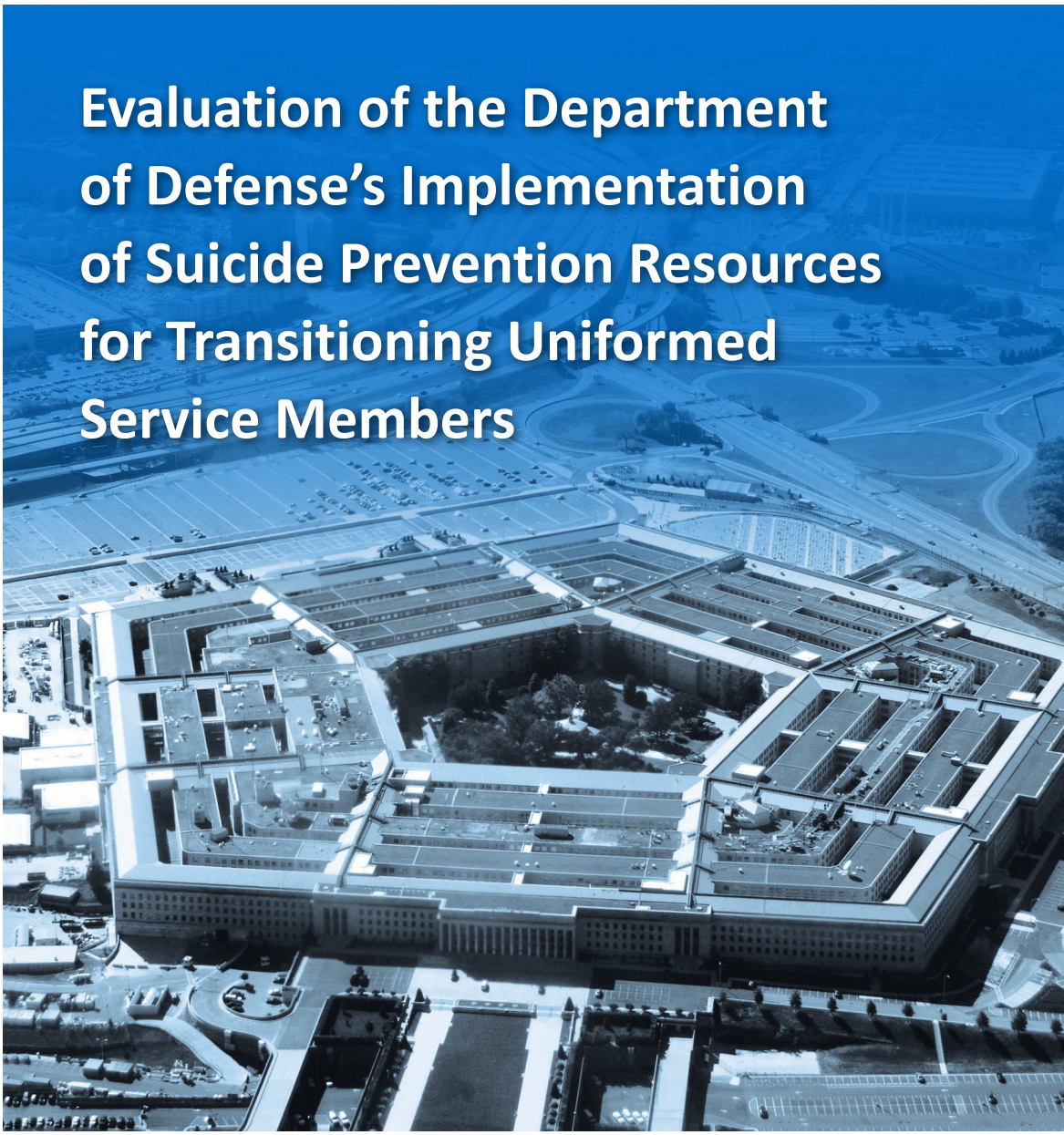
Report No. DODIG-2022-030

INSPECTOR GENERAL

*U.S. Department of Defense*

NOVEMBER 09, 2021

# Evaluation of the Department of Defense's Implementation of Suicide Prevention Resources for Transitioning Uniformed Service Members



INTEGRITY ★ INDEPENDENCE ★ EXCELLENCE

INSPECTOR GENERAL

INTEGRITY

EFFICIENCY

DEPARTMENT OF DEFENSE

# Results in Brief

*Evaluation of the Department of Defense's Implementation of Suicide Prevention Resources for Transitioning Uniformed Service Members*

**November 09, 2021**

## Objective

The objective of this evaluation was to determine whether the Department of Defense (DoD) provided suicide prevention resources for transitioning Service members as required by Presidential Executive Order 13822, Presidential Executive Order on Supporting Our Veterans During Their Transition From Uniformed Service to Civilian Life.[1]

## Background

The DoD continues to face the challenge of preventing suicides by DoD military personnel. Each Military Service seeks to address suicide prevention with efforts such as training, data collection and analysis, and strategic communications about suicide-related behaviors.
The Joint Action Plan created in response to Executive Order 13822 implemented several initiatives targeting mental health care and suicide prevention, particularly for transitioning Service members, to include mental health screenings on all Service members before they transition. Additionally, DoDI 6490.10 requires that health care providers "arrange for an appropriate transfer of care at the time of transiting to another command or out of military service."

For the purpose of this evaluation, a transitioning Service member includes all individuals with a planned or pending

[1] Executive Order 13822, "Presidential Executive Order on Supporting Our Veterans During Their Transition From Uniformed Service To Civilian Life," January 9, 2018.

### *Background (cont'd)*

separation from active duty military service. This definition extends to cover individuals completing service commitment contracts, retiring, or undergoing medical evaluations boards or administrative separation proceedings.

## Finding

The DoD did not screen for suicide risk or provide uninterrupted mental health care to transitioning Service members as required by Federal and DoD guidance. Specifically, we determined that the DoD did not establish and implement oversight of Mental Health Assessment (MHA) and suicide risk screening processes for transitioning Service members. We further determined that DoDI 6490.10 lacks a clear definition of a warm handoff, provider training protocols, standardized documentation methods, and oversight procedures to ensure compliance. The overall DoD approaches and services for arranging continuity of mental health care are not resulting in uninterrupted care for all Service members.

The DoD did not establish and implement oversight of MHA and suicide risk screening processes because the Defense Health Agency (DHA) and Military Services did not include a mental health assessment and suicide risk screening as part of the Separation History and Physical Exam (SHPE), which is the only medical exam required to be administered to the transitioning Service member population. Additionally, the DoD and Military Services relied on expired policy to govern suicide risk screening and referral processes.

The DoD did not implement a warm handoff approach, as required by DoDI 6490.10, to create continuous mental health care during the transition from the Military Health System (MHS) to the Veterans Health Administration (VHA) because DoD policy is reliant on Service members and automatic systems to initiate a transition of mental health care from the MHS to the VHA.

# Results in Brief

*Evaluation of the Department of Defense's Implementation of Suicide Prevention Resources for Transitioning Uniformed Service Members*

### *Finding (cont'd)*

Failure to identify suicide risk and arrange for uninterrupted mental health care in transitioning Service members may result in a lack of mental health care for transitioning Service members and jeopardize patient safety.

## Recommendations

We recommend that the Assistant Secretary of Defense for Health Affairs (ASD[HA]), in coordination with the Director of the Defense Health Agency (DHA) and the Services' Surgeons General, establish consistent policies and procedures to manage suicide risk screening and referral as part of the medical process for transitioning Service members. At a minimum, the policies and procedures should designate an organization to have responsibility for the clinical implementation of the policy and designate an organization to have oversight responsibility for mental health assessment.

We recommend that the Director of the DHA, in collaboration with the Director of the DoD and Veterans Affairs Collaboration Office, identify the causes for the breaks in arranging for continuous mental health care for Service members in care who are transitioning from the MHS to the VHA; create and implement solutions to increase the number of Service members who have continuous care arranged between the MHS and the VHA at the time of transition; and provide support, time, and budget resources to initiatives intended to improve the quality of the warm handoff of care.

## Management Comments and Our Response

The Under Secretary of Defense for Personnel and Readiness (USD[P&R]), responding for the ASD(HA), agreed with the recommendation that the ASD(HA) designate an organization to be responsible for the clinical implementation of the policy and oversight responsibility for mental health assessment processes for transitioning Service members. Comments from the USD(P&R) partially addressed the recommendation. The USD(P&R) did not designate an organization to be responsible for the clinical implementation of the policies and procedures to manage suicide risk screening and referral as part of the medical process for transitioning Service members, nor did the USD(P&R) designate an organization to have oversight responsibility for mental health assessment processes for transitioning Service members. Therefore, these recommendations are unresolved.

The USD(P&R), responding for the ASD(HA), agreed with the recommendation that the ASD(HA) establish a standard mental health assessment and suicide risk screening process to be used by all Services. Comments from the USD(P&R) addressed all specifics of the recommendation. Therefore, this recommendation is resolved but will remain open.

Both the USD(P&R), responding for the ASD(HA), and the DHA Director agreed with the recommendation that the DHA Director identify the causes for the breaks in arranging for continuous mental health care for transitioning Service members, create and implement solutions to increase the number of Service members who have continuous care arranged between the military health system and the Veteran's Health Administration or civilian mental health providers at the time of transition, and determine the resources required to implement policy and training that improves the quality and consistency of the warm handoff of care. Comments from the USD(P&R) addressed all specifics of the recommendation. Therefore, this recommendation is resolved but will remain open.

Please see the Recommendations Table on the next page for the status of the recommendations.

## *Recommendations Table*

| Management | Recommendations Unresolved | Recommendations Resolved | Recommendations Closed |
|---|---|---|---|
| Assistant Secretary of Defense for Health Affairs | A.1.a, A.1.b | A.1.c | None |
| Director, Defense Health Agency | | A.2.a, A.2.b | None |

**Note:** The following categories are used to describe agency management's comments to individual recommendations.

- **Unresolved** – Management has not agreed to implement the recommendation or has not proposed actions that will address the recommendation.
- **Resolved** – Management agreed to implement the recommendation or has proposed actions that will address the underlying finding that generated the recommendation.
- **Closed** – OIG verified that the agreed upon corrective actions were implemented.

INSPECTOR GENERAL

DEPARTMENT OF DEFENSE

**INSPECTOR GENERAL**
**DEPARTMENT OF DEFENSE**
4800 MARK CENTER DRIVE
ALEXANDRIA, VIRGINIA 22350-1500

November 09, 2021

MEMORANDUM FOR UNDER SECRETARY OF DEFENSE FOR HEATH AFFAIRS
DIRECTOR, DEFENSE HEALTH AGENCY

SUBJECT: Evaluation of the Department of Defense's Implementation of Suicide Prevention Resources for Transitioning Uniformed Service Members (Report No. DODIG-2022-030)

This final report provides the results of the DoD Office of Inspector General's evaluation. We previously provided copies of the draft report and requested written comments on the recommendations. We considered management's comments on the draft report when preparing the final report. These comments are included in the report.

The Under Secretary of Defense for Personnel and Readiness (USD[P&R]) agreed with Recommendation A.1. The comments and actions taken by the USD(P&R) partially addressed recommendations A.1.a and A.1.b. However, the USD(P&R) did not designate an organization to be responsible for the clinical implementation of the policies and procedures to manage suicide risk screening and referral as part of the medical process for transitioning Service members, nor did the USD(P&R) designate an organization to have oversight responsibility for mental health assessment processes for transitioning Service members. Therefore, these recommendations are unresolved. Comments from the USD(P&R) addressed all specifics of Recommendation A.1.c. This recommendation is resolved but will remain open. Comments from the USD(P&R) and from the DHA Director addressed all specifics of recommendation A.2; therefore, this recommendation is resolved but will remain open.

As described in the Recommendations, Management Comments, and Our Response section of this report, we will close the recommendations when the USD(P&R) and the DHA Director provide documentation that the guidance, policies, and procedures addressing the recommendations have been established and implemented.

DoD Instruction 7650.03 requires that recommendations be resolved promptly. Therefore, please provide us within 30 days your response concerning specific actions in process or alternative corrective actions proposed on the unresolved recommendations.

If you have any questions or would like to meet to discuss the evaluation, please contact [redacted] We appreciate the cooperation and assistance received during the evaluation.

