

INTERAGENCY TASK FORCE ON
MILITARY AND VETERANS
MENTAL HEALTH

2013 ANNUAL REPORT

Department of Defense

Department of Veterans Affairs

Department of Health and Human Services

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Executive Summary

On August 31, 2012, President Obama signed Executive Order 13625 directing the Departments of Defense (DoD), Veterans Affairs (VA), and Health and Human Services (HHS), in coordination with other federal agencies, to take steps to ensure that Veterans, Service members and their Families receive the mental health and substance use services and support they need. These steps include strengthening suicide prevention efforts across the Military Services and in the Veteran community; enhancing access to mental health care by building partnerships between VA and community providers; increasing the number of VA mental health providers serving our Veterans; and promoting mental health research and development of more effective treatment methodologies. Pursuant to the Executive Order, the designated federal agencies undertook action in the following areas:

- Suicide Prevention:
 - Implementation of joint DoD/VA national suicide prevention campaign
 - Increased capacity of the Veterans Crisis Line by December 2012 by 50 percent and hired an additional 57 staff in 2014
 - Ongoing review of all DoD mental health, suicide prevention and substance abuse programs
- Enhanced Partnerships Between VA and Community Providers
 - New VA partnerships established with 24 community-based mental health and substance abuse providers across nine states and seven Veterans Integrated Service Networks; initiation of evaluation of outcomes and satisfaction with the partnership clinics
 - Jointly developed DoD/VA training to assist civilian mental health providers in the treatment of Service members and their Families
- Expanded VA Mental Health Staffing:
 - Implementation of an aggressive recruitment and marketing effort to fill mental health and substance abuse positions
 - An additional 1,669 mental health clinical providers and 932 peer support staff hired and trained, exceeding staffing mandates
- Improved Research and Development:
 - Release of the National Research Action Plan on August 10, 2013
 - Launch of two initiatives to establish joint DoD/VA research consortia with academia and industry partnerships on chronic effects of mild traumatic brain injury and posttraumatic stress disorder
 - Over 100,000 Soldiers enrolled in the Army Study To Assess Risk and Resilience in Service Members longitudinal prevention study



These activities are occurring during a critical period of financial and systemic health care reform that increasingly recognizes the central role of behavioral health services in ensuring the overall health, readiness and productivity of all Americans. The Executive Order brings together the leadership of three Departments to coordinate and direct improvements to a complex continuum of care that must provide effective prevention, appropriate diagnosis, referral and treatment capabilities across a range of behavioral health services, including through community-based providers, for behavioral health promotion and care for Veterans, Service members and their Families.

The Departments continue to take action to execute the President's Executive Order through an Interagency Task Force, co-chaired by the DoD Assistant Secretary for Health Affairs, VA Under Secretary for Health, and the HHS Administrator for Substance Abuse and Mental Health Services Administration. The inaugural Interagency Task Force Interim Report, summarizing agency review efforts to date and identifying recommendations for future action, was released on May 21, 2013 and was supplemented by a mid-year Joint Fact Sheet in August 2013. The 2013 Interagency Task Force Interim Report included seven recommendations in direct alignment with Executive Order requirements. An action group from the Interagency Task Force met on a weekly basis to discuss approaches toward achieving Executive Order requirements and recommendations outlined in the 2013 Interim Report. Throughout the year, actions and accomplishments revolving around the Executive Order requirements and Interagency Task Force recommendations were tracked and executed. Actions in response to the Executive Order were detailed in the previous report and are highlighted above. Actions on the Task Force's 2013 recommendations are outlined in greater detail below.

Mental health is an Administration priority and is often publicly addressed by the President, First Lady, and Vice President. This summary provides status updates on each of the Executive Order requirements and 2013 recommendations. It also provides the new 2014 Task Force Recommendations. In the coming year, the Interagency Task Force will continue meeting the requirements of the Executive Order and will be executing a newly-established Cross-Agency Priority Goal framework overseen by the Office of Management and Budget and the Performance Improvement Council. The Cross-Agency Priority Goal, *Improving Mental Health Outcomes for Service members and Veterans*, was announced on March 10, 2014, and will continue over a three year period. On August 26, 2014 President Obama also announced 19 additional Executive Actions that further builds on the interagency work in this arena and directs specific additional activities within DoD and VA that will continue improving the mental health of Service members, Veterans and their families.

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I. 2013 Designated Lead Agency Officials

As stipulated in the Executive Order, the specific agencies identified the following individuals as co-chairs of the Interagency Task Force on Military and Veterans Mental Health:

Department of Defense (DoD)

Jonathan Woodson, M.D.
Assistant Secretary of Defense Health Affairs

Department of Veterans Affairs (VA)

Robert A. Petzel, M.D.
Under Secretary for Health

Department of Health and Human Services
(HHS)

Pamela S. Hyde, J.D.
Administrator, Substance Abuse and Mental
Health Services Administration

II. Acronyms and Definitions

Acronyms

Army STARRS	Army Study to Assess Risk and Resilience in Service members
BRAIN	Brain Research through Advancing Innovative Neurotechnologies
CDE	Common Data Elements
DARPA	Defense Advanced Research Projects Agency
DCoE	Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury
DoD	Department of Defense
DoDI	Department of Defense Instruction
DSPO	Defense Suicide Prevention Office
FY	Fiscal Year
HHS	Department of Health and Human Services
HIV	Human Immunodeficiency Virus
HRSA	Health Resources and Services Administration
LGBT	Lesbian, Gay, Bisexual and Transgender
MCL	Military Crisis Line
MH	Mental Health
NAASP	National Action Alliance for Suicide Prevention
NIH	National Institutes of Health
NIMH	National Institute of Mental Health
NRAP	National Research Action Plan
NSSP	National Strategy for Suicide Prevention
PH	Psychological Health
PTSD	Posttraumatic Stress Disorder
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening Brief Intervention and Referral to Treatment
TBI	Traumatic Brain Injury
VA	Department of Veterans Affairs
VAMC	Department of Veterans Affairs Medical Center
VCL	Veterans Crisis Line
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Definitions	
Behavioral Health	Refers to the correlation between one’s psychological and physical overall well-being. As a result of psychological distress, individuals may exhibit behaviors that contribute further to the detriment of their overall physical health. Problematic behaviors such as substance use, unhealthy behaviors, sedentary lifestyle and social withdrawal create an unhealthy cycle which individuals may find difficult or unable to resolve. The term is also used to describe the interdisciplinary health services focused on the prevention, treatment and support of individuals predisposed to or experiencing behavioral health issues.
Mental Health	The screening, detection, diagnosis and treatment of psychiatric disorders.
Military Sexual Assault	Intentional sexual contact while serving in the military, characterized by use of force, threats, intimidation, or abuse of authority or when the individual does not or cannot consent.
Military Sexual Harassment	<p>A form of sex discrimination that involves unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature while serving in the military when:</p> <ul style="list-style-type: none"> • Submission to such conduct is made either explicitly or implicitly a term or condition of a person's job, pay, or career, or • Submission to or rejection of such conduct by a person is used as a basis for career or employment decisions affecting that person, or • Such conduct has the purpose or effect of unreasonably interfering with an individual's work performance or creates an intimidating, hostile, or offensive working environment.
Military Sexual Trauma	Primarily a VA term that refers to psychological trauma, which in the judgment of a VA mental health professional, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment that occurred while a Veteran was serving on Active Duty or training.
Psychological Health	Refers to a person’s overall psychological well-being. Psychological in general refers to cognitive, emotional, and spiritual functioning.

III. Summary of Action in Response to 2013 Recommendations

The Interagency Task Force formally reviews and documents progress toward achieving each recommendation throughout the year, coordinating advancements and continual improvements to ensure that Veterans, Service members, and their Families receive the mental health and substance use services and support they need. The stakeholder community and practitioners nationwide informed the recommendations outlined in the 2013 Interagency Task Force Interim Report. Each 2013 recommendation and its corresponding highlights are outlined below.

1. Increase awareness and education among Service members, Veterans and their Families about the prevention and treatment of mental health and substance abuse conditions.

- DoD, VA and HHS have on-going successful national campaigns which focus on overcoming the negative attitudes associated with mental health and substance use concerns and seeking treatment.
 - DoD's *Real Warriors* multimedia campaign won three industry awards in Fiscal Year (FY) 2013.
 - VA's *Make the Connection* national public awareness campaign has garnered more than 50 awards since its launch in 2011.
 - HHS launched *MentalHealth.gov* to provide a one-stop source for information and resources on mental health issues for Veterans and the general public.

2. Implement the 2012 National Strategy for Suicide Prevention.

- As recommended by Goal 4 of the National Strategy for Suicide Prevention, VA and DoD jointly developed and implemented a national suicide prevention campaign (<http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/>) to connect Veterans and Service members to mental health services in FY 2013. The Departments have continued to work together on these efforts since that time.
- Consistent with Goal 9 of the National Strategy for Suicide Prevention, VA increased the capacity of the Veterans Crisis Line / Military Crisis Line by 50 percent and all new staff members have been trained. The Veterans Crisis Line /Military Crisis Line connects Veterans and Military Service Members in crisis with qualified, caring VA responders through a confidential toll-free hotline, online chat, or text 24 hours a day, seven days a week, and 365 days a year. Immediate access to care at the local level is facilitated, if needed, regardless of where the Veteran is located.
- Also consistent with Goal 9 of the Strategy, VA and DoD have established clinical guidelines for the identification and treatment of an individual who is suicidal.

3. Align goals and metrics of mental health and substance abuse programs with national goals and metrics.

- The Interagency Task Force established a Metrics Work Group on Common Metrics in October 2013, and in February 2014, the Work Group submitted recommendations for a core set of common measures across the Departments to capture posttraumatic stress disorder (PTSD), depression, anxiety, alcohol and tobacco use to be implemented incrementally depending on available resources, with some implementation possible immediately.
- HHS, DoD and VA are also implementing the National Research Action Plan, which includes developing a process for identifying common data elements and reaching consensus regarding measurement to track progress in addressing psychological health conditions among Service members and Veterans.

4. Encourage and partner with communities to support mental health and substance abuse outreach, prevention, treatment and recovery services for Veterans, Service members, and their Families.

- At the National Conference on Mental Health, the President called for the Veterans Administration to host Mental Health Summits at VA Health Care Facilities across the country. Over a three month period, VA hosted 152 Mental Health Summits across the country. Through these Summits, VA partnered with community organizations to identify areas of need in the community and strategies for connecting Veterans and their Families to services while increasing awareness of existing VA programs and resources. Prior to September 2014, VA will work with community partners to host another 152 Mental Health Summits to build upon the work that was done in 2013.
- On January 16, 2013, the President released the *Now Is the Time* report that aims to reduce gun violence through multiple actions, including increasing access to services and increasing community awareness of mental health illness. Following the President's call for community conversations surrounding these issues, HHS launched a national conversation to increase understanding and awareness of mental health. Since the release of *Now Is the Time* in January 2013, 100 dialogues, sponsored by community civic organizations, have taken place in 36 states and the District of Columbia. Sixty-three outcomes of these conversations have been posted on CreatingCommunitySolutions.org.

5. Build partnerships that enhance the capacity of the health care workforce to serve Veterans, Service members and their Families in VA, TRICARE and the community.

- VA pilot partnerships were established with 24 community-based mental health and substance use clinics, across nine states and seven Veterans Integrated Service Networks, to enhance and expand delivery of mental health and substance use services to Veterans. Evaluation of the clinical outcomes of these Veteran patients and their satisfaction with these partnership clinics has begun. Based on local Veterans Integrated Service Networks decisions, many of these partnerships will continue past the one-year pilot period, and some plan to increase the number of VA/community partnerships. Veterans surveyed from the pilot sites indicate they are satisfied with their

community clinic care and most find it to be comparable to VA care. The decision to continue a VA /Community Mental Health pilot is based on a wide variety of factors including patient feedback and mental health outcomes. The evaluation of the 24 VA/Community Mental Health pilots is in process and the final report is projected to be completed in the first quarter of FY 2015. The preliminary data, most of which is from one Veterans Integrated Service Network, suggests that Veterans have been satisfied with their care but many other aspects need to be evaluated. The details of this evaluation are described below in the section on enhanced partnerships between the Department of Veterans Affairs and community providers.

- The first module of the jointly developed DoD and VA web-based training curriculum, *Military Culture: Core Competencies for Healthcare Professionals*, launched in November 2013. Three additional modules were launched in February 2014. This training assists civilian mental health providers in better understanding, communicating and effectively interacting with Service members and their Families.
- DoD will be submitting a legislative proposal for mental health parity under TRICARE that will more closely align TRICARE's inpatient mental health benefit with TRICARE's inpatient medical/surgical benefit.

6. Implement the National Research Action Plan called for in the Executive Order to inform federal research in Posttraumatic Stress Disorder, Traumatic Brain Injury and other critical issues.

- Since the release of the National Research Action Plan on August 10, 2013, substantial progress has been achieved through collaboration between VA, DoD, HHS/National Institutes of Health (NIH) and Department of Education. Progress and accomplishments have been achieved in many of the one-year objectives, described fully under Recommendation 6. These objectives delineate progress in all National Research Action Plan areas including PTSD, Traumatic Brain Injury (TBI), suicide prevention and data sharing (please see the section below on Recommendation 6 for details).

7. Develop and implement targeted mental health and substance abuse strategies that respond to the diversity of Veterans, Service members and their Families.

The Departments have made significant strides in developing and implementing strategies to meet the needs of diverse populations. For example, minorities, women, and lesbian, gay, bisexual and transgender individuals. For example:

- DoD provides the same benefits, including TRICARE health benefits, to all military spouses regardless of sexual orientation.
- VA has developed three trainings for VA providers on issues specific to transgender health to be launched this summer. Content in these trainings includes mental health issues to consider, prescribing issues related to cross-sex hormones, and basic education and awareness. In addition, VA has created two internal SharePoint sites for employees on (1) lesbian, gay and bisexual specific topics to consider in health care, and (2) transgender specific topics to consider in health

care. Over 200 unique visitors have visited the lesbian, gay and bisexual site and there have been over 360 visitors to the transgender site since March 14, 2014.

- HHS created a list of federally-supported curricula that help behavioral health and primary care practitioners assess, treat and refer lesbian, gay, bisexual and transgender clients in a culturally competent manner. The list includes curricula identified by HHS staff and technical assistance providers and that are available for Continuing Medical Education/Continuing Education Unit credit. The list is available at samhsa.gov/lgbt/curricula.aspx and hrsa.gov/lgbt/.

IV. 2014 Recommendations

The 2014 Interagency Task Force recommendations build on strong inter-departmental accomplishments on the 2013 recommendations over the past year to maximize Department best practices and establish joint initiatives which further benefit our Veterans, Service members and their Families in the prevention and treatment of mental health and substance use conditions.

1. Advance suicide prevention infrastructure and training across agencies to support Veterans, Service members, and their Families.

Suicide remains a significant challenge for Service members, Veterans and their Families. Since 2012, VA and DoD have concentrated on developing common messaging and information for Service members, Veterans and their Families concerning help seeking and crisis intervention. HHS has sponsored on-going Policy/Implementation Academies that have focused on behavioral health and suicide prevention and have provided training and tools to help participants successfully implement best practices across a spectrum of behavioral health activities. Policy Academy Teams consist of ten members, each appointed by the Governor and representing the Governor's office, the state mental health and substance abuse authorities, the Adjutant General, the Medicaid authority, school and court leadership, VA centers and hospitals, and Veterans Service Organizations.

From 2008 to 2013, seven policy academies were held with 46 states and four territories, completing their strategic plans to meet the behavioral health needs of this population. Implementation Academy Teams consist of four members, each appointed by the Governor/Team Lead, to focus on the selected topics for 2014: Military Families (in March); Justice Involved Veterans (in April); and Suicide Prevention (in late summer). Representatives from 15-20 states were present at each of the Implementation Academy Team meetings resulting in participation from every state that created a strategic plan and who plan to return for an implementation academy over the course of FY 2014. VA and DoD will support the development and execution of these Academies, with curricula focused on suicide prevention with special attention on initiatives to help primary care providers, community emergency departments, and substance use programs effectively engage Service members, Veterans and Families who access care in those settings. A toolkit of resources that will be developed through the National Action Alliance for Suicide Prevention will also be piloted among Implementation Academy participants and will include information for community providers on Veteran and Service member behavioral health care, crisis intervention and peer support; the VA / DoD Clinical Practice Guidelines, and information for Veterans and Service members regarding community and civilian workplace expectations.

2. Support and implement National Research Action Plan initiatives within HHS, DoD, and VA agencies.

The Departments will begin implementing the two- to four-year action items outlined in the National Research Action Plan supporting federal research in PTSD, TBI and Suicide Prevention. The two- to four-year action items include:

- Eight initiatives focused on PTSD Research;
- Eight initiatives focused on TBI Research;
- Six initiatives focused on Suicide Prevention Research; and
- Two Comprehensive Longitudinal Mental Health Study initiatives.

The largest interagency initiatives outlined in the National Research Action Plan in 2014, in terms of study population and funding, are the Army Study to Assess Risk and Resilience in Service members through DoD and NIMH, the Consortium to Alleviate PTSD through the DoD and VA, and the Chronic Effects of Neurotrauma Consortium through DoD and VA. Work on these two- to four-year initiatives will continue through 2017.

3. Initiate data collection for joint clinical and outcome measures to track behavioral health service utilization and outcomes across agencies to support Veterans, Service members and their Families.

By February 2014, the Departments had reached consensus on joint clinical and outcome measures regarding specific mental health and substance use conditions. The Departments believe that common measures will help to drive coordination across DoD, VA and civilian clinical settings in a way that will improve coordination and care. Next the Departments will consider platforms appropriate to each specific Department to gather, analyze and report on these metrics that measure patient treatment outcomes. Within three months from the final release of the 2013 Interagency Task Force Annual Report, each Department will submit a draft plan detailing the implementation of the initial recommendations from the Metrics Work Group. The Work Group will also continue to meet quarterly to develop additional measures to advance the psychological health of Active Duty, Guard and Reserve personnel and Veterans. Within six months of the approved Implementation Plans, the Work Group will submit a supplemental report detailing progress towards implementation of Department-specific action plans, status of Work Group activities, recommended modifications to selected metrics (if appropriate), and reporting of available data for selected measures.

4. Build and enhance community partnerships to support Military and Veteran Families.

The Departments will work together to identify, develop and implement strategies for strengthening relationships with community systems of support. Building on the lessons learned from the 152 VA Mental Health Summits in 2013, VA is implementing strategies for strengthening relationships between VA and community health providers. The goal is to help ensure that Veterans and their Families are effectively integrated into community services as appropriate; local VA and local social service agencies are better connected; and there is an ongoing liaison between VA and Community

Mental Health providers. Additional details on lessons learned are provided in the progress and accomplishments section on the VA Mental Health Summits.

The DoD has defined the Family Readiness System as collaborative network of agencies, programs, services, and individuals that promotes readiness and quality of life of Service members and their Families. Efforts are ongoing to promote awareness among military and community-based service providers that they are a part of the Family Readiness System and how they support family readiness, or can be tailored to do so. One initiative is the Military Families Learning Network which, in partnership with eXtension and the United States Department of Agriculture/National Institute of Food and Agriculture, assists family service professionals to work with military families through online communities that identify and make use of the highest quality, best practices, research- and evidence-based information, educational and curriculum materials, and programming activities and efforts. The primary concentration areas for the Military Families Learning Network are Personal Finance, Family & Youth Development, Community Capacity Building, Special Needs Families, Caregiver Support and Network Literacy. Another initiative, again, through the United States Department of Agriculture partnership, is the development of a Community Capacity Building curriculum planned for use by family service providers as well as their civilian counterparts.

5. Implement and enhance policies and procedures to support full inclusion of Lesbian, Gay, Bisexual and Transgender populations in Departmental programs.

Changes in federal and state law over the past three years have enhanced the need to address service delivery for lesbian, gay, bisexual and transgender populations. Some of the Interagency Task Force mental health and substance use initiatives currently addressing the lesbian, gay, bisexual and transgender populations include disseminating culturally-sensitive training programs for community behavioral health and public health providers; developing research and data collection strategies tailored to meet some of the distinctive needs of this population; providing strategic communication and outreach on topics such as family acceptance; establishing resource centers within each department for a one-stop training and technical assistance capacity; and establishing educational outreach websites to inform interested consumers, organizations and professionals about the importance of health and behavioral health conditions for these populations. In 2014, the Departments will continue to share best practices and lessons learned from the development of cutting-edge, cost-effective training methods, from increased outreach and from establishment of specialized services for lesbian, gay, bisexual and transgender populations. The Departments will also pursue additional data collection to ensure that researchers, policy makers, mental and physical health care providers, and advocates continue to understand health disparities affecting the lesbian, gay, bisexual and transgender population within the Service member and Veteran communities. Health disparities are indicators of the lack of equality among populations and refer to areas such as limited access to care, less than competent care, limited numbers of culturally specific professionals, and difficulties in educating certain populations regarding health needs. The lesbian, gay, bisexual and transgender, Native American, and African American communities are considered some of the populations that experience health disparities.

6. Ensure effective policy and practice integration addressing Substance Use Disorders in populations served by the Departments.

The Departments are working to promote the use of the Screening, Brief Intervention, and Referral to Treatment model across the continuum of care. The Screening, Brief Intervention, and Referral to Treatment model is a comprehensive, integrated, evidenced-based, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders, and the model is practical for use in a variety of health care settings. The White House Office of National Drug Control Policy, the Substance Abuse and Mental Health Services Administration, and VA support the use of the Screening, Brief Intervention, and Referral to Treatment program in primary care. In 2003 the Substance Abuse and Mental Health Services Administration began the first large scale implementation of Screening, Brief Intervention, and Referral to Treatment and has a grant program that funds competitive states (22), tribes (one), federally qualified health centers (two states), the Iowa National Guard project, medical residency programs, and other programs to train nurses, behavioral health workers and other health professionals in the model.

VA/DoD Guidelines recommend this model for primary care detection and intervention of alcohol use and referral to treatment for drug use disorders. DoD has recently promulgated policy to require regular and systematic medical screening for alcohol misuse and implementation of the Screening, Brief Intervention, and Referral to Treatment model in primary care settings. These efforts will continue to ensure a standardized, integrated approach to the screening, education, and early intervention for unhealthy alcohol use. The Departments will also review VA/DoD clinical practice guideline recommendations on screening for alcohol misuse and tobacco use, identify strategies to improve implementation of these guideline recommendations, and make specific recommendations for what should be updated in the next version of the clinical practice guidelines. Since the evidence varies across a wide range of screening and treatment protocols for alcohol misuse and tobacco use compared to illicit or prescription drug use, the Departments will incorporate the U.S. Preventive Services Task Force's recommendations regarding different screenings and brief interventions dependent on the type of substance (e.g., alcohol, illicit drug use, and tobacco) due to different levels of evidence (uspreventiveservicestaskforce.org/index.html).

7. The Departments will advance policies and practices that address military sexual assault, military sexual harassment and military sexual trauma and health concerns related to these experiences.

Since 2011, DoD and VA have been examining the existing research on gender differences in the delivery and effectiveness of mental health services, including mental health screening and detection and prevention and treatment services for both men and women who have experienced military sexual assault, military sexual harassment, and/or military sexual trauma. DoD and VA have been examining

the literature in response to Integrated Mental Health Strategic Action 28 (Gender Differences), action step three: “Summarize the current status of research on treatment and prevention of female Service members and Veterans, and research on those (both men and women) who have experienced Military Sexual Trauma in VA and DoD.” DoD also established the Sexual Assault Advisory Group in late 2013 as an ad hoc group to advise the DoD Psychological Health Council on matters related to the clinical response to sexual assault.

