Mayor's Office of
Community Mental Health

Testimony of
Susan Herman, Senior Advisor
and
Director, Mayor's Office of Community Mental Health

Before the New York City Council
Committee on Veterans
and
Committee on Mental Health, Disabilities and Addictions

Regarding Intro. 2442

November 17, 2021

Mayor's Office of
Community Mental Health

Good morning, Chair Louis, Chair Dinowitz, and members of the Committee on Mental Health, Disabilities, and Addiction—and the Committee on Veterans. My name is Susan Herman and I am a Senior Advisor to the Mayor and Director of the Mayor's Office of Community Mental Health. Thank you for the opportunity to testify in support of Intro. 2442.

Long before the COVID-19 pandemic, mental illness was common in New York City. Every year, one in five New Yorkers experiences mental illness—and hundreds of thousands of them are not connected to care. Over nearly two years of loss, uncertainty, and trauma, the pandemic has exacerbated pre-existing mental health needs and created new ones. These years have also highlighted deep historical structural inequities: New Yorkers of color are more likely to experience mental health needs than white New Yorkers, yet less likely to get the care they need. These profound needs and persistent disparities demand an all-government approach to mental health, and sustained leadership from the highest levels of City government.

That is why, earlier this year, Mayor de Blasio signed Executive Order 68 to establish the Mayor's Office of Community Mental Health, or OCMH. Our office builds on the vision of ThriveNYC, which represented the first time a large American city dedicated its own funding—not just State and Federal funds—to support the mental health of people who had long been underserved. Today, the Mayor's Office of Community Mental Health partners with dozens of City agencies and nearly 200 community-based organizations to promote mental health for all New Yorkers.

With the wide-ranging mental health impact of the COVID-19 pandemic likely to linger for years to come, the work of our office is more important than ever. Accordingly, the City strongly

supports Intro. 2442, which amends the City's charter to codify an office of community mental health. To demonstrate the value such an office brings to our city, I would like to describe the core functions of the Mayor's Office of Community Mental Health.

We work in two distinct ways. First, we close gaps in mental healthcare through innovative approaches. Second, we provide strategic policy guidance and inter-agency coordination to maximize the promotion of mental health across City government. I would like to share some of the remarkable progress we have made over the last few years—progress that is having a measurable impact on the lives of New Yorkers.

CLOSING GAPS IN MENTAL HEALTHCARE THROUGH INNOVATION AND PARTNERSHIP

OCMH oversees initiatives implemented by City agencies and community-based partners—all designed to close gaps in mental healthcare. These initiatives supplement and enhance the pre-existing mental healthcare system. They were never intended to replace it. Our focus on closing gaps in care has led to new or enhanced mental health services in many locations, including shelters, schools, family justice centers, senior centers, residences and drop-in centers for runaway and homeless youth—and mobile services that can reach New Yorkers wherever they are.

In a city our size, it is especially important to test innovative solutions, so we know what to bring to scale. Our office provides programmatic oversight. We assess program performance, meet regularly with agencies to discuss progress, troubleshoot obstacles, and refine our approach when appropriate.

Reach and impact data for each of our programs is publicly available in a user-friendly data dashboard—on our website. Here are a few examples of how our programs are making a measurable impact.

First, New Yorkers are getting help right when they need it. NYC Well, the City's free, 24/7 helpline for mental health and substance misuse issues, has responded to more than 1.3 million calls, texts, and chats since 2016. People call for crisis counseling, referrals to providers, or urgent care from a mobile crisis team. **Over 93 percent of callers consistently say they are satisfied with NYC Well's services.**

Second, victims of crime are feeling safer. Because we recognize that crime can have a serious impact on victims' mental health, we launched the Crime Victim Assistance Program or CVAP, which places Safe Horizon advocates in every police precinct and Police Service Area citywide. CVAP advocates have served over 200,000 New Yorkers, through supportive counseling, safety planning, referrals to legal and social services, and assistance applying for victim compensation. **Last year, almost 95 percent (94.7%) of people surveyed reported feeling safer emotionally and/or physically after receiving assistance from a CVAP advocate.**

Third, older New Yorkers are seeing improvements in depression. In partnership with the Department for the Aging, we have added clinicians to 46 senior centers across the city. These clinicians have screened over 3,600 older New Yorkers for a variety of mental health needs and provided more than 38,000 therapy sessions. Therapy helped. **In the most recent**

reporting period, almost 55 percent (54.7%) of older adults experienced a clinically significant improvement in depression after three months of treatment.

A fourth example—more New Yorkers with serious mental illness are staying connected to care. Around 90 percent of people served by Intensive Mobile Treatment teams—people previously disconnected from care—remain in treatment consistently for at least 12 months—a remarkable success given their history.

All of these initiatives are now part of our dynamic portfolio. Here's how it works: when a strategy or program has achieved proof of concept, it becomes fully integrated into the functions of the implementing agency. Several initiatives have already gone through this process.

Another way we eliminate barriers to care for underserved populations is through partnerships with the non-profit and private sectors. For example, we have provided technical assistance, training and support—to MTA employees who need to know how to identify and respond to people in need—to over 400 faith leaders who wanted training on trauma and grief—and to people working in the nightlife and creative sectors who wanted mental health support. We have also embedded mental health resources into key locations, including public libraries, private sector and non-profit workplaces, and NYCHA Cornerstone Community Centers.

COORDINATING AN ALL-GOVERNMENT APPROACH TO MENTAL HEALTH

The second core function of our office is to provide strategic policy guidance and inter-agency coordination to improve the mental health of New Yorkers. This work—critical to

ensuring an all-government approach to promoting mental health—is needed now more than ever. Let me give you a few examples.

This year, we convened four agencies—H+H, FDNY, NYPD, and DOHMH—to bring emergency mental healthcare to people—wherever they are—in their homes or in public places--for the first time in New York City's history. B-HEARD—our new health-only mental health emergency response—is currently operating across five precincts in upper Manhattan (25, 28, 32, 26, 30 precincts), where social workers and EMTs respond together to mental health 911 calls. The B-HEARD response has already reduced unnecessary hospitalizations and unnecessary use of police resources. **For example, in the first three months, 43 percent of people served by B-HEARD were assisted on-site or transported to community-based care—options not available ever before. A cross-agency collaboration of this complexity requires the high-level leadership that a mayoral office can provide.**

Recently, we initiated new cross-agency work to prevent 911 mental health emergencies. About 300 people call 911 more than three times a month—that's a tiny fraction of one percent of our city accounting for six percent of mental health emergencies. We believe these people could be getting more effective care—care that might prevent these costly emergency interventions. That's why the FDNY and the Health Department are now beginning to connect frequent utilizers of 911 to teams of peers and social workers, to engage them in ongoing care. More than anything, this initiative required a simple shift in how agencies do business—one that we believe will have long-term positive impact. **It likely would not have happened without the coordination function of a mayoral office.**

We also have a more formalized coordination role through the Mental Health Council—first created by Executive Order 15—and convened by our office. Over 30 agencies across government come together regularly to share best practices, request information, and collaborate to create an all-government approach to mental health.

Over recent years, the Mental Health Council discussions have led to development of resource guides for vulnerable populations, embedding mental health screening and referrals into emergency food delivery during the pandemic, and new strategies to prevent vicarious trauma among frontline City workers. **Intro. 2442 would incorporate the Mental Health Council into the Charter, with the Mayor's Office of Community Mental Health continuing to serve as the convener.**

ENSURING A LASTING COMMITMENT TO MENTAL HEALTH

New York City has done something that no other large city has done. We have made mental health a priority for City government. With Mayor de Blasio and First Lady Chirlane McCray's leadership, we started an unprecedented conversation about mental health that is having a lasting impact—but we didn't stop there. We have significantly expanded support for people with serious mental illness, strengthened our response to mental health crises—and just as importantly—made investments in early intervention, and prevention. All of this with a focus on mental health equity—that will transform our city for years to come.

We have done this intentionally, with innovative solutions designed to address longstanding gaps in care. We have done this transparently, with data for every single program available on our website, to help the public understand the reach and impact of our work. We have done this

responsibly, with careful stewardship of taxpayer dollars documented in publicly available programmatic budgets.

This work must continue. In the wake of the pandemic, it must go even further to make sure every New Yorker has mental healthcare, whenever, wherever, and however they need it. Now is the time to enshrine the City's high-level commitment to mental health—and the office needed to fulfill it—into the Charter of our city.

Thank you for the opportunity to testify today, and for your continued leadership and partnership.

Testimony of James Hendon

Commissioner for the New York City Department of Veterans' Services (DVS)

New York City Council Committee on Veterans & Committee on Mental Health, Disabilities and Addictions

Topic: Oversight - Mental Health Services for Veterans in Response to COVID-19, and Alternative Treatments for Post-Traumatic Stress Disorder (PTSD)

November 17th, 2021, 10:00 AM (Virtual)

Introduction

Good morning, Chair Dinowitz, Chair Louis, committee members, and advocates. My name is James Hendon, and I'm proud to serve as the Commissioner for the New York City Department of Veterans' Services (DVS). I am joined today by Susan Herman, Senior Advisor to the Mayor and Director of Community Mental Health and Jamie Neckles, Acting Assistant Commissioner for the Bureau of Mental Health at Department of Health and Mental Hygiene. I welcome this opportunity to testify about Mental Health Services for Veterans in Response to COVID-19, and Alternative Treatments for Post-Traumatic Stress Disorder (PTSD)

COVID-19 & Mission: VetCheck

The coronavirus outbreak exacerbated existing mental health needs as well as creating new ones for many New Yorkers, making it more important than ever to stay connected to one's community. This time has also increased citywide rates of food insecurity, unemployment, social isolation, and the need for housing, medical and benefit assistance. VetCheck was designed to offer New York City's veterans support and connection to the veteran community during this

crisis, as well as immediate information about essential public services, including free meals, COVID-19 test site locations, vaccination information and mental health resources. Veterans were also referred to DVS for additional resources and support such as housing, benefits, or healthcare needs. VetCheck trained volunteers from New York City's veteran community to make compassionate check-in calls to other veterans. Training was delivered by DVS and the Mayor's Office of ThriveNYC, and volunteer management was overseen and conducted by New York Cares. Volunteers were also offered supplemental training resources through PsychArmor, an organization that provides military-specific trainings. The New York National Guard helped pilot the initiative by making over 4,000 calls to city veterans. Almost a quarter of the veterans whom volunteers were able to speak with were referred to services. The most common service requests have been for food assistance, unemployment, information about COVID testing, and healthcare question.

Background & Data

Since the launch of Mission: VetCheck in April 2020, we have facilitated over 34,000 total calls with an approximate 25% answer rate. Resulting in an average of over 21 answered calls per business day. Of those answered calls, DVS is proud to have been able to serve the over 1,200 requests for help during that period. These requests ranged from food assistance, eviction prevention, mental health, benefits navigation and more.

Additionally, DVS began the implementation of two health assessments, known as the Patient Health Questionnaire-9 (PHQ-9) and the Generalized Anxiety Disorder-7 (GAD-7), to screen our clients for depression and anxiety. Since February 2021, DVS staff have conducted over 220 health assessments, for which 49 resulted in a score indicating severe anxiety or depression. In this same period, DVS has made 95 referrals for mental health services. This is three times the

number of referrals compared to the period before the implementation of the health screeners. Further enhancing DVS' ability to uncover the mental health needs of our clients more accurately.

DVS' Collaborative Approach to Mental Health Services

DVS have also made suicide prevention among service members, veterans, and their families (SMVFs) a top priority through collaboration. DVS has been the beneficiaries of trainings by experts affiliated with the U.S. Substance Abuse and Mental Health Services Administration and the U.S. Department of Veterans Affairs to develop a network of military culturally competent community-based organizations able to tackle the challenges of servicing returning warriors and veterans coping with physical and emotional distress.

