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PERSONNEL AND READINESS

SEP 19 2007

The Honorable Carl Levin
Chairman, Committee on Armed Services
United States Senate
Washington, DC 20510-6050

Dear Mr. Chairman:

Section 723 of the National Defense Authorization Act for Fiscal Year 2006 directed the Secretary of Defense to "establish within the Department of Defense a task force to examine matters relating to mental health and the Armed Forces." In addition, the Act required the Department to develop a plan based on the recommendations of the task force and submit the plan to the congressional defense committees not later than six months after receipt of the report from the Task Force. The Department of Defense Task Force on Mental Health delivered its report on June 12.

The report of the Task Force contained 95 recommendations for improvements in the psychological health of members of the Armed Forces and their families. With one exception, the Department accepts these recommendations. We have developed the attached plan for improving access to mental health care and fostering an integrated, community-based approach to strengthen our Service members' psychological health. The actions in this plan are designed to change attitudes and implement a cultural change throughout the Department.

Thank you for your continued support of the Military Health System.

Sincerely,

David S. C. Chu

Enclosure:
As stated

cc:
The Honorable John McCain
Ranking Member

The Department of Defense Plan to Achieve the Vision of the DoD Task Force on Mental Health

Report to Congress

September 2007

The Department of Defense Plan to Achieve the Vision of the DoD Task Force on Mental Health

The Department of Defense (DoD) Task Force on Mental Health, established by Section 723 of the National Defense Authorization Act for Fiscal Year 2006, delivered its report of findings on June 12. That report contained 95 recommendations and a strong, positive vision that called for a cultural change to improve and enhance the psychological health and fitness of all our Active and Reserve component Service members as well as their families. The DoD has embraced the vision and the spirit embodied in the recommendations.

We recognize that the Global War On Terror has raised questions about the adequacy of psychological health services and service delivery systems established by DoD during the Cold War era. We accept the responsibility to make the changes needed to provide the highest possible level of care and support to our military community. A roadmap for change has been offered to us not only by the Mental Health Task Force, but also by other independent, external review groups as well as internal review procedures. We appreciate the efforts of the dedicated citizens who identified ways to improve our system of care. To address these recommendations, we envision an end state that provides a comprehensive integrated system of excellence in prevention and care that flexes to meet the needs of individual Service members and their families, looking through their eyes, across the military lifecycle.

To achieve those ends, we are moving forward to create a culture that develops and supports a state of robust psychological health that is consistent across the Services. This culture puts into practice the adage "sound mind and sound body." This practice can only be accomplished when we put psychological health and fitness on an equal footing with physical health and fitness.

The Task Force recognized that there are points of excellence in the Military Health System. With some notable operational exceptions, those excellent practices have typically been associated with traditional medical practices that are based on identification and treatment of illness or disease. Although we have put in place some early intervention practices, such as our deployment health assessment and education programs, most prevention and protection efforts have come at the expense of clinical care, calling on our clinicians to do "double duty." In the long-term, this business practice is unsupportable and ineffective. A change is clearly needed to make psychological fitness an equal priority to psychological treatment.

We fully believe that psychological health means much more than just the delivery of traditional mental health care. It is a broad concept that covers the entire spectrum of well-being, prevention, treatment, and health maintenance. It refers to a strong, resilient military force ready to serve a nation at war and ready to return and reunite with their families with peace of mind in a home environment. At the same time, we fully understand that military

service, and especially combat, carries a psychological cost for all of our warriors and the families that support them. Clearly, we have a responsibility to effectively identify and treat all psychological health conditions and ill-effects of war, and we are committed to accomplishing that task through a consistently excellent standard of care across the DoD. But we can do more. We also hold a responsibility for promoting psychological health, a responsibility that must be shared by our military leaders as well as individuals, community support organizations, and a robust health care system. Our plan of action to address the recommendations in the Task Force report reflects these priorities.

Plan of Action

Our specific plans to address each of the 95 recommendations of the Mental Health Task Force are detailed in the Appendix to this report. Our plan of action began immediately upon receipt of the report using multiple summits, planning and implementation teams, as well as important ongoing senior leader oversight of the plan of action. In addition, we formed a strong partnership with our Federal partners in the Department of Veterans Affairs (VA) and the Department of Health and Human Services (HHS) to build a safety net of care and a transparent picture of service to our military families. In a parallel effort, we are applying the generous funding levels provided by Congress specifically for psychological health and traumatic brain injury to begin the process of change, and we will further determine the sustainment costs associated with these changes.

In developing our plan, we worked aggressively to analyze the recommendations and cut through any potential organizational obstacles to rapidly accelerate the planning and implantation cycle to get the solutions in place as quickly as possible. We accepted all the recommendations in the spirit in which they were intended and made plans accordingly. Where action was clear, it will be taken immediately. When additional clarification or more data are needed, we will devote time and resources to clarify or study the extent of the problem, pilot alternative solutions before they are implemented, and avoid the potential for ineffective reactions so we can achieve our objective and the Task Force's objective to create lasting, quality change. In this process, our clear intent is to create a learning organization that embodies continuous quality improvement. The problems did not emerge overnight and for sustained improvements to be institutionalized, an iterative, data-informed process is clearly warranted. We will continue to review, implement, and revise our plan as we move forward to ensure the best possible solutions are identified and implemented in the most appropriate time frame. We are working toward a target completion date for implementation of the major elements of change by May 2008, approximately one year from receipt of the report.

We are addressing the broad categories of recommendations in the Task Force's vision of change through a focus on six key objectives, including leadership, culture, and advocacy; access to care; quality of care; resilience building and stigma reduction; surveillance, research and evaluation; and care transition and coordination.

1. To promote empowered leadership, culture, and advocacy for psychological health.

Center of Excellence. Changing a culture takes time and a long-term commitment to sustain the efforts we are now beginning. While we can put into place new structures, policies, and procedures, it is ultimately a leadership responsibility to maintain the vision and pursue the ongoing changes required to achieve the vision of the Mental Health Task Force and our own vision of excellence. We therefore have taken steps to create a Center of Excellence that will develop and maintain a strategic plan, monitor the plan, and institutionalize excellence in both psychological health and traumatic brain injury across the military system and across the continuum of care. The Deputy Secretary of Defense signed into policy the Center of Excellence on August 31, and a flag officer has been appointed as the interim director to begin this important work.

While focused on research, education and training, and clinical care, the Center of Excellence will also house an information clearinghouse and ombudsman that will serve an advocacy function for Service members and family members who have questions, concerns, or need assistance in navigating the system of care. It will further serve an advocacy and staff assistance function for clinicians who seek assistance in maintaining excellent care delivery. In this way, we can promote aggressive advocacy and identify early concerns from the perspective of those we serve.

Psychological Health Leadership. We are creating a governance structure through a system of Directors of Psychological Health and dedicated mental health management teams that will place the highest priority on the full continuum of psychological health. We are placing those psychological health leaders as advisors to our commanders as well as at senior Department and Service leadership levels. This system will carry over to our important Reserve and National Guard organizations to ensure the same level of attention and care is provided to the Reserve component.

To ensure our leaders have ongoing access to the most up-to-date expertise we will establish both an internal advisory panel and an external advisory board. The internal advisory panel will be organized as a subcommittee of the existing Medical and Personnel (MEDPERS) Council and will reduce stove-piping by bringing together all the disciplines and organizational elements associated with psychological health to ensure joint planning and execution of policies and programs. The external advisory board will be organized as a subcommittee of the Defense Health Board and will include Federal partner representatives, as well as civilian expert advisors representing each of the major categories that represent psychological health. These advisory bodies will inform our DoD leadership as well as the Center of Excellence.

Leadership Education and Training. Specialized leader education and training in psychological health-related issues and supportive supervision strategies are critical to

promoting a healthy organizational culture and climate as well as to preventive stress management, early identification, and destigmatizing care. We will work to develop and implement training at all leadership and supervisory courses.

