PTSD, Substance Abuse, Mental Health, Treatment Courts

Dr. Kathleen M. West
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New At-Risk Population: Military-Connected Families

- An estimated 2 million-plus children have been affected by a parent’s recent wartime deployments - usually multiple deployments.
- Specific high risk groups include parents with PTS symptoms, PTSD or other mental health diagnoses, or physical health injuries and chronic pain.
- High rates of physician-prescribed medication for pain and psychotropic drugs for military and veteran mental injuries; high risk of complications with self-medication, primarily alcohol.
- Fluctuating rates of child maltreatment (higher during deployments; doubled between ‘02 and ‘07 among military families with lasting sequelae).
Most Iraq and Afghanistan veterans' injuries didn't occur during combat. But their ailments have become an enduring consequence of the conflicts.

ABOUT THE SERIES
A multipart series examining the effects of the Afghanistan and Iraq wars on the 2.6 million American troops who served and fought.
Deployment Spiral and Children

Deployment Spiral credit to NMFA
Graphics to FOCUS Project
A Central Problem in Current Conflicts: Post-traumatic Stress

- Service members & veterans of every war have battled PTS, addictions, family problems, and incarceration

- Post-traumatic stress disorder (PTSD) include intrusive memories, nightmares, feeling numb or detached, difficulty sleeping, hypervigilance, hyperarousal. Can be treated and managed; can become chronic

- Both treatment and disorder affects family functioning and relationship formation
Rise and Fall of Medicalization in Operational Stress Reaction Conceptions and Labels

(Capt, Ret. William Nash, MD)

“nostalgia”

gods, vice, fate

“railway spine,” insanity, soldier’s heart

“shell shock”

“hysteria,” fatigue

weakness, personality disorder

PTSD

Combat stress reaction

Trojan War, Napoleonic Wars, American Civil War, World War One, World War Two, Vietnam War, Today
Post-Traumatic Stress
Risk Factors for Mental Health Problems – Depression, Anxiety, PTSD, Addiction

- **Adverse Childhood Experiences (ACE) Study**: increased ACE score $\rightarrow$ increased risk for PTS and mental health diagnoses  

- Adult mental health outcomes of high ACE score include: suicide attempts, smoking, drug abuse, depression, alcoholism, etc. Physical health outcomes were also excessively poor: increased heart disease and diabetes

- About 25% of military recruits required a waiver to enter service in 2006, up from 20% across services in 2003; in 2011, the rate was down to 12%; lower in 2014
The “Invisible Wounds of War”: TBI & PTSD Often Overlap

TBI is caused when external force “significantly disrupts brain function” evidenced by: a period of loss or alteration in consciousness (confusion, disorientation); amnesia for events around the injury; neurological deficits (weakness, loss of balance, change in vision); or intracranial lesions.

Mild, moderate, & severe TBI present different long-term problems:

-Mild TBI (“concussion” = amnesia for less than 24 hrs, loss of consciousness for less than 30 min) often leads to sleep disorders, irritability, & thinking problems.

-Severe & moderate TBI often involve hearing & visual impairments, depression, chronic musculoskeletal pain, & headaches.
Traumatic Brain Injury (TBI)

- The “signature injury” of OEF/OIF, with incidence of various types of TBI as high as 50% for combat-exposed troops and those with multiple deployments.

- Explosion-related injuries account for 81% of all OEF/OIF injuries with multiple sequelae.

- Emotional regulation problems with anger, anxiety, impulse control, interpretation of communication with others, processing problems.

- Cognitive problems with memory and concentration.

- Effects of concussions - "mild" TBI often not immediately apparent.
MTBI = Increased Risk for Addiction-Related Disorders

- Within first 30 days, the hazard ratio for drug dependence is 7.7; for Opioid dependence is 6.1; for amphetamine is 4.8; for alcohol is 3.5
- All hazard ratios EXCEPT for ALCOHOL & Opioid Dependence/Abuse decrease over time
- ETOH, drug, nicotine, caffeine, and nondependent abuse of drugs/ETOH were all elevated in 1-30 days; ALCOHOL persisted
- Screening may be warranted in military (as well as civilians) at both short- and long-term milestones following MTBI
- TBI survivors are known to have blunted dopamine systems

Chronic Pain, TBI and PTSD Overlap

- All these injuries lead to disruption in family’s life: school, home, support systems, finances, parental roles, parent-child interactions and views of the future.

- Chronic pain commonly co-occurs with TBI, independent of PTSD and depression.

- Frequency at which these 3 present in combination is about 42% (rare in isolation).

- Impact on children is often underestimated; about 25,000 have a parent physically injured in combat-related duties. More than 2200 have experienced military service-related parental death in the "Long War".

