



SWPAG NEWSLETTER

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DECEMBER 2009

“USPHS Social Worker Helps DoD Combat Suicide”

By CDR Janet Hawkins

**THIS ISSUE - -
SPECIAL FOCUS:
PHS-DOD
PARTNERSHIP**

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**ALL 2009 SWPAG
MEETINGS COMPLETE
SEE YOU NEXT YEAR!**

CDR Janet Hawkins is a social worker currently serving with the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) with the Resilience and Prevention Directorate. CDR Hawkins is one of over sixty Health Service Officers assigned with the Department of Defense through the Memorandum of Agreement. She is the Division Chief for the Prevention Branch. As the Chief of the Preventive Branch, she is the Chair for the DoD Suicide Prevention and Risk Reduction Committee (SPARRC). SPARRC was developed because of the lack of a centralized forum for collaboration between experts to advance the practice and science of suicide prevention activities across the DoD system. The committee functions as a venue to address risk reduction policy initiatives, suicide surveillance metrics, programs and implementation of these programs.

Back in December, the Secretary of Defense made a request that a DoD Task Force be formed to examine



CDR Hawkins and MG Vople

matters related to prevention of suicide by members of the Armed Services. SPARRC was asked to form a working group and submit a list of nominees for consideration on the Task Force. Since that time, five SPARRC members have been assigned to the Task Force. It has been established as a newly chartered federal advisory committee under the Defense Health Board and being chaired by MG Phillip Vople, an Army physician. The group is working diligently on the following tasks:

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*The mission of the U.S. Public Health Service Commissioned
Corps is to protect, promote, and advance the health and safety of
our Nation*



Continued from front page

- Identify trends and common causal factors in suicides.
- Establish or update suicide education and prevention programs conducted by each military department based on identified trends and causal factors.
- Conduct an assessment of current suicide education and prevention programs of each military department.
- Conduct an assessment of suicide incidents by military occupation to include identification of military occupations with a high incidence of suicide.
- Identify the appropriate type and method of investigation to determine the causes and factors surrounding each suicide.
- Identify the qualifications of the individual appointed to conduct an investigation of a suicide.
- Identify the required information to be determined by an investigation in order to determine the causes and factors surrounding suicides.
- Identify the appropriate official or executive agent within the military department and Department of Defense to receive and analyze reports on investigations of suicides.
- Identify the appropriate use of information gathered during investigations of suicides.
- Methods for protecting confidentiality of information contained in reports of investigations of suicides by members of the Armed Forces.

CDR Hawkins is planning to present the findings of the Task Force at the upcoming Commission Officers Association (COA) Conference scheduled for March 2010. She is optimistic that the findings of the Task Force will prove useful and promote even more collaborative efforts between DoD and PHS.



USPHS Social Workers deploy to assist Mescalero Apache Tribe with suicide cluster.

By LCDR Betty Hastings

On October 16, 2009 the Tribal Council for the Mescalero Apache Tribe of New Mexico declared a “state of emergency” in response to the sudden suicide cluster taking place on the Mescalero Apache Reservation.

CDR Dorlynn Simmons, MSW and CEO for the IHS Mescalero Service Unit requested the assistance of LCDR Betty Hastings, MSW and other key IHS staff to conduct a community emergency assessment of the suicide cluster in the Mescalero Apache community. Upon reporting the findings of the Team’s assessment, the Tribal Council immediately passed resolutions that included requesting the assistance of the Office of Force Readiness and Deployment in deploying PHS mental health Officers to support the mitigation and stabilization of this crisis.

Utilizing the “IHS Emergency Response to Suicide Model,” developed by LCDR Hastings, the first deployed Officers were on the ground November 21, 2009 and included LCDR Todd Johnson, MSW and LT Joel Nelson, MSW, MPH. The second rotation of Officers deployed to Mescalero Apache December 5, 2009 and included LCDR Tracey Powell, MSW. The third rotation deploying on December 19, 2009 will include CAPT Guy Mahoney, MSW, Officer in Charge, CAPT Julia Dunaway, MSW and LCDR Karen Hearod, MSW.

