ARTICLE

The Advantages of Behavioral Health Care in the United States Army

J. Jun Oh, D.O., Hannah Russin, M.D., Aaron Wolfgang, M.D.

This article explores the unique advantages of behavioral health care in the United States Army from a biopsychosocial perspective. Numerous initiatives emphasize prevention through ongoing screening and maintenance of physical and behavioral health. Access to care is improved because there are no out-of-pocket costs, a high resource commitment to behavioral health services, and fewer insurance limitations. Continuity of care is established worldwide through a universal electronic health record. Providers face minimal utilization management pressures and can prescribe occupational interventions that are unavailable in civilian practice. The distinguishing features of Army behavioral health care may provide a framework for analogous initiatives in civilian health systems.

Nearly 1.4 million men and women currently serve in the United States Armed Forces. Of those, nearly 500,000 serve in the Army, the largest branch of the military. In 2016, 26.4% of active duty Army soldiers had a diagnosis of a mental disorder (1), compared with 18.3%–26.2% of the general U.S. population (2, 3). Over 200 Army psychiatrists stationed around the globe, along with their multidisciplinary teams, deliver care to these soldiers on a daily basis within the Military Health System, which is a system entirely independent from the Veterans Health Administration, which serves the health care needs of the 20 million veterans in the United States.

Military service introduces numerous assets across the entire biopsychosocial spectrum that better allow soldiers to engage in behaviors and interact with services that are ultimately advantageous to their overall well-being. This article will further explore the many distinguishing assets of behavioral health care throughout the United States Army from the perspectives of prevention, screening, evaluation, diagnosis, treatment, and disposition. More than solely showcasing Army behavioral health care, the objective of this exploration is to provoke a broader discussion of how understanding the differences between the military and civilian systems can ultimately lead to improvements in patient care.

PREVENTION

Primary prevention of behavioral health conditions for soldiers occurs on all three biopsychosocial levels. Regular scheduled physical training may occur up to five times per week, in addition to the physical activity of regular duties. Soldiers are also incentivized to stay physically active as physical fitness is assessed semiannually, the results of which have direct implications on career progression. Physical activity is one of the three components of the performance triad (4), a service-wide wellness initiative that promotes mental and physical health by encouraging optimization of the fundamentals of sleep, activity, and nutrition.

Soldiers are trained annually on a variety of topics to include suicide prevention, substance abuse prevention, antihazing, and resilience. Master Resilience Training (5), a program jointly designed by the University of Pennsylvania and the United States Army, uses evidence-based principles of positive psychology to improve resilience and prevent the development of behavioral health conditions.

In deployed environments, an extensive program known as Combat and Operational Stress Control is utilized to prevent, identify, and manage adverse reactions to the unique stressors related to combat and deployment (6). Psychological first aid is recognized as the first step in preventing these complications.

SCREENING

Behavioral health screening first occurs prior to acceptance for military service. At an initial evaluation, prospective soldiers are screened for medical and behavioral health conditions, allowing early identification of needs and screening out those with certain behavioral health or medical diagnoses incompatible with service. This screening continues annually via a mandatory health assessment consisting of an extensive online questionnaire that includes screening for a wide range of behavioral health conditions, followed by a face-to-face appointment with a provider to discuss any concerns, including positive screens (7). In addition, patients are routinely screened at primary care appointments for symptoms of depression, anxiety, and posttraumatic stress. Those with positive findings on screening are further evaluated and subsequently referred to behavioral health care if necessary. Screening increases in both frequency and intensity before, during, and after deployment, providing multiple opportunities for intervention if required (8).

EVALUATION

Commanding officers are authorized to request an emergent behavioral health

evaluation for soldiers who demonstrate an imminent safety risk to themselves or others (9). In nonemergent situations, commanding officers may request a routine behavioral health evaluation for soldiers who show signs of behavioral health conditions. In either case, the commanding officers' ability to request behavioral health evaluations allows soldiers to receive behavioral health care that they may not otherwise seek themselves (10). Although commanding officers are authorized to request behavioral health evaluations, they cannot mandate treatment. Soldiers may also self-refer for behavioral health evaluation without command's knowledge.

DIAGNOSIS

The Army behavioral health care system utilizes Behavioral Health Data Portal (BHDP), which is a comprehensive online database that collects a host of demographic and clinical data essential to making diagnosis and formulating a treatment plan (11). Evidence-based scales, such as the Patient Health Questionnaire–9, Generalized Anxiety Disorder–7, PTSD Checklist for DSM-5, Insomnia Severity Index, and several others, are employed to gather pertinent clinical data. Soldiers complete BHDP questionnaires at each visit, which over time results in a wealth of clinical data available for providers to use in their diagnostic and clinical decision-making process (11).

