



UNDER SECRETARY OF DEFENSE

4000 DEFENSE PENTAGON  
WASHINGTON, DC 20301-4000

OCT 10 2013

PERSONNEL AND  
READINESS

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

Dear Mr. Chairman:

I am pleased to provide the enclosed final report in response to section 596(b)(8) of the National Defense Authorization Act for Fiscal Year 2010 (Public Law 111-84), "Update to the Comprehensive Plan on Prevention, Diagnosis, and Treatment of Substance Use Disorders." The report revises the comprehensive plan included in the Department of Defense (DoD) July 2011 interim report to Congress and addresses findings from an independent study conducted by the Institute of Medicine (IOM), "Substance Use Disorders in the U.S. Armed Forces," made publicly available on September 17, 2012.

The DoD is revising its Military Health System policies and the TRICARE benefit for substance use disorder treatment in response to the internal review findings and the IOM Study. These actions are highlighted in the report, which also includes recent findings on alcohol and prescription drug use and misuse from the 2011 Health Related Behaviors Survey.

Thank you for your interest in the health and well-being of our Service members, veterans, and their families. A similar letter is being sent to the chairpersons of the other congressional defense committees.

Sincerely,

  
Jessica L. Wright  
Acting

Enclosure:  
As stated

cc:  
The Honorable James M. Inhofe  
Ranking Member



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WASHINGTON, DC 20301-4000

OCT 10 2013

PERSONNEL AND  
READINESS

The Honorable Howard P. "Buck" McKeon  
Chairman  
Committee on Armed Services  
U.S. House of Representatives  
Washington, DC 20515

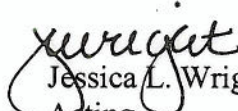
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Sincerely,

  
Jessica L. Wright  
Acting

Enclosure:  
As stated

cc:  
The Honorable Adam Smith  
Ranking Member



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OCT 10 2013

PERSONNEL AND  
READINESS

The Honorable Barbara A. Mikulski  
Chairwoman  
Committee on Appropriations  
United States Senate  
Washington, DC 20510


Dear Madam Chairwoman:

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Sincerely,

  
Jessica L. Wright  
Acting

Enclosure:  
As stated

cc:  
The Honorable Richard C. Shelby  
Vice Chairman





UNDER SECRETARY OF DEFENSE  
4000 DEFENSE PENTAGON  
WASHINGTON, DC 20301-4000

OCT 10 2013

PERSONNEL AND  
READINESS

The Honorable Harold Rogers  
Chairman  
Committee on Appropriations  
U.S. House of Representatives  
Washington, DC 20515

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Sincerely,

  
Jessica L. Wright  
Acting

Enclosure:  
As stated

cc:  
The Honorable Nita M. Lowey  
Ranking Member

**Section 596 (b)(8) of the FY 2010 National Defense Authorization  
Act (NDAA)**

**Update to the Comprehensive Plan on Prevention, Diagnosis, and  
Treatment of Substance Use Disorders (SUDs) and  
Disposition of Substance Use Offenders in the Armed Forces**

**July 2013**



**Department of Defense  
TRICARE Management Activity  
Office of the Chief Medical Officer**

The estimated cost of report or study for the Department of Defense is approximately \$22,000 for the 2013 Fiscal Year. This includes \$0 in expenses and \$22,000 in DoD labor.

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# Executive Summary

## Background

The National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2010, section 596, required the Department to conduct a review of policies and programs for the prevention, diagnosis, and treatment of substance use disorders (SUD) in members of the Armed Forces (July 2011<sup>1</sup>). The NDAA concurrently required the Department to solicit an independent review of similar parameters, conducted by the Institute of Medicine (IOM) (2012<sup>2</sup>).

The IOM presented 20 broadly stated findings (Appendix B) under 3 major topic areas: (a) Policies and Programs on Substance Use Disorders; (b) Access to Care for Service members and beneficiaries with a SUD; and, (c) Strengthening the Substance Use Disorder Workforce. The findings are matched against the earlier Department of Defense (DoD) findings in Appendix C to highlight commonalities and differences between the reports.

In keeping with the Department's culture for critical self-examination and commitment to the care of all eligible beneficiaries, actions have already begun to address the findings uncovered in both the IOM and DoD reviews of SUDs in the military. This report outlines 21 current or proposed DoD actions that address the 12 targeted recommendations from the IOM study. These 21 actions will improve DoD's overall approach to SUDs in the U.S. Armed Forces in the areas of:

- Increasing emphasis on efforts to prevent SUDs;
- Developing strategies for identifying, adopting, implementing, and disseminating evidence-based programs and best practices for SUD care;
- Increasing access to care; and,
- Strengthening the SUD workforce.

## Increasing Emphasis on Efforts to Prevent Substance Use Disorders

In order to combat stigma associated with mental healthcare and to improve the early screening, identification, and intervention of many mental health conditions, 470 behavioral health positions have been funded and positioned in primary care medical settings. In order to educate medical providers on prevention strategies and early intervention for SUDs, educational toolkits and computer-based training has been developed. The Department continues to improve the flexibility of information technology (IT) platforms that track prescription medications in an effort to inhibit the diversion and misuse of prescribed medications. Additionally, the Department has revised the drug testing panel for Active Duty (AD) personnel to include the detection of a broader range of drugs with the potential for abuse.

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<sup>1</sup> National Defense Authorization Act (NDAA) 2010, Section 596 "Comprehensive Plan on Prevention, Diagnosis, and Treatment of Substance Use Disorders and Disposition of Substance Abuse Offenders in the Armed Forces"

<sup>2</sup> "Substance Use Disorders in the U.S. Armed Forces."

### *Developing Strategies for Identifying, Adopting, Implementing, and Disseminating Evidence-Based Programs and Best Practices for Substance Use Disorder Care*

Recognizing the need to reinforce the use of Clinical Practice Guidelines in the delivery of SUD treatment, the Department has two policies related to evidence-based practices currently in coordination. The first policy is a revision of Departmental policies which specify the activities that are necessary to foster the prevention, screening, early identification, and treatment of personnel suffering with a SUD. The second is a DoD policy which delineates the roles and responsibilities of behavioral health providers in primary care. Together, these policies provide a structure for the delivery of evidence-based SUD care within the military treatment facility (MTF).

There are several proposed changes to the SUD benefit which are ongoing or under review. DoD has published a proposed rule lifting the ban on opioid replacement therapies, thus increasing the pharmacologic options for those suffering with an opiate addiction. In addition, the Department is reviewing recommendations to lift selected current lifetime and annual benefit limits on SUD care and is exploring alternatives that would permit the delivery of SUD care in settings outside of a TRICARE certified Substance Use Disorder Rehabilitation Facility (SUDRF).

### *Increased Access to Care*

The Department is monitoring the implementation of the U.S. Army's Confidential Alcohol Treatment and Education Pilot (CATEP), which has expanded confidential substance use treatment services for AD personnel. Lessons learned from this pilot may provide new insights and strategies for broadening the implementation of SUD treatment without impacting force health and readiness. Concurrently, DoD has tasked the Addictive Substance Misuse Advisory Committee (ASMAC), which shares best practices across the Department, to follow the development of the CATEP initiative.

### *Strengthening the SUD Workforce*

The DoD is implementing policies that set a uniform level of certification for para-professional staff who deliver SUD care. The Services continue to assess their training materials, and modify them accordingly, ensuring they are consistent with current practices in the treatment of SUDs. The ongoing training and development of para-paraprofessional staff provides the Department access to qualified personnel that deliver SUD services.

In order to properly project behavioral manning requirements the Department seeks to account for all of the activities assigned to prevention, screening, and intervention personnel. The result is the creation and on-going development of the Psychological Health Risk Adjusted Model for Staffing (PHRAMS), which is intended to properly account for the many activities associated with mental health, prevention, screening, and treatment.



## 1.0 Introduction

Extended military operations, which have included Operation Iraqi Freedom (OIF), Operation Enduring Freedom (OEF), and Operation New Dawn (OND), have exposed Active Duty Service members (ADSM) and activated members of the Reserve Component (RC) to hostile environments, extended and frequent deployments, and multiple separations from their loved ones. In the context of these operations the Department is addressing issues such as suicide, depression, anxiety, post-traumatic stress disorder (PTSD), and problems subsequent to traumatic brain injury. Co-occurring with such disorders is often substance abuse, posing a public health concern within the military.

This report reconciles the findings and recommendations from two reports that assessed DoD policies and programs related to the prevention, diagnosis, and treatment of SUDs among military personnel and their family members. NDAA FY 2010, section 596, required DoD to conduct a study and report to Congress. The same NDAA provision required DoD to solicit an independent study of similar parameters, with a revision to DoD's comprehensive plan in consideration of any additional findings.

The IOM study reported 20 findings across the 3 major topic areas of policies and programs on SUDs, access to care for SUDs, and the SUDs workforce. The 20 IOM findings are matched against the findings of the DoD's 2011 report in Appendix C. Of the 20 IOM findings, DoD identified 12 of these major findings in the initial report to Congress and comprehensive plan.

The IOM study also provided a series of 12 recommendations to the Department. Many DoD initiatives were embedded in the IOM's recommendations. These are discussed in the body of this report (Chapter 2). Appendix D lists the 12 IOM recommendations and DoD actions related to them.

Since the initial DoD review of SUD policies and programs, and the subsequent report to Congress, findings from the 2011 Health Related Behaviors (HRB) survey have become available. The HRB survey provides a current depiction of substance use among military personnel, which is discussed in Chapter 3, "Update on Substance Use in the Military."

## 2.0 Updated DoD Comprehensive SUD Plan, Actions, and Initiatives in Response to IOM Findings

The following sections list the 12 categories of IOM recommendations:

- Increasing Emphasis on Efforts to Prevent Substance Use Disorders;
- Developing Strategies for Identifying, Adopting, Implementing, and Disseminating Evidence-Based Programs and Best Practices for Substance Use Disorder Care;
- Increasing Access to Care; and,
- Strengthening the Substance Use Disorder Workforce.

Each IOM recommendation is followed by related DoD actions. These actions serve as updates to DoD's 2011 "Comprehensive Plan on Prevention, Diagnosis, and Treatment of Substance Use Disorders (SUDs) and Disposition of Substance Use Offenders in the Armed Forces." The Department will be issuing its policy, "Problematic Substance Use by DoD Personnel," to provide direction to the Services and other DoD components to implement these recommendations as well as the actionable requirements of Section 596 of Public Law 111-84.

