Suicide Prevention: Valuable Information Learned from Army Surveillance and Research

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A Brief History of Psychological Reactions to War

- World War I--"shell shock", over evacuation led to chronic psychiatric conditions
- World War II--ineffective pre-screening, "battle fatigue", lessons relearned, 3 hots and a cot
- The Korean War---initial high rates of psychiatric casualties, then dramatic decrease

  Principles of "PIES" (proximity, immediacy, expectancy, simplicity)
- Vietnam
  - Drug and alcohol use, misconduct
  - Post Traumatic Stress Disorder identified later
- Desert Storm/Shield
  - "Persian Gulf illnesses", medically unexplained physical symptoms
- Operations Other than War (OOTW)
  - Combat and Operational Stress Control, routine front line mental health treatment
- 9/11
  - "Therapy by walking around"
  - Increased acceptance by leadership over past eight years

Operation Enduring Freedom/ Operation Iraqi Freedom

- Numerous stressors
  - Multiple and extended deployments
  - Battlefield stressors
    - IEDs, ambushes, severe sleep deprivation, direct combat, etc.
  - Medical
    - Severely wounded Soldiers, injured children, detainees
- Changing sense of mission
- Strong support of American people for Soldiers
- Major Focus of senior Army Staff
- Numerous new programs developed to support Soldiers and Families

Recent Background

- Volunteer Army
  - Know they are going to war
  - Seasoned, fatigued
  - Large Reserve Component
  - Reserve, National Guard
- Mental Health Advisory Teams (MHATs)
  - MHAT I through V, 2003 through 2007
- DoD Mental Health Task Force
- Congress provides supplemental funds to DoD in Summer 07
  - 96 M to Army for “Psychological Health”
  - Defense Center of Excellence
- Elevated suicide rate
- Wounded Soldiers
- Effects on Families
  - Continuous deployments
  - Families of deceased
  - Families of wounded

Range of Deployment-Related Stress Reactions

- Mild to moderate
  - Combat Stress and Operational Stress Reactions (Acute)
  - Post-traumatic stress (PTS) or disorder (PTSD)
  - Symptoms such as irritability, bad dreams, sleeplessness
  - Family / Relationship / Behavioral difficulties
  - Alcohol abuse
  - “Compassion fatigue” or provider fatigue
  - Suicidal behaviors
- Moderate to severe
  - Increased risk taking behavior leading to accidents
  - Depression
  - Alcohol dependence
  - Completed suicides

PTSD Diagnostic Concept

- Traumatic experience leads to:
  - Threat of death/serious injury
  - Intense fear, helplessness or horror
- Symptoms (3 main types)
  - Reexperiencing the trauma (flashbacks, intrusive thoughts)
  - Numbing & avoidance (social isolation)
  - Physiologic arousal ("fight or flight")
- Which may cause impairment in
  - Social or occupational functioning
- Persistence of symptoms

mTBI may be associated with PTSD, especially in the context of Blast or other weapons injury

Behavioral Health: Where We've Been

- Robust surveillance in theater and upon return
  - Mental Health Advisory Teams (MHATs)
  - Post Deployment Health Assessment and Re-Assessment
- Difficulties with access to care
- Stigma about mental health care despite:
  - Chain teach on PTSD and TBI with 900,000 Soldiers in 2007
  - Beyond the Front and Shoulder to Shoulder in 2009
- Increasing surveillance of PTSD and TBI
- Rising suicide rate (multiple reasons: fractured relationships, alcohol abuse).
- Services to help only partially integrated
  - Numerous helping agencies, including medical, behavioral health, chaplains, Family programs
- Close collaboration with DCoE (Defense Center of Excellence)

Behavioral Health: Where We Are

- Evolving Comprehensive Behavioral Health Strategy
  - Comprehensive Soldier Fitness
  - Army's Campaign Plan for Health Promotion, Risk Reduction & Suicide Prevention (ACPHP)
  - Child and Adolescent Center of Excellence (Madigan)
- MHAT VI pending release; will emphasize returned focus on Operation Enduring Freedom (OEF)
- Army PH spend plan
  - The Army has implemented over 45 initiatives under the categories of access to care, resiliency, quality of care, and surveillance
  - Funding: $120M obligated in FY 08, expecting $145M obligations in FY09, POM funds FY10-15
- Improved access to care
  - 48% increase in behavioral health providers since 2007
  - Number of visits has more than doubled since 2003
- Stigma reduction
  - Battlemind lifecycle products fielded to TRADOC (Basic Battlemind)
- New policies to screen for PTSD and TBI
- Extensive unit and population-based research

Behavioral Health: Where We Are Going

- Mature Behavioral Health Strategy
  - Comprehensive Soldier Fitness
  - MEDCOM Behavioral Health Campaign Plan (BHCP)
  - Army's Campaign Plan for Health Promotion, Risk Reduction & Suicide Prevention (ACPHP)
- Continue to improve health surveillance as new issues arise
- Continue to improve access to care
  - Integrated behavioral health and primary care
  - Telemedicine implemented nationally and internationally
  - Revised force structure with increased behavioral health providers
- Reduce stigma
  - Defense Center of Excellence (DCoE) leading anti-stigma campaign: Real Warriors
- New treatments, research, and clinical guidelines for PTSD, TBI and pain management

Surveillance

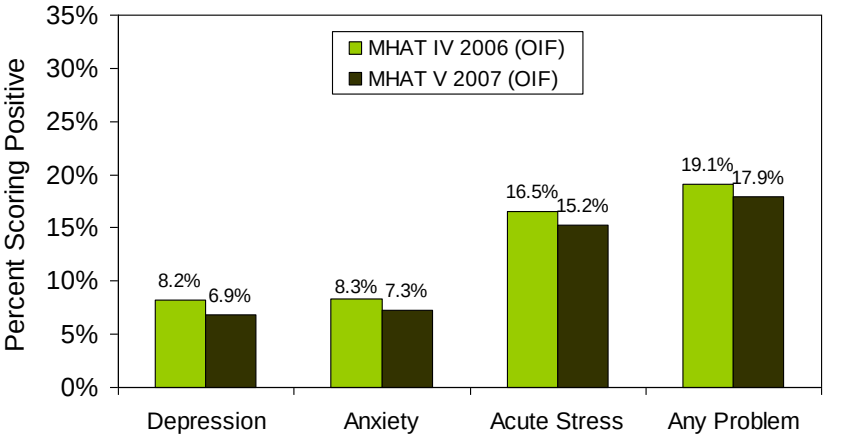
- Land Combat Study
  - Surveys of infantry Brigade Combat Teams throughout deployment cycle (n>30,000).
  - Anonymous with informed consent
- Post Deployment Health Assessment (PDHA) /Post Deployment Health Re-Assessment (PDHRA) (population-based)
  - Brief validated screening survey plus primary care interview
  - Not anonymous, linked to clinical care
- Health Care Utilization Data (population-based)
  - Military Treatment Facilities
  - VA Facilities
- Mental Health Advisory Teams
- Epidemiological Consultation Teams
- Suicide numbers and cases (Army/DoD Suicide Event Report)
- DoD Mental Health Task Force
- President's Commission on Wounded Warriors "Dole-Shalala Report"
- Rand Study: Invisible Wounds of War
- Suicide Analysis Cell

Mental Health Advisory Teams

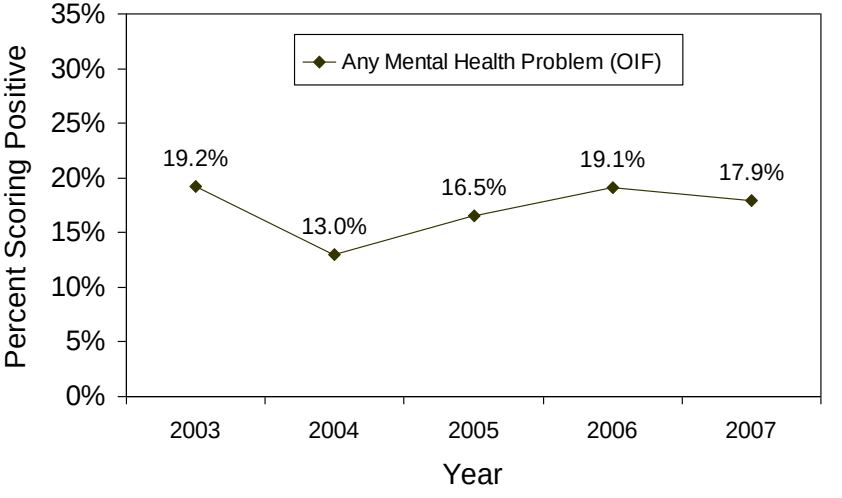
- MHATs I through V have consistently shown that 14-20% of Soldiers from Brigade Combat Teams (BCTs) in Iraq are experiencing mental health symptoms
- MHAT I (data collection 2003)
  - First ever in theater assessment
  - Identified problems with distribution of behavioral health resources
- MHAT II (data collection 2004)
  - Mission confirmed that many of the recommended changes had been implemented
- MHAT III (data collection 2005)
  - Longer deployments and repeated deployments were associated with higher rates of mental health symptoms
- MHAT IV (data collection 2006)
  - First assessment of battlefield ethics attitudes / behaviors
  - Repeated deployments and longer deployments again confirmed to be associated with higher rates of mental health symptoms
- MHAT V (data collection 2007)
  - Included Afghanistan
  - See next slides

OIF Behavioral Health Status: Mental Health

- Reports of mental health problems did not statistically differ from 2006 to 2007.

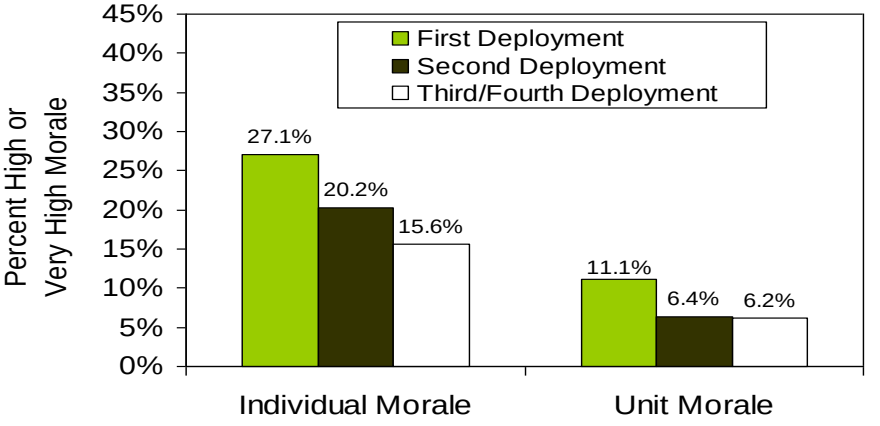


- Rates of mental health problems are comparable to every year except 2004.

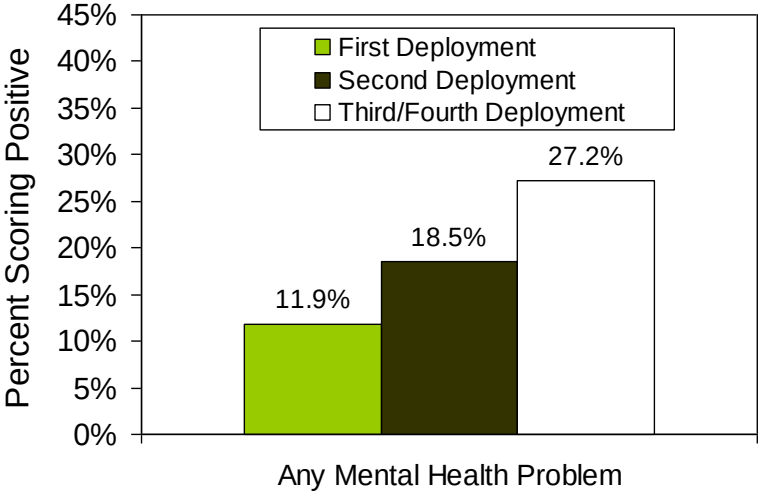


OIF Risk Factors: Multiple Deployments

- NCOs on either their second deployment to Iraq or their third/fourth deployment to Iraq report significantly lower morale than NCOs on their first deployment.



