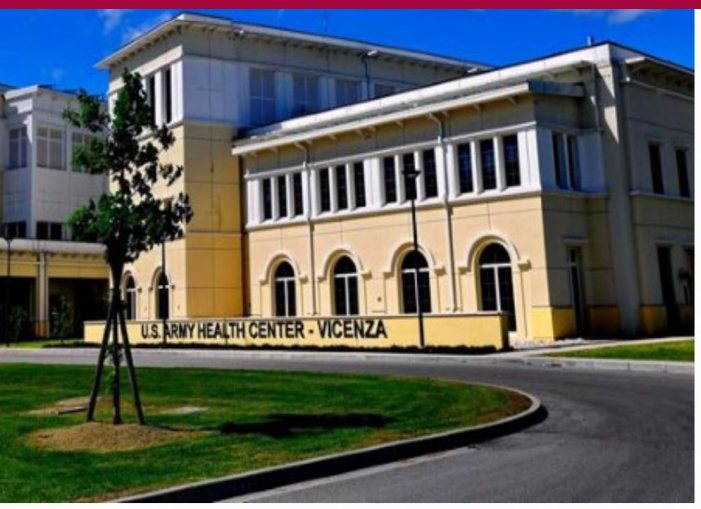
VICENZA BEHAVIORAL HEALTH

Commander's Handbook

U.S. ARMY HEALTH CLINIC
VICENZA, ITALY
READY AND TRUSTED



US Army Health Clinic – Vicenza
Department of Behavioral Health

Mission

To support operational readiness through the delivery of safe and effective behavioral health (BH) assessment and treatment for active-duty service members, their families, and other eligible beneficiaries.

Structure

The Department of Behavioral Health (DBH) is divided into four subsections.

1. Embedded Behavioral Health (EBH).
    a. The EBH Clinic is located on Caserma Del Din and provides services for active-duty members of the 173rd Airborne Brigade and SETAF.
    b. Multidisciplinary Outpatient Behavioral Health Clinic (Multi-D). The Multi-D Clinic is in US Army Health Clinic – Vicenza (USAHC-VZ) on Caserma Ederle and provides services to all other active-duty service members and military family members to include children.
    c. Family Advocacy Program - Clinical (FAP). The FAP clinic is collocated with Multi-D on Caserma Ederle and provides evaluation, intervention, and treatment for cases involving domestic violence, child abuse, neglect, or problematic sexual behavior.
    d. Educational and Developmental Intervention Services (EDIS). The EDIS Clinic is also located in USAHC-VZ on Caserma Ederle and provides services to children, adolescents, and young adults with special learning needs.

Specific Services Provided by the DBH

Individual Psychotherapy
Routine one-on-one appointments occurring weekly, biweekly, or monthly with the goal of resolving or improving a psychiatric disorder or symptom(s).

Group Psychotherapy
Routine appointments in a group setting usually occurring weekly with the goal of resolving or improving a psychiatric disorder or symptom(s).

Medication Evaluation & Management
Routine outpatient medication management often delivered in addition to individual and/or group psychotherapy with the goal of resolving or improving a psychiatric condition or symptom(s).

Command-Directed Evaluations
Non-emergent and emergent command-directed evaluations conducted at the request of a commander to provide the command feedback about a service member's mental status and fitness for duty.

Command Consultation
Clinicians and leaders in the DBH are available to consult with commanders about specific or general behavioral health concerns in their formations.

Traumatic Event Management
Upon request, teams of DBH personnel can respond to traumatic events that impact a unit such an accidental death or suicide.

Specialty evaluations
Specialty evaluations are necessary for many military duties and other situations. Examples include security clearances, recruiting duty, aviation packets, and administrative separations.

Substance Use Disorder Clinical Care
Command-mandated and voluntary treatment for alcohol and other substance-related disorders.

Family Advocacy Program (Clinical)
Assessment & Intervention in response to allegations of intimate partner violence, child abuse/neglect, & problematic sexual behavior among children and adolescents.

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HIPAA – Health Insurance & Portability Accountability Act and Privacy Policies

A commander can ALWAYS PROVIDE information:

1. Commanders can communicate any information about a soldier at any time to the DBH. HIPAA limits the release of information FROM healthcare professionals, but not TO healthcare professionals.
2. Even in situations when healthcare professionals cannot acknowledge if someone is a patient in the clinic or not, they can still take incoming information.

A commander can ALWAYS request info regarding:

1. Whether or not a soldier showed up for a scheduled appointment.
2. Future scheduled appointments for a soldier.
3. Any BH-related info for which the soldier provided consent to release
4. Results of a command-directed evaluation limited to planned treatment, prognosis (likelihood of soldier getting better), recommended duty limitations, safety/mission implications, and ways the command can support the treatment.