The fact that soldiers closely live and work together allows for more granular collateral information from a perspective that may otherwise be inaccessible in civilian practice. Whether soldiers are being evaluated in the emergency department, an inpatient ward, a clinic, or a deployed environment, providers have direct access to additional perspectives—not only from patients' supervisors but also from their coworkers, who are often their cohabitants as well. These avenues of collateral information allow providers to make more informed clinical diagnoses and treatment decisions.

TREATMENT

All branches of the armed forces use a single unified electronic medical record (EMR) system that is available worldwide—whether on a base in the United States or in a deployed overseas setting (12). Even when a soldier experiences frequent relocations around the globe, the unified EMR allows all behavioral health providers to have full access to the soldier's treatment history (12). This allows for seamless continuity of care and collaboration between providers, which may not always occur in civilian settings.

All soldiers are entitled to unlimited behavioral health services at no cost (13). This includes expensive treatments, such as electroconvulsive therapy, newly released psychotropic medications, and prolonged inpatient hospitalizations without utilization management pressures. The current standard for access to care is for all soldiers to be seen within 28 calendar days of a new referral. If care within that time frame is unavailable, soldiers are referred to nearby civilian clinics with full coverage of services. Walk-in hours are available for soldiers who may require a same-day appointment. All health-related appointments are regarded as the soldier's "place of duty," thus reducing occupational barriers to care. Under military law, supervisors must allow soldiers to attend all health-related appointments, and there is no limitation of sick day usage or loss of pay while on convalescent leave (14).

A behavioral health clinic is integrated into every deployable Army brigade, which typically consists of 4,000–5,000 soldiers. The clinic provides comprehensive behavioral health services, such as psychiatric evaluation, medication management, and individual and group psychotherapy, by a team of psychiatrists, psychologists, social workers, and behavioral health technicians (15). The clinic is physically located near soldiers' workplace, facilitating easy access to care. The close proximity of the clinic aims to normalize engaging with behavioral health care, but it could inadvertently create an obstacle to seeking care because of increased visibility. The integration of the behavioral health clinic allows for providers to track specific brigade issues, which enables providers to make more informed clinical decisions that consider all biopsychosocial aspects of soldiers' well-being (15).

Providers are able to make explicit biopsychosocial interventions by prescribing specific duty limitations that supervisors are legally obligated to support (14). Such interventions may include prescribing temporary alcohol abstinence, a minimum amount of sleep per night, or a period of convalescent leave to allow for optimal recovery.

Duty limitations can also be utilized to communicate safety plans to soldiers and their supervisors, particularly when soldiers are seen in the emergency room or discharged from the hospital (14). Providers may recommend that supervisors check in with their soldiers periodically or provide alternative housing options to more effectively meet a soldier's psychosocial needs.

Additional psychosocial recommendations may include temporarily withholding a soldier from deployment, restricting access to firearms, or relocating the soldier to another workplace. A no-contact order can be issued for cases of domestic violence or intense interpersonal conflict.

BEHAVIORAL HEALTH CARE FOR MILITARY FAMILIES

The influence of Army behavioral health care extends beyond the individual soldier into the wider ecology of the needs of the family as well. Family members have access to unlimited adult and child behavioral health services in both inpatient and outpatient settings with no out-of-pocket costs (13). Elementary schools on Army bases typically have embedded child behavioral health services, which offer medication management and psychotherapy during the school day (16).

Soldiers and their families have access to a spectrum of psychosocial services that provide additional support. The Family Advocacy Program (FAP) provides seminars, workshops, counseling, and interventions, with the overall mission of strengthening the cohesiveness of Army families (17). FAP is notably involved in intervening in cases of domestic abuse, child abuse, and neglect of family members by offering education, reporting, investigation, and prompt intervention. The New Parent Support Program serves families with

young children by arranging home visits by social workers, support groups, and parenting classes (18). The Department of Defense also facilitates Military One-Source, an employee assistance program available 24/7 that provides a wide range of individualized coaching and counseling services for all military personnel and their families (19).

DISCUSSION

Soldiers who sustain substantial impairment from their behavioral health conditions and are no longer able to fulfill their duty requirements receive a referral to the Medical Evaluation Board to be medically retired (20). Once medically retired, soldiers continue to receive care through the Department of Veterans Affairs (21). These soldiers receive a medical pension based on the diagnosis and severity of their behavioral health conditions, which aims to ensure adequate compensation.

CONCLUSIONS

United States Army behavioral health care introduces a wide range of assets across the biopsychosocial spectrum that enable soldiers to optimize their overall well-being in ways that are often unavailable to their civilian counterparts. Understanding of the assets that differentiate military from civilian behavioral health care may help to inform a framework for analogous initiatives to be implemented throughout the civilian sector.

