Health of Military Families

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LETTER FROM THE EDITORS

During his second Inaugural Address Abraham Lincoln appealed to a divided nation: “[L]et us strive to finish the work we are in, to bind up the nation’s wounds, to care for him who shall have borne the battle and for his widow and his orphan…” In 2010 we are a nation still struggling to heed Lincoln’s call. While the conditions of war have changed dramatically since 1865, we still seek to heal wounded service personnel and to serve their family members.

Most military families are resilient and adapt to the unique circumstances of military life, which include family relocation, as well as separation and reunification with an active-duty family member. Military families face the same kind of financial and emotional stressors as civilian families, but the magnitude and the etiology of their stressors may be unique. For example, military families are more likely than civilian families to experience the death, prolonged illness, or disability of a young or middle-aged loved one. As deployments get longer, children in military families may move through important developmental periods without one—and sometimes both—parents at home. Military family members may also be exposed to negative and stigmatizing cultural norms about military engagement that could affect their ability to feel integrated in their communities, schools, and workplaces.

In this short volume we have highlighted some of the policies and practices that affect military families. We have attempted to consider the varied roles of women—as service-members and as civilian mothers and caretakers—and the dual roles of men and women who may be both service personnel and parents. We recognize that the breadth and depth of the experiences of military families extend far beyond our brief examination. Our intention is to reinforce interest in the millions of Americans who are members of military families.

—Andrea Mayfield, Wendy Hellerstedt, MPH, PhD, and Julia Johnsen, MPH
Military Families: Diverse and Unique

Military families are as diverse as civilian families, but the magnitude and nature of some of their challenges are unique. Active duty service members are as likely to be married as civilians: 57% of active duty service members are married, compared with 56% of the U.S. population. About one-third of active duty service members are married with children and about 5% are single parents (about 11% of the U.S. households are headed by single parents). The average age of active duty service members at the birth of their first child is 25 years, which is similar to that of the civilian population. The majority of children of active service duty parents are young: 41% are younger than 6 years-old, 31% are 6–11 years-old, 24% are 12–18 years-old, and 5% are adult dependent children.

The quality of family life may be affected by unique military demands:

- **Residential mobility.** Military families move households more often than civilian families, affecting employment and educational opportunities. Moves often bring great disruption, as they are not between neighborhoods, but between states and even countries.

- **Under-employment of military spouses.** In 2007, 46% of active duty service members spouses were employed in the civilian labor force, 14% were in the military themselves, and 7% were seeking work. Spouses are less likely to be employed than civilians. Those who are employed earn less than civilians in similar jobs. The majority of participants in a survey of 1,100 military spouses cited frequent residential moves and childcare as employment barriers.

- **Family separation.** Over half of the families who have experienced the deployment of a loved one have been separated 12 months or longer. About 1.6 million active service members have been recently deployed; the average length of deployment is 12–15 months and the average number of deployments is 2.2. The more days that married service members are deployed, the greater their risk of divorce may be when they return. The data about the effects of deployment largely reflect the experiences of family members of military personnel who served in Operation Desert Storm or in earlier conflicts. The current conflicts in Iraq and Afghanistan are different for the U.S. all-volunteer force: deployments are longer than they have been and breaks between deployments are shorter. A 2008 survey of 1507 11–17 year-olds in military families reported that their rates of emotional difficulties were higher than those reported for general populations of youth. Parental deployment was related to school, family, and peer-related difficulties, especially for older youth and girls of all ages, as was the health of the non-deployed caregiver and other family and housing characteristics.

- **Risk of injury or death of a family member.** Military families whose loved ones are in combat zones are acutely aware of their risks for death or serious injury. “We’re seeing complex injuries — individuals who simply would not have survived previous conflicts, and this has placed an enormous load on families,” said U.S. Army Brigadier Gen. Loree Sutton. Among the most challenging injuries are traumatic brain injuries (affecting perhaps 320,000 veterans who served in Iraq or Afghanistan) and “invisible injuries” like post-traumatic stress disorder. The care of a soldier who has had physical or cognitive injuries is often performed by family members.

When we think about military families, we often think about spouses and children. But families include the parents, siblings, and other relatives of a soldier. Families may include same-sex partners, with or without children, and opposite sex unmarried partners without children. There is a need for future studies to examine the health and social impacts of military service on all family members, in every kind of family unit.

REFERENCES


“Other things may change us, but we start and end with family.” — Anthony Brandt

Continued on page 13
The Health of Women in the U.S. Military

by Andrea Mayfield

In 2009, there were 208,829 women in the military (14.3% of all military personnel) and over 10% of the forces in Iraq and Afghanistan were women. The involvement of female troops in the U.S. armed forces—the number of women and the breadth of their roles—is unprecedented. Female service members and veterans face unique physical and psychosocial challenges, in addition to health issues that mirror those of their majority male counterparts.

Health Effects of Military Service

Deployment can involve exposure to a variety of potentially stressful or traumatic experiences for female personnel, including service in a combat zone, separation from families and loved ones, and employment in a male-dominated environment. Most of the deployment health research has focused exclusively on understanding the impact of combat exposure (e.g., being attacked or ambushed, being fired on or firing on others, witnessing the injury or death of other individuals). Existing—albeit limited—research about Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) suggests that women experience lower rates of combat exposure than men, in part because women are excluded from serving in direct ground combat positions. As women’s involvement in the military expands, however, their risk for combat-related experiences increases.

For both men and women in the military, combat exposure is associated with adverse mental health outcomes, including major depression, anxiety, post-traumatic stress disorder (PTSD), alcohol misuse, and suicide. One study found that of nearly 300,000 Iraq and Afghanistan veterans using Veterans Affairs (VA) health care, over 35% received mental health diagnoses between 2002 and 2008. Women in this study—including active duty service personnel and national guard/reserve veterans—were more likely than men to experience depression, but less likely to report drug use.

Independent of their level of combat exposure, women in the military may experience sexual assault and harassment during military service. Estimates of sexual violence experienced by women veterans range from 13% to 30%. In 2009, 2,670 female active duty members reported sexual assaults, an 11% increase from 2008. The majority of victims were young women under the age of 25 in junior-ranking positions. Given that the military is traditionally male-dominated and is characterized by large power differentials between service members, it is disturbing—but not surprising—that unwanted sexual contact is a common experience for female service members. The prevalence and context of sexual abuse in the military requires more research. Results from two studies suggest that a pre-military history of trauma and childhood sexual abuse may put women at increased risk for repeated sexual abuse.

In addition to the immediate trauma of sexual violence, victims of military assaults may experience long-term mental and physical health problems. Research indicates that women in the military who have experienced sexual trauma are more likely than other veterans to be diagnosed with a mental health condition after returning from war. Additionally, repeated assault during deployment is associated with poorer physical and emotional health.