Establish or Revise Policies. A number of policies will need revision or modification to create the culture of psychological health that we envision. Our policy experts are working to effect those changes as quickly as possible. At first review, these changes will not require legislative change. As we pursue the issues more fully, we will update our analysis of any needed foundational requirements.

Fiscal Planning. To ensure our psychological health system does not falter in the future, we are in a rapid planning cycle to determine the right level of resources to devote to building and maintaining our community of care. Fiscal advocacy reinforces our commitment to achieving our vision.

2. To build psychological fitness and resilience, while dispelling stigma.

Building resilient forces and families while reducing stigma are objectives closely tied with our first objective related to leadership and culture. To achieve a vision of psychological fitness requires a change in perspective. Just as we encourage our Service members to go to the gym to maintain their physical fitness, we must also encourage them to go to the "psychological gym" to maintain their psychological fitness. Building a continuum of care that values prevention and resilience means tearing down some of the stove-pipes that exist between our health care, community support, and line programs. Our system of psychological health leadership will help us to accomplish this goal by bringing together under one leadership function all the related services to plan and carry out a program tailored to the needs of the Active and Reserve components.

Embedded psychological health. More importantly, we will embed operational psychological health professionals into line units to be trusted advisors to our line leaders and trusted supporters of our military Service members. We are relying on existing models, such as the Operational Stress Control and Readiness (OSCAR) program in the Marine Corps and the embedded providers in our Special Operations units in the Army and Air Force to form a core set of principles to deploy across the DoD. We will then pilot the core program to better refine the principles, build the training, and create the appropriate career paths for our embedded officers across the next three years.

Anti-stigma campaign. In the best of circumstances, resilience and prevention will reduce but not eliminate the need for treatment. Our structural and functional changes will help, but stigma is a pervasive problem that permeates our civilian society as well as our military community. Therefore, our Center of Excellence will work with the Military Departments to develop and execute an anti-stigma campaign, using some of the best and brightest minds in the Military, Federal family, and civilian professional community to

ensure the right tools are created and used to reduce stigma associated with seeking mental health care when needed and at the earliest possible time.

Psychological health education. One of the most effective tools in decreasing stigma is education. We will develop and provide training that is targeted to our leaders, families, Service members, medical staff and community support staff. This training will provide accurate information that can be used to better promote psychological health and effectively identify causes for concern along with information about resources available when ill-health arises.

One important area for education is with our children. For our middle school and high school children in DoD schools, we have already implemented a mental health education program including a Signs of Suicide program, which is the only program of its kind that has been scientifically demonstrated to work. We also were expanding the popular Sesame Street Deployment Educational Program that teaches children better ways to cope with the deployment of a parent. This television program has been nominated for an Emmy award and is the most sought-after link on our military family support Web site.

3. To improve access to care.

Our military community can only derive benefit from care and support services when they have easy and ready access to those services. Access to care involves ensuring that the right professionals are available at the locations where they are needed.

Expand Staff. We have developed a comprehensive model based on the best evidence available, which will tell us how many staff we need, what types of professionals are needed, and where they are needed depending on the risk involved in the communities they serve. Obviously, communities with high levels of personnel who deploy for combat operations will have a higher risk and will have a corresponding higher need for prevention, support, resilience, and treatment services. Similarly, their families will have a higher need for extra support and care as well.

We will use our risk-adjusted model to staff our psychological health system of care immediately. We are committed to getting this staffing model right, so we have contracted with the Center for Naval Analysis to refine and validate the model to ensure that our military community has ready access to the services they deserve.

Integrate psychological health into primary care. We know that virtually all of our Service members have a visit in primary care at least once a year. Primary care clinics provide a readily available, low-stigma way to gain access to psychological health expertise. We have included behavioral health providers in primary care clinics for some time in selected locations. We will increase the integration of dedicated behavioral health professionals into primary care clinics across the Military Health System (MHS). Our VA

partners are pursing the same goal, which will provide a standardized and recognizable face of care across the Federal health care system.

Rapidly increase providers through Federal partnerships. To better meet our goals to increase staff and assure access, we are entering into an agreement with the Public Health Service (PHS) of the HHS to provide uniformed mental health professionals to supplement our staff at military treatment facilities (MTF) across the country. Up to 200 PHS officers will soon move into our military communities to rapidly increase the number of providers and improve access to care.

Ensure access to care for everyone. There are specific groups within our military community who have unique needs that must be considered and addressed as part of our improved programs of support, including our Reserve component personnel, our military families, and our military women.

While our Active Duty members have access to a rich infrastructure of support and health care services, the Reserve component members are often not geographically located to take advantage of those support structures. Our Guard and Reserve members often live in rural areas where mental health resources can be difficult to locate. To better serve them, we are establishing a state-of-the-art telepsychological health system of care with a Telepsychological Health and Technology (TPHT) Operations Center to ensure consistency and excellence across the system and geographically dispersed care centers that will service the country as well as overseas sites. The Telepsychological Health Operations Center will also stay abreast of technological advancements and make recommendations to our health care system to leverage advances that will improve access and quality services to our total military community. Distance learning and educational systems will also be a part of our telehealth operations.

The mission of the Military is to select, train, and maintain a fit and healthy force. Nevertheless, this force cannot be sustained without a fit and health family to support them. We must ensure that our families have access to the same level of quality care afforded to the Military members. Much of that care is provided through our TRICARE network. We will be taking action to ensure that mental health care is easily and quickly accessible through TRICARE for our families. To facilitate access, we are clarifying policy for both our MTFs and for our TRICARE network providers that limits wait time for initial mental health visits to seven days. To help our families obtain those initial appointments, and to track the waiting time for appointments, we are establishing mental health care finders to assist with timely appointments within the TRICARE system.

The only Task Force recommendation that we did not accept was a recommendation to extend the TRICARE benefit to cover situational problems in living. This type of counseling program is currently available and fully funded through both our Military OneSource program and other family support programs. The Military OneSource program is

a highly valued, widely used preventive, non-medical program work-life counseling program that provides up to six counseling visits per person per problem with counselors located in hometown communities. Extending TRICARE to cover the same services would duplicate Government payment for the same program. Rather than extending TRICARE, we will work with our Office of Family Policy and Military Quality of Life program office to ensure that the counseling provided by Military OneSource and our family support programs continue to meet the needs of our military families.

As the number of women serving in combat theaters has increased, it is important that we understand and be prepared to respond to their unique psychological health needs. We will review the state of science specific to psychological health in women and work with our VA colleagues who are pursuing similar objectives to create a world class women's psychological health system of prevention and care.

For those families and Service members who experience serious health conditions and concerns, we will examine our intensive outpatient and partial hospitalization services both in our MTFs and in our TRICARE network to ensure that the full continuum of evidence-based care is readily available.

4. To provide consistently excellent quality care.

Building and maintaining quality care for 9.1 million beneficiaries across different Service cultures and configurations can be challenging, but that is clearly our goal. This multi-faceted process will require that we develop standards of care so that no matter where our military members and families seek care, they can expect the same standards. In addition, once standards are developed, our clinicians, whether they are military, civilian, contractors, or TRICARE network providers must receive the training necessary to accomplish them. We are charging our National Center of Excellence, in partnership with the Military Departments and the VA, with developing and training clinicians to achieve this quality standard.

Clinical standards. We seek to establish and maintain a consistent standard of excellence across the MHS. Clinical standards are typically established through clinical practice guidance and clinical practice guidelines. With VA collaboration, these standards will continue to be established, refined, implemented, monitored, and renewed as coordinated at our National Center of Excellence.

Clinical training. Establishing standards is not enough to ensure quality care. All our providers must be trained and prepared to provide care according to the standards. The Center of Excellence will establish the curriculum for clinical training. It will be joined by other training groups in the DoD to develop and operate a robust distance learning system.

