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Buddy-to-Buddy, a citizen soldier peer support program to counteract stigma, PTSD, depression, and suicide

John F. Greden,^{1,3} Marcia Valenstein,^{1,2} Jane Spinner,¹ Adrian Blow,⁴ Lisa A. Gorman,⁴ Gregory W. Dalack,¹ Sheila Marcus,¹ and Michelle Kees¹

¹University of Michigan Department of Psychiatry and Comprehensive Depression Center, University of Michigan, Ann Arbor, Michigan. ²Ann Arbor Veterans Administration Hospital, University of Michigan, Ann Arbor, Michigan. ³Molecular and Behavioral Neurosciences Institute, University of Michigan, Ann Arbor, Michigan. ⁴Michigan State University, Lansing, Michigan

Address for correspondence: John F. Greden, M.D., University of Michigan Health System, 4250 Plymouth Road, Ann Arbor, Michigan 48109. gredenj@umich.edu

Citizen soldiers (National Guard and Reserves) represent approximately 40% of the two million armed forces deployed to Afghanistan and Iraq. Twenty-five to forty percent of them develop PTSD, clinical depression, sleep disturbances, or suicidal thoughts. Upon returning home, many encounter additional stresses and hurdles to obtaining care: specifically, many civilian communities lack military medical/psychiatric facilities; financial, job, home, and relationship stresses have evolved or have been exacerbated during deployment; uncertainty has increased related to future deployment; there is loss of contact with military peers; and there is reluctance to recognize and acknowledge mental health needs that interfere with treatment entry and adherence. Approximately half of those needing help are not receiving it. To address this constellation of issues, a private–public partnership was formed under the auspices of the Welcome Back Veterans Initiative. In Michigan, the Army National Guard teamed with the University of Michigan and Michigan State University to develop innovative peer-to-peer programs for soldiers (Buddy-to-Buddy) and augmented programs for military families. Goals are to improve treatment entry, adherence, clinical outcomes, and to reduce suicides. This manuscript describes training approaches, preliminary results, and explores future national dissemination.

Keywords: citizen soldiers; peer-to-peer; PTSD; depression; suicide

Introduction

Forty percent or more of the approximate two million troops that have been deployed to military conflicts in Afghanistan and Iraq have been members of America's National Guard or military Reserve units.¹ These "citizen soldiers" experience traumas and stresses comparable to those encountered by active duty soldiers, such as battlefield conflicts and injuries; improvised explosive device explosions; deaths among fellow soldiers in their units; "downrange funerals" (a colloquial term used by some deployed military soldiers); and prolonged separation from loved ones.

The clinical and social consequences of these experiences include posttraumatic stress disorder (PTSD) symptoms, clinical depression, sleep dysregulation and nightmares, self-medication, substance use and abuse, and suicide thoughts, acts, and occasional tragic deaths by suicide. For some, co-occurring traumatic brain injuries confound the clinical presentation.^{2–5}

Military personnel experience major psychiatric disorders at rates comparable to the general population, but these rates increase following deployment.^{6,7} In one study, combat experience during Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) was significantly associated with use of mental health services and military attrition following deployment.⁶ Forty-two percent of citizen soldiers from Reserve and National Guard units report mental health issues suggesting the need for evaluation and possible treatment; yet, many do not initiate treatment.^{5,8} Only 54% of soldiers referred through the Post Deployment Health Assessment screening process subsequently followed

through with a mental health visit,⁶ and only 30% with identified need reported receiving minimally adequate treatment (adequate medication trial or at least eight psychotherapy sessions).⁵

Although research is needed to improve effectiveness of available treatments, innovative programs to overcome stigma and associated barriers to treatment entry and adherence are arguably as crucial.

Unique stresses and barriers to treatment entry and adherence among citizen soldiers

Citizen soldiers commonly encounter additional stressors or barriers that are different from active duty soldiers and interfere with entry and adherence into treatment. Perhaps most important is the inexorable stigma associated with seeking care. Although a common barrier to active duty soldiers as well, stigma may be even more difficult to overcome in community settings. Other postdeployment stresses include financial pressures and for some, income reductions; concerns about job availability or job security upon returning from deployment; home foreclosures; future prospects of being deployed; and absence of the readily available medical and psychiatric facilities that would have been available had they returned to an active duty military post. For those in rural areas, clinical services sometimes are available only at great distances, generating long travel times that make appointments difficult to keep. Finally, the dispersal and separation across large state regions and loss of everyday contact with military buddies mean that citizen soldiers do not have colleagues and comrades readily available for valuable sharing of experiences and support. A key consequence is that many of those needing professional treatment are reluctant, and far less likely to receive it unless these barriers are overcome; without treatment, clinical and functional deterioration is more likely.

This report does not focus upon specific treatment interventions for PTSD, depression, suicide, or their co-occurrence. Available treatments are described in detail elsewhere and extensive Department of Defense projects are under way to improve available treatments.⁹ Instead, we aim to describe refinements and innovations in peer-to-peer strategies to help counter the unique barriers faced by citizen soldiers to aid them in overcoming stigma and promote essential entry into and adherence with appropriate treatments.