DVS established Crisis Intercept Mapping Teams in Staten Island and Queens to strengthen the delivery of evidence-based suicide prevention policies and practices for SMVFs during the period surrounding an episode of acute care when the risk of suicide is higher. These teams comprised of Community and Veteran Medical Centers, Behavioral Health Providers, Social Service Organizations and New York City agencies.

Following the formal training sessions, these teams have evolved into virtual learning communities in which best practices in crisis care have been more intensively explored with subject matter experts focusing on the benefits of asking the question whether their clients have ever served in the armed forces, Reserves, or National Guard, peer to peer connectedness, suicide prevention screening and lethal weapon safety planning, gambling addiction among veterans, and most recently, impact of the withdrawal of Afghanistan had on our veterans.

In a related initiative to reduce suicides among service members transitioning from active-duty to veteran status, DVS is supporting the national Department of Defense/Veterans Affairs endorsed Expiration of Term Service Sponsors Program, by identifying community-based organizations which can assist in recruiting and managing veteran and civilian sponsors willing to ease the reintegration of returning warriors to their hometowns or new residential communities in New York City. We have been successful in enlisting the Staten Island Participating Provider System as a lead agency for this network and continue our efforts in reach out to other suitable organizations.

The National Suicide Prevention Lifeline and Veterans Crisis Line 9-digit telephone number will be replaced by the three-digit 988 in July 2022. In planning for this roll-out, NYS Office of Mental has formed several working groups to assist in the implementation and expansion of mental health crisis call centers. DVS has joined the Community Education and Marketing Working Group to ensure that appropriate messaging is crafted and effectively disseminated to the military and veteran communities.

Conclusion

We thank you for the opportunity to testify on this matter and look forward to any questions you or other Committee members may have.

Testimony to the New York City Council's
Committee on Veterans and Committee on Mental Health, Disabilities, and Addiction
Delivered virtually on November 17, 2021
by Ashton Stewart, SAGEVets Program Manager

Thank you, members of the New York City Council Committee on Veterans and Committee on Mental Health, Disability and Addiction, for holding this oversight hearing. My name is Ashton Stewart, and I am the manager of SAGEVets, SAGE's statewide program for lesbian, gay, bisexual, transgender and queer or questioning (LGBTQ+) veterans. I am also a member of the Intrepid Sea, Air and Space Museum's Council of Veterans Advisors, and the New York State Council of Veterans' Organizations.

SAGE is the country's first and largest organization dedicated to improving the lives of LGBTQ+ older people. Founded in New York City in 1978, SAGE has provided comprehensive social services and programs to LGBTQ+ older people for more than four decades. SAGEVets is one of SAGE's programs and, in fact, is the only program in the state designed for older LGBTQ+ veterans.

Support from the New York City Council has been instrumental to our SAGEVets program – allowing SAGE to engage older LGBTQ+ veterans across this great city and making a real difference in the lives of many older LGBTQ+ veterans.

New York is home to approximately one million men and women who served their country in the Armed Forces – many of whom are LGBTQ+. New York City and State are among the top ten cities and states with the highest concentrations of gay and lesbian veterans, both in number and per capita. In fact, the Urban Institute estimates there are over 38,000 lesbian and gay veterans living in New York State, with 17,000 residing in New York City.

According to a survey by the New York State LGBTQ+ Health and Human Services Network, 56% of those LGBTQ+ people who were veterans were over the age of 50. Many LGBTQ+ older veterans in New York are struggling and yet, are not accessing the services they need. In fact, according to the New York State LGBTQ+ Health and Human Services Network:

- 43% of lesbian, gay and bisexual vets live at under 200% of the Federal Poverty line; for transgender veterans, this number was nearly 60%
- 30% of lesbian, gay and bisexual veterans were homeless; 46% of transgender vets were homeless
- 34% of lesbian, gay and bisexual veterans were food insecure; over 61% of transgender vets struggle with food insecurity
- 30% of lesbian, gay and bisexual veterans and 48% of transgender vets fear discrimination from providers

SAGEVets was created to identify, support, and improve access to care among older LGBTQ+ veterans across the city and state and to respond to the swelling needs described above. Further, to elevate the visibility of older LGBTQ+ veterans and their unique needs, SAGEVets program works in partnership with veteran service programs throughout the city to provide legal information and referrals for VA benefits including medical, pension, and education.

Serving a population of veterans, who struggle with the identity as a veteran is no easy task. The anti-LGBTQ+ policy that existed in the U.S. military from the Revolutionary War through 2011 when Don't Ask Don't Tell (DADT) ended has taken its toll on the veterans we serve. And with COVID-19 that challenge has been exasperated.

For LGBTQ+ veterans, many of whom were already struggling with financial insecurity, food insecurity, acute social isolation, and exacerbating health disparities, COVID-19 has presented mounting challenges, most acutely with mental health. Many of the LGBTQ+ older veterans who need help with food, connection, healthcare, or financial security often do not turn to the VA or other veteran services providers who can help for fear of discrimination. This has created a chasm between the need and access to care – one that is especially dangerous in the middle of the COVID-19 public health crisis.

Additionally, not all service providers, including the VA, can offer the full suite of services they offered prior to the pandemic. The Home-Based Primary Care program at the VA has been significantly impacted, leaving especially vulnerable veterans at risk; they can, however, still conduct telephone intakes and screenings. To work around these issues, we have encouraged veterans to keep up with their primary care doctors with virtual appointments as a secondary option.

A saving grace during the pandemic is the Vet Center Program offered by the VA. These community-based counseling centers provide a wide range of social and psychological services, including professional readjustment counseling to eligible Veterans, active duty service members, including National Guard and Reserve components, and their families. The greatest thing about Vet Centers is they do not consider types of discharges, meaning all veterans are welcome. This is especially helpful to older veterans who received less than honorable discharged for being LGBTQ+. It is estimated that 114,000 veterans were discharged between WWII and 2011, when Don't Ask Don't Tell ended.

With the shift from in person to virtual services, at SAGE, we quickly adapted our programs and services to connect with older LGBTQ+ veterans. Since the summer of 2020 SAGEVets has offered virtual programs where we share veteran resources and legal information, and feature celebrated LGBTQ+ veterans sharing their personal stories. This includes a weekly virtual Veteran Support Group facilitated by a social worker. Recently, we have expanded our virtual offerings include partnership events such as a Transgender and Gender Diverse Veteran Awareness program in collaboration with the VA.

And on November 18 together with the New York State Division of Veterans' Services, we are proud to offer the first-ever national program bringing together five states with Restoration of Honor legislation, an event sponsored by the New York State Bar Association. Bringing people

together in these virtual spaces has helped alleviate some of the isolation issues that can lead to mental health challenges. We are pleased that we are beginning to see more in-person events offered such as the recent New York City Veterans Day parade.

On Veterans Day, SAGEVets was honored to march along Fifth Avenue for the 102nd annual parade along with our fellow veterans. Thousands of spectators lined the streets warmly extending their appreciation and support for our contingent, including "Joe," a veteran of the U.S Army who served during the Vietnam Era, who not long-ago reported feelings of depression and helplessness. Joe marched up Fifth Avenue using his rollator and grinning ear to ear. It was a wonderful site to see him get cheered on by supportive spectators! Joe also commented on his appreciation for the United Veterans War Council and the NYPD for putting together such a remarkable show of unity and support for our veterans.

Marching in the NYC Veterans Day parade and engaging with spectators, could be viewed as an indication that things will soon be improving. But the reality is we continue to see an uptick in older LGBTQ+ veterans struggling with their mental health, an increase that can create long wait times for support. Further, we are concerned that like the Home-Based Primary Care program, Vet Centers will to soon be at capacity or overwhelmed.

SAGE is deeply grateful for the support of the New York City Council and the Committee on Veterans. We look forward to our ongoing collaboration with the Council in our shared work to ensure that our City's older LGBTQ+ veterans can access the care, services that they deserve.

City Council Committee on Mental Health, Addictions and Developmental Disabilities Jointly with the City Council Committee on Veterans: Oversight Hearing on Mental Health Services for Veterans in Response to COVID-19, and Alternative Treatments for Post-Traumatic Stress Disorder (PTSD)

November 17, 2021

Chair Louis, Chair Dinowitz, and distinguished members of the City Council, thank you for the opportunity to testify today. I'm Claire Kozik, Associate Director of Policy & Advocacy at The Coalition for Behavioral Health. The Coalition represents over 100 community-based mental health and substance use providers, who collectively serve over 600,000 New Yorkers annually.

The COVID-19 pandemic has catalyzed and exacerbated mental health challenges and substance use disorders for hundreds of thousands of New Yorkers, and veterans were no exception. In 2020, 30% reported having suicidal thoughts over a two-week period[i] and sadly, the number of U.S. military suicides increased by 15% nationwide.[ii] New York State, in particular, has a veteran suicide rate that is almost twice that of the national average.[iii]

Moreover, 52% of veterans reported that their mental health declined as a result of isolation that came from the necessity of social distancing. The rate of generalized anxiety disorders has increased, particularly among veterans aged 45-64, with one in seven experiencing increased distress.[iv] There was also a 15% national increase in the number of veterans' crisis calls in 2020. Veterans, like many other New Yorkers, are experiencing significant mental health and substance use challenges as a result of the pandemic.

Unfortunately, the behavioral health workforce is insufficient to meet this increased need, and, as a result, veterans and many others are not able to access the care they need. Prior to the pandemic, the behavioral health field already had a workforce shortage, due low salaries and benefits across the sector. This shortage has now reached crisis levels, as staff have left the field for higher paying positions in other sectors, such as retail and restaurants, while record numbers of New Yorkers seek help.

Nationally, 97% of mental health and substance use treatment organizations reported that it has been difficult to recruit staff. Our providers tell us everyday of the staffing crisis they face. We have agencies that have over 100 open positions, but have only received a handful of applications. Behavioral health providers are pausing new admissions, decreasing the size of programs, and in some cases, closing programs entirely due to insufficient staffing. Many of our members are hesitant to take on new contracts because they do not know where they would find

the staff for these programs. Veterans will not be able to access the mental health and substance use care they need unless significant action is taken to address the workforce crisis.

Lack of access to care, or delays in receiving care, has a detrimental effect. Veterans who screened positive for depression before the pandemic demonstrated higher levels of substance use after the pandemic's onset.[v] This increase in substance use runs parallel to the 40% increase in overdose deaths among all New Yorkers in 2020. The City Council should support efforts to expand and reinforce the behavioral health workforce to ensure that there are behavioral health professionals available to care for mental health and substance use treatment needs of its 138,000 veterans.

Most importantly, the Council should increase funding for city-contracted mental health and substance use providers so that they can raise wages and provide better benefits for their staff. The City must work with providers to ensure that city services are funded adequately. For too long, the City has forced providers to accept contracts that provide poverty level wages for staff. There should be a living wage floor set on all city contracts, as well as annual cost-of-living adjustments. Additionally, the City should create, fund, and incorporate a comprehensive wage and benefit schedule for government contracted human services workers comparable to the salaries made by City and State employees in the same field.

Just recently, we saw providers lose hundreds of social workers who were providing clinical services to New Yorkers every day, when the City hired those same social workers at a salary thousands of dollars higher than the City paid for the contracted services. This counterproductive move means that rather than increasing the capacity for mental health services at a time when it is desperately needed, the City disrupted care for thousands of New Yorkers. If the City had provided equitable funding for contracted providers, this never would have occurred. For the City to ensure services for veterans, the City must provide adequate fund for the staff who provide these services.

