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Inspector General
United States Department of Defense

Observations and Critique of the DoD Task Force on Mental Health

DEPARTMENT OF DEFENSE
OFFICE OF INSPECTOR GENERAL

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Observations and Critique of the DoD Task Force on Mental Health

April 15, 2008

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What Was Done.

This report summarizes Office of the Inspector General, DoD observations of the DoD Task Force on Mental Health; the task force's final report, "An Achievable Vision," June 2007; and the Secretary of the Defense's "Report to Congress: The Department of Defense Plan to Achieve the Vision of the DoD Task Force on Mental Health," September 2007.

The Secretary established the task force in May 2006 in response to the requirements of Section 723 of the Fiscal Year 2006 National Defense Authorization Act. Concurrently, on May 17, 2006, Senator Joseph Lieberman requested that the Office of the Inspector General conduct a complete investigation of the military's current mental health practices.

The Office of the Inspector General arranged to have an Office of the Inspector General observer on the task force. Senator Lieberman's staff agreed to an Inspector General observer in lieu of a separate effort, and requested the Inspector General's critique of the task force's final report.

The OIG DoD representative observed all of the open sessions, most of the closed sessions, and accompanied the task force on several of their 39 site visits. The OIG DoD observer did not make direct inputs to the task force's report, nor did he review the draft report. He did, however, provide advice, as appropriate, when the task force requested his input.

What Was Identified.

The DoD Task Force on Mental Health fully satisfied the intent and requirements of Section 723 of the Fiscal Year 2006 National Defense Authorization Act, and address Senator Lieberman's concerns expressed in a May 17, 2006 letter. The task force report provided 15 findings and 95 recommendations to improve DoD's mental health program for members of the Armed Forces and their families. The Secretary of Defense's report to Congress summarized ongoing activity and provided target completion dates for recommendations.

The Office of the Inspector General observer noted three topics raised by the task force that did not receive significant mention in the report: suicide, inpatient treatment, and physical evaluation boards/medical evaluation boards. These issues deserve continued attention. However, we concluded that the task force's report and the report to Congress represent a comprehensive examination of DoD's mental health care programs for members of the Armed Forces and their families. Management should organize and oversee resources to meet or improve the completion target dates listed in the Secretary of Defense's report to Congress.

GENERAL INFORMATION

Forward questions or comments concerning the report of the Observations and Critique of the DoD Task Force on Mental Health and other activities conducted by the Inspections & Evaluations Directorate to:

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REPORT TRANSMITTAL

We are providing this report for information and use. We considered management comments to our observations in preparing this final report. Comments provided by the Under Secretary of Defense for Acquisition, Technology, and Logistics conformed to the requirements of DoD Directive 7650.3, "Follow-up on General Accounting Office (GAO), DoD Inspector General (DoD IG), and Internal Audit Reports," June 3, 2004. Therefore, additional comments are not required. We appreciate courtesies extended to the staff

Wm Brem Morrison, III
Assistant Inspector General
for Inspections and Evaluations

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Purpose and Background

Purpose of this Report. The purpose of this report is to summarize Office of the Inspector General, DoD (OIG DoD) observations of the DoD Task Force on Mental Health (hereafter referred to as the "task force"), the task force's final report[1]; and the Secretary of the Defense's (SecDef) "Report to Congress: The Department of Defense Plan to Achieve the Vision of the DoD Task Force on Mental Health," September 2007.[2] Because the two reports are readily available, our critique will only comment on selected findings and recommendations. The OIG DoD concludes that the DoD Task Force on Mental Health fully satisfied the intent and requirements of Section 723 of the Fiscal Year (FY) 2006 National Defense Authorization Act (NDAA). Moreover, we conclude that the task force's recommendations address Senator Lieberman's concerns expressed in a May 17, 2006 letter to the OIG DoD (Appendix A).

Background. The FY 2006 NDAA directed the SecDef to "examine matters relating to mental health and the Armed Forces." The SecDef established the task force in May 2006 in response to this Congressional mandate.

