



*The Future of
Mental
Health Care
in DoD:
Carpe Diem*

Presented to:

*DoD Mental
Health Task
Force, San Diego,
CA (10/19/06)*

By:

*Mark Russell, Ph.D.,
CDR, MSC, USN*

Carpe Diem?

- The DoD, by far, is in best position to be a leader in the World on scientific advancement in:
 - *Understanding*
 - *Assessment*
 - *Prevention (resilience) and*
 - *Treatment of traumatic stress*
- We have yet to seize the opportunity!

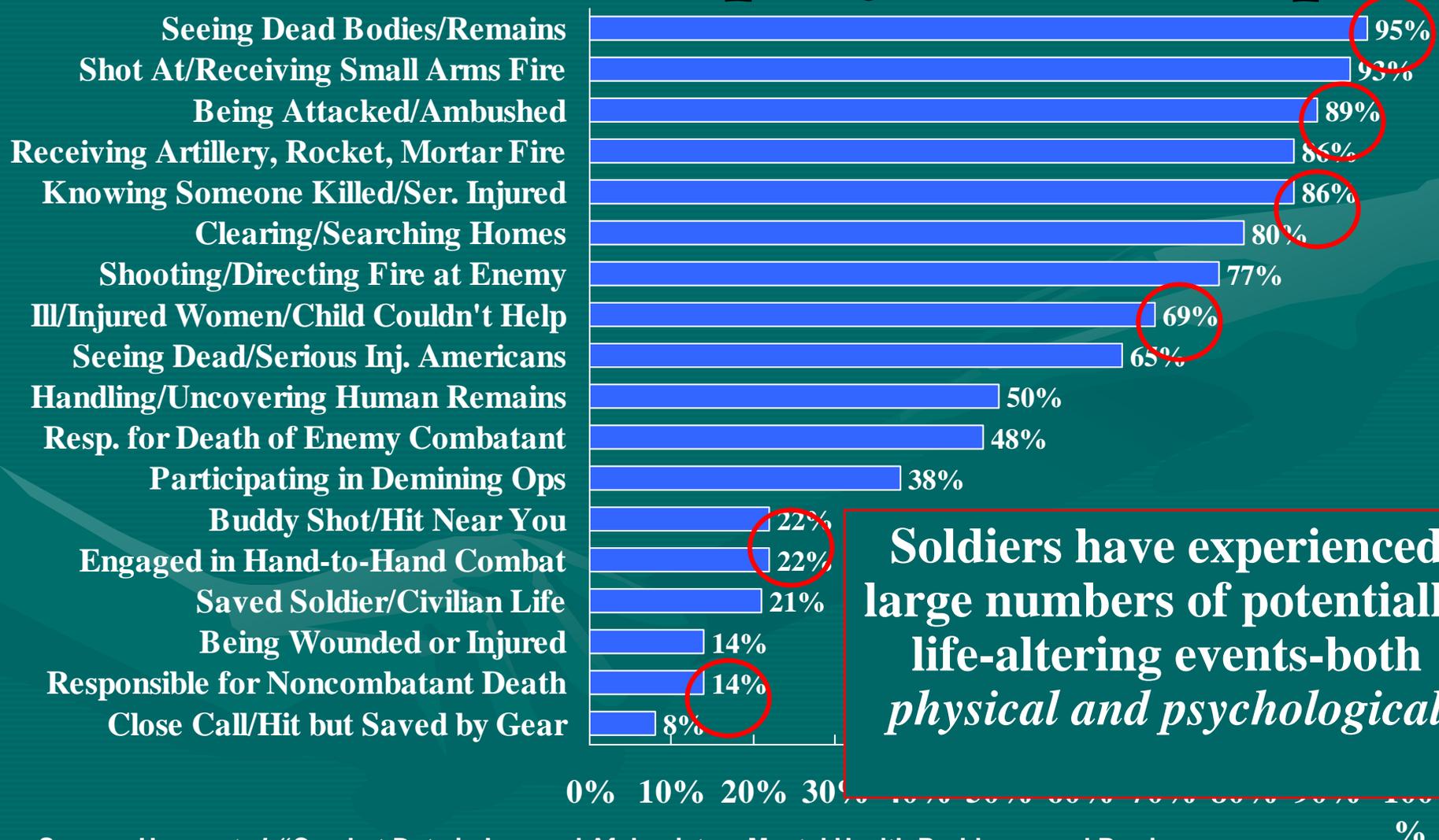
“The Perfect Storm”

- (1) When Overwhelming Demand**
- (2) Meets Lack Of Access To
Quality Mental Health Care**
- (3) With Strong Undercurrent of
Indifference and MH Disparity**

The MH Demand

- 40% in theatre seek MH; 35% sought MH within 1 yr of return; 30% or more have MH condition in DoD
- 160,000 OIF vets in VA: 32% MH; 30% psychosomatic dx
- 26% annual prevalence rate of MH dx -adults (1:4)
- 20% annual prevalence rate of MH dx -children/teens
- 8% life time prevalence rate of PTSD in U.S. adults
- 61% men; 51% women w/ one traumatic event in life
- 30% life time prevalence rate of PTSD in Vietnam vets; 40% divorce; 23% parenting problems; 39% substance abuse
- (NIMH Fact sheet, 2006; Surgeon General's Rpt on MH-06)

Combat Experience of US Army Soldiers Deployed to Iraq



Soldiers have experienced large numbers of potentially life-altering events-both physical and psychological