Drs. Oh and Wolfgang are fourth-year residents, and Dr. Russin is a second-year resident, at Tripler Army Medical Center, Honolulu. Dr. Oh is a major, and Dr. Russin is a captain, in the U.S. Army. Dr. Wolfgang is a captain in the U.S. Army and guest editor for the military psychiatry section theme of this issue of the *Residents' Journal*.

The authors thank Drs. Millard Brown and Judy Kovell for their guidance and assistance with this article.

The views expressed in this article are those of the authors and do not necessarily reflect the official policy or position of the Department of the Army, Department of Defense, or the U.S. government.

KEY POINTS/CLINICAL PEARLS

- Military service introduces numerous factors across the entire biopsychosocial spectrum that are advantageous to the overall well-being of soldiers.
- The system of behavioral health care in the U.S. Army offers a broad range of services, resources, and interventions to its soldiers and families that are often unavailable to patients within civilian health systems.
- The distinguishing aspects of U.S. Army behavioral health care may help to inform a framework for analogous initiatives to be further explored and potentially implemented in civilian health systems.

REFERENCES

1. Mental Health Disorder Prevalence Among Active Duty Service Members in the Military Health System, Fiscal Years 2005–2016. Arlington, VA, US Department of Defense, Deployment Health Clinical Center, 2017. https://www.pdhealth.mil/sites/default/files/images/mental-health-disorder-prevalence-among-active-duty-service-members-508.pdf
2. Mental Illness. Bethesda, MD, National Institute of Mental Health, 2019. https://www.nimh.nih.gov/health/statistics/mental-illness.shtml
3. Kessler RC, Chiu WT, Demler O, et al: Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. Arch Gen Psychiatry 2005; 62:617–627
4. A Leader's Guide to Soldier Health and Fitness. Army Techniques Publication ATP 6-22.5. Washington, DC, Department of the Army, Feb 10, 2016
5. Reivich KJ, Seligman ME, McBride S: Master resilience training in the US Army. Am Psychol 2011; 66:25–34
6. Brusher EA: Combat and operational stress control; in Combat and Operational Behavioral Health. Edited by Ritchie EC. Fort Detrick, MD, Office of the Surgeon General of the Unites States Army, 2011
7. Periodic Health Assessment. DoD Instruction 6200.06. Washington, DC, Department of Defense, Sept 8, 2016
8. Ramirez-Wylie JA, Garrett A: New Behavioral Health Data Portal Launches Patient-Centered Care Effort at Fort Leonard Wood. Fort Meade, MD, Department of the Army, Dec 4, 2012. https://www.army.mil/article/92339/new_behavioral_health_data_portal_launches_patient_centered_care_effort_at_fort_leonard_wood
9. Mental Health Assessments for Service Members Deployed in Connection with a Contingency Operation. DoD Instruction 6490.12. Washington, DC, Department of Defense, Oct 2, 2013
10. Mental Health Evaluations of Members of the Military Services. DoD Instruction 6490.04. Washington, DC, Department of Defense, March 3, 2013
11. Randall TS: Command-Directed Mental Health Evaluations: A Simplified Process. The Army Lawyer, Jan 2017, pp 24–25
12. DoD Health Record Life Cycle Management. DoD Instruction 6040.45. Washington, DC, Department of Defense, April 11, 2017
13. TRICARE Prime. Falls Church, VA, Defense Health Agency, 2019. https://www.tricare.mil/Plans/HealthPlans/Prime
14. Medical Readiness. AR 40-502. Washington, DC, Department of the Army, Headquarters, June 27, 2019
15. Ovel S: Making Behavioral Health Care Easy. Falls Church, VA, Defense Health Agency, May 11, 2018. https://www.health.mil/News/Articles/2018/05/11/Making-behavioral-health-care-easy
16. Operations Manual: School Behavioral Health Programs. Falls Church, VA: Office of the Surgeon General of the United States Army, Child, Adolescent and Family Behavioral Health Office, 2011
17. Family Advocacy Program. DoD Instruction 6400.01. Washington, DC, Department of Defense, May 1, 2019
18. Collins EM: New Parent Support Program Helps Army Families Navigate Trials of Parenthood. Fort Meade, MD, Department of the Army, 2015. https://www.army.mil/article/154124/new_parent_support_program_helps_army_families_navigate_trials_of_parenthood
19. Counseling Services for DoD Military, Guard and Reserve, Certain Affiliated Personnel, and Their Family Members. DoD Instruction 6490.06. Washington, DC, Department of Defense, March 31, 2017
20. Disability Evaluation System. DoD Instruction 1332.18. Washington, DC, Department of Defense, May 17, 2018
21. Kudler H, Batres AR, Flora CM, et al: The continuum of care for new combat veterans and their families: a public health approach; in Combat and Operational Behavioral Health. Edited by Ritchie EC. Fort Detrick, MD, Office of the Surgeon General of the United States Army, 2011