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30 May 2023

SUBJECT: H.R. 2482 Accessibility of mental healthcare for active duty service members

TO: Representatives Vern Buchanan, Jennifer Kiggans, Brittany Pettersen, and Robert Scott

CC: Representative Melanie Stansbury

I am writing this letter in reference to H.R. 2482, which was introduced on 6 April 2023 and would require the Secretary of Defense to conduct a study on the accessibility of mental health care providers and services for active duty service members (ADSM).

I served as an active duty psychologist in the United States Air Force (USAF) until 2017 and currently retain my commission as a Major. Upon my separation from active duty service, I founded a mental health clinic that specializes in treating the military-connected population (i.e., current service members, veterans, and dependent spouses). We also emphasize training civilian mental health clinicians in military cultural competency to expand the availability of mental healthcare to our patients. Despite our staffing growth, our waiting list continues to swell, which is a testament to the burgeoning need for specialized, culturally competent care for the military-connected population.

Resultantly, we enthusiastically support the DoD study described in HR 2482. Further, we provide the following information to inform your efforts – and/or subsequent legislative efforts derived from the results of HR 2482:

1. Measuring DoD access to mental healthcare should be multidimensional to yield a meaningful picture of the circumstances. When I was an active duty psychologist, the primary means of measuring access to mental healthcare was vis-à-vis initial contact. Specifically, our chain of command was most interested in the time lapse between when an ADSM first contacted the clinic and when they were scheduled for their initial appointment. While this is an important metric of access, it is narrow in scope and ignores a host of problems.

    a. There was not much, if any, attention paid to access to care following that initial session. If we got that service member seen within 7 days of initial contact, we were in the green. No one seemed to care that we would not see that service member again for 6 weeks due to lack of provider availability. Industry standard and standard of care both dictate that we see therapy patients weekly or biweekly, but as an active duty psychologist, my workload only permitted me to see patients once every 4-8 weeks. A provider cannot adequately or effectively treat posttraumatic stress disorder (PTSD), for example, when they see the patient that infrequently. Further, such infrequent sessions typically relegate the session content to processing and problem-solving stressors that have occurred since the last session, rather than making forward progress on the core issue (e.g., PTSD). Because this follow-up access was not being routinely measured, however, this problem was ignored.

    b. A byproduct of insufficient frequency of sessions is that the patients do not receive adequate treatment and, resultantly, do not experience adequate symptom remission. The USAF Medical Standards Directory (MSD), as an example, instructs that retention in service is questionable, at best, if a service member requires psychotherapy for greater

than one year. Following a year of psychotherapy, the service member is supposed to be referred for a Medical Evaluation Board (MEB) for potential medical separation or retirement. This standard, which is likely mirrored in the other branches, does not account for the low session count that is available to a service member in a year. By standard of care, a service member should be able to receive 50 or so sessions in a year's time [which is needed per the psychological literature (Consumer Reports, 1995; Delboy & Michaels, 2021; Lambert, Hansen, & Finch, 2001; Morrison, Bradley, & Westen, 2003)], but at a pace of once-every-six-weeks, that service member is relegated to 8-9 sessions – provided that none are canceled by the provider or facility. Do we really believe that a service member should be evaluated for medical discharge after receiving only 8-9 sessions of therapy for chronic PTSD?

c. As an active duty psychologist, I was task-saturated. In addition to being required to provide 25 hours of face-to-face patient care weekly, I was also the Suicide Prevention Program Manger for the full installation, served on the crisis response team, served on the Commander's process improvement committee, wrote clinical practice guidelines, conducted peer reviews and standard of care reviews, served on a weekly triage shift, etc. – all in addition to meeting my military and psychology continuing education and other professional requirements. These extra duty taskers sometimes required me to cancel patient sessions for meetings with Commanders, installation briefings, or training exercises. When my duties required me to cancel on patients, my patients were relegated to next-available-follow-up, which involuntarily pushed them out to up to 12 weeks between sessions. For this reason, I generally reported for duty when I was ill, as I knew missing work for illness would negatively impact my patients. Leadership supported and promoted having providers work while ill – due to the dire nature of our access problems.