Jefferson DuBinok
Acting Assistant Inspector General, Evaluations
Programs, Combatant Commands, and Overseas
Contingency Operations

# Contents


## Introduction

Objective ..... 1

Background ..... 1

## Finding. The DoD Did Not Consistently Screen for Suicide Risk or Arrange for Uninterrupted Mental Health Care to Transitioning Service Members as Required by Federal and DoD Guidance ..... 10

The DoD Did Not Screen for Suicide Risk or Arrange for Uninterrupted Mental Health Care to Transitioning Service Members as Required by Federal and DoD Guidance ..... 11

Recommendations, Management Comments, and Our Response ..... 25

## Appendixes

Appendix A. Scope and Methodology ..... 28

Use of Computer-Processed Data ..... 30

Use of Technical Assistance ..... 31

Prior Coverage ..... 31

Appendix B. DoD and Military Services Suicide Prevention Efforts for Transitioning Service Members Include Nonmedical Counseling and Outreach and Caring Contacts Programs ..... 34

## Management Comments

Assistant Secretary of Defense for Health Affairs ..... 37

Director, Defense Health Agency ..... 39

## Acronyms and Abbreviations ..... 42

## Glossary ..... 43

# Introduction

## Objective

The objective of this evaluation was to determine whether the DoD provided suicide prevention resources for transitioning Service members as required by Presidential Executive Order 13822.[2]

## Background

The DoD continues to face the challenge of preventing suicides by DoD military personnel. Each Military Service seeks to address suicide prevention with efforts such as training, data collection and analysis, and strategic communications about suicide-related behaviors. In May 2019, the Department of Veterans Affairs (VA) and the DoD published the "Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide."[3] This guidance explained that the rise in suicide rates in the VA and DoD populations caused the DoD and the Military Services to significantly increase their efforts to identify individuals at risk for suicide and implement programs and policies to mitigate that risk. The DoD and the Military Services continue to identify high-risk populations, such as transitioning Service members, and provide them with access to suicide prevention resources, which include suicide awareness campaigns, suicide intervention training, and suicide crisis hotline marketing.

The VA and DoD Clinical Practice Guidelines identify suicide risk as a multifaceted issue. The Office of the Assistant Secretary of Defense for Health Affairs (OASD[HA]) Director of Mental Health Policy and Oversight stated that risk factors for suicide risk are very complex. There are a vast number of intertwined risk factors that affect the overall suicide risk for an individual. Several factors, including current or past mental health treatment, and stressors such as job loss, physical health issues, or demographic factors, should be considered during a comprehensive evaluation of suicide risk. The Defense Suicide Prevention Office (DSPO) provides non-clinical resources for individuals to use to help someone in a suicidal crisis. One of these resources identified several top risk factors for suicide.[4] These factors include:

- access to lethal means, such as firearms;
- mental health problems;

[2] Executive Order 13822, "Presidential Executive Order on Supporting Our Veterans During Their Transition From Uniformed Service To Civilian Life," January 9, 2018.

[3] The DoD and U.S. Department of Veterans Affairs (VA), "VA/DOD Clinical Practice Guideline For The Assessment And Management Of Patients At Risk For Suicide," Version 2.0, May 2019.

[4] The Defense Suicide Prevention Office (DSPO), Resources for Everyday Life Challenges, www.dspo.mil.

- relationship challenges;
- emotional and psychological pain;
- a lack of belongingness and sense of being a burden;
- an inability to deal with stress; and
- a "fall from glory," such as an administrative or legal problem.

The Veterans Health Administration (VHA) Office of Suicide Prevention released a flyer explaining that a Service member's risk of suicide was nearly three times higher immediately following separation than while on active duty.[5] The VHA also found that "most suicide attempts by those who are, or will become, veterans occur following separation from military service." In February 2021, the OASD(HA) Director of Mental Health Policy and Oversight stated that transition can be a "very risky time" for Service members with mental health issues, as issues related to transition increase risk for negative mental health outcomes. A study from the Journal of the American Medical Association found transition from military service can create psychosocial stressors and adjustment challenges, such as disruptions in social support, financial strains, and changes in access to health care and mental health care that might be associated with increased risk of suicide.[6] The study identified that understanding the social and demographic characteristics of transitioning Service members can help identify those most at risk for suicide.

For this evaluation, a transitioning Service member includes all individuals with a planned or pending separation from active duty military service. This definition extends to cover individuals completing service commitment contracts, retiring, or undergoing medical evaluations boards or administrative separation proceedings.

## *Transition Assistance Program's Risk Assessment for Transitioning Service Members*

The Transition Assistance Program (TAP) is a DoD program that provides transition assistance, information, training, counseling, and services to eligible transitioning Service members to ensure they are career-ready upon separation, retirement, or release from active duty. The Military-Civilian Transition Office (MCTO) and TAP Federal interagency partners provide the core curriculum for TAP trainings. Each Service has its own individual TAP, which provides information and training to help Service members transitioning from active duty prepare for

[5] U.S. Department of Veterans Affairs, Veterans Health Administration, "Help With Readjustment And Social Support Needed For Veterans Transitioning From Military Service," May 2019.

[6] Journal of the American Medical Association, "Association of Suicide Risk With Transition to Civilian Life Among US Military Service Members," September 11, 2020.

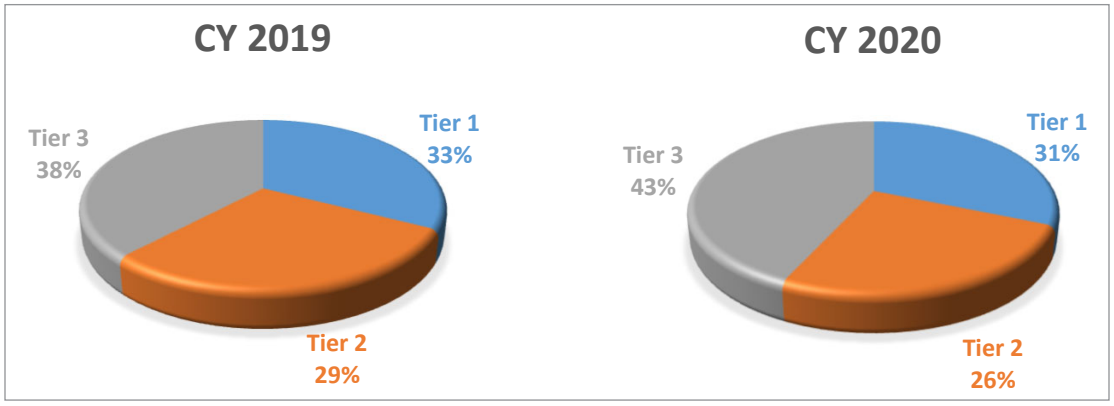
their next step in life. The TAP educational curriculum provides transitioning Service members with resources, tools, and training. TAP counselors connect transitioning Service members who may need further assistance to agency partners, who provide these Service members with additional support.

Service TAPs do not screen for suicide risk; however, TAP counselors do screen for transition risk. As previously discussed, transition from military service can create psychosocial stressors and adjustment challenges that might be associated with increased risk of suicide; consequently, each Service TAP has developed its own Service member self-assessment tool. The TAP self-assessment tool allows Service members to identify personal areas where they require additional support during the transition process. Additionally, the self-assessment tool helps TAP counselors determine the appropriate transition pathway for Service members by establishing a suggested transition risk tier level. The DoD TAP identifies the transition risk tiers as follows.

- Tier I - Service member is fully prepared and career-ready based on their personal self-assessment and Individual Transition Plan.
- Tiers II - Service member is moderately prepared and career-ready, but may require some assistance based on their personal self-assessment and Individual Transition Plans.
- Tier III - Service member is not fully prepared or career-ready to transition and, based on their personal self-assessment and Individual Transition Plans, will require maximum support to address post-transition goals.

As shown in Figure 1, in 2019, TAP counselors rated 17,878 of the 47,085 (38 percent) active duty Service members as Tier 3. In 2020, TAP counselors rated 26,326 of the 60,991 (43 percent) active duty Service members as Tier 3. This data reveals that the majority of individuals recently transitioning out of military service needed additional assistance to become career-ready.

*Figure 1. Total Percentage of Transitioning Active Duty Service Members by Tier Level for 2019 and 2020*




Source: Military Career Transition Office.

## *The DoD and Military Services' Suicide Prevention Resources*

The DoD and Military Service suicide prevention offices and programs are available to all Service members, including those transitioning to civilian life. Transitioning Service members may be connected to available suicide prevention programs, resources, and nonmedical counseling resources.[7] Nonmedical counseling resources are discussed further in Appendix B. These offices and programs include the following.

- The Defense Suicide Prevention Office (DSPO) provides advocacy, program oversight, and policy for DoD suicide prevention, intervention, and postvention efforts to reduce suicidal behaviors in Service members, their families, and DoD civilians.[8]
- Military OneSource is a confidential, DoD-funded program providing comprehensive information on all aspects of military life at no cost to active duty, Guard, and Reserve Component members and their families.
- The Army Suicide Prevention Program has a comprehensive list of suicide prevention information including policy guidance, frequently asked questions, training links, references and resources, and a Commander's Tool Kit.

[7] Medical counseling specifically addresses medically diagnosable issues, such as mental illness, post-traumatic stress disorder, and traumatic brain injuries. Whereas, nonmedical counseling addresses issues, such as relationship concerns at home or work, managing stress, adjusting to change or dealing with a transition, parenting difficulties, and dealing with grief or loss.

[8] Postvention is an organized response in the aftermath of a suicide to facilitate the healing of individuals from the grief and distress of suicide loss, mitigate other negative effects of exposure to suicide, and prevent suicide among people who are at high risk after exposure to suicide.

- The Air Force Suicide Prevention Program has a comprehensive list of suicide prevention information, including policy guidance, resources, suicide prevention videos, an outreach and communication toolkit, and frequently asked questions about suicide, as well as many other resources.
- The Navy's Suicide Prevention Program provides an overview of the Navy's suicide prevention efforts and various links to relevant statistics and informational products, training materials, policy and guidance, resources, suicide prevention videos, and other resources.
- The Marine Corps Suicide Prevention Program is implemented within units through awareness campaigns and training and provides on its website both general suicide prevention resources and specific links for Marines and Family, Command and Leaders, and Health Professionals.
- The Psychological Health Center of Excellence collaborates across the DoD, the VA, and other agencies to provide leadership and expertise, inform policy, and drive improvements in psychological health outcomes.

## *Policy and Resource Offices in Support of Transitioning Service Members*

The transition process involves many Office of the Under Secretary of Defense for Personnel and Readiness (USD[P&R]) entities, including the MCTO, the DSPO, the Military Community and Family Policy Office, and the OASD(HA). The DSPO Director explained that the transition process is very complex and multiple agencies are involved throughout the process. Additionally, she stated that a successful transition requires the support of many partners.

### *Military-Civilian Transition Office*

The MCTO is under the authority of the USD(P&R) and provides policy guidance, curriculum development, data and statistical analysis, evaluation, research, performance management, and information technology for TAP. The MCTO oversees the NDAA requirements for the TAP programs, as required by section 552 of the 2019 National Defense Authorization Act (NDAA).

### *Defense Suicide Prevention Office*

The DSPO is under the authority of the USD(P&R). The DSPO works with the Military Services to implement suicide prevention programs and publish related policies. In November 2017, the DoD issued DoD Instruction (DoDI) 6490.16, which established processes for planning, directing, guiding, and resourcing to effectively develop and integrate the Suicide Prevention Program within the DoD. On September 11, 2020, the DSPO issued an update to DoD Instruction 6490.16, which required the Director of the DSPO to provide suicide prevention and

resource information to the MCTO for incorporation into transition goals, plans, and programming for eligible Service members.[9] Additionally, the updated DoDI 6490.16 required the Director of the DSPO to provide representation to the MCTO councils and working groups, as necessary.

## *Military Community and Family Policy Office*

The Military Community and Family Policy Office is under the authority of the USD(P&R). This office supports Service members and their families from the start of military service to the transition to civilian life. The Military Community and Family Policy Office supports the military community by overseeing and implementing programs designed to improve Service members' quality of life. The Military Community and Family Policy Office provides the following programs.

- Spouse Education Community Support Programs provide career support for military spouses in an effort to strengthen the financial security of military families throughout the military life cycle, which begins at a Service member's first duty station and continues through the transition to civilian life.
- The Military Family Life Counseling Program assigns behavioral health providers to military installations to provide nonmedical counseling to military members and their families. According to a senior official from the Military Community and Family Policy Office, transitioning Service members can access services within this program.
- Military OneSource provides confidential services and nonmedical counseling to support Service members through a 24 hour, 7-day a week call center, a website, and consultants located at support centers across the United States. The program specifically supports Service members and their families during pre-separation, separation, and post-transition. Transitioning Service members and their families continue to receive care within their program for up to 1 year after separation.

## *Defense Health Agency and Service Medical Departments*

The Defense Health Agency (DHA) and the Service medical departments provide Separation History and Physical Exam (SHPE) health assessments. Service members separating, retiring, or deactivating from military service should receive a SHPE or Separation Health assessment provided by a military hospital or clinic or the VA. Medical providers use the SHPE to assess Service members' medical history, mental health history, and current health status. Military Treatment Facility (MTF) personnel pre-screen the Service member's records for mental health care.

[9] DODI 6490.16, "Defense Suicide Prevention Program," September 11, 2020, updated September 11, 2020.