BH providers will ALWAYS notify a commander when:

1. There is imminent concern for the safety of the soldier, others, or the mission.
2. Prescribed medication could impair a soldier's ability to complete their duties.
3. A soldier is entered into or discharged from non-voluntary Substance Use Disorder Clinical Care (SUDCC) treatment.
4. A patient requires transfer to a hospital or higher level of care.
5. At completion of a command-directed evaluation.

Ways DBH will communicate with command:

1. E-Profile system
2. DA Form 3822 (Report of Mental Status Examination)
3. Phone/Encrypted E-mail
4. In person at command meetings

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Ways command can communicate with the DBH:

1. General questions can be directed to the front desks (636-9140/636-9900)
2. Soldier-specific questions can be directed to aligned providers or clinic chief.
3. Phone/Encrypted email
4. In person at command meetings

Dealing with Suicidal/Homicidal Behavior

Suicide Attempt

Intentional acts of self-harm should be responded to immediately by gaining positive control over the soldier, dialing the emergency number, and providing buddy aid/support until paramedics take positive control.

Suicidal Thoughts Expressed or Discovered

Soldier's who express thoughts of suicide or for whom concerns for suicide arise from the soldier's statements, writings, social media posts, or behavior should be escorted to their respective outpatient behavioral health clinic during duty hours (Del Din EBH/Ederle Multi-D) or to the nearest emergency room after duty hours. The emergency number and military police should be called if positive control cannot be obtained or the soldier is unwilling to be escorted, or whose safety cannot otherwise be assured. If any acts of self-harm actually occurred or it is unclear (e.g., soldier "might have" took pills), treat the situation as a suicide attempt and dial the emergency number.

Assault & Threats of Violence

Regardless of whether or not a soldier is known to have or is suspected of having BH problems, all acts or threats of physical violence should be directed immediately to law enforcement. Never attempt to escort a soldier to the clinic or hospital who is acting violently or threatening violence. Take immediate action to protect others by calling law enforcement and any BH concerns can be addressed later.

Command-Directed Evaluations (CDE)

Non-Emergent Command-Directed Evaluations

Concerns for a soldier's mental health or ability to perform their duties due to suspected BH symptoms that do not include imminent concerns for the safety of the soldier, others, or the mission are non-emergent. Commanders should contact their respective BH clinic to request that a CDE be scheduled. In addition to making the request, it is important that the command provide sufficient details to the provider regarding the specific concerns.

Emergency Command-Directed Evaluations

Commands with serious and imminent concerns about soldier safety, safety of others, or the safety of the mission can initiate an emergency CDE by having the soldier immediately escorted to the clinic. The command should make every attempt to speak with the provider and provide sufficient details pertaining to their concerns. A primary goal of this evaluation is to determine whether the soldier needs emergency or higher-level care and to ensure safety.

Evaluations for Administrative Separation

Not all types of administrative separations require a BH evaluation. Verify this requirement prior to requesting the evaluation by consulting the regulation(s) and/or your legal team. Administrative separation evaluations are routine scheduled appointments initiated similarly to a non-emergent CDE. A primary focus of this evaluation is to determine whether the soldier meets medical retention standards and if they should be referred for an MEB. Soldiers should not attempt to walk in without a scheduled appointment to complete these.

Specialty Evaluations

Certain duties such as recruiting, special forces, and aviation may require a behavioral health evaluation. Contact your BH clinic to ensure an evaluation is necessary and that the type of evaluation can be completed locally before scheduling the appointment. These require a scheduled appointment.

Walk-in Services

Scope

Unscheduled walk-in services are for acute crises/emergencies only. Examples of appropriate utilization of walk-in services include those who are actively having suicidal/homicidal thoughts, those displaying highly unusual and possibly psychotic behavior, and those in a state of panic. Soldiers who walk-in should be expected to be evaluated for acute/emergent concerns and should not expect to see their usual provider or to have a complete psychotherapy session.

After Hours

Routine, non-emergent problems after hours can be addressed with peer support, chain-of-command support, MFLC, chaplaincy, or other organic unit assets. After hours BH emergencies, including suicidal thoughts and behaviors and other alterations to mental status require an emergency room setting for a number of important reasons. BH emergencies often require pharmaceutical intervention, medical monitoring of intoxication levels, and other radiology and lab services to rule out a serious underlying medical problem. During duty hours the clinic has physicians onsite, an open pharmacy, lab and other support services, ease of transportation to the emergency room, and sufficient personnel to ensure provider safety.