From the above-described efforts, over the course of 2014, the Departments will build on the findings and recommendations to explore, share, and leverage each other’s efforts (to include training, tools and best practices) to promote trauma-informed care and the prevention and treatment of acute and long term symptoms that may arise from military sexual assault, military sexual harassment, and military sexual trauma. The Departments will continue implementation of best practices related to clinical screening and treatment addressing exposure to trauma, including trauma stemming from sexual assault and harassment, at DoD health care appointments to facilitate referrals from health care providers to services. In particular, VA will share best practice information about its military sexual trauma universal screening and treatment monitoring programs and collaborate with DoD and HHS partners to assist in developing screening and treatment protocols to meet their specific needs. The goal of these efforts is to reduce barriers that preclude survivors of military sexual assault, military sexual harassment, and/or military sexual trauma from reporting these crimes, and improve survivors’ access to needed care. DoD and VA will also continue refining their data capture systems to monitor and evaluate reporting of military sexual assault, military sexual harassment, and/or military sexual trauma and the disposition of those cases.

8. Advance workforce development models that support Service members, Veterans and their Families.

The Departments will develop and/or share models with community and military providers for training and deploying a workforce to effectively deliver timely mental health and substance use services for Service members, Veterans and their Families. The National Defense Authorization Act for 2014 (*Title V, Subtitle C, Mental health counselors for Service members, Veterans and their Families*) directed the DoD and VA to provide a joint, coordinated plan to ensure adequate mental health counseling resources across the Departments to address the long-term needs of Service members, Veterans and their Families. As part of this request, the Defense Health Agency requested each of the services to provide data on all their available types of trained counseling providers and a comprehensive staffing plan (or gap analysis). The Departments will work together to develop strategies that reflect an inventory of the existing mental health workforce and develop future workforce strategies for military treatment facilities and community based mental health agencies nationwide. Further work is needed to develop joint and collaborative strategies so that the Departments are not routinely exchanging professionals across the three systems. This recommendation provides the opportunity for the Departments to share best practices; build on the peer supports and services delivered in each department as a cornerstone for workforce development; share retention strategies; and communicate competencies necessary for delivery of recovery oriented evidenced based care in multiple settings.

SAMHSA's Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues will be the cornerstone of that effort. VA and DoD are also working to train community mental health providers in military culture, so community clinicians are aware of the impact of military culture on help seeking behavior and better address mental health conditions of Veterans seeking care outside of VA. In addition, VA has hired over 950 certified peer specialists who are part of VA's implementation of recovery concepts throughout its mental health services across the country. Peer specialists are Veterans who are in recovery from a mental health condition, who promote recovery by sharing their own recovery stories, providing encouragement and hope, and teaching a variety of skills to Veterans.

V. Update of Federal Activities

The federal government's efforts to improve mental health care for Service members, Veterans and their Families are complex. The Departments take a holistic approach to mental health treatment, focusing on improving patients' access to care, identifying and providing optimal therapy for each individual requiring treatment, and ensuring that federal government and community-based providers work together seamlessly to ensure the best possible care for Service members, Veterans and their Families. This report describes some of the most significant and impactful efforts that each Department has made toward achieving the Executive Order since the Interagency Task Force on Military and Veterans Mental Health 2013 Interim Report was released on May 21, 2013. Highlights and accomplishments related to each 2013 recommendation are outlined below.

Recommendation 1

Increase awareness and education among Veterans, Service members, and their Families about the prevention and treatment of mental health and substance abuse conditions.

The Departments of Defense (DoD), Veterans Affairs (VA), and Health and Human Services (HHS) have launched successful national public awareness campaigns aimed at increasing knowledge among Service members, Veterans and their Families about the prevention and treatment of mental health and substance use conditions. These campaigns are also focused on overcoming the negative attitudes associated with mental health concerns and seeking treatment. Several campaigns, including VA's *Make the Connection* and DoD's *Real Warriors* campaigns, are described below. Although they are separate campaigns designed to target their respective audiences somewhat differently, they are complementary to one another, and there is ongoing coordination between the teams working on both campaigns. Additionally, HHS launched *MentalHealth.gov* in June 2013, which offers information and resources on mental health and substance use issues for Veterans, their Families and the general public.

Progress/Accomplishments

Make the Connection

In November of 2011, VA launched *Make the Connection*, a national public awareness campaign at maketheconnection.net to connect Veterans and their Families with information about mental health resources and to help them discover ways to live more fulfilling lives. The campaign seeks to reduce the negative attitudes Veterans and their Families associate with seeking mental health and substance use services; educate Veterans and their Families about the signs and symptoms of mental health and substance use issues; increase awareness of and trust in VA's advances in mental health and substance use services and its commitment to delivering accessible, high quality, patient-centered care; and promote help-seeking behavior for those who need care. The campaign launched a mobile website that maintains the dynamic features of the desktop site and experienced substantial high volume growth throughout Fiscal Year (FY) 2013 that has continued into FY 2014:

Make the Connection Campaign

The *Make the Connection* campaign connects Veterans and their Families with information about mental health resources and helps them discover ways to live more fulfilling lives. The campaign has captured more than 12 million web and video views since 2011, and garnered more than 50 awards from many notable organizations and associations for communications materials including video, website and social media.

- 1,390,618 million website visits during FY 2013 for a total of over 2.8 million visits since its launch – a 96 percent increase in FY 2013.
- 3,461,449 *Make the Connection* video views in FY 2013 for a total of over 6.6 million views since its launch – an increase of 108 percent.
- More than 7,692 viewers are subscribed to the campaign’s YouTube channel.
- During the first six months after the campaign’s launch in June 2012, the campaign’s Facebook page was the fastest growing community in the government/military sphere. The page now has over two million followers, including 734,994 new followers in FY 2013. In addition, engagement rates continue to stay high with an 11 percent “People Talking About This” rate (reported by Facebook, this includes fans commenting on, sharing, or *liking* posts and/or the page on a weekly basis). This is five times greater than the average rate of engagement for similar pages. Finally, the Facebook page has achieved more than 4.2 billion total impressions from fan engagement, activity and paid advertisements.
- The campaign’s second public service announcement, *Veteran Strength and Connection*, began distribution in March 2013 and has achieved over 115 million impressions for a media value of over two million dollars. Matching the results of the campaign’s first public service announcement in FY 2012.
- The campaign’s paid media has included online, television, radio and print advertising, achieving more than four billion impressions.

Real Warriors Campaign

DoD’s *Real Warriors* campaign at realwarriors.net is a multimedia public awareness campaign launched by DoD to encourage help-seeking behaviors and to promote awareness and use of available resources among Service members, Veterans and their Families coping with psychological health concerns.

The campaign is an integral part of DoD’s overall effort to eliminate negative attitudes and encourage Service members and Families to seek appropriate care and support for psychological health concerns. To reach the broadest audience possible, the campaign employs a variety of strategies including event outreach and partnership engagement, print materials development and dissemination, media outreach, an interactive website, and social media engagement. The campaign features stories of real Service members who reached out for psychological support or care with successful outcomes, including learning coping skills, maintaining their security clearance, and continuing to succeed in their military or civilian careers. There were 326,509 visits to the *Real Warriors* campaign Web site in FY 2013. This reflects a 43 percent increase over the 228,417 Web site visits in FY 2012 and surpasses the 10 percent increase target. Since its launch in 2009, the *Real Warriors* campaign has:

Real Warriors Campaign

The *Real Warriors Campaign* is a multimedia awareness campaign designed to encourage Service members and veterans coping with invisible wounds to reach out for appropriate care and / or support. The campaign reaches Service members, Veterans and their Families. To reach the broadest audience possible, the campaign features a variety of strategies including outreach and partnerships, print materials, media outreach, an interactive website, mobile website and social media. The campaign features stories of real Service members who reached out for psychological support or care with successful outcomes.

- Produced 45 multimedia (e.g., video and radio) products.
- Video profiles and public service announcements have aired more than 54,000 times on 753 civilian stations or networks and in 177 countries worldwide.
- Garnered 487,000 interactions with audiences on social media channels, engaging with audiences an average of 1,055 times per day.
- Developed 58 unique campaign products that have been viewed online 41,949 times and ordered or downloaded 2,597 times.
- Partnered with more than 223 federal, national and community organizations, resulting in potentially reaching 135 million individuals through 240 campaign articles in partner newsletters, blogs or other publications.
- Through 125 events (i.e., conference exhibit and presentation), directly interacted with 17,882 individuals and distributed 82,085 pieces of materials.
- Published more than 115 online articles that have been accessed more than 1.5 million times.

Through video and radio public service announcements on Armed Forces Radio and Television Service, the campaign continued to reach international military audiences. Public service announcements have aired more 83,000 times in 177 countries including Iraq and Afghanistan, potentially reaching more than 2 million Service members. Additionally, FY 2013 accomplishments for the *Real Warriors* campaign as of August 31, 2013, include:

- Garnered 350,704 interactions via social media channels, potentially reaching 850,000 unique individuals, through 4,557 campaign messages.
- Online audiences engaged with the campaign 24/7/365 and, on average, 1,042 times every day - representing an 889 percent increase in engagement from FY 2012.
- Posted five new Web articles, one new mini-brochure for Veterans, one new mini-brochure for Service members, and 11 updated articles on the *Real Warriors* campaign website.
- Confirmed 17 partners in FY 2013 for a cumulative 223 partners (including partners within DoD, other federal agencies, and private organizations including community-based groups and others with national reach).

Partners enable the *Real Warriors* campaign to offer the most relevant and updated resources to members of the military community and spread campaign communications and information to DoD's target audience worldwide. Partners include federal, military and civilian organizations of local and national reach including, for instance, Operation Gratitude, Defense Commissary Agency, Yellow

Ribbon Reintegration Program, National Center for Posttraumatic Stress Disorder, American Red Cross, Army Wife Network, among many others. Partners support the Real Warriors Campaign through a variety of activities such as:

- Establishing a link to the campaign website on the partner website
- Publishing a news brief or article about the campaign
- Including campaign updates in newsletters and blogs
- Displaying and distributing campaign materials

Parenting for Service members and Veterans

VA and DoD have launched a website to provide a free online course featuring key tools to support military parents (militaryparenting.t2.health.mil). The course includes parenting information and strategies to help Service member and Veteran parents balance service and family life, and to reconnect with children after deployment and beyond. Individual modules in the course review topics such as: positive discipline; managing stress and emotions as a parent; parenting strategies for parents with an emotional and/or physical diagnosis (e.g. PTSD or chronic back pain); and helping children with difficult emotions and behaviors.

Alcohol Misuse Prevention Campaigns

DoD's Defense Health Agency, formerly TRICARE Management Activity, launched the *That Guy* Campaign in 2006 as an integrated marketing campaign targeting military enlisted personnel ages 18 to 24 across all branches of service. The *That Guy* campaign includes a variety of offline marketing materials and promotional items in addition to an award-winning desktop and mobile Web site, ThatGuy.com, and social media channels including Facebook and YouTube. Based on research and behavior change marketing concepts, the campaign uses a multimedia, peer-to-peer approach to raise awareness of the negative short-term social consequences of excessive drinking. In doing so, *That Guy* promotes peer disapproval of excessive drinking and helps discourage binge drinking as demonstrated by the results of the 2008 DoD Survey of Health Related Behaviors which noted a decrease in binge drinking among military enlisted personnel ages 18 to 24. Binge drinking among the target audience dropped from 51 percent in 2005 to 46 percent in 2008. In addition, the 2008 Health Related Behaviors survey results revealed that the binge drinking rate was 38 percent among installations using *That Guy* versus 49 percent for control installations that had not adopted the campaign -- a statistically significant difference of 11 percentage points at installations using the *That Guy* campaign (excluding Marine installations because the control sample was too small compared to the treated sample).

To date, over 4 million branded materials have been disseminated to all Services to successfully engage with the target audience. *That Guy* is now actively deployed around the world with more than 6,100 locations engaged across the globe and a campaign presence in 47 states and 23 different countries. A number of attitudinal questions about binge drinking were added to the Status of Forces Survey before *That Guy* was launched in an effort to track shifts in attitudes among the target audience over time. According to analysis of the annual Status of Forces Survey performed by the Defense Manpower Data Center, there has been a steady increase in campaign awareness within the target audience population,

rising from a *phantom awareness* of three percent in 2006 prior to the campaign being launched to 14 percent in 2007, 29 percent in 2008, 45 percent in 2009, 58 percent in 2011 and up to 64 percent in 2012, more than four times the awareness level of 2007. The 2012 Status of Forces Survey indicates that the target audience's support of the campaign's messages was strongest in 2012, surpassing the levels first measured in 2006 before the campaign was actually launched. In particular, the target audience's level of agreement with the following statement has positively increased from 53 percent in 2006 to 64 percent in 2012: "It's important to me that I keep my drinking under control and act responsibly."

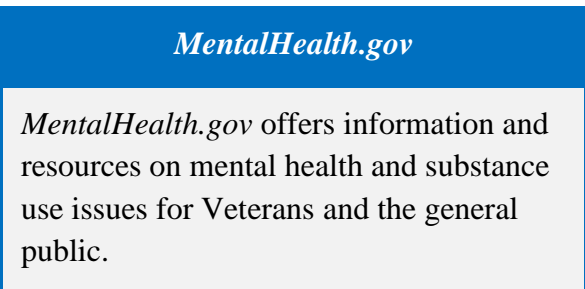
In addition to DoD-wide efforts, the Services have fielded their own unique efforts to educate Soldiers, Sailors, Airmen and Marines. The Department of the Army is using its *Warrior Pride* campaign to encourage Soldiers not to drink. It aims to educate Soldiers that substance abuse is incompatible with Army values and with the warrior ethos. Commanders are trained on ways that they can deglamorize alcohol use within their commands, and they are encouraged to conduct *smart testing* to deter drug use. Commanders are also required to make clear, through words and action, that drug and alcohol use is not acceptable.

The Department of the Navy has rolled out a *Keep What You Earned* campaign. This campaign seeks to encourage responsible drinking among Sailors through recognition of their career achievements and accomplishments, all the while reminding them of consequences and what they stand to lose when making poor choices regarding alcohol. The campaign actively engages Sailors as advocates for responsible drinking, promotes alternatives to drinking, and creates partnerships with Navy and civilian programs focused on Sailor well-being. The *Navy Alcohol and Drug Prevention* website includes resources for Sailors, Navy leadership, and Alcohol and Drug Control Officers, as well as tips for Sailors and links to order related social media messaging and fact sheets encouraging responsible drinking. Within the campaign, the Navy has developed a mobile app, *Pier Pressure*, a role-playing game true to the "Navy experience" that is coupled with resources to help Sailors practice responsible drinking behaviors in everyday life, including a blood alcohol content calculator and a local taxi cab search. The Navy is also reaching out to communities surrounding Navy bases to encourage community members to act to prevent bars and establishments from serving alcohol to underage individuals and to raise awareness among servers that they should not continue to serve alcohol to customers who are already intoxicated.

MentalHealth.gov

In June 2013, HHS launched *MentalHealth.gov* as an online resource available to the general public. To date, more than 4,600 online readers have visited the Veterans page of the website, which includes numerous links to online resources and help-lines specifically for Veterans and their Families.

The web site also offers general information on suicidal behavior, mental health and substance use disorders, and personal stories of hope and recovery from mental health problems, including a Veteran's story. *MentalHealth.gov* further supports Veterans by

A blue rectangular box with a white border. The top portion of the box is a solid blue bar containing the text "MentalHealth.gov" in white, italicized font. Below this bar, the background is white with a thin blue border. The text inside this white area reads: "MentalHealth.gov offers information and resources on mental health and substance use issues for Veterans and the general public." in a black, italicized font.

MentalHealth.gov

MentalHealth.gov offers information and resources on mental health and substance use issues for Veterans and the general public.

highlighting appropriate Veterans' mental health related events and messages on Twitter and Facebook. Additionally, the *MentalHealth.gov* blog features stories authored by both Veterans and experts from VA about Veterans who have successfully transitioned out of the military and advocate for mental health services.

Since its launch, *MentalHealth.gov* has seen a steady increase of the number of visitors, with more than 28,000 visitors in October 2013 alone. It currently has more than 4,300 followers on Twitter and more than 2,500 likes on Facebook. In addition, the National Association of Broadcasters' new mental health awareness campaign, OK2Talk, has been promoting the importance of talking about mental health through more than 195,800 TV and radio airings and 3,700 personal stories about mental health published on OK2Talk.org. The campaign has generated more than 51,000 visitors to *MentalHealth.gov*.

Recommendation 2

Implement the 2012 National Strategy for Suicide Prevention.

“The effect of suicide on communities across our nation goes beyond the personal. Suicide affects some of the most important concerns of our time. Suicide among those who serve in our Armed Forces and among our Veterans has been a matter of national concern.” ~ VADM Regina Benjamin, former U.S. Surgeon General

The revised National Strategy for Suicide Prevention (NSSP) was released on September 10, 2012, by the U.S. Surgeon General VADM Regina Benjamin and the co-chairs of a public private coalition, the National Action Alliance for Suicide Prevention (Action Alliance). The Action Alliance is co-chaired by the Secretary of the Army, John McHugh and former Senator Gordon Smith, and oversees the implementation of the NSSP through its various subcommittees. The NSSP has 13 goals and 60 objectives, within four strategic directions. The NSSP has a Military/Veteran Working Group that is co-chaired by the VA National Mental Health Program Director for Suicide Prevention and the DoD Defense Suicide Prevention Office Director. HHS continues to be the prime funder for the Action Alliance, and chairs the Federal Working Group on Suicide Prevention (launched in 2005) whose members include representatives from DoD, VA, the Department of Homeland Security and multiple other federal agencies that coordinate their work in the field.

NSSP Strategic Directions

1. Creating supportive environments
2. Enhancing quality care
3. Promoting access to care
4. Improving surveillance systems

Progress/Accomplishments

National Strategy for Suicide Prevention

Both VA and DoD have aligned with and support the implementation of the NSSP goals and objectives. VA efforts align with NSSP and continue to embrace both public health approaches and individual

treatments. While DoD’s efforts are in concert with the objectives of the NSSP, DoD has been able to take suicide prevention efforts even beyond the four strategic directions as outlined below.

<p>1. Collaborating with the Services to create a strategic map of the NSSP goals and objectives and how they may apply to DoD.</p>	<p>This mapping effort has helped identify areas of overlap in priorities between national suicide prevention efforts and that of DoD. It has also suggested additional areas for consideration for DoD suicide prevention efforts, and has helped inform the national efforts about the need for community resources for returning Active Duty, Guard and Reserve personnel.</p>
<p>2. Working with the Services and DoD entities to map all suicide prevention programs and activities on the NSSP strategic map.</p>	<p>These efforts have helped identify objectives that have adequate coverage, those that have inadequate coverage, and areas of possible redundancy. By further analysis, DoD is able to inform resource re-allocation to achieve maximum efficiency and objectively determine need for additional resources.</p>
<p>3. Developing metrics for suicide prevention and resilience program evaluation with the Services.</p>	<p>When data is collected and reported on these outcome metrics, DoD will be able to recommend funding for effective programs and suggest alternatives for programs that do not demonstrate effectiveness. This effort is being conducted in concert with SAMHSA with the goal to evaluate the implementation of the NSSP objectives.</p>
<p>4. Improving access to and quality of behavioral health care in partnership with the Services.</p>	<p>With attention to the practice of embedding behavioral health care providers in operational units, evaluating access to care, continuity of care across transition points, defining resilience and resilience programs, and collaborating with VA, DoD is taking the lead on implementing NSSP’s strategic directions 2 and 3.</p>
<p>5. Releasing the DoD Suicide Event Report and developing operational definitions for the data fields.</p>	<p>In addition, DoD has developed the Wellness Assessment and Risk Nexus system that uses historical data on suicide risk and protective factors to develop a predictive analytical tool for determining risks to personnel wellness and resilience. These efforts address NSSP’s strategic direction 4.</p>
<p>6. Creating a Research Work Group, which has created an inventory of all DoD suicide prevention research and aligned them to the NSSP.</p>	<p>This group is currently helping identify metrics for evaluating this research and will be part of DoD’s effort on Translation and Implementation of Evaluation and Research Studies to enable timely dissemination of research results. This is partially aligned with NSSP’s strategic direction 4 and it has been conducted in concert with the Action Alliance Research Task Force.</p>
<p>7. Working with agencies</p>	<p>HHS/SAMHSA chairs the Federal Working Group on</p>

<p>across the federal government to ensure that DoD's efforts are synchronized and in keeping with the latest findings on effective suicide prevention.</p>	<p>Suicide Prevention, launched in 2005, whose members include representatives from DoD, VA, Department of Homeland Security and multiple other federal agencies that coordinate their work in the field.</p>
<p>8. Offering education opportunities for community, clinical and research perspectives in collaboration with VA and HHS.</p>	<p>In addition to the 152 VA hosted mental health summits in 2014, DoD conducted education and outreach events in September 2013 as part of Suicide Prevention Month. DoD and VA are seeking approval to host a joint event in 2014. This action aligns with NSSP's strategic direction 1.</p>
<p>9. Collaborating with Vets4Warriors and the Military Crisis Line to ensure that Service members have 24/7 access to trained crisis workers.</p>	<p>This effort aligns with the NSSP strategic directions 2 and 3.</p>

The Task Force has demonstrated its commitment to implementing the NSSP through initiation of current and future suicide prevention programs that further NSSP objectives. In partnership with DoD, VA, the National Guard Bureau and private sector partners, HHS/Substance Abuse and Mental Health Services Administration (SAMHSA) held three additional *Service members, Veterans and their Families Policy Academies* this past FY. A total of 46 states, four territories and the District of Columbia have participated and are implementing plans to enhance their behavioral health systems for these populations. 17 states and territories have targeted suicide prevention as a top priority. In September 2014, HHS/SAMHSA will host a Policy/Implementation Academy focused on suicide prevention, with special attention on initiatives to engage Service members, Veterans and Families who access community emergency department and substance use programs. Each state involved in these Policy/Implementation Academies will communicate to Service members, Veterans and their Families about the availability of and means to access established programs.

Crisis Line Expansion. Since the Executive Order was signed on August 31, 2012, VA, in cooperation with HHS, increased the capacity of the Veterans Crisis Line/Military Crisis Line (VCL/MCL) by 50 percent before the December 2012 deadline. The VCL/MCL is a 24-7 crisis intervention call center for Veterans and Military Service Members, including phone, chat, and text services. Consistent with the sensitive nature of dealing with Service members and Veterans in crisis, all new staff members have received four weeks of training, including specific training on topics such as Military Culture; Post Traumatic Stress; Military Sexual Trauma; Traumatic Brain Injury; Intimate Partner Violence; and lesbian, gay, bisexual, and transgender issues. The VCL/MCL continually monitors capacity and based

on evaluation of use and capacity limits, VCL/MCL is in the process of hiring an additional 57 staff to continue meeting the growing need for crisis intervention services.

As of April 2014, 46 staff members are hired, and the remaining 11 staff members are being recruited for hire as soon as possible. The VCL/MCL staff facilitates callers' immediate access to Suicide Prevention Coordinators and community resources at the local level, if needed. Regardless of where the Veteran/Service member is located, in terms of rural and remote areas, on military bases, etc., emergency services are dispatched to any Service member or Veteran in need of crisis intervention. Service members calling the VCL/MCL in crisis receive immediate crisis intervention, including connection with Vets4Warriors for resources and follow-up, as appropriate. Any Veteran presenting to a VA medical center in crisis receives immediate access to care as necessary.

