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

PERSONNEL AND
READINESS

The Honorable John McCain
Chairman
Committee on Armed Services
United States Senate
Washington, DC 20510

JAN 11 2017

Dear Mr. Chairman:

The enclosed is in response to section 593 of the National Defense Authorization Act for Fiscal Year 2016 (Public Law 114-92), requiring the Secretary of Defense to submit a report on the feasibility of conducting, before the accession or enlistment of an individual into the Armed Forces, a mental health screening to bring mental health screenings to parity with physical screenings of prospective members.

The report explains that recent revisions in the accessions screening process place mental health screenings on par with physical screenings of prospective members, to include screening for learning, psychiatric, and behavioral issues in concert with screening for physical systems including neurologic disorders and brain injuries. Further, once personnel are accessed into a Service, an extensive annual and deployment-related screening process allows changes in mental health screenings relating to traumatic brain injuries, post-traumatic stress, and other conditions to be tracked across time and incorporated in the annual Periodic Health Assessment. Finally, the Military Entrance Processing Command (MEPCOM) has a secure and centralized electronic database housing mental and medical screening and applicant information. Based upon these findings, the report concludes that modifications to the current MEPCOM screening process are not recommended.

A similar letter is being sent to Chairman of the Committee on Armed Services of the House of Representatives. Thank you for your interest in the health and well-being of our Service members, veterans, and their families.

Sincerely,

Peter Levine
Performing the Duties of the Under Secretary of
Defense for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Jack Reed
Ranking Member

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

PERSONNEL AND
READINESS

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

JAN 11 2017

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Sincerely,

Peter Levine
Performing the Duties of the Under Secretary of
Defense for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Adam Smith
Ranking Member

Report on Section 593 of the National Defense Authorization Act for Fiscal Year 2016, (Public Law 114-92)

Report on Preliminary Mental Health Screenings for Individuals Becoming Members of the Armed Forces

The estimated cost of this report or study for the Department of Defense is $11,300 for the 2016 Fiscal Year. This includes $5,020 in expenses and $6,300 in DoD labor.
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Report on Preliminary Mental Health Screenings for Individuals Becoming Members of the Armed Forces

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PRELIMINARY MENTAL HEALTH SCREENINGS FOR INDIVIDUALS BECOMING MEMBERS OF THE ARMED FORCES

INTRODUCTION

This report is in response to section 593 of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2016 (Public Law 114-92), which requires the Secretary of Defense to "submit to the Committees on Armed Services of the Senate and the House of Representatives a report on the feasibility of conducting, before the accession or enlistment of an individual into the Armed Forces, a mental health screening to bring mental health screenings to parity with physical screenings of prospective members." The report is required to include the following elements: recommendations with respect to establishing a secure, electronically-based preliminary mental health screening of new members of the Armed Forces and recommendations with respect to the composition of the mental health screening, evidenced-based practices, and, how to track changes in mental health screenings relating to traumatic brain injuries, post-traumatic stress disorder, and other conditions.

EXECUTIVE SUMMARY

Prospective members of the Armed Forces are screened at the time of accession for both currently present, and histories of, physical and mental conditions that may be disqualifying for accession. The Department of Defense (DoD), specifically the United States Military Entrance Processing Command (USMEPCOM), has processes in place to conduct these screenings and to identify individuals who do not meet the standards outlined in Department of Defense Instruction (DoDI) 6130.03 "Medical Standards for Appointment, Enlistment, or Induction in the Military Services," dated April 28, 2010. Each of these screening steps in the Military Entrance Processing Station (MEPS) examination process is detailed in the Attachment of this report.

These Medical Standards require screening for learning, psychiatric, and behavioral issues inclusive with screenings for all physical systems (e.g., neck, eyes, spine) and other conditions (neurologic and sleep disorders). If, at the time of this screening, a physical or mental condition is identified that may be disqualifying, the prospective member can be referred for additional assessment by a medical specialist consultant prior to a final medical qualification decision being made by USMEPCOM. Not all applicants are referred. If the MEPS provider has enough information to make the medical qualification decision, a consult is not necessary. The consultants never make the qualification decision; they just provide medical information regarding the applicant, and the MEPS medical provider, as the DoD authority for this decision, can independently medically qualify or disqualify the applicant based on their clinical judgment.

The USMEPCOM currently has an established, secure, and centralized electronic database, the United States Military Entrance Processing Command Integrated Resource System (USMIRS), in which the above referenced mental and medical screening and applicant

information is housed. The system is used at the 65 MEPS across the continental United States, Puerto Rico, Alaska, Hawaii, and at the USMEPCOM headquarters, North Chicago, IL, but there is no existing electronic pipeline from the MEPS to the Services for screening question results as all the forms are in paper.

Given the uncertainty of the benefit of additional measures, and the added costs and time associated with administration of psychological and neuropsychological assessment measures as distinguished from the mental and physical screening currently in place, modifications to the current USMEPCOM screening process would not be advised. For personnel already accessioned, the DoD is currently working on implementing an annual screening process that incorporates the same screening questions used in DoD's deployment-health screening tools. This will allow changes in mental health screenings relating to traumatic brain injuries, post-traumatic stress disorder, and other conditions to be tracked across time. In the near future, these changes will be incorporated in the annual Periodic Health Assessment (PHA), for the approximately 50 percent[1] of Active Duty Service members who never deploy. All of the psychological and behavioral questions included in the Pre-Deployment Health Assessment Questionnaire and the Post-Deployment Health Reassessment will be incorporated into the PHA, allowing comparisons across a consistent set of health and mental health issues throughout a Service member's term of service, with additional administrations focused on screening before and after deployments (one before and three at intervals post-deployment).

