



PERSONNEL AND
READINESS

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

APR 17 2015

The Honorable John McCain
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 the Senate Report 113-44, page 133, accompanying S. 1197, National Defense Authorization Act for Fiscal Year 2014, "Mental Health Counselors for Service Members, Veterans, and their Families," which was requested no later than 270 days after enactment.

The report provides a joint Department of Defense (DoD) and Department of Veterans Affairs (VA) response that describes a coordinated, unified plan to ensure adequate mental health counseling resources to address the long-term needs of all members of the Armed Forces, veterans, and their families. The DoD and VA continue to focus on meeting the needs of our beneficiaries for mental health services through investments in prevention and early intervention. Both Departments are working to provide a spectrum of services to ensure delivery of preventive care and information, access to mental health services in primary care, a reduction of stigma associated with seeking mental health care, and assistance in coordination of care.

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,



Brad Carson
Acting

Enclosure:
As stated

cc:
The Honorable Jack Reed
Ranking Member



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WASHINGTON, DC 20301-4000

APR 17 2015

The Honorable Thad Cochran
Chairman
Committee on Appropriations
United States Senate
Washington, DC 20510

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Sincerely,

A handwritten signature in black ink that reads "Brad Carson". The signature is stylized and cursive.

Brad Carson
Acting

Enclosure:
As stated

cc:
The Honorable Barbara A. Mikulski
Vice Chairwoman



PERSONNEL AND
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4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

APR 17 2015

The Honorable William M. "Mac" Thornberry
Chairman
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

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Sincerely,

A handwritten signature in black ink that reads "Brad Carson".

Brad Carson
Acting

Enclosure:
As stated

cc:
The Honorable Adam Smith
Ranking Member



PERSONNEL AND
READINESS

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

APR 17 2015

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


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Sincerely,


Brad Carson
Acting

Enclosure:
As stated

cc:
The Honorable Nita M. Lowey
Ranking Member

**DoD/VA Report to the Congress in Response to
Senate Report 113-44, pg. 133, Accompanying S.
1197, the National Defense Authorization Act for
Fiscal Year 2014**

**Mental Health Counselors for Service Members,
Veterans, and Their Families**

The estimated cost of this report is:

**Department of Veteran Affairs approximately
\$5770 for the 2014 Fiscal Year.**

**Department of Defense approximately \$6060
for the 2014 Fiscal Year.**

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Department of Defense (DoD) & Department of Veterans Affairs (VA)

Introduction

Senate Report 113-44, page 133 (Mental Health Counselors for Service members, Veterans, and their Families), accompanying S. 1197, the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2014, requests the Secretary of Defense and the Secretary of Veterans Affairs provide a joint report that describes a coordinated, unified plan to ensure adequate mental health counseling resources to address the long-term needs of all members of the Armed Forces, Veterans, and their families. In developing the plan and report the Department of Defense and the Department of Veterans Affairs are to consider all available types of trained counseling providers, including psychiatrists, psychologists, social workers, chaplains, and other counseling professionals, as appropriate. The report shall also include a comprehensive staffing plan to ensure an appropriate alignment of mental health resources and needs. This report is submitted in response to the committee's request.

Executive Summary

The Department of Defense (DoD) and the Department of Veterans Affairs (VA) are committed to providing the necessary funding, coordination, and support to ensure adequate mental health resources to meet the mental health treatment needs of beneficiaries. Mental health staffing continues to be a priority as both VA and DoD have seen significant increases in delivery of mental health services from 2005 to 2013 (63 percent and 32 percent respectively). In the Spring of 2014, DoD and VA convened a workgroup to discuss the joint staffing requirement. This workgroup consisted of members of the Armed Services, VA and other DoD components to include chaplains and the Office of the Deputy Assistant Secretary of Defense for Military Community and Family Policy. Results of the collaboration are summarized in this report.

Several initiatives are underway to provide improved access to mental health care, increased provider availability, and more effective recruitment and retention incentives to mental health providers. TRICARE plays a significant role in caring for our beneficiaries and is continually evaluating and adjusting its programs and policies to ensure that eligible beneficiaries are receiving the mental health services required. Civilian medical workforce planning efforts throughout DoD have streamlined the hiring process of civilian mental health care providers. Utilizing appointing flexibilities such as direct-hire authority, as well as compensation incentives, DoD has increased competitiveness in light of the shortage of mental health care providers. As a result, DoD has been able to increase recruitment and hiring of many mental health care positions.

DoD used 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. PHRAMS provides the Services with a tool using a consistent methodology to define the appropriate number of mental health personnel to meet the mental health care needs of Military Health System (MHS) beneficiaries. The VA Office of Policy and Planning generates actuarial projections of future demand for mental health services based on historical trends, Veteran population demographics, and expected transformations in mental health care delivery.

In response to VA's 63 percent increase in the number of Veterans receiving mental health treatment, VA has increased mental health encounters or treatment visits from 10.5 million in 2005 to 18.0 million in 2013 – a 71 percent increase. VA continues to increase mental health treatment capacity, most recently through the Mental Health Hiring Initiative in May of 2012 through December 31, 2013, resulting in the recruitment and hiring of: (1) 927 peer support specialists (peer specialists and peer support apprentices); (2) 2,467 mental health providers for vacant positions; and (3) 1,720 mental health clinicians for newly created positions to better serve Veterans. The current projected growth in demand for mental health services will likely require an increase in general mental health providers over the next 3 years, with local facilities determining the allocation of staff. However, ongoing refinement of staffing models for Veterans Health Administration (VHA) mental health providers could yield somewhat different estimates in the future.

Since 2003, in an effort to reach and support the mental health needs of Veterans and their families, Readjustment Counseling Service (RCS) has added an additional 94 Vet Centers (currently 300 total), the Mobile Vet Center Program and Vet Center Combat Call Center. The RCS projects an additional 63 positions through this report period to maintain current services. In addition, VA medical center mental health chaplains provide spiritual and counseling services to Veterans and their families. In order to increase their presence in large treatment centers and maintain their current level of service, an additional 163 positions would be required.

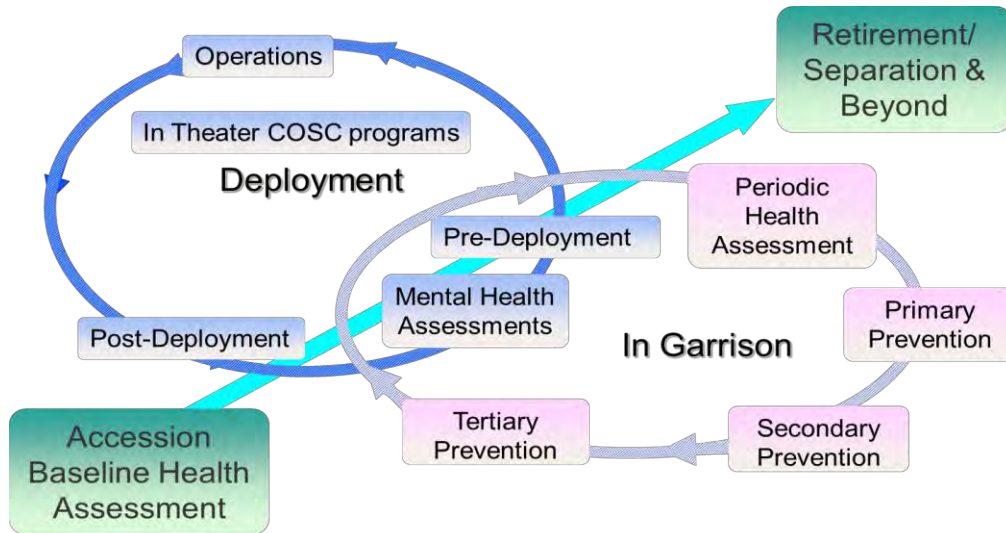
Finally, VA's Therapeutic and Supported Employment Services (TSES) was established for Veterans whose lives have been disrupted by mental illness or coexisting physical disabilities, and who would benefit from a supportive, stable, approach to work. At three percent annual growth in demand for mental health services by FY 2017, an increase in program staffing may be required in order to continue to provide TSES services to five percent of Veterans receiving mental health treatment.

Background

The DoD and the VA are committed to providing the necessary resources to ensure adequate mental health services to meet the needs of DoD and VA beneficiaries. A full spectrum of mental health care is available to Service members, Veterans, and their

families before, during, after deployment and throughout the Service member lifecycle (see Figure 1).

Figure 1 Service Member Life-Cycle



Due to increased screening referrals and help-seeking in the face of sustained combat operations, DoD has increased civilian mental health staffing, including contractors and government civilians, in garrison to augment care in instances when military mental health providers have been deployed in order to meet the demand for care. When deployed, each Service provides mental health services most appropriate for their unique operational requirements, and Mental Health professionals are currently embedded as assets in line units.

TRICARE, through its managed care contractors, has established networks of civilian providers. These network providers usually offer discounts from the TRICARE maximum allowable charges, agree to file claims on behalf of beneficiaries, and comply with the referral and authorization procedures of the TRICARE Prime health plan option. Other purposes of the network include providing convenient access to care and controlling health plan costs.

Additional initiatives are underway to provide improved access to mental health care, increased provider availability in the network, and more effective recruitment and retention incentives to mental health providers. For example, the Defense Health Agency (DHA) has partnered with regional contractors in the three U.S regions to provide health care services and support to beneficiaries. The TRICARE regional contractors assist the TRICARE regional offices and military treatment facility (MTF) Commanders in operating a world-class health benefit. The three overseas areas are supported by TRICARE area offices (TAOs). TAOs, in collaboration with MTF Commanders and Directors, are responsible for the development and execution of an integrated plan for the delivery of health care within each overseas area.

TRICARE plays a significant role in caring for our Service members and is continually evaluating and adjusting its programs and policies to ensure that eligible beneficiaries are receiving the mental health services required. Some of the specific program enhancements include:

- TRICARE Behavioral Health Information line is a program to provide information regarding the TRICARE mental health benefit and respond to general mental health inquiries.
- Behavioral Health Provider Locator and Appointment Assistance Line which provides one-on-one assistance to beneficiaries to identify TRICARE providers and assist with getting an appointment if desired.
- On-Line Behavioral Health Resources including self-assessment tools and articles.
- Telehealth programs utilize secure audio-visual conferencing capabilities to provide assessment, diagnostic, and intervention services to eligible beneficiaries across distance in order to increase access to care, decrease need for travel, and delivery services to remote locations where traditional mental health services may not be available.
- Warrior Navigation & Assistance Program supports Active Duty, Guard and Reserve warriors and their families in transition with information about the TRICARE program and assistance with navigation through the MHS.