VA continues to work closely with SAMHSA, which supports the National Suicide Prevention Lifeline's telephonic infrastructure, as well as community crisis center backup in support of the VCL/MCL. Community crisis center backup is particularly important for ensuring that Veterans who are not in crisis or who are not eligible for VA services receive appropriate community referrals. Veterans in crisis are served by the VCL/MCL and Suicide Prevention team at local VA Medical Centers, regardless of eligibility for VA services. In August 2013, the DoD, through the Defense Suicide Prevention Office expanded the Vets4Warriors call center, which provides peer support and resilience case management. While the VCL/MCL currently provides referrals to Chaplains, Military OneSource, and community providers, DoD and VA have also established a memorandum of agreement for warm-handoffs (i.e., direct call transfers ensuring connection to the other service) between VCL/MCL and the Vets4Warriors call center. The memorandum of agreement states Vets4Warriors will *warm transfer* Service Members at imminent risk of suicide to the VCL/MCL for assessment and emergency crisis intervention, and Vets4Warriors may provide follow-up services, when appropriate. Additionally, Suicide Prevention Coordinators remain a resource for Service members, when needed.

Ongoing Awareness Campaigns. In September 2012, VA and DoD launched a nationwide campaign to expand help-seeking in the military by emphasizing the importance of accessing the VCL/MCL. In the campaign, the partners co-branded materials and used the same key messaging. The joint campaign theme for FY 2013 was *Stand by Them—Take a Stand*, which reinforces the importance of supporting Service members, Veterans, Friends and Families without reinforcing barriers to seeking treatment. Through this work, DoD and VA reached more than 30 major milestones they jointly set to accomplish. Work ranged from co-developing Public Service Announcements and holding educational sessions on suicide prevention to updating and enhancing awareness of DoD and VA web sites.

Additionally, DoD provided more than 52,000 VCL/MCL materials to stakeholders at dozens of help-seeking events and to installations nationwide. VA Suicide Prevention Coordinators provided millions of pieces of VCL materials at a wide variety of both local and national events that ranged from educational programs to national sporting events. There were 178 nationally coordinated outreach events in FY 2013.

DoD worked closely with the producers of the National Memorial Day Concert to ensure they used safe and effective suicide prevention messaging that conformed to internationally recognized guidelines when discussing this subject in order to reduce the potential for suicide contagion. The concert is an annual event on the National Mall, which was broadcasted on the Public Broadcasting Service and the American Forces Network to 9 million Service members and civilians. On the concert's website, the two chief suicide prevention resources provided were for VCL/MCL and the Defense Suicide Prevention Office. The Public Broadcasting Service put one phone number--that of VCL/MCL--on the screen for all viewers to see at the end of the piece on military suicide.

Additionally, the VCL/MCL crisis service was expanded in 2013. Prior to FY 2013, Service members in Europe could contact a VCL/MCL Defense Switched Network line (118) and phone number if they were in distress. DoD established a similar Defense Switched Network line in Korea in June 2013. DoD leveraged VCL/MCL messaging and branding to provide support to United States Forces Afghanistan in their implementation of an internal, Operation Enduring Freedom crisis line and related products for Service members in theater.

To encourage Service members and their Families to contact VCL/MCL in FY 2014, the partners are jointly supporting the themes: *It's Your Call* and *It Matters*. The FY 2014 campaign was launched during Suicide Prevention Month in September 2013. DoD provided VCL/MCL materials at the Army Health Fair, which was held at the Pentagon in September of 2013, as well as at more than a dozen installations in the U.S. and abroad, including in Kuwait, and at six military hiring events held by DoD's Hiring Heroes (Fort Sam Houston Community Center, TX; Joint Base San Antonio, TX; Fort Riley, KS) and the U.S. Chamber of Commerce's Hiring Our Heroes (Quantico, VA; New Orleans, LA ; Peterson Air Force Base, CA).

Both DoD and VA also participated in the American Foundation for Suicide Prevention's annual *Out of the Darkness Walk* in Washington, DC. VA Suicide Prevention Coordinators participated in events across the country at local and national levels. There were over 111,000 visits to the VCL/MCL website during Suicide Prevention Month and the first photo sharing campaign was also initiated. A toolkit for materials was created for use both internally and externally and there were over 1,000 downloads of the toolkit in September. Over 3.9 million items were shipped for the Suicide Prevention Coordinators to use during the campaign. Social media was used extensively for the first time to increase awareness in the community. Government officials and celebrities were encouraged to assist in this effort. Celebrity tweets and posts drove over 14 million social media impressions and the VCL had over 2,250 social media mentions during the month of September. There was expanded support this year from Veteran Service Organizations, corporations and sports teams. VA posted nine blogs on Huffington Post's *Invisible Casualties* blog series and out of home advertising in five selected markets produced more than 160 million impressions. The suicide prevention month public service announcement (*Talking About It Matters*) was distributed to 1,200 TV and 4,000 radio stations and has 130,000 YouTube views to date.

Conference	Highlights
Using Community-Based Approaches to Prevent Suicide	<ul style="list-style-type: none"> • Held September 20, 2013, with federal partners to enhance collaborative support for Service members and their Families. • Approximately 120 people attended the summit, including line leaders, Chaplains, family program managers, suicide prevention managers and coordinators, substance use counselors, mental health clinicians and primary care clinicians.
Clinical Approaches-System Dynamics Summit	<ul style="list-style-type: none"> • Held November 21, 2013, with more than 200 people attending. • DoD and VA discussed with stakeholders the practical tools and solutions for implementing evidence-based assessment, management, treatment and after-care approaches in clinical settings. • Continuing education units were provided. VA held an additional day of education events and suicide program activities for VA Suicide Prevention Coordinators on November 22, 2013.
Improving Practices in Research	<ul style="list-style-type: none"> • Held on December 13, 2013. Clinicians, non-clinical support staff and researchers explored new approaches and techniques for conducting and implementing military suicide research.

As part of the DoD/VA Integrated Mental Health Strategy, DoD and VA will continue to plan and host annual DoD/VA suicide prevention conferences as they are approved by the two Departments.

Clinical Practice Guidelines. DoD and VA jointly developed a clinical practice guideline for suicide prevention, *Assessment and Management of Patients at Risk for Suicide*, which was released in June 2013 and announced at the Clinical Approaches summit in November 2013. The Departments are collaborating to produce tools to assist with implementation of these guidelines. VA developed a pocket guide entitled *Patients at Risk for Suicide* (healthquailty.va.gov) based off of the guidelines set forth in the 2013 VA/DoD clinical practice guideline on suicide prevention. The tool walks providers through risk factors, protective factors, suicide risk levels, admission criteria, evidence based practice, discharge planning, and other details to assist with management of patients who are at risk for suicide.

A joint training program has also been developed and is currently available for both VA and DoD employees through their respective on-line training sites (qmo.amedd.army.mil/Video/SUICIDE_CPG_130911-F4MHD_WMV_854x480_639Kstd.wmv). In support of this joint initiative, the DoD Deployment Health Clinical Center posted suicide specific clinical guidance, policies and directives, implementation tools, education and training, research information, and brochures and fact sheets for clinician use (pdhealth.mil/clinicians/suicide.asp#EAT).

On-going Efforts. VA Suicide Prevention Coordinators are required to provide Veteran-specific suicide awareness training to all new VA clinical and non-clinical employees on an ongoing basis. All Suicide Prevention Coordinators are also required to provide training and information to community based groups and organizations, at a minimum of five outreach activities per month. This is tracked and monitored through the VA Suicide Prevention Coordinator outreach tracking system and reported to the National Suicide Prevention Office on a monthly basis. In FY 2013, Suicide Prevention Coordinators

averaged over seven outreach actions per Suicide Prevention Team per month. Veterans Benefit Administration staff also receive training by the Veteran's Health Administration Suicide Prevention Coordinators. DoD is providing crisis management and suicide prevention training and educational sessions to disseminate best practices. This includes training Public Affairs officers at the Defense Information School, recovery care coordinators, military commanders, mental health providers, DoD supervisors, Chaplains and other DoD personnel.

Military Services. In addition to supporting joint DoD/VA programs, the Defense Suicide Prevention Office provides oversight and guidance to each Service in the area of suicide prevention. Specifically, each Service:

- Has a full-time suicide prevention program manager who leads the Service's efforts on behalf of its senior leaders.
- Has a formal suicide prevention program that includes directives and regulations that guide program oversight, the tracking of fatal and non-fatal suicide attempts, reporting, training, and leadership responsibilities and engagement.
- Encourages leaders to engage with their troops at all levels and create a command climate that promotes and encourages a proactive help-seeking environment in their units.
- Takes action to address drug and alcohol use, safety violations and criminal activity, as well as enhancing protective factors and building resilience among their members using the Total Force Fitness Framework directed by the Chairman of the Joint Chiefs of Staff.
- Recognizes that suicide prevention efforts must be taken as part of a comprehensive effort to address various high-risk behaviors.

Department of Veterans Affairs. In VA, the Suicide Prevention Coordinators serve a key role. There are between one and three Suicide Prevention Coordinators at each Medical Center and very large Community-Based Outpatient Clinics. Suicide Prevention Coordinators are mental health professionals who devote 100 percent of their time to suicide prevention activities. Among many other functions, Suicide Prevention Coordinators have the following roles and responsibilities:

- Ensuring all referrals sent to them from the Veterans Crisis Line, other call lines, e-mails and external and internal sources are appropriately responded to within one business day.
- Continuing contact and monitoring with Veterans who have been identified as being at high risk for suicide to ensure that they receive appropriate care and treatment. They ensure that each high-risk Veteran has a medical record notification entered into the medical record and that they receive suicide-specific enhanced care which includes evidence-based treatment strategies for their diagnosed concerns.
- Ensuring that providers are trained on the VA Safety Planning procedure and understand the basics of using Safety Planning as an intervention. Safety plans are developed with Veterans and used to guide on-going care.
- Ensuring that patients identified as being at high risk for suicide receive prompt follow-up care for any missed mental health and substance use appointments. Patients who miss appointments are called to determine why the appointment was missed. The appointment is rescheduled if

possible or if a Veteran cannot be found, a safety check occurs by identified family or emergency responders.

- Delivering Operation S.A.V.E. training (Know the Signs of Suicide, Ask the question, Verify the experience with the Veteran, Expedite getting help) or other approved training to all non-clinical staff. The Suicide Prevention Coordinators are also responsible for the delivery of other training programs at the site by request of the facility. All clinical staff members take the *Clinical Risk Assessment and Treatment for Suicide* training in the VA Learning Management System.
- Building relationships with local and state suicide prevention organizations, local crisis line organizations and local Veteran Service Organizations.
- Tracking and monitoring all suicide-related events in an internal data collection system which allows VA to determine trends, common risk factors, and provide information on how best and where to address concerns.
- Providers work with patients to maintain the lowest number of prescription drugs as possible. Suicide Prevention Coordinators are well aware of this risk factor.

The number one strategic goal of the Veterans Health Administration (VHA) is to provide Veterans personalized, proactive, patient-driven health care. VA Mental Health Services, the Office of Mental Health Operations, and the Office of Patient Centered Care and Cultural Transformation are embarking on an initiative to capitalize on the personalized, proactive, patient-driven approach to health care as an expanded strategy for Suicide Prevention. The VA established the Mental Health Innovations Task Group to lead a Veteran centered initiative that will focus on the five diagnoses associated with increased risk for suicide: PTSD, depression, sleep disorders, substance use disorders and chronic pain. At the core of this new approach is a model of care that is focused on what matters to the patient in which providers partner with the patient to create a strategy to optimize the patient's health and well-being, while providing state-of-the-art disease and illness management. This approach is designed to address the full range of physical, emotional, mental, social, spiritual and environmental influences. VA is interested in finding new ways to establish relationships with Veterans who have these conditions and engage them early in care. VA will consult with DoD and HHS regarding new innovations that may have broader applicability.

There are multiple factors that contribute to suicide behaviors. These include societal factors, cultural and racial differences, gender and sexual orientation and the presence of substance use disorders and mental illness (see VA 2012 Suicide Data Report for examples of demographic factors as they relate to Veteran suicide va.gov/opa/docs/Suicide-Data-Report-2012-final.pdf). It is difficult to evaluate existing efforts that are intended to create supportive environments to promote the general health of the population and reduce the risk for suicidal behaviors and related problems at the general population level because of these variances in risks at the sub-population levels.

Additionally, data is not readily available to track suicide thoughts, plans, attempts and deaths among persons who are Family members of persons who have served or are serving in the military services. The stress on Family members of Veterans and Service members is, however, well documented. SAMHSA is working to capture some of this information in its National Survey on Drug Use and

Health that tracks national substance use and mental health issues among the non-military U.S. population. New questions were added to the Survey in 2013 to help identify the era/conflict served by Veterans and questions will be added in 2015 to identify Family members of Active Duty personnel, allowing for a better understanding of how respondents actually served (e.g., when served and if it was in a combat zone), and providing the data to generate tables showing the number of persons who ever served in the armed forces and attempted suicide and respondents not on Active Duty status. The Survey can also generate tables of suicidal ideation and attempted suicide among Veterans, Service members and Family. More detail on the type of Veteran respondent, including the conflict in which they served, in the Survey will be possible with the analysis of the 2013 data. SAMHSA will begin analyzing the data runs to provide some information on these questions. Further work also needs to be done to identify, track and address the special mental health and substance use needs of Family members of Veterans and Military Service members.

Recommendation 3

Align goals and metrics of mental health and substance abuse programs with national goals and metrics.

In October 2013, the co-chairs of the Interagency Task Force charged representatives from HHS SAMHSA and Health Resources and Services Administration (HRSA), DoD, VA and the National Research Action Plan to develop recommendations around a core set of metrics for use in the provision of services, program management and evaluation to track progress in addressing psychological health conditions among Veterans and Active Duty, Reserve and Guard components. VA is able to monitor trends, but ICD-9 codes and DSM-5 diagnoses do not distinguish the source of drugs (illicit, prescription, etc.). VA is already implementing monitoring of patient report of drug use days within substance use disorder specialty care. As noted above, this will be a topic for future discussion by the Interagency Task Force. The Interagency Task Force Work Group on Common Mental Health Metrics held face-to-face meetings in November and December 2013 and a telephone conference in early January 2014 to consider metrics, implementation issues and additional issues that will need further consideration as the recommendations are acted upon. It was agreed that this effort should continue to be coordinated with but remain distinct from efforts to identify and promote common data elements for TBI, PTSD and suicide prevention research that are being undertaken by the National Research Action Plan agencies in response to the Executive Order.

A significant factor underlying this effort is a common understanding that reducing mental distress and improving psychological health among Veterans and Active Duty, Reserve and Guard components is a critical task for the nation. These conditions are associated with reductions in readiness among Active Duty and Reserve personnel and are also associated with high levels of disability and substantial costs that can lead to significant morbidity and premature mortality. The goal of the Metrics Work Group is to afford providers who work with Veterans and Active Duty, Reserve and Guard components a common set of metrics to measure mental distress and related conditions and track progress to inform clinical and programmatic decisions.

Emphasis has been placed on identifying measures that could address high volume and high impact psychological health conditions and on finding instruments that:

- Could be easily administered across various settings to track progress in recovery
- Have the potential to harmonize with other measurement initiatives
- Have strong reliability and validity
- Could reflect outcomes relevant both to improved psychological health and readiness
- Would be useful within the range of episodes of care within the various service and program-centered episodes of care

To that end, the group focused on identifying a core set of measures that capture PTSD, depression, anxiety, alcohol and tobacco use, and reflect critical and common priorities across Departments at this time. The Metrics Work Group recognizes that its current recommendations are not comprehensive and that other areas of concern (e.g., prescription drug misuse) will need to be considered in the future as the effort of standardized outcome measurement matures. The Work Group submitted a detailed report in February 2014 that provides a brief set of recommendations for measures to be implemented in the immediate future by the Departments. However, the group recognizes that making infrastructure changes within each Department to support data collection, analysis, and data sharing across Department-specific information technology platforms will require substantial resource investment and training initiatives and, consequently, full implementation of routine psychological health outcome data collection will likely require 18-24 months. Upon acceptance of the recommendations outlined in this document, each service/agency will develop an implementation plan within three months. This plan shall take into account factors that are expected to impact each service/agency's ability to administer specific instruments, collect data, and enter and analyze data electronically. Implementation plans will include strategies for implementation, identify agency-specific barriers to implementation, and establish a realistic timeline within which there will be full implementation.

In addition to the Interagency Task Force Work Group on Common Mental Health Metrics, an Integrated Mental Health Strategy joint DoD/VA task group focusing on quality and outcome measurement in 2013 provided recommendations on mental health metrics that would be appropriate in both Departments. The task group used the adapted National Quality Forum process to provide consensus recommendations for an initial set of process-oriented quality metrics. Currently, the task group is using the same approach in finalizing recommendations for an initial set of patient-reported outcome metrics.

Progress/Accomplishments:

Review of Department of Veterans Affairs Mental Health Outcomes Monitoring and Population Health Programs

VA has initiated development of a comprehensive framework of outcome monitors, based on the mental health outcomes framework of the National Quality Forum, with emphasis on the following categories

of outcomes (1) direct patient health outcome; (2) health care utilization as an indicator of clinical adverse event; or (3) clinical processes associated with patient outcomes. To date, 23 measures in nine of the 12 National Quality Forum categories have been developed.

The work has been divided into three phases. The first phase was the definition and coding of desired metrics; this was completed in June 2013. The metrics are currently undergoing evaluation and validation. When validation is complete, these metrics will be integrated in the 2014 VHA site visits as part of the following process:

National Quality Forum Category	Mental Health Outcomes-Oriented Metric
Recovery	<ul style="list-style-type: none"> • Percent of patients with Serious Mental Illness diagnosis who receive Mental Health (MH) Intensive Case Management or Psychosocial Rehabilitation and Recovery Center services • Percent of patients with Serious Mental Illness diagnosis who receive any Transitional Work or Supported Employment services
Incidence/Prevalence of Conditions	<ul style="list-style-type: none"> • Percent of primary care patients screened as at risk of alcohol misuse (also moderate/severe and severe risk) (three metrics) • Percent of primary care patients screened for alcohol misuse • Percent of outpatients screened for tobacco use • Percent of patients diagnosed with a MH condition
General Medical	<ul style="list-style-type: none"> • Influenza immunization rates for patients aged 50-64 and over age 65 who receive outpatient MH services (two metrics) • Number of VA emergency department visits among patients with MH diagnoses
Direct Physiological Markers	<ul style="list-style-type: none"> • One-year rate of new diagnoses of diabetes in patients who receive a new atypical antipsychotic medication prescription (which increases risk of obesity) • Incidence of obesity among overweight patients who receive an atypical antipsychotic medication prescription
Symptoms	<ul style="list-style-type: none"> • None presently available (see Phase 2)
Functioning	<ul style="list-style-type: none"> • None presently available (see Phase 2)
Patient Experience	<ul style="list-style-type: none"> • None presently available (see Phase 2)
Change in Health-Related Behaviors	<ul style="list-style-type: none"> • Percent of outpatients with a positive screen for tobacco use • Percent of VHA outpatients with low, good, and high antipsychotic medication possession ratio (three metrics)

National Quality Forum Category	Mental Health Outcomes-Oriented Metric
Social Determinants of Health	<ul style="list-style-type: none"> • Percent of patients with MH diagnosis who have onset homelessness
Service Use	<ul style="list-style-type: none"> • Rate of inpatient readmission among patients with MH diagnosis • Loss to VHA care among patients with Serious Mental Illness
Safety/Adverse Events	<ul style="list-style-type: none"> • Percent of patients on chronic opioid therapy who receive drug screen
Mortality	<ul style="list-style-type: none"> • Adjusted suicide re-event rate • Standardized mortality ratios for patients with MH diagnosis

The second phase is the implementation of a telephone-based survey for Veterans who have recently begun a new episode of mental health care. A pilot project was completed in 2013, with 1,140 Veterans included from six VA Medical Centers. This has informed a larger scale effort for the Veterans Outcome Assessment Survey, which is currently in development. The plan is to include a telephone survey of 400 Veterans each quarter. Calls will be made from the VA National Call Center staff. Sampling will be from individuals who have utilized mental health care, and calls will be targeted to reach individuals near the time that they first receive care and at a three-month follow-up point. This will include Veterans who are no longer utilizing mental health care, something that is not possible when measurement is only completed in the care setting. The 42-item survey includes questions designed to help VA understand the patient’s symptoms, their functioning, and satisfaction with VA mental health care. Objectives of the Veterans Outcome Assessment Survey include; (1) describing symptoms and level of functioning at the onset of MH treatment in VA; (2) measuring satisfaction and improvements in symptoms and level of functioning during the initial period of treatment; and (3) identifying Veterans Integrated Service Networks-level variations and change in satisfaction and outcomes over time.

Phase 3 is planned for longer-term implementation of measurement-based care that includes the symptom monitoring tools being identified through the Interagency Task Force Work Group.

Review of Department of Defense Psychological Health Programs

To provide the best mental health and substance use prevention, education and outreach support to our military and their Family members, the Executive Order required that DoD review all existing mental health and substance use prevention, education and outreach programs to identify the key areas that produce the greatest impact on quality and outcomes. The programs were then ranked within each of these areas using metrics to assess their effectiveness.

The purpose of the analysis is to improve the effectiveness of DoD Psychological Health and Traumatic Brain Injury programs by identifying industry best practices for establishing systems and/or monitoring efficacy and effectiveness, conducting an assessment of the current state of DoD Psychological Health and Traumatic Brain Injury programs, and developing a Report of Findings to inform senior

management of programmatic and resource-related decision-making. The intended results of this initiative are (1) increased visibility and monitoring of Psychological Health and Traumatic Brain Injury programs and outcomes; (2) allocated funds to programs that can demonstrate effectiveness to the DoD; and (3) increased access for Service members and their Families to Psychological Health and Traumatic Brain Injury programs that are constructed on evidence-based practices, address their unique needs and are proven to be cost-effective.

To date, the following progress has been made:

- Defense Center of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) launched Psychological Health PH Effectiveness Initiative in January 2012.
- DCoE completed the Psychological Health Program information collection procedures in March 2013.
- Scientific Panel review was completed in April 2013.
- DCoE developed an internal Report of Findings in September 2013 as part of the five year ongoing effort through 2017 to evaluate PH and TBI programs and provide support in improving their effectiveness.
- DCoE provided a Summary Report to Office of Management and Budget in September 2013.
- DCoE provided internal individual program-specific reports to Program POCs and Service-level points of contact in September 2013.

Current Status and Way Forward. In FY 2014, DCoE received additional direction from the Office of the Assistant Secretary of Defense for Health Affairs to collect and evaluate more comprehensive information from both Psychological Health and Traumatic Brain Injury programs toward identifying program characteristics that indicate effectiveness and program cost. As such, DCoE improved upon FY 2013's Information Collection and Assessment methodology by gathering programmatic information via telephonic interviews in lieu of web-based collection. This improved methodology enhances accuracy by minimizing the variation in responses across programs and reducing the amount of missing data submitted by programs. Another key feature of DCoE's improved methodology in FY 2014 is a rapid evaluation review process of the collected programmatic information by subject matter experts. This review process enables evaluations with both clinical and non-clinical Psychological Health and Traumatic Brain Injury programs at different stages of maturity.

In addition to the above phased approach with regard to FY 2014 Information Collection and Rapid Evaluation efforts, Traumatic Brain Injury programs are being reviewed in Quarter 3 by a Scientific Panel of federal (non-DoD) personnel with shared expertise in program evaluation, in addition to expertise in Traumatic Brain Injury and other health care fields. This Scientific Panel is comparable to the Scientific Panel review that occurred in FY 2013 with Psychological Health programs. Scientific Panelists will review and score each Traumatic Brain Injury program using the Program Scoring Tool. The results of the Traumatic Brain Injury Scientific Panel will be compared to the rapid program evaluation scores provided by the program evaluation subject matter experts. This comparison will be

included in the Quarter 4 report to the Office of the Secretary of Defense for Cost Assessment and Program Evaluation.