BACKGROUND

The Accession Medical Standards Working Group

The Accession Medical Standards Working Group (AMSWG) was tasked in 2009 by the Under Secretary of Defense for Personnel and Readiness (P&R), to review accession screening for mental health disorders. In June 2009, an Army Memorandum to the Assistant Secretary of Defense for Health Affairs and Deputy Under Secretary of Defense for Military Personnel Policy recommended use of a 4-question depression screen, the Alcohol Use Disorders Identification Test-Consumption (AUDIT-C), and four other questions targeting self-mutilation, suicidal behavior, impulsivity, and sleep disturbance for use in USMEPCOM applicant medical processes. In October 2009, the USMEPCOM implemented supplemental behavioral health and alcohol use questions for applicants of all Services during their medical screenings for accession.

In 2010, the U.S. Army called for the AMSWG to determine mental health accession screening questions that would identify those recruits who may be at future risk for death by suicide. After a thorough review of the literature and examination of multiple content related screening instruments, a mental health Subject Matter Expert panel concluded that no validated mental health screening tool exists that reliably predicts suicide. As recently identified in

[1] Defense Manpower Data Center, "March 2016 Contingency Tracking System Deployment File Reports", March 2016; ADSMs with no deployment experience (50.65%)

research conducted by Franklin and Ribiero[2], our ability to predict suicidal thoughts and behaviors is hardly better than chance, despite 50 years of research on the topic.

In 2011, the AMSWG recommended to the Medical and Personnel Executive Steering Council (MEDPERS) that existing accession tools be evaluated through multiple pilot projects and develop new tools as needed; that the MEPS medical officers be given past behavior data obtained by recruiters; and that behavioral health questions be administered face-to-face during medical screening. MEDPERS approved implementation of five face-to-face questions to provide behavior data during medical history interviews for applicants for use by all Services. In July 2011, USMEPCOM added these questions to the medical history owing to the potential for face-to-face medical interviews conducted by MEPS Chief Medical Officers to elicit more behavioral health information from applicants than just answering behavioral health questionnaires on a form. Today, this screening tool is referred to as the *Applicant Behavioral Health Interview* which is augmented by having applicants answer the 2009 supplemental health and alcohol use questions. USMEPCOM has analyzed data periodically from 2009-2015 and found that the Applicant Behavioral Health interview elicited approximately a 70 percent increase in additional disclosures. However, USMEPCOM medical providers continue to be challenged by applicants who do not disclose their past medical histories and, over time, the USMEPCOM analyses have indicated that applicant disclosures have decreased for the supplemental health questions

Current DoD Accession Screening

DoD's accession screening processes are meant to determine the applicants' suitability for military service, not to establish a baseline of mental health functioning in anticipation of their future need for clinical care or release from service. DoDI 6130.03 establishes accession medical standards at the DoD level.

Existing mental health requirements are outlined in DoDI 6130.03, Section 29. During the medical interviews and physical examinations that are required for accession processing, specific questions are incorporated to evoke potential markers of psychological and behavioral dysfunction potentially incompatible with military service. There are six screening steps in the entrance processing examination process (as detailed in the Attachment) each of which includes mental health and forensic screening components. The Medical History Provider Interview form has augmented the standard Report of Medical History (DD 2807-1) since 2009. Figure 1 provides the background and details pertaining to the use of this Interview. This form includes 12 questions eliciting past history of behavioral health issues and alcohol use. No additional mental or physical health accession screen has yet been identified, or validated, to have adequate

[2] Franklin, J. C., Ribeiro, J. D., Fox, K. R., Bentley, K. H., Kleiman, E. M., Huang, X., Musacchio, K.M., Jaroszewski, A. C., Chang, B. P., & Nock, M. K. (2016, November 14). Risk Factors for Suicidal Thoughts and Behaviors: A Meta-Analysis of 50 Years of Research. Psychological Bulletin .Advance online publication. http://dx.doi.org/10.1037/bul0000084

reliability or the ability to predict potential adverse behavioral health outcomes for the large and heterogeneous population of recruits.

Figure 1

Medical History Provider Interview

In 2009 USMEPCOM implemented the Supplemental Health Screening (SHSQ) Questionnaire consisting of 12 behavioral health and 3 alcohol use questions to be completed at the MEPS at the time of filling out the health history. In 2010, owing to concern with non-disclosure issues, the AMSWG recommended a person-to-person behavioral health screening interview based on the belief that applicants would be more likely to disclose this history in an interview than on paper. This resulted in the use of five focus areas about each applicant's behavioral health history (law enforcement encounters, school authority encounters, behavioral health professional encounters, self-mutilation encounters, and home environment encounters) being implemented in 2011. While not standardized or subjected to reliability or validity testing, exploratory analyses have indicated that over time these interview focus areas have continued to generate additional behavioral health disclosures. For example, during the last analysis window of USMEPCOM data, approximately 1 percent of applicants answered "yes" to six supplemental behavioral health questions (depression [2 questions], less interested in most things [2 questions], considered or attempted suicide, or had trouble sleeping nearly every night) but during the medical history interview with the focus area of "Have you ever seen a psychologist, psychiatrist or counselor or taken any medication for depression, anxiety, or to help you concentrate better?", an additional 2.9 percent of applicants disclosed some type of history. Between the two methods, the disclosure percentage is 3.9 percent, indicating that the overall the percentage of applicants disclosing issues is very small.

