total</b>	947,664	354,031	372,571	246,777	3,767	1,924,810

These up-tempo cycles induced considerable stress and strain that can disrupt social lives of the former “weekend warriors” damaging relationships and disordering once familiar ways of behaving. The concepts presented herein, in part, focus on how prolonged and often repetitive deployments have traumatized and otherwise impaired the mental health of too many part time soldiers who, due to geopolitical exigencies, found themselves standing as full time regulars upon occasion -- perhaps too many occasions (Chandra, et al., 2011; Chandra, et al., 2008; Wong & Gerras, 2010; O’Connor, 2009).

### **Impact of the Global War on Terror on the Traditional Militia Mission**

The post “9/11” GWOT has generated two of America’s longest wars and has clearly changed the National Guard’s traditional role, which had been to support state needs under USC Title 32 (32 U.S.C., § 109; Commission on the National Guard and Reserve, 2008) and to stand as a strategic reserve under USC Title 10 (10 U.S.C., Chapter 13; National Governor’s Association, 2007). Their repetitive and often prolonged combat deployments as part of the all-volunteer force were necessary as they constituted almost one-third of all personnel involved in the now referenced “global contingency operation” (GTO) (Department of Defense, 2009a; Wilson & Kamen, 2009).

This watery designation belies the stark and stress saturated realities faced by soldiers engaged in struggles like those of their Viet Nam era fathers, that have no defined “front lines,” where each civilian -- man, woman, or child -- might be a hostile agent, assailant, or attacker waiting for any chance to ambush and annihilate, even at the casual or welcomed risk of self-extermination. The recent spate of green-on-blue killings are just one such example. These oppressive yet almost constant uncertainties, punctuated for some by moments of acute shock, raise stress levels to constants unmatched by any normative civilian experience in comparable time spans (Katz, et al., 2007; Manderscheid, 2007). The gnawing boredom of day to day-to-day routines punctuated by terrifying extremes (sometimes involving physical injuries that were un-survivable only a decade ago) can cause psychic damage that can follow the soldier home like a hidden parasite to emerge when the conditions are right to attack its host by triggering affective reactions (Lafferty, et al., 2008). These sometimes alter or even shatter comfortable pre-war patterns of family, workplace, and community life.

### **The Dual Life of the National Guard Soldier**

Members of the National Guard live in two worlds. The citizen soldier is mostly a civilian and only an occasional warrior, floating between each status when called up or stood down (Harnett & DeSimone, 2011; Manderscheid, 2007; McNutt, 2005). They leave and re-enter their civilian roles and circles and their friends and family remain largely unaware of the soldier's martial existence which is impenetrable to those unschooled by military culture and the crucible of war. This lack of shared experience impairs the civilians' ability to recognize or understand the psychic wounds that scar too many returning NG soldiers and reservists.

Of course, active force regulars are not immune to these pressures: however, they are more inured to them. After all, they serve in combat with the same people that they worked with stateside. Although they too leave their families behind, but their loved ones are cocooned in military communities where they are socialized to the familiar values, risks and expectations of military life (Griffith, 2009). This creates a common culture that is increasingly distinguished from civil *otherness*. When deployed, Active Force warriors do not shift roles as such. Their passage to combat follows a more familiar corridor.

Reservists, on the other hand are more sharply uprooted (Jackson, 2009). Their dominant civil roles are temporarily suppressed and remain latent while in theater where they serve with other weekend warriors who they may know only causally. Now, they must embrace a highly differentiated set of war-role expectations that are less familiar to them than to their active duty counterparts who they must emulate. Even if the weekend warrior adheres to the drilled in guiding cues of more highly trained regulars, this may make them better prepared for battle, but possibly less prepared to revert to civil life (American Psychological Association, 2007; Goldich, 2011).

The difficulties of civil readjustment are compounded by the fact that their folks back home may also be less acculturated to the ways of war than are the families of regulars (Harnett & DeSimone, 2011). Their military support networks, if they exist at all, may be more attenuated by the family members' dispersion into increasingly diverse communities. They simply do not enjoy the strong institutionalized social support networks that bind Active Force military families together. Consequently, these family members are less able to realistically anticipate and deal with the personal after effects of war's often harsh vicissitudes, or help their loved ones deal with the invisible scars of war (Harnett & DeSimone, 2011).

It should be emphasized that most veterans--militia or not--successfully transition back from their normal life-skipping war zone experience (Eisen, et al., 2012). Still, although research is less than definitive, it is clear that too many veterans encounter a range of problems that, in many cases, appear to exceed community norms. Consider employment for example. One would think that returning warriors would be sought after by employers due to their skills, discipline, reliability, and can-do attitudes? Apparently not. They actually suffer higher unemployment rates standing at 31% for "veterans in the 20 to 24 age group ...:compared to the national average of the same age group at 15 percent ..." (McIlvaine, 2011). Although speculative, this gap may be due to employers' concerns about former *soldiers who may snap*, or who are somehow debilitated by PTSD, and other *problems of coping with their horrible experiences*. They might also worry that returned Guardsmen might be called up again. Other problems are less salient. For instance, one study found that returning Gulf War veterans were more prone to traffic accidents:



“Troops coming off deployment had 13 percent more at-fault auto accidents compared to their time before deployment, said USAA. The increase was largest among Army soldiers, at 23 percent, followed by Marines at 12.5 percent. Losing control of the vehicle was the most common type of accident” (Lienert, 2012).

Speaking more broadly, veterans seem to be overrepresented in the ranks of the homeless as well. One study found that veterans comprised fully 23 percent of the homeless population (Burt, et al. 1999). The National Coalition for the Homeless (2009). paints a grimmer picture, pointing out that “approximately 40% of homeless men are veterans, although veterans comprise only 34% of the general adult male population (The Greater Cincinnati Homeless Coalition, n.d.). Further research is needed to determine the representation of militia and reserves in these rates, but it may be conjectured that since mental health problems with substance comorbidities, which as we shall see, are higher among returning Reserve Force personnel, then similar representational asymmetries may be expected in the homelessness data.

