Raquel Wilson
Deputy General Counsel
U.S. Sentencing Commission
Thurgood Marshall Judiciary Building
One Columbus Circle NE
Washington DC 20002-8002

March 21, 2010

Dear Ms. Wilson:

I am writing in response to the U.S. Sentencing Commission's request for written public comment regarding Proposed Amendments to the Sentencing Guidelines published in the January 21, 2010, edition of the Federal Register. Specifically, I wish to strongly support proposed changes that would allow judges to consider alternatives to incarceration and to make departures from the usual sentencing guidelines for Veterans. It is especially important to seek alternatives for Veterans living with, or suspected of having, any of a variety of mental health conditions including, but not limited to, Post-Traumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI), and Depression, as well as substance abuse disorders. Questions in the proposal seem to specifically focus attention on behavioral health problems other than substance abuse, but the use or abuse of alcohol and illicit drugs is very often inextricably tied to efforts to manage trauma-related symptoms and co-occurs. Evidence-based approaches to co-morbid mental health and substance use disorders demand that these be treated in an integrated fashion by cross-trained professionals. Policies and law must reflect this "natural state" of co-occurring conditions.

I am a clinical psychologist and an Associate Director at Community Connections, the largest not-for-profit mental health agency in the District of Columbia. There I have two primary sets of job responsibilities that both give me a window into the issues I wish to address in my comments regarding Veterans. First, I oversee a dozen or more supportive housing programs, including one transitional program and one permanent housing program for homeless Veterans. I will speak briefly below about the interacting forces and correlates associated with homelessness, trauma and criminal conduct among Veterans, but it is important to note that President Obama recognizes the disproportionate rates of homelessness among Veterans has repeatedly expressed a "zero tolerance" policy and a mandate to end homelessness among Veterans within five years.

Secondly, I am a longstanding member of the trauma workgroup at Community Connections and am a frequent trainer and consultant in the areas of men's trauma treatment and creating trauma-

informed systems of care the CC's training arm, the National Center for Trauma, Recovery and Empowerment (NCCTRE). In this role, it has been my privilege to be involved with two different initiatives aimed at modifying the Trauma Recovery and Empowerment Model (TREM)—a model of trauma recovery developed at Community Connections—for application with Veterans. Based on data reported from several studies funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) in the U.S. Department of Health and Human Services and NIMH, the TREM model has been chosen for listing on the National Registry of Evidence-Based Programs and Practices (NREBPP) published by SAMHSA. The State of Connecticut's Veterans Jail Diversion and Trauma project has contracted with Community Connections to adapt the men's version of TREM and to provide trauma-informed care consultation. A similar effort is underway with Resources for Human Development (RHD) as they launch an initiative known as Healing Ajax, a peer-to-peer, Vet-to-Vet model of trauma education and recovery that borrows heavily on the TREM model. A State of Pennsylvania Veterans, Trauma and Jail Diversion initiative begun in Pittsburg will be expanded to Philadelphia in the near future, and there is significant interest in the Healing Ajax and Vet-TREM approaches there. My involvement with both the Connecticut and Philadelphia projects has afforded me the opportunity to engage Veterans from different eras in an extended series of discussions about the mental health treatment needs of Veterans. My comments here are for them and where possible will reflect specific experiences and opinions that they have shared with me.

PTSD, TBI and Depression are the signature injuries of the OEF and OIF conflicts and frequently co-occur.

In general, the case for giving consideration to Veteran status and evidence of mental injuries lies in a few key statistics. The US Department of Justice reports that while only 5% of the US population has a serious mental illness, about 16% of the prison and jail population has a mental illness. RAND Corporation researchers found that almost 20% of Iraq and Afghanistan veterans meet the criteria for depression or post-traumatic stress disorder (PTSD).

Specific kinds of criminal activity may be directly or indirectly related to the impact of trauma.