During medical interviews and physical examinations, every applicant is asked to respond to specific questions and meet other criteria such as identifying adverse encounters with law enforcement and schools, but the information USMEPCOM obtains is limited to what is disclosed by candidates. Obtaining this objective historical medical data, as well as law enforcement and school encounter information, is considered important and useful in identifying indicators of need for more in-depth evaluation by MEPS to assess the risk of possible future psychological and behavioral dysfunction incompatible with military service.

Any condition reported or identified during the medical examination that does not meet the DoDI 6130.03 standard is considered disqualifying. In any case in which the MEPS examiner has reasonable suspicion that the applicant may manifest psychological or behavior health conditions incompatible with military service, the provider can also decide to obtain additional supporting medical information from the applicant's personal physician or refer the applicant for further psychological evaluation. Consultation evaluations are provided back to the MEPS and the MEPS medical provider ultimately determines whether an applicant is medically qualified or disqualified based on the DoDI 6130.03 medical accession standards. Each Service still has the authority to waive the fitness for accession standard on a case by case basis. Applicants who are medically disqualified at the MEPS may be referred to the Service Waiver Review Authority for waiver consideration based on their Service's unique requirements.

Current DoD Mental Health Screening Programs for Active Duty Service Members

The DoD has invested significant attention and resources to ensure routine mental health screenings are incorporated across the DoD from the time of accession throughout the Service member's tenure. This emphasis on screening for mental health concerns occurs before, during

and after deployments, and by additionally embedding mental health providers within operational units.

Mental health screenings consist of a two-stage self-report assessment using validated tools to screen for alcohol use, posttraumatic stress disorder (PTSD), and symptoms of depression. These self-reported measures are followed by a person-to-person interview with a healthcare provider to assess for suicidal ideation and violence risk, address specific mental health concerns, provide reassurance and information about available resources, and make any necessary referrals for additional care and follow-up. The two-stage assessment has resulted in greater specificity of symptoms upon which to base provider referrals.

As directed by DoD policy, these deployment-related screenings are conducted during four time frames in a consistent manner across the Military Services and are administered at least 90 days apart; within 120 days before the estimated date of deployment; between 90 and 180 days after return from deployment; between 181 days and 18 months after return from deployment; and, between 18 and 30 months after return from deployment. A recent policy revision now includes the requirement to conduct screenings in the deployed setting once every 180 days. Service members who screen positive receive further evaluation with a trained mental healthcare provider to determine the full nature and severity of any indicated mental health problem.

Of additional importance is the incorporation of these same question sets into the required annual PHA. This provides the means for comparison of the physical and mental health status of Service members and for conducting surveillance across the entire life cycle of a member's service time, inclusive of the estimated 50 percent of Service members who never deploy. Further, Service members exiting active duty are required to have a separation physical exam. When mental health conditions are identified, treatment is initiated and, depending upon severity, may be compensated through the Integrated Disability Evaluation System. For those who are not medically retired, care may be transitioned to the Department of Veteran Affairs or civilian providers depending upon the preference of the Service member. All Service members who are undergoing mental health treatment at the time of transitioning to civilian status are automatically enrolled in the *inTransition* program, which supports Service members by providing global, specialized, telephonic transition coaching to facilitate the connection to a new provider. By supporting Service members and enhancing coordination between referring and gaining providers, the *inTransition* program supports a reduction in the number of Service members who disengage from mental health care during a period of transition.

It is also a DoD priority and policy to reduce stigma associated with accessing mental health care, and each of the Services has been actively engaged in developing policies, programs, and campaigns designed to reduce stigma and increase Service members' comfort with seeking, receiving and following through with mental health care. Commanders and other senior leaders are also being trained about suicide risk factors, the best ways to identify Service members at risk and strategies for timely intervention.

EVIDENCE-BASED CONSIDERATIONS RELATED TO COMPOSITION OF MENTAL HEALTH PSYCOLOGICAL ASSESSMENTS

Distinguishing Between Screening and Assessment

For purposes of addressing the requirements of this NDAA, it is important to define what is meant by "screening" and what is meant by "assessment." As detailed in a Statement from a 2014 American Psychological Association Practice Organization Work Group on Screening and Psychological Assessment (APAPO WG), the terms screening and assessment are not synonymous: "Screening for mental and behavioral health problems is part of comprehensive healthcare and population health as described by the Patient Protection and Affordable Care Act. The associated healthcare regulations, proliferation of online measures and web-based evaluation systems have created a need to distinguish between screening and assessment in the health care arena."