d. The only pathway for a patient to receive weekly sessions was for them to decompensate to the point of suicidality, in which case we were required to place them on the high interest list (HIL) and check in with them weekly. Some providers checked this box by making 5-minute check-in phone calls, but others of us conducted in-person, weekly sessions (i.e., the intent of the guidance) with HIL patients. Since we were already booked out for 6 weeks, we had to work these HIL sessions in on our lunches and administrative time. For perspective, it was not unusual for me to have 5-6 HIL patients on my caseload at any given time.

e. Despite these working conditions, my new patient "faucet" was never turned off. In other words, I was required to maintain multiple intake slots each week for new patients – to protect that initial access to care that was being tracked by leadership. This meant that my existing patients were waiting weeks between follow-ups, but the size of my caseload continued to grow – further elongating the time between follow-up sessions.

f. Patients waiting weeks between follow-up sessions regularly expressed dissatisfaction with the length of time between follow-ups. As providers, all we could do was validate their dissatisfaction and advise them that there was nothing we could do about it. The patients knew they were not getting better. We providers knew they were not getting better. And we were simultaneously helpless to fix the access problem. These circumstances, coupled with task saturation, create moral injury and burnout in military mental health providers. Moral injury and burnout increase patient safety issues, decrease provider empathy, and puts providers at a higher risk for psychological decompensation – up to and including suicidality.

g. When patients are not receiving adequate care or symptom remission, they are more likely to decompensate to a state of suicidality. Thus, the overwhelmed DoD mental healthcare system allows for scenarios where patients are exponentially likely to decompensate, after which the DoD mental healthcare system takes a reactionary approach to suicidality. Increased access to and quality of care would be a prevention posture that meaningfully invests in the psychological well-being of ADSMs.

h. Many USAF bases have "solved" the access problem, as well as staffing problems, by creating policies requiring almost all new patients to attend group therapy prior to being eligible for individual therapy. This helps to keep new patient access numbers in the green. Not all patients, however, are good candidates for group therapy. Evidenced-based practice in psychology (EBPP) requires 3 elements: best available evidence, clinical expertise (aka: clinical judgment), and the preferences/characteristics/circumstances of the patient (APA, 2016; Brodhead et al., 2018; Berg, 2019; Norcross, Hogan, & Koocher, 2008). It is not always empirically supported (Resick et al., 2016) or good clinical judgment to relegate all or most patients to group settings, and, in my clinical experience, the majority of military-connected patients prefer individual therapy.

i. The staffing and access problems in DoD mental health are prohibitive of attending to goodness of fit between the patient and provider and/or the patient and the desired treatment approach. Research shows that the therapeutic relationship is the single best predictor of treatment outcomes (Gnaulati, 2021; Huibers & Cuijpers, 2015; Imel & Wampold, 2008; Laska, Gurman, & Wampold, 2014; Mulder, Murray, & Rucklidge, 2017; Rosenzweig, 1936; Zilcha-Mano, Roose, Brown, & Rutherford, 2019), so inattention to the goodness of fit directly ignores and violates psychological science.

j. Many people – particularly in military culture – have limited experience with mental health therapy. Many suffer alone for years before working up the nerve to contact mental health. If their sole experience with mental healthcare is negative, they are more likely to permanently swear off mental health. This not only results in them needlessly suffering in isolation, but if they reach a crisis point in the future and friends/family recommend therapy, they are more likely to refuse and say, "I've tried that, and it didn't help." We cannot afford to be short-sighted in thinking about the therapy experience of our service members, because lives are on the line.

