Defense Advisory Committee on Investigation, Prosecution, and Defense of Sexual Assault in the Armed Forces (DAC-IPAD)

Request for Information

RFI Set 20

Topic: Psychotherapist-Patient Privilege

Date of Request: November 8, 2024

I. Purpose

The DAC-IPAD requests the below information to facilitate its assessment of the scope of the psychotherapist-patient privilege under Military Rule of Evidence (M.R.E.) 513 and to inform the following research questions:

A. Whether the psychotherapist-patient privilege under M.R.E. 513 should be expanded to include diagnosis and treatment, including prescribed medications.

B. Whether the psychotherapist-patient privilege under M.R.E. 513 should be expanded to include primary care practitioners when treating patients for mental health conditions.

II. Authority

A. The DAC-IPAD is a federal advisory committee established by the Secretary of Defense pursuant to section 546 of the Carl Levin and Howard P. "Buck" McKeon National Defense Authorization Act for Fiscal Year 2015 (Public Law 113-291), as amended.

B. The mission of the Committee is to advise the Secretary of Defense on the investigation, prosecution, and defense of allegations of rape, forcible sodomy, sexual assault, and other sexual misconduct involving members of the Armed Force.

III. Requested Response Date

Suspense	Question(s)	Proponent
Dec. 2, 2024 (rev'd Jan. 10, 2025)	10	Defense Health Agency

IV. Questions

Question 1: What is the availability of DoD mental health providers to meet the needs of military members and their families? (narrative response)

Question 2: Data on mental health care for the following:

a. Direct Care (DC) and Private Sector Care (PSC) access to care for Active Duty Service members (ADSMs) and their dependents.

b. Volume of care in the DC system and PSC network.

c. Volume of referrals to the PSC network.

Question 3: For installations in which there are not enough mental health providers to meet the needs of active duty members and their families, how do treatment facilities determine who should be seen by a mental health provider, rather than a primary care provider? Does this depend on the mental health condition or severity of the condition? Or the status of the individual (active duty v. family member or retiree)?

Question 4: For overseas military installations, how does the Defense Health Agency ensure there are sufficient mental health care providers to treat active duty service members and their families? If provider shortages or provider gaps to adequately meet the patient demand are identified, how are these concerns resolved?

Question 5: Approximately what percentage of primary care providers' patients are they treating for mental health conditions?

Question 6: When a provider treats a patient presenting for mental health concerns, how does the provider arrive at a diagnosis for that patient (e.g., assessment, patient observations)?

Question 7: When treating a patient for mental health concerns, how does a provider develop a treatment plan (e.g., recommend prescription medication)?

Question 8: When treating a patient for mental health concerns, do providers discuss confidentiality with a patient? If so, what are the limits of confidentiality?

Question 9: What concerns might arise for providers when they treat, consult, or document during patient care based on M.R.E. 513?

Question 10: What concerns might arise for patients when engaging in treatment due to M.R.E. 513?

Request for Information
Defense Advisory Committee on Investigation, Prosecution, and Defense of Sexual Assault in the Armed Forces (DAC-IPAD)

Question 1: What is the availability of DoD mental health providers to meet the needs of military members and their families? (narrative response)

The DoD provides mental health (MH) services to Service members and other eligible beneficiaries through military medical treatment facilities (MTFs; also called Direct Care [DC]). The Defense Health Agency (DHA) manages MTFs. MH providers (e.g., psychiatrists, clinical psychologists) deliver services in MTFs and clinics via primary care behavioral health (PCBH), specialty outpatient MH, alcohol and substance use programs, inpatient hospitalization, intensive outpatient programs, and virtual appointments.

The DoD subscribes to access to care (ATC) standards for urgent and acute care, routine care, initial specialty appointments, and wellness or preventative care pursuant to Section 199.17 of Title 32 Code of Federal Regulations (CFR). Section 199.17 of Title 32 CFR provides that the wait time for an initial specialty appointment is 28 calendar days or less. ATC data from December 2021 through October 2024 indicates that the DoD generally meets the 28-calendar day MH specialty care standard for Active Duty Service members (ADSMs) and their dependents in the DC system.

