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February 3, 2022

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Committee on Armed Services
United States Senate

The Honorable Adam Smith
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The Honorable Mike Rogers
Ranking Member
Committee on Armed Services
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Defense Health Care: DOD Expanded Telehealth for Mental Health Care during the COVID-19 Pandemic

The COVID-19 pandemic presented stressors for both members of the military services and military mental health providers. For some, these challenges were likely similar to those experienced in the civilian population—illness, financial challenges, and isolation. For others, the COVID-19 pandemic meant they were on the front lines of fighting the virus, such as treating patients diagnosed with COVID-19 in both civilian and military settings and supporting COVID-19 testing and vaccination efforts. These stressors may have affected servicemembers' mental health care needs during the COVID-19 pandemic.

As part of its mission, the Department of Defense's (DOD) Military Health System (MHS) provides a full range of medical care and services, including mental health care, to servicemembers and other eligible individuals. Within DOD, the Defense Health Agency (DHA) supports the delivery of military health care across MHS, which includes direct care provided at military treatment facilities (MTFs) and through the military's network of civilian healthcare providers.[1] Mental health care can include the treatment and management of conditions like anxiety and depression, among others, and a range of therapies such as medication and talk therapy.

[1]During the period of this audit, DHA was in the process of completing its legislatively mandated transition to begin management and administration of MTFs in the United States and around the world, which were traditionally administered by the individual military services.

The William M. (Mac) Thornberry National Defense Authorization Act for Fiscal Year 2021 includes a provision for GAO to review mental health care for servicemembers during the COVID-19 pandemic.[2] In this report, we describe

1) what DOD did to provide mental health care during the COVID-19 pandemic, and

2) the information DOD shared with mental health providers and servicemembers to help cope with the potential mental health impacts of the COVID-19 pandemic.

To describe what DOD did to provide mental health care during the COVID-19 pandemic, we reviewed DOD reports and briefing materials that addressed mental health care during the pandemic, from March 2020 through November 2021.[3] We also obtained and analyzed data from the DHA on the utilization of telehealth for mental health care services from January 2019 through April 2021, the most recent data available at the time of our review.[4] To assess the reliability of these data, we reviewed DOD documentation regarding the data source, interviewed knowledgeable agency officials about the quality of the data, and checked for obvious errors; we determined the data were sufficiently reliable for purposes of reporting telehealth utilization rates. We also examined DOD policies and guidance on the provision of telehealth, including documents that address the provision of mental health care via telehealth and DOD policies on mental health screening.

To describe the information DOD provided to mental health providers and servicemembers to help cope with the potential mental health impacts of the COVID-19 pandemic, we reviewed DOD's COVID-19 clinic guidance, materials from DOD research entities, and other related resources compiled by military service officials. For both objectives we interviewed officials from DHA, and from each of the military services—Army, Navy, Air Force, and the Marine Corps—as well as officials from the military reserves and the National Guard.[5] This report focuses on active duty servicemembers. In addition, we provide information on mental health care for reserve component servicemembers during the pandemic in enclosure I.

We conducted this performance audit from April 2021 through February 2022 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

[2]Pub. L. No. 116-283, § 736, 134 Stat. 3388, 3704-3705 (2021).

[3]For the purposes of this review, the start of the COVID-19 pandemic is based on the January 31, 2020, declaration of a public health emergency for the United States, retroactive to January 27, 2020.

[4]We analyzed data on total outpatient mental health encounters, or visits, provided in person or via telehealth by DOD providers at military treatment facilities and through the military's network of civilian health care providers.

[5]The military services also include Coast Guard and the newly created Space Force. Our scope for this report excludes Coast Guard, which is part of the Department of Homeland Security, and Space Force.

