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Contribution of Military Organization and Leadership Factors in Perpetuating Generational Cycle of Preventable Wartime Mental Health Crises: Part One

Mark C. Russell[1] · Sue Nicholson Butkus[2] · Charles R. Figley[3]

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Abstract This is the first of a two-part series of the contribution of organizational and leadership factors in perpetuating a generational cycle of preventable wartime behavioral health crises. The current study includes a comprehensive review of government-initiated studies on the policies, leadership, and organizational structure of military mental healthcare. Among other things, the paper reports on the persistent, serious inadequacies within the U.S. Department of Defense including fragmentation, gross inefficiencies, inadequate coordination, lack of leadership accountability and responsibility both within and across military mental health across all branches. It is hypothesized that these problems have led to past and present wartime crises and are linked to ignoring documented lessons learned. These lessons point to the need for an integrated, coordinated organizational structure with a clear chain-of-command and accountable leadership. Such leadership, it is argued, will ensure adequate planning, preparation, and implementation to meet military mental health needs. While first-order changes have been made over the years through several incremental system corrections that have been tried, second-order (structural and systemic) change is necessary to "fix" the system. The latter section of the paper calls for and describes a complete reorganization of military mental health to improve mental healthcare for military populations.

✉ Mark C. Russell
mrussell@antioch.edu

[1] Antioch University Seattle, 2326 Sixth Avenue, Seattle, WA 98121-1814, USA

[2] Washington State University, Pullman, WA, USA

[3] Tulane University, New Orleans, LA, USA

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> "Each moment of combat imposes a strain so great that men will break down in direct relation to the intensity and duration of their exposure. Thus psychiatric casualties are as inevitable as gunshot and shrapnel wounds in warfare" (Appel & Beebe, 1946; p. 185).

The psychosocial consequences of war are real and obvious to most Americans. The drumbeat of media reports of suicides among military veterans continues; reports of inadequate care for veteran mental health problems continues to draw wide-spread criticism from the public. As of 4 June 2015, after 13 years of war, a total of 5353 American military personnel have been killed in action (KIA) while deployed in support of Operations Enduring and Iraqi Freedom (OEF/OIF), Operation New Dawn (OND), Operation Inherent Resolve (OIR), and/or Operation Freedom Sentinel (OFS). Another 52,298 combatants were physically wounded in action (WIA), reflecting the inevitable physical sacrifice of war (U.S. military casualty statistics available at http://www.defense.gov/news/casualty.pdf). Tragic as the physical mortality statistics are, progressive advancements in military medicine have led to unprecedented 97 % survival rates—clearly reflecting organizational priority and commitment to properly plan and prepare and learn from hard-won battlefield medical lessons of war (e.g., Gabriel, 2013).

Meeting the Psychological Wounds of War

What of the military's planning and preparation to address the equally predictable psychological effects of war? In stark

contrast to meeting the medical needs of the military population, the USA is mired in another costly behavioral health crisis (Russell & Figley, 2015a) with an estimated $1 trillion price tag (Blimes, 2011). Prevalence estimates of the spectrum of war stress casualties within the 2.7 million deployed service members vary chaotically from 5 to 50 % in posttraumatic stress disorder (PTSD) diagnosis alone (e.g., Ramchand, Schell, Karney, Osilla, Burns, & Caldarone, 2010), reflecting a deeply fragmented, confounding, decentralized, and dysfunctional military and veterans' mental healthcare systems (e.g., Institute of Medicine (IOM), 2014b; Russell & Figley, 2015a). For example, answers to a relatively straightforward question such as "how many military personnel and veterans have been killed by suicide during the current wars?" is unknown. The Department of Veterans Affairs (VA) did not track veteran suicide until 2008, and the Department of Defense (DoD) had no centralized tracking and reporting mechanism until 2009. Both initiatives were spurred by Congressional and Presidential directives in the context of public outcry from inflammatory media reports of high veteran suicide rates, as opposed to a proactive organizational response (e.g., Congressional Research Service, 2013; Ramchand, Acosta, Burns, Jaycox, & Pernin, 2011; Russell & Figley, 2015a). Despite subsequent VA and DoD improvements in suicide prevention and surveillance programs (Ramchand et al., 2011), the combined total of OEF/OIF/OND military personnel and veterans killed by suicide remains elusive due to the absence of comprehensive tracking (Congressional Research Service, 2013).

Estimating Wartime Behavioral Health Needs

What are the needs? No one knows for sure. Unlike the DoD's centralized monitoring and reporting of the physical casualties of war, there is no single agency responsible or accountable for comprehensive tracking of wartime behavioral health outcomes (e.g., Institute of Medicine, 2013b, 2014a). Only piecemeal estimates of behavioral health are available to those responsible for provision or oversight of mental health services to military populations.

A RAND study (Ramchand et al., 2011) illustrates this lack of reliable data regarding wartime suicide. The study looked at 1609 active-duty personnel who committed suicide between 2001 and 2008, excluding suicides by reserve and National Guard components. Coupled with DoD annual suicide reports from 2009 to 2013 (Department of Defense Suicide Event Report, n.d.), a total of 3515 military suicides can reasonably be deduced.

A recent study of OEF/OIF/OND-era veterans discharged from 2001 to 2009 reported an additional 1868 suicides, a 41 to 61 % higher suicide rate than the US general population irrespective if deployed or not (Kang, Bullman, Smolenski, Skopp, Gahm, & Reger, 2015). In all, the crude total number of known suicides among OEF/OIF/OND-era veterans (5383) exceeds the total number of military personnel KIA (5353). This is an alarming trend evident during the First Gulf War, and likely the Vietnam War (Russell & Figley, 2015b), highlighting the critical importance of organizational accountability in terms of planning, preparation, monitoring, and coordination in service provision.

The problem is growing if the focus is on other common manifestations of war stress injuries. The Congressional Research Services (CRS) reported that a total of 936,283 military personnel were diagnosed with at least one psychological disorder between 2001 and 2011, 49 % of which were diagnosed with multiple conditions including 255,852 service members diagnosed with traumatic brain injury (TBI) (Congressional Research Service, 2013). According to the Department of Veterans Affairs (2015), between 2001 and 2014, a sum of 662,722 OEF/OIF/OND veterans received VA treatment for a mental health diagnosis including PTSD (364,894), depressive disorders (294,967), anxiety disorders (281,992), psychotic disorders (185,826), and substance use disorders (190,923).

Despite the publication of several systematic reviews focusing on the scope and depth of wartime mental health crises, the gaps of incomplete data are wide and troubling. This is especially true in relation to prevalence of psychiatric conditions, TBI, suicide, medically unexplained physical symptoms, traumatic grief, moral injury, posttraumatic anger, domestic violence, child abuse, divorce, familial impact, unemployment, misconduct, incarceration, homelessness, resilience, and intensification of stigma (IOM, 2013b; Russell & Figley, 2015a, b). Over and over again, however, every study or report on military and veterans' mental healthcare attaches a caveat of the incomplete picture presented given inherent gaps and divergence in data collection, policies, procedures, and reporting within and across numerous DoD agencies, the VA, and the private sector (e.g., Congressional Research Service, 2013; IOM, 2013b; Russell & Figley, 2015a; etc.).

Indeed, when viewed systematically and historically, psychiatric casualties have far surpassed the combined physical sacrifice of 57,651 service members KIA and WIA which is a historical trend first established during the Second World War (WWII, Russell & Figley, 2015b). Aside from the laudable, but likely unrealistic goal of avoiding war altogether, is there anything the military and its government could have done to possibly avert or mitigate a wartime behavioral health crisis? Russell & Figley (2015a) concluded the present crisis is largely self-inflicted due to institutional neglect. However, what evidence exists implicating the military's organization, leadership, and policies in the current and possibly future crisis?