Expanding Access and Ensuring Parity for the Department of Defense’s TRICARE Mental Health

Millions of Americans with mental health or substance use disorders do not have adequate insurance protection against the costs associated with treatment of these disorders. The Mental Health Parity and Addiction Equity Act makes it easier for those Americans to get the care they need by prohibiting certain discriminatory practices that limit insurance coverage for behavioral health treatment and services.

DoD provides a generous and comprehensive mental health benefit via TRICARE to Active Duty Service members, Retirees and their Families, including psychiatric outpatient, inpatient, partial hospitalization and residential treatment services. The Department is intently focused on ensuring that the behavioral health of its Service members and their Families remains a top priority. Over the last several years, DoD has hired more behavioral health specialists, brought on Public Health Service medical professionals, expanded the TRICARE network, issued regulations to recognize the independent practice of certified mental health counselors, worked to further de-stigmatize mental health treatment and expanded the ways by which our beneficiaries can access mental health services.

Although the TRICARE program is governed by a separate set of statutes than those applicable in the civilian sector, DoD fully supports the principle of mental health parity and is taking steps to remove statutory and regulatory limitations which may create barriers to accessing mental health treatment. DoD has commenced a review of TRICARE mental health, substance use and medical/surgical benefits in order to assess and address any perceived gaps in parity. DoD will modify its regulations and request legislation where necessary to eliminate any requirements the Department believes are no longer necessary and may be viewed as barriers to medically necessary and appropriate mental health services.

Mental Health Parity under TRICARE

The Department of Defense regularly reviews TRICARE benefits and has taken the opportunity created by the recent release of the final rule implementing the Mental Health Parity and Addictions Equity Act to take a fresh look at mental health benefits covered for our Active Duty Service members, Retirees, and their Families.

Review of Department of Defense Suicide Prevention Programs

The DoD Defense Suicide Prevention Office has embarked on an effort, in concert with the military Services, to evaluate all DoD programs that attempt to directly reduce the rate of suicides and suicide attempts. This will be followed by an evaluation of other programs within DoD that may demonstrate a relationship to suicide prevention efforts because they indirectly contribute to resilience factors. The

Defense Suicide Prevention Office will use an electronic Planning, Programming, Budgeting, and Execution System tool to help measure suicide prevention and resilience program effectiveness. The ultimate purpose of these efforts is to improve the efficiency and effectiveness of the DoD suicide prevention and resilience portfolio.

Department of Defense Substance Use Disorder Policy and Programs

In 2012, DoD released a review of policies and programs for the prevention, diagnosis, and treatment of substance use disorders in members of the Armed Forces, and in parallel, an external review of DoD substance use disorder policy and programs was conducted by the Institute of Medicine. The results were conveyed in a report entitled *Substance Use Disorders in the U.S. Armed Forces* which was published in September 2012. The Institute of Medicine presented 20 broadly stated findings under three major topic areas: (1) Policies and Programs on substance use disorders; (2) Access to Care for Service members and beneficiaries with a substance use disorder; and (3) Strengthening the substance use disorder Workforce. As a result, DoD revised policies related to the management of substance use disorders and recently published (in February 2014) DoD Instruction (DoDI) 1010.04, *Problematic Substance Use by DoD Personnel*, which address prevention, screening and intervention for substance use disorders in the military. In addition, DoD has published a proposed rule lifting the ban on opioid replacement therapies.

Screening, Brief Intervention, and Referral to Treatment

The Screening, Brief Intervention, and Referral to Treatment (SBIRT) model is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. SBIRT includes the routine screening of patients for unhealthy alcohol use by using an empirically validated measure and prescribes interventions consistent with an identified risk.

DoD conducts alcohol screenings for Active Duty Service members using an empirically validated instrument as part of the deployment cycle. DoD Instruction 6490.12, *Mental Health Assessments for Service members Deployed in Connection with a Contingency Operation*, signed February 26, 2013, requires screening at four time periods surrounding deployment: within 120 days of deployment; between 90 and 180 days after return from deployment; between 180 days and 18 months after return from deployment; and between 18-30 months after return from deployment. Post-Deployment Health Assessment and Post-Deployment Health Re-Assessment forms were recently revised to provide additional guidance for providing feedback to Service members based on their risk for unhealthy alcohol use. To date, over 800,000 Active Duty personnel have been screened using this method.

While Service members are routinely screened for mental health concerns during the deployment cycle, widespread implementation of SBIRT within primary care settings provides an opportunity for early identification of substance use, allowing for proper intervention with military treatment facility beneficiaries as needed. The Office of National Drug Control Policy, SAMHSA, and VA support the use

of the SBIRT program in primary care. DoD policy has recently been promulgated to require regular and systematic medical screening for alcohol misuse and implementation of the SBIRT model in primary care settings. Use of the three-item Alcohol Use Disorders Identification Test has been incorporated into electronic medical record primary care workflow forms for use in the Patient-Centered Medical Home. These efforts will ensure a standardized, integrated approach to the screening, education and early intervention of personnel for unhealthy alcohol use. In support of DoD's implementation of SBIRT, the Defense Health Agency and Defense Center of Excellence For Psychological Health and Traumatic Brain Injury are collaborating on the development and implementation of a training protocol intended to train primary care physicians and behavioral health personnel on the SBIRT model. For 2014, DoD will begin tracking rates of alcohol screening in primary care encounters.

SAMHSA, through its funding of SBIRT programs to states, has seen the implementation of the SBIRT model within several National Guard units that have partnered with state SBIRT grantees. Since 2013, the states of Iowa, Tennessee, North Carolina, Connecticut and Indiana have worked with state National Guard units to provide SBIRT services to Guardsmen and women. Each program has its own unique aspects, though typically, the screening and brief intervention process primarily occurs during yearly health assessments, weekend drill activities and Yellow Ribbon events. The results of the screenings and subsequent brief interventions or referrals are confidential and typically conducted by civilian providers. This appears to have led to greater degree of disclosure of substance misuse or abuse, and led to increased numbers of Service members being motivated to address their substance use problems. Additionally, SAMHSA facilitated a series of SBIRT trainings of resident physicians at the Walter Reed National Military Medical Center which educated and trained residents in addressing substance use problems with their patients using the SBIRT model.

DoD Population Health Metrics on Alcohol and Tobacco Use

The DoD Survey of Health Related Behaviors of Active Duty military personnel represents the largest anonymous, population-based health survey of Service members. The survey is conducted approximately every three years and assesses the health of Service members on a wide range of topic areas to include alcohol and illicit and prescription drug use. This study informs DoD actions on the revision and development of effective policy and program strategies intended to improve the prevention, diagnosis and treatment of substance use disorders.

Due to the significant changes in survey questions and methodology for the 2011 Health Related Behaviors survey, direct comparison of the 2011 Health Related Behaviors survey findings with those of previous reports is not appropriate (i.e., survey findings from different survey years cannot be used to identify trends over time). However, changes to the 2011 survey methodology have proposed a more transparent and accurate assessment of the status of health related behaviors in the military.

Alcohol Use. Overall, the survey found that 84.5 percent of Active Duty Service members are current drinkers, with 58.6 percent classified as light or infrequent drinkers. However, 8.4 percent are heavy drinkers and 33.1 percent reported binge drinking. The definitions for heavy drinking and binge drinking

were modified between the 2008 and 2011 Health Related Behaviors survey, with the recent survey utilizing definitions established by the 2010 National Health Interview Survey from the Centers for Disease Control and Prevention.

When examining the relationship between age and alcohol use, the findings reveal that 18 to 35 year old personnel report heavy drinking almost double their civilian comparison groups (2010 National Health Interview Survey Questionnaire, sponsored by Centers for Disease Control and Prevention). Reported heavy drinking is less in populations who are 36 years and older. However, binge drinking rates by age tend to be below the civilian rate (2010 National Survey on Drug Use and Health Questionnaire, sponsored by SAMHSA), but still higher than the Healthy People 2020 target of 24.3 percent.

Additional improvements to the screening of personnel during medical encounters may result in early identification of unhealthy drinking and provide opportunities for early intervention. In 2014, DoD will conduct the next iteration of the Health Related Behaviors survey, which will provide updated data on alcohol and prescription drug use patterns within the military population.

Smoking Cessation. While tobacco use has dropped significantly for Americans during the last two decades, the Health Related Behaviors survey found 24 percent of Service members smoke cigarettes compared to the civilian average of 21.2 percent, with younger Service members having a higher frequency rate compared to the civilian age-matched population (2011 Health Related Behavior Survey). Tobacco use impairs DoD's war-fighting mission. Military personnel who use tobacco products experience reduced capacity for physical performance. Smoking impairs endurance and night vision, increases risk of respiratory illnesses and, especially pertinent for our Wounded Warriors, delays wound healing and increases surgical complications. Nicotine in tobacco may increase the risk of sudden death from a condition where the heart does not beat properly. Active duty personnel who use tobacco often remain long-term beneficiaries of the military health system or enter the VA system. Tobacco related medical care and lost work related to tobacco use costs the DoD \$1.6 billion annually, and the DoD and/or VA may bear the costs associated with an individual's tobacco use for decades. As part of efforts to reduce smoking and tobacco cessation in the military, DoD announced TRICARE in March 2013 that beneficiaries were eligible for tobacco cessation medication in addition to 24/7 chat via instant messaging, toll-free telephone coaching, and counseling with certified tobacco cessation counselors, upon referral by a primary care physician.

In 2013, DoD published the final rule, *TRICARE: Smoking Cessation Program* (Federal Register, Vol. 78, No. 39, February 27, 2013) implementing a comprehensive smoking cessation program under TRICARE to include: the availability, at no cost to the beneficiary, of pharmaceuticals used for smoking cessation; face-to-face smoking cessation counseling; access to a toll-free quit line 24 hours a day, 7 days a week; and, access to print and Internet web-based tobacco cessation material. The Department is near full implementation of all components of the TRICARE Smoking Cessation Program and is currently developing procedures to report on program metrics required by Section 713 of National Defense Authorization Act for FY 2009, including smoking cessation rates and estimated medical cost savings as a result of these interventions. For 2014, DoD will begin collecting data on utilization of

these program components and any available findings on their effectiveness in helping TRICARE beneficiaries to quit smoking.

Recommendation 4

Encourage and partner with communities to support mental health and substance abuse outreach, prevention, treatment and recovery services for Veterans, Service members and their Families.

On June 3, 2013, President Barack Obama and Vice President Joe Biden hosted a National Conference on Mental Health at the White House as part of the Administration's effort to launch a national conversation to increase understanding and awareness about mental health. The conference brought together people from across the country, including mental health advocates, educators, health care providers, faith leaders, Members of Congress, representatives from local governments and individuals who have struggled with mental health problems, to discuss how they can work together to reduce negative attitudes and help the millions of Americans struggling with mental health problems recognize the importance of reaching out for assistance. The conference builds on a number of steps to raise awareness and improve care for those experiencing mental health issues, including Veterans and their Families. For example:

- **Expanding Mental Health Coverage.** The Affordable Care Act expands mental health and substance use benefits and parity protections for about 62 million Americans. Thanks to the health care law, beginning in 2014, insurers can no longer deny anyone coverage because of a pre-existing mental health condition. The law already ensures that new health plans cover recommended preventive benefits without cost sharing, including depression screening for adults and adolescents and behavioral assessments for children.
- **Supporting Young People.** The President's FY 2014 Budget includes a new \$130 million initiative to help teachers and other adults recognize signs of mental illness in students and refer them to help if needed, support innovative state-based programs to improve mental health outcomes for young people age 16 to 25, and helps train 5,000 additional mental health professionals with a focus on serving students and young adults.

At the conference, the President highlighted that VA directed 152 of its health care centers nationwide to conduct Mental Health Summits with community partners, including local government officials, community-based organizations and Veterans Service Organizations between July 1, 2013 and September 27, 2013. The Summits were designed to identify and link community-based resources to support the mental health needs of Veterans and their Families, as well as help increase awareness of available VA programs and services.

On July 11, 2013, the White House hosted Veterans and Military Family Mental Health Conference, bringing together Administration leaders, Veterans Service Organizations, military service organizations, nonprofit and nongovernment organizations, along with mental health professionals and

leaders from DoD and VA. This event served as a precursor to the 152 VA Mental Health Summits convening across the country in an effort to continue this conversation at a local level.

At the event, representatives of the Administration affirmed their commitment to raising awareness, building treatment capacity, investing in research and increasing access to mental health care. Active collaboration and coordination with partners in the community is critical to ensuring all the men and women who served our country and their Families have the care they need and deserve. Conference participants discussed best practices for partnerships, the health and mental needs of military children, and the unique role Veterans Service Organizations, nonprofit and nongovernment organizations, medical associations and community providers play in addressing these particular needs.

Progress/Accomplishments:

Department of Veterans Affairs Mental Health Summits

Planning Guidance for VA Mental Health Summits

- Direction provided by memorandum and VHA announcements at key teleconferences.
- A series of technical assistance calls with facility designated points of contact.
- A web based repository for all materials and information was developed.
- An electronic map of sites and summits placed on web page.
- Informal responses to e-mails and phone calls were provided to support the sites.

Responding to the President's call, the VA Under Secretary for Health instructed each VA Medical Center (VAMC) to host a Community Mental Health Summit. The purpose of the summits was to build or sustain collaborative efforts with community providers that would enhance mental health services for Veterans and their Families. These Summits supported the Executive Order charge for VA to ensure that Veterans and their Families receive mental health services in partnership with community providers through "an integrated network of support."

Each VAMC framed the specific purpose and objectives of their summit slightly differently and included community participants based on its

unique needs and community dynamics. Mental health staff and facility leadership (e.g., Director, Chief of Staff) were well represented at every summit.

Each VA Medical Center submitted a Mental Health Summit Plan by June 26, 2013. The VA Central Office Mental Health Summit Work Group reviewed each plan and provided feedback as needed. With the exception of one VAMC which postponed its summit until November 7, 2013 as a result of physical facilities issues almost all VAMCs completed a summit between July 1, 2013 and September 30, 2013. The format for the summits included breakout sessions or small group discussion to encourage active dialogue and engagement. Within two weeks of completion of their Mental Health Summit, each VAMC

submitted an After Action Report which included participant survey results as well as action items developed as a result of the summit.

Post-Summit Data is outlined below:

- Over 12,000 participants attended 152 summits
 - Average of 84 attendees per site.
 - VA employees attending the Summits included a broad range of VA staff including Facility Leadership, Public Affairs Officers, Chaplains, Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn Care Managers and Women’s Health Coordinators among others.
- Just over half of the sites devoted a full day to the summit;
 - Average of 4.82 hours.
- Post-Summit Surveys received from 4,569 participants nationwide;
 - 36 percent response rate.
- More than 60 percent of respondents were community-based.
- Veterans and Families were well represented in both VA and community-based attendees, comprising nearly one-half of all respondents.
- Each facility provided narrative descriptions of the agenda, breakout groups, lessons learned, and areas for follow-up action.

As a result of the Mental Health Summits, areas for future collaboration were identified. More than 85 percent of respondents said the following outcomes were likely as a result of these meetings: (1) better understanding of available VA mental health care services and how to refer Veterans to VA for care; and (2) better understanding of available community-based programs and services to support the mental health needs of Veterans and their Families. Seventy percent reported that the Summits were likely to result in strengthened VA and community relationships. Of note, respondents endorsed significantly lower expectations for improvement in the status of Veterans’ Families than for that of Veterans themselves, indicating a need for action on the family front across the VA/Community continuum.

Responses across 152 Mental Health Summits reveal common needs and concerns. The leading issues and corresponding action steps are as follows:

Survey Responses
<ul style="list-style-type: none">• Almost 90 percent “...more likely to collaborate with VA and other community-based organization going forward to enhance mental health care of Veterans or their Families.”• More than 85 percent gained better understanding of VA mental health services and how to refer to VA.• 85 percent of respondents agreed that the summit resulted in “tangible” methods to improve/enhance the mental health and wellness of Veterans.• 70 percent said that the summit process strengthened community-VA relationships.• Near unanimous endorsement (94 percent) among respondents of desire to attend another Mental Health Summit.

- 84 sites are developing joint Community Resource Directories with contact information for VA and community programs and helpful descriptions of each resource.
 - The Issue: The National Resource Directory has been developed by VA, DoD and the Department of Labor to connect Service members, Veterans, their Families and caregivers with needed support. The Mental Health Summit process has the potential to serve as a facilitated pathway to fully populating and promoting the National Resource Directory through the joint efforts of VA and Community partners.
 - Action: VA Mental Health (MH) will work with VA and Community Summit participants at each site and with the National Resource Directory team to improve dissemination of information both within and outside VA through enhanced population of the National Resource Directory.
- Forty-three sites plan to identify a VA POC with whom Community Partners can approach for prompt information about VA eligibility and a *warm handoff* to VA MH services in routine as well as urgent situations.
 - The Issue: Although VA has established a broad range of specialty points of contact, Community Partners are often unsure about VA eligibility requirements, unaware of key VA services, and uncertain about who to call at VA for quick response and appropriate triage. By the same token, VA staff often lack knowledge about Community Partners necessary to optimize transitions between VA and Community systems of care. Establishing a Community MH point of contact, “navigator,” at each VA Medical Center would cultivate a valuable repository of knowledge about VA and Community Partners and a dynamic new set of working relationships. The Navigator would also be well positioned to identify opportunities for dissemination of VA trainings/best practices in Community settings (much desired by Summit Participants) and provide ongoing liaison with Community MH Partners between Summit meetings.
 - Action: By April 30, 2014 each VA Medical Center had identified a Community MH point of contact/Navigator to provide ready access to information about eligibility and VA clinical services, warm handoffs at critical points of transition between systems of care and ongoing liaison between VA and Community Partners.
- Seventy percent of the 4,569 survey participants reported that they left the Summit without having improved their military and Veteran cultural competency.
 - The Issue: Cultural Competence has long been considered central to clinical practice but it is only recently that the need for Military Cultural Competence has been recognized. This is unfortunate since approximately one in 10 Americans age 17 or older is either a Service member or a Veteran and as many as one in five Americans is either a Service member, a Veteran or a Family member. Service members, Veterans and their Family members tend to adhere to core assumptions of military culture including a sense that they should “suck it up” rather than “complain” about health problems. They are also reticent about sharing their military experiences and military-related health problems with civilians (including their civilian health care providers). In order to ensure that cultural barriers don’t prevent

recognition of medical problems or, at a still more fundamental level, interfere with the very identification of a patient as a Service member or a Veteran, it is important that community partners understand military culture.

- Action: Every VA Medical Center will work with its community partners to disseminate available curricula and best practices regarding military culture created as part of the DoD/Integrated Mental Health Strategy process (available at deploymentpsych.org/military-culture) and those developed by a partnership of the HRSA, the National Area Health Education Center Organization and Citizen Soldier Support Program (aheconnect.com/citizensoldier). VA Medical Centers will also promote awareness of the Community Provider Toolkit (www.mentalhealth.va.gov/communityproviders/). Since its launch in October of 2012, the site has been viewed 92,623 times (total page views) through March 31, 2014.
- The words *Family* or *Families* appeared 66 times in facility reports indicating that Family issues are of significant concern among Summit participants. On the other hand, 64.6 percent of survey respondents reported that their participation in the Summit had not improved their understanding of Veteran Families' mental health needs and care. In addition, 61.3 percent of respondents reported that the Summit had not contributed to better identification and enhanced understanding of community-based programs and services to support the mental health needs of Veterans' Families.
 - The Issue: VA has made significant strides in recognizing and addressing the needs of Family members as an essential component of care for Veterans, yet Summit responses indicate that Veterans' Families still face significant challenges across the VA/Community continuum of care.
 - Action: VA will prepare a briefing packet of VA Family services and resources including but not limited to family counseling, caregiver support, parenting assistance and access to VA support services including the Coaching Into Care call center and the VA Crisis Line. This packet will be distributed to Community Partners through each VA Medical Center by April 30, 2014. Future Summits will include at least one breakout session on Family Issues and the Mental Health point of contact/Navigator will incorporate this information into all community trainings and liaison activities as part of a national effort to better engage and inform Family members in VA and Community care.

In addition, survey responses identify the following common set of recommendations as key elements of ongoing VA/Community response:

- Identify VA enrollees also receiving care in the community to optimize Veteran-centered, coordinated health care.
- Enhance the ability of community providers to identify Veterans and their Family members whether or not the Veteran is enrolled in VA.
- Train community providers to take a military history and document it in the medical record.

- Support Veterans by addressing the needs of Veterans’ Families across the VA/community continuum.
- Recognize that no Veteran can be treated in a vacuum.

Findings indicate that the VA Community Mental Health Summits were effectively implemented and enthusiastically received. The summits provide a facilitated pathway to the President’s vision of “an integrated continuum of care capable of providing effective mental health services for Veterans, Service members and their Families.” Local facilities will work to schedule additional, follow-up summits over the course of the coming year. Another round of 152 Summits have been slated for 2014 and will be held prior to September 15, 2014.

Community Conversations

The sense of shame and secrecy associated with mental illness prevents too many people from seeking help. To address this, the President, through The Time Is Now report, directed Secretaries Sebelius and Duncan to launch a national dialogue about mental illness with young people who have experienced mental illness, members of the faith community, foundations, and school and business leaders. As a result, several communities held conversations addressing the concerns about and solutions for seeking appropriate help for mental illness.

Substance Abuse and Mental Health Services Administration Policy Academies

In partnership with VA, DoD, the National Guard and private organizations, SAMHSA hosted seven Service members, Veterans and their Families Policy Academies to assist 46 states, four territories and the District of Columbia, in meeting their goals to address the behavioral health needs of their military members, Veterans and their Families. The Policy Academies support a 10-member interagency, long-term team of state or territory leadership by providing trained facilitators and subject matter experts in a variety of fields, to help them build a strategic plan. The resulting plans developed through the Policy Academies address increasing access to care, closing gaps in the system, building the system’s capacity, increasing interagency communication/collaboration, and incorporating promising best and evidence-based practices. A technical assistance center provides support after each policy academy to the states and territories to ensure successful implementation of their plans.

SAMHSA Grants
<p>HHS recognizes the importance of collaborating with the community to ensure Service members, Veterans and their Families receive the behavioral health care they deserve. To encourage community collaboration, SAMHSA includes language in requests for application for discretionary grants encouraging applicants to focus on this population as a priority when providing a service funded by the grant.</p>

Enhanced Partnerships between Department of Veterans Affairs and Community Providers

In response to the current Executive Order, VA initiated a group of pilots that will be used to examine how community partnerships can help provide mental health and substance use services in geographical areas that have staff recruitment concerns and/or difficulty with longer wait times for mental health and substance use services. Sites were selected using recruitment information, performance measure information and the site's desire to participate. Both HRSA and SAMHSA of HHS helped to identify potential community partners for VA to consider.

By May 31, 2013, VA pilot projects were established with 24 community-based mental health and substance use providers across nine states and seven Veterans Integrated Service Networks, and were funded for a period of one year. The 24 pilots were established across Georgia, Tennessee, Wisconsin, Mississippi, Alaska, South Dakota, Nebraska, Indiana and Iowa. Pilot projects are varied and include provisions for inpatient, residential and outpatient mental health, and substance use services. HHS assisted VA in identifying community providers to support these pilot programs. Sites may have included capabilities for telemental health, staff sharing and space utilization arrangements to allow VA providers to provide services directly in communities that are distant from a VA facility. Some sites used these partnerships to allow community providers to provide direct services to Veterans. The current set of 24 Community Mental Health Pilot projects is listed below along with their associated VA Medical Centers and start dates. All pilots were initiated between January 15, 2013 and May 31, 2013. Continued provision of care through these community arrangements for Veterans will be determined by each local site at the end of a year, based on the quality and effectiveness of the services provided to the Veterans.