### Increasing Emphasis on Efforts to Prevent SUDs

The prevention of SUDs includes activities designed to influence individual attitudes, peer group, family affiliations, and broader socio-cultural environments which can inhibit the development of substance abuse in personnel.

***IOM Recommendation 1:** DoD and the individual branches should implement a comprehensive set of evidence-based prevention programs and policies that include universal, selective, and indicated interventions.*

The IOM proposed a series of actions which include: addressing the distribution of alcohol on installations and in communities; increasing medical provider education and tracking related to prescription drugs; adopting universal, selective, and indicated prevention strategies for personnel and their families; improved program evaluation; continued revision to drug testing panels; and, the integration of Screening, Brief Intervention, and Referral to Treatment (SBIRT) protocol into primary care.

This finding is consistent with DoD's review. The listed DoD actions address this IOM recommendation.

**DoD Action 1: The Department will implement a comprehensive set of evidence-based prevention programs and policies that include universal, selective, and indicated interventions.**

DoD policy will require the DoD Components: (a) to utilize empirically validated programs to prevent problematic substance use on installations and facilities under DoD control; (b) to

educate DoD personnel about health and other risks to military readiness associated with problematic substance use; (c) to ensure that commanders and healthcare personnel receive annual training on the identification, assessment and referral of personnel displaying signs of problematic substance use; and, (d) to identify beneficiaries who are problematic substance users and provide treatment, consultative, or psycho-educational services.

Specifically, DoD and the Services will broaden collaboration with the Office of Juvenile Justice and Delinquency Prevention (OJJDP) to expand the Enforcement Underage Drinking Laws (EUDL) program, which utilizes a social community approach to the prevention of underage drinking. Service members are often assigned to locations that permit drinking at ages below what is allowed in the United States. This may contribute to the adoption of drinking behavior that is unacceptable in U.S. culture. In an effort to combat underage drinking, the Air Force entered into a partnership with the OJJDP to establish community coalitions aimed at enforcing underage drinking laws nationwide. Nine Air Force bases participated in the EUDL program funded by the OJJDP, with four additional bases currently in the implementation phase. The initial published studies<sup>3</sup> of this program have shown reductions in “Driving While Intoxicated” and underage drinking arrests, while other research revealed reductions in self-reported alcohol consumption.

**DoD Action 2: To enhance community collaborations that are consistent with providing broad preventive strategies for children and families, the recently reissued DoD Instruction (DoDI) 1010.01, “Military Personnel Drug Abuse Testing Program (MPDATP),” requires the Secretaries of the Military Departments to issue guidance supporting participation of Service members and their families in community anti-drug awareness and education programs in schools, local sporting events, and other community activities.**

DoD sponsors universal prevention campaigns at military installations, such as the Drug Abuse Resistance Education program and the National Family Partnership’s Red Ribbon Week which encourage Service members, families, and citizens to lead healthy, drug-free lifestyles. A collaborative prevention effort between each military Service and the Department of Defense Education Activity resulted in the overseas school-based Adolescent Substance Abuse Counseling (ASAC) program. ASAC professional counselors provide community and individual substance abuse education, as well as screening and treatment to adolescents and their families.

**DoD Action 3: DoD will continue to improve the flexibility of IT systems to improve the transfer of pharmacy information.**

The dispensing and tracking of prescription medications in a manner that best safeguards and provides oversight of their therapeutic use is both a national and DoD concern. TRICARE beneficiaries receive prescription medications from both the direct care system through MTFs and the purchased care system through a civilian network of authorized pharmacies.

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<sup>3</sup> U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention. (2011). *Reducing Drinking Among Underage Air Force Members in Five Communities [Bulletin]*. Washington, DC: Spera, C., Franklin, K., Uekawa, K., Kunz, J. F., Szoc, R. Z., Thomas, K. R., & Cambridge, M. H.

The DoD Pharmacy Data Transaction Service (PDTS) matches real-time prospective drug utilization with a patient's medication history for each new or refilled prescription before it can be dispensed to the patient. PDTS flags beneficiaries associated with an excessive number of: controlled substance claims; pharmacies used to obtain controlled drugs; and/or prescribing providers. These beneficiaries are then asked to enroll in the Department's "1-1-1 Program" which identifies a single prescribing physician, a single pharmacy, and a single emergency room and facility for their care. Flagged beneficiaries who decline to participate in the program are blocked from TRICARE reimbursement for their pharmacy claims.

Prescription drugs issued in deployed locations are inconsistently received by the PDTS due to varying connectivity in austere conditions. Additionally, although PDTS receives pharmacy data from the States, the reciprocation of information sharing is not automatic due to unique state laws and IT requirements. As states request PDTS interoperability, DoD coordinates with each state's IT experts to build network bridges that facilitate pharmacy exchanges.

**DoD Action 4: DoD will continue the dissemination of provider education toolkits and will pursue development of an interactive computer-based training program on substance use treatment issues, particularly prescription drug misuse and abuse.**

The Assistant Secretary of Defense for Health Affairs (ASD/HA) issued a memorandum in March 2011 tasking the Services to educate providers on the management of opioid therapy. Consistent with the ASD/HA's direction, the DoD disseminated the Veterans Administration (VA)/DoD Clinical Practice Guidelines (CPG) for the Management of Opioid Therapy, and the Defense Center of Excellence for Psychological Health and Traumatic Brain Injury is promoting a new CPG-based Substance Use Disorder Toolkit to medical providers.

**DoD Action 5: DoD will continue to revise the drug testing panel to include a broader range of potential drugs of abuse when scientifically feasible and legally binding means permit it.**

The benefits of drug testing as a surveillance tool and deterrent to the misuse and abuse of illicit drugs are well documented and recognized by the DoD, resulting in the expansion of the current drug testing panel to include additional drugs of abuse. However, the advent of designer drugs and the lag in the development of new drug assays to test for such drugs presents a challenge to the Department's comprehensive drug testing program. The Drug Demand Reduction Program and the Armed Forces Medical Examiner's Office are engaged in pilot programs and studies to identify reliable and legally-sufficient drug testing methods to allow for the detection of synthetic cannabinoids (that is, "spice") and other designer drugs. As scientifically validated assays for the screening of such drugs become available, the Department will assess their addition to the drug testing program.



## **Developing Strategies for Identifying, Adopting, Implementing, and Disseminating Evidence-Based Programs and Best Practices for Substance Use Disorder Care**

***IOM Recommendation 2:** DoD should assume leadership in ensuring the consistency and quality of SUD services. DoD also should require improved data collection on substance use and misuse, as well as the operation of SUD services.*

The IOM proposed a series of actions to address a perceived underutilization of evidence-based practices and a lack of standardization, monitoring, and evaluation of SUD policies and programs by DoD and the Services, including implementation of published VA/DoD CPGs.

### **DoD Action 6: DoD policy will require the Services to reinforce utilization of VA/DoD SUD Clinical Practice Guidelines in accordance with current policy.**

The implementation of programs and services that are consistent with current evidence-based practices is a primary responsibility of each Military Health System (MHS) medical provider. DoD acknowledges the need to make the application of such standards overt in policy and provide guidance on the implementation of such care.

### **DoD Action 7: DoD will develop program evaluation metrics via the Addictive Substance Misuse Advisory Committee.**

Consistent with its charter, the ASMAC continues to review surveillance systems, data collection needs, data requirements, and efforts related to the prevalence, reduction, prevention, and treatment of addictive substance use, abuse, and addiction.

***IOM Recommendation 3:** DoD should conduct routine screening for unhealthy alcohol use, together with brief alcohol education interventions.*

The IOM proposed a series of actions related to alcohol use screening, including utilization of the SBIRT program.

### **DoD Action 8: The Department will require standardized screening for unhealthy alcohol use in primary care and educating primary care medical providers on the proper use of screening tools and appropriate interventions, including patient education and brief interventions that do not require command notification.**

The Office of National Drug Control Policy, the Substance Abuse and Mental Health Service Administration, and the VA endorse the use of the SBIRT program in primary care and the Department is currently in the implementation phase. SBIRT includes the routine screening of patients for unhealthy alcohol use by using an empirically validated measure and prescribes interventions consistent with an identified risk. While AD personnel are routinely screened during the deployment cycle, widespread implementation of SBIRT within primary care settings

provides an opportunity for early identification of substance abuse, allowing for proper intervention with MTF beneficiaries as needed.

DoD policies are in coordination that require implementation of the SBIRT model in primary care settings. To date, 6477 providers received training in conducting these types of assessments and brief interventions. Use of the three-item Alcohol Use Disorders Identification Test has been incorporated into electronic medical record primary care workflow forms for use in the Patient Centered Medical Home (PCMH). In addition, Post-Deployment Health Assessment (PDHA) and Post-Deployment Health Re-Assessment (PDHRA) forms were recently revised to provide additional guidance for providing feedback to Service members based on their risk for unhealthy alcohol use.

***IOM Recommendation 4: Policies of DoD and the individual branches should promote evidence-based diagnostic and treatment processes.***

DoD proposed a series of actions consistent with current evidence-based practices which include increasing the use of pharmacotherapies, including maintenance therapies for opioid dependence and allowing individual providers to deliver treatment for SUDs outside of SUDRF. Such actions include proposed revisions to the Code of Federal Regulations and DoD policy.

**DoD Action 9: DoD has published a proposed rule lifting the ban on the use of opioid replacement therapies and will incorporate public comments in considering policy changes regarding the use of such pharmacotherapies as an additional intervention for SUD when indicated.**

Currently, TRICARE excludes treatment using drugs with addictive potential, that is, drug substitution therapies or opioid replacement therapy. DoD published a Proposed Rule to lift the ban on these pharmacotherapies in the Federal Registry on December 29, 2011. DoD received public responses to that proposed rule and is completing its internal review prior to publication of a Final Rule. Pharmacological treatment of opioid dependence is consistent with modern day medical practice. Lifting of the ban on the use of opioid replacement therapies would make these pharmacotherapies available to all TRICARE beneficiaries.

**DoD Action 10: DoD will explore alternatives that would permit the delivery of SUD care in settings outside of a SUDRF in a broader range of treatment settings.**

The TRICARE benefit currently limits SUD care to treatment services delivered only by a hospital-based or free-standing SUDRF. The Department is reviewing regulatory language that would recognize individual providers and non-SUDRFs institutions as authorized SUD treatment providers.