We also encourage the Council to continue efforts to address the digital divide. Telehealth proved to be an invaluable tool for many individuals who sought care during the pandemic. Many programs, including outpatient services and substance use treatment groups, were able to transition to telehealth, avoiding gaps in service and maintaining access to care. However, many veterans were unable to access telehealth, as they lacked sufficient internet bandwidth or did not have a sufficient device. While providers worked to fill these gaps, conducting sessions over the telephone and purchasing devices for clients, it is clear that access to the internet has become a social determinant of health. The City Council should continue efforts to close the digital divide, by providing affordable internet and subsidizing the purchase of devices for telehealth.

Lastly, we want to highlight the importance of the Council’s funding for veteran’s mental health. Two of our member agencies receive funding through this initiative. It is critical to connecting veterans to community-based mental health and substance use care. This initiative directly funds mental health and substance use care for veterans, including medication management, psychiatry services and treatment for opioid use disorder. The Coalition encourages the City Council to maintain funding for this initiative.

Thank you for the opportunity to testify today. We look forward to working with the City Council to ensure robust mental health and substance use services are made available to our veterans.

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[i] https://nyshealthfoundation.org/wp-content/uploads/2021/01/new-york-veterans-mental-health-covid-19-fact-sheet.pdf

[ii] https://apnews.com/article/coronavirus-pandemic-health-army-lloyd-austin-aa9971be75f6a78d9b6530d6ff3d6d72

[iii] https://nyshealthfoundation.org/resource/veteran-suicide-in-new-york-state/

[iv] Hill ML, Nichter B, Na PJ, Norman SB, Morland LA, Krystal JH, Pietrzak RH. *Mental health impact of the COVID-19 pandemic in U.S. military veterans: a population-based, prospective cohort study*. Psychol Med. 2021 Jun 14:1-12. doi: 10.1017/S0033291721002361. Epub ahead of print. PMID: 34120667; PMCID: PMC8245339.

[v] https://onlinelibrary.wiley.com/doi/full/10.1111/ajad.13211

Testimony of Kevin W. Hertell

Founder/President of the New York Nonprofit named,
"The Veterans Suicide Awareness & Remembrance Flag Corporation"
& SAR Flag Creator - www.sarflag.com

Topic: Mental Heath/Suicide Awareness & Prevention for Veterans & Military of New York City

November 17th, 2021

According to the American Foundation for Suicide Prevention, mental health conditions are treatable and suicide is preventable.

Greetings, New York City Council.

My name is Kevin W. Hertell and I am an Air Force Veteran. I served as an F-16 Crew Chief before, during, and after 9/11.

I am the Founder and President of the New York nonprofit named, "The Veterans Suicide Awareness & Remembrance Flag Corp." and creator of the "Suicide Awareness & Remembrance Flag," or SAR Flag (spoken as S-A-R). I am also the originator of "Veterans Suicide Awareness & Remembrance Day."

Veterans and Active Military continue to be at greatest risk to die by suicide among the U.S. population.

According to the VA, we've lost over **100,000** Veterans and Active Military to suicide since 2001, and we continue to lose around 20 a day, to this day.

Each year, an average of approximately 7,000 Veterans and Active Military die by suicide in the United States, which is equal to all of the casualties from the wars of Iraq and Afghanistan combined, going back to 9/11.

In New York, in 2018 alone, 172 Veterans died by suicide.

In New York State, suicide is the 12th leading cause of death, and Veterans and Military die by suicide by almost double the rate as their civilian counterparts.

The Dept. of Veterans Affairs has spent millions in outreach and prevention, yet these suicides persist.

There are nonprofits across the country and in the State and City of New York that work to combat Veteran/Military suicide, yet the suicides persist.

There have been ruck marches and hikes in NYC and beyond to promote positive mental health and camaraderie among Veterans/Military, yet the suicides persist.

There are social media campaigns and challenges to raise awareness, like the 22 Push-up challenge, in New York City and beyond, yet the suicides persist.

There is a Veterans Crisis Line, yet the suicides persist.

Veteran/Military suicides continue despite the efforts of our beloved City, State, and Nation because of the stigma associated with mental health, suicide, and seeking treatment; especially within our warrior culture.

According to rand.org, fewer than half of eligible Veterans use VA health benefits, and of those, even fewer use it to access mental health treatment. We also know even fewer Active Military seek out mental health treatment during their enlistment. This behavior only facilitates the deaths by suicide of the approximately 20 Active Military and Veterans we lose every day.

Raising our continued awareness and breaking the stigma of suicide and mental health are key steps to preventing this unnecessary loss of life.

We can end the stigma of mental health and suicide in New York City and beyond with the Suicide Awareness & Remembrace Flag or SAR Flag.

The SAR Flag was created to honor and forever remember the Veterans and Active Military lost to the Veteran suicide epidemic, as well as honoring, respecting, and uniting their families. The SAR Flag also stands as a tangible symbol of hope to living Veterans and Active Military to show that we care as a City, State, and Nation, and to know that they are not alone.

By honoring those lost we can change the perception of suicide, and we can then work to prevent living Veterans/Military from becoming a part of the suicide epidemic.

The mission of my NY nonprofit is to see that the SAR Flag is officially recognized by Congress. One day, similar to the POW flag, we aim to fly the SAR Flag over the Capitol, the White House, Main Street, and everywhere in between, uniting the nation, as well as unifying nonprofits working to combat this crisis across the country in our common goal to recognize, and then end the Veteran/Military suicide epidemic.

Our efforts originated in New York and we are currently working with the New York State Assembly after the Senate unanimously passed legislation designating September 22nd as “Veterans Suicide Awareness and Remembrance Day,” as well as legislation to have New York State officially adopt the SAR Flag.

By having “Veterans Suicide Awareness & Remembrance Day” as an annual observance, we elevate this issue in the public consciousness and raise our continued awareness, which facilitates discussion about Veteran/Military suicide, thereby taking away the stigma associated with it. And by normalizing an otherwise taboo subject of mental health among Veterans and Active Military, we will allow them to seek out the care they need without fear of judgment while simultaneously showing that we care as a State and Nation, to prevent living Veterans and Active Military from dying by suicide.

Please help us help Veterans & Military by supporting New York Assembly bills A6200 and A6975.

Let the great State of New York be the example for the Nation to follow, and let it originate in the heart of America, New York City.

We can prevent this loss of life and make a difference in the suicide rate among our Veterans and Military. It starts with removing the stigma of mental health and suicide so our warriors and defenders can get the help they need. It starts by New York State adopting the SAR Flag and annually recognizing September 22nd as “Veterans Suicide Awareness & Remembrance Day.”

If we can show living Veterans and Military that we care as a City, State, and Nation by braking the stigma of mental health and suicide, we can save lives. - Let us End Veteran and Military Suicide, together.

Thank you for this opportunity to testify.

Sincerely & Respectfully,

Kevin W. Hertell

LiveOn NY

Making New York a better place to age

New York City Council
Committee on Aging
Chair Council Member Chin
November 19, 2021
Oversight - Home Care and Caregiving Strategy

Thank you for the opportunity to testify.

LiveOn NY's members include more than 100 community-based nonprofits that provide core services which allow all New Yorkers to thrive in our communities as we age, including senior centers, home-delivered meals, affordable senior housing, elder abuse prevention, caregiver support, NORCs, and case management. With our members, we work to make New York a better place to age.

Background

Today, we have an opportunity to discuss a key pillar in the continuum of care that enables thousands of older New Yorkers and people with disabilities to age in place: home care. In many ways home care, along with the entire continuum of community-based services, are the critical bulwarks to ensuring individuals can age in communities, rather than in institutional settings, as research has shown to be preferred.

Unfortunately, like much of the network of services that supports an individual's ability to age in place, our home care system relies on a workforce that is both underappreciated and underpaid. Even further, waiting lists, due to inadequate government investment, limit the reach that our non-Medicaid funded home care program could have for older New Yorkers.

Historically, and even more so during the pandemic, the unmet need for home care for older New Yorkers and people living with disabilities was exacerbated by high turnover and staff shortages due to low wages. Further, COVID-19 disproportionately impacted older adults, and individuals of color, revealing existing inequities and the overburdened state of our long-term care system.

Evidence of the inequitable, underappreciated nature of care work — which is predominantly executed by women and Black, Indigenous, and People of Color (BIPOC) individuals — the median annual earnings of New York's home care workers are only $22,000. In comparison to other industries, the home care industry will require significant resources and investments to ensure *all* workers receive a livable, competitive wage.

The high rates of turnover in the home care industry can greatly impact the quality of care for older adults and people living with disabilities. A 2019 qualitative study by BMC Health

Services found that high turnover rates can be costly and negatively contribute to "both the quality of care for patients and staff- patient relationships." Along with rapid turnover and low wages, the physical and emotional toll home care workers face creates a challenge to retain and recruit new workers.

Recommendations

Today, we have the opportunity to address the challenges that arose during the pandemic to provide improved and long-lasting care services for older adults. Many of whom prefer to age in place. It is crucial to stress the importance of improving and expanding our long-term care system in our City. In order to tackle these important issues, LiveOn NY recommends the following:

1. **Full funding and an outyear plan to consistently eliminate home care and case management waiting lists.** Waiting lists for home care and case management remain a chronic issue in New York City, with waiting lists for services existing for years, despite modest investments. Notably, the two programs are inextricably linked, with a waiting list for one service impacting the accessibility of the other, as case management is first required in order to assess an individual for home care eligibility. Together, these services enable older adults in all five boroughs to age safely and independently in their communities, avoiding unwanted moves to costlier institutional care settings. Further, given the exacerbated strain from the pandemic, the City must address unmet need for critical services with significant long-term investments and solutions. Finally, given the chronic nature of these waiting lists, the City must articulate a five year plan for increased investments based on historical and demographic data that make clear the likelihood of continued growth in demand.
2. **The City should advocate to the State to pass and fund Fair Pay for Home Care.** The purpose of this legislation is to "establish a base wage for home care workers at 150% of the regional minimum wage," thereby ensuring the role of home care workers remains competitive, at least in comparison to positions funded at minimum wage. Without such a mandate and corresponding funding from the government, wage compression will continue to diminish the viability of this demanding, highly emotional role, thereby exacerbating the existing home care attendant shortage.
3. **$48 Million Cost of Living Adjustment (COLA) for essential human services workers, including those that execute the DFTA caregiving, case management and home care programs.** Throughout COVID-19, human services workers across sectors have stepped up to provide critical services in new ways, including to keep New Yorkers older New Yorkers fed, assist older adults in receiving vaccinations, and combating the life-threatening effects of social isolation. Despite this, the wages of these workers, the

majority of whom are women and Black and brown individuals, are slated to remain stagnant in a City where costs are notoriously high.

Legislative Positions

LiveOn NY strongly supports Council Member Chin's Resolution in support of Senate Bill 598B and Assembly Bill 3922 which seeks to create a task force to reimagine long term care and study the long run impacts of long-term care services in New York State. We join in echoing the Resolution's call for the Governor to sign this important legislation into law. LiveOn NY has long advocated for the emergence of a Task Force to seize the opportunity to emphasize the cost-effective, community-based long term care models that already exist and could be further expanded. For example, one of LiveOn NY's members, Selfhelp Community Services, have designed the Selfhelp Active Services for Aging Model (SHASAM) which provides a culturally competent social worker in affordable senior housing to serve their diverse residents. This model also provides other supportive services such as benefits and entitlement assistance and health programming. Additionally, Naturally Occurring Retirement Communities (NORCs) offer the NORC model which employs social workers, nurses, and in programming to encourage physical activity and combat social isolation. By mobilizing a dedicated Task Force to oversee the growth and expansion of these models and others alike, New York will contribute to the larger cause of enabling older adults to age in place with their care needs addressed.

