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March 2015

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Released by – Eric L. Lang

## BACKGROUND

Individuals vetted by the government for initial or continuing eligibility to access classified information must fill out a personnel security questionnaire as part of a screening process designed to identify those who are not likely to be trustworthy, reliable, or loyal to the United States. Question 21 in the *Questionnaire for National Security Positions* (SF-86) asks applicants if they have consulted with a mental health professional in the last 7 years, with certain groups exempted. This approach identifies too many individuals for investigative follow-up who do not have a mental health condition that poses an unacceptable risk, and likely misses other at-risk individuals. Disagreements over the goal, effectiveness, and adverse consequences (e.g., stigmatizing the use of mental health services) associated with this question have resulted in previous Question 21 wording changes but have not significantly resolved concerns.

## HIGHLIGHTS

A proposed "relevant risk" approach to Question 21—focusing only on standardized clinical conditions that could pose a security risk as well as mental health related hospitalizations—would not represent an obstacle to mental health care for the vast majority of personnel and would be consistent with Department of Defense (DoD) policy to foster a culture of support with respect to mental health. This approach would reduce the costs associated with unnecessary Question 21 follow-up investigative work, as well as much of the stigma-related adverse consequences associated with the current Question 21. At the same time, the "relevant risk" approach would identify more effectively the small number of individuals with mental health conditions that may pose security risks. In addition, this report evaluates the benefits for both security and clinical care for having separate professionals conduct security fitness evaluations vice individuals' mental health treatment.

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# PREFACE

Question 21 on the *Questionnaire for National Security Positions* (Standard Form-86) needs revision in a manner that encourages the use of mental health services, minimizes stigma, and reliably identifies the small percentage of individuals who present a mental health condition that raises concern with granting them eligibility for access to classified information. Question 21 should neither impose unreasonable burdens on those who must answer it nor lead to unproductive investigative activity that adversely affects the cost, timeliness or fairness of personnel security investigations. In short, Question 21 needs to reflect the basic tenets of personnel security vetting—to be effective, efficient, and fair.

This report proposes a revised Question 21 based on the "relevant risk" approach that is based on data, policy, and logic. We hope the report will stimulate productive discussions among policy-makers and other stakeholders who are interested in revising Question 21 to address repeatedly expressed concerns with the stigma and over-inclusiveness of the current version of the question.

Eric L. Lang
Director, PERSEREC

# EXECUTIVE SUMMARY

Question 21 in the *Questionnaire for National Security Positions* (SF-86) asks applicants for access to classified information if they have consulted with a mental health professional in the last 7 years. The very broad and ambiguous language of the question limits its value in making security clearance determinations. Research has demonstrated that Question 21 is not productive as a source of information leading to security clearance denials or revocations and does not adequately screen those with mental health conditions that *do* pose security risks.

Additionally, Question 21 is associated with a number of adverse consequences and inefficiencies. The use of this question: (a) leads to misallocation and waste of government resources; (b) provides an incentive for honest personnel to lie or withhold information; (c) serves as a barrier to accessing mental health care; (d) adversely impacts the quality of mental health care available to personnel who hold or may wish to hold security clearances; (e) does not adequately screen individuals with mental health conditions that do constitute security threats; and (f) is inconsistent with Department of Defense (DoD) policy to foster a culture of support with respect to mental health care.

A revision that is more likely to meet the intended goals of Question 21—supporting the screening and continuous evaluation of reliable employees in sensitive positions while minimizing adverse consequences—would utilize a "relevant risk" approach. This report proposes refocusing Question 21 on specific mental health conditions likely to have an actual bearing on security risk. Such a focus would yield more productive and verifiable information, in contrast to the current approach of inquiring about mere utilization of mental health services. The rationale for selecting the specific mental health conditions relevant to security investigations is discussed.

This report proposes the following mental health questions replace the current Question 21 in form SF-86:

*21a. Have you ever been diagnosed by a physician or mental health professional with psychosis, schizophrenia, schizoaffective disorder, delusional disorder, bipolar mood disorder, borderline personality disorder, or antisocial personality disorder?*

*21b. In the past 7 years, have you been hospitalized for an emotional or mental health condition?*

# TABLE OF CONTENTS



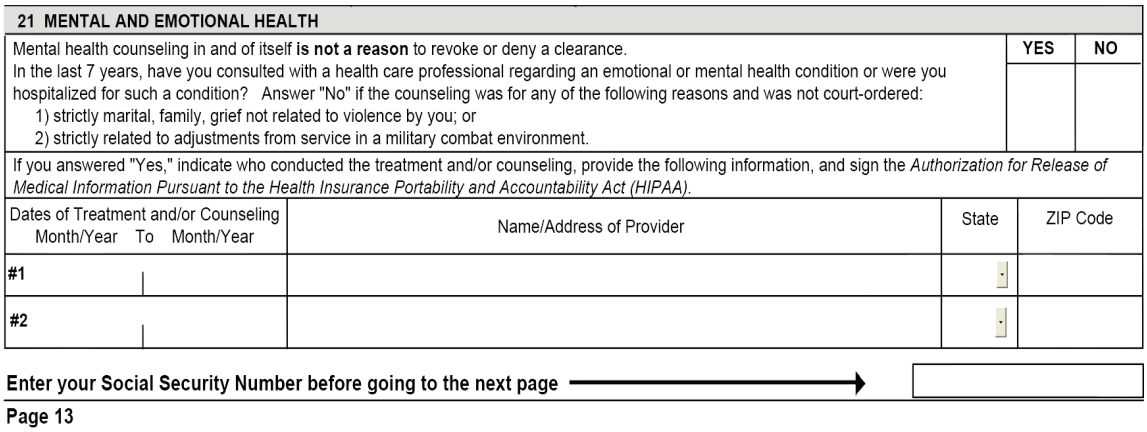
## LIST OF FIGURES



## LIST OF FIGURES IN APPENDICES

# INTRODUCTION

Individuals seeking national security positions complete the *Questionnaire for National Security Positions* (SF-86) and undergo a personnel security investigation. Per Executive Order 12968, this is part of the vetting process to help determine if an individual is trustworthy, reliable, and loyal to the United States—required for eligibility to access classified information. Question 21 of SF-86 asks applicants if they have consulted with a mental health professional in the last 7 years (see Figure 1).