DoD is working to ensure a full continuum of psychological health services is available and accessible to all Service members and their eligible family members regardless of location. The Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury established the Telehealth and Technology (T2) Center in July 2008. The T2 Center's mission is to lead the innovation of health technology solutions for psychological health and traumatic brain injury, and deliver tested, valued health solutions that improve the lives of our nation's warriors, Veterans, and their families. The DoD has additionally opened the National Intrepid Center of Excellence at the National Capital Region Medical Directorate (NCR-MD), to assess, diagnose, and treat military personnel with complex psychological health and traumatic brain injury issues. The Services have all implemented their own telehealth programs:

- The Army established a global Tele-Mental Health (TMH) system. Army clinicians conduct approximately 30,000 TMH encounters per year, enabling the Army to cross-level support across the globe and connect beneficiaries in remote locations with mental health care.
- The Navy Medicine telehealth program office has begun TMH services at several Navy healthcare facilities; expansion of telehealth initiatives are planned for enhanced services with regard to psychological health, traumatic brain injury, substance abuse, pain management, and consultative services.
- The Air Force telehealth program office, working collaboratively with the Air Force Medical Operations Agency, has established TMH Initiatives leveraging video teleconferencing and soon to be desk top internet protocol technologies

to enhance, expand and augment the delivery of care in a more cost effective and efficient manner to our Service members and their families.

Since September 11, 2001, more than two million Service members have deployed to Iraq or Afghanistan. Long deployments and intense combat conditions require optimal support for the emotional and mental health of Veterans and their families. Accordingly, VA continues to develop and expand its mental health system. The number of Veterans receiving specialized mental health treatment from VA has risen each year, from 927,052 in FY 2006 to more than 1.4 million in FY 2013. We anticipate that VA's requirements for providing mental health care will continue to grow for a decade or more after current operational missions have come to an end. VA believes this increase is partly attributable to proactive screening to identify Veterans who may have symptoms of depression, post-traumatic stress disorder (PTSD), substance use disorder, or those who have experienced military sexual trauma. In addition, VA continues to partner with the DoD through a number of initiatives to advance a coordinated public health model to improve access, quality, effectiveness, and efficiency of mental health services for Service members, National Guard and Reserve, Veterans, and their families.

VA has many entry points for mental health care, which include 150 medical centers, 820 Community-Based Outpatient Clinics, 300 Vet Centers that provide readjustment counseling, the Veterans Crisis Line, VA staff on college and university campuses, and other outreach efforts. To serve the growing number of Veterans seeking mental health care, VA has deployed significant resources and increases in staff toward mental health services. VA has also expanded access to mental health services with longer clinic hours, TMH capability to deliver services, and standards that mandate immediate access to mental health services to Veterans in crisis. Starting in the latter half of 2012, site visits were conducted to evaluate mental health programs in each VA facility. All facilities were visited in 2012, and subsequently one third are being visited each year. The facilities are informed by ratings on performance measures; findings from the visits are used to develop action plans; and improvements are evaluated by following performance measures as well as the milestones and deliverables included in the plans.

In an effort to increase access to mental health care and reduce the stigma of seeking such care, VA has integrated mental health into primary care settings. From FY 2008 to March 2014, VA has provided more than 3.6 million Primary Care-Mental Health Integration (PC-MHI) clinic visits to more than 942,000 unique Veterans. This improves access by bringing care closer to where the Veteran can most easily receive these services and quality of care by increasing the coordination of all aspects of care, both physical and mental. Among primary care patients with positive screens for depression, those who receive same-day PC-MHI services are more than twice as likely to receive depression treatment than those who did not.

The VA has made deployment of evidence-based therapies a critical element of its approach to mental health care and offers a continuum of recovery-oriented, patient-centered services across outpatient, residential, and inpatient settings. State-of-the-art treatment, including both psychotherapies and biomedical treatments, are available for

the full range of mental health problems, such as PTSD, substance use disorders, and suicidality. For example, VA has substantially invested in the availability and effective implementation of Evidence Based Psychotherapies. Every VA facility has mental health providers who are trained in Evidence Based Psychotherapy treatments and is required to have these treatments available for PTSD, depression, and serious mental illness. In support of these standards more than 9,000 unique VHA psychologists, social workers, marriage and family therapists, licensed professional counselors, clinical nurse specialists, and nurse practitioners have been trained in one or more of these proven interventions. VA operates the National Center for PTSD, which guides a national PTSD mentoring program, working with every specialty PTSD program across the VA health care system. The Center has begun a PTSD consultation program for any VA practitioner (including primary care practitioners and Homeless Program coordinators) who request consultation regarding a Veteran in treatment with PTSD. So far, over 500 VA practitioners have utilized this service.

In addition to the previously mentioned mental health treatment and services, VA is also concurrently addressing Veteran homelessness and employment in order to focus on total recovery and personal functioning. VA is committed to serve those who have served in our armed forces.

This report assesses the projected mental health/counseling personnel needs through 2017, based on what is currently known about effective treatments and care management strategies for mental health related issues and empirically informed assumptions about predicted demand for such services.

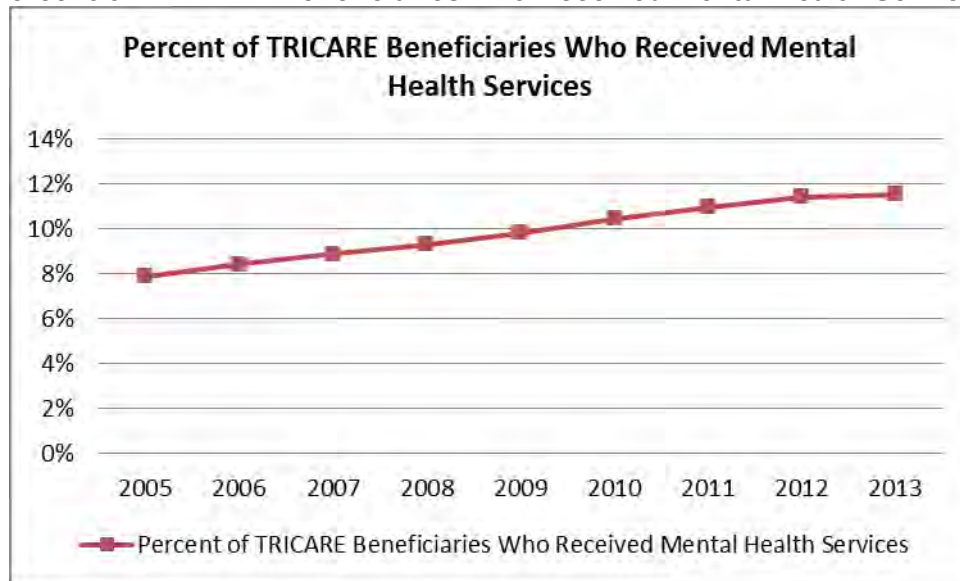
Mental Health Staffing in DoD

The Services continue to focus on recruiting and retaining sufficient mental health providers. Staffing data are gathered quarterly from the Services to determine mental health staffing requirements.

Demand for Mental Health Services

Between 2005 and 2013, the number of beneficiaries who received mental health care from the MHS grew by 32 percent (Figure 2). As a consequence, the proportion of beneficiaries receiving mental health services has increased from 8 percent in 2005 to 12 percent in 2013.

Figure 2 Percent of TRICARE Beneficiaries who Received Mental Health Services



Mental Health Staffing

The overall numbers for the Services' current mental health staffing indicate near 100 percent staffing, although the number of billets may lag actual requirements. Several initiatives are currently underway to increase provider availability in the network, optimize access, and to provide more effective recruitment and retention incentives to mental health providers.

Civilian medical workforce planning efforts throughout DoD have streamlined the hiring process of civilian mental health care providers. Utilizing appointing flexibilities such as direct-hire authority, as well as compensation incentives, DoD has increased competitiveness in light of the shortage of mental health care providers. As a result, DoD has been able to increase recruitment and hiring for many mental health care positions. It should be acknowledged that any discussion of the future healthcare workforce should consider alternative practice models (e.g., group visits or peer counseling), advances in clinical care, and the introduction of new technologies such as telehealth. Such changes may either decrease or increase demand for services. Therefore, all staffing models and projects, whether for mental health or more general clinical needs, should be viewed as provisional and highly dependent on evolving conditions.

In order to properly project mental health manning requirements the Department seeks to account for all of the activities assigned to prevention, screening, and intervention personnel. Central to this effort is the creation and on-going development of the PHRAMS, which is intended to properly account for the many activities associated with mental health, prevention, screening, and treatment. PHRAMS provides the Services with a tool using a consistent methodology to define the appropriate number of mental health personnel to meet the mental health care needs of beneficiaries. PHRAMS is a flexible, population-based staffing model and user application that projects the total staffing requirements for psychological health services for MHS beneficiaries. The model takes into account demographic and deployment risk factors to forecast future psychological health staffing needs throughout the MHS.

Since its inception, the PHRAMS has involved collaboration among the Services' clinical, manpower, and programming experts. PHRAMS permits the Services to make adjustments in planning assumptions to meet the needs of individual communities to determine the appropriate number and mix of mental health personnel required in MTFs. The Services have also identified requirements and developed guidelines to integrate mental health professionals into primary care settings to further supplement the mental health treatment capacity. A DoD planning working group has agreed on appropriate staffing models and has identified associated resource requirements. Figure 3 shows mental health staffing trends since FY 2009.

Figure 3 – Mental Health Staffing in the DoD



The Health Affairs, Chief Human Capital Office monitors the DoD Mental Health Care Provider staffing status on a quarterly basis using feeder reports submitted by the Service and Defense Health Agency Manpower/Human Resource offices. Gap differentials are measured for mental health staffing by comparing the difference between the civilian, military, and contractor needs/billet authorizations and assigned

(positions filled) which include: psychologists, psychiatrists, social workers, mental health nurses, mental health nurse practitioners, and technicians/counselors.

The DoD continues to experience increases in staffing patterns. During the end of FY 2009, there were a total of 6,590 civilian, military, and contractor mental care providers. By the end of the first quarter in FY 2014 the mental health strength rose to 9,425, representing an increase of 2,835 or 43 percent. Current staffing, as of December 31, 2013, of MHS civilian, military, and contractor mental health care providers is at 94.1 percent or 9,425 on-board against target needs/authorization of 10,012 (Table 1). This includes: psychologists, psychiatrist, social workers, mental health nurse (registered nurses and nurse practitioners), and tech/counselors and composed of 4,316 (45.8 percent) military, 3,965 (42.1 percent) civilians, and 1,144 (12.1 percent) contractors as shown in Table 2.