Family Strain

The physical and psychosocial effects of military service for women may be amplified by family responsibilities. Though similar proportions of women and men in the military have children, military mothers are three times more likely to be single parents and five times more likely to be married to a military spouse (who is also eligible for deployment) than military fathers. In addition to the anxieties of family separation, securing adequate
Health Care

The availability and accessibility of health care for female veterans introduce additional readjustment issues. Despite marked improvements in health care services for veteran women over the past two decades (see “History of Health Care for Women Veterans,” page 4), over half of women veterans do not access their health care through the VA.10 Reasons cited for lack of VA use include inconvenience (including longer waiting times and lack of continuity compared to civilian providers), perceived lower quality of VA services, lack of knowledge about VA eligibility and services, and lack of privacy.10,11 Women who receive health care services outside of the VA often do not discuss their military history with their physicians.12 Without considering a woman’s military history, physicians may not be apprised of traumatic events in the woman’s past that affect her mental and physical well-being.12

Military service is a job that provides rewards and strain. Women have a long history of service, and—like men—their health is linked to their employment environments and experiences. The military provides an environment where women experience minority status as well as sex and gender biases. The majority of research about service-related stressors and readjustment issues is based on male experiences, but that is changing. The expanded role of women in the military presents opportunities and challenges for evolving sex- and gender-specific health care and support services.

REFERENCES


<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
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<tbody>
<tr>
<td>1775-1783</td>
<td>Women played an invaluable role in the American Revolution as nurses, cooks, and laundresses.</td>
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<tr>
<td>1847</td>
<td>Elizabeth Newcom, dressed in male attire, enlisted during the Mexican War and served ten months prior to being discovered and discharged.</td>
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<tr>
<td>1861-1865</td>
<td>Throughout the Civil War, women provided care to the sick and wounded, as well as disguised themselves as men in order to serve. Dr. Mary Walker, a surgeon, received the Medal of Honor and to date remains the only woman to ever receive the award.</td>
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<tr>
<td>1917-1918</td>
<td>During World War I, the number of Army nurses increased in size to a total of 21,480 with the Navy contributing an additional 1,476 nurses who served both stateside and overseas. The Navy enlisted 11,880 women as Yeomen (F), the Marine Corps enlisted 305 Marine Reservists (F) in an effort to “free men to fight” by filling positions on the home front, and two women joined the Coast Guard.</td>
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<td>1920</td>
<td>The Army Reorganization Act of 1920 allowed military nurses the status of officers with “relative rank,” ranging from second lieutenant to major, but denied women full rights and privileges.</td>
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<td>1941-1945</td>
<td>Army nurses exceeded 60,000 during World War II, while an additional 14,000 Navy nurses offered their services. In all, 83 nurses were captured in Guam and the Philippines and held as prisoners of war. During the war, more than 400,000 American military women either served at home or overseas, mostly all in non-combat positions.</td>
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<tr>
<td>1942</td>
<td>The creation of the Women’s Army Corps (WAAC), later known as the Women’s Army Corps (WAC), resulted in the recruitment of over 150,000 women, with thousands serving overseas. The Navy recruited over 80,000 women in Women Accepted for Volunteer Emergency Services (WAVES). Throughout the war, these women completed a wide variety of work in communications, intelligence, medicine and administration.</td>
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<tr>
<td>1943</td>
<td>The Marine Corps Women’s Reserve was created and women served stateside in a variety of positions, such as clerks, cooks, and mechanics.</td>
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<tr>
<td>1947</td>
<td>The Army-Navy Nurse Act of 1947 recognized Army Nurse Corps and Women’s Medical Specialist Corps as a part of the Army, and granted Army and Navy nurses permanent commissioned officer status.</td>
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<tr>
<td>1948</td>
<td>The Women’s Armed Services Integration Act of 1948 gave women permanent status in all four branches of the armed services. The Navy added 12,000 women to the military reserve.</td>
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<tr>
<td>1951</td>
<td>The Defense Advisory Committee on Women in the Services (DACOWITS) was created to assist in the recruitment of military women for the Korean War.</td>
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<tr>
<td>1965-1975</td>
<td>7,000 women served during Vietnam, the majority as nurses.</td>
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<tr>
<td>1967</td>
<td>Provisions regarding the 2% cap on the number of women allowed to serve and a ceiling on the highest grade achievable by a woman were repealed.</td>
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<tr>
<td>1972</td>
<td>The Reserve Office Training Corps (ROTC) was made available to Army and Navy women.</td>
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<tr>
<td>1973</td>
<td>The U.S. Supreme Court ruled that inequities in benefits for dependents of military women are unconstitutional.</td>
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<tr>
<td>1975</td>
<td>DoD gave pregnant women the option of discharge or remaining on active duty, a reversal of the previous policy which required discharge upon pregnancy or adoption.</td>
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<tr>
<td>1978</td>
<td>The Coast Guard allowed women to serve in all assignments.</td>
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<tr>
<td>1990-1991</td>
<td>40,000 American military women were deployed and served during Operations Desert Shield and Desert Storm during the Persian Gulf War.</td>
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<tr>
<td>1991</td>
<td>Congress repealed laws banning women from flying into combat zones.</td>
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<tr>
<td>1993</td>
<td>Women deployed with the USS Fox after Congress repealed the law banning women from serving on combat ships.</td>
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<tr>
<td>1996</td>
<td>For the first time in the history of the armed forces, women were promoted to three-star rank.</td>
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<tr>
<td>2002</td>
<td>DACOWITS narrowed its focus to address issues pertaining to military families, recruitment, readiness, and retention.</td>
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<tr>
<td>2005</td>
<td>Sgt. Leigh Ann Hester was the first woman to receive the Silver Star for combat action. She is one of only 14 women to ever receive the award.</td>
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<tr>
<td>2008</td>
<td>For the first time, the U.S. Army promoted a woman, Lt. Gen. Ann E. Dunwoody, to the rank of four-star general.</td>
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Andrea Mayfield is an MPH student in the Maternal and Child Health Program at the University of Minnesota.

**History of Health Care for Women Veterans**

Women have served in the U.S. military since the Revolutionary War, as nurses and domestic workers, but were not allowed access to veteran’s health benefits until the 1970s. Today, women are the fastest growing population eligible for use of health care services through the Veterans Administration (VA). The recent adaptation of VA health care services to accommodate women illustrates an awareness that sex and gender considerations are critical to providing health care for veterans and active service personnel.

The concern about services for women veterans was first clearly articulated in 1982 when a Women Veterans Advisory Committee was appointed to address inequalities in the treatment of women veterans. The committee requested a 1982 General Accounting Office (GAO) study, the results of which highlighted insufficient staff capacity and facilities (e.g., toilet and sleeping areas) to ensure privacy of female patients. The report also revealed that women were being excluded from many specialized medical services, including certain psychiatric care services, drug and alcohol treatment programs, and gynecological and obstetrical care.