2. Mental health professionals are required to be dual-hatted in DoD settings. That is, they must be both occupational medicine professionals and therapists. The task of occupational medicine in the DoD is surveillance of suitability, fitness, and readiness, which is obviously necessary to protect DoD missions and assets. When therapists are simultaneously tasked with the responsibility of surveillance and therapy, it can undermine the unconditional regard for and trust from a patient that are essential to therapeutic outcomes. In other words, dual-hatted mental healthcare can create a conflict of interest that can introduce bidirectional suspicion, distrust, and hostility in the therapeutic relationship.

   I have heard that the Defense Health Agency (DHA) is considering separating these roles, which I wholly support. The separation of these roles preserves therapeutic alliances, which optimizes treatment outcomes.

3. As an active duty psychologist, I repeatedly witnessed leadership hire civil service employees and contractors (i.e., civilians) that were child psychologists, neuropsychologists, and other specialty

mental health providers that had little-to-no experience in psychotherapy, adult psychology, and/or other areas relevant to our ADSMs.

Our ADSM patients were not informed of these clinicians' backgrounds and were led to believe their clinician's experience level was on par with other clinicians in the clinic.

Similarly, DoD mental health providers are commonly pressured or forced to practice outside their scope of competency (e.g., eating disorders, addiction), which violates our professional codes of ethics.

Again, ADSM patients were not informed of the limits of these clinicians' professional competencies and were led to believe their therapist was competent to treat their presenting concerns.

Access to care is of relatively little consequence if the treating provider is not clinically competent to treat the DoD population or presenting concern in question.

4. Among active duty mental health clinicians, the bulk of patient care is relegated to the most junior, most inexperienced clinicians (i.e., lieutenants and captains), as more experienced clinicians are exponentially pushed up leadership chains. This immeasurably impacts the quality and wisdom of care when we are treating combat-weary ADSMs.
   When I first entered active duty, my residency class was told there were 3 USAF career pipelines for psychologists: leadership, clinical, and research. Since my desire is (and has been) to be a clinician, I was happy to see the clinical pipeline option. What I found, however, was immense pressure for all psychologists to move through the leadership pipeline – even to the extent that we were repeatedly told we would be pushed out (e.g., through high year tenure, loss of favor, etc.) if we did not set ourselves up to move through the leadership pipeline.
   Given nationwide shortages of mental health professionals, this is not a sustainable model for an emphasis on reliable access to mental healthcare or the retention of skilled clinicians.

5. When ADSMs do seek mental health treatment in DoD settings, they are commonly forced into one-size-fits-all, standardized treatment approaches – irrespective of their preferences, personalities, prior experiences, or current circumstances, which is a direct violation of EBPP (American Psychological Association, 2016; Berg, 2019; Norcross, Hogan, & Koocher, 2008). As noted previously, EBPP requires three key components: best available evidence, clinical expertise, and the preferences/characteristics/circumstances of the patient, which is depicted in Image 1.

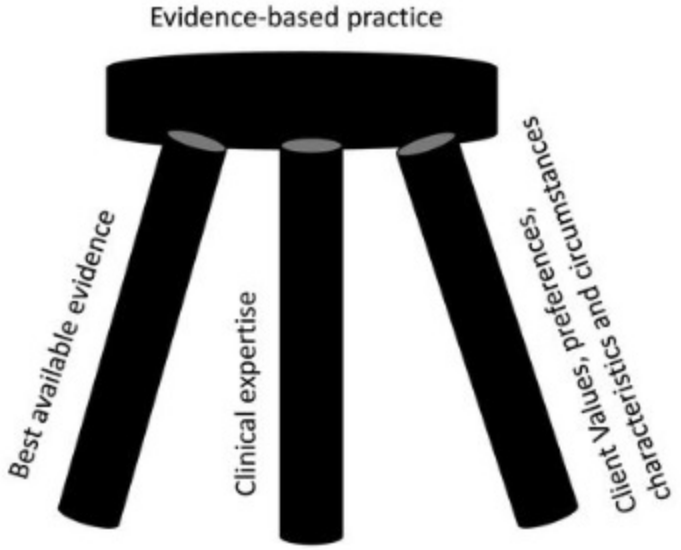

Image 1: Three-legged stool analogy (Brodhead et al., 2018)

When any one of the 3 components of EBPP is missing, we are not practicing EBPP, as depicted in Image 2.