As alluded to above the data regarding mental health issues are even more foreboding. Veterans suffer a number of problems disproportionately to similar demographic groups. Consider suicide, for example rates among active duty soldiers and veterans in the 17 to 24 year age range are nearly four times greater than non-veterans in the same age group (Gibbons, Brown & Hur, 2012; Bossarte, et al., 2012). This trend has been accelerating for uniformed personnel and reached highest point in July 2012, when the army reported 39 deaths, twelve of whom were Guardsmen or reservists (Kime, 2012). Previously in 2012, a total of 187 uniformed personnel had killed themselves, including 71 citizen soldiers (about 38%),

Other problems abound. Traumatic brain disorder (TBI) has been called the “signature injury of the Afghanistan and Iraq Wars” (Goodale, et al., n.d.). The various cognitive, behavioral, and social effects of TBI would be the subject of a separate paper. Other problems include domestic violence (Office of the Surgeon Multi-National Force-Iraq, 2009; Tanielian, et al., 2008); diminished family resilience (Lester, et al., 2012). Depression, PTSD, sleep disorders, and other mental adjustment troubles, both at work and at home, are widely addressed in the literature (Pigeon, et al., 2012; Seal, et al., 2007; Shen, Arkes, & Williams, 2012; Taneiljan, et al., 2008; Lafferty, et al., 2008), and alcohol abuse and other substance comorbidities (Eisin, et al., 2012; Hoge, Auchterlonie & Miliken, 2006). Although research dealing specifically with the NG is scant, one study of 596 Gulf War veterans, including 149 who were NG or Reservists, found that nearly 14% suffered from PTSD and nearly 40% may misuse alcohol (Elsen, et al., 2012). Other research shows that service people who experience multiple deployments have almost twice the incidence of PTSD than warriors with a single deployment (MacGregor et al., 2012).

In 2009 there were more than 1.1 million Reserve Force military personnel whose families must cope with the burdens discussed above (Hoseck, Cavanagh & Miller, 2006). Not only must they deal with chaotic separation problems, but they must handle the emotional pressures as well. This can lead to considerable stress affecting marriages and children with the latter complicating the former. And, although divorce rates don’t appear to have trended up for Gulf War veterans (Karney & Crown, 2011), lifestyle changes can still trigger emotional

exhaustion and multi-tasking demand overload. These pressures have been predicted to follow a five stage causal pattern broadly reflecting the deployment cycle (Pincus, et al., 2005). These stages are:

- (a) pre-deployment -- Beginning with “warning orders” and ending with relocation to an operational area, it may last as long as 12 months. This period vacillates between denial and anticipation of loss resulting in conflicts. Stage One requires family affairs to be set in order and possible fears about the separation to be confronted.
- (b) deployment -- Beginning with relocation and lasting a month, it consists of mixed emotions, disorientation, anger, abandonment, anxiety. Ability to communicate is a two-way door, on the positive side reduced anxiety and stabilization, on the negative side increased stress when issues remain unresolved and new events occur. Electronic participation in family events is a plus.
- (c) sustainment -- Beginning in the second month and ending in the fifth, it consists of increased support from family, friends, religious leaders, the military’s Family Readiness Group and others. Confidence increases with communication as long as topics that arouse anger and resentment are avoided. Children may exhibit negative behavior and mood while the parent is deployed.
- (d) re-deployment -- Beginning the month before coming home from deployment and ending with the return, it consists of anticipation and excitement on the one hand and concern over loss of independence and second guessing decisions made during deployment on the other.
- (e) post-deployment -- Beginning with arriving at home and ending from three to six months, it ranges from celebration to frustration. Following a honeymoon period there is a need to determine their new roles and a continuing family routine. Tension can result as the veteran attempts to regain his former role while the spouse becomes resentful over a possible loss of independence. This stage requires patience, communication, lower expectations, reacquainting among family members.

This model provides insight into how the family should and might react during a member’s deployment; a helpful tool when used to help planners reduce the practical and mental pressures of deployment. Recognizing this utility, Morse (2006) proposed a revised seven-stage model to account for multiple deployments, extended deployments and rapid re-deployments. These stages are: (a) Anticipation of Departure, (b) Detachment and Withdrawal, (c) Emotional Disorganization, (d) Recovery and Stabilization, (e) Anticipation of Return, (f) Return Adjustment and Renegotiation, and (g) Reintegration and Stabilization.

## **SUPPORT MEASURES**

Understandingly, soldiers and their families need a variety of resources to assist them throughout the deployment stages. The most notable of these include The Yellow Ribbon Reintegration Program which was passed by Congress in 2008 (Public Law 110–181 § 582, 2008). This provides an array of information about various support events, resources,

treatment programs, and other benefits (c.f., Appendix A). Augmenting this are the Joint Family Resource Centers that were established, in part, to support the military commanders, soldiers, trainers and civilian volunteers who sustain the extensive system of unit affiliated, command sponsored Family Readiness Groups (FRGs) (Department of Defense Office of the Under Secretary for Reserve Affairs, 2008) and the Defense Center of Excellence Outreach Center's OneSource (Defense Center of Excellence, 2009c). Unfortunately, reservists rarely have regular military peer support, which complicates reintegration (Lafferty, et al., 2008). These mixed teams provide mutual support and other resources to the *whole unit community*. FRGs provide ombudsmen, school and other liaison services; they establish phone and email networks, organize educational seminars and social events, and provide referral services that nurture the soldiers' and their families' sense of community in order to better deal with changes wrought by the deployment cycle (Department of Defense, 2011). Colonel O'Connor, USA, (2009) offers a series of recommendations to the Army to remove barriers to the care and treatment of mental health problems for soldiers and their families, and recommendations for Army follow-on studies.

The DOD has also developed a mental health assessment protocol to detect the presence and effects of PTSD and other physical and behavioral problems so that afflicted soldiers can receive the restorative experiences needed to lead competent and productive lives and have successful relationships (Department of Defense Task Force on Mental Health final report, 2007). Known, as the Post-Deployment Health Reassessment (PDHRA), these comprehensive screenings do not take place immediately upon returning home. Instead, the Reserve Force warrior (now veteran) receives healthcare where available from the military medical system; however, six months following return from deployment he must depend on such care from the Veterans Affairs (VA). Unfortunately, the veteran must live near a VA facility (Harnett & Gafney, 2011), which is often not the case. When the veteran depends upon health care from private healthcare he must seek leave from work, thus, some elect not to obtain needed treatment (Friedman, 2011).