***IOM Recommendation 5: DoD and the individual branches should better integrate care for SUDs with care for other mental health conditions and ongoing medical care.***

The IOM proposed a series of actions that would integrate SUD prevention activities and deliver behavioral healthcare in primary care settings.

**DoD Action 11: DoD will continue to hire behavioral health personnel for placement in primary care settings and ensure they are trained in SUD prevention, screening, and brief intervention activities.**

In addition to the instituted military service programs that assign behavioral health providers to primary care clinics, DoD has funded 470 additional behavioral health positions in PCMH clinics. A DoD policy document is currently in internal coordination to provide guidance and standardization regarding the duties and roles of behavioral health providers in primary care.

Along with the integration of behavioral health providers in primary care, a parallel revision of DoD policy is in coordination that requires screening for SUDs and appropriate interventions in primary care. These combined efforts will ensure an integrated approach to the screening, education, and early intervention of personnel for unhealthy alcohol use.

**DoD Action 12: DoD and the Services will further assess the privileging and credentialing of SUD providers to ensure that the practice of independently licensed practitioners is not needlessly restricted.**

DoD will refer the IOM's finding on credentialing to the DoD/VA Credentialing Workgroup for further evaluation and appropriate action. In addition, the ASMAC will work with the Services to examine credentialing.

***IOM Recommendation 6:** The Military Health System should reduce its reliance on residential and inpatient care for SUDs in its direct care system and build capacity for outpatient and intensive outpatient SUD treatment using a chronic care model that permits patients to remain connected to counselors and recovery coaches for as long as needed.*

The IOM proposed a series of actions which include the ongoing monitoring and support of those undergoing treatment and provision of additional levels of treatment beyond residential and inpatient SUD care.

**DoD Action 13: DoD policy will specify the provision of a full spectrum of SUD treatment and aftercare services.**

DoD will reconcile the IOM recommendation to reduce its reliance on residential and inpatient care for SUDs in its direct care system with the requirement from Congress specified in the 2010 NDAA, section 596, that DoD must build up its long-term inpatient SUD treatment capacity. The policy will direct the MHS to provide all levels of SUD treatment consistent with the American Society of Addiction Medicine recommendations.

## **Increased Access to Care**

***IOM Recommendation 7:** DoD should update the TRICARE SUD treatment benefit to reflect the practices of contemporary health plans and to be consistent with the range of treatments available under the Patient Protection and Affordable Care Act.*

The IOM recommends that the DoD comply with the Patient Protection and Affordable Care Act, which mandates adherence to the Mental Health and Parity and Substance Abuse Equity Act. Specifically the IOM states, “TRICARE benefits for mental health and SUDs should conform to the Mental Health Parity and Substance Abuse Equity Act, and quantitative and nonquantitative limits on behavioral health services should be eliminated. The requirement to use SUDRFs should be removed from the TRICARE benefit for the treatment of SUDs, and the benefit should be expanded to include care in outpatient and intensive outpatient treatment settings.”

**DoD Action 14: TRICARE coverage for SUD treatment will continue to be reviewed and revised within the constraints of governing laws and current standards of practice in addiction medicine.**

Department reviews of the TRICARE SUD benefit have examined the full range of proven SUD treatment interventions available to beneficiaries. These efforts have resulted in a series of proposed actions, to include the expansion of the TRICARE benefit for intensive outpatient treatment, allowing office-based treatment services provided outside of a SUDRF, and the removal of lifetime limits on SUD treatment services.

SUD treatment services for military personnel and TRICARE beneficiaries, provided through MTFs and contracted services through the TRICARE purchased care system, must comprise a full range of evidence-based treatments and services. TRICARE has covered intensive outpatient program (IOP) treatment to date by reimbursing for IOP services when the institutional provider is certified as a Partial Hospitalization provider. Proposed revisions to the TRICARE SUD benefit under review include making IOP coverage more explicit in TRICARE regulations, with the goal of increasing the number of TRICARE-authorized IOP programs available to beneficiaries.

***IOM Recommendation 8: DoD should encourage each service branch to provide options for confidential treatment of alcohol use disorders.***

The IOM proposed the expansion of confidentiality for SUD treatment.

**DoD Action 15: Department policy will reinforce the implementation of DoDI 6490.08 “Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members,” which encourages voluntarily sought substance abuse education and helps to fosters a culture of support in the provision of mental health care.**

DoD recognizes that stigma is a barrier to seeking mental healthcare and published in August, 2011, DoDI 6490.08 “Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members” encourages provision of voluntarily drug and alcohol abuse education for Service members and provides guidance for the balance between patient confidentiality rights and the commander’s right to know regarding the health status of personnel for operation and risk management decisions.



**DoD Action 16: DoD will review the findings of the U.S. Army's CATEP, which has expanded confidential substance use treatment services.**

Confidential education and treatment for substance use related problems has many potential benefits. Greater privacy may increase the number of personnel self-referring for services due to the decrease of stigmatization in individuals receiving SUD treatment services. DoD continues to monitor the U.S. Army's CATEP pilot program which offers confidential SUD treatment services to personnel who self-refer for care. The U.S. Army's CATEP program was initiated in 2009 and to date has had over 1300 soldiers inquire about services with more than 900 of them receiving services. Program outcomes are currently being analyzed to assess the program's effectiveness.

***IOM Recommendation 9:** DoD should establish a joint planning process with the VA, with highly visible leadership (perhaps recently retired military personnel), to address the SUD needs and issues of access to care for Reserve Component personnel before and after mobilization.*

The IOM proposed a series of actions which include the leveraging of technologies to reach RC personnel and veterans, including those with other than honorable discharges from military service.

**DoD Action 17: DoD will leverage the DoD-VA Health Executive Committee (HEC) to improve the continuity of care and transition for demobilized RC personnel and coordinate opportunities for outreach.**

The DoD and VA have existing administrative structures designed to address SUDs and other behavioral healthcare issues through the DoD-VA HEC and its subordinate DoD-VA Psychological Health and Traumatic Brain Injury workgroup (PH/TBI WG). The new charter for the PH/TBI WG will designate Addictive Disorders subject matter experts for both DoD and VA as permanent members.

The HEC also commissioned the DoD-VA Integrated Mental Health Strategy (IMHS), which contains several joint strategic actions between the two Departments designed to address access to care for the Reserve Component. IMHS Strategic Action #13, "the *inTransition* Program," currently assigns a masters-level mental health coach who is available by telephone to Service members that are transitioning between health care systems. The *inTransition* Program is being expanded to include referral resources for redeploying Service members identified with mental health or substance use concerns on the PDHA/PDHRA.

Three IMHS Strategic Actions address outreach to personnel after mobilization: IMHS Strategic Action #3, "Vet Center Expansion to OEF/OIF Active Duty;" Strategic Action #4, "Reintegration Counseling Service Mobile Vet Center expansion to Service Members and Veterans in Rural Areas;" and, Strategic Action #18, "Community Partnerships." DoD will review the milestones associated with these strategic actions and propose revisions to ensure that SUD issues are specifically addressed.

**DoD Action 18: DoD will consider new approaches to leverage tele-medicine as a medium to implement services to both AD and RC personnel.**

IMHS Strategic Action #6, “Telemental Health,” develops technical, business, and clinical processes for implementing joint DoD and VA telemental health services. The National Center for Telehealth and Technology recently completed a comprehensive gap analysis of DoD telemental health services for behavioral healthcare. They are currently implementing several initiatives to increase access to care. Some initiatives include increased access to care via technological resources, online resource locators, and training for military behavioral health providers.

***IOM Recommendation 10:** DoD and the individual service branches should evaluate the use of technology in the prevention, screening, diagnosis, treatment, and management of SUDs to improve quality, efficiency, and access.*

The IOM proposed expanding technological approaches in the delivery of SUD prevention and treatment services.

**DoD Action 19: DoD and the military Services will standardize new TriService Workflow forms and automation of an Armed Forces Health Longitudinal Technological Application (AHLTA)-based clinical tool for screening, review of systems, evaluation, and intervention.**

The primary care electronic medical record for the PCMH incorporated an AHLTA-based tool for screening, review of systems, evaluation, and intervention for unhealthy alcohol use. This tool also incorporates clinical reminders and training videos for medical providers. The standardization of the Tri-Service Workflow Forms and the automation of the AHLTA-based clinical tool will improve quality, efficiency, and access to care.

The ASMAC is facilitating cross-Service sharing of successful technological innovations. For example, the findings of the 2011 HRB survey suggest that social marketing and messaging could be effective in SUD prevention, education, and treatment.

## **Strengthening the SUD Workforce**

***IOM Recommendation 11:** The individual service branches should restructure their SUD counseling workforces, using physicians and other licensed independent practitioners to lead and supervise multidisciplinary treatment teams providing a full continuum of behavioral and pharmacological therapies to treat SUDs and comorbid mental health disorders.*

The IOM proposed a series of actions which include addressing any shortages in addiction trained personnel and the updating of training materials used to educate para-professional personnel.

**DoD Action 20: DoD will implement policy changes to provide a more uniform level of certification for all para-professional staff who deliver SUD care and will direct that academic training materials and policy standards are updated and consistent with their role in the delivery of care.**

The military Services employ para-professional personnel to deliver SUD services as part of a multidisciplinary team. These personnel practice under the direct supervision of licensed professional personnel who are privileged by the MTF to provide care. Although the IOM stated the role of “individuals certified as alcohol and drug counselors is increasingly limited and in the near future may disappear,” these para-professional SUD counselor personnel provide a level of service that is unique and necessary to the DoD health care mission.

The Services continue to seek qualified personnel to fill SUD positions. Para-professional personnel bring unique and necessary experiences to the delivery of SUD services. Para-professional counselors are often embedded in units and act as a liaison between commanders and medical treatment personnel. These para-professionals provide unit training improving access to SUD services in austere locations, and combat stigma associated with SUD care.

DoD policy will standardize para-professional certification and training in SUD care, and each military Service is reviewing training for para-professionals to ensure that they are consistent with current standards of practice in addiction medicine.

***IOM Recommendation 12:** DoD should incorporate complete data on SUD encounters into the MDR database and recalculate the PHRAMS estimates for SUD counselors.*

The IOM proposed adjustments to the PHRAMS for projecting the need for behavioral health personnel.