Concurrently, on May 17, 2006, Senator Joseph Lieberman requested that the OIG DoD "conduct a complete investigation of the military's current [mental health] practices…" In his letter, Senator Lieberman expressed concern that current procedures "…are not meeting the mental health needs of our servicemen and women."

On June 12, 2007, the task force submitted its final report to the SecDef. The report provided 15 findings and 95 recommendations to improve DoD's mental health program for members of the Armed Forces and their families. In September 2007, SecDef submitted the DoD report to Congress (hereafter referred to as the "report to Congress"). In that report it stated that the Department "has embraced the vision and the spirit embodied in the recommendations" of the task force's report.

Role of the OIG DoD During the Task Force Process. Considering the potential for duplication of effort between the then ongoing task force evaluation and Senator Lieberman's request, we arranged with the task force to have an OIG DoD observer on the task force. Subsequently, during a meeting with the then Acting IG DoD, Senator Lieberman's staff agreed to an IG observer in lieu of a separate IG effort. As a condition, however, the Senator's staff requested the IG's critique of the task force's final report; hence, this report.

The OIG DoD representative observed all of the open sessions and most of the closed sessions and accompanied the task force on field trips. The OIG DoD observer did not make direct inputs to the task force's report, nor did he review the draft report. He did, however, provide advice, as appropriate, when the task force requested his input.

[1] A copy of the Task Force's final report can be found at http://www.ha.osd.mil/dhb/mhtf/MHTF-Report-Final.pdf
[2] A copy of the DoD report to Congress can be found at http://www.ha.osd.mil/asd/downloads/MHTF-Report-to-Congress.pdf

Review of the Task Force Report

The task force report documents their examination of DoD's mental health care programs for members of the Armed Forces and their families, with special consideration of mental health issues related to Operations Enduring Freedom (OEF) and Iraqi Freedom (OIF).

The task force based its work on its vision for transforming the military mental health system by identifying the following four interconnected mental health goals on which they structured their review and report:

- a culture of support for psychological health,
- a full continuum of excellent care,
- sufficient and appropriate resources, and
- visible and empowered leaders.

The task force final report represents the results of a comprehensive process to analyze research data, perceptions, and ideas. The task force conducted 39 site visits—25 locations within the United States and 14 locations overseas. During these visits, task force members interviewed subject matter experts, commanders, military program managers, patients, family members, providers, medical researchers, advocates, and others.

The task force established two basic notions to anchor their debate and help distil the data collected and discussed:

- DoD's mental health mission has fundamentally changed in the past few years.
- Mental health includes "resiliency" and personal well-being, not just the presence or lack of mental illness.

The task force included 15 findings with 89 associated recommendations in the final report. The task force also provided six recommendations, not related to a specific finding, concerning three topics for special consideration: Reserve Components; Female Service Members and Veterans; and Traumatic Brain Injury.

OIG Comments on Task Force Findings and Recommendations. In order to demonstrate the wide range of the review, we will comment on the task force's findings and recommendations related to the previously mentioned four interconnected task force goals.

Goal 1. *"A culture of support for psychological health."* Task force findings addressed culture, access to professional care, training, policy, and existing procedures. The finding concerning stigma is especially relevant.

> *Finding: "Stigma in the military remains pervasive and often prevents Service members from seeking needed care."*

There is no empirical data to tell us how many military members who have emotional or mental health problems avoided seeking mental health care. There is a cultural reluctance to self-disclose a condition that may jeopardize one's fitness for duty. The task force relied somewhat on the Mental Health Advisory Team (MHAT) reports--reports derived from OEF/OIF data—as one possible inference for this unknown number. The MHAT reports are very thorough, but are inherently stand-alone, short-term accounts. Hence, the task force advocates the need for "post-deployment longitudinal studies." These studies will require a comprehensive system of Post-Deployment Health Assessments and Re-Assessments and recognition of the pervasive nature of stigma. Likewise, DoD should include a universal population of military members and not limit the study to just those who served in combat zones. DoD should consider additional efforts to destigmatize mental health conditions and to alleviate patient confidentiality concerns over the potential release of "privacy" information.