Purpose of the Review

This paper is the first of two parts which addresses the need to improve mental healthcare of military personnel. Part one reviews government sponsored studies on the organizational and leadership structure of military mental healthcare, as well as examines recurring themes and recommendations to improve the Department of Defense's mental health system. A follow-up on paper addresses part two. That paper will propose a comprehensive restructuring of military mental healthcare. This restructuring would address the problems noted in this paper and should dramatically improve the quality of services and end the cycle of preventable wartime behavioral health crises.

War Trauma Lessons and Preventable[1] Wartime Behavioral Health Crises

Preliminary investigations into present and past wartime behavioral health crises have revealed a clear pattern of self-inflicted or preventable crises caused primarily by the military's repetitive neglect and failure to learn from its own documented lessons of war trauma (Jones, 1995; Russell & Figley, 2015a, b). Military medicine acknowledges the immense value of knowing the history of war stress injuries in that "the past can enable mental health professionals to avoid mistakes made earlier and to devise new ways to deal with modern stress" (Jones, 1995; p. 6). Each of the military medical departments (Air Force, Army, and Navy) is responsible for provision of mental health services to their respective service personnel and family members during times of peace and war (IOM, 2013b). The Navy provides all medical, dental, and mental health services for the United States Marine Corps. Throughout the paper, whenever Navy medicine is used, it also implies their coverage of the Marine Corps.

The clearest proof of the military's actual learning from its war trauma lessons is the absence of forgetting or ignoring basic tenets for meeting wartime mental health needs and preventing crisis. The many psychiatric lessons of war are available through numerous retrospective analyses and official reports conducted by the military, historians, commissioned investigations, and memoirs by military leaders (Russell & Figley, 2015a).

Ten Foundational Lessons of War Trauma

An extensive review of the military's lessons learned literature has identified ten interrelated foundational war trauma lessons that each war generation has either implied or explicitly stated as essential for meeting basic wartime mental health and social reintegration needs (Russell, Figley, & Robertson, 2015). Those foundational lessons are as follows:

1. War inevitably causes a legitimate spectrum of war stress injury.
2. Adequate research, planning, and preparation are indispensable during war and peace.
3. A large cadre of well-trained mental health specialists is compulsory during peace and war.
4. A holistic public health approach to war stress injuries necessitates close collaboration with the private sector along with mental health treatment coverage that is equal to treatment for other health issues.
5. Effective mental health services demand an empowered leadership of an independent, unified, organizational structure (e.g., "Behavioral Health Corps") providing integrated, well-coordinated continuity of care equal to medical services.
6. Elimination of mental health stigma, barriers of care, and disparity must be a priority leadership issue at all levels directly impacting individual, family, and military readiness.
7. Ready access to high quality mental health services including definitive care (comprehensive treatment) prior to military separation or discharge needs to be ensured.
8. Families must receive adequate mental health and social support during and after military service.
9. Accurate, regular monitoring and reporting are crucial for timely, effective management of mental health needs.
10. Robust dedicated mental health "lessons learned" policy and programs are integral to meeting present and future needs and prevent crisis.

Surprisingly, military cohorts from each war generation readily admit to failing to heed the foundational psychiatric lessons of their predecessors. For example, the introductory chapter in the US Army's *Textbook of Military Medicine: War Psychiatry* entitled "The Psychiatric Lessons of War" (Jones, 1995), summarizes the history of war stress management with the table headers of "Lessons Learned/Relearned" and "Lessons Available But Not Learned" (Jones, 1995; p. 5), thus forming the genesis for investigating preventable wartime crises (Russell et al., 2015).

Historical Lessons of Mental Health Organization and Leadership

There has also been a failure of leadership. Every war generation similarly describes problems associated with the gross disparity between medical and mental health organization,

[1] The term "preventable" is intended to convey the extent of unnecessary suffering, disability, and premature death due to organizational neglect of providing basic mental health and social services (Russell & Figley, 2015a).

leadership, and policies. For instance, during the Persian Gulf War, military authors cite "Operation Desert Storm demonstrated marked differences between policies and practice for managing physical casualties and those for managing stress casualties" (Kirkland, 1996; p. xxx), and the US Army's Chief Neuropsychiatric Consultant during WWII observes, "In spite of the fact that the number of psychiatric casualties created a problem of such size that it could not be ignored, in too many instances psychiatrists were only tolerated very reluctantly; often they were resisted" (Menninger,1948; p. 20–21). Concerns over a deeply flawed organizational structure of military mental healthcare is far from new as WWII era's Chief Army Neuropsychiatric Consultant asserts "Certain factors within the Army—its organizations and system—further added to the difficulty for psychiatry. Each of these contributed directly to the production of psychiatric casualties. All of this could be changed so that they would be much less of a menace to mental health" (Menninger, 1948; p. 516). The General's candid appraisal is corroborated by other senior WWII psychiatrists who report, "A frequent comment by frustrated and harassed psychiatrists during World War II was that responsible authorities failed to heed the lessons learned by psychiatry in World War I" (Glass, 1966b; p. 735), thus giving credence to the proposed solution during WWII that "Some clinical psychology officers believe that a separate corps within the Medical Department should have been created" (Seidenfeld, 1966; p. 586).

The Role of Military Organization and Leadership in the Present Crisis

Today, the crisis continues. The central and unifying psychiatric lesson across war generations is the pivotal role of mental health organization, leadership, policies, and practices in causing or exacerbating behavioral health crises in the past (Russell & Figley, 2015b) and present day (Russell & Figley, 2015a). According to the IOM (2013b), "Providing uniform services within the DoD and VA healthcare systems across geographic locations, facilities, and providers should be a priority" (p. 426), and conversely that "Fragmentation of care diminishes continuity and coordination, often resulting in higher use of emergency departments, increased hospitalization, duplication of tests, and increased costs" (p. 424).

In June 2007, after nearly 7 years of war, the congressionally mandated DoD Task Force on Mental Health (DoD TF-MH, 2007) released a 12-month long review of its prewar planning and preparation and organizational capacity to meet basic mental health needs of 21st century war fighters and their families. The DoD TF-MH (2007) concluded "The Task Force arrived at a single finding underpinning all others: The Military Health System lacks the fiscal resources and the fully trained personnel to fulfill its mission to support psychological health in *peacetime* or fulfill the enhanced requirements imposed during times of conflict (DoD TF-MH, 2007; p.ES.2)." Similar deficits in effective planning and preparation for the treatment of mental health issues was evident in World War II as evidenced by Glass' (1966a) comments, "Despite the foregoing data that were available to responsible authorities, there was no effective plan or real preparation for the utilization of psychiatry by the Army in World War II. Facilities for the care and treatment of psychiatric cases were only barely sufficient for the small peacetime Army" (p. 18).

The DoD TF-MH Report is quite explicit about the costs of inaction. The task force's report makes a fervent appeal to end the cycle of failure to learn so-called psychiatric lessons of war asserting "The time for action is now. The human and financial costs of unaddressed problems will rise dramatically over time. Our nation learned this lesson, at a tragic cost, in the years following the Vietnam War. Fully investing in prevention, early intervention, and effective treatment are responsibilities incumbent upon us as we endeavor to fulfill our obligation to our military service members" (DoD TF-MH, 2007; p. 63). Previous implorations to never again neglect the hard-won lessons of war trauma are documented by every generation since the First World War (WWI). For instance, US Army Surgeon General Leonard D. Heaton (1966) sternly warns in the massive two-volume Army Medical Department compilation of WWI and WWII psychiatric lessons "With this information so readily available, there can be little excuse for repetition of error in future wars, should they occur" (cited in Glass & Bernucci, 1966; p. xiv). Unfortunately no excuses were offered.