Table 1 - DoD Staffing Status

DoD-wide	<u>Needs/ Authorized</u>	<u>Assigned</u>	<u>Delta</u>	<u>% Filled</u>
Psychologist	1,984	2,048	64	103.2%
Psychiatrist	903	774	-129	85.7%
Social Worker	2,588	2,445	-143	94.5%
Mental Health Nurse (RN)	529	548	19	103.6%
Mental Health Nurse (Nurse Practitioner)	159	178	19	111.9%
Other Licensed MH Provider	119	93	-26	78.5%
Tech/Counselor	3,731	3,339	-392	89.5%
TOTAL	10,012	9,425	-587	94.1%

Table 2 – DoD Staffing Assigned/On-Board

<u>Speciality</u>	<u>Military</u>	<u>Civilian</u>	<u>Contractor</u>	<u>Total</u>
Psychologist	631	1,126	291	2,048
Psychiatrist	428	231	115	774
Social Worker	567	1,577	301	2,445
Mental Health Nurse (RN)	208	214	126	548
Mental Health Nurse (Nurse Practitioner)	99	51	28	178
Other Licensed Mental Health Provider	0	54	39	93
Tech/Counselor	2,383	712	244	3,339
TOTAL	4,316	3,965	1,144	9,425

Projected Gaps between Supply and Demand

The Services report that they currently have the provider types they need and do not need any new mental health specialties. The existing mental health specialties for officers or enlisted members of the Armed Forces runs parallel to those recognized as licensed mental health providers in the private sector inclusive of such specialties as Psychiatry and Psychology (inclusive of all sub-specialties), Social Work, Psychiatric Nurses, Counselors, Advanced Practice Nurses, alcohol and drug abuse counselors. In efforts to build on integrating mental health and substance use care into primary care programs, 470 mental health positions have been funded and positioned in primary care medical settings. Currently, 69 percent of primary care clinics have mental health providers. There are ongoing efforts to increase the number of mental health providers in primary care. No categories of mental health specialties in the private sector have been identified that are not also recognized military mental health specialties. In fact, the military recognizes mental health specialties beyond what is found in civilian practice (e.g., mental health technicians). Mental health staffing levels are influenced by complex and difficult-to-predict factors. These factors vary by Service and are addressed separately in the following section.

Army

Specific to clinical service delivery, as reflected by the US Army Medical Command (MEDCOM) Manpower Professional Services Model and the Behavioral Health Service Line Matrix resourcing tool, the MEDCOM has an earned provider (Psychiatrist, Psychologist, and Social Worker only) requirement of 1,793, and an on-hand of approximately 1,902 providers documenting clinical care. The reference to “earned” refers to Manpower’s Professional Service Model (PSM). Based on the current output of that model, which is maintained by MEDCOM Manpower, the formula calculates an “earned” value translating into how many Psychiatrists, Psychologists and Social Workers are required, and subsequently documented on published TDAs. Documented TDAs are adjusted based on PSM output. This is different than on hand inventory, which generally reflects a higher count than the TDA (documented value based on PSM). The most recent analysis of workload data indicates a demand driven provider basis that exceeds documented providers. The current demand basis is approximately 2,149 providers. To achieve full staffing, the MEDCOM requires approximately 247 additional providers. Future requirements are expected to change as a function of a number of factors, including the proposed drawdown and realignment of military end strength and the incidence and prevalence of behavioral health conditions in the beneficiary population at various locations. It is premature to estimate the magnitude of these potential changes at this time.

MEDCOM currently has 270 hiring actions open to fill vacant Psychiatrists, Psychologists, Social Workers and mental health nurse practitioner positions, which if fully achieved, would staff Army MTFs at 105 percent of its need basis (to meet direct care mission). MEDCOM’s historical turn-over rate is around 18 percent annually, so current staffing is within expected ranges and open hires appropriately reflecting actions to sustain inventory levels.

Additionally, Army telehealth provides an invaluable capability for Soldiers and family members. Army clinicians offer care via telehealth across 18 time zones and in over 30 countries and territories. All-in-all, Army telehealth provides clinical services across the largest geographic area of any telehealth system in the world, civilian or military. This enables the Army to compare clinical care capacity across the globe for routine and emergent needs. As an example of the latter, after the Ft. Hood shooting incident, clinical support from Washington D.C., Honolulu, and San Antonio was surged via TMH to support our Soldiers at Ft. Hood, Texas. In FY 2013, Army TMH providers completed approximately 29,000 garrison and 1,350 deployed patient encounters to support beneficiaries in locations throughout the Army, to include geographically remote locations.

Navy

Mental health specialist staffing continues to improve as Navy Medicine places particular emphasis on increasing the inventory of mental health specialists. Since 2009, funded positions for Active Duty and civilian (excluding contractors) have

increased by 59 percent (497 to 750), while inventory in mental health specialties has increased by 40 percent (415 to 580) to meet new demand.

The manning percentages for specific types of active duty mental health providers as of the end FY 2013 are as follows: Clinical Psychologist: 88 percent, Social Worker: 58 percent, Psychiatrist: 90 percent, and Mental Health Nurse Practitioner: 100 percent. Social work manning is continuing to recover from a decision made during the late 1990s to terminate this specialty from the Active Duty ranks. Through an aggressive training pipeline the Social work community is rapidly growing. Similarly, there are now five separate training programs through which we access Active Duty clinical psychologists. These training pipelines account for the increased manning percentage of this specialty even with a growing number of Active Duty billets.

Navy Medicine is supplementing this increase in Active Duty providers through aggressive expenditures to meet the immediate need. In FY 2013, Navy Medicine provided \$85.5M (Defense Health Program funds) for psychological health programs to provide timely access to comprehensive and appropriate levels of care. For FY 2014, Navy Medicine has budgeted \$79.8M to fund these mental health positions. Efforts have focused on ensuring appropriate staffing, meeting access standards, identifying recommended and standardized evidence-based practices, and reducing stigma and barriers to care in order to provide world class treatment.

Two programs in particular are helping us ensure adequate access to mental health care for our Sailors and Marines. The Behavioral Health Integration Program (BHIP) in the Medical Home Port will be implemented in 76 sites by the end of FY 2014. This program integrates mental health providers in the primary care setting to address the unmet needs of Service members and their families, and remove the stigma associated with seeking mental health care. Additionally, embedded (Active Duty) mental health providers are now stationed on all large seagoing platforms, in all Marine Corps infantry units, and in all Navy and Marine Corps Special Operations Commands. These embedded operational providers allow for improved access to care for our Active Duty beneficiaries while reducing the workload at our MTFs.

Air Force

The Air Force is pursuing a range of options to close the narrowing gap of authorized versus assigned mental health providers. As part of the resourcing process, the Air Force has increased authorizations for FY 2014 by 27 percent. The Air Force is continually providing input on the PHRAMS to ensure the health care provider requirements are appropriately identified and resourced to meet the on-going mental health demand for our patient population. Below are additional examples, by specialty, of efforts to narrow these gaps:

Psychology: Since 2009, the Air Force has been offering special pay plans for psychologists including incentive bonuses for licensed psychologists of \$5,000 per year and retention bonuses of up to \$20,000 per year for a 4-year commitment. To attract new psychologists, the Air Force has also continued with its clinical psychology

internship capacity of 20 per year, and to entice applicants to the program, we are funding 15 3-year Health Profession Scholarship Program (HPSP) quotas. The Air Force has also introduced accession bonuses up to \$15,000 per year for fully qualified applicants, resulting in the accession of three fully qualified applicants in FY 2013. Additionally, the mental health psychology consultant is continuing to work closely with the Air Force Personnel Center to maintain and further develop specialty-specific sustainment models. These efforts appear to be paying dividends as assigned psychology staffing is now at 95 percent, up from 89 percent last year, and 70 percent three years ago.

Social Work: Social Work is projected to gain 20 additional authorizations in FY 2015, bringing the total authorized to 263 (including line funded authorizations). Social Work currently has 237 assigned (including students/interns). The Air Force Social Work Internship program remains the main pipeline for Air Force Social Work. This year, we have 18 social work interns graduating in August. We also have eight HPSP graduates who are being placed at MTFs as entry level social workers to help fill the gap. The Air Force continues to offer Health Professions Loan Repayment and accession bonuses for fully qualified applicants. In addition, a retention bonus for social work has been approved and is awaiting implementation. The Air Force Social Work Consultant continues to work closely with the Air Force Personnel Center to maintain and further develop specialty-specific sustainment models.

Psychiatry: There is risk to shortfall the increase in authorizations for psychiatry unless recruitment and retention improve. To close this gap, the Psychiatry Consultant has: contacted all the psychiatrists who are scheduled to complete their Active Duty service commitment in 2015 to discuss their plans for the future and opportunities in the Air Force; implemented a regular psychiatry update to Air Force psychiatrists to improve communication; and is working to request incentive special pay increase as the psychiatry incentive special pay has not increased in the last five years, though the need for military psychiatrists has increased. Lastly, the consultant has continued to work with recruiting services to access viable Air Force psychiatrists.

In an effort to offset the psychiatry short fall and efficiently provide psychiatry services to smaller isolated bases, the Air Force tele-psychiatry program has three locations that provide psychiatry services to support to 12 bases across the Air Force without assigned psychiatrists

Psychiatric Mental Health Nursing: Currently a small gap exists for clinical mental health nurses. To that end, a 6-week transition course was implemented at Travis Air Force Base in March 2011 to provide career cross-training for Total Force Nurse Corps officers who desire specialization in the mental health Nurse career field. Twenty quotas are offered annually for this course. Although there is currently no gap for advance practice Psychiatric Mental Health Nurse Practitioners, once the Air Force authorizations that were increased per the NDAA are realized, a gap may develop authorized versus assigned. Given the similar scope of practice, the Psychiatric Mental Health Nurse Practitioner has been able to fill some of the gap experienced in

psychiatry. The Air Force Medical Service is actively recruiting and training generic and advance practice Psychiatric Mental Health Nurse Practitioners.

Mental Health Technicians: There still remains a gap in authorized versus assigned and scope of practice for the Air Force mental health technicians. For example, end-strength is projected to grow through FY 2016. However, Medical Education and Treatment Campus Trained Personnel Requirement shows a decrease of students allowed to be trained by approximately 13 students annually. The only way the field can grow is through training pipeline input and output. This training will give students their first exposure to real world outpatient and inpatient clinical settings. This valuable training will enhance their knowledge, program familiarity, and expedite first duty station on-job-training.

National Capital Region

The DHA NCR-MD was formally established on October 1, 2013 by the Deputy Secretary of Defense as part of the MHS Governance Reform. The DHA NCR-MD has authority, direction and control over the NCR-MD health system, which provides behavioral health services to beneficiaries throughout the NCR-MD Enhanced Multi-Service Market (eMSM). This eMSM includes seven referral sources organic to the NCR-MD (Walter Reed National Military Medical Center, Fort Belvoir Community Hospital, Dumfries Health Clinic, Fairfax Health Clinic, Carderock Health Clinic, the National Intrepid Center of Excellence, the Dilorenzo Tricare Health Clinic and the Pentagon Dental Clinic), as well as 10 non-NCR-MD facilities organic to the Army, Navy, and Air Force. For several years prior to 2013, these facilities faced significant access challenges related to the regular influx of evacuated wounded Service members, the NCR-MD Base Realignment and Closure process, and the construction of a new hospital on Ft. Belvoir. Demand for behavioral health care among Service members was great, so a significant number of family members and retirees were sent to the network to receive care. Over the past year, the NCR-MD has been actively working to recapture care currently being provided through network services, and has successfully recaptured 6,000 enrollees since the fall of 2013 with a target of recapturing a total of 60,000 enrollees over the next several years. As these efforts further increase enrollment of our beneficiary population, there will be an increased demand for not only clinical staff, but also the support staff required to ensure efficiencies in the delivery and management of clinical care.