In addition, we are collaborating with the VA to provide training in evidence-based treatment for post-traumatic stress disorder (PTSD). This training uses national experts who provide not only intensive training, but on-going supervision to ensure knowledge is applied in clinical practice. The training began in September 2006 and, as of August 2007, nearly 120 providers had been trained. The Services also have contracted with the same expert providers to deliver similar training at a variety of locations across the country. Part of our TRICARE enhancements will include training in the area of PTSD to TRICARE network providers to ensure that our total military community receives the most up-to-date treatment available for PTSD related to combat and military operations.

Outcomes measures, metrics, and monitoring. For care to be truly considered quality service, it must produce the desired effect. If a patient fails to improve, the treatment is not working and should be revised. An important function of the Center of Excellence will be to develop outcomes measures and measures of patient satisfaction to track the effectiveness of care. In addition, all new programs developed will be required to develop and report metrics and measures of evaluation. These metrics will be reported on a regular basis to the Center of Excellence to track progress made across the system in institutionalizing quality.

5. Expanded and enhanced screening, surveillance, research, and program evaluation

We believe that in the world of psychological health, as with physical health, "an ounce of prevention is worth a pound of cure." In that vein, we will conduct a broad range of activities aimed at maintaining the psychological health of the military beneficiary population. Some of these activities include direct preventive services such as screening for PTSD, depression and other conditions. Others include tracking of treatment effectiveness and satisfaction with care.

Longitudinal surveillance. The Millennium Cohort Study, the largest prospective health project in military history following approximately 140,000 members across 20 years, is designed to evaluate the long-term health effects of military service, including deployments. The study, which was designed to collect more information about the long-term health of Service members, includes items, which measure symptoms of PTSD. As force health protection continues to be a priority for the future of the United States Military, the study will add cognitive screening measures as well and will provide critical information towards enhancing the long-term health of future generations of Military members.

Deployment health assessments. We are aware that symptoms of psychological conditions are not necessarily recognizable under times of direct stress, but may appear after periods of stress have ended. Often, Service members will not form a connection in their minds between the symptoms they may be experiencing and any specific incidents that occurred while on the battlefield. This may serve to confuse and frustrate them as they attempt to re-adapt to the peacetime environment. In an attempt to anticipate and proactively deal with such potential problems, the Department employs the Post-Deployment Health

Assessment (PDHA) and Post-Deployment Health Reassessment (PDHRA) processes which address potential problems head-on through careful clinical screening and referral for more definitive evaluation and treatment. We are assessing the efficacy of these processes to ensure that Service members have every chance to express their needs so that they can be followed through the referral process.

Reserve component deployment issues. When National Guard units return home from deployment, they cannot be required to participate in routine drill training for 60 days after return. We are re-examining this policy to determine if an earlier return to training would better allow post-deployment education and re-union support services, or better allow commanders to determine how well their personnel are adjusting to their return. In all decisions, the needs and best interests of the National Guard members will be the ultimate guide.

Needs assessment. The Reserve and National Guard, as well as the Active component will soon benefit from development and deployment of a comprehensive, community-based needs assessment. This assessment will help determine unit needs in regard to psychological health services, pervasiveness of stigma of mental illness and its impact on seeking appropriate care, and leader attitudes with respect to stigma and psychological well-being.

Annual preventive health assessments. We acknowledge the need to understand the changes that occur in the psychological health and cognitive abilities of Service members as they enter on Active Duty, and on through the deployment cycle. The Health Assessment Review Tool for Accession (HART-A) contains a set of questions designed to collect baseline health data on new recruits for the Military Health System. The HART-A soon will include psychological health and cognitive baseline measures to help identify health risks as individuals enter the Military and to help develop intervention and prevention programs for them. In conjunction with regularly administered annual assessments, this tool creates a record of changes in Service members' health over their careers. In addition, alternative cognitive assessment tools will be pilot tested to find the tools that are most appropriate to support broad implementation.

An annually administered Periodic Health Assessment (PHA) is intended to determine changes in Service members' health status over time. We are currently refining this process across the Services and expanding this assessment to include cognitive evaluation in addition to the existing mental health assessment procedures.

Program evaluation and outcome measures. It is not enough to develop prevention and treatment programs without knowing the extent to which they are of real use to our beneficiary population. We will aggressively develop as well as deploy measures of patient outcome and patient satisfaction with care, and we will track those measures on an ongoing

basis. Where feedback from these tracking processes so indicate, we will make changes to our methods, then continue to monitor and again improve on an ongoing basis.

Dedicated program of research. As we continue to monitor our own processes, we are also reaching out to the research community, in efforts to bring new science to the process of maintaining psychological health. To that end, we have solicited research proposals, and will be spending up to $150 million dollars in an effort to apply the very latest knowledge to promoting psychological health.

6. Improved care transition and coordination.

Provider-to-provider transfer. An optimal health care system for Service members is one that is seen as coordinating and tracking patients through their DoD-provided care, both in garrison and during deployment, followed by a provider-to-provider transfer regardless of the new location of care, whether it is to another military medical facility, to a VA facility, returned from a VA facility back to DoD, or to a civilian point of care. Procedures will be put in place to ensure that transition describes an active, ongoing process. Our intent is to maintain clinical relationships among all the providers of a Service member's care.

Medical documentation and information sharing. A vital component of transition is enhanced medical documentation and information sharing. In service of this essential aspect of care, we are developing standardized mental health documentation processes, so that communication from provider to provider on the status and history of a patient is optimized. We already provide DoD and VA clinicians access to deployment health assessments (PDHA and PDHRA) to support the clinician's need for information regarding symptom report history. Through the development of commonly accepted DoD/VA requirements for a mental health module in our automated medical records, we will facilitate collection of mental health care information, and by so doing, ensure that our clinicians are providing excellent care, guided by science-based clinical practice guidelines. Finally, by providing for bi-directional information exchange between DoD and VA facilities, we will ensure that care provided to the Service member is continued and maintained on an individualized basis when that Service member separates or is released from Active Duty and arrives at a VA facility as well as when they are reactivated and return to the DoD health care system.

Conclusion.

The Department is moving forward to integrate changes as reflected in the Report of the DoD Task Force on Mental Health, An Achievable Vision. We will introduce interim changes to meet critical needs while we pursue more lasting solutions. Our ultimate goal is, as it has always been, to ensure that the health and well-being of our military personnel and their families is at the top of our list of priorities. Apart from the war itself, we have no higher priority! In fact, we firmly believe the health and resilience of our Military members is an integral part of the war. Without fit and ready forces

supported by fit and ready families, we would have no potential to fight and win a war. Taking care of our soldiers, sailors, airmen, and marines is our key to winning America's wars and we will ensure those objectives receive our highest level of attention and support.

APPENDIX A: Department of Defense (DoD) Mental Health Task Force Recommendations

This appendix provides the milestones for completion of actions responsive to the recommendations of the DoD Mental Health Task Force. For tracking purposes, the recommendations keep the numbering used in the Task Force report. Each recommendation has many actions associated with it, but only key ones are listed herein, and each recommendation has a target date for completion of all actions. Completed tasks are marked with a checkmark (✓).

5.1.1 Dispel Stigma

Recommendation 5.1.1.1 *Target Completion beyond May 2008*
The DoD should implement an anti-stigma public education campaign, using evidence-based techniques to provide factual information about mental health conditions.

- ✓ Continue education campaign through Mental Health Self Assessment Program until additional initiatives are deployed.
- Review literature and develop anti-stigma campaign initiatives through Center of Excellence.
- Initiate pilot programs in each Service.
- Complete initial assessment of campaign effectiveness.

5.1.2 Make Mental Health Professionals Easily Accessible to Service members

Recommendation 5.1.2.1 *Target Completion beyond May 2008*
The military Services should embed mental health professionals as organic assets in line units.

