

**A Behavioral Health Corps:
The Foundation for Exemplary Military Mental Health Services
Proposed Policy Change**

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This proposal is for a BEHAVIORAL HEALTH CORPS to provide leadership accountability and responsibility for military mental health across all branches, coordinate services, and assure adequate planning, preparation, staff training for mental health services and timely access to services by soldiers. A Behavioral Health Corps will address the serious inadequacies within the Department of Defense's current mental health system----fragmentation, gross inefficiencies, lack of coordination and disconnectedness. Implementation of this policy will assure that the US never again goes to war grossly unprepared to manage psychological injuries.

Psychological Injuries and the Current System

Since WWII, psychological injuries have shown a progressive trend to exceed total KIA/WIA in numbers and costs. Today, psychological injuries are the most unrecognized and untreated war injuries with approximately 30% of all soldiers affected.

Military mental health has been extensively criticized for lack of accountability, fragmentation, inefficiency and disconnectedness. Rampant duplication and waste have been reported for treatment of PTSD (IOM, 2014), substance abuse (IOM, 2012), suicide prevention (RAND, 2011), and social reintegration (IOM, 2010).

In DoD and each service branch, leaders at all levels of the chain of command are not consistently held accountable for implementing policies and programs to manage PTSD effectively, including those aimed at reducing stigma and overcoming barriers to accessing care. In each service branch, there is no overarching authority to establish and enforce policies for the entire spectrum of PTSD management activities. A lack of communication among mental health leaders and clinicians in DoD can lead to the use of redundant, expensive, and perhaps ineffective programs and services...(IOM, 2014:6)

After every war since WWI, the noted "lessons learned" have included the need for adequate prewar mental health planning, preparation, training, staffing, treatment, anti-stigma, and reintegration services. Lack of implementation of these lessons has created a recurring cycle of mental health problems both in the military and in the civilian population (Russell & Figley, 2014).

A BEHAVIORAL HEALTH CORPS WILL:

1. Fulfill the promise of military and societal moral obligation to ensure every veteran and family member receives the highest quality of care possible.
2. Provide psychological care on par with the excellent care for physical injuries.
3. Ensure psychiatric lessons of war are actually "learned" and implemented, and the nation never again goes to war with grossly inadequate mental health planning, preparation, training, and resources.
4. Position the U.S. military as a progressive world leader defining the cutting edge in prevention, assessment, and treatment of mental health and eliminating the stigma and disparity of mental health.

SPECIFICALLY A BEHAVIORAL HEALTH CORPS WILL:

(1) Establish leadership accountability and responsibility for military mental health across all branches.

Currently, DoD assigns primary responsibility of mental health services to military medical departments with the Surgeon General given overall responsibility. IOM has repeatedly noted that leaders are not held accountable for mental health. There is no organizational structure or “Behavioral Health Corps” charged with comprehensive coordination of military mental health services unlike other specialties, i.e. “Medical Corps,” “Dental Corps,” “Chaplain Corps,” “Legal Corps,” “Supply Corps,” “Nursing Corps,” “Civil Engineering Corps,” and even “Veterinary Corps.”

Military mental health consists of thousands of behavioral health specialists including those assigned to military medicine, fleet/line community counseling programs, EDIS, and civilian contractors representing all the specialties and subspecialties of civilian behavioral healthcare. Military Mental Health Personnel may be assigned to fixed military medical facilities, to deployable operational units, community counseling centers, EDIS, warrior transition units, VA facilities, or to military medical research and development duties.

Active-duty and DoD-civilian mental health providers (psychiatrists, psychologists, social workers, and counselors) are widely dispersed across an array of disconnected professional organizations and agencies, each governed by divergent policies. Mental health services are split between four, types of separate, uncoordinated treatment modalities: 1) military medicine treatment facilities, 2) military/fleet (non-medicine) community counseling centers, 3) non-DoD civilian mental health contractors (e.g., TRICARE providers, military life consultants), and 4) pastoral care (highly confidential).

Additionally, all four military branches operate family/community counseling centers that employ thousands of licensed civilian psychologists, clinical psychologists, social workers, substance abuse counselors, art therapists, marriage and family counselors, and mental health counselors. These agencies, operate independently and are not coordinated with military mental health; military medicine does not have access to non-military mental health assets (e.g., community counseling centers).