Procedures

BH emergencies occurring after hours must be directed to the nearest emergency room by direct transport or by utilizing the emergency number. USAHC-VZ does not have 24/7 medical or BH services.

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Hospitalizations

Acute/Inpatient

Acute/inpatient admissions occur when the soldier is deemed an imminent risk to themselves or others, is actively psychotic (e.g., hallucinating), is seriously intoxicated, or presents with some other condition that requires immediate emergency care. When a soldier is identified as requiring an immediate admission to an inpatient psychiatric unit/facility the commander can expect:

1. To be contacted by the BH case manager, provider, or clinic chief upon admission (if done internally) or upon notification by the hospital.
2. To be asked to provide two escorts or transportation with one being an NCO (E5) or one rank higher than the Soldier being admitted. Two escorts are necessary to ensure safety and to maintain positive control.
3. To receive feedback at least weekly from the nurse case manager and/or BH provider regarding the Soldier's progress and status.
4. That the Soldier's initial stay will be short. Inpatient psychiatry units are primarily for acute treatment and stabilization. That is, longer term care will not typically occur in this setting and the soldier will be discharged as soon as the acute issue has resolved. Most are discharged within a few days and very rarely would an acute admission exceed two weeks. Most acute admission occur locally at San Bortolo in Vicenza, and a portion of those are eventually transferred to LRMC.

Residential Treatment

A residential treatment facility offers extensive care in a hospital setting that typically lasts 6 weeks to 90 days. Facilities exist stateside and throughout Europe, each typically having a certain specialty area focus. Criteria typically includes evidence that outpatient care has failed, is not appropriate, or is not available. Soldiers must be willing to attend. When a soldier is being considered for residential treatment command can expect:

1. To be notified by DBH of the recommendation and discuss the process as well as administrative and logistical matters.
2. Coordination with DBH's nurse case manager regarding transportation, escorts, and other varying requirements.
3. To receive feedback at least weekly from the nurse case manager and/or BH provider regarding the Soldier's progress and status.

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Discharging from the Hospital

When a soldier is preparing to be discharged from a psychiatric inpatient facility the Commander can expect:

1. To be contacted by the psychiatric unit or DBH nurse case manager to coordinate or communicate a discharge plan for the Soldier.
2. To be notified of a post-discharge outpatient follow-up appointment date/time at their respective clinic.
3. To receive a DA Form 3822 following the post-discharge follow-up appointment and a phone call.
4. That the Soldier will automatically enter into the DBH's At-Risk Tracking program for at least 30-day which will be accompanied by a profile that will usually include limitations on deployment and access to firearms and will sometimes include recommendations to prohibit alcohol or to increase supervision.

Intensive Outpatient Programs

An intensive outpatient program (IOP) is typically a 6-week program during which a Soldier will receive daily care but will not be hospitalized or supervised after duty hours. For example, if attending an IOP at Landstuhl Regional Medical Center (LRMC) the soldier will return to the barracks or hotel each evening and return the next morning on their own. IOPs are appropriate for consenting Soldiers who have serious BH conditions that have not improved with routine outpatient care but do not rise to the severity of needing around-the-clock supervision.

1. The DBH will notify command of the recommendation and discuss the process as well as administrative and logistical matters.
2. The DBH's nurse case manager will coordinate with the unit regarding transportation, escorts, and other requirements that may vary. Command will receive feedback at least weekly from the nurse case manager and/or BH provider regarding the Soldier's progress and status.

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Common BH Conditions among Active Duty

Serious psychiatric illness is uncommon among active-duty service members. Most Soldiers seen by the DBH are diagnosed with adjustment disorder which is simply a term we used to describe symptoms, such as sadness and nervousness, that result from a stressful life event(s). Mood, anxiety, and sleep disorders are also relatively common followed by alcohol or substance related disorders. Posttraumatic stress disorder as the result of combat or sexual trauma is occasionally seen as well. Very rarely a serious psychiatric condition such as schizophrenia will be discovered. Overall, the active-duty population is young, healthy, but many have difficulty coping with the stress of military life and dealing with family and financial problems.

Commander Expectations for BH Treatment

Evidence-based treatment for most BH conditions consists of approximately 12 one-hour psychotherapy sessions, but the effectiveness is highly contingent on consistency and frequency. That is, patients must be seen at least every other week and preferably weekly for treatment to have the desired effect. No-shows, cancellations, and other interruptions to treatment prolong the entire process. Soldiers who do not improve with treatment may simply discontinue care if they continue to meet medical retentions standards, or they may be elevated to a higher level of care such as an intensive outpatient program (IOP). At any time during their treatment, it is determined that they no longer meet medical retention standards and are unlikely to meet them in the next 12 months an MEB will be initiated.