**21 MENTAL AND EMOTIONAL HEALTH**

| Mental health counseling in and of itself **is not a reason** to revoke or deny a clearance.<br>In the last 7 years, have you consulted with a health care professional regarding an emotional or mental health condition or were you hospitalized for such a condition? Answer "No" if the counseling was for any of the following reasons and was not court-ordered:<br>1) strictly marital, family, grief not related to violence by you; or<br>2) strictly related to adjustments from service in a military combat environment. | YES | NO |
|---|---|---|

If you answered "Yes," indicate who conducted the treatment and/or counseling, provide the following information, and sign the *Authorization for Release of Medical Information Pursuant to the Health Insurance Portability and Accountability Act (HIPAA).*

| Dates of Treatment and/or Counseling Month/Year To Month/Year | Name/Address of Provider | State | ZIP Code |
|---|---|---|---|
| #1 | | | |
| #2 | | | |

**Enter your Social Security Number before going to the next page** →

**Page 13**

**Figure 1 Question 21, SF-86 (Fillable PDF Version—Revised July 2008)**

Applicants who answer "yes" are required to provide names and addresses of the mental health providers and sign a form authorizing release of mental health information to investigators. The applicants thereby waive their right to confidentiality that otherwise is protected by law. Consultations with mental health professionals are normally considered privileged communications. Not only is mental health information confidential, but even the fact that a person has consulted a mental health professional is considered confidential. Applicants for national security positions necessarily waive certain rights, but the government should make reasonable efforts not to infringe on privacy rights where unnecessary and potentially harmful.

Eligibility requirements for national security positions are based on *The Adjudicative Guidelines for Determining Eligibility for Access to Classified Information* (2005). Psychological conditions fall under one of 13 guidelines used in determining eligibility for a security clearance. *Adjudicative Guideline I, Psychological Conditions* states that "certain emotional, mental, and personality conditions can impair judgment, reliability, or trustworthiness." Refer to Appendix A to see *Guideline I* in its entirety.

The fact that an individual has seen a mental health professional, or has or may have a mental health condition, does not constitute grounds for denying or revoking a security clearance. The relevant issue is whether the individual's condition causes, or may cause, impairment in judgment, reliability, or trustworthiness. This

is an important distinction, emphasized in the *Adjudicative Guidelines*. The vast majority of mental health conditions carry no implications vis-à-vis security risk, and many individuals who consult mental health professionals do not have diagnosable psychiatric disorders.

To avoid discouraging personnel from accessing mental health care, Question 21 includes a statement that "mental health counseling in and of itself is not a reason to deny or revoke security clearance." Additionally, the question allows certain exclusions whereby individuals who have received counseling for specified reasons (marriage, family, grief, and adjustment to military service) are permitted to answer "no" to the question. In these cases, respondents need not disclose that they have consulted a mental health professional.

A primary purpose of the personnel security investigation is to identify individuals who are unfit to hold security clearances, and ultimately to ensure the fitness for service (e.g., judgment, reliability, trustworthiness) of cleared personnel (e.g., as specified in E.O. 12968). This report considers whether Question 21 furthers these ends. The rationale for the proposed Question 21 revision reflects consultations with several leaders in psychiatry and psychology (e.g., contributors to the *Diagnostic and Statistical Manual of Mental Disorders*, members of American Psychiatric Association Practice Guidelines committees, faculty members responsible for shaping training requirements for psychologists and psychiatrists). The subject matter experts who provided input supported a "relevant risk" approach as proposed in this report. Some noted parallels with application requirements for physician licensing which, in the past, required disclosure of mental health utilization or conditions but now focus only on mental health issues specifically relevant to potential physician impairment. Experts believe this type of "relevant risk" approach better protects the public interest.

The primary conclusion of this report is that Question 21, in its current form, does *not* further national security interests and represents an example of the law of unintended consequences. Inclusion of the question likely serves to *undermine* rather than enhance the overall fitness of a cleared workforce. Additionally, the question appears inconsistent with Department of Defense (DoD) goals and policies with respect to mental health.

## CONTROVERSY SURROUNDING QUESTION 21

Question 21 has been problematic and a source of controversy for years. The major concern is that its inclusion in SF-86 contributes to the stigma associated with mental health care and discourages individuals from accessing mental health services due to fear that reporting it could jeopardize their security clearance or otherwise adversely impact their careers (Department of Defense Task Force on Mental Health, 2007). There is a widespread perception, especially in military circles, that seeking mental health care is a "career ender" (Acosta, et al., 2014). Whether this is true or not, the perception constitutes a barrier to seeking care.

The DoD Task Force on Mental Health explicitly recommended revision of Question 21 due to concerns about stigma and over-inclusiveness, stating, "It is the opinion of the Task Force that this requirement is too broad" (Department of Defense Task Force on Mental Health, 2007, p.21). The report also advocated a "relative risk" approach to security screening, recommending that DoD "should work to clarify those mental health conditions that must be reported because they are indicative of defects in judgment, reliability, or emotional stability" (p. 21 ) (see also Burnam et al., 2009; Department of Defense Task Force on Mental Health, 2007; Rand Center for Military Health Policy Research, 2008).

More recently, in March 2014, the Secretary of Defense approved recommendations of the Washington Navy Yard Shooting Internal and Independent Reviews and directed the Under Secretary of Defense for Intelligence (USD(I)) to conduct further analysis for the recommendation to strengthen mental health care (Secretary of Defense, 2014). This recommendation called for substantially revising the wording of Question 21 as well as developing more effective measures to screen recruits, separate those unfit for service, further de-stigmatize treatment, and ensure the quality of mental health care within the Department.