If the Service member's health record indicates specialty or primary care behavioral health services were received during the last 180 days of duty at the current installation, then the MTF staff reviews the Service member's record to ensure that prior care received was terminated if there were no adverse clinical implications, verify that there was no known need for follow up care, and determine if out processing with the MTF is required.

## *Integrated Disability Evaluation System and Wounded Warrior Programs*

The Integrated Disability Evaluation System (IDES) Office evaluates Service members' physical and mental disabilities to determine if they are fit to continue active duty military service. Army Regulation 635-40 states that the purpose of the IDES program is to provide benefits for eligible Soldiers whose military service is terminated because of a service-connected disability.[10] An official from the Air Force IDES office stated that the basic goal of IDES is to ensure a warm handoff of care and benefits between Air Force and the VA, to occur within 30 days of the Service member's separation from active duty service.

An official from the Navy IDES office explained that there are three phases of IDES: (1) the medical evaluation board, (2) the physical evaluation board, and (3) the retention control point, which refers to a transition or return to duty. Fewer than 10 percent of overall transitioning Service members fall under IDES, but roughly 50 percent of those in IDES have a mental health condition. According to an official from the Navy IDES office, the IDES and Wounded Warrior Programs use recovery care coordinators as part of the warm handoff. The recovery care coordinators are assigned a Service member whom they guide through the first phase before connecting them to the VA at the second phase.

The Recovery Coordination Programs are titled differently among the Services. The Navy has the Wounded, Ill, and Injured program and the Army has the Recovery Care Program. For this evaluation, the Recovery Coordination Program will be referred to as the Wounded, Ill, and Injured Program.

DoDI 1300.24 establishes policy, assigns responsibilities, and prescribes uniform guidelines, procedures, and standards for improvements to the care, management, and transition of recovering Service members (RSMs) across the military Services.[11] This Instruction states that the DoD will coordinate with the VA to develop and implement medically related processes, procedures, and standards for the wounded, ill, and injured transitioning Service members transferring from

[10] Army Regulation 635-40, "Disability Evaluation for Retention, Retirement, or Separation," January 19, 2012.

[11] DoD Instruction 1300.24, "Recovery Coordination Program," December 1, 2009.

DoD care and treatment to VA care, treatment, and rehabilitation. Additionally, in 2007 the DoD and the VHA established a memorandum of understanding, to direct the use of the VA liaison to ensure a seamless transition of care for transitioning Service members who are ill, injured, or both.[12]

## *inTransition Program*

The inTransition program offers coaching and assistance for active duty Service members, National Guard members, reservists, veterans, and retirees who need access to mental health care during relocation, returning from deployment, or transitioning out of active duty service. Transitioning Service members can use the program to locate a new psychological health care provider or to transition care from a current psychological health care provider to a new psychological health care provider.

All inTransition coaches are required to be licensed, master's degree-level psychological health clinicians. Anyone working with the Service member, including TAP counselors, chaplains, Military OneSource, and health care professionals can refer Service members to inTransition. Additionally, Service members can self-refer. All Service members who have received psychological health care within 1 year prior to their separation are automatically enrolled in the inTransition program; however, Service members may decline participation at any time. If a Service member experiences a mental health crisis during their transition period, inTransition coaches are required to provide a warm handoff of care to the Military Crisis Line or other local resources.

## *Military Service Prevention Programs*

DoD Instruction 6400.09 states that the military community should participate in the prevention of suicide-related behaviors.[13] The Military Services' primary prevention programs focus on stopping suicide-related behaviors before they occur. The Military Services can implement these programs and activities for an entire group or population without regard to risk categories. Alternatively, the Military Services can implement programs specific to at-risk individuals, groups, or populations. Primary prevention activities include leadership training, community training, and bystander intervention training. The Military Services also have separate command or installation-level programs that oversee awareness campaigns, assistance, and response to suicide-related behaviors.

[12] The DoD and the VA, "Expanding the Joint Seamless Transition Program, Specifically With Regard To Veterans Health Administration Office Of Seamless Transition (OST) Nursing And Social Work Liaisons Assigned To Military Treatment Facilities (MTFs)," May 2007.

[13] DoD Instruction 6400.09, "DoD Policy On Integrated Primary Prevention of Self-Directed Harm and Prohibited Abuse or Harm," September 11, 2020.

### *DoD/Veterans Affairs Collaboration Office*

The DoD/VA Collaboration Office is the executive level office for the DoD's interactions with the VA. The office was established to coordinate sharing activities between the two departments. The primary outputs of the office are cross-agency policies and memorandums of understanding, including the drafting of Executive Order 13822, which highlighted the need for seamless access to mental health treatment and suicide prevention resources for transitioning Service members. The office also oversees the Joint Executive Committee, which is a forum for cross-agency discussion and collaboration.

### *Department of Veterans Affairs Programs*

The VA Liaison Program integrates VA liaisons with DoD clinical teams and provides onsite clinical consultation and education to DoD clinical staff. VA Liaisons are located onsite at select MTFs and facilitate the transfer of health care from the MTF to the appropriate VA medical facility. As of 2020, the VA had 21 in-person VA liaison centers that supported 21 MTFs. The VA also has virtual liaisons to aid Service members from MTFs without an in-person VA Liaison.

## *Executive Order 13822*

In January 2018, the President signed Executive Order 13822 requiring the Secretary of Defense, the Secretary of Veterans Affairs, and the Secretary of Homeland Security to submit a Joint Action Plan to the White House describing actions to provide seamless access to mental health treatment and suicide prevention resources for transitioning Service members.[14] This guidance emphasizes access to mental health services during the critical first year period following discharge, separation, or retirement from military service.

### *Joint Action Plan*

In April 2018, the Secretary of Defense, the Secretary of Veterans Affairs, and the Secretary of Homeland Security submitted a Joint Action Plan, which described actions to provide seamless access to mental health care and suicide prevention resources for transitioning Service members.[15] The Joint Action Plan sought to eliminate barriers to care and gaps in access to mental health care and suicide prevention services. Initiatives resulting from the Joint Action Plan included mental health screenings, connection to suicide prevention resources, and the implementation of a warm handoff to create continuity of care for transitioning Service members in need of mental health services prior to separation.

[14] Executive Order 13822, January 9, 2018.

[15] "Joint Action Plan for Supporting Veterans During Their Transition From Uniformed Service to Civilian Life," April 18, 2018.

# Finding

## The DoD Did Not Consistently Screen for Suicide Risk or Arrange for Uninterrupted Mental Health Care to Transitioning Service Members as Required by Federal and DoD Guidance

The DoD did not consistently screen for suicide risk or arrange uninterrupted mental health care for transitioning service members as required by Presidential Executive Order 13822 and DoDI 6490.10.[16] Specifically, we determined that the DHA and the Military Services are not conducting mental health and suicide risk screenings as part of the separation medical processes for transitioning Service members as required by the Joint Action Plan for Supporting Veterans During Their Transition from Military Service to Civilian Life. We determined that the DHA and Military Services are not conducting mental health and suicide risk screenings because the DoD and Military Services have inconsistent processes for and oversight of suicide risk screening and mental health assessments (MHA) for the transitioning Service member population. For example, the OASD(HA) Director of Mental Health Policy and Oversight stated his office is responsible for drafting and coordinating mental health care policy for the DoD. In this role, the Director monitors compliance to policy and reviews the effectiveness of the policy; however, the implementation of policy and guidance is developed and owned by the DHA. Additionally, the OASD(HA) Director of Mental Health Policy and Oversight stated that his office conducts data reviews of the total number of transitioning Service members who receive a mental health assessment 180 days before separation. However, his office does not have oversight of the implementation of the separation MHA policies and process. In our analysis we determined that the DoD has not assigned an office to maintain oversight of separation MHA processes. On November 8, 2018, the DHA issued Interim Procedures Memorandum 18-019, which provided guidance on mandatory separation MHAs.[17] However, the guidance expired in November 2019, and new guidance has not been issued. According to senior leaders from the DHA, official guidance on mandatory separation assessments is "on pause" until the DoD and VA complete the joint development of the One-Separation Health Assessment processes.[18]

---

[16] Executive Order 13822, "Presidential Executive Order on Supporting Our Veterans During Their Transition From Uniformed Service To Civilian Life," January 9, 2018.

DoDI 6490.10, "Continuity of Behavioral Health Care for Transferring and Transitioning Service Members," March 26, 2012, Incorporating Change 1, Effective October 28, 2015.

[17] DHA Interim Procedures Memorandum 18-019, "Guidance for Service Implementation Of Separation Mental Health Assessments," February 4, 2020.

[18] The One-Separation Health Assessment initiative's goal is to develop one comprehensive medical evaluation, including mental health questions, for each transitioning Service member at separation in order to streamline the transition of health care from DoD to VA; improve clinical documentation of health status at the time of separation; and improve the VA claims process for those separating Service members who apply for Benefits Delivery at Discharge.

We determined that the DoD has comprehensive systems to arrange for uninterrupted mental health care limited populations, such as members of the IDES and Wounded, Ill, and Injured programs, but not for the broader population of transitioning Service members actively in care for mental health conditions. We determined that the DoD does not have a comprehensive approach to arrange for uninterrupted mental health care for transitioning Service members in accordance with DoDI 6490.10 because this policy lacks a clear definition of a warm handoff, provider training protocols, standardized documentation methods, and oversight to ensure compliance. Additionally, the DoD's current approach to the transition of mental health care requires Service members who are transitioning out of military service and are receiving care for mental health conditions to find a facility and provider for continued care and communicate the need for a transition of care to their DoD mental health provider.

As a result, the DoD may not have identified mental health issues and suicide risk in transitioning service members. Failure to identify suicide risk and mental health issues in transitioning Service members can impair the ability of DoD and VA to identify all current conditions, predict future health care needs, or provide benefits at discharge. Additionally, the DoD may not arrange for continuing mental health care for the thousands of transitioning Service members with existing mental health conditions.

## The DoD Did Not Screen for Suicide Risk or Arrange for Uninterrupted Mental Health Care to Transitioning Service Members as Required by Federal and DoD Guidance

The DoD did not screen for suicide risk or arrange for uninterrupted mental health care for transitioning Service members as required by Executive Order 13822 and DoDI 6490.[19] We reviewed the prevention goals outlined in the Joint Action Plan for the October 2020 to June 2021 time period. Specifically, we examined the DoD's suicide risk screening actions within the transition process and the DoD's actions to ensure continuity of mental health care for transitioning Service members. We interviewed officials from the Office of Health Affairs, the Defense Manpower Data Center, the DSPO, the Military-Civilian Transition Office and Transition of Veterans Program Office, the DHA, the Service Surgeons General, the Service Suicide Prevention Offices, the Service Personnel Offices, the Service Transition

[19] Executive Order 13822, January 9, 2018.
DoDI 6490.10, March 26, 2012, Incorporating Change 1, Effective October 28, 2015.

Assistance Program offices, and six installation level staffs corresponding to the Service offices. Additionally, we reviewed Federal criteria, DoD guidance, and Military Service policies.

## *The DoD Has Not Implemented Mental Health Assessments and Suicide Risk Screenings in Accordance With the Joint Action Plan*

We found that the Joint Action Plan for Supporting Veterans During Their Transition from Uniformed Service to Civilian Life, which was submitted as a requirement of Executive Order 13822, stated that, by December 2018, the DoD must fully implement the mental health screening, which includes suicide risk screening, of all transitioning Service members prior to separation.[20] The Joint Action Plan has three main goals, with multiple objectives under each goal.

- Goal 1: Improve actions to ensure ALL transitioning Service members are aware of and have access to mental health services.
- Goal 2: Improve actions to ensure the needs of at-risk veterans are identified and met.
- Goal 3: Improve mental health and suicide prevention services for individuals that have been identified (indicated populations) in need of care.

As shown in Table 1, over 160,000 Service members transitioned out of active duty service each year from 2017 through 2019. These Service members may have transitioned out of active duty service without the VA's knowledge of their current mental health or suicide risk status. This may have resulted in delays in the provision of mental health care services to those transitioned Service members.

[20] "Joint Action Plan for Supporting Veterans During Their Transition From Uniformed Service to Civilian Life," April 18, 2018.

*Table 1. Aggregate Count of Active Duty Service Members Transitioning From Active Duty Service by Year, January 1, 2017 Through December 31, 2019*

| | Service | Count | | Service | Count | | Service | Count |
|---|---|---|---|---|---|---|---|---|
| 2017 | Air Force | 38,719 | 2018 | Air Force | 32,001 | 2019 | Air Force | 31,756 |
| | Army | 89,197 | | Army | 69,028 | | Army | 60,081 |
| | Marine Corps | 37,422 | | Marine Corps | 36,447 | | Marine Corps | 36,558 |
| | Navy | 44,151 | | Navy | 31,597 | | Navy | 34,265 |
| | **DoD Total** | **209,489** | | **DoD Total** | **169,073** | | **DoD Total** | **162,660** |

Source: Military-Civilian Transition Office.

