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Measuring the Effectiveness of Navy Embedded Mental Health: Supporting Warfighting Readiness

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Introduction

This commentary is based on the author's chapter entitled "The Future of Embedded Mental/Behavioral Health in the Military" in the recently published book Embedded Behavioral Health in the Military: A Guide for Behavioral Health Officers and Leaders. This commentary expands on the book chapter's discussion of the value and effectiveness of embedded mental health (EMH). In this commentary, the author presents reasons why the ultimate measure of effectiveness of EMH is to return Service members to duty in direct support of the warfighting readiness mission. The author discusses how this is accomplished in the United States Naval Surface Forces.

Measuring the Value and Effectiveness of EMH

Embedded mental health origins: Preserving the fighting force

It appears reasonable that an appropriate starting point for a discussion of the measure of effectiveness of embedded mental health (EMH) should begin with the origin of this practice. The embedding of mental health providers with/near deployed units dates to World War I and the development of the proximity, immediacy, expectancy, and simplicity (PIES) model [1]. The PIES model was developed for treating psychological casualties (e.g., "shell shock", "war neurosis") as close to the front lines as possible (proximity), as soon as possible (immediacy), with the underlying conveyed expectation that the Servicemember would get better with simple interventions (e.g., consistent sleep, hot food, and brief respite). The PIES model, sometimes referred to as "forward psychiatry" or "combat psychiatry" [2] gained success in returning Service members back to duty, thereby preserving the fighting force.

The principles of combat/forward psychiatry have been used in military conflicts in the decades following development of the PIES model in World War I. These principles have been employed by mental health providers in World War II, the Vietnam War, and the Korean War [2].

Contemporary Embedded Mental Health

The modern emphasis on embedded mental health providers in/with operational military units began in early part of this century. Following the Department of Defense (DOD) Task Force on Mental Health Report in 2006 that recommended to "embed mental health professionals as organic assets in line units," [3] the military services have been rapidly expanding the number of mental health jobs/billets directly attached or assigned to specific operational units. For example, in 2009 the Army stood up an Embedded Behavioral Health Team at Fort Carson, Colorado assigned to specific brigade-sized elements [4]. In 2012, the Air Force began assigning mental health and other specialists to special operations units under the Preservation of the Force and Family initiative [5]. The Navy's modern foray into embedding mental health providers in operational units started in the late 1990s with the placement of clinical psychologists on aircraft carriers [6]. Due to the success of these Navy psychologists in decreasing medical evacuations during deployment, there has been an increasing interest by operational commanders in having their own embedded/assigned mental health providers. As a result, the percentage of embedded mental health billets in the Navy and Marine Corps is now 45% of all mental health officer billets, and 40% of all enlisted Behavioral Health Technician (BHT) billets [7].

Treating disease, illness, and injury with the objective of returning Service members to full duty status is the inherent mission of all Military Health System (MHS) providers. However, this mission takes on even more significance in combat/warfighting and is the fundamental tenet for having uniformed providers in the first place. The fundamental purpose of uniformed healthcare professionals is to deploy with operational units, to include deploying to/near the front lines of battle, with the explicit mission of treating injured service members and returning them to battle. If this were not the case, then the MHS could simply be comprised of an entirely civilian healthcare force.

The fact that Navy and Marine Corps line leaders continue to ask and pay for their own embedded mental health (EMH) providers is a testament of the value of their services (note: most Navy mental health officer billets are funded through the Navy Bureau of Medicine & Surgery using Defense Health Program/DHP funds; whereas EMH billets are funded by operational communities using Operations and Maintenance/O&M funds). Nearly every Navy and Marine Corps operational community that has added EMH has testified how much they appreciate and value the support that EMH provides in taking care of their Sailors or Marines as well as the subject matter expertise provided to operational leaders [8].