Because mental health conditions that represent security risks are the rare exception, the majority of individuals who may avoid mental health care, due to their concerns of having to report the treatment, likely do not pose a security risk, have honorably served their country, and would continue to honorably serve their country. In many cases, mental health problems developed or were exacerbated as a result of military service, as illustrated by high rates of Post-Traumatic Stress Disorder (PTSD), depression, and suicidality among soldiers returning from service in Iraq and Afghanistan.

When personnel avoid utilizing mental health services because of stigma, the long-term impact is a *less* fit workforce and an associated increase in security risk. By way of analogy, a soldier's fitness for duty would not be enhanced by avoiding necessary *medical* care; on the contrary, fitness could be adversely and severely impacted. The same is true for mental health care. Impediments to health or mental health care detract from the overall fitness of a cleared workforce or any workforce.

These issues are widely recognized and DoD has taken steps to address better the mental health needs of service members (e.g., U.S. Army, 2010). The Army's *Comprehensive Soldier Fitness* program utilizes psychological interventions proactively to develop mental resilience, and there are parallel efforts in other branches of the military including the Air Force, Navy, and Marine Corps. Such programs can be considered the psychological equivalent of preventive medicine. Post-deployment mental health screening of soldiers returning from combat duty is routine and congressionally mandated.

The August 17, 2011 DoD Instruction (Subject: "Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service

Members") explicitly addresses military culture and stigma associated with mental health care (Appendix I). Per this Instruction, it is DoD policy to "foster a culture of support in the provision of mental health care…in order to dispel the stigma of seeking mental health care." The instruction further states, "Healthcare providers shall follow a presumption that they are *not* to notify a Service member's commander when the Service member obtains mental health care" (emphasis added).

Inclusion of Question 21 in SF-86 appears to be at cross-purposes with DoD policy in that it fosters stigma, contributing to a culture that is *not* supportive with respect to mental health care. The question appears to be a holdover from an earlier, less psychologically enlightened time when prejudice and misunderstanding of mental health issues were commonplace and there was often an implicit or explicit presumption that "people who go to therapists are crazy."

Question 21 appears anachronistic in the present day. Service members routinely receive preventive mental health care (e.g., the Comprehensive Soldier Fitness program). Congress mandates routine screening of U.S. soldiers for depression, PTSD, and other mental health conditions upon return from deployment (Hyams et al., 2002; Wright et al., 2005). In addition, epidemiological studies show that mental health conditions (e.g., depression, adjustment disorders) are the most common condition seen in primary care medical settings.

With respect to utilization of mental health services, a report in the *Journal of the American Medical Association* found that approximately *one third* of Operation Iraqi Freedom veterans accessed mental health services within the first year of post-deployment (Hoge, et al, 2006). This figure underestimates actual utilization of mental health services because it does not include service members who obtained mental health services through civilian providers and did not utilize military benefits, and because mental health issues are often addressed in primary care settings where they are not recorded as primary diagnoses. More recently, the 2014 *Medical Surveillance Monthly Report* found that "Mental Disorders" were the second leading reason for "medical encounters" among active duty U.S. military servicemembers (approximately two million encounters reported in 2013), and the leading cause for "lost work time" and "hospital bed days" (Armed Forces Health Surveillance Center, 2014).

Counterbalancing the previously noted considerations regarding stigma and barriers to mental health care is the need to protect national security by identifying individuals with mental health conditions that could impair judgment, reliability, trustworthiness, or otherwise pose a security risk. Thus, there are inherent contradictions between DoD policies intended to reduce stigma and policies intended to ensure that unsuitable individuals do not hold security clearances. Historically, there has been resistance in the security community to proposals to eliminate or substantially alter Question 21.

The outcome of these contradictions has thus far been a series of modifications to Question 21 beginning in the mid-1990s (initially through the influence of Hillary Clinton following the suicide of Deputy White House Counsel Vince Foster). The modifications have followed the general strategy of retaining the substance of Question 21 while adding *exemptions* that permit individuals who have received mental health counseling to answer "no" to the question depending on the reason for counseling (thus the current exemptions for counseling related to marriage, family, grief, or adjustment from service in a military combat environment). In 2007, the main DoD concern was that military personnel returning from Afghanistan and Iraq might not seek treatment for PTSD because they would be forced to respond "yes" to Question 21 and potentially lose their security clearance (the question was revised in 2008 so that individuals treated for combat-related PTSD were exempted from answering "yes"). Currently, DoD is concerned that military personnel who are victims of sexual assault may avoid counseling for the same reason (see, e.g., Department of the Army, 2012; Defense Task Force on Sexual Assault in the Military Services, 2009). Although it is likely that the great majority of exempted individuals do not have a mental health condition that poses a security risk, exempting such groups categorically will necessarily overlook a small but important percentage of individuals with high-risk conditions.

An Office of the Director of National Intelligence (ODNI)-led Question 21 Working Group (WG) recommended new language for Question 21in June 2013. The goal of the WG was to develop language targeting only mental health issues of concern to national security while de-stigmatizing treatment and protecting privacy of respondents to the greatest degree possible. On July 18, 2013, this new version of Question 21 was posted in the Federal Register on behalf of ODNI for comment. Though the new version offers some improvements over the July 2008 version, it retains the same basic weaknesses.

The American Psychological Association (APA) responded to the 30-day notice and request for comments on the new version of Question 21 in the Federal Register.[1] The APA noted "…the revision does not address the key deficiency of the existing version of Question 21, namely, its over-inclusiveness. Both the existing question and the proposed revision incorporate the vague term 'mental health condition': (or, 'emotional or mental health condition'). 'Mental Health condition' … could be understood to include many minor disorders of no relevance to national security."