- ✓ Schedule Operational Psychology conference to review current Service-specific program elements.
- Develop core elements and principles and pilot program.
- Refine and implement across a three-year period.

Recommendation 5.1.2.2 *Target Completion beyond May 2008*
The military Services should integrate mental health professionals into primary care settings.

- ✓ Establish small scale implementation using best practice guidance.
- ✓ Provide funding to begin hiring of mental health professionals for small scale implementation projects.
- Review Service and civilian best practices.
- Establish core requirements, staffing requirements, and definition of care for integration into primary care.
- Issue guidance to the field.

- Execute staff recruitment, training, and placement.

5.1.3 Embed Training about Psychological Health throughout Military Life

Recommendation 5.1.3.1 *Target Completion beyond May 2008*
Develop and implement DoD core curricula on psychological health as an integral part of all levels of leadership training.

- ✓ Fund Service-specific training programs pending core curriculum development.
- Develop core curriculum for leadership psychological health training through Center of Excellence.
- Put in place a pilot program in each of the Services.
- Assess effectiveness; refine and establish final program.
- Implement policies to direct leadership training across DoD.

Recommendation 5.1.3.2 *Target Completion beyond May 2008*
Develop and implement DoD core curricula on psychological health for family members. Effectively market these materials to all family members.

- ✓ Establish and fund Center of Excellence.
- Develop core training program and appropriate media configuration.
- Put in place a pilot program across the Services; assess effectiveness; refine and establish final program and media.
- Implement policies to direct training and distribute media across DoD.

Recommendation 5.1.3.3 *Target Completion beyond May 2008*
Develop and implement a DoD core curriculum to train all medical staff on recognizing and responding to Service members and family members in distress.

- ✓ Establish and fund Center of Excellence.
- Develop curriculum and multiple distribution methods.
- Put in place a pilot program; assess effectiveness; refine and establish final program and media.
- Implement policies to direct training and distribute across DoD.

Recommendation 5.1.3.4 *Target Completion November 2007*
Develop and implement a core curriculum to train all mental health personnel on current and emerging clinical practice guidelines.

- ✓ Continue collaboration with Department of Veterans Affairs (VA) to provide training in evidence-based treatment for post-traumatic stress disorder (PTSD).
- ✓ Fund Service-specific training pending DoD-wide training curriculum for evidence-based treatment of PTSD.
- Continue DoD/VA clinical practice guideline working group's ongoing review and revisions of existing DoD and VA clinical practice guidelines, including

PTSD, major depressive disorder, substance use disorder, and medically unexplained symptoms.

- Integrate training into Center of Excellence for broader dissemination; issue policy establishing Center of Excellence as the training lead agent

5.1.4 Revise DoD Policies to Reflect Up-to-Date Knowledge about Psychological Health

Recommendation 5.1.4.1 *Target Completion May 2008*
The DoD should promote earlier recognition of alcohol problems to enhance early and appropriate self-referral.

- Review alcohol policies and programs for DoD and Services for needed revisions.
- Coordinate policy changes with Services.
- Develop new programs in accordance with revised policy.
- Publish policy on alcohol-related issues.

Recommendation 5.1.4.2 *Target Completion May 2008*
Department of Defense medical assets, the security adjudication facilities of each Service, and the Defense Office of Hearings and Appeals should work to clarify those mental health conditions that must be reported because they are indicative of defects in judgment, reliability, or emotional stability that are potentially disqualifying or raise significant security concerns, and publish updated guidance accordingly.

- ✓ Memo signed by Assistant Secretary of Defense (Health Affairs) and submitted for processing to revise security clearance questions.
- Approve new question language and integrate into security questionnaire.

Recommendation 5.1.4.3 *Target Completion May 2008*
The DoD should carefully assess history of occupational exposure to conditions potentially resulting in post-traumatic stress disorder, traumatic brain injury, or related diagnoses in Service members facing administrative or medical discharge.

- ✓ Review current procedures; occupational exposure currently documented and addressed in all deployment health assessment procedures and Health Assessment Review Tool – Readiness Form (HART-A).
- Draft policy to clarify any additional requirements needed for Service member screening before administrative separation.
- Coordinate administrative separation policy memo through Services and promulgate.

Recommendation 5.1.4.4 *Target Completion May 2008*
The DoD should revise Medical Evaluation Board (MEB) and Physical Evaluation Board (PEB) policies and processes to better foster the psychological health of wounded Service members.

- Review and evaluate the DoD policies on MEB evaluation and disposition as well as PEB disposition and disability decisions for mental health conditions.
- Review current VA guidelines and procedures for disability determinations for mental health conditions.
- Develop guidelines for disability criteria and processing for mental health conditions in collaboration with DoD/VA disability re-engineering efforts.

Recommendation 5.1.4.5 *Target Completion May 2008*
Revise DoD Directive (DoDD) 6490.1, DoD Instruction (DoDI) 6490.4 and if necessary, their underlying legislation, to normalize the process of command referral for and communication about psychological problems.

- Review DoDD 6490.1 and DoDI 6490.4.
- Draft and coordinate revision of language to normalize referral process.
- Review any needed underlying foundational legislative changes.
- Revisions published and promulgated.

5.1.5 Make Psychological Assessment an Effective, Efficient, and Normal Part of Military Life

Recommendation 5.1.5.1 *Target Completion beyond May 2008*
Each Service member should undergo an annual psychological health needs assessment addressing cognition, psychological functioning, and overall psychological readiness.

- ✓ Periodic Health Assessments (PHA) procedures currently address psychological functioning and overall psychological readiness.
- Review and refine PHA questions and procedures regarding adequacy in covering all relevant issues and conditions.
- Establish pilot project and evaluation procedures for expanded mental health assessment during PHA.
- Deploy as three-year evaluation project.

Recommendation 5.1.5.2 *Target Completion November 2007*
The DoD should establish clear policy and procedures assuring privacy during all mental health assessments and have mental health professionals accessible at assessment locations.

- ✓ Current policy requires mental health professionals at all health assessment procedures.
- Policy for deployment health assessments specifically require a private clinical environment; re-issue policy to emphasize private clinical environment for deployment health and PHA procedures.

Recommendation 5.1.5.3 *Target Completion May 2008*
The items on the Pre-Deployment Health Assessment, the Post-Deployment Health Assessment (PDHA), and the Post-Deployment Health Re-Assessment (PDHRA) assessments should be coordinated to ensure maximum reliability and validity.

- ✓ All items of the PDHA and PDHRA forms fully coordinated with all Services as documented on coordination form.
- ✓ Complete initial validity study data collection phase.
- Report of validity study due in October.
- ✓ Initiate second phase evaluation study through contract with evaluation expert.
- ✓ Add traumatic brain injury (TBI) questions to the PDHA and the PDHRA.

5.2 ENSURING SERVICE MEMBERS AND THEIR FAMILIES RECEIVE A FULL CONTINUUM OF EXCELLENT CARE

5.2.1 Make Prevention, Early Intervention, and Treatment Universally Available

Recommendation 5.2.1.1 *Target Completion beyond May 2008*
The DoD should ensure a full continuum of care to support psychological health is available and accessible to all Service members and their eligible family members, regardless of location.

- Develop Telepsychological Health and Technology (TPHT) Operations Center concept of operations as part of Center of Excellence network.
- Select Interim Director.
- Initiate operations.

5.2.2 Maintain Continuity of Care across Transitions

Recommendation 5.2.2.1 *Target Completion May 2008*
For transferring Service members, each military Service should issue policy and guidance outlining the responsibilities of mental health professionals at the losing and gaining installations to ensure seamless transitions in care from one mental health provider to another.

- Review existing Service-specific policies.
- Draft clarifying policy regarding methods to be used in transition from one military facility to another.

Recommendation 5.2.2.2 *Target Completion beyond May 2008*
The DoD should accelerate development of a mental health module for AHLTA.