Aggravating the existing crisis was the DoD's significant delay in publicly acknowledging and proactively addressing a worsening tragedy as evidenced by years of contradictory pronouncements to the national media (e.g., Zoroya, 2007), official military public affairs guidance (e.g., U.S. Army 2006; U.S. Navy, 2007), and sworn congressional testimony (e.g., Kilpatrick, 2007). The extent of an organizational, self-inflicted wound, is further exemplified in the military task force's 99 corrective actions indicating major systemic deficiencies in every aspect of mental healthcare (i.e., staffing, training, stigma elimination, assessment, data collection, prevention, treatment, monitoring outcomes, family support, continuum of care, timely access, research, and social reintegration) (DoD TF-MH, 2007). Each deficiency represents organizational failure to learn the foundational lessons of war trauma documented by every generation since WWI (Russell et al., 2015). The DoD's belated and contradictory disclosure begged uninvestigated questions of "why" military medicine was so grossly ill-prepared and to what extent the present crisis could have been prevented, or at least significantly mitigated in its scope and cost (Russell & Figley, 2015a).

Organizational Deficiencies Reported by the 2007 Department of Defense Task Force on Mental Health

The DoD TF-MH (2007) described the fragmented nature of the military mental healthcare system by noting "Provision of a full continuum of support for psychological health for military members and their families depends on many organizations." (p. 53). The report notes that in addition to the services offered by clinical mental health providers at military treatment facilities or mental health specialty clinics, for example, military and family members can acquire services from local counseling centers, religious programs, family services, health promotions, family advocacy, new parent support teams, substance abuse prevention, and treatment programs and numerous others. Additional organizations provide services outside installations such as Military OneSource and the TRICARE Network.

Lastly, in relation to DoD's mental health policies and chain-of-command, the DoD-TF-MH (2007) candidly reported, "The services exist in different authority structures and funding streams. The Task Force found various degrees of segregation for these programs and no consistent plan for collaboration in promoting psychological health of service members and their families. The services are stove-piped at the installation and Service levels" (p. 53), leading to the insightful conclusion, "The lack of an organized system for installation-level management of psychological health is paralleled by the lack of a DOD wide or Service-level strategic plan for the delivery of services to support psychological health" (p. 53), and adding that, "A strategic plan should address all aspects of psychological well-being such as access to a continuum of care, TRICARE network adequacy and access, staffing of uniformed and civilian personnel, retention, recruitment, family violence, suicides, substance abuse, and wait times" (p. 53). The term *stove-piping* signifies that each entity has its own separate chain of command, personnel, policies, record-keeping, and data collection procedures with widely varying levels of collaboration with other mental health entities at the installation or headquarters levels.

In sum, there was no cohesive plan or leadership structure responsible or accountable for meeting basic mental health and social reintegration needs. However, it took 7 years of contradictory Congressional testimony for American military leaders to admit it. These leaders confessed with impunity that there was a self-inflicted mental health crisis caused largely by ignoring their predecessor's prophetic warning to heed the lessons of war trauma. As a result of inaction the cycle of preventable wartime behavioral health crises continues (Russell et al., 2015). How could this happen? One key factor is US military culture and organization in relation to mental healthcare.

Comparison of Military Organization in Meeting Physical and Mental Health Needs

Of the estimated 9.66 million beneficiaries eligible for military medical services in 2013, 15.2 % were active military personnel and 3.7 % were reserve or National Guard members, along with 5.5 million enrollees in TRICARE including family members, retirees, and DoD civilians (IOM, 2014b). The DoD's capacity for meeting the physical and mental health needs of such a large and diverse population, in a variety of challenging environments worldwide, requires a straightforward, coherent, and efficient "chain of command" organizational structure with leaders from headquarters to installation level held responsible and accountable for complying with policies and practices required to fulfill the healthcare mission. In order to fix the organizational and leadership deficiencies reported by the DoD TF-MH (2007), it is essential to understand the critical differences in organizational structure between military medicine and mental healthcare.

Overview of Military Medicine Organizational Structure

A civilian physician is appointed as head of the Military Health Service (MHS) with the positional title of Assistant Secretary of Defense for Health Affairs [ASD(HA)] whose responsibilities include "maintaining the readiness of military personnel by promoting physical and mental fitness, providing emergency and long-term casualty care, and ensuring the delivery of healthcare to all service members, retirees, and their families. MHS coordinates efforts of the medical departments of the Army, Navy, and Air Force; the Joint Chiefs of Staff; the combatant command surgeons; and private-sector healthcare providers" (IOM, 2013b; p. 48).

The ASD(HA) is supported by several Deputy Secretaries who divide up general oversight of their medical purviews. However, the essential management of military medicine is the responsibility of a "flag officer" (rank of general or admiral) physician, assigned as the Surgeon general (SG) to their respective service branch (Army medicine, Air Force medicine, or Navy medicine). The SG is supported by flag officers assigned to be responsible and accountable for managing their particular "Corps" in carrying out medical policies and its mission.

Corps

A corps provides professional identity and critical central management for a group of specialists, led by a flag officer who is responsible and accountable for tracking, managing, and reporting on its manpower requirements (e.g., recruiting,

retention, promotions, etc.), training, readiness, assignments, career progression, and implementation of lessons learned. Current military corps includes Medical Corps (MC), Nursing Corps (NC), Dental Corps (DC), Legal Corps (JAG), Civil Engineering Corps (CEC), Chaplain Corps (CC), Supply Corps (SC), Medical Service Corps (MSC), and Veterinary Corps (VC). The corps flag officers are supported by mid-level officers assigned as specialty leaders or assistants to the SG, who manage a specific discipline of specialists for their service branch (e.g., Navy Psychiatry Specialty Leader, Army Psychiatry Specialty Leader, etc.).

Summary of Military Medicine Organization

Essentially, the physical needs of service members, their families, veterans, and DoD civilians, contractors, etc., are all managed directly by the MHS organization. Each base or installation has a military hospital or military treatment facility (MTF) and/or medical clinic(s). There is a unified, coherent chain of command responsible for medical policies and delivery of physical medicine, dentistry, nursing, etc., with a single, centralized electronic record-keeping and data collection system used across the DoD. Medical policies and practices across the service branches do not significantly vary. Other than outsourcing some aspects of medical care via the TRICARE network in the private sector, there are no competing or alternative agencies responsible and accountable for medical or dental care within the DoD.

Overview of Military Mental Healthcare Organization

The IOM (2013b) has reviewed the military mental health system and its vast array of programs. In regard to the military's organization of its PTSD programs, the IOM (2014b) concluded that "PTSD management in DoD appears to be local, ad hoc, incremental, and crisis-driven with little planning devoted to the development of a long-range, population-based approach for the disorder by either the Office of the Assistant Secretary of Defense for Health Affairs or any of the service branches. Each service branch has established its own prevention programs, trains its own mental health staff, and has its own programs and services for PTSD treatment" (p. 6). Perhaps an illustration of the inherent fragmentation of military mental healthcare, all prevention and resilience building programs are the responsibility of the Under Secretary of Defense for Manpower and Readiness, not the ASD(HA), despite the recent creation of the Defense Health Agency to consolidate responsibility for healthcare (IOM 2014b).

Essentially, there are three major organizational components involved in providing mental health services: (a) military medicine/MHS; (b) family community counseling centers; and (c) other miscellaneous programs. Complicating matters even further is that each mental health-related entity within the four military service branches (Army, Air Force, Marine Corps, and Navy) have different policies and practices. Readers are referred to the IOM (2013b) study for more detailed description and organizational charting. We provide an overview of each of the major entities responsible for provision of mental health services.