DoD GWOT DEPLOYMENT

Based on the Contingency Tracking System through June 30, 2005

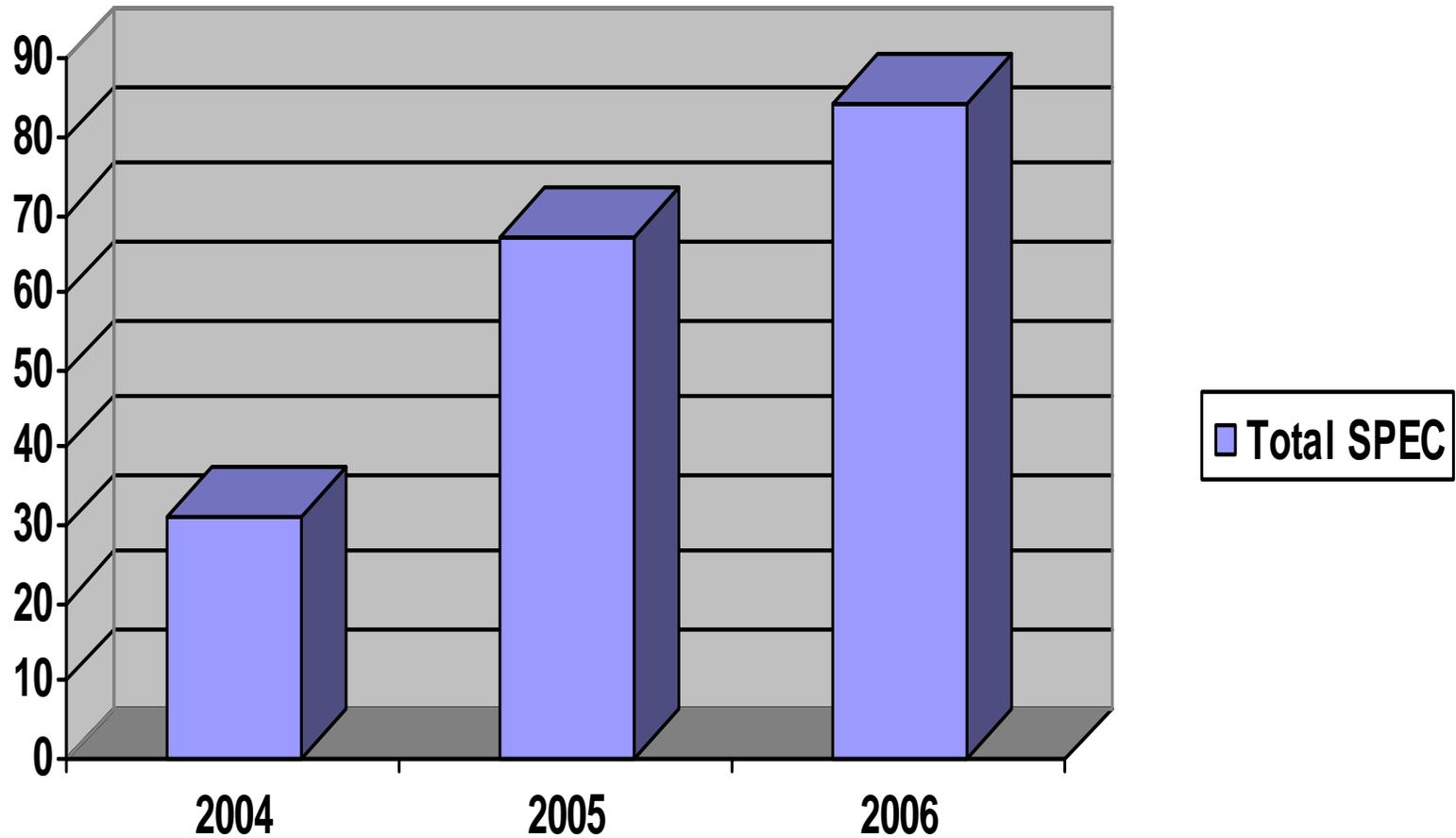
A deployment of a member occurring at any time during a month is counted in that month's total.

Army deployment numbers after October 2004 may be modified or adjusted in the future due to Army data submission issues.

excluding currently deployed

	SERVICE	Total Deployments	All Guard	All Active	All Reserve
Single Deployments	Personnel	733,311	98,432	547,305	87,574
	Events	733,311	98,432	547,305	87,574
	Cumulative Days Deployed	147,586,348	22,338,424	105,303,237	19,944,687
	Average Days Deployed	201	227	192	228
Two Deployments	Personnel	184,018	24,074	142,610	17,334
	Events	368,036	48,148	285,220	34,668
	Cumulative Days Deployed	49,572,490	4,839,057	40,530,132	4,203,301
	Cumulative Days Between Deployments	51,832,145	4,903,559	43,510,328	3,418,258
	Average Days Deployed	269	201	284	242
Average Days Between Deployments	282	204	305	197	
Three Deployments	Personnel	35,234	6,584	24,330	4,320
	Events	105,702	19,752	72,990	12,960
	Cumulative Days Deployed	9,881,641	1,422,806	7,407,274	1,051,561
	Cumulative Days Between Deployments	15,139,245	2,696,665	10,900,436	1,542,144
	Average Days Deployed	280	216	304	243
Average Days Between Deployments	430	410	448	357	
Four Deployments	Personnel	10,111	2,051	6,271	1,789
	Events	40,444	8,204	25,084	7,156
	Cumulative Days Deployed	3,094,776	498,428	2,145,083	451,265
	Cumulative Days Between Deployments	5,070,527	1,069,748	3,221,023	779,756
	Average Days Deployed	306	243	342	252
Average Days Between Deployments	501	522	514	436	
Five Deployments	Personnel	4,115	851	2,365	899
	Events	20,575	4,255	11,825	4,495
	Cumulative Days Deployed	1,366,671	237,501	870,437	258,733
	Cumulative Days Between Deployments	2,270,067	497,060	1,326,697	446,310
	Average Days Deployed	332	279	368	288
Average Days Between Deployments	552	584	561	496	
More Than Five Deployment	Personnel	4,678	659	2,100	1,919
	Events	36,143	4,598	15,948	15,597
	Cumulative Days Deployed	1,751,858	231,266	665,714	854,878
	Cumulative Days Between Deployments	2,616,141	411,987	1,102,484	1,101,670
	Average Days Deployed	374	351	317	445
Average Days Between Deployments	559	625	525	574	

Mental Health New Referrals: BHC Iwakuni (Russell, May 2006)



Mental Health Trends: MCAS Iwakuni (Jan-Jun 2006)

	CY 2004	CY 2005	CY 2006
MH referrals (BHC)	34	67	84
MH referrals (MCCS)	188	227	189
Alcohol Tx	122	209	173
Domestic Violence	21	14	17
Sexual Assaults		7	10
	Mark Russell, CDR, USN		

Problems With Access to Quality

MH Care (VA/DoD CPG Management of PTSD, Jan 2004)

- *“Psychotherapies should be provided by practitioners who have been trained in the particular method of treatment, whenever possible [Expert Consensus] (pg 9 summary).”*

C. PSYCHOTHERAPY INTERVENTIONS

Table C1: Summary Table

R	Significant Benefit	Some Benefit	Unknown	No Benefit/Harm
A	Cognitive Therapy [CT] Exposure Therapy [ET] Stress Inoculation Training [SIT] Eye Movement Desensitization and Reprocessing [EMDR]			
B		Imagery Rehearsal Therapy [IRT] Psychodynamic Therapy		
C				
I		PTSD - Patient Education		
D				

R = level of recommendation (see page 15)

Table C2. Adjunctive Treatments

B		Dialectical Behavioral Therapy [DBT]		
B		Hypnosis		

2003-2005 – DoD Mental Health Training Needs Survey (Russell, 2006)

- 133 MH providers in DoD surveyed
- **90%** reported they have received **no** training or supervision per VA/DoD CPG on any of the best treatments of PTSD
- No systematic training (internship/residencies) on management or treatment of traumatic stressors
- Little to no change! 2006 survey of OCONUS MH providers reveals 80% without training
- What if these were dentists or surgeons?

