

# Chapter 34

## ESTABLISHING AN INTEGRATED BEHAVIORAL HEALTH SYSTEM OF CARE AT SCHOFIELD BARRACKS

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## INTRODUCTION

In 2003, members of four US combat infantry units (three Army units and one Marine Corps unit) participated in an anonymous mental health survey taken either before deployment or 3 to 4 months after their return.<sup>1</sup> The percentage of soldiers and marines whose responses met the screening criteria for major depression, generalized anxiety, posttraumatic stress disorder (PTSD), or alcohol misuse was significantly higher after duty in Iraq (15.6%–17.1%) than after duty in Afghanistan (11.2%), particularly with regard to PTSD. The rates of PTSD are similar to those experienced in Vietnam, which led to large numbers of soldiers becoming disabled. Soldiers and marines whose responses were positive for a mental disorder were twice as likely to distrust mental health professionals, viewed seeing mental health practitioners as harmful to their career, and believed that mental healthcare does not work. The stigma of seeking help increased with the presence of mental disorders. Notwithstanding the reported stigma, veterans of Operation Iraqi Freedom (OIF) utilized mental healthcare at a higher rate during the first year postdeployment than veterans of Operation Enduring Freedom (OEF) in Afghanistan or those from other deployments. About one third of the OIF veterans sought mental healthcare during their first year as compared to 22% for OEF and 24% for other regions.<sup>2</sup>

Recent ongoing studies suggest that deployment also significantly increases the risk of mental health problems in military children, family violence, and divorce. Anecdotal reports from the field suggest that soldiers who are worried about their families are not as able to focus on the mission. Family satisfaction and resilience are important factors contributing to soldier readiness and retention, and attrition of soldiers with mental health issues is particularly high. Hoge and colleagues<sup>2</sup> found that attrition for any reason during the first year postdeployment from OIF was 17%, and those who reported a mental health concern were significantly more likely to leave the service. Other studies reported that 47% of all soldiers hospitalized for the first time for any mental disorder were separated from the Army within 6 months.<sup>3</sup> Innovative mental health initiatives are required to meet these and other challenges facing the volunteer Army to conserve the fighting strength and meet the needs of soldiers and their families.

The lineage of community mental healthcare in the military is rich, beginning in earnest during World War II, when clinicians and commanders alike recognized that psychiatric casualties decreased as morale increased.<sup>4</sup> Psychiatrists grasped the importance of treating soldiers within their social structures and strengthening their identification with their units,

which led to cohesion with their peers and unit leadership. As clinicians came to recognize the soldier as a part of an interdependent network of social forces, they realized that much of their treatment amounted to intervention in some part of the social structure, and that the psychiatrist was often poorly equipped for these tasks.<sup>5</sup> Individuals in the community—social workers, chaplains, and spouses of active duty members in volunteer positions—encountered less stigma and had greater knowledge of individual units and access to a wider pool of community programs than did hospital-based psychiatrists. As psychiatrists embraced multidisciplinary approaches, treatment moved out of medical centers and became integrated into the military social network, shifting emphasis toward prevention and leading to the community mental healthcare system.

The impetus for extending community mental healthcare to military family members, especially during deployments, rests on the emerging belief that strong social supports enhance the mental well-being of the parent remaining at home, which in turn prevents psychopathology in children. Research has shown that children's behavioral problems increase (especially in young boys) when the nondeployed parent suffers from psychopathology.<sup>6</sup> Practical remedies, such as strong spouse and family support groups; male companionship for young boys (eg, a big brother program or family members); education programs for spouses about separation and reunion; and regular communication with the deployed parent require community-level intervention.<sup>6</sup> Rear detachment units, wives' clubs, schools, childcare groups, and other community organizations can greatly contribute to building resilience in family members. Mental health providers have unique skills for identifying individual problem areas, but their interventions are most effective when integrated with the work of community groups that support families. Likewise, mental health providers working in interdisciplinary clinics located close to military housing areas are better able to implement treatment plans that involve these vital social support systems than those who work in hospital-based programs.

The responsibility for taking care of the physical and emotional needs of soldiers and their families is shared by numerous military, federal, and state agencies. These agencies each have specific portions of the overall caring "pie," but historically have functioned independently. Often agencies staunchly protect their own areas of concern, which unfortunately may result in inefficient and costly duplication of services and staff. It is a significant challenge to integrate agencies

in a common goal. Wenger and Synder<sup>7</sup> describe the emerging concept of “communities of practice” and discuss how disparate groups with a shared agenda can come together, learn from each other, and develop strategies that work toward a common goal. Large numbers of corporations and governmental agencies are employing these principles with success; however, many organizations need leadership “buy-in” to facilitate cooperation and collaboration.

The objective of this chapter is to describe the development of a multidisciplinary, integrated system of mental health support and care at Schofield Barracks in Oahu, Hawaii, during the deployment of the 25th Infantry Division Light (25th ID), aimed at promoting resilience and wellness in the Army community. Primary focus will be on the Soldier and Family Assistance Center (SAFAC), followed by a brief discussion

of a school mental health initiative,<sup>8</sup> mental health support to family readiness groups (FRGs [composed of Army spouses who support families]), and the Army Community Service (ACS). The discussion of the latter programs will focus on how these efforts came together to provide care for the soldiers and family members in the Schofield catchment area during OIF and OEF. (This chapter will not include detailed discussion of the Family Advocacy Program or the Army Substance Abuse Program [ASAP]. The Family Advocacy Program provides services when domestic violence is identified, and the ASAP delivers a wide range of prevention and treatment services for alcohol and drug abuse.) The overall development of the Schofield community behavioral health system is presented in chronological order to emphasize the importance of the process as it evolved within the entire community.