- Review requirements; revise as needed to meet current requirements.
- Evaluate alternative solutions to be used while AHLTA is being programmed.
- Implement AHLTA enterprise solution.

Recommendation 5.2.2.3 *Target Completion May 2008*
The DoD should issue policy and guidance that ensures continuity of care for those who transition to and from deployment and the transfer of deployment-related mental health notes.

- Draft policy on use of AHLTA-Theater.
- Review examples of problems to clarify problem scope.
- Develop and implement solutions to improve care transition and address identified problems.

Recommendation 5.2.2.4 *Target Completion May 2008*
The DoD should ensure that patients who transition from military providers to civilian providers, including those in the Department of Veterans Affairs, receive provider-to-provider handoffs.

- Develop methodology with VA regarding procedures for bi-directional transfer for Reserve component Service members.
- Develop methodology with TRICARE for provider transfers.
- Develop methodology for transfer post-military service to non-DoD providers.

Recommendation 5.2.2.5 *Defer to VA*
The Department of Veterans Affairs should ensure that any veteran with diagnosed post-traumatic stress disorder (PTSD) can enroll and receive health care services, and any presentation of possible PTSD will be fully evaluated.

- Review policy with VA on veterans eligibility.
- VA will determine if legislation is required.

Recommendation 5.2.2.6 *Defer to VA*
The Department of Veterans Affairs should establish access standards for mental health care of seven days or fewer (depending on the acuteness of the presenting concern).

- ✓ Review policy and procedures with VA.
- ✓ VA established policy August 1, 2007, to allow 24-hour triage and 14-day appointment access for mental health concerns for OIF/OEF veterans.

Recommendation 5.2.2.7 *Target Completion beyond May 2008*
The DoD and the Department of Veterans Affairs should ensure all medical records can be mutually transferred between their electronic medical record systems.

- Revise the capabilities of AHLTA related to mental health records.
- Expand the capabilities of the Bi-directional Health Information Exchange (BHIE).

Recommendation 5.2.2.8 *Target Completion September 2007*
The DoD should develop a robust low-cost TRICARE Reserve Select benefit to cover treatment for post-deployment mental health issues for National Guard and Reserve Service members.

- ✓ TRICARE Reserve Select premium system was refined and simplified to include single rather than multi-tiered system that involves a low-cost premium across all Reserve component groups in accordance with NDAA07 requirements.

Recommendation 5.2.2.9 *Target Completion November 2007*
The military Services should ensure the staff of all recruiting centers are aware of, and have materials to distribute regarding, key resources for current or former Service members who need assistance.

- ✓ Issue TRICARE Communication release to recruiters.
- Continue ongoing periodic communication and materials dissemination to recruiters.

Recommendation 5.2.2.10 *Target Completion November 2007*
National Guard units should resume their usual 30-day drill interval immediately after deactivation; the first drill should focus on reintegration issues with attention to discussion of deployment experiences, aspects of reintegration into community life, coping strategies and resilience supports, and other appropriate topics.

- Review policy requirements that would require involuntary 30-day drill after deployment.
- National Guard Bureau will coordinate with the office of the Under Secretary of Defense for Personnel and Readiness to determine optimal policy.
- Draft and issue policy changes as needed.

Recommendation 5.2.2.11 *Target Completion May 2008*
All individuals, regardless of status (e.g., active duty, Reserve, Guard, family member, retiree) should be briefed on the possible need for transfer of information upon transition as part of their initial orientation to treatment.

- Draft policy to revise informed consent statement for medical records.
- Collaborate with VA to establish clear policies and practices.
- Include information in TRICARE and VA communications products.
- Consult with Reserve components to determine most effective method to disseminate information as part of routine benefits briefings.
- Issue appropriate policies.

Recommendation 5.2.2.12 *Target Completion beyond May 2008*
The DoD and the Department of Veterans Affairs should establish a formal agreement for sharing clinical information concerning Service members who are part of the National Guard or Reserve systems and subject to activation.

- ✓ PDHA and PDHRA information available to clinicians in DoD and VA
- ✓ VA approved concept to make VA mental health records available for members of the National Guard and Reserve.
- Define a procedure to transfer electronic mental health records from VA to National Guard and Reserve units via BHIE.
- Fund an expansion to AHLTA to support National Guard and Reserve units to increase their access to both DoD and VA records.

5.2.3 Ensure High-quality Care

Recommendation 5.2.3.1 *Target Completion May 2008*
The DoD should solicit and fund research to assess barriers to accessing services to support psychological health, particularly in areas remote to military installations, with special emphasis on gaps in the continuum of care identified earlier in this report.

- ✓ Develop initial comprehensive staffing model for psychological health services, based on a risk-adjusted, population-based model using existing scientific information.
- ✓ Initiate contract to conduct research on a model staffing plan to assure access to psychological services including areas that are remote to military installations.
- Execute TRICARE Mental Healthcare Finder System that will track access times and assess barriers to care.
- Stand-up telepychological health and technology (TPHT) operations center to better serve needs of hard-to-serve population; link with Center of Excellence for consistent standards and access across DoD.
- Commission additional research on barriers to psychological health services through Congressionally Directed Medical Research Program and through newly developed Center of Excellence.

Recommendation 5.2.3.2 *Target Completion May 2008*
The DoD should regularly survey deployed Service members and providers to monitor the quality of support for psychological health in the deployed environment.

- Develop needs assessment survey questions.
- Develop standardized needs assessment survey through Center of Excellence.
- Establish lines of responsibility within each Service and Joint Staff/Combatant Command for survey administration.
- Direct Army to track and report results and implementation status from MHAT to determine utility of information.
- Implement new survey.

Recommendation 5.2.3.3 *Target Completion May 2008 and beyond*
The DoD should ensure that mental health professionals apply evidence-based clinical practice guidelines.

- ✓ DoD/VA Clinical Practice Guidelines on PTSD, major depressive disorder, acute psychosis, and substance use disorders readily available across DoD and VA.
- Emphasize use of existing DoD/VA Clinical Practice Guidelines on PTSD, major depressive disorder, psychosis, and substance use disorders through policy memo.
- ✓ Continue VA/DoD partnership to train mental health professionals on Clinical Practice Guidelines.
- ✓ Fund Service requests for training events pending core curriculum for Center of Excellence.
- Consolidate training programs into Center of Excellence; review and expand remote staffing for major medical centers as needed.
- Review, develop, update, and disseminate as needed additional Clinical Practice Guidelines over the next two years.

Recommendation 5.2.3.4 *Target Completion May 2008*
The DoD should routinely track and analyze patient outcomes to ensure treatment efficacy.

- Review existing outcome measures and policies.
- Develop evidence-based outcome measures, as needed.
- Issue policy to require use and reporting of outcome measures.

Recommendation 5.2.3.5 *Target Completion beyond May 2008*
Current pre- and post-deployment programs and those planned for the future should be studied in controlled clinical trials.

- ✓ Initiated an evaluation study of the PDHA and PDHRA to validate the assessment process.
- Publish report of the evaluation.
- Initiate Phase II of evaluation of PDHA and PDHRA.

Recommendation 5.2.3.6 *Target Completion November 2007*
The DoD should complete an evaluation of the effectiveness of the Mental Health Self-Assessment Program.

- ✓ Establish contract to conduct evaluation.
- ✓ Complete data collection for evaluation.
- Publish report.
- Begin second year of evaluation.

Recommendation 5.2.3.7 *Target Completion beyond May 2008*
The DoD should expedite development of an electronic record that facilitates the systematic collection and analysis of data on the processes and outcomes of care.

- Develop/refine existing requirements for mental health (MH) module within AHLTA to include measures of MH outcomes.
- Fund and execute AHLTA modifications.

Recommendation 5.2.3.8 *Target Completion May 2008*
Current epidemiological studies designed to determine factors which mediate or modify the observed risk of mental health problems after deployment should be continued. In addition, new studies should focus on Service members at increased risk due to special circumstances.

