



## THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON  
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

FEB - 1 2011

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

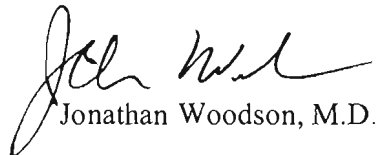
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The final report provides a description of several initiatives that are currently underway to increase provider availability in the networks, optimize access, and provide more effective recruitment and retention incentives for mental health providers. In addition, it provides the Services' assessment of supply and demand needs for the mental health care of their beneficiaries and projects future authorizations for mental health staff.

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Sincerely,

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Enclosure:  
As stated

cc:  
The Honorable John McCain  
Ranking Member



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The Honorable James H. Webb  
Chairman, Subcommittee on Personnel  
Committee on Armed Services  
United States Senate  
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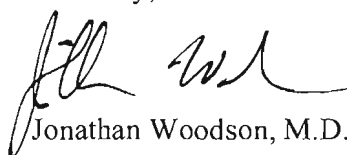
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Ranking Member



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Vice Chairman



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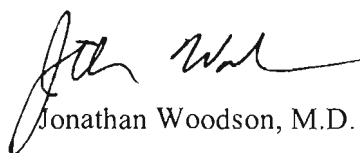
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Chairman, Committee on Armed Services  
U.S. House of Representatives  
Washington, DC 20515

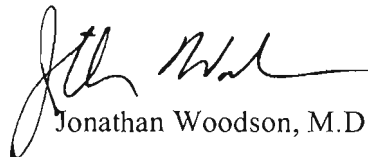
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Ranking Member



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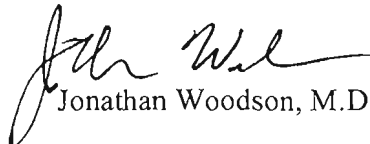
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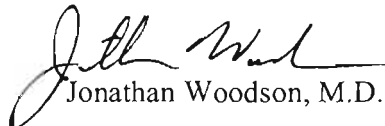
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Ranking Member



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Chairman, Subcommittee on Defense  
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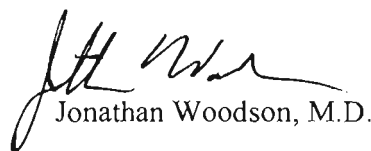
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# Mental Health Personnel Required to Meet Mental Health Care Needs of Service Members, Retired Members, and Dependents

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REPORT TO CONGRESS

PREPARED BY:  
ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS)

FEBRUARY 2011

## **Introduction**

Section 714 of the National Defense Authorizations Act for Fiscal Year 2010 requires the Secretary of Defense 1) to report on the appropriate number of mental health personnel required to meet the mental health care needs of Service members, retired members, and dependents; 2) to develop and implement a plan to significantly increase the number of Department of Defense military and civilian mental health personnel by September 30, 2013; 3) to assess the feasibility and advisability of establishing one or more military mental health specialties for officers or enlisted Service members; and 4) to determine if the Services have increased their authorized mental health providers to fulfill the requirements of NDAA 2010, section 708.

## **Mental Health Resources**

The Assistant Secretary of Defense, Health Affairs, is committed to providing the necessary funding, coordination, and support to Service and benefit operations to ensure adequate mental health resources to meet the mental health treatment needs of Military Health System beneficiaries. A full spectrum of mental health care is available to Service members and their families through the Military Health System and TRICARE before, during and after deployment. Mental health services are also available through the Department of Veterans Affairs for separating Service members who have been deployed to Operation Enduring Freedom or Operation Iraqi Freedom for a period of up to five years.

Due to increased screening referrals and help-seeking in the face of sustained operations, military Services have increased civilian mental health staffing, including contractors and government civilians, in garrison to augment care in instances when military mental health providers have been deployed in order to meet requirements for urgent and routine appointments to be available within established access standards. When deployed, each Service provides

mental health services designed to best serve their unique operational requirements, and mental health professionals are also currently being embedded as organic assets in line units.

