



Interagency Task Force on Military and Veterans Mental Health

2016 ANNUAL REPORT

Department of Defense
Department of Veterans Affairs
Department of Health and Human Services

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Table of Contents

I. Executive Summary	4
II. Contributing Offices	6
III. Introduction.....	7
IV. Interagency Progress.....	9
Recommendation #1: Suicide Prevention	10
Recommendation #2: National Research Action Plan	15
Recommendation #3: Joint Clinical and Outcome Measures.....	24
Recommendation #4: Community Partnerships	27
Recommendation #5: Lesbian, Gay, Bisexual, and Transgender Inclusion	31
Recommendation #6: Substance Use Disorder Policies and Practices	34
Recommendation #7: Sexual Assault, Sexual Harassment, and Military Sexual Trauma Policies and Practices	40
Recommendation #8: Workforce Development	46
V. Appendices	49
Appendix A: Acronym List	50
Appendix B: Resource List	53



I. Executive Summary

Executive Order (EO) 13625, *Improving Access to Mental Health Services for Veterans, Service Members and Military Families*, was released on August 31, 2012, and directed the Departments of Defense (DoD), Veterans Affairs (VA), and Health and Human Services (HHS) to ensure that Veterans, Service members, and their families have access to needed mental health services and support. EO 13625 established the Interagency Task Force on Military and Veterans Mental Health (ITF) and directed it to provide an annual review of agency actions, to define specific goals and metrics to aid in measuring progress, and make additional recommendations as appropriate to the President to improve mental health and substance use disorder treatment services for Veterans, Service members, and their families.

The ITF, co-chaired by the DoD Assistant Secretary for Health Affairs (ASD[HA]), the VA Under Secretary for Health, and the HHS Administrator for the Substance Abuse and Mental Health Services Administration (SAMHSA), tracks and reports progress in executing all activities resulting from recommendations made pursuant to the 2012 EO. The 2013 ITF Annual Report, released in November 2014, included the following recommendations:

1. Advance **suicide prevention** infrastructure and training across agencies to support Veterans, Service members and their families
2. Support and implement **National Research Action Plan** (NRAP) initiatives within HHS, DoD, and VA agencies
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
4. Build and enhance **community partnerships** to support Military and Veteran families
5. Implement and enhance policies and procedures to support full **inclusion of Lesbian, Gay, Bisexual and Transgender** (LGBT) populations in Departmental programs
6. Ensure effective **policy and practice integration addressing substance use disorders** (SUD) in populations served by the Departments
7. Advance **policies and practices that address military sexual assault, military sexual harassment and military sexual trauma** and health concerns related to these experiences
8. Advance **workforce development** models that support Veterans, Service members and their families

This report provides an update on interdepartmental actions during 2015 and 2016 to fulfill the ITF recommendations, and outline continuing efforts to further improve mental health treatment and programs for Veterans, Service members, and their families. These ITF recommendations build on strong inter- and intra-departmental accomplishments related to the EO and have been continuously implemented and refined thereafter. The success of the ITF in driving activities of the many recommendations under its purview was enabled through strong interagency collaboration forged over the past four years.

The Departments have placed high value on developing integrated governance structures, information technology (IT) infrastructures, and human capital investments across the eight recommendations. With experienced staff, embedded resources, committed leadership, and a history of interagency cooperation, the ITF continues to spearhead joint federal efforts to improve mental health services for Veterans, Service members, and their families. Going forward, the ITF will sustain progress and identify opportunities to augment existing initiatives through new collaborations.

Highlighted activities across each ITF recommendation include, but are not limited to:

Recommendation	Initiatives
#1: Suicide Prevention	<ul style="list-style-type: none"> - Suicide Data Repository - Outreach Programs: Military OneSource and Suicide Safe App - Crisis Resources: Military and Veterans Crisis Lines and National Suicide Prevention Lifeline - Clay Hunt Suicide Prevention for American Veterans Act
#2: NRAP	<ul style="list-style-type: none"> - Posttraumatic Stress Disorder Research - Suicide Prevention Research - Army STARRS Comprehensive Longitudinal Mental Health Study - Traumatic Brain Injury Research
#3: Joint Clinical and Outcome Measures	<ul style="list-style-type: none"> - Department-wide Implementation of Five Core Mental Health Outcome Measures - Behavioral Health Data Portal Implementation
#4: Community Partnerships	<ul style="list-style-type: none"> - Community Provider Toolkit Website - Annual Mental Health Summits - Military Families Learning Network
#5: LGBT Inclusion	<ul style="list-style-type: none"> - Interagency LGBT Training Dissemination - Update on DoD's Revised Transgender Policies
#6: SUD Policies and Practices	<ul style="list-style-type: none"> - VA/DoD Clinical Practice Guideline on the Management of SUD - Medication-Assisted Treatment Expansion and Provider Training - TRICARE Mental Health Parity Coverage Changes - Drug Take-Back Programs
#7: Sexual Assault, Sexual Harassment, and Military Sexual Trauma Policies and Practices	<ul style="list-style-type: none"> - Veterans Access, Choice, and Accountability Act Provisions - Joint and Department-specific Sexual Assault, Sexual Harassment, Military Sexual Trauma, and Transition Programs
#8: Workforce Development	<ul style="list-style-type: none"> - Military Culture Training Dissemination - Expansion of Peer Support Principles and Programs - VA/United States Public Health Service Staff Pilot Program



II. Contributing Offices

Interagency Task Force on Military and Veterans Mental Health (ITF) Co-Chairs*

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**Prior Co-Chairs overseeing the ITF activities and preparation of the 2016 Annual Report included Dr. Jonathan Woodson (DoD), Dr. Carolyn Clancy (VA), and Ms. Pamela Hyde (SAMHSA).*

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***Served as primary editors of the 2016 Annual Report content and serve as staff leads for each Department on ITF activities. In addition, we would like to recognize multiple working groups and offices among each of the partnering Departments that contributed subject matter expertise to the ongoing work of the ITF and to the content in this report.*



III. Introduction

Executive Order (EO) 13625, *Improving Access to Mental Health Services for Veterans, Service Members and Military Families*, was released on August 31, 2012, and directed the Departments of Defense (DoD), Veterans Affairs (VA), and Health and Human Services (HHS) to ensure that Veterans, Service members, and their families have access to needed mental health services and support. EO 13625 established the Interagency Task Force on Military and Veterans Mental Health (ITF) and directed it to provide an annual review of agency actions, to define specific goals and metrics to aid in measuring progress, and make additional recommendations as appropriate to the President to improve mental health and substance use disorder (SUD) treatment services for Veterans, Service members, and their families.

The initial goals of EO 13625 have been completed and the framework for interagency governance is fully established after four years of federal collaboration. By remaining flexible and leveraging relationships forged through the ITF and with cooperating agencies, the Departments will continue to partner and align resources, streamline operations, and share best practices to advance mental health policies and programs. The ITF has been widely recognized as an integrator and facilitator of federal mental health programs, and will continue to pursue cutting edge solutions to advance American mental health care and associated policies.

This report provides an update on interdepartmental actions during 2015 and 2016 to fulfill the ITF recommendations, and outlines continuing efforts to further improve mental health treatment and programs for Veterans, Service members, and their families. While each of the ITF recommendations varies in scope, affected populations, and intra- and inter-agency resource allocations, the ITF partners offer this report to demonstrate the significant strides and future goals for mental health policies and programs across the federal government. Readers should consider this report both a summary of progress and a roadmap to comprehensively address the mental health needs of Veterans, Service members, and their families.

Several activities within the purview of the ITF agencies have been or will be completed in the coming year, including:

- Implementation of Joint Legacy Viewer, a technology platform to integrate Armed Forces Health Longitudinal Technology Application (AHLTA) and Veterans Information Systems and Technology Architecture (Vista) interfaces across DoD and VA¹
- Update of the VA/DoD Clinical Practice Guideline (CPG) on the Management of Substance Use Disorders²
- Issuance of the TRICARE Mental Health Parity³ Final Rule

¹ Defense Medical Information Exchange Program Office. (February 19, 2016). Available from <http://www.health.mil/Reference-Center/Fact-Sheets/2015/05/19/Defense-Medical-Information-Exchange>

² Department of Veterans Affairs and Department of Defense. (December 2015). Clinical Practice Guideline: Management of Substance Use Disorders. Available from: <http://www.healthquality.va.gov/guidelines/MH/sud/>

³ National Archives and Records Administration. (September 2, 2016). TRICARE; Mental Health and Substance Use Disorder Treatment; Final Rule. *Federal Register*. Available from <https://www.gpo.gov/fdsys/pkg/FR-2016-09-02/pdf/2016-21125.pdf>



While these activities will no longer be tracked regularly by the ITF, they will be incorporated into the ongoing responsibilities of the Departments, and in that way, they will continue to contribute to the goal of improving mental health and substance use treatment services for Veterans, Service members, and their families. Efforts such as healthcare provider opioid misuse training and treatment, evidence-based practices for pain management, military culture training (MCT), resiliency and prevention strategies, and transition assistance programs require continued ITF leadership support and attention to proactively address emerging mental health issues.

Additional Responsibilities of the ITF

In addition to the continued work on the initiatives established under the EO, the Departments are partnering on the Cross-Agency Priority (CAP) Goal and the 2014 Executive Actions (EAs). The Administration established the CAP Goal on Service Members and Veterans Mental Health in March 2014. The mental health CAP Goal is a three-year initiative focusing on reducing barriers to seeking mental health care, enhancing access to and improving the quality of mental health care, and supporting innovative research on mental health and substance use care and treatment. ITF leadership and staff serve as the coordinating and oversight body of the mental health CAP Goal. Additional activities under the CAP Goal were launched in 2016 to address emerging priorities including same day access to care, expanded care for other-than-honorable discharges, and enrollment of separating Service members into a VA health plan.

The President also initiated 19 EAs on mental health in August 2014, which target the transition of care from DoD to VA, enhance access to mental health care, raise awareness of mental health conditions and treatment, and strengthen community resources in DoD and VA.

Highlights of successful efforts from the CAP Goal and EAs include initiation of a program to assist with mental health care transitions from active duty to Veteran status, development and implementation of numerous drug take-back programs, and dissemination of DoD, VA, HHS, and joint media campaigns to reduce barriers to seeking mental health care. Accomplishments from both initiatives are detailed in a report released each quarter by the Administration.⁴

A major piece of suicide prevention legislation was signed into law on February 12, 2015 entitled the Clay Hunt Suicide Prevention for American Veterans Act (Clay Hunt Act). The Clay Hunt Act focuses on VA suicide prevention efforts and does not contain specific provisions for the other ITF agencies; therefore, detailed reporting for this Act is not included in this report. However, given the significance of this legislation and the ITF focus on suicide prevention, the Clay Hunt Act is briefly described in the report section on suicide prevention activities.

In the coming years, the ITF will continue its governance function, with the Co-Chairs shaping the design and execution of the ITF recommendations to proactively identify and address emerging issues in American mental health. The Departments will also continue to work with each Administration and federal mental health care experts to advance care and improve outcomes for Veterans, Service members, and their families.

⁴ The White House. (August 2016). Cross-Agency Priority Goal: Service Members and Veterans Mental Health. Available from <https://www.performance.gov/node/3405/view?view=public#progress-update>



IV. Interagency Progress

ITF Recommendation #1: Suicide Prevention



“We’re trying to recognize what works for VA and what works in preventing suicides... It was really our partnerships in reaching out to government and community partners [that resulted in reductions in Veterans’ homelessness] and this is the model to end Veteran’s suicides.”

—DR. DAVID J. SHULKIN, VA UNDER SECRETARY FOR HEALTH

Background: Suicide Prevention

Every loss due to suicide is tragic with each one impacting families, military units, Veterans, and our communities at large. While evidence indicates suicides are preventable, an effective suicide prevention strategy requires a comprehensive approach based on inter-agency collaboration and integrated lines of effort throughout the community. DoD, VA, and HHS continue to strengthen their partnership and build on the synergies that exist among their suicide prevention efforts. Borrowing from evidence-based and best practices in the clinical and public health arenas, these agencies approach suicide prevention as a complex, multifaceted public health challenge that requires robust clinical and community components, and a systematic and multi-pronged approach.

Historically, DoD and VA have drawn in subject matter experts (SMEs) from HHS’s Substance Abuse and Mental Health Services Administration (SAMHSA) for strategic initiatives such as VA’s *Blue Ribbon Work Group on Suicide Prevention in the Veteran Population*; DoD’s *Task Force on the Prevention of Suicide by Members of the Armed Forces*; the VA/DoD CPGs for the Assessment and Management of Patients at Risk for Suicide; and numerous other task forces, working groups, and summits. The agencies’ strong collaborative work manifests itself through participation in the federal Working Group on Suicide Prevention, the National Action Alliance for Suicide Prevention (including its Military/Veterans Task Force), and behind-the-scenes work such as the current development of a dashboard to utilize risk stratification data as a means to target services and outreach within VA. Further, resources such as SAMHSA’s National Registry of Evidence-based Programs and Practices, its Suicide Prevention Resource Center grantees, and its National Survey on Drug Use and Health (which captures data on suicidal behavior among Veterans) offer valuable information and assistance that help advance the work of DoD and VA.

Key Stats*

55 million records

Included within the 2012-2014 Suicide Data Repository search roster

34,000 downloads

Of SAMHSA’s new Suicide Safe App, which is reaching providers critical to care and treatment of patients at risk of suicide nationwide

2.2 million

Calls answered by the Military Crisis Line/Veterans Crisis Line from 2007 to March 2016

* Additional information on key statistics can be found within text for each recommendation



Suicide Data Repository

DoD and VA created the Suicide Data Repository (SDR)⁵ to store all mortality-related information including suicide-related data for Service members and Veterans. The SDR supports DoD and VA researchers and decision makers by serving as the integrated mortality data repository for DoD, VA, and the Centers for Disease Control and Prevention (CDC). Eight different databases from these three agencies comprise the SDR.