Background

Mental health care is provided by several types of health care workers, including therapists, clinical social workers, and psychologists. DOD makes a variety of mental health care services available to active duty servicemembers, ranging from outpatient services such as psychotherapy and medication management, to inpatient services such as acute psychiatric care. Mental health care can also be provided remotely through synchronous video or telephone communications, which DOD refers to as telehealth.[6] In addition to treating servicemembers who seek care, DOD and the military services are required to screen for mental health conditions to ensure military readiness. These screenings occur during servicemembers' annual health assessment and before, during, and after certain deployments.

Servicemember utilization of mental health care services has remained relatively stable in recent years. According to DOD, from fiscal years 2016 through 2020, active duty servicemembers' use of mental health care remained about the same, with around 3.1 million outpatient visits annually. Although utilization of mental health care services has remained stable, we and others have reported that perceived stigma continues to be a barrier to servicemembers seeking mental health care.[7] For example, in 2021 we reported that perceived stigma may discourage servicemembers from seeking help for themselves or for their colleagues.[8]

The mental health impacts of the COVID-19 pandemic on servicemembers (and the general population) may take time to fully understand. A survey fielded by Army Public Health between May and June of 2020 found that the rates of positive screens for generalized anxiety among Army servicemembers were similar to pre-COVID-19 rates.[9] However, a December 2020 internal DOD presentation noted that DOD's research on this topic continues, as there is not yet sufficient information to determine the potential mental health impacts of the COVID-19 pandemic on servicemembers.[10]

DOD Significantly Increased Its Use of Telehealth to Provide Mental Health Care during the COVID-19 Pandemic

DOD significantly increased its use of telehealth to provide mental health care to servicemembers during the COVID-19 pandemic, beginning in March 2020. According to DOD

[6]Asynchronous care—the transmission of information in one direction at a time via electronic communication—is rarely used by DOD to provide mental health care, according to DHA. An example of asynchronous mental health care is the exchange of emails about a condition between a patient and a provider.

[7]See GAO, *Defense Health Care: DOD Needs to Fully Assess Its Non-clinical Suicide Prevention Efforts and Address Any Impediments to Effectiveness,* GAO-21-300, (Washington, D.C.: Apr. 26, 2021); GAO, *Human Capital: Additional Actions Needed to Enhance DOD's Efforts to Address Mental Health Care Stigma*, GAO-16-404 (Washington, D.C.: Apr. 18, 2016); and Joie D. Acosta et al., *Mental Health Stigma in the Military* (Santa Monica, Calif.: RAND Corporation, 2014).

[8]GAO-21-300.

[9]Walter Reed Army Institute of Research, Center for Military Psychiatry and Neuroscience and U.S. Army Public Health Center Behavioral and Social Health Outcomes Program & Public Health Assessment Division, *Behavioral Health Advisory Team – COVID-19 Survey Phase I Findings*, Technical Report No. S.0079120-20 (November 2020).

[10]Army Public Health fielded a second phase of this survey in the spring of 2021. Army officials told us that a report covering the spring 2021 survey and additional efforts is expected to be completed during late spring 2022.

