Defense Health Board Report

Beneficiary Mental Health Care Access

June 28, 2023

President's Memo

DEFENSE HEALTH BOARD
7700 ARLINGTON BOULEVARD, SUITE 5101
FALLS CHURCH, VA 22042-5101

MEMORANDUM FOR ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS

SUBJECT: Beneficiary Mental Health Care Access

The Defense Health Board (DHB) is pleased to submit its report on Beneficiary Mental Health Care Access. This review summarizes the DHB's findings and presents recommendations to improve the availability of mental health services of Military Health System (MHS) Beneficiaries.

On July 7, 2022, the Assistant Secretary of Defense for Health Affairs (ASD(HA)) directed the DHB, through its Neurological and Behavioral Health Subcommittee, to provide recommendations to enhance the MHS capacity and capability to meet beneficiaries' mental health care needs. The Neurological and Behavioral Health Subcommittee reviewed the current state of MHS mental health care, along with relevant policies and practices within the Department of Defense (DoD) and peer-reviewed scientific literature. The Subcommittee received briefings from, and consulted with, experts from both government and civilian institutions.

The Subcommittee presented its report to the DHB on June 28, 2023. Many of the DHB's findings and recommendations focus on creating a more capable and competitive mental health care workforce within the MHS. This focus mirrors concerns at the national and international level. Still, many other findings and recommendations uniquely address the barriers and specific needs of the MHS beneficiary community. The DHB's recommendations aim to decrease stigma associated with mental health care, promote resilience, encourage awareness of the many variables influencing mental health, and increase the availability and quality of mental health care available to MHS beneficiaries. Following two rounds of public deliberation on the findings and recommendations, the DHB unanimously approved the report.

On behalf of the Board, I appreciate the opportunity to provide this independent review to the Department. I hope that it drives lasting positive change for MHS beneficiary mental health care access.

Karen Guice, M.D., M.P.P.
President, Defense Health Board

Attachment:
As stated

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Executive Summary

The United States (US) is experiencing a mental health (MH) crisis. Diagnosis rates for MH disorders are rising steadily, especially among younger Americans. These trends were exacerbated by the coronavirus (COVID-19) pandemic. In the face of high and rising demand for MH care, the supply of MH providers has proven inadequate.

This national crisis harms America's military families by layering additional burdens atop those inherent to military family life: frequent moves, deployments, and a rigorous operations tempo in both deployed and non-deployed settings. The Military Health System (MHS) currently lacks the resources it needs, in terms of providers and treatment options, to meet the MH needs of its beneficiary population: Service members (SMs), retirees, and military families.

The MHS provides for beneficiaries' health care needs through its direct and purchased care systems. Active Duty SMs (ADSMs) primarily access direct care at military treatment facilities (MTFs). Military family members, including dependent spouses and children, primarily access care through the purchased care system, which is an external network of contracted civilian providers.

Rising demand for MH care subjects military families to severe access barriers, including waitlists and "ghost networks" (i.e., MH provider networks with few, if any, available providers). These delays compromise military family well-being and military readiness. The military requires mentally fit SMs supported by mentally fit families. Increasing rates of youth MH disorders further compromise readiness by reducing the pool of future recruits. This concern takes on additional weight for children of military families, given their higher-than-average propensity to serve.

On July 7, 2022, the Acting Assistant Secretary of Defense for Health Affairs (ASD(HA)) directed the Defense Health Board (DHB), through its Neurological/Behavioral Health Subcommittee, to provide recommendations to enhance the MHS capacity and capability to meet beneficiaries' MH care needs. Specifically, the ASD(HA) requested the DHB recommend guidance to eliminate barriers to accessing and delivering MH care for both adult and child beneficiaries and promote innovative MH care research and treatment strategies.

In addressing current and projected MH access challenges, the MHS's foremost responsibility is to bring its own capabilities in line with the needs of its beneficiary population. The MHS must therefore address provider shortages, inconsistent standards, and appointment delays. To this end, the MHS must also improve recruitment and retention of providers in high-demand locations and prioritize initiatives to meet key staffing requirements.

The DHB recognizes that these reforms will not resolve the national MH crisis. That challenge is beyond the scope of this report's tasking and likely beyond the capabilities of the Defense Health Agency (DHA) or even the DoD. At the same time, the national crisis clearly contributes to beneficiary MH access challenges by driving "demand" for MH care beyond the limits of existing MHS capabilities ("supply"). The MHS and DoD must therefore work to bolster resilience in military families.

Finally, to maximize access and deliver the best possible MH care to military families, the MHS

must leverage recent successful technological innovations like tele-mental health (TMH) and invest in promising future innovations.

In its investigation of beneficiary MH access challenges, the DHB has reviewed published reports documenting military family MH challenges, including those from the Office of the President of the United States, the Congress of the United States, the DoD, the Office of the Surgeon General of the United States, the Department of Health and Human Services Administration, the Substance Abuse and Mental Health Services Administration, the World Health Organization, the American Academy of Pediatrics, the National Center for Children in Poverty, the Commonwealth Fund, the American Psychiatric Association (APA), the American Hospital Association, the RAND Corporation, Blue Star Families, the National Military Families Association (NMFA) and Bloom: Empowering the Military Teen organization, the Military Family Advisory Network, and the TRICARE for Kids Coalition.

The DHB reports the following findings from its investigation and makes recommendations below in response to the tasking.

Finding 1: The MHS does not have sufficient MH providers to manage existing beneficiary demand for MH care, much less projected increases in demand. There is a shortage of MH providers in the civilian sector, as well. In competing with other health systems to recruit and retain MH providers, the MHS is at a competitive disadvantage.

> **Recommendation 1a:** The DHA should increase salary and benefits packages for MH providers to meet or exceed salary and benefit compensation rates of MH providers working in regionally similar federally qualified healthcare agencies.

> **Recommendation 1b:** The DHA should expedite MH provider hiring timelines to be competitive with those of other federally qualified healthcare agencies.

> **Recommendation 1c:** The DHA should develop a program to alleviate financial burdens associated with obtaining licensure for allied MH providers who commit to providing care for MHS beneficiaries.

> **Recommendation 1d:** The DHA should assess and implement additional ways to facilitate recruitment of allied MH providers.

> **Recommendation 1e:** The DHA should continue to work with the Defense State Liaison Office (DSLO) to facilitate relevant mental and behavioral health licensure portability for military spouses.

Finding 2: Allocating MH personnel efficiently, in alignment with beneficiary demand for MH care, is critical to meeting beneficiaries' MH needs. This task is complicated by the existence of separate direct and purchased care staffing systems that utilize separate estimates of beneficiary demand. The MHS is a dynamic system in which patient demand shifts between direct and purchased care networks. Such shifts can overwhelm existing staffing capacities.

> **Recommendation 2:** The DHA should create and staff regional market-level offices tasked with monitoring beneficiary demand for MH care from local direct and purchased care providers and with proactively responding to changes in beneficiary demand.

Finding 3: MH access barriers pervade the purchased care network. Alongside rising demand and provider shortages, low provider reimbursement rates and regulatory compliance burdens discourage MH providers from enrolling TRICARE patients. Although TRICARE provider reimbursement rates are limited by law, the DHA is authorized to grant locality-based reimbursement rate waivers in cases where access to health care services is "severely impacted." Additional research is needed to identify factors limiting TRICARE provider participation.

Recommendation 3a: The DHA should utilize its waiver-granting authority to increase TRICARE provider reimbursement rates in targeted purchased care markets experiencing provider shortages. The DHA should regularly inform Congress of the additional costs associated with this recommendation.

Recommendation 3b: The DHA should investigate and advocate for legislative remedies to increase TRICARE provider reimbursement rates.

Recommendation 3c: The DHA should investigate the factors limiting TRICARE provider participation and work with Managed Care Support Contractors (MCSCs) to address the issues.

Recommendation 3d: The DHA should ensure a simplified mechanism for providers with questions regarding TRICARE requirements and billing.

Finding 4: The scope of purchased care access challenges is difficult to determine due to conflicting reports.

Recommendation 4: The DHA should contract with independent 3rd party reviewers to conduct regular "secret shopper" assessments of access to evaluation and treatment in the purchased care network.

Finding 5: In addressing MH access challenges for military families, the DHA is constrained by the limits of its authority over the purchased care network, which is the route through which most military families receive MH and other medical care. However, MCSCs are required to adhere to standards for access to care. The DHA's ability to enforce access to care standards is unclear.

Recommendation 5a: The DHA should leverage its authority to enforce and enhance access to MH care across direct and purchased care networks.

Recommendation 5b: The DHA should review its authorities to determine whether it possesses underutilized mechanisms to enhance access to MH care.

Finding 6: Ongoing efforts to address MHS MH shortages, including provisions in the 2023 National Defense Authorization Act (NDAA), do little to address purchased care network-specific MH access challenges.

Recommendation 6: The DHA should encourage MCSCs to develop academic and community partnerships to increase the MH workforce.

Finding 7: Group therapy can be a force multiplier when clinically appropriate. Triaging is critical to maximizing existing and future capacity to meet beneficiary demand for MH care. Given that direct care compares favorably to purchased network care in terms of cost and quality, beneficiaries receiving MH/BH in the direct care system stand to benefit from Targeted Care, as does the MHS. The larger population of military family beneficiaries also stands to indirectly benefit from reduced demand pressure on the purchased care network.

Recommendation 7a: The DHA should develop evidence-based metrics for assessing the effectiveness of group therapy.

Recommendation 7b: The DHA should reduce barriers to the clinically appropriate use of group therapy, including financial disincentives in the purchased care network.

Recommendation 7c: The DHA should collaborate with academic institutions, issue collaborative grants, and co-sponsor training workshops to encourage the use of group therapy by licensed MH providers in the purchased care network.

Recommendation 7d: The DHA should continue efforts to implement triaging procedures for MH patients accessing care through the direct care system.

Finding 8: Ghost networks frustrate military families seeking MH care in the purchased care networks, which is where most military families access MH care. Better management of provider lists and centralized MH appointment booking and oversight through systems like Integrated Referral Management and Appointing Center (IRMAC) is needed to ensure beneficiary access to care.

Recommendation 8a: The DHA should assess the feasibility of extending IRMAC oversight to behavioral health (BH) appointments in the purchased care network.

Recommendation 8b: DHA market offices should ensure a regularly updated list of purchased care providers for their regions is available for patient and MTF use.

Finding 9: DoD MH and suicide prevention pilot programs are an effective way to design, implement, and assess evaluation and treatment initiatives. Military families, who are treated primarily within the purchased care network, should benefit from lessons learned through pilot efforts in DoD and other federal health care agencies.

Recommendation 9a: The DHA should continue to scale up and establish relevant policy to sustain successful pilot programs and implement evidence-based research efforts.

Recommendation 9b: The DHA should prioritize the development of new and effective behavioral health integration (BHI) practices.

Recommendation 9c: Pilot studies and other evidence-based research should include quality and outcome measurements.

Recommendation 9d: The DHA should develop a strategy to disseminate successful treatments identified through pilot studies in the direct care system, Department of Veterans Affairs (VA), and other federal agencies to purchased care network providers.

Finding 10: Improved resilience reduces demand for MH services and improves quality of life. The Services recognize the importance of resilience to family readiness and mission readiness. Recently, SM-focused efforts to bolster MH have demonstrated some success in building SM resilience.

Research and experience demonstrate that resilience in military families is enhanced through activities that promote identification with and connection to the military community. Existing DoD family support programs and services make important contributions to military family resilience independently, by supporting military families' health, education, and other needs, and through their impact on social connection and community engagement. Reservist and National Guard families have less access to these social supports than Active Duty (AD) families.

Recommendation 10a: The DoD and the Services should evaluate the effectiveness of existing family support programs in promoting social connection, well-being, and family readiness and use evidence-based strategies to improve these programs.

Recommendation 10b: The DoD and the Services should pay particular attention to identifying less socially connected members of the military community when providing support programs. The DoD and the Services should consider ways of assessing social connectedness to identify those most in need.

Recommendation 10c: Where appropriate and feasible, the DoD and the Services should provide "opt-out" programs that foster social connections between military families with special attention to Reserve and National Guard families.

Finding 11: Stigma is a potent barrier to accessing MH care. Military leadership, including mid-level enlisted leaders, has an important responsibility in destigmatizing MH to promote early access and treatment. This responsibility extends to military families, especially given their importance to readiness.

Recommendation 11a: The DoD and the Services should tailor de-stigmatization efforts towards military families.

Recommendation 11b: The DoD and the Services should tailor de-stigmatization efforts through leadership training for mid-level unit leaders.

Recommendation 11c: The DoD and the Services should periodically assess military family climate by institutionalizing surveys of military spouses to ensure that military families have a mechanism to inform military family policy.

Finding 12: DoD has invested heavily in resilience training programs and, in the case of the Army, such training incorporates military families. Military family resilience training is urgently needed; however, evidence demonstrating the effectiveness of current programs is lacking.

Recommendation 12a: The DoD and the Services should identify areas where resilience programs positively contribute to military family resilience and develop Service-tailored military family resilience programs.

Recommendation 12b: The DoD and the Services should facilitate information exchange among Service resilience training leaders.

Recommendation 12c: The DoD and the Services should ensure that that the Behavioral Health Clinical Community is made aware of DoD resilience training program resources.

Finding 13: Sleep disorders are often present as comorbidities in patients with MH disorders and can impact MH treatment outcomes. Adequate sleep is critical to resilience, and sleep impacts every dimension of Total Force Fitness (TFF) and readiness. Training and treatment for providers, SMs, and families must emphasize and address the significance of sleep to MH and well-being. Insomnia and sleep apnea demand special emphasis.

Recommendation 13a: The DHA should ensure training of MH and primary care providers on the impact of sleep and sleep disorders on MH outcomes.

Recommendation 13b: The DHA should ensure that provider training for evidence-based treatment for sleep disorders is widely available in the MHS.

Recommendation 13c: The DHA and the Services should develop and implement sleep education and training for beneficiaries, including military families, that emphasizes prioritization of sleep, optimization of circadian alignment, and recognition of symptoms of insufficient sleep and sleep disorders.

Finding 14: The efficacy of telehealth (TH) is well-established, although critical TH access barriers remain for outside the continental US (OCONUS) located beneficiaries. There is a risk of regression towards pre-pandemic TH usage in private-sector medicine. This change could impact healthcare access and continuity of care for TRICARE beneficiaries, particularly families undergoing a Permanent Change in Station (PCS). Potential changes in coverage for audio-only visits may exacerbate access issues for beneficiaries who lack video capability. Mobile MH app developments appear promising and merit further evaluation.

Recommendation 14a: The DHA should maintain and consider expanding COVID-19 pandemic levels of access to TMH in MTFs and in TRICARE by continuing reimbursement for TMH services.

Recommendation 14b: The DHA should eliminate TH barriers, within its authority, to enable continental US (CONUS) located providers to treat OCONUS located beneficiaries.

Recommendation 14c: The DHA should advocate for reimbursement for audio-only TH care rendered to patients who lack video capability.

Recommendation 14d: The DHA should advocate for parity in TRICARE reimbursement rates for TMH and in-person services. TRICARE reimbursement rates for these services should be comparable to reimbursement rates of other leading health care plans.

Recommendation 14e: The DHA should continue to work with the DSLO to promote interstate licensing flexibility for TRICARE providers through existing interstate licensing compacts.

Recommendation 14f: The DHA should ensure that TMH services are available to patients in purchased care networks whenever in-person MH services are unavailable.

Recommendation 14g: The DHA should promote access to TMH for military families.

Recommendation 14h: The DoD should continue to evaluate mobile MH apps for further study, including but not limited to issues of efficacy, privacy, and security.

Finding 15: There are many novel approaches and emerging therapies that may benefit patients with posttraumatic stress disorder (PTSD) and other BH conditions, including, but not limited to, Schedule 1 substances. The posture of the federal government is that approval of use of these medications will adhere to the same assessments of risk and benefit as for other medications and therapies.

DoD researchers may face barriers to participating in preclinical and clinical trials of Schedule 1 substances due to interagency and inter-institution administrative processes, stigma associated with these substances within the military community, and DoD policy restrictions.

Recommendation 15: The DoD should clarify conditions for research support of and participation in emerging MH therapies and novel therapeutics.

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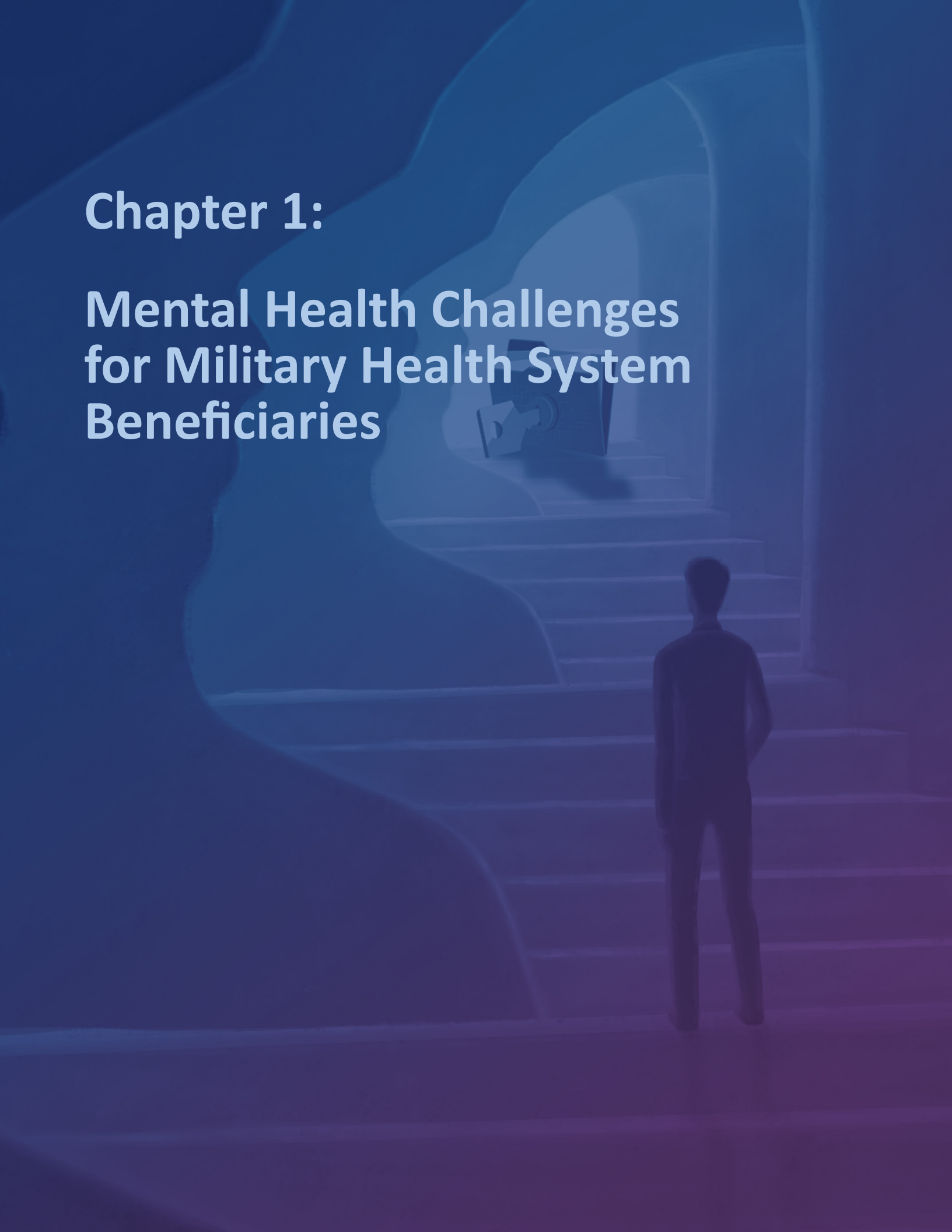
Chapter 1:

Mental Health Challenges for Military Health System Beneficiaries



Beneficiaries of the Military Health System (MHS) include US Service Members (SMs), retirees, and dependent spouses and children.[1] This report focuses on these four broad beneficiary categories in lieu of more discrete groups such as inactive reservist Marines or National Guard child dependent survivors.[a] Special attention is paid to spouses and children of Active Duty SMs (ADSMs), given their importance to readiness: just as SM mental health (MH) challenges impede readiness and harm military spouses and children, military family MH challenges harm readiness through their impact on SMs.[2-4]

This is the first of four chapters addressing MH access challenges faced by MHS beneficiaries. Chapters 5-8 propose remedies to these challenges. Chapter 1 begins with an overview of beneficiary MH disorder diagnose rates. It then discusses the utility and limitations of using national reference group comparisons to provide context for beneficiary MH. Trends in beneficiary MH are considered next, followed by a discussion of the deteriorating national MH environment, including the contribution of the coronanvirus (COVID-19) pandemic.

Incidence and Prevalence of Beneficiary Mental Health Disorders

The World Health Organization describes MH as a "state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community."[5] Poor MH, including diagnosed MH disorders like depression, anxiety, and posttraumatic stress disorder (PTSD), imposes serious and sometimes severe burdens on individuals, limiting their ability to lead productive and fulfilled lives.

Among beneficiaries with a diagnosed MH disorder in 2021, the most common diagnosis for active duty (AD) spouses was anxiety disorder (11.3%), followed by depression (6.8%), adjustment disorder (6.1%), and PTSD (2.3%).[6,7] Among Active Duty (AD) military children, the most common diagnosis was likewise anxiety disorder (3.2%), followed closely by adjustment disorder (2.9%), depression (2.1%), and PTSD (0.4%). [6,7]

The context surrounding MH diagnoses differs by beneficiary group. Consider, for example, adjustment disorders, defined by the Diagnostic and Statistical Manual of Mental Disorders as "the presence of emotional or behavioral symptoms in response to an identifiable stressor/s, which occurred within three months of the beginning of the stressor/s."[7] An adjustment disorder diagnosis may be used as a kind of "catch all" for recruits administratively separated from the military during basic training.[8] This scenario would not apply to military spouses or children; rather, adjustment concerns might emerge here in response to a permanent change of station (PCS) move, or to an SM parent deploying or returning from deployment.[9-13]

Beneficiary Mental Health in Context

How do MHS beneficiaries compare to the national population in terms of MH? The question matters because if a given beneficiary group (e.g., military children) is more often diagnosed with a MH

[a] Issues affecting broader beneficiary groups (e.g., military spouses) may be relevant to more discrete beneficiary groups (e.g., Army wives)

condition (e.g., depression) than the relevant national reference group (e.g., American children), the cause of the disparity may reside somewhere in the military environment. Conversely, in the absence of beneficiary or national reference group disparities, beneficiary MH challenges may have more to do with factors external to the military environment, such as pre-existing risks or larger societal issues. The MHS provides for beneficiaries' medical needs, taking SMs and their families as they come; however, it is better able to accomplish this mission when armed with a better understanding of the scope and causes of MH challenges.

In practice, data quality concerns may frustrate efforts to infer the root causes of differences when MHS beneficiary groups are compared to national data. In the case of SMs, stigma and career concerns reduce MH care-seeking and contribute to underreporting of MH conditions.[14-16] In this context, it is possible that MH providers "down code" SM MH diagnoses, even while rendering appropriate care. Direct evidence to this effect is difficult to obtain. However, trends in MH diagnosis rates suggest that MH "Z codes," defined as "other conditions that may be a focus of clinical attention," may be substituting for MH diagnoses (Figures 1, 2).[6,7] For these reasons, SM MH diagnosis rates should be taken as a "floor" rather than as accurate estimates of SM MH.

