Improving Military Mental Health
Ending the Repetitive Cycle of Preventable Mental Health Crisis

While military medicine has made impressive advances incorporating battlefield lessons, saving the lives of 97% of wounded soldiers, well-documented, basic "psychiatric lessons of war" are consistently neglected resulting in preventable crises of unmet mental health needs and suicide. Since WWI, military officials have reported gross failure to adequately prepare for inevitable war stress casualties by learning from previous generations of war trauma lessons such as the fundamental need for adequate numbers of well-trained specialists to provide critical early intervention - directly contributing to exorbitant societal costs from high attrition, long-term suffering and premature death of war veterans.

Consequently, Congressional and Presidential actions are urgently required to address the military's uncharacteristic planning deficiency and ignoring of historical lessons. To date, no investigation has been conducted on the underlying causes of wa1time mental health crises. None of the myriad of corrective actions enacted thus far begins to address organizational contributors-thereby ensuring future perpetuation. Leaders of this war generation are faced again with a rapidly narrowing oppo1tunity to transform military mental healthcare to end a predictable cycle, and serve as a working model for overhauling the national mental healthcare system.

Unresolved Military Mental Healthcare Issues:

1. Lesson of War: War stress casualties are as inevitable as physical injuries.

After every war since WWI, Army Surgeon Generals have described at least I 0 foundational psychiatric lessons of war essential to meeting wartime needs: Ex. The military must equally prepare to care for war stress casualties as well as physical wounds. However, no dedicated behavioral health ''lessons learned" policy or programs exist, nor lead agency charged to ensure lessons are incorporated, and not ignored.

2. Self-Afflicted Crises: Well-documented via military post-war analyses.

The military publicly acknowledges its propensity to ignore and "rediscover" basic war trauma lessons in the U.S. Army's *Textbook on War Psychiatry,* and every post-war "lessons learned" analysis since WWI. Leaders in the present war, had foreknowledge of most critical shortcomings reflected in the June 2007 congressionally-mandated DoD Task Force of Mental Health, yet did not act until compelled by Executive Order or congressional mandate. In congressional testimony and news accounts as late as May 2007, senior military officials delayed recognition of widely-known systemic deficiencies (e.g., severe shortages in well-trained mental health specialists). Yet, no subsequent congressional hearings or investigations questioned the military's 180 degree reversal in disclosing gross inadequacies in planning, preparation, and training to meet basic "peacetime" mental health needs-resulting in the present crisis.

Prepared on: 2 July, 2013

3. Mental Health Disparity: Fragmented organization and leadership.

After every major American war, behavioral health becomes a high profile issue as more veterans suffer from war stress injuries than physical wounds. However, unlike "Medical Corps," "Dental Corps," "Chaplain Corps," ''Legal Corps," "Supply Corps," "Nursing Corps," or "Civil Engineering Corps," there is no organizational accountability or "Behavioral Health Corps" charged with comprehensive coordination of military mental health services. Instead, active-duty and DoD-civilian mental health providers (psychiatrists, psychologists, social workers, and counselors) are widely dispersed across disconnected array of professional organizations and agencies, each governed by divergent policies. The inherent redundancy, dyscoordination, and fragmentation of military mental healthcare erodes quality of care, significant financial waste, and creates major leadership vacuum whereby no particular leader or agency, other than Surgeon General, is held responsible or accountable for provision of critically needed services.

4. No Centralized, Accurate Tracking of War Stress Casualties: Impairs leadership ability to plan and respond.

Since WWII, the Army discontinued detailed reporting of war stress casualties. Current 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., PTSD), thereby chronically under-estimating the likely and actual incidence of war stress casualties contributing to crises of unmet needs.

Sample of Recommended Corrective Actions:

1. Commission fact-finding investigation(s) into the preventable causes of the current wartime mental health crisis.

2. Maintain funding for military mental health during peacetime.

3. Establish a "Behavioral Health Corps" including Flag and General Officers equal to other Corps to oversee elimination of antiquated dualistic policies, stigma, and disparity that devalues mental health services, and ensures accountability.

4. Create dedicated behavioral health lessons learned policy and programs consistent with military medicine.

5. Develop a centralized system for accurately reporting mental healthcare across all branches of service including follow- up of veteran's post war treatment. Note: CDC centrally collects data on suicide, but only 18 states report.

FOR MORE INFORMATION CONTACT: *Mark Russell, Ph.D., ABPP, CDR, MSC, USN (Ret) at* mrussell@antioch.edu

Prepared on: 2 July, 2013