Prior to the establishment of the SDR, the lack of a centralized, de-duplicated, authoritative data register made it practically impossible to conduct robust longitudinal analysis to further understand protective and harmful suicide risk factors. There are now approximately 55 million

Unprecedented Research Power

The SDR can address existing knowledge gaps:

- Accurate comparisons between and among group populations (e.g., prevalence of suicide among military and Veterans, women in the military, or populations of different races and ethnicities)
- Suicide counts and rates for Reserve Component and Veterans who do not receive care from VA
- Potential relationships between suicide behaviors and risk factors in active duty, Veteran, Guard, and Reserve populations
- Effectiveness of suicide prevention programs

records included within the 2012-2014 SDR search roster, allowing researchers to analyze suicide risk factors across the entire active duty and living Veteran population, and deceased Veterans dating back to 1979. All research is conducted under appropriate institutional review board protocols to ensure protection of human subjects and personal data.

Since the SDR contains information on causes and manners of death, it allows for a comprehensive understanding of suicide prevalence, contributing factors to suicide-related events, and the identification of mortality control groups to enhance understanding about suicide in the military. Principal investigators for DoD- or VA-sponsored research may request

data from the SDR. Third-party organizations, such as academic and other research organizations, may serve as co-investigators, but the principal investigator must be affiliated with DoD or VA.

Information Sharing

DoD and VA recognize the importance of information sharing to foster the translation of research findings into effective suicide prevention action. Both agencies support and are active participants in the following forums:

- **Suicide Prevention Conference:** Held biennially since 2004, this is the only national suicide prevention conference that specifically addresses suicide in the military and Veteran populations. It is well attended by VA, the military Services, other federal agencies, academia/research communities, and civilian provider and support communities.
- **Webinar Series:** Composed of four webinars (two hosted by DoD and two by VA), the 2016 series addresses different elements of a public health approach to suicide

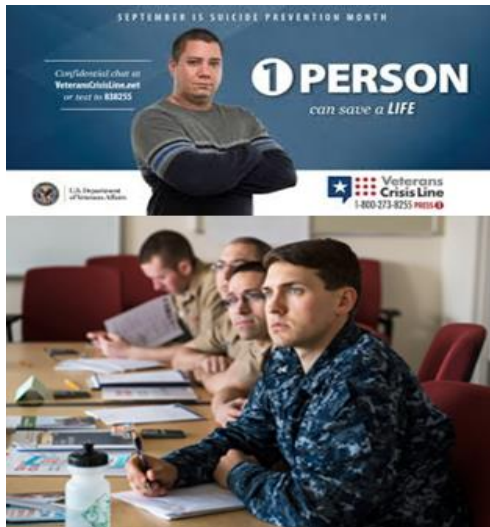
⁵ Defense Suicide Prevention Office. Suicide Data Repository Fact Sheet. Available from <http://www.dspo.mil/Portals/113/Documents/SDR%20Fact%20Sheet.pdf>



prevention. The series focuses on evidence to support a public health, community focused approach to suicide prevention; the importance of using a prevention science framework to guide and implement suicide prevention efforts; and how to engage an entire community to prevent suicide. The first webinar consisted of over 1,000 registrants and reached numerous more through the use of social media.

- **Suicide Prevention Implementation Academy:** SAMHSA's Service Member, Veterans, and their Families Technical Assistance Center held a Suicide Prevention Implementation Academy for ten states: Colorado, Illinois, Indiana, Kentucky, Missouri, Nevada, Oklahoma, Tennessee, Texas, and Washington. States' teams convened to discuss the latest research regarding suicide in military and Veteran populations, and to implement individualized suicide prevention plans in their communities. Outcomes included direct communication between DoD installations and their local public mental health system leadership, coordination of information with Veterans Integrated Service Network (VISN) Mental Health leads, and increased community-based gatekeeper trainings with personnel from both National Guard (NG) and local VA Medical Centers (VAMCs).

Outreach Programs and Campaigns



"Power of One" campaign and Service members attending the GPS Program.

Military OneSource: Military OneSource⁶ (MOS) provides confidential, face-to-face, online, telephonic, and video non-medical counseling (up to 12 sessions), and specialty consultation, which includes peer to peer services providing information and resources to assist in making a successful transition to VA.

"Power of One" Suicide Prevention Campaign

This joint educational outreach initiative launched in September 2015 and will continue through August 2016. It conveys the power that one-person, one-conversation, or one-small act can have towards preventing suicide. The message is that everybody in the community can be a positive force in the prevention of suicide. The recent "Power of One" television public service announcement ranked in the top two percent of Public Service Announcements nationally, achieving over 700 million media impressions.

Suicide Safe: Research tells us that nearly half (45%) of individuals who die by suicide have visited a primary care provider in the month prior to their death, and 20% have had contact with mental health services.⁷ Of the estimated 20 Veterans who die by suicide each day in this country, 14 do not receive VA care.⁸ It is therefore critically important that community behavioral health and primary care providers are trained to identify and effectively treat

⁶ Department of Defense. Military OneSource. Available from <http://www.militaryonesource.mil/>

⁷ Luoma, et al. (2002). Contact with mental health and primary care providers before suicide: a review of the evidence. *American Journal of Psychiatry*. Volume 159, Issue 6: 909-916.

⁸ Department of Veterans Affairs; VA Suicide Prevention Program. (July 6, 2016). Fact about Veteran Suicide.

Veterans at risk for suicide. Suicide Safe,⁹ SAMHSA's suicide prevention application ("app") for mobile devices, helps providers integrate suicide prevention strategies into their practice and address suicide risk among their patients. The app is based on SAMHSA's Suicide Assessment Five-Step Evaluation and Triage (SAFE-T) card. In the year since its launch, it has been downloaded more than 34,000 times.

Intra-Agency Legislative Spotlight: Clay Hunt Suicide Prevention for American Veterans Act (Clay Hunt Act)

On February 12, 2015, President Obama signed the Clay Hunt Act into law. This legislation is unique to VA, providing additional authority to advance suicide prevention efforts, and builds on existing VA activities and programs. The Clay Hunt Act includes major provisions to bolster VA suicide prevention, such as multi-layer evaluation of mental health and suicide prevention programs, strengthening community partnerships, development of new web resources to provide information on mental health care services, and expansion of mental health coverage eligibility for Veterans. Clay Hunt Act initiatives are not closely detailed within this report, as the response is specific to VA; however, additional information about expanded Veteran eligibility is available at: http://www.va.gov/healthbenefits/news/clay_hunt_suicide_prevention_for_america_veterans.asp.

Crisis Resources

To promote help-seeking behaviors, the ITF partners have streamlined access and enhanced services to provide 24/7/365 telephonic support to individuals in crisis. A single, national toll-free phone number provides callers the option to access responders specially trained in crisis response for Veterans, Service members, their families, or to be directed to those that serve the civilian population.

Military and Veterans Crisis Line Call Center: Created in 2007, through a partnership between SAMHSA and VA, the caring responders on the line are specially trained and experienced in helping military personnel and Veterans of all ages and circumstances. Since its launch in 2007 through March 2016, the Military and Veterans Crisis Line¹⁰ has answered more than 2.2 million calls and dispatched emergency services over 58,000 times. In 2009, an anonymous, online chat service was added and responders have engaged in more than 280,000 chats. Continuing with its commitment to reach Service members and Veterans in crisis, a text messaging service was added in November 2011, and over 51,000 texts have been received and answered, directing Veterans and Service members to critical resources and services.



Veterans Crisis Line/Military Crisis Line Contact Information.

⁹ Substance Abuse and Mental Health Services Administration. Suicide Safe: The Suicide Prevention App for Health Care Providers. Available from <http://store.samhsa.gov/apps/suicidesafe/>

¹⁰ Veterans Crisis Line. Available from <https://www.veteranscrisisline.net/ForVeterans.aspx>



National Suicide Prevention Lifeline: SAMHSA's National Suicide Prevention Lifeline¹¹ is a network of more than 160 certified local crisis centers, linked together by a single toll-free number, so that anyone in the country—civilian, Veteran, Service member, or family—can call one number and receive the help needed when in crisis. Lifeline's greeting invites callers to "press 1" if they are a Veteran, Service member, or concerned about a Veteran or Service member. Callers who press 1 are routed to the VA's Military and Veterans Crisis Line. Callers who do not press "1" are routed to the nearest certified local crisis center. In Calendar Year 2015, the Lifeline network answered more than 1.5 million calls.

¹¹ Substance Abuse and Mental Health Services Administration. National Suicide Prevention Lifeline. Available from <http://www.suicidepreventionlifeline.org/>

ITF Recommendation #2:

National Research Action Plan



“What we’ve learned about the brain over the past decade of PH and TBI research outpaces any advancement of knowledge to date — and only through continued effort will we reap the benefits of the research we have begun ... NRAP has accelerated the knowledge we have gained and strengthened inter-agency cooperation and coordination.”

—CAPTAIN MICHAEL COLSTON, DIRECTOR, DEFENSE CENTERS OF EXCELLENCE FOR PSYCHOLOGICAL HEALTH AND TRAUMATIC BRAIN INJURY

Background: National Research Action Plan

The National Research Action Plan (NRAP)¹² is a 10-year blueprint for interagency research to enhance the diagnosis, prevention, and treatment of posttraumatic stress disorder (PTSD) and traumatic brain injury (TBI), and to improve suicide prevention. It was released on August 10, 2013, by President Barack Obama. Senior research leaders and program managers across federal agencies established an interagency committee to develop, implement, and manage the NRAP in response to Section 5 of EO 13625.

Participating federal agencies include DoD, VA, HHS, and Department of Education.¹³ HHS representation includes National Institute of Mental Health (NIMH), National Institute of Neurological Disorders and Stroke (NINDS), National Institute on Alcohol Abuse and Alcoholism (NIAAA), National Institute on Drug Abuse (NIDA), National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILRR), and CDC.

The NRAP includes 86 specific action items over a 10-year period. Seventy (70) action items began during Years 1 and 2 (August 2013 to August 2015). It focuses on research efforts to accelerate discovery of the

Key Stats

Since 2013, **35** research action items have been completed, **35** are ongoing, and **16** additional action items will start in 2018

60,000 Soldiers' research interviews in the Army Study to Assess Risk and Resilience in Service members (Army STARRS) publicly shared with qualified researchers

930,000 Clinical data elements representing **21,000** subjects submitted to the Federal Interagency TBI Research (FITBIR) Informatics System, as of May 2016

¹² Department of Defense, Department of Veterans Affairs, Department of Health and Human Services, and Department of Education. (August 2013). National Research Action Plan: Responding to the Executive Order, Improving Access to Mental Health Services for Veterans, Service Members, and Military Families. Available from https://www.whitehouse.gov/sites/default/files/uploads/nrap_for_eo_on_mental_health_august_2013.pdf

¹³ In 2015, NIDILRR transitioned from the Department of Education to HHS. Therefore, Department of Education activities are covered under HHS for the execution of the NRAP going forward.



causes and mechanisms underlying PTSD, TBI, and other comorbid conditions (e.g., suicide, depression, and SUDs). These efforts include collaborative research to detect disorders early and accurately, as well as to identify safe, effective treatments that improve function and quality of life. The NRAP also synthesizes research to accelerate and translate new findings into effective prevention strategies and clinical innovations. Collaboration among the Departments is a key emphasis of the NRAP. Collaboration spans multiple areas of activity, including planning joint research programs, developing shared resources for research, joint funding of research to discover and advance new approaches, and conducting clinical trials of promising therapies. Beyond the immediate and short term action items, sixteen (16) long term action items are planned to start in 2018 to move the field closer to optimizing prevention, diagnosis, and treatment. This vision requires continued investment in relevant research and a strong commitment to important, high-priority collaborative endeavors in the coming years.

The NRAP has six focus areas: (1) PTSD research; (2) suicide prevention research; (3) comprehensive longitudinal mental health study; (4) TBI research; (5) sharing of PTSD, TBI, and suicide prevention research; and (6) electronic health records and research and clinical care. For each of the NRAP focus areas, this report includes: (1) an introduction to the focus area, (2) highlights of the progress made since the last report, and (3) significant upcoming activities.

Posttraumatic Stress Disorder Research

People diagnosed with PTSD experience diverse symptoms and comorbidities, making it difficult to match the best treatment to individual patient's needs. Coordinated efforts to understand the underlying causes of symptoms at multiple levels (e.g., neurobiological, behavioral, cognitive, genetic) provide an opportunity to improve diagnostic and therapeutic interventions. Highlights of work in this area include:

Replicate and Confirm Emerging Data on Promising Biomarker Candidates and Other Diagnostic Tools for PTSD:

Identifying potential genomic markers of risk for PTSD may be an important step to understand mechanistic pathways in disease development and to identify targets for intervention. Few PTSD Genome-Wide Association Studies are published and findings from published studies have limited scalability or potential for replication. The early results identified in smaller studies must be replicated in larger samples to improve detection and confirm genomic risk markers. Scientific experts are reviewing emerging results in a PTSD-specific group established by the Psychiatric Genomics Consortium (PGC). The PGC spans mental health and includes data from over 250,000 subjects and more than 5,000 PTSD cases. (Data are expected from more than 12,000 PTSD cases by the end of 2016). The PGC PTSD group's first analytic paper is expected for publication submission in 2016. NIMH intends to support the PGC PTSD group's analyses, which are expected to include data from over 76,000 PTSD cases and trauma-exposed controls. Also of note, in 2014, VA initiated an effort to analyze approximately 10,000



Military service exposes Service members to a variety of stressors, including exposures to death, risk to life, sustained threat of and actual injuries, and family stress.

PTSD cases within the Million Veteran Program (MVP), a component of the President's Precision Medicine Initiative (PMI).

Conduct Systematic Reviews to Inform PTSD Clinical Practice: VA publications include a large review that reports on effective PTSD treatments for Service members and Veterans.¹⁴ Prolonged Exposure and Cognitive Processing Therapy delivered individually predicted treatment effectiveness over group-only delivery. Systematic reviews conducted by VA have also shown support for psychotherapy to treat PTSD comorbid with SUDs,¹⁵ as well as telehealth for PTSD.¹⁶ For example, a review article of 11 studies points to short-term effectiveness of telehealth delivery for PTSD treatment; however, the durability of the telehealth-delivered intervention was not clear at long-term follow-up.