- Each deployment to Iraq puts NCOs at significantly more risk of reporting a mental health problem.



OIF Stigma and Barriers to Care

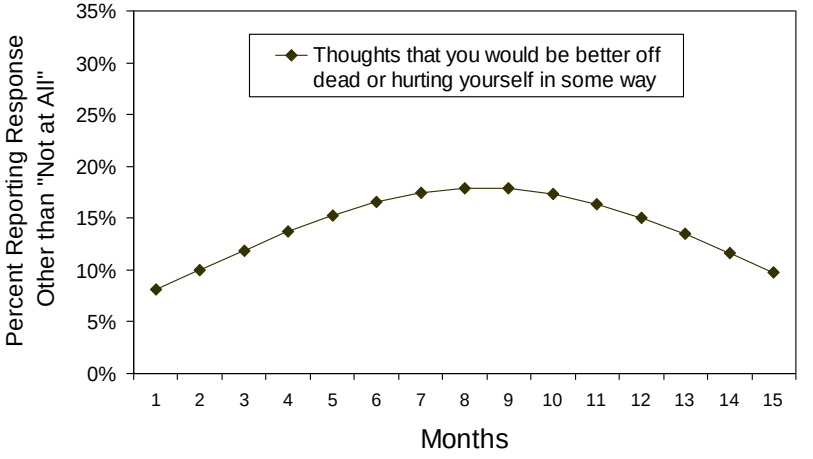
Factors that affect your decision to receive mental health services	Percent Agree or Strongly Agree		
	MHAT IV (OIF) 2006	MHAT V (OIF) 2007	p-value
It would be too embarrassing.	36.6%	32.0%	0.04
It would harm my career.	33.9%	29.1%	0.02
Members of my unit might have less confidence in me.	51.1%	44.8%	0.00
My unit membership might treat me differently.	57.8%	52.1%	0.00
My leaders would blame me for the problem.	43.0%	38.5%	NS
I would be seen as weak.	53.2%	49.8%	NS

- Soldiers who screened positive for mental health problems reported significantly lower stigma about receiving care in 2007 than in 2006.
- Soldiers report higher barriers to care (not shown). The increase is likely due to the high percentage of Soldiers way from the main Forward Operating Bases (FOBs).

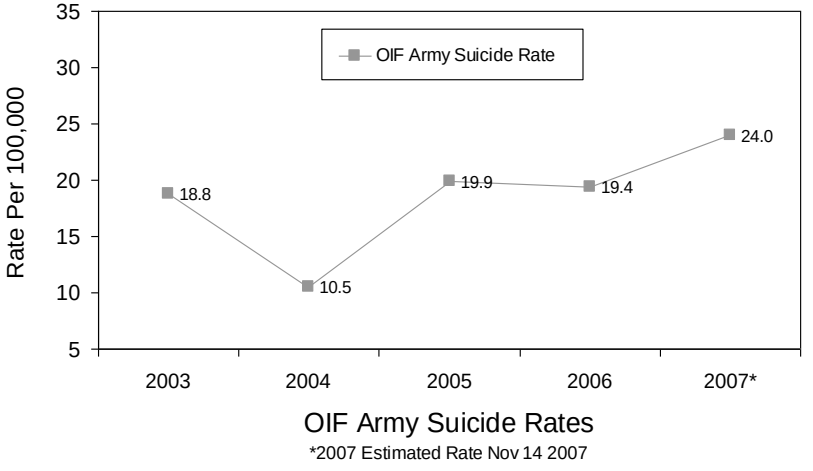
NS=Not significant

OIF Risk Factors: Months Deployed (cont.)

- The risk for reports of suicide ideation increase mid-deployment.



- Suicide rates continue to be elevated relative to historic rate of 12.36 per 100,000. Many suicides involve failed relationships.

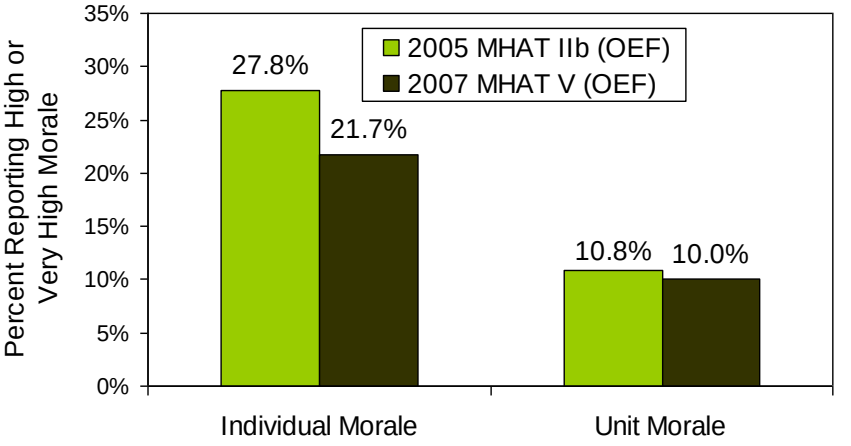


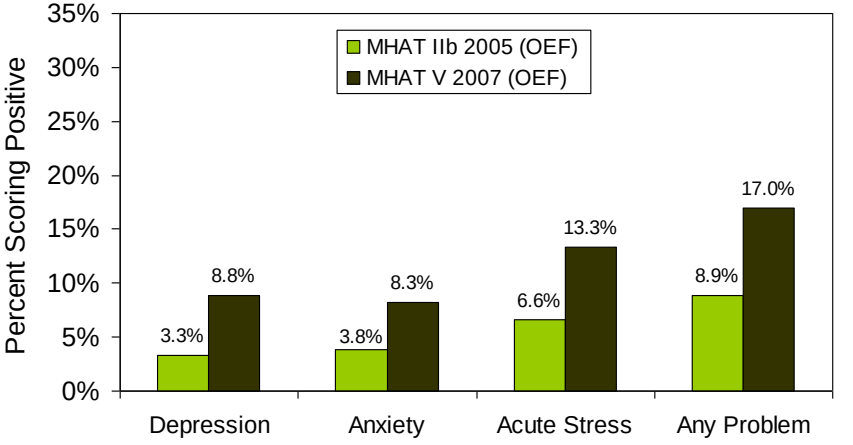
OEF Behavioral Health Status

- Soldiers' reports of individual morale are significantly lower than in 2005. OEF rates in 2007 are similar to OIF 2007 rates (page 12).

- Soldiers' reports of mental health problems are significantly higher than in 2005. OEF rates in 2007 are similar to OIF 2007 rates (page 13).

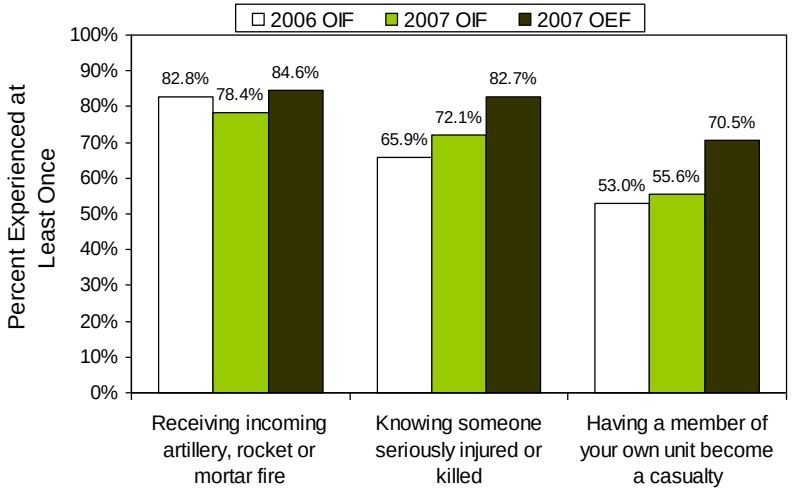
- OEF Soldiers in BCTs (n=282) report higher levels of mental health problems than OIF Soldiers (not shown).





OEF Risk Factors: Combat Experiences

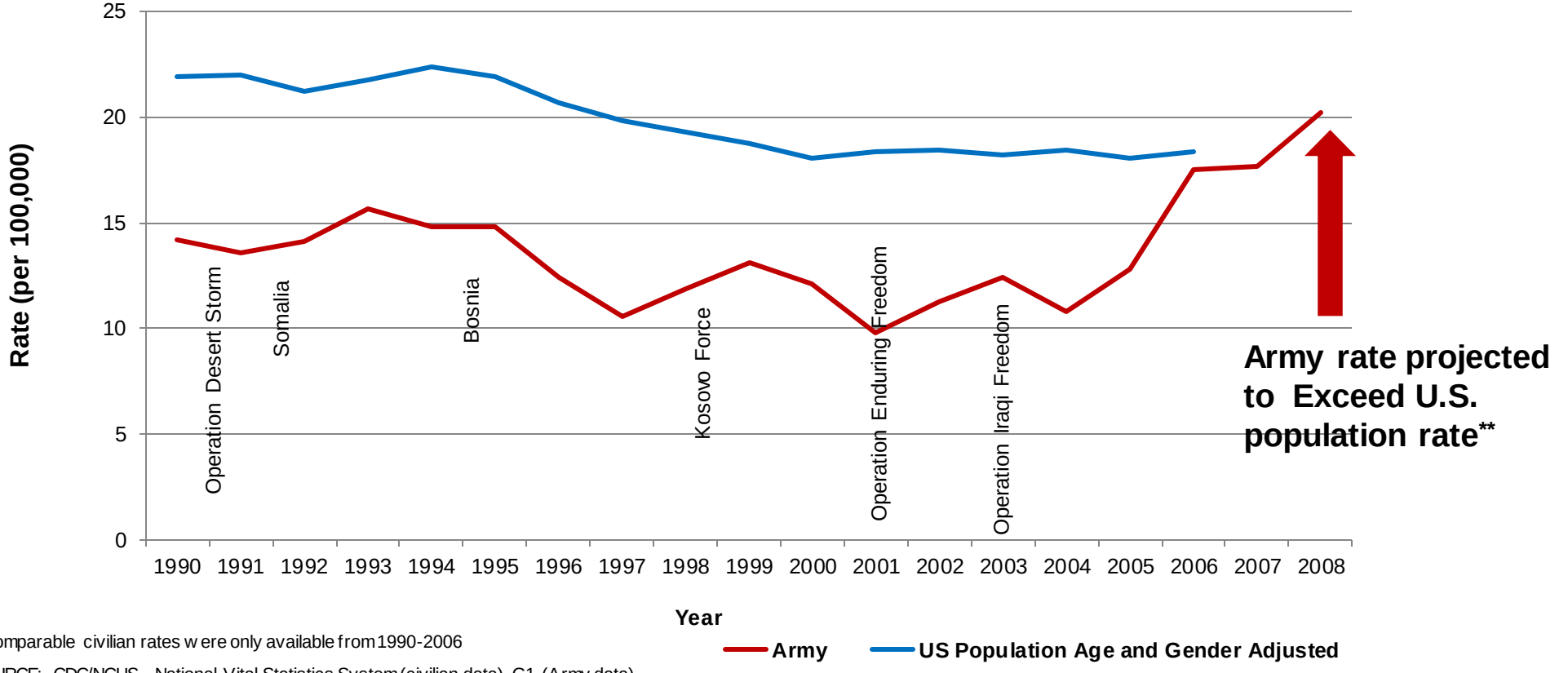
- A number of combat experiences significantly changed from 2005 to 2007.
- MHAT V OEF Soldiers in BCTs (n=282) reported levels of combat equal to or higher than 2006 and 2007 OIF levels.



