Military Psychology

Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/hmlp20

Substance Abuse and Mental Health Treatment in the Military: Lessons Learned and a Way Forward

Katie Witkiewitz & Armando X. Estrada

Department of Psychology, Washington State University, Vancouver, Washington

Available online: 13 Jan 2011

To cite this article: Katie Witkiewitz & Armando X. Estrada (2011): Substance Abuse and Mental Health Treatment in the Military: Lessons Learned and a Way Forward, Military Psychology, 23:1, 112-123

To link to this article: http://dx.doi.org/10.1080/08995605.2011.548651

PLEASE SCROLL DOWN FOR ARTICLE

Full terms and conditions of use: http://www.tandfonline.com/page/terms-and-conditions

This article may be used for research, teaching, and private study purposes. Any substantial or systematic reproduction, redistribution, reselling, loan, sub-licensing, systematic supply, or distribution in any form to anyone is expressly forbidden.

The publisher does not give any warranty express or implied or make any representation that the contents will be complete or accurate or up to date. The accuracy of any instructions, formulae, and drug doses should be independently verified with primary sources. The publisher shall not be liable for any loss, actions, claims, proceedings, demand, or costs or damages.
whatsoever or howsoever caused arising directly or indirectly in connection with or arising out of the use of this material.
Substance Abuse and Mental Health Treatment in the Military: Lessons Learned and a Way Forward

Katie Witkiewitz and Armando X. Estrada

Department of Psychology, Washington State University,
Vancouver, Washington

Articles in this issue, “Stigma as a Barrier to Treatment,” provide an excellent overview of the challenges associated with the treatment of substance abuse and mental health disorders in military settings. The issue serves to document substance abuse rates in the military; identify factors that influence and impede entry and participation in treatment, negative beliefs about treatment, and factors influencing perceived stigma; and examine the acceptability and feasibility of new substance abuse treatment models being employed at three Army installations. Two overarching conclusions can be made from the articles in this issue. First, the problems, barriers, and stigma associated with substance abuse and mental health disorders are not unique to military settings. Second, the military setting has unique characteristics that may help to destigmatize substance abuse and mental health problems, remove barriers to treatment, and facilitate access to military members to deal with substance abuse and mental health problems. In this article, we review similarities among military and civilian populations with respect to substance abuse and mental health problems; highlight strategies to reduce substance abuse among individuals in military service; and identify unique opportunities to improve substance abuse and mental health services within the military settings.

In the introductory article for this issue, McFarling, D’Angelo, Drain, Gibbs, and Rae Olmsted (2011/this issue) note that the articles provide an overview of stigma toward substance abuse and mental health problems in the military and identify
ways to reduce stigma and remove barriers for individuals serving in the military. Each of the articles addresses these issues and highlights areas in need of further research. The articles also serve to stimulate potential policy changes that could help to further reduce stigma and barriers to treatment. In this article, we summarize the major lessons learned from these papers and examine implications of this research for extending substance abuse and mental health treatment and services to the military. Specifically, we draw comparisons from existing research and recent advances in the prevention and treatment of substance abuse and mental health disorders of civilian populations to compare and contrasts efforts to deal with such issues in military settings.

MAJOR LESSONS LEARNED

Lesson 1: Rates of substance abuse and mental health problems among military and civilian populations are quite similar.

As noted by Ramchand and colleagues (2011/this issue), rates of alcohol use and binge drinking (i.e., 5+ drinks on a single occasion) across military and civilian samples were similar. Seventy percent of previously deployed military personnel in their sample reported drinking in the past 30 days, consuming an average of 3.31 drinks per day of drinking, and 2.9 days of binge drinking in the past 30 days. Sixty-nine percent of adult civilian male respondents, matched on age and race, reported drinking in the past 30 days, consuming an average of 4.24 drinks per day of drinking, and 3.4 days of binge drinking in the past 30 days as measured by the National Survey on Drug Use and Health (NSDUH). The rate of illicit drug abuse (not including prescription drugs) among military and civilian populations is somewhat different. Bray and colleagues (2010) found that 2% of active duty military personnel responding to the Department of Defense Survey of Health Related Behaviors reported using illicit drugs, a rate that is considerably lower than that reported for the U.S. population aged 12 or older, estimated at 8.7%. Thus, rates of alcohol use and binge drinking among individuals serving in the military are comparable to those found in studies of civilians.