In contrast to the extensive tracking, coordination, and reporting of nation-wide medical statistics by the Centers of Disease and Control (CDC), there is no single government entity within or outside military medicine that is responsible or accountable for ensuring mental health needs are met, or the proper monitoring of wartime mental healthcare (e.g., Weinick, Beckjord, Farmer, Martin, Gillen, et al., 2011; IOM, 2014. See Appendix 1.

(2) Standardize Assessment, Diagnosis and Treatment for cutting edge, high quality, integrated mental health, neurological, substance abuse and social reintegration services across a continuum of care including post military populations. _

As of 2014, there were no standardized assessment or diagnostic procedures in DoD resulting in great disparity within and between service branches, and community counseling centers and between DoD and VA which greatly complicates a seamless transition to VA (IOM, 2014). There are no standardized mental health treatments or outcome measurements for military populations, or

requirement for all service members to receive maximum benefit of treatment prior to military separation/discharge as existed during WWII (e.g., IOM, 2014). See Appendix 2.

(3) Increase cost efficiency and improve utilization of resources.

Increase cost efficiency. An integrated, coordinated approach across the continuum of care would eliminate administrative costs associated the duplicative mental health services provided by each service branch. Further savings could be realized though trainings, manpower tracking, clinical supplies, and other redundancy costs within and across services. Integrating MTF and community counseling centers would maximize full utilization of resources.

Reduce long-term costs for disability. Substandard care during military service directly contributes to unnecessary personnel loss and long-term disability costs. Harvard economist Blimes (2013) reported cost of current wars in PTSD and TBI treatment alone likely to top \$1 trillion, and span 40 years. Currently, a large proportion of disability is due to neglect of implementing lessons of war trauma. Implementation of “lessons Learned” means that actually implementing the mental health lessons can significantly reduce long-term financial and personal costs of disability.

(4) Improve military readiness and reduce attrition (manpower readiness). _

The Army's Combat Stress Control Directives (2006) cite mental health as a central "military readiness" issue that can directly impact the capacity to fight and win wars. Early identification and treatment by expert consensus is best chance to prevent attrition and long-term disability, reducing premature and unnecessary loss of manpower, training/experience and leadership that clearly detracts from military readiness.

After WWII, the Army discontinued detailed reporting of war stress casualties. Currently official prevalence reports exclude significant proportion of mental health load in DoD (e.g., community counseling centers) and VA (e.g., Vet centers), and inaccurately restricts reporting to handful of psychiatric diagnoses (e.g., PTS), thereby chronically under-estimating the likely and actual incidence of war stress casualties. This inaccurate reporting impairs leadership’s ability to plan and respond.

In 2007, the congressionally mandated DoD Task Force on Mental Health found it nearly impossible to determine the manpower needs for mental health services within DoD. Estimates were confounded by the number of services specialities that do not report mental health issues and by non-military providers (e.g., community counseling centers) who do not write to military records.

(5) Reduce/eliminate mental health stigma and disparity.

The lack of recognition of mental health, by military leadership has created a fear of career repercussions when soldiers seek out or are screened positive for war stress injury. Elevation of a BH to the "corps" level signifies the military's commitment to end the status quo that currently reinforces stigma and barriers to care; dramatically decreases the reality and/or expectation of forced or voluntary separation for PTS-related conditions and removes stigma and deterrent for seeking care; treating mental and physical health as equal, inseparable priorities will decrease stigma and treatment of seeking delays

A BHC with a top-down "zero tolerance" policy for mental health stigma and disparate treatment between mental and physical health, along with a "maximum benefit" treatment mandate (prior to military separation) can reasonably be expected to improve overall military readiness.

HISTORICAL PRECEDENCE - PREDECESSOR OF A BEHAVIORAL HEALTH CORPS

The earliest origins of the BHC can be traced to the U.S. Army's Neuropsychiatry Division of the Medical Department of the Army developed during the Second World War in 1944 that included the multidisciplinary Consultation and Liaison Division and Reconditioning Corps (Farrell, 1966). During WWII, a Behavioral Health Corps was established and comprised of neurologists, psychiatrists, psychiatric nursing, clinical psychologists, social workers, occupational therapists, vocational counselors, recreational therapists, and chaplains (Farrell, 1966). However, after WWII, the "Medical Service Corps" (MSC) was established that led to psychiatrists and neurologists being assigned to Medical Corps, psychiatric nurses to Nursing Corps, and psychologists, social workers, and occupational therapists assigned to MSC along with 22 other administrative and clinical specialties.