In general, experts usually use the term *screening* to refer to a procedure in which a standardized instrument or protocol is used to identify individuals who may be at risk for mental health disorders and suicide. Screening can be done independently or as part of a more comprehensive health or behavioral health screening. Screening may be done via interview (with the screener asking questions), with pencil and paper, or using a computer. *Assessment* usually refers to a more comprehensive evaluation done by a clinician to confirm suspected mental health disorders and suicide risk, estimate the immediate risks to the patient, and decide on a course of treatment. Although assessments can involve structured questionnaires, they also can include a more open-ended conversation with a patient and/or friends and family to gain insight into the patient's thoughts and behavior, risk factors (e.g., a history of suicide attempts), protective factors (e.g., immediate family support), and medical and mental health history. The APAPO WG published a list of the characteristics of each (see Figure 2).

The APAPO WG Statement further emphasized that the psychometric properties of tests used meet the criteria for acceptable psychological tests for their intended purpose. Mental health assessments should be provided by licensed or board-certified mental health professionals eligible to administer or supervise the administration of the respective test to assure the competent, evidence-based, and ethical administration of the measures.

For purposes of clarification and consistency in response to the elements required in this report, we will use the above American Psychological Association definition of the term, "screening" and be as consistent with the language in the NDAA requirements as possible.

Additionally, mental health assessments that are not part of ongoing therapy cannot be used as comparisons to one another to determine decrements in functioning, especially when there is a significant time interval or intervening events (e.g., deployment) between assessments. Each assessment must stand on its own to determine psychopathology or behavioral health deterioration.

Figure 2

Screening

- Is used for the early identification of individuals at potentially high risk for a specific condition or disorder
- Can indicate a need for further evaluation or preliminary intervention
- Is generally brief and narrow in scope
- May be administered as part of a routine clinical visit
- Is used to monitor treatment progress, outcome, or change in symptoms over time
- May be administered by clinicians, support staff with appropriate training, an electronic device (such as a computer), or self-administered
- Support staff follows an established protocol for scoring with a pre-established cut-off score and guidelines for individuals that score positive.
- Is neither definitively diagnostic nor a definitive indication of a specific condition or disorder

Assessment (including psychological and neuropsychological testing)

- Provides a more complete clinical picture of an individual
- Is comprehensive in focusing on the individual's functioning across multiple domains
- Can aid diagnosis and/or treatment planning in a culturally competent manner
- Can identify psychological problems and conditions, indicate their severity, and provide treatment recommendations
- Integrates results from multiple psychological tests, clinical interviews, behavioral observations, clinical record reviews, and collateral information
- May include screening measures that are used in conjunction with other information from the assessment, providing a broader context for interpreting the results
- May use screening results to determine the choice of instruments for an assessment
- May cover domains of functioning, such as memory and language, visual and verbal problem solving, executive functioning, adaptive functioning, psychological status, capacity for self-care, relevant psychosocial history, and others needed to respond to the referral questions

Comparison to Industry (Civilian Law Enforcement) Practices

A comparison to civilian industrial practices was explored in response to a 2014 inquiry from the Senate Armed Services Committee about the application of civilian law enforcement mental health assessments to the Armed Forces. There are significant differences between civilian police officer application processes and those used for accession to military service, which makes direct comparisons problematic. Because of the similarity of job requirements and performance expectations for police officers, it is possible for law enforcement agencies to develop specific assessment criteria for identifying candidates who possess the personality characteristics that predict success in law enforcement, and the psychological assessment tools commonly used have been chosen specifically for this purpose. In contrast, the DoD has innumerable career fields, highly varied across Military Services, each with widely ranging job requirements and qualifying criteria.

The Pre-Employment Psychological Health Evaluation Guidelines, ratified by the International Association of Chiefs of Police (IACP) in 2009, provide guidelines for civilian law enforcement agencies based on commonly accepted practices and allow a wide range of variance in how they are applied. As consistent with the American Psychological Association tests and measurements regulations and State Boards of licensure, the guidelines state that evaluations should be conducted by licensed doctoral-level psychologists who are trained and experienced in

psychological evaluations for public safety positions and that there be a written test battery, including objective, job-related psychological assessment instruments and individual face-to-face interviews. As well, the IACP guidelines require that relevant background investigation data and health records be made available to the psychologist conducting the evaluation when possible. Finally, the guidelines stipulate that pre-employment psychological evaluations should only be used as one component of the overall hiring process.

Peer–reviewed literature indicates that pre-employment assessment processes can vary greatly across police agencies and that there is limited support regarding what protocols should be used to conduct evaluations. A survey found that the majority perform a background investigation, medical examination, interview with the applicant, drug test, physical fitness examination, and a polygraph test. More than 90 percent of the agencies in this survey performed a psychological evaluation, most using three to four different psychological tests.

DoD found that law enforcement psychological assessment firms reported 15 to 20 percent of applicants supplied answers that failed to meet validity criteria (e.g., signs of inconsistent or deceptive responses). Further, evidence suggests that a review of past history, a significant part of DoD's current approach, is the best clinical predictor of future behavior. As a result of the current approach, approximately 2.7 percent of approximately 48,000 officer candidates and 3 percent of approximately 295,000 potential enlistees are identified with disqualifying mental health problems annually. While the majority of police agencies use formal psychological testing measures, only 5 percent are rejected solely on the basis of the results of these assessments. This is a fairly close correlation with the rates found for military officer candidates and potential enlistees.