Combat Experiences	Percent MHAT IIB (OEF) 2005	Percent MHAT V (OEF) 2007
Significant Increases		
Being attacked or ambushed.	43.3%	53.0%
Being wounded/injured.	5.1%	11.4%
Being directly responsible for the death of an enemy combatant.	9.0%	14.0%
Had a close call, dud landed near you.	14.7%	20.6%
Significant Decreases		
Seeing destroyed homes and villages.	61.2%	46.5%
Disarming civilians	33.7%	20.3%
Clearing/searching homes or buildings.	42.7%	26.1%
Clearing/searching caves or bunkers.	34.6%	23.6%
Seeing ill/injured women or children who you were unable to help.	43.9%	30.0%

Suicide Rates from 1990-2008

- Historically, the US Army rate has been lower than the US population rate
- Both populations experienced a downward trend from the mid-90's to 2001
- From 2001 to 2006, the US population rate was steady at 1x/100k while the Army rate doubled from 10 to 20/100k
- The U.S. population was age adjusted to the Army population by excluding those under 15 years of age and over 60 years of age, as well as adjusting the gender and age distribution within the population to a comparable Army distribution.



**Comparable civilian rates were only available from 1990-2006

SOURCE: CDC/NCHS, National Vital Statistics System (civilian data). G1 (Army data)

Screening and Surveillance
Annual and Post Deployment Screens

- The Department of Defense has mandated annual and post-deployment screening for suicidality.
  - Periodic Health Assessment (PHA): Conducted annually
  - Post-deployment Health Assessment (PDHA): Conducted within 30 days of service members returning from deployment
  - Post-deployment Health Re-assessment (PDHRA): Conducted within 3-6 months for service members returning from deployment
- Screening is based on an interview with a behavioral health care provider using a standardized interview guide. Service members at risk will received immediate intervention or a mental health referral.

Screening and Surveillance

The DoD Suicide Event Report

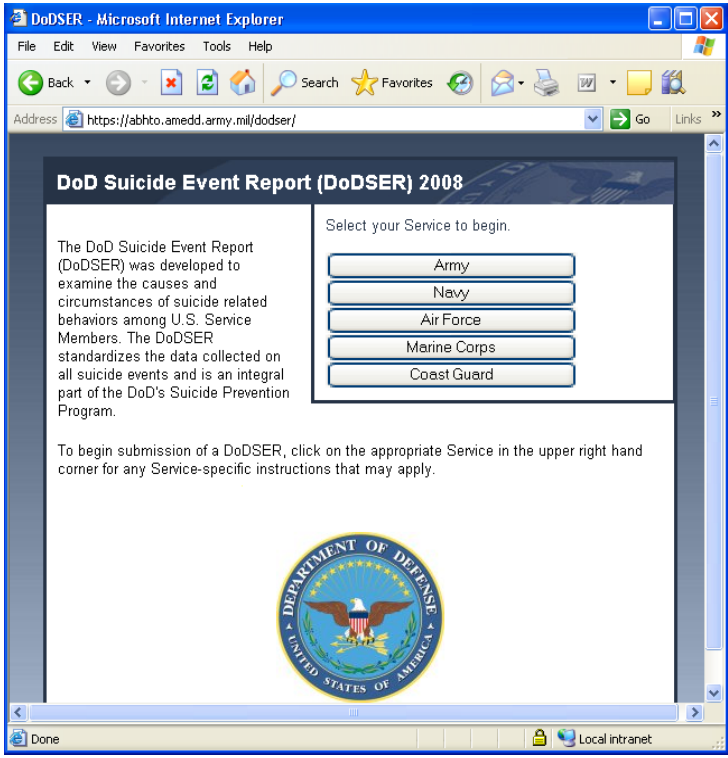
- The Department of Defense implemented the DoD Suicide Event Report (DoDSER) based on the Army Suicide Event Report (ASER), which was validated by the U.S. Army Medical Research and Materiel Command.
- DoDSERs are submitted for suicide behaviors that result in death, hospitalization or evacuation from theater.
- Data collected from standardized records

(e.g., medical records, CID).

- Army DoDSERs due w/in 60–days.
- Objective, detailed, and standardized information

collected:

- Comprehensive data (method, location, fatality)
  - Extensive risk factor data
    - Dispositional or personal
    - Historical or developmental
    - Contextual or situational
    - Clinical or symptom factors



Common BH EPICON Themes

Theme	Ft Leonard Wood 2001 (suicide)	Ft Bragg 2002 (homicide)	Ft Riley 2005 (suicide)	Ft Hood 2006 (suicide)	Ft Campbell 2008 (suicide)	Ft Carson 2009 (homicide)
INDIVIDUAL RISK FACTORS						
Deployment: length, multiple, unpredictability		X	X	X	X	
Combat Intensity						X
Family Separation - Relationship Stress - Lack of Support		X	X	X	X	X
Increased violence against persons including spouse/family		X	X	X	X	X
Increased use of alcohol and drugs, and related offenses			X	X	X	X
Previous gestures/attempts/BH contact	X	X	X	X	X	X
Manipulating - Malingering	X		X		X	X
Legal and Financial Issues		X	X	X	X	X
History of misconduct						X
SYSTEMS ISSUES						
Stigma: personal, peer, leadership, career		X	X	X	X	X
Poor Service Delivery for dependents		X	X	X		
Transition, Reintegration (One size fits all)		X	X	X	X	X
Problems wit BH Services, FAP, ASAP	X	X	X	X	X	X
Lack standardized screening, tracking, intervention, data collection	X	X	X	X	X	X
Leadership Management/climate	X	X	X	X	X	X

Source: EPICON published reports

Stigma

- Four types of stigma generally seen: career, leadership, peer-to-peer, and personal
- Stigma was reported differently across rank groups; lower enlisted were more concerned about peer and self-perceptions, senior enlisted were most concerned about their career and perceived leadership abilities

Career	Leadership	Peer-to-Peer	Personal
On permanent record, effects future promotion and employment	Some old school, senior NCOs, and early promoted NCOs create/maintain stigma	Peer stigma is the worst	Weak, isolated, embarrassed
End career, lose retirement	More stigma for senior enlisted, others think they can't lead, fear of effecting retirement	More stigma if never deployed	Profile makes them feel worthless
Lose security clearance	Many squad/platoon leaders don't support	Treated differently, Ridiculed	Pride/Denial
"Boarded out" rather than rehabilitated	Treated differently; doubt 'warrior' abilities; ridicule those with a profile	Gossiped about/Perceived faking	Don't want to be viewed as a "bad" soldier

Resiliency Programs

- **Battlemind**
  - The US Army psychological resiliency building program. This term describes the Soldier's inner strength to face fear and adversity during combat, with courage and speaks to resiliency skills that are developed to survive. It represents a range of training modules and tools under three categories: Deployment Cycle, Life Cycle and Soldier Support.
- **Suicide Prevention**
- **Provider Resiliency Training**
- **Reunion and Reintegration**
  - Deployment Cycle Support is in process of being upgraded.
- **Other Programs in Development**
  - New resiliency programs are being funded under congressional TBI/PH supplemental dollars
- **Warrior Adventure Quest**