The APA pointed out that the "…proposed revision to Question 21 assumes that the applicant him or herself is well-positioned to assess whether any such 'mental health condition' has 'adversely affected [his or her] judgment, reliability, or trustworthiness'. It would be difficult enough for a highly trained mental health professional to arrive at an educated opinion regarding such ambiguous personal

[1] APA submitted comments on September 23, 2013 (H. O'Beirne Kelly, personal communication, September 23, 2013). The comments were not considered by the Office of Personnel Management (OPM) since they were received after the August 19, 2013 deadline.

characteristics as an individual's 'judgment,' 'reliability,' and 'trustworthiness.' Relying on the applicant to self-report whether or not a mental health condition has 'adversely affected' him or herself is plainly inadequate."

The APA recommended revising Question 21 so that individual responses to the question are verifiable by recourse to evidence other than the applicant's self-reported information. In addition, Question 21 should be relevant, in that the disorders listed in the question are limited to those whose relationship to behavior bearing on national security concerns is most firmly established by clinical experience and empirical research.

This report argues that the strategy of adding *exemptions* to Question 21 has resulted in a cumbersome and ambiguous question that fosters stigma *and* fails to adequately protect security interests where mental health conditions may pose a security risk. A new approach is needed.

## PERVASIVENESS AND IMPACT OF STIGMA

The role of stigma as a barrier to care is not hypothetical but represents a serious and pressing problem. Mental illness stigma "directly affects people with mental illness, as well as their support system, provider network, and community resources…Policy change is essential to overcome the structural stigma that undermines government agendas meant to promote mental health care" (Corrigan et al., 2014).

As noted earlier, many in military circles believe that utilization of mental health services is a "career ender." Empirical studies confirm this and highlight the magnitude of the problem. A report in the *New England Journal of Medicine* examined the issue of stigma, studying members of four U.S. combat infantry units (three Army units and one Marine Corps unit) using an anonymous survey (Hoge et al., 2004). The survey screened for mental health conditions and inquired about perceived barriers to mental health care. Barriers to accessing mental health care due to stigma *were greatest among service members who met screening criteria for a mental disorder*. In other words, those who most needed help were the least likely to seek it. The study found that *fifty percent of service members who screened positive for a mental health condition believed that mental health treatment would harm their careers*. Approximately 60% believed that their leadership would treat them differently, that they would be perceived as weak, and that members of their unit would have less confidence in them. Nearly 40% reported that they did not trust mental health professionals, presumably due to concerns that the professionals might disclose private information to their leadership or otherwise fail to protect their confidentiality. Another indication of the pervasiveness of stigma is the discrepancy between soldiers' responses to anonymously completed mental health screening questionnaires versus responses to the official Post-Deployment Health Assessment which becomes part of soldiers' medical record. Reporting of depression, PTSD, suicidal ideation, and interest in receiving mental health care is

*two-fold to four-fold higher* on anonymous surveys compared to the non-anonymous military survey. Other research also documents the persistence and high level of concern among service members about adverse consequences of accessing mental health care (see also Kim et al., 2011; Rand Center, 2008; Weinick et al., 2011).

# UNINTENDED CONSEQUENCES OF QUESTION 21: AN ANALOGY WITH MEDICAL CARE

An analogy with medical care serves to highlight both the ineffectiveness and unintended adverse consequences of Question 21 as it is currently written.

Certain medical conditions necessarily preclude individuals from holding certain positions. For example, a person who suffers from epilepsy and experiences uncontrolled seizures is not suited to be a pilot. He or she may perform admirably in any number of positions of responsibility, but the danger the individual would pose as a pilot is obvious. The existence of the medical condition is a legitimate and necessary reason to deny or revoke flight clearance.

It seems doubtful that a personnel selection procedure would attempt to screen for this type of risk by asking, "In the last seven (7) years, have you seen a doctor?" The unworkability of such an approach vis-à-vis medical conditions is self-evident. The question casts such a broad net that the information it yields would be of little practical use. The over-inclusivity of the question could not be adequately remedied by adding exemptions that allow applicants to answer "no" depending on the medical condition. The list of appropriate exemptions would be potentially infinite (e.g., "Answer no if the medical appointment was due to influenza, skin rash, high cholesterol, pneumonia, fractured ribs… etc., etc."). If the question led pilots to avoid medical care due to fear that merely seeing a doctor could adversely affect their careers, safety risk would *increase* rather than decrease.

If it could be determined with absolute certainty that the person's medical condition was strictly related to military service, the individual would *still not be capable of performing safely* as a pilot and should not have flight clearance. If the condition adversely impacts safety or security, the cause of the condition is ultimately irrelevant from a security perspective. Moreover, the question of whether a physical health or mental health condition is or is not service-related often has no clear answer. For example, if a service member developed high blood pressure while deployed, would it be considered related to combat service? Would the service member have developed high blood pressure if he were not deployed? Was it caused by combat service, genetic predisposition, diet and lifestyle, or some complex combination of these and other factors? Such questions are often inherently unanswerable.

While the illogic of attempting to screen personnel by asking whether they have seen a doctor is self-evident when applied to *health* conditions, this approach to screening seems reasonable and acceptable to some when applied to *mental health* conditions, despite the fact that the logic is identical. Among all health concerns, mental health remains singled out for "special" treatment. The fact that such an approach appears reasonable when applied to mental (but not physical) health speaks to the persistence of prejudice and stigma.

In the context of screening for *medical* conditions, it is apparent that casting so broad a net is counterproductive. People go to the doctor for countless reasons that have no bearing on issues related to security. It is also self-evident that discouraging people from getting medical care would result in a *less fit* workforce, ultimately increasing rather than decreasing security risk. The same considerations apply to mental health care.

## ADVERSE IMPACT ON QUALITY OF MENTAL HEALTH CARE FOR CLEARED PERSONNEL

When patients receiving mental health treatment authorize the release of mental health information, even voluntarily, or believe they may have reason to authorize release of such information in the future, the relationship between patient and therapist is unavoidably changed in ways that can profoundly and adversely affect treatment and lead to sub-standard care. A basic therapy principle is that psychotherapy requires *absolute* privacy and confidentiality.