TRICARE, through its managed care contractors, has established networks of civilian providers in certain areas. These network providers usually offer discounts from the TRICARE maximum allowable charges, agree to file claims on behalf of beneficiaries, and comply with the referral and authorization procedures of the TRICARE Prime health plan option. While TRICARE has not required that its contractors establish networks in areas other than around military treatment facilities (MTFs) and around sites where MTFs used to exist but have been closed in accordance with Base Realignment and Closure (BRAC) legislation, the contractors have added networks in some additional areas. TRICARE has limited the number of areas in which the contractors must establish networks because the primary purpose of the networks is to provide a means of augmenting MTF capability and capacity. Secondary purposes of the network, whether located around an MTF or not, include providing convenient access to care and controlling health plan costs.

Because TRICARE beneficiaries usually constitute only a small portion of any particular civilian provider's practice, TRICARE has a good deal of flexibility in expanding or contracting the size, composition, and use of the network in response to changes in MTF capability and capacity. A good example of this flexibility is the increase in provision of network behavioral health services as demand for such services has increased over the past nine years. During the period since 11 September 2001, private sector outpatient behavioral health care visits for active duty family members has increased at a compound annual growth rate of 15 percent per year. This increased demand is due to increased numbers of eligible beneficiaries and to the stresses of repeated deployments upon many Service members and their families. Satisfying this intense

increase in demand for services has been achieved by drawing on nationwide unused network capacity and by adding thousands of additional providers to the network.

<b>Mental Health Staffing</b>			
<b>Specialty</b>	<b>2007</b>	<b>2008</b>	<b>2009*</b>
DoD (Military Facilities**)	4,129	4,373 (Net +244 from '07)	6,061 (Net +1,688 from '08)
DoD (TRICARE***) Network Providers	39,587	45,215 (Net +5,628 from '07)	49,807 (Net +4,592 from '08)
<b>Net Increase since 2007:</b>			
DoD (Military Facilities)		+ 1,932	
DoD (TRICARE)		+10,220	
<b>Total</b>		<b>+12,152</b>	

\* As of 30 Jun 2009

\*\* Military, Civilian, and Contractor FTEs in MTFs

\*\*\* Represents expansion of mental health providers in TRICARE network including psychiatrists, psychologists, social workers, licensed mental health counselors, and psychiatric nurse practitioners (community based providers)

Several initiatives are underway to provide improved access to mental health care, increased provider availability in the network, and more effective recruitment and retention incentives to mental health providers. For example, TMA has partnered with regional contractors in the three U.S regions to provide health care services and support to beneficiaries. The TRICARE regional contractors assist the TRICARE Regional Offices and military treatment facility commanders in operating a world-class health benefit. Other contractors do not provide retail pharmacy, dental and TRICARE For Life claims processing services. The three overseas areas are supported by TRICARE Area Offices. (TAOs). TAOs, in collaboration with military treatment facility commanders, are responsible for the development and execution of an integrated plan for the delivery of health care within each overseas area.

A robust staffing model, the Psychological Health Risk-Adjusted Model for Staffing (PHRAMS), has been developed to provide the Services with a tool using a consistent methodology to define the appropriate number of mental health personnel to meet the mental health care needs of Service members, retired members, and their families. Since its inception, the PHRAMS has involved collaboration among the Services' clinical, manpower, and programming experts. PHRAMS permits the Services to make adjustments in planning assumptions to meet the needs of individual communities to determine the appropriate number and mix of mental health personnel required in MTFs.

The Services have also identified requirements and are developing guidelines to integrate mental health professionals into primary care settings to further supplement the mental health treatment capacity. A joint planning working group has agreed on appropriate staffing models and has identified associated resource requirements.