### **A Measure of Posttraumatic Stress Disorder**

In response to the report and the need it addresses the Department of Defense (DOD) has developed a sequence of health assessment tools to address its concern over the impact and effects of Posttraumatic Stress Disorder (PTSD), defined to be "... an anxiety disorder that can develop after exposure to one or more terrifying events in which grave physical harm occurred or was threatened. It is a severe and ongoing emotional reaction to an extreme psychological trauma ..." (Staff, n.d.), with some of the symptoms being hyper arousal, drinking, drugs, hopelessness, shame, despair, divorce, violence and employment problems (Veterans Affairs, 2007). Admiral Mike Mullen, chairman of the Joint Chiefs of Staff, said:

... he was particularly disturbed by the emergence of homelessness as a problem among war veterans and also was worried by a rising number of suicides among U.S. military members. "The trends are all in the wrong direction," he said, adding that "we're just at the beginning of understanding" how to deal with the psychological wounds and scars that military members incur during combat service. (Burns, 2009).

The sequence begins with a Pre-Deployment Health Assessment (PDHA), where all active duty and reserve soldiers deploying for more than 30 days are required to complete a pre-deployment health assessment form (DD Form 2795) within 30 days of deployment (Joint Medical Surveillance, 1997). The purpose of this screening is to review each service member's perceived current health, mental health or psychosocial issues commonly associated with deployments, special medications taken during the deployment, possible deployment-related occupational/environmental exposures and to discuss deployment-related health concerns. This review is conducted by a trained health care provider (physician, physician assistant, nurse practitioner, advanced practice nurse, independent duty corpsman, independent duty medical technician or Special Forces medical sergeant). Positive findings require use of supplemental assessment tools and/or referrals for medical consultation.

The final step in the sequence of the assisted self-assessment is a Post-Deployment Health Reassessment (PDHRA) [Post-Deployment Health Reassessment (PDHRA) Program (DD Form 2900), 2011; Post-Deployment Health, 2006]<sup>1</sup> where active and reserve service members must be screened between 90 and 180 days (sometimes possibly both) after returning from certain qualifying deployments.

Following demobilization the veteran must depend on his NG or Reserve unit to conduct the PTSD testing; however, the NG functioning on state funds under Title 32 (32 U.S.C., n.d.), arguably has insufficient funds and medical staff to perform this function at consistently optimal levels. Twenty-three states have a volunteer military unit reporting to the Governor through the state's Adjutant General that can, as evidence shows, augment this function. These units, authorized under Title 32 (32 U.S.C., § 109) and their state legislature are designated the State Defense Force (SDF), with the mission to support their NG (sometimes they are designated as the State Guard or the State Military Reserve). Some of these units have the needed medical capability, but most do not.

## **NEW BEHAVIORAL HEALTH SUPPORT ROLES FOR THE STATE DEFENSE FORCE**

In addition to relationships with various state health departments, universities and other agencies, the existing State Defense Force (SDF) units are also showing a capacity to support returning NG soldiers and airmen through their mission to support the NG, and to a lesser extent, VA clients. The SDF is a state military unit authorized to the states by Congress under Title 32 USC §109. Twenty three states currently maintain these lawful volunteer military units as part of the state military department in conjunction with their organized militia (which includes the National Guard in its non-Federal status). The SDF cannot be federalized and is constituted primarily for in-state duty, although it may serve out of state for domestic disaster relief and other civil support roles if its services are requested by another state's Governor through an Emergency Management Assistance Compact (EMAC) request (Nelson, et al., 2007). Although some SDF medical commands have served in many emergency services and other Defense Support to Civil Authority missions, their main function is to provide professional medical and behavioral health support to the National Guard (Nelson, et al. 2007; Nelson & Hershkowitz, 2007).

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<sup>1</sup> In some cases the Enhanced Post-Deployment Health Reassessment DD Form 2796 may be used first [Enhanced Post-Deployment Health Assessment (PDHA) Process (DD Form 2796). (2008)].

Currently, at least three states have robust medical commands (i.e., Maryland, Texas and North Carolina), and at least one these SDF units, the Maryland Defense Force (MDDF), has a behavioral health team with several psychologists, Licensed Clinical Social Workers and other mental health professionals who serve in a psychological/behavioral health company within MDDF's 10<sup>th</sup> Medical Regiment. It is important to note that the three SDF medical commands mentioned above are also dually-hatted as Medical Reserve Corps units which are part of a larger network of over 200,000 volunteers in more than 970 overwhelmingly civilian units across the country (Medical Reserve Corps, 2012).

One of MDDF's most important health support roles has been taking a lead in providing Post-Deployment Health Reassessments (PDHRAs) that have been required by the DOD since 2005 (McCarthy, Thompson, & Knox, 2012; Post-Deployment Health Reassessment, 2006), as described above. Briefly, the PDHRA must take place between three and six months after a service member returns from Iraq or Afghanistan. The PDHRA does not involve an actual physical. Rather, it is a process that collects data from returning soldiers and airmen via an online structured interview questionnaire based on DOD health self-assessment Form 2900 (Nelson, 2007; BUMED, 2006). This form is designed to systematically identify poorly healed injuries, chronic health problems, depression, anxiety, PTSD, alcohol abuse and suicidal risk factors among other health and behavioral problems (Loftus as cited in McCarthy et al., 2007). Once a soldier has completed the questionnaire, a provider conducts a further interview to identify any adjustment issues including "family and social adjustment." In Maryland, the form is then reviewed by an MDDF mental health professional (Post Deployment Health Reassessment Program, 2006). These assessments have been credited with uncovering a staggering number of physical, and, in terms of the present focus herein, behavioral health problems.

Consider that nationally, over 1.6 Million services personal have returned from tours of duty in Iraq and Afghanistan. Of these, nearly 19% have been identified as suffering mental health issues including depression and PTSD (Southwick, et al., as cited in McCarthy, Thompson, & Knox, 2012). A recent Associate Press release (Marchione, 2012) states that "... A staggering 45 percent of the 1.6 million veterans from the wars in Iraq and Afghanistan are now seeking compensation for injuries ..." more than double an earlier 21%; however, the release states that others believe that the dramatic increase is due to the economy and lost or unavailable jobs. A counter position is suggested by a Seattle Times release (Bernton, 2012), where "... soldiers under consideration for medical retirement complained that their original PTSD diagnoses were reversed by a screening team, with some of the soldiers labeled as possible malingers ..." causing "... a major review of post-traumatic stress disorder (PTSD) and other behavioral-health diagnoses received by soldiers evaluated for medical retirement ..." and that the system is broken (Howell, 2012) with 886,000 claims in backlog.