Highlights of Upcoming PTSD Activities

- VA and DoD are working collaboratively to combine data from the VA MVP (currently more than 450,000 Veterans; 10,000 PTSD cases) and the DoD Millennium Cohort Study (more than 200,000 Active Duty Service members [ADSMs] and Veterans; 20,000 reports of PTSD). This interagency effort to study the genetic contribution to diseases of military interest is part of the national PMI that President Obama announced in 2015.
- NIMH is working to explain well-known heterogeneity in disease mechanisms in PTSD, in keeping with the PMI. The Institute has established a specific program to study dimensional measurements and interventions, and is anticipating results from several studies to understand heterogeneity.
- The VA National PTSD Brain Bank will expand available tissue for researchers through voluntary donations conducted under appropriate research protocols.
- Results from several studies, jointly funded by VA and National Institutes of Health (NIH), on co-occurring PTSD and SUD will be available in 2016.

Suicide Prevention Research

Cross-agency suicide prevention research collaboration is essential to advance our understanding in this critical area. Factors contributing to suicide risk are complex, and multiple approaches are needed to prevent suicide in different populations, including Veterans, Service members, and their families. Highlights of research activities in this area include:

Generate Complex Models to Predict Suicide Risk and Consider Actionable Policy Implications, Informed by Army STARRS: Few evidence-based methods are available to assess prospective suicide risk. The agencies initiated several efforts to develop, test, and validate highly specific and sensitive risk detection tools to clarify the complexity of suicide risk.

¹⁴ Haagen, et al. (August 2015). The Efficacy of Recommended Treatment for Veterans with PTSD: A Metaregression Analysis. *Clinical Psychology Review*. Volume 40: 184-194. Available from <http://www.sciencedirect.com/science/article/pii/S0272735815000987>

¹⁵ Roberts, et al. (June 2015). Psychological Interventions for Post-Traumatic Stress Disorder and Comorbid Substance Use Disorder: A Systematic Review and Meta-Analysis. *Clinical Psychology Review*. Volume 38: 25-38. Available from <http://www.sciencedirect.com/science/article/pii/S0272735815000380>

¹⁶ National Center for PTSD. (April 2015). *Clinician's Trauma Update Online*. Issue 9(2). Available from http://www.ptsd.va.gov/professional/newsletters/ctu-online/ctu_v9n2.pdf



For example, Army and NIMH collaborated on the “Army Study To Assess Risk and Resilience in Servicemembers” (Army STARRS) to develop and refine risk algorithm tools. A recent memorandum of understanding (MOU) between NIMH and VA allowed the use of VA data to develop a risk stratification model similar to those developed in Army STARRS to inform VA healthcare for suicide prevention.¹⁷ Work to refine risk detection in Army STARRS will inform efforts by the Military Suicide Research Consortium (MSRC), both of which have been extended through 2020. These two projects are continuing to collaborate to apply Army STARRS findings rapidly into novel research efforts on prevention and treatment.

New Clinical Trials and Progress in Preventing Suicide: In 2015, VA launched a clinical trial of the benefit of lithium for preventing suicide; this multi-site study is now enrolling at eight VAMCs. Additionally, VA completed a “Systematic Review of Suicide Prevention in Veterans”¹⁸ on evidence related to methods for identifying those at increased risk for suicidal behavior and effectiveness of suicide prevention interventions. One promising approach is widespread screening in healthcare settings. For example, results from a large risk prediction effort found prior self-injury and alcohol use disorder are among the variables that predict suicidal behavior, one year after an initial positive screen for suicide risk in an emergency department setting. Also, a VA study demonstrated that safety planning interventions, paired with structured follow-up/planning, were effective in fostering treatment engagement.

Highlights of Upcoming Suicide Prevention Research Activities

- NIMH has issued a request for applications for quality improvement research intended to reduce suicide events (attempts, deaths) among patients seen in healthcare systems. Two to four awards are anticipated in 2016.
- NIMH has provided additional major funding to a study that is developing the first psychometric scale for predictive validity of suicide risk following a clinical examination.

Comprehensive Longitudinal Mental Health Study

EO 13625 directed DoD and HHS to engage in a comprehensive longitudinal mental health study with an emphasis on PTSD, TBI, and related injuries to develop better prevention, diagnosis, and treatment options. The goal was to enroll at least 100,000 Service members and plan for long-term follow-up with enrollees through a coordinated effort with VA. Army STARRS enrolled 107,000 Service members, and follow-up is underway. Data from 60,000 of the Service members’ interviews have recently been made available to qualified investigators. The agencies worked together and are now supporting the efforts initiated through Army STARRS for an additional five-year longitudinal project (STARRS Longitudinal Study, STARRS-LS).

¹⁷ McCarthy, et al. (2015). Predictive Modeling and Concentration of the Risk of Suicide: Implication for Preventive Interventions in the U.S. Department of Veterans Affairs. *American Journal of Public Health*. Volume 105, Issue 9:1935-42.

¹⁸ Department of Veterans Affairs, Health Services Research and Development. (November 2015). Evidence-based Synthesis Program Reports. Available from <http://www.hsrd.research.va.gov/publications/esp/reports.cfm>



Implement the Second Phase of Army STARRS: The Office of the Assistant Secretary of Defense for Health Affairs (ASD[HA]) committed \$32 million to support a follow-on effort, called STARRS-LS, which will be conducted through June 2020. The ASD(HA), NIMH, and Army are engaged in strategic planning for STARRS-LS with a Memorandum of Agreement signed in June 2015. A Government Steering Committee (GSC) was established to provide Government oversight to facilitate STARRS-LS progress.

Translate Army STARRS Findings: Army continues to review Army STARRS research findings to determine the types of actions that might be taken to improve operational and clinical practice. The Office of the Assistant Secretary of the Army for Manpower and Reserve Affairs is leading a multidisciplinary team of experts to review research findings and determine which specific actions should be taken. When action is warranted, the group develops an implementation plan. This process will continue to be applied to Army STARRS and STARRS-LS findings, and serves as a model that can be applied to other research study findings.

Highlights of Upcoming Longitudinal Studies Activities

- DoD and NIH held the first GSC meeting for STARRS-LS, launching the long-term follow-up of the health of 107,000 Soldiers (February 2016).
- In addition to STARRS-LS, other large-scale efforts offer the opportunity for collaboration on suicide prevention across multiple studies, including the DoD Millennium Cohort Study, the VA MVP, and follow-on studies that will be supported through the DoD MSRC.

Traumatic Brain Injury Research

TBI can result in a broad range of life-long, physical, cognitive, behavioral, emotional, and social impairments. Over 333,000 ADSMs were diagnosed with TBI between 2000 and August 2015.¹⁹ TBI places a substantial medical care burden on DoD and VA. Research on methods for diagnosis and treatment are needed to maximize recovery. Highlights in this focus area include:



New tools are needed to understand the mechanisms of TBI and its contributions to other disorders.

Publish Evidence-based Clinical Recommendations for Mild TBI Management: DoD continues to expand evidence-based guidance regarding the treatment of Service members with mild TBI (mTBI). Adding to the growing number of clinical recommendations (CRs) released by the Defense and Veterans Brain Injury Center (DVBIC)²⁰ since 2004, two new CRs were released in 2014, with another expected in 2016. The “Progressive Return to Activity Following Acute Concussion/mTBI” provides guidance for the primary care manager and the rehabilitation manager in deployed and non-deployed settings. The “Management of Sleep Disturbances following mTBI” and the “Management of Headache following mTBI” provide

¹⁹ Defense and Veterans Brain Injury Center. DoD Worldwide Numbers for TBI. Updated June 10, 2016. Available from <http://dvbic.dcoe.mil/dod-worldwide-numbers-tbi>

²⁰ Defense and Veterans Brain Injury Center. Clinical Tools for Providers on Mild TBI. Available from <http://dvbic.dcoe.mil/resources/clinical-tools>

evidence-based guidelines for healthcare providers to identify, diagnose, and treat Service members who have TBI-related sleep disturbances and/or headaches.

Develop Standard Operating Procedures for Collection of Biospecimens: Brain tissue banking to support research is currently limited. In response, NIH is developing the National TBI Donor Program to include civilian and military/Veterans' brains, and it has established protocols for processing mTBI brains. A standard operating procedure (SOP) was also developed to standardize collection procedures used by NIH/VA/DoD investigators. NIH, VA, and DoD brain banks have coordinated efforts to collect civilian, Veteran, and ADSM brain specimens, respectively. All brain bank specimens are donated voluntarily with explicit consent by the donor. Biorepositories and standard protocols for collection and storage of brain tissue, blood, cerebrospinal fluid, and/or DNA exist within various projects such as the NINDS Biorepository, NIDILRR Traumatic Brain Injury Model Systems (TBIMS), DVBIC Longitudinal Study, DoD/VA Chronic Effects of Neurotrauma Consortium (CENC), and Army STARRS.

The absence of validated TBI biomarkers limits the ability to understand the history of TBI and develop drug therapies. Recent interagency research efforts, including Transforming Research and Clinical Knowledge in TBI (TRACK-TBI), TBI Endpoints Development (TED) Initiative, and CENC, led to the development of a TBI biofluids working group. This group developed an initial set of SOPs for the collection of biofluids in TBI. Standardized practices support the reproducibility of knowledge in TBI research.

Launch of the VA's Longitudinal Study on TBI: In collaboration with NIDILRR, VA initiated a longitudinal study expanding data collection to the five VA Polytrauma Rehabilitation Centers. The VA database includes data on pre-injury, injury, acute and rehabilitation care, and medical, functional, social, and community integration outcomes at one, two, and five years post-injury (and every five years thereafter). As of June 2015, 712 Veterans and Service members were enrolled following rehabilitation hospitalization. Initial findings revealed elevated rates at one year post-injury of behavioral health issues including sleep and SUDs, and this will inform clinical practice and future research.²¹

Identify Future Research Priorities — TBI State of the Art (SOTA) Conference: VA sponsored the TBI SOTA Conference in August 2015. The conference identified the next steps for research in the following areas: pre-clinical research; TBI co-morbidities (e.g., PTSD and suicide); diagnostic methods and tools; health services; community re-integration; chronic degenerative conditions; caregiving strategies; and CPGs. The SOTA will inform the VA's grant priorities for TBI research.

Highlights of Upcoming TBI Activities

- The CENC, funded by VA and DoD over five years for \$62 million, has ten approved studies linked by integrated research cores and will continue to expand the reach of its activities, including collaboration with other major federal activities such as the TED initiative and the FITBIR Informatics System.

²¹ National Data and Statistical Center: VA Polytrauma Center Database. Publications: TBI Model Systems Newsletter. Available from <http://va.tbndsc.org/>



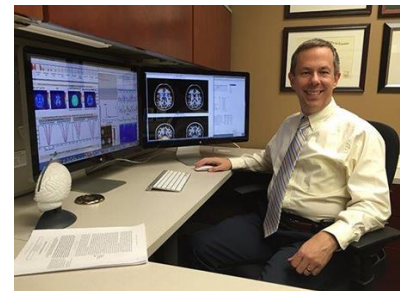
- NIH is launching new initiatives to increase awareness for the necessity of voluntary brain donation for understanding the long-term effects of TBI, including coordination with multiple TBI non-profit organizations (e.g., Brain Injury Association and OneMind for Research).
- NIH is planning the funding of the first longitudinal study designed to develop diagnostic criteria for chronic traumatic encephalopathy (CTE). The 7-year study will use behavioral, neuroimaging, and biofluid markers in patients with potential and probable CTE.

Sharing PTSD, TBI, and Suicide Prevention Research

Researchers continue to develop new and improved methods for sharing and better using data. Some examples of interagency work in this area include:

Develop Common Data Elements (CDEs) for PTSD, TBI, and Suicide Prevention to Support Data Sharing: In 2014, DoD, VA, and NIMH participated in a CDE consensus process to identify CDEs for PTSD and suicide prevention research, complementing similar CDEs developed for TBI and SUD research. In December 2014, two topic-specific sets of CDE measures for PTSD and suicide prevention research were released to the scientific community. The agencies published funding announcements in 2015, which encouraged awardees to use the recently developed CDEs for PTSD and suicide prevention research.

Improving Access to Research Results: The agencies released plans addressing the White House Office of Science and Technology Policy requirements to increase access to federally funded research results and open sharing of machine-readable data.^{22,23,24} These include data sharing expectations for grantees and ensuring that data are accessible via peer-reviewed publications and digital scientific data. Collectively, these actions will increase the rate of dissemination of research results to help fill knowledge gaps and focus new research.



Sharing of federally funded research results and data enhances future research and expedites improvements in clinical care.

Expand the FITBIR Informatics System: NIH and DoD are partnering to develop and maintain the FITBIR Informatics System. This system is a central repository for new TBI research data and links to other databases. It promotes the sharing of data and methods, collaborations, re-analysis of data, and comparisons across research studies. The system currently captures a variety of clinical data types from medical images to clinical assessments and behavioral histories. A key feature is the use of CDEs to enable the sharing, combining, and comparing of data and results. As of May 2016, 116 clinical TBI studies

²² Department of Health and Human Services. HHS Public Access Policy for Research Data. Available from <http://www.hhs.gov/open/plan/hhs-public-access-policy-for-research-data.html>, and individual agency sites

²³ Department of Defense. Plan to Establish Public Access to the Results of Federally Funded Research. Available from http://www.dtic.mil/dtic/pdf/dod_public_access_plan_feb2015.pdf

²⁴ Department of Veterans Affairs. Policy and Implementation Plan for Public Access to Scientific Publications and Digital Data from Research Funding by the Department of Veterans Affairs. Available from http://www.va.gov/ORO/Docs/Guidance/VA_RSCH_DATA_ACCESS_PLAN_07_23_2015.pdf

have entered data into the FITBIR system which, collectively, accounts for approximately 930,000 clinical data elements from 21,000 total subjects.

Highlight of Upcoming Data Sharing Activities

- Several agencies' research to refine Natural Language Processing has made advances to enable computers to extract information more accurately from health records under appropriate research protocols. Now, researchers seeking to improve patient outcomes will be able to use Natural Language Processing to advance research in learning healthcare systems.

Use of Electronic Health Records for Research and Clinical Care

The NRAP acknowledged that electronic health records (EHRs) can provide valuable data for tracking and improving patient care. Use of EHR systems in research may help identify individuals requiring a particular prevention or treatment related to TBI or PTSD, and determine eligibility for clinical trials.

