INSPECTOR GENERAL
U.S. Department of Defense

Statement of

Michael J. Roark

Deputy Inspector General

Department of Defense

for a Hearing on

"Suicide Prevention and Related Behavioral Health Interventions in the Department of Defense"

Before the

Subcommittee on Personnel

Senate Armed Services Committee

United States Senate

April 6, 2022

Good morning, Chairwoman Gillibrand, Ranking Member Tillis, and distinguished members of the Subcommittee. Over many years, the DoD OIG has conducted a number of audits and evaluations related to the health and safety of Service members and their families. My testimony today will focus on three recent evaluation reports on suicide prevention for transitioning Service members, access to mental health care, and the impact of the COVID-19 pandemic on the military treatment facilities.

Suicide Prevention for Transitioning Service Members

First, I will discuss our November 9, 2021, report on suicide prevention for transitioning Service members. The objective of this evaluation was to determine whether the DoD provided suicide prevention resources for transitioning Service members as required by Presidential Executive Order 13822, "Presidential Executive Order on Supporting Our Veterans During Their Transition From Uniformed Service to Civilian Life."

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

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

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

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

The DoD did not implement a warm handoff approach, as required by DoD Instruction 6490.10, to create continuous mental health care during the transition from the Military Health System (MHS) to the Veterans Health Administration (VHA) because DoD

policy is reliant on Service members and automatic systems to initiate a transition of mental health care from the MHS to the VHA. Failure to identify suicide risk and arrange for uninterrupted mental health care in transitioning Service members may result in a lack of mental health care for transitioning Service members and jeopardize patient safety.

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

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

As of March 31, 2022, these recommendations are resolved, but remain open.

Access to Mental Health Care

Second, I will discuss our August 10, 2020, report on access to mental health care. The objective of this evaluation was to determine whether the DoD meets outpatient mental health access to care standards for active duty Service members and their families, in accordance with law and applicable DoD policies.

We determined that the DoD did not consistently meet outpatient mental health access to care standards for active duty Service members and their families, in accordance with law and applicable DoD policies. Specifically, for the December 2018 to June 2019 time period, we found that:

- 7 of 13 medical treatment facilities (MTFs) in the direct care system or their supporting TRICARE network in the purchased care system did not meet the specialty mental health access to care standard each month; and
- an average of 53 percent (4,415 of 8,328 per month) of all active duty Service members and their families, identified as needing mental health care and referred to the purchased care system, did not receive care, and the MHS did not know why.

Additionally, during our site visits between August and October 2019, 9 of 13 MTFs reported the inability to meet evidence-based treatment (treatment proven successful in controlled studies) or monitor the prescribed behavioral health treatment dosage (including visit frequency) in accordance with DHA Procedural Instruction 6490.02, which means the patient's follow-up treatment may have been delayed or did not occur.

The DoD did not consistently meet outpatient mental health access to care standards because the DHA lacked an MHS-wide model to identify appropriate levels of

staffing in direct and purchased care, and published inconsistent and unclear access to mental health care policies. In addition, the DHA did not have visibility of patients who attempted, but were unable, to obtain mental health appointments in the purchased care system, and measured the 28-day specialty access to care standard differently between the direct and purchased care systems—both of which included only those patients who were able to get an appointment, excluded patients who self-referred, and considered only the patients' first appointment.

As a result, thousands of active duty Service members and their families may have experienced delays in obtaining mental health care. The delays may have involved numerous members not being able to: (1) see the right provider at the right time, (2) obtain mental health care at all, or (3) receive timely follow-up treatment. All of these types of delays in mental health care increase the risk of jeopardizing patient safety and affecting the readiness of the force.

We made a total of 14 recommendations to the ASD(HA) and the DHA Director to improve access to mental health care in the DoD. As of March 31, 2022, seven recommendations were unresolved, and seven recommendations are resolved, but open.

Impact of COVID-19 on Military Treatment Facilities

Finally, for our third report, on April 5, 2022, we issued a report on the challenges that MTFs are facing due to the ongoing COVID-19 pandemic. Although this report focused on a wide variety of challenges, one of the primary challenges we identified was burnout of medical personnel.

We asked senior leadership at 30 MTFs, "What is the most serious concern that might be encountered in the future by medical personnel working at your MTF during the COVID-19 pandemic?" Officials from 11 of the 30 MTFs stated that staff burnout and fatigue was the most serious concern that might be encountered in the future. MTF officials also related their manpower and staffing challenges at the time to the levels of staff burnout and fatigue. During our interviews, officials from 25 of the 30 MTFs discussed burnout as a serious challenge, an impact or cause of a serious challenge, or a future concern.

MTF officials specifically reported the following concerns related to staff burnout and fatigue:

- staff working overtime or being overworked,
- increased staff exposure to death and dying, and
- limited staff access to behavioral and mental health care.

MTF officials stated that burnout has caused some staff to quit, further exacerbating staff shortages. MTF officials also stated that burnout adversely affected staff members' psychological health and caused them to use emergency mental health services for behavioral health problems and suicidal ideations.

We asked officials from the OASD[HA] what actions they have taken or plan to take to address the challenge of MTF staff burnout. They stated that the OASD(HA) is revising DoD Instruction 6490.05, which recognizes that stress can occur in personnel who did not directly experience war or combat, including individuals exposed to stressful or traumatic events in military operations related to COVID-19. An OASD(HA) official also stated that

the DHA has developed provider resilience tools that include self-care tips and digital health tools to promote resilience among providers.

We recommended that the ASD(HA) develop DoD policy for the maximum consecutive hours to be worked, maximum shifts per week, and coverage of duties when absent for MHS staff working in MTFs to reduce the physical impacts leading to fatigue and burnout, and develop the appropriate waivers of this policy for MHS staff.

This concludes my statement and I would be happy to answer any questions you have.