The 10<sup>th</sup> (MDDF) Medical Regiment's PDHRA work not only supports these statistics, but, more broadly, illustrates a potentially important and demonstrably viable role that SDF units can play in helping assess and monitor their state's returning warriors. MAJ William M. Fox, the Deputy State Surgeon for the Maryland Army National Guard deemed these volunteer provider services to be "invaluable" to meeting the National Guard's health service needs (personal communication, February 9, 2012). The MDDF's involvement began in 2006 when 11 MDDF personnel were initially trained by the Maryland Army National Guard PDHRA

program manager to administer and review the questionnaire FORM 2900. Many more have since been trained and have participated in regular PHDRA missions. The NG has stressed the need for these medical personnel be issued either Common Access Cards (CAC) so that they can use the military computers to enter the assessment data, or in other cases (e.g., physician assistants involved in Periodic Health Assessments and PDHRAs) to be issued Volunteer Logical Access Credentials (VOLACs). Both cards provide MDDF volunteers essential information technology (IT) access, but the CAC contains a picture ID that is required for frequent service in restricted areas for which more than a handful of MDDF medical providers have been cleared. Regardless, these cards are essential for MDDF volunteers to reach their “maximum point of effectiveness” in servicing the Maryland National Guard’s health service missions, including PDHRAs.<sup>2</sup>

The first PDHRA screening involving the MDDF took place in December 2006 at the Baltimore Medical Center when 95 NG soldiers from the combat tested 243<sup>rd</sup> Engineering Company showed up for this review six months after their return from Iraq (Nelson, 2007). After filling out the form, the soldiers met with MDDF behavioral health team members to further assess their socioemotional needs (Nelson, 2007). Seventy one of the 95 soldiers were identified as needing additional care, including 31 who needed mental health treatment—a rate that far exceeds the national norm of 19% reported above. After the interviews, the SDF practitioners, as a matter of standard practice, made referrals for further treatment or evaluation, and the reports became part of the returning soldiers’ medical record. The resulting data set is ultimately entered into the “Defense Medical System Surveillance data base” (Milken, Auchterionie, & Hoge as cited in McCarthy et al. 2012).

The many subsequent PDHRAs involving MDDF providers have revealed rates much closer to the national norm than the exceptionally high rates effecting the 243<sup>rd</sup> Engineering Company. Consider, for example, the first combined PDHRA in Maryland involving National Guard Airmen and Soldiers which took place on May 7, 2011 at the Baltimore Veterans Administration Center. Five MDDF medical providers and two MDDF behavioral health providers assisted in the assessment of 13 MDANG Airmen and nine MDARNG soldiers. This small group resulted in six medical referrals (27%) and four psychological assistance referrals (19%), that match the aforementioned national rate cited above.<sup>3</sup>

Research on the effectiveness of the PDHRA program at any level is scant. Although MDDF providers seem to be matching or exceeding the average national problem identification rates, some researchers argue that the process in general has room for improvement. One recent study, for instance, suggested the while the assessment instrument is at least “moderately effective” in some domains, that improvements in the questionnaire’s “sensitivity and specificity” should be pursued (Mcarthy et al, 2012, p. S60). Still, these researchers concluded that the PDHRA is “central to maintaining healthy military population and decreasing the risk for suicide” (McCarthy, et al, 2012, p. S61). This coupled with the evidence of the MDDF’s critical contributions to Maryland’s PDHRA review processes clearly

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<sup>2</sup> Major Fox also noted that the issuance of CAC and VOLACS allows the NG to quantify and demonstrate the financial impact.

<sup>3</sup> Colonel Walter Hettinger, M.D., Commander, 10 Medical Regiment provided this information through personal communication.

argue for an expanded role for SDF medical commands across the nation. It also suggests, at least indirectly, that there may be a role for the Nation's civilian Medical Reserve Corps who explore by partnering with their respective state's National Guard. The issue of deficits in the PDHRA process will be further explored below.

### **Span of Potential SDF Professional Health Support**

Although the MDDF 10<sup>th</sup> Medical Regiment's professional support has focused primarily on PDHRAs, and, to a slightly lesser extent routine periodic health assessments (PHAs) and flight physicals, the mental/behavioral and psycho-social support provided by the MDDF to the Maryland National Guard extends throughout the deployment cycle and involves a wide array of community outreach and training interventions. This has involved MDDF participation in state and national committee memberships on veterans' behavioral health issues and National Guard deployment issues. Notably, an MDDF psychologist<sup>4</sup> took the lead behavioral health assessment role on the Adjutant General's Health and Safety Council spearheading a report on the strengths, weaknesses and opportunities for improvement concerning various National Guard behavioral health programs, including:

- Suicide prevention.
- Domestic violence.
- Sexual harassment and assault.
- Substance abuse.
- General mental health climate on operations.

In addition, members have responded to specific requests for mental health assistance for crisis incidents around the loss of deployed service members and family support activities, including those falling along the entire deployment cycle. A systematic review of the scope of MDDF support follows.

#### **Pre-Deployment Phase**

The pre-deployment timeline includes any period after a National Guard unit receives orders and training begins until the unit leaves the country. The members of the 10<sup>th</sup> Medical regiment have been very active in both developing training modules and sessions for pre-deployment briefings for soldiers and their spouses and significant others. They have also participated as presenters/facilitators of those psycho-educational modules. For example, a member of the regiment, a psychologist,<sup>5</sup> co-developed the resilience briefing which was delivered in workshop format as a core component of the pre-deployment event for deploying Maryland National Guard units.

#### **Deployment Phase**

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<sup>4</sup> Major Wayne Hunt, Ph.D.

<sup>5</sup> Christine Harnett, Ph.D.

During deployment, members support the Guard's mission by developing and delivering Family Readiness briefings for spouses of deployed members.