Leverage EHRs for Research Networks: NIMH established the Mental Health Research Network (MHRN)²⁵ in 2010. MHRN institutions belong to a consortium of 16 healthcare delivery organizations (Health Maintenance Organization [HMO] Research Network). The parent HMOs provide care for approximately 11 million individuals and offer substantial resources that are useful for the conduct of mental health research. MHRN investigators enhanced a Virtual Data Warehouse to harmonize mental health diagnosis and treatment data across sites; established standard definitions for key exposures and outcomes; developed procedures for aggregating data across sites; and analyzed practice variation and patient outcomes across sites. Procedures were also established for multisite collection of biological specimens. In 2014, MHRN was funded for an additional five years and expanded to include two rural population research sites. Among the projects relevant to NRAP, MHRN supports: a longitudinal analysis of selective serotonin reuptake inhibitor warnings and suicide in youth; optimizing suicide risk identification in primary care and general medical settings; reducing cardiovascular risk in adults with mental illness using electronic medical record (EMR) decision support; and automated outreach for depression treatment dropout.

NIH also invested in the Health Care Systems Research Collaboratory and Distributed Research Network.²⁶ This program supports cost effective, large-scale studies that engage healthcare delivery organizations and EMRs. These include: (1) population-based selective prevention programs for suicidal behavior within a nationwide healthcare infrastructure; and (2) a randomized trial across 20 trauma centers for preventing chronic PTSD, depressive symptoms, alcohol use problems, and physical disability in survivors of both TBI and non-TBI injuries.

²⁵ Health Care Systems Research Network. Mental Health Research Network. Available from <http://www.hcsrn.org/en/Collaboration/Consortia/mhrn.html>

²⁶ National Institutes of Health. Health Care Systems Research Collaboratory and Distributed Research Network. Available from <https://www.nihcollaboratory.org/Pages/distributed-research-network.aspx>



Highlight of Upcoming EHR Activities

- Continued investment by NIH, VA, and DoD in research that leverages EHRs has the potential to improve care for Service members, Veterans, and civilians with PTSD, TBI, and suicidality. For example, the VA's MVP is making extensive use of EHR from voluntary participants in MVP to enable PTSD research that links medical care data with genomic data.

NRAP Summary

The agencies launched the implementation of NRAP in August 2013, and have made substantial progress towards the scientific goals outlined for PTSD, suicide prevention, and TBI research. Collaboration among the agencies in program planning, sharing of resources, and funding of research and clinical trials has proven critical to the progress. The agencies will continue to promote the translation of scientific findings into actionable information, new clinical guidelines, predictive and preventive measures, and more effective treatment approaches for our nation's Veterans, Service members, and their families.

ITF Recommendation #3:

Joint Clinical and Outcome Measures



“Measurement of the effectiveness of clinical services for beneficiaries is required for the delivery of high quality care. When used as an adjunct to the practices of conducting a comprehensive clinical interview and consistently adhering to standardized treatment protocols, outcome measures address the effectiveness of treatment at multiple evaluation points.”

— EXCERPT FROM SEPTEMBER 9, 2013 MEMORANDUM SIGNED BY DR. JONATHAN WOODSON,
FORMER ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS

Background: Common Mental Health Measures

In February 2014, the ITF recommended a core set of common symptom measures to assess PTSD, depression, anxiety, alcohol, and tobacco use for Service members and Veterans. This common set of measures is intended to facilitate outcome tracking and mental health service transitions across the Departments. Core measures to be utilized by DoD, VA, and SAMHSA include:

- Patient Health Questionnaire (PHQ-9)
- Generalized Anxiety Disorder 7 (GAD-7)
- Posttraumatic Stress Disorder Checklist 5 (PCL-5)
- Frequency of heavy drinking over past 30 days
- Frequency of tobacco use over past 30 days

Each Department is undertaking development of necessary systems and information technology (IT) infrastructure to support collection and storage of the core set of mental health metrics to facilitate analysis of cross-sectional and longitudinal clinical outcome data. The Departments convene regularly through the ITF Common Mental Health Metrics (CMHM) Working Group (WG) to share best practices and apply lessons learned as these systems are implemented and outcome data is collected.

The ITF CMHM WG authored a report in June 2015 outlining the current status and action plan for interdepartmental mental health symptom measures. Data collected for the report revealed that the core measures were cumulatively administered approximately seven million times (some patients assessed more than once) across the Departments in FY 2015. In September 2016, the WG submitted an implementation progress report for each Department to compare and contrast administration of core measures and resulting outcome data. The report reflects implementation progress of the core and supplemental mental health outcomes measures to date, best available data, and the planned way forward. The preliminary data is intended to establish a baseline for outcome measure collection and help each Department identify gaps in data measurement.

Key Stats

7 million

Administrations of five core mental health measures across DoD, VA, and SAMHSA in Fiscal Year (FY) 2015

93%

Behavioral Health Data Portal (BHDP) implementation at target military treatment facilities across Services through September 2016

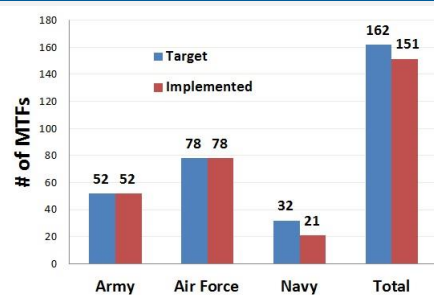


Common Mental Health Metrics Implementation Progress

The ITF CMHM WG convened multiple times throughout 2015 and 2016 to discuss successes and challenges, IT systems and interoperability, gaps in information collection and standardization, and remediation strategies. The Departments will continue to jointly monitor progress and barriers to mental health metric deployment and data collection and coordinate with stakeholders. This ongoing effort to institute common mental health outcome measures for the large number of persons receiving mental health services from the Departments is an example of the successful implementation of large-scale, standardized outcome measurement.

DoD utilizes the information management system and web application Behavioral Health Data Portal (BHDP) to collect standardized assessment and clinical outcome data across the military Services and treatment locations. BHDP, implemented system-wide by Army in 2012, is a secure, automated screening and data collection tool that allows providers, patients, and clinical leaders access to vital patient-centered clinical outcome data for mental health conditions. In a September 9, 2013 Memorandum: “Military Treatment Facility Mental Health Clinical Outcomes Guidance,” the ASD(HA) mandated that BHDP be modified for use by all Services in their mental health specialty care clinics.²⁷

Case Study: BHDP Implementation



BHDP Implementation by Service/MTF through September 2016.

BHDP has been fully implemented at all Army behavioral health clinics at medical treatment facilities (MTFs) within Army's system of care (52 sites) since late 2013. Army Behavioral Health currently averages between 55,000 to 60,000 completed questionnaires every month. A questionnaire is a computer-generated set of behavioral health screening sections available for display to a patient at each behavioral health clinic visit. Through July 2016, Army Behavioral Health has collected over 1.9 million questionnaires.

All targeted Air Force clinics have implemented BHDP through September 2016, which includes every Air Force-affiliated enhanced Multi-Service Market (eMSM) site. Training has been administered to 1,295 providers, counselors, psychological technicians, and administrative staff. The first

major round of Air Force modifications has been completed, with ongoing requests for modifications and Air Force customizations occurring in conjunction with the Army BHDP team. Air Force continues to track usage and has convened a WG to begin the process of building an Alcohol and Drug Abuse Prevention and Treatment intake survey to add to BHDP.

Implementation of BHDP continues across Navy. Through September 2016, BHDP has been implemented at 78 clinics across 21 MTFs, and BHDP-trained Navy staff includes 863 providers, counselors, psychological technicians, and administrative staff. Implementation at all identified Navy sites (134 clinics across 32 MTFs) is projected to be complete by March 2017. After initial programming delays, the latest version of BHDP adapted for Navy is now fully funded and being rapidly implemented at remaining sites.

Through September 2016, BHDP was implemented at approximately 93% of targeted sites across Army, Air Force, and Navy. BHDP is the primary tool for addressing DoD's response to the FY 2016 National Defense Authorization Act, Section 729, requiring DoD to submit a “plan for the development of procedures to measure data on mental health care.”

VA currently has more than 100 standardized assessments electronically available to support clinician efforts to evaluate patients and monitor symptoms. Since 2004, VA has been

²⁷ Assistant Secretary of Defense for Health Affairs. (September 9, 2013). Memorandum: Military Treatment Facility Mental Health Clinical Outcomes Guidance. Available from http://www.pdhealth.mil/ehc/OASDmemo_dtd09sep13.pdf

incorporating standardized screening tools within the EHR. Screening and symptom monitoring measures are available for use as clinically indicated. Some standardized clinical instruments are required to be administered in specific settings within VA, particularly in Primary Care Mental Health Integration (PCMHI) clinics and specialty mental health clinics, and within the context of delivering specific evidence-based psychotherapies (EBPs). For the purpose of this report, VA is reporting on those agreed upon standardized instruments addressed by the ITF.

VA continues to refine the IT infrastructure to facilitate a measurement-based care approach for mental health services delivery and to include outcomes assessment as a routine part of care. The results are being integrated into the clinical workflow and will allow for the monitoring of measurement use through automated reporting tools.

Working to advance the federal focus for the nation's civilian mental health and SUD treatment and prevention programs, SAMHSA supports an array of state block grant and discretionary grant programs nationwide to provide training and clinical care. Unlike VA and DoD, SAMHSA does not operate an agency controlled healthcare services system and therefore does not directly perform mental health screenings. Despite this difference, encouraging the adoption of these common measures remains an agency priority, and SAMHSA continues to work closely with community healthcare partners to track the use in healthcare settings of the five core measures. Further efforts to expand use of these measures with other HHS operating divisions are being explored.

Mental Health Measures Tracked Enterprise-wide			
Measure	VA	HHS/SAMHSA	DoD
PHQ-9	✓ Utilized as a symptom monitor within the PCMHI and EBP programs.	✓ (selectively) Used in some discretionary grant programs to track depression and suicidality.	✓ Administered at selected sites by all Services through BHDP and as part of pre- and post-deployment mental health assessments.
GAD-7	Available for administration but no protocols require it.	Not required by HHS/SAMHSA grant programs.	✓ Administered at selected sites by all Services through BHDP.
PCL-5	Scheduled to be released in VA assessment software in early FY 2017. Currently, programs are either using the PCL-C (electronic) or administering the PCL-5 as a paper and pencil instrument.	⊘ Not used.	✓ Administered at selected sites by all Services through BHDP and as part of pre- and post-deployment mental health assessments.
Alcohol Use	✓ Alcohol Use Disorders Identification Test (AUDIT) and AUDIT-C are used as screening tools for problem drinking.	✓ (selectively) A variety of alcohol screening tools including the AUDIT and AUDIT-C are used in some of HHS/SAMHSA's discretionary grant portfolio.	✓ AUDIT-C administered at selected sites by all Services through BHDP and as part of pre- and post-deployment mental health assessments.
Tobacco Use	✓ VA conducts annual screening for tobacco use. This information is captured using health factors, a data element within the EHR.	✓ (selectively) A variety of tobacco screening tools are used in some of HHS/SAMHSA's discretionary grant portfolio.	✓ Administered at selected sites by all Services through BHDP.

Table depicts core measure implementation by Department.

ITF Recommendation #4: Community Partnerships



Civilian and uniformed Service member join hands in partnership.



“Everybody can do something. Every American. Every business. Every profession. Every school. Every community. Every state. All of us, as one American team. That's how we will truly honor our veterans. That's how we will truly say thank you. That's how we will uphold the sacred trust with all who've served in our name.”

—PRESIDENT BARACK OBAMA

Background: Community Partnerships

In recent years, DoD, VA, and HHS/SAMHSA have worked together to enhance mental health partnerships between each Department, community healthcare centers, and social support providers. Sparked by recommendations put forth in the 2013 ITF Interim Report, this expanded collaboration resulted in:

- Completion of 24 pilot programs in nine states (Alaska, Georgia, Indiana, Iowa, Mississippi, Nebraska, South Dakota, Tennessee, and Wisconsin) and seven VISNs to strengthen partnerships between VA and community providers.
- Joint development and promulgation of web-based resources and training materials for community providers.
- Expansion of HHS-hosted implementation academies featuring the expertise of state-level policymakers as well as SMEs from VA and DoD.

Key Stats

49 states, 4 territories

Participated in HHS Policy or Implementation Academies, including training sessions and technical assistance by DoD and VA, from 2009 to 2015. These efforts assisted state teams to develop and implement programs to engage and coordinate access to culturally competent care at the community level for Veterans, Service members, and their families

35,000+ participants

Total Attendance at VA Community Mental Health Summits with 9 out of 10 indicating interest to attend future summits (2013-2015)

101,149 page views

Number of website hits on VA's Community Provider Toolkit website from April 2014 to December 2015

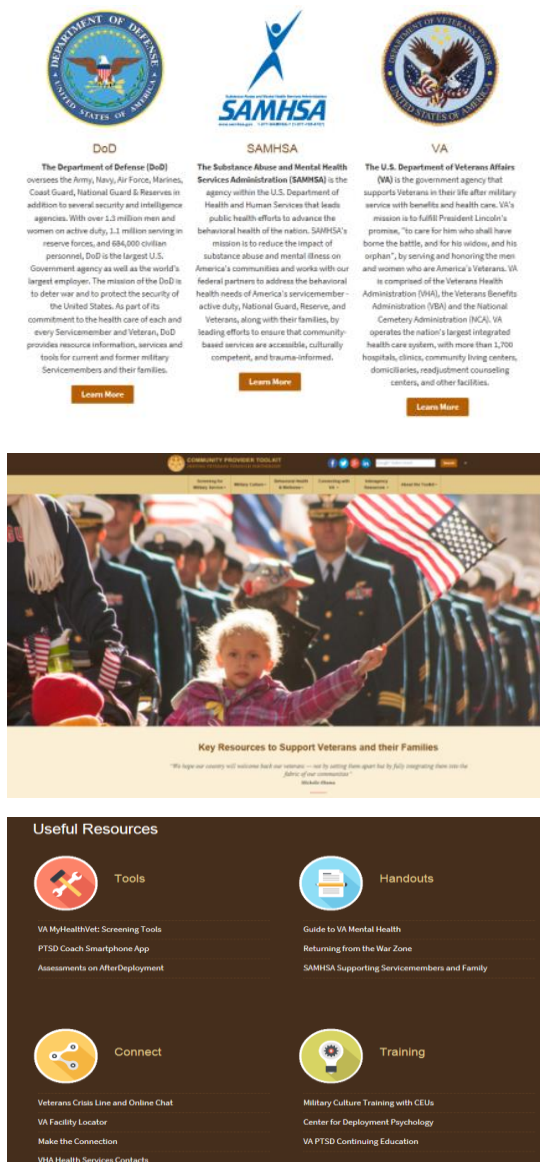
Community Provider Resources

VA launched the Community Provider Toolkit in Fall 2012, with the intent of increasing community providers' knowledge of and ability to access key DoD, VA, HHS/SAMHSA, and other vetted resources to support their work with Veterans. From April 2014 to December 2015, there were over 100,000 website hits to the Community Provider Toolkit. In December 2015, HHS and VA staff conducted a focus group of state policy academy team leads (n = 5) to solicit feedback on the toolkit. The focus group discussed how stakeholders used the toolkit to support

the state planning process and examined perceived gaps in information provided in the toolkit. Stakeholders reported that the toolkit was an integral part of their state-level planning efforts and that they refer to and disseminate the toolkit regularly. Participants noted that the toolkit is being disseminated beyond community providers to various groups who encounter Veterans, Service members, and their families. For example, one stakeholder reported that the toolkit is used as a resource by judges and lawyers within the justice system. The military Service screening questions, military culture information, and reimbursement information were identified as particularly helpful.