Military Medicine/Military Health Service

Active-duty and DoD civilian psychiatrists, neurologists, psychiatric nurses, clinical psychologists, clinical social workers, and occupational therapists are assigned to inpatient hospitals at MTFs, outpatient mental health clinics, Wounded Warrior programs, embedded in combat units, and operational platforms (e.g., combat and operational stress control units, aircraft carriers, etc.). According to the IOM (2014b), "Mental health staff in DoD increased from about 4000 in 2007 to almost 6500 in 2010" with numbers growing (p. 126). Services include diagnostic evaluations, medication management, prevention activities, outreach, personnel-related functions, and individual and group psychotherapeutic treatments for mental health conditions, such as PTSD and major depression, substance abuse screening and treatment, sexual assault prevention and response, behavioral medicine, and integrated primary care (IOM, 2013b). Military-related clientele may also seek mental health services from civilian TRICARE network providers.

The organizational chain of command and policies are identical to those described above in regard to medical services, with the notable exception at the corps level. The military has no Mental Health Corps or Behavioral Health Corps. Instead, neurologists and psychiatrists are assigned to the Medical Corps; psychiatric nurses belong to the Nursing Corps; clinical psychologists, social workers, and occupational therapists are assigned to the MSC along with 22 other non-mental health-related clinical and administrative specialists (e.g., pharmacists, industrial hygienists, physical therapists, accountants, hospital administrators, nutritionists, etc.), with the lone exception of occupational therapists assigned to the Army's Medical Support Corps.

Therefore, policies, chain of command, manpower, training requirements, staff utilization, and careers are vastly dissimilar across mental health-related disciplines. For instance, military officers responsible for the bulk of psychotherapy (e.g., clinical psychologists and social workers) do not get promoted to flag officer level and receive significantly smaller recruitment and retention bonuses than their

medical mental health colleagues (Russell, 2006a). Moreover, each service corps (e.g., Army MSC, Navy MSC, etc.) varies in policy and practice, so there is no standardization in staffing, training, assessment, diagnosis, prevention, and treatment services among the same discipline types (Russell, 2006b; Weinick, Beckjord, Farmer, Martin, Gillen, Acosta, & Scharf, 2011).

Impact of Military Corps Fragmentation on Mental Health

How does the absence of a Behavioral Health Corps impact the military's capacity to meet mental health needs? One clear example of the inherent disconnect between the existing corps structure is a February 2007 memorandum from the admiral responsible for managing the Navy's MSC, announcing the elimination of all Navy-uniformed social workers and occupational therapists. The Navy quickly reversed its policy after public release of the June 2007 DoD TF-MH report revealing a chronic, severe mental health staffing crisis both within the Navy and the DoD. The Navy's misguided action is perhaps understandable given the 22 specialties lumped together in the MSC and the lack of a corps dedicated to managing military mental healthcare as a whole. In addition, MSC officers compete for career promotion with 22 disciplines. By law, eligible military officers failing to promote to the next highest rank after two attempts are typically involuntarily discharged or forced to retire. Therefore, every year, active-duty mental health providers are involuntarily separated from the military regardless of their clinical competency and productivity, thus aggravating the staffing crisis (e.g., DoD TF-MH, 2007).

Moreover, military psychotherapists (clinical psychologists and social workers) are ineligible to be promoted to flag and general officer ranks; therefore, prewar planning of psychotherapy provision is a low-ranked priority (Russell, 2006a). In short, the absence of a Behavioral Health Corps helps explain the 2007 DoD TF-MH finding that "A thorough review of available staffing data…clearly established that current mental health staff are unable to provide services to active members and their families in a timely manner; do not have sufficient resources to provide newer evidence-based interventions in the manner prescribed; and do not have the resources to provide prevention and training for service members or leaders that could build resilience and ameliorate the long-term adverse effects of extreme stress" (p. 43).

Family and Community Counseling Centers

As per the IOM (2013b), "Family and community services play a critical role in supporting the psychological health of service members and their families. While each branch of the military offers a slightly different mix of programs and services (e.g., the Marine Corps Community and counseling centers provide substance abuse services), they generally fall under four broad areas: (1) family support; (2) child and youth services; (3) counseling and advocacy support; and (4) morale, welfare, and recreation.

Each of the four service branches employs thousands of DoD civilian mental health professionals (psychiatrist, psychologists, social workers, marriage and family counselors, substance abuse counselors, etc.). These family community counseling centers are funded and managed by the military service branch, independent of military medicine (IOM, 2013b). For example, the Navy Fleet and Family Counseling Centers are accountable to regular Navy "fleet or line," commanders, not Navy medicine or the Navy SG (IOM, 2013b). Community counseling centers are located at every military base and have separate headquarters, policies, budgets, trainings, organizational chain of command, staff management requirements, record-keeping, and databases. The installation commander, not the base medical commander, is responsible for the military's community counseling centers. Further complicating the picture is that each service branches' community counseling center varies in its policies, programs, and data management from the other services, and the degree or coordination with other mental health organizations widely varies from military base to base (e.g., IOM, 2013b).

Example of Organizational Dysfunction and Mental Health Crisis

It may not be obvious as to how the aforementioned fragmentation between military medicine and family community counseling center organizations may contribute to behavioral health crises so a case example is provided. On 5 November 2013, leaders of Navy medicine and the Navy and Marine Corps' community counseling centers, reissued a "memorandum of understanding" (MOU) reinforcing a long-standing agreement of how the agencies collaborate and coordinate mental health services (Department of the Navy (DoN), 2013). According to the DoN (2013) MOU, licensed civilian Navy and Marine Corps mental health staff are prohibited from assessing, diagnosing, and/or treating service members seeking help for potentially disabling conditions such as depressive disorders, anxiety disorders, eating disorders, PTSD, suicide, or other major mental health problems, "regardless of the severity of the condition" (p. 3). Instead, all such military clients and their family members must be referred to mental health provider(s) at the MTF (DoN, 2013). As an example, a sole credentialed military mental health provider stationed at a rural overseas Marine Corps base of about 6000 personnel, reported that per Navy/Marine Corps instruction, the cadre of licensed civilian mental health staff employed at the Marine

Corps Community Counseling Services (MCCS) center were forced to refer Marines experiencing PTSD, depression, or suicide symptoms to the MTF (military with a 3–4-week wait-list (Russell, 2006a). In the midst of a mental health crisis and severe staffing shortages as reported by the DoD TF-MH (2007), institutional policies reinforcing organizational fragmentation can potentially cause or exacerbate a crisis. Moreover, family community counseling centers operated by the Army and Air Force do not place such restrictions on the scope of practice for their clinical specialists thus exemplifying an incoherent policy.

Other Mental Health Entities

As noted earlier, there are mental health services available from outside of military medicine/MHS and family community counseling center organizations. There is an array of mental health-related agencies, programs, and practitioners contracted by each service branch (e.g., Military and Family Life Consultants program; chaplains; suicide hotlines; web-based counseling programs via Military OneSource); as well as DoD-contract civilians providing mental health services to children, adolescents, and families via the military's Educational and Developmental Intervention Services (EDIS) and the TRICARE network consisting of more than 3300 network acute care hospitals and 914 behavioral health facilities providing purchased care IOM, 2014a, b). To further complicate matters, a National Council for Community Behavioral Healthcare (2012) study reported 23 % (630,000) of veterans and active military are currently seeking mental healthcare within the private sector, which is estimated to increase to 40 % by 2014. There is no single organization or leadership structure to properly monitor and manage these diverse programs with their disparate funding streams, databases, and practice guidelines (e.g., IOM, 2013b).

There continues to exist mass confusion when navigating the military mental healthcare system among both clients and practitioners (e.g., Weinick et al., 2011), in part because of the way data are collected and interpreted. Workload data from community counseling centers and other mental health entities are kept separate from military medicine's records, and therefore are invisible in DoD prevalence statistics, thus resulting in gross underestimations of mental health needs (Russell & Figley, 2015a).