Per the Assistant Secretary of Defense for Health Affairs Policy Memorandum 11-005, "TRICARE Policy for Access to Care," February 23, 2011, if an MTF does not have the capability to provide the needed care or cannot provide the care within the required access standards, then the care will be referred to the private sector care (PSC) network.

Question 2: Data on mental health care for the following:

a. DC and PSC ATC for ADSMs and their dependents.

DC, ATC:
The DoD generally meets the standard ATC for MH specialty care of 28 days for MH care in the DC system.

The DoD assesses ATC in MH specialty clinics by appointment type for a rolling 36 months. ATC in the DC system is measured by the number of days between the date a patient makes an appointment to the date the appointment occurs.

From December 2021 through October 2024, average ATC for MH specialty care for ADSMs and their dependents across all MTFs was 17.8 days. For follow-up care appointments (no access standard), the average number of days to care was 22.2.

ADSM ATC for specialty care and follow-up appointments were 17.6 and 22.0 days, respectively.

Comparatively, dependent ATC for specialty care and follow-up appointments were 19.2 and 23.0 days, respectively.

PSC, ATC:
Data for the PSC network is assessed differently than the DC system, as the level of detail of data available from systems external to the DoD is not as robust as internal data systems. Thus, PSC ATC is measured as the number of days between a referral's approval date and the first date of service of the first matching claim indicating care was rendered.

Data for the PSC is subject to additional limitations, including a data lag of at least 6 months to confirm claims data for care rendered in the PSC network. Additionally, referrals are based on subjective preference of a patient. For example, patients may choose to wait for an extended period of time before scheduling an appointment or choose appointments based on convenience or provider preference, despite earlier appointments being available. Further, referrals are not required for non-ADSM patients, which may impact the data.

From October 2021 through April 2024, the monthly average ATC for ADSMs and their dependents in PSC ranged from 24.9 to 37.3 days.

From February 2024 to April 2024, ATC slightly exceeded the 28-day standard, with ATC at 28.3, 30.0, and 28.5 days for February, March, and April, respectively.

ADSM ATC ranged from 26.2 to 38.8 days from October 2021 through April 2024. ATC for ADSMs was 27.1, 29.2, and 27.7 days for February, March, and April, respectively.

Comparatively, dependent ATC ranged from 23.7 to 33.7 days from October 2021 through April 2024. ATC for dependents averaged 29.4, 30.5, and 29.2 days for February, March, and April, respectively.

b. Volume of care in the DC system and PSC network.

In the DC system and PSC network, MH outpatient volume includes the number of patient visits (i.e., encounters) and the number of patients with outpatient MH encounters. Encounters and number of patients seen for MH is broadly defined and includes care that occurred in an MH clinic, care that occurred with an MH provider, or care where the primary diagnosis was an MH diagnosis.

From October 2021 through December 2023, the number of ADSMs and dependents seen in the DC system and the PSC network ranged from ~200,000 to ~300,000 patients per month. The number of encounters for the same time period ranged from ~600,000 to ~800,000 encounters per month.

The number of ADSMs seen from October 2021 through December 2023 ranged from ~100,000 to ~120,000 patients per month, with the number of ADSMs seen in the DC system slightly decreasing from ~100,000 to ~80,000 patients per month. The number of ADSMs seen in the PSC network nearly doubled in this time period from ~20,000 to ~40,000 patients per month.

ADSM encounters showed similar trends, decreasing in the DC system from ~250,000 to ~190,000 encounters per month, and increasing in the PSC network from ~50,000 to ~90,000 encounters per month.

The number of dependents seen from October 2021 through December 2023 remained relatively consistent, ranging from ~130,000 to ~140,000 patients per month, and encounters ranging from ~300,000 to ~400,000 encounters per month.