RESPONDING TO CRITICISMS, Overcoming Arguments Against a Behavioral Health Corps

It's too costly to change and reorganization.

While it is costly to make changes, lack of treatment of psychological injuries is likely more costly for the nation, families and the individual in the long term.

We don't need any more bureaucracy!

While no one wants more bureaucracy, the current system is fragmented and dysfunctional and not working to provide the necessary mental health services. Nothing short of complete reorganization will achieve the visions and goals articulated by the 2007 DoD Task Force on Mental Health and multiple commissioned studies, to provide world-class, integrated mental healthcare and eradicate mental health stigma and disparity, as well as end the cycle of preventable wartime behavioral health crisis. Anything short, will lead to revisiting the same issues at the next war.

The current system just needs a few modifications to "fix" the system.

Incremental change has been recommended and even implemented in some cases. One recommendation has been to align the new BHC under the respective medical departments overseen by the service Surgeon Generals (SG), and/or only align military versus DoD civilian community counseling centers, with a false illusion of step-wise changes preferred over a major overhaul. For example, the DoD Task Force (2007) recommended each service branch assign an individual as "Director of Psychological Health" under the respective SG, and that each military base identify a "Psychological Health Coordinator." While both initiatives share face validity, both inherently lack the authority to effect meaningful change, essentially amounting to tweaking the status quo. The current system continues to be dysfunctional.

IMPACT OF BHC BEYOND THE MILITARY

If successfully implemented, the military's BHC can serve as a model for integrating VA and DoD healthcare, with BHC personnel assigned to either or both VA or DoD during their careers as a "purple suit." Moreover, a National BHC could be envisioned whereby personnel can be mobilized to respond to disasters, mass shootings, rural areas, or locations facing racial disparity in accessing mental healthcare. The National BHC can serve to supplement the VA and DoD during and after times of war, but can be redeployed to other segments of society when wars end, in addition to meeting peacetime needs.

Appendix 1: Examples of Fragmentation of Military Mental Health Services

Military medicine. Active-duty and DoD-civilian psychiatrists, clinical psychologists, social workers, occupational therapists are assigned to inpatient hospitals at military treatment facilities (MTF), outpatient mental health clinics, and operational platforms (e.g., combat stress control units, aircraft carriers, etc.). DoD assigns primary responsibility of mental health services to military medical departments with Surgeon General given overall responsibility. The SG is assisted by 0-6 level mental health specialists (psychiatry, clinical psychology, social work) with rotating 3-year duties as “specialty advisor” who oversee manpower and assignments. There is little coordination between specialties within a service branch, and little coordination between service branches. Ex. In February 2007, the Navy Medical Service Corps acted to disband its military social workers during a time of acute DoD personnel shortages. Rationale was that unlike Army social workers, Navy social workers did not deploy to war zones, and assigned traditional case manager work in garrison. Both disparate Navy policies were reversed after the June 2007 DoD Task Force on Mental Health report. Standardized clinical training is largely non-existent within and across DoD (IOM, 2014).

Community counseling centers. All four military branches employ 1000s of licensed civilian psychologists, clinical psychologist, social workers, substance abuse counselors, art therapists, marriage and family counselors, and mental health counselors in family/community counseling centers. These are non-medical agencies, assigned to the “line” or “fleet” not military medicine, and operate independently, uncoordinated with military treatment facilities. Workload data is kept separate from military medicine's records, and therefore invisible in DoD prevalence statistics. Advantage is less stigma because community centers and other external groups don't use military's electronic medical record, therefore less chance of command finding out, etc. A 2013 MOU prohibits Marine Corps Counseling Services (MCCS) and Navy Fleet and Family Service Center staff to treat anything other than adjustment disorder and non-clinical conditions (V-codes), and refer anyone who may be suicidal or have PTSD to the MTF-with long waiting lists. The Army and Air Force do not place such restrictions on their community counseling center personnel.

Mental health consultants. The four branches employs 100s of non-DoD civilian contractors across DoD to serve as military life consultants (MLC), or contracted TRICARE mental health providers were MTF staffing shortages exists. There is greatly discordant policies, training standards, and outcome measurements to assess utilization & efficacy of such programs, with no single agency responsible for monitoring or reporting.

Appendix 2. Issues with Mental Health Assessment, Diagnosis and Treatment.

