A PROGRAM OF

ASSOCIATION OF DEFENSE COMMUNITIES | BLUE STAR FAMILIES

COVID-19 MILITARY SUPPORT INITIATIVE

PRESENTED BY

Booz | Allen | Hamilton

Pain Points Poll Deep Dive:

UNDERSTANDING THE IMPACT OF COVID-19 ON MENTAL HEALTH

People are experiencing high levels of mental distress due to the fear, anxiety, grief, and loss brought by both the coronavirus itself and the attempts to slow the spread through social distancing and closures. This has prompted organizations like the United Nations to issue policy briefs recommending immediate action from governments to support their citizens' mental health. Several experts predict the pandemic may cause long-term challenges for children, including potential traumatic responses. This may also cause setbacks for children with existing behavioral or mental health challenges. Children may also be experiencing isolation, loneliness, anxiety, and irritability, particularly as the stay-home orders and school closures prevented them from connecting with their social supports—their friends.

ON AVERAGE, 23% OF MILITARY FAMILY RESPONDENTS WITHOUT A PRE-EXISTING DEPRESSIVE DISORDER OR ANXIETY DIAGNOSIS NOW HAVE SYMPTOMS.

"I am a veteran with a PTSD diagnosis. I am having to control my exposure to stressful media and phone call[s] from other people at this time."

- Veteran

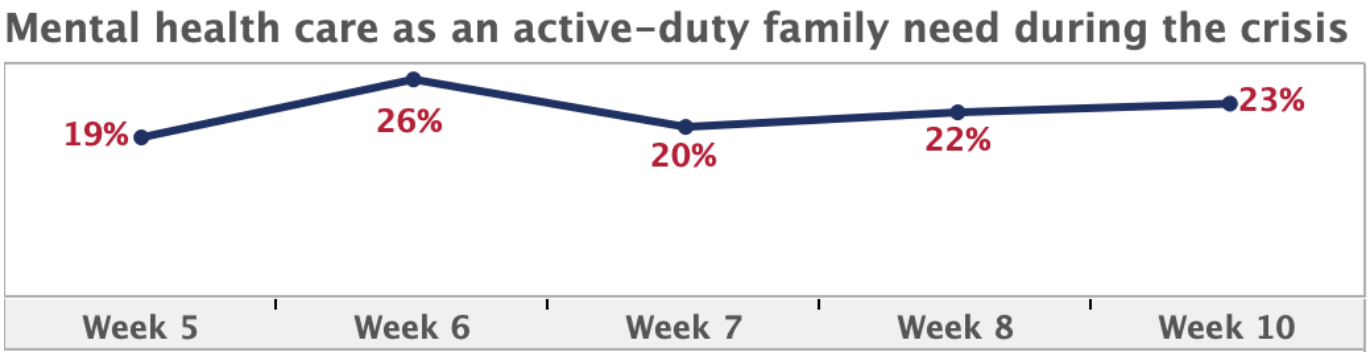
According to the Pew Research Center, a third of Americans have experienced high levels of psychological distress during the coronavirus outbreak, including symptoms of anxiety, depression, or sleeplessness. Military and veteran families frequently manage stressful situations. Still, the Pain Points Poll findings suggest additional uncertainty posed by the pandemic (including policies such as the stop movement order) is exacerbating pre-existing mental health challenges. This finding is in line with civilian researchers' understandings about the relationship between

mental health and uncertainty. **More than half of both military (62%) and veteran family respondents (58%) reported being considerably more stressed** than before the crisis. This stress appears to be exacerbating existing mental health concerns and instigating new symptoms.

BLUE STAR FAMILIES' 2019 MILITARY FAMILY LIFESTYLE SURVEY RESULTS (UNPUBLISHED) - PRE-COVID-19 STATE OF MILITARY AND VETERAN FAMILY MENTAL HEALTH			
	Active-duty service member	**Spouse of active-duty service member**	**Veteran**
Reported diagnosis of depression	10%	17%	21%
Reported diagnosis of anxiety	20%	32%	32%
Reported sleep disorder diagnosis	23%	9%	38%
PAIN POINTS POLL RESULTS (AVG. ACROSS WEEKS 5-10)			
Reported a pre-existing anxiety or depressive disorder diagnosis; symptoms have worsened	15%	29%	30%
Reported NO pre-existing anxiety or depressive disorder diagnosis, but is now experiencing symptoms	18%	24%	16%
Reported a pre-existing sleep disorder diagnosis; symptoms have worsened	10%	7%	15%
Reported NO pre-existing sleep disorder diagnosis, but is now experiencing symptoms	16%	24%	20%

ON AVERAGE, 22% OF MILITARY FAMILY RESPONDENTS REPORTED THEIR FAMILY NEEDED MENTAL HEALTH CARE SERVICES DURING THE PANDEMIC; HOWEVER, THIS RESOURCE REMAINED INACCESSIBLE FOR SOME.