#### Demobilization: Arrival Back in Country

The demobilization phase begins upon arrival back home and ends a brief time after that when soldiers are discharged home. Members from the 10<sup>th</sup> Medical Regiment have participated in this phase. During a briefing event at Fort Dix, New Jersey on the subject they attended as mental health support for the debriefing team composed of military members and civilians; essentially, this function was to be on-call for any mental health emergency that might arise.

### **THE HELL OF MENTAL/BEHAVIORAL HEALTH ISSUES POST DEPLOYMENT**

#### **The Invisible Wound: A Critique of the Current Mental Health Support Network.**

Posttraumatic stress disorder is no longer treated as the Gulf War **equivalent** of "Agent Orange," although the Torah describes battle hysteria and the Priest Anointed for War in Deuteronomy 16:8-21:9 (Trachtman, 2008). The Department of Defense has recognized it as a serious and debilitating illness and is establishing programs to diagnose and treat it. Active duty military are diagnosed and treated in military hospitals, while the National Guard and Reserve military are diagnosed and treated by their respective commands. As shown above, despite expanding partnerships and drawing on new levels of volunteer state militia available to some states, most states are not fully prepared to meet this need, so many National Guard troops are not receiving the treatment that they need, which appears to be the case for the Reserves as well. The Department of Veterans Affairs is designated as the agency to provide this service; however, many veterans are not using their program for a variety of reasons. Described herein is a program to identify, examine, diagnose and provide outpatient treatment to those Reserve Force warriors no longer eligible for military medical treatment.

The Department of Defense Task Force on Mental Health final report (2007) found that:

"Among the most pervasive and potentially disabling consequences ... is the threat to the psychological health of our nation's fighting forces, their families, and their survivors. Our involvement in the Global War on Terrorism has created unforeseen demands not only on individual military service members and their families, but also on the Department of Defense itself, which must expand its capabilities to support the psychological health of its service members and their families."

And that:

"The system of care for psychological health that has evolved over recent decades is insufficient to meet the needs of today's forces ... and will not be sufficient to meet their needs in the future."

#### **Complications in the Program**



The Program design appears to be implemented as a meaningful operation rather than what is all too often the typical bureaucratic application of a Congressional “mandate.” There is no research nor are there individual reports that speak to such failings. Rather, articles and reports that speak to consistent implementation across the services. An example of this trend is one from the U.S. Navy, where Vice Admiral Adam Robinson, Jr., U.S. Navy Surgeon General, in speaking of the Program (NMCSO, 2007) stated that:

“Navy Medicine is already in the process of making the changes recommended by the Mental Health Task Force ... We are moving forward to enhance our current culture to ensure it continues to more fully develop and support a state of robust psychological health throughout the Navy and the Marine Corps, and that is consistent across the Services.”

Yet, the reality is that the Program is in jeopardy of not obtaining its goals. The reason was stated in the DOD Task Force report, “the system ... is insufficient to meet the needs of today’s forces ... and will not be sufficient to meet their needs in the future” (Department of Defense Task Force on Mental Health, 2007). The Program needs physicians, nurses, psychologists, health service personnel and chaplains. Yet today and into the future there are critical shortages in all those categories within the military: physicians, psychologists, dentists (Philpott, 2006); nurses (Cooper & Parsons, 2002); chaplains (Hershkowitz, 2007; Hershkowitz and Tenenbaum, 2008). The Canadian military reports much the same problems (Staff reporter, 2008).

The Pentagon has reported that “... the military’s cadre of mental-health workers is ‘woefully inadequate’” ... “National Guard and reserve members ... face ‘particularly constrained’ access to clinical care as well as to the military chaplains and family support networks ...” (Tyson, 2007). “Colonel Peter Duffy, with the National Guard Association of the United States, said reservists returning from deployments do not have the same access as active-duty members.

M. Audrey Burnam, et al., (2009) observed in *Health Affairs*, “Despite recent efforts to increase access to appropriate mental health care for veterans returning from conflicts in Iraq and Afghanistan, many challenges remain. These include veterans’ reluctance to seek care, insufficient mental health workforce capacity and competency in evidence-based practice, and inadequate systems support for improving care.

A significant research effort recently released by the RAND Corporation explores the need in great detail and concludes that this meaningful program is in jeopardy due to lack of resources, inability to ensure quality of care and a sense that the availability of rehabilitative facilities may not be prepared to treat the problem (Tanielian & Jacox, 2008; Tanielian, et al., 2008):

“... identified gaps in organizational tools and incentives that would support the delivery of high-quality mental health care to the active duty population, and to retired military who use TRICARE ... In the absence of such organizational supports, it is not possible to provide oversight to ensure high quality of care ... OEF/OIF (Operation Enduring Freedom/Operation Iraqi Freedom) veterans

report feeling uncomfortable or out of place in VA (Veterans Affairs) facilities (some of which are dated and most of which treat patients who are older and chronically ill) ...”

In addition to diagnosing and treating military suffering from PTSD-TBI, DOD has established an organization, the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE), that, among other missions, is addressing the issue of stigma, “Stigma presents a significant barrier to seeking out mental health care, particularly in the military, where many service members have concerns about the impact of documented mental disorders or mental health care on their careers.” (Defense Center of Excellence, 2008):

“DCoE Mission: ... assesses, validates, oversees and facilitates prevention, resilience, identification, treatment, outreach, rehabilitation, and reintegration programs for psychological health (PH) and traumatic brain injury (TBI) to ensure the Department of Defense meets the needs of the nation's military communities, warriors and families.”

The Washington Post reported that “... The military is also battling a crisis in mental-health care. Licensed psychologists are leaving at a far faster rate than they are being replaced. Their ranks have dwindled from 450 to 350 in recent years. Many said they left because they could not handle the stress of facing such pained soldiers. Inexperienced counselors muddle through, using therapies better suited for alcoholics or marriage counseling ...” (Priest and Hull, 2007).

Colonel Richard Thomas, the director of health services at Fort Campbell, has roughly doubled his authorized staff of psychologists and behavioral specialists to 55 and is trying to hire a few more. “I think we have enough staff to meet the demands of the soldiers here, but I could use more, and I'll hire more if I can.” (Baldor, 2008).