Each Officer deploying is provided on-site training provided by CDR Simmons, the Incident Commander for the mission and her staff. The training includes instruction in IHS Electronic Health Record/Resource and Patient Management System, IHS IT security training, QA and Risk Management training, and training to enhance cultural competence for working with Mescalero Apache community members.

The many services that PHS Social Workers have provided to this community while on deployment include but are not limited to:

- building infrastructure that will meet the needs of the community;
- establishing and implementing processes regarding referrals from law enforcement, tribal courts, schools, and other programs to mental health;
- outreach activities to community;
- grant writing initiatives; and
- individual and group counseling to students and adults in the schools and at the IHS behavioral health clinic

There have been no suicide completions since the deployment began.



SWPAG SPOTLIGHT

Introducing the 2010 SWPAG Chair and Secretary



CDR Jean O. Plaschke

received her Master's Degree in Social Work (MSW) from the University of Maryland, with a concentration in Clinical and Ad-

ministration. She received a Bachelor of Arts degree in Psychology and Therapeutic Recreation from the University of North Carolina at Chapel Hill. CDR Plaschke is a Licensed Certified Social Worker-Clinical in the State of Maryland.

CDR Plaschke began her career as a clinical social worker in an outpatient mental health clinic in St. Louis, MO, and in an inpatient psychiatric hospital in Baltimore, MD. CDR Plaschke completed two Commissioned Officer Student Training and Extern Program assignments, including one with the Substance Abuse and Mental Health Services Administration, and the

other with the Health Resources and Services Administration.

CDR Jean Plaschke entered the Commissioned Corps of the U.S. Public Health Service in July 1996. After accepting her commission, she was assigned to the Office of the Secretary's Office of Minority Health (OMH) in the Division of Information and Education, and in 2001 she joined OMH's Division of Program Operations. For more than five years, CDR Plaschke served as project officer on OMH's single largest grant program, the Family and Community Violence Prevention (FCVP) program. In addition, CDR Plaschke oversaw a number of other "umbrella" cooperative agreements with national minority organizations.

August 2006 CDR Plaschke began working as a Senior Program Management Officer with the Substance Abuse and Mental Health Services Administration's

Center for Mental Health Services, in the Division of Prevention, Traumatic Stress and Special Programs, Emergency Mental Health and Traumatic Stress Services Branch. In this capacity, CDR Plaschke serves as a project officer on the National Child Traumatic Stress Network program, overseeing 22 cooperative agreement projects, with funding totaling over \$10 million.

CDR Plaschke has served on a number of Corps-related workgroups, including the American Indian/Alaska Native Commissioned Officers Advisory Committee (AIANCOAC) as treasurer and vice-chair; the AIANCOAC representative and voting member of the Minority Officer's Liaison Council; and the Social Work Professional Advisory Group, as secretary and chair-elect. CDR Plaschke is a member of Services Access Team (SAT) 5.

LT Kelley Smith is an officer in the Health Services category and is a licensed social worker. She works as a social science analyst for SAMHSA in the Office of Applied Studies. She received her Bachelor of Arts in Sociology from Louisiana Tech University and her Master of Social Work from Louisiana State. She completed a post-graduate fellowship at Tulane University's School of Public Health Department of Psychiatry and Neurology in Infant and Early Childhood Mental Health. Currently, she is a doctoral candidate and is working on her dissertation at The Catholic University of America's National Catholic School of Social Services.



Deployment Opportunities for Social Workers on PHS Mental Health Teams

Second in a series on social work deployment opportunities on OFRD Response Teams

By LT Jonathan D. White

Among the assets key to the US Public Health Service Commissioned capacity for prompt response to a health crisis are the five Tier I Rapid Deployment Force (RDF) teams. These 125-member teams are “on-call” for deployment on 12 hours’ notice every fifth month to respond to Emergency Support Function (ESF) 8, health and medical emergency, as well as other public health crises. PHS social workers are active contributors to the success of these “advance forces” of health and medical emergency response, and considerable opportunities exist for social workers looking to grow as responders.