Walking The Walk: Joint DoD/VA

Grassroots Training Initiative (Russell, Silver, et al., 2005)

- Sponsors: Naval Hospital Bremerton; Madigan Army Medical Center; VAMC Coatesville, PA; and EMDR HAP.
- First ever attempt to provide training on CPG recommended treatment for PTSD and monitor MH treatment quality and effectiveness in DoD!
- Field research in actual vs. artificial clinical settings in DoD
- Use of standardized treatment outcome tracking forms and baseline measures

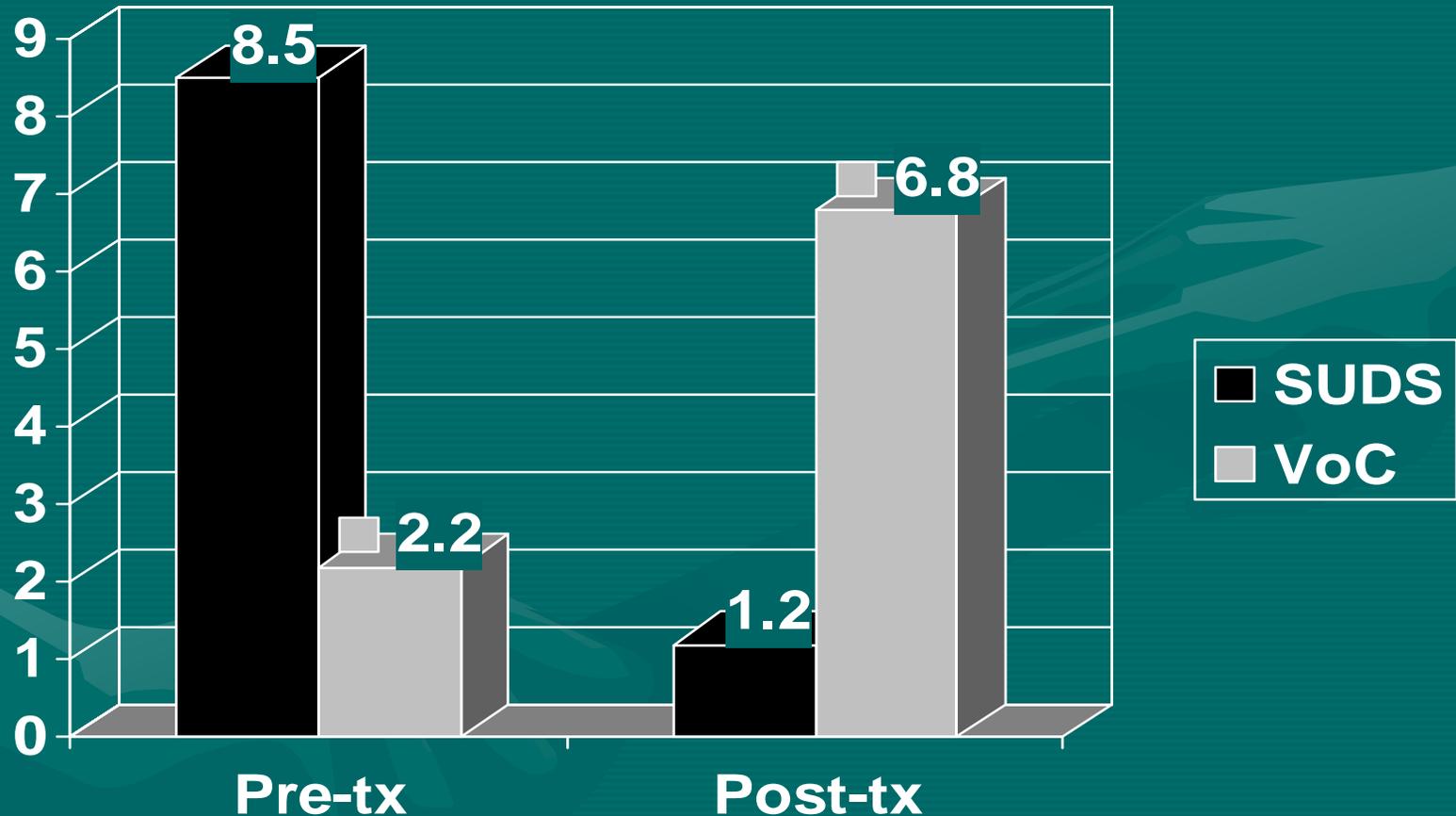
DoD/VA MH-Training Project

(Russell, Silver, Rogers, & Darnell, 2005)

<u>Dates of Training</u>	<u>Location</u>	<u>#MH providers trained</u>
12-13 Jan 05 (part I)	PACNORWEST region. Ft. Lewis Army Base, WA	<u>70</u> total: (DoD = 60; VA = 10)
28 Jan – 4 Feb (part I)	NH Great Lakes, MI	<u>10</u> total: (DoN)
8-10 Apr 05 (part I)	NAS Brunswick, ME	<u>8</u> total: (DoD)
19-20 Apr 05 (part I)	NH Bremerton, WA	<u>10</u> total: (DoN/DoA)
4-5 May 05 (part II)	PACNORWEST Region, Ft. Lewis Army Base, WA	<u>62</u> total: (DoD = 57; VA = 5)
9-10 May 05 (part I)	NMCSD, San Diego	<u>15</u> total: (DoN)
Aug 05 (part I & II)	NH Camp Pendleton, CA	<u>12</u> total: (DoN)
Sep 05 (part I & II)	Ft. Hood, TX	<u>70</u> total: (DoA)
Total of <u>10</u> Trainings	Mark Russell, CDR, USN	*<u>257</u> total participants