> *Recommendation: "The Department of Defense should implement an anti-stigma public education campaign, using evidence-based techniques to provide factual information about mental disorders." (Recommendation 5.1.1.1)*

For military members with psychological health problems, stigma is the primary barrier to self-disclosing these problems and seeking mental health care. The task force also recognized that its assessment and scope was not just about OEF and OIF experiences and concerns. It is clear that the intent of the task force was to recommend long-term solutions, applicable to both wartime and peacetime scenarios and effects. Addressing the strategic view of mental disorders in an anti-stigma public education campaign will be a challenge while combat "signature mental injuries" dominate public attention. For example, one study[3] concluded that 13 percent of all military hospitalizations and 28 percent of all military hospital bed days from 1990 to 1999 (relative peacetime) were due to mental disorders. Any public mental health campaign must delicately balance and maintain attention on the disorders amplified in wartime, but quietly persist in peacetime. As stated in the report to Congress, DoD plans to review literature and develop anti-stigma campaign initiatives through a DoD Center of Excellence.

DoD has a successful history of transforming culture. An effective anti-stigma campaign should follow the models used for race relations, sexual harassment, EEO, smoking, seat belts, and others. If military personnel, especially commanders and leaders, are aware of the indicators of mental health problems, it is more likely that those who need help will find support, treatment, and maintenance.

Goal 2. *"A full continuum of excellent care."* Task force findings uncovered gaps in service, continuity of care, treatment types and monitoring, and aid for family members.

> *Finding: "There are not sufficient mechanisms in place to assure the use of evidence-based treatments or the monitoring of treatment effectiveness."*

Like stigma, success in psychiatric medicine is difficult to measure. There are no x-rays, lab tests, or surgeries to provide immediate feedback. Confidentiality complicates and can threaten

[3] "Millennium Cohort", Journal of Clinical Epidemiology 60

continuity of care. There is no universal method to track patient outcomes within a Service or across Services. There is no objective source of information that universally addresses quality or effectiveness of care. If patients are dissatisfied with either, they are likely to "vote with their feet" (terminate treatment), which is one non-intrusive measurement that could initiate a clinical discussion on outcome-based improvements. While it is commendable that the task force did not ignore this issue, health care program managers need to do more to monitor, oversee, and improve effectiveness and make psychological assessments a normal part of patient care and military life.

> *Recommendation: "The Department of Defense should create (and continually validate) a measurement tool that will inform the military Services of Service members' psychological strengths and weaknesses at accession. This tool will help direct training and educational programs tailored to the Service members' needs. It will also provide data for longitudinal studies assessing the efficacy of and guiding the improvement of training programs." (5.2.3.12)*

This is a new "intervention" that recognizes individuals have unique strengths and vulnerabilities. The report notes this is an attempt to influence an oddity within the military environment: "little attention is paid to enhancing cognitive fitness and psychological resilience—the attributes most celebrated in the military's finest leaders and combat heroes." A tool is needed for "cognitive" testing, and all recruits should be tested to "baseline" their cognitive abilities in order to validate a Service-connected traumatic brain injury. To implement this recommendation, DoD plans to accelerate the use of the Health Assessment Review Tool-Accession (HART-A).

Personal resilience and psychological strength varies by individual, based on genetic makeup and life experiences. For example, two soldiers experiencing the same horrific event, with similar physical injures will process the trauma differently and at dissimilar life stages. This recommendation will help leaders understand that resilience varies among individuals.

Goal 3. *"Sufficient and appropriate resources."* Task force findings addressed the adequacy of fiscal resources, mental health professional positions, military treatment facilities, and TRICARE network benefits for psychological health. The finding concerning the existing and projected staffing of active duty mental health professionals relates to Senator Lieberman's concern.