Several policies enacted in the 1990s dramatically improved health services for women veterans at VA facilities. As a result of the Veterans Health Care Act of 1992 and the Veteran’s Health Care Eligibility Reform Act of 1996, VA facilities were redesigned to provide privacy for women. Additionally, Congress appointed a full-time director for the Women Veterans Health Program and authorized the expansion of VA services to include counseling for priority cases of sexual trauma, cervical cancer and breast cancer screening, general reproductive health care, and maternity and infertility services.

Today, the Women Veterans Health Program (which provides comprehensive medical and mental health care services for female veterans) extends to all VA facilities. Every VA Medical Center employs a Women Veterans Program Manager who helps women establish eligibility, understand their benefits, and access services through the VA system. Additionally, the VA supports several Comprehensive Women’s Health Centers that provide sex- and gender-specific services and general reproductive care; one of the Centers is located in Minneapolis, MN.

VA services continue to expand and improve, with an emphasis on provision of services related to post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), and military sexual trauma (MST) for both male and female veterans. As the VA strives to recognize and address the unique health needs of veteran women, it has made substantial improvements in the quality of care for all veterans.

**REFERENCES**


3. U.S. General Accounting Office. Actions needed to authorize the expansion of VA services to include counseling for priority cases of sexual trauma, cervical cancer and breast cancer screening, general reproductive health care, and maternity and infertility services. The Veterans Health Care Eligibility Reform Act of 1996, VA facilities were redesigned to provide privacy for women. Additionally, Congress appointed a full-time director for the Women Veterans Health Program and authorized the expansion of VA services to include counseling for priority cases of sexual trauma, cervical cancer and breast cancer screening, general reproductive health care, and maternity and infertility services.


5. GAO. The recent adaptation of VA health care services to accommodate women illustrates an awareness that sex and gender considerations are critical to providing health care for veterans and active service personnel. Today, women are the fastest growing population eligible for use of health care services through the Veterans Administration (VA).


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**Number of Women Serving Active Duty, 2009**

<table>
<thead>
<tr>
<th>Women</th>
<th>Total</th>
<th>% Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Army</td>
<td>74,411</td>
<td>553,004</td>
</tr>
<tr>
<td>Marine Corps</td>
<td>12,951</td>
<td>202,786</td>
</tr>
<tr>
<td>Navy</td>
<td>51,029</td>
<td>329,304</td>
</tr>
<tr>
<td>Air Force</td>
<td>64,984</td>
<td>333,404</td>
</tr>
<tr>
<td>Total DoD*</td>
<td>203,375</td>
<td>1,418,542</td>
</tr>
<tr>
<td>Coast Guard</td>
<td>5,454</td>
<td>43,628</td>
</tr>
<tr>
<td>Total DoD*</td>
<td>208,829</td>
<td>1,462,170</td>
</tr>
</tbody>
</table>

* Department of Defense


**REFERENCES**


According to the Department of Veterans Affairs (VA), there are about 23.4 million veterans (1.8 million of whom are women). Enumerating homeless veterans is challenging because they are not generally accessible. The VA estimates that in 2008 there were 131,000 homeless veterans in the U.S. (4% were estimated to be women). This translates to a national rate of 58 homeless veterans for every 10,000 veterans, more than twice the rate of homelessness in the general U.S. population. Estimates vary throughout the U.S., with as few as 10 homeless veterans/10,000 in Maine and as many as 460/10,000 in Washington D.C. in 2008. The average rate of homelessness among veterans in 2008 in the Midwest was 44/10,000, ranging from 19/10,000 in Minnesota and Wisconsin to 179/10,000 in North Dakota.

About 45% of homeless veterans are African-American and 46% are white. The homeless veteran population is overwhelmingly male (96%), but women are increasingly represented among younger veterans: 3% of homeless veterans aged 55 and older, 12% of 35–44 year-olds, and 18% of 18–34 year-olds are female. Several factors are associated with homelessness in male veterans, including housing costs, negative childhood experiences (e.g., physical or sexual abuse), social isolation after returning from active duty (e.g., single relationship status, lack of close friendships), mental health diagnoses, and alcohol and drug abuse. A small, but growing, body of research suggests that the risk markers for homelessness among female veterans are similar, although their prevalence may be different than that of men. Female veterans are more likely than males to report a history of sexual and physical abuse and a history of psychiatric problems, but less likely to report substance abuse. They are also slightly more likely than males to be unable to meet housing costs (13% vs. 10%, respectively), which may be related to their lower median income or their disproportionate experience of single parenthood. While similar proportions of men (44%) and women (38%) are military parents, women (11%) are more likely than men (4%) to be single caregivers of children.

Responding to the Needs of Homeless Veterans

The VA is the only federal agency that provides assistance directly to homeless people. Some VA resources to address housing costs, health care needs, and lack of secure employment are:

- **The Department of Housing and Urban Development and Department of Veterans Affairs Supported Housing (HUD-VASH)** allocates “Housing Choice” Section 8 vouchers to Public Housing Authorities so veterans and military families can find permanent housing and provides ongoing case management treatment services for homeless veterans. About $75 million was spent on this program in each of fiscal years 2008 and 2009, with 238 public housing agencies awarded the ability to distribute a total of about 10,000 vouchers.

- **The Homeless Providers Grant and Per Diem Program** has awarded more than 400 grants to community-based agencies to provide transitional housing

Meeting Future Needs

With its integrated network of homeless treatment and assistance services, the VA has made progress in addressing the needs of homeless veterans, but challenges will continue to emerge as the population of...
Homeless veterans changes. Most of the homeless veterans served in Vietnam, but veterans of the Iraq and Afghanistan wars are joining them. These veterans are younger and their risk markers for homelessness may be unique. For some, homelessness may be a direct consequence of returning home to a limited job market for which they may be underprepared. In 2009, the unemployment rate for veterans who served in the military since September 11, 2001 was 10.2%, compared to a jobless rate for all veterans of 8.1%.11 Their combat exposures and related disabilities (e.g., higher rates of traumatic brain injuries) may also be different than those of older veterans. About 21% of post-9/11 veterans had a service-connected disability in 2009 compared with about 13% of all veterans.11 The percentage of women among the homeless is increasing as their representation increases in the military. About 15% of the current military are women and about 18% of post-9/11 veterans are women.14

Based on their 2007 analysis of CHALENG data,2 the National Alliance to End Homelessness made four recommendations to reduce homelessness among veterans:

- **Accurately assess the problem:** the VA should improve data collection methods to reconcile their estimates with those of homeless service providers;
- **Prevention:** Almost half a million veterans are at risk for homelessness. Primary prevention programs could include eviction prevention education and one-time assistance;
- **Reduce chronic homelessness:** Between 44,000–66,000 veterans have been homeless for a long time; many suffer from substance abuse, mental illness, or other disabilities. Stable housing, that provides a supportive treatment environment, could be a cost-effective measure; and
- **Expand rental assistance,** perhaps through a shallow subsidy program. The Alliance estimated that a subsidy of about $250/month could prevent homelessness for thousands of veterans.