**DoD Action 21: DoD will explore options for capturing complete SUD counselor workload and staffing requirements in future iterations of the PHRAMS.**

DoD’s development of PHRAMS is intended to estimate medical personnel requirements using the Medical Data Record (MDR) for encounter-based clinical care and does not record non-medical workload, such as preventive and educational counseling. Version 4 of PHRAMS was released in December 2012, and changes to Version 5 for FY13 are already completed. The ASMAC will explore adding SUD encounter data in AHLTA for capture by the MDR database, and for the next iteration of PHRAMS, DoD will alternatively explore adding non-medical SUD counseling workload as an adjustment to the treated prevalence rates and/or projected encounters that contribute to staffing forecasts in the PHRAMS algorithm.

PHRAMS is a flexible, population-based staffing model and user application that projects the total staffing requirements for psychological health services for Defense Health Plan eligible beneficiaries. The model takes into account demographic and deployment risk factors to forecast future psychological health staffing needs throughout the MHS.

## 3.0 Update on Substance Use in the Military

### 2011 Health Related Behaviors Survey

The HRB survey, which is administered every 3 years to ADSMs, requests that members of the Armed Forces voluntarily respond to an anonymous automated survey that collects data related to the prevalence of smoking, substance misuse, and other areas of behavioral health. This study informs Departmental actions on the revision and development of effective policy and program strategies intended to improve the prevention, diagnosis, and treatment of SUDs.

The initial DoD report to Congress relied on both internal data analysis and the overall findings from the 2008 HRB survey. The recent IOM report also relied heavily on findings of the 2008 HRB survey. While these reports were underway, DoD was actively preparing and implementing the 2011 HRB survey. Due to the significant changes in survey questions and methodology for the 2011 HRB survey, direct comparison of the 2011 HRB survey findings with those of previous reports is not appropriate (that is, survey findings from different survey years cannot be used to identify trends over time). However, improvements to the 2011 survey methodology have resulted in a more transparent and accurate assessment of the status of health related behaviors in the military. Below are selected findings from the 2011 HRB survey.

### Alcohol-related Findings of the 2011 HRB Survey

Overall the survey found that 84.5 percent of AD personnel are current drinkers, with 58.6 percent classified as light or infrequent drinkers. However, 8.4 percent are heavy drinkers (defined as averaging more than 14 drinks/week for males and more than 7 drinks/week for females in the past 12 months), and 33.1 percent reported binge drinking (defined as 5 or more drinks for males and 4 or more drinks for females on one occasion in the past month). The definitions for heavy drinking and binge drinking were modified between the 2008 and 2011 HRB survey, with the recent survey utilizing definitions established by the 2010 National Health Interview Survey from the Centers for Disease Control and Prevention.

Figures 1-4 report percentages based on weighted data and not the raw percentage of respondents. When examining the relationship between age and alcohol use (Figures 1 and 2), the findings reveal that 18 to 35 year old personnel report heavy drinking almost double their civilian comparison groups. Reported heavy drinking is less in populations who are 36 years and older. However, binge drinking rates by age tends to be below the civilian rate, but still higher than the Healthy People 2020 target of 24.3 percent. This suggests that the Department's efforts to address binge drinking are contributing to lower binge drinking rates. Additional improvements to the screening of personnel during medical encounters may result in early identification of unhealthy drinking and provide opportunities for early intervention.

Heavy and binge drinking rates vary by Service and gender (Figures 3 and 4). At 18 percent, the prevalence of heavy drinking is highest among Marine Corps enlisted personnel. While each Service differs in their demographic make-up and mission, the specific reasons for such a wide



variation in alcohol use rates are unclear. However, these data provide the Department with identified demographic groups who may be targeted for specific prevention programs and services. Further study is necessary to determine causation, motivation, and potential protective factors needed to reduce harmful alcohol use among specific sub-populations.