The five Tier I RDFs are geographically-based to foster opportunities for in-person training together and rapid team transport during periods of activation. RDFs 1 and 2 are based in the Washington, DC, metropolitan area; RDF 3 is based in Atlanta, Georgia; and RDFs 4 and 5 comprise Officers from western states. The multidisciplinary team members train to work together and to fulfill their respective team roles, and active participation, a three-year commitment and supervisory approval to join are expected.

Although RDF teams train for a variety of missions, including point-of-distribution (mass vaccination), on-site incident management, mass casualty triage, and isolation/quarantine operations, likely the most visible RDF mission involves setting up and staffing a Federal Medical Station (FMS), providing special needs sheltering and direct health care service to persons with significant medical needs who are unable to receive care in their communities due to damaged health infrastructure or due to

displacement following evacuation. In the FMS, PHS Rapid Deployment Force is able to stand up a 250-bed field hospital and special needs shelter in approximately eight hours, and subsequently to run it, providing medical care, food, shelter, and safety to evacuees.

In the FMS setting, the population served is comprised of people with medical needs and their caregivers. Disproportionately, since evacuated residents with financial resources have greater access to shelter and healthcare outside the impact zone, those “left behind” to enter an FMS are frequently also people who were living in poverty before the impact phase of the disaster, vulnerable adults such as elders with dementia disorders, uninsured people, and people with significant psychosocial challenges such as chronic behavioral health issues, substance abuse histories, and homelessness. Working with these underserved and often marginalized populations, the professional training and experience of social workers has time and again proven its value to the multidisciplinary RDF teams.

“As a social worker, I have felt very welcome and valued on my RDF Team. On deployment, you are going to find yourself in a situation of austere conditions, with very limited resources, and faced with formidable and constantly changing challenges. That’s a situation social workers, as a group, are trained to confront, and our teammates from other disciplines seem to welcome our background and professional skill set,” notes LT Chad Wheeler, a social worker and the Deputy Leader of the Mental Health and Laboratory Services Group of RDF PHS-2.

Many Commissioned Officers trained as social workers have found their niche on RDF teams as a mental health responder. While RDFs do not have the behavioral health assessment and intervention capacity of a Tier II Mental Health Team, there are significant behavioral health needs in the FMS and on other types of RDF missions. Mental health officers on RDFs often juggle several roles, such as psychological force protection of team members, clinical services to evacuees with pre-disaster behavioral health issues, and supportive counseling to address grief, loss, and trauma issues in survivors of disasters. For social workers looking for a less clinical role on the team, there are opportunities to serve in admin/finance, logistics, planning, and public information/liaison roles, as these sections within the large RDFs are often deep. Like other Tier I and Tier II response teams, Rapid Deployment Force Teams can provide junior officers in particular with opportunities for leadership that may not be as readily accessible in their primary duty billets.

Social workers have helped build the response capacity of RDFs with their clinical training in behavioral health, familiarity with crisis service delivery models, systems approach to problems, and career-long experiences at improvising solutions with scarce resources.

“Social workers have the ability to look at systems in a disaster setting. That provides a multi-dimensional capacity to respond to problems as they unfold,” observes LCDR Betty Hastings, a social worker who served in the past as the Ancillary Services Branch Chief of Rapid Deployment Force PHS-2.