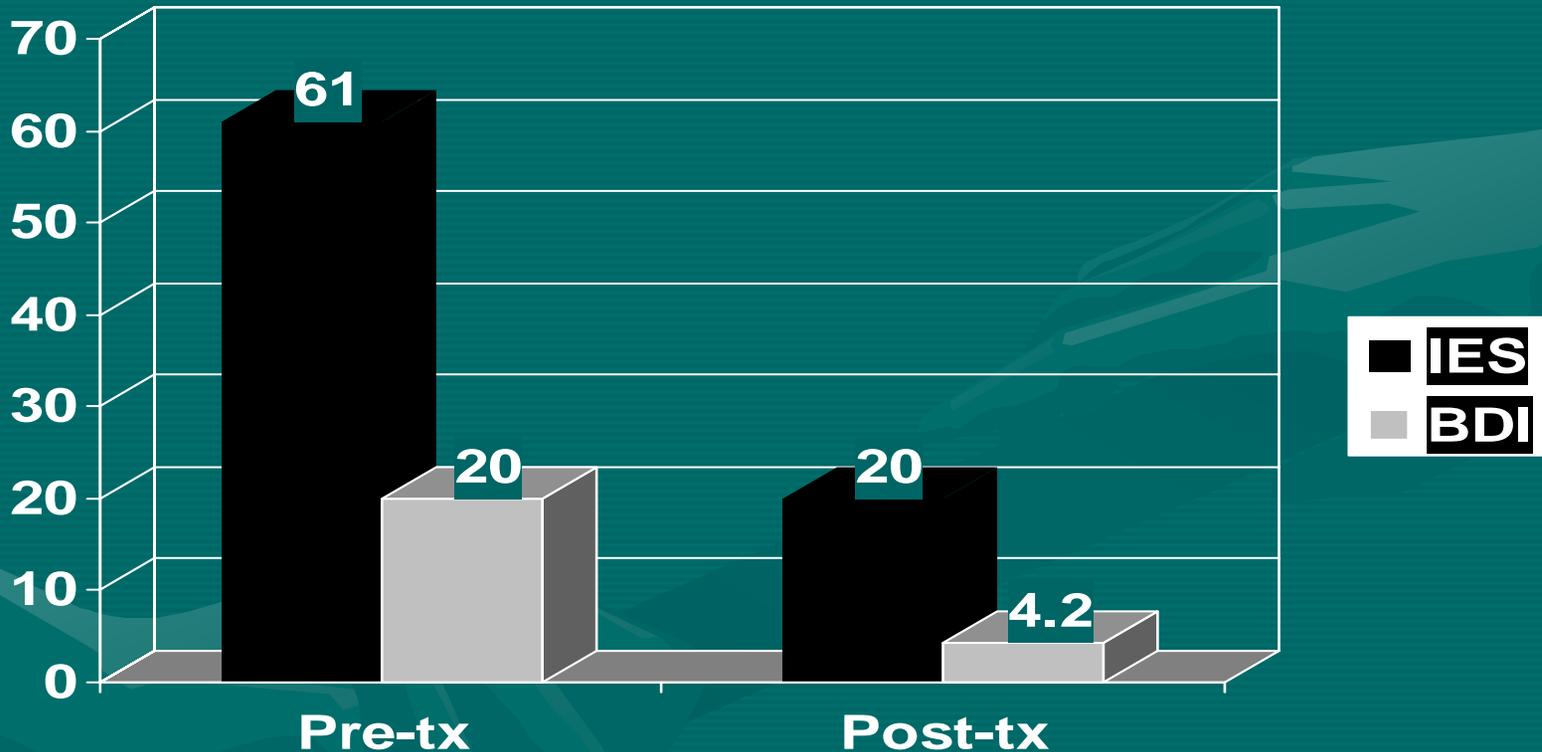
EMDR Treatment Outcome: Combat-PTSD

Mean # sessions = 4.3 (n = 48)



EMDR Treatment Outcome: Combat PTSD

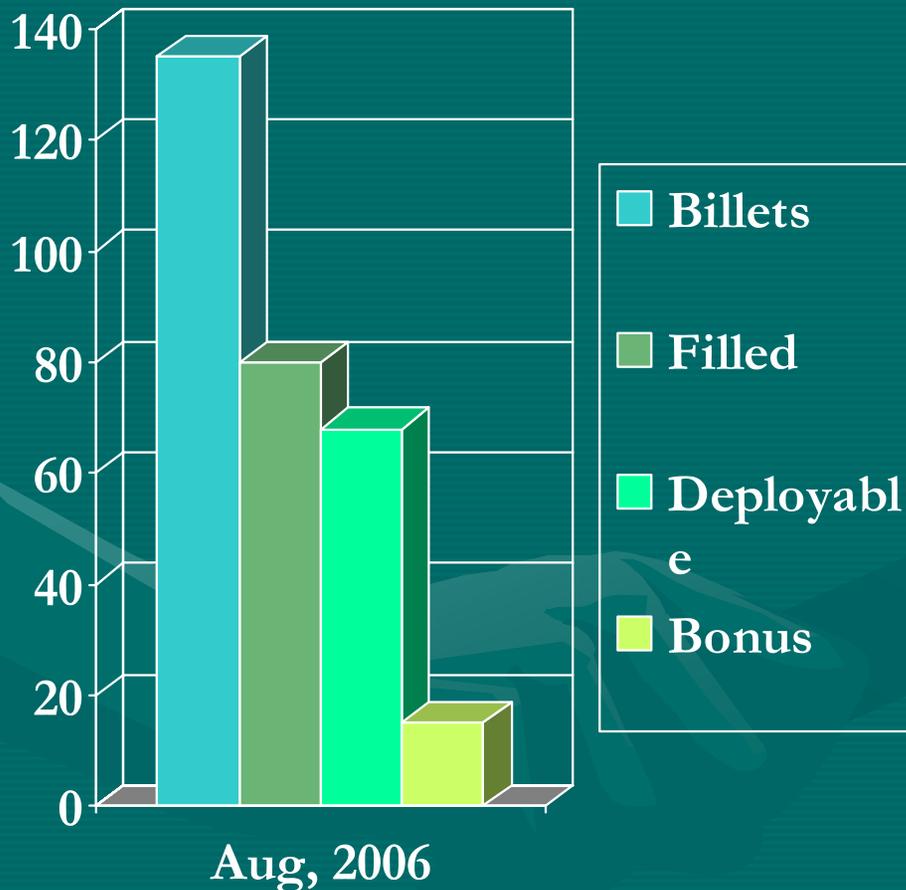
Impact of Events (IES) & Beck Depression Inventory (BDI) (n = 48)



Staffing Crisis: Mental Health Advisory Team (MHAT-II) 30 Jan 05

- Compassion Fatigue and Burnout
- 33% of Army Behavioral Health personnel reported high burnout
- 27% low motivation; 22% low morale
- 15% said operational stressors impaired BH job
- *“If our providers are impaired, our ability to intervene early and assist soldiers may be degraded”*
- What training and services available for the healers?
- Failure to address the issue is leading to a sustained and significant attrition of MH providers

Rapid Attrition of DoD Mental Health Providers: The Silent Crisis In Navy Psychology



- **135 Total Billets**
- **80 Filled (59%)**
- **12 Training**
- **68 Deployable**
- **10 on Carriers**
- **5 RAD/retirement request per month**

Etiology of the Current MH Crisis: The 3 D's

1. **Disconnect** - planning, coordination, communication
2. **Disparity** - toward MH care
3. **Diffusion** - of responsibility

The Disconnects

- Within and between MH disciplines at Service level
- Between each Service & Family Support programs
- Between DoD and VA
- Within and between local (base) support programs
 - MH/BHS/Life Skills
 - SAC/SARP/ASAP
 - Family Support Centers
 - Pastoral Care
 - Medical
 - Health Promotions
 - EDIS/DoDDS

MH Disparity

- Historic misunderstanding, stigma and mistreatment associated with mental illness is legendary
- Advances in research and treatment of mental illness have been significant, however, a chasm still exists between mental and physical health sciences
- Military's view of MH care has evolved, but long standing stigma and barriers to care exists despite general acceptance of psychological impact of traumatic events (e.g., warfare)

Name One Medical Innovation by DoD

Medical Research and Practice?

- Importance of sanitation in field medicine – U.S. Civil War
- Infection control – Army Major Walter Reed proves cause of yellow fever led to eradication – Spanish-American War
- Use of x-ray machine, plastic surgery, tetanus antitoxin – WWI
- Blood transfusions – WWI
- Blood plasma – WWII
- Helicopter medevac, MASH, - Korea
- Damage control surgery, use of gortex to keep wounds open
- Army designed tourniquet – used w/ one hand
- Bandage made compressed shells of shrimp – fuses to red blood cells
- Burn, amputees, prosthetics, traumatic brain injury, chronic pain
- 93% survival rate in OIF/OEF!!!