Baseline for Determining Future Outcomes and Presumption of Sound Condition

There is a lack of evidence supporting the implementation of wide-ranging pre-accession mental health assessments. First, the assumption that a preliminary psychological assessment can be used as a baseline to determine whether any subsequent deterioration in mental health is a consequence of military service has not been empirically demonstrated. There are no instruments that have been validated for this purpose in military populations. DoD has hundreds of career fields—varied across Military Services, each with widely ranging job requirements and qualifying criteria— so far precluding the adoption of a universal, cost effective assessment strategy for identifying suitable candidates using currently available instruments and techniques.

A baseline assessment is likewise not necessary to establish a "service connection" at some future date. When looking at the value of a pre-separation assessment to complement a pre-accession assessment in determining service-connected disability, an important consideration is DoD's presumption of sound condition at accession for Service members not manifesting a condition or disorder within 30 days of entering Active Duty. This presumption applies in all cases in which a member on Active Duty for more than 30 days is found to have a disability not noted at the time of the member's entrance and not due to the member's misconduct or gross negligence. The presumption is only overcome if clear and unmistakable evidence demonstrates that the disability existed before the Service member's entrance on Active Duty and was not aggravated by military service.

Example of DoD and Service Initiated Research Efforts

DoD has been accumulating data and conducting analyses for several years that could inform future policy and practices. A study to assess the predictive validity of the Army's Tailored Adaptive Personality Assessment System (TAPAS) will end in FY 2018. TAPAS was developed to assess personality factors related to performance in the Army and measures 15 personality traits or dimensions. Of particular importance is that TAPAS is designed to be resistant to "faking good" scores and recognizing applicant psychiatric risk factors. Additionally, RAND has an ongoing research project studying TAPAS across all Services except the United States Marine Corps (USMC). The results of that study are expected in late 2017, and the USMC has recently initiated a similar TAPAS type pilot study.

The Air Force published a cross-validation study in March 2015[3], which found that "… at best, those with the lowest TAPAS scores are at only a slightly higher risk of negative outcomes than the highest scorers…" and concluded that a decision to not access a recruit based on the lowest TAPAS scores may result in many high-quality applicants' rejection from service or their preferred specialty based on a small increased risk of future problems. The Air Force further concluded that "it is critically important to comprehensively examine … [the TAPAS]… psychometric characteristics and predictive validity. Continued research is required before the Air Force would consider using the TAPAS as a sole or adjunctive measure for decision making.

Does screening help identify those who may be at risk for future mental health or behavioral issues?

To date, efficient and appropriately validated predictive tools for use with military recruits motivated to gain entrance into military service do not exist. The DoD has used a number of non-validated questionnaires for many years. Some include questions selected from validated instruments such as the AUDIT-C and the Mini, while other question sets were based on subject matter expert opinion (medical history interview focus areas). Most recently, the TAPAS has been used in some populations to predict successful completion of military training, but has not been validated across every Service.

Establishing "normals" for unvalidated tests is scientifically unsound and fraught with legal, political, and fairness problems. Establishing cut points for any medical test is a balance between acceptable false positive and false negative rates. In general, setting a threshold to minimize the likelihood of accessing a recruit likely to have future problems would result in the disqualification of a large number of individuals who would never have future behavioral health issues. Some of these "false positives" might be able to be qualified after extensive psychiatric evaluation, but many would likely remain "unfit." The cost of clinical psychological evaluation, and who bears it, is a significant policy issue. More important, the impact of increased and

[3] Statistical Prediction of the Reliability of Air Force Personnel. Schneider, K., Bezdijian, S., and Burchett, D. Psychology Research Service Analytic Grouop, DOD Center – Monterey Bay, for United States Air Force Medical Operations Agency (AFMOA)

unnecessary medical disqualifications on accession volume and military mission must be understood before any proposed policy change can be fully understood.

RELIABILITY OF SELF-REPORTED MEDICAL HISTORY AND POTENTIAL BENEFITS OF LONGER PROBATIOARY PERIOD

Given current scientific knowledge, past and current behavioral health history is the best predictor of future behavioral issues. DoDI 6130.03 includes rigorous behavioral health standards designed to identify recruits who present unacceptable risks to the military mission. However, USMEPCOM is almost entirely dependent on self-reported medical history, and it is well documented that applicants often fail to report critical medical information. USMEPCOM has been unable to complete rigorous analyses of non-reporting of behavioral health problems, but work by the Accessions Medical Standards Analysis and Research Activity indicates that recruits separated during initial training for behavioral health issues were often subsequently found to have behavioral illnesses that existed prior to enlistment (EPTS). USMEPCOM does receive some EPTS medical records from training bases and based on records received, estimates non-disclosed medical conditions account for 40-50 percent of medical EPTS discharges. Although applicants are asked to provide names and addresses of all previous medical providers and insurers when completing the DD Form 2807-2 Accessions Medical Prescreen Report, USMEPCOM manual review of small samples of records shows that the majority of applicants report never having had a medical provider or health insurance.