Image 2: Three-legged stool analogy (Brodhead et al., 2018)

ADSMs presenting with PTSD, for example, are typically automatically tracked into Prolonged Exposure (PE) or Cognitive Processing Therapy (CPT) and are advised that these are the "gold standard" treatments for PTSD. These automatic tracks are doggedly pushed, despite research demonstrating that up to 98% of veterans dropout of these treatments prior to receipt of an "adequate dose" of treatment, and there is limited unbiased data suggesting that these treatments yield better outcomes than other treatments or yield improvements that endure at long-term follow-up (Cook et al., 2019; Delboy & Michaels, 2021; Gnaulati, 2019; Hundt et al., 2020;

Kehle-Forbes et al., 2015; Leichsenring & Steinert, 2017; Sakaluk et al., 2019; Schnurr et al., 2022; Steenkamp et al., 2014; Steenkamp et al., 2020).

Both PE and CPT are empirically supported treatments (ESTs), but so are a range of other treatments that are less frequently researched (Kudler, 2019; Leichsenring & Steinert, 2017; Leichsenring et al., 2023; Levi et al., 2015; Markowitz et al., 2015; Steinert et al., 2017). In brief, an EST means that the intervention yielded statistically significant results in a controlled laboratory setting (Roeske, 2017; Shedler, 2018). Often, these controlled settings exclude comorbid conditions or examine populations that are markedly different than the populations we are treating in real world settings (Henrich, 2010). Further, measures of improvement or effectiveness are most often selected by researchers without regard to the patient's idiosyncratic definition of improvement or effectiveness. These limitations of controlled studies in psychology demonstrate, in part, why we must also utilize clinical judgment and consider patient preferences/characteristics/circumstances to meaningfully engage in EBPP (Shedler, 2017; Wachtel, 2010).

Thus, universally doling out ESTs is saying to our ADSMs: "This worked for voluntary research participants in a controlled laboratory setting, so that is all we are offering you." If we are actually incorporating clinical judgment and patient preference into our EBPP, the cultural needs, demands, and preferences of our population should be paramount considerations in our clinical offerings, and DoD clinicians should be afforded the professional liberty to provide the intervention dictated by all 3 pillars of EBPP.

6. The lack of continuity of care is a significant problem for ADSMs utilizing mental health services. In brief, continuity of care is the uninterrupted provision of mental healthcare. Continuity is an ethical standard for mental health professionals (section 10.9; APA, 2017), and it is considered "an essential feature of high quality health care" (Biringer et al., 2017). Patients themselves cite the need to have enough time to process their experiences and resultant emotions and difficulties (Morant et al., 2017).

   On average, ADSMs receive military orders to move (aka: PCS) to a different installation every 2-3 years (DeSimone, 2018). Further, ADSMs, Reservists, Guardsmen, and DoD employees are frequently sent on short term business trips (aka: TDY) to other installations for training, inspections, evaluations, etc. These trips can take individuals to other states for days-to-months at a time. By the letter of the law, we mental health providers must discontinue an ADSM's care when they PCS to a different installation, and we must temporarily halt their care when they TDY out-of-state. I faced this reality as an active duty psychologist, and as a current owner of a network group practice, I face the same problem.