Michigan Army National Guard: a prototype of citizen soldier in America

The Michigan Army National Guard's (MI ARNG) experiences illustrate the growing importance of citizen soldiers in ongoing military conflicts. Since 2001, around 90% of the approximate 9,000 members of the MI ARNG have deployed to Afghanistan and/or Iraq, many on multiple occasions. Citizen soldiers, as already summarized, manifest symptoms compatible with PTSD, depression, substance use, and interpersonal conflicts to a greater degree as active duty soldiers. Such symptoms are sometimes not evident until after significant time delays. Some returning soldiers also have manifestations of traumatic brain injury, sometimes referred to as a new signature injury in the OEF/OIF conflict.^{2,5} To help respond to these concerns and proactively address these "silent injuries," MI ARNG leaders forged collaborations with faculty and staff members of Michigan State University and the University of Michigan; steps involved in forging such collaborations are described in a separate report.9

A survey tool was used to understand the scope of veterans' problems and mental health needs. This survey was completed by 926 returning MI ARNG soldiers and spouses. Approximately, 40% of this sample screened positive for a mental health problem of some kind translating to approximately 3,500 of the 9,000 MI ARNG soldier force. Approximately, 8% of those assessed for a mental health problem reported suicidal thoughts (Table 1).

A crucial issue was identified: only 47% of returned citizen soldiers with reported clinical problems had sought any help. The most common reported reasons for not seeking help were linked to

Table 1. Reported reasons for not seeking help

- Do not want it in military records (27%)
- Unit leadership might treat me differently (20%)
- Too embarrassing (17%)
- Harm career (17%)
- Costs (15%)
- Do not know where to go to get help (6%)
- No providers in my community (6%)
- Transportation (5%)



Figure 1. Scope of problems among citizen soldiers and families: need for innovative peer-to-peer programs and national dissemination strategies. (In color in Annals online.)

stigma, fear of being seen as weak, concerns about confidentiality of military records, fears about damaging their future careers, and for a much smaller percentage, uncertainty about where to go for treatment or practical barriers in getting there.

Efforts to counteract these stigma barriers appear fundamental if we are to successfully identify and treat PTSD, depression, suicide, and related problems among returning veterans. Treatments can not work unless they are delivered; innovative strategies are required. A summary of the issues is portrayed in Figure 1.

Welcome Back Veterans: a private-academic-military partnership to address mental health problems of returning veterans

Responding to the well-reported problems of returning military veterans nationally, start-up philanthropic funding was provided in a national initiative known as "Welcome Back Veterans" (WBV) (www.welcomebackveterans.org). WBV leadership worked in partnership with Major League Baseball, the McCormick Foundation, and initially the Ad Council to generate funding. The University of Michigan, Weill-Cornell, and Stanford University were selected as three "WBV core centers" to help mobilize clinical outreach and national dissemination efforts to address some of the unmet needs of returning veterans. The aims were to integrate and disseminate gains and specialty knowledge from each university, coordinate with advances occurring elsewhere, and augment the veterans administration programs available to returning veterans. A University of Michigan team and a Michigan State University team collaborated with the leadership of the MI ARNG to design and implement an innovative peerto-peer program for returning soldiers. Although not the focus of this report, the University of Michigan team also forged accompanying strategies to reach out to families and children of MI ARNG citizen soldiers.

Buddy-to-Buddy: a peer-to-peer program for returning citizen soldiers

The collaborative team hypothesized that the crucial steps of counteracting stigma and improving treatment entry and adherence might best be enhanced by "using culture to change culture." When discussing their OEF/OIF deployments, many soldiers conveyed, that "if you haven't been there, you don't get it," "we believe in taking care of our own," and "other veterans can be trusted." For many, the nation's established system of medical and psychiatric programs and traditional clinical teams of medical, psychology, or social work leaders are not necessarily starting points. Correlative comments occasionally conveyed optimism, such as "another veteran who has been there may make it easier to get help." A logical extension of these observations led to the realization that when cultural barriers impeded treatment entry or adherence, peer-to-peer influences may be a crucial cultural starting point in overcoming them.¹⁰

For these reasons, university partners worked with the MI ARNG leaders and staff to develop what became known as "Buddy-to-Buddy." More detailed descriptions of Buddy-to-Buddy will be described in forthcoming publications. This manuscript aims to summarize Buddy-to-Buddy concepts, goals, acceptance, and dissemination to date; future steps required to confirm the clinical effectiveness of peerto-peer strategies; and future recommendations as to how this and other related programs may play crucial roles for returning veteran populations. We also hypothesize that these initiatives may be a valuable adjunct and foundation in efforts to reduce veteran suicides.

Buddy-to-Buddy components, goals, principles, and philosophies: a brief summary

Buddy-to-Buddy ensures contact with every returning MI ARNG soldier by using soldier peers. Trained peers regularly contact their assigned panel of soldiers to "check in," help identify those with clinical needs, encourage registration and entry into Veterans Administration Hospital (VAH) or military programs, and develop strategies to enhance enrollment in community treatment programs that are perceived as safe and acceptable should other alternatives be unworkable or unacceptable. In addition, soldier peers support adherence after starting treatment.

The program also seeks to identify and train selected community clinicians, orienting them to military culture and combat issues. This serves to enhance the resource pool and optimizes the likelihood for readily available interventions. These efforts build on earlier efforts initiated by Michigan State University and MI ARNG to emphasize collaboration with an array of quality providers, because community resources and a geographically dispersed network of clinical providers are essential to address the approximately 50% of citizen soldiers that need and would benefit from clinical intervention but are not currently receiving it. More such efforts are planned.

Consistent with military traditions, "buddies, families, and resiliency" became constant messages, accompanied by the messages of "you are not alone, treatment works, it has helped many of your buddies, and pursuing help is a sign of strength." Another major thrust sought to link veterans with other concrete resources they need to reduce stressors, such as employment benefits, housing, and financial guidance.