There is strong indication based on research that increasing the probationary observational period to six months may prove beneficial in identifying those who may not be able to fulfill the military mission (e.g., deployability) or tenure (e.g., early attrition) over the long term owing to pre-existing conditions undetected during the first 30 days following accession.[4,5] At present, there is a presumption of sound condition at the time of accession for any Service member not manifesting a condition or disorder within 30 days of entering active duty. This means that if a member is on active duty for more than 30 days and is found to have a condition (e.g., a mental or physical condition incompatible with continued service), which was not noted at the time of the member's entrance on active duty, the condition is presumed to be connected to military service and the individual will be eligible for disability. This determination is only overcome if clear and unmistakable evidence demonstrates that the disability existed before the Service member's entrance on active duty and was not aggravated by military service. As there is often a remitting and relapsing course for many psychiatric illnesses and as relapses are often precipitated by longer periods of time requiring social, personal, and psychological resiliency (e.g., the emotional and cognitive ability to constructively

[4] Personality Assessment Questionnaire as a Pre-Accession Screen for Risk of Mental Disorders and Early Attrition in U.S. Army Recruits. Neibur, D.W., Gubata, M.E., Oetting, A.A., Weber, N.S., Feng, X., and Cowan, D.N. , Psychological Services, Vol 10, No4, 378-385, 2013

[5] Association Between Mental Health Conditions Diagnosed During Initial Eligibility for Military Health Care Benefits and Subsequent Deployment, Attrition, and Death by Suicide Among Active Duty Service Members. Ireland, R.R., Kress, A.M., and Frost, L.Z. Military Medicine 177, 10:1149, 2012

and effectively adapt, adjust, and cope with the demands of military onboarding and sustained training), pre-existing conditions will continue to manifest beyond the 30-day threshold.

PARITY OF MENTAL HEALTH SCREENINGS WITH PHYSICAL SCREENINGS

Although the Department of Defense is not a group health plan subject to the 2008 Mental Health Parity and Addiction Equity Act (MHPAEA), the DoD has taken actions to ensure that mental health and substance use disorder (SUD) benefits meet the intent of the MHPAEA[6] (to require parity between mental health or SUD and medical care with regard to payment and benefits). Similarly, although also not legislatively mandated, the DoD has increasingly integrated mental health and traumatic brain injury screening into physical health screening questionnaires, especially since the initiation of the addition of the Post Deployment Health Reassessment in 2005.

Across-the-board revisions in the pre- and post-deployment screening questionnaires were implemented in 2012 and continue to be refined resulting in the now current practice of equally screening both the mental and physical health of our deploying Service members using the same set of questions across these measures.[7] Similarly, within the accessions medical examination processes, mental health, behavioral, and history of neurologic problems and injury screening questions are asked in the same manner as with physical screening questions (see Attachment).

ESTABLISHING SECURE, ELECTRONICALLY BASED MENTAL HEALTH SCREENING

USMEPCOM is already the authoritative source for establishing a Service member's lifecycle medical record; however, its paper-based medical record system currently requires a recruit to hand-carry their medical record to their first assignment (normally a training base). During the accession medical process, USMEPCOM relies on paper-based medical forms to collect self-disclosed medical history information and supplements this information with medical history and examination information discovered during the MEPS examination process. USMEPCOM conducts its work through 65 MEPS across the United States and Puerto Rico. The main objectives of the 65 MEPS is to conduct aptitude tests, medical examinations and determine acceptability, administratively process, allocate, induct and ship Selective Service System registrants, when required; and provide aptitude and medical examination services for other Federal agencies, as requested.

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[6] The Final Rule implementing the MHPAEA of 2008 was published on November 13, 2013, in the Federal Register (FR) (78 FR 68240).

[7] 10 U.S.C. 1074f, Medical Tracking System for Members Deployed Overseas; 10 U.S.C. 1074m, Mental Health Assessments for Members of the Armed Forces Deployed in Support of a Contingency Operation; DoDI 6490.03, Deployment Health; DoDI 6490.12, Mental Health Assessments for Service Members Deployed in Connection with a Contingency Operation; and E.O. 9397 (SSN), as amended

USMEPCOM's existing secure electronic system, USMIRS, interfaces with recruiting capabilities for the Services, incorporating the concept of electronic data sharing using standard DoD data elements between USMEPCOM and all the Armed Services recruiting and accession commands. The type of information collected is personal, medical, employment, educational, and military. The primary use of this information is to ensure only qualified individuals enlist in the Armed Forces. USMIRS captures medical determinations, employment, education, military and overall medical examination results such as vision, hearing, and qualification decisions, but does not contain individual applicant responses to the medical history questions answered on the DD Form 2807-2, DD Form 2807-1 or the UMF 40-1-15-E nor an applicant's medical treatment records, all of which are currently paper-based. The primary use of this information is to qualify applicants for enlistment and later to assist with job classification and placement after the enlistment decision is final.

Proposed USMEPCOM medical transformation initiatives still in the planning stages include an electronic applicant medical history record; obtaining not self-disclosed electronic medical history information from sources both within the federal government and in the public and private medical communities; and developing an interactive, symptoms-based electronic questionnaire for obtaining applicant self-disclosed medical history. In a June 15, 2016, memorandum, P&R directed the inclusion of accession organizations (including USMEPCOM) in the Defense Healthcare Management System Modernization Program as the solution for an electronic applicant medical record. DoD's Defense Medical Information Exchange initiatives have the potential to positively impact the accession community for obtaining applicant medical history information in the future.