## EARLY EFFORTS

Schofield Barracks, including Wheeler Army Airfield, is located in central Oahu on 167,919 acres of land. It is home to the 25th ID and supports approximately 14,500 active duty soldiers. Additionally, about 9,500 civilian employees and 3,000 contract employees work at Schofield. On post there are three elementary schools and an intermediate school that are part of the Hawaii Department of Education (DoE). Besides the usual stressors for military families, such as frequent moves and transitions, additional stressors of living in Hawaii are the high cost of living, parents’ concerns about their children’s education, and cultural differences. As with other overseas assignments, most families living in Hawaii are isolated from their extended families and visit their relatives on an infrequent basis because of travel costs. The Army community receives its primary healthcare at Schofield Barracks Health Clinic, except for specialty care, which occurs at Tripler Army Medical Center (TAMC), located 20 miles from Schofield and over an hour’s commute during rush hour. Before the establishment of the SAFAC, almost all child, adolescent, and adult mental health services (other than services for active duty personnel) were delivered at TAMC.

In June 2003, the leadership of the 25th ID began preparation for deployment of a brigade combat team (BCT) to Afghanistan. By early fall of that year, the unit rotation schedule had expanded to include deployment of the entire 25th ID at Schofield. The 2nd BCT was slated for deployment to Iraq in January/February 2004, and the 3rd BCT and Division Headquarters were slated for Afghanistan between February and May. At the time, the 25th ID was the only division deploying to two separate theaters of combat operations. The division was also called upon to mobilize

the US Army Reserves and Hawaii National Guard as part of the deployment.

Through a combined effort of the 25th ID, Schofield Garrison Command, and TAMC, plans immediately began for soldier and family readiness and assistance during the deployment cycle, which presented significant challenges to these organizations. The 25th ID was deploying over 11,000 soldiers and leaving behind 25,000 family members, including nearly 800 pregnant women. Because of the availability of medical care at TAMC, the division had a higher proportion of families than usual with “exceptional family members,” individuals with medical and mental health needs that require specialized care. During the first deployment, 80% of the families of deployed soldiers elected to remain in Hawaii rather than return to their homes on the mainland during the deployment, which increased the need for mental healthcare.

The predeployment preparation for soldiers and families began in earnest in November 2003 with coordination of services among the various on- and off-post agencies. Mental healthcare was already becoming integrated with the involvement of FRGs, schools, and the ACS; for example, since 2001, Child and Adolescent Psychiatry Service (CAPS) at TAMC had already been involved in a school mental health program at Schofield.

During the summer of 2004, it became clear that the OIF and OEF deployments were resulting in significant mental health casualties.<sup>1</sup> The FRGs, CAPS, and ACS began discussing ways to meet the projected increased need for support and mental health services for the entire community, and informed the commander of the 25th ID, Major General Eric Olson, of their concerns. In December 2004, the 25th ID division surgeon returned from Afghanistan to meet with the commander of

Schofield Barracks Health Clinic and leaders in mental health at TAMC. This meeting resulted in a commit-

ment to develop a mental health initiative, which later became the SAFAC.

## SOLDIER AND FAMILY ASSISTANCE CENTER

### Concept Development, Structural Framework, and Financing

The purpose of the SAFAC was to execute a plan that provides mental health support for returning soldiers and their families. Early in the process, six guiding principles for SAFAC's development emerged:

1. a variety of mental health resources would be developed and integrated under a single umbrella organization to facilitate coordination of services and increase capacity and flexibility in delivery of these services;
2. a single point of entry would be established to make access to care easy and simple;
3. the mental health resources of the 25th ID would be combined with those of the Schofield Barracks Community Mental Health Clinic;
4. the funding of the SAFAC would be shared between Schofield Barracks Health Clinic and the 25th ID;
5. leadership for the newly established clinics could come from either the 25th ID or from Schofield Barracks Health Clinic; and
6. every effort would be made to decrease the stigma in seeking mental health assistance.

Several of these principles were unique to the Army experience, specifically principles 3, 4, and 5. Responsibility and leadership for the SAFAC would be shared so that the 25th ID had a vested interest in the direction and success of the initiative. A process action team, which was established and chaired by the rear division commander of the 25th ID, met monthly to evaluate progress and institute new initiatives or major changes in directions. A work group headed by the commander of Schofield Barracks Health Clinic met weekly to plan the next steps and evaluate progress.

The first task of the work group was to estimate the numbers of various specialty providers that would be required for the SAFAC to adequately meet the needs of the community. This process required estimates of baseline morbidity rates in soldiers and family members during peacetime, as well as rates resulting from deployment. Early estimates for the soldiers deployed to OIF and OEF were based on the research of Hoge et al,<sup>1</sup> and the work group assumed that not all soldiers with difficulties would seek help. Hoge et al<sup>1</sup> reported that rates for PTSD were lower in OEF than

OIF. Soldiers of the 25th ID deployed to either OIF or OEF. Rates of PTSD for soldiers were projected to be approximately 8% to 11%. Rates of other anxiety / depression were estimated at 5% to 7%, serious domestic violence at 8%, moderate domestic violence at 22%, divorce at 10%, and children with mental health issues at 25%. Projections of the rates of the mental health problems in the adult family members were based on the rates in soldiers. Because the SAFAC needed to care for not only the current active duty population but also the deployed reserve and National Guard soldiers and their family members, actual numbers for the entire population were not available.

No algorithm was available to estimate the numbers of providers in each specialty needed to serve this population; the Army's system of resource allocation is not based on empirical evidence. To develop an algorithm that later could be tested, several assumptions were necessary. These assumptions were (a) the average number of visits per year each individual would make, (b) the proportion of individuals who would require medications, (c) the numbers of patient visits each specialty provider could reasonably provide in a year, and (d) the ratio of patients who could be seen by a nurse practitioner versus a psychiatrist versus another provider. Based on these assumptions and those listed below, algorithms were developed and later refined.