The rates of mental health disorders among individuals returning from military service are not considerably higher than that of the U.S. population. Hoge, Auchterlonie, and Milliken (2006) estimated the rate of mental health problems among individuals returning from service in Afghanistan and/or Iraq at around 30%, out of which roughly 7% meet criteria for depression, 7.5% meet criteria for an anxiety disorder, and 12% meet criteria for posttraumatic stress disorder (PTSD). Among individuals receiving services by the Department of Veterans Affairs, 22% were diagnosed with PTSD and 17% were diagnosed with depression (Seal et al., 2009). The estimates above do not include individuals receiving professional help, which past research suggests that less than 40% of soldier and Marines meeting cri-
criteria for a mental health disorder seek professional help (Hoge et al., 2004). Kessler, Chiu, Demler, and Walters (2005) estimated the rate of mental disorders among American adults aged 18 or older at around 26.2%, out of which roughly 6.7% meet criteria for depression, 18% meet criteria for any anxiety disorder, and approximately 25% meet criteria for PTSD. The rate of PTSD in the general public (3.5%) is approximately one quarter of that found among individuals returning from military service; however, it has been estimated that 25% of accident victims meet criteria for PTSD within 12 months following the accident (Baranyi et al., 2010) and 31% of rape victims develop PTSD during their lifetime (National Center for Victims of Crime & Crime Victims Research and Treatment Center, 1992). Thus, rates of PTSD among individuals serving in the military are similar to the rates of PTSD among civilians who experience trauma outside of military service.

Lesson 2: Efforts to refer and enroll individuals to treatment for substance abuse and mental health problems are as effective as those found in studies of civilians, but these efforts are more successful in dealing with mental health than substance abuse problems.

Clinton-Sherrod, Barrick, and Gibbs (2011/this issue) provided a comprehensive analysis of data from the Post-Deployment Health Reassessment (PDHRA), the Army’s Drug Administration and Management Information System (DAMIS), and the Defense Medical Surveillance System (DMSS) in order to gain a better understanding of alcohol abuse and mental health issues and referral to treatment among military personnel. Results indicated that 4% of those at risk for alcohol abuse were enrolled in substance abuse treatment (2% referred by PDHRA) and 30% of those at risk for mental health problems were enrolled in mental health treatment (14% referred through PDHRA). An additional 1% and 11% of those not identified as “at risk” for alcohol abuse or mental health issues, respectively, also enrolled in treatment. These rates are not much lower than the treatment utilization rates found in national surveys of the civilian population (NSDUH, 2009), Substance Abuse and Mental Health Services Administration (SAMHSA, 2010). According to the NSDUH (2009), 8.1% of those who needed alcohol treatment ever received treatment. Likewise, the Surgeon General’s report (U.S. Department of Health and Human Services, 1999) on mental health concluded that fewer than 30% of adults with a diagnosable mental health disorder receive mental health services. These statistics suggest that though efforts to refer and enroll military personnel in substance abuse and mental health treatment appear to be as successful as those involving civilian populations within the United States, the referral and enrollment process appears to be more effective in dealing with mental health problems than substance abuse problems in both populations.