BATTLEMIND

ARMOR FOR YOUR MIND

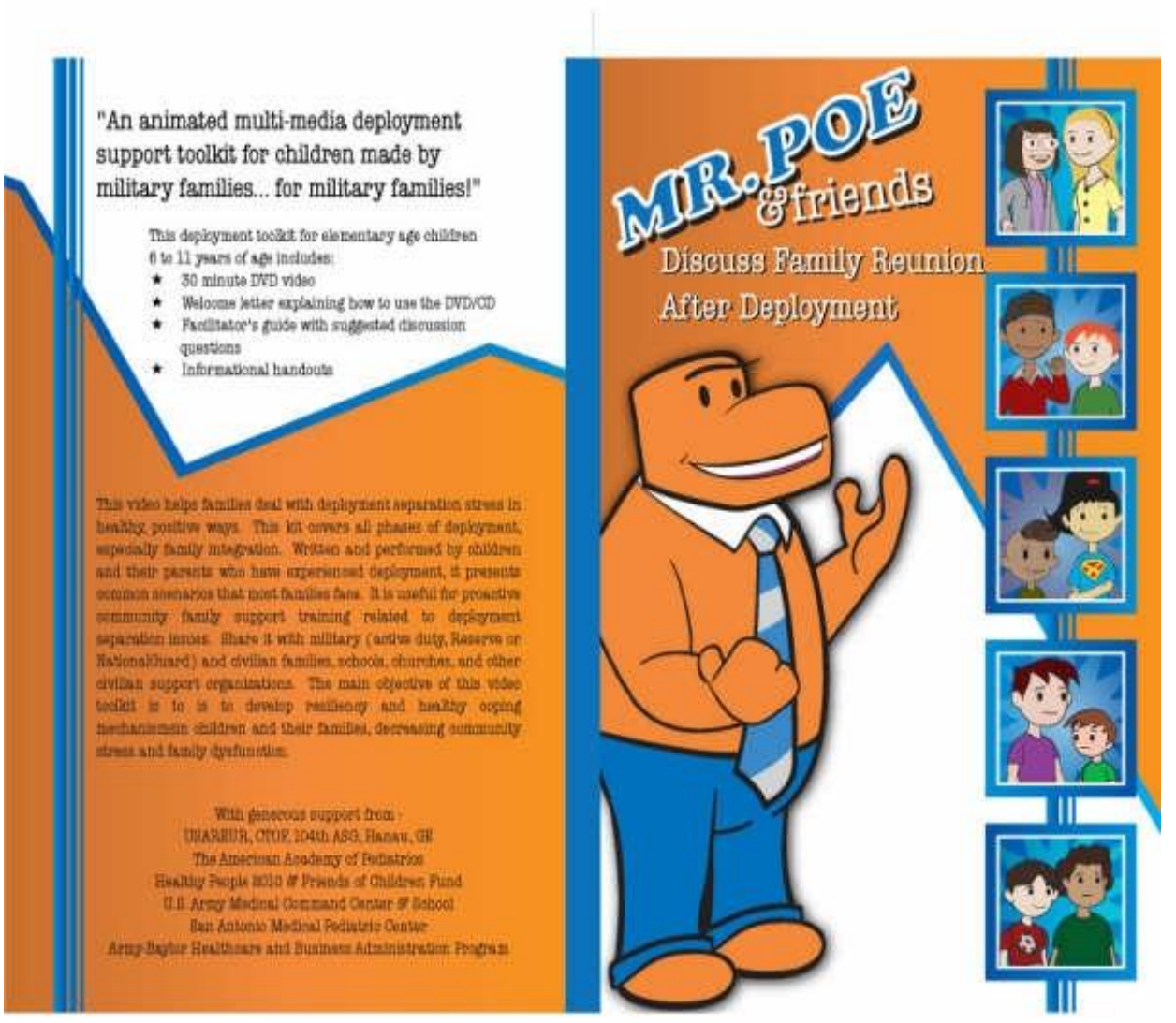
www.battlemind.army.mil

Battlemind Training System: Web Page

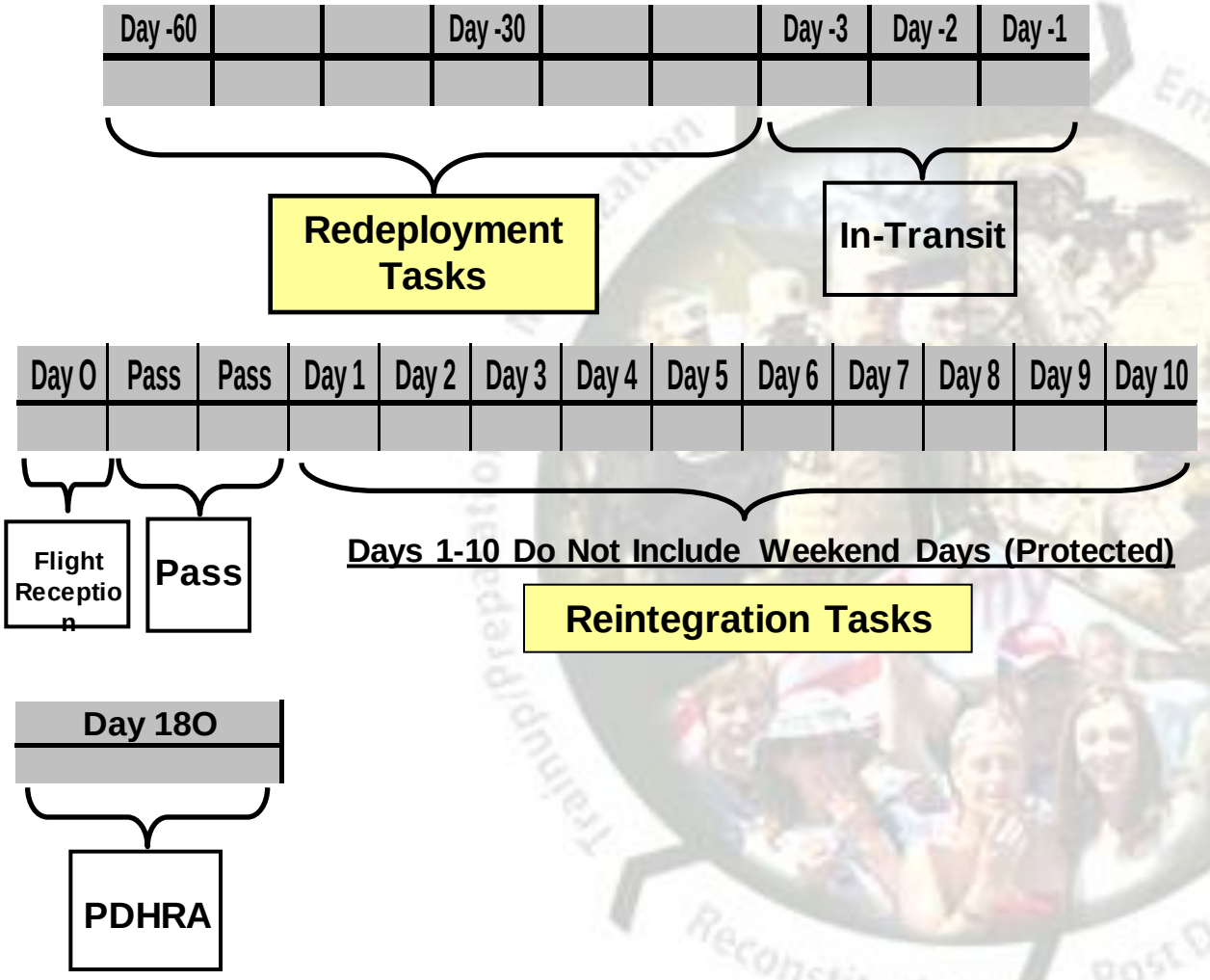
www.battlemind.army.mil

Military Youth Coping with Separation: When Family Members Deploy

Mr. Poe and Friends Discuss Reunion after Deployment



Updates in Decompression/Reintegration



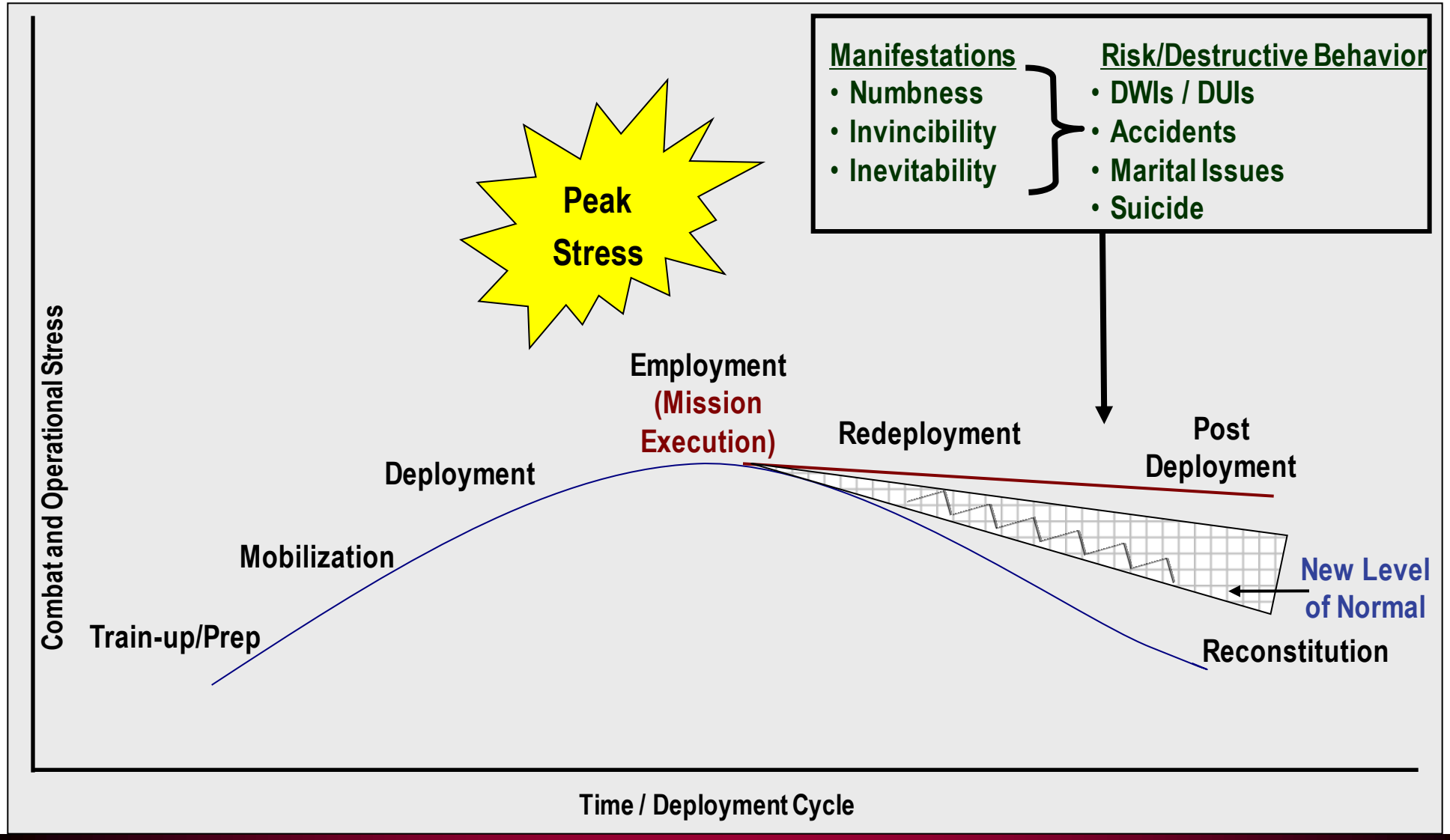
Key Components

- Commander's program
- Structured decompression / reintegration
- Mental health risk stratification program prior to departure from theater
- Active tracking and monitoring which involves coordination b/w BCT/Div and the local AMEDD resources.
- Tailored to both active component and reserve

WARRIOR ADVENTURE QUEST

- WAQ utilizes high risk/extreme sports in coordination with a debriefing tool to provide Soldier/Leader/Unit mitigation and coping skills that can address unresolved transition issues and build unit cohesion and moral, contributing to combat readiness.
- WAQ is NOT specific to reintegration, it is a training tool that can be incorporated across the ARFORGEN cycle.

Reintegration and Reconstitution



Unit Resiliency Fundamentals

Horizontal Bonding: Trust

Vertical Bonding: Trust

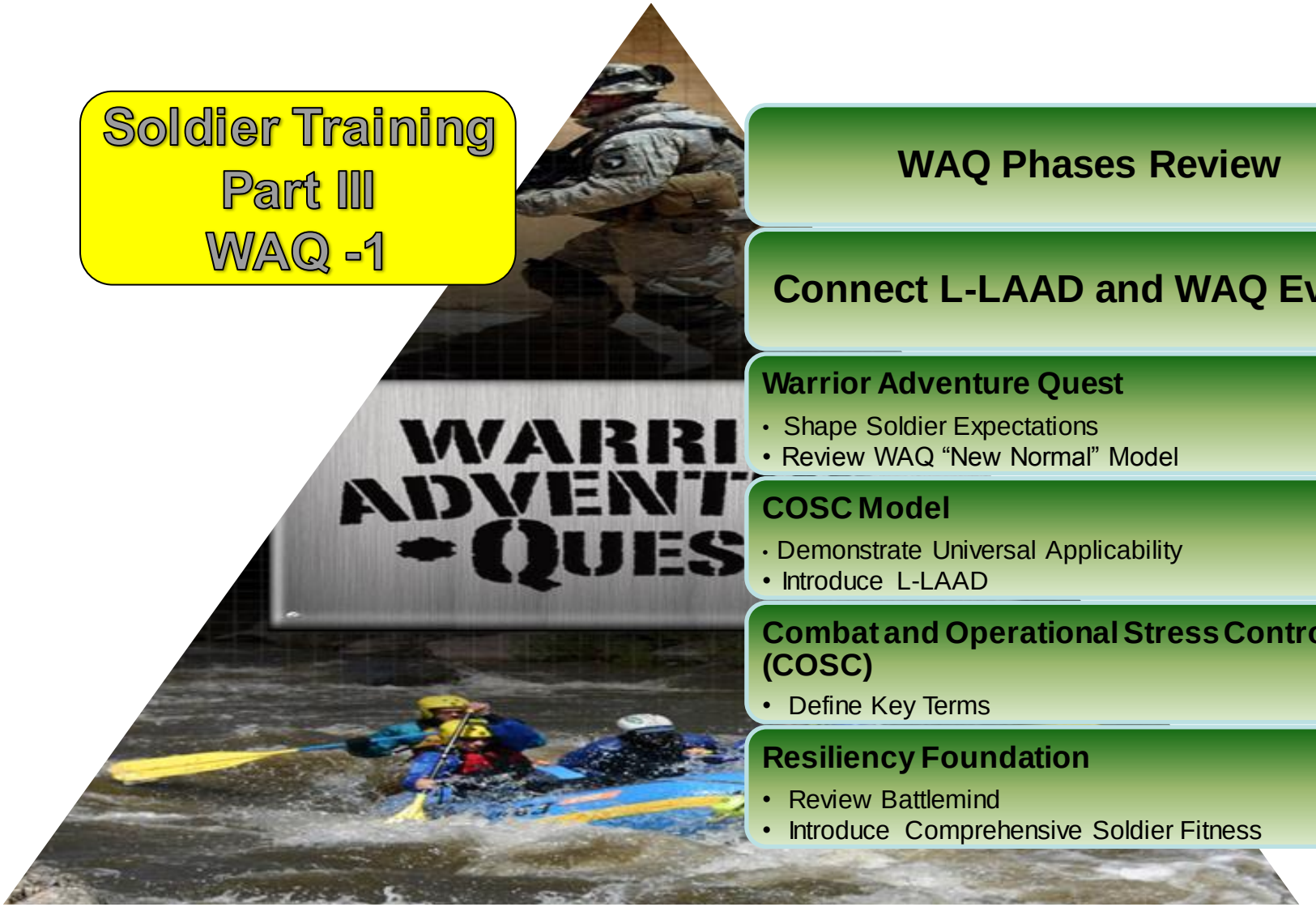
Esprit de Corps: Sense of

Unit Cohesion: Binding force which combines 3 previous concepts

- FM 6-22.5, COSC Guide, Leaders and Warriors (DRAFT, FEB 09)

WAQ Soldier Training

Soldier Training Part III WAQ -1



WAQ Phases Review

Connect L-LAAD and WAQ Events

Warrior Adventure Quest
- Shape Soldier Expectations
- Review WAQ "New Normal" Model

COSC Model
- Demonstrate Universal Applicability
- Introduce L-LAAD

Combat and Operational Stress Control (COSC)
- Define Key Terms

Resiliency Foundation
- Review Battlemind
- Introduce Comprehensive Soldier Fitness