Exhibit 34-1 lists the assumed number of visits per year per specialty provider and the formula for its calculation. For example, it was assumed that an adult psychiatrist would be able to handle 3,290 visits per year based on 7 hours of patient contact a day, two patients per hour, 5 days a week, for 47 weeks each year; each patient visiting the three clinics would require an average of six visits a year; 0.8 of the adults being seen in the Soldier Assistance Center or the Adult Family Member Assistance Center would require medications; and approximately 50% of the patients under 18 years of age seen in the Child and Adolescent Assistance Center would require medications. There would be three psychiatrists to every one nurse practitioner for adults and one child psychiatrist to one nurse practitioner for children and adolescents. The ratio of social workers to psychologists would be 6 to 1. Child psychiatrists, child nurse practitioners, and child psychologists would be in equal proportion. This algorithm could be further refined as actual data were collected, and it could be easily modified to adjust to differences in other clinics or at other installations.

**EXHIBIT 34-1**

**ALGORITHMS FOR CALCULATING PROVIDER NUMBERS**

**Visits per Practitioner per Year**

- Psychiatrist: 3,290\*
- Social worker: 1,645<sup>†</sup>
- Psychologist: 1,645<sup>†</sup>
- Nurse practitioner: 3,290\*
- Child psychiatrist or child nurse practitioner: 2,467<sup>‡</sup>
- Psychologist: 1,645<sup>†</sup>

\*7 h × 2/h × 5 days/wk × 47 wks = 3,290

<sup>†</sup>7 h × 1/h × 5 days/wk × 47 wks = 1,645

<sup>‡</sup>7 h × 1.5/h × 5 days/wk × 47 wks = 2,467

**Formulas for Number of Practitioners Required**

- Psychiatrists and nurse practitioners: population × 6 visits/patient/year × .8 needing medications ÷ 3,290 visits/psychiatrist/year
- Social workers and psychologists: population × 6 visits/patient ÷ 2,209 visits/provider/year
- Nurse practitioners: population × 6 visits/patient × .8 needing medications ÷ 3,290 visits/year
- Child psychiatrists: population × 6 visits/patient × 0.5 needing medications ÷ 2,467 visits per year
- Child nurse practitioners: population × 6 visits/patient × 0.5 needing medications ÷ 1,645 visits/year
- Child psychologists: population × 6 visits/patient ÷ 1,645 visits/year

**Proposed Ratios**

- Adult psychiatrists to nurse practitioner = 3:1
- Adult social workers to psychologists = 6:1
- Child psychiatrists to child nurse practitioners = 1:1

By January 2005, five areas of care (Exhibit 34-2) were identified and a timeline for implementation of the clinics determined. Table 34-1 lists the projected deployed population and the estimated number of providers required in each of the five areas using the various algorithms. There would be a single point of entry into the mental health system (to be available 24 hours a day), which became known as the Triage Assistance Center. Other areas of care were the establishment of three new clinics and augmentation of the Marriage and Family Assistance Center and the ASAP. The new clinics were called the Soldier Assistance Center (SAC), the Adult Family Member Assistance Center (AFMAC), and the Child and Adolescent Assistance Center (CAAC). The designation “assistance center” was utilized in an attempt to decrease the stigma surrounding mental healthcare.

Funding was approved the same month. Preliminary estimate of the cost of the SAFAC for one year was \$5.4 million. The 25th ID agreed to fund approximately 20% of the total, including renovation of a floor in a

clinic to house the AFMAC, and hiring three providers to augment drug and alcohol treatment for family members and six social workers to bolster the AFMAC and the Marriage and Family Assistance Center. The remainder of funds came from TAMC. The 25th ID also assumed an active role in the SAFAC’s develop-

**EXHIBIT 34-2**

**SOLDIER AND FAMILY ASSISTANCE CENTER FIVE AREAS OF CARE**

1. Triage Assistance Center telephone line (24 hours a day / 7 days a week)
2. Soldier Assistance Center
3. Adult Family Member Assistance Center
4. Child and Adolescent Assistance Center
5. Marriage and Family Assistance Center

**TABLE 34-1**  
**PROJECTED DEMAND OF PROVIDERS BASED ON POPULATION**

	Psychiatrists	Psychologists	Nurse Practitioners	Social Workers
Soldier Assistance Center	4.10	1.95	1.37	11.72
Adult Family Member Assistance Center	2.41	1.15	0.80	6.88
Child and Adolescent Assistance Center	1.06	2.13	1.06	0
Marriage and Family Assistance Center	0	0	0	8.07

ment, providing additional leadership and assistance to the assistant division surgeon and technical support through the loan of a division logistics officer.

**Recruitment, Advertising, and Implementation**

The reorganization of the Community Mental Health Clinic and division mental health services into the SAC occurred immediately, and the SAC opened the second week in January 2005. Demand at the start far outweighed availability, and additional providers were immediately needed. In February, TAMC’s chief of psychiatry (Colonel CJ Diebold) and residency program director (Colonel David Orman) provided staff psychiatrists’ and residents’ time to the SAC as part of the graduate medical education program. This interim solution was essential to maintaining the SAC’s function while providers were recruited and hired. Specialty experts at Schofield Barracks Health Clinic or TAMC interviewed prospective candidates and made hiring recommendations. By April 2005, essentially all the positions had been filled.

Although some family members were already being seen in limited numbers in the SAC, the AFMAC and Triage Assistance Center opened on March 15. In April, the division mental health staff returned from OEF and OIF, including the chief, Major Brian Bacon, who was appointed chief of the SAC, and division psychologist Captain Richard Schobitz, who became chief of the AFMAC and CAAC. The opening of the CAAC was delayed a month due to difficulty in recruiting child psychiatrists, but by May 2005 all clinics were operating at or above optimal staffing levels.