Name One Major Mental Health Innovation by DoD?

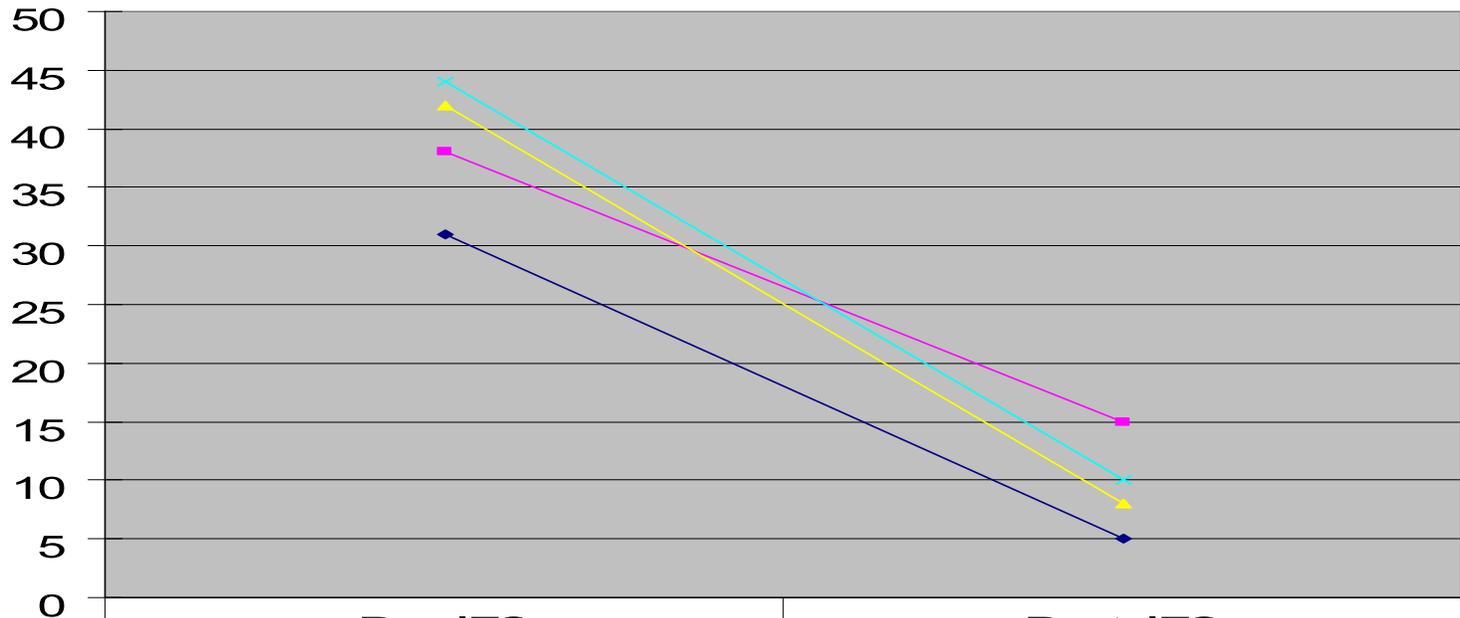
-???

- There have been no known significant MH discoveries or interventions developed by DoD

EMDR Treatment for OIF-related ASD/PTSD

Russell, M. (2006) Military Psychology

EMDR Treatment For Combat Related Stress



	Pre IES	Post IES
◆ Patient 1	31	5
■ Patient 2	38	15
▲ Patient 3	42	8
✕ Patient 4	44	10

Other Related Concerns

- Quality of web-base and alternative interventions (self-help, chatting, e-counseling, hot-lines, and 6-visit contracts).
- Lack of standardized assessments
- Lack of monitoring (PDHA, Tx progress etc.)
- Lack or insufficient MH-related training for non-MH providers and troops
- Lack of consideration of provision of MH treatment
- Lack of coordination and awareness within MH community

Further Evidence of MH Disparity

- Lack of Regional treatment centers for traumatic stress reactions
- Non-medical MH providers (psychologist, social workers, and chaplains) - provide majority of psychotherapy
- Glass ceiling - disparity in career opportunities
- MSC - disparity in eval/promotion - lead to loss of MH staff
- Financial incentives/compensation
- **MH provider Maximum specialty bonus is \$2,000 annual (10 yrs of less) or \$5,000 (10 or more yrs)**
- **Medical specialty pays include Dermatology \$18,000; Pediatrics \$12,000; Family Practice \$13,000; and Psychiatry \$15,000.**

Diffusion in Responsibility

- Who is responsible for ensuring coordination between multiple community support agencies to ensure optimal continuum of MH care for active-duty and family members?
- Who is responsible for developing, monitoring, and enforcing policies regarding MH care? - *each support agency and discipline are marching to different tune*
- Organizations that rely upon multiple, interdependent CoC and rules, often breed confusion and diffusion that lead to dysfunction
- Who is responsible for fixing these problems?

Screaming Into The Storm

- **After 2003 OEF/OIF deployment**, extensive efforts made to utilize military complaint resolution system to prevent the current MH crisis including:
- **27** - Memoranda, point papers, data-driven reports sent to over **50** military/civilian leaders:
 - (2003-06) found **90%** of **133** DoD MH staff not trained to tx PTSD per VA/DoD CPG
 - (2004-05) trained **257** DoD/VA MH staff and monitored outcomes of **68** cases, **48** OIF vets w/combat-PTSD
- **15** -Approved media appearances; **6** -professional publications; **16** - professional presentations; and **9** - awards received
- **2**- Formal IG complaints (Dec 05/Jan 06)
- **1** - Appearance w/ DoD MH Task Force (Oct 06)