LiveOn NY is actively reviewing Council Member Chin's Resolution in support of Assembly Bill 3145A and Senate Bill 359, which would require non-sequential split shifts for care workers. Home care workers are essential in assisting older adults with daily responsibilities in their home. Having this service allows older adults to remain in their homes and have extra support. Currently, care workers are entitled "to eight hours of sleep and three hours for meals during a 24-hour shift under the '13-hour rule." This state implemented rule creates significant challenges for both home care agencies and workers alike, as it does not accurately capture the extra hours that may be served should the client need services during the night or at another point in the unpaid working hours. Given this challenge, LiveOn NY looks forward to fully reviewing and determining a position on this potential legislative solution, and all other solutions that may be brought to light, to determine a path forward that ensures full compensation for hours worked across home care workers and full state reimbursement towards such wages.

Thank you for the opportunity to testify.

LiveOn NY

Making New York a better place to age

older New Yorkers annually. Our members provide services ranging from senior centers, congregate and home-delivered meals, affordable senior housing with services, elder abuse prevention services, caregiver supports, case management, transportation, and NORCs. LiveOn NY advocates for increased funding for these vital services to improve both the solvency of the system and the overall capacity of community-based service providers.

LiveOn NY also administers a citywide outreach program and staffs a hotline that educates, screens and helps with benefit enrollment including SNAP, SCRIE and others, and also administers the Rights and Information for Senior Empowerment (RISE) program to bring critical information directly to seniors on important topics to help them age well in their communities.

NYU School of Medicine

Written Submission to the November 17th New York City Council Committees on Veterans and Mental Health, Disabilities and Addictions Oversight Hearing: Mental Health Services for Veterans in Response to COVID-19, and Alternative Treatments for Post-Traumatic Stress Disorder (PTSD)

Amanda Spray, PhD, ABPP

Good Morning, Chair Dinowitz, Chair Louis and members of the New York City Council Committees on Veterans, and Mental Health, Disabilities, and Addictions. I am Dr. Amanda Spray, Clinical Psychologist and Director of the Steven A. Cohen Military Family Center at NYU Langone Health.

We deeply appreciate the Committees for holding this hearing today as this is a crucial time for the mental health of our city's veterans. Not only does the COVID-19 pandemic continue but this year has also brought the 20th anniversary of the 9/11 terror attacks and the withdrawal of troops from Afghanistan – veterans are facing significant stressors that can threaten their mental health. It is essential that we ensure our veterans have access to high quality, evidence based care at the time they need it the most.

The Steven A. Cohen Military Family Center at NYU Langone Health was established over nine years ago in July 2012 with the goal to fill in the gaps in mental health services available to veterans and their families in the New York City area. The Center's mission is to address the mental health challenges of this population by providing accessible, high quality, evidence based treatment to veterans and their family members. We strive to remove barriers to care through a number of ways: by providing our services completely free of charge; offering our services to veterans regardless of their discharge status, combat exposure, or era served; opening our services not only to veterans but their family members who we define very broadly; making appointments available outside of business hours to accommodate our patients' academic or employment pursuits; and offering our services not only face to face but also through a telehealth platform that allows us to reach those individuals who are unable to attend in person, which has been particularly essential during the pandemic.

Veterans and their family members are seeking mental health services at a higher rate this year than they were at this time last year. Our Center has observed an 170% increase in individuals calling our intake line for services thus far in 2021 as compared with the first 10 months of 2020. This sharp increase has resulted in struggles to meet the demand and ultimately a waitlist for services. Additionally, we have observed that veterans and their family members are presenting with higher rates of Depressive Disorders, Substance Use Disorders, and Relationship distress diagnoses this year compared to last. For example: Depressive Disorders (an increase from 28% in FY20 to 40% in FY21), Substance Use Disorders (an increase from 28% in FY20 to almost 43% in FY21), and Relationship distress (an increase from 20% in FY20 to almost 29% in FY21). We provide evidence based treatments for these difficulties we are seeing more of this year. We also provide treatment for substance use disorders, an area that is often siloed from mental health services and can render someone ineligible for mental health care. We have also experienced student veterans struggling with online learning and seeking evaluation to determine the nature of their challenges and our recommendations on how to address these difficulties

The Steven A. Cohen Military Family Center at NYU Langone Health
One Park Avenue, 8th Floor, New York, NY 10016 T 646-754-4822 F 646-754-4770 amanda.spray@nyulangone.org

in order to remain enrolled in school. Our Center is also uniquely equipped to assist with these difficulties often caused by traumatic brain injury, PTSD, and/or longstanding ADHD that was previously undiagnosed.

Our Center is dedicated to delivering evidence based care that has demonstrated efficacy. We employ measures at the beginning of treatment and throughout to ensure the treatments that have been shown effective in research are also helping the patients we serve. Analysis of our data reveals that veterans and their family members show clinically and statistically significant improvements pre- versus post-treatment in symptoms of PTSD (an average of an 8.8 point decrease on the PCL-5 from pre- to post-treatment, $p<.001$), depression (an average of a 3.3 point decrease on the PHQ-9 from pre- to post-treatment, $p<.001$), and anxiety (an average of a 3.29 point decrease on the GAD-7 from pre- to post-treatment, $p<.001$), and improved quality of life (an average of a 3.9 point increase on the QLESQ from pre- to post-treatment, $p<.001$). At the Military Family Center at NYU, our veterans and military families are being provided with gold standard treatments with strong evidence of their effectiveness.

As described, we are experiencing an increased need for mental health services by veterans and their family members in recent months. These veterans deserve the gold standard mental health care and to not have further barriers presented to them as they seek to address their mental health challenges. Our Center is equipped to work together with the community to address the ever-growing needs of veterans and their families. We hope the Council will further invest in the Veteran population to ensure we are not leaving folks behind.

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The Steven A. Cohen Military Family Center at NYU Langone Health addresses a wide range of mental health concerns including posttraumatic stress, traumatic brain injury, depression, anxiety, readjustment difficulties, alcohol and substance use, relationship problems, along with a variety of other challenges military families may experience. The services we provide include individual, couples, family, and group therapy, parenting training, psychiatric evaluations and medication management, neuropsychological assessments and interventions, among others. Our highly skilled clinicians have deep appreciation for and sensitivity to the military culture and its unique strengths and challenges and are passionate about helping veterans and military families.

In addition to our core clinical program, we have established several specialty programs with the goal of addressing specific needs we identified in the veterans community in NYC.

Dual Diagnosis Program
Our Dual Diagnosis Program offers flexible, integrative care for veterans and their family members struggling with Substance Use Disorders and co-occurring mental health problems. Our harm reduction approach provides flexibility in setting treatment plans and goals, which may vary between patients. Goals may include reduced harm associated with use or full abstinence, and treatment may include individual therapy, group therapy, and medication management.

The Steven A. Cohen Military Family Center at NYU Langone Health
One Park Avenue, 8th Floor, New York, NY 10016 T 646-754-4822 F 646-754-4770 amanda.spray@nyulangone.org

NYU School of Medicine

Traumatic Brain Injury Program
Approximately 300,000 veterans sustained a TBI as a result of serving in the recent wars in Iraq and Afghanistan; 57% were not evaluated or treated for TBI. Our TBI Program, funded by NYC Council, is offering services to fill this gap in treatment. We offer neuropsychological evaluations for TBI as well as cognitive training to develop strategies to work around cognitive difficulties and to learn problem solving, organizational strategies and memory and attention techniques. This program would not exist without the support of the NYC Council Veteran's Initiative.

Child/Family Program
Military children are faced with unique stressors related to relocation, parental separation, family reunification, and reintegration. These stressors may result in disrupted relationships, behavioral problems, and academic difficulties. Many children struggle to adjust to their parent's combat injury or deal with a parent's death. Our Child and Family Program provides individual child therapy, parent-child therapy, family therapy, and parenting training. These services are offered to veterans and their families, as well as families of the fallen.

Telemental Health Program
Our Telemental Health Program provides mental health care to veterans and their families in every part of New York City and New York State who are unable to attend therapy in person. Services are provided via computer or tablet and can be done in the privacy of one's home. This program has allowed for our center to remain fully operational throughout the pandemic.

Contact:

To contact the clinic, interested individuals call our intake line at (855) NYU-4677 or e-mail us at: militaryfamilyclinic@nyumc.org. Visit our website at: http://nyulangone.org/locations/steven-a-cohen-military-family-clinic

The Steven A. Cohen Military Family Center at NYU Langone Health
One Park Avenue, 8th Floor, New York, NY 10016 T 646-754-4822 F 646-754-4770 amanda.spray@nyulangone.org

Testimony of Derek Coy, Veterans' Health Officer, New York State Health Foundation

Presented to the New York City Council Committee on Veterans and Committee on Mental Health, Disabilities and Addiction
Oversight Hearing on Mental Health Services for Veterans in Response to COVID-19 and Alternative Treatments for Post-Traumatic Stress Disorder (PTSD)

November 17, 2021

Chairperson Dinowitz, Chairperson Louis, and distinguished members of the Committee on Veterans and Committee on Mental Health, Disabilities and Addiction:

My name is Derek Coy, and as a former sergeant in the United States Marine Corps and veteran of the Iraq War, I appreciate the opportunity to provide testimony on behalf of the New York State Health Foundation (NYSHealth) focused on mental health services for veterans in response to COVID-19.

NYSHealth's Work to Improve Veterans' Health
NYSHealth is a private, independent foundation that works to improve the health of all New Yorkers, including the approximately 700,000 veterans who call New York home. Our Veterans' Health program area seeks to underscore that the health care, mental health, and social services issues returning veterans and their families face are not solely military issues, but public and community health issues that should be addressed by local and national government agencies, community-based organizations, and health funders. Our grantmaking in this area provides us with in-depth knowledge of the mental health challenges facing veterans, interventions that improve the mental well-being of veterans, and barriers to care. You can learn more about our work at our website, www.nyshealth.org.

Veterans' Mental Health
Most veterans return from deployments and transition to civilian life relatively smoothly; they are healthy, ready to work or go to school, and eager to settle back into life at home. But for some, the adjustment is not as easy. They may struggle with physical injuries and disabilities and they may also be dealing with the invisible wounds of war: mental health issues including post-traumatic stress disorder (PTSD), suicidal ideation, and substance use.

Before the COVID-19 pandemic, veterans in New York State were already experiencing unique mental health challenges.

- Between 2015 and 2018, approximately 20% of veterans in New York State identified as ever feeling sad, empty, or depressed for several days or longer. Over the same time period, about 6% of New York veterans reported having experienced serious psychological distress in the past year.[1]
- Over that same time period, 10% of New York State veterans reported ever receiving treatment for drug or alcohol use, a rate about twice as high as for the nonveteran population.[2]
- Nationally, the rate of PTSD in the veteran population has been found to be double that of the general population (12.9% compared with 6.8%).[3]

- Veterans in New York State die by suicide at nearly twice the rate as the general State population. 156 veterans died by suicide in New York State in 2019—one nearly every other day.[4] In New York City, 86 veterans died by suicide between 2016 and 2018.[5]

The COVID-19 pandemic has since exacerbated existing mental health challenges and introduced new ones.