Early in the program’s development organizers initiated an aggressive campaign to decrease the stigma associated with seeking mental health assistance at the SAFAC, and increase awareness among providers of war-related psychological trauma. Hoge and colleagues<sup>1</sup> found that the greater the likelihood of trauma, the greater the stigma in seeking help. The

advertising campaign was initiated in February 2005, promoting the SAFAC and its available resources throughout the community. Ten thousand refrigerator magnets were produced that listed SAFAC’s mission and services, as well as the 24-hour triage telephone number. The television channel on post also promoted the new resources and encouraged people in need to seek help. Unit leaders were informed by their chains of command that any soldier having emotional difficulties should be identified and offered the opportunity to visit the SAFAC. Division leaders met regularly before and after redeployment to ensure that soldiers at risk were identified.

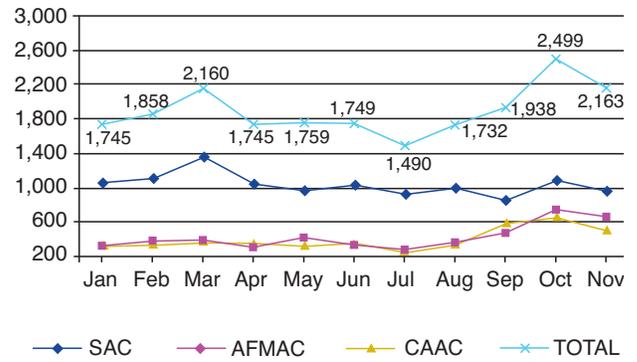
The National Center for PTSD was invited to Schofield Barracks to instruct primary care providers in recognizing war-related mental health disorders and to teach behavioral health providers cognitive-behavioral therapy for PTSD. National Center for PTSD staff Matthew Friedman, MD, PhD (the center’s director); Frederick Gusman, MSW; Julia Whealin, PhD; and Gregory Leskin, PhD, conducted 3 days of classes for the staff at Schofield Health Clinic and TAMC. Dr Whealin continued to come once a week to colead a soldier PTSD group at the SAC. Efforts by the center increased the knowledge of PTSD and depression among primary care providers and have been very beneficial to the entire Schofield Barracks community. The effectiveness of this campaign in decreasing stigma cannot be known; however, the demand for SAFAC services, particularly during the initial stages, has taxed its resources.

One of the SAFAC’s initial efforts was the Soldier Readiness Program (SRP), in which a mental health provider interviewed every soldier prior to and immediately upon redeployment, and those having serious concerns or requesting assistance were immediately referred to a doctoral-level provider. The psychology and psychiatry departments at TAMC supplied additional staff for the SRPs until the SAFAC was fully operational (currently the majority of the staffing of SRPs is done by the SAFAC).

### Outcomes and Current Activities

Key to success of the SAFAC team is flexibility. With regular moves of the active duty staff, contracts that require year-to-year negotiation, and deployments, staff flexibility to meet the demand of the current situation is critical. The clinics are organized under an “umbrella” of services, which allows for movement of staff between clinics to meet the changing needs of the population. For example, when some of the soldiers of the 25th ID deployed in summer 2006, staff were shifted from the SAC to the AFMAC, increasing services for family members while the soldiers were deployed. Additionally, two social workers transitioned from the AFMAC to the Marriage and Family Assistance Center in response to increased need. Recently the ASAP had a 2-month backload, which was relieved when the SAC developed a behavioral change group specifically for ASAP clients. In September 2005, the CAAC opened evening hours to see children, facilitating access for parents who work. A new position has been added to conduct outcome studies on the SAFAC’s efficacy. Despite minor fluctuations over time in each clinic’s staffing, the initial estimates for overall numbers of the various providers have proven to be fairly accurate. Figure 34-1 illustrates the number of client appointments at the three clinics from January 2005 to November 2006.

Within the Schofield Barracks community, the SAFAC is involved in a variety of activities. Staff members teach classes and present seminars at ACS. A team composed of an AFMAC child psychologist and an ACS social worker present briefings at district schools on topics relevant to military children, such



**Figure 34-1.** Monthly patient or client visits in the three Soldier and Family Assistance Center clinics, January 2005 to November 2006.

AFMAC: Adult Family Member Assistance Center  
 CAAC: Child and Adolescent Assistance Center  
 SAC: Soldier Assistance Center

as “Effects of Deployment on Children,” “Children and Redeployment,” and “Building Resilience.” Every unit that returns from OIF or OEF receives a reintegration briefing from the SAFAC. In addition, a monthly caregiver team meeting is dedicated to improving community outreach, family support, and crisis intervention.

Since the deployments of the Hawaii Army Reserve units and the National Guard, numerous requests have been made for outreach services on other islands in Hawaii, as well as in Alaska, Samoa, Guam, and Saipan. A SAFAC team was appointed to provide services at these geographically remote areas through ongoing visits to each of these locations.

### SCHOOL-BASED MENTAL HEALTHCARE

In partnership with Solomon Elementary School in Schofield Barracks, CAPS developed a model for school mental health preventive care, early intervention, evaluation, and treatment of military children. Dr Mark Weist, director of the Center of School Mental Health at the University of Maryland, was consulted during the establishment of the Solomon Wellness Educational Program (SWEP), which began in 2001 with the goal of facilitating easy access to mental healthcare for students.<sup>8</sup> The project initially expanded to four schools. The following discussion only pertains to Solomon Elementary School, because it has the longest history and has received the most evaluation. Although not discussed here, programs at the three other schools are ongoing and highly valued by each school.