A one-stop web-based interagency repository²⁸ of resources and tools was developed with input from VA, DoD, and SAMHSA and launched for public use in March 2016. Based on feedback from ITF partnering agencies, the repository provides a single point of access to resources including the National Resource Directory, SAMHSA Treatment Locator, MOS, Military Families Learning Network (MFLN), including the Community Capacity Building Curriculum, and resources from the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury.

To improve awareness of the repository and all it has to offer, the Departments' public affairs offices conducted a social media campaign for the Interagency Resource Center. The webpage, including the interagency section, was also presented to partners at the VA's Brain Trust: Pathways to InnoVAtion conference on April 20-21, 2016. Interagency participation, in the form of website views, will be tracked to identify reach, potential target groups, and areas for expanded outreach. Dissemination and evaluation of the Community Provider Toolkit site will continue throughout 2016 and will inform continued improvements.



*Screenshots from ITF
Community Provider Toolkit Page.*

²⁸ Department of Veterans Affairs. Community Provider Toolkit: Key Resources to Support Veterans and their Families. Available from <http://www.mentalhealth.va.gov/communityproviders/itf.asp>

Annual Mental Health Summits

Given that most Veterans (and virtually all of their dependents) utilize at least some healthcare services outside of VA, it is critically important to determine whether community providers are prepared to identify Veterans and their family members and treat or triage medical issues in collaboration with VA. It is equally important to promote VA awareness of community services and programs that may support the mental health needs of Veterans and their families. From 2013 to 2015, more than 35,000 individuals have participated in VA Community Mental Health Summits.

Annual Mental Health Summits, held in partnership with local community organizations at all VAMCs, have resulted in more than 80% of attendees leaving with a better understanding of VA and willing to work with VA and community organizations to improve care for Veterans and their families. The two most reported needs by attendees were: 1) a desire for a comprehensive resource directory (i.e., Community Provider Toolkit website), and 2) nine out of ten wanted additional meetings beyond the annual summits. Participant feedback indicated that the VA Community Mental Health Summit process was effectively implemented locally, regionally, and nationally, and has been enthusiastically received, offering 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." Participant feedback also overwhelmingly supported the Community Mental Health Summits and expressed hope that the events will continue.



Staff gather during the Annual Mental Health Summit Event at West Palm Beach VAMC, August 2015.

The FY 2015 VA-wide Mental Health Summit after action report and draft FY 2016 toolkit were circulated to DoD and HHS in May 2016. The documents detailed VA best practices and lessons learned during the FY 2015 process. Recommended collaborations for future summits include participation by SAMHSA State Policy Team leads on Summit Planning Committees, connecting to National Guard Bureau's Directors of Psychological Health, and broadening topic areas to include issues facing Veterans' families.

Federal Collaborations result in local resource events for Veterans, Service members, and families

Hawaii is one of many states that engaged with VA/DoD/HHS experts at SAMHSA State Policy Academy offerings in FY 2015. These events helped to support a local day of community collaboration designed to connect Veterans, Service members, and their families to resources and referral services for those who are homeless along the Wai'anae Coast. The event offered free resources to Veterans including information on medical services, healthcare, SUD treatment, clothing, entitlement benefits, and housing opportunities. The event highlighted services from various federal partners. Hawaii also determined several ways to implement the HHS/SAMHSA-sponsored Social Security Income/Social Security Disability Income Outreach, Access, and Recovery training process into currently scheduled training to strengthen the skills of Veteran peers.

Military Families Learning Network

The purpose of the MFLN is to provide military family service professionals with information, education, training, and resources to enhance their capacity to support Service members and their families. MFLN works by connecting military family service professionals to information and each other within online communities, such as Facebook and Twitter, and on DoD-authorized social media sites. MFLN networks include the Cooperative Extension family specialists²⁹ and military family service professionals from DoD, branch Services, and non-governmental organizations that concentrate on family development, family transitions, military caregiving, personal finance, nutrition and wellness, and network literacy.³⁰ MFLN offers professional development opportunities through web conferencing and online learning modules. DoD, VA, and HHS are actively engaged to promote MFLN among Department providers.



Military Families Learning Network Promotional Flier.

²⁹ Cooperative Extension family specialists are land grant university faculty with expertise in family development whose mission is to improve the lives of families through research and education.

³⁰ Developing network literacy is a continuous process of becoming comfortable and proficient with a variety of tools to use in interactive online environments. The Network Literacy community of practice concentrates on helping military family service professionals use online technologies to enhance communications, sharing, and learning.

ITF Recommendation #5:

Lesbian, Gay, Bisexual, and Transgender Inclusion



“There is a much larger community out there that is looking for opportunities to show its support of us — that’s certainly been my experience as I’ve come out in my professional network, and it’s picking up steam. It’s gone from tolerance to acceptance to embrace. Today, there is a caucus there, and now there is support for all of us.”

—ERIC FANNING, SECRETARY OF THE ARMY,
FIRST OPENLY GAY SERVICE SECRETARY



Service member shaking hands with healthcare professional.

Background: Lesbian, Gay, Bisexual, and Transgender (LGBT) Inclusion

The repeal of DoD’s “Don’t Ask, Don’t Tell” policy on sexual orientation among ADSMs by the President and senior Department leadership in 2011 marked a historic moment for the inclusion of LGBT populations in the federal government. This change, coupled with legislative and judicial mandates to recognize same sex couples and extend benefits to them, is the culmination of a significant period of diversity advancement in the federal workforce. The shift to lift restrictions on open service and full benefits in the nation’s defense apparatus, known widely for its battle-tested ethos and hierarchy, signified the continued acceptance and inclusion of various sexual and gender identities manifesting throughout federal institutions and society as a whole.

DoD, VA, and HHS are committed to a diverse workforce and an inclusive workplace. The Departments understand that diversity and inclusion are essential for high organizational performance that delivers the best service to our Veterans, Service members, and their families. Each Department has implemented several policies and programs addressing issues facing the LGBT community and is committed to continued partnership through the ITF to align efforts and foster best practices in LGBT inclusion across the federal government healthcare systems. The Departments are also facilitating employees’ and patients’ access to benefits made available by changes to federal policy. A knowledgeable, culturally responsive workforce will help reduce barriers to services for LGBT Veterans, Service members, and their families.

Key Stats

311,000

Number of individuals and organizations who have already received information about LGBT training through VA and HHS outreach partnership

84%

Percentage of VAMCs achieving leadership status in four key areas after participating in Healthcare Equality Index survey and training

DoD ends ban on open military Service by transgender troops

On June 30, 2016, the Secretary of Defense issued a directive-type memorandum to allow transgender individuals to openly serve in the military Services. The Services are reviewing all related policies and will submit recommended changes to the Under Secretary of Defense for Personnel and Readiness to streamline implementation of a new DoD policy, Department of Defense Instruction (DoDI) 1300.28, "In-Service Transition for Transgender Service Members." Both documents reflect DoD's finding that open service by transgender Service members, while being subject to the same standards and procedures as other members with regard to their medical fitness for duty, physical fitness, uniform and grooming, deployability, and retention, is consistent with military readiness.

This policy was crafted through a comprehensive and inclusive process and will be implemented in stages over 12 months through July 2017 — starting most immediately with addressing the needs of current Service members and their commanders, followed by training for the entire force, and ultimately, beginning to admit transgender recruits. The Military Health System (MHS) will be required to provide transgender Service members with all medically necessary care related to gender transition based on the guidance issued.

Interagency Dissemination of LGBT Training

VA offers five LGBT-specific trainings, including three that focus on transgender health. There is significant benefit in partnering more broadly within HHS to disseminate this information through SAMHSA's Grantee Data Technical Assistance Center (GDTA) for SAMHSA staff and grantees to share these publicly available trainings. Through an e-blast coupled with a blog, SAMHSA dissemination is expected to reach 13,000 individuals and organizations.

The five Veterans Health Administration (VHA) trainings have been distributed to approximately 298,764 VHA administrative and clinical staff. Also, as a demonstration of reach and training, 96 (84%) of 114 VA facilities that participated in the Human Rights Campaign's Healthcare Equality Index (HEI) survey in 2015 achieved Leadership status. Leadership status³¹ is granted to facilities that have met performance standards on four criteria: Patient Non-Discrimination, Equal Visitation, Employment Non-Discrimination, and Training in LGBT Patient-Centered Care.



*Healthcare Equality Index
Leadership Criteria.*

As part of the ongoing effort to build interagency collaboration to benefit LGBT Service members and Veterans in the area of mental health, HHS has committed to broadly disseminate trainings developed by VA to HHS service providers and program officers. Thus far, more than 311,000 individuals and organizations have received information about the trainings through joint outreach. Given the significant number of Veterans and their families who receive care in community settings, increasing the cultural competency of civilian providers to treat LGBT Service members and Veterans is consistent with the ITF's mandate and interagency mission.

Expanded dissemination of training and the release of LGBT graphic media occurred during LGBT Health Awareness Week in March 2016. LGBT Pride Month in June, the Transgender

³¹ Veterans Health Administration, Office of Health Equity. Healthcare Equality Index. Available from http://www.va.gov/healthequity/Healthcare_Equality_Index.asp



Day of Remembrance, and Veterans Day provide additional opportunities for the Departments to generate interest in these trainings. By November 2016, both HHS and VA will have new information to add to the trainings with respect to the availability and cost of care for transgender individuals.

DoD, VA, and SAMHSA began partnering with the Health Resources and Services Administration to disseminate VA trainings to staff and grantees in March 2016. All Departments are collaborating to streamline this effort and partner with VA on future versions of the trainings to ensure that civilian-specific information (such as access to transition-related care through private and public health plans) can also be included.

Department of Defense Instruction on Diversity and Inclusion

DoD's Office of Diversity and Military Equal Opportunity is developing the DoDI for Diversity and Inclusion. This instruction establishes policy, assigns responsibilities, and provides guidelines and procedures for maintaining a comprehensive Diversity and Inclusion Management Program for DoD.

The DoDI builds upon the precedent established by EO 13583, titled "Establishing a Coordinated Government-wide Initiative to Promote Diversity and Inclusion in the Federal Workforce." The DoD Diversity and Inclusion Management Program will implement diversity and inclusion focused programs and practices to foster an inclusive environment that encompasses all the different characteristics and attributes of the Total Force. The DoDI is on track for publication by late 2016.

"It's always been very important for me that my patients feel comfortable talking about anything, but for various reasons, some don't. Recently I was seeing one of my female Veteran patients who I've seen for many years and she noticed the 'We Serve All Who Served' graphic with the rainbow dog tags on my desktop background and says, 'You know, that's me. I'm a lesbian.' I was so surprised but delighted that she felt safe enough to tell me. That visual graphic gave me the opportunity to better understand my patient's healthcare needs and at end of the encounter she came over and gave me a big hug."

—FEEDBACK FROM THE FIELD, JONATHAN G. BECHARD, MD, VA MONTANA HEALTH CARE SYSTEM

Expanding Gender Dysphoria Coverage

To address limitations in access to mental health and SUD treatment, DoD published a Final Rule, "TRICARE: Mental Health and Substance Use Disorder Treatment," in the Federal Register (FR) on September 2, 2016.³² The Rule includes a provision to remove the categorical exclusion on treatment of gender dysphoria. The change permits coverage of all non-surgical medically necessary and appropriate care including psychotherapy in the treatment of gender dysphoria, consistent with the program requirements applicable for treatment of all mental or physical illnesses. VA and HHS SMEs provided input on the Rule prior to its publication in the FR.

³² National Archives and Records Administration. (September 2, 2016). TRICARE; Mental Health and Substance Use Disorder Treatment; Final Rule. *Federal Register*. Available from <https://www.gpo.gov/fdsys/pkg/FR-2016-09-02/pdf/2016-21125.pdf>

ITF Recommendation #6:

Substance Use Disorder Policies and Practices



Prescription drugs on the ground next to a Service member's boots.

“This Administration is committed to helping military families and Veterans by promoting prescriber training for doctors who treat Veterans and those who care for people in the military, expanding access to medication-assisted treatment, connecting justice-involved Veterans with treatment and reentry services, and providing recovery support services.”

— MICHAEL P. BOTTICELLI, DIRECTOR,
NATIONAL DRUG CONTROL POLICY

Background: Substance Use Disorder

SUD, including the misuse of alcohol and other controlled or illicit substances, is a national public health problem. Military ethos and culture may compound the risk factors associated with particular substances, resulting in high incidence among certain active duty and Veteran population segments. For example, illicit drug use remains well below the national average for ADSMs, driven largely by drug testing and a zero tolerance policy for infractions; however, pain reliever prescriptions written by military physicians quadrupled between 2001 and 2009.³³ Disproportionate alcohol misuse among junior, enlisted ADSMs is well-documented,³⁴ and other contemporary public health concerns, such as opioid misuse, are increasingly common among military and Veteran populations.