Medical Evaluation Boards (MEB)

Soldiers will be referred to the Integrated Disability Evaluation System (IDES) when their behavioral health condition no longer meets medical retention standards per AR40-501 and is not expected to meet medical retention standards in the next 12 months. Eligibility for referral to IDES will always be a consideration during command-directed evaluations and administrative separation evaluations. The DBH does not determine whether a soldier is medically discharged or is returned to duty. DBH simply refers the Soldier to IDES if/when they meet the criteria.

No-Shows & Cancellations

The DBH and its ability to provide quality access to care is seriously degraded when there is a high no-show and cancellation rate. Many appointment slots go unfilled due to no-shows and last-minute cancellations. Commanders are highly encouraged to review the no-show reports which are provided weekly through senior NCO channels. Commanders are also encouraged to verify appointment attendance for accountability purposes. Commanders are always able to request appointment attendance as well as receive future scheduled appointments by contacting the front desk.

Things to Keep in Mind

Normal Behavior

Sadness, grief, anger, and frustration are all parts of the normal human experience. In most cases, soldiers who are experiencing these emotions do not need BH services. Coping with emotions and stress independently or with the support of fellow soldiers and family should be encouraged.

Disciplinary Issues

Failing to report to duty, disrespecting superiors, or otherwise failing to follow lawful orders should be treated as a disciplinary issue regardless of whether the Soldier is being seen by BH or claims to have a BH problem.

Unnecessary referrals

Soldier facing disciplinary action or facing other stressors should not be referred to BH “just in case.” There should be some observation or concern with reasonable justification that indicates a psychiatric problem may be present.

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Resiliency

Resiliency is fostered by persevering through adversity, not by escaping it. Although BH services can help equip Soldiers with skills to help them cope with the stressors of military life it is important that they be encouraged to face and overcome these stressors. BH providers may have specialized training, but they typically have less than one hour per week with each patient. Team, squad, and platoon level leaders have far more opportunity to have a positive impact on a Soldier's mental health through firm, supportive, and inspirational leadership.

Unit-Clinic Relations

Most units have a provider who is "aligned" to them. This aligned provider should be a commander's primary point of contact within the DBH. The chief of a subsection or the department chief is also available for any command inquiries. Commander should not hesitate to call the aligned provider, clinic chief, or department chief with any questions related to BH. This is especially true when command is uncertain about a referral or a process. Commanders at all levels are encouraged to get to know their BH staff. We welcome scheduled meetings or just popping in to talk to the clinic leadership. We are also happy to have a presence in your unit's footprint upon your request to conduct walkabouts or participate in organizational activities.

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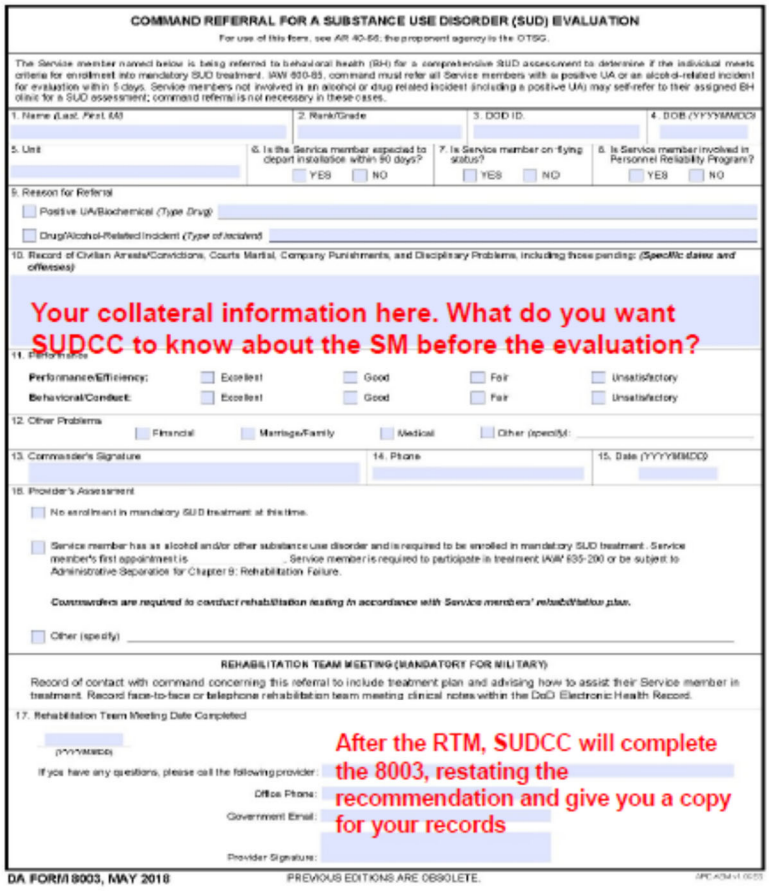
Substance Use Disorder Clinical Care (SUDCC)

DA 8003 & Rehabilitation Team Meeting



COMMAND REFERRAL FOR A SUBSTANCE USE DISORDER (SUD) EVALUATION

For use of this form, see AR 40-66; the proponent agency is the OTSG.