Creating and training the pool of Buddy Ones and Buddy Twos

A starting principle of the Buddy-to-Buddy outreach program was to ensure that all soldiers were contacted, not just the ones who were exhibiting clear and unmistakable signs of needing help. A twotier program was created. The first tier of peer-topeer, called Buddy Ones, consists of soldiers within each National Guard unit. The recruitment, operation, and oversight are provided by the MI ARNG. A second, smaller tier, called Buddy Twos or Volunteer Veterans, is operated by veterans outside of the Guard, and is overseen by University of Michigan staff.

"Buddy-One" individuals were identified for further training by their Chain of Command. They were chosen either by their position in the chain of command or because they were informal leaders of their units, depending on the preferences of the Command of each specific Battalion. Care was taken that peers supporters and their soldiers did not have great disparity in rank.

Training for Buddy Ones approximates 3 h and conveys the program rationale and philosophy, roles, communications skills, including what to do in case of emergencies, and an overview of resources of all types. A manual and quick reference cards were prepared and are distributed to Buddy One personnel. These are available online or upon request. Support and retraining are provided during drill weekends and ongoing consultation continues to be integral to refinements.

"Check-in" calls are incorporated into the design. A strong message for Buddy One personnel is that "your job is not to give help, it's to get help." Special strategies emphasize earlier identification of worrisome behavior, believing that those who know the soldier can assess whether something is wrong; legitimize seeking help; communicate knowledge of referral sources; and follow-up to aid adherence. Buddy Twos are veterans from outside the Guard who serve as back up for the Buddy Ones. They receive more intensive training in communication skills, including motivational interviewing, and become well-versed in both military and community resources that they can use as needed. The Buddy Twos staff the National Guard Armories statewide during drill weekends and serve as on-site resources to address concerns. Buddy Twos often help individuals navigate systems, such as the Veterans Administration in order to facilitate access. To date, approximately 350 Buddy Ones and 32 Buddy Twos have been trained.

Importantly, MI ARNG command leaders have been invested in identifying and supporting citizen soldiers with these "invisible injuries." Their leadership and partnership have been essential. Individual soldiers identified as potential Buddy Ones or Buddy Twos have been similarly invested, helpful, and committed to helping their returning veteran colleagues; their participation and suggestions were instrumental in planning, shaping, and implementing the program as well as suggesting modifications.

Buddy-to-Buddy: preliminary observations and evaluations

Among the Buddy-to-Buddy participants surveyed, 9 of 10 understand the intent of the program; approximately two-thirds are receiving regular calls from their Buddy and feel comfortable talking with their Buddy. More than half reported using resources or services suggested by their Buddy. In many cases, these were referrals for concrete resources, such as assistance with benefits, jobplacement services, financial assistance, or legal help. Of primary relevance to this report, more than 20% have been referred to formal treatment by their Buddy, reflecting previously unmet clinical needs. These referrals have been made to VAHs and Vet Centers, community-based mental health providers, military-sponsored agencies, such as Military One Source, and to community clinical resources. These referrals are in the process of being evaluated in greater detail and longer-term outcome evaluations are being proposed.

MI ARNG leaders and participants have endorsed these initiatives, conveying that they merge favorably with the fundamentals of National Guard culture. Predictably, not all returning citizen soldiers are likely to be responsive to peer-to-peer initiatives, but clearly more of those in need of treatment are being reached by this use of buddy culture. Even more would be reached with extensions of the program. Synergy with adjunct innovative strategies may be required to reach those not yet receptive to the Buddy-to-Buddy approach. Examples include family outreach programs, incorporation of respected speakers to help counteract stigma, and others.

Potential role of peer-to-peer programs in reduction of suicides among citizen soldiers

Rates of suicide in active military personnel have been increasing since 2003 and now surpass age- and gender-matched nonveterans. These increases have led to a fervent search for new interventions.¹¹⁻¹⁴ In a recent Department of Defense and Veterans Administration Conference on Suicide Prevention among Veterans, Shinsheki conveyed that of the approximate 85 deaths a day by suicide in America, about 18 are by veterans and most are not currently receiving treatment in the VAH.15

It is our hypothesis that the Buddy-to-Buddy program has strong potential to augment suicide prevention programs by applying the previously described, that is, the "use of culture to change the culture of treatment avoidance." Strategies would emphasize earlier identification of worrisome, threatening or self-injurious behaviors, knowing about referral sources, "helping show the way," and longer-term support of adherence to treatment once started.¹⁶

Determining whether suicide prevention efforts among returning soldiers are effective requires close attention to co-occurring diagnoses or comorbidities. PTSD and clinical depression commonly coexist among returning soldiers.^{17,18} Stresses during and after deployment play a role in both, and may precipitate both PTSD and/or major depressive disorder (MDD). MDD is the diagnosis most closely associated with suicide and its primary ages of onset (15-24 years of age) overlap closely with the age range for most soldiers and returning veterans.¹⁹⁻²¹ In the general population, 80% or more of those who die by suicide are struggling with MDD¹⁹; yet, depression often remains undiagnosed in all populations.²² Reasons are multiple: depressive symptoms may be mild and sporadic in early stages so they may be overlooked or attributed exclusively to external stresses. In some cases, symptoms may be clouded or "hidden" by co-occurring diagnoses. PTSD, for example, may have greater cultural acceptance in military populations than a diagnosis of depression, although this has not been adequately studied. Unfortunately, co-occurring clinical depression, when untreated, routinely evolves over subsequent years into an episodic, recurrent, worsening chronic illness that becomes more difficult to treat.²²

Because co-occurrence is the norm, concomitant treatment of all prevailing clinical syndromes should be the norm. Treatment of the individual citizen soldiers should be as comprehensive as possible, addressing all existing contributors. This includes PTSD, depression, sleep dysregulation, and substance misuse.