Impulse control issues and emotional dysregulation are cardinal features related to both PTSD and TBI, making differential diagnosis of these conditions difficult. Those veterans who screened positive also described a wide variety of trauma experiences, more serious current legal problems, higher lifetime use of alcohol and other substances, more psychiatric symptoms, and worse general health. Reactions to combat is revealed via problematic responses that are often treated as misconduct, such as reckless driving / excessive speeding / DUIs; misuse or abuse of alcohol and substances; domestic violence or abuse of family members; sexual misconduct; or feigning illness to get out of work. A Bureau of Justice Statistics (BJS) report on incarcerated veterans found that veterans with a dishonorable discharge status are incarcerated in higher proportions, and have more serious criminal and substance abuse histories. The National Alliance to End Homelessness determined in 2007 that although veterans make up little more than 10% of the general population, they comprise one in four homeless adults.

<u>Screening efforts are insufficient and accurate diagnosis and treatment are often delayed years after separation from service</u>.

For many, many reasons, some relating to expedited out-processing of men and women in the military eager to return to families, initial screening often fail detect emergent problems. The military and the Veterans Administration have made concerted efforts to conduct repeated assessments over longer periods of time in order to more fully capture, diagnose and treat behavioral health problems. However, huge numbers of individuals suffering significant post-traumatic stress responses go unrecognized and experience cascading negative life consequence for 10 years or longer. Criminal justice contacts must be understood as opportunities for thorough evaluation leading to appropriate treatment.

<u>Stigma regarding behavioral health problems within military culture remains an enormous barrier to early detection and treatment of problems</u>.

The Department of Defense (DOD) Task Force on Mental Health noted in 2007 that military service can result in "hidden wounds," which includes PTSD and trauma disorders. Symptoms of these injuries can include behaviors such as:

- "Difficulty controlling one's emotions, including irritability and anger;
- Self-medicating with alcohol, other medications, or illicit drugs in an attempt to return to 'normalcy'; and
- Thrill-seeking behavior such as driving too fast or other reckless/high-risk behaviors"

Those serving in the military develop a set of values specific to the Army and its culture. In particular, there are seven major components to these values: loyalty, duty, respect, honor, selfless service, integrity, and personal courage. Aspiring to these values can create a perceived expectation that one should not seek treatment for mental health issues. Soldiers asked what would happen is they sought mental health services reported that their leadership would treat them differently, they would be seen as weak, and that it would harm their career.

A related discussion about central attitudes and dynamics within the military culture that discourage treatment-seeking are also summarized in the attached PowerPoint presentation that summarizes a discussion in the Rand report, The Invisible Wounds of War (Tanielian & Jaycox, 2008).

<u>Unemployment, homeless, substance abuse and involvement with the criminal justice system are common secondary developments associated with combat trauma and other forms of exposure to traumatic violence</u>.

<u>SAMHSA recognizes the need for diversion and alternative strategies and is funding multi-year state grants to develop integrated strategies for addressing trauma and co-occurring disorders among Veterans with criminal justice contact</u>.

2008 "Jail Diversion and Trauma Recovery—Priority to Veterans" grantees include Colorado, Connecticut, Georgia, Illinois, Massachusetts and Vermont.

[Comments from Mr. David Kennedy, a Veteran and project staffer on the Connecticut project follow the overview comments offered by Richard Bebout.]

2009 Grantees include Florida, New Mexico, North Carolina, Ohio, Rhode Island, and Texas.

There is an emerging consensus regarding evidence-based practices for PTSD and other mental health "injuries" for combat veterans and calls for trauma-informed care.

VA Evidence-Based Psychotherapy Training Programs - VA is strongly committed to making state-of-the-art, evidence-based psychological treatments widely available to veterans. To stimulate efforts to make these treatments widely available throughout VHA, the Office of Mental Health Services has developed national initiatives to train VA mental health staff in the delivery of evidence-based psychotherapies for PTSD, depression, and serious mental illness, which are actively underway.

The Local Evidence-Based Psychotherapy Coordinator supports the local implementation and sustainability of evidence-based psychotherapies. Each medical center has a designated Local Evidence-Based Psychotherapy Coordinator who serves as a champion for EBPs at the local level, providing clinical support and education and promoting local systems and administrative structures to facilitate the implementation of EBPs on the ground.

A growing body of information and resources are available for educating the judiciary and supporting the implementation and sustained operation of alternative "treatment" courts designed to promote linkage to appropriate treatment.