DoD is working to ensure a full continuum of psychological health services is available and accessible to all Service members and their eligible family members regardless of location. The Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) established the Telehealth and Technology (T2) Center in July 2008. The T2 Center's mission is to identify and pilot technological capabilities to facilitate the provision of tele-mental health services to remote locations where current access to care is limited. The DoD has additionally opened the National Intrepid Center of Excellence (NICoE) at the National Naval Medical Center, Bethesda, to assess, diagnose, and treat military personnel with complex psychological health and traumatic brain injury issues.

TRICARE plays a significant role in caring for our Service members and is continually evaluating and adjusting its programs and policies to ensure that eligible beneficiaries are

receiving the mental health care services required. TRICARE network providers have significantly increased in numbers from 39,587 (2007), 45,215 (2008) to 49,807 (2009). Some of the specific program enhancements include:

- TRICARE Behavioral Health Information line is a program to provide information regarding the TRICARE behavioral health benefit and respond to general behavioral health inquiries.
- Behavioral Health Provider Locator and Appointment Assistance Line which provides one-on-one assistance to beneficiaries to identify providers in their area who are accepting TRICARE patients and assist with getting an appointment if desired.
- On-Line Behavioral Health Resources where users have access to a variety of behavioral health resources, self-assessment tools and articles.
- TRICARE Assistance Program (TRIAP) is a Web-based program that allows eligible stateside Prime beneficiaries to use their home computers to contact licensed counselors 24 hours a day, seven days a week.
- Telemental Health Program (TMH) uses secure audio-visual conferencing to connect stateside beneficiaries in a medical office to offsite providers in another medical office for medically necessary behavioral health services.
- Warrior Navigation & Assistance Program (WNAP) supports active duty, Guard and Reserve warriors in transition and their families with information about the TRICARE program and assistance with navigation through the Military Health System.

### **Department of Defense Staffing Actions**

The Services continue to focus on recruiting and retaining sufficient mental health providers. Staffing data are gathered quarterly from the Services to determine mental health staffing requirements, and we are testing the PHRAMS model and working with the Services to permit them to validate how well the tool reflects and helps them describe their needs.

Number of Mental Health Personnel Reported at the End of Fiscal Year 2009 by the Health Manpower Personnel Data System			
	#Personnel	#Billets	Percentile Filled
Psychiatry	322	326	99%
Mental Health Nurse Practitioner	65	52	125%
Psychology	528	537	98%
Social Work	401	394	102%
Mental Health Nurse	165	131	126%

The overall numbers for the Services' current mental health staffing fills are improving, although the number of billets may lag actual requirements. In the past two years, the Military Health System has funded an additional 1700 positions for mental health providers, to include government civilian employees and contractors. We are also partnering with the Public Health Service to increase their number of mental health providers serving in DoD with a target goal of two hundred. Several initiatives are currently underway to increase provider availability in the network, optimize access, and to provide more effective recruitment and retention incentives to mental health providers. The Services report that they currently have the provider types they do not need any new mental health specialties. The existing mental health specialties for officers or enlisted members of the Armed Forces runs parallel to those recognized as licensed mental health providers in the private sector inclusive of such specialties as Psychiatry and Psychology (inclusive of all sub-specialties), Social Work, Psychiatric Nurses, Counselors, Advanced Practice Nurses, alcohol and drug abuse counselors. No categories of mental health specialties in the private sector have been identified that are not also recognized military mental health specialties. In fact, the military recognizes mental health specialties beyond what is found in civilian practice (e.g., mental health technicians). The results of the Service feedback demonstrated cross-Military Department concurrence that there is no perceived need or

expressed desire to establish new military mental health specialties for officers or enlisted members. This rendered exploration of feasibility without any practical reason for further consideration.