Department of Defense Response to Task Force and Other Recommendations

The 2007 DoD TF-MH identified four broad goals in its vision to transform military mental healthcare as a "world class health system involved in supporting the psychological health of military members and their families" (p. 7). Those goals are as follows:

1. A culture of support for psychological health will be promoted wherein all service members and leaders will be educated to understand that psychological health is essential to overall health and performance. Early and non-stigmatizing psychological health assessments and referral to services will be routine and expected.
2. Service members and their families will be fully and psychologically prepared to carry out their missions. Service members and their families will receive a full continuum of excellent care in both peacetime and wartime, particularly when service members have been injured or wounded in the course of duty.
3. Sufficient and appropriate resources will be allocated to prevention, early intervention, and treatment in both the Direct Care and TRICARE Network systems, and will be distributed according to need.
4. At all levels, visible and empowered leaders will advocate, monitor, plan, coordinate, and integrate prevention, early intervention, and treatment (DoD TF-MH, 2007; pp. 7–8).

Subsequently, both the office of the ASD(HA) and each service branch have issued policy directives and instructions related to improving prevention, assessment, treatment, and management of PTSD (e.g., ASD(HA) 2012 memorandum "Clinical Policy Guidance for Assessment and Treatment of Post-Traumatic Stress Disorder").

The military addressed its monumental organizational and leadership deficits by establishing new Directors of Psychological Health (DPH) positions at the service headquarters and installation levels. The purpose was to "ensure visible leadership and advocacy for psychological mental health services" (DoD, 2012; p. 1). Another purpose was to create a DoD-wide oversight committee (DoD Psychological Health Council) consisting of the Active Duty, National Guard, and Reserve DPHs, along with multiple high level leaders responsible for developing a DoD vision and strategic plan. The purpose of the plan was to provide support for the psychological health of service members and their families, provide policy and guidance, and develop standardized indicators for tracking and reporting outcomes (DoD, 2012; DoD TF-MH, 2007).

Directors of Psychological Health

The DoD Instruction 6490.09 "establishes policy, assigns responsibilities, and prescribes procedures to ensure visible leadership and advocacy for the psychological health and mental health disease and injury protection of the military service members" by designating specific roles of the DoD

TF-MH (2007) recommended DPH positions and DoD Psychological Health Council (DoD, 2012; p. 1). By 2011, each service branch, reserve, and National Guard components established the service level DPH positions. Their jobs would include critical tasks that would collect and apply data relevant to assisting with strategic planning on psychological health and TBI; monitoring and reporting on the availability, accessibility, and quality of mental health services; monitoring the psychological health of service members and their families; and ensuring communication with the departments responsible for the provision of mental healthcare at relevant installations and military treatment facilities (DoD, 2012; Weinick et al., 2011). The new service branch DPHs report directly to the SG and Medical Officer of the Marine Corps or equivalent, though they lack authority to develop or enforce policies (DoD, 2012). It is unclear how the consultant role of service branch DPHs to the SG differs from existing mental health specialty leaders assigned to advise the SG or how adding another mid-level advisor significantly enhances "visible leadership and advocacy for psychological health" in a transformative manner needed to accomplish DoD's vision and goals (DoD, 2012).

Per DoD instruction, the DPHs are assigned at each military base to serve as consultant to the installation commander. Among other responsibilities, they are expected to make recommendations regarding staffing and ability to meet mental health needs, as well as ensure coordination of services between the various programs providing support for psychological health (DoD, 2012).

This organizational change appears to have face validity in terms of improving collaboration and coordination among multiple, diverse agencies. However, DoD's (2012) policy does not create a unified, single chain of command, or establishes standardized policies, procedures, centralized databases across the three major mental health components, or grants installation DPHs authority to enforce policies. Therefore, installation and service branch DPHs appear to have limited to no authority to realistically affect necessary changes in military mental healthcare.

Other Efforts to Improve Military Mental Health

Additionally, the military implemented congressional mandates to develop Wounded Warrior programs to meet the unique needs of its own wounded, ill, or injured service members. According to RAND researchers, "These programs have distinct oversight by their respective branches of service and vary in the content of the services provided (Weinick et al., 2011; p. 6).

Other notable corrective actions taken by DoD include establishing a wounded, ill, and injured Senior Oversight Committee in 2007 to address concerns related to treatment, evaluation, and VA transition of wounded military personnel, as well as creation of the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) in 2007 to assess, validate, oversee, and facilitate prevention, resilience, identification, treatment, outreach, rehabilitation, and reintegration programs for psychological health and traumatic brain injury to ensure the Department of Defense meets the needs of the nation's military communities, warriors, and families (see IOM, 2014b for details).

The DCoE merges eight directorates and six component centers. These include, for example, the Defense and Veterans Brain Injury Center, Center for Deployment Psychology, Deployment Health Clinical Center, Center for Traumatic Stress, National Center for Telehealth and Technology (T2), and The National Intrepid Center of Excellence (see Weinick et al., 2011 for details).[2]

Despite incremental changes, the IOM's (2013b) comprehensive review of military mental healthcare, the Committee concluded:

> "The federal government, in particular DoD and VA, is actively seeking to understand the scope of readjustment challenges, implement appropriate policies, and provide programs and services. In many cases, however, the response does not match the magnitude of the problems, and many readjustment needs are unmet or unknown" (p. 472).

Furthermore, the IOM (2013b) warns, "The urgency of addressing those issues is heightened by the sheer number of people affected, the rapid draw down of personnel…and the long-term effects that many of the issues might have not only on military personnel and veterans and their families, but on the country as a whole" (p. 472). The remaining question is whether the military's current organizational reforms are sufficient to meet wartime need and end the cycle of preventable crises.

Subsequent Studies of the Organizational Structure of Military Mental Healthcare

Six years after the DoD TF-MH (2007) published its recommended overhaul of military mental healthcare, multiple government-sponsored studies have been conducted on DoD's mental health system as a whole (e.g., IOM, 2013b), in addition to specific program components including psychological health and traumatic brain injury (RAND; Weinick et al., 2011); PTSD assessment and treatment (IOM, 2014b);

[2] The above list is only partial and does not represent the overabundance of new mental health and family support initiatives, resilience building, research, and transition support services developed throughout the DoD, VA, and private sector—all of which are in stark contrast to the neglected status of mental healthcare evident during the pre and early war phases (e.g., DoD TF-MH, 2007).

suicide prevention (RAND; Ramchand et al. 2011); substance abuse (IOM, 2013a); and prevention, resilience, and reintegration services (IOM, 2014a).

Evaluation of Military Mental Healthcare System and Meeting Readjustment Needs

The IOM (2013b) conducted a comprehensive review of the DoD and VA's capacity to meet the readjustment needs for military personnel, veterans, and their families. Many notable improvements were reported. Table 1 contains corrective actions recommended representing the full spectrum of mental healthcare indicating major deficiencies remain due in large part to the absence of standardized policies and practices managed by a unified, accountable chain of command. For example, the IOM (2013b) reported "Screening, assessment, and treatment approaches for brain injuries and psychological health problems are not always implemented between and within DoD and VA in a consistent manner or aligned with the evidence base" (p. 238), and "The committee has serious concerns about inadequate and untimely clinical follow-up and low rates of delivery of evidence-based treatments, particularly psychotherapies to treat PTSD and depression and approved pharmacotherapies for substance use disorder" (p. 238), as well as "Unwarranted variability in clinical practices and deviations from the evidence base are threats to high quality patient care" (p. 238). These concerns provide further evidence that the military's existing mental health organization and leadership structure needs to be overhauled.

Overall, the present status of the organizational structure and leadership is best summarized by RAND researchers: "Further, one key finding from our work is that no branch of service maintains a complete list of these programs, tracks the development of new programs, or has appropriate resources in place to direct service members and their families to the full array of programs that best meet their needs" (Weinick et al., 2011; p. 8).