In other words, for therapy to be maximally effective, the confidentiality and privacy of therapy sessions must be protected by an inviolable firewall. Although the patient is legally entitled to waive his or her right to confidentiality, a knowledgeable therapist may strongly and rightfully advise the patient not to do so. The patient's legal right does not necessarily coincide with the requirements of effective treatment. The reasons are not readily apparent and may initially seem counter-intuitive. However, the following example will serve to clarify.

Treatment of PTSD typically requires that the patient discuss the trauma and the meanings it holds for him or her. Some of the most severe cases of PTSD are not, in fact, caused by situations in which the soldier's life is endangered, but rather by the soldier's own actions that violate core morals and beliefs and with which they are subsequently unable to tolerate. Irrespective of whether the soldier has acted properly in the eyes of the military, they may *feel* that they are murderers or have committed atrocities or war crimes. In such cases, the soldier is overcome by a level of guilt and shame that often makes it impossible to think about, let alone talk about, the experiences underlying the post-traumatic condition. It will take work on the part of both patient and therapist to make it possible for the soldier to speak about the traumatic experiences and the feelings associated with them.

The outcome of the treatment is uncertain even under optimal conditions, and the work of the therapy will be difficult. Therapy requires that the patient have absolute freedom to explore their inner experience and to think and discuss *anything*. They may reveal things to the therapist that they have never revealed to anyone before. They may reveal things in therapy that they have not previously revealed to themselves. The freedom to engage in such self-exploration depends on the certainty that *nothing said in therapy* will impact their life circumstances or be disclosed outside of therapy for any reason (with precious few exceptions; see section, "Exceptions to the General Principal of Confidentiality" later in this report).

If the service member believes that what they tell the therapist could negatively impact their career, therapy productivity suffers. The solution in such cases is a firewall protecting the confidentiality of the therapy. Specifically, the functions of fitness evaluation and treatment are fundamentally incompatible and should be kept separate. Psychological evaluation is one function psychologists perform and treatment is another. A psychologist (or other counselor) should not attempt to provide both functions for the same patient.

If a mental health assessment is required for purposes of a personnel security investigation, it should be conducted on behalf of DoD by a professional *other than the treating therapist*. Failure to separate the functions of evaluation and treatment results in sub-optimal care and may close off the only pathway to recovery for many individuals. Under such circumstances, a knowledgeable and ethical therapist may not only advise a patient that it is not in his or her best interest to authorize the release of mental health information, but they may reasonably refuse to comply with a request for mental health information even if authorized. The patient cannot be expected to recognize the negative implications for therapy of authorizing the release of mental health information; the therapist, however, must recognize them. Asking a treating clinician to offer an opinion in the context of a personnel security investigation often creates an untenable bind for the clinician, even where the clinician's input regarding security clearance would be favorable.

Policies that separate treatment and assessment functions have been implemented in government agencies, notably in Department of Energy (DoE) and National Nuclear Security Administration sites where DoE psychologists perform evaluations specifically for assessing fitness, and independent clinicians provide clinical care when needed.

The need for a "firewall" to protect the confidentiality and privacy of therapy is recognized by the United States Supreme Court. In Jaffee v. Redmond (1996), the U.S. Supreme Court stated, "Effective psychotherapy depends upon an atmosphere of trust in which the patient is willing to make a frank and complete disclosure of facts, emotions, memories, and fears. Because of the sensitive nature of problems for which people consult psychotherapists, disclosure of confidential information made during counseling sessions may cause embarrassment or disgrace. For this reason, *the mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment*" (emphasis added).

It does not serve the interests of national security to implement a policy that leads to a lower standard of care for individuals who hold, or may wish to hold, security clearances. This report argues that personnel security investigations should *not* routinely seek access to mental health information or records, ask applicants to disclose names of providers, or ask them to authorize release of mental health information. If a psychological evaluation regarding security or reliability fitness is warranted, it should be conducted by an independent mental health professional qualified to conduct such evaluations.

## SPECIFIC LIMITATIONS AND ADVERSE CONSEQUENCES OF QUESTION 21

(1) ***It is not productive as a source of information leading to security clearance denial or revocation.*** Statistical analyses of over 3.5 million security determinations from 2006 to 2010 make clear that mental health conditions alone almost never lead to adverse determinations (Fischer & Morgan, 2002). In virtually all cases of adverse determinations where mental health, personality, or other psychological factors may have played a role, personal conduct (e.g., as observed by supervisors or co-workers), not information obtained from mental health providers, led to the adverse determination. Security clearance denials or revocations due to mental health alone accounted for 0.002% of adverse determinations. Even in these cases, responses to Question 21 did not necessarily play a role, as the question was likely answered "no" in an unknown number of cases (relevant data were not available for analysis).

(2) ***It wastes government resources.*** The false positive rate (i.e., "yes" responses to Question 21 that ultimately do not bear on security determinations) is exceedingly high—over 99%—based on data from the Joint Personnel Adjudication System (JPAS, see #1). Each false positive nevertheless prompts additional investigation, interviews, etc., costing time, resources, money, and labor that would be better allocated elsewhere.

(3) **Mental health conditions that *do* pose security risks are not adequately screened.** Question 21 allows exemptions so that applicants who have received mental health treatment may answer "no" (e.g., if the mental health condition is "related to adjustments from service in a military combat environment"). These exemptions fail to protect national security interests. Individuals who have mental health conditions that in fact impair reliability, judgment, or trustworthiness pose a threat to national security *irrespective of the cause of the mental health condition*. To return to the earlier analogy of a pilot who suffers from uncontrolled seizures, the reason for the medical condition is ultimately irrelevant. Irrespective of the cause of the condition, the pilot is unsafe to fly and should not have flight clearance.

(4) ***The question often has no meaningful answer.*** The question permits exemptions so that individuals who have received mental health treatment may answer "no" if the counseling was "strictly" for marital, family, or grief, or for adjustments from military service in a combat environment. However, mental health issues are complexly determined and rarely lend themselves to clear determinations of cause and effect. It is nearly always impossible to determine whether counseling is "strictly" for the reasons covered by the exemptions. Issues related to marriage, family, and grief give rise to, and are typically accompanied by, depression, anxiety disorders, and a range of other diagnosable conditions described by the *Diagnostic and Statistical Manual of*

*Mental Disorders* (DSM-5). Conversely, such mental health conditions virtually always impact marriage and family. In short, few if any psychological treatments could legitimately be determined to be "strictly" related to the exempted issues and any form of objective verification would be virtually impossible.