REFERENCES


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DID YOU KNOW?

Child care needs affect military readiness and retention. The Department of Defense (DOD) supports the largest employer-sponsored system of high-quality child care in the U.S. In fiscal year 2006, the DOD provided approximately 176,000 spaces for military children aged 0–12 years through child development centers, family child-care homes, youth centers, and other after-school programs. Half of the children cared for through the DOD are younger than 3 years-old. In a survey of 1,137 active-duty military families, about one-fifth said it was likely or very likely that they would leave the military because of child care issues.


DID YOU KNOW?

HIV testing has not always been easy to get. In August 2009 the U.S. Department of Veterans Affairs (VA) implemented a policy guideline making HIV testing available to all patients as part of routine medical care for any patient that consents to it, not just those with identified risk factors.

Post-traumatic Stress Disorder
Uncertain Estimates of Prevalence

Before the formalization of the diagnosis of post-traumatic stress disorder (PTSD) in 1980, war-related psychiatric syndromes were identified by a variety of names, including “shell shock,” “gross stress syndrome” and “combat fatigue.” Whatever it was called, it is likely that PTSD, a chronic reaction to trauma, has always existed among military personnel. As defined in the Diagnostic and Statistical Manual of Mental Disorders-IV, individuals with PTSD must have experienced a severe trauma (e.g., threatened death or severe injury). It is not necessary that they experienced the trauma directly: witnesses of traumatic events and people who have heard about such events could develop PTSD. For adults, PTSD reactions include intense fear, horror, or helplessness. PTSD has 17 symptoms, which may be categorized as: (1) re-experiencing symptoms (e.g., flashbacks, nightmares, memories, physiologic responses); (2) avoidance symptoms (e.g., avoiding thoughts, places, or people; loss of enjoyment in people or events); and (3) hyperarousal symptoms (e.g., agitation, sleep disturbance, difficulty concentrating). The duration of the symptoms must be greater than one month and must result in “significant distress or impairment in social, occupational, or other important areas of functioning.”

Variations in the definition of PTSD, study designs, data collection, and study populations yield disparate estimates of PTSD. A recent national survey estimates that about 7.7 million Americans aged 18 or older (or 3.5% of adults) have PTSD in any given year. In contrast, about 19% of Vietnam veterans may have experienced PTSD after the war, although some estimates are as high as 30%. A recent analysis of 29 studies of military personnel involved in the Iraq and Afghanistan wars reported estimates ranging from 5–20% for deployed personnel, with diagnostic data usually gathered through self-report questionnaires. The authors found 14 different definitions of PTSD in 29 studies and great variation in study designs and analytic methods. While estimates are not precise, it is clear that combat involvement puts individuals at risk for PTSD.

Because mental illness is stigmatized by the military, as it is by many other employers, it is likely that estimates of PTSD in military personnel are low. The reduction of such stigma has been a priority for Defense Secretary Robert Gates. In early 2008, he removed the question on the application for a government security clearance that asks: “In the last seven years, have you sought mental-health counseling?” He said that, “For far too long and for far too many, this question has been an obstacle to care.” At Fort Bliss Texas, after announcing this policy change, he encouraged military personnel and veterans to get treatment for PTSD and other psychological conditions: “You’re tough and you go into the hospital when you receive a physical wound. That doesn’t mean you’re weak in some way. And so why wouldn’t you [seek care] when you’ve received a psychological wound? It’s the same difference. They’re all wounds.” Also in 2008, Admiral Michael Mullen, Chairman of the Joint Chiefs of Staff, launched a campaign to change the military’s outdated attitude, stating, “It’s way past time for the military to recognize the war’s toll inside our minds, as well as outside our bodies.”


REFERENCES
Two federal agencies—the U.S. Department of Defense (DOD) and the Department of Veterans Affairs (VA)—provide medical benefits and care to military personnel and their families during and following the military member’s tenure of service. The DOD provides medical services through the Military Health Services System (MHSS), which operates 75 hospitals and 461 clinics in the U.S. and internationally. The MHSS serves 8.9 million people, primarily active duty members. Retirees and their dependents, and survivors of deceased members, also receive services if space is available. The MHSS is supplemented by TRICARE (previously called CHAMPUS), a network of civilian medical providers that provides government-subsidized medical and dental care.

In addition to TRICARE, retired military personnel (who have been discharged honorably) may enroll for health care benefits through the VA. Congress requires that the VA prioritize care for veterans with service-related illnesses and disabilities, special health care needs, and low incomes. The VA also provides limited health care benefits for family members of eligible veterans. Dependents of permanently disabled veterans and survivors of veterans who died during duty or from service-related conditions may receive reimbursement for medical expenses through a program called CHAMPVA. Children born to Vietnam War vets with Spina Bifida are also eligible for a Vocational Rehabilitation and Employment program through the VA after their 18th birthday. Despite the complex network of health benefits and services offered through the DOD and the VA, gaps may still prevent service and family members from receiving necessary services. One issue that challenges both the VA and the DOD is the period of transition when service members move from active duty into the VA health care system. As the two agencies operate two different health care systems (that have different eligibility criteria and benefits), former military personnel and family members may experience disruptions in medical service. The two health systems also suffer from staffing shortages and financial constraints that prevent them from meeting the demand of military personnel and their families. Such capacity issues may translate into logistical barriers to care (e.g., increased wait time for VA services) and limited availability of services (e.g., mental health care at military treatment facilities).

Particularly for family members—who rank second to military personnel in receipt of medical services—lack of facilities and staff availability can mean that military family members must receive care from civilian providers who are not familiar with issues related to family separation and reintegration. Finally, the DOD and the VA must continually adapt to the growing health needs of service members and their families. For troops returning from Iraq and Afghanistan, for example, the increasing incidence of mental health disorders requires improved post-deployment mental health assessments and treatment services from the two military health systems.

For more information about health benefits for service members and their families, please go to: http://www.military.com/benefits

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Sexual Stressors among Military Personnel

The military is an employer and—like all employers—its work environment presents challenges and opportunities for employee health and wellness. The psychosocial work environment influences employee health and health behaviors in all work sectors. For example, job stress is associated with poor physical and/or mental health and job satisfaction is associated with good health. Military personnel have a varied range of employment-related stressful exposures related to combat, absence from family, occupation in a foreign country, institutional hierarchies, negative stereotyping by civilians, and close living quarters. Among the social hazards of all workplaces, including the military, are sexual harassment and sexual assault.

Maureen Murdoch, MD, MPH has focused much of her research on the unique stressors and stress disorders of military personnel. She is a Core Investigator in the Center for Chronic Disease Outcomes Research at the Minneapolis Veterans Administration (VA) Medical Center. Because the majority of veterans are seen outside of the VA system, she has encouraged all health-care providers to assess the military history of patients and to understand that some stressful exposures may vary by sex. For example, Murdoch and colleagues conducted a survey of 3,337 veterans who applied for post-traumatic stress disorder (PTSD) disability benefits and found sex differences in reports of in-service or post-service sexual assault.