In regard to the DoD's organizational remedy of creating Director of Psychological Health (DPH) consultant and coordinator positions, the IOM (2013b) reports:

> "Directors of psychological health for each of the services do not have readily available information on all programs offered within their service. There is also no centralized responsibility for authorizing the development of new programs or for tracking them in any way over the course of their efforts. Finally, programs may be initiated in a number of different ways, including centrally by an OSD component, by a branch of service, or based on the interests of a small number of individuals at a single installation, further complicating efforts to identify and track programs over time" (p. 37).

Psychological Health and Traumatic Brain Injury Programs

A thorough review of the military mental healthcare system was completed by RAND (Weinick et al., 2011) 5 years after the 2007 DoD TF-MH report, leading to the conclusion that "The most common barriers mentioned by our interviewees included inadequate funding, resources, or staff capacity; potential concerns about the stigma associated with mental health, including fear of career repercussions" (p. xvii). Most if not all of the corrective actions described in Table 1 reflect the lack of a cohesive mental health organization and uniformed policies. For instance, researchers reported that, "During our interviews, a number of program representatives noted that they did not know whether others in the DoD community had similar programs or materials they could borrow or learn from, what approaches other programs had used, and whether other programs had been successful in the past. In part, as a result of this lack of sharing of knowledge, programs proliferate without utilizing a centralized evidence base or source for materials. This can lead to significant inefficiencies, such as multiple programs developing teaching points and training materials on the same topic" (Weinick et al., 2011; p. xvii), as well as "relatively few programs are established in partnership with or sustain formal relationships with existing clinical or supportive counseling services, except where such programs are embedded as an inherent part of the existing care system. This lack of linkage and partnership can leave programs without a consistent course of action when follow-up care is needed" (Weinick et al., 2011; p. xvii).

After acknowledging the relentless pressure, the DoD has been under, due to negative news media reports of unmet mental health needs, along with numerous recommendations by highly visible task forces and advisory committees, as well as the military's attention toward implementing many of those corrective actions including the creation of the DCoE, RAND researchers concluded that "While this attention is both necessary and laudable, the proliferation of programs creates a high risk of a poor investment of DoD resources. Our report suggests that there is significant duplication of effort, both within and across branches of service. Without a centralized evidence base, we remain uncertain as a nation about which approaches work, which are ineffective, and which are—despite the best intent of their originators—potentially harmful to service members and their families" (Weinick et al., 2011; p. 73).

Furthermore, the RAND report concludes that "Given the financial investment that the nation is making in caring for service members with mental health problems and TBI, service members and their families deserve to know what these investments are buying. Strategic planning, centralized coordination, and the sharing of information across branches of service, combined with rigorous evaluation, are imperative for ensuring that these investments will result in better

Table 1 Recent recommendations for transforming military mental health system

Study	Subject area	Recommendations
IOM (2013a)	Substance use programs	DOD needs to acknowledge that the current levels of substance use and misuse among military personnel and their dependents constitute a public health crisis.
		Require consistent implementation of prevention, screening, and treatment services
		DoD and individual branches should implement a comprehensive set of evidence-based prevention programs and policies that include universal, selective, and indicated interventions.
		DoD should assume leadership in ensuring the consistently and quality of substance use disorders (SUD) services. DoD also should require improved data collection on substance use and misuse, as well as the operation of SUD services.
		DoD should conduct routine screening for unhealthy alcohol use, together with brief alcohol education interventions.
		Policies of DoD and the individual branches should promote evidence-based diagnostic and treatment processes.
		DoD and the individual branches should better integrate care for substance use disorders SUDS with care for other mental health conditions and ongoing medical care.
		The Military Health System should reduce its reliance on residential and inpatient care for SUDS in its direct care, system and build capacity for outpatient and intensive outpatient SUD treatment using a chronic care model that permits patients to remain connected to counselors and recovery coaches for as long as they need.
		DoD should update the TRICARE SUD treatment benefit to reflect the practices of contemporary health plans and to be consistent with the range of treatments available under the Patient Protection and Affordable Care Act.
		DoD should encourage each service branch to provide options for confidential treatment of alcohol use disorders.
		DoD should establish a joint planning process with the VHA, with highly visible leadership (perhaps recently retired military personnel), to address the SUD needs and issues of access to care of reserve component personnel before and after mobilization.
		DoD and individual service branches should evaluate the use of technology in the prevention, screening, diagnosis, treatment, and management of SUDs to improve quality, efficiency, and access.
		The individual service branches should restructure their SUD counseling workforces, using physicians and other licensed independent practitioners to lead and supervise multidisciplinary treatment teams providing a full continuum of behavioral and pharmacological therapies to treat SUDS and comorbid mental health disorders.
		DoD should incorporate complete data on SUD encounters into the MDR database and recalculate the PHRAMS estimates for SUD counselors.
IOM (2013b)	Readjustment needs of military personnel, veterans, and family members	DoD and DVA should sponsor longitudinal studies to answer many of the questions regarding long-term effects of TBI, PTSD, and other mental health disorders.
		DoD should develop policies to eliminate military sexual trauma as research demonstrates that it is associated with poor readjustment and mental health and physical health outcomes.
		DoD should reinforce existing polices on military sexual trauma by adding specific mandatory evaluation criteria regarding how well military leaders address the issues.
		DoD and VA should select instruments and their thresholds for mental health screening and assessment in a standardized way on the basis of the best available evidence.
		Ensure that mental health treatment offerings are evidence-based, and that all patients consistently receive first-line treatments as indicated
		DoD and VA should incorporate continuing supervision and education into programs that train clinicians in the use of selected assessment instruments and evidence-based treatments. Once trained, DoD and VA should systematically and periodically evaluate the programs to assess the degree to which the training is accurately implemented.
		DoD and VA should place greater focus on coordinated, interdisciplinary care to ensure optional treatment for service members and veterans.
		DoD and VA should conduct systematic assessments to determine whether screening and treatment interventions are being implemented according to clinical guidelines.

Table 1 (continued)

Study	Subject area	Recommendations
		Data systems should be developed to assess treatment outcomes, variations among treatment facilities, and barriers to the use of evidence-based treatment.
		DoD should ensure that policies, programs, and practices aim to support and strengthen all military families including nontraditional ones.
		DoD should use evidence-based primary prevention programs and treatments that have been specifically evaluated on service members and their families and that are focused on preventing and treating mental health and relationship problems.
		DoD and other relevant federal agencies should fund methodologically rigorous research on the social, psychological, and economic effects of deployments on families, including nontraditional families.
		DoD should place a high priority on reducing domestic violence because it degrades force readiness and the well-being of military family members.
		DoD and VA should fund research on the effect of OEF and OIF deployments on communities. Such research should include indicators of community well-being, economic performance, availability of social and support services, law enforcement activity, and school and educational functioning.
		DoD and VA should evaluate the effectiveness of transition assistance programs to ensure they are effective in reducing unemployment among returning veterans.
		Comprehensive evaluation of the effect of post 9/11 GI Bill on the educational attainment of veterans and eligible family members
		Comprehensive long-term forecasts of the costs of VA medical care and benefits associated with combat deployments
		Improved coordination of care and services between DoD and VA, including completion of inter-operative or single combined electronic health record for all care that begins with entry into military service and continues throughout care in the VA after transition
		DoD should promote an environment that reduces stigma and encourages treatment for mental-health and SUD.
		DoD should systematic review of its policies regarding mental health and SUD treatment with regard to issues of confidentiality and the relation between treatment seeking and military advancement.
		DoD should regularly issue reports describing the actions taken with regard to its policies and procedures to determine progress.
		DoD and VA should conduct a needs assessment to determine the numbers and types of providers needed to address the long-term health needs of active duty personnel and veterans.
		DoD and VA should determine the optimal composition of mental health teams to ensure that providers function efficiently and perform at the highest levels of their credentials and privileges.
		DoD and VA should fund research to determine whether culturally sensitive treatment approaches improve retention in care and other clinical outcomes.
		DoD and VA should remove barriers and improve women's access to and use of healthcare.
		DoD and VA should develop a comprehensive analysis of relevant data that resides in each department and other agencies. Databases should be linked and integrated to effectively address questions regarding readjustment.
Institute of Medicine (2014a)	PTSD programs	Develop an integrated, coordinated, and comprehensive PTSD management strategy that plans for the growing burden of PTSD for service members, veterans, and their families, including female veterans and minority group members.
		PTSD research priorities in DoD and VA should reflect the current and future needs of service members, veterans, and their families. Both departments should continue to develop and implement a comprehensive plan to promote a collaborative, prospective PTSD research agenda.
		Increase engagement of family members in the PTSD management process for service members and veterans who have PTSD
		Use evidence-based treatments as the treatment of choice for PTSD, and these treatments should be delivered with fidelity to their established protocols. As innovative programs