Similar considerations apply with respect to the exemption concerning "adjustments from service in a military combat environment." Here, too, there is no simple cause and effect with respect to the development of mental health conditions and it is impossible to define clearly what this exemption might or might not cover. The following examples illustrate this shortcoming.

There is a high prevalence of depression in service members returning from combat missions, but assertions that the military service "caused" the depression would be simplistic and psychologically naïve. Depression results from a confluence of psychological factors. If a service member who has (for example) witnessed deaths on the battlefield subsequently suffers depression, the "cause" of the depression lies as much in early experiences that shape the psychological meaning of loss as it does in the battlefield experience *per se*. "Causes" may likewise occur subsequent to the combat experience, as when stressors, blows to self-esteem, or subsequent losses trigger vulnerabilities that may be traceable in part to combat experiences. Again, it is often impossible to clearly identify causes or allocate degree of causation. Multiple factors are inherently psychologically intertwined.

As another example, consider a woman who is sexually assaulted in the line of service. She may or may not seek counseling or develop mental health symptoms. Her reaction to the assault *is shaped by every previous experience of trauma in the woman's life* and by the psychological meanings they hold. Neither the sexual assault nor earlier trauma is "the cause" of subsequent symptoms. A person with a history of childhood abuse may become completely dysfunctional, and a person whose early circumstances were more favorable may suffer little lasting effect. Here, too, past and present are intertwined.

(5) **The question creates an incentive for honest personnel to misrepresent or hide information.** Because of the inherent ambiguity of determining the reason for counseling, the response to the question ultimately rests on subjective interpretation. Respondents may not know the "correct" answer and have a strong incentive to rationalize a "no" response to Question 21. Objective verification of the information provided (or omitted) is generally impossible.

(6) **It adversely impacts the quality of mental health care.** The mere possibility that information disclosed in the course of therapy could impact the determination of a security investigation necessarily changes the nature of

a therapy relationship and may lead to sub-optimal or sub-standard care. This is true irrespective of whether an opinion offered by the provider is ultimately favorable or unfavorable. (See section "Unintended Consequences of Question 21: Adverse Impact on Quality of Mental Health Care.")

(7) **It adversely impacts the mental health professions**. Because the confidentiality of psychotherapy is not just a legal or professional ethical issue but also a *clinical* issue that impacts quality of care, providers who are asked to provide opinions for purposes of personnel security investigations are necessarily placed in a compromised position. Irrespective of legal requirements, providers should not serve in the dual capacity of providing evaluations and providing clinical treatment. To ensure optimal care, these functions should be kept separate. Knowledgeable therapists (and Supreme Court justices) understand this and will seek to protect the "firewall" of privacy surrounding psychotherapy. Less knowledgeable therapists may not understand this, and professional standards can be eroded by policies that seek to normalize dual professional roles that are inherently problematic. Such policies may also compromise the perceived trustworthiness of the mental health professions due to ambiguities regarding privacy and confidentiality.

(8) **Information obtained from mental health providers is unverifiable and of questionable value.** When psychologists or other mental health professionals are placed in a situation that inherently leads to divided loyalties and motives, they are likely to resolve the contradiction by treating interviews with investigators as a *pro forma* activity and providing stock answers that are of little value with respect to security determinations. There is generally no possibility of objective verification of information provided (or withheld) by mental health providers.

## EXCEPTIONS TO THE GENERAL PRINCIPLE OF CONFIDENTIALITY

Although this report has argued strongly that it is counterproductive to inquire about mental health utilization in personnel security investigations, and for the need to respect the privacy and confidentiality of a therapy relationship, there are circumstances that represent necessary exceptions to the general rule. The law recognizes some limits to patient confidentiality, as when there is imminent risk of harm to self or others. In a military combat environment, confidentiality would likewise end where the provider believes there is a serious risk of harm to a specific military operational mission (as noted in the August 17, 2011 Department of Defense Instruction, subject "Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members," Enclosure 2). The last situation parallels the "duty to warn" that applies when a clinician believes that a patient poses an imminent danger to others (as initially established by the 1976 *Tarasoff* decision by the California Supreme Court). Note, however, that *these*

*exceptions to the general rule of confidentiality apply in extreme and dire circumstances*.

Under specific circumstances involving imminent risk of harm to self, others, or a military mission, there is justification for breaching the therapy "firewall" and overriding the otherwise inviolable principal of confidentiality. However, a policy of *routinely* overriding confidentiality ultimately detracts from the overall mental fitness of a cleared workforce. Application for security clearance or review of clearance status does not meet the standard of imminent risk and does not justify breaching the confidentiality of a therapy relationship.

# PROPOSED REVISION TO QUESTION 21

For the reasons discussed earlier, Question 21 as currently written casts so wide a net as to be of little practical value, and in the long run undermines rather than protects national security interests. The importance of patient confidentiality would suggest elimination of Question 21 from form SF-86 altogether. However, the *Adjudicative Guidelines* recognize that some mental health conditions do impair, or have significant potential to impair, judgment, reliability, or trustworthiness and to pose security risks.

The solution to this contradiction is not to cast the widest possible net with Question 21 by requiring disclosure of *any* consultation with a mental health professional, then adding exemptions that are inherently ambiguous and unverifiable. The optimal solution is to cast a targeted and focused net aimed specifically at the relatively limited number of mental health conditions where risk of impairment of a kind likely to compromise judgment, reliability, or trustworthiness is high. In other words, a revision to Question 21 should use a "relevant risk" approach to refocus the question on the specific conditions that *should* be of interest with respect to personnel security ("what do we care about") rather than attempting to specify what need not be reported ("what you do not have to disclose").