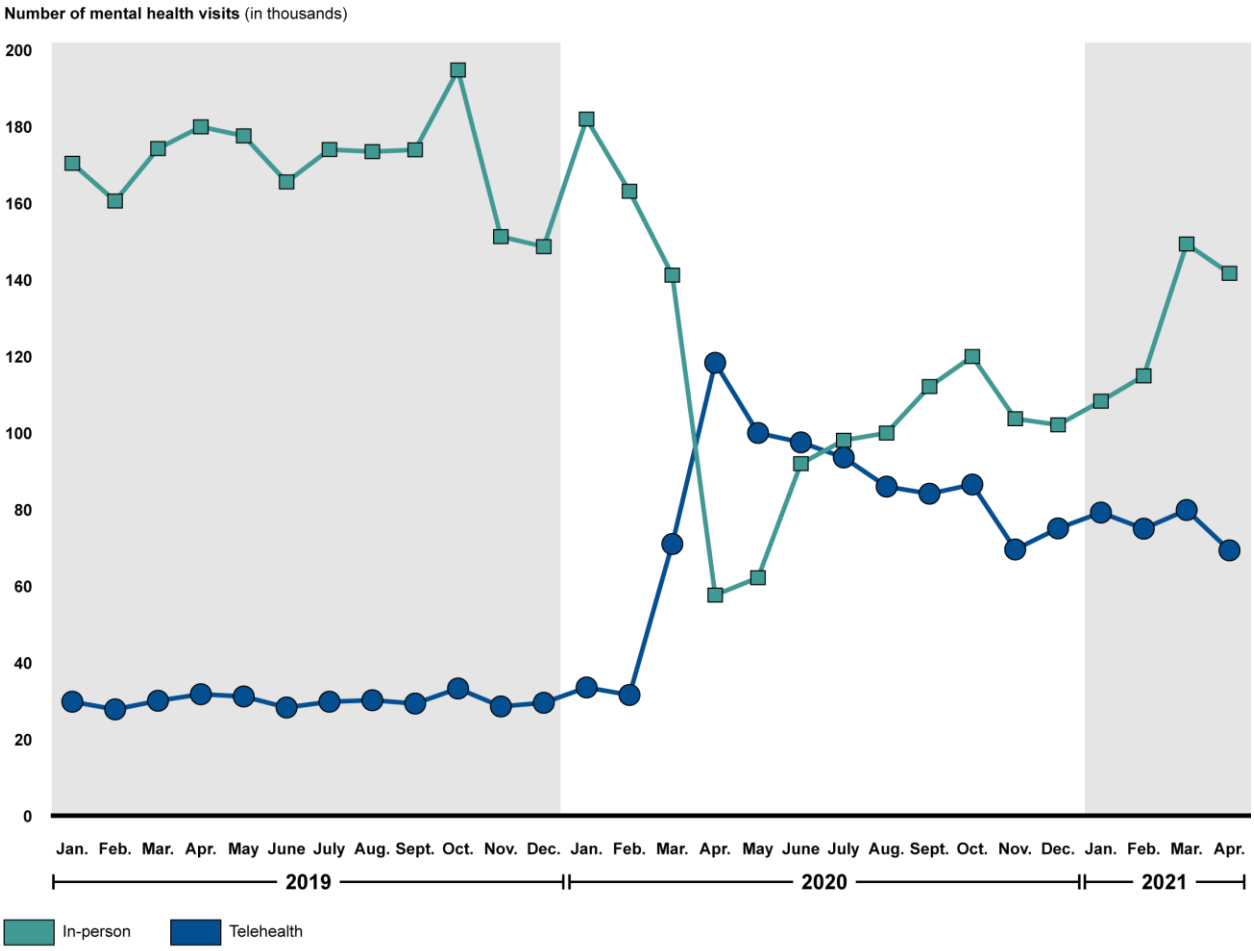
documents, DOD made changes to its telehealth guidance to provide enhanced access to mental health care services during the early months of the COVID-19 pandemic when MTFs limited in-person appointments to slow the spread of COVID-19. Military service officials also told us that telehealth has been valuable, and that despite some of the challenges providing care through telehealth presented, they would likely continue its use once the pandemic recedes.

Prior to the pandemic, telehealth visits represented about 15 percent of total outpatient mental health care visits from January 2019 through February 2020, DHA data show. These data also show that the number of telehealth visits for outpatient mental health care increased 275 percent from February 2020 to its peak in April 2020, rising from 31,504 visits in February to 118,246 visits in April (see fig. 1).[11] This increase in telehealth visits came as DOD shifted its delivery of outpatient mental health care from in-person visits to telehealth; DHA data show in-person outpatient mental health care simultaneously decreased from 163,039 visits in February 2020 to 57,593 visits in April 2020.[12] While the utilization of outpatient mental health care DOD provided through telehealth decreased following its peak in April 2020, it remained above pre-pandemic levels, accounting for 33 percent of all outpatient mental health care visits provided in April 2021.