Section 661 of the National Defense Authorization Act (NDAA) for Fiscal Year 08, “Consolidation of Special Pay, Incentive Pay, and Bonus Authority,” provided special pay authority for broader spectrum of health professional officers than just physicians and dentists, to include behavioral health professionals. While the number of active-duty numbers remains relatively flat, we expect the recently implemented Consolidation of Special Pay (37 US code §335) to have a significant effect. Our first specialties targeted included psychologists and social workers. To improve civilian behavioral health recruitment, legislation has been proposed to allow us to "grow our own." This legislation, the “Health Professions Financial Assistance Program for Civilians”, has been approved by the Office of Management and Budget (OMB). The proposal is waiting for Senate review as part of NDAA 2011. If approved, this program will establish a scholarship program for civilian medical professionals, similar to the Health Professional Scholarship Program (HPSP) which has been very successful for recruiting military medical and dental officers.

Civilian medical workforce planning efforts throughout the Department of Defense have streamlined the hiring process of civilian behavioral health care providers. Utilizing appointing flexibilities such as direct-hire authority, as well as compensation incentives, we are now much more competitive for scarce and shortage mental health care providers. As a result, DoD has been able to increase recruitment and hiring of many behavioral health care positions.



<b>Mental Health Provider Staffing (Military and Civilian [Excluding Contractors])</b>		
<b>2001-2009</b>		
<b>Fiscal Year</b>	<b>Number</b>	<b>+/- Positions Added</b>
<b>2001</b>	2010	Baseline
<b>2002</b>	1999	-11
<b>2003</b>	1999	0
<b>2004</b>	1967	-32
<b>2005</b>	1911	-56
<b>2006</b>	1950	+39
<b>2007</b>	2530	+580
<b>2008</b>	2811	+281
<b>2009</b>	3515	+704

Mental health provider staffing numbers fluctuated from 2001 through 2006 with an overall decline until 2006. Since 2006, however, there has been on a continuous increase in provider numbers to help meet increased patient demand. Overall, since 2001, we have increased military and civilian mental health providers by 1505 (excluding contractors). Although we do not have similar historical information on contract mental health providers, we currently have 711 working in our military medical treatment facilities.

### **Military Service Actions**

#### **Army**

The U.S. Army Manpower Analysis Agency updated its Automated Staffing Assessment Model Behavioral Health model on July 30, 2010. This model utilizes the Medical Command Behavioral Health Bridge Tool, a tool used to determine requirements by utilizing a combination of fixed and calculated requirements, to provide detailed authoritative historical workload data and projected behavioral health utilization rates. For each medical treatment facility, workload-based manpower requirements for each behavioral health provider specialty (psychiatrists, psychologists, social workers, and nurse practitioners) were generated based on projected

utilization rates and projected changes in supported population. Support staff requirements, which include registered nurses, behavioral health specialists, social work assistants and administrative support personnel, were then generated from provider requirements using authoritative support ratios recognized in professional medical association literature. The Army proposed an updated plan to ensure sufficient recruitment and retention incentives are available and successfully marketed to potentially qualified recipients. The Army reports that they have sufficient provider types and do not advise establishing any new military mental health specialties.

The Army is divided into two functionally discrete but organizationally integrated entities, the operational Army and the generating force. The operational Army consists of those forces whose primary mission is to participate in combat. The generating force is that part of the Army whose primary purpose is generating and sustaining operational Army units by performing functions specified and implied by law. The Army reports total Active Component behavioral health military authorizations for both the Army's Operating Force and Generating Force totaled 1,277 in FY10 and has programmed an increase to 1,794 by FY17, an increase of 517 mental health provider billets in the Active Component Army. This growth of 40% exceeds the 25% objective stated in the statute.

Total Army Analysis 2012-2017 indicates that the Army increased behavioral health capability in all Brigade Combat Teams, Multi-Functional Support Brigades, and Functional Support Brigades by adding two Behavioral Health Officers and two enlisted Behavioral Health Specialists.