The number of dependents seen in the DC system remained relatively consistent and ranged from ~20,000 to ~25,000 patients per month and averaged ~40,000 encounters per month. Comparatively, the number of dependents seen in the PSC network ranged from ~100,000 to ~110,000 patients per month and averaged ~350,000 encounters per month.

c. Volume of referrals to the PSC network.

PSC referrals for MH care include referrals with a "referred to" provider or facility MH "Health Insurance Portability and Accountability Act" taxonomy code. This includes all referral types such as retrospective, inactivated, inpatient, and outpatient. A referral to the PSC does not indicate that care was rendered.

The volume of referrals increased from October 2021 through November 2023 from ~19,000 to ~21,000 referrals per month.

For ADSMs, referrals increased from ~8,000 to ~10,000 referrals per month. ADSM referrals peaked in March 2023 (~13,000 referrals); however, the number of ADSM referrals exhibited a decrease at the end of the time period, with ~9,000 referrals in November 2023.

The number of referrals for dependents fluctuated from October 2021 to November 2023, with an average of ~11,000 referrals per month. Referrals for dependents peaked in March 2022 (~14,000 referrals) and have exhibited a small decrease since that time, with ~10,500 referrals in November 2023.

Question 3: For installations in which there are not enough mental health providers to meet the needs of active duty members and their families, how do treatment facilities determine who should be seen by a mental health provider, rather than a primary care provider? Does this depend on the mental health condition or severity of the condition? Or the status of the individual (active duty v. family member or retiree)?

Nationwide, demand for MH services is outpacing the supply of MH services. To address these challenges, the DHA is introducing a new approach at MH clinics, called targeted care, to help improve access to MH resources.

Targeted care refers Service members and other beneficiaries to the clinical or non-clinical MH resources best suited to support their needs, offering earlier interventions and promoting force resilience and readiness. The main principles behind targeted care include: 1) most Service members who experience MH concerns do not have an MH disorder; 2) most resources to

address MH concerns are non-clinical; and 3) getting help early and often prevents the need for clinical MH.

Through vectoring, the needs of a Service member are assessed, and a counseling resource may be recommended if a non-clinical or other prevention resource could address the issue before it reaches clinical levels. The process allows the MH providers to focus their efforts on evidence-based interventions for patients with the most critical needs while offering support and resources to others.

The DoD also provides guidance via policy. Per DHA-Administrative Instruction (DHA-AI) 6490.01, "Behavioral Health System of Care," February 22, 2023, within the DHA Behavioral Health System of Care, needs of ADSMs are prioritized, followed by active duty family members, then other beneficiaries or others authorized to receive care in the MTF with an identified health plan and guarantor. Additionally, DHA-AI 6490.01 assigns responsibilities to the Directors, DHA Components, to provide all ADSMs within their area of responsibility with MH treatment and evaluation services and indicates that ATC for ADSMs shall be based on severity of illness rather than geographic location.

Question 4: For overseas military installations, how does the Defense Health Agency ensure there are sufficient mental health care providers to treat active duty Service members and their families? If provider shortages or provider gaps to adequately meet the patient demand are identified, how are these concerns resolved?

DHA establishes standardized appointment capacity targets and provides centralized reports and measures for monitoring ATC and capacity. Local PSC resources can be utilized to supplement DC capacity. When demand cannot be met locally, MTFs can connect virtually within the Defense Health Network (DHN) to meet care needs. If DHNs are unable to support, MTFs can apply for additional virtual assistance from the DHA's centralized Behavioral Health Resources and Virtual Experience program.

Question 5: Approximately what percentage of primary care providers' patients are they treating for mental health conditions?

Overall, approximately 64 percent of ADSMs, members of the National Guard and Reserve Component on active duty, and ADSM dependents who had an MH encounter had at least one MH encounter with a primary care provider. However, many patients had multiple MH encounters with different provider types with approximately 75 percent of patients having at least one MH encounter with an MH or other provider. These proportions varied by beneficiary category and care setting (DC and PSC).