Suicide in the Army

- Suicide rates are increasing in all components of the US Army, across all age groups, and in both male and female Soldiers
- PDHA/PDHRA does not serve as an optimal way to identify and intervene
  - Need to develop tools for suicide risk assessment
  - Improve suicide assessment training for providers
- The suicide rate among Soldiers who have deployed to OIF/OEF is higher than for Soldiers who have never deployed.
- A comprehensive approach to suicide prevention is required which includes identification and treatment of high risk individuals as well as risk mitigation efforts in the Army population

Risk Factors for Suicide in Army Personnel

- Major Psychiatric Illness Not a Significant Contributor
  - Adjustment disorders, substance abuse common
- Relationships
- Legal/Occupational Problems
- Substance Abuse
- Pain/Disability
- Weapons
  - 70% with firearm
- Recent Trends
  - Older, higher rank, more females

Army Suicides: 2001 through 31 JULY 2009

	2001-2009†		Overall ARMY‡	
NUMBER OF SUICIDES	817			
	N	%		
MALE	774	94.7	86.0	***
FEMALE	43	5.3	14.0	
AVERAGE AGE	28		25	***
Aged 18-25	365	44.7	43.2	
Aged 25-35	287	35.1	38.4	
Aged 36-60	165	20.2	18.4	
RACE-ETHNICITY				
Caucasian/White	615	75.3	74.6	*
African American	104	12.7	15.7	
Hispanic and Other	98	12.0	9.7	
MARITAL STATUS				
SINGLE	365	44.7	39.1	***
MARRIED	423	51.8	53.4	
DIV/SEP/WIDOWED	29	3.5	7.5	

† Through 31 July 2009; ‡ Based on 2008 figures; * p<.05;** p<.01; ***p<.001

Prepared by: USACHPPM BSHOP

Source: ABHIDE

Estimated Rate of Suicide by Army Functional Group, 2004-2009

Functional Group	# Suicides (N=508)	% of Suicides	Population 2004-July 2009	Estimated Rate per 100,000*	99% Confidence Limits
OVERALL	***508***	***100***	***2,831,568***	***18.1***	***18.07-18.13***
Maneuver, Fire & Effects	267	52.6	1,226,517	21.8	21.75-21.86
Force Sustainment	118	23.2	708,260	16.7	16.65-16.75
Operations Support	70	13.8	559,224	12.5	12.46-12.54
Special Branches	36	7.1	212,933	16.9	16.81-16.99
Other	17	3.3	106,574	16.0	15.87-16.13

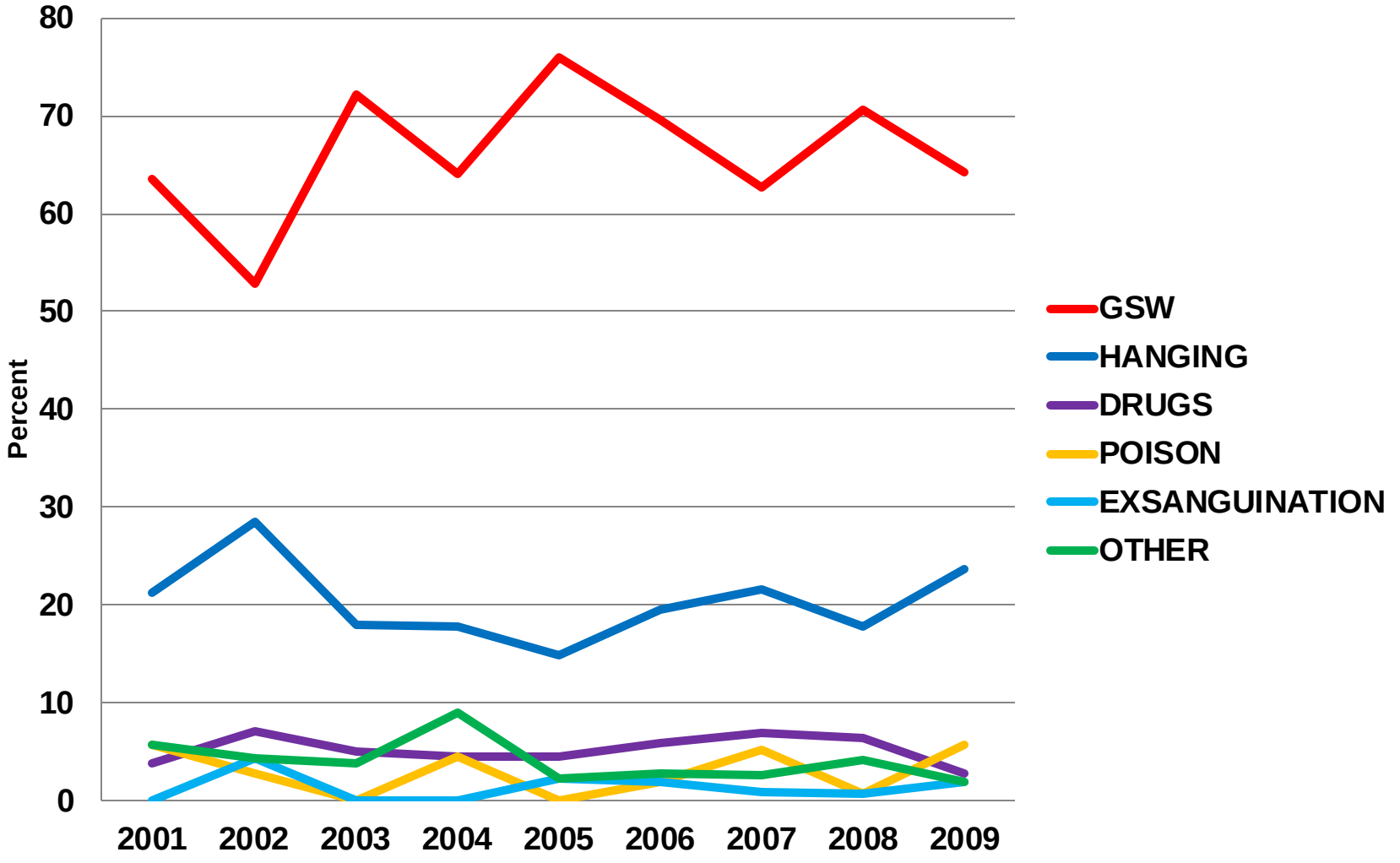
* Based on number of individuals, not person-years;

Significantly greater than average

Source: ABHIDE

Prepared by: USACHPPM BSHOP

US ARMY Suicides: Method of Death



Source: ABHIDE

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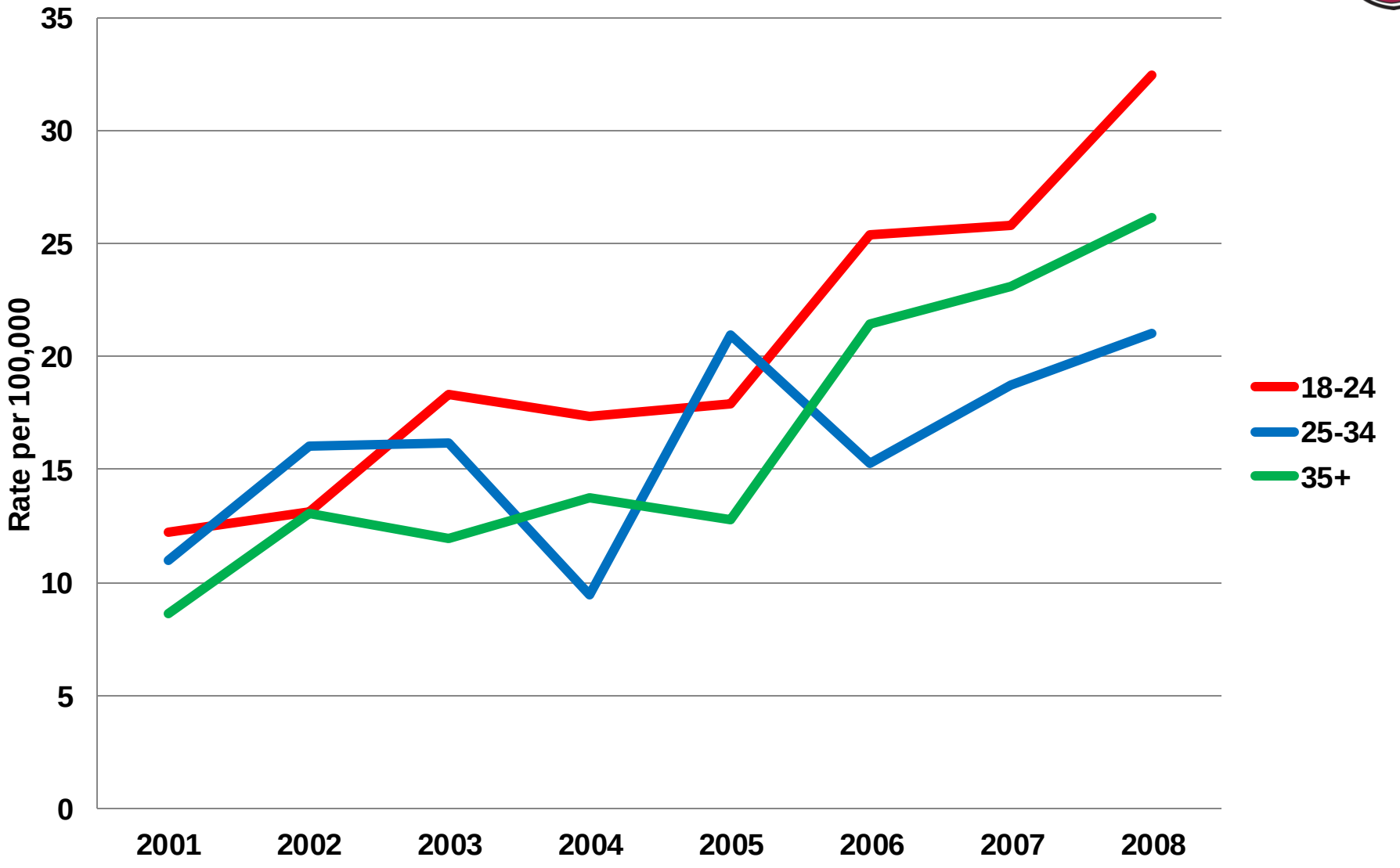
ARMY Suicide Rate Trends, by Age Group