<b>The Programmed Increase in Authorizations for the Army's Operating Force (mental health billets) for 2012 - 2017</b>	
<b>Active Component</b>	+ 433
<b>National Guard</b>	+ 414
<b>Army Reserve</b>	+ 236

The Army's Medical Command (MEDCOM) recently launched its Comprehensive Behavioral Health System of Care to promote enhanced delivery of behavioral health support to Army soldiers and their families. On April 19, 2010, the Vice Chief of Staff approved the allocation of 545 additional military authorizations to MEDCOM to meet increases in medical workload generated by the "Grow the Army" initiative. "Grow the Army" was the Army undergoing the largest organizational change since World War II as it transformed to a Brigade-centric modular force and grew to about 7,000 additional soldiers. In addition, the civilian behavioral health capabilities were also increased as indicated in the following table.

<b>Army MEDCOM Increases (Effective FY 2011)</b>	
<b>Psychiatrists</b>	+ 12
<b>Psychiatric/Behavioral Health Nurses</b>	+ 5
<b>Psychiatric/Behavioral Health Nurse Practitioners</b>	+ 10
<b>Social Workers</b>	+ 8
<b>Clinical Psychologists</b>	+ 10
<b>Enlisted Behavioral Health Specialists</b>	+ 34

## **Navy**

Navy Medicine has adopted the PHRAMS model for capturing its mental health requirements and personnel costs. Navy Medicine's accession plan has programmed increases in military mental health billets in FYs 09-12 by 30% or an increase of 199 billets (overall), exceeding the NDAA for FY10 requirement of increasing manpower authorizations by 25%. The Navy reports that they have all of the necessary mental health specialties. Targeted

specialties (Psychiatrists, Clinical Psychologists, Social Workers and Psychiatric Nurse Practitioners) and billets are funded.

<b>Navy Specialties Net Growth from FY 2009 to FY 2012</b>	
<b>Psychiatrists</b>	+ 28
<b>Clinical Psychologists</b>	+ 28
<b>Social Workers</b>	+ 62
<b>Psychiatric Nurse Practitioners</b>	+ 14
<b>Mental Health Nurses</b>	+ 10
<b>Psychiatric Technicians</b>	+ 57

## **Air Force**

In compliance with the NDAA FY10, Section 714, the Air Force Medical Service (AFMS) has programmed a 25% increase in active duty mental health personnel authorizations. In determining the allocation of these new mental health authorizations, the AFMS considered calculations from the PHRAMS, as well as the capacity to fill mental health billets and desired mental health care capabilities. The programmed increases will occur in Fiscal Years 2012-2016. A total of 339 authorizations will be added.

<b>Air Force Mental Health Billet Increases (FY 2012 to FY 2016)</b>	
<b>Psychiatrists</b>	+ 18
<b>Psychologists</b>	+ 31
<b>Social Workers</b>	+ 79
<b>Psychiatric Nurse Practitioners</b>	+ 27
<b>Psychiatric Nurses</b>	+ 15
<b>Enlisted MH Technicians</b>	+ 169

This increase will enable the AFMS to expand the Behavioral Health Optimization Program, which integrates mental health providers into primary care at each medical treatment facility; screening, treatment, and support services for families with special needs; mental health case management for high risk cases; psychiatric medication management; inpatient mental

health capacity; and mental health outreach and prevention. The Air Force report that they currently have the provider types they require and are training more psychiatric nurse practitioners through USUHS to aid in increasing the Mental Health prescribing capability, and adding psychiatric nurses to help with the Mental Health case management.

### **Conclusion**

In accordance with the Department of Defense Task Force on Mental Health's (2007) recommendation to "Ensure an Adequate Supply of Uniformed Providers," all of the Services have assessed the supply and demand needs for the mental health care of their enrollees and subsequently formulated their future authorizations for mental health staff to meet these needs. All three Services have met the requirement for significantly increasing the number of military and civilian mental health personnel of the Department of Defense.

The Department is working to meet the needs of our beneficiaries for mental health services through investments in prevention and early intervention. We are also working to provide a spectrum of services to ensure delivery of preventive care and information, easy access to Behavioral Health services in primary care, access to mental health providers, focus on reducing stigma, and assistance in coordination of care. We expect this balanced approach to produce savings by reducing untreated dysfunction and long-term costs in medical utilization and disability payments, attrition, and training.