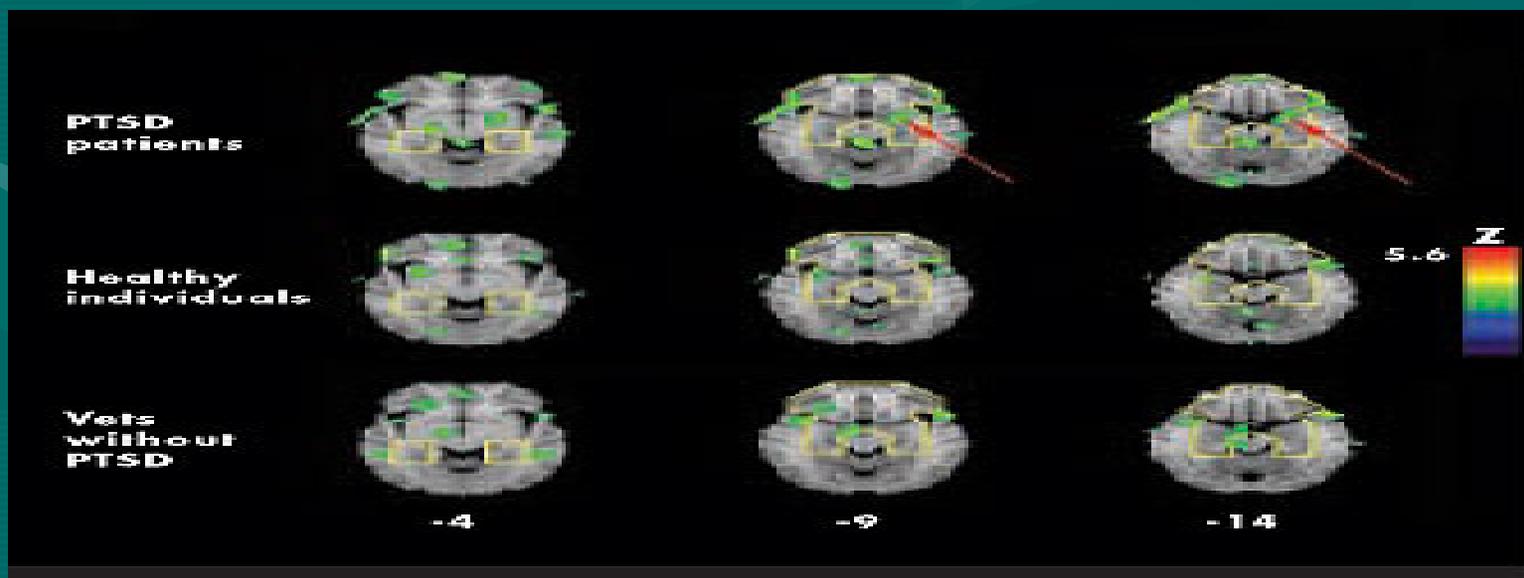
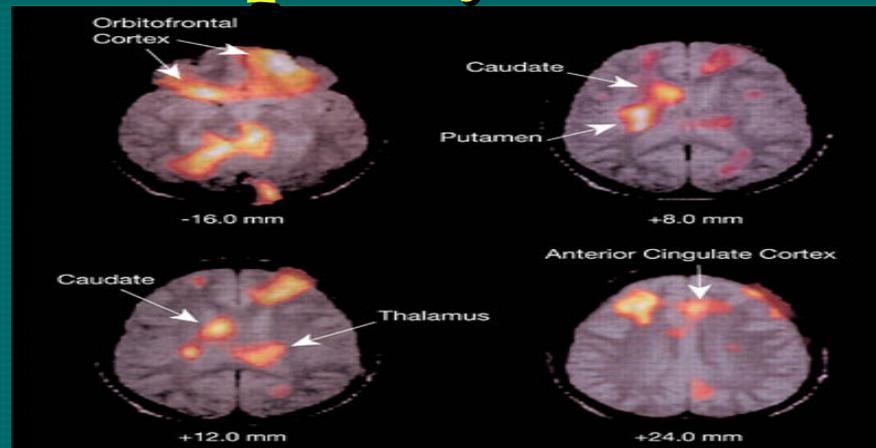
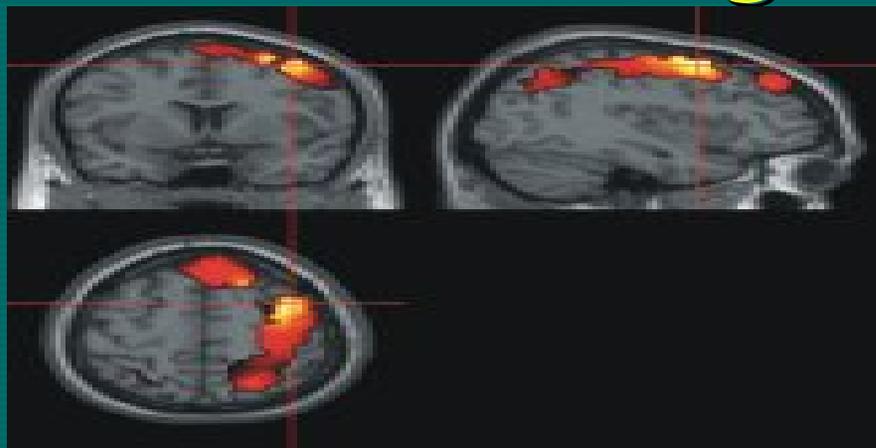
Carpe diem: Mere Symptom Reduction or Bold New Vision?



Need Bold, Creative, Comprehensive and Decisive Actions

- No military in history has done as much to advance science of physical healthcare of troops, but MH has historically been neglected leading each generation to repeat the same mistakes, it is time to heed these lessons learned so we never need to look back again
- Establish new vision, scope, and commitment of military medicine (UMC) -effect substantial, groundbreaking MH reforms
- UMC will become the world leader in the research and development, training, and treatment of combat and operational traumatic stress reactions.
- Provides reason why a MH professional would want to stay or enter DoD
- This type of bold pronouncement will elevate the status of MH providers in DoD and start systematic elimination of stigma
- Also sends clear message that MH in DoD will no longer be neglected and raises expectations in DoD.

DoD Medicine's Initiative to Advance Mental Health Science and Eliminate MH Stigma & Disparity



Proposed Vision for DoD Medicine

- DoD personnel are frequently exposed to wide-range of traumatic stressors given the diversity of missions that include humanitarian, disaster relief, training accidents, peacekeeping and armed conflict.
- All DoD personnel if exposed to sufficiently intense or prolonged combat and operational stress can be expected to develop a wide-range of MH conditions including traumatic stress reactions and ill-defined medical syndromes
- It is a historical fact, however, that individuals who develop a MH condition often face considerable stigma, negative bias, and discrimination that create barriers to seeking MH care, in and outside of the DoD.

Vision

- UMC is committed to become the premier leader in the advancement of the neuroscience of the understanding, assessment, prevention and treatment of combat and operational stress reactions.
- The UMC is also committed to the elimination of the long-standing false dichotomy, stigma, and disparity between physical and mental health care

Vision

- The costs of delayed and/or inadequate MH treatment is significant for service members, their family, the Armed services, and society.
- Goal is to ensure the service members receive cutting edge MH care commensurate with physical health.

