Defense Advisory Committee on Women in the Services Requests for Information
Office of the Assistant Secretary for Health Affairs and Defense Health Agency Response
August 2022

PREGNANCY IN THE MILITARY

In accordance with DACOWITS' Terms of Reference, the Well-Being and Treatment (WB&T) Subcommittee will determine if there are gaps in institutional policies and procedures that obstruct pregnant servicewomen from progressing in their military career and recommend policy changes.

***RFI 12.** The Committee is concerned about the medical and mental health needs of pregnant servicewomen who experience an abortion, miscarriage (i.e., spontaneous abortion), still birth, or death of newborn after birth.*

The Committee requests a written response from the Army, Navy, Marine Corps, Air Force, Space Force, Coast Guard, National Guard, as well as the Health Affairs and the Defense Health Agency identifying:

ANSWER:

Pregnant Service members who experience an abortion, miscarriage (i.e., spontaneous abortion), stillbirth, or death of newborn after birth, often experience elevated rates of physical and/or mental illness compared to persons without a loss. Risk factors can include pre-existing condition(s) that can affect a Service member's mental and/or physical health, which may be amplified if they are separated from support systems and families. DHA healthcare providers should be assessing the medical and mental health needs of each Service member during every visit, especially those experiencing loss, following evidence-informed clinical guidance. The clinical guidance should take into account an individual's physiology, impact on the body, and overarching emotional impact. These guidelines are designed to support physical recovery and acknowledge the need for grieving, and are based primarily on the American College of Obstetricians and Gynecologists (ACOG) recommendations on Early Pregnancy Loss,[i] Management of Stillbirth,[ii] and Optimizing Postpartum Care.[iii]

a. *What medical, mental health, and other support and leave opportunities are provided to servicewomen who experience an abortion, miscarriage (i.e., spontaneous abortion), still birth, or death of newborn after birth?*

RESPONSE:

Medical Support: The end of a pregnancy by miscarriage or abortion may require medical follow up to ensure pregnancy tissue is not still in the uterus (i.e., an incomplete abortion or miscarriage), as it can cause complications, including bleeding and/or infection. Removal of the tissue can be done medically (with a pill regime), or surgically (via dilatation and curettage). For Service members experiencing stillbirth or death of an infant (either as the birth parent or partner/spouse), regardless of gestational age (i.e., fetal or neonatal death), a medical evaluation of the birth parent is conducted as part of routine postpartum care, with attention to grieving and mental health (discussed below).

Mental Health Support: Mental health support is provided as a continuum throughout life, with specific attention to the physical and mental health challenges during major life changes, to include pregnancy and postpartum. Mental health screening in pregnancy and postpartum uses standardized validated tools for pregnancy at first visit, seven months (28 weeks gestation), and the initial visit after delivery. Currently, tools employed within military Medical Treatment Facility based care are the Edinburgh Postnatal Depression Scale (EPDS) or the 9-item Patient Health Questionnaire. Each interaction with the healthcare team includes an overview of the health and functional capacity of the Service member. Newborn well-child visits also include EPDS. If there is a concern or need to provide additional coping mechanisms, a primary care or obstetrical care provider will conduct initial screening, with referral for treatment to a behavioral healthcare clinician, as needed. Mental health screening and treatment following loss must take into account a Service member's history, current and resolved mental health conditions, individual needs and preferences, and be supported by open communication between the healthcare team and the Service member. Service members may also be directed to non-clinical support sources, include peer-to-peer support, chaplain services, and community resources (e.g., The Compassionate Friends,[1] or Miscarriage, Infant Death, and Stillbirth Support group,[2] etc.). The Defense Health Agency will be piloting a reproductive behavioral health consultation program through an agreement with the Veterans Health Administration to leverage the agency's existing program. The pilot will offer military behavioral health providers the opportunity to receive free consultation services from reproductive behavioral health experts on key issues and areas of consideration in clinical practice with individuals who experience a whole host of reproductive health concerns, including perinatal and neonatal loss.