> *Finding: "The number of active duty mental health professionals is insufficient and likely to decrease without substantial intervention."*

This finding noted that uniformed mental health workers are the best resource to educate commanders and make crucial judgments concerning an individual's health readiness, deployment, and retention status. The task force believes that military mental health providers have better credibility with Service members then civilian providers and, thus, they can foster a strong therapeutic relationship with the military member. Notwithstanding this perceived advantage, there is no discussion or recommendation in either report regarding how the use of TRICARE services would reduce stigma. Since active duty can use TRICARE under certain circumstances, DoD should further expand this option to leverage the availability of civilian

mental health providers and reduce stigma concerns. As noted in the report to Congress, DoD will consider "TRICARE enhancements [to] include training in the area of PTSD [post-traumatic stress disorder] to TRICARE network providers to ensure that our military community receives the most up-to-date treatment available for PTSD related to combat and military operations."

> *Recommendation: "The Department of Defense should make recruiting and retaining mental health professionals in the military a high priority in decisions to eliminate positions or convert positions to civilian status. An adequate number of billets must be allocated to mental health professionals to ensure the increase in providers recommended elsewhere in this report includes an adequate balance of military and civilian mental health professionals." (5.3.3.5)*

Military mental health professionals are often in the best position to make complex determinations regarding deployability and retention. However, this recommendation may unintentionally overshadow the importance of the "adequate balance" of civilians in military mental health settings. Civilian providers, by nature of their non-uniformed status, may be in a better position to initially create the confidence and trust necessary for effective psychotherapy. Network mental health providers should be an option for military members if access barriers (to include stigma) delay or deny prompt care, similar to other TRICARE specialty referrals.

Goal 4. "*Visible and empowered leaders*." Task force findings for the final goal highlighted that cooperation and collaboration among the many agencies tasked to provide psychological support throughout the Department are insufficient.

> *Finding: "Provision of a continuum of support for psychological health for military members and their families depends on the cooperation of many organizations with different authority structures and funding streams."*

Leadership is the key element that drives any military operation, policy, or program. This finding should prompt a systemic process to educate and train all military personnel—leaders, Service members, medical staff—and community support providers to enhance general awareness of issues related to mental health access and treatment. The complexity involved with the natural tensions of confidentiality and care continuity make cooperation, coordination, and accountability difficult to achieve. However, many non-clinical leaders are reluctant to treat discussions of mental health as they would conversations about physical care. The task force noted that a DoD-wide strategic plan could address how the many mental health and support agencies should collectively and effectively collaborate for delivery of care.

> *Recommendations: "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. Each military Service's Medical Inspector General staff should include subject-matter experts on programs related to psychological health to ensure compliance with the strategic plan." (5.4.1.8/9)*

The military Services have a strong history of successful oversight by Inspectors General. Inspectors General trained on mental health programs could provide proper oversight of the

Service-level strategic plan for the delivery of care. Inspector General oversight will create needed command and leadership attention to help ensure effective and efficient installation-level management of mental health care.

Issues Raised by the Task Force but Without Significant Mention in the Report

The OIG DoD representative noted three topics reviewed by the task force that did not receive coverage in the report: suicide, inpatient treatment, and physical/medical evaluation boards.

Suicide. The task force's report does not specifically address the topic of suicide. Military mental health professionals consider suicide prevention a non-clinical, leadership issue, and suggest that unit leaders are better positioned to notice behavioral indicators and suicidal tendencies. The task force perhaps rightly avoided a major discussion on suicide because many non-medical leaders incorrectly use suicide rates as a "barometer" of their unit's (or Service's) mental health. For example, even though the Army's 2006 suicide rate was the highest in over 20 years, the Army's mental health community does not see this as a crisis—but many non-clinical military and political leaders have raised the alarm.