Many of the metrics measuring the success of EMH have been related to cost savings such as reducing the number of psychological casualties and early returns from deployments (e.g., medical evacuations that are historically the highest for orthopedic injuries and mental health), as well as reductions in unplanned losses for mental health reasons [9]. EMH also purports to offer better/sooner access to care than most military treatment facilities (MTFs), with many EMH programs reporting an average of only 1-2 weeks for an initial intake evaluation, compared to an average of 4 weeks at most MTFs [10]. While timely access to care is a traditional metric used in MTFs, it is something that line leaders and Service members continue to value. This is reflected in the fact that most of the relatively rare negative feedback about EMH is related to poor access to care/longer, than expected wait times for a mental health appointment.

Although these measures of effectiveness are important and valued, there is still no consensus on the most appropriate measure of effectiveness of embedded mental health [11]. An argument can be made that operational commander satisfaction with EMH is the ultimate reflection of success. However, given the increasingly fiscally constrained environment within the DoD, there has been a push by senior Navy officers for more objective measures of the return on investment of EMH [11,12]. In addition, the value of a resource should go beyond mere satisfaction. There needs to be evidence of tangible results of that resource.

Return to Duty Rate as Core Metric of EMH Effectiveness

Return to duty (RTD) rates are often calculated and reported as a measure of the success of individual mental health providers [13]. This fact supports RTD being a core metric that should be measured in all embedded mental health (EMH) billets. Return to duty rates are most often calculated as a ratio of the total number of Service members evaluated and treated (denominator) in a given time period (usually monthly), minus those that were treated and unable to be returned to full duty (numerator). There are many reasons a Service member may be unable to return to duty that are not related to poor mental health provider clinical skills or ineffective treatment. Most unplanned losses due to mental health reasons result from Service members who have mental health conditions that are incompatible with military service. Most of these conditions consist of adjustment disorders (where the stressor is the military itself) or personality disorders (that existed prior to entering the military) that impair the Service member's ability to do their job [13]. In the case of adjustment disorders, because the stressor that causes the distress is often military service, symptoms are unlikely to remit for as long as the Service member remains in the service. In these cases, the most effective intervention is removal from the Service. This is accomplished by the EMH provider recommending to the Service member's commanding officer to administratively separate (ADSEP) the Service member for the Condition Not Constituting a Physical Disability [14]. A CND ADSEP would be considered an unplanned loss and decreases an EMH provider's RTD rate.

Administrative separation runs contrary to the overall objective of returning Service members to duty and maintaining a high return to duty (RTD) rate [13]. For that reason, in pursuit of maintaining a high return to duty some embedded mental health (EMH) providers may feel pressured to not recommend administrative separation when a Service member clearly demonstrates impairment despite an appropriate trial of treatment. This author has seen cases where during an EMH provider's reluctance to recommend separation a Service member further deteriorates in their operational environment. An example is a Service member with borderline personality disorder whose distress worsens, causing an escalation of self-harm behaviors, including suicide-related behaviors, to the point of requiring psychiatric hospitalization(s). In contrast, some EMH providers are frustrated when they appropriately recommended separation for these impaired Service members, but the commanding officer refuses to separate that Service member out of concern for maintaining their unit's manning/staffing. In these situations, EMH providers and unit commanding officers should be reminded that although their manning and return to duty rates will decrease in the short term, unit readiness will be restored in due time when the unit obtains a new Service member who is fit for fully duty. Thus, these types of

mental health cases and recommendations for administrative separation can be viewed as a "good catch" [13]. Many of these Service members also require extraordinary demands on the time and attention of their leaders and otherwise take away leaders' time from other activities focused on maintaining their unit's readiness. Therefore, the sooner EMH providers identify these Service members whose mental health conditions are incompatible with military Service and remove them from Service, the better the overall readiness of the unit.

There is no consensus in the Navy mental health community on what constitutes an acceptable return to duty rate, or what the average rate is across the Navy or Marine Corps, or within each operational community/unit [13]. The reason for this lack of consensus is because these rates have not been consistently tracked and reported. However, it might also be because some embedded mental health providers are wary of having their return to duty scrutinized, perhaps being anxious that having a lower rate may be perceived as a reflection of poor clinical skills. However, for the Navy to move forward return to duty rates need to be consistently tracked to establish a baseline/average across the Navy enterprise. Once a baseline is established for each unit, operational community, or provider, deviations from this average would provide more meaningful insight as well as opportunities for action. For example, this data could be used to follow-up on why a particular operational unit or EMH provider has a lower rate than other similar units or other similar EMH providers. This surveillance might reveal different levels of risk from individual operational commanders or with individual EMH providers that could be followed up with additional training or education to help move return to duty rates towards the mean/baseline. This is just one example of how this metric might be used to not only measure the success of EMH but also used in an actionable way to influence command decision-making and individual provider practice patterns aimed towards improving overall mission readiness.