A recent Time, Inc., news release reported that “... It's not easy for soldiers to admit the problems that they're having over there for a variety of reasons, ... If they do admit it, then the only solution given is pills ... (from the Army's fifth Mental Health Advisory Team report) ... about 12% of combat troops in Iraq and 17% of those in Afghanistan are taking prescription antidepressants or sleeping pills to help them cope ... (quoting Colonel Charles Hoge the top Army psychiatrist) ... Nearly 30% of troops on their third deployment suffer from serious mental-health problems ... “ (Thompson, 2008).

## **The Reality**

Recognizing the need, yet unable to resolve it, the active duty and reserve forces struggle to conduct the elements of the Program. Personnel from the Department of Veterans Affairs are used to augment the DOD staffs (Department of Veterans Affairs, 2006) and contracts for civilian personnel are let as well. The Uniformed Corps of the Public Health Service has pledged its medical and health personnel in support of the PDHRA Program (U.S. Public Health Service, 2008). Still, there are insufficient personnel to fully staff the needs of the Program.

Representative Bob Filner, the head of the House Veterans Affairs Committee, in speaking of General Shinseki's appointment to head the Department of Veterans Affairs (DVA), quoted a RAND report (Leopold, 2008):

"There is a major health crisis facing those men and women who have served our nation in Iraq and Afghanistan ... Unless they receive appropriate and effective care for these mental health conditions, there will be long-term consequences for them and for the nation. Unfortunately, we found there are many barriers preventing them from getting the high-quality treatment they need."

As mentioned above some, The State Defense Force (SDF)<sup>6</sup> are trying to help fill the gap, and so are many more civilian partners. These efforts show some promise, but are unlikely to even begin to realistically meet the need. They, are not widespread nor quickly proliferating.

#### Anecdotal Support for the Reality

A series of news media interviews provide some insight into the scope of the problem and into some of the reasons that the currently designed PDHRA Program cannot fully succeed without additional support:

- "... More than 80 percent of people serving there have witnessed or been a part of a traumatic event ... Minor family arguments, disagreements, detachment from their family members, all the way to the divorce rate ..." (Felder, 2007).
- "... A few years into the war, Laural had a mental breakdown and a short hospital stay. That's when Brian decided to retire. He left the Army at the end of last year. The Millers would like to be able to say the problems ended there. But the emotional and financial cost of their war were high" (Baer, 2008).
- "... Families are often the next to fall victim. Psychologist Harriet Zeiner says nearly two-thirds of the severely wounded will wind up divorced in less than a year ... And, for those who don't get the treatment they need, who don't reach out for help, it can be life-threatening ..." (Cooper, 2007).
- "... The mental-health unit didn't open for an hour. In her suicidal state ... was told to wait ... told her story to five different psychologists. None ... offered therapy or relief ... medical students wanted to "present her" to the staff as an interesting case ... a military and VA surgeon, was shocked ... to see a staff so unfamiliar with post-traumatic stress disorder, given the hospital's proximity to several military posts ... (Priest and Hull, 2007).

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<sup>6</sup> The State Defense Force is a USC Title 32 (32 U.S.C., § 109, 1955) authorized volunteer military organization reporting to the Governor through the State Adjutant General, often with missions to support the National Guard and through it homeland security.

- "... According to a recent American Psychiatric Association report ... More attention has been paid to the mental health of American troops in Iraq and Afghanistan than in any previous war. Yet shame remains a significant barrier to military personnel and their families getting the psychiatric treatment they need ... service members often find it easier to seek therapy outside the military setting than within it ... (and for the) mental health of military spouses ... about 70% ... said they worried that their loved ones would be harmed or killed in battle. But nearly two-thirds also reported that handling domestic issues alone or being a single parent was a major source of stress ..." (Kingsbury, 2008).
- "... During the first week of the war in Iraq, a Military Times photographer captured the arresting image of Army Spc. Joseph Patrick Dwyer as he raced through a battle zone clutching a tiny Iraqi boy named Ali ... rather than going on to enjoy the public affection for his act of heroism, he was consumed by the demons of combat stress he could not exorcize ... the battle for his own health proved too much to bear ... (o)n June 28, Dwyer, 31, died ... of an accidental overdose..." (Kennedy, 2008).

## ELEMENTS OF A PROPOSED PTSD TREATMENT PROGRAM

It remains clear that the DOD PTSD Program is well designed, was implemented with the intent to succeed and to be a meaningful health assessment and treatment effort. Unfortunately, it is becoming equally clear that the Program is in jeopardy of failing due the lack of trained resources and the lack of a variety of supportive elements that would facilitate the soldier and the soldier's family to enter into the Program and receive its full benefits. If the program for active duty military is in jeopardy, the diagnosis and treatment for the NG and Reserve military might be considered to be fractured (Burnam, 2009; Maze, 2008; Hoge, et al., 2008).

The most needed elements are: more professional staff; better trained staff; complete mental health treatment facilities; elimination of stigma associated with problem identification and treatment; convenient access; convenient location of the mental health treatment facility to the family's home area; possible assistance for the soldier's family to obtain needed employment and/or schooling. Although some of these elements may be difficult to arrange, the more that can be put in place will ensure the likelihood of the soldier to recuperate and the soldier's family to weather this awful storm.

The RAND Report identifies four areas that need to be addressed in order to improve the program and enhance care (Tanielian & Jacox, 2008):

- "1. Increase the cadre of providers who are trained and certified to deliver proven (evidence-based) care, so that capacity is adequate for current and future needs ...
- "2. Change policies to encourage active duty personnel and veterans to seek needed care ...<sup>7</sup>

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<sup>7</sup> The National Guard and Reserve forces should be included (author).

“3. Deliver proven evidence-based care to service members and veterans whenever and wherever services are provided ...”<sup>8</sup>

“4. Invest in research to close information gaps and plan effectively ...”

All soldiers, sailors, airmen and marines may be subject to the problems brought on by PTSD; however, those on active duty and retired have DOD medical facilities available to them. National Guard and Reserve forces lose routine DOD treatment for PTSD 180 days following discharge or release from active duty (GAO Report to Congressional Committees, 2006). A contact representative for the VA Health Resource Center (personal communication, October 21, 2012),<sup>9</sup> explained that National Guard and Reserve personnel suffering conditions that are clearly combat related, may pursue enhanced eligibility as a “combat veteran” beyond the 180 days (Department of Defense, 2011a). Although speculative, much anecdotal evidence suggests that this continued support may be difficult to obtain, at best,<sup>10</sup> and the proposed augmentation services explored herein is looking to fill this service gap should it exist.