In 2014, an estimated 8.1% of the U.S. population met criteria for a SUD within the past year. An estimated 6.4% of these individuals met criteria for alcohol use

Key Stats

77,000 pounds

Total weight of unwanted prescriptions returned by military members and families to 113 MTFs during 2015 and 2016 DEA/DoD drug take-back events, and by Veterans through mail and at VA facilities during take-back initiatives through September 2016

5.5 million screenings

Administered by the military Services and VA with an alcohol screening tool (AUDIT-C) during FY 2015

85 providers

Trained and eligible to apply for buprenorphine waiver to treat opioid use disorders following SAMHSA/DoD sponsored trainings (includes DoD, VA, and community providers)

³³ National Institute on Drug Abuse; National Institutes of Health. (March 2013). Drug Facts: Substance Abuse in the Military. Available from <https://www.drugabuse.gov/publications/drugfacts/substance-abuse-in-military>

³⁴ Department of Defense. (July 2013). Report to Congress on Section 596 (b)(8) of the FY 2010 National Defense Authorization Act (NDAA): Update to the Comprehensive Plan on Prevention, Diagnosis, and Treatment of Substance Use Disorders and Disposition of Substance Use Offenders in the Armed Forces. Available from: http://health.mil/mwg-internal/de5fs23hu73ds/progress?id=YdtFcfDOhQnFHzOeGsPUnSubeXD_2Cf9qANz1PS2fJQ

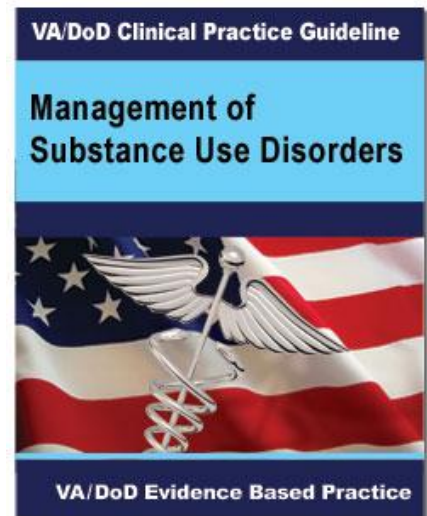
disorder, while 2.7% were affected by an illicit drug use disorder.³⁵ Alcohol misuse is particularly prevalent among ADSMs as a legal substance not prohibited by Department policy, with almost 40% of current drinkers reporting binge drinking within the past month according to the 2011 Health Related Behaviors Survey.³⁶ SUD commonly co-occurs with and complicates other conditions or issues such as PTSD or chronic pain. Among Veterans with PTSD, co-occurring SUD is common and has been found to be associated with an increase in mortality.³⁷

With targeted support from the White House Domestic Policy Council and the Office of National Drug Control Policy (ONDCP), DoD, VA, and HHS are coordinating to align and strengthen SUD policies and programs for prevention, screening, and treatment for SUD among Veterans, Service members, and their families. Interagency collaborations aim to establish and maintain a continuum of care through enlistment, discharge, civilian reintegration, and life as a Veteran.

SUD Clinical Practice Guideline

The *VA/DoD Clinical Practice Guideline on the Management of Substance Use Disorders*³⁸ was revised through an interagency review process, culminating in the publication of an updated CPG in January 2016. The CPG WG included an expert panel of DoD and VA physicians (including family practice, internal medicine, pain medicine, addiction psychiatry, and addiction medicine), psychologists, pharmacists, and social workers. SAMHSA was also engaged for an objective review of the CPG during the development process. Sections were added to the CPG to address clinically important topics not covered previously, including:

- Patient-centered care
- SUD and co-occurring conditions
- Engagement strategies
- Addiction-focused medical management
- Accreditation standards
- Shared decision-making
- Management of SUD in DoD healthcare settings



Cover of 2016 VA/DoD SUD CPG.

The CPG describes the critical decision points in the management of SUD and provides clear and comprehensive evidence-based recommendations incorporating current information and practices for clinicians throughout the DoD and VA healthcare systems. The guideline is intended to improve patient outcomes, recovery, and local

³⁵ Center for Behavioral Health Statistics and Quality. (2015). Behavioral health trends in the United States: Results from the 2014 National Survey on Drug Use and Health. HHS Publication No. SMA 15-4927, NSDUH Series H-50.

³⁶ Department of Defense. (February 2013). 2011 Department of Defense Health Related Behaviors Survey of Active Duty Military Personnel.

³⁷ Bohnert et al. (February 1, 2013). The association between substance use disorders and mortality among a cohort of Veterans with posttraumatic stress disorder: Variation by age cohort and mortality type. *Drug and Alcohol Dependence*. Issue 128, Volumes 1-2: 98-103.

³⁸ Department of Veterans Affairs and Department of Defense. (December 2015). Clinical Practice Guideline: Management of Substance Use Disorders. Available from: <http://www.healthquality.va.gov/guidelines/MH/sud/>

management of patients with SUD. The revised CPG is supplemented by a Screening and Treatment Pocket Card³⁹ to guide the practitioner through the SUD management algorithm.

Medication-Assisted Treatment

DoD, VA, and HHS are pursuing and coordinating efforts to address problematic opioid use and expand treatment options for chronic opioid misuse and administration of life-saving overdose reversal kits. Medication-assisted treatment (MAT), including opioid treatment programs (OTPs), combines behavioral therapy and medications to treat SUDs. An October 2015 Presidential Memorandum, *Addressing Prescription Drug Abuse and Heroin Use*, called on federal agencies to address the barriers to MAT in federal programs and to train federal healthcare providers in the appropriate prescribing of opioid medications.⁴⁰ The VA/DoD CPG for Management of SUD also strongly recommends buprenorphine, extended-release injectable naltrexone, and methadone provided through federally regulated OTPs, as evidence-based treatments for opioid use disorder (OUD).



ONDCP Director Michael Botticelli receives naloxone tutorial from police officer.

In recent years, DoD has expanded the availability of MAT to MHS beneficiaries by updating the TRICARE benefit and expanding education and training to MTF physicians on evidence-based practices for provision of MAT. DoD also is reviewing comprehensive training options to expand evidence-based practices for MAT.

VA also promotes the use of MAT for OUD. Thirty-two VAMCs provide MAT through federally regulated OTPs and others provide OTP through purchased care options.

In 2015, HHS launched a new web resource⁴¹ to assist Americans in understanding the impact of opioids on communities and families. The SAMHSA Providers' Clinical Support System for Medication Assisted Treatment (PCSS-MAT) and Providers' Clinical Support System for Opioids (PCSS-O) offer online resources and free continuing education credits for providers. PCSS program websites offer training materials and educational resources to support evidence-based treatment of OUD. Both PCSS-MAT and PCSS-O also provide a mentoring component to guide and assist prescribers and key health professionals who are new to the field of MAT on how to incorporate the use of medications for prescription opioid-addicted patients in their practices. Additionally, SAMHSA sponsors a video-based training for providers⁴² who serve Veterans and military personnel in how to safely and competently initiate, modify, continue, or discontinue opioids when managing patients with severe chronic pain. VA promotes provider participation in

³⁹ Department of Veterans Affairs and Department of Defense. VA/DoD CPG for the Management of SUD: Screening and Treatment Pocket Card. Available from <http://www.healthquality.va.gov/guidelines/MH/sud/VADoDSUDCPGPocketcardScreeningandTreatmentRevised12716.pdf>

⁴⁰ The White House, Office of the Press Secretary. (October 2015). Presidential Memorandum – Addressing Prescription Drug Abuse and Heroin Use. Available from <https://www.whitehouse.gov/the-press-office/2015/10/21/presidential-memorandum-addressing-prescription-drug-abuse-and-heroin>

⁴¹ Department of Health and Human Services. Opioids: The Prescription Drug & Heroin Overdose Epidemic. Available from <http://www.hhs.gov/opioids/>

⁴² Boston University School of Medicine. Safe and Competent Opioid Prescribing For Providers Working with Veterans and Military Service Personnel. Available from http://www.opioidprescribing.com/military_module_2-video

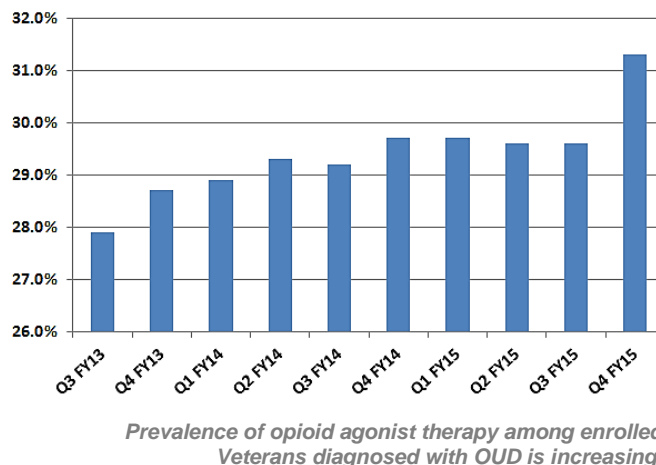
PCSS-MAT webinars, Drug Addiction Treatment Act of 2000 (DATA 2000) buprenorphine waiver trainings to prescribe treatments for MAT, and other resources.

SAMHSA also developed MATx, a free mobile app for healthcare practitioners who currently provide MAT, as well as those who plan to do so in the future. In the current version of MATx, the Veterans Crisis Line is a featured helpline resource. In future versions, the app will include a link that directs users to a page focused on MAT for Service members and Veterans and will include partner resources from DoD and VA. The official launch of the app occurred in October 2016. DoD and VA will be engaged for feedback throughout the planning and development process for future versions.

Opium Safety Initiatives

The use of opioid agonist therapy is promoted through provider education and consultation in the Buprenorphine VA Initiative and through the Psychotropic Drug Safety Initiative (PDSI), a VHA nation-wide psychopharmacology quality improvement program that aims to improve the safe and effective use of evidence-based psychopharmacologic treatments across VHA.

Since the launch of PDSI in December 2013, the proportion of Veterans with OUD who received opioid agonist therapy has increased from 27.9% (in Q3 FY 2013) to 31.3% (in Q4 FY 2015), as the number of Veterans diagnosed with OUD has increased from 55,884 to 63,877. In addition, over 2,800 Veterans received extended-release injectable naltrexone in FY 2015.



Every military Service is tracking administration of “Do No Harm” training for providers, and a new training package addressing both opioid prescribing practices and pain management will be available to DoD providers in November 2016. DoD is also coordinating efforts to ensure that opiate overdose reversal kits (e.g., naloxone) and training are available to every first responder (e.g., Emergency Medical Services, Fire, and Police) on military bases or DoD-controlled facilities. This important safeguard to combat opioid overdose was formalized by a February 2016 memorandum by the Deputy Secretary of Defense requiring the Service Secretaries and Under Secretaries to create implementation plans for the expansion of naloxone treatment.



The VA Overdose Education and Naloxone Distribution (OEND) Program

The OEND program aims to decrease opioid-related overdose deaths by providing education on opioid overdose prevention, recognition of opioid overdose, and training on rescue response, including provision of naloxone. VA promotes OEND through individualized, evidence-based, educational outreach visits and consultation for clinicians by clinicians; academic detailers completed 1,140 such visits in FY 2015. Since implementation of the OEND program in 2014, every VA station has provided naloxone and more than 17,800 kits have been provided to Veterans. The impact of these efforts is apparent across VHA, with at least 170 lives saved as documented through reporting of overdose reversal events.

Buprenorphine Waiver Training

Buprenorphine was approved by the U.S. Food and Drug Administration in October 2002 for use to treat patients who are addicted to opioids. While certain forms of buprenorphine are used to treat pain, Subutex and Suboxone are approved only for opioid addiction treatment. The agonist effects of buprenorphine increase linearly with increasing doses until at moderate doses they reach a plateau. Thus, as a partial opioid agonist, buprenorphine carries a lower risk of abuse, addiction, and side effects compared to full opioid agonists.

Since 2015, DoD and SAMHSA have partnered to provide buprenorphine waiver training to eligible healthcare providers from the Uniformed Services, VA, and the community. Trainings are endorsed and provided with the support of ONDCP and the American Academy of Addiction Psychiatry. Upon completion of the eight-hour course and Drug Enforcement Administration (DEA) approval of the waiver application, providers may prescribe buprenorphine as a form of MAT to treat patients with OUD. Feedback from the 85 providers who have completed the waiver training was highly positive, and further quarterly buprenorphine trainings are planned.

A SAMHSA Final Rule published in the FR on July 8, 2016 allows for a physician who is currently qualified and waived to serve up to 100 patients to apply for an approval to prescribe buprenorphine for up to 275 patients.⁴³ Under previous regulations, physicians certified to prescribe buprenorphine for MAT were allowed to treat up to 30 patients initially and after one year could request authorization to treat up to a maximum of 100 patients with buprenorphine. The intent of the change is to strike an appropriate balance between expanding buprenorphine access, encouraging use of MAT, and minimizing the risk of drug diversion. The rule has undergone interagency review and comment by DoD and VA.

TRICARE Mental Health Parity Final Rule

TRICARE currently covers medically necessary services for SUD treatment, including detoxification, rehabilitation, and outpatient care. Outpatient care was previously covered only if provided in a TRICARE-authorized substance use disorder rehabilitation facility (SUDRF).

To address limitations, a Final Rule, "TRICARE: Mental Health and Substance Use Disorder Treatment,"⁴⁴ was published in the FR on September 2, 2016, to expand the SUD benefit to

⁴³ Department of Health and Human Services. (July 6, 2016). HHS announces new actions to combat opioid epidemic. Available from <http://www.hhs.gov/about/news/2016/07/06/hhs-announces-new-actions-combat-opioid-epidemic.html>

⁴⁴ National Archives and Records Administration. (September 2, 2016). TRICARE; Mental Health and Substance Use Disorder Treatment; Final Rule. *Federal Register*. Available from <https://www.gpo.gov/fdsys/pkg/FR-2016-09-02/pdf/2016-21125.pdf>

include provision of care in OTPs and allow for coverage of opioid treatment outside of SUDRFs via office-based opioid treatment. The Rule expands TRICARE coverage for SUD treatment without imposing copayments, benefit limitations, and other restrictions that are more stringent than those imposed on medical and surgical benefits. Although TRICARE is not a group health plan subject to the 2008 Mental Health Parity and Addiction Equity Act (MHPAEA), the provisions of MHPAEA serve as a model for TRICARE in implementing changes to existing benefit coverage. The Final Rule incorporates feedback received by VA and SAMHSA SMEs during interagency review of the Proposed Rule prior to publication in the FR.