EMH in Support of Warfighting Readiness

Finally, the most important reason for using return to duty rates as a core metric and measure of the effectiveness of embedded mental health (EMH) is because it directly impacts unit manning and readiness, which affects overall warfighting capability. Recently U.S. military forces have been engaged in kinetic operations in the Middle East, to include Naval Surface Force ships shooting down anti-ship missiles and unmanned drones launched by Houthi rebels in Yemen. Although these combat engagements have been the primary focus of our Naval forces, Navy leadership has kept a larger and more enduring focus on China's significant expansion of their Navy and their Navy's increasing presence and confrontation in the South China Sea, a strategic waterway for a large portion of global economic trade. More specifically the focus in the DoD has been Chinese President Xi's direction to his military to be ready to take back Taiwan by force by 2027. As a result of this time-based threat, the 33rd Chief of Naval Operations (CNO) Admiral Lisa Franchetti recently set a goal for 80 percent of all Navy warfighting assets (e.g., ships, aircraft, submarines) to be combat surge ready (CSR), meaning at least 80 percent of our naval forces need to be minimally ready to deploy on a moment's notice in support of potential combat operations [15]. Some key barriers to achieving this goal include ship building and ship maintenance delays, broken equipment and delays in obtaining repair parts, as well as shortfalls in training and certifications.

However, in addition to these materiel barriers, another critical barrier to achieving these combat readiness goals is manning shortfalls. The Navy is currently short of almost 22,000 Sailors for sea duty assignments [16]. Approximately 7,000 of these manning gaps at sea are on Naval Surface Forces ships [17]. Part of the reason for these critical operational manning gaps is because of the poor recruitment of new Sailors into the Navy. As publicized in national news, the Navy has fallen short on recruiting goals by tens of thousands of Sailors in recent years [18].

However, Service members who do not complete their enlistment contracts/obligated service also contribute to manning shortfalls. These permanent losses are sometimes referred to as unplanned losses, which includes Service members medically separated or retired via the Disability Evaluation System (DES) as well as members administratively separated for Conditions Not amounting to a Disability (CND) as discussed previously. In fact, these medical/mental health losses are the number one reason enlisted Navy Sailors fail to complete their military contract [19]. Unplanned losses due to medical separation/disability (i.e., DES cases) mostly include medical illnesses and mental health disorders that are chronic and generally permanently disabling. These chronic and disabling illnesses/disorders are mostly unavoidable and though "unplanned" are relatively stable in frequency over time. CND administrative separations (ADSEPs) on the other hand have fluctuated in frequency over time [19]. Navy policy includes two types of CND ADSEPs: member-initiated (i.e., voluntary) and command-initiated (i.e., involuntary). In addition to the overall number of CND ADSEPs for mental health increasing in recent years [20], the percentage of member-initiated CND ADSEPs has increased [19]. Despite this author's assertion above that CND ADSEPs amount to a "good catch," these unplanned losses nonetheless contribute to manning shortfalls, which in turn directly impacts unit readiness. CNO Franchetti has asserted in relation to her 80% combat surge ready goal, the Navy needs to "put more players on the field" [21]. Mental health CND ADSEPs directly remove players from the field. For this reason, mental health providers, and EMH providers specifically, contribute towards this warfighting readiness imperative.