USPHS Social Work in the DoD/TMA behavioral health initiative

By LCDR Scott Eppler



I am assigned to a pilot concept in Army behavioral health at Ft. Carson, Colorado called the Mobile Behavioral Health Team (MBHT). These teams are the first of their kind in the US Army. It is very exciting to join with fellow USPHS behavioral health professionals in representing the commissioned corps in this joint DoD opportunity. By “mobile” the concept intent of the MBHT is to decentralize behavioral health services with smaller teams geographically located in the supported units’ footprint; within walking distance of Soldiers’ work, living and dining areas. We are located in a Battalion (600+ soldiers) Aid Station and provide direct services for a unit known as a Brigade Combat Team (BCT; 3600+ mix of armor and infantry). Our mission includes providing expedited behavioral health assessment and treatment throughout the deployment cycle; maximizing commander visibility on soldier fitness for duty and deployability issues through regular consultation; providing expeditious fitness for duty evaluations; decreasing stigma associated with behavioral health treatment; enhancing access to care; collaboration with medical providers to synchronize medical and behavioral health care; and enhancing brigade suicide prevention initiatives and resiliency training. Within these mission objectives more specific services often include urgent walk-in/crisis intervention services and subject matter expert combat and operation (Post-Traumatic) stress mitigation training. Frequently, we have opportunity to provide care and services to those with traumatic brain injuries as well. We also serve to link soldiers to substance abuse services, domestic violence/family advocacy services and other more specialized services as needed. A mobile behavioral health team is comprised of one behavioral health provider as-

signed to each battalion (2 psychologists and 4 LCSW’s), 1 prescribing clinician, 2 social service assistants/mental health technicians, 1 medical support assistant and 1 nurse care manager provide support and augment the care. These teams truly comprise a multi-disciplinary mix of civilian clinicians and support staff, USPHS behavioral health professionals, and active duty Army behavioral health professionals. Currently at Ft. Carson there are three MBHTs with a fourth currently being formed.

Our current mission interventions have resulted in appointment wait times reduced by approximately 50%. Further mission impact has resulted in a 90% reduction in TRICARE referrals at the time of redeployment. Greater contact and “visibility” with first line supervisors, first sergeants, company (150+) and battalion commanders has resulted in reduced stigma and greater acceptance of behavioral health services as crucial to the DoD wartime mission.

Proper uniform wear and adherence to proper customs and courtesies makes an immediate, powerful, and positive impression on US Army personnel with regards to the professionalism of our USPHS commissioned corps. Just as USPHS was originally created to provide medical services to the Merchant Marine circa 1780-1870, serving in a DoD/TMA billet is truly a great opportunity to continue that great tradition of service by caring for our nation’s war fighters.





"HHS and Department of Defense sign an agreement to increase mental health services"

All PHS officers detailed to DoD assignments are expected to serve 3 years before a permanent change of station (PCS) will be approved.

If you would like to extend at the DoD assignment after the 3 year period, a request may be made for an extension.

The Department of Health and Human Services (HHS) announced on June 4, 2008, an agreement between the Department of Defense (DoD) and the Commissioned Corps of the U.S. Public Health Service (PHS) to increase mental health services available to returning war fighters, their family members, and to military retirees. For more information on the DoD-PHS Initiative see, <http://www.usphs.gov/articles/dod.aspx>

How to apply for DoD positions

Current PHS officers:

1. Please e-mail a cover letter and Curriculum Vitae (CV) to DoDBHTBI@hhs.gov. The cover letter should state the DoD location(s) you would like to work (in rank order if interested in more than one location) and your date of availability (using month and year format). The CV should include your phone number and e-mail.
2. Professional records (eOPF and PIR) will be reviewed for all PHS officers prior to the dissemination of your information to DoD for a position
3. OCCO/DCCR will send your information to the appropriate DoD service for consideration. The DoD will contact you directly for an interview.
4. If you are matched to a DoD assignment, your current agency representative will be contacted for final approval and a release date. Transfer orders will be completed after approval is obtained.