Among women, 69% of the combat veterans and 87% of the noncombat veterans reported such sexual assault. Among men, the reports of sexual assault were 6.5% for combat and 16.5% for non-combat veterans. “What we found in this select sample,” Murdoch said, “is that the prevalence of sexual assault for male combat veterans seeking disability benefits for PTSD was 5–9 times higher than veterans than what is reported for the general population of men. Among female combat veterans seeking those benefits, sexual assault was 3–10 times higher than that reported for the general population of women.”

Maureen Murdoch, MD, MPH has focused much of her research on the unique stressors and stress disorders of military personnel. She is a Core Investigator in the Center for Chronic Disease Outcomes Research at the Minneapolis Veterans Administration (VA) Medical Center. Because the majority of veterans are seen outside of the VA system, she has encouraged all health-care providers to assess the military history of patients and to understand that some stressful exposures may vary by sex. For example, Murdoch and colleagues conducted a survey of 3,337 veterans who applied for post-traumatic stress disorder (PTSD) disability benefits and found sex differences in reports of in-service or post-service sexual assault.

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For veterans without combat exposure, she said, the rates of reported sexual assault was 13–24 times higher for men and 3–12 times higher for women compared with the general population. She and her colleagues have also reported significant associations between in-service sexual harassment and post-traumatic stress disorder (PTSD) for women, with less clear associations for men.

“It is important,” Murdoch said, “to raise awareness about sexual stressors in the military.” Sexual stressors range from sexual assault, harassment, identity challenges, and denigration or bullying about not meeting conventional gender roles.

“Sexual stressors affect women and men. Because their reported prevalence is higher in women, we rarely study sexual stressors, or their consequences, in men,” Murdoch said. “Men and women who experience sexual stressors have similar negative psychological responses.” Murdoch is currently assessing the sexual stressors, by service era, of male veterans who are seeking PTSD benefits. “We must study men, as well as women,” Murdoch said. “If we do not acknowledge that men can be victims, then men who are victimized will feel isolated and unique. They will not come to us for treatment. We will also lose the opportunity to develop the evidence base we need to understand potentially preventable risk factors and effective treatment.”

For more information: The National Center for Post-traumatic Stress Disorder has several publications about Military Sexual Trauma (MST) at http://www.ncptsd.va.gov. For a summary of some recent research on MST, please go to http://www.ptsd.va.gov/professional/newsletters/research-quarterly/v20n2.pdf.

REFERENCES
President Clinton attempted unsuccessfully to overturn the ban in 1993. The resulting “Don’t Ask, Don’t Tell” (DADT) policy restricted the military from attempts to discover the sexual orientation of service members, but mandated the discharge of openly gay, lesbian, or bisexual personnel or people who engage in homosexual acts. Critics of the DADT policy argue that it is discriminatory, inhibits military readiness and retention, and may inadvertently sanction violence against women (as men may use allegations of a woman’s sexuality as a threat for refusing sexual advances). Gay, lesbian, bisexual or transsexual military personnel may also delay seeking health care screening, treatment, and counseling—fearing disclosure and thus a dishonorable discharge.

Despite the DADT policy, 2000 U.S. Census data estimates that more than 36,000 gay men and lesbians are active duty members. When National Guard and reserve members are included, an estimated 65,000—or 2.8%—of all military personnel are gay or lesbian. Coupled lesbians, aged 18-27 years-old, are three times more likely to serve in the military than heterosexual women.

Discussions of the DADT policy resurfaced after President Obama’s 2010 State of the Union pledge to repeal it. In March, 2010, Senator Joe Lieberman (I-CT) and 25 co-sponsors introduced the Military Readiness Enhancement Act, which would prohibit discrimination based on sexual orientation in the military. Top Defense officials support the repeal of DADT. Adm. Mike Mullen (chairman of the Joint Chiefs of Staff) told the Senate Armed Services Committee: “No matter how I look at the issue, I cannot escape being troubled by the fact that we have in place a policy which forces young men and women to lie about who they are in order to defend their fellow citizens.” As this issue goes to press, lawmakers and DOD officials have reached a compromise that would repeal DADT, but ensures that no changes to the policy occur until after the Pentagon completes a study about its impact on military personnel (due December 2010).

For more information: The “Don’t Ask, Don’t Tell” policy is at: http://www.law.georgetown.edu/solomon/background.html#history

REFERENCES
Since the early 1990s, state and federal lawmakers have implemented or expanded dozens of laws that address the unique challenges today’s military families face. These policies—whether health, employment, or education-related—have profound implications for the well-being of service members and their families. The post-9/11 GI Bill, for example, boosts family income by providing tuition and housing allowances for military veterans, while the 2009 National Defense Authorization Act (an extension of the 1993 Family and Medical Leave Act) assists children with special health needs by establishing an Office of Community Support within the Department of Defense (DOD). On the surface, such legislation may not appear health-related, but it does reflect a new understanding of the intrinsic connections between education, employment, and health across the lifecourse.

**Health Care: Rising Costs, Increasing Demands**

Health care costs for military service members and their families made up nearly 9% of the total DOD budget in 2009.1 As these costs continue to increase,2 TRICARE, the military’s standard health care system, remains under review. Policymakers have requested an assessment of both the health care needs (physical and mental) of military families and the capability of our military system to provide them.

During the 2010 budget year, the National Defense Authorization Act will cap co-payment increases for inpatient care in civilian hospitals; increase the amount of behavioral health counselors available to service members and their families; expand eligibility to include some retirees;3 and work to develop a pilot program to address the mental health care needs of military children and adolescents.

**Intimate Partner and Family Violence: Stigmatized Conditions Require Special Attention**

Sexual violence has long plagued the armed forces, for both men and women, and has been identified in recent years as a major concern among military leaders. Since 2005 the DOD has overseen multiple Sexual Assault Prevention and Response Offices (SAPRO) within the Army, Navy, Marines, Air Force and Coast Guard. The goal of these efforts is to eliminate sexual assault for service members (including those who live off base) through comprehensive policies that focus on training, education, victim advocacy, and accountability. Victims of sexual assault who choose to report assaults may do so in two ways: by making restricted or unrestricted reports. Restricted reporting allows victims to receive medical treatment and counseling “without triggering the official investigative process,” which may have previously prevented individuals...
from making a full disclosure. Unrestricted reporting allows for an official investigation by both military and civilian authorities. In either case, the policy is designed to assure victims that their privacy is protected by “limiting information to ‘need to know’ personnel.”