   Let us say an ADSM with undiagnosed chronic PTSD and a history of 3 combat deployments is stationed at Kirtland AFB in summer 2020. It may take them until midway through 2021 to conclude they need therapy, assess whether their new leadership is safe for/supportive of seeking therapy, and work up the nerve to call me. Due to overwhelming demand, I place them on my waiting list where they sit until fall of 2022, and perhaps we start their therapy in October 2022. In January or February of 2023, they have orders drop to another installation with a report no later than (RNLT) of June 2023. In the 8 months I am afforded to work with them, they have multiple out-of-state and overseas TDYs – each interrupting their care. They also must miss multiple sessions due to last minute meetings scheduled by their Commander, base exercises, high visibility deadlines, and tasks associated with their upcoming move. Simultaneously, they must request a new referral from base every 8 sessions and meet with a case manager in the base Mental Health Clinic to "validate" their treatment and retainability. So, in those 8 months, we

manage to get 20 sessions in and are consistently distracted by stressors, adversities, and perceived threats the ADSM is managing while trying to prioritize their mental health. Following those 20 chaotic sessions, they are moved out-of-state, which artificially terminates their care with me and starts the process over in their new local area.

As noted previously, research shows that the therapeutic relationship is the single best predictor of treatment outcomes. Thus, when a strong therapeutic relationship is achieved, it should be carefully preserved until treatment goals are satisfactorily met. Forcibly ending these therapeutic relationships prematurely due to an out-of-state military move disrupts continuity of care and is contraindicated for ethical, patient-centered care. Further, treatment outcomes show a dose-response curve (Consumer Reports, 1995; Delboy & Michaels, 2021; Lambert, Hansen, & Finch, 2001; Morrison, Bradley, & Westen, 2003), which suggests that the longevity of care, as clinically indicated, in the context of a strong therapeutic relationship should be prioritized over the barriers imposed by state boundaries. Importantly, *Ethical Principles of Psychologists and Code of Conduct* states that "paramount consideration given to the welfare of the client/patient" when interrupting therapy (section 10.9; APA, 2017).

Across my years of experience working exclusively with military-connected populations, I have had numerous patients independently conclude that their suffering was prolonged by their inability to get the help they needed, when they needed it, how they needed it, and from whom they needed it. One patient recently stated that they probably would not still need to be in therapy today if they were able to get quality care at an earlier stage in their military career.

As an active duty psychologist, I was permitted to acquire my license in any state and practice in any state where I was stationed – due to my status as a federal asset. In other words, my federal service superseded state licensure boards, and I did not have to be licensed in the state where I was stationed and practicing psychology.

This is not the case in my status as a veteran, independent practice psychologist, even though 100% of my patients are military-connected and funded by federal sources. This gap in licensure portability for the treatment of federal assets continually forces the disruption of patient care. For this reason, I have advocated for the State of New Mexico to sign onto PSYPACT (i.e., the interstate compact for psychological practice). These efforts have been unsuccessful. Nevertheless, ensuring continuity of care for our ADSMs should not be relegated to grassroots efforts. Further, any future PSYPACT success in my state does not solve the same problem faced by clinical social workers, professional counselors, etc.

The profitability to mental health clinics is not a factor here. Our earnings are not harmed by this systemic oversight, as mental health waiting lists are long across the nation. Rather, our ADSMs and their families are taking the brunt of the harm resulting from these gaps in legislation and mental healthcare, as artificially relegating military-connected practice to state boundaries undermines clinicians' ability to deliver high quality, patient-centered, clinically indicated, medically necessary, continuous care.

In sum, it is highly possible for the DoD to present access to mental healthcare numbers that appear acceptable, if not glowing. Knowing the implications of access numbers, as well as systemic problems that hide between the layers of uncontextualized numbers empowers legislators to meaningfully digest the data and appreciate the ongoing problems in mental healthcare across the armed forces.

If the goal of H.R. 2482 is to prevent suicides and ensure the well-being of our ADSMs, it is critical that Congress is afforded a full field of vision on the contingencies of DoD mental health, as opposed to a carefully curated subset of data.

I thank you each for your time and efforts in sponsoring/co-sponsoring H.R. 2482, and I ask that you each continue to do your due diligence in safe-guarding the lives and well-being of our nation's service members.

Sincerely,

Joye L. Henrie, PhD
Licensed Clinical Psychologist, NM PSY1457
Founder and Clinical Director: Desert Wise
www.DesertWise.com

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