Table 1 (continued)

Study	Subject area	Recommendations
		and services are developed and piloted, they should include an evaluation process to establish the evidence base on their efficacy and effectiveness
		Ensure there is an adequate workforce of mental healthcare providers-both direct care and purchased care-and ancillary staffing to meet the growing demand for PTSD services
		Develop and implement clear training standards.procedures, and patient monitoring and reporting requirement for all of their mental health care providers
		Resources need to be available to facilitate access to mental health programs and services
		Develop, coordinate, and implement a measurement-based PTSD management system that documents patient's progress over the course of treatment and long-term follow up with standardized and validated instruments
		DoD and VA leaders should be identified as accountable for the delivery of high-quality health care for their populations, and they should communicate a clear mandate through their chain of command that PTSD management and use of best practices is a high priority.
IOM (2014b)	Prevention, resilience, and reintegration programs	Employ only evidence-based resilience, prevention, and reintegration programs and policies and eliminate non evidence-based programs
		Consistently use validated psychological screening instruments appropriate to the type of screening
		Conduct systematic targeted prevention annually and across the military life cycle for service members and their families
		Employ existing evidence-based measures using systematic approaches identified in this report
		When appropriate outcome measures are unavailable, DoD should develop and test measures to assess the structure, process, and outcomes of prevention interventions across the phases of the military life cycle.
		Use existing evidence-based community level prevention interventions and polices to address the psychological health of military members and their families
RAND Ramchand et al. (2011)	Military suicide prevention	Track suicides and suicide attempts systematically and consistently across all services
		Evaluate existing programs and ensure that new programs contain an evaluation component when they are implemented
		Include training in skill building, particularly help-seeking behavior, in programs and initiatives that raise awareness and promote self-care
		Identify what is relevant to preventing suicide, and form partnerships with the agencies and organizations responsible for initiatives in other areas
		Evaluate training of healthcare, pastoral care, and mental health professionals
		Develop prevention programs based on research and surveillance. Selected and indicated programs should be based on clearly identified risk factors specific to military populations and to each service
		Ensure that continuity of services and care is maintained when service members or their caregivers transition between installations in a process that respects service members' privacy and autonomy
		Make service members aware of the benefits of accessing behavioral healthcare and specific policies on repercussions for accessing such care
		Make service members aware of the different types of behavioral health caregivers available to them, including information on caregivers' credentials, capabilities, and the confidentiality afforded by each
		Improve coordination and communication between caregivers and service providers
		Assess whether there is an adequate supply of behavioral healthcare professionals and chaplains available
		Mandate training on evidence-based or state-of-the-art practices for behavioral health generally and in suicide risk assessment specifically for chaplains, health-care providers, and behavioral health professionals

Table 1 (continued)

Study	Subject area	Recommendations
		Develop creative strategies to restrict access to lethal means among military service members or those indicated to be at risk of harming themselves
		Provide formal guidance to commanders about how to respond to suicides and suicide attempts
RAND (Weinick et al. 2011)	Psychological health and TBI among military personnel and their families	Defines "programs" as "entities that provide active services, interventions, or other interactive efforts to support psychological health, as well as care for service members (and their families) who are experiencing such problems as PTSD, anxiety, depression, and TBI" (p. xiv).
		DoD should develop programs' capacity for early identification, promotion of help-seeing, and appropriate referrals for members of the military community with mental health concerns.
		Further develop programs focusing on prevention and resilience
		Establish clear and strategic relationships between programs and existing mental health and TBI care delivery systems
		Examine existing gaps in routine service delivery that could be covered by current programs
		Reduce barriers faced by programs
		Evaluate and track new and existing programs, and use evidence-based interventions to support program efforts
		Ensure programs complement or supplement existing services
		Ensure that systems exist to support appropriate hand offs between programs and other settings and that transitions in care are appropriately coordinated
		Track referrals from programs to existing clinical care systems on a continual basis, including the volume of referrals and rates of follow-up on referrals received
		Conduct a comprehensive needs assessment designed to identify how many service members and family members are in need of service, what their characteristics are, what types of assistance they need, and where they are located
		Conduct a formal gap analysis to identify how well programs are meeting the identified needs, opportunities that exist to improve current programs, and where need exists to develop new programs
		Adopt a single, integrated, conceptual framework for psychological health across DoD
		Continue widespread efforts to reduce stigma and institutional barriers associated with seeking treatment for mental health problems and TBI
		Improve continuity of services over the course of the deployment cycle and during transitions associated with permanent change of station
		Improve the sharing of information across programs
		Develop the evidence base for evaluating program effectiveness
		Centralize the evidence base of program effectiveness accessible across DoD
		Discontinue programs shown to be ineffective
		Establish a central authority to set overall policies and establish guidelines regarding programs, including guidelines governing proliferation of new programs
		Establish a single entity to track new and existing programs on an ongoing basis, preferably the same organization that is charged with developing guidance regarding program proliferation

outcomes and will reduce the burden that service members and their families face" (Weinick et al., 2011; p. 73).

Posttraumatic Stress Disorder Programs

The IOM's (2014b) recent review of the DoD and VA PTSD assessment and treatment programs led to the conclusion that "Many of the programs and services are under different commands and authorities in the departments, which make it difficult to identify and evaluate them. This is particularly true for DoD, where various mental health programs are under the authority of the DoD central office and dispersed across the service branches, installation commanders, and medical commanders" (p. 47), and that "Most PTSD programs were developed at local levels and operate under the authority of local commanders. Such fragmentation

and stove-piping of components of PTSD-related care hampers communication, coordination, and efforts to address population needs. No central point of contact in DoD appears to be cognizant of all efforts to prevent, screen for, or treat PTSD in the military, let alone have sufficient knowledge, responsibility, and authority to ensure the quality and consistency of efforts to manage PTSD in all service branches or at the national level, including resilience and stress prevention programs" (p. 107).

Prevention Programs

The IOM (2014a) assessed the military's numerous prevention, resilience, and reintegration programs, concluding that, "the majority of DoD resilience, prevention, and reintegration programs are not consistently based on evidence and that programs are evaluated infrequently or inadequately" and that "by targeting resources to develop the evidence base and facilitate the process of evidence dissemination and implementation, DoD can optimize the effectiveness and cost effectiveness of intervention to prevent psychological health problems." (p. 5). In addition, the IOM (2014a) recommended corrective actions (see Table 1) reflect strongly on the absence of cohesive organizational structure and policies such as the lack of systematic psychological health screenings for military spouses and children, no routine health screenings targeting service members separating from the military, inadequate follow-up of individuals and families with at-risk psychological profiles, and use of empirically untested programs for preventing domestic violence, sexual assault, and psychological disorders.