Domestic violence policy has also expanded, in light of mounting, (albeit conflicting) evidence regarding the prevalence of domestic violence among military families. The Domestic Violence Amendment to the Gun Control Act of 1997 (The Lautenberg Amendment) made it illegal for service members who have been convicted of domestic abuse to own or handle a firearm—even those in “hostile fire areas.” A 2007 directive from the DOD emphasizes the severity of penalties for those who are convicted of domestic abuse, and aims to coordinate reporting services with local civilian authorities. Branch-specific programs, such as the Army’s Family Advocacy Program, have worked to increase funding for their services, which include developing site-specific protocols for reporting domestic or child abuse for soldiers, particularly those who are transitioning to family life after deployment.

**Employment and Education**

Policy-makers have expanded educational opportunities for service members and their families through federal educational allowances. The GI bill offers significant benefits to service members enrolled since September 11, 2001, additional aid has been directed toward the needs of children of service members, who attend an average of 7.5 different schools between kindergarten and 12th grade. Congress has authorized $30 million in supplemental educational aid for children in military families, $14 million to local school districts to streamline paperwork and enrollment procedures, and $5 million in “impact aid” for children with severe disabilities.

Many states have expanded their provisions for service members and their families in conjunction with these federal measures. Twenty-six states have enacted the “Interstate Compact on Educational Opportunity for Military Children,” which addresses issues relating to public school enrollment and graduation. Twenty-three states provide unemployment compensation to spouses of service members under certain circumstances (e.g., during relocation when spouses often look for new employment). Four states provide tax exemptions and unemployment insurance for military families, and 11 provide additional "supports and protections," which range from child care reimbursement to compensation for caretakers of disabled service members.

**Ongoing Efforts**

In 2010, as the U.S. continues to fight two wars, policy-makers are addressing the expanding and diverse needs of military families. The Secretary of Defense has a number of new initiatives, including:

- Assessments of the emotional impact of deployment on children;
- Research on domestic violence in military families;
- A pilot employment program for military spouses;
- A centralized website with benefits information for service members and their families; and
- The newly created Office of Community Support for Military Families with Special Needs.

More work, of course, is necessary, particularly to understand the unique impact of today’s “War on Terror” on the health of military members and their families. For example, a 2007 APA Task Force report acknowledged the gaps in current research in mental health and accessibility of mental health services. Some of its recommendations—which include “ensur[ing] that military leadership is well educated on the value of mental health services, increase[ing] unrestricted access to high-quality mental health care within the military’s direct care system for both military members and their families,” and making sure that policies take into account the diversity of military populations—will likely take decades to implement fully.

**REFERENCES**


Laura Andersen is an MPH student in the Maternal and Child Health Program at the University of Minnesota.
MILITARY FATHERS

About 85% of active duty military service members are men. Men are more likely than women to be married: 50% of enlisted men and 71% of officers are married compared with 42% of enlisted women and 51% of women who are officers. Men in the military are more likely than women to be parents: 44% of men and 28% of active duty service members are also parents.

Some resources specifically for military fathers and their families are:

The National Fatherhood Initiative offers resources to prepare fathers and their families for the difficulties of deployment and to ease the strain during the transition back to home.

Go to: http://www.fatherhood.org/Military/

The National Responsible Fatherhood Clearinghouse offers information to fathers on preparing their children for deployment and on staying connected throughout the entire separation.

http://www.fatherhood.gov/index.cfm

REFERENCES


Military Families Diverse and Unique continued from page 1

The prevalence of cigarette use in the military is 32% compared with 21% among U.S. adults. Cigarette use prevalence is highest in the Army (38%) and lowest in the Air Force (23%). About 38% of smokers in the military began after enlistment. The rate of smokeless tobacco use among service members (15%) is twice that of civilians.

REFERENCES


In the U.S. about 25% of adults are obese. About 44% active-service members are overweight and 12% obese, according to the Department of Defense 2005 Survey of Health Related Behaviors. The cost of remedial bariatric surgery for the military was $15 million in 2002. Obesity is currently the largest single cause for the discharge of uniformed personnel. Veterans and non-veterans in the U.S. appear to have similar rates of obesity (and overweight).

REFERENCES


*It is difficult to obtain gender-specific demographic data for military personnel. The data presented here were compiled and estimated using multiple sources, which may have affected their accuracy.

Stigma and Service-related Traumatic Brain Injuries

Experiences of Caregivers

Every war presents a unique array of health concerns and prevention and treatment responses. For example, World War I was the first war in which battlefield fatalities outnumbered deaths by battlefield diseases, because of the introduction of heavily armored tanks, machine guns, and gas warfare. This new warfare raised awareness about certain conditions, including “shell shock” (which may have been attributed to what we now call traumatic brain injury).¹

As the conditions of war change, so do injuries. Because of improved protective equipment, a higher percentage of soldiers in Iraq and Afghanistan are surviving injuries that would have been fatal in previous wars. It is estimated that one-quarter of evacuated service members from these conflicts have experienced head and neck injuries, including severe brain trauma.² Even mild traumatic brain injuries (TBIs) like a concussion could be associated with post-traumatic stress disorder, depression, and physical health problems three to four months after soldiers return home.³

Sean Phelan, an epidemiology PhD student at the University of Minnesota, is conducting research to examine TBI and its effects on veterans and caregivers. “I am interested in the experience of having a stigmatized social identity, the various ways stigma affects our health and behavior, and strategies to reduce those effects,” Phelan says. He was awarded a Veterans Affairs (VA) Associated Health Rehabilitation Research Predoctoral Fellowship to study: (1) stigma and discrimination among family caregivers of veterans returning from war in Iraq or Afghanistan with traumatic injuries, and (2) how stigma is associated with health outcomes for both families and the veteran. His work is part of a study led by Joan Griffin in the Center for Chronic Disease Outcomes Research at the Minneapolis VA Medical Center. His primary collaborators at the University of Minnesota are Michelle van Ryn (Medical School) and Greta Friedemann-Sanchez (Hubert H. Humphrey Institute of Public Affairs). “With this study,” Phelan says, “we hope to increase knowledge of the social, emotional, financial, and medical needs of family caregivers of injured veterans in order to identify ways to support these individuals and the work they do.” He presented preliminary results in November 2009 at the American Public Health Association conference and has begun the main study of about 600 informal caregivers of veterans with traumatic injuries. The following are Phelan’s responses to our questions about why stigma is an important element of his work and why he is studying caregivers, who are primarily female family members.

HG: How do you define stigma?

SP: I think of stigma as a specific set of contingencies that occur when someone has an attribute, behavior, or reputation that is socially discredited and conveys a devalued social identity within a particular context. These contingencies include expectations and stereotypes about the individual, and prejudice and discrimination on the part of others, as well as internalized contingencies that change how people perceive their own value and ability.

HG: How do you think about stigma as a public health issue?

SP: First of all, many of the diseases we are concerned with are either stigmatized or associated with behaviors or characteristics that are stigmatized. This can profoundly affect behavior in domains that are relevant to the stigma. If a person expects that they may be embarrassed or discriminated against in a certain situation because of their stigmatized identity, then they may avoid those situations, which may include things like attaining health care or being physically active. Furthermore, if an individual repeatedly experiences stigma in a certain domain, he or she may separate his/her self esteem from achievements in that domain and cease expending energy in it, a process called disidentification.