Question 6: When treating a patient who you are seeing for mental health concerns, how do you arrive at a diagnosis for that patient? What goes into your assessment in diagnosing the patient—observations of the patient, communications with the patient?

MH Provider: An MH diagnosis is an interpersonal process distinct from the diagnostic process in most other medical specialties. Unlike conditions reliably identified through laboratory tests

or imaging studies (e.g., blood tests or X-rays), an MH diagnosis stems from a patient's communication of their experiences, thoughts, emotions, and behaviors. To diagnose, an MH provider utilizes a structured, bidirectional dialogue with the patient (or their guardian). This diagnostic interview develops trust and models a compassionate care-centered relationship between the MH provider and patient. An MH diagnosis is the result of considering the symptom severity, impact on a patient's ability to function in daily life, individual distress, derivative disability, or consequence to society more broadly.

Such assessments require MH providers to build rapport and gather critical diagnostic information simultaneously. MH providers work to understand the patient's current symptoms, their development over time, and ultimately the impact of disturbances in cognition, emotion regulation, or behavior on functioning in important domains of life such as self-care, interpersonal relationships, or occupational attainment. The quality and completeness of information required to accurately render a diagnosis depends on establishing a trusting and collaborative professional relationship, termed "therapeutic alliance."

Patient diagnosis requires skilled interviewing techniques that follow standardized assessment protocols, such as evaluation guidelines from the American Psychiatric Association and the Department of Veterans Affairs (VA) and DoD Clinical Practice Guidelines (CPGs), while remaining responsive to each patient's individual presentation (e.g., appearance, rate of speech). The DoD co-develops CPGs for MH concerns with the VA and provides guidance for providers to implement VA/DoD CPGs. These documents are the "gold standard" for objective and evidence-based clinical decision-making for screening, diagnosis, and treatment.

A patient's inability or limited ability to communicate may impact the diagnosis. There are also times where a patient's confidential communication to the MH provider is itself their diagnosis. For example, a patient self-reporting that a stranger sexually assaulted them may receive a diagnosis for "Adult Sexual Abuse by Non-spouse or Non-partner, Suspected" in accordance with International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) code T76.21XA.

Reliance on self-reported information presents unique challenges that may impact the diagnosis. Patients have varying levels of insight into their conditions, which may affect the reliability of a patient's report. For example, memory issues, perception differences, and the impact of MH stigma may all influence how patients describe their experiences. Patients may not share the entirety of their symptoms or experiences due to external concerns or motivations including fear of consequences, lack of trust, fear of judgement, or previous negative experiences. MH providers carefully consider these factors while maintaining a therapeutic alliance that encourages honest disclosure, which is particularly important when gathering collateral information or addressing sensitive topics that may affect the patient's willingness to engage in treatment.

Beyond self-reporting, MH providers gather and integrate information from multiple sources to develop a wholistic diagnostic assessment. This includes direct behavioral observations of the patient, findings from the mental status examination, review of the patient's general medical history and physical health status, and input from others that the patient authorizes. Previous

treatment records can provide valuable historical context, though all information must be evaluated within the current clinical presentation.

Lastly, cultural factors fundamentally shape how patients understand and communicate their experiences. The diagnostic process must account for cultural influences on symptom presentation, family dynamics, and beliefs about MH treatment. Where language barriers exist, skilled interpreters are essential. The cultural aspects of the therapeutic relationship itself may also influence what information patients choose to share and how they engage in the assessment process. For military specific contexts, understanding the military sub-culture and unique differences between and within the Military Services are critical for accurate diagnosis.

Primary Care Provider: Primary care providers who treat patients for MH concerns arrive at diagnoses based primarily on the history, including information learned through asking clarifying questions. Patients self-report this information and other individuals, who the patient has permitted to provide information, can augment the reported information. Observations also play a role in arriving at diagnoses. An MH provider determines an MH diagnosis in accordance with the diagnostic criteria as outlined in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, Text Revision, or the ICD-10-CM.