A recent analysis of projected demand through 2017 did not even account for these recapture efforts and still revealed an overall deficit of 106 behavioral health position authorizations within NCR-MD. Specialties that are particularly understaffed include psychologists, psychiatric nurses, and licensed counselors, all of which currently have fewer than 70 percent of the staff they are projected to require in 2017. There is only one specialty that is currently resourced to meet projected demand, and that is psychiatric nurse practitioners. Psychiatrists, clinical social workers, psychiatric technicians, and substance abuse counselors will have an authorization rate less than

90 percent of that required by 2017 unless additional positions are created or uniformed billets authorized.

To mitigate the impact of these shortcomings, NCR-MD leadership is requesting retention of military billets, amplifying efforts to increase comfort among primary care providers in managing simple behavioral health conditions, exploring more efficient psychotherapy modalities, advocating for the sustainment of the DoD-Public Health Service Memorandum of Agreement, and attempting to convert term and contract positions to permanent federal positions.

Procedures to Ensure Continuity of Mental Health Care

Department of Defense Instruction (DoDI) 6490.10, "Continuity of Behavioral Health Care for Transferring and Transitioning Service members," defines policy and procedures to ensure continuity of mental health care when Service members transition from one health care provider to another when transferring to a new duty station or transitioning out of the Service. Furthermore, DoD developed the *inTransition* program in response to the DoD Mental Health Task Force recommendation to "maintain continuity of care across transitions" for Service members and Veterans. *InTransition* is a voluntary program to provide mental health care support to Service members and Veterans as they move between health care systems or providers. Personal coaches, along with resources and tools, assist Service members during the transition period, empower them to make healthy life choices, and are available 24/7 via toll-free call. Family members are also encouraged to call the program to find out how their Service member can get started with *inTransition*. The Defense Centers of Excellence manages the program and its support coaches. Individual Service efforts to ensure continuity of mental health care are detailed in the following section.

In 2012, the Joint Executive Council approved implementation of the Warrior Care Coordination Task Force recommendation to develop and implement an interagency overarching policy for a common model of complex care coordination for Service members and Veterans. The VA/DoD Interagency Care Coordination Committee was established to oversee these efforts in accordance with the VA and DoD Secretaries' objectives to support "One Mission-One Policy-One Plan." The program ensures that Service members and Veterans requiring complex care coordination have an established interagency comprehensive plan to ensure the best continuity of care.

Army

Currently, MEDCOM complies with DoDI 6490.10, through Army Medical Command Policy 13-07. Utilizing a patient-centered Information Technology solution through the Army's Behavioral Health Data Portal (BHDP), the current process will be improved to track transition during Soldier movement during change of duty station. The Army is currently examining all medical screening that occurs during in/out process, to include mental health. Once a standardized solution is determined, current mental health

processes will be updated and a revised Policy 13-07 will be published, which will operationalize the BHDP technical solution.

Navy

The policy to ensure proper handoff of care to VA is currently under review in order to maximize our care processes. The smooth transition of care between providers is a focus of the Joint Commission (the accrediting agency of our hospitals) and is a core tenet of our standards of care. Navy has a robust case management program that assists Service members in this transition process. Process improvement initiatives underway include: increasing the marketing of these services to medical providers who are responsible for referring cases in need of these services and to set standards above the current Joint Commissions Transfer of Care requirements.

Air Force

In reference to the procedures for continuity of mental health care, the Air Force complies with DoDI 6490.10, through Air Force Instruction 44-172, Mental Health. When transferring to a new command, transfer of clinical care of a Service member receiving mental health care within the MTF system of care is arranged through direct provider-to-provider communication. Additionally, mental health providers at the gaining base track all incoming mental health patients. Service members are made aware of available resources for care during and after the permanent change of station, separation or retirement move to ensure continuity of care during transition. If the patient is an active service component member, then the member may choose to utilize the “*In Transition*” program as described in Assistant Secretary of Defense for Health Affairs Memorandum, “Department of Defense in Transition Program,” January 12, 2010. This program helps Service members locate a suitable, non-military program.

National Capital Region

The NCR currently has an established process in place to ensure the continuity of mental health care during transition from MHS to VA mental health care. These processes and procedures are not limited solely to the directorate of mental health but include other directorates as well who provide case management, discharge planning, and a myriad of other services. Throughout the transition process, these services are designed to assist patients in navigating care and treatment at the National Capital Region MTFs (Walter Reed National Military Medical Center and Fort Belvoir Community Hospital) as well as during their transition to VA system.

Non-Medical Counseling – DoD

Overview

Non-medical counseling is aimed at preventing the development or exacerbation of psychological challenges that may undermine military and family readiness. Issues

addressed by non-medical counseling include, but are not limited to: relocation adjustment, separation, reintegration, relationship issues, parenting skills, communication, anger management, grief, stress, adjustment, deployment, life skills, coping skills, interpersonal skills, and academic or occupational problems.

The confidential nature of non-medical counseling addresses stigma concerns expressed by Service members and their families. Issues not amenable to non-medical counseling include, but are not limited to the following: active suicidal or homicidal thought or intent or other threats of harm to self or others, sexual assault, child abuse/neglect, domestic violence, alcohol and substance abuse, mental health conditions that yield recurring in-patient hospitalizations, conditions treated with psychoactive medication, individuals receiving therapy by multiple practitioners, fitness for duty evaluations and court ordered counseling. Situations meeting the diagnostic criteria for common mental disorders found in the Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition will be referred via a warm handoff to military medical mental health care providers, TRICARE, or other mental health care professionals. The current staffing of non-medical counselors is listed in Table 3.

Table 3 - DoD Non-Medical Counselor Status – Assigned/On-Board

<u>Specialty</u>	<u>Total</u>
Clinical Pastoral Counseling	1,996
Family Advocacy Programs	509
Substance Abuse Programs	15
Resiliency, Education, & Prevention Programs	7
Other, Non-Medical Counseling	71
TOTAL	2,598

Note: The Family Advocacy Program staffing numbers include clinical social workers

Services provided by the Military and Family Life Counseling (MFLC) and Military One Source are included in the DoD Family Readiness system. Both programs are DoD funded and centrally managed in the Office of the Deputy Assistant Secretary of Defense for Military Community and Family Policy. Non-medical counselors possess a master’s or doctorate degree in a mental health field and are licensed or certified in a state, territory or the District of Columbia to practice independently. Non-medical counselors are mandated reporters of situations that include harm to self or others, domestic violence, child abuse and neglect, violence against any person, and any present or future illegal activity.

The Military OneSource and the MFLC Programs evolved as a means to provide non-medical counseling support to Service members and family members who might otherwise not seek assistance due to the stigma associated with the more formal

avenues to mental health care or other reasons. Both Military OneSource and the MFLC Program are 'pull' programs. This means that Service Headquarters points of contact, commanders, installation points of contact, or participants (i.e., eligible Service members and their family members) request the support; thus, demand for both the MFLC Program and Military OneSource determines the number of non-medical counselors utilized and/or deployed. These programs are described in detail in the following sections.

Military & Family Life Counseling Program

Overview

MFLCs provide in-person confidential, short term non-medical counseling sessions and briefings, both on and off installation. The non-medical counseling sessions are at no cost to Active Duty members, the National Guard and Reserves (regardless of activation status) and their families. MFLC non-medical counseling sessions are performed by Contractors may range in duration from 15 minutes to two hours, and may be individual, couples, family or group settings. Briefings include a wide variety of topics tailored to the military community.

The following types of flexible MFLC service delivery are available to meet emerging needs: at Family Centers, Child and Youth Programs, schools, and youth summer programs; embedded in military units; "surge" counseling support for up to 90 days for units returning from combat and/or to meet emerging needs; and on-demand support for up to three days to support pre-deployment, deployment, and reintegration events for Service members and their families.

MFLC services are available to Service members and their families for up to 180 days after discharge, separation, deactivation or retirement.

Current Military & Family Life Counseling Program Summary

The MFLC Program is a "pull" program. This means that Service headquarters points of contact, commanders, installation points of contact, or participants request the support; thus, demand for the MFLC Program determines the number of non-medical counselors utilized and/or deployed. As of May 2014, MFLCs are assigned to 247 military installations on an ongoing rotational basis, support Army Recruiting and Marine Corps Recruiting commands, and are embedded within military units to include Special Forces units. MFLCs provide support on 88 Air Force Installations, 77 Army Installations, 25 Marine Corp Installations, 51 Navy Installations and support Special Operations Command units on 19 installations.

MFLCs support 150+ on-demand events monthly, and provide surge support when requested. During FY 2013, MFLCs provided support at 43 surges. This surge capacity addressed short term non-medical counseling needs arising from emergency incidents such as the Ft. Hood shooting and the Japan earthquake/tsunami in addition to support

for units returning from combat. For example, MFLCs on installation at Fort Hood for the April 2014 incident were able to be utilized flexibly to meet potential need: Some MFLCs were used to provide 24 hour support for a short period of time immediately after the shooting occurred, while other embedded MFLCs were requested by the chaplain to be available to support family members at one of the medical centers where Service members were taken.

Military OneSource

Overview

The Military OneSource Program provides confidential, comprehensive information on every aspect of military life at no cost to Active Duty, Guard and Reserve Service members, and their families, regardless of activation status (24 hours a day, 7 days a week).

Current Military OneSource Summary

Military OneSource is also a “pull” program. Demand for Military OneSource determines the number of non-medical counselors utilized. Services, including specialty consultations, are available 24 hours a day by telephone and the Military OneSource website. Specialty consultants provide individualized support in the areas of wounded warrior care, adoption, elder care, special needs, education, adult disability, and health and wellness coaching. Military OneSource also provides the following types of support: financial and tax counseling sessions, to include the opportunity for the filing of electronic federal and state tax returns through the Military OneSource website; educational materials available in a variety of topics and formats to include printed, online, audio and video; and translation of official documents and simultaneous interpretation in over 160 languages.

Military OneSource also offers confidential non-medical counseling services. Eligible participants may receive up to 12 sessions per person, per issue at no cost to the participant. Military OneSource offers these services either online, via telephone or face to face. Military OneSource providers engage participants in a traditional 50-minute session in an office setting with a provider located in the community within 15 miles/30 minutes of the participant, telephonically with a Military OneSource provider, or via a secure online chat with a Military OneSource provider.

Military OneSource services are available to Service members and their families for up to 180 days after discharge, separation, deactivation or retirement. Eligible individuals are able to schedule non-medical counseling sessions with a Military OneSource non-medical counseling provider by contacting the Military OneSource call center. During FY 2013, Military OneSource non-medical counselors provided more than 200,000 in-person counseling sessions, more than 20,000 financial counseling sessions and ensured participant safety in more than 2,000 duty to warn situations.