The Service member named below is being referred to behavioral health (BH) for a comprehensive SUD assessment to determine if the individual meets criteria for enrollment into mandatory SUD treatment. IAW 600-85, command must refer all Service members with a positive UA or an alcohol-related incident for evaluation within 5 days. Service members not involved in an alcohol or drug related incident (including a positive UA) may self-refer to their assigned BH clinic for a SUD assessment; command referral is not necessary in these cases.

1. Name (Last, First, MI) | 2. Rank/Grade | 3. DOD ID | 4. DOB (YYYYMMDD)

5. Unit | 6. Is the Service member expected to depart installation within 90 days? YES NO | 7. Is Service member on flying status? YES NO | 8. Is Service member involved in Personnel Reliability Program? YES NO

9. Reason for Referral

Positive UA/Biochemical (Type Drug)

Drug/Alcohol-Related Incident (Type of Incident)

10. Record of Civilian Arrests/Convictions, Courts Martial, Company Punishments, and Disciplinary Problems, including those pending: (Specific dates and offenses)

Your collateral information here. What do you want SUDCC to know about the SM before the evaluation?

11. Performance

Performance/Efficiency: Excellent Good Fair Unsatisfactory

Behavioral/Conduct: Excellent Good Fair Unsatisfactory

12. Other Problems: Financial Marriage/Family Medical Other (specify):

13. Commander's Signature | 14. Phone | 15. Date (YYYYMMDD)

16. Provider's Assessment

No enrollment in mandatory SUD treatment at this time.

Service member has an alcohol and/or other substance use disorder and is required to be enrolled in mandatory SUD treatment. Service member's first appointment is _____. Service member is required to participate in treatment IAW 635-200 or be subject to Administrative Separation for Chapter 9: Rehabilitation Failure.

Commanders are required to conduct rehabilitation testing in accordance with Service members' rehabilitation plan.

Other (specify)

REHABILITATION TEAM MEETING (MANDATORY FOR MILITARY)

Record of contact with command concerning this referral to include treatment plan and advising how to assist their Service member in treatment. Record face-to-face or telephone rehabilitation team meeting clinical notes within the DoD Electronic Health Record.

17. Rehabilitation Team Meeting Date Completed (YYYYMMDD)

After the RTM, SUDCC will complete the 8003, restating the recommendation and give you a copy for your records

If you have any questions, please call the following provider:

Office Phone:

Government Email:

Provider Signature:

DA FORM 8003, MAY 2018 PREVIOUS EDITIONS ARE OBSOLETE. APD AGM v1.00.03

DA 8003 forms should be provided for all Command referrals; suspected problems with substances, positive UAs, blotter reports, Alcohol Related Incidents(ARIs), DUIs, etc.

May be sent in an encrypted email to SUDCC SSA or Counselor or brought into the SUDCC clinic.

Rehabilitation Team Meetings (RTMs) can be conducted face to face, electronically, or telephonically. An RTM will be scheduled to follow an assessment of your SM when there is Command involvement to discuss the findings and recommendations.

Note that SUDCC is **not** a Commander's Program. This means that a SM will only be enrolled in SUDCC for treatment when it is clinically indicated and recommended. **This is TREATMENT not PUNISHMENT.** If you want your SM not to drink, then give the SM a No Drinking Order, do not demand that they be enrolled in SUDCC so you can chapter them if they drink.

SUDCC (continued)

When to Command Refer

- Any time the Commander or 1SG is aware of an incident or suspects the Service Member might have a problem with Alcohol or Drugs, Command refer with a DA 8003 to Service Member to SUDCC for an Evaluation.
- A referral for an Evaluation does not mean the Service Member will be enrolled in SUDCC; it means that they will receive an Evaluation to determine what is needed.
- If there is a known incident, you must refer within 5 days (IAW AR 600-85)
  - Late to formation due to alcohol use
  - Showing up to formation appearing still intoxicated
  - Any incident alcohol related that you are aware of

Do not bring a SM who is intoxicated to SUDCC. They need to be evaluated by a medical personal for safety and SUDCC is not permitted to see them.

