



The Case for a Regimental Psychiatrist

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3D MARINES

- High operational tempo and heavy casualties in support of OIF/ OEF
- 1 to 2 battalions deployed at all times
- Geographical separation from Division
- Distant from NHC Pearl Harbor
- Absence of nearby Navy MTF as compared to Okinawa, Camp Pendleton, and Camp Lejeune
- NHC Pearl Harbor supportive including DHC; tasked with IA deployments of providers
- Tripler AMC supportive but also busy; differences in culture and administration



State of affairs, pre-October 2007

- Limited access to care; 4+ weeks for routine appt
- Non-organic providers varying understanding of operational needs, treating without dispositional / administrative end in site – large backlog of LimDU and PEB
- Limited communication – Battalion Surgeons and Marine Commanders sometimes unaware of recommendations and disposition
- Battalion Surgeons and IDCs without adequate mental health training and overly reliant upon specialists
- No OSCAR capability; no direct source of mental resiliency, self-aid, and buddy-aid training for Corpsman and Marines



The TOECR

- 25 Oct 06; TOECR was initiated by 3d Marine Division for a Psychiatrist and Psych Tech for 3d Marines (T/O&E-1096F/M13101)
- As of 10 July 08, still in deliberation at MCCDC
- Spring '07 - In order to mitigate obvious need in face of slow process, a Contingency Billet (RTN) was established by “double stuffing” a GMO billet with a Psychiatrist (but no Psych Tech) pending the TOECR approval



State of Affairs, August 2008

- High clinical demand (accessibility and stigma-reduction)
- Timely, accessible care
 - Routine appts: 2 weeks
 - Acute appts: 48 hours with IMMEDIATE “curbside” accessibility
- Timely administrative decisions
- Improved Communications
 - Single point liaison for all health providers (Pearl Harbor, DHC, MCCS, TAMC)
- Ongoing training of Surgeons / IDC’s, Corpsman on the initial management of common mental health presentations
 - Early recognition and simple interventions, aiming for 20% reduction in specialty care referrals
 - Surgeons / IDC’s and Marine leaders feel empowered



LIMDU/ PEB

LIMDU

- September 2007
 - 85 LIMDU, 6 Mental Health (7%)
 - 12 months of LIMDU the norm
- August 2008
 - 55 LIMDU, 12 Mental Health (22%)
 - 2nd period of LIMDU rare

PEB

- September 2007
 - 40 PEB, no situational awareness on mental health PEBs
- August 2008
 - 40 PEB, 16 Mental Health (40%)
 - 12 months from start to home the goal



LIMDU/ PEB Conclusions

- Stigma Reduction + Accessibility = Recognition
- Compliance Monitoring
- Efficient Delivery of Time-Intensive Multidisciplinary Care
- Ongoing Assessment of Progress Allows for Earlier Prognostication
- Timely PEBs



Surveillance

- Approximately 350 Marines (8% of 3D Marines) involved in some form of mental healthcare during any one month period
 - Regimental Psychiatry
 - DHC Psychology
 - Marine Corps Community Services
 - Substance Abuse Counseling or Rehabilitation
- November 2007 to May 2008
 - 590 patient encounters
 - 214 new evaluations
 - 58 new cases of PTSD (27%)
 - 20 PEB



OSCAR at 3d Marines

- Clinical, Preventive, Expeditionary
 - 90% Clinical (accessible but inefficient)
 - 6.5 clinical hours daily (taking 8 hours), plus administrative and consultation responsibilities
 - 9% Preventive (consultation and training)
 - MOSST briefs (with incorporation of Psych First Aid)
 - One hour of provider training each month
 - Collaboration with FROs/ Chaplains/ FOCUS assets to promote and encourage family resiliency training
 - 1% Expeditionary



Remaining Challenges

- 90/9/1- Need to attain synergy (rather than balance)
 - Psych tech assistance
 - Improve efficiency through practice management support and acute evaluations under supervision
 - Development and delivery of training, especially at the new join/ NCO levels.
 - Mentoring and support to 8404s
 - Create time for, and assist with, “train the trainer” mental resiliency programs for more efficient use of resources (GMOs/IDC’s, chaplains, Line Corpsmen as physician extenders)



Achieving Synergy to Maximize Use of Limited Resources

- Synergy (deploying well-trained battalion assets)
 - Will require the addition of a permanent Psych Tech (8485) at 3d Marine Regiment - this is essential!
- Balance (deploying the psychiatrist)
 - Will require addition of another licensed provider and two Psych Techs at 3d Marine Regiment
- With time to focus on education and training, the preventive and expeditionary components of the OSCAR concept will flourish



Conclusions

- Regimental Psychiatrist at 3d Marines has been a great success
 - Improved access to care
 - Improved coordination with supporting and parallel resources
 - Operational needs regarding expedient disposition and processing of cases being met
 - OSCAR presence felt – training of Corpsman as provider extenders, Marines and Sailors in mental resiliency, self, and buddy aid (Psych First Aid) begun
- Psych Tech is needed to further advance OSCAR / training, facilitate clinical practice
 - One Psych Tech for each battalion would not be too much



Conclusions – cont.

- Ideally, Regimental Psychiatrist should have much less clinical responsibilities and more OSCAR
- Must guard against merely shifting clinical management to the Regimental level without added OSCAR benefit
- In an undermanned community, utilization of non-psychiatry resources for the preventive and expeditionary components of OSCAR is key >>

Training, equipping, and empowering non-psychiatrists as clinical extenders



Discussion