The proposed revised Question 21 is as follows:

**21a. Have you ever been diagnosed by a physician or mental health professional with psychosis, schizophrenia, schizoaffective disorder, delusional disorder, bipolar mood disorder, borderline personality disorder, or antisocial personality disorder?**

**21b. In the past 7 years, have you been hospitalized for an emotional or mental health condition?[2]**

## RATIONALE

Mere utilization of mental health services is not and should not be of relevance for the purpose of security clearance determinations. In the overwhelming majority of cases, even the existence of a diagnosable mental health condition is not of relevance. For example, depression is epidemiologically the most prevalent mental health condition seen in health care settings. It carries no implications vis-à-vis

[2] For military personnel, it may seem appropriate to expand 21b to include a "Commander directed mental health evaluation"; however this would (1) result in greater "false alarms," stigmatization and other adverse consequences outlined throughout this paper and (2) be unnecessary, given that most or all individuals who present a true risk would likely be identified by the psychological conditions or hospitalization triggers in Question 21 as presently proposed. In addition, if a Commander directs that a service member undergo a mental health evaluation, and that Commander is concerned that the service member may pose an imminent security, reliability, or safety risk, the Commander is authorized and responsible for forwarding the concern to an appropriate clearance adjudication facility, human resources department, or security office.

security except in the most extreme cases where functioning is substantially impaired, and even in these extreme cases periods of such acute impairment are generally time-limited and treatable. The likelihood of depression reaching that level of severity is substantially *increased* where there are barriers to mental health care due to stigma and fear of losing a security clearance. Ready access to mental health care is the best insurance that mental health conditions will *not* escalate to a level of impairment that could compromise security.

The number of mental health conditions that should, in fact, raise alarms about judgment, reliability, or trustworthiness, is small. They can be asked about simply and directly. An effective and practical security-screening question would cast a focused net by directly addressing these specific conditions and only these conditions, as in the proposed revised Question 21. The rationale for the inclusion of each condition is described in the following list.

(1) *Psychosis*. The term "psychosis" refers to failure in reality testing. More specifically, the diagnosis of a psychotic condition refers to disorganized thinking and aberrations in logic and reasoning. It may also refer to the presence of delusions or hallucinations. Such aberrations in thinking and perception can severely compromise judgment and reliability and have a high potential to pose a security risk.

"Psychosis" is not a single disorder but is an inclusive diagnosis that subsumes a range of disorders, all characterized by cognitive or perceptual aberrations. Inclusion of "psychosis" in Question 21 therefore casts a wide net with respect to conditions that could cause substantial impairment in thinking, reasoning, or perception. The DSM-5 groups psychotic conditions together in one section of the manual which subsumes Schizophrenia, Schizophreniform Disorder, Schizoaffective Disorder, Delusional Disorder, Brief Psychotic Disorder, Catatonia, Psychotic Disorder Due to Another Medical Condition, Substance/Medication-Induced Psychotic Disorder, and "Unspecified Schizophrenia Spectrum and Other Psychotic Disorder."

Psychotic conditions have a wide range of causes and may be temporary or permanent. They may or may not be controllable with medications. It is possible that someone who has experienced a temporary psychotic state (e.g., as a consequence of a medical condition, an adverse response to a medication, extreme and highly unusual conditions such as prolonged sensory deprivation, etc.) may recover and function well thereafter. It is also possible that a person with a psychotic condition, if properly treated and managed, could potentially function effectively in a sensitive position. There may be cases where a diagnosis of a psychotic condition (e.g., a transient episode in the past, without recurrence) would not preclude a security clearance. However, the degree of impairment associated with psychosis is severe enough that any diagnosis of psychosis should prompt careful investigation.

(2) *Schizophrenia*. Schizophrenia is a specific psychotic disorder characterized by some combination of delusions, hallucinations, disorganized speech (e.g., frequent derailment or incoherence), grossly inappropriate behavior, and what DSM-5 terms "negative symptoms" such as severe restriction in emotional experience, thought or speech, or goal-directed behavior.

(3) *Schizoaffective Disorder*. Schizoaffective Disorder refers to symptoms of schizophrenia with a mood disorder (major depression or mania) superimposed.

(4) *Delusional Disorder*. Delusional Disorder is characterized by the presence of persistent delusions. It is not as severe a mental illness as schizophrenia or schizoaffective disorder in that functioning is generally intact in areas unrelated to the delusion. Delusional Disorder is nevertheless classified by DSM-5 with the psychotic disorders and the degree of dysfunction associated with a delusion may well pose a security risk.

(5) *Bipolar Mood Disorder.* Bipolar Mood Disorder (historically termed manic depression) exists on a continuum of severity. The classic manifestation of the disorder is periodic episodes of mania ("a distinct period during which there is an abnormally and persistently elevated, expansive, or irritable mood") in conjunction with periodic episodes of major depression, although the diagnosis can be made on the basis of a manic episode alone. DSM-5 distinguishes between several subtypes of bipolar mood disorder. Bipolar I Disorder is characterized by one or more full-blown manic episodes, which can reach a psychotic level of severity and often lead to hospitalization. Bipolar II Disorder is characterized by one or more major depressive episodes accompanied by at least one hypomanic episode (less severe in intensity than a full-blown manic episode). Unspecified Bipolar and Related Disorder (previously Bipolar Disorder Not Otherwise Specified [NOS] in DSM-IV) may be diagnosed in individuals who show bipolar symptoms or features but do not meet clear diagnostic criteria for a more specific diagnosis.

Bipolar Disorder can often be managed with medication and would not necessarily preclude a security clearance if the condition is properly treated, the person is under the care of a psychiatrist, and the person has not experienced a manic or hypomanic episode in some time. In recent years, bipolar II and bipolar NOS have become "grab bag," overused diagnoses and it is likely that a substantial number of people who have received these diagnoses do not, in fact, have a bipolar disorder. Despite the ambiguity of meaning of some bipolar diagnoses, the potential for dysfunction is sufficient that further investigation is warranted.

