THE ASSISTANT SECRETARY OF DEFENSE
1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

AUG - 4 2008

The Honorable John P. Murtha
Chairman, Subcommittee on Defense
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

The enclosed report responds to the request in S.1547, National Defense Authorization Act, Fiscal Year 2008, SR 110-77, Title VII that the Department of Defense (DoD) study and develop a plan to address the Mental Health Advisory Team (MHAT) IV findings. The report fulfils two separate congressional report requirements due on June 20, 2007 and March 1, 2008.

The report covers the resources needed to address the mental health issues the MHAT IV identified; length and frequency of deployment, and the extent to which the finding that deployment length was related to higher rates of mental health and marital problems was taken into consideration by the DoD in the decision to extend Army tours; and strategies to improve battlefield ethics training. The section, "Length and Frequency of Deployment and DoD Considerations," addresses the reporting requirement due June 20, 2007.

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

Sincerely,

S. Ward Casscells, MD

Enclosure:
As stated

cc:
The Honorable C.W. Bill Young
Ranking Member

THE ASSISTANT SECRETARY OF DEFENSE
1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

AUG - 4 2008

The Honorable Daniel K. Inouye
Chairman, Subcommittee on Defense
Committee on Appropriations
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

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S. Ward Casscells, MD

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cc:
The Honorable Ted Stevens
Ranking Member

THE ASSISTANT SECRETARY OF DEFENSE
1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

AUG - 4 2008

The Honorable Robert C. Byrd
Chairman, Committee on Appropriations
United States Senate
Washington, DC 20510

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As stated

cc:
The Honorable Thad Cochran
Ranking Member

THE ASSISTANT SECRETARY OF DEFENSE
1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

AUG - 4 2008

The Honorable Susan Davis
Chairwoman, Subcommittee on Military Personnel
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Madam Chairwoman:

The enclosed report responds to the request in S.1547, National Defense Authorization Act, Fiscal Year 2008, SR 110-77, Title VII that the Department of Defense (DoD) study and develop a plan to address the Mental Health Advisory Team (MHAT) IV findings. The report fulfils two separate congressional report requirements due on June 20, 2007 and March 1, 2008.

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S. Ward Casscells, MD

Enclosure:
As stated

cc:
The Honorable John McHugh
Ranking Member

THE ASSISTANT SECRETARY OF DEFENSE
1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

AUG - 4 2008

The Honorable Ike Skelton
Chairman, Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

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As stated

cc:
The Honorable Duncan Hunter
Ranking Member

THE ASSISTANT SECRETARY OF DEFENSE
1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

AUG - 4 2008

The Honorable Ben Nelson
Chairman, Subcommittee on Personnel
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

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S. Ward Casscells, MD

Enclosure:
As stated

cc:
The Honorable Lindsey O. Graham
Ranking Member

THE ASSISTANT SECRETARY OF DEFENSE
1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

AUG - 4 2008

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

Dear Mr. Chairman:

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S. Ward Casscells, MD

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As stated

cc:
The Honorable John McCain
Ranking Member

THE ASSISTANT SECRETARY OF DEFENSE
1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

AUG - 4 2008

The Honorable David R. Obey
Chairman, Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

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Sincerely,

S. Ward Casscells, MD

Enclosure:
As stated

cc:
The Honorable Jerry Lewis
Ranking Member

Report to Congress

Response to Senate Report 110-77

Responses to Mental Health Advisory Team IV Findings

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Introduction

The Mental Health Assessment Team IV Report to Congress, delivered in November of 2006, notes that MHAT IV was chartered by the Office of the U.S. Army Surgeon General at the request of the Commanding General, Multi-National Forces-Iraq (MNF-I), and was conducted between 28 August and 03 October 2006 with the express purpose of (a) assessing the mental health and well being of Soldiers and Marines in theater for Operation Iraqi Freedom, (b) examining the delivery of behavioral health in theater, and (c) generating recommendations for sustainment and improvement to command.