Completed suicide is the sentinel tragic event within mental health care since almost all suicides involve a mental health disorder component. Stigma usually aggravates prevention and treatment options. Within the Army, women dominate suicide attempts. However, for young enlisted males, suicide is the second leading cause of all deaths for this group. According to the 2005 Army Suicide Event Report, 96 percent of all completed soldier suicides in calendar year 2005 were men. As implied in this Army report, the young male population is also most impacted by stigma and least likely to ask for help with any mental disorder or brain injury. For example, as patients in military mental health clinics, female counterparts out-number male Service members 3:1. The male military population, overall, outnumbers females 4:1. Empirically measured, the young male cohort is not getting the tailored outreach they need with respect to suicide.

Because suicide is generally a collision of many complex factors—depression, stress, post-traumatic stress disorder, interpersonal problems, family conflicts, stigma, resiliency, and other factors—a "special topic" in the report acknowledging this fact with corollary recommendations would have been beneficial. Meanwhile, as published in a November 18, 2007, Journal of the American Medical Association article, "Longitudinal Assessment of Mental Health Problems Among Active and Reserve Component Soldiers Returning From the Iraq War," offers credible data and findings on the issues of post-deployment factors and the importance of screening programs and the referral and use of mental health services.

Inpatient Treatment. The task force's report does not discuss inpatient psychiatric treatment (other than a brief discussion related to shortfalls in substance abuse treatment). Generally, inpatient care is limited to small, yet critical, goals. For example, one key goal is simply patient stabilization. It would have been helpful for the task force to examine inpatient care in the military system, given the current public debate in the media and among government officials, commissions, and study groups. Most patients currently seen at Walter Reed's Ward 54 (inpatient care) are combat veterans recently returned from Iraq. Major media outlets have published less than positive stories regarding military inpatient (and outpatient) psychiatric care.

Diagnoses of military inpatients with certain psychiatric disorders trigger Service disability evaluation systems and lead to discharge actions. The public debate suggests that many of these service discharges do not properly weigh Service-connected disorders (e.g., post-traumatic stress disorder or depression). There have been cases of Service members claiming their Service connected "unseen wound" was improperly diagnosed or misdiagnosed during their inpatient status, resulting in discharge, financial consequences, and missed treatment (see multiple internet sites under "unseen wounds military"). A discussion by the task force on this topic would have been helpful.

Physical Evaluation Board (PEB) / Medical Evaluation Board (MEB). The PEB and MEB process is a significant bureaucratic challenge to injured and ill Service members. Board decisions greatly affect future benefits, but frequently yield results that are not intuitive. Allegations of unfair PEB and MEB decisions often relate to mental health diagnosis because service members are less likely to contest fit-for-duty or disability decisions based on visual injury or laboratory data. It is inherently more difficult to prove or disprove "injury" caused by psychic trauma. In addition, PEB and MEB adjudication will not include unreported or undiagnosed brain injury or post-traumatic stress, again affecting future benefits.

Summary. Taken together, the task force's report and the report to Congress represent a comprehensive examination of DoD's mental health care programs for members of the Armed Forces and their families. In general, the OIG DoD concurs with the intent of the task force's recommendations and with DoD's plan to implement solutions. Management should organize and oversee resources to meet or improve the completion target dates listed in the report to Congress. As noted, however, additional topics—suicide, inpatient treatment, and PEB/MEB process—deserve additional attention.

Appendix A–Management Request

JOSEPH I. LIEBERMAN
CONNECTICUT

United States Senate
WASHINGTON, DC 20510

May 17, 2006

Mr. Thomas F. Gimble
Principle Deputy Inspector General
Department of Defense Inspector General
400 Army Navy Drive (Room 801)
Arlington, VA 22202-4704

Dear Mr. Gimble,

This letter reflects my deep concern about a recent series of articles published in the *Hartford Courant* detailing case-studies of servicemen that were deployed overseas despite manifesting strong signs of mental illness. I am asking that you conduct an investigation into the military's current practices for conducting mental health screenings with deploying servicemen and women. Through Freedom of Information Act (FOIA) requests and over 100 interviews, the *Courant* identified 11 service members who committed suicide in 2004 and 2005 after being kept in Iraq and Afghanistan despite repeated signs of psychological disorders prior to, and during, deployment in combat zones. I am concerned that the military's current procedures for screening those being deployed and systematically referring them for evaluations and treatment are not meeting the health needs of our servicemen and women.