While the need for mental health care has increased due to the coronavirus crisis, access to care remains barred for some respondents. Mental health care was perceived as a top-three unmet community need among both military (25%) and veteran (30%) family respondents across the polling period. When asked about what resources their family needed during the COVID-19 pandemic, 22% of military family respondents reported they needed mental health care (Pain Points Poll, Weeks 5-10).



Over the course of weeks 5-10, 5% of active-duty family respondents reported they were unable to continue mental health/behavioral health care services, and 7% were unable to begin mental health services due to the crisis. Five percent also reported they did not seek care due to concerns for their or their service member's career. This was consistent in both the quantitative polling and open-ended questions. **When asked in an open-ended question about specific barriers that prevented the respondent from effectively supporting their physical and mental health through the crisis, 26% of respondents reported challenges obtaining or maintaining regular mental health care** (Pain Points Poll, Weeks 5-7).

ACCESS TO MENTAL HEALTH CARE PAIN POINTS POLL RESULTS (AVG. ACROSS WEEKS 5-10)	
Unable to **BEGIN** mental health care due to the current crisis	7%
Unable to **CONTINUE ONGOING** mental health care due to the current crisis	5%
Concerns for service member's career prevent seeking help	5%

RESTRICTED SELF-CARE OUTLETS

"Shelter in place restrictions have restricted most of the outlets I used prior to COVID to manage my PTSD/Depression and as a result I have increased anxiety, which has required taking PRN anxiety meds much more frequently." - Veteran

Not only has the crisis increased the need for mental health care, but it has also prevented many of the traditional outlets individuals use to informally support their own mental health. While the large majority of respondents (66% of military families and 67% of veteran families, on average) indicated they are taking steps to protect and sustain their own mental health through a variety of outlets (see graph below), many reported that restrictions have reduced their ability to care for their own physical and mental health. Ten percent of respondents of an open-ended question on the barriers to effective mental and physical health reported that gym closures and difficulty exercising were barriers, and 9% reported finding time for self-care was challenging (Pain Points Poll, Weeks 5-7).

How military family respondents reported they are caring for their own mental health

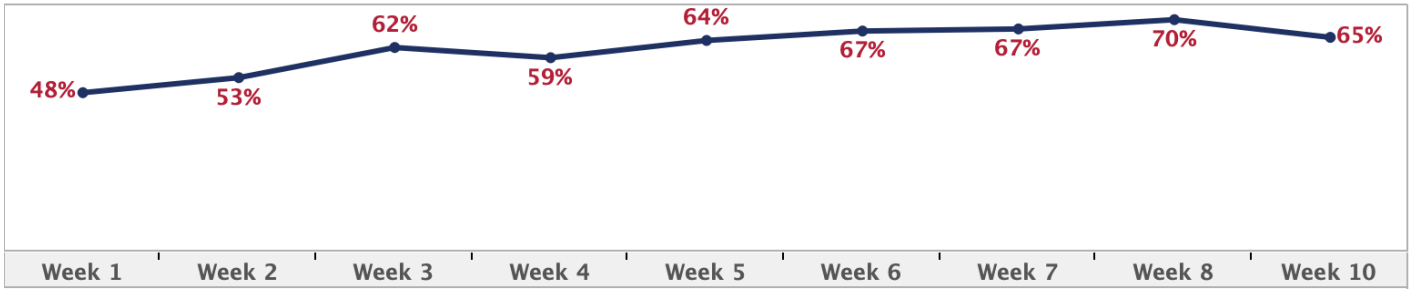
Talking with friends and/or family via video or phone	57%
Doing hobbies and other things I enjoy	56%
Meditation or Prayer	49%
Maintaining a well-balanced nutritious diet	48%
Regular exercise and/or walks	45%
Ensuring I get enough good quality sleep to function effectively	44%
Spending time outside each day	44%
Finding time to be alone (e.g., trading child care duties with spouse, taking a trip to the store alone, etc.)	34%
Participating in virtual social events	28%
Seeking or maintaining medication to support my mental health	17%
Seeking or utilizing spiritual supports (pastor, chaplain, or other religious support)	17%
Seeking or utilizing formal mental health care through counseling or therapy	12%
Journaling	11%

THE PERCENTAGE OF RESPONDENTS REPORTING THEIR CHILD EXPERIENCED BEHAVIORIAL CHANGES INCREASED THROUGHOUT THE POLLING PERIOD; ACTING OUT WAS THE MOST COMMON FORM OF BEHAVIORAL CHANGE.