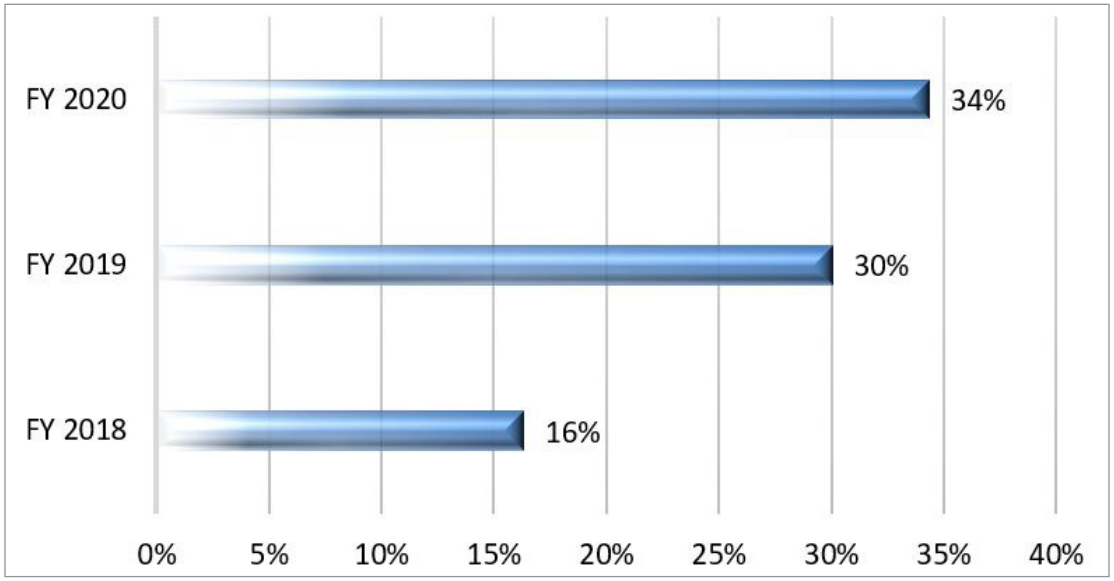
The Joint Action Plan did not identify when in the transition timeline the mental health screening would take place. Goal 2 of the Joint Action Plan, which was to improve actions to ensure the mental health needs of at-risk veterans are identified and met, outlines the following action and its accompanying metric.

- Screening and Identification: Conduct mental health screening on all transitioning Service members prior to separation to determine level of suicide risk to proactively intervene.
- Metric: The DoD will screen 100 percent of Service members prior to separation.

The Joint Action Plan does not provide a timeline of "prior to separation."

According to the Executive Order 13822 Status Report, the DoD was expected to implement mental health screening processes in 70 percent of transitioning Service members by December 31, 2018, with a full implementation target of screening 100 percent of transitioning Service members. The OASD(HA) Director of Mental Health Policy and Oversight provided us with data on total number of Service members transitioning from active duty Service with an MHA within 180 days before separation for FY 2018 through FY 2020. The percentage of transitioning Service members that received an MHA was 16 percent (28,200 of 172,617) for FY 2018, 30 percent (47,410 of 157,697) for FY 2019, and 34 percent (53,051 of 154,349) for FY 2020. As shown in Table 2, although the numbers are increasing, 34 percent falls short of screening 100 percent of transitioning Service members prior to separation. Consequently, as many transitioning Service members are not receiving an MHA within 180 days before separation, they are not being screened for suicide risk as part of the transition process.

*Table 2. Percentage of Separations With a Qualifying Mental Health Assessment Within 180 Days Before Separation for FY 2018 Through FY 2020*




Source: OASD(HA).

## *The DoD Has Not Established Oversight of Mental Health Assessments and Suicide Screening Processes for Transitioning Service Members*

The Director of the DSPO stated that Executive Order 13822 directed that 100 percent of transitioning Service members receive a mandatory MHA prior to separation. The OASD(HA) Director of Mental Health Policy and Oversight and the Director of the DSPO stated that DHA Interim Procedures Memorandum 18-019 is the key guidance supporting the requirement for mental health assessments for transitioning Service members. The Director of the DSPO stated that in December of 2018 all three Services began implementing the DHA's Interim Procedures Memorandum (DHA-IPM) 18-019, "Guidance for Service Implementation of Separation Mental Health Assessments." DHA-IPM 18-019 required the MHA to occur within 180 days prior to a Service member's discharge.[21] We reviewed Executive Order 13822, the Joint Action Plan for the Executive Order, and DHA-IPM 18-019 and determined that the processes and oversight for implementation of the MHA was not established to determine when in the transition process the MHA is supposed to be implemented. The Director of the DSPO further stated that the Military Services are required to provide the OASD(HA) monthly reports on the total number of transitioning Service members

[21] DHA-IPM 18-019, February 4, 2020.

with MHAs completed 180 days before separation. However, the OASD(HA) Director of Mental Health Policy and Oversight stated that this information is not used for oversight activities by the DHA or the Service Surgeons General.

The OASD(HA) Director of Mental Health Policy and Oversight further stated that his office does not provide oversight of the implementation of policies, including MHA processes for transitioning Service members. He explained that his office receives monthly updates on the total number of MHAs completed for transitioning Service members.

## *Mental Health Assessments and Suicide Risk Screenings Are Not Part of Separation History and Physical Exams*

In addition to Executive Order 13822, DHA-IPM 18-019, and DoDI 6040.46, the Separation History and Physical Examination (SHPE) for the DoD Separation Health Assessment Program states that all transitioning Service members must have a separation history and physical exam. This physical must be done within 12 months of separation and no later than 30 days prior to separation. The SHPE is the only medical exam required to be administered to the transitioning Service member population, per DoD Instruction 6040.46. This exam does not include a specific mental health and suicide risk screening, as required by the Joint Action Plan.[22] However, DoD Instruction 6040.46 requires that the SHPE include completion of Report of Medical History DD Form 2807-1 and Report of Medical Examination DD Form 2808.[23] Out of 92 questions in the DD Form 2807-1, 9 questions relate to mental health. Similarly, out of 88 fields in the DD Form 2808, 3 fields pertain to mental health issues. The DD Form 2807-1's nine questions related to mental health seek information about:

- nervous trouble of any sort, such as anxiety or panic attacks;
- habitual stammering or stuttering;
- loss of memory or amnesia, or neurological symptoms;
- frequent trouble sleeping;
- counseling of any type;
- depression or excessive worry;
- evaluation or treatment for a mental condition;
- suicide attempts; and
- use of illegal drugs or abuse of prescription drugs.

[22] DoDI 6040.46, April 14, 2016.

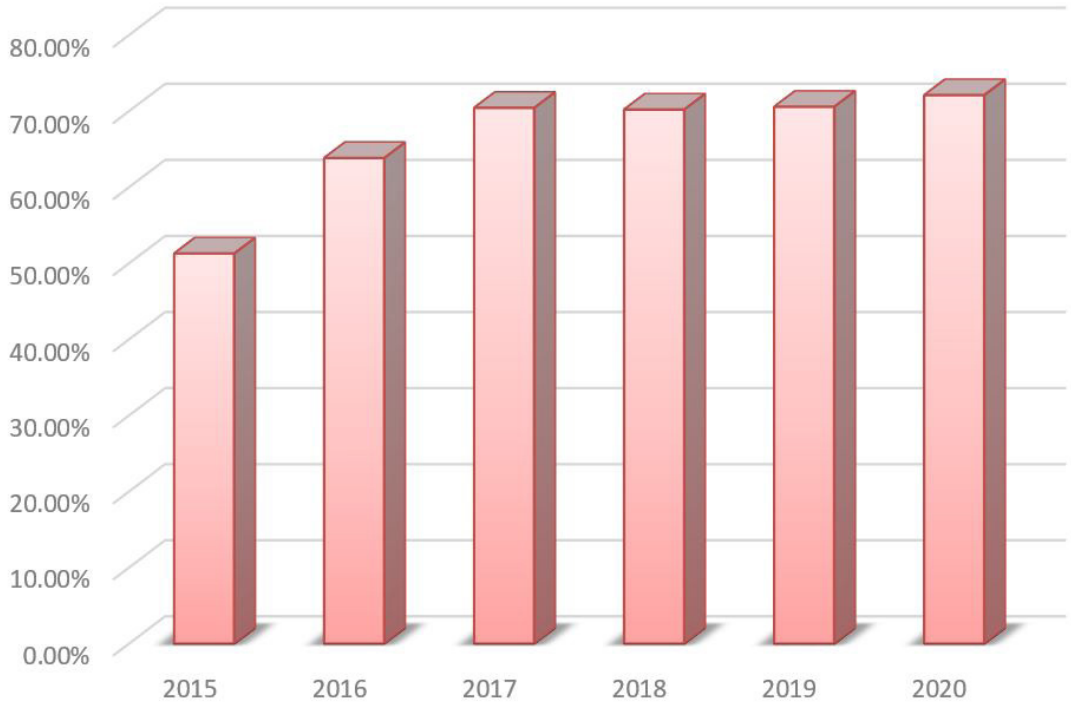
[23] DD Form 2807-1, Report of Medical History, October 1, 2018.
DD Form 2808, Report of Medical Examination, July 2019.

The DD Form 2808 has three fields that record mental health issues, including:

- psychiatric disorders, including personality disorders;
- misuse or abuse of drugs; and
- misuse or abuse of alcohol.

Additionally, we found that the DoD has not completed the SHPE for all Service members transitioning to civilian life, in accordance with the guidance. As shown in Table 3, the percentage of SHPEs that were completed before active duty separation in the DoD rose from 51.27 percent in FY 2015 to 72.09 percent in FY 2020. We determined that the DoD's SHPE processes do not fully meet the intent of the screening and identification goal outlined in the Joint Action Plan.

*Table 3. Percentage of Active Duty Separations With a SHPE Before Separation, FY 2014 Through FY 2020*




Source: OASD(HA).

## *The DoD and Military Services Relied on Expired Guidance to Govern Suicide Risk Screening and Referral Processes*

We determined that the DHA has not published consistent guidance on the MHA process for transitioning Service members. The lack of clear guidance was partially due to the continued reliance on expired guidance. The OASD(HA) Director of Mental Health Policy and Oversight told us that the DoD is currently working on implementing the One-Separation Health Assessment initiative.

The One-Separation Health Assessment is intended to streamline the transition of health care from the DoD to the VA and improve clinical documentation of health status at the time of separation. The targeted completion date for this effort is October 2022.

DHA-IPM 18-019 provides interim guidance for the implementation of the MHA goals identified in the Joint Action Plan and requires that all Service members transitioning from the Service receive an MHA within 180 days before separation. As discussed previously, the OASD(HA) Director of Mental Health Policy and Oversight and the Director of DSPO stated that DHA-IPM 18-019 is the key guidance supporting the requirement for mental health assessments for transitioning Service members.[24]

DHA-IPM 18-019 provides a timeline and process for the completion of MHAs and suicide risk screening. The guidance also includes broader mental health and suicide risk screening processes than found by using the DD Forms 2807-1 and 2808 used within the SHPE process. DHA-IPM 18-019 states that providers can use the Pre-Deployment Health Assessment, the Deployment Mental Health Assessment, the Post Deployment Health Re-assessment, and the Periodic Health Assessment forms to complete a mental health assessment. These four forms have the same 41 questions that are answered by the Service member and the same 26 questions that the medical provider asks, which are related to mental health; additionally, these questions are not on the DD Form 2807-1 and DD Form 2808. Figure 2 shows the suicide risk evaluation questions asked by the medical provider as part of the mental health assessment that are found in the Annual Periodic Health Assessment form, which are also found in the Pre-Deployment Health Assessment, the Deployment Mental Health Assessment, and the Post Deployment Health Re-assessment forms.

[24] DHA-IPM 18-019, February 4, 2020.

*Figure 2. Suicide Risk Evaluation Questions Found on the Annual Periodic Health Assessment Form*

**6. Suicide risk evaluation.**

a. **Ask** "Over the **PAST MONTH**, have you been bothered by thoughts that you would be better off dead or of hurting yourself in some way?"

◯ Yes

◯ No (*go to block 7*)

b. If 6.a. was yes, **ask**: "How often have you been bothered by these thoughts?"

◯ Few or several days

◯ More than half of the time

◯ Nearly every day

c. If 6.a. was yes, **ask**: "Have you had thoughts of hurting yourself?"

◯ Yes (*If yes, ask questions 6.d. through 6.g.*)

◯ No (*If no thoughts of self-harm, go to block 7*)

d. **Ask** "Have you thought about how you might actually hurt yourself?"

◯ Yes ◯ No If Yes, how?

e. **Ask** "There is a big difference between having a thought and acting on a thought. How likely do you think it is that you will act on these thoughts about hurting yourself or ending your life over the next month?"