(6) *Borderline Personality Disorder*. Borderline Personality Disorder is a complex personality disorder associated with significant emotional instability, identity disturbance, impulse regulation problems, and unstable and chaotic

interpersonal relationships. It was explicitly identified in empirical research conducted by the Defense Personnel and Security Research Center (PERSEREC) as a security risk factor (Shechter & Lang, 2011).

(7) *Antisocial Personality Disorder.* Antisocial Personality Disorder is characterized by exploitiveness, deceitfulness, irresponsibility, and likelihood of unlawful behaviors. It is discussed in the Adjudicative Guidelines as a disorder that disqualifies an individual from holding a security clearance.

(8) *Hospitalization for an emotional or mental health condition.* Psychiatric hospitalization may occur for a wide range of reasons, often when a person is judged to represent a threat to self or others. A psychiatric hospitalization in and of itself need not preclude a security clearance, especially if the hospitalization occurred long ago, was not indicative of a chronic condition, and the circumstances leading to hospitalization were transient and unlikely to recur. Irrespective of the mental health condition leading to hospitalization, hospitalization indicates a degree of severity that warrants further investigation.

In addition, any revision of Question 21 should include the strongest possible introductory text explaining that treatment and counseling are positive behaviors, supported by the government and that, for most individuals, follow-up on "yes" answers does not result in any consequences for an individual's employment or clearance eligibility.

## VERIFIABILITY

The conditions and treatments addressed by the proposed revised Question 21 are generally independently verifiable. In contrast to patients treated in outpatient settings where diagnostic records are often lax, incomplete, or unavailable, proposed Q21 items #1-#5 would likely be evaluated in a medical setting in which accurate diagnostic records are required and enforced by regulatory agencies. "True" and "false" answers to the proposed question leave little room for subjective interpretation and will generally be independently verifiable via investigation.

Although specifying standardized clinical diagnostic conditions could generate stigmatization for individuals who have received such diagnoses but may be fit for sensitive positions, using less standardized descriptors, such as "conditions related to unstable, unreliable or untrustworthy behavior" would be less effective because the definitional ambiguity inherent in such terms would lead some or many acceptable individuals to answer "yes", i.e., over-report, out of fear that they would be accused of lying on Q21. More importantly, ill-defined descriptors would enable individuals who pose a real risk to answer "no" on the grounds that there are no strict and accepted definitions that connect their condition or behavior of concern to the listed colloquial descriptors.

# CONCLUSION

The current wording of Question 21 is problematic in several respects that undermine its purpose for effective vetting of personnel for sensitive positions. The proposed ”relevant risk” approach to Question 21—focusing only on standardized clinical conditions that could pose a security risk—would not represent an obstacle to mental health care for the overwhelming majority of personnel and is consistent with DoD policy to foster a culture of support with respect to mental health. At the same time, it would be considerably more effective in screening the minority of individuals with mental health conditions that may constitute security risks. The clinical language in the “relevant risk” approach remains valid with respect to the DSM-5.

“Yes” responses to the proposed revised question would carry meaningful implications for security investigations and could trigger psychological evaluations focused specifically on security risk. Such evaluations could be conducted by psychologists authorized by the government for that purpose, not by clinical treatment providers. Clinical treatment and evaluation for investigatory purposes are both functions provided by psychologists, but psychologists should not provide them for the same individual. Blurring of these functions necessarily creates a problematic dual relationship for clinicians that undermines quality of clinical care and generally yields evaluation information of questionable value. Policy should reinforce clear boundaries for mental health professionals between patient care and psychological evaluation for investigative purposes.

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# APPENDIX A:

# GUIDELINE I FROM THE ADJUDICATIVE GUIDELINES FOR DETERMINING ELIGIBILITY FOR ACCESS TO CLASSIFIED INFORMATION

## GUIDELINE I: PSYCHOLOGICAL CONDITIONS

27. *The Concern.* Certain emotional, mental, and personality conditions can impair judgment, reliability, or trustworthiness. A formal diagnosis of a disorder is not required for there to be a concern under this guideline. A duly qualified mental health professional (e.g., clinical psychologist or psychiatrist) employed by, or acceptable to and approved by the U.S. Government, should be consulted when evaluating potentially disqualifying and mitigating information under this guideline. No negative inference concerning the standards in this Guideline may be raised solely on the basis of seeking mental health counseling.

28. *Conditions that could raise a security concern and may be disqualifying include*:

(a) behavior that casts doubt on an individual's judgment, reliability, or trustworthiness that is not covered under any other guideline, including but not limited to emotionally unstable, irresponsible, dysfunctional, violent, paranoid, or bizarre behavior;

(b) an opinion by a duly qualified mental health professional that the individual has a condition not covered under any other guideline that may impair judgment, reliability, or trustworthiness;[1]

(c) the individual has failed to follow treatment advice related to a diagnosed emotional, mental, or personality condition, e.g., failure to take prescribed medication.

29. *Conditions that could mitigate security concerns include*:

(a) the identified condition is readily controllable with treatment, and the individual has demonstrated ongoing and consistent compliance with the treatment plan;

(b) the individual has voluntarily entered a counseling or treatment program for a condition that is amenable to treatment, and the individual is currently receiving counseling or treatment with a favorable prognosis by a duly qualified mental health professional;

(c) recent opinion by a duly qualified mental health professional employed by, or acceptable to and approved by the U.S. Government that an individual's

1 Under the provisions of 10 U.S.C. 986, and person who is mentally incompetent, as determined by a credentialed mental health professional approved by the Department of Defense, may not be granted or have renewed their access to classified information.



**Figure A-1 Guideline I: Psychological Conditions**

previous condition is under control or in remission, and has a low probability of recurrence or exacerbation;

(d) the past emotional instability was a temporary condition (e.g., one caused by death, illness, or marital breakup), the situation has been resolved, and the individual no longer shows indications of emotional instability;

(e) there is no indication of a current problem.