Another potential rationale for developing Buddy-to-Buddy type programs to aid suicide prevention is that the goals, culture, and strategies are parallel to those emphasized by suicide prevention programs encountered by veterans during their military deployments. Examples are ACE (Ask, Care, Escort),²³ ACT (Ask, Care, Treat),²⁴ and R.A.C.E. (Recognize, Ask, Care, Escort)²⁵.¹⁰

In essence, we hypothesize that coupling Buddyto-Buddy or comparable documented peer support programs with evidence-based treatment interventions would help address many untreated individuals; improve entry and adherence into treatment; accelerate clinical improvements by enabling exposure to effective treatments for PTSD, depression and other risk variables; and hopefully reduce suicides for returning veterans. Lessons learned to date are summarized in Table 2.

Augmenting strategies: family outreach and use of spokespersons

Survey data indicate high levels of parenting and marital stress at the time of reintegration. In addition, spouses uniformly report a desire to have increased support during deployment, suggesting

Table 2. Buddy-to-Buddy program summary highlights

- *Similar risks:* Citizen soldiers struggle with PTSD, clinical depression, sleep dysregulation, substance use disturbances, and increased risk of suicide upon returning from deployment at rates comparable or greater than active duty soldiers. Comorbidity (co-occurrence of one or more diagnostic syndromes) is the norm, not the exception.
- Unique barriers and stresses: Citizen soldiers encounter additional stresses and unique hurdles to receiving treatment upon returning to their community, including financial and family stresses, stigma, unavailability of treatment resources, and separation from military support systems. Stigma remains formidable.
- *Inadequate treatment entry and adherence:* Only about half of those in need enter treatment. Overcoming stigma-related barriers is an essential first step for these returning citizen soldiers if clinical help is to be provided and suicides and other problems prevented.
- *Prevailing culture is a barrier:* Advice to seek treatment often ignored. The prevailing culture remains "If you haven't been there you don't get it."
- "Buddy-to-Buddy:" using culture to change culture: Buddy-to-Buddy uses military culture to change the stigma culture; peer-to-peer appears to be a powerful approach to addressing stigma and associated barriers.
- Goals of Buddy-to-Buddy are to get help, not to give help.
- *Private–Public–Academic–Military partnerships are fundamental:* When dealing with citizen soldiers in the National Guard and Reserves, collaborations, mutual respect, and understanding are essential. Involvement of military leadership is fundamental at all stages.
- *Buddy-to-Buddy may aid suicide prevention:* studies are required but treatment entry is essential if treatments are to work.
- *Dissemination strategies are needed:* Because of national scope, dissemination strategies must be developed. Multiple voices must be recruited to help counteract stigma. Emerging clinical networks are positioned to aid and would greatly accelerate dissemination strategies.

that early interventions both preceding and during deployment may reduce symptom severity in spouses. Such interventions also could target risk factors for parenting and marital strain. These prevention strategies might reduce marital dyadic and parenting stress upon reintegration, in turn reducing stresses impacting the soldier. Moreover, providing spouses with resources needed for their own symptoms often serves as a motivation for spouses to encourage their soldier partners toward intervention.

Other trusted spokespersons similarly can be recruited and educated in mental health literacy to help destigmatize these silent brain injuries, and to emphasize the importance of early treatment and maintenance of wellness, support systems, and suicide prevention strategies. They often are equally valuable in helping community members understand the problems being faced by returning veterans. These may be celebrities, athletes, politicians, or local citizens willing to lend their voices to help educate the public while simultaneously decreasing stigma.

Future recommendations

Citizen soldiers live in coexisting cultures. They are military personnel who spend most of their lives in civilian settings. They have played crucial roles in ongoing military conflicts. During deployment and postdeployment, they experience similar clinical problems to active duty soldiers, but upon returning home often lack the available support systems of military posts. Although Veterans Administration and community resources are available for most, among many there is prevailing reluctance to use them. A major national initiative is needed to enable a far greater percent of returning citizen soldiers with mental health problems to break through their internal resistance, enter, and hopefully benefit from available treatments.

We strongly recommend that Buddy-to-Buddy be thoroughly evaluated for efficacy and that if it is effective in improving soldier outcomes, that it be disseminated nationally, national training programs be launched, efforts be linked with evaluation outcome assessments, and proxy serial evaluation measures be used when seeking to evaluate possible suicide risk.^{11,21} Suicide has a low base rate so truly large samples must be studied, accompanied by serial assessments of suicide ideation, acts, prior history of suicide attempts, and identification of well-documented risk variables, such as depression, PTSD, substance abuse, and sleep dysregulation. Dissemination predictably can be accelerated if already existing national networks are incorporated into these academic-military-community partnerships.

We also recommend that flexibility and individual preference be recognized as important variables when seeking to get reluctant individuals into treatment. Stigma promotes strong recalcitrance to treatment, so it may be essential to match referral resources to the veterans' and family members' preferences. Motivational interviewing can be used effectively as an approach to encourage treatment entry.²⁶ Finally, to maintain follow-up when geographic barriers exist, telemedicine interventions may be essential.^{27,28}

The strategy we are emphasizing uses trusted fellow veterans (buddies) and augmenting supporting personnel as allies to improve treatment entry and adherence. Evidence to date indicates that this approach may help many overcome prevailing stigma. Consistent with both military culture and centuriesold clinical values, the goals are that no citizen soldiers will be left behind and that those struggling with invisible wounds of war will be welcomed back to a healthier future.

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Conflicts of interest

The authors declare no conflicts of interest.