◯ Not at all likely ◯ Somewhat likely ◯ Very likely

f. **Ask** "Is there anything that would prevent or keep you from harming yourself?"

◯ Yes ◯ No If Yes, what?

g. **Ask** "Have you ever attempted to harm yourself in the past?"

◯ Yes ◯ No If Yes, how?

h. **Conduct further risk assessment** (*e.g., interpersonal conflicts, social isolation, alcohol/substance abuse, hopelessness, severe agitation/anxiety, diagnosis of depression or other psychiatric disorder, recent loss, financial stress, legal disciplinary problems, or serious physical illness*).

Comments:

Source: Annual Periodic Health Assessment, DD Form 3024, April 2016.

The OASD Director of Mental Health Policy and Oversight further stated that it is his understanding that MHAs for transitioning Service members must use the assessment tools outlined in the DHA-IPM 18-019. However, we found that DHA-IPM 18-019 expired on November 8, 2019, and new guidance has not been issued as of the date of this report. DHA senior leaders stated that the issuance of new guidance related to MHAs for transitioning Service members is "on pause" until completion of the development of the One-Separation Health Assessment between the DoD and the VA.

## *The DoD Did Not Implement a Warm Handoff Approach to Create Continuous Mental Health Care From the MHS to the VHA for All Transitioning Service Members*

DoDI 6490.10 states that transitioning Service members receiving mental health care are responsible for obtaining a mental health care provider within the VHA system unless they are enrolled in the IDES or the Wounded, Ill, and Injured programs, where care coordination is provided. Once the Service member identifies a mental health care provider, the Service member must then notify their DoD mental health provider of the need to initiate the transition of care process.

DoDI 6490.10 states that the DoD mental health care provider must ensure that appropriate transfer of care occurs at the time of transitioning to another command or out of military service by:

> contact, as applicable, with a privileged health care provider at the gaining facility to directly communicate the patient's history, current status, needs during the transition period, and to establish a follow-up appointment [with the gaining provider] to ensure continuity of care. Ultimately, the plan for the patient's health during the transition period is a shared responsibility of the losing facility's health care provider and the patient.[25]

The requirement for the warm handoff is reiterated in Federal and DoD guidance. DoD Manual (DoDM) 6025.13 outlines the requirement for all Military Treatment Facilities (MTFs) to be accredited by the Joint Commission.[26] The Joint Commission is an independent, not-for-profit organization that accredits and certifies more than 20,500 health care organizations and programs in the United States reflecting an organization's commitment to meeting certain performance standards. The Joint Commission for health care accreditation defines a warm handoff as a transfer and acceptance of patient care responsibility achieved through effective communication. The purpose of the warm hand off process is to pass patient-specific information from one caregiver to another or from one team of caregivers to another to ensure the continuity and safety of the patient's care. According to the Joint Commission, the process of communicating from sender to receiver during a warm handoff should include critical information such as illness assessment, including severity, and a patient summary, including events leading up to illness or admission, hospital course, ongoing assessment, and plan of care.

## *The DoD Arranged for Continuous Mental Health Care for Select Populations of Transitioning Service Members*

We found that the DoD developed several programs to aid in the continuity of mental health care for transitioning Service members; however, we determined the comprehensive approaches for arranging the continuity of care applies only to a small and specific population within the IDES and Wounded, Ill, and Injured programs and the Army's embedded behavioral health system.

The DoD defines "seriously ill or injured" as "an injury, physiological or psychological disease or condition, or a mental disorder that requires medical attention and medical authority declares that the condition is life threatening or life-altering." The IDES programs are jointly executed by the DoD and the VA to

[25] DoDI 6490.10, March 26, 2012, Incorporating Change 1, Effective October 28, 2015.

[26] DoDM 6025.13, "Medical Quality Assurance and Clinical Quality Management in Military Health System," October 29, 2013, Incorporating Change 1, July 23, 2020.

provide a seamless and consistent approach to evaluate and determine appropriate disposition and compensation for those Service members identified with conditions that impact their ability to continue their military service, such as those in the "seriously ill or injured" population. The Wounded, Ill, and Injured programs coordinate with the VA to implement medically-related processes, procedures, and standards for the severely wounded, ill, and injured transitioning Service members transferring from DoD care and treatment to VA care, treatment, and rehabilitation.

Senior representatives for the IDES and Wounded, Ill, and Injured programs stated that Service members enrolled in these programs have recovery care coordinators, VA liaisons, and physical evaluation board liaison officers who provide assistance throughout the transition process. The Service member's organization and the VA liaisons develop a transition plan created to prevent interruptions in care.

In addition to the IDES and Wounded, Ill, and Injured programs, the Army created approaches within the embedded behavioral health system to arrange for uninterrupted continuity of mental health care for Soldiers. According to the Army Medicine public website, the Embedded Behavioral Health teams are currently being implemented throughout active duty deployable combat units to provide improved access to and continuity of behavioral health care for Soldiers assigned to deployable units. The embedded behavioral health case managers assist Service members who are in active mental health care transitioning out of military service to obtain a provider and create a bridge for continuous care between the DoD and the VHA. However, an Army Medical Command representative stated that it was difficult to conduct a warm handoff for transitioning Service members because often the Service members do not know where they will be living, which means they cannot always identify a new provider.

In addition to the DoD programs, the VHA established procedures for the transition of care for Service members who are seriously ill or injured by creating the VA Liaison program. The program was originally established to transition military personnel returning from theaters of combat but now transitions other active duty military personnel and veterans who are seriously ill or injured and transitioning to the VA. The role and responsibility of the VA Liaison is to participate in the planning of health care services between the DoD and the VA, including working onsite at the MTFs, responding to referrals to coordinate inpatient care and outpatient appointments at VA Medical Centers near the patient's intended residence, coordinating the transfer of care, following up with patients to verify the discharge plan is successful, and ensuring continuity of care, therapy, and medications.

## *Overarching DoD Policy Is Reliant on Service Members and Automated Systems to Initiate a Transition of Mental Health Care From the MHS to the VHA*

DoD Instruction 6490.10, the overarching policy for the continuity of mental health care, outlines two required processes to create continuity of care for Service members who have received care within the MHS as they transition to civilian life.[27] These required processes are the Service member initiation of provider-to-provider communication and automatic referral to the inTransition Program.

According to DoDI 6490.10, the first required process is provider-to-provider communication, which begins when the Service member gives their current provider contact information for the provider or health care facility from which they wish to receive followup care. The Service member's current DoD provider may then initiate direct provider-to-provider communications. Mental health providers reported that there is no training on how to conduct a warm handoff and that the process is not standardized within the DoD. This process is dependent on the Service member navigating the VHA system to select an available provider and initiating mental health care with the VHA.

DoDI 6490.10 identified that the second required process for Service members who have had engagement with mental health services is automatic enrollment into the inTransition program. However, we found that automatic enrollment into the inTransition program does not provide a comprehensive approach for arranging the continuity of care for all transitioning Service members who have had engagement with mental health services. As previously discussed, the inTransition program is intended to help Service members engage in continuing mental health care throughout and after their transition. Enrolled participants receive coaching and assistance for active duty Service members transitioning out of active duty service. The program also provides enrolled Service members one on one assistance with mental health care needs, to include information on how to successfully change providers at the time of transfer and referrals to new providers to ensure effective continuity of care. However, these services are only provided to Service members enrolled in the program.

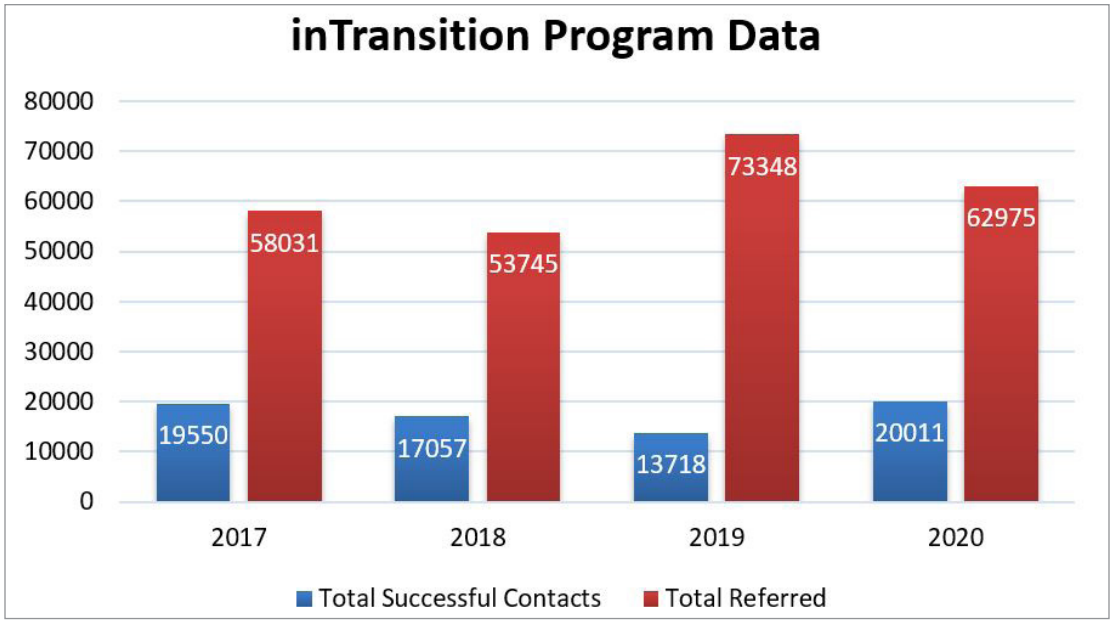
According to Defense Health Agency Procedural Instruction 6490.01, all Service members who are separating from the military and have received mental health care within 1 year prior to their separation are automatically enrolled in the inTransition Program. According to the OASD(HA) Director of Mental Health Policy

[27] DoDI 6490.10, March 26, 2012, Incorporating Change 1, Effective October 28, 2015.

and Oversight, the inTransition call center personnel reach out to the automatically enrolled service members to offer inTransition services. Service members have the right to opt out of inTransition Services.

We found that the inTransition program referral processes are not implemented in a way that ensures each Service member who has been seen for a mental health appointment within the DoD receives arrangement for the continuity of care. Senior officials from a Service medical office stated that the inTransition program monitors Service members during the transition; however, some transitioning Service members do not continue contact and services with the inTransition program. Additionally, inTransition program counselors do not update the referring provider on the status of Service members referred. As shown in the table below, data provided by the Psychological Health Centers of Excellence reported that in 2020, only 20,011 of the auto-enrolled 62,975 Service members were reached by the inTransition program. Historically, from 2017 to 2020, less than one-third of the Service members meeting the criteria of having received mental health care within 1 year of transitioning were reached by the inTransition program.

*Table 4. The Number of Automatic Referrals to inTransition Successfully Contacted, FY 2017 Through FY 2020*




Source: Psychological Health Centers of Excellence.

## *The DoD's Joint Longitudinal Viewer Does Not Provide Two-Way Communication Between the DoD and the VHA*

Multiple representatives from the Services stated that they use the Joint Longitudinal Viewer (JLV) as the warm handoff method between the DoD and the VHA. The JLV is a clinical application that provides a read-only display of real time health data from electronic medical records for the treatment of patients from the DoD, VA, and private sector partners. The DoD uses the JLV as a tool to view medical records; however, the system is not a two-way communication tool. A senior representative from the Psychological Health Center of Excellence explained that when a Service member receives a separation health assessment from the MHS or the VA, the assessment is primarily a part of the medical transition process, which involves electronic sharing of records. There is no structured time in which a DoD provider contacts a VA provider to discuss the assessment. The unified DoD medical record and the JLV provide an opportunity for the VHA provider to look in the DoD medical record. However, this does not create a transition of care plan or continuous care for a Service member. Rather, it is a read-only interface for viewing medical records, which requires the VHA provider to actively open the individual record to view the patient's medical history. Therefore, the use of the JLV does not create a continuous system of care, which would include the alerting and accepting of transferred patients as required by the Joint Commission's warm handoff guidelines.

## *The DoD Is Not Arranging for Uninterrupted Care for All Service Members*

Active duty Service members with mental health conditions are not all receiving uninterrupted care during their transition from the MHS to the VHA because, although TAP and the Joint Commission have defined approaches for conducting a warm handoff, the MHS only has defined processes for limited populations. The approaches for these limited populations all report specialized engagement processes for enrolled transitioning Service members in need of additional mental health support. As previously discussed, the Service members involved in the IDES and the Wounded, Ill and Injured programs receive greater assistance with mental health care coordination than the general transitioning Service member population. The Army Embedded Behavioral program provides Soldiers expedited evaluations and community-level treatment from a single provider, improving the continuity of care. According to the Defense Centers of Excellence for Physiological Health and Traumatic Brain Injury, the inTransition program provides enrolled Service members with one-on-one assistance with mental health care needs, including information on how to successfully change providers at the time of transfer and referrals to new providers to ensure effective continuity of care.