Question 7: When treating a patient for mental health concerns, how do you arrive at a treatment plan? How do you decide whether to recommend prescription medication for the patient? What factors influence that decision?

MH Provider: Treatment planning for patients with MH conditions is a collaborative, ongoing process with the patient. CPGs articulate that treatment planning begins with thorough discussion of the diagnostic assessment and continues through shared decision-making with a patient (or their guardian) about treatment options. MH providers explain the nature of the MH condition, the differential diagnosis (e.g., alternative hypotheses considered to account for a clinical presentation), risks of untreated illness, available treatment alternatives, and the benefits and risks of each option.

Treatment planning is inherently individualized and considers the patient's specific symptoms, circumstances, goals of care, and values. Clinical expertise guides recommendations while patient consent drives the final treatment approach (outside of emergencies, court-ordered treatment scenarios, and involuntary inpatient admission). MH providers often use psychiatric medications, psychotherapy, and other interventions (e.g., inpatient rehabilitation for substance use disorders [SUD]) in combination, depending on their professional background. Treatment plans must also address any identified risks, including specific protocols for managing suicidal ideation or aggressive behaviors. This includes clear documentation of risk assessment, safety planning, and criteria for referral to higher levels of care.

The treatment plan requires careful attention to factors that could influence treatment, including cultural considerations, available support systems such as family or military command, and practical barriers to care such as cost, transportation, or provider availability. In military, law enforcement, aviation, or occupational contexts, fitness for duty impacts are significant factors in developing a practical, implementable treatment plan.

MH providers regularly review initial treatment plans and modify based on factors such as treatment response. Regular assessment of treatment response using both clinical observation and self-assessment measures helps guide ongoing treatment modifications. This includes, but is not limited to, monitoring for medication side effects, evaluating therapeutic progress, and adjusting interventions based on patient feedback and clinical outcomes. Throughout this process, maintaining a strong therapeutic alliance remains essential for treatment.

The outcome of any treatment plan depends heavily on bidirectional communication and mutual understanding of goals and expectations.

Primary Care Provider: Primary care providers treating patients for MH concerns determine treatment plans designed to best meet the needs of an individual patient. Factors considered include, but are not limited to, the diagnosis, severity of condition, urgency of treatment, a patient's acceptance of different modalities of treatment, and benefits, risks, and potential side effects of medications. Continued follow-up and reassessment are essential to assess whether treatment a patient is receiving is meeting the patient's needs, and when it is not, offers opportunities for providers to adjust treatment to better meet patient needs. Additionally, a primary care provider will first determine the appropriate treatment setting for the patient. When the appropriate treatment setting is in primary care, a provider may offer medication as part of the treatment plan when indicated by the diagnosis, the severity, and patient-specific factors.

Question 8: Do primary care providers routinely integrate counseling into their treatment plans or ongoing follow-up care in their practice once mental health medications have been prescribed, or does it depend on the type of medication and underlying diagnosis?

MH Provider: The DoD adheres to the VA/DoD CPGs for objective and evidence-based clinical decision-making on treatment planning for MH conditions. MH providers use the CPGs, which grade evidence along with clinical experience and patient preference, to determine whether to prescribe or refer for medication, provide psychotherapy, or provide a combination of the two. In many cases, a primary care provider may prescribe a medication to treat an MH condition and refer the patient to an MH provider for psychotherapy.

Primary Care Provider: There are three main scenarios when primary care providers integrate counseling into treatment plans: (1) clinics in which primary care providers have been trained in self-management skills; (2) clinics in which there are embedded MH providers in the primary care clinic, referred to as Integrated Behavioral Health Consultants (IBHCs) in DoD's PCBH model; and (3) clinics where they refer patients to or coordinate with outpatient specialty MH providers.

Question 9: When treating a patient for mental health concerns, do you discuss confidentiality with the patient and what the limits are of that confidentiality?