Over the course of weeks 1-10, the majority of active-duty family respondents reported their children had behavioral changes due to their inability to interact with peers during the outbreak. Respondents also most commonly reported that the child was acting out more than usual, more anxious than usual, sadder than usual, angrier than usual, more withdrawn than usual, or more affectionate than usual.

"I have 4 that are school aged. 2 are okay. 1 has had behavior regression and just needs an outlet like school. 1 is angry. Angry at the world. Angry that everything she knows has been taken away. And all wish the Navy didn't need dad now because they need dad now too." - Military Spouse

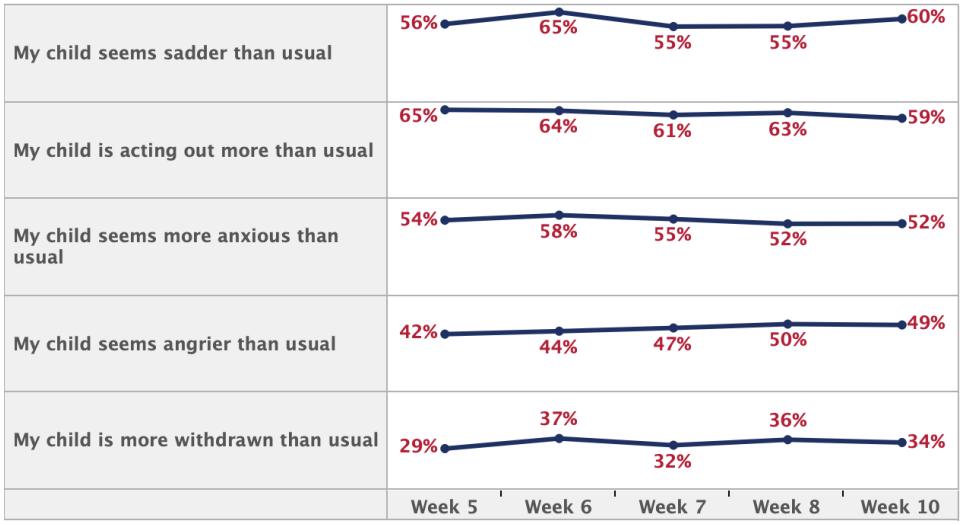
Military family respondents who reported they have noticed changes in their child(ren)'s behavior, which they believe is due to their inability to socialize with peers



"Large outbursts of anger have been occurring and did not occur prior to the pandemic. Several friends are social workers and psychologists and I am following their guidance. My son does not want to talk to an MFLC even though I have tried."

- Military Spouse, Veteran

Perceived child(ren)'s behavioral changes among active-duty family respondents who indicated their child had experienced a change



Recommendations to Mitigate the Impact of COVID-19 on Mental Health

TAKE STEPS TO REDUCE THE STIGMA AND CONSEQUENCES OF ACCESSING MENTAL HEALTH CARE

"[I won't take] the risk of being flagged for EFMP. We have an overseas PCS coming up and I won't risk having my family separated in the future because of the need for mental health services. I am also caring for a terminally ill father and my mother just died, I would dearly love to get help. I hate EFMP. That program destroys families and causes more mental health issues by separating spouses from their only support person. It's happened to me before (unaccompanied tour [because] of EFMP status in 2016 and 2021 [because] I sought mental health services after a miscarriage in 2011); I will NEVER use mental health services again. The Army betrayed us."

- Army Spouse

Concerns for the impacts on the service member's career continue to prevent both service members and family members from seeking needed care, even during the global crisis of COVID-19. Open-ended responses suggest families may be reluctant to report mental health concerns to avoid mandatory enrollment in the Exceptional Family Member Program (EFMP), which is sometimes perceived as punitive to the service member and family. Recently proposed legislation[1] would also allow service members to obtain mental health care without informing their command. Steps to reduce perceived punishment for accessing care is a start, but command also needs to signal that accessing mental health care, for both the service member and family members, is essential for a healthy, ready military force.