Subsequently, Senate Report 110-77 requests the Department of Defense (DoD) study and develop a plan to address the Mental Health Advisory Team (MHAT) IV findings. The committee directed a report on the implications on all DoD policies concerning:

1) Resources needed to address the mental health issues the MHAT IV identified;
2) Length and frequency of deployment, and the extent to which the finding that deployment length was related to higher rates of mental health and marital problems was taken into consideration by the DoD in the decision to extend Army tours; and
3) Strategies to improve battlefield ethics training.

Mental Health Resources

The Assistant Secretary of Defense, Health Affairs is committed to providing the necessary funding, coordination, and support to Service and Benefit operations to ensure adequate mental health resources to meet patient needs and demand in the Military Health System and beneficiary population.

Actions and Initiatives

While healthcare delivery operations occur at Service-level treatment facilities and in the TRICARE network, several initiatives are underway to provide improved access to mental health care, increased provider availability in the network, and more effective recruitment and retention incentives to mental health providers.

In a policy memorandum (HA POLICY 07-022) to the Assistant Secretaries of the Army, Navy, Air Force, and the Deputy Director of TRICARE Management Activity (TMA), dated 09 October 2007, the Assistant Secretary of Defense, Health Affairs provided policy and guidance clarification for TRICARE Prime access standards for mental health care. A copy was sent to each Service Surgeon General. The guidance stated, "All initial appointments to evaluate service or family member's new or

reemerged behavioral health needs are considered primary care and will result in an evaluation by a provider who is professionally capable or specifically privileged to perform behavioral health assessments." In addition, it reaffirmed acceptable behavioral health assessment time frames: Emergency (threatening life, limb, or sight), Urgent (24 hours or less), or Routine (within one week – seven days). Beneficiaries may choose to exceed the seven day access standard to procure their preferred choice of provider and/or service location. It also reaffirmed the four-week standard for routine network specialist referrals. More urgent requests are annotated with priority indicators of STAT, within 24 hours, as soon as possible, today, or within 72 hours. The memorandum directed the TRICARE Regional Office Directors to monitor and report quarterly on the effectiveness of their behavioral health provider locators to assist and facilitate beneficiaries with network appointment-making within the access standards. The Services were directed to monitor and report quarterly on degree of compliance with behavioral health access standards in the military treatment facilities (MTF).

In September 2007, the Deputy Director, TMA, assigned a coordinating official to oversee the 26 behavioral health care initiatives under its purview, and assigned suspense dates and responsible officials to each of the 26 initiatives. The initiatives are categorized under Access to Behavioral Health Care (6), Communication and Outreach (9), Reimbursement Rates (2), Hospital-based Psychiatric Partial Hospitalization Programs (2), Intensive Outpatient Program Benefit (2), Residential Treatment Centers (3), and Substance Use Disorder Treatment Settings (2). (Table 1)

Initiative No.	Initiative
	Access to Behavioral Health Care
1a	Require the managed care support contractors to provide Active Duty Service Members (ADSMs) and active duty family members (ADFMs) assistance in locating and making timely appointments, satisfactory to the beneficiaries, with behavioral health care providers.
1b	Gather data to quantitatively characterize the "user friendly" status of the process for obtaining an appointment for mental health treatment sought, both in the TRICARE private sector network and outside the network, by spouses and children of Service Members on Active Duty.
1c	Determine the number and location of TRICARE-authorized behavioral health providers, both in the network and outside it. Compare the location of these providers to the location of TRICARE beneficiaries.
1d	If deficiencies are identified in Initiatives #1b or #1c, then develop and implement process improvement activities to close gaps.
1e	If appointing process deficiencies are identified as a result of Initiatives #1b or #1c, TRICARE Regional Offices monitor contractors' performance to ensure beneficiaries have a "user friendly" means of obtaining mental health appointments in the private sector network.
1f	Coordinate recurring town hall meetings and take other steps to determine if beneficiaries consider the process for obtaining behavioral health appointments in the private sector network to be "user friendly."