Naval Surface Forces EMH 'North Star': Return to Duty

As the Force Mental Health Officer for Naval Surface Force, U.S. Pacific Fleet (SURFPAC), and the author has promulgated to all SURFPAC embedded mental health (EMH) providers, the overarching objective (i.e., our 'North Star') of SURFPAC EMH is keeping and returning our Sailors to full duty status. To accomplish this objective, SURFPAC EMH has established a rigorous process. The process starts with a thorough mental health evaluation of each Sailor referred to EMH, and a conservative preliminary mental health diagnosis. The most critical part of the process involves obtaining collateral information from the Sailor's chain of command to validate occupational impairment and overall functioning. This written collateral information includes information related to the Sailor's job performance, any misconduct or disciplinary issues, leaders' assessment of the Sailor's safety to go underway/deploy, as well as any interventions or resources the Sailor's command has provided. This important collateral information combined with each SURFPAC EMH provider's knowledge of Naval Surface Forces culture is what allows the EMH provider to make more informed conclusions and recommendations to the Sailor's Commanding Officer.

The SURFPAC EMH process also includes each EMH provider taking their time over several sessions to refine their diagnosis (es), as well as allowing time for a trial of treatment for each Sailor before making any type of potentially career ending duty disposition such as recommending Condition Not amounting to a Disability (CND) administrative separation (ADSEP) (see discussion above) or referring the Sailor to the Disability Evaluation System (DES). SURFPAC EMH providers are also encouraged to employ their entire repertoire of skills to help keep/return Sailors to duty including such as interventions as Motivational Interviewing [22] and Single Session Therapy [23]. This rigorous process differs from the traditional process employed by Military Treatment Facility (MTF) mental health providers who do not have the time or opportunity to obtain detailed collateral information from a Sailor's command and therefore are mostly limited to the patient's self-report in making their duty disposition decisions. This rigorous process also ensures that patients have been thoroughly evaluated, given an appropriate trial of treatment, and objective evidence has been obtained of occupational impairment (the primary criteria for CND ADSEP or DES referral) prior to any potential career ending recommendation such as ADSEP or DES referral.

To further ensure the appropriateness of each of these critical disposition recommendations, the author in his role as the SURFPAC Force Psychologist reviews every EMH provider's disposition recommendation. As a result of this rigorous process, SURFPAC EMH has maintained an almost 90% RTD rate in the past three years, and in turn, we are doing our best to keep "more players on the field" in direct support of the warfighting mission of Naval Surface Forces.

Conclusions and Future Directions

By many standards (e.g., operational commander satisfaction, improved access to care, decreased medical evacuations from deployment) Navy embed mental health (EMH) has been a success. Despite these successes, because of the increasingly resourced constrained military budget, it will be important to objectively measure the value and effectiveness of EMH. Because the Navy is a warfighting organization/profession and warfighting requires warfighters, the mission of EMH must be to 'preserve the fighting force.' In this commentary the author has made the argument that the primary measure of the value and effectiveness of Navy EMH is to "put more players on the field" by keeping or returning Sailors to full duty status, which is most directly measured by Return to Duty rate.

Not all Navy mental health providers agree that return to duty rate is the ultimate measure of effectiveness of embedded mental health. The primary counter argument is that although Navy mental health contributes to unplanned losses via recommendations for administrative separation (ADSEP) of Service members, these unplanned losses are unavoidable because the Navy will always have Service members with pre-existing mental health conditions such as personality disorders or who lack the necessary resilience skills to sufficiently adapt to the rigors of military service. Some would argue using CNO Franchetti's mandate language that these Service members are "not the right players to be put on the field." Nonetheless, the reason active-duty mental health providers wear the uniform and are considered a critical wartime specialty is to support the warfighting mission by helping Sailors do their job and effectively treat those who struggle. To that end EMH, providers must employ every clinical skill, every ounce of care and compassion, and every tool at their disposal in support of this mission. That is the ultimate mission and purpose of embedded mental health.

Future research should include a systematic assessment of return to duty rates of various operational units to establish a baseline for further analysis. Future research might also include formal surveys of operational leaders to validate that returning Service members to duty is the primary value of embedded mental health that the author has argued in this article. Future research should also evaluate to what extent prevention and early education, another important duty of embedded providers, contributes to reducing unplanned losses. Fortunately, the RAND National Defense Research Institute recently initiated a large-scale study to better understand the role of embedded mental health in overall mental health care across the Military Health System, to include the benefits and risks of embedded mental health [24].

Disclaimer

The views expressed in this article are those of the author and do not reflect official policy of the Department of Defense,

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