Leaders must communicate clearly, through both words and behavior, that maintaining mental health is a priority. Employers, including military and civilian leadership, should provide flexibility for employees to seek and obtain mental health care for themselves or family members, up to and including providing time to access care during working hours. Leaders must avoid actions whenever possible that unintentionally punish service members or family members for seeking treatment, such as removing a service member from their team or shifting assignments against the wishes of the service member.

[1]*As of publication, the Brandon Act has been included in the version of the National Defense Authorization Act passed by the House of Representatives, and has been introduced as a new standalone Bill in the Senate.*

Improve clinician and client understanding of the Exceptional Family Member Program (EFMP) to reduce stigma

Integrating mental health clinicians and professionals into the EFMP process may also reduce the punitive perception of the program. Increasing integration between the EFMP and community mental health providers can ease the burden for enrolled military families. Because the needs of EFMP families are varied and depend greatly on individual circumstances, clinicians can provide guidance to EFMP professionals on individual treatment requirements and their accessibility. Not all mental health diagnoses require ongoing EFMP enrollment, particularly if the family is experiencing an adjustment difficulty such as reintegration stress, a family member loss, or an acute but temporary stressor. Additionally, while therapy services may appear to be available in the area, they may not be accessible for the family due to language barriers or developmental needs, effectively eliminating their utility. Clinicians integrated in the EFMP can ensure services that are accessible to the family are truly available and meet the family's needs.

EXPAND ACCESS TO CARE, PARTICULARLY FOR CHILDREN

The pandemic and its far-reaching impacts have created unprecedented stressors for children. It has the potential to cause developmental trauma (Adverse Childhood Experiences, ACEs), leading to long-term challenges and increasing risk of many other negative outcomes, such as heightening the propensity for developing post-traumatic stress disorder after experiencing trauma later in life. As the military is increasingly becoming a "family affair," ensuring the mental health and well-being of military children should be conceptualized as a current and future readiness issue. Not only is it important for service members to feel confident in their family's current well-being to maximize current readiness, but because military children are more likely than civilian children to join the military, preventing and reducing Adverse Child Experiences is also necessary to ensure future readiness.

Increase insurance panel size to improve provider availability

Even before the crisis, the U.S. faced a severe shortage of pediatric mental health providers. In the 2019 Military Family Lifestyle Survey, families with children with special needs, including mental and behavioral health care needs, indicated before the pandemic that finding providers for mental health care for children was difficult; 40% could not obtain a referral and see a specialist within a reasonable time after a relocation. Increasing the number and availability of providers for pediatric clients is critical. Allowing a greater number of providers on the Tricare provider panels may help increase accessibility. While panels may be fully staffed, providers on those panels may be unable to accept new patients, effectively limiting access to an available provider.

Remove barriers preventing military spouses from becoming mental health providers or using their existing skills

A ready and culturally competent workforce to support military families' mental health already exists. Many military spouses are trained mental health providers but are limited in providing care. The 2017 Military Family Lifestyle Survey found that 18% of military spouse respondents reported their field of study was health care/medicine, and another 14% reported their field of study was social and behavioral science. Even so, only 11% were working in health care and only 6% in community and social services. Despite training, military spouses continue to experience barriers to employment due to frequent relocation and licensing issues, as well as their service member's day-to-day job demands that make it difficult to balance work and home demands (2019 MFLS). Measures to increase license reciprocity and allow providers to serve patients in other states, particularly via telehealth, could increase provider availability and accessibility. Reducing other barriers to employment for military spouses, such as providing predictability and flexibility in the service member's day-to-day job demands, may also allow spouses to fill the critical gap in mental health care provision, especially for children.

POLICYMAKERS MUST ACT DECISIVELY AND COMMUNICATE A CLEAR, COHERENT, AND CONSISTENT MESSAGE

*"**Uncertainty is causing huge stress**. The stop movement order has paused a planned PCS, but we were immediately informed the new command had submitted a waiver for us to move as planned. The idea that we have been told not to move for our own safety, but to be waiting to hear that we are still expected to move is concerning and causing a lot of stress and questions about why we would be moving at all."* - Marine Corps Spouse

The uncertainty that comes from indecision and unclear communication can cause real harm to mental health. Decisive action and clear, coherent, and consistent communication is essential in crisis. Leaders who delay decisions or equivocate risk doing harm by extending the uncertainty. Accurate communication, issued broadly, is more effective in reducing the corrosive effects of uncertainty, even if the message must change later when new information emerges.