Most definitive mental health treatments are provided in VA or after military discharge or retirement. Every PTSD practice guideline domestic and international, cites necessity of early identification and treatment to prevent chronic disability and co-morbidities. However, mental health treatment is not mandatory.

Substance Abuse (SA). All four military branches provide outpatient and residential SA programs with some services offered by military medicine (e.g., Navy Substance Abuse Rehabilitation Programs) or by non-medical agencies (e.g., Marine Corps Community Counseling Services). There is no single agency responsible for ensuring adequacy of SA in DoD (IOM, 2012). There is no standardized training, assessment, or treatment including provision of co-occurring mental health treatments within or across DoD or VA (IOM, 2012).

Traumatic Brain Injury (TBI). At present, DOD instruction assigns responsibility for mild TBI screening and early intervention on military medical departments. However, cognitive rehabilitation is often fragmented and inconsistent across services and DoD and VA. That majority of mTBI involve co-morbid mental health, spiritual, substance abuse, and family stressors, such comprehensive, integrated care is largely non-existent today except at specialized regional centers. There is no single agency responsible for ensuring adequacy of TBI management in DoD (DoD 2007). There is no standardized training, screening, assessment, or treatment including provision of co-occurring mental health treatments within or across DoD or VA (GAO, 2011a).

PTS Treatment. While every PTSD practice guideline, both domestic and international, cites necessity of early identification and treatment to prevent chronic disability and co-morbidities; mental health treatment in US military is not mandatory.

Suicide Prevention. National studies by RAND (2013) and IoM, cited inherent fragmentation, duplication, and inefficiencies plagues military systems. Recommendations for centralized tracking of suicide across the DoD, VA, and private sector were made in Vietnam-era (CDC, 1983). Each military medical service, the non-medical community counseling centers, and general line contractors offer diverse, overlapping services. Suicide intervention is highly inconsistent, with several military branches prohibiting by instruction licensed community counseling staff (psychologist, social worker, MTF) from assessing and treatment suicidal clientele, compelling referral to long-wait list in overburdened military treatment facilities. There is no single agency responsible for ensuring adequacy of TBI management in DoD. There is no standardized training, screening, assessment, or treatment including provision of co-occurring mental health treatments within or across DoD or VA (DoD, 2010).

Military Sexual Trauma (MST). All four military branches provide sexual assault prevention and counseling services. At present, DoD assigns primary responsibility of MST policy implementation to military medicine or to non-medical community counseling centers. There is no single agency responsible for ensuring adequacy of MST management in DoD. There is no standardized training, screening, assessment, or treatment including provision of co-occurring mental health treatments within or across DoD or VA.

Complicated Bereavement & Moral Injury. Traumatic grief, post-traumatic anger, and moral injury are all potential outcomes of exposure to war and other traumatic stressors, however, education, training, prevention, and intervention is routinely inconsistent, unintegrated, and deeply fragmented.

At present, normal bereavement and spiritual wounds are the acknowledged purview of pastoral care, whereas complicated bereavement (traumatic grief), if recognized, is covered by a range of unintegrated services (e.g., psychiatry, pastoral care, family practice, substance abuse counselors, family counseling).. No lead agency exists to provide education, training, prevention, and intervention services across DoD.. There is no single agency responsible for ensuring adequacy of traumatic grief in DoD.

Medically Unexplained Physical Conditions (MUPS). Historically, MUPS are often equally represented outcome of war along with psychiatric casualties. There is no single agency responsible for ensuring adequacy of MUPS management in DoD. There is no standardized training, screening, assessment, or treatment within or across DoD or VA.

Education and Development Intervention Services (EDIS). The DoD has assigned (DODI 1392.12) military medical departments to oversee the congressionally-mandated EDIS (under IDEA) providing comprehensive, multidisciplinary care (child psychiatry, developmental pediatrics, child psychology, social work, community nursing, pediatric audiology, physical therapy, occupational therapy, and speech therapy) services for children and family members with special needs ages birth to 21-years. Mental health related services are a major EDIS component. Historically, inherent fragmentation of current systems often results in DoD non-compliance with federal law, resulting in critical gaps of services to vulnerable populations, particularly mental healthcare in overseas locations where TRICARE is unavailable.