Source: ABHIDE

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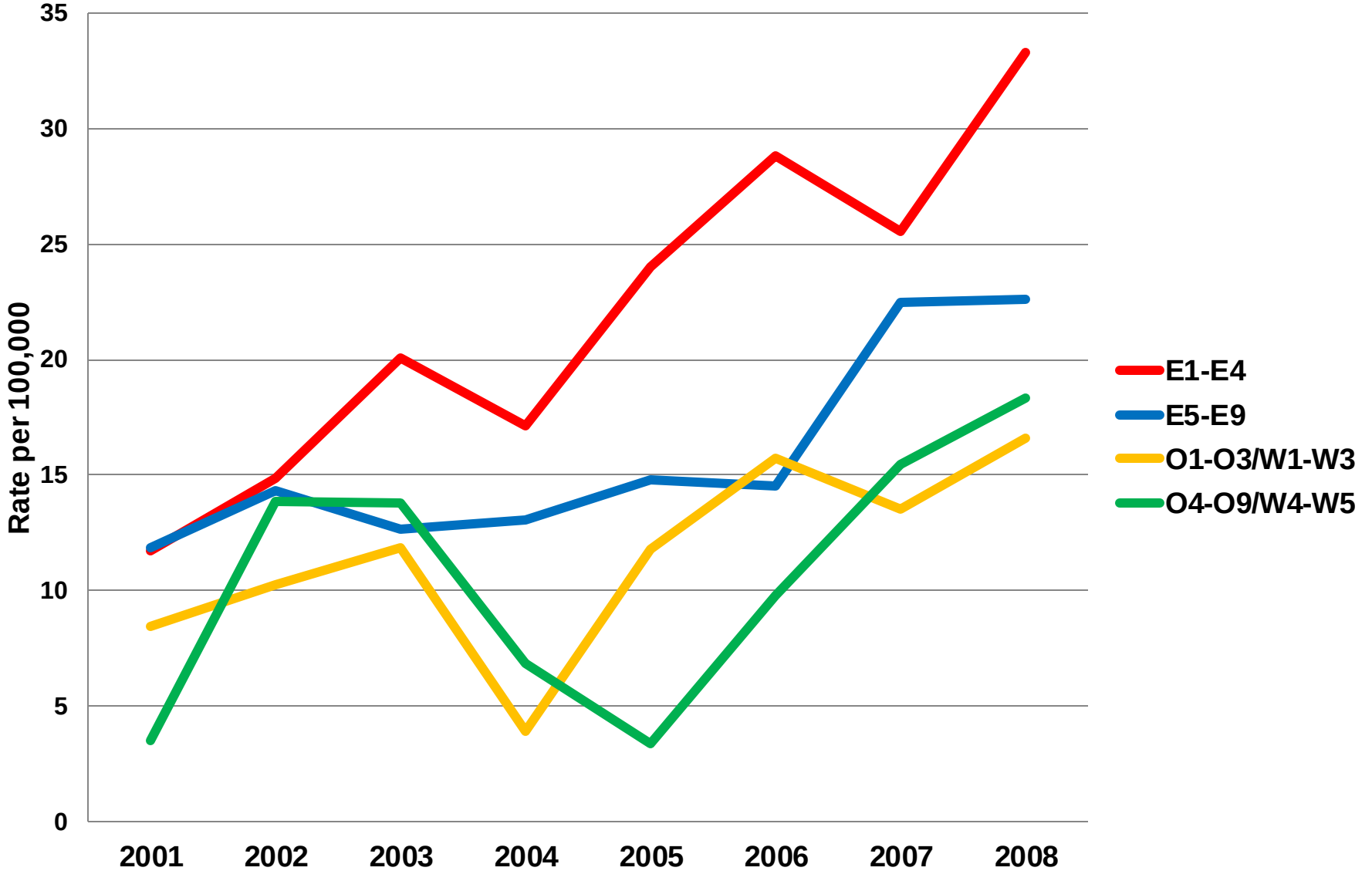
Army Suicide Rate Trends, by Rank



Source: ABHIDE

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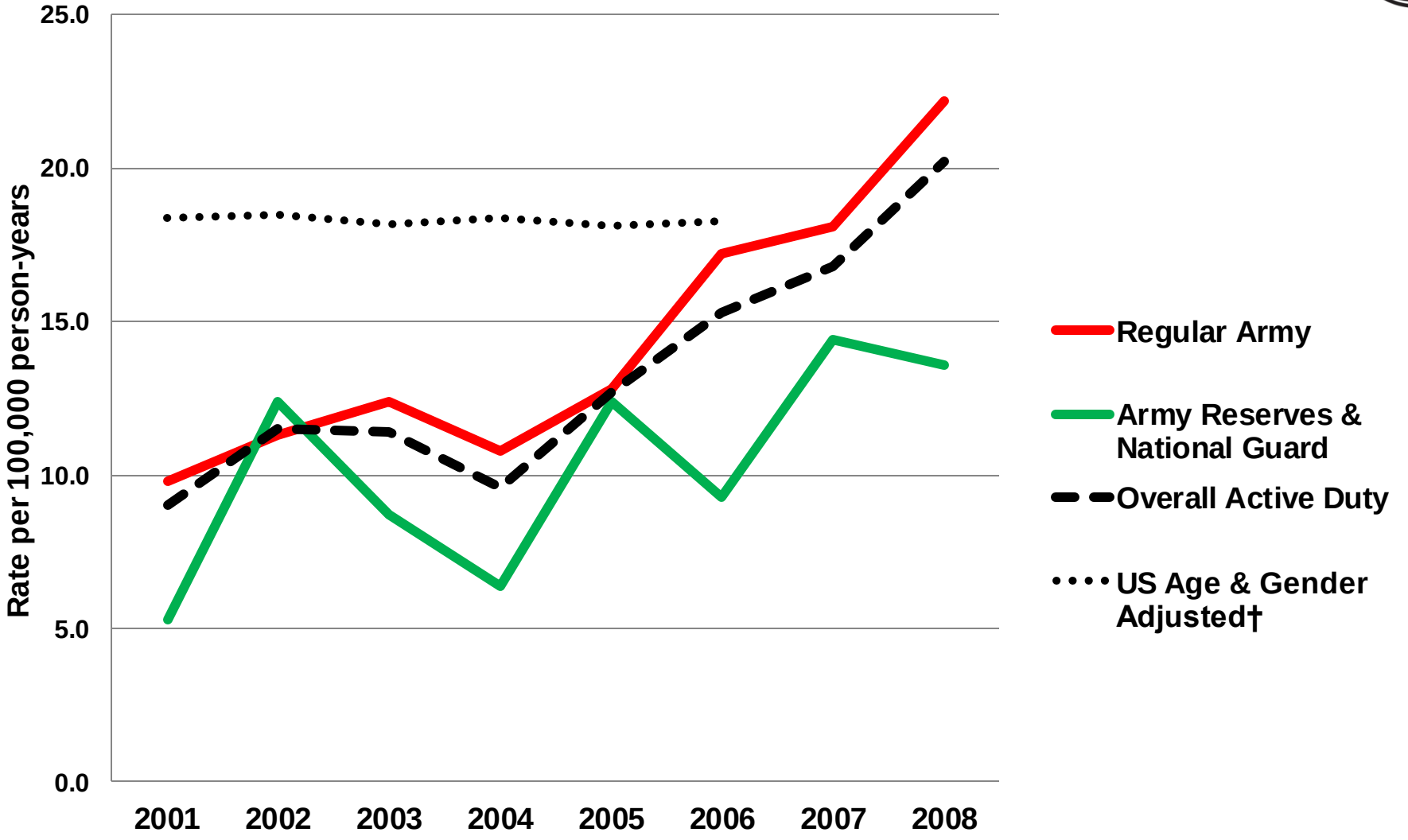
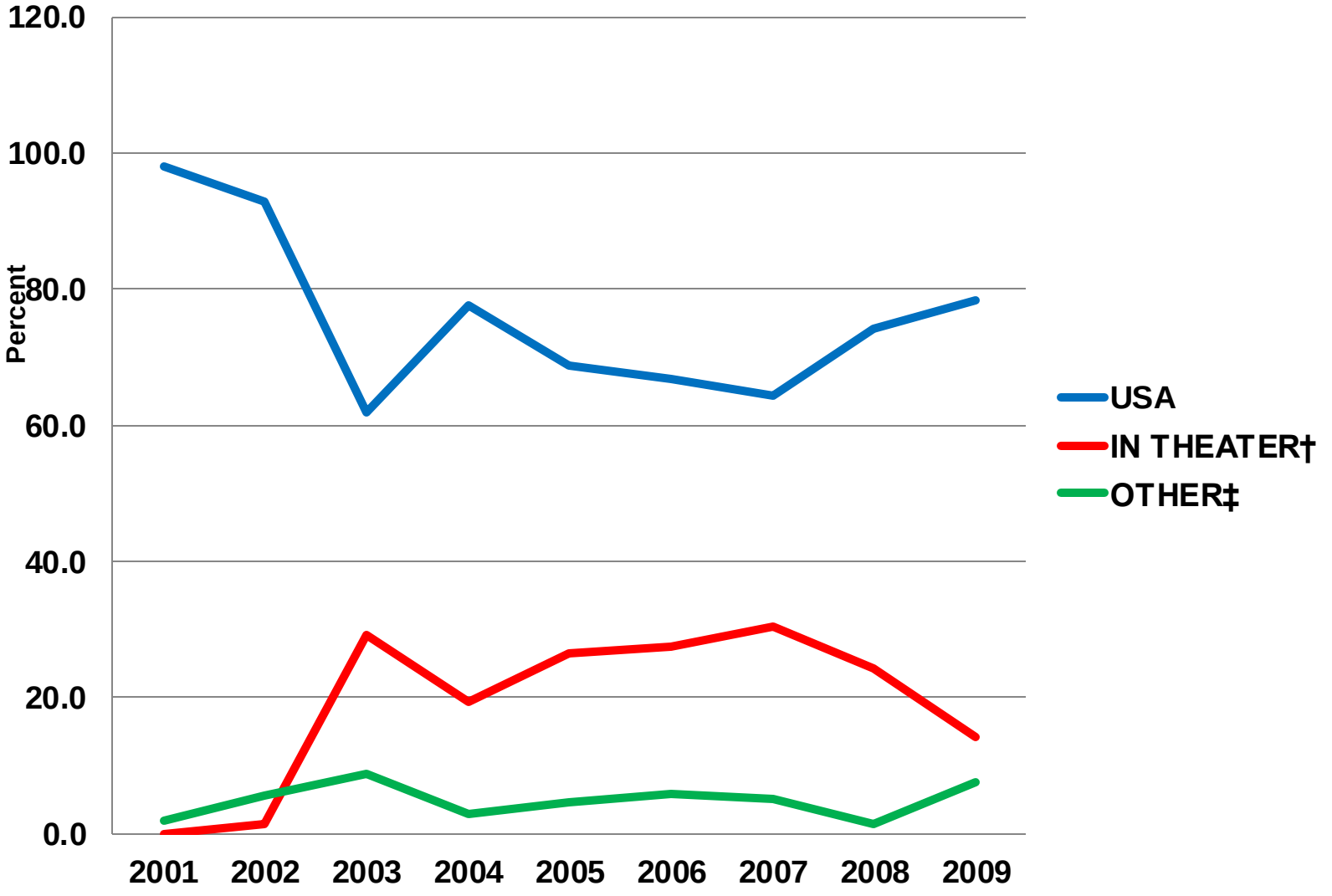
ARMY Suicide Rate Trends, by Component



