Post-Deployment Mental Health. It’s Not Just PTSD.

Governor's Working Group on Military, Veterans, and Family Members

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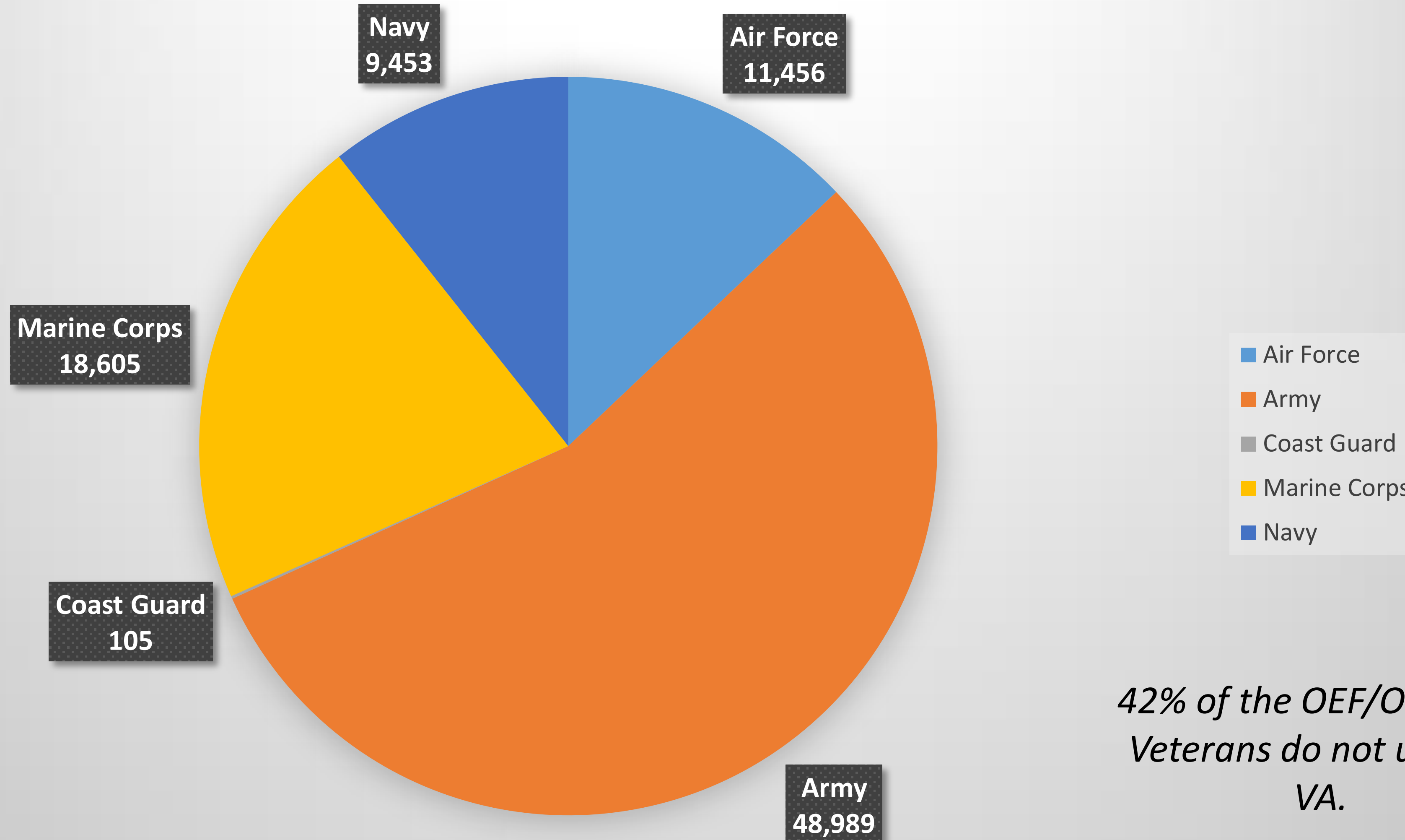
Topics

- Insomnia
- Anxiety
- Depression
- Suicide risk


OEF/OIF/OND Veterans in North Carolina, as of May 2015
Navy
9,453
Air Force
11,456
Marine Corps
18,605
Coast Guard
105
Army
48,989
Air Force
Army
Coast Guard
Marine Corps
Navy
42% of the OEF/OIF/OND Veterans do not use the VA.

Substance Use and OEF/OIF/OND Veterans

- Among the 46,627 OEF/OIF/OND veterans seen at a VA facility in North Carolina since 9/11/01, substance use disorder present as:
  - Alcohol: 5,460 (11.7%)
  - Drug: 1,152 (2.5%)
  - Tobacco: 9,536 (20.5%)

- For comparison, PTSD: 13,386 (28.7%)

- This will be a theme throughout today's talk.