Initiative No.	Initiative
	Communication and Outreach
2a	Design and conduct an outreach program to inform National Guard and Reserve members of the programs available to them for treatment of post-deployment mental health issues.
2b	Prepare and distribute, via appropriate media, to National Guard and Reserve members information about identification, prevention, and treatment of deployment-related mental health conditions.
2c	Include in provider bulletins sent to network providers one or more articles reminding them that referrals for mental health treatment can specify the degree of urgency of the request, with the urgency ranging from "STAT" to "routine."
2d	Prepare and forward to the Services for distribution to the MTFs an article in *The Clinical Ops Corner* giving MTF providers information similar to that communicated under Initiative #2c.
2e	Include in provider and beneficiary bulletins reminders that beneficiaries, except for Active Duty members because of fitness-for-duty concerns, may self-refer for the first eight outpatient mental health visits to a TRICARE authorized provider.
2f	Prepare and forward to the Services for distribution to the MTFs an article in *The Clinical Ops Corner* giving MTF providers information similar to that communicated under Initiative #2e.
2g	Develop a plan and related materials to train civilian mental health providers in issues related to military experiences.
2h	Distribute to civilian mental health providers, via appropriate media and channels, the training materials developed under Initiative #2g.
2i	Design and implement a communication campaign to inform beneficiaries about sources of assistance for locating and accessing resources to address mental health well-being issues (e.g., job dissatisfaction, caring for an aged parent, retirement transition).
	Reimbursement Rates
3a	Perform a comprehensive comparison of commercial, TRICARE and other Government health plan reimbursement rates for outpatient mental health services.
3b	Assess impact of results from Initiative #3a on access to behavioral health care by TRICARE beneficiaries. If warranted, make adjustments to the TRICARE reimbursement rates as permitted within current statutory authority.
	Hospital-Based Psychiatric Partial Hospitalization Programs
4a	Revise the CFR, TRICARE Reimbursement Manual, managed care support contracts, and National Quality Monitoring Contract (NQMC) so that Joint Commission accreditation of a hospital will be sufficient for it to be a TRICARE authorized provider of psychiatric partial hospitalization program (PHP) services. Upon implementation of this initiative, TRICARE certification of hospital-based psychiatric PHPs would no longer be required.
4b	Develop and put in place a method of auditing the results of implementing Initiative #4a to ensure that elimination of unique TRICARE certification standards for hospital-based PHPs has no untoward clinical effects.
	Intensive Outpatient Program Benefit
5a	Develop a proposed TRICARE intensive outpatient program (IOP) benefit package for approval by ASD (HA).
5b	Conduct the rule-making process necessary to incorporate the IOP benefit developed under initiative #5a into the TRICARE benefit. Modify the managed care support contracts and TRICARE manuals as necessary to implement the benefit.
	Residential Treatment Centers

Initiative No.	Initiative
6a	Conduct a study to determine the type of residential treatment center (RTC) services covered by commercial health plans and compare those to TRICARE RTC coverage.
6b	Review TRICARE certification standards for RTCs to determine the advisability of modifying or eliminating some or all of them.
6c	If the review conducted under Initiative #6b concludes that modifying TRICARE's certification standards for RTCs is warranted, revise the CFR, TRICARE Reimbursement Manual, managed care support contracts, and National Quality Monitoring Contract (NQMC) to effect the modifications.
Substance Use Disorder Treatment Settings	
7a	Conduct a study to determine the advisability of incorporating into the TRICARE benefit the treatment of substance use disorders conducted by authorized providers in outpatient group therapy settings outside of SUDRFs and by individual providers.
7b	If the review conducted under Initiative #7a concludes that incorporating into the TRICARE benefit the treatment of substance use disorders conducted by authorized providers in outpatient group therapy settings outside of SUDRFs and by individual providers is warranted, revise the CFR, TRICARE Reimbursement Manual, and managed care support contracts to effect the benefit change.