Chaplains and Mental Health Care in DoD

Overview

The Chaplain Corps of the Military Departments ensures that its chaplains are able to respond directly to individuals in need to include those with mental health issues. The mission of the Chaplain Corps is to directly or indirectly provide religious support to Service members and their families. Service members are encouraged to speak with chaplains and many do so because they are often the “gateway” which members seek due to unique accessibility, confidentiality and trust. At most installations, duty chaplains are available for confidential counseling on 24 hours, 7 day a week basis.

Most chaplains enter military service fully qualified to provide religious and pastoral care. Some enter with advanced counseling skills and credentials, but they are not the norm. Thus, to ensure Chaplain Corps personnel have basic counseling skills in their toolkit, all first-term Active Component, Guard and Reserve chaplains receive initial pastoral counseling training at Fort Jackson, SC.

Current Chaplain Assessment

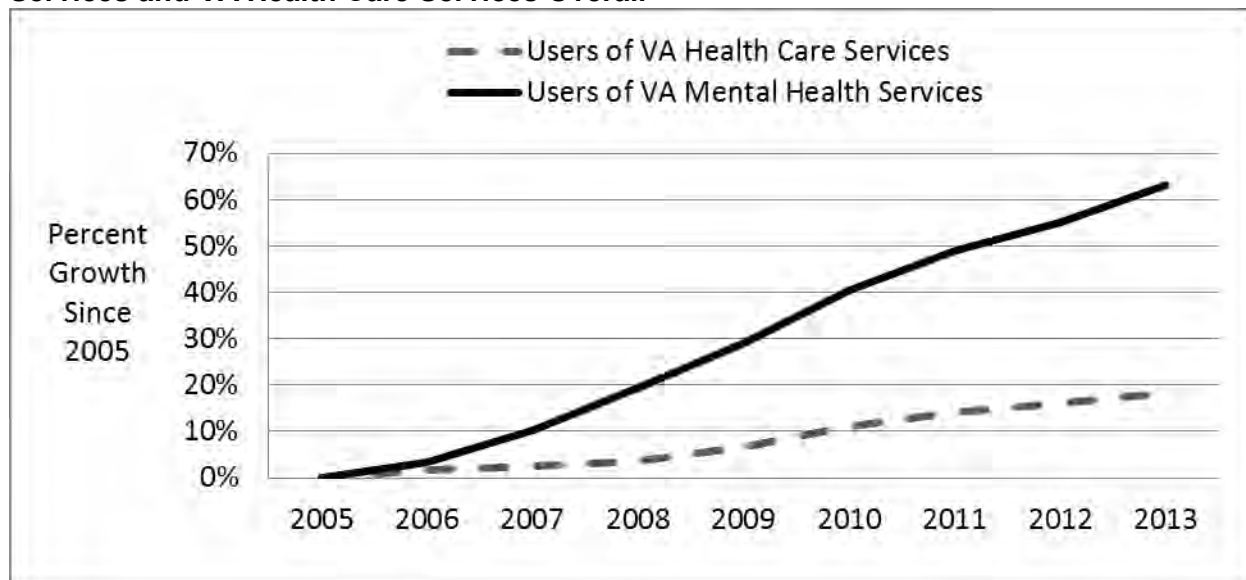
The Chaplain Corps currently consist of 2883 Active Duty chaplains. Of this number, the Army has 1590; the Navy 792; and the Air Force 501. The counseling expertise for these chaplains is defined in three levels: basic, intermediate and advanced skills. The education, training and credentialing included in these levels are: (1) Basic: Master of Divinity and initial chaplain school training, (2) Intermediate: Four units of Clinical Pastoral Education (CPE) and/or Masters Degree in pastoral counseling, and (3) Advanced: Board Certified Chaplain, Licensed Marriage and Family Therapist, Licensed Professional Counselor, Professional Counselor (American Association of Pastoral Counseling credential), Doctorate in pastoral counseling and/or certified CPE supervisor.

Mental Health Staffing in VA

Demand for Mental Health Services

Between 2005 and 2013, the number of Veterans who received mental health care from the VA grew by 63 percent, over three times the rate of increase seen in the overall number of VA users (Figure 4). As a consequence, the proportion of Veterans receiving mental health services has increased from 19 percent in 2005 to 26 percent in 2013. The growth in number of mental health encounters or treatment visits has been even more dramatic; mental health encounters have increased from 10.5 million in 2005 to 18.0 million in 2013 – a 71 percent increase.

Figure 4 Percent Growth since 2005 in Numbers of Veterans using VA Mental Health Services and VA Health Care Services Overall



A significant portion of this increase in utilization of mental health services is due to the influx of Veterans from recent conflicts, Operation Enduring Freedom (OEF)/ Operation Iraqi Freedom (OIF)/Operation New Dawn. From 2002 to 2013, 1,724,058 Veterans left Active Duty and became eligible for VA care. Of those, 998,004 (58 percent) have accessed VA care, and of these, 55 percent have received a provisional or confirmed diagnosis for a mental health disorder.

Factors Influencing Future Growth in Demand

Whether or not the numbers of Veterans using VA mental health services continues to grow at an average rate of approximately 8 percent per year, is dependent on a large number of factors, many of which are relatively unpredictable. These factors include possible downsizing of the military and the impact of the Affordable Care Act on private health insurance coverage. VA monitors the proportion of Veterans with disabilities related to their military service (i.e., service connected) in the community who are receiving VA mental health care; however, this proportion is likely to be quite elastic. At present, 5.9 percent of Veterans are receiving mental health care from VA, but these proportions increase for those with a service connected disability, particularly if it is for a mental health condition. In 2013, 23 percent of all service-connected Veterans and 50 percent of Veterans who have a service-connected mental health condition received mental health care from VA.

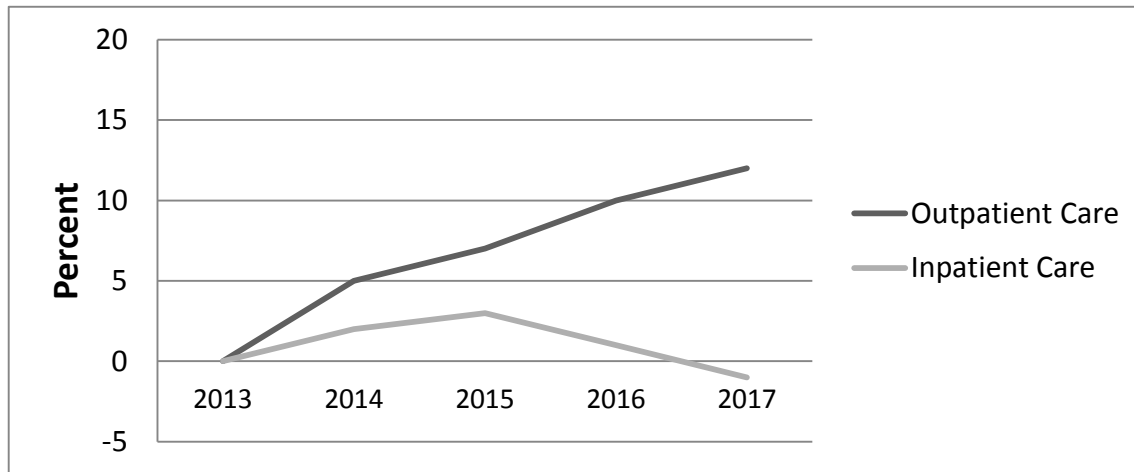
In addition to service-connected disabilities, another factor influencing the use of VA mental health care is the distance that Veterans must travel to receive VA services. Currently, 79 percent of VA patients are less than an hour from the nearest VA facility

providing mental health outpatient services. When Veterans have to travel farther, they are less likely to use services. Thus, any expansion of settings in which VA provides mental health services or in the use of telehealth services will likely increase the proportions of Veterans accessing those services.

In addition to Veteran characteristics, the demand for VA mental health treatment is likely to be responsive to capacity measures such as the space available for providing mental health treatment, the availability of open appointments, and the types of treatment that are offered and whether they meet Veterans' expectations and needs. Restrictions on physical space and equipment can reduce capacity to provide mental health care, even when all other elements of capacity are adequate. This is especially true in the face of rapid expansion of demand for services, which has occurred recently in VA. Such restrictions may lead Veterans to seek mental health treatment outside of VA.

The VA Office of Policy and Planning generates actuarial projections of future demand for mental health services based on historical trends, Veteran population demographics, and expected transformations in mental health care delivery. These projections are summarized in Figure 5, which shows that growth in demand for outpatient mental health care is expected to level off somewhat from that experienced over the past decade, with an average annual growth rate of three percent. Demand for inpatient mental health care is projected to be relatively stable over this period. Given the projected growth in demand and current organization and productivity levels of VA mental health services, a roughly 12 percent increase in mental health personnel would be needed to maintain current Veteran staffing ratios in FY 2014-2017. VA continues to seek efficiencies in the mental health care service line to help meet the increasing demand, but anticipates that additional hiring will be necessary to meet the demand.

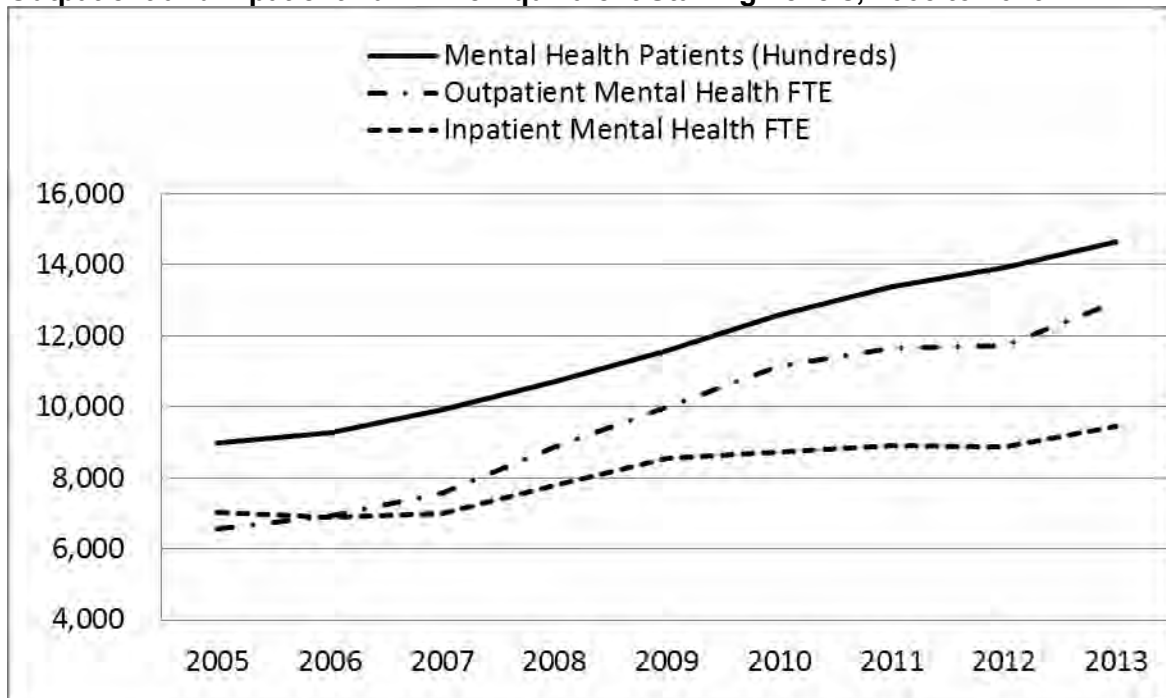
Figure 5 Projected Yearly Growth in Demand for Outpatient and Inpatient Mental Health Care, VA Office of Planning and Policy