Community Mental Health Pilot Sites and Associated VAMCs

	Geographic Location	VAMC	Community Provider	12-month Date
1	Griffin, Georgia	Atlanta VAMC	McIntosh Trail Community Service Board	Feb. 2014
2	Flowery Branch, Georgia		Avita Community Partners	Feb. 2014
3	Atlanta, Georgia		Peachford Behavioral Health System	March 2014
4	Atlanta, Georgia		DeKalb Community Service Board	May 2014
5	Canton, Georgia		Highland Rivers Community Service Board	May 2014
6	Lawrenceville, Georgia		View Point Health	May 2014

	Geographic Location	VAMC	Community Provider	12-month Date
7	Newport, Tennessee	James H. Quillen VAMC, Mountain Home, TN	Cherokee Health Systems	Feb. 2014
8	Mountain City, Tennessee		Frontier Health	May 2014
9	Bedford, Indiana	Richard L. Roudebush VAMC, Indianapolis, IN	Affiliated Service Providers of Indiana, Inc.	May 2014
10	Columbus, Indiana			May 2014
11	Kokomo, Indiana			May 2014
12	Cashton, Wisconsin	Tomah VAMC	Scenic Bluffs Health Center	Feb. 2014
13	Bolivar County, Mississippi	G. V. (Sonny) Montgomery VAMC, Jackson, MS	Delta Community Mental Health Services	Feb. 2014
14	Gulfport/Coastal Mississippi	VA Gulf Coast Veterans Health Care System, Biloxi, MS	Gulf Coast Community Mental Health Clinic	Feb. 2014
15	Wrangall, Alaska	Alaska VA Healthcare System	Alaska Island Community Services	May 2014
16	Southeastern Alaska	Alaska VA Healthcare System	South East Alaska Regional Health Consortium Behavioral Health Department	May 2014
17	Huron, South Dakota	Sioux Falls VA Health Care System	Community Counseling Services	Feb. 2014
18	Sioux Falls, South Dakota		Southeastern Behavioral Health Care	Feb. 2014
19	Mitchell, South Dakota		Dakota Counseling Institute	March 2014
20	Cedar Rapids, Iowa	Iowa City VA Health Care System	Abbe Center for Community Mental Health	Feb. 2014

	Geographic Location	VAMC	Community Provider	12-month Date
22	Iowa City, Iowa		Community Mental Health Center for Mid-Eastern Iowa	March 2014
21	Des Moines, Iowa	Central Iowa VA Health Care System	Eyerly Ball Community Mental Health Center	Feb. 2014
23	Omaha, Nebraska	VA Nebraska-Western Iowa Health Care System	One World Community Health Center	Feb. 2014
24	Omaha, Nebraska		Charles Drew Health Center	March 2014

Working together, these local VA/Community Pilot teams have defined and refined processes and procedures for referral, care and coordination. Constant oversight of the care and recovery of the Veteran patients was and remains a top priority for both parties. In addition to VA teams engaging locally with their partners, the teams are also participating in regular, ongoing national calls with VA Central Office where lessons learned and best practices are shared to assist sites in executing these agreements.

The VA/Community Pilot teams have reported a number of key successes, lessons learned, implementation challenges and plans for continuing or expanding these partnerships in the future. Several pilot sites have reported strong collaborations with their community partners and found community providers were enthusiastic and interested in learning more about Veteran culture and VA treatments, even on their own time. Many of the staff at the community partnership sites attended local VA Mental Health Summits. Some Veteran patients reported that their proximity to and ability to access behavioral health care services was improved at the community sites. VA will work to quantify this impact. VA Medical Centers involved in these pilots have reported that community clinics were enthusiastic about working with VA and learning more about Veteran culture and population-specific characteristics that may better inform care delivery.

In terms of lessons learned, VA/Community Pilot teams reported that having good communication between partners was crucial to creating successful working relationships between VA staff and community providers. Several teams noted that having an in-person meeting early in the process was key to working through later implementation issues. Regular communication between various key staff at VA and community pilot sites (including mental health and substance use services, information technology, contracting, fee-basis and fiscal departments) was also important. In addition, teams reported that since these partnerships were new, standard operating procedures regarding many logistical (e.g., information technology issues, invoice billing, setting up non-VA care consults, referral and capacity tracking) and clinical processes (e.g., determining what clinical services were available, supervisory oversight, no-show policies, quality monitoring, outcome measurement, and release of information issues) were best developed during the contracting phase and refined over time. As a result of these pilots, some VA sites are interested in broadening their partnerships beyond HRSA funded clinics that were part of the initial pilot implementation. Since the pilots started, VA announced and is now implementing new nationwide Indefinite Delivery, Indefinite Quantity contracting vehicles, called Patient Centered Community Care that will greatly facilitate local sites contracting with community providers when VA Medical Centers have difficulty ensuring Veterans have timely and geographically convenient access to needed services.

VA has created a plan for evaluating the Community Mental Health Pilots, which includes conducting a detailed quantitative and qualitative evaluation. This evaluation will be completed over FY 2014, with results available for review early in FY 2015. The initial clinical outcomes and Veterans' satisfaction with their community mental health care will be assessed. Veterans who are receiving mental health care at a community mental health care pilot site are completing phone interviews at treatment entry (baseline) and again at three months post-entry (follow-up). VA National Call Center staff complete these phone interviews with Veterans. Since December, over 400 referred Veterans have been identified, and baseline calls have been completed with 125 Veterans. Additional Veterans are being added to the call roster at a rate of approximately 40 per week. Baseline interviews are often conducted within a few days of a Veteran's referral to a community site. For this reason, some Veterans were not able to answer all the treatment satisfaction questions. The preliminary results, based on the responses of Veterans who were able to provide responses (responses of "I don't know" were not included) indicate that: 72 percent of Veterans reported they were seen within 14 days of their referral date; 52 percent said their commute to the community clinic was under 30 minutes, and 82 percent said it was under an hour; when asked how long their commute would be to a VA site for the same kind of care, only 9 percent said less than 30 minutes, and 63 percent said less than an hour. Ninety percent of Veterans reported

Veteran Phone Interviews at Baseline on Community Clinic Care

90 percent reported they were "completely or somewhat satisfied" with their community clinic care.

71 percent said the quality of care at the community clinic is comparable to VHA care.

85 percent stated they would recommend the community clinic to other Veterans.

being completely or somewhat satisfied with their community clinic care, and 80 percent said they received an adequate amount of care to meet their mental health needs. Seventy-one percent of the Veterans who responded felt the quality of care at the community clinic was comparable to VA care, and 85 percent said they would recommend the community clinic to other Veterans. Additionally, 78 percent that they had “goals in life I want to reach,” and 65 percent stated they were “hopeful about the future.”

These results are promising but preliminary and should be interpreted with caution. Completion of additional follow-up interviews will result in having a more thorough understanding of Veterans’ experiences with community mental health care over a longer time period. The Veterans’ assessment information is being shared with the clinical providers in order to improve program quality and individual treatment planning. The evaluation team has verified that VA facility clinical points of contact are actively reviewing this Veteran data and taking needed action with Veterans who are flagged as at-risk for suicidal behavior. This collected quality improvement data will allow VA to determine whether these Veterans are experiencing improvements in mental health and substance use symptoms and functioning that is consistent with other Veterans who have received high quality, evidence-based mental health care. Additionally, this data will also allow VA to rapidly identify and address potential problems with care coordination or other adverse effects.

Since a key focus of the community pilot projects is to improve Veteran access to mental health and substance use treatment, VA will evaluate Veteran patient access to and wait times for mental health and substance use treatment using existing VA operational and quality metrics. Overall patient access to and wait time for mental health clinics will be evaluated for all community pilots, and additional quality metrics will be examined at individual sites in accordance with the specific treatments and patient populations targeted by the pilot project. Since the pilots vary substantially in organization and services provided, the evaluation will also characterize the programs to help identify structural elements that may affect the quality of these community pilot programs.

This part of the evaluation process will collect qualitative information on (1) organization and roles and responsibilities of VA and the community partner in the pilots, (2) barriers and facilitators to setting up the community collaboration, (3) challenges and solutions to delivery of coordinated patient care across VA and community providers, (4) processes for ensuring quality of care delivered by the community provider, and (5) key characteristics of policy documents or memoranda of understanding between facilities. The success of individual pilot projects will be judged based on a balance of the clinical benefits to participating Veterans, including care coordination and community care quality, effects on overall patient access to mental health care, and participating Veterans’ satisfaction with the services they received. Broader evaluation will help identify characteristics of successful programs to guide future design and implementation of community collaborations.

The timeline for deciding if and how to continue the community partnership projects will be made locally by VA facilities involved in the project. Several VA/Community teams plan to continue their partnerships after the formal pilot projects are completed and some VA Medical Centers plan to expand their number of community partnerships. One VA Medical Center is working on developing telehealth

supervision standards that will meet accreditation standards so that mental health trainees can provide telemental health services to community sites. Development of these standards will benefit training and care across VA and other mental health care systems.

Mental health offices in VA Central Office will be creating materials that detail the key knowledge and experience gained during the Community Mental Health Pilots Project. VA will create a resource web page so other VA facilities can access these materials and will educate key leaders in each of the Veterans Integrated Service Network regarding the availability of these resources. VA mental health offices will provide technical assistance to additional facilities in the future as necessary.

DoD Military and Family Life Counseling and Military OneSource Program

The DoD Family Readiness System consists of the network of military and community agencies, programs, services, and individuals, and the collaboration among them that promotes the readiness and quality of life of Service members and their Families. Efforts are ongoing to promote awareness among military and community-based service providers that they are a part of the Family Readiness System and how the services they provide support family readiness, or can be tailored to do so. Included within the DoD Family Readiness system are services provided by the Military and Family Life Counseling and Military OneSource Programs. Both Programs are DoD-funded. The Military OneSource Program provides confidential, comprehensive information on every aspect of military life at no cost to Active Duty, Guard and Reserve Service members, and their Families, regardless of activation status (24 hours a day, seven days a week). Services, including specialty consultations, are available 24 hours a day by telephone and the Military OneSource website. Specialty consultants provide individualized support in the areas of wounded warrior care, adoption, elder care, special needs, education, adult disability, and health and wellness coaching.

Military and Family Life Counselors provide confidential non-medical counseling sessions and briefings, both on and off installation. Military and Family Life Counseling support has been enhanced to offer *surge* non-medical counseling support, which maximizes the flexibility of the Military and Family Life Counseling Program by allowing Commanders to request Military and Family Life Counselors and personal financial counselors to support unit members returning from a combat zone.

Military OneSource and Military and Family Life Counseling services are available to Service members and their Families for up to 180 days after discharge, separation, deactivation or retirement.

Similar to the Military and Family Life Counseling Program, Military OneSource also offers confidential non-medical counseling services. Military OneSource offers these services either online, via telephone, or face to face. The Military and Family Life Counseling Program offers non-medical counseling face to face. Eligible individuals may receive non-medical counseling addressing issues requiring short-term attention, including everyday stressors, deployment and reintegration concerns, parenting, grief and loss, and marital problems. In addition, through a DoD and United States

Department of Agriculture partnership, development of community capacity building curriculum is in progress for use by military service providers as well as their civilian counterparts.

Recommendation 5

Build partnerships that enhance the capacity of the health care workforce to serve Veterans, Service members and their Families through VA, TRICARE, and in the community.

The three Departments worked collaboratively throughout the year to build partnerships that enhance the capacity of the health care workforce to serve Veterans, Service members, and their Families. A DoD/VA/HHS Behavioral Health Workforce Development Work Group was developed to create an inventory of the programs and initiatives each Department supports. The Work Group met to review current agency programs and initiatives outlined in the Workforce Development Inventory, and discussed possible collaborations and partnerships to enhance behavioral health workforce efforts. Additional conversation focused on disparate personnel, retention, hiring, and staffing models. The Departments are working together to understand and share best practices in these portfolios, which is driving a collective approach to a behavioral health workforce model in both large and small communities across America.

The following section highlights the progress and accomplishments each Department has made to enhance the capacity of the health care workforce.

Progress/Accomplishments:

Department of Veterans Affairs Hiring Goals

In response to the Executive Order, VA announced on June 30, 2013, that 4,308 mental health professionals and administrative support had been hired and were providing services to Veterans. Of these, 1,669 mental health providers were hired specifically as part of the Executive Order's initiative to add 1,600 clinical mental health professionals by June 30, 2013. A comprehensive recruitment and hiring plan was also implemented to ensure that 800 peer specialists were hired and trained by December 31, 2013. As of November 3, 2013, VA had hired 815 peer specialists and peer apprentices, exceeding the hiring goal set in the Executive Order. Peer specialists and peer support apprentices are a unique cadre of people joining VA's mental health care teams. They are Veterans who have successfully dealt with their own mental health recovery for a minimum of one year. Peer specialists are trained and certified, while peer support apprentices are undergoing training and certification to become peer specialists. Per the mandate set by President Obama in this Executive Order, the hiring requirement of 800 peer support counselors to help Veterans living with mental health and substance use issues was met

in October 2013. As of January 9, 2014, VA has hired and provided certification training to a total of 932 peer support staff.

Department of Defense Hiring Goals

Within DoD, strategies for hiring and retention of mental health providers resulted in a 37 percent increase in licensed providers over the last four years, from 6,590 in FY 2009 to 9,706 in FY 2013. These numbers reflect a 40 percent increase in the number of psychologists, a 26 percent increase in the number of psychiatrists, a 42 percent increase in the number of social workers, and a 27 percent increase in the number of mental health nurses. This represents a fill rate of 99 percent of funded positions, which compares favorably to industry averages. The Military Health System has similarly added over 10,000 mental health providers participating in its purchased care system, from 54,385 in FY 2010 to 65,524 in 2013, representing a 20 percent increase over this three year period.

In efforts to expand the workforce, DoD Health Affairs has facilitated the recruitment and retention of civilian mental health professionals through:

- Public Health Service Support establishing a Memorandum of Agreement with Health and Human Services to supplement DoD mental health staff at the Military Health System military treatment facilities with Public Health Service officers;
- Implementing a Direct Hire Authority through the Office of Personnel Management to reduce the hiring times for critical occupations to include the mental health care providers
- Execution of the Expedited Hiring Authority - Under Title 10, 1599c, to assist with recruitment efforts to include civilian mental health care professionals; standardizing of civilian titling where the Office of the Assistant Secretary of Defense (Health Affairs) is responsible for overall human resource policy for DoD's health care workforce
- Establishing qualification standards consistent with the current practices for licensing, certification, education, experience, credentialing and privileging requirements (as applicable) in the health care professions.

DoD Policy Coverage of Substance Abuse Treatment

TRICARE'S substance use disorder benefit was identified as an area of improvement in the 2012 IOM Report, *Substance Use Disorders in the U.S. Armed Forces* and in DoD's own review of its substance use disorder policies and programs. DoD has already removed the exclusion in the TRICARE benefit on coverage of substitution therapies for the treatment of opioid dependence through the *Final Rule: Removal of the Prohibition To Use Addictive Drugs in the Maintenance Treatment of Substance Dependence in TRICARE Beneficiaries* (Federal Register Volume 78, Number 204). This will allow TRICARE to change treatment coverage policy to allow substitution therapy for opioid dependence treatment when considered medically necessary and as part of a comprehensive treatment plan for an individual with a substance use disorder. The TRICARE Policy Manual and the TRICARE Reimbursement Manual will be revised to allow provision of substitution therapy in TRICARE-

authorized Substance Use Disorder Rehabilitation Facilities. These revisions will increase access to evidence-based treatment for opioid dependence. DoD continues to provide substance abuse training and education to military health care providers. Specifically, DoD will increase efforts to train providers at military treatment facilities on opioid substitution treatment through a buprenorphine training pilot project via a partnership between DoD and SAMHSA.

Health and Human Services Workforce Development Efforts

Not all Service members, Veterans, or their Family members may access mental health services through VA and DoD. Moreover, some may feel more comfortable receiving services from peers than from professionals in the community. To address this need, SAMHSA has developed a number of initiatives to build and strengthen the peer workforce serving Service members, Veterans and their Family members in community-based settings.

SAMHSA is developing a set of core competencies for peer specialists and (addiction) recovery coaches that delineate the knowledge, abilities and skills necessary to provide recovery support services to all populations. In addition, SAMHSA is developing national practice guidelines for peer specialists and recovery coaches. SAMHSA anticipates that specialized modules of knowledge, skills and abilities will be developed for specific populations, one of which will be military and Veteran populations. The core competencies and national practice guidelines are intended to help ensure consistency in quality, nature and scope of the services provided by peer workers across the nation.

HHS Workforce Initiatives

In January 2013, SAMHSA published a report to Congress regarding its efforts related to workforce development. The report detailed programs and partnerships to address the behavioral health workforce. A number of the programs directly support the need to increase workforce to address the Service members', Veterans' and their Families' gaps in services.

Through several of the agency's discretionary grant programs, SAMHSA is training and certifying peer specialists to work with Service members, Veterans and their Families. For example, SAMHSA Recovery Support Program supports several grant projects that train Veterans to become peer-recovery coaches to work with Veterans in the community. To date, approximately 200 Veterans have been trained.

As a specific example, one Recovery Community Services Program, *Dryhootch*, trains Veterans to serve as peer mentors who lead addiction recovery groups, PTSD support groups, and support groups for Family members. *Dryhootch* also offers legal and housing support, linkage to community-based services and other resources, expressive arts (music, theater, art) groups, alcohol- and drug-free social activities, and virtual support groups through *Dryhootch.org*. Located in Milwaukee, Wisconsin, *Dryhootch* is planning to replicate its program across the country.

As another example, SAMHSA’s Jail Diversion Trauma and Recovery with Priority to Veterans Program trains Veterans to work as peer specialists and Veteran navigators. Many of the peer workers graduate from state certified peer specialist training programs in their state, often with assistance from SAMHSA-funded Statewide Consumer Network Programs.

VA Community Provider Toolkit

Over 2.4 million people have deployed to Iraq or Afghanistan and while the majority return without any mental health issues, an estimated 25 percent of returning Veterans are diagnosed with a mental health or substance use condition.¹ Statistics indicate that 49 percent of returning Veterans in need of care actually seek care.² Many of these individuals will seek care outside of VA for various reasons, including: (1) a desire to maintain confidentiality; (2) ineligibility for VA services; (3) availability of services in rural areas; (4) logistical barriers (e.g., schedules); and (5) availability of spouse and family care. Outside of VA, Veterans may seek services from private practitioners, community mental health providers, non-VA health care systems, college campus counseling centers, employee assistance providers and other community support services.

Community providers have various levels of expertise and understanding in Veteran-specific concerns and knowledge of VA resources. VA can offer expertise and tools to community providers to support the care they provide to Veterans. As a result, Veterans benefit from stronger connections between VA and community providers.

In 2013, VA officially introduced the online Community Provider Toolkit, aimed at delivering support, therapeutic tools, and resources to community providers treating Veterans for mental health concerns. The goal of the Community Provider Toolkit is to further enhance the delivery of mental health and substance use services to Veterans through increased communication and coordination of care between

community providers and VA. It not only provides information about accessing, communicating with, and, if needed, making referrals to VA, but also provides effective tools to assist Veterans who are dealing with a variety of mental health and substance use challenges. The Community Provider Toolkit also includes sections intended to increase providers’ knowledge about military culture.

Following its launch, the Community Provider Toolkit was the third most viewed site on VA Mental Health main site with 14,337 active views and 19,489 page views during its first month online. It is currently listed as the fifth most visited site on VA Mental Health main site. From October 2012 to April

Community Provider Toolkit Content

- Screening for military background
- Connecting with VA
- Understanding the military experience
- Mental Health and Wellness (Mini-clinics)

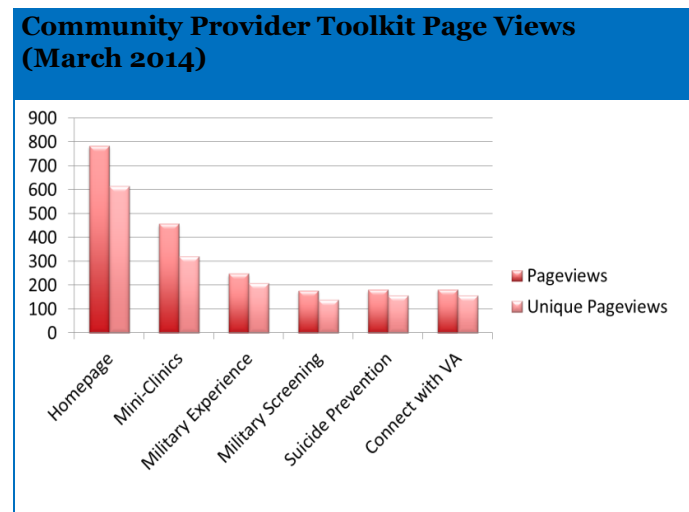
www.mentalhealth.va.gov/communityproviders

¹ Seal, Maguen, Cohen, Gima, Metzler, Ren, ...Marmar, 2010

² Adamson, Burman, Burns, Caldarone, Cox, D’Amico, ...Yochelson, 2008

2013, community providers viewed the page 51,000 times. From April to December 1, 2013, community providers viewed the site approximately 28,559 times, with 22,759 unique views.

Specific page views for the month of March 2014 are depicted in the graph. A mobile beta version of the Community Provider Toolkit is available. Providers are able to save the application icon to their smartphone to quickly access the site.



Military Culture Training

Increasing numbers of health care professionals without prior military experience are being called upon to deliver patient care to rapidly growing populations of Service members, Veterans and their Families. For current and former military Service members, the organizational structures and military culture play a significant and lifelong role in response to injury, illness and recovery. To meet this training need, VA and DoD have developed a variety of training resources for VA, DoD and community health care providers.

Specifically, as part of DoD/VA Integrated Mental Health Strategy, the Departments developed a web-based training curriculum entitled, *Military Culture: Core Competencies for Healthcare Professionals*. The curriculum for this training encourages military cultural competency in health care professionals through the provision of interactive online training in the requisite knowledge, skills and attitudes. The first of four modules launched November 7, 2013 and the remaining three launched February 28, 2014. The fully integrated DoD/VA training curriculum includes a self-awareness assessment and training on military culture, deployment stress, and related mental health and substance use issues facing Veterans, Service members and their Families. All DoD, VA, and community providers can access this training on the web at deploymentpsych.org/military-culture. It is also available on VA's internal training website at tms.va.gov/learning.

Clinicians are able to earn free continuing education credits for completing each module of the course (two credits per module) and the Departments have the capacity to track the number of providers that take the course and receive continuing education credits. A companion website has also been developed to support the online curriculum and the site has been accessed over 4,500 times since it was launched November 7, 2013 (3,500 since January 2014). Full dissemination of the *Military Culture: Core Competencies for Healthcare Providers* curriculum is being planned and coordinated communication activities across both Departments in collaboration with external community partners are being finalized.

