Corrective Actions Essential for Fixing Military Mental Healthcare *by Mark C. Russell, Ph.D., CDR, USN (Ret.)*

The following 17 corrective actions are essential for transforming military mental healthcare and end the generational cycle of mental health neglect and self-inflicted crises:

1. Conduct the first-ever investigations by Congressional armed services oversight committees into the preventable root causes of the current wartime crisis in order to identify specific policies and practices requiring change (Russell & Figley, 2015a; 2015b).
2. Creation of a dedicated '*Behavioral Health Lessons Learned Center'* with dedicated policies, programs, and personnel equal to those that exist for military medicine. Require the DoD to ensure all ten foundational lessons of war trauma are implemented and monitored for compliance on a regular bases (Russell, Figley & Robertson, 2015).
3. Establish a '*Behavioral Health Corps'* that integrates all three independent components of military mental healthcare (military medicine, family/community counseling centers, and DoD contractors) into a single, accountable, chain-of-command equal to power, resources, and status that exists for military medicine. The Behavioral Health Corps will critically raise the status and priority of mental health services and its providers in-keeping with the military's existing Medical Corps, Nursing Corps, Dental Corps, Legal Corps, Chaplain Corps, Civil Engineering Corps, Supply Corps, Medical Service Corps, and Veterinary Corps (Russell, Butkus, & Figley, 2016a; 2016b).
4. Compel DoD to adopt a '*zero tolerance*' policy for mental health stigma, disparity, and organizational barriers to seeking mental healthcare similar to existing zero tolerance policies to eliminate other forms of social injustice such as discrimination based on race, gender, and sexual orientation.
5. Commission the Institute of Medicine to investigate the efficacy and potential harm caused by the military's forward psychiatry (COSC) programs in light of recent research findings that frontline psychiatry is harmful to the health and well-being of veterans' and their families (Russell, Gellman, Rodriquez, & Figley, 2016).
6. Require the DoD and VA to implement recommendations by the Institute of Medicine (e.g., 2013, 2014) and RAND (e.g., Ramchand et al., 2011;Weinick et al., 2011) to ensure seamless transition of veterans and their families.
7. Reinstate President Roosevelt's executive order mandating the military to provide 'maximum benefit' of comprehensive, multidisciplinary treatment and reconditioning services prior to discharging military personnel to include reconditioning, vocational training, family support, and peer networking (Russell, Zinn, & Figley, 2016).
8. Develop a centralized database to track and transparently report the full spectrum of war stress injury, program outcomes, and treatment outcomes across the DoD and VA (Russell, Butkus, & Figley, 2016b).
9. Establish and maintain a '*National Re-entry Program*' providing coordination between DoD, VA, and non-profits consisting of peer mentors and a centralized, searchable database and coordination service covering the full-spectrum of re-entry needs for veterans and their families (Russell, Butkus, & Figley, 2016b).
10. Issuance of a deployment policy limiting deployment length to 6-months similar to the MoD "*Harmony Guidelines*" and enact legislation requiring institution of the military draft without any exemptions after the second deployment cycle. (Russell, Zinn, & Figley, 2016).
11. Pass legislation prohibiting the military's use of 'backdoor' or wrongful 'bad paper' discharges of war veterans (e.g., Government Accountability Office, 2010).
12. Issuance of legislation ensuring all war veterans and their families, regardless of length of service or characterization of military discharge have access to VA mental health services for perpetuity similar to the U.K (Russell, Zinn, & Figley, 2016).
13. Issuance of legislation requiring the DoD and VA to ensure they maintain adequate large numbers of well-trained behavioral health specialists during times of peace and war including substantial increase in recruiting mental health trainees via Uniformed Health Services University and hiring marriage and family therapists or other graduate level counselors per Institute of Medicine (2010).
14. Pass legislation for the DoD and VA to conduct research, training, and provide access to all evidence-based psychotherapies per VA/DoD (2010) clinical practice guidelines including eye movement desensitization and reprocessing (EMDR), as well as complimentary alternative medical services.
15. Establish a DoD/VA oversight committee including veterans, family members, and key non-profits to track and report on implementation and compliance with the above injunctions (Russell, Butkus, & Figley, 2016b).
16. Eliminate the 203 DoD policies the GAO (2016) identified as responsible for maintaining organizational sanctioned mental health stigma and barriers to seeking care.

17. Pass legislation to amend the Feres Doctrine by adding the inception under FCTA allowing class action for medical and mental health negligence outside warzones similar to U.K. laws in order to provide equal constitutional protection for citizen-soldiers (Russell, Zinn, & Figley, 2016).

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