**Figure 1: Heavy Alcohol Use by Age Among Military Personnel**

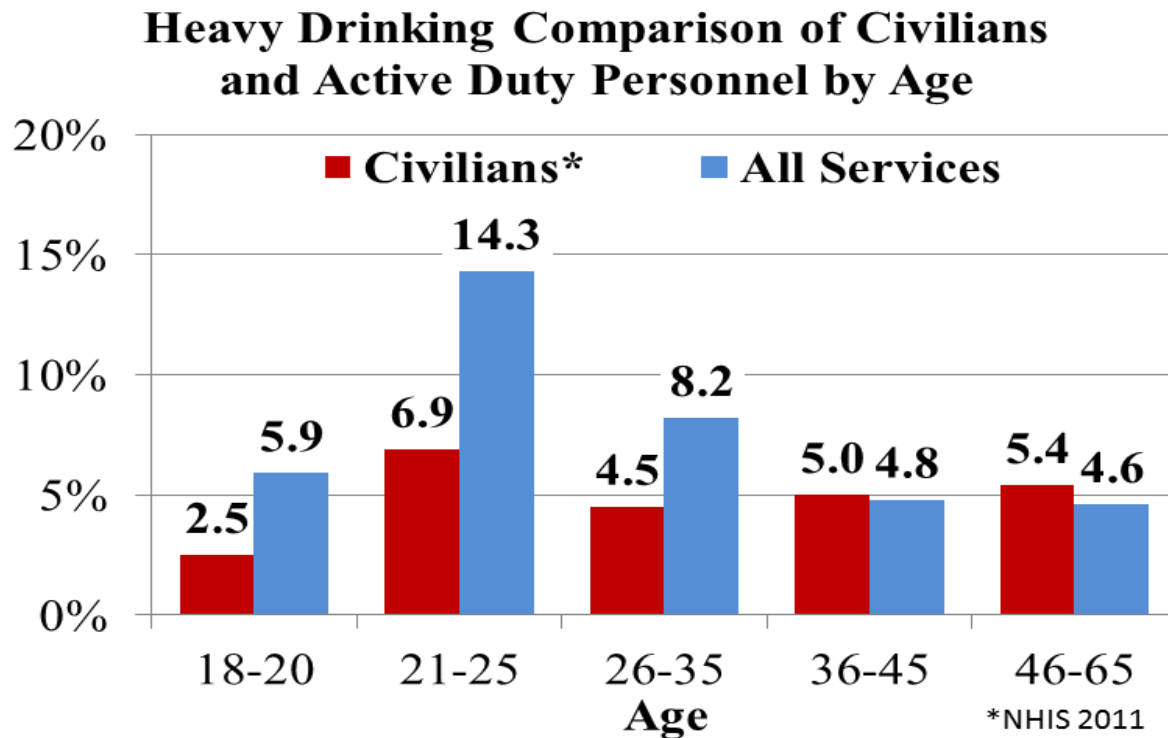


Figure 2. Binge Drinking by Age Among Military Personnel

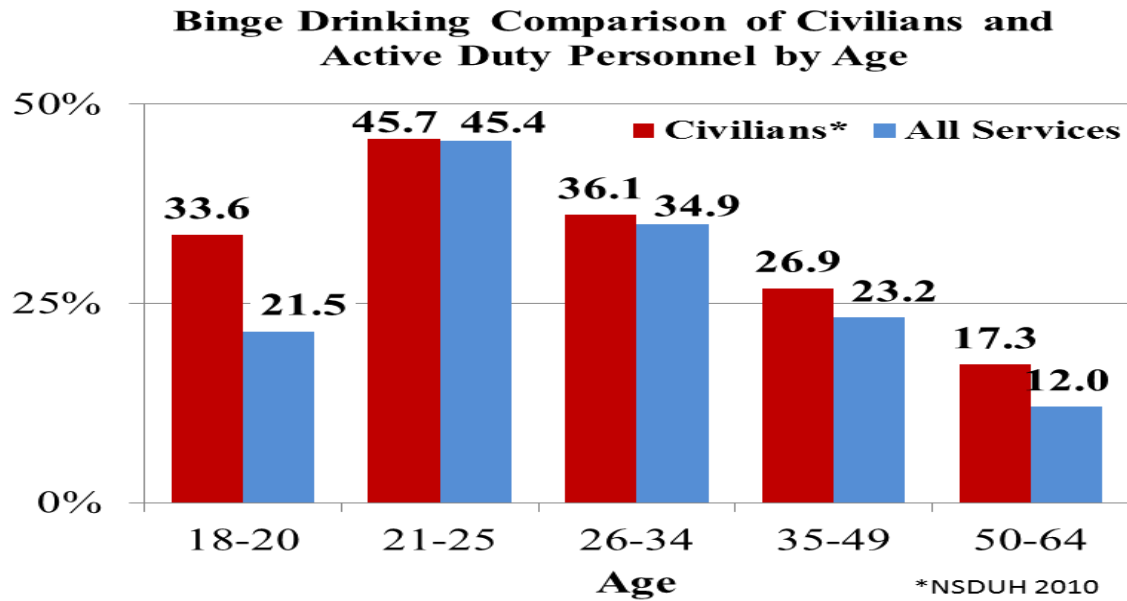
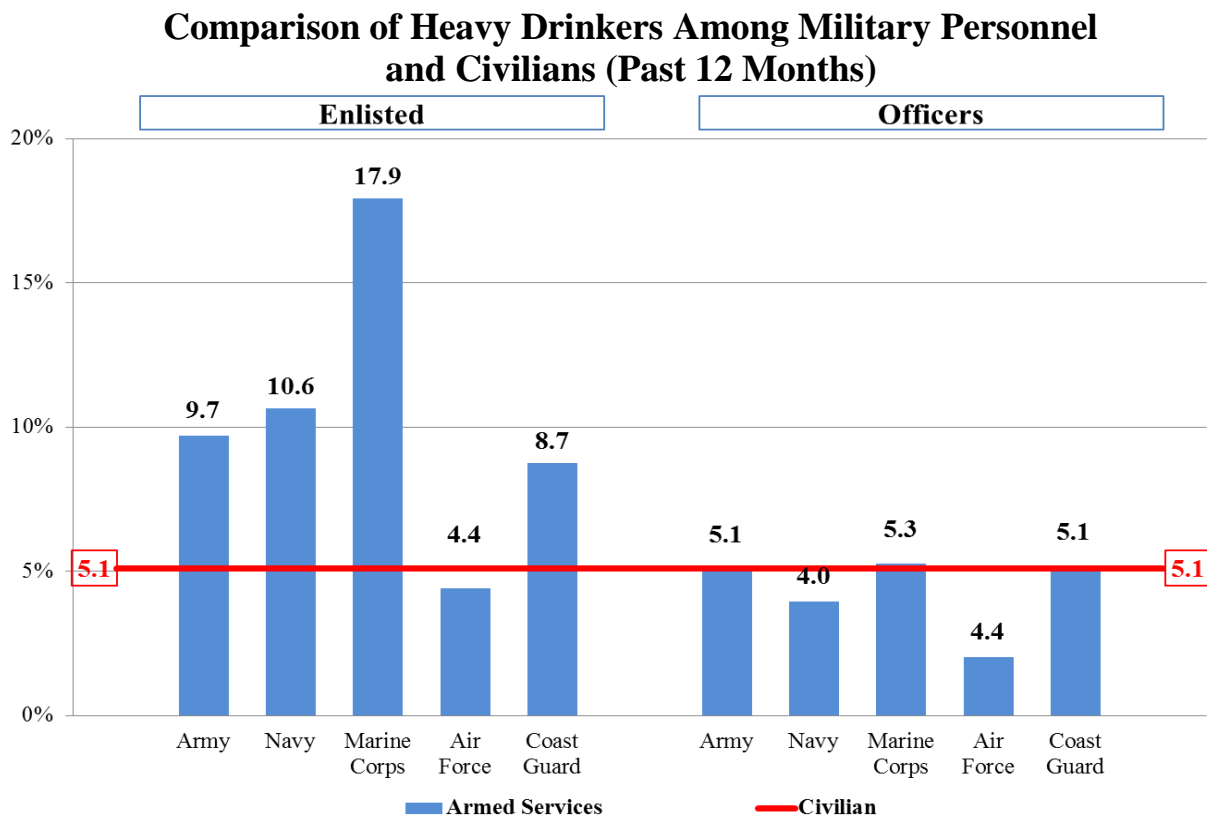
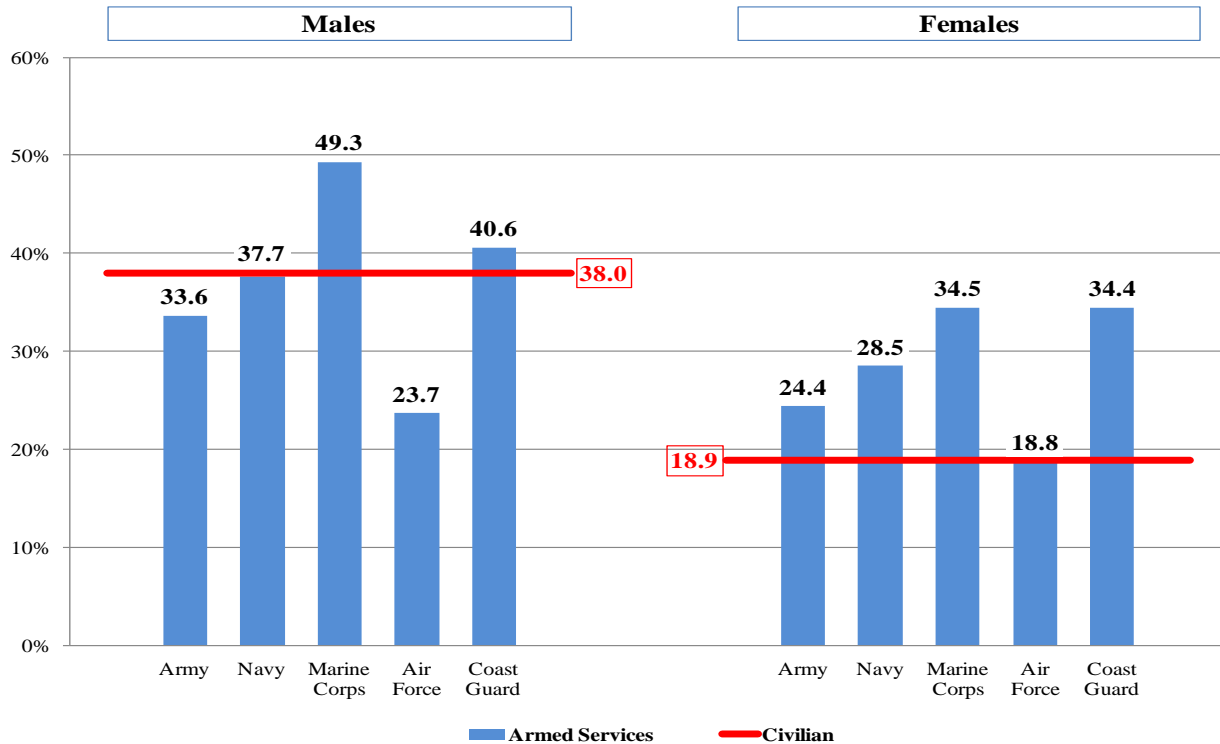


Figure 3: Heavy Drinking by Service Affiliation



**Figure 4: Binge Drinking by Service Affiliation**  
**Binge Drinking Estimates Among Military Personnel**  
**and Civilians Past 30 Days**



The HRB survey included questions to inform the Department about the types of behavioral and environmental conditions which serve as alcohol use deterrents (Figure 5). The findings suggest that the cost of alcohol in particular may be leveraged to reduce alcohol consumption. As was identified in the initial 2011 DoD report to Congress, educating family members about alcohol abuse may inhibit unhealthy alcohol use, or facilitate the early identification of those requiring assistance.

**Figure 5: Alcohol Use Deterrents**  
**Drinking Deterrents Among Current Drinkers**

Deterrent	Percent of		
	Light Drinkers	Moderate Drinkers	Heavy Drinkers
1 Costs too much	24.1%	16.4%	17.7%
2 Makes me do things I'm sorry for later	4.1%	2.9%	6.6%
3 Family/friends get upset	4.7%	3.2%	6.5%
4 Might interfere with military career	4.4%	2.5%	3.8%
5 Drinking can get me in trouble with police	3.5%	1.8%	2.7%
6 Difficult to get	1.6%	1.1%	1.9%

### **Prescription Drug Findings of the 2011 HRB Survey**

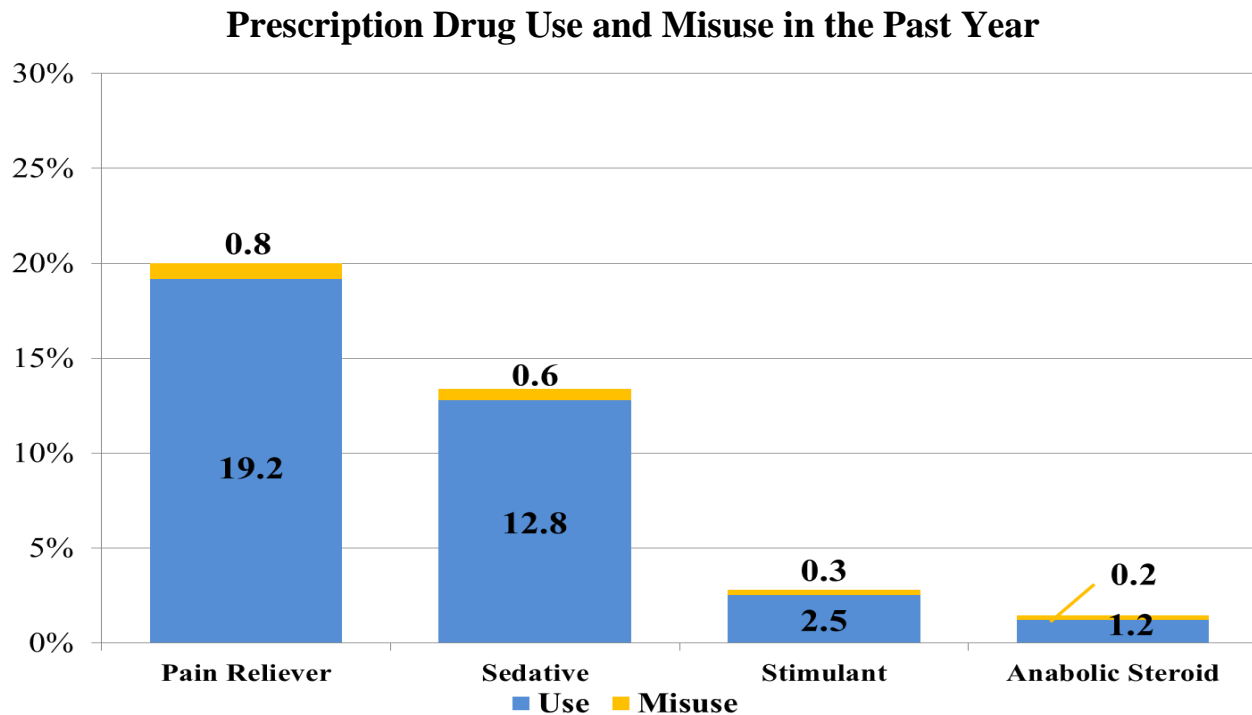
Tremendous innovations have been made in the treatment of battlefield trauma. The survival rate of U.S. Service members who have suffered a combat injury has never been higher. However, after the initial treatment of trauma there is often a need to manage the enduring effects of pain and disability. This has contributed to an increased number of prescriptions being issued to treat pain stemming from injuries.

As a result of DoD concerns related to prescription drug misuse, questions related to the use and misuse of prescription drugs were revised not only for the 2011 HRB survey, but also for the 2008 and 2005 HRB surveys. In the current 2011 survey, responses to prescription drug misuse questions were clarified to read as follows:

- 1) The drug was prescribed for someone else and I used in the past year, or obtained prescription medication another way and I used in the past year (prescription target); OR
- 2) Used a greater amount than prescribed (prescription amount used); OR
- 3) Used to feel good, get high, or buzzed, etc.

The survey data reveal that Service members more often reported proper use of prescription drugs than misuse, with use of prescription pain relievers (17 percent) and sedatives (11 percent) reported most often in the past year, and stimulants and anabolic steroids reported least often. Less than 1 percent of respondents reported misusing each of the four prescription drugs categories queried (Figure 6).