Key resources that should be referenced in considering alternative sentencing strategies include (1) the Rand Corporation's seminal report, ***The Invisible Wounds of War***, published in 2008; (2) the National Center for Mental Health Services GAINS Center, including the consensus recommendations coming out of the 2008 forum on meeting the needs of returning veterans with criminal justice involvement; and (3) the SAMHSA grants awarded in 2008 and 2009 known as "Jail Diversion and Trauma Recovery—Priority to Veterans." This cohort of grants is supported through technical assistance provided by the National CMHS Gains Center.

Mr. Kennedy is a Veteran and a member of the project staff for the SAMHSA/CMHS "Jail Diversion and Trauma Recovery—Priority to Veterans" grant awarded in 2008 to the State of Connecticut Department of Mental Health and Addiction Services, Hartford, Conn. This is a project on which the lead author (RB) of Community Connections is a minor partner. Kennedy was invited to comment about the proposed amendments. His comments are incorporated in their entirety; these are his opinions and not those of Connecticut DMHAS.

Dave Kennedy
Comments on USSC, 2010 Proposed Amendments
19 March 2010

Page 16, Item 2:

The Commission requests comment on whether defendants with a condition other than drug addiction, such as a mental or emotional condition, should be eligible for treatment programs as an alternative to incarceration.

By all means - if we, as a nation, are to be considered serious in our attempts to reduce rates of incarceration! It's plain to see we can't, at once, spend billions on prisons and staffing of prisons, and merely millions on treatment alternatives to prison.

Page 16, Item 3:

The Commission requests comment on whether the proposed amendment should include standards for effective treatment programs. The Commission has provided standards for other types of programs; for example, §8B2.1 (Effective Compliance and Ethics Program)) provides minimum requirements for corporate compliance and ethics programs. Should the Commission similarly provide standards for effective treatment programs? If so, what standards should the Commission provide?

Yes, the Commission should provide standards for effective treatment programs and evidence-based programs, preferably; and at the very least, programs with evidence of their efficacy, not merely evidence of their existence. And ones that don't cost an arm and a leg to field! Peer-support models come to mind – mentoring, leadership…these don't cost much, but the investment of time in training those who will conduct more thoughtful interventions. But one problem with evidence-based practices is that they continue to have 95% success ratios – so, more honesty in evaluation and reporting of outcomes is necessary. Otherwise we wouldn't have more homeless than ever, with every program boasting 90 percentile outcomes. Clearly, we have to empower communities as a whole to develop their own responses, organic to the service systems already therein to deliver those services. I don't mean to pontificate – but the sentencing guidelines should do the same, empower judges to use those service systems in lieu of incarceration – particularly for low-level offenses, but even certain higher level offenses. Take, for example, some domestic violence/assault/strangulation and certain narcotics possession, or possession with intent to sell, charges – these are serious charges to be certain – but making mandatory sentences out of mandatory arrests without considering the mental condition of the accused is certain to exhaust all hopes of reversing the trend over time.

Page 17, Item 5:

The Commission requests comment on what revisions to Chapter Five, Part B (Probation), and Chapter Five, Part F (Sentencing Options), may be appropriate to provide more guidance on the use of alternatives to incarceration.

Given the definition of probation and all of its derivatives, the state's should be given discretion from the bench to not only delay adjudication, but give the offender a chance to not carry a record forward for the rest of his or her life. This is what the Sentencing Commission would do well to address…the incidence of life-long records that essentially sentence offenders to life-long, low-paying jobs due to backgrounding by third-party data harvesters, lack of access to safe, affordable housing and education opportunities as a result thereof, which keeps them exposed to crime, poverty and substances and increases the likelihood of future contact with law enforcement and arrest and a long embrace by the criminal justice system. I don't know that much about sealing legislation and records and reporting, but in a post-911 world, many companies and corporations maintain proprietary relationships with these types of background investigations firms. This means that a lot of money goes into the lobby to keep access to arrest records, court documents, etc. open under the rubric of the public's right to know, and virtually nothing goes into protecting the rights of the accused – even if his or her charges were nolled or dismissed. And in that instance, a community's police log in the newspaper also available on-line, the court docket and records, the police reports, the county jail admission, the bail commission or other court support agencies all have a established a record of that individuals criminal justice system contact and without substantial investment of time and money, a private citizen would have no chance of tracing where his or her information is kept or to whom it is being made available or disseminated. Even in the case of a dismissal, that individual is marked for life. Now, if it is the case of a (temporarily) mentally ill individual who is not even using illegal substances, (or is off his or her meds for some reason or another) and they are not provided a substantive treatment alternative in the community, then what are we doing? And how is it that individual is ever going to rise above some level of dependence on the government?