I am aware of the extreme pressures our servicemen and women are under in Iraq and Afghanistan and that many exhibit signs of distress and discomfort on a daily basis. I also know that the military healthcare providers, supervisors, and peers are important sources of information in determining when an individual needs additional support and psychological intervention. However, the articles in the *Hartford Courant* detailed numerous case examples of soldiers who had long histories of serious mental illness, such as bipolar disorder and who resided in institutional settings, who were deployed into combat situations.

The National Defense Authorization Act for Fiscal Year 1998 (PL 105-85, Sect. 765), required the military to conduct an "assessment of mental health" for all deploying troops. The assessment currently being used is a single mental health question on a pre-deployment form filled out by service members. However, only 6.5% of those indicating mental health problems were referred for mental health evaluations from March 2003 to October 2005. Unfortunately, the army has also seen a resurgence in its suicide rate with rates of 20 per 100,000 deployed in Iraq. In the general US population, the Centers for Disease Control and Prevention estimate that there are 11 deaths per 100,000 Americans. Clearly, our soldiers are experiencing unusually high levels of stress, but if the military is

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doing an inadequate job of assessing the severity of mental health problems in those deploying, and then placing them in further danger, their lives are at even greater risk.

I believe that it is essential for you to conduct a complete investigation of the military's current practices in screening those that are being deployed and redeployed so that military leadership and Congress can ascertain whether or not practices and protocols require revision. As a member of the Senate Armed Services Committee, I believe this analysis will provide information necessary to conduct appropriate oversight functions. I appreciate your attention to this matter and look forward to a prompt response.

Sincerely,

Joseph I. Lieberman
UNITED STATES SENATOR

Appendix B–OIG Response to Management Request

INSPECTOR GENERAL
DEPARTMENT OF DEFENSE
400 ARMY NAVY DRIVE
ARLINGTON, VIRGINIA 22202-4704

APR 1 1 2008

The Honorable Joseph I. Lieberman
United States Senate
Washington, D.C. 20510-0703

Dear Senator Lieberman:

This is in response to your letter dated May 17, 2006, requesting that we "conduct an investigation into the military's current practices for conducting mental health screenings with deploying servicemen and women." Concurrent with your request, DoD established the Task Force on Mental Health in response to provisions in the National Defense Authorization Act for FY 2006. Considering the potential for duplication of this effort and your request, your office agreed to have the Inspector General observe the task force process. As a condition, your staff requested our critique of the task force's efforts and their final report.

Our representative to the task force observed all open sessions, most closed sessions, and accompanied task force members on site visits. In June 2007, the task force sent its final report to the Secretary of Defense, and in September 2007, the Secretary sent his report to Congress.

We concluded that the task force addressed the concerns expressed in your letter. Moreover, we concluded that the task force's recommendations and the Secretary's response fully satisfied the intent and requirements of Section 723 of the Fiscal Year 2006 National Defense Authorization Act.

Should you have any questions regarding this matter, please contact me at (703) 604-8324.

Sincerely,

John R. Crane
Assistant Inspector General
Communications and Congressional Liaison

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Team Members

The Inspections and Evaluations Directorate, Office of the Deputy Inspector General for Policy and Oversight, Office of the Inspector General for the Department of Defense prepared this report. Personnel who contributed to the report include Wm. Brem Morrison – Assistant Inspector General, George P. Marquardt – Division Chief, and Lieutenant Colonel Steven P. Luke (USAF) – OIG DoD Representative to the Task Force.

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