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Working Together to Meet the Needs of Army National Guard Soldiers: An Academic-Military Partnership

Gregory W. Dalack, M.D. Adrian J. Blow, Ph.D. Marcia Valenstein, M.D., M.S. Lisa Gorman, Ph.D. Jane Spinner, M.S.W., M.B.A. Sheila Marcus, M.D. Michelle Kees, Ph.D. Susan McDonough, Ph.D. John F. Greden, M.D. Barbara Ames, Ph.D. Brig. Gen. Burton Francisco Brig. Gen. (Ret.) James R. Anderson, Ph.D. Col. James Bartolacci Maj. Robert Lagrou, D.O.

The conflicts in Afghanistan and Iraq have greatly increased the number of veterans returning home with combat exposure, reintegration issues, and psychiatric symptoms. National Guard soldiers face additional challenges. Unlike active duty soldiers, they do not return to military installations with access to military health services or peers. The authors describe the formation and activities of a partnership among two large state universities in Michigan and the Michigan Army National Guard, established to assess and develop programming to meet the needs of returning soldiers. The process

of forming the partnership and the challenges, opportunities, and benefits arising from it are described. (*Psychiatric Services* 61: 1069–1071, 2010)

The mental health needs of U.S. military veterans returning from Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) are substantial: 25%–40% of veterans returning from these conflicts report significant mental health symptoms or interpersonal difficulties (1,2). Psychiatric morbidity, particularly posttraumatic stress disorder (PTSD), depression, and substance use disorders, has a significant impact on these soldiers' mental and general health status, role functioning, and employment (3).

High rates of suicide among veterans have become a pressing concern (4), as have family difficulties (5) and the stigma surrounding the use of mental health services (1). Improved screening, facilitated connection to services, and increases in the availability of evidence-based treatments are needed. To achieve this, a coordinated response from military, U.S. Department of Veterans Affairs (VA), academic, and community organizations is necessary. Partnerships among these groups can facilitate the engagement in treatment of soldiers and families, provide evidence-based services, and expand the evidence base to improve outcomes (6,7).

During several periods of the OEF and OIF conflicts, National Guard soldiers have constituted between 40% and 50% of U.S. fighting forces (8). Most National Guard soldiers do not return to guaranteed employment and do not live on or near military installations. They return to civilian communities, where they rapidly reintegrate into the civilian workforce and depend on their community's supports and mental health services. For these citizen-soldiers, additional innovation is required in developing and providing services.

In Michigan, the Michigan Army National Guard (MIARNG), the VA, and university faculty from Michigan State University (MSU), and the University of Michigan (UM) initially had separate efforts to assist returning National Guard soldiers. Over the course of four years, an increasingly close and active partnership was forged to jointly assess and meet the needs of returning MIARNG veterans and their families. In this column, we describe how we have worked together on projects aimed at assessing soldier needs and assisting with reintegration. We also discuss challenges and obstacles faced when forming the partnership and our continued efforts to synergize.

Initial steps

Before the September 11, 2001, attacks, MIARNG's concerns were fo-

Dr. Dalack, Dr. Valenstein, Ms. Spinner, Dr. Marcus, Dr. Kees, Dr. McDonough, and Dr. Greden are affiliated with the Depression Center, Department of Psychiatry, University of Michigan, 4250 Plymouth Rd., Ann Arbor, MI 48109 (e-mail: gdalack@umich.edu). Dr. Valenstein is also with the Department of Veterans Affairs, Ann Arbor Healthcare System, Ann Arbor, Michigan. Dr. Blow, Dr. Gorman, and Dr. Ames are with the Department of Human Development and Family Studies, Michigan State University, East Lansing. Brig. Gen. Francisco, Brig. Gen. (Ret.) Anderson, Col. Bartolacci, and Maj. Lagrou are with the Michigan Army National Guard, Lansing. Lisa B. Dixon, M.D., M.P.H., and Brian Hepburn, M.D., are editors of this column.

cused on enlisting, training, and equipping a strategic reserve force. After September 11, 2001, MIARNG became increasingly aware of the challenges faced by their civilian soldiers returning from OIF and OEF deployments. A new, emerging, and critical focus for the National Guard became the reintegration of soldiers after return from deployments.

Linkage with MSU

The collaboration between MIARNG and MSU was the result of a graduate student's (LG) interest in military families. Her research interest was supported by faculty from the Departments of Human Development and Family Studies, Epidemiology, and University Outreach and Engagement. A conference meeting in 2005 between MIARNG leaders and MSU faculty and graduate students led to a collaboration to develop and deliver programming during weekend reintegration events that followed unit demobilization and to develop referral options for community resources where needed. Activities like these are part of the military's Yellow Ribbon program to support soldiers and their families throughout all phases of the deployment cycle.

MIARNG launched its first twoday reunion and reintegration workshop for soldiers and their supporters in 2006. These workshops were implemented with a small staff from the state family program office, chaplain support, faculty and clinical interns from MSU, and volunteers from the private sector. These two-day events, held at a retreat location approximately 45 days after the MIARNG soldiers' return home, aim to assist soldiers and their supporters with reintegrating back into civilian work, family, and community life. Attendance is mandatory for soldiers and optional for family. Programming includes education about depression, suicide, PTSD, addictions, traumatic brain injury, and information about community resources and entitlements. In facilitated process groups, soldiers and their families have an opportunity to talk openly about their reintegration experiences.

In 2007, with the support of an internal MSU grant, survey data were collected at these weekends to understand how MIARNG soldiers and their families were faring postdeployment. These data were summarized and discussed with MIARNG leadership to guide and change programmatic efforts. Further input came from members of the MIARNG-MSU collaboration, who were all actively involved in delivering programs. Additional input was gained from two Vietnam veteran advocates who were active in reintegration weekends and provided informal peer outreach to soldiers.