Solomon Elementary is a public school administered and funded by the Hawaii DoE. Administrators, teach-

ers, counselors, and support staff are state employees. The school currently has an enrollment of about 830 students, 99% of whom are military dependents. The students come mainly from families of junior enlisted active duty soldiers who are usually assigned to a 3-year tour in Hawaii. Of the students, at least one third transition (move from the area) each year. A large proportion of these families have young children, as reflected by the school’s eight kindergarten classes, eight first-grade classes, six second-grade classes, five third-grade classes, four fourth-grade classes, and four fifth-grade classes. Of the children at Solomon, 49% qualify for a reduced-price or free lunch. In addition, seven self-contained special education preschool classes serve 51 young children with severe communication disorders, autistic disorder, global developmental delays, or severe behavioral disorders. An additional 69

special education students are in kindergarten through fifth grade. Three self-contained classrooms are for children with severe behavioral disorders, serving 12 children from 5 years to 11 years of age.

### Early History

A formal agreement has existed between Solomon Elementary and the Child Psychiatry Service at TAMC since 1985. Second-year child psychiatry fellows spent one half day per week for 6 months providing consultation services at the school for children referred by school counselors. Fellows mainly provided triage after observing the children and discussing the counselors' concerns. Children in need of services were referred to TAMC or to a civilian provider through TRICARE—the military's health insurance program. In 2000, CAPS decided to offer more services by sending the child psychiatry fellow into the school for a full day each week for the entire school year. The referral process remained the same, but full evaluations were now conducted at the school. These early experiences helped form the vision and goals of a comprehensive, integrated, school mental health program:

**Vision:** Develop and implement a comprehensive array of school programs and services to support students, family, and community.

#### Goals:

- Provide a full continuum of mental health promotion and intervention programs and services, including early identification and intervention, prevention, evaluation, and treatment.
- Remove barriers to learning and improve the academic success of students.
- Enhance strengths and protective factors in students, families, and the school community.
- Promote quality of life and wellness in military families.
- Provide training, staff development, and research opportunities to improve children's mental health and education.<sup>8</sup>

Several tenets were developed concurrently to guide program decisions. The first tenet stated that SWEP is a collaborative program responsive to the needs of its stakeholders. An advisory board composed of various stakeholders in the school and community meets on a monthly basis. The board's responsibility is to attend to the mental health of the students, teachers, parents, and the community. For example, to deal with the increased interpersonal difficulties between

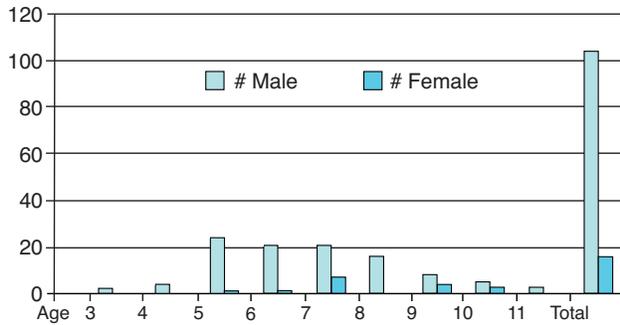
students at recess, the board developed a program of structured games and contests that resulted in declining referrals to the office during recess. Another example was the regular publication of a newsletter for teachers on mental health topics. During the first OIF deployment of the 25th ID, the advisory board held parent support meetings at the school to help the nondeployed parent and children successfully cope with the situation. The board also established a crisis plan to ensure a coordinated, empathic response to the children and families of soldier parents who were killed or severely injured. The plan called for verification of all information before intervention, followed by a clearly defined, graded approach to meeting families' needs with sensitivity.

The second tenet required that all programs and services for children and families be coordinated. DoE and TAMC policies needed to be integrated, followed by frequent and clear communication. This led to weekly triage meetings following an algorithm for how a child is referred for evaluation and provided care, attended by the treating physicians, counselors, a school behavioral specialist, a student services coordinator, the school principal, and the medical director. After appropriate parental consents are given, information about the child and family is shared, and a coordinated, multidisciplinary treatment plan is devised.

### Program Evaluation and Student Demographics

SWEP incorporates ongoing performance improvement to ensure timeliness and quality of services, including a recent review of 133 closed charts of students evaluated from August 2001 to February 2007. Of the 133 children referred to SWEP, nine failed to appear for their initial appointments, for a noncompliance rate of 7%, and 113 of the 124 evaluated were seen within 4 weeks of the date of referral, including over one third of the children who were seen within 10 days of referral. Although 11 children were seen after 4 weeks, three were delayed due to cancellations by the parents and four because of school vacations, particularly during the winter holiday vacation when school was closed for 2 weeks. The majority of the children evaluated were 7 years of age and under (Figure 34-2).

The majority of children had externalizing disorders, with a boy-to-girl ratio of about 4 to 1. Modalities of treatment at the school included individual and group therapy, family therapy, parent guidance, and pharmacotherapy. Of the children treated, only four required a higher level of behavioral intervention, including special education certification. Three of these children were diagnosed with bipolar disorder and the other child (whose parents were both deployed) was



**Figure 34-2.** Ages and gender of children evaluated at Solomon Elementary School in the Solomon Wellness Educational Program, from August 2001 to February 2007 (total: 133).

diagnosed with severe attention deficit hyperactivity disorder and oppositional defiant disorder.

Other services provided by SWEP included quarterly teachers' workshops and parent workshops on behavioral interventions, as well as a recently initiated bullying awareness and prevention program. For the past 3 years, SWEP physicians have provided weekly consultations to the Primary School Adjustment Program, which screens all younger children and identifies those having trouble adjusting to the school environment. Two paraprofessionals then offer individual and small group services to these children. The child psychiatry fellows have given guidance and instruction on topics such as child development, as well as offering workshops to the parents. Addition-

ally, support groups for children whose parents are separating and divorcing have been initiated.