P: MH Disparity - Leadership

- Appoint flag-level officer as head, MH/BHS Corps who is committed and dedicated to implementing and monitoring MH reforms - *sense of urgency!*
- Establish joint DoD/VA COSC committee that conducts regular staff/patient surveys, monitors training/compliance, quality of care, develops website, and conducts field inspections
- Requires Top-Down sustainable leadership commitment and frequent and regular public statements and need to monitor progress
- Establish separate “MH/BHS Corps” in UMC that includes psychiatry - eliminates inherent bias in MSC promotions
 - raises MH care to equal status as physical health
- Mandate and track leadership MH training at all levels

MH Disparity - Leadership

- Monitor and hold MTF CO responsible for PDH®A and MH-related training compliance of their staff
- Develop DoDINST that codifies MH reforms and closely track implementation w/ sense of urgency
- Do not allow history to repeat itself during peacetime in order to avoid future crises

Streamline Organizational System

- One Specialty Advisor for each of three MH specialties
- Establish DHCC as official website
- Establish Community and Deployment Health Centers
- Align base community support services under a with BHS OIC (0-5/0-6) will include MH, Family Services, Substance Abuse, New parent support, FAP, EDIS, OT, Health promotions etc
- Single organization, to provide coordinated, comprehensive, multidisciplinary services along continuum of deployment cycle

P: MH Disparity - Staffing Fixes

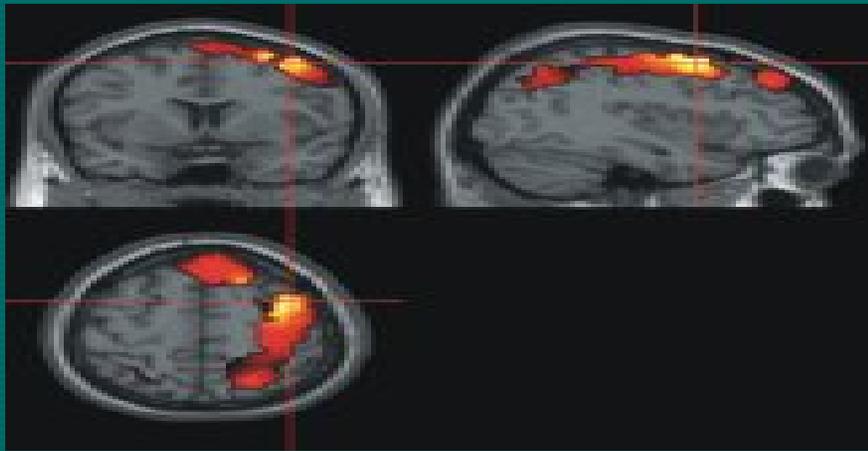
- Immediate stop loss of MH providers!
- 14-day survey by all base CO on current/future MH staffing needs
- Fill those needs w/ best qualified staff
- Establish MH specialty pay program equal to MC rates at current psychiatry level and increase psychiatry pay
- Make retrospective this year - to improve morale
- Institute retention and recruitment incentives for MH immediately to hire and retain best quality MH providers (consider age-waivers)

P: MH-Disparity Staffing

- Increase numbers of well-qualified MH staff in garrison to provide troop access for MH treatment
- Periodically but immediately survey MH providers for compassion fatigue, morale, training, intent to stay on AD, suggestions etc
- Ensure all DoD/DVA, civilian MH providers receive adequate training IAW DVA/DoD CPG

A: Public Awareness

- Greatly increase the public awareness of PD issues and new MH initiative via t.v./radio
- Include top civilian and military leaders vs. only voice overs to advance MH parity
- Educate public and troops on neuroscience of MH, especially conditions like PTSD to remove stigma and barriers to care
- Air frequently and during peacetime the message is that failure to seek MH care is failure of leadership that impacts readiness and morale same manner as if someone was physically sick or injured and didn't seek care
- Educate leaders at all levels during leadership courses, GMT, on need benefits of early intervention and costs of untreated MH conditions



A New Proposed Paradigm Shift: The Brain Is Source of COSR and PTSD

Understanding the Nature and
Treatment of PTSD from
Neuroscience Perspective

A: Public Awareness

- Include training that describes neuroscience of MH conditions like PTSD to help reduce stigma and raise level of education
- Develop COSC GMT training series for all-DoD personnel to increase awareness of COSC, PTSD/MH neuroscience, ill-define syndromes, PDHA program, support & Tx services available, expectation of RTD, elimination of stigma, career impact etc
- Consider adding harassment/discrimination against those seeking MH care to CMEO program and grievance system

B: Access and Efficacy MH programs

- Greatly impacted by staffing shortages that existed prior to GWOT and now at critical mass
- Re-examine frontline MH policy and force distribution to ensure optimal utilization
- Survey every MTF commander about existing MH resources and current-future staffing needs to determine access issues
- Peacetime - MH staff would integrate with PCM and could assist DVA with aftercare of separated vets
- Efficacy assessed by providing MH providers training in best tx available and tracking clinical outcomes (Russell et al., 2005)

B: MH Training

- Mandate all healthcare providers complete at minimum the PDHA, PTSD, and ill-defined medical symptoms trainings available w/ DHSC within strict timeline
- Explain rationale to ensure providing best care possible and eliminate long-standing stigma and barriers of care so everyone needs to be brought up to speed - track same manner as CBRNE, GMT etc.
- Develop COSC GMT training series for all-DoD personnel
- Utilize the Regional Joint DoD/VA MH Training Model (Russell et al., 2005) to ensure that 100% DoD/VA & TRICARE providers receive at least one of VA/DoD CPG recommended treatments: CBT or EMDR -by end of CY 06.

B: MH Training

- Ensure that online, hotline, civilian contractors have received adequate training in understanding, triaging, and psychoed for PD-MH conditions - (could be same GMT as above)
- Develop MH certification continuum training beginning in internships/residencies with goal that ALL DoD MH providers achieve level of expected expertise in COSC-related MH (EDIS CSPD model)
- Require COSC, anti-MH stigma training during recruit/OCS accession; base/command orientation; annual update

B: Standardized Assessments

- Establish standardized assessment protocol in concert w/ VA preferably - but need immediate action (recommend dx of PTSD occur in no less than 3 visits by adequately trained MH provider - use provisional dx until PTSD can be established)
- Will help decrease false positives and false negatives
- Reinforce expectation of successful adjustment/ RTD to troops
- Develop means to track MH related assessments and treatment progress
- Diagnosis of PD MH condition should include documentation of impairment

B: Efficacy MH Treatment

- Develop Regional COSC Treatment Centers - provide state of the art research, training, and treatment. - fisher house
- Include neuroimaging, psychophysical, psychological measures for assessment and monitor treatment progress, detect malingering, establish severity/disability
- Establish continuum of MH care (in-theatre, local MTF, Regional Center, VA).
- Using Public Health model expectations are that members will RTD, few should be separated and put into VA disability system without thorough work-up and access to highest quality of care while in uniform
- Troops and leaders need to be appropriately informed
- Have MH/BHS Corps interns/residents, direct accessions, complete training at the Regional Centers.

C: Research

- Establish central PoC, to coordinate research past and present and provide info. Out to field
- Develop DoD/DVA MH website to provide research updates, trainings, bi-directional flow, forms, measures, SOP
- Current DoD/DVA research centers are UN-friendly to field
- Streamline IRB process especially for field purposes of MH treatment of ASD and track what field interventions are being used and long-term efficacy - (e.g., EMD field training)
- Reduce existing barriers in DoD for conducting field research including outcomes - need a more common-sense approach that protects welfare of subjects but is not so prohibiting (ex PI project)

C: Neuro-imagining Studies and Treatment of PTSD

- Current studies involving EMDR show pre-post changes in brain scans in relation to changes in symptom measures
- Lanius et al., (2004) use fMRI
- Levin et al., (1999) use SPECT (n= 1 of 6)
- Lansing et al., (2005) use SPECT (n =6)

- Regional Tx Centers should conduct full range of treatments available

C: Research

- Develop Regional COSC Treatment Centers - provide state of the art research, training, and treatment. - fisher house
- Include neuroimaging, psychophysical, psychological measures for assessment and monitor treatment progress, detect malingering, establish severity/disability Conduct follow-on research w/ EMDR, CBT for ASD treatment on frontlines - provide training to frontlines and track long-term progress (immediate deploy)
- Revise MH assessment at time of accession to establish pre (service) deployment history - a comprehensive evaluation using testing, neuro-imaging etc, would be groundbreaking when track over military career!