In addition to the joint efforts above, VA has continued to promote a one-hour web-based training through VA National Center for PTSD entitled, *Understanding Military Culture*. This site has been viewed 3,300 times since June 2013. Further, recognizing a gap in knowledge and skills related to military culture and common injuries associated with deployment, DoD, through Center for Deployment Psychology at the Uniformed Services University of the Health Sciences, conducts training and education courses for civilian mental health care providers. One-, two- and five-day live courses are held all over the country, and online courses including: *An Introduction to Military Culture*, *The Impact of the Deployment Cycle*, *Combat Stress on Families and Children*, *the Fundamentals of TB*, *Prolonged Exposure Therapy for PTSD*, and *Cognitive Processing Therapy for PTSD* are available to behavioral health providers working with Service members, Veterans and their Families. To date, 47,284 providers have accessed these online courses for credit and over 2,500 have attended in-person trainings that include military cultural awareness. Additionally, Center for Deployment Psychology hosts a course at locations across the country for civilian providers who care for Service members (Active Duty, Reserve and National Guard), Veterans and Family members. The course covers military culture, deployment cycle stressors, suicide and depression, substance use, TBI, and training in treatment for PTSD and insomnia. A course for those interacting with Service members and Veterans on college campuses introduces them to military culture, deployment cycle stress, reintegration issues, and major psychological health concerns.

In supporting DoD and VA efforts to educate community providers in military culture and related topics, HHS offers training to community health center and community mental health center providers to ensure their sensitivity to Veterans and Reserve component members using services provided by these community-based providers. HHS agencies are collaborating to provide technical assistance to the behavioral health and primary care workforce that is focused on the mental and substance use issues of Veterans, Service members and their Families and includes training on the military experience, risk and protective factors, and additional culturally relevant information to help providers prepare for serving Veterans, Service members, and their Families. SAMHSA and HRSA jointly encourage grantees to provide military culture training to community-based providers by offering participation in Operation Immersion Training, which provides *hands-on* training to understand military culture by having participants sleep in National Guard barracks, eat at a military dining facility, participate in physical training, and listen to Veterans, Service members, and their Families share their experiences.

Integration of Behavioral Health in Primary Care

In 2013, the integration of mental health care providers in primary care settings remained a critical element in increasing access to mental health care and contributing to reducing negative attitudes associated with seeking mental health care across all three Departments. This initiative has been an ongoing focus for DoD/VA Integrated Mental Health Strategy with regards to developing standardized models of care and addressing common issues related to the integration. In 2010, a joint DoD/VA Work Group was established and has met regularly to coordinate across the Departments. This year, efforts

focused upon training courses on the clinical, operational, and administrative standards as pertaining to integrated mental health care in primary care.

DoDI 6490.15, *Integration of Behavioral Health Personnel Services into Patient-Centered Medical Home Primary Care and Other Primary Care Services Settings*, was issued on August 8, 2013. This policy provides minimum program standards and staffing, Service-specific responsibilities, and quality assurance mechanisms for the integration of behavioral health into primary care. In addition, each Service has established funding, hiring and training practices for associated behavioral health personnel. Per DoDI 6490.15 requirements, 302 Military Health System direct care primary care clinics will be staffed with behavioral health personnel. As of September 15, 2013, 225 clinics have been staffed, representing 298 full-time behavioral health providers and care facilitators and reflective of an increase of 91 full-time behavioral health staff from September 2012 numbers. Full implementation is planned for completion by the end of FY 2014.

Annual adult screening and intervention for at-risk alcohol use for beneficiaries enrolled in military treatment facilities in primary care medical settings is an essential component of educating and identifying personnel who may be at-risk for developing problems related to their alcohol use. The goals within primary care medical settings are to promote health and readiness through the early identification of risky alcohol use and provide early opportunities for military treatment facility health care providers to intervene with enrolled beneficiaries who are at-risk for an alcohol use disorder, as clinically indicated. Implementation of the three-item *Alcohol Use Disorders Identification Test* as a screening tool for at-risk alcohol use has been incorporated into the primary care setting.

The established VA Primary Care-Mental Health Integration Programs combine co-located collaborative care and care management functions to support primary care providers in treating common mental health conditions within the primary care setting. In 2013, expansion of these programs continued, as did support for the virtual education and regional-based training of these integrated mental health and patient-aligned care team staff. As of August 31, 2013, 319 (93 percent) of the 342 VA Medical Centers and Community Based Outpatient Clinics classified as large and very large had integrated behavioral health programs, compared to only 89 percent at the end of FY 2012. In FY 2014, efforts will focus on maintaining program penetration and reducing variation/increasing standardization of care.

SAMHSA's Center for Mental Health Services developed the Primary and Behavioral Health Care Integration Program in order to establish projects for the provision of coordinated and integrated services through the co-location of primary and specialty care medical services in community-based behavioral health settings. Grantees must utilize funding to implement a continuum of preventive and health promotion services, including a specific focus on tobacco cessation. The goal of the Primary and Behavioral Health Care Integration Program is to improve the physical health status of adults with severe mental illness who have or are at risk for co-occurring primary care conditions and chronic diseases, with the objective of supporting the triple aim of improving the health of those with severe mental illness, enhancing the consumer's experience of care (including quality, access and reliability), and reducing/controlling the per capita cost of care.

Recommendation 6

Implement the National Research Action Plan called for in the Executive Order to inform federal research in PTSD, TBI, and other critical issues.

Section 5 of the Executive Order directs DoD, VA, HHS and Education (henceforth referred to as *the agencies*) to develop a National Research Action Plan (NRAP). HHS representation includes the National Institute of Mental Health (NIMH), the National Institute of Neurological Disorders and Stroke, the National Institute of Drug Abuse, and the National Institute of Alcohol Abuse and Alcoholism. Education representation includes the National Institute on Disability and Rehabilitation Research. Senior research leaders and program managers at these institutions established an interagency committee to develop, implement and manage the NRAP.

The NRAP is a 10-year blueprint for interagency research to enhance the diagnosis, prevention, and treatment of PTSD and TBI, and to improve suicide prevention, including immediate, short-term, and long-term initiatives (12 months, two to four years, and five to 10 years, respectively). In the NRAP, the agencies outline coordinated research efforts to accelerate discovery of the causes and mechanisms underlying PTSD, TBI and other comorbid conditions, including suicide, depression and substance use disorders. These efforts include collaborative research on biomarkers to detect disorders early and accurately; and safe, effective treatments to improve function and quality of life. The NRAP also describes research to accelerate the implementation of new methods, through the rapid translation of new findings into effective prevention strategies and clinical innovations. On August 10, 2013, President Obama released the NRAP during the National Convention of the Disabled American Veterans Service Organization. The NRAP is available online at

http://www.whitehouse.gov/sites/default/files/uploads/nrap_for_eo_on_mental_health_august_2013.pdf.

Requirements for the National Research Action Plan in the Executive Order

“The National Research Action Plan shall include strategies to establish surrogate and clinically actionable biomarkers for early diagnosis and treatment effectiveness; develop improved diagnostic criteria for TBI; enhance our understanding of the mechanisms responsible for PTSD, related injuries, and neurological disorders following TBI; foster development of new treatments for these conditions based on a better understanding of the underlying mechanisms; improve data sharing between agencies and academic and industry researchers to accelerate progress and reduce redundant efforts without compromising privacy; and make better use of electronic health records to gain insight into the risk and mitigation of PTSD, TBI, and related injuries. In addition, the National Research Action Plan shall include strategies to support collaborative research to address suicide prevention.”

Since the release of the NRAP, substantial progress has been achieved through collaboration among the agencies to implement the NRAP, particularly the action items which fall within the first 12-month time frame. This progress is summarized below, starting with cross-cutting items that span conditions and followed by each major section of the NRAP.

Progress/Accomplishments:

Cross-Cutting Research Priorities

The agencies provide critical support related to research on PTSD, suicide and TBI to advance the knowledge necessary to positively impact those affected and their Families. The agencies routinely meet throughout the year to coordinate efforts. They also conduct annual comprehensive portfolio analyses and reviews to address the goals of NRAP.

One major knowledge gap is the limited number of efforts to collect postmortem brains for research on PTSD, TBI and related conditions. Increasing the inventory of scarce resources is a cross-cutting priority outlined in the NRAP. National Institutes of Health (NIH) NeuroBioBank was recently funded to begin registration of potential donors, establish standards for tissue quality and create a web-based portal for a national registry of brain tissue available for research. With a goal to collect 100 brains per year for five years, NIH NeuroBioBank will quickly advance the availability of resources necessary to facilitate research on post-mortem tissue.

Another NRAP priority is building new tools and technologies to understand the underlying mechanisms of PTSD, TBI, suicide and other conditions. The President's FY 2014 budget includes a proposal for the Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative with the goal of building new tools and technologies to understand mechanisms underlying brain functions. NIH established a Work Group to help shape the initiative, and it has already received an initial report to develop a multi-year scientific plan to achieve the BRAIN Initiative goals and released initial funding opportunity announcements.

Efforts are also underway at the Defense Advanced Research Projects Agency (DARPA). In October 2013, DARPA held a collaborative BRAIN Data Exploitation workshop, which included participation of DoD and NIH staff. In November 2013, DARPA announced two programs as a part of the BRAIN Initiative: Systems-Based Neurotechnology for Emerging Therapies and Restoring Active Memory. DARPA recently launched a new Biological Technologies Office to execute these and other initiatives. Systems-Based Neurotechnology for Emerging Therapies is aimed at creating knowledge-driven approaches to treating Service members with psychiatric and neurologic disorders. The Restoring Active Memory program is aimed at developing neuroprosthetics for memory recovery for Service members with brain injuries. An additional project is the Reorganization and Plasticity to Accelerate Injury Recovery, which involves creating a biologically accurate computational model of the brain that will predict and compensate for changes over time due to neural plasticity. Finally, the DARPA Neuro Function, Activity, Structure, and Technology approach is designed to develop new optical methods to

acquire real-time detailed wiring of neural circuits and couple it with brain activity in order to get a deeper understanding of brain function.

The process of combining data as appropriate is recognized as a key way to maximize investments; therefore, there must be a minimum set of common data elements (CDE) across the data sets. NIMH recently initiated a process to develop CDEs for PTSD and suicide prevention research. Work Groups are being formed that include members from NIMH, DoD, and VA. The National Institute of Neurological Disorders and Stroke is building on the previously developed CDEs for TBI to incorporate a larger range of studies. DoD Military Suicide Research Consortium established an effort on CDE that will be leveraged for suicide prevention. The PTSD and suicide prevention research CDEs should be available for use in early 2015.

Additional progress related to cross-cutting research priorities is included, as appropriate, in the sections that follow.

Posttraumatic Stress Disorder Research

Completed Activities. Completed PTSD research efforts reflect interagency progress towards reaching NRAP goals. For example, the agencies have completed the NRAP action to convene an interagency biomarker meeting, held in May 2013. At this meeting, participants discussed early findings from ongoing biomarker efforts and explored how to advance the biological understanding of PTSD. One outcome was the formation of a PTSD-specific group in the Psychiatric Genomics Consortium (<http://www.med.unc.edu/pgc>) to share data as appropriate to maximize the utility of investments, as well as to better power meta-analyses. The Psychiatric Genomics Consortium is a large effort that spans mental health and includes data from over 170,000 DNA samples across multiple conditions. The PTSD-specific group meets routinely and is planning future analyses. This new group will add PTSD samples for the first time to the Psychiatric Genomics Consortium for meta analyses. The group is currently working on the first analysis. In 2014, additional samples will be added, including those of Service members and Veterans. Through collaboration within this much larger effort, the group is able to follow up on the emerging genomic and molecular findings on causal pathways and changes that contribute to PTSD, including the findings on specific genes, such as RORA and FKBP5 that suggest a relation to risk for PTSD. This group is also harmonizing analysis of other biomarker data to facilitate comparison of findings across studies to ease interpretation, replication, and extension of preliminary findings, as well as future meta-analysis of small samples in individual studies. Other follow-up studies are planned, for example, *Analysis of RORA and other candidate genes in PTSD*. This project has been approved by VA to begin in FY 2014. Although still early in the discovery phase, research is being conducted to identify sex-specific risk allele biomarkers for PTSD. For example, several papers have already been published on initial findings from the Grady Trauma Project (see gradytraumaproject.com), including one study that examined trauma history and exposure from an Atlanta-based medical clinic.

Ongoing and Newly Launched Activities. To meet the objectives of the NRAP in PTSD research, the agencies are focusing their investments on NRAP priorities. The largest single PTSD-related investment

in the past year is the Consortium to Alleviate PTSD (Consortium), which was jointly funded by DoD and VA in September 2013. This major effort is focused on the goals related to biomarkers detailed in the NRAP. A study entitled, *Randomized Clinical Trial of Cognitive Behavior Therapy for Posttraumatic Headache*, has been approved within the Consortium; and two additional studies will be reviewed early in 2014 for funding consideration. Key Consortium activities include: (1) establishment of core infrastructures for neuroimaging, genetics and data management; and (2) in December 2013, Consortium investigators met with DoD Systems Biology Enterprise investigators and subsequently, they plan to work together on conducting biomarker analyses of emerging genomic data.

Independent of the Consortium, NIH has efforts underway to correlate changes in biomarkers with the trajectory of disease development. DoD Systems Biology Enterprise has initiated an effort to distinguish PTSD biomarkers specific to males or females, and to identify specific relationships between biomarkers and symptom presentation, in order to stratify PTSD diagnoses and move toward optimized treatment selection/personalized medicine. In FY 2014, VA will launch the *Genetics of PTSD in Veterans* study to utilize samples, surveys and electronic health record data as appropriate from VA's Million Veteran Program to evaluate emerging genetic and molecular findings on pathways and changes that contribute to PTSD. Another new effort is NIMH's Research Domain Criteria Project Initiative (nimh.nih.gov/research-priorities/rdoc/index.shtml). This initiative seeks to translate progress in basic neurobiological and behavioral research into an improved integrative understanding of psychopathology. NIMH plans to fund eight to 12 new Research Domain Criteria project-focused applications in 2014, in addition to 18 applications already funded through two Funding Opportunity Announcements. The Research Domain Criteria Project is attempting to relate biological underpinning and markers to observable and self-reported symptoms to develop a new classification of mental disorders based upon the ability to understand the biology of illnesses. The Research Domain Criteria project is part of the NRAP priorities. The ultimate goal is to be able to identify and intervene with individuals who are likely to develop PTSD and to monitor their treatment, by tracking changes in these biomarkers through analysis of routine blood draws.

Studying comorbidities of PTSD is also a focus of new initiatives across the agencies, as outlined in the NRAP. In FY 2013, NIH and DoD jointly released a funding announcement to solicit applications related to *Prevention and Health Promotion Interventions to Prevent Alcohol and Other Drug Abuse and Associated Physical and Psychological Health Problems in U.S. Military Personnel, Veterans and their Families*. NIH offices included National Institute on Drug Abuse, National Institute on Alcohol Abuse and Alcoholism, and National Center for Complementary and Alternative Medicine. This funding opportunity announcement is focused on the prevention of substance use and associated comorbidities within military personnel, Veterans, and their Families, and the solicitation resulted in the funding of seven new NIH grants (three National Institute on Drug Abuse, two National Institute on Alcohol Abuse and Alcoholism, and two National Center for Complementary and Alternative Medicine), as well as approval for funding of four DoD grants. In August 2013, DoD-funded Institute of Molecular Neurobiology (Gallo Institute) funded four basic science awards addressing the development of substance use as a co-occurring disorder with PTSD and mild TBI. The purpose is to accelerate research

on: health promotion and prevention interventions to reduce the onset and progression of alcohol, tobacco, and other drug use and abuse (including illicit and prescription drugs) and associated mental and physical health problems; and on the promotion of health-enhancing behaviors among active-duty or recently separated Service members, Veterans and their Families.

In addition to the Army Study to Assess Risk and Resilience in Service members (STARRS) (described below), the agencies are conducting additional longitudinal studies on Service members' and Veterans' mental health, which is an explicit goal highlighted in the NRAP. The National Institute of Mental Health is developing an FY 2015 initiative to acquire longitudinal data from trauma patients seen in acute trauma settings to identify and probe early pathophysiological changes and adjustment post-exposure, identify markers of specific phenotypes of distress and dysfunction, develop risk prediction algorithm(s) based on biomarkers and cognitive tests, and evaluate emerging targets for early intervention. National Institute on Drug Abuse has issued a Small Business Innovative Research 2014 contract solicitation on *Technological Tools to Facilitate Implementation of Evidence-Based Substance Abuse Prevention Interventions among the Military*, with awards anticipated in FY 2014. Additionally, DoD is planning to fund efforts in FY 2014 focused on PTSD biomarkers to refine a diagnostic panel to further investigation into disease vulnerability, trajectory, and the development of optimized treatment. DoD will continue to fund ongoing PTSD research including drug development, the identification of new compounds, and the re-purposing of existing Food and Drug Administration-cleared compounds, in order to identify the best treatment for the military population and optimize treatment delivery.

Traumatic Brain Injury Research

Completed Activities. Several reports and one clinical trial were completed during 2013. The Institute of Medicine released the report *Sports-Related Concussion in Youth* on October 30, 2013. This report was supported by DoD, National Institute on Disability and Rehabilitation Research, and NIH (among others). VA completed the *Complications of Mild TBI in Veterans and Military Personnel: A Systematic Review* effort. The DoD completed a report on *Concussion Guidelines Part 1. Systematic Review of Prevalent Indicators*. Collectively, the three reports provide a comprehensive review of the research literature and highlight important gaps in knowledge, as well as the need for high-quality data. Additional reports include the Defense and Veterans Brain Injury Center report on *Neurocognitive Assessment Tools* and DoD's *Analysis of Alternatives for Therapeutic Neurostimulation Devices*. Scientific conferences that were relevant to the NRAP include: (1) the *Forum on Neuroscience and Nervous System Disorders Meeting on Developing Standards for Diffusion Magnetic Resonance Imaging (dMRI)*, which was jointly sponsored by NIH and VA and provided a foundation for the development of a standard protocol that is now nearing completion; (2) the *Brain Trauma-Related Neurodegeneration Workshop*, which was sponsored by NIH to develop a research agenda for studying this complex problem to be used in the development of a request for application in the coming year; and (3) the second International TBI Research meeting, which recently convened to facilitate coordination and data sharing of TBI clinical studies funded by NIH, DoD, the European Union, and Canada. The NIH-funded multicenter clinical trial to test the effectiveness of progesterone following TBI was

discontinued prior to completion because the drug was found to be ineffective; thus, freeing up resources for other higher priority projects.

Ongoing and Newly Launched Activities. Federal agencies have coordinated on several new research initiatives and funding opportunities for TBI, as aligned with NRAP goals. DoD announced the TBI Endpoints Development Award (W81XWH-13-PHTBI-TED) with NIH coordination, which aims to validate clinically relevant endpoints and outcome measures supporting regulatory approvals for TBI clinical trials. NIH published the request for application *Adding Legacy Data to the FITBIR Informatics System* (RFA-NS-14-002) to provide a competitive opportunity for investigators to archive and share their existing clinical TBI research data. Applications in response to two NIH Sports Health Research Program requests for application were reviewed and awards are pending. These were the RFAs for *Pilot Projects on Sports-Related TBI and SCI* (RFA-NS-13-14 and 15) and for *Collaborative Research on Chronic Traumatic Encephalopathy and Delayed Effects of Traumatic Brain Injury: Neuropathology and Neuroimaging Correlation* (RFA-NS-13-13). The creation of a brain donor program for TBI is part of the latter request for application. The Defense Advanced Research Projects Agency published a Request for Information to obtain information on novel approaches for understanding and advancing knowledge on *Functional Architecture of the Brain, Restoring Impairments and Improving Cognition* (DARPA-SN-14-08).

Other newly launched activities include several large, prospective studies to improve diagnosis and treatments for TBI. A DoD/VA collaboration that jointly supports the Chronic Effects of Neurotrauma Consortium focuses on long-term outcomes in military and Veteran populations and was funded in September 2013 for five years. The purposes of the Chronic Effects of Neurotrauma Consortium are to investigate the long-term effects of mTBI and to develop biomarkers, such as blood biomarkers and neuroimaging. One study within the Chronic Effects of Neurotrauma Consortium will be a long-term follow-up study of a large population of Service members who have had a mild TBI. NIH and DoD are supporting *Transforming Research and Clinical Knowledge in TBI*, which will study 3,000 children and adult civilians who have sustained mild to severe injuries. National Institute on Disability and Rehabilitation Research continues to fund the expansion of the longitudinal TBI Model Systems National Database. This database has recently been shown to be nationally representative of those with moderate or severe TBI who receive inpatient rehabilitation. The database is currently receiving follow-up data from those first enrolled 20 years ago. Through an FY 2013 Interagency Agreement, National Institute on Disability and Rehabilitation Research and VA continue to collaborate in expanding the VA TBI Polytrauma Rehabilitation Centers Database, which shares data elements with the TBI Model Systems National Database. National Institute on Disability and Rehabilitation Research and Centers for Disease Control are also collaborating in order to study the long-term outcomes of TBI in civilians. The studies are utilizing the TBI Model Systems National Database to yield additional knowledge regarding long-term outcomes such as mortality, disability, employment, and functional status after TBI.

Other efforts that have already begun or are just beginning. National Institute on Disability and Rehabilitation Research has also launched a new clinical trial Multicenter Evaluation of Memory

Remediation after TBI with Donepezil to study the effects of the medication Donepezil, currently used to treat Alzheimer's associated dementia, on improving outcomes following TBI. DoD launched the *Dynamic Model Initiative* for TBI to explore opportunities for using existing datasets to develop more precise and predictive criteria for diagnosing TBI. These efforts support NRAP goals of continuing trials for TBI therapeutics and developing more precise and predictive criteria for diagnosing TBI. A new interagency Work Group has also been established to generate a central repository of resources available for TBI, PTSD, and suicide neuropathology research and biomarker studies.

Suicide Prevention Research

Completed Activities. National Action Alliance for Suicide Prevention (Action Alliance), a public-private partnership including NRAP agencies, recently released *A Prioritized Research Agenda for Suicide Prevention: An Action Plan to Save Lives*. This report sets ambitious goals for saving lives by preventing suicide for all U.S. citizens, and it outlines theoretical models to advance the science of understanding precursors and causes of suicide and its prevention. The report was the focus of an interagency meeting in December 2013 to review initial research portfolio analyses and to evaluate gap areas. The outcome of this meeting was an increased awareness of each Agency's portfolios, as well as privately-funded research, which will assist in identifying gaps such as studies addressing comorbid conditions and biomarkers for suicidal behaviors. This work will be updated as findings emerge through annual portfolio analyses, to develop improved prevention and interventions. NRAP and Action Alliance plan are aligned and the agencies have research underway that support many of the findings of the report, such as the *Home-Based Mental Health Evaluation (HOME) Intervention: A Model for Assisting Suicidal Veterans with the Transition from Inpatient to Outpatient Settings*.

Ongoing and Newly Launched Activities. More than a dozen investigations are now underway to identify actionable risk markers for suicide and to inform screening and follow-up services, as outlined in the NRAP. The Army/National Institute of Mental Health *Army Study to Assess Risk and Resilience in Service members (Army STARRS)* has developed and continues to refine risk algorithm tools (discussed below), which the Army Analytics Group is working to replicate. A Defense Advanced Research Projects Agency (DARPA) initiative, *Detection and Computational Analysis of Psychological Signals (DCAPS)*, is developing a distress cue algorithm relevant to suicidal ideation, depression and PTSD by analyzing patterns of subtle changes in sleep, eating, social interactions and nonverbal cues. DoD is funding research to review underlying theories of suicide, along with imaging studies examining neurobiological correlates of suicide behaviors in order to inform development of more efficient and effective targeted interventions.