From Page 19, With regards to a review of departure provisions:

Third, the Act directs the Commission to ensure that the guidelines and policy statements "are entirely neutral" as to five other characteristics – race, sex, national origin, creed, and socioeconomic status. See 28 U.S.C. § 994(d).

I remember one time when I was homeless, penniless, freezing from being out of doors overnight and very hungry after having being let out of a VA hospital with no discharge plan – in Maryland. I was walking home to Connecticut from Washington, D.C. Along the way, I saw a construction site and trailer from which a man walked out carrying a plain white Styrofoam cup. I deduced that there must be hot coffee in there and so I walked in and drew a cup from the pot and while I was there took a muffin, as well. I did feel remorseful as I was walking away but I remembered something I had heard and it made sense…"when men are hungry, they help themselves." Being hungry can lead to the commission of a crime. Now that I have money in

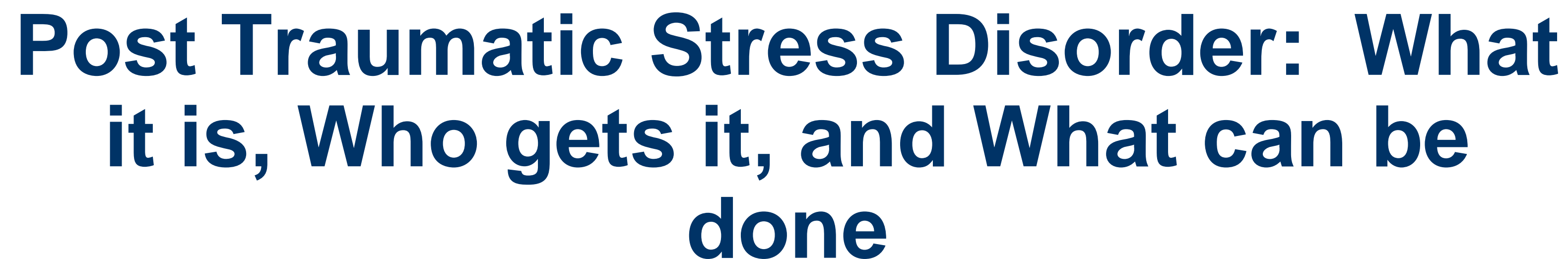
my pocket and a home and family, I think back with a certain amount of shame about that time of my life – and I sometimes think that someone in that position *should* be made to pay…I have to pay for my muffins today. But should they be made to pay with jail time? Then we all pay and pay and pay for that individual to be incarcerated and still have done nothing to prevent re-offense, re-arrest and so on. I think what I am trying to say is that with regards to guidelines and policy, it is as irrational to strive for "entirely neutral" sentences as it is to strive for "entirely neutral" characterization of offenders. Each incident of arrest is different and each defendant is different. In the same way, each judge is different, and likewise, the treatment services in the community at the disposal of the judge to which he or she might refer an offender are different. We mustn't mandate too strict or homogenous a response from the top-down…it stifles creativity. After all, if we are to empower individuals to recover, or be restored to wellness through treatment alternatives to incarceration, then we must also empower communities to do the same lest we make complete and utter dependents on federal money of them both.

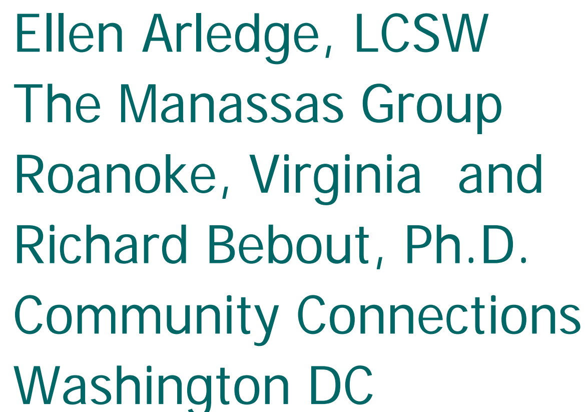
From Page 26, With regards to a review of departure provisions:

Section 5H1.11 (Military, Civic, Charitable, or Public Service; Employment-Related Contributions; Record of Prior Good Works) provides that military, civic, charitable, or public service; employment-related contributions; and similar prior good works are not ordinarily relevant in determining whether a departure is warranted. Should the Commission revise this policy statement? If so, how?