Figure 6: Prescription Drug Use and Misuse



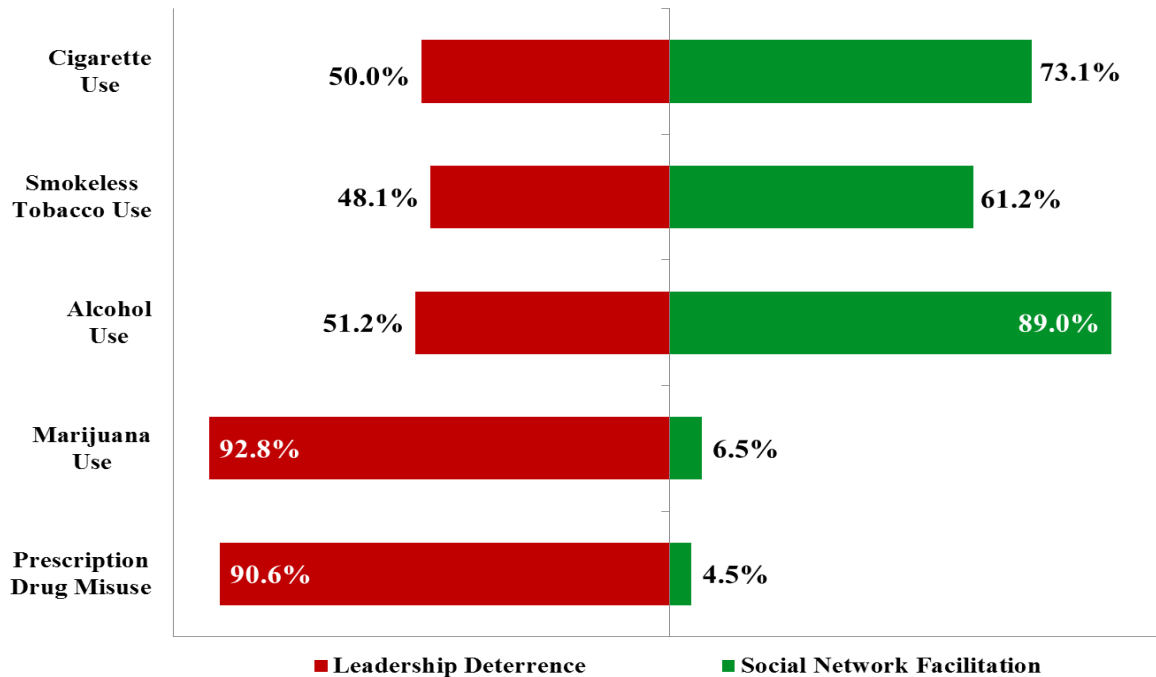
### Military Cultural Attitudes Regarding Substance Use

As a global assessment of the influence that military culture may have on substance use, the 2011 HRB Survey asked respondents about the social determinants for substance use. Figure 7 depicts two independent issues: One is leadership deterrence, or the extent to which supervisor and installations discourage the use of the substance, which can range from zero to 100 percent. The second is social network facilitation, or the extent to which an individual's friends are using each of the substances, which can also range from zero to 100percent. The figure represents two different scales displayed side-by-side and is not cumulative.

The majority of Service member's reported experiencing greater social network facilitation than leadership deterrence for legal substance use, including alcohol. Only about half of personnel perceived that their leadership deterred tobacco or alcohol use. However, the vast majority of personnel reported greater leadership deterrence of illegal drug use (marijuana and prescription drug misuse) compared to social network facilitation for use of these drugs. Although these findings reveal lower rates of substance use for military cultures with greater leadership deterrence, respondents may be less willing to acknowledge illegal substance use, and their behavior may be shaped by on-going drug testing and medical oversight. However, these findings suggest further opportunities for military leadership to make their expectations clear regarding the misuse of substances.



**Figure 7: Military Culture of Substance Use**



### Implications of the 2011 Survey of Health Behaviors

The findings from the 2011 HRB survey are consistent with the qualitative reports received from substance use treatment programs across the Services. Alcohol remains the dominant substance of misuse and abuse. Each Service has utilized unique programs, social marketing, and messaging to combat binge drinking. The abuse of alcohol is contrary to military readiness and remains a Department focus.

The Department also recognizes that prescription medication misuse and abuse remains a threat to the management of personnel with acute and chronic pain. The availability of medications that provide relief to those who suffer also creates opportunistic avenues for drug diversion. It is incumbent on Service medical departments to educate practitioners on these risks and to ensure that all methods of pain control are employed as part of a comprehensive pain management plan. Whether personnel use greater amounts of prescription medication than prescribed due to poor pain control or due to drug diversion for abuse, prescribing practitioners must be sensitized to the potential for prescription drug misuse and the risks associated with it.

## 4.0 Summary

This report reconciles the findings resulting from IOM study on substance use issues in the U.S. Armed Forces and the DoD's 2011 review of policies and programs related to the prevention, diagnosis and treatment of SUDs. This report updates the DoD's 2011 "Comprehensive Plan on Prevention, Diagnosis, and Treatment of Substance Use Disorders (SUDs) and Disposition of Substance Use Offenders in the Armed Forces," and identifies activities that are either established or pending that DoD will pursue to address the policy and program gaps identified in the two reports.

The Department has engaged in a series of activities intended to re-energize SUD prevention efforts which include universal, selective, and indicated prevention strategies. The placement of behavioral health personnel in primary care medical settings is intended to combat stigma associated with receiving mental healthcare and provides an opportunity to improve the early screening, identification, and intervention of many mental health conditions.

In the MHS direct care system, the DoD is implementing policies that set a uniform level of certification for para-professional staff who deliver SUD care, and the military Services will ensure that academic training material and standards are updated and consistent with their role in the delivery of SUD treatment services.

DoD currently has policies in coordination that requires the use of the VA/DoD SUD CPGs when delivering treatment services. In the purchased care system, several proposed changes to the TRICARE SUD benefit are under review in order to ensure a SUD benefit that is consistent with current standards of practice.

This report also highlights the most recent (2011) population-based HRB survey findings related to substance use. New study methods more accurately depict behaviors consistent with substance abuse. The latest findings provide DoD with current information that will be used to develop and target SUD prevention and intervention programs.

## List of References

- DoD. (July 2011). Report to Congress – Comprehensive Plan on Prevention, Diagnosis, and Treatment of Substance Use Disorders and Disposition of Substance Abuse Offenders in the Armed Forces.
- DoD Instruction 1010.01, Military Personnel Drug Abuse Testing Program (MPDATP), September 13, 2012.
- DoD Instruction 6490.08, Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members, August 17, 2011.
- ICF International. (2012, pending public release). Department of Defense Survey of Health Related Behaviors Among Active Duty Military Personnel, 2011.
- Institute of Medicine. (September 2012). Substance Use Disorders in the U.S. Armed Forces.
- RTI International. (2009). Department of Defense Survey of Health Related Behaviors Among Active Duty Military Personnel, 2008.
- RTI International. (2006). Department of Defense Survey of Health Related Behaviors Among Active Duty Military Personnel, 2005.

## Appendix A – List of Acronyms

AD – Active Duty  
ADSM – Active Duty Service Member  
ASD/HA – Assistant Secretary of Defense for Health Affairs  
ASAC – Adolescent Substance Abuse Counseling Program  
ASMAC – Addictive Substance Misuse Advisory Committee  
CATEP – Confidential Alcohol Treatment and Education Pilot  
CPG – Clinical Practice Guidelines  
DoD – Department of Defense  
DoDD – Department of Defense Directive  
DoDI – Department of Defense Instruction  
EBP – Evidence-Based Practices  
EUDL – Enforcing Underage Drinking Laws  
FHP&R – Force Health Protection and Readiness  
HEC – Health Executive Council  
HRB –Health Related Behaviors, Department of Defense Survey  
IMHS – Integrated Mental Health Strategy  
IOM – Institute of Medicine  
MTF – Military Treatment Facility  
MHS – Military Health System  
NDAA – National Defense Authorization Act  
NSDUH – National Survey on Drug Use and Health  
OEF – Operation ENDURING FREEDOM  
OIF – Operation IRAQI FREEDOM  
OJJDP – Office of Juvenile Justice and Delinquency Program  
OSD – Office of the Secretary of Defense  
PCMH – Patient Centered Medical Home  
PDHA – Post Deployment Health Assessment  
PDHRA – Post Deployment Health Re-Assessment  
PDTs – Pharmacy Data Tracking Service  
PHA – Periodic Health Assessment  
PHRAMS – Psychological Health Risk-Adjusted Model for Staffing  
RC – Reserve Component  
SBIRT – Screening, Brief Intervention, Referral and Treatment  
SC – Service Component  
SUD – Substance Use Disorder  
SUDRF – Substance Use Disorder Rehabilitation Facility  
TBI – Traumatic Brain Injury  
VA –Department of Veterans Affairs  
VHA – Veterans Health Administration

## Appendix B – IOM Subject Heading and Findings

### Policies and Programs on Substance Use Disorders

*Finding 6-1: DoD and branch policies recognize the deleterious effects of alcohol and other drug use and support the need for SUD prevention, but programs fall short of meeting this need.*

*Finding 6-2: DoD and branch screening policies and programs fall short of identifying all service members who have or are at risk for developing SUDs.*

*Finding 6-3: Military policies reflect different attitudes toward alcohol and other drug use.*

*Finding 6-4: There is substantial variability among SUD-related policies, programs, procedures, and instruments across the military branches.*

*Finding 6-5: DoD and the branches do not evaluate programs and initiatives consistently and systematically.*

*Finding 6-6: DoD and branch policies support the use of evidence-based prevention and treatment but do not identify specific practices.*

*Finding 6-7: Integration of SUD care with other behavioral health and medical care is lacking.*

*Finding 6-8: DoD and branch policies are largely silent on comprehensive programs and services for SUD prevention, screening and brief intervention, diagnosis, and treatment for military dependents.*

*Finding 6-9: DoD and the branches rarely use technology to enhance the delivery of screening, diagnosis, and treatment services.*

### Access to Care for Substance Use Disorders

*Finding 7-1: There is a significant unmet need for SUD care among service members in the U.S. armed forces.*

*Finding 7-2: Access to care is restricted by the TRICARE SUD benefit's lack of coverage of intensive outpatient services, office-based outpatient services, and certain evidence-based pharmacotherapies.*

*Finding 7-3: Low rates of ADSM self-referral to treatment corroborate reports provided to the committee regarding the perceived stigma of receiving treatment.*

*Finding 7-4: Access to SUD care is inhibited by various structural, social, and cultural barriers that are specific to military procedures, programs, and policies.*

*Finding 7-5: Members of the National Guard and Reserves have no or limited access to SUD care within the Military Health System.*

## **Strengthening the Substance Use Disorder Workforce**

*Finding 8-1: Credentialing and required training for SUD counselors vary among the branches.*

*Finding 8-2: The SUD counselor training manuals of the Air Force and Navy are dated, do not address the use of evidence-based pharmacological and behavioral therapies, and do not reference the VA/DoD Clinical Practice Guideline for Management of Substance Use Disorders.*

*Finding 8-3: Physicians who provide care in military treatment facilities and have received training in addiction medicine or addiction psychiatry are a rarity.*