Lesson 3: Individual and organizational factors play a role in the referral and treatment process for both substance abuse and mental health problems.
Several articles in this issue highlight individual and organizational barriers to treatment for substance abuse and mental health problems. At the individual level, Clinton-Sherrod and her colleagues (2011/this issue) note that marital status, ethnicity, and pay grade appear to influence enrollment in treatment for substance abuse and mental health problems. Military personnel who were male, single, and lower in pay grade were more likely to enroll in substance abuse treatment than their counterparts, whereas military personnel who were female, married, and higher ranking were more likely to enroll in mental health treatment than their counterparts. Rae Olmsted and colleagues (2011/this issue) reported that stigma associated with treatment for both substance abuse and mental health problems was higher for military personnel in treatment than for those not receiving treatment. Britt and colleagues (2011/this issue) reported that general attitudes and beliefs about psychological problems coupled with positive norms associated with treatment and perceived control for receiving treatment were associated with seeking treatment of mental health problems among military personnel in the reserve component. However, overall attitudes and beliefs about psychological problems emerged as the best predictors of treatment seeking. Furthermore, qualitative analyses revealed that insufficient resources and the belief that the problem was not severe enough were frequently cited reasons for not seeking treatment among military personnel in the reserve component. Similarly, Kim, Britt, Klocko, Riviere, and Adler (2011/this issue) found that negative attitudes toward mental health treatment were inversely related to treatment utilization for any type of mental health treatment among soldiers who had recently been deployed to Afghanistan or Iraq.

In addition, there appear to be differences in military personnel’s perception of substance abuse and mental health problems. Rae Olmsted and colleagues (2011/this issue) found that stigma associated with mental health treatment was higher than stigma associated with substance abuse treatment. Gibbs, Rae Olmsted, Brown, and Clinton-Sherrod (2011/this issue) found that soldiers tend to view substance abuse problems (e.g., binge drinking) as a normative behavior that is widely accepted within the larger military culture, whereas soldiers view mental health problems as being counter to the military culture—akin to admitting weakness or inability to perform. Moreover, they found that efforts to encourage help-seeking or self-referral are viewed negatively because either strategy may adversely impact job performance, either directly by interfering with work schedules or indirectly through stigmatization that results from admitting that a soldier needs help.

At the organizational level, Kim and colleagues (2011/this issue) found that perceptions of organizational barriers to treatment (e.g., accessibility and knowledge of services) were associated with greater likelihood to seek treatment for mental health problems from civilian mental health professionals. Gibbs, Rae Olmsted, Brown, and Clinton-Sherrod (2011/this issue) found that soldiers’ views regarding treatment are influenced by the command’s perceptions of substance
abuse and mental health problems. In the case of substance abuse, military personnel often enter into treatment after they either had an alcohol-related infraction (e.g., driving under the influence) or after an incident where alcohol abuse led to impairment in their job performance. As a consequence, alcohol abuse treatment is viewed as a punitive result of the individual’s inability to use alcohol in ways consistent with the military culture—that is, drink heavily but do not let it affect your performance, because if it does it will be your fault. In the case of mental health, military personnel increasingly consider mental health problems as a part of the job and are less likely to attribute these problems to the individual. Therefore, when military personnel seek treatment for mental health problems, they may have more latitude to pursue treatment than when seeking treatment for substance abuse problems. Nonetheless, seeking help for either problem carries a potential cost for one’s career, because the command is required to be informed whenever military personnel are undergoing treatment for these issues.

The barriers to treatment identified by the articles in this issue have also been identified as significant barriers to treatment in studies involving the civilian population. Tucker, Vuchinich, and Rippens (2004) found that stigma and privacy concerns; negative attitudes toward treatment, including the belief that treatment was unnecessary; and practical/economical impediments were perceived as the largest barriers to seeking alcohol treatment among problem drinkers. Likewise, a survey by the National Mental Health Association and data from the National Comorbidity Survey (Kessler, Chiu, Demler, & Walters, 2005) indicated that lack of perceived need for treatment, stigma, accessibility (practical and economical impediments), and negative attitudes toward treatment were the most significant reasons for individuals to not seek treatment. Thus, individual and organizational barriers associated with substance abuse and mental health problems in military settings appear to be the same as those found in civilian settings.