[11]We analyzed data on total outpatient mental health encounters, or visits, provided in person or via telehealth by DOD providers at military treatment facilities and through the military's network of civilian health care providers.

[12]This trend was not unique to the military. For example, a January 2021 study found that of the general population, between mid-March and early May 2020, telehealth was used by over 50 percent of those with a mental health condition. See: S.H. Fischer, L. Uscher-Pines, E. Roth, and J. Breslau, "The Transition to Telehealth during the First Months of the COVID-19 Pandemic: Evidence from a National Sample of Patients," *Journal of General Internal Medicine*, vol. 36, no.3 (2021): 849-51.

Figure 1: In-Person and Telehealth Outpatient Mental Health Visits for Active Duty Servicemembers, 2019-April 2021



Source: GAO analysis of Department of Defense data. | GAO-22-105149

Notes: We analyzed data on total outpatient mental health encounters, or visits, provided in person or via telehealth by Department of Defense providers at military treatment facilities and through the military's network of civilian health care providers. Telehealth is care provided remotely through synchronous video and telephone communication. Telehealth can also be provided asynchronously—the transmission of information in one direction at a time via electronic communication—but asynchronous telehealth is infrequently utilized to provide mental health care, according to Defense Health Agency officials. This figure shows active duty servicemembers' utilization of outpatient mental health visits where one of the primary diagnoses was related to mental health care, including, for example, the treatment and management of conditions such as anxiety and mood disorders. This figure excludes substance use disorders such as those related to alcohol.

To support increased use of telehealth in response to the pandemic, DHA released guidance to the military services on March 27, 2020, which allowed providers to use commonly available programs such as Apple FaceTime and Microsoft Skype to provide telehealth services.[13] This

[13]Specifically, DHA's March 27, 2021 guidance allowed the optional use of three non-public facing everyday communication applications—Apple FaceTime, Google Duo, and Microsoft Skype—across the MHS to supplement DHA's existing telehealth capabilities, which included voice communication and network video applications.

DHA's guidance was based on a Department of Health and Human Services (HHS) announcement that went into effect on March 17, 2020. The announcement provided that HHS would not impose penalties for noncompliance with certain Health Insurance Portability and Accountability Act (HIPAA) regulatory requirements in connection with the good faith provision of telehealth during the COVID-19 public health emergency. 85 Fed. Reg. 22,024 (Apr. 21, 2020). Subsequent guidance from DHA also allowed the use of Microsoft Teams.

guidance also allowed providers to use their personal devices to provide telehealth services to their clients. Officials we spoke to from the Navy and Air Force told us that this guidance was instrumental in allowing for care to be conducted virtually via telehealth.

DOD officials described the following benefits associated with expanded telehealth services for mental health care.

Bolstering access and continuity of care. DOD officials told us that telehealth was a valuable tool in providing mental health care during the COVID-19 pandemic, with some officials noting its use will likely continue after the pandemic recedes. For example, a Navy official noted that the quick rollout of telehealth for mental health care ensured that people could still be evaluated and treated during the pandemic. In addition, an Air Force official described how the ability to provide telehealth by remote providers helped offset staffing shortages the Air Force faced in its smaller, more rural MTFs. An official from the Marine Corps also noted that the Marine Corps is looking for ways to maximize telehealth across health services and MTFs, and that telehealth is now a routine way for the Marine Corps to deliver mental health care.

Reducing perceived stigma. Officials also described the value of telehealth in mitigating the stigma of seeking mental health care. For example, a Marine Corps official told us that by logging on to a telehealth appointment from their barracks, servicemembers could reduce the fear they may have about running into somebody they know in a clinic waiting room. As a result, telehealth may greatly reduce servicemember concerns about confidentiality. Similarly, a DHA official told us that in the past, servicemembers waiting for mental health care appointments in the clinic waiting room of a MTF were required to be in uniform—uniforms may include information that is identifiable such as a servicemember's name, rank, and service branch. This official noted that receiving care through telehealth gave servicemembers confidentiality and eliminated the concern of being seen waiting for mental health care services.