*Finding 8-4: The PHRAMS program is a reasonable start toward determining the quantitative relationship between the need for SUD care and staffing levels.*

*Finding 8-5: All of the branches appear to have shortages of SUD counselors.*

*Finding 8-6: Each of the military branches could benefit from a better trained and staffed prevention workforce.*



## Appendix C – Matched DoD and IOM Findings

PREVENTION, DIAGNOSIS, & TREATMENT OF SUBSTANCE USE DISORDERS (SUDs)	
DoD FINDINGS (as of 27 Jul 11)	IOM FINDINGS
DoD and military Service-level policies related to the prevention, diagnosis, and treatment of SUDs are permissive enough to allow for the adaptation of existing programs and services to the individual needs of the DoD populations served.	
DoD and Service policy does not currently address the use of alcohol screening instruments within the primary care setting.	
DoD and Service policy does not currently address the standardized collection of clinical and administrative data and common patient outcome measures for SUD prevention, diagnosis, and treatment.	<b>Finding 6-5:</b> DoD and the branches do not evaluate programs and initiatives consistently and systematically.
DoD and Service policy does not currently address the degree to which DoD clinical practice guidelines related to the assessment and treatment of substance related disorders are implemented.	<b>Finding 6-6:</b> DoD and branch policies support the use of evidence-based prevention and treatment but do not identify specific practices.
The Code of Federal Regulations does not permit SUD treatment delivered by health care providers outside of a TRICARE-certified Substance Use Disorder Rehabilitation Facility.	<b>Finding 7-2:</b> Access to care is restricted by the TRICARE SUD benefit's lack of coverage of intensive outpatient services, office-based outpatient services, and certain evidence-based pharmacotherapies.
By statute, under TRICARE, Licensed Mental Health Counselors must practice under the supervision of a physician.	
Current TRICARE regulation places yearly and lifetime limits on inpatient SUD rehabilitation treatment, partial hospitalization, outpatient treatment and family therapy.	
TRICARE is prohibited by regulation from paying for certain drug maintenance treatments such as maintenance treatment for opioid dependence.	
	<b>Finding 6-3:</b> Military policies reflect different attitudes toward alcohol and other drug use.  <b>Finding 7-1:</b> There is a significant unmet need for SUD care among service members in the U.S. armed forces.

DISPOSITION OF SUBSTANCE USE OFFENDERS	
DoD FINDINGS (as of 27 Jul 11)	IOM FINDINGS
DoD and Service-level policies related to substance use offenders are consistent with stated mission priorities and goals and are sufficiently permissive to allow health care providers and commanders the opportunity to assist service members with treatment and recovery rather than pursuing disciplinary action.	
Military Service-level policies and practices may provide too much flexibility in response to service members with unresolved substance misuse issues, thereby undermining the deterrence benefit of potential disciplinary action.	

CONFIDENTIALITY POLICY WHEN SEEKING SUD CARE AND TREATMENT	
DoD FINDINGS (as of 27 Jul 11)	IOM FINDINGS
The confidentiality policies covering military service members when seeking or receiving SUD treatment was found to balance the need to preserve mission readiness, the safety of military service members, and the imperative of getting service members the treatment and support services that they require.	
Confidentiality of clinical information related to SUDs is integral to ensuring that ADSMs seek care when they need it.	
	<b>Finding 7-3:</b> Low rates of ADSM self-referral to treatment corroborate reports provided to the committee regarding the perceived stigma of receiving treatment.
	<b>Finding 7-4:</b> Access to SUD care is inhibited by various structural, social, and cultural barriers that are specific to military procedures, programs, and policies.

REVIEW OF DoD INSTRUCTIONS RELEVANT TO SUBSTANCE USE DISORDERS	
DoD FINDINGS (as of 27 Jul 11)	IOM FINDINGS
<p>DoD or military Service level instructions substantially address the following areas:</p> <ul style="list-style-type: none"> <li>• Abuse of alcohol, illicit drugs, and non-medical use and abuse of prescription drugs</li> <li>• Appropriate training of providers including health professionals and other trained providers in the prevention, screening, diagnosis, and treatment of SUDs</li> <li>• Services for dependents, including instructions on making such services available to the maximum extent possible</li> <li>• Appropriate staffing levels for providers including health professionals and other trained providers at MTFs for the prevention, screening, diagnosis, and treatment of SUDs</li> <li>• Training and credentialing requirements for physicians/non-physicians in the prevention, screening, diagnosis, and treatment of SUDs</li> <li>• Availability of SUD services for ADSM's</li> <li>• Relationship between disciplinary action and treatment of substance use disorders</li> <li>• Confidentiality for members of the Armed Services seeking or receiving services or treatment for substance use disorders</li> <li>• Involvement of the chain of command in matters relating to the diagnosis and treatment of substance abuse and disposition of members.</li> </ul>	<p><b>Finding 8-3:</b> Physicians who provide care in military treatment facilities and have received training in addiction medicine or addiction psychiatry are a rarity.</p>
Gender specific policies related to gender specific care and treatment is absent.	
Policies related to the integration of efforts of SUD programs addressing concomitant mental disorders (PTSD and depression) and suicide prevention are absent.	

AVAILABILITY OF AND ACCESSIBILITY TO SUD PROGRAMS AND SERVICES	
DoD FINDINGS (as of 27 Jul 11)	IOM FINDINGS
Access to mental health providers and SUD assessment and treatment within primary care settings is limited.	<b>Finding 6-7:</b> Integration of SUD care with other behavioral health and medical care is lacking.
Gender-specific SUD treatment programs are not available in DoD MTFs and is very limited in the private sector and TRICARE network	
Availability of SUD care remains a challenge in remote locations for both family members and the RC.	<b>Finding 7-5:</b> Members of the National Guard and Reserves have no or limited accesses to SUD care within the Military Health System.
Utilization of federal and non-governmental resources in the prevention, assessment and treatment of SUDs has not been explored sufficiently.	

CREDENTIALS FOR HEALTHCARE PROFESSIONALS INVOLVED IN THE PROVISION OF SUD CARE	
DoD FINDINGS (as of 27 Jul 11)	IOM FINDINGS
The military Services have sufficient policies and procedures in place to ensure the quality of independent and non-independent providers of SUD care to DoD beneficiaries.	
The evolution of substance misuse and substance use disorders and the practices to assess and treat them requires that DoD providers be aware of new developments and needed competencies in the field.	
	<b>Finding 8-1:</b> Credentialing and required training for SUD counselors vary among the branches.
	<b>Finding 8-2:</b> The SUD para-professional training manuals are dated.

STAFFING METHODOLOGY FOR HEALTHCARE PROFESSIONALS INVOLVED IN PROVISION OF CARE	
DoD FINDINGS (as of 27 Jul 11)	IOM FINDINGS
The DoD is exploring a deliberative process to predict behavioral health provider (including substance abuse counselors) staffing requirements for MTF's.	<b>Finding 8-4:</b> The PHRAMS program is a reasonable start toward determining the quantitative relationship between the need for SUD care and staffing levels.
In certain circumstances SUD treatment professionals are providing care that is not captured in databases upon which staffing models such as PHRAMS rely.	
	<b>Finding 8-5:</b> All of the branches appear to have shortages of SUD counselors.
	<b>Finding 8-6:</b> Each of the military branches could benefit from a better trained and staffed prevention workforce.

DoD OVERSIGHT OF SUD PROGRAMS AND SERVICES	
DoD FINDINGS (as of 27 Jul 11)	IOM FINDINGS
A multilayered system of clinical care oversight exists within the direct care system, starting at the patient-provider interface and extending to agencies of the Office of the Secretary of Defense.	
All military Services ensure compliance with DoD policies through internal inspection agencies, elevating chronic policy or program concerns to DoD through senior level oversight committees.	

SCREENING FOR SUDs	
DoD FINDINGS (as of 27 Jul 11)	IOM FINDINGS
Evidence-based screening tools are not consistently utilized across the military Services. NOTE: With exception of the deployment cycle.	<b>Finding 6-2:</b> DoD and branch screening policies and programs fall short of identifying all service members who have or are at risk for developing SUDs.
Positive SUD screening in primary care for non-ADSM beneficiaries, likely results in a referral to the TRICARE network, decreasing the likelihood of patient follow-up for care.	<b>Finding 6-8:</b> DoD and branch policies are largely silent on comprehensive programs and services for SUD prevention, screening and brief intervention, diagnosis, and treatment for military dependents.
Staff shortages may prevent adequate screening and identification of at-risk substance use behavior, particularly during high demand periods as when a large number of service members are returning from deployment.	

SUD PREVENTION PROGRAMS AND SERVICES	
DoD FINDINGS (as of 27 Jul 11)	IOM FINDINGS
Military Services prefer centralized population based prevention efforts that provide the opportunity to adapt and implement already available DoD specific activities and products to their military Service.	
DoD prevention efforts could be improved by targeting at-risk populations.	<b>Finding 6-1:</b> DoD and branch policies recognize the deleterious effects of alcohol and other drug use and support the need for SUD prevention, but programs fall short of meeting this need.
Family members of AD and RC members are under-leveraged as proponents of SUD prevention.	

SUD DIAGNOSIS AND TREATMENT	
DoD FINDINGS (as of 27 Jul 11)	IOM FINDINGS
Utilization of DoD/VA SUD clinical practice guidelines is inconsistent across DoD facilities.	<b>Finding 6-4:</b> There is substantial variability among SUD-related policies, programs, procedures, and instruments across the military branches.
MTFs may have incomplete knowledge of services and programs available in the VA and Network and vice-versa.	
Self-help strategies for SUD concerns that make use of Web services, coaching, print material, and seminars are underutilized in the DoD.	
The use of telemental health technology to deliver SUD services is underutilized within the MHS.	<b>Finding 6-9:</b> DoD and the branches rarely use technology to enhance the delivery of screening, diagnosis, and treatment services.
Providers caring for service members and their families may be insufficiently educated about military culture, deployment stress and related mental health and substance abuse issues.	