Current Mental Health Staffing

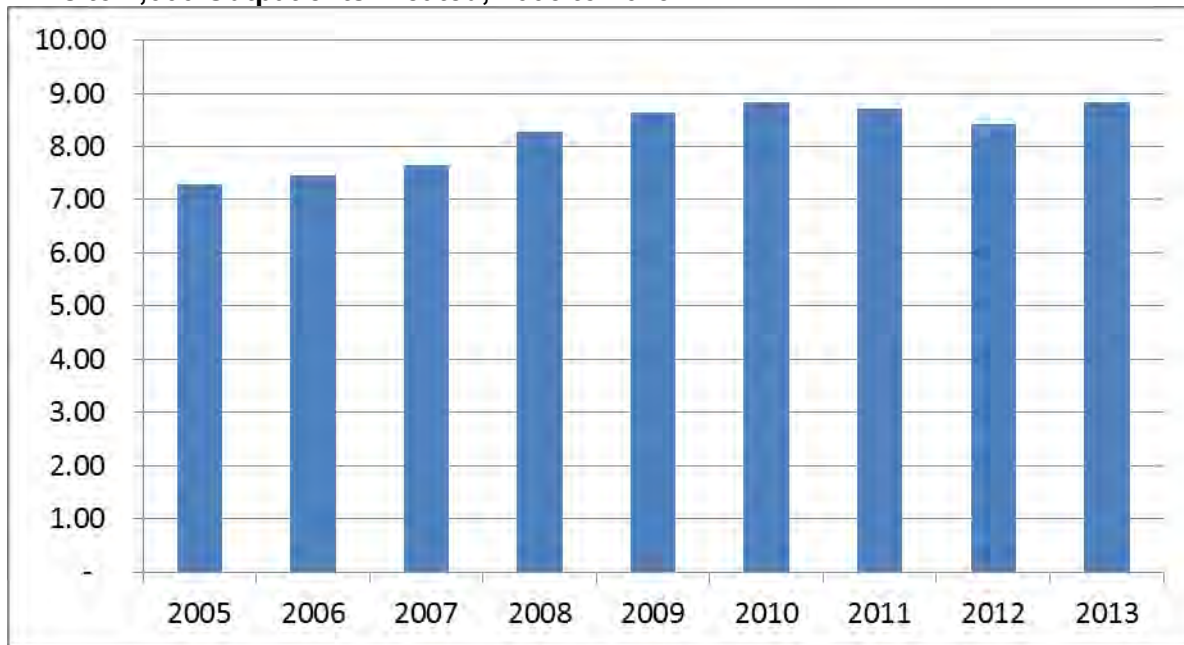
The recent rapid growth in the number of Veterans seeking mental health treatment in VA has posed challenges in the area of staffing. In Figure 6, the growth in numbers of Veterans using mental health services is depicted by the solid line, which shows an increase from 897,643 in 2005 to 1,464,654 in 2013. (The number of patients is expressed in terms of hundreds in order to show staff and patient numbers on the same graph. For example, 10,000 on the vertical axis represents 1,000,000 patients and 10,000 staff.)

Figure 6 Growth in Annual Numbers of Patients using Mental Health Services and in Outpatient and Inpatient Full-Time Equivalent Staffing Levels, 2005 to 2013



This graph also shows the growth in mental health clinical staff, measured in terms of the full-time equivalent staff providing outpatient and inpatient treatment. These providers include all VA-paid psychologists and psychiatrists who are not trainees and other providers, such as social workers, nurses, counselors, peer support specialists, and other medical professionals, when they are included in mental health encounters. The inpatient mental health staff Full Time Equivalents (FTEs) began to level off after 2009 consistent with a shift in mental health spending from inpatient to outpatient care. The hiring of outpatient mental health clinical staff grew somewhat faster than mental health patient numbers through 2010 and then began leveling off. A 2013 hiring initiative resulted in gains in both inpatient and outpatient staff FTEs, bringing overall staff to patient ratios closer to those present in 2010 (Figure 7, below).

Figure 7 Change over Time in the Ratio of Annualized Outpatient Mental Health Staff FTEs to 1,000 Outpatients Treated, 2005 to 2013



Factors Influencing Future Growth in Staffing

As with demand for mental health services, mental health staffing levels are influenced by complex and difficult-to-predict factors. These factors include staff vacancy rates, which can reflect staff burnout and turnover but also a variety of factors outside the control of a facility, such as local economic conditions and availability of mental health staff. For example, the pool of capable mental health staff in a VA facility's service area may not be proportionate to the potential pool of Veterans who might seek VA mental health treatment. Building space also may constrain a facility's ability to accommodate additional mental health staff and impact staffing levels and hiring decisions. Lower staff turnover, better staff training and experience, and availability of support staff and technology also can increase staff efficiency, whereas demands for additional tracking and documentation can reduce their efficiency. Challenges such as the geographic distribution of facilities and sub-specialty programming may also impact efficiency of service delivery.

As a consequence of such influences, VA facilities vary substantially in their staff-to-patient ratios. In early 2012, for example, the ratio of mental health outpatient clinical staff FTEs per 1,000 mental health patients seen during the year varied substantially across VA facilities, from a low of approximately five staff FTEs per 1,000 patients to a high of about 14 staff FTEs per 1,000 patients. To bolster staffing at VA medical facilities with low mental health staffing levels, facilities engaged in an active campaign to fill vacancies and hire new mental health clinical and clerical staff.

VA Staffing Model

Both patient demand for treatment and efficiency of care delivery are expected to increase over time. Therefore, to accurately determine staffing needs, staffing models need to account for both growth in needs and changing delivery patterns. Despite the many unknowns that will influence future demand for VA mental health services and staff hiring and training, VA is actively evaluating different approaches to developing staffing guidelines for individual facilities. As a key first step in the initiative to develop a staffing model for mental health treatment, VA has examined the relationships of clinical hours with measures of desired outcomes, such as appointment timeliness, proportions of patients who receive what is considered a typical effective dose of treatment, and patient and staff satisfaction. These analyses are shedding light on these relationships and will provide an empirical basis for setting targets for clinical and clerical staffing required to achieve desired outcomes. These efforts will allow VA to identify facilities with good clinical outcomes at comparatively lower staffing and to better understand the work processes that make this possible.

VA is currently refining staffing models to ensure they are both useful and meaningful and will then establish refined staffing guidelines that will continue to be monitored relative to a recommended target. Variations from these recommendations and explanations for these variations will improve VA's understanding of facility staffing practices. Achievement of these recommended staffing targets will likely require the hiring of additional staff at some facilities and staff realignment at others.

The current working model includes staffing for three settings of outpatient mental health care: PC-MHI, general mental health, and specialty mental health. PC-MHI works with patients in primary care to address mental health concerns that typically require low intensity treatment and maintenance treatment to stabilized patients with chronic mental health conditions. General mental health settings provide interdisciplinary recovery-oriented care for patients in need of standard care, including medication, case management, psycho-education, and common psychotherapies for mental health conditions (e.g., cognitive mental therapy for depression). Specialty mental health provides time-limited or diagnosis-specific specialty care for patients, including intensive substance use disorder and PTSD treatment, mental health intensive case management, psychosocial rehabilitation and recovery programs, methadone maintenance, and other typically sub-specialist delivered mental health care.

The mental health staffing workgroup, formed in 2011, has examined the distribution of care between general and specialty mental health services and found that the organization of care delivery between these two services varied substantially. Specifically, facilities that performed best on quality measures (based on site visits and other monitoring) varied extensively in the distribution of personnel and organization of their mental health programs. The workgroup therefore determined that the overall mental health staffing model should allow for local flexibility in the organization of staff between general and specialty mental health services. Consequently, to accommodate

such local variation, the workgroup decided to provide only an approximate range for the proportion of total staff that might be assigned to specialty programming.

Overall Mental Health Outpatient Clinical Staffing Model

During development of the overall staffing model, analyses have shown that higher staff-to-patient ratios are associated with better mental health population access, treatment quality, patient and staff satisfaction, and implementation of a variety of quality improvement measures designed to represent compliance with the Uniform Mental Health Services Handbook. Moreover, enhancements in mental health staffing during 2005-2009 were associated with decreases in suicide rates. Because no data exist on optimal staff-to-patient ratio, the current VA effort focuses on recommending that facilities increase to and then maintain a staff-to-patient ratio that is consistent with ratios observed in the top half of the current distribution. Because staffing ratios are population dependent and the population is growing at a substantial rate, the number of staff needed to reach this goal depends on the timing of the calculation. However, the mean ratio achieved prior to implementation of the 2013 mental health hiring initiative was 7.72 FTE staff for every 1,000 mental health patients, suggesting that overall, VA facilities would require 1,550 additional FTE mental health providers. As facilities examine their site-specific needs, develop goals for mental health staff of various professional disciplines as is appropriate to their populations, and hire according to these goals, VA will evaluate the impacts of this staffing level on access and quality as a basis for continuing refinement of the staffing model. As the demand for mental health services grows, some additional hiring may be necessary. Moreover, turnover in mental health staff will require vacancies be filled promptly to maintain mental health outpatient clinical staff-to-patient ratio. Future staffing recommendations will be monitored, and analyses will be undertaken to understand the reasons for a facility maintaining a staffing ratio that is inconsistent with these recommendations.

As noted above, the VA Office of Policy and Planning generates actuarial projections of future demand for mental health services, and VA is developing systems to present these projections in terms of expected clinical hours of care for use in facility planning. Additional information on current staff-to-patient ratio, proportion of staff time allocated to clinical care delivery (versus alternatives such as education, research or administrative activities), and staff productivity (e.g., encounters completed per unit of clinical time) will be considered by facilities to develop plans for meeting capacity needs in the coming years. Plans might include hiring additional staff, process or organizational redesign to increase the productivity of existing staff, or realignment of staff job duties to increase time spent in clinical care delivery. Currently, variations in staff-to-patient ratio, allocation of staff time, and productivity are being examined to understand the optimal range for these factors associated with clinical effectiveness and patient access and to provide guidance for organizational decision-making.