I applaud the Commission and others for hearing testimony relative to the plight of recently returned service members and would hope that we all might acknowledge that there are veterans in prison right at this moment that would benefit from a review of their cases in light of this recent testimony. Furthermore, there are many, many trauma survivors who become perpetrators from all walks of life and backgrounds in prison right at this moment, from whose stories we might also learn a great deal. The prevalence of psychological trauma is without dispute. We must foster a deeper understanding and a more enlightened approach based on that understanding to inform culture-change if we are to remain hopeful and not succumb to apathy. Many people I know have this sense that "things are getting worse by the day." That's trauma. They feel overwhelmed psychologically. They have this feeling not only about society, but about themselves, their own condition and they don't respond as well to encouragement. I saw the same thing among refugees in Somalia suffering from disease and grinding poverty, violence and atrocities we haven't seen in this country. And I saw some of these same traits in the Marines I served with after the first Gulf War. I observed similar patterns of thought and behavior in my "peers" while I was in the homeless shelter and while eating in the soup kitchen. And now, I have to say I see it in some of the most well paid staffers who have the best educations and benefit packages available anywhere. I think it has a lot to do with our being human, so I tend not to take the easier "reductionist" view and say "we have to do better by our honorably discharged combat veterans" but by everyone, maybe letting this population open the door for others. In my work today, I see veterans of all stripes and eras come through the court. A lot of them are not honorably discharged and most do not have combat deployment. However, they do have trauma in their backgrounds exacerbated by substances which has had negative impacts on their ability to socialize, relate and maintain employment which has led to crime. Is this a reason for jail? I think not. One thing this population might benefit from is leadership. Particularly peer-leadership, but not because of the sometimes-true adage "only a veteran can help a veteran" but because they have at one time or another in the military experienced and benefited from

leadership. They have something to draw on to facilitate their recovery. This is oft-overlooked by even the best of peer-support/mentoring models for veterans. And it shouldn't be overlooked by the Commission when reviewing departure guidelines. This population has a darn good chance of recovery, and treatment oriented alternatives to incarceration, preferably pre-adjudication alternatives with the possibility of a dismissal are an excellent alterative that I am proud to say has been accepted by local judges here and has worked successfully for some of those veterans to whom this intervention has been prescribed.


Post Traumatic Stress Disorder: What it is, Who gets it, and What can be done


Ellen Arledge, LCSW
The Manassas Group
Roanoke, Virginia and
Richard Bebout, Ph.D.
Community Connections
Washington DC

- Direct exposure to an extreme stressor
- Actual or threatened death or serious injury, or threat to one’s physical integrity; or
- Witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or
- Learning about unexpected or violent death, serious harm or threat of death or injury experienced by a family member or other close associate.
- Marked by intense fear, helplessness, or horror…

Trauma Triad

- Re-living, re-experiencing and intrusive memories (nightmares, intense daydreams, flashbacks)
- Hyper-arousal, hyper-vigilance, intense physiological distress and reactivity (including difficulty falling or staying asleep; exaggerated startle response; irritability or outbursts of anger; and difficulty concentrating or completing tasks.)
- Dissociation, avoidance and numbing (feelings of detachment, diminished interest, avoiding contact and experiences that remind one of traumatic event)

What kinds of events are traumatic?

- Combat (including veterans or civilian victims of war)
- Sexual or physical abuse
- Severe neglect
- Physical trauma (mugging, car jacking, car accident)
- Domestic or intimate partner violence
- Witnessed violence and cruelty to others
- Deprivation cause by extreme poverty

What kinds of events are traumatic?

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Traumatic events (cont.)