However, we found that active duty Service members with mental health conditions who are not enrolled in these programs do not receive care coordination to ensure effective continuity of care.

Representatives from the medical and transition assistance departments stated that they were concerned with the lack of standardized process for the warm handoff. DoDI 6490.10 states that transfer of care for Service members begins with the Service member initiating the process. The Service member must provide contact information for a provider or health care facility with whom they have established, or with whom they have agreed to have health care provider involvement in establishing, followup care.

The DoD and the VA's medical data sharing system is not an active communication tool that can arrange uninterrupted provision of care. The JLV is a clinical application that provides an integrated, read-only display of health data from the DoD, the VA, and private sector partners in a common data viewer. This system allows VHA providers to access real time medical data to aide in the treatment of their patients. The benefit of the JLV is that it provides a faster and more complete understanding of a patient's documented health status. However, the read-only design creates a lack of two-way communication, which impedes the ability of the DoD and the VA to use the JLV to coordinate or arrange for the transfer of care.

### *The DoD's Inconsistency in Identifying Suicide Risk and Arranging for Uninterrupted Mental Health Care in Transitioning Service Members May Result in a Lack of Mental Health Care and May Jeopardize Patient Safety*

As a result of the DoD's inconsistent screening for suicide risk in and arranging for uninterrupted mental health care for transitioning Service members, the DoD may fail to identify suicide risk and mental health issues in this population. Failure to identify suicide risk and mental health issues in transitioning Service members may impair the ability of the DoD and the VA to identify all current mental health conditions, predict future mental health care needs, and provide mental health treatment during and after the Service member's separation. Additionally, the DoD may fail to arrange for continuing mental health care for thousands of transitioning Service members with existing mental health conditions. DoD Instruction 6490.10 states that it is DoD policy to maintain continuity of behavioral health care for a Service member who requires further care or followup care when transitioning out of military service. We determined that it is necessary for the DoD to arrange for the transfer and acceptance of patient care and continuity of care and to ensure the safety of transitioning Service members engaged in mental health care.

# Recommendations, Management Comments, and Our Response

## *Recommendation A.1*

**We recommend that the Assistant Secretary of Defense for Health Affairs, in coordination with the Director of the Defense Health Agency and the Service Surgeons General, establish consistent policies and procedures to manage suicide risk screening and referral as part of the medical process for transitioning Service members. At a minimum, the policies and procedures should:**

**a. Designate an organization to have responsibility for the clinical implementation of the policy.**

**b. Designate an organization to have oversight responsibility for mental health assessment processes for transitioning Service members.**

**c. Establish a standard mental health assessment and suicide risk screening process to be used by all Services.**

## *Assistant Secretary of Defense for Health Affairs Comments*

The Under Secretary of Defense for Personnel and Readiness (USD[P&R]), responding for the ASD(HA), agreed and stated that the DoD is collaborating with the VA to review and update the Separation History Physical Examination and develop a single baseline examination. The USD(P&R) further stated that the DoD will provide additional mental health screening questionnaires at the time of separation, including suicide and violence risk assessments. The DoD and the VA are collaborating to finalize these processes by October 2022.

## *Our Response*

Comments from the USD(P&R) partially addressed Recommendations A.1.a and A.1.b. The USD(P&R) did not designate an organization to be responsible for the clinical implementation of the policies and procedures to manage suicide risk screening and referral as part of the medical process for transitioning Service members, nor did the USD(P&R) designate an organization to have oversight responsibility for mental health assessment processes for transitioning Service members. Therefore, these recommendations are unresolved. We request that the USD(P&R) provide comments in response to this report.

Comments from the USD(P&R) addressed the specifics of Recommendation A.1.c. This recommendation is resolved but will remain open. We will close the recommendation when the DoD publishes implementing guidance for standard mental health assessment and suicide risk screening process to be used by all Services.

## *Recommendation A.2*

**We recommend that the Director of the Defense Health Agency, in collaboration with the Office of the Assistant Secretary of Defense for Health Affairs Director of Mental Health Policy and Oversight and the Director of the DoD and Veteran's Affairs Collaboration Office:**

**a. Identify the causes for the breaks in arranging for continuous mental health care for all Service members in care who are transitioning from the military health system to the Veteran's Health Administration and create and implement solutions to increase the number of Service members who have continuous care arranged between the military health system and the Veteran's Health Administration or civilian mental health providers at the time of transition and continuity of care.**

**b. Determine the resources required to implement policy and training that improves the quality and consistency of the warm handoff of care.**

### *Assistant Secretary of Defense for Health Affairs and Director of Defense Health Agency Comments*

Both the USD(P&R), responding for the ASD(HA), and the DHA Director agreed and stated that the OASD(HA) initiated a review of DoD Instruction 6490.10, which assigns responsibilities and prescribes guidelines to promote continuity of behavioral health care. The USD(P&R) stated that updates to this policy will be incorporated in the reissuance of the DoD Instruction, which is anticipated in 2023.

In response to Recommendation A.2.a, the DHA Director stated that the DoD is transitioning to a new Electronic Medical Records (EMR) system. The new EMR system will facilitate separation health assessment utilization and tracking as Service members' transition from the MHS to care at the VA. The DHA Director stated that the DHA will use the inTransition program to connect separating Service members who have received behavioral health care 12 months prior to their separation to behavioral health care at their next health care setting. The DHA Director further stated that the DHA will increase MTF leadership and clinician awareness of the inTransition program. In addition, the DHA will implement a plan to socialize inTransition with Service-level Transition Assistance Programs. The new DHA EMR system will record whether a referral was made to inTransition and how the referral was done. The DHA Director stated that the DHA will document the rates of contact with referring providers to inform them of the status of their former patient and indicate when their patients have made contact with a gaining behavioral health provider.

In response to Recommendation A.2.b, the DHA Director stated that the DHA will monitor resource allocations and analyze if personnel and time are appropriately resourced in the most timely and effective manner. The DHA will also track the number of clinician-initiated referrals to the inTransition program to determine if outreach and socialization efforts are having the desired effect of greater levels of proactive program enrollment. The DHA Director further stated that these metrics will be reviewed no less than quarterly for impact and potential adjustment in resource allocation to decrease breaks in the continuity of mental health care.

## *Our Response*

Comments from the USD(P&R) and from the DHA Director addressed the specifics of the recommendation; therefore, the recommendation is resolved but will remain open. We will close the recommendation when the USD(P&R) and the DHA Director provide documentation that the guidance, policies, and procedures addressing the recommendations have been established and implemented.

# Appendix A

## Scope and Methodology

We conducted this evaluation from October 2020 through July 2021 in accordance with the "Quality Standards for Inspection and Evaluation," published in January 2012 by the Council of Inspectors General on Integrity and Efficiency. Those standards require that we adequately plan the evaluation to ensure that objectives are met and that we perform the evaluation to obtain sufficient, competent, and relevant evidence to support the findings, conclusions, and recommendations. We believe that the evidence obtained was sufficient, competent, and relevant to lead a reasonable person to sustain the findings, conclusions, and recommendations.

We focused this evaluation on suicide prevention data, processes, policies, and resources for active duty Service members in the process of discharge, medical separation, administrative separation, or retirement, transitioning out of active duty service through the end of their term of service obligation. Our scope included:

- DoD offices, activities, officials, and guidance related to suicide prevention for transitioning Service members; and
- directives, instructions, charters, strategic plans, implementation plans, and documents related to suicide prevention for transitioning Service members.

In September 2020, leadership and staff from the DoD OIG and the VA OIG conducted conference calls to discuss cross-agency collaboration for oversight of suicide prevention resources for transitioning uniformed Service members. The attendees agreed to assess and consider such opportunities on an ongoing basis and as issues pertaining to suicide prevention for transitioning Service members were presented at their respective agencies. Additionally, the DoD OIG staff requested supporting documents, policy, and data from the VA OIG to support any future evaluations. In November 2020, the VA OIG and DoD OIG signed a Memorandum of Agreement to define the roles and responsibilities of the DoD OIG and the VA OIG in support of the DoD OIG's "Evaluation of the Department of Defense's Implementation of Suicide Prevention Resources for Transitioning Uniformed Service Members."

To obtain sufficient evidence to analyze and develop the findings, we interviewed over 100 officials from the following entities.

- Office of the Secretary of Defense
- Defense Manpower Data Center

- Defense Suicide Prevention Office
- MCTO
- DHA
- Service Surgeons General
- Service Suicide Prevention Offices
- Service Human Resources Commands
- Service Transition Assistance Program offices
- 18 installation-level offices, corresponding to the Service offices

We reviewed documentary evidence, including Federal criteria, DoD guidance, and Military Service policies from 2012 to 2019. Additionally, we reviewed data on the transitioning Service member population. The date range for these data was from FY 2015 through FY 2020 and CY 2019 through CY 2020.

To determine whether the DoD provided suicide prevention resources for transitioning Service members as required by Presidential Executive Order 13822, we compared the actions that DoD officials took to the public laws and DoD-provided plans and policies, such as the guidance titled, "Joint Action Plan for Supporting Veterans During Their Transition from Uniformed Service to Civilian Life." We obtained data from the ASD(HA) that identified the percentage of transitioning Service members with a qualifying MHA within 180 days before separation and the percentage of active duty Service members with a completed SHPE prior to separation from FY 2014 to FY 2020.

## *Criteria for Suicide Prevention for Transitioning Service Members*

We reviewed the following criteria and policies.

- Executive Order No. 13822, 83 Federal Register 1513 (2018)
- "Joint Action Plan for Supporting Veterans During Their Transition from Uniformed Service to Civilian Life," May 3, 2018
- DoD Instruction 1332.35, "Transition Assistance Program (TAP) for Military Personnel," September 26, 2019
- DoD Instruction 6490.10, "Continuity of Behavioral Health Care for Transferring and Transitioning Service Members," October 28, 2015
- DoD Instruction 6490.16, "Defense Suicide Prevention Program," November 6, 2017
- Air Force Instruction 90-505, "Suicide Prevention Program," October 6, 2014

- Army Regulation 600-63, "Army Health Promotion," April 14, 2015
- Marine Corps Order 1720.2, "Marine Corps Suicide Prevention Program (MCSPP)," April 10, 2012
- Office of the Chief of Naval Operations Instruction 1720.4A, "Suicide Prevention Program," August 4, 2009

## Use of Computer-Processed Data

This evaluation used computer-processed data. Specifically, we used computer-processed data obtained from the MCTO to determine the total number of active duty Service members transitioning from active duty by year from January 1, 2017, through June 30, 2020, and the total percentage of transitioning active duty Service members by tier level for 2019 and 2020. These data were retrieved from the DoD Transition Assistance Program Information Technology system, the system of record for the military-civilian transition process. Additionally, the OASD(HA) provided computer-processed data obtained from the MHS Data Repository. We used these data to determine the percentage of transitioning Service members with a qualifying MHA within 180 days before separation and the percentage of active duty Service members with a completed SHPE prior to separation from FY 2014 to FY 2020. Finally, we used computer-processed data obtained from the DHA's Psychological Health Centers of Excellence to determine the number of inbound and outbound automatic referrals to inTransition that are successfully contacted for FY 2017 through FY 2020. These data were retrieved from a non-DoD system of record managed by the contract vendor for the inTransition program.

To assess the reliability of this data, we interviewed agency officials and discussed the mechanisms they use to assess the quality of their data and the extent to which the agency employs quality control mechanisms. Psychological Health Centers of Excellence personnel informed us that the inTransition data they provided was extracted from Magellan Health, a contract vendor for inTransition. These data are not stored in a DoD system of record. Psychological Health Centers of Excellence personnel informed us that the data preparation for monthly in-progress reviews is independently reviewed by Government staff. Psychological Health Centers of Excellence personnel told us that they use data quality control mechanisms that standardize inputs in accordance with established documentation policies at Magellan Health, administer monthly in-progress reviews to allow for identification of problems or trends, and conduct data reconciliation prior to outreach to ensure that Service members are not counted twice.

MCTO personnel informed us that the active duty Service member transition data they provided was extracted from the DoD Transition Assistance Program Information Technology. This system is the official system of record for all

transitioning program-related data collection and dissemination. The data provided is stored at the Defense Manpower Data Center, which is the hosting agency. MCTO personnel informed us that the data is used as the official repository and record of the military-civilian transition process to improve the transition process, inform Congress on the status of transitioning Service members, and comply with DoD OIG-mandated public reports. The mechanism for assessing the quality of data is to verify all records against Service member data available in the Defense Enrollment Eligibility Reporting System.