Linkage with UM-VA

UM Medical School faculty, several of whom also had appointments with the VA Ann Arbor Healthcare System, became involved with the MIARNG and MSU faculty in the summer of 2008. UM activity was spurred in 2007 by a U.S. philanthropist with ties to the UM. His initiative ("Welcome Back Veterans" [WBV]), sought to involve the general population in a nationwide campaign to support Centers of Excellence in developing and providing services for returning OIF and OEF veterans. WBV partnered with Major League Baseball and the Mc-Cormick Foundation to administer procured funds through its gift and grant process.

UM-VA faculty initially planned to develop an inventory of current service activities extant in 2007 for veterans in Lower Michigan. The information gathered made UM-VA faculty aware of the broad array of community initiatives that were already in place but not accessible in a centralized location.

These efforts were aided by the liaison activities of a UM psychiatry fellow (RL) who was also a member of MIARNG. Through him, UM-VA project leaders became aware of MIARNG's work with MSU and the reintegration workshops. MSU colleagues and MIARNG leadership were consulted about their programming preferences, and a grant was funded through the WBV-McCormick Foundation initiative, which provides important seed monies to develop a more systematic peer-outreach program and additional family initiatives for MIARNG veterans.

Partnership building

Utilizing the principles of community-based participatory research (9), group members from each institution met regularly so each party could contribute to developing a shared mission, setting goals and priorities, and developing new programming for returning soldiers. This group also provided oversight for program implementation and evaluation. MSU and UM-VA staff regularly attended reintegration weekend events to spend time with MIARNG soldiers and to facilitate breakout groups. In addition there were joint UM-VA and MSU brainstorming sessions, regular in-person monthly meetings with all group members, and numerous emails or telephone conference calls among collaborators.

Challenges in forming the partnership included the National Guard ethos that it was "important to take care of our own" and feeling besieged at times by offers of assistance from disparate community groups. The relatively flat management structure and informal atmosphere of academic departments also contrasted with the hierarchical military structure. Guard leadership were sometimes frustrated about who was "in command" in the university structure or bristled when academics accessed high-level officers without "going up the chain of command." In addition, both the MIARNG and WBV sponsors were reluctant to consider the idea of conducting research evaluations as part of program development. It was clear that research was secondary and would need to follow program implementation. Trust was facilitated through forming a clear joint agenda and repeatedly demonstrating commitment and respect.

As the partnership evolved, it became clear that the academics had a new opportunity to deliver services designed to have a direct impact on a population in need. In turn, the National Guard found that the academics had useful knowledge about mental health treatment and program evaluation. Academic partners also had expertise in writing grant applications, which brought more resources to MIARNG programs.

Collaborative activities

Surveys and needs assessment UM-VA and MSU combined evaluation activities to further inform intervention development. They documented baseline symptoms and services used by sequential waves of MIARNG soldiers. Surveys also asked about soldiers' treatment preferences, assessing to whom soldiers turned when they experienced mental health symptoms or other life difficulties. These data informed programming needs and allowed MIARNG to obtain funding for services from higher National Guard echelons.

A comprehensive compilation of community agencies and providers was developed, including information about experiences and expertise in treating military populations, fees and insurances, and types of treatment offered. This guide was distributed to National Guard personnel.

Family programming initiatives

Family programs that focused on parenting, family reintegration, and dealing with stress were offered at reintegration events. Additional predeployment programming was included to prepare families for their loved one's deployment and to connect them to services, providers, and other families with similar experiences.

Peer outreach and linkage

Based on MIARNG programming preferences and the military culture that supports "leaving no one behind," a proactive, systematic peeroutreach and linkage program, called Buddy-to-Buddy, was developed. Peer outreach was thought to be well suited to address the stigma associated with treatment seeking. A UM-VA faculty member (MV) with expertise in developing peer support programs with veterans and other populations led the planning. Also involved were the two Vietnam veteran peer advocates. Their prior activities and influence throughout the MIARNG helped the new program gain acceptance. Buddy-to-Buddy was implemented in January 2009 for returning MIARNG soldiers. Each returning soldier is assigned a firsttier Buddy (Buddy One) from within the same unit. Buddy Ones are trained in communication techniques and systematically telephone returning soldiers in their panel to identify those who may benefit from further evaluation. Soldiers and Buddy Ones also are able to access second-tier Buddies, who are volunteer veterans trained in motivational interviewing techniques, are well versed in VA and other local mental health resources, and receive regular supervision by UM staff. Buddy Two volunteer veterans help soldiers who might be ambivalent about care, have difficulty accessing treatment resources, or require more complex treatment coordination.

Effectiveness evaluation

After services projects were implemented, a joint research agenda began to be developed. On the basis of the collaborative's priorities, research applications to more rigorously evaluate the Buddy-to-Buddy program were submitted and funded by the VA Health Services Research and Development office.

Lessons learned

The important mental health needs of returning soldiers and their families attract the interests and energies of a wide range of professionals. Collaboration required flexibility and humility to adapt and change initial individual and institutional aims into joint aims.

We recognized the need to integrate different cultures. The academic institutions had similar aims for their respective involvement, but their institutional cultures differed in some ways. The goals and timeline of the MIARNG were dramatically different from those of either academic partner, and the MIARNG had a culture less tolerant of the research focus and leadership ambiguities that typically characterize academic endeavors. The final product has benefited from these somewhat disparate cultures: program development and implementation moved at a more rapid pace than is typical for academia, and an evaluation and research component has been developed to a greater extent than might ever be planned by a military organization. It was critical to establish trust between university partners and the MI-

ARNG, including all levels of commanders and civilian staff working in the family programs office. There has been no substitute for ongoing faceto-face work to blend efforts and achieve mutually desired goals.