- Serious emotional and psychological abuse
- Gang and drug related violence
- Repeated abandonment or sudden loss
- Rape (sexual assault)
- Political violence and torture
- Natural disasters, such as tornadoes or earthquakes
- Life threatening illness or invasive medical procedures

Estimated risk for developing PTSD:

- Rape 49%
- Severe beating or physical assault 31.9%
- Other sexual assault 23.7%
- Serious accident or injury (e.g., car or train accident) 16.8%
- Shooting or stabbing 15.4%
- Sudden, unexpected death of family member or friend 14.3%
- Child’s life-threatening illness 10.4
- Witness to killing or serious injury 7.3%
- Natural disaster 3.8%

What does trauma feel like?

- Intense fear
- Fear of complete destruction
- Total helplessness
- Profound emptiness
- Loss of control
- Total disconnection
- Horror

A basic understanding of trauma

- Survivors of trauma experience its’ impact throughout their lives.
- The impact of trauma can be felt in areas of functioning seemingly unrelated to the abuse itself.
- Current problematic behaviors and symptoms may have originated as legitimate and even courageous attempts to cope with or defend against trauma.

Core elements of a trauma philosophy

- Experiences of trauma betray a person’s core assumptions about herself, her family, and her world.
- Trauma severs fundamental connections to oneself, one’s family, and one’s community.

Symptoms are adaptations

- People are adaptive. A trauma model frames survivors' symptoms as adaptations, rather than as pathology.
- Every symptom helped a survivor in the past and continues to help in the present – in some way.
- An adaptation model emphasizes resiliency in human responses to stress. It helps survivors recognize their own strengths and inner resources, rather than defining themselves by weakness and failure

Prevalence Rates

- An estimated 70% of adults in the U.S. have experienced a traumatic event at least once in their lives and up to 20% of these people go on to develop PTSD.
- Almost seven percent of Americans will develop PTSD in their lifetime.
- An estimated one out of 10 women will get PTSD at some time in their lives. Women are about twice as likely as men to develop PTSD.

Prevalence rates for Veterans

- Of nearly 60,000 Marines who served in OIF and were released from the Marine Corps, less than 10% have received a mental health diagnosis and only about five percent have been given a diagnosis of PTSD.
- Of several battalions of Army soldiers and two battalions of Marines three to four months after they returned from OEF or OIF, 17% had significant symptoms of PTSD, depression or anxiety based on self-report.

Prevalence rates for Veterans

- The lifetime prevalence of PTSD among combat veterans is 39% (from the National Comorbidity Study).
- Difficulty distinguishing PTSD and Traumatic Brain Injury (19% of troops report a probable TBI during deployment).

Women Veterans

- Women comprised 14% of the U.S. active duty force (up from 2% in 1973)
- Of 1.6 million service members who have deployed to Afghanistan and Iraq since 2001, more than 200,000 are women

Risk Factors

- Three phases of risk:

  Pre traumatic

  Peri traumatic

  Post traumatic

- Younger troops
- Combat wounded
- Multiple deployments
- Longer tours
- National Guardsmen & Reservists
- Military Sexual Trauma (MST)

Risk factors for women veterans

- Women who experience sexual harassment or trauma before or during their military service are more likely to suffer PTSD than those who were not sexually traumatized.
- Work-family conflicts
- Military Sexual Trauma (MST)

Effects of traumatic events

- Substance abuse
- Suicidality
- Homelessness
- Family problems/divorce
- Shame, feeling stigmatized by the trauma
- Hopelessness and despair
- Feelings of isolation and withdrawal
- Helplessness

Economic costs

- The annual cost to society of anxiety disorders is estimated to be approximately 42.3 billion (in 1990 dollars), often due to misdiagnosis and under treatment. This includes psychiatric and nonpsychiatric medical treatment costs, indirect workplace costs, mortality costs and prescription drug costs.
- More than half of these costs are attributed to repeat use of healthcare services to relieve anxiety-related symptoms that mimic those of other physical conditions.

Economic costs (continued)

- The oncoming wave of service members with mental illness will cost the U.S. about $6.2 billion in direct medical care and lost productivity in just the first two years after they return from deployment.