Along with training opportunities for TAMC child psychiatry fellows, SWEP has expanded to include training of social work students from the University of Hawaii. A formal memorandum of agreement was established whereby master's-level students obtained practicum experience at SWEP under the supervision of the medical director, child fellows, and a DoE school social worker. Practicum students performed intakes and offered individual and family therapy, parent guidance, and group therapy. A similar collaborative agreement was established with the university's Counseling Education Department, whose practicum student performed intakes, provided therapy, and received training in psychological testing.

### Future Directions

Efforts are underway to use measurements before and after program participation to document student progress. The Strengths and Difficulties Questionnaire<sup>9</sup> has been administered to teachers and parents before and at selected intervals after to determine the treatment's effect. In addition, patterns of behavioral referrals to counselors or the vice principal are being analyzed before and after treatment to determine if treatment has an impact on disciplinary referrals. Further efforts are planned to identify deployment-related stresses on parents and children, including effects of reunions and postdeployment family readjustment.

## BEHAVIORAL HEALTH LIAISON PROJECT

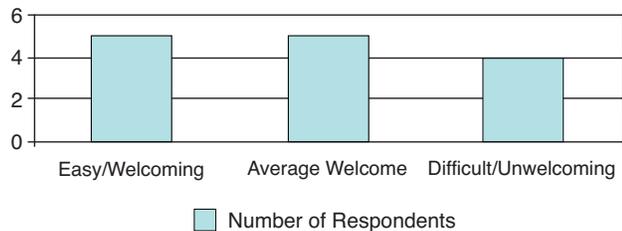
In February 2004, the TAMC psychiatry residency program launched a behavioral health liaison (BHL) project, modeled on a similar program conducted at Letterman Army Medical Center in San Francisco, California (1988–1989), aimed at familiarizing psychiatry residents with operational Army units.<sup>10</sup> Unbeknownst to organizers, it also resembled a program being piloted simultaneously by ACS in the 1st Armored Division using social workers as consultants, which later gained widespread acceptance as the Soldier and Family Life Consultants (or Military Family Life Consultants) program.

The BHL program was different, however, in that residents supported the rear elements of a deployed military force. It included both service and training missions, providing preventive and consultative mental healthcare to rear-detachment units and FRGs, as well as familiarizing residents with these units and their day-to-day activities. The BHL team consisted of 17 TAMC psychiatry residents at various levels of

training, along with a supervising attending psychiatrist. Each resident was assigned a 25th ID unit to support; junior residents were given battalions and senior residents were given brigades. Over the course of a 12-month deployment cycle, BHLs provided education on relevant psychosocial issues to rear-detachment commanders and FRG leaders, and facilitated access to mental health resources for soldiers and their family members.

Initial challenges included generating interest among residents while minimizing additional demands on their already burdensome academic schedules. At a minimum, residents were required to contact their assigned unit's FRG leader and offer the group an initial educational briefing. Beyond that, they were encouraged, but not required, to attend their unit's monthly FRG meetings and provide additional education and consultation as requested.

Outcome data later revealed that almost exactly one third of the residents perceived their welcome by the



**Figure 34-3.** Quality of welcome by unit in the behavioral health liaison project.

unit as “easy/welcoming,” one third perceived their welcome as “average,” and one third perceived their welcome as “difficult/unwelcoming” (Figure 34-3). Although these relationships were not objectively measured, a direct correlation was perceived between the openness with which units welcomed their BHL and the amount of contact the BHLs subsequently had with their assigned units; disinterested units did not receive as many visits or educational briefings as units that proactively reached out for assistance.

Every interested unit received an initial briefing from their BHL on the emotional cycle of deployment, a concept originally described by Pincus and colleagues.<sup>11</sup> Topics covered in subsequent briefings are listed in Exhibit 34-3. Beyond the initial contact, residents had a substantial amount of flexibility in choosing how to work with their FRGs and remained involved with the groups on a variable basis. Some attended FRG meetings every month, kept in close contact with FRG leaders, and attended various unit functions. Others took a more passive role, remaining available to field questions from FRG leaders only when issues arose.

When the program ended, feelings about the pro-

**EXHIBIT 34-3**

**FAMILY READINESS GROUP BRIEFING TOPICS**

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- Behavioral health liaison introduction
- Emotional cycle of deployment
- Common mental illnesses
- Combat stress/posttraumatic stress disorder
- Children and deployment
- Midtour rest and recuperation
- Loss and grieving
- Reunion and reintegration

gram were overwhelmingly positive among FRG leaders, who unanimously felt that the program should be continued following redeployment. The psychiatry residents, however, had a mixed response. Ultimately, the program was discontinued and replaced with a mandatory 2-month senior resident rotation through the SAC, with supervision by either the 25th ID division psychiatrist or an active duty community psychiatrist.

### Army Community Service Support for 2004–2005 Deployments

The deployment of the 2nd BCT to Iraq in January 2004, followed by the deployment of the 3rd BCT to Afghanistan in March 2004, prompted further community efforts to prepare and support soldiers and families of the 25th ID. ACS took a leadership role in ensuring that 25th ID soldiers and families were trained and ready to handle what became a long and challenging 18 months. ACS concentrated on preparing the families of the 2nd BCT first, followed by the 3rd BCT, and then launched an aggressive sustainment program of continued support to families during the deployment. Finally, ACS developed a robust redeployment program that strategically addressed reintegration issues.