Military service officials also explained that the use of telehealth for mental health care presented challenges. For instance, telehealth may not be the appropriate modality to deliver certain types of mental health care services. Navy and DHA officials described the difficulty of conducting group therapy sessions via telehealth. For example, while a provider could ensure privacy for participants in an in-person group therapy session by locking the door and limiting entry, an official noted that a group therapy session conducted via telehealth raises concerns about group confidentiality and may require additional provider training on how to lock down the virtual room to ensure privacy for participants. In addition, Army and Marine Corps officials noted that outdated computer systems and web camera equipment made providing care via telehealth difficult for some mental health providers.

Officials also told us that telehealth may not be appropriate for patients with high-risk diagnoses or for those experiencing acute symptoms. For example, a Marine Corps official and provider told us that if they are seeing a patient with suicidal thoughts, they prefer to deliver treatment to that patient face-to-face. Another provider noted that if the option was to provide care to a high-risk patient via telehealth or not at all, a telehealth session would be that provider's preference. When delivering mental health care via telehealth, one official told us that additional planning is required for the visit to ensure the safety of the patient. For example, the provider needs to obtain the patient's location and contact information during the appointment in the event the patient disconnects from the telehealth visit. If the provider cannot reach the patient and has concerns about the patient's wellbeing, then the provider can arrange for a welfare check by local authorities.

DOD Shared Information on Coping with the Mental Health Impacts of the COVID-19 Pandemic with Providers and Servicemembers

Our review of DOD documents and interviews with department officials found that DOD shared information on coping with the mental health impacts of the COVID-19 pandemic with mental health providers and servicemembers. This included information on providing care via telehealth and tip sheets for providers, resources for servicemembers on topics like stress reduction and wellness promotion, and information provided by DOD research entities.

Information for Mental Health Providers

Starting in the first few months of the pandemic (March through May 2020), DOD shared information with mental health providers to help cope with the potential mental health impacts of the COVID-19 pandemic, including resources intended to help prevent provider burnout, information on providing care via telehealth, and information regarding mental health clinic management during the COVID-19 pandemic.[14] DOD officials told us this information was disseminated in a variety of ways, including through posting resources online, hosting expert speakers in meetings, and emailing newsletters.

Military service officials described resources intended to promote wellness among mental health providers and help prevent burnout. For example, a Navy official described how leadership at one MTF brought in speakers to talk about how mental health providers could manage stress during the pandemic. The official said the Navy provided this support because mental health providers were struggling during the pandemic like the rest of the population. An Army official noted that the Army created and disseminated newsletters to mental health providers through regional leadership. Examples of items included in these newsletters include links to an informational paper on how providers can mitigate family violence, a sleep checklist developed by the Walter Reed Army Institute of Research for health care providers during the pandemic, and American Psychological Association tip sheets on how to support employee mental health.

DOD also shared information with providers to help them adapt to providing mental health care via telehealth during the COVID-19 pandemic. Military service officials we spoke with noted that many mental health providers had not used telehealth to deliver mental health care prior to the pandemic, and told us that there were online trainings on how to provide health care via telehealth. Another military service official noted that providers have also used online resources from the American Psychological Association and the National Association for Social Workers on providing mental health care through telehealth. This official noted that the telehealth trainings included information on technical aspects like lighting and sound, administrative requirements like obtaining accurate contact information in case of an emergency or technical issue, and privacy considerations like dissuading a patient from conducting a telehealth visit in public. DOD also created a guide to help providers adapt to delivering care in the pandemic environment.[15] While this guide is not specific to mental health care, it includes a section on

[14]GAO did not assess the effectiveness of DOD resources in addressing potential mental health risk factors.