Efforts are underway to assist in the translation of research findings into effective prevention strategies, policy to improve clinical care and clinical innovations. The Military Suicide Research Consortium is a five year effort, including 24 intervention research projects to advance suicide screening, assessment and prevention interventions with the goal of rapidly moving science to practice. The Military Suicide Research Consortium is a unique partnership between DoD, VA and Florida State University. In addition to the work that the Military Suicide Research Consortium is doing, DoD is funding several

large randomized clinical trials to test the efficacy of suicide prevention strategies that can be used in emergency departments, inpatient and outpatient settings and non-clinical settings. Similarly, to promote new and targeted research on risk factors for use in suicide screening and intervention, National Institute of Mental Health is supporting the Emergency Department-Safety Assessment and Follow-Up Evaluation project to test emergency department screening for suicidal behavior, and to test and refine an intervention for at-risk patients. Based on promising preliminary findings, NIMH issued a new funding opportunity (RFA-MH-14-070 *Pediatric Suicide Prevention in Emergency Departments U01*) soliciting research grant applications to utilize a similar model in pediatric patients. NRAP mandates the Agencies “Develop and test rapid, brief, and effective prevention and treatment interventions for suicide (including suicide ideation and attempts) applicable to a variety of settings, with rigorously designed randomized controlled trials that address comorbid problems.” The Emergency Department is a setting where prevention may be effective. Beyond improving detection of risk, investigators are looking to improve the care and recovery from suicidal thoughts and behaviors. VA is supporting research to increase treatment-seeking. It also approved a large multi-site trial of Lithium to prevent suicide re-attempt, which will begin August 2014. Recognizing one of the challenges with existing treatments is the lag between delivery and patient improvement, NIMH is funding a randomized controlled trial on the efficacy of a rapid-acting drug (Ketamine) to reduce suicidal ideation, compared to an active control (Midazolam).

To enhance the reliability of suicide data, the Defense Suicide Prevention Office is coordinating and developing a process to improve the DoD Suicide Event Report and other surveillance data, to analyze data and translate findings into policy updates and program strategy. DoD, VA, and Centers for Disease Control have established an inter-agency agreement to exchange National Death Index mortality outcome (including suicides) and military personnel data, in order to improve the completeness of suicide death surveillance of current and former Service members from 1979 to present. DoD/Defense Suicide Prevention Office, Army Ready and Resilient Campaign, and VA/Suicide Prevention Program are all focused on integrating military and civilian research findings into comprehensive suicide prevention approaches.

Comprehensive Longitudinal Mental Health Study

NRAP directed DoD and NIH to jointly develop a “comprehensive longitudinal mental health study with an emphasis on PTSD, TBI, and related injuries to develop better prevention, diagnosis, and treatment options. The agencies shall continue ongoing collaborative research efforts, with an aim to enroll at least 100,000 Service members by December 31, 2012, and include a plan for long-term follow-up with enrollees through a coordinated effort with the Department of Veterans Affairs.” In response, NIMH and Army jointly funded Army STARRS. Army STARRS was designed to identify risk and resilience factors for suicide and behavioral health that the Army could use to focus prevention efforts. This study has collected health data from more than 100,000 Active Duty Soldiers, fulfilling the requirement of the Executive Order. Participants provided detailed background information, completed neurocognitive assessments, gave blood samples, and volunteered to link these data to Army and DoD administrative

records. In addition, approximately 85 percent of the participants provided information that could be used to re-contact the Soldier for additional follow-up studies. This multi-component approach collected Soldier data from basic training to separation from the military, at sites across the world, and in many different phases of the Army readiness cycle. Prospective data collection of measures of psychiatric correlates, substance use, suicidality, and biosamples is nearly complete, and data analyses are underway. Using retrospective administrative data, the study has adopted an epidemiological approach to develop risk prediction models to identify groups of Soldiers at increased risk for adverse outcomes, primarily focused on suicide. These risk algorithms were delivered to the Army for refinement and extension to more recent data to predict groups at increased risk of committing suicide. Army STARRS findings will also be used to assist in targeting intervention studies in the Military Suicide Research Consortium. Study goals include developing risk prediction models for additional outcomes of interest to military leaders (e.g., predicting groups at increased risk for accidental death) and the full-scale analyses of data from the prospective elements of the study. Army STARRS has been working with Federal partners on establishing the scope of a potential next phase. Leaders from across the agencies met in November 2013 to discuss the current status of three national cohort studies, the Army STARRS (funded by Army and NIMH), the Millennium Cohort Study (funded by DoD and VA), and the Million Veteran Program (funded by VA). The leaders discussed the feasibility and potential scientific value of long-term follow-up of these studies to improve prevention, diagnosis, and treatment options in Service members and Veterans. The outcome of these discussions was that the Agencies agreed that there was value in continuing all three studies and they agreed to explore leveraging the strengths of each study through coordinated interagency planning.

Appropriate Data Sharing

Completed Activities. The Executive Order stated that agencies should work to “improve data sharing between agencies and academic and industry researchers to accelerate progress and reduce redundant efforts without compromising privacy”. Agencies are also cognizant of the related Executive Order on making open and machine readable the default for government information and the subsequent Office of Management and Budget memo 13-13. In response to the February 22, 2013 memo from the Office of Science and Technology Policy, *Increasing Access to the Results of Federally Funded Scientific Research*, DoD, NIH, the Department of Education and VA have submitted their agency’s data-sharing plans to the Office of Science and Technology Policy and plan to release them to the public once they are completed later this year.

As noted earlier, a significant accomplishment is the expansion of the Psychiatric Genomics Consortium to include PTSD cohorts. Researchers are now depositing de-identified genetic and health data to facilitate meta-analyses, replication, and extension of early findings. The PTSD group began their first analysis in December 2013, with additional analyses planned on an ongoing basis. The National Institute on Drug Abuse has a data-sharing website (datashare.nida.nih.gov) that allows de-identified data from completed National Institute on Drug Abuse-supported clinical trials to be distributed to the public and researchers to facilitate new research, secondary and exploratory analyses, and the dissemination of

research findings to the research community and public. This is one part of meeting the goal for data sharing in the Executive Order and the National Research Action Plan (NRAP) in the first year.

Ongoing and Newly Launched Activities. Several new research initiatives and funding opportunities have been created. NIMH is planning to expand the Mental Health Research Network, a network of 11 research sites in 16 health care delivery organizations, which have integrated research divisions that are engaged in health care research. The planned expansion would include additional health systems and investigators to enhance capacity for high priority research related to PTSD, mental health and substance use. The Mental Health Research Network efforts are consistent with the Executive Order and NRAP goals related to improving data sharing between agencies and academic and industry researchers and making better use of electronic health records. The Mental Health Research Network is linking health information databases for a common electronic medical record system and measurement assessment, harmonization of procedures for protecting patients' rights and privacy, and creating an efficient process for assessing outcomes and understanding best practices. To accomplish the expansion, NIMH released RFA-MH-14-110 *Mental Health Research Network II* in May 2013, and applications will be considered for funding in early 2014.

VA and DoD initiated a collaboration between newly launched activities include a collaborative effort between DoD's Millennium Cohort Study and VA's Office of Research and Development and Office of Public Health. VA researchers will be hired on site at the Naval Health Research Center in San Diego, where the Millennium Cohort Study is based. These VA researchers will investigate how analysis of existing Millennium Cohort Study data may inform future directions of VA research, and they will explore the feasibility of data sharing between the Millennium Cohort Study and ongoing and future VA studies. In 2013, the agreement between VA and DoD to initiate this collaboration was executed. One VA researcher was hired in late 2013, and a second researcher is scheduled to come on board in 2014.

In another effort, DoD's Congressionally Directed Medical Research Programs is working with NIH to perform a pilot study on the feasibility of transferring DoD research funding information into the NIH electronic research administration system and ultimately to the NIH RePORTER website. NIH RePORTER currently contains funded projects from multiple agencies including NIH and VA. The addition of DoD-funded research projects to this site would allow central public access to federally funded research from multiple funding agencies. National Institute on Disability and Rehabilitation Research is also communicating with NIH regarding NIH RePORTER, as a first step in exploring the feasibility of using NIH RePORTER.

NIH's funding opportunity to solicit applications for *Accelerating the Pace of Drug Abuse Research Using Existing Data*, which involves National Institute on Drug Abuse, National Institute on Alcohol Abuse and Alcoholism, and National Cancer Institute, invites applications proposing the innovative analysis of existing social science, behavioral, administrative and neuroimaging data to study the etiology and epidemiology of drug-using behaviors (defined as alcohol, tobacco, prescription, and other drugs) and related disorders, associated Human Immunodeficiency Virus (HIV) risk behaviors, prevention of drug use and HIV and health service utilization. The plan is that a message will be sent to

appropriate agency grantees from participating agencies encouraging their use of PAR-13-080, which is focused on the use of existing data for secondary data analysis.

Finally, the agencies are facilitating collaboration related to the Federal Interagency Traumatic Brain Injury Research data repository. National Institute on Disability and Rehabilitation Research is working with NIH/National Institute of Neurological Disorders and Stroke and DoD to evaluate the feasibility of linking the National Institute on Disability and Rehabilitation Research-funded TBI Model Systems National Database with the Federal Interagency Traumatic Brain Injury Research Informatics System.

Summary on the National Research Action Plan

The agencies launched the implementation of the NRAP in August 2013. This progress report summarizes the substantial accomplishments related to the 12-month action items. A more detailed progress report will be released in August 2014, which will evaluate the progress and next steps on the deliverables and priorities set in the NRAP. The agencies will start the implementation of the two-year to four-year action items in 2014. In 2014, the agencies will continue to work collaboratively to achieve the scientific goals in the Executive Order, which are:

- Establish surrogate and clinically actionable biomarkers for early diagnosis and treatment effectiveness.
- Develop improved diagnostic criteria for TBI.
- Enhance our understanding of the mechanisms responsible for PTSD, related injuries and neurological disorders following TBI.
- Foster development of new treatments for these conditions based on a better understanding of the underlying mechanisms.
- Improve data sharing between agencies and academic and industry researchers to accelerate progress and reduce redundant efforts without compromising privacy.
- Make better use of electronic health records to gain insight into the risk and mitigation of PTSD, TBI and related injuries.
- Support collaborative research to address suicide prevention.

Recommendation 7

Develop and implement targeted mental health and substance abuse strategies that respond to the diversity of Veterans, Service members and their Families.

The military community is one of the most diverse populations in America. The *2012 Demographics: Profile of the Military Community* (released 2013) indicates that the total number of Active Duty and Reserve and Guard component military personnel is over 2.2 million strong, with over 3 million Family members, including spouses, children, and adult dependents. Nearly one-third (30.3 percent) of Active

Duty members and approximately one quarter (24.5 percent) of Reserve and Guard component identify themselves as a minority. Women comprise 15 percent of the Active Duty force and 18.2 percent of the Reserve and Guard component. To meet the needs and respond to the diversity of Service members, Veterans and their Families, each Department is committed to developing and implementing targeted mental health and substance use strategies. Additionally, DoD, VA, and HHS have made strides to improve the care and resources provided to the lesbian, gay, bisexual and transgender (LGBT) populations. The below section highlights each Department's progress and accomplishments in developing and implementing strategies for the following diverse populations: (1) LGBT; (2) minorities, and (3) women.

Progress/Accomplishments:

Lesbian, Gay, Bisexual and Transgender

Health and Human Services Accomplishments. In 2010, HHS, under the direction of Secretary Kathleen Sebelius, established a Department-wide LGBT Issues Coordinating Committee in response to the Presidential request to improve the health and well-being of LGBT individuals, Families, and communities. The Committee, on behalf of the Secretary, developed the Secretary's Recommended Actions to the President to Improve LGBT Health and Well-Being, which were sent to the President and released to the public in 2011 ([hhs.gov/secretary/about/lgbthealth.html](https://www.hhs.gov/secretary/about/lgbthealth.html)). In 2012, the Committee released the 2012 report of accomplishments in 2011 and goals for the following 12 months ([hhs.gov/secretary/about/lgbthealth_objectives_2012.html](https://www.hhs.gov/secretary/about/lgbthealth_objectives_2012.html)). Recognizing the need to address the special needs of the sub-populations within the LGBT population, some organizations and programs extended their reach to span additional groups or alternatively focused their efforts on only a few particular groups within the population. This factor explains the seemingly inconsistent description of populations served below.

In 2013, the Committee efforts included the following areas:

- *Federal Recognition of Same-Sex Spouses/Marriages:* HHS continued to work quickly to implement the Supreme Court ruling invalidating Section 3 of Defense of Marriage Act.
- *Health Insurance Marketplace Outreach and Enrollment:* Beginning in 2013, HHS has engaged in broad outreach to help uninsured Americans gain access to affordable health insurance coverage through the Health Insurance Marketplaces under the Affordable Care Act. HHS has been focused on ensuring that all communities understand their options and how to enroll in coverage. In conjunction with the first open enrollment season for the Marketplaces, HHS hosted an outreach and engagement summit for the LGBT community to equip the community leaders with tools, information, and resources to assist LGBT individuals.
- *Research and Data Collection:* In 2013, NIH continued efforts on growing the field of health research relating to the LGBT community and is planning a first annual NIH Lesbian, Gay, Bisexual, Transgender and Intersex Research Symposium. This meeting will further explore critical topics in

lesbian, gay, bisexual, transgender and intersex health research. Additionally, NIH will analyze the FY 2012 lesbian, gay, bisexual, and intersex-research related portfolio. HHS has developed survey questions on gender identity and sexual orientation as a module that the states can use in Center for Disease Control's Behavioral Risk Factor Surveillance System to help develop scientific survey data on this population's health status and health care experience. HHS will be testing these questions, as well as dedicating resources to providing technical assistance and support to states that use the questions. SAMHSA is testing sexual orientation questions within its deployment of the 2013 National Survey on Drug Use and Health.

- *Youth and Families*: SAMHSA, working with the Family Acceptance Project, developed a resource document for practitioners who work with LGBT youth for use in multiple service sectors (e.g., behavioral health, child welfare, juvenile justice, primary care, schools, homeless and runaway programs, etc.). This document helps them understand the role of family acceptance/rejection in overall health, behavioral health and well-being and be able to implement best practices in engaging and creating supportive families. The Administration for Children and Families will be funding two grantees to begin a systematic review of practices and services aiming to improve the well-being of LGBT individuals. One effort will focus upon homeless lesbian, gay, bisexual, transgender and questioning youth, while the other will focus on domestic violence, intimate partner violence, and dating violence prevention for lesbian, gay, bisexual, transgender and questioning and their Families.
- *Training*: SAMHSA and HRSA coordinated to compile and maintain a list of six training curricula for behavioral health and primary care practitioners to help assess, treat, and refer LGBT clients in a culturally sensitive manner. Continuing Medical Education and continuing education unit credits are available. This list is comprised of Federal and non-Federal resources to provide information to consumers; however, views and content in the resources have not been formally approved by HHS or HRSA. The course list includes: (1) Effective Communication Tools for Health Professionals, (2) HIV/AIDS and Substance Use Disorders in Ethnic Minority Men Who Have Sex With Men, (3) National LGBT Health Education Center Continuing Education, (4) Nurses Health Education About LGBT Elders Curriculum, (5) A Provider's Introduction to Substance Abuse Treatment for LGBT Individuals: Training Curriculum, and (6) Removing the Barriers.

Throughout FY 2013, HHS continued to make important strides toward improving the health and well-being of LGBT individuals, Families, and communities. For additional information, please refer to the Department's report on these activities available at hhs.gov/lgbt/health-objectives-2013.html.

Extending TRICARE Health Benefits to Same-Sex Spouses of Military Members. DoD implemented the Supreme Court's 2013 decision declaring Section 3 of the Defense of Marriage Act unconstitutional, and it is DoD's policy to treat all married military personnel equally. TRICARE health benefits are extended to members and certain former members, and their dependents, including spouses, as defined in Section 1072 of title 10, United States Code. For purposes of TRICARE eligibility, a spouse is a lawful husband or wife of a member or former member. Prior to the Supreme Court ruling, the Defense of Marriage Act had prevented federal recognition of same-sex marriages as lawful marriages, notwithstanding state law. DoD is implementing the Supreme Court's decision in consultation

with the Department of Justice and other executive branch agencies. DoD construes the words *spouse* and *marriage* to include same-sex spouses and marriages, and DoD provides the same benefits, including TRICARE health benefits, available to all military spouses, regardless of sexual orientation.

Veterans Health Administration Lesbian Gay Bisexual and Transgender Initiatives. In February 2013, Veterans Health Administration (VHA) reissued its transgender and intersex care Directive 2013-003 with an appendix of Frequently Asked Questions. The VHA also appointed two LGBT Program Coordinators to advise Patient Care Services on culturally and clinically appropriate care, develop and deliver training to clinical staff, and respond to clinical questions from the field. The LGBT Program Coordinators led several training initiatives. Two expert-led national teleconferences were provided to broad clinical audiences within VA. These trainings were entitled *Quality Healthcare for Lesbian, Gay and Bisexual Veterans* and *Clinical Skills in Obtaining a History of Sexual Health*. Approximately 750 VHA staff attended these presentations. Two lesbian, gay and bisexual awareness campaign posters were released to VA facilities. The posters, LiveMeeting presentations, clinical resources, and other materials were archived on a VA Lesbian, Gay and Bisexual Education SharePoint site accessible to all VA staff. A Transgender Education SharePoint site had previously been established and loaded with training materials and resources. In addition, LGBT Program Coordinators and additional subject matter experts worked with the Employee Education System to develop a three-part online training program on transgender Veteran health care for VA staff. This program will be released in 2014.

In June 2013, four interdisciplinary teams received intensive training by experts to lead two transgender consultation programs that will be launched in 2014. Using telehealth, one team will train clinical teams in every VA Network by providing case-based consultation over several months. Three teams will provide brief consultation on transgender care to facilities in multiple VA Networks via e-consults. VHA also competitively funded seven postdoctoral psychology fellowships on LGBT health care this year: Bedford, MA; Honolulu, HI; West Haven, CT; San Francisco, CA; Boston, MA; Milwaukee, WI; and Houston, TX. Two additional LGBT fellowship programs (Hines, IL and San Diego, CA), summing to a total of nine, will be established in 2014.

In 2013, the Office of Health Equity led efforts to encourage VA Medical Centers to participate in the Human Rights Campaign 2013 Healthcare Equality Index. The Healthcare Equality Index score is an indicator of a LGBT-positive health care environment. Participation in the Healthcare Equality Index involves reporting the facility's policies and trainings related to LGBT patients and their Families. One hundred and twenty-one (80 percent) VA facilities participated, and 92 achieved Healthcare Equality Index Leadership status. The Office of Health Equity also asked VA Medical Centers to identify initiatives to make their facility more welcoming for LGBT Veterans and received 570 proposed activities from 145 VA Medical Centers.

Center for Minority Veterans

The Center for Minority Veterans is the VA model for inter-and intra-agency cooperation, to ensure all Veterans receive equal service regardless of race, origin, religion or gender. The Center for Minority

Veterans was established by Public Law 103-446, in 1994. Title 38, United States Code, Section 317 reflects the current responsibilities of the Center for Minority Veterans. The Center director serves as principal advisor to the Secretary on the adoption and implementation of policies and programs affecting minority Veterans. The Center for Minority Veterans serves as an advocate for minority Veterans by conducting outreach activities to promote the awareness and use of VA benefits and services.

Veterans Health Administration Center for Health Equity Research and Promotion

The mission of the VA Center for Health Equity Research and Promotion, a VA Health Services Research and Development Center of Innovation, is to promote equity and quality in health and health care among Veterans and other populations. The VA Center for Health Equity Research and Promotion is focused on detecting, understanding, and reducing disparities in health and health care in vulnerable populations. The VA Center for Health Equity Research and Promotion has been selected for funding as a VA Health Services Research and Development National Center of Innovation for five years beginning in October 2013.

The VA Center for Health Equity Research and Promotion focuses on vulnerable Veteran populations, including those who face potential discrimination because of race, ethnicity or social status, and those at risk for disparities in health or health care due to other physical and/or mental conditions. For equity research, the Center for Health Equity Research and Promotion uses a framework that recognizes three generations of health equity research:

- Detection of disparities in health and health care
- Understanding the causes and mechanisms of these disparities
- Development and testing of interventions to reduce or eliminate disparities

SAMHSA’s Office of Behavioral Health Equity

SAMHSA’s Office of Behavioral Health Equity was established in accordance with Section 10334 of the Affordable Care Act of 2010. Section 10334(b) of the Affordable Care Act required six agencies within HHS to establish offices of minority health. The Office of Behavioral Health Equity launched in 2012 and coordinates SAMHSA efforts to reduce behavioral health (mental health and substance use) disparities for diverse racial, ethnic and LGBT populations. The Office of Behavioral Health Equity’s efforts are geared to promote health equity for all racial, ethnic and LGBT populations, and support populations vulnerable to behavioral health disparities.

OBHE Strategic Framework
<ul style="list-style-type: none">• Data• Communications• Policy• Workforce Development• Customer Service

The Office of Behavioral Health Equity seeks to impact SAMHSA policy and initiatives by:

- Creating a more strategic focus on racial, ethnic and LGBT populations in SAMHSA investments
- Using a data-informed quality improvement approach to address racial and ethnic disparities in SAMHSA programs
- Building on the Affordable Care Act’s attention to health disparities to influence how SAMHSA does its work, including grant-making operations and policy development

VA’s Women Health Services Office

VA's Women Health Services Office provides programmatic and strategic support to implement positive changes in the provision of care for all women Veterans. In 1988, the Women Veterans Health Program was created to streamline services for women Veterans in order to provide more cost-effective medical and psychosocial care. The reorganization affords greater opportunities for collaboration between VA Women's Health Services Office and programs including Primary Care, Mental Health, Specialty Care (e.g., cardiology and pain management), and other offices within Patient Care Services.

VA Women’s Health Services Office addresses the health care needs of women Veterans and works to ensure that timely, equitable, high-quality and comprehensive health care services are provided in a sensitive and safe environment at VA health facilities nationwide. Strategic priorities focus on six pillars designed to deliver the best health care services to all women Veterans:

- Comprehensive primary care
- Women's health education
- Reproductive health
- Communication and partnerships
- Women's health research
- Special populations

VA Women’s Health Services Office is coordinating closely with Primary Care Services to redesign the delivery of primary care to women Veterans to include gender-specific care at every VA site. Ultimately, comprehensive primary care delivered by a single provider in the same location—including gender-specific care and mental health—will be the predominant model of care throughout the VA health care network.

Women Veterans Health Care

Women Veterans Health Care works to make certain that all eligible women Veterans requesting VA care are assured of:

- Comprehensive primary care by a proficient and interested primary care provider
- Privacy, safety, dignity and sensitivity to gender-specific needs
- Right care in the right place and time
- State-of-the-art health care equipment and technology
- High-quality preventive and clinical care, equal to that provided to male Veterans

Additionally, VA Women's Health Services Office is working to ensure that the needs of all women Veterans are addressed, including those populations that require special attention, such as women Veterans with mental illnesses that can benefit from the integration of mental health services within primary care, so that necessary treatment is provided in a comprehensive and coordinated way. VA Women's Health Services Office is also working to enhance the availability of woman-safe inpatient psychiatric acute units.

Appendix 1: Interagency Task Force August Update

Joint Fact Sheet: Interagency Task Force on Military and Veterans Mental Health Update

On August 31, 2012, President Obama signed Executive Order 13625 directing the Departments of Veterans Affairs (VA), Defense (DoD), and Health and Human Services (HHS), in coordination with other Federal agencies, to take steps to ensure that Veterans, Service members, and their Families receive the mental health services and support they need³. These steps include strengthening suicide prevention efforts across the Force and in the Veteran community; enhancing access to mental health care by building partnerships between the VA and community providers; increasing the number of VA mental health providers serving our Veterans; and promoting mental health research and development of more effective treatment methodologies.