### Predeployment Support

ACS developed a four-pronged approach to predeployment support including (1) dissemination of information, (2) training and education, (3) community outreach, and (4) mental health integration. The extensive community outreach element included three deployment information fairs with more than 20 community service organizations participating, such as finance, legal, and housing assistance organizations; TRICARE; child development centers; and SAFAC. Military and civilian organizations were available to answer questions and provide information about making personal deployment decisions for soldiers and families. The fairs were open to the entire community; local sponsors provided door prizes and refreshments. More than 2,500 soldiers, families, and community members attended the three fairs.

A separate job fair was conducted with the community employment assistance program to educate spouses about employment opportunities. Many spouses were undecided about whether to remain in Hawaii or move back to the mainland during deployment. Because employment factored into this decision, ACS partnered with over 30 local businesses and organizations to extend employment opportunities to

spouses. More than 250 spouses attended the fair.

Community town hall meetings, beginning several months before deployment, offered the latest information from the division commander about deployment status and myriad community service providers. The division commander and his staff were on hand to answer questions and quell any rumors or misinformation. The town hall meetings continued on a monthly basis throughout the duration of both deployments. Free childcare during the meetings ensured high attendance. Additionally, over 30 school briefings were presented to teachers, school administrators, counselors, and parents, in partnership with CAPS, on deployment-related topics affecting children.

ACS training and education opportunities included:

- preparation and guidance for FRG leaders, either as individuals or in classes, on how to best support families and themselves during deployment;
- education of rear-division commanders (nondeployed) in collaboration with division training resources;
- financial readiness classes for soldiers and families to prepare them for the financial issues of deployment; and
- family wellness classes teamed with various TAMC child and adolescent psychiatrists, SAFAC staff, and chaplains.

The ACS provided over 58 sessions of financial readiness training. Numerous other classes for families covered such topics as “Impact of Deployment on Children,” “Helping Children Cope With Stress,” and “Dealing With Rumors.” Several classes addressed relationship issues for parents and the importance of meaningful communication during separation between spouses. ACS contracted Drs John and Jane Covey to train 27 ACS employees and chaplains for certification in “Seven Habits of Highly Effective Families”; the trainees in turn conducted almost two dozen 1-day sessions for Army couples.

ACS joined with the SRP to offer soldiers a plethora of information, as well as collecting data on soldiers and their families. ACS designed a predeployment information sheet, distributed to all soldiers, asking for information on the soldiers and their families, their needs, potential concerns, and requested assistance. Data were collected for ACS to determine where spouses would be residing during the deployment and any special needs they may have. Single soldiers were asked to provide an address of a parent or friend they wanted to be kept informed during their time

deployed. Upon completion of the forms, over 8,500 records were collected and input into a database. Demographics such as spouse or parent addresses, pregnancies, family members with special needs, non-English-speaking spouses, and planned relocations were used to develop specific deployment programs for target audiences. Approximately 22% of spouses moved to the mainland, 9% of married women were pregnant, 13% of spouses did not speak English as their first language, 15% had a special-needs family member, 56% of soldiers were married, and 69% of those married had children. A deployment newsletter was published bimonthly and mailed to over 8,000 spouses, parents, and friends of soldiers, containing information on Army community services available to families and important resource telephone numbers.

### **Deployment Sustainment**

To ensure that quality services were available for spouses, ACS extended its operations to 7 days a week. Classes and training for FRG leaders and family members continued, with frequent seminars on such topics as “Coping With Deployment,” “Care for the Care-Giver,” and “Taking Care of Me.” ACS offered a weekly “spouses night out” every Thursday with pizza and other refreshments provided by sponsors, fun activities, and free childcare (also available for the FRG Wednesday meetings). Guest speakers, craft nights, game nights, support groups, and more were offered during the 52 weekly sessions. In addition, ACS made 20 hours a month of free childcare easily accessible to spouses to provide child-free opportunities for errands or respites. However, 88% of childcare employees were spouses of deployed soldiers, and burnout and stress were common among staff. In hindsight, the free childcare was excessive and created challenges for subsequent deployments when expectations could not be sustained because of decreased funding.

ACS worked directly with the 125th Signal Battalion to connect soldiers and families via video teleconference (VTC) equipment available 7 days a week. Spouses found seeing their deployed spouses and speaking to them face to face to be comforting, but children had mixed experiences with the VTC sessions. Younger children sometimes became visibly upset by seeing mom or dad on the screen, while others used the opportunity to update their parents on school and home activities. In general, the VTC sessions proved to be very valuable to families.

### **Redeployment and Reintegration**

In December 2004, ACS developed a workshop to

prepare spouses and families for reunion after deployment. ACS again invited Drs John and Jane Covey to participate. The workshop included a list of local professionals who offered such classes as “Effects of Combat Stress on Families,” “Helping Children Prepare for Reunion,” and “Putting the Welcome in Welcome Home.” The workshop was in a “round-robin” format, affording spouses the opportunity to attend three of the five sessions provided. Over 150 spouses attended. The workshop was followed by a series of programs with guest speakers offered every 2 weeks in the evenings. Mental healthcare providers, chaplains, and social workers were brought in to present topics on reunion and reintegration.

ACS developed a “Ready 4 Reunion” DVD with three segments that addressed reunion and reintegration, one of which focused on children and deployment and was produced by ACS with the help of local volunteers and a TAMC child psychiatrist. The other two segments were taken from “Operation Ready” material ([www.mwrarmyhawaii.com/acs/managing\\_deployment.asp](http://www.mwrarmyhawaii.com/acs/managing_deployment.asp)). Mailed to over 6,000 family members, the DVD had a 3-fold purpose: (1) to reach as many spouses as possible, both those who remained in Hawaii and those who had moved back to the mainland; (2) to provide spouses with reunion information in their own homes; and (3) to generate awareness of the postdeployment reintegration process and encourage spouses to take advantage of the training and services available to them. The DVD was successful in generating interest in reunion training and was later made accessible on the ACS Web site (<http://www.mwrarmyhawaii.com/>).