General Mental Health Staffing

Based on the success of the primary care Patient Aligned Care Team model in VA, a stable, an assigned interdisciplinary team that coordinates and delivers Veteran general mental health care is expected to result in many improvements to patient care. These potential benefits include improved Veteran engagement in care, care coordination, quality, and recovery-oriented care, as well as increased efficiency. Efficiencies are expected to result from reducing redundant assessment and overlapping care and preventing adverse events through better case management. When applied to general mental health staffing, this approach has been termed the BHIP.

A BHIP staffing model was developed to provide staffing guidance to VA medical facilities that would facilitate successful full implementation of interdisciplinary team-based mental health care within general mental health settings. Based on consultation with external healthcare systems and review of existing literature and VA utilization and staffing data, initial staffing guidelines were generated that outline the number of clinical and non-clinical staff needed to provide care within the general mental health setting for panels of 1,000 Veteran mental health patients who require this level of care. The current model, which is being piloted, recommends 6.1-6.5 FTE clinical providers and 0.5-1.0 FTE administrative/clerical staff for a team panel size of 1,000 Veterans receiving general mental health care. This general mental health team staffing model suggests that Veterans who require residential or inpatient care or three or more outpatient encounters per year should be assigned to a BHIP team/panel. Notably, this model outlines the full set of functions that team members must collectively perform, but does not specify the provider types that need to be included on the team. The broad staffing recommendations, exclusive of provider type, recognizes that many mental health functions can be effectively performed by multiple types of providers and that local medical facilities require some discretion in determining specialty needs based on population demand.

This initial model is being pilot tested in four Veterans Integrated Service Networks (VISN), and detailed specifications of the model and effective methods for implementation are being refined based on experience in these four networks. Interviews focusing on the BHIP team implementation process and its impact were conducted with 16 pilot sites in February and March of 2013. Core elements of BHIP teams were highlighted in conversations with pilot sites. Pilot sites identified regularly-occurring, weekly team meetings, attended by all BHIP team members, as well as daily “huddles” to discuss patient issues, as the single most important core element of BHIP. In addition to patient outcomes, pilot sites have recognized the importance of incorporating evaluation of team processes into standard BHIP practice. Thus, the staffing model and productivity standards need to reflect the critical value of these activities.

BHIP pilot sites have identified several barriers to incorporating BHIP practices into VA mental health services. Resource constraints included challenges with scheduling exclusive team meetings within ongoing practice, lack of facility space, and insufficient

mental health staff. Additional challenges arose as BHIP teams restructured the assignment of some personnel (e.g., nurses) whose disciplines were not traditionally housed in mental health areas.

When asked to assess the impact of BHIP team implementation, most sites indicated the transition to BHIP teams within their mental health services was associated with improved continuity of mental health care (76.5 percent of sites), improved relationships between medical providers (93.8 percent of sites), increased Veteran access to mental health care (50 percent), and improved overall Veteran health status (50 percent of sites). Though pilot sites identified the need for regular weekly team meetings, 18.8 percent of the sites believed that such a meeting reduced Veteran access to care as clinical hours were utilized for these meetings.

Although this initial evaluation of BHIP pilot implementation has provided valuable data regarding the BHIP model and its usefulness within VA, continued evaluation of the implementation and maintenance of the model is necessary and planned. As BHIP is more broadly implemented across VA and evaluation of this model is more mature, refinement of the mental health staffing model is expected.

Assessment of Staffing in VA Mental Health Care

Based on current projections, the demand for VA mental health service is expected to grow, but the rate of growth will vary by location and patient population. Where additional personnel are needed, some VA facilities may encounter recruiting difficulties. Such facilities will be encouraged to meet patient demand using alternate strategies, such as contracting with community providers or expanding telehealth models of care.

Finally, it should be acknowledged that any discussion of future healthcare workforce needs is fraught with uncertainty about the impact of alternative practice models (e.g., group visits or peer counseling), advances in clinical care, and the introduction of new technologies such as telehealth. Such changes may either decrease or increase demand for services (National Health Policy Forum, 2013). Therefore, all staffing models and projects, whether for mental health or more general clinical needs, should be viewed as provisional and highly dependent on evolving conditions.

Non-Medical Counseling - VA

Readjustment Counseling Service

Overview

VA's Vet Centers present a unique service environment—a personally engaging setting that goes beyond the medical model—in which eligible Veterans, Service members, and their families can receive professional and confidential care in a convenient and safe community location. Vet Centers are community-based counseling centers that provide

a wide range of social and psychological services including professional readjustment counseling to eligible Veterans, Service members, and their families; counseling for those that have experienced a military sexual trauma; and bereavement counseling for eligible family members who have experienced an Active Duty death. Vet Center staff also provides community outreach, education, and coordination of services with community agencies that link Veterans and Service members with other needed VA and non-VA services. A core value of the Vet Center is to promote access to care by helping those who served and their families overcome barriers that may impede them from using those services. For example, all Vet Centers have scheduled evening and/or weekend hours to help accommodate the schedules of those seeking services.

Current Readjustment Counseling Service Staffing

Since 2003, the beginning of combat operations in Afghanistan and Iraq, RCS has experienced significant expansion, including an increase of 94 Vet Centers, the creation of the Mobile Vet Center Program and Vet Center Combat Call Center. This represents more than double of the authorized FTE (103 percent increase).

There are currently 300 Vet Centers located throughout the United States, Puerto Rico, Guam, and American Samoa. RCS also operates 70 Mobile Vet Centers that extend access to readjustment counseling into communities that are located far distantness from existing services, and the Vet Center Combat Call Center. This 24/7 confidential call center is a place for Veterans, Service members, and their families to call and talk about their military experience and transition home.

RCS is currently authorized 1,917 FTEs of which 95 percent provide direct readjustment counseling services to Veterans, Service members, and their families. Each Vet Center is comprised of a small multidisciplinary team (average of six FTEs) reminiscent of a military squad. The staff is comprised of a team leader, readjustment counselors, outreach staff, and an office manager. Vet Center team leaders and readjustment counselors typically have an advanced degree in their given field (Psychology, Social Work, Professional Counseling, Marriage Family Therapy, etc.). As of March 1, 2014, RCS employs 134 Psychologists, 762 Social Workers, and 386 counselors with other types of advanced degrees (Professional Counseling, Marriage Family Therapy, etc.).

Recent legislation has extended Vet Center eligibility to the following new Veteran and Service member cohorts:

- Current member of the Armed Forces who served in any combat theater or area of hostility
- Any Veteran or current member of the Armed Forces who provided direct emergency medical or mental health care or mortuary services to the casualties of combat operations or hostilities, but who at the time was located outside the theater of combat operations or area of hostilities, and
- Any Veteran or current members of the Armed Forces who engaged in combat with an enemy of the United States or against an opposing military force in a

theater of combat operations or an area at a time during which hostilities occurred in that area by remotely controlling an unmanned aerial vehicle.

Assessment of Readjustment Counseling Service Staff

To determine the additional staff requirements to fully implement services to these new cohorts, projected Active Duty Service member usage was estimated using existing Veteran's Vet Center usage rates. It was estimated that an additional 63 positions were required to provide services to these cohorts. Staffing adjustments will be made as actual service usage is assessed. RCS has already received additional resources to augment Vet Center staff and services in FY 2014.

Chaplains and Mental Health Care in the VA

Overview

Chaplains in VA fulfill a number of important roles: They ensure Veterans receive appropriate clinical pastoral care; they protect Veterans' constitutional right to free exercise of religion; and they protect patients from having religion imposed on them. Additionally, chaplains often serve as a trusted point of contact for Veterans and Service members with mental health needs. Understanding the importance of this mental health role, VA and DoD included as part of the Joint Integrated Mental Health Strategy (IMHS) an explicit focus on how to close the gap between existing integration of chaplains with mental health care and optimal integration (Nieuwsma et al., 2013).

Current Chaplain Assessment

The VA/DoD IMHS gap analysis resulted in a series of recommendations that are currently being implemented on a limited scale with two-year funding from the VA/DoD Joint Incentive Fund (JIF). The \$2.7 million in JIF monies are being used to implement systems redesign processes at seven VA medical centers and seven DoD medical treatment facilities. Participating facilities are aiming to systematically incorporate chaplains with mental health care services to decrease the stigma associated with mental health care and increase access to needed mental and spiritual care for Veterans and Service members. JIF monies are also being used to equip and certify a cohort of 20 VA chaplains and 20 DoD chaplains to better care for Veterans and Service members with mental health needs. This is being done via a year-long distance education program to be completed by chaplains who are concurrently working in medical treatment facilities. Table 4 provides a description of the gap that needs to be closed between existing and optimal practices, ongoing efforts to close this gap on a limited scale via the two-year JIF project, and future needs for sustaining and spreading strong practices.

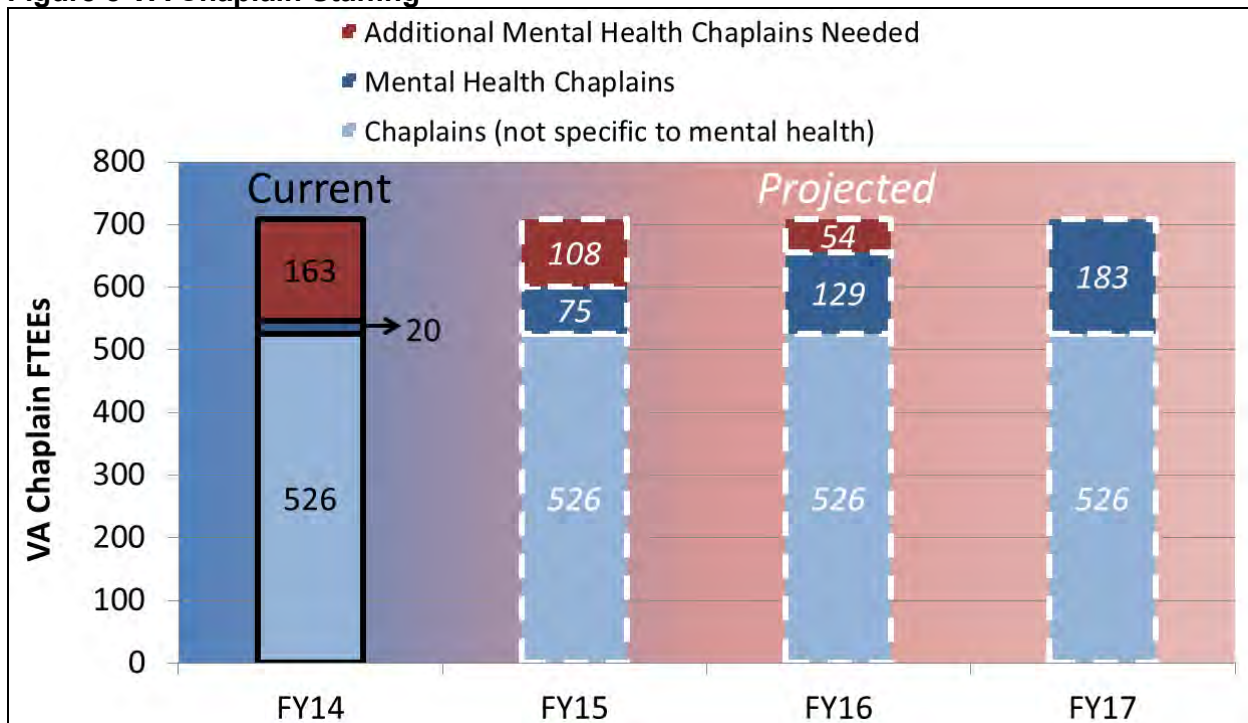
Table 4 Addressing Gaps in Integration of Chaplain and Mental Health Care Services