- ✓ Include PTSD in the Millennium Cohort Study.
- ✓ Issue Program Announcement for additional research.
- Fund meritorious research proposals.

Recommendation 5.2.3.9 *Target Completion May 2008*
The DoD should conduct research on the processes of post-deployment adjustment for family members.

- ✓ Issue Program Announcement for research.
- Fund meritorious research proposals.

Recommendation 5.2.3.10 *Target Completion Beyond May 2008*
The DoD should study the long-term adjustment of survivors of Service members killed during deployment, including their access to support for psychological health issues.

- Implement research through Defense Medical Research Program in collaboration with Center of Excellence.

Recommendation 5.2.3.11 *Target Completion Beyond May 2008*
The DoD should conduct research on children who have been separated from their parents by deployment and children whose parents have been severely wounded or injured as a result of military service.

- Implement research through Defense Medical Research Program in collaboration with Center of Excellence.

Recommendation 5.2.3.12 *Target Completion beyond May 2008*
The DoD should create (and continually validate) a measurement tool that will inform the military Services of Service members' psychological strengths and weaknesses at accession.

- Review existing tools; select appropriate measurement process.
- Accelerate implementation of the Health Assessment Review Tool - Accession (HART-A).

- Execute, track, and evaluate utility.

Recommendation 5.2.3.13 *Target Completion May 2008*
The DoD should create a tri-Service center of excellence for the study of resilience.

- ✓ Develop Center of Excellence concept of operations.
- ✓ Appoint interim director.
- Execute Center operations.

5.2.4 Provide Family Members with Excellent Access to Care

Recommendation 5.2.4.1 *Target Completion December 2007*
The DoD should improve coordination of care by ensuring appropriate access to installations for designated family members who are caring for family members but who do not possess military identification cards.

- Coordinate with personnel community to develop and implement appropriate policy.

Recommendation 5.2.4.2 *Target Completion November 2007*
Contact forms completed prior to deployment should be amended to permit Service members to indicate names and contact information of multiple family members for whom they give permission for different levels of communication to occur.

- ✓ Revise forms.
- Issue a policy memo to implement revised forms.

Recommendation 5.2.4.3 *Target Completion beyond May 2008*
The DoD should ensure needed deployment support information and resources are delivered to family members and stimulate family member participation through information-sharing activities.

- ✓ Implement outreach efforts to family members across DoD through the Mental Health Self Assessment Program
- Develop comprehensive practice through Center of Excellence Information Clearinghouse and Outreach procedures, leveraging and standardizing programs currently being conducted across the Services.

Recommendation 5.2.4.4 *Target Completion May 2008*
The military Services should formalize and fund volunteer family support services for the families of deployed Service members.

- ✓ Funded family readiness group coordinators in the Army.
- Review the Army process with family volunteer support representatives from Navy, USMC, and Air Force to consider similar programs for their Services.

Recommendation 5.2.4.5 *Target Completion beyond May 2008*
The military Services should develop effective evidence-based return and reunion programs for all Service members, including National Guard and Reserve members, and their families.

- ✓ Implement Sesame Workshop Program for children on Military OneSource Web site.
- Expand Sesame Workshop Program.
- Initiate curriculum development and outreach for overall family program through Center of Excellence.
- Assess Effectiveness of Sesame Workshop Outreach.
- Assess pilot programs for return and reunion.

Recommendation 5.2.4.6 *Target Completion May 2008*
The DoD should ensure that spouses and children of Service members on active duty have access to mental health care as readily as Service members, including at military treatment facilities.

- Review staffing model for military-civilian mix.
- Review resource sharing agreements and innovative models.
- Review and implement TRICARE Mental Health Care Finder system to ensure it answers the recommendations.
- Data gathering system for Network Access and Resource Sharing initiatives; modify contracts as needed.
- Monitor for access or timely appointment problems; modify as needed to meet standards.

Recommendation 5.2.4.7 *Target Completion November 2007*
The DoD should develop evidence-based educational materials to assist teachers and school administrators in supporting children of deployed parents.

- ✓ Evidence-based Signs of Suicide Program implemented in DoD School System for middle and high school.
- ✓ Sesame Street Workshop program available for younger children.
- Develop and execute plan with the DoD Educational Activity to expand to schools serving military children.

Recommendation 5.2.4.8 *Target Completion November 2007*
Each Service Casualty Assistance Calls Office (CACO) should provide appropriate staff for long-term support and follow-up of survivors after the conclusion of Casualty Assistance Calls Officer responsibilities.

- Revise policy in coordination with Personnel and Readiness office.

Recommendation 5.3.1.2 *Target Completion May 2008*
The DoD should provide sufficient funding to support the full continuum of psychological health services for Service members and their families.

- ✓ Develop initial staffing model based on best available evidence to permit full continuum of care.
- ✓ Initiate contract to review and refine staffing model.
- Develop OSD-level working group with community and family support, chaplain, and military personnel to ensure appropriate funding for non-DHP resources to provide a full continuum of care.
- Prepare GWOT supplemental and appropriation request to support required resourcing.

Recommendation 5.3.1.3 *Target Completion beyond May 2008*
Congress should provide, and the military Services should allocate, sufficient and continuing funding to fully implement and properly staff an effective system delivering a full continuum of psychological care to Reserve and National Guard Service members and their eligible family members.

- Convene Reserve component ad hoc working group to develop definition of full continue requirements for Reserve component as part of the Center of Excellence system of are.
- Institute telepsychological health network model.
- Determine funding and staffing mechanisms available to augment Reserve component resources.
- Create statewide models for telepsychological health to reach Reserve component.
- Execute Reserve component plan.

Recommendation 5.3.1.4 *Target Completion beyond May 2008*
The DoD should immediately act on the recommendations in this report to refine recruiting programs for uniformed and civilian mental health providers and develop new programs to attract and retain mental health professionals in military service.

- ✓ Initiated agreement with Public Health Service to provide uniformed providers to military medical treatment facilities to rapidly increase available mental health providers.
- Data call from Services for high need/high density platforms for immediate placement of Public Health Service officers.
- Finalize Memorandum of Agreement with Public Health Service to solidify agreement and begin assigning providers.
- Finalize and execute accession package for civilian providers.
- Establish and execute resource sharing agreements to bring providers onto installations to fill gaps.
- Review, revise, and fund accession, bonus, and incentive pay system for military providers.

5.3.2 Provide Sufficient Staff and Allocate Them Properly

Recommendation 5.3.2.1 *Target Completion beyond May 2008*
The DoD should ensure staffing levels are sufficient to permit Service members and their families to receive timely mental health treatment services from staff assigned to military treatment facilities, and to permit Service members to receive timely consultations in their line units.

- ✓ Created initial staffing model.
- ✓ Contracted for more refined, comprehensive staffing model.
- Finalize and execute comprehensive staffing model.

Recommendation 5.3.2.2 *Target Completion May 2008*
The DoD should establish access standards for mental health care at seven days or fewer (depending on the acuteness of the presenting concern), paralleling the access standards for primary care services.

- Draft policy and coordinate with Services.
- Release and disseminate policy; modify contracts as needed.
- Communicate to beneficiaries.
- Monitor compliance and refine procedures as indicated.

Recommendation 5.3.2.3 *Target Completion beyond May 2008*
The DoD should adopt a risk-adjusted population-based model for allocating resources to military mental health facilities and services embedded in line units. Allocations should be regularly reviewed to update risk assessments.

- ✓ Created initial staffing model based on best available evidence.
- ✓ Contracted for further refinement and testing of model.
- Finalize and execute staffing model.

5.3.3 Ensure an Adequate Supply of Uniformed Providers

Recommendation 5.3.3.1 *Target Completion May 2008*
The DoD should thoroughly review and increase the effectiveness of incentives to attract and retain highly qualified active duty mental health professionals and initiate new programs to meet recruiting and retention goals.