Figure 1. Prevalent Mental Health Diagnoses: Active Duty Service Members (ADSMs), Ages 18-24, by Gender, 2005-2021

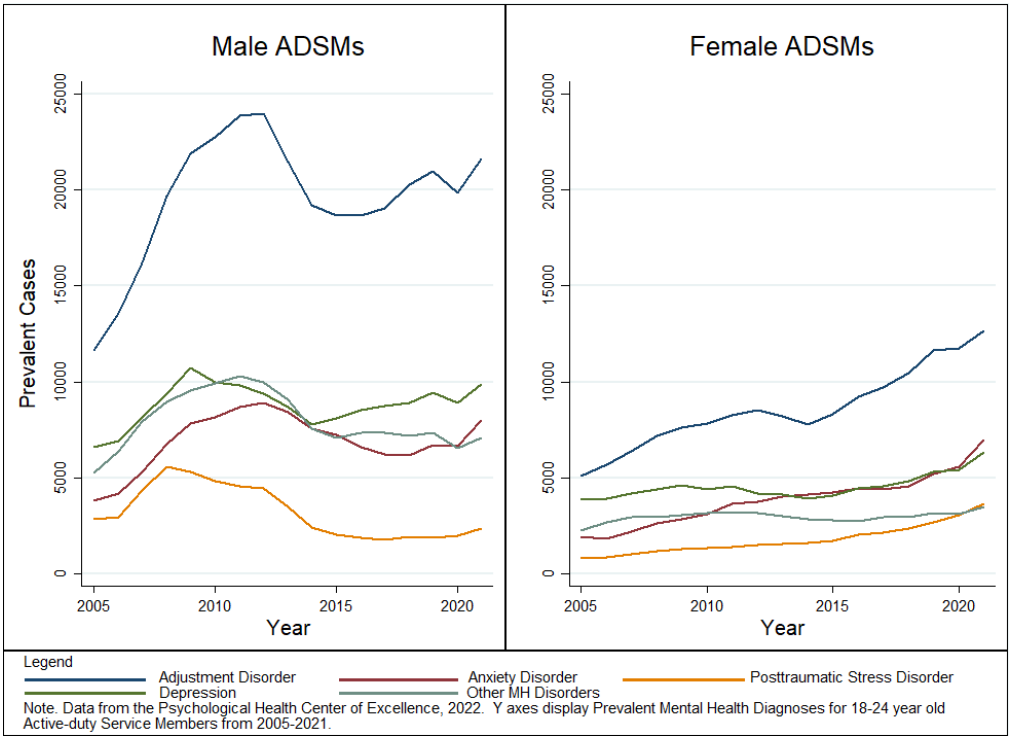
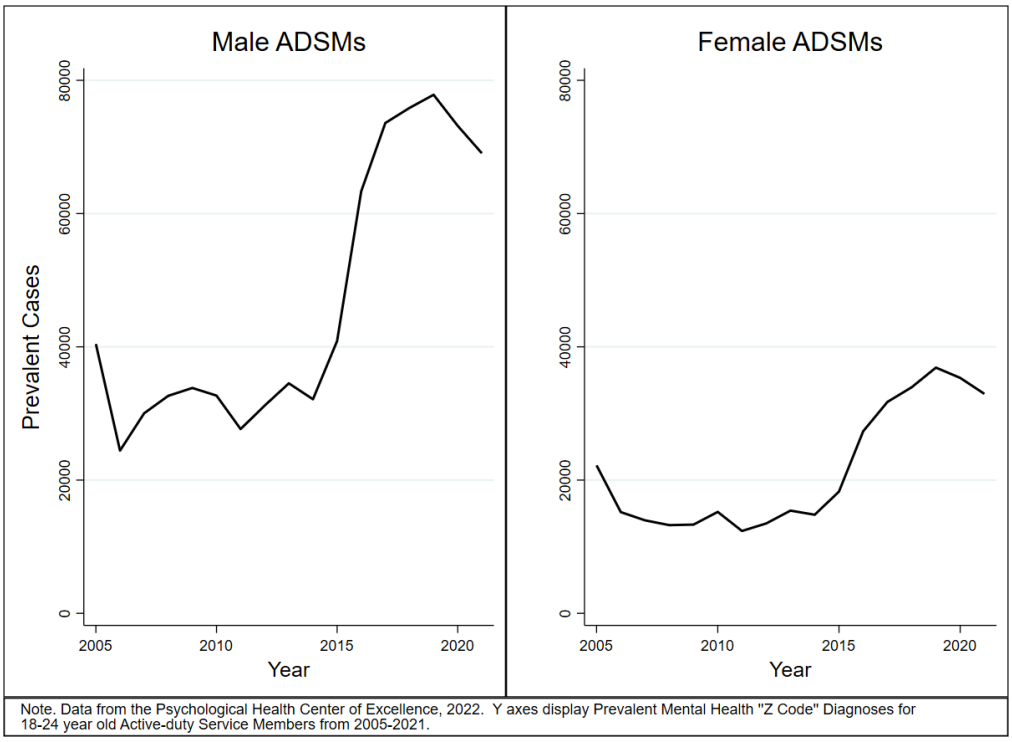


Figure 2. Prevalent Mental Health "Z Code" Diagnoses: Active Duty Service Members (ADSMs), Ages 18-24, by Gender, 2005-2021



Note. Data from the Psychological Health Center of Excellence, 2022. Y axes display Prevalent Mental Health "Z Code" Diagnoses for 18-24 year old Active-duty Service Members from 2005-2021.

A similar problem affects MH diagnosis data pertaining to military children. A 2021 poll from Blue Star Families found that 21% of AD military family respondents avoid MH care for their children out of concern that a documented MH diagnosis could later be used to deny them entry to military service.[17] These concerns are reasonable, given that military health records are more accessible by the Services during the MH accessions process than civilian health records; however, reduced MH care seeking harms military children and may contribute to an underreporting of military child MH conditions.[8, 17, 18] Given that military children display a higher-than-average propensity to serve, the Service's inequitable MH screening process also threatens future readiness.[19]

Notwithstanding these limitations, most research supports the view that MHS beneficiaries experience MH challenges at rates similar to those of appropriate national reference groups.[6, 20]

- 26% of American adults suffered from a diagnosable MH disorder in 2022 compared to 29.1% of military spouses and 19.6% of SMs in 2021
- 9.5% of American adults suffered from a depressive disorder in 2022 compared to 6.8% of military spouses and 3.6% of SMs

Among spouses, military wives are more likely to report MH challenges than other married women (29.1% vs. 19.7%); however, the difference in MH service utilization (22.6% vs.16.9%) is not statistically significant.[21] MH diagnosis and service utilization rates are likewise comparable for military and civilian children.[21] Military retirees compare favorably to their civilian peers: 14.5% of Americans aged 50 and older had a prevalent MH condition in 2020 compared to 4.4% of military retirees aged 45 and older.[6, 22]

Regarding suicide, rates for spouses and SMs are broadly in line with national rates, controlling for population age and sex differences:[23, 24]

- Among females aged 18-60 years in 2019, military wives committed suicide at a rate of 6.8/100,000 in comparison to a national all-ages rate for women of 6/100,000
- Among males of all ages in 2020, SM suicide rates ranged from 26.8-32.2/100,000 across the Service components (Active, Reserve, and National Guard) while nationally men committed suicide at a rate of 21.9/100,000

Groups for whom suicide rates exceed national rates for appropriate reference groups include the following:[23-25]

- Male military spouses (51.7 vs 28.4/100,000 for 18-60-year-old US males in 2019)
- Female SMs (14.4 vs 6.4/100,000 for 17-30-year-old US females in 2020)
- White SMs (67.5-77.3/100,000 across Service components vs 29.8/100,000 nationally in 2020)

It is possible that American Indian and Alaskan Native (AIAN) SM suicide rates exceed national rates for that group (33.4/100,000 in 2020), given average AIAN veterans suicide rates of 47/100,000 from 2014-2018.[26] DoD did not include AIAN SM suicide estimates in its 2020 suicide report due to sample size concerns.[23, 24]

The ongoing veteran and SM suicide epidemic partly reflects national suicide trends among groups overrepresented in the Services. In 2020, for example, 82.8% of SMs were male, in comparison to 49.5% of the US.[27, 28] Nationally, men were 3.7 times more likely that women to have died of suicide in 2020 (21.9 vs 5.5/100,000).[24] Similarly, 68.9% of SMs were recorded as "White" by the DoD in 2020 (DoD numbers do not separate Hispanic and non-Hispanic Whites), while non-Hispanic Whites represented 57.8% of the US.[28, 29]

Trends in Beneficiary Mental Health

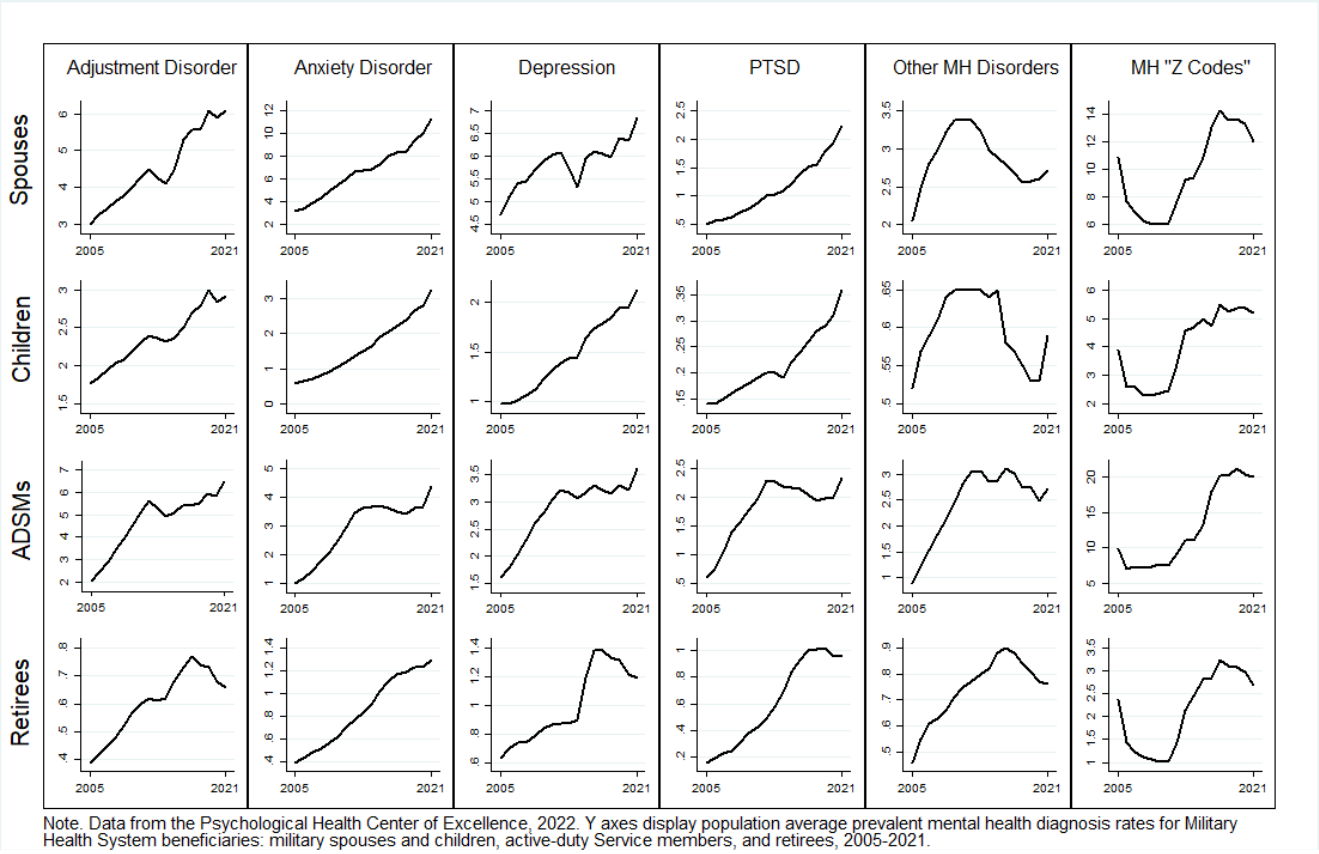
MH disorder diagnosis rates among MHS beneficiaries are increasing over time. Figure 3 displays prevalent MH conditions from 2005 to 2021 for the following MHS beneficiary groups: spouses, children, ADSMs, and retirees.[6] Major increases are present for common MH diagnoses, like anxiety disorders:

- 3-fold increase (3.5 → 10.7%) among spouses
- 6-fold increase (0.6 → 3.6%) among children
- 4-fold increase (1 → 4%) among ADSMs
- 3-fold increase (0.4 → 1.3%) among retirees

Increases are also seen for less common MH diagnoses like PTSD:[6]

- 4-fold increase (0.6 → 2.4%) among ADSMs
- 5-fold increase (0.2 → 1.0%) among retirees

Figure 3. Average Rates of Prevalent Mental Health Diagnoses among Military Health System Beneficiaries



Note. Data from the Psychological Health Center of Excellence, 2022. Y axes display population average prevalent mental health diagnosis rates for Military Health System beneficiaries: military spouses and children, active-duty Service members, and retirees, 2005-2021.

Youth MH trends are especially concerning. For example, anxiety diagnoses increased by more than seven times from 2005-2021 among 15-17 year olds ADSM children.[6] Trends in MH diagnosis data are corroborated by findings from a 2022 survey conducted by the National Military Family Association (NMFA) and Bloom: Empowering the Military Teen organizations. The NMFA and Bloom report that, among teenaged military dependents, 37% have thoughts of harming themselves or others and over 90% place their own mental well-being in the low-to-moderate ("at risk") range.[30] Among military teens in the lowest mental well-being range, 28% reported difficulty "thinking clearly and making decisions."[30]

The National Mental Health Environment

The national MH environment drives beneficiary MH trends. Drawing on pre-COVID-19 US data, diagnosed MH disorders (all categories) increased by 7.9% (17.7 → 19.1%) from 2008-2018 across all age groups.[31] "Serious mental illness" increased 24.3% (3.7 → 4.6%) during this same period.[b, 31, 32] By 2017, 20% of American children aged 3-17 had a diagnosis of a mental, emotional, or behavioral disorder, and mental illness had risen to the most common major illness affecting American children.[33]

[b] The Substance Abuse and Mental Health Services Administration defines a "serious mental illness" as the presence of "a diagnosable mental, behavior, or emotional disorder that causes [a] serious functional impairment that substantially interferes with or limits one or more major life activities" in someone over 18 years of age within the past year.[33]

The national MH crisis most severely impacts younger Americans.[34] The following data reflect the time period 2008-2018:[35]

- Mental illness increased 37.7% (19.1 → 26.3%) among 18-25 year olds
- Depression increased 64.3% (8.4 → 13.8%) among 18-25 year olds
- Depression increased 73.5% (8.3 → 14.4%) among 12-17 year olds
- One in three teenagers (13 to 18 year olds) suffered from an anxiety disorder

As youth MH has deteriorated, suicide has risen to the second-leading cause of death among 10-24 year old Americans.[33, 36] Suicide rates are rising fastest among the very young, as seen in the following increases from 2000-2017:[35, 36]

- 36% (12.5 → 17/100,000) for 20-24 year olds
- 47.5% (8 → 11.8/100,000) for 13-19 year olds
- 66.7% (1.5 → 2.5/100,000) for 10-14 year olds

Trends in MH disorder diagnosis rates reflect changes in individuals' need for MH care, but what about their willingness to seek MH care? MH stigma is a powerful access barrier.[14-16] As this barrier erodes, MH disorder diagnoses should increase. It is possible that some portion of recent trends reflects progress against MH stigma; however, caution is warranted in drawing rosy conclusions from available data. Recent research suggests some limited progress against MH stigma, but only in the case of depression.[37] The same research found that stigma surrounding schizophrenia increased in recent years.[37]

The more likely explanation for national and beneficiary trends is that the nation is experiencing a MH crisis. Rising suicide (especially youth suicide), opioid addiction, and overdose deaths cannot be accounted for by declining stigma.[35, 36, 38] Surges in demand for MH services following national crises (e.g., COVID-19) are likewise not easily attributed to declining stigma.[39-41]

The Coronavirus (COVID-19) Pandemic

The national MH statistics reported here largely draw on pre-pandemic data. However, the COVID-19 pandemic further worsened the existing MH crises by adding additional MH stressors, including the following:[39, 40, 42]

- Feelings of isolation, loneliness, irritability, and anxiety in response to social distancing and other pandemic mitigation measures
- Anxiety and fear related to catching the virus (or of loved ones and friends catching the virus)
- Grief associated with the loss of loved ones and friends

COVID-19 has been especially harmful to children. Pandemic mitigation efforts isolated children and disrupted their daily routines.[40] School closures separated children from vital school-based MH resources.[40, 43] Experts fear that the price for combatting COVID-19 will be borne by the nation's children in the form of long-term MH, social, academic, and even cognitive challenges.[43-45] Children at greatest risk for negative MH and developmental outcomes include the following:[43]

- Autistic children
- Children who had preexisting MH conditions
- Children residing in abusive homes

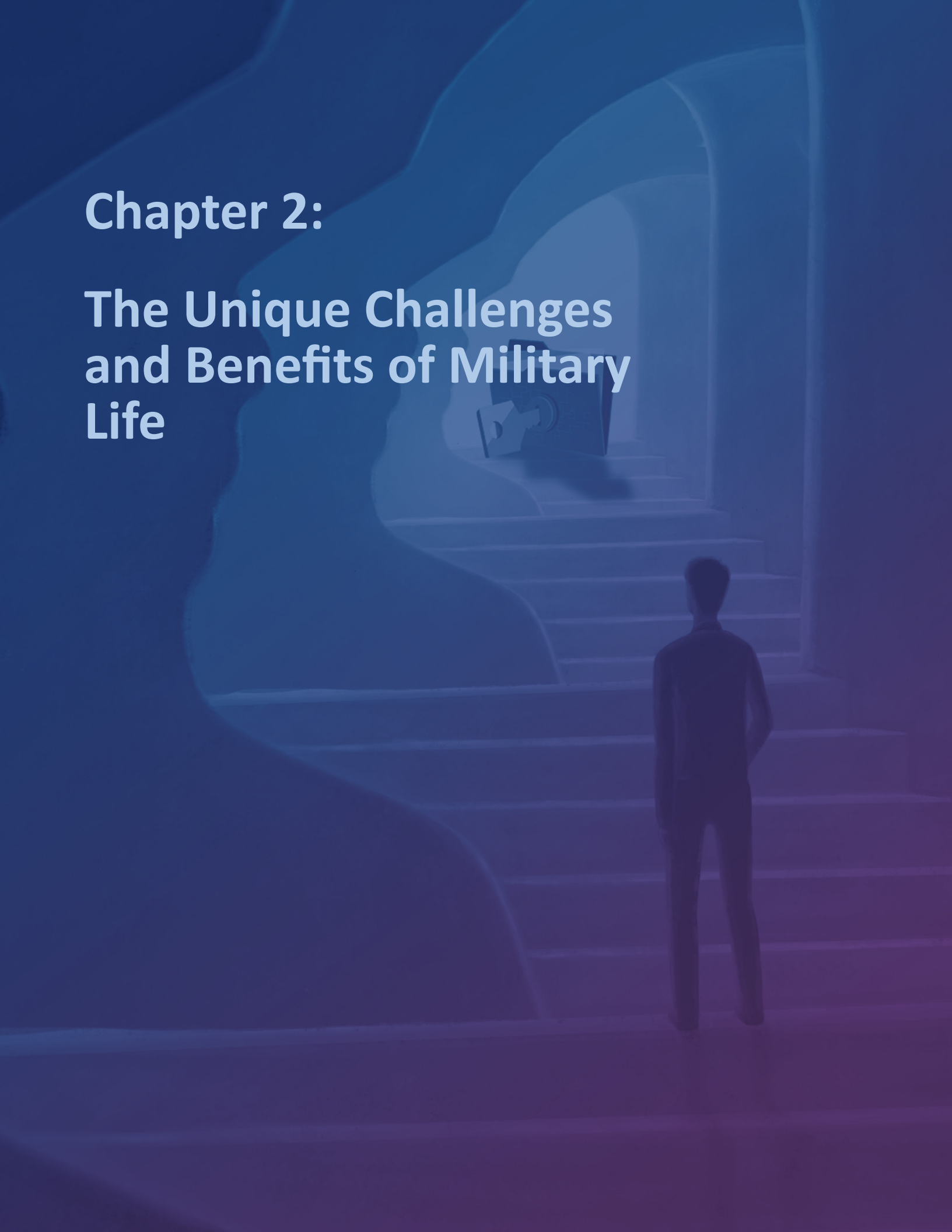
Military families were no exception to this trend. A 2020 poll found that 23% of military family respondents received a new diagnosis of a depressive or anxiety disorder since the onset of the COVID-19 pandemic.[40] The same poll found that 62% of SMs were "considerably more stressed" in 2020 than prior to the pandemic.[40]

Summary

MH disorder rates are rising for MHS beneficiaries, paralleling trends for the nation at large. In some cases, beneficiary rates exceed national reference group rates, such as in military vs. civilian female spouses. In other cases, the reverse is true (e.g., military retirees and civilians aged 50 years and older). In still other cases, rates in beneficiary and national reference groups are comparable, such as military and civilian children. The national MH environment impacts MHS beneficiary trends in terms of both increased need (i.e., the MH crisis) and declining MH stigma. However, the national MH environment, including COVID-19, accounts for only part of beneficiary demand. The contribution of the military environment to the demand for MH services is considered in Chapter 2.

Chapter 2:

The Unique Challenges and Benefits of Military Life



Like their civilian counterparts, military spouses and children are impacted by the ongoing national MH crisis. However, they also bear the additional weight of unique MH stressors inherent to military family life. These stressors include frequent moves, a rigorous non-deployed operations tempo, and deployments. The family MH environment is interconnected: MH challenges experienced by one family member impact the psychological well-being of other members. This dynamic is especially evident during the deployment cycle.

Although the unique and potent stressors inherent to military family life take a toll on military families, well-being metrics for military and civilian family members appear broadly comparable. The surprising resilience of military families points to aspects of the military environment that *support* MH, particularly the military culture and family support resources. The availability of these resources is largely dependent upon the integration of military families into the military community.

Frequent Moves

PCS moves are a common occurrence for military families. AD families move an average of 2.4 times more frequently than their civilian counterparts.[46, 47] These moves limit employment opportunities for military spouses (especially females), thereby reducing household earnings.[46-48] Relocation additionally disrupts access to health and education services, creating serious concerns for families with special needs children.[46, 47, 49, 50] Finally, relocation disrupts social networks which are critical sources of emotional, instrumental (e.g., ride sharing and babysitting), and informational (e.g., military family support resources) support.[2, 46, 51-53]

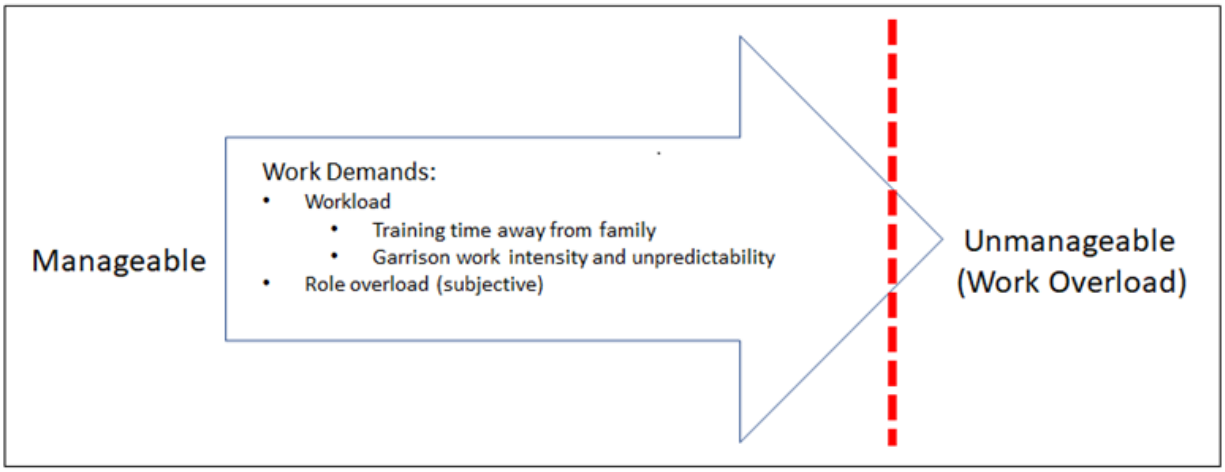
The disruptions caused by frequent PCS moves can be particularly challenging for children. Among military children, a move in the previous year is associated with increased MH encounters, psychiatric hospitalizations, and emergency room visits.[9] Among military adolescents, more frequent moves are associated with increased depression and anxiety and with behavioral problems including skipping class, increased sexual activity, fighting, carrying weapons, and gang membership.[54-59] More frequent moves (>5 vs 3-4) harm academic achievement, especially among younger children, children from single-parent homes, and children whose SM parent is their mother.[60]

Operations Tempo in the Non-deployed Environment

The term "operations tempo" (OPTEMPO) describes the pace or load of military work conducted in deployed or non-deployed (garrison or training) settings.[c, 61-63] This includes "time away from home spent on deployment and training exercises and the intensity of the daily work schedule including work hours, working on scheduled days off, and the predictability of work hours."[62] Each of these components constitutes a potential source of "work overload," a state in which job demands exceed the ability to meet them (Figure 4).[62-64] Subjective assessments to this effect – sometimes labeled "role overload" – additionally contribute to work overload.[63, 65] Given that work overload represents the high end of OPTEMPO, the two terms are sometimes used synonymously.[63]

[c] Relevant OPTEMPO research is largely a decade or more old

Figure 4. Operations Tempo in the Non-deployed Environment



The OPTEMPO specific to US military deployments increased dramatically in the wake of the Cold War and again during the War on Terrorism.[61, 66] Deployment-associated OPTEMPO difficulties experienced by military families are well-documented; however, the impact on military families of OPTEMPO in the non-deployed environment (OPTEMPO-NDE) is relatively understudied.[d, 2, 67] Operations tempos in the deployed and non-deployed environments are linked in that frequent deployments place additional support requirements on garrison units and leave less time for all units (deployed and non-deployed) to complete required training evolutions.[61]

Heightened OPTEMPO-NDE presents serious quality-of-life challenges for military families.[61, 68] Garrison workloads often exceed deployment workloads, in part due to understaffing.[61] Training exercises, much like deployments, separate military families from SMs and are associated with similar burdens, such as stress and adverse health events.[61] Indeed, research points to the following subcomponents of OPTEMPO as independent causal factors for work-family life conflicts:[68-73]

- Number of hours worked per week
- Amount and frequency of overtime and irregular work
- Number of days training
- Role overload