Common Causes of Insomnia

- Habits (caffeine, TV in bed, lack of exercise)
- Psychiatric Conditions
  - Depression
  - PTSD
  - Substance Use Disorders (alcohol, nicotine, stimulants)
- Traumatic Brain Injury
  - Elevated rates of sleep apnea even without obesity
- Medical Conditions
  - Chronic pain, Diabetes, Genitourinary system disorders

Diagnosis Determines Treatment

- Insomnia treatment does not equal Ambien.
- Behavior change is the first intervention.
  - Sleep hygiene: undo the bad habits.
  - Minimize alcohol, caffeine, and nicotine.
- Manage associated medical conditions (pain, GU).
- Manage associated psychiatric conditions.
- Then, consider medication for insomnia.

Medication for Insomnia

- Initial insomnia
  - Trazodone or hydroxyzine
  - Zolpidem (Ambien and others) can be acceptable

- Middle insomnia
  - Prazosin for nightmares

- Eliminate the unhelpful medications: alcohol, caffeine, and nicotine.

Anxiety

- Common psychiatric diagnoses
  - Panic Disorder
  - Obsessive – Compulsive Disorder
  - PTSD (moved to traumatic disorders in DSM5)
- Differential diagnosis
  - Medical
  - Substance use disorders (alcohol, stimulants)

Anxiety Treatments

- Medications and Psychotherapy
  - As a general rule, psychotherapy causes a greater effect than medication.
- Specific treatment choices depend upon the diagnosis.
  - In general, first-line medications are SSRI/SNRI antidepressants.
  - Benzodiazepines can mitigate panic attacks but are not recommended for general anxiety or PTSD. These medications should not be used alone.
- Psychotherapy is the most effective treatment.
  - For treating PTSD, both CPT and PE are incredibly effective. In the right setting, EMDR also is highly effective.

Depression

- Depression can be a symptom or a diagnosis.
- As a symptom
  - Mood response to changing events. This often is normal.
  - Can be due to external causes.
- Differential diagnosis
  - Medical (thyroid, TBI, medication side effect)
  - Substance Use Disorders (alcohol, stimulants)
  - Psychiatric

"Treatment – Resistant Depression"

- Typically from
  - Inadequate treatment (see STAR*D trial)
  - Unrecognized substance use disorder
  - Psychiatric co-morbidity (OCD, PTSD, personality traits)

Depression Treatments

- As with anxiety, psychotherapy is more effective than medication .
- Medications
  - STAR*D is an excellent guide for medication management.
  - Again, stop the non-helpful "medications" (alcohol, nicotine).
- Psychotherapy
  - CBT is a first-line treatment. I have trouble believing there is a licensed psychotherapist in the U.S. who doesn't know how to deliver CBT for depression.

Suicide: “22 veterans die each day”

This sound bite is from a 2012 VA report, but you may not know this same report includes:

- The average age of veterans who commit suicide is 59.
- These data are based upon state death certificates with a ‘measurable amount of error’ in reporting veteran status.
- The percent of suicide deaths that were classified as veterans ranges from 7% – 27%. Which explanation is more likely: a four-fold higher suicide rate among veterans in some states, or, problems with the data?

So, what *is* the Veteran suicide rate?

- Death certificates that include Veteran status do not separate current from prior military service: suicides among active-duty military might be misclassified as veterans.
- A 2014 study re-calculated veteran suicide rates with adjustments for the Defense Casualty Analysis System (DCAS), which includes Active and Reserve Component casualties.
  - Without DCAS adjustment: veteran suicide rate = 108-119 per 100k
  - With DCAS adjustment: veteran suicide rate = 50-60 per 100k