[15]DOD noted that this document was designed to provide information and did not supersede DOD policy. Department of Defense, Defense Health Agency, *DOD COVID-19 Practice Management Guide: Clinical Management of COVID-19* (Falls Church, Va.: June 18, 2020).

mental health; for example, it notes that providers should use telehealth tools as much as possible when caring for isolated patients.

Information for Servicemembers

DOD officials noted that they shared information with servicemembers to help cope with the potential mental health impacts of the COVID-19 pandemic, including adapting existing resilience efforts for the pandemic environment and sharing relevant DOD research.

DOD officials told us that some existing resources for servicemembers had been refocused to address the potential mental health impacts of the COVID-19 pandemic. For example, an Air Force official described how a tip sheet for servicemembers was revised to focus on COVID-19 related mental health topics. This resource addressed self-care topics like ensuring servicemembers get good quality sleep and providing alternatives to stress relief other than drinking alcohol. DOD officials also described resources intended to help prevent worsening of existing stressors and mental health conditions, such as information on fitness and wellness programs tailored to the COVID-19 pandemic and non-medical counseling offered through Military OneSource.[16]

DOD research entities also provided a range of information intended for a broader DOD and military service audience. Examples of these entities and their resources include the following:

- Uniformed Services Center for the Study of Traumatic Stress, which offers a range of public resources for healthcare workers, leaders, and families on topics including stress management in mortuary affairs operations and how healthcare providers can help patients concerned about COVID-19.
- DHA's Psychological Health Center of Excellence "Clinician's Corner" blog, which includes posts on topics like offering support and compassion for COVID-19 positive colleagues, coping with separation from family and friends during the pandemic, and connecting to psychological health care resources during the pandemic.
- The Walter Reed Army Institute of Research, which has a public facing website with behavioral health resources, including fatigue management and sleep checklists.

Agency Comments

We provided a draft of this report to DOD for review and comment. DOD concurred with the draft report and had no comments.

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We are sending copies of this report to the appropriate congressional committees and the Secretary of Defense. In addition, the report will be available at no charge on the GAO website at http://www.gao.gov.

[16]Military OneSource is a resource DOD provides to servicemembers and their families and offers a range of services including non-medical counseling and health coaching. Military OneSource's non-medical counseling is offered in-person, on the phone, through online chat, or via video, and can address issues like parenting, marital problems, grief and loss, and financial concerns, according to the Military OneSource website.

If you or your staff members have any questions about this report, please contact me at (202) 512-7114 or HundrupA@gao.gov. Contact points for our offices of Congressional Relations and Public Affairs may be found on the last page of this report. In addition to the contact named above, Ann Tynan (Assistant Director), Luke Baron (Analyst-in-Charge), and Elaina Stephenson made key contributions to this report. Also contributing were Jacquelyn Hamilton, Vikki Porter, and Cathy Hamann Whitmore.

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Enclosures – 1

Enclosure I: Reserve Servicemembers and Mental Health during the COVID-19 Pandemic

The military reserve component comprises the Army Reserve, the Navy Reserve, the Air Force Reserve, the Marine Corps Reserve, the Army National Guard, and the Air National Guard. Reserve component members typically spend most of their time as civilians, with training requirements that vary by the Reserve component and type. They can be activated for service overseas and domestically and may serve in armed conflicts or respond to emergencies like natural disasters and the COVID-19 pandemic. The Army, Navy, Air Force, and Marine Corps Reserves are exclusively federal organizations, and are governed by their respective military services. National Guard units are managed in part by their respective state's Adjutant General and governor, and can be activated for both state and federal missions.[1]