REMEMBER: You are not protecting your Soldier by enabling their behavior and waiting for the 2nd, 3rd, or 4th time "this happens" before sending them to SUDCC for an evaluation. You ultimately may be saving their career or their life.

Enrollment

Soldiers must meet certain criteria to be enrolled in SUDCC even when command referred. It is important that command provide any relevant information to better inform the assessment.

SUDCC (continued)

Levels of Care

LEVELS OF CARE/TREATMENT

*Level 0.5 – Prevention Education

ASAP for Prime for Life course

*Level 1.0 – Outpatient Treatment

Enrolled in mandatory SUDCC or engage voluntarily in SUDCC

SMs must meet the criteria to engage in voluntary treatment

*Level 2.5 – Intensive Outpatient Treatment

Send to LRMC to the AMIOP (Addiction Medicine Intensive Outpatient Program) for 6 weeks

*Level 3.0 Residential Treatment

Send to a Residential Treatment Facility for varying length of treatment, typically 6-8 weeks.

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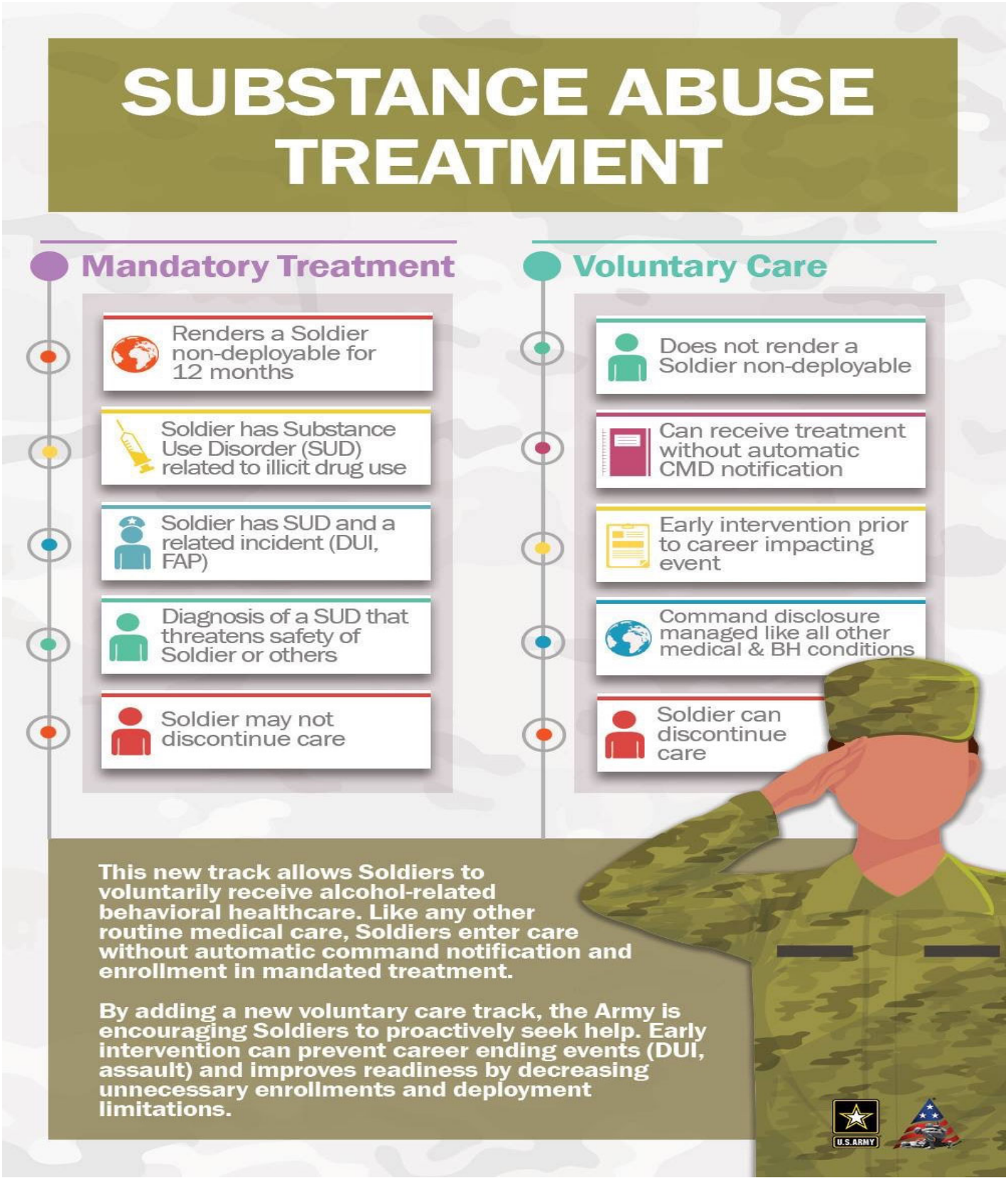
SUDCC (continued)



Voluntary care is converted to Mandatory w/scheduled RTM if an event occurs during voluntary care

Aftercare

Aftercare is continuation of treatment after the Soldier is discharged from mandatory SUDCC treatment. Soldiers who continue with treatment after being discharged from mandatory care will be considered voluntary and command involvement would be discontinued.