MH Provider: MH providers discuss confidentiality with all patients as it is an element of obtaining informed consent to treatment. Discussing confidentiality is in accordance with DoD Instruction (DoDI) 6000.14, "DoD Patient Bill of Rights and Responsibilities in the Military

Health System (MHS)," September 26, 2011, as amended; DoD Manual (DoDM) 6025.18, "Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in DoD Health Care Programs," March 13, 2019; and DHA-Procedural Instruction 6025.10, "Standard Processes, Guidelines, and Responsibilities of the DoD Patient Bill of Rights and Responsibilities in the Military Health System (MHS) Military Medical Treatment Facilities (MTFs)," October 9, 2018. Throughout a treatment relationship, new questions about confidentiality often emerge and the provider addresses them as needed.

Treatment requires that patients trust their providers to keep both their identity and the content of their sessions confidential. An MH provider's treatment recommendations are informed by the patient's communication of their symptoms.

Professional practice and ethics guidelines emphasize that MH records require protection due to the uniquely sensitive nature of psychiatric therapy and the relationship between an MH provider and a patient. The scope of protected communications from a clinical perspective is that an MH assessment, diagnosis, and treatment plans convey personal and psychological history, private thoughts and feelings, details of interpersonal relationships, MH symptoms and treatment information, sexual orientation and intimate behaviors, substance use history, personal beliefs, and family dynamics. Broad protection recognizes that treatment requires patients to share deeply personal information that could make them particularly vulnerable if the information is disclosed.

MH providers balance this confidentiality with certain ethical and legal obligations to disclose information in specific circumstances, including those provided in DoDI 6490.04, "Mental Health Evaluations of Members of the Military Services," March 4, 2013, as amended; DoDI 6490.08, "Command Notification Requirements to Dispel Stigmas in Providing Mental Health Care to Service Members," September 6, 2023; DoDI 6400.06, "DoD Coordinated Community Response to Domestic Abuse Involving DoD Military and Certain Affiliated Personnel," December 15, 2021, as amended; and DoDI 6495.02, Volume 1, "Adult Sexual Assault Prevention and Response: Program Procedures," March 28, 2013, as amended.

These limitations primarily involve situations where there are specific threats of harm requiring a duty to warn or protect, mandated reporting requirements for abuse of vulnerable populations, court orders, emergency treatment needs, insurance requirements, or coordination of care with other providers (with appropriate authorization). MH providers must clearly explain these limitations at the outset of treatment, ensuring patients understand both their privacy rights and the circumstances under which information might need to be shared.

MH treatment depends on establishing clear parameters for confidentiality that allow patients to feel secure in sharing their most personal information while understanding the legitimate limitations of these protections.

Primary Care Provider: Confidentiality is a patient's right that is not specific to MH treatment. The patient receives the Bill of Rights, which includes confidentiality, at their first appointment in the primary care clinic. A primary care provider may once again discuss confidentiality if

they feel it is appropriate for the conversation or if the patient asks, although it is not a requirement.

Limits of confidentiality include intent to harm oneself, intent to harm others, communication of acts providers have taken that mandatory reporters are required to report to the appropriate authorities (e.g., child abuse, child sexual assault, and elder abuse), communication of being the victim of acts that mandatory reporters are required to report to the appropriate authorities (e.g., child abuse, child sexual assault, and elder abuse), and communication with an individual's commander when required by DoDI 6490.08 to include:

1. Harm to Self: The provider believes there is serious risk of self-harm by the Service member.
2. Harm to Others: The provider believes there is a serious risk of harm to others. This includes any disclosures concerning child abuse or domestic violence consistent with DoDI 6400.06.
3. Harm to Mission: The provider believes there is a serious risk of harm to a specific military operational mission. Serious risk may include disorders that significantly impact impulse control, insight, reliability, and judgment.
4. Special Personnel: The Service member is in the Nuclear Weapons Personnel Reliability Program as described in DoDI 5210.42, "DoD Nuclear Weapons Personnel Reliability Assurance," April 27, 2016, as amended, is in a position that has been pre-identified by Service regulation, or the command as having mission responsibilities of such potential sensitivity or urgency that normal notification standards would significantly risk mission accomplishment.
5. Inpatient Care: The Service member is admitted or discharged from any inpatient MH or SUD treatment facility, as these are considered critical points in treatment and support nationally recognized patient safety standards.
6. Acute Medical Conditions Interfering with Duty: The Service member is experiencing an acute MH condition, a substance misuse induced condition, or is engaged in an acute medical treatment regimen that impairs the Service member's ability to perform assigned duties.
7. Problematic Substance Use Treatment Program: The provider determines the Service member requires treatment for a SUD.
8. Command-Directed MH Evaluation: The MH services are obtained as a result of a command-directed MH evaluation consistent with DoDI 6490.04.
9. Other Special Circumstances: The notification is based on other special circumstances in which proper execution of the military mission outweighs the interests served by avoiding notification, as determined on a case-by-case basis by a health care provider (or other authorized official of the MTF involved) at the O-6 or GS-15 civilian equivalent level or above, or an MTF commanding officer at the O-6 or equivalent level or above.

Question 10: In a 2022 decision, *United States v. Mellette*, the Court of Appeals for the Armed Forces held that while communications between the patient and therapist are privileged, the diagnosis and treatment plan, including prescription medications, are not privileged. What concerns might arise for providers regarding how they treat, advise, or document during patient care?

MH Provider: DoD policy provides guidance regarding the psychotherapist patient privilege as recognized by Military Rule of Evidence (M.R.E.) 513. For instance, per DoDI 6400.06, Family Advocacy Program clinical providers will inform the victim of the psychotherapist-patient privilege to, with certain exceptions, refuse to disclose, and to prevent other persons from disclosing, confidential communications between the psychotherapist and the patient as recognized by M.R.E. 513.

Accreditation standards, practice and ethics guidelines, and board certification requirements such as those set by the American Psychological Association and the American Psychiatric Association require MH providers to take reasonable precaution to protect confidential information, understand legal limitations of patient-provider privilege, discuss the relevant limits of confidentiality, and obtain informed consent. As applied, M.R.E. 513 may create a situation that is at odds with an MH provider's professional obligation to communicate a patient's diagnosis and treatment plan in detail with the patient to obtain their informed consent for assessment facilitating diagnosis and treatment. Communication between the patient and MH provider naturally includes communications by the MH provider to the patient. MH providers may experience challenges balancing clinical standards of practice and ethics with the requirements of M.R.E. 513 as interpreted by the Court of Appeals for the Armed Forces (C.A.A.F.) in *United States v. Mellette*.

MH diagnoses and treatments may inherently reveal something of the patient's confidential communications, as they may reflect private, sensitive concerns that led the patient to seek treatment.

MH providers must always be thoughtful about documentation. For instance, a patient might make specific statements which the MH provider documents in their written clinical assessment. MH providers, military or not (given enforceable military subpoena authority over civilian alleged crime victims or witnesses via Rules for Courts-Martial 703), must clearly explain the contours of these privacy limitations to patients while maintaining the therapeutic alliance necessary for treatment.

Primary Care Provider: It is possible that the limits of confidentiality as understood by a provider may impact what the provider chooses to document in the medical record. Additionally, to the extent a provider informs a patient on the limits of confidentiality, could in some cases, influence what a patient chooses to disclose to a provider. These elements could impact the continuity and quality of care for a patient over time. This is of particular significance in situations in which a patient needs help, but is hesitant to seek it, such as patients who were victims of sexual assault.

Question 11: How do providers determine which records are relevant for a request from counsel to produce diagnosis and treatment records for your patients? How do providers determine how much information to provide to meet the request?

MH provider: Military providers redirect all requests for records to the medical records office or advising legal counsel at the cognizant MTF.