Drug Take-Back

Both DoD and VA have implemented programs to allow for the return and appropriate disposal of excess or unwanted medications. Jointly, DoD and VA have collected over 77,000 pounds of unwanted prescriptions through respective drug take-back programs. The MHS Drug Take-Back Program is an enterprise-wide program that will provide beneficiaries with a way to properly and safely remove unused and expired medications from circulation to mitigate suicide attempts, prescription misuse, diversion, or accidental poisoning. A DoDI on drug take-back was published in April 2016.

The military Services have participated in all DEA-hosted Prescription Drug Take-Back Days since 2010. These events help reduce the risk of prescription drug diversion and misuse, while also increasing awareness of this critical public safety and public health issue. The DoD Defense Health Agency conducts outreach to beneficiaries informing them of Drug Take-Back Day at MTFs for each event. During three events in 2015 and 2016, 113 participating MTFs collected approximately 29,000 pounds of unwanted, unused, or expired medications.

VA policy requires each VHA facility to evaluate all options in an inter-professional process and implement at least one practical, accessible, and secure option for patient disposal of controlled substances when appropriate and in settings that are applicable to the rule. VHA budgeted approximately 6.5 million dollars in FY 2015 to purchase take-back envelopes that VHA facility staff will distribute to Veterans.

Through September 2016, Veterans have returned approximately 48,000 pounds of unwanted prescriptions, including 20,350 pounds by mail and 28,017 pounds of unwanted/unneeded medications deposited in receptacles at VA facilities and sent for environmentally responsible destruction. VA has approximately 70 planned receptacle locations encompassing medical centers, long term care, and community-based outpatient clinics. Funding was released in February 2016 to expand receptacle locations.

Screening, Brief Intervention, and Referral to Treatment (SBIRT) at SAMHSA

The SAMHSA Center for Substance Abuse Treatment SBIRT program provides an approach to the delivery of early intervention and treatment to individuals exhibiting symptoms or at risk for SUD. Recently, SAMHSA expanded the locations and populations for the implementation of SBIRT in state grants to include special groups. In an effort to reach Service members and Veterans, the NG was specifically designated as one of these groups. Three states — Indiana, Iowa, and Tennessee — are spearheading the effort to implement SBIRT into NG primary care sites. Other states grants are also bolstering interaction with their respective Guard units. During the active period of these grants, SAMHSA has provided SBIRT services to over 6,000 NG members.

ITF Recommendation #7:

Sexual Assault, Sexual Harassment, and Military Sexual Trauma Policies and Practices



“These victims are coming forward because they have renewed confidence that they will have support, that they will get good information and that the system is not stacked against them.”

— SENATOR CLAIRE MCCASKILL

Background: Sexual Assault, Sexual Harassment, and Military Sexual Trauma

Over the past three years, DoD has intensified its work to encourage survivors of sexual assault and sexual harassment to report incidents, and VA has focused on improving Veterans’ access to sensitive, high quality military sexual trauma (MST)-related care. Sexual assault refers to a broad category of sexual offenses specified in the Uniform Code of Military Justice or attempts to commit these offenses. MST is VA-specific terminology for sexual assault or repeated, threatening, sexual harassment experienced by a Service member during active duty, active duty for training, or inactive duty training. It does not indicate the presence of a mental health condition or diagnosis. The Departments’ efforts are expanding the choices both Service members and Veterans have for seeking support, mental health care, and/or physical concerns subsequent to sexual assault and harassment.



Sexual Assault Awareness Month at the Pentagon, April 2015.

Expanding Access to Care

The Veterans Access, Choice, and Accountability Act (VACAA) of 2014 included two provisions that assisted in expanding access to MST-related services at VA:

- Section 401 expanded the definition of MST to include sexual assault and harassment occurring while on inactive duty for training. This closed an eligibility gap, such that NG and Reserve members who experienced sexual trauma while on weekend drill are now able to receive MST-related services at VA.

Key Stats

300

Number of community-based Vet Centers where counseling is available to Service members and Veterans

367

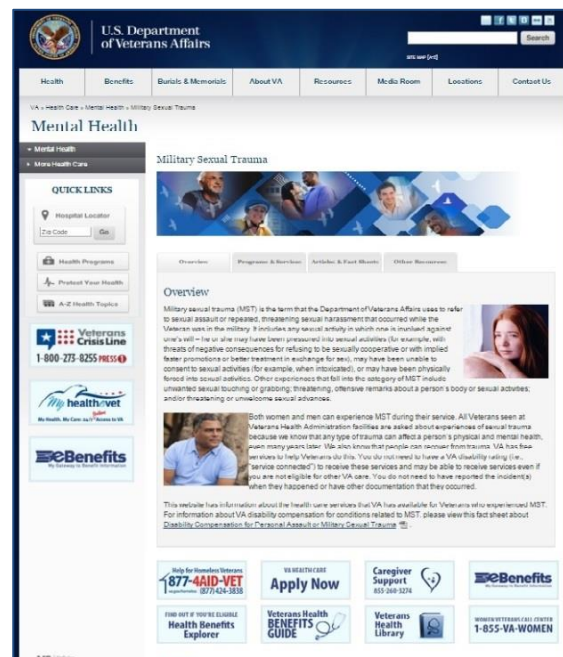
Number of ADSMs seen at Vet Centers for MST-related issues, as of October 2015

1,163,241

Number of ADSMs stationed within 20 miles of the 300 community-based Vet Centers

- Section 402 also expanded access to care by authorizing VA to provide counseling and treatment for sexual trauma to ADSMs without a referral from DoD. The central locus for implementation of this provision will be VA's 300 community-based Vet Centers, which provide non-medical counseling services. Vet Center MST counselors and licensed mental health professionals include psychologists, social workers, and marriage and family therapists.

Currently, both Departments are working to ensure that ADSMs who require services not available from a Vet Center for treatment related to sexual assault and harassment are assisted and referred back to a medical care facility as appropriate. Vet Centers are conducting outreach to ADSMs regarding availability of confidential MST-related readjustment counseling, with particular focus on military installations, NG Armories, and DoD health screening and Transition Assistance Program (TAP) events. VA's Readjustment Counseling Service (RCS), which has national oversight for Vet Centers, is distributing both its own informational materials as well as DoD's Sexual Assault Health Care Support for Patients pamphlet to all Vet Centers. Information for transitioning Service members is also available via the Safe Helpline.⁴⁵ This is the DoD 24/7 hotline for sexual assault support. DoD is also working with RCS to ensure staff have training related to the support and services available to ADSMs through DoD.



Screenshots of DoD Safe Helpline and VHA MST Homepages.

⁴⁵ Department of Defense. Safe Helpline: Sexual Assault Support for the DoD Community. Available from <https://safehelpline.org>



Activities Supporting Joint Efforts in Sexual Assault, Sexual Harassment, and Military Sexual Trauma

VA and DoD have implemented a range of programs to provide transitioning Service members and new Veterans with coordinated healthcare services and benefits assistance, including services related to sexual assault, sexual harassment, and MST. General programs assisting all Service members and Veterans are the best option for reaching individuals who may have experienced sexual assault but not reported it, and for protecting the confidentiality of individuals who have filed a report of sexual assault.

DoD Sexual Assault Response Coordinators (SARCs) and VHA MST Coordinators: Both DoD and VA have established designated staff members to serve as the primary, central points of contact for their respective services related to sexual assault and MST. DoD SARCs are unit- or base-level staff members who work with Service members throughout the reporting and victim assistance process, and who coordinate access to needed medical and mental health services. VA MST Coordinators are medical facility-level staff members who serve as advocates and sources of information for Veteran MST survivors and facilitate access to needed VA services. VA and DoD have worked to foster strong relationships between SARCs and MST Coordinators to facilitate communication, consultation on cases as needed, and participation in each Department's training efforts.

Touchpoints for Reaching Service Members: DoD and VA have coordinated to establish opportunities for all transitioning Service members to learn about the VA MST-related services available to them if needed. This is an important strategy for reaching individuals who may have chosen not to disclose an MST experience prior to separating from the military. All transitioning Service members participate in TAP to help with readiness for civilian life. A major TAP component is orientation to VA benefits and healthcare services. All participants are advised about the availability of free MST-related healthcare services and their options for filing a disability claim related to MST.

Similarly, all transitioning Service members receive a comprehensive Separation History and Physical Examination (SPHE) to document their health status at the end of active duty. Service members who have their SPHE completed by a VA provider receive information about VA MST-related services.

Healthcare Coordination Programs: VA and DoD have created several programs to help coordinate healthcare services across Departments. These programs are attuned to the types of health issues commonly reported by MST survivors. DoD's *inTransition* program⁴⁶ pairs Service members who are engaged in mental health treatment with experienced clinicians, who serve as coaches and advisors during the Service member's transfer between stations or separation from the military. Coaches assist Service members to remain engaged in their mental health care during the transition. The joint VA Liaison Program sponsors the placement of VA providers directly in MTFs, who assist ill and injured Service members with establishing a plan for entering VA care after leaving the MTF. VA's Transition and Care Management teams,

⁴⁶ Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury. *inTransition*. Available from <http://intransition.dcoe.mil/>

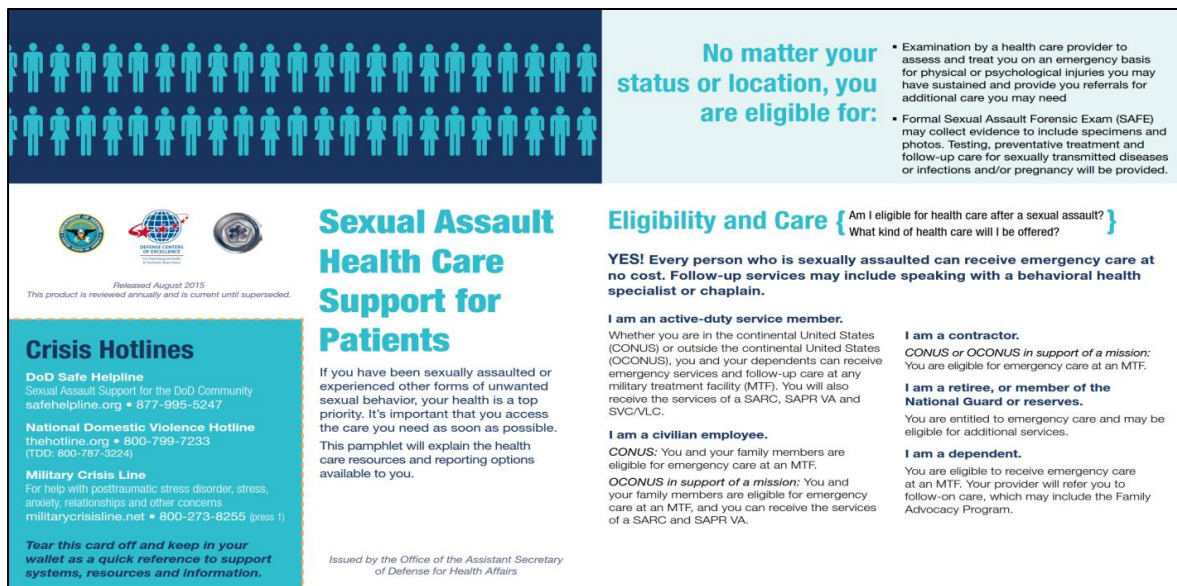
located in each VAMC, provide comprehensive assessment and case management services for all Veterans newly entering the system, and frequently work with the facility MST Coordinator. VA further ensures that all Veterans seen for VA care are screened for MST and connected with care if requested.

Key DoD Initiatives

In FY 2015, DoD experts developed a new suite of clinical resources to enhance the quality and consistency of healthcare and support resources for patients who disclose sexual assault or sexual harassment, and to provide training for healthcare providers.

These resources:

- Help MHS providers implement the procedures set forth in DoDI 6495.02, “Sexual Assault Prevention and Response (SAPR) Program Procedures,” dated July 7, 2015.
- Provide guidance on the healthcare management of patients in the MHS who disclose, have been accused of, or have committed sexual assault or sexual harassment.
- Establish consistency in the quality of clinical care provided to patients in the MHS who disclose, have been accused of, or have committed sexual assault or sexual harassment.



The screenshot shows a pamphlet titled "Sexual Assault Health Care Support for Patients". At the top, it states "No matter your status or location, you are eligible for:" followed by two bullet points: "Examination by a health care provider to assess and treat you on an emergency basis for physical or psychological injuries you may have sustained and provide you referrals for additional care you may need" and "Formal Sexual Assault Forensic Exam (SAFE) may collect evidence to include specimens and photos. Testing, preventative treatment and follow-up care for sexually transmitted diseases or infections and/or pregnancy will be provided." Below this, there is a section titled "Eligibility and Care" with a sub-header "Am I eligible for health care after a sexual assault? What kind of health care will I be offered?". It lists four categories: "I am an active-duty service member.", "I am a contractor.", "I am a retiree, or member of the National Guard or reserves.", and "I am a dependent." Each category has a brief description of the services available. On the left side, there is a section titled "Crisis Hotlines" with contact information for the DoD Safe Helpline, National Domestic Violence Hotline, and Military Crisis Line. At the bottom, it says "Tear this card off and keep in your wallet as a quick reference to support systems, resources and information." and "Issued by the Office of the Assistant Secretary of Defense for Health Affairs."

Screenshot of Sexual Assault Health Care Support for Patients Pamphlet.

The following resources are included in the clinical products suite and are expected to be widely available by the end of 2016:

- *DoD Health Care Management of Sexual Assault/Sexual Harassment (SA/SH) Provider Resources*: A resource to help healthcare providers navigate legal, ethical treatment, and privacy considerations when a patient discloses sexual assault or sexual harassment (in web-based, mobile friendly, print, or download versions).