Specific to organizational barriers, the IOM (2014a) reported "MTFs are commanded by senior medical leaders who answer to their service branches' surgeons general, whereas prevention and resilience programs for the same military population are managed through an entirely separate chain of command. Other mental health resources may be under the installation command" (p. 5).

Suicide Prevention Programs

The RAND was commissioned to study the DoD's plethora of suicide prevention programs. Per Table 1, multiple deficiencies were evident resulting in recommended corrective actions. These corrective actions include improving standardization of policies and procedures in tracking suicide and risk factors across all services; regular evaluation of programs; standardizing general and specialist training; enhancing greater interagency collaboration and coordination; developing, disseminating, and monitoring evidence-based programs; reducing stigma and barriers to care; improving continuity of care; ensuring adequate staffing and resources; and standardizing community guidance (Ramchand et al., 2011).

Substance Abuse Programs

The IOM (2013a) reviewed the DoD's substance use disorder (SUD) programs for military personnel and their families. Common themes of inherent organizational fragmentation, disarray, and inefficiency were reported, "The committee's research further revealed wide variability in SUD-related policies, programs, processes, and instruments across the branches, resulting from the lack of standardization mechanisms in place at the DoD level" (p 4). Moreover, the IOM (2013a) concluded that "The existence of distinct programs in each of the military branches creates the potential for unnecessary duplication and variation from best practices. Further, branch-specific policies that divide program responsibilities among the military human resources, legal, installation management, and medical domains create challenges for delivering SUD services. In addition, neither DoD nor the individual branches evaluate their respective programs or initiatives consistently or systematically" (p 4).

Recommended corrective actions contained in Table 1 reflect major systemic inconsistencies and deficiencies within DoD in screening, prevention, assessment, treatment, integration and coordination of care, staffing, training, stigma reduction, recordkeeping and data analysis, and treatment access. A frequent citing is the lack of coherent policy and standardization within and across the various services. For instance, in regard to specialist training, the IOM (2013a) found "Credentialing and training vary considerably across the different branches…the committee found that the training manuals for counselors in the Air Force and Navy are dated, do not address the use of evidence based pharmacological and behavioral therapies…physicians who have received SUD related training in addiction medicine or psychiatry are a rarity in any of the branches" (p 6).

Leadership Accountability and Communication

Themes of organizational fragmentation and the lack of leadership accountability were rampant across studies. For instance, according to the IOM (2014b), "DoD and VA leaders at the national and local levels set the priorities for PTSD care for their respective organizations. Authority, responsibility, and accountability for PTSD management need to begin at the central office level—at the level of the assistant secretary of defense for health affairs and the VA under secretary for health—and extend down to facility leaders and unit leaders. Leadership accountability can help ensure that information on PTSD programs and services is collected and that their success is measures and reported. Effective leadership extends to supporting innovation in new processes and approaches for treatment for PTSD." (p. 6).

However, after extensive review of VA and DoD management of its PTSD programs, IOM (2014b) concluded, "In DoD and each service branch, unit commanders and 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, while other programs may be more effective, languish, or disappear" (p. 6). The IOM (2014b) goes on to state that "In the DoD, there is no central leader who has sufficient responsibility and authority to ensure the quality and consistency of efforts to manage PTSD in all service branches or at the national level; different PTSD services and programs are the responsibility of different commands and service branches" (p. 123), as well as, "Furthermore, in each service branch, there is no overarching authority to establish and enforce policies for the entire spectrum of PTSD managements activities (prevention, screening, treatment, and rehabilitation)" (p. 218).

Central Database of Programs and Services

The IOM (2014b) states the importance of adequate data collection "tracking outcome measures is fundamental in ensuring quality throughout the care continuum, from prevention through treatment" (p. 83) and adds that "DoD lacks a mechanism for the systematic collection, analysis, and dissemination of data for assessing the quality of PTSD care…there are no specific DoD policies or procedures that stipulate the use of measurement-based care…and no consistent set of standardized outcome measures" (p. 87). The DOD does not track information on wait times or time between appointments, and "In many cases, the committee was unable to determine what, if any, therapies most service members or veterans who have PTSD receive in any care setting, and whether the care they receive results in improvement" (IOM 2014b; p. 225).

The DoD Instruction 6490.05 (DoD, 2013) "Maintenance of Psychological Health in Military Operations," requires medical and military leaders to evaluate the effectiveness of their prevention programs empirically and to collect and analyze data on the stressors and stress reactions experienced by service members (IOM, 2014b). In addition, the IOM (2014b) reported that previous IOM studies had called on DoD to "dedicate funding, staffing, and logistical support for data analysis and evaluation" (p. 84); however, during its most recent site visit, the IOM reported "the committee found minimal or no use of outcome data to improve performance of DoD PTSD programs or services regardless of the care setting" (p. 84). DoD does not have a central database of PTSD programs and services that are available throughout the service branches. Without such a database, it is impossible to compare programs and services, to identify the ones that are effective and use best practices, and to recognize the ones that need improvement or should be eliminated. There remain separate, disconnected databases of mental health statistics and workload across DoD.

Monitoring Effectiveness of Military Mental Healthcare

According to the IOM (2014a), DoD lacks a strategy, a framework, and a range of measures for monitoring performance that ultimately can be used to assess resilience, reintegration, and good psychological health to determine program effectiveness" (pp. 6–7). Similarly, RAND researchers concluded that "Programs are evaluated infrequently—fewer than one third of programs in any branch of service reported having had an outcome evaluation in the past 12 months. At the same time, for those programs conducting an evaluation, the rigor of the evaluation may vary in terms of whether it was conducted by an independent party or by program staff" (Weinick et al., 2011; p. xvii).

Summarizing the Status Quo

Seven years after the DoD TF-MH report, the IOM (2014b) best summarizes the military's current command and leadership structure in relation to mental healthcare, "Through its review, the committee found that PTSD management in DoD appears to be local, ad hoc, incremental, and crisis-driven with little planning devoted to the development of a long-range, population-based approach for this disorder by either the office of the Assistant Secretary of Defense for Health Affairs (OASD(HA)) or any of the service branches" (p. 216), and goes on to conclude that "Each service branch has established its own prevention programs, trains its own mental health staff, and has its own programs and services for PTSD treatment. The ASD(HA) and Undersecretary of Defense for Personnel and Readiness have not developed a comprehensive plan for mental health generally or PTSD specifically" (p. 216).

Therefore, is the current profusion of changes sufficient in transforming military mental healthcare in order to avert another preventable crisis? The evidence indicates that it clearly is not. The IOM (2014b) aptly sums up the status quo, "Although the ASD(HA) has issued some directives and instructions that apply to all service branches, implementation typically is at the discretion of each service branch's surgeon

general, installation commander, or even military treatment facility (MTF) leaders. The committee recognizes that, in part, such stove-piping of responsibility is inherent in the organizational structure of DOD and serves a purpose, given the different mission and culture of each service branch, but these differences do not preclude a more systematic and integrated approach to PTSD management. Standardization and consistency of PTDS programs and services among facilities and service branches are not evident, and they often appear to have been developed and sustained at the local level without coordination with similar programs on other installations" (p. 216).

In conclusion, there is clear and convincing evidence from several objective and credible sources that the DoD's current organizational and leadership structure as it pertains to mental healthcare is critically failing military personnel and their families, as well as society. Rampant fragmentation, inefficiency, and lack of leadership accountability prohibit the military from learning its psychiatric lessons of war, thus perpetuating the tragic cycle of preventable wartime behavioral health crises. The second part of this analysis will examine the proposal to establish a viable alternative to the status quo, a Behavioral Health Corps, a unified, centralized command structure with leaders held accountable for managing mental health services akin to physical medicine.

Compliance with ethical standards

Conflict of Interest The authors declare that they have no conflict of interest.

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