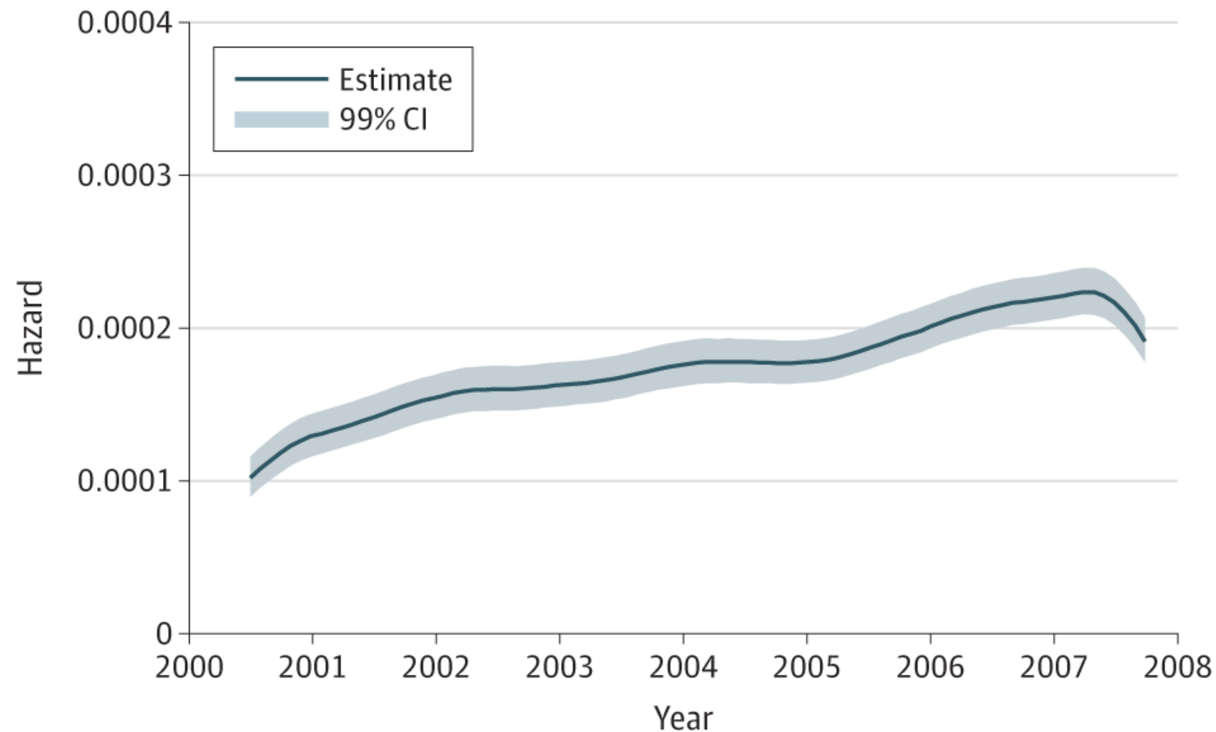
Huguet N, Kaplan MS, McFarland BH. The effects of misclassification biases on veteran suicide rate estimates.
Am J Public Health. 2014;104(1):151–155. doi:10.2105/AJPH.2013.301450.

However…

- The previous slide does not mean deaths did not occur.
- Instead, those deaths were among Active or Reserve Component military.
  - Active Component = active duty
  - Reserve Component = National Guard or Reserves
- Employers and Colleges/Universities: pay attention!
  - Reclassifying these suicide rates suggests there may be a larger than expected suicide issue among your Reserve Component students and employees.
  - Further research is required to understand Guard & Reserve suicide rates.

It was combat, wasn't it?

- Actually, no. Wartime deployment does not increase suicide risk.



One or more deployments was not associated with greater suicide risk.

An early discharge from military service was associated with elevated suicide risk. The cohort that was discharged prior to deployment showed the highest suicide risk.

Reger MA, Smolenski DJ, Skopp NA, et al. Risk of Suicide Among US Military Service Members Following Operation Enduring Freedom or Operation Iraqi Freedom Deployment and Separation From the US Military. JAMA Psychiatry. 2015. doi:10.1001/jamapsychiatry.2014.3195.

Our Largest Knowledge Gap in Suicide

- Our usual methods to study medical problems do not work.
  - Nonsensical and unethical to randomize study subjects to survive vs. suicide.
  - Suicide attempt survivors may be very different from non-survivors.
  - Despite appallingly high numbers, the absolute rate of suicide remains low and thus very difficult to study. Valid scientific conclusions about rare conditions require extremely large (i.e., expensive) studies.
- Population metrics become less useful as the granular increases
  - The "high risk" group includes young, single, Caucasian, males with chronic pain and a psychiatric disorder. That describes about 20% of my outpatients.

Important Messages

- The most important risk factor in suicide: mental health and substance use conditions.
- Even worse: untreated MH or SUD conditions.
- Don't let your family, friends, employees, colleagues, or students suffer with untreated conditions.
  - MH and SUD conditions are treatable and people get better every day.
  - They should go somewhere for help.
  - They don't need to come to the VA. About 42% of all OEF/OIF/OND veterans in NC don't use the VA. NC has excellent community resources.

Suicide: a useful tool

- Columbia Suicide Severity Rating Scale (C-SSRS)
  - Free to download and use from http://cssrs.columbia.edu.
  - Well-validated in multiple clinical studies.
- VISN 6 (VA mid-Atlantic Region) will begin using the C-SSRS soon.
- Aside from a careful clinical evaluation by a licensed mental health professional who knows a particular individual, the C-SSRS is the best available assessment of suicide risk.

The C-SSRS is Free, and it is the Best Available Tool

Did you write that down? Please do so now.

Download it from:

http://cssrs.columbia.edu

One Last Comment

- These individuals are not only your employees, students, or colleagues.

- They are your neighbors. The woman next to you at Bible study. The man you met at last week's PTA meeting. Please don't perpetuate the mass media myths about veterans.

- 1-800-273-TALK is the VA's National Crisis Hotline. Write it down today in case a buddy needs it tomorrow.

Thank you!

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