TRACKING CHANGES FROM THE TIME OF PRE-ACCESSION TO ACTIVE DUTY FOR MENTAL HEALTH AND TBI

The mental and neurological screening questions asked on the Accessions Medical Prescreen, History, and Supplemental forms were compared with the PHA and deployment screening questions to determine if the accession related screening questions could be correlated with those questions routinely asked once accessed (e.g., annual PHA, deployment-related). In all areas of interest for tracking purposes, the accession medical and supplemental forms contained questions which could – if needed – be mapped to a corresponding PHA-deployment related screening topic. For example, the Accessions Medical Prescreen Report asks if the applicant has any history of "Posttraumatic Stress Disorder or excessive stress requiring counseling and/or medication following a traumatic experience." Endorsement of this question would provide a post-accession correlation for tracking purposes or identification of potential new incident cases to the PTSD 4-question initial screener (Primary Care PTSD Screen) contained on the PHA-deployment screening tools.

The ability to track the emergence or changes in health screenings relating specifically to traumatic brain injuries, post-traumatic stress disorder, and other conditions, begins once accessed and continues throughout a Service member's time of service. The DoD policy and the standardization of the questions asked across all of the deployment and health screening measures has provided the schedule and means to track changes in mental health screenings

across time relating to neurologic problems or injuries, post-traumatic stress disorder, and other conditions. Of additional importance is the work presently underway to incorporate these same question sets into the PHA. This will provide additional means for comparison of the physical and mental health status of Service members and for conducting surveillance across the entire life cycle of a member's service time, inclusive of the estimated 50 percent of Service members who never deploy (e.g., a 2015 study of risk factors for suicides among Army personnel[8] noted an increase in deaths by suicide among never-deployed SMs between 2004 and 2009.)

If the deployment and annual PHA processes were mirrored for pre-enlistment screening, those who screen positive during routine pre-enlistment screening would require review by a provider and further evaluation in a person-to-person assessment with a trained mental healthcare provider. This would require additional specialized resources and personnel and the additional value to the current mental and physical screenings pre-enlistment would need to be demonstrated. However, MEPS accession screening is time-limited and not currently staffed for the person-to-person clinical assessment and intervention by a mental health professional that this would require.

COST IMPLICATIONS OF AN EXTENDED MENTAL HEALTH EVALUATION AT ACCESSION

Each year DoD evaluates, through use of the existing screening processes, approximately 48,000 officer candidates and approximately 295,000 potential enlistees. There is a critical absence of scientific evidence supporting the ability of even extended psychological assessment to identify recruits who will exhibit substantive mental health symptoms or a diagnosable condition in the future unless the recruit admits to either past illness or past or current significant psychological health symptoms. Even if such prediction were possible, the cost implications for implementing an extended mental health evaluation across all recruits are serious. A moderate expansion of assessment practices would require a minimum of 90 additional full time psychologists and according to a cost-estimate analysis conducted by USMEPCOM in 2012, an estimated additional $85-136 million to cover comprehensive pre-accession mental health psychological testing. Time is also a factor that merits consideration, as completion of the additional testing could take candidates from 1 to 7 hours depending on the number of measures used, the length of the measures, and factors including candidates' attention, reading ability, and speed.

CONCLUSIONS

USMEPCOM Medical is currently unable to access objective historical data about an applicant's medical, behavioral, law enforcement or school encounters, or pharmaceutical history as this information is limited to what is voluntarily disclosed by candidates. Until more objective

[8] Friedman, M.J., Risk Factors for Suicides Among Army Personnel, JAMA Psychiatry, March, 17, 2015.

information is available, we will need to rely on the current DoD screening process. Having access to such background information would greatly improve the ability to identify significant mental or other health problems, providing critical information that is unintentionally or intentionally excluded by applicants. There is currently a dividing line between USMEPCOM's mission to medically evaluate a candidate and consideration of administrative issues pertaining to law enforcement and school encounters. At present, only when the applicant's behavioral background is assessed as medically significant does USMEPCOM medical use that background information in their assessment of the recruit.

The Department is seeking to develop capabilities to improve access to pharmacy and medical records for use in applicant screening. Current technology, industry proprietary rights, and privacy legislation are all pertinent issues being reviewed. Finally, efforts are underway to identify effective means to facilitate both prevention and early intervention for mental health conditions during basic military training and throughout Service members' careers.

The theory that a preliminary screening might be used as a baseline to assess subsequent deterioration in mental health as a consequence of military service does not have support in the medical literature. Given the current lack of validated screening instruments and the paucity of replicable predictive research, it would not be cost effective for USMEPCOM or the DoD Medical Examination Review Board to acquire the specialized personnel necessary to review and make a clinical mental health assessment of every recruit or officer candidate. Replicating these mental health tests and assessment processes prior to accession for all enlistees and officer candidates would place significant workload and financial burdens on the Department for no clear benefit over current mental health screening processes. Assessment of mental health fitness for military service should probably continue through basic training and for some "probationary" period (approximately six months) post entry. This initial period of service should be studied further to determine whether processes are in place to track, assist, and if necessary disqualify high risk individuals.