- *SA/SH Environment of Care Quick Reference Charts*: An at-a-glance version of the information contained in the expanded SA/SH resources.
- *SA/SH Resources Training Course*: A course to assist all MHS providers to implement guidance in DoDI 6495.02 and use the product suite.
- *DoD Guide for Sexual Assault Safety Assessment and Planning*: A resource to help professionals conduct a safety assessment and develop a safety plan for patients who have experienced sexual assault (in print and web-based mobile friendly versions, to include assessment and safety planning tools).
- *Sexual Assault Health Care Support for Patients Pamphlet*: A resource that explains healthcare resources and eligibility, reviews health coping strategies, defines common DoD terms for patients who have been sexually assaulted, and explains reporting options.

Key VA Initiatives

In FY 2015, VHA launched a number of training and outreach initiatives to complement its existing efforts.

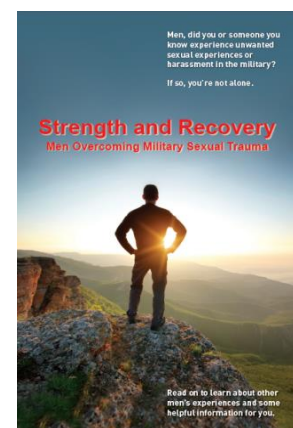


MST Consultation Program Banner.

MST Consultation Program: VA's national MST Support Team launched this one-on-one consultation program. It is open to any VA staff member to support their work with Veterans who experienced MST. The program offers staff the opportunity for personalized conversations, often about specific cases, with experts and thereby deepens their understanding of potential issues that arise in working with MST survivors.⁴⁷

Clinically-focused Workshop Series: Building on the success of a pilot workshop in FY 2014, VA's national MST Support Team hosted a set of multisession, small group workshops in FY 2015. The format involves lecture, didactic experiential activity, interactive role-playing, weekly practice assignments, and an opportunity for staff to receive in-depth training on complex clinical topics. For example, one set of sessions focused on the screening of MST by primary care providers, with one track training primary care providers with self-rated low skill in screening and the other training providers with self-rated high skill and with an interest in serving as "champions" for MST screening at their site.

Men's Outreach Brochure: Knowing that men can face unique challenges in their recovery from MST, VA developed and disseminated a new psychoeducational booklet targeting male survivors of MST. The booklet reviews definitions and prevalence of MST in male Veterans seeking VA care, factors that affect men in their recovery, common reactions and concerns, VA's free and confidential care for conditions



VA Men's Outreach Brochure Cover.

⁴⁷ Department of Veterans Affairs. Military Sexual Trauma: Treatment Services. Available from <http://www.mentalhealth.va.gov/msthome.asp>



related to MST, and additional resources and ways to access services. It also highlights key concerns that many male Veterans have, such as the myth that men do not experience sexual trauma and issues related to masculinity and identity.

Clinical Reminder Revision: In FY 2015, VA rolled out a revised version of the clinical reminder used in the EMR to assist providers in screening for MST. VA's universal screening program is an important means of ensuring Veterans receive care to assist in their recovery. The revised clinical reminder will play a central role in promoting best practices in screening. In the revised reminder, changes have been made to make the language more readily understood by Veterans, to provide information about VA's free MST-related services to all Veterans (regardless of whether they disclose MST or not), and to include a mental health services referral question. This referral question will streamline access to care and facilitate VA's national monitoring of access to care.

ITF Recommendation #8: Workforce Development



Service members at a training event.

“Military Culture Competency Training will help ensure Veterans receive high quality healthcare whether it is from VA or a provider in the community.”

—DR. CAROLYN CLANCY, VA DEPUTY UNDER SECRETARY OF HEALTH FOR ORGANIZATIONAL EXCELLENCE

Background: Workforce Development

ITF Recommendation #8 is a continuation of an early ITF priority to work with mental health and SUD providers and collaborate among federal Departments to maximize the opportunities to grow a technically and culturally competent workforce in the federal government and in the community to best serve Veterans, Service members, and their families.

The ITF Workforce Development recommendation focuses on scopes of practice for various mental health professionals, with the aim of more effective and efficient delivery of services. DoD, VA, and HHS/SAMHSA mental health leadership requested the incorporation of research and existing recommendations on workforce integration into the ITF recommendations. The Workforce Development WG is pursuing initiatives with the greatest potential impact for patients and providers on the ground to facilitate progress through recruitment, retention, practice change and integrated care, and peer support services.

Key Stats

109,000 web hits

Total visits to the MCT webpage from launch to August 2016

25 clinicians

Number of United States Public Health Service officers projected to be assigned to VA billets as a result of MOU and staffing pilot

962

Number of peer specialists in VA mental health positions

Dissemination of Military Culture Training

Military Culture: Core Competencies for Healthcare Professionals⁴⁸ is a free, four-module course that trains healthcare professionals to be more culturally competent when working with Veterans, Service members, and their families. The online course was developed jointly by DoD and VA and educates providers, including psychologists, psychiatrists, nurses, social workers, licensed professional mental health counselors, and marriage and family therapists about military culture and its unique effect on a patient's views and behaviors. The ITF partner agencies continue their collaboration to:

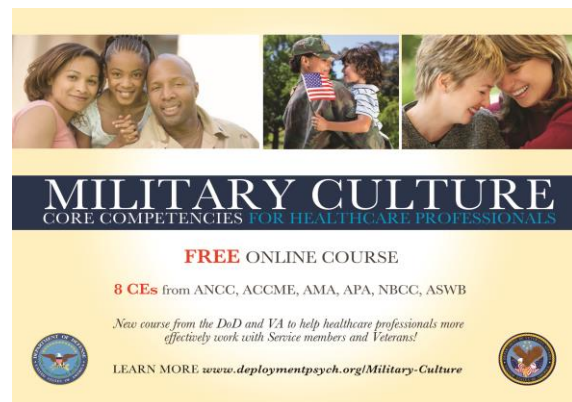
- Produce and disseminate current materials to community providers;
- Assess the effectiveness of the course; and
- Improve the course based on feedback from both providers and patients.

In 2015, extensive stakeholder outreach was conducted to notify professional associations, federal healthcare programs, private healthcare systems, and military/Veteran stakeholders about MCT. Additionally, a targeted mailing campaign disseminated materials to approximately 24,000 licensed psychologists and social workers in DoD's eMSMs. Through August 2016, 2,344 non-federal civilian providers had completed the first module of the course, and there were over 109,000 total visits to the MCT webpage.

On September 22, 2015, a webinar training session sponsored by SAMHSA's Service Members, Veterans, and their Families (SMVF) Technical Assistance Center on Military Culture Training for Strengthening Access to SMVF Behavioral Health Services was presented to 568 community-based participants.

SAMHSA's SMVF Technical Assistance Center assisted in connecting representatives of state policy academy teams from five states (Arizona, California, Illinois, Missouri, and North Carolina) with VA to provide feedback on VA's Community Provider Toolkit website. All of the participants indicated that the toolkit is helpful and complements their work. They all noted that they refer clinicians and non-clinicians, such as family court judges, advocates, and Arizona's health exchange navigators, to the site.

Six states working with SAMHSA's SMVF Technical Assistance Center have developed and implemented cultural competence training programs ranging from one hour to one day. A congressionally authorized, federally funded grant overseen by SAMHSA reports nearly 1,000 clinicians and over 18,000 community partners (e.g. first responders, teachers, employers, etc.) have accessed cross-agency online training materials focused on topics such as PTSD and TBI, women returning from combat, and family issues over the last seven years.



Postcard distributed to licensed community providers in 2015 to promote military culture training.

⁴⁸ Center for Deployment Psychology. *Learn About Military Culture*. Available from <http://deploymentpsych.org/military-culture>



For 2016, HHS/SAMHSA is spearheading outreach to the National Association of State Mental Health Program Directors (NASMHPD) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD) to request support in disseminating military culture training and potentially cosponsoring additional provider trainings on behalf of the ITF. NASMHPD and NASADAD respectively represent state mental health commissioners and state alcohol and drug abuse single state authority directors. The organizations' directors indicated their capacity to support this effort during initial meetings in January 2016, and joint planning continues utilizing the framework of integrated care and peer support.

Peer Support Working Group

In late 2015, the Departments created a sub-work group to determine best practices for developing the skills of peers (people with lived experience), peer services, and their role in supporting prevention, treatment, and recovery support. VA and SAMHSA are pursuing peer support through an expanded peer workforce and research. DoD principles of peer support are embedded through military unit training and buddy programs.

The group will provide a set of recommendations in 2016 detailing the similarities and differences in each Department's peer support services, opportunities to standardize aspects of the training curriculum, and opportunities to expand the use of peers to supplement the workforce. The recommendations will highlight how existing VA and SAMHSA initiatives, for example, outcome measurement for 962 existing VA peer specialist positions, can be leveraged to facilitate evidence-based assessment of peer support for potential translation across healthcare systems.



Participants join hands during a peer support meeting.

VA/United States Public Health Service (USPHS) Staff Pilot Program

VA, HHS, and USPHS are working to finalize an MOU to implement a pilot project that places USPHS clinicians in VA mental health and primary care clinics. VA's Business Office projects that the pilot will support approximately 25 USPHS officers assigned to VA billets with the potential for long-term employment opportunities throughout VA.



USPHS Officers at an HHS staff training event in 2015.

This collaboration is a concerted effort by VA and HHS to develop an agreement that supports Veteran care in VA and is consistent with the USPHS mission. The design of the MOU and pilot project drew on DoD experiences regarding the larger scale MOU that provides USPHS officers to augment DoD mental health operations.

V. Appendices

Appendix A: Acronym List

ACRONYM	DESCRIPTION
ADSM	Active Duty Service member
AHLTA	Armed Forces Health Longitudinal Technology Application
ASD(HA)	Assistant Secretary of Defense for Health Affairs
AUDIT	Alcohol Use Disorders Identification Test
BHDP	Behavioral Health Data Portal
CAP Goal	Cross-Agency Priority Goal
CDC	Centers for Disease Control and Prevention
CDE	Common Data Element
CDMRP	Congressionally Directed Medical Research Programs
CENC	Chronic Effects of Neurotrauma Consortium
CMHM	Common Mental Health Metrics
CPG	Clinical Practice Guideline
CR	clinical recommendation
CTE	chronic traumatic encephalopathy
DATA 2000	Drug Addiction Treatment Act of 2000
DEA	Drug Enforcement Administration
DHA	Defense Health Agency
DoD	U.S. Department of Defense
DoDI	Department of Defense Instruction
DVBIC	Defense and Veterans Brain Injury Center
EA	Executive Action
EBP	evidence-based psychotherapy
EHR	electronic health record
EMR	electronic medical record
eMSM	Enhanced Multi-Service Market
EO	Executive Order
FITBIR	Federal Interagency Traumatic Brain Injury Research Informatics System

ACRONYM	DESCRIPTION
FR	Federal Register
FY	fiscal year
GAD	Generalized Anxiety Disorder
GDTA	Grantee Data Technical Assistance Center (SAMHSA)
GSC	Government Steering Committee
HEI	Healthcare Equality Index
HHS	U.S. Department of Health and Human Services
HMO	health maintenance organization
IT	information technology
ITF	Interagency Task Force on Military and Veterans Mental Health
LGBT	lesbian, gay, bisexual, transgender
MAT	medication-assisted treatment
MCT	Military Culture Training
MFLN	Military Families Learning Network
MHPAEA	Mental Health Parity and Addiction Equity Act
MHRN	Mental Health Research Network
MHS	Military Health System
MOS	Military OneSource
MOU	memorandum of understanding
MSRC	Military Suicide Research Consortium
MST	military sexual trauma
mTBI	mild traumatic brain injury
MTF	medical treatment facility
MVP	Million Veteran Program

ACRONYM	DESCRIPTION
NASADAD	National Association of State Alcohol and Drug Abuse Directors
NASMHPD	National Association of State Mental Health Program Directors
NDA	National Defense Authorization Act
NDCT	National Database for Clinical Trials
NG	National Guard
NIAAA	National Institute on Alcohol Abuse and Alcoholism
NIDA	National Institute on Drug Abuse
NIDILRR	National Institute on Disability, Independent Living, and Rehabilitation Research
NIH	National Institutes of Health
NIMH	National Institute of Mental Health
NINDS	National Institute of Neurological Disorders and Stroke
NRAP	National Research Action Plan
NSDUH	National Survey on Drug Use and Health
OEND	Overdose Education and Naloxone Distribution
ONDCP	(White House) Office of National Drug Control Policy
OTP	opioid treatment program
OD	opioid use disorder
PCL	Posttraumatic Stress Disorder Checklist
PCMHI	Primary Care Mental Health Integration
PCSS-MAT	Providers' Clinical Support System for Medication Assisted Treatment (SAMHSA)
PCSS-O	Providers' Clinical Support System for Opioids
PDSI	Psychotropic Drug Safety Initiative

ACRONYM	DESCRIPTION
PGC	Psychiatric Genomics Consortium
PHQ	Patient Health Questionnaire
PMI	Precision Medicine Initiative
PTSD	posttraumatic stress disorder
RCS	(VA) Readjustment Counseling Service
SA	sexual assault
SAFE-T	Suicide Assessment Five-Step Evaluation and Triage
SAMHSA	Substance Abuse and Mental Health Services Administration
SAPR	Sexual Assault Prevention and Response
SARC	Sexual Assault Response Coordinator
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SDR	Suicide Data Repository
SH	sexual harassment
SME	subject matter expert
SMVF	Service Members, Veterans, and their Families (SAMHSA's Technical Assistance Center)
SOP	standard operating procedure
SOTA	State of the Art (TBI Conference)
SPHE	Separation History and Physical Examination
STARRS	(Army) Study To Assess Risk and Resilience in Servicemembers
STARRS-LS	(Army) Study To Assess Risk and Resilience in Service members Longitudinal Study
SUD	substance use disorder
SUDRF	substance use disorder rehabilitation facility
TAP	Transition Assistance Program
TBI	traumatic brain injury
TBIMS	Traumatic Brain Injury Model Systems
TED	TBI Endpoints Development

ACRONYM	DESCRIPTION
TEDS	Treatment Episode Data Set
TRACK-TBI	Transforming Research and Clinical Knowledge in TBI
USD(P&R)	Under Secretary of Defense for Personnel and Readiness
USPHS	United States Public Health Service
VA	U.S. Department of Veterans Affairs
VACAA	Veterans Access, Choice and Accountability Act
VAMC	Veterans Affairs Medical Center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VistA	Veterans Information Systems and Technology Architecture
WG	working group

Appendix B: Resource List

Introduction
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