Vicenza Health Clinical Ederle
EBH/SUDCC Clinic (BLDG 2) at Del Din

SUDCC Del Din (DSN) 636-9900
SUDCC Ederle (DSN) 636-9140

Monday-Friday 0715-1615

Closed 1145-1245, Federal Holidays, 3rd Thursday Afternoons

SUDCC Coordinator	Mr. Antwan Robinson/636-9579	**Antwan.s.Robinson.civ@health.mil**
1/503rd & all Ederle	Ms. Deborah Timperio/636-9601	Deborah.a.Timperio.civ@health.mil
2/503 & SETAF (Del Din)	Ms. Lisa Andreucci/636-9685	lisa.m.Andreucci.civ@health.mil

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Family Advocacy Program (FAP)

Clinical

It is important to note there are two separate FAP services – Clinical FAP (BH) and Prevention FAP (Army Community Services; ACS). Clinical FAP is within the DBH and provides assessment and treatment of child abuse & neglect, domestic abuse and violence, and problematic sexual behavior of children and youth. Clinical FAP aims to intervene as early as possible, ensure each reported incident is thoroughly assessed for risk of further abuse, ensure victims of abuse receive a FAP assessment, and provide treatment for affected family Members.

Commander Responsibilities

1. Attend FAP command training within 45 days after assuming command. Training can be scheduled with the FAP-M by calling DSN 314-64-5824.
2. Immediately report known or suspected spouse/intimate partner abuse/violence to MPs. Anyone in the chain of command with credible information of child abuse/neglect must report.
3. Issue a Military Protective Order in all cases involving physical abuse allegations. MPOs are discretionary for emotional abuse. Complete DD 2873.
4. Ensure at least 24 hours separation during which a FAP assessment will be coordinated. On a case-by-case basis, if offender is a dependent and refuses to cooperate with assessment and safety planning, battalion command can coordinate with garrison command to revoke civilian on-post privileges and/or initiate early return of dependent.
5. Temporary housing plans should promote safety for all parties. Victims should never be separated from their children.
6. Participate in Incident Determination Committee (IDC) meetings as invited by FAP Clinical after incidents of domestic abuse and neglect.
7. Maintain contact with the assigned FAP social worker about safety recommendations and treatment progress.

Prevention FAP

Prevention FAP operates within ACS and provides a range of programs including the New Parent Support Program and education. Although ACS's FAP works closely with clinical FAP only clinical FAP belongs to the DBH.

MAKE THE CALL

24-Hour Military Police Desk	0444-71-5300 or DSN 314-646-5300
Family Victim Advocate	+39 335-805-7867
Installation SHARP Hotline	+0444 74 8540 or DSN 314-646-8540
European Union All-Emergency #	112

WHO IS EDIS

The Educational and Developmental Intervention Services (EDIS) program is a free service directed by the Department of Defense to provide early intervention and related services that fulfills the Individuals with Disabilities Education Act (IDEA). The EDIS program is part of the Department of Behavioral Health. The EDIS office is located on the second floor of the Vicenza Health Clinic. EDIS can be reached by calling **0444-61-9230** or DSN **314-636-9230.**

WHAT DOES EDIS DO?

EDIS Early Intervention (EI) provided services for children from birth to 36 months of age with delays in one or more areas of development, including communication, social skills, motor skills, and problem solving. EDIS Related Services (RS) are for individuals between the ages of 3-21 and are provided through the school. The EDIS team includes a speech and language pathologist, an early childhood educator, a pediatric occupational therapist, a clinical psychologist, and a pediatric physical therapist (providing services virtually or in-person quarterly). Intervention services provided will be based on the needs of each child.

HOW DO KIDS BECOME ELIGIBLE?

Army EDIS provides early intervention services to military and civilian families in the Department of Defense who 1) have a child less than three years of age with a development delay or has a diagnosed medical condition that places the child at high risk for developmental mental delay and 2) live on military installations in the USA or live in an overseas area with a DoD sponsor on a “command -sponsored” tour. EDIS services are voluntary, and they provide educational therapy by non-medical providers. All services are voluntary, and parents can decide if they want to accept EDIS services. Referrals for Early Intervention can be made through the child’s primary care provider or parents can self-refer. Referrals for Related Services (3 years and older) are made by the child’s school.