OASD(HA) personnel informed us that the MHA data they provided was extracted from the Military Health System Data Repository, the official data system used by the Military Health System. According to OASD(HA) personnel, this data is used to help improve the mental health of Service members. The mechanisms for assessing the quality of data are internal quality controls in the programs that compile the data and compare the data with past and present trends to ensure consistency. OASD(HA) personnel informed us that irregular trends are examined to determine the explanation. We believe the computer-processed data were sufficiently reliable.

## Use of Technical Assistance

During the course of the evaluation, the evaluation team determined that additional site visits at the installation levels were necessary to fully answer the evaluation objectives and provide insight into the effects of the observed concerns. The team met with the DoD OIG's Quantitative Methods Division (QMD) to determine the sample of virtual site visits to add to the project plan. QMD established that the selection factor for site visits should be similarly sized installations from each Military Service. Based on this advice, the team selected to virtually visit the following installation site locations.

- Joint Base CONUS: Joint Base Lewis-McChord, Washington
- Joint Base OCONUS: Camp Humphries, South Korea
- Army: Fort Bliss, Texas
- Navy: Naval Base San Diego, California
- Air Force: Travis Air Force Base, California
- Marine Corps: Camp Pendleton, California

## Prior Coverage

During the past 5 years, the DoD OIG did not issue any reports related to DoD suicide prevention policies or programs. However, the DoD OIG issued one report in 2014 and another in 2015 related to DoD suicide prevention processes and

reporting of suicide events within the DoD. The Institute for Defense Analyses (IDA) issued one report in response to a request from the Defense Suicide Prevention Office (DSPO) to review the DSPO's overall program.

Unrestricted DoD OIG reports can be accessed at http://www.dodig.mil/reports.html/. The IDA report can be found at https://www.ida.org/-/media/feature/publications/s/st/strengthening-the-contributions-of-the-defense-suicide-prevention-office-to-dods-suicide-prevention-efforts/p-8248.ashx.

## *DoD OIG*

Report No. DODIG-2015-182, "Assessment of DoD Suicide Prevention Processes," September 30, 2015

> The objectives of this evaluation were to evaluate DoD processes used to develop suicide prevention policy and determine what process changes are required to improve suicide prevention and intervention policies and programs. The evaluation found that the DoD lacked a clearly defined governance structure and alignment of responsibilities for the Defense Suicide Prevention Program. The report also found that the DSPO lacked clear processes for planning, directing, guiding, and resourcing to effectively develop and integrate the Suicide Prevention Program within the DoD. The evaluation recommended that the Under Secretary of Defense for Personnel and Readiness revise DoD suicide prevention policies and committee charters. The evaluation also recommend the DSPO develop a comprehensive suicide prevention strategic plan, budget, research strategy, and plan to implement evidence-based suicide prevention research findings into standard practices across the DoD.

Report No. DODIG-2015-016, "DoD Suicide Event Report (DoDSER) Assessment," November 14, 2014

> The objectives of this evaluation were to review the number of "don't know" responses on the DoD Suicide Event Report (DoDSER) death by suicide submissions and examine the sharing of DoD medical information with the Department of Veterans Affairs (VA). The evaluation identified seven topics for DoDSER submissions improvement, including sharing data with the VA and identifying technical questions presenting challenges for nontechnical DoDSER submitters. The evaluation recommended that the DoD improve the processes for collecting DoDSER information and submitting DoDSER data, including establishing a multidisciplinary team approach to data collection to ensure accuracy; the Services improve subject matter expert participation in DoDSER data collection process and empower local commanders to use DoDSER data to produce reports specific to their units and locations; and to provide appropriate DoDSER data to the VA to use in their public health surveillance.

## *Institute for Defense Analyses*

Institute for Defense Analyses, "Strengthening the Contributions of the Defense Suicide Prevention Office to DoD's Suicide Prevention Efforts," November 2016

The DSPO tasked the Institute for Defense Analyses (IDA) with reviewing its strategic plans, assessing its organizational structure and effectiveness, examining data and analyses capabilities and challenges, reviewing program evaluation approaches, and providing recommended improvements. While the IDA study team's overall assessment of the DSPO's status and direction was positive, the report provided 80 recommendations on actions to continue progress and to further improve the DSPO's functions and deliverables. The review stated that the priority action needed in this area was for the DoD to close the guidance gap on roles and responsibilities through prompt completion of the DoD Instruction 6490.16 for suicide prevention, which was subsequently published in 2017. The report also recommended that the DSPO should work to expand participation in the DoD suicide prevention governance structures, which DSPO did by including the Reserve and Guard participation, ensure that these bodies are structured to drive decisions informed by evidence-based research. Finally, the report recommended that the DSPO should leverage its newly-hired outreach staff to fulfill its clearinghouse role for the community through actions such as maintaining a repository of suicide prevention resources on its website.

# Appendix B

## DoD and Military Services Suicide Prevention Efforts for Transitioning Service Members Include Nonmedical Counseling and Outreach and Caring Contacts Programs

Transitioning Service members may be connected to available suicide prevention programs, resources, and nonmedical counseling resources. Nonmedical counseling addresses issues like approaching relationship concerns at home or work, managing stress, adjusting to a change or transition, handling parenting difficulties, dealing with grief or loss, and returning from deployment.

Nonmedical counseling differs from medical counseling. Medical counseling is available separately through the Military Health System. Medical counseling specifically addresses medically diagnosable issues, such as drug and alcohol abuse, mental illness, post-traumatic stress disorder, traumatic brain injuries, child abuse or neglect, domestic violence, and thoughts of suicide.

The Director of the DoD's Military Community and Family Policy Office stated that the office provides nonmedical counseling through the Military and Family Life Consultant and Military OneSource programs. These programs provide brief counseling support to augment counseling provided by the Active and Reserve Components. Referrals to Military and Family Life Consultant and Military OneSource programs can come from multiple sources, including:

- Service member self-referral,
- Service members' command referrals, and
- Transition Assistance Program Offices.

The Director of the DoD's Military Community and Family Policy Office stated that the Military and Family Life Consultant and Military OneSource programs do not have a directorate or a suicide risk screening tool. However, all program consultants are trained on how to respond when a client expresses a suicide ideation or attempt. The Director further stated that program consultants call emergency services if the Service member expresses intent for self-harm. The Military Community and Family Policy Office staff tracks all calls to emergency service to verify that the Service member was connected to services at the installation. When appropriate, the program consultants also follow up with the Service member within 72 hours to ensure that they received services.

The DoD suicide prevention programs are available to all Service members, including those transitioning to civilian life. Suicide prevention is implemented through varied processes at each command level and oversight of these programs varies by Military Service. Service policies are written to be implemented for localized populations, which requires a local assessment and the customization of interventions to address the specific needs of high-risk and vulnerable populations. The Services' suicide prevention programs provide transitioning Service members with information about suicide prevention resources; however, these programs do not ensure transitioning Service members are connected to services within the DoD.

In addition to the suicide prevention resources provided by the DoD, the Navy offers the Navy Sailor Assistance and Intercept for Life (SAIL) Program, and the Marine Corps offers the Marine Intercept Program (MIP). These programs document the care provided to Service members through internal databases that do not connect to the VA systems.

The SAIL program is available to active duty Sailors who experienced a suicide ideation or attempt. SAIL provides rapid assistance, ongoing risk assessment, care coordination, and reintegration assistance through a series of contacts over 90 days following a suicide ideation or attempt. SAIL does not replace needed mental health services and is not a form of treatment. SAIL case managers are Fleet and Family Support Center counselors who maintain contact with Sailors, health care providers, and command leadership, assisting with care coordination and engaging additional resources as needed. Sailors are automatically referred to SAIL by their command and participation in this program is voluntary.

MIP is a targeted intervention using evidence-informed practices for followup to a suicide ideation or a suicide attempt. MIP supports commanders by ensuring those Marines and Sailors who were identified as having a suicide ideation or attempt receive followup contact and necessary service coordination. The Service member's command is required to provide the Service member's contact information to MIP, as MIP services must be offered following suicide ideation or a suicide attempt. Licensed installation Community Counseling Program (CCP) counselors provide followup contact, care coordination, and suicide risk assessment to Marines and attached Sailors. The CCP MIP counselors will make a series of outreach phone calls for 90 days post-suicide ideation or suicide attempt. MIP provides brief outreach phone calls and is not intended to provide telephonic therapy or fulfill the role of a medical case manager. The counselor will consult with the commander of the Marine or Sailor after each contact to ensure appropriate command coordination is in place throughout care coordination process. Participation in MIP is voluntary.

The Navy Suicide Prevention Section Lead stated that if a SAIL participant is transitioning out of the military, the Service member will receive a warm handoff to the VA through the inTransition program. Additionally, the SAIL Commander's Toolkit states that SAIL case managers will work with transitioning Sailors to create a plan for mental health care during and after the transition and will also provide referrals and a warm handoff directly to the gaining provider, as needed.

A Marine Corps Community Counseling Program Manager stated that Headquarters Marine Corps refers all transitioning Service members involved in MIP to the inTransition program for continuing support. Additionally, on March 20, 2017, the Marine Corps issued a policy letter identifying that the inTransition Program provides support to Service members who recently engaged in behavioral health services and are relocating to a new duty station, returning from deployment, or preparing to leave Military Service. The policy letter further states that all MIP counselors must refer program participants who meet the criteria to the inTransition Program prior to the completion of MIP services. Although inTransition is a voluntary program, Marine Corp policy letter instructs MIP counselors to encourage Marines and Sailors to participate in the program. MIP counselors refer MIP participants to inTransition by calling the inTransition program and providing the participating Marine or Sailor's:

- name;
- home phone number, cell phone number, and e-mail address;
- destination or discharge status; and
- behavioral health conditions.

Additionally, MIP counselors provide Marines and Sailors participating in MIP with the contact information for the inTransition program.

Senior leaders from the Army Suicide Prevention Office told us that their office does not provide services for a when a Solider experiences a suicide ideation or attempt. When a Service member is identified as at-risk for suicide, the intervention comes from a resource such as the chaplain or medical provider. Senior leaders from the Air Force Suicide Prevention Office also told us that their program provides self-help information and resources but does not provide Service members direct intervention services.

# Management Comments

## Assistant Secretary of Defense for Health Affairs

PERSONNEL AND READINESS

**UNDER SECRETARY OF DEFENSE**
**4000 DEFENSE PENTAGON**
**WASHINGTON, D.C. 20301-4000**

OCT 2 5 2021

MEMORANDUM FOR INSPECTOR GENERAL OF THE DEPARTMENT OF DEFENSE

SUBJECT: Response to Department of Defense Inspector General's Draft Report No. D2021-DEV0PB-0025.000, "DoD Implementation of Suicide Prevention Resources for Transitioning Service Members."

In response to the request to review recommendations associated with the Department of Defense Inspector General's Draft Report No. D2021-DEV0PB-0025.000, "DoD Implementation of Suicide Prevention Resources for Transitioning Service Members," the Department concurs with Recommendation A.1:

> *We recommend that the Assistant Secretary of Defense for Health Affairs, in coordination with the Director of the Defense Health Agency and the Service Surgeons General, establish consistent policies and procedures to manage suicide risk screening and referral as part of the medical process for transitioning Service members. At a minimum, the policies and procedures should:*
> *a) Designate an organization to have responsibility for the clinical implementation of the policy.*
> *b) Designate an organization to have oversight responsibility for mental health assessment processes for transitioning Service members.*
> *c) Establish a standard mental health assessment and suicide risk screening process to be used by all Services.*

The Department also concurs with Recommendation A.2:

> *We recommend that the Director of the Defense Health Agency, in collaboration with the Office of the Assistant Secretary of Defense for Health Affairs Director of Mental Health Policy and Oversight and the Director of the DoD and Veteran's Affairs Collaboration Office:*
> *a) Identify the causes for the breaks in arranging for continuous mental health care for all Service members in care who are transitioning from the military health system to the Veteran's Health Administration and create and implement solutions to increase the number of Service members who have continuous care arranged between the military health system and the Veteran's Health Administration or civilian mental health providers at the time of transition and continuity of care.*
> *b) Determine the resources required to implement policy and training that improves the quality and consistency of the warm handoff of care.*

The DoD is collaborating with the Department of Veterans Affairs (VA) to review and update the Separation Health Assessment (SHA)/Separation History Physical Examination (SHPE), and develop a single baseline examination, currently referred to as "One SHA," for use across VA and the DoD. Included in these efforts are updates to policy and associated processes. Additionally, the DoD and VA are collaborating to finalize the One SHA, develop One SHA

## Assistant Secretary of Defense for Health Affairs (cont'd)

supplemental guidance for clinicians and Service members, and develop corresponding policy, including Departmental responsibilities and procedures. The Office of the Assistant Secretary of Defense for Health Affairs (OASD(HA)) is leading the development of policy. The Defense Health Agency provided a separate response on October 13, 2021. Implementation of the One SHA is anticipated in October 2022.