Social Re-integration. There is no lead agency assigned to oversee or coordinate social reintegration services across DoD, VA, HHS, or private sector (IOM, 2011). Historically, the need for reintegration support was recognized after WWI. Then and now, service members often report a sense of betrayal, abandonment, and alienation upon leaving active-duty after having to negotiate by themselves transitions to VA or over 48,000 civilian non-profits offering some reintegration including school and work support (GAO, 2011b). .Ex. There is no single composite listing of reintegration services in given locales across the nation made available to military populations and family members upon transition.

Anti-Stigma and Mental Health Parity. There is no lead agency responsible for developing, coordinating, or monitoring public health campaign to eliminate mental health stigma and disparity in DoD, VA, and HHS (DOD, 2007). Sustainment of anti-stigma, holistic health and mental health parity public health campaign is historically absent after wars end.

Appendix 3 Organizational Structure of the Proposed Behavioral Health Corps

Administrative, Leadership Structure

The New Behavioral Health Corps is a staff corps (non-combat specialty branch) of the U.S. Air Force, Army and Navy/Marine Corps consisting of commissioned active-duty, National Guard, and reserve officers, DoD-civilian, and non-DoD civilian contractors– who are specialists in a neurological or mental health-related specialty with a graduate degree and a state license, supported by enlisted specialty technicians,

The Chief of the Behavioral Health Corps is a Flag/General Officer afforded equal status as special assistant to the Assistant Secretary of Defense for Health Affairs as military medicine’s Surgeon Generals of the Air Force, Army, and Navy/Marine Corps. The Chief serves as Special Assistant to the ASD-HA on equal status as the medical Surgeon General.

Senior Enlisted Leader (SEL), Behavioral Health Corps. An E-8/E-9 enlisted neurologic, psychiatric, nursing, or occupational therapy technician will be appointed by the ASD-HA for the Air Force, Army and Navy/Marine Corps to assist the respective Chief, BHC, in overseeing enlisted members assigned to the BHC.

The Assistant Corps Chiefs provide career direction to their respective division personnel (divisions listed below) as well as recommend policies to the Chief, BHC.

Specialty Leaders. Officers at O-6 level and Enlisted at E-7 to E-8 level will be assigned by the Chief, as specialty leaders for their respective specialties. (see membership above)

Divisions/Sections of the Behavioral Health Corps

To ensure adequate resourcing in fulfillment of its varied missions, the following seven BHC divisions are recommended to be led by Flag/General Officers assigned as Assistant Corps Chiefs by the Chief, BHC:

Therapeutic Management/Reconditioning – oversee treatment services including substance abuse, family counseling, and definitive care prior to discharge.

Prevention, Education & Training – oversees general military, resilience building, standardized specialty care training and oversees elimination of stigma, disparity, and dualism, and caregiver support.

Center for Research and Lessons Learned—oversees collection and dissemination of psychiatric lessons learned, provide centralized, integrated behavioral health-related data tracking, conduct primary clinical research, track & report program outcomes, & monitor program effectiveness.

Transition and Social Reintegration—oversees military transition including VA transition, develops, coordinates a national social reintegration plan in concert with VA and civilian non-profit and profit organizations.

Educational and Developmental Intervention Services (EDIS)

Operational – oversees training and deployment of assets to operational platforms

Personnel management. Oversees career progression and promotion within the BHC similar to specialists assigned to the Medical Corps. This will allow career progression to Flag/General Officer level of mental health specialties previously barred from such leadership roles (clinical psychologists, social workers, occupational therapists).

Specialties Assigned to the New Behavioral Health Corps

Neurology

Psychiatry

Clinical Psychology

Social Work

Substance Abuse Counselors

Occupational Therapy

Psychiatric Nursing

Marriage and Family Counselors

Mental Health Counselors

Recreational/Art Therapist

Vocational Counselors

Case Managers

Research Psychology

Education and Development Intervention Services (EDIS) currently comprised of active-duty and civilian contractors pediatric physical therapy, occupational therapy, developmental pediatrician, child clinical psychology, child psychiatry, community health nursing, speech and language pathologist, early childhood special educator, and office administrators.

Enlisted technicians: Neurology, Psychiatry, Occupational Therapy, Peer Substance Abuse Counselors, and Nursing assistants.

Active-duty, DoD-civilian, and civilian contractors (e.g., Military Life Consultants, EDIS) from military medicine and fleet community counseling services, along with respective enlisted technicians (e.g., psychiatric, neurologic, occupational therapy, substance abuse counselors) will be reassigned to the new BHC.

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