Applicants to the PHS:

In one mailing envelope, please provide the following:

1. PHS-50 (Application for Appointment as a Commissioned Officer in the USPHS Commissioned Corps) available at <http://www.usphs.gov/applynow/>
2. Four letters of recommendation using the form PHS-1813 (Reference Request for Applicants to the USPHS Commissioned Corps) available at <http://www.usphs.gov/applynow/>
3. Official transcripts from all colleges/universities attended (must remain in sealed envelope from school)
4. Copy of professional license
5. Updated Curriculum Vitae (CV)
6. Cover letter stating the DoD location(s) you would like to work (in rank order if interested in more than one location) and your date of availability (using month and year format)
7. If you are a prior/current DoD officer, a copy of your last 3 officer evaluation reports
8. The PHS will send your information to the appropriate DoD service and location for consideration. The DoD will contact you directly for an interview.

Mail the required items to:
Office of Commissioned Corps Operations
Division of Commissioned Corps Recruitment
LCDR Christopher Dunbar
Tower Building, Plaza Level, Suite 100
1101 Wootton Parkway
Rockville, MD 20852



Take It Back, “a program to both educate and process combat stress experiences”

By CDR Thomas Costello

The Naval Medical Center Portsmouth (NMCP) in the Hampton Roads area of Virginia, has been a welcoming presence for PHS mental health officers since the beginning of the PHS and DOD partnership last year. As the initiative began searching for officers, I saw that NMCP had an opening for a clinical social worker with an interest in leadership. After a series of telephone interviews, my orders were cut and I started work at the end of October of 2008.

As sailors, marines and soldiers return from theater, there are a number of psychosocial stressors on the individual, his or her unit and his or her family and community. The Navy is aggressively addressing these stressors through a number of new programs and interventions, and it's been exciting to be on the ground floor of several of these initiatives. As a Commissioned Corps officer, I used to describe the Corps as a sort of "cousin" to the Navy. Public Health Service officers here have been easily assimilated into Navy culture, in part because of our rank structure and uniform. I now view us as a sibling to the Navy. There is an abundance of mutual respect and esprit d' corps. It's been a pleasure to serve alongside the Navy.

As I mentioned, the Navy has been in a growth mode to foster resiliency and meet the mental health needs of its members and dependents. I was the first PHS officer assigned to Portsmouth, but it became obvious that more were needed and welcomed. We currently have seven officers and plan to expand to eleven by early in 2010. We expect at least two or three more officers to join us during the course of 2010. We currently have three LCSWs and one more coming next month. As the Psychiatric Social Work Division Officer, I supervise 22 LCSWs and Licensed Marriage & Family Therapists. LT J.J. Lewis, a newly commissioned PHS officer, is my assistant Division Officer and is involved the same supervision and program management duties as I am. LCDR Jenny McCorkle has just transferred to the Corps from the Air Force and is working in our Recovery Services programs. She will be joined by another newly commissioned social worker (early 2010), Ms. Marion Collins.

Two programs I am involved in are PTSD psychoeducational initiative called Take It Back and the newly formed Caregiver Occupational Stress Control Team. Take it Back was developed by me and an interdisciplinary team of experienced PTSD therapists. This group both educates and processes combat stress experiences--it is for combat stress induced PTSD only. Many of our patients move on to more intense therapies, such as EMDR, Prolonged Exposure, and Cognitive Behavioral therapy.

The Caregiver Occupational Stress Control Team uses the Stress Continuum Model and Stress First Aid techniques developed by the Navy. The mission is to reach out and respond to units within the medical system who are experiencing unusual amounts of stress and can benefit from group training and/or intervention. The team is made up of mental health professionals, chaplains, psych techs and other enlisted members. The Naval Medical Center Portsmouth is the largest medical facility in the Navy and encompasses nine branch clinics stretching from Yorktown to Virginia Beach. Thus, the need to take care of our "caregivers" is a big task. Anyone who provides any level of medical care is considered a caregiver.

I have been on Active Duty with the Corps for sixteen years and have been assigned to four agencies in five states. I feel very strongly that the DOD is a wonderful match for our officers, giving us clinical and leadership opportunities in a supportive, professional environment.

Our social worker positions at Portsmouth are currently filled, however, I'm happy to share my experiences and assist as needed for those interested in the DoD initiative. My email is thomas.costello@med.navy.mil





TAKING IT BACK!