- Review existing incentive pay policies and plans.
- Submit packages for incentive and accession pay for mental health providers.
- Establish with Services methods to implement incentive pay packages.
- Contact Recruiting Services to discuss programs to attract and retain mental health professionals.
- Execute access and incentive pay schedule.

Recommendation 5.3.3.2 *Target Completion November 2007*
The DoD should ensure an adequate career path for professional development. Excellence in all aspects professional life, including clinical excellence, must be equitably rewarded.

- Review Service procedures for career paths in the different specialties.
- Review options for changing or rewarding of career decisions.
- Execute directives regarding career path options.

Recommendation 5.3.3.3 *Target Completion November 2007*
The DoD should consistently use the full spectrum of mental health professionals, including social workers, to provide a comprehensive continuum of mental health care.

- ✓ Developed initial staffing model including social workers in all Services.
- Coordinate with social worker consultants/specialty leaders to develop statement on standardized scope of care for Social Workers that is consistent across Services.
- Develop and promulgate policy standardizing use of social workers across Services.

Recommendation 5.3.3.4 *Target Completion May 2008*
The DoD should fully utilize the skills and training of military mental health technicians.

- Develop initial staffing model.
- Review Service policies and practices regarding use of mental health technicians.
- Develop consistent joint training program to ensure mental health technicians have the skill set needed to conduct consistent practices.
- Develop and disseminate policy delineating authorized uses and directing consistent use of Mental Health Technicians; track compliance through routine reporting from Services and training center.

Recommendation 5.3.3.5 *Target Completion May 2008*
The DoDshould make recruiting and retaining mental health professionals in the military a high priority in decisions to eliminate positions or convert positions to civilian status.

- Reinforce awareness of stop on military to civilian conversions.
- Review mix of military and civilian staff.
- Review deployment requirements from Services according to doctrine.
- Establish model for optimal mix of military to civilian mental health providers.
- Develop and promulgate military mix in staffing policies for mental health.

Recommendation 5.3.3.6 *Complete*
The DoD should move clinical psychologists and clinical social workers into the Professional (YH) pay career group in the National Security Personnel System (NSPS).

- ✓ Clinical psychologists and social workers are already included in the YH pay career group in the NSPS per DoD 1400.25.M, 28 April 2006.

Recommendation 5.3.3.7 *Target Completion May 2008*
The DoD should ensure local leadership has sufficient flexibility and financial resources to compete in recruiting highly qualified civilian mental health professionals, including those with recent military experience.

- Coordinate with the Military Services to determine their need to support local hiring procedures.
- Provide central agreement with Public Health Service to provide uniformed providers in hard-to-serve areas where it may be difficult to hire locally.
- Review alternative central contracting and/or central recruiting procedures; coordinate with Services to avoid conflicting recruiting procedures.
- Develop and implement options for recruiting and contracting procedures; revise as needs and conditions fluctuate across the country.

5.3.4 Ensure TRICARE Networks Fulfill Beneficiaries' Psychological Health Needs

Recommendation 5.3.4.1 *Target Completion May 2008*
The DoD should require TRICARE contractors and subcontractors for mental health services to monitor, at least quarterly, whether network mental health providers are accepting new patients to ensure a continuum of mental health services is available in each locale.

- Implement TRICARE Mental Health Care Finder System.
- Issue requirement for TRICARE Regional Offices to report quarterly to the Center of Excellence the results of their efforts to track and monitor mental health provider availability and access.
- Monitor and review need for changes based on quarterly reporting.
- Report to ASD (HA) any needed changes and recommendations for implementation.

Recommendation 5.3.4.2 *Target Completion May 2008*
The DoD should require that TRICARE contracts include a case management system for mental health referrals. This should include a means for obtaining timely assistance in securing an appointment.

- Implement Mental Health Care Finder System.
- Develop data gathering system for Network access.
- Implement contract changes, as needed.
- Monitor for access or timely appointment problems.
- Modify system as needed to meet standards; modify contracts as needed.
- Continue to monitor for compliance and report change recommendations to Assistant Secretary of Defense (Health Affairs) (ASD (HA)).

Recommendation 5.3.4.3 *Target Completion May 2008*
TRICARE regional offices should monitor access to mental health providers and require contractors to ensure a readily available continuum of care.

- Implement Mental Health Care Finder System.
- Develop data gathering system for Network Access.
- Implement contract changes, as needed.
- Monitor for access or timely appointment problems.
- Modify system as needed to meet standards; modify contracts as needed.
- Continue to monitor for compliance and report change recommendations to ASD (HA).

Recommendation 5.3.4.4 *Target Completion May 2008*
The DoD should revise TRICARE access standards to equate access to basic mental health services with access for basic primary medical care – seven days or fewer (depending on the severity of the presenting concern).

- Draft policy and coordinate with Services.
- Release and disseminate policy; modify contracts as needed.
- Communicate to beneficiaries; monitor compliance.

Recommendation 5.3.4.5 *Target Completion May 2008*
The DoD should ensure TRICARE reimbursement rates for mental health services are competitive with local rates paid by other major payers to ensure military families are given priority by area providers.

- Review TRICARE Reimbursement Rate System.
- Issue policy regarding reimbursement rates in line with existing flexibility.
- Proposed legislative relief, if needed.

Recommendation 5.3.4.6 *Target Completion May 2008*
The DoD should modify TRICARE regulations to permit updates as new treatment approaches for psychological disorders emerge.

- Review of intensive outpatient coverage.
- Replicate Specialized Care Program at major medical centers.
- Review training requirements and ongoing continuing medical education requirements for TRICARE network providers to cover emerging evidence-based treatment.
- Release policies and directives to govern identified changes.
- TRICARE Regional Offices required to report annually on effectiveness of implementation.

Recommendation 5.3.4.7 *Target Completion May 2008*
TRICARE should accept accreditation of residential treatment facilities for children by any nationally recognized accrediting body, as is the norm in the civilian sector.

- Review residential treatment center certification standards.
- Review of residential treatment center coverage by commercial health plans.
- Pursue regulatory and contractual changes, as needed.

Recommendation 5.3.4.8 *Target Completion May 2008*
TRICARE should allow outpatient substance abuse care to be provided by qualified professionals, regardless of whether they are affiliated with a day hospital or residential treatment program, including standard individual or group outpatient care.

- Review TRICARE substance abuse coverage.
- Review direct care substance abuse treatment program access and outcomes.
- Implement regulatory and contractual changes as needed.

Recommendation 5.3.4.9 *Target Completion May 2008*
The DoD should improve TRICARE providers' training in issues related to military experiences.

- Review with TRICARE current contractor training and orientation practices and polices.
- Develop training curriculum in collaboration with Center of Excellence.
- Modify current contracts and policies.
- Implement training and monitor compliance.

Recommendation 5.3.4.10 *No action required*
The DoD should ensure that covered TRICARE mental health services include V-codes related to partner relational problems, physical/sexual abuse, bereavement, parent-child relational problems, and other appropriate services.

- ✓ Coverage for situational problems currently available across the system through fully-funded Military OneSource program and other family support programs. Expanding the TRICARE benefit to duplicate this existing program is not needed.

5.4 EMPOWERING LEADERSHIP

5.4.1 Establish Visible Leadership and Advocacy for Psychological Health

Recommendation 5.4.1.1 *Target Completion May 2008*
The military Services should ensure that each military installation has a Director of Psychological Health who serves as the installation commander's consultant for psychological health.

- Develop organizational model and policy for director of psychological health system.

- Publish policy.
- Implement model.

Recommendation 5.4.1.2 *Target Completion May 2008*
Where installations of different military Services exist in proximity, the Directors of Psychological Health should establish a standing committee to ensure coordination of services to facilitate equitable coverage and access to care for all Service members and their families, regardless of Service affiliation.