Table 1

Section 661 of the National Defense Authorization Act (NDAA) for FY08, "Consolidation of Special Pay, Incentive Pay, and Bonus Authority," provided a special pay authority for the broad spectrum of health professional officers, to include behavioral health professionals. The statute stipulates there is to be no effect on FY08 obligations. Monies for FY09 are outside the Program Objective Memorandum (POM) cycle, thereby requiring reallocation of funds to execute. As such, DoD efforts to rapidly provide incentives to recruit and retain behavioral health professionals are delayed; however, the Department continues to evaluate its future needs, available funding mechanisms and resources, and is committed to attracting and retaining that broad spectrum of behavioral health professionals noted in the legislation.

Defense Center of Excellence

Supporting psychological health and optimizing mental health care in the Military Health System (MHS) is the newly established Defense Center of Excellence DCoE) for Psychological Health (PH) and Traumatic Brain Injury (TBI). Established in November of 2007 by the Department of Defense (DoD) in cooperation with the Department of Veterans Affairs (VA), it serves as the focal point for a national collaborative network to advance and spread PH/TBI knowledge, enhance clinical and management approaches and facilitate other vital services to best serve the urgent and enduring needs of warrior families, help enhance resiliency, and meet PH needs. Temporarily located in Rosslyn, VA, the DCoE will be permanently housed at the National Military Medical Center in Bethesda, MD and is projected to be fully operational by October 2009.

The DCoE will establish evidence-based clinical guidelines, sponsor research, and provide input to senior MHS leadership on recommended personnel policy and programs to enhance resiliency. The DCoE's programs will be specially designed to meet Service Member needs by building a robust professional mental health and behavioral workforce support network, enhancing access to those mental and behavioral health services, establishing and enhancing educational resources, and conducting leading edge research. It is, therefore, critical that the DCoE receive adequate and sustained funding in the coming years to develop its organization and execute its responsibilities to our military Service Members and the MHS.

Length and Frequency of Deployment and DoD Considerations

In the course of creating policy for deployment tour lengths, the DoD considers all factors, including mental health stressors, which affect force strength and readiness to accomplish the strategic mission. The DoD must and does focus on Service Member and family preparation prior to deployment via programs like Service Ombudsman Programs, Pre-Deployment Health Assessments (PDHA), and various other pre-deployment training in host nation and in-theater environments. Following deployment, the DoD is committed to providing Reunion Programs for families, ensuring Service Members and their families have access to the highest quality mental health services and family support services for counseling, including Military One-Source, should they need assistance.

The Army, using operationally deployed mental health personnel, continues to actively support prevalence and intervention research studies to address mental health issues of soldiers across the deployment cycle. In addition, they now require Post-Deployment Battlemind Training for all returning Service Members, and risk management teams are employed to identify high-risk soldiers. There are approximately 230 mental health providers and technicians deployed in support of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF). Each brigade combat team (BCT) has a behavioral health section assigned to them. The Army also has fielded a new trauma risk program call Traumatic Event Management (TEM). It is actively employed in all phases of military operations, both in garrison and while deployed. The goal of TEM is to successfully address issues related to deployment transition for both units and individuals--building resilience, strengthening post-traumatic coping, and/or improving functioning following traumatic events. Behavioral health appointments currently average 5000 per month in theater. Return to duty rate is 93% from the 3-5 day treatment programs at the four restoration centers and 99% for outpatients. Less than 0.5% of the fighting force is evacuated annually for psychiatric reasons.

Strategies to Improve Battlefield Ethics Training

Battlefield ethics training is conducted at the Service level and each Service is committed to supporting and continuously improving existing training programs. The

Service Academies and the Uniformed Services University of Health Sciences (USUHS) also offer battlefield ethics courses in their respective curricula.