D: MH Access for Families

OCONUS

- Require all base CO to provide results of survey within 14-day as to required MH staff to meet current and future MH needs of base population
- To fullest extent possible, provide the staff requested and monitor productivity, tx. Outcomes etc.
- OCONUS is particularly problematic ex FFSC/MCCS turnover rate, poor staff quality, and DoD MH deployment - increase GS-11 to 12 to attract higher quality
- Ensure all MH providers receive adequate training at time of accession and periodic follow-on
- Require community MH committees be established on each base to include MH, BHC/MTF commanders, base CO, chaplains, FFSC/MCCS, Substance abuse, DoDDS MH

E: Reduce Barriers to Care

- Confidentiality should be same as those who seek physical health
- Stigma and barriers to care are due to leadership and organization ignorance and negative bias toward MH - causes fear of discrimination, stigma,
- Public awareness campaign led by those on top more with focus on injuries to the brain vs. mental illness will help reduce troop ignorance
- Making MH care a priority as physical health, a readiness and leadership issue is a must
- Leaders who can't step into the 21st century and understand brain-body are connected should not be in leadership positions

E: Reduce Barriers To Care

- Using Public Health model expectations are that members will RTD, few should be separated and put into VA disability system without thorough work-up and access to highest quality of care while in uniform
- Troops and leaders need to be appropriately informed by regular training and public awareness campaign
- Ensure all MH provider's receive training IAW VA/DoD CPG and monitor effectiveness (outcomes)

E: Reduce Barriers To Care

- Establish standardized assessment protocol in concert w/ VA preferably - but need immediate action (recommend dx of PTSD occur in no less than 3 visits by adequately trained MH provider - use provisional dx until PTSD can be established)
- Will help decrease false positives and false negatives
- Reinforce expectation of successful adjustment/ RTD to troops
- Develop means to track MH related assessments and treatment progress
- Diagnosis of PTSD should include documentation of impairment

G: Outreach Families

- Great resources available via One source, DHHC, but need increase public awareness via mailings, tv/radio spots
- Recommend DoD align with current APA task force on military families chaired by LCDR Johnson
- Strongly advise that before developing new programs need to survey family members about their level of awareness available resources, satisfaction, unmet needs, etc.
- Need sense of urgency and mandate base CO distribute, collect, and submit surveys to TF within 30-day timeframe
- Ensure TF feedback of surveys is sent back to CO's and made available to families

H: Substance Abuse

- Mandating all-hands training on PDHA to increase awareness
- Holding MTF CO vs. provider's responsible
- Ensure adequate staffing levels exists at SARP, ASAP, DVA programs to meet current and future needs
- Mandate GMT training of Substance Abuse identification for all hands
- Mandate SA counselors receive COSC/PTSD trainings
- Establish policy of referral to SA assessment by PCM at time of pre-post deployment HA and track referral and basis of referral via DoD/DVA MH dbase

I: Seamless Transition

- Have NC-PTSD and DoD MH work group establish standardized assessment, treatment progress measures and procedures within 30-days and deploy immediately along continuum of care
- Mandate immediate compliance from top-level that this is standard of care required and subject to review and refinement by the joint work group
- Utilize electronic dbase to track time of accession to death along continuum of care

J: Long-Term Follow-up

- Establish standardized assessment and tx progress procedures across continuum of care (DoD, DVA, TRICARE, civilian contractors)
- Develop patient readjustment surveys for service members and families to be assessed on periodic long-term basis after leaving service (what's working and what's not)
- Maintain dbase to track time of accession to death and include immediate family - (e.g., generational impact)
- Monitor MH assessments, tx, and tx progress - (reservists/natl guard) - shows we care enough to ask (family)

K: Collaboration

- Develop Regional COSC Treatment Centers - provide state of the art research, training, and treatment. - fisher house
- Have MH/BHS Corps interns/residents, direct accessions, complete training at the Regional Centers.
- Revise MH assessment at time of accession to establish pre (service) deployment history - a comprehensive evaluation using testing, neuro-imaging etc, - would be groundbreaking when track over military career and beyond!
- Develop DoD/DVA MH website include TRICARE civilian, provide updates on research, training, etc
- Utilize the Regional MH Training Model (Russell et al., 2005) to ensure that all DoD/VA & TRICARE providers receive at least two of VA/DoD CPG recommended treatments: CBT and EMDR

K: Collaboration

- Resource sharing - greatly expand number of MH staff in DoD to meet current crisis and mitigate numbers going to DVA for disability
- Monitor utilization of DoD MH staff who can split w/ DVA to assist w/ aftercare based on needs of MTF/DVA in region

L: Coordination

- Mandate civilian TRICARE MH providers complete Regional Clinical trainings provided free of charge
- Require use of standardized sx survey to track progress (intake, 1 mo, 6 mos, termination, post-tx)
- Provide access to DoD/DVA MH website for civilian and TRICARE MH providers to establish bi-directional feedback and support

M: Commander's MH Training

- Current training is available (e.g., NKO), but optional and not tracked who has completed it
- Efficacy of current training should be reviewed by MH TF - but MH training should be required for civilian leadership too (I.e., reasons to eliminate disparity; neuroscience of MH)
- Make mandatory and immediate same urgency as CBRNE and include PDHA training
- Effectiveness of MH initiatives limited to degree that commander's understand their boss's level of interest - need top-down monitor
- Require mandatory training at all levels of leadership trainings and periodic refreshers courses (GMT) - cannot assume command position without it

N: Pre-Post Deployment Screening

- Revise MH assessment at time of accession to establish pre (service) deployment history - a comprehensive history, evaluation using testing, measures of dissociation, psychophysical and/or neuro-imaging etc, - this would be truly groundbreaking when track over military career!
- Revise current Pre-deployment HA and assess for relevant changes since initial entry into military (ie, trauma, MH tx)
- Revise PDHRA as mandatory at 6-12 months after most recent PDHA and then every 12-months until separation
- Expand current PDHA® electronic dbase include accession, pre-deployment, and tx progress
- Give MTF commander's rpt card on PDHA® compliance - currently provider driven
- Conduct on-site inspection of #deployed, screened, referrals

O: Languages

- If not already developed, the public awareness, education materials related to fight against MH disparity/stigma, deployment cycle adjustments for family, support services available etc should be in following languages;
- Spanish, Tagalog, Korean, Japanese, German
- All of this informational brochures should be available at DoD/DVA MH website in addition to One Source, MTF, DoDDS, DHHC, etc

Carpe Diem!