- We know that social isolation and loneliness are associated with poor mental health outcomes.[6] In a recent national survey, a majority of veterans said their mental health worsened since socially distancing.[7]
- Factors associated with living through a pandemic (e.g., losing friends and family, loss of perceived control, and uncertainty about the future) are risk factors for poor mental health.[8,9] Other risk factors for poor mental health—including food insecurity, housing instability, and economic hardship—have also increased during the pandemic.[10,11] For example, the unemployment rate among New York State veterans increased during the pandemic, from 4% in 2019 to 7.1% in 2020.[12]
- We also hear from our grantees and partners who have witnessed firsthand the mental health challenges veterans are facing during the pandemic. For example, NYU Langone's Military Family Center has reported higher diagnosis rates of depressive disorders, relationship stress, and substance use disorder.
- The pandemic has made access to mental health care more challenging for many veterans. Half of veterans in a national survey reported having a mental health appointment canceled or postponed during the pandemic.[13]
- Finally, aging veterans are at a particularly high risk of social isolation during the pandemic.[14] More than 70% of New York's veterans are age 55 or older.[15]

NYSHealth-funded Initiatives to Improve Veterans' Mental Health

To address these mental health challenges faced by veterans in New York City, the Foundation has invested in programs focused on three critical areas:

1. identify and stabilize veterans experiencing a mental health crisis and at highest risk of dying by suicide,
2. expand high-quality mental health care to those in need, and
3. conduct outreach to ensure veterans in need have access to a full range of health and social services that can alleviate a mental health challenge they may be experiencing.

<u>Stop Solider Suicide</u>

First, we have helped Stop Solider Suicide's (SSS) Disrupt Military Suicide program expand into all five boroughs of the City. This program rapidly identifies those at greatest risk for dying by suicide, using cutting-edge marketing and client acquisition techniques, and then connects clients to comprehensive support services based on their unique physical and mental health needs.[16] Since the first months of the COVID-19 pandemic, SSS has served more than 141 at-risk service members and veterans in crisis. Compared with clients nationally, veteran clients in New York City are at higher risk of dying by suicide, generally older, more likely to be African American or Latino, and more likely to have housing issues. Since engaging in the program, clients on average reported a 57% reduction in self-hate, a 33% reduction in psychological pain, and an 18% reduction in hopelessness.

NYU Langone's Military Family Center

For veterans and family members who are in need of mental health care but not in crisis, NYU Langone's Military Family Center is providing free telemental health services to veterans and their families in hard-to-reach, under-resourced areas of New York State.[17] Thanks to the expansion of their services and increased presence in new markets, the Military Family Center has seen a 50% increase in client intakes compared with pre-pandemic levels.

Mission: VetCheck

Finally, because mental health challenges and crises often stem from previously unaddressed social needs and increased social isolation, we have supported the expansion of Mission: VetCheck, a unique partnership between New York City's Department of Veteran Services, the Mayor's Office of Community Mental Health, and New York Cares.[18] These efforts have led to 20,000 veteran outreach calls each year. These calls serve primarily as wellness check opportunities that connect veterans in need to an appropriate service provider. But part of the value is simply having friendly phone calls that can reduce social isolation for veterans who live alone or have reduced social connectivity as a result of the ongoing pandemic.

Moving Forward

Addressing unmet mental health needs and providing high-quality treatment, both in and out of the clinical environment, has no single solution. It requires a community-based approach that engages a variety of diverse stakeholders. The COVID-19 pandemic has laid bare many issues preventing New Yorkers from accessing the care they need. For veterans who call New York City home, a unique coalition of public and private providers has stepped up both to increase the services they provide and conduct targeted outreach to identify veterans in need of services. NYSHealth will continue to identify gaps in services for veterans and invest in organizations that address these unmet needs.

The Foundation is grateful for the committee's recognition of the importance of delivering high-quality mental health care and social services to veterans in New York City, whether within or outside a clinical environment. We appreciate the opportunity to testify today and look forward to continuing our partnerships with the City and other like-minded organizations that are working to ensure veterans have access to the care they have earned.

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COLUMBIA UNIVERSITY
College of Physicians and Surgeons

New York State Psychiatric Institute and
Department of Psychiatry
1051 Riverside Drive, Unit #129
New York, NY 10032
Phone: (646) 774-8098
Fax: (212) 288-3071
Email: jcm42@cumc.columbia.edu

John C. Markowitz M.D.
Professor of Clinical Psychiatry
Columbia University;
Research Psychiatrist
New York State Psychiatric Institute

Committees on Veterans and Mental Health, Disabilities, and Addiction
Department of Veterans' Services
1 Center Street
New York, NY 10007
testimony@council.nyc.gov

November 15, 2021

Dear Committee Members,

I am writing to you as the son of a Veteran and as a Professor of Clinical Psychiatry at Columbia University and a Research Psychiatrist at New York State Psychiatric Institute. I know you do wonderful work to help struggling military Veterans in New York obtain housing, work, and needed legal services. For many years I have researched the treatment of posttraumatic stress disorder (PTSD), depression, and their combination, conditions that have soaring, much too highly prevalent rates among the shell-shocked Veterans you are trying to help. These psychiatric conditions are highly debilitating, and they lead to homelessness, joblessness, and legal problems. They are treatable.

Roughly 11-15% of Veterans from the Iraq and Afghanistan wars suffer from PTSD, 12% from the Gulf War, 15% from Vietnam.[1] More than six thousand (6,000) Veterans killed themselves in 2019, the year with the most recent statistics; and this is an undercount, as it does not include National Guard and Reserve personnel. Suicide rates among Veterans are 32 per 100,000 – more than 50% higher than among non-Veteran civilians.[2]

It's hard to function when you are numbed from feeling your feelings and can't trust people, which are symptoms of PTSD. It's equally hard to get through life when you feel depressed, hopeless, exhausted, and suicidal. At Columbia/New York State Psychiatric Institute my colleague Dr. Yuval Neria has set up a Military Family Wellness Center, a refuge for Veterans and their family members (who are also at high psychiatric risk) who suffer from PTSD, depression, and other psychiatric diagnoses. For years we have offered them no-cost treatment using evidence-based therapies, treatments proven to work. Many of these Veterans either fear the Veterans

Administration system or do not qualify for treatment there; nor do their families qualify for needed, effective help. We have shown that these short-term (10-14 week, once weekly) treatments, such as Prolonged Exposure and Interpersonal Psychotherapy, really work to relieve symptoms in Veterans and their families, just as they work in helping civilians.[3,4] When Veterans feel better, their lives proceed more smoothly.

I hope that as part of your deliberations over funding priorities you will not only consider housing, employment, and legal services, but also crucial psychiatric treatment. Non-profit charity programs like the Military Family Wellness Center, which helps Veterans both uptown at Columbia/NYS Psychiatric Institute in Washington Heights and at Cornell Medical Center on the Upper East Side, deserve your attention. Please make mental health a priority on your website.

Sincerely,

John C. Markowitz, M.D.
Professor of Clinical Psychiatry, Columbia University
Research Psychiatrist, New York State Psychiatric Institute

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Columbia University Irving Medical Center | NewYork-Presbyterian Military Family Wellness Center | Weill Cornell Medicine

Good afternoon Chair Dinowitz, councilmembers, veterans, and community partners,

My name is Matthew Ryba, I am a Marine Corps combat veteran of Iraq and Afghanistan, and the director of community outreach and education at New-York Presbyterian's Military Family Wellness Center. Thank you for taking the time to hear my testimony today.

I speak today with first-hand experience, both as a combat veteran and from working in the field of veteran mental health care in NYC for the last 7 years. I cannot stress enough the importance of access to mental health care for service members, veterans, their family members, and caregivers in NYC.

Since I began working at Presbyterian's Military Family Wellness Center I have seen hundreds of New York's veterans, suffering from PTSD, major depression, anxiety disorders, military sexual trauma (MST), and adjustment disorders, receive the help they needed to overcome their mental wounds from military service and go on to live happier, more productive lives. Our clinical sites, at the Columbia University Irving Medical Center and Weill Cornell Medicine have conducted thousands of mental health screens for New York City veterans, enrolled hundreds of patients, and have yielded fantastic results. The overwhelming majority of our patients overcome their mental health issues and no longer meet criteria for the diagnosis they came with after completing their therapy.

Although referral traffic from DVS has dropped off significantly over the last year, during the time our clinics have been registered on the Unite Us/ Vet Connect NYC platform we have received nearly 50 patient referrals from the Department of Veteran Services.

The chief complaints we receive from veterans trying to navigate the mental health care systems in NYC are the difficulty they had in accessing quality care, including wait times for appointments, lack of options for treatment, and feeling like they were not being heard as individuals, rather treated as a number. At the MFWC we pride ourselves in four key areas: ease of access, minimal bureaucracy, confidentiality and privacy, and a wide range of high-quality treatment options. Veterans need options. In addition to traditional modalities like prolonged exposure, cognitive behavior, and interpersonal therapies our innovative PTSD research protocols include new and novel treatments, such as Columbia's recently tested, effective, standardized and manualized Equine Therapy for PTSD project and Weill Cornell's virtual reality enhanced exposure therapy.

We know that here in NY only about half of the veteran population are registered to use the VA's services, and of those registered, only about half actually do. That means that the overwhelming majority of veterans, north of 70%, who reside in NY are receiving care outside the VA system. The MFWC, by comparison to the VA, is a very small non-profit entity. Rather than compete with, we strive to compliment the VA, by offering additional modalities of therapy that may not be available, and offering services to all veterans regardless of discharge status, disability rating, or service era. We also care for the veteran's family members and caregivers – trying to fill the gaps in services and help those in the veteran community who do not qualify or

are not amenable to using the VA. The MFWC also experiences a much lower treatment dropout rate than similar veteran mental health centers. For your convenience, I have included our recently published paper in the *Journal of Psychological Trauma* showing these results with my written testimony.

As always, I feel compelled to highlight that our clinics, along with many of the other service providers and advocates you are hearing from today are non-profit organizations, many who struggle to find funding in order to continue serving the veteran community of New York.

NYC DVS serves an extremely important purpose in connecting veterans to the resources they need. Mental health services should be front and center, as in many cases the mental health issues that veterans experience can be the driving cause behind joblessness, homelessness, and suicide. We know from the Department of Veteran Affairs that as many as 20% of veterans from Iraq and Afghanistan suffer from PTSD. Additionally, 12% of veterans from the Gulf War era and 15% of surviving Vietnam Veterans also carry a PTSD diagnosis. The suicide rate for veterans is more than 53% higher than the general population [when adjusted for age and sex]. It is imperative to address these issues, and the nonprofit organizations providing veteran services, who are in dire need of funding support in order to be able continue to offer resources, educating our veterans on mental health, and provide the care and services they need.

The challenges facing military families are enormous. Thousands of individuals seeking service-related mental health treatment in the New York region do not receive it. The MFWC has established a record of excellence in addressing these gaps in service. Through focus on ease of access, privacy, and high-quality care, we have become a recognized and valued resource in the local military family community. With the help of local government leaders in City Council, the city's Department of Veteran Services, and with community collaborators like the Veteran Mental Health Coalition of NY, the Veteran Advocacy Project, and our academic partners at NYU Langone Military Family Center, we can together tackle the stigma associated with mental health and continue providing vital treatment to this highly-valued but under-served population.

Councilmembers, thank you for your time, I would be happy to answer any questions you may have.