REGIONAL LONG-TERM INPATIENT SUD TREATMENT PROGRAMS	
DoD FINDINGS (as of 27 Jul 11)	IOM FINDINGS
<p>The military Services believe that available and expanding sources of SUD treatment in the direct care system and the TRICARE network sufficiently serve the outpatient, partial hospitalization, residential and inpatient treatment needs of their populations. In addition, a large expansion of direct care services such as long term inpatient and residential SUD treatment programs provided by the Services will require the addition or reallocation of personnel and infrastructure, largely from existing programs.</p>	

## Appendix D – Summary of DoD Comprehensive SUD Plan, Actions and Initiatives in Response to IOM Findings

IOM Recommendation	DoD Actions and Initiatives
<p><b>1. DoD and the individual branches should implement a comprehensive set of evidence-based prevention programs and policies that include universal, selective, and indicated interventions.</b></p> <ul style="list-style-type: none"> <li>- Environment: Enforce underage drinking laws; reduce number of alcohol outlets; limiting hours of operation for outlets; community partnerships</li> <li>- Prescription drug: Increase provider education; improve pharmacy tracking of medications; impose limits on medication duration; monitor/implement VA/DoD CPG for Management of Opioid Therapy for Chronic Pain</li> <li>- Adopt universal, selective, indicated prevention strategies for children and families</li> <li>- Evaluate programs consistently and systematically</li> </ul>	<p><b>DoD Action 1:</b> DoD will implement a comprehensive set of evidence-based prevention programs and policies that include universal, selective, and indicated interventions.</p> <p><b>DoD Action 2:</b> To enhance community collaborations that are consistent with providing broad preventive strategies for children and families, the recently reissued DoD Instruction 1010.01, “Military Personnel Drug Abuse Testing Program (MPDATP),” requires the Secretaries of the Military Departments to issue guidance supporting participation of Service members and their families in community anti-drug awareness and education programs in schools, local sporting events, and other community activities.</p> <p><b>DoD Action 3:</b> DoD will continue to improve the flexibility of information technology (IT) systems to improve the transfer of pharmacy information.</p> <p><b>DoD Action 4:</b> DoD will continue the dissemination of provider education toolkits and will pursue development of an interactive computer-based training program on substance use treatment issues, particularly prescription drug misuse and abuse.</p> <p><b>DoD Action 5:</b> DoD will continue to revise the drug testing</p>

<ul style="list-style-type: none"> <li>- Continue to revise drug testing panel</li> <li>- Integrate Screening, Brief Intervention, and Referral to Treatment (SBIRT) into primary care</li> </ul>	<p>panel to include a broader range of potential drugs of abuse when scientifically feasible and legally binding means permit it.</p>
IOM Recommendation	DoD Actions and Initiatives
<p><b>2. DoD should assume leadership in ensuring the consistency and quality of SUD services. DoD also should require improved data collection on substance use and misuse, as well as the operation of SUD services.</b></p> <ul style="list-style-type: none"> <li>- Identify problems arising from a lack of standardization, monitoring, and evaluation of SUD policies and programs by DoD or individual branches, as well as the underutilization of EBP's</li> <li>- Specifically full implementation of DoD/VA Clinical Practice Guideline (CPG) for Management of Substance Use Disorder</li> </ul>	<p><b>DoD Action 6:</b> DoD will require the Services to reinforce utilization of VA/DoD SUD Clinical Practice Guidelines in accordance with current policy.</p> <p><b>DoD Action 7:</b> DoD will develop program evaluation metrics via the Addictive Substance Misuse Advisory Committee.</p>
IOM Recommendation	DoD Actions and Initiatives
<p><b>3. DoD should conduct routine screening for unhealthy alcohol use, together with brief alcohol education interventions.</b></p> <ul style="list-style-type: none"> <li>- Implement Screening, Brief Intervention, and Referral to Treatment (SBIRT)</li> </ul>	<p><b>DoD Action 8:</b> DoD will require standardized screening for unhealthy alcohol use in primary care and educating primary care medical providers on the proper use of screening tools and appropriate interventions, including patient education and brief interventions that do not require command notification.</p>

<ul style="list-style-type: none"> <li>- Provide annual screening in all patients</li> <li>- Conduct such screening and education without stigma or disciplinary consequences</li> </ul>	
IOM Recommendation	DoD Actions and Initiatives
<p><b>4. Policies of DoD and the individual branches should promote evidence-based diagnostic and treatment processes.</b></p> <ul style="list-style-type: none"> <li>- Increase use of pharmacotherapies, including maintenance therapies for opioid dependence</li> <li>- Permit use of individual providers outside of a SUDRF</li> </ul>	<p><b>DoD Action 9:</b> DoD has published a proposed rule lifting the ban on the use of opioid replacement therapies and will incorporate public comments in considering policy changes regarding the use of such pharmacotherapies as an additional intervention for SUD when indicated.</p> <p><b>DoD Action 10:</b> DoD will explore alternatives that would permit the delivery of substance use disorder care in settings outside of a SUDRF in a broader range of treatment settings.</p>
IOM Recommendation	DoD Actions and Initiatives
<p><b>5. DoD and the individual branches should better integrate care for SUDs with care for other mental health conditions and ongoing medical care.</b></p> <ul style="list-style-type: none"> <li>- Integrate behavioral health into primary care</li> <li>- Integrate drug and alcohol prevention into primary care</li> <li>- Ensure that credentials for qualified providers do not limit their scope of practice to just SUDs</li> </ul>	<p><b>DoD Action 11:</b> DoD will continue to hire behavioral health personnel for placement in primary care settings and ensure they are trained in SUD prevention, screening, and brief intervention activities.</p> <p><b>DoD Action 12:</b> DoD and the Services will further assess the privileging and credentialing of SUD providers to ensure that the practice of independently licensed practitioners is not needlessly restricted.</p>

IOM Recommendation	DoD Actions and Initiatives
<p><b>6. The Military Health System should reduce its reliance on residential and inpatient care for SUDs in its direct care system and build capacity for outpatient and intensive outpatient SUD treatment using a chronic care model that permits patients to remain connected to counselors and recovery coaches for as long as needed.</b></p> <ul style="list-style-type: none"> <li>- Provide intensive outpatient and individual level treatment</li> <li>- Provide ongoing monitoring and support for improved outcomes</li> </ul>	<p><b>DoD Action 13:</b> The Department will specify the provision of a full spectrum of substance use disorder treatment and aftercare services.</p>
IOM Recommendation	DoD Actions and Initiatives
<p><b>7. DoD should update the TRICARE SUD treatment benefit to reflect the practices of contemporary health plans and to be consistent with the range of treatments available under the Patient Protection and Affordable Care Act.</b></p> <ul style="list-style-type: none"> <li>- Cover Intensive Outpatient Program (IOP) treatment services</li> <li>- Allow office-based treatment and treatment outside of a Substance Use Disorder Rehabilitation Facility (SUDRF)</li> <li>- Lift lifetime limits on SUD treatment episodes</li> </ul>	<p><b>DoD Action 14:</b> TRICARE coverage for SUD treatment will continue to be reviewed and revised within the constraints of governing laws and current standards of practice in addiction medicine.</p>

IOM Recommendation	DoD Actions and Initiatives
<p><b>8. DoD should encourage each service branch to provide options for confidential treatment of alcohol use disorders.</b></p> <ul style="list-style-type: none"> <li>- Expand some level of confidential treatment across DoD</li> </ul>	<p><b>DoD Action 15:</b> The Department will reinforce the implementation of DoDI 6490.08 “Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members,” which encourages voluntarily sought substance abuse education and helps to foster a culture of support in the provision of mental health care.</p> <p><b>DoD Action 16:</b> DoD will review the findings of the U.S. Army’s Confidential Alcohol Treatment and Education Pilot (CATEP), which has expanded confidential substance use treatment services.</p>
IOM Recommendation	DoD Actions and Initiatives
<p><b>9. DoD should establish a joint planning process with the VHA, with highly visible leadership (perhaps recently retired military personnel), to address the SUD needs and issues of access to care of RC personnel before and after mobilization.</b></p> <ul style="list-style-type: none"> <li>- Address lack of continuity of care once Reserve members are demobilized</li> <li>- Fund research to determine how best to do this</li> <li>- Investigate telemedicine, phone applications for screening and motivational interventions</li> <li>- Provide SUD care for veterans with other than honorable discharges</li> </ul>	<p><b>DoD Action 17:</b> DoD will leverage the DoD-VA Health Executive Committee (HEC) to improve the continuity of care and transition for demobilized RC personnel and coordinate opportunities for outreach.</p> <p><b>DoD Action 18:</b> DoD will consider new approaches to leverage tele-medicine as a medium to implement services to both Active Duty (AD) and RC personnel.</p>



<ul style="list-style-type: none"> <li>- Provide outreach to demobilized and discharged reservists through community providers or contracting with existing systems (i.e. military one-source)</li> </ul>	
IOM Recommendation	DoD Actions and Initiatives
<p><b>10. DoD and the individual service branches should evaluate the use of technology in the prevention, screening, diagnosis, treatment, and management of SUDs to improve quality, efficiency, and access. TRICARE should cover IOP services.</b></p> <ul style="list-style-type: none"> <li>- Promote technological approaches to evidence-based screening and interventions.</li> </ul>	<p><b>DoD Action 19:</b> DoD and the military Services will standardize new TriService Workflow forms and automation of an Armed Forces Health Longitudinal Technological Application AHLTA-based clinical tool for screening, review of systems, evaluation, and intervention.</p>
IOM Recommendation	DoD Actions and Initiatives
<p><b>11. The individual service branches should restructure their SUD counseling workforces, using physicians and other licensed independent practitioners to lead and supervise multidisciplinary treatment teams providing a full continuum of behavioral and pharmacological therapies to treat SUDs and comorbid mental health disorders.</b></p> <ul style="list-style-type: none"> <li>- Reexamine roles of para-professionals in providing SUD care as rates and severity of co-morbidities have increased</li> <li>- Address shortage of SUD counselors across all Services, particularly addiction medicine physicians and psychiatrists</li> </ul>	<p><b>DoD Action 20:</b> DoDI 6490.04 implements changes to policy to provide a more uniform level of certification for all para-professional staff who deliver SUD care and directs the Services to ensure that academic training materials and policy standards are updated and consistent with their role in the delivery of care.</p>

<ul style="list-style-type: none"> <li>- Update dated technician training materials, and address wide variation of training and credentialing requirements for counselors</li> </ul>	
IOM Recommendation	DoD Actions and Initiatives
<p><b>12. DoD should incorporate complete data on SUD encounters into the MDR database and recalculate the PHRAMS estimates for SUD counselors.</b></p> <ul style="list-style-type: none"> <li>- Address perceived underestimation of manning requirements</li> </ul>	<p><b>DoD Action 21:</b> DoD will explore options for capturing complete SUD counselor workload and staffing requirements in future iterations of the Psychological Health Risk Adjusted Model for Staffing (PHRAMS).</p>