To facilitate reintegration, the 25th ID planned to provide comprehensive training to redeploying soldiers and families beginning 90 days before homecoming and ending 30 days after redeployment. The resulting Tropic Lighting University, based on Iron Horse University at Fort Hood, Texas, was a three-phase reunion program designed specifically for intensive reunion training to soldiers and their spouses.

Phase I included intensive reunion training to spouses beginning 90 days prior to homecoming. Phase II, the 3-day deployment cycle support program mandated by the Army, included a series of briefings, mental health screenings, and medical checks. Spouses were invited to attend the briefing portion of this phase. Phase III occurred immediately following the soldier’s 30-day leave period and consisted of a series of classes over 2.5 days. Four target audiences were identified for training: (1) single soldiers, (2) single soldiers with children, (3) married soldiers, and (4) married soldiers with children. Unit integrity was maintained throughout the program. Tropic Lighting

University trained over 10,000 soldiers. The curriculum included

- stress management (2 hours) for all soldiers,
- anger management (1 hour) for all soldiers,
- money management (1.5 hours) for all soldiers,
- single parent workshop (1.5 hours),
- single soldier workshop (1.5 hours),
- marriage workshop (3 hours),
- communication with children (1 hour), and
- divorce recovery (2 hours) for soldiers going through a divorce.

### Lessons Learned

- Partnership with the mental health community was invaluable and should be mirrored on all Army installations.
- Global war on terror funds provided ACS with the needed financial resources to provide extensive deployment services.
- Twenty hours a month of free childcare was excessive and created an unsustainable expectation.
- ACS and childcare staff experienced burnout. Extended hours and additional childcare requirements put a great deal of stress on the staff, many of whom were spouses of deployed soldiers.
- Keeping the community informed and building relationships with schools helped identify potential family issues and at-risk families, and connected families with available resources before issues became elevated. The community served as ACS’s eyes and ears.

The responsibility for taking care of the physical and emotional needs of soldiers and their families is shared by numerous military, federal, and state agencies. These agencies each have specific portions of the overall caring “pie,” but historically have largely functioned independently. Often agencies staunchly protect their own areas of concern (“defend their turf”), which unfortunately may result in duplication of services and staff, and that is not only inefficient and costly, but also results in barriers to care due to lack of coordination of services and multiple portals of access. It is a significant challenge to integrate agencies in a common goal. Wegner and Synder<sup>10</sup> describe the concept of “Communities of Practice” as being the “organizational frontier” and define how disparate groups that have a “shared agenda” may come together, learn from each other, and develop

strategies that work toward a common goal. Large numbers of corporations and governmental agencies are employing the principals embodied in the concept

of a “community of practice” with success. However, within many organizations there needs to be a “buy in” from the leadership.

## SUMMARY

The rapid development and success of SAFAC is attributable to strong leadership in the 25th ID and TAMC. Likewise, strong leadership from the Schofield Barracks Garrison Command, the National Center for PTSD, and the Hawaii DoE district superintendent facilitated the coming together of the various agencies, schools, and the SAFAC in maximizing resource utilization and cooperation. For example, the SAC, composed of the combined mental health resources of the 25th ID and the Community Mental Health Clinic, greatly increased capacity and access to care for soldiers returning from OIF and OEF. Such collaboration greatly expands the Army’s ability to provide mental healthcare for soldiers. Taking mental healthcare to the community is another important principle. School mental healthcare brings services to youth where they spend a large portion of their day. It is often more convenient for parents and has less stigma for children and parents alike than going to a mental health clinic. Outreach in collaboration with ACS educates the community and further decreases stigma. Embedding mental health resources within the FRGs provides direct support to spouses during deployments and makes seeking help easily accessible.

Occasional conflict in Schofield’s program had a negative impact on services. Areas that presented difficulties were the direction and control of social work resources and, to a lesser extent, integration of substance abuse resources, particularly for family members. These problems were never fully overcome.

Based on the experience with integrating mental health resources in an Army community like Schofield Barracks, the following is recommended:

- Command and control of mental health resources must be established and made clear under a single umbrella organization. The combination of all mental health resources under a single organization greatly facilitates integration and coordination of services. Failure to integrate such services generates numerous and costly problems even in a

peacetime environment. If psychology, psychiatry, and social work need to respond to a crisis as a team, then these agencies should be organized as a team with a leader.

- The current system of accounting for providers’ clinical time must be changed to reflect the value of prevention and early identification programs. Under the present accounting system, programs that emphasize prevention and early identification are not counted as patient care and actually count against “productive work.” Similarly, community outreach is not quantified as productive workload.
- Army combat units such as the 25th ID should play an integral role in any mental healthcare initiative. Shared responsibility between mental health components and combat units greatly enhances the care of soldiers and their families.

Another important concern is allocation of mental health resources within the Army system. Traditionally, Army staffing guidelines have called for approximately one adult psychiatrist for every 7,000 adults and one child psychiatrist for every 18,000 youths under age 18. The experiences described in this chapter, as well as empirical evidence, suggest that one medication-prescribing practitioner is needed for every 3,000 adults, and one child medication provider for every 3,300 children. This is a greater than 2-fold increase in adult providers and almost a 5-fold increase in child providers. Even so, this staffing level does not take into account the numbers of youth seen in schools or those treated at TAMC. Additionally, these data represent a system that permits ready access to care. Within the SAFAC, nurse practitioners were used as much as possible for prescribing medication in both the adult and child clinics to reduce expenses. The assumptions in the algorithms described in this chapter need further testing; however, the estimated numbers of providers the equations predicted appear to be fairly accurate, and in general do not overestimate the need.

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