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MENTAL HEALTH AND MILITARY

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Abstract

This study mental health and military. The present research has studied the mental health of soldiers. The mental health of a soldier defending the country is essential. One who is physically, mentally, and socially strong can render good service to the country. Because being physically strong does not mean good health but one should be mentally and socially strong. So this topic was selected.

Introduction

It is also important to recognize that neither physical nor mental health exist separately – mental, physical, and social functioning are interdependent (WHO 2004). Furthermore, all health issues need to be considered within a cultural and developmental context, as do the social constructs of childhood and adolescence (Walker 2005). The quality of a person's mental health is influenced by idiosyncratic factors and experiences, their family relationships and circumstances, and the wider community in which they live (WHO 2004). Additionally, each culture influences people's understanding of, and attitudes towards, mental health issues. However, a culture-specific approach to understanding and improving mental health can be unhelpful if it assumes homogeneity within cultures and ignores individual differences (WHO 2004). Culture is only one, albeit important, factor that influences individuals' beliefs and actions (Tomlinson 2001; Dogra 2003). Interaction between different factors may lead to different outcomes for different individuals.

"Mental health is a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community."

Mental health literacy Finally, in this section, it is also worth considering how the mental health 'literacy' of adults and children in the general population varies from that of professionals. In all phases of a recent research project, conceptual confusion was identified in the literature review and among adolescent participants (Leighton 2006, 2008). Focus group participants did not find the single continuum model suggested by the WHO (2000) helpful (Leighton 2006). Furthermore, in the focus group feedback session, participants suggested that labelling serious mental illnesses such as

schizophrenia and major depression, as 'mental health problems', diminishes the seriousness of mental illness, with implications for attitudes towards, and treatment of, those with mental illness (Leighton 2006). It is also evident that there is considerable confusion for young people between the terms 'mental health', 'mental illness' and 'learning disability' (Dogra et al. 2007; Rose et al. 2007). However, whatever terminology is used, the scale of individual suffering from mental health problems and illness is significant, and this is now briefly outlined.

Review

Oldham, John MD (2014) study of Mental Health Needs in the Military results of a survey sent to mental health clinicians in the Army to investigate the status of mental health treatment access and quality. Although only 26% of those surveyed responded, the good news is that the majority of the clinicians felt that they had sufficient time with patients and the ability to set follow-up frequency in a way that met the patients' needs. In contrast, however, the majority of the clinicians felt that access to appropriate care for families of the service members was insufficient, identifying an important unmet need. Also in this issue, From son and colleagues remind us that returning veterans often seek help from clergy; the authors report that an educational event about trauma-induced conditions designed for the clergy can improve their understanding of these concerns. In a separate report, Levitt provides a primer on the culture of the military as a guide for civilian mental health providers who treat active duty members of the military—a particularly important goal since significant numbers of the military who have returned from combat duty and are willing to seek treatment are cared for by civilian providers.

C. Hoge, C.G. Ivany, E.A. Brushner, M.D. Brown, J.C. Shero, A.B. Adler, D.T. Orman (2016) Transformation of mental health care for U.S. Soldiers and families during the Iraq and Afghanistan wars; where science and politics intersect. The cumulative strain of 14 years of war on service members, veterans, and their families, together with continuing global threats and the unique stresses of military service, are likely to be felt for years to come. Scientific as well as political factors have influenced how the military has addressed the mental health needs resulting from these wars. Two important differences between mental health care delivered during the Iraq and Afghanistan wars and previous wars are the degree to which research has directly informed care and the consolidated management of services. The U.S. Army Medical Command implemented programmatic changes to ensure delivery of high-quality standardized mental health services, including centralized workload management; consolidation of psychiatry, psychology, psychiatric nursing, and social work services under integrated behavioral health departments; creation of satellite mental health clinics embedded within brigade work areas; incorporation of mental health providers into primary care; routine mental health screening throughout soldiers' careers; standardization of clinical outcome measures; and improved services for family members. This

transformation has been accompanied by reduction in psychiatric hospitalizations and improved continuity of care. Challenges remain, however, including continued underutilization of services by those most in need, problems with treatment of substance use disorders, overuse of opioid medications, concerns with the structure of care for chronic post deployment (including post concussion) symptoms, and ongoing questions concerning the causes of historically high suicide rates, efficacy of resilience training initiatives, and research priorities. It is critical to ensure that remaining gaps are addressed and that knowledge gained during these wars is retained and further evolved.

Discussion

Hoge at all.

(1) for their thoughtful Review and Overview Article, published in the April 2016 issue of the Journal, of military mental health care post-9/11. They present major clinical and policy initiatives, unapologetically discuss need for improvements, and outline a path forward. We are reminded that the Military Health System is a large, complex, and global system that is distinct from the U.S. Department of Veterans Affairs. Nearly 10 million Military Health System beneficiaries (including uniformed service members, their families, and retirees) receive direct health care services delivered at more than 300 military treatment facilities or are eligible for third-party (Tricare) health insurance reimbursement. A National Research Action Plan

(2) calls for health services research, and many recommendations from a recent Institute of Medicine report on posttraumatic stress disorder in military members and veterans

(3) are grounded by findings in the health services literature. For example, key elements of successful integrated care models for mental health include accountability, measurement-based care, decision support tools, proactive follow-up, and real-time use of disease registries. Care can improve with better integration of services

(4) These elements allow for a paradigm shift at the health systems level and can be continuously refined, evaluated, and tested through research. Positive findings from efficacy trials offer promising signals, but design limitations often prevent ready-to-implement solutions that address major mental health service delivery issues such as access, continuity, quality, equity, effectiveness, efficiency, and cost of care. These issues, as Dr. Hoge and colleagues' seminal and ongoing work reminds us, remain central Military Health System challenges. There is much to learn across the Military Health System about how to optimize care, deliver innovations, and develop models of care for testing. We cannot rely on evidence gathered from non-military health care settings or from academic medical centers alone. Collaborations with patients, providers, and clinic leaders within the Military Health System

may help identify areas for future inquiry and pragmatic evidence-supported solutions. In this way, and to ultimately reduce the science-to-service delivery gap, a learning health care system.

(5) for military mental health is created, which seeks to develop, study, implement, and reimburse for services in highly variable and often unusual settings. Such information can also be useful to others seeking mental health services in non-military settings.

CONCLUSION

Treating active duty and veteran military personnel can involve complex clinical and occupational decisions. It can be difficult to determine when what is reported is true, when adequate levels and the right types of treatment have been utilized, and when there is sufficient distress/ dysfunction to warrant changes in diagnosis, treatment, and occupational status. More research is needed to best understand and care for service members with psychiatric disorders, both their mental health and their careers.

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