Matthew Ryba
USMC Veteran OIF/OEF
Director of Community Outreach and Education
Military Family Wellness Center
New York-Presbyterian/Columbia University Medical Center
New York-Presbyterian/Weill Cornell Medicine
T| 347-949-1193
E| Matthew.Ryba@nyspi.columbia.edu
http://www.nyp.org/mfwc

Psychological Trauma: Theory, Research, Practice, and Policy

Treatment Dropout Among Veterans and Their Families: Quantitative and Qualitative Findings

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Treatment Dropout Among Veterans and Their Families: Quantitative and Qualitative Findings

Doron Amsalem[1, 2], Andrea Lopez-Yianilos[1], Ari Lowell[1, 2], Alison M. Pickover[1, 2], Shay Arnon[2], Xi Zhu[1, 2], Benjamin Suarez-Jimenez[1, 2], Matt Ryba[2], Maja Bergman[2], Sara Such[2], Hemrie Zalman[2], Arturo Sanchez-Lacay[1, 2], Amit Lazarov[1, 2, 3], John C. Markowitz[1, 2], and Yuval Neria[1, 2, 4]

[1] New York State Psychiatric Institute, Columbia University Irving Medical Center
[2] Department of Psychiatry, Columbia University Irving Medical Center
[3] School of Psychological Sciences, Tel Aviv University
[4] Department of Epidemiology, Columbia University Irving Medical Center

Background: Psychotherapy noncompletion rates for veterans and their families are high. This study sought to (a) measure noncompletion rates of such patients at a university-based treatment center, (b) compare veteran and family member attrition rates, (c) identify dropout predictors, and (d) explore clinicians' perspectives on treatment noncompletion. ***Method:*** Using quantitative and qualitative approaches, we analyzed demographic and clinical characteristics of 141 patients (90 military veterans; 51 family members) in a university treatment center. We defined *dropout* as not completing the time-limited therapy contract. Reviewing semistructured interview data assessing clinicians' perspectives on their patients' dropout, three independent raters agreed on key themes, with interrater coefficient kappa range .74 to 1. ***Results:*** Patient attrition was 24%, not differing significantly between veterans and family members. Diagnosis of major depression (MDD) and exposure-based therapies predicted noncompletion, as did higher baseline Hamilton Depression Rating Scale (HDRS) total scores, severe depression (HDRS $>$ 20), lack of Beck Depression Inventory weekly improvement, and history of military sexual trauma. Clinicians mostly attributed noncompletion to patient difficulties coping with intense emotions, especially in exposure-based therapies. ***Conclusion:*** Noncompletion rate at this study appeared relatively low compared to other veteran-based treatment centers, if still unfortunately substantial. Patients with comorbid MDD/PTSD and exposure-based therapies carried greater noncompletion risk due to the MDD component, and this should be considered in treatment planning. Ongoing discussion of dissatisfaction and patient discontinuation, in the context of a strong therapeutic alliance, might reduce noncompletion in this at-risk population.

Clinical Impact Statement

The findings of this study have the potential to improve clinical care for veterans and family members in a number of ways. For example, providing nonexposure-based interventions to veterans, particularly to depressed patients, may reduce dropouts, and facilitate treatment completion. Furthermore, the findings suggest that openly discussing difficulties to continue treatment among patients who might consider dropping out, may lower dropout rates.

Keywords: dropout, veterans, PTSD, depression, treatment

Doron Amsalem https://orcid.org/0000-0002-8056-3211
Andrea Lopez-Yianilos https://orcid.org/0000-0002-2865-1062
Ari Lowell https://orcid.org/0000-0003-0811-4558
Benjamin Suarez-Jimenez https://orcid.org/0000-0002-4765-2458
Matt Ryba https://orcid.org/0000-0001-6046-354X
Maja Bergman https://orcid.org/0000-0001-9833-5834
Amit Lazarov https://orcid.org/0000-0002-2811-2739

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Correspondence concerning this article should be addressed to Yuval Neria, Department of Psychiatry, New York State Psychiatric Institute, Columbia University Irving Medical Center,1051 Riverside Drive, New York, NY 10032, United States. Email: ny126@cumc.columbia.edu

Veterans who initiate outpatient treatment have distressingly high dropout rates across settings and diagnoses (M = 42%, range = 36%–68%; Fischer et al., 2018; Garcia et al., 2011; Goetter et al., 2015; Steenkamp & Litz, 2013). In comparison, a recent meta-analysis found only 19.7% dropout for the general adult population, with 18.3% for manualized, time-limited treatments (Leichsenring et al., 2019; Swift & Greenberg, 2012). Recent meta-analyses have shown that patients with posttraumatic stress disorder (PTSD) alone had a higher dropout rate (22–30%) than major depressive disorder (MDD) alone (17.5%; Cooper & Conklin, 2015; Lewis et al., 2020). The use of exposure-based therapy may have raised PTSD attrition (Berke et al., 2019). Our previous randomized controlled trial (RCT) found that patients with comorbid MDD/PTSD., when randomly assigned to exposure-based therapy, dropped out nine times more than both nondepressed exposure-based patients and patients in nonexposure interpersonal psychotherapy (IPT), suggesting that comorbid MDD/PTSD is a risk factor for attrition (Markowitz et al., 2015).

Although veterans' family members also face high risk for psychopathology (Diehle et al., 2017), almost no research has addressed their treatment. Veterans' family members, whom veterans' psychiatric issues often affect (Yager et al., 2016), frequently lack access for treatment services. No studies have examined attrition rates among veterans and their family members nor compared the rates of veterans and family members. Differences in dropout rates may reflect difficulties specific to treating veterans, such as receiving treatment in the same setting that determines their eligibility for disability, and receiving treatment at no cost (Hoge et al., 2014; Kehle-Forbes et al., 2016).

Although *dropout* is an accepted term in outcome research, we have generally substituted *noncompletion* in this article in recognition of its potential stigma. Patients have various reasons for not completing treatment, and our goal is to understand rather than to blame. Understanding noncompletion is critical for improving treatment outcome in mental health services. Prior studies exploring therapist and patient characteristics influencing attrition have yielded predictors including younger age, lower intelligence, less education, ethnicity (Rizvi et al., 2009; Sánchez-Lacay et al., 2001), greater symptom severity, disability status, and comorbidities (e.g psychotic or anxiety disorders, history of traumatic brain injury; Berke et al., 2019; Fischer et al., 2018; Garcia et al., 2011; Gros et al., 2018). Other studies have contradicted these findings (Gros et al., 2013; Olfson et al., 2009; van Minnen et al., 2002). These mixed findings might partly reflect the definition of treatment noncompletion, which has varied across studies: for example, discontinuing treatment against therapist advice before the tenth session, regardless of therapy length (Brogan et al., 1999), failure to meet for a predetermined number of sessions (Beckham, 1992; Gunderson et al., 1989), and not completing the treatment contract (Maher et al., 2010). Psychotherapy type, such as exposure therapy, has also been suggested as possibly predicting noncompletion (Kehle-Forbes et al., 2016).

Although prior studies have explored patient perspectives on noncompletion, limited research has addressed therapist perspectives. One pilot study (Palmer et al., 2009) found that outpatients with substance use disorder (n = 22) and their therapists (n = 22) identified similar reasons for noncompletion: lack of social supports, staff limitations, connection issues, and readiness to change. Nordheim et al., also studying patients with substance use disorders (n = 15), reported that emotion regulation difficulties triggered noncompletion (Nordheim et al., 2018). The single study to date investigating attrition of veterans with PTSD from a patient perspective identified therapy-related (Prolonged Exposure [PE] and Cognitive Processing Therapy [CPT]) issues, including viewing treatment as ineffective, weak therapeutic alliance, practical barriers, and high stress levels in treatment (Hundt et al., 2020). Yet interpreting patient accounts of noncompletion can be difficult: some patients leave without comment, while others may offer polite excuses, obscuring actual motivations (Clinton, 1996). However, no studies have examined patient or clinician perspectives of veterans' noncompletion from IPT (Pickover et al., 2021).

To assess noncompletion rates and their correlates among veterans and their family members, we utilized data collected at a university-based clinical center between January 2016 and March 2020. Quantitative and qualitative methods identified noncompletion risk factors to deepen our understanding of treatment noncompletion in these populations. Specifically, this study sought to 1) measure noncompletion rates of such patients at a university-based treatment center, 2) compare veteran and family member on attrition rates, 3) identify noncompletion predictors, and 4) explore clinicians' perspectives on treatment noncompletion. Based on our previous RCT (Markowitz et al., 2015), we expected to find (1) higher noncompletion in patients with comorbid MDD/PTSD., and (2) higher noncompletion in exposure than in nonexposure therapy. The remaining aims were more exploratory in nature.

Method

Design and Participants

This university-based research center, located in New York City and provides cost-free assessment and treatment to active duty service members, veterans regardless of discharge status, and their first degree family members or partners/spouses (Lowell et al., 2019). The center assesses treatment needs and preferences, provides treatment, and monitors treatment outcome for mood, anxiety, and trauma-related symptoms and disorders. The center accepts patients without Department of Veterans Affairs (VA) benefits or who are not interested to seek care at the VA system, and in addition to treatments provided at the VA system, it also provides some treatments (e.g Interpersonal Psychotherapy for PTSD) that the VA typically does not. All treatments were voluntary as our center does not treat involuntary patients. Patients are recruited via advertisement (Internet, local media, flyers), referrals from community organizations and hospitals, and word-of-mouth.

Of 150 individuals evaluated and found eligible, 141 patients (90 military veterans; 51 family members) began treatment between January 2016 and March 2020. Inclusion criteria were prior or active military service, or 1st degree relatives; age $\geq$18, significant distress affecting social and/or occupational functioning, ability to sign informed consent, and English fluency. Exclusion criteria were history of psychosis, current unstable bipolar disorder or substance use disorder, antisocial personality disorder, unstable medical condition, and acute suicide or homicide risk.

Ten clinicians (six women, four men) with 12.1 ($\pm$9.6, range 2–32) years of experience, treated the 141 patients: one psychiatrist, three Ph.D. psychologists, two Psy.D. postdoctoral fellows, two master's level doctoral externs, a licensed master's level

social worker, and a nurse practitioner. Traumas included combat or military related, interpersonal violence, childhood physical abuse, childhood sexual abuse, traumatic loss, and terrorism or mass shooting. Intake clinical interview and standardized diagnostic assessments determined eligibility. Ineligible individuals were referred locally. Eligible patients were invited to discuss treatment options and preferences. Following team discussion, patients signed written informed consent and began treatment.

Procedure

Upon obtaining written consent, clinicians discussed with patients the available, appropriate treatment options, both exposure- and nonexposure-based (Markowitz et al., 2015; Schneier et al., 2012), which included IPT, PE., time-limited Cognitive Behavioral Therapy (CBT), CPT, Brief Supportive Psychotherapy (BSP), Emotion Focused Therapy (EFT) for couples, and group CBT for Insomnia (CBT-I), either as monotherapy or combined with pharmacotherapy. Contributing factors included known differential therapeutics, response to previous treatments, the patient's preference regarding the treatment focus (interpersonal relationship in IPT, trauma exposure in PE), and so forth Treatment duration ranged from six (CBT-I) to 14 weekly sessions (IPT for PTSD). We defined dropout as not completing the therapy contract upon which patient and therapist agreed on in their initial meeting prior to signing consent. This definition encompasses noncompleters across stages of therapy (Beckham, 1992; Brogan et al., 1999; Gunderson et al., 1989; Leichsenring et al., 2019; Maher et al., 2010; Swift & Greenberg, 2012). Following missed sessions, staff members routinely attempted to contact patients by phone and voicemails. Patients who did not reply after two to three weeks were mailed a formal noncompletion letter.

Measures

Data were gathered retrospectively from electronic medical records, session notes, intake reports, and the clinical center research database. Clinicians used either the Structured Clinical Interview for *DSM–5* Research Version (SCID-5-RV; First et al., 2015) or Mini-International Neuropsychiatric Interview (MINI; Sheehan et al., 1998) for diagnosis. Measures included demographic, Military Sexual Trauma (MST), and the Life Events Checklist (LEC; F. W. Weathers et al., 2013) questionnaires at baseline.