WHEN DO SERVICES START?

An initial appointment is scheduled with the family within 7 days after receiving an EDIS referral. The team will determine if additional screening is necessary or if a developmental evaluation is warranted following the first parent interview. Services will be coordinated based on the needs identified at the evaluation.

WHERE ARE SERVICES PROVIDED?

The EDIS early intervention team offers developmental support tailored to each child’s and each family’s needs. Services are provided in the child’s natural environment (home or community) through a primary service provider. Related services are provided through the child’s school as part of the child’s Individualized Education Plan.

EDERLE MULTI-D/FAP & DEL DIN EBH/SUDCC					
	NAME	SPECIALTY	PHONE	Alignment & Focus Areas	Notes
Department Chief	MAJ Moore, Rich	Clinical Psychologist	636-9591	Aviation, Chapters, & Specialty Evals	
Department NCOIC	SGT Angel Rojas-Raso	Behavioral Health NCO	636-9565	ALL	
Front Desk Ederle			636-9140		
Ederle Multi D	Dr. Janke, Shonda	Psychiatrist	636-9051	Psychiatric medications adults & children	
Multi D NCOIC	SGT Frazier, Exie	Behavioral Health NCO	636-9606	All	
	Dr. Benavides,Dulce	Psychologist	636-9607	Dependents, 7th ATC Regional Support Division South AFN, 414th CSB, 839th Trans BN, MI Detachment CID, USADC-V (Dental).	
	Ms. Robillard, Sarah	LCSW	636-9575	1/503rd, 509th, 21st TSC Ammo Center, 106th FMSU, 266th Finance, 529th MP, 731st MUNS/MSE/LRC-Italy, AFSBN-Africa, Remote locations, USAHC-VZ	
	Ms. Horak, Kristin	LCSW	636-9610	207th MI BDE/307th/522nd, 386 Trans Det., PHA-I (Public Health), USAG-Italy, Dependents	
	Mrs. Canova, Susanna	SSA	636-9517	All	LN
	Mrs. Francescato, Lisanna	MSA	636-9722	Front Desk	LN
Supervisor, FAP	Mr. Elliot, Scott	LCSW	636-9641	FAP Supervisor	
	Mr. Robillard, Brian	SSA	636-9629	FAP	
	Ms. McManis, Sandra	LCSW	636-9558	FAP Social Work	
	Ms. Smith, Terri	LCSW	636-9645	FAP Social Work	
	Mrs. Adelman, Jacqueline	LCSW	636-9787	FAP Social Work	
	Mrs. Dalla Riva, Ilaria	MSA	636-9703	FAP Admin Support	LN
Chief, EBH	Major Lee, Eric	Psychiatrist	636-9585	173rd/SETAF/Del Din	
NCOIC	SGT Rojasraso, Angel	Behavioral Health NCO	636-9565	ALL	
	Dr. Gardner, Ben	Psychologist	636-9391	173rd/SETAF/Del Din	
	Ms. Robinson, Alejandra	LCSW	636-9644	173rd/SETAF/Del Din	
	Mr. Ray, Deondre	MSA	636-9624	173rd/SETAF/Del Din	
	Ms. Buford, Giovanna	Nurse Case Manager	636-9553	173rd/SETAF/Del Din	
	Dr. Liss, Julie	Clinical Pharmacist	636-9507	173rd/SETAF/Del Din	
	Ms. Bitar, Victoria	Nurse Practitioner	636-9526	173rd/SETAF/Del Din	
Front Desk Del Din			636-9900	173rd/SETAF/Del Din	
SUDCC	Ms. Andreucci, Lisa	LCSW	636-9685	173rd/SETAF/Del Din	
	Ms. Timperio, Deborah	Clinical Counselor	636-9601	Ederle	
	Mr. Robinson, Antwan	SSA	636-9579	ALL	
Front Desk					
173rd BH	MAJ Lammers, John	Psychologist	636-9592	173rd	
	SGT O'Gara, Shannon	Behavioral Health NCO	636-9664	173rd	
	SGT Fuller, Michael	Behavioral Health NCO	636-9664	173rd	
EDIS	Dr. Garcia, Rocio	Child Psychologist	636-9586	Elgible Dependents	
	Ms. Sandra Marlin	Pediatric OT	636-9571	Elgible Dependents	
	Ms. Ashley Simpson	Childhood Educator	636-9439	Elgible Dependents	