Post-Traumatic Stress Educational Group for

Combat Stress

Description: The group will focus on educating patients about PTSD as well as teaching them effective means to cope and process altered (i.e. negative) beliefs and behaviors due to the combat trauma/stress. Each session will focus on a different topic listed below.

1. Learning about PTSD
2. Getting Out of the Box:
Increasing Motivation to Change
3. Coping: Discovering Your Choices
4. Relaxation: Bringing on the Calm
5. Keeping Your Feet on the Ground
6. Spirituality: What It Means to You
7. Expressing Your Anger
8. Communication: Talk to Me
9. Family and Support: You're Not Alone
10. Cinema-therapy Day

Facilitated by:
CDR Costello, LCSW
Ms. Leneave, LCSW
Mr. Alcalá, NPT

Referrals requested either via AHLTA under "Psychiatry-PTSD Clinic" or by contacting Mr. Alcalá at 953-5269.

Time:
Thursdays 11:30-13:00
(10 sessions revolving group)

Location:
Outpatient Psychiatry



Reminder:

The next official report of **BASIC READINESS** compliance will occur on **31 December 2009**.

Verify your information is correct in OFRD, Please click this link <http://ccrf.hhs.gov/ccrf> (OFRD Website)

Verify your information is correct in Direct Access,

Please click the link <https://ep.direct-access.us/psp/UCGPIPP/?cmd=login&languageCd=ENG> (Direct Access Website)

Logging in to Direct Access

1. Get your log in information from the CCMIS Secure area (<http://dcp.psc.gov/SecureArea.asp>).
2. Log in to Direct Access at above referenced link and you will see the logo "ORACLE Peoplesoft Enterprise" when you arrive at the site.
3. Change your Direct Access password after successfully entering Direct Access.
4. Provide a password reminder question in case you forget your password

Please use this link for FAQs about Direct Access

http://www.usphs.gov/transformation/self_service.aspx

Please use this link to view your user guide for Direct Access - <http://www.uscg.mil/ppc/phs/PHSSelfServiceProcedureGuide.pdf>

CANNOT login to Direct Access?

OFRD is not able to reset your password for Direct Access. You will need to use the password reset button on the Direct Access login page.

1. Forgot My Password is the first tool officers should employ if they cannot log into Direct Access.
2. The Coast Guard Helpdesk (link is provided at <http://www.uscg.mil/ppc/phs/>) remains is the second line of help if the Forgot My Password function of Direct Access does not work (the officer should wait 15 minutes to receive the email).
3. Third line of help - Dennis Brown has indicated that OFRD can send to Dennis all officers who have been unable to successfully use Forgot My Password and have not heard from Coast Guard Helpdesk for 3 days (a rare occurrence often tied to the use of incorrect email address)

Special Thanks:

Thank You for your Service 2009 SWPAG Leadership

CDR Jay Seligman, Chair
CDR Marinna Banks-Shields, Policy
CDR Douglas Mowell, Communications
CDR Tom Hochberg, Awards
LCDR John Maynard, Readiness
LCDR Todd Lennon, Mentoring
LCDR Jerry Mahlau-Heinert, Career Development
LCDR Scott Conner, Secretary

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CAPT Gail Hamilton
CDR Christopher McGee
CDR Janet Hawkins
CDR Thomas Costello
LCDR Anita Glenn-Reller
LCDR Betty Hastings
LCDR Carlos Castillo
LCDR Christopher Cline
LCDR Deanna Paul
LCDR Dwayne Buckingham
LCDR Christopher Cline
LCDR Scott Eppler
LT Jonathan White



**“Achievement:
Unless you try to do
something beyond
what you have
already mastered,
you will never
grow.”**

~Author unknown

*Volume I of SWPAG Newsletter created by
2009 Communications Committee Members*

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We're on the web http://usphs-hso.org/pags/swpag/swpag_main.shtml