Mental health screening questionnaires provided at time of separation will include the Post-Traumatic Stress Disorder (PTSD) Screen (PC-PTSD-5), Depression Screen (Patient Health Questionnaire – Item 2) (PHQ-2), and Alcohol Use Disorders Identification Test – Concise (AUDIT-C). Further, the clinical evaluation will include suicide and violence risk assessments via the Columbia – Suicide Severity Rating Scale (C-SSRS) and Violence Risk Assessment, respectively.

The OASD(HA) also initiated a review of Department of Defense Instruction (DoDI) 6490.10, "Continuity of Behavioral Health for Transferring and Transitioning Service Members." DoDI 6490.10 assigns responsibilities and prescribes guidelines to promote continuity of behavioral health care when Service members transition from one health care provider to another upon transferring to a new duty station or transitioning out of the Service. Policy updates will be incorporated in the reissuance of the DoDI, which is anticipated in 2023.

Thank you for the opportunity to review and respond to the draft report recommendations. My point of contact for this topic is [redacted]

Gilbert R. Cisneros, Jr.

2

# Director, Defense Health Agency

**DEFENSE HEALTH AGENCY**
7700 ARLINGTON BOULEVARD, SUITE 5101
FALLS CHURCH, VIRGINIA 22042-5101

10/13/2021

Mr. James F. Degaraff
Program Director for Audit
Acquisition, Contracting, and Sustainment
U.S. Department of Defense Office of Inspector General
4800 Mark Center Drive
Alexandria, VA 22350-1500

Dear Mr. Degaraff:

I am in receipt of the Department of Defense Inspector General's (DoD IG) Draft Report No. D2021-DEV0PB-0025.000, "DoD Implementation of Suicide Prevention Resources for Transitioning Service Members." The Defense Health Agency (DHA) concurs with Recommendation (A.2.a): "Identify the causes for the breaks in arranging for continuous mental health care for all Service members in care who are transitioning from the military health system to the Veteran's Health Administration and create and implement solutions to increase the number of Service members who have continuous care arranged between the military health system and the Veteran's Health Administration or civilian mental health providers at the time of transition and continuity of care"; and A.2.b: "Determine the resources required to implement policy and training that improves the quality and consistency of the warm hand-off of care."

Please see the DHA attached response to the audit's findings and recommendations. In response to Recommendation (A.2.a), DHA and Veterans Affairs (VA) are developing a Separation Health Assessment (SHA) with multiple mental health screening tools and a decision tool to refer to the inTransition program. The implementation date is October 2022. The DoD transition to Military Health System GENESIS will provide a seamless Electronic Medical Record (EMR) with the VA and facilitate the SHA. The DHA supports inTransition program referrals in Service separation programs and within the EMR to increase clinician-initiated program referrals. In response to Recommendation (A.2.b), the DHA will monitor resource allocation and care continuity metrics to decrease breaks in mental health care continuity.

Thank you for the opportunity to review and respond to the draft report recommendations. My point of contact for this topic is [redacted]

PLACE.RONALD.J OSEPH [redacted] Digitally signed by PLACE.RONALD.JOSEPH [redacted] Date: 2021.10.13 21:08:59 -04'00'

RONALD J. PLACE
LTG, MC, USA
Director

Attachment:
As stated

# Director, Defense Health Agency (cont'd)

**DEPARTMENT OF DEFENSE INSPECTOR GENERAL DISCUSSION DRAFT REPORT UNDATED**
**PROJECT NUMBER PROJECT NO. D2021-DEV0PB-0025.000**

**"Evaluation of the Department of Defense's Implementation of Suicide Prevention Resources for Transitioning Uniformed Service Members"**

**Department of Defense Comments to the Inspector General Recommendations**

**RECOMMENDATION A.2.a**: Identify the causes for the breaks in arranging for continuous mental health care for all Service members in care who are transitioning from the military health system to the Veteran's Health Administration and create and implement solutions to increase the number of Service members who have continuous care arranged between the military health system and the Veteran's Health Administration or civilian mental health providers at the time of transition and continuity of care.

**DoD RESPONSE**: The Defense Health Agency (DHA) acknowledges breaks in arranging for continuous mental health care for all Service members in care who are transitioning from the military health system to the Veteran's Health Administration or civilian mental health provider.

The Department of Defense (DoD) is coordinating and collaborating with Veterans Affairs (VA) to review and update the SHA/Separation History Physical Exam (SHPE), and develop a single baseline examination, a "One SHA," for use by VA and the DoD. Included in these efforts are updates to policy and associated processes. Currently, the DoD and VA are collaborating to finalize the One SHA, develop One SHA supplemental guidance for clinicians and Service members, and develop corresponding policy, including Departmental responsibilities and procedures. The Office of the Assistant Secretary of Defense (Health Affairs) is leading the development of policy, with the DHA managing and executing implementing the One SHA. Implementation of the One SHA is anticipated in October 2022.

Mental health screening questionnaires provided at time of separation will include Posttraumatic Stress Disorder (PTSD) Screen (PC-PTSD-5), Depression Screen (Patient Health Questionnaire – Item 2) (PHQ-2), and Alcohol Use Disorders Identification Test – Concise (AUDIT-C). Further, the clinical evaluation will include suicide and violence assessments via the Columbia – Suicide Severity Rating Scale (C-SSRS) and Violence Risk Assessment, respectively.

The DoD is transitioning to MHS Genesis across all Military Treatment Facilities (MTFs). MHS Genesis will provide a seamless Electronic Medical Record with the VA and will facilitate SHA utilization and tracking as service members transition from the MHS to care at the VA

The DoD's inTransition program facilitates connecting separating Service members who have received behavioral health care 12 months prior to their separation to behavioral health care at their next health care setting. Service members who meet this criterion are automatically enrolled although inTransition is a voluntary program and disenrollment by the Service member may occur at any time.

# Director, Defense Health Agency (cont'd)



inTransition program participation is significantly greater, and breaks in care significantly reduced, when incumbent clinicians socialize the program with their patients and proactively enroll them. To encourage clinician-initiated referrals with both the clinician and patient present, the DHA has facilitated the implementation of an inTransition decision tool within the military disposition tab of MHS Genesis to include a drop-down menu to capture if a referral was made to inTransition and how it was done. Further, DHA will increase MTF leadership and clinician awareness of inTransition by highlighting the program through no less than quarterly contact with designated MTF inTransition points of contact as required by DHA-PI 6490.01. Further, DHA will focus programmatic outreach efforts on (MTFs, specifically specialty mental health departments, substance misuse clinics, and Intrepid Spirit Centers, so that leadership and clinicians will be familiar with the program and feel comfortable offering it to patients and enrolling them proactively. In addition, DHA will implement a plan to socialize inTransition with Service-level Transition Assistance Programs. This is especially important in reaching those transitioning Service members who are not automatically enrolled in inTransition per DHA-PI 6490.01, but who are eligible for the coaching-to-care services offered by the program should they wish to use them either during their transition or after. Last, DHA will document the rates of contact with referring providers to inform them of the status of their former patient and indicate when their patients have made contact with a gaining behavioral health provider. These initiatives are reviewed for impact no less than quarterly.

**RECOMMENDATION A.2.b**: Determine the resources required to implement policy and training that improves the quality and consistency of the warm handoff of care.

**DoD RESPONSE**: DHA concurs with this recommendation, and will monitor resource allocation needed to support these ongoing efforts. DHA will analyze if personnel and time are appropriately resourced in the most timely and effective manner to accomplish these goals. Further, DHA will track the number of clinician-initiated referrals to the inTransition program to determine if outreach and socialization efforts are having the desired effect of greater levels of proactive program enrollment. These metrics will be reviewed no less than quarterly for impact and potential adjustment in resource allocation.

# Acronyms and Abbreviations

| | |
|---|---|
| **DDFORM** | Department of Defense Form |
| **DHA** | Defense Health Agency |
| **DSPO** | Defense Suicide Prevention Office |
| **EMR** | Electronic Medical Records |
| **IDES** | Integrated Disability Evaluation System |
| **JLV** | Joint Longitudinal Viewer |
| **MIP** | Marine Intercept Program |
| **MHA** | Mental Health Assessment |
| **MHS** | Military Health System |
| **MTF** | Military Treatment Facility |
| **OASD(HA)** | Office of the Assistant Secretary of Defense for Health Affairs |
| **SAIL** | Sailor Assistance and Intercept for Life |
| **SHPE** | Separation History and Physical Exam |
| **TAP** | Transition Assistance Program |
| **VA** | Veterans Affairs |
| **VHA** | Veterans Health Administration |

# Glossary

**InTransition Program.** Offers specialized coaching and assistance to support Service members receiving mental health or moderate to severe traumatic brain injury care who are relocating to another assignment, returning from deployment, transitioning from active duty to Reserve Component or Reserve Component to active duty, or preparing to leave military service.

**Joint Commission.** An independent, not-for-profit organization that accredits and certifies more than 20,500 health care organizations and programs in the United States reflecting an organization's commitment to meeting certain performance standards.

**Joint Longitudinal Viewer.** A clinical application that provides a read-only display of real time health data from electronic medical records for the treatment of patients from the DoD, VA, and private sector partners.

**Mental Health.** A state of subjective wellbeing and successful performance of mental function resulting in productive activities, fulfilling relationships with other people, and the ability to adapt, change, and cope with adversity. Mental health is indispensable to personal wellbeing, family and interpersonal relationships, and contributions to community or society.

**Military Health System.** The DoD medical and dental programs, personnel, and facilities by which the DoD provides health care services and support to the Military Services during military operations, and health care services and support under TRICARE to members of the Military Services, their family members, and others entitled to DoD medical care.[28]

**Military Treatment Facility.** A DoD hospital or clinic operated to provide health care to active duty Service members or other DoD beneficiaries.

**Psychological Health Center of Excellence.** A Division of the J-9 (Research and Development) Directorate of the DHA responsible for work on the health care-related aspects of the DoD's suicide prevention programs and policies. The Center is also responsible for operating and sustaining the DoDSER system, as well as analyzing and communicating DoDSER data and findings. Its mission is to improve the lives of Service members, veterans, and families by advancing excellence in psychological health care and the prevention of psychological health disorders.

[28] TRICARE is the health care program for uniformed service members, retirees, and their families around the world.

**Risk Factors.** Factors caused by stress, trauma, or other circumstances that produce a schism in protective factors. Risk factors make it more likely that individuals will develop a disorder or predispose an individual to being high-risk for self-injurious behaviors. Risk factors may encompass biological, psychological, or social factors in the individual, family, and environment.

**Screening.** Administration of an assessment tool to identify persons in need of more in-depth evaluation or treatment.

**Screening Tools.** Instruments and techniques (such as questionnaires, checklists, and self-assessment forms) used to evaluate individuals for increased risk of certain health problems.

**Separation Health Assessment.** A complete history, review of systems, and physical exam performed by the VA.

**Separation History and Physical Exam.** A complete history, review of systems, and physical exam performed by the DoD.

**Suicide.** Death caused by self-directed injurious behavior with an intent to die as a result of the behavior.

**Transition.** A period of adjustment which includes the planning and preparation accomplished during military service, when Service members and their families explore and embark on endeavors in the civilian world upon leaving active duty.

**Transition Assistance.** Activities and curriculum that provide eligible Service members with the targeted set of knowledge, skills, documentation, and assistance required to meet career readiness standards before transition and enable a successful transition from active duty to civilian life.

**Transitioning Service Member.** All individuals with a planned or pending separation from active duty military service, including individuals completing service commitment contracts, retiring, or undergoing medical evaluations boards or administrative separation proceedings.

**Veterans Heath Administration.** The largest integrated health care system in the United States, providing care at health care facilities, including VA Medical Centers and VHA outpatient clinics, to over 9 million veterans enrolled in the VA health care program.

**Warm Handoff.** Process of the transfer and acceptance of care responsibility through person-to-person connection of Service members to services and followup resources for the purpose of ensuring the continuity and safety of care.

## Whistleblower Protection
### U.S. Department of Defense

*Whistleblower Protection safeguards DoD employees against retaliation for protected disclosures that expose possible fraud, waste, and abuse in Government programs. For more information, please visit the Whistleblower webpage at http://www.dodig.mil/Components/Administrative-Investigations/Whistleblower-Reprisal-Investigations/Whisteblower-Reprisal/ or contact the Whistleblower Protection Coordinator at Whistleblowerprotectioncoordinator@dodig.mil*

## For more information about DoD OIG reports or activities, please contact us:

**Congressional Liaison**
703.604.8324

**Media Contact**
public.affairs@dodig.mil; 703.604.8324

**DoD OIG Mailing Lists**
www.dodig.mil/Mailing-Lists/

**Twitter**
www.twitter.com/DoD_IG

**DoD Hotline**
www.dodig.mil/hotline

DEPARTMENT OF DEFENSE | OFFICE OF INSPECTOR GENERAL

4800 Mark Center Drive
Alexandria, Virginia 22350-1500
www.dodig.mil
DoD Hotline 1.800.424.9098