Secondly, stigma elicits strong physiologic and psychological stress responses. Stress has many long-term health effects, including cardiovascular, inflammatory and immune diseases. In the short term, stress can also impair cognitive performance, affecting communication, decision-making, and learning.

HG: You have chosen to focus your work on caretakers of military personnel who are affected by TBI. Why?

SP: TBI is an important health concern for a number of reasons. First, moderate-to-severe TBI can have cognitive and behavioral effects like difficulty communicating and impulsivity. TBI is often caused by explosions, so there may be visible scarring, burns, or loss of limbs that may exacerbate negative reactions from others. It is also possible that visible injuries may temper reactions because they remove ambiguity about the cause of behavioral effects. The behaviors of those with TBI and no visible injuries may stimulate reactions like
confusion, disgust, or fear because there are no visual cues that such individuals are injured.

Many veterans with TBI rely on an informal caregiver, usually a family member, to provide help with activities of daily living, medical care, community reintegration, and provide financial support. Though many caregivers have positive experiences, the role can be a tremendous source of strain. Across numerous studies, caregiver strain is associated with negative caregiver and care recipient health outcomes. In our study, we are investigating whether experiences of discrimination—felt or expected family stigma, and the perception that the caregiver identity is stigmatized—contribute to the strain of caregiving and caregiver and veteran outcomes. In our early work, there was a high prevalence of experiences of discrimination—felt or expected family stigma, and the perception that the caregiver identity is stigmatized—contribute to the strain of caregiving and caregiver and veteran outcomes. In our early work, there was a high prevalence of experiences of discrimination—felt or expected family stigma, and the perception that the caregiver identity is stigmatized—contribute to the strain of caregiving and caregiver and veteran outcomes. In our early work, there was a high prevalence of experiences of discrimination—felt or expected family stigma, and the perception that the caregiver identity is stigmatized—contribute to the strain of caregiving and caregiver and veteran outcomes.

HG: What are some challenges faced by military families after their loved ones return home?

SP: Families face a tremendous task in helping veterans reintegrate into the family and their communities and understanding how individuals and their roles have changed. Many of the family relationships are very new and some families include young children who may or may not know the veteran. Add to this a severe injury or head trauma that may require ongoing care or possibly prevent someone from working or filling all of the roles they had before deployment, it is no wonder that the strain these families experience during reintegration can be extreme. We need to ask: “What can we do to support these families emotionally, medically, spiritually, and financially during this trying time?”

HG: What kinds of resources are needed for caretakers of injured military personnel—and do you think needs are being met?

SP: I think that the VA is making great strides toward meeting the needs of the huge population of injured veterans and their families, but there is a great deal more to be done. The VA recently designated four rehabilitation facilities for veterans with injuries to multiple organ systems; called Polytrauma Rehabilitation Centers (PRCs). Another example is The Family Care Map, a recently implemented web-based platform to improve communication between healthcare providers, patients, and families in the PRCs. Importantly, the VA seems to understand the vital role that families and caregivers play in the reintegration and recovery of injured veterans, and have devoted resources to developing a better understanding of the best ways to support families. The study that I am a part of is a testament to that dedication.

For information about Sean Phelan’s research, please go to: http://www.dcoe.health.mil/DCoEV2/Content/navigation/documents/griffin_sota_jrrd.pdf

In 2008 there were almost half a million children of active service members between the ages of 0–5 years-old: 263,591 were aged 0–2 years and 233,136 were aged 3–5 years. The following summarizes a 2009 article from Zero to Three[1] that highlights the difficulties that infants and toddlers may face when their parents are deployed or return home from service.

Because young children cannot verbally express their concerns, parents may be unaware they are stressed. However, there are several signs of early childhood stress, including difficulty sleeping, general irritability, trouble with feeding, withdrawal, and/or regression to earlier behaviors. The deployment and the reintegration of a parent or caregiver may affect mental and physical development, as well as later childhood and adult health outcomes.

Deployment: During deployment, young children experience feelings of loss and insecurity, which may affect their trust, attachment, and bonding behaviors with both absent and existing family members. These issues can increase with multiple deployments, a common situation for many military families today. Zero to Three suggests offering educational materials to parents about what an infant might be feeling and strategies for mediation. For example, videoconferencing, e-mailing, and instant messaging may help families stay connected and relieve some of the stress that younger children experience.

Re-integration: Although reintegration can be a happy time for military families, it may be stressful as families re-learn how to live together and, in some cases, re-shuffle roles and responsibilities. Toddlers and infants may become confused and anxious toward a service member parent. Zero to Three notes that there are many resources about successful reintegration, but family members may be overwhelmed by their variety.

Policy Recommendations: To support the health and wellness of military families, Zero to Three made the following recommendations for policy considerations:

- Increase the level of research on infants and toddlers in military families. Most of the resources available to military families to help children cope with grief, loss, separation, and reunion are geared toward older children;
- Increase collaboration between military agencies and other organizations to centralize support resources for parents in a physical and virtual location to help parents identify the varied resources available; and
- Initiate awareness campaigns targeted toward military professionals that focus on the special needs of toddlers and infants.

References


For further information, see the Zero to Three website about the health of military families at http://www.zerotothree.org/about-us/funded-projects/military-families/.

For information about stereotyping, a consequence of stigma, please go to: http://reducingstereotypethreat.org/

References

For Clarence Jones, a community leader with more than 25 years of experience working with social service organizations and other agencies, a Master of Public Health (MPH) degree in Maternal and Child Health (MCH) offered the chance to get the additional training he needs to do more effective work as a fatherhood practitioner and health educator. Jones was introduced to MCH in 2008 through a partnership with the U of MN Center for Leadership Education in Maternal and Child Health as a trainer for a continuing education workshop on how MCH programs could engage fathers. It was through this partnership that Jones realized that he had been working in public health his entire career. In fall 2009 Jones enrolled in his first public health course.

Interested in Making a Difference?

Consider a Master’s in Public Health (MPH) degree in Maternal and Child Health (MCH)

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Working to create healthy families has always been a deep passion for Jones because of his own history. He says he always felt the weight of not knowing his father and has committed himself to education about the importance of parents being positively involved in the lives of their children. His passion and commitment led him to work in the areas of healthy fatherhood and male responsibility, including co-authorship of the book, *Black Fathers: An Invisible Presence in America*. He stresses the importance of men being positively involved with their families and their community, and the need to develop strategies that encourage this participation.

Seven years ago, while working in a health clinic, a community member commented about the number of Vietnam veterans and their families who were affected by post-traumatic stress disorder (PTSD). Jones heard about veterans who withdrew to their rooms and had minimal contact with their families and community. From that conversation, he helped convene a group of community partners who had several meetings with the Minnesota Veterans Affairs (VA) Department to discuss the mental health needs of veterans. As a result of those conversations, an outreach program was created by the VA to provide families with health, financial and emotional support services. Seven years later, that department has grown from one case manager to more than seven staff members and has distributed approximately $20 million in services to veterans and their families in Minnesota.