We used the Clinician Administered PTSD Scale-5 (CAPS-5, Weathers et al., 2018), a 30-item structured interview (range 0–80), for diagnosing *DSM–5* PTSD., and the PTSD Checklist for *DSM–5* (PCL-5, Blevins et al., 2015), as a self-report measure for PTSD symptoms. For the diagnosis of depression, we used the Hamilton Depression Rating Scale (HDRS; Hamilton, 1960), a 17-item structured interview (range 0–52). A score of 20 or more was considered severe depression. We used the CAPS-5, PCL-5, and HDRS at baseline, mid-, posttreatment, and 3- and 12-month follow-up; Beck Depression Inventory-II (BDI-II., 21-item self-report questionnaire for depression symptoms, range 0–63; Beck et al., 1996), and Intent to Attend (ITA; a 0–9 patient self-rating of likelihood of attending the next session) scale weekly (Leon et al., 2007). The CAPS-5 and PCL-5 were only repeated after baseline for individuals reporting trauma history.

Data Analysis

Quantitative Analysis

Statistical analyses were carried out using IBM SPSS software, Version 26.0. Pearson's chi-square tested possible associations between treatment completers/noncompleters and demographic characteristics as sex, patient's status (veteran vs. family member), country of birth, marital status, race, ethnicity, sexual orientation, level of education, employment, and level of annual salary. Independent sample t-tests were used to compare mean score differences between treatment completers/noncompleters on continues variables as age and baseline clinical measures (CAPS-5 and HDRS). Logistic regressions were used to compare categorical variables as diagnosis, level of depression (HDRS $\geq$20), treatment type, and use of medications between completers and noncompleters, accounting for possible confounders. Repeated measure ANOVAs were used to compare BDI-II mean scores (continuous variables) between completers and noncompleters. A two-tailed p-value of .05 determined statistical significance. For this exploratory study, we did not employ Bonferroni correction for multiple comparisons.

Qualitative Analysis

Three authors (Doron Amsalem, Andrea Lopez-Yianilos, and Yuval Neria) developed two semistructured qualitative interviews. The first, comprising fourteen open-ended and four yes/no questions, assessed clinician perspectives on patient noncompletion. The second included nine open-ended questions assessing patient perspectives on noncompletion. The first author conducted clinician interviews between September 2018 to March 2020. All interviews were recorded and transcribed verbatim. Three raters independently reviewed the transcriptions for emerging themes, then discussed them and reached agreement on each item (see Table 2). Interrater agreement (kappa), calculated separately for each rater dyad, ranged from .74 to 1. Due to low compliance (25%) among patients who had dropped out, we decided not to include the data from patient interviews.

Results

Quantitative

Sample Demographic Characteristics

The study sample comprised 90 veterans (64%) and 51 family members (36%). Of the 141 patients, 107 (76%) completed treatment ("completers") and 34 (24%) did not ("noncompleters"). Noncompleters attended 4.1 ($\pm$3.4) mean sessions (range 1–10). Completers and noncompleters did not significantly differ by age, sex, marital status, country of birth, race, ethnicity, sexual orientation, education, or income (see Table 1). Although veteran and family member noncompletion rates did not significantly differ, veterans were more likely to be male (73 [83%] vs 21 [41%], χ^2 = 25.7, $p < .000$), nonwhite (60 [67%] vs 26 [51%], χ^2 = 16.5, p = .035), Hispanic (24 [34%] vs 6 [15%], χ^2 = 5.1, p = .024), and reportedly heterosexual (66 [93%] vs 31 [76%], χ^2 = 5.4, p = .04). Veterans and family members did not differ in age, country of origin, marital status, education level, employment, or annual salary. *M* ITA score at last attended session was 8.4 ($\pm$1.4) for completers

Table 1
Demographic Data for Groups Treatment Completer (n = 107) and Treatment Dropout (n = 34)

Item	Completer n (%) or ($M \pm SD$)	Dropout n (%) or ($M \pm SD$)	χ^2	p
Age	(41.9 ± 13.6)	(39.7 ± 12.1)	.799[a]	.43
Sex				
Male	70 (66.0)	25 (73.5)	0.66	.42
Patient status	67 (62.6)	23 (67.6)	2.83	.59
Veteran				
Country of birth	71 (78.9)	22 (75.9)	3.13	.21
United States				
Marital status				
Single	58 (63.5)	20 (69.0)	2.30	.89
Ethnicity				
Hispanic	21 (23.3)	9 (31.0)	1.77	.41
Race				
White	42 (56.1)	12 (52.9)	8.04	.62
Sexual orientation				
Heterosexual	75 (83.3)	22 (75.9)	5.35	.25
Level of education				
College degree or higher	43 (48.9)	10 (35.7)	15.6	.16
Employment				
Full-time or part-time work	42 (47.7)	13 (46.4)	1.96	.96
Annual salary				
More than $50,000	42 (47.2)	10 (39.3)	14.9	.13

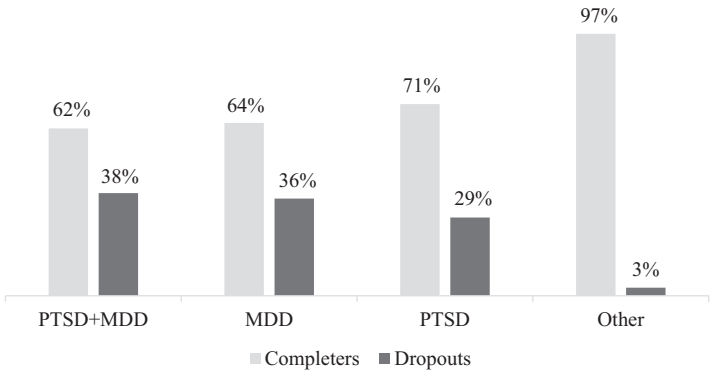
[a] Independent t test.

versus 7.8 (±2.1) for noncompleters, indicating all patients reported high motivation to attend the following session. Noncompletion by clinician ranged from 18% to 27%, with no significant difference between clinicians.

Sample Clinical Characteristics

All patients had at least one *DSM–5* based diagnosis. Most patients (84%) received diagnoses of either PTSD only (64%), MDD only (65%), or both (45%). Eighty-seven percent (n = 123) were treated with IPT or PE. Diagnosis of MDD., either alone (36% attrition) or combined with PTSD (38%) increased noncompletion risk, while PTSD diagnosis alone (29%) did not significantly raise noncompletion, and patients with neither MDD nor PTSD diagnosis (3%) had lower attrition risk (see Figure 1). Furthermore, MDD with or without PTSD predicted noncompletion (p = .001, CI [1.87–11.39]). Baseline HDRS total scores and percentage of HDRS > 20 (defining severe depression) significantly differentiated completers from noncompleters: noncompleters were more depressed, with higher rates of severe depression (see Table 2). In contrast, PTSD measures (CAPS-5, PCL-5) did not

Figure 1
Comparison of Treatment Completer and Treatment Dropout (n = 34; 24%) Groups on Diagnosis



Note. Treatment completers (n = 107; 76%); treatment dropouts (n = 34; 24%). MDD = major depressive disorder; PDD = persistent depressive disorder; SAD = social anxiety disorder; GAD = general anxiety disorder; OCD = obsessive compulsive disorder; PD = panic disorder; ADHD = attention-deficit/hyperactivity disorder; SUD = substance use disorder. PTSD + MDD (χ^2 = 7.54, p = .006), MDD (χ^2 = 10.95, p = .001), other (χ^2 = 8.52, p = .004).

Table 2
Comparison of Groups Treatment Completer (n = 107) and Treatment Dropout (n = 34) on Clinical Scores, Psychotherapy Type, and Use of Medication

Item	Completer	Dropout	*t*	*p*
		Clinical score		
CAPS-5	35.14	36.33	0.52	.60
PCL-5	48.62	46.00	0.61	.55
HDRS	14.19	18.06	2.72	.007
HRDS ≥20[a]	29 (27%)	17 (50%)	6.15	.015
		Psychotherapy		
IPT	78 (80.4)	19 (19.6)		
PE and CPT	16 (61.5)	10 (38.5)	17.8	.003
Other[b]	12 (66.7)	6 (33.3)		
		Pharmacotherapy		
	53 (73.6)	19 (26.4)	0.41	.51

Note. CAPS-5 scores were included only for people diagnosed with PTSD. IPT = interpersonal psychotherapy; PE = prolonged exposure; CPT = cognitive processing therapy.
[a] Pearson chi-square; percentage of total score of 20 and above (severe depression) on baseline HDRS scores. [b] Other = cognitive-behavioral therapy, emotionally focused therapy for couples, cognitive-behavioral therapy for insomnia group, and supportive therapy.

significantly differ between completers and noncompleters (see Table 2). Psychotherapy type significantly differed between completers and noncompleters: patients treated in PE were more likely to drop out. Furthermore, in the subgroup of patients with comorbid MDD/PTSD., PE predicted noncompletion (p = .037, CI [1.06–7.55]). Pharmacotherapy use did not significantly differ between completers and noncompleters (see Table 2). Veterans were more likely to be treated with IPT (67 [76%] vs 30 [59%], p = .032), whereas family members were more likely to be treated in PE (11[13%] vs 15 [29%], p = .014).

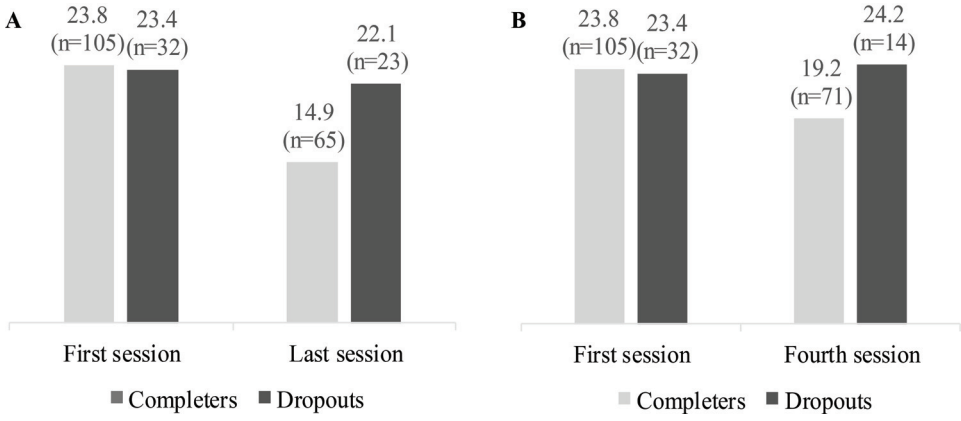
Weekly BDI scores showed a similar completer/noncompleters pattern. Two 2X2 group-by-time ANOVAs were conducted, one comparing the first and last attended session of each group (Figure 2A), the latter using completers' fourth session as time 2, as session 4 was the mean final session for dropouts (Figure 2B). The first analysis revealed a significant group by time interaction (F = 6.99, p = .010): completers' BDI scores significantly decreased during treatment, while noncompletion scores did not decrease at all. Groups did not differ at baseline (t = .28, p = .784), noncompleters' last session BDI scores were significantly higher than completers' last session scores (t = 2.28, p = .025). The second ANOVA yielded no significant interaction effect; time showed a significant main effect (F = 10.28, p = .002). Completers' BDI scores significantly decreased at session 4 (t = 4.59, $p < .001$), whereas noncompleters' BDI scores did not decrease (see Figure 2).