A WAY FORWARD: OPPORTUNITIES FOR PREVENTING AND TREATING SUBSTANCE ABUSE AND MENTAL HEALTH PROBLEMS IN THE MILITARY

As noted above, there are numerous similarities among individuals who serve in the military and the civilian population with respect to rates of substance abuse and mental health problems, rates of treatment seeking, and perceived barriers to treatment for substance abuse and mental health problems. The primary difference between mental health and substance abuse problems in the military and the civilian population at large is the opportunity for prevention and treatment in military settings that is generally not available for the entire civilian population. Thus, there are numerous opportunities and potential for changes in military policy that could help prevent the development of mental health and substance abuse problems.
within military settings. We believe that many of these efforts could serve to inform and advance similar efforts in society at large.

Unlike any other area of society, the military has the opportunity to reach 100% of its members with substance abuse and mental health prevention programming. This is a huge benefit when one considers recent data on the effectiveness of prevention. The Institute of Medicine (O’Connell, Boat, & Warner, 2009) and the National Institute of Drug Abuse (2003) use a tiered preventive intervention classification system. The first tier, universal prevention (i.e., primary prevention), is targeted toward an entire population (e.g., local community, school, military units) and aims to prevent or delay substance abuse and mental health problems. All individuals in the population are provided with information about the problem and an introduction to the skills necessary to prevent the problem. The second tier, selective prevention, focuses on subgroups whose risk for developing problems with substance abuse or mental health disorders is above average. The third tier, indicated prevention (i.e., secondary prevention), includes a screening process with the goal of identifying individuals who exhibit early signs of substance abuse or mental health problems. Finally, tertiary prevention (i.e., relapse prevention, counseling) targets the prevention of future harm among those who already exhibit problematic levels of substance abuse or mental health problems. In the remainder of this article we highlight recent research and opportunities for the military to intervene at each level of preventive interventions.

Universal Prevention

As noted previously, there appear to be differences in the military’s ability to address substance abuse problems compared to mental health problems. Evidence provided in the articles in this issue suggests that efforts to address mental health problems are more effective than those involving substance abuse problems. Accordingly, it would be advisable to increase universal prevention efforts aimed at increasing education and training related to substance abuse problems, especially in light of normative beliefs concerning the use of alcohol within military culture. The Substance Abuse and Mental Health Administration’s National Registry of Evidence-Based Programs and Practices (NREPP; http://nrepp.samhsa.gov) provides information on over 90 school, workplace, or community-based universal mental health promotion or substance abuse prevention programs with strong empirical support. As mentioned above, universal prevention programs target an entire population of individuals, regardless of risk for mental health or substance abuse problems. Many universal prevention programs are group-based programs that include educational information about substance use or mental health problems, as well as skills training for improving decision making and prevention of negative consequences. One example of a universal prevention program already in place in the Navy is the Alcohol-Aware program, which is a 4-hour command-ad-
ministered course that discusses risks of alcohol abuse and provides guidance on responsible drinking. The Alcohol-Aware course is required for all Navy members and is part of a larger “Right Spirit” educational alcohol abuse prevention campaign. Thus, we advocate for the continued use of systems-based approaches that take into account the characteristics of the participants (e.g., gender, rank for military personnel; military spouses and family members) and situational context (e.g., education and training; deployment context) in which universal prevention efforts are designed to intervene.

Considering the widespread distribution of military units across the world, we believe that it would be particularly efficient for Web-based universal prevention programming to be available. Simon-Arndt, Hurtado, and Patriarca-Troyk (2006) described a brief alcohol use feedback Web-based program that was developed for members of the U.S. Marine Corps. The program consisted of personalized assessment of alcohol use, feedback that compared an individual’s level of alcohol use to existing Marine Corps normative data, information about heavy drinking risks and tips to reduce the risks associated with alcohol use, and a non-fear-based motivational feedback section highlighting the discrepancy between how much the individual was spending on alcohol and how much money could be spent on other desirable items. The program concluded with a personalized summary outlining the probable level of risk that alcohol posed for the Marine’s health and career and identified local resources that were available to help the individual reduce his or her drinking. A survey of 167 individuals who participated in the program indicated that the program was generally well received; 41% reported that they liked or very much liked the program, 44% rated the program as useful, 45% reported that they were likely to recommend the Web site to others, and 80% felt that the feedback was appropriate for Marines in their community.