The joint mission and shared gratification in working effectively to assist returning soldiers and their families have sustained and enhanced the motivation and energy of each team member and continually fueled the collaborative's resolution to work together to meet the needs of soldiers and families who have given and sacrificed so much to serve their country.

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OUR RETURNING TROOPS COME HOME TO FAMILIES WHO HAVE LEARNED TO MANAGE WITHOUT THEM, JOBS THAT MAY HAVE DISAPPEARED, COMMUNITIES THAT DON'T UNDERSTAND WHAT THEY'VE BEEN THROUGH, AND SERVICES THAT THEY MAY NOT EVEN BE AWARE OF, MUCH LESS KNOW HOW TO ACCESS.

BY JEFF MORTIMER \bigstar Illustration by C.J. Burton \bigstar Photography by scott Galvin



OR MOST OF THE LAST CENTURY, nearly all of the troops in America's wars have been military service members on active duty. For most of the last decade, upwards of 40 percent of the troops in Iraq and Afghanistan have been either members of the National Guard or reservists called to active duty.

When these soldiers are demobilized, they usually don't return to a military base, where there are support services onsite and peers who can empathize with the stresses they've endured. They are prime candidates for depression, posttraumatic stress disorder, sleep disturbances, substance abuse and other mental health problems. And the reluctance that many civilians feel about seeking assistance is reinforced by the military's culture of "we take care of our own."

Helping them get help by countering entrenched beliefs and working through that remaining stigma is a key mission of the University of Michigan's portion of Welcome Back Veterans (WBV), a national initiative to address the reintegration challenges of these returnees.

"Once you meet the people who are coming back, you get very involved," says Marcia Valenstein, M.D., an associate professor of psychiatry. "You realize how much we're asking from these people and their families."

Valenstein is also a clinician and researcher at the Veterans Administration Ann Arbor Healthcare System, director of the U-M Depression Center, where the program is housed.

Helped considerably by Major Robert Lagrou, a member of the National Guard who was also a child psychiatry resident at the U-M, the Depression Center and psychiatry department — and Michigan State University, a frontrunner in such efforts — had been talking with the Michigan Army National Guard about what kind of programs might be most helpful to them. The guard expressed a particular interest in peer outreach and linkage. Valenstein was already involved in a project within the VA where people who were in treatment for depression are enlisted to support each other in addition to receiving their regular treatment. "The new initiative applied the same soldier-to-soldier concept in a new way," she says.

There are two tiers of "buddies" in the system.

Buddy Ones are individuals within each returning unit who are trained in communication skills and recognizing signs of difficulty, and charged with staying in regular contact with seven to 10 of their comrades. "The thought was that these were the people they deployed with, know well, and trust most," says Valenstein. "Their buddies check in on how they're doing in the same way you might check in on a friend who has had a difficult experience."

If there are, indeed, signs of trouble, the returnee can be referred to a number of resources, including a

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THE RELUCTANCE THAT MANY CIVILIANS FEEL ABOUT SEEKING ASSISTANCE IS, IN THE CASE OF RETURNING SOLDIERS, REINFORCED BY THE MILITARY'S CULTURE OF 'WE TAKE CARE OF OUR OWN.'

where many physicians hold a joint U-M faculty appointment. Because of her considerable experience with peer interventions there, Valenstein was asked to help write the application for WBV funding and has been instrumental in devising and implementing a program called Buddy-to-Buddy under the initiative's auspices.

"The whole premise was that no one can be a more credible source of both support and overcoming the stigma around asking for help than another veteran who's been there," says John Greden, M.D., the Rachel Upjohn Professor of Psychiatry and Clinical Neurosciences and executive Buddy Two, one of a group that's also known as Volunteer Veterans. Buddy Twos receive intensive training in interviewing techniques and how to access resources. They can maintain confidentiality because they are not affiliated with the National Guard or governed by its chain of command.

These volunteers aren't required to have served overseas or in combat, but the overwhelming majority of them have, according to Brandon Brogan, the Buddy-to-Buddy program coordinator. "Soldiers returning from Iraq and Afghanistan are far more likely to open up to those who know what it's

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like to come home and try to transition back," he says.

Brogan knows whereof he speaks. He's an ex-Marine who served three tours of duty in Iraq.

"I got out a little over two years ago and know what it's like to return home and try to create a life out of nothing," he says. "I was pretty much on my own. I did a fair amount of research to make sure I knew where to go to get my GI bill started and how to get VA medical care, but it was quite time-intensive and not everyone is able to do that."

While buddies are briefed on the availability of a range of services from housing to employment, encouraging veterans to seek assistance with psychosocial difficulties carries an added degree of complexity.

The military has a stigma regarding mental health, Brogan says, and this is a way of breaking down that stigma. "The leadership in the military sees the issues and will admit they're there, but getting guys on the ground level to admit they have a mental health issue is a completely different thing."

"What we would hear from people was, 'If you haven't been there, you don't get it,'" says Greden. "If you can find the right soldiers — people they identify with, people they served with — the simple message is, 'You're not alone, treatment works, it's a sign of real strength to get help. I would like to help you do that. I'll even go with you. Let's do it.'"

According to Brogan, they have definitely found the right group of veterans.

"We have a fantastic group of volunteers that go above and beyond any expectation," he says. "It's humbling to see the work these guys do. A lot of them are Vietnam veterans who definitely weren't supported when they got home, and they're dedicated to seeing that doesn't happen to these veterans."