A further complication is caused by Traumatic Brain Injury (TBI) caused by a “... mild blow to the head that causes just enough of a physical injury that normal brain functions of memory, attention, mental organization and logical thinking can be compromised ...” while “... PTSD is an emotional injury in response to a traumatic event ...” “... Both can have similar symptoms, so at times, it can make distinguishing between the two very difficult ...” (Terri, 2007). The program proposed herein would treat all National Guard and Reserve troops displaying these symptoms until it is determined that the individual is suffering from TBI instead of PTSD, in which case the treatment staff would recommend the individual to an appropriate facility for further treatment.

It is most important to understand that the augmentation program explored herein does not intend to create a new non-military bureaucratic entity in opposition to the DOD-DVA PTSD Program. Rather, the concept is designed to: identify communities where NG and Reserve military suffering from PTSD cannot or will not use available DVA mental health resources; identify, examine, diagnose and treat as outpatients those NG and Reserve military living in or near those communities who have been exposed to conditions that may cause PTSD; provide the additional needed mental health resources to ensure proper diagnosis and treatment. These communities will have medical delivery systems that can accommodate additional work loads and provide the needed mental health diagnosis and treatment in that locale, which considerations are vital to the overall design.

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<sup>8</sup> The National Guard and Reserve forces no longer on active duty should also be included (author).

<sup>9</sup> Rosemary Artzen.

<sup>10</sup> The Compensation Benefits Handbook (Department of Defense, 2011a) lists seven general rules for assignment to a priority group for medical support beyond the 180-day threshold (p. 52). Four of the rules require a VA rated disability and the remaining three have a financial requirement with one of those having an additional requirement for exposure to ionizing radiation.

The elements of this proposed PTSD augmented civilian effort are:

### **Professional Staff**

Although the military's reducing staff of competent professionals is being augmented by the Uniformed Public Health Service, the Department of Veterans Affairs and contract physicians and other specialists, and in some states, as discussed above, SDF volunteers, the problem is growing at a more rapid rate. What is needed is a single source of knowledgeable professionals in a local area.

Such a source would be a locale where there are several respected teaching hospitals and a distribution of local mental health treatment centers and/or psychiatric hospitals. Through a suitable funding mechanism, these hospitals could increase their principal staff and attract many more students all in support of this program.

### **Training**

Training is plentiful and available from military sources. Once appropriate professionals have been identified and brought on board, classroom and on-the-job training will be provided and within a short time the staff can begin functioning as needed, particularly: in the use and analysis of the DOD Form 2900 for measuring Post-Deployment Health Reassessment; in the use and analysis of the psychological and physical tools suitable for diagnosing PTSD; and in the use of psychological, physical and psycho-social methods for treating PTSD.

### **Mental Health Treatment Facilities**

There are three possibilities for locating a mental health treatment center under this proposed concept: (1) utilize, convert or donate a portion of a wing of a teaching hospital; (2) establish a working relationship with existing mental health treatment centers and psychiatric hospitals in the region; or (3) build or rent an existing building dedicated to medical and health services to create a program-owned distinct mental health treatment facility in the region. In this manner the proposal will assist the DOD PTSD Program; however, the third option is unlikely due to cost, time delays and increased staffing.

The proposed program plans to assist the soldier's family by providing outpatient therapy for the spouse and children to assist in coping with the situation.

It is important to note that the intent of this proposed effort is to serve those soldiers not covered by DOD facilities and that it is oriented toward outpatient services. Those individuals determined by the treatment staff to need inpatient services will be transferred to a nearby Veterans Affairs Hospital or suitable psychiatric hospital or ward as appropriate and desirable.

### **Facility Location**

Convenient access to the facility is important for both the soldier receiving treatment as well as the soldier's family. The concept discussed herein proposes to establish mental health treatment facilities located in major cities such as New York, Chicago, Los Angeles and in

large multi-city regions such as Washington-Baltimore. From these major city locations the proposal plans to reach out into outlying cities within convenient commuting for the mental health treatment facility; thus, providing convenient PTSD support to a broader population of soldiers needing this medical support.

The rapid recovery of the soldier is closely intertwined with the proximity of the treatment facility to the home of the patient, which has an impact on the health of both the soldier and the soldier's immediate family. It becomes incumbent upon this proposal to establish suitable mental health treatment centers in convenient locations in order to encourage a complete and rapid recovery.

To demonstrate the potential of this approach a demonstration model or test-bed in the Baltimore-Washington corridor is strongly suggested.

### ***Elimination of Stigma***

The fact that the military has not been able to remove the stigma attached to receiving mental or psychological help presents a most complex issue, virtually impossible to achieve under normal conditions. This proposal believes that by removing the soldier from the military cocoon during the outpatient treatment process conducted in the home region, thus surrounding the soldier with immediate family, the stigma associated with suffering from a mental disorder would be greatly reduced. This would be more clear to the soldier and the Command if the soldier and the unit know that the soldier would be restored to his or her unit when the treatment is complete. Likewise, the soldier's promotion potential should not be adversely impacted.

### ***Assistance in Obtaining Education for the Family***

The soldier's rehabilitation depends on being assured that the family unit is well and living as normal a life as possible. By ensuring that family members needing or wanting employment and/or schooling are accommodated, the rehabilitative process has one less problem to interfere with the soldier's recovery. Accordingly, this concept proposes to assist the family in seeking and obtaining employment, educational opportunities and/or learning assistance while their family member is in treatment.

## **ANOTHER AVENUE TO TREATMENT: THE VETERANS COURT**

For two decades, rehabilitative sentencing alternatives for criminal defendants, such as drug and domestic violence courts, have made positive inroads in reducing recidivism and costs associated with incarceration. According to a 2005 U.S. Government Accountability Office (GAO) Study, "problem solving" drug court rehabilitative programs, which permit treatment of addiction in lieu of incarceration, significantly reduced recidivism (U.S. Government Accountability Office, 2005).