- Impact of Traumatic Brain Injury on parenting and family life is also often underestimated. Long-term effects are likely to require significant intervention from many sectors of society.
Psychotropic drug use policy in the military: Use in field

- Ritalin/methylphenidate & sometimes Dexedrine/dextroamphetamine were “standard issue” drugs carried by patrols to “enhance performance”. (Mild rebound depression & fatigue were only reported adverse effects)

- “Revolution” in military operational psychiatry in mid-90s with SSRIs; had not been prior practice to treat ongoing mental health disorders *during* combat operations. Iraq’s “mature theatre” permitted psychiatric practice patterns to be established in combat environment = service members receive treatment for ongoing mental health issues beyond COSR

- 2005 review of 5542 mental health contacts showed 30% psychiatric disorders (top 2: 42% generalized anxiety disorder & 33% major depressive disorder) & 70% combat operational stress reactions (COSR)

*From Combat & Operational Behavioral Health, Textbooks of Military Medicine, Office of the Surgeon General, US Army, 2011*
<table>
<thead>
<tr>
<th>Medications</th>
<th>Medications</th>
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<tbody>
<tr>
<td><strong>Antidepressants/Antianxiety:</strong></td>
<td>Citalopram 20mg, Sertraline 100mg, Prozac 10mg, Paroxetine 20mg, Venlafaxine XR 37.5mg, Venlafaxine XR 150mg, Bupropion XL 150 mg, Bupropion XL 75mg, Mirtazapine 20mg</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>Lorazepam 1 mg tabs, Clonazepam 1 mg tabs, Lorazepam 2 mg injectable</td>
</tr>
<tr>
<td><strong>Antipsychotics/Antimanics:</strong></td>
<td>Risperidone 1 mg tabs, Quetiapine 100 mg tabs, Olanzapine 5 mg tabs, Haloperidol injectable</td>
</tr>
<tr>
<td>Sleep Medications</td>
<td>Trazodone 100mg tabs, Zolpidem 10mg tabs</td>
</tr>
<tr>
<td>Adrenergic Agents</td>
<td>Clonidine 0.1mg tabs (for startle, flashbacks in PTSD), Prazosin 1mg tabs (better for nightmares in PTSD), Propranolol 20mg tabs</td>
</tr>
<tr>
<td>ADHD Medications</td>
<td>Atomoxetine 20 mg tabs, Methylphenidate or Dexedrine (may want to combine long-/short acting forms)</td>
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Drugs and Alcohol: Co-occurring Challenges of Combat & Reintegration

• At least 1 in 8 (12.5%) active duty service members are prescribed opioid pain meds and mood disorder drugs, including benzodiazepines for sleep disorders and combat stress

• 43% of active duty military report binge drinking and 20% report frequent heavy drinking

• The percentage is estimated to be greater than 50% for returning veterans (reporting unreliable)
Moral Injury and Betrayals of Moral Beliefs: A Military Occupational Hazard

• **Actions** that betray one’s own beliefs and expectations

• **Failures to act** that betray one’s own beliefs and expectations

• **Witnessing and failing to prevent** betrayals of one’s own beliefs and expectation

• **Being the victim** of acts that betray one’s own beliefs and expectations
SUD Treatment Protocol Must Address Overlap of Traumatic Experiences & Substance Abuse

- Trauma-related substance abuse treatment protocols must ensure that safety and protection are provided to participants (similar to protocols for children exposed to domestic violence, and physical or sexual abuse)

- Improved understanding of neurobiology suggests that acquisition of safety/security engages brain “reward centers”

- Substance abuse relapse prevention strategies must also include management of trauma and loss reminders – in addition to substance abuse triggers (per se)

SAMHSA TIP 57, 2014
No Question: Treatment Courts Make a Difference

--“Catch, Treat, and Release” ?...

SAMHSA evaluations of Veteran Drug Treatment Courts demonstrate significantly reduced PTSD symptoms and substance use

Other Models for Problem-Solving, Collaborative Courts: Family Drug Treatment Courts, Mental Health Courts, Homeless Courts, Traffic Courts, etc. work for specific purposes of diversion from criminal justice system
Making Therapeutic Alliances with Parents Makes a Difference in FDTCs - with clear goal

<table>
<thead>
<tr>
<th>CUSTODY Site</th>
<th>Family Drug Treatment Court</th>
<th>Regular Family Court</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biological Parent(s)</td>
<td>56%</td>
<td>36%</td>
</tr>
<tr>
<td>Kinship Care</td>
<td>29%</td>
<td>21%</td>
</tr>
<tr>
<td>Foster Care</td>
<td>15%</td>
<td>37%</td>
</tr>
<tr>
<td>Institutional Care</td>
<td>0%</td>
<td>6%</td>
</tr>
</tbody>
</table>
Family Veteran Treatment Diversion Courts?

• Diversion from criminal justice – for DV/IPV? Mental Health/PTSD? Substance Abuse?

• WHAT MODEL will work for Veterans? And Military-Connected Families?

• To be continued....
For questions & comments:

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Thank You