Other Available Support: A Service member's mental health and well-being is a key component in readiness and fitness. Grief is not a linear process, and may require time away from duty, based on the impact and experience of the Service member. Over time, unresolved grief can turn into physical and/or emotional manifestations that affect physical health. DHA is currently developing resources for clinicians who support and consult with Service members experiencing perinatal and neonatal loss. DHA healthcare providers are encouraged to consider and address the wide variety of individualized needs of each Service member, and recommend leave to optimize physical and emotional recovery, as well as have a positive long-term impact on Service member's long-term mission readiness. Although grief and mourning is individual, loss impacts the entire family. Additional resources for the Service member and family are:

- **The Military Crisis Line** (988) is a free, confidential resource for all Service members, including members of the National Guard and Reserve and Veterans. Services and resources include clinical care or counseling, assistance with benefits, and other needed support systems. Connection through text message is also available at 838255.
- **Military OneSource** promotes readiness and resilience in military Service members and families to include confidential, non-medical counseling, as well as resources and support to address a variety of issues and build important skills to tackle life's challenges. Sessions are

[1] https://www.compassionatefriends.org/stillbirth-miscarriage-infant-death/
[2] https://www.misshare.org/

available through the Military and Family Life Counseling at (800) 342-9647 and consultants are available 24 hours a day, seven days a week, from anywhere in the world.

- **TRICARE Non-Emergency Mental Health Care.** No referral or pre-authorization for any outpatient mental health (except psychoanalysis) and substance use disorder care. This includes services like therapy and counseling. Several telehealth services are available to TRICARE beneficiaries seeking mental health and substance use disorders treatments.
- **The MHS Nurse Advice Line** is available 24 hours a day, seven days a week by phone, web chat, and video chat. Visit MHSNurseAdviceLine.com for web chat and video chat, or dial 1-800-TRICARE (874-2273), option 1.

b. *What directives, regulations, and policies address/provide for such care and leave?*

RESPONSE:

Section 707 of the National Defense Authorization Act for Fiscal Year 2022, signed December 27, 2021, requested that the Secretary of Defense address postpartum care for members of the Armed Forces and dependents. The Department is publishing clinical guidance in response to all four components of the Section 707(a)(1) requirement, incorporating recommendations of established professional medical associations to address postpartum mental health assessments, including the appropriate intervals for furnishing such assessments and screening questions for such assessments (including questions relating to postpartum anxiety and postpartum depression). This clinical guidance addressing postpartum mental health will apply to those who experience an abortion, miscarriage (i.e., spontaneous abortion), still birth, or death of newborn after birth as well as those who have uncomplicated pregnancies carried to term.

Additionally, the Department of Veterans Affairs/Department of Defense (VA/DoD) Clinical Practice Guideline for the Management of Pregnancy (2018) is currently scheduled for update and revision with a release in 2023. The medical and mental health needs of pregnant Service women who experience an abortion, miscarriage (i.e., spontaneous abortion), still birth, or death of newborn after birth will be addressed utilizing the DHA standardized policy on "Appointing Processes, Procedures, Hours of Operation, Productivity, Performance Measures and Appointment Types in Primary, Specialty, and Behavioral Health Care in Medical Treatment Facilities" which is currently being updated. DHA continues to review evidence-informed resources to provide policy considerations, outline leading practices and optimize the care for all beneficiaries, especially families experiencing miscarriage, abortion, stillbirth or neonatal death.

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[i] ACOG. *Early Pregnancy Loss*. Practice Bulletin Number 200 (Replaces Practice Bulletin Number 150, May 2015. Reaffirmed 2021). Retrieved July 22, 2022 from https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2018/11/early-pregnancy-loss

[ii] ACOG. *Management of Stillbirth*. Obstetric Care Consensus Number 10. (Replaces Practice Bulletin Number 102, March 2009. Reaffirmed 2021). Retrieved July 22, 2022 from https://www.acog.org/clinical/clinical-guidance/obstetric-care-consensus/articles/2020/03/management-of-stillbirth

[iii] ACOG. *Optimizing Postpartum Care*. Committee Opinion Number 736, May 2018. (Replaces Committee Opinion Number 666, June 2016. Reaffirmed 2021). Retrieved July 22, 2022 from https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum-care