Gap Analysis Need	Ongoing Efforts in VA/DoD	Sustain and Spread
<p>1. <u>Equipped Systems</u></p> <p><i>Need medical treatment facilities that systematically integrate and utilize chaplains to decrease mental health care stigma, increase access to services, and provide holistic care for Veterans and Service members.</i></p>	<p>A “learning collaborative” model is being used to implement systems redesign practices at 7 VA and 7 DoD facilities.</p>	<p>Implement systems redesign practices at remaining VA medical centers and DoD medical treatment facilities.</p>
<p>2. <u>Equipped Chaplains</u></p> <p><i>Need chaplains appropriately equipped to provide care to Veterans and Service members with mental health problems and serve on mental health teams.</i></p>	<p>A year-long distance education training program is being completed by 20 VA chaplains and 20 DoD chaplains.</p>	<p>Train new cohorts of chaplains each year, placing these chaplains in settings where they have been traditionally underutilized (e.g., outpatient mental health).</p>

Projected Pastoral Care/Counseling Staffing

Among Post-9/11 Veterans who screen positive for a mental health problem, research indicates that over the course of a year 45 percent will talk with a mental health professional and a full 20 percent will talk with a pastoral counselor or chaplain (Elbogen et al., 2013). Issues of stigma and trust lead many Veterans with mental health problems to initially turn to chaplains instead of mental health professionals, as is well understood by both VA and DoD chaplains (Nieuwsma et al., 2013). Yet for FY 2014, “mental health chaplains” i.e., chaplains with a position description specific to mental health – account for only 20 FTEs in VA (see Figure 8). The majority of VA facilities do not currently have a mental health chaplain. In order to supply all 151 VA medical facilities with at least one mental health chaplain and to supply an additional mental health chaplain community coordinator to larger, complex VA facilities (i.e., the 32 Level 1a VA facilities that see a larger volume of patients, train residents, conduct research, and have more complex patients), an estimated total of 183 mental health chaplains are needed (actual distribution of FTEs to vary depending on particular facilities’ needs and capacities). This would require VA to support the hiring of 163 new FTEs. Should VA support this increase, hiring could be accomplished incrementally over a period of three fiscal years (55 chaplains in FY 2015, 54 in FY 2016, and 54 in FY 2017) in order to ensure that the most highly qualified applicants are hired and that these chaplains can be accommodated and appropriately equipped as part of existing mental health chaplain trainings (see Table 3). For FY 2015-2017, Figure 7 displays projections for the additional staffing needed to move from the current level of having 11 percent of needed FTEs in FY 2014 to 41 percent in FY 2015, 70 percent in FY 2016, and 100 percent in FY 2017.

Figure 8 VA Chaplain Staffing



Figures in graph are rounded to nearest whole number. As of FY14, VA employs 545.6 FTEE chaplains (20 mental health chaplains, and 525.6 not specific to mental health). Of these, 490 are full time, 91 (39.4 FTEE) are part-time, and 69 (16.2 FTEE) are intermittent basis chaplains. Additionally, VA has 115.0 Clinical Pastoral Education residents in FY 2014 (not shown in graph).

Therapeutic and Supported Employment Services

Overview

The VA's TSES was established for Veterans whose lives have been disrupted by mental illness or coexisting physical disabilities, and who would benefit from a supportive, stable approach to work. TSES utilizes work-based treatment to facilitate and strengthen vocational rehabilitation potential and to provide a continuum of vocational skill development services leading to long-term, career community employment. These programs are distinct and unique from the Vocational Rehabilitation and Employment program administered by the Veterans Benefits Administration in two primary ways, (1) VA service connection, disability compensation, or VA pension are not required to receive treatment through TSES, and (2) TSES vocational services are integrated in the Veteran's medical treatment and continuum of care. TSES programs provide paid work experience and vocational assistance services to approximately 80,000 Veterans each year, including 6,000 OEF/OIF Veterans. These services are integrated into the Veteran's overall mental health treatment plan. VA benefits including service-connected compensation and non-service connected pensions cannot be reduced, denied, or discontinued based on participation in either Compensated Work Therapy (CWT) or Incentive Therapy. Earnings generated through IT, CWT/Workshops, and CWT/Transitional Work (CWT/TW) are also tax exempt and

excludable as income for Social Security Administration Supplemental Security Income purposes. Additional information may be found at the TSES website: www.cwt.va.gov.

Current Major TSES Programs

- **CWT/TW:** CWT/TW is pre-employment vocational assessment program that operates in VA medical centers and/or local community business and industry. CWT/TW participants are matched to actual work assignments for a time limited basis. Veterans are supervised by personnel of the sponsoring site, under the same job expectations experienced by non-CWT workers. CWT/TW participants are not considered employees and receive no traditional employee benefits. Participants receive the greater of Federal or state minimum wage, or more, depending on the type of work.
- **CWT/Supported Employment (CWT/SE):** CWT/SE consists of full-time or part-time competitive employment with extensive clinical supports. The focus of CWT/SE is to assist Veterans with psychosis and other serious mental illness gain access to meaningful competitive employment. CWT/SE support services are phased out after the Veteran is able to maintain employment independently. CWT/SE is used for Veterans with spinal cord injury, traumatic brain injury and/or PTSD through VA Research & Development sponsored research.
- **Vocational Assessment:** This service includes individual vocational guidance, counseling, and assessment of Veterans skills, abilities, and vocational interests for rapid job search in the community for competitive employment.

Assessment of TSES Service Staff

TSES staffing levels are determined locally by facility leadership. In FY 2013, approximately 1,250 TSES FTE provided TSES services to almost 73,000 Veterans nationwide. This represents a national average of 5 percent of Veterans who were treated in VHA for a mental health condition in FY 2013. Using the VA Office of Policy and Planning projections summarized in Figure 2 above, a 3 percent annual growth in demand for mental health services is expected. By FY 2017 an additional 160 FTE would be required in order to continue to provide TSES services to 5 percent of Veterans receiving mental health treatment, for a total of approximately 1410 FTE.

However, we expect that demand for TSES services is much higher than existing modeling efforts suggest. A report on services in the VHA by RAND-Altarum indicates that 10.5 percent of Veterans with a psychiatric diagnosis receiving VHA services reported a need for vocational support, twice as many currently receiving TSES services. Thus, there is likely an unmet need for vocational services among Veterans receiving mental health services in VHA. Secondly, existing TSES services predominantly serve Veterans with mental health diagnoses. Ongoing VA research on Supported Employment for Veterans with physical disabilities such as traumatic brain injury, polytrauma/blast injuries, and spinal cord injuries suggests that Supported

Employment services increase rates of employment for these Veterans and thus many could benefit from TSES services.

In summary, by FY 2017, 1,410 TSES FTE would be needed in order to maintain existing demand. However, for the reasons stated above, this is likely an underestimate of true demand. We will continue to assess the need for vocational services among Veterans receiving health services in VHA and revise estimates for needed staffing for TSES services as necessary.

Summary

Several initiatives are underway to provide improved access to mental health care, increased provider availability, and more effective recruitment and retention incentives to mental health providers. TRICARE plays a significant role in caring for beneficiaries and is continually evaluating and adjusting its programs and policies to ensure that eligible beneficiaries are receiving the mental health services required. Civilian medical workforce planning efforts throughout DoD have streamlined the hiring process of civilian mental health care providers. Utilizing appointing flexibilities such as direct-hire authority, as well as compensation incentives, DoD has increased competitiveness in light of the shortage of mental health care providers. As a result, DoD has been able to increase recruitment and hiring of many behavioral health care positions.

Similarly, VA continues to seek empirically validated approaches to guide the revision of mental health services provided to Veterans. An explicit responsibility of the VA is the provision of healthcare (including mental health care), that ranges from young adulthood to geriatric care and to do so with a focus on recovery, quality of life, and a satisfactory level of daily functioning. Though the VA leverages private sector care to meet the medical needs of a Veteran as necessary, VA care is the Veteran-centric based in an understanding of and appreciation for the culture of military service. The DoD and VA acknowledge that any discussion of the future healthcare workforce must acknowledge that alternative practice models (e.g., group visits or peer counseling), advances in clinical care, and the introduction of new technologies will affect the delivery of future services. Such changes may either decrease or increase demand for services and impact the prediction of future staffing projections.

The DoD and VA continue to focus on meeting the needs of our beneficiaries for mental health services through investments in prevention and early intervention. Both Departments are working to provide a spectrum of services to ensure delivery of preventive care and information, access to mental health services in primary care, a reduction of stigma associated with seeking mental health care, and assistance in coordination of care. We expect this balanced approach to produce savings by reducing untreated dysfunction and long-term costs in medical utilization and disability payments, attrition, and training.

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Acronym List

BHDP	Behavioral Health Data Portal
BHIP	Behavioral Health Interdisciplinary Program
CWT	Compensated Work Therapy
CWT/SE	Compensated Work Therapy /Supported Employment
CWT/TW	Compensated Work Therapy /Transitional Work
CPE	Clinical Pastoral Education
DHA	Defense Health Agency
DoD	Department of Defense
DoDI	Department of Defense Instruction
eMSM	Enhanced Multi-Service Market
FTE	Full Time Equivalent
FY	Fiscal Year
HPSP	Health Profession Scholarship Program
IMHS	Integrated Mental Health Strategy
JIF	Joint Incentive Fund
MEDCOM	US Army Medical Command
MFLC	Military and Family Life Counseling
MHS	Military Health System
MTF	Military Treatment Facilities
NCR-MD	National Capital Region Medical Directorate
NDAA	National Defense Authorization Act
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
PC-MHI	Primary Care-Mental Health Integration
PHRAMS	Psychological Health Risk Adjusted Model for Staffing
PSM	Professional Service Model
PTSD	Posttraumatic Stress Disorder
RCS	Readjustment Counseling Service
T2	Telehealth and Technology
TAO	TRICARE Area Office
TMH	Tele-Mental Health
TSES	Therapeutic and Supported Employment Services
VA	Department of Veterans Affairs
VHA	Veteran's Health Administration