- Neurohormonal profiles are different among those with PTSD compared to those without PTSD.
- Norepinephrine: too much
- Serotonin: too little
- Neuropeptide Y (NPY): a natural anti-anxiety chemical

Changes in brain structures

- The amygdala – increased blood flow
- The medial prefrontal cortex and the anterior cingulate – decreased blood flow
- Hippocampus – neurodegenerative aspect

Stigma

- One fifth of people returning from the wars in Afghanistan and Iraq are reporting symptoms of PTSD or major depression, but only half seek treatment.
- DoD has revised its security clearance questionnaire so that people who seek mental health care for combat related reasons do not have to report it.

Stigma

- Only three percent of people who referred themselves for mental health treatment had a negative career impact, as compared with 39% of people who were referred by their commanders.
- Less than one percent of those investigated for clearances are rejected solely on the basis of their mental health profiles.

- One study indicated that 86% of those who had symptoms realized it.
- Only 45% said they wanted help.
- 29% admitted to having received any help at all in the past year.

The Warrior Ideal

- Strength
- Valor
- Courage
- Fortitude – the ability to withstand any stress for however long without flinching, without failing, without faltering.

Treatment Options

- Cognitive behavioral therapy
- Exposure therapy
- Virtual reality techniques
- Pharmacotherapy
- Education
- Psychotherapy
- Group psychotherapy

Factors Impacting Veterans' Access to Mental Health Care

Insights and Recommendations from the Rand Report—

Invisible Wounds of War

Social, Cultural and Personal Factors that Impede or Facilitate Access to Mental Health Care

- Stigma— “negative and erroneous attitude about a person, a prejudice, or negative stereotype” (Corrigan & Penn, 1999)
- Widely held by servicemembers

Consequences of Negative Attitudes

- Societal or public stigma—public misperceptions, reactions regarding persons with emotional, psychological problems
- Individual stigma—results from internalizing public misperception, beliefs
- Institutional-level stigma—policies and practices unreasonably limit opportunities
- Mitigation must address all three levels

Consequences (cont.)

- Public perception of increased likelihood of violence leads to isolation
- Labeling depressed vs. “troubled”, reduced willingness to socialize, work with
- Persons subject to public stigma less likely to seek treatment
- Internalized negative attitudes lead to shame, degrades quality of life, decreases treatment seeking, adherence

Military Culture and Attitudes

- Military culture promotes individual strength and selfless devotion to nation, comrades—necessary for development and maintenance of effective fighting force
- Attitudes and beliefs
- Unit cohesion
- Unit dynamics

Military Culture—Attitudes and Belief

- Toughness, independence, not needing help, not being weak, inner strength
- Able to master any stressor without problems, self-reliance, pride in being able to “shake off”
- Formidable barrier to acknowledging need for help, discordant with “suck it up” or “tough it out” attitudes

Perceived Barriers Among Deployed Servicemembers

- I would be seen as weak—66%
- Unit leadership might treat me differently—64%
- Members of unit would have less confidence in me—61%
- Would harm my career—52%
- Difficult to schedule appointment—45%
- Too embarrassing—41%
- Don’t trust mental health professionals—38%

Unit Cohesion

- Close bonds arising out of arduous, stressful training, lead to reliance on unit for support, encouragement, culture of interdependence
- Powerful factor effecting morale, psychological resilience, important protective factor reducing “stress casualties”
- Conversely, isolation best predictor of combat-stress reactions in Israeli soldiers
- Helmus, Glenn 2005; Solomon et al., 1986;

Unit Cohesion (cont.)

- Resistance to separation from unit due to conventional or stress injuries
- Shame, guilt
- Treatment takes time away from training between deployments
- Variable climate in unit command
- Referred by command leads to better adherence vs. self-referred
- Distrust of mental health providers separated from line units vs embedded

Unit Dynamics

- NCO's must know whereabouts at all time—thus treatment isn't confidential
- Treatment available only during regular hours
- Practice of requiring escorts for servicemembers receiving evaluations
- Career Implications
- Widespread perceptions regarding faking of PTSD symptoms, malingering

Addressing Negative Attitudes

- Combating public stigma through public education campaigns— “Real Men. Real Depression” or “It takes the strength and courage of a warrior to get help”
- Implement and publicize use of “evidence-based” practices, treatment effectiveness
- Embedded treatment providers (rapport, trust)
- Integrating MH treatment into primary care
- Characterizing treatment as accelerating “a return to normal” allows it to be seen as a fulfillment of one’s duty vs a betrayal