*"We are planning to DITY move across [the] country for Captain Career Course and are not [sure] of when. The housing is very difficult to come by in that area so it is stressful not knowing if we will have a safe and adequate place to live. There's just a **lot of uncertainty**."* - Army Spouse

METHODOLOGY

The Pain Points Poll is a program of the COVID-19 Military Support Initiative. It is presented by Booz Allen Hamilton with additional support from USAA. Analysis is conducted by Blue Star Families' Applied Research Team; analysis and survey instrumentation is informed by input from military family members, advocates, subject matter experts, and policymakers who work with military families.

Polling began on March 18, and analysis is conducted on a weekly basis. With the exception of week one, when polling was conducted using a different survey platform, the response rate includes the aggregate number of individuals who began the survey, and the completion rate represents those who completed the entire questionnaire. Week one of polling includes only those respondents who completed the entire questionnaire. The number of respondents varies by question due to skip logic that removed questions that were not applicable to the respondent (i.e., questions about child care and children's education were removed for respondents who indicated they did not have children). Participants were able to skip questions that they preferred not to answer.

POLLING WEEK	POLLING PERIOD	TOTAL RESPONSES
1	March 18 - 24	1,321
2	March 25 - 31	1,234
3	April 1 - 7	690
4	April 8 - 14	668
5	April 15 - 21	749
6	April 22 - 28	560
7	April 29 - May 5	822
8	May 6 - 12	562
9	May 13 - 19	160
10	May 20 - 26	655
11*	May 27 - June 2	

**Week 11 yielded an abnormally low response rate and is excluded from the quantitative dataset. Qualitative responses were, however, included in qualitative reports and analysis.*

A survey branching technique was introduced in week four of polling, whereby the answers to certain questions were a gateway to specific follow-on questions (detailed branching is available upon request). Prior to that, respondents who left the question blank or indicated it was not applicable to their experience were excluded from the analysis for that question.

Polling also included several open-ended questions; new qualitative questions were introduced at several time points. The responses to these open-ended questions were analyzed daily and coded into themes. These responses provided context for the quantitative findings and guided the development of new polling questions and policy initiatives.

Sampling

It should be noted that the sample population for this poll is not representative of the military or veteran community as a whole, due to a non-probability sampling method. The sample demographics varied from week to week, and therefore the representativeness of the sample also varied. These findings guide inquiry and can highlight trends, but are not intended to be generalized to the entire military and veteran-affiliated community. Possible biases introduced due to the utilization of a non-probability sampling method include over- or under-representation, particularly the case when looking at race/ethnicity among all respondents. Additionally, representativeness by service branch differs weekly. The majority of the sample, in all weeks, is spouses of active-duty service members. This polling does allow respondents to select more than one military affiliation, so there is overlap among respondents reporting they are spouses of active-duty service members, they are themselves service members, or they are themselves veterans. With the exception of week one of polling, which utilized the survey functionality in Form Assembly, polling was conducted online using GetFeedback, a product of Survey Monkey, generating a self-selected, convenience sample.

Recruitment

Polling participation was voluntary, and information provided was kept confidential unless respondents provided permission to share their information. Participants were recruited through multiple efforts, including social media outreach, announcements at virtual town halls, and meetings held by the CMSI.

References to "family respondents" indicate that those who selected they are the service member or veteran are grouped with those who selected they are the spouse of a service member or veteran; those who selected both are only counted once based on a unique respondent identifier. Any comparisons that are made from week to week are subject to sample bias, and identified trends are most reliable for active-duty spouses and active-duty families due to the sample size of those populations. This is not a panel data set, and there is no way to distinguish whether the same individuals have taken the poll multiple times over the course of the polling period. This introduces the opportunity for dual-counting when analysis groups polling weeks to increase the response rate on a question for analysis or to look at an average descriptive statistic.

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- **AARP**
- **American Armed Forces Mutual Aid Association**
- **The Association for Defense Communities**
- **Cohen Veterans Network**
- **Division-19 Association of Military Psychologists**
- **Enlisted Association of the National Guard of the United States**
- **The Institute for Veterans and Military Families**
- **Military Child Education Coalition**
- **Military Family Research Institute**
- **Military Interstate Children's Compact Commission**
- **Military Officer Association of America**
- **The National Guard Bureau**
- **Our Military Kids**
- **PsychArmor Institute**
- **RAND**
- **The Retired Enlisted Association**
- **Uniformed Services University of the Health Sciences**

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