Heightened OPTEMPO-NDE also directly impacts SM well-being. Work overload is associated with poor mental and physical health, as is role overload.[74-77] Irregular work schedules are associated with psychological and physical health complaints, including sleep deprivation.[78-81] Sleep deprivation, in turn, is linked to compromised mental and physical health, reduced motor and cognitive functioning, safety risks, and increased work-family life conflicts.[68, 82-85] Not surprisingly, Soldiers who leave the Army (forgoing a longer career) cite workload and demands on family life as reasons for leaving.[e, 61, 86]

[d] Operations tempo in the non-deployed environment are not discussed by Hawkins et al. or by Huebner et al.[2, 67]
[e] The 2023 NDAA, Sec. 747, tasks the Secretary of Defense (SecDef) to report to Congress on the impact of OPTEMPO on ADSM MH visits, suicide rates, musculoskeletal injuries, and retention.[86]

Deployment

A third prominent source of stress in military families is spouse/parent deployment.[13, 87, 88] Among military spouses, deployment is associated with increased stress, loneliness, role overload, and financial difficulties.[13] As seen below, spouses of deployed SMs experience worse MH than spouses of non-deployed SMs:[12, 89]

- Wives of deployed Soldiers are more often diagnosed with depression, anxiety, and adjustment disorders than wives of non-deployed soldiers
- Spouses of combat-deployed junior SMs report greater anxiety, insomnia, and somatization than spouses of non-combat-deployed SMs[f]

Deployment-related spousal stress, in turn, strains marital relations.[90] Among pregnant spouses, deployment-related stress is associated with a 3.25-fold increased risk of delivering early.[91, 92] Deployment can be especially challenging for military children. Children with deployed parents report increased feelings of sadness, hopelessness, and concern for their deployed and non-deployed parents.[93-97] They are more likely to experience MH difficulties than other military children or civilian children and are more likely to utilize MH services.[11, 93, 98-106] Deployments are associated with increased child emotional-behavioral challenges, worse academic performance, and increased risk of maltreatment and neglect.[11, 60, 98, 107-112]

Not surprisingly, deployment frequency and duration are both associated with worse outcomes for military families.[12, 96, 104, 112, 113] Among AD Army wives, longer deployments (>11 months) are associated with increased MH diagnoses.[12] Among Army spouses, cumulative number of months deployed is associated with decreased relationship functioning.[114] Among military children, longer deployments (>6 months) are associated with increased psychiatric hospitalizations, and cumulative number of months deployed are associated with increased MH diagnoses, behavioral challenges, and lower test scores.[9, 106, 109, 112, 113, 115]

A prominent source of deployment-related stress for military families is the fear that their SM parent/spouse will be killed.[116] However, even when SMs return home, the post-deployment period may be challenging for military families.[13] SMs and spouses may struggle to reconnect due to the perception that they and/or their spouse has changed during the deployment.[117-119] SMs report difficulties reconnecting with their (especially younger) children.[117, 120] A key challenge for military families is renegotiating household roles that changed in the SM's absence.[107, 112, 113, 121, 122]

Another challenge of the post-deployment period is managing the aftermath of various deployment-related hardships. Non-deployed family members may have endured emotional, financial, and other difficulties, including children's academic and behavioral challenges.[109, 112, 113, 122] Returning SMs may struggle to reacclimate themselves to the non-deployment environment, which features different routines, role expectations, and work and family life expectations than the deployed environment.[120, 123]

[f] Steenkamp et al. operationalize somatization as "being bothered 'a lot' by 3 or more of 15 physical symptoms."[89]

Military families may also struggle to adapt to injuries sustained by SMs during the deployment. Such injuries can be physical (e.g., a missing limb), psychological (e.g., PTSD), and/or "moral."[g, 124] A prominent feature of recent conflicts has been an increase in rates of such "invisible injuries" as PTSD and traumatic brain injury among returning SMs.[125] The tendency for these injuries to go undiagnosed and uncompensated further burdens military families.[125]

The Interrelatedness of Active Duty Service Members and Family Mental Health

When a family member experiences a MH challenge, the effects may be felt throughout the household.[126, 127] This dynamic is evident in the military family context.[2, 128] SM MH challenges are associated with family member challenges such as the following:[104, 129-137]

- Emotional distress and poor psychological adjustment in military spouses and caregivers
- Internalization of problems among military children
- Low-quality parenting and strained parent-child relationships
- Increased rates of domestic violence, child abuse, and child neglect

Among military spouses, symptoms of depression are related to attachment behaviors (healthy/unhealthy) in children.[138] Among both military spouses and SMs, symptoms of depression increase risks of MH conditions in children, especially when young.[139]

The interconnectedness of military family MH is particularly evident during deployments.[104, 112, 113, 122, 140] Deployment-related spousal stress increases risks of child neglect and maltreatment as well as MH symptoms in children, including stress, anxiety, and depression.[11, 101, 110, 111, 141] Indeed, parental stress – whether in non-deployed spouses, deployed SMs, or both – is associated with internalizing (social withdrawal) and externalizing (aggression) behavior in military children.[104] Deployment-related spousal depression is further linked to reduced involvement in children's education and poor child emotional, behavioral, academic, and social functioning.[112, 113, 122, 140]

As might be expected, the relationship between parent and child MH is evident as well in the civilian family context. Children of parents who experience MH challenges are more likely to suffer maltreatment and neglect and are more likely to experience MH challenges themselves.[142-145] Research on civilian families further suggests that the long-term consequences of poor MH in children are significant. Childhood MH challenges are associated with reduced income and health, increased legal difficulties, and worse social functioning.[146, 147] Child maltreatment and neglect, in turn, are associated with increased rates of adult chronic physical and MH conditions.[148-150]

Military Family Resilience

Military families face unique and potent challenges. However, they also possess unique strengths. Notwithstanding deployment-specific challenges, military children are by some measures more resilient than civilian children or better able to meet challenges and to thrive in the face of adversity.[151, 152] Military children compare favorably to civilian children in terms of the strength of family bonds,

[g] "Moral injuries" are emotional/psychological/behavioral/spiritual/social injuries sustained due to perpetrating, failing to prevent, or witnessing events that contradict deeply held moral beliefs and expectations.[124]

emotional self-regulation, and academic achievement.[151] One reason may be that military family life stressors create opportunities for personal growth. For example, relocation allows children to "reinvent" themselves in a new social environment, and deployments encourage children to develop independence and accountability as they assume new family responsibilities.[151]

Table 1 displays military and civilian family outcome measures, drawing on research reviewed by Hawkins et al.[h, 2] Given the noted stressors associated with military family life, the broadly comparable outcomes recorded in the military family literature is surprising. Comparability, in this case, suggests the presence of one or more unaccounted-for positive variables contributing to *enhanced* MH and well-being in military families. There is good reason to believe that military culture and family support institutions play this supporting role.[67, 152]

Table 1. Select Military and Civilian Well-being Measures[2]

Comparison	Measure
Worse	Post-partum depression (increased, ADSMs)
	Distress, anxiety, and depression (increased, military spouses)
	Depression and PTSD (increased, Reserves spouses)
	Suicide attempt and ideation (increased, military children)
	Violence, harassment, and carrying weapons (increased, military children)
Better	Child neglect (reduced)
	Marriage (increased)
	Divorce (reduced, ADSMs)
	Academic performance (improved, military children)
	Social support networks (larger, military spouses)
	Social anxiety (reduced, military children)
Comparable	Child abuse
	Intimate partner violence
	Infidelity
	Depression (military children)
Unknown/ Mixed Evidence	Alcohol and drug use (military children)

Military culture confers a unique, shared identity on military families and a sense of pride in contributing to the defense of the nation.[67, 152] This identity appears to function as a psychological bulwark against the stressors of military family life. For example, among military spouses, those who derive a sense of meaning and purpose from supporting their SM spouse experience better emotional well-being and demonstrate greater aptitude in managing life challenges.[113, 118, 153, 154] Spousal

[h] See Hawkins et al. for a more detailed review military family readiness[2]

acceptance of the military lifestyle is associated with reduced stress, and positive feelings towards the military are associated with fewer symptoms of depression and with a moderation of the impact of stress on depression.[155, 156] Military spouses who grew up in military families – a reasonable proxy for acculturation – report experiencing fewer MH symptoms during deployments.[157]

The relationship between identification and resilience is evident as well in military children. Identification with the military as an institution and with its mission encourages children to view the burdens of military family life as "badges of honor."[152] Perhaps for this reason, military children who perceive greater public support for ongoing military operations experience less stress during deployments.[158] Identification additionally facilitates a sense of felt connection to other military youth who may serve as emotional support resources during deployments and other difficult times.[i, 152, 159-165]

DoD family support and wellness programs constitute another key source of military family resilience.[2, 67] These programs help to counterbalance the unique stressors of military life through their positive impacts on military family health, finances, relationships, and emotional and social supports.[2, 67] Examples are listed below:[166-172]

- TRICARE Prime: a health plan with little to no out-of-pocket costs for qualifying military family members
- TRICARE Select: an alternative health plan with lower average out-of-pocket costs than private health insurance
- High-quality childcare programs with income subsidies for qualifying military family members
- The Exceptional Family Member Program, which provides resources to military families with members (including dependent adults) who have special health or educational needs
- Counseling, emotional, and other support resources provided by Service Chaplains, Military Family Life Counselors (MFLCs), Military OneSource, and the Family Advocacy Program, among others
- Morale Welfare and Recreation Centers, which provide fitness, entertainment, recreation, leisure, and other activities
- Department of Defense Education Activity K-12 schools, which help to address the problem of frequent PCS moves by providing a continuous curriculum for K-12 students

Social Connectedness

The vital role played by military culture and family support institutions in bolstering military family resilience depends in part on the integration of military family members into the military community. A large body of research links a greater number of more supportive social connections to a host of resilience-enhancing outcomes, including mental and physical health and happiness.[173-175] Social connections, sometimes referred to as "social support" or "social capital," are key sources of support for needs in such realms as emotional (caring and validation), instrumental (financial assistance and babysitting), and informational (family support resources accessible through Military OneSource).[j, 51, 52, 173]

[i] These findings are in line with a large body of social science literature linking "in-group" identification to positive self-esteem, and pro- (in-group) social behaviors.[159-161] The link between identification and resilience may have to do with evolutionary psychology, given that human beings are social animals evolved to live near one another.[163, 165] Research linking social connectedness to reduced stress responses to adverse events may be interpretable in this light.[164]

[j] Trail, Sims, and Hall address "social support"; however, "social capital" similarly describes networks of social connection and the socially beneficial results of those networks, such as trust and reciprocity.[51, 52, 173]

These resources are especially valuable in the military family context, as illustrated by the following examples:[2, 176-179]

- Greater community engagement is associated with improved resilience among spouses (e.g., coping with stress) and children (e.g., reduced MH symptoms)
- An increased "sense of community" is associated with improved family well-being and adaptation to military life
- Increased connections to other military spouses are associated with better adjustment to Army life and culture
- More supportive friendships are associated with reduced depression and anxiety and with increased feelings of self-efficacy
- Increased social support reduces risks for intimate partner violence

Among military children, social isolation – the opposite of social connectedness – is associated with increased risk of depression and anxiety.[54, 55, 180] Older military youth who participate in fewer military-sponsored activities experience greater symptoms of depression.[181] Friendships with other military children have been shown to be especially beneficial, given that frequent relocation limits other friendship and social opportunities, such as sports.[53] Such friendships are likely to form through active participation in military-sponsored activities.[181] Finally, military children who feel supported by their communities, by the military and by religious organizations experience less stress during deployments.[182]

The instrumental and informational value of social connections benefits military families independently as well as through their impact on emotional and MH support. A recent analysis of the Millennium Cohort Family Study identified logistical challenges, such as costs and time constraints, as barriers to MH care for military spouses.[183] In the case of time constraints, social connections can be a valuable resource. For example, military families can alternate carpooling to and from school and after-school activities and assist each other with childcare and doctor's visits.[52] Intra-military community social connections are especially valuable to military families, given that they tend to have younger children and to move frequently, distancing them further from family and civilian friend networks.[46] These same connections additionally serve as valuable sources of information about DoD family support programs.[52]

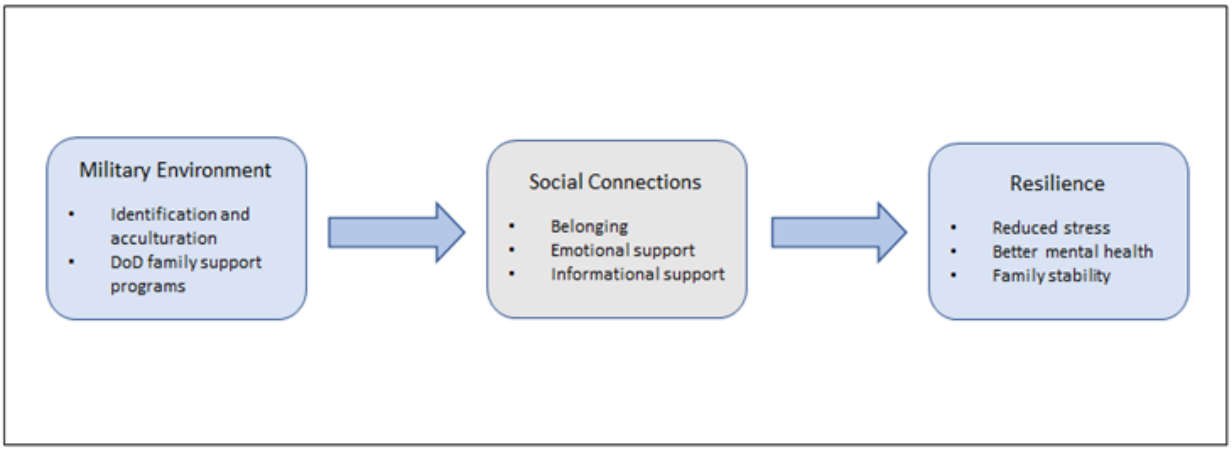
The importance of social connectedness is further evidenced by the comparatively greater difficulties experienced by less-integrated military families, such as those headed by junior enlisted SMs and families residing off-base, including families headed by Reservists and members of the National Guard.[46, 113, 184-186] Junior enlisted families are often new to the military environment and thus tend to have fewer military community friendships and to be less familiar with military practices, culture, and support resources.[52]

For military families residing off base, distance from base equates to distance from the military community. For example, distance from post increases the likelihood of Army spouses reporting stress, difficulties navigating military support resources, having greater unmet needs after accessing said support resources, and feeling less connected to the Army community.[184] Among both spouses and

SMs, distance from post additionally predicts more negative attitudes towards the Army and reduced desire to remain in the Army.[178] Reserve Component spouses report poorer emotional well-being than their Active Component counterparts.[113] Reservist SMs are nearly 1.5 times more likely than ADSMs to report MH problems and are more than three times as likely to be referred for MH services after deployment.[186]

The negative association between military family resilience and distance lived from the physical locations around which military community life centers suggests an important moderating role for social connectedness in the relationship between military culture and military family resilience (Figure 5). Communities are networks of people rooted in *places*. People meet in physical locations and develop relationships.[k, 187] In the case of military families, those relationships and social connections enhance resilience by adding *depth* to family members' psychological attachments to the larger military community, enhancing identification and acculturation. Indeed, social connections make the idea of a "military community" something tangible.

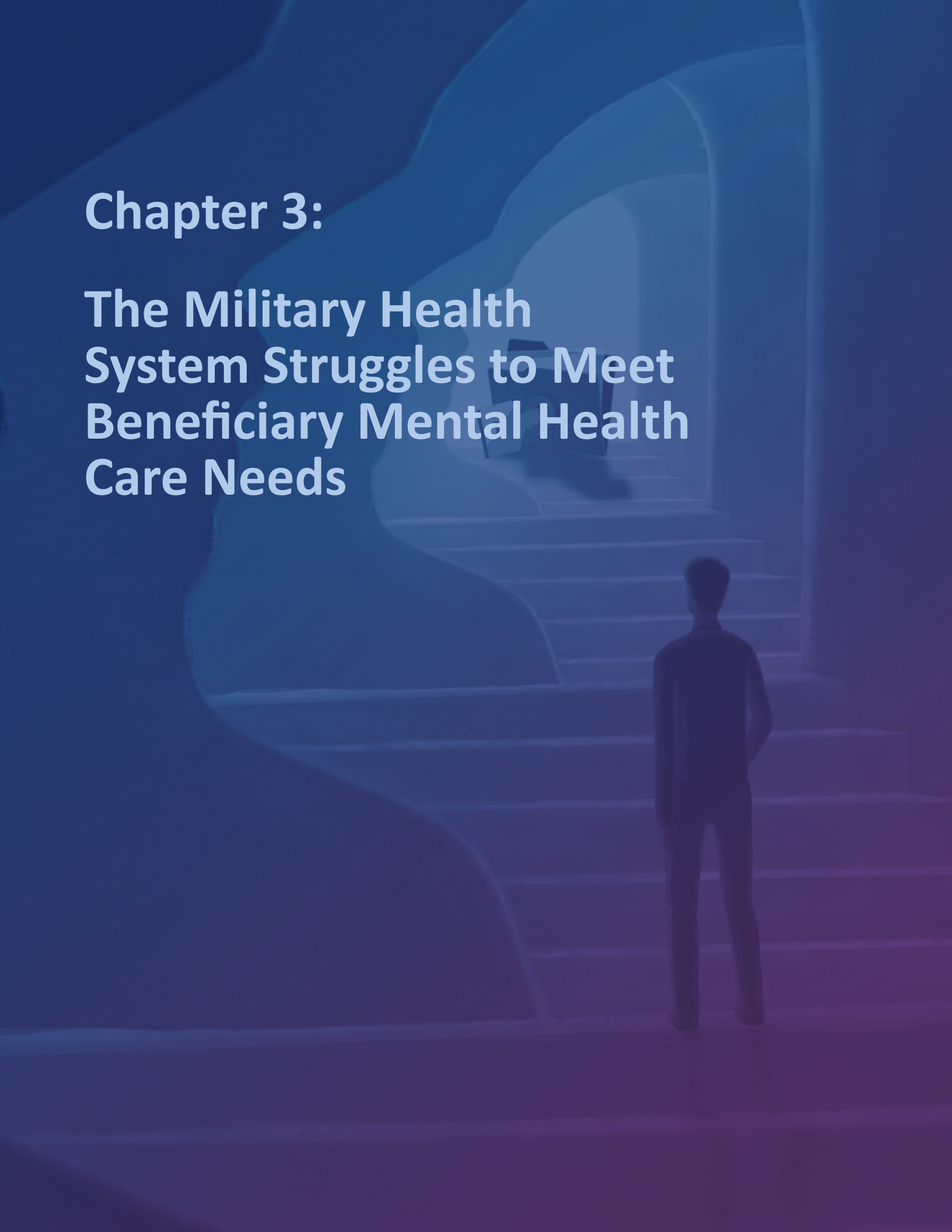
Figure 5. The Role of Social Connectedness in Military Family Resilience



Summary

The military environment is a unique and potent contributor to military family MH challenges insofar as frequent moves, a heightened operational tempo, and deployments are among its inherent features. The ability of military families to weather the burdens the nation asks of their SM parents/spouses – and therefore, of them – is a critical component of well-being and of readiness. Research suggests that military culture and institutional supports bolster military family resilience to the extent that military families are integrated into the military community. The resilience-enhancing features of the military environment take on greater importance in the context of the national MH crisis in that they may help to restrain beneficiary demand for MH services. The following chapter addresses the "supply side" of the MH equation, examining challenges in access to care for military families.

[k] Trail, Sims, and Hall discusses supporting social media networks for information support purposes.[52]



Chapter 3:

The Military Health System Struggles to Meet Beneficiary Mental Health Care Needs

The MHS provides health services to 9.7 million beneficiary SMs, retirees, and their families across the system's direct and purchased care networks (Table 2).[188-190] In the face of high and rising beneficiary demand for MH services, the supply of MHS MH care has proved insufficient. Key challenges include inconsistent compliance with access-to-care standards and provider shortages – overall and in high-demand locations – due to recruitment and retention difficulties. Resolving these challenges and bringing the supply of MH care in line with beneficiary demand is key to achieving the MHS's mission.

Table 2. Military Health System Workload, Providers, and Beneficiaries (Numbers in Millions)[188, 190]

	Number, in millions (Percentages)
Workload	
Direct Care	(40%)
Purchased Care	(60%)
Providers	
Direct Care, Military	0.07 (6%)
Direct Care, Civilian	0.06 (5%)
Purchased Care	1.01 (89%)
Eligible Beneficiaries	
Active Duty Service Members	1.41 (15%)
Active Duty Service Members Families	1.62 (17%)
Guard/Reserve/Inactive SMs	0.44 (6%)
Guard/Reserve/Inactive SM Families	0.64 (6%)
Retirees	2.22 (23%)
Retiree Families	2.73 (27%)
Others (includes Survivors)	0.63 (6%)

Widespread Barriers to Accessing Mental Health Care

The MHS is not adequately meeting the MH needs of its beneficiary population. Federal regulations establish access standards for care delivered by the MHS's direct (MTFs) and purchased care networks through TRICARE: [l, 191, 192]

- "(i) Under normal circumstances, enrollee travel time may not exceed 30 minutes from home to primary care delivery site unless a longer time is necessary because of the absence of providers (including providers not part of the network) in the area," and
- "(ii) The wait time for an appointment for a well-patient visit or a specialty care referral shall not exceed four weeks; for a routine visit, the wait time for an appointment shall not exceed one week; and for an urgent care visit the wait time for an appointment shall generally not exceed 24 hours."

[l] "TRICARE is the DoD program that implements the health care benefit provided to ADSMs, retirees, and their families. Managed by the DHA under the ASD(HA), it complements and supplements the military's direct care system with civilian providers' networks. As of 2020, the program serves 9.6 million beneficiaries, including ADSMs, retirees, and their dependents. ADSMs are eligible for TRICARE after 30 days of service."[190]

According to a 2020 report by the Department of Defense Office of Inspector General (DoDIG), seven out of 13 assessed MHS care systems failed to meet the legally mandated specialty MH access-to-care standards each month from December 2018 to June 2019.[193] Five of the six remaining care systems only met the required specialty access-to-care standards during a single month.[193] The DoDIG additionally found that 53% of beneficiaries (4,415 of 8,328, per month) referred to the TRICARE network "did not receive care and the MHS did not know why."[193]

Of the 13 MTFs audited by the DoDIG, nine were unable to meet evidence-based treatment standards or to monitor behavioral health (BH) treatment dosages (e.g., how frequently patients were treated) as required by DHA procedural instructions.[193, 194] The DoDIG additionally found that the MHS lacked visibility of patients who attempted but failed to obtain MH appointments within the purchased care network.[193] In both direct and purchased care networks, self-referring patients and patients seeking subsequent appointments were improperly excluded from the 28-day specialty access to care requirement.[193] The DoDIG concluded that thousands of beneficiaries experienced MH care delays, failed to receive timely follow-up care, or in some cases were unable to access any MH care.[193]

The DoDIG's findings echo beneficiary concerns as recorded by recent surveys. Only half of AD military families surveyed in 2019 by the Military Family Advisory Network gave positive assessments of MHS MH care (52.5%) or of their ability to access MH appointments (48.8%).[m, 195] SMs and families cite appointment availability, time constraints, and negative career implications of seeking MH care as top concerns.[195] Twenty-five percent of military family respondents surveyed in 2019 by Blue Star Families rated MH care as a "top 3 unmet community need."[40] Twenty-six percent of respondents overall – a group that also includes veterans and veteran families – reported negative MH consequences resulting from challenges accessing MH care.[40]

Regarding MH care accessed through the purchased care network, researchers and beneficiary advocates point to ongoing quality and access concerns, including those listed below:[196-199]

- Worse outcomes for children with complex BH conditions in comparison to children in competing care systems
- The continued absence of a pediatric medical necessity standard of care aligned with evidence-based best practices, as recommended by the American Academy of Pediatrics
- Age eligibility restrictions for dependent healthcare enrollment, contrary to civilian heath care practices
- Increased copays for MH visits

TRICARE MH care is additionally undermined by the following inconsistent and unclear policies that make it difficult to assess whether access to care standards are being met:[193, 200, 201]

- The Office of the ASD(HA) requires self-referring patients to be seen within seven days; however, this requirement is not included in the DHA's TRICARE Policy Manual
- Direct and purchased care systems employ different approaches to measuring the 28-day specialty access to care requirement
- MTFs do not define requirements for initial BH assessments

[m] The Military Family Advisory Network surveyed SMs, SM families, veterans, and veteran families.[195] This reports uses the findings for SMs and SM families.