- Develop organizational model and policy for director of psychological health system.
- Publish policy.
- Implement model.

Recommendation 5.4.1.3 *Target Completion May 2008*
Each military Service should establish a full-time Director of Psychological Health who reports directly to the Surgeon General or, for the Marine Corps, the Medical Officer of the Marine Corps.

- Develop organizational model and policy for director of psychological health system.
- Publish policy.
- Implement model.

Recommendation 5.4.1.4 *Target Completion May 2008*
The military Services should ensure coordination among the medical department specialty leaders/consultants and other military organizations that support psychological health.

- Develop organizational model and policy for director of psychological health system and related council or committee of psychological health.
- Publish policy.
- Implement model.

Recommendation 5.4.1.5 *Target Completion May 2008*
Each Service Surgeon General's annual report to Congress should include data about the psychological health of Service members and their families, and on the efforts to improve psychological health.

- Develop standardized needs assessment through Center of Excellence.
- Issue policy to the Service to require annual report contribution.
- Implement standardized data collection and reporting requirements consistent across the Services to ensure similar pictures are presented.
- Establish a timeline for reporting; collect data and report as required.

Recommendation 5.4.1.6 *Target Completion May 2008*
The Assistant Secretary of Defense for Health Affairs should establish a DoD Psychological Health Council consisting of the Active Duty, National Guard and Reserve Directors of Psychological Health and other senior leaders as appropriate to develop a DoD vision and strategic plan for supporting the psychological health of Service members and their families.

- Develop organizational model for DoD/Service level director of psychological health.
- Establish psychological health council as subcommittee under the MEDPERS Council.
- Develop and disseminate policy to implement model.

Recommendation 5.4.1.7 *Target Completion May 2008*
The Defense Health Board should establish a standing sub-committee, including subject-matter experts, to focus on psychological health. One duty of this subcommittee should be to review the DoD's progress in fulfilling the recommendations contained in this report.

- Establish subcommittee under the Defense Health Board.
- Seek representation for all appropriate disciplines and functional areas.
- Fund subcommittee work.

Recommendation 5.4.1.8 *Target Completion May 2008*
Each military Service's Inspector General staff should include subject-matter experts on programs related to psychological health to ensure compliance with the strategic plan.

- Collaborate with the Inspector Generals of DoD and the Services to establish appropriate staffing and functional alignment.
- Publish policy to ensure action taken in accordance with Inspector General recommendations.

Recommendation 5.4.1.9 *Target Completion May 2008*
Each military Service's medical Inspector General's staff should include subject-matter experts on programs related to psychological health to ensure strategic plan compliance.

- Collaborate with Inspector Generals of DoD and the Services to establish appropriate staffing and functional alignment.
- Publish policy to ensure action taken in accordance with Inspector General recommendations.

Recommendation 5.4.1.10 *Target Completion May 2008*
Each of the states and U.S. territories should appoint a full-time National Guard Director of Psychological Health to ensure that psychological health is effectively addressed.

- Develop organizational model and policy for director of psychological health system and related council or committee of psychological health.

- Publish policy; ensure funding availability.
- Implement model.

Recommendation 5.4.1.11 *Target Completion May 2008*
Congress should adequately fund the National Guard Bureau to ensure the National Guard Director of Psychological Health is a permanent full-time position.

- Develop organizational model and policy for director of psychological health system and related council or committee of psychological health.
- Publish policy; ensure funding availability.
- Implement model.

Recommendation 5.4.1.12 *Target Completion May 2008*
The National Guard Bureau should establish provisions for a council networking all state and territory National Guard Directors of Psychological Health.

- Develop organizational model for director of psychological health system in National Guard.
- Establish psychological health council, ensure understanding of National Guard and Reserve component unique issues.
- Develop and disseminate policy to implement model.

Recommendation 5.4.1.13 *Target Completion May 2008*
Each state and territory should establish statewide psychological well-being programs and leverage existing community resources to provide robust access to care for National Guard members and their families.

- Review existing program portfolio.
- Develop solid collaboration between Center of Excellence and National Guard director and council of psychological health.
- Implement and track programs through the Center of Excellence.

Recommendation 5.4.1.14 *Target Completion May 2008*
The National Guard Bureau should establish a Director of Psychological Health who serves as a member of the DoD Psychological Health Council.

- Develop organizational model for National Guard and Reserve component level director of psychological health.
- Develop and disseminate implementing policy.

Recommendation 5.4.1.15 *Target Completion May 2008*
The Assistant Secretary of Defense for Reserve Affairs should appoint a Director of Psychological Health who serves as a member of the DoD Psychological Health Council.

- Develop organizational model and policy to implement model.
- Establish mechanisms to implement changes needed to execute the model.
- Establish position requirements and hire staff.

Recommendation 5.4.1.16 *Target Completion May 2008*
Each Service Reserve component should appoint a full-time Director of Psychological Health to the staff of the Reserve component Surgeon. Where Reservists are organized by region, a full-time Regional Psychological Health Director should be appointed.

- Develop organizational model for National Guard and Reserve component level director of psychological health.
- Develop policy to implement model; ensure appropriate funding.
- Establish mechanisms, as needed, to implement changes needed.
- Execute the model.

5.5 SPECIAL TOPICS

5.5.1 Reserve Components: Special Considerations

Recommendation 5.5.1.1 *Target Completion beyond May 2008*
The DoD should earmark sufficient funds for and mandate that the National Guard Bureau and Reserve Component Commands conduct regular anonymous surveys of National Guard and Reserve members, their families, and survivors assessing barriers, satisfaction, stigma, knowledge, and training for mental health issues.

- ✓ Fund development and implementation through Center of Excellence.
- Develop the survey, tracking and reporting mechanisms through Center of Excellence.

Recommendation 5.5.1.2 *Target Completion May 2008*
The DoD should ensure problems uncovered by surveys result in timely action plans to improve access to and the quality of psychological health services for Reservists, their families and survivors.

- Develop organizational model for National Guard and Reserve component level director of psychological health; develop initial draft policy.
- Establish link between Reserve component psychological health system and Center of Excellence for staff assistance in executing survey and responsive action.
- Implement and track actions through the Center of Excellence.

5.5.2 Female Service members and Veterans

Recommendation 5.5.2.1 *Target Completion May 2008*
The DoD Psychological Health Strategic Plan should include specific attention to the psychological health needs of women.

- ✓ Schedule conference to review women's mental health issues and resources with DoD and VA stakeholders.
- Include women's health issues in Center of Excellence program planning.

- Ongoing monitoring and action on women's health through Center of Excellence.

Recommendation 5.5.2.2 *Target Completion May 2008*
The DoD should develop treatment programs specifically geared towards the psychological health needs of female Service members.

- ✓ Schedule conference to review women's mental health issues and resources with DoD and VA stakeholders.
- Include women's health issues in Center of Excellence program planning.
- Ongoing monitoring and action on women's health through Center of Excellence.

Recommendation 5.5.2.3 *Target Completion November 2007*
The DoD should continue to aggressively conduct prevention, early identification and treatment of military sexual trauma among Service members of both sexes.

- Conduct joint planning with domestic violence and sexual assault prevention points of contact.
- Finalize joint plan for domestic violence prevention and community based sexual assault prevention.
- Publish plan.

5.5.3 Traumatic Brain Injury and Its Psychological Health Implications

Recommendation 5.5.3.1 *Target Completion May 2008*
We suggest acceptance of the Independent Review Group's traumatic brain injury recommendations and endorse close examination of recommendations proposed by the other DoD and Department of Veterans Affairs traumatic brain injury working groups when they are issued.

- ✓ Conduct two DoD/VA summits to review recommendations and generate actions needed in TBI area.
- ✓ Establish Center of Excellence for Psychological Health and TBI.
- Complete action plan in response to recommendations on TBI by all review groups, including the Independent Review Group; track through Senior Oversight Committee.