The University of Minnesota’s MCH program was a good fit for Jones for several reasons. First, he recognized the influence that the School of Public Health (SPH) graduates have in shaping public health policies. Secondly, he valued the SPH efforts to inform the community about health issues. Lastly, he saw the efforts made by MCH to ensure that males were included in the conversation regarding healthy families and he wanted to continue to be a part of that conversation.

Jones says he is thankful for the opportunity to apply his work experiences in an academic environment that challenges him to be more effective in his work. He says he enjoys interacting with some of “the best and brightest young minds.” His willingness to share his expertise, and his passion to protect and enhance the health of families, has made him a valuable member of our MCH family.

A 21-YEAR STUDY OF MILITARY LIFE

The Millennium Cohort Study is the largest prospective health project in military history. Stimulated by the experiences of Gulf War soldiers, the Department of Defense designed the study to assess the long-term health effects of military service, including deployment. This 21-year study began in 2001 and involves almost 152,000 participants, including active duty and reserve/guard members. The study participants are surveyed every 3 years to assess aspects of family life (e.g., cohesion, expressiveness, conflict, resilience, support dynamics), health services utilization, health behaviors (e.g., sleep, substance use), and perceived stress among family members. In 2010, the study began surveying 10,000 military spouses of original study participants. The study is funded by the Department of Defense, and supported by military, Department of Veterans Affairs, and civilian researchers. Information about the study and related publications is available at http://www.millenniumcohort.org/index.php.

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Department of Veterans Affairs, Women Veterans Health (WVH) works on behalf of women veterans to ensure that timely, equitable, high-quality, comprehensive health care services are provided in a sensitive and safe environment at VA health facilities nationwide. The WHV’s mission is to be a national leader in the provision of health care to women, thereby raising the standard of care for all women. www.publichealth.va.gov/womenshealth/index.asp

National Institute of Mental Health, in accordance with its mission of transforming the understanding and treatment of mental health through research, has partnered with the U.S. Army in conducting Army STARRS, (Army Study to Assess Risk and Resilience in Service Members), the largest study undertaken to study suicide and mental health among members of the military in an effort to prevent suicide and promote overall well-being. www.nimh.nih.gov/index.shtml

Navy and Marine Corps Public Health Center provides leadership and expertise to ensure military readiness by emphasizing disease prevention and health promotion through health assessments, deployment health services, encouraging general wellness, and by serving as a source of medical information for service members and their families. www-nehc.med.navy.mil/

Afterdeployment.org serves as a wellness resource for the military community. The site offers comprehensive information on a variety of topics, including physical and emotional health, relationships with families, friends, and children, and substance abuse. Online assessments and workshops are offered, as well as online videos of military personnel and families dealing with similar issues. www.afterdeployment.org

Minnesota Department of Veterans Affairs serves all the state’s veterans, including their dependents and survivors, by helping secure the federal and state benefits to which they are entitled. www.minnesotaveteran.org

U.S. Army Sexual Harassment Assault Response and Prevention Program works to engage all soldiers in the prevention of sexual assault and to create an environment free of sexually offensive language and gestures. www.sexualassault.army.mil

Beyond the Yellow Ribbon uses a comprehensive approach to provide services, training and resources to Minnesota service members and their families throughout the deployment process and serves as a reminder to support these individuals during the course of reintegration upon returning home. www.beyondtheyellowribbon.org/HomePage

National Military Family Association supports military personnel and their families by advocating for benefits and programs, offering innovative programs to spouses and children, and empowering military families to be their own advocates, all in an effort to better their quality of life. www.militaryfamily.org/

Military HOMEFRONT, a project by the Department of Defense, serves as a site for all official Military Community and Family Policy (MC&FP) information, which offers quality of life programs and establishes policies to assist troops, their families, leaders, and service providers. www.militaryhomefront.dod.mil/

Military Family Research Institute conducts research about, with and for military families, as well as develops and delivers outreach materials for military and civilian organizations dedicated to supporting, understanding and working with these families. www.mfri.purdue.edu/

Operation Military Kids is a collaborative effort between the U.S. Army and communities nationwide that provides program opportunities and support services to children and adolescents affected by deployment. Readers can also visit OMK’s web site to read stories from military children. www.operationmilitarykids.org/public/home.aspx
Save these dates
for upcoming conferences and events

JUNE 16, 2010
National Children's Study Speaker Series: Maternal Mental Health during Pregnancy and the Postpartum
3:00-4:00 p.m., followed by a Town Hall about the National Children's Study 4:15p.m.-5:00p.m.
Wilder Center—Amherst A. Wilder Auditorium
451 Lexington Parkway North, St. Paul, MN 55104.
http://www.epi.umn.edu/mch/index.php/Page/View/Events

Sponsored by: National Children’s Study, Ramsey County location; Center for Leadership Education in Maternal and Child Public Health, University of Minnesota

JULY 26–29, 2010
2010 Summer Institute in Adolescent Health: Positive Pathways to Prevent Youth Violence
Minnesota Department of Health, Snelling Office Park
St. Paul, MN
http://www.nursing.umn.edu/Adolescent_Nursing/Continuing_Education/home.html

Sponsored by: Center for Adolescent Nursing, University of Minnesota, School of Nursing; Coordinated School Health, Minnesota Departments of Health and Education; Healthy Youth Development-Prevention Research Center and Konopka Institute, Division of Adolescent Health and Medicine, Department of Pediatrics, University of Minnesota; Center for Leadership Education in Maternal and Child Public Health, University of Minnesota

JULY 28–30, 2010
National Maternal & Infant Nutrition Intensive Course
University of Minnesota, Hubert H. Humphrey Center
http://www.sph.umn.edu/ce/trainings/mnic/

Sponsored by: Division of Epidemiology and Community Health and Centers for Public Health Education and Outreach, University of Minnesota, School of Public Health; Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services, and Food and Nutrition Service U.S. Department of Agriculture

SEPTEMBER 20, 2010
7th Annual Women's Health Research Conference
McNamara Alumni Center, University of Minnesota
8:30 a.m.-3:30 p.m.
http://www.ahc.umn.edu/wmhlth/Research/whrc/7thannualwhrc/index.htm

Sponsored by: The Deborah E. Powell Center for Women’s Health and the University of Minnesota Medical School

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Subscribe to our Children, Youth, and Family Health Listserv that shares resources and enhances networks among multidisciplinary professionals who work to improve the health and well-being of children, adolescents, families, and communities. To sign up send a message to: listserv@lists.umn.edu. Leave the subject line blank. In the body of the text write: Sub cyfhealth YOUR FIRST AND LAST NAME (example: sub cyfhealth Mary Jones). You will receive an email asking you to confirm your request.