Army

Actions. While training is required for all deploying Service Members, regardless of Service, training is primarily focused on deploying Army and Marine forces; as such, the training program is administered via the Army's Training and Doctrine Command (TRADOC). MHAT IV recommended to the Army that ethics training be developed based on "Soldiers' Rules," using OIF-based scenarios. The Army TRADOC and the Army Judge Advocate General are currently revising the training.

Marine Corps

Actions. The Marine Corps recently implemented initiatives to strengthen Core Value training. They include: Value-based drill instructor "foot locker talks," publication of pocket-sized versions of Law of War and ethical case study discussion guides, and a re-invigorated values component of the Marine Corps Martial Arts Program. They also increased entry-level Marine Corps Core Values Training from 14 to 41.5 hours at Marine Corps Recruit Depots (MCRD), extended moral development instruction to the officers and staff at MCRDs, added 11.25 hours of Combat Instructor's discussion time at Marine Combat Training, and added instruction to the commander's course on command climate and the commander's role in ensuring battlefields ethics, accountability, responsibility. From June to November 2007, Marine leadership directed a survey of over 1000 active duty and reserve Marines to better understand their perceptions of moral conduct, the role of the Marine Corps in developing their conduct, and to assess their grasp of the standards and expectations of ethical warriors. The results of the survey were summarized for the Commandant of the Marine Corps and will be used in the ongoing development of leadership doctrine, policy, and curriculum. Recognizing the need for a single point of coordination for the training, education, and practice of leadership and ethics, additional structure and resources will be applied to the John A. LeJeune Leadership Institute (LLI) which provides instruction at Marine Corps University Schools, and will be on par with the structure and capability of their sister Service centers of leadership (Center for Naval Leadership and Center for Army Leadership). In addition, leadership and ethics curricula, tools, and assessment metrics have been developed for formal schools (education and training), and for operational forces (sustainment). In March 2008, LLI developed and delivered Senior Enlisted Professional Military Education (PME) Instruction that covered issues of moral decision-making and responsibility, and has been delivered to unit commanders, their spouses, and senior enlisted advisors who support active and reserve components.

Programs. The Combat Operational Stress Control (COSC) Program addresses resiliency training and stress injury recognition for Marines and families through a

variety of programs. Its primary program is the Marine Operational Stress Training (MOST) which consists of briefs and trainings conducted pre, during and post deployments. In addition, Marines receive COSC education and training in various milestone schools. The Operational Stress Control and Readiness (OSCAR) program incorporates assigning mental health personnel to ground units to provide assistance where and when it is needed most. This embedded approach fosters early trust, increasing likelihood that Marines will seek early intervention.

Research. There are a variety of COSC research initiatives, which will provide data on current and future mental health needs; studies include:

- Marine Resiliency Study: Longitudinal study spanning the pre to post-deployment period to analyze mental and biological stress indicators. This is a joint study between the Marine Corps, the Department of Veterans Affairs and the University of California, San Diego.

- Marine Warfighter Status Survey: Mental health assessment survey conducted by Naval Health Research Center, which included over 1500 Marines and 2000 Sailors deployed to the Middle East. This survey will aid in addressing the effects multiple deployments have on mental health.

- Marine COSC Effectiveness Survey: Bureau of Medicine and Surgery funded self assessment survey conducted by the Center for Naval Analyses to identify factors contributing to individual and family resilience. The survey will be a three to four month study beginning in June 2008. The individual surveys will be sent to over 33,000 Navy and Marine Corps active and reserve Service Members and spouses (spouses and Service Members will not be matched; they will be independently sampled).

- Project DE-STRESS (Delivery of Self-Training and Education for Stressful Situations): The Deployment Health Clinical Center at Walter Reed Army Medical Center in conjunction with the Boston University School of Medicine developed an approach in treating Service Members who have experienced traumatic stress. The goal of this project is to significantly improve symptoms of depression and general anxiety by allowing a Service Member to access computer-based mental health treatment in their own home.