Determining whether the patient consents to providing a signed release of information for their records (or specific portions of their records) may also be important. Without a signed release of information from the patient covering records, MH providers generally require a subpoena or court order and seek legal counsel regarding any disclosures.

Primary Care Provider: DoDM 6025.18 and DoDI 6400.06 provide guidance on disclosure of protected health information. Per DoDI 6400.06, the disclosure will be limited to the information necessary to satisfy the purpose of the disclosure.

Question 12: How does the treatment of patients with mental healthcare concerns in primary care differ from the treatment of patients in outpatient mental health?

MH Provider: While the mainstays of diagnosis and treatment are the same, there are ways in which treatment differs in primary care as compared with MH spaces. These include, but are not limited to:

- DoD MH services include Specialty Outpatient MH, Alcohol and Substance Use Programs, Inpatient Hospitalization, and Intensive Outpatient Programs where patients receive evidence-based assessment, psychotherapy, and psychiatric care based on their MH concerns. In primary care, the DoD implements PCBH where IBHCs are integrated into the primary care medical home to increase the availability of MH services to adult patients and prevent gaps in care. Primary care providers manage the majority of MH care in primary care clinics. They are not trained to provide counseling or therapy.
- Primary care providers have a narrower scope of practice in regard to MH conditions they treat when compared with MH providers. For example, while most primary care providers are trained to treat patients with mood disorders including depression and anxiety, fewer are trained to treat patients with Post-traumatic Stress Disorder and Bipolar Disorder, and even fewer are trained to treat patients with thought disorders (e.g., Schizophrenia).
- As a general rule, primary care providers offer a narrower array of medication options and treatment modalities than MH providers.

Primary Care Provider: Primary care providers review screenings, assess patient concerns and symptoms, determine the appropriate treatment setting, and work with the patient on a management plan that may include development of self-management skills, medication, and/or referral for additional evaluation and treatment. Primary care providers' recommended treatment plans may include development of self-management skills, psychotherapy and/or pharmacotherapy. A variety of factors are considered including, but not limited to, risk, severity and chronicity, previous treatment response, and patient preference.

Question 13: Is there collaboration between primary care providers and mental health providers? What does that look like?

MH Provider: Yes. Providers with clinical responsibility for a shared patient openly exchange information as needed for care and often record information from multidisciplinary team

meetings in the patient record. Collaborations may include messages between primary care providers and MH providers (similar to other specialists) about referrals and follow-up requirements. Primary care providers may relay pertinent information, such as a patient's communications to the primary care provider, directly to the MH provider. For example, in inpatient settings where a patient is hospitalized for a general medical condition but requires an MH consultation, a psychiatry consultant may integrate portions of their notes, which may include direct patient communications to a psychiatrist or social worker, into the general medical record and narrative discharge summary.

Regular case conferences, where MH providers meet to discuss patient presentations and treatment progress, are a common method of facilitating bidirectional information sharing between primary care and MH providers. As a result of this, primary care providers may inquire about specific information from or statements made during MH treatment, which they may subsequently document in the primary care portion of a patient's medical record.

Collaborative care blends information between primary care and specialists like MH providers with the goal of providing MH providers with the best available data to develop unified diagnoses and treatment plans. Goals of collaboration include earlier detection and intervention for MH conditions, improved treatment adherence, reduced emergency room visits, cost savings, and improved patient satisfaction and outcomes.

Primary Care Provider: Multidirectional communication and collaboration are essential in an interprofessional and interdisciplinary healthcare team, including with primary care providers and MH providers. Per DHA- Procedures Manual 6025.01, "Primary Care Behavioral Health (PCBH) Standards," December 20, 2019, within the PCBH model, Behavioral Health Care Facilitators may facilitate communication between the primary care manager (PCM) and the specialty MH provider to increase coordination of patient care. The PCM is ultimately responsible for the healthcare plan of the patient and the MH provider must document any care recommendation in the medical record.