That dedication includes attendance at monthly drill weekends, which both Brogan and Valenstein cite as a major step forward. Once guard members see the volunteers on a regular basis, they get to know them as interested, concerned citizens who are knowledgeable about resources. They have credibility in advance of any need for their assistance.

"We had to develop trust with the Michigan Guard before we could have the volunteer veterans go to the drill weekends," says Valenstein.

INVISIBLE INJURIES

HE LONG-STANDING LINK BETWEEN the U-M and the VA is an obvious one, and it began to take on an added dimension when Greden got a phone call from Fred Wilpon, a Michigan alumnus and donor. "I think we actually talked on a Saturday," says Greden, "which is an indication of how much someone cares about a topic."

Wilpon and others interested in the problems being faced by returning veterans had visited Walter Reed Army Medical Center in Washington. He came away impressed by the sophisticated care that patients were receiving for their physical injuries, but distressed at what he saw as the despair and demoralization among those who were coming back with "invisible injuries" — post-traumatic stress disorder, depression, suicidal thoughts, sleep disturbances.

"The VA is a wonderful system that's delivering terrific care," Greden says, "but not everyone can access a VA facility, some are not eligible, and some prefer to go outside the VA for care. The idea was to get some of the interested

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"THE WHOLE PREMISE WAS THAT NO ONE CAN BE A MORE CREDIBLE SOURCE OF BOTH SUPPORT AND OVERCOMING STIGMA AROUND ASKING FOR HELP THAN ANOTHER VETERAN WHO'S BEEN THERE."

universities who had expertise in this area to start working together with the VA to really jump into this."

WBV was launched late in 2008 with funding from several organizations, including the McCormick Foundation and Major League Baseball Charities. Later, funding was supplemented by the Department of Veterans Affairs. Of the initial



universities to receive WBV grants, Michigan chose a path that led to the Buddy-to-Buddy program. "Michigan's belief was that addressing stigma issues was necessary before you could get people into treatment programs, no matter how effective those programs were," says Jane Spinner, who oversees the veterans project for the Depression Center. "We chose to help address those challenges through the peer-to-peer approach, using military culture to help change the culture. This program fit well with the expertise of our faculty and our Depression Center mission."

The team members recognized that even though many troubled returnees were isolated in terms of access to services, their problems did not exist in isolation, nor could they be addressed that way. Strong Families, in effect a support program for supporters of soldiers, was created to focus on that need.

"We're doing a more intensive parenting intervention for the military service members who have young children because the impact on children is particularly worrisome," Spinner says, "and we saw that the reintegration challenges faced by military families are just as significant as those of the returning veterans."

Not surprisingly, all of those challenges are intertwined. Every member of a soldier's family is affected by deployment, and their responses affect the soldier.

"What we've found is that both the parent-child dyad and the marital dyad tend to be pretty fragile in these families," says Sheila Marcus (M.D. 1983, Residency 1991), professor of psychiatry and head of the child and adolescent psychiatry section, who leads the Strong Families team. "They really suffer because of the separation and reunion."

Strong Families participants attend eight weekly sessions. After a welcoming meal, the children participate in activities supervised by social workers and psychologists, while the moms and dads go to a parenting course that includes information about sensitivity to children's cues, attachment security issues, self-care skills like deep breathing and meditation, and the availability of services, as well as interactions with other families who have been through the deployment cycle.



Marcus' team also runs support and education groups for parents at the pre- and post-deployment weekends that the VA offers its members and their families, and is about to launch a series of workshops for spouses that will take place during deployment.

There's already evidence that these efforts are paying off, according to Spinner. "We're just analyzing the data now," she says, "but it appears as if we have worked with very distressed families who have greatly benefited in terms of both the marital relationship and parenting skills."

BRIDGING CULTURE GAPS

UCCESSFULLY LAUNCHING THESE programs required navigating the differences between the military culture's emphasis on speedy implementation and a clearly defined chain of command, and academia's more deliberate pace and fluid leadership structure.

Moreover, says Greden, "Sometimes those of us in university settings think inaccurately that we provide every answer, and sometimes those in military units don't necessarily want to acknowledge they're not meeting all the needs. But we've managed to build really strong partnerships across the boundaries of the military leadership, the VA, and the academic units. We're pulling it off — Afghanistan and Iraq veterans are getting better access to resources because we've been able to work our way through things."

It took only eight weeks for Valenstein and her associates

to get the Buddy-to-Buddy program started, although it took far longer to get the program fully implemented and embedded. Early on, the Michigan Army National Guard sought and received funding for the Buddy One portion of the program and later assumed full responsibility for running it. The U-M continues to operate the Buddy Two tier, whose members helped about 350 of their peers in 2010, but the number of veterans touched by the U-M's work will soon be vastly higher as more volunteer veterans are trained and attached to units.

A prior VA-funded study by Valenstein of suicide among veterans had shown that veterans with mental health problems were at their highest risk for suicide in the period immediately following hospital discharge. She notes that there is now more structural support and close followup for veterans after discharge. Buddy-to-Buddy extends support to soldiers who may not have full-fledged mental health difficulties, but need support for successful reintegration. This, in turn, may prevent more severe difficulties from emerging.

"Intriguingly, I think, the military right now is far more invested than in the past in partnering with other organizations," says Greden. "It's trying to work with civilian resources and communities, and the military leadership has gone out of its way to try to build bridges with academic settings."

The results so far are more than merely promising.

"When I found out about this program and the concept behind it — using veterans as advocates for other veterans it made so much sense," says Brogan, "but I'm still surprised at how effective it is." [M] MORE ON THE WEB #

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