Source: ABHIDE; Not Available for 2009

Prepared by: USACHPPM BSHOP

US Army Suicides by Place of Death, 2001-2009

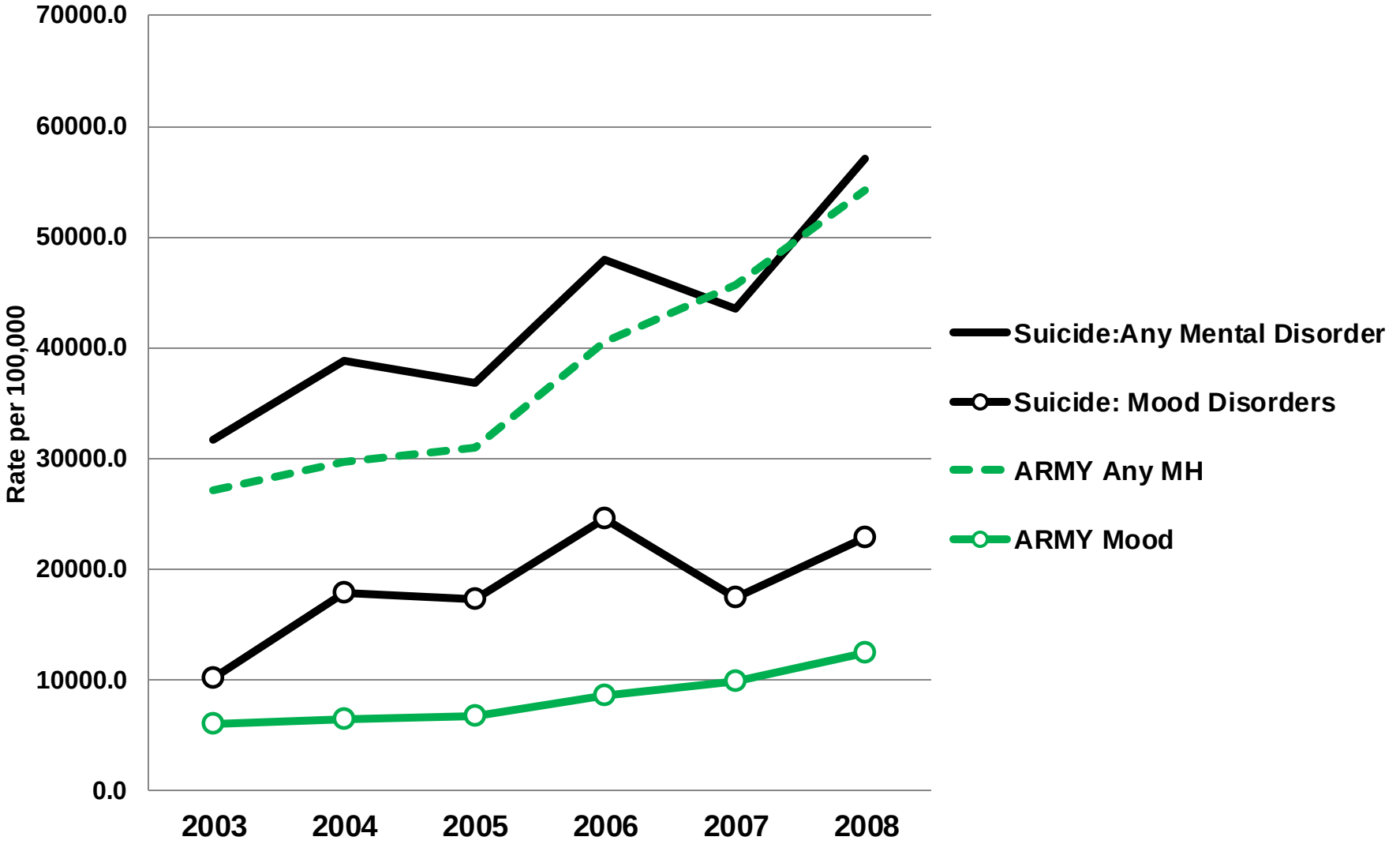


Source: G-1 and AFHSC

† OEF/OIF

‡ Africa, Cyprus, Germany, Kosovo, South Korea, Cuba, Italy, Belgium, Djibouti, Mexico, Poland, Thailand, Uzbekistan

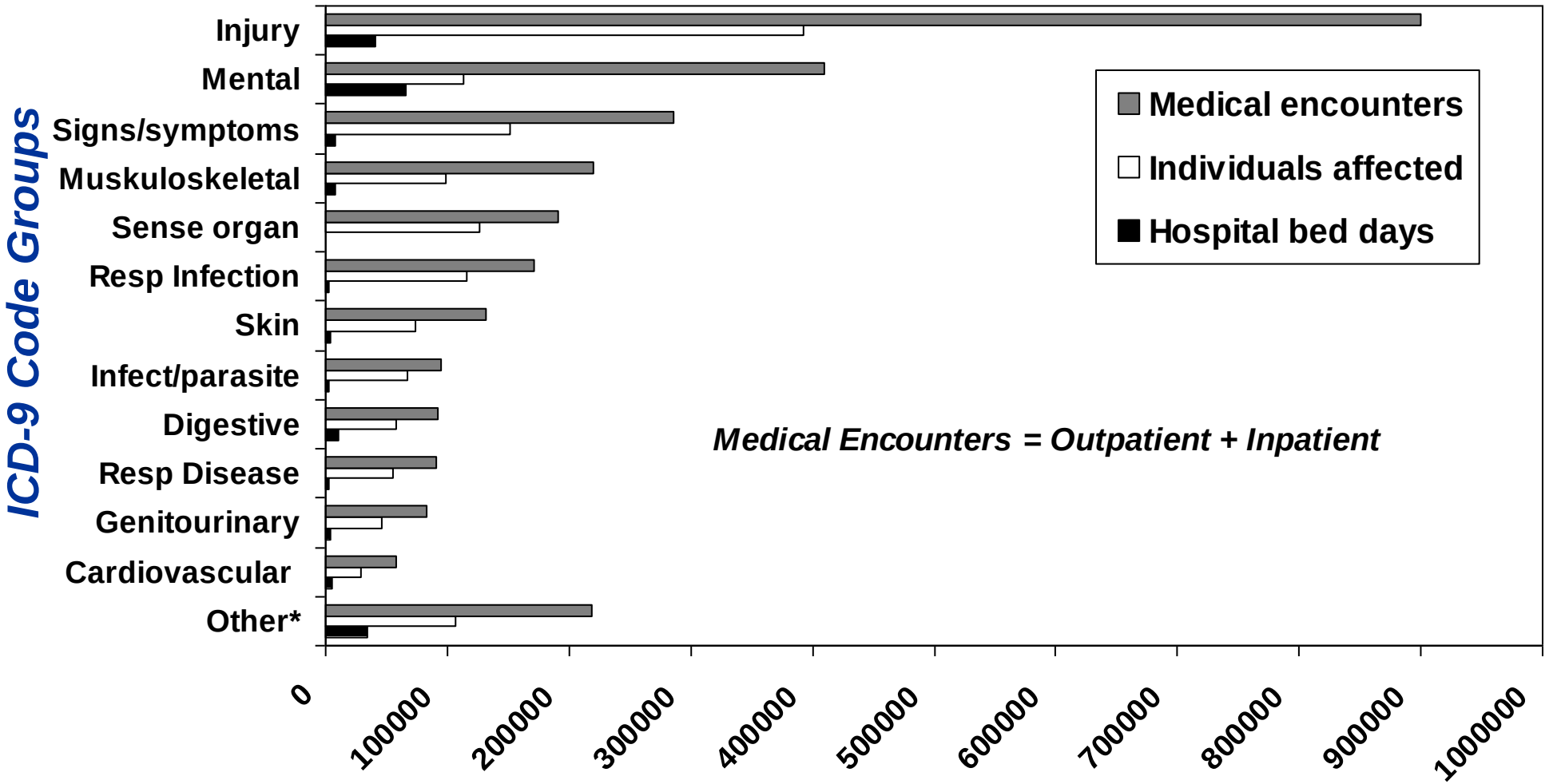
US Army Suicides: Mental Health Trends, 2001-2008



Prepared by: USACHPPM BSHOP

Source: ABHIDE & DMED

Burden of Injuries and Diseases
U.S. Army active duty, 2007



Medical Encounters/ Individuals Affected

**Includes all ICD-9 codes groups with less than 50,000 medical encounters*

Prepared by: USACHPPM BSHOP

Source: Defense Medical Surveillance System, Jul08

Past Suicide Mitigation Approaches

- Analysis of Incident Suicides
  - DOD Suicide Event Report (DODSER)
  - Epidemiologic Consultations (EPICONS)
- Clinical interventions to identify and treat high risk individuals
  - PDHA/PDHRA Screening
  - Respect.mil training for providers
- Training Soldiers, Leaders and Family Members to recognize and respond
  - ASSIST
  - ACE
  - Battlemind
  - Beyond the Front
  - Stand-Down Training

Suicide Awareness Training

- State-of-the-art universal suicide prevention effort involving a multidisciplinary approach.
- The Army's suicide awareness and training efforts represent several components
  - An educational program based on the "ACE" acronym that provides Soldiers behavioral-based training to help a fellow Soldier in need
  - An interactive training video entitled, "Beyond the Front" in which Soldiers experience firsthand the impact their actions can have when assisting a Soldier who is suicidal. All Soldiers received this training Feb-March 2009.
  - "Shoulder to Shoulder" chain teach March to July 2009.
- New Army Suicide Prevention Task Force
- Pending DoD Suicide Prevention Task Force

Changing Our Perspective of Suicide

"The Army's charter is more about holistically improving the physical, mental, and spiritual health of our Soldiers and their families than solely focusing on suicide prevention. If we do the first, we are convinced that the second will happen."

GEN Peter W. Chiarelli, VCSA, 29 March 2009

Army vice chief addresses suicide rate across Army

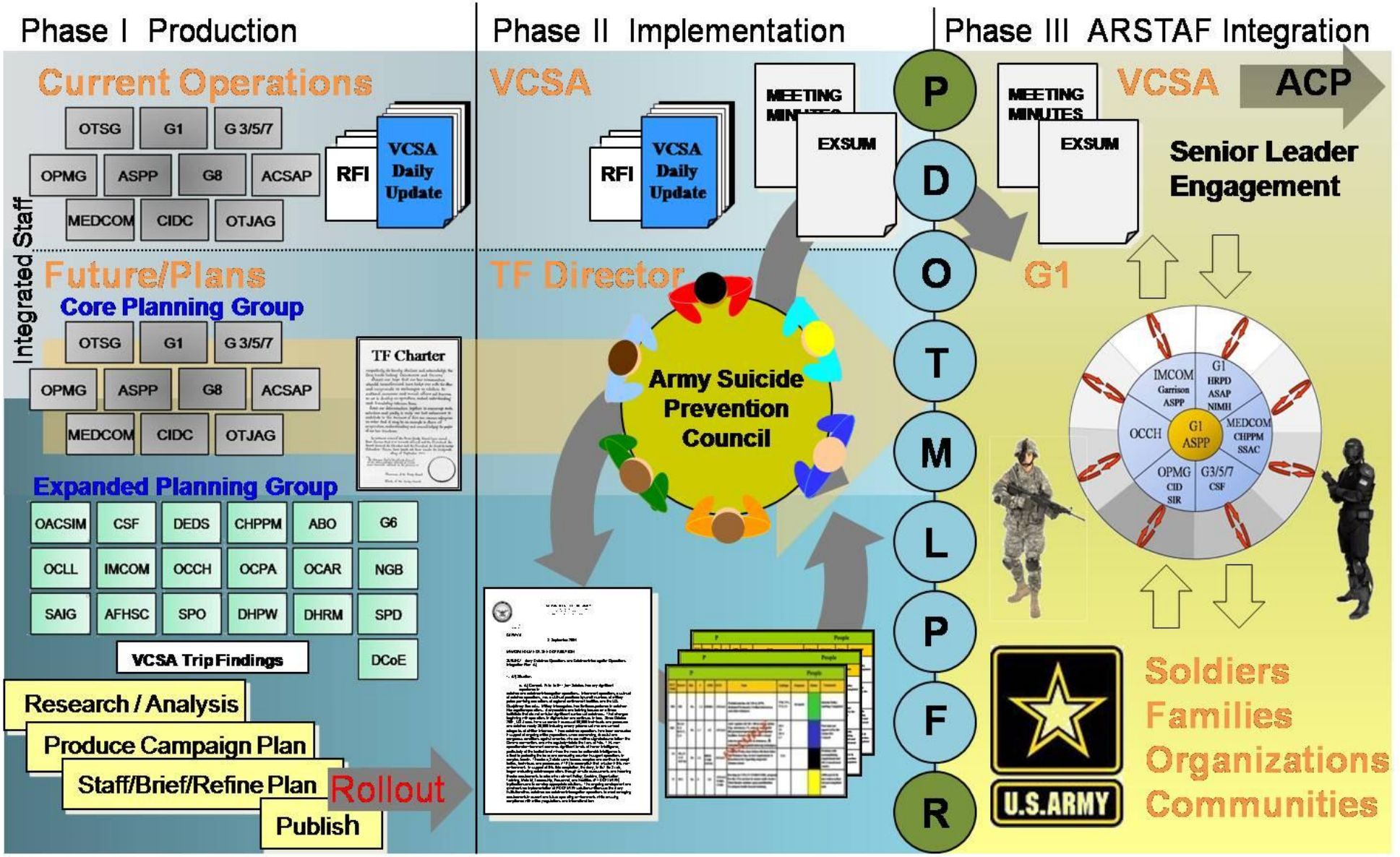
Mar 31

By **Eve Meinhardt**

Photo credit ***Eve Meinhardt***

Gen. Peter W. Chiarelli, Army vice chief of staff, speaks at Fort Bragg, N.C., March 25, during his visit to look at the implementation of suicide prevention training and best practices.

Army Suicide Prevention Campaign



Suicide Risk Assessment

Behavioral health care providers and key unit members play an active role in the management and treatment of suicidal Soldiers.