Selective Prevention

Selective prevention involves the targeting of substance abuse prevention and mental health promotion to individuals who are determined to be at risk for developing substance use or mental health problems. Given the higher rates of mental health problems and alcohol abuse among those who were previously deployed (Ramchand et al., 2011/this issue), providing prevention programming that targets trauma symptoms, depression, anxiety, and alcohol misuse among those who are returning from a deployment would be an example of selective intervention. Though selective prevention programs are in place as part of the postdeployment reintegration process for deployed personnel (e.g., Army’s “BATTLEMIND” program; Marine Corps “Warrior Transition” program; Air Force’s “Crossroads” program), these programs could be modified to focus on the systemic nature of postdeployment stressors beyond the immediate period following the deployment process. To be sure, we believe that there are many opportunities to provide nor-
mative feedback about levels of mental health symptoms and alcohol use among those who were previously deployed upon return but fewer opportunities to address these factors on a more systematic and long-term basis when problems are likely to emerge. For example, the Department of Defense recently initiated a pilot study of the Program for Alcohol Training, Research, and Online Learning (PATROL), which recruited a general military sample and assigned individuals to one of two Web-based alcohol interventions: the Drinker’s Check-Up (Hester, Squires, & Delaney, 2005) or Alcohol Savvy (Cook, Back, Trudeau, & McPherson, 2002). The Drinker’s Check-Up (Hester et al.), which is a selective preventive intervention designed to reduce problematic alcohol use, demonstrated positive program effects on average number of drinks per occasion, binge drinking, and estimated peak blood alcohol concentration in the past month (Williams, Herman-Stahl, Calvin, Pemberton, & Bradshaw, 2009). Less positive effects were found for Alcohol Savvy. Other research suggests that PTSD prevention efforts could similarly be enhanced by targeting specific events that were experienced during deployment (Renshaw, 2010). Thus, providing continual education and training beyond the postdeployment period is likely to help reduce stigma by helping individuals realize that they are not alone in their struggle with mental health symptoms or substance use problems.

Indicated Prevention

The PDHRA program could provide an excellent opportunity for indicated prevention interventions. Although Gibbs, Rae Olmsted, Brown, and Clinton-Sherrod (2011/this issue) identified some problems with identification and referral of at-risk individuals, the theory behind providing a comprehensive screening and referral resource for previously deployed servicemembers is entirely consistent with recent successes in providing screening, brief intervention, and referral to treatment in trauma and primary care settings. The Screening Brief Intervention and Referral to Treatment (SBIRT) program was developed to address the high degree of substance use among individuals receiving care in trauma settings (Gentilello et al., 1999), with almost 23% of trauma patients screening positive for substance use, abuse, or dependence at the time of admission (Madras et al., 2009). Essentially the SBIRT program aims to provide a brief screening of hazardous substance use, a brief intervention for those who are engaging in hazardous use, and a referral to treatment for those who could benefit from additional treatment. SBIRT programs have been shown to significantly reduce alcohol use, reinjury, and reoffenses (see Gentilello et al.; Madras et al.).

In primary care, the Re-Engineering Systems of Primary Care for PTSD and Depression in the Military (RESPECT-Mil) has recently been shown to be feasible as a collaborative care approach to provide screening and treatment for depression and anxiety in a primary care military setting (Engel, Oxman, Yamamoto, Gould,
Barry, et al., 2008). In a preliminary feasibility study, 30 primary care providers were trained in the RESPECT-Mil model and screenings were conducted for 4,159 primary care active duty patient visits. Of those screened, 9.7% (n = 404 of 4,159 screened) were positive for depression, PTSD, or both and 60% (n = 69 of 115 who completed follow-up) of patients who subsequently participated in the RESPECT-Mil collaborative treatment programs reported clinically significant improvement in mental health symptoms. Thus, we believe that the substance abuse and mental health screening currently in use in the military provides opportunities for linking individuals and services.