Health Care Coverage and Access for Reserve Component

Generally, when activated for federal duty for more than 30 days, reserve component members can access the Military Health System (MHS), including receiving care at military treatment facilities (MTFs) and through the military's network of civilian healthcare providers.[2] Non-activated reserve members can purchase health care coverage through TRICARE Reserve Select, a premium-based Department of Defense (DOD) healthcare benefit, if they meet certain eligibility criteria.[3] Some reserve members may also have insurance through their employer.[4]

While the Reserve components employ mental health providers, the role of these providers is primarily to conduct mental health assessments of reserve members and provide referrals for mental health services in the reserve member's community when needed. Such referral services are provided to reserve members by the psychological health programs for each of the military services in the reserve component. A reserve component official told us that the military services generally do not provide mental health care treatment directly to reserve members when members are not activated–the focus on referrals rather than treatment was also noted in reserve component documents.[5]

[1]An Adjutant General is appointed by the governor of each state; the duties of the Adjutant General are laid out in each state's statutes. The Adjutant General is typically the senior officer of the National Guard unit of the state. For the District of Columbia, this officer is referred to as the Commanding General.

[2]Under DOD's TRICARE program, eligible beneficiaries can obtain health care, including mental health care services, through the department's direct care system of MTFs or through its private sector care system of civilian providers.

[3]National Guard personnel health eligibility is based on their military status as defined in Title 10 of the United States Code. Members of the National Guard on state activations receive state benefits, which may differ from federal benefits.

[4]A 2021 RAND report based on 2018 DOD survey data found that around 8 percent of reserve members did not have health insurance. Sarah O. Meadows, et al., *2018 Department of Defense Health Related Behaviors Survey (HRBS): Results for the Reserve Component* (Santa Monica, Calif.: RAND Corporation, 2021).

[5]If a reserve component member incurs or aggravates an injury, illness, or disease, including mental health conditions, in the line of duty (performing active duty or inactive duty training, at a drill weekend, or in other training while on orders), they may be eligible for health care, referred to as Line of Duty Care. Assuming a line of duty determination is made, this would allow a reserve component member to receive care through the MHS while in reserve status.

The Reserve Component Role in the COVID-19 Pandemic and Impacts on Mental Health

Reserve component servicemembers played a role in responding to the COVID-19 pandemic and served in various capacities, with Reserve and National Guard personnel providing medical care and logistical support related to the COVID-19 pandemic. For example, Army and Air Force Reserves deployed personnel to COVID-19 hotspots to assist civilian and military medical personnel providing medical care to patients with COVID-19, and National Guard members supported COVID-19 testing and vaccination efforts, provided medical care, and conducted mortuary affairs missions.

Reserve component officials told us that some COVID-19 activations were challenging for their members and may have resulted in additional stress. For example:

- Officials told us that early on in the pandemic in 2020, National Guard members on a mortuary affairs mission in New York retrieved the bodies of people who had died in their homes. An official told us this was challenging both because of the nature of the work, and because some Guard members assigned to these duties were not trained in mortuary affairs. For example, an official described a deployment in which finance specialists were assigned to assist in body retrievals; the official noted that the National Guard did not train or prepare the finance specialists to carry out these duties prior to deployment.

- Additionally, an official noted that some Guard members had their activations extended from 30 days to 90 days, which caused additional stress for some members and their families.

Reserve officials also described efforts to address reserve component members' mental health during the COVID-19 pandemic. For example, National Guard officials told us that around March of 2020 they started weekly meetings with the National Guard Directors of Psychological Health at the state level to discuss COVID-19 related messaging and topics, which officials told us they held regularly for about a year. They also noted that they sent out newsletters with information on resilience—for example, officials said one newsletter promoted a guide describing resources on preventing substance abuse, improving social connectedness, and other topics. Other officials described adaptations to existing reserve mental health resources. For example, a Navy Reserve official noted that staff from the Navy's Psychological Health Outreach Program who previously checked in with Navy Reserve members in person during drill weekends had transitioned to doing those check-ins remotely by phone.

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