- Improve suicide assessment and evaluation (primary care, behavioral health clinic, VA).
  - Establish best clinical practices and standards of care
  - Train behavioral health and medical care providers at all levels
  - Conduct routine reviews and audits to ensure compliance
- Improve engagement and retention in behavioral health care employing motivational interviewing techniques.
- Involve close family members and friends where ever possible.
- Inform and educate unit leaders as appropriate.
- Enhanced focus on postvention efforts (maintain vigilance post crisis), including cases of completed suicides.

Evidence-Based Treatments

Adapt evidence-based treatments for suicidality among Soldiers.

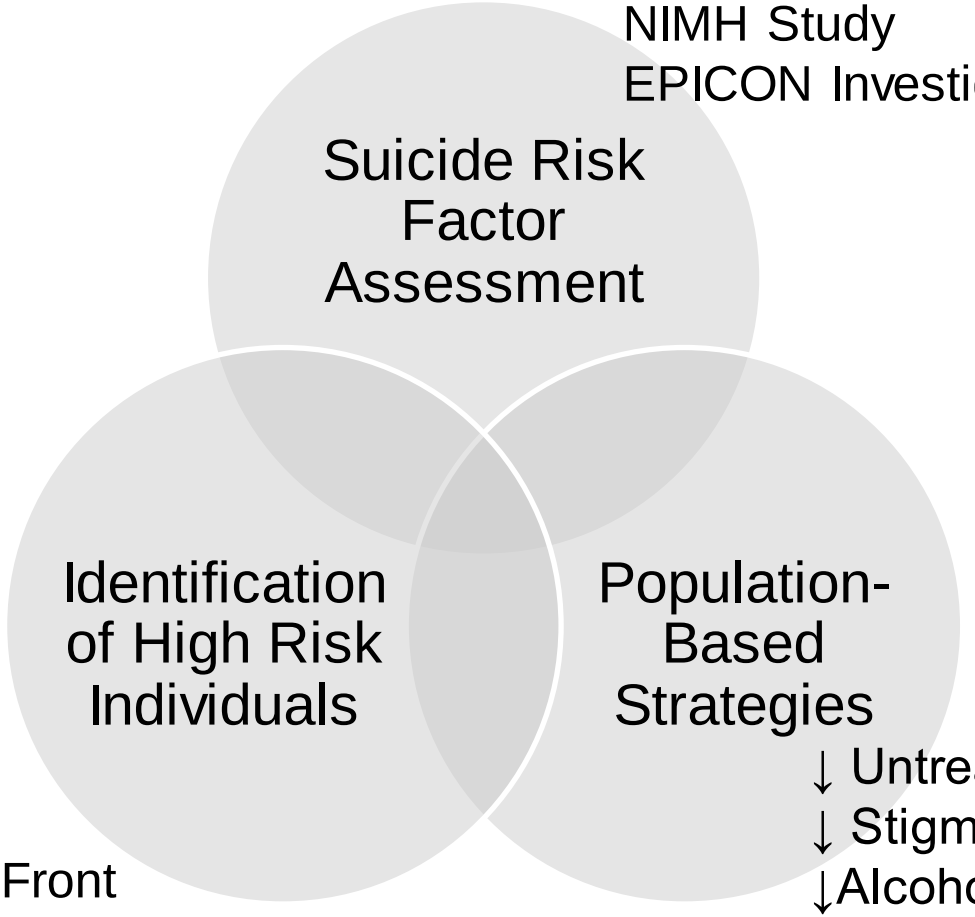
- Two generally accepted psychotherapeutic approaches for treating suicidal patients:
  - Cognitive behavioral therapy (based on social learning theory that focuses on changing distorted beliefs and cognitions about self and the world).
  - Dialectical behavioral therapy (a cognitive behavioral approach that includes social skills and problem solving).
- Treat the underlying behavioral health disorder.

Population-Based Strategies for Suicide Mitigation

- *The best evidence-based suicide mitigation strategies are optimal identification of high-risk groups and treatment of suicidal individuals*
- "Gatekeeper" strategies, which identify high risk individuals, may decrease suicides if identification leads to appropriate clinical management or reduction of stress
- Recent literature suggests interventions which decrease risk-factors in the population may impact suicide rates
- Current Army suicide mitigation programs focus on identification/treatment of high risk individuals, not groups.
- Incorporating strategies to mitigate risk-factors in the general Army population and among specific high risk groups may decrease risk for suicide in the population

Multi-dimensional Suicide Prevention Strategy

Strategic Analysis Cell
NIMH Study
EPICON Investigations

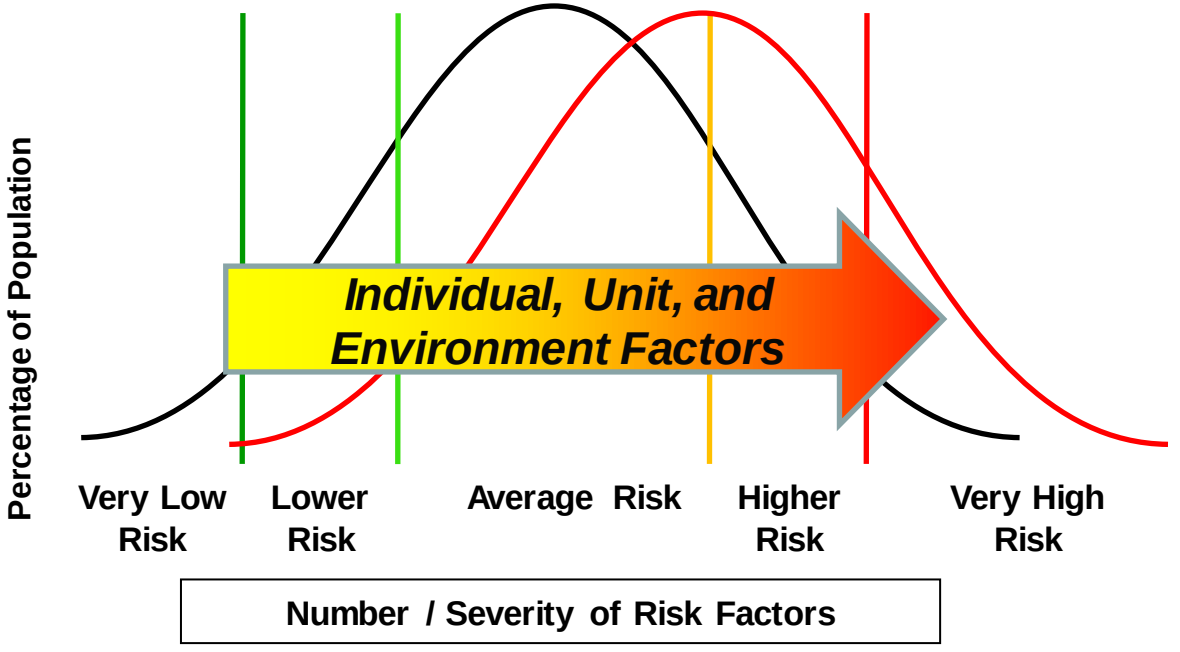


Treatment
ACE
ASSIST
Beyond the Front
Battlemind
Respect.mil

↓ Untreated/Undertreated BH
↓ Stigma to Seeking Care
↓Alcohol/Drug abuse
↓ Relationship/Family Problems
↓ Legal/Financial Issues
↑ Resilience

Causal Factors

- **Multiple individual, unit, and community factors appear to have converged to shift the population risk to the right**
- **This would put more Soldiers in the Very High Risk category making clustering more likely**



Facts

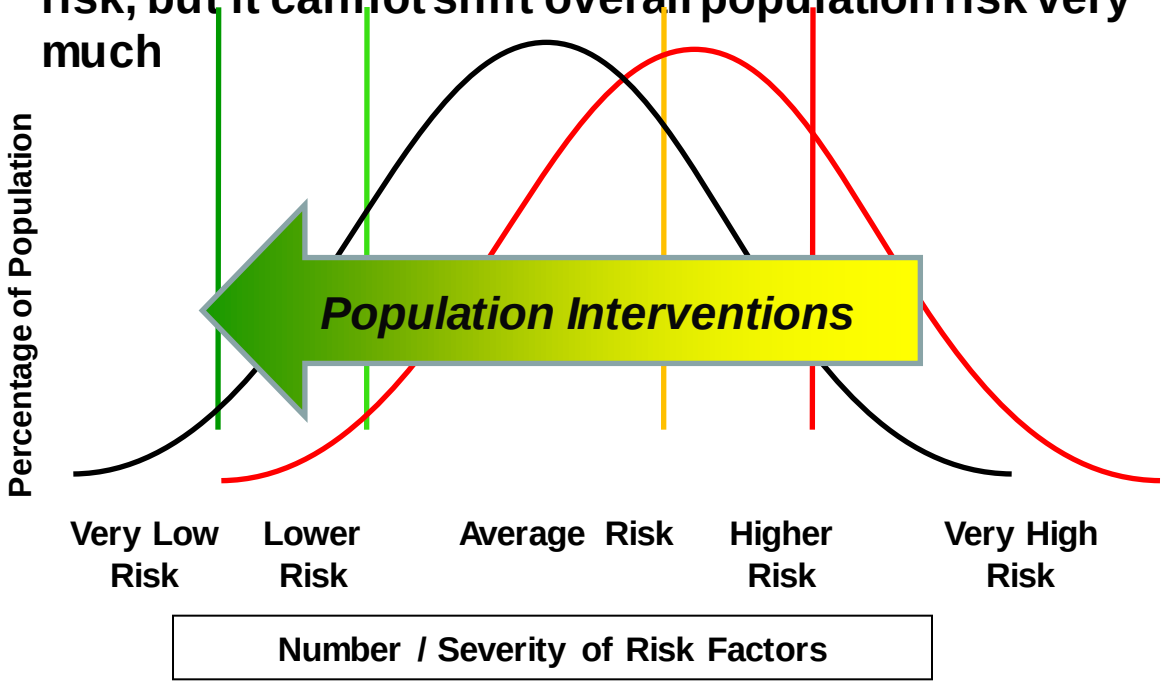
Individual
- Criminality/Misconduct
- Alcohol / Drugs
- BH Issues (untreated/under-treated)

Unit
- Turnover
- Leadership (Stigma)
- Training / Skills

Environment
- Turbulence
- Family Stress / Deployment
- Community
- Stigma

Factors to Consider

- **While it is important to identify and help individual Soldiers, the biggest impact will come from programs that shift the overall population risk back to the left**
- **Effective medical treatment can prevent individuals from increasing in risk or decrease their risk, but it cannot shift overall population risk very much**



Army Campaign Plan:

- Health Promotion, Risk Reduction, and Suicide Prevention
- Increase Resiliency
- Decrease Alcohol/Drug Abuse
- Decrease Untreated/Undertreated BH
- Decrease Stigma to Seeking Care
- Decrease Relationship/Family Problems
- Decrease Legal/Financial Issues

Installation:

- Reintegration (Plus)
  - Mobile Behavioral Health Teams
  - Mental Toughness Training
  - Resiliency Training
  - Military Family Life Consultants
  - Decompression Reintegration
  - Warrior Adventure Quest
- Consistent Stigma Reduction themes

Continuing Challenges and Way Ahead

Continuing Challenges

- **Array of services**
- **Stigma**
- **Increasing number of Soldiers with mTBI and PTSD**
- **Shortage of Providers**
- **Remote locations**
- **High OPTEMO**
- **Public Perceptions**
- **Suicide rate**
- **Lack of providers who accept TRICARE**
- **Provider fatigue**
- **Warrior Transition Office Soldiers**
- **Reintegration**
- **Guard/Reserve Soldiers**
- **Pain Control**

Way Ahead

- **Integration of services**
- **Policy changes, education**
- **Integration with primary care, other portals of care**
- **Grow number of providers**
- **Tele-Behavioral Health**
- **Optimal Reintegration**
- **Strategic communication**
- **Re-engineered suicide prevention**
- **Actively recruit providers to TRICARE**
- **Provider resiliency training**
- **Mental health organic in WTUs**
- **Enhanced reintegration strategies**
- **Mental health organic in Guard/Reserve**
- **Updated Clinical Practice Guidelines in Pain**