Future Plans. The Marine Corps COSC program is in the process of evaluating effectiveness of existing programs through these initiatives:

- Study of the "Warrior Transition" training;
- New video version of the "Warrior Transition" training;

- New training in Psychological First Aid for all first responders; and
- New Warrior Preparation Training to develop more skills in stress reduction and mental and emotional self care.

Navy

Actions. Deploying Navy Service Members receive training in "stress management" and resiliency factors pre, post and during deployments through Navy Fleet and Family Service Centers (FFSC) programs. Family members also have access to the FFSC training and support functions as well as internet stress management/resiliency resources. Navy members deploying with Army units receive the Army Battlemind training provided by Army personnel. Navy members deploying with Marine Units receive "Warrior Preparation" and "Warrior Transition" training modules.

Programs. The Naval Center for Combat/Operational Stress Control was established at Naval Medical Center, San Diego. Warrior Transition Program for Navy Individual Augmentees (IA) was implemented in Aug 2007 to include a three day "de-brief" in Kuwait. In June 2008, a family centered resiliency training program (Project Focus) will be piloted for USMC, SEALS, Seabees, and families. This program, developed by UCLA Center for Community Health with Duke National Center for Child Traumatic Stress, is a skills-based resiliency training program that addresses challenges facing military families by enhancing family communication and support. In August 2006, the CNO directed an in-theater health needs assessment be undertaken to address the needs of mental health needs of sailors since the MHAT did not include sailors. The second Navy Behavioral Health Needs Assessment (BHNAS), similar to the MHAT survey without battlefield ethics questions, has been completed and the third phase will begin summer 2008. IA Sailor Handbooks are provided to all Sailors deploying to potential combat zones and include information about combat operational stress, stress management techniques and sources of help. Training and a handbook are provided to commands of Sailors returning from combat assignments to assist the Chain of Command in identifying Sailors who may exhibit signs of PTSD and to make appropriate referrals for assistance. Fleet and Family Support Centers provide homecoming briefs to family members that address PTSD and TBI. Ongoing in-person and virtual family support sessions are held for family members of Sailors deployed to potential combat zones.

Future Plans. The Navy is tapping into the work of the Marine Corps to coordinate and align efforts. Initiatives include:

- The Navy/Marine Corps COSC doctrine is in development.
- Standardized Navy/Marine Corps COSC training is in development.
- COSC for Non-Mental Health Caregivers training kick-off held in September 2007. An additional 12 trainings are to be held throughout FY08.
- The third phase of the BHNAS will begin summer of 2008.

Air Force

Actions. The Air Force routinely conducts Law of Armed Conflict (LOAC) training for all deploying civilian and active duty Air Force personnel.

Position

While we believe our Service training in battlefield ethics to be the finest in the world, conducting combat operations in settings where combatants are mixed into the non-combatant populace blurs the distinction and makes operations challenging. No training can model all possible scenarios, nor provide comprehensive assurances, nor completely prevent violations of battlefield ethics by Service Members. The theory that mental health issues result in battlefield ethics violations has not been established; it seems more likely Service Members sometimes take actions in combat scenarios about which they later feel guilt and/or remorse, if not significant depression.

Conclusion

The DoD is continuing to improve the mental health support of our Service men and women. Enhancing access to appropriate psychological health and other support services for Service Members and their families is being addressed as an immediate priority, and these efforts are supported by the ongoing assessment of stressors and satisfaction within the Services. The establishment of the DCoE will help us to meet the clinical needs of our personnel most seriously affected by their wartime experiences, and will help us identify ways to enhance resiliency for all personnel and strategies to most effectively restore psychological health. We are also continuing to improve battlefield ethics training as another strategy to strengthen Service Members' decision-making skills and to help mitigate the potential psychological impact of the challenging combat environments in which our Service men and women operate in defense of our nation.