Tertiary Prevention

Tertiary prevention targets the prevention of future harm among those who already exhibit problematic levels of substance abuse or mental health problems. Several articles in this issue note the importance of organizational support and confidentiality as factors influencing treatment seeking among military personnel (Clinton-Sherrod et al., 2011/this issue; Gibbs & Rae Olmsted, 2011/this issue; Kim et al., 2011/this issue). Gibbs and Rae Olmsted highlight the lack of confidentiality as a major drawback of the existing Army Substance Abuse program (ASAP) and introduce initial acceptability and feasibility data from the Confidential Alcohol Treatment and Education Pilot (CATEP), which allowed for confidential self-referral to alcohol treatment outside normal duty hours. The results from this initial qualitative investigation showed that the overall response to the pilot program was resoundingly positive. Confidentiality, off-duty treatment provision, and the opportunity to attend treatment in civilian attire were noted as benefits of the program, although greater protection of confidentiality and increasing awareness of the CATEP program were identified as potential concerns. Nonetheless, the data from this early trial provide evidence for the acceptability of off-duty, confidential treatment.

Keeping with a tiered prevention model, it is critical for the military to draw from existing empirically validated interventions for substance abuse and mental health programming. For some servicemembers a brief intervention could be sufficient (Larimer & Cronce, 2007), whereas for those with significant problems or ongoing stressors, a longer term treatment, such as the CATEP, might be necessary. As noted by Britt and colleagues (2011/this issue), it could be important to acknowledge self-reliance during deployments and then normalize the necessity to seek treatment when problems become more severe or unmanageable.

Top Down Approach?

A consistent finding across several articles in this issue is that individuals higher in command could have a particularly influential effect on military servicemembers.
Given that the military can assert a high degree of control over its members, the military environment may provide a unique opportunity to influence stigma and treatment seeking for substance abuse and mental health problems from the top down. For example, leaders at all levels could receive tailored education and training on screening and intervention services available to deal with substance abuse and mental health problems. Leaders could use this information to supplement standard postdeployment education and training, received upon return, to address responsible drinking behaviors and provide guidance on ways to reduce alcohol use without formal treatment or how to seek treatment whenever it is warranted. The Alcohol-Aware program developed by the Navy provides an example of a commander-led alcohol education program administered to military personnel. The top-down approach would require fewer central resources by providing the brief intervention training at the small unit level. Unit leaders would be responsible for disseminating the information and providing guidance to individuals in their command. In addition, unit leaders who require more extensive treatment will have the opportunity to share positive treatment experiences while encouraging help-seeking behaviors and reducing stigma toward both substance abuse and mental health disorders.

SUMMARY AND CONCLUSIONS

The articles in this issue highlight numerous ways in which the military could work to reduce stigma toward substance abuse and mental health disorders and improve access to treatment. This review highlights similarities between military and civilian populations as well as introduced a variety of prevention and intervention programs that could be extended to military settings. This review also highlights potential directions for the way ahead. Though we recognize that the military has and continues to invest resources to understand challenges related to substance abuse and mental health problems among military personnel, we hasten to note that empirical evidence on the efficacy of these efforts is still lacking. Thus, we encourage additional research to assess whether these programs (e.g., Alcohol-Aware, CATEP, PATROL, RESPECT-Mil, PDHRA, BATTLEMIND) are effective at reducing substance abuse and improving mental health among military personnel. In addition, we believe that it is critical that these programs develop more systematic (e.g., extend beyond postdeployment to the military lifecycle) and culturally sensitive (i.e., sensitive to the military organizational culture) efforts to deal with substance abuse and mental health problems. Such efforts should contextualize substance abuse and mental health problems within the unique occupational context of the military, taking into account cultural norms and values concerning drinking behaviors, expectations concerning self-reliance and resilience among military personnel, and organizational context variables (e.g., command
climate and institutional barriers) that are likely to influence self-referral and treatment seeking among military personnel. Finally, we believe that it is important to focus attention on issues concerning substance abuse because current efforts appear to be more successful in dealing with mental health than with substance abuse problems.

REFERENCES