On the MST questionnaire, 39.1% of veteran noncompleters reported military sexual trauma, versus 13.4% of veteran completers (χ^2 = 11.93, p = .001). Almost one fifth of veterans (18%; n = 15) endorsed experiencing uninvited or unwanted sexual attention or being forced or threatened to engage in sexual contact while in the military, and 60% (n = 9) of them dropped out.

Qualitative

Clinicians were asked to describe each dropout patient's reported reason for prematurely discontinuing treatment. Of the 34 cases, clinicians reported possible reasons for 27 patients. From their own perspective, clinicians reported an external cause as their patients' self-reported reason for noncompletion in 22 of 27 cases (81%): moving out of state, problems commuting to the clinic, and increased life demands or responsibilities. Conversely, in most cases (70%) clinicians also attributed noncompletion to an internal, treatment-related cause rather than an external cause. While stratifying by treatment method, in 17 cases (63%), clinicians' and patients' attributions for dropout were discrepant. In noncompletion during exposure-based therapies (n = 10), clinicians indicated an internal reason for 80% (8 of 10) of dropout cases, compared to 53% of IPT cases (10 of 19).

Figure 2
Comparison of Treatment Completers and Treatment Dropouts on Beck Depression Inventory



Note. Last session for dropouts was the last therapy session before the patient dropped out of treatment (range 0-10, average of 4.22, mode of 4). Panel A: First session and last attended session. Panel B: First session and fourth session attended.

Three thematic reasons for noncompletion emerged: difficulty coping with intense emotions, readiness for change, and suitability for outpatient treatment. Therapists in 13 cases explicitly described the intensity of emotions experienced during treatment itself, mostly (n = 11) as an outcome of an exposure (see Table 3, quote #1). One clinician described noncompletion as an outcome of exposure-related anxiety during CBT treatment (quote #2), while other clinician identified difficulty of coping with emotions aroused during IPT (quote #3). Second, clinicians reported that five patients lacked motivation or readiness to change (quote #4). Third, in four cases clinicians attributed noncompletion to the suitability of the clinical center for the patients' needs, feeling they required a level or type of care beyond what the clinic could offer (quote #5).

Although most clinicians identified the treatment itself as a possible reason for noncompletion, the clinicians nonetheless asserted the chosen treatment was the appropriate treatment for 79% of patients who eventually dropped out, that the selected treatment did not lead to noncompletion in 74% of the cases, and that a different treatment would not have changed the course (71%, quote #6). Having affirmed the selected treatment type, 68% of clinicians reported that, in hindsight, they could have acted differently. They emphasized the importance of early detection in eight cases (quote #7). Others described the need to discuss noncompletion with the patient (quote #8). Although 87% of patients did not forewarn clinicians of dropout, resulting in no termination session, clinicians reported thinking they had good rapport with 77% of dropouts, and 93% denied a mismatch between themselves and the patient (quote #9).

Discussion

This retrospective study sought to determine rates of, identify predictors of, and describe clinicians' perspectives on treatment dropout. Twenty-four percent of patients dropped out of treatment, without significant attrition differences between veterans and family members. Noncompletion was associated with MDD diagnosis, with or without PTSD. Exposure-based therapies (i.e PE and CPT) for PTSD were both associated with noncompletion and predicted dropout among patients with comorbid MDD/PTSD. Noncompletion was associated with higher HDRS scores, severe depression, and lack of BDI improvement during treatment.

Previous research reported a mean 42% dropout rate among veterans receiving clinical care (exposure and nonexposure therapies), rising to 68% for veterans treated for PTSD (Goetter et al., 2015). Our 24% dropout rate, while lower, may also reflect the fact that our university-based center does not accept patients with bipolar disorder, psychotic disorder or substance abuse, diagnoses that often carry higher noncompletion rates (Fischer et al., 2018; Garcia et al., 2011; Gros et al., 2018). Veterans have higher noncompletion rates than general population patients across diagnoses and settings (Leichsenring et al., 2019; Swift & Greenberg, 2012). Age and ethnicity did not differentiate completers from

Table 3
Quotes

	First theme, difficulty coping with intense emotions
1	"He just got overwhelmed. We were doing Prolonged Exposure and it was too much. He just couldn't tolerate the anxiety." "She was starting to get very emotionally aroused during the imaginal exposures and while doing the homework . . . she couldn't handle the emotions anymore; it was too much for her." "I believe that when we got to the hot spot [most arousing aspect of the trauma], that's when things got a little too intense for her."
2	"It was really anxiety-provoking for her, and I think she used it [knee surgery] as an excuse not to come . . . from my understanding, she gave up. She succumbed to her fears and avoidance."
3	"He was starting to feel more anger, which means that the treatment was working, and he didn't like that."
	Second theme, readiness for change
4	"I think the patient wasn't ready to engage in therapy . . . [the patient preferred] to get more medications rather than do the work of psychotherapy." "I think that he had trouble committing to even starting the treatment . . . he was never really, on some level, on board with it."'Asking him to change a lot . . . was something that was going to be too disruptive . . . he was used to what his routine was already." "I think there was just some part of him that just didn't want to deal with it, wasn't fully committed."
	Third theme, suitability for outpatient treatment
5	"We were eager to provide treatment and he was a veteran . . . he wasn't the kind of guy who was appropriate for our setting. I think he needed more formal structure, like a partial hospitalization or outpatient day program." "I don't think he was a good fit for our center . . . he needed something that our clinic was not designed to do."
	Role of treatment and communication
6	"I would still choose IPT for him. Like I said, he made a lot of progress. I think this is what he needed"; "I don't think I would have chosen a different treatment for her [PE]. If I were back in that position, I think my train of thought made sense." "I didn't want to reinforce the thought that she couldn't handle this, to discontinue treatment, that she couldn't handle the negative emotions." "IPT was the appropriate choice for him . . . I don't think that other treatment modality would have addressed that, and that was something that was salient for him."
7	"I could have maybe pointed out more directly to him earlier on in the treatment that guardedness and kind of fear of intimacy with me and others." "I should have taken more into consideration that her being able to complete the therapy was going to be an issue and this should have been spoken about in each and every session." "I wish that, in the last moment, in the last session, I had sensed she was uneasy, and I wish that I would have stopped the session to say, 'What is going on today? You seemed unsettled,' and to encourage her to tell me . . . I wish I had found the way to tell her what was bothering her . . . and I think if I could have done that, she would have continued treatment."
8	"We didn't discuss it at all, I took it for granted that she would come back after the knee surgery and I think this is where I might have missed." "I should have been more aware and made her more aware of this potential stress that she can, you know, get up and leave."
9	"She felt very comfortable here, she would voice that." "He felt comfortable talking about things that he didn't talk about with anyone else." "We had a great relationship I would say, our alliance was very strong."

noncompleters, whereas previous research had found younger age and Hispanic ethnicity predicted noncompletion in PTSD (for PE and CPT; Rizvi et al., 2009) and MDD (Karyotaki et al., 2015). Additional prospective research needs to address this clinical concern.

Our findings indicating high dropout (36%) among patients with MDD., and especially those with severe depressive symptoms (41%, HRDS $\geq$ 20), exceed those reported in a meta-analysis finding 20% overall and 17% IPT dropout rates for MDD (Cooper & Conklin, 2015). Our finding that exposure-based therapies predicted dropout among patients with PTSD accords with previous PE and CBT studies (Goetter et al., 2015; Gros et al., 2018). We found higher attrition in patients with comorbid MDD/PTSD (38%). However, more research is needed to define depression and/or exposure-based therapies as predictors to noncompletion.

In a previous trial, we had found IPT had lower dropout and therefore better outcome than PE among patients with comorbid MDD/PTSD (Markowitz et al., 2015). That study randomized treatment regardless of patient preference (Markowitz et al., 2015; 2016), whereas the current nonrandomized trial respected patient choice. This corroborates and reinforces the importance of the finding. However, the risk in the comorbid group appeared to stem from the presence of the MDD., rather than PTSD per *SE* We also found higher MST rates among dropouts. To our knowledge, no prior research has examined the association between MST and treatment dropout, although research has linked MST, child abuse, and suicidal ideation (Bryan et al., 2015; Wilson et al., 2015). The complexity of MDD., PTSD and MST may contribute to elevated dropout rates.

Although family members face elevated psychopathology rates, they do not typically receive free care, and no individual outcome research has assessed their mental health treatment (Johnson et al., 2007; Ramchand et al., 2017; Sheppard et al., 2010). Family member and veteran dropout rates did not significantly differ; family members were more likely to report nonheterosexual orientation and being white. Army regulations like "Do not ask, do not tell" (1994–2011) could help explain differences in reported sexual orientation. In addition, we found veterans were more likely to prefer IPT treatment, whereas family members more often preferred PE. One explanation of this finding could be that nonexposure therapies are not frequently offered in VA clinics, leading veterans to seek out our clinic (Lowell et al., 2019). No research has previously compared dropout rates of veterans and family members. Family members of veterans, a high risk but understudied group, warrant treatment research.

Clinicians primarily attributed dropout to general treatment-related factors, yet said their patients mostly cited external causes for dropout. Clinician reports suggested three underlying themes for dropout: difficulty coping with intense emotions (mostly in exposure-based therapies), lack of readiness for change, and unsuitability of the treatment setting. Most clinicians reported good rapport with dropouts and denied a therapist-patient mismatch. Yet, clinicians believed they, in conjunction with patient preference, had employed the appropriate treatment (e.g IPT, PE., CBT) and that treatment elements specific to those modalities did not account for dropout. Future dropout studies should focus on aspect of communication between the patient and the clinician, around the decision to terminate the treatment, preferably immediately after dropout. Furthermore, future studies should measure the therapeutic alliance to gain deeper understanding of the clinician-patient relationship.

That patients, per clinician reports, mostly attributed dropout to external reasons contradicts a previous qualitative study on veterans' perspectives of their treatment dropout from exposure-based therapies, which reported therapy-related barriers as the most common reason (Hundt et al., 2020). Some clinicians felt that because treatment was free, patients hesitated to express their discontent, and proffered external reasons to conceal their disappointment. Yet therapy-related barriers such as "too stressful" treatment and not committing to specific therapy tasks were similar to themes in the current study (Hundt et al., 2020). Those themes seem inherent to the diagnoses of PTSD and MDD., which most of our patients met, themes that clinicians would probably have reported for both completers and dropouts. Moreover, most of our clinicians reported good communication with patients and having the appropriate treatment (chosen with the patient), factors known to increase retention and decrease treatment dropout (Gros et al., 2013; Markowitz et al., 2016).

Several study limitations bear mention. First, sample size (N = 141) was relatively small and included both veterans and families, who might have different characteristics. Second, in this retrospective, *post hoc* study, knowing that the patient had dropped out may have influenced clinician accounts. However, dropout is inherently a finding that could be assessed only in hindsight. Third, while clinicians reviewed their intake evaluations and session notes prior to this study, patients had dropped out over the course of the past two years before the interview, also introducing potential recall bias. Future studies should prospectively (or at least, immediately after dropout) compare patient and clinician reports to facilitate deeper understanding of reasons for dropout. Finally, despite our attempts to assess patient views, few responded, precluding understand of patients' perspectives.

In conclusion, MDD and exposure-based treatment were each associated with dropout. Future studies should further explore risk factors. Most patients did not communicate their intention to leave treatment, and clinicians often failed to predict it. Identifying these risk factors and openly discussing them early in treatment might lower dropout rates. The difficulty of predicting dropout emphasizes the need for deeper understanding predictors (quantitative and qualitative), and for developing strategies to reduce the likelihood of treatment discontinuation. Family members of veterans, and especially minorities, should be encouraged to seek treatment. Future studies should prospectively measure both patients and clinicians' perspectives regarding dropout.

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