The stressful experiences of combat duty in the wars in Iraq and Afghanistan do not necessarily end for veterans returning home. Many return with post-traumatic stress syndrome, other mental health concerns, or with drug or alcohol abuse issues, which have

been exacerbated by military service. Sometimes a physical injury further compounds the stressors. Returning veterans are faced with family and employment issues that may stem from physical and mental impairments from their service. These physical and mental health conditions are associated with violent or non-violent felonies as well as misdemeanor crimes. Often, the veterans are in need of treatment and rehabilitative services which are available through the Department of Veterans Affairs (VA). The United States Bureau of Justice Statistics reported that in 2011 over 1.1 million veterans were arrested and as many as 10% were incarcerated (Noonan & Mumola, 2007).

Utilizing the therapeutic or treatment approach of problem solving courts as modeled on the first Veterans Court in Buffalo New York (Veterans Service Agency, n.d.), Delaware has established the very first statewide veterans court in the country that is both a diversion and probation court. No other court with this expansive capability exists in the United States. This court was established on February 18<sup>th</sup>, 2011 and meets twice a month with a current docket of 38 participants (Administrative Office of the Courts, 2011). There have been two graduates at this stage and no failures.

The Veterans Court of Delaware has the authority to operate as a unique, problem solving court pursuant to Article IV, Section 7 of the Delaware Constitution (Delaware Code-a, n.d.) and under Title 10 of the Delaware Code (Delaware Code-b, n.d.). The court partners with the VA under Title 38 of the United States Code (38 U.S.C. § 6306, n.d.). The court will allow one who has been in the military, regardless of time frame, who has committed a violent crime such as assault or theft or other non-violent crimes to enter the program if approved by the Delaware Attorney General's Office. The case may be transferred from other counties to Kent County where the Court sits. The veteran is evaluated and may be recommenced for treatment at a VA or State facility depending on whether the serviceman is eligible for VA benefits. The program can be from six months to one year, and must meet in court each month to evaluated progress. If the veteran completes the program(s) required, he or she will graduate and the charges which are held in abatement are dismissed; if he or she is on probation before entry, that probation may be discharged.

A key aspect of the program is the mentorship component. To support the veteran through the court process, volunteer mentors are assigned. They are veterans themselves and assist the veteran to make appointments and be a person to call on when in need. The volunteer mentors are a crucial part of the process because they understand the stresses of military life and can offer necessary understanding, assistance and support through the difficult process of recovery.

The Court has achieved success due to the cooperation of the Delaware Attorney General's Office, the Office of the Public Defender, the VA and the resource agencies of the State of Delaware.

## **CONCLUDING THOUGHTS**

Posttraumatic Stress Disorder (PTSD), the "invisible wound," is and will be for the foreseeable future a major concern for military medicine and Veterans Affairs as it is for police



and firefighters and other occupations where the incumbent faces dangerous events. Consider the following:

- Notification of deployment begins a painful process within the family, particularly for the Reserve Force warrior's family who do not have the familial support of the Active Force warrior's family.
- The Reserve Force warrior deploys amongst troops he barely knows reducing the level of expected support from comrades.
- An horrendous event will occur.
- The painful process continues and perhaps compounds following return from deployment.
- DOD has developed a series of tests, discussed above, to measure the mental/behavioral health of returning warriors and augmented it in selected cases with the Minnesota Multiphasic Personality Inventory, Assessing Personality and Psychopathology (MMPI-2) (Ford, 2009).
- Questions have been raised about the use and accuracy of the PDHRA.
- Many NG commands do not have the expertise or funds to conduct the PDHRA testing effort.
- Some states have a Title 32 authorized volunteer military unit, the State Defense Force, and very few of those have the expertise.
- Identification, diagnosis and treatment of PTSD is considered to be a broken system; lack of trained mental/behavioral health professionals, disagreement among them on treatment methods, disagreement on length of treatment.
- Fear of stigma from being identified as a mental patient.
- Difficulty in accepting and/or receiving treatment from the VA.
- The need for a stigma-free complete program to identify, examine, diagnose and provide outpatient treatment for Reserve Force veterans who would otherwise not receive treatment.
- The Veterans Court is an interesting concept in assisting veterans displaying symptoms of PTSD who have committed a violent crime such as assault or theft or other non-violent crimes by sentencing them to appropriate treatment.

In summary: Who performs the mental health treatment, who restores the Reserve Force veteran to useful service is much less meaningful than the restored health of the armed force. By establishing a non-profit corporation that will seek private as well as public funds to

perform its mission, the proposed corporation will face less constraints to implement the six (6) elements discussed in the text above. To convert a possible criminal conviction and incarceration into a mandatory treatment regimen through the Veterans Court program is a plus.

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## **Appendix A**

### **SEC. 582. YELLOW RIBBON REINTEGRATION PROGRAM**

The Secretary of Defense shall establish a national combat veteran reintegration program to provide National Guard and Reserve members and their families with sufficient information, services, referral, and proactive outreach opportunities throughout the entire deployment cycle. This program shall be known as the Yellow Ribbon Reintegration Program ...

The Yellow Ribbon Reintegration Program shall consist of informational events and activities for members of the RCs of the Armed Forces, their families, and community members to facilitate access to services supporting their health and well-being through the four phases of the deployment cycle: (1) Predeployment, (2) Deployment, (3) Demobilization, (4) Postdeployment-Reconstitution ... The Secretary shall designate the Under Secretary of Defense for Personnel and Readiness as the Department of Defense executive agent for the Yellow Ribbon Reintegration Program ...

The Under Secretary of Defense for Personnel and Readiness shall establish the Office for Reintegration Programs within the Office of the Secretary of Defense. The office shall administer all reintegration programs in coordination with State National Guard organizations. The office shall be responsible for coordination with existing National Guard and Reserve family and support programs. The Directors of the Army National Guard and Air National Guard and the Chiefs of the Army Reserve, Marine Corps Reserve, Navy Reserve, and Air Force Reserve may appoint liaison officers to coordinate with the permanent office staff.

The office may also enter into partnerships with other public entities, including the Department of Health and Human Services, Substance Abuse and the Mental Health Services Administration, for access to necessary substance abuse and mental health treatment services from local State-licensed service providers.  
(HR 4986, 120-121).