REFERENCES

DoDI 6025.19 Individual Medical Readiness (IMR), June 9, 2014

DoDI 6130.03 Medical Standards for Appointment, Enlistment, or Induction in the Military Services, September 13, 2011

DoDI 6490.12 Mental Health Assessments for Service Members Deployed in Connection with a Contingency Operation, October 2, 2013

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ACRONYMS & INITIALISMS

AMSWG	Accession Medical Standards Working Group
APAPO WG	American Psychological Association Practice Organization Work Group on Screening and Psychological Assessment
AUDIT-C	Alcohol Use Disorders Identification Test-Consumption
DoD	Department of Defense
DoDI	Department of Defense Instruction
EPTS	Existed prior to enlistment
FY	Fiscal Year
IACP	International Association of Chiefs of Police
MEDPERS	Medical and Personnel Executive Steering Council
MEPS	Military Entrance Processing Station
MHPAEA	Mental Health Parity and Addiction Equity Act
NDAA	National Defense Authorization Act
P&R	Personnel and Readiness
PHA	Periodic Health Assessment
PTSD	Posttraumatic stress disorder
SUD	substance use disorder
TAPAS	Tailored Adaptive Personality Assessment System
USMC	United States Marine Corps
USMEPCOM	United States Military Entrance Processing Command
USMIRS	United States Military Entrance Processing Command Integrated Resource System

DEFINITIONS

Accession Screening	A process in which a prospective Service member is investigated to verify qualifications and confirm that the person is qualified to perform in service career assignments, to identify personality traits which may be beneficial or problematic (inclusive of conducting a criminal background check & drug tests), to identify any potential safety risks including threats to physical safety in the workplace and security, to determine capacity and competence to perform potential work as assigned, and that the prospective member be will be a safe and appropriate match for employment within the military workplace.
Accession Standards	The standards applied to the acquisition of personnel by the Military Services via appointment, enlistment, or induction
Enlistment	Assignment to an enlisted grade
Grade	A step or degree, in a graduated scale of office or military rank that is established and designated as a grade by law or regulation
Induction	The formal enlistment of a civilian into military service
Medical Screening	A review of medical and behavioral health systems, histories, conditions,

ATTACHMENT

SCREENING STEPS[9] IN THE MILITARY ENTRANCE PROCESSING STATION (MEPS) EXAMINATION PROCESS

1. DD Form 2807-2 "Accessions Medical Prescreen Report": This form is completed by the applicant prior to their physical examination at the MEPS. This form asks the member to disclose whether they have (a) seen a psychiatrist, psychologist, social worker, counselor or other professional for any reason (inpatient or outpatient), (b) current or prior history of evaluation, treatment, or hospitalization for alcohol (or other substance) use/abuse, dependence, or addiction, or dependence. This form also requests applicants provide current and previous primary care physician(s)/practitioner(s) and/or clinic(s) as well as current and previous insurance and/or pharmacy benefit manager(s).

2. DD Form 2807-1 "Report of Medical History": This form is completed by the applicant at their MEPS physical before their medical history interview and assesses past or present "nervous trouble of any sort (anxiety or panic attacks)" including trouble sleeping, depression or excessive worry, evaluation or treatment for a mental condition, counseling of any type, suicide attempts, and use of illegal drugs or abuse or prescription drugs. It also asks the applicant to disclose any history of hospitalizations.

3. USMEPCOM Form 40-1-15-E, Medical History Provider Interview: The front side of this form is a questionnaire applicants complete in addition to completing the DD Form 2807-1 and is reviewed during an interview with a medical provider. It includes a set of questions that were specifically designed to identify areas of concern or problematic behaviors that are often associated with subsequent problems completing military training or adjusting to military duty. The questions address the following concerns or behaviors: depression, self-injury, suicidal ideation and attempts, arrests, suspensions for school, termination of employment, kicked out of home, multiple traffic violations, sleep problems, and alcohol use. The back side captures data from the medical history interview behavioral health focus areas.

4. Medical History Interview: Each applicant meets individually with a MEPS medical provider to discuss their medical history disclosed on DD Forms 2807-1, 2807-2, and the front side of USMEPCOM Form 40-1-15-E, as well as any other relevant medical concerns. During this interview, MEPS medical providers are required to discuss five behavioral health focus areas: law enforcement, school authority, behavioral health professional, self-mutilation, and home environment encounters. Results of this behavioral health interview are recorded on the back side of USMEPCOM Form 40-1-15-E.

[9] Listed in chronological order

5. Physical Screening Examinations: During the course of the MEPS physical, medical providers examine the applicant for physical findings associated with behavioral health issues (e.g., self-mutilation scars).

6. Referral for Mental Health Consultation: If at any point the medical provider completing the MEPS physical requires additional medical information in order to determine whether an applicant has a disqualifying mental health concern, they can refer the applicant to a mental health provider for further evaluation. Results are returned to the MEPS medical decision authority who ultimately determines if an applicant meets the medical accession standard and thus is or is not medically qualified to serve in the Armed Forces.