There is a clear alignment between these Executive Order Requirements and objectives from the World Health Organization Global Mental Health Action Plan 2013-2020, which calls for reducing the rate of suicides, addressing negative attitudes, and applying targeted interventions for mental illness. Objectives include developing priority health policies, plans, and research agendas as well as applying a *community-based service delivery* of mental health services. This congruence between the Executive Order and World Health Organization Global Mental Health Action Plan highlights the emerging global focus on mental health issues and emphasis on suicide research and prevention.

The Interagency Task Force on Military and Veterans Mental Health 2013 Interim Report⁴ was released on May 21, 2013. This document summarized the action steps in several key areas that designated Federal Departments have taken since the release of the interim report, with updates as of August 15, 2013.

Suicide Prevention

Implement the National Suicide Prevention Campaign

- *Stand by Them* was successfully launched in September 2012. This national suicide prevention campaign is a coordinated DoD/VA outreach initiative that encourages Veterans, Service members, Family, friends, and other key individuals to connect with VA for confidential support in times of need. This vital message is distributed through in-person participation in local and national events as well as through joint DoD/VA media efforts. The campaign is used by both Departments to highlight the services and resources available from the Veterans and the Military Crisis Line.
- *It Matters* is the 2013 National Suicide Prevention Campaign theme and launched in September.

³ <http://www.whitehouse.gov/the-press-office/2012/08/31/executive-order-improving-access-mental-health-services-Veterans-service>

⁴ http://www.whitehouse.gov/sites/default/files/uploads/2013_interim_report_of_the_interagency_task_force_on_military_and_Veterans_mental_health.pdf

- The Veterans Crisis Line has met the goal of increasing capacity by 50 percent. Over 29,000 rescues of actively suicidal callers have been accomplished by the Crisis Line since its launch. All new staff members are trained to ensure that Veterans in crisis can readily access help.

Align Metrics to Measure Program Effectiveness

- The Defense Centers of Excellence (DCoE) for Psychological Health and Traumatic Brain Injury held a Metrics Meeting on September 18-19, 2013, with representation from DoD, HHS and VA. The group aimed to assess current and recommended mental health metrics, and how those measurements can be aligned to national standards.
- DCoE completed an effectiveness review of 141 clinical and non-clinical psychological health programs and ranked them according to how well they met criteria across five dimensions according to the FY 2013 DoD Agency Priority Goal. DCoE convened a scientific panel of 46 U.S. Federal Government (non-DoD) personnel, including those from SAMHSA, NIH, and VA. DCoE has initiated a review of DoD Traumatic Brain Injury Programs and will have an interim report at the end of Q2 FY 2014.

Enhanced Partnerships Between VA and Community Providers

Encourage and Partner with Communities

- On May 29th, 2013, VA Undersecretary for Health, Dr. Robert Petzel, charged all VA Medical centers with hosting Community Mental Health Summits this summer. VA's Mental Health Services is coordinating Mental Health Summits at all VA Medical Facilities by the end of September 2013. The Summits identified community-based programs and services to support the mental health needs of Veterans and their Families. Summit activities focused on building and strengthening collaborations with community based organizations.
- As directed by the Executive Order, 24 pilot programs across nine states and seven Veterans Integrated Service Networks (VISNs) were established to strengthen partnerships between VA and community providers. As of May 31, 2013, the pilots have been established across Georgia, Tennessee, Wisconsin, Mississippi, Alaska, South Dakota, Nebraska, Indiana, and Iowa. Pilot programs are varied and include provisions for inpatient, residential, and outpatient mental health and substance use services. HHS assisted VA in identifying community providers to support these pilot programs. Sites were established based upon community provider available capacity, levels of care available, Veteran acceptance of external care, location of care with respect to Veteran population, and mental health needs in specific areas.

Expanded VA Mental Health Staffing

Recruit, Hire and Place 1,600 Mental Health Professionals

- As of June 30, 2013, 4,308 mental health professionals and administrative support have been hired and are providing services to Veterans since the start of VA's Mental Health Hiring

Initiative in April 2012. Of these, 1,669 mental health providers have been hired specifically as part of the Executive Order's initiative to add 1,600 clinical mental health professionals by June 30, 2013.

- A comprehensive recruitment and hiring plan is also being implemented to ensure that 800 peer specialists are hired and trained by December 31, 2013. As of July 31, 2013, VA has hired 551 new peer specialists and is on track to meet this goal.

Enhance Capacity of Mental Health Care Work Force

- DoD, VA, and HHS are jointly engaged in developmental work on training and recruitment aspects of strengthening the national mental health workforce.
- Within HHS, Health Resources and Services Administration (HRSA) and SAMHSA are holding a joint session with behavioral health stakeholders about workforce issues as a follow-up to a March 2013 report to Congress on behavioral health workforce issues.

Improved Research and Development

Implement a National Research Action Plan

- The National Research Action Plan (NRAP) was released on August 10, 2013⁵. This strategic guide informs development of tools and strategies for the prevention, diagnosis and treatment of mental health conditions and outlines clear strategies to support research to address suicide prevention. The NRAP was the result of collaboration between DoD, VA, HHS, and the Department of Education.

Understanding of Posttraumatic Stress Disorder and Traumatic Brain Injury Enhanced

- DoD and VA have established two joint research consortia, at a combined investment of \$107 million. The Consortium to Alleviate Posttraumatic Stress Disorder (PTSD), a collaboration between the University of Texas Health Science Center – San Antonio, San Antonio Military Medical Center and the Boston VA Medical Center will discover and develop biomarkers.
- The Chronic Effects of Neurotrauma Consortium is a collaboration between Virginia Commonwealth University, the Uniformed Services University of the Health Sciences, and the Richmond VA Medical Center and will study the links between concussions, chronic mild traumatic brain injury (TBI), neurodegeneration and comorbidities.
- A DoD collaboration with the University of Pittsburgh has used high definition fiber tracking to accurately diagnose TBI. A similar collaboration with the University of Wisconsin-Madison produced a non-invasive neurostimulation therapy for TBI patients.

Develop and Implement Targeted Mental Health Strategies

⁵ http://www.whitehouse.gov/sites/default/files/uploads/nrap_for_eo_on_mental_health_august_2013.pdf

- The NIH and DoD will build on their collaborative 100,000 Service member study, the Army Study to Assess Risk and Resilience in Service members, to assess how a longitudinal follow-up can define risk and resilience for suicide.
- Research portfolios are under review to identify current ongoing projects, deliverables to date, and future direction for PTSD, TBI, and other mental health issues. Various projects revolving around new treatments, improved data sharing, and enhanced use of electronic health records are on track to be well underway by the end of 2013.

Appendix 2: February Report of ITF Work Group on Common Mental Health Metrics

TO: Jonathan Woodson, M.D., Assistant Secretary of Defense for Health Affairs, DoD
Robert Petzel, M.D., Undersecretary for Health, DVA
Pamela Hyde, J.D., Administrator, Substance Abuse and Mental Health Services
Administration, DHHS

FROM: Working Group on Common Mental Health Metrics

SUBJECT: Recommendations for Common Metrics for Assessing Progress in Addressing
Psychological Health Problems

DATE: 7 February 2014

The report is in response to a request from the co-chairs of the Military and Veterans Mental Health Interagency Task Force (Task Force) for recommendations for a core set of metrics for use in the provision of services and program management and evaluation to track progress in addressing psychological health conditions among Active Duty and Reserve personnel and Veterans. A workgroup was formed with staff from the Department of Veterans Affairs, the Department of Defense, and the Department of Health and Human Services. This effort has been coordinated with but is distinct from efforts to identify and promote common data elements for TBI, PTSD, and suicide prevention research that are being undertaken by the National Research Action Plan agencies in response to the Executive Order.

Reducing mental distress and improving psychological health among Active Duty and Reserve personnel and Veterans is a critical task for the nation. Mental distress and mental disorders are associated with reductions in readiness among service men and women. They are also associated with high levels of disability and substantial costs that can lead to significant morbidity and premature mortality. One of the primary goals of this paper is to provide providers who work with Active Duty personnel and Veterans a common set of metrics to measure mental distress and related conditions and track progress to inform clinical and programmatic decisions.

For the purposes of this report, psychological health incorporates the concepts of well-being of mind, body, and spirit with a focus on resilience and readiness.¹¹ Accurate and timely measurement of psychological health and improvement among Active Duty and Reserve personnel and Veterans is central to assessing the impact of programs and policies and improvement at the population level. This paper provides a brief set of recommendations for measures to be used by those agencies/services that can be implemented incrementally depending on available resources, with some implementation possible immediately. The group recognizes that implementation will require making infrastructure changes in clinical informatics and providing necessary staff training. This plan shall take into account factors that are expected to impact each service/agency's ability to administer specific instruments, collect data, and make it available for clinical use electronically. Each service/agency will be asked to develop strategies for implementation, identify agency-specific barriers to implementation, and establish a realistic timeline within which there will be full implementation.

In selecting measures to recommend to the Task Force, workgroup members determined that limiting the recommendations to measures that could address high volume and high impact psychological health conditions would be of greatest value in tracking overall progress at a clinical and population level. Further, the workgroup was guided by the common goal of finding instruments that:

- Could be easily administered across various settings to track progress in recovery within the restrictions of availability for care, deployments, and transfers
- Had the potential to harmonize with other measurement initiatives
- Had strong reliability and validity
- Could reflect outcomes relevant both to improved psychological health and readiness

To that end, the group focused on identifying a core set of measures that capture PTSD, depression, anxiety, alcohol and tobacco use. These measures serve as diagnostic aids, measure symptom severity, and assist in the monitoring of these conditions but are not substitutes for actual diagnostic assessment.

Recommended Measures

Posttraumatic Stress Disorder (PTSD): The PTSD Checklist – PCL-5

Background Information: The PCL-5 is a newly created 20-item self-report measure for PTSD that can be used for screening, assessing symptom severity, and monitoring treatment response. The PCL-5 takes between 5-10 minutes for an individual to complete. Items on the PCL-5 correspond to the revised DSM-5 PTSD diagnostic criteria published in 2013. Of note, prior to the development of the PCL-5, PTSD was often assessed using the PCL, a 17-item self-report measure of PTSD symptoms with items that corresponded to the DSM-IV diagnostic criteria. On the PCL, respondents were asked to rate symptoms over the past month on a scale from 1-5 with scores ranging from 17-85. Cut-off scores on the PCL were between 30 and 50, depending on the sample and clinical context. Given the recommended shift to a measure consistent with DSM-5, clinicians will need to be sensitive to differences in scoring between the PCL and the PCL-5. On the PCL, data suggested that a 5-10 point change represented reliable change (greater than chance measurement error) with a >10 point change representing clinically significant change (clinical significance consistent with treatment response). As the PCL-5 is a new measure, research is currently underway to determine the appropriate magnitude of change for a score that represents reliable change (any change in severity beyond chance measurement error) and the change scores that represent clinically significant change that may reflect treatment response. The PCL-5 is a standardized metric which will allow for examination of group differences and permit for assessment of change over time.

Scoring Criteria: Respondents rate how much they are bothered by symptoms over the past month on a scale from 0 (not at all) to 4 (extremely). Overall PCL-5 scores range from 0-80. The cut-off score on the PCL-5 is 38 for likelihood of meeting DSM-5 diagnostic criteria for PTSD.

Recommended Administration Frequency: It is recommended that the PCL-5 be given at the initiation of treatment and as clinically indicated during treatment (preferably at each treatment session), but at least once between 60-120 days after intake (with a target of approximately 90 days consistent with the duration of most evidence-based psychotherapy protocols). The PCL-5 can be interpreted by a range of providers so is recommended for self-administration or administration by any mental health or substance abuse professional interacting with the client.

Implementation: The PCL-5 is a patient/client self-report measure and is, therefore, subject to response biases including to social desirability factors and occupational concerns. The PCL-5 is not yet available in the electronic medical record of any of the Departments and the date of availability is not yet determined. At this time, some providers across departments continue to use paper versions of this measure, while others continue to use the original PCL for DSM IV which has full electronic health record (EHR) implementation. . The expectation is that, over time, all providers will move to using the PCL-5 electronically. Providers will not be encouraged to use the older version of the PCL as this is not consistent with DSM-5 diagnostic criteria.

Depression: Patient Health Questionnaire – 9 (PHQ-9)

Background Information: The PHQ-9 is a nine-item scale with demonstrated applicability for screening, assessing symptom severity, and outcome monitoring of depressive disorders, including suicidality. Scale items are mapped against DSM IV criteria for Major Depressive Disorder and are scored based on symptom frequency during the past two weeks from 0 (not at all) to 3 (nearly every day), yielding a total scale score that ranges from 0 to 27. No significant changes to diagnostic criteria for major depressive disorder were made with the publication of DSM-5. Consequently, there are no expected changes to the operating characteristics of the PHQ-9 under the revised diagnostic system.

Scoring Criteria: PHQ-9 scores greater than 4 indicate depression symptoms that are clinically relevant. Clinical cut scores of 5, 10, 15, and 20 represent symptom severity levels corresponding to mild, moderate, moderately severe, and severe depression, respectively. Using a cut point of 10, the PHQ-9 has a demonstrated sensitivity of 88% and specificity of 88% for major depressive disorder.

Recommended Administration Frequency: For symptom severity and outcome monitoring purposes, we recommend administration of the PHQ-9 at every clinical encounter where a depressive disorder is the focus of treatment. At a minimum, the PHQ-9 should be administered upon treatment initiation and at least once between 60-120 days after intake. More frequent administrations are recommended due to high rates of patient attrition.

Implementation: The PHQ-9 is a patient/client self-report measure and is, therefore, subject to response biases including to social desirability factors and occupational concerns.

Anxiety: Generalized Anxiety Disorder – 7 (GAD-7)

Background Information: The GAD-7 is a seven-item scale with demonstrated applicability for the screening and symptom monitoring of a variety of anxiety disorders. Scale items are mapped against DSM-IV criteria for Generalized Anxiety Disorder and are scored based on symptom frequency during the past two weeks from 0 (not at all) to 3 (nearly every day) yielding a total scale score that ranges from 0 to 21. No significant changes to diagnostic criteria for generalized anxiety disorder were made with the publication of DSM-5. Consequently, there are no expected changes to the operating characteristics of the GAD-7 under the revised diagnostic system.

Scoring Criteria: GAD-7 scores greater than 4 indicate anxiety symptoms that are clinically relevant. Clinical cut scores of 5, 10, and 15 represent symptom severity levels corresponding to mild, moderate, and severe anxiety, respectively. Using a cut point of 10, the GAD-7 has a sensitivity of 89% and a specificity of 82% for Generalized Anxiety Disorder. Using the same cut-point, the GAD performs well as a screening instrument for two other common anxiety disorders: Panic Disorder, and Social Anxiety Disorder; however as an instrument for symptom monitoring, it lacks items for avoidance and panic.

Disorder	Sensitivity	Specificity
Panic Disorder	74%	81%
Social Anxiety Disorder	72%	80%

Recommended Administration Frequency: For symptom monitoring purposes, we recommend administration of the GAD-7 at every clinical encounter where Generalized Anxiety Disorder is the focus of treatment. At a minimum, the GAD-7 should be administered upon treatment initiation and at least once between 60-120 days after intake. More frequent administrations are recommended due to high rates of patient attrition.

Implementation: The GAD-7 is a patient/client self-report measure and is, therefore, subject to response biases including to social desirability factors and occupational concerns.

Alcohol and Tobacco Use

How many times in the past 30 days have you had X or more drinks in a day? Where X is 5 for men and 4 for women (Standard drinks should be defined with visual display or use verbal description).

If response indicates heavy drinking as defined above, alcohol use should be monitored at each subsequent visit or as appropriate clinically.

In the past 30 days, how many days have you had any tobacco use (cigarettes, cigars, chew, or pipes)?

How soon after you wake up do you first use a tobacco product?

- Within 5 minutes
- Within 6-30 minutes
- Within 31-60 minutes
- After 60 minutes

Recommended Administration Frequency: For outcome monitoring purposes, we recommend assessing alcohol and tobacco use consistent with the other clinical outcome measures, at least once 60—120 days after intake though clinical needs typically require more frequent monitoring.

Implementation: The items selected to assess alcohol and tobacco dependence are self-report items and, therefore, subject to response bias.

Demographics

1. Preferred language
2. Gender
3. Race – American Indian/Alaska Native, Asian, Black or African American, Native Hawaiian/Pacific Islander, and White.
4. Ethnicity – Hispanic or Latino OR Not Hispanic or Latino
5. Date of Birth

Considerations Regarding Interpretation of Measurement-Based Care Results

Measuring psychological symptoms over time allows clinicians to develop initial treatment plans, determine early treatment response, and adjust treatment plans if necessary to maximize health benefits. However, contextual variables can influence interpretation of psychological symptoms by providing, for example, information about the conditions under which a patient/client has improved or failed to improve. We focus on two general context domains: (1) the treatment context, e.g. characteristics of services such as type or intensity of care, and (2) the whole person context, e.g., patient/client health, general functioning, well-being, and experiences of care beyond symptom reduction.

Note that we focus on clinical, patient or client-level outcomes. Client or patient-level receipt of treatment is the immediate context for understanding symptoms. Facility-level performance on a treatment metric might provide the context for the client or patient-level treatment. Facility-level performance on a treatment metric should not work independently on patient/client symptoms, however, except through the path of treatment receipt. If it does, then it is acting as a marker of general quality or proxy for access to some other aspect of treatment or extra-treatment/environmental factors that directly impacts symptoms.

We also note that contextual metrics may vary depending on the health care system. For example, in DoD, functional status related to readiness may be the appropriate metric while in VA, a broader definition of functioning may be a better fit for evaluating outcomes of care. For this reason, we have not identified specific core metrics but rather have focused on suggesting the variables that may need to be developed within each health care system to better interpret outcomes.

Type of Treatment

Understanding the conditions under which improvement or lack of improvement has occurred provides important information for treatment planning and/or adjustments in care. A VHA clinician interpreting PHQ scores for a patient/client treated for depression in DoD will benefit from information about the patient's or client's utilization of antidepressants and/or psychotherapy. Interpretations of longitudinal scores for a patient/client with GAD should vary depending on whether the patient/client was using benzodiazepines or receiving cognitive behavioral therapy. At minimum, it may be useful to understand whether the patient/client was treated with medication, psychotherapy, or a combination of the two. At a systems level, it may be helpful to understand population utilization rates to assess demand.

Suggested metrics:

1. Percent patients/clients on medications alone
2. Percent patients/clients receiving therapy/counseling
3. Percent receiving therapy/counseling and medications

Levels of Care

Similarly, interpreting change in patient/client symptoms may vary as a function of the level of care. Knowing whether /clients were treated in inpatient treatment, residential programs, intensive outpatient programs, general mental health outpatient programs, or primary care mental health settings helps contextualize the observed treatment response, the type and dosage of treatment received and can be useful in decisions to either intensify or de-intensify the level of care. At a systems level, it may be helpful to understand population utilization rates to assess demand and rates of improvement.

Suggested metric:

1. Treatment setting (Inpatient, Residential, Outpatient, Primary Care)

Type of Provider

Improvement may also vary as a function of contact with the types of providers or interdisciplinary teams of providers required to implement relevant services, e.g., access to social workers and prescribing medical providers for patients/clients with mental health issues who are homeless. Patients/clients without reasonable levels of contact with these providers may not be receiving the same type of care as a patient/client who has ready access. While there is no data on the optimal staff mix or

required providers, systematic review of data on provider type or access to an interdisciplinary team can be helpful in understanding patient/client and system level improvement data.

Suggested metrics:

1. Individual provider type: MD/Psychiatrist, MD/Primary Care, Nurse/Nurse Practitioner, Psychologist, Social Worker, Marriage and Family Therapist, Licensed Professional Mental Health Counselor, Other
2. Interdisciplinary team based care

Treatment Engagement/Retention/Dose

Measuring whether patients/clients engage in care and are retained in care as well as the amount/dose of care they receive is critical for interpreting clients'/patients' response and may have important implications for understanding clients'/patients' symptoms over time. Note that quantity of treatment must be evaluated in conjunction with type of treatment.

Suggested metric:

1. Percent of patients/clients completing 3 visits in 6 weeks

The Whole Person or Recovery Context

Psychological symptoms occur in a context that includes clients'/patients' overall quality of life, functioning, co-morbid conditions, social support, and experience of care. For example, some patients/clients may experience only moderate symptom reduction in a specific domain (e.g., chronic pain), but improve significantly in functioning or quality of life as a result of treatment. Appropriate interpretations may require assessing functioning or readiness, quality of life, the therapeutic relationship or patient/client satisfaction with care. When considering the use of such measures, service/agency components should determine the relevancy of the measure to the stated outcomes as well as determine if there are restrictions related to ownership or other factors.

Suggested measures:

Quality of Life

- WHO – 8
- Centers for Disease Control and Prevention –Quality of Life
- HRQOL-14 Healthy Days Measure—Healthy Days Core Module
- Global Quality of Life Scale

Functioning

- Veterans RAND 12 item Health Survey (VR-12)
- Pain Scale

- WHO Disability Assessment Schedule 2.0 (WHODAS 2.0)
- Schwartz Outcomes Scale-10 (SOS-10)
- Illness Management and Recovery (IMR) Scales

Experience of Care/Patient Satisfaction

- Tailored patient/client satisfaction surveys
- Patient Global Impression of Improvement (PGI-I) Scale
- Therapeutic Alliance (WAI)
- Experience of Care and Health Outcomes (ECHO) Survey
- TCU Treatment Engagement- Treatment Satisfaction

General Distress

- Kessler 6

Access to Care

Access to care is another dimension that is important to consider in evaluating clinical and system level outcomes. Although access is often considered synonymous with timeliness, there are other dimensions of access that are also important including proximity to care (how far is the nearest treatment setting?), convenience of care (can care be received at times that are convenient for the client/patient – weekends, nights, etc.?), culturally appropriate care (is care delivery consistent with cultural values?), financial (is care affordable?). The group agreed that metrics associated with access to care are important in an overall evaluation of care. However, due to the complexity of the topic and the lack of standardized metrics, this area will be developed in the future.

Measuring Care Coordination/Informatics and Interoperability:

Care coordination is recognized as an important element in quality health care, but one that is difficult to measure. At this point in time, there is not an identified objective, easy to administer, measure of care coordination to recommend for inclusion in this effort. Any current efforts to measure care coordination are very labor intensive and include significant resources for chart review. While measurement of care coordination is an important consideration in advancing measurement based care, the current lack of recognized tools in this area makes it unfeasible to consider inclusion of this as a preliminary measure.

Implementation of a core set of metrics requires quality informatics tools for the administration of assessment instruments, collection of data, and comparison of data across settings and agencies. Significant challenges exist for all involved agencies in the area of implementation of strong informatics solutions to support the administration, data collection, analysis and feedback of the proposed metrics. These issues may impede recognizing full benefit of this effort if not resolved.

Quality of Data

Kilbourne, Keyser, and Pincus (2010)ⁱⁱ, note that some of the key reasons for the poor quality in the measurement of mental health conditions include lack of sufficient evidence regarding appropriate mental health care, poorly defined quality measures, limited descriptions of mental health services, and lack of linked health information. Poor quality in the data can lead to problems in patient/client care, communication challenges among providers and patients/clients, and difficulties in accurately assessing client/patient and program outcomes, among other concerns. Common causes of poor data quality can be both systematic (unclear definitions and guidelines for collection, lack of sufficient data checks, and no system for correcting data checks) and random (illegible handwriting, data entry errors, frequent turnover of staff). A number of steps have been identified by several authors to improve data quality including creating a minimum set of data items necessary to measure client improvement and program outcomes, develop common collection and data entry protocols that are user friendly, compose data checks and have a quality assurance plan, train and motivate staff, implement accessible electronic medical records, and provide data quality reports to users and payers.ⁱⁱⁱ

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