National Challenges: The "Terror of Geography"

MH access barriers are a national problem. Across the US, one in three Americans reside in locations where MH professionals are in short supply.[202, 203] MH providers are overrepresented in coastal and urban areas – close to graduate medical programs and major medical centers – and underrepresented in rural, low-income, and inland areas.[204-207] In practice, these disparities create state-to-state variation in access to MH care. For example, Delaware has a shortage of 15 providers while Texas is short 638 providers.[203] At the county-level, three out of four counties with populations between 2,500-20,000 lack psychiatrists, and half lack a social worker or psychologist with a masters or doctoral degree.[208]

The geographic imbalance of MH care, which is projected to worsen by 2030, is especially concerning to the MHS given its geographically dispersed beneficiary population.[202] Approximately 300,000 SMs and 1 million military family dependents reside in geographically remote locations, defined as places "more than 30 minutes away from BH care or in a low provider density area."[n, 209] Remote-residing beneficiaries, who represent approximately 19% of SMs (300,000/1.57 million) and 41% of family dependents (1 million/2.46 million), have less access to MH care and receive a lower quality of MH/BH care overall.[206, 209-211]

A 2021 RAND study found that, among direct-care patients, remote-residing SMs were less likely than non-remote-residing SMs to receive psychotherapy for a new treatment episode (NTE) for PTSD (59% vs. 70%) or depression (45% vs. 57%) or a psychosocial treatment intervention for a NTE for substance abuse (30% vs 61%).[211] Remote-residing direct-care SMs were also 2-5% less likely to receive minimally adequate care for the first eight weeks of a NTE for PTSD.[211] Within the TRICARE network, remote-residing SMs make fewer BH and psychotherapy visits in comparison to non-remote SMs.[209] This remote/non-remote disparity in MH care exceeds disparities in civilian care.[209]

Inadequate Staffing

Provider shortages are an important factor underlying the failure of the MHS' direct and purchased care networks to meet beneficiary MH demand. A recent DoD report to Congress identified a deficit of 1,050 AD MTF BH providers.[212] There is an urgent need to improve recruitment and retention of licensed MH providers, including psychiatrists, psychologists, clinical social workers, licensed counselors, clinicians, and therapists.[212] The DoD estimates the cost of hiring and retaining these providers at $702,117,619.[212]

There is also a shortage of "allied MH providers" including BH technicians, case coordinators, patient educators, and patient navigators.[212] Allied MH providers function as "physician extenders" by assisting licensed MH providers to optimize delivery of care.[213] Given their familiarity with the military environment, military spouses are a potential recruitment pool for allied MH providers.

Direct care provider shortages shift beneficiaries to the purchased care network, i.e., to civilian providers who accept TRICARE patients.[214] Patient difficulties accessing such care are described in

[n] Federal regulations permit beneficiary travel time exceeding 30 minutes from home to primary care in low provider areas.[192]

numerous reports as well as recorded in patient surveys.[193, 195, 214-216] In the face of widespread access challenges, the term "ghost networks" has been coined to describe provider networks with few if any available providers.[215] State licensure barriers contribute to purchased care staffing shortages by restricting employment opportunities for MH professionals who move frequently, such as military spouses.[30, 40, 217, 218]

At the present time, MTFs have yet to implement a centralized booking process for BH appointments, as required by the 2017 NDAA and by DHA policy at the time.[193, 219, 220] Furthermore, the MHS does not provide beneficiaries with an updated "master list" of verified TRICARE-participating MH providers.[197] Beneficiaries are consequently left to self-navigate ghost networks in search of care, which is a time-consuming and emotionally draining process that unnecessarily delays access to care.[193, 215, 216]

No Unified Staffing System

The negative impact of provider shortages on beneficiary MH care access is exacerbated by the absence of a centralized, unified approach to determining staffing needs across the MHS.[193] At the present time, staffing decisions are managed separately by the individual Services and by TRICARE East and West based on separate projections of beneficiary demand.[193] The DoDIG raises several methodological concerns with these projections.[193]

This decentralized staffing approach is further limited in several key respects. First, the separate and methodologically distinct estimates of beneficiary MH demand are inherently inconsistent. Second, in practice, such models rely on proprietary data.[221] This means that, for example, when the Army allocates BH personnel to an MTF based on demand projections, it does so without a clear picture of the proportion of that demand likely to be absorbed by local TRICARE providers.[193] As a unified health system, the MHS would presumably benefit from a system-wide approach that incorporates all relevant data to make system-wide staffing decisions.[193]

National Challenges: Blockages in the "Talent Pipeline"

Entering medical professionals are less likely to specialize in MH than in other fields. Pay discrepancies are a contributing factor. For example, psychiatrists earn an average of $275,000/year while plastic surgeons earn an average of $526,000/year.[222] A systematic review of medical students found poor appraisals of psychiatry due in part to the following perceptions:[223]

- Low compensation
- Low status and prestige
- Poor evaluations of psychiatrists as role models
- Perceptions that the field is "unscientific"
- The difficulty of psychiatric work

Consequently, between 2013 and 2014, only 1.6% of matriculating medical students chose to specialize in psychiatry and nearly 80% of current psychiatrists entered medical school seeking to specialize in another field.[224] Recruitment to psychiatry is improving, but not nearly enough to meet projected

demand. Indeed, the national psychiatrist shortage is projected to increase to 17,430 in 2030, up from 9,050 in 2016.[202, 225] Critical shortages remain in areas like child and adolescent MH, and these shortages have been linked to rising youth suicide.[193, 226]

The Military Health System Struggles to Compete

The national MH provider shortage places the MHS in a difficult position vis-à-vis competitor health systems. The MHS' hiring process is excessively time-consuming. For example, at Walter Reed National Military Medical Center, below are listed average times to hire civilian BH professionals:[212]

- 224 days for social workers
- 304 days for psychologists
- 546 days for psychiatrists

In the case of psychiatrists, half of selected candidates decline the offered position.[212] This means that, in half of its attempts to hire psychiatrists, Walter Reed National Military Medical Center spent a year and a half recruiting, and then had to repeat this same lengthy process at least one more time before successfully hiring the staff member.[212]

The MHS is also uncompetitive in terms of provider salaries and available billets, even in comparison to other government systems like the Department of Veterans Affairs (VA).[212] Direct care MHS civilian salaries and billets are limited by law, a factor that impedes recruitment to remote and austere geographically underserved areas.[193, 212, 227] Expanding direct care workforce capacity will require Congressional action.[227]

In the competitive marketplace for MH providers, recent workforce improvements at the VA risk exacerbating the MHS's competitive disadvantage. The Hannon Act, for example, streamlines VA hiring and creates new MH provider categories.[228, 229] The recently passed PACT Act likewise aims to speed up VA hiring (Secs. 903, 909) as well as boost recruitment and retention by authorizing the following:[230]

- Recruitment and retention bonuses (H.R. 3967, Sec. 909)
- Provider pay increases (H.R. 3967, Secs. 904, 907, 908, 909) and awards (H.R. 3967, Secs. 906, 908, 909)
- Student loan repayment up to $40,000 per year and $100,000 per employee (Sec. 909)
- Buying out service contracts from AD BH providers in the Services (H.R. 3967, Secs. 902)

Congressional statute links TRICARE rates to Medicare rates, which are generally lower than private sector rates.[188] Surveys of civilian MH providers indicate that low reimbursement rates and limited TRICARE provider awareness contribute to reduced enrollment of MHS beneficiaries.[231] The DHA's locality-based reimbursement waiver authority enables it to increase TRICARE reimbursement rates up to 115% of the Civilian Health and Medical Program of the United States Maximum Allowable Charge; however, as of June 5, 2020, no such waivers had been granted for MH/BH providers.[200, 232]

Efforts to Address Beneficiary Access Challenges

In the three years following the publication of the DoDIG's 2020 report, Congress and the DHA have taken commendable steps to address beneficiary MH access challenges. The 2023 NDAA includes numerous provisions directed at expanding BH provider supply.[o, 86, 233] These include the following:[86]

- A 10-year scholarship-for-service pilot program offering payments to cover tuition, fees, and other expenses for students enrolled in a graduate program in "clinical psychology, social work, counseling, or a related field (as determined by the Secretary)," and student loan repayment for credentialed BH providers holding graduate degrees in the same fields (Sec. 737b)
- Tasking the Secretary of Defense (SecDef) to develop, in coordination with the President of the Uniformed Services University of the Health Sciences (USUHS), a curriculum and certification program to train civilian MH professionals and students in MH fields to better meet the MH needs of SMs and military families (Sec. 738)
- Tasking the SecDef to commission a direct care BH workforce development report followed by a plan to address direct care BH staffing shortfalls (Secs. 737c, d)
- Tasking the SecDef to conduct studies assessing the feasibility and advisability of expanding the clinical psychology graduate program at the USUHS, establishing new USUHS graduate degree programs in counseling and social work, and establishing service-linked pre and postdoctoral internships programs for civilian clinical psychologists (Secs. 737a, 742)
- Tasking the Government Accountability Office (GAO) to identify discrepancies between TRICARE MH/BH coverage and coverage requirements under existing health parity laws and to describe the DoD's efforts to close these gaps (Sec. 709)
- Tasking the Comptroller General (CG) to audit TRICARE BH provider lists (Sec. 705)
- Prohibiting reductions in military medical billets for five years, with some exceptions (Sec. 741)

In discussions with senior DHA and Service representatives, the DHB has learned of additional, ongoing efforts to remedy beneficiary MH access challenges, including those listed below:[234-237]

- Increase graduate medical education training slots and develop a human capital distribution plan to assist with this task
- Expand tele-mental health (TMH) services to remote and underserved military families[p]
- Address wait times and ghost networks by expanding the Integrated Referral Management and Appointing Center (IRMAC) to centralize BH appointment booking and track patients throughout their care
- Relieve patient BH demand pressure on MTFs by triaging subclinical care to alternative care providers, such as Military OneSource, MFLCs, and Service chaplains, as appropriate, based on the Air Force's (AF) successful Targeted Care Initiative[q]

[o] A recent report to the Committees on Armed Services of the Senate and the House of Representatives challenges the feasibility of expanding BH provider supply using scholarship-for-service programs, incentive pay, and paygrade increases.[233]
[p] Tele-mental health is discussed in greater detail in Chapter 7.
[q] Targeted Care Initiative is discussed in greater detail in Chapter 5.

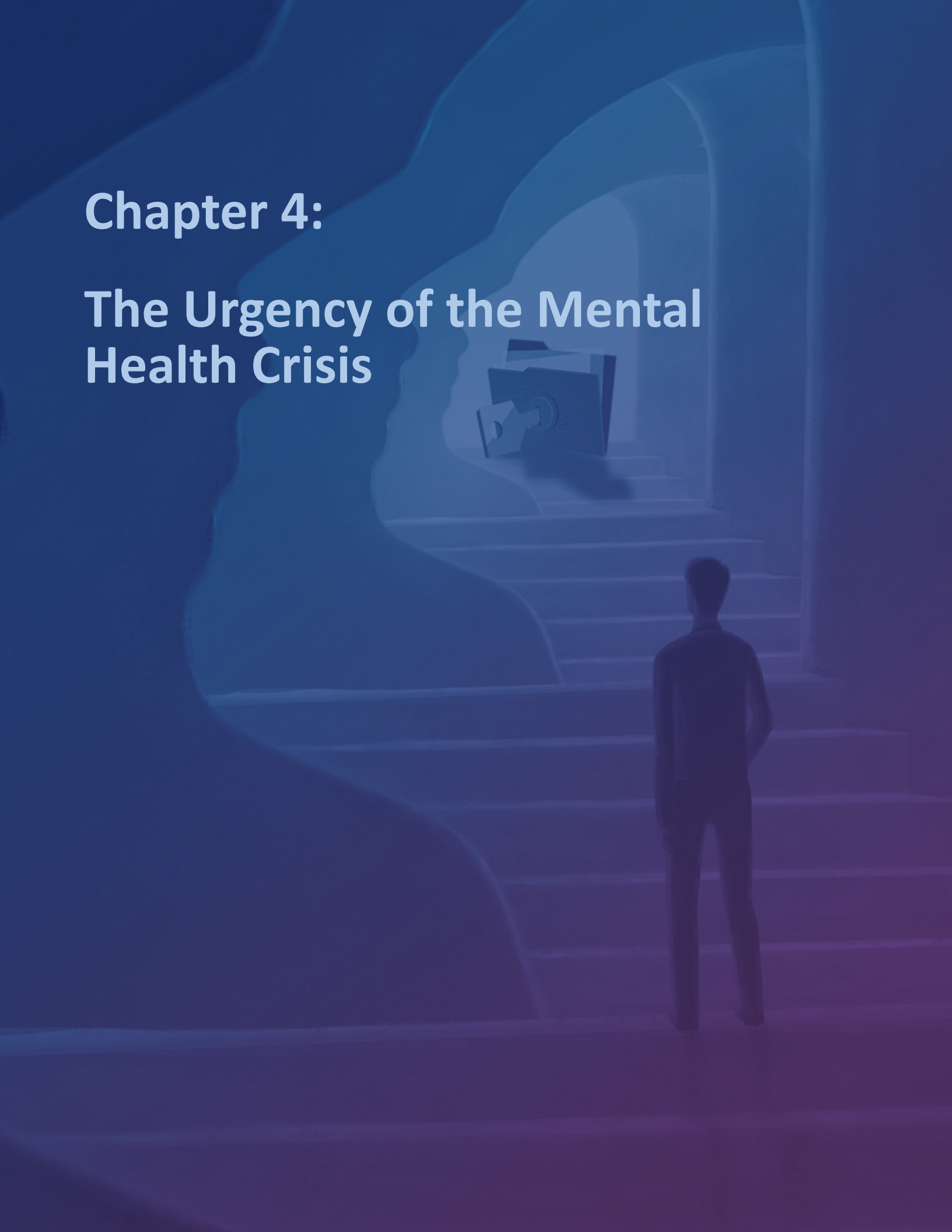
In other respects, responses from the DHA and other stakeholders have been mixed. Representatives from the DoDIG report that DHA's response to the seven/28-day access to specialty care discrepancy they identified was to *increase* patient wait times across the board to 28 days.[221] The DHA is also developing a dual (direct and purchased care systems) staffing model rather than the unified model advocated by the DoDIG.[221] DHA representatives told the DHB they did not believe that a single model was necessarily more efficient.[235] Finally, in terms of the accessibility of TRICARE MH services, there was a notable disconnect between the positive assessments given by DHA and TRICARE representatives and concerns expressed by the DoDIG and by TRICARE patient advocate groups.[193, 197, 198, 238, 239] TRICARE's new T5 contract provides opportunities to address many of challenges identified by the DoDIG as well as feedback from patient advocacy groups.

Summary

MH access challenges for MHS beneficiaries reflect both the national trend of rising demand for MH care and constraints on the availability of MH care. Addressing access challenges will require action on both the demand and supply sides of the MH equation. From the standpoint of the provider (or supplier) of MH care, supply concerns naturally take the center stage. This chapter has addressed several such concerns, including procedural barriers and discrepancies, provider recruitment and retention difficulties, and staffing inefficiencies. The DHA's ongoing efforts, and additional efforts discussed further in Chapters 5-8, are critical to meeting the MHS' mission to provide for the health needs of SMs and their families. The following chapter addresses the importance of succeeding in this mission.

Chapter 4:

The Urgency of the Mental Health Crisis



The MHS is tasked with ensuring the health of the nation's SMs and their families.[1] This obligation is vital to ensuring the readiness of the US Military.[1] As discussed in Chapter 3, the MHS' present capacities are inadequate to address the MH needs of military families. These "supply" inadequacies are compounded by high and rising beneficiary demand for MH care (see Chapters 1 and 2). The MHS thus risks failing in its mission. This chapter discusses the consequences of failure for America's military families and for readiness.

The Consequences of Poor Mental Health for Military Families

Sound MH is critical to coping with life challenges, realizing one's potential, and living a productive and fulfilling life.[5] Below are listed some of the adverse events for which individuals with MH challenges are at increased risk:[31, 240-245]

- Suicide
- Self-harm
- Substance and alcohol use disorders
- Incarceration
- Relationship difficulties
- Poor physical health, including hypertension, type 2 diabetes, heart disease, and strokes

Poor MH is also implicated in the development of further MH difficulties insofar as diagnosed MH disorders are more frequently comorbid than individually morbid.[246] This is true at the individual level but also at the family level, where parent MH challenges predict child MH challenges.[11, 104, 122, 139, 145]

In many cases, the effects of poor MH on well-being are difficult to quantify, such as pain and suffering. Accordingly, attempts have been made to estimate the ***financial*** impact of mental illness. MH conditions are major contributors to unemployment and lost earnings.[247, 248] These and related "indirect" costs can be added to the "direct" costs of treating MH disorders. Using this approach, a recent study estimates the cost of PTSD in the United States at $232.2 billion in 2018.[249] Globally, the excess costs of all diagnosed MH disorders in 2010 have been estimated at $8.5 trillion.[250]

For military family members, the direct (treatment) and indirect (reduced earnings) financial costs of poor MH represent tangible harms to well-being. For military children, poor MH may have a lifelong impact and lead to some of the following adverse outcomes:[146, 147]

- Lower incomes
- Worse health
- Worse social functioning
- Greater legal difficulties

Readiness Consequences: Service Member Performance and Retention

Readiness describes "the ability of military forces to fight and meet the demands of assigned missions."[251] The readiness of the US military depends on the performance and health of SMs, including psychological health.[3, 4] To this end, the DoD's Total Force Fitness (TFF) framework establishes

"a methodology for understanding, assessing, and maintaining the fitness of the [Joint Force]." (Figure 6)[3, 252, 253] TFF includes eight integrated and mutually reinforcing domains of fitness:[253-255]

- "Social fitness" describes engaging with healthy social networks that promote well-being and performance
- "Physical fitness" describes being able to complete all aspects of the mission while remaining healthy and injury-free
- "Financial fitness" (added in 2020) describes sound financial management, sustaining mission readiness
- "Ideological and spiritual fitness" (formerly "spiritual fitness") describes adherence to beliefs, principles, or values that sustain mission readiness
- "Medical and dental preventative care fitness" (formerly "medical and dental fitness") describes meeting medical and dental standards for mission readiness and taking appropriate preventative care
- "Environmental fitness" describes performing mission-specific duties in any environment
- "Nutritional fitness" describes recognizing and selecting nutrition to drive physical and cognitive performance and health
- "Psychological fitness" describes coping with mental stressors and challenges

An earlier version of TFF included a "behavioral fitness" domain to account for the relationship between behavior and health, including sleep and drug, alcohol, and tobacco use.[254, 256] This ninth (currently deemphasized) domain is likewise crucial to readiness.[256]

Figure 6. Total Force Fitness[252]

Among SMs, poor MH or "psychological fitness" directly impedes the performance of military duties.[257] Poor MH also indirectly erodes readiness through its impact on other aspects of fitness, including social isolation ("social fitness"), behavioral disorders like substance abuse ("behavioral fitness"), and even poor health and fitness ("medical/dental fitness" and "physical fitness").[3, 253, 258] These effects are compounded by subsequent-order consequences (second, third, etc.). For example, substance abuse may result in disciplinary action, and reduced physical fitness and poor nutrition contribute to increased injuries.[259, 260] In such cases, SMs may be removed from training and from their duties. In extreme cases, they may be separated from Service. From a readiness standpoint, poor retention of

SMs results in one or both of the following suboptimal outcomes:

- Reduction in the military's end strength
- Increased financial cost associated with maintaining the desired end strength

The latter results from the front-loaded costs of military training. For example, the cost of Army basic training ranges from $55,000 – $74,000, to include recruitment costs.[261] To replace an SM separated from service due to injury or a BH problem, the military incurs these costs twice.

Readiness Consequences: Recruitment

MH's impact on readiness is likewise evidenced by the military's ongoing recruiting challenges. In 2022, the Army reduced its recruitment target by 9,000 but still missed this target by 15,000 recruits.[262, 263] The Army's troop deficit is projected to increase to 23,000 in 2023.[262] The other Services are experiencing similar challenges and are responding with efforts to boost retention while lowering recruitment targets, and in some cases by reducing standards.[263, 264] The Services' problem is twofold:[265-267]

- The vast majority (77%) of military-aged Americans are ineligible for military service
- Among military-aged Americans fit to serve, fewer are interested in serving today as compared to years past

The national MH crisis impacts both aspects of the recruiting challenge. Alongside obesity, physical frailty, health concerns, drug use, prior convictions, and poor academic achievement, a MH diagnosis or a documented history of prior MH treatment is grounds for disqualification from military service.[268, 269] The national trend towards deteriorating MH is disproportionately concentrated among the nation's youth (see Chapter 1). The result has been labeled a "perfect storm" for military recruiting.[263]

Recent changes to medical screening during military accessions may be exacerbating this problem. Through programs like Medical Review of Authoritative Data and more recently, MHS GENESIS, MH evaluators at military entrance processing stations can access applicants' medical histories to a greater degree than in years past.[270] These new tools add objective data to information provided by applicants and enable a fuller picture of medical and MH qualifications. The Services continue to manage the gap between DoD accessions criteria and applicant conditions or histories through use of the MH waiver process. However, this entire process – from in-depth review of medical records at the military entrance processing stations through waiver assessment – takes time. Increased wait times have led some potentially qualified recruits to withdraw from the process in frustration.[270]

To some degree, recruit MH concerns are being addressed after accession through resilience training by the Services (discussed further in Chapter 6). Resilience training for SMs and their families is not designed to address recruitment challenges. However, children of SMs and veterans are approximately 22% more likely than other children to join the military; as such, military family resilience training can be viewed as an investment in the military's future end strength.[19]

Regarding declining youth interest in military service, surveys suggest that many young Americans believe that serving in the military will cause them to develop MH conditions like PTSD.[267, 271] It has been proposed that such perceptions may depress recruitment by reducing young Americans' reverence for the military as an institution and even for the country itself.[271-273] Alternatively, these may be separate phenomena.[274] Regardless, it is likely that recruitment will suffer if young Americans believe that military service "breaks" people.

Readiness Consequences of Military Family Mental Health

The US military requires mentally fit SMs supported by mentally fit military families.[4] The national MH crisis thus threatens readiness through its impacts on military families. Family MH challenges, much like financial, legal, or relationship challenges, burden SMs and distract them from the performance of their duties.[2, 3, 253, 275] For example, a family member psychiatric hospitalization may result in SMs missing work and even returning home early from a deployment.[276]

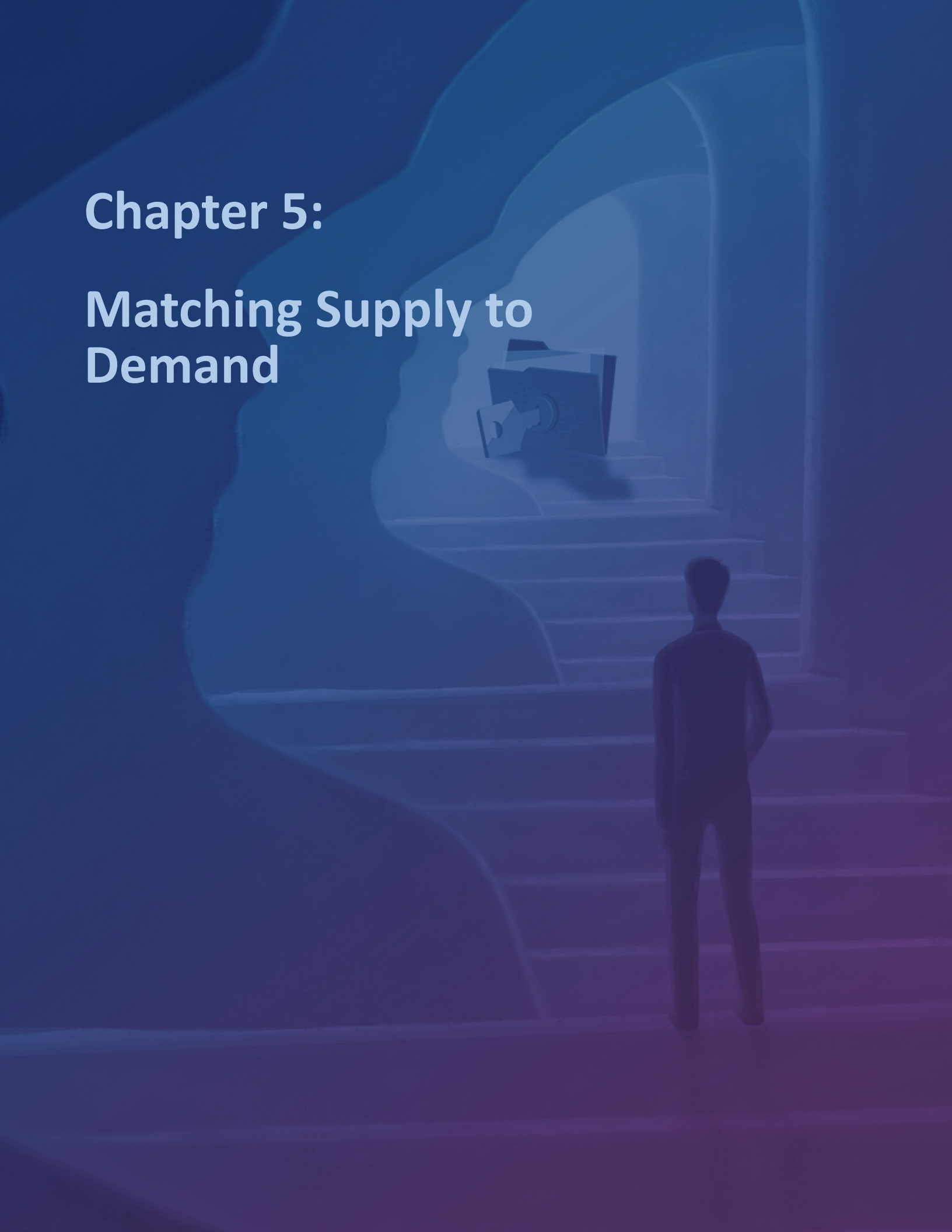
Conversely, strong and stable military families function as a bulwark against the many stresses of military life.[2-4] Effective family functioning is associated with improved performance of duties and, remarkably, with faster recovery from injuries.[2, 3, 275, 277] Marriage is a protective factor for all military family members as well as a boon to SM readiness.[2, 278] Social support reduces the impact of stressors on MH.[2, 178, 279] Indeed, the link between military family well-being ("social fitness") and SM performance is explicitly recognized by the DoD in the TFF framework.[253]

Summary

The national MH crisis threatens the well-being of America's SMs, retirees, and their families. This crisis also threatens the readiness of the US military. Declining MH reduces quality of life for MHS beneficiaries, undermines SM performance and retention, compromises recruitment, and erodes the contribution of military families to SM readiness. These consequences are stark, but they are not unavoidable. In the chapters to follow, this report proposes reforms to help the MHS succeed in its mission by addressing the present (and growing) disconnect between beneficiary demand for MH care and its supply in the MHS.

Chapter 5:

Matching Supply to Demand



The first half of this report (Chapters 1-4) has detailed the current and looming challenge of ensuring access to MH care for MHS beneficiaries, focusing particular attention on the needs of military families. In the second half of this report, Chapters 5-8 propose recommendations to remedy these access challenges:

- In Chapter 5, increasing the supply of MHS MH providers
- In Chapter 6, reducing beneficiary demand for such services by shoring up military family MH resilience
- In Chapter 7, capitalizing on recent developments in Telehealth (TH)
- In Chapter 8, facilitating research in, and beneficiary access to, cutting-edge MH treatments

In addressing supply constraints on beneficiary access to MH care, Chapter 5 first targets recommendations addressing staffing shortages and misalignments in the direct care system. Recommendations are then proposed to improve access in the purchased care system, to enhance the efficiency of MH care through use of "force multipliers," to improve patient appointment booking, and to support continuous quality-of-care improvements.

Addressing Direct Care Staffing Shortages and Misalignments

The DoDIG has documented widespread MH access barriers for MHS beneficiaries.[193] The direct care network is presently short 1,050 AD MTF BH providers, including psychiatrists, psychologists, clinical social workers, licensed counselors, clinicians, and therapists, and there is a national shortage of licensed MH providers.[202, 212] MHS efforts to recruit and retain licensed MH providers are impeded by the following barriers:[193, 212, 227]

- Uncompetitive salaries
- An excessively long hiring process
- Statutory limitations on provider billets

There is also a need to expand recruitment and retention of allied MH providers. This group includes BH technicians, case coordinators, patient educators, and patient navigators. Military spouses are a potential pool of allied MH providers in both direct and purchased care; however,tate licensure and other barriers impede employment opportunities for the latter.[40, 217, 218]

MH provider shortages are further compounded by staffing inefficiencies. This problem is twofold. Providers and patients may be geographically misaligned, and the MHS lacks a centralized BH staffing system to match provider supply to patient demand.[193] Beneficiaries residing in provider shortage areas consequently receive less (and lower quality) MH care.[206, 209-211]

When the MHS is unable to provide care for beneficiaries directly at MTFs, care is referred to local civilian providers ("purchased care"). Because the capacity for care at MTFs is dynamic and can change based on MTF operational requirements and staffing, patients may receive no, some, or all of their care in purchased care settings. SMs largely receive their care at MTFs, whereas other beneficiaries (like family members) typically receive care in purchased care settings.[188] For example, the DHA intends to treat up to 20% of family member beneficiaries in direct care settings.[235] Taken together, direct care

staffing inefficiencies impede access to care for military families and place additional burden on the purchased care network, which may or may not be prepared to accommodate the additional demand.

Sections 737a-c, 738, 741, and 742 of the 2023 NDAA address MHS MH provider shortages (see also Chapter 3).[86] Section 737c additionally addresses provider-patient geographic mismatch challenges by tasking DoD to develop a plan to ensure adequate BH providers in remote locations (Sec. 737c).[86] Regarding staffing model concerns, the DHA intends to separately centralize staffing decisions for the direct and purchased care networks.[221, 235] The DHA is pursuing this two-track approach in lieu of the DoDIG's recommendation for a unified staffing model.[193]

Findings and Recommendations

Finding 1: The MHS does not have sufficient MH providers to manage existing beneficiary demand for MH care, much less projected increases in demand. There is a shortage of MH providers in the civilian sector, as well. In competing with other health systems to recruit and retain MH providers, the MHS is at a competitive disadvantage.

> **Recommendation 1a:** The DHA should increase salary and benefits packages for MH providers to meet or exceed salary and benefit compensation rates for MH providers working in regionally similar federally qualified healthcare agencies.
>
> **Recommendation 1b:** The DHA should expedite MH provider hiring timelines to be competitive with those of other federally qualified healthcare agencies.
>
> **Recommendation 1c:** The DHA should develop a program to alleviate financial burdens associated with obtaining licensure for allied MH providers who commit to providing care for MHS beneficiaries.
>
> **Recommendation 1d:** The DHA should assess and implement additional ways to facilitate recruitment of allied MH providers.
>
> **Recommendation 1e:** The DHA should continue to work with the Defense State Liaison Office (DSLO) to facilitate relevant mental and behavioral health licensure portability for military spouses.

Finding 2: Allocating MH personnel efficiently, in alignment with beneficiary demand for MH care, is critical to meeting beneficiaries' MH needs. This task is complicated by the existence of separate direct and purchased care staffing systems that utilize separate estimates of beneficiary demand. The MHS is a dynamic system in which patient demand shifts between direct and purchased care networks. Such shifts can overwhelm existing staffing capacities.

Recommendation 2: The DHA should create and staff regional market-level offices tasked with monitoring beneficiary demand for MH care from local direct and purchased care providers and with proactively responding to changes in beneficiary demand.

TRICARE Reforms

The purchased care network is a vital component of TRICARE healthcare coverage, particularly for military families and remote-residing beneficiaries. TRICARE provider reimbursement rates are fixed to Medicare rates by law and are generally lower than private-sector reimbursement rates.[188] Low provider reimbursement rates and limited provider awareness of TRICARE procedures reduce enrollment of TRICARE beneficiaries.[231] The DHA's Locality-based Reimbursement Rate Waiver authority authorizes provider reimbursement rate increases up to 115% of the Civilian Health and Medical Program of the United States Maximum Allowable Charge in cases of demonstrated need.[200]

Financial considerations assume additional weight in locations where MTF MH/BH provider cuts shift beneficiaries onto the purchased care network.[280, 281] The combination of increased demand for MH care and provider supply limitations (e.g., ghost networks) renders such care inaccessible for many military families.[193]

Other TRICARE access and quality concerns are recorded in medical journal articles, patient surveys, and news reports related to quality, cost, and access.[40, 195, 196, 199] These same concerns have been brought to the DHB's attention from such sources as the DoDIG, MH providers, and TRICARE family advocates.[193, 197, 198, 280]

In its investigation of TRICARE network access challenges, the DHB found a discrepancy between the concerns raised by these sources and the more positive assessments provided by TRICARE representatives (see Chapter 3).[238] Selection bias may explain this discrepancy if TRICARE assessments are based on the experiences of patients who succeed in accessing MH care and if such patients represent only a subset of a larger care-seeking population, many of whom fail to access MH care.[193] Nonetheless, the full scope of beneficiary access challenges is difficult to account for in this context. A so-called "secret shopper" investigation of provider networks – e.g., a third-party audit of provider lists – may help to provide additional leverage on this question.[239, 282]

As discussed in Chapter 3, the 2023 NDAA addresses purchased care access challenges by directing the GAO to identify gaps in coverage between MH/BH care in TRICARE and MH parity laws, and to describe DoD's current efforts to close these gaps (Sec. 709).[r, 86] The NDAA additionally directs:[86]

- The CG to audit TRICARE BH provider lists (Sec. 705)
- The GAO to conduct a review of TRICARE Managed Care Support Contracts (Sec. 708)
- The SecDef to brief the Congress on the contribution of civilian BH provider information sharing barriers to PCS-related purchased care access challenges (Sec. 703b)

[r] "Mental health parity laws" here refer to "(A) Section 2726 of the Public Health Service Act (42 U.S.C. 300gg–26); (B) Section 712 of the Employee Retirement Income Security Act of 1974 (29 U.S.C.1185a); (C) Section 9812 of the Internal Revenue Code of 1986 (26 U.S.C. 9812); or (D) Any other Federal law that applies the requirements under any of the sections described in subparagraph (A), (B), or (C), or requirements that are substantially similar to those provided under any such section, as determined by the Comptroller General" (Sec 709b).[86]

Excepting these sections, the 2023 NDAA does little to address purchased care access challenges. For example, NDAA provisions target recruitment and training for direct care civilian BH providers, but no comparable investments are made in the purchased care network, the site where 80% of military families access MH care (Secs. 737a-b, 738, and 742).[86, 188] TRICARE managed care support contractors (MCSCs) are contractually required to ensure beneficiary access.[283] Such obligations are not self-executing, however.

Findings and Recommendations

Finding 3: MH access barriers pervade the purchased care network. Alongside rising demand and provider shortages, low provider reimbursement rates and regulatory compliance burdens discourage MH providers from enrolling TRICARE patients. Although TRICARE provider reimbursement rates are limited by law, the DHA is authorized to grant locality-based reimbursement rate waivers in cases where access to health care services is "severely impacted." Additional research is needed to identify factors limiting TRICARE provider participation.

> **Recommendation 3a:** The DHA should utilize its waiver-granting authority to increase TRICARE provider reimbursement rates in targeted purchased care markets experiencing provider shortages. The DHA should regularly inform Congress of the additional costs associated with this recommendation.
>
> **Recommendation 3b:** The DHA should investigate and advocate for legislative remedies to increase TRICARE provider reimbursement rates.
>
> **Recommendation 3c:** The DHA should investigate the factors limiting TRICARE provider participation and work with MCSCs to address the issues.
>
> **Recommendation 3d:** The DHA should ensure a simplified mechanism for providers with questions regarding TRICARE requirements and billing.

Finding 4: The scope of purchased care access challenges is difficult to determine due to conflicting reports.

> **Recommendation 4:** The DHA should contract with independent 3rd party reviewers to conduct regular "secret shopper" assessments of access to evaluation and treatment in the purchased care network.

Finding 5: In addressing MH access challenges for military families, the DHA is constrained by the limits of its authority over the purchased care network, which is the route through which most military families receive MH and other medical care. However, MCSCs are required to adhere to standards for access to care. The DHA's ability to enforce access to care standards is unclear.

> **Recommendation 5a:** The DHA should leverage its authority to enforce and enhance access to MH care standards across direct and purchased care networks.

> **Recommendation 5b:** The DHA should review its authorities to determine whether it possesses underutilized mechanisms to enhance access to MH care.

Finding 6: Ongoing efforts to address MHS MH shortages, including provisions in the 2023 NDAA, do little to address purchased care network-specific MH access challenges.

> **Recommendation 6:** The DHA should encourage MCSCs to develop academic and community partnerships to increase the MH workforce.

Leveraging Force Multipliers

As the MHS surges capacity to meet high and rising patient demand for MH care, there is an urgent need to maximize the capabilities of the existing MH/BH workforce. Two important tools in this regard are expanded use of group therapy sessions and triaging patients in need of non-medical counseling to ancillary MH support caregivers, including Service chaplains, Deployment Resiliency Counselors, and MFLCs.

Group therapy allows a single MH/BH provider to guide and treat up to a dozen patients simultaneously over a 60–90 minute therapy session.[284] Group therapy has been shown to be effective in the treatment of the most commonly presenting clinical MH disorders, including depression and anxiety.[284] Greater utilization of group therapy for such patients conserves provider time, thereby improving access to individual therapy for those patients for whom group therapy is less ideal, such as PTSD patients.[284] However, barriers to increased use of group therapy for MH care exist, including reimbursement rates and provider training and comfort administering group therapy.[284]

Regarding triaging, a substantial portion of beneficiaries seeking clinical MH do not present with diagnosable MH conditions but instead seek counseling services for more typical life stressors such as difficulties with work, relationships, and finances as well as homesickness.[237] Seeking MH care in such cases is appropriate and encouraging insofar as it reflects continued progress against the stigma surrounding MH care. At the same time, non-medical counseling can be effectively provided by non-clinically licensed providers including chaplains, Deployment Resiliency Counselors, and MFLCs, and through other programs and resources available through Military OneSource.[170, 237, 285]

Triaging appropriate cases away from clinical MTF care conserves time and resources for patients requiring specialty MH care, defined as "advanced medically necessary care and treatment… provided by a specialist."[237, 286, 287]

For non-specialty MH care patients, triaging expands access to a larger MH care network.[237, 286] Indeed, results from the Targeted Care Pilot Study, which utilized triaging as well as group therapy, include the impressive gains in patient access listed below:[286]

- 1,263 recovered individual appointments across nine bases over five months
- 8% increase in patients seen in clinic
- 16% increase in direct care encounters
- 57% increase in patient utilization of group treatment
- 80% increase in group treatment encounters

While Targeted Care's contributions to patient access are promising, evidence of improvements in quality of care are still lacking. However, MHS direct care compares favorably to purchased care in terms of quality and cost.[281] By expanding the MH care capacities of the MHS' direct care system, Targeted Care enables greater access to that system by beneficiaries, including for dependent spouses and children.[235]

The DHA is presently working to implement Targeted Care across the MHS' direct care system with a goal of treating 100% of SMs and up to 20% of family beneficiaries seeking MH/BH care at MTFs.[235]

Findings and Recommendations

Finding 7: Group therapy can be a force multiplier when clinically appropriate. Triaging is critical to maximizing existing and future capacity to meet beneficiary demand for MH care. Given that direct care compares favorably to purchased network care in terms of cost and quality, beneficiaries receiving MH/BH in the direct care system stand to benefit from Targeted Care, as does the MHS. The larger population of military family beneficiaries also stands to indirectly benefit from reduced demand pressure on the purchased care network.

Recommendation 7a: The DHA should develop evidence-based metrics for assessing the effectiveness of group therapy.

Recommendation 7b: The DHA should reduce barriers to the clinically appropriate use of group therapy, including financial disincentives in the purchased care network.

Recommendation 7c: The DHA should collaborate with academic institutions, issue collaborative grants, and co-sponsor training workshops to encourage the use of group therapy by licensed MH providers in the purchased care network.

Recommendation 7d: The DHA should continue efforts to implement triaging procedures for MH patients accessing care through the direct care system.

Improving Patient Appointment Booking

Although MTFs are not currently tasked with managing purchased care MH/BH appointments, "ghost networks" are a major barrier to MH/BH care.[217, 218] Beneficiaries seeking MH/BH care in the purchased care system must self-navigate provider networks that, in many cases, contain few available providers.[193, 217, 218] To be successful, non-active-duty beneficiaries must first identify providers, determine if they are accepting new clients, and schedule an appointment. However, barriers at each step in this process may result in failure to access MH. For example, although providers may be listed within the TRICARE network, they may not actually have availability to provide MH care within statutory access-to-care timelines.

Section 705 of the 2023 NDAA tasks the CG to conduct a detailed audit of TRICARE's BH provider lists and to report to Congress on the number of TRICARE providers that fall into the following groups:[86]

- Currently accepting new patients (including previously unlisted providers)
- Listed more than once (duplicate entries)
- Unavailable
- Unreachable
- No longer practicing (Sec. 705a, b)

The CG is further tasked with reporting to Congress:[86]

- The number of beneficiaries in each TRICARE region, listed by beneficiary category
- How the SecDef measures the accuracy of TRICARE provider lists
- How the SecDef assesses the adequacy of TRICARE BH care providers
- How the SecDef recruits and retains BH providers
- Recommendations to improve beneficiary purchased care access (Sec. 705b)

The DHA is additionally working to centralize BH appointment scheduling at MTFs using the IRMAC.[236] Centralizing MTF BH appointment booking relieves patients of the burden of self-navigating through ghost networks and creates opportunities for improved oversight and coordination of care, including patient appointment tracking and a dedicated nurse advice line to triage patients to the appropriate providers.[236] Although these features are currently applicable only to direct care patients, the DHA has indicated its intent to extend IRMAC coverage of BH appointments into the purchased care network.[236]

Findings and Recommendations

Finding 8: Ghost networks frustrate military families seeking MH care in the purchased care networks, which is where most military families access MH care. Better management of provider lists and centralized MH appointment booking and oversight through systems like IRMAC are needed to ensure beneficiary access to care.

Recommendation 8a: The DHA should assess the feasibility of extending IRMAC oversight to BH appointments in the purchased care network.

Recommendation 8b: DHA market offices should ensure a regularly updated list of purchased care providers for their regions is available for patient and MTF use.

Developing and Implementing Quality of Care Improvements

The tasking of this report pertains to beneficiary access to MH care, with a focus on MHS capacities and capabilities. However, some consideration should be paid to quality-of-care concerns insofar as better care may reduce demand on limited provider resources. Improvements may involve incorporating or "scaling up" best practices and procedures identified through policy experimentation on a smaller scale. For example, the DHA's current efforts to implement Targeted Care and Zero Suicide Systems Approach are based on successful AF pilot programs.[235, 237, 288]

Another promising policy reform involves integrating MH/BH into primary care (BHI).[289, 290] As both the primary point for patient health care access and as gatekeepers controlling access to specialty care, primary care physicians (PCPs) are responsible for just over half (51.2%) of all healthcare appointments.[240, 291] PCPs' unique access and perspectives are especially valuable given that MH conditions are often comorbid with other mental and physical health conditions, and given that up to 70% of primary care visits include a BH component.[292] Family physicians have an additional point of leverage in that MH of family members is interrelated (see Chapter 2). Finally, in their role as "gatekeepers" to specialized healthcare, PCPs can facilitate improved "whole person" care (including preventive care) in coordination with MH/BH specialists, and by formally introducing patients to specialty MH care providers via "warm handoffs."[289, 293]

Research suggests that BHI can improve access to and quality of MH care. Improved MH screening, prevention, and coordination reduce the need for later, more costly interventions.[294] These concerns are particularly potent for military children, given that approximately half of MH conditions emerge by age 14.[295] Research examining the impact of warm handoffs (one aspect of coordination) on patient access is mixed, though generally positive.[293, 296, 297] Finally, BHI can help to normalize MH discussions in health care and thereby ameliorate MH stigma.[298] According to a 2018 Milliman Report estimate, the cost savings from BHI to commercial healthcare, Medicare, and Medicaid amount to $38-68 billion annually.[294]

The DHA's Military Health Systems Research (MHSR) program funds grants for research pertaining to the MHS.[299] From the DHB's communication with MHSR program representatives, BH research appears to have been well-represented among MHSR's clinical priority areas funding during recent fiscal years (FY), as demonstrated below:[300]

- One of seven projects in FY19
- Seven of 12 projects in FY22
- One of eight projects in FY23

In addition, Section 703a of the 2023 NDAA mandates warm handoffs from primary care managers to specialty care providers in cases where beneficiaries enrolled in TRICARE Prime are undergoing a PCS move (Sec. 703a).[86]

Findings and Recommendations

Finding 9: DoD MH and suicide prevention pilot programs are an effective way to design, implement, and assess evaluation and treatment initiatives. Military families, who are treated primarily within the purchased care network, should benefit from lessons learned through pilot efforts in the DoD and other federal health care agencies.

Recommendation 9a: The DHA should continue to scale up and establish relevant policy to sustain successful pilot programs and implement evidence-based research efforts.

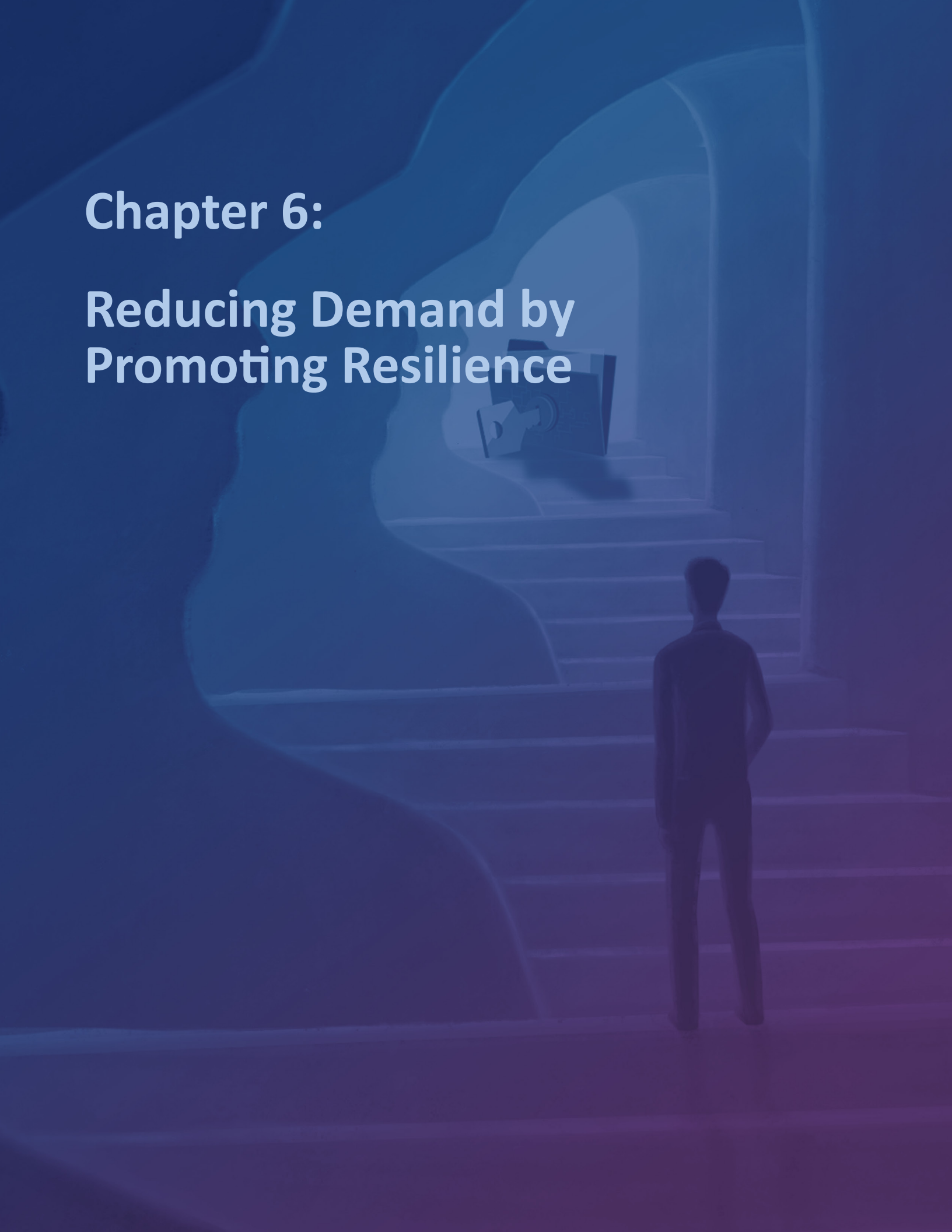
Recommendation 9b: The DHA should prioritize the development of new and effective BHI practices.

Recommendation 9c: Pilot studies and other evidence-based research should include quality and outcome measurements.

Recommendation 9d: The DHA should develop a strategy to disseminate successful treatments identified through pilot studies in the direct care system, the VA, and other federal agencies to purchased care network providers.

Chapter 6:

Reducing Demand by Promoting Resilience



Addressing MHS beneficiary MH access challenges requires action on both sides of the MH "equation:" supply and demand. This chapter considers the demand side of that equation with recommendations to support resilience in military families. As summarized below, resilience has been described in several ways:[151, 301, 302]

- "A set of characteristics, skills, and resources that facilitate coping, recovery, and possibly even growth"
- "Sustained competence or positive adjustment in the face of adversity"
- "The capacity of a dynamic system to adapt successfully to disturbances that threaten system function, viability, or development"

Stated succinctly, and for the purpose of this report, resilience describes the condition of being impervious to MH challenges. To provide a theoretical foundation for the resilience recommendations to follow, this chapter considers the Occupational Mental Health (OMHM) and Stress Continuum (SCM) models.[279, 303]

The Occupational Mental Health Model

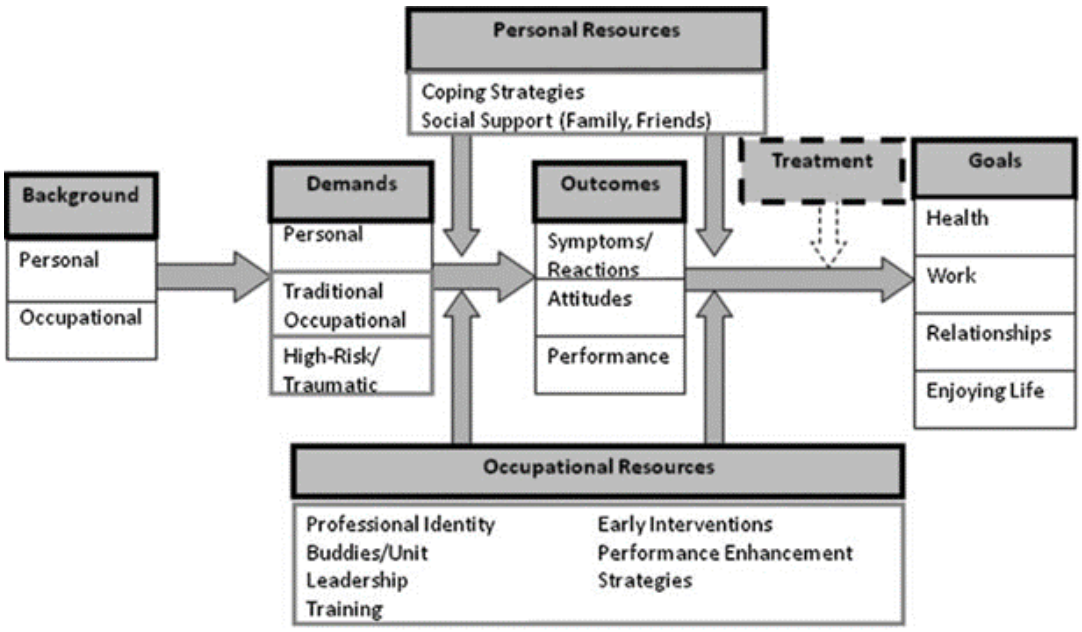
The OMHM was developed to better account for unique features of the military occupational MH context (e.g., combat deployment) and to differentiate that context from civilian occupational MH contexts.[279] Given this origin, the appropriateness of the OMHM is perhaps more evident for some beneficiary groups than for others. It can be expected that active SMs' and retired SMs' MH is impacted by the military occupational context, but what about military spouses and children?

As described in Chapter 2, the lives of military families are profoundly impacted by the unique features of the military occupational environment, including frequent moves, deployments, and the operational tempo of military work.[47, 61, 87] The possibility of injury and death that is an inherent risk of military service is borne directly by SMs but also indirectly as MH stressors by their family members.[13, 87] Military culture – service, hierarchy, and order – pervades and defines the broader military community.[67] Finally, the interrelatedness of the MH of all members of a family means that the military occupational context impacts military families through its impact on SM and family MH.[2] With these considerations in mind, the OMHM is an appropriate framework from which to consider the impact of the military occupational context on the MH of MHS beneficiaries broadly defined, including military spouses and children.

Resilience in the Occupational Mental Health Model

Adler and Castro define the OMHM as "a framework for understanding the relationship between occupationally relevant demands and subsequent MH adjustments, taking into account individual and organizational factors that can mitigate the impact of those demands" (Figure 7).[279] The OMHM holds that resilience is a function of individual and organizational factors – "personal" and "occupational" resources, respectively – that serve to moderate the impact of occupational demands on MH.[279] Personal resources include coping strategies and social supports (e.g., family and friends).[279] Occupational resources include professional identity, buddies/unit, leadership climate, training, early interventions, and performance enhancement strategies.[279]

Figure 7. The Occupational Mental Health Model[279]



The OMHM resource lens provides context to beneficiary MH trends discussed in Chapter 1 as well as a framework for conceptualizing MHS MH demand reduction efforts. For example, disparate MH outcomes among people experiencing comparable MH stressors may be a function of disparate access to personal or occupational resources.[279] Generational trends, such as deteriorating MH, may reflect generational changes in access to and quality of personal resources.[304, 305] Apparent differences in resilience between communities may reflect the impact of culture on access to personal resources.[s, 306]

At the same time, the OMHM demonstrates that resilience is not solely determined by individual factors ("personal resources"). Occupational resources – including MHS resources – play an important role in bolstering or diminishing resilience. Military culture, for example, is a "double-edged sword." It supports resilience in some respects, such as its "mission-first" orientation, acculturation process ("professional identity"), and emphasis on camaraderie ("buddies/unit").[279] However, other key aspects of military culture impede resilience by creating barriers to early treatment. The emphasis on self-reliance and grit in military culture may contribute to the stigmatization of MH insofar as MH challenges are perceived as weaknesses or character flaws.[t, 279, 307-311] Surveys of SMs demonstrate that stigma is commonly attached to MH struggles and that it impedes access to care.[14, 309, 311] A cultural shift is needed to reframe perceptions of MH, such as depicting MH as "healthcare," "fitness," and "readiness," and to ensure leaders communicate to subordinates that seeking MH care will not threaten their careers.[4, 253, 279, 312]

[s] For example, the impact of religious practices and culture on social integration may contribute to suicide rate disparities between predominantly Catholic and Protestant countries.[306]

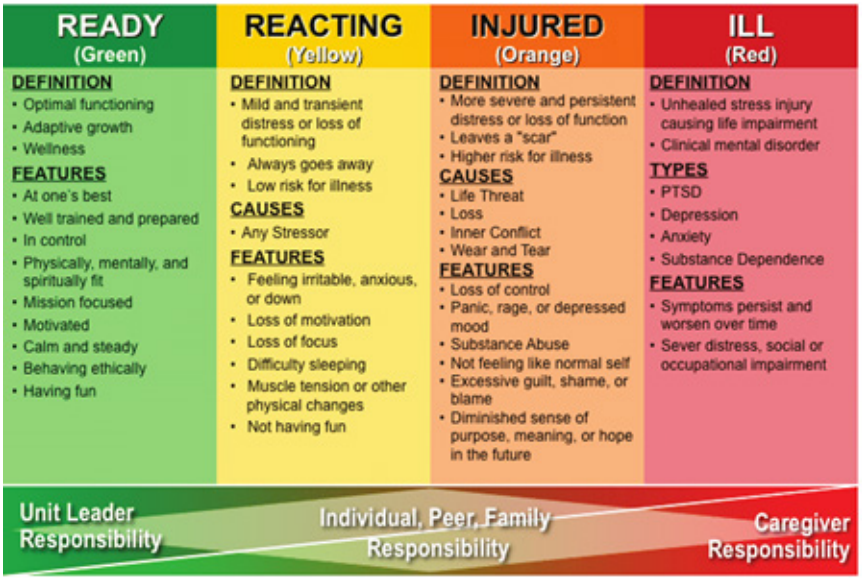
[t] These same values (self-reliance and grit) may also impede access to care independent of their effects on MH stigma. For example, SMs may prefer self-directed MH treatment to traditional provider-led treatment or may feel that they can handle their MH challenges without treatment.[279, 309-311]

The Stress Continuum Model

Whereas the OMHM provides a framework from which to understand the factors that drive resilience, the SCM provides a framework connecting levels of stress (MH demand) to appropriate MH interventions (Figure 8).[u, 303, 313] This model, which has been adopted by the DoD and is used in a variety of resilience-related programs, depicts a continuum of resilience ranging from "ready" (green), to "reacting" (yellow), to "injured" (orange), and finally to "ill" (red). Beneficiary movement along this continuum represents the addition of MH stressors and/or diminished resilience.[303]

In terms of MH interventions, rightward movement indicates that a higher level of MH care is needed. For example, someone experiencing relatively mild stress may fall in the yellow/reacting zone and may demonstrate slightly decreased resilience in the form of occasional irritability, anxiety, and poor concentration.[303] In contrast, someone experiencing relatively extreme stress may fall in the red/ill zone and may demonstrate clinical MH disorders and persistent MH symptoms.[303] Beneficiaries in the yellow/reacting zone may be adequately supported by social and welfare programs (e.g., Family Readiness Group events), while those in the orange/injured zone may require counseling by alternative MH providers, and those in the red/ill zone may require treatment from a clinical provider in an inpatient and/or outpatient setting.[303] Although the MHS currently recognizes the requirement to provide care for those in the red/ill zone, expanding the scope of care to earlier stages of the stress continuum could reduce the number of people progressing all the way to the red/ill zone, thereby reducing the need for more intensive and costly care.[303]

Figure 8. Stress Continuum Model[303]



[u] The SCM, developed by Nash (2011) and named the "Combat Occupational Stress Continuum," has been adapted and renamed to fit other organizations (e.g., "the Responder Stress Continuum").[303, 313]

Applying Mental Health Models to Support Resilience

"Professional Identity" and "Buddies/Unit"

Research has linked group identification and social connectedness to improved resilience, social functioning, and general well-being.[51, 52, 173] Human beings appear to be "wired" for communal living.[163, 165] Militaries leverage this aspect of group psychology to drive performance and to maintain resilience under extreme conditions by emphasizing esprit de corps (i.e., identification) and "battle buddies" (i.e., social connection) (see Chapter 4).[314]

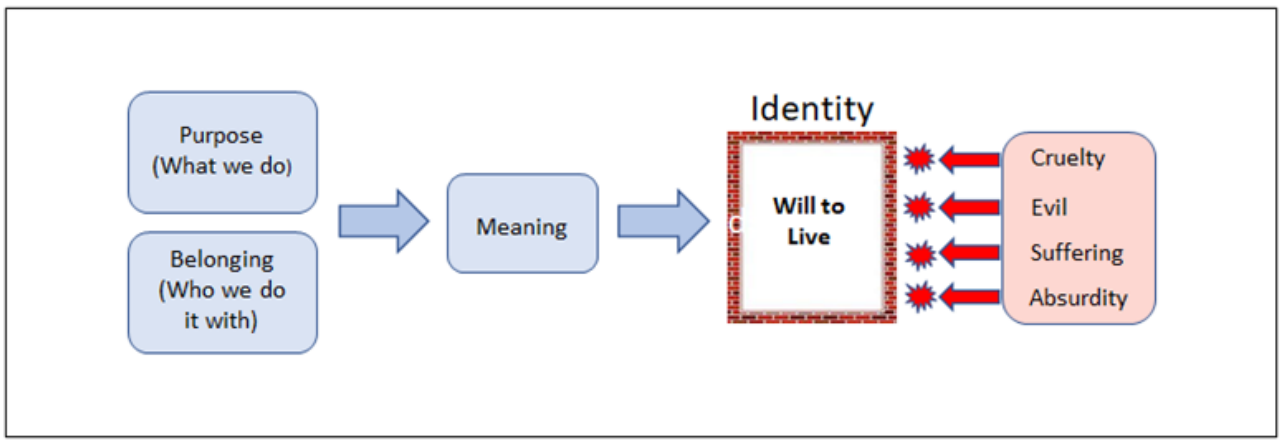
Though they are not combatants, military families are likewise impacted by group psychology and likewise benefit from enhanced identification with and connections to the larger military community (see Chapter 2). Integration in the military community additionally improves access to resilience-enhancing DoD programs and resources, including counseling services and recreation centers.[52] Greater social connection – "social fitness," in the TFF framework – is additionally linked to increased willingness to seek MH care.[253, 315, 316]

A recent surge in SM and veteran suicides generated interest in improving SM MH.[317] The Army's Spiritual Readiness Initiative (ASRI) is one such effort. The ASRI aims to improve soldiers' spiritual fitness through the following initiatives:[318, 319]

- Embedding chaplains trained to assess and promote spiritual readiness
- Coordinating chaplain services with Army BH and other support services
- Working to overcome trust barriers to accessing MH/BH care

One component of ASRI training, the "Pathfinder Program," emphasizes the importance of identity and social connection to MH and well-being.[320] Pathfinder builds on the connection posited by psychiatrist Viktor Frankl between meaning and identity, and the will to live.[319-321] Pathfinder asserts that individuals derive meaning from possessing a sense of purpose and a sense of belonging.[319, 320] This meaning, in turn, creates a positive sense of identity, thereby preserving the will to live in the face of life's inherent difficulties, including cruelty, evil, suffering, and absurdity (Figure 9).[319, 320, 322] Preliminary results are encouraging: Army suicide rates declined slightly from 2021 to 2022.[323]

Figure 9. Army Spiritual Readiness Initiative Pathfinder Program



"Mission 100," a second Army suicide mitigation effort, commenced in February of 2022 at Joint Base Elmendorf-Richardson and Fort Wainwright.[324] The 11th Air Borne Division (11th ABN DIV) surged chaplain support to Alaska in response to an uptick in SM suicides.[325] Chaplains ("Arctic Angels") provided soldiers with BH and spiritual counseling services, maintained contact with soldiers' families, assessed base MH resource gaps, and worked to break stigmas associated with MH counseling and seeking help.[324]

As with ASRI, Mission 100 emphasizes the importance of identity, purpose, and social connection to MH. As described by 11th ABN DIV's Command Chaplain, Mission 100 aims to do the following:[324]

> *… Build strong connections that improve the holistic wellness of the force by strengthening relationships, minds, and spirits to increase hope. Mission 100 reinforces the importance of Soldiers connecting with family members, leaders, and teammates (and leaders connected with Soldier family members). Mission 100 amplifies that we are a Team and are united in purpose. The success of this operation is the foundation upon which all our Team's success is built.*

Early results from Mission 100 were encouraging. During the first nine months of 2022, the Army lost two soldiers to suicide, down from seven in 2021.[326] A 90-day assessment reported to the DHB in October additionally revealed significant reductions in BH issues and other harmful behaviors (Mission 100).[324] However, by November 2022, Army Alaska suicide deaths had climbed to six, demonstrating that additional efforts are still needed to resolve this crisis.[326]

While Mission 100's impact on SM resilience remains unclear, the resilience-enhancing benefits of social connectedness and DoD family support programs are well-established for military families.[2, 52, 67, 176-179] The impact of these social supports on military family resilience is perhaps best demonstrated in their absence. For example, in comparison to AD families, reservist and National Guard families have less access to DoD family support programs like Morale Welfare and Recreation Centers and typically reside off base, apart from other members of the military community.[v, 46, 88, 184, 185, 327, 328] These families experience greater MH challenges than their active-duty counterparts and are more likely to be referred to MH care.[88, 113, 186] Meeting the social support needs of reserve and National Guard families is key to ensuring military family readiness. Family readiness, in turn, is critical to mission readiness, according to the Services (see Chapter 4).[329-332]

Findings and Recommendations

Finding 10: Improved resilience reduces demand for MH services and improves quality of life. The Services recognize the importance of resilience and family readiness to mission readiness. Recent, SM-focused efforts to bolster MH have demonstrated some success in building SM resilience.

Research and experience demonstrate that resilience in military families is enhanced through activities that promote identification with and connection to the military community. Existing DoD family support programs and services make important contributions to military family resilience

[v] Among all Army spouses (AD, Reservist, and National Guard), distance from post is associated with a reduced sense of connection to the Army community and with increased stress, unmet needs, and difficulties navigating family support resources.[184]

independently, by supporting military families' health, education, and other needs, and through their impact on social connection and community engagement. Reservist and National Guard families have less access to these social supports than do AD families.

Recommendations 10a: The DoD and the Services should evaluate the effectiveness of existing family support programs in promoting social connection, well-being, and family readiness and use evidence-based strategies to improve these programs.

Recommendations 10b: The DoD and the Services should pay particular attention to identifying less socially connected members of the military community when providing support programs. The DoD and the Services should consider ways of assessing social connectedness to identify those most in need.

Recommendations 10c: Where appropriate and feasible, The DoD and the Services should provide "opt-out" programs that foster social connections between military families with special attention to Reserve and National Guard families.

"Leadership Climate" and "Early Interventions"

Leadership climate impacts subordinate MH and well-being in both military and civilian occupational contexts.[333, 334] Leaders set the tone for how MH issues are perceived within organizations, such as whether MH is stigmatized or viewed as a vital component of health and readiness.[3, 4, 335, 336] This tone is critical because early access to MH care is associated with better MH outcomes.[4, 337] Surveys reveal that SMs often delay or fail to seek MH care due to stigma-related concerns, including embarrassment, fears of negative career repercussions, and loss of confidence from fellow SMs.[14,334, 335, 338]

Perceptions of leadership are integrally related to MH stigma. Among junior enlisted SMs, higher overall appraisals of leaders (commissioned/non-commissioned officers) are associated with reduced perceptions of both stigma and practical barriers to accessing MH care.[334] Higher MH-specific appraisals of leaders, including perceptions of leaders' management of combat operational stress, are associated with better MH and greater comfort seeking MH care.[336]

While leadership climate research understandably emphasizes SMs over family dependents, this tasking primarily addresses the latter. As with the OMHM and SCM, it is likely that findings from such research carry over to military families, given the impact of the military occupational environment on military family life. Military family members are at risk for both MH concerns and stigma.[4, 12, 106] In exercising MH leadership, officers and non-commissioned officers have an opportunity to extend their campaign against MH stigma to military family members and to encourage family members to seek needed care and preventive treatment.

Congress and the DoD are addressing MH stigma in the Services through policy changes included in the 2023 NDAA and in Directive-type Memorandum 23-005. In NDAA Section 704a, DoD Instruction 6490.08 is updated with additional direction aimed at combatting stigma and encouraging SMs to seek

MH care.[86] For example, providers are required to protect patient confidentiality except in "exigent circumstances," as determined by the SecDef (Sec. 704a).[86] In such cases, patient confidentiality may be limited only as necessary to address the exigent circumstances at issue (Sec. 704a).[w, 86] Section 704b adds confidentiality and anti-retaliation protections for SMs requesting or receiving MH services, among other provisions.[86] SM access to MH evaluation is further supported by Directive-type Memorandum 23-005, wherein the DoD establishes a SM self-referral to MH evaluation process.[339]

NDAA Section 749 further tasks the SecDef to brief the Congress on the feasibility of implementing stigma reduction and suicide prevention efforts, including:[86]

- Eliminating MH history restrictions from the accessions process, including from military occupational specialty restrictions
- Implementing comprehensive, in-person annual SM MH assessments
- Providing new evidence-based suicide training for TRICARE BH providers
- Requiring new MH and suicide awareness training for Service leaders (Sec. 749)

In terms of military families, existing leadership climate and early intervention efforts include those related to normalizing MH and to BHI (see Chapter 5). Command Climate Surveys provide an opportunity for SMs to relay unit-level leadership concerns to commanders.[340] No such mechanism appears to exist for military families.

Findings and Recommendations

Finding 11: Stigma is a potent barrier to accessing MH care. Military leadership, including mid-level enlisted leaders, has an important responsibility in destigmatizing MH to promote early access and treatment. This responsibility extends to military families, especially given their importance to readiness.

> **Recommendations 11a:** The DoD and the Services should tailor de-stigmatization efforts towards military families.
>
> **Recommendations 11b:** The DoD and the Services should tailor de-stigmatization efforts through leadership training for mid-level unit leaders.
>
> **Recommendations 11c:** The DoD and the Services should periodically assess military family climate by institutionalizing surveys of military spouses to ensure that military families have a mechanism to inform military family policy.

"Training" and "Performance Enhancement Strategies"

Research suggests that MH training can improve resilience.[341, 342] The Army developed Battlemind in 2007 to address stress management following combat deployments.[341] Battlemind debriefing and training programs framed post-deployment transition difficulties in a positive light as part of reorienting

[w] NDAA Section 704a extends SMs confidentiality protections to veterans.[86]

soldiers towards the expectations of state-side, civilian, and family life.[341, 342] Post-training evaluations for Battlemind were generally positive and soldiers who received Battlemind debriefing/training compared favorably to soldiers receiving alternative stress-management training in terms of PTSD, depression, sleep disorder symptoms, and MH stigma.[341, 342]

Building on the success of Battlemind and on the theory of positive psychology, the Army developed the Comprehensive Soldier and Family Fitness (CSF-2) - Performance and Resilience Enhancement Program in 2009.[343, 344] In its current incarnation, CSF-2 aims to improve the resilience of Soldiers, family members, and Army civilians.[x, 345-347] The program consists of the following four components, the last three of which are available to Army families:[345-346]

- Unit-level institutional resilience training
- An online self-assessment tool (Global Assessment Tool) used to identify areas of strength and weakness
- Individualized training programs corresponding to different aspects of resilience (emotional, social, family, and spiritual)
- Master Resilience Trainers embedded in Army units and Army community and Family Readiness Groups

Resilience training programs like CSF-2 may be conceptualized as both training and performance enhancement.[346] They may also be described as preventive MH care insofar as training aims to disrupt the translation of MH stressors into MH stress.[279] However, such characterizations depend on the demonstrated efficacy of resilience programs. Researchers have raised concerns that evidence for the effectiveness of resilience training programs is underwhelming, but conversely, recent research links CSF-2 training to reduced stigma in student veterans.[343, 348-351]

Sleep education and training is another strategy for enhancing psychological fitness and overall well-being and performance. Sleep disorders, including insomnia, short sleep duration, and nightmares, are common reactions to stress.[352] Sleep disorders often occur as comorbidities with other problems, including the following:[68, 84, 352-363]

- MH conditions including depression, anxiety, and PTSD
- Physical health conditions including cancer, cardiovascular disease, obesity, and pain
- Work-family life conflicts
- Reduced motor and cognitive functioning
- Compromised moral reasoning
- Increased accidents, injuries, and mortality

An important aspect of proper sleep hygiene is avoiding unnecessary circadian rhythm disruptions. Circadian rhythms are internally generated rhythms that evolved to cope with light and dark cycles within the environment.[364] Many biologic processes, including sleep-wake cycles, are organized within a 24-hour period to optimize internal and external resources.[365] Morning sunlight exposure helps entrain (synchronize) the internal rhythms to the external light and dark cycles.[364] Misalignment (desynchrony) of the circadian rhythms with the environment – for example, due to evening light

[x] Resilience promoting programs exist in the other Services; however, the Army's resilience training programs stand apart in terms of both scope and cost: over $125 million, not counting sustainment costs.[347]

exposure and life-style factors such as shift work, eating late, or watching television – leads to adverse effects including poor sleep, fatigue, low mood, and health and performance deficits.[364, 366-368]

Circadian rhythm disruptions are implicated in MH disorders including depression, anxiety, and bipolar disorders.[364, 369-371] The onset of major depressive disorder, anxiety, and bipolar affective disorder in adolescence has been linked to this age groups' increased vulnerability to circadian rhythm disruption.[372] Individuals with evening chronotypes (delayed sleep phase) are more likely to experience depression than individuals with morning chronotypes.[366, 373, 374] Sleep onset difficulties and delayed sleep phase often precede the onset of depressive episodes.[375] Individuals with low amplitude (i.e., less distance between "peaks" and "troughs") and flexible circadian rhythms show greater resilience to stress in comparison to individuals with high amplitude and rigid circadian rhythms.[376]

Sleep disorders and disruptions undermine resilience as well as family and mission readiness.[355, 361, 377, 378] For SMs, sleep disorders are commonly caused by operational demands such as operations tempo, noise exposure, the need for vigilance, and combat.[355, 378-381] Compromised performance in such scenarios can result in injury, death, and mission failure.[361] For all members of the military family as well as others, sleep disorders can be both a cause and/or a consequence of poor MH.[14, 352, 364, 382] Sleep disorders can also complicate the treatment of MH disorders.[355, 383, 384] In terms of treatment interventions, pharmacological and non-pharmacological (behavioral/cognitive-behavioral) treatments show comparable effect sizes for treating insomnia.[355, 385, 386] However, the effects of non-pharmacological treatments appear to last longer.[387] The use of pharmacological treatments also raises safety concerns in military settings, and the efficacy of these treatments in military-specific settings is underexamined.[388] By contrast, the efficacy of Cognitive Behavioral Therapy for Insomnia and Imagery Rehearsal Therapy for insomnia is established in SM populations.[389-393] Circadian rhythm dysregulation treatments for mood disorders include light therapy, chronotherapy (e.g., altering sleep patterns) and behavioral therapies.[364, 394, 395]

Current Service resilience training programs include those listed below:

- The Army's CSF-2 programs
- The Marine Corp's Operational Stress Control and Readiness and Unit, Personal, and Family Readiness programs
- The Navy's Warrior Toughness and Expanded Operational Stress Control programs

Under Operation Arc Care, the AF is currently developing a new resilience strategy.[396] Except for the Army's CSF-2 and the Marine Corp's Unit, Personal, and Family Readiness Program, current Service resilience training programs are generally limited to SMs. Of these two, only CSF-2 can claim to offer a comprehensive resilience training program for military families.

Existing DoD sleep-related programs and policies include SM screening tools like the Post-deployment Health Assessment and Re-assessment programs and the Army Performance Triad, which emphasizes sleep, physical activity, and nutrition, and includes tools for monitoring sleep duration, quality, and psychosocial vigilance.[397, 398] A RAND survey of DoD sleep policies found that sleep education is most frequently embedded within resilience and stress management training rather than trained separately

as "sleep training," per se.[355] Research also suggests that the use of effective non-pharmacological sleep disorder therapies is limited in military settings by a shortage of providers training in sleep medicine and by a lack of awareness of the efficacy of sleep therapies in military and civilian settings.[399]

Findings and Recommendations

Finding 12: The DoD has invested heavily in resilience training programs and, in the case of the Army, such training incorporates military families. Military family resilience training is urgently needed; however, evidence demonstrating the effectiveness of current programs is lacking.

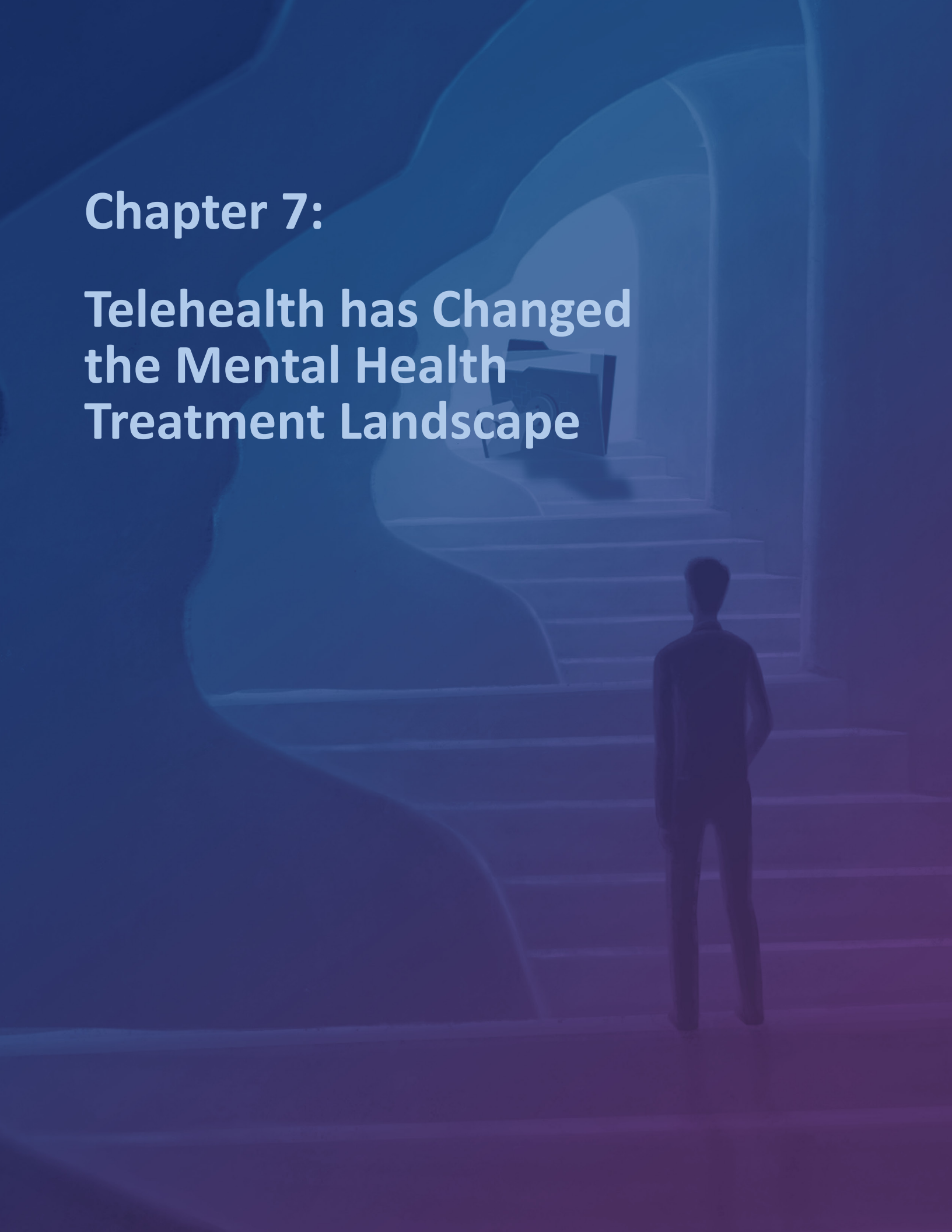
> **Recommendation 12a:** The DoD and the Services should identify areas where resilience programs positively contribute to military family resilience and develop Service-tailored military family resilience programs.
>
> **Recommendation 12b:** The DoD and the Services should facilitate information exchange among Service resilience training leaders.
>
> **Recommendation 12c:** The DoD and the Services should ensure that that the Behavioral Health Clinical Community is made aware of DoD resilience training program resources.

Finding 13: Sleep disorders often present as comorbidities in patients with MH disorders and can impact MH treatment outcomes. Adequate sleep is critical to resilience, and sleep impacts every dimension of TFF and readiness. Training and treatment for providers, SMs, and families must emphasize and address the significance of sleep to MH and well-being. Insomnia and sleep apnea demand special emphasis.

> **Recommendation 13a:** The DHA should ensure training of MH and primary care providers on the impact of sleep and sleep disorders on MH outcomes.
>
> **Recommendation 13b:** The DHA should ensure that provider training for evidence-based treatment options for sleep disorders is widely available in the MHS.
>
> **Recommendation 13c:** The DHA and the Services should develop and implement sleep education and training for beneficiaries, including military families, that emphasizes prioritization of sleep, optimization of circadian alignment, and recognition of symptoms of insufficient sleep and sleep disorders.

Chapter 7:

Telehealth has Changed the Mental Health Treatment Landscape



This report has thus far addressed the challenges faced by MHS beneficiaries in obtaining access to MH care through the lens of "supply and demand." In this chapter, and in the chapter that follows, we move beyond this framing to address recent changes to the MH landscape that have implications for beneficiary access to MH care. The development and widespread adoption of TH has brought beneficial changes to the MH care landscape. This chapter discusses these developments and proposes recommendations for leveraging TH to improve access and quality of MH care for military families.

Telehealth and Tele-mental Health[y]

TH describes the use of telecommunications technologies such as computers, smartphones, or tablets to access health care.[401] TH encompasses care delivered "synchronously" and "asynchronously," as well as "remote patient monitoring" and recent "technology-enabled modalities."[402, 403] During synchronous TH visits, patients interact with providers over telephones, through a computer, or through mobile devices such as a smartphones or tablets.[402, 403] Asynchronous TH care describes "store and forward" communications, such as a patient portal to facilitate appointments, follow-ups, and prescription refills.[402, 403] These communication methods are well-established in healthcare (e.g., telephone and email communication); however, newer technologies, such as those enabling video communication, increase the range of what TH can offer. Remote patient monitoring relies on wireless devices, wearable sensors, implanted health monitors, smartphones, and mobile applications (apps) to transmit patient data to healthcare providers, sometimes with the assistance of artificial intelligence and machine learning programs.[403] Finally, technology-enabled modalities include such services as "physician-to-physician consultation, patient education, data transmission, data interpretation, digital diagnostics… and digital therapeutics."[403]

The potential benefits of TH are numerous and include improved convenience and privacy and reduced transportation costs (Table 3).[404] From the standpoint of the MHS, TH capabilities are especially valuable to MH care.[402, 404] TMH is well-suited to patient-to-provider video conferencing technologies and has been shown to be effective in treating depression and anxiety and in increasing session attendance.[403-407] By connecting patients and remote providers to MH/BH specialists, TMH helps to mitigate distance-related barriers to beneficiary access, including patient-provider geographic mismatch and continuity of care disruptions caused by PCS moves.[402] The enhanced privacy afforded by remote consultations additionally helps to mitigate stigma-related access barriers.[402, 408-410]

Telehealth During the Pandemic

With the onset of the COVID-19 pandemic, health policymakers adjusted TH regulations to expand TH usage and thereby shield patients and providers from unnecessary exposure to the virus.[411] Key reforms included the following:[411-413]

- Expanding TH coverage
- Matching reimbursement rates for TH and in-person care
- Encouraging the provision of TH across state lines
- Waiving HIPAA barriers to sharing patient information online
- Waiving out-of-pocket co-pays for TH patients

[y] TH in the MHS is addressed in greater detail in *Optimizing Virtual Health in the Military Health System*[400]

Table 3. Telehealth Benefits[404]

Benefits	Examples
Improvements for patients	• Confidential delivery of BH services • Improved access, including access to specialists • Better outcomes and shorter lengths of stay • Reduced wait times • In-home monitoring
Better population health	• Mobile health apps aid management of addiction, chronic pain, and BH • Promotion of better health management for tech-savvy patients • More effective monitoring of chronic conditions • Enhanced care coordination for remote populations • Mobile health apps assist with maternal and child health, including vaccination reminders • More effective tracking of health trends in populations • Enhanced ability to conduct health systems research
Reduced per-capita costs	• Less reliance on in-person visits to costly brick-and-mortar facilities • More efficient use of provider time • Greater use of physician extenders • Potential reduction of preventable emergency room visits, hospitalizations, and hospital readmissions • Expanded access to a small number of specialists by a larger number of providers • Reduction of unproductive clinic downtime due to no-shows • Prevention of disease progression and complications through earlier diagnosis and treatment
Enhanced Readiness	• Reduced stigma from easy and confidential access to BH • Improved ability to support providers caring for rural populations and military personnel in remote locations, aboard ships, and in theater • Better decision-making at the point of contact, earlier initiation of needed treatment, and reduced medically unnecessary medevacs due to ready access to specialist consultation

The DHA followed suit by issuing the following temporary regulatory revisions:[414]

- Allowing audio remote health consultations for beneficiaries lacking capacity for video consultations
- Encouraging the provision of TH across state lines
- Temporarily waiving patient cost-sharing for TH services

Partly due to these efforts, nationwide TH usage increased dramatically in 2020, rising to 20% of all medical visits.[415] These same trends were evident in TMH. In a sample of 500 psychiatrists surveyed by the American Psychological Association (APA), 64% reported zero use of TH prior to the onset of the pandemic; however, two months into the pandemic, 85% of respondents reported using TH for more than 75% of their patient consultations.[416]

Responses from patients and providers to TH expansion have been largely positive. For example, 90% of psychiatrists surveyed by the APA reported positive patient assessments and significant reductions in appointment cancellations.[416] Similar findings are echoed by other surveys. A survey conducted in the wake of a 2014 TH rollout at Landstuhl Regional Medical Center of the Regional Health Command Europe found overwhelming support for TH among patients (98%) and providers (91-93%).[417] A 2015 survey by the American Hospital Association likewise found high public enthusiasm for TH (70-76%).[418] As evidenced by a 2017 study, positive patient assessments of TH services reflect perceptions that TH is convenient, private, comfortable, and efficient.[419]

Conversely, results of research addressing TH's cost impact have been equivocal. TH likely increases health spending overall because the greater efficiency and convenience it affords contributes to increased patient demand and service utilization.[411] In short, TH produces cost savings when it substitutes for in-person care, but cost increases when it adds to existing care.[420, 421] It is noteworthy, however, that research on the financial impact of TH largely ignores cost-savings associated with reduced travel expenditures and forgone work.[420, 421] This oversight may be attributable to the fact that these benefits primarily accrue to patients rather than to the medical system.[z, 422] However, as viewed from the perspective of the MHS, such cost savings are non-negligible.[404]

Mobile Mental Health Applications

Mobile MH apps, a subset of TH, are programs installed on smartphones and wearable devices that enable users to monitor and affect their own mental states.[423, 424] These tools are used individually for self-care, in combination with support groups, or under the supervision of MH providers or (potentially) artificial intelligence programs.[424] MH apps are designed to help users manage mood and anxiety disorders, combat and find help for suicidality, and pursue overall mental well-being.[406, 425, 426] Given the ubiquity of smartphones, MH apps have significant potential to increase access to MH care, particularly for evidence-backed skill building treatments like cognitive behavioral therapy.[427]

Early research on MH apps provides cause for both optimism and caution. MH apps excel in terms of cost and availability. Essentially any smartphone user can download a MH app at little or no cost.[423] Research examining the efficacy of MH apps is likewise generally positive, although many available MH apps have not undergone rigorous, evidence-based evaluations.[423, 428, 429] Health experts have additionally raised concerns regarding low utilization rates, privacy and security issues, and the tendency for MH apps to focus exclusively on a single disorder.[430-434]

[z] Using a return-on-investment analysis, Snoswell et al. finds cost savings associated with TH uptake in a health system that reimburses patients for travel expenses.[422]

Nationally, many barriers to TH utilization were overcome by the exigencies of providing care during the pandemic. Limited broadband internet access remains a significant barrier for residents of some rural and urban communities, including MHS beneficiaries.[435] Within the global MHS, national solutions are largely ineffective for outside the contintental US (OCONUS) located military families due to licensure and other barriers that prevent continental US (CONUS) located DoD providers from providing TH services (including TMH) to OCONUS located patients. These families are effectively excluded from receiving care.[436] This is a serious problem in cases where locally available MH care is inadequate.[436-438] Unresolved challenges notwithstanding, TH's efficacy is well established and for the MHS, the post-pandemic environment is likely to include continued widespread TH usage.[403, 411]

TH's position in private-sector medicine appears less secure. There is cause to suspect that fee-for-service incentive structures may encourage insurers to revert to lower, pre-pandemic TH provider reimbursement rates in some cases.[411] It is also possible that policymakers will allow TH licensure waivers to expire.[439] If civilian providers respond to such changes by shifting away from TH, this change could impact beneficiary MH (TMH) access across the purchased care network.

Anticipating similar concerns, the Commonwealth Fund proposes several recommendations for managing the post-pandemic transition in private sector care. The authors recommend continuing "all forms of telemedicine" for high-risk populations and for those facing access barriers (such as rural residents), excepting audio-only (telephone) visits reasoning that these primarily add to, rather than substitute for, in-person visits.[411] The Commonwealth Fund further recommends reducing TH reimbursement rates relative to in-person reimbursement rates, reasoning that TH's long-term cost savings are sufficient financial motivation for providers to offer TH services and that parity requirements may raise costs to consumers and discourage provider competition.[411]

Given the MHS' comparatively limited exposure to private sector incentives to limit TH uptake and given the pressing MH access challenges faced by its beneficiary population, there is cause to believe that the MHS could lean into TH to a greater degree than might be possible in civilian medicine. Overutilization concerns appear to be less pressing than access and stigma concerns.[193, 408] TH can be an effective solution for geographically mobile military families who experience unique continuity of care issues, and remote and elderly beneficiaries could benefit from maintaining reimbursement parity for audio-only TMH services.[402-404, 440]

Regarding Mobile MH apps, DHA currently offers the following:[441]

- "Breathe to Relax" and "Tactical Breather," which focus on stress relieving breathing techniques
- "Virtual Hope Box," which provides a variety of tools centered on coping, relaxation, inspiration, positive thinking, mindfulness, and event planning

Additional DHA apps include the following:[442]

- "Provider Resilience," a psychoeducation and resilience self-assessment tool for healthcare providers
- "Positive Activity Jackpot," which promotes resilience through pleasant event scheduling

DHA has additionally developed an App Rating Inventory Checklist to evaluate MH and other medical apps on measures of quality/efficacy, user-friendliness, and customizability.[443] Similar rating systems have been developed by the APA, the National Institute of Mental Health, and others to help direct consumers towards evidence-supported and effective MH apps.[423, 444]

Findings and Recommendations

Finding 14: The efficacy of TH is well-established, although critical TH access barriers remain for OCONUS located beneficiaries. There is a risk of regression towards pre-pandemic TH usage in private-sector medicine. This change could impact healthcare access and continuity of care for TRICARE beneficiaries, particularly families undergoing a PCS. Potential changes in coverage for audio-only visits may exacerbate access issues for beneficiaries who lack video capability. Mobile MH app developments appear promising and merit further evaluation.

Recommendation 14a: The DHA should maintain and consider expanding COVID-19 pandemic levels of access to TMH in MTFs and in TRICARE by continuing reimbursement for TMH services.

Recommendation 14b: The DHA should eliminate TH barriers, within its authority, to enable CONUS located providers to treat OCONUS located beneficiaries.

Recommendation 14c: The DHA should advocate for reimbursement for audio-only TH care rendered to patients who lack video capability.

Recommendation 14d: The DHA should advocate for parity in TRICARE reimbursement rates for TMH and in-person services. TRICARE reimbursement rates for these services should be comparable to reimbursement rates of other leading health care plans.

Recommendation 14e: The DHA should continue to work with the DSLO to promote interstate licensing flexibility for TRICARE providers through existing interstate licensing compacts.

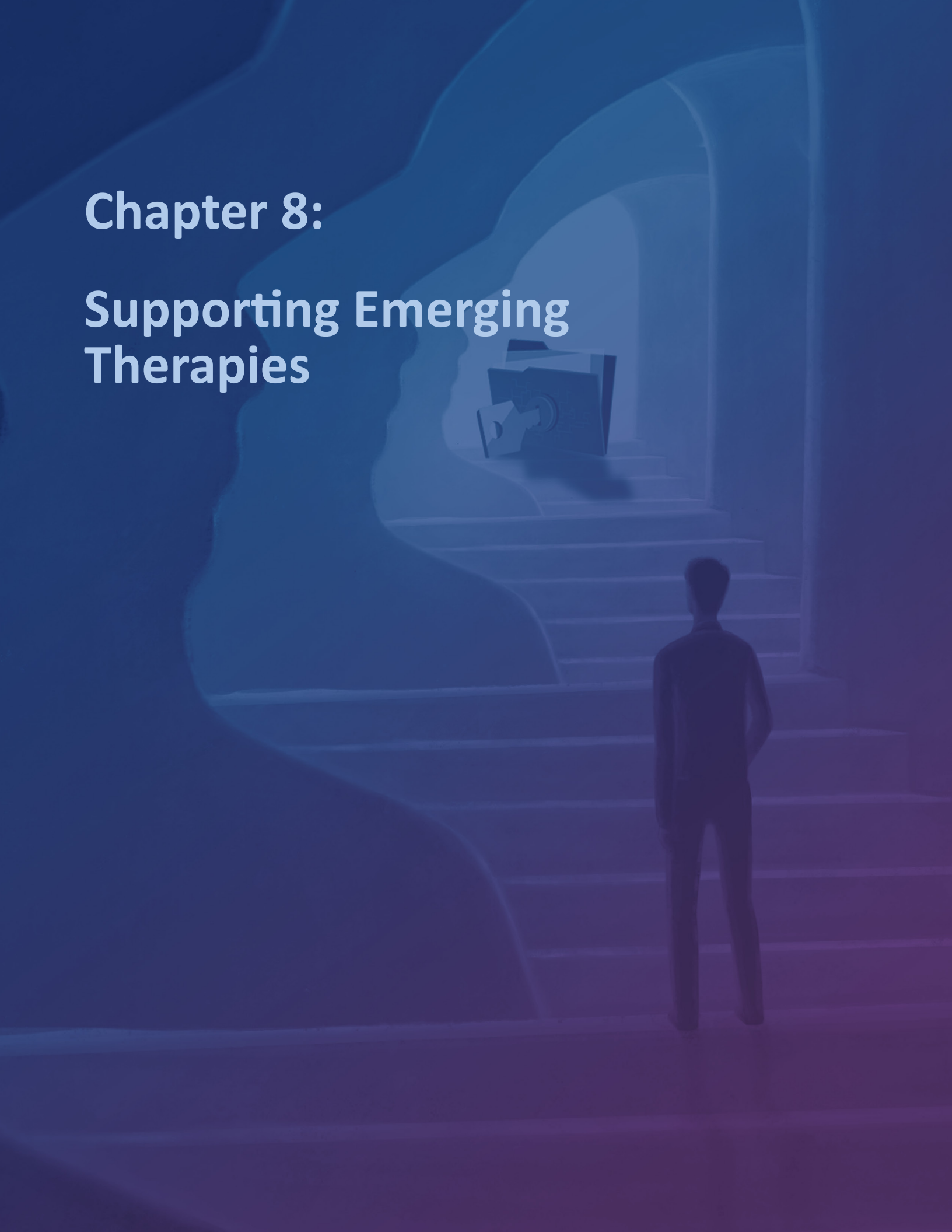
Recommendation 14f: The DHA should ensure that TMH services are available to patients in purchased care networks whenever in-person MH services are unavailable.

Recommendation 14g: The DHA should promote access to TMH for military families.

Recommendation 14h: The DHA should continue to evaluate mobile MH apps for further study, including but not limited to issues of efficacy, privacy, and security.

Chapter 8:

Supporting Emerging Therapies



Standardization of evidence-based practices for prevention, identification, equitable access, and delivery of MH/BH care best meets the needs of DoD beneficiaries. However, excessively rigid adherence to standardization may deny beneficiaries, clinicians, and researchers access to emerging and promising therapies. A wealth of literature addresses the use of complementary and alternative treatments to treat MH conditions.[445, 446] Recent innovative treatments, such as written exposure therapy and collaborative care, show promise for the treatment of PTSD and depression.[447-450] The DoD should ensure a mechanism to allow innovation within its clinical, academic, and health research arms, as well as access to innovations in the wider US medical community.

Two such emerging therapies for MH conditions – psychedelic medications and electronic neurostimulation – provide examples that illustrate barriers for the MHS and its beneficiaries to participation in research and access to emerging therapies. Overcoming these barriers requires a commitment to innovation, recognition of the inadequacies of current treatments, acceptance of a measure of failure, and a willingness to work within the regulatory and legal framework of medical and interagency research.

Schedule 1 Controlled Substances as Behavioral Health Therapeutics

Multiple compounds with neurologic and psychologic effects carry the government label of Schedule 1 substances, defined as those with no legitimate medical use. Research has challenged this definition. Two classes of Schedule 1 substances under investigation for potential beneficial effects in a variety of mostly neurologic and BH conditions are so-called psychedelic medications and cannabinoids. Psychedelic medicines, a lay term that transferred to the scientific literature, include compounds that cause specific psychological or neurologic changes in the perception of vision, hearing, or consciousness.[451, 452] Psychedelic users report visual and auditory hallucinations, changed and heightened emotions, spiritual and "mystical" experiences, perceptions of a broadened understanding ("elevated consciousness"), euphoria, illusions, and synesthesia.[453-465] Prominent psychedelics include lysergic acid diethylamide (LSD or "acid"), psilocybin ("Magic Mushrooms"), ayahuasca, and 3,4-methylenedioxymethamphetamine (MDMA).[466] The Controlled Substances Act, passed in 1970, classifies these and other psychedelic compounds as Schedule 1 narcotics, thereby prohibiting their possession and recreational use.[aa, 466-468]

Schedule 1 classification impeded research on the medicinal applications of psychedelics.[466] However, some research continued and recently bore fruit in the form of promising findings for the treatment of PTSD (e.g., MDMA) and depression (e.g., psilocybin).[466] In response, the Food and Drug Administration (FDA) awarded the designation of "breakthrough therapy" to MDMA in 2017 and to psilocybin in 2018.[469, 470] As of 2023, Phase 3 clinical MDMA trials are underway, and psychedelic medicine appears to be gaining "mainstream" acceptability in the medical community.[467, 471]

PTSD is a condition of particular concern to MHS beneficiaries, particularly SMs. Research suggests that several PTSD clinical symptoms, such as hyperarousal and dissociation, can be effectively treated

[aa] Schedule 1 substances are determined by the US Drug Enforcement Administration to possess no currently accepted medical use, a lack of accepted safety for use, and a high potential for abuse.[468] MDMA was classified as a Schedule 1 substance in 1985.[467]

using psychedelic compounds, alone or in combination with other therapies.[466] These findings are noteworthy, given the limitations of existing non-pharmacologic and pharmacologic PTSD therapies.

For example, consider front-line "exposure-based" therapies, including "prolonged exposure," "cognitive processing," and eye movement desensitization and reprocessing therapies. Exposure therapies attempt to reorient patient perceptions of traumatic events by directing attention to the details of and/or to beliefs and assumptions associated with those events. Prolonged exposure therapy, for example, involves actively recalling ("imaginal visualization") "traumatic events and exposure to trauma-related cues that trigger fear responses" to "extinguish conditioned fear to cues associated with trauma."[472]

The challenge for exposure therapies is that recalling traumatic events is emotionally taxing and, in some cases, retraumatizing for patients.[473, 474] Forty to sixty percent of patients respond poorly to exposure therapy, and patient withdrawal rates are high (27-40%).[473-477] Despite these limitations, exposure therapies are generally more effective than available pharmacotherapies (sertraline and paroxetine) in treating PTSD.[478] This is a low bar, given the dearth of evidence supporting the efficacy of antidepressants, anticonvulsants, antipsychotics, sedative hypnotics, and opioids for treating PTSD.[ab, 479, 480]

The limitations of current PTSD therapies have led to calls for continued research into novel treatments. Drawing on neural imaging of PTSD patients, recent research suggests that psychedelic agents can improve patient responses to exposure therapy by mediating activity in the brain's amygdala, insula, and prefrontal cortex.[481]

Therapeutic Applications for Emerging Neurotechnologies

Electronic neural stimulation is an accepted FDA-approved therapy for depression and some forms of epilepsy. These therapies involve invasive surgeries or cumbersome devices, such as vagal nerve stimulators, deep brain stimulators, and transcranial magnetic stimulators. The next generation of neurostimulators to treat neurologic and BH conditions promises to be smaller, less invasive, and targeted to a wider array of conditions, many of which are relevant to the DoD and its beneficiaries. On April 2, 2013, the White House announced the Brain Research Through Advancing Innovative Neurotechnologies Initiative, a $100 million effort to jumpstart research into potential therapeutic applications for neurotechnology.[481] As part of that initiative, the Defense Advanced Research Projects Agency, a DoD research and development agency with decades of experience in neurotechnology, launched the Systems-based Neurotechnology for Emerging Therapies (SUBNETS) program.[ac, 483-485] The SUBNETS program ran from 2014-2019 with the goal of developing a proof of concept for a closed-loop brain-computer interface to detect and treat neuropsychological illness through targeted stimulation of brain activity.[484-487]

[ab] Marijuana, a common "self-treatment" for PTSD, has likewise not been shown effective in clinical trials for the treatment of PTSD.[480]

[ac] See "DARPA and the Brain Initiative" (https://www.darpa.mil/program/our-research/darpa-and-the-brain-initiative) for additional details on the SUBNETS and other neurotechnology initiatives.[485]

Psychedelic Medicine

Recent research suggests that MDMA can be safely and effectively paired with exposure therapy to treat PTSD.[466] For example: [ad, 488, 489]

- A phase 2, randomized, double-blind, placebo-controlled study found combining exposure therapy with MDMA to be more effective than exposure therapy alone in treating military veterans, firefighters, and police officers
- A phase 3, randomized, double-blind, placebo-controlled study found that MDMA reduced PTSD symptoms

Research likewise supports the therapeutic use of other psychedelic agents, including the following:[460, 466, 490-498]

- Psilocybin for depression, obsessive-compulsive disorder, end-of-life anxiety, and substance use disorder
- Ayahuasca for depression
- LSD for mood disorders

Promising developments aside, psychedelic medicine remains controversial. One set of concerns relates to psychedelics' effects on users. Although psychedelics appear to be well-tolerated by participants in recent clinical trials, psychedelic use has been associated with disturbing and traumatic experiences ("bad trips") in both clinical and recreational settings.[499-501] Psychedelics' potential lingering side effects are perhaps more concerning, including those listed below:[502-505]

- Increased suggestibility
- Personality and worldview changes
- A disrupted sense of self ("ego dissolution")

Another set of concerns relates to the ethics of psychedelic research. These include patient safety, informed consent, conflicts of interest, emotional transference, and researchers practicing outside of the scope of their competencies.[501] These concerns are common to psychotherapy, but they take on additional weight when psychotherapy is combined with mind-altering hallucinogenic substances associated with increased suggestibility.[501]

The unique properties of psychedelic compounds additionally raise methodological concerns. Studies may be compromised by selection bias if participants are drawn to psychedelics' recreational rather than medicinal properties.[506, 507] The exclusion of participants with known risk factors likewise raises selection bias concerns.[ae, 500, 506] Findings may also be impacted by patient expectations or by placebo and "nocebo" effects.[506, 507] The relationship between the compounds' "mystical" and medicinal properties also remains unclear, and viable research opportunities remain limited due to legal and regulatory barriers.[467, 507]

[ad] See Reiff et al. for a meta-analysis of psychedlic medical research.[466]
[ae] For example, individuals with family histories of schizophrenia and/or schizoid or paranoid dispositions are at increased risk for LSD-induced psychosis.[500]

Given these concerns, a final consideration involves weighing the merits of psychedelic medicine against those of alternative, less risky treatment options. For example, research suggests that collaborative care approaches and written exposure/narrative therapy may be effective alternatives for PTSD treatment.[508]

Therapeutic Neurotechnologies

The SUBNETS program reached several important milestones. One team working out of the University of California, San Francisco (UCSF) used implanted sensors to construct a map of brain activity in epilepsy patients.[509, 510] The UCSF team was then able to record patient mood states associated with specific networks of brain activity and then relieve depression symptoms through direct brain stimulation.[510, 511] A second SUBNETS team working out of Massachusetts General Hospital successfully mapped patients' brain activities while testing neuropsychological functions implicated in MH disorders, including impulsivity and cognitive inflexibility.[486] The Massachusetts General Hospital team likewise mitigated patients' symptoms by stimulating brain activity.[486]

It is noteworthy that the SUBNETS program evaluated the effects of brain stimulation via implanted devices alone rather than in combination with other treatment interventions like psychotherapy, as is common in psychedelic medicine.[486, 488, 512-514] This is one of the potential benefits of therapeutic neurotechnologies: the potential for alleviating patient MH symptoms without the need for active and ongoing patient involvement. Indeed, as self-regulating, "closed-loop" systems, implanted devices would not require excessive amounts of active monitoring or intervention from MH or other medical professionals.[515] However, the potential benefits of neurotechnologies must be weighed against serious health concerns, including surgical risk, infections, local inflammatory reactions, and potential irreversibility of the implanted device. As with psychedelic medicine, consideration should be given to alternative and less risky treatment options, including noninvasive neural stimulation devices.

Findings and Recommendations

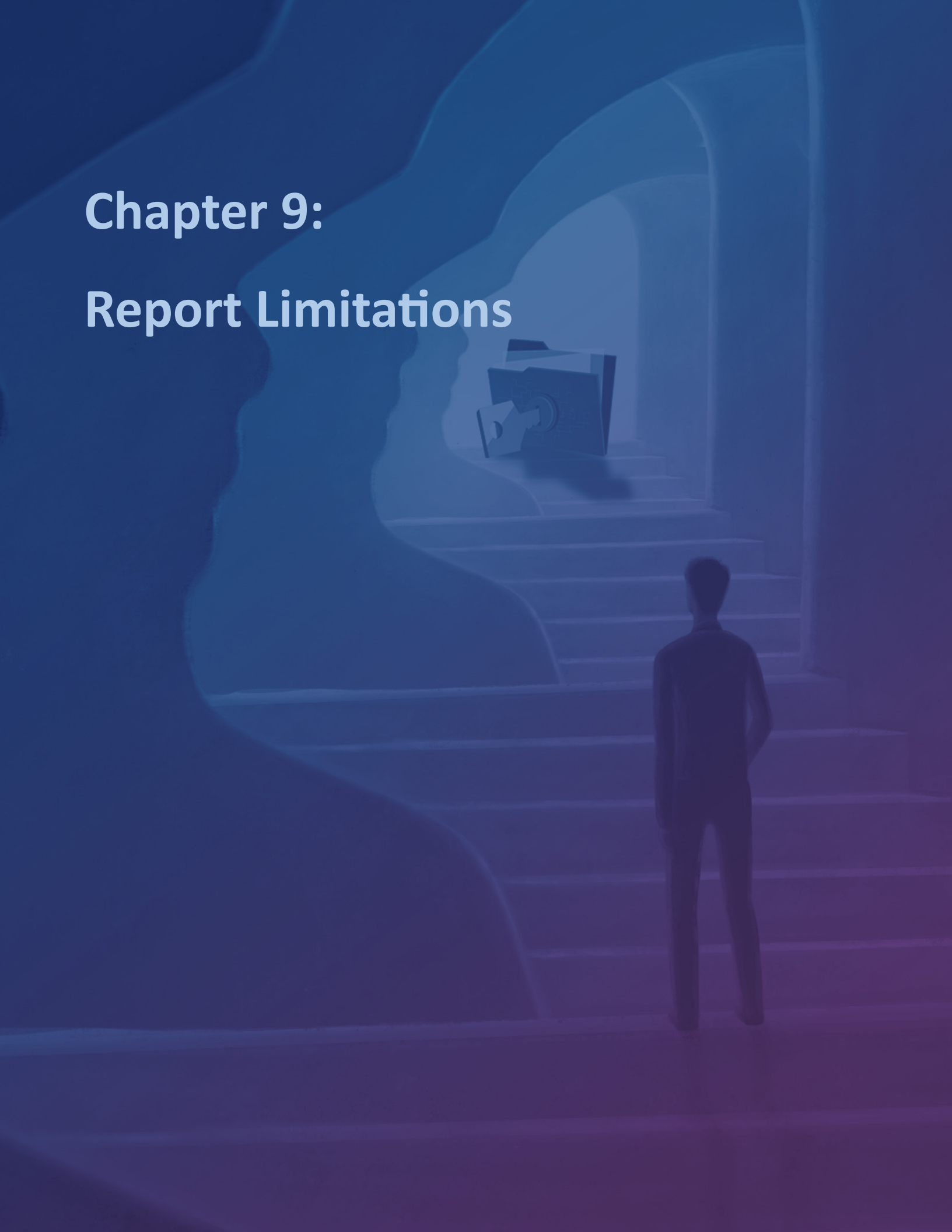
Finding 15: There are many novel approaches and emerging therapies that may benefit patients with posttraumatic stress disorder (PTSD) and other BH conditions, including, but not limited to, Schedule 1 substances. The posture of the federal government is that approval of use of these medications will adhere to the same assessments of risk and benefit as for other medications and therapies.

DoD researchers may face barriers to participating in preclinical and clinical trials of Schedule 1 substances due to interagency and inter-institution administrative processes, stigma associated with these substances within the military community, and DoD policy restrictions.

Recommendation 15: The DoD should clarify conditions for research support of and participation in emerging MH therapies and novel therapeutics.

Chapter 9:

Report Limitations



The DHB's review of MHS beneficiary access challenges has several key limitations. First, as has been noted, the DHB could not determine the full scope of purchased care access challenges due to conflicting accounts from patient advocate groups and DHA and TRICARE representatives.

Second, throughout the DHB's investigation, the inherent limitations of the DHA's leverage over access in the purchased care network were evident. The DHA can neither direct purchased care providers to increase their MHS beneficiary caseload nor can it directly incentivize uptake by increasing TRICARE provider reimbursement rates. The leverage the DHA possesses is instead exercised by TRICARE program representatives in private negotiations with MCSCs. From the DHB's standpoint, these private negotiations are a "black box." Thus, the structure of the purchased care system limits both the DHA's authority over and the DHB's insight into beneficiary MH access challenges.

These structural limitations were further evident in the DHB's review of the DoDIG's staffing model recommendations and the DHA's response to them. The DHA's decision to implement separate direct and purchased care staffing models makes little sense in the absence of MCSC proprietary data and related considerations.

Third, the scope of the DHB's tasking was MHS beneficiaries seeking MH care. Given the contribution of the national MH crisis to beneficiary MH access challenges, the DHB's focus on beneficiary (rather than national) MH may be considered a limitation.

Finally, the DHB's recommendations concerning Schedule 1 drug therapies face practical limitations. Among MHS beneficiaries, SMs stand to benefit most from such treatments; however, SMs are also likely to face severe access barriers due to safety and other vital mission-related concerns.

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Appendix B: Terms of Reference

THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

MEMORANDUM FOR PRESIDENT, DEFENSE HEALTH BOARD

SUBJECT: Request for Defense Health Board Review, Beneficiary Mental Health Care Access

Pursuant to the attached Terms of Reference (TOR) on "Beneficiary Mental Health Care Access," I direct that the Defense Health Board (DHB), working through its Neurological/Behavioral Health Subcommittee, provide recommendations to enhance the Military Health System capacity and capability to meet beneficiaries' mental health care needs. Specifically, the Board should recommend guidance to:

- Eliminate barriers to accessing and delivering mental health care for both adult and child beneficiaries.
- Promote innovative mental health care research and treatment strategies.

The TOR for this review provides a detailed description and scope of the tasking. The point of contact for this action is the DHB Designated Federal Officer CAPT Gregory Gorman. He may be reached at (703) 275-6060, or gregory.h.gorman.mil@mail.mil. Thank you for your support and commitment to optimizing the health and force-readiness of the military.

MULLEN.SEILEEN.MARIE.1519853007
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Date: 2022.07.07 09:52:39 -04'00'

Seileen M. Mullen
Acting

Attachment:
As stated

cc:
Group Federal Officer
Advisory Committee Management Officer
Defense Health Board Designated Federal Officer

Defense Health Board
Beneficiary Mental Health Care Access
TERMS OF REFERENCE

These terms of reference establish the objectives for the Defense Health Board ("the Board") to review, through the Neurological/Behavioral Health Subcommittee ("the Subcommittee"), the provision of mental health care services for Service members and military beneficiaries in the Military Health System (MHS).

Mission Statement: The mission of the Board is to provide independent advice and recommendations to maximize the safety and quality of, as well as access to, health care for members of the Armed Forces and other Department of Defense (DoD) beneficiaries.

Issue Statement:

Access to mental health care is an issue of increasing urgency to Service members and military beneficiaries (e.g., spouses and children). However, the supply of military mental health resources (i.e., providers and treatment options) has not kept pace with the needs of the beneficiary population.[1] As a result, many Service members and military beneficiaries attempt to seek mental health care outside of the DoD.[2] In fact, a 2020 evaluation of access to mental health care by the DoD Inspector General found that "DoD is not consistently meeting the requirements under law and by DoD policy, for access to outpatient mental health care, causing patients to experience delays."[1] The evaluation also found "pre-COVID-19 — 53 percent of all active duty service members and their families who got referrals to TRICARE because they needed mental health care didn't receive the care."[2]

The COVID-19 pandemic caused a spike in demand for mental health care for military beneficiaries, exacerbating the shortage.[3,4] In response, Senators Jeanne Shaheen and Martha McSally sent a letter to then Assistant Secretary of Defense for Health Affairs Thomas McCaffery requesting expanded telephone-based telehealth services for Medicare and TRICARE beneficiaries in May 2020. The use of telehealth greatly expanded during the pandemic, increasing access to mental health care in particular. A 2020 survey of the impact of eased telehealth regulations during COVID-19 by the American Psychiatric Association (APA) found similar results; telehealth for video and audio-only mental health appointments resulted in "improved access to care, reduced no-show rates, and a high rate of patient satisfaction."[5] These findings underscore the value and feasibility of telehealth reducing geographic barriers and expanding access to psychiatric and substance use treatment for patients.

In February 2021 the Military Officers Association of America (MOAA) recommended a variety of strategies to alleviate mental health care access problems. These strategies include implementation of mental health appointment schedulers, enhancing TRICARE contract requirements for mental health services, telehealth licensure flexibility, reduced mental health visit copays, and integration of mental health care services into primary care settings.[6] These

strategies can be effective tools to support particularly vulnerable beneficiaries, such as military children who face unique mental health challenges compared to both their civilian peers and military parents.[7]

The benefits of improved access to services may be augmented by enabling access to cutting edge treatments. Schedule I substances such as psilocybin, mescaline, lysergic acid diethylamide (LSD), and 3,4-Methylenedioxymethamphetamine (MDMA), for example, have been found beneficial in treating behavioral health conditions pertinent to the military such as post-traumatic stress disorder (PTSD)[8,9] but are not offered in the MHS. Existing studies are insufficiently representative or generalizable to inform the immediate use of these compounds among active duty and beneficiary populations[10]; military-specific studies to establish safety and therapeutic benefits in a military population are needed.[11]

Military beneficiaries and Service members need access to more mental care professionals, less barriers to seeking and receiving mental health care, and wider availability of emerging treatments.

Objectives and Scope:

- Provide recommendations to enhance MHS capacity and capability to meet beneficiaries' mental health care needs, and to eliminate barriers to accessing and delivering mental health care for both adult and child beneficiaries
- Provide recommendations to promote innovative mental health care research and treatment strategies for PTSD and other behavioral health conditions

Methodology:

1. The Subcommittee may conduct interviews and site visits as appropriate.
2. The Subcommittee may seek input from other sources with pertinent knowledge or experience.
3. In accordance with the November 26, 2018, Deputy Secretary of Defense Memorandum, "Advisory Committee Management," the Subcommittee shall receive full and timely cooperation of each office of the Secretary of Defense or DoD Component Head in providing analyses, briefings and other DoD information or data necessary for the fulfillment of its responsibilities as provided for by this TOR.

Compliance:

The Board and Subcommittee will operate in conformity with and pursuant to the Federal Advisory Committee Act, the Government in the Sunshine Act, and other applicable federal statutes and regulations. Individual Board and Subcommittee members do not have the authority to make decisions or recommendations on behalf of the Board, nor report directly to any federal representative. The members of the Board and Subcommittee are subject to certain Federal ethics laws, including Title 18, U.S. Code, §208, governing conflicts of interest, and the Standards of Ethical Conduct regulations in Title 5, Code of Federal Regulations, Part 2635.

Deliverables:

The Subcommittee will complete its work within one year of being tasked and report to the Board in a public forum for full and thorough deliberation. The Board will report to the Assistant Secretary of Defense for Health Affairs, who has been delegated the authority to evaluate the independent advice and recommendations received from the Board and, in consultation with the Under Secretary of Defense for Personnel and Readiness, identify actions or policy adjustments to be made by DoD in response. The Subcommittee will provide progress updates at each Board meeting while working the tasking.

Required Support:

1. The Defense Health Board Support Division will provide any necessary research, analytical, administrative, and logistical support for the Board.

2. Funding for this review is included in the division's operating budget.

References:

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Appendix C: Crosswalk Terms of Reference Objectives and Recommendations

Terms of Reference Objectives	Report Recommendations
• Provide recommendations to enhance MHS capacity and capability to meet beneficiaries' mental health care needs, and to eliminate barriers to accessing and delivering mental health care for both adult and child beneficiaries	1a-e, 2, 3a-d, 4, 5a-b, 6, 7b-d, 8a-b, 10c, 11a-c, 12 b-c, 13a-c, 14a-g
• Provide recommendations to promote innovative mental health care research and treatment strategies for PTSD and other behavioral health conditions	7a, 9a-d, 10a-b, 12a, 14h, 15a

Appendix D: Methods

The DHB Staff performed a comprehensive search and review of information addressing:

- Service member and military family mental health (MH), wellbeing, and readiness
- Military Health System (MHS) MH beneficiary access challenges
- MHS behavioral health (BH) workforce challenges and requirements
- Recent policy reforms addressing beneficiary MH access challenges
- Recent developments in telehealth and emerging MH therapies

The team identified a pool of subject matter experts from published work and organizations relevant to the DHB's tasking and objectives, as stated in the Terms of Reference. These experts from government, advocacy organizations, and the military briefed the Subcommittee about MH trends, barriers to MHS beneficiaries accessing MH care, and current and prospective efforts to remedy beneficiary MH access challenges. During briefings, Subcommittee members asked clarifying questions of experts to better understand the factors that influence supply and demand for MHS MH services, with special attention paid to Service members, family members, and retirees. Through multiple meetings and an iterative review of scientific literature, government documents, and subject matter expert briefings, the Subcommittee members coalesced around a series of evidence-supported reform proposals. The DHB Staff assisted the Subcommittee in developing its findings and recommendations by synthesizing information and research for their review and analysis.

The Subcommittee Chair briefed the findings and recommendations to the DHB in an open forum, with discussion by DHB members and opportunity for input by the public. On March 30, 2023, the DHB recommended the Subcommittee Chair to include additional information into the report based on the discussion. On June 28, 2023 the Subcommittee Chair publicly briefed the updated findings and recommendations to the DHB and members of the public. The DHB members approved of the recommendations with minor amendments.

Appendix E: Meetings and Presentations

March 30, 2022: Defense Health Board Meeting
Virtual

The DHB met virtually and received briefings from subject matter experts (SMEs) on priority topic areas of beneficiary mental health and virtual health within the MHS.
The SMEs who briefed at the meeting include:

- Dr. Lee Beers, Children's National Hospital
- Lt. Col Nathan Reynolds, USAF, MSC, FACHE

June 6, 2022: Defense Health Board Meeting
Virtual

The DHB met virtually and received a briefed by Dr. Kate McGraw, Chief, Psychological Center of Excellence, DHA, on mental health access from a DoD perspective. Dr. Valadka presented the DHB with an overview of the tasking.

June 28, 2022: Neurological/Behavioral Health Subcommittee Kickoff Meeting
Virtual

The Subcommittee met virtually and received a briefing on the 2020 DoDIG Report by Mr. Andre Brown, Program Director for Military Health Care and Operations, and Mr. Thomas Bickett, Senior Program Analyst, both with the DoD Office of the Inspector General. The Subcommittee discussed beneficiary mental health access challenges from the Blue Star Families' Military Lifestyle Survey with Dr. Jessica Strong, Senior Director of Applied Research, Blue Star Families.

July 14, 2022: Neurological/Behavioral Health Subcommittee Meeting
Virtual

The Subcommittee met virtually to discuss the mental health needs of military families. Ms. Eileen Huck, Government Relations Senior Deputy Director, National Military Families Association, briefed on the National Military Families Association's perspective on beneficiary mental health challenges.

August 10, 2022: Defense Health Board Meeting
North Chicago, IL

The DHB met in person and received a briefing from by Dr. Darrin Worthington, Veterans Integrated Services Network, VHA, on the VHA's telehealth services, VISN12. Dr. Alex Valadka provided an update on the tasking for the DHB.

August 18, 2022: Neurological/Behavioral Health Subcommittee Meeting
Virtual

The Subcommittee met virtually and received a briefing on the TRICARE for Kids Coalition's priorities from Ms. Kara Oakley, principal, Oakley Capitol Consulting, LLC, and founder of TRICARE for Kids Coalition. CAPT Meghan Corso, Chief Behavioral Health Clinical Operations, DHA, also briefed the Subcommittee on mental health care access in the direct care system.

September 8, 2022: Neurological/Behavioral Health Subcommittee Meeting
Virtual

The Subcommittee met virtually and discussed sections of the report, including the report outline. There were no briefings at this meeting.

October 13, 2022: Neurological/Behavioral Health Subcommittee Meeting
Virtual

The Subcommittee met virtually and received a briefing on the Army Spiritual Readiness Initiative and Mission-100 to Alaska by COL Stanley Smith, Chaplain, DHA, and COL Timothy Maracle, Executive Officer, Chief of Chaplain, Army. Lt Col Aaron Tritch, AF Mental Health Targeted Care Lead, and Col Catherine Callender, Deputy, AF Deputy Director of Psychological Health, briefed the Subcommittee on the AF Targeted Care Initiative.

November 10, 2022: Neurological/Behavioral Health Subcommittee Meeting
Virtual

The Subcommittee met virtually and received a briefing on TRICARE reimbursements for mental health by Ms. Elan Green, Chief of Medical Benefits and Reimbursement Section, TRICARE.

November 30, 2022: Defense Health Board Meeting
Falls Church, VA

The DHB met in person and received a briefing on DoD Healthcare and State Laws & Regulations from Dr. Ken Yale, Chief Execture, TRICARE Health Plan, and Ms. Geraldine Valentino-Smith, Director, Defense State Liaison Office. Dr. Valadka provided an update of the BMHA report.

December 8, 2022: Neurological/Behavioral Health Subcommittee Meeting
Virtual

The Subcommittee met virtually and received a briefing on substance abuse trends by Mr. Robert Vincent, Associate Administrator for Alcohol Prevention and Treatment Policy, and Dr. Melinda Baldwin, Special Assistant to the Director of the Center for Mental Health Services, SAMHSA.

January 12, 2023: Neurological/Behavioral Health Subcommittee Meeting
Virtual

The Subcommittee met virtually and discussed sections of the report. There were no briefings at this meeting.

January 26, 2023: Neurological/Behavioral Health Subcommittee Meeting
Virtual

The Subcommittee met virtually and discussed sections of the report. There were no briefings at this meeting.

February 9, 2023: Neurological/Behavioral Health Subcommittee Meeting
Virtual

The Subcommittee met virtually and discussed sections of the report, including the Findings sand Recommendations. There were no briefings at this meeting.

February 23, 2023: Neurological/Behavioral Health Subcommittee Meeting
Virtual

The Subcommittee met virtually and discussed sections of the report. There were no briefings at this meeting.

March 22, 2023: Defense Health Board Meeting
Falls Church, VA

Dr. Valadka, the Subcommittee Chair, provided a decision brief to the DHB members. During deliberation, the DHB voted to send the report back to the Subcommittee and include additional information based on the discussion.

April 27, 2023: Neurological/Behavioral Health Subcommittee Meeting
Virtual

The Subcommittee met virtually and discussed sections of the report. There were no briefings at this meeting.

June 28, 2023: Defense Health Board Meeting
Falls Church, VA

Dr. Valadka, the Subcommittee Chair, provided an updated decision brief to the DHB members. After some admendments to the language, the DHB voted to approve the report and its findings and recommendations.

Appendix F: Glossary

11th ABV DIV: 11th Air Borne Division

AD: Active Duty

ADSMs: Active Duty Service Members

AIAN: American Indian and Alaskan Native

APA: Amcan Psychiatric Association

ASD(HA): Assistant Secretary of Defense for Health Affairs

ASRI: Army's Spiritual Readiness Initiative

BH: behavioral health

BHI: behavioral health integration

CG: Comptroller General of the US

CONUS: Continental United States

CSF-2: Comprehensive Soldier and Family Fitness

DHA: Defense Health Agency

DHB: Defense Health Board

DoD: Department of Defense

DoDIG : Department of Defense Office of Inspector General

DSLO: Defense-State Liaison Office

FDA: US Food and Drug Administration

FY: Fiscal Year

GAO: US Government Accountability Office

IRMAC: Integrated Referral Management and Appointing Center

LSD: Lysergic Acid Diethylamide

MCSC: Managed Care Support Contracts

MDMA: 3,4-methylenedioxymethamphetamine

MFLCs: Military Family Life Counselors

MH: mental health

MHS: Military Health System

MHSR: Military Health Systems Research

MTFs: Military Treatment Facilities

NDAA: National Defense Authorization Act

NMFA: National Military Families Association

OCONUS: Outside the Continental United States

OMHM: Occupational Mental Health Model

OPTEMPO: operations tempo

OPTEMPO-NDE: operations tempo in the non-deployed environment

PCPs: primary care physicians

PCS: permanent change of station

PTSD: posttraumatic stress disorder

SCM: Stress Continuum Model

SecDef: Secretary of Defense

SMs: Service members

SUBNETS: Systems-based Neurotechnology for Emerging Therapies

TFF: Total Force Fitness

TH: telehealth

TMH: tele-mental health

USUHS: Uniformed Services University of the Health Sciences